Sandwell and West Birmingham Hospitals NHS
NHS Trust

# AGENDA

## Trust Board – Public Session

**Venue** Boardroom, Sandwell Hospital **Date** 20 December 2012; 1530h

**Members**

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| 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**

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| 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] |

**Guests**

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| Mrs F Sanders | (FS) | [Chief Information Officer] |

**Secretariat**

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

| Time | Item | Title | Reference Number | Lead |
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| 1530h | 1 | **Apologies** | **Verbal** | **SGP** |
| | 2 | **Declaration of interests**<br>*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**<br>*To approve the minutes of the meeting held on 29 November 2012 as a true and accurate record of discussions* | **SWBTB (11/12) 283** | **Chair** |
| | 4 | **Update on actions arising from previous meetings** | **SWBTB (11/12) 283 (a)** | **SG-P** |
| | 5 | **Chair and Chief Executive's opening comments** | **Verbal** | **Chair/ CEO** |
| | 6 | **Questions from members of the public** | **Verbal** | **Public** |
| 1540h | | **MATTERS FOR APPROVAL** | | |
| | 7 | **Execution of a contract as a Simple Contract: building works for Gamma camera accommodation at City Hospital** | **SWBTB (12/12) 285** | **GS** |
| | 8 | **Execution of a contract as a Simple Contract: building works for Endoscopy decontamination suite at Sandwell Hospital** | **SWBTB (12/12) 286** | **GS** |
| | 9 | **Execution of a contract as a Simple Contract: building works for Blood Sciences Laboratory at Sandwell Hospital** | **SWBTB (12/12) 287** | **GS** |

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| | **10** | **HIS strategy – Version 2.0** | **SWBTB (12/12) 288**<br>**SWBTB (12/12) 288 (a)** | **FS** |
| | **11** | **Workforce strategy** | **To follow** | **MS** |
| | **12** | **Assurance & Escalation Framework** | **To follow** | **KD** |
| | **13** | **Long Term Quality goals** | **To follow** | **KD** |
| **1630h** | **MATTERS FOR CONSIDERATION AND NOTING** | | | |
| | **14** | **Safety, Quality and Governance** | | |
| | 14.1 | Update from the meeting of the Quality & Safety Committee held on 14 December 2012 | Verbal | OD |
| | 14.2 | Quality report | To follow | RO/ KD/ RST |
| | 14.3 | Emergency Department performance update | SWBTB (12/12) 291<br>SWBTB (12/12) 291 (a) - SWBTB (12/12) 291 (d) | RB |
| | 14.4 | Fire safety annual report | SWBTB (12/12) 292<br>SWBTB (12/12) 292 (a) | GS |
| **1715h** | **15** | **Performance Management** | | |
| | 15.1 | Update from the meeting of the Finance & Performance Management Committee held on 20 December 2012 | Verbal | CR/ RT |
| | 15.2 | Monthly finance report | SWBTB (12/12) 293<br>SWBTB (12/12) 293 (a) | RW |
| | 15.3 | Monthly performance monitoring report | SWBTB (12/12) 294<br>SWBTB (12/12) 294 (a) | RW |
| | 15.4 | NHS Performance Framework & FT Compliance Framework report | SWBTB (12/12) 295<br>SWBTB (12/12) 295 (a) | RW |
| | 15.5 | Performance Management Regime – monthly submission | SWBTB (12/12) 296<br>SWBTB (12/12) 296 (a) | MS |
| | 15.6 | Update on the delivery of the Transformation Plan | SWBTB (12/12) 297<br>SWBTB (12/12) 297 (a)<br>SWBTB (12/12) 297 (b) | RB |
| **1745h** | **16** | **Strategy and Development** | | |
| | 16.1 | Reconfiguration | | |
| | ▶ | Minutes from the meeting of the Clinical Reconfiguration Board held on 6 December 2012 | SWBTB (12/12) 298<br>SWBTB (12/12) 298 (a) | GH |
| | 16.2 | 'Right Care, Right Here' programme: progress report including update on decommissioning | SWBTB (12/12) 300<br>SWBTB (12/12) 300 (a) | MS |
| | 16.3 | Communications and Engagement strategy update | SWBTB (12/12) 301<br>SWBTB (12/12) 301 (a) | JK |

