Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 29 November 2012; 1530h

Members

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

In attendance

Mr M Sharon	(MS)	[Director of Strategy and Dep CEO]
Mr G Seager	(GS)	[Director of Estates & New Hosp Project]
Miss K Dhami	(KD)	[Director of Governance]
Mrs J Kinghorn	(JK)	[Head of Communications & Engagement]
Mr R Trotman	(RT)	[Board Adviser]
Mrs C Rickards	(CRI)	[Trust Convener]
Mr B Hodgetts	(BH)	[Sandwell LINks]

Secretariat

Mr S Grainger-Payne (SG-P) [Trust Secretary]

Guests

Dr M Poulson (MP) [Clinical Director for Emergency Care]

Time	Item	Title	Reference Number	Lead
1530h	**1**	**Apologies**	**Verbal**	**SGP**
	2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 25 October 2012 as a true and accurate record of discussions*	**SWBTB (10/12) 256**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (10/12) 256 (a)**	**SG-P**
	5	**Chair and Chief Executive's opening comments**	**Verbal**	**Chair/ CEO**
	6	**Questions from members of the public**	**Verbal**	**Public**
1535h		**MATTERS FOR APPROVAL**		
	7	**Appointment of Senior Independent Director/Vice Chair**	**SWBTB (11/12) 258** **SWBTB (11/12) 258 (a)**	**RSM**
	8	**Emergency Departments**		
	8.1	Quality & performance update	SWBTB (11/12) 259 SWBTB (11/12) 259 (a)	RB
	8.2	Emergency Department investment plan	To follow	JA/ MP

	9	**Pensions auto enrolment proposal**	**SWBTB (11/12) 261** **SWBTB (11/12) 261 (a)**	**RW**
1545h	**MATTERS FOR CONSIDERATION AND NOTING**			
	10	**Safety, Quality and Governance**		
	10.1	Update from the meeting of the Quality & Safety Committee held on 22 November 2012	Verbal	OD
	10.2	Quality report	To follow	RO/ KD/ RST
	10.3	Board Assurance Framework update – Quarter 2	SWBTB (11/12) 262 SWBTB (11/12) 262 (a)	SG-P
	10.4	Interim declaration against same sex accommodation guidance	SWBTB (11/12) 263 SWBTB (11/12) 263 (a)	RB
	10.5	Medical revalidation update	SWBTB (11/12) 264 SWBTB (11/12) 264 (a) SWBTB (11/12) 264 (b)	RST
	10.6	CQC reports following visits to Sandwell and City Hospitals	SWBTB (11/12) 265 SWBTB (11/12) 265 (a) SWBTB (11/12) 265 (b)	KD
1645h	**11**	**Performance Management**		
	11.1	Draft minutes from the meeting of the Finance & Performance Management Committee held on 23 November 2012	To follow	CR/RT
	11.2	Monthly finance report	SWBTB (11/12) 266 SWBTB (11/12) 266 (a)	RW
	11.3	Monthly performance monitoring report	SWBTB (11/12) 267 SWBTB (11/12) 267 (a)	RW
	11.4	NHS Performance Framework report	SWBTB (11/12) 268 SWBTB (11/12) 268 (a)	RW
	11.5	Performance Management Regime – monthly submission	SWBTB (11/12) 269 SWBTB (11/12) 269 (a)	MS
	11.6	Update on the delivery of the Transformation Plan	SWBTB (11/12) 270 SWBTB (11/12) 270 (a) SWBTB (11/12) 270 (b)	RB
1715h	**12**	**Strategy and Development**		
	12.1	'Right Care, Right Here' programme: progress report including update on decommissioning	SWBTB (11/12) 271 SWBTB (11/12) 271 (a)	MS
	12.2	Foundation Trust application programme		
	▶	Monitoring report	SWBTB (11/12) 272 SWBTB (11/12) 272 (a)	MS

	13	**Any other business**	**Verbal**	**All**
	14	**Details of next meeting** *The next public Trust Board will be held on 20 December 2012 at 1530h in the Boardroom, Sandwell Hospital* *Non-routine agenda items due to be considered at the meeting are:* • Update on implementation of revised nurse leadership model (CN) • Nursing annual report (CN) • Integrated risk report – Quarter 2 (DG) • Fire safety annual report (DENHP) • Radiation protection annual report (COO) • Communications and engagement strategy update (HCE) • Owning the Future update (HCE) • Listening into Action update (CEO) • Reconfiguration update (DSOD) • Research strategy update (MD)		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Boardroom, Sandwell Hospital **Date** 25 October 2012

Present

Mr Richard Samuda (Chairman)
Mr Roger Trotman
Mrs Gianjeet Hunjan
Dr Sarindar Sahota OBE
Ms Olwen Dutton
Mr Phil Gayle
Mr John Adler
Mr Robert White
Miss Rachel Overfield
Dr Roger Stedman

In Attendance

Mr Mike Sharon
Miss Kam Dhami
Mr Graham Seager
Mrs Jessamy Kinghorn
Ms Clare Robinson
Mr Harjinder Kang

Secretariat

Mr Simon Grainger-Payne

Observer

Mr John Deverill (Finnamore Ltd.)
Mr Paul Johnson (Finnamore Ltd.)

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mr Bill Hodgetts from Sandwell LINks.	
2 Declaration of Interests	**Verbal**
The Chairman advised that he wished to declare an interest, which covered his involvement as a Non Executive Director/trustee of a healthcare charity 'Kissing it Better' run by his wife. He notified the Board that the Trust had recently agreed to	

work with this charity on a programme of innovative volunteering activities on selected wards and outpatients to improve patient experience. It was proposed that the Chief Nurse would be responsible for approving any direct expenses incurred by the Trust that related to this programme and these would be overseen by the chair of the Trust's Audit Committee. The Board was informed that although the charity charges for some services at other NHS Trusts, there would be no payments for services to the charity required for the support delivered in view of the involvement with the Chairman. Mr White advised that he would prepare a routine report detailing any expenses met for the charity, which would be presented to the Audit Committee. Mrs Hunjan advised that she had been appointed as the responsible officer at Oldbury Academy.	
3 Minutes of the previous meeting	**SWBTB (9/12) 231**
The minutes of the Trust Board meeting held on 27 September 2012 were approved.	
AGREEMENT: The minutes of the last meeting were approved	
4 Update on actions arising from previous meetings	**SWBTB (9/12) 231 (a)**
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. Miss Overfield reported that she would present an interim report concerning the effectiveness of the new ward leadership model to the meeting of the Trust Board planned for December 2012.	
ACTION: Miss Overfield to present an update on the effectiveness of the ward leadership model at the December 2012 meeting of the Trust Board	
5 Chair and Chief Executive's opening comments	**Verbal**
The Chairman highlighted that the meeting would be Mr Gayle's last as a Non Executive Director and he was thanked for his service to the Trust during his period in office. Ms Robinson and Mr Kang were welcomed to the meeting as attendees, in advance of their formal positions as Non Executive Directors taking effect from November 2012. The Chairman advised that in future, the focus of the Chair and Chief Executive's update would focus on the external environment, however for the current meeting the item would focus on internal matters. The Board was advised that the Chairman had recently chaired the Equality & Diversity Conference which had been well attended and energetic. The Chairman also reported that he had attended the Healthcare Assistants Conference which had been well represented from across the Trust. Miss Overfield confirmed that that evaluation of the conference had been very positive and was regarded as	

being a valuable event. The Chairman reported that he had attended a West Midlands Chair's event which had focussed on the development of the Health and Wellbeing boards. The Board was advised that the Chairman has continued to attend a number of meetings with the Trust's clinicians. Mr Adler advised that the staff awards event had been enjoyable and he reported that sponsorship had been obtained for a number of the tables. He reported that a significant amount of time had been dedicated to completing the Transformation Savings Plan 'sign off' meetings for all clinical and corporate divisions. It was highlighted that quality impact systems were now much better embedded. The Board was advised that in future, the reports back from the Board Committee chairs would be delivered as the first items within the relevant section of the meeting agenda.	
6 Questions from members of the public	**Verbal**
There were no members of the public present.	
7 Quality Report	**Hard copy**
Miss Overfield asked the Board to note that performance against the CQuIN targets had been included in the report and that in future a narrative would be provided. It was reported that performance against the Safety Thermometer had deteriorated slightly. Performance against the Infection Control target was reported to be tight and attention was reported to be needed to achieve a better position in relation to MRSA screening. The Board was advised that a number of infection outbreaks had occurred recently, mainly related to diarrhoea and vomiting originating in the community. It was reported that some infections had been reported at Leasowes Intermediate Care Centre. Miss Overfield reported that a review of antenatal screening was underway and nearly all women on the caseload had been reviewed, which had revealed c. 90 women who had not been offered screening, of which 30 were attributable to the Trust, the rest being women who were due to deliver at other organisations. Although the Board was advised that more detail would be provided in connection with resuscitation as part of the Quality Report to be presented at the next meeting, Miss Overfield advised that the Trust had a good survival rate post cardiac arrest compared with the national average. Dr Stedman reported that the Hospital Standardised Mortality Rate (HSMR) had been rebased. Mr White asked whether recoding of cases was part of this baseline exercise and was advised that this was the case. Dr Stedman advised that there was a significant difference in mortality rates between Sandwell and City	

Hospitals, some of which was reported to be due to coding and risk adjustment models. It was highlighted that the majority of deaths were associated with a small number of specialities.

In terms of performance against the CQuIN targets, it was highlighted that the VTE assessment target had been met, although it was noted that this was not by a significant margin.

Regarding medicines management, it was reported that much attention was being focussed on antibiotic stewardship, where it had been determined that 95% of prescribing was in line with guidelines, however recording this on drugs charts was poor. It was reported that there was a general drive to improve medicines management, which was being driven through the Medicines Safety Committee.

Miss Overfield reported that the Net Promoter Score stood at 63 against a year end target of 65. The target related to the Community Services aspect was reported to be to retain a score of 75, however this had deteriorated to 71.

In terms of complaints handling, Miss Dhami reported that the backlog of complaints was being reduced and that 38 were now within the backlog against a position of 127 in September 2012. It was highlighted that this represented a minor adverse variation of four from the trajectory and there was an anticipation that the backlog could be cleared as planned. The Chairman asked when the plans for revising the complaints handling system would be shared with the Board. Miss Dhami advised that this would be presented to the Quality & Safety Committee in December 2012, following the conclusion of the external review of current process. It was reported that a 'Listening into Action' event would be held to provide adequate engagement for development of the process.

Miss Overfield advised that targeted support continued to be directed to the Trust's Emergency Departments. It was reported that this would be discussed more fully in the next agenda item.

It was highlighted that gaps in the complement of nurses continued to be an issue, particularly given the higher than planned beds that were open at present. Miss Overfield advised that the nurse staffing issues were anticipated to be resolved by December 2012.

The Chairman asked what progress had been made with investigating the mortality position in connection with biliary tract disease. Dr Stedman advised that the matter had been investigated and coding issues had been found to be influencing the position. The Board could therefore take assurance that there was little need for concern about this situation.

Miss Overfield advised that future quality priorities would be discussed at the forthcoming Trust Board 'Time Out' session, however would be likely to include stroke services, achieving the fractured neck of femur national target, VTE assessment and pneumonia.

Dr Stedman reported that overall performance with adherence to the use of the

World Health Organisation (WHO) checklist was sound, however targeted work to improve completion of steps 1 and 5 of the 'five steps' was needed. The Trust's use of bank and agency staff was discussed, where Mr Adler advised that the Trust was using a significant amount of temporary staff to ensure wards were adequately staffed. Miss Overfield added that 5000 shifts per month were covered by agency or bank staff. Prof Lilford asked what reasons prevented a reduction in the use of these staff and was advised that the delay in delivering the bed reconfiguration plan was a key issue in this respect. It was reported that at present 35 beds were open which should have been closed according to the original plan and that winter capacity was now open. Prof Lilford asked whether there were sufficient numbers of nurses available in the region to be able to recruit into vacant positions successfully. Miss Overfield confirmed that this was the case, however the majority were newly qualified. Mr White advised that the nature of the emergency contract with commissioners was a fixed sum of money, however additional funds had recently been made available in recognition of the operational pressures which the Trust was facing. Mr Sharon asked what early warning signs were used to detect deterioration in quality on the wards. Miss Overfield reported that an increase in pressure damage rates, an increase in falls, deterioration in ward review assessments and an increase in sickness absence rates would all suggest deterioration in quality of care delivered. Dr Stedman advised that in 2011/12 a decline in emergency activity had been seen across the region, however the situation was very different in 2012/13 with a significantly higher than forecast level of activity being experienced. Ms Robinson asked whether there were any means of communicating with the public in place to advise that Primary Care facilities should be used when appropriate rather than Accident and Emergency. Miss Barlow advised that these messages were being communicated through Birmingham and Sandwell fora at which the Trust was represented. She was asked whether specific messages were targeted to the public. Miss Overfield advised that some hard to reach groups were not registered with a GP and would therefore use Accident and Emergency instead of Primary Care. Miss Barlow added that the opportunity was taken to register such patients with GPs when presenting at Accident and Emergency and work was underway with Primary Care to avoid these attendances.	
7.2 Emergency Department performance update	**SWBTB (10/12) 233** **SWBTB (10/12) 233 (a)**
Miss Barlow reminded the Board that the quality and safety performance of the Emergency Departments had been discussed earlier within the private session of the meeting. The Board was advised that the Trust's Emergency Departments had been subject to a number of external reviews during recent months, which mainly focussed on quality and safety performance. It was reported that performance against the nationally mandated four hour waiting time in the Emergency Departments was deteriorating, with current performance being 94.45%, below the 95% threshold. The Board was informed that performance at City Hospital was a concern in particular, where the 95%	

target was not being met on a routine basis.

Reasons for the poor performance were highlighted to relate to issues with patient flow and interdepartmental delays. The higher than forecast emergency activity being experienced by the Trust was also reported to be exacerbating the position. To mitigate the position, it was reported that considerable focus was being directed to developing escalation mechanisms and expected standards for staff. A recovery action plan was reported to have been developed and the Board was informed that a new Clinical Director had been appointed. Work to review and revise the patient flow mechanisms and clinical pathways was also reported to be underway. The Board was advised that a revised staffing model was under development and a case for investment was being prepared, which the Board would be asked to approve in due course.

Miss Barlow highlighted that the trajectory to achieve the 95% national target was a significant risk to the Trust, however it was anticipated that the recovery plan that had been developed would assist with achieving this.

The Board was informed that behaviours and commitment of staff to improving the performance were not as positive as had been seen in previous times when additional effort had been needed to achieve the targets.

Mr Trotman observed that there was a marked difference in performance between City and Sandwell Hospitals and asked what reasons lay behind this position. Miss Barlow reported that the layout of the departments contributed to some degree to this variation, in addition to the difference in behaviours by staff at the two hospitals. It was highlighted that poor performance at Sandwell Hospital was generally related to downstream capacity issues. Dr Stedman advised that Sandwell Hospital also employed a more integrated approach to care. Miss Overfield added that the two hospitals experienced a difference in case mix which also contributed to the difference. Prof Lilford asked whether the issue related to poor use of existing resources within the departments or whether there was insufficient staffing to handle the cases being received. He was advised that there was a need for more senior doctors within the areas who could review the patients. Mr Adler advised however, that similar level of cases had been handled by the Trust in previous years with a similar staffing model, therefore the current staffing arrangements were not solely responsible for the position. Dr Sahota asked whether performance was being impacted by the Urgent Care Centres in the area now handling simpler cases, leaving those that were more complex for the Trust to receive. Mr Adler confirmed that this could be a contributory factor.

The Chairman suggested that a dashboard of performance against key indicators would be useful to assess more fully the position. Miss Barlow circulated an update of performance against the Accident and Emergency clinical indicators. Ms Robinson asked whether a root cause analysis of each breach was undertaken. Miss Barlow advised that this was the case, however the current IT capacity to assist with this was limited. Ms Robinson suggested that there was a need to review common trends. She asked to what extent the staff working in the area had been engaged with developing a solution to the issues. Miss Barlow reported

that all consultants, middle grade staff and nurses in the area had been interviewed, which had revealed a lack of team working and team effectiveness. With the development of the Special Measures action plan, however it was reported that an understanding of the issues and the means to improve the position were more clearly owned. Ms Robinson asked whether this ownership was at all levels in the area and was advised that this was the case. Miss Overfield added that all findings from the interviews had been reviewed and 'Listening into Action' events had been held to achieve staff engagement with the work. Ms Robinson asked whether charts showing performance were visible to staff. Miss Overfield advised that the current measures boards used would include this performance information and that a special 'Hot Topics' briefing was being arranged for all managers to engage them with the wider work that was needed. The Chairman asked whether there were other influences on patient flow outside of the Emergency Department remit of which the Board needed to be aware. Dr Stedman advised that the key issues changed regularly, however the lack of speedy discharges was a significant influence on patient flow. Mr Kang suggested that external influences which could assist the position needed to be borne in mind, such as use of intermediate care and reablement facilities and the use of discharge clinics. Dr Sahota observed that the recovery action plan did not appear to take into account work to accommodate unplanned attendances. Miss Barlow advised that replanning was underway in this respect. Mr Adler summarised that in the light of the deteriorating performance, the recovery action plan would be delivered with greater vigour and that more robust action would be taken to reverse the trend.	
7.3 Update from the meeting of the Quality & Safety Committee held on 19 October 2012	**Hard copy**
Ms Dutton reported that the Quality & Safety Committee held on 19 October 2012 had received further updates from the Imaging Division in respect of delivery of the integrated governance plan and from the Head of Midwifery on the progress with identifying cases of missed Downs Syndrome screening. The Board was advised that the good progress had been made to achieve an improvement in the speed with which Imaging diagnostic results were being reported, however there were concerns in respect of the poor clinical engagement with the required new ways of working in the area. Ms Robinson asked whether this situation would be addressed through the appraisal process. Dr Stedman confirmed that this was the case. Miss Dhami advised that the Divisional Director had advised that he would be discussing performance with individuals within the area where necessary. In terms of the Downs Syndrome screening work, the Board was advised that work to review the caseload of women was continuing, however it had been highlighted that a national Standard Operating Procedure was not in place to govern the way in which test requests and results were handled. Ms Dutton advised that the Whistleblowing policy had been considered and it had been agreed that the most appropriate area to own the policy was the	

Governance division, rather than Workforce. It was reported that the complaints backlog was reducing broadly in line with the planned trajectory. The Board was advised that as part of the Committee's new reporting cycle, the Executive Directors would highlight the most appropriate division to attend the meetings to present their performance updates. Mr Sharon suggested that the Committee should also consider as part of this update, the financial performance of the Division.	
7.4 Reporting schedule for corporate meetings	**SWBTB (10/12) 234** **SWBTB (10/12) 234 (a)**
Mr Grainger-Payne reminded the Board that one of the key recommendations from the external FT readiness reviews was to consider which reports were presented at which Board or Committee and in what level of detail. It was highlighted that at the meeting of the Trust Board in August 2012, a map of all reports considered by the Trust Board and its Committees had been presented and that since this meeting all Executive Directors had been asked to review the reports for which they were cited as the sponsoring director, with a view to streamlining the reporting and reducing the duplication of information between meetings. Mr Grainger-Payne reported that the schedule presented, detailed the outcome of the work and outlined the planned changes to the reporting. It was pointed out that particularly within the section of the report dealing with quality and safety matters, many of the proposed changes had been undertaken already as part of the development of the new reporting cycle for the Quality & Safety Committee. The Board was asked to note the significant areas of changes planned, which largely suggested that exceptions to performance be reported to the Trust Board rather than the full detailed reports which would be presented to the relevant Committee. It was reported that the planned changes would be delivered over the next few months and that they would be kept under review for the near future. Mr Grainger-Payne was asked where workforce matters would be considered. He advised that the Finance & Performance Management Committee reviewed the workforce dashboard on a quarterly basis. Ms Dutton added that elements of workforce performance would also be considered by the Quality & Safety Committee. It was suggested that a Whistleblowing update should be added into the reporting cycle for the Audit Committee. Mr White also suggested that the payments made to the voluntary organisation with which the Chairman had declared an interest earlier, would be included within the losses, compensation and special payments	

register considered by the Audit Committee. Mr Sharon suggested that the review of the reporting cycles of the Executive-led Governance Board and Trust Management Board should be undertaken as a next step with a view to simplifying the reporting structure further.	
7.5 Whistleblowing policy	**SWBTB (10/12) 235** **SWBTB (10/12) 235 (a)**
Miss Dhami presented the Whistleblowing policy, advising that historically the ownership of the policy had rested with Workforce, however at the recent meeting of the Quality & Safety Committee, it had been agreed that it should more appropriate sit within the Governance area. It was highlighted that there was much work to do to embed Whistleblowing within the culture of the organisation. Ms Robinson noted that the policy required the nomination of a named Non Executive Director to which matters should be escalated if needed. Ms Dutton advised that she would assume this role in her capacity as Chair of the Quality & Safety Committee.	
7.6 Annual Audit Letter	**SWBTB (10/12) 236** **SWBTB (10/12) 236 (a)**
Mr White presented the Annual Audit Letter which he advised had been reviewed by the Audit Committee at its last meeting. The Board was asked to note that the letter made three recommendations, one of which related to consultancy services, where it was reported that HM Treasury had undertaken a review of public sector departments to identify those senior individuals who were employed but not on the organisation's payroll. It was reported that a particular issue had been identified in the NHS in this respect and therefore the Trust had been recommended to check the tax arrangements of all members of staff employed in these positions. It was reported that this work was underway.	
7.7 Health and Wellbeing update	**SWBTB (10/12) 247** **SWBTB (10/12) 247 (a)**
Miss Overfield reported that the Health and Wellbeing concept was designed to boost performance by paying attention to staff wellbeing. It was highlighted that a significant number of initiatives had been undertaken in line with this agenda, some of which focussed on reducing stress and addressing obesity. The Chairman asked what information was available to benchmark the Trust's performance on Health and Wellbeing matters with that of other trusts. Miss Overfield advised that the Trust was regarded as a role model in this respect. The Board was advised that there was a concern with sickness absence levels within the Trust at present, where deterioration was being seen. Mrs Kinghorn asked whether there were any measures when staff returned to work following a period of sickness absence which could be delivered which might assist the	

position. Miss Overfield advised that the Occupational Health department took responsibility for this work at present. Mr Adler advised that the current sickness absence position was at variance with that of previous years where a steady reduction had been seen. Mr Kang asked whether staff satisfaction 'pulse checks' were undertaken. Miss Overfield advised that the Trust participated in a national staff survey and that the reasons behind staff turnover were reviewed routinely. It was also reported that staff satisfaction could also be gauged by the letters received for the 'Your Right to be Heard' column of the Trust's staff newsletter, 'Heartbeat'.	
8 Performance Management	
8.1 Monthly finance report	**SWBTB (10/12) 237** **SWBTB (10/12) 237 (a)**
Mr White reported that the financial position was ahead of plan at present and that the year to date surplus generated was £1.3m. At a divisional level, it was reported that performance was largely stable, although the Surgery B division was carrying a small deficit at present. The Board was advised that the use of agency staffing had fallen within the month. The adverse variance in delivery of the Transformation Savings Plan was reported to have reduced. Mr White reported that that capital programme had been reviewed and some additional commitments had now been included. The Board was informed that some additional support had been provided to the Medicine and Emergency Care division and therefore a revised performance trajectory and Transformation Savings Plan for the area would be set shortly. Mr White explained that additional funding would be received from commissioners to address the current referral to treatment time positions in Trauma & Orthopaedics and Plastic Surgery.	
8.2 Draft minutes from the meeting of the Finance and Performance Management Committee held on 19 October 2012	**Tabled paper**
Mr Trotman provided a summary of the discussions held at the Finance and Performance Management Committee meeting held on 19 October 2012. The Board was advised that Surgery B had reported to the Committee, where it had been noted that the main source of income related to Ophthalmology, which accounted for c. 75% of the total. Whilst income generated was above plans was noted to have been over budget and payroll costs being slightly less than anticipated, it was reported that the position did not in itself reflect the use of bank and agency staff due to premium rate working in Oral Surgery and ENT, in addition to junior doctor vacancies in the area. Expenditure on drugs was	

reported to have been above plan, however the Board was advised that this was mainly compensated by income. The Board was advised that although the division was in deficit by £22k, assurances had been given that the year end position would be in line with plan. The Board was advised that the Committee had noted that the overall financial position for the Trust for month six was good, meaning that the position was further ahead of the half year target by £266k or 22.7% of the target set by the Department of Health. It was reported that there was still some concern over the Medicine & Emergency Care division's position and that the division would be coming to report in detail at the November 2012 meeting. It was reported that the Committee had expressed concern over the performance of the Emergency Departments and it had been emphasised that there was a need to achieve the relevant targets and a requirement to see a comprehensive plan that would deliver an improved performance.	
8.3 Monthly performance monitoring report	**SWBTB (10/12) 238** **SWBTB (10/12) 238 (a)**
Mr White highlighted that a number of quality metrics had been discussed as part of the Quality Report earlier on the agenda, including MRSA screening and VTE assessment. It was reported that Mandatory Training compliance was being given additional focus at present, with training in Information Governance being a particular issue. Ms Dutton asked whether any work was being undertaken around preferred learning styles which might assist the position. Miss Overfield advised that no specific work was underway in this respect, however many staff did not have access to computer to be able to access e-learning packages. It was reported that as such, most Mandatory Training modules were offered as both electronic and classroom based sessions. The Chairman observed that there appeared to be some belief from clinicians in particular, that they were being asked to attend courses that were irrelevant or inappropriate. Miss Overfield advised that many courses were nationally mandated and therefore there was little choice but for staff to attend. Mr Adler advised that bespoke day-long classroom based training packages were being devised. Dr Sahota noted that there was some disparity between the data included in the Quality Report and the corporate performance dashboard and suggested that the information should be harmonised. He also highlighted that the success in reporting times for diagnostic tests did not appear obvious from the corporate performance dashboard. Mr Adler confirmed that the performance in this respect had improved from 13% of cases being reported within 24 hours to c. 70%. Mr Adler advised that following the recent Board observation by the Strategic Health Authority, it had been recommended that the corporate performance dashboard should better highlight the successes and exceptions. Mr White advised that the Trust's performance according to the FT Compliance Framework was amber/red in reflection of the underperformance against the 62 day cancer waiting time, *C Difficile* infection rates and Accident & Emergency	

targets. It was highlighted however, that it was likely that the position would be recovered next month. Miss Barlow reported that in terms of the issue with cancer waiting time targets, there had been nine breaches to the targets in the Oncology and Urology specialities, which had been escalated but not handled. The Board was advised that measures had been put into place to prevent a reoccurrence of the situation. Prof Lilford observed that within each target, there was likely to be considerable variation in performance and suggested that it would be useful to see the distribution and comparison of performance against the targets.	
8.4 NHS Performance Framework report	**SWBTB (10/12) 239** **SWBTB (10/12) 239 (a)**
Mr White advised that according to the NHS Performance Framework the Trust was classified as 'performing'.	
8.5 Provider Management Regime monthly return	**SWBTB (10/12) 240** **SWBTB (10/12) 240 (a)**
Mr Sharon presented the proposed Provider Management Regime return for submission to the Strategic Health Authority. It was highlighted that the Governance Risk Rating was 3. It was noted that the cancer waiting times breaches and the under performance against the Accident and Emergency targets was reflected in the submission. In respect of the latter, the Board was advised that under performance against the target for two successive quarters could generate a risk that the Trust's overall performance would be classed as being at red status. In terms of the MRSA screening position, the Board was advised that it was anticipated that the position would be improved shortly. Compliance with the use of the WHO checklist was reported to be 99.83%. Mr Sharon asked the Board to note that there had been no changes to the declarations made against the Board statements. Compliance with Level 2 of the Information Governance toolkit was reported to be declared in December 2012, in line with the milestone within the Trust's Tripartite Formal Agreement. The Chairman asked what confidence was placed on the achievement of this requirement. Miss Dhami reported that capacity to train 600 staff per day in Information Governance had been arranged, however at present, few staff were joining the training sessions. Ms Dutton asked whether this situation was a Trustwide issue and was advised that this was the case.	
AGREEMENT: The Trust Board gave its approval to the submission of the Provider Management Regime return	
8.6 Update on the delivery of the Annual Plan – Quarter 2	**SWBTB (10/12) 241** **SWBTB (10/12) 241 (a)**
Mr Sharon asked the Board to note the revised format for reporting progress with delivery of the activities within the annual plan. It was highlighted that the means by which the Board received assurance that the areas of the annual plan were	

being delivered had been included in the update where relevant. The delay to the 'Right Care, Right Here' trajectory was highlighted to be outside the control of the Trust and that the Clinical Commissioning Group (CCG) was agreeing a revised structure and plan to address the gap in the decommissioning plans. Ms Dutton questioned whether this delay affected the Board's ability to sign off the statement in the Provider Management Regime (PMR) concerning the delivery of the annual operating plan. The Board discussed the matter and agreed that on balance a declaration of compliance with the statement could still be made.	
8.7 Update on the delivery of the Transformation Plan	**SWBTB (10/12) 242** **SWBTB (10/12) 242 (a)**
Miss Barlow reported that work was underway to develop the 2013/14 and 2014/15 Transformation Savings Plans and that the appropriate equality impact assessments and quality impact assessments were being undertaken. Good progress with the delivery of the theatre utilisation workstream was highlighted and the Board was informed that patient flow work was progressing well, including the resolution of delays with issuing drugs for patients to take home enabling a more rapid discharge. Dr Sahota asked whether effort was being directed to ensuring that discharges happened before midday. He was advised that further work was planned to achieve this. It was reported that intermediate care and reablement wards had introduced ward rounds and bed boards. The Board was advised that an Associate Director of Transformation had been appointed, following a recent recruitment and selection exercise. Mr Adler highlighted that although the schemes within the Transformation Savings Plans for the coming years had been themed, in some cases it was not clear how those that were aligned to the Transformation Plan workstreams translated into savings. The Board was advised that the Transformation Plan Reporting System (TPRS) was assisting in this respect however. Ms Robinson asked whether the level of 'Did Not Attend' cases was being addressed through the Outpatient workstream. She was advised that this was the case. Dr Stedman reported that there was good engagement with the Outpatient work and a session at the recent Consultant Conference had assisted.	
9 Strategy & Development	
9.1 'Right Care, Right Here' programme: progress report, including an update on decommissioning	**SWBTB (10/12) 243** **SWBTB (10/12) 243 (a)**
The Trust Board received and noted the 'Right Care, Right Here' programme progress report. Mr Sharon reported that some outputs of the whole Health Economy work had been received which would be supported by the CCG. The Board was advised that the Partnership Board would meet quarterly and it would be supported by an Executive Board. It was highlighted that a more integrated approach to operationalising the programme was planned. Mr Sharon	

reported that a refresh of the activity and capacity model would be undertaken. Dr Sahota asked who would be represented on the Partnership Board. Mr Sharon advised that this remained unchanged as the CCG, the Local Authorities and local providers. The Chairman and the CEO would form the membership of the Board for the Trust. Mr Adler advised that the membership had been rebalanced to make representation more even across the organisations and that the meetings would be independently chaired.	
9.2 Foundation Trust application: programme director's report	**SWBTB (10/12) 244** **SWBTB (10/12) 244 (a)**
The Trust Board received and noted the Foundation Trust programme director's report. It was reported that the completion of the two year Transformation Savings Plans was underway and a number of meetings had been held recently to ensure that this was achieved. It was agreed that the feedback from the Strategic Health Authority on the Board Observation and on the Integrated Business Plan would be considered at the forthcoming Trust Board 'Time Out' session. The Board was advised that the Board Governance Assurance Framework (BGAF) process was underway and preparations were being made for the second phase of the Historical Due Diligence process. The Board was advised that the scope of this work was to be agreed, however it would involve further Board interviews. Mr Sharon advised that during the next period work would commence on how the Council of Governors would be set up and the self-certification statements would be considered.	
9.3 Birmingham Compact update	**SWBTB (10/12) 236**
Mr Sharon suggested that the refreshed Birmingham Compact be endorsed. Mr Adler highlighted that the Trust was held as an exemplar in terms of Paediatrics as a reconfigured and outreach service. It was reported that the Compact would also consider the Central Care records programme, where the means to access basic healthcare information would be developed further. Mr Sharon advised that there was a desire to create a set of metrics to identify how the Health Economy was operating in terms of overall performance.	
10 Operational matters	
10.1 Sustainability update	**SWBTB (10/12) 245** **SWBTB (10/12) 245 (a)**
Mr Seager reported that the Trust had been nominated for a Health Service Journal (HSJ) award for its work on sustainability. It was reported that much work had been directed to improving internal sustainability arrangements and a garden party had been held. The Board was advised that the sustainability work linked in with the Transformation Plan and the associated efficiencies arising from this.	

Waste recycling management was reported to have been introduced and much effort was highlighted to be being put into carbon management overall.	
11 Any other business	**Verbal**
The Chairman again thanked Mr Gayle for his contribution during his time as a Non Executive Director and wished him well.	
10 Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1530h on 29 November 2012 and would be held in the Anne Gibson Boardroom at City Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 29 November 2012, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

25 October 2012, Boardroom @ Sandwell Hospital

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

In Attendance: Mr M Sharon (MS), Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Ms C Robinson (CR), Mr H Kang (HK)

Apologies: Mr B Hodgetts (BH) [Sandwell LINks]

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 23 November 2012

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
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-13	Subsumed by action SWBACT.233	B
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	~~26/10/2012~~ 29/11/2012	Included on the agenda of the November 2012 meeting	B
SWBTBACT.233	Update on actions arising from previous meetings	SWBTB (9/12) 231 (a)	25-Oct-12	Present an update on the effectiveness of the ward leadership model at the December 2012 meeting of the Trust Board	RO	20/12/12	ACTION NOT YET DUE	G

KEY:

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Appointment of the Vice Chair and Senior Independent Director**
SPONSOR (EXECUTIVE DIRECTOR):	**Richard Samuda, Trust Chairman**
AUTHOR:	**Simon Grainger-Payne, Trust Secretary**
DATE OF MEETING:	**29 November 2012**

EXECUTIVE SUMMARY:

The Board is asked to support the nomination of Mrs Clare Robinson for appointment as the Trust's Vice Chair and shadow Senior Independent Director.

Attached is a reminder of the role and the responsibilities of the individual in relation to the Chair, Non Executive Directors and the Council of Governors.

REPORT RECOMMENDATION:

The Board is asked to approve the nomination of Clare Robinson as the Trust's Vice Chair and Senior Independent Director with immediate effect.

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

Accept	Approve the recommendation	Discuss
	X	

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

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

Comments: Nomination made in line with the requirements of Monitor's Code of Governance for NHS Foundation Trusts

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

Supports the work to achieve authorisation as a NHS Foundation Trust

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

NOMINATION OF A VICE CHAIR/SENIOR INDEPENDENT DIRECTOR

1 Background

Monitor's Code of Governance for NHS Foundation Trusts recommends the appointment of one of the Trust's Non Executive Directors as the Senior Independent Director (SID).

2 The role and responsibilities of the Senior Independent Director

2.1 The Senior Independent Director, the Chair and Non Executive Directors

The SID is a Non Executive Director appointed by the Board of Directors in consultation with the Council of Governors to undertake the role. The SID may be, but does not have to be, the Vice Chair of the Board of Directors.

The SID will be available to members of the Foundation Trust and to governors if they have concerns that contact through the usual channels of the Chair, Chief Executive, Finance Director and Trust Secretary has failed to resolve or where it would be inappropriate to use such channels. In addition to these duties, the SID holds the same responsibilities as the other Non Executive Directors.

The SID has a key role in supporting the Chairman in leading the Board of Directors and acting as a sounding board and source of advice for the Chair. The SID also has a role in supporting the Chairman as Chair of the Council of Governors.

It is usual practice for the SID to hold a meeting with the other Non Executive Directors in the absence of the Chairman at least annually as part of the appraisal process, however there may be additional circumstances where such meetings may be appropriate.

2.2 The Senior Independent Director and the Council of Governors

While the Council of Governors determine the process for the annual appraisal of the Chairman, the SID is responsible for carrying out the appraisal of the Chairman on its behalf as set out as best practice in the Code of Governance. The SID often also takes responsibility for an orderly succession process for the Chairman role where a reappointment or new appointment is necessary.

The SID should maintain regular contact with the Council of Governors and attend meetings of the Council of Governors to obtain a clear understanding of the governors' view on the key strategic and performance issues facing the Trust. The SID should also be available to

the governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the Chairman.

In rare cases where there are concerns about the performance of the Chairman, the SID should provide support and guidance to the Council of Governors in seeking to resolve concerns or in the absence of a resolution in taking formal action. Where the Trust has appointed a Lead Governor, the SID should liaise with this individual in such circumstances.

3 Proposed appointment

The Trust Board is asked to accept the recommendation that following the retirement of Mr Roger Trotman in November 2012, Ms Clare Robinson be appointed as the Trust's Vice Chair and Senior Independent Director. Clare took up post as a Non Executive Director on 20 November 2012 and will Chair of the Finance and Performance Management Committee. Prior to joining the Trust, Clare has 14 years' experience as a Non Executive Director of two NHS acute hospitals where she has previously carried out the roles of Senior Independent Director, Chair of Audit Committee and Chair of Investment Committee.

Clearly many of the responsibilities of the SID will come into effect when the Trust is authorised as a Foundation Trust, however the key duties and principles of offering support to the Chairman and interaction with the other Non Executive Directors will be discharged with immediate effect.

4 Recommendation

The Trust Board is asked to APPROVE the appointment of Clare Robinson as the Vice Chair and Senior Independent Director with immediate effect.

Richard Samuda
CHAIRMAN

November 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Emergency Department quality and performance update**
SPONSOR (EXECUTIVE DIRECTOR):	**John Adler, Chief Executive**
AUTHOR:	**Rachel Barlow, Chief Operating Officer**
DATE OF MEETING:	**29 November 2012**

EXECUTIVE SUMMARY:

The attached paper provides an update on quality and waiting time performance in the 2 main Emergency Departments on the City and Sandwell sites.

Key points:

- Emergency Care Assurance Group (ECAG)established - Terms of reference included for approval
- Clinical incident trend demonstrating sustaining downward trend in serious incidents
- Progress continues on special measure action plan
- Workforce proposal submitted separately to Trust Board
- Escalation standards agreed and to be launched in November
- Emergency Flow project group established to mitigate any capacity related delays. Also launching revised capacity escalation standards and new internal professional standards in November.
- Performance trajectory currently falls short of 95% for the year
- Additional project support for ED to be established in November
- Intensive Support Team contacted to review improvement plans

For approval: Terms of reference for ECAG

REPORT RECOMMENDATION:

Noting the contents of this report, the Board is recommended to:

- Approve the terms of reference for the Emergency Care Assurance Group.

- The Board are also asked to note the current trajectory for the 4 hour target considered at PMB and support the decision to seek assistance from the Intensive Support Team.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	X

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

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

Comments:

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

Access and performance, FT,

PREVIOUS CONSIDERATION:

ED Performance was last considered at the October 2012 Board meeting

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

TRUST BOARD

November 2012

EMERGENCY DEPARTMENT

Update on Quality & Performance

1.0 Introduction

This paper provides an update on ED Quality & Performance and outlines key areas of focus to correct performance and sets a revised trajectory for this improvement.

