

# AGENDA

## Trust Board – Public Session

**Venue** Anne Gibson Boardroom, City Hospital                                      **Date** 27 September 2012; 1530h

**Members**

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

**In Attendance**

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

**Secretariat**

Mr S Grainger-Payne	(SGP) [Secretariat]
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**Guests**

Mrs F Sanders	(FS) [Item 7]
Prof C Clarke	(CC) [Item 8]

Time	Item	Title	Reference Number	Lead
1530h	1	<b>Apologies</b>	Verbal	SGP
	2	<b>Declaration of interests</b> <i>To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting</i>	Verbal	All
	3	<b>Minutes of the previous meeting</b> <i>To approve the minutes of the meeting held on 30 August 2012 as a true and accurate record of discussions</i>	SWBTB (7/12) 202	Chair
	4	<b>Update on actions arising from previous meetings</b>	SWBTB (7/12) 202 (a)	SG-P
	5	<b>Chair and Chief Executive’s opening comments</b>	Verbal	Chair/ CEO
	6	<b>Questions from members of the public</b>	Verbal	Public
1540h	<b>MATTERS FOR APPROVAL</b>			
7	<b>Health Informatics Service strategy</b>	SWBTB (9/12) 204 SWBTB (9/12) 204 (a)	FS	

	<b>8</b>	<b>Research and Development strategy</b>	<b>SWBTB (9/12) 205 SWBTB (9/12) 205 (a) SWBTB (9/12) 205 (b)</b>	<b>CC</b>
	<b>9</b>	<b>Clinical strategy</b>	<b>SWBTB (9/12) 206 SWBTB (9/12) 206 (a)</b>	<b>RO/ RST</b>
	<b>10</b>	<b>Membership strategy</b>	<b>SWBTB (9/12) 207 SWBTB (9/12) 207 (a)</b>	<b>JK</b>
	<b>11</b>	<b>Estates strategy</b>	<b>SWBTB (9/12) 208 SWBTB (9/12) 208 (a)</b>	<b>GS</b>
	<b>12</b>	<b>Execution of a lease of the Old Chapel, Sandwell Hospital</b>	<b>SWBTB (9/12) 209 SWBTB (9/12) 209 (a)</b>	<b>GS</b>
	<b>13</b>	<b>Estates rationalisation – closure of City Hospital Block 70 Former Cook Chill</b>	<b>SWBTB (9/12) 210 SWBTB (9/12) 210 (a)</b>	<b>GS</b>
<b>MATTERS FOR CONSIDERATION AND NOTING</b>				
<b>1630h</b>	<b>14</b>	<b>Safety, Quality and Governance</b>		
	14.1	Quality report	To follow	RO/ KD/ RST
	14.3	Update from the meeting of the Quality & Safety Committee held on 20 September 2012	Verbal	OD
	14.4	Integrated Risk Report – Quarter 1	SWBTB (9/12) 211 SWBTB (9/12) 211 (a)	KD
	14.5	Delivering the Health Visiting Officer appraisal of progress and support requirements	SWBTB (9/12) 212 SWBTB (9/12) 212 (a)	RO
<b>1700h</b>	<b>15</b>	<b>Performance Management</b>		
	15.1	Monthly finance report	SWBTB (9/12) 213 SWBTB (9/12) 213 (a)	RW
	15.2	Draft minutes from the meeting of the Finance & Performance Management Committee held on 20 September 2012	To follow	RT
	15.3	Monthly performance monitoring report	SWBTB (9/12) 214 SWBTB (9/12) 214 (a)	RW
	15.4	NHS Performance Framework report	SWBTB (9/12) 215 SWBTB (9/12) 215 (a)	RW
	15.5	Performance Management Regime – monthly submission	SWBTB (9/12) 216 SWBTB (9/12) 216 (a)	MS
	15.6	Update on the delivery of the Transformation Plan	SWBTB (9/12) 217 SWBTB (9/12) 217 (a)	MD
<b>1730h</b>	<b>16</b>	<b>Strategy and Development</b>		

	16.1	Clinical reconfiguration update & draft minutes from the Reconfiguration Board meeting held on 13 September 2012	SWBTB (9/12) 218 SWBTB (9/12) 218 (a)	GH
	16.2	'Right Care, Right Here' programme: progress report including update on decommissioning	SWBTB (9/12) 220 SWBTB (9/12) 220 (a)	MS
	16.3	Foundation Trust application programme		
	▶	Monitoring report	SWBTB (9/12) 219 SWBTB (9/12) 219 (a)	MS
<b>1750h</b>	<b>17</b>	<b>Update from the Board Committees</b>		
	17.1	Audit Committee – 13 September 2012	Verbal	GH
	17.2	Charitable Funds Committee – 13 September 2012	Verbal	SS
	<b>18</b>	<b>Any other business</b>	<b>Verbal</b>	<b>All</b>
	<b>19</b>	<b>Details of next meeting</b>		
		<i>The next public Trust Board will be held on 25 October 2012 at 1530h in the Boardroom, Sandwell Hospital</i>		

## MINUTES

### Trust Board (Public Session) – Version 1.0

**Venue** Boardroom, Sandwell Hospital

**Date** 30 August 2012

#### Present

Mr Richard Samuda (Chairman)  
Mrs Gianjeet Hunjan  
Dr Sarindar Sahota OBE  
Ms O Dutton  
Mr P Gayle  
Mr John Adler  
Mr Robert White  
Miss Rachel Barlow  
Miss Rachel Overfield

#### In Attendance

Miss Kam Dhami  
Mrs Jessamy Kinghorn  
Mr Graham Seager  
Mr Mike Sharon

#### Secretariat

Mr Simon Grainger-Payne

Minutes	Paper Reference
<b>1 Apologies for absence</b>	<b>Verbal</b>
Apologies were received from Mr Roger Trotman, Dr Roger Stedman and Prof Derek Alderson.	
<b>2 Declaration of Interests</b>	<b>Verbal</b>
Mr Grainger-Payne highlighted that Non Executive Directors would not be eligible to vote to accept the proposals to indemnify them under agenda item 8 which he would present.	
<b>3 Minutes of the previous meeting</b>	<b>SWBTB (6/12) 171</b>
The minutes of the Trust Board meeting held on 28 June 2012 were approved.	
<b>AGREEMENT: The minutes of the last meeting were approved</b>	



<b>4</b>	<b>Update on actions arising from previous meetings</b>	<b>SWBTB (6/12) 171 (a)</b>
	The Board reviewed the meeting action log and noted that there were no matters requiring escalation or needed to be raised for the Board's attention.	
<b>5</b>	<b>Chair and Chief Executive's opening comments</b>	<b>Verbal</b>
	<p>The Chairman advised that he had undertaken a visit to Leasowes Intermediate Care Centre and a tour of the Halcyon Birthing Unit. He reported that he had also participated in a walk about in the Accident and Emergency Department, during which he advised that it was apparent that the Children's area was not manned at all times. The Board was advised that the Chairman had attended a Pressure Ulcer Roadshow.</p> <p>Mr Adler advised that he had been spending the majority of time since the previous meeting working on activities associated with the FT Integrated Development Plan and undertaking divisional reviews.</p>	
<b>6</b>	<b>Questions from members of the public</b>	<b>Verbal</b>
	There were no members of the public present.	
<b>7</b>	<b>Appointment of a Senior Independent Director</b>	<b>SWBTB (8/12) 173 SWBTB (8/12) 173 (a)</b>
	<p>The Chairman presented a proposal to nominate Mr Roger Trotman as the Senior Independent Director, a role which it was highlighted would play a significant role when the organisation gained Foundation Trust status. It was highlighted that it was customary for the role to be fulfilled by the Vice Chair where this position existed.</p> <p>Miss Overfield suggested that this role could be linked to the Whistleblowing process which was currently being refreshed. It was agreed that this was a sensible approach and that the process should also be monitored either by the Audit Committee or the Quality &amp; Safety Committee. It was agreed that the Whistleblowing policy would be presented to the Trust Board when appropriate.</p> <p>The Trust Board was asked for and gave its approval to the appointment of Mr Roger Trotman as the Senior Independent Director.</p>	
	<b>AGREEMENT: The Trust Board was gave its approval to the appointment of Mr Roger Trotman as the Senior Independent Director</b>	
<b>8</b>	<b>Indemnification of Non Executive Directors</b>	<b>SWBTB (8/12) 174 SWBTB (8/12) 174 (a)</b>
	Mr Grainger-Payne presented a proposal for the indemnification of the Trust's Non Executive Directors, which he advised was linked to the fact that Non Executive Directors were not technically employees of the Trust and were not therefore subject to the usual protections afforded to the Executive members of	

<p>the Board under the standard terms and conditions of employment.</p> <p>The Board was asked to approve a statement that Mr Grainger-Payne advised would be issued to all Non Executive Directors as an indemnity should they be subject to legal action being taken against them personally in the course of their duties for the Trust.</p> <p>It was highlighted that the risk of legal action on the Non Executive Directors was slim, therefore the proposal was as reassurance that they would be reimbursed if needed.</p> <p>The Board was advised that the proposal had been subject to review by the Trust's legal advisers and was in line with practice in place in other Trusts including a number of Foundation Trusts.</p> <p>The Executive members of the Board approved the statement and proposal to indemnify the Non Executive Directors.</p>	
<p><b>AGREEMENT: The Executive members of the Board approved the statement and proposal to indemnify the Non Executive Directors</b></p>	
<p><b>9 Terms of Reference for the Board Committees</b></p>	<p><b>SWBTB (8/12) 192</b>  <b>SWBTB (8/12) 192 (a) -</b>  <b>SWBTB (8/12) 192 (d)</b></p>
<p>Mr Grainger-Payne advised that a review of the Board Committee's terms of reference was included in the annual reporting cycle for the Trust Board but had also been recommended as part of the recent external reviews of the readiness of the Trust for Foundation Trust status.</p> <p>The main changes were highlighted to relate to the format, which it was highlighted followed best practice laid out by the Foundation Trust Network, where in particular, the authority and purpose of the Committee had been clarified.</p> <p>Mr Grainger-Payne reported that the Finance &amp; Performance Management Committee has reviewed its proposed terms of reference at the meeting held on 24 August 2012, and two changes had been suggested which would be incorporated into the final version: the stipulation that the Trust chairman needed to be one of the Non Executive members attending would be removed to allow to provide a degree of flexibility and that the consideration of post project evaluations would be limited to those business cases approved by the Trust Board.</p> <p>It was reported that the annual cycles of business for the Committees would be considered next to ensure that any changes as a result of the revised terms of reference were built into the reports needing to be considered.</p> <p>The Board was asked to approve the terms of reference for the Board</p>	

<p>Committees.</p> <p>In terms of the Audit Committee terms of reference, it was suggested that the assurances that the Committee was to provide to the Board needed to be made more explicit, in addition to its responsibilities for monitoring Data Quality. Ms Dutton noted that the quorum for the Committee was proposed to include two Non Executive Directors, whereas other Committees required the attendance of one. Mrs Hunjan explained that difference was reflective that all Non Executive Directors were members of the Audit Committee, whereas the membership of other Committees was limited to a subset of the team of Non Executive Directors.</p> <p>Mr Adler highlighted that representation on the Quality and Safety Committee was higher than that on other Board Committees. Mrs Dutton advised that this has been discussed as part of the consideration of the Quality &amp; Safety Committee terms of reference, where it had been agreed that for now, this membership was appropriate.</p> <p>The Chairman suggested that every effort was needed to ensure that reporting back from the Committees to the Trust Board was as effective and robust as possible.</p> <p>Ms Dutton suggested that appropriate connections between the Board and the Committees needed to be created to facilitate effective flows of information. She also recommended that a statement be inserted into each terms of reference to advise that Committee members were permitted to nominate a deputy of an appropriate seniority to attend meetings that they were not able to, however these individuals would not count towards the quorum. It was suggested that regulatory requirements should be built into terms of reference where appropriate. Ms Dutton further suggested that the Quality and Safety Committee's responsibility with respect to the Quality Account needed to be incorporated into the terms of reference. It was agreed that the content of the Quality Account should be a matter reserved for the Quality &amp; Safety Committee, whereas the process for the development, External Audit involvement and monitoring the measures to meet any recommendations arising from the review should be a matter to concern the Audit Committee.</p> <p>Subject to the comments and amendments made, the Trust Board approved the terms of reference for the Board Committees.</p>	
<p><b>AGREEMENT: Subject to amendments suggested, the Trust Board approved the terms of reference for the Board Committees</b></p>	
<p><b>10 Risk management strategy</b></p>	<p><b>SWBTB (8/12) 201</b> <b>SWBTB (8/12) 201 (a)</b></p>
<p>Miss Dhami reported that the risk management strategy had been refreshed and an early version had been considered by the Quality &amp; Safety Committee. It was highlighted that the strategy did not provide guidance on the operational handling of risks as this was contained within the Risk Management Policy. The</p>	

<p>Board was advised that the strategy was designed to provide a sounder base from which to manage risk within the organisation and to clarify the accountability for risk management and the assurances that were to be gained from the process. It was noted that the strategy did not provide an explicit reference to the work of Internal Audit.</p> <p>Ms Dutton suggested that the strategy should focus on how risk should be managed down through the organisation and that that an annual review of risk management should be undertaken. It was agreed that this suggestion and the sign off of the risks to be added to the risk register would be included within the Risk Management Policy.</p> <p>Mr Sharon highlighted that the development of the strategy addressed an action raised as part of the Historical Due Diligence review. It was suggested and agreed that an annual discussion of the six strategic priorities and the way in which the agreement of the annual priorities in this context should be included in the strategy. Mr Adler highlighted that a number of the annual priorities were driven by external influences. Miss Dhami advised that this suggestion was captured within section 7.5.2 of the strategy, however she agreed to make this more explicit.</p> <p>The process for the management of the Board Assurance Framework (BAF) was discussed.</p> <p>It was noted that the responsibility for the management of Information Governance should be amended from being the Chief Information Officer to the Director of Governance to reflect the outcome of the portfolio review of the Executive Team. It was also highlighted that the reference to the Governance and Risk Committee should be replaced by the Quality &amp; Safety Committee.</p> <p>The relevance of the number of people impacted by a risk within the Risk Severity Matrix was questioned. It was agreed however that the categories of people affected provided adequate flexibility.</p> <p>Subject to the amendments suggested, the Trust Board approved the Risk Management Strategy.</p>	
<p><b>AGREEMENT: Subject to amendment, the Trust Board approved the Risk Management Strategy</b></p>	
<p><b>11 Quality and Safety strategy</b></p>	<p><b>SWBTB (8/12) 195</b> <b>SWBTB (8/12) 195 (a)</b></p>
<p>Miss Dhami presented the Quality and Safety strategy which she advised had been subject to an annual review. The changes made since the Board approved the previous version were highlighted.</p> <p>It was reported that the strategy would need to be further updated following approval, to incorporate the requirements of the Assurance and Escalation</p>	

<p>Framework that was currently under development.</p> <p>The Chairman suggested that clarity should be provided to ensure that quality and staff performance measures were linked. Mr Adler advised that this linkage was picked up through the monthly quality and performance monitoring reports. It was noted that the Workforce dashboard provided an additional source of information and it was agreed that greater integration with the other reports should be undertaken where possible. Mr Adler suggested that local ownership and clinical management of quality and safety matters needed to specifically include how divisions were supposed to act in relation to their directorates. It was agreed that this would be captured within the implementation plan for the strategy.</p>	
<p><b>AGREEMENT: Subject to minor amendment, the Trust Board approved the Quality &amp; Safety strategy</b></p>	
<p><b>12 Safety, Quality &amp; Governance</b></p>	
<p><b>12.1 Quality Report</b></p>	<p><b>Tabled paper</b></p>
<p>Miss Overfield reported that 93% had been achieved as part of the recent Safety Thermometer audit, with the target being 95% harm free care by the end of the financial year. The Board was advised that the Trust was performing well in this respect in comparison to other Trusts in the region. Ms Dutton asked whether the Safety Thermometer was measured annually. Miss Overfield advised that the Trust had been set CQUIN targets to ensure that the audit was implemented and that 95% harm free care was achieved by the end of 2012/13. The Board was advised that additional local harm indicators were being added into the audit.</p> <p>The measures to achieve eradication of all Grade 3 and 4 pressure sores were reported to be being delivered well. The number of falls was reported to be on a downward trajectory, although it was highlighted that the number of falls at Sandwell Hospital remained higher than those at City Hospital, possibly due to the difference in the configuration of the wards.</p> <p>A baseline audit of avoidable weight loss was reported to have been undertaken and determined that 4.5% of patients experienced avoidable weight loss. Given the low baseline, Miss Overfield reported that renegotiation of the target was being undertaken with commissioners at present. The Board was advised that this measure would be included within the Safety Thermometer audit.</p> <p>The Board was asked to note that there had been some slippage in adherence to protected mealtimes, which it was highlighted appeared to be reflective of the current operational pressures.</p> <p>MRSA rates were reported to be within trajectory, however Miss Overfield advised that additional attention would be given to reaching the screening targets.</p>	

In terms of nurse staffing ratios, it was reported that there had been some delay in bed closures in the Medicine & Emergency Care division, however the workforce plans had progressed, meaning that there was currently a deficit of 40 WTE nurses. Given the additional beds open at present and the plan to open a further complement of beds to handle winter pressures, it was reported that overall the Trust was carrying a gap of 100 nurses and therefore a significant recruitment drive was planned. At present, the Board was informed that the position was being mitigated by bank and agency staff usage. Recruitment for permanent staff to fill the gaps was in progress.

Miss Overfield reported that significant issues had been reported concerning medicines safety, particularly related to the storage of drugs. The Board was advised that Controlled Drugs were not being routinely stored appropriately. It was highlighted that the situation was common in a number of other trusts. The Chairman asked how quickly the situation could be mitigated. Miss Overfield advised that there was confidence that the position could be addressed speedily, however the audits to monitor the situation had only recently been commissioned, therefore there was uncertainty as to the level of previous performance. Much good work was reported to have been delivered in respect of medicines omissions. Mrs Hunjan advised that the Audit Committee was appraised of drugs write offs arising from Pharmacy. Mr White advised that the value of such write offs was now under £100k per year, which represented a significant improvement on previous levels.

In terms of maternity staffing, it was reported that community midwife caseloads were improving. The significant gap in staffing on the labour wards was reported to be being addressed through a recruitment exercise.

The Board was asked to note the outcome of the recent round of ward reviews, where it was highlighted that due to ward reconfiguration, like for like comparison of performance between periods and wards was not possible in some cases. Sickness absence levels in the Medicine & Emergency Care division were highlighted to be concerning, however the position in the Surgery, Anaesthetics & Critical Care division was reported to be showing a steady improvement. Three areas were reported to be in Special Measures at present, including the assessment units and the Emergency Departments.

Regarding the inpatient survey, it was reported that the number of responses received had deteriorated.

The Trust's position in terms of the Net Promoter Score was highlighted to be improving, albeit at a rate less rapidly than that in other trusts. The performance was reported to be 60% in August, which Miss Overfield suggested may reflect the current method of data handling and the structure of the questionnaires used.

The targeted areas of support were reported to include the Emergency Assessment Units. A condition report on Lyndon 4 and Priory 4 was reported to

<p>have been commissioned.</p> <p>Miss Dhama reported that in terms of the complaints backlog, an action plan was being developed and an external body had been engaged to assist with clearing the outstanding complaints and to provide a view on the future handling of complaints. The position as at 31 August 2012 was reported to be expected to show that 67 complaints responses had been issued, which it was acknowledged was a position on which there was a need to improve significantly. As such, the Board was advised that it was planned to issue 70 responses per month with a view to clearing the backlog by November 2012. As a priority, work was being diverted to ensuring that no further cases breached the failsafe targets set. The Chairman asked how the Trust was planning to perform in future against other top performing trusts on complaints handling. Miss Dhama advised that the desired situation would be that all cases, apart from those in exceptional circumstances, were issued by the target dates set. Mr Adler noted that 131 cases were breaching the failsafe targets at present, which represented a deterioration in the position. He remarked that the position did not represent an acceptable trend and therefore requested that a week by week improvement trajectory be set which reversed the trend. Miss Dhama advised that each complaint manager would be assigned a personal target for responses to be issued and that monitoring would be undertaken in real time. Mr Gayle asked whether complaints handling was being devolved to divisions yet. Miss Dhama advised that this measure would be introduced as part of the future complaints handling strategy that was to be developed jointly with the external agency that the Trust had engaged. It was reported that the interim recommendations from the agency would be available in September 2012. Ms Dutton suggested that the position needed to be monitored by the Quality &amp; Safety Committee and agreed that a weekly status report would be produced. Mr Gayle asked whether the complaints handling team was coping adequately with the workload involved with clearing the backlog. Miss Dhama advised that the team was working well, although they were being required to devote some time to support the work of the external agency.</p> <p>The Chairman noted that there were some site specific differences in performance, such as those associated with pressure sores. Miss Overfield reported that some of the ward managers had been changed and additional training and resources had been arranged to address this situation. The Board was advised that measurement of some metrics would be undertaken in an automated way in future.</p>	
<p><b>ACTION: Miss Dhama to develop a week by week improvement trajectory for complaints handling to eliminate the backlog of cases</b></p>	
<p><b>12.2 Bed reconfiguration update</b></p>	<p><b>Hard copy paper</b></p>
<p>Miss Barlow reported that as part of the Transformation Plan, a bed reconfiguration programme delivering a reduction in the number of beds by 98 in the Medicine &amp; Emergency Care Division had been developed. The Board was</p>	

<p>advised however, that delivery of the plan was delayed at present with 45 beds having been closed to date. The Board was advised that substantive staff reduction associated with the bed reconfiguration programme had continued despite this delay and more beds were due to be opened in line with plans to handle winter operational pressures. It was highlighted that the increase in the non-elective emergency activity had exacerbated the position. At a service level, the Board was advised that the Medicine &amp; Emergency Care division had not achieved the pathway redesign requirements to achieve the planned reduction in length of stay.</p> <p>Miss Barlow reported that should the situation not be addressed, there was a risk that staffing levels might become unsafe and that a number of operational and clinical risks may materialise.</p> <p>It was reported that the recruitment programme to equip the Trust for winter operational pressures would not cease and that a second phase of recruitment would be arranged. Ms Dutton asked how these plans related to the current redundancy programme. Miss Overfield reported that a virtual ward had been created to capture those nurses displaced by the programme by siting them into short term vacancies for an interim period. As a result, there was no expectation that any nurses would be made redundant on compulsory terms. In terms of staff morale and engagement however, it was suggested that there was a need to communicate with the staff expecting to move as a result of the bed reconfiguration plans, but had not yet done so as a result of the delayed bed reconfiguration programme to advise that the staff reduction plans would be paused.</p> <p>Mr Gayle noted that the situation predominantly affected the wards at Sandwell Hospital. Miss Barlow advised that this was reflective of the higher level of emergency activity in Sandwell, which had not been equalled at City Hospital. The Chairman asked whether the delivery of the Trust's readiness plans for winter were underway. Miss Overfield reported that the position was encouraging in that early approval had been received to commence recruitment.</p> <p>Mr Adler advised that the delayed bed reconfiguration plan presented significant financial implications which were being considered by the Performance Management Board. The reason for the position was reported to relate to the funds that had been removed from the nursing budgets on the assumption that the beds would close, therefore some open beds were currently unfunded. It was noted that nurse staffing ratios on wards Lyndon 4 and Newton 4 presented a particular concern at present. Mr White advised that the financial implications were not yet impacting on the overall position of the Trust and that there was sufficient financial flexibility to address the position at present.</p> <p>Ms Dutton commented that the plans suggested that the Trust was acting flexibly based on the evidence available, to ensure that patient experience was not compromised.</p>	
<p><b>12.3 Update from the meeting of the Quality &amp; Safety Committee held on 19</b></p>	<p><b>Verbal</b></p>



<b>July 2012</b>	
<p>Ms Dutton advised that the discussions at the Quality &amp; Safety Committee meeting held on 19 July 2012 considered the future role of the Committee and the type of reports that would be presented in line with the revised remit.</p> <p>In terms of the significant areas of concern that the Committee considered, it was reported that the positions of the Emergency Departments, compliance with the use of the World Health Organisation (WHO) checklist and the outcome of the Care Quality Commission visit to Sandwell Hospital had been presented.</p> <p>It was reported that the decision had been taken to hold the meetings on a monthly basis and that divisions would attend the meeting on a rotational basis.</p>	
<b>12.4 Care Quality Commission report on Sandwell Hospital</b>	<b>SWBTB (8/12) 177</b> <b>SWBTB (8/12) 177 (a)</b>
<p>Miss Overfield presented the formal report received following the visit by the Care Quality Commission to Sandwell Hospital. It was reported that the visit was a responsive review prompted by a complaint, therefore the outcome where no recommendations for improved practice had been proposed, was pleasing.</p> <p>The Board was advised that as part of a recent meeting with the Care Quality Commission local representatives, the Trust had been reminded that a review against general standards was expected at both City and Sandwell hospitals by March 2013.</p>	
<b>12.5 LINKs 'Enter and View' visit</b>	<b>SWBTB (8/12) 189</b> <b>SWBTB (8/12) 189 (a)</b>
<p>Miss Overfield presented a report received from the Local Involvement Networks (LINKs) following a recent 'Enter and View' visit. It was highlighted that the outcome had been generally satisfactory.</p>	
<b>12.6 Health &amp; Safety policy</b>	<b>SWBTB (8/12) 179</b> <b>SWBTB (8/12) 179 (a)</b> <b>SWBTB (8/12) 179 (b)</b>
<p>Miss Dhimi presented the Health and Safety policy that she advised had been approved recently by the Trust Management Board.</p> <p>It was highlighted that the changes made to the policy were minimal.</p> <p>The Trust Board received and noted the refreshed policy.</p>	
<b>12.7 Board Assurance Framework</b>	<b>SWBTB (8/12) 199</b> <b>SWBTB (8/12) 199 (a)</b>
<p>Mr Grainger-Payne presented the Board Assurance Framework (BAF) which he advised represented the steps being taken to address any gaps in control and assurance in the management of the risks to the delivery of the Trust's annual priorities as of the end of Quarter One.</p> <p>It was highlighted that the new format for the BAF incorporated the</p>	

<p>recommendations from the recent FT readiness reviews and the annual Internal Audit evaluation in that in particular, greater effort had been directed to ensuring that there was a closer link made between the sources of control and assurance and the agendas on which the associated reports were considered.</p> <p>The Board was asked to note that in the majority of cases, the actions being taken to address the gaps in control and assurance reduced the severity of the risk, however in three instances the pre and post mitigation status remained at red: care delivered by the Emergency Departments; delivery of the key activities of the FT programme plan; and implementation of the 'Right Care, Right Here' patient pathways.</p> <p>Mr Grainger-Payne advised that at a future meeting, the Board would be asked to agree the addition of the red risks reported within the BAF to the Corporate Risk Register.</p> <p>It was suggested that the proposed risk scores for the entry related to the 'Right Care, Right Here' patient pathway might need to be reviewed. Mr Sharon advised that the score was reflective of the magnitude of exposure to financial risk as a result of non-delivery of some parts of the programme. He reminded the Board that the 'Right Care, Right Here' programme was a key element of the Trust's strategy. Mr White added that the assumed efficiencies from the programme had been removed from the contract. It was agreed however that a more realistic post mitigation status would be amber.</p> <p>Ms Dutton questioned whether the post mitigation score for the risks concerning care delivered from Emergency Departments should be higher given the nature of the issues reported in connection with this area recently. Mr Adler advised that the additional Special Measures provided a good source of control, however this did not warrant the residual risk being rated as any lower than 15. In terms of additional measures that could be implemented, Mr Adler suggested that improved local leadership needed to be delivered and arranging supplementary capacity.</p> <p>In terms of the risk assessment for the delivery of the FT programme, it was agreed that the assessment made was appropriate given the challenge presented by the need to develop the detailed two year Transformation savings Plans.</p> <p>It was agreed that the BAF was a useful tool for highlighting the areas of high risk that required the focus of the Board.</p>	
<p><b>12.8 Information and reporting map</b></p>	<p><b>SWBTB (8/12) 198</b> <b>SWBTB (8/12) 198 (a)</b></p>
<p>Mr Grainger-Payne reported that a number of key recommendations from the external FT readiness assessments had suggested that the information flows between the Board and the Committees needed to be reviewed.</p> <p>The Board was asked to note a summary of all reports currently presented to the Trust Board, the Board Committees and the Executive Boards.</p> <p>It was reported that as a next step, each report would be reviewed by the</p>	

<p>relevant sponsoring director, who would be asked to make an assessment as to how it should be handled in future, bearing in mind a set of key principles such as the need to reduce duplication of information being considered, ensure that the Board Committees took a more active role in considering detailed information and reporting by exception.</p> <p>The Board was asked to note that considerable progress had been made with rationalising some of the reporting to the Board with the introduction of the monthly Quality report.</p> <p>Mr Grainger-Payne advised that the consideration of the reports would occur at a future meeting of the Executive Team and that the work would be informed by the revised terms of reference that had been approved earlier in the meeting.</p> <p>The Board was advised that a proposal as to how the reporting might operate in future would be brought to a future meeting of the Trust Board for approval.</p>	
<p><b>ACTION: Mr Grainger-Payne to present a proposal for the future handling of reports at a future meeting of the Trust Board</b></p>	
<p><b>12.9 Board performance assessment template and process</b></p>	<p><b>Hard copy paper</b></p>
<p>Mr Adler advised that a recommendation arising from the external FT readiness reviews suggested that the Board should review its performance on a routine basis.</p> <p>It was highlighted that although the process was straightforward, there was at present an overlap with the Board Governance Assurance Framework (BGAF) process.</p> <p>Mr Adler suggested that the timings of the assessment should coincide with appropriate points in the FT application process initially.</p> <p>The Trust Board approved the proposed template and process for Board self evaluation.</p>	
<p><b>AGREEMENT: The Trust Board approved the proposed template and process for Board self-evaluation</b></p>	
<p><b>13 Performance Management</b></p>	
<p><b>13.1 Monthly finance report</b></p>	<p><b>SWBTB (8/12) 176</b> <b>SWBTB (8/12) 176 (a)</b></p>
<p>Mr White reported that financial performance was £29k ahead of plan, with a surplus of £195k having been achieved in month against a plan of £166k. It was highlighted that the monthly surplus targets would increase in the coming periods.</p> <p>In terms of divisional performance, the Board was advised that there had been no significant pressure in month, apart from in the Facilities division.</p>	

<p>The Board was advised that higher than planned income was being received by the Trust, which was associated with the higher than forecast activity.</p> <p>The Board noted that pay expenditure was higher than plan, despite the lower than budgeted WTE position.</p> <p>The Trust's cash position was reported to be strong at £53.5m.</p>	
<p><b>13.2 Draft minutes from the meeting of the Finance and Performance Management Committee held on 24 August 2012</b></p>	<p><b>Tabled paper</b></p>
<p>In Mr Trotman's absence, Mr White presented the key highlights of discussions from the meeting of the Finance and Performance Management Committee that had been held on 24 August 2012.</p> <p>It was reported that the Committee had considered the Trust's financial performance, including additional information provided concerning the handling of slippage in the delivery of Transformation Savings Plan schemes due to the delay in the bed reconfiguration plan. The Committee was also highlighted to have considered a review of the performance and key activities undertaken by the Health Information Service (HIS) division.</p> <p>Other key items discussed by the Committee were reported to include the delivery of the Transformation Savings Plan, the corporate performance monitoring report and the revised terms of reference for the Committee, which had been presented for approval.</p>	
<p><b>13.3 Monthly performance monitoring report</b></p>	<p><b>SWBTB (8/12) 187</b> <b>SWBTB (8/12) 187 (a)</b></p>
<p>Mr White reported that performance against the CQUIN targets was good.</p> <p>Performance against the stroke care targets was reported to be concerning across a number of indicators, including the time to CT scan.</p> <p>Performance against the Emergency Department key targets was reported to have deteriorated, with current performance being 94.62% year to date. The impact of the Bank Holiday and the increased level of activity were reported to have exacerbated the position to some degree. It was reported that there was a need to better embed systems and processes as part of the application of Special Measures to the area, in order to achieve an improved level of performance. It was highlighted that clinical leadership in the area was an issue at present and the proposal to appoint an interim Clinical Director was being considered. Miss Barlow reported that an assessment was being made of medical staffing models and how the team currently operated in the Emergency Departments. The Chairman suggested that incentivisation could be considered in the area. It was reported that a communications plan had been developed. The number of complaints and incidents arising from the Emergency Departments was reported to have stabilised. The Board was advised that a recovery plan for the area had been requested.</p>	

<b>13.4 NHS Performance Framework report</b>	<b>SWBTB (8/12) 186</b> <b>SWBTB (8/12) 186 (a)</b>
The Board was advised that according to the NHS Performance Framework the Trust's performance was classified as 'performing'.	
<b>13.5 Provider Management Regime monthly return</b>	<b>SWBTB (8/12) 200</b> <b>SWBTB (8/12) 200 (a)</b>
<p>Mr Sharon reported that the template for the monthly Provider Management Regime (PMR) return had changed significantly, with new measures now being included.</p> <p>In terms of the Governance Risk Rating, it was noted that the status was rated as amber given the inability of the Trust to fully meet the community services data set requirement and the Accident and Emergency performance against clinical indicators.</p> <p>The Financial Risk Rating was reported to be at green status.</p> <p>An amber rating was highlighted on the contractual position, given that performance notices had been received which had not been resolved. The Board was asked to note the failure to achieve the 18 weeks referral to treatment target in all specialities.</p> <p>It was reported that the Trust was an outlier in terms of non-elective screening for MRSA, on the basis that the trajectories had been reset to include a wider group of patients. The target for screening was reported to be 85%. Miss Overfield expressed confidence that this target could be achieved by the end of the financial year.</p> <p>In terms of compliance with the use of the World Health Organisation (WHO) checklist, Ms Dutton noted that six issues had been reported in connection with one operating theatre. Mr Adler advised that this situation was being investigated at present. Ms Dutton suggested that a process was needed where multiple incidents originating from a single area should be flagged. Miss Dhami advised that the matter would be considered by the Quality and Safety Committee.</p> <p>Mr Grainger-Payne provided an explanation as to the process and evidence that the Board could use to inform its declaration against the new Board statements within the PMR template.</p> <p>It was agreed that the actions to address underperformance or achieve compliance with those elements of the PMR where this was not currently the case should be included within the FT Integrated Development Plan. It was suggested that the evidence available to inform the assessment of compliance or otherwise should be considered in more detail outside of the Board meeting.</p> <p>It was suggested that the Internal Audit plan could encompass a review of compliance against some of the key elements of the PMR. Mr White drew an analogy of the process with that of the Auditor Local Evaluation (ALE) which relied on the development of a repository of evidence to support the declarations made.</p>	

<p>The Board agreed that based on the suggested evidence to inform the position against the Board statements, compliance should be declared against all except that concerning the Information Governance toolkit.</p> <p>The Board approved the proposed submission of the Provider Management Return.</p>	
<p><b>AGREEMENT: The Trust Board was asked for and gave its approval to the submission of the Provider Management Regime return</b></p>	
<p><b>13.6 Annual Plan activities update – Quarter 1</b></p>	<p><b>SWBTB (8/12) 194</b> <b>SWBTB (8/12) 194 (a)</b></p>
<p>Mr Sharon reported that progress against the annual plan priorities and key activities was rated as being at green status against 24, amber against 15 and red against 3 elements.</p> <p>The three areas attracting a red status were highlighted to be the development of EAU at City Hospital; progress on the delivery of ‘Right Care, Right Here’ commissioning; and site rationalisation.</p> <p>The brief statements of progress against each annual priority and activity were noted.</p> <p>It was suggested that consideration needed to be given to presenting the information by exception in future, particularly given the significant duplication with information in other reports, such as the Board Assurance Framework. It was agreed that a more focussed report would be presented in future.</p>	
<p><b>13.7 Annual Plan process and timetable – 2013/14</b></p>	<p><b>SWBTB (8/12) 193</b> <b>SWBTB (8/12) 193 (a) -</b> <b>SWBTB (8/12) 193 (c)</b></p>
<p>Mr Sharon reported that the guidance on the annual plan process and timetable was consistent with practice in previous years. It was highlighted that the process had commenced by a request for divisions to submit Transformation Savings Plans for the coming years.</p> <p>The Chairman asked which bodies reviewed the outputs of the planning process and was advised that the detail was primarily for internal consumption. It was highlighted that lessons learned from the development of plans in previous years contributed to some degree to the guidance provided.</p> <p>Mr Adler sought clarity on the timing for the development of the annual priorities. Mr Sharon advised that the ‘Time Out’ session in October 2012 would be used for this purpose. Mrs Kinghorn advised that a ‘Hot Topics’ discussion was planned which would contribute to the setting of annual priorities and a staff engagement event was also planned.</p> <p>Mr White suggested that there was a need to be explicit about the need to raise matters concerning service developments that required consideration by commissioners as part of the agreement of the Local Development Plan.</p>	

<b>AGREEMENT: The Trust Board approved the annual plan process and timetable for 2013/14</b>	
<b>13.8 Update on the delivery of the Transformation Plan</b>	<b>SWBTB (8/12) 185 SWBTB (8/12) 185 (a)</b>
<p>Miss Barlow reported that the key Transformation Plan activity concerned the development of the 2013/14 and 2014/15 Transformation Savings Plans. It was reported that a number of facilitated workshops had been arranged to prepare transformational style savings targets.</p> <p>Much work was reported to be underway as part of the Outpatient workstream, including close focus on the clinics currently run by the Trust. It was reported that job planning work was being undertaken to support this work, in addition to identification of further opportunities around service redesign.</p>	
<b>14 Strategy &amp; Development</b>	
<b>14.1 'Right Care, Right Here' programme: progress report, including an update on decommissioning</b>	<b>SWBTB (8/12) 196 SWBTB (8/12) 196 (a)</b>
<p>The Trust Board received and noted the 'Right Care, Right Here' programme progress report.</p> <p>It was reported that a Partnership event was planned on 13 September 2012.</p>	
<b>14.2 Foundation Trust application: programme director's report</b>	<b>SWBTB (8/12) 197 SWBTB (8/12) 197 (a)</b>
<p>The Trust Board received and noted the Foundation Trust programme director's report. It was reported that the Board Governance Assurance Framework assessment was due to commence, including a set of interviews with Board members. It was reported that interviews would also be arranged with the Strategic Health Authority and with Price Waterhouse Cooper as part of the next stage of the Historical Due Diligence process.</p>	
<b>15 Operational Management</b>	
<b>15.1 Sustainability update</b>	<b>SWBTB (8/12) 178 SWBTB (8/12) 178 (a)</b>
<p>Mr Seager reported that the Trust had received a nomination for a Health Service Journal Efficiency Award in recognition of its work on sustainability.</p> <p>In terms of the Carbon Management Plan, the Board was informed that the profile of the Trust reflected the assumption of the Community Services property and the plans to rationalise the Trust's estate.</p> <p>As part of its Carbon Reduction Commitment, it was highlighted that the tax on fossil fuel needed to be met by the Trust.</p> <p>New waste management bins were reported to have been introduced, which</p>	

<p>provided on-site recycling facilities in response to staff suggestions.</p> <p>The Board was advised that its position on sustainability formed a key element of the Annual Report and the business planning submissions.</p>	
<p><b>16 Any other business</b></p>	<p><b>Verbal</b></p>
<p>There was none.</p>	
<p><b>17 Details of the next meeting</b></p>	<p><b>Verbal</b></p>
<p>The next public session of the Trust Board meeting was noted to be scheduled to start at 1530h on 27 September 2012 and would be held in the Anne Gibson Boardroom at City Hospital.</p>	

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Signed: .....

Name: .....

Date: .....



## Next Meeting: 27 September 2012, Anne Gibson Boardroom @ City Hospital

## Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

30 August 2012, Boardroom @ Sandwell Hospital






**Members present:** Mr R Samuda (RS), Dr S Sahota (SS), Mrs G Hunjan (GH) Mrs O Dutton (OD), Mr P Gayle (PG), Mr J Adler (JA), Mr R White (RW), Miss R Barlow (RB), Miss R Overfield (RO)

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






**Apologies:** Mr R Trotman, Dr R Stedman and Professor D Alderson

**Secretariat:** Mr S Grainger-Payne (SGP)

Last Updated: 20 September 2012

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.195	Update on complaints handling	Hard copy papers	28-Apr-11	Consider the suggestion made to organise a 'walk through' a complainant's experience and the complaints process	KD	<del>31/07/2011</del> <del>31/12/12</del> <del>22/09/2011</del> <del>15/12/2011</del> <del>22/03/2012</del> 31/12/2012	Now built into the work being lead by the Chief Nurse concerning bring patient stories to the Board. Paper presented to the Quality & Safety Committee on 20 September 2012	
SWBTBACT.231	Quality Report	Hard copy paper	30-Aug-12	Develop a week by week improvement trajectory for complaints handling to eliminate the backlog of cases	KD	27/09/12	Included within the Quality Report	
SWBTBACT.220	Ward leadership capacity expansion plan	SWBTB (4/12) 070 SWBTB (4/12) 070 (a)	26-Apr-12	Prepare a Post Project Evaluation for the ward leadership capacity expansion plan for review by the Trust Board in April 2013	RO	01-Apr-12	ACTION NOT YET DUE	
SWBTBACT.227	Same Sex Accommodation declaration	SWBTB (6/12) 152 SWBTB (6/12) 152 (a)	28-Jun-12	Present an update on compliance with the Single Sex Accommodation guidance at the October meeting of the Trust Board	RB	26-Oct-12	ACTION NOT YET DUE	
SWBTBACT.232	Information and reporting map	SWBTB (8/12) 198 SWBTB (8/12) 198 (a)	30-Aug-12	Present a proposal for the future handling of reports at a future meeting of the Trust Board	SG-P	25/10/12	To be presented at the October 2012 meeting of the Trust Board	

## KEY:

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

**TRUST BOARD**

<b>DOCUMENT TITLE:</b>	<b>Informatics Strategy - 2012-2017</b>				
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	<b>John Adler, Chief Executive</b>				
<b>AUTHOR(S):</b>	<b>Fiona Sanders, Interim Chief Information Officer</b>				
<b>DATE OF MEETING:</b>	<b>27 September 2012</b>				
<b>EXECUTIVE SUMMARY:</b>					
<p>The Sandwell and West Birmingham Hospitals NHS Trust (The Trust) Informatics Strategy sets a five-year framework for transforming the Trusts capability and capacity for informatics.</p> <p>The strategy aims to harness information and new technologies to achieve higher quality and safer patient care that will improve outcomes for patients and service users. This strategy aims to lever information and new technologies to support the Trust becoming an integrated care provider.</p> <p>The HIS strategy is one of the enabling strategies that will be submitted with the Integrated Business Plan to the Strategic Health Authority in September 2012.</p>					
<b>REPORT RECOMMENDATION:</b>					
Trust Board is asked to approve the strategy.					
<b>ACTION REQUIRED</b> <i>(Indicate with 'x' the purpose that applies):</i>					
The receiving body is asked to receive, consider and:					
<b>Accept</b>	<b>Approve the recommendation</b>			<b>Discuss</b>	
				X	
<b>KEY AREAS OF IMPACT</b> <i>(Indicate with 'x' all those that apply):</i>					
Financial	X	Environmental		Communications & Media	X
Business and market share		Legal & Policy	X	Patient Experience	X
Clinical	X	Equality and Diversity		Workforce	X
Comments:					
<b>ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:</b>					
The policy forms a key enabler to the delivery of the Transformation Plan.					
<b>PREVIOUS CONSIDERATION:</b>					
Trust Management Board on 18 September 2012					

# Sandwell and West Birmingham Hospital NHS Trust Informatics Strategy 2012-2017

Version 1.0 Final



## Health Informatics Service Strategy

<b>Reference</b>	<b>HIS_ Strategy_v1.0</b>	<b>HIS Strategy</b>	
<b>Owner</b>	John Adler	<b>Version</b>	1.0
<b>Author</b>	Fiona Sanders		
<b>Date</b>	20 <sup>th</sup> September	<b>Status</b>	Issued

### Distribution

This document has been distributed to:

Name	Date of issue	Version
Sue Wilson, Scott Paterson, Matthew Maguire, John Borland	23/06/12	V0.1
Sue Wilson, Scott Paterson, Matthew Maguire, John Borland	01/08/12	V0.2
Sue Wilson, Scott Paterson, Matthew Maguire, John Borland	07/08/12	V0.3
Sue Wilson, Scott Paterson, Matthew Maguire, John Borland	14/08/12	V0.5
The Trust Chair, Chief Executive, Health Informatics Steering Group, HIS Management Team, Divisional General Managers, Chief Executive.	23/08/12	V0.6
Incorporating comments from Medical Director	07/09/12	V0.7
Version 1.0 issued to Trust Board	20/09/12	

This document requires the following approvals:

### Approvals

**Health Informatics Steering Group**  
**Chief Executive**

Version	Description of Version	Approval Body	Date
0.1	First draft	HIS Leadership Team	23 <sup>rd</sup> June 2012
0.2	Second draft, incorporating comments from the HIS Leadership Team	HIS Leadership Team	1 <sup>st</sup> August 2012
0.3	Third draft, additional revisions	HIS Leadership Team	7 <sup>th</sup> August 2012
0.4	General editing		10 <sup>th</sup> August 2012
0.5	Including revisions from Scott Paterson and Matthew Maguire		13 <sup>th</sup> August 2012
0.6	Editing by Fiona Sanders	HIS Steering Group	23 <sup>rd</sup> August 2012
0.7	Incorporating comments from the review of version 0.6	HIS Steering Group	7 <sup>th</sup> September 2012
1.0	Issued to Trust Board	Trust Board	20 <sup>th</sup> August 2012

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## 1 Executive Summary

The Sandwell and West Birmingham Hospitals NHS Trust (The Trust) Informatics Strategy sets a five-year framework for transforming the Trusts capability and capacity for informatics. It aims to harness information and new technologies to achieve higher quality and safer patient care that will improve outcomes for patients and service users. This strategy aims to lever information and new technologies to support the Trust becoming an integrated care provider.

The Informatics Strategy is aligned with the national directives such as the Health and Social Care Act 2012 and the Information Strategy and it also supports the Trust's Integrated Business Plan, Transformation Plan and our Foundation Trust application.

This strategy sets out how we will continue to build upon our investment in technology and how our approach to information and IT across the Trust can lead to more joined up, safer, better care for us. The strategy spans information for patients, service users, clinicians and other care professionals. The strategy covers the requirements of clinical and non-clinical users and embraces the challenge of integrated care pathways across our local health community. The NHS Information Strategy 2012 states that "Information can bring enormous benefits. It is the lifeblood of good health and wellbeing, and is pivotal to good quality care."<sup>1</sup>

The benefits of information to clinical practice are understood, however all too often, the information picture is disjointed. The Trust's recent experience with data quality and validation of the 18 week referral to treatment (RTT) target has highlighted that the information needed, such recorded outcomes are incompletely recorded or recorded outside of the case note in locally held systems.

This informatics strategy does not advocate the introduction of large-scale information systems or set down detailed mechanisms for delivery. It provides a framework and a route map to lead a transformation in the way we use our information systems and the latest technologies to deliver changes and efficiencies in the delivery of safe, high quality patient care. This strategy addresses the needs of both clinical and non-clinical systems. It recognises the importance of technical and telecommunications infrastructure in the delivery of patient care.

The previous strategy was produced in 2008; the 2008 strategy has informed the development of the 2012 strategy however the strategy has been refreshed to reflect

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<sup>1</sup> NHS Information Strategy, April 2012, Page 6



the changes in both the NHS landscape and the strategic priorities of the Trust and the emerging informatics strategies of our local Clinical Commissioning Groups. This document, reflects fundamental changes following the Trust's Health Informatics Review, the cessation of the NPfIT programme, and the initiation of the Transformation Plan which articulates the Trust's cost savings in 2012/13, 2013/14 and 2014/15.

This strategy recognises that technology alone will not resolve the problems that already exist in process and procedures. Delivering the infrastructure and systems to support the delivery of patient care is not enough on its own. It will require us as users of the systems to work in different ways to lever the advantages offered by the new capabilities.

Importantly this strategy recognises that informatics is always advancing and therefore demands upon the solutions in place will need to evolve to meet the needs of users. To address the changes in our operation and clinical environments we will review our strategy annually to ensure continued alignment with national and local needs, clinical and patient need and the business objectives of the Trust and the Clinical Commissioning Groups.

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## 1.1 Our Strategic Vision

Our vision for health informatics within the Trust to improve the quality, safety and consistency of the care that we deliver to our patients by realising the enormous potential of health informatics this strategy sets the following ambitions:

***Sandwell and West Birmingham Hospitals NHS Trust  
Informatics Vision***

- 1. We will harness technology and information to improve the quality, safety and consistency of our patient care***
- 2. We will use technology and Information to drive integrated care across the entire health and social care sector, both within and between organisations;***
- 3. We will develop and strengthen the role of health informatics in clinical practise***
- 4. We will harness technology and information to develop a PaperLite environment.***
- 5. We will change our organisational and professional behavioural mind-sets to recognise that information and technology can improve the quality and safety of patient care. We recognise that technology alone, will not resolve the procedural and operational challenges that already exist;***
- 6. We will strive to ensure that patient information is recorded once, as a by-product of the delivery of patient care, and that this information is shared securely between those providing care within our local health community. We will ensure that this is supported by consistent use of information standards that enable data to flow (interoperability) between systems whilst keeping our confidential information safe and secure;***
- 7. We will ensure that our electronic care records evolve and mature in line with the needs of patient care and our objectives and become the source for core information used to improve our care, improve services and to inform research.***
- 8. We will develop an informatics culture where all health and care professionals take responsibility for recording, sharing and using information to improve the quality and safety of the patient care we deliver.***

## 1.2 Delivery of the Strategy

Historically, the Trust's IM&T strategy was based upon the deployment of NHS Connecting for Health national application and associated health systems. The Trust's EPR is comprised of the CSC iPM PAS solution with iCM providing clinical functionality. Various departmental and other services have stand-alone systems which have been installed as part of the National Programme; these also contribute to the EPR e.g. Radiology, Maternity and Theatres. The Trust has also developed the Clinical Data Archive (CDA) which is a repository of clinical reports, letters and clinical results. The EPR has been closely integrated with other key systems, such as radiology and pathology and the clinical letters system. This has been crucial to supporting improved working practices and greater efficiencies.

As a result of the Trust's alignment with the then national policy, the change in central funding and organisation and the expiry of a number of core systems the Trust is now in a position to refresh and agree its own strategic direction which meets patient, clinical and business needs. Whilst this provides a number of opportunities and significant benefits for the Trust, it also produces a number of investment challenges that will be resolved by bolstering informatics in the Trust's long term financial model (LTFM)

The Trust has made a sustained investment into the deployment of an Electronic Patient Record (EPR) over the past 10 years. This has led to a steadily increasing level of IT support across care settings, with increasing use of the Trust's clinical and non-clinical systems and databases within the Trust. However the impact of changes in the availability and access to national funding are as yet unclear. In view of the current funding discussions the Trust is taking a pragmatic view to the delivery of the Informatics Strategy.

In order to deliver the Informatics Strategy within a climate of economic and financial uncertainty the Trust will approach the delivery of this strategy by the **“aggregation of marginal gains”**<sup>2</sup> This approach will ensure that the Trust builds upon existing investment and knowledge and delivers the enhanced capability within capital and revenue targets. The overall delivery approach is summarised below

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<sup>2</sup> Dave Brailsford, Team GB Cycling Performance Director

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**Sandwell and West Birmingham Hospitals NHS Trust  
Informatics Delivery Approach**

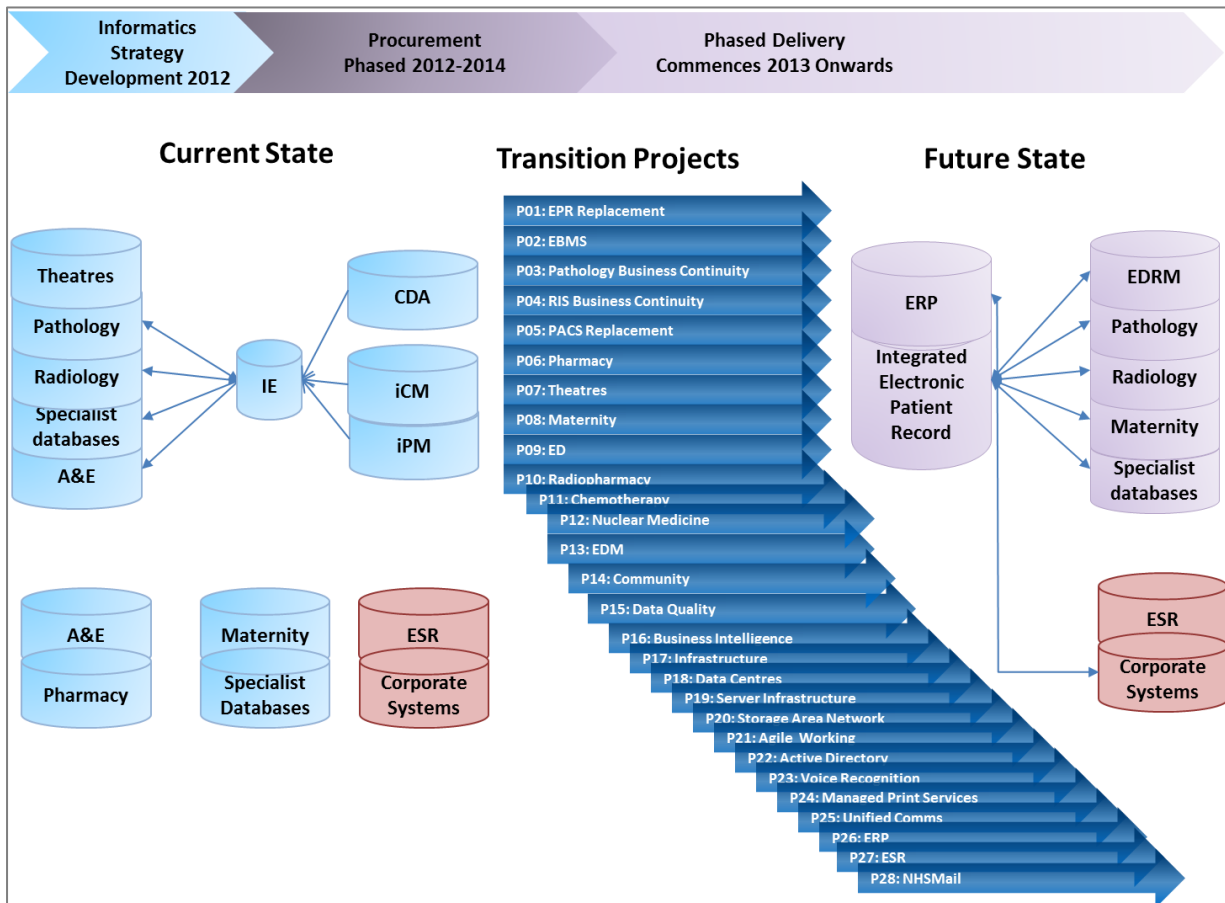
***The Trust will build upon the existing investment made by the Trust in informatics by:***

- 1. Recognise that there is a Trust wide imperative to co-ordinate all investment and implementation to ensure compliance with the overall Trust vision.***
- 2. The Trust will “make better use of what we have” by leveraging the capabilities of current systems by optimising current functionality and process.***
- 3. The Trust will embark on incremental transformation, replacing priority systems first. By adopting this approach the Trust recognise that there will be a requirement to replace systems during the migration to the integrated solution in order to maintain patient services.***
- 4. The Trust will consolidate and integrate clinical and non-clinical systems to support the delivery of safe patient care and support the Trust meeting both clinical and strategic business objectives;***
- 5. The Trust recognise that there will always be a requirement to provide specialist departmental systems such as pathology, radiology, radiopharmacy and chemotherapy. These systems have specific clinical functionality. However these systems must be capable of integration in order to meet the overall Trust vision***
- 6. The Trust will initiate a number of transformation work streams which will drive out efficiencies and support innovative flexible service within our local health economy;***
- 7. The Trust’s strategy is to continue to consolidate the clinical systems into a single Electronic Patient Record (EPR) solution to enable better integrated care records and reduce the complexity of managing multiple systems and interfaces.***
- 8. The Trust will invest in new technologies and system capabilities that complement this approach***
- 9. The Trust will invest in a number of emerging informatics technologies to support the delivery of patient care.***

Whilst significant progress has already been made with the Trust’s informatics agenda, there are substantial further steps which must be taken over the next 5 years to provide informatics capability that the Trust requires in order to deliver the improvement in efficiencies and innovation in patient care and meet the overall Trust business objectives.

### 1.3 Purpose of Document

This document provides an overview of the Trust’s Informatics strategy. The previous strategy was produced in 2008; this strategy has been refreshed to reflect the changes in both the NHS landscape and the strategic priorities of the Trust. The development of this strategy draws upon the Trust’s Health Informatics Review, the cessation of the NPfIT programme, and the initiation of the Transformation Plan which articulates the Trust’s cost savings in 2012/13, 2013/14 and 2014/15. This document provides a Trust roadmap to achieve the informatics future operating model, as detailed in the schematic below:



**Section 2** provides the strategic context outlining a number of business drivers and priorities.

**Section 3** provides an overview of the current status of IT systems in the Trust and the plan for replacement;

**Section 4** describes the role and importance of information services in the Trust;

**Section 5** describes the Trust's plans for infrastructure and telecommunications;

**Section 6** outlines the Trust corporate systems and proposals for development of these systems;

**Section 7** explains the structure of the Health Informatics Service, following the completion of the Health Informatics Review and the review of executive responsibilities by the Trust Board

**Section 8** set out the approach that the Trust will take to the management, both delivery and on-going service provision of the Health Informatics Service.

**Section 9** explains the governance structure and that will oversee the delivery of this strategy and ensure that it meets both clinical and business needs;

**Section 10** identifies some of the key risks, it should be noted that this is not a definitive risk log and all transformation projects will be required to keep a project specific risk register;

**Section 11** explains the approach he Trust will take to funding Informatics Strategy.

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## 2 Strategic Context and the Trust's Strategy for the Health Informatics Service

“**Informatics The Future**” and the “**The Power of Information**” outline the direction of health informatics in the NHS. Used effectively Information and IT will facilitate and drive integration across care settings, however to achieve this and generate the greater efficiencies and productivity required the Trust will need to maximise the technology it already has and ensure a cohesive and cogent approach to the development of the Health Informatics Service. The Government's Information Strategy “The Power of Information” details the 10 year framework for transforming information in the NHS. The Trust's previous IM&T strategy was aligned with the National Programme for IT (NPfIT). “Informatics for the future” redefines informatics, both information services and IT systems, within the NHS. As part of this strategy it is envisaged that “providers will buy and implement their own IT services and solutions from a vibrant healthcare market, supported by open and transparent information on the available products and their costs and benefits”<sup>3</sup>.

The Trust is operating in an environment of unprecedented change and economic. The **NHS Health and Social Care Act 2012** puts clinicians at the centre of commissioning, and frees up providers to innovate, empowers patients and gives a new focus to public health. This is underpinned by the and the **NHS Operating Framework for 2012/2013** and the **NHS Performance Framework 2012/13** These combined with the savings outlined in the Health and Social Care Act 2012 inform not only the Trust's integrated business plan but also the Transformation plan for 2012/2013, 2013/14 and 2014/2015 and therefore the strategic direction of Health Informatics within the Trust.

In order to support both the strategic and local requirements, the Trust must look at the HI systems which are installed and establish a coherent and rolling improvement plan to meet the strategic needs of the Trust and migration to the future operating model.

The strategy is required to balance competing needs, making the best use of limited resources and develop the optimum solution which builds on existing investments and provides a coherent road map for development of our vision.

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<sup>3</sup> Informatics for the Future, Page 4

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## 2.1 Guiding Principles

The vision for informatics in the Trust is outlined in section 1.1. It is the Trust's objective to ***“harness technology and information to improve the quality, safety of our patient care”***

We will use health informatics to achieve operational efficiencies, tangible cost savings and improved patient outcomes. We will achieve this by providing a collaborative and integrated environment, where critical patient and business information is available to employees and healthcare professionals. In order to provide this environment we will apply eight guiding principles:

### ***Sandwell and West Birmingham Hospitals NHS Trust Informatics Guiding Principles***

- 1. The Trust will build on existing investment to achieve an integrated electronic patient record which will operate in a PaperLite environment;***
- 2. The Trust will develop an incremental improvement plan that will result in the development of an integrated solution for the Trust. The Trust will not embark up a “rip and replace” system replacement approach;***
- 3. The Trust will maintain the existing level of functionality within core systems. It should be noted that a number of core systems will reach their contract expiry date in 2013 and will need to be re-procured, the Trust will procure those systems in line with the overarching principles***
- 4. Certain core systems are not considered fit for purpose, these will be replaced in line with the core principles.***
- 5. The Trust will endeavour to reduce the number of standalone departmental systems and focus on the integration and/or replacement for these systems via the EPR solution;***
- 6. The Trust recognises that some specialist departmental systems will be retained and these have been identified as part of this of strategy. Given the evolving nature of service and systems this will continue to be reviewed;***
- 7. Any systems outside of the core EPR, whether existing or new, must comply with interoperability standards;***
- 8. All systems outside of the core EPR solution must be support timely data accessibility.***



## 2.2 The National Programme for IT

To date the Trust has committed to taking the IT solutions provided by NPfIT; this includes the Trust EPR solution, Radiology, PACS system, NHS Mail and the Electronic Staff Record. In September 2011, the Department of Health's review of the NPfIT concluded that a centralised, national approach to information systems is no longer required and that a more locally-led plural system of procurement should operate. The Department of Health Informatics Directorate stated that a new approach to implementation will take a modular approach, allowing NHS organisations to introduce smaller, more manageable change, in line with their business requirements and capacity. This change in the national policy has further influenced the development of the Trust's strategy. However at the time of production of this strategy the direction of centralised funding remains unclear. This uncertainty will have significant impact on the Trust's investment case.

### 3 System Replacement and Development Plan

The following section describes the position with regard to a number of key Trust applications. It also provides an emerging strategic direction in response to the Trust's on-going demand for modern health informatics solutions.

As stated in section 2, the Trust has previously committed to taking the NPfIT EPR solutions. As a consequence of this decision, the Trust has delayed the procurement of a number of core applications and now faces a number of procurement decision points in 2012-2017. Achieving these efficiencies and changes to service delivery will be heavily dependent upon a robust and flexible infrastructure and maximising existing investments to ensure that they support the Trust's future Health Informatics vision.

As a result of the delays associated with the NPfIT, a number of departments have legacy systems, which are now approaching contract end dates. As part the system replacement plan the Health Informatics Strategy will co-ordinate to ensure that every operational and service department has a business and patient application that:

2. Support the Trust's strategic vision for the delivery of digital care
3. Are fit for purpose,
4. Meet the operational requirements of the service and are properly managed in line with NHS health informatics guidance.

### 3.1 The Electronic Patient Record

Project 1 EPR replacement	High Level Requirements	Benefits
Cost: TO be confirmed  Funded:  Subject to outline business case  Year: 2013/14	Replacement of existing clinical systems with a single user interfacing solution  Integrated multi-resource scheduling  Integration with medical devices  Intelligent patient management & escalation workflow process	Integrated patient care in the hospital and across the health system  Safer patient care  Smarter decision making  Single access to all patient information  Improved efficiency and productivity  Responsive and agile organisation  Paper lite organisation  Improved business intelligence

The National Programme for IT (NPfIT), delivered by NHS Connecting for Health (NHS CfH) agency was expected to provide some early benefits, and the Trust had planned to take the CSC Lorenzo product as replacement for its legacy EPR solution set. However, significant slippage in the programme and the change in national direction, allow providers to “buy and implement their own IT services and solutions”.

The Trust is currently running on a PAS (iPM, iSoft) as delivered and supported by Computer Sciences Corporation (CSC), the NPfIT local Service Provider. This system is provided to the Trust through the NPfIT and it is currently nationally funded and therefore provided at “no cost” to the Trust until the contract ceases in 2016.

In late 2002, the Trust procured an electronic patient record system (iCM supported by iSoft); iCM at that time was the main EPR product offering from iSoft until the adoption of Lorenzo in 2004. iCM at that time was a well-established advanced EPR with full functionality. However, with the cessation of the partnership with Eclipsys, iSOFT froze development until 2009.

In 2007, following the merger of the City and Sandwell Hospitals in 2002, the Trust developed a Clinical Data Archive (CDA) the primary purpose of which was to store the historical data from the two legacy PAS solutions in the Trust. These PAS systems held traditional PAS data, results, clinical letters, clinical alerts, allergies and some other clinical documents. The CDA, which uses modern web-based technology, was designed as a historical Trust-wide archive for patient administrative and clinical data. As a result of the delay with Lorenzo, and with increasing demand from clinicians for better functionality than was available from iCM to view clinical data, the CDA has been enhanced and is now the main data warehouse for the storage of all clinical information which is either imported from legacy systems or sent via HL7 messaging via the Trust Interface Engine (TIE).

In summary the iPM, iCM, CDA and TIE solutions have developed organically and have been adapted and developed in response to clinical and Trust needs, pending the stabilisation and implementation of the Lorenzo position (through the NPfIT).

The initial plan, as part of the rollout of NPfIT applications to the North, Midlands and East cluster, was that the CSC iPM PAS, eVolution Maternity, ORMIS Theatres and the local iSoft iCM system would migrate to the CSC/iSoft Lorenzo Regional Care Solutions.

The Trust however, had been concerned over the functionality and quality of systems provided by the Local Service Provider and in March 2010 the Trust advised the SHA that they would not commit to any implementation timeframes for the year 2010/11 and until:

1. Implementation and evaluation of Lorenzo at University Hospital Morecambe Bay NHS Trust.
2. The final scope of Lorenzo Regional Care is agreed and its formal signing off under the Memorandum of Understanding (MOU) between CSC Alliance and NHS Connecting for Health.
3. Until Care Pathways, Guidelines, Protocols and Advanced Clinical Decision Support are put back into the contract, even if it means they are at a reduced level of functionality from the original OBS/Contract.