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| | 16.4 | Staff engagement update | SWBTB (12/12) 302<br>SWBTB (12/12) 302 (a) | JK |
| | 16.5 | Foundation Trust application programme | | |
| | ▶ | Monitoring report | SWBTB (12/12) 303<br>SWBTB (12/12) 303 (a) | MS |
| **1815h** | **17** | **Update from the Committees** | | |
| | 17.1 | Audit Committee – 6 December 2012 | Verbal | GH |
| | 17.2 | Charitable Funds Committee – 6 December 2012 | Verbal | SS |
| | **18** | **Any other business** | **Verbal** | **All** |
| | **19** | **Details of next meeting**<br>*The next public Trust Board will be held on 31 January 2013 at 1530h in the Anne Gibson Boardroom, City Hospital*<br>*Non-routine agenda items due to be considered at the meeting are:*<br>• Update on implementation of revised nurse leadership model (CN)<br>• Nursing annual report (CN)<br>• Integrated risk report – Quarter 2 (DG)<br>• Radiation protection annual report (COO)<br>• Update on Medical Education (MD)<br>• Sustainability update (DENHP) | | |

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# MINUTES

## Trust Board (Public Session) – Version 0.2

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

| Present | | In Attendance | Guests |
|---|---|---|---|
| Mr Richard Samuda | (Chairman) | Mr Mike Sharon | Dr Mark Poulson |
| Ms Clare Robinson | | Miss Kam Dhami | Ms Kathryn Lennon |
| Mr Harjinder Kang | | Mr Graham Seager | Mr Andy Ferguson |
| Mrs Gianjeet Hunjan | | Mrs Jessamy Kinghorn | |
| Dr Sarindar Sahota OBE | | Mr Roger Trotman | |
| Prof Richard Lilford | | | |
| Mr John Adler | | **Secretariat** | |
| Mr Robert White | | Mr Simon Grainger-Payne | |
| Miss Rachel Overfield | | | |
| Miss Rachel Barlow | | | |
| Dr Roger Stedman | | | |

| **Minutes** | **Paper Reference** |
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| **1 Apologies for absence** | **Verbal** |
| Apologies were received from Ms Olwen Dutton. | |
| **2 Declaration of Interests** | **Verbal** |
| Mrs Hunjan advised that she had been appointed as a Finance Manager at the University of Birmingham. | |
| **3 Minutes of the previous meeting** | **SWBTB (10/12) 256** |
| The minutes of the Trust Board meeting held on 25 October 2012 were approved subject to a minor amendment requested by Prof Lilford. | |

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| **AGREEMENT: The minutes of the last meeting were approved** | |
| **4 Update on actions arising from previous meetings** | **SWBTB (10/12) 256 (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.<br><br>Miss Overfield reminded the Board that she would present an interim report concerning the effectiveness of the new ward leadership model at the meeting of the Trust Board planned for December 2012. | |
| **5 Chair and Chief Executive's opening comments** | **Verbal** |
| The Chairman reported that he had continued to meet with the clinical groups and had attended an event hosted by the Kings Fund. The Board was advised that a major activity in which the Chairman was involved at present was the recruitment of a new Chief Executive. It was reported that the interviews for the successor to Mr Adler were to be held on 11 December 2012.<br><br>Mr Adler advised that he had spent a day at University Hospitals Leicester where he would take up post as Chief Executive from the New Year. He advised that he had been mainly internally focussed on matters including performance of the Emergency Departments. He reported that the Trust had been successful in winning a Health Service Journal Award for staff engagement and a team had attended the awards dinner. Mrs Kinghorn added that an additional award had been won for media handling and a member of her team had been awarded a prize as 'Communicator of the Future'. The Trust was reported to have received an additional award for service redesign and had been shortlisted for an award for Maternity Services. The Chairman remarked that the success of the 'Listening into Action' approach had been evident by the staff engagement scores as part of the staff survey and the wide national recognition of the Trust's performance on staff engagement. Regarding the award for maternity, Mrs Kinghorn reported that a consultant midwife had been recognised. Prof Lilford asked that the Board's congratulations be offered to the member of staff. | |
| **6 Questions from members of the public** | **Verbal** |
| There were no questions asked. | |
| **7 Appointment of a Senior Independent Director/Vice Chair** | **SWBTB (11/12) 258**<br>**SWBTB (11/12) 258 (a)** |
| The Chairman reminded the Board that a Senior Independent Director (SID) played a key role in a Foundation trust and summarised the responsibilities of this position.<br><br>The Board was asked to approve the recommendation that following Mr Trotman's end of tenure, Ms Clare Robinson be appointed as the SID and Vice Chair. It was highlighted that Ms Robinson held 14 years experience as a Non Executive Director in the NHS and therefore she possessed adequate experience | |