2.0 Emergency Care Assurance Group

The Emergency Care Assurance Group (ECAG) has met for the first time and agreed terms of reference, which are attached in appendix 1 for approval.

ECAG received an update on the Emergency Department Special Measures action plan which is being monitored on a fortnightly basis by the Emergency Department Task & Finish Group.

ECAG also received an update from the EAU Special Measures action plan and agreed that the outstanding actions will be monitored through the Emergency Flow Taskforce.

3.0 Emergency Department Quality

3.1 Incident Trends

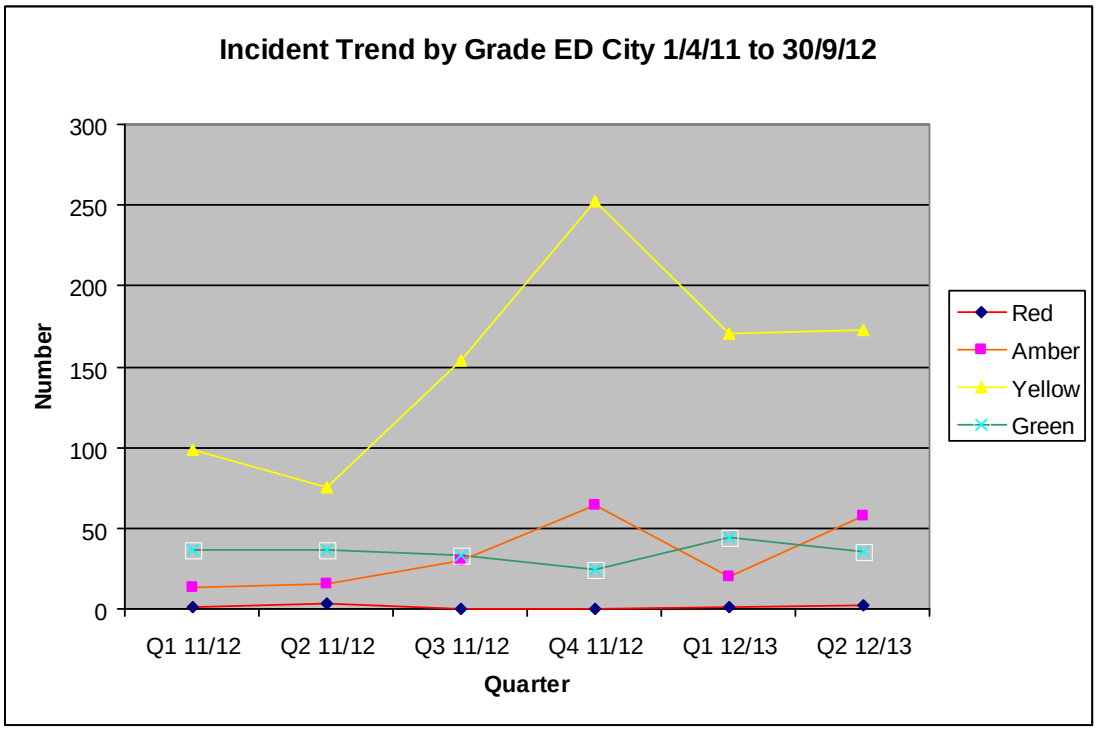
Incidents trends are monitored through the directorate Governance structure with monthly governance meetings and incident review meetings. Working with the Governance team, the directorate has developed a bespoke governance training programme which commences in December; this will support a good governance culture and identify further training needs of staff in the department.

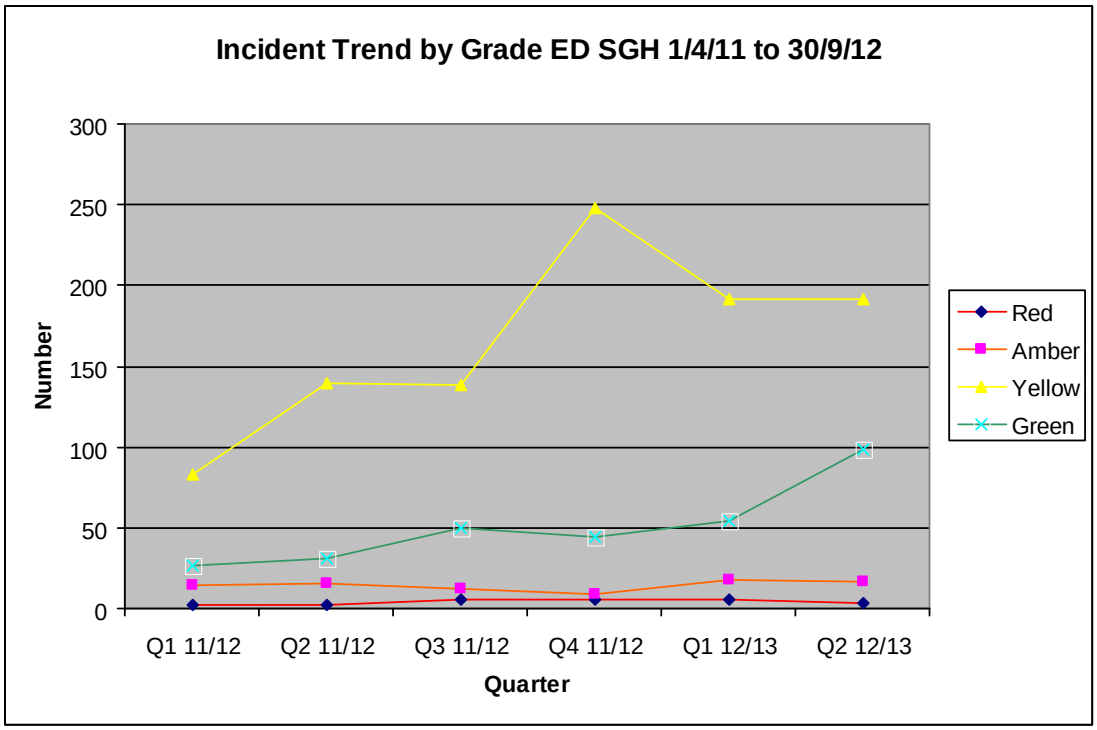
The number of serious untoward incidents has continued to reduce and there have been no red incidents attributable to ED reported since the last report to Board. The last red incident attributable to the EDs was in Q1 2012/13 (05.06.12 ED SGH). The directorate is focusing on reviewing amber incidents in detail to ensure actions are taken and there is learning within the department.

The table below shows the number of red incidents from April 2011 to Oct 2012.

Quarter	City	Sandwell
Q1 2011/12	1	3
Q2 2011/12	1	1
Q3 2011/12	0	3
Q4 2011/12	2	4
Q1 2012/13	1	5
Q2 2012/13	0	0

The graphs below show the trends in all incident categories for each site. The rise in the number of reported green and yellow incidents would generally be regarded as indicating an improvement in reporting culture.





3.2 Special Measures Progress

- A Staff Engagement Session was held on Monday 22 October 2012, led by the Clinical Director, General Manager, Matrons & Assistant Head of Nursing. The work undertaken will be used to produce 'ED Promises' and a vision for the future. Further staff engagement sessions are currently being planned, to ensure more staff are able to attend;

- The first edition of the Governance Newsletter has been published and was well received. This will be written monthly and include learning points from incidents and complaints and recommendations from audits;

- A mental health escalation policy has been drafted in partnership with RAID to ensure appropriate and timely escalation of delays takes place within the relevant organisation. This will be replicated for Sandwell and presented to the EDTF. There are significant concerns with the current pathway for these patients and further work is required. The Chief Officer for Quality from Sandwell & West Birmingham Clinical Commissioning Group has agreed to take this forward

- The twice daily MDT review has been further developed with an hourly departmental review which is conducted by the Senior Nurse & Senior Doctor in charge of the department.

3.3 Next Steps and Key Milestones

The Directorate must continue to focus on the quality improvements required through the Special Measures Programme:

- The first Governance Training Session will take place on Monday 26 November. There are three dates currently set for Session 1 which will be lead by the Medical Director and the Head of Risk & Governance. This will develop into a rolling programme for all staff to attend;

- The workforce paper will be presented to Trust Board on 29 November 2012 for initial consideration;

- The implementation of an effective communication and handover tool, similar to SBAR and fit for purpose within the ED;

- The implementation of clinical guidelines, in collaboration with BMJ or West Mercia.

4.0 Emergency Department Performance

Emergency Department 4 hour performance continues at an unsatisfactory level.

Table 1: ED Performance – 4 hours

	4 hour performance			
	EYE	**CITY**	**SGH**	**TRUST**
October 2012	**99.5%**	**89.7%**	**93.5%**	**92.4%**
November 2012 *1 – 20 Nov*	**98.9%**	**87.8%**	**94.2%**	**91.7%**
Q1	**99.21%**	**93.72%**	**95.33%**	**95.14%**
Q2	**99.50%**	**91.36%**	**95.41%**	**94.09%**
Q3 *1 Oct – 20	**99.09%**	**88.96%**	**92.30%**	**91.55%**

Nov*				
YTD	**99.29%**	**91.80%**	**94.50%**	**93.86%**

The ED Clinical Indicators also highlight significant issues for the ED at City in particular:

Table 2: ED Clinical Quality Indictors

City		**October 2012**	**YTD 12-13**
Dept wait	All	350	313
	Admitted	466	435
	Non-admitted	239	238
Assessment Wait		25	21
Treatment Wait		70	77
Left not seen		5.7	6.0
Unplanned reattendance		7.8	8.3

Sandwell		**October 2012**	**YTD 12-13**
Dept wait	All	356	270
	Admitted	532	413
	Non-admitted	235	232
Assessment Wait		14	14
Treatment Wait		47	58
Left not seen		4.3	4.6
Unplanned reattendance		8.1	8.6

4.1 Focus & Initiatives to correct performance

The Directorate Management Team has identified the following areas of focus:

- Escalation

Departmental & Organisational response to emergency demand;

- Departmental Leadership / Shop-floor Management

Competent medical and nursing co-ordination of the ED

- Departmental Flows & Patient Pathways

Fit for purpose infrastructure for patient flow and agreed pathways to eliminate delays.

- Performance Monitoring

Meaningful performance monitoring to identify and resolve problems

Initiatives for each of these areas have been included in the Emergency Department special measures plan.

4.1 Progress

- Staff from the Emergency Medicine & Acute Medicine directorates and IM&T department have visited the ED at University Hospitals North Staffordshire to view the IT system MSS Patient First. The system has enhanced operational functionality and offers other benefits such as password protected entry. A project group is being established and an options appraisal will be presented to the Emergency Department Task & Finish Group in December;

- The directorate is working with Capital Projects to produce a patient flow policy to identify the needs of the department at City, with the intention of redesigning the layout and function. Important features include more capacity in the ambulance assessment area and resus and the creation of a Clinical Decisions Unit;

- The ED Escalation Policy has been finalised and signed off by the Clinical Director for Emergency Medicine & Chief Operating Officer;

- Breach analysis is being undertaken to create a priority list for meetings with services and specialties to reduce delays. Initial meetings have taken place with Imaging and RAID.

4.2 Next Steps & Key Milestones

- The ED Escalation Policy goes live on Monday 26 November 2012. The Assistant Head of Nursing for ED and the General Manager for Emergency Care have been released from other commitments for an initial period of 2 weeks to ensure that the plans are embedded within the departments;

- The Trust is commissioning additional support for the Directorate team via Transformation advisors whose role will be to deliver 'Real Time Practical Problem Solving'. This approach will deliver a robust and well communicated process for mitigating blocks and overseeing consistent application of standards through on the floor coaching and supervision. The intention is that this support commences on 26.11.12

- The implementation of a GP diversion scheme on the City site, to replicate that in place at Sandwell. The directorate management team is working with the CCG to implement this from 1 December 2012;

- The implementation of the revised Trust Capacity and Flow Escalation Policy on Monday 26 November 2012 to support and improve patient flow.

There remains a risk in implementation that the Clinical Director, a key leadership role, is not currently full time.

5.0 Emergency Flow Project

In addition to the ED improvement plans an Emergency Flow Project group has been established. The scope of this project group is to mitigate any breaches caused by capacity. The work plan aligns to 3 areas:

- Defining clinical standards for patient flow e.g. daily senior review by 10am, real time use of the electronic bed management system including expected discharge information
- Discharge flow service improvements e.g. systems and processes to avoid internal delays in pathways and rolling out successful transformation pilots pan Trust.
- Escalation and communication standards

The project group has executive membership and representative from bed holding Divisions, AHP and the Transformation Support office. The project reports to the Executive Directors meeting weekly.

5.1 Progress

- Internal Professional Standards to support patient flow agreed

- Escalation standards for capacity and flow agreed

- TSO pilot work extended to City Hospital including Transport pilot

- EBMS development of dashboards to support escalation communication in train

- Joint meeting with Birmingham social services and planned workshop to develop joint discharge team model scheduled for 22.11.12

5.2 Next steps and key milestones

- Launch Trust wide escalation standards 26.11.12

- Implementation to be intensively supported by COO and Deputy COO supervision over this period through release from other diary commitments and support of other Executive Director colleagues (particularly out of hours) and project group.

- Workshop with social services 22.11.12

4.3 Trajectory for improvement

Based on the above, the Performance Management Board has considered the trajectory of improvement to be incremental in Q4, achieving 95 – 96% month on month. This assumption would fall just short against the 4 hour target for the whole year. The modeling to achieve 95 % for the whole year indicates that sustained performance in excess of 98% would be required. The PMB considers this is unlikely to be achieved in the time frame and, equally importantly, believes that the pressure which would be generated by the pursuit of such a high target would likely compromise the significant improvements that we have seen in terms of safety within our EDs. The trajectory which achieves sustained Q4 performance above 95% but not 95% for the full year has been submitted to the CCG. From both the CCG and Trust position, the trajectory is unsatisfactory. The decision has therefore been made to seek the assistance of the DH Emergency Care Intensive Support Team. If the Team is able to identify further actions that we can take quickly and safely to further

improve performance, we will of course action these and this may lead to an improved trajectory.

6.0 Recommendation

Noting the contents of this report, the Board is recommended to approve the terms of reference for the Emergency Care Assurance Group. The Board is also asked to note the current trajectory for the 4 hour target approved at PMB and to support the decision to seek assistance from the Intensive Support Team.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Pensions Auto Enrolment
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Tony Wharram/Anne Davies
DATE OF MEETING:	29 November 2012

EXECUTIVE SUMMARY:

The report provides a summary of the proposed changes to be implemented as a result of the 2011 Pensions Act and specifically the requirement for the Trust to provide an Alternative Qualifying Pension Scheme (AQPS) for workers from 1st April 2013 and automatically enrol workers into either the NHS Pension Scheme or the AQPS as appropriate.

REPORT RECOMMENDATION:

The Board is requested to accept the Finance & Performance Management Committee's recommendation that the Trust applies to the National Employment Savings Trust (NEST) for the provision of an alternative pension scheme in accordance with the requirements of the 2011 Pensions Act.

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

Accept	Approve the recommendation	Discuss
	x	

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

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

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

None specifically

PREVIOUS CONSIDERATION:

Finance & Performance Management Committee on 23 November 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT OF THE DIRECTOR OF FINANCE AND PERFORMANCE MANAGEMENT TO THE TRUST BOARD

29th November 2012

ALTERNATIVE PENSION SCHEME – AUTOMATIC ENROLMENT

1. Purpose of Report

The purpose of this report is to provide the Board with some high level information regarding the introduction of the Alternative Pension Scheme. Implementation at Sandwell & West Birmingham Hospitals will take place over the coming months with a "go live" date of 1st April 2013 and further updates on progress and/or issues with implementation will be provided during the implementation period.

2. Background

Following the provisions of the Pensions Act 2011 and starting from October 2012, employers will need to enrol workers into a workplace pension if they meet the following criteria:

- they are not already in a pension at work
- they are aged 22 or over
- they are under State Pension age
- they earn more than £8,105.00 a year
- they work in the UK.

The particular point of enrolment depends on the size of the organisation with very large employers undertaking enrolment in late 2012 or early 2013 and other employers following, potentially over several years.

The Government's justification for this change is essentially based around the following principles:

- people are living longer and need to think about how they will fund this extended retirement period;
- the State Pension is regarded only as a "foundation for retirement" with an expectation that. if people want more, they should consider contributing to a workplace pension scheme; and
- the government is getting employers to enrol their workers automatically into a workplace pension so it's easier for people to start saving.

3. Automatic Enrolment within the NHS

The NHS Pensions Scheme (NHSPS) is a qualifying pension scheme within the terms of the Pensions Act 2011 and all NHS employees must be automatically enrolled into it unless they are restricted from active membership of the scheme.

In practice, the vast majority of people working within the NHS are members of the NHS Pension Scheme (NHSPS) in one or other of its current forms. However, with effect from 1st April 2013 Sandwell & West Birmingham Hospitals has a statutory obligation to provide an Alternative Qualifying Pension Scheme (AQPS) for workers who are excluded from the NHS scheme.

The Government Actuary's Department has estimated that 10% of retirees from NHS employment are re-employed each year and are excluded from NHSPS. This is likely to be the largest group of employees with restricted membership to NHSPS and therefore requiring access to an AQPS.

A worker is defined as an employee or someone who has a contract to perform work or services personally i.e. they cannot send a substitute worker or sub contract out the work as part of their own business. Non-Executive Directors are not classified as workers.

Workers aged between 22 and state pension age with annual earnings of £8,105 or more who are excluded from the NHS pension scheme are called "eligible workers" and must be automatically enrolled into an alternative pension scheme on 1st April 2013. All other workers who have earnings of £5,564 or more who are excluded from the NHS pension scheme must not be automatically enrolled into an alternative pension scheme but do have the right to opt into it on or after 1st April 2013, should they choose to do so. Workers who have earnings below £5,564 and who are excluded from the NHS pension scheme are also excluded from joining the alternative pension scheme. They will however have their circumstances and earnings assessed at each pay period and, should they fulfil the criteria for auto enrolment at any time, they must be automatically enrolled into the alternative scheme from that time. (Note: earnings levels are subject to review in November 2012 for implementation in the 2013/2014 tax year.)

Examples of workers excluded from the NHS pension scheme and who may be assessed for automatic enrolment include:

- re-employed pensioners who retired from the 1995 section of the NHS Pension Scheme;
- members of the NHS pension scheme who achieve maximum service in the 1995 section of the scheme; and
- workers who already pay contributions on whole time hours and who take up a second job with another NHS employer.

In practice, the Trust will need to automatically enroll all eligible workers into either the NHS Pension scheme (where they are not excluded from membership of this scheme) or the alternative scheme (where they are excluded from membership of the NHS Pension Scheme) unless they

positively opt out. This will need to be done for 1st April 2013 and at each three year interval thereafter as people who opt out will be automatically enrolled back into a pension scheme every 3 years beginning on 1st April 2016.

4. Flexible Workers

Any jobholder who has fluctuating earnings or a zero hour contract will need to be automatically enrolled into a pension scheme once they become an eligible jobholder. The jobholder will need to be assessed at each pay reference period (generally monthly for SWBH but weekly for bank workers). Once qualifying earnings fall below the relevant automatic enrolment trigger for their pay reference period, they become a non-eligible jobholder. However, they will stay in the pension scheme and contributions will no longer be deducted (unless scheme rules dictate otherwise). They will then need to be assessed each pay reference period and will become an eligible jobholder whenever their earnings are above the relevant trigger.

5. Choosing an AQPS Provider

The legal obligation to select an AQPS rests with each local NHS employer.

The view of NHS Employers is that the majority of workers requiring an alternative qualifying pension scheme will be re-employed pensioners or those with greater than maximum service within NHSPS. They are not likely to be working full-time and the Trust is not likely to contribute long-term as automatic enrolment only applies up to state pension age.

Procurement for those workers with flexible earnings who may fall above or below the qualifying limits in different periods will be difficult. Comments received by NHS Employers from Standard Life and The Prudential suggest that providing an automatic enrolment pension for these groups is not commercially viable.

NEST

The National Employment Savings Trust (NEST) has been set up specifically to help employers to comply with automatic enrolment duties. NEST Corporation is the Trustee body that has overall responsibility for running NEST. It is a non-departmental public body that operates at arm's length from government and is accountable to Parliament through the Department of Work and Pensions (DWP).

NEST levies a contribution charge of 1.8% and an annual management charge of 0.3% which is paid for from the employee contributions. There are no separate employer charges levied by NEST and NHS organisations do not have to enter into a contract to utilise NEST qualifying pension schemes.

Standard Life and The Prudential

In 2001, Standard Life and The Prudential were selected through a competition to provide Stakeholder Pensions to the NHS in England and Wales. Automatic Enrolment Qualifying Pension Schemes (QPS) are similar to stakeholder pension schemes and Standard Life have confirmed that they are prepared to offer a QPS to those NHS organisations in England and Wales with whom they already have an existing stakeholder or money purchase additional voluntary contributions. Employers who wish to choose a QPS from Standard Life will not need to carry out a further procurement exercise. The Prudential have confirmed that they will not be offering an automatic enrolment QPS.

In practice, as Prudential have declined to offer a QPS and Standard Life will only offer a scheme if an organisation already has an existing arrangement (which SWBH does not) then, unless the Trust were to conduct its own procurement of an AQPS (which is unlikely to succeed anyway given the lack of interest at a national level) then there is no option other than to use the NEST offering.

6. Key Participants in Future Pension Arrangements

The Pension Regulator

The pension regulator will monitor compliance of auto enrolment by employers.

Trust Nominated Officer

The Trust must nominate an officer who will be the main contact for the Pension Regulator. The Trust has nominated the Payroll Services Manager and details have been registered with the Pension Regulator. This ensures receipt of all essential information and alerts by the Trust throughout the automatic enrolment process.

Trust Working Group

The Trust has established a Working Group comprised of Finance/Payroll and HR/Workforce officers which will lead the implementation process, produce detailed project plans and ensure compliance both during and post implementation.

7. Communications

Employers are required by law to write to all workers (except those aged under 16, or 75 and over) explaining what automatic enrolment into a workplace pension means for them. A letter template tool has been created by DWP on their website.

Information requirements and opt out procedures must be provided once, when the person is first assessed as an eligible jobholder, non eligible job holder or entitled worker, and then again at re-enrolment.

The employer is required to provide a "Dear colleague" letter to all active members of the NHSPS, advising them of the benefits within NHSPS and their rights under automatic enrolment. All workers must be informed, including those who are absent from work, for example on maternity leave. The letter must be sent no later than two months after the staging date to meet legislative requirements. The letter may be sent by post or email, whichever method is chosen, it is not adequate to post information on web pages or use other general communication methods.

The employer must also write to inform workers who are not currently active members of a qualifying pensions scheme about automatic enrolment and what this means no later than one month after the staging date. However, recommended practice is to provide information to workers in advance of them being automatically enrolled. This letter can be sent by post or email, but must be specifically addressed to the individual worker. The employer must inform the worker that they are being automatically enrolled into a qualifying pension scheme and their right to opt out. Decisions to opt out or leave a pension scheme should be taken freely and without influence by the employer.

Although a significant majority of existing staff are already members of one of the NHS pension schemes, the changes being implemented as a result of the requirements of the 2011 Pensions Act may still impact on a sizeable number of staff either on the basis of them being automatically enrolled into either the current NHS pension scheme or the AQPS or having to take action to positively opt out of whichever scheme is applicable.

The clear emphasis of the 2011 Pensions Act Is to encourage as many people as possible to make personal pension arrangements in addition to the state pension and the process which the Trust will operate in future (which will be the same nationally) is geared to assuming people to be members of a scheme with action being required by individuals on a repeated basis to opt out if this is what they choose. There will need to be a clear communication strategy employed on an ongoing basis to ensure that all staff are aware of these changes and the potential effects that they may have. This communication will need to be both at a generic level informing staff generally of the changes and their potential effects and then targeted communication at those people believed to be specifically impacted although there are strict rules laid down by the Pension Regulator on what employers can and cannot say.

Communication through Trade Union representatives will also be beneficial in helping staff understand the impact of the changes and it is proposed to present this paper for information at the next meeting of JCNC.

8. Outline Timetable of Events

On the basis of working backwards from the "go live" date of 1st April 2013, a draft timetable of key events is as follows:

Date	Event
31st October 2012	Working group established project leads in place (achieved).
November 2012	General information issued to all staff on changes to pension arrangements. Confirmation of AQPS provider.
November – December 2012	Collection and analysis of current pension status of all workers.
January 2013	Specific letters to all workers: • information for those who are already members of the NHS scheme • information and details of opt out for those to whom the provisions of 2011 Pensions Act apply (note constraints imposed by the Act and the Pension Regulator)
March 2013	Issue guidance notes on opt out
1st April 2013	Scheme Go Live Date
April 2013	Opt out forms returned

A detailed timetable of all events and actions will be drawn up by the Trust working group.

9. Registration

The Trust must register details of its alternative pension scheme choice with the Pension Regulator within four months of its staging date of 1st April 2013.

10. Resource Implications

It is difficult at this stage to assess the exact amount of resources required within the Trust to implement and fulfil employer commitments for automatic enrolment particularly with regard to the following outstanding issues.

- The level of service offered by providers of alternative pension schemes can vary significantly.
- McKesson (the national provider of the ESR HR/payroll system) have yet to define how much of the process they will support. Whilst the contract for the provision of the system is currently subject to tender at a national level, McKesson appear reluctant to make significant investment into adapting ESR for auto enrolment.
- There is currently no definitive number of eligible workers within the Trust.

At the moment, there is no indication at a national level of the potential cost impact of the introduction of this scheme nor whether there will be any recognition of potential or actual cost increases within the national tariff inflation allowance.

Until further progress is made in identifying those people who are eligible to join but are not currently members of a pension scheme, an accurate assessment cannot be made, either at a local or a national level, of the potential financial impact. For SWBH, if all staff who do not currently make pension contributions were to join either the NHS scheme or the AQPS, the Trust could face a cost pressure of around £4m in additional employer contributions. This is a worst case scenario which would be offset by any agreed funding via the tariff not dissimilar to agreed pay award funding. The Trust is in discussion with other leading acute Trust's in terms of scoping the extent of the policy change to widen access to pension to all staff.

11. Conclusion

Changes in national pension regulations require the Trust, along with all other employing organisations, to operate and automatically enrol workers into an alternative pension scheme where they are not already members of an existing scheme (in the case of NHS organisations, almost certainly the NHS Pension Scheme). Currently, over 80% of SWBH workers are members of the NHS Pension Scheme and would therefore not automatically be considered for the alternative pension scheme. Of the remaining 20%, it is likely that many will have chosen not to be members of the NHS Pension Scheme rather than be ineligible. However, in line with national requirements, the Trust must act to enrol relevant people unless they make the positive decision to opt out.

The only practical option open to the Trust for the provision of an AQPS on the basis of negotiations which have been conducted at a national level is to join the National Employment Savings Trust (NEST).

12. Recommendation

The Trust Board is requested to:

6.1 NOTE the contents of the report; and

6.2 APPROVE the recommendation of the Finance & Performance Management Committee that the Trust applies to the National Employment Savings Trust (NEST) for the provision of an alternative pension scheme in accordance with the requirements of the 2011 Pensions Act.

Robert White
Director of Finance and Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Quarter 2 update**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Simon Grainger-Payne, Trust Secretary**
DATE OF MEETING:	**29 November 2012**

EXECUTIVE SUMMARY:

The Quarter 2 update on the plans to address the gaps in control and assurance against the risks to the delivery of the Trust's annual priorities is attached.

Good progress has been made with addressing the gaps in control and assurance.

The Board is asked to note that those risks rated as red, following the closure in the gaps in control and assurance relate to:

- Failure to deliver sustained improvement in safety and performance as indicated in incident trends and performance and clinical indicators
- Underperformance against the Emergency Department four hour target
- Data quality in respect of reporting performance against the 18 week referral to treatment time target
- Development of the Transformation Savings Plans and workforce reductions
- Lack of clear processes and agreement within the Clinical Commissioning Group (CCG) and reduced CCG engagement whilst new structure being established

Two objectives have been achieved during the period:

- Reconfiguration of the orthopaedics inpatient surgery service
- Reconfiguration of vascular services

The delivery of one objectives has been put on hold:

- Reconfiguration of Emergency Assessment Unit at City Hospital

REPORT RECOMMENDATION:

The Board is asked to receive the Board Assurance Framework

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

Relates to all annual priorities

PREVIOUS CONSIDERATION:
None

BOARD ASSURANCE FRAMEWORK 2012/13 – QUARTER 2 UPDATE

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
Detail the objective/ annual priority 2012/13 to which this entry relates	*Which member of the Executive Team is responsible for the delivery of the annual objective?*	*Which Board or Committee considers a report discussing the risk and its management? What is the name of the agenda item under which the report is discussed?*	*What could prevent the objective being achieved?*	*What controls or systems do we have in place to assist in securing the delivery of the objective and managing the associated risks?*	*Provide examples of recent initiatives or reports considered by the Board and/or Committee where delivery of the objectives is discussed AND where can the Board gain evidence that the controls and systems are effective to manage the risks and secure delivery of the objective?*	*What gaps in systems, controls and assurance have been identified?*	*What actions are planned and what progress has been made to address the gaps identified?*	*When will the action be completed?*	*Which standard/ aim/ target does the risk relate to or in which other document is the risk reported?*	*Before the actions to address the gaps in control & assurance have been taken , what risk severity score applies?*	*After the actions to address the gaps in control & assurance have been taken, what risk severity score applies?*
ANNUAL PRIORITY 1: Delivering the quality priorities set out in the Quality Account. Strategic objectives to which the Priority is linked:											
Patient safety: Improv'ts in stroke services and outcomes and in the way in which we deal with TIAs	MD	Trust Board; Stroke Reconfiguration Group	Ward refurbishment (including capital investment - replacement CT scanner) not delivered on schedule Reconfigured model at Sandwell does not align with preferred SHA model for HASUs strategic and geographic organisation	Commissioning access to mobile second CT scanner at Sandwell Collaborative working with neighbouring Acute Trusts. CEO linking with SHA and local	Monthly monitoring via Stroke Reconfiguration Project Board with quarterly reports to Clinical Services Reconfiguration Programme Board	None identified	None identified	End of Q4	Quarterly Reconfiguration progress reports to Trust Board	**9**	**6**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
			of Stroke Services and Trust loses HASU element of service to alternative provider	commissioners SWBHT Clinicians engaged and input to SHA service redesign steering group and working groups. Engagement with local ambulance service leads in strategic planning Appointment of Associate Medical Director with responsibility for Patient Safety							
Patient Safety: 5 steps to Safer Surgery – improv't in monitoring and assurance systems	MD	WHO CL Steering Group Quality & Safety Committee Governance Board	Poor frontline staff engagement Failure to realise true safety improvement – ticking the box and 'missing the point' (latent culture) Delay with data entry (timely) Multiple IT systems Non-automated	Communication of key messages Theme in Consultants' conference Safety champions in theatre Appointment of Associate Medical Director with responsibility for Patient Safety	Monitoring compliance Reports Feedback from frontline practitioners Monitoring incidents Formative visits	Non-core operating areas e.g. Cardiology, endoscopy and interventional radiology – harder to reach	Communication of key messages Observation and Feedback Improved engagement with Health Informatics Department	End of Q4		**12**	**6**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
			reporting								
Patient Safety: Reduction in avoidable weight loss in elderly patients (acute and community)	CN	***BODY:*** PEPAG; Trust Board ***AGENDA ITEMS:*** Nutrition; Quality Report	• Patients suffer avoidable weight loss at higher level than expected.	• Trust Nutrition Action Plan • Ward audits around nutrition • Ward performance review process • Adequate meal and snack provision • Dietician services • Protected meal times	• Regular audits • Quality report to TB • Patient feedback via surveys	None identified	None identified	Ongoing		**9**	**6**
Patient Safety: Delivery in national and local standards for reducing hospital acquired infections	CN	Infection Control Operational Committee; Trust Board; TMB; Quality & Safety Ctte; Clinical Quality Review Group; SHA reporting ***AGENDA ITEMS:*** Quality Report; Infection Control Monthly Report	• Failure to achieve standards expected for rates of CDiff, MRSA bacteraemia and MRSA screening rates.	• Infection control action plans • Effective reporting and monitoring practices • Good infection control practice that is audited via a variety of means • Reports to TMB, Gov Board and Trust Board • Divisional and Directorate level reporting.	• Regular audits • Screening and monitoring data • Included in Quality report to TB • CCG, SHA and national benchmarking	• Elective MRSA screening numbers too low.	• Action plan to improve screening numbers ~~to be developed~~has been developed • Expected issues with data reported – investigation and resolution underway.	~~Oct 12~~December 12		**9**	**9**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				• Include in ward review metrics.							
Patient safety: Harm-free care in four key areas – pressure damage, falls with harm, VTE, catheter-associated infections	CN	***BODY:*** PEPAG Trust Board; Quality & Safety Ctte; Clinical Quality Review Group; SHA reporting ***AGENDA ITEMS:*** High Impact Actions; Quality report	• Failure to deliver expected rates of harm free care across 4 indicators of harm.	• Monthly ST audit and reporting process • Action plans across all specific harms • Reported via Quality report to TB and Gov Board • Ward, directorate and divisional level data • Accountability meetings for pressure ulcers and falls.	• Quality report based on audit results • SHA benchmarking reports	None identified	Not applicable	Not applicable		**9**	**9**
Effectiveness of Care: Improv't in outcomes for Trauma & Orthopaedic surgery	MD	Governance Board	PROMs reported as below expectations Patients perceive that their care is poor	Action plan developed to address PROMs issues Monitoring progress against plan Appointment of Associate Medical	Divisional Review Patient satisfaction surveys		Monitor through newly formed T&O Action Team Track impact of reconfiguration of inpatient services on PROMs	End of Q4		**12**	**8**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				Director with responsibility for Patient Safety							
Effectiveness of Care: Exceed CQUIN target for mortality reporting and analysis	MD	Mortality and Quality Alerts Committee Governance Board	Large numbers falling disproportionately on acute and emergency care specialties. Lack of dedicated reviewers – additional work load to current roles Problems with accessing online Delays due to wrong consultants recorded on the system	Streamlining of selections for review. 25% 'expected' deaths, 100% 'unexpected'. Standard assessment proforma Developing proposals for even distribution of reviews Engaging with IT	Reviewed regularly at MQuAC – Monthly. Performance management by Medical Director's team Daily reports to Clinical Directors	Unable to provide additional manpower Engagement with Informatics Service to improve data issues	Re-distribute workload amongst non-acute specialties Ensure IT Systems data quality clinical leads in place	End of Q3		**3**	**2**
Effectiveness of Care: Improv't in awareness and diagnosis of Dementia	CN	~~Will be R~~reported to PEPAG; Quality & Safety Cttee and Trust Board in future within the Quality Report Dementia Steering Group	Failure to deliver dementia action plan resulting in patients not being diagnosed and therefore not adequately cared for	• Memory test now in place • Referral pathways agreed • Audit process agreed and data collection commenced • Some training in place • Gap analysis and action plan completed and in place • Specialist	• Reported to Safeguarding Committee and as part of performance report • Status of RAG reports • Key audit data	~~• Do not currently include in Quality report.~~ • Training currently available is insufficient in volume	~~• Include in Quality report~~ • Invest in increase training	Dec 12		12	9

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				support available via RAID and Community Liaison • Dementia nurse in place • Commenced implementation of Wolverhampton standards project							
Effectiveness of Care: Improv't in mortality of patients with Pneumonia – avoiding admission where possible	MD	Trust Board Mortality and Quality Alerts Committee	Reliably deploying Clinical Process Model at all potential points of access to care	Carrying out BTS audit to establish benchmark Appointment of Associate Medical Director with responsibility for Integration	Awaiting output from audit.	Working on implementing guidelines Facilitating close working between the Sepsis Care Bundle project Calling Respiratory Directorate to account at MQuAC	Work closely with CCGs, GPs and Sepsis Project to improve adoption of Sepsis Care Bundle Mandate Trust wide endorsement of Sepsis proforma usage.	End Q4		16	8
Patient Experience: Ensure more safe and more consistent clinical	CE	Emergency Department Action Team reporting to Trust Board	Failure to deliver sustained improvement in safety and performance as indicated in incident trends and performance and	Integrated Action Plan. EDAT Chaired by Chief Executive. External assurance visits.	Monthly report to Trust Board. Performance and Clinical Indicators included in Corporate	Lack of sufficient pace and consistency of improvement. Suboptimal functioning of	Implement Special Measures escalation. Development of new ED and Emergency Flow	~~From Q2 12/13~~New actions due for delivery by November 2012	Reports to Trust Board on emergency pressures and EDAT report to	**20**	**15**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
practice in Emergency Departments			clinical indicators.		Dashboard. Incident trend reports to EDAT and summarised to TB.	EDAT due to multiple roles	action plans Formation of new EC Assurance Group and separate ED Task and Finish Group, both chaired by CEO. Also weekly review of Flow Plan at executive Team.		Board, both in October 2012		
Patient Experience: Improv't in responsiveness of personal needs of patients	CN	***BODY:*** PEPAG; Trust Board, Quality & Safety Ctte; Clinical Quality Review Group ***AGENDA ITEMS:*** Patient Satisfaction Survey; Quality report	• Failure to achieve national improvement target	• In patient survey that mirrors national survey. • Various plans that support the specific areas of measurement • Ward, directorate, division and TB reporting on a monthly basis. • Good response rate most wards	• Survey results • Friends & Family Test results benchmarked across SHA	• Do not have a patient experience strategy or action plan. • ~~Do not resource patient experience actions appropriately~~ • Tracking resources now identified	• Develop strategy and plan • ~~Identify additional resources~~ • Tracking resources now identified	Oct 12 – Achieved ~~Nov 12~~Dec 12		**12**	**9**
Patient Experience: Improv't in experience of patients at the end of	CN	***BODY:*** PEPAG; Trust Board; Quality & Safety Cttee; Clinical Quality Review Group	• Failure to provide patients and carers with a good end of life experience.	• End of life Strategy • End of life action plan • Regular audits and	• EoL reports monthly and included Quality report to TB, Quality &	• SCP in Community • 24 hour access to palliative care advice • Audit of	• Action plan to roll out to Community • SIRG paper Dec 12. • Commence	March 13 Dec 12 Dec 12		**16**	**12**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
their life		***AGENDA ITEMS:*** High impact actions; Quality Report		data collection – reported board → ward • Implementation of supportive care pathway ~~in acute~~ • Palliative care team • Palliative care training • Include Quality report	Safety Cttee & Clinical Quality Review Group	DNAR/CPR decisions for appropriateness	audits and action plan as a result				
Patient Experience: Offering health improv't opportunity to expectant mothers who drink alcohol and smoke	CN	***BODY:*** PEPAG; Trust Board; Quality & Safety Cttee; Clinical Quality Review Group	• Mothers continue to smoke and consume alcohol at current level – no long term health improvement	• Training into brief into brief interventions in place • Assessment of risk in place • Referral pathways in place	• Training records • Manual midwifery records • Referral numbers available • Performance reports	• Do not currently record smoking/alcohol status on records	• Maternity IT system • Develop manual system	Long term Nov 12		**10**	**10**
Patient	CN	***BODY:***	• Failure to introduce	• Friends and	• Weekly and	Full electronic	Invest in further e-	End of		**4**	**2**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
Experience: Introduction of the 'Friends and Family Test' and establish't of real time monitoring and response to patient views		PEPAG; Trust Board; Quality & Safety Cttee; Clinical Quality Review Group ***AGENDA ITEMS:*** Patient Satisfaction Surveys; Quality Report	the tool and to achieve 10 point improvement by year end	family test in place • Manual and e systems in place • Weekly and monthly reporting established • Links to patient experience improvement plan and strategy	monthly reporting • Included in Quality report	data collection	devices	~~2012/13~~Q4			
Patient Experience: Eradication of Grade 2,3 & 4 hospital acquired avoidable pressure ulcers	CN	***BODY:*** PEPAG; Trust Board; Quality & Safety Cttee; Clinical Quality Review Group ***AGENDA ITEMS:*** High Impact Actions, Quality Report	• Number of hospital acquired grade 2, 3 and 4 sores does not decrease	• Extensive action plan • Good reporting • Audits of assessment and care regularly • Accountability meetings • Training • Campaign approaches • Equipment	Included in Quality report and Safety Thermometer reporting	Ward dashboard not available for real time monitoring	Establish ward dashboard	~~Oct 12~~Dec 12		**12**	**12**
Patient Experience: Continuation of roll out of alcohol prevention strategy to	MD	Alcohol Strategy Committee	Proforma not being completed by directorates Mixed electronic:\Paper-based system	New forms being piloted and revised Committee meeting monthly with membership	Monitoring performance data using the Clinical Data Archive	Managing dependency on a single individual Formalizing the reporting structure	External supervision of project progress Ensure monthly updates submitted to Medical	End of Q3		**16**	**8**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
outpatient specialities			Key individuals carrying out the majority of the work – single person data collation Lack of formal reporting structure needs formalizing Lack of clarity around delivery timeframe	across the health community Inducting Junior Doctors to complete proformas Appointment of Associate Medical Director with responsibility for Integration and 'Right Care, Right Here' project support		Delivery framework Project management structure required for implementation	Director's Team Clarify formal project structure and remedy any identified deficiencies				
ANNUAL PRIORITY 2: Delivery of the Transformation Plan. Strategic objectives to which the Priority is linked:											
Delivery of the Transform'n Plan targets for 2012/13	COO	TPSG reporting to Trust Board	Under delivery of financial targets in the Transformation Plan Impact on quality whilst reducing resource in some areas	Work streams established for cross cutting themes. Divisional projects documented with milestone plans. Risk assessments and QIA for all schemes. Project plans for significant projects. Weekly	Delivery of plans and related quality and financial milestones Delivery of workforce plan and associated cost reduction Weekly and monthly monitoring against key milestones and exception	Need to establish a way of working with the incoming CCG and governance process to deliver transformation plan.	Meetings established with senior Trust and CCG team.	Reviewed monthly Deadline March ~~1~~2013		**4**	**3**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				governance assurance process reports to executive steering group by exception. ~~.~~Appointment of Associate Medical Director with responsibility for Innovation & Transformation	reports. KPI agreed for quality and impact balance scores. Monthly Programme update to Trust Board. Paper submitted for exceptional programme issue. Monthly Finance report to F&PC / Trust Board						
ANNUAL PRIORITY 3: Achievement of key access targets. Strategic objectives to which the Priority is linked:											
Achievement of key access targets relating to Emergency Department performance	COO	PMB, TMB, F&PC	Underperformance on 4 hour target	ED's in special measures programme continues. Special measures action plan in place to include performance and outcome/recommendation of previous external visits. ~~From July. Recruitment strategy revised including key leadership posts. Additional non~~	Daily – monthly performance reporting~~. .~~ Breach analysis and exception reporting. Review of escalation triggers to be included in Q3. Review of special measures action plan via Emergency	Clinical Director appointment not full time. This is	~~Await recommendations from external visits to further inform development / special measures plan.~~Site lead consultants appointed to work and deputise to the Clinical Director. Allow new arrangements to embed and initially review after 3	Monthly	Achievement of key access targets relating to Cancer	**20**	**16**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				~~recurrent staffing resource provided in Q1.~~ ~~Review of clinical systems and processes associated with quality systems and effectiveness of patient flow.~~ ~~External SHA peer review and clinical advisory visit completed in July /August.~~ Assurance and governance system revised: fortnightly executive ED taskforce reporting to monthly Emergency Care Assurance Group. Revised escalation triggers to be implemented 26.11.12 and a trajectory of performance improvement to	Taskforce and delivery via ~~EDAT~~ECAG. Embedding of outcomes and recommendations from various external reviews included in action plan. Review of plans with the CCG.		months .				