As of December 2011, the current status of these conditions was:

- 1. Implementation and evaluation of Lorenzo at University Hospital Morecambe Bay NHS Trust (UHMB).**

The UHMB went live on Lorenzo 1.9 in June 2010 and the Trust reported that it planned to go live with the pathology requesting and reporting module of the iSOFT electronic patient in the autumn 2011. A deployment lessons learned report was released in February 2012; however there is no formal evaluation report available. It should be noted that a number of Trusts have shelved implementation plans for Lorenzo as it is still not considered to be stable in a number of areas.

**2. The final scope of Lorenzo Regional Care is agreed and its formal signing off under the Memorandum of Understanding (MOU) between CSC Alliance and NHS Connecting for Health.**

The current position regarding the contract extension remains unclear. As of January 2012, it is expected that the CSC contract will not be renewed and no new sites will be added to the current implementation schedules. The Trust is waiting for confirmation of the position from the SHA.

**3. The Trust will not consider an implementation date until Care Pathways, Guidelines, Protocols and Advanced Clinical Decision Support are put back into the contract, even if it means they are at a reduced level of functionality from the original OBS/Contract.**

With regard to care pathways, guidelines, protocols and advanced decision support. These were scheduled for delivery in release 4 of Lorenzo Regional Care. In light of the current status of the contract extension it is anticipated that the planned de-scoping of the release will remain. This has major implications for the Trust's HI plan.

The position of negotiations between the Department of Health and the CSC remains unchanged and the planned agreement of the Letter of Agreement between the parties, initially planned for June 2012, remains unsigned however it is believed that there is an emerging agreement between CSC and the Department of Health. In effect, the Trust has delayed decisions regarding system re-procurements until the position on both NPfIT and specifically the iSoft Lorenzo product were clearer.

As of December 2011, 21 months after the original communication and given the impending re-procurement challenges, the Trust must now make decision regarding the future of EPR, its replacement and implementation of the paper light delivery model.

Clinicians are increasingly frustrated with the number of applications they need to access and also the amount of information held in silos within the Trust and across the health community. Integrated care beyond the boundaries of the Trust is becoming the accepted service model and this needs to be supported by the IT and governance arrangements over the sharing of patient records.

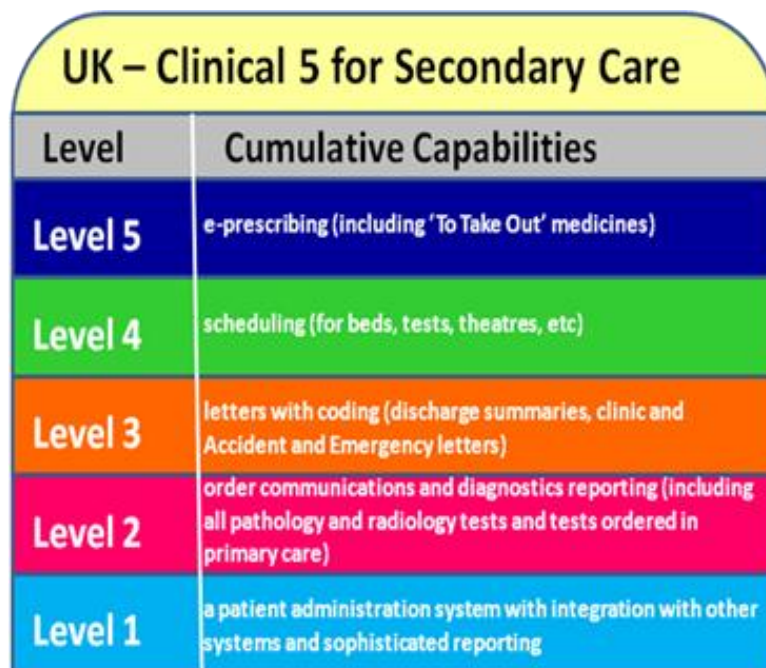
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Workflow is a key component to ensure that clinicians are presented with the right information at the right time to make effective clinical decisions enabling patients to receive appropriate treatment. It also leads to improved team work across the clinical domains reducing delays in each handover process and ultimately reduced length of stay prior to discharge from the Trust. Patient scheduling is carried out across multiple systems so there is no holistic view of the patient journey and a number of manual processes are in place to ensure the Trust delivers on key operational targets

Retention of the current solution and the planned de-scoping of the CSC Lorenzo solution will leave the Trust without a viable solution to meet its objectives and will also see a reduction in current functionality. In the light of this intelligence and recognising that the Trust will bear significant costs once the NPfIT contract ceases the Trust has now embarked upon an options appraisal to determine the future of the EPR solution.

### 3.1.1 Options Appraisal

In 2012, taking into consideration the Trust's vision and the change in national informatics strategy, the Trust embarked upon a review of the options available. Taking into consideration the Trust's emerging requirements from the Transformation Plan, the objective of improving the use of health informatics in clinical practise and also the requirement for systems replacement the Trust's options were reviewed in light of the **NPfIT's "Clinical 5 Model"**. **NPfIT's "Clinical 5 Model"** outlines the minimum level of EPR functionality that all secondary care Trusts should attain, and also reflects the migration path. This is referenced in the diagram below.



The Trust is currently working around Levels 2/3. As a result of the requirements that have emerged from the Transformation Plan and feedback from clinical colleagues, the Trust must look to procure a system that reaches the level 5 solution. In order for the Trust to come to a decision on the best way forward over the next 5 years, a number of options were considered these are:

- A. **Do Minimum** – Stay with iCM and iSoft solution set
- B. **Lorenzo Regional Care** – Take the previous NPfIT solution from CSC Alliance
- C. **Best of Breed** – Procure the best solutions for each area and integrate through inter-operability
- D. **Integrated EPR** – Procure a fully integrated EPR which could include a mix of supplier options and varying degrees of ROI depending on how advanced functionality is.
- E. **Develop In-House** – develop the Clinical Data Archive (CDA) and eBMS to become a bespoke active Electronic Patient Record.
- F. **UHB Solution** – Procure or outsource the Trust's Health Informatics Solution to University Hospital Birmingham

Option	Positive	Negative
<p><b>Option 1</b>  <b>Do Minimum</b> – Stay with iCM and iSoft solution set</p>	<ol style="list-style-type: none"> <li>1. Established system</li> <li>2. No training or re-implementation costs</li> <li>3. Annual support costs within current budget</li> </ol>	<ol style="list-style-type: none"> <li>1. Poor levels of service delivery</li> <li>2. Poor levels of support.</li> <li>3. Antiquated system and architecture.</li> <li>4. iCM product set is scheduled for “sunset” strategy. The timescales for this have yet to be confirmed</li> <li>5. Does not include advanced decision support or protocol driven pathways, and clinical guidelines.</li> <li>6. The products do not currently support prescribing or enterprise wide scheduling as an integrated product set.</li> <li>7. The Trust will still be required to re-procure at the end of the contract in 2016</li> <li>8. Trust will still be required to procure a number of core systems</li> </ol>
<p><b>Option 2</b>  <b>Lorenzo Regional Care</b> – Take the previous NPfIT solution from CSC Alliance</p>	<ol style="list-style-type: none"> <li>1. Significant financial incentives</li> <li>2. Maintenance does not commence until 12 months after the implementation does not occur until 5 years after</li> </ol>	<ol style="list-style-type: none"> <li>3. Poor levels of service delivery , though improved in past 2 years</li> <li>4. Products not officially signed off at pilot sites</li> <li>5. Poor levels of support, though improved in past 2 years</li> </ol>



Option	Positive	Negative
	<p>start of 1<sup>st</sup> implementation</p>	<p>6. Does not include advanced decision support or Protocol driven pathways, and clinical guidelines. The products do not currently support prescribing &amp; medicines administration or enterprise wide scheduling.</p> <p>7. Trust will still be required to procure a number of core systems to meet the overall vision</p>
<p><b>Option 3 Best of Breed –</b> Procure the best solutions for each area and integrate through inter-operability</p>	<p>1. Functional rich solutions</p> <p>2. Highly interoperable and some solutions are more advanced in patient – context integration.</p>	<p>1. Significant costs associated with interoperability and integration.</p> <p>2. Level of integration required prevents enterprise wide scheduling.</p> <p>3. Does not include advanced decision support or Protocol driven pathways, and clinical guidelines.</p> <p>4. Annual maintenance costs could be higher for multiple systems</p> <p>5. Lower ROI than for fully integrated systems</p>
<p><b>Option 4 Integrated EPR –</b> Procure a fully integrated EPR which</p>	<p>1. Significant evidence for Return on Investment</p>	<p>1. Cost</p> <p>2. Operational impact during transition.</p>

Option	Positive	Negative
<p>could include a mix of supplier options and varying degrees of ROI depending on how advanced functionality is.</p>	<ol style="list-style-type: none"> <li>2. Meets needs of Transformation programme now &amp; in future</li> <li>3. Integration of Enterprise wide scheduling with beds, Theatres, and resources for staff, equipment &amp; locations.</li> <li>4. Integration of ePrescribing, results reporting &amp; full clinical decision support</li> <li>5. Sound Implementation methodology and capacity to deliver</li> </ol>	
<p><b>Option 5</b>  <b>Develop In-House</b> – develop the Clinical Data Archive (CDA) and eBMS to become a bespoke active Electronic Patient Record.</p>	<ol style="list-style-type: none"> <li>1. Cost</li> <li>2. Clinicians get the functionality they want, relatively when they want</li> </ol>	<ol style="list-style-type: none"> <li>1. Requires significant in house development resource.</li> <li>2. Will still be required to develop a procure a number of commercial solutions</li> <li>3. Sustainability over long term keeping abreast with changes in health care – becomes too bespoke</li> </ol>
<p><b>Option 6</b>  <b>UHB Solution</b> – Procure or outsource the Trust’s Health</p>	<ol style="list-style-type: none"> <li>1. Established solution liked by clinicians at UHB</li> </ol>	<ol style="list-style-type: none"> <li>1. Strategic direction driven by UHB.</li> <li>2. Solution based upon the CSC iPM</li> </ol>

Option	Positive	Negative
Informatics Solution to University Hospital Birmingham	<ol style="list-style-type: none"> <li>2. Relatively low cost compared to more advanced fully integrated solutions</li> <li>3. Junior Doctors &amp; Consultants move between SWBH &amp; UHB – same system, easier training, though they have to learn different systems at HEFT.</li> <li>4. More cost effective than some other options on the market.</li> <li>5. Could be a more attainable model in terms of affordability</li> <li>6. Would not have to procure as many separate systems as some other “best of breed” offerings, which would reduce the annual support costs and technical infrastructure that could be incurred.</li> <li>7. Could realize some key benefits such as drug savings</li> </ol>	<ol style="list-style-type: none"> <li>3. Does not support outpatient prescribing</li> <li>4. Requirement to maintain and procure department systems</li> <li>5. Does not support order entry, which is a core requirement for service departments</li> <li>6. Does not support enterprise wide scheduling.</li> <li>7. ROI far lesser degree than fully integrated solution</li> <li>8. Product now with commercial supplier – competing priorities with other Trusts for development</li> <li>9. Older architecture which is not supported on modern mobile devices such as iPADS</li> </ol>

Given the current operational and strategic needs identified within the Trust it is proposed that a blend of option 4 and 3 needs is progressed. In a blended approach the Trust will proceed to market test for an integrated EPR solution with best of breed functionality retained for core departmental systems. Retained departmental systems would be radiology, PACS, pathology, maternity and identified specialist departmental systems such as chemotherapy and radio pharmacy.

By taking a blended approach to the replacement of the EPR system, would support

- I. Clinical effectiveness and efficiencies - NHSLA premiums, savings from reduction in adverse drug events, unnecessary tests in particular MRI scans, spend on medication, reduced length of stay;
- II. Operational efficiencies – reduced administrative posts and improved commissioning payments.

The value of these savings will be developed further through the development of the business case to procure an EPR and indicative costs and ROI will be identified in the Strategic Outline Case (SOC).

### **3.1.2 Approach to Transition**

The Trust will adopt an incremental approach to transition. Transition to a single integrated solution would occur over the medium and longer term. This would include core clinical, diagnostic, scheduling and non-clinical functionality. Our plan, over the next 2-4 years will be to rationalize, and where supportive to the Trust vision, replace existing solutions. The objective being to reduce the number of systems and the complexity of managing those systems and ensure that system replacement supports the overall Trust vision.

The Trust would transition from the current systems to the new integrated solution at a pace that fits with the clinical and organisational requirements as well as the Trust's own capacity to change. Under this model, the Trust would only retain those specialist systems that cannot be delivered effectively through an EPR.

Based on best practice a typical implementation would take some 3 – 4 years from contract signing to being fully implemented. Although timescales can be altered, it highlights the need to commence market testing for integrated solutions and for the Trust to commence planning for the replacement of the current EPR.

Once such a solution is fully deployed it is anticipated that it would be our primary clinical platform for the next 10 – 15 years, and would enable the Trust to drive workflow and pathway redesign across departments and the wider healthcare community.

### **3.1.3 The Pan Birmingham Shared Care Record**

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It should be noted that in Birmingham is in the process of developing a Pan Birmingham Shared Care Record. This will provide a single portal view of a patient's clinical information across the Acute Trust and the natural community. Information from disparate systems and medical devices is pulled together to give a comprehensive view of the patient record. This functionality will be procured across Birmingham and will be an extension of the shared care record developed for the Heart of Birmingham Teaching PCT.

IT is anticipated that the solution will not require the Trust to replace systems but to provide information and integration capabilities to the shared care record. This requirement will be an essential aspect of the Trust's EPR procurement.

### 3.2 Electronic Bed Management System

Project 2 eBMS	High Level Requirements	Benefits
<b>Cost:</b>  <b>To be estimated</b>  <b>Funded:</b>  <b>Yes, from HIS resources</b>  <b>Year:</b> <b>2012/13</b>	<b>Real time patient tracking</b>  <b>High level view of patient pathway</b>  <b>Interactive whiteboard to view patient status</b>  <b>Patient status at a glance e.g. diagnostic results, prescribing, therapy treatments, social services referrals, TTOs</b>  <b>Escalation of patients outside of care plan</b>	<b>Reduction in patient LOS</b>  <b>Better bed utilisation and availability</b>  <b>Reduce number of wards and staffing</b>  <b>Reduction / elimination of outlying patients</b>  <b>Legible whiteboard</b>  <b>From board round Clinical coding</b>

The patient journey through the hospital is a complex multi-disciplinary process from the point a patient is admitted to the point a patient is discharged there are multiple points in the process where errors, inefficiencies and mis-communications can occur which cumulatively can result in the patient discharge being delayed. Often discharges are delayed through situations such as:

- not knowing accurately where patients are in the process;
- waiting for diagnostic results and not knowing when these are available;
- unavailability of equipment or not knowing the exact location of equipment;
- not knowing the exact location of patients in a ward – time can be spent trying to hunt down patients unnecessarily;
- waiting for beds to be cleaned and turned prior to being made available for a new patient.

All of these create bottlenecks in the discharge process and delay the availability of beds within the Trust. Generally, much of the data and information relating to the patient journey is known but is not readily available or systematically recorded. This often delays the commencement of procedures or delays in discharges.

The Trust has developed in house and implemented a bed management tool that provides clinicians with a real-time view of patients on the ward and the discharge planning. This tool has become an essential tool and supports the daily board round

This system facilitates the better co-ordination of information and help to manage patient flows by consolidating real time information from a variety of sources. Additionally, this information should be made available to staff with the minimum of interaction so that information can be made available ideally “at a glance”. This not only supports patient management at a local clinical level but also via organisation wide views such as those required to manage capacity issue from a central point.

### 3.2.1 Electronic Bed Management System Product Plan

It is the intention that further enhancements will be made to the electronic bed management systems to further support patient flow processes and efficiencies in the total admission to discharge flow process. It is also intended to rename the eBed Management system to reflect this totality of patient flow and the development of an intelligent tool to support planning and delivery of patient care and safety. The proposed product plan has been scoped, though as it is supporting a fast-moving Transformation programme, it will be a continuous development cycle. The functionality will be able to be integrated with an EPR or if it provides the required level of functionality or supplier willing to develop, will at some point in the future be fully integrated with the EPR.

The proposed development will be over the next 3-6 months and will include:

- links to Theatre work stream with wider roll-out of eWhiteboard to all surgical wards to track patients and the development of functionality to support pre-operative assessment
- Launch of the electronic Board Round
- Development of functionality to support Consultant ward rounds (eWard Round) and also Post-Take and MDT ward rounds
- Development of electronic handovers – both medical and nursing with perhaps a standard clinical eHandover. This will also link into the Safety briefing and Safety Thermometer
- Various workflow dashboards to support key stakeholders in the Patient Flow process e.g. Transport, Pharmacy, Therapists, Ward Manager/Matrons
- Pilot of clerking in for nurses and medical staff.



### 3.3 Pathology

Project 3 Pathology Business Continuity	High Level Requirements	Benefits
Cost:  TBC  Funded:  Yes, from HIS Capital  Year:  2012/13	Installation of business continuity and disaster recovery solution  Upgrade of hardware  Provision of storage and backup capability to provide a fully redundant, high availability cluster across the Sandwell and City sites	A fault tolerant and a fail over solution to maintain service levels

The Trust's Pathology Department currently uses the iLab™ Pathology system provided and supported by iSOFT. There are no immediate performance issues with the Pathology system, however it is overdue for a hardware refresh, this should be scheduled in 2012 and at the same time disaster recovery options should be reviewed.

A proposal from CSC is due which will utilise the existing Trust storage infrastructure (SAN) implemented in 2012/13 for storage and backup of the iLab data. The proposed configuration will be for a single server on each site connected to the SAN to provide primary data storage and replication and for backups of the data to be configured on the Trust centralised backup solution. This will minimise the cost of the upgrade to the Trust whilst significantly improving the fault tolerance of the iLab system over the current single site solution.

The upgrade will require a staged approach as the hardware and software will be refreshed which will entail revised testing for MHRA compliance. Anticipated completion of this project is end March 2013.

Costs for this upgrade are currently awaited.

It should be noted, that whilst the iLab™ is a mature system supported by iSoft, it is considered to be functionally rich. Any decisions to replace the system are currently on hold until a decision is made regarding a Cluster wide pathology system.

### 3.4 Radiology Information System (RIS)

Project 4 RIS business continuity & Replacement	High Level Requirements	Benefits
Business Continuity  Cost: £16K for  Funded:  Yes  Year:  2012/13  RIS Replacement  Cost: Subject to business case  Funded:  HIS Capital	Procurement and implementation of the Radiology Information System disaster recovery solution	Providing a fail over solution to maintain service levels  Supports the migration to RIS following expiration of the CSC contract

<p><b>Project 4</b></p> <p>RIS business continuity &amp; Replacement</p>	<p><b>High Level Requirements</b></p>	<p><b>Benefits</b></p>
<p><b>Year:</b></p> <p>2013/14</p>		

The Trust Imaging Department is a mature and informed user of technology, and is a leader in innovation and service re-design. The Department is a major stakeholder of HIS, this combined with its innovation and leadership gives the department a unique position in service redesign and the transformation programme. Current intelligence suggests that the demands for service redesign will accelerate in line with the transformation plan and in preparation for the move to the Midland Metropolitan. Within the next 18 months, the Trust will be heavily dependent upon Imaging and HIS to support the following re-configurations:

1. Stroke Services
2. Breast Services
3. Vascular Services
4. Radio pharmacy
5. Nuclear Medicine
6. Neurophysiology
7. Radiology
8. Fluoroscopy
9. Cardiac Imaging

Clearly, with the demand for imaging services increasing, combined with the departments innovation and leadership, if service re-configurations are to be optimised and the Trust to maximise the benefits of such re-configurations, a long term investment and action plan is required. There are some key decision points for the Trust in 2012 which include introduction of business continuity and disaster recovery capabilities for radiology.

In addition the Trust must plan for the replacement of Radiology Information System

The Trust uses the HSS CRIS Radiology™ Information System, which is currently provided by CSC. The contract for this system expires in 2013. The department is satisfied with the service provided by HSS.

The department has the opportunity to procure a second version of CRIS, which would provide a disaster recovery solution. This would allow the historical data to be migrated out of the CSC solution at a reduced cost and complexity over the traditional route.

A number of options for continuation of the HSS solution at the end of the contract with CSC are currently being investigated including locally hosting the live service and continuing the service arrangements with CSC. The benefits of each approach are being looked at carefully by imaging however the preference would be to retain a cluster wide service as this enables more seamless communication of images with other Trusts.

### 3.5 PACS

Project 5  PACS Replacement	High Level Requirements	Benefits
Cost: £500K  Funded:  Subject to business case approval.  Proposed use of HIS Capital 2013/14  Year:  2013/14	Provision of storage and exchange of mechanism for DiCOM images	Site wide access to images  Improved access to images by clinicians and subsequent improvement to patient care.

The adoption of PACS by all acute trusts across England has been widely recognised as a great success story for the NHS. PACS is well embedded now in day-to-day clinical

practice within the Trust. The Central PACS contract managed by NHS CFH expires in June 2013

Given the Trust's reliance on PACS it is a priority that the Trust commences planning for the future PACS service provision. This approach supports the wider NHS direction of putting the management of systems like PACS and RIS into the hands of local NHS organisations.

The Trust currently has the Merge Fusion PACS solution which has been in place for a number of years and was re-procured in 2010. The contract was to provide PACS services to the Trust for 7 years. Merge have offered the Trust a free upgrade to their latest solution (Merge PACS) which would address limitations with the current software, particularly around performance of cross-sectional and mammography images and provide a platform to migrate to a vendor neutral archive (VNA) for the long term storage of medical images.

A move towards a VNA can also provide a scalable image and information management platform for the storage of medical imaging from other clinical departments (ophthalmology, neurophysiology, cardiology etc.) and also serves as the foundation for an overall enterprise imaging strategy. The Trust is also involved in an existing project to review the imaging requirements for the Trust, but an opportunity to provide a solution integrated with PACS and networked Trust wide would provide a low cost solution to the image storage challenge. This solution is offered to the Trust at 100% discount in return for the Trust being a reference site.

### 3.6 Pharmacy

Project 6 Pharmacy	High Level Requirements	Benefits
Cost: TBC  Funded:  Business case developed as part of the EPR	Integration of Pharmacy System into EPR  Availability of inpatient and outpatient prescribing.	Reduction in drug budget  Increased patient safety

<b>Project 6</b>  Pharmacy	<b>High Level Requirements</b>	<b>Benefits</b>
solution  Year:  2013/14		

The Trust uses JAC Pharmacy, one of two pharmacy information systems in common use in the NHS. JAC provides both a stock control and dispensing. The JAC Pharmacy system does include a prescribing module but does not support prescribing messaging. To achieve full benefits from ePrescribing, and higher ROI, ideally both the dispensing and prescribing components should be integrated with full clinical decision support, results reporting, and eRequesting of tests and investigations. It is therefore proposed that the procurement of pharmacy is included in the EPR procurement.

### 3.7 Theatres

<b>Project 7</b>  Theatre Integration	<b>High Level Requirements</b>	<b>Benefits</b>
Cost:  TBC  Funded:  Business case developed	Integration of Theatre System into EPR	Overview of Trust capacity  Integrated reporting and scheduling

Project 7 Theatre Integration	High Level Requirements	Benefits
as part of the EPR solution  Year: 2013/14		

The Ormis theatre system is provided as part of the CSC solution set and is provided at no cost to the Trust until 2016. No issues have been identified with the Trust’s theatre system, and therefore there no immediate requirement to replace the theatre system. It should be noted that it is anticipated that the Theatre systems will be incorporated into the EPR replacement solution. Incorporation into the EPR solution is a requirement support integrated enterprise scheduling and the support of operative and anaesthetic documentation and processes.

### 3.8 Maternity

Project 8 Maternity Replacement	High Level Requirements	Benefits
Cost: £120K Funded: Yes, HIS Capital Year: 2012/13	Procurement of a fit for purpose maternity system which supports community contacts	Integration of the Maternity record within EPR Availability of community record

The Trust currently uses the eVolution maternity system. The Clinical Director and Head of Midwifery have indicated that the system is not fit for purpose and presents significant operational risk to the specialty.

Initially it was anticipated that maternity would be procured as part of the Lorenzo Regional Care; however current intelligence suggests that maternity has been removed from release 3.

With this in mind the Trust will evaluate the risks associated with maintaining the two current Maternity systems and where possible mitigate through local information processing. The Trust will plan for the replacement of the maternity system during 2012/13. The evaluation of replacement systems is underway and the emerging contender for the Trust is BadgerNet. The BadgerNet Platform offers users the ability to create a seamless patient record across Maternity Units as well as Neonatal, Paediatric intensive care and Transport. The software is typically provided as a high quality managed to meet the on-going needs of the clinical community. The BadgerNet Platform can interface with all existing local, regional, and national patient data systems and bedside medical devices which support



As part of the re-procurement of the maternity system the Trust will also evaluate agile working technologies in order to secure and improve information governance and security.

### 3.9 Emergency Department

Project 9 ED Integration	High Level Requirements	Benefits
Cost:  TBC  Funded:  Business case developed as part of the EPR solution  Year:  2013/14	Scanned records (indexed)  Electronic docs and forms  Central repository for all documents  Workflow process	Real time access to patient records  Reduced storage costs  Reduced clerical effort with filing, retrieving and transportation

The Emergency Department (ED) is an important health informatics system for the Trust. The Trust currently utilises the Sigma ED system and the CSC solution. The Sigma solution whilst clinical richer than the CSC solution is not integrated with the PAS. As a result the ED systems remain in information silos. The ultimate objective for ED is the replacement of the system with the integrated EPR system, However as a migration plan a three stage approach is proposed:

1. As an interim solution, the Trust will consolidate on to one product set. This solution will be integrated with the EPR utilising either presentational level integration. This will be known as the interim solution.
2. ED the interim solution will be included in the EPR procurement
3. Full ED integration with the EPR solution

### 3.10 Radiopharmacy

Project 10 Radiopharmacy replacement	High Level Requirements	Benefits
<b>Cost:</b> Estimated £80K  <b>Funded:</b> HIS Capital  Year 2012/13	Accurate measurement of radiotherapy materials.  Production of supporting documentation.	Maintenance of Trust's license and ability to produce radio therapy products.

The Trust's radiopharmacy system was built in-house and is now unsupported. It is used to produce documents which the Trust needs to legally transport radioactive materials. If the system is unavailable there are significant delays to supplying our external customers. The department have expressed concerns over the systems processing of data particularly in relationship to the measuring of radioactive content and management of units of measurement and document production.

The new system will support compliance with quality standards, and if networked to the rear clean room, will support the department achieve a paper free operation and improve levels of microbes within the clean area. Failure to address the deficiencies in the system will compromise the Trust's license to produce radiopharmaceuticals.

Given the specialist requirements for both nuclear medicine and radiopharmacy the Trust will consider a joint procurement for an information system.

### 3.11 Chemotherapy prescribing

Project 11 Chemotherapy prescribing	High Level Requirements	Benefits
Cost: Estimated 80K Funded: Yes, HIS Capital Year: 2012/13	Electronic chemotherapy prescribing. Interoperability to ePrescribing/EPR solution	The risks include for example the potential for delivery of inadvertent and potentially fatal overdoses of cytotoxic drugs, or of inappropriate or mistimed chemotherapy agents and treatment protocols.  It facilitates standardised protocol based prescribing and reduced the risk of errors, and improves patients safety  It facilitates monitoring of the use of chemotherapy

Chemotherapy prescriptions are complex. A cycle of treatment often consists of a number of different chemo-therapeutic agents administered on a different day of the cycle, via different routes of administration and over different time periods. The regimen may include a period of pre and /or post treatment hydration and prophylactic anti-emetics. The prescriptions are therefore time consuming to write and a potential source of error.

The full introduction of electronic prescribing will improve standards of clinical governance and facilitate risk management by providing a fully auditable record of all chemotherapy prescribed and administered. To meet this requirement the Trust will evaluate the solutions available for chemotherapy prescribing and their integration with the ePrescribing/EPR solution. The Trust will review the requirement for an interim solution. Chemotherapy prescribing is a complex and very specialist prescribing function and is likely to require a specialist solution to meet the necessary requirements.

### 3.12 Nuclear Medicine

Project 12 Nuclear Medicine	High Level Requirements	Benefits
Cost:  Estimated 80K  Funded:  Yes, HIS Capital  Year:  2012/13	Nuclear medicine information system  This system has been developed internally and needs to be placed on a sustainable platform. Failure to do so will compromise the Trust's service capability	It facilitates standardised protocol based prescribing and reduced the risk of errors, and improves patients safety  It facilitates monitoring of the use of nuclear medicine

The Trust has developed the Nuclear Medicine Information system in-house and this now needs to be placed on a sustainable support platform and replaced with a commercially sustainable product. This will maintain and improve the tracking, dosing and quality control records associated with nuclear medicine doses and drugs. Given the specialist requirements for both nuclear medicine and radiopharmacy the Trust will consider a joint procurement for an information system.

### 3.13 Electronic Document Management

Project 13 EDM	High Level Requirements	Benefits
Cost: Funded: Yes Year:	Scanned records (indexed) Electronic docs and forms Central repository for all documents Workflow process	Real time access to patient records Reduced storage costs Reduced clerical effort with filing, retrieving and transportation

The Trust maintains paper records through the Medical Records service, 100 staff are involved in the distribution and collection of these documents. To support the moving to electronic documents and to support the development of the PaperLite environment the Trust has developed the Clinical Data Archive which is a store of electronic clinical records.

The Trust currently runs 6500 clinics per month. Documents are collated and distributed to the clinical areas up to 4 days prior to the clinic date. Additionally, with 4,400 events in A&E per week there are a number of ad hoc requests also to be dealt with. There approximately 2 million case notes in the Trust with the majority held off-site. Although the medical records are barcoded and tracked, in some cases records become displaced for a period of time and therefore are not available for clinical colleagues. In an instance such as this a duplicate temporary paper record is compiled. When the original case notes are located the two records are then merged and updated.

Much of the information held on paper is duplicated on many of the clinical systems or on shared network drives across the organisation. Leaving in the main ward and clinic based clinical notes that are handwritten and external referral letters that are the sole copy in the patient based paper record.

In addition many departments hold their own paper based records for patient care including services such as A&E and maternity. This is due to the need for records to be accessible, for specialist care and for confidentiality.

The scanning and indexing of selected paper based records (new and historic) enables immediate retrieval of those electronic records at the point of need – this is referred to as Electronic Document and Records Management (EDRM). EDRM ensures a single view of all records (paper and electronic) associated with a patient as well as other Trust documentation.

Robust indexing of records ensures that they are securely linked to a patient where applicable and full audit capabilities are available to ensure that data security breaches and errors are mitigated. Electronic records are retrieved via a search interface in real time; physical records are tracked and the paper assets are “sweated” to provide greatest value.

A document management solution that combines data held electronically across multiple systems and supplemented by an electronic view of paper based records will provide significant benefit. By maintaining a mixed economy of paper and electronic documentation the need for paper records is reduced over time which will provide savings for the Trust and support the migration to a PaperLite Operating model.

The introduction of electronic document management must be supported by the creation of a central repository for all clinical notations to enable the migration from handwritten, paper based systems to a solution that enables real time data capture of patient documentation.

The system must enable form type data entry and workflow processes, standardising where possible the hundreds of forms and templates currently in circulation. The Trust is currently looking at voice recognition and the reconfiguration medical typing services. In addition a central repository for certain documents such as ward round notes, theatre notes, and discharge summaries. A number of these documents need to be shared with other healthcare professionals within and external to the Trust to maintain continuity of care plus copies to the patients.

EDRM benefits the Trust by supporting the Transformation Plan, by embedding the use and management of electronic records. Its adoption also reduces the amount of data digitization and migration to the EPR and supports the Trust’s migration to a PaperLite operating model.

It is proposed that the Trust proceeds to evaluate further the EDRM market leaders and options appraisal. The implementation of an EDRM solution compliments and enhances the Trust’s migration to integration EPR and supports the Trust’s migration to a PaperLite operating model.

### 3.14 Community Systems

Project 14 SystemOne	High Level Requirements	Benefits
Cost: TBA  Funded: Yes  Year: 2013/14	Review of existing functionality and modules with planned rollout to community and palliative care.  SystemOne in the Community, with increased use of SystemOne over mobile devices	Real time access to patient records  Improved information governance and security  Real-time data access at the point of care  Completeness of the patient record.

The Trust SystemOne developed by TPP. This solution is implemented within the PCT and also within our Community and Therapy Services. The solution was inherited by the Trust as a result of the TCS project, it has a flexible capability and can be implemented as part of a fully integrated system across an entire PCT or as individual solutions for Community, Child Health, Prison, Urgent Care, Palliative and General Practice.

The Trust has yet to fully exploit this capability; however the solution is seen as fundamental to supporting the integrated care pathway. As part of the development of this Informatics Strategy, the Trust will develop a roadmap for the rollout of the functionality within the community. There are a number of key areas that the Trust wishes to exploit by the rollout of the SystemOne functionality.

#### 3.14.1 Agile Working in Community

SystemOne offer a variety of mobile solutions including use of SystemOne via laptops and PDAs. SystemOne also offers the SystemOne Briefcase which the Trust will evaluate as part of the agile working project

## 4 Information Services

The Information Services team provide information to meet the operational needs of the Trust; this includes but is not limited to:

1. All National Commissioning datasets to the secondary user service (SUS)
2. National dataset submission to a variety of destinations
3. National Unify Submissions
4. National/SHA/Local Returns
5. Operational Reporting within the Trust
6. Management Reporting for the Trust
7. Data Quality Improvement in the areas of NHS number, GP Practice, DOB, Ethnic Origin
8. Provides feedback on data quality to the operational services and the Trust Board.

The Trust has placed significant focus on meeting its regulatory and performance obligations over the past few years. This has required effective information management to provide the Trust with accurate, timely and relevant information reporting that provides a true picture of the performance of the Trust services across a range of parameters. The demand for information is growing at an unprecedented rate as a result of more complex commissioning rules, greater regulatory requirements and the drive for quality and efficiency.

Information Services are the conduit for information flows in support of the business. As the focus turns to implementing clinical information systems, the Trust will see an increased demand for data to support the performance management, QIPP and Transformation programme. This will place further demands on Information Services to support care and capacity planning. The Trust will therefore require Information Services to change and modernise to meet these challenges. Investment in training to use additional products will need to be increased to help realise some of the benefits that can be realised with better analysis of the available data to provide better information. The Trust when purchasing new systems must take into consideration the ability of any system purchased to integrate with existing systems and also in the system's ability to allow interrogation to allow for clinical reporting and analysis.

Information is a vital asset for the Trust, supporting both day to day clinical operations and the effective management of services and resources. The Trust requires accurate, timely and relevant information to enable it to deliver the highest quality health care and to operate effectively. Having accurate relevant information available at the time and place

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where it is needed, is critical in all areas of the Trust's business and plays a key part in corporate and clinical governance, strategic risk, service and workforce planning and performance management.

The introduction of Clinical Commissioning Groups (CCGs) will result in commissioning decisions and budgets being amended across the local health economy.

Trusts' use of resources is assessed by the Audit Commission's ALE assessment which is based on financial reporting, management and standing as well as internal controls and value for money.

These two assessments provide an integrated approach is more stringent than that previously adopted and requires robust, consistent reporting across all areas of activity and performance. The current infrastructure needs strengthening to ensure accurate and timely data recording and collation in all areas.

The HIS is a key component to the Performance Management Framework (PMF), both as holders of the data held in operational systems and as developers and publishers of performance indicators. This involvement is expected to increase during the life time of this strategy particularly when the Trust achieves Foundation status.

The Information department have developed a Quality Management Framework (QMF) System around Key Performance Indicators produced as a by-product of other information processes. This will mean that the KPIs will be available as soon as the data is available from any daily or automatic downloads from the IT systems.

## 4.1 Data Quality

<p>Project 15</p> <p>DQ Managed Service</p>	<p>High Level Requirements</p>	<p>Benefits</p>
<p>Cost: £32K</p> <p>Funded: Provisionally</p> <p>Year: 2012/13</p>	<p>Managed service that provides real time data quality updates</p>	<p>Improved data quality</p> <p>Preparation for data migration</p>

The Trust is aware of the need to maintain and improve data quality. Data quality is a known issue within the Trust and currently has a direct impact upon the Trust's operational systems. Data quality is essential to the current operations within the Trust and is also essential in supporting data migration to the new integrated EPR

Information is a vital asset, both in terms of clinical management of individual patients and the efficient and effective management of services and resources. It plays a key part in clinical governance, service planning and performance management and is crucial to support Payment by Results (PbR).

The increasing demand for the provision of information within shorter timescales and the support of the 18 week patient pathway means the Trusts no longer have the luxury of being able to perform extensive data quality checks before information is released. Consequently, it is more important than ever that information is recorded promptly and accurately at source, and is 'fit for purpose'.

The structural changes outlined in Shifting the Balance of Power mean that a large number of commissioners will be looking for more information including service quality. With the disappearance of health authorities and regional offices there may be fewer external checks on the integrity of trust-generated information.

Since 1989 comprehensive national data has been collected in the form of HES. The Kennedy Report recognised that HES data will only be used if it is reliable. At national level HES data has been considered fit for purpose: accurate and timely enough for epidemiologists and planners. However, there are widespread doubts as to whether HES data is fit for all purposes. A higher standard of accuracy is required if decisions are to be based on information from local data sets which can be distorted by a few significant errors.

Models of care are changing. Single episodes of treatment within a single specialty at a particular trust are not relevant. Information needs to follow the patient journey. Different people will be making use of data with different assumptions, this can and will cross-organisational boundaries. Data must be collected in a consistent manner. Clinical networks are becoming increasingly important and these networks will play a vital role in developing good practice. Clinical data sets are becoming the norm and this is widening the range of patient information that can be made available. Clinical governance demands better-quality data.

Improving data quality is more about encouraging positive attitudes than installing the best IT systems. The delivery of Electronic Patient Records will ensure comprehensive patient-based health care records are delivered and this certainly widens the scope of what information is currently available to support the delivery of patient care.

Internal validation is a pre-requisite of any modern IT solution and should be an essential feature. In addition, the greater the integration of systems to support the EPR, the more likely it will be to support data quality and reconciliation of information.

The current Data Quality policy has been reviewed and updated. A detailed data quality and reporting plan will be developed to ensure accuracy of data from all major IT systems to support trust performance targets. A major focus will be on achieving robust real-time data input by users of IT systems and operational ownership and clear understanding about the data staff key into systems and how that can impact on patient care delivery and the Trust's Quality accounts, performance targets and financial systems.

## 4.2 Business Intelligence

Project 16 Business Intelligence	High Level Requirements	Benefits
Cost: TBC Funded: HIS Establishment Year: 2013/14	Integrated dashboard on all key metrics (clinical quality, finance & productivity, patient & customer experience; workforce & learning)  Real time transactional updates to extract, load and transform data  Toolsets appropriate to the roles accessing, analysing and acting on the data	Improved insight  Improved operational efficiency and productivity  Improved performance management through robust and transparent data  Better use of national bench marking data

The Trust is dependent on high quality data, and it is essential that the Information Services function develops to a business intelligence function which is established to target, gather, deliver and analyse data, to support the Trust objectives. A business intelligence (BI) function is at the centre of informed and precise decision-making that will improve patient and service outcomes in addition to ensuring the Trust's future.

Access to relevant and timely information enables rapid decision making ensuring the Trust is making the right strategic decisions either for long term planning purposes and operational decisions ensuring that patients are receiving the right care at the right time. Both would improve the effectiveness and efficiencies in the management of our services and resources.

To achieve the full benefits of BI, the Trust must take an enterprise wide, strategic approach to BI rather than an ad hoc tactical approach to information management. The greatest efficiencies come from integrating data historically siloed in financial, operational and clinical systems. A strategic approach to BI, which cuts across the organisation, requires buy-in from not only Trust executives but also corporate and clinical staff.

Finally, it is important to ensure that the Business Intelligence Platform is underpinned by a robust and managed technology platform. The physical infrastructure drives performance, reliability, flexibility and integration of the system and must be considered as part of the wider Service Management and Infrastructure strategy at the Trust.

### **4.3 Clinical Coding**

Clinical Coding has become a critical function for the Trust following the introduction of Payment by Results. Coding is currently carried out using ICD-10 and OPCS-4. It is likely that the standard of SNOMED-CT will be adopted in the future with the implementation of Electronic Patient Records and clinical documentation. This is unlikely to replace clinical coders; however roles are likely to change, as they will be required to work more closely with clinical staff and provide a high degree of audit and training. In addition, there are many other codes which will be unlikely to be collected as a by-product of clinical practice, but are required for epidemiology and research at both national and local level e.g. accident and morphology codes.

Applications, such as SimpleCode (clinical encoder) will be increasingly used to monitor the Trust's performance of coding, whereby codes are loaded into the application to make suggestions to the coding staff of coding alterations, which in turn also highlights areas of training required.

Electronic Discharge Summaries are currently created by clinicians from iCM in real time and the introduction of electronic board rounds will assist in the improvement of accuracy of this data.

In 2011 a review of the clinical coding service was carried out by CHKS and that review identified some key changes that are needed to improve the service delivery and accuracy of clinical coding. These are summarised below:

1. The Trust should restructure the Clinical Coding Team.
  2. Coding staff should cease to code radiology and diagnostic imaging that has already been electronically coded.
  3. Introduce a systematic approach to the delivery and allocation of coding work.
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4. Encoder software should be implemented.
5. To facilitate the introduction of encoder software two training seminars should be held, enabling staff to raise any concerns about the software.
6. Ensure greater engagement between clinicians and coding staff to help improve the coding process.
7. The Coding Department should reintroduce the appraisal process for all staff and ensure that staff has sufficient time and opportunity to undertake relevant training.
8. Reasonable time should be allocated to allow staff to update their coding books.
9. For future employees, coders should be awarded band 4 pay upon passing their qualification and being awarded Accredited Clinical Coder status.
10. Implement an income recovery coding review to assess the level of coding and the extent of any lost revenue
11. Reduce the quantity of coding checking and replace with an auditing framework.
12. Provide staff with greater autonomy over their workload and give personal responsibility for achieving deadlines.
13. Reduce the reliance on overtime and agency staff by recruiting the establishment, harmonising pay scales and training staff to deliver work efficiently at acceptable quality standards.
14. Staff at both sites should be brought under a single management structure with the head of coding managing both sites on a regular basis.

15. The Trust should consider rotating staff between sites to ensure staff experience different working practices on both sites.

16. Introduce bi-monthly meetings for all staff and monthly meetings for senior coders and management to improve communication and share working practices.

17. Policy and Procedures documents should be updated and placed on the SharePoint site for easy access by all staff.

18. The policy and procedure documents should be used to help harmonise working practices and ensure that staff are encouraged to work at alternative sites, for example to cover sickness absence, do not experience different working practices.

19. A performance framework could be used to incentivise staff to achieve targets but it should take into account case mix and training responsibilities to ensure equity of targets.

These recommendations will be fully implemented as part of this strategy.

Coding needs to be accurate and the Head of Information will ensure the timely completion and accuracy of clinical coding to meeting contracting and Payment by Results. An external annual clinical coding audit will also be performed.

## 5. Infrastructure and Telecommunications

The Trust have a mature and well developed IT and telecommunications infrastructure that supports the delivery of IT systems to departments across the main sites and also to community sites and staff homes.

Investment in this core infrastructure is essential to allow rapid and reliable deployment of existing and new systems. Demand for access to systems and adequate resources to allow those systems to expand (storage capacity etc.) is continually increasing and the Trust must ensure that there is planned growth of all the key areas so that the reliability and resilience of these systems is not reduced or compromised.

### 5.1 Network Infrastructure

Project 17	High Level Requirements	Benefits
<b>Infrastructure</b>		
<b>Cost:</b> TBC <b>Funded:</b> HIS Capital <b>Year:</b> 2012-2017	Completion of migration to new core network Completion of rollout of new Wireless network services Development of Public Wi-Fi Access capability Expansion of capacity of Trust VPN Development of mobile device management capability and services	Improvement in performance/capacity and resilience of the IT network Improved access to network for mobile devices Improvement in Patient/public satisfaction Ensure access to Trust VPN for remote users is secure and robust Improve capability for supporting mobile devices. Information governance improvements.

The Trust IT network is absolutely fundamental to the use of systems, communications and the future operation of the Trust. The use of modern Storage Area Networks (SANs) and replication/backup of data between data centres is dependent on fast dependable network links. The demand for mobile access to IT through the use of campus wide Wi-Fi networks requires a robust network infrastructure to deliver.



All of the services in this strategy are dependent on the Trust IT network to deliver them.

The development and rollout of the network on both sites will continue to enable the delivery of these services.

Outside of the Trust the network now extends into a range of community sites that were previously managed by Sandwell PCT. In addition the move towards agile is driving the demand for connectivity to the Trust network at an increasing number of sites that either have limited or no N3 connectivity available. A review of the solution in place will be undertaken to understand the limitations of the services being provided and to provide a plan for replacement/upgrade of the service where possible/appropriate.

With the movement towards “agile” working there is also a rapid increase in demand for access to systems from outside of the Trust network, specifically from staff in their homes etc. The provision of robust access to the Trust network through the use of Virtual Private Networks (VPN's) is essential.

A project to develop a “public” Wi-Fi network within the Trust for patients/visitors to access will be established with pilot areas setup in the restaurant/café facilities within the Trust. If successful this pilot may then be rolled out more widely to other areas of the hospital

To support the development of the use of mobile devices (iPads etc.) within the Trust a mobile device management (MDM) service will be setup and deployed to the existing devices in use within the Trust (iPhones).

## 5.2 Data Centres

Project 18 Data Centre	High Level Requirements	Benefits
Cost: TBC Funded: HIS Capital Year: 2013/14	Upgrade to City Computer Room infrastructure ( air conditioning, UPS protection, physical estate )	Improvement in service availability and reduction in impact of major infrastructure failures (power etc.)

The Trust has three data centres that house the local server/network facilities, two at Sandwell and one at City. A new data centre was procured and installed at Sandwell in 2010 and services have been transferred from the legacy room over the last couple of years. A small number of services remain in the old room (core network switches, backup facility) but all the essential servers are now located in the new custom built facility (located in the site of the old mortuary).

The new Sandwell data centre was built to a high specification and has robust air conditioning and UPS protection in place.

The existing centre at City is around 30 years old and whilst it was a custom built computer room it has a number of areas that require investment. Primarily this is the existing 30 year old air conditioning service which is now at end of life. There is a new unit in the room which provides backup to the original hardware but neither the old or new units are capable of cooling the room on their own which is a risk should one of them fail completely. The old air conditioning unit at City needs to be replaced with another new unit and the existing unit upgraded to provide a full N+1 service.

UPS protection at City is provided through rack mounted UPS units rather than a room wide service. These individual units are difficult to maintain (downtime on racks is required to swap out faulty UPS's). A room wide service could be centrally maintained and would make individual rack downtime for maintenance unnecessary.

The planned development of the two primary data centres is to migrate towards Sandwell becoming the Primary data centre and for City computer room to act as the secondary or disaster recovery site. This work entails significant re-development of the server/SAN and network infrastructure and is at least a 2 year programme of work to achieve, however it is essential that this work is undertaken to enable a robust and well defined DR capability.

### 5.3 Server Infrastructure

Project 19 Server Infrastructure	High Level Requirements	Benefits
Cost: Funded: Year:	Continue to transition physical servers into virtual environment ( VMware )  Continue consolidation of server infrastructure towards establishing a primary and secondary data centre model	Improved DR capability.  Improvement in time to deploy new services, reduction in resource required to deploy.  Reduction in heat/power requirements ( cost saving in electricity )

The Trust strategy for the server infrastructure is to move towards a “virtual” environment. Virtual server technology allows many servers to be run on a small number of high powered physical servers. This has many benefits including reduction in power/heat/cooling requirements, improvements in the actual utilisation of the server infrastructure (typical standalone servers operate at very low levels of utilisation, virtual servers reduce this inefficiency by compressing many servers onto one physical server), improvement in ability to recover from server failures etc.

The Trust virtual server platform is VMWare and there are currently two VMWare clusters (four servers in each cluster) in operation, one at City and one at Sandwell.

These cluster currently run around 120 servers. The remaining physical servers on each site that can be virtualised are planned to be migrated into these environments.

The current work to transfer legacy physical servers to the virtual environment will continue and new servers will be provisioned in this way also unless the requirements of the solution preclude the use of VMWare (few systems fall into this category).

## 5.4 Storage Area Network Infrastructure

Project 20 SAN	High Level Requirements	Benefits
Cost: Funded: Year:	Continue development of new SAN infrastructure  Complete migration of data and infrastructure from legacy SAN's on both sites to new SAN	

Modern data centres have moved away from the traditional model of each server having its own local data storage (hard drives) towards the concept of shared storage. In this model all the servers are connected to a separate network by high speed adapters that allow storage space on a large central pool of hard drives to be configured as if it was local to that server. This pool of storage is known as a Storage Area Network or SAN for short.

The investment in upgrade to the Trust Storage Area Network (SAN) in 2012 will support the virtualisation of physical servers as well as the transition towards the use of Sandwell as the primary Data Centre and City as a secondary disaster recovery site.

The new SAN was designed to support replication of data between the Sandwell and City data centres by default. This replication ensures that in the event of failure of a data centre the data held on corporate servers is not lost and can be provided from the recovery site in a short space of time.

The use of SAN technologies is also key to providing the rapid, on-demand availability of storage demanded by modern IT systems and the continued investment in and development of the SAN is crucial to supporting the Trusts IT systems now and in the future.

Demand for storage is constantly increasing and whilst the capacity purchased in 2012 was planned to provide growth for a number of years the expansion of this service must be planned and budgeted for going forward.

## 5.5 Agile Working

Project 21 Agile Working	High Level Requirements	Benefits
<b>Cost:</b>  <b>Funded:</b>  Yes  <b>Year:</b> 2012/13	User virtualisation profile management  Application virtualisation  Desktop virtualisation  VPN solutions / BYOD / Cloud based systems and data  Fax server  Centralized print management services  Standardized Multi-Functional Devices  Follow me print capability	Improved desk/space utilisation  Flexibility  Enhanced team working  PaperLite working  Reduced IT support required

The delivery of high quality healthcare is increasingly dependent upon technology, both within the Trust and within the local health care community. Today’s workplace is no longer a static physical place and a variety of devices from laptop to tablet to smartphone are in use within the Trust. The objective of Agile working is to bring people, processes, connectivity and technology, time and place together to find the most appropriate and effective way of working to carry out a particular task. It is working within guidelines (of the task) but without boundaries (of how you achieve it).

The Trust’s approach to agile working has been piloted with the development of the Management suite, the objective being to embrace both the physical and digital “workplace” by empowering and supporting people to work where, when and how they choose to maximise their productivity, innovation and ultimately to deliver best value to the organisation. The Trust’s approach to agile working will underpin the development of service delivery and the future operating model of the Trust the objective is to “develop an approach to enable the Trust to deliver safe, high quality patient care to meet the needs of the local health community care with maximum flexibility and minimum constraints. It goes beyond just

flexible working or telecommuting and focuses on eliminating the barriers to getting work done efficiently.

The Trust has already embarked upon an agile working pilot as part of the Trust's Transformation plan. The Executive Team have already moved to an agile working mode. This includes the deployment of "follow me" print services enabling users to retrieve printouts previously sent from any PC in an agile working area from any printer configured in an agile working area and a user profile management (user virtualisation) solution so a user's personal configuration settings follows them to any computer they log on to in an agile working area resulting in no system configuration being required before they are able to start working at the computer they are using. Further work is required to manage the large number of software applications (application virtualisation) to be used in agile working areas to enable applications to follow users to whichever PC they are currently logged onto and eventually to provide a hosted and/or virtual desktop (desktop virtualisation) solution to enable simple agile working from any network connected location either at a Trust site or over the internet using VPN. A planned future development is to introduce a fax server to remove the need for the large number of physical fax machines used across the Trust to receive faxes while using NHSmail to send faxes having scanned any documents required using standardized multi-function devices already in place to provide copying and printing facilities.

## 5.5 Active Directory

Project 22 Active Directory	High Level Requirements	Benefits
Cost: TBC Funded: HIS Capital Year: 2013/14	Upgrade Active Directory to Windows Server 2008 Domains  Decommission link to Sandwell PCT AD  Decommission SWELLHOT domain	Enhancements in granularity of AD tools for restoring/rollback of changes  Enhanced security through fine grained password policy etc.

The Trust Active Directory (AD) service underpins almost all of the existing IT systems by providing a single directory of staff and devices. This directory is used by many of the Trust IT systems to validate and authenticate users.

The AD users database is integrated with the NHS ESR through the use of a third party tool ( Directory Manager from BDS ) which provides for the automatic creation of new user accounts when staff are added to ESR, and also the automatic removal of accounts when staff are removed ( leave the organisation ).

The current AD environment was setup in 2004 through the merger of the existing City and Sandwell directories (NT Domains). Subsequently a link to Sandwell PCT domain was created in 2011 for the transfer of community services.

The Trust will upgrade the current Active Directory environment from the existing Windows Server 2003 servers to Windows Server 2008. This upgrade will help to provide a more

robust service through the enhancements in the latest software through better security facilities, improved controls and capabilities.

## 5.6 Medical Voice Recognition

Project 23 Voice Recognition	High Level Requirements	Benefits
Cost:  Subject to options appraisal  Funded:  Subject to business case  Year:  2012-13	Integration with diagnostic reporting and clinical documentation	Improved turnaround time for reporting and communications  Rationalisation of secretarial services

Medical Voice Recognition offers numerous benefits, alleviating the burden of documentation, which is one of the most trying tasks in the practice of modern medicine. Over the years, there have been various approaches towards facilitating data entry from large groups of transcribers to online forms listing the most common findings and procedures. Medical voice recognition and computer dictation has been a technology offering promise for efficient documentation since the 1980s. As the technology has improved tremendously, more facilities are working easier while enjoying time and cost savings.



In the last 10 years there have been significant improvements in medical voice recognition, including vocabulary size, continuous speech opposed to word-by-word discrete recognition, recognition accuracy, integration with standard and IP telephony systems and other technologies.

The implementation of medical voice recognition software, allows the clinician to interact with the program engine on the PC until the report is to their liking. When it has been created, the report is signed off which completes the process. The obvious advantage here is immediacy. The user gets to interact with the system in real-time, giving them the ability instantly correct errors. As soon as the report is printed, it is ready for signing. With a faster turn-around, patients can be diagnosed and treatments can be applied in a more timely fashion, something that is critical in a large medical facility.

The Trust has a number of digital dictation solutions in place and there is a need to standardise the options. This will allow the Trust to improve the timeliness and cost of producing consultant letters following an attendance at outpatients and other clinical documentation that is typed, posted and a copy filed into the patient record.

Voice recognition is currently used within the radiology department with significant success.

In terms of ease of use and ability to get information to patients, GPs and clinical colleagues, voice recognition will be a significant development for the Trust in terms of process change and the expected reduction in administrative staff.

With these advantages in mind we would like to take advantage of voice recognition technology to help resolve some of the business problems relating to transcription of clinical data. The solution should combine digital dictation with intelligent, integrated speech recognition, electronic signature and document distribution. The intelligent speech recognition components should produce a formatted draft document which can be edited rather than typed from the start. It is envisaged that productivity improvements along with workforce optimisation/changes may lead to cost savings for the Trust. This will also increase productivity of existing staff members.

## 5.7 Managed Print Services

<b>Project 24</b>	<b>High Level Requirements</b>	<b>Benefits</b>
<b>Managed Print Services</b>		
<b>Cost:</b>	<b>Centralized print management services</b>	<b>Reduced paper</b>
<b>Subject to options appraisal</b>	<b>Standardized Multi-Functional Devices</b>	<b>Increased information security</b>
<b>Funded:</b>	<b>Follow me print capability</b>	<b>Remote printer diagnostics and support</b>
<b>Subject to business case</b>		<b>SLA for printer fixes and replacement programme</b>
<b>Year:</b>		<b>Reduced environmental impact</b>
<b>2012-13</b>		

Currently the Trust maintains a significant network of colour copiers, printers and multi-functional devices (MFDs) throughout the three sites. A significant number of these are stand-alone printers. They also cover a number of manufacturers, including Ricoh (predominantly system printers) and Hewlett Packard (local printers). The equipment base is diverse comprising both owned and leased equipment. A significant number of these are approaching end of life. Maintenance of these devices come under the HIS service desk and second line technical support or through a managed service contract for the MFDs. This leads to in-effective use of technical resources, re-active approach to print repairs, poor user experience, poor utilisation of printers and expensive commodities.

The Trust requires the managed print service to provide:

- all print equipment required to support printing across the Trust (including multi-functional devices);

- proactive maintenance of all printing equipment including the use of devices that automatically alert a central server to any printer problems;
- monitor usage of printing devices, providing intelligence to the Trust on who is printing and at what volume, as well as the rate of use of printing supplies to support more efficient purchasing;
- centrally co-ordinate and support print related policies, such as black & white duplex printing by default, ensuring policies are adhered to throughout the Trust;
- support the trust in meeting its environmental and sustainability obligations and act as an environmentally responsible organisation;
- optimisation of print service over time to support on-going cost savings and delivery of service that supports the differing print needs across the Trust.

Use of multi-functional devices which are networked and support *'follow-me'* printing and capabilities is key to the implementation of agile working and to an efficient and effective print service. Multi-functional devices provide faxing and scanning capabilities in addition to printing. Therefore, reducing the number of devices required across the Trust.

The Trust, as part of the agile working pilot has enabled *'follow-me'* capability of a number of devices which enables users to securely print anywhere in the Trust as prints are queued and only output when the legitimate user swipes a SMART card or enters a personal code at the printer device. This addresses issues with data security and patient confidentiality where confidential information could be left on a printer for unauthorised users to access or view as well as avoiding print jobs that are not collected.

A managed print service will also develop custom interfaces as required for legacy systems that cannot connect to networked printers and for future systems. Interfaces will mimic a connection to a desktop printer and therefore enable fully centralised printing. These interfaces will be supported and maintained in the same way as printing equipment.

These printers hold data and are subject to the same policies around information governance and security and will be subject to the same legal and security requirements as other electronic devices.

The Trust would expect to develop a print reduction strategy that aligns the incentives across the different operational and transformation projects. This strategy will also need to link and align with the EDRM.

## 5.8 Unified Comms/Location Based Services/Patient Services Access

Project 25 Unified Comms	High Level Requirements	Benefits
<p>Cost: Subject to options appraisal Funded: Subject to business case Year: 2012-13</p>	<p>Continued rollout of IP Telephony services where possible.</p> <p>Single number ID</p> <p>Hybrid of IP / smart phones and other mobile devices</p> <p>Integration with clinical apps and medical devices</p> <p>Bedside communications and multi-media devices</p>	<p>Real-time alerting and communications</p> <p>Presence awareness based on rosters and availability</p> <p>Geographic tracking and logistics management</p> <p>Removal of bleeps / pagers</p> <p>Improved access and communications for patients and carers</p> <p>Real-time asset management</p> <p>Real-time location services</p>

### 5.8.1 Unified Communications

Unified communications (UC) is the integration of real-time communication services such as instant messaging (chat), presence information, telephony (including IP telephony), video conferencing, data sharing (including web connected electronic whiteboards aka IWB's or Interactive White Boards), call control and speech recognition with non-real-time communication services such as unified messaging (integrated voicemail, e-mail, SMS and fax). UC is not necessarily a single product, but a set of products that provides a consistent unified user interface and user experience across multiple devices and media types. There have been attempts at creating a single product solution however the most popular solution is dependent on multiple products.

The Trust has already started the implementation of an IP telephony solution as a result of the introduction of agile working and has other UC elements in place (voice messaging, video conferencing) in certain areas, however the major benefits of UC are dependent on wide scale adoption and availability of these new solutions which to date has been limited due to the legacy infrastructure in place.

Migration from the existing PABX solutions to IP telephony can be achieved through a gradual transfer over a number of years. This would reduce the risk of implementation in critical locations and enable the embedding of solutions in safer environments such as office locations initially and in parallel in clinical areas so there is a backup solution.

The move to IP Telephony provides a potential platform for tighter integration of IT systems and improvements in communications flow as a result. Some areas of improvement are highlighted below:

1. **Presence awareness** – IP Phones can be integrated with systems to determine if a particular member of staff is available (by virtue of the fact that they have logged into their phone), and potentially route calls to the most effective type of connection (voice, video, instant message).
  2. **Single number ID** – individuals could be contacted using a single number incorporating multiple devices e.g. office number, mobile numbers, off-site numbers, home numbers (setup by the user and hidden to callers with rules supporting routing preferences). This supports the removal of multiple portable devices (mobile, Good technology, bleeps and pagers) carried by doctors, other clinicians and on-call teams. It would facilitate flexible working arrangements, reduce delays in routing calls and also re-route calls back through the Trust for charging and quality monitoring.
  3. **Reduction of bleep/pager and directory services** - will reduce the demand for switchboard services and realise consequent savings, whilst reducing risk through
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minimising delays in contacting the right clinical support team, on-call managers or individuals. This will require a change in current processes and working practices, including users more effectively managing their own call rosters.

4. ***Integration with medical devices and clinical applications*** will support the provision of key data and clinical alerts to clinicians to improve clinical decision making and the patient care experience.

The move from standalone telephony solutions to Unified Communications solutions will typically entail integration of telephony with desktop PC's and laptops to deliver seamless connection between voice, data and video. The Trust will need to evaluate the most appropriate way to manage this transition to determine the best fit for our existing solutions.

### **5.8.2 Location Based Services**

Location based services covers the use of IT networks and software in conjunction with wireless positioning (either by GPS or by Wi-Fi network triangulation techniques) to identify the position of an asset. This positioning information can be used to locate people/equipment within the hospital environment and communicate this to anyone who might need it. Simple examples might be to locate the nearest member of staff to an event (cardiac arrest) and to alert them or to find an item of equipment in the hospital to prevent wasted time in searching departments.

The use of Wi-Fi to provide positioning information necessary requires a very high density of wireless access points to be installed. The current Trust wireless network would not support accurate positioning of devices; however in defined areas (A&E etc.) suitable network upgrades to allow the implementation of location based services may be possible.

This may for example provide the ability to know in real time who is on duty, their location and be able to contact the appropriate clinician to discuss patient conditions and results. The impact of such a solution would be particularly advantageous in managing emergency care flow where poor communications are directly impacting our ability to deliver timely care and meet national ED targets.

Modern and effective communications between clinicians, staff and patients is critical to the delivery of effective modern healthcare. A solution that enables effective and timely communication across care settings and sites is a key enabler for safe and efficient clinical care and enabling many of the transformation challenges that we face.

### **5.8.3 Patient Bedside Devices/Patient Access**

Patient access to communications is an important aspect of the care provided during stay in hospital. Access to the Internet, TV/Video, telephony, patient call is all vital services which are currently not integrated and consistently delivered.

The Trust should develop a solution that enables patients to access these services through the use of an integrated solution at the bedside. Such a service could also provide easy access to patient health information, communications with clinicians and other interactive services such as meal booking/surveys etc.

All of the above services are underpinned by a robust and scalable wireless network infrastructure. Provision of wireless networks can allow much more rapid deployment of communication services than has been possible in the past. As a result development and expansion of the current wireless network is key to the rollout of all of these facilities.

### **5.8.4 Mobile Devices**

Mobile devices such as Smartphones and other handheld devices are now in common use within society and within the Trust. The Trust already uses the smart phones (iPhone) as part of our Telephony solution. There are increasing demands to use mobile devices within the Trust, however this represents a number of challenges to the organisation in terms of licensing, information security and information governance. In addition a number of core Trust applications are not optimised for use with mobile devices. As part of the development of the HIS strategy and the development of agile working within the Trust we will establish a mobile device group and establish a mobile device policy which will support our strategic informatics vision.

### **5.8.5 Bring Your Own Device Policy**

Bring your own device (BYOD) is a business policy of employees bringing personally owned mobile devices to their place of work and using those devices to access privileged Trust resources such as email, file servers and databases as well as their personal applications and data. This is an increasing trend and offers a number of advantages and disadvantages to the Trust. If left unmanaged the Trust runs the risk of data breaches and risks to information governance and security. In addition licensing and developing and enforcing policies on acceptable use and behaviour offer a number of challenges.

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However there is a positive aspect, which sees users change their behaviour and there is a benefit to the organisation in that high-priced devices that the Trust would normally be required to purchase for employees are purchased by employees who then have control on the type of technology that they wish to use. Employees may take better care of devices that they view as their own property. This allows the Trust to take advantage of newer technology faster.

As part of the Trust's evaluation of mobile devices the Trust will also evaluate BYOD policies.

### **5.8.6 Telehealth**

The development and delivery of a unified communications structure within the Trust will support the use of telehealth and Telemedicine within the Trust. Telehealth encompasses preventative, promotive and curative aspects. Originally used to describe administrative or educational functions related to telemedicine, today telehealth stresses a myriad of technology solutions. For example, physicians use email to communicate with patients, order drug prescriptions and provide other health services. One of the most significant increases in telehealth usage is the home monitoring of conditions by patients.

The benefits case for telehealth is still being actively debated and as yet there is still a limited evidence base. However with an aging population and also a focus on the preventative medicine this is a natural development within the Trust's Service delivery model.



## 6. Corporate Systems

### 6.1 Electronic Staff Record

The Electronic Staff Record (ESR) programme is a Department of Health (England) led initiative, providing an integrated HR and Payroll system across the whole of the NHS in England and Wales. The current contract for the provision of the ESR will come to an end on 31 August 2014.