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| to undertake the role.<br><br>The Board approved the recommendation. | |
| **AGREEMENT: The Board approved the appointment of Ms Clare Robinson as the SID and Vice Chair** | |
| **8 Emergency Departments update** | |
| **8.1 Emergency Department quality & performance update** | **SWBTB (11/12) 259**<br>**SWBTB (11/12) 259 (a)** |
| The Chairman welcomed Dr Poulson, the recently appointed Clinical Director for Emergency Care, Mr Ferguson, the Assistant Head of Nursing for Emergency Care and Ms Lennon, General Manager.<br><br>Miss Barlow reported that the incident trends in the Emergency Departments continued to be much improved and that no red incidents had been reported in Quarters 2 and 3. It was reported that the work in the Emergency Departments continued through the execution of the Special Measures plan. Miss Barlow advised that the Emergency Department escalation procedures had gone 'live' and that the clinical standards had been launched. The Board was pleased to learn that there had been good engagement with these new procedures.<br><br>Average performance against the four hour waiting time in the Emergency Departments was reported to have improved from c. 79% to 90% following the implementation of the revised procedures. The Board was advised that the improvement trajectory to the end of the year was short of the required 95% level. It was highlighted that to attempt to achieve a higher performance than this would potentially incur adverse quality and safety implications.<br><br>It was reported that robust clinical leadership model in the area was critical to the delivery of an improved performance in the area. The Board was also advised that the Intensive Support Team from the Department of Health had been invited into the Trust to review the situation in the Emergency Departments and to offer support where required.<br><br>The Chairman noted that a view on performance could be gained through the consideration of a dashboard of information and asked whether this was a report considered by other organisations. Dr Poulson agreed that the review of data was important and that there was a need to arrange for an effective reporting system to be implemented, particularly at City Hospital. It was emphasised that information in real time was required, rather than in retrospect. Ms Robinson suggested that this information was needed as a matter of priority. Dr Poulson advised that this was part of the process to plan and forecast proactively. The Chairman observed that a new IT system may be needed, rather than a temporary solution. Dr Poulson advised that it was likely to take 3 – 6 months to implement a fit for purpose solution, however there were a number of interim solutions which could be used in the meantime. | |

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| Prof Lilford highlighted that behind the overall performance information lay a distribution analysis and suggested that it would be useful to be able to review this.<br><br>It was pointed out that there was a shortage of resource in the Emergency Departments to be able to respond to the issues. Dr Poulson agreed and advised that the current staffing levels were some way from the benchmarked position for consultants and middle grade medical staff. He also advised that there were insufficient nurses in the area.<br><br>Dr Stedman noted that a key constraint was the ability to process medical admissions and asked whether capacity was being added in the most appropriate places. Dr Poulson advised that there were a number of 'pinch points' in the system, which when combined, presented a significant issue. He added that work was needed to reduce the level of emergency admissions. Mr Kang asked whether the pattern of attendances was random. The Board was advised that it was usual to treat a higher number of attendances during the winter months. Miss Barlow reported that every effort was made to align staffing levels with the times when the most attendances were anticipated.<br><br>The Chairman observed that the physical environment of the areas appeared to be an issue. Dr Poulson outlined some short term solutions which could assist patient flow and segregate more effectively those patients requiring different levels of intervention. Mr Seager advised that these solutions needed to be reviewed in terms of timescales for implementation. Dr Stedman added that the speed of different parts of the process varied and therefore a form of operational separation was required. Dr Poulson advised that a temporary means of segregation would be put into place to achieve this. Ms Robinson asked what consideration had been given to employing a virtual solution within the same environment. Dr Poulson advised that this had not been progressed as yet. | |
| **8.2 Emergency Department investment plan** | **Hard copy** |
| The Board was advised that one of the key issues in the Emergency Departments related to staffing levels, despite the additional staff arranged as a consequence of the Special Measures plans and the recurrent investment agreed in 2011/12. Dr Poulson advised that the Royal College of Physicians suggested that the minimum number of consultants per Emergency Department should be ten, a standard which the Trust did not meet at present.<br><br>A business case to improve the staffing model in the Emergency Departments was presented.<br><br>Mr Trotman highlighted that the Emergency Departments had been under scrutiny for some time and therefore there was a need to progress any required recruitment as soon as possible. Mr Adler advised that a recent consultant advertisement failed to attract any applicants. It was reported that it was now planned to advertise all posts together in the context of a vision for the area, which was hoped would attract candidates of the desired calibre. It was suggested that the use of a higher level of Programme Activities (PAs) could be used as an | |