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				be delivered by site . Leadership: Clinical Director appointed and new Assistant Head of Nursing in post.							
Achievement of key access targets relating to Stroke Care	MD	Stroke Action Team Trust Management Board	Standards (defined below) not met, indicating poor standards of patient care. CQUIN income lost because of failure to meet KPIs (as defined by the WMQRS and Nationally for Acute Stroke and TIA).	Project implementation group targets work on rota redesign early in process as advised by Gateway review team. Monthly meetings of Stroke Action Team Regular reporting on mortality and KPIs Imaging Division represented on monthly Stroke action team and some KPIs monitored. Divisional imaging team planning developing	Monitoring the Stroke Dashboard Updates to TMB	Nothing identified	Introduce monthly written reports on progress, to TMB Provide additional operational support in systems improvement through TSP team Establish greater range and precision of expected service improvement targets for imaging for CT, MRI and US reporting and performance manage delivery. Manage and meet any resource implications	End of Q4		**12**	**8**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				neuroradiology reporting capacity and enhancing CT, Doppler and MRI.							
Achievement of key access targets relating to Cancer	COO	PMB, TMB, F&PC	Underperformance on 4 hour target Failure to meet key access targets	~~ED's in special measures programme from July. Recruitment strategy revised including key leadership posts. Additional non recurrent staffing resource provided in Q1. Review of clinical systems and processes associated with quality systems and effectiveness of patient flow. External SHA peer review and clinical advisory visit completed in July /August.~~ See ED targets separately reported in : Achievement of key access targets	~~Daily – monthly performance reporting. Breach analysis and exception reporting.~~ ~~Review of special measures action plan and delivery via EDAT.~~ Waiting list controls and outputs Performance management locally at service level, reporting to Trust access meeting or relevant other forum (eg: Cancer managed separately).		~~Await recommendations from external visits to further inform development / special measures plan~~.	Monthly	Achievement of key access targets relating to Emergency Department performance	**15**	

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Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				relating to Emergency Department performance. Other performance areas: waiting list and pathway management system in place. Root cause analysis process for breaches to investigate and mitigate performance risks.	Trust overview via COO Performance meeting and reported to PMB. Internal audit programme includes data quality and process audit.						
Achievement of 18 weeks waiting time targets for all specialities	COO	Waiting list meeting. PMB, TMB, F&PC	Underperformance against targets	Waiting list management. Service level demand and capacity planning. Backlog reduction plans in place. Review of plans for T&O and Plastics with business case approved for	Orthopaedics and plastics are exceptions to the admitted patient performance.	Both specialities have internal backlog reduction plans in place.	Continue backlog recovery. Agreed trajectory for orthopaedics and plastics.	Monthly		**15**	**12**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				backlog reduction to meet 18 weeks year end.							
		Internal audit and assurance processes. 18 week review	Data quality	~~Outlying admitted specialties are plastics and orthopaedics. Improvements achieved in these areas and over all backlog reducing. Data quality review under way.~~ 18 week project in progress: 1. Current state process clarified 2. Revised future state processes to designed and implemented Q3/4. 3. Data validati	Await outputs of validation project	New processes to be established – project timeline set for December/January.	Complete data quality review.	Monthly		**20**	**15**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				on process in train with forensic analytical support. . Above work supported by KPMG and Solutions for E EHealth,							
ANNUAL PRIORITY 4: Achieve progress towards Foundation Trust status. Strategic objectives to which the Priority is linked:											
Delivery of elements of the FT Project Plan due for completion in year	DSOD	FTPB	Delivery of TSPs and workforce reductions	Clear targets and timescales for delivery are set. Reporting systems set up	Regular reporting to TSG and F&P Committee. Additional detail now provided to Board	None	Not applicable	Not applicable		**20**	**15**
ANNUAL PRIORITY 5: Delivery of the 'Right Care, Right Here' and key Service Developments. Strategic objectives to which the Priority is linked:											
~~**Achieve clinical service reconfigur'n:** Vascular Surgery~~	~~DSOD~~	~~Reconfiguration Board~~	~~Finalisation of agreement with UHB on Consultant job plans~~	~~COO receives updates Division escalate issues they cannot deal with~~	~~Update provided for annual plan quarterly reporting~~	~~None~~	~~Not applicable~~	~~Not applicable~~		~~9~~	~~6~~
Achieve clinical	MD	Stroke Reconfiguration	Chose model, when implemented may not	Project implementation	Monthly Monitoring	None	A more Integrated approach to	End of Q4	Quarterly Reconfigura	**9**	**6**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
service reconfigur'n: Stroke & TIA services		Group Trust Management Board	deliver the quality of service anticipated. Current imaging & reporting capacity Not adequate to support planned service	group targets work on rota redesign early in process as advised by Gateway review team, Monthly meetings of Stroke action team Imaging Division represented on monthly Stroke action team and some KPIs monitored.	Stroke Dashboard Conducting snap-shot audit and needs assessment at both sites for existing inpatients to determine the likely level of demand for complex rehabilitation.		service redesign through collaborative working with community stroke teams in Sandwell Community and liaison with Birmingham community stroke team. Introduce monthly written reporting on progress to TMB Commissioning access to mobile second CT scanner at Sandwell		tion progress reports to Trust Board		
Achieve clinical service reconfigur'n: Orthopaedic inpatient surgery	COO	TPSG and TSO project meeting	Slippage on project delivery	Engagement with public and staff Robust project plans Mitigation to capacity impact for theatre installation	On track to complete			~~Q2~~Complete		**3**	**2**
Achieve clinical service reconfigur'n:	COO	TPSG and TSO workstream meeitng	Delay to implementation	Overall project has encountered some delays. Vision not yet	Project on hold.		Programme timeline to be reset as capacity for change is a risk	~~Review Q3~~ This is now on hold and should be		**4**	**3**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
development of EAU at City Hospital				agreed between the acute medical, surgical and Emergency Medicine teams. Achievements have been made on delivering service improvements in specialty pathways to a more appropriate ambulatory model, particularly in surgery.			with special measures programme in ED's. This is now on hold.	reexplored in 2013/14 as part of the Transformation Plan for Urgent Care. .			
Achieve clinical service reconfigur'n: development of Pathology services and integrated blood sciences laboratory at Sandwell Hospital	DSOD	Reconfiguration Board	Failure to reach agreement with Dudley on integrated services	Project team and board developed External expert advice commissioned to support development of business case	Report to Reconfiguration Board	None	Not applicable	Not applicable		**15**	**9**
		Reconfiguration Board	Failure to win GP direct access tender	External support for integration supports cost reduction Joint project team with DGFT will include response to tender	Report to SIRG	None	Not applicable	Not applicable		**20**	**12**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
Implement'n of 'Right Care, Right Here' patient care pathways	DSOD	RCRH Implementation Board	Lack of clear processes and agreement within CCG and reduced CCG engagement whilst new structure being established	Regular meetings with CCG lead Appointment of Associate Medical Director with responsibility for Integration Membership of new 'Right Care, Right Here' meeting structure	Report to RCRHIB and Trust Board	Unable to achieve real traction with CCG on delivering a change programme	Escalation to CCG SRO and Partnership Board	September	Monthly 'Right Care, Right Here' reports to the Trust Board	**20**	**16**
Major refurbishment of the endoscopy unit at Sandwell Hospital	DENHP	JAG	Key milestones of capital scheme not met causing project and hence accreditation delay	*Project management arrangements in place, monitored by SIRG. Engagement with external (JAG) accreditation body*	SIRG reports	None	Not applicable	Not applicable	CQC Outcome 10 and 11	**4**	**4**
Development of National Behçet's Syndrome Centre	MD	Behçet Service Operation Group Trust Management Board	Insufficient capacity to meet demand	Monitoring within Behcets Service operational group Developing Project implementation plan.	Monthly reports to TMB	None	Early stage of project	End Q4		**4**	**4**
Development of specialist gynaeoncology service	MD	Exec Review structure Women &	None identified	Business planning through the Directorate and divisional review	Divisional / Directorate Review process	Nothing identified	Nothing identified	Paper on laparoscopic service to go to SIRG in Q2		**4**	**2**

Objective	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
		Childrens' Division review process		process							
Development of Sandwell Health Visiting service	CN	PEPAG, Quality & Safety Cttee; Clinical Quality Review Group; ***AGENDA ITEMS:*** SHA agenda items; Quality Report; Clinical Quality Review Group	• Failure to deliver the HV implementation plan	• HV plan in place • HV workforce increases agreed and resourced • HV early implemented site plan in place • Excellent leadership • Good staff support	Monthly reports available Quarterly to PEPAG; Clinical Quality Review Group; Quality & Safety Ctte	~~Reporting regularly to Trust Committee~~ Track achieved	~~Include in reports to Q&S Committee~~ Track achieved	~~Oct 12~~ Achieved		**9**	**9**

KEY:

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

●	Accessible and Responsive Care
●	Safe, High Quality Care
●	Care Closer to Home
●	Good Use of Resources
●	21st Century Facilities
●	An Engaged Effective Organisation

RISK SEVERITY MATRIX

Q1. PROBABILITY - What is the likelihood of the risk occurring? Use the table below to assign this incident a category code.

MEASURES OF PROBABILITY		
Descriptor	**Level**	**Description**
Rare	1	The event may only occur in exceptional circumstances
Unlikely	2	The event is not expected to happen but may occur in some circumstances
Possible	3	The event may occur occasionally
Likely	4	The event is likely to occur, but is not a persistent issue
Almost Certain	5	The event will probably occur on many occasions and is a persistent issue

Q2. SEVERITY - Identify the highest consequence of this risk? (Use this table as a general guide; you may need to apply similar methodology for consequences not considered here)

Descriptor	**Potential Impact on Individual(s)**	**The Potential for complaint/ Litigation**	**Potential Impact on Organisation**	**Number of Persons likely to be affected or Direct Cost to Trust**
Insignificant 1	• NO INURY OR ADVERSE OUTCOME	• Unlikely to cause complaint/ litigation	• No risk at all to organisation	0-1 Person **£0 - £25K**
Minor 2	• SHORT TERM INJURY /DAMAGE e.g. injury that is likely to be resolved within one month	• Complaint possible • Litigation unlikely	• Minimal risk to organisation • RIDDOR reportable (>4 day absence from work)	2-4 **£25K - £100K**
Moderate 3	• SEMI-PERMANENT INJURY/DAMAGE e.g. injury that may take up to 1 year to resolve. • Long term sickness e.g. 4 weeks	• Litigation possible but not certain. • High potential for complaint.	• RIDDOR reportable (Major) • Needs careful PR • MHRA reportable • Short term sickness • External investigation (e.g. HSE)	5-10 Persons **£100K - £0.5M**
Major 4	• PERMANENT INURY i.e. disabling	• Litigation certain expected to be settled for < £1M	• Service closure • Threat to Divisional/Directorate objectives/priorities	10-20 Persons **£0.5M - £3M**
Catastrophic 5	• Non-Clinical DEATH • Loss of body part(s)	• Litigation certain: expected to be settled for >£1M	• National adverse publicity • Threat to Trust objectives/priorities	Over 20 Persons **£3M & Above**

Q3 **Risk Score** - Use the matrix below to grade the risk.

e.g. 2 x 4 = 8 = Yellow or 5 x 5 = 25 = Red

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Same Sex Accommodation compliance declaration**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Rachel Barlow - Chief Operating Officer**
DATE OF MEETING:	**29 November 2012**

EXECUTIVE SUMMARY:

The attached report updates the Board on Same Sex accommodation compliance following an earlier compliance statement being submitted in Q1. The Trust has reported compliance with standards for this financial year to date.

However, at times of increased activity this can be a challenge, but the Trust remains focussed on meeting same sex accommodation standards.

REPORT RECOMMENDATION:

The Trust Board is recommended to:

1. NOTE the progress report on ensuring compliance with same-sex standards and performance last year

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Accessible and responsive care
Safe high quality care.
Quality and safety

PREVIOUS CONSIDERATION:

This is related to the annual compliance declaration previously approved at Trust Board

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAME-SEX ACCOMMODATION

REPORT FOR TRUST BOARD – 29 NOVEMBER 2012

1. INTRODUCTION

This paper reaffirms the Trust position of declared compliance with single sex accommodation standards.

2. PROGRESS

The Trust continues to focus on standards of privacy and dignity on all of our wards through our system of regular ward reviews and audits.

For the year 2012-2013 to date, the Trust has reported full compliance with the standard.

As part of everyday business, gender specific bed issues are included in daily capacity planning meetings.

Sometimes when emergency activity is exceptionally busy it has been necessary to admit patients to mixed-sex bays in these units and we are continuing to work with these units to avoid this by changing the gender profile of bays which makes the management of patient flow internally challenging. There remains the potential occasions when clinical issues may have to take priority. Escalation processes are in place to manage such an issue.

3. BREACH REPORTING

There have been no breaches reported this financial year.

4. DECLARATION OF COMPLIANCE

All NHS Trusts and NHS Foundation Trusts are required to publish a formal annual declaration of compliance with the national same-sex accommodation requirements.

The proposed declaration of compliance for 2012, is attached as an appendix to this paper, and was submitted to the Trust Board and accepted in June 2012.

5. CONCLUSION AND RECOMMENDATIONS

This paper has provided the Trust Board with an update on progress in our work to ensure full compliance with the national same-sex accommodation standards.

The Trust Board is recommended to:

1. NOTE the progress report on ensuring compliance with same-sex standards and performance last year

2. NOTE the declaration of compliance with the national standards

Rachel Barlow
Chief Operating Officer
19th November 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

DRAFT

SAME-SEX ACCOMMODATION STANDARDS
ANNUAL PUBLIC DECLARATION

Our Approach

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Sandwell and West Birmingham Hospitals NHS Trust (SWBH) is committed to providing every patient with same-sex accommodation because it helps to safeguard their privacy and dignity.

Level of Compliance

SWBH is able to confirm full compliance with the Government's requirement to eliminate mixed-sex accommodation except when it is in the patient's overall best interest or reflects their personal choice.

All our wards at City Hospital, Sandwell General Hospital, Rowley Regis Hospital and Leasowes Intermediate Care Centre are compliant with the national standards.

What does Same-Sex Accommodation Mean?

Same-sex accommodation means:

- the room where your bed is will only have patient of the same-sex as you;
- the toilet and bathroom will be just for your gender and will be close to your bed area.

It is possible that there will be both men and women patients on the ward but they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom but you will not have to walk through the opposite-sex areas.

You may share some communal space such as day rooms or dining rooms and it is very likely that you will see both men and women patients as you move around the hospital (e.g. on your way to x-ray or to the operating theatre).

It is probable that visitors of the opposite gender will come into the room where your bed is and this may include patients visiting each other. It is almost certain that both male and female nurses, doctors and other staff will come into your bed area.

If you need help to use the toilet or take a bath then you may be taken to a “unisex” bathroom used by both men and women but a member of staff will be with you and other patients will not be in the bathroom at the same time.

The NHS will not turn away patients just because a “right-sex” bed is not available immediately.

What This Means in Our Hospitals

In our Trust this means that:

- Patients admitted to Sandwell Hospital, Rowley Regis Hospital or the wards in the Sheldon Block at City Hospital are admitted to same-sex bays clearly separate from the main ward corridor. Patients have access to separate male and female toilet and washing facilities on each ward.

- Patients admitted to the main wards at City Hospital are admitted to same-sex wards.

- Patients admitted to Leasowes Intermediate Care Centre are admitted to single rooms with ensuite separate washing and toilet facilities. A shared large shower room is used however for patients unable to use their en-suite facilities as a result of their clinical condition.

- We are committed to ensuring high standards of privacy and dignity for all our patients all of the time. These standards are regularly audited on all of our wards to ensure they are maintained,

There are a small number of specialist areas where we may not always be able to separate men and women including:

- the Critical Care Units at both hospitals;
- the Coronary Care Units at both hospitals;
- the Acute Stroke and Brain Injury unit at City Hospital
- Recovery areas in our Theatres.

Our Emergency Assessment Unit at Sandwell Hospital and the Medical Assessment Unit and Surgical Assessment Unit at City Hospital operate with a series of same-sex bays. Sometimes when we are exceptionally busy it has been necessary to admit patients to mixed-sex bays in these units and we are continuing to work with these units to avoid this in future.

What are our plans for the future?

We are continuing to work to improve standards of privacy and dignity including:

- continuing our focus on standards of privacy and dignity on all of our wards through our system of regular ward reviews and audits;

- ensuring that high standards of privacy and dignity are built into the estates plans.

How do we measure success?

We measure our success in meeting these standards in a range of ways including:

- patient surveys – both the annual national patient survey and our rolling programme of local surveys;

- monitoring the number of occasions on which we breach these standards – these are reported monthly to our board in public;

- regular reviews of standards of care on all of our wards;

- regular (six-monthly) reports to the Trust Board on progress with delivering same-sex accommodation.

Who do I contact for more information?

For more information or if you have any comments or concerns please contact:

Rachel Barlow
Chief Operating Officer

0121 507 4439
Rachel.barlow2@nhs.net

This declaration was approved by the Trust Board on 28th June 2012. It will be formally reviewed annually.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Medical Revalidation: Update of Organisational Readiness and Next Steps**
SPONSOR (EXECUTIVE DIRECTOR):	**Dr Roger Stedman, Medical Director**
AUTHOR:	**Philip Andrew, Head of Medical Staffing**
DATE OF MEETING:	**29 November 2012**

EXECUTIVE SUMMARY:

This report sets out the updated national requirements for Medical Revalidation, an overview of progress to date and the next steps required in implementing Medical Revalidation.

REPORT RECOMMENDATION:

The Board is asked to discuss the national guidance (including the letter from Sir David Nicholson and Sir Bruce Keogh), to note the progress made since the previous board report and to acknowledge the next steps required for the ongoing implementation of revalidation.

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Inclusion in monthly Provider Management Regime return

PREVIOUS CONSIDERATION:

Medical Revalidation process and plans were presented to the Board at its meeting in May 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Medical Revalidation: Update of Organisational Readiness and Next Steps

Introduction

1. It has now been confirmed by the Secretary of State for Health that Medical Revalidation will be introduced from December 2012 (see attached letter from Sir David Nicholson and Sir Bruce Keogh at Appendix 1)). Medical Revalidation is being introduced to assure patients, the public and the medical profession that doctors are up to date and fit to practice, and to support their development and where necessary, remediation. It will be a positive affirmation that doctors are safe to practise rather than an absence of concerns.

2. A paper was presented to the Trust Board in May 2012 (SWBTB (5/12) 096 a) which confirmed that at that time the Trust was RAG rated `red' by the SHA following the submission of Organisation Readiness Self Assessments (ORSA).

3. This paper outlines the updated national requirements, highlights the progress that has been made since the previous Board report and sets out the next steps required.

Update of National Revalidation Requirements

4. It has now been confirmed revalidation recommendations will be based on a 5 year cycle of Good Medical Practice based appraisals that review approved supporting evidence as outlined by the GMC. However it has been confirmed that during the implementation phase, recommendations can be made by reviewing a smaller number of revalidation-ready appraisals, with the proviso that the Responsible Officer (RO) is able to assure him/herself of the quality of the doctor's activities over the previous five year period. The RO is the Trust's Medical Director.

5. The GMC have required each designated body to confirm which doctors have a prescribed connection to them. In July 2012 the Trust had to complete a spreadsheet for the GMC confirming which doctors we employed (excluding doctors in training).

6. In September 2012 the Trust was required to schedule revalidation dates with the GMC for all its doctors with 20% required to be scheduled in the period 1 April 2013 - 31 March 2014 and 40% in each of the next two years so that all doctors have a revalidation date between 1 April 2013 and 31 March 2016 (except ROs who will revalidate in advance of 1 April 2013).

Overview of Progress

7. The Trust has continued to work with the SHA via the submission of regular ORSAs to formulate a detailed implementation plan to ensure that we are ready for revalidation.

The most recent ORSA was submitted in October 2012 and whilst we have yet to receive formal feedback on our RAG rating informal discussions with the SHA have indicated that the Trust will now be rated as `green'.

8. The Medical Revalidation Implementation Group (MRIG) chaired by the RO is now well established and has been the focal point for overseeing the progress being made with the requirements for revalidation.

9. A key development is that the Trust's Appraisal Policy for Career Grade Medical Staff has been rewritten to ensure it complies with the requirements of revalidation. The new policy is now in place and it will enable all doctors to undertake their annual appraisal in the new revalidation style.

10. A number of Appraiser training sessions have taken place in recent months so that now the vast majority of Divisional Directors (DDs), Clinical Directors (CDs) and other designated medical appraisers have the knowledge and skills to undertake effective appraisals. There will continue to be a programme of Appraiser training to further increase the available pool of trained medical appraisers.

11. The Trust has purchased an IT system (PReP) to help manage the medical appraisal system and PReP should become operational from late November 2012. PReP will allow Clinical Directors, Divisional Directors and the RO to keep track of appraisal progress for those doctors they are responsible for. The PReP system uses the national MAG appraisal form as its basis which enables appraisees to upload supporting information in a range of areas (egs Continuing Professional Development, Quality Improvement Activity, Significant Events, Colleague Feedback, Patient Feedback, Complaints and Compliments) for their appraiser to see in advance of and during the appraisal meeting. This supporting information can also be recorded against the different domains of the GMC's Good Medical Practice on the system. PReP will record the Personal Development Plan (PDP) agreed between the appraisee and appraiser and will require both parties to sign off the outputs of the appraisal. The appraiser will then be required to confirm a number of statements for the RO to give assurance that the appraisal process has been undertaken in accordance with revalidation requirements and whether there is any information relevant to the RO's revalidation recommendation. PReP will also host the Patient and Colleague Feedback process. Presentations of the PReP system were made to the Consultant Conference in September and the SAS Doctors conference in October 2012.

Next Steps

15. Roll out of the PReP system to all the doctors is to take place in December 2012 and January 2013. This roll out will require that appropriate information and training is provided to ensure that full engagement with medical staff is achieved. A Project Manager has been appointed to lead this roll out and other aspects of revalidation implementation.

16. Significant work will now be required in collating, validating, manipulating and presenting information in areas such as Complaints, Serious Untoward Incidents, Audit Data, Patient Safety data so that this information is more easily accessible for individual doctors, their medical managers and the RO in the form of an individual report.

Conclusion

17. In conclusion, the Trust has moved forward successfully in recent months with the implementation of revalidation. There is still a significant amount of work to be done in advance of the first scheduled revalidation dates of April 2013.

Recommendations

18. The Board is asked to discuss the national guidance including the letter from Sir David Nicholson and Sir Bruce Keogh, to note the progress made since the previous board report and to acknowledge the next steps required for the ongoing implementation of medical revalidation.

19. A Board report will be produced in April 2013 to provide a further update.

Philip Andrew
Head of Medical Staffing

November 2012

SWBTB (11/12) 264 (b)

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000

19 October 2012

CEOs and MDs of all Designated Bodies in England
NHSCB ROs

CC CEO Monitor
CEO GMC
CEO CQC
CMO

Your Ref: Gateway 18261

Dear Colleague

Subject: Medical Revalidation

On behalf of the Department of Health and NHS Commissioning Board we are delighted that the Secretary of State has today announced the commencement of revalidation in England in December 2012.

This represents a major step forward in both the effective regulation of doctors and the creation in law of further measures to improve quality and safety of care across the entire health sector. Medical revalidation, and the associated mandatory requirements for individual licensed doctors, responsible officers and designated bodies, will provide additional assurance to patients and should improve confidence in the quality and safety of the services commissioned and provided for them.

In preparing for revalidation, we have already seen significant improvement in clinical governance and in appraisal processes for doctors, but there is still room for considerable further improvement in the coming months and years.

This is the start of a process that will bring quality to the fore; an example of a practical enabler that underpins all of the domains of the NHS CB's quality and outcomes frameworks designed to transform the health service.

We urge responsible officers of designated bodies and their boards to embrace, champion and maximise the impact of the process of revalidation as part of their quality improvement programmes. We are confident, based on evidence from the Organisational Readiness Self Assessment (ORSA) process, that the health sector is well-placed to further strengthen systems at local, regional and national level in the future.

We will maintain a firm grip on implementation and will continue to monitor the organisational readiness and implementation plans of all designated bodies through the implementation stages to a 'business as usual' state in years to come.

Boards of designated bodies should lead and promote this process in their organisations and we would be grateful if your boards discuss this letter.

Yours sincerely

Sir David Nicholson
NHS Chief Executive

Sir Bruce Keogh
NHS Medical Director

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**CQC Inspection Visits**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR(s):	**Kam Dhami, Director of Governance**
DATE OF MEETING:	**29 November 2012**

EXECUTIVE SUMMARY:

The CQC carried out unannounced inspection visits to City Hospital and Sandwell General Hospital on the 27 September 2012 as part of a scheduled programme. A further visit was made on the 1 October to provide verbal feedback to members of the Executive Team. The attached reports set out the CQC findings

No serious patient safety concerns were found. In summary, of the 7 essential standards of quality and safety reviewed by the visiting team, 5 were assessed as compliant and 2 as requiring action. The non-compliant standards were:

- Consent to care and treatment
- Assessing and monitoring the quality of service provision.

Action plans to address the areas for improvement identified by the CQC are under development and will be presented to the Quality and Safety Committee in December 2012.

REPORT RECOMMENDATION:

The Trust Board is asked to NOTE the findings of the CQC Inspection Visits to City Hospital and Sandwell General Hospital in September 2012.

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

Accept	Approve the recommendation	Discuss
✓		

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

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

Comments:

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

Safe High Quality Care

PREVIOUS CONSIDERATION:

Quality & Safety Committee at its meeting on 22 November 2012.

CareQuality Commission

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Sandwell General Hospital

Lyndon, West Bromwich, B71 4HJ

Tel: 01215531831

Date of Inspections: 01 October 2012
28 September 2012

Date of Publication: November 2012

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✖ Action needed
Complaints	✓ Met this standard

Details about this location

Registered Provider	Sandwell and West Birmingham Hospitals NHS Trust
Overview of the service	Sandwell General Hospital is part of Sandwell and West Birmingham Hospitals NHS Trust. It is a busy acute hospital with 470 beds.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 28 September 2012 and 1 October 2012, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and talked with stakeholders.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

During this inspection we visited three departments. We spoke with ten people who were using the service on the day and 19 staff.

People felt that they were able to give their consent before being treated or examined. One person said "Yes, they tell you what they are about to do, for example take blood." We found that improvement was needed to show how the trust determined that people lacked the capacity to make some decisions for themselves.

People told us that their medical and nursing needs were met. One person told us that they had been seen immediately on arrival at the emergency department due to their condition. This person said they had been to the hospital before with the same complaint they told us that, "Both times they have been excellent. I can't fault the staff."

People said that all their records had been transferred with them when they moved between departments. Staff we spoke with said they had good access to people's medical information.

Everyone who used the service that we spoke with felt they had received safe care. Staff knew how to report concerns about people's safety and welfare should they need to.

People we spoke with spoke highly of the staff. We found that overall staff received the training and support they needed to do their job.

Most people we spoke with said they did not know how to complain. However we found that there was a robust system in place for investigating complaints.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 04 December 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✖ Action needed

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was not meeting this standard.

Where people did not have the capacity to consent, it was not always clear that the provider acted in accordance with legal requirements.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with ten people who used the emergency department and the emergency assessment unit on the day of our inspection. On the whole people felt that they were able to give their consent before being treated or examined. One person said "Yes, they tell you what they are about to do, for example take blood." Another person told us that they didn't know what treatment they were going to have but said they were confident that they would be told.

Some people said that they understood how to change decisions about examinations, care and treatment previously agreed. On the whole people were very positive about the way the outcomes of nursing and medical assessments and medical tests were explained to them. Although some people felt that it depended on the staff that gave the explanation. One person said, "Different doctors emphasise different things." This meant that on the whole people using the service were given the information they needed to help them to make informed decisions about their care and treatment.

All the staff we spoke with were clear about how they obtained people's consent on a day to day basis before offering care and treatment. Staff were aware that people had the right to refuse treatment if they wished. All staff spoken with said that in an emergency situation they would act to save lives in the first instance and would ensure that their decisions were recorded. Staff told us they would give people the information they needed about the proposed treatment and give them time to decide if they wanted it. One member of staff said I would ensure that people knew the risks and benefits and check their understanding." This meant that staff were aware of people's rights.

We were told that staff had access to a translation and interpreting service where they were able to book an interpreter. A language line was also available on a 24 hour basis and staff can access this directly should the need arise. The trust employed staff from different linguistic back grounds and the staffs language skills were utilised in supporting

people whose first language was not English. This meant that staff were able to communicate with people to ensure that they understood information about their care and treatment.

On one of the units we visited all staff we spoke with talked about what action they would take should they identify that a person using the service lacked the capacity to make an informed decision. Staff talked about the tool that was in place for assessing people's capacity to make decisions. Staff told us they would seek senior staffs' guidance and opinion should they have any concerns about someone's capacity. We were also told about the link teams that were available to offer support and guidance to staff when assessing the needs of people with learning disabilities and mental health needs. Most staff spoken with were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards. In the main staff confirmed that they had received training in this area. This meant that they were aware of how to provide care and treatment that protected the rights of people using the service.

We looked at the nursing assessment record for one person who appeared to us to be confused. We saw that at the start of the assessment the person's relative had signed a form giving consent for valuables that were to be kept with the person whilst they were in hospital. It was not clear how it was established for the relative to sign this document. We went through the assessment record with a member of staff and we could not establish the process used for assessing that the person didn't have the capacity to sign this document. One person told us that their father was told to sign a form but no one had explained to them what they were signing. This meant that the process for establishing people's capacity to give consent to care and treatment was not always clear.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

All of the people who were receiving a service that we spoke with during the inspection told us that their acute medical and nursing needs were met.

We spoke with six people who had been admitted to the emergency assessment unit the day before our visit. Everyone we spoke with on this unit said that staff assessed their medical and nursing needs. They all said that they felt that they received safe care in a timely manner and that the care met their needs. They said that staff asked them about their medical history including current medications when being examined. They all said that staff had taken account of any specific needs they had. One person commented that staff had been mindful of their arthritic condition. Another person said that the staff were aware of their hearing difficulties. We looked at the nursing record of one person on this unit. We saw that an assessment of the person's needs had been completed. This gave clear indication of the risks associated with caring for this person and a plan of care had been developed to meet the person's needs. We saw that the appropriate equipment was provided to reduce the risks of caring for this person. We saw daily care records which detailed each day the care that the person had received. This meant that the person's needs was being met in a safe way.

Five of the six people we spoke with on this unit said that their privacy and dignity was respected while they were receiving care. Comments included, "The curtains are drawn when I want to use the toilet." "When I want to speak privately the curtains are drawn." "Yes, very much. The curtains are always drawn, even the window ones." We saw that staff treated people who used the service with dignity and respect, for example they fully drew the curtains when attending to people. We saw a nurse asking a person who was waiting to be moved to a bed if they would like to go to a more private place to get their blood taken. We saw another member of staff placed aprons around two frail people and gently helped them to sit up before food was brought to them. We saw that catering staff checked with nurses about peoples' dietary requirements. We saw that staff were thoughtful. For example we saw that one person who had been discharged was asked to have lunch before they left. This meant that people received care and treatment in a way that respected their privacy and dignity.

We spoke with four people who used the emergency department on the day of our inspection. People told us that their medical needs were met. One person told us that they

had been seen immediately on arrival as they had chest pain. This person said they had been to the hospital before with the same complaint. This person told us that, "Both times they have been excellent. I can't fault the staff." Another person told us that they had also visited the department before and waited six hours to be seen. However they commented that once they were seen the treatment was okay. This meant that people were clear that their immediate and acute medical needs were assessed and met.

We saw that people received emergency treatment in an environment where there were good facilities and accessible equipment to ensure that they were assessed and treated in a safe way.

We looked at the records of three people who visited the department that day. We saw that they had been seen by medical staff and had either had various tests or were waiting for tests to be done. We saw that observations were recorded and where necessary peoples' assessment and treatment records had been reviewed by a senior doctor. This showed that peoples' medical needs were reviewed by medical staff with the appropriate levels of skills to ensure they were treated safely.

On the day of our inspection the emergency department was very busy. We saw that at some point during the day a number of people were waiting on trolleys to be seen. We were told that there was a computerised system that was used so that staff could see and identify who had been in the department the longest. People were seen in order of time of arrival or injury. For example priority was given to people who arrived by ambulances and children. A new assessment procedure had been implemented. This meant every person who comes into the department by ambulance was initially assessed within one hour or quicker this was to make sure that they were safe to wait to be treated by a doctor. There were two triage rooms within view of the waiting room. This meant that staff could see if people's conditions were deteriorating so that they could take action.

A member of staff told us that there was a robust escalation procedure in place, which was managed by capacity managers. This meant that if a patient was in the department for more then four hours the escalation process would be implemented and they would be assessed every two hours for any changes to their condition. A fast track system was in place to assess and treat people quickly.

Throughout the day we observed that people were generally assessed quickly following registration. We were told that following peoples' assessment there was sometimes a blockage in the department due to inpatient beds not being available. We saw that this affected some people's experiences and we discussed this with the trust at the time of our inspection.

We spoke with a range of staff in the radiology department to ensure that the systems for undertaking x rays were robust. Staff told us that they had good systems in place for ensuring that they were undertaking x rays on the correct person and were clear that if they were in doubt they would refer back to the referring medical team. This meant that people should receive the correct x rays as required.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

We spoke with four people who had transferred from the emergency department to the emergency assessment unit. All said that they were aware that their records and medication were transferred with them when they were transferred between wards. One person said, "I saw four doctors and they had different opinions about where I should go. But when they were moving me they brought all my stuff along in a wheelchair, so yes it was transferred."

We spoke with staff across the different departments and they told us that results of tests and x rays were usually available electronically. These were usually reviewed by the appropriate staff and there were usually no delays in interpreting results. This meant that staff got the information they needed to make assessments about peoples' needs in a timely manner.

X rays undertaken at GP requests were reported on and sent through to the respective GP's. Staff talked about an increase in referrals for computed tomography (CT scans), which had resulted in some difficulty in reporting on the scans done in a timely way. This was mainly due to staffing levels in the department.

We were told that peoples' records were usually transferred to the wards with them. Although staff said there was sometimes a slight delay in transfer of medical notes from one department to the other. Overall staff did not feel that this was a major problem.

Staff told us that there were good transfer arrangements for handing over of people between wards. This was usually a nurse to nurse handover and all relevant documents would go with the person using the service. Two staff commented that there were usually good relationships between wards and departments to facilitate transfer of people.