In May 2011 the Department of Health announced its commitment to ESR after August 2014 and that a feasibility study would be conducted to scope out the requirement of retaining ESR as a central Workforce Solution for the NHS.

That feasibility study is now complete and the Department of Health has concluded that there is a clear economic case for on-going central payment of ESR, and this is now being taken forward as the preferred option for the business case.

The NHS ESR Central Team is committed to ensuring that users and stakeholders are kept informed as key decisions are made and the process gathers pace.

### 6.2 Enterprise Resource Planning

Project 26 ERP	High Level Requirements	Benefits
Cost: Subject to options appraisal Funded: Subject to business case Year:	Financial Management Procurement Human Resources Customer relationship management	Improved alignment between strategy and operations Reduced back office costs through increased flexibility and automation Process standardisation Integrated of end-to-end processes Reduced risk Improved financial management and

Project 26 ERP	High Level Requirements	Benefits
2012-13		corporate governance  Enables strategic and tactical planning of resources  Better utilisation of stock and less waste  Supports a commercial approach

The Trust currently uses a number of systems for our finance/procurement and HR functions. A number of these are stand-alone solutions and include XX financials and procurement, patient level information costing system (PLICS) and the national ESR system managed by McKesson within HR. It should be noted that the national ESR system is scheduled for procurement by the Department of Health Informatics Directorate in 2013/14. The systems still require manual processes of form filling and paper chasing prior to data entry due to lack of electronic form and workflow processes. The systems are unwieldy and do not provide management information to assist the Trust Executive Team in a timely manner. Forecasting is a time consuming and a problematic area resulting in significant staff time being deployed on a monthly basis, both within the corporate areas as well as the clinical divisions.

The Trust requires a single central ERP solution to support all aspects of resource planning across the areas described below. The key being that intelligence will be gathered such that strategic decision making can be supported and business processes streamlined with the end goal of reducing cost and increasing efficiency.

In the first instance the Trust must develop an ERP strategy that optimises the solutions in place until the end of the contract period, provides solutions to plug the gaps and assists the Trust with the replacement of these business solutions which would include, but not exclusively, the following requirements:

**Financial Management**

- Budget planning and forecasting at both Trust, Divisional and Service levels including a combination of bottom-up budgeting and day to day process management and delivery, with top-down strategic planning;
- Recording of financial information for cost/revenue related reporting – money coming in and money going out of the Trust and each individual Division, and Service Line;

- Self-service data entry and reporting capabilities, with the flexibility to address the needs of different user groups with drill-down through layers of data; and efficient invoicing, procurement, cash-management and account payable capabilities.

### ***Procurement***

- Recording material consumption down to the individual patient and episode level;
- Understanding where objects/assets are and the demand for those materials based on the needs of patients as well as associated impacts on storage, distribution, replenishment and inventory control;
- Self-service ability to procure objects/assets at departmental level with Trust level pricing of the objects.

### ***HR***

- Integrated payroll including self-service HR capabilities such as expenses, time reporting, absence reporting and training;
- Capabilities for speedy management of bank, agency and fixed term staff with processes for requisition and approval of staff requests linked to time reports and invoicing from agencies.

### ***CRM***

- Contact management functions allowing the Trust to proactively manage patients, commissioners, tariffs and costs;
- Proactively manage our patients to reduce DNA rates and manage rebooking;
- Meet the key target of reduce admissions through preventative measures prior to onset of chronic disease.

### 6.3 Email (NHSmial)

Project 27 ERP	High Level Requirements	Benefits
Cost: Funded: Year: 2012-13	Continue to utilise the centrally funded NHSmial service  Potentially develop local archive solution  Evaluate options for integration with Unified Comms solutions  Evaluate options for migrating from PST files to centralised managed email archive	

The Trust migrated from a locally managed email infrastructure to the central NHSmial service during the Autumn of 2010. This migration transferred the risk and costs of managing the Trusts email to NHS Connecting For Health.

There have been rumours that the central funding for NHSmial may be withdrawn but so far there are no firm plans to do this and as such the Trust strategy is to continue to utilise the service and all the associated benefits of free fax/mobile access etc.

There are a number of areas of development that impact or depend on email services that the Trust should plan to develop. Section 5.8.1 of this strategy refers to Unified Communications. One of the central elements of UC solutions is typically the email service which integrates to provide voicemail/chat services and presence information. It is not clear if being an NHSmial site will prevent the development of this sort of capability. The Trust should ensure that plans to develop UC capabilities integrate with NHSmial.

One capability that was lost when the Trust migrated to NHSmial was in the area of email archiving. Previously the Trust had a local service that archived user's emails for search/long term storage and provided a Trust wide journal which could be used for investigations where access to historical emails was required. This facility was lost in the migration to NHSmial

and the Trust had to return to utilising Personal Folders Files (PST) as a means of email archiving. PST files present a number of issues to users and the Trust and an alternative solution to the issue of email archiving should be considered as part of the strategic use of NHSmail as the Trust email platform.

## 7. The Health Informatics Service

The Trust must have a robust Health Informatics Service which has both the capability and capacity to respond to both national and local changes and support the Trust achieving its strategic and business objectives. In addition the Trust faces a number of key decisions related to the overall vision for health informatics and core system replacements over the next 4 years. In order to support these changes a new organisational structure is proposed for the Health Informatics Service. It should be noted that this is a re-configuration of the HIS, and is funded from within the existing establishment.

### 7.1 Organisational roles

In order to support the Trust in delivering the Health Informatics Service, it is proposed that a number of key posts be re-configured to reflect the need for a customer services function (business as usual functions) and programme and project delivery functions.

As a result of this reconfiguration, there will be 6 direct reports to the Chief Information Officer, as can be seen the organisation chart in section 4. This organisation chart shows the reporting lines and with reconfigured posts detailed in red. As can be seen above the future organisation structure of the HIS includes 3 new posts:

- I. Chief Information Officer
- II. Head of Health Systems
- III. Head of Customer Services

### 7.2 Chief Information Officer

A common theme throughout this strategic review is the requirement for senior strategic leadership and direction; someone who can take control of the health informatics agenda and make the service work for the Trust. The HI Service is an important contributor and enabler to the Trust achieving its strategic objectives, implementing revised model of cares and achieving efficiencies. In view of the strategic HI agenda the Trust was advised to appoint a Chief Information Officer (CIO), this is a new post and is a cost pressure on the Chief Executives cost centre.

In order to maintain momentum the Trust has appointed an interim Chief Information Officer. The position of CIO would usually be a board position however; it is not uncommon for the CIO to report to the Chief Executive Officer, and the interim CIO reports to the Chief Executive Officer. The CIO is responsible for leading the development and delivery of the HI service and strategy and is responsible for providing board assurance.

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The CIO is has overall delivery responsibility for both the HI portfolio, HI Strategy, the Improvement Pan and is SRO for the IT enablement in the Transformation Plan.

### **7.3 Head of Information Technology**

The Head of Information Technology is already identified in the current establishment. The Trust must ensure that the infrastructure meets the current and future needs of the organisation. The initial review established that there were a number of areas where the infrastructure was causing operational problems to departments and clinical users.

The Trust will maintain the role of Head of Information Technology to manage the Trust's information technologies infrastructure, set the technology direction for the Trust's infrastructure and consider the investment case for insource and outsource activities. The Head of Information Technology will set technology standards appropriate to the Trust's needs, taking into account national standards and guidance; to manage the service level agreement with suppliers, ensuring that the Trust gets maximum value from the service level agreement; and that suppliers are held to account for the services they provide and to manage the services to the end users.

### **7.4 Head of Telecommunications**

It should be noted that Telecommunications is not a function of the HIS, however the dependencies upon telecommunications for on-going service delivery and the implementation of digital care within the Trust are significant, and therefore the organisational position of telecommunications has been reviewed by the Trust Executive and this function will now report into the Chief Information officer. The Head of Telecommunications is already identified in the current establishment, but currently reports into the Chief Operating Officer.

### **7.5 Head of Health Systems**

It is proposed that the Trust create the post of Head of Health Systems, this is a new post, but it is already identified in the current establishment. It is proposed that an experienced Health Informatics professional is recruited to the post. The Head of Health Systems will be responsible for:

- I. The development of the vision and strategy for the EPR and subsequent requirements and procurement activity
- II. Be responsible for HIS integration strategy.
- III. Ensure compliance with the Trusts PPM standards
- IV. Run the Trust's Health Informatics Programme Office, to plan and control all HI PPM activities ensuring compliance and integration with the TSO.

- V. Be responsible for the development of the business case and OBS for the EPR replacement
- VI. Lead the procurement of the EPR system
- VII. Lead the transition and transformation to the new EPR and the paper light care model.

## **7.6 Head of Information Services**

The Head of Information Services is already identified in the current establishment. Currently the Head of Information Services includes responsibility for all HI development. This portfolio is too large and complex for one individual and therefore the portfolio will be reviewed with the potential for the portfolio being reconfigured. The Trust will strengthen Information Services through the appointment of a senior and experienced full time information services professional. The Head of Information Services will lead on the development of a customer facing Information Services to meet the Trusts corporate and operational needs. Currently all commissioning information, the majority of performance information and all patient flows are processed by Information Services. Health Informatics is responsible for the delivery of systems implementations to support the development and delivery of the electronic patient record.

## **7.7 Head of Customer Services**

The Trust will strengthen the HI service and support function by integrating the information, infrastructure and application support functions. The Trust will create the post of Head of Customer Services and appoint an experienced customer services practitioner to the role. This integration will be supported by the implementation of ITIL™ standards and led by a senior and experienced full time information services professional. The role of Head of Head Customer Services will be created from the reconfiguration and integration of the support functions within HIS. This role is already identified in the current establishment.

## **7.8 Information Governance**

Following a review of the executive portfolios, the Information Governance Function will be transferred to the Director of Risk and Governance.



## 8. Management Approach

Delivery of the HI Strategy will initiate a number of programmes, which will also be enablers to the Transformation Plan. This will require robust management and the use of industry best practice to ensure delivery and mitigate risk. The Strategy and Transformation Plan will place a significant demand upon the Trust and the service.

The Health Informatics Review and subsequent Health Informatics Improvement Plan indicated that both the HIS and wider Trust needs to implement and ensure compliance with industry standard programme and project management methodologies. This will not only support the delivery of health informatics projects but also ensure that the Trust co-ordinates the direction and implementation of all projects and transformation activities that are dependent upon realising the benefits offered by the health informatics capability. It should be noted that these recommendations relate to the management and governance of the HIS projects. The Transformation Support Office (TSO) retains overall responsibility for the portfolio, programme and project management (PPM) capability within the Trust. In addition it provides a robust mechanism for handling the interface between businesses as usual (BAU) activities and programme and project delivery. To ensure that the Trust remains sighted on the importance of management and governance it is appropriate to reflect this in the Health Informatics Strategy, and clear set the expectations of the standards and processes required.

### 8.1 Portfolio Management

The delivery of the Health Informatics Strategy will require a management of the programme and project delivery environment, the business as usual environment and the change in the operational environment. Portfolio management is increasingly being applied to organisations and corporate functions which are undertaking large-scales corporate change. The portfolio management function is *“increasingly becoming established as the interface between organizational ownership and the delivery of that change”*<sup>4</sup>

The HIS operates in a complex environment. Given the scope of proposed changes within the HIS, the need to co-ordinate the deliverables within the Improvement Plan, maintain the business as usual functions of the HIS and support the IT enablement of the transformation plan; the Trust must ensure that the HIS operates a robust methodology and have the capability to advise senior stakeholders. It is therefore proposed that the HIS will adopt a portfolio management approach. This will ensure that the HIS remains

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<sup>4</sup> Page3, Managing Portfolios of Change, Chris Venning, TSO

aligned to the corporate objectives and the corporate, strategic-level processes operated by the TSO. The HIS portfolio management approach, represented in figure 4, represents the complete picture of the Trust’s commitment of programme and project resources and investments to deliver its strategic objectives.

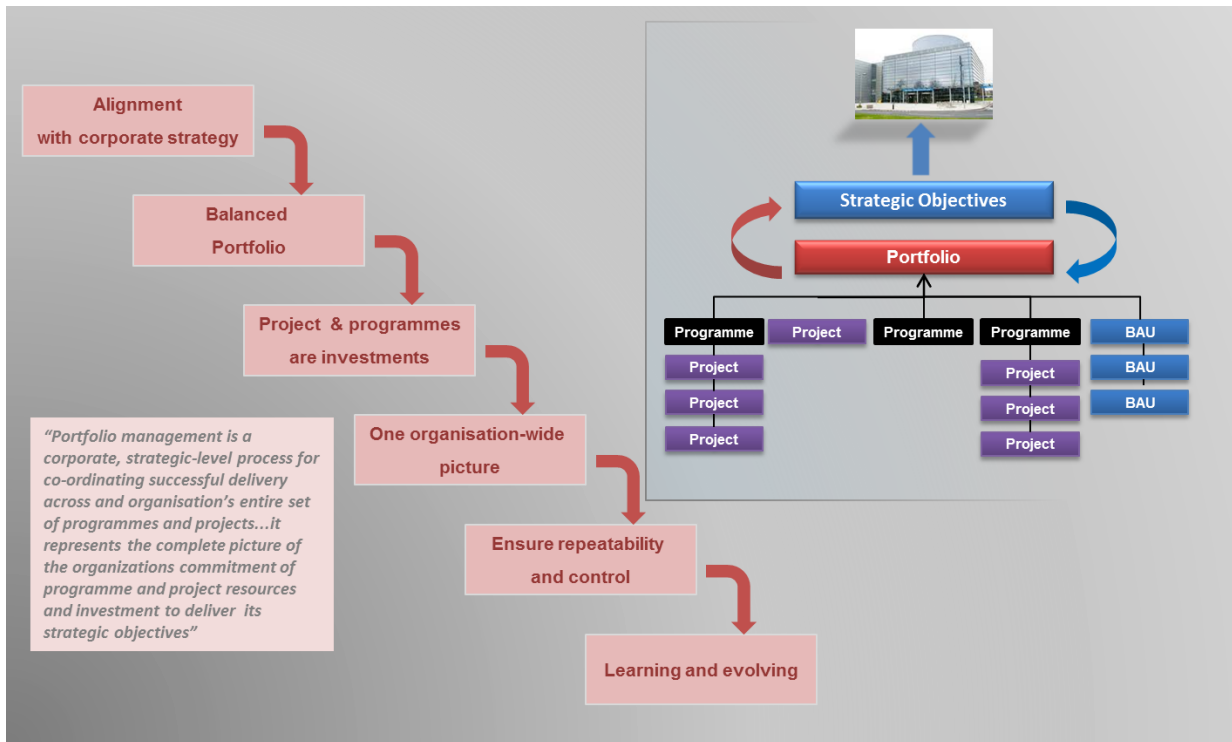


Figure 1 Portfolio Management

It should be noted that there is a clear distinction between **managing the portfolio** and **managing the programmes and projects** within the portfolio. Portfolio Management is an on-going business as usual function, like any corporate function, it is a permanent activity of the Trust. Programmes and projects are temporary activities, managed in line with best practice.

The objective of recommending a portfolio approach to the management of the HI Strategy is to ensure that there is an integrated process which links the Trust’s strategic objectives with the delivery objectives of the HIS and effectively manages the interfaces between BAU and programme and project delivery.

## 8.2 Programme and Project Management

Implementing complex health informatics systems, such as a replacement of the electronic patient record and the replacement of operational systems, represent significant investment on the part of the Trust. As referenced in 3.1, the implementation of replacement systems has to occur in parallel to the delivery of services and patient care, with disruption to the operational and clinical environment kept to the minimum and risks proactively managed. The HIS portfolio will establish a structure for selecting the right projects and programmes and assessing whether those requirements can be accommodated within the existing organisational capability and capacity. However the programmes and projects must be managed by unified standards, governance, frameworks and control. With this in mind the Trust will adopt a formal programme and project management approach for all major HI and associated change programmes. The de-facto standards and methodologies for programme and project management are the OGC **Managing Successful Programmes**<sup>™</sup> and the **PRINCE2**<sup>™</sup> project management methodology.

## 8.3 Benefits Management

The Trust will adopt a structured approach to benefits management, which will be managed by the TSO. The Trust users in the clinical and operational environments will be responsible for taking advantage of the new capability delivered by the Health Informatics Service and the identification and realisation of the benefits.

## 8.4 Service Management

The delivery of the HI Strategy will place demands on the customer service. To ensure optimised customer service the Trust will implement the **ITIL**<sup>™</sup> Service Management Framework. The objective of the **ITIL**<sup>™</sup> service management framework is to provide end users with services that are fit for purpose, stable and reliable so the Trust recognises the HIS as a trusted provider.

Our objective is to deliver a business led service that is not driven by technical silo's but by the needs of the organisation as a whole. To achieve this objective the Trust will develop an IT service catalogue and associated service level agreements against which performance can be monitored and reported. Service levels will be aligned with the business to ensure that the service meets the needs of the Trust IT users in a reliable and consistent fashion.

We will agree a set of Key Performance Indicators ( KPI's ) which will be developed to measure the service provided these will include :-

- I. Customer satisfaction ratings
- II. Average time to resolve SLA requests
- III. Percentage of calls meeting SLA
- IV. Percentage of calls exceeding SLA
- V. Exception reporting
- VI. Percentage of HIS staff ITIL-aware
- VII. Percentage of HIS staff ITIL certified

## 9. Governance

The Trust is, dependent upon the HIS and the availability and accessibility of high quality information and services to ensure that the Trust meets its corporate objectives and achieves the economies and efficiencies that are required. Given the scope and during the delivery of the HI Strategy within the Trust. In order to mitigate this risk it is proposed that the existing HIS governance be used to oversee the delivery of the strategy. This structure is detailed below:

### 9.1 Health Informatics Steering Group

The Health Informatics Steering Group effectively oversees all HI activity within the Trust. It contains the investment decision makers and will include the Senior Responsible Officer (SRO) for the Improvement Plan. The Steering Group will be accountable for the success of the Health Informatics programmes, provides top level endorsement of rationale and objectives of the programme and prioritise resources. The Health Informatics Steering Group will be the ultimate arbitrator for priority and resource contention issues.

### 9.2 Health Informatics Programme Board

The Health Informatics Programme Board will provide overall management and guidance to HIS projects within the portfolio which **do not have a dedicated project board**. Projects that do require dedicated project boards will be decided on a case by case basis.

### 9.3 Clinical Assurance Group

The Clinical Assurance Group will provide overall assurance to informatics with a clinical component. They will be responsible for reviewing and prioritising clinical developments and for evaluating their clinical effectiveness thereby reducing costs associated with duplication and integration of heterogeneous HIS and TP developments. They will also be responsible for ensuring that the Informatics Strategy and associated deliverables remains aligned with the quality and safety objectives.

#### **9.4 Informatics Futures Group**

The futures group is responsible for reviewing the emerging technologies and assessing how these technologies can be incorporated and integrated within the Informatics Strategy and assessing their impact upon both the Informatics Strategy and delivery plan and also the transformation plan.

#### **9.5 Health Informatics Programme Office**

Health Informatics programme office function will provide the information hub for the HIS, and act as a single point of truth for the Trust. The programme support office will provide the following functions:

1. Tracking and reporting functions
2. Information Management
3. Financial accounting
4. Risk and issue monitoring
5. Quality and change control

## 10. Key Risks

Key risks, associated with the HIS strategy have been identified. Detailed risk and issues registers will be maintained within each project work stream.

No	Risk	Probability 1-Rare 2- Unlikely 3 – Possible 4 – Likely 5- Almost Certain	Severity 1 – Insignificant 2 – Minor 3 – Moderate 4 – Major 5 - Catastrophic	Mitigation
1	Sufficient project funds cannot be secured leading to delayed or abandoned projects.	3	4	Agree funding through this strategy. Agree external funding with PCT, SHA, CCG and DH Prepare contingency plans for funding shortfalls.
2	Project run late or over-budget, delaying delivery of benefits.	2	4	Use 'best practice' project management methods (PRINCE 2). Adopt a development methodology to ensure projects and developments are managed in a quality controlled and consistent manner.
3	Projects completed, but Benefits not fully realised.	3	3	Appoint Business Change managers from Operations to support the Trust take advantage of the new capability.  Prepare and monitor Benefits Realisation plans for all major projects.
4	Loss of efficiencies and disruption to organisation arising from unreliable systems	3	4	Implement 'best practice' support structures (based on ITIL). Create highly resilient Data Centre. Strengthen Disaster Recovery capabilities as part of corporate Business Continuity plan.
5	Failure to attract and retain high quality staff leads to project failures and unreliable systems.	3	4	Develop HIS managers with strong focus on leadership and people management skills.  Ensure effective communications with all HIS staff.  Develop succession plans.

No	Risk	Probability 1-Rare 2- Unlikely 3 – Possible 4 – Likely 5- Almost Certain	Severity 1 – Insignificant 2 – Minor 3 – Moderate 4 – Major 5 - Catastrophic	Mitigation
6	Failure to identify project risks.	3	3	Ensure PRINCE 2 methodology is followed.
7	IM&T are not involved earlier enough in hospital projects.	3	4	Continually educate or reinforce that the business MUST involve IM&T at the outset.
8	Trust fails to change its organisational behaviour and working practices to take advantage of the new capability	3	4	Appoint Business Change managers from Operations to support the Trust take advantage of the new capability.



## 11. Costs

Provision of a detailed cost model for the Informatics Strategy is currently not possible due to the absence of confirmation regarding national funding, for the previously nationally funded and procured systems. Funding for the health informatics function in recent years has been from 3 main sources and it is envisaged that this will remain the main source of funding for delivery of the informatics strategy. Those sources of funding are as follows:

**Recurring funding:** from the SWBH NHS Trust baseline HIS budget. This is subject to the normal Trust budget setting process, with provision being made for salary awards but any other increases in spending being subject to justification in competition with other requirements across the organisation. Each year there is the obligation to achieve an agreed percentage saving in line with the Trust wide Transformation Plan. Health informatics is a major enabler to the Transformation Plan and in line with the LTFM; HIS would be expected to support the Trust in achieving a 20% drop in expenditure over the next 5 years.

It should be noted that the systems replacement plan and the proposed transformation projects will have implications for future recurring costs. This will require proactive management and prioritisation of maintenance contracts but realistically this result in additional cost pressures within the HIS budget. As a result the HIS will make an annual bid for cost pressure support into the annual business planning process.

**Capital Programme:** The Trust has committed £2,000,000 of operating capital for the financial year 2012/13. Funding for the projects identified in this project is subject to business case approval by SIRG. It is anticipated that the capital programme will be used to deliver the informatics strategy however additional capital funding may be required to support projects that have previously be funded nationally such as EPR, PACS and ESR replacement

**National Programme Funding:** Formerly known as NPfIT, funding has been made available centrally for a number of core systems. The availability of funding following the cessation of the National Programme has yet to be confirmed.

Until the outcome of discussions surrounding the central funding is agreed it is inappropriate to confirm the costs for this strategy. A number of projects can be funded from planned annually capital expenditure, however this will impact upon delivery.

**Business Cases:** Each of the identified transformation programmes will require the development of an options appraisal and business case which will submitted to the Health

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Informatics Steering Group in the first instance and then to SIRG. It is proposed that each transformation work stream is aligned with both the transformation plan and that this is reflected in the annual integrated business plan.

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## 12. Feedback

Should you wish to submit observations or feedback, please use this form.

<b>Section:</b>
<b>Submitted by:</b>
<b>Please submit this form to the CIO by email: <a href="mailto:fjsanders@nhs.net">fjsanders@nhs.net</a></b>
<b>Date :</b>
<b>Observation:</b>

<b>TRUST BOARD</b>
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<b>DOCUMENT TITLE:</b>	Research & Development Department Report		
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Kam Dhami, Director of Governance		
<b>AUTHOR:</b>	Professor CE Clarke / Jocelyn Bell		
<b>DATE OF MEETING:</b>	27 September 2012		
<b>EXECUTIVE SUMMARY:</b>			
<p>The attached paper is the draft Research &amp; Development (R&amp;D) Strategy for 2012-15. The strategy defines the current National and Local position in relation to R&amp;D and outlines the Trust future strategy.</p> <p>The Board is invited to approve the strategy.</p>			
<b>REPORT RECOMMENDATION:</b>			
The Board is recommended to accept the contents of the strategy			
<b>ACTION REQUIRED</b> <i>(Indicate with 'x' the purpose that applies):</i>			
The receiving body is asked to receive, consider and:			
<b>Accept</b>	<b>Approve the recommendation</b>	<b>Discuss</b>	
	X		
<b>KEY AREAS OF IMPACT</b> <i>(Indicate with 'x' all those that apply):</i>			
Financial	x	Environmental	Communications & Media
Business and market share		Legal & Policy	Patient Experience
Clinical	x	Equality and Diversity	Workforce
Comments:			
<b>ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:</b>			
Aligned to performance indicators set out in the Quality Accounts			
<b>PREVIOUS CONSIDERATION:</b>			
R & D Committee and Governance Board on 7 September 2012.			

# Research and Development Strategy (2012-2015)

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# Research and Development Strategy 2012/15

## 1. Introduction

**1.1** In the past three years, the Trust has made significant advances in Research and Development (R&D), particularly in increasing the number of research studies and patient recruitment in the areas of Oncology, Ophthalmology, Rheumatology, Gastroenterology, Neurology and Cardiology and in continued development of the R&D supporting infrastructure. In 2011/12 the value of R&D activities to the Trust was in the region of £2.5m.

**1.2** This document proposes a strategy to build on past achievements to further improve the R&D profile of the Trust. The research climate in the NHS continues to change at a rapid pace. These changes are driven by many factors, especially the needs of patients for new drugs and other interventions, relationships with the pharmaceutical industry, and cost containment within the NHS. These are taken into account in the Trust R&D Strategy.

## 2. National Context

**2.1** The Government is committed to the promotion and conduct of research as a core NHS role. Research is vital in providing the new knowledge needed to improve health outcomes and reduce inequalities.

**2.2** A range of policy statements defined the expectations with respect to NHS R&D:

**2.2.1** The new Health and Social Care Act 2012<sup>1</sup>, published on 29 March 2012, recognises the need to promote research and the use of research evidence, and creates unprecedented powers and duties, at all levels, to meet that need.

**2.2.2** In particular, the Act requires the Secretary of State, the NHS Commissioning Board and Clinical Commissioning Groups to monitor and promote research on matters relevant to the health service, and the use in the health service of evidence obtained from research. These parties are also empowered, together with local authorities to conduct, commission and assist the conduct of research.

**2.2.3** The NHS Constitution<sup>2</sup> speaks of an 'NHS committed to the promotion and conduct of research' requiring that the 'NHS will do all it can to ensure that patients, from every part of England, are made aware of research that is of particular relevance to them'.

**2.2.4** The White Paper, 'Equity and Excellence, Liberating the NHS'<sup>3</sup> confirmed that the Government is committed to the promotion and conduct of research as a core NHS role and that it is essential in order to improve quality and productivity and is critical to the ability of the NHS to deliver world-class health outcomes.

**2.2.5** The Operating Framework for the NHS in England 2012/13<sup>4</sup> states "The promotion and conduct of research continues to be a core NHS function and continued commitment to research is vital if we are to address future challenges. Further action is needed to embed a culture that encourages and values research throughout the NHS".

**2.3** The National Institute for Health Research (NIHR) was established in 2006 by the Department of Health (DH) to transform research in the NHS in England. The

NIHR aims to maintain a health research system in which the NHS supports outstanding individuals working in world-class facilities conducting leading-edge research focussed on the needs of patients and the public through its Clinical Research Network (CRN).

**2.4** The NIHR CRN comprises a Coordinating Centre, six Topic Specific Research Networks (TSRN), a Primary Care Research Network (PCRN) and a Comprehensive Clinical Research Network (CCRN). The CCRN consists of 25 Comprehensive Local Research Networks (CLRN) which cover the whole of England by region. These locally based research networks coordinate and facilitate the conduct of clinical research.

**2.5** The CRN measures its effectiveness against a set of high level objectives. In broad terms, these objectives include:

Increasing the proportion of Portfolio studies that deliver in line with the study's planned delivery time and patient recruitment targets

- Doubling the number of participants recruited into studies on our Portfolio
- Reducing the time it takes to get NHS permission for a study to start
- Reducing the length of time it takes to recruit the first participant onto Portfolio studies
- Increasing the number of life-sciences studies on our Portfolio

**2.6** The NIHR CRN allocates and manages funding to meet NHS Service Support Costs (SSC) in line with the guidance provided in the ARCO/AcoRD documents for well design research studies that are adopted into the NIHR Portfolio. The CLRN funding comprises a fixed (per capita) and flexible (activity based) allocation. The NIHR has developed a model for activity based funding arrangements to inform budget allocations.

### **3. The Vision**

**3.1** The Trust vision is that 'Sandwell and West Birmingham Hospitals NHS Trust exists to contribute to improving the health of the population of Sandwell, western Birmingham and surrounding areas through the provision of the highest quality healthcare'.

**3.2** In order to support this vision, a key priority is research which translates into changes in practice and treatments that lead to improved outcomes, a better patient experience and provision of high quality care.

**3.3** The vision for research and development at Sandwell and West Birmingham Hospitals (SWBH) NHS is to apply the national aim *"to improve the health and wealth of the nation through research"* at a local level.

### **4. Local Health Research Position**

**4.1** Clinical research at SWBH Trust is supported primarily by the Birmingham and Black Country (BBC) CLRN, along with contributions from TSRNs; e.g. Pan Birmingham Cancer Research Network, West Midlands Stroke Research Network.



**4.2** The BBC CLRN channels support centrally from the NIHR to Trusts in the Birmingham and Black Country area. Since their introduction in 2007, the BBC CLRN has developed a funding model based largely upon the Member Organisations own stated needs for support. Falls in recruitment to NIHR Portfolio adopted studies in the BBC CLRN area as a proportion of the national recruitment for two consecutive years (2010-11 & 2011-12) has resulted in two 10% reductions in funding allocations from the NIHR. These reductions have led to a reassessment of the funding model and for 2012/13 the model has been changed towards activity based funding (ABF) with capping applied. It is anticipated that from 2013/14, Member Organisations will receive ABF allocations in relation to the proportion of weighted recruitment they contribute locally. Strategic funding will be made available through a bidding process to allow Trusts to supplement their research income from the CLRN.

**4.3** Although recruitment to Portfolio adopted studies has fallen in the BBC CLRN area, other performance measures were more positive, including the proportion of industry studies increasing from 7% of its local portfolio at the end of 2009/10 to 13% at the end of 2010/11.

**4.4** In addition to the local NIHR CRN's, much of the research undertaken at SWBH Trust is delivered in collaboration with the local Universities, primarily the University of Birmingham but also Aston University and Birmingham City University.

## **5. Strategic Aims**

**5.1** The aims of the R&D strategy are:

**5.1.1** To promote high quality, ethical, clinical research to improve patient outcomes by identifying, approving and supporting relevant studies and ensuring that information about research is available to patients and staff.

**5.1.2** To increase Trust R&D activity in line with high level objectives of the NIHR CRN.

**5.1.3** To deliver all research studies to time and target.

**5.1.4** To ensure involvement in research is a key element of business in the Trust. Trust R&D Strategy must align with the Trust's strategic direction and corporate objectives and reflect Divisional objectives.

**5.1.5** To maintain a support and governance function for Trust staff undertaking research.

**5.1.6** To further develop R&D infrastructure, both in terms of accommodation/facilities and stable, trained research workforce

**5.1.7** To expand the number of clinical areas recruiting into clinical trials and increase the number of clinicians engaging in portfolio research by directing research support to those staff who will contribute to high quality, relevant clinical research

**5.1.8** To promote and encourage an environment that supports and values multidisciplinary research

**5.1.9** To expand links with academic partners supporting well established and productive research collaboration and creating new opportunities.

**5.1.10** To increase the number of high quality grant applications

**5.1.11** To manage budgets and funding prudently and transparently, maximising opportunities to apply for additional monies to support research activity via dedicated R&D finance support.

**5.1.12** To ensure that the findings of research are fed back into practice.

## 6. SWBH Trust Health Research Situation

### 6.1 R&D Infrastructure

**6.1.1** There has been a radical overall of the R&D infrastructure during the last three years. The R&D Office has been expanded and is now staffed by the Director of R&D (0.05WTE), Head of R&D (1.0WTE), RM&G Manager (1.0 WTE), Finance Manager (1.0WTE), R&D Administrator (1.0WTE), and a Clerical Assistant (0.8WTE).

**6.1.2** The R&D Department is also directly responsible for a team of 13 research nurses/clinical trial practitioners and six data managers under the leadership of a Trust Lead Research Nurse to support teams wishing to do clinical research.

### 6.2 R&D Funding

**6.2.1** Table 1 below outlines the annual income that the Trust has received from the BBC CLRN since 2009/10. This shows that the combined income for research SSC and Research Management and Governance (RM&G) has declined since 2010/11. In addition to the CLRN budget the Trust also receives Research Capability Funding (RCF) (previously Flexibility & Sustainability Funding (FSF)) directly from the DH. RCF is a research funding stream designed to help research-active NHS organisations attract, develop and retain high quality research, clinical and support staff. The funding is directly related to grant funding from NIHR Partner organisations.

**Table 1: SWBH Trust Income for Research Activity from DH and CLRN**

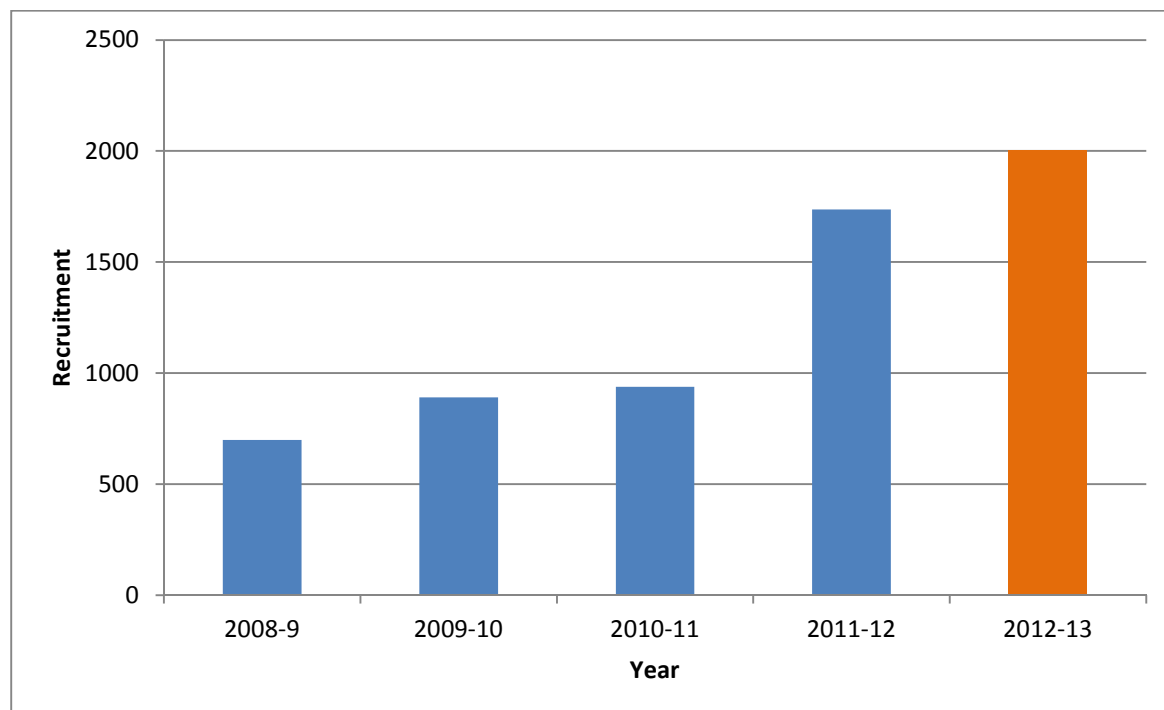
	2009/10	2010/11	2011/12	2012/13
CLRN SSC	£842,169	£969,887	£895,964	£696,144
RM&G Funding	£12,042	£67,833	£69,309	£62,423
<b>TOTAL CLRN Income</b>	<b>£854,211</b>	<b>£1,037,720</b>	<b>£965,273</b>	<b>£758,567</b>
FSF / RCF income	£386,210	£186,896	£97,000	£62,491
<b>TOTAL</b>	<b>£1,240,421</b>	<b>£1,224,616</b>	<b>£1,062,273</b>	<b>£821,058</b>

**6.2.2** Since the appointment of the R&D Accountant in August 2012, systems are being developed to ensure that all research income received from the CLRN, non-Portfolio adopted studies, research Grants and industry supported clinical trials is identified and tracked prospectively to ensure the Trust is recouping all appropriate funds.

### 6.3 R&D Performance

**6.3.1 Patient Recruitment:** SWBH Trust recruitment into NIHR Portfolio adopted research studies has increased year on year.

**Figure 1: SWBHT Recruitment into NIHR Portfolio Studies 2008-2012**



These increases have resulted not only from an increase in activity in historically active research areas but also through the involvement of with newly active departments including obstetrics, gastroenterology/surgery and paediatrics.

**6.3.2 Research Governance and Study Approvals:** Table 2 shows the number of new research studies that have been granted NHS Permission annually. There has been a progressive increase in the number of NIHR Portfolio adopted studies approved and greater numbers being processed through the Co-ordinated System for gaining NHS Permissions (CSP) year on year. The R&D Office has been successful in reducing the median time taken to process studies through CSP and for 2011-12 was well below the national NIHR target of 30 days.

**Table 2: Studies granted NHS Permission to proceed at SWBHT since 2009**

	No of studies granted NHS Permission	No. of studies processed through CSP	No. of Portfolio studies processed outside CSP	No of non-Portfolio studies granted NHS Permission	Median time (days) to process studies in CSP
2009-10	62	12	26	24	46
2010-11	92	43	17	32	29
2011-12	94	54	13	27	19
2012-13 (to date)	41	31	0	10	TBC

**6.3.3 Participation in Commercial Research:** Historically, SWBH Trust has developed strong links with Industry and actively participated in Commercially funded research in specific disease areas particularly cardiology, diabetes and oncology. Although the number of Commercial studies opened each year has remained fairly consistent, there has been an increase in the number of these studies that are adopted onto the NIHR Portfolio: in 2010-11, 10 of 19 new studies were Portfolio adopted, in 2011-12, 15 of 16 and to date for 2012-13, 10 of 12 studies.

## **7. R&D Priorities**

**7.1** The priorities for the R&D strategy are:

**7.1.1** The NIHR objective to increase the number of NHS patients participating in research studies is supported by a static national income from the DH. Therefore as recruitment to research increases the proportionate reimbursement decreases. SWBH Trust has already received a substantial decrease in the funding it receives from the BBC CLRN despite a doubling of recruitment to Portfolio adopted studies and it is probable that further cuts in research income will be incurred. In this economic climate, current income needs to be re-distributed within the Trust to ensure that it follows research activity and alternative sources of income need to be identified e.g. commercial income.

**7.1.2** Challenging RM&G timelines and quality standards for R&D are being set by national and commercial bodies. We must meet these standards.

**7.1.3** Under the Trust Estates Rationalisation Programme, space and facilities are being reduced to facilitate cost savings for the Trust which could result in a loss of capacity for delivery of research and thereby threaten research income and our ability to recruit high-calibre clinicians. We must ensure that accommodation and facilities for staff contributing to research is made available within the Programme.

**7.1.4** The NIHR has developed a range of Grant funding programmes which must be administered through an NHS organisation including the Research for Patient Benefit (RfPB), Efficacy and Mechanism Evaluation (EME) and Programme grants for Applied Research (PGfAR) programmes. Actively seeking opportunities to apply for such grants would benefit the Trust as obtaining such income would have a positive impact on the amount of RCF funding received which would provide support to invest in further research studies, staff and infrastructure.

**7.1.5** The NIHR has recently proposed a revision of the current national research network structure whereby the TSRN's, PCRN's and CLRN's will be replaced by 16 Integrated Clinical Research Networks. It is anticipated that these simplified networks will be in place by April 2014. The Trust needs to maintain close involvement and engagement in the implementation of the new network at a local level.

## **8. Implementation**

### **8.1 Embed R&D as a core Activity within the Trust**

**8.1.1** Recognition of research as a core activity within the Trust will be sought by:

- Developing an R&D Strategy for ratification by the Trust Board
- Establishing a programme of regular six monthly reporting of R&D activity to the Governance Committee and Trust Board by the R&D Director.

## **8.2 R&D Department Staffing**

**8.2.1** In order to meet the reducing timelines for study approval set by the NIHR, the Trust will appoint a further member to the RM&G team in the Office.

**8.2.2** The Trust will support the continued development of the Research Nurse/Clinical Trial Practitioner and other research support staff pool within the Corporate Team to provide researchers with high quality assistance to deliver projects.

**8.2.3** There will be an ongoing commitment to provide all members of the R&D staff with appropriate training to ensure that they are working to the highest standard and delivering the most up to date advice to researchers in the Trust.

**8.2.4** Members of the R&D Department will continue to provide training to researchers in Good Clinical Practice (GCP) and regulatory requirements both at a local and regional level.

## **8.3 R&D Financial Systems**

**8.3.1** The Trust will continue with the development of transparent financial processes for the distribution of research income ensuring that funding follows research activity. These processes will be regularly reviewed and updated to accommodate changes in external funding for research.

**8.3.2** Work will continue to develop systems to ensure Commercial studies undertaken at the Trust are accurately costed prior to participation and that funding from industry sources is proactively invoiced and outstanding sums chased.

## **8.4 Investigator Support**

**8.4.1** The R&D Department will support researchers in the Trust with regulatory submission for new and existing research applications.

**8.4.2** In conjunction with the CLRN and TSRN's, the R&D Department will assist research groups to identify suitable studies for participation and to manage the research portfolio for their speciality area to ensure a balanced portfolio to maximise recruitment potential whilst providing important and beneficial outcomes for their patient population.

**8.4.3** The Trust will support senior researchers who apply for academic clinical fellows and academic scheme junior posts to work in their departments.

**8.4.4** The Trust will actively encourage and assist senior researchers to apply for research grants.

**8.4.5** The Trust will continue to provide support for employees wishing to undertake research studies for the attainment of higher degrees in order to enhance professional development.

**8.4.6** With the introduction of the new Trust Intranet and Internet sites, the R&D pages will be regularly updated to allow researchers and the public access to information and guidance.

## 9. Key Performance Indicators for 2012-15

KPI 1 – Increase patient recruitment into NIHR Portfolio adopted research studies.

KPI 2 – Reduce RM&G timelines for completion of study-wide and local checks.

KPI 3 – Reduce the time taken from NHS Permission to the recruitment of first participant.

KPI 4 – Increase the number of life science studies on the Trust Portfolio.

KPI 5 – Demonstrate robust financial management.

## References

1. Health and Social Care Act 2012.
2. The NHS Constitution for England March 2010. The handbook to the NHS Constitution for England. Department of Health, 2010.
3. Equality and Excellence, Liberating the NHS. Department of Health, 2011.
4. The Operating Framework for the NHS in England 2012/13. Department of Health, 2011.

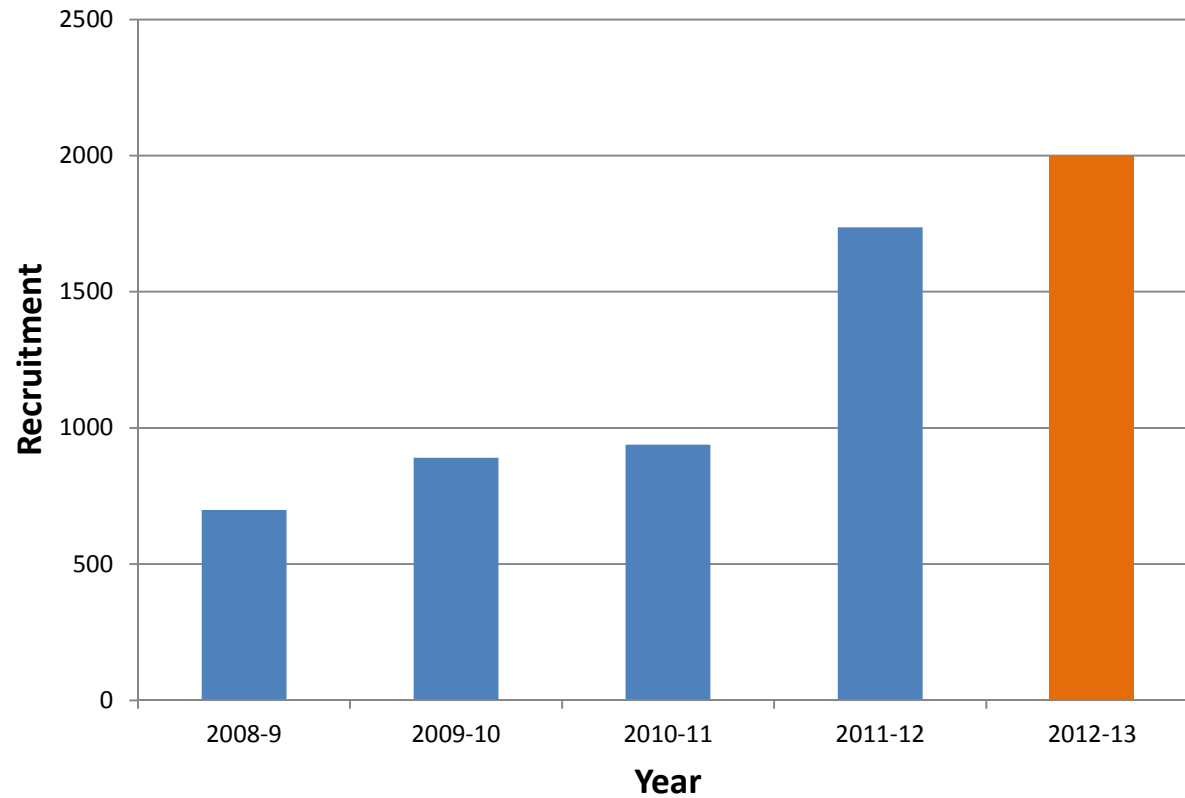
SWBTB (9/12) 205 (b)

# **Research and Development Strategy 2012-2015**

Professor C E Clarke  
R & D Director

# Patient Recruitment

## SWBHT Recruitment into NIHR Portfolio Studies 2008-2012





# Research Governance and Study Approvals

## Studies granted NHS Permission to proceed at SWBHT since 2009

	No of studies granted NHS Permission	No. of studies processed through CSP	No. of Portfolio studies processed outside CSP	No of non-Portfolio studies granted NHS Permission	Median time (days) to process studies in CSP
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<b>2012-13 (to date)</b>	41	31	0	10	TBC

# National Context

- The Operating Framework for the NHS in England 2012/13 states “The promotion and conduct of research continues to be a core NHS function and continued commitment to research is vital if we are to address future challenges. Further action is needed to embed a culture that encourages and values research throughout the NHS”.

# National Context

- The Comprehensive Clinical Research Network measures its effectiveness against a set of high level objectives
  - Doubling the number of participants recruited to trials by April 2014
  - Reducing the time it takes to get NHS permission for a study to start
  - Reducing the length of time it takes to recruit the first participant
  - Increasing the number of life-sciences studies on our Portfolio

# Local Health Research Position

- Clinical research at SWBH Trust is supported primarily by the Birmingham and Black Country (BBC) CLRN, along with contributions from TSRNs; e.g. Pan Birmingham Cancer Research Network, West Midlands Stroke Research Network

**Table 1: SWBH Trust Income for Research Activity from DH and CLRN**

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<b>TOTAL</b>	£1,240,421	£1,224,616	£1,062,273	£821,058

# Strategic Aims

- The aims of the R&D strategy are:
  - To **promote high quality, ethical, clinical research** to improve patient outcomes by identifying, approving and supporting relevant studies and ensuring that information about research is available to patients and staff.
  - To **increase Trust R&D activity** in line with high level objectives of the NIHR CRN.
  - To deliver all research studies **to time and target**.
  - To ensure involvement in research is a **key element of business in the Trust**. Trust R&D Strategy must align with the Trust's strategic direction and corporate objectives and reflect Divisional objectives.
  - To maintain a support and **governance** function for Trust staff undertaking research.
  - To further develop **R&D infrastructure**, both in terms of accommodation/facilities and stable, trained research workforce

# Strategic Aims

- To **expand the number of clinical areas** recruiting into clinical trials and increase the number of clinicians engaging in portfolio research by directing research support to those staff who will contribute to high quality, relevant clinical research
- To promote and encourage an environment that supports and values **multidisciplinary research**
- To expand links with **academic partners** supporting well established and productive research collaboration and creating new opportunities.
- To increase the number of high quality **grant applications**
- To **manage budgets** and funding prudently and transparently, maximising opportunities to apply for additional monies to support research activity via dedicated R&D finance support.
- To ensure that the findings of research are **fed back into practice**.

# Implementation

- **Embed R&D as a core activity within the Trust**
  - Developing R&D Strategy for ratification by the Trust Board
  - Six monthly reporting of R&D activity to the Governance Committee and Trust Board by the R&D Director.
- **R&D Department Staffing**
  - In order to meet the reducing timelines for study approval set by the NIHR, the Trust will appoint a further member to the RM&G team in the Office.
  - The Trust will support the continued development of the Research Nurses/Clinical Trial Practitioners
  - Members of the R&D Department will continue to provide training to researchers in Good Clinical Practice (GCP) and regulatory requirements both at a local and regional level.

# Implementation

- **R&D Financial Systems**

- The Trust will continue to develop transparent financial processes for the distribution of research income.
- Commercial studies will be accurately costed and funding from industry sources will be proactively invoiced and outstanding sums chased.

- **Investigator Support**

- The R&D Department will support researchers in the Trust with all aspects of research.



# Key Performance Indicators for 2012-15

- KPI 1 – Increase patient recruitment into NIHR Portfolio adopted research studies.
- KPI 2 – Reduce RM&G timelines for completion of study-wide and local checks.
- KPI 3 – Reduce the time taken from NHS Permission to the recruitment of first participant.
- KPI 4 – Increase the number of life science studies on the Trust Portfolio.
- KPI 5 – Demonstrate robust financial management.

## TRUST BOARD

<b>DOCUMENT TITLE:</b>	Transforming Clinical Services: Clinical Strategy for 2012-2013
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Roger Stedman, Medical Director and Rachel Overfield, Chief Nurse
<b>AUTHOR:</b>	Jayne Dunn, Redesign Director – RCRH
<b>DATE OF MEETING:</b>	27 September 2012

### **EXECUTIVE SUMMARY:**

Our Clinical Strategy, *Transforming Clinical Services*, sets out our clinical priorities and describes how we will develop our services over the next five years to ensure we can deliver our strategic vision. Our commitment to maintain and improve quality and safety for our patients will remain central to our clinical services and future strategy.

This Strategy covers the key areas of:

- Clinical Leadership and becoming a Clinically Led Organisation.
- Beacon services: Our specialist services that we will support to remain at the leading edge of clinical innovation.
- Emergency Care: We will provide safe, robust, high quality emergency assessment and treatment 24/7 with access for unselected emergencies at both City and Sandwell Hospitals. At the same time we will work in partnership with primary care and other colleagues to develop and promote appropriate alternative pathways and services for those patients who do not require the facilities and expertise of an Emergency Department.
- Long Term Conditions: Working in partnership we will provide a new integrated approach to care for people with long term conditions ensuring improved continuity, services which keep people well and out of hospital and care closer to home whenever possible.
- Planned Care: As much care as possible will be planned along agreed, easy to navigate care pathways based on best clinical practice.
- Diagnostics: We will deliver high quality, timely and appropriate diagnostic services to support our specialties and primary care in the delivery of integrated care pathways.
- Clinical Capacity: We will deliver efficient clinical services tailoring our clinical capacity to meet clinical demand and facilitate delivery of efficient care pathways.

This strategy represents an overarching framework within which individual directorates have developed their own clinical strategies. It is thus both informed by the aspirations of those services and a framework through which those aspirations are realised.

### **REPORT RECOMMENDATION:**

The Trust Board is recommended to:

APPROVE this version 1 of the Clinical Strategy, *Transforming Clinical Services: Clinical Strategy for 2012-2013*.

<b>ACTION REQUIRED</b> <i>(Indicate with 'x' the purpose that applies):</i>					
The receiving body is asked to receive, consider and:					
Accept		Approve the recommendation		Discuss	
		x			
<b>KEY AREAS OF IMPACT</b> <i>(Indicate with 'x' all those that apply):</i>					
Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy	x	Patient Experience	X
Clinical	x	Equality and Diversity	x	Workforce	X
Comments:					
<b>ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:</b>					
<ul style="list-style-type: none"> <li>This report aligns to our Corporate Objective 2: Safe, High Quality Care</li> </ul>					
<b>PREVIOUS CONSIDERATION:</b>					
None					

# Transforming Clinical Services

## Clinical Strategy for 2012-2018



## **FORWARD: From Our Medical Director and Chief Nurse**

Sandwell and West Birmingham Hospitals NHS Trust currently provides high quality emergency, elective and community services from the following locations:

- Hospital services based at City Hospital in Birmingham and Sandwell General Hospital in West Bromwich.
- Ambulatory services based at the Birmingham Treatment Centre.
- Comprehensive community services to the Sandwell area in people's own homes and from Rowley Regis Community Hospital, Leasowes Intermediate Care Centre, the Lyng Centre for Health and Social Care and the Halcyon Birthing Centre.

We are also a centre for research, innovation, teaching and take regional and national referrals for a number of specialist services including specialist eye services in the Birmingham and Midlands Eye Centre, the National Poisons Information Service, Pan-Birmingham Gynaecology Oncology Unit, National Behçet's Syndrome Centre and Sickle Cell and Thalasaemia Service.

We are committed to the delivery of high value care and the continuous improvement of our services. This means where quality, safety and outcome are improved by care closer to home we will integrate our services both internally and with our external partners in order to provide seamless care from home to hospital and back again. It also means where quality, safety and outcome can be improved by the consolidation of services on to one site we will re-configure to do this, whilst continuing to provide local access to emergency care from our two acute hospitals and from the new acute hospital development when this is delivered.

This Clinical Strategy sets out our clinical priorities and describes how we will develop our services over the next five years to ensure we can deliver our strategic vision. Our commitment to maintain and improve quality and safety for our patients will remain central to our clinical services and future strategy.

In the longer term our strategy includes the development of the Midland Metropolitan Hospital, a single site new acute hospital, with community treatment centres and hospitals at the Birmingham Treatment Centre, Birmingham Midlands Eye Centre, Rowley Regis Hospital and on the Sandwell Hospital site as well as a range of community services provided in people's homes and through other community facilities. In the medium term our clinical service developments will start to deliver models of care that underpin this longer term strategy.

Our Clinical Strategy supports the Integrated Business Plan for Foundation Trust status and will be implemented through specialty specific strategies and annual plans.

## INTRODUCTION AND CONTEXT

We are a large teaching Trust with a reputation for excellent, friendly staff that provide high quality care from City Hospital in Birmingham, Sandwell General Hospital in West Bromwich and community services from Rowley Regis Community Hospital, Leasowes Intermediate Care Centre and the Lyng Centre for Health and Social Care. The two acute hospitals provide many specialist services and a broad range of emergency services, including Accident & Emergency at both sites.

The Birmingham Treatment Centre on the City Hospital site provides state of the art facilities for one-stop diagnosis and treatment. It includes an Ambulatory Surgical Unit with six theatres, an outpatient department, extensive imaging facilities, an integrated breast care centre and teaching accommodation.

The modern Emergency Services Centre on the Sandwell Hospital site incorporates a comprehensive A&E facility, Emergency Assessment Unit and Cardiac Care Unit.

We host the Birmingham and Midland Eye Centre, which is a supra-regional specialist facility, as well as the Pan-Birmingham Gynaecological Oncology Centre, Sickle Cell and Thalassaemia Centre, the regional base of the National Poisons Information Service and one of three national Behçet's Syndrome Centres.

We also have a substantial teaching and research agenda with several academic departments including Rheumatology, Ophthalmology, Cardiology, Gynaecological Oncology and Neurology. In addition we are a pioneer in developing new and more effective approaches to staff engagement through our "Listening into Action" programme which harnesses the energy and ideas of front line staff to improve services. This is the largest programme of its kind in the NHS and has received widespread national recognition. We are increasingly using these techniques to obtain the view of patients and carers.

Located at the heart of the West Midlands conurbation we operate within a competitive environment. Within the wider Birmingham and the Black Country area, there are five other acute hospital trusts (including three NHS Foundation Trusts), three of which also provide community health services, three specialist NHS Foundation Trusts and a large community services Trust. Our population is served by two local authorities, Sandwell Metropolitan Borough Council and Birmingham City Council.

We serve a population of circa 500,000 including some of the most diverse and economically deprived communities in the country. Compared to England as a whole the key features of our population can be summarised as young, deprived and diverse with health outcomes which are worse and marked by significant inequalities.

Our local GPs have come together to form a single Clinical Commissioning Group (CCG) called the Sandwell and West Birmingham CCG. For us this means that, with the exception of three practices, all of our main referring practices, as well as a

number of practices that split their referrals between us and the Dudley Group of Hospitals Foundation Trust, will be in a single CCG.

Whilst the CCG is a new organisation it is comprised of five established and experienced Local Commissioning Groups which will remain a key feature in order to reflect the highly diverse set of local communities each with specific local needs. The CCG has a vision of 'Healthcare without boundaries' with a mission 'To value diversity and tackle inequality. We will improve the health and well being of all communities in Sandwell and West Birmingham, reducing inequalities as we do so'. The CCG has identified its strategic priorities as being to:

- Initiate – intervening early to prevent problems before they occur
- Integrate – putting the patient at the centre of their care
- Innovate – changing the way we do things to deliver more with less
- Improve – focusing on the quality and safety of services in all parts of the system
- Influence – playing a full role in local partnerships, affecting the determinants of health.

This CCG strategy provides an opportunity to increase the effectiveness of partnership working in the local health economy especially around the redesign of care pathways and to accelerate the pace of implementing new models of care.

We are a key partner along with the CCG, PCT Clusters and local authorities in the Right Care Right Here Partnership (RCRH) which seeks to deliver an ambitious redevelopment of local health services. Following a successful public consultation, implementation of the RCRH Programme is underway with a growing range of traditional secondary care services now being provided via new models of care and in community locations.

The incorporation of community services for the Sandwell area into the Trust in April 2011, creates an exciting opportunity for providing truly seamless care for patients with long term conditions and the complex problems of ageing through the integration of acute and community services. It is our ambition to expand this opportunity into the West Birmingham area either through partnership with Birmingham Community Health Trust or through the expansion and development of our own community services.

We have reconfigured a number of clinical services between our acute sites so as to ensure their quality, safety and sustainability. We will continue to provide 24/7 Emergency Department access at both City and Sandwell Hospitals but within this context will continue our programme of clinical reconfiguration over the coming period. Alongside this, we have embarked on a 5 year Transformation Plan, designed to ensure that the quality and safety of our services can be maintained and enhanced whilst at the same time responding to national requirements for increased efficiency. The Transformation Plan takes in all of our key clinical and non-clinical work streams.

In the light of our strategic, operational and financial strength we are applying to become a NHS Foundation Trust, which we expect to achieve by April 2014.

**CLINICAL STRATEGY: *we will develop our clinical services over the next 5 years to deliver high quality, safe and improved care to our patients.***

The Strategic Vision for our Trust is that:

***“We will improve the health and well-being of people in Sandwell, western Birmingham and surrounding areas, working with our partners to sustain the highest quality healthcare in hospital and closer to home.”***

Our six strategic objectives are designed to ensure we make progress towards the successful delivery of the vision, these are:

- Safe, High Quality Care
- Accessible and Responsive Care
- Care Closer to Home
- Good Use of Resources
- 21<sup>st</sup> Century Facilities
- An Engaged, Effective Organisation

Each year we will develop our Annual Priorities to support the delivery of these objectives.

Our Clinical Strategy supports these objectives and at its core is our commitment to develop our clinical services over the next 5 years to deliver high quality, safe and improved care to our patients.

In defining high quality, safe care we have identified the following three long-term priorities.

<b>Top Three Quality and Safety Related Priorities</b>		
<b>Patient safety</b>	<b>To reduce adverse events which result in avoidable harm</b>	<b>= We do no harm to patients</b>
<b>Effectiveness of care</b>	<b>To reduce avoidable mortality and morbidity</b>	<b>= Fewer patients dying and fewer having complications</b>
<b>Patient experience</b>	<b>To increase the percentage of patients who would recommend the Trust to family and friends</b>	<b>= Improved patient satisfaction</b>



Our Quality and Safety Strategy sets out the requirements to deliver these priorities and so this is not repeated in our Clinical Strategy but they underpin all our clinical services and any service development will have as a key driver, improvements in care against these priorities.

Whilst in the longer term we remain committed to the development of a single site new acute hospital, the Midland Metropolitan Hospital, within the next five years we will continue to deliver acute services at both City Hospital and Sandwell General Hospital and will maintain our Emergency Departments in both hospitals.

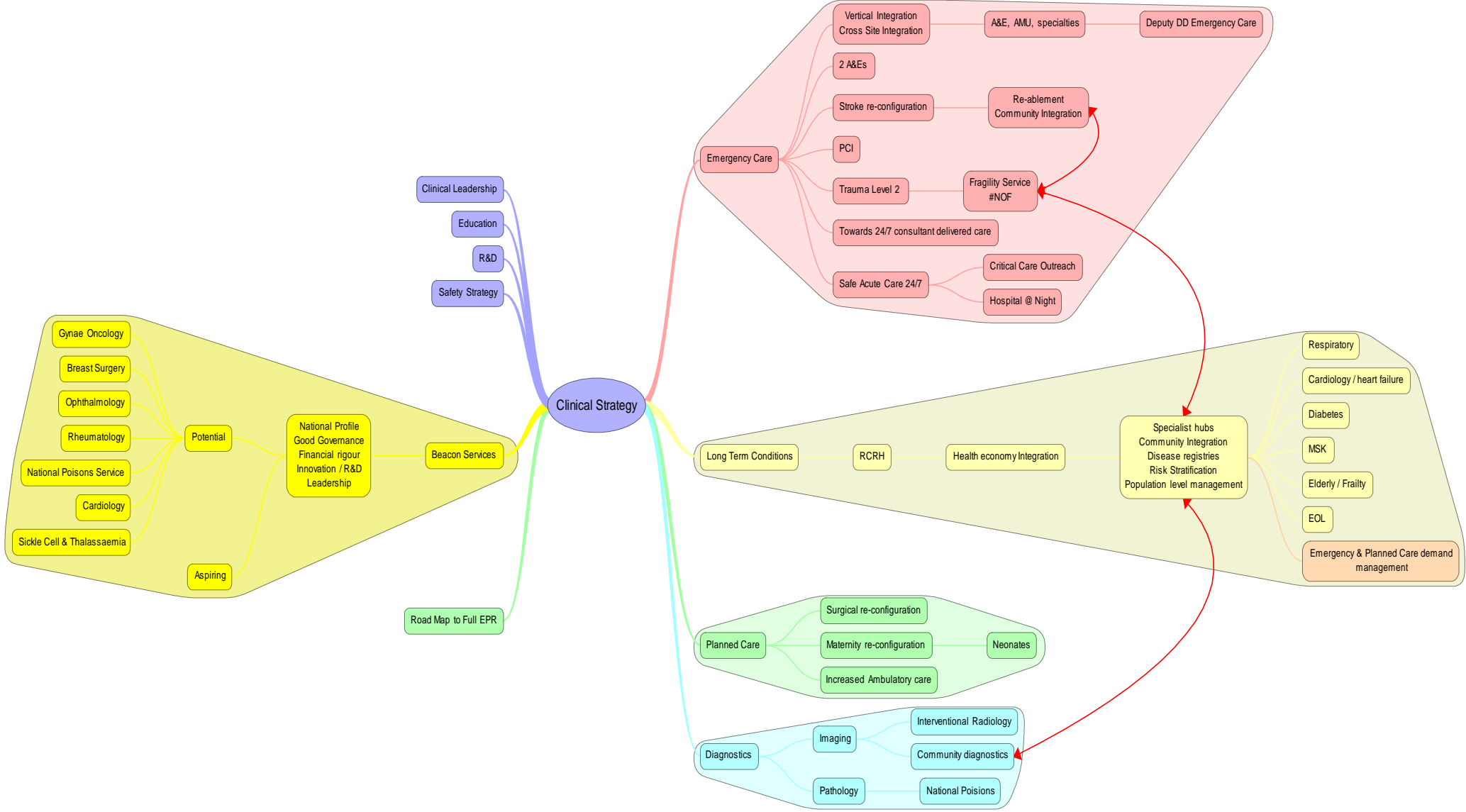
We will however continue through our Clinical Services Reconfiguration Programme to centralise those services where there is evidence that this is necessary to deliver improved patient outcomes that meet the highest quality standards by concentrating clinical expertise and specialist equipment but will do so in a way that supports the Emergency Departments in both hospitals. We will also be developing a Long Term Clinical Configuration Plan as an alternative to the Midland Metropolitan Hospital should this not become feasible, but again this plan will concentrate on a period beyond 2018.

Central to delivering our strategic objectives and vision is our commitment to strong partnership working with other health and related service providers in our local health economy and wider clinical networks. This is reflected in our ongoing commitment to the *Right Care Right Here Partnership*.

Strong and effective clinical leadership remains central to our commitment to maintain and improve quality and safety for our patients particularly in times of service change. We have done much to strengthen this in recent years through the introduction of Clinical Directorates, Service Line Management and ensuring nurse leadership at the level of direct patient care. Further development of clinical leadership remains central to our future Clinical Strategy.

We recognise the challenging financial climate we are currently facing and the need to deliver efficient services to meet this but maintain safe and high quality clinical care. Our five year Transformation Plan is designed to improve the quality and safety of our services whilst meeting the demanding national efficiency targets. The detail of the Transformation Plan is not repeated in this strategy but it is key to the future delivery of clinical services and so many of the work streams within the plan are led by senior clinicians.