incentive to attract individuals. Dr Poulson advised that some consultants within the department had already been granted an increase in PAs from 10 to 12. Dr Stedman highlighted that the staffing level of middle grade doctors was the key issue. Dr Poulson also suggested that there was a need to build more robust links with acute medical teams to streamline the processes. Ms Robinson asked whether there was an opportunity to second medical staff from specialities outside the Emergency Departments. Dr Poulson advised that in the longer term there should be harmony in terms of processes, between the Acute Medicine area and the Emergency Departments. Ms Robinson suggested that consideration needed to be given to the way in which morale and support in the departments could be boosted using secondments, for instance. Dr Stedman advised that these measures were in place currently, with diabetologists being seconded into the Emergency Assessment Unit at Sandwell Hospital.

In terms of financing the investment plan, Mr White advised that the funding would be provided from discretionary spend budgets given that alternative sources of funding for the plan could not be identified. Mr Adler highlighted that the Board was being requested to approve the quantum of spend at this point, with the detail of the spending profile spending plan being presented at the December Board meeting. Dr Sahota suggested that the detail of the IT plan to support the work needed to be presented shortly. On a separate note, he asked what degree of confidence there was that the appropriate calibre of candidates could be attracted into the area. Dr Poulson advised that there was a need to articulate the vision for the area to doctors completing training programmes which would assist with attracting the required level of applicants.

Prof Lilford noted that the investment plans would ensure that the staffing levels were on par with the national average but did not necessarily meet the national standards. Ms Robinson asked what view the Trust's commissioners would take of the plans which did not meet national standards. Mr Adler advised that on a national level, few trusts fully met the suggested staffing model. Dr Poulson added that given staff availability stepwise recruitment was needed and that it was important that the level of nurses and middle grade medical staff arranged was adequate.

Mr Sharon asked whether there was an expectation that the required additional nursing staff and Assistant Nurse Practitioners could be recruited. Mr Ferguson advised that there were no foreseen difficulties with this recruitment and a high calibre of candidates was envisaged. Miss Overfield advised that skill mix changes in the area would also assist the position.

Ms Robinson, referring to the terms of reference for the Emergency Care Assurance Group (ECAG), asked whether the establishment of the group was necessary. Mr Adler advised that the group provided a forum for discussion around Emergency Department matters with commissioners and to disband it was likely to be received poorly. Ms Robinson suggested that a management or Chairman's update could be provided to the Clinical Commissioning Group instead. Mr Adler advised that it was usual in situations such as this, that commissioners wished to engage more closely with the Trust in fora such as the ECAG. He also reminded the meeting that at the previous meeting the Board had