On one of the units we were told that planning for peoples' discharge from hospital started at the point of admission. The maximum stay for people on this unit was for 24 hours unless clinical needs indicated that people should stay longer. Staff talked about working with the hospital avoidance team to assess peoples' social situation to enable discharge. We were told that unreasonable discharges were avoided during the night, so that people were not discharged home without the appropriate social support being in place.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

All the people we spoke with during the inspection felt that they were receiving safe care and treatment.

We spoke with a range of different staff who worked in three different departments in the hospital. All staff knew that they needed to report concerns about vulnerable people to the senior person in charge of their respective departments. Staff were aware that there was an internal safeguarding team available for dealing with safeguarding issues. Some staff we spoke with also talked about the role of social services and the police in investigating safeguarding concerns.

Some staff said they had received both vulnerable adults and children safeguarding training, others said they had received children safeguarding training only. The trust may wish to review staffs training in this area, so that they can be assured that all staff have had the necessary training.

Staff knew about the whistleblowing policy and that they could use this policy to raise concerns about bad practice.

Staff said they had a current Enhanced Criminal Records Bureau Check (CRB) and one member of staff told us that all staff recently had updated CRB checks. This meant that the trust ensured that the staff they employed were safe to work with vulnerable people.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Staff received appropriate professional development.

With the exception of one person, all of the people we spoke with said that they felt that staff were trained to meet their needs and spoke highly of them. Everyone said that staff had treated them very well. All said they had seen two or more doctors, including specialists, during their stay in hospital. One person said that at one time there was a team of three doctors looking after them.

During this inspection we spoke with 19 staff undertaking a variety of roles, across three departments within the hospital. Everyone we spoke with confirmed that they had received core training to do their job. Such as moving and handling, blood transfusion procedures, emergency procedures, infection control, medication and safeguarding vulnerable people. This meant that staff had the training they need to meet people's needs.

We spoke with new staff to the hospital and some trainees and junior doctors. All said they received an induction into their role at the hospital. They all said they felt supported and that senior members of staff were available for them to refer to throughout the day and night. One junior doctor said, "Really good support. There is always a registrar or a consultant around to ask for advice. I have never been in a position where I have lacked support."

A trainee radiograph told us that they had a mentor with whom they met with weekly and works along side once per week. They said they were supervised by an experienced radiographer during procedures. This meant that should they make a mistake this would be highlighted and corrected.

All staff told us that they were supervised and had their work appraised by their respective line managers. On one of the units staff talked about the matron and chief nurse undertaking spot checks to check on the quality of their work. They also said that training events were arranged on the unit to support them in updating their skills. Some staff felt that there were good training opportunities for developing skills in their departments. We were told about the development nursing post that had been formed to ensure that training was kept up to date.

Most staff spoken with said that staff meetings took place within their wards and departments. Overall the majority of staff we spoke with felt that they were well supported in their role. However this very much depended on which department they worked in. For example some staff felt that they did not always get the personal support they needed after incidents had occurred. Across all departments staff commented on the shortage of staff and the impact this had on their work load and consequently their view as to how well they were supported.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people received.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

On the day of our inspection eight of the ten people that we spoke with spoke said they were satisfied with the service they had received. One person said, "It can't be improved, care is very good." Another person said, "Staff know what they are talking about and I can rely on them."

The trust quality report dated August 2012 showed a decrease in the overall level of satisfaction of people using the service. The complaints process showed that there were significant delays in investigating and responding to complaints. The trust risk management report 2012/13 showed that a number of all complaints were linked. That was people being dissatisfied or making additional complaints. No analysis of the reasons for the level of dissatisfaction was undertaken, so that trends and themes could be identified. Although the trust believed this may be due to the delay in the investigations.

Across all of the departments that we inspected staff talked about the shortage of staff at all grades and the impact this had on service delivery. Some staff were aware that the trust had plans in place to recruit new staff into posts. One member of staff told us that this was taking too long and that at times the number of people needing treatment in one of the departments was too high. However we were told that a risk assessment had been completed for this department and plans were in place to address the immediate risks. The trust internal audit processes had identified the number of staff vacancies across all departments. Following these audits the trust was in the process of trying to recruit to vacant post. This has included advertising oversees to get suitably qualified candidates.

Before we inspected the trust we were aware that there had been a number of reported serious untoward incidents mainly across the critical care pathway. The trust quality report dated August 2012 stated that the emergency department had been placed in special measures. We were told that they had commissioned an external review of this department. This meant that the trust had identified that there were issues with the systems and had taken a proactive approach to trying to identify and address the root cause.

We spoke with all the staff about reporting of incidents, and they were all aware of how to report incidents. Some staff were aware that incidents were analysed and information about the outcome was available via an e bulletin. However a significant amount of staff reported that they were unsure what happened after they reported incidents. This meant that it was difficult to see how learning from incidents would be incorporated into practice across all wards and departments to prevent repeat of incidents.

Following concerns raised with us we had conducted an inspection of the trust under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME) in February 2012. We had made a number of recommendations to the trust. During this visit we saw that the trust had in general responded very well to the recommendations and was undertaking mock IRMER inspections, to ensure that people received safe care during x ray procedures. This meant that the trust acted on reports prepared by the Care Quality Commission.

We saw that the trust undertook a number of audits relating to how the service was managed. These resulted in various action plans, which were overseen by different committees. We were told that there was system in place for the various committees to identify patterns across the trust. However we saw that there was no overarching action plan to incorporate the wider trends and to ensure that peoples' experiences shaped policies. Whilst it was clear that the trust undertook analysis of incidents we saw that there were inconsistencies how lessons learnt was embedded in some areas. Which may potential impact on the quality of care people using the service experience. In addition we saw that some of the objectives within these needed to be written in a more measurable way.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

The majority of people we spoke with said that they did not know how to complain if they were unhappy with their care or treatment. One person said that they would speak to the person in charge. Another person said, "I don't but my sister does." None of the people we spoke with had made a complaint, because they said there was no need to complain.

On one of the units we saw some information about complaints. For example at the entrance to the unit there was a notice board. This contained the analysis of the number of complaints that had been received from December 2011 to February 2012. The telephone contact number for the Patient advisory liaison service was also available on a notice board. We saw no complaints leaflets in the departments that we visited, but we were told that these leaflets were usually available.

We looked at the investigation process for three complaints received by the Trust. We saw that there was a detailed process in place for investigating and responding to complaints. There was a 90 days timescale for investigation of complaints. We were told that the new matron role on the wards and departments included responsibilities for investigation complaints, which should help in reducing the length of time that people waited for a response to their complaints.

Information about complaints was not readily available in alternative formats. This may make it difficult for people whose first language was not English or for people with different communication needs to access the complaints process. However we were told that the complaints procedure was under review and would be made available in the most used community languages and alternative formats for the respective locations.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: People were sometimes asked to sign documents without an explanation of what they were being asked to sign. It was not clear how it was established that people did not have the capacity to sign documents for themselves. This is in line with Regulation 18 (a) (b) (2)
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The systems for monitoring the quality of care were not sufficiently robust. Complaints were not investigated in a timely manner. Appropriate systems were not in place to ensure that learning from incidents informed staff's practice. Staffing levels were not currently at a level to enable a quality service to be maintained. This is in line with Regulation 10 (1)(a) (2)(b)(i) (c)(i)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

The provider's report should be sent to us by 04 December 2012.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

City Hospital

Dudley Road, Birmingham, B18 7QH

Tel: 01215543801

Date of Inspections: 01 October 2012
27 September 2012

Date of Publication: November 2012

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✖ Action needed
Complaints	✓ Met this standard

Details about this location

Registered Provider	Sandwell and West Birmingham Hospitals NHS Trust
Overview of the service	City Hospital Is an acute hospital which is part of Sandwell and West Birmingham NHS Trust
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Family planning Maternity and midwifery services Nursing care Personal care Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 27 September 2012 and 1 October 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

During this inspection we looked at the care and treatment people experienced across the emergency department (ED) and the medical assessment unit (MAU). We spoke with twenty people using the service, four relatives, a carer and twenty members of staff this included nursing and medical staff as well as senior managers. We looked at seven sets of records for people using the service.

People felt that they were able to give their consent before being treated or examined. One person told us "Staff always ask before they do anything". We found that improvements were needed to show how the trust determined that people lacked the capacity to make some decisions for themselves.

People said that they received good care which met their needs. One person told us " I am happy with the standard of care". We saw that care was coordinated to ensure that people received safe care and treatment.

People that we spoke with felt they had received safe care. Staff knew how to report concerns about people's safety and welfare should they need to. People we spoke with spoke highly of the staff. We found that overall staff received the training and support they needed to do their job.

Systems were in place to regularly assess and monitor the quality of service but improvements were needed to ensure findings influenced practice. Most people we spoke with said they did not know how to complain. However we found that there was a robust system in place for investigating complaints.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 11 December 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✖ Action needed

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was not meeting this standard.

Where people did not have the capacity to consent, it was not always clear that the provider acted in accordance with legal requirements.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Our conversations with people and relatives on the day indicated that consent to care and treatment was sought and treatment options were explained. People that we spoke with said that staff has obtained consent for examination and tests and gave appropriate explanation. One person said "Staff told me what they were doing and asked me if it was ok, the doctor also explained why I needed a blood test".

We saw staff in both departments give information and explanation to people. We saw a member of staff in the ED undertaking a person's clinical observation, they explained what they were doing before they had started. This reassured the person who was clearly anxious and meant that consent was also obtained.

All of the staff that we spoke with were clear about how they obtained people's consent on a day to day basis before offering care and treatment, as well as respecting people's right to refuse treatment if they wished. However our conversations with some people indicated that their option to refuse treatment was not always discussed. Some of the people that we spoke with were not aware of how to change their mind on a decision that was previously agreed. One person said "I can't remember been told about changing my mind". Without the right information people may not be aware that they have the right to withdraw consent.

Records showed that personal property disclaimers were obtained which were signed by the person or someone acting on their behalf and a member of staff. This meant that people had the information they needed to ensure safety of their personal belongings.

All of the staff that we spoke with had knowledge and awareness of mental capacity although not all had received formal training. We saw that capacity assessments formed part of some assessment processes, such as when a person was admitted with a head

injury or when a ' do not attempt cardiopulmonary resuscitation' (DNACPR) was required.

We saw that the general admission process lacked consideration for issues around mental capacity and this could mean that people lacking capacity may not always have their needs assessed. A family member accompanying a person who lacked capacity to the ED told us that no questions were asked during the admission regarding the person's capacity and what decisions they were able to make for themselves. We saw that the person's records reflected that no discussion had taken place about their consent to treatment. One person in the MAU had a DNACPR in place, nursing and medical staff that we spoke with confirmed that the person lacked capacity. However the capacity assessment section of the DNACPR form had not been completed. Both the nursing and medical staff that we spoke with were unable to provide evidence of how the decision had been made. Without appropriate assessments people lacking capacity may not have their rights protected by ensuring that decisions were made in their best interest.

We were told that staff had access to a translation and interpreting service where they were able to book an interpreter. A language line was also available on a 24 hour basis and staff could access this directly should the need arise. The trust employed staff from different linguistic back grounds and the language skills of members of staff were utilised in supporting people whose first language was not English. This meant that staff were able to communicate with people to ensure that they understood information about their care and treatment.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

All of the people that we spoke with were very positive about the care that they had received in both of the departments. People that had previous experience of care in the ED and the MAU felt that improvements had been made since their last admission. People said that they felt that they received safe care which met their needs. One person that we spoke with in the MAU commented "My husband was admitted here a few years ago and it was not pleasant but things seem to have improved, since my admission everything has been great". A person in the ED said "I have been here a lot I get a good service".

Some of the people that we spoke with in the ED said that although they received care in a timely manner they were not provided with adequate information on waiting times. We did not see any information on display in the waiting area informing people of what the expected times were so they were kept informed of any delays. A senior member of staff in the ED told us that there was a robust escalation procedure in place and if a person was in the department for more than four hours the escalation process would be implemented.

A fast track system was in place to assess and treat people quickly. An emergency nurse practioner and a GP operated in the ED and reviewed people with minor ailments. We saw that when people were admitted both medical and nursing assessments were undertaken. Assessments included information about past medical history and any current medications taken. Relevant tests and investigations were also ordered as part of the plan of care. It was also clear from the records that senior medical staff had either reviewed the person or had been consulted.

Staff in the MAU told us that when people were admitted a detailed nursing and medical assessment would be undertaken. This involved a nursing assessment within fifteen minutes of admission to the unit and medical staff assessment within four hours. This included senior medical staff reviewing people and making decisions about their care and treatment. Records that we looked at in the MAU showed that care plans and risk assessments were in place such as nutritional and pressure sore assessments. The provider may wish to note that there were some inconsistencies in care planning undertaken in the MAU. One person who had a high pressure sore risk assessment score had a care plan in place but another person with a much higher score did not have a care plan in place. Staff that we spoke with said a care plan was not in place as the person had

been admitted for a short stay. It was evident that the person was on a pressure relieving mattress which would reduce the risk of developing pressure sores but without appropriate care plans people may not always receive the care that they need.

We saw in both departments when people were on regular observations these were recorded on a colour coded observation chart which would flag up any abnormal results. Staff told us and we saw observations, examinations, investigations and tests were recorded on people's records this ensured they were reported and acted on accordingly.

People in the ED were afforded dignity and respect, we saw staff closing curtains when undertaking assessments and investigations. We saw signs informing people that bays included both male and female patients so that people were aware and could take steps to reduce any impact on their privacy and dignity.

In the MAU we saw that in one bay there was a separate male and female area. Other areas in the unit included male and female beds but we saw people had curtains drawn if they wished. Staff told us that they tried to ensure male and female beds were kept separated as much as possible to ensure that people were afforded privacy and dignity.

We asked staff how nutritional needs were met in the ED for people who were able to eat and drink. A member of staff told us that drinks were offered on request and people who had been in the department for more than four hours would be offered something to eat. People that we spoke with did not report receiving anything to eat or drink but most of the people that we spoke with on the day had not been waiting over four hours. It was not clear if a formal monitoring system was in place to ensure that people would be offered something to eat or drink if their were delays. If people are not on any fluid or diet restrictions on medical grounds then consideration should be given to their nutritional needs when waiting long periods of time. This would be particularly important for people who may be vulnerable due to health conditions or language barriers.

In the MAU staff that we spoke with said people were offered hot drinks on admission. One person that we spoke with said "I only have to ask for a cup of tea and I get it".

We saw that people received treatment in an environment where there were suitable facilities and accessible equipment to ensure that they were assessed and treated in a safe way.

On the day of our inspection the ED became very busy quickly. We saw at one point during the day a number of people were waiting on trolleys to be seen. We saw discussions took place amongst senior staff and that people were moved as soon as possible. We were told an 'overflow area' would be utilised when needed to ensure people were not waiting on trolleys. Relevant staff would be mobilised to cover the area. We were told by senior staff that there was a computerised system that was used so that staff could see and identify who had been in the department the longest. People were seen in order of time of arrival or injury and priority was given to people who arrived by ambulances and children.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

In the ED we saw a person with a known mental health condition had been admitted. Staff had made contact with the mental health team who attended to review the patient to ensure that they were stable. Discussions had also taken place with other professional involved in their care. This meant that the person's care had been coordinated to ensure that good outcomes were achieved for them. We spoke with the person who was very happy with the care that they had received from all of the professionals involved in their care.

We spoke with staff across the different departments and they told us that results of tests and x-rays were available electronically. These were reviewed by an appropriate member of staff and there were usually no delays in interpreting the results. This meant that staff had the information they needed to make assessments about people's needs in a timely manner. Staff told us that that x-rays were on a computerised system and that medical staff had to acknowledge on the system that they had seen them. This would provide some assurance that important investigations were reported on.

Staff told us that a board had been set up in the ED to help improve communication between staff so that important information was shared to help improve care. Senior staff told us that regular discussions took place to ensure the ongoing monitoring of capacity and dependency levels in the ED. Some of the staff that we spoke with in the ED told us of the difficulties in coordinating care for people with sometimes complex mental or social health problems which could place additional pressure on beds. Senior staff explained that when necessary conference calls took place to discuss concerns regarding high numbers of admissions in to the ED. This involved senior management and the local primary care trust who would consider what actions were required to manage the situation safely.

Staff in the ED told us how information about people's health was assessed on admission, this included relevant handover from other professionals such as the paramedics. We saw staff receiving a handover from paramedics so that they had all the information they needed to be able to assess the person's needs. Nursing staff told us that they were usually involved in decisions about admissions and discharges although medical staff would make the overall decision. This would ensure that both medical and nursing

assessments contributed to the decision making process so people received the care that they needed.

Senior staff in the ED told that us that relevant information such as what tests people had done were handed over both in writing as well as verbally. A system was in place which meant that important information such as investigations would be recorded and anything requiring follow up would be highlighted. This would ensure anything not reviewed or completed could be followed up and relevant information would be shared between staff and departments. Senior staff in the MAU confirmed that verbal and written handovers took place between the two departments. Anything outstanding would be documented in people's records so that people received the care that they needed.

Senior staff in the MAU told us the maximum stay for people on the unit would be under twelve hours unless clinical needs indicated that the person should stay longer. Staff talked about the systems that were been put in place to improve the pathway between the ED and the MAU so that people were admitted and discharged appropriately.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

All of the people that we spoke with during the inspection felt that they were receiving safe care and treatment.

We spoke with a range of different staff who worked in both departments in the hospital. All of the staff understood their role in reporting concerns about vulnerable people and referring to the senior person in charge of their respective departments. Staff demonstrated knowledge and awareness on how to report and escalate safeguarding concerns and involve relevant agencies such as social services and the police.

Some of the staff that we spoke with gave us examples of how they responded to safeguarding concerns appropriately. Staff told us of the support available to them from the trust safeguarding team and the safeguarding lead.

The majority of staff said they had received both vulnerable adults and children safeguarding training. This would ensure that staff had the knowledge they needed to recognise and respond to any allegations of abuse.

Some of the staff that we spoke with were aware of the trust's whistle blowing policy, staff could use this policy to raise concerns about poor practices should they choose to.

The trust had a robust recruitment process in place which meant that staff had an Enhanced Criminal Records Bureau Check (CRB). This demonstrated that the trust employed staff who were safe to work with vulnerable people.

We saw information on display with contact details of the adult safeguarding nurse so staff had the information they need to access support and advice should they need it.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

During this inspection we spoke with twenty members of staff undertaking a variety of roles across the two departments within the hospital. Staff that we spoke with said that they had received core training in areas such as safeguarding and fire safety although some staff reported that they were due updates. Staff had also received training specific to their job.

People that we spoke with felt that staff were trained to meet their needs and spoke highly of them. One person said " I have never met an unpleasant nurse or doctor". Another person told us "I am very comfortable here, they are brilliant with me". People said that staff had explained what was happening and they felt that staff knew what they were doing.

We were told the trust implemented newsletters to staff in the ED to keep them updated about changes and plans were in place to bring in regular team reviews during each shift to keep staff informed of ongoing changes. A senior member of staff in the ED told us that they were also looking at developing an education forum for doctor and nurses so that staff could learn from clinical incidences. We were told junior medical staff received regular teaching to develop their knowledge and skills.

Senior staff in the ED recognised that some improvements were required and told us that systems were been implemented so that positive changes could be achieved.

Some of the staff in the ED said team meetings took place but they were infrequent. Staff reported that generally support was available but could not recall formal supervision although said that they had received an appraisal. Senior staff told us that the matron had recently left and a new post had been advertised, this would provide strong leadership and support for staff.

In the MAU staff that we spoke with felt supported and said that the morale was good. One member of staff commented that they had a "brilliant team " and support was readily available. Staff said they had monthly staff meetings so that important information was communicated. Senior medical staff told us of the importance of ensuring good team work which they encouraged by joint teaching and learning between nursing and medical staff. Senior medical staff said that they were supported in their role.

We were told that people were always reviewed by senior medical staff, this was reflected in the records that we looked at in both departments. This would ensure that junior medical staff were supported and supervised to provide safe care. Staff said they received a trust induction when they started which prepared them for their role. Some staff felt that there were good training opportunities for developing skills in their departments.

The majority of staff that we spoke with felt that they were well supported in their role. However this very much depended on which department they worked in. For example some staff felt that they did not always get the personal support they needed after incidences had occurred. Across all departments staff commented on the shortage of staff and the impact this had on their work load and consequently their view on how well they were supported.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people received.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

On the day of our inspection eighteen of the twenty people that we spoke with spoke said they were satisfied with the service they had received. One person said "I am very comfortable here they have been brilliant with me". Another person said "Everything has been just fine I can't complain".

The trust quality report dated August 2012 showed a decrease in the overall level of satisfaction of people using the service. The complaints process showed that there were significant delays in investigating and responding to complaints. The trust risk management report 2012/13 showed that a number of complaints were linked to people being dissatisfied or making additional complaints. No analysis of the reasons for the level of dissatisfaction had been undertaken so that themes and trends could be identified. The trust believed that the dissatisfaction may be due to the delay in the investigation process.

Across all of the departments that we inspected staff talked about the shortage of staff at all grades and the impact this had on service delivery. Some of the staff were aware that the trust had plans in place to recruit new staff into posts. One member of staff told us that this was taking too long and that at times the number of people needing treatment in one of the departments was too high. However we were told that a risk assessment had been completed for this department and plans were in place to address the immediate risks. The trust internal audit processes had identified the number of staff vacancies across all departments. Following these audits the trust was in the process of trying to recruit in to vacant posts. This had included advertising oversees to get suitably qualified candidates.

Before we inspected the trust we were aware that there had been a number of reported serious untoward incidences mainly across the critical care pathway. The trust quality report dated August 2012 stated that the ED had been placed in special measures. We were told the trust had commissioned an external review of the department. This meant that the trust had identified that there were issues and had taken a proactive approach in trying to identify and address the root cause.

We spoke with all of the staff about the reporting of incidences and they were all aware of the reporting system. Some staff were aware that incidences were analysed and information about outcome were available via the e bulletin. However a significant number of staff reported that they were unsure what happened after they reported an incident. This meant that it was difficult to see how learning from incidences would be incorporated into practice across all wards and departments to prevent incidences reoccurring.

Following concerns raised with us we had conducted an inspection of the trust under the Ionising Radiation Medical Exposure Regulations 2000 (IRME) in February 2012. We had made a number of recommendations to the trust. During this inspection we saw that the trust had in general responded very well to the recommendations and was undertaking mock IRMER inspections to ensure that people received safe care during x -ray procedures. This meant that the trust acted on reports prepared by the Care Quality Commission.

We saw that the trust undertook a number of audits relating to how the service was managed. These resulted in various action plans which were overseen by different committees. We were told that there was a system in place for the various committees to identify patterns across the trust. However we saw that there was no overarching action plan to incorporate the wider trends and to ensure that people's experiences shaped policies. Whilst it was clear that the trust undertook analysis of incidences, we saw that there were inconsistencies in how lessons learnt were embedded in some areas. This may potentially impact on the quality of care people using the service experienced. In addition we saw that some of the objectives within these needed to be written in a more measurable way.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

The majority of people we spoke with said that they were aware of how to make a complaint if they needed to. One person said that they would speak to the person in charge. Another person told us they had no complaints because the care that they had received had been " excellent". None of the people that we spoke with had made any complaints because they said they were happy with the care and treatment that they had received.

We saw some information about complaints were displayed in various areas of both departments as well as information about the Patient Advisory Liaison Service (PALS). We did not see any information regarding how to complain in the outside waiting area of the ED although a suggestion box was in place but was empty at the time of our inspection. Staff told us that the PALS team were responsible for collecting comments from the box, it was not clear from speaking with staff how this information was fed back to them. We saw no complaints leaflets in the departments that we inspected but we were told that these leaflets were usually available.

We looked at the investigation process for three complaints received by the trust. We saw that there was a detailed process in place for investigating and responding to complaints. There was a 90 days timescale for investigation of complaints. We were told that the new matron role on the wards and departments would include responsibility for the investigation of complaints. This would help in reducing the length of time that people waited for a response to their complaints.

Information about complaints was not readily available in alternative formats. This may make it difficult for people whose first language was not English or for people with different communication needs to access the complaints process. However we were told that the complaints procedure was under review and information would be made available in the most used community languages and alternative formats.

Staff that we spoke with were aware of how to deal with complaints. This would ensure that any complaints raised would be handled appropriately.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: People were sometimes asked to sign documents without an explanation of what they were being asked to sign. It was not clear how it was established that people did not have the capacity to sign documents for themselves. This is in line with Regulation 18 (a) (b) (2)
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The systems for monitoring the quality of care were not sufficiently robust. Complaints were not investigated in a timely manner. Appropriate systems were not in place to ensure that learning from incidents informed staff's practice. Staffing levels were not currently at a level to enable a quality service to be maintained. This is in line with Regulation 10 (1)(a) (2)(b)(i) (c)(i)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

The provider's report should be sent to us by 11 December 2012.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – October 2012
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	29 November 2012

EXECUTIVE SUMMARY:

The report presents the financial performance for the Trust and operational divisions for the period to 31st October 2012.

Measured against the DoH target, the Trust generated an actual surplus of £537,000 during October against a planned surplus of £462,000. For the purposes of its statutory accounts, the in month surplus was slightly higher at £566,000.

REPORT RECOMMENDATION:

The Trust 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.

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

Accept	Approve the recommendation	Discuss
x	x	

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 20 November 2012; Finance & Performance Management on 23 November 2012

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – October 2012

EXECUTIVE SUMMARY

• For the month of October 2012, the Trust delivered a "bottom line" surplus of £537,000 compared to a planned surplus of £462,000 (as measured against the DoH performance target).

• For the year to date, the Trust has produced a surplus of £1,706,000 compared with a planned surplus of £1,370,000 so generating an positive variance from plan of £336,000.

• The planned surplus continues to rise significantly towards the year end.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 102 below planned levels. After taking account of the impact of agency staff, WTE's were 16 above plan. Total pay expenditure for the month, inclusive of agency costs, is £159,000 below the planned level.

• The month-end cash balance was approximately £26m 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	75	336	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	67	278	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	159	638	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(476)	(2,581)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	(16)	27	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	20,949	20,949	>= 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	Year to Date Actual £000
Income and Expenditure	1,370	1,706
Capital Resource Limit	9,860	17
External Financing Limit	---	20,949
Return on Assets Employed	3.50%	3.50%

2011/2012 Summary Income & Expenditure Performance at October 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	382,553	32,011	32,218	207	224,080	225,885	1,805	388,220
Other Income	38,390	3,210	3,387	177	22,496	22,912	416	39,466
Operating Expenses	(394,324)	(32,859)	(33,176)	(317)	(231,903)	(233,846)	(1,943)	(401,106)
EBITDA	26,619	2,362	2,429	67	14,673	14,951	278	26,580
Interest Receivable	100	8	11	3	58	83	25	144
Depreciation & Amortisation	(14,738)	(1,228)	(1,228)	0	(8,597)	(8,597)	0	(14,738)
PDC Dividend	(5,594)	(466)	(466)	0	(3,263)	(3,263)	0	(5,594)
Interest Payable	(2,157)	(185)	(180)	5	(1,294)	(1,261)	33	(2,162)
Net Surplus/(Deficit)	**4,230**	**491**	**566**	**75**	**1,577**	**1,913**	**336**	**4,230**
IFRS/Impairment/Donated Asset Related Adjustments	(353)	(29)	(29)	0	(207)	(207)	0	(353)
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,877**	**462**	**537**	**75**	**1,370**	**1,706**	**336**	**3,877**

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.

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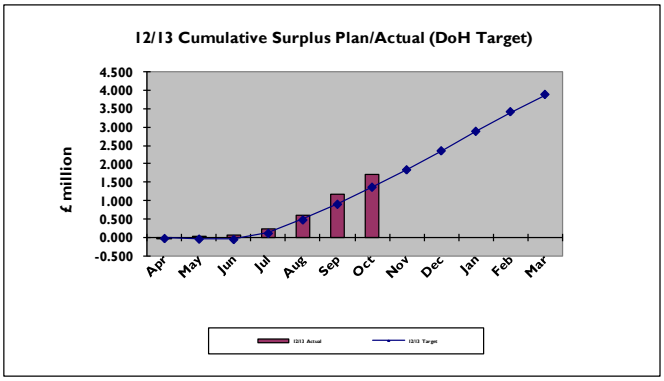
Overall Performance Against Plan

• 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 £537,000 in October against a planned surplus of £462,000. The resultant £75,000 positive variance moves the year to date position to £336,000 above targeted levels.



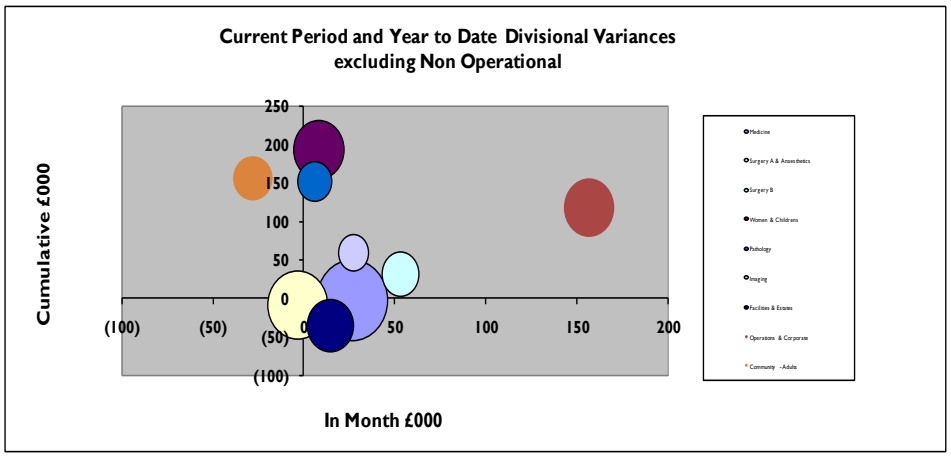
Divisional Performance

• For October, there are again no major variances from plan among operational divisions with only Surgery A and Community - Adults posting small in month deficits (£3k and £28k respectively).

• Performance in non operational areas reflects a cautious view of a number of uncertain items, including patient related SLA income where year end projections are subject to ongoing review with commissioners.

• SLA performance which is based on fully costed information for September shows an ongoing significant overall positive variation from plan particularly within Medicine (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 and Facilities all have relatively small adverse variances.



The tables adjacent and below show small adverse year to date variance for Medicine, Surgery A and Facilities

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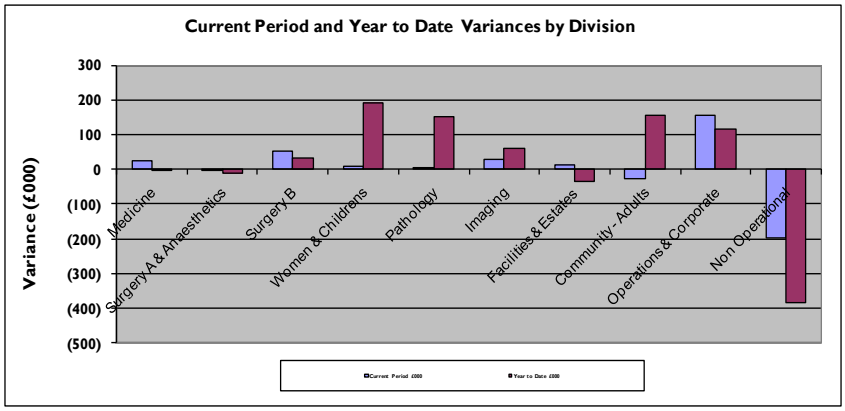
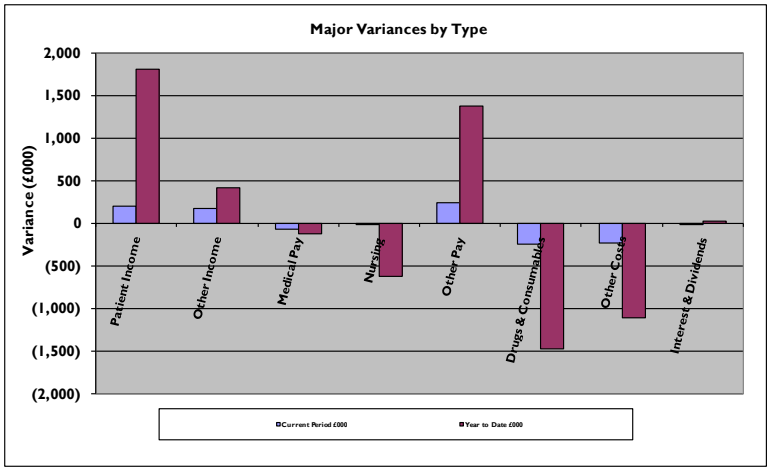
Divisional Variances from Plan	Current Period £000	Year to Date £000
Medicine	27	(3)
Surgery A & Anaesthetics	(3)	(9)
Surgery B	53	31
Women & Childrens	8	193
Pathology	6	151
Imaging	27	59
Facilities & Estates	15	(35)
Community - Adults	(28)	156
Operations & Corporate	157	117
Non Operational	(199)	(384)



For October, patient related SLA income again shows a positive variation from plan . Other income, particularly ICR charges and research & development also remain above plan. Overall pay expenditure is below planned levels particularly with the scientific, therapeutic & technical and management pay groups at £75k and £89k lower than plan respectively. Overall non pay expenditure is £476,000 higher than plan in month, largely in respect of drugs (which are largely matched by income), medical consumables , postage, printing & stationery and hotel services costs.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	207	1,805
Other Income	177	416
Medical Pay	(70)	(116)
Nursing	(14)	(622)
Other Pay	243	1,376
Drugs & Consumables	(241)	(1,474)
Other Costs	(235)	(1,107)
Interest & Dividends	3	25



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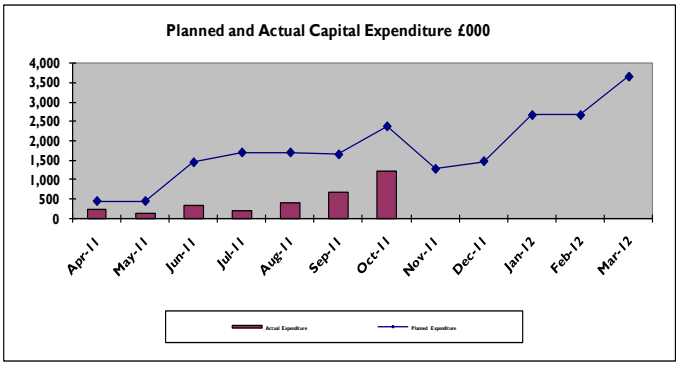
Capital Expenditure

• Planned and actual capital expenditure by month is summarised in the adjacent graph.

• Although in month expenditure is significantly higher than that for previous months, the year to date actual spend remains significantly lower than planned levels although this is primarily the result of delays in the acquisition of Grove Lane land.

• For the year to date, actual expenditure is almost £3.2m primarily related to statutory standards , estates rationalisation , land acquisition and medical equipment.

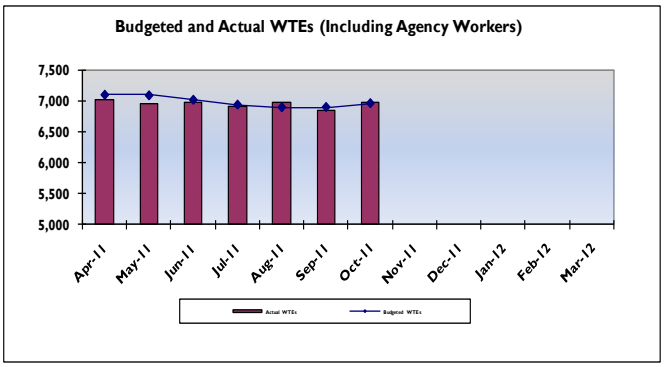


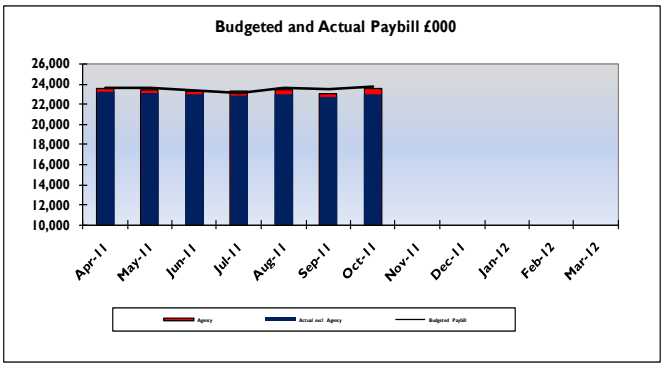
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 16 above plan compared with 56 below plan for September. Excluding the impact of agency staff, wte numbers are around 102 below plan. Actual wte's have risen by 133 compared with September. To a significant extent this reflects ongoing demands on capacity and includes increases in bank and agency usage.

• Total pay costs (including agency workers) are £159,000 lower than budgeted levels for the month , particularly within the scientific, therapeutic & technical and management pay groups.

• Expenditure for agency staff in October was £552,000 compared with £415,000 in September, an average of £526,000 for 2011/12 and an October 2011 spend of £425,000. The biggest single group accounting for agency expenditure remains medical staffing.





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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 October					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	43,827	42,086		1,857	43,943	(116)
Management	9,039	8,350		0	8,350	689
Administration & Estates	18,092	16,868	779	276	17,923	169
Healthcare Assistants & Support Staff	18,172	16,748	1,560	11	18,319	(147)
Nursing and Midwifery	49,788	47,647	2,151	612	50,410	(622)
Scientific, Therapeutic & Technical	25,370	24,360		345	24,705	665
Other Pay	13	13			13	0
Total Pay Costs	164,301	156,072	4,491	3,100	163,663	638

NOTE: Minor variations may occur as a result of roundings

Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the statutory accounts for the year ended 31st March 2012.

• Cash balances at 31st October are approximately £49.9m which is around £15.5m higher than at 31st March and £5.0m higher than in September, primarily the result of the quarterly receipt of education and training funding.