The key features of our Clinical Strategy are summarised below.



This strategy represents an overarching framework within which individual directorates have developed their own clinical strategies. It is thus both informed by the aspirations of those services and a framework through which those aspirations are realised.

### **Scope**

This document outlines at a strategic level our thinking and plans/aspirations for the shape of our clinical services over the next 5 years in order to deliver our Strategic Vision and objectives and to maintain and develop further high quality and safe clinical services. It does not seek to describe these plans in detail or to provide an action plan for the delivery of these. Rather we are developing specialty level strategies that will set out in more detail our plans and service developments. Implementation of these will be through specialty specific annual plans, development of specific business cases and action plans.

This Clinical Strategy needs to be considered alongside a number of our other Strategies and in particular our:

- Quality and Safety Strategy
- Workforce Strategy
- Transformation Plan
- Health Informatics Strategy
- Research and Development Strategy.

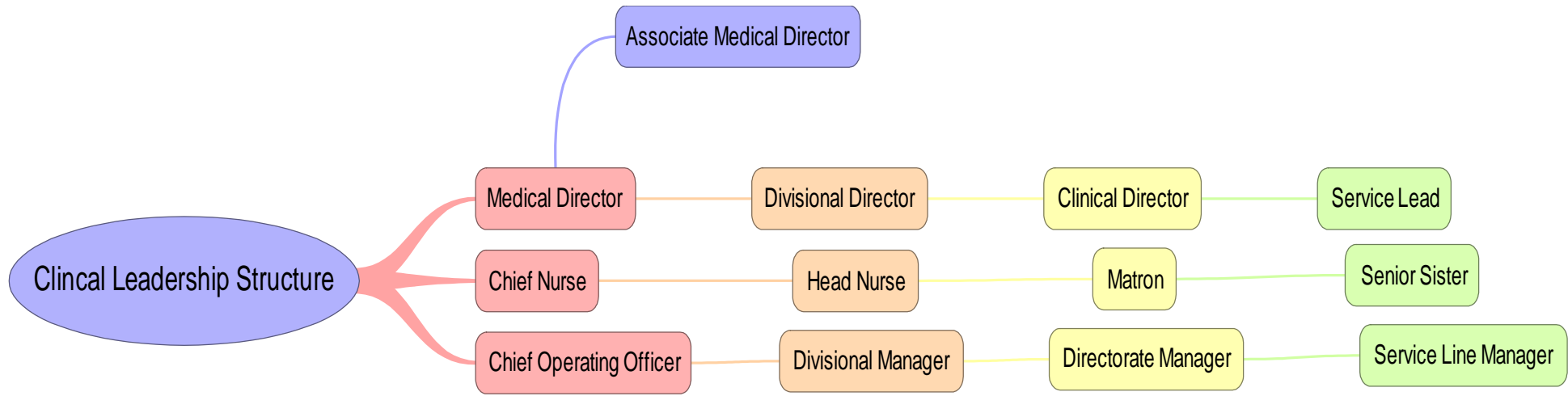
In addition the Integrated Plan for Sandwell and West Birmingham Clinical Commissioning Group should also be considered alongside this clinical strategy.

## **CLINICAL LEADERSHIP: *Becoming a Clinically Led Organisation.***

Our ambition is to develop as a clinically led organisation. This means having strong and capable senior clinicians of all professional groups in senior leadership positions throughout the organisation, including at board level. It also means that a leadership culture pervades all levels of the organisation and becomes a career aspiration for a significant proportion of all our staff.

### **Clinical Leadership Structure**

The fundamental unit of leadership within the organisation is the triumvirate of the Medical (or AHP/Clinical Scientist), Nursing and Management professions. This again reflects the necessity for multi-professional team working for delivering modern healthcare. This close working relationship is reflected at board, divisional, directorate and team level. The diagram below summarises this triumvirate approach to clinical leadership.



The ability to work in an integrated and collaborative way both within teams and transcending traditional boundaries (within the hospital and outside) is a core skill for which all leaders will be selected and developed.

Our leaders also have the task of delivering large scale cultural change across the Trust and the healthcare system. The leadership structure will deliver this through the development of the Associate Medical Director Roles (formerly Deputy Medical Director) covering the domains of, Safety and Quality, Innovation and Service Redesign, Governance & Risk, and System Integration.

Accountability for outcomes and performance is a fundamental aspect of good leadership. The accountability of leaders and their teams for the safety, quality and outcomes of services to patients means that structures and chains of accountability need to meaningfully reflect the nature of care delivered to patients – from the ward to the board. The move to ward based matrons and the direct accountability for this group of leaders for performance and outcomes in their areas reflects this desire. Similarly the development of a robust Service Line Management structure reflects the nature of clinical services delivered as they are experienced by the patient. The Divisional, Directorate and Service Line structure provides a direct line of accountability through the organisation from Board through the Medical Director and Chief Nurse to staff delivering care to our patients.

### **Clinical Leaders Delivering High Quality Patient Care**

Our aspiration is that patients attending our services for investigation or treatment, whether for planned elective care or unplanned acute care, will have excellence in clinical care with rapid availability of clinical expertise at all points of their individual care pathways.

We will achieve this by applying the following principles:

- The hospitals provide high quality care 24/7 and 365 days per year.
- Continuity of care is assured through multidisciplinary teams working to pathways and protocols agreed by expert led teams.
- The initial assessment and treatment of patients is undertaken by experienced clinicians – our clinical strategy is to move towards 24/7 consultant delivered emergency care.
- Where immediate more specialised expertise is required, this will be available on site across a range of clinical specialties.
- High-level diagnostic support, including imaging and pathology, will be immediately available 24/7.
- There will be separation of acute unplanned and elective patient flows.
- Individuals responsible for planned care of patients will not be simultaneously responsible for the delivery of unplanned care.
- Sub-specialty expertise across the entire range of non-acute specialties will be available to in-patients in a timely fashion.
- Leadership at the point of care delivery e.g. wards, departments and theatres will be provided by experienced clinicians with sufficient time to lead and supervise staff and standards.

The combined financial and demographic challenges will mean that there will be relatively fewer staff providing care for more people with more complex needs. The overall impact of the changes in the way care will be organised and delivered in the future means our staff in the future will be:

- More focused on prevention of ill health aiming to prevent the development of long term conditions
- Keeping patients with long term conditions well, preventing deteriorations in condition and health crises.
- Demonstrating better quality outcomes to meet the quality and productivity challenge
- Delivering healthcare closer to home with the development of community based teams, and individual staff members having greater autonomy and less direct supervision
- Smaller in numbers and delivering a range of highly specialised acute hospital care or community services
- Working in more flexible ways across organisational and professional boundaries and, in some cases, for different employers
- Developing new and extended roles for non-medical practitioners.
- Working new patterns of employment e.g. 24/7, 7-day working and delivering routine services in the evenings and at the weekends
- Embracing new ways of working to provide safe and efficient services
- Increasingly more involved in shaping our future direction and our plans for how we go about improving the health of our local community

We have done much in recent years to strengthen clinical leadership through the introduction of Clinical Directorates, Service Line Management and ensuring nurse leadership at the level of direct patient care. This needs to be developed further to ensure we have:

- A proactive safety culture
- High performing teams
- Provide Reliable Care.

We will do this through a triumvirate approach to leadership at ward level, i.e. joint medical, nursing and therapy leadership. This will include ensuring our matrons and more experienced nursing staff are the clinical leaders at ward level.

We will continue to develop ways of using our information systems to consistently measure clinical performance for example, specialty dashboards, safety thermometers, care bundles etc, and will establish performance reviews by our Executive Team at Clinical Directorate level.

Harnessing the energy and ideas of front line staff and patients to improve services through the use of the tools and approaches in our “Listening into Action” programme will be key to our clinical leadership roles as will working in partnership with primary care colleagues.

Our Leadership and Management Development Framework is designed to provide a platform for developing current and aspirant leaders from all professional groups in the organisation.

Training for non medical clinical staff is largely provided via post basic registration contracts with a range of HEi providers. The nursing division run a clinical MOT for nursing staff and a range of care specific training opportunities. The Trust is also opening a 'Learning Works' in Autumn 2012 to support the education and development of our Band 1 – 4 staff.

### **Research, Development and Innovation**

In line with national policy we are committed to the promotion and conduct of research as a core NHS role. Research translates into changes in practice and treatments that lead to improved outcomes, improved productivity, provision of high quality care, better patient experience, and to reduced inequalities. As such it is critical to the ability of the NHS to deliver world-class health outcomes.

Our vision for research and development is to apply the national aim *“to improve the health and wealth of the nation through research”* at a local level.

In the past three years, we have made significant advances in Research and Development (R&D), particularly in increasing the number of research studies and patient recruitment in the areas of Oncology, Ophthalmology, Rheumatology, Gastroenterology, Neurology and Cardiology and in continued development of the R&D supporting infrastructure.

We will build on past achievements to further improve the R&D profile of the Trust. In doing this we will take into account the rapidly changing research climate in the NHS. These changes are driven by many factors, especially the needs of patients for new drugs and other interventions, relationships with the pharmaceutical industry, and cost containment within the NHS.



## **BEACON SERVICES: *Our specialist services will remain at the leading edge of clinical innovation.***

We deliver a range of specialist services which have a regional and national reputation. These beacon services are known for their innovation in clinical care and clinical outcomes. They take referrals from outside of our local population and are underpinned by strong clinical leadership, governance and research. They contribute to our delivery of safe, high quality care and to the recruitment and retention of excellent clinical staff both within these services but also more widely within our Trust. As such they support our strategic objectives of Safe, High Quality Care and being an Engaged, Effective Organisation.

In summary our Beacon Services are:

	<b>Current Service</b>	<b>Future Development</b>
<b>Gynae Oncology</b>	We provide Gynaecology Oncology services for the West Midlands. This includes working closely with our specialists in Colorectal Surgery.	We will continue to develop our expertise in undertaking advanced radical surgery receiving referrals from other specialist Gynae-oncology centres. We aim to be recognised as a Supra-Regional Centre
<b>Ophthalmology</b>	We provide specialist Ophthalmology for Birmingham and the Black Country.	We will promote our eight sub-specialities. We are exploring options for regional or national commissioned status for our more specialised services
<b>Rheumatology</b>	34% of our new outpatient attendances are from outside of our usual catchment population. We have a regional reputation for our services relating to connective tissue disorders and Vasculitis.	We will develop our specialist services further including the research and academic elements of Rheumatology.
<b>Behçet's Syndrome Centre</b>	We are one of three designated national centres. We provide the service in partnership with specialists based at University of Birmingham Hospitals NHS Foundation Trust.	The Centre was established in 2012/13 and will be embedded and developed this further over the next 5 years.
<b>Sickle Cell &amp; Thalassaemia Service</b>	We are a specialist adult haemoglobinopathy unit caring for the Birmingham patients & receiving national referrals. We train health professionals at a regional level.	We will develop the service further as a regional centre and strengthen the transition of young people to adult services. We aim to offer a 'one stop' high quality service to adults with major haemoglobin disorders. We will continue to widen the range of training opportunities.
<b>Breast Surgery</b>	We provide breast screening to Walsall residents as well as our local population. We have a national reputation for	We will continue to develop alternatives to surgery in partnership with Imaging specialists and will further develop our breast surgery onco-plastic service.

	service redesign including the introduction of day case mastectomy surgery.	
<b>National Poisons Service (NPIS)</b>	<p>The NPIS is funded by the DH through the HPA and provides advice to doctors and other health care workers nationally on the management of acute and chronic poisoning,</p> <p>The West Midlands Poisons Unit was established to develop optimal treatments for patients suffering from acute and chronic poisoning, with the intent that these treatment protocols would be utilized nationally. The Unit also offers specialist treatment for patients withdrawing from alcohol and other substances of abuse.</p>	We will continue to support and develop both the NPIS and West Midlands Poisons Unit.
<b>Cardiology</b>	We have a well established Cardiovascular Research Department. We undertake a broad range of clinical and laboratory based research and as a consequence we are an early implementer of treatments. We have strong links with the University of Birmingham.	We will continue to build on our regional and national reputation for research.

We will develop these services further including the academic, research and education elements. We also see other services being identified as beacon services in the future. We will need to ensure the development of beacon services and in particular any expansion in services, contributes to improving their Service Line Reporting positions.

In delivering our beacon services we recognise the importance of partnership working with other acute providers, clinical networks and commissioners to ensure an integrated approach to care for patients as they move between services along a care pathway.

**EMERGENCY CARE: We will provide safe, robust, high quality emergency assessment and treatment 24/7 with access for unselected emergencies at both City and Sandwell Hospitals. At the same time we will work in partnership with primary care and other colleagues to develop and promote appropriate alternative pathways and services for those patients who do not require the facilities and expertise of an Emergency Department.**

Whilst we remain committed to our longer term plan to develop a single site acute hospital, the Midland Metropolitan Hospital, over the next 5 years we will continue to provide Emergency Departments at both City and Sandwell Hospitals with 24/7 access for unselected emergencies. We will develop our emergency services to ensure early, senior assessment and decision making is available 24/7. We also recognise that a significant number of patients attending our Emergency Departments have symptoms and conditions that could appropriately be managed in a primary care or community setting. We are therefore committed to continue the work with our commissioners and primary care colleagues to develop and promote alternative services for these patients.

In summary this will mean for our services:

- **A greater focus on seven day working with a priority to deliver consistent standards of emergency and inpatient services 24 hours a day, 7 days a week.** We will be working towards a consistent 24 hour, 7 day a week standard of care with early senior decision making. This will mean more of our clinical services providing a routine service over extended hours or at least 7 days a week. It will also mean having more senior clinical staff present on site for extended hours and in some services - Towards 24/7 consultant delivered care in emergency and acute medicine.
- **An intense focus on providing safe acute inpatient care 24/7 on both sites** through the strategic development and integration of Critical Care Outreach Services, Hospital at Night services and robust systems for detecting and escalating the care of the deteriorating patient. A review of traditional specialty and professional boundaries through a common development platform for the extended practitioner role in emergency, acute and critical care medicine.
- **A reduction in attendances at our Emergency Departments and emergency admissions through the increased community-based urgent care and out-of-hours services and the development of new ways of delivering care to patients with long term conditions.** Through RCRH a number of approaches and services have been developed as alternatives to attendance at Emergency Departments (for example the Urgent Care Centres

at Parsonage Street and Summerfield Health Centre) and over the last few years we have seen a 6% reduction in attendances at our Emergency Departments which has shown to be a greater reduction than has been seen by other acute hospitals in the West Midlands. We will build on this approach and work in partnership with colleagues in the local health economy to promote existing services and develop others.

Whilst continuing to provide 24/7 Emergency Departments at both City and Sandwell Hospitals we will, where appropriate, consolidate more specialist, acute services to provide a greater critical mass of services within larger clinical teams so reducing professional isolation and enabling the delivery of high quality care through greater sub-specialisation, robust 24 hour senior cover and on-going service development.

In this context we have undertaken a number of clinical service reconfigurations over the last 5 years and these are summarised in the table below. We have also participated in a number of SHA wide reconfigurations. As part of each clinical service reconfiguration arrangements (e.g. care pathways, transfer protocols, medical staff rotas) have been put in place to ensure specialist support to the Emergency Departments at both sites. 24/7 on site medical teams (at junior and middle grade) are provided on the site with emergency inpatient beds (therefore not specified below) but in some specialties are also provided on the site without emergency inpatient beds (specified below). Emergency consultant cover is provided to both sites.

<b>Reconfigured Acute/Emergency Inpatient Clinical Services</b>			
	<b>City Hospital</b>	<b>Sandwell Hospital</b>	<b>Other</b>
<b>Paediatrics</b>	Initial assessment and stabilisation of emergency patients with up to 23 hour stay on the Paediatric Assessment Unit. On site 24/7 medical team. Does not take blue light ambulance with children.	Paediatric Assessment Unit, Paediatric inpatients	Community Paediatric Nursing Team  Children requiring intensive care (other than initial assessment/stabilisation) are transferred to Birmingham Children's Hospital (BCH).
<b>Urology</b>	Emergency Assessment Unit, Urology inpatients (emergency & elective)		Inpatient cancer services at Queen Elizabeth Hospital (University Hospitals of Birmingham Foundation NHS Trust – UHBFT)
<b>General Surgery</b>	Initial assessment and stabilisation of emergency patients with up to 23 hour stay on the Surgical Assessment Unit.	Emergency Assessment Unit, General Surgery, Colorectal & Upper GI inpatients (emergency &	

	On site 24/7 medical team. Access to an emergency theatre 24/7.	elective)	
<b>Trauma and Orthopaedics</b>	Initial assessment and stabilisation of emergency patients with up to 23 hour stay on the Surgical Assessment Unit. On site 24/7 medical team. Access to an emergency theatre 24/7.	Emergency Assessment Unit, Trauma and Orthopaedic inpatients.	
<b>Major Trauma</b>	Designated Trauma Unit	Designated Trauma Unit	Major Trauma in line with Trauma Network criteria taken directly to Major Trauma Centre (MTC) at UHBFT or BCH or transferred to MTC if self present at Trauma Unit.
<b>Maternity and Neonatal Services</b>	Consultant led obstetrics services  Neonatal Unit  Serenity Midwifery Led Birth Centre		Halcyon Birth Centre (stand alone midwifery led Birth Centre) in Sandwell  Community Midwifery services
<b>Gynaecology Services</b>	Gynaecology inpatients (emergency and elective).	Early Pregnancy Assessment Unit (EPAU)	
<b>Vascular Surgery Services and Vascular Interventional Radiology</b>	Day cases and outpatients  Emergency consultant cover for ED, inpatients in other specialties via joint on call rota with UHBFT.	Day cases and outpatients  Emergency consultant cover for ED, inpatients in other specialties via joint on call rota with UHBFT.	Inpatients and vascular Interventional Radiology at UHBFT.
<b>Stroke, Transient Ischaemic Attack and Neurology (from March 2013)</b>	Does not take blue light ambulances with patient with FAST positive assessment.  Telemedicine support from Stroke Unit for patients who self present or inpatients in other specialties who develop symptoms of a stroke.	Stroke Unit with hyper-acute, acute and rehabilitation beds for stroke and Neurology and TIA clinics.	

It is likely that during the next 5 years a number of other clinical services will require greater consolidation in order to enable the delivery of high quality care through greater sub-specialisation, robust 24 hour senior cover, consolidation of modern high technology equipment and on-going service development. These will again be undertaken in a way that supports our Emergency Departments at both City and Sandwell Hospitals. Given the majority of our surgical specialties, maternity and paediatric services now have inpatient services consolidated on one hospital site it is likely that these future clinical service reconfigurations will be in relation to medical specialties. Potential clinical reconfigurations over the next 5 years include inpatient clinical Haematology, Interventional Radiology, Primary Cardiology Intervention, other medical speciality areas. These clinical reconfigurations will be overseen by our corporate Clinical Reconfiguration Programme Board and will be managed in line with our agreed process to ensure they meet national and local guidelines and good practice for service reconfiguration.

We have identified the need to develop further competencies, role expansion and service development in the following areas and in the longer term to be available at the most senior level on site for the delivery of 24/7 acute care:

- Emergency and Acute medicine
- Emergency surgery
- Critical care including Critical care outreach
- Anaesthesia
- Peri-operative medicine
- Emergency cardiological intervention
- Emergency endoscopy
- Obstetrics
- Neonatology
- Acute paediatrics
- Stroke intervention
- Imaging

Most of these developments will be associated with particular clinical or specialty teams. However, some might be provided by extending the range of competencies in an existing clinical team and some may be supported by the use of telemedicine. Over the next five years we will make progress in delivering these competencies at a senior level, on site for extended hours.

In addition to the above we will require access to expertise from a number of other specialties at a senior level, though these need not necessarily be on site 24/7. Some of these services will be provided entirely by specialty teams employed by us and some may be provided by specialty teams providing services to a number of Trusts with a few being provided in their entirety by other organisations, but with ready access for our patients.

We will also be developing a Long Term Clinical Configuration Plan as an alternative to the Midland Metropolitan Hospital should this not become feasible, but again this plan will concentrate on a period beyond 2018.

**LONG TERM CONDITIONS: *Working in partnership we will provide a new integrated approach to care for people with long term conditions ensuring improved continuity, services which keep people well and out of hospital and care closer to home whenever possible.***

In the UK, 15% of the entire working age population have a chronic illness or disability and there are a growing number of people who suffer with more than one long term illness. People who are diagnosed make up 31% of the population but account for 52% of GP appointments and 65% of outpatients appointments. There is therefore, a fundamental need to change the way services are delivered in order to provide a more holistic and integrated approach that can enable rapid improvements to people's lives and also earlier identification of those who are at risk of developing a long term illness.

We will continue to deliver and transform our clinical services within the context of the vision agreed by our local health economy under RCRH. A key element of this will be to work in partnership with our primary care and community colleagues, and others, to develop and implement care pathways for people with long term conditions that enhance self care with support and ongoing monitoring close to people's homes from health care professionals in primary and community care. People with long term conditions should only be seen in acute hospital settings when specialist facilities, equipment or expertise is required and is not available elsewhere.

This vision requires a major step change in service provision across the health economy through service redesign and with a re-balancing of capacity to reflect a greater focus on delivering care in community and primary care settings and services in acute hospital settings operating at maximum productivity.

Our lead clinicians have worked with clinical colleagues from primary care and commissioners over the last five years in developing the RCRH vision, in identifying the high level service model required to deliver this vision and redesigning a number of care pathways. The Sandwell and West Birmingham CCG has confirmed its ongoing commitment to RCRH and has identified the opportunity to accelerate implementation of redesigned care pathways. This commitment will continue to be reflected in the annual commissioning agreements (LDPs) and the CCG QIPP plans.

The implications of this vision for our services can be summarised as:

- ***A shift in provision of outpatient care*** from consultant based services in acute hospital settings to care delivered by other health care professionals in community settings and primary care with direct access to secondary care expertise. This will involve our consultants and other specialist clinical staff working alongside primary care colleagues to deliver alternative services. For example our Rheumatology consultants provide support to a GP with a special interest in Rheumatology who provides an alternative service for Rheumatology referrals in one locality. Our Pain Management service with commissioners and primary care has developed a service model with different

levels of care provided in different primary and community settings by a multidisciplinary team and only those patients requiring treatment with specialist imaging equipment are now seen by the secondary care team in an acute setting.

- ***A reduction in emergency admissions for people with long term conditions and in the average length of stay in the acute hospital setting.*** Some of this reduction will be supported through new intermediate care bed capacity in community locations and community services delivered in people's own homes. We will provide some of the community beds, particularly in Rowley Regis Hospital and Leasowes Intermediate Care Centre as well as community services for the Sandwell population in people's own homes. Again we will work with colleagues in primary care, social services and other community providers (particularly in Birmingham) to develop other services. We recently opened a new style of intermediate care beds at Rowley Regis Hospital with a focus on reablement so that as many people as possible are able to return to their usual place of residence following a hospital admission. We will also support our primary care colleagues as they develop their referral centres and risk stratification approach to the management of patients with long term conditions so that more patients can be cared for safely and appropriately within primary care and closer to home. We will co-ordinate and monitor progress with this change through our corporate level Right Care Right Here Implementation Board.
- ***A growth in our community services.*** We will develop and expand our community services in order to support the transfer of care from acute settings to community and primary care and also in line with national standards. This will include growth in specialist community services such as our Community Orthopaedic Service which has seen an increase in referrals for assessment and treatment along an agreed care pathway as an alternative to referral to a consultant Orthopaedic service. There will also be a growth in our core community services to support more people in their own homes as an alternative to hospital. Another key aspect will be the development of the Sandwell Health Visiting Service and expansion in numbers of Health Visitors over the next three years in line with national standards for Health Visiting, reduction in the caseload for each Health Visitor and support for families.

We will deliver these changes through joint working with partners in the local health economy with a clear focus on implementing the care pathways that have been redesigned and approved by our consultants, local General Practitioners and other clinical leaders through RCRH. Through our Transformation Plan, which is described in more detail below, we will also be transforming our own internal pathways and processes to make sure these deliver safe, high quality and efficient care.



**PLANNED CARE: *As much care as possible will be planned along agreed, easy to navigate care pathways based on best clinical practice.***

In the future, as much care as possible will be planned and this will:

- Be based on agreed pathways that are understood by patients and are based on best clinical practice
- Be easy to navigate – all involved will know where they are on the pathway
- Respect the diversity of our patients and seek to respond appropriately to the full range of patient needs
- Be organised, thereby not wasting patient or clinical time or resources
- Provide planned care as locally as possible – only where clinically necessary will services be concentrated in more specialist centre.

Fundamental to this is the structure of pathways, i.e. the fundamental stages of the patient journey:

- Self assessment and care
- Diagnosis
- Referral
- Specialist assessment
- Intervention including surgery
- Supra specialist treatment
- Follow up

For our services this will mean:

- ***Appropriate and probably fewer referrals.*** Referrals from GPs should be made along agreed care pathways and are likely to have been triaged within primary care first to ensure appropriate alternative services have been considered prior to referral to secondary care. Routine diagnostics should have been undertaken within primary care and the results should be available as part of the referral. There should be a higher conversion of referrals to treatment/surgery. Our consultants and other specialist clinical staff are likely to be involved in supporting the referral centres in primary care. Our Gastroenterologists have worked with primary care colleagues to develop a telephone and email triage service for referrals to Gastroenterology.
- ***One stop approach to appointments.*** Where clinically appropriate required diagnostics will be undertaken and results given at the same time as an outpatient appointment. This will require careful scheduling of appointments and partnership working between specialities and diagnostic departments.
- ***Reduction in elective inpatient surgery and increase in day case surgery.*** There is Royal College support for day surgery, with evidence that this provides for the best and most cost-effective care for patients. All patients needing planned surgery should be treated as day case/23-hour

stay unless there is a clear reason not to. We are forecasting our day surgery rate to be 88%. This will require a focus on pre-operative assessment and preparation and scheduling of day surgery. Our Breast Surgery team developed and introduced new pathways that have allowed a move towards undertaking mastectomy surgery on a day case basis and we now perform over 90% of this surgery on a day case basis. Most specialities will provide day surgery in the dedicated day surgery facilities at both Sandwell and City (including BMEC) Hospitals. The exception to this will be where specialist and costly equipment necessitate concentration on one site (for example Breast Surgery) and/or emergency cover by medical teams only provided on one site (for example ENT).

- **Reduced stay in hospital for the minority of patients that do require elective inpatient surgery.** The principle will be that all patients needing surgery are admitted on the day of surgery unless there is a clear clinical reason not to. We will further develop Enhanced Recovery Programmes to reduce the overall length of stay in hospital. To date we have undertaken Enhanced Recovery Programmes for Colorectal Surgery and Elective Joint Replacement Surgery. For Elective Hip and Knee Joint Replacement Surgery our length of stay is now 3.5 days and we are aiming to reduce this further to 48 hours. These Programmes are evidence-based approaches to care designed to prepare patients for, and reduce the total impact of surgery, helping them to recover more quickly. Balancing demand and capacity at all stages of the process is essential.
- **Concentration of Elective Inpatient Services.** Given the reduction in the amount of elective inpatient surgery and the increased complexity of those patients who do require this type of surgery, we will continue to review the need to concentrate elective inpatients in each specialty on one site. In considering this the requirements for emergency out of hours cover will be considered and account taken of any consolidation of emergency inpatient services. At times this may mean that specialist inpatient services need to be concentrated at another Trust (for example Vascular Surgery) in order to deliver the best patient outcomes through greater critical mass and expertise in larger units. We will continue to work with wider clinical networks to ensure patient care is delivered in a joined up and smooth way between our services and more specialised services where these are required. At times this will include our consultants and other clinical staff working at specialist units in other Trusts to deliver this care. This approach helps to ensure continuity of care for patients whilst still receiving the benefits of care in the more specialist unit. It also helps our clinical staff to develop and retain specialist skills.

Our current configuration of elective inpatient services is summarised below – day case (including 23 hours stay) surgery and outpatient clinics are provided at both City and Sandwell Hospitals unless otherwise stated.

<b>Reconfigured Elective Inpatient Clinical Services</b>			
	<b>City Hospital</b>	<b>Sandwell Hospital</b>	<b>Other</b>
<b>Urology Inpatient Services</b>	Urology inpatients (alongside emergency inpatients)		Inpatient cancer services at Queen Elizabeth Hospital (University Hospitals of Birmingham Foundation NHS Trust)
<b>General Surgery Inpatient Services</b>	Support to Gynae Oncology surgery	Colorectal and Upper GI inpatients (alongside emergency inpatients)	
<b>Trauma and Orthopaedic Inpatient Services</b>		Orthopaedic inpatients (alongside trauma inpatients)	
<b>Maternity and Neonatal Services</b>	Consultant led obstetric services  Neonatal Unit  Serenity Midwifery Led Birth Centre		Halcyon Birth Centre (stand alone midwifery led Birth Centre) in Sandwell  Community Midwifery services
<b>Gynaecology Services</b>	Gynaecology inpatients (alongside emergency inpatients)		
<b>Gynaecology Oncology Services</b>	Gynaecology Oncology inpatients		
<b>Breast Surgery</b>	Breast Screening Programme, Day Case Surgery and Outpatients based in the BTC  Inpatients and reconstructive surgery		Elements of Breast Screening using mobile units in Birmingham, Sandwell and Walsall
<b>Vascular Surgery Services and Vascular Interventional Radiology</b>			Inpatients and vascular Interventional Radiology at Queen Elizabeth Hospital (University Hospitals of Birmingham Foundation NHS Trust)

**DIAGNOSTICS: *We will deliver high quality, timely and appropriate diagnostic services to support our specialties and primary care in the delivery of integrated care pathways.***

High quality, timely and appropriate diagnostic investigations are essential requirements for all clinical services and care pathways. There is evidence that demonstrates how lack of access to diagnostics creates bottlenecks for patients, leading to delays along the pathway and great frustration from clinicians including GPs. We provide a wide range of diagnostic services to our specialties, primary care and at times other hospitals. We will develop these in a way that ensures their integration in care pathways across primary, community and secondary care settings. This provides the opportunity for our diagnostic department to provide a high quality diagnostic service directly to primary care clinicians who in turn will use the results to avoid referral to a secondary care service or where this is clinically appropriate make the referral to the most appropriate specialist with the diagnostic results available on referral.

Many of our diagnostic services are delivered via our Imaging and Pathology services. Others are delivered through smaller more specialised services often integrated with a speciality (for example cardiology and respiratory diagnostics).

A number of our diagnostic services have a regional or national reputation and provide services to other Trusts. These include Radio-pharmacy, Neurophysiology and Toxicology. We will support the further development of these where there is evidence of demand and contribution to the Trust's financial/business position.

## **Imaging**

Our Imaging Division provides services to support the Trusts Clinical Specialities, GP practices and other Trusts. Internally it is a key enabler to support specialities in providing quality and timely patient care and in addition to work proactively with specialities where revised service models are required. It is also integral in supporting a number of the corporate transformation projects and the local health economy's redesigned care pathways and QIPP plans.

Imaging offers GPs and other healthcare professionals, direct access to high quality diagnostic and imaging scans and tests throughout Sandwell and West Birmingham. The tests and scans are delivered a range of sites - including acute and community based facilities. Access for GPs to refer patients directly for diagnostic tests is electronic with the diagnostic report being sent to the GP electronically.

Our vision is to remain at the forefront of the Imaging community through our innovative structure and systems and our expectation is that our patients will view us as a tried and true centre of clinical excellence.

Our priorities for the next 5 years include:

- Develop a long term vision for Interventional Radiology that considers a Trust delivered service that grows and develops or as a service developed in partnership with another Provider particularly with regard to 24/7 on call.
- Develop and implement an action plan to ensure full compliance with new regional standards and achieve ISAS accreditation over the next 18 – 24 months.
- Explore options for a Managed Equipment Service including the need to introduce a 4<sup>th</sup> CT scanner and third MRI scanner.
- Develop further external relationships with GPs and explore options to increase GP direct access.

## **Pathology**

We plan to accommodate our main Pathology Service on the Sandwell Hospital site to provide integrated and modern facilities that allow us to take advantage of the latest technology and to streamline our processes. We are working collaboratively with Dudley Group FT on the future planning of our Pathology services. There will be a phased approach to this work over the medium term. The first phase is an Integrated Blood Sciences Laboratory and we plan to start work on this in 2012. A mini laboratory will remain at City Hospital to deal with emergency requests and support the Emergency Department and inpatient services.

In addition NHS Midlands and East are proposing a centralisation of Pathology services for GP direct access tests and will be undertaking a tendering process for this during 2013. Again, we are working in partnership with Dudley Group of Hospitals NHS Foundation Trust to develop a joint response.

**CLINICAL CAPACITY: *We will deliver efficient clinical services tailoring our clinical capacity to meet clinical demand and facilitate delivery of efficient care pathways.***

Delivering efficient clinical services is a key to improving quality and safety. During the summer of 2011 we worked with external consultants to consider our approach to the Quality and Efficiency Programme and the Cost Improvement Programme.

As a result, a five year Transformation Plan has been established designed to improve the quality and safety of our services whilst meeting the demanding national efficiency targets.

The Transformation Plan consists of a series of Trust-wide themes (see below), each including a series of key projects. A Transformation Support Office has been established to help drive and offer support to staff delivering the Plan and associated Transformation Savings Plans (TSPs). In addition to changing the ways in which services are delivered the Transformation Plan aims to save £125 million over the next five years (c£25m per year). Rather than savings being approached in a piecemeal way, Divisional savings targets have been set in line with the Plan.

- Demand and capacity planning
- Outpatient efficiency
- Urgent care re-design
- Theatre productivity
- Effective patient flow and bed utilisation
- Community Service efficiency and integration
- Workforce efficiency
- Medical workforce efficiency
- Diagnostics
- Procurement
- Corporate Services and Facilities productivity
- Estates rationalisation
- Strategic IT enablement

The first six of these Trust-wide themes are focused on the way we deliver our clinical services and as such have clinical leads. These will deliver improvements to clinical care through streamlined processes. An early example has been the introduction of daily Board Rounds on medical wards which ensure a high level multi-disciplinary daily review of all patients and progress against their management plan.

In addition to our Transformation Plan the service redesign work we are undertaking with our commissioners, primary care colleagues and others under RCRH will significantly shape the clinical capacity we require in both our acute and community services. The impact of both the Transformation Plan and RCRH service redesign have been embedded in our future activity modelling which in turn underpins our Long Term Financial Plan.

Key themes for the next 5 years in terms of the most significant projected changes to activity, capacity and key performance measures are:

**Admitted Patient Care:**

- Overall 2% growth in elective admissions but with a
  - 36% reduction in elective inpatient admissions
  - Increase in day case rates to 88%.
- Operating sessions static with more day case sessions, minor operating sessions & improved session utilisation to 90%.
- Reduced length of stay (LofS) from 3.95 days to 3.61 days with a:
  - Emergency LofS from 4.3 days to 3.7 days
  - Increase in average LofS for elective inpatients from 2.1 to 2.7 days
- Bed occupancy from 88% to 86%.
- 966 acute beds (2010/11) to circa 702 acute beds & 60 new intermediate care beds (in addition to the existing 42 intermediate care beds)

**A&E:**

- Overall 7% growth in A&E and Urgent Care attendances but with:
  - 31% transfer from traditional A&E attendances to Urgent Care (provided by us in addition to current primary care Urgent Care Centres)
  - 3% growth in Eye A&E attendances (BMEC).

**Outpatients:**

- Overall 33% reduction in acute outpatient attendances with:
  - Stable new outpatient attendances
  - Review to new follow up rate from c2.6:1 to c1.7:1

**Community:**

- 10% growth in community contacts with:
  - 3% growth in core contacts
  - 7.5% growth as a result of transfer of activity (mainly follow up outpatient attendances) from acute settings as part of RCRH redesign.

## APPENDIX 1

### Summary of Key Changes Arising From the Clinical Strategy with Indicative Timelines

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
<b>Clinical Leadership</b>						
Move towards 24/7 consultant delivered emergency care						
Leadership at the point of care delivery						
<b>Beacon Services</b>						
Behçet's Centre						
Specialist Ophthalmology						
Gynaecology Oncology						
<b>Emergency Care</b>						
An intense focus on providing safe acute inpatient care 24/7 on both sites						
Transfer of activity from ED to Urgent Care						
Stroke, Neurology & TIA Reconfiguration with new Stroke Unit						
<b>Long Term Conditions</b>						
Implement , in partnership, RCRH redesigned care pathways						
Grow our community services & introduce alternatives to acute care						
Implement Health Visiting Strategy						
<b>Planned Care</b>						
Increase our day case rate to 88%						
<b>Diagnostics</b>						
Achieve ISAS accreditation						
4 <sup>th</sup> CT scanner & 3 <sup>rd</sup> MRI scanner						
Integrated Blood Sciences Laboratory at Sandwell						
SHA centralisation of GP direct access pathology testing						
<b>Clinical Capacity</b>						
Reduce Acute beds						
Increase Intermediate Care beds						





**APPENDIX 2****DOCUMENT CONTROL****Revision History:**

<b>Version</b>	<b>Date</b>	<b>Author</b>	<b>Summary of Changes</b>
V1	20/9/12	Jayne Dunn Redesign Director RCRH	Updated to take account of amendments from Dr Roger Stedman, Medical Director, Rachel Overfield, Chief Nurse and Mike Sharon, Director of Strategy and include additional information from other clinical leads. Main changes in this draft: <ul style="list-style-type: none"> <li>Clinical Leadership section updated.</li> </ul> Version 1 to be presented to Trust Board on 27/9/12 for approval.
V1: draft 3	5/9/12	Jayne Dunn Redesign Director RCRH	Further draft to take account of discussions with Dr Roger Stedman, Medical Director (2 & 21/8/12) and Rachel Overfield, Chief Nurse (2/8/12), list of service developments for next 5 years submitted by Clinical Directorates, development of Chapter 5 (Service Developments) of the Integrated Business Plan and feedback on this from Foundation Trust Programme Board. Main changes in this draft: <ul style="list-style-type: none"> <li>Addition of summary diagram</li> <li>Restructure of headings/sections to reflect diagram</li> <li>Addition of examples</li> </ul> More information about CCG.
V1: draft 2	11/7/12	Roger Stedman Medical Director	Tracked changes on draft 1.
V1: draft 1	12.6.12	Jayne Dunn Redesign Director RCRH	First draft following discussion with Dr Deva Situnayake, Acting Medical Director and Rachel Overfield, Chief Nurse.  Also incorporates elements of the future clinical service model developed with clinical leads to support the OBC for MMH.

**TRUST BOARD**

<b>DOCUMENT TITLE:</b>	<b>Membership Strategy</b>				
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	<b>Jessamy Kinghorn, Head of Communications and Engagement</b>				
<b>AUTHOR(S):</b>	<b>Jessamy Kinghorn, Head of Communications and Engagement</b>				
<b>DATE OF MEETING:</b>	<b>27 September 2012</b>				
<b>EXECUTIVE SUMMARY:</b>					
<p>The Membership Strategy defines the Trust's membership community and sets out the Trust's approach to membership development and involvement. It has been updated since last being approved by the Trust Board in November 2011, following a Board Seminar discussion on membership in June 2012.</p> <p>The main changes involve combination of two objectives into one (now the first objective), removal of a specific objective around defining membership rights and responsibilities as these are described in the strategy itself, and adding an objective around partnership working to improve the health and well-being of the local community.</p> <p>More detail has been added as to how the strategy will be delivered, including outlines of plans to target under-represented areas, and more evidence included of work carried out to date.</p> <p>The remaining changes are mainly presentational and removing sections of text that were not necessary to the strategy.</p>					
<b>REPORT RECOMMENDATION:</b>					
Trust Board is asked to approve the strategy.					
<b>ACTION REQUIRED</b> <i>(Indicate with 'x' the purpose that applies):</i>					
The receiving body is asked to receive, consider and:					
<b>Accept</b>	<b>Approve the recommendation</b>			<b>Discuss</b>	
	X			X	
<b>KEY AREAS OF IMPACT</b> <i>(Indicate with 'x' all those that apply):</i>					
Financial	X	Environmental		Communications & Media	X
Business and market share		Legal & Policy	X	Patient Experience	X
Clinical		Equality and Diversity	X	Workforce	X
Comments:					
<b>ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:</b>					
The strategy is a required supporting document to the Integrated Development Plan as part of the Trust's NHS Foundation Trust application.					
<b>PREVIOUS CONSIDERATION:</b>					
Trust Board in November 2011 and the Board development seminar in June 2012.					

# Membership Strategy

Version 9

September 2012



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## 1.0 About the Trust

Sandwell and West Birmingham Hospitals NHS Trust is a large teaching hospital trust providing services from two busy acute hospitals – City Hospital in Birmingham and Sandwell General Hospital in West Bromwich – as well as community services - from Rowley Regis Community Hospital, Leasowes Intermediate Care Centre and the Lyng Centre for Health and Social Care, in other locations and in patients' homes.

The Trust is located in the heart of the West Midlands, delivering care to a core population of around 500,000 people in Sandwell and the central and western parts of Birmingham, as well as to some patients from other parts of the West Midlands and beyond for specialties such as ophthalmology and gynae-oncology. 7,738 members of staff work for the Trust.

The area is one of the most diverse in the country, with large proportions of people from black and minority ethnic communities, and large numbers of young people within the local area. The area also has high levels of deprivation and poor health, often connected with long-term conditions such as heart disease, diabetes or respiratory problems.

### 1.1 Our vision is:

***We will improve the health and wellbeing of people in Sandwell, western Birmingham and surrounding areas, working with our partners to provide, improve and sustain the highest quality health care in hospital and closer to home.***

Our membership strategy is key to realising our vision, providing an excellent opportunity to recruit local people as members and educate them about healthy lifestyles, support them in taking steps to improve their health and use their feedback to improve and sustain high quality health care.

### 1.2 Our values:

Following consultation with staff, patients and local people, we have developed a set of values that underpin everything we do as an organisation, and which sit at the heart of this membership strategy:

- ***Caring and compassionate***
- ***Accessible and responsive***
- ***Professional and knowledgeable***
- ***Open and accountable***
- ***Engaging and empowering***

## 2.0 Membership

The Trust Board has identified one of the key benefits of NHS Foundation Status as membership which will improve engagement with staff and our public in shaping the future of the Trust and holding the Trust to account for current performance.

Membership will mean local people can become more involved in helping us develop our plans and improve our services. This engagement will be integral to the running of the Trust.

This membership strategy recognises the process of building meaningful membership structures will take a serious commitment of time and resources.

It defines the membership community and sets out how we will build on work we have already done to establish and maintain an active membership that gives local people a real say in how we develop future plans.

A shadow membership of around 7,500 local people has been running since 2008. Members have been involved in a range of activities which continue to form the core of our membership strategy.

### 2.1 Objectives of our membership strategy:

*Table one:*

Theme	Objective
<b>Building the membership base</b>	<ul style="list-style-type: none"> <li>To build and maintain an active membership that is reflective of our local communities, ensuring the public membership remains larger than the staff membership (in line with the majority of public governors on the Council of Governors)</li> </ul>
	<ul style="list-style-type: none"> <li>To encourage staff to remain members of the NHS Foundation Trust</li> </ul>
<b>Managing active membership</b>	<ul style="list-style-type: none"> <li>To encourage members to run for election to the Council of Governors, and support elected governors in effective engagement with their constituencies</li> </ul>
	<ul style="list-style-type: none"> <li>To encourage and empower the membership to become a community of influence within the Trust</li> </ul>
<b>Communicating with members</b>	<ul style="list-style-type: none"> <li>To ensure local people, staff and patients have a say in the development of our services and priorities</li> </ul>
<b>Playing a key community role</b>	<ul style="list-style-type: none"> <li>To improve the health and wellbeing of local people by educating and empowering our members</li> </ul>
	<ul style="list-style-type: none"> <li>To educate our members in healthcare related careers and opportunities in the Trust, including work experience and volunteering</li> </ul>
<b>Working with other membership organisations</b>	<ul style="list-style-type: none"> <li>To ensure the Trust works closely with partner and community organisations to achieve its vision to improve the health and well-being of local people</li> </ul>

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## 2.2 Our membership community

Our membership is divided into two categories: public members and staff members.

### 2.2a Public members:

Public members are patients, local people and volunteers who request to become members. Public members must be over 11 years old and must live in the West Midlands.

They will be represented on our Council of Governors by 19 governors, between them representing eight geographical constituencies (Table 2). Governors must be aged 16 or over.

Seven constituencies will cover Sandwell and the areas of Birmingham where most of our patients live and a further constituency will cover the rest of the West Midlands (Figure 1). The number of Governors per constituency has been allocated based on the geographical areas the majority of our patients come from.

Together these constituencies will allow more than 99% of our patients who are over 11 years old to become members.

*Table two:*

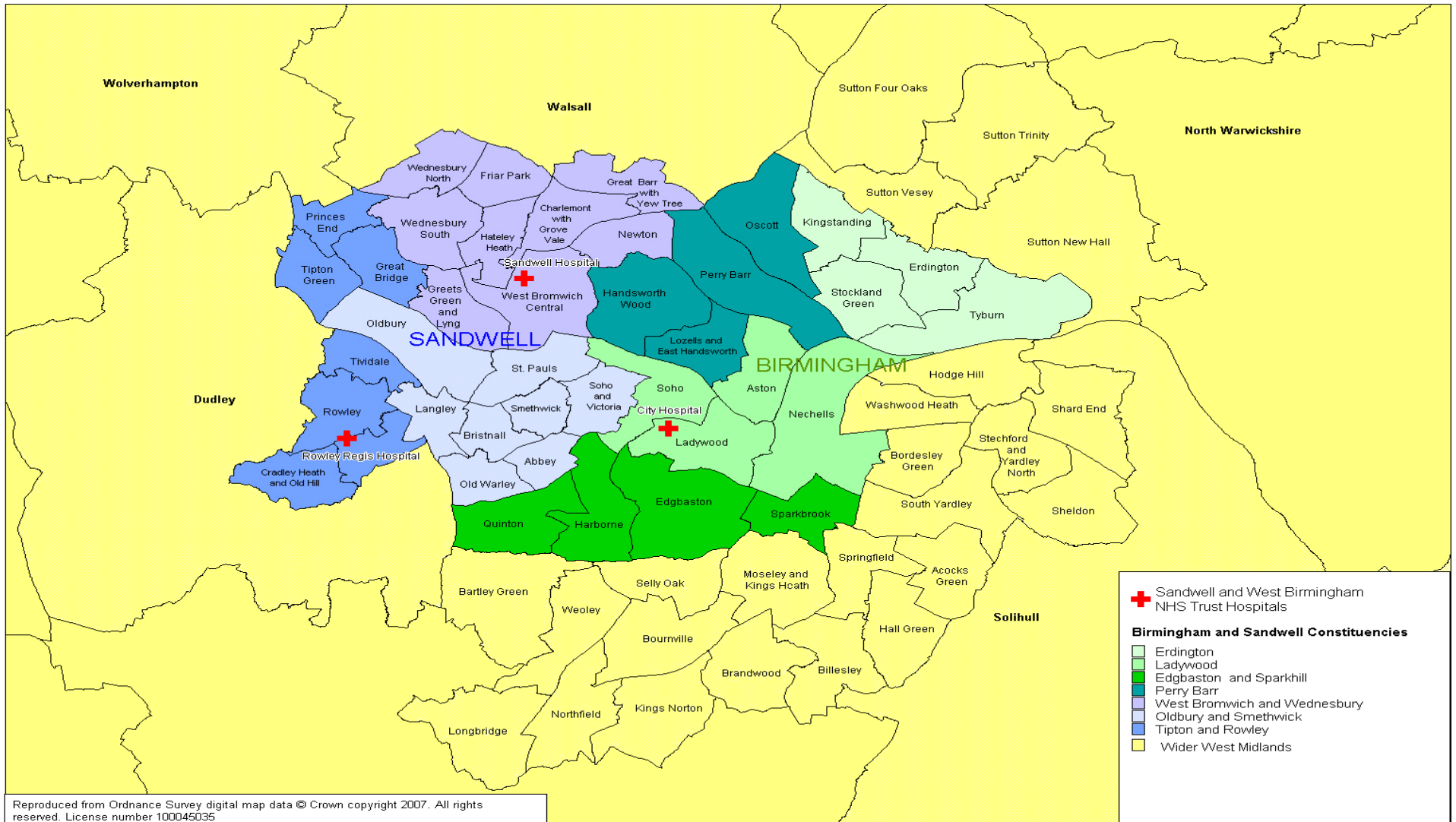
Constituency	Number of Governors	Size of population
Ladywood	3	94,538
Edgbaston and Sparkbrook	1	96,388
Perry Barr	3	100,476
Erdington	1	90,654
Wednesbury and West Bromwich	3	105,770
Oldbury and Smethwick	3	94,969
Tipton and Rowley Regis	3	82,165
The wider West Midlands	2	4,602,348
<b>Total</b>	<b>19</b>	<b>5,267,308</b>

There are fewer governors per member of the local population for Edgbaston and Sparkbrook, Erdington and the wider West Midlands because these areas fall outside our main catchment area.

The minimum age of members has been set at 11 following public consultation. There were strongly held views both for and against the age, with young people in particular keen to be involved. The main additional factors influencing the selection of 11 as the minimum age were:

- The Trust has a well established paediatric service and seeks to engage young people in developing that service
- Birmingham has a large and growing young population
- Membership provides a powerful opportunity to influence lifestyle choices made by young people at an important stage in their development
- Membership of secondary school age children provides an opportunity to educate and involve local young people in the wide range of health related careers we provide, before they make their subject and career choices. This is particularly important in an area which has below average educational attainment and higher than average long term unemployment

Figure one:





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We serve a population that is comparatively deprived, ethnically mixed, and which is growing broadly in line with the national rate, but higher than the West Midlands average.

Broadly, the population in the Heart of Birmingham (HoB) PCT area is relatively young, whilst that in the Sandwell PCT catchment is older.

Overall, from 2013, the total population for the combined area will increase by 6% by 2023, and 12% by 2033.

The highest growth rates will be in the population aged 64 and over. There will also be growth in the young population in Birmingham, and an increase in the prevalence of long-term conditions.

## 2.2b Staff members

All permanent staff will automatically become members unless they choose not to be by 'opting out.'

Those working for a third party under a contract with the Trust for more than 12 months, those on temporary contracts of more than 12 months and staff working continuously on the Trust bank for more than 12 months can also become members.

Staff members will be represented on the Council of Governors by 11 governors elected from four professional constituencies. The number of governors in each constituency is proportionate to the total number of staff within the constituency.

*Table three:*

Constituency	Number of Governors	Number of eligible staff at December 2011
Medical and dental staff	2	805
Nursing and midwifery staff	3	2,260
Other clinical staff	3	2,248
Non clinical staff	3	2,557
<b>Total</b>	<b>11</b>	<b>7,870</b>

## 2.3 What it means to be a member

Membership empowers staff and local people to have greater influence and hold the Trust to account through elected governors.

It gives members an opportunity to stand for election as a governor and participate in the activities of the governors' Council.

Membership enables members to find out more about what is going on in the Trust, provide feedback and have a greater say in the Trust's service developments, strategy and priorities. Members will also help the Trust better understand the specific needs of the diverse communities we serve.

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It gives members opportunities to participate in Trust activities and learn more about the Trust and its services, health related topics and conditions which affect our local population, living healthier lifestyles and career options.

Members also have the opportunity to get involved in volunteering and fundraising.

Membership is free. Members will not receive any payment or preferential clinical treatment. Local people who choose not to become a member of the NHS Foundation Trust will continue to have the same access to local hospital and community health services as those who do.

## **2.4 What membership means to Sandwell and West Birmingham Hospitals NHS Trust**

By becoming an NHS Foundation Trust, we will be changing the way the organisation operates. Local people and staff will have a real say in helping us decide how we will work to improve services and enhance patients' experiences of care.

We will plan and deliver services with local people rather than for them.

Our vision is both to improve the health and wellbeing of local people and work with our partners (including our members and governors), to provide, improve and sustain the highest quality health care.

We see ourselves as an engaging and empowering organisation, accessible, responsive, open and accountable to local people.

Membership and elected governors give us a real opportunity to genuinely place engagement with staff and local people at the heart of decision making and service improvement. Members will be 'critical friends' who will provide us with useful feedback on our services and work with us to shape improvements.

We established a 'shadow' membership in 2008 and already seek to involve patients, members of the public and local stakeholder and community groups in our plans and ask for their feedback on issues including service change and Trust priorities through a variety of activities and events.

Since 2008 we have been working towards a culture of staff engagement in decision making. Improvements in staff involvement and empowerment can be demonstrated through staff survey results which have seen significant movement in the right direction.

Our membership strategy will be the catalyst for this engagement. Staff, patient and public involvement will be built directly into the corporate governance and decision-making processes so that staff and local people will genuinely help shape the future of their local healthcare services.

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### 3.0 Resourcing membership development

The Trust has established an in house membership office. We believe that this is the most effective way of developing sustainable relationships between the Trust, its members, local people and the diverse communities we serve.

The Head of Communications and Engagement has overall responsibility for the development and delivery of the membership strategy. A Membership Engagement Manager has lead responsibility to ensure the strategy is delivered on a day by day basis and to recruit and liaise with members. Some less senior, mainly administrative support is available. A non pay budget is available for delivering member activities.

The Director of Governance and the Trust Secretary will directly support the Council of Governors and the Chairman of the Trust, especially in managing the relationship between the Council of Governors and the Board of Directors.

A database of both staff and public members will be maintained by the Trust. The data will be held in accordance with the Data Protection Act.

In certain cases, specialist functions may be commissioned from certain providers, the distribution of membership communication, for example.

Members details are kept purely for the purpose of membership outlined in this strategy. Where the membership database needs to be shared with those outside the membership office, appropriate governance arrangements will be put in place to ensure the safety of member information.

The database will be cross-referenced with our patient database on a regular basis to reduce the risk of deceased members receiving membership mail.

The membership resource will need to be reviewed as the Trust progresses its NHS Foundation Trust application, to ensure elections can be fully supported and appropriate member and governor development and training provided.

## 4.0 Building the membership base

In April 2011, the Trust acquired Sandwell community health services, increasing our workforce by c. 800 staff to 7,611, taking the number of staff members above the number of public members, which was 7,556 in December 2011.

The Trust Board approved an increase in the target for public members from 7,500 to a minimum of 8,000 members to ensure we maintain a public membership that is larger than our staff membership, in line with having a majority of public governors on the Council of Governors.

To build and maintain an active membership that is reflective of our local communities, the membership office will:

- Implement a recruitment plan that uses a range of online, face to face and written communication to increase the number of registered public members to 8,000 by April 2013, presenting progress to the Trust Board twice yearly in June and December.
- Develop and implement targeted recruitment plans to ensure the number of members within constituencies is at least 300 members per governor within that constituency, presenting progress to the Trust Board twice yearly in June and December (previously this has been annually in December). See table four.
- Develop and implement targeted recruitment plans to target under-represented demographic areas, presenting progress to the Trust Board twice yearly in June and December (previously this has been annually in December). See table five.
- Continue to build, promote and develop 'engage' as an online membership portal. See figure two in appendix one.
- Maintain an accurate database of member details and interests, recording one of three levels of interest members have (low, medium or high) so communication can be appropriately targeted
- Work with elected governors to review and monitor the membership strategy and recruitment plans once the Council of Governors is established
- Engage elected governors to lead recruitment initiatives in their constituencies
- Provide timely information to staff and local people on the benefits of membership and provide timely introduction packs to make sure they feel welcome
- Interview / survey staff who 'opt out' to ensure they are fully informed before doing so and to gather and respond to the reasons staff may choose not to participate.

### 4.1 Targeted recruitment plans – under-represented constituencies

Targeted recruitment plans will be put in place for constituencies that have less than 300 members per governor.

Membership numbers at December 2011 are outlined in the table overleaf. Constituencies where the number of members is above the target are rated green, where the number of members is within 5% of the target are rated amber and rated red where the number of members is more than 5% below target.

Table four:

Constituency	Governor seats	Minimum member target	Members	Population	Change since 2010
Ladywood	3	900	871	94538	↑
Edgbaston and Sparkbrook	1	300	389	96388	↑
Perry Barr	3	900	1084	100476	↑
Erdington	1	300	315	90654	↑
Wednesbury and West Bromwich	3	900	1116	105770	↑
Oldbury and Smethwick	3	900	1314	94969	↑
Rowley Regis and Tipton	3	900	748	82165	↑
The Wider West Midlands	2	600	1710	4602348	→
Not Specified	0		9		
<b>Total</b>	<b>19</b>		<b>7556</b>	<b>5267308</b>	

Plans to target the Ladywood and Rowley Regis and Tipton constituencies include:

- Visits to community groups
- Increase and promote member activities at Rowley Regis Hospital
- School assemblies and talks
- Careers and health stands at libraries, health and community centres
- Writing to recent patients as part of evaluating the quality of the service they have received
- Meeting with the local MP for each area
- Meeting reporters from relevant local and community papers to increase interest in member activities (such as the Halesowen News, Voices of Ladywood)

#### 4.2 Targeted recruitment plans – under-represented communities

The table overleaf describes how reflective of the local community the Trust's membership was at December 2011.

Targeted recruitment plans will be implemented where parts of the community are under represented by more than 5% (amber), and particularly focused on areas under represented by more than 10% (red). Those areas where membership is broadly representative of the local population (within 5%) are highlighted in green, and over represented areas are indicated in blue.

Table five:

	Membership compared to eligible population - over / under (-) represented 2011	Membership compared to eligible population - over / under (-) represented 2011, excluding wider West Midlands constituency
<b>Age (years):</b>		
0-16	-3.7%	-6.2%
17-21	-0.9%	-4.4%
22+	4.70%	10.6%
<b>Ethnicity:</b>		
White	-30.8%	-11%
Mixed	0.30%	-1.3%
Asian or Asian British	15.8%	2.8%
Black or Black British	8.70%	4.2%
Other	2.00%	1.3%
<b>Socio-economic groups:</b>		
ABC1	-9.6%	-3.3%
C2	-0.6%	-0.8%
D	1.6%	-2.2%
E	8.2%	5.7%
<b>Gender analysis:</b>		
Male	-10.2%	-9.3%
Female	8.2%	7.4%

The areas of membership most vulnerable to under-representation are:

- Young people
- People from a white ethnic background
- Professional, working men and women
- Men

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There will be a significant amount of overlap in membership recruitment activities, and wherever appropriate, recruitment activities will be designed to respond to more than one under-represented area at any one time. Some of the highlights in these targeted areas include:

#### **4.2a Young people:**

- Further developing and promoting on-line / virtual membership through 'engage'
- Increasing the number of twitchats on topics of interest to young people and linking them to the 'engage' website
- Continuing to develop content aimed at young people on 'engage' and sharing it via social networks
- Visiting schools, taking assemblies and working with children and young people studying health and social care related qualifications
- Working with youth groups and young people's organisations (such as Connexions) to deliver health promotion roadshows
- Linking with careers events
- Working with the paediatric directorate to engage young patients

#### **4.2b People from a white ethnic background:**

- Working with community and religious organisations to promote the benefits of membership
- Reviewing the ethnicity of membership by constituency and identifying geographical areas where white members are significantly under represented
- On-line membership recruitment
- Recruitment activities in outpatients
- Health promotion activities in shopping centres, libraries etc.
- Using Governors to build membership

#### **4.2c Professional working people:**

- Liaising with commissioners to promote membership to their staff
- Partnering with local NHS Trusts, local authorities and other public sector organisations to promote membership to their staff
- Partnering with local businesses, particularly in the City Centre, to promote membership to their staff
- Promoting membership through local gyms and fitness centres
- Ensuring the young people's content on 'engage' is consistent with the national curriculum and promoting the benefits of engage to schools to encourage teachers to join

#### **4.2d Men:**

- Working with local football and sports clubs to engage their members
- Arranging and promoting men's health topics in membership activities
- Recruitment drives in outpatients
- Promotional activities in and around pubs
- Working with religious and community organisations to encourage male membership

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## 5.0 Managing active membership

Becoming an NHS Foundation Trust will mean local people, including patients and carers, staff and other healthcare and related organisations will have more influence on the way the Trust works.

The Trust will be a democratic organisation with elected members who actively participate in the governance arrangements. All members have equal voting rights (one member, one vote).

Several key areas of activity that will take place to manage active membership include:

- In preparation for elections to the Council of Governors, events will be held for members to find out more about what might be involved, along with traditional and online communications materials designed to encourage members to support the elections.
- A development plan for governors will be developed by the Director of Governance that will ensure the individual needs of governors are appropriately catered for.
- A governor communication plan will be developed by the membership office to enable governors to engage with their members. This will support governors to carry out activities including newsletter updates, constituency surgeries, and online engagement.
- A session will be held with the Council of Governors to discuss membership development
- The Trust intends the membership to become a community of influence within the Trust building on existing opportunities for involvement such as Patient Environment Action Team visits, volunteering, and influencing Trust priorities, and developing further opportunities for members to become involved.
- In order to encourage the active participation of members in planning future strategies and service improvements, commenting on services and engaging with governors, a range of initiatives will be implemented by the membership office, including communication material, events and an active online membership where members will be encouraged engage with the Trust in real-time over a range of issues.

Since the 'shadow' membership was formed in 2008, a range of such activities has already been embedded. In addition to distributing the members' newsletter, events are held at different times of the day and in different locations to ensure they are as accessible as possible.

Typically between 15 and 50 members attend events, although some events attract larger numbers and some smaller. Some members attend a high percentage of events. Examples of some of the events of the last twelve months include:

- Health talks on subjects such as heart disease
- Meetings to discuss proposed service change, such as stroke services
- Events to discuss strategy and plans, such as plans for NHS Foundation Status
- Discussions about priorities for the next year
- Training workshops on online communication / social networking
- Members attending our annual general meeting
- Community fun day to celebrate the Olympic Torch procession

These types of activities are essential to support the continued development and maintenance of the membership base.



## 5.0 Communicating with members

The Trust has established eight principles to communication and engagement as part of its Communications and Engagement Strategy.

*Table six:*

<b>Principle</b>	<b>What this means</b>
<b>Two-way (responsive)</b>	<ul style="list-style-type: none"> <li>• We will listen and act on feedback</li> <li>• We will give people the opportunity to ask questions</li> <li>• We will encourage communications that starts at the front line</li> </ul>
<b>Accurate</b>	<ul style="list-style-type: none"> <li>• We will ensure our communication with staff, patients, stakeholders and local people is correct</li> <li>• Spelling and grammar will be of high quality</li> </ul>
<b>Clear</b>	<ul style="list-style-type: none"> <li>• Our communications will be clear, simple and consistent</li> <li>• Communications will be to Plain English standards</li> <li>• Our standard font will be Arial, size 12 for most documents, we will not use small or hard-to-read fonts</li> <li>• We will produce large-print documents when appropriate</li> <li>• Handwritten correspondence will be legible</li> <li>• We will avoid information overload</li> <li>• We will consider the impact of our body language on communication</li> </ul>
<b>Open</b>	<ul style="list-style-type: none"> <li>• We will use the most appropriate form of communications, including face to face communication and engagement whenever possible</li> <li>• We will reinforce messages using a range of communication channels</li> <li>• We will be prepared to engage about all aspects of the Trust</li> </ul>
<b>Honest</b>	<ul style="list-style-type: none"> <li>• Our communications will be honest and factual</li> <li>• We will own up to mistakes and offer appropriate apologies</li> <li>• We will not mislead our audiences</li> <li>• We will be up front about the influence people can have when we ask their views</li> </ul>
<b>Timely</b>	<ul style="list-style-type: none"> <li>• Our communications will be prompt</li> <li>• Engagement will take place as early in the process as possible</li> </ul>
<b>Sensitive (empathetic)</b>	<ul style="list-style-type: none"> <li>• We will try to put ourselves in the position of those we are communicating with and treat people how we would like to be treated</li> <li>• We will aim to be reassuring</li> <li>• We will respect the views, opinions and rights of others</li> <li>• We will treat others with dignity</li> </ul>
<b>Inclusive</b>	<ul style="list-style-type: none"> <li>• We will make appropriate efforts to include staff, patients and local people who may otherwise be excluded</li> <li>• We will encourage involvement</li> <li>• We will consider the needs and views of under represented groups</li> </ul>

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These principles run through the communications and engagement activities the Trust will use to assist members, elected governors, managers and staff contribute effectively to the development of the Trust, having a say in the development of our services and priorities.

Activities primarily aimed at public members will include:

- Online membership will be very important given the usual communication methods used by young people and increasingly older people. Daily use of dedicated membership portal – ‘engage’ to provide mechanism for two-way, timely communication between public and staff members, managers and governors. On the website, members can participate in consultations and discussion forums, sign up for events, suggest events, learn more about healthy lifestyles and much more. New visitors registering on the site will automatically become Trust members if they meet the membership criteria.
- Governor pages on ‘engage’ will enable members to communicate with their governor, with training to enable governors to engage members online, as well as traditional formats
- Annual member meetings to discuss priorities, membership and strategy etc.
- Directorate talks or focus groups, covering each directorate at least once every two years which will ensure at least one talk every month
- Service change events / consultation events
- Targeting of member communications to level of involvement requested
- Publication of all opportunities to get involved on membership calendars
- Encouragement of members to use email to improve timeliness of communication
- Continued production of membership newsletter to ensure members have information about what is happening in the Trust in order to help shape their involvement
- Establishment of membership communication and engagement group made up of members, governors and the membership office and communications team to shape future membership strategy, activities and content of communication
- Efforts to be sensitive to the needs of different community groups, avoiding arranging meetings on holy days, and producing information in different formats where necessary
- Facilitating working groups when appropriate

Activities primarily aimed at staff members will include:

- ‘Listening into Action’ (LiA), which is used to engage frontline staff (as well as patients and members) in driving improvements in services for patients. Every area of the Trust has now been involved in LiA and there has been significant movement in staff survey results
- ‘Owning the Future’ (OtF), which aims to give staff a real sense of influence in the organisation on a permanent basis through the election of ambassadors in every team. Ambassadors will work with their team leaders, and ultimately Governors, to prioritise areas for action and develop solutions. This approach is being piloted in three areas.
- ‘Your Right To Be Heard’ is a well established form of open and transparent two-way communication, where letters from staff and responses from managers are published.
- ‘Hot Topics’ is a method of engaging teams in important issues each month by seeking their views, using their feedback to influence decisions and providing feedback to staff.
- Continued production of Heartbeat, the staff newspaper, to ensure staff members have relevant information about what is happening in the Trust to help shape their involvement.
- Development of the staff zone section of Connect (Trust intranet) to provide discussion forums, calendars of activity and information

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## 7.0 Playing a key community role

We intend to play a major part in our local communities. Our vision emphasises our intention to work with our partners to improve the health and well-being of local people. We believe that to achieve our vision, we need to have a high level of involvement with our local communities.