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| decided that the ECAG should meet more frequently than had been proposed. Mr Sharon confirmed that commissioners were encouraged to review the quality concerns proactively through such means. On this basis, the Board approved the terms of reference.<br><br>The Board was asked for and gave its approval to Option 3 of the business case for investment in the Emergency Department workforce: to progress an achievable increase in staffing over the next 12 months, with final cash flow to be confirmed at the next meeting. | |
| **AGREEMENT: The Board approved Option 3 of the business case for investment in the Emergency Department workforce: to progress an achievable increase in staffing over the next 12 months, with final cashflow to be confirmed at the next meeting.** | |
| **9 Pensions auto enrolment plans** | **SWBTB (11/12) 261**<br>**SWBTB (11/12) 261 (a)** |
| Mr White summarised the proposed changes that were 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 staff from 1 April 2013.<br><br>It was reported that the proposal to apply to the National Employment Savings Trust (NEST) for the provision of an alternative pension scheme had been discussed and supported by the Finance & Performance Management Committee at its recent meeting. The Board was asked for and gave its acceptance to the Committee's recommendation that NEST be approached. | |
| **AGREEMENT: The Trust Board accepted that Finance & Performance Management Committee's recommendation that an application should be submitted to the National Employment Savings Trust (NEST) for the provision of an alternative pension scheme** | |
| **10 Safety, Quality & Governance** | |
| **10.1 Update form the meeting of the Quality & safety Committee held on 22 November 2012** | **Verbal** |
| Mrs Hunjan, in Ms Dutton's absence, advised that an update on progress with the delivery of the Imaging integrated governance plan had been received and that following this, it had been agreed that local monitoring arrangements should be used in future.<br><br>The Board was advised that the reports from the recent unannounced visits by the Care Quality Commission (CQC) had been presented and that the Committee had been pleased at the positive messages contained within them.<br><br>It was reported that the draft Assurance & Escalation Framework had been presented. | |

| **10.2 Quality Report** | **Hard copy** |
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| Miss Overfield reported that the results from the Safety Thermometer audit had deteriorated in October, which it was highlighted was reflective of an increase in occurrences of pressure damage. The Board was advised that a separate process was in place to determine the breakdown of avoidable and unavoidable cases, in addition to those that had not been acquired within the hospital. The Board was advised however, that looking at the results of the Safety Thermometer audit there was little suggestion that vulnerable patients were being subject to neglectful care.<br><br>Instances of pressure damage overall were reported to show a trend of continual decline, despite the slight increase in occurrences in September and October 2012. It was highlighted that as a result of the 'Happy Feet' campaign the incidence of heel damage had been reduced to zero.<br><br>The Board was advised that a higher level of falls was reported at Sandwell Hospital, than at City Hospital.<br><br>The results of an audit of performance against nutrition targets were highlighted to suggest a slight decline in quality standards.<br><br>Performance against Infection Control targets was reported to be acceptable, although much work was noted to be required to cleanse the data concerning MRSA screening. The Board was advised that although it appeared that the Trust's performance was poorer than a number of other organisations in the region, if the Trust reported in a consistent manner, performance would be comparable. As such, Miss Overfield reported that the same approach to reporting by peers would be adopted, in addition to the mechanism that was currently used.<br><br>It was reported that the Trust had experienced a number of outbreaks of diarrhoea and vomiting, however there was no evidence to suggest that the infections were being transmitted between wards. The Board was advised that these type of infections were prevalent in the community at present. Miss Overfield advised that the level of infections usually increased during winter months. The Chairman asked how long it took to fully decontaminate a ward. He was advised that a ward deep clean usually took a week to complete. It was highlighted that there was little flexibility in terms of decant facilities at Sandwell Hospital at present.<br><br>The Board was advised that there were no safeguarding issues to highlight, however an assurance report in response to the 'Saville' case would be presented at a future meeting. Dr Sahota asked whether the Trust should aim to complete CRB checks for all staff and asked whether it was a legal requirement. Miss Overfield advised that this was not the case for existing staff and highlighted that to CRB check all staff would incur a significant cost. It was reported however, that investment was being made to retrospectively CRB check staff in areas seen to be high priority. | |