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION 2012/2013

		Opening Balance as at 1st April 2012 £000	Balance as at end October 2012 £000	Forecast at 31st March 2013 £000
Non Current Assets	Intangible Assets	1,075	995	1,125
	Tangible Assets	227,072	221,604	228,882
	Investments	0	0	0
	Receivables	865	865	950
Current Assets	Inventories	4,065	4,133	4,050
	Receivables and Accrued Income	14,446	15,457	13,500
	Investments	0	0	0
	Cash	34,465	49,940	26,310
Current Liabilities	Payables and Accrued Expenditure	(33,751)	(46,806)	(31,513)
	Loans	(2,000)	(2,000)	(2,000)
	Borrowings	(1,166)	(1,166)	(1,221)
	Provisions	(15,649)	(13,262)	(10,389)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	0
	Loans	(5,000)	(4,000)	(3,000)
	Borrowings	(29,995)	(29,420)	(28,969)
	Provisions	(2,532)	(2,532)	(1,600)
		191,895	193,808	196,125
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	160,231
	Revaluation Reserve	41,228	41,228	41,228
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	(18,622)	(16,709)	(14,392)
		191,895	193,808	196,125

Sandwell and West Birmingham Hospitals NHS

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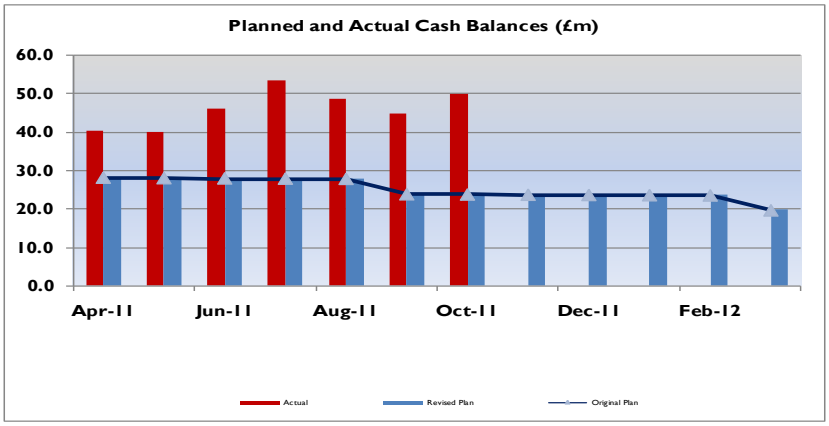

Cash Forecast

• A forecast of the expected cash position for the next 12 months is shown in the table below. The significant increase in capital related payments towards the year end reflects the expected payment profile for the current capital programme (and is dependent on the programme being fully delivered) and the experience of actual payments in previous years.

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT October 2012

ACTUAL/FORECAST	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	Sep-13 £000s	Oct-13 £000s
Receipts													
SLAs: Black Country Cluster	**17,124**	17,165	17,165	17,165	17,165	17,165	16,993	16,993	16,993	16,993	16,993	16,993	16,993
Birmingham & Solihull Cluster	**11,341**	11,341	11,341	11,341	11,341	11,341	11,228	11,228	11,228	11,228	11,228	11,228	11,228
Other Clusters	**617**	629	629	629	629	629	623	623	623	623	623	623	623
Pan Birmingham LSCG	**1,944**	1,944	1,944	1,944	1,944	1,944	1,925	1,925	1,925	1,925	1,925	1,925	1,925
Education & Training	**4,330**			4,347			4,300	0	0	4,300	0	0	0
Loans													
Other Receipts	**4,482**	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900
Total Receipts	**39,838**	33,979	33,979	38,326	33,979	33,979	37,968	33,668	33,668	37,968	33,668	33,668	33,668
Payments													
Payroll	**13,904**	13,215	13,215	13,215	13,215	13,214	13,068	13,068	13,068	13,068	13,068	13,068	13,068
Tax, NI and Pensions	**9,166**	9,556	9,556	19,111	9,556	9,555	9,455	9,455	9,455	9,455	9,455	9,455	9,455
Non Pay - NHS	**2,296**	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	**7,922**	6,814	5,361	8,995	8,314	9,527	8,000	7,500	7,500	7,500	7,500	7,500	7,500
Non Pay - Capital	**535**	1,375	1,775	1,975	5,165	5,470	1,750	1,750	500	500	500	500	500
PDC Dividend						2,797						2,700	
Repayment of Loans						1,000						1,000	
Interest						25						20	20
BTC Unitary Charge	**383**	416	416	416	416	832	430	430	430	430	430	430	430
Other Payments	**585**	175	175	175	175	175	175	175	175	175	175	175	175
Total Payments	**34,791**	34,051	32,998	46,387	39,341	45,095	35,378	34,878	33,628	33,628	33,628	37,348	33,648
Cash Brought Forward	**44,893**	49,940	49,868	50,849	42,788	37,426	26,310	28,901	27,691	27,732	32,073	32,114	28,434
Net Receipts/(Payments)	**5,047**	(72)	981	(8,061)	(5,362)	(11,116)	2,591	(1,209)	41	4,341	41	(3,679)	21
Cash Carried Forward	**49,940**	49,868	50,849	42,788	37,426	26,310	28,901	27,691	27,732	32,073	32,114	28,434	28,455

Actual numbers are in bold text, forecasts in light text.

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Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	6.0%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	101.9%	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	0.8%	2
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	24.7	3
Overall Rating			**3.0**

Risk Ratings

•The adjacent table shows the Monitor risk rating score for the Trust based on performance at October.

• 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.

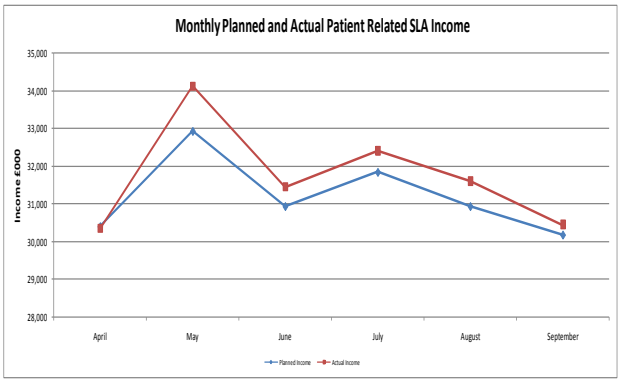
•I&E Surplus Margin continues to be lower than would normally be expected due to relatively low levels of surplus being delivered in the first half of 2012/13 (surpluses are profiled towards the latter part of the year). In month performance rather than year to date would generate a score of 3.

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 – September. 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	30,392	30,343	(49)
May	32,933	34,127	1,194
June	30,930	31,447	517
July	31,841	32,408	567
August	30,929	31,600	671
September	30,169	30,441	272
Total	**187,194**	**190,366**	**3,172**

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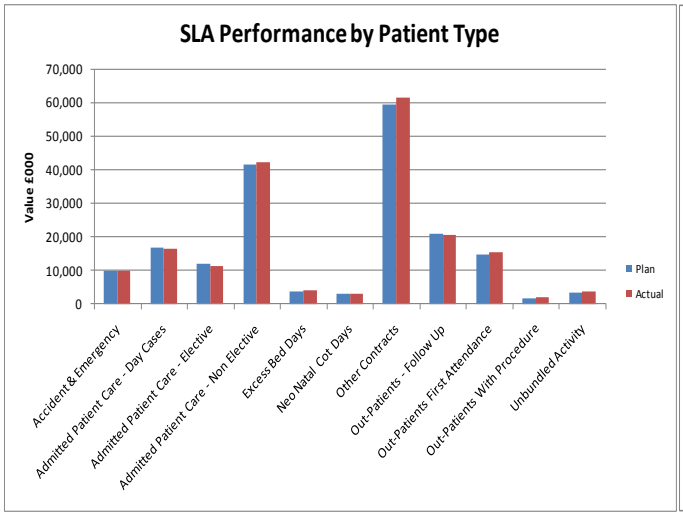
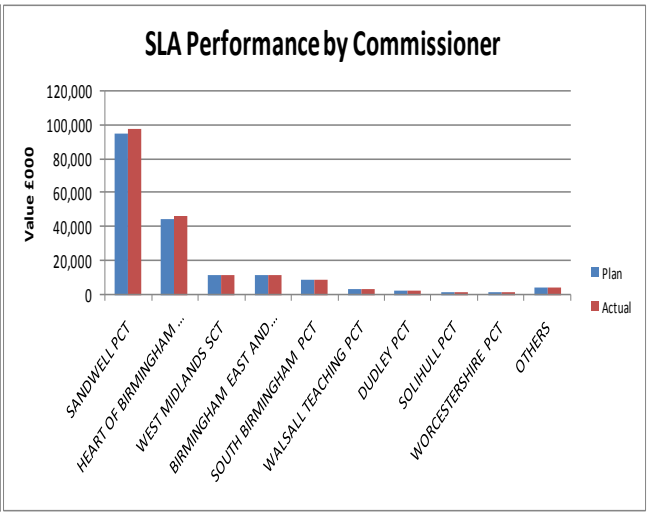
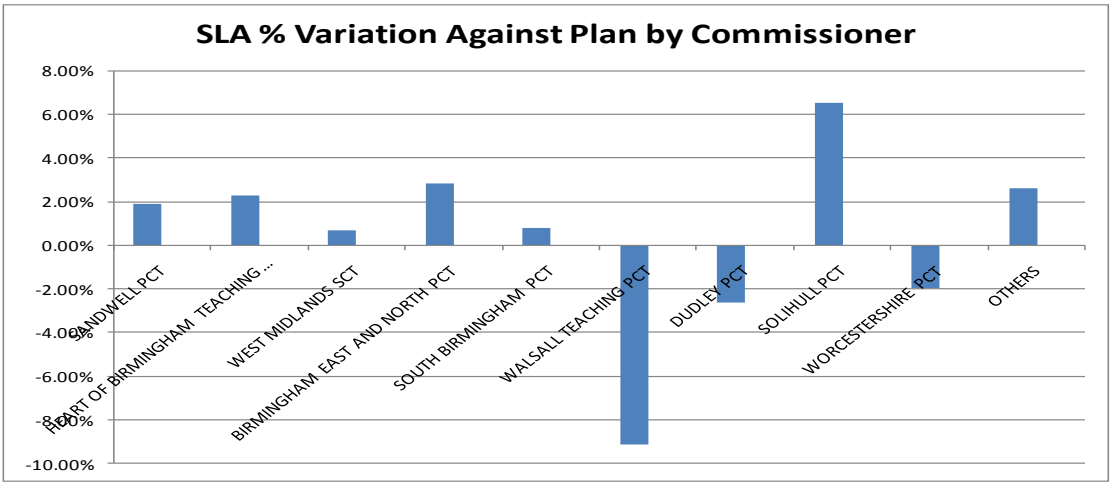
Performance by Activity Type and Commissioner

• 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.







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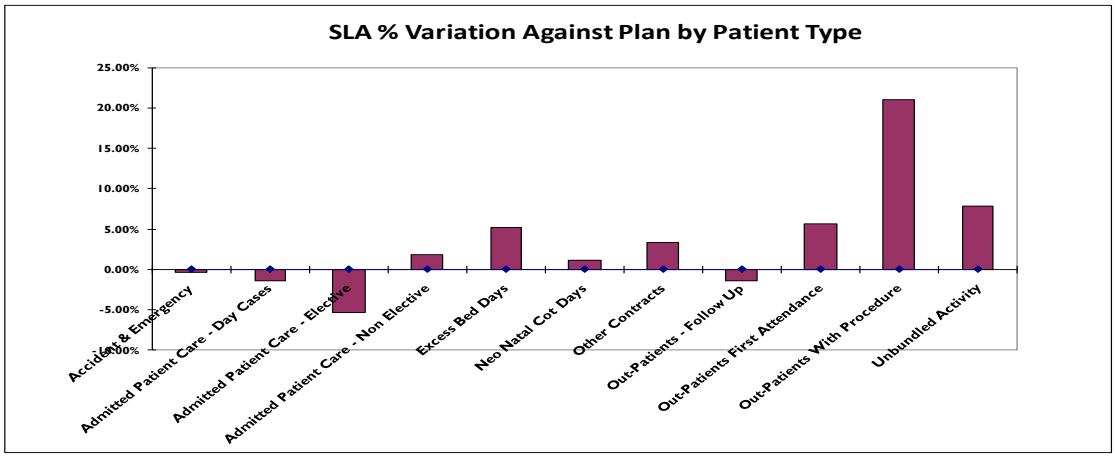
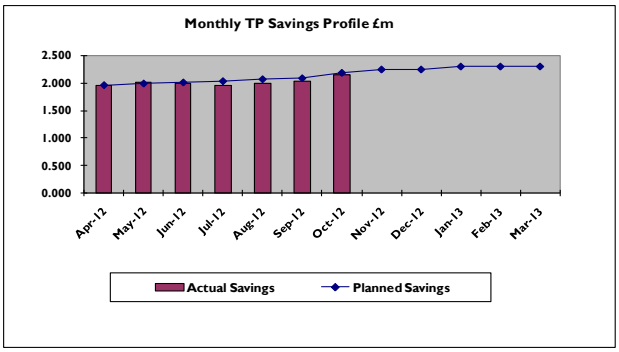


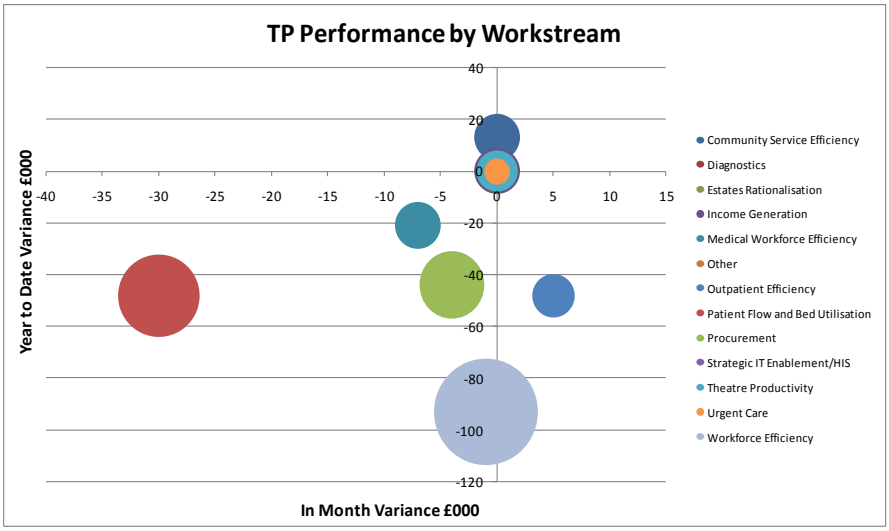
Transformation Programme

•The adjacent table shows actual progress against the Trust's Transformation Programme for 2012/13, inclusive of RCRH related changes.

• At 31st October, actual savings were £243,000 or 1.7% 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 October, 5 workstreams have an adverse year to date variance against plan although the majority of these are fairly negligible. The largest adverse variance of (£93,000) relates to workforce efficiency.

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NHS Trust

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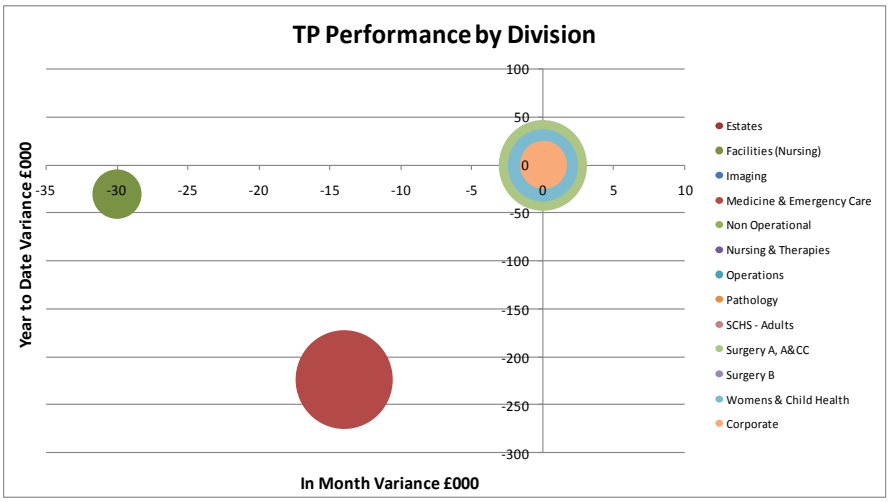
Transformation Programme

•At the end of October, only Medicine & Emergency Care and Facilities are reporting deficits against plan.

• Mitigating strategies remain 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 continue to recommend appropriate actions to the F&PMC sub-committee of the Board



External Focus

• The Bank of England's Monetary Policy Committee again decided to keep interest rates at 0.5%, the rate they have been at since March 2009, and chose not to extend its quantitative easing stimulus programme further.

• The UK came out of recession recently, growing 1% between July and September.

• The Public Accounts Committee recently published its findings on the NHS Financial Failure Regime and concluded that decisions were being made "on the hoof" and expressed concern that ministers could not offer adequate assurances that access to good quality care would be maintained when trusts had problems. Health Minister Lord Howe denied there were problems on the scale being described and said that government was working with NHS trusts and regulators to ensure where financial problems developed they were dealt with properly.

• Significant concerns have also been raised recently regarding the financial health of the NHS and that of individual organisations within it including the following:

- the proposals for the restructure of services in South London following the financial issues at South London Healthcare;
- a reduction in the size of services provided and in the workforce at Rotherham Foundation Trust; and
- issues with the impact of PFI costs at Sherwood Forest Hospitals Foundation Trust.

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Conclusions

• Measured against the DoH target, the Trust generated an actual surplus of £537,000 during October against a planned surplus of £462,000. For the purposes of its statutory accounts, the in month surplus was higher at £566,000. This represents a further increase in the year to date surplus and reflects the profiling of the Trust's financial plan and particularly the impact of the TSP in the later months of the year.

• The £537,000 surplus in October is £75,000 better than planned for the month.

• For the year to date, the Trust has generated a surplus (as measured against the DoH target) of £1,706,000 which is £336,000 better than the planned position.

• In month capital expenditure is £1,225,000 which represents a significant increase on previous months but remains lower than plan. The main reason for the variance from plan is the later than planned acquisition of land in Grove Lane and the incorporation of this assumption into the profiling of the Trust's Capital Resource Limit (CRL).

•At 31st October, cash balances are approximately £26m higher than the cash plan and around £15.5m greater than the balance held at 31st March.

• Performance for most divisions in month has been in line with or better than plan and there are no material adverse year to date positions. Nevertheless, monitoring of divisional performance continues with action being taken as necessary to rectify any potential and/or actual variances. Monitoring of the performance of the Transformation Programme will remain 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

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – October 2012

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Corporate Performance Monitoring Report
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Planning & Performance Management
DATE OF MEETING:	29 November 2012

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – October 2012.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
		x

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

Performance Management Board, Trust Management Board and Finance & Performance Management Committee

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST CORPORATE DASHBOARD - OCTOBER 2012

EXECUTIVE SUMMARY AND KEY EXCEPTIONS

KEY EXCEPTIONS

a

Infection Control - the number of C Diff cases reported during the month (5) and year to date (21) remains within the respective trajectories for both periods. The number of cases of MRSA Bacteraemia reported for the year to date remains 1, with no cases reported during October. Data for the percentage of Elective and Non-Elective MRSA screens undertaken is reported as both the number of screens undertaken compared with the number of screens required (not patient matched), and the number of screens undertaken matched (best practice) to patients who require screens, for which performance during October was 53.7% (Elective) and 66.3% (Non-Elective).

Instructions to nursing staff regarding which patients require screens is being simplified and short stay Non-Elective patients, will also in future be screened, both actions are identified to improve current performance.

c

Workforce - **PDR** (12-month rolling) compliance improved during October to 68.2%, with 5087 staff reported as having received a PDR within the last 12 months. **Mandatory training** compliance also improved to 85.1% as at the end of October, with the range by Division 78% - 97%. Divisions are currently focusing on compliance with the various modules which comprise Information Governance, against which the Trust is required to demonstrate 95% compliance by end December to the SHA, as part of requirements for FT status. The Trust's overall **Sickness Absence** rate was 4.52% during October (<3.15% trajectory), an increase from 4.19% during September.

Consideration is being given as to how to streamline the PDR process and a range of training options are available for Mandatory Training, including on line and classroom based sessions / assessment.

d

Emergency Department & Patient Flow - performance against the **A&E 4-hour maximum wait** target reduced to 91.5% during October and 94.0% for the year to date. During October the Trust met 2 of the 5 **A&E Clinical Quality Indicators**, 1 in each of the Timeliness and Patient Impact sections. 1 indicator, 'Left Department without being seen', remains within the operational target (<5.00%) for the year to date, with performance of 4.94%. Reporting Times of **Imaging Requests** from the Emergency Department have improved over the course of the last few months. The current performance trajectory of 70% of requests to be reported within 24 hours is being met in all principal Imaging modalities, with the exception of Plain Radiography where performance is 63%. Other elements of Patient Flow; Delayed Transfers of Care, Elective Admission Cancellations, Day of Surgical Admission Rate and Length of Stay are all within operational thresholds.

A comprehensive Emergency Flow Recovery Plan is about to be launched which will contain a set of agreed Clinical Standards, clear Escalation Triggers, real-time Patient Flow Dashboards at ward level and further communication and training in the use of the electronic Bed Management System. Discharge and Transport pilots have also begun at City Hospital based upon those in place at Sandwell.

e

Ambulance Turnaround - the indicators within the report reflect those contained in the Quality section of the Trust's 2012 / 2013 contract with its commissioners, with delivery of the required targets requiring a whole systems collaborative approach between the Trust and West Midlands Ambulance Service. Actual performance against each of the 3 components deteriorated in month, with 70.3% of clinical handovers within 15 minutes (target 85%+), an Average Turnaround Time of approximately 36 minutes (target less than 30 minutes) and 232 ambulances with a turnaround time in excess of 60 minutes (target 0).

Confirm & Challenge Events are scheduled involving the Trust and the West Midlands Ambulance Service which reflects the joint working required to improve performance. Additionally, an 'Intelligent Conveyancing' pilot has been agreed for the Black Country, designed to ensure ambulance crews take patients to hospitals, where they are able to handover patients most quickly.

g

Cancer - the 62-day Urgent GP Referral to Treatment target of 85% was not met during the month of September, with actual performance of 80.2%. All other high level cancer targets were met in month, and all high level cancer targets continue to be met for the year to date.

A root cause analysis has been undertaken to identify reasons for the poor performance and identify measures which can be implemented to address these. Additionally, the Chief Operating Officer is to meet with each of the clinical teams involved.

h

Referral to Treatment Time & Diagnostic Waits - All high level RTT targets were met during October, however there were 4 specialties which failed to meet the operational threshold of 90% for Admitted Care; Trauma & Orthopaedics (68.60%), Plastic Surgery (80.77%), Ophthalmology (87.57%) and Dermatology (86.89%). 2 specialities did not meet the Incomplete Pathway Operational Threshold of 92%; Trauma & Orthopaedics (86.22%) and Plastic Surgery (91.76%). Diagnostic Waits in excess of 6 weeks at the end of October were 1.98%, the majority of which were waits for Endoscopy.

Immediate RTT rectification plans have been requested from Ophthalmology and Dermatology. Trauma & Orthopaedics and Plastic Surgery remain on an improvement trajectory. A number of actions are identified to address Diagnostic Waits; An urgent review of the current service plan, centralisation of administrative functions (including appointment scheduling) and additional lists in Surgery 'A'.

CQUIN PERFORMANCE

b

	Patient Safety			tiveness of Care			Patient Experience			ALL		
	R	A	G	R	A	G	R	A	G	R	A	G
Acute			9			2			5			16
Community			3			1			4			8
Specialised									4			4

CONTRACTED ACTIVITY PLAN

	Month				Year to Date				Year on Year Comparison (to date)			
	Actual	Plan	Variance	%	Actual	Plan	Variance	%	2011/12	2012/13	Variance	%
IP & DC Elective	5614	5315	299	5.6	36540	34158	2382	7.0	37260	36540	-720	-1.9
IP Non-Elective	5028	4631	397	8.6	33444	32310	1134	3.5	31340	33444	2104	6.7
OP New	15781	13139	2642	20.1	99810	85204	14606	17.1	92669	99810	7141	7.7
OP Review	34608	39509	-4901	-12.4	228415	254458	-26043	-10.2	244878	228415	-16463	-6.7
OP Review:New	2.19	3.01	-0.81	-27.1	2.29	2.99	-0.70	-23.4	2.64	2.29	-0.35	-13.4
AE Type I	13884	15059	-1175	-7.8	104872	103961	911	0.9	104384	104872	488	0.5
AE Type II	2158	2774	-616	-22.2	16739	19149	-2410	-12.6	22267	16739	-5528	-24.8
Adult Community	45297	43366	1931	4.5	276859	249097	27762	11.1	241384	276859	35475	14.7
Child Community	12435	13884	-1449	-10.4	74588	80258	-5670	-7.1	69999	74588	4589	6.6

f

Overall Elective activity for the month and year to date remains in excess of the plan by 5.6% and 7.0% for the periods respectively. Non Elective activity exceeded the plan for the month by 8.6%, and exceeds the plan for year to date by 3.5%. Month and year to date New and Review Outpatient performance is such that the Follow Up : New Outpatient Ratio for the year to date further improved (reduced) to 2.29 which compares favourably with a ratio derived from plan of 2.99. A&E Type I activity (+0.9%) is essentially on plan for the year to date although Type II (BMEC) activity (-12.6%) remains well below plan. Adult Community activity is currently 11.1% above plan for the year to date. Child Community activity is 7.1% below plan.

NATIONAL PERFORMANCE FRAMEWORKS

NHS PERFORMANCE FRAMEWORK - Summary					
	June	July	August	September	October
Performing	17	17	16	14	17
Underperforming	2	2	2	4	1
Failing	0	0	1	1	1
Weighted Score	**2.86**	**2.86**	**2.64**	**2.54**	**2.71**

The Trust failed to meet the A&E 4-hour wait operational threshold during the month and is projected to underperform against the indicator 'RTT Delivery in all specialities'. The Trust continues to meet all high level RTT targets, but the specialities of Trauma & Orthopaedics and Plastic Surgery are on an improvement trajectory and are unlikely to meet the performance thresholds for each of the 3 RTT targets in month. The overall weighted score for service delivery is 2.71, which attracts a **PERFORMING** classification.

MONITOR COMPLIANCE FRAMEWORK - Summary					
	June	July	August	September	October
Performing	14	14	14	13	15
Failing	1	1	1	2	1
No Data	1	1	1	1	0
Governance Rating	**2.0**	**2.0**	**2.0**	**3.0**	**1.0**

The Trust failed to meet A&E 4-hour wait operational threshold during the month. The Trust is now able, with effect from October, to report its compliance against the 'Data Completeness Community Services Indicator', for which no data was previously available. The overall governance score for the month is 1.0 which attracts an **AMBER / GREEN** Governance Rating.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST CORPORATE DASHBOARD - OCTOBER 2012

Exec Lead			PATIENT SAFETY				June	July	August	September		October		To Date (*=most recent month)	TARGET		Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
							Trust	Trust	Trust	S'well	City	S'well	City	Trust	YTD	12/13							
RS	H	3	Stroke Care	Pts spending >90% stay on Acute Stroke Unit		%	94.1 ▲	85.1 ▼	88.9 ▲	→		→		87.2 ▼	89.0	83	83		No Variation	0 - 2% Variation	>2% Variation	●	72.8	85.9
	K			Pts admitted to Acute Stroke Unit within 4 hrs		%	73.1 ▲	65.3 ▼	68.7 ▲	→		→		65.1 ▼	68.9	90	90		No Variation	0 - 2% Variation	>2% Variation	●●		68.7
	K			Pts receiving CT Scan within 24 hrs of arrival		%	92.3 ■	94.0 ▲	93.8 ▼	→		→		100 ■	96.3	100	100		No Variation	0 - 2% Variation	>2% Variation	●		100
	K			Pts receiving CT Scan within 1 hr of arrival		%	58.3 ▼	51.3 ▼	53.1 ▲	→		→		61.5 ▲	57.7	50	50		No Variation	0 - 2% Variation	>2% Variation	●		37.5
	H			TIA (High Risk) Treatment <24 h from initial presentation		%	100 ■	66.7 ▼	80.0 ■	50.0 ■	71.4 ▼	75.0 ■	100.0 ▲	84.6 ▲	70.2	60	60		No Variation	0 - 2% Variation	>2% Variation	●	46.15	53.2
	K			TIA (Low Risk) Treatment <7 days from initial presentation		%	47.4 ▼	58.3 ■	82.5 ■	83.3 ▼	84.2 ▲	91.7 ▲	68.0 ▼	75.7 ▼	67.0	60	60		No Variation	0 - 2% Variation	>2% Variation	●		30.4
R0	A	4	Infection Control	C. Difficile (DH Reportable)		No.	1 ▲	2 ▼	6 ■	1 ▲	1 ■	2 ■	3 ▼	5 ▼	21	35	57	a	No variation		Any variation	●	120	95
	K			C. Difficile (Best Practice Numbers)		No.	5 ▲	7 ▼	12 ■	2 ▲	2 ■	5 ▼	4 ▼	9 ▼	50	56	95					●	120	95
	A			MRSA Bacteraemia		No.	1 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	1	2	2		No variation		Any variation	●	5	2
				MSSA Bacteraemia		No.	4	0	1	1	0	0	0	0	13	No. Only	No. Only						22	12
				E Coli Bacteraemia		No.	5	3	3	3	3	1	4	5	28	No. Only	No. Only						73	50
	F			MRSA Screening - Elective	Patient Not Matched	%	118.5 ▲	113.3 ▼	110.6 ▼	Numerator = 2736	Denominator = 2379	Numerator = 3020	Denominator = 2886	104.6 ▼	104.6*	60	85		No variation		Any variation	●	40.3	40.6
	F	3			Best Practice - Patient Matched	%	42.9 ▲	42.1 ■	39.5 ▼	Numerator = 965	Denominator = 2494	Numerator = 1277	Denominator = 2379	53.7 ▲	53.7*	60	85		No variation		Any variation	●●	40.3	40.6
	F			MRSA Screening - Non Elective	Patient Not Matched	%	66.1 ▲	67.7 ▲	69.2 ▲	Numerator = 2343	Denominator = 3531	Numerator = 2476	Denominator = 3751	66.0 ▼	66.0*	60	85		No variation		Any variation	●	18.9	26.0
	F				Best Practice - Patient Matched	%	68.7 ▲	68.2 ▼	69.1 ▲	Numerator = 1255	Denominator = 1898	Numerator = 2344	Denominator = 3537	66.3 ▲	66.3*	60	85		No variation		Any variation	●	18.9	26.0
RS	A	3	Acute CQUIN	VTE Risk Assessment (Adult IP)	396	%	91.0 ▼	91.4 ▲	87.5 ■	→		→		91.0 ■	91.6*	90	90	b	=>90		<90	●	92.3	92.4
RB	K	20		Appropriate Use of Warfarin	372		Compliant	→	→	→		→			Compliant	Comply with audit			No variation		Any variation	●		
RO	H	8		Safety Thermometer	396	%	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	→	→	→		→		83 ▲	83	70	80		No variation		Any variation	●		
RO	D	8		Reducing Avoidable Pressure Ulcers	372	No.	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	Compliant	Comply with audit			No variation		Any variation	●		
RS	H	9		Safe Surgery - Operating Theatres	743	%	→	→	99.7 ■	→		→		99.8 ■	99.8	99	100		No variation		Any variation	●		
RS	H	9		Safe Surgery - Other Areas		%	→	→	99.6 ■	→		→		100 ▲	99.8	98	98		No variation		Any variation	●		
RS	H	10		Stroke Care	743	%	Met Q1 req's	→	→	→		→		Met Q2 req's	Met Q2 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	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	→		→		Compliant	Compliant	Comply with audit			No variation		Any variation	●		
KD	F	14	Never Events - in month			No.	0 ■	1 ■	0 ■	→		→		1 ■	0*	0	0		No variation		Any variation	●		
	F		Open Serious Incidents Requiring Investigation (SIRI)			No.	9	10	4	→		→		2	3*	No. Only	No. Only							
	F		Open Central Alert System (CAS) Alerts			No.	17	14	9	→		→		10	8*	No. Only	No. Only							
DS	D		100% Compliance WHO Surgical Checklist			Y / N	N ■	N ■	N ■	→		→		N ■	No	Y	Y		Y		N	●		N
RO	D		Falls Resukting In Severe Injury or Death			No	1 ■	1 ■	2 ▼	→		→		6 ▼	0*	0	0		No variation		Any variation	●		
RO		8	High Impact Nursing Actions	Inpatient Falls reduction		%	60 ▼	79 ▼	62 ▲	→		→			334	171	684		=<57/m		>57/m	●	1024	763
				Nutritional Assessment (MUST)		%	94 ▼	85 ■	90 ■	→		→		91 ▲	89*	90	90		=>90		<90	●		89.0
				Fluid Balance Chart Completion		%	100	98	94.0	→		→		97.0	97*									100

Exec Lead			PATIENT SAFETY (Continued)			June	July	August	September		October		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	S'well	City	Trust	YTD	12/13							
RS		3	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	0 ▲	0 ■	1 ▼	→		→		3 ▼	0 ▲	4	28	48		=<2	3 - 4	>4	●	9	7
				Admissions to Neonatal ICU	%	10.4 ■	10.5 ▼	8.7 ■	→		→		9.4 ▼		10.0	=<10	=<10		=<10	10.0-12.0	>12.0	●	7.2	10.7
				Adjusted Perinatal Mortality Rate (per 1000 babies)	/1000	7.6 ▼	7.6 ■	7.1 ▲	→		→		7.9 ▼		7.9*	<8.0	<8.0		<8	8.1 - 10.0	>10	●	6.5	11.9*
				Caesarean Section Rate	%	19.8 ▲	23.9 ▼	27.1 ■	→		→		21.4 ■	22.6 ▼	23.3	<25.0	<25.0		=<25.0	25-28	>28.0	●	23.6	22.2
	H			Early Booking (Completed Assessment <12+6 weeks)	%	79 ▼	84 ▲	84 ■	→		→		80 ▼		80*	=>90	=>90		=>90	75-89	<75	● ●		76.0
RO		2	Infant Health & Inequalities	Maternal Smoking Rates	%	10.4 ▼	→	→	→		→		9.5 ▲	→	9.9	<11.5	<11.5		<11.5	11.5 - 12.5	>12.5	●	11.9	9.8
				Breast Feeding Initiation Rates	%	71.9 ▼	→	→	→		→		72.8 ▲	→	72.3	>63.0	>63.0		>63.0	61-63	<61.0	●	65.6	73.0
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	9-12 days	>12 days	●	<9 days	<9 days
RO		7	Learning & Development	PDRs (12-month rolling)	No. (%)	5166 (69.9) ▼	4805 (65.0) ▼	4836 (65.4) ▲	→		→		4904 (65.6) ▲	5087 (68.2) ▲	5087 (68.2)	7389 (100)	7389 (100)	c	0-15% variation	15 - 25% variation	>25% variation	● ●	4635	5348
RS				Medical Appraisal and Revalidation	%	69	71	79	→		→		84	83	83	No. Only	No. Only							
RO	K	3		Mandatory Training Compliance	%	78.9 ▲	79.4 ■	80.8 ■	→		→		83.3 ■	85.1 ■	85.1	100	100		=>90	85 - 89	<85	● ●	86.8	71.9
EFFECTIVENESS OF CARE																								
RO	H	8	Acute CQUIN	Dementia	396	%	Met Q1 req's	Met Q2 req's	Met Q2 req's	→		→	Met Q2 req's	→	Meeting Q3 req's	Meeting Q3 req's	70	90		No variation		Any variation	●		
RS	H	3		Mortality Review	743	%	68.2 ▲	63.6 ▼	64.9 ▲	→		→	66.4 ▲	→		66.4	66	80	b	No variation		Any variation	●		66.9
RO	H	11	Community CQUIN	Dementia	44	%	Met Q1 req's	Met Q2 req's	Met Q2 req's	→		→	Met Q2 req's	→		Met Q2 req's	70	90		No variation		Any variation	●		
RS		6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate		HSMR	90.5 Apr'11 to Mar'12	89.7 May'11 to Apr'12	88.3 Jun'11 to May'12	→		→	96.4 Jul'11 to Jun'12	→	95.5 Aug'11 to Jul'12	95.5									
				Peer (SHA) HSMR		HSMR	95.8	94.9	93.3	→		→	101.3	→	100.2	100.2									
				Peer (National) HSMR - Quarterly		HSMR	90.5	→	→	→		→	97.0	→	→	97.0									
	D	19		SHMI		SHMI	99.8 Dec'10 - Nov'11	99.1 Jan'11 - Dec'11	99.1 Jan'11 - Dec'11	→		→	99.1 Jan'11 - Dec'11	→	96.8 Apr'11 - Mar'12	99.1									
RB		3	Readmission Rates (to any specialty) within 30 days of discharge - Operating Framework Definition effective April 2011	Following initial Elective Admission		No.	117 ■	140 ■	141 ▼	→		→	138 ▲	→	131 ▲	967	853	1463		No Variation	0 - 5% Variation	>5% Variation	●		1463
				Following initial Elective Admission		%	1.15 ■	1.26 ■	1.34 ▼	→		→	1.36 ▼	→	1.16 ■	1.29	1.15	1.15		No Variation	0 - 5% Variation	>5% Variation	●		1.15
				Following initial Non-Elective Admission		No.	614 ▲	727 ▼	648 ▲	→		→	613 ▲	→	567 ■	4455	3991	6842		No Variation	0 - 5% Variation	>5% Variation	●		6842
				Following initial Non-Elective Admission		%	6.05 ▼	6.57 ▼	6.17 ▲	→		→	6.04 ▲	→	5.02 ■	5.97	5.38	5.38		No Variation	0 - 5% Variation	>5% Variation	●		5.38
RB	K	3	Hip Fractures	Operation <24 hours of admission		%	62.5 ▲	80.0 ■	76.2 ▼	→		→	80.0 ▲	→	85.7 ▲	72.7	70.0	70.0		No Variation	0 - 2% Variation	>2% Variation	●	64.7 (Q4)	66.4
RB		3	Data Quality	Valid Coding for Ethnic Category (FCEs)		%	94 ▼	95 ▲	95 ■	→		→	95 ■	→	95 ■	95	90	90		>/=90	89.0-89.9	<89	●	94.5	95
		3		Maternity HES		%	6.1 ▲	6.4 ▼	6.3 ▲	→		→	6.2 ▲	→	6.7 ▼	6.3	<15	<15		=<15	16-30	>30	●	5.4	6.0
	G	11		Data Completeness Community Services		%	No Data	No Data	No Data	→		→	No Data	→	>50	>50	=>50	=>50		=>50		<50	●		
	H	2		SUS Altered Data		%				→		→		→											
PATIENT EXPERIENCE																								
RB	A	2	A&E 4-hour waits	4-hour waits		%	94.3 ■	94.5 ■	93.4 ▼	95.7 ■	92.4 ■	93.9 ▲	91.1 ■	91.6 ▼	91.5 ▼	94.00	=>95	=>95	d	=>95		<95	● ●	96.99	95.38
	D	3	A&E Timeliness	Total Time in Department (95th centile)		h : m	4 : 41 ■	4 : 34 ▲	4 : 37 ▼	→		4 : 58 ▼	→		5 : 38 ▼	4 : 46	=<4hrs	=<4hrs		=<4hrs		=<4hrs	● ●		3 : 59
	D			Time to Initial Assessment (=<15 mins)(95th centile)		mins	17 ■	17 ■	18 ▼	→		18 ■	→		19 ▼	17	<15	<15		<15		<15	● ●		21
	D			Time to treatment in department (median)		mins	67 ▼	66 ▲	60 ■	→		53 ▲	→		54 ▼	61	=<60	=<60		=<60		>60	●		59
	D		A&E Patient Impact	Unplanned re-attendance rate		%	8.38 ▼	8.26 ▲	8.25 ▲	→		7.88 ▲	→		7.59 ▲	7.97	=<5.0	=<5.0		=<5.0		>5.0	● ● ●		8.66
	D			Left Department without being seen rate		%	5.57 ■	5.26 ▲	4.91 ■	→		4.23 ▲	→		4.77 ▼	4.94	=<5.0	=<5.0		=<5.0		>5.0	●		4.83
RB		21	Reporting Times of Imaging Requests from ED - **pecentage reported within 24 hours / next day**	Plain Radiography		%	4	11	14	→		46	→		63 ■	63*	70	90		No variation		Any variation	●		
				Ultrasound		%	100	97	100	→		100	→		98 ■	98*	70	90		No variation		Any variation	●		
				MRI		%	62	82	60	→		60	→		76 ■	76*	70	90		No variation		Any variation	●		
				CT		%	98	98	98	→		99	→		99 ■	99*	70	90		No variation		Any variation	●		