Through our membership we will undertake a range of activity to increase the knowledge of members on health matters and promote healthy lifestyles and health related career options. We have already been undertaking a significant amount of activity in this area including:

- Health talks, such as heart disease and infection control
- Health promotion roadshows, particularly targeting young people
- Career events
- School assemblies
- Developing healthy lifestyle information and discussions on our membership website – ‘engage’
- Holding ‘twitchats’ on subjects including sexual health, migraine and eye health
- Articles in the membership newsletter
- Established apprenticeship and work experience schemes to help get people back into work
- Embedded a health and wellbeing strategy for staff that encompasses a wide range of initiatives such as a staff gym, lunchtime walks, aromatherapy sessions and stress workshops

We will continue to deliver these activities. In addition we will:

- Develop a health promotion strategy for local people
- Maintain our database of local organisations and groups
- Improve our processes for capturing, responding to and feeding back member views
- Participate in appropriate local community events
- Improve the way we work with community partners, such as Health Exchange
- Develop our plans for Learning Works
- Involve members in our sustainability agenda
- Involve members in developing and delivering our fundraising strategy
- Promote opportunities for members to volunteer at the Trust

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## 8.0 Working with other membership organisations

NHS Foundation Trusts are public benefit corporations, dedicated to serving their communities. Sandwell and West Birmingham Hospitals NHS Trust already has a strong sense of shared purpose with our local commissioning organisations, local authorities and other local health organisations, primarily through the Right Care Right Here programme.

We will seek to build on this to strengthen our relationships with other local organisations that have similar aims to us in a number of ways, including:

- Work closely with the local universities over the development of roles and opportunities within the Trust, and ensure the university governor roles are effective
- Engage closely with commissioners to improve communication and ensure the Clinical Commissioning Group governor roles are effective
- To develop closer relationships with the local authorities, supporting their governors to ensure the governor role is effective
- Continue to prioritise partnership working through the Right Care Right Here programme
- Undertake some of our membership activity in conjunction with the two local mental health NHS foundation trusts
- Continue to develop our relationship with the John Lewis Partnership to learn from their model of staff engagement and incentivisation as we develop 'Owning the Future'
- Work with a local social media partnership to develop the membership website

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## 9.0 Evaluating success

Progress against the membership strategy will be reported to the Council or Governors and to the Trust Board, or a designated sub-committee.

Membership numbers will be monitored by constituency and demographics. Attendance at membership events and participation in online membership activities will also be reported.

The key role played by the Council of Governors in monitoring the effectiveness of the strategy will ensure it remains a meaningful and relevant document as the membership of the Trust develops.

Member involvement events where members will have the opportunity to contribute to the development of the strategy will take place annually.

A group of governors and members will be established to discuss and review membership activities and shape future membership activity.

## Appendix one: Membership and membership recruitment to date

Membership numbers by constituency for December 2011 are given in table xx in the main document. The public membership has remained stable at around 7,500 for the last few years. The full demographic breakdown of members over the last few years is detailed in table xx on the following page.

Attendance at membership events is variable.

For example, at events to discuss our plans for NHS Foundation Status, we recorded:

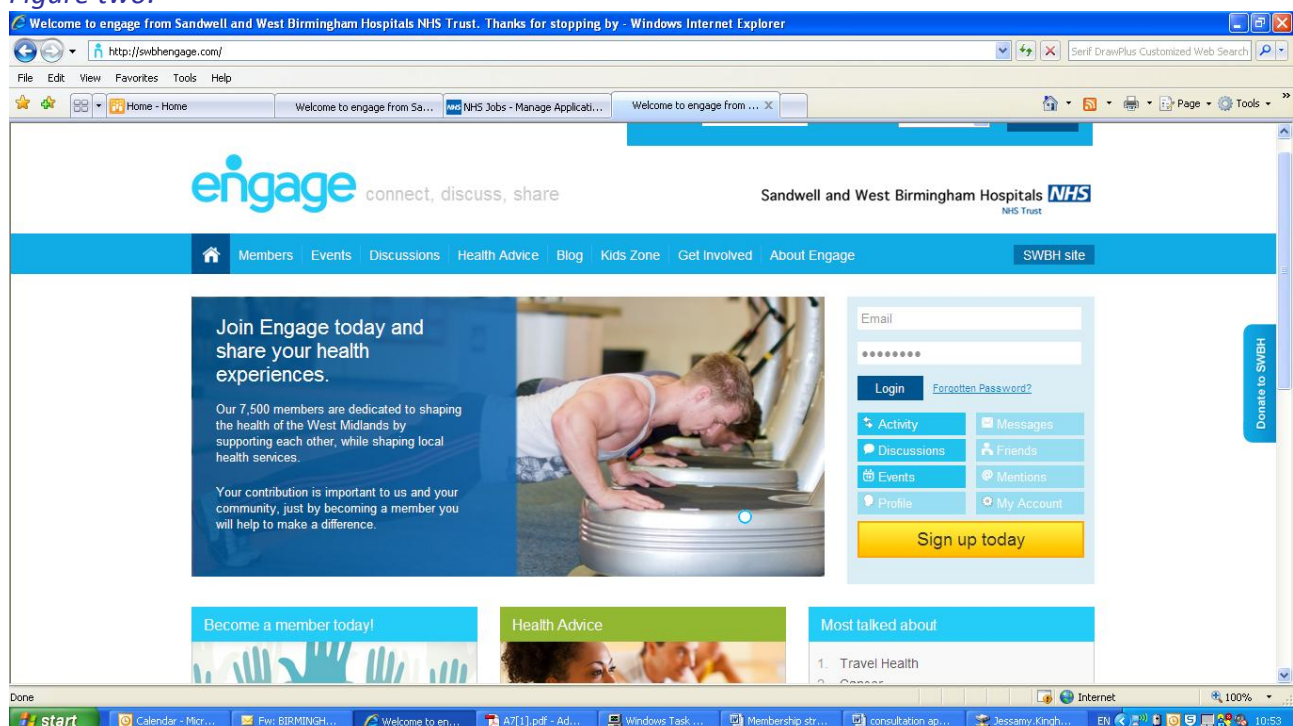
- 19<sup>th</sup> March 2012: 56 recorded attendances
- 22<sup>nd</sup> March 2012: 19 recorded attendances
- 26<sup>th</sup> March 2012: 58 recorded attendances

At a talk on health disease given by one of our cardiologists, we recorded:

- 3<sup>rd</sup> September 2012: 25 recorded attendances

Within one month of launching our membership website 'engage': [www.swbhengage.com](http://www.swbhengage.com), with minimal promotion, we had registered 100 members to the site, including staff and public members and new public members.

Figure two:





Member newsletters are sent to members three times per year (this is set to increase to four times following member feedback). Letters, surveys and a calendar of activities are normally sent with the newsletter, although occasionally additional contact is required.

Figure three:



The colour code key to table seven on the following page is:

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

Table seven:

Public constituency	Members 2009	Members 2010	Members 2011	Number	Proportion of membership 2011	Eligible members 2011	Over / Under represented 2009	Over / Under represented 2010	Over / Under represented 2011	Excl. wider West Midlands
Age (years):										
0-16	253	430	432	↑	5.70%	428612	-6.08%	-3.70%	-3.7%	-6.2%
17-21	442	480	486	↑	6.40%	332660	-1.44%	-0.90%	-0.9%	-4.4%
22+	6,435	6,577	6,638	↑	87.90%	3768599	2.74%	4.70%	4.70%	10.6%
Ethnicity:										
White	4,494	4,354	4,379	↑	58.0%	4674296	-28.73%	-30.60%	-30.8%	-11%
Mixed	40	128	128	=	1.7%	73225	-0.86%	0.30%	0.30%	-1.3%
Asian or Asian British	1,584	1,725	1,744	↑	23.1%	385573	13.83%	7.30%	15.8%	2.8%
Black or Black British	808	799	805	↑	10.7%	104032	8.82%	2.00%	8.70%	4.2%
Other	266	188	191	↑	2.5%	30182	2.98%	0.60%	2.00%	1.3%
Socio-economic groups:										
ABC1	2,820	2,784	2,827	↑	46.70%	1913858	-9.09%	-9.60%	-9.6%	-3.3%
C2	1,235	1,211	1,230	↑	16.70%	685541	-0.25%	0.60%	-0.6%	-0.8%
D	1,560	1,579	1,602	↑	19.40%	794461	1.43%	1.70%	1.6%	-2.2%
E	1,873	1,911	1,924	↑	17.10%	700084	7.91%	8.40%	8.2%	5.7%
Gender analysis:										
Male	2,946	2,903	2,923	↑	48.90%	2575111	-9.55%	-10.10%	-10.2%	-9.3%
Female	4,386	4,437	4,483	↑	51.10%	2692197	7.46%	8.20%	8.2%	7.4%



<b>TRUST BOARD</b>
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<b>DOCUMENT TITLE:</b>	Estates Strategy 2012/13 to 2017/18				
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Graham Seager, Director of Estates/New Hospital Project				
<b>AUTHOR:</b>	Rob Banks, Graham Seager				
<b>DATE OF MEETING:</b>	27 September 2012				
<b>EXECUTIVE SUMMARY:</b>					
<p>The Estates Strategy document:-</p> <ul style="list-style-type: none"> <li>• Reviews the current key estate issues of the Trust</li> <li>• Sets out how the clinical services will be supported by a safe, secure and appropriate environment.</li> <li>• Ensures that capital investments support service strategies and plans.</li> </ul> <p>The Strategy cover the time period 2012/13 to 2017/18.</p> <p>The Estates strategy supports the Clinical Strategy of the Trust</p> <p>As in previous years the Estates Strategy will be reviewed and updated annually</p>					
<b>REPORT RECOMMENDATION:</b>					
The Board is asked to consider and approve the attached Estates Strategy document					
<b>ACTION REQUIRED</b> <i>(Indicate with 'x' the purpose that applies):</i>					
The receiving body is asked to receive, consider and:					
<b>Accept</b>	<b>Approve the recommendation</b>	<b>Discuss</b>			
	X				
<b>KEY AREAS OF IMPACT</b> <i>(Indicate with 'x' all those that apply):</i>					
Financial	X	Environmental	X	Communications & Media	
Business and market share		Legal & Policy		Patient Experience	X
Clinical		Equality and Diversity		Workforce	
Comments:					
<b>ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:</b>					
21 <sup>st</sup> Century Facilities					
<b>PREVIOUS CONSIDERATION:</b>					
The Trust Board reviews the Estates strategy annually as part of its annual cycle of business					

# ESTATES STRATEGY 2012/13 – 2017/18

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## 1.0 INTRODUCTION

A patient's first impression of healthcare services is formed by the appearance of healthcare buildings and facilities. Services should be delivered in safe and suitable environments. Patients and staff need to feel safe, secure and comfortable. Healthcare buildings should ensure good functionality, meet expectations in terms of privacy and dignity, provide good access to all, reduce infection and minimise accidents.

In line with guidance (Developing an Estate Strategy) this strategy has been developed on a framework asking three fundamental questions across a range of criteria, as follows:

- Where are we now?
- Where do we want to be?
- How do we get there?

## 2.0 AIMS OF AN ESTATE STRATEGY

The Trust's Strategic Objectives are summarised:-



To support these objectives the Estates Strategy document:-

- Reviews the current key estate issues of the Trust
- Sets out how the clinical services will be supported by a safe, secure and appropriate environment.
- Ensures that capital investments support service strategies and plans.

### **3.0 OBJECTIVES**

1. To analyse the estate condition and its performance.
2. To identify costs to achieve Estatecode Condition B for key facets of Condition Survey.
3. To prioritise capital investment in estate statutory compliance issues.
4. To support compliance with Care Quality Commission registration
5. To achieve year-on-year improvement on performance in line with the Trust approved Carbon Management Plan
6. To operate all Estate and Facilities services at a benchmark between the lower and upper quartiles of the Estates Return Information Collection (ERIC) returns of comparable Trusts and demonstrate value for money.
7. Maintain Patient Environment Action Team – “Good or Excellent Standards” status year on year.
8. To have a formal system of control to ensure a robust Development Control Plan (DCP) to support clinical services.

### **4.0 TIMESCALE**

This strategy considers the period from 2012/13 to 2017/18. It will be reviewed on an annual basis as part of the Trust’s business planning process.

### **5.0 ESTATE PERFORMANCE – ACHIEVING OBJECTIVES 1, 2 & 3**

#### **5.1 Where are we now?**

As can be seen from Table 1 overleaf, (Building Age and Asset Profile) much of the existing estate is of a significant age and does not comply with Department of Health guidelines or aspirations for 40% of the NHS estate to be less than 15 years old by 2010. Currently more than 50% of City site is over 30 years old and over 60% of Sandwell site is over 20 years old.

Compliance with Department of Health requirements is dependant upon the implementation of the Trust’s long term strategic plan for the construction of the Midland Metropolitan Hospital as part of the Right Care, Right Here programme.

**Table 1 – Building Age and Asset Profile**

Age & Asset Profile	Unit	Sandwell	City	Rowley	Trust %
Age Profile - 2005 to present	%	28	13	0	18
Age Profile - 1995 to 2004	%	0	2	0	1
Age Profile - 1985 to 1994	%	0	10.5	100	11
Age Profile - 1975 to 1984	%	48	8	0	23
Age Profile - 1965 to 1974	%	15	21	0	18
Age Profile - 1955 to 1964	%	0	8	0	4
Age Profile - 1948 to 1954	%	0	4	0	2
Age Profile - pre 1948	%	9	33.5	0	23
Age Profile - Total (must equal 100)	%	100	100	100	100
Building Asset Value by Age - 2005 to present	£	22,295,280	12,919,400	0	
Building Asset Value by Age - 1995 to 2004	£	0	1,987,600	0	
Building Asset Value by Age - 1985 to 1994	£	0	10,434,900	13,502,000	
Building Asset Value by Age - 1975 to 1984	£	38,220,480	7,950,400		
Building Asset Value by Age - 1965 to 1974	£	11,943,900	20,869,800		
Building Asset Value by Age - 1955 to 1964	£	0	7,950,400		
Building Asset Value by Age - 1948 to 1954	£	0	3,975,200		
Building Asset Value by Age - pre 1948	£	7,166,340	33,292,300		
<b>Total Building Asset Value</b>	£	<b>79,626,000</b>	<b>99,380,000</b>	<b>13,502,000</b>	<b>192,508,000</b>

Condition surveys of the two principle sites were undertaken in December 2002 by French Thorpe Consultancy supported by Malcolm Lamb Associates. The criteria that were used to assess the estate were those defined by Estatecode:

- Physical Condition
- Space Utilisation
- Statutory standards
- Energy performance
- Functional suitability

Desktop surveys were undertaken in August 2007 and the additional facet of Quality was included in June 2012 to identify areas where condition has deteriorated or improved via capital investment. The following pie charts summarise the performance for the categories. Note the 'Part Dangerous and Inoperable' areas are generally disused areas of the estate with the exception of the upper floors of Arden House where the lack of passenger lifts limits operational use of the building for staff.

The findings of the survey are summarised graphically as follows:-

	Trust	City	Sandwell	Rowley Regis
<b>Physical Condition</b> <b>Key</b> A = As new (built within last 2 years) B = Sound, operationally safe and exhibits only minor deterioration C = Operational but major repair/replacement needed soon, within 3 years for building elements and one year for engineering elements D = Runs serious risk of imminent breakdown X = Supplementary rating added to C or D to indicate that nothing but a total rebuild or relocation will suffice	<b>Physical Condition (Combined)</b> 	<b>Physical Condition (City Hospital)</b> 	<b>Physical Condition (Sandwell Hospital)</b> 	<b>Physical Condition (Rowley Regis Hospital)</b> 
<b>Functional Suitability</b> <b>Key</b> A = Very satisfactory, no change needed B = Satisfactory, minor change needed C = Not satisfactory, major change needed D = Unacceptable in its present condition X = Supplementary rating added to C or D to indicate that nothing but a total rebuild or relocation will suffice	<b>Functional Suitability (Combined)</b> 	<b>Functional Suitability (City Hospital)</b> 	<b>Functional Suitability (Sandwell Hospital)</b> 	<b>Functional Suitability (Rowley Regis Hospital)</b> 
<b>Space Utilisation</b> <b>Key</b> A = Empty or grossly under used at all times (excluding temporary closure) U = Under-used, utilisation could be significantly increased F = Fully used – a satisfactory level of utilisation O = Overstretched, overcrowded, overloaded and facilities generally overstretched	<b>Space Utilisation (Combined)</b> 	<b>Space Utilisation (City Hospital)</b> 	<b>Space Utilisation (Sandwell Hospital)</b> 	<b>Space Utilisation (Rowley Regis Hospital)</b> 
<b>Quality</b> <b>Key</b> A = A facility of excellent quality B = A facility requiring general maintenance investment only C = A less than acceptable facility requiring capital investment D = A very poor facility requiring significant capital investment or replacement X = Supplementary rating added to C or D to indicate that nothing but a total rebuild or relocation will suffice	<b>Quality (Combined)</b> 	<b>Quality (City Hospital)</b> 	<b>Quality (Sandwell Hospital)</b> 	<b>Quality (Rowley Regis Hospital)</b> 
<b>Statutory Requirements</b> <b>Key</b> A = Complies with all statutory requirements and guidance B = Action needed in the current plan to comply with statutory requirements and guidance C = Known contravention of one or more standards which falls short of B D = Dangerously below B standard X = Supplementary rating added to C or D to indicate that nothing but a total rebuild or relocation will suffice	<b>Statutory Requirements (Combined)</b> 	<b>Statutory Requirements (City Hospital)</b> 	<b>Statutory Requirements (Sandwell Hospital)</b> 	<b>Statutory Requirements (Rowley Regis Hospital)</b> 
<b>Energy Performance</b> <b>Key</b> A = 35-55 GJ per 100 cubic metres B = 56-65 GJ per 100 cubic metres C = 66-75 GJ per 100 cubic metres D = 76-100 GJ per 100 cubic metres X = Supplementary rating added to C or D to indicate that nothing but a total rebuild or relocation will suffice	<b>Energy Performance (Combined)</b> 	<b>Energy Performance (City Hospital)</b> 	<b>Energy Performance (Sandwell Hospital)</b> 	<b>Energy Performance (Rowley Regis Hospital)</b> 

The cost to Condition B for key facets, which is the Trust's Backlog Maintenance Level, has also been estimated:-

• City Hospital	-	99,925 m <sup>2</sup>	-	£80,339,000
• Sandwell Hospital	-	49,410 m <sup>2</sup>	-	£48,504,000
• Rowley Regis Hospital	-	7,556 m <sup>2</sup>	-	£ 1,133,000
		-----		-----
		<b>156,891 m<sup>2</sup></b>		<b>£129,976,000</b>
		=====		=====

The High and Significant Risk elements of this assessment value approximately £3.4m, £3.0m has been allocated to date with a planned review of investment to be made later in 2012/13

## 5.2 Where do we want to be?

Backlog of this magnitude has potential safety implications and may influence patient perception, this could also affect business with greater patient choice arrangements.

The issues of poor physical condition need to be addressed to maintain the building fabric and to ensure patient's expectations are met. This is assessed through the Patient Environment Action Teams (PEAT) initiative. A strategic objective for the Trust is to achieve 21<sup>st</sup> century facilities, achieving condition B for all facets of the survey through strategic capital investment and to achieve good or excellent standards for PEAT Assessments would meet this objective. However, this cannot be achieved without strategic investment; therefore, detailed risk assessments are undertaken in line with the Trust's formal risk assessment process and managed through the governance/risk management structure to ensure a safe facility.

## 5.3 How do we get there?

Issues associated with statutory compliance have to be managed through the Trust's risk management arrangements. These arrangements consist of the Estates and Facilities Governance Group, which meets on a monthly basis and reports to the Trust's Governance Board. The risk management process identifies a number of estates and facilities issues as red risks; these are reported with their control measures to the Trust's Risk Management Group. All risks are updated annually and implications identified through the business planning process. Continued investment into the Estate is required in order to improve the backlog position, maintain compliance with statutory standards and minimise risk.

Specific funding is made available to address the high and significant backlog issues. Wider condition survey related issues are addressed as part of the briefing process for capital investments.

## 5.4 2012/13 Capital Programme

The capital programme for the 2012/13 financial year includes £3m allocated to statutory standards and estates related improvement schemes. The £3m expenditure has been identified through a detailed risk assessment process and covers areas including:

- Fire Safety
- Asbestos Management
- Legionella precautions
- Electrical Safety

Other capital schemes to support the implementation of the Trust's Transformational Service Plans (TSPs) will also include elements of environmental improvements and statutory standards compliance works as well as facilitating the functional change required to deliver these TSPs.

However, to achieve condition "B" for all facets requires strategic investment. Notable capital schemes for 2012/13 are as follows:

- Major estate rationalisation
- Improved decontamination facilities
- Endoscopy reconfiguration at Sandwell
- Pathology reconfiguration, blood sciences laboratory
- Stroke reconfiguration
- Imaging reconfiguration
- Replacement Gamma cameras at City
- Provision of Clean Air Hospital Theatre (Ultraclean) Sandwell

## **6.0 RISK MANAGEMENT AND GOVERNANCE - ACHIEVING OBJECTIVE 4**

### **6.1 Where are we now?**

The Estates division has a robust system of risk management managed through the division's Governance Group. Chaired by either the Director of Estates or the Head of Estates, this group meets monthly and reports to the Trust Governance Board.

The standing agenda items are:

- Privacy and Dignity
- Disability Discrimination Act
- PEAT/Better Hospital food
- Compliance with HTMs, HBNs, Best Practice Guides
- Complaints and Litigation
- Statutory Enforcement Bodies
- Risk Management
- Consultation and Patient Involvement
- Staff Management
- Education and Training
- Governance Development
- External Publications
- HEFMA
- Divisional Health & Safety Meetings

All significant Estates related risk assessments are managed through the Trust's risk management processes.

Also, in relation to Risk Management and Governance, on the 4<sup>th</sup> January 2012 The Medical Director of the Strategic Health Authority wrote to all Chief Executive Officers regarding Estates Maintenance, Medical Equipment and Premises Maintenance Procedures, stating that:-

*"The Chief Executive and the Board should; with advice from an informed person of Estates and Medical Equipment, set the Level of Planned Preventative Maintenance for the organisation ranging from:*

- a. Minimum standard: covering Statutory and Mandatory maintenance only*
- b. Business continuity: all estates and equipment maintained to minimize service failures*
- c. Full Life cycle Maintenance: to ensure value for money over the asset lifetime, typically 30/60 years*

*The purpose of writing to you is to ask you to review your Estates Maintenance, Medical Equipment and Premises Maintenance procedures and to ensure that you and your Board have an agreed maintenance strategy"*



In considering this letter, the Board is advised by its Director of Estates who is a Chartered Engineer and so considered to be an informed person, equally the Trust's Head of Estates is also a Chartered Engineer. The maintenance arrangements for the estates are managed by this team within the resources allocated.

The life cycle maintenance has not been addressed as a formal plan over 30/60 years. Much of the Trust's estate and equipment is beyond its planned life. Therefore, rather than managing to a Full Lifecycle Maintenance plan (such as adopted in PFI), the Trust follows a risk management based approach as outlined above.

Taking these issues into account (and recognising that the budget for building and engineering maintenance cost per occupied floor area ratio is one of the lowest in the country but the Backlog Maintenance levels are one of the highest) to assure the Board that management of the estate is appropriate, external advisors have been appointed to review key aspects of estates services.

## **6.2 Where do we want to be?**

The Trust needs to maintain progress on all of the above issues and provide its services in a safe, suitable and secure environment. This needs to be achieved in a transparent way and responsive to patient perception and views through surveys and complaints. The objective is to maintain compliance with Outcome 10 and 11 for Care Quality Commission registration requirements and maintain the robust approach to Risk Management and Governance.

## **6.3 How do we get there?**

The Risk Management and Governance arrangements of the Trust provide a framework to meet the objective of maintaining a safe and secure environment.

The Risk Register is a statutory requirement and an aid in determining the prioritisation of funding for capital investment and informs ongoing service provision. The division will maintain its Risk Register and ensure the divisional "red risks" and associated control measures are notified to the Trust Risk Management Committee.

The current risk assessment process is based around the long term strategic objectives to move to the Midland Metropolitan Hospital with the risks managed over a 5 year planning horizon.

Establishing external assurance of Estates will become an annual occurrence.

## 7.0 ENVIRONMENTAL PERFORMANCE – ACHIEVING OBJECTIVE 5

### 7.1 Where are we now?

#### Carbon Management Plan

The Carbon Management Plan is the Trust's route-map to achieving sustainability and carbon related targets. The Carbon Management Plan document includes a series of projects and programmes that will help the Trust achieve rigorous carbon reduction goals over the next five years.

The Trust is currently in the process of re-baselining the Carbon Management Plan so that it is aligned with the Transforming Community Services programme and the timeline for the new hospital.

The Trust's baseline carbon emissions footprint for 2011/2012 encompassing energy, business travel, water and waste was 24,938 tCO<sub>2</sub>. This can be broken down as follows:

	Electricity (kWh)	Fossil fuels (kWh)	Water (m3)	Waste (tonnes)	Transport (km)	Business Travel (km)	Total
Amount	24,038,073	55,247,002	211,000	2,424	1,368,553	2,656,881	
CO <sub>2</sub> emissions (tonnes)	13,201	10,419	85	440	288	505	<b>24,938</b>

#### Sustainability Working Group and Sustainability Action Plan

The Trust has an active Sustainability Working Group with membership from key stakeholders such as Procurement, Estates, Pharmacy and Information Technology and is chaired by The Director of Estates and New Hospital Project with lead responsibility for sustainability.

The Sustainability Working Group members have identified a range of actions and have developed a Sustainability Action Plan.

#### Sustainability Champions

The Trust has developed a network of around 100 Sustainability Champions, with an additional 100 Sustainability Supporters. The Sustainability Champions and Supporters are vital in driving forward the Trust's sustainability objectives including energy reduction, waste reduction and recycling, water conservation, promoting sustainable travel and transport.

#### Sustainability Events and Engagement

Sustainability events are run annually, with additional engagement campaigns run throughout the year. Future events include the 'Sustainability Garden Party' to be held in September 2012.

The aim of these events is to gain further support and engagement across the organisation and to demonstrate the successes we have achieved to date.

## Good Corporate Citizen

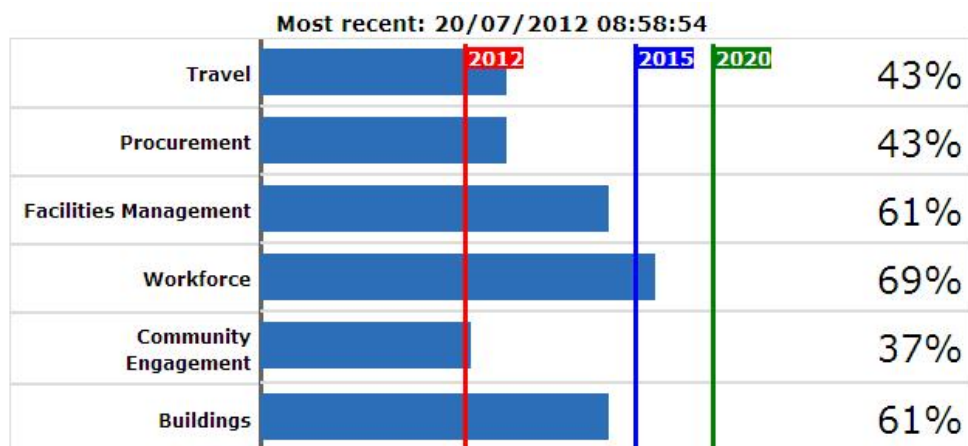
The Trust continues to report to the Sustainable Development Unit bi-annually via the Good Corporate Citizen assessment tool. This assessment tool covers a range of sustainable development topics, including:

- Transport
- Procurement
- Facilities management
- Workforce
- Community engagement
- New buildings

For each of the above areas, the Trust answers a series of questions to gauge what we are doing and to track progress. The last submission was in July 2012 and showed positive results.

Figure 1 shows the Trust position in terms of performance to date. The Trust is ahead of progress in all areas and is performing well compared with other NHS Trusts nationally.

**Figure 1: SWBH performance to date in line with the SDU targets**



## Carbon Reduction Commitment

There is a statutory requirement for the Trust to comply with Carbon Reduction Commitment. The Trust completed the first (Phase 1) submission of 2010/11 data in July 2011 and data for Phase 2 in July 2012. Work is underway to collect data and evidence for submission in July 2013 (2012/13 data).

The Carbon Reduction Commitment is in force to encourage organisations to actively reduce carbon emissions through becoming more energy efficient.

## Display Energy Certificates

All Trust buildings over 1,000m<sup>2</sup> and where there is access to the public, are required to display their energy performance/efficiency rating on a scale of A to G by use of Display Energy Certificates. The Trust has updated these for 2010/11 and they are on display at the main entrances to buildings included within the scheme.

There are seventeen buildings across the Trust that fall into the category of requiring a Display Energy Certificate. Due to the variety and different ages of the buildings the energy performance varies significantly. In summary most buildings fall with the mid-range of C to F. Display Energy Certificates are also accompanied by an Energy Advisory Report that contains recommendations for improvement in

energy performance. The recommendations are being considered as part of the Carbon Management Plan identified above.

As can be seen in more detail in the ERIC Returns, generally the Trust is operating environmental related performance indicators below the lower quartile for both cost of energy and the carbon emissions per occupied floor area. The Trust is proactively monitoring its energy usage and implementing measures to reduce consumption.

## **7.2 Where do we want to be?**

The Trust is committed to ongoing improvement in its environmental impact, energy reduction programme and sustainable development, whilst providing a cost efficient service to the public. The Trust will undertake a voluntary BREEAM Assessment for its existing sites and aspire to a 'Good' rating.

The Trust will undertake a mandatory BREEAM Assessment on the Midland Metropolitan Hospital development and attain an 'Excellent' rating.

## **7.3 How do we get there?**

The revised carbon target will be a 15% reduction in carbon by 2016/17 (from the 2011/12 baseline). The Carbon Management Plan will be assessed and accredited by the Carbon Trust over the next few months. Work is underway to progress us towards this ambitious target, including:

- The estate rationalisation programme
- Installation of energy efficient lighting and controls
- Installation of air conditioning controls
- Investigating solar panels at Rowley Regis Hospital

## 8.0 **ERIC AND PERFORMANCE INDICATORS – ACHIEVING OBJECTIVE 6**

### 8.1 **Where are we now?**

#### Estates Return Information Collection (ERIC) Returns

The Trust has a mandatory requirement to submit information annually to the Department of Health on a whole range of hard and soft FM services. This information is provided in line with the Estates Return Information Collection requirements. Trusts are categorised according to their size and type. Sandwell and West Birmingham Hospitals NHS Trust is in the category of 'Large Acute Trusts Outside Of London'. Obviously the benchmarking information is more meaningful when provided in this way.

The returns are summarised for each service into quartiles, lower, median and upper. Any service that fall outside the upper and lower quartiles will be identified and further detailed analysis undertaken to understand the reasons why.

### 8.2 **Where do we want to be?**

For each element of service delivery the objective remains to keep the cost of provision of those services within the benchmark between lower and upper quartiles and demonstrate value for money.

### 8.3 **How do we get there?**

To inform the business planning process, the division will utilise the 2011/12 ERIC returns, factor in the current TSP plans and forecast its benchmark position. Areas outside of the benchmark will be reviewed and these are shown below.

Where appropriate, proposals will be developed to make changes to operational services to comply with objective.

### 8.4 **Summary of ERIC returns where the Trust lies outside of the Upper or Lower Quartile**

#### Capital Investment for new build per Occupied Floor Area – Upper Quartile

<b>Finance</b>	<b>Unit</b>	<b>Trust Value</b>	<b>Lower Quartile</b>	<b>Median</b>	<b>Upper Quartile</b>
Capital Investment for new build per Occupied Floor Area	£/m2	62.23	0.00	20.86	40.46

Almost £10.3 million has been invested in new build during 2011/12 a large amount of which was utilised to purchase land and property at Grove Lane for the proposed new hospital project. The Trust Value excluding Grove Lane land and property purchases is £40.25, just below the upper quartile.

#### Total Capital Investment per Occupied Floor Area – Upper Quartile

<b>Finance</b>	<b>Unit</b>	<b>Trust Value</b>	<b>Lower Quartile</b>	<b>Median</b>	<b>Upper Quartile</b>
Total Capital Investment per Occupied Floor Area	£/m2	95.42	39.47	65.28	89.16

The capital invested in new build together with the £5.4 million invested in improving existing buildings and addressing statutory standards has resulted in the total capital investment being above the upper quartile. The Trust value excluding Grove Lane land and property purchases is £73.44, placing the Trust between Median and Upper Quartile.

Building and Engineering maintenance cost per occupied floor area – Lower Quartile

<b>Finance</b>	<b>Unit</b>	<b>Trust Value</b>	<b>Lower Quartile</b>	<b>Median</b>	<b>Upper Quartile</b>
Total Building and Engineering Maintenance Cost per Occupied Floor Area	£/m2	20.54	20.54	25.47	32.04

Despite continued resources being expended to maintain compliance and address engineering and building maintenance a significant cost improvement programme has resulted in the Trust's position being below the lower quartile.

Total backlog cost – Upper Quartile

<b>Quality of Buildings</b>	<b>Unit</b>	<b>Trust Value</b>	<b>Lower Quartile</b>	<b>Median</b>	<b>Upper Quartile</b>
Cost to eradicate Backlog	£	99,833,609	11,310,000	19,431,900	40,525,712

Significant investment has been utilised from Capital Programme to address high and significant backlog and minimise risk to the organisation. It is accepted that the Trust will continue to have a very high backlog maintenance until such time as the Midland Metropolitan Hospital is opened. The emphasis must continue to be to keep high and significant backlog to a minimum.

Percentage of Risk Adjusted Backlog to Total Backlog – Lower Quartile

<b>Quality of Buildings</b>	<b>Unit</b>	<b>Trust Value</b>	<b>Lower Quartile</b>	<b>Median</b>	<b>Upper Quartile</b>
Percentage of Risk Adjusted Backlog to Total Backlog	%	7.04	17.28	35.50	50.37

Despite reporting a huge figure required to eradicate total backlog maintenance, the Trust has continued to expend Capital investment in addressing Statutory Standards which has resulted in a reduction of high and significant risks.

Water volume per Occupied Floor Area – Lower Quartile

<b>Water Services</b>	<b>Unit</b>	<b>Trust Value</b>	<b>Lower Quartile</b>	<b>Median</b>	<b>Upper Quartile</b>
Water volume per Occupied Floor Area	M3/m2	1.28	1.40	1.59	1.80

A detailed analysis of water consumption has been undertaken and as a result a number of water saving initiatives have been successfully introduced.

### Contracted Out Services per Occupied Floor Area - Lower Quartile

<b>Contracted Out Services</b>	<b>Unit</b>	<b>Trust Value</b>	<b>Lower Quartile</b>	<b>Median</b>	<b>Upper Quartile</b>
Contracted Out Services per Occupied Floor Area	£/m <sup>2</sup>	19.27	30.23	63.23	114.26

The majority of Facilities services are in-house inclusive of PTS and Security.

### Total Hard FM (Estates) and Soft FM (Hotel Services) costs (Cost of Occupancy) per Occupied Floor Area Upper Quartile

<b>Finance</b>	<b>Unit</b>	<b>Trust Value</b>	<b>Lower Quartile</b>	<b>Median</b>	<b>Upper Quartile</b>
Total Hard FM (Estates) and Soft FM (Hotel Services) costs (Cost of Occupancy) per Occupied Floor Area	£/m <sup>2</sup>	352.49	227.02	286.60	352.49

Cost of occupancy per occupied floor area is high due to the extensive service provision.

### High Temperature Waste Cost per Tonne – Lower Quartile

<b>Waste</b>	<b>Unit</b>	<b>Trust Value</b>	<b>Lower Quartile</b>	<b>Median</b>	<b>Upper Quartile</b>
High Temperature Waste Cost per Tonne	£/Tonne	349.82	360.79	450.72	659.90

Recently re-tendered – competitive contract price agreed

### WEEE Cost per Tonne – Lower Quartile

<b>Waste</b>	<b>Unit</b>	<b>Trust Value</b>	<b>Lower Quartile</b>	<b>Median</b>	<b>Upper Quartile</b>
Waste Electrical and Electronic Equipment (WEEE) Cost per Tonne	£/Tonne	0.00	140.44	406.48	795.51

During 2011/12 WEEE waste was collected and registered carrier and disposed of without charge

### Total Waste Cost per Occupied Floor Area – Lower Quartile

<b>Waste</b>	<b>Unit</b>	<b>Trust Value</b>	<b>Lower Quartile</b>	<b>Median</b>	<b>Upper Quartile</b>
Total Waste Cost per Occupied Floor Area	£/M2	2.63	2.83	3.52	4.32

Recently re-tendered – competitive contract price agreed

## 9.0 PATIENT PERCEPTION & PEAT – ACHIEVING OBJECTIVE 7

### 9.1 Patient Environment Action Team (PEAT)

#### External PEAT Audits

The NHS Information Centre are now able to confirm the results of the PEAT 2012 programme for environment, food and privacy and dignity score for each hospital within the Trust.

Site Name	Environment Score	Food Score	Privacy & Dignity Score
SANDWELL GENERAL HOSPITAL	4 Good	5 Excellent	4 Good
CITY HOSPITAL	4 Good	5 Excellent	4 Good
BIRMINGHAM & MIDLAND EYE HOSPITAL	4 Good	5 Excellent	4 Good
ROWLEY REGIS HOSPITAL	4 Good	5 Excellent	4 Good

National publication of the individual PEAT scores will take place in July; the precise date has yet to be confirmed. Further notice will be sent to all PEAT contacts when this date has been determined.

#### PEAT – Patient-led Inspection Programme

The Prime Minister announced the establishment of a new 'Patient-led inspection regime' to be in place by April 2013 - with piloting scheduled for October this year. This will replace the existing PEAT programme, although we expect the current structure (annually and self-assessed) and infrastructure (online reporting through the EFM system) to broadly remain the same.

The term 'Patient-led' does not imply that patients will be charged with delivering the process but it does require that they be involved in all aspects of the design and delivery of any replacement inspection programme. There will also be a programme of work with patient groups and others with an interest to gain their views on what are the important aspects which should be included in the new programme (recognising that the existing broad PEAT categories of cleanliness, environment, food and privacy and dignity should be retained).

SWBH NHS Trust has expressed an interest in being part of the pilot project in October 2012.



## 10.0 SUMMARY DISPOSAL AND PROCEEDS OF SALE – ACHIEVING OBJECTIVE 8

The Trust currently provides its services from an estate that covers over 80 acres and 160,000m<sup>2</sup> of buildings. There are currently a number of building areas that have been vacated and plans are developing to vacate further areas as the Trust improves its performance and implements the interim reconfiguration. The Estates division are developing plans to “right size” its estate by closing peripheral buildings through the Estate Rationalisation Transformation Savings Plan. However, until such time as the Outline Planning Application and Outline Business Case for the Midland Metropolitan Hospital have been approved and there is much more certainty about the future of the remaining estate, site disposal will be put on hold.

An Estates Terrier summary of the three existing sites is shown in Table 2 below:

General Information	City Hospital <sup>(1)</sup>	Sandwell Hospital <sup>(2)</sup>	Rowley Regis Hospital <sup>(3)</sup>
Gross internal site floor area	99,505m <sup>2</sup>	67,024m <sup>2</sup>	8,735m <sup>2</sup>
Occupied floor area	90,573m <sup>2</sup>	63,374m <sup>2</sup>	8,735m <sup>2</sup>
NHS Estate occupied floor area	100%	100%	100%
Site heated volume	237,139m <sup>3</sup>	192,062m <sup>3</sup>	22,760m <sup>3</sup>
Site building footprint	60,067m <sup>2</sup>	27,790m <sup>2</sup>	4,868m <sup>2</sup>
Site land area	19.47 hectares	9.97 hectares	2.76
Leased in land area <sup>(2)</sup> All Saints Way Car Park Hallam Street Car Park (2.66h) Unit 3, Church Lane, West Bromwich, (no details of land or buildings)	Nil	2.97 hectares	Nil
Patient occupied floor area	57,835m <sup>2</sup>	40,499m <sup>2</sup>	5,990m <sup>2</sup>
Non-patient occupied floor area	32,738m <sup>2</sup>	22,875m <sup>2</sup>	2,745m <sup>2</sup>
Unoccupied floor area	8,932m <sup>2</sup>	3,650m <sup>2</sup>	Nil
Main circulation area	7,300m <sup>2</sup>	8,012m <sup>2</sup>	832m <sup>2</sup>
Leased in floor area	Nil	Nil	Nil
Leased out floor area <sup>(1)</sup> Artificial Eye BHBN	869m <sup>2</sup>		
Leased out floor area <sup>(2)</sup> WRVS MRI 24 and 25 Hallam Close GP Deputising?		60m <sup>2</sup>	
Leased out floor area <sup>(3)</sup>			Nil
Temporary buildings and portacabins	540m <sup>2</sup>	176m <sup>2</sup>	Nil

## 11.0 DEVELOPMENT CONTROL PLANS – ACHIEVING OBJECTIVE 8

The Trust's Development Control Plan has to take into account clinical service requirements in the form of:-

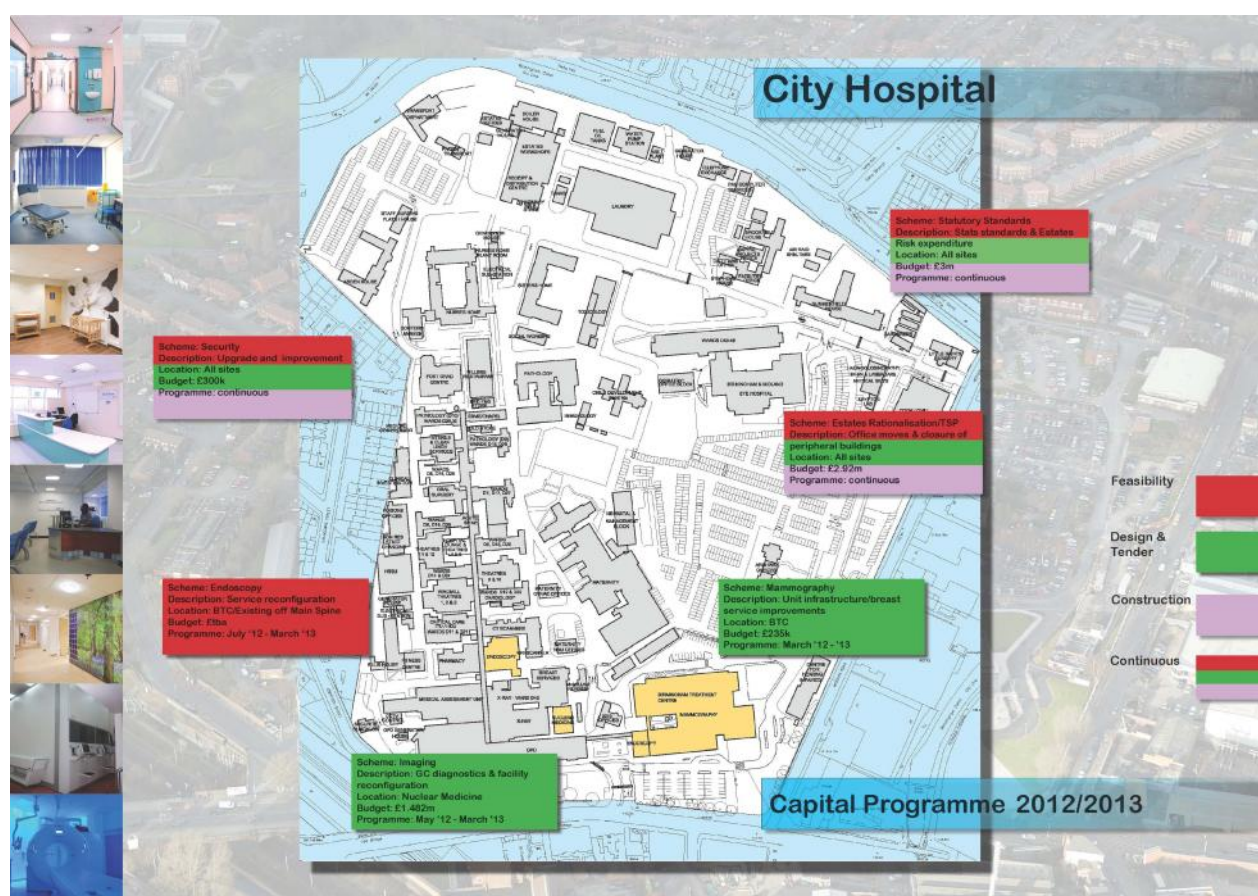
- Clinical service developments
- Clinical service reconfigurations
- Clinical service Transformation Savings Plans
- Long Term clinical configuration

Estates related issues:-

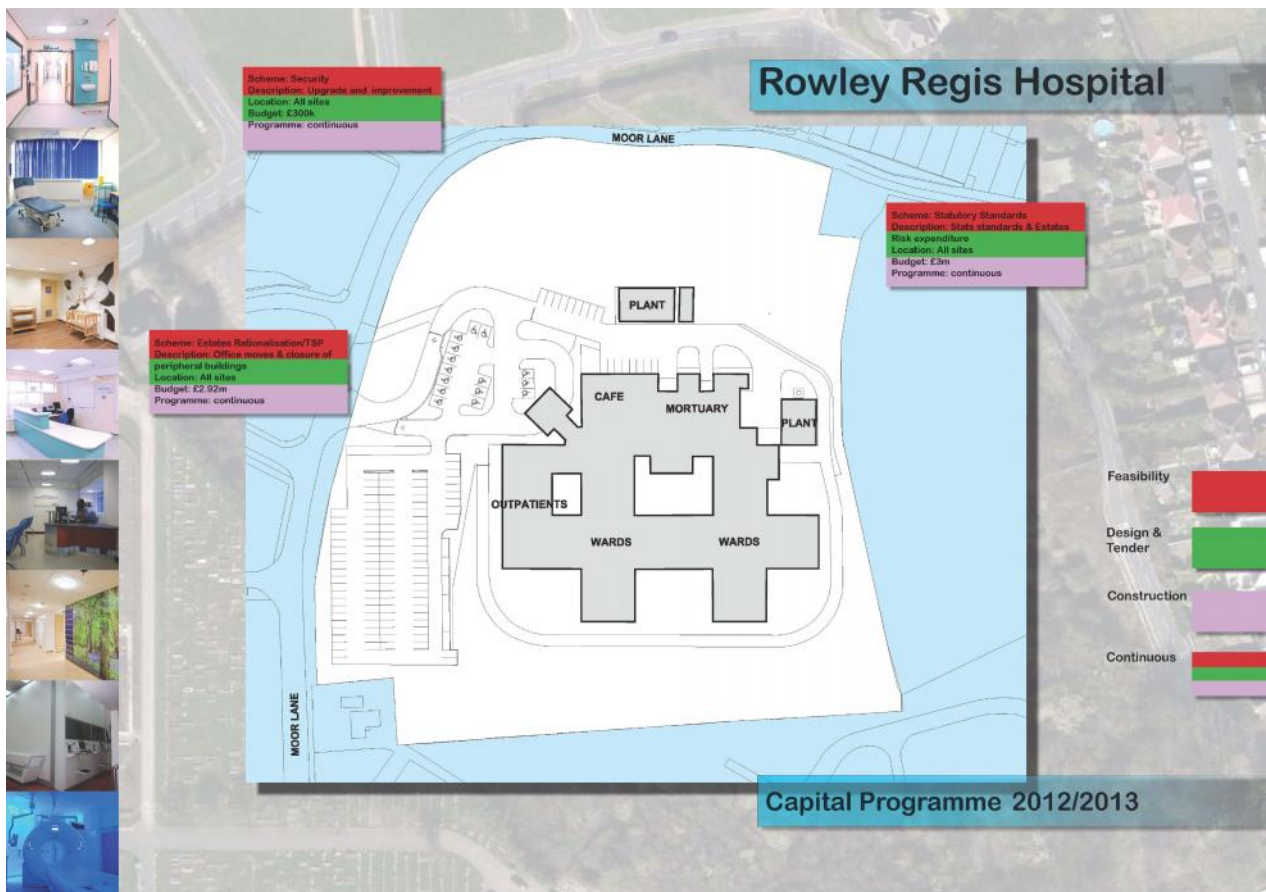
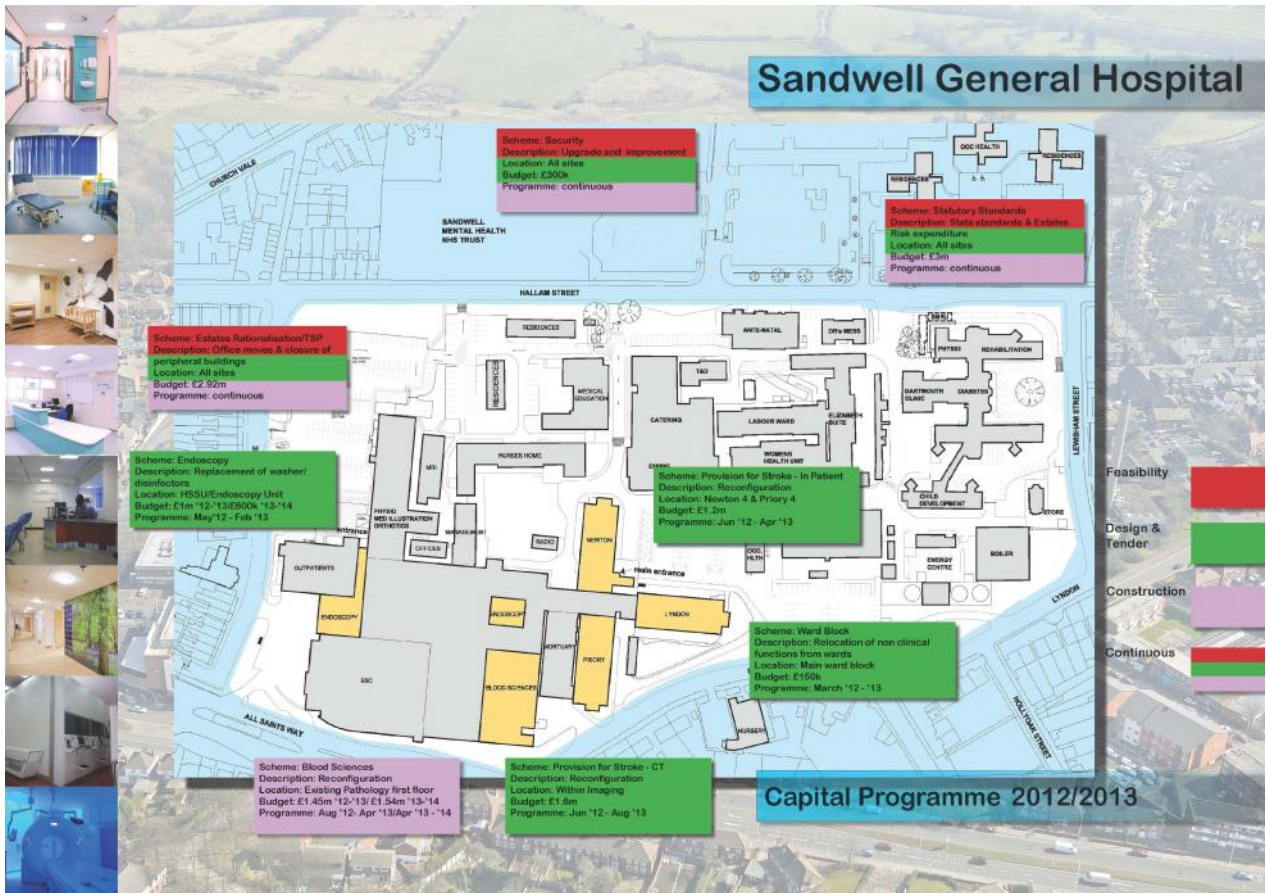
- Condition of the estate
- Statutory Compliance issues
- Transformation Savings Plans - Estates Rationalisation Programme
- Long term estates plans

The Estates Strategy Group has been formed to manage the Trust's Development Controls Plan. The following extracted section from the Clinical Services Strategy outlines the key considerations for the Development Control Plan for the next 5 years. This will then inform the Trust's capital planning process

The following illustrations show the 2012/13 development control plans for each site:







## 11.1 Development Control Plan for City Hospital 2012/13 to 2017/18

	Clinical Service Development	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
1.	Achieving Right care Right Here Activity projections	Over time should release acute capacity (beds & clinics) but requires increase in community capacity					
2.	Other Possible Reconfigurations: Clinical Haematology (inpatients & chemotherapy units)			If inpatients and/or day cases integrated onto one site will need increase in beds & day case facilities for the specialty on that site & possible ward refurbishment e.g. hepafiltration to some isolation rooms (areas currently where service delivered are: Newton 5, BTC, D7 & D41). Any change likely to happen in 14/15 (assuming consultation required).			
3.	Other Possible Reconfigurations: emergency PPCI (Cardiology)		If emergency PPCI integrated onto one site may need increase in CCU/Cardiology beds on that site & review of Cardiac Cath Lab capacity y& upgrade of Cath Lab (City). Areas currently where service delivered are: City & Sandwell - CCU, Cath Lab, Cardiology ward on each site. Any change likely to happen in 13/14 or 14/15 (assuming consultation not required).				
4.	Other Possible Reconfigurations: Interventional Radiology (IR). Others may be identified via specialty strategies or TSPs		If IR based on one site may have implications for recovery space in Imaging & upgrade of existing rooms/equipment (especially at Sandwell)				
5.	Development of Gynae Oncology as supra regional service; may include reconfiguration of Urogynaecology (in partnership with BWH), increase in laparoscopic surgery, development of radical & ultra radical surgical skill (including with colorectal surgery). 13/14-14/15		May have implications for equipment, theatre capacity, ? Beds				
6.	Development of specialist/tertiary Ophthalmology Services; includes developing R&D capacity, securing national or regional commissioned status for specialised services in		Will have implications for BMEC capacity in outpatients especially, development of teaching facilities e.g. simulation theatre and potential development of private patient facilities				

	e.g. mucous membrane pemphigoid, posterior Uveitis, scleral contact lenses etc., enhancing training facilities. 13/14-17/18					
7.	Development of Breast Surgery including Oncology plastic work, expansion of breast screening service. 13/14-15/16		Unclear at this stage but will require investment in Imaging technology			
8.	Development of EGAU (on D27) & EPAU (to BTC) in support of closure of SAU on City site. 12/13-13/14		yes - Development of EGAU on D27 & EPAU in BTC			
9.	Development of observation bays in PAU to support ED targets & reduce admissions. 12/13-13/14		yes but unclear at this stage			
10.	Reduce the number of theatres (excluding BMEC) from 26 to 25 (in 12/13) & then to 23 (13/14)	yes releases space				

## 11.2 DCP for Sandwell Hospital 2012/13 to 2017/18

	Clinical Service Development	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
1.	Achieving Right care Right Here Activity projections	Over time should release acute capacity (beds & clinics) but requires increase in community capacity					
2.	Stroke Services	<b>SWBH stroke reconfiguration</b> requires ward refurbishment (N4&P4), telemedicine, additional CT scanner at SGH with investment of £2.8m across 12/13 & 13/14. If catchment increases under <b>SHA Review</b> will need additional beds & possibly use of L4 ward with some refurbishment - likely to be in 13/14 or 14/15.					
3.	Pathology	<b>Integrated Laboratory:</b> development at SGH. <b>SHA tendering:</b> implications for integrated lab considered as part of Trust Board business case.					
4.	Other Possible Reconfigurations: Clinical Haematology (inpatients & chemotherapy units)			If inpatients and/or day cases integrated onto one site will need increase in beds & day case facilities for the specialty on that site & possible ward refurbishment e.g. hepafiltration to some isolation rooms (areas currently where service delivered are: Newton 5, BTC,			

				D7 & D41). Any change likely to happen in 14/15 (assuming consultation required).			
5.	Other Possible Reconfigurations: emergency PPCI (Cardiology)		If emergency PPCI integrated onto one site may need increase in CCU/Cardiology beds on that site & review of Cardiac Cath Lab capacity & upgrade of Cath Lab (City). Areas currently where service delivered are: City & Sandwell - CCU, Cath Lab, and Cardiology ward on each site. Any change likely to happen in 13/14 or 14/15 (assuming consultation not required).				
6.	Other Possible Reconfigurations: Interventional Radiology (IR). Others may be identified via specialty strategies or TSPs		If IR based on one site may have implications for recovery space in Imaging & upgrade of existing rooms/equipment (especially at Sandwell)				
7.	Development of Gynae Oncology as supra regional service; may include reconfiguration of Urogynaecology (in partnership with BWH), increase in laparoscopic surgery, development of radical & ultra radical surgical skill (including with colorectal surgery). 13/14-14/15		May have implications for equipment, theatre capacity, Beds				

### 11.3 DCP for Rowley Regis Hospital 2012/13 to 2017/18

	Clinical Service Development	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
1.	Close Rowley Day Hospital and transfer services to the community. 12/13-13/14	release space at RRH	release space at RRH				
2.	Reduce the number of theatres (excluding BMEC) from 26 to 25 (in 12/13) & then to 23 (13/14)	yes releases space	yes releases space				

### 11.4 DCP for Community 2012/13 to 2017/18

	Clinical Service Development	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
1.	Increase in Health Visitors (Sandwell Community). 12/13-14/15	Additional bases required for additional staff; needs discussion with GPs re best locations	Additional bases required for additional staff; needs discussion with GPs re best locations	Additional bases required for additional staff; needs discussion with GPs re best locations			

## **12.0 STRATEGIC OPTIONS FOR ESTATE CHANGE**

### **12.1 Where are we now?**

Sandwell and the west of Birmingham have some of the highest levels of deprivation in the country. This is a major factor in determining the poor health of the diverse and disadvantaged communities. Local health and social care services face very challenging health needs that are a major cause for concern. For example:

- Men and women live three to four years less than the national average
- Infant mortality rates are high, in some parts they are twice the national average
- One in five people have a long-term illness that affects their daily life
- There is significant variation in health status within the area, and in general Black and Minority Ethnic groups have poorer health than others.

The need for major investment to develop and improve health and social care services to address these needs was formally recognised by the development of a Strategic Outline Case during 2003 and 2004. The Strategic Outline Case sets out a clear direction of travel to deliver a vision of improved physical, mental and social well being for the population of Sandwell and the west of Birmingham and described the need to redesign the whole health and social care system by creating a major step change in service provision.

The Strategic Outline Case indicated a required rebalancing of capacity to reflect a substantial transfer of care into a primary care setting alongside a demanding performance improvement in acute hospital services. Substantial reductions in hospital lengths of stay are anticipated, with much of the consequent reduction in acute hospital capacity being re-provided in new services and facilities closer to people's homes. Investment in community health and social care services, as well as investment in acute hospital facilities, is seen as key to making the vision a success. This investment will also enable new models of care to be put in place in advance of any changes to acute hospital facilities.

The development of an Outline Business Case for all of the investment needed across the local health and social care system commenced under the auspices of the Right Care Right Here Partnership.

Milestones of progress;-

- The Strategic Outline Case was approved by the Department of Health in July 2004.
- Department of Health approved the Outline Business Case in August 2009 to enable application for Trust to activate a Compulsory Purchase Order. Caveats were made that HM Treasury would need to approve the Outline Business Case before procurement is initiated.
- Compulsory Purchase Inquiry completed in June 2010 and Secretary of State Health confirmed that the Compulsory Purchase Order can be made in January 2011.
- Right Care, Right Here review to the programme and subsequent scope review process leading to revision of size of the Midland Metropolitan Hospital and change to assumptions (Trust will now retain facilities on the City and Sandwell sites) - winter 2009/10. Driven by more adverse financial environment.
- Full update of the Outline Business Case approved by Trust Board in September 2010 and Strategic Health Authority in October 2010 – this addressed the new requirements to meet International Financial Reporting Standards to model partial indexation and to meet Monitor's Prudential Borrowing Ratios.
- General Vesting Declaration 1 activated in July 2011 – the most complex properties are now owned by the Trust (taking ownership to circa 50% of the total site).
- Detailed Department of Health scrutiny of the Outline Business Case and Long Term Financial Model (LTFM) during 2011 /12, approval not yet granted.
- Procurement documents completed by September 2011.

- General Vesting Declaration activated in June 2012 – secures all remaining areas of the site.
- HM Treasury review of Private Finance Initiative procurement route commenced with collection of evidence in December 2011, report pending.

The Trust is awaiting the outcome of the HM Treasury review before proceeding with acquisition.



<b>TRUST BOARD</b>
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<b>DOCUMENT TITLE:</b>	Approval and execution of a lease of the Old Chapel, Sandwell Hospital to HHI Limited trading as Healthy Hearts
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Graham Seager, Director of Estates/New hospital Project
<b>AUTHOR:</b>	John Turner HHI/Graham Seager
<b>DATE OF MEETING:</b>	27 September 2012

**EXECUTIVE SUMMARY:**

It is proposed to grant a lease of the Old Chapel building, Sandwell Hospital to HHI Limited, trading as Healthy Hearts.

The key terms of the Lease are:-

- Term – 3 years from the date of commencement;
- Rent – Peppercorn
- Repair – Tenant
- Insurance – Tenant to insure (in joint names)
- Outgoing – All payable by Tenant
- Alterations – Non-structural only (with Landlord consent)
- Alienation – All assignment, underletting and sharing is prohibited.
- Permitted User – Clinical and associated activities
- Break Clause – Either party at any time on 12 months notice

**REPORT RECOMMENDATION:**

It is recommended that the Board resolves that the Trust execute the lease. As the Lease is a document which must be created by deed the Board is requested to authorise the use the seal to execute the engrossment.

**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:**

Trust Vision  
Accessible and Responsive Care  
Good Use of Resources

**PREVIOUS CONSIDERATION:**

None

## **EXECUTION OF A LEASE OF THE OLD CHAPEL BUILDING AT SANDWELL HOSPITAL**

**Trust Board – 27 September 2012**

### **Background**

It is proposed to grant a lease of the Old Chapel building on Sandwell site to HHI Limited, (trading as Healthy Hearts). The Old Chapel has long been disused as a chapel, until recently it was a stores area for the Estates Department. It is in a poor state of repair.

Healthy Hearts is a long running heart health, stroke and diabetes prevention programme, established by doctors, nurses and health care professionals from Sandwell Hospital. In particular it is based on the research work undertaken by Professor Elizabeth Hughes and her team at the Sandwell Medical Research Unit.

In line with Department of Health strategy and guidance, a social enterprise company HHI Limited was founded in 2008 to broaden the work of Healthy Hearts in the community. It undertakes heart health screenings in the community such as the recent one at the Sandwell Show.

Healthy Hearts has also now been established as a linked charity, which will shortly be seeking Charity Commission registration. The social enterprise and charity have a very experienced and well qualified board chaired by Tony Deep Wouhra MBE, the chairman of East End Foods plc., one of Sandwell's leading businesses.

### **Present Position**

- Healthy Hearts has completed 2 years' of screening of hard to reach communities for Sandwell PCT for cardiovascular risk factors. Together with previous programmes Healthy Hearts has screened over 5000 people including clients from both the deaf and visually impaired communities.
- This supports the Equality and Diversity Strategy requirements of the NHS outcomes framework as updated in 2012 where reducing inequalities in access to healthcare is one of the performance metrics
- The staff used to deliver the activity are all from the Trust and are provided through SMRU, including appropriate bank staff. The Trust receives the income from such activities.
- Healthy Hearts now needs a permanent home to develop its work and a space for administration and the storage of equipment.
- The SMRU portacabins are becoming unserviceable and alternative accommodation is being sought. It may be possible to co-locate some of the SMRU activities to the Old Chapel in due course.

## Future Developments

- Further discussions are underway with the PCT for next year's contract of Healthy Hearts screening events.
- The charity Silver Star is to donate a fully equipped mini bus to Healthy Hearts to carry out mobile screening for diabetes and other cardiovascular risk factors
- Demand for screenings from communities in Sandwell greatly outstrips the contract from the PCT, so Healthy Hearts is set to raise a significant amount of money through its charity by way of events and donations to provide more screenings.
- Because of the increased activity it is most important that Healthy Hearts has a base at Sandwell for the minibus and all equipment. Healthy Hearts also needs space for administration and the ability to conduct screenings on site.

## The Lease

A form of lease had previously been agreed with Health Hearts for signing a few years ago. To facilitate the swift completion of the Lease now this form will be used. Browne Jacobson have reviewed the Lease and confirmed it is acceptable to be used for this letting subject to going through the procedural requirements to exclude the lease from the Landlord and Tenant Act 1954 which Browne Jacobson will attend to.

The key terms of the Lease are:-

- Term – 3 years from the date of commencement;
- Rent – Peppercorn
- Repair – Tenant
- Insurance – Tenant to insure (in joint names)
- Outgoing – All payable by Tenant
- Alterations – Non-structural only (with Landlord consent)
- Alienation – All assignment, underletting and sharing is prohibited.
- Permitted User – Clinical and associated activities
- Break Clause – Either party at any time on 12 months notice

The remaining provisions are all standard for a letting of this type. There are no onerous obligations on the Trust as Landlord.