Miss Overfield reported that a high level of bank and agency staff was being used at present, however recruitment exercises were underway to fill gaps substantively. It was highlighted that staffing shortfalls were likely to be an ongoing issue for the winter period. The Board was advised that at least 20% of gaps in shifts were unfilled by bank and agency staff at present, however the position was mitigated to some degree by the use of non-ward based nurses. Ms Robinson asked whether moving staff between wards would assist. Miss Overfield advised that there was a limit to the degree to which this could be done from a staff morale point of view and highlighted that the risk of staff shortages could not be fully mitigated overall. Mr Kang asked whether the use of pay incentives would assist, however Miss Overfield advised that the situation reflected issues with supply rather than pay. Ms Robinson asked what level of consideration was given to the timing of ward closures. Miss Overfield advised that this was based on a decision taken jointly by herself and the Chief Operating Officer. It was highlighted that to resolve the staffing issues, the bed reconfiguration plan needed to be delivered as proposed. Ms Robinson asked whether the Trust's commissioners had expressed a view about the situation. Miss Overfield advised that the CCG was aware of the position. Mr Adler remarked that the treatment of the situation was based on the level of risk that was evaluated. Mr Sharon added that much work was underway to reduce the level of delayed discharges which would assist with alleviating some operational pressure. Ms Robinson asked at what point patient admissions ceased on the basis of quality and safety concerns due to staffing levels. Miss Overfield advised that in reality unsafe practice was not delivered as a result of the position. It was noted that the operational pressures would reduce over the Christmas period and that the recruitment plans would also assist the position. The Chairman asked whether there were any further measures which could be implemented to achieve a more satisfactory position. Mr Adler advised that the position was being mitigated as robustly as it could be. Miss Overfield added that the Trust's early warning systems highlighted the areas of pressure. Prof Lilford advised that elective surgery could be cancelled if needed which would alleviate operational pressure to some degree. Dr Stedman advised that in reality, this measure would not release a significant number of beds. Mr Kang asked whether there was any collaboration which could be used to assist. Miss Overfield advised that other trusts would be likely to be in a similar position, therefore there was limited scope for collaboration. Miss Barlow reported that discussions had been held with the local ambulance service which had identified that considerable operational pressure was being experienced regionally.

Dr Stedman reported that no 'Never Events' had been reported during the month. The Board was asked to note the performance against the mortality review target. Mr Adler advised that there was no national target for this work. It was highlighted that there had been a marked change in the mortality position reported, which Dr Stedman advised was reflective of the external rebasing of mortality information. It was highlighted that the Trust's mortality rate was lower than that of a number of peer organisations. The Board was advised that the mortality position would be reported on a site specific basis in future given that it had been noted that there was a significant difference between that of City and

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| Sandwell Hospitals.<br><br>Performance against the World Health Organisation (WHO) checklist use target was reported to be acceptable and performance against the stroke care access targets was also highlighted to have improved.<br><br>Miss Overfield reported that there had been an improvement against the Net Promoter Score (NPS), with the year end target of 65% having been met in November.<br><br>The Chairman asked, given the recent media attention, whether there were any matters related to the use of the Liverpool Care Pathway, which needed to be brought to the Board's attention. Miss Overfield advised that the Trust employed a Supportive Care Pathway, although the use of this needed to be better embedded into the Community Services.<br><br>Miss Dhami reported that in terms of the complaints backlog, 127 complaints had been breaching the failsafe targets in September 2012 and that as of 28 November 2012, 22 remained to be cleared, the majority of which had been drafted and were being checked pending issue. It was highlighted that there were a small number of exceptions to this that would not be issued by the end of November 2012, which were mainly delayed at the request of complainant. The work to devise a future model for complaints handling was reported to be continuing jointly with external consultants. It was reported that the proposal for a future system would be presented to the Quality & Safety Committee at its meeting in December 2012. Mrs Hunjan asked whether this was likely to include staff restructuring and was advised that this was the case. | |
| **10.3 Board Assurance Framework – Quarter 2** | **SWBTB (11/12) 262**<br>**SWBTB (11/12) 262 (a)** |
| Mr Grainger-Payne presented the updated Board Assurance Framework, which he highlighted presented the progress with the plans to address the gaps in control and assurance against the risks to the delivery of the Trust's annual priorities as at the end of Quarter 2.<br><br>The Board was asked to note that the Board had received reports relating to the majority of areas where the scores of the risks following the application of mitigating measures remained red.<br><br>It was highlighted that the annual priority concerning the reconfiguration of the Medical and Surgical Assessment Units at City Hospital had been placed on hold pending re-evaluation.<br><br>The Chairman asked whether service developments would be included within the Board Assurance Framework in future. Mr Grainger-Payne advised that there were plans to refine the document further in the coming months and that the matter would be addressed as part of this refresh. | |
| **10.4 Interim declaration against same sex accommodation guidance** | **SWBTB (11/12) 263**<br>**SWBTB (11/12) 263 (a)** |