Exec Lead			PATIENT EXPERIENCE (Continued)				June	July	August	September		October			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							
	H		Ambulance Turnaround	Clinical Handovers completed within 15 minutes		%			79.4 ■	73.5 ▼	80.7 ▼	77.6 ▼	55.9 ▼	80.8 ▲	70.3 ▼	70.3*	=>85	=>85		=>85		<85	● ●		
RB	H	18		Average Turnaround Time		m : s	32:14 ▼	32:44 ▼	32:37 ▲	33:50 ▼	32:34 ▼	33.07 ▼	35:40 ▼	36:07 ▼	35:56 ▼	32:42	=<30:00	=<30:00	e	=<30:00		>30:00	●		29:23
	H			In Excess of 60 minutes		No.	131 ▼	166 ▼	149 ▲	84 ▼	79 ■	163 ▼	98 ▼	134 ▼	232 ▼	1069	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	0.0	0.0		0.00	0.00 - 0.50	>0.50	●		0.07
KD	F	14	Complaints	First Formal Complaints Received		No.	61	62	79	→		56	→		62	431	No. Only	No. Only							834
RO	H	8	Acute CQUIN	Personal Needs	396	%	67.9 ▲	→	→	→		→	→		→	67.9	67.6	71.6		No variation		Any variation	●		
RO	H	8		Net Promoter	372	No.	58 ▲	58 ■	60 ▲	→		63 ▲	→			63	60	65		No variation		Any variation	●		
RO	H	8		End of Life Care	372	%	47 ▼	55 ▲	57 ▲	→		60 ▲	→			60	48	53		No variation		Any variation	●		
RS	H	10		Every Contact Counts - Alcohol	372	%	55 Base	→	→	→			→		→	55 Base		80					●		
RO	H	12		Every Contact Counts - Smoking	372	%	→	→	→	→		Baseline established	→			Baseline established							●		
RO	H	11	Community CQUIN	Pt. (Community) Exp'ce - Personal Needs	44	Score	→	91 ■	95.5 ▲	→		91.5 ▼	→			91.5	90	90		No variation		Any variation	●		
RO	H	11		Net Promoter	88	No	75 Base	91 (H'son) & 80 (L'wes)	71 ■	→		81 ■	→			81	75	75	b	No variation		Any variation	●		
RO	H	11		Every Contact Counts	132	%	→	Base data being captured	Base data being captured	→		Baseline established	→			Baseline established							●		
RO	H	11		Smoking Cessation	132	%	→	Base data being captured	Base data being captured	→		Baseline established	→			Baseline established							●		
RS	H		Specialised Commissioners	Clinical Quality Dashboards	49		Q1 Data Submitted	→	→	→		Q2 Return Submitted	→		→	Q2 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●		
RS	H	13		Neonatal - Hypothermia Treatment	73	%	Q1 Data Submitted	→	→	→		Q2 Return Submitted	→		→	Q2 Return Submitted	Derive Base	Derive Base		No variation		Any variation	●		
RS	H	13		Neonatal - Discharge Planning / Family Experience and Confidence	122	%	Q1 Data Submitted	→	→	→		Q2 Return Submitted	→		→	Q2 Return Submitted	Derive Base	Derive Base		Met		Not Met	●		
RS	H	12		HIV - Optmum Therapy	147	%	Q1 Data Submitted	→	→	→		Q2 Return Submitted	→		→	Q2 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●		
RB		15	Elective Access Contact Centre	Number of Calls Received		No.	11426	12755	12090	→		11492	→			71270	No. Only	No. Only						137824	111793
				Average Length of Queue		mins	0.36 ▼	0.34 ▲	0.29 ▲	→		0.39 ▼	→			0.39*	<1.0	<1.0		<1.0	1.0-2.0	>2.0	●	0	0.21
				Maximum Length of Queue		mins	7.2 ■	12.4 ■	9.1 ▲	→		13.2 ▼	→			13.2*	<6.0	<6.0		<6.0	6.0-12.0	>12.0	● ●	6.3	10
			Telephone Exchange	Number of Calls Received		No.	71289	74174	75331	→		70935	→		83144	520137	No. Only	No. Only						909301	849502
				Calls Answered		%	91.0	92.4	89.8	→		90.7	→		89.4	91.1	No. Only	No. Only						90.5	90.2
				Answered within 15 seconds		%	51.1	57.0	54.6	→		64.4	→		54.3	56.6	No. Only	No. Only						52.4	52.5
				Answered within 30 seconds		%	67.2	72.9	70.1	→		77.1	→		69.5	71.8	No. Only	No. Only						68.4	68.1
				Average Ring Time		Secs	25.0	21.6	25.3	→		19.5	→		25.8	25.8*	No. Only	No. Only						21.2	25
				Longest Ring Time		Secs	462	780	1173	→		734	→		782	782*	No. Only	No. Only						731	718
TRANSFORMATION PLAN																									
RB		2	Spells	Elective IP		No.	848 ▲	1113 ■	1034 ▼	→		672 ■	→		721 ▼	6001	6471	10981	f	No Variation	0 - 2% Variation	>2% Variation		11748	10610
				Elective DC		No.	3899 ▼	4278 ▲	4017 ▼	→		4213 ▲	→		4893 ▼	30539	27687	46983		No Variation	0 - 2% Variation	>2% Variation		53959	53685
				Total Elective		No.	4747 ▼	5391 ▼	5051 ▼	→		4885 ▲	→		5614 ▼	36540	34158	57964		No Variation	0 - 2% Variation	>2% Variation	●	65707	64295
				Total Non-Elective		No.	4718 ▼	4937 ▲	4732 ▲	→		4618 ▼	→		5028 ▲	33444	32310	57105		No Variation	0 - 2% Variation	>2% Variation	●	59000	55675
			Outpatient Attendances	New		No.	12428 ▼	15147 ▲	13634 ▼	→		13605 ▲	→		15781 ▲	99810	85204	144072		No Variation	0 - 2% Variation	>2% Variation	●	163493	159051
				Review		No.	28797 ▼	33831 ▲	31369 ▼	→		30151 ▲	→		34608 ▼	228415	254458	430846		No Variation	0 - 2% Variation	>2% Variation	●	440812	421494
			A/E Attendances	Type I (Sandwell & City Main Units)		No.	15317 ▼	15819 ▲	14293 ▼	5942 ■	7134 ■	13076 ■	5802 ▼	8082 ▲	13884 ▲	104872	103961	175107		No Variation	0 - 2% Variation	>2% Variation	●	181494	177201
				Type II (BMEC)		No.	2293 ▼	2359 ▲	2143 ▼	→	1973 ▼	1973 ▼	→	2158 ▲	2158 ▲	16739	19149	32254		No Variation	0 - 2% Variation	>2% Variation	● ● ●	36756	36362
		16	Community	Adult - Aggregation of 18 Individual Service Lines		No.	44182 ▼	49385 ▲	47984 ▼	→		45297 ▼	→			276859	249097	492472		No Variation	0 - 2% Variation	>2% Variation	●	461797	493163
				Children - Aggregation of 4 Individual Service Lines		No.	11471 ■	12909 ▲	10284 ▼	→		12435 ▲	→			74588	80258	158876		No Variation	0 - 2% Variation	>2% Variation	●	102773	143400
		2	Outpatient Efficiency	New : Review Rate		Ratio	2.32 ■	2.23 ▲	2.30 ■	2.70 ▲	2.03 ▲	2.22 ▲	2.57 ▲	2.03 ■	2.19 ▲	2.29	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	●	2.70	2.65
				DNA Rate - New Referrals		%	11.9 ▼	11.8 ▲	12.6 ▼	→		11.9 ▲	→		12.0 ▼	11.3	10.0	10.0		No variation		Any variation	● ●	13.1	11.8
				DNA Rate - Reviews		%	10.6 ■	11.4 ▼	10.9 ▲	→		11.0 ▼	→		11.1 ▼	10.2	10.0	10.0		No variation		Any variation	●	11.9	10.5

Exec Lead			TRANSFORMATION PLAN (Continued)		June	July	August	September			October			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	A	2	Patient Flow	A&E 4-hour waits	%	94.3 ■	94.5 ■	93.4 ▼	95.7 ■	92.4 ■	93.9 ▲	91.1 ■	91.6 ▼	91.5 ▼	94.00	=>95	=>95	d	=>95		<95	● ●	96.99	95.38
	C			Acute Delayed Transfers of Care	%	2.7 ■	2.6 ▲	2.5 ▲	2.8 ▼	4.3 ■	3.6 ■	2.1 ▲	2.8 ■	2.5 ■	3.1	<3.5	<3.5		<3.5	3.5 - 5.0	>5.0	●	4.6	5.2
	H			Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.6 ▼	0.7 ▼	0.4 ▲	0.5 ▼	0.9 ■	0.7 ▼	0.3 ▲	0.7 ■	0.5 ▲	0.5	<0.8	<0.8		<0.8	0.8 - 1.0	>1.0	●	0.8	0.6
				Average Length of Stay	Days	3.9 ▲	3.4 ▲	3.5 ▼	4.0 ■	3.2 ■	3.6 ▼				3.8	4.3	4.3		No Variation	0 - 5% Variation	>5% Variation	●	4.3	4.2
				Day of Surgery (IP Elective Surgery)	%	90.6 ▼	92.4 ▲	91.6 ▼	88.4 ▼	85.3 ▼	86.5 ▼	91.4 ▲	93.4 ▲	92.6 ▲	91.2	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	●	88.7	89.5
				Daycase Rate - All Procedures	%	80.7 ▼	78.3 ■	78.4 ▲	87.3 ▲	83.3 ■	85.0 ■	88.1 ▲	84.6 ▲	86.0 ▲	82.9	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	●	81.5	82.7
RO		7	Sickness Absence	Long Term (> 28 days)	%	3.33 ▲	3.26 ▲	3.34 ▼	→		3.28 ▲	→		3.43 ▼	3.43 (Q3)	<2.15	<2.15	c	<2.15	2.15-2.50	>2.50		3.12	2.95
				Short Term (<28 days)	%	0.90 ▲	0.90 ■	0.76 ▲	→		0.91 ▼	→		1.08 ■	1.08 (Q3)	<1.00	<1.00		<1.00	1.00-1.25	>1.25		1.05	0.95
	D			Total	%	4.23 ▲	4.16 ▲	4.10 ▲	→		4.19 ▼	→		4.51 ▼	4.51 (Q3)	<3.15	<3.15		<3.15	3.15-3.75	>3.75	● ●	4.17	3.90
RO		17	Bank & Agency Use	Nurse Bank Fill Rate	%	85.7	89.1	86.9	→		87.0	→		83.2	86.8	No. Only	No. Only						86.2	87.2
				Nurse Bank Shifts covered	No.	4685 ▼	4895 ▼	5389 ▼	→		5003 ▲	→		4835 ▲	33721	27405	46980		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	● ● ●	54952	56396
				Nurse Agency Shifts covered	No.	577 ▼	495 ▲	703 ▼	→		641 ▲	→		920 ▼	4559	2234	3830		0 - 5% Variation	5 - 10% Variation	>10% Variation	● ● ●	4550	6948
KEY ACCESS TARGETS																								
RB	A	1	Cancer	2 weeks	%	94.0 ▼	95.6 ▲	94.4 ▼	→		93.0 ▼	→			94.4	=>93	=>93	g	No variation		Any variation	●	94.5	94.8
	A			2 weeks (Breast Symptomatic)	%	93.0 ▼	100 ▲	98.0 ▼	→		93.3 ▼	→			96.8	=>93	=>93		No variation		Any variation	●	94.7	95.8
	A			31 Day (diagnosis to treatment)	%	100 ■	100 ■	98.8 ▼	→		98.7 ▼	→			99.5	=>96	=>96		No variation		Any variation	●	99.7	99.5
	A			31 Day (second/subsequent treatment - surgery)	%	100 ■	100 ■	97.8 ▼	→		97.6 ▼	→			99.1	=>94	=>94		No variation		Any variation	●	99.5	100.0
	A			31 Day (second/subsequent treatment - drug)	%	100 ■	100 ■	100 ■	→		100 ■	→			100	=>98	=>98		No variation		Any variation	●	100	99.2
	A			31 Day (second/subsequent treat - radiotherapy)	%	100 ■	n/a	100 ■	→		100 ■	→			100	=>94	=>94		No variation		Any variation	●	100	100
	A			62 Day (urgent GP referral to treatment)	%	86.0 ▼	86.4 ▲	93.7 ▲	→		80.2 ■	→			86.5	=>85	=>85		No variation		Any variation	●	88.0	86.9
	A			62 Day (referral to treat from screening)	%	100 ■	90.0 ▼	92.9 ▲	→		96.0 ▲	→			97.8	=>90	=>90		No variation		Any variation	●	99.2	98.5
	H			62 Day (referral to treat from hosp specialist)	%	97.1 ▲	84.4 ■	97.9 ■	→		96.0 ▼	→			93.6	=>85	=>85		No variation		Any variation	●	95.6	91.6
RB	A	2	RTT 18-Weeks	Admitted Care (RTT <18 weeks)	%	93.6 ▼	94.3 ▲	95.3 ▲	→		93.3 ▼	→		93.5 ▲	93.5*	=>90.0	=>90.0	h	=>90.0	85-90	<85.0	●	92.7	93.2
	A			Non-Admitted Care (RTT <18 weeks)	%	96.7 ▼	99.0 ▲	98.5 ▼	→		96.5 ▼	→		98.4 ▲	98.4*	=>95.0	=>95.0		=>95.0	90 - 95	=<90.0	●	96.7	97.5
	A			Incomplete Pathway (RTT <18 weeks)	%	97.4 ▲	97.5 ▲	97.7 ▲	→		97.0 ▼	→		97.1 ▲	97.1*	=>92.0	=>92.0		=>95.0	87 - 92	=<87.0	●		97.2
	E			Treatment Functions Underperforming	No.	3 ▲	4 ▼	3 ▲	→		4 ▼	→		6 ▼	6*	0	0		0 / month	1 - 6 / month	>6 / month	●		10 (Q4)
	H			Audiology D.A Patients seen in <18 weeks	%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	100	100		100		<100	●		100
RB	E	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks	%	0.62 ▲	0.26 ▲	0.97 ▼	→		1.47 ■	→		1.98 ▼	1.98*	<1.0	<1.0		<1.0	1.0 - 5.0	>5.0	●		0.99
RB	C	2	Delayed Transfers of Care	Acute	%	2.7 ■	2.6 ▲	2.5 ▲	2.8 ▼	4.3 ■	3.6 ■	2.1 ▲	2.8 ■	2.5 ■	3.1	<3.5	<3.5		<3.5	3.5 - 5.0	>5.0	●	4.6	5.2
				Pt's Social Care Delay	No.	10 ■	3 ▲	11 ▼	8 ▼	3 ▲	11 ■	6 ▲	3 ■	9 ▲	9*	<18	<18		No Variation	0 - 10% Variation	>10% Variation		23	13
				Pt.'s NHS & NHS plus S.C. Delay	No.	13 ■	4 ■	8 ▼	2 ■	8 ■	10 ■	2 ■	5 ■	7 ■	7*	<10	<10		No Variation	0 - 10% Variation	>10% Variation		22	20
RB	H	2	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.6 ▼	0.7 ▼	0.4 ▲	0.5 ▼	0.9 ■	0.7 ▼	0.3 ▲	0.7 ■	0.5 ▲	0.5	<0.8	<0.8		<0.8	0.8 - 1.0	>1.0	●	0.8	0.6
	H			28 day breaches	No.	0 ■	0 ■	0 ■	→		1 ■	→		0 ■	1	1	3		3 or less	4 - 6	>6	●	1	1
				Sitrep Declared Late Cancellations by Speciality	No.	27 ■	34 ■	17 ■	9 ■	25 ■	34 ■	5 ▲	23 ▲	28 ■	179	187	320		0-5% variation	5 - 15% variation	>15% variation	●	500	363
RB		10	Cardiology	Primary Angioplasty (<150 mins)	%	88.2 ▼	100 ▲	92.3 ▼	77.8 ■	75.0 ■	76.9 ■				91.9	=>80	=>80		=>80	75-79	<75	●	90.7	88.4
				Rapid Access Chest Pain	%	100 ▲	93.6 ■	96.0 ▲	100 ■	94.7 ▲	97.7 ■				97.0	=>98	=>98		=>98	96 - 97.9	<96	●	100.0	99.1
RB		12	GUM 48 Hours	Patients offered app't within 48 hrs	%	100 ■	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	Y ■	Y ■	Y ■	→		Y ■	→		Y ■	Yes	Full	Full		Y		N	●		N

KEYS TO DATA SOURCES, PERFORMANCE ASSESSMENT SYMBOLS AND INDICATORS WHICH COMPRISE NATIONAL & LOCAL PERFORMANCE ASSESSMENT FRAMEWORKS

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

INDICATORS WHICH COMPRISE THE PERFORMANCE ASSESSMENT FRAMEWORKS	
A	NHS Performance F'work, Monitor Compliance F'work, SHA Provider M'ment Return & Local Priority / Contract.
B	NHS Performance F'work, SHA Provider M'ment Return & Local Priority / Contract.
C	NHS Performance Framework & Local Priority / Contract.
D	SHA Provider Management Return & Local Priority / Contract.
E	NHS Performance Framework only
F	SHA Provider Management Return only
G	Monitor Compliance Framework only
H	Local & Contract (inc. CQUIN)
K	Local

FORWARD PROJECTION ASSESSMENT	
●	Maintain (at least), existing performance to meet target
●	**Improvement** in performance required to meet target
● ●	**Moderate Improvement** in performance required to meet target
● ● ●	**Significant Improvement** in performance required to meet target
XXX	**Target Mathmatically Unattainable**

PERFORMANCE ASSESSMENT SYMBOLS	
▲	Fully Met - Performance continues to improve
■	Fully Met - Performance Maintained
▼	Met, but performance has deteriorated
▲	Not quite met - performance has improved
■	Not quite met
▼	Not quite met - performance has deteriorated
▲	Not met - performance has improved
■	Not met - performance showing no sign of improvement
▼	Not met - performance shows further deterioration

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report and summary NHS FT Governance Risk Rating (FT Compliance Report)
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Mike Harding, Head of Performance Management and Tony Wharram, Deputy Director of Finance
DATE OF MEETING:	29 November 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 (October):
There were 3 areas of underperformance during the month of October; A&E 4-hour waits, with performance of 91.5%, RTT Delivery in all specialities (6 treatment functions underperforming) and Diagnostic Waits greater than 6 weeks of 1.98%.

The overall average weighted score for service performance is 2.64. CQC Registration Status remains Unconditional. As such for the month of October the Trust continues to attract a **PERFORMING** classification.

Financial Performance (October):
The weighted overall score remains 2.93 with underperformance reported in 2 areas; Better Payment Practice Code (Volume) and Creditor Days. The classification for the month of October remains **PERFORMING.**

Foundation Trust Compliance Summary report (October):

Within the Service Performance element of the Risk Rating for the month of October the Trust underperformed against the A&E 4-hour wait target. The Trust is now able, with effect from October, to report its compliance against the 'Data Completeness Community Services Indicator', which is reported as >50%, and as such meets the operational threshold.

The overall score for the month is 1.0 which attracts an **AMBER / GREEN** Governance Rating.

Performance in areas where no data are currently available for the month are expected to meet operational standards.

REPORT RECOMMENDATION:

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

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		x

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

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

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

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

PREVIOUS CONSIDERATION:

Performance M'ment Board, Trust M'ment Board and Finance & Performance M'ment Committee

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2012/13

QUALITY OF SERVICE

Integrated Performance Measures

Indicator	Weight	Performance Thresholds: Performing (Score 3)	Score 2	Underperforming (Score 0)	Quarter 1 2012/13	Score	Weight x Score	Quarter 2 2012/13	Score	Weight x Score	October 2012/13	Score	Weight x Score
A/E Waits less than 4-hours	1.00	95.00%	94.00 - 95.00%	94.00%	95.14%	3	3.00	93.91%	0	0.00	91.50%	0	0.00
MRSA Bacteraemia	1.00	0		>1.0SD	1	3	3.00	1	3	3.00	1	3	3.00
Clostridium Difficile	1.00	0		>1.0SD	6	3	3.00	10	3	3.00	5	3	3.00
18-weeks RTT 90% Admitted	1.00	=>90.0%	85.00 - 90.00%	85.0%	93.8%	3	3.00	94.3%	3	3.00	93.3%	3	3.00
18-weeks RTT 95% Non -Admitted	1.00	=>95.0%	90.00 - 95.00%	90.0%	98.4%	3	3.00	98.0%	3	3.00	96.3%	3	3.00
18-weeks RTT 92% Incomplete	1.00	=>92.0%	87.00 - 92.00%	87.0%	97.1%	3	3.00	97.4%	3	3.00	96.8%	3	3.00
18-weeks RTT Delivery in all Specialities (number of treatment functions)	1.00	0	1 - 20	>20	11	2	2.00	11	2	2.00	6	2	2.00
Diagnostic Test Waiting Times (percentage 6 weeks or more)	1.00	<1%	1.00 - 5.00%	5%	0.87%	3	3.00	0.90%	3	3.00	1.98%	2	2.00
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.00 - 93.00%	88.0%	94.5%	3	1.50	94.4%	3	1.50	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms	0.50	93.0%	88.00 - 93.00%	88.0%	96.2%	3	1.50	98.1%	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers	0.25	96.0%	91.00 - 96.00%	91.0%	99.8%	3	0.75	99.1%	3	0.75	>96.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (surgery)	0.25	94.0%	89.00 - 94.00%	89.0%	99.7%	3	0.75	98.5%	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)	0.25	98.0%	93.00 - 98.00%	93.0%	100.0%	3	0.75	100.0%	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)	0.25	94.0%	89.00 - 94.00%	89.0%	100.0%	3	0.75	100.0%	3	0.75	>94.0%*	3	0.75
Cancer - 62 day urgent referral to treatment for all cancers	0.50	85.0%	80.00 - 85.00%	80.0%	86.4%	3	1.50	86.7%	3	1.50	>85.0%*	3	1.50
Cancer - 62 day referral to treatment from screening	0.50	90.0%	85.00 - 90.00%	85.0%	100.0%	3	1.50	93.2%	3	1.50	>90.0%*	3	1.50
Delayed Transfers of Care	1.00	<3.5%	3.5 - 5.00%	>5.0%	3.50%	2	2.00	<3.50%	3	3.00	2.50%	3	3.00
Mixed Sex Accommodation Breaches (as percentage of completed FCEs)	1.00	0.0%	0.0 - 0.5%	0.5%	0.00%	3	3.00	0.00%	3	3.00	0.00%	3	3.00
VTE Risk Assessment	1.00	90.0%	80.00 - 90.00%	80.0%	92.13%	3	3.00	89.96%	2	2.00	91.61%	3	3.00
Sum (all weightings)	**14.00**												
Average Score (Integrated Performance Measures)							**2.86**			**2.64**	* projected		**2.64**

CQC Registration Status

		Unconditional or no enforcement action by CQC	The assessment of non-compliance / outstanding conditions from the initial registration	Enforcement action by CQC			**Performing**			**Performing**			**Performing**

Overall Quality of Service Rating

							Performing			**Performing**			

Assessment Thresholds for Integrated Performance Measures Average Score	
Underperforming if less than	2.1
Performance Under Review if between	2.1 and 2.4
Performing if greater than	2.4

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2012/13

Financial Indicators				SCORING			2012 / 2013			2012 / 2013			2012 / 2013		
Criteria	**Metric**	**Weight (%)**		**3**	**2**	**1**	**August**	**Score**	**Weight x Score**	**September**	**Score**	**Weight x Score**	**October**	**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**
Year to Date	YTD Operating Performance	25	20	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	**0.15%**	**3**	**0.6**	**0.28%**	**3**	**0.6**	**0.40%**	**3**	**0.6**
	YTD EBITDA		5	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	**5.70%**	**3**	**0.15**	**5.85%**	**3**	**0.15**	**6.01%**	**3**	**0.15**
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	**0.00**	**3**	**0.6**	**0.00**	**3**	**0.6**	**0.00**	**3**	**0.6**
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	**6.27%**	**3**	**0.15**	**6.27%**	**3**	**0.15**	**6.21%**	**3**	**0.15**
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	**0.00%**	**3**	**0.45**	**0.00%**	**3**	**0.45**	**0.00%**	**3**	**0.45**
Underlying Financial Position	Underlying Position (%)	10	5	Underlying breakeven or Surplus	An underlying deficit that is less than 2% of underlying income.	An underlying deficit that is greater than 2% of underlying income	**0.91%**	**3**	**0.15**	**0.91%**	**3**	**0.15**	**0.91%**	**3**	**0.15**
	EBITDA Margin (%)		5	Underlying EBITDA equal to or greater than 5% of underlying income	Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income	Underlying EBITDA less than 1% of underlying income	**6.27%**	**3**	**0.15**	**6.27%**	**3**	**0.15**	**6.21%**	**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	**94.00%**	**2**	**0.05**	**91.00%**	**2**	**0.05**	**96.00%**	**3**	**0.075**
	Better Payment Practice Code Volume (%)		2.5	95% or more of the volume of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days	Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days	**95.00%**	**3**	**0.075**	**95.00%**	**3**	**0.075**	**94.00%**	**2**	**0.05**
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	**1.10**	**3**	**0.15**	**1.10**	**3**	**0.15**	**1.10**	**3**	**0.15**
	Debtor Days		5	Debtor days less than or equal to 30 days	Debtor days greater than 30 and less than or equal to 60 days	Debtor days greater than 60	**11.44**	**3**	**0.15**	**12.99**	**3**	**0.15**	**13.19**	**3**	**0.15**
	Creditor Days		5	Creditor days less than or equal to 30	Creditor days greater than 30 and less than or equal to 60 days	Creditor days greater than 60	**38.26**	**2**	**0.1**	**36.87**	**2**	**0.1**	**41.81**	**2**	**0.1**
						Weighted Overall Score			**2.93**			**2.93**			**2.93**

*Operating Position = Retained Surplus/Breakeven/deficit less impairments

Assessment Thresholds	
Performing	> 2.40
Performance Under Review	2.10 - 2.40
Underperforming	< 2.10

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Provider Management Regime Return
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Strategy & Organisational Development & Kam Dhami, Director of Governance
AUTHOR:	Mike Harding, Head of Planning & Performance Management & Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	29 November 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 October 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)	Not required by SHA

Key Features of the return for October are:

- TFA Progress – agreement with the SHA that the final submission of the IBP / LTFM is now December 2012 (previously November 2012)
- Governance – Now able to report compliance against the 'Data Completeness Community Services', indicator with effect from October 2012. A&E performance for the month of October is 91.5%, below the operational threshold of 95.0%.
- Contractual – Areas subject to performance improvement notices earlier in the year; RTT in all specialties and Diagnostic Waits (>6 weeks) do not meet operational thresholds for the month.

REPORT RECOMMENDATION:

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

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

Performance Management Board on 20 November 2012

SELF-CERTIFICATION RETURNS
Organisation Name:
Sandwell & West Birmingham Hospitals NHS Trust
Monitoring Period:
October 2012
NHS Trust Over-sight self certification template

Returns to XXX by the last working day of each

TFA Progress

Oct-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	Fully achieved in time	
7	Submit IBP/LTFM to SHA for review	Sep-12	Fully achieved in time	
8	Final cut Quality Governance self-assessment	Sep-12	Fully achieved in time	
9	Submission of key FT application documentation for review	Sep-12	Fully achieved in time	
10	External validation of final Quality Governance sef-assessment	Oct-12	On track to deliver	
11	FT readiness review with SHA	Oct-12	On track to deliver	
12	Final IBP/LTFM - SHA submission	Nov-12	Risk to delivery within timescale	Agreed with SHA that this will be submitted in Dec 12
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	

NHS Trust Governance Declarations : 2012/13 In-Year Reporting

Name of Organisation:	Sandwell & West Birmingham Hospitals NHS Trust	Period:	October 2012

Organisational risk rating

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

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	A
Financial Risk Rating (Assign number as per SOM guidance)	G
Contractual Position (RAG as per SOM guidance)	Not required by SHA

*** 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.

Governance declaration 1

The Board is satisfied that plans in place **are sufficient** 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:	TO BE ADDED	Print Name:	Richard Samuda
on behalf of the Trust Board	Acting in capacity as:	Chairman	

Signed by:	TO BE ADDED	Print Name:	John Adler
on behalf of the Trust Board	Acting in capacity as:	Chief Executive	

Governance declaration 2

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 **insufficient assurance available** 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.

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

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	Thresh-old	Weight-ing	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Current Data: Oct-12	Current Data: Nov-12	Current Data: Dec-12	Current Data: Qtr to Dec-12	Comments where target not achieved
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	No	No	No	Yes			Yes	Status changed October 2012
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		No	No	No	Yes			Yes	Status changed October 2012
			Patients dying at home / care home	50%		No	Yes	Yes	Yes			Yes	
	1c	Data completeness: identifiers MHMDS		97%	0.5	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			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	
	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	
	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	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	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	September 2012 performance confirmed from National Cancer Waiting Times system report. October performance projected.
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	Yes			Yes	September performance; from urgent GP referral (80.2%), Screening (96.0%) and Q2 performance; from urgent GP referral (86.7%), Screening (93.2%). October performance projected.
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes			Yes	September 2012 performance confirmed from National Cancer Waiting Times system report. October performance projected.
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes			Yes	September 2012 performance confirmed from National Cancer Waiting Times system report. October performance projected.
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	Yes	Yes	No	No			No	Performance in October was 91.5%. 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			Yes	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a			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			Yes	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	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			Yes	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	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	
	4b	MRSA	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	Yes	Yes	Yes			Yes	
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No			No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	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	
				TOTAL		**1.5**	**1.0**	**2.0**	**1.0**	**0.0**	**0.0**	**1.0**	

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											
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 signficant outbreaks of C.difficile, as defined by the Health Protection Agency.											
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter; The non-admitted patients 18 weeks waiting time measure for a third successive quarter; The incomplete pathway 18 weeks waiting time measure for a third successive quarter											
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.											
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter; the 62-day cancer waiting time target for a third successive quarter											
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter; the category A 19-minute response time target for a third successive quarter											
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter											
viii)	Any Indicator weighted 1.0	Breaches the indicator for three successive quarters.											
		Number of Overrides Triggered				***0.0***	***0.0***	***0.0***	***0.0***	***0.0***	***0.0***	***0.0***	

FINANCIAL RISK RATING

Sandwell & West Birmingham Hospitals NHS Trust

Insert the Score (1-5) Achieved for each Criteria Per Month

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position*: Year to Date	Normalised Position*: Forecast Outturn	Comments where target not achieved
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
Weighted Average		**100%**						**3.0**	**3.1**	**3.0**	**3.2**	
Overriding rules												
Overall rating								**3**	**3**	**3**	**3**	

Overriding Rules :

Max Rating	Rule	
3	Plan not submitted on time	No
3	Plan not submitted complete and correct	No
2	PDC dividend not paid in full	No
2	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 Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	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	
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	There are two areas of older debt which contribute to this financial trigger, bith of which are in escalation and expect to be resolved prior to Q4
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No			No	
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No			No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No			No	
8	Quarter end cash balance <10 days of operating expenses	No	No	No	No			No	
9	Capital expenditure < 75% of plan for the year to date	No	Yes	Yes	Yes			Yes	The capital programme is showing a planned incrase in completion in Q3 & Q4, largely due to a small handful of material schemes

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 Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	
Are the prior year contracts* closed?	Yes	Yes	Yes	Yes			Yes	
Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes			Yes	
Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes			Yes	
Are there any disputes over the terms of the contract?	No	No	No	No			No	
Might the dispute require SHA intervention or arbitration?	No	No	No	No			No	
Are the parties already in arbitration?	No	No	No	No			No	
Have any performance notices been issued?	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 during October was such that performance thresholds were met for 2 of the 5 indicators, 1 in each of the Timeliness and Patient Impact groupings. Diagnostic Waits in excess of 6 weeks were 1.98%.
Have any penalties been applied?	No	Yes	Yes	Yes			Yes	

QUALITY

Sandwell & West Birmingham Hospitals NHS Trust

Insert Performance in Month

	Criteria	Unit	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Comments on Performance in Month
1	SHMI - latest data	Ratio	99.8	99.7	99.7	99.7	99.7	99.7	99.8	99.1	99.1	99.1	99.1	96.8	SHMI data relates to period April 2011 - March 2012, which is the most recent period for which data is available (source HED).
2	Venous Thromboembolism (VTE) Screening	%	93.3	90.8	92.9	92.4	92.6	92.4	92.9	91	90.3	87.2	90.1	91.6	
3a	Elective MRSA Screening	%	41.6	42.5	40.2	39.4	40.8	38.1	39.9	40.7	42	39.5	38.7	104.6	Data reported is screens not matched with patients. Screens matched to patients for the month is 53.7%.
3b	Non Elective MRSA Screening	%	66.5	54.2	50.5	58.7	61.7	70.3	64.1	66.3	68	69.1	66.1	66	Data reported is screens not matched with patients. Screens matched to patients for the month is 66.3%.
4	Single Sex Accommodation Breaches	Number	0	0	0	8	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number		8	8	8	2	8	7	9	10	4	2	3	None of the October open incidents were in excess of 45 days at month end.
6	"Never Events" in month	Number		1	1	1	1	0	0	0	1	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	10	8	5 alerts overdue but one signed off since on 5/11
9	RED rated areas on your maternity dashboard?	Number	4	4	4	4	4	2	1	2	4	3	3	2	September - Midwifery Staff Vacancies (11.6%) and Midwifery Staff Sickness Absence (5.2%).
10	Falls resulting in severe injury or death	Number	1	4	2	6	2	3	0	1	1	2	6	0	
11	Grade 3 or 4 pressure ulcers	Number	0	5	14	5	7	12	4	1	3	0	0	12	
12	100% compliance with WHO surgical checklist	Y/N	No	No	No	No	No	No	No	No	No	No	No	No	Compliance was 99.77% in October (3902 records compliant of 3911 total). 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	67	51	59	69	72	60	51	61	62	79	56	62	
14	Agency as a % of Employee Benefit Expenditure	%	1.3	1.5	1.7	1.8	2.5	1.7	1.4	1.9	1.9	2.24	1.8	2.35	
15	Sickness absence rate	%	4.43	4.28	4.34	4.39	4.13	4.06	4.51	4.23	4.16	4.1	4.18	4.52	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%				78	72	74	78	69	71	79	84	83	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

dwell & West Birmingham Hospitals NHS T

October 2012

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 (www.hm-treasury.gov.uk).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the 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:	*Print name*	*Date*
CEO	**TO BE ADDED**	**John Adler**	**29/11/2012**
Chair	**TO BE ADDED**	**Richard Samuda**	**29/11/2012**

Notes

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

Notes

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Transformation Plan Status Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow, Chief Operating Officer**
AUTHOR:	**Paul Crabtree, Interim Associate Director of Transformation**
DATE OF MEETING:	**29 November 2012**

EXECUTIVE SUMMARY:

Urgent Care

- Cardiologist of the week pilot at City now completed with clear results for reducing length of stay (see attached data)
- First General Surgery pathway (abscess) underway for implementation, with second pathway identified as PR bleed.

Patient Flow progress (see attached KPIs):

- Over the last 2 weeks a specific review has been carried out looking at the measurable results of the Patient Flow workstream. The key headlines are:
- Daily discharges form Medical Sandwell wards: was averaging 15 ; now averaging 20. Now rolling out daily discharge meetings at City.
- EDDs set within 24hrs of admission – Rate is steadily increasing, but below target. Following as part of board round activities.
- Transport booked 24 hours before journey – Was at 0%, on plan at 15%, with final target of 60%.
- % discharges before 12:00 – result consistent at 17% against 40% target. However KPI needs adjustment to show trend, as earlier discharges not being represented as not hitting the 12:00 time target.
- TTO preparation time. "Near Patient Pharmacy" pilot has achieved:
    - 6.2 hrs -> 0.88 hrs on L2
    - 38 hrs -> 4.6 hrs on L4
    - Now preparing equipment for wider roll out.

Community

- Working closely with Patient Flow workstream to facilitate improved patient discharge.
- Discharge Board Review meeting started at Leasowes
- Work begun to develop visual monitoring board to aid discharge on Henderson & Leasowes Units
- Further work required to define work scope for Single Point of Access project

Theatres

- Theatres engagement event held on 7th Nov to define projects and priorities with all stakeholders
- SIRG approval given for pilot of centralised booking within T&O
- Capacity model developed, highlighting possible opportunities including shifting main spine demand in day case.

Outpatients

- Priority redesign pathways identified at speciality level for medicine, surgery A and Surgery B which will receive targeted support from TSO to design and implement.
- Partial booking for new and review appointments currently being piloted in T&O
- OP LiA held on 8th November was used to develop operational plan and vision for BTC

Workforce Efficiency:

- e-rostering now running on 23 wards as of 5th Nov.
- e-rostering business case being prepared to support roll-out to other disciplines
- Review of long-term Bank workers employment status now underway by HR
- Annualised hours concept has been under review by Women's & Child, Surgery A & Community Adults. Initial review indicates no direct benefit of moving to annualised hours.

Estates:

- Final cohorts now moving into D22
- SCAT move taking place on 23rd Nov, which will allow closure of existing building.
- Moves now planned for groups into the Management Block.
- Day hospital construction now underway.
- Closure of D43 delayed due to restriction in being able to move patients to D20. Review of schedule planned for next week.

Procurement:

- Supplier staff now allocated to specific divisions to provide more direct support.
- Initial discussions started with neighbouring Trusts to explore shared services opportunities.

HIS:

- Outline case developed, with options appraisal, for Electronic Patient Records.
- Development of eBMS carried out to support the operational side of Patient Flow workstream.
- Outpatient dashboard development on plan. Need to agree next steps with outpatient workstream to roll out to specialities.
- Demonstration Suite being prepared to ensure the Trust are getting maximum benefit from existing systems / hardware.

Development of FY13/14 & 14/15 TSPs:

- All schemes now input to TPRS with financial values.
- Exec 1 by 1 reviews with all divisions complete.
- Approval of QIAs and EIAs being manages through TPRS with formal sign-off being managed through TPRS.
- Divisions now working to ensure all project information populated onto TPRS by 23rd Nov.

REPORT RECOMMENDATION:

The Board is asked to receive, note and accept the update.