## Recommendation

It is recommended that the Board resolves that the Trust execute the lease. As the Lease is a document which must be created by deed the Board is requested to authorise the use the seal to execute the engrossment.

<b>TRUST BOARD</b>
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<b>DOCUMENT TITLE:</b>	Estates Rationalisation		
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Graham Seager, Director of Estates/ New Hospital Project		
<b>AUTHOR:</b>	Graham Seager, Director of Estates/ New Hospital Project		
<b>DATE OF MEETING:</b>	27 September 2012		
<b>EXECUTIVE SUMMARY:</b>			
<p>The Board will recall the approval of the Estates Rationalisation programme at its March 2012 meeting. The paper outlined an on going programme of building closures as part of the rationalisation programme.</p> <p>The process for declaring buildings surplus requires Board approval as they occur. The following buildings are planned to be unused from the 30<sup>th</sup> September and so are recommend to be declared non operational.</p> <p>City Block 70 Former Cookchill</p>			
<p>The Board is recommended to approved the closure of the buildings identified above.</p>			
<b>ACTION REQUIRED</b> <i>(Indicate with 'x' the purpose that applies):</i>			
The receiving body is asked to receive, consider and:			
<b>Accept</b>	<b>Approve the recommendation</b>	<b>Discuss</b>	
	<b>X</b>		
<b>KEY AREAS OF IMPACT</b> <i>(Indicate with 'x' all those that apply):</i>			
Financial	<b>x</b>	Environmental	Communications & Media
Business and market share		Legal & Policy	Patient Experience
Clinical		Equality and Diversity	Workforce
Comments:			
<b>ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:</b>			
Strategic Objective -Good Use of Resources			
Trust Priority- Delivering the Transformation Plan			
<b>PREVIOUS CONSIDERATION:</b>			
Estates Rationalisation proposal considered at Trust Board March 2012			

<b>TRUST BOARD</b>
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<b>DOCUMENT TITLE:</b>	<b>Integrated Risk Report – Q1 2012-13</b>				
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	<b>Kam Dhami – Director of Governance</b>				
<b>AUTHOR:</b>	<b>Allison Binns – Head of Risk Management Dally Masaun – Head of Health &amp; Safety</b>				
<b>DATE OF MEETING:</b>	<b>27 September 2012</b>				
<b>EXECUTIVE SUMMARY:</b>					
This report combines information on incidents (both clinical and Health & Safety), complaints, PALS and claims.					
Key incident statistics:					
<ul style="list-style-type: none"> <li>• There were 3321 reported incidents during Q1 2012/13 (2743 in Q1 2011/12)</li> <li>• Reported Clinical incidents increased from 1846 in Q1 2011/12 to 1919 in Q1 2012/13</li> <li>• Reported Health &amp; Safety incidents rose from 897 in Q1 2011/12 to 1402 in Q1 2012/13.</li> <li>• There were 50 incident forms received relating to red incidents (2% of the total), compared with 85 in Q1 2011/12 (3% of the total).</li> </ul>					
Key complaints statistics:					
<ul style="list-style-type: none"> <li>• During the reporting period the Complaints Team received 191 new complaint contacts. By means of comparison, 252 contacts were received in Q1 2011/12 and 243 in Q4 2011/12.</li> </ul>					
Key claims statistics:					
<ul style="list-style-type: none"> <li>• Of the 34 Clinical claims received in Q1, there were 5 that had a reported clinical incident related to the case. 16 claimants had already raised their concerns via the Complaints Procedure.</li> <li>▪ Of the 14 personal injury claims received, 8 had a reported incident related to the case. At present the Trust has 407 Clinical claims and 126 personal injury claims at various stages of the legal process..</li> </ul>					
Key PALS statistics:					
Total enquiries to PALS team during the reporting period was 1001					
<b>REPORT RECOMMENDATION:</b>					
Note the contents					
<b>ACTION REQUIRED</b> <i>(Indicate with 'x' the purpose that applies):</i>					
The receiving body is asked to receive, consider and:					
<b>Accept</b>	<b>Approve the recommendation</b>	<b>Discuss</b>			
<b>X</b>					
<b>KEY AREAS OF IMPACT</b> <i>(Indicate with 'x' all those that apply):</i>					
Financial		Environmental	x	Communications & Media	X
Business and market share	<b>X</b>	Legal & Policy	X	Patient Experience	X
Clinical	<b>x</b>	Equality and Diversity		Workforce	x
Comments:					
<b>ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:</b>					
High Quality Care, NHSLA					
<b>PREVIOUS CONSIDERATION:</b>					
Governance Board on 7 September 2012 and Quality & Safety Committee on 20 September 2012.					

# Risk Management Report

## Quarter 1 - 2012-2013

An Integrated report from Clinical Risk, Health & Safety, PALS  
and Complaints & Claims



Where  
**EVERYONE**  
Matters



## Integrated Risk, PALS, Complaints and Claims Report: Quarter 1 2012/13

### 1. Overview

This report highlights key risk activity including:

- Summary incident data and details of lessons learned
- Summary complaints data and details of lessons learned
- Summary PALS data
- Aggregated analysis of incidents and complaints, and lessons learned.

### 2. Introduction

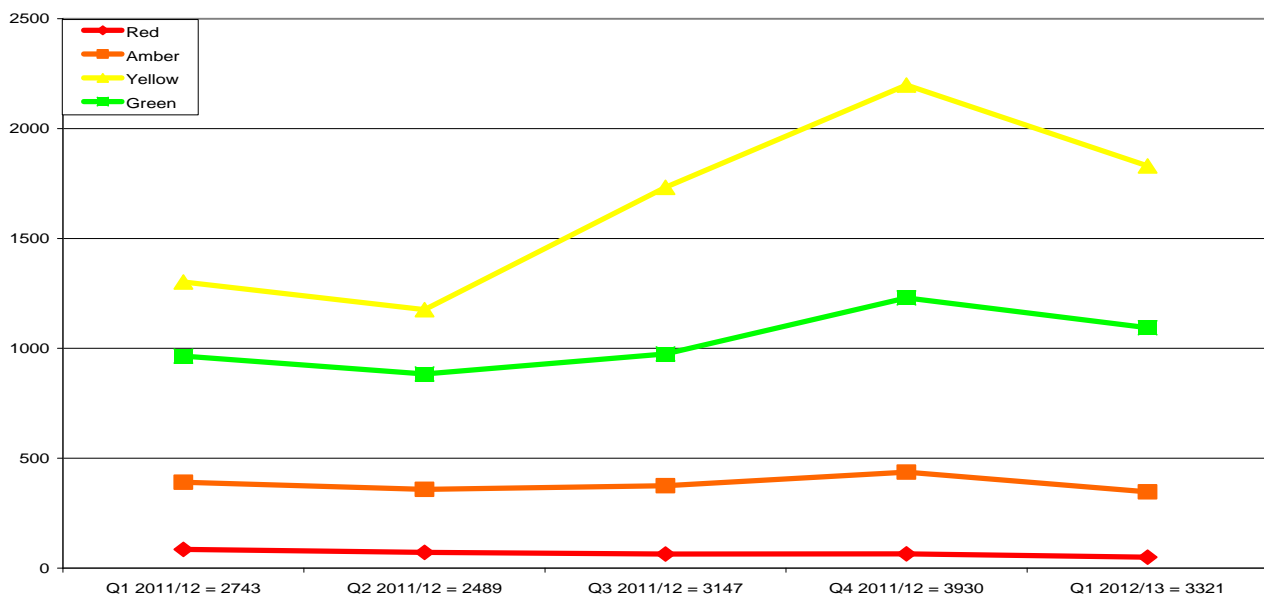
This report combines previous quarterly reports on incident/risk and complaints to implement the Policy for the Investigation, Analysis and Learning of Lessons from Adverse Events and meet NHS Litigation Authority assessment requirements. Where possible, comparisons across these areas of activity are made to try to identify common trends and actions. Future reports will also include claims and inquest data.

### 3. Key Issues

#### 3.1 Review of Quarter 1 Incident Data

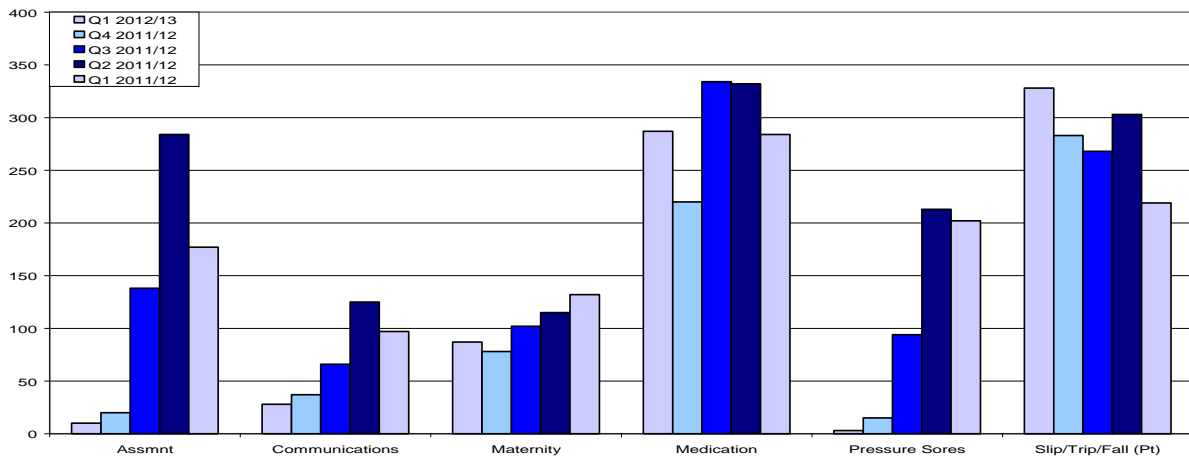
- There were 3321 reported incidents during Q1 2012/13 (2743 in Q1 2011/12)
- Reported Clinical incidents increased from 1846 in Q1 2011/12 to 1919 in Q1 2012/13
- Reported Health & Safety incidents rose from 897 in Q1 2011/12 to 1402 in Q1 2012/13.
- There were 50 incident forms received relating to red incidents (2% of the total), compared with 85 in Q1 2011/12 (3% of the total).

**Graph 3.1a:** Incident Trends by risk rating Q1 2011/12 – Q1 2012/13





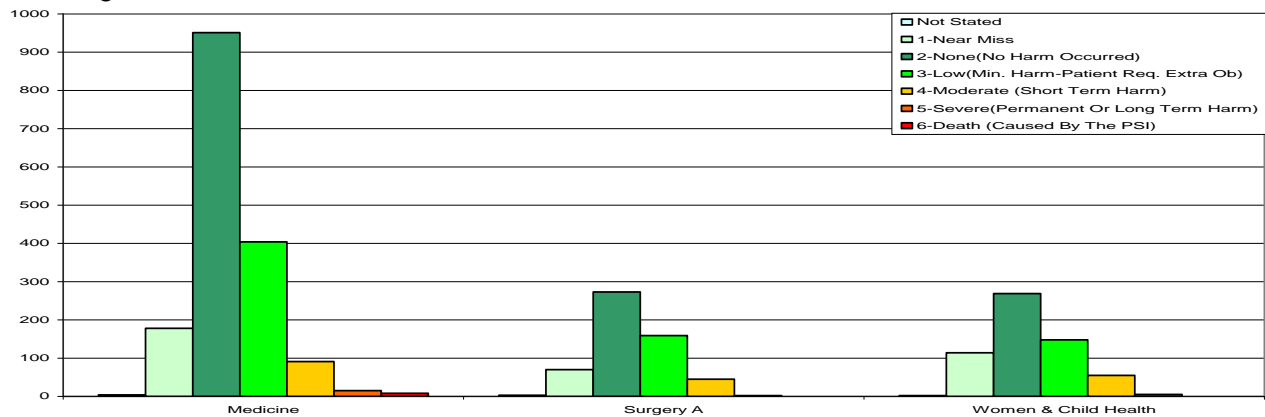
**Graph 3.1b: Top 6 reported Clinical incident categories by quarter (Q1 2011/12 – Q1 2012/13)**



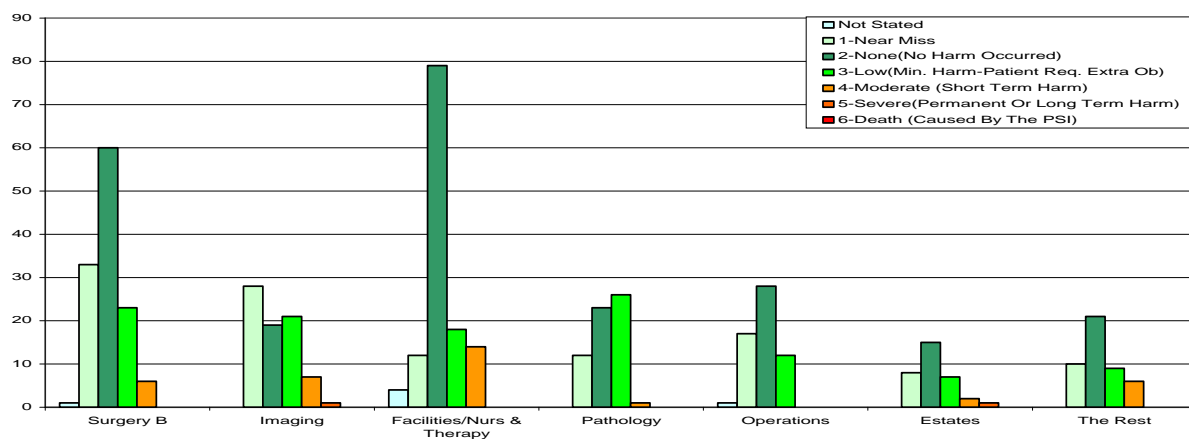
The top 6 most frequently reported categories remain consistent.

**Graph 3.1c: Incidents by impact by division within Q1 2012/13**

Larger Divisions



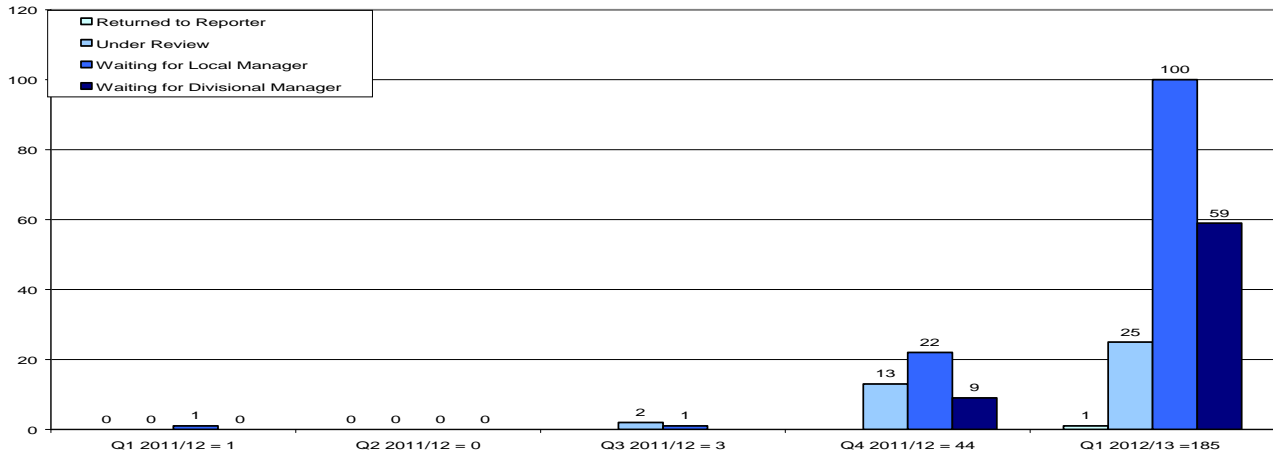
Smaller Divisions



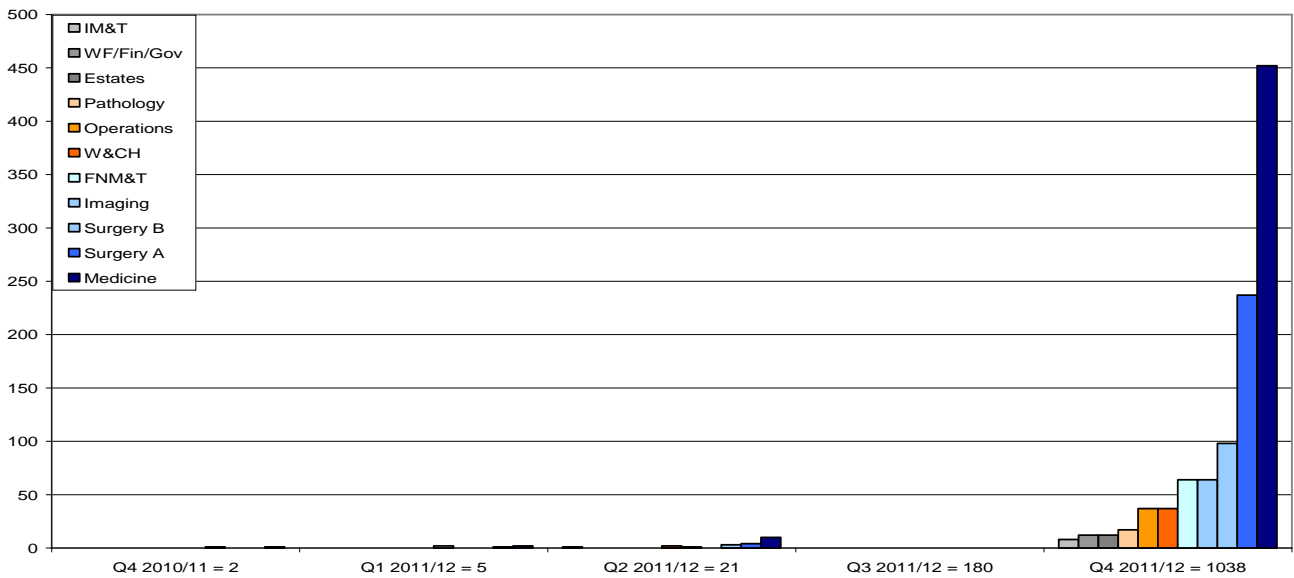
### 3.1.1 Web Holding

Following transition to the electronic reporting system within the hospital setting, incidents that are in the process of being “managed” are held in a virtual file before being merged into the live system. This file is called Web Holding.

**Graph 3.1.1a: Incidents waiting to be managed in Web Holding**



**Graph 3.1.1b: Incidents in Web Holding by division**



There are no Incidents in Web Holding more than 45 day old

### 3.2 Complaints

During the reporting period the Complaints Team received 191 new complaint contacts. By means of comparison, 252 contacts were received in Q1 2011/12, 233 in Q2 2011/12, 215 in Q3 2011/12 and 243 in Q4 2011/12.

**First contact complaint:** where the Trust's substantive (i.e. initial) response has not yet been made.

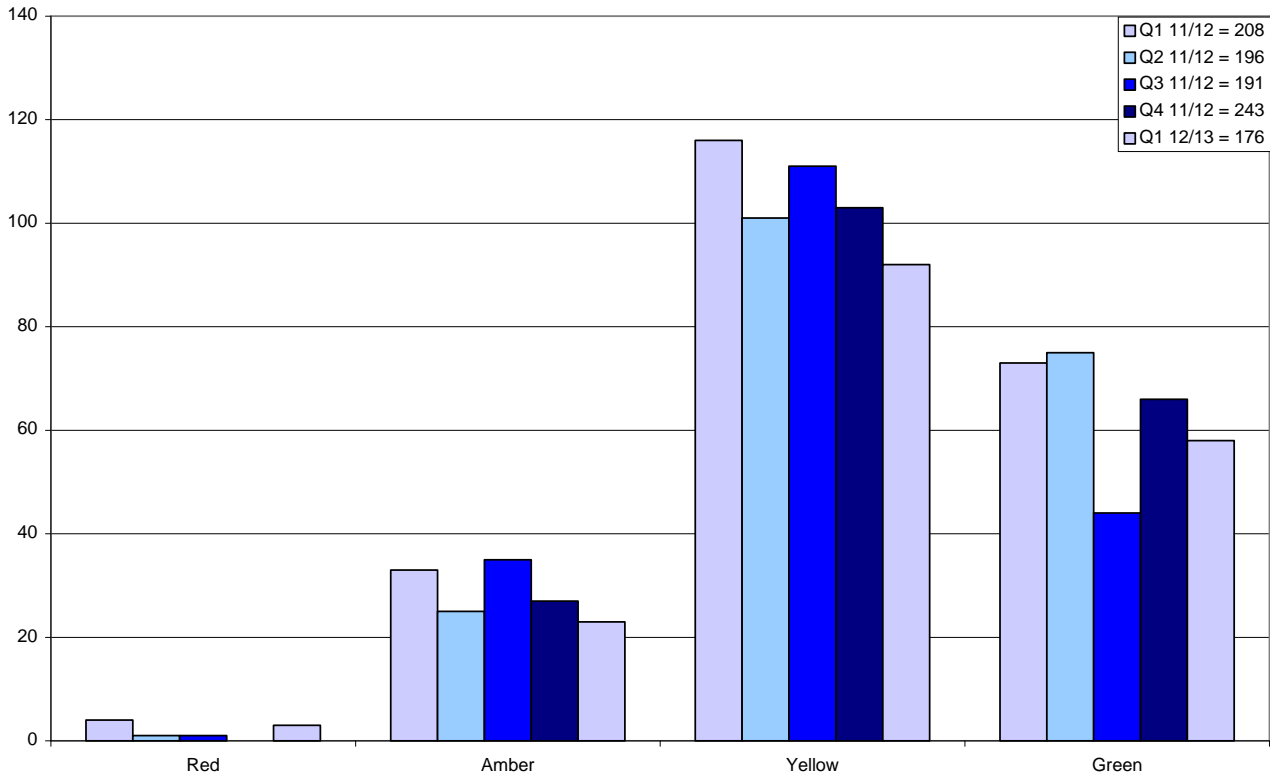
**Table 3.2a:** Types of Contact during Q1

Types of Contact	Q4	Notes
Formal Complaints	176	Formal complaints with negotiated timescales
Can't Accept	4	Concerns not addressed (due to time elapsed since incident etc)
General Query/Feedback	11	Not dealt with formally (concerns/query addressed via letter)
GP/intra NHS Concerns	0	Concerns raised by GPs or other NHS organisations/staff members
Dealt with informally	0	Not dealt with formally (concern/query addressed via phone or meeting)
Under Review	0	Pathway not finalised (e.g. reviewing records to establish whether a complaint can still be reviewed given time elapsed)
Withdrawn	7	Complaints are typically withdrawn if a relative has made the complaint, but patient consent cannot be obtained. Occasionally complaints are withdrawn as the complainant changes their mind about taking their concerns forward.

The following link complaint contacts were received:

Types of Contact	Q1	Q2	Q3	Q4	Q1	Notes
Link Complaints	34	39	37	25	32	The complainant has received the substantive response to their complaint but has returned as they remain dissatisfied/or require additional clarification.

**Graph 3.2a: Number of Formal Complaints received by quarter**



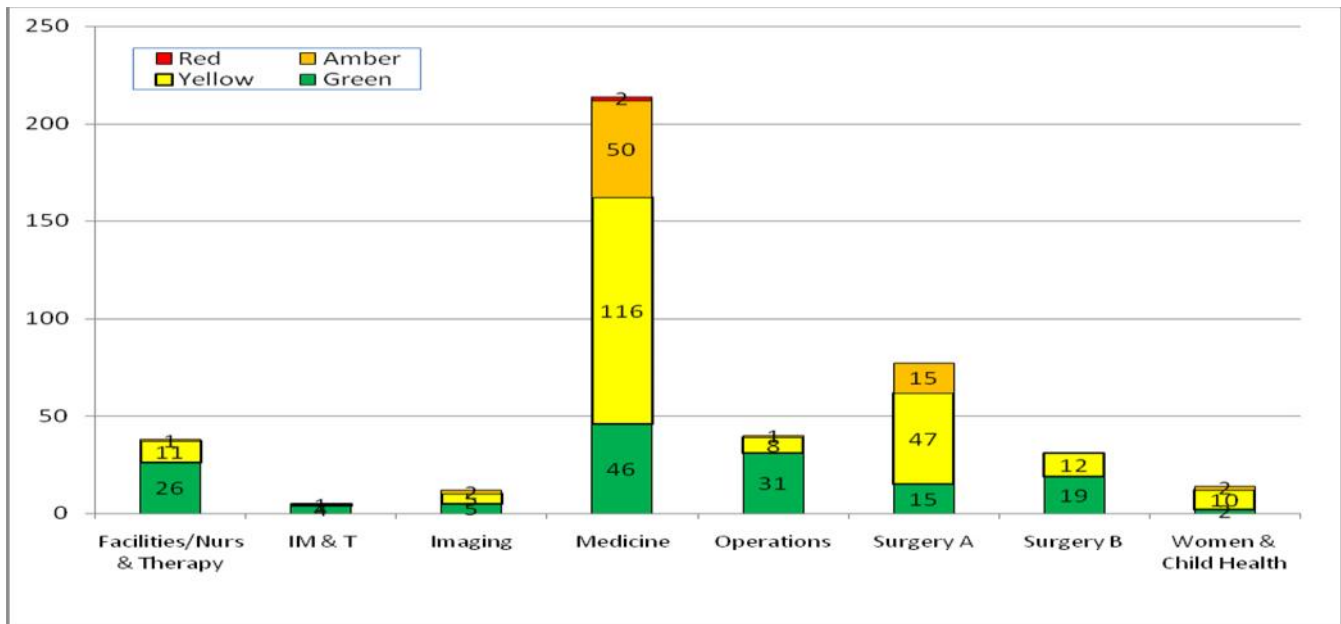
The severity of the grading remains broadly consistent with previous quarters.

Action Plan Completion

All divisions are required to submit a copy of a completed action plan to the Complaints Department following the finalising of the Trust’s investigation and response to the complainant. Monthly reports are being issued to relevant divisional managers containing details of any action plans yet to be submitted.

The graph below is a breakdown by division of action plans currently outstanding for complaints responded to up until the end of June 2012. The chart shows how many of each grade is outstanding.

**Graph 3.2b:** Number of Action Plans Outstanding by divisional lead  
(responses to end of Q1 2012/13 – period 1/4/11 to 30/6/12)



The results show overall decrease in action plans outstanding when compared to previous reporting periods. Notwithstanding this work will continue to be undertaken with the divisions to ensure that (i) action plans are completed in a timely manner and (ii) where action plans are completed in a timely manner, this is appropriately logged on the Complaints Department database.

#### Referral of Complaints to the Health Service Ombudsman

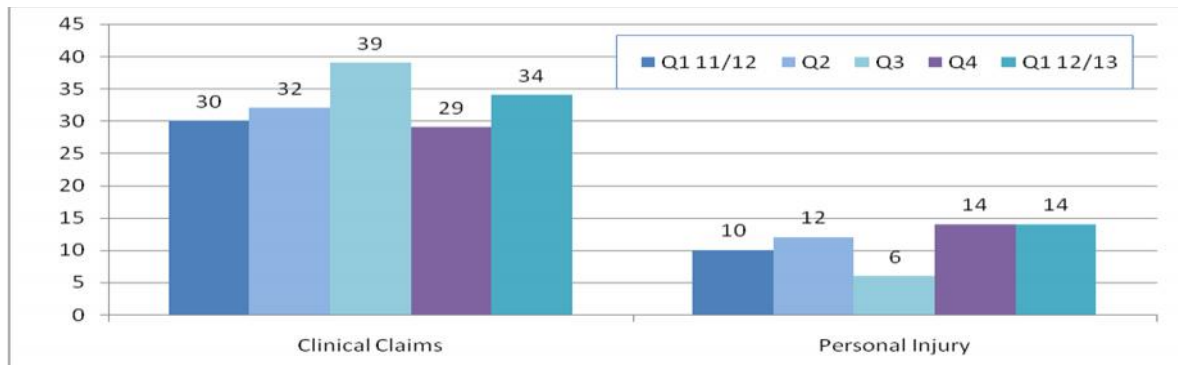
Six cases were received from the Ombudsman during the reporting period. The current position in relation to these cases is:

- 1 – Not being investigated
- 3 – Ombudsman's decision awaited
- 1 – Under investigation
- 1 – Ombudsman taking no further action at present.

### 3.3. Claims

The claims received are as follows:

**Graph 3.3a:** Claims Received by Quarter



Of the 34 Clinical claims received in Q1, there were 5 that had a reported clinical incident related to the case. 16 claimants had already raised their concerns via the Complaints Procedure.

Of the 14 personal injury claims received, 8 had a reported incident related to the case. None of the claimants had previously raised their concerns via the Complaints Procedure. However, personal injury claims typically relate to staff injuries and staff are not able to raise their concerns via the NHS Complaints Procedure.

**Table 3.3a:** Categories of Claims

Allegation Category	Clinical Claims Q1	Personal Injury Q1
Burns/scalds/reactions	-	-
Delay in Treatment	1	-
Dissatisfied With Treatment	4	-
Drug Error	-	-
Failure Or Delay In Diagnosis	9	-
Failure to Recognise Complications	2	-
Fall/slip	-	2
Infection - Other	-	-
Lacerations/Sores	-	-
Late Diagnosis And Treatment	1	-
Lifting/moving/handling	-	1
Moving/falling Objects	-	3
Needlestick	-	6
Not Known	4	1

Operation Carried Out Negligently	6	-
Other	-	-
Toxic Fumes	-	-
Treatment Carried Out Negligently	7	-
Violence and Aggression	-	1
<b>Total</b>	<b>34</b>	<b>14</b>

At present the Trust has 407 Clinical claims and 126 Personal Injury claims at various stages of the legal process.

**Table 3.3b:** Status of Active Claims

Status Type	Clinical Claims	Personal Injury Claims
Defence Served	3	-
Disclosure Of Records*	330	5
Early Stages	6	3
Letter Of Claim	32	97
Letter Of Response	4	-
Liability Admitted	4	11
Liability Being Assessed	9	4
Liability Denied	5	-
Negotiate Settlement	12	2
Part 36 Offer	4	1
Proceedings Issued/served	4	1
Settlement Made	18	3

\* It is worth noting that not all requests for disclosure of records progress into a claim.

**Table 3.3c:** Claims by Division (*excludes records disclosure*)

Division	Clinical Claims	Personal Injury Claims
Development/Cancer		
Estates	1	19
Facilities		26
Finance		1

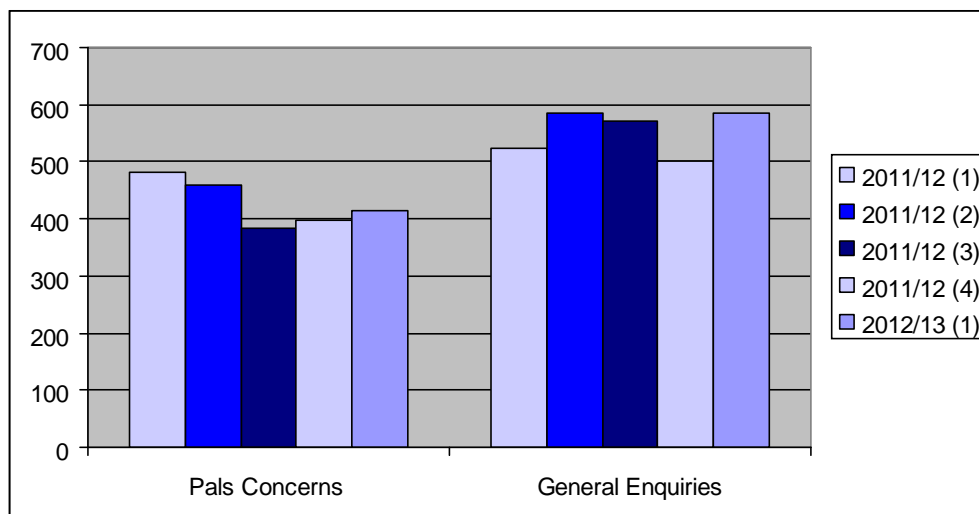
Imaging		3
IM&T		
Medicine	26	42
Not Known/Stated	2	2
Operations		
Pathology	1	
SCAH		1
Surgery A	29	10
Surgery B	11	4
Women & Child Health	32	3
Workforce		10

#### 4. Patient Advice & Liaison Service (PALS)

The PALS provides a one-stop service for patients/relatives and their carers to speak to someone who will listen to their issue of concern and provide support, information and advice. The PALS works in partnership with Trust staff to improve the patient experience.

The enquiries detailed within this report have been dealt with by the PALS team.

**Graph 4.1a:** Trends of number of enquiries received (Q4 2010/11 – Q1 2012/13)



The following methods identify ways in which patients, their relatives and carers can access the PALS:

- Telephone (calls are centralised at City Hospital via a direct line)
- Email
- Fax
- Appointment to meet PALS Lead
- Face-to-face contact at the Patient Support Centre BTC



- Completing a 'have your say' form and posting it in red boxes provided at main reception areas on 3 sites
- Dedicated phone line for direct access to PALS for Rowley Regis Hospital patients/relatives/carers.

**Table 4.1a:** Top 10 categories of issues raised with PALS Q1 2012-13

<b>Category breakdown</b>	<b>Number of Contacts Q1</b>
<b>APPOINTMENTS</b>	
Appointment Cancellation	11
Appointment Delay	11
Appointment Notification	7
Appointment time	16
Appointment Booking (Choose and Book)	0
Appointment (other)	3
<b>ATTITUDE OF STAFF</b>	
Admin	8
AHP	1
Ancillary	0
Doctor/Consultant	6
Nurse	11
<b>CLINICAL TREATMENT</b>	
Clinical Care	23
Clinical Treatment	10
Delay in Investigations	1
Delay in Results	4
Delay in Surgery	7
Delay in Treatment	6
Delay in X-ray/Scan	0
Information – Condition	3
Medicines	9
Low Staffing levels	0
Support	0
Waiting time	0
Consent	0
<b>COMMUNICATION</b>	
Verbal	13
Written	10
<b>ADMISSION/DISCHARGE/TRANSFER</b>	
Admission Arrangements	0
Discharge Arrangements	11
Transfer Arrangements	2
<b>FORMAL COMPLAINTS</b>	
Complaint Handling	2
Complaint Advice	65
Complaint Process	3
Complaint Referral	12
Complaint Response time	2
<b>PERSONAL RECORDS</b>	
Records – Access	12
Records – Content	3

Records – Mislaid	0
<b>GENERAL ENQUIRY</b>	
Advice	23
Information	24
Referral	5
Support/other	3
NHS Services	0
NHS Funding	0
Costs	1
<b>PERSONAL RECORDS</b>	
Access	12
Content	3
Mislaid	0
<b>ESSENCE OF CARE</b>	
Continence	1
Hygiene	0
Nutrition	1
Privacy and Dignity	3
Safety	5
Safety of patient with MH	0
Mouthcare	0
Pressure Sores	2

## 5. Recommendations

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

<b>TRUST BOARD</b>
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<b>DOCUMENT TITLE:</b>	<b>Delivering the Health Visiting Officer appraisal of progress and support requirements</b>
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	<b>Rachel Overfield, Chief Nurse</b>
<b>AUTHOR:</b>	<b>Rachel Overfield, Chief Nurse</b>
<b>DATE OF MEETING:</b>	<b>27 September 2012</b>
<b>EXECUTIVE SUMMARY:</b>	
<p>The SHA commissioned a region wide review of where all provider organisations are with their Health Visitor Implementation Plans.</p> <p>Each provider organisation is required to have a comprehensive plan around the development of it's HV services following the national public commitment (A Call to Action) to expand and enhance HV contributions to the health, safety and well being of families. Each health economy has been reviewed and SWBH/Sandwell HV services were reviewed in August of this year.</p> <p>The summary findings have been attached. Generally the views of the reviewers is positive but more work is required specifically around:</p> <ul style="list-style-type: none"> <li>• Detailed planning and communication of the plan to HV staff</li> <li>• Development of a robust service specification</li> <li>• Relationships with the developing CCG</li> <li>• Embedding good communication processes</li> <li>• Developing a clear vision for HV</li> </ul> <p>The reviewers were impressed with:</p> <ul style="list-style-type: none"> <li>• Integration into the Trust</li> <li>• Integrated working with midwifery</li> <li>• Standard of supervision and leadership development</li> <li>• Improvements in safeguarding</li> <li>• Listening into Action process</li> <li>• Partnership working with commissioners</li> <li>• Integrated plan – based along a child's journey through community and acute services</li> <li>• Workforce plan</li> </ul> <p><u>Key next steps</u></p> <p>We need to ensure findings from the review are incorporated into a more detailed implementation plan. We are also progressing work around:</p> <ul style="list-style-type: none"> <li>• A HV dashboard</li> <li>• IT systems support</li> </ul> <p>The Board is asked to note the summary findings of the report.</p>	
<b>REPORT RECOMMENDATION:</b>	
The Board is asked to note the report.	

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

Safe High Quality Care

**PREVIOUS CONSIDERATION:**

The Board received a presentation on Health Visiting at its meeting held on 28 June 2012



## Delivering the Health Visiting Offer

### Appraisal of Progress and Support Requirements

Provider: Sandwell and West Birmingham Hospitals NHS Trust

Review Date: 7<sup>th</sup> August 2012

Commissioner: NHS Black Country Cluster

SHA Region: Midlands and East SHA (West Midlands)



Delivered by



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## Introduction

The purpose of this review is to provide an appraisal of the progress made by Sandwell and West Birmingham Hospitals NHS Trust in delivering the Health Visiting Offer and identify what if any support should be considered by the organisation to ensure delivery by 2015.

The Core Brief provided to the organisations at the start of the project identified the process that would be undertaken, the format of the standard report that would be provided by Sustain and the individuals who would receive the final report. The following report will be provided to the:

- Strategic Health Authority (SHA) Health Visiting Lead
- Commissioning Director of Nursing
- Provider Organisation Professional lead/CEO

This report sets out:

- A high level summary of our findings.
- Dashboards for each area detailing an objective assessment of the organisations current position across a range of required deliverables along with the organisation's appraisal of their expected status at the end of March 2013. The Organisation produces a self-appraisal of its position as at the review date and while this is not shown in the report we use the output in our review and highlight major variations against our results within the comments below.
- A range of specific observations made during the review. This section has been used to identify Good Practice (Green), Area of Note (Amber) and Area of Concern (Red). It should be noted that the RAG status is used purely to identify the level of impact an area will/may have on the Health Visiting service and is NOT intended to be a reflection on the Health Visiting service or its performance. In addition this section provides formal recommendations where appropriate.
- A summary of the support which has been identified by the participants and we believe is required by the organisation.
- A list of people we met during the appraisal.

## Summary

We would like to extend our thanks to the management team of Sandwell and Birmingham Hospitals NHS Trust, Children's Community Directorate for their support and assistance in organising the meetings required for completion of the appraisal. In addition we would like to express our gratitude to all involved in the meetings for their openness and honesty.

1. The Head of Service for the Children's Community Directorate (CCD) has a vision and passion for the development of Health Visiting along with the drive and ability to deliver the wide reaching changes within the Health Visiting Services. We believe they are keen to embrace any support assistance that is available to enhance the pace of delivery or to reduce the learning time required.

2. The CCD has an “Integrated Development Plan to 2015” of which Health Visiting and the delivery of the Health Child Programme (HCP) is an integral part. For the Health Visiting service specifically there is an excellent scoping document<sup>1</sup> for most of the actions we believe are required in A Call To Action 2011 - 2015. We acknowledge there is a top level Health Visitor Implementation Plan arising out of the CCD Integrated Development Plan along with a vision for the Directorate. We feel however, that the service lacks an individual communicated vision for Health Visiting and a significantly more detailed Implementation Plan and management process. The organisation does appear to have a track record of sustainable implementation of policies e.g. supervision etc ; suggesting that, with a clear plan, there is a high probability of successful implementation of the required Call To Action deliverables.
3. A key part of the overall Health Visitor Implementation Plan will be the development of the Service Specification relevant to the area. The draft service specification, currently out for consultation, contains some of the key deliverables of HCP and A Call To Action. The service needs to have this specification developed for Sandwell and current/future commissioners will need to engage fully in this process.
4. Wider strategic engagement has been a challenge for the service mostly owing to the transition within commissioning and a change in Local Authority structure and priorities. GP engagement at a strategic level has not been developed to the level required to date but we believe that the emerging Clinical Commissioning Group (CCG) is keen to develop relationships and joint working. Both of these elements need to be developed further from a Trust wide perspective and within the Health Visitor Implementation Plan via a marketing and engagement plan.
5. All levels of supervision appear to be very good across the service which is both appreciated and understood by staff. Children in Need supervision has been effectively added in the area and warrants recognition.
6. The Health Visitor (HV) Leadership Development Programme offered by the SHA, which is open to all HV’s, is held in high regard by staff who have attended from the service and appears relevant in developing the leadership expectations defined in A Call To Action. The availability and funding for such training needs to be considered going forward.
7. The Sustain team were impressed by the level of integration that has been achieved in the short period of time following the transition of community services into CCD of Sandwell and Birmingham Hospitals NHS Trust. An area of particular benefit for local children and families is the closer working relationships between HV and Maternity services where they are starting to address a number of the often seen “handover issues”.
8. Significant improvements to the delivery of safeguarding initiatives have been made through effective partnership working with the PCT safeguarding team. This has resulted in a number of initiatives including the introduction of their safer sleeping initiative.
9. The Trust has embedded a staff engagement programme of Listening into Action. This was used effectively as part of the Integrated Development Plan development and was positively received. Communication activity since this time appears not to have been in a mode that HV’s have felt informed of progress, in fact there was a discernible difference in some knowledge levels between the HV’s and Team Leaders/Specialist HV level.

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<sup>1</sup>Named: Workforce Plan



10. The comparison between the Self-Assessment Dashboard as at the review date (not reported in this document) and Sustains findings has highlighted three areas of notable variation. They fall in the following areas:
- a. Organisational Alignment – Delivery Structure & Management. We don't believe the structure is as robust as self-scored and have not seen evidence of the current process.
  - b. Staff & Workforce – Leadership Development. We believe commitment to development is higher than self-scored. e.g..SHA Leadership Course & BCC
  - c. Defining the Service Offering – Understanding the Current & Future Service Offering. While we have seen a good example of current Best Practice Standards for the Universal / Core service the future service offer is we believe less developed than the self-scoring indicates. There is however development work on-going as part of EIS which is likely to show progress in this area.

<b>TRUST BOARD</b>
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<b>DOCUMENT TITLE:</b>	Financial Performance Report – August 2012		
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Robert White, Director of Finance and Performance Management		
<b>AUTHOR:</b>	Robert White/Tony Wharram		
<b>DATE OF MEETING:</b>	27 September 2012		
<b>EXECUTIVE SUMMARY:</b>			
<p>The report presents the financial performance for the Trust and operational divisions for the period to 31<sup>st</sup> August 2012.</p> <p>Measured against the DoH target, the Trust generated an actual surplus of £365,000 during August against a planned surplus of £363,000. For the purposes of its statutory accounts, the in month surplus was slightly higher at £394,000.</p>			
<b>REPORT RECOMMENDATION:</b>			
The Trust Management Board is requested to NOTE the contents of the report and ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.			
<b>ACTION REQUIRED</b> <i>(Indicate with 'x' the purpose that applies):</i>			
The receiving body is asked to receive, consider and:			
<b>Accept</b>	<b>Approve the recommendation</b>	<b>Discuss</b>	
x			
<b>KEY AREAS OF IMPACT</b> <i>(Indicate with 'x' all those that apply):</i>			
Financial	x	Environmental	
Business and market share		Legal & Policy	x
Clinical		Equality and Diversity	
		Communications & Media	
		Patient Experience	
		Workforce	x
Comments:			
<b>ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:</b>			
Good use of Resources (under 11/12 OfE, key Strategies & Programmes)			
<b>PREVIOUS CONSIDERATION:</b>			
Performance Management Board and Trust Management Board on 18 September 2012 and Finance & Performance Management Committee on 20 September 2012			

# Sandwell and West Birmingham Hospitals

NHS Trust

## Financial Performance Report – August 2012

### EXECUTIVE SUMMARY

- For the month of August 2012, the Trust delivered a “bottom line” surplus of £365,000 compared to a planned surplus of £363,000 (as measured against the DoH performance target).
- For the year to date, the Trust has produced a surplus of £620,000 compared with a planned surplus of £485,000 so generating a positive variance from plan of £135,000.
- The planned surplus continues to rise significantly in the latter part of the year and towards the year end.
- At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 8 below planned levels. After taking account of the impact of agency staff, WTE's were 89 above plan. Total pay expenditure for the month, inclusive of agency costs, is £110,000 below the planned level.
- The month-end cash balance was approximately £25½m above the planned level.

### Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	2	135	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	(3)	118	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	110	147	<= Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(491)	(1,786)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	(89)	33	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	20,863	20,863	>= 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	485	620
Capital Resource Limit	5,735	1,305
External Financing Limit	---	20,863
Return on Assets Employed	3.50%	3.50%

2011/2012 Summary Income & Expenditure Performance at August 2012	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	382,453	31,911	32,350	439	159,450	161,063	1,613	385,453
Other Income	38,205	3,284	3,223	(61)	16,090	16,234	144	38,405
Operating Expenses	(394,038)	(32,932)	(33,313)	(381)	(165,555)	(167,194)	(1,639)	(397,268)
EBITDA	26,620	2,263	2,260	(3)	9,985	10,103	118	26,590
Interest Receivable	100	8	13	5	42	59	17	130
Depreciation & Amortisation	(14,738)	(1,228)	(1,228)	0	(6,141)	(6,141)	0	(14,738)
PDC Dividend	(5,594)	(466)	(466)	0	(2,331)	(2,331)	0	(5,594)
Interest Payable	(2,157)	(185)	(185)	0	(925)	(925)	0	(2,157)
<b>Net Surplus/(Deficit)</b>	<b>4,231</b>	<b>392</b>	<b>394</b>	<b>2</b>	<b>630</b>	<b>765</b>	<b>135</b>	<b>4,231</b>
IFRS/Impairment/Donated Asset Related Adjustments	(353)	(29)	(29)	0	(145)	(145)	0	(353)
<b>SURPLUS/(DEFICIT) FOR DOH TARGET</b>	<b>3,878</b>	<b>363</b>	<b>365</b>	<b>2</b>	<b>485</b>	<b>620</b>	<b>135</b>	<b>3,878</b>

The Trust's financial performance is monitored against the DoH target shown in the bottom line of the above table. IFRS and impairment adjustments are technical, non cash related items which are discounted when assessing performance against this target.

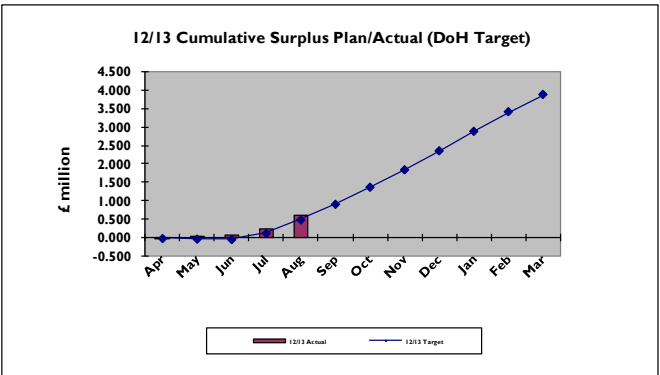
# Sandwell and West Birmingham Hospitals

NHS Trust

## Financial Performance Report – August 2012

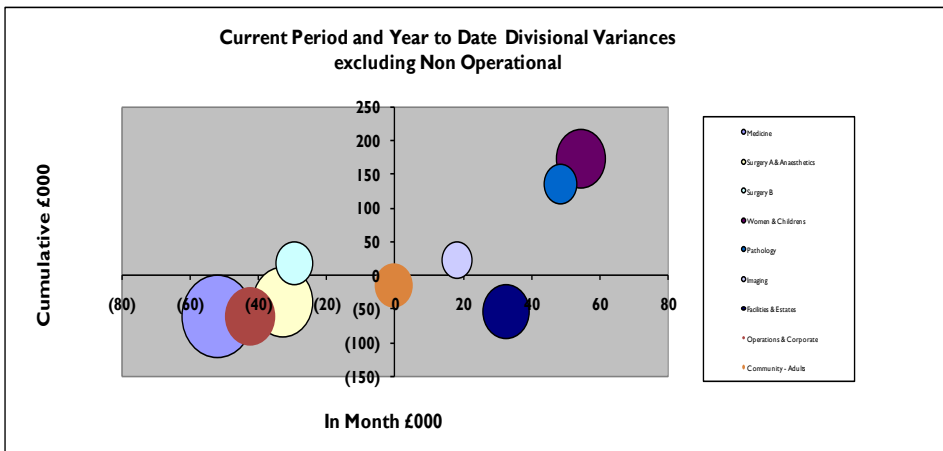
### Overall Performance Against Plan

The overall performance of the Trust against the DoH planned position is shown in the adjacent graph. Net bottom-line performance delivered an actual surplus of £195,000 in August against a planned surplus of £166,000. The resultant £29,000 positive variance moves the year to date position to £134,000 above targeted levels.



### Divisional Performance

- For August, there are again no major variances from plan among operational divisions although Medicine, Surgery A, Surgery B and Corporate Services have all posted relatively small in month deficits.
- SLA performance which is based on fully costed information for July shows an ongoing sizeable overall positive variation from plan particularly within medical specialties (although a significant element of this relates to high cost drugs for which there is an equivalent higher level of expenditure) and some smaller variations in other areas.
- There are no material year to date adverse variances from plan although Medicine, Surgery A, Facilities, Community – Adults and Corporate Services all have relatively small adverse variances.



The tables adjacent and below show small adverse year to date variance for Medicine, Surgery A, Facilities, Community – Adults and Corporate Services. The adverse in month and year to date performance of Operations & Corporate is largely driven by non recurrent items and it is expected that the year end position will be no worse than the planned position.

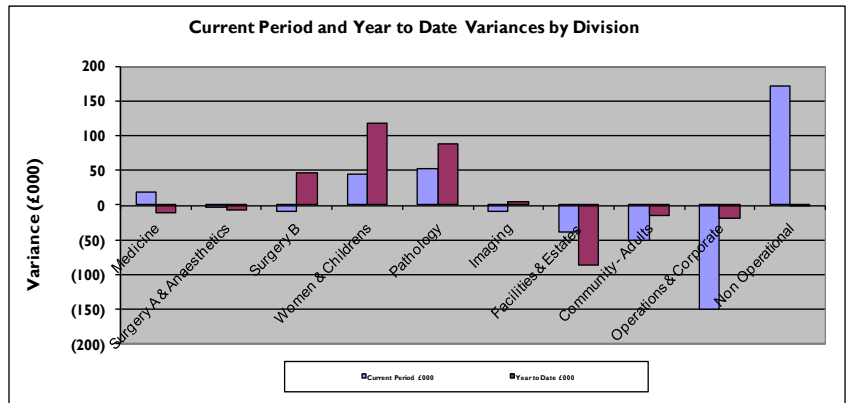
## Sandwell and West Birmingham Hospitals



NHS Trust

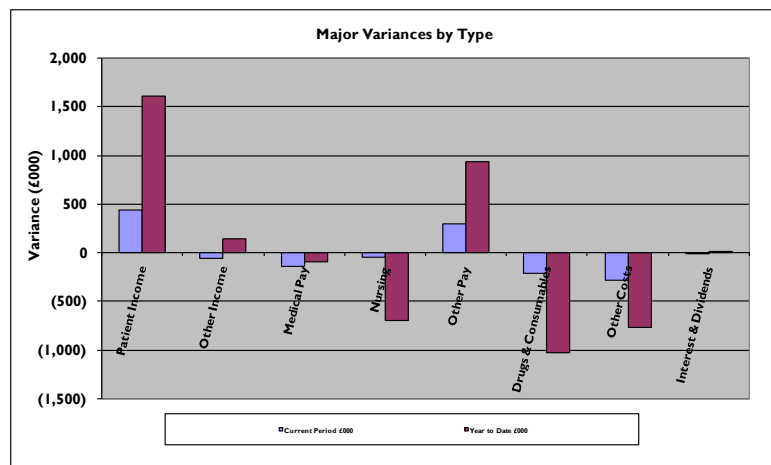
## Financial Performance Report – August 2012

Divisional Variances from Plan			
	Current Period	Year to Date	Budget
	£000	£000	
Medicine	(52)	(62)	87,295
Surgery A & Anaesthetics	(33)	(40)	62,434
Surgery B	(29)	17	24,310
Women & Childrens	55	173	43,866
Pathology	49	137	20,163
Imaging	18	23	16,962
Facilities & Estates	33	(54)	36,168
Community - Adults	(0)	(15)	26,192
Operations & Corporate	(42)	(61)	44,587
Non Operational	(1)	1	28,329



For August, patient related income again shows a positive variation from plan. Overall pay expenditure is below planned levels with higher levels of spend on medical, nursing and admin & estates being offset by under spending elsewhere, particularly for the management pay group. Overall non pay expenditure is £491,000 higher than plan in month, largely in respect of medical consumables and other expenditure items which covers a wide range of relatively small individual items.

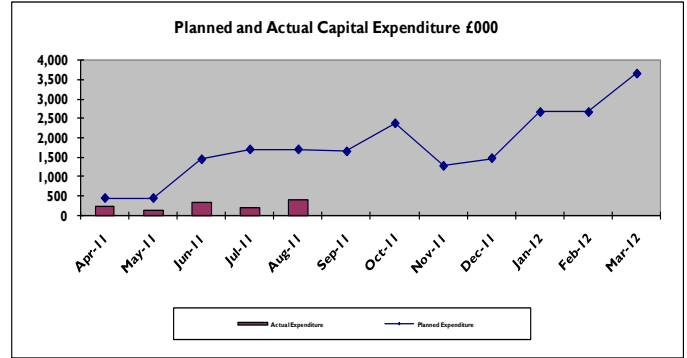
Variance From Plan by Expenditure Type		
	Current Period	Year to Date
	£000	£000
Patient Income	439	1,613
Other Income	(61)	144
Medical Pay	(146)	(94)
Nursing	(45)	(692)
Other Pay	301	933
Drugs & Consumables	(206)	(1,025)
Other Costs	(285)	(761)
Interest & Dividends	5	17



**Financial Performance Report – August 2012**

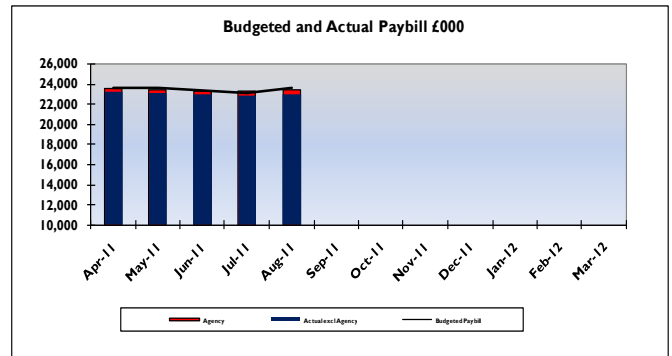
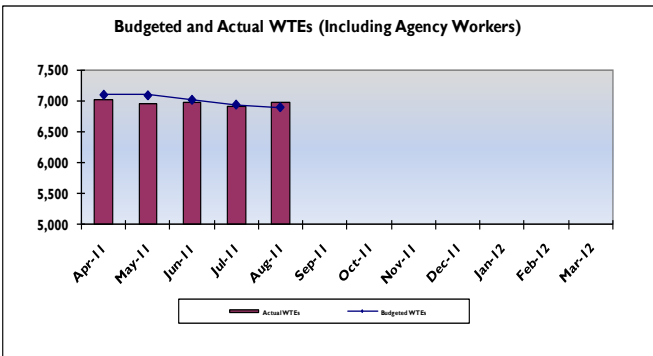
**Capital Expenditure**

- Planned and actual capital expenditure by month is summarised in the adjacent graph.
- In month and year to date expenditure continues to be lower than planned although the plan is significantly phased towards the latter part of the year. The original plan assumed significant expenditure on Grove Lane land over the summer and the absence of actual expenditure on land is the most significant cause of the variance from plan.
- For the year to date, actual expenditure is £1.3m primarily related to balances on brought forward schemes, capitalised salaries, estates rationalisation and statutory standards.



**Paybill & Workforce**

- Workforce numbers, including the impact of agency workers, are approximately 89 above plan compared with 18 below for July. Excluding the impact of agency staff, wte numbers are around 9 below plan. Actual wte's have increased by 67 compared with July, which is a level in excess of a planned decrease of 41 wtes for the month reflecting the ongoing requirements of the TSP. Most of the increase in actual wtes is accounted for by a rise in the numbers of bank staff by 94 along with a smaller rise in the use of agency staff. This is associated with ongoing heightened levels of activity.
- Total pay costs (including agency workers) are £110,000 lower than budgeted levels for the month, particularly within the management pay groups.
- Expenditure for agency staff in August was £525,000 compared with £447,000 in July, an average of £427,000 for 2011/12 and an August 2011 spend of £490,000. The biggest single group accounting for agency expenditure remains medical staffing.



# Sandwell and West Birmingham Hospitals

NHS Trust

## Financial Performance Report – August 2012

### Pay Variance by Pay Group

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

Analysis of Total Pay Costs by Staff Group						
	Year to Date to August					Variance £000
	Budget £000	Actual				
		Substantive £000	Bank £000	Agency £000	Total £000	
Medical Staffing	31,217	30,000		1,311	31,311	(94)
Management	6,424	5,929		0	5,929	495
Administration & Estates	12,974	12,127	536	190	12,853	121
Healthcare Assistants & Support Staff	13,024	12,084	1,003	3	13,089	(65)
Nursing and Midwifery	35,522	34,327	1,535	352	36,214	(692)
Scientific, Therapeutic & Technical	18,137	17,453		277	17,730	407
Other Pay	(123)	(98)			(98)	(25)
<b>Total Pay Costs</b>	<b>117,175</b>	<b>111,822</b>	<b>3,074</b>	<b>2,133</b>	<b>117,028</b>	<b>147</b>

NOTE: Minor variations may occur as a result of roundings

### Balance Sheet

- The opening Statement of Financial Position (balance sheet) for the year at 1<sup>st</sup> April reflects the statutory accounts for the year ended 31<sup>st</sup> March 2012.
- Cash balances at 31<sup>st</sup> August are approximately £48.8m which is around £14.3m higher than at 31<sup>st</sup> March and £4.7m lower than in July, mainly the result of the NHSLA correcting the delay in implementing direct debit transfers.

**Sandwell & West Birmingham Hospitals NHS Trust**  
**STATEMENT OF FINANCIAL POSITION 2012/2013**

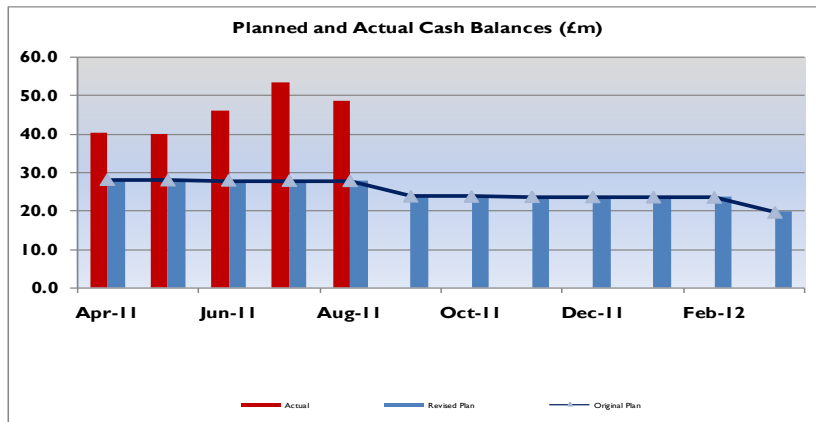
		Opening Balance as at 1st April 2012 £000	Balance as at end August 2012 £000
<b>Non Current Assets</b>	Intangible Assets	1,075	1,020
	Tangible Assets	227,072	222,071
	Investments	0	0
	Receivables	865	865
<b>Current Assets</b>	Inventories	4,065	4,101
	Receivables and Accrued Income	14,446	12,417
	Investments	0	0
	Cash	34,465	48,810
<b>Current Liabilities</b>	Payables and Accrued Expenditure	(38,987)	(41,641)
	Loans	(2,000)	(2,000)
	Borrowings	(1,166)	(1,166)
	Provisions	(10,508)	(14,613)
<b>Non Current Liabilities</b>	Payables and Accrued Expenditure	0	0
	Loans	(5,000)	(5,000)
	Borrowings	(29,995)	(29,767)
	Provisions	(2,437)	(2,437)
		<b>191,895</b>	<b>192,660</b>
<b>Financed By</b>			
<b>Taxpayers Equity</b>	Public Dividend Capital	160,231	160,231
	Revaluation Reserve	41,228	41,228
	Other Reserves	9,058	9,058
	Income and Expenditure Reserve	(18,622)	(17,857)
		<b>191,895</b>	<b>192,660</b>

## Sandwell and West Birmingham Hospitals



NHS Trust

## Financial Performance Report – August 2012



### Cash Forecast

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

#### Sandwell & West Birmingham Hospitals NHS Trust

#### CASH FLOW

#### 12 MONTH ROLLING FORECAST AT August 2012

ACTUAL/FORECAST	Aug-12 £000s	Sep-12 £000s	Oct-12 £000s	Nov-12 £000s	Dec-12 £000s	Jan-13 £000s	Feb-13 £000s	Mar-13 £000s	Apr-13 £000s	May-13 £000s	Jun-13 £000s	Jul-13 £000s	Aug-13 £000s
<b>Receipts</b>													
SLAs: Black Country Cluster	<b>17,071</b>	17,165	17,165	17,165	17,165	17,165	17,165	17,165	16,993	16,993	16,993	16,993	16,993
Birmingham & Solihull Cluster	<b>11,137</b>	11,341	11,341	11,341	11,341	11,341	11,341	11,341	11,228	11,228	11,228	11,228	11,228
Other Clusters	<b>369</b>	629	629	629	629	629	629	629	623	623	623	623	623
Pan Birmingham LSCG	<b>1,944</b>	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,733	1,733	1,733	1,733	1,733
Education & Training	<b>0</b>	0	4,347	0	0	4,347	0	0	4,300	0	0	4,300	0
Loans													
Other Receipts	<b>3,903</b>	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900
<b>Total Receipts</b>	<b>34,424</b>	33,785	38,132	33,785	33,785	38,132	33,785	33,785	37,776	33,476	33,476	37,776	33,476
<b>Payments</b>													
Payroll	<b>13,918</b>	13,266	13,220	13,215	13,215	13,215	13,215	13,214	13,068	13,068	13,068	13,068	13,068
Tax, NI and Pensions	<b>9,327</b>	9,591	9,559	9,556	9,556	9,556	9,556	19,110	9,455	9,455	9,455	9,455	9,455
Non Pay - NHS	<b>6,436</b>	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Non Pay - Trade	<b>8,461</b>	6,814	7,541	6,814	5,361	8,995	8,314	9,881	8,000	7,500	7,500	7,500	7,500
Non Pay - Capital	<b>350</b>	1,700	1,750	2,375	1,275	1,475	4,165	4,165	1,750	1,750	500	500	500
PDC Dividend			2,698					2,698					
Repayment of Loans			1,000					1,000					
Interest			30					25					
BTC Unitary Charge	<b>416</b>	416	416	416	416	416	416	832	430	430	430	430	430
Other Payments	<b>216</b>	175	175	175	175	175	175	175	175	175	175	175	175
<b>Total Payments</b>	<b>39,124</b>	38,190	35,161	35,051	32,498	36,332	38,341	53,600	35,378	34,878	33,628	33,628	33,628
<b>Cash Brought Forward</b>	<b>53,510</b>	48,810	44,405	47,376	46,110	47,397	49,197	44,641	24,826	27,225	25,823	25,672	29,821
<b>Net Receipts/(Payments)</b>	<b>(4,700)</b>	(4,405)	2,971	(1,266)	1,287	1,800	(4,556)	(19,815)	2,399	(1,401)	(151)	4,149	(151)
<b>Cash Carried Forward</b>	<b>48,810</b>	44,405	47,376	46,110	47,397	49,197	44,641	24,826	27,225	25,823	25,672	29,821	29,669

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



## Financial Performance Report – August 2012

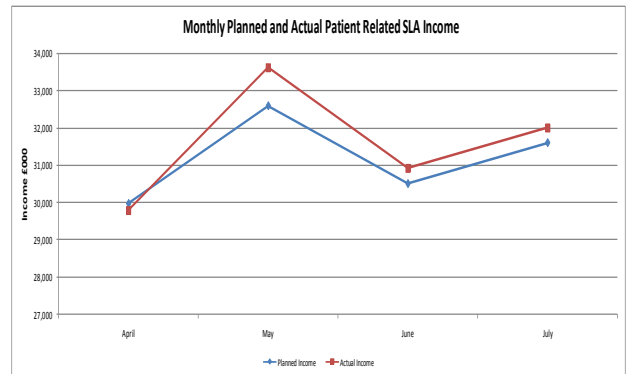
Risk Ratings			
Measure	Description	Value	Score
EBITDA Margin	Excess of income over operational costs	5.7%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	101.2%	5
Net Return After Financing	Surplus after dividends over average assets employed	1.8%	3
I&E Surplus Margin	I&E Surplus as % of total income	0.4%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	24.6	3
<b>Overall Rating</b>			<b>3.0</b>

### Risk Ratings

- The adjacent table shows the Monitor risk rating score for the Trust based on performance at August.
- An adjustment has now been made to the liquidity ratio to reflect an uncommitted overdraft facility (which would be in place as an FT) as this more accurately reflects performance against the Monitor risk rating regime. This changes the Liquid Ratio score from 1 to 3.
- I&E Surplus Margin is lower than would normally be expected due to relatively low levels of surplus being delivered in the early months of 2012/13 (surpluses are profiled towards the latter part of the year).