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| Miss Barlow presented an interim declaration confirming that the Trust continued to adhere to the requirements of the same sex accommodation guidance. The Board was advised that abiding by the requirements continued to be a challenge.<br><br>The Chairman asked whether the CQC reviewed the Trust's position against the guidance. Miss Overfield advised that the CQC considered the position as part of privacy and dignity audits, however not against the same sex accommodation guidance specifically. | |
| **10.5 Medical revalidation update** | **SWBTB (11/12) 264**<br>**SWBTB (11/12) 264 (a)**<br>**SWBTB (11/12) 264 (b)** |
| Dr Stedman reported that the assessment of medical revalidation plans (Organisational Readiness Self Assessment) was judged to be at green status and that the software required to deliver the plans would be implemented by mid December 2012. The Board was advised that the plans required all doctors to be declared as fit to practice, based on evidence from appraisals. It was reported that the appraisal process had been strengthened to ensure that the evidence provided was more robust.<br><br>Mr Kang asked whether there was any external validation of the work. Dr Stedman advised that the minimum data set and standards were to be assured through the appraisal training, however there was no specific external validation expected. | |
| **10.6 CQC reports following visits to City and Sandwell Hospitals** | **SWBTB (11/12) 265**<br>**SWBTB (11/12) 265 (a)**<br>**SWBTB (11/12) 265 (b)** |
| The Board was asked to receive and note the CQC reports following the recent visits to City and Sandwell Hospitals. Miss Dhami advised that the action plans to address the recommendations in the reports were to be received by the Quality & Safety Committee at a future meeting.<br><br>The Board was asked to note the positive feedback on the visit that was included in the reports. | |
| **11 Performance Management** | |
| **11.1 Draft minutes from the meeting of the Finance and Performance Management Committee held on 23 November 2012** | **Hard copy** |
| Mr Trotman reported that the meeting of the Finance and Performance Management Committee held on 23 November 2012 had included a detailed review of the performance of the Medicine & Emergency Care division. | |
| **11.2 Monthly finance report** | **SWBTB (11/12) 266**<br>**SWBTB (11/12) 266 (a)** |
| Mr White reported that in month a surplus of £0.5m had been generated, | |

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| resulting in a year to date suplus of £1.7m, a position that was slightly ahead of plan. It was highlighted that the delivery of the Transformation Savings Plans was slightly behind the expected position.<br><br>Activity and income were reported to remain strong.<br><br>The Board was advised that there was confidence that the forecast year end position would be achieved. | |
| **11.3 Monthly performance monitoring report** | **SWBTB (11/12) 267**<br>**SWBTB (11/12) 267 (a)** |
| Mr White asked the Board to note the revised format of the monthly corporate performance dashboard, which now highlighted the exceptions and the actions being undertaken to mitigate them. Performance against the CQUIN targets was reported to be good at present.<br><br>It was reported that according to the Foundation Trust Compliance Framework, the Trust was classed as being at amber/green status. | |
| **11.4 NHS Performance Framework report** | **SWBTB (11/12) 268**<br>**SWBTB (11/12) 268 (a)** |
| Mr White advised that according to the NHS Performance Framework the Trust was classified as 'performing'. | |
| **11.5 Provider Management Regime monthly return** | **SWBTB (11/12) 269**<br>**SWBTB (11/12) 269 (a)** |
| Mr Sharon presented the proposed Provider Management Regime return for submission to the Strategic Health Authority.<br><br>It was highlighted that the Governance Risk Rating had improved as a declaration of compliance with the provision of a Community Information Dataset was now made. It was highlighted that the Financial Risk Rating remained unchanged as did the declarations against the Board Statements.<br><br>Dr Sahota asked whether it was anticipated that 100% compliance with the use of the World Health Organisation checklist would be achieved. Mr Sharon advised that, unlike most Trusts, the Trust undertook a 100% audit (as opposed to a random sample), so achieving 100% was likely to be challenging. Ms Robinson asked whether a feedback loop was in place, should it be identified that a checklist had not been completed. Dr Stedman advised that this was the case. | |
| **AGREEMENT: The Trust Board gave its approval to the submission of the Provider Management Regime return** | |
| **11.6 Update on the delivery of the Transformation Plan** | **SWBTB (11/12) 270**<br>**SWBTB (11/12) 270 (a)**<br>**SWBTB (11/12) 270 (b)** |
| Miss Barlow reported that the patient flow work was seen to be delivering some benefit and that agile pharmacy plans had been rolled out. It was reported that centralised booking in Trauma & Orthopaedics was being piloted and partial | |