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

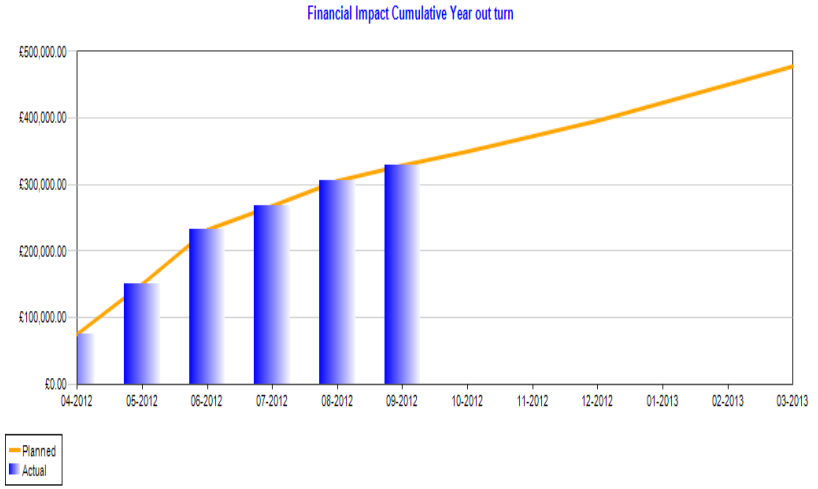
Deliver the Transformation Plan

PREVIOUS CONSIDERATION:

Routine monthly update by the Trust Board

Urgent Care Workstream:

Financial status



Milestone status

Major milestones impacting savings

Overdue
Due soon
Complete

RAG	Milestone(s)	Impact	Actions
	Embed cardiologist of the week to City Site	Increased length of stay on MAU	•Formal Handover TBA •Risk startification to be shared
	General Surgery abscess pathway slippage	Clinical agreement not fully agreed	Escalated to project lead

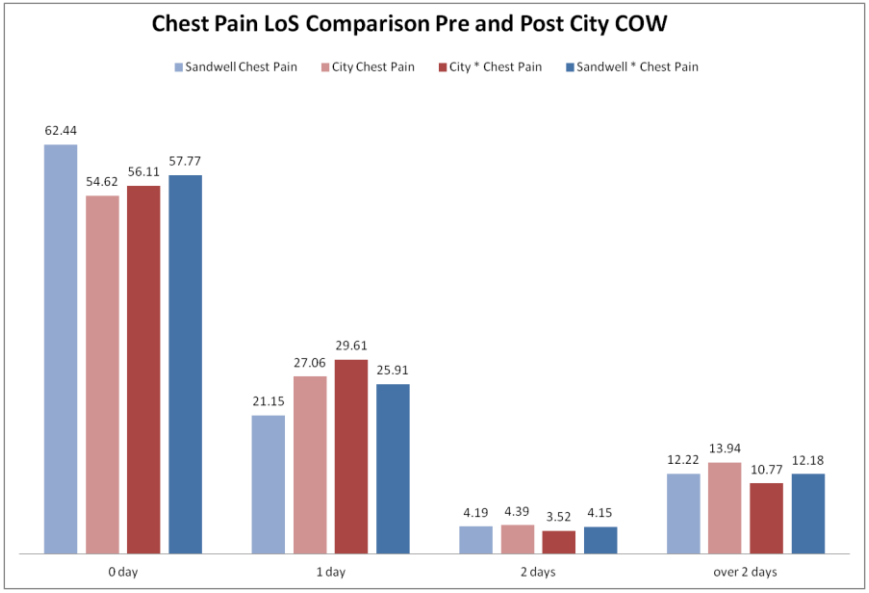
Next steps

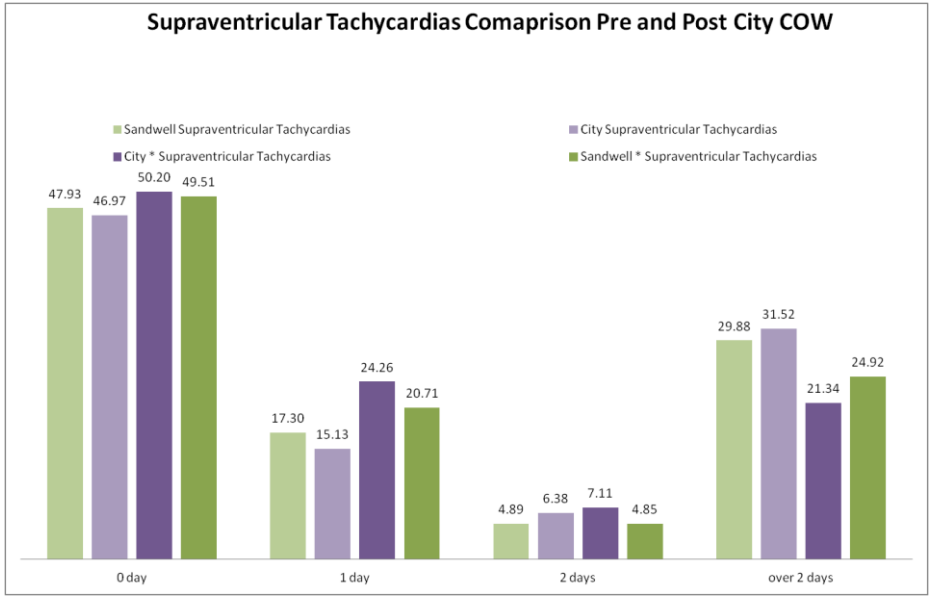
- General Surgery –
  - Abscess pathway agreement between ED and surgery. Nursing checklist has been completed. Medical checklist needs to be finalised prior to go live
  - PR bleed pathway to be developed once abscess pathway has been implemented and embedded
- Cardiologist of the week, City has been reviewed following trial. Improvements to be implemented e.g. classification of low risk patients that can be treated as ambulatory, handover between cardiology and acute physician teams
- Rapid assessment model with consultant led team within ED being reviewed. Will be compared against a nurse led model, to commence on 12th November (Nurse and HCA)

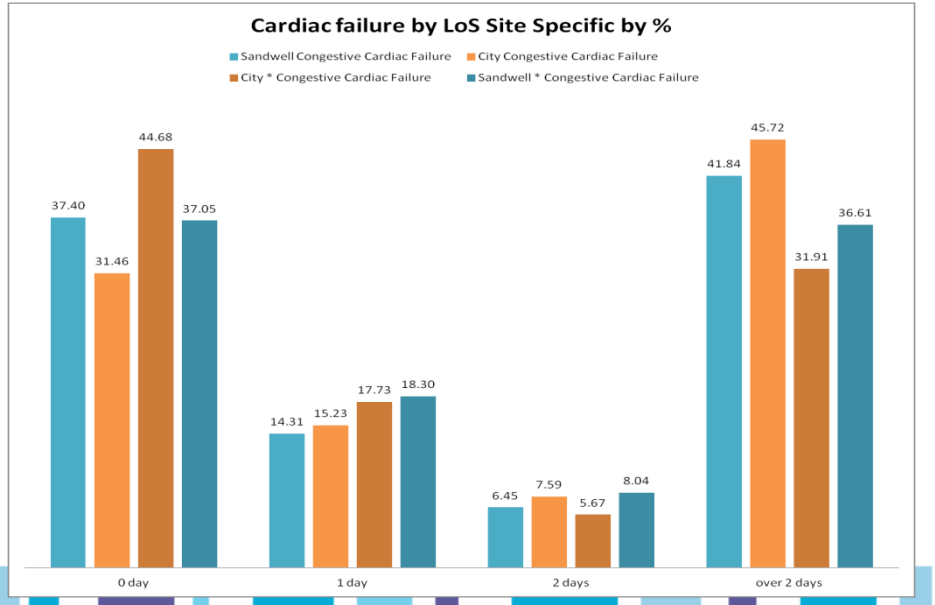
Risks / Issues / Escalation

- Clinical sponsor and key stakeholders meeting not until 15 Nov to identify key activities to be taken forward as part of the work stream
- Availability of clinical staff to develop clinical guidelines for ambulatory pathways
- Continued ad-hoc representation of all specialities in Urgent Care Working Group
- Gynae assessment unit to be realised would need funding agreement , currently writing business case for SIRG

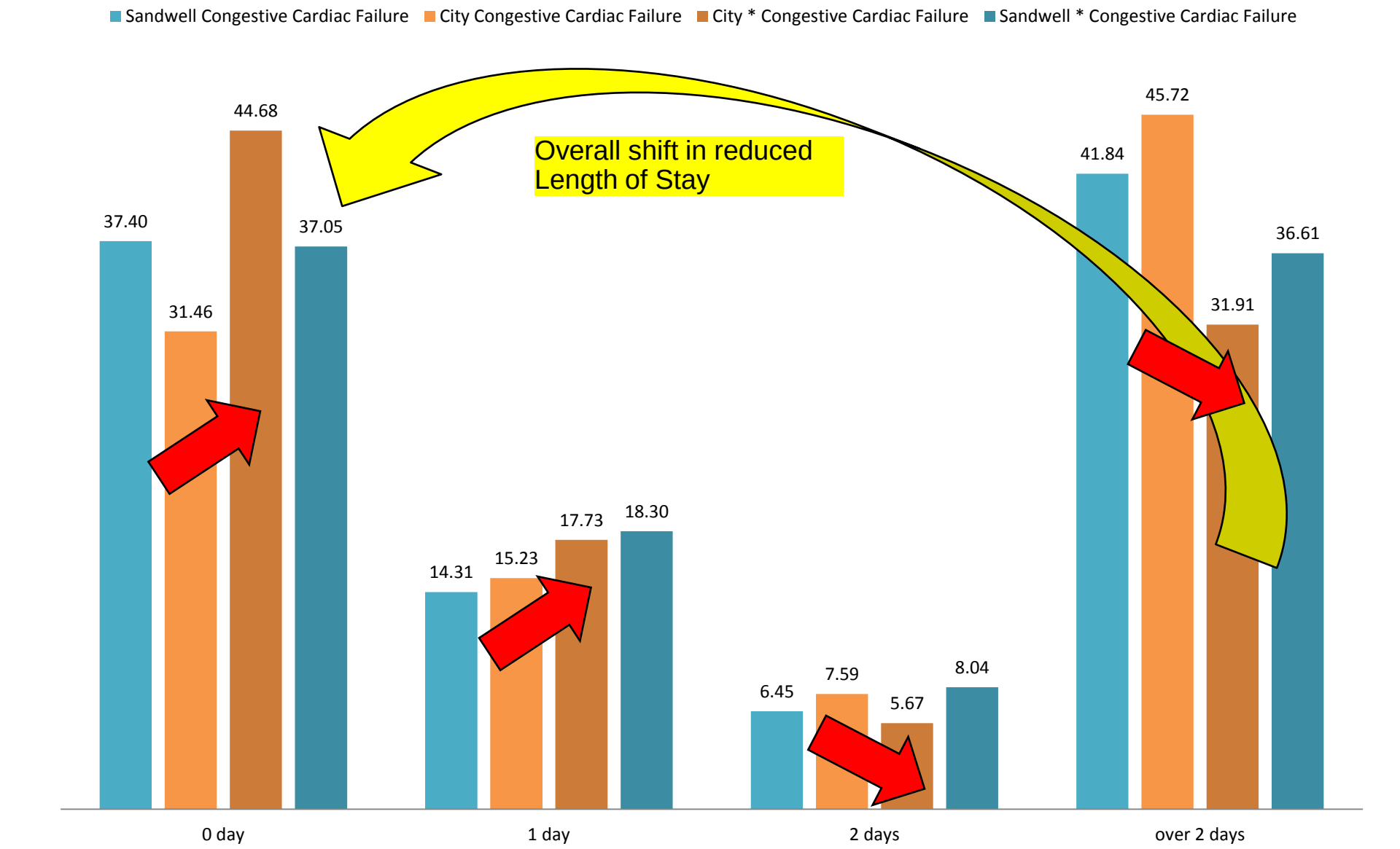
Comparison Pre and Post Implementation of COW, City







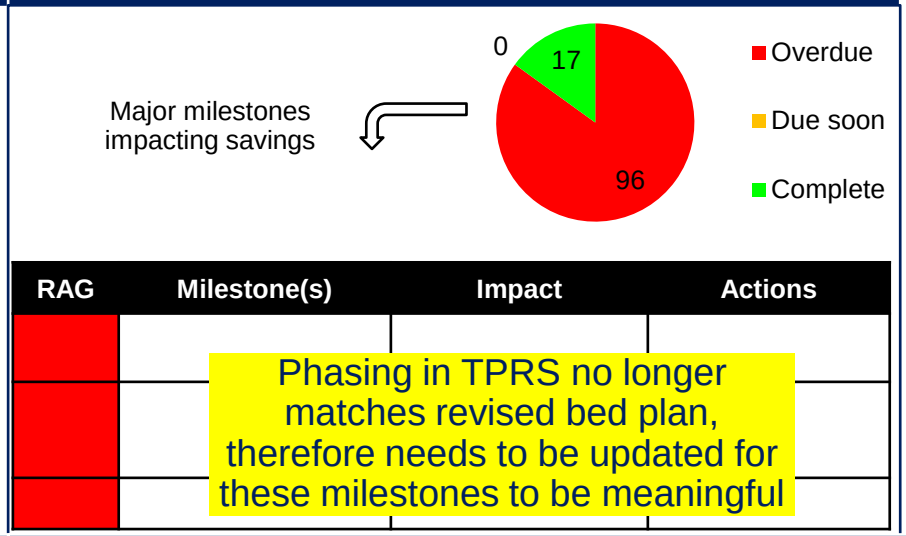
Cardiac failure by LoS Site Specific by %



Patient Flow Workstream:

Financial status

Milestone status



RAG	Milestone(s)	Impact	Actions
	Phasing in TPRS no longer matches revised bed plan, therefore needs to be updated for these milestones to be meaningful		

Next steps

- Establish clear roles and responsibilities for those involved in the Daily Discharge Reviews
- Ensure that Emergency Flow recovery plan and Transformational projects for patient flow are intrinsically linked
- Roll out of the Daily Discharge Reviews at City
- Transport Booking Process to be implemented at City
- Roll out of the 'near-patient' pharmacy model at Sandwell and City

Risks / Issues / Escalation

- Continued challenges with 4 hour performance
- MDT support to implement standardised board round
- Ability to establish and develop the Daily Discharge Review at both sites
- TTO project dependent on funding and timing of IT/Kit set up
- Capacity and capability of the divisional leadership teams to support programme delivery
- Ability to reconfigure pathways internally and to secure external support as and when required
- Pan-divisional schemes (gastro/GI and City EAU) more challenging with high risk of non-delivery
- Potential increase in A&E attendances and impact on non-elective profile
- Unforeseen operational issues and delivery of capital schemes

ey Performance Indicators

Process Measures

95% of board rounds happening to the agreed local standard

95% patients have an EDD within 24hrs of admission and 100% of those are 'live' EDDs

Confirmed Discharges – actually go

95% of patients transport status understood within 24hrs of admission

50% of patients journeys to be booked at least 24-48hrs in advance

60% of journeys to occur before 12noon

80% of TTOs to be started at least 24hrs prior to discharge

90% of TTOs processed within 2hrs of reaching the dispensary

Less than 5% error rate in the TTOs

Outcome Measures

40% of discharges happening before 12noon

(Total number of discharges per day, per division, per site and total number before midday)

Transfers happening earlier in the day from:

- EAU to wards
- SGH ward to Priory 3
- SGH ward to Community

Reduction in overall ALOS from 3.78 to 3.5

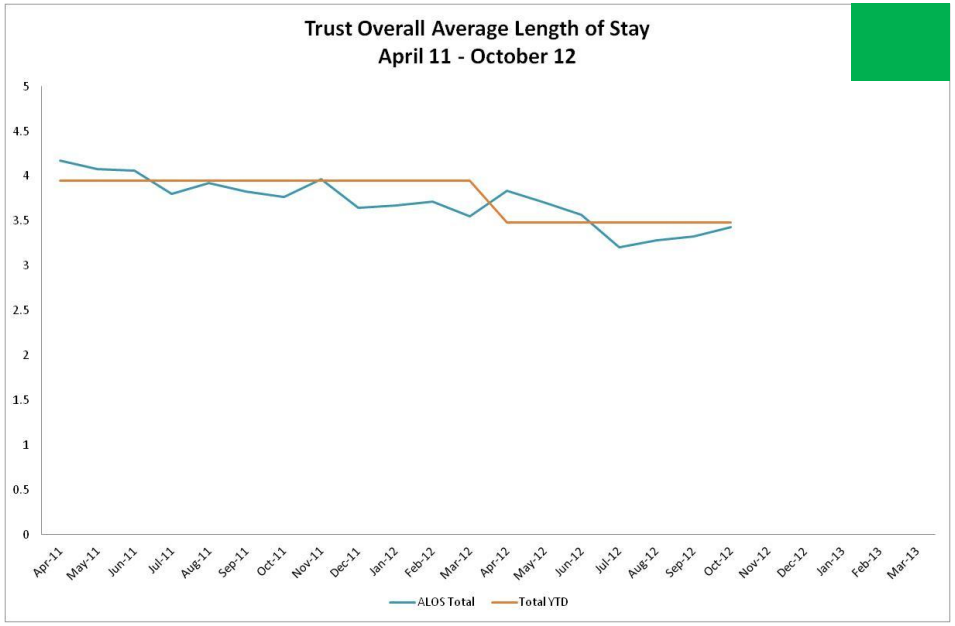
(sustain 4hr performance)

Balancing Measures

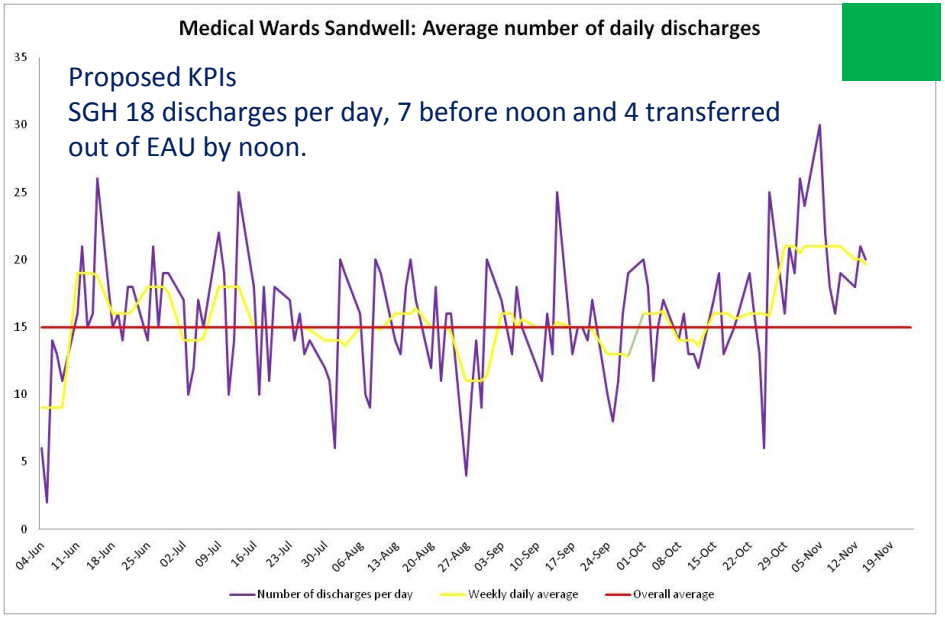
Readmission rates - no significant changes

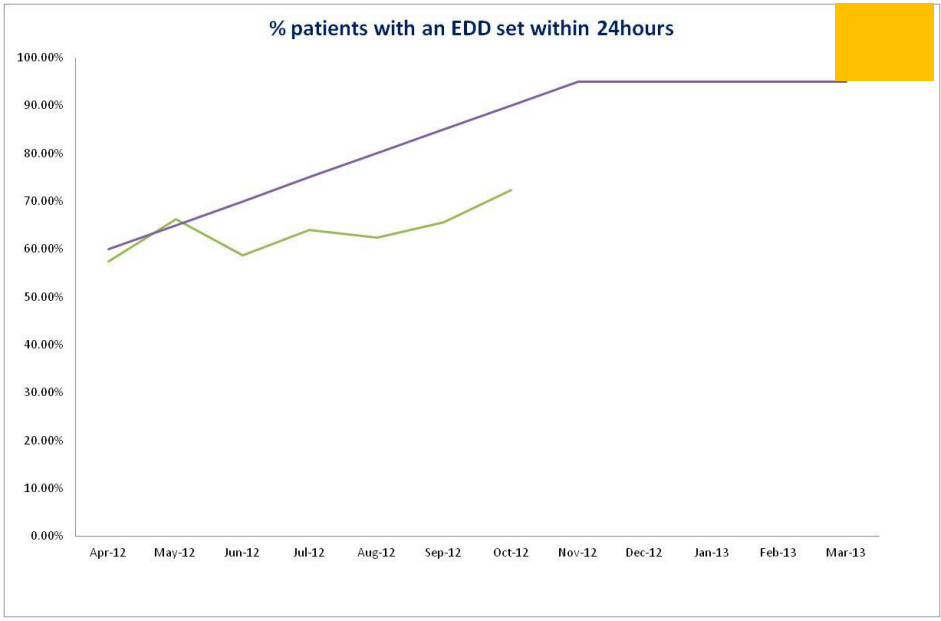
Number of emergency admissions – no significant changes

Patient Flow – Delivery KPI review

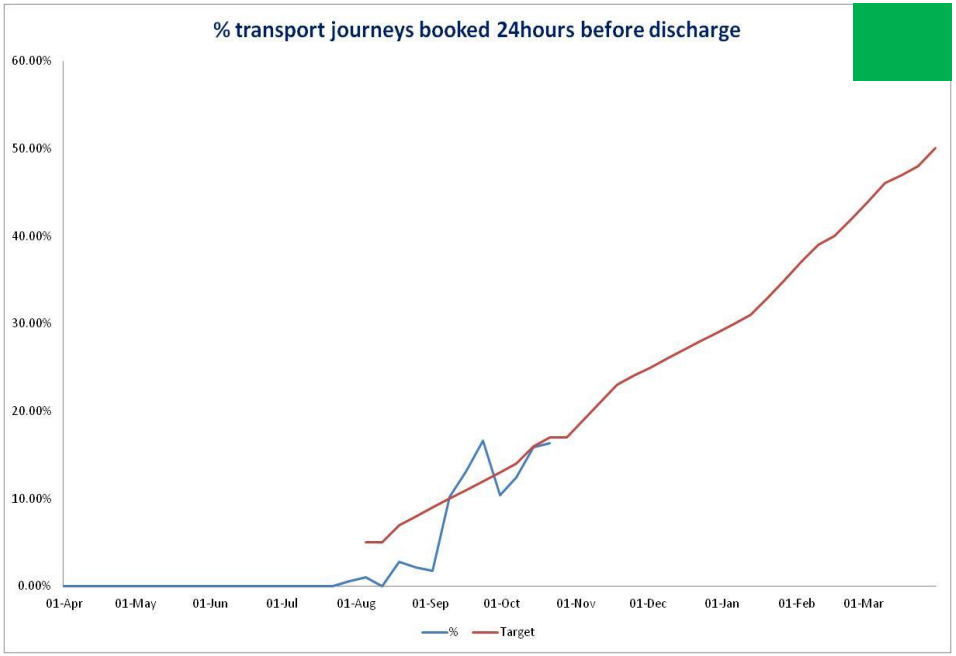


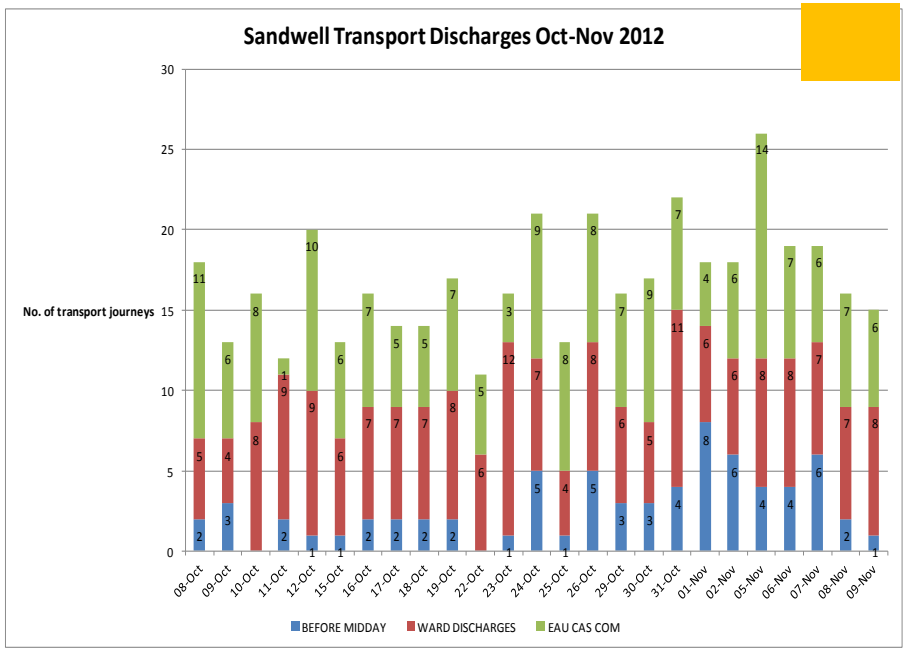
- Occupancy Rates
- Total number of opened beds
- Total number of outliers

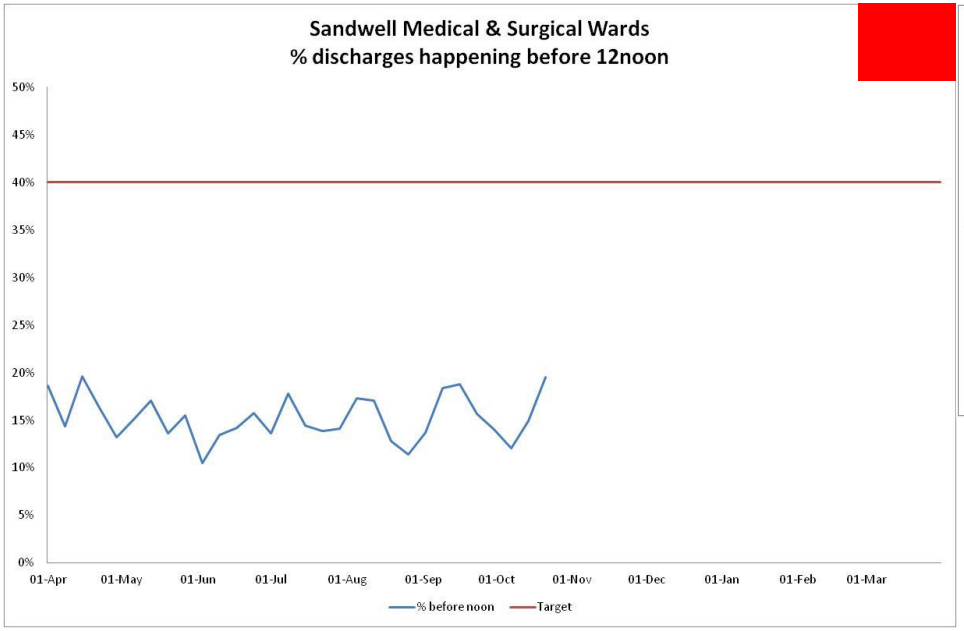


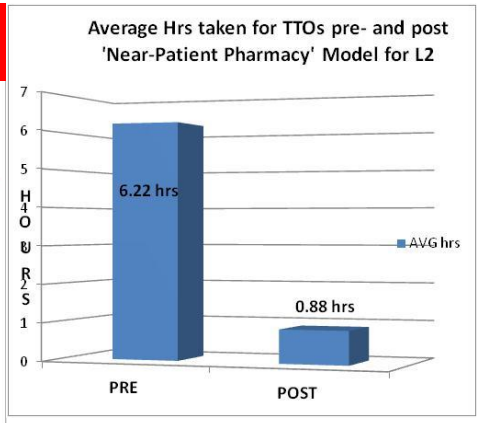


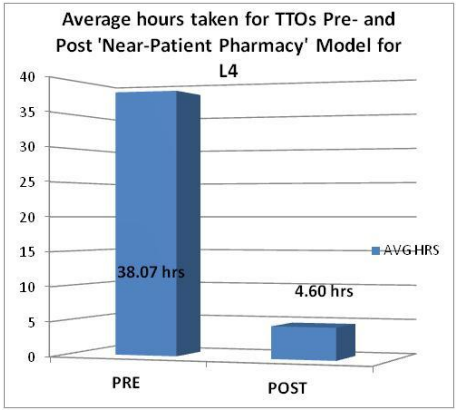
Patient Flow – Delivery KPI review









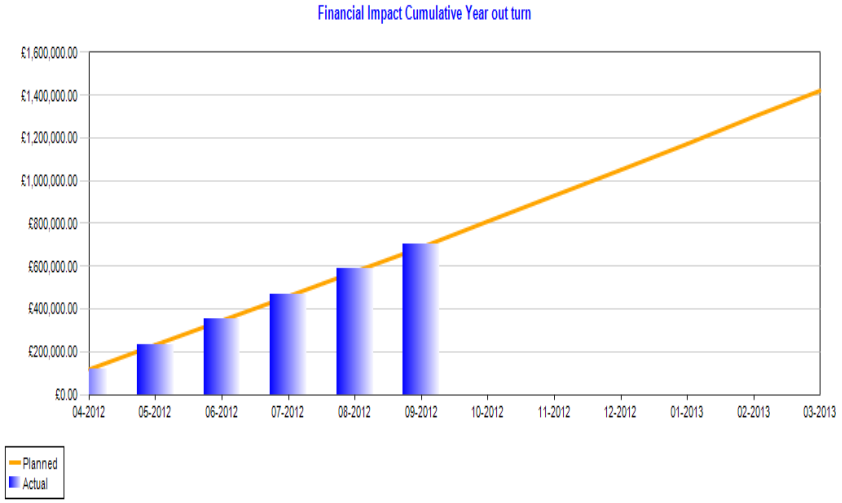


Pharmacy KPI in development

80% of TTOs to be started at least 24hrs prior to discharge

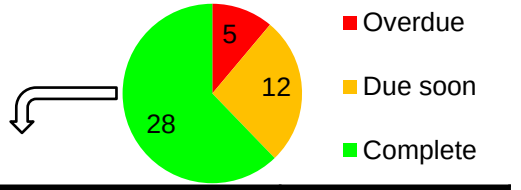
Workstream: COMMUNITY

Financial status



Milestone status

Major milestones impacting savings



RAG	Milestone(s)	Impact	Actions
	Not cross cutting – Division are aware and working to correct		
	CROSS CUTTI NG		

Next steps

- Review of small number of patients who attended A&E and are known to community to establish if by doing something differently we could have avoided an admission
- Work with SPARTIC to develop a pull process from acute wards into community beds
- Work with STAR to understand processes, share good practice and address issues
- Work with therapies staff in EAU at Sandwell to develop communications and sign posting into community services
- Review of MDT's on both Henderson & Leasowes
- Scoping & development of plan to get data collection onto S1 at Leasowes & Henderson

Risks / Issues / Escalation

- Pace of demand for change from other work programmes – community workstream is a key enabler to savings from UC, Beds and OPD in acute
- Complexities around introduction of SPA
- Vascular Repatriation – Receiving a few queries relating to community beds and delayed discharges
- Unmet need for complex stroke care
- ESD target remains a problem discussion with Commissioners planned

Workstream: Community

Delivery status

1. Rehab Workstream

Monthly forum set up on Henderson Unit to manage patient/carers expectations and action any issues

Review and development of patient leaflets for Intermediate Care beds underway

The re-admissions audit work is defined - needs to go to Governance meeting (scheduled for November)

Discharge Board Review meeting started at Leasowes

Work begun to develop visual monitoring board to aid discharge on Henderson & Leasowes Units

2. Integrated Teams

SPARTIC and STAR have joined the 2.30 p.m. daily Board Review Conference Call - feedback so far positive and both teams felt that this had helped them plan ahead

Review of single referral form for ICARES/SPARTIC underway

KPI's developed to monitor new ICARES performance

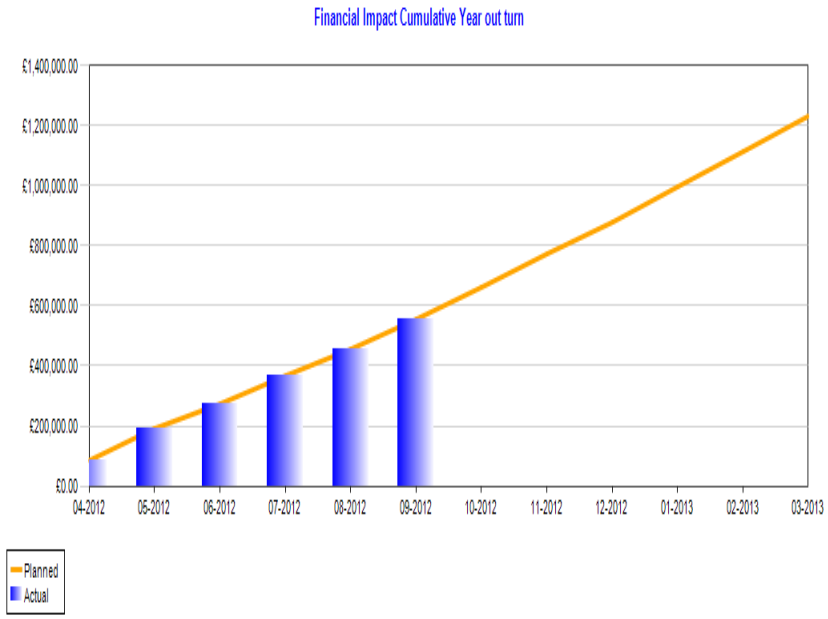
3. PCS

"Deep Dive" into DN service at Neptune completed – currently analysing data

Review of Sexual Health Service has taken place – analysis of data collected underway, next steps will be to an action plan to address some of the issues

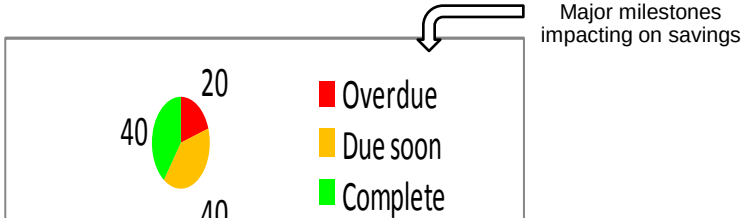
Workstream: Theatres

Financial status



Milestone status

RAG	Milestone(s)		Actions
1	Theatre productivity savings	Replacement Scheme identified Funding in place Workforce in place	Additional procurement Delays in finance to support



Next steps

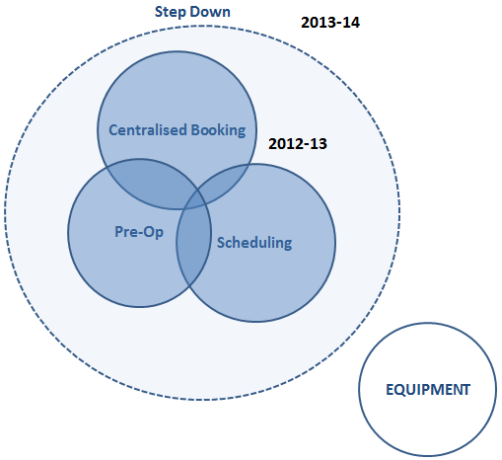
Theatres Workout Event being held on 7th November
PPAC paper re "one Stop" paper being presented on 7th November
Centralised Booking Business Case going to SIRG on 13th November.
Standardised Operating Procedures being developed
Capacity/demand model being validated
Deep Dive data being presented to stakeholders

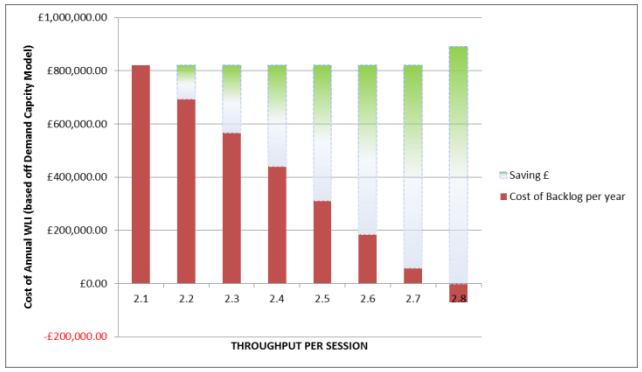
Risks / Issues / Escalation

1. Appropriate Capacity to meet demand in theatres
2. Team flexibility to support changing theatre sessions to maximise efficiency
3. Centralised booking timescales/resource practicalities
4. Location of centralised booking team
5. Clinical Engagement

Workstream: Theatres

Delivery status





Major (Sandwell)

Throughput	Capacity (sessions)	Number Patients Treated	Backlog	Cost £ of Backlog per week	Cost of Backlog per year	Saving £
1.8	19.66667	35.4	19.77	£15,488.91	£666,023.14	£0.00
1.9	19.66667	37.3667	17.81	£13,948.35	£599,779.25	£66,243.89
2	19.66667	39.3333	15.84	£12,407.80	£533,535.36	£132,487.78
2.1	19.66667	41.3	13.87	£10,867.24	£467,291.47	£198,731.67
2.2	19.66667	43.2667	11.91	£9,326.69	£401,047.59	£264,975.56
2.3	19.66667	45.2333	9.94	£7,786.13	£334,803.70	£331,219.44
2.4	19.66667	47.2	7.97	£6,245.58	£268,559.81	£397,463.33
2.5	19.66667	49.1667	6.01	£4,705.02	£202,315.92	£463,707.22
2.6	19.66667	51.1333	4.04	£3,164.47	£136,072.03	£529,951.11
2.7	19.66667	53.1	2.07	£1,623.91	£69,828.14	£596,195.00
2.8	19.66667	55.0667	0.11	£83.35	£3,584.25	£662,439.89
2.9	19.66667	57.0333	-1.86	-£1,457.20	-£62,659.64	£728,682.78

Re-Prioritisation

•2012-13 Our focus will be on the Highlighted blue circles above.

•To enable scheduling (strategic priority)to work effectively it is vital to have in place a centralised booking process as well as a robust pre-op service (interdependent projects).

•The original focus was on 8 projects with a light touch transformation approach. To enable the above it was required to narrow our scope, enabling transformation to have a hands on approach to change.

Financial Gap

•Demand capacity model has highlighted that we can only reduce/eliminate WLI for 2012-13 TSP rather than reduce capacity (sessions) (**T&O only**)

•2013-14 theatre work-stream aims to eliminate both WLI and session reduction in all other specialties. This will also be enabled through theatre step down.