### Performance Against Service Level Agreement Target

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



Month	Planned Income £000	Actual Income £000	Variance £000
April	29,988	29,797	(191)
May	32,607	33,632	1,025
June	30,521	30,930	409
July	31,618	32,014	396
<b>Total</b>	<b>124,734</b>	<b>126,373</b>	<b>1,639</b>

### Performance by Activity Type and Commissioner

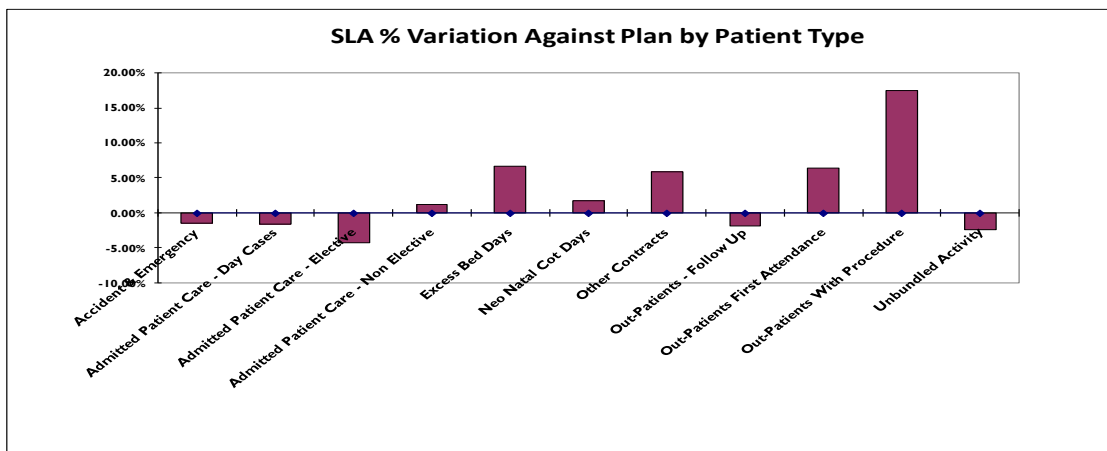
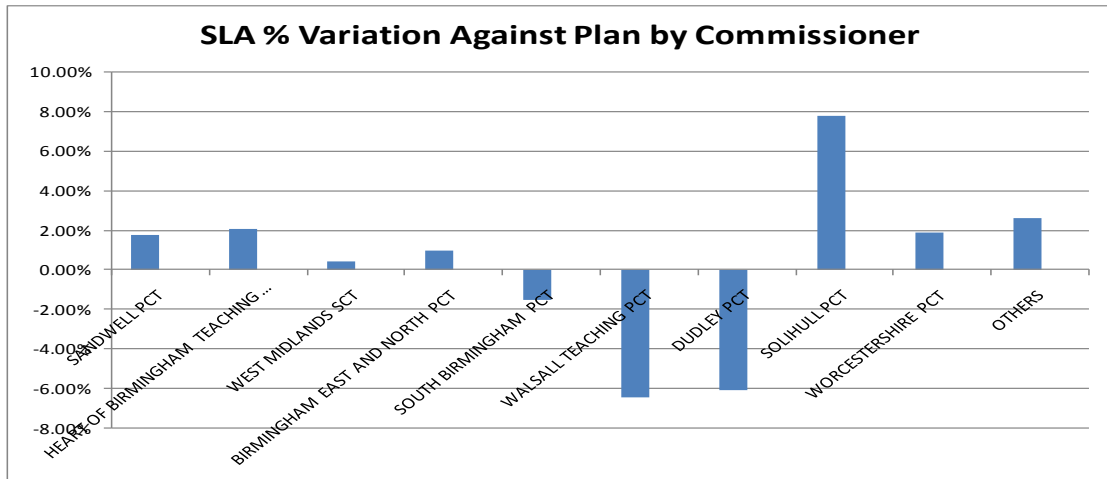
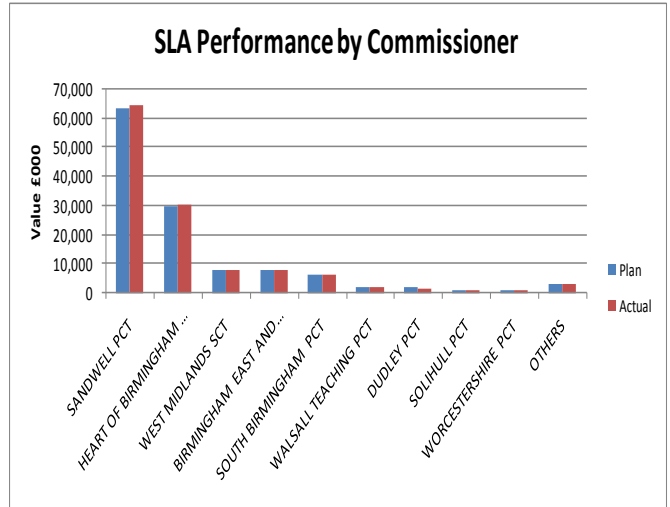
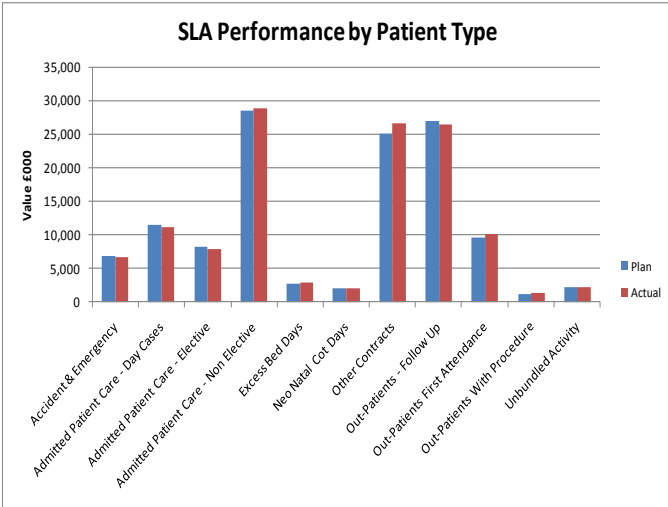
- The following graphs show performance by activity type and commissioner comparing planned and actual financial values for the year to date and the percentage variance from plan for each type of activity and commissioner.

# Sandwell and West Birmingham Hospitals



NHS Trust

## Financial Performance Report – August 2012



# Sandwell and West Birmingham Hospitals

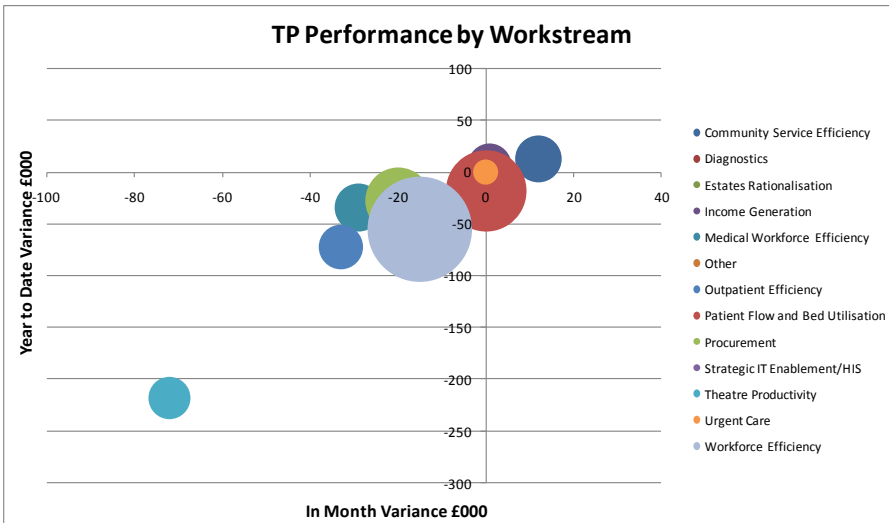
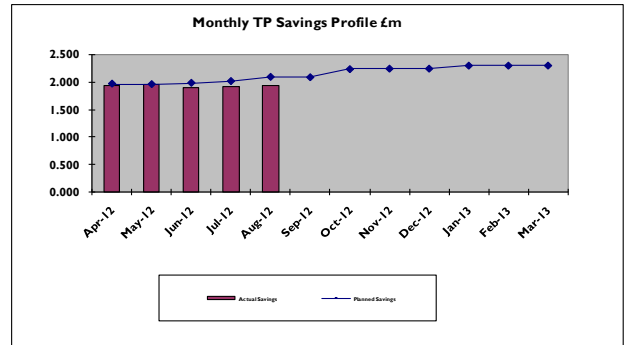


NHS Trust

## Financial Performance Report – August 2012

### Transformation Programme

- The adjacent table shows actual progress against the Trust's Transformation Programme for 2012/13, inclusive of RCRH related changes.
- At 31<sup>st</sup> August, actual savings were £405,000 or 4.03% lower than planned levels although the full year effect is maintained at the level of the initial plan.
- The forecast outturn for the programme remains in line with the original plan and the full year recurrent effect of the programme remains in excess of the 2012/13 requirement.



**Transformation Programme**

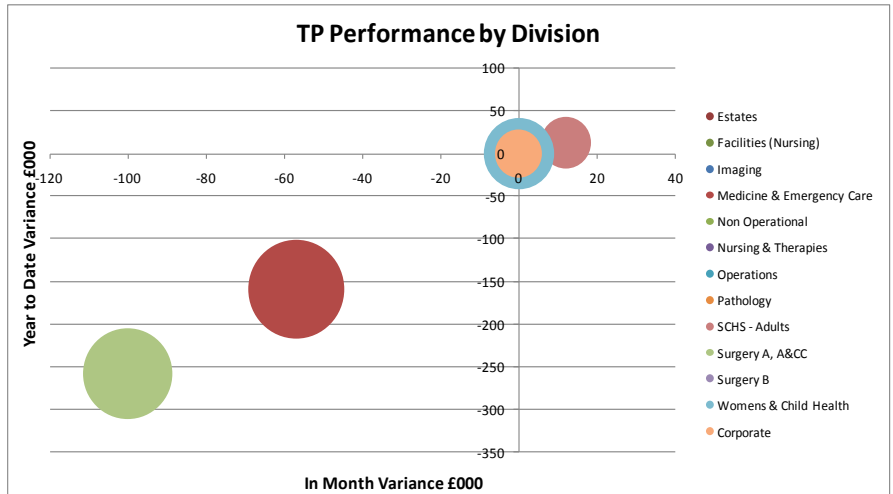
• The adjacent chart shows in month and year to date performance of the Transformation Programme by workstream.

• At August, 6 workstreams have an adverse year to date variance against plan although the majority of these are fairly negligible. The largest adverse variance of (£218,000) relates to theatre productivity.

**Transformation Programme**

• At the end of August, 2 divisions are reporting a cumulative adverse variance: Surgery A, Anaesthetics & Critical Care and Medicine & Emergency Care.

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



## Financial Performance Report – August 2012

### External Focus

- Economic news, both nationally and internationally, generally continues to be poor with ongoing indications of a sustained slowdown.
- Within the local NHS, Birmingham & Solihull Cluster continues to regard the 2012/13 financial position as challenging with a requirement to achieve QIPP savings of £58m, 2.4% of the overall Cluster budget, a control total surplus of £4m having been agreed with the SHA.
- Its latest financial report shows that overall the Cluster is £0.7m ahead of the year to date surplus target of £1.3m mainly due to the contingency sum and non recurrent reserves released against the contractual over performance. The report identifies pressures beginning to emerge against certain contracts – in particular UHB and more recently at Sandwell & West Birmingham. The cluster expects to fully use its contingency sum of £24m in 2012/13.
- The report specifically identifies elements outside the risk sharing agreement with SWBH and particularly electives on a best practice tariff, obstetrics and high cost drugs with a current year end forecast overspend of £2m although the high level of referrals being experienced may result in further pressures later in the year.
- The Black Country Cluster generated a revenue surplus of £5.5m up to June 2012, slightly ahead of trajectory, with the full year forecast being a £19.8m planned surplus. Based on the first two months data (which, given its limited extent, needs to be treated with a degree of caution), the cluster has not recognised any significant variance against NHS trust contracts. However, this position obviously may change as the year progresses both as more data become available and as more up to date position on referrals is identified.

### Conclusions

- Measured against the DoH target, the Trust generated an actual surplus of £365,000 during August against a planned surplus of £363,000. For the purposes of its statutory accounts, the in month surplus was higher at £394,000. This represents a significant increase on the surplus delivered in previous months and reflects the profiling of the Trust's financial plan and particularly the impact of the TSP.
- The £365,000 surplus in August is £2,000 better than planned for the month.
- For the year to date, the Trust has generated a surplus (as measured against the DoH target) of £620,000 which is £135,000 better than the planned position.
- In month capital expenditure is £394,000 which remains lower than planned although the plan is significantly weighted towards the latter part of the year. The main reason for the variance from plan is the later than planned acquisition of land in Grove Lane.
- At 31<sup>st</sup> August, cash balances are approximately £20.9m higher than the cash plan and around £14.3m greater than the balance held at 31<sup>st</sup> March.

**Financial Performance Report – August 2012****Conclusions cont**

- There are a significant number of non material adverse variances reported in month and all divisions remain broadly in line with the bottom line plan for the year to date. However, performance is reflective of the increased bottom line and TSP targets in month and these targets increase steadily further as the year progresses. The TSP performance reflects pressure in delivery in certain divisions for which mitigation/contingency plans will be required. This in part reflects high levels of demand both on bed capacity and in the Emergency departments leading to additional expenditure in these areas.
- Monitoring of divisional performance continues with action being taken as necessary to rectify any potential and/or actual variances. Similarly, monitoring of the performance of the Transformation Programme will continue to be a key component of this.

**Recommendations**

The Trust Board is asked to:

- i. **NOTE** 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**

**TRUST BOARD**

<b>DOCUMENT TITLE:</b>	Monthly Corporate Performance Monitoring Report				
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Robert White, Director of Finance and Performance Mgt				
<b>AUTHOR:</b>	Mike Harding, Head of Performance Management				
<b>DATE OF MEETING:</b>	27 September 2012				
<b>EXECUTIVE SUMMARY:</b>					
The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – August 2012.					
<b>REPORT RECOMMENDATION:</b>					
The Trust Board is asked to NOTE the report and its associated commentary.					
<b>ACTION REQUIRED</b> <i>(Indicate with 'x' the purpose that applies):</i>					
The receiving body is asked to receive, consider and:					
<b>Accept</b>		<b>Approve the recommendation</b>		<b>Discuss</b>	
				<b>x</b>	
<b>KEY AREAS OF IMPACT</b> <i>(Indicate with 'x' all those that apply):</i>					
Financial	<b>x</b>	Environmental	<b>x</b>	Communications & Media	<b>x</b>
Business and market share	<b>x</b>	Legal & Policy	<b>x</b>	Patient Experience	<b>x</b>
Clinical	<b>x</b>	Equality and Diversity		Workforce	<b>x</b>
Comments:					
<b>ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:</b>					
Accessible and Responsive Care, High Quality Care and Good Use of Resources. National targets and Infection Control. Internal Control and Value for Money					
<b>PREVIOUS CONSIDERATION:</b>					
Performance Management Board & Trust Management Board on 18 September 2012 and Finance & Performance Management Committee on 20 September 2012.					

**SUCCESSSES AND EXCEPTIONS**

<b>Patient Safety</b>	
	<b>SUCCESSSES</b>
a	<b>Stroke Care</b> - performance against the target for patients who spent at least 90% of their hospital stay on a Stroke Unit continues to be maintained above the 80% threshold. Data for August for <b>TIA</b> (High Risk) Treatment (within 24 hours of initial presentation) indicates performance of 75.0% overall, comprising 66.7% at Sandwell and 100% at City.
b	<b>Infection Control</b> - The number of C Diff cases reported during the month of August was 6 compared with a trajectory for the month of 5. Year to date cases total 14, well within the trajectory for the period of 25. The Department of Health NHS Performance Framework states that Trusts with a number of cases at the level of, or better than plan for the period to date, will be performance managed as Green or Achieving. Monitor's Compliance Framework states that if a Trust remains within the in-year trajectory for the national objective, no (adverse) score will be applied. The number of cases of MRSA Bacteraemia reported for the year to date remains 1, with no cases reported during August.
	<b>Appropriate use of Warfarin</b> - this CQUIN requires a quarterly audit of patients admitted taking warfarin with an International Normalised Ratio (INR) above 5.0 whose dosage has been adjusted or reviewed prior to the next warfarin dose. Systems are now established to monitor performance and report. the Trust was fully compliant with audit requirements during Q1.
	<b>Safety Thermometer (Acute Services)</b> - this CQUIN requires the monthly (one day per month) surveying of all appropriately defined patients to collect data on 4 outcomes; Pressure Ulcers, Falls, Urinary Tract Infection and VTE and its submission to the Information Centre. Data collection systems have been established and data submitted for each month year to date.
	<b>Use of Antibiotics - Antimicrobial Stewardship</b> - requires a quarterly self-assessment audit of prescribing of antibiotics in agreed specialities. A baseline compliance score of 60 has been established. An improvement trajectory / action plan to an end of year target of 80 is identified. Other requirements of this CQUIN; Prescribing Audit and Snapshot of Antibiotic Prescribing are also being met.
	<b>Reducing avoidable pressure ulcers for all (Acute) inpatients</b> - target is the continued provision of data through audit (as part of Safety Thermometer). Compliant to date.
	<b>Nutrition and Weight Management (Acute Services)</b> - this CQUIN is to reduce avoidable hospital acquired weight loss in elderly care and stroke patients. The requirement is to provide data through audit, for both Acute and Community services, across an extended (from original) scope of patients, with the intention that the process is fully integrated with the Safety Thermometer audit in Quarter 4 and demonstrate that 95% of patients receive harm-free care.
e	<b>Ensuring Safe Surgery (WHO Checklist)</b> - To take measures to ensure 100% compliance with SHA defined areas (theatres) and improvement trajectory for other (non-SHA defined) areas following Q1 baseline assessment. Performance in Theatres during August is 99.7%, performance in non-Theatre areas (Endoscopy, Radiology, Pain Management and Cardiology) is 99.6%.
	<b>Stroke Discharge</b> - comprises 4 components, a) CT Scan within 24 hours of arrival (95%), b) Swallow Screen completed within 4 hours of presentation (70%), c) Prescription / Administration to eligible patients within 24 hours of presentation of anti-platelet agents (90%), d) Commencement of anti-coagulation / Management Plan in place on discharge (60%). a) is assessed quarterly. b), c) and d) have had a Q1 baseline assessment and an improvement trajectory has been determined. The first component (CT Scans within 24 hours of arrival) has been met for the period to date.
	<b>Safety Thermometer (Community IP Services - Henderson and Leasowes)</b> - this CQUIN requires the monthly (one day per month) surveying of all appropriately defined patients to collect data on 4 outcomes; Pressure Ulcers, Falls, Urinary Tract Infection and VTE and its submission to the Information Centre. Submission of data for 3 consecutive months within the quarter triggers payment for the period Quarters 2 - 4 inclusive. Data has been collected and submitted for each month year to date.
	<b>Reducing avoidable pressure ulcers (Community IP Services - Henderson &amp; Leasowes)</b> - target is the continued provision of data through audit (as part of Safety Thermometer). Compliant to date.
	<b>Nutrition and Weight Management (Community Services - Henderson &amp; Leasowes)</b> - this CQUIN is to reduce avoidable hospital acquired weight loss in elderly care and stroke patients. The requirement is to provide data through audit, for both Acute and Community services, across an extended (from original) scope of patients, with the intention that the process is fully integrated with the Safety Thermometer audit in Quarter 4 and demonstrate that 95% of patients receive harm-free care.
	<b>EXCEPTIONS</b>
c	<b>MRSA Screening</b> - the percentage of Elective and Non-Elective MRSA Screens has remained essentially stable during recent months. An improvement trajectory was set earlier in the year, leading to a target screen rate of 85%, the trajectory for Elective Screens is not currently being met.
d	<b>VTE (Venous Thromboembolism) Risk Assessment</b> - provisional data for August indicates performance of 86.2%, below the minimum 90% threshold.
f	<b>PDR</b> (12-month rolling) compliance improved slightly to 65.4%. Overall <b>Mandatory Training</b> compliance at the end of August also improved slightly to 80.8%, but is below the 85% end of August performance improvement trajectory.
	<b>Effectiveness Of Care</b>
	<b>SUCCESSSES</b>
g	<b>Dementia Risk Assessment (Acute Services)</b> - comprises 3 elements, a) Assessment (by screening question) of all emergency admissions aged 75+ for risk of dementia, b) Indicate the percentage of patients at risk, assessed using the dementia screening tool, c) Percentage of patients referred for specialist diagnosis / GP follow up following assessment using the dementia screening tool. The Quarter 4 target is to meet 90% for each of the 3 categories. A system to gather, report and record data has been established. Requirements for each month year to date have been met.
	<b>Mortality Review</b> - trajectory currently to review 60% of all qualifying (adult) deaths within hospital within 42 days of death each month is being met for each month reported to date, with year end (March 2012) target of 80%.
	<b>Dementia Risk Assessment (Community Services)</b> - comprises 3 elements, a) Assessment (by screening question) of all new patients to District Nursing caseload (wef April 2012) aged 75+ for risk of dementia, b) Indicate the percentage of patients at risk, assessed using the dementia screening tool, c) Percentage of patients referred for specialist diagnosis / GP follow up following assessment using the dementia screening tool. The Quarter 4 target is to meet 90% for each of the 3 categories. Requirements for each reported month year to date have been met.
h	The <b>Hospital Standardised Mortality Rate (HSMR)</b> of 88.3 for the Trust for the most recent 12-month cumulative period (ending May 2012) remains below 100, and compares with a Peer (SHA) rate of 93.3 and a Peer (National) rate of 90.5. The report also includes the most recent data for the <b>Summary Hospital-level Mortality Indicator (SHMI)</b> for 12-month cumulative periods, which for the Trust is 99.1.
i	Provisional data for August indicates 73.3% of patients with a <b>Fractured Neck of Femur</b> received an operation within 24 hours of admission. Year to date performance has improved to 69.5%.
	<b>Patient Experience</b>
	<b>SUCCESSSES</b>
m	<b>Mixed Sex Accommodation</b> - No breaches have been recorded for the 5 months year to date.
n	<b>Improve responsiveness to personal needs of patients (Acute Services)</b> - this CQUIN is a composite, calculated from 5 monthly in-patient survey questions, each relating to a different element of patient experience. The average composite score during the period September - November (66.6%) defines the baseline, against which an improvement of 5% is required during Quarter 4. Performance during the first 3 months has met the performance trajectory. Quarterly (in house) surveys are to be undertaken.
	<b>Net Promoter Score (Acute Services)</b> - the target is to deliver a 10 point improvement (by Q4) in the Net Promoter Score from a minimum survey size of 10% of inpatients. The month of April determined the baseline score of 55 with most recent performance during July meeting the trajectory of 58.



n (cont'd)	<b>End Of Life Care (EOL)</b> - To improve the percentage of patients receiving effective EOL care from the integrated SWBH NHST palliative care team including dying in their place of choice, and reduce the variation in use by ward of the supportive care pathway by patients known to palliative care. SWOT baseline established and end of year target of 53% identified. Performance during July was 55%.									
	<b>Alcohol Screening</b> - screen all defined (EAU, MAU and Cardiology, Diabetic Medicine and Gastroenterology Outpatients) patients aged 16 and over and offer brief intervention. I.T. Data system expanded to capture Cardiology and Endocrinology data. Q1 baseline established, audit periods and improvement trajectory to 80% determined.									
	<b>Smoking During Pregnancy</b> - comprises 2 elements, a) 80% eligible maternity staff to complete locally agreed training in delivering brief stop smoking advice by Q4 and improvement trajectory following baseline assessment of patient smoking status, checking and recording at booking, or first midwife contact. During Q1, 34% of eligible staff were trained. Smoking status baseline data awaited.									
	<b>Improve responsiveness to personal needs of patients (Community IP Services - Henderson and Leasowes)</b> - this CQUIN is a composite, calculated from 5 monthly in-patient survey questions, each relating to a different element of patient experience. The proposal is to maintain a score of 90% each quarter. July data for Leasowes is 91%.									
	<b>Net Promoter Score (Community IP Services - Henderson and Leasowes)</b> - the proposed target is to maintain the baseline score of 75, from a minimum survey size of 10% of inpatients. During the month of July this was achieved.									
	<b>Every Contact Counts (Community Services - new patients to District Nursing caseload (wef April))</b> - comprises 3 elements, a) Staff completing locally agreed training in delivering brief advice as required to implement the Making Every Contact Count (MECC) ambition, b) Delivery of advice, c) Referrals to any lifestyle service from contacts. Requires a Q1 baseline and improvement trajectory. Data capture system to be implemented mid August. First full month of data anticipated for September. Training component being met.									
	<b>Smoking Cessation (Community Services - new patients to District Nursing caseload (wef April))</b> - comprises 3 elements, a) Number of patients with smoking status recorded, b) Number of patients given brief stop smoking advice, c) Number of patients referred to the Stop Smoking Service. Requires a Q1 baseline and improvement trajectory. Data capture system to be implemented mid August. First full month of data anticipated for September.									
	<b>Clinical Quality Dashboards (Specialised Services)</b> - CQUIN is to implement and demonstrate routine use of clinical quality dashboards for specialised services (Cardiology, Paediatric Intensive Care and Neonatal Services). Required progress is on track.									
	<b>Neonatology (Specialised Services) - Increase effective use of hypothermia treatment</b> - CQUIN is for pathway for therapeutic hypothermia to be utilised for all babies meeting criteria (excluding those born at home). Q1 baseline assessment completed and submitted to commissioners.									
	<b>Neonatology (Specialised Services) - Discharge Planning / Family Experience and Confidence</b> - CQUIN is for 95% of babies transitioned / discharged from neonatal care by 44 weeks corrected gestation. Baseline assessment completed and submitted to commissioners.									
<b>HIV (Specialised Services - Ensure therapy is optimised)</b> -Number of patients failing therapy (as measured by a detectable viral load) who are stabilised quickly and regain an undetectable viral load. Required progress is on track.										
<b>EXCEPTIONS</b>										
j	<b>Accident &amp; Emergency</b> - performance during August against the 4-hour maximum wait target was 93.2%, remaining below the 95.0% operational threshold. Performance for the year to date is also below the operational threshold, at 94.6%. The Trust met 2 of the 5 <b>Clinical Quality Indicators</b> during the month, 1 in each of the 2 groupings, timeliness and patient impact.									
k	<b>Imaging Reporting Times</b> - data on the percentage of Imaging Requests from A&E, by modality, reported within 24 hours is included. A trajectory to deliver to the national standard of 90% is to be determined.									
l	<b>Ambulance Turnaround</b> - the indicators within the report reflect those contained in the Quality section of the Trust's 2012 / 2013 contract with its commissioners, which focus on Clinical Handovers (% in <15 mins), Average Turnaround (mins : secs) and the number of ambulances turned around in excess of 60 minutes. Currently the Trust is not meeting any of the targets identified. Clinical Handover data is now provided by WMAS with effect from August.									
<b>Transformation Plan</b>										
<b>SUCCESSES</b>										
o	Activity (trust-wide) to date is compared with the contracted activity plan for <b>2012 / 2013</b> - Month and Year to Date.									
		Month				Year to Date				
		Actual	Plan	Variance	%	Actual	Plan	Variance	%	
		IP Elective	1034	936	98	10.5	4597	4622	-25	-0.5
		Day case	4017	4003	14	0.3	21399	19775	1624	8.2
		IPE plus DC	5051	4939	112	2.3	25996	24397	1599	6.6
		IP Non-Elective	4751	4397	354	8.1	23644	23133	511	2.2
		OP New	13634	12333	1301	10.5	70140	60712	9428	15.5
		OP Review	31369	37354	-5985	-16.0	162529	181386	-18857	-10.4
		OP Review:New	2.30	3.03	-0.73	-24.0	2.32	2.99	-0.67	-22.4
	AE Type I	14293	13763	530	3.9	75670	74438	1232	1.7	
	AE Type II	2143	2925	-782	-26.7	12334	15821	-3487	-22.0	
	Adult Community	49385	42253	7132	16.9	183578	164245	19333	11.8	
	Child Community	12909	13985	-1076	-7.7	51871	54623	-2752	-5.0	
	Activity to date is compared with <b>2011 / 12</b> for the corresponding period									
		2011 / 12	2012 / 13	Variance	%	Overall Elective activity for the month and year to date remains in excess of the plan by 2.3% and 6.6% for the periods respectively. Non Elective activity exceeded the plan for the month by 8.1%, and exceeds the plan for year to date by 2.2%. Month and year to date New and Review Outpatient performance is such that the Follow Up : New Outpatient Ratio for the year to date remains 2.32 which compares favourably with a ratio derived from plan of 2.99. A&E Type I activity (+1.7%) is essentially on plan for the year to date although Type II (BMEC) activity (-22.0%) remains well below plan. Adult Community activity is currently 11.8% above plan for the year to date. Child Community activity is 5.0% below plan. Activity for the period to date is compared with the corresponding period last year in the table opposite.				
	IP Elective	4535	4597	62	1.4					
	Day case	22087	21399	-688	-3.1					
	IPE plus DC	26622	25996	-626	-2.4					
	IP Non-Elective	22423	23644	1221	5.4					
	OP New	65840	70140	4300	6.5					
	OP Review	173840	162529	-11311	-6.5					
	OP Review:New	2.64	2.32	-0.32	-12.2					
	AE Type I	74835	75670	835	1.1					
	AE Type II	16096	12334	-3762	-23.4					
	Adult Community	160825	183578	22753	14.1					
	Child Community	48082	51871	3789	7.9					
<b>EXCEPTIONS</b>										
p	<b>Sickness Absence</b> - overall Sickness Absence reduced slightly during July to 4.16% (4.23% during June). The range by Division has also reduced to 0.00% - 4.92%. The current trajectory is <3.25%.									
<b>Key Access Targets</b>										
<b>SUCCESSES</b>										
r	During the month (August) <b>Delayed Transfers of Care</b> remain stable at a level well below the 3.5% target. Year to date delays are 3.1%.									
s	<b>Cancelled Operations</b> - the overall number and proportion of cancelled operations reduced during the month of August. There remain no breaches of the 28-day guarantee for the year to date.									
<b>EXCEPTIONS</b>										
q	<b>Cancer</b> - All high level Cancer Waiting times targets were met within month (July) with the exception of the 62-day referral (upgrade) to treatment from hospital specialist, where this standard was met in 84.4% of cases (85% performance threshold). Other cancer waiting times standards were met within month, and all continue to be met for the year to date.									



Exec Lead	PATIENT SAFETY						April	May	June	July			August			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn										
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13														
DS	H	3	Stroke Care	Pts spending >90% stay on Acute Stroke Unit	%	91.2	▼	93.9	▲	94.1	▲	→	85.1	▼	→	84.9	▼	89.7	83	83	a	No Variation	0 - 2% Variation	>2% Variation	●	72.8	85.9								
	K			Pts admitted to Acute Stroke Unit within 4 hrs	%	79.3	▲	72.2	▼	73.1	▲	→	→	→	64.0	▼	→	→	70.8	▲		71.2	90	90	No Variation	0 - 2% Variation	>2% Variation	●●		68.7					
	K			Pts receiving CT Scan within 24 hrs of arrival	%	100	■	100	■	92.3	■	→	→	→	94.0	▲	→	→	91.7	▼		95.3	100	100	No Variation	0 - 2% Variation	>2% Variation	●		100					
	K			Pts receiving CT Scan within 1 hr of arrival	%	72.4	▲	61.1	▼	58.3	▼	→	→	→	51.3	▼	→	→	45.8	■		57.9	50	50	No Variation	0 - 2% Variation	>2% Variation	●		37.5					
	H			TIA (High Risk) Treatment <24 h from initial presentation	%	61.5	▼	50.0	■	100	■	71.4	▼	42.9	■	57.1	■	66.7	▼	100		■	75.0	■	66.1	60	60	No Variation	0 - 2% Variation	>2% Variation	●	46.15	53.2		
	K			TIA (Low Risk) Treatment <7 days from initial presentation	%	53.6	■	48.2	▼	47.4	▼	50.0	■	61.1	■	58.3	■	86.7	■	80.0		▲	82.5	■	60.9	60	60	No Variation	0 - 2% Variation	>2% Variation	●		30.4		
RO	A	4	Infection Control	C. Difficile (DH Reportable)	No.	3	▲	2	▲	1	▲	0	■	2	▼	2	▼	2	▼	4	■	6	■	14	25	57	b	No variation		Any variation	●	120	95		
	K			C. Difficile (Best Practice Numbers)	No.	7	■	6	▲	5	▲	2	■	5	▼	7	▼	4	▼	8	■	12	■	12	■	37		40	95	No variation		Any variation	●	120	95
	A			MRSA Bacteraemia	No.	0	■	0	■	1	■	0	■	0	■	0	■	0	■	0	■	0	■	0	■	1		1	2	No variation		Any variation	●	5	2
				MSSA Bacteraemia	No.	1		6		4		0		0		0		0		1		1		1		12		No. Only	No. Only					22	12
				E Coli Bacteraemia	No.	3		3		5		1		2		3		1		2		3		3		17		No. Only	No. Only					73	50
	F			MRSA Screening (Elective)	%	38.3	■	42.2	▲	42.9	▲	Numerator = 1219	Denominator = 2898	42.1	■	Numerator = 1046	Denominator = 2650	39.5	▼	39.5*	50	85	c	No variation		Any variation		●●	40.3	40.6					
F	MRSA Screening (Non-Elective)	%	70.5	■	68.6	▼	68.7	▲	Numerator = 1358	Denominator = 1992	68.2	▼	Numerator = 1341	Denominator = 1941	69.1	▲	69.1*	50	85	No variation		Any variation		●	18.9	26.0									
DS	A	3	VTE Risk Assessment (Adult IP)	396	%	92.4	▼	92.9	▲	91.0	▼	→	90.3	▼	→	86.2	■	86.2*	90	90	d	=>90		<90	●	92.3	92.4								
RB	K	20	Appropriate Use of Warfarin	372		→		→	Compliant		→	→	→	→	→	→	Compliant	Comply with audit		No variation			Any variation	●											
RB	H	8	Safety Thermometer	396	%	Data Submitted	Data Submitted	Data Submitted	→	→	→	→	Data Submitted	→	→	→	Data Submitted	Data Submitted	Monthly data collection		No variation		Any variation	●											
RB	H	20	Antibiotic Use	743	Score	→	→	60	Base	Quarterly Audit			Quarterly Audit			60	Base		80		No variation		Any variation	●											
RO	D	8	Reducing Avoidable Pressure Ulcers	372	No.	Compliant	Compliant	Compliant	→	→	→	→	Compliant	→	→	→	Compliant	Compliant	Comply with audit		No variation		Any variation	●											
RO	H	8	Nutrition and Weight Management	743		→	→	Q1 Base Audit Complete	→	→	→	→	Compliant	→	→	→	Compliant	Compliant	Comply with audit		No variation		Any variation	●											
DS	H	9	Safe Surgery - Operating Theatres	743	%	→	→	→	→	→	→	→	→	→	→	→	99.7	■	99.7	99	100	e	No variation		Any variation	●									
			Safe Surgery - Other Areas		%	→	→	→	→	→	→	→	→	→	→	→	→	99.6	■	99.6	98		98	No variation		Any variation	●								
DS	H	10	Stroke Care	743	%	→	→	Met Q1 req's	→	→	→	→	→	→	→	→	→	Met Q1 req's	Comply	Comply		No variation		Any variation	●										
RO	H	11	Community CQUIN	Safety Thermometer	88	%	Data Submitted	Data Submitted	Data Submitted	→	→	→	Data Submitted	→	→	→	Data Submitted	Data Submitted	Monthly data collection		No variation		Any variation	●											
RO	D		Reducing Avoidable Pressure Ulcers	176		Compliant	Compliant	Compliant	→	→	→	→	→	Compliant	→	→	→	Compliant	Comply with audit		No variation		Any variation	●											
RO	H		Nutrition and Weight Management	176		→	→	Q1 Base Audit Complete	→	→	→	→	→	Compliant	→	→	→	Compliant	Comply with audit		No variation		Any variation	●											
KD	F	14	Never Events - in month	No.	0	■	0	■	0	■	→	→	1	■	→	→	0	■	0*	0	0		No variation		Any variation	●									
	F		Open Serious Incidents Requiring Investigation (SIRI)	No.	8		7		9		→	→	→	10		→	→	4		4*	No. Only	No. Only													
	F		Open Central Alert System (CAS) Alerts	No.	20		19		17		→	→	→	14		→	→	9		9*	No. Only	No. Only													
DS	D	100% Compliance WHO Surgical Checklist	Y / N	N	■	N	■	N	■	→	→	→	N	■	→	→	N	■	No	Y	Y		Y		N										
RO	D	Falls Resukting In Severe Injury or Death	No	3	▼	0	■	1	■	→	→	→	1	■	→	→	2	▼	2*	0	0		No variation		Any variation	●									
RO		8	High Impact Nursing Actions	Inpatient Falls reduction	%	74	■	59	▲	60	▼	→	→	→	→	→	→	193		171	684		=<57/m		>57/m	●	1024	763							
			Nutritional Assessment (MUST)	%	98	▲	96	▼	94	▼	→	→	→	85	■	→	→	90	■	90*	90	90		=>90		<90	●		89.0						
			Fluid Balance Chart Completion	%	100		99		100		→	→	→	98		→	→	98*										100							

Exec Lead	PATIENT SAFETY (Continued)				April	May	June	July			August			To Date (*most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn				
					Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13											
DS	H	3	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	0	3	0	→	0	→	0	3	20	48	≤<2	3 - 4	>4	●	9	7						
				Admissions to Neonatal ICU	%	11.4	9.9	10.4	→	10.5	→	10.5	≤<10	≤<10	≤<10	10.0-12.0	>12.0	●	7.2	10.7							
				Adjusted Perinatal Mortality Rate (per 1000 babies)	/1000	4.1	2.0	7.6	→	→	→	7.6*	<8.0	<8.0	<8	8.1 - 10.0	>10	●	6.5	11.9*							
				Caesarean Section Rate	%	22.9	24.1	19.8	→	→	→	23.9	<25.0	<25.0	≤<25.0	25-28	>28.0	●	23.6	22.2							
				Early Booking (Completed Assessment <12+6 weeks)	%	78	80	79	→	→	→	79*	⇒90	⇒90	⇒90	75-89	<75	●●●●	76.0								
RO	2	Infant Health & Inequalities	Maternal Smoking Rates	%	→	→	10.4	→	→	→	→	10.4	<11.5	<11.5	<11.5	11.5 - 12.5	>12.5	●	11.9	9.8							
			Breast Feeding Initiation Rates	%	→	→	71.9	→	→	→	→	→	71.9	>63.0	>63.0	>63.0	61-63	<61.0	●	65.6	73.0						
RB	H	12	Number of Health Visitors in Post	No.				→																			
RB		5	Cervical Cytology	Diagnostic Report Turnaround	Days	<9 days	<9 days	<9 days	→	<9 days	→	<9 days	<9 days	<9 days	<9 days	<9 days	<9 days	●	<9 days	<9 days							
RB	K	3	Learning & Development	PDRs (12-month rolling)	No. (%)	5291 (71.6)	5390 (72.9)	5166 (69.9)	→	4805 (65.0)	→	4836 (65.4)	4836 (65.4)	7389 (100)	7389 (100)	No. Only	No. Only	f	0-15% variation	15 - 25% variation	>25% variation	●●	4635	5348			
				Medical Appraisal and Revalidation	%	74	78	69	→	71	→	79	79	No. Only	No. Only												
				Mandatory Training Compliance	%	74.6	77.8	78.9	→	79.4	→	80.8	100	100	⇒85	80 - 85	<80	●●	86.8	71.9							
EFFECTIVENESS OF CARE																											
RO	H	8	Acute CQUIN	Dementia	396	%	Met Q1 req's	Met Q1 req's	Met Q1 req's	→	Meeting Q2 req's	→	Meeting Q2 req's	Meeting Q2 req's	70	90	g	No variation	Any variation	●	66.9						
DS	H	3		Mortality Review	743	%	71.9	69.0	70.6	→		→		70.6*	60	80		No variation	Any variation	●							
RO	H	11		Community CQUIN	Dementia	44	%	→	Met Q1 req's	Met Q1 req's	→	Meeting Q2 req's	→		Meeting Q2 req's	70		90	No variation	Any variation		●					
DS	D	19	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate	HSMR	93.1	Feb'11 to Jan'12	92.3	Mar'11 to Feb'12	90.5	Apr'11 to Mar'12	→	89.7	May'11 to Apr'12	→	88.3	Jun'11 to May'12	88.3	h								
				Peer (SHA) HSMR	HSMR	98.3	97.4	95.8	→	94.9	→	93.3	93.3														
				Peer (National) HSMR - Quarterly	HSMR	→	→	90.5	→	→	→	90.5															
			SHMI	SHMI	99.8	Oct'10 - Sep'11	101.3	Nov'10 - Oct'11	99.8	Dec'10 - Nov'11	→	99.1	Jan'11 - Dec'11	→	99.1	Jan'11 - Dec'11	99.1										
RB	K	3	Readmission Rates (to any speciality) within 30 days of discharge - Operating Framework Definition effective April 2011	Following initial Elective Admission	No.	136	164	117	→	139	→	127	683	610	1463	No Variation	0 - 5% Variation	>5% Variation	●	1463							
				Following initial Elective Admission	%	1.36	1.43	1.15	→	1.26	→	1.23	1.29	1.15	1.15	No Variation	0 - 5% Variation	>5% Variation	●	1.15							
				Following initial Non-Elective Admission	No.	604	682	612	→	710	→	501	3109	2850	6842	No Variation	0 - 5% Variation	>5% Variation	●	6842							
				Following initial Non-Elective Admission	%	6.03	5.94	6.03	→	6.41	→	4.87	5.86	5.38	5.38	No Variation	0 - 5% Variation	>5% Variation	●	5.38							
RB	K	3	Hip Fractures	Operation <24 hours of admission	%	66.7	56.3	62.5	→	80.0	→	73.3	69.5	70.0	70.0	i	No Variation	0 - 2% Variation	>2% Variation	●	64.7 (Q4)	66.4					
RB	G	11	Data Quality	Valid Coding for Ethnic Category (FCEs)	%	94	95	94	→	95	→	95	95	90	90	≥90	89.0-89.9	<89	●	94.5	95						
				Maternity HES	%	6.1	6.2	6.1	→	6.4	→	6.3	6.2	<15	<15	≤<15	16-30	>30	●	5.4	6.0						
				Data Completeness Community Services	%	No Data	No Data	No Data	→	No Data	→	No Data	No Data	⇒50	⇒50	⇒50	<50	●●●●									
				SUS Altered Data	%				→		→																
PATIENT EXPERIENCE																											
RB	D	3	A&E 4-hour waits	4-hour waits	%	95.3	95.7	94.3	→	95.0	→	94.1	94.5	94.3	92.4	93.2	94.63	⇒95	⇒95	⇒95	<95	●	96.99	95.38			
				Total Time in Department (95th centile)	h : m	3 : 59	3 : 59	4 : 41	→	4 : 34	→	4 : 37	4 : 30	⇒<4hrs	⇒<4hrs	⇒<4hrs	⇒<4hrs	⇒<4hrs	⇒<4hrs	⇒<4hrs	⇒<4hrs	⇒<4hrs	⇒<4hrs	⇒<4hrs	3 : 59		
				Time to Initial Assessment (≤15 mins)(95th centile)	mins	18	15	17	→	17	→	18	17	<15	<15	<15	<15	<15	<15	<15	<15	<15	<15	●●	21		
				Time to treatment in department (median)	mins	64	62	67	→	66	→	60	64	<60	<60	<60	<60	<60	<60	<60	<60	<60	<60	●	59		
				Unplanned re-attendance rate	%	7.70	7.94	8.38	→	8.26	→	8.25	8.09	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	8.66
				Left Department without being seen rate	%	4.88	4.91	5.57	→	5.26	→	4.91	5.10	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	⇒<5.0	4.83
RB		21	Reporting Times of Imaging Requests from A&E (by Modality) - percentage reported within 24 hours	Plain Radiography	%	8	7	4	→	11	→	14	14*	90													
				Ultrasound	%	81	100	100	→	97	→	100	100*	90													
				MRI	%	53	71	62	→	82	→	60	60*	90													
				CT	%	97	97	98	→	98	→	98	98*	90													

Exec Lead	PATIENT EXPERIENCE (Continued)					April	May	June	July			August			To Date (=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn		
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13									
RB	H	18	Ambulance Turnaround	Clinical Handovers completed within 15 minutes	%							74.5	83.2	79.4	79.4	=>85	=>85	I	=>85	<-85	●●	18:41				
	H			Average Turnaround Time	m : s	31:20	30:56	32:14	34:26	31:28	32:44	33:49	31:39	32:37	31:57	=<30:00	=<30:00		=<30:00	>30:00	●	29:23				
	H			In Excess of 60 minutes	No.	106	122	131	94	72	166	70	79	149	674	0	0		0	>0	●●●	1256				
RB	B	2	Mixed Sex Accommodation (Total Number of Breaches)	%	0.00	0.00	0.00	→	0.00	→	0.00	→	0.00	0.00	0.0	0.0	m	0.00	0.00 - 0.50	>0.50	●	0.07				
KD	F	14	Complaints	First Formal Complaints Received	No.	60	51	61	→	62	→	79	313	No. Only	No. Only							834				
RO	H	8	Acute CQUIN	Personal Needs	396	%	68.3	69.4	67.9	→	→	→	→	67.9	67.6	71.6	n	No variation	Any variation	●						
RO	H	8		Net Promoter	372	No.	55	Base	57	58	→	→	→	58	58	65		No variation	Any variation	●						
RO	H	8		End of Life Care	372	%	36	48	47	→	55	→	→	55	46	53		No variation	Any variation	●						
RB	H	10		Every Contact Counts - Alcohol	372	%	→	→	55	Base	Requires Quarterly Data Submission		Requires Quarterly Data Submission		55	Base		80			●					
RO	H	12		Every Contact Counts - Smoking	372	%	→	→	→	→	→	→	→													
RO	H	11		Pt. (Community) Exp'ce - Personal Needs	44	Score	→	→	→	→	90	→	→	90	90	90		No variation	Any variation	●						
RO	H	11	Community CQUIN	Net Promoter	88	No.	→	→	75	Base	→	Met	→	91	75	75	No variation	Any variation	●							
RO	H	11		Every Contact Counts	132	%	→	→	→	→	→	→	→													
RO	H	11		Smoking Cessation	132	%	→	→	→	→	→	→	→													
DS	H			Clinical Quality Dashboards	49		→	→	Q1 Data Submitted	Quarterly Assessment / Data Submission		Quarterly Assessment / Data Submission		Q1 Data Submitted	Submit Data	Submit Data	No variation	Any variation	●							
DS	H	13	Specialised Commissioners	Neonatal - Hypothermia Treatment	73	%	→	→	Q1 Data Submitted	Quarterly Assessment / Data Submission		Quarterly Assessment / Data Submission		Q1 Data Submitted	Derive Base	Derive Base	No variation	Any variation	●							
DS	H	13		Neonatal - Discharge Planning / Family Experience and Confidence	122	%	→	→	Q1 Data Submitted	Quarterly Assessment / Data Submission		Quarterly Assessment / Data Submission		Q1 Data Submitted	Derive Base	Derive Base	Met	Not Met	●							
DS	H	12		HIV - Optimum Therapy	147	%	→	→	Q1 Data Submitted	Quarterly Assessment / Data Submission		Quarterly Assessment / Data Submission		Q1 Data Submitted	Submit Data	Submit Data	No variation	Any variation	●							
RB	Elective Access Contact Centre	15	Number of Calls Received	No.	10379	13128	11426	→	12755	→	→	→	47688	No. Only	No. Only	<table border="1"> <tr> <td>&lt;1.0</td> <td>1.0-2.0</td> <td>&gt;2.0</td> <td>●</td> </tr> <tr> <td>&lt;6.0</td> <td>6.0-12.0</td> <td>&gt;12.0</td> <td>●●</td> </tr> </table>	<1.0	1.0-2.0	>2.0	●	<6.0	6.0-12.0	>12.0	●●	137824	111793
			<1.0	1.0-2.0	>2.0	●																				
			<6.0	6.0-12.0	>12.0	●●																				
	Average Length of Queue	mins	0.35	0.35	0.36	→	0.34	→	→	0.34*	<1.0	<1.0	0	0.21												
	Maximum Length of Queue	mins	16.4	16.5	7.2	→	12.4	→	→	12.4*	<6.0	<6.0	6.3	10												
	Telephone Exchange	Number of Calls Received	No.	69821	75443	71289	→	74174	→	→	75331	366058	No. Only	No. Only	909301	849502										
		Calls Answered	%	92.2	92.6	91.0	→	92.4	→	→	89.8	91.6	No. Only	No. Only	90.5	90.2										
		Answered within 15 seconds	%	57.0	57.9	51.1	→	57.0	→	→	54.6	55.6	No. Only	No. Only	52.4	52.5										
Answered within 30 seconds		%	72.7	73.7	67.2	→	72.9	→	→	70.1	71.3	No. Only	No. Only	68.4	68.1											
Average Ring Time		Secs	21.1	20.6	25.0	→	21.6	→	→	25.3	25.3*	No. Only	No. Only	21.2	25											
Longest Ring Time	Secs	523	940	462	→	780	→	→	1173	1173*	No. Only	No. Only	731	718												
TRANSFORMATION PLAN																										
RB	Spells	2	Elective IP	No.	717	917	848	→	1113	→	→	→	1034	4597	4622	10981	o	No Variation	0 - 2% Variation	>2% Variation		11748	10610			
			Elective DC	No.	4123	5003	3899	→	4278	→	→	4017	21399	19775	46983	No Variation		0 - 2% Variation	>2% Variation		53959	53685				
			Total Elective	No.	4840	5920	4747	→	5391	→	→	5051	25996	24397	57964	No Variation		0 - 2% Variation	>2% Variation	●	65707	64295				
			Non-Elective - Short Stay	No.	581	635	536	→	602	→	→	482	2829	2599	6416	No Variation		0 - 2% Variation	>2% Variation		16460	13918				
			Non-Elective - Other	No.	3981	4243	4182	→	4335	→	→	4269	20815	20534	50689	No Variation		0 - 2% Variation	>2% Variation		42540	41757				
			Total Non-Elective	No.	4562	4878	4718	→	4937	→	→	4751	23644	23133	57105	No Variation		0 - 2% Variation	>2% Variation	●	59000	55675				
	Outpatient Attendances	New	No.	12629	15663	12428	→	15147	→	→	13634	70140	60712	144072	No Variation	0 - 2% Variation	>2% Variation	●	163493	159051						
		Review	No.	30272	35673	28797	→	33831	→	→	31369	162529	181386	430846	No Variation	0 - 2% Variation	>2% Variation	●	440812	421494						
	A/E Attendances	Type I (Sandwell & City Main Units)	No.	14309	15951	15317	→	7071	8748	15819	6530	7763	14293	75670	74438	175107	No Variation	0 - 2% Variation	>2% Variation	●	181494	177201				
		Type II (BMEC)	No.	2762	2777	2293	→	2359	2359	2359	→	2143	2143	12334	15821	37217	No Variation	0 - 2% Variation	>2% Variation	●●●	36756	36362				
16	Community	Adult - Aggregation of 18 Individual Service Lines	No.	41538	48473	44182	→	49385	→	→	→	→	183578	164245	492472	No Variation	0 - 2% Variation	>2% Variation	●	461797	493163					
		Children - Aggregation of 4 Individual Service Lines	No.	11589	15902	11471	→	12909	→	→	→	→	→	51871	54623	158876	No Variation	0 - 2% Variation	>2% Variation	●	102773	143400				

Exec Lead	TRANSFORMATION PLAN (Continued)				April	May	June	July			August			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn	
					Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13		No Variation	0 - 5% Variation	>5% Variation				
RB	2	Outpatient Efficiency	New : Review Rate	Ratio	2.40	2.28	2.32	2.70	2.03	2.23	2.93	2.06	2.30	2.32	2.30	2.30	No Variation	0 - 5% Variation	>5% Variation	●	2.70	2.65		
			DNA Rate - New Referrals	%	11.4	10.7	11.9	→	→	11.8	→	→	12.6	11.3	10.0	10.0	No variation	0 - 5% Variation	>5% Variation	●●	13.1	11.8		
			DNA Rate - Reviews	%	10.6	9.7	10.6	→	→	11.4	→	→	10.9	10.3	10.0	10.0	No variation	0 - 5% Variation	>5% Variation	●	11.9	10.5		
RB	2	Patient Flow	Average Length of Stay	Days	4.2	4.0	3.9	3.8	3.2	3.4				3.9	4.3	4.3	No Variation	0 - 5% Variation	>5% Variation	●	4.3	4.2		
			Day of Surgery (IP Elective Surgery)	%	90.6	91.6	90.6	91.8	92.7	92.4	89.6	92.7	91.6	91.4	82.0	82.0	No Variation	0 - 5% Variation	>5% Variation	●	88.7	89.5		
			Daycase Rate - All Procedures	%	83.8	83.2	80.7	83.9	74.3	78.3	82.7	75.6	78.4	81.6	80.0	80.0	No Variation	0 - 5% Variation	>5% Variation	●	81.5	82.7		
RB	7	Sickness Absence	Long Term (> 28 days)	%	3.28	3.51	3.33	→	→	3.26	→	→		3.26 (Q2)	<2.20	<2.20	p	<2.20	2.20-2.55	>2.55	●	3.12	2.95	
			Short Term (<28 days)	%	0.78	0.99	0.90	→	→	0.90	→	→		0.90 (Q2)	<1.05	<1.05		<1.05	1.05-1.20	>1.20	●	1.05	0.95	
			Total	%	4.06	4.50	4.23	→	→	4.16	→	→		4.16 (Q2)	<3.25	<3.25		<3.25	3.25-3.75	>3.75	●●	4.17	3.90	
RB	17	Bank & Agency Use	Nurse Bank Fill Rate	%	86.3	90.6	85.7	→	→	89.1	→	→		87.6	No. Only	No. Only						86.2	87.2	
			Nurse Bank Shifts covered	No.	4451	4461	4682	→	→	4887	→	→	5333	23814	19575	46980		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	●●	54952	56396	
			Nurse Agency Shifts covered	No.	655	569	577	→	→	491	→	→	565	2857	1596	3830		0 - 5% Variation	5 - 10% Variation	>10% Variation	●●●	4550	6948	
KEY ACCESS TARGETS																								
RB	A	1	Cancer	2 weeks	%	94.6	94.8	94.0	→	→	95.6	→	→	94.8	⇒93	⇒93	q	No variation	Any variation	●	94.5	94.8		
				2 weeks (Breast Symptomatic)	%	96.5	98.7	93.0	→	→	100	→	→		97.0	⇒93		⇒93	No variation	Any variation	●	94.7	95.8	
				31 Day (diagnosis to treatment)	%	99.3	100	100	→	→	100	→	→		99.8	⇒96		⇒96	No variation	Any variation	●	99.7	99.5	
				31 Day (second/subsequent treatment - surgery)	%	98.9	100	100	→	→	100	→	→		99.7	⇒94		⇒94	No variation	Any variation	●	99.5	100.0	
				31 Day (second/subsequent treatment - drug)	%	100	100	100	→	→	100	→	→		100	⇒98		⇒98	No variation	Any variation	●	100	99.2	
				31 Day (second/subsequent treat - radiotherapy)	%	n/a	n/a	100	→	→	n/a	→	→		100	⇒94		⇒94	No variation	Any variation	●	100	100	
				62 Day (urgent GP referral to treatment)	%	86.5	86.7	86.0	→	→	86.4	→	→		86.4	⇒85		⇒85	No variation	Any variation	●	88.0	86.9	
				62 Day (referral to treat from screening)	%	100	100	100	→	→	90.0	→	→		98.9	⇒90		⇒90	No variation	Any variation	●	99.2	98.5	
RB	A	2	RTT 18-Weeks	Admitted Care (RTT <18 weeks)	%	94.1	93.9	93.6	→	→	94.3	→	→	94.3*	⇒90.0	⇒90.0	r	⇒90.0	85-90	<85.0	●	92.7	93.2	
				Non-Admitted Care (RTT <18 weeks)	%	98.8	99.4	96.7	→	→	99.0	→	→		99.0*	⇒95.0		⇒95.0	⇒95.0	90 - 95	<90.0	●	96.7	97.5
				Incomplete Pathway (RTT <18 weeks)	%	96.7	97.1	97.4	→	→	97.5	→	→		97.5*	⇒92.0		⇒92.0	⇒95.0	87 - 92	<87.0	●		97.2
				Treatment Functions Underperforming	No.	4	4	3	→	→	4	→	→		4*	0		0	0 / month	1 - 6 / month	>6 / month	●		10 (Q4)
				Audiology D.A Patients seen in <18 weeks	%	100	100	100	→	→	100	→	→		100	100		100	100	<100	●		100	
RB	E	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks	%	1.34	0.67	0.62	→	→	0.26	→	→	0.26*	<1.0	<1.0	s	<1.0	1.0 - 5.0	>5.0	●	4.6	5.2	
				Acute	%	3.6	4.4	2.7	2.5	2.7	2.6	2.5	2.6	2.5	3.1	<3.5		<3.5	<3.5	3.5 - 5.0	>5.0	●		
RB	H	2	Cancelled Operations	Pl's Social Care Delay	No.	16	19	10	2	1	3	4	7	11	11*	<18	<18	t	No Variation	0 - 10% Variation	>10% Variation		23	13
				Pl's NHS & NHS plus S.C. Delay	No.	12	7	13	2	2	4	2	6	8	8*	<10	<10		No Variation	0 - 10% Variation	>10% Variation		22	20
				Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.2	0.4	0.6	0.5	0.8	0.7	0.4	0.3	0.4	0.5	<0.8	<0.8		<0.8	0.8 - 1.0	>1.0	●	0.8	0.6
RB	H	2	Cancelled Operations	28 day breaches	No.	0	0	0	→	→	0	→	→	0	1	3	u	3 or less	4 - 6	>6	●	1	1	
				Sitrep Declared Late Cancellations by Speciality	No.	12	27	27	11	23	34	8	9	17	117	133		320	0-5% variation	5 - 15% variation	>15% variation	●	500	363
				Primary Angioplasty (<150 mins)	%	100	95.2	88.2	100	100	100	→	→		95.1	⇒80		⇒80	⇒80	75-79	<75	●	90.7	88.4
RB	12	GUM 48 Hours	Rapid Access Chest Pain	%	98.2	98.3	100							98.8	⇒98	⇒98	v	⇒98	96 - 97.9	<96	●	100.0	99.1	
			Patients offered app't within 48 hrs	%	100	100	100	→	→	100	→	→	100	⇒98	⇒98	⇒98		95-98	<95	●	100.0	100		
RO	G	8	Access to healthcare for people with Learning Disability (full compliance)	Y / N	N	N	Y	→	→	Y	→	→	Y	Yes	Full	Full	Y	N	●		N			

KEYS AND SUMMARY PERFORMANCE AGAINST INDICATORS WHICH COMPRISE NATIONAL PERFORMANCE FRAMEWORKS

NHS PERFORMANCE FRAMEWORK	April	May	June	July		August	
Performing	16	17	17	→	17	→	16
Underperforming	3	2	2	→	2	→	2
Failing	0	0	0	→	0	→	1
No Data	0	0	0	→	0	→	0
Average weighted Score	2.79	2.86	2.86	→	2.86	→	2.64

MONITOR COMPLIANCE FRAMEWORK	April	May	June	July		August	
Performing	14	14	14	→	14	→	14
Underperforming	1	1	1	→	1	→	1
No Data	1	1	1	→	1	→	1
Overall Governance Rating	1.5	1.5	2.0	→	2.0	→	2.0

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

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

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

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

<b>TRUST BOARD</b>
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<b>DOCUMENT TITLE:</b>	The NHS Performance Framework Monitoring Report and summary NHS FT Governance Risk Rating (FT Compliance Report)
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Robert White, Director of Finance and Performance Management
<b>AUTHOR:</b>	Mike Harding, Head of Performance Management and Tony Wharram, Deputy Director of Finance
<b>DATE OF MEETING:</b>	27 September 2012

**EXECUTIVE SUMMARY:**

The report provides an assessment of the Trust's performance mapped against the indicators which comprise the NHS Performance Framework.

**Service Performance (August):**

There were 3 areas of underperformance during the month of August; A&E 4-hour waits, where performance was 93.20%, VTE Risk Assessments (86.2%) and RTT Delivery in all specialities (projected). The overall average weighted score for service performance is 2.64. CQC Registration Status remains Unconditional. As such for the month of August the Trust attracts a **PERFORMING** classification.

**Financial Performance (August):**

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

**Foundation Trust Compliance Summary report (August):**

Within the Service Performance element of the Risk Rating for the month of **August** the Trust underperformed against the A&E 4-hour wait target and is currently unable to report its performance against the 'Data Completeness Community Services Indicator'. The overall score for the month is 2.0 which attracts an **AMBER / RED** Governance Rating.

(The number of C Diff cases reported during the month of August was 6 compared with a trajectory for the month of 5. Year to date cases total 14 (trajectory 25). Monitor's Compliance Framework states that if a Trust remains within the in-year trajectory for the national objective, no score will be applied.) Performance in areas where no data are currently available for the month are expected to meet operational standards.

**REPORT RECOMMENDATION:**

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

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		<b>x</b>

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

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

Comments:

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

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

**PREVIOUS CONSIDERATION:**

Performance M'tment Board, Trust M'tment Board and Finance & Performance M'tment Committee

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

QUALITY OF SERVICE

Integrated Performance Measures

Indicator

A/E Waits less than 4-hours
MRSA Bacteraemia
Clostridium Difficile
18-weeks RTT 90% Admitted
18-weeks RTT 95% Non -Admitted
18-weeks RTT 92% Incomplete
18-weeks RTT Delivery in all Specialities (number of treatment functions)
Diagnostic Test Waiting Times (percentage 6 weeks or more)
Cancer - 2 week GP Referral to 1st OP Appointment
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms
Cancer - 31 day diagnosis to treatment for all cancers
Cancer - 31 day second or subsequent treatment (surgery)
Cancer - 31 day second or subsequent treatment (drug)
Cancer - 31 Day second/subsequent treat (radiotherapy)
Cancer - 62 day urgent referral to treatment for all cancers
Cancer - 62 day referral to treatment from screening
Delayed Transfers of Care
Mixed Sex Accommodation Breaches (as percentage of completed FCEs)
VTE Risk Assessment

Weight	Performance Thresholds		
	Performing (Score 3)	Score 2	Underperforming (Score 0)
1.00	95.00%	94.00 - 95.00%	94.00%
1.00	0	>1.0SD	>1.0SD
1.00	0		
1.00	=>90.0%	85.00 - 90.00%	85.0%
1.00	=>95.0%	90.00 - 95.00%	90.0%
1.00	=>92.0%	87.00 - 92.00%	87.0%
1.00	0	1 - 20	>20
1.00	<1%	1.00 - 5.00%	5%
0.50	93.0%	88.00 - 93.00%	88.0%
0.50	93.0%	88.00 - 93.00%	88.0%
0.25	96.0%	91.00 - 96.00%	91.0%
0.25	94.0%	89.00 - 94.00%	89.0%
0.25	98.0%	93.00 - 98.00%	93.0%
0.25	94.0%	89.00 - 94.00%	89.0%
0.50	85.0%	80.00 - 85.00%	80.0%
0.50	90.0%	85.00 - 90.00%	85.0%
1.00	<3.5%	3.5 - 5.00%	>5.0%
1.00	0.0%	0.0 - 0.5%	0.5%
1.00	90.0%	80.00 - 90.00%	80.0%

Sum (all weightings) 14.00

Average Score (Integrated Performance Measures)

Quarter 1 2012/13	Score	Weight x Score	July 2012/13	Score	Weight x Score	August 2012/13
95.14%	3	3.00	94.45%	2	2.00	93.20%
1	3	3.00	1	3	3.00	1
6	3	3.00	2	3	3.00	6
93.8%	3	3.00	94.3%	3	3.00	=>90.0%*
98.4%	3	3.00	99.0%	3	3.00	=>95.0%*
97.1%	3	3.00	97.5%	3	3.00	=>92.0%*
11	2	2.00	4	2	2.00	>0 and <7*
0.87%	3	3.00	0.28%	3	3.00	<1.00%*
94.5%	3	1.50	95.6%	3	1.50	>93.0%*
96.2%	3	1.50	100.0%	3	1.50	>93.0%*
99.8%	3	0.75	100.0%	3	0.75	>96.0%*
99.7%	3	0.75	100.0%	3	0.75	>94.0%*
100.0%	3	0.75	100.0%	3	0.75	>98.0%*
100.0%	3	0.75	n/a	3	0.75	>94.0%*
86.4%	3	1.50	86.4%	3	1.50	>85.0%*
100.0%	3	1.50	90.0%	3	1.50	>90.0%*
3.50%	2	2.00	2.60%	3	3.00	2.50%
0.00%	3	3.00	0.00%	3	3.00	0.00%
92.13%	3	3.00	90.29%	3	3.00	86.20%

2.86

2.86 \* projected

Performing

Performing

Performing

Performing

CQC Registration Status

Unconditional or no enforcement action by CQC	The assessment of non-compliance / outstanding conditions from the initial registration	Enforcement action by CQC
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Overall Quality of Service Rating

Assessment Thresholds for Integrated Performance Measures Average Score	
Underperforming if less than	2.1
Performance Under Review if between	2.1 and 2.4
Performing if greater than	2.4

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

Financial Indicators				SCORING			2012 / 2013			2012 / 2013			2012 / 2013				
Criteria	Metric	Weight (%)		3	2	1	June	Score	Weight x Score	July	Score	Weight x Score	August	Score	Weight x Score		
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	0.00%	3	0.15	0.00%	3	0.15	0.00%	3	0.15		
				YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	0.01%	3	0.6	0.06%	3	0.6	0.15%	3	0.6		
Year to Date	YTD EBITDA	25	5	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	5.44%	3	0.15	5.53%	3	0.15	5.70%	3	0.15		
	Forecast Operating Performance			40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	0.00	3	0.6	0.00	3	0.6	0.00	3	0.6
Forecast Outturn	Forecast EBITDA	5	5			Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	6.32%	3	0.15	6.29%	3	0.15	6.27%	3	0.15
	Rate of Change in Forecast Surplus or Deficit			15	15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	0.00%	3	0.45	0.00%	3	0.45	0.00%	3	0.45
Underlying Financial Position	Underlying Position (%)	10	5			Underlying breakeven or Surplus	An underlying deficit that is less than 2% of underlying income.	An underlying deficit that is greater than 2% of underlying income	0.92%	3	0.15	0.92%	3	0.15	0.91%	3	0.15
	EBITDA Margin (%)			5	5	Underlying EBITDA equal to or greater than 5% of underlying income	Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income	Underlying EBITDA less than 1% of underlying income	6.32%	3	0.15	6.29%	3	0.15	6.27%	3	0.15
Finance Processes & Balance Sheet Efficiency	Better Payment Practice Code Value (%)	20	2.5			95% or more of the value of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the value of NHS and Non NHS bills are paid within 30days	Less than 60% of the value of NHS and Non NHS bills are paid within 30 days	87.00%	2	0.05	96.00%	3	0.075	94.00%	2	0.05
	Better Payment Practice Code Volume (%)			5	5	95% or more of the volume of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days	Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days	94.00%	2	0.05	91.00%	2	0.05	95.00%	3	0.075
	Current Ratio					Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	1.05	3	0.15	1.07	3	0.15	1.10	3	0.15
	Debtor Days					Debtor days less than or equal to 30 days	Debtor days greater than 30 and less than or equal to 60 days	Debtor days greater than 60	10.94	3	0.15	10.45	3	0.15	11.44	3	0.15
	Creditor Days					Creditor days less than or equal to 30	Creditor days greater than 30 and less than or equal to 60 days	Creditor days greater than 60	37.99	2	0.1	42.83	2	0.1	38.26	2	0.1

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

**Weighted Overall Score**

**2.90**

**2.93**

**2.93**

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



**TRUST BOARD**

<b>DOCUMENT TITLE:</b>	Provider Management Regime return – August 2012
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Mike Sharon, Director of Strategy & Organisational Development & Kam Dhami, Director of Governance
<b>AUTHOR:</b>	Mike Harding, Head of Planning & Performance Management & Simon Grainger-Payne, Trust Secretary
<b>DATE OF MEETING:</b>	27 September 2012

**EXECUTIVE SUMMARY:**

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

The organisational risk ratings as reported for August 2012 are as follows:

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

**REPORT RECOMMENDATION:**

That the Trust Board:

APPROVES the submission of the Provide Management Regime submission

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

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

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

Comments:

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

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

**PREVIOUS CONSIDERATION:**

Routine monthly update.