| | |
|---|---|
| booking had been introduced in theatres. It was noted that the performance of the Trauma & Orthopaedics directorate had improved considerably over recent months. Miss Barlow was asked to draft a letter for the Chairman to send to the team to express his recognition of the improvement.<br><br>It was reported that electronic rostering software was in place on 23 wards and that the Health Informatics Service (HIS) team was supporting the further development of the Electronic Bed Management System.<br><br>Ms Robinson suggested that future updates needed to present the successes and exceptions on the delivery of the Transformation Plan more clearly. Mr Adler agreed that there was a need to review the level of detail presented. | |
| **ACTION:** **Miss Barlow to prepare a letter on behalf of the Chairman to recognise the improvement in the performance of the Trauma & Orthopaedics team**<br><br>**ACTION:** **Miss Barlow to revise the level of detail in the Transformation Plan update** | |
| **12 Strategy & Development** | |
| **12.1 'Right Care, Right Here' programme: progress report, including an update on decommissioning** | **SWBTB (11/12) 271**<br>**SWBTB (11/12) 271 (a)** |
| The Trust Board received and noted the 'Right Care, Right Here' programme progress report.<br><br>Mr Sharon reported that all care pathways had been reviewed and action plans to deliver improvements had been prepared. It was noted that progress with the programme continued to be slow however. | |
| **12.2 Foundation Trust application: programme director's report** | **SWBTB (11/12) 272**<br>**SWBTB (11/12) 272 (a)** |
| The Trust Board received and noted the Foundation Trust programme director's report. Mr Sharon reported that the next version of the Integrated Business Plan (IBP) and the Long Term Financial Model (LTFM) were under development.<br><br>The Board was advised that the second phase of the Historical Due Diligence audit (HDD2) was due to start.<br><br>It was reported that the external assessment of the Trust's position against the Board Governance Assurance Framework (BGAF) had been received from Finnamore Ltd., which largely corroborated the Trust's self-assessment. | |
| **13 Any other business** | **Verbal** |
| There was none | |
| **14 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 20 December 2012 and would be held in the Boardroom at | |

| | |
|---|---|
| Sandwell Hospital. | |

Signed: …….

Name: …….

Date: ……

**Next Meeting: 20 December 2012, Boardroom @ Sandwell Hospital**

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

**29 November 2012, Anne Gibson Boardroom @ City Hospital**

**Members present:** Mr R Samuda (RSM), Dr S Sahota (SS), Mrs G Hunjan (GH), Prof R Lilford (RL), Ms C Robinson (CR), Mr H Kang (HK), Mr J Adler (JA), Mr R White (RW), Miss R Overfield (RO), Miss R Barlow (RB), Dr R Stedman (RST)

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

**Apologies:** Ms O Dutton (OD)

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

Last Updated: 13 December 2012

| Reference | Item | Paper Ref | Date | Action | Assigned To | Completion Date | Response Submitted | Status |
|---|---|---|---|---|---|---|---|---|
| SWBTB(P)ACT.095 | Corporate risk register | Hard copy paper | 25-Oct-12 | Consider revising the Corporate Risk Register and mode of Board consideration in line with suggestions made at the meeting | KD | 31-Dec-12 | ACTION NOT YET DUE | G |
| SWBTB(P)ACT.099 | Corporate Risk Register | SWBTB (11/12) 279 (PR)<br>SWBTB