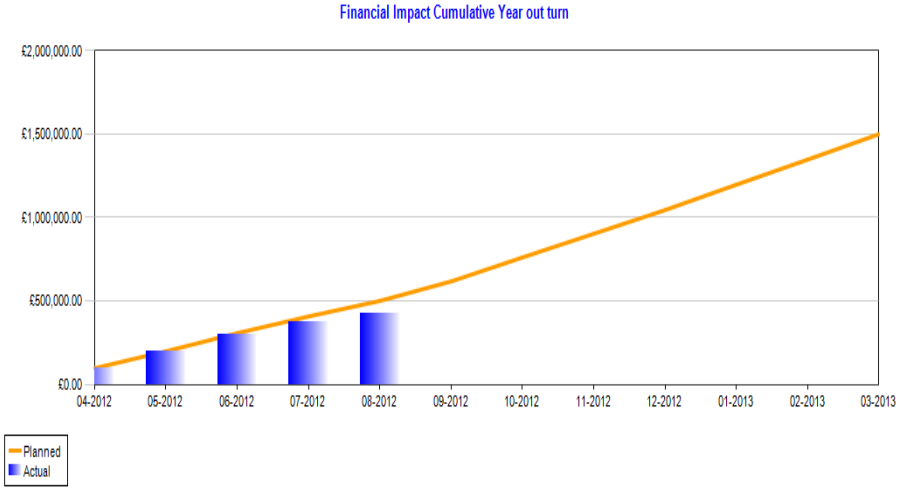
Data Analysis

•Demand capacity model has highlighted a throughput target for both day case and main spine in order to eliminate WLI

•Model highlights possible opportunities including shifting main spine demand in day case. Taking sessions from day case and converting to main spine

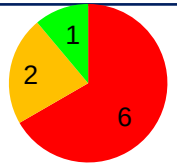
Work stream: Outpatients

Financial status



Milestone status

Major milestones impacting savings



Overdue
Due soon
Complete

RAG	Milestone(s)	Impact	Actions
	Divisional delays in translating PA reduction to job plans	£72K miss on august TSP target	Manage through Divisional leads at COO

Next steps

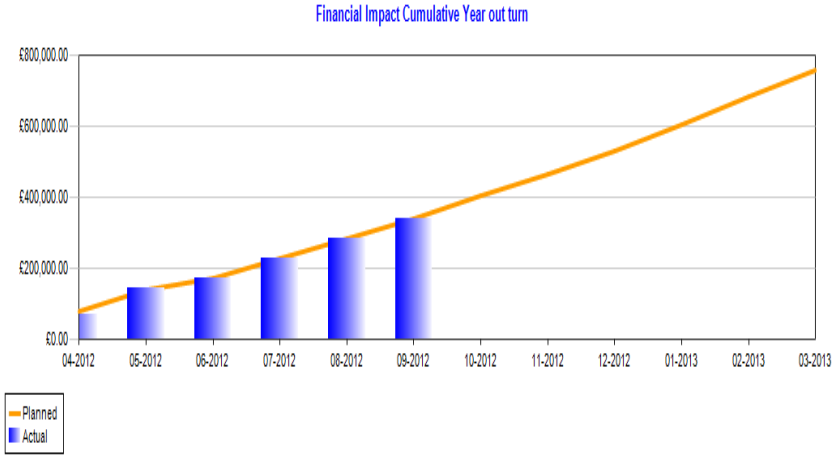
- Priority redesign pathways indentified at speciality level for medicine, surgery A and Surgery B which will receive targeted support from TSO to design and implement.
- Partial booking for new and review appointments currently being piloted in T&O. The plan is to scope resource implications and roll out to more specialities – possibly up to 10 areas (further update on this area will be available after discussion with project lead this week.
- The deep dive plus work running in parallel- specialities have not decommissioned clinics on the back of analysis but are becoming focussed on the need to run clinics efficiently and manage DNA and cancellations.
- The Op TSO team will be focussing on working with medicine, surgery A and surgery B (Ophthalmology) to scope level of support and input- essentially around the pathway designs. PMO to be developed in each location.
- OP LiA on 8th November – will be used to develop operational plan and vision for BTC

Risks / Issues / Escalation

- Lack of engagement with consultant body with OP project.
- Unclear senior nursing and general operational management structure for Outpatients
- Lack of clarity on how much outpatient activity the CCGs will agree to provide in primary care
- Speed of decommissioning will not meet TSP savings trajectory
- Resource implications within divisions which may result in a delay in the decommission of clinics or failure to progress projects
- Specialities do not have a clear strategy for OP activities

Workstream: Estates

Financial status



Milestone status

On Track

Next steps

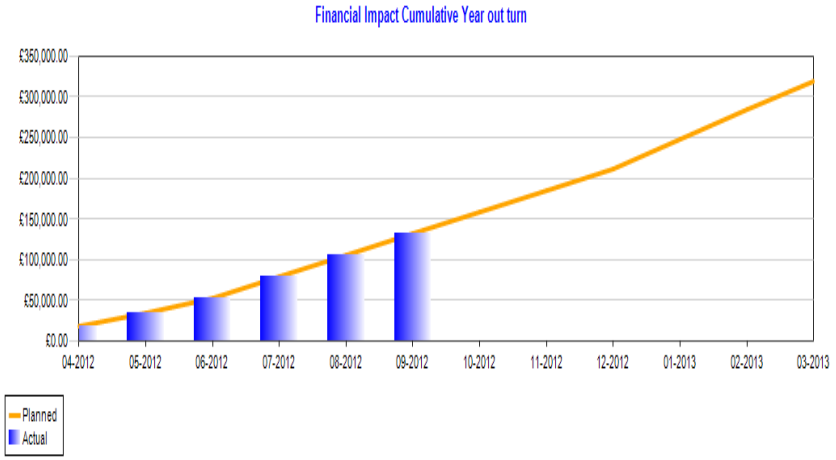
- D22: final cohorts moving in
- SCAT move 23/11/12 and then close building
- Closure Maternity Building
- Sign off Cardiac Rehab design and commence construction
- Moves into Management Block
- Day Hospital under construction

Risks / Issues / Escalation

- Closure of D43
- Closure of old Maternity Building at SGH – storage, tunnel
- Review of Staff Gym at City - contract
- Availability of HISS resource

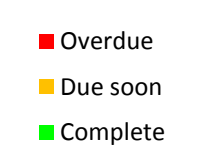
Work stream: Procurement

Financial status



Milestone status

Major milestones impacting savings



RAG	Milestone(s)	Impact	Actions
	SB049 Off Track	Forcing Surg B to identify alternative scheme in the short-term.	Bringing in additional resources to assist with MSC projects.
	ME063 – Drug saving	Collaborative effort, benefit share, region-wide price and volume initiatives delayed	Engaging with regional project to bolster specialist pharmacy procurement

Next steps

- Short term additional resources brought in to assist divisions to get certain schemes moving more quickly
- Assigned 'Supplies' staff to specific divisions rather than having a more generalised service offering
- Due to rollout pilot on MSC now that GenMed is on a national framework agreement
- In exploratory discussions with other Trusts regarding shared services initiatives and opportunities to participate in existing contracts without need for retender
- Planning for supporting next 2 years TSPs features as part of standard workstream agenda

Risks / Issues / Escalation

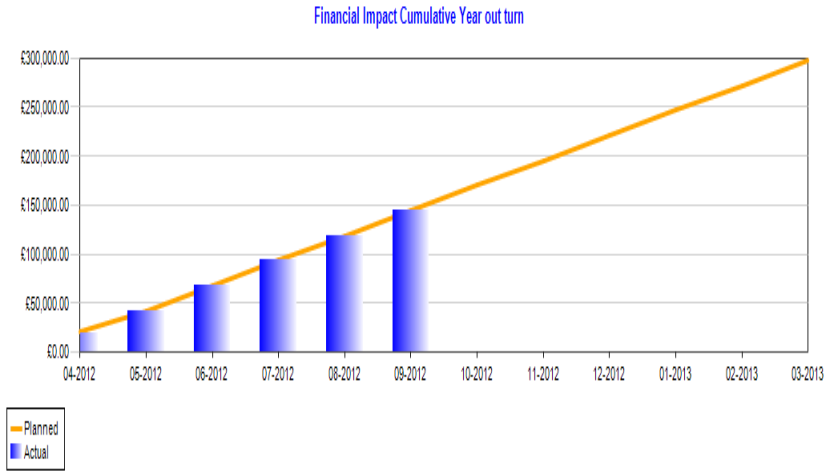
Held most recent procurment workstream meeting 7th November. Attendance slightly improved following reminder.

Worked through the line by line TSP plans and the H.T.E. workplan and specialist Supplies dept projects to get improved alignment. This is a reducing risk, but there was in some cases projects being worked on that didn't have a TSP placeholder and vice versa.

Broadly savings accruing in line with plan.

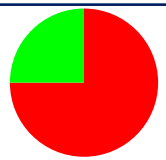
Work stream: HIS

Financial status



Milestone status

Major milestones impacting savings



RAG	Milestone(s)	Impact	Actions
	IT001 – Integration of the Help Desk	Delays incurred with PPAC of 6 months	Now underway – identify recovery plan for any shortfall or alternative scheme

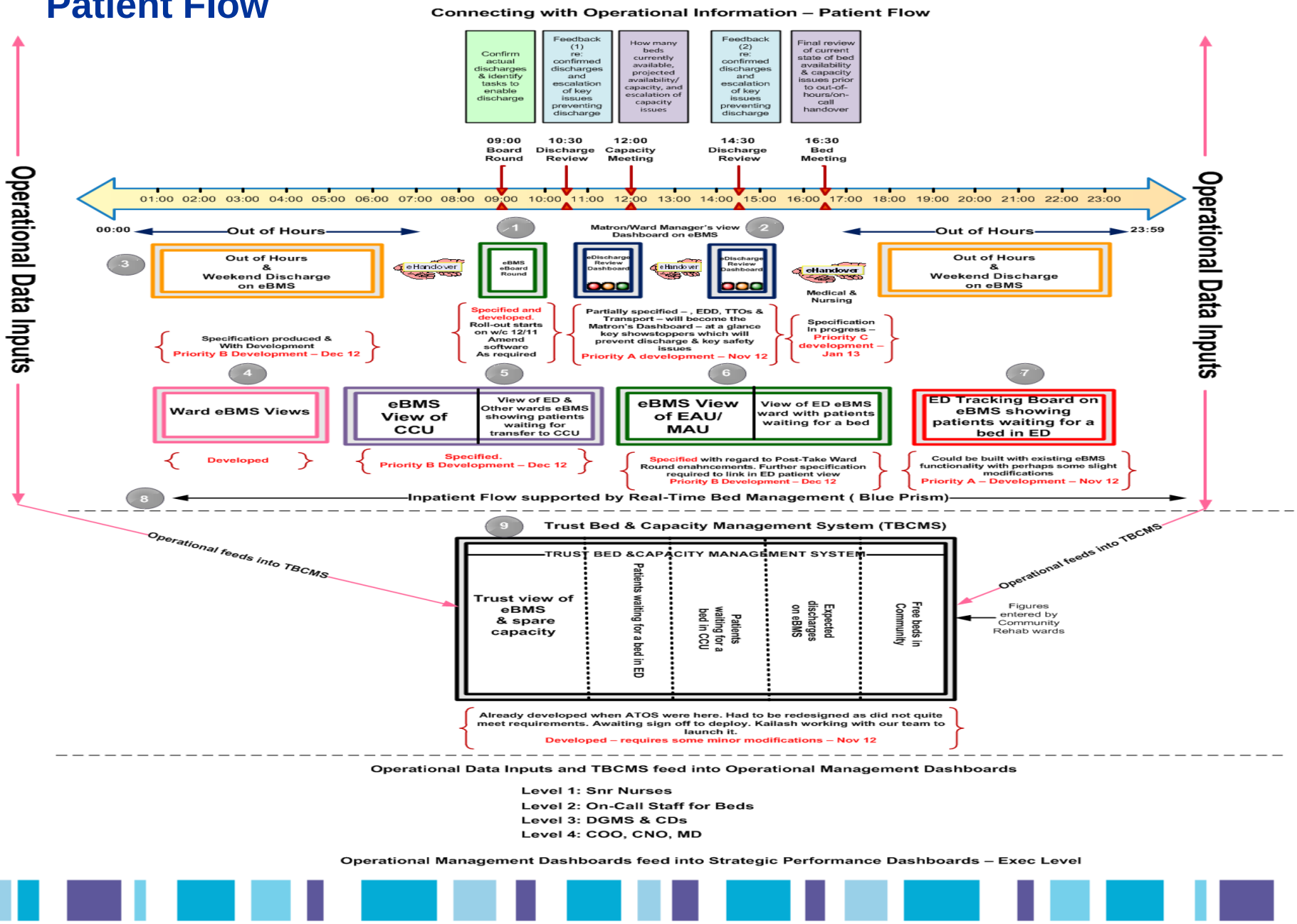
Next steps

1. All milestones achieved for 2012/13 – except IT001 – Integration of Help Desk which is now underway.
2. Complete plans for 2013/14 and 2014/15 and ensure all objectives and milestones are recorded on TPRS. Ensure relevant QIA & EIAs are completed.
3. Continue with development and IT enablement for Transformation projects 2012/13
4. FS to meet with RO & PC to discuss alignment of HIS Strategy with Transformation Programme & Divisional TSP for Future Years
5. EPR Strategic Outline Case (SOC) for review. Options Appraisal linked to Benefits and ROI – EPR will cut across and support Quality & Safety and Efficiency savings
6. Clinical Consultation on 4 and 5

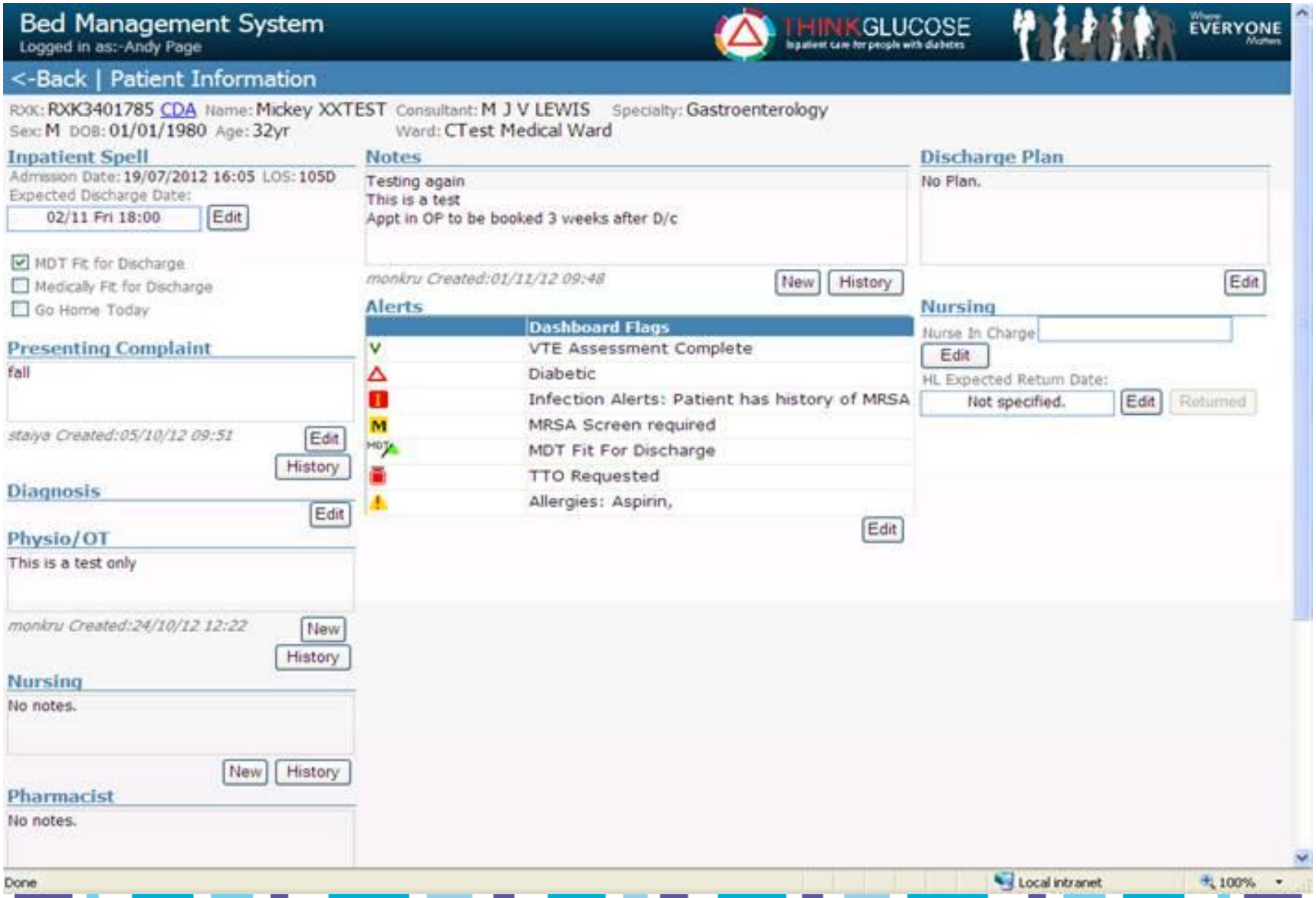
Risks / Issues / Escalation

1. Integration of the help desk and establishment of the HIS Customer Service function requirement is now underway. Delayed due to PPAC,
2. Scope of agile working programme has been extended to cover a number of other locations in the Trust
3. Alignment of HIS Strategy with Transformation programme for future years and Divisional TSP
4. Demand on both development and training resources remain high

Patient Flow

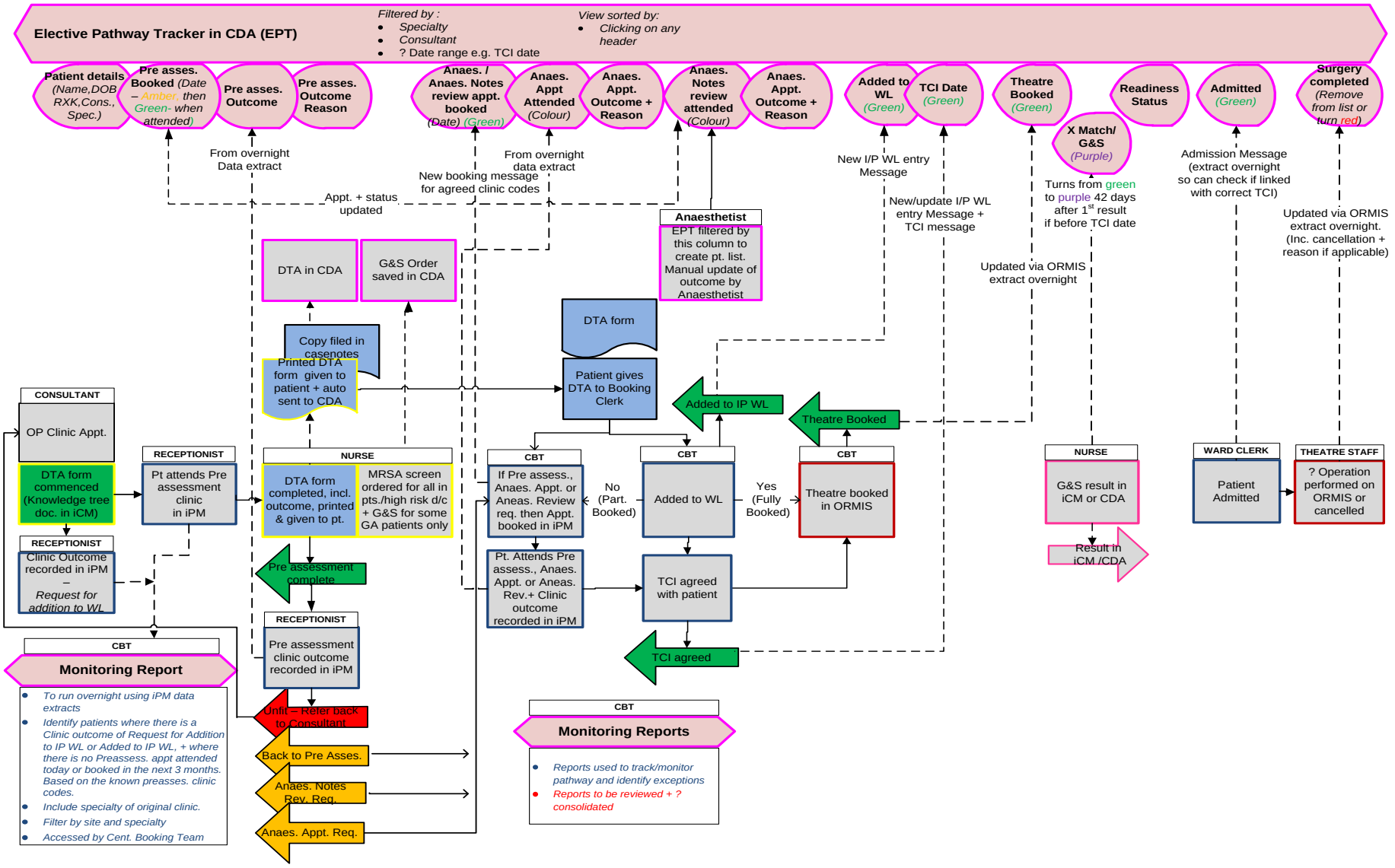


Electronic Board Round

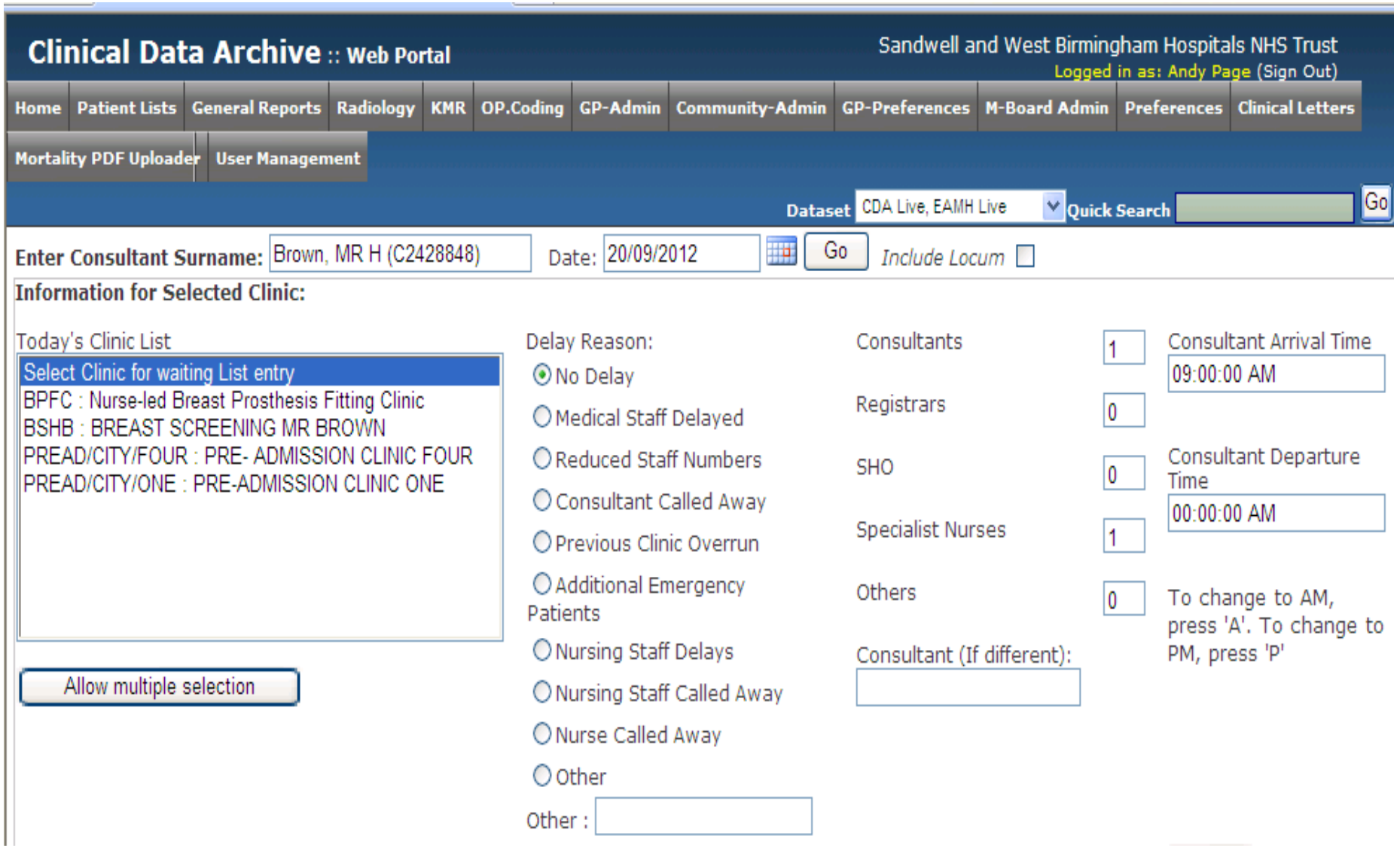


Theatre Workstream

Elective Pathway Tracker



Outpatient Workstream



Other workstreams

- **Community**
  - Further roll-out of paperLite working across Sandwell Community within SystmOne
  - Implementation of the Disconnected Briefcase – Home Visits
  - Integrated Care Pathway with Acute Continence service and GPs, closer joint working.

- **Urgent Care**
  - Requirements analysis for ED Virtual Wards for patients with Decision to Admit and Red patients who are likely to be admitted within eBMS and link to EAU/MAU
  - Participating in steering group on replacement ED system
  - Handover from ED to EAU/MAU – Andy Jinks
  - Summary Care Record – Access initially Sandwell ED, EAU & Pharmacy

- **Technical**
  - Demonstration Suite in progress in Telecomms for Unified Comms

    Large video conferencing screen/system to be installed. VOIP phones. Wireless VOIP phones. Softphones on PCs. Videoconferencing on PCs. Plus unified comms on iPhones and iPads.

Workforce Efficiency Programme Group Update
for Transformation Steering Group 16.11.12

Progress to date:

E-Rostering

- Currently have 33 wards at varying parts of progress within Eroster.
- From November 5th 2012 have 23 wards with working rosters (Priory 4 have asked for delay due to merging/ MAU will launch Dec 2012 and D26 now closed)
- Payroll set up has been commenced, with testing now taking place.
- Eroster Quarterly Report format agreed and 2nd report has been shared at PEPAG and with Team leaders.
- Business case written by GF to take forward for more staffing if rolling out to other disciplines.

Health & Wellbeing

- Meetings continuing with stakeholder group to progress development of IT systems for sickness absence management.
- Funding obtained for managers' training on mental health issues at work – date set for December 2012. Invitations to managers with high levels of mental health related absence
- Self care course rolled out to Women and Children's division next – date TBC. Excellent feedback from first course, data being collated
- "stoptober" – smoking cessation national promotion – supported by HWB with digital promotion via Facebook and Twitter, extra staff available in smoking cessation
- Free support from "the health exchange" – a local PCT service – for chronic disease support, weight management etc obtained for all staff via OH referral, commencing with screening events
- Flu vaccination campaign launched Trust-wide
- Sickness absence rates declining picture
- Targeted support to areas where sickness is high

Flexible Working

- Review of long-term bank workers employment status – now on-going – being led by the HR Department.
- Annualised hours concept reviewed for consideration within Divisional TSP schemes (discussions with Women's and Child Health, Surgery A and Community Adults). W&CH and Surg A, are not convinced the concept will generate savings. Community Adults were interested and have reviewed with HR whether moving to annualised hours would improve efficiency. Unfortunately analysis of activity suggests that Community Adults will not benefit from the concept.
- Nursing bank/agency rates worse position for last 4 years due to paused bed closure/winter beds.

New Roles

- Terms of Reference and membership for the workstream established and agreed
- New Roles and New Ways of Working emphasised in Trust's revised Recruitment and Selection Procedure
- Vacancy Approval Form revised to enforce requirement for recruiting managers to consider new ways of working and role redesign before entering the recruitment process
- 'Redesigned roles' guidance and directory posted on Trust website
- Attendance at transformation events to raise the profile of new ways of working and role redesign as part of the service redesign/transformation process
- Review of divisional annual plans and TSPs to identify opportunities and scope for new roles/changes to skill mix commenced

- Directory of 'new roles' by transformational themes commenced and completed for urgent care, community services and RCRH partner organisations (health and social care)
- ESR Recording process developed (not up and running)
- Process and programme of work being developed to identify new roles requirements for next 5 years and facilitate the take up of new ways of working/new roles.
- Review of new roles workstream action plan to reflect the above and replace the 'enabling actions' that have been completed.

"The Learning Works"

- Project management group meeting weekly.
- Development of SOPs ongoing
- Meeting held on 27th September with Local Authority to discuss and finalise 'Terms of Lease'. Outcomes from the meeting forwarded to Trust solicitor for sign-off.
- Office furniture now installed into 'The Learning Works.'
- Job Description for The Learning Works Coordinator Post approved by Job Matching Panel.
- Person appointed as part of Learning & Development internal restructure process.
- Implementation of effective risk management.
- Occupancy of building taken place

Widening Participation

- Work Experience success story – one of the individual's on the current cohort has secured full time employment working in a call centre with Connect Distribution in Small Heath. Story to go into Heartbeat
- Meetings held with two local colleges with a view to creating 'income generation pathways' in exchange for Work Experience placements that are tied to further educational activities such as BTEC diplomas etc.
- Ongoing recruitment of apprenticeships in both acute and community settings in all disciplines
- Working closely with recruitment team to concentrate on securing apprenticeships (Bands 1-4) through Trust Recruitment and Selection process.
- Continue to work with Job Centre Plus to set up Work Club strategy
- Approx. 70 apprentices in the Trust – including 16/17 year olds.

Workforce Implication

- 2012/13 Programme –Status report attached
- 20113/14 Programme – scoping of workforce implications on-going.
- Work on-going to develop IT systems to record expressions of interest and develop template reports for managers
- Redeployment process for staff selected as being formally 'at risk' on-going.
- Revised Organisational Change Policy submitted at PPAC in July 2012. Staff side feedback received in September and consultation on-going.
- TPRS – Workforce Efficiency work stream updated for all TSP schemes
- Review of internal IT systems and software on-going to minimize difficulties experienced to date and support the development of the revisions required to the TPRS
- Probationary Period discussion paper developed for consideration by WEG

Please note cases approved include pools as well as unique posts

Next Steps (Month):

E-Rostering

- Payroll testing to continue ad then plan launch for departments to payroll. Need to ensure best practice at capturing attendance before this can happen.
- Test runs for theatres.

Health & Wellbeing

- Continue sickness absence reviews by ward and long term absence case conferences
- Commence programme of Drug and alcohol quarter events
- Continued development of intranet based Sickness Absence Tracker to improve management of short and long term cases.
- Flu vaccination programme to continue
- Skin health to be included in dashboard reports as per HSE advice
- Discussion for joint HWB / ergonomics project to reduce headaches as cause of absence, (new NICE guidance recently published)
- Annual plan for next year to be arranged after November HWB meeting
- Joint working with Dr Doug Robertson, Champion for patient health promotion, commenced to minimise duplication of effort

Flexible Working

- Toolkit developed and ready for communication.
- HR Managers to continue to promote the concept and use activity data to encourage divisional interest.
- Complete review of Long-term bank worker employment status.
- Trust wide communication on 'Flexible Working' options.

New Roles

- To start work on modelled scenarios to aid and facilitate the uptake of redesigned roles
- To map interplay of new roles and new ways of working and develop powerful messages for divisions
- To determine headline new roles/ways of working for the next 5 years
- To take urgent care as a pilot for surfacing opportunities for new ways of working and new roles.
- To work with imaging to facilitate new ways of working/new roles

"The Learning Works"

- Project management group to meet weekly
- SOP's to be developed for the Learning Works
- Look at the possibility becoming a Social Enterprise Scheme with Friends & Neighbours (opens
- Ongoing exploration of appropriate pathways and resources to help unemployed people within the community to gain employment.
- Map internal resources to action plan
- Official opening/launch date to be arranged
- Distribute publicity materials for event to relevant groups

Widening Participation

- Ongoing scoping exercise required to identify demand for work experience and apprenticeships
- Partnerships to be developed with community projects to enable access to funding.
- Liaison required with service managers to support Widening Participation Agenda and work placement positions
- Link with new roles project as part of workforce efficiency program

Workforce Implication

- Complete formal consultation process for outstanding schemes.
- Continue with redeployment process
- Continue with Organisational Change/Pay Protection consultation.

- Work with Martin Chadderton to update TPRS system to monitor and report on redundancy related TSP's
- Complete scoping of workforce implications of 13/14 TSP's – develop project plan, identify process for recording compliance against plan and reporting assurance to a standard in line with feedback from SHA (Board to Board)

Scope workforce implications arising from Divisional submissions for 13/14

Key Issues:

E-Rostering

- Nurse Bank to confirm readiness for roll out. ? if recruitment functions now used in ESR instead of old system and ? if work done by SMART was sufficient for linking intranet with Bank. GF arranging meeting with another Trust to review their Bank use.
- ESR absence interface - GF to arrange meeting with another Trust to gain confidence in this working also.

Health & Wellbeing

- Complete reliance on free resources for HWB events / promotions
- Adverse sickness absence trend.
- Resources/capacity to develop IT enabling system to support sickness absence.
- Improving case closure of long term sickness absence
- Potential loss of funding for HWB co-ordinator

Flexible Working

- Capacity at the current time, given current focus on Workforce Rationalisation Programme.

New Roles

- Trust's tendency to replace posts on a like for like basis and the need to act now to maximise opportunities
- Limited capacity available to ensure role redesign is achieved as part of the significant transformation process
- Ability to identify savings target and appropriate metrics

"The Learning Works"

- Stakeholder Engagement – only SMBC has shown interest to date.
- RCRH project itself.
- Delay in signing of lease – delays to occupancy of building and initiation of project.
- Operational concerns – Delays in setting up IT and Telecom infrastructures. Relevant parties to meet up on 8th October to find solutions.
- Delay in arrival of new computes.

Widening Participation

- Engagement of service managers – withdrawing staff from apprenticeships/training etc.
- Trade unions – lack of understanding regarding apprenticeships and work experience concepts.
- Lack of 'income generation' to support project sustainability.

Workforce Implication

- Early indications suggest that scoping of workforce implications of 13/14 TSP's by the end of November 2012 may prove to be challenging as a number of projects are at too early a stage to provide the level of detail required.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	'Right Care, Right Here' Progress Report
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Organisational Development and Strategy
AUTHOR:	Jayne Dunn, Redesign Director – RCRH
DATE OF MEETING:	29 November 2012

EXECUTIVE SUMMARY:

The paper provides a progress report on the work of the *Right Care Right Here* Programme as at November 2012.

REPORT RECOMMENDATION:

The Trust Board is asked to ACCEPT the progress made with the Right Care Right Here Programme.

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Supports strategic objective: Care Closer to Home
Supports 2012/13 Annual Priority: Progressing the "Right Care Right Here" vision of service change

PREVIOUS CONSIDERATION:

Monthly report to Trust Board

Sandwell and West Birmingham Hospitals NHS
NHS Trust

RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT NOVEMBER 2012

Introduction

This brief paper provides a progress report for the Trust Board on the work of the Programme as at the 20th November 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. 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.

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. To date a schedule of acute activity reductions/transfers has been identified equating to £6.3 million income reduction. This has been discussed with the CCG. There continues to be a shortfall of acute activity reductions/transfers equating to £3.7million which creates a potential gap for the 2013/14 LDP.

The activity reductions (for the £6.3million) have now been applied to the contracts and monitoring for the period April – end of September (month 1-6) shows that against these activity lines there is an over-performance on activity (and under performance on QIPP savings) of circa £271k (a slight improvement compared to the contract line over performance of £800k for months 1-5). This is primarily as a result of over-performance of non-elective admissions (i.e. emergencies). As reported last month there have been discussions with the CCG about the implications of the increased demand for emergency admissions and what is required to support this over the winter period. In addition the CCG are continuing with a risk stratification exercise to identify patients that are at risk of frequent emergency admissions to hospital in order to put in place clinical management plans for clinical alternatives to hospital admission where clinically appropriate.

A small QIPP Steering Group has been established with joint membership from the CCG and Trust. A meeting was held in early November to review progress, current position, key steps and timescales to full implementation for each approved RCRH pathway or area of service redesign work (MSK, Cardiology, Stroke/TIA, Falls, End of Life Care, DVT, Diabetes, Respiratory, Ophthalmology, Urgent Care). Lead commissioning managers from the CCG and operational and service redesign leads from SWBH for each service were invited. As this was very much a 'stock take' for each area clinical leads were not involved at this stage. Whilst the meeting confirmed implementation to date has been variable and slow in several areas, key actions and timescales for each area were identified to ensure progress is now made. This will be monitored by the Steering Group. The CCG are planning a number of evaluations where there are different models across the CCG for the same service area (e.g. MSK and Cardiology triage and community services) and these may lead to one or more recommended model to be adopted across the CCG and some form of tendering process to commission this.

RCRH Partnership

As reported last month the RCRH Partnership Board have agreed a number of priorities and a new meeting structure which includes:

- The RCRH Partnership Board which will meet quarterly
- A supporting Partnership Executive that will meet monthly with the first meeting scheduled for 13th December
- The following subgroups (membership and first meeting dates currently being agreed):
    - Finance and Performance
    - Implementation of Pathways and Redesign
    - Communications and Engagement
    - Regeneration.

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
20th November 2012

SWBTB (11/12) 272 (a)

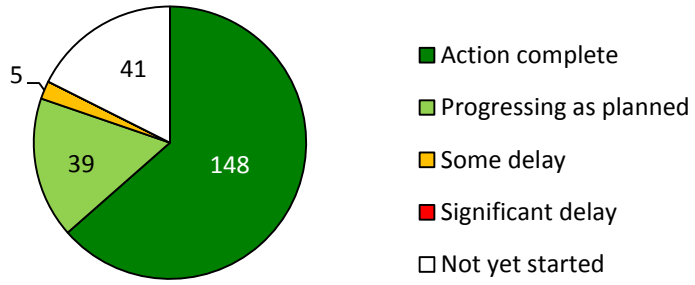
Sandwell and West Birmingham Hospitals NHS
NHS Trust

FT Programme Monitoring Status Report

Amber

Milestone status

Milestone Deliverables



Activities Last Period

- 8th draft IBP/LTFM in preparation for submission to SHA in Dec 12.
- SHA finance feedback session held on LTFM Sept 12 submission.
- BGAF/SHA Board 1:1 meetings and Board observations held.
- HDD 2 preparation commenced.
- Updated assets register and protected assets compiled.
- Deloitte independent validation of Quality Governance self assessment completed and submitted to SHA.
- Presentations to staff on IBP/LTFM content commenced.
- Further work on 13/14 and 14/15 TSP plans in train.

Issues for Resolution/Risks for Next Period

- Finalise TSPs and downside mitigations

Planned Next Period

- Submission of 8th draft IBP/LTFM to SHA incorporating SHA feedback on draft 0.7 (21/12/12)
- Finalise downside modelling and mitigation strategies
- Finalise TSPs
- BGAF - formal independent assessment of BGM completed
- HDD 2 process
- Continue programme of raising staff awareness of FT issues
- Appointment of election advisors
- Development of Monitor Board self-certification statements for review/agreement in December 2012 and for SHA submission in January 2013.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Foundation Trust Programme Monitoring and Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Mike Sharon, Director of Strategy and Organisational Development**
DATE OF MEETING:	**29 November 2012**

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
x		x

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

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

Comments:

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

'Becoming an effective organisation' and 'Achieving FT Status'

PREVIOUS CONSIDERATION:

FT Programme Board on 29 November 2012