<b>SELF-CERTIFICATION RETURNS</b>
<b>Organisation Name:</b>
<b>Sandwell &amp; West Birmingham Hospitals NHS Trust</b>
<b>Monitoring Period:</b>
<b>August 2012</b>
<b>NHS Trust Over-sight self certification template</b>

**Returns to XXX by the last working day of each**

# TFA Progress

Aug-12

Sandwell & West Birmingham Hospitals NHS Trust

Select the Performance from the drop-down list

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

Note - Revised TFA now agreed with SHA / DH

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

<b>Name of Organisation:</b>	<b>Sandwell &amp; West Birmingham Hospitals NHS Trust</b>	<b>Period:</b>	<b>August 2012</b>
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### Organisational risk rating

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

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

\* Please type in R, A or G

### Governance Declarations

NHS Trusts must ensure that plans in place are sufficient to ensure compliance in relation to all national targets and including ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, CQC Essential standards and declare any contractual issues.

**Supporting detail is required where compliance cannot be confirmed.**

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

<b>Governance declaration 1</b>			
The Board is satisfied that plans in place <b>are sufficient</b> to ensure continuing compliance with all existing targets (after the application of thresholds), and with all known targets going forward. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code) and CQC Essential standards. The board also confirms that there are no material contractual disputes.			
Signed by:		Print Name:	Richard Samuda
on behalf of the Trust Board	Acting in capacity as:	Trust Chairman	
Signed by:		Print Name:	John Adler
on behalf of the Trust Board	Acting in capacity as:	Chief Executive	

<b>Governance declaration 2</b>			
For one or some of the following declarations Governance, Finance, Service Provision, Quality and Safety, CQC essential standards or the Code of Practice for the Prevention and Control of Healthcare Associated Infections the Board cannot make Declaration 1 and has provided relevant details below.			
The board is suggesting that at the current time there is <b>insufficient assurance available</b> to ensure continuing compliance with all existing targets (after the application of thresholds) and/or that it may have material contractual disputes.			
Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		
Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		

### If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For each area such as Governance, Finance, Contractual, CQC Essential Standards, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

<b>Target/Standard:</b>	
<b>The Issue :</b>	
<b>Action :</b>	
<b>Target/Standard:</b>	
<b>The Issue :</b>	
<b>Action :</b>	

**GOVERNANCE RISK RATINGS**

**Sandwell & West Birmingham Hospitals NHS Trust**

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)  
See separate rule for A&E

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

Area	Ref	Indicator	Sub Sections	Threshold	Weighting	Historic Data			Current Data			Comments where target not achieved	
						Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12		Qtr to Sep-12
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	No	No	No	No	No		No	Action plan exists to achieve compliance. Will be compliant by the month of October 2012.
			Referral information	50%		No	No	No	No	No	No		
			Treatment activity information	50%		No	No	No	No	No	No		
	1b	Data completeness, community services: (may be introduced later)	Patient identifier information	50%	No	No	No	No	No		No	As above	
Patients dying at home / care home			50%	No	No	Yes	Yes	Yes		Yes			
1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a		Yes		
1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a		Yes		
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	No	No	Yes	Yes	Yes		Yes	Status changed June 2012
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	July 2012 performance confirmed from National Cancer Waiting Times system report. August performance projected.
			Anti cancer drug treatments	98%		Yes	Yes	Yes	Yes	Yes		Yes	
			Radiotherapy	94%		Yes	Yes	Yes	Yes	Yes		Yes	
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	Yes	Yes		Yes	As above
			From NHS Cancer Screening Service referral	90%		Yes	Yes	Yes	Yes	Yes		Yes	
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes		Yes	As above
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals for symptomatic breast patients (cancer not initially suspected)	93%	0.5	Yes	Yes	Yes	Yes	Yes		Yes	As above
				93%		Yes	Yes	Yes	Yes	Yes		Yes	
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	Yes	Yes	Yes	No	No		No	Performance in August was 93.2%. Departments are in Trust's special measures regime in order to resolve issues. External reviews by SHA and independent expert completed. Action plan being further refined.
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a		Yes	
Having formal review within 12 months			95%	N/a		N/a	N/a	N/a	N/a		Yes		
3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a		Yes		
3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a		Yes		
3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a		Yes		
3j	Category A call – emergency response within 8 minutes		75%	1.0	N/a	N/a	N/a	N/a	N/a		Yes		
3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a		Yes		
Safety	4a	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	Enter contractual ceiling	1.0	Yes	Yes	Yes	Yes	Yes		Yes	C. Diff numbers during August (6) exceeded the in-month trajectory of 5, but numbers for the year to date (14) remain within the in-year trajectory of 25.
	4b	MRSA	Are you below the ceiling for your monthly trajectory	Enter contractual ceiling	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
	<b>CQC Registration</b>												
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No		No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No		No	
C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No		No		
<b>TOTAL</b>						1.5	1.5	1.0	2.0	2.0	0.0	2.0	

**RAG RATING :**

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

Overriding Rules - Nature and Duration of Override at SHA's Discretion												
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective	No	No	No	No	No	No	No	No	No	No
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective Reports important or significant outbreaks of C.difficile, as defined by the Health Protection Agency.	No	No	No	No	No	No	No	No	No	No
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter	No	No	No	No	No	No	No	No	No	No
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.	No	No	No	No	No	No	No	No	No	No
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter	No	No	No	No	No	No	No	No	No	No
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter	No	No	No	No	No	No	No	No	No	No
vi)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
viii)	Any Indicator weighted 1.0	Breaches the indicator for three successive quarters.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
<b>Number of Overrides Triggered</b>						2.0	2.0	2.0	2.0	2.0	0.0	2.0

# FINANCIAL RISK RATING

## Sandwell & West Birmingham Hospitals NHS Trust

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

### Risk Ratings

Criteria	Indicator	Weight	Risk Ratings					Reported Position		Normalised Position*		Comments where target not achieved
			5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	3	3	3	3	
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	5	4	5	5	
Financial efficiency	Net return after financing %	20%	>3	2	-0.5	-5	<-5	3	3	3	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	3	2	3	Reflects in year profiling of surplus.
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	3	3	3	3	Includes effect of assumed working capital facility
<b>Weighted Average</b>		<b>100%</b>						<b>3.0</b>	<b>3.1</b>	<b>3.0</b>	<b>3.2</b>	
Overriding rules												
<b>Overall rating</b>								<b>3</b>	<b>3</b>	<b>3</b>	<b>3</b>	

### Overriding Rules :

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

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

# FINANCIAL RISK TRIGGERS

## Sandwell & West Birmingham Hospitals NHS Trust

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

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

**CONTRACTUAL DATA**

**Sandwell & West Birmingham  
Hospitals NHS Trust**

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

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



# QUALITY

## Sandwell & West Birmingham Hospitals NHS Trust

### Insert Performance in Month

Criteria	Unit	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Comments on Performance in Month	
1	SHMI - latest data	Ratio	100.6	101.3	99.8	99.7	99.7	99.7	99.7	99.7	99.8	99.1	99.1	99.1	SHMI data relates to period January 2011 - December 2011 which continues to be the most recent period for which data is available (source HED).
2	Venous Thromboembolism (VTE) Screening	%	92.6	92.2	93.3	90.8	92.9	92.4	92.6	92.4	92.9	91	90.3	86.2	
3a	Elective MRSA Screening	%	38.8	42.2	41.6	42.5	40.2	39.4	40.8	38.1	39.9	40.7	42	39.5	Data represents actual screens matched to specific patients requiring screens. An improvement trajectory leading to a 85% March 2013 target has been set. The Trust will review the target and trajectory and report
3b	Non Elective MRSA Screening	%	69.2	68.3	66.5	54.2	50.5	58.7	61.7	70.3	64.1	66.3	68	69.1	Data represents actual screens matched to specific patients requiring screens. An improvement trajectory leading to a 85% March 2013 target has been set. The Trust will review the target and trajectory and report
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	8	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number				8	8	8	2	8	7	9	10	4	
6	"Never Events" in month	Number				1	1	1	1	0	0	0	1	0	
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number				10	14	19	23	20	19	17	14	9	
9	RED rated areas on your maternity dashboard?	Number	2	1	4	4	4	4	4	2	1	2	4	3	Vacancies, Midwifery Staff Sickness Absence and Neonatal Mortality Rate (0 – 28 days). This is not believed to be statistically significant
10	Falls resulting in severe injury or death	Number	3	3	1	4	2	6	2	3	0	1	1	2	
11	Grade 3 or 4 pressure ulcers	Number	5	2	0	5	14	5	7	12	4	1	3	0	
12	100% compliance with WHO surgical checklist	Y/N	No	No	No	No	No	No	No	No	No	No	No	No	Compliance was 99.7% in August. 983 lists counted 3753 individual records counted All list and individual checklists are checked for completeness by senior staff at the end of the session and then entered onto a data base
13	Formal complaints received	Number	71	77	67	51	59	69	72	60	51	61	62	79	
14	Agency as a % of Employee Benefit Expenditure	%	2	1.8	1.3	1.5	1.7	1.8	2.5	1.7	1.4	1.9	1.9	2.24	
15	Sickness absence rate	%	3.72	4.19	4.43	4.28	4.34	4.39	4.13	4.06	4.51	4.23	4.16	4.1	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%						78	72	74	78	69	71	79	These figures indicate the percentage of Consultant Appraisals that were completed at that time without reference to completed PDPs which are seen as a more dynamic document.

# Board Statements

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

For CLINICAL QUALITY, that:		Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes
For FINANCE, that:		Response
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	Yes
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes
For GOVERNANCE, that:		Response
6	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.	Yes
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.	Yes
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans for mitigation of these risks.	Yes
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury ( <a href="http://www.hm-treasury.gov.uk">www.hm-treasury.gov.uk</a> ).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR; and a commitment to comply with all known targets going forwards.	Yes
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	No
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	Yes
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	Yes
Signed on behalf of the Trust:		Date
CEO	To be added	JOHN ADLER 27/09/2012
Chair	To be added	RICHARD SAMUDA 27/09/2012

## Notes

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

## Notes

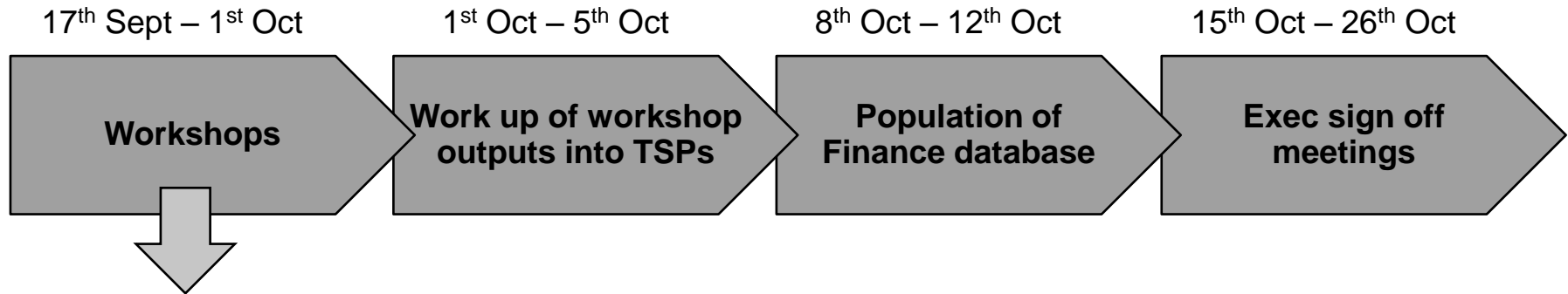
Ref	Indicator	Details
3d	Cancer	<p>Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional). Failure against either threshold represents a failure against the overall target. The target will not apply to trusts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

**TRUST BOARD**

<b>DOCUMENT TITLE:</b>	<b>Transformation Plan Status Update</b>		
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	<b>Rachel Barlow</b>		
<b>AUTHOR:</b>	<b>Paul Crabtree</b>		
<b>DATE OF MEETING:</b>	<b>28<sup>th</sup> September 2012</b>		
<b>EXECUTIVE SUMMARY:</b>			
<b><u>Development of FY13/14 &amp; 14/15 TSPs:</u></b>			
A series of workstream workshops are being held, in September. These are designed to help inform Divisions and support their TSP delivery over future years. These will be followed by a series of Executive review meetings before final inclusion to FT application process.			
<b><u>Outpatients workstream:</u></b>			
The “deep dive” clinic analysis is on-going with the final Directorates. For completed Directorates, a series of “Task Force” meetings are established for reviews between the CD, DGN, COO and MD. These meetings are focussed on achieving improved clinic utilisation and PA use. The first meetings have confirmed a planned reduction of 8 PAs. The next phase of Transformation activity is now starting to review pathway performance to focus on reducing patient pathway times (i.e. improved patient experience in conjunction with improved efficiency).			
<b><u>Bed Reconfiguration:</u></b>			
A revised plan is currently being reworked to incorporate the future winter planning as well as balancing the current demand pressures. This revised plan will be complete and submitted to TB w/c 24/09/12. The governance structure to monitor progress for bed numbers, pathway redesign, supporting projects and Quality measures will report directly to the COO.			
<b><u>Urgent Care / Patient Flow / Community:</u></b>			
The 3 work streams have been reviewed and will focus jointly on developing specific service level pathways across the complete patient journey. A session is being hosted by BMJ in October to develop standardised clinical action sets.			
<b><u>Transformation team development:</u></b>			
To ensure the sustainability of the internal Transformation Team a formal development framework has been developed. This will ensure the team are developed based on their individual requirements as well as the Trusts requirements for the future. Also in discussion is how to transfer this knowledge to the wider organisation through a wider Organisational Development programme.			
<b>REPORT RECOMMENDATION:</b>			
<b>ACTION REQUIRED</b> <i>(Indicate with 'x' the purpose that applies):</i>			
The receiving body is asked to receive, consider and:			
<b>Accept</b>	<b>Approve the recommendation</b>	<b>Discuss</b>	
		X	
<b>KEY AREAS OF IMPACT</b> <i>(Indicate with 'x' all those that apply):</i>			
Financial	X	Environmental	Communications & Media
Business and market share		Legal & Policy	Patient Experience
Clinical		Equality and Diversity	Workforce
Comments:			
<b>ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:</b>			
<b>PREVIOUS CONSIDERATION:</b>			



- **Transformation future year's**  
**-Workshop process to inform Divisional TSPs**



## Objectives:

- To provide an understanding of Workstream plans in terms of:
  - Current activities that will continue into future years
  - Planned activity that will start / realise benefits in future years
  - Get input from Divisions on projects and prioritisation

## Expected outcomes:

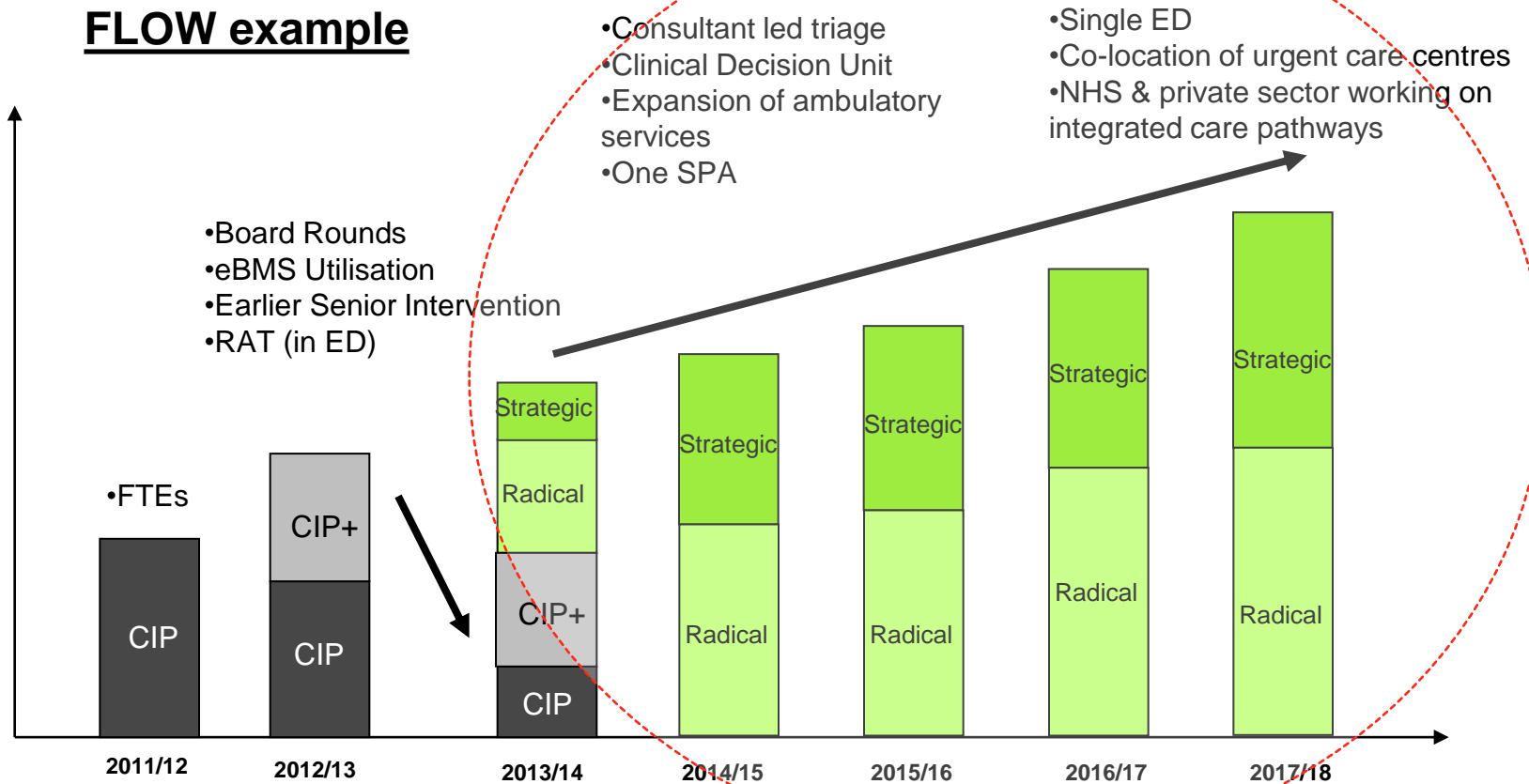
- Provide Divisions with enough understanding of intended future years activity on which they can calculate TSPs
- Ensure Workstreams have inputs from Divisions and confirmed priorities



# Transformation future year's

## -Informing TSPs through thinking differently in the future

### FLOW example



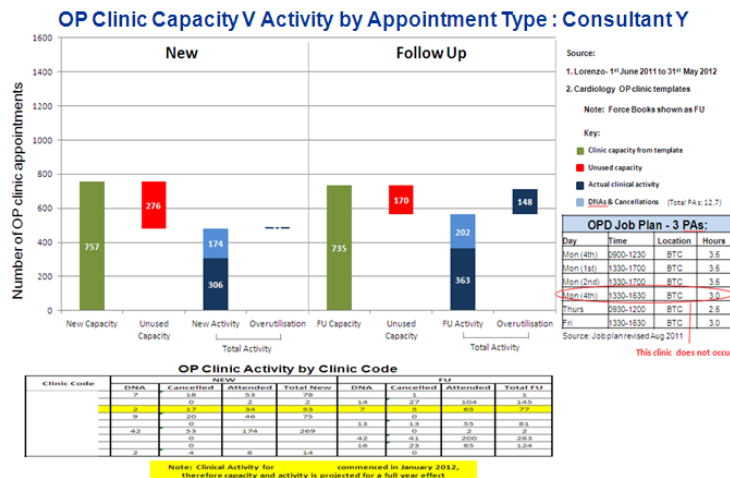


# OUTPATIENT TRANSFORMATION

## STAGE 3 – DEEP DIVE + (including Task Force approach)

- Revisit each specialty on a rolling programme
- Detailed analysis of clinic capacity against actual activity to highlight unused capacity / DNAs and cancellations
- Unused capacity / DNAs & cancellations converted to PAs to identify TSP opportunities
- Specialty to provide action plan for clinics identified, PA reduction and timeline for delivery at the Executive Task Force Meeting
- Executive sign off action plan and date for progress update agreed

### OUTPUTS



### Specialty X - OP Decommissioning Opportunity

Consultant	Available Capacity		Unused Clinic Capacity		PA Opportunity from unused Clinic Capacity		DNAs & Cancellations		PA Opportunity from DNAs & Cancellations	
	New	FU	New	FU	New	FU	New	FU	New	FU
	508	3000	29	188	0.3	0.2	172	328	0.1	0.1
	508	3000	184	184	0.2	0.4	142	36	0.3	0.1
	525	1807	19	204	0.0	0.2	149	259	0.1	0.1
	734	546	155	0	0.2	0.0	131	92	0.2	0.2
	851	935	69	93	0.1	0.1	140	130	0.2	0.2
	134	200	0	1	0.0	0.0	54	10	0.4	0.0
	547	672	180	92	0.3	0.1	135	147	0.2	0.2
	757	730	276	170	0.4	0.2	174	202	0.2	0.2
	872	872	204	151	0.2	0.2	127	181	0.2	0.2
	546	3000	14	41	0.0	0.0	168	280	0.1	0.1
	729	207	177	0	0.3	0.0	128	138	0.2	0.1
<b>TOTAL</b>	<b>6603</b>	<b>8701</b>	<b>1303</b>	<b>1270</b>	<b>2.1</b>	<b>1.7</b>	<b>1513</b>	<b>1797</b>	<b>2.6</b>	<b>2.6</b>

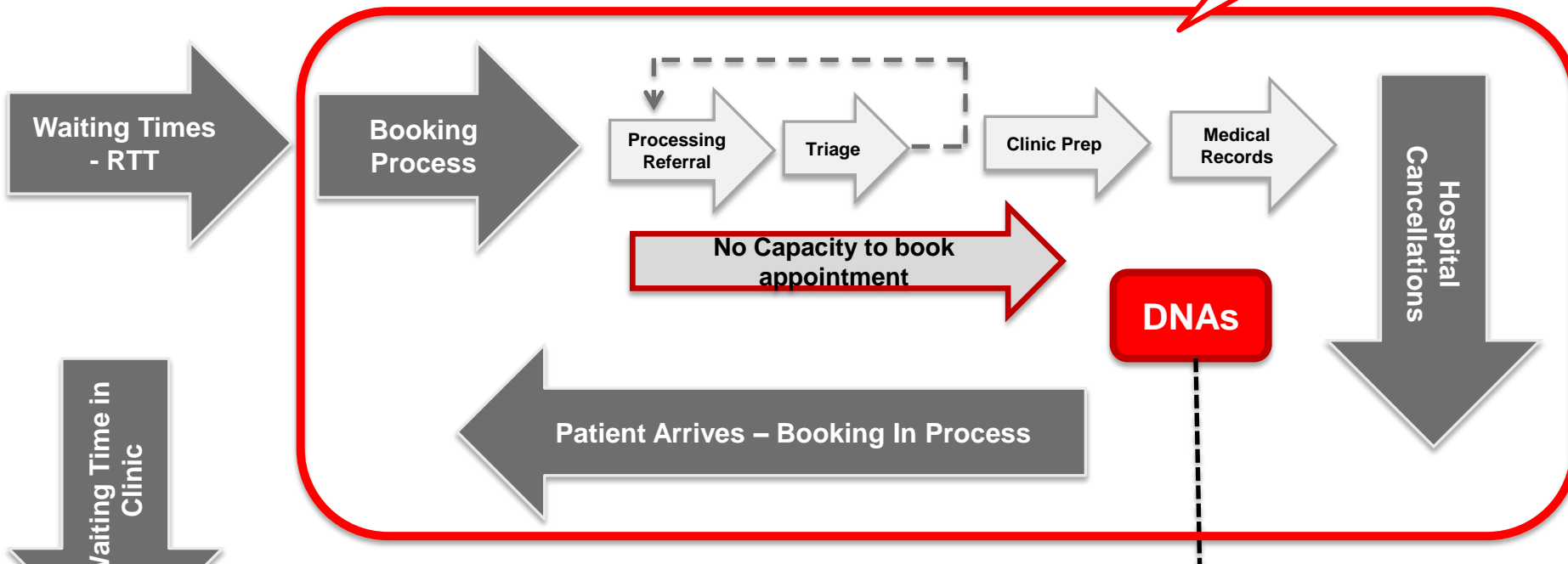
	NEW	FU	TOTAL
<b>PA Opportunity (from unused capacity)</b>	<b>2.1</b>	<b>1.7</b>	<b>3.8</b>
<b>PA Opportunity (from DNAs &amp; Cancellations)</b>	<b>2.9</b>	<b>2.6</b>	<b>5.5</b>
<b>TOTAL OPPORTUNITY</b>	<b>5.0</b>	<b>4.3</b>	<b>9.3</b>

# OUTPATIENT TRANSFORMATION

## Pathway approach

### OUTPATIENT JOURNEY

Corporate, cross cutting approach to Outpatient-wide processes



Clinical led, directorate specific pathway review



# OUTPATIENT TRANSFORMATION Clinical Pathways

promote organised & efficient patient care using evidence based practice

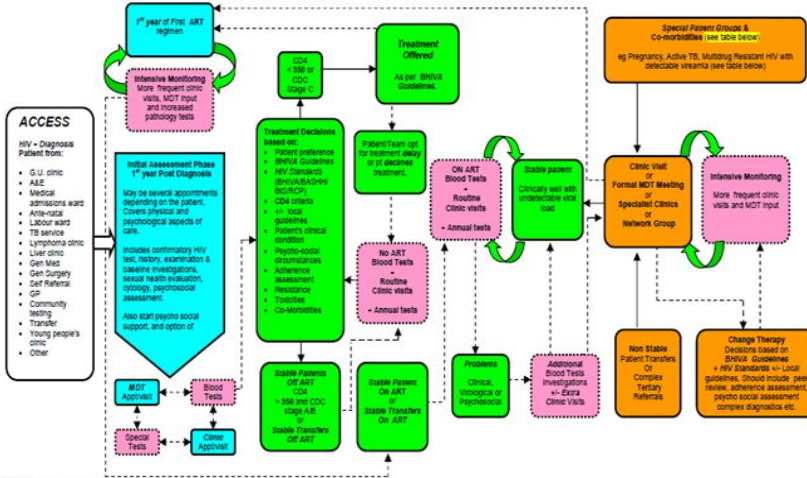
## Standardisation of care processes

CAT 1: 1<sup>st</sup> year after HIV diagnosis or 1<sup>st</sup> year of first ART regimen\*

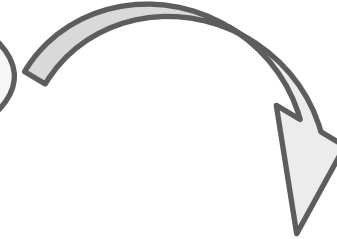
CAT 2: Monitoring stable patients not on ART or stable on ART > 1yr

CAT 3 Special Patients Groups, Complex ART

## Reduces variability in clinical practice



HIV Outpatient Care Pathway  
May 09 Version 9: Attendances amended in line with HPA Data Collection Results  
Feb 11 Version 10: Final version handed over to DH



PATIENT TYPE	Average ATTENDANCES	TESTS	CURRENTS and DATA	STAFFING	TRUST OVERHEADS
<b>CATEGORY 1 PATIENTS</b> 1a. Patient within 1 <sup>st</sup> year of HIV Diagnosis within the UK Or 1b. Any patient starting ART for the first time	Annual pathology, including costs Plus New patient pathology and laboratory costs	OR 2 year pathology costs for patient starting on ART. (ignoring any pathology tests costs)	All Patients can be seen by more than 1 staff group per patient	To include corporate overheads + patient costs	To include corporate overheads + patient costs

PATIENT TYPE	Average ATTENDANCES	TESTS	CURRENTS and DATA	STAFFING	TRUST OVERHEADS
<b>CATEGORY 2 PATIENTS</b> Patients who do not fit into categories 1 or 3 will by default be classified as Category 2 I.e. Monitoring stable patients not on ART > 1 year diagnosis in UK or stable on ART > 1 yr	Annual Pathology including costs For stable patients				To include corporate overheads + patient costs

PATIENT TYPE	Average ATTENDANCES	TESTS	CURRENTS and DATA	STAFFING	TRUST OVERHEADS
<b>CATEGORY 3 PATIENTS</b> Special Patients Groups or High Intensive Highly Dependent Patients These include: 1 Current TB co-infection on anti-tuberculosis treatment 2 Hepatic Co-infection with advanced liver disease or chronic hepatitis treatment 3 Any other high dependency requiring extensive management in addition to ART (not routine care) 4 All current hepatitis B co-infection 5 HIV co-infection with resistant > 1 mutation on ART 6 All other chronic viral co-infections 7 All other chronic viral co-infections 8 All other chronic viral co-infections 9 Non infectious high dependency greater than 1 attendance in 12 months and relevant	Pathology. This includes new and repeat tests, and 3-4 monthly blood tests and related tests				To include corporate overheads + patient costs

## Improves outcomes

# Flow Workstream (deploying principles from Patient Flow workstream across the wide pathway)

Some principles applied in the Patient Flow workstream

**MDT Care Co-ordination**

**Introduction of Board & Senior Reviews  
Move from “discharge when safe” to  
“discharge when criteria met”**

**Visual Management -  
Understanding patient  
Status**

**Use of eBMS (flags on system) –  
teams starting to use the same information  
source to inform decisions**

**PULL SYSTEMS**

**Transport – slots for wards to book into (17/9)  
Pharmacy – mobile dispensary on ward (7/10)  
Wards – “pull” patients from ED & EAU**

**Where can we apply these principles  
elsewhere in our organisation?**

# Flow Workstream – defined priorities and measures

## Priority Projects

1. Daily Board Rounds & Senior Reviews  
(Matthew Lewis)

2. Multidisciplinary Team Meetings  
(Fiona Shorney)

3. Criteria-Led Discharges  
(Jo Wakeman)

4. Timeliness of TTOs (completion & dispensing)  
(Marion Smith)

5. Improve Transport  
(Dawn Hall)

6. Internal Waits  
(Anne Townsend)

7. Discharge Planning/Daily Flow  
(Caroline Rennalls)

8. Social Care & Community  
(Caroline Rennalls)

9. Enhanced Recovery Programme  
(Rose Pritchard)

eBMS Developments

## Outcome Measures

Reduced overall length of stay

Target 3.5

Actual 3.3



% discharges before noon

Target 40%

Actual 20%



Process Measures (examples)

% patients with 'live' EDD

Target 95%

Actual Overall – 47%, >90% where BRs happening

Transport status – understood within 24hrs of admission

Target 95%

Actual 50% SGH, 10% City

Journeys before noon

Target 60%

Actual 15%

TTOs started at least 24hrs prior to discharge

Target 80%

Actual <50%



# Transformation Team Development

## SWBH Transformation - Organisational Development

### Background

Delivery of the initial phases of FY12/13 Transformation Plan have highlighted required development areas for the wider organisation. These include:

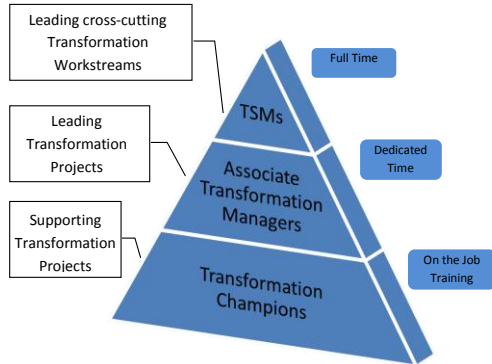
- Lean skills knowledge by the TSO team
- Overall Transformation projects management by senior management
- Project delivery skills from divisional project leads
- Specific lean skills awareness at all levels of the organisation

### Objectives

To implement a Trust wide development programme focussed on enabling efficient implementation of all Transformation Programmes (large and small). This should include:

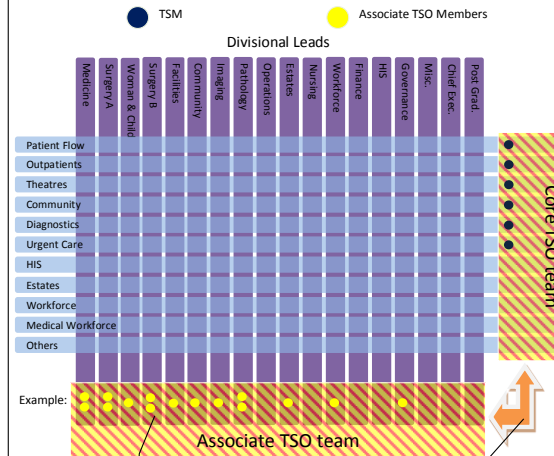
- Developing a Trust wide team specifically focussed on delivery of the Transformation Programme
- Provide appropriate development for all, based on the delivery support they are providing
- Design a development programme to provide sustained support for future years Transformation Programmes

### 1. Tiered Transformation Support



Integration of the wider Trust into the Transformation Office, to build a sustainable structure, for future year's transformation activity.

### 2. Engaging/Enabling the Wider Organisation

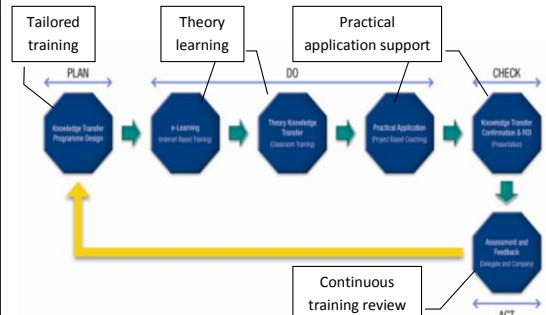


Nominated "local" TSO members to support/facilitate delivery of local projects

Clearly defined link to TSO

Identified employees, who are directly supporting Transformation Projects and will have a clearly defined support link with the TSO.

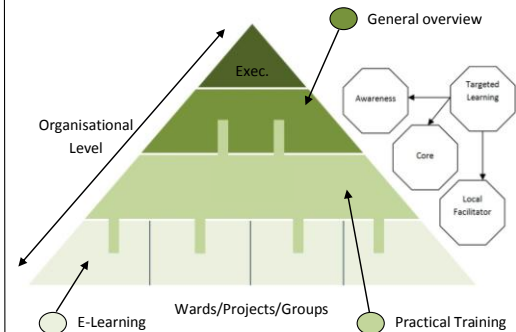
### 3. Blended Approach Model



"I hear and I forget, I see and I remember, I do and I understand"

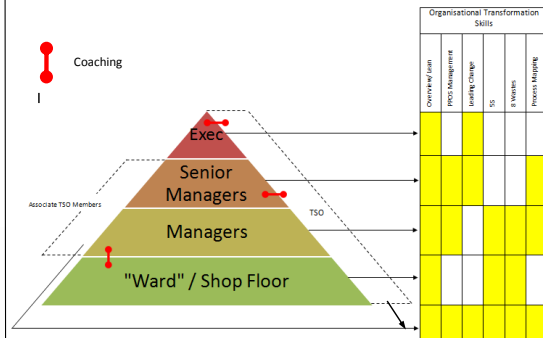
Development of a training programme that provides the practical support to implement the things learnt in the classroom.

### 4. Targeted Learning



Each training topic should have the appropriate depth of training, based on the intended application by the trainees.

### 5. Targeted Learning Modules



A full suite of training modules should be developed, with each tier of the organisation mapped out against each subject. This should form part of each person's development programme over the coming years.

### Next Steps

Define how to integrate TSO development into overall Trust Organisational Development strategy.

PC/RB – Sept 2012

<b>TRUST BOARD</b>
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<b>DOCUMENT TITLE:</b>	Clinical Services Reconfiguration Programme: Minutes from the Programme Board Meeting on 13 <sup>th</sup> September 2012
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Mike Sharon, Director of Organisational Development and Strategy
<b>AUTHOR:</b>	Jayne Dunn, Redesign Director – RCRH
<b>DATE OF MEETING:</b>	27 September 2012

**EXECUTIVE SUMMARY:**

The paper presents the minutes from the Clinical Services Reconfiguration Programme Board meeting held on 13<sup>th</sup> September 2012.

The minutes cover an update of progress with each area of clinical service reconfiguration projects that the Trust is involved in, including a range of wider SHA/health economy plans for clinical service consolidation. In summary the minutes provide details of:

1. The service reconfigurations we have recently implemented:
  - The reconfiguration of Breast Surgery services to City Hospital, primarily in the Birmingham Treatment Centre (BTC), at the end of July.
  - The reconfiguration of planned Orthopaedic inpatient services to Sandwell Hospital at the end of August.
  - The transfer of our Vascular Surgery inpatient service and our Vascular Interventional Radiology service to the Queen Elizabeth Hospital in Birmingham, at the beginning of September.
2. Our preparations for a peer review visit in early October to validate our Trauma Unit status.
3. Progress with delivering the implementation phase of our stroke reconfiguration project which will consolidate all inpatient Stroke and Neurology services along with TIA services at Sandwell Hospital from February 2013. In addition it outlines the latest progress with the Midlands and East strategic review of stroke services.

**REPORT RECOMMENDATION:**

The Trust Board is recommended to:

1. ACCEPT this progress report regarding our ongoing clinical service reviews and reconfiguration projects.

**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	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:**

This report aligns to our Corporate Objective 2: High Quality Care and the following priorities for 2012/13:

- Delivering the quality priorities set out in our Quality Account
- Delivering the Transformation Plan
- Progressing the “Right Care Right Here” vision of service change

**PREVIOUS CONSIDERATION:**

May 2012: Progress report relating to Clinical Service Reconfiguration

May 2012: Report on Vascular Surgery Equality Impact Assessment and Implementation

June 2012: Business Case For: the Preferred Option For Reconfiguration Of Acute Stroke, TIA And Neurology Services



## MINUTES

### Clinical Service Reconfiguration Programme Board

**Venue** Room G19, Hilda Lloyd Building , City

**Date** 13<sup>th</sup> May 2012

**Present:**

Mrs. G Hunjan (Chair)

Miss R Barlow

Mrs J Dunn

Mr R Trotman

Mr R White

**Secretariat:**

Mrs J Dunn

MINUTES	PAPER REFERENCE
<b>1. Apologies for absence</b>	
Apologies were received from Mr R Samuda, Mr J Adler, Mr M Sharon, Dr D Situnayake, Mr M Beveridge, Mrs J Morton, Mrs S Murray, Miss R Overfield, Mr G Seager, Mrs G Gadd, Dr R Stedman and Dr J Berg.	
<b>2. Introduction</b>	
Mrs Hunjan commented on the low attendance and recognised this was partly because a health economy wide meeting to review the RCRH Programme had been arranged for the same time. It was agreed that as the meeting was quorate (one NED and two Executive Directors) the meeting should continue.	
<b>3. Minutes of the previous meeting</b>	<b>SWBRB (09/12) 58</b>
The minutes of the meeting held on 17 <sup>th</sup> May 2012 were accepted as a true and accurate record.	
<b>4. Matters Arising</b>	
<b>4.1 Feedback From Joint Health Scrutiny Committee (JHSC) re Orthopaedic Reconfiguration</b>	
4.1 Mrs Dunn reported that, following the last Programme Board meeting Trust representatives had met with the JHSC on two occasions (in May and July) to present the proposals to reconfigure elective Orthopaedic inpatient beds and consolidate these at Sandwell Hospital. At the first meeting the JHSC asked the Trust to undertake further patient	

MINUTES	PAPER REFERENCE
engagement. This was done and presented at the second meeting at which the JHSC concluded that formal public consultation was not appropriate for this reconfiguration but asked the Trust to undertake some further engagement with user and interest groups. This was subsequently done.	
<b>4.2 Update re Junior Doctor Training in Trauma and Orthopaedics (T&amp;O)</b>	
An update was not available but Mrs Dunn reported that the reconfiguration of inpatient elective Orthopaedics to Sandwell will address most of the issues. Miss Barlow explained the management of patients following a head injury (currently admitted under the care of T&O) remained outstanding. A new pathway has been agreed with these patients being managed for the first 24 hours by the Emergency Department (ED) medical team. However due to ongoing issues within the EDs it is not possible to implement the new pathway at present and so for now they will continue to be admitted under the care of T&O. It was noted that junior doctor training experience in T&O will be monitored via the Education Committee.	
<b>4.3 Process for Reconfiguration</b>	
The draft process was presented to the JHSC in May and was agreed by the JHSC. The process was subsequently updated and approved by Mrs. Hunjan as Chair of the Programme Board. It will be circulated to Divisional Directors, Clinical Directors and Divisional General Managers by the end of September.	
<b>ACTION: Mrs Dunn to circulate the approved Process for Reconfiguration.</b>	
<b>5. Emergency Gynaecology Reconfiguration</b>	<b>SWBRB (09/12) 65</b>
<p>Mrs Dunn presented the progress report for Emergency Gynaecology Services. It was noted the future location of EPAU (Early Pregnancy Assessment Unit) at City Hospital was still outstanding. Miss Barlow confirmed discussions about these were ongoing and options had changed as a result of the bed configuration plan within the Transformation Plan. The Division are preparing a business case for the preferred option and required refurbishment work which will then be presented to SIRG.</p> <p>The progress report highlighted a new issue around concerns raised by the Deanery with respect to Gynaecology SHO training and lack of senior on site supervision at Sandwell Hospital. As a result the SHO cover at Sandwell will cease from October 2012 leaving a gap in on site cover between 8 pm and 8 am and at weekends. The Division are putting in place locum middle grade cover for these times. It was noted that junior doctor arrangements and training experience had been considered as part of the implementation plans (and discussed with the Divisional Director, Clinical Director and Medical Staffing Department) for both Maternity reconfiguration and emergency Gynaecology reconfiguration but the</p>	

MINUTES	PAPER REFERENCE
<p>concerns now raised by the Deanery had not been apparent at the time.</p> <p>In order to provide a permanent solution the Division are proposing to consolidate all inpatient elective Gynaecology at City Hospital with day case surgery, outpatient surgery and clinics and an EPAU being provided at Sandwell as well as City. This change will impact on a relatively small number of women (circa 275 based on activity in 2011/12) who will require surgery at City Hospital after the change.</p> <p>The Programme Board discussed whether formal public consultation was appropriate. Given the relatively small number of women the reconfiguration will impact on and in line with the Trust's Reconfiguration Process it was felt formal public consultation is not appropriate. It was felt however that robust engagement and communication with patients and GPs is important. There also needs to be engagement with other specialities at Sandwell Hospital and in particular the ED to identify any concerns they have about not having on site Gynaecology cover 24/7. Robust pathways need to be agreed for patients who present at Sandwell ED and require Gynaecology assessment and treatment and for existing inpatients in other specialties at Sandwell who require Gynaecology support.</p> <p>Mrs Hunjan asked if the proposed reconfiguration and the need to undertake the engagement work would impact on delivery of the Division's TSP. Mr White explained that the proposed reconfiguration is not a TSP but that the need to employ locum middle grade cover for the Sandwell site until a permanent solution is agreed and implemented would create a cost pressure that the Division will need to cover.</p> <p>It was therefore agreed that before reconfiguring elective Gynaecology inpatients to Sandwell the Division should present a report to the Programme Board at its meeting in December outlining:</p> <ul style="list-style-type: none"> <li>• engagement and communication plans with patients and GPs</li> <li>• engagement that has taken place with other specialties and arrangements put in place to provide Gynaecology support to them</li> <li>• agreed pathways for patients that present to Sandwell ED or are inpatients in other specialties at Sandwell and require Gynaecology assessment and treatment.</li> </ul>	
<p><b>ACTION: Mrs Geary to present a report to the Programme Board meeting in December outlining engagement and communication work with patients and GPs, engagement with other specialties and agreed arrangements to provide Gynaecology support and revised pathways for patients presenting to Sandwell Hospital or an inpatient under another specialty, requiring Gynaecology assessment and/or treatment.</b></p>	
<p><b>6. Vascular Surgery Reconfiguration</b></p>	<p><b>SWBRB (09/12) 66</b></p>

MINUTES	PAPER REFERENCE
<p>Mrs Dunn presented the progress report for Vascular Surgery Reconfiguration. The transfer of our Vascular Surgery inpatient service and our Vascular Interventional Radiology service to the Queen Elizabeth Hospital in Birmingham took place on 10<sup>th</sup> September 2012. Vascular Surgery, day case surgery, outpatient clinics, advice to other specialties and on call consultant cover for emergencies continue to be provided at both Sandwell and City Hospitals. It was noted that the joint project meetings with UHBFT will continue in order to monitor progress and address any issues that arise following the service change. A progress report will be presented to the Programme Board at its meeting in December.</p>	
<p><b>7. Surgical Services Update</b></p>	<p><b>SWBRB (09/12) 67</b></p>
<p>Mrs Dunn presented the progress report for the Orthopaedic and Breast Surgery Reconfiguration.</p>	
<p><b>7.1 Orthopaedic Reconfiguration</b></p>	
<p>It was noted that the reconfiguration of planned Orthopaedic inpatient services to Sandwell Hospital took place on the 28<sup>th</sup> August 2012. Orthopaedic day case, outpatient and therapy services continue to be provided at both Sandwell and City Hospitals. This reconfiguration also relates to TSPs within the Division of Surgery A, Anaesthetics and Critical Care and so is part of the Transformation Plan.</p> <p>A progress report will be presented to the Programme Board at its meeting in December.</p>	
<p><b>7.2 Breast Surgery Reconfiguration</b></p>	
<p>The reconfiguration of Breast Surgery services to City Hospital, primarily in the Birmingham Treatment Centre (BTC) took place in 30<sup>th</sup> July 2012. This involved centralising all rapid access clinics and operating to the BTC, installing new imaging equipment and new ways of working (including a patient initiated follow up system).</p> <p>A progress report will be presented to the Programme Board at its meeting in December.</p>	
<p><b>8. Stroke Services Reconfiguration</b></p>	<p><b>SWBRB (09/12) 68 &amp; SWBRB (09/12) 59</b></p>
<p>Mrs Dunn presented the Progress Report for the Stroke and TIA Reconfiguration Project and the OCG Gateway Review Report. It was noted that the Business Case for the Preferred Option was approved by the Board in June and subsequently by the Black Country PCT Cluster Board in July. The approved option is that all inpatient Stroke and Neurology services along with TIA services will be located at Sandwell Hospital. This will be implemented from the end of February 2013 with some ongoing refurbishment work to upgrade ward accommodation and install a second CT scanner, scheduled until May 2013. It was noted this is a delay to the phased implementation date starting in January 2013 presented to the</p>	

MINUTES	PAPER REFERENCE
<p>Trust Board in the Business Case for Change in June. This delay is primarily related the required refurbishment work and in particular to a change in the wards to be used for the Stroke Unit post reconfiguration, to allow both wards to be collocated on the same floor. The delay is not considered significant as it provides a better clinical and operational model and was agreed by clinical leads.</p> <p>In line with national guidelines for significant service reconfigurations the project underwent an external OGC (Office of Government Commerce) Gateway Review in July 2012 to consider the investment decision (i.e. the Business Case for the Preferred Option) and the project's readiness for moving into the implementation phase. This Gateway Review gave the project a Green delivery confidence assessment, i.e. 'successful delivery of the project appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery significantly'. The Review made 4 recommendations. An action plan has been developed for these and incorporated into the overall project implementation plan. Mrs Dunn explained that the Action Plan should have been circulated with meeting papers and apologised that it wasn't. She therefore summarised the actions and progress against these as:</p> <ul style="list-style-type: none"> <li>• <i>Recommendation 1: The ownership for the delivery of benefits realisation plans be identified – Do Now i.e. July.</i> Each benefit now has a named owner and this had been agreed through the Clinical Implementation Group (see below) at its meeting on 7<sup>th</sup> September.</li> <li>• <i>Recommendation 2: The reasons for proceeding with implementation in the context of a planned wider SHA review of stroke services are recorded – Do Now i.e. July.</i> This was done by the Sandwell PCT project manager for the stroke reconfiguration project in July and agreed by the Stroke Reconfiguration Project Board. It has been included as an appendix to the Gateway Review Action Plan.</li> <li>• <i>Recommendation 3: Plan to achieve early resolution of operational policies and procedures and medical staffing rotas – Do By end August 2012.</i> The operational policies have been developed, agreed with the clinical team and form part of the design brief for the refurbishment work. The operational procedures, patient pathways and medical staff rotas are still being discussed and will be finalised by the end of October.</li> <li>• <i>Recommendation 4: Communicate and verify the congruence of key stakeholder understanding of the cash flow implications and timing of capital expenditure - Do By end August 2012.</i> This has now been agreed via the September SIRG meeting (the August meeting was cancelled).</li> </ul> <p>It was noted that although not all recommendations had been addressed by the end of August as recommended the delay has not compromised the implementation date.</p>	

MINUTES	PAPER REFERENCE
<p>It was noted that a Clinical Implementation Group, chaired by the Clinical Director for Stroke and Elderly Medicine, has been set up to lead delivery of the implementation plan. Progress is monitored fortnightly. The key issues identified in the progress report and the actions being taken to resolve these were discussed.</p> <p>With regard to the NHS Midlands and East strategic review of stroke services, the External Expert Advisory Group has developed a service specification for stroke services. We have completed a return to show how we will meet this specification following the reconfiguration of our stroke services. Our return was submitted with those of other local acute Trusts via the Birmingham and Solihull and Black Country Stroke Networks. The Network proposals would result in 5 Hyper-Acute Stroke Units (HASUs) across the two networks with one being located at Sandwell. The response from the External Expert Advisory Group suggests support for 4 or 5 HASUs within the two networks and has asked for some further information and clarification on detail in the next submission. We are currently working with the Networks to prepare the next submission.</p> <p>Overall the progress report assessed the project status as amber (remedial action required before the next report). Mrs Hunjan asked why this assessment had been made. Mrs Dunn explained it was because of the delay to the implementation date (see above) and to the delay in meeting the Gateway recommendations. She explained that whilst some actions are slightly delayed, the project overall is on track to meet the implementation date and is envisaged to remain so providing the end of October date for agreeing the operational procedures, patient pathways and medical staff rotas is met. It was agreed that future progress reports should monitor progress against the revised implementation</p> <p>A progress report will be presented to the Programme Board at its meeting in December.</p>	
<p><b>9. Trauma Centres and Units</b></p>	<p><b>SWBRB (09/12) 69</b></p>
<p>Mrs Dunn presented the Progress Report for Trauma Unit Designation. The forthcoming validation visits to confirm Trauma Unit status were discussed. The Trust has to present an updated portfolio of evidence two weeks before the visit and so work is ongoing to ensure this is ready. An informal pre-validation visit by the Trauma Network Medical, Rehabilitation and Specialised Commissioning Leads had taken place at the end of August. The key areas identified in the report, where the Trust needs to provide additional evidence of compliance with the standards were discussed and are:</p> <ul style="list-style-type: none"> <li>• <i>Providing evidence of Continuous Practice Development (CPD).</i> Mr Trotman asked for further information on this and whether the evidence would be available before the visits. Mrs Dunn explained that the evidence required (for consultants and middle grade doctors) and how to collect these through appraisals had been</li> </ul>	

MINUTES	PAPER REFERENCE
<p>discussed and agreed with the relevant Clinical Directors (ED, General Surgery, T&amp;O, Anaesthetics) through the Trauma Steering Group. Dr Ahee the Trauma Clinical Lead had recently emailed Clinical Directors to remind them of this and produced a matrix for them to complete. Mr Hazle the project manager for this work is now contacting the Clinical Directors and collating the evidence. The evidence is therefore expected to be available but it is recognised that in some cases further training will need to be planned e.g. if ATLS training has expired.</p> <ul style="list-style-type: none"> <li>• <i>Consultant in Rehabilitation Support.</i> The standard is that Trauma Units should have a sessional commitment from a Specialist Rehabilitation Consultant, based at Birmingham Community HealthCare Trust (BCHC) to support Trauma Unit staff in delivering rehabilitation prescriptions. BCHC have been funded to provide this support and whilst a meeting with BCHC was set up to discuss this it was necessary to cancel the meeting and a new date needs to be agreed. To date only one patient has been transferred back from the MTC for inpatient rehabilitation and was admitted directly to Henderson Ward. The Trauma Network lead for Rehabilitation confirmed that other Trauma Units are in a similar position.</li> <li>• <i>Rehabilitation after Critical Illness.</i> The Trust has undertaken a pilot to update the current documentation and expand the nurse led follow up to include therapy input. This has been successful and will be continued. Evidence from the pilot will be included in the portfolio and is expected to meet the Trauma Unit standard.</li> </ul> <p>Mrs Hunjan asked Mrs Dunn to ensure the portfolio of evidence shows compliance with the Trauma Unit standards or clear actions to deliver compliance (e. g. meeting date with BCHC) and is submitted within the required timescale.</p> <p>Mrs Dunn also advised that the Network leads during the pre-validation visit had asked why both City and Sandwell were seeking Trauma Unit status and whilst this had been addressed at the time it may be an issue that is raised again.</p> <p>Miss Barlow felt that the current issues within ED may be raised during the visit and explained that staffing models were being reviewed to ensure robust medical support from relevant specialties in ED.</p> <p>The outcome of the validation visit will be reported to the Programme Board meeting in December.</p>	
<p><b>ACTION: Mrs Dunn to ensure the portfolio of evidence shows compliance with the Trauma Unit standards or clear actions to deliver compliance (e. g. meeting date with BCHC) and is submitted within the required timescale.</b></p>	
<p><b>10. Future Clinical Reconfiguration</b></p>	<p><b>SWBRB (09/12) 70</b></p>
<p>Mrs Dunn presented the paper outlining future potential reconfigurations</p>	

<b>MINUTES</b>	<b>PAPER REFERENCE</b>
<p>and explained we are currently undertaking a programme of Specialty Strategy development with the aim of working with each clinical specialty to develop a 5 year strategy and set out key service changes and developments. A number of specialties have raised the potential need for clinical service reconfiguration. In line with the Trust's process for clinical service reconfiguration these specialties first need to outline the clinical drivers for change and potential options, including reconfiguration, to address these.</p> <p>The Programme Board noted this work and agreed that the Clinical Case for Change for each potential service reconfiguration should be presented to the Clinical Reconfiguration Programme Board in order to determine whether a clinical reconfiguration project should be established and whether public consultation is likely to be required.</p>	
<b>10. Pathology Update</b>	<b>SWBRB (09/12) 71 &amp; 72</b>
<p>Dr Berg had hoped to attend the meeting to present the report but his other commitment did not finish in time to allow this. He had sent a further update report regarding the SHA tendering of Direct Access which Mrs Dunn tabled at the meeting. From this it was noted that three procurement lots for the tendering had now been finalised. We are within Lot 2 and given the size of the Lot need to develop a joint submission with a third provider (in addition to the work previously undertaken with Dudley). The timescales for submission of returns were noted.</p> <p>Mr Trotman gave an update on the blood sciences laboratory project and explained consideration was being given as to how additional capacity in the facility could be developed if required in response to the SHA tendering of Direct Access work. Mr White explained with Dudley we had jointly commissioned a process engineering study to help create additional capacity.</p> <p>Mr White explained that we had submitted a business case jointly with Dudley in response to the Black Country PCT Cluster's commissioning intention to rationalise Cytology and future HPV testing to one site within the Black Country. We are awaiting feedback from the commissioners.</p>	
<b>11. REPORTS FOR INFORMATION</b>	<b>SWBRB (09/12) 60-64</b>
<p>The following reports/notes were received for information:</p> <ul style="list-style-type: none"> <li>• Trust Board Reconfiguration Progress Report (May)</li> <li>• Notes from the Stroke Reconfiguration Project Board (10/5/12, 30/5/12, 21/6/12, 3/7/12 &amp; 19/7/12)</li> <li>• Notes from Stroke Clinical Implementation Group (13/7/12 &amp; 10/8/12)</li> <li>• Notes from SWBH Vascular Surgery Reconfiguration Project Team (2/4/12 &amp; 2/8/12)</li> <li>• Notes from Joint Meeting with UHB re Vascular Surgery Reconfiguration (24/5/12, 6/6/12 &amp; 11/7/12)</li> <li>• Notes from Trauma Steering Group (14/5/12)</li> </ul>	



<b>MINUTES</b>	<b>PAPER REFERENCE</b>
<b>12 ANY OTHER BUSINESS</b>	
There was no further business.	
<b>12 DATE &amp; TIME OF NEXT MEETING</b>	
Thursday 6 <sup>th</sup> December 2012, from 1 pm to 3.00 pm in the Executive Meeting Room, City Hospital.	

## TRUST BOARD

<b>DOCUMENT TITLE:</b>	'Right Care, Right Here' Progress Report		
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Mike Sharon, Director of Organisational Development and Strategy		
<b>AUTHOR:</b>	Jayne Dunn, Redesign Director – RCRH		
<b>DATE OF MEETING:</b>	27 September 2012		
<b>EXECUTIVE SUMMARY:</b>			
The paper provides a progress report on the work of the <i>Right Care Right Here</i> Programme as at September 2012.			
<b>REPORT RECOMMENDATION:</b>			
The Trust Board is asked to ACCEPT the progress made with the Right Care Right Here Programme.			
<b>ACTION REQUIRED</b> <i>(Indicate with 'x' the purpose that applies):</i> The receiving body is asked to receive, consider and:			
<b>Accept</b>	<b>Approve the recommendation</b>	<b>Discuss</b>	
X			
<b>KEY AREAS OF IMPACT</b> <i>(Indicate with 'x' all those that apply):</i>			
Financial	X	Environmental	X
Business and market share		Legal & Policy	
Clinical	X	Equality and Diversity	X
		Communications & Media	X
		Patient Experience	
		Workforce	X
Comments:			
<b>ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:</b>			
<b>Supports strategic objective:</b>	Care Closer to Home		
<b>Supports 2012/13 Annual Priority:</b>	Progressing the "Right Care Right Here" vision of service change		
<b>PREVIOUS CONSIDERATION:</b>			
Monthly report to Trust Board			

**SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST****RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT  
SEPTEMBER 2012****Introduction**

This brief paper provides a progress report for the Trust Board on the work of the Programme as at the 17<sup>th</sup> September 2012. It provides an update with regard to progress with the Right Care Right Here (RCRH) Programme and the QIPP (Quality Innovation Productivity and Prevention) Schemes. It should be noted due to the recent incorporation of the management of the RCRH Programme into the new structure of the Sandwell and West Birmingham Clinical Commissioning Group (CCG) neither a RCRH Programme Director's Report nor a RCRH Service Redesign Report were produced for August or September. The work of the RCRH Programme and involvement of the Trust in this is discussed on a monthly basis at the Trust's Right Care Right Here Implementation Board meetings although there was not a meeting in September.

**Transfer of Activity: QIPP Schemes**

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

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

Work continues to translate these schemes into a detailed schedule with clear agreement between ourselves and the CCG about how and when they should be implemented and arrangements to monitor progress. To date a schedule of acute activity reductions/transfers has been identified equating to £6.1 million income reduction and this has been sent to the CCG for agreement. There is therefore a shortfall of acute activity reductions/transfers equating to £3.9million which needs to be discussed with the CCG in order to identify additional schemes. To date there has been no feedback from the CCG. In addition and as reported in August there has been a delay in establishing working groups and implementation plans for the approved RCRH care pathways. This is now expected to progress following appointments being made to the new CCG structure.

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

**RCRH Activity and Capacity Model**

As previously reported a full revision of the RCRH Activity and Capacity model is desired. However, This work has not been progressed pending clarity about the scope of the work, the

priority the CCG attaches to this work and who would support it. **Mike do you want to still include this if there is no further update??**

### **RCRH Partnership**

A health economy event was held on 13<sup>th</sup> September to review progress with the RCRH Partnership and agree a refresh of the Partnership/Programme in light of the new commissioning arrangements in the NHS and locally. **Mike to add feedback from the event**

### **Recommendations:**

The Trust Board is asked to:

- ACCEPT the progress made with the Right Care Right Here Programme.

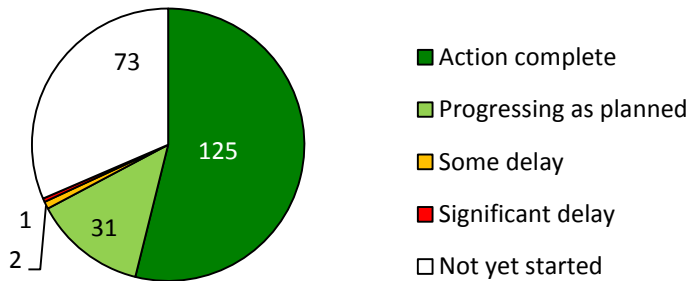
Jayne Dunn  
Redesign Director – Right Care Right Here  
17<sup>th</sup> September 2012

# FT Programme Monitoring Status Report

**Amber**

## Milestone status

### Milestone Deliverables



Milestone	Lead	End Date	RAG	Planned Actions
Review/re-develop Business Development Strategy	MS	28/09/12	2	Business Development Strategy to now be developed by December 2012

## Activities Last Period

- Agreed revised TFA with SHA/DH
- 7<sup>th</sup> draft IBP/LTFM prepared for SHA submission
- Supporting strategies and annexes prepared for SHA submission
- Mock Board to Board undertaken
- Deloitte assessment of Quality Governance progress against integrated development plan Quality Governance related activities
- Next Board quality governance self-assessment undertaken
- Independent BGAF assessors commenced
- HDD 2 operational planning meeting – 24<sup>th</sup> September 2012
- SHA FT Quality review date agreed
- Presentations to staff on IBP/LTFM content commenced

## Planned Next Period

- 8<sup>th</sup> draft IBP/LTFM prepared to incorporate SHA feedback on draft 0.7
- SHA FT readiness meeting – 10<sup>th</sup> October 2012
- Prepare updated assets register and agree protected assets and compile protected property register
- BGAF/SHA board observations and 1:1 meetings
- BGAF independent assessment of BGM
- Finalise downside modelling and mitigation strategies
- Finalise TSPs
- Continue programme of raising staff awareness of FT issues

## Issues for Resolution/Risks for Next Period

- Finalise TSPs and downside mitigations

<b>TRUST BOARD</b>
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<b>DOCUMENT TITLE:</b>	<b>Foundation Trust Programme Monitoring and Status Report</b>
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	<b>Mike Sharon, Director of Strategy and Organisational Development</b>
<b>AUTHOR:</b>	<b>Mike Sharon, Director of Strategy and Organisational Development</b>
<b>DATE OF MEETING:</b>	<b>27 September 2012</b>

**EXECUTIVE SUMMARY:**

The report gives an update on:

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

**REPORT RECOMMENDATION:**

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

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
<b>X</b>		<b>X</b>

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

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

Comments:

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

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

**PREVIOUS CONSIDERATION:**

FT programme Board on 27 September 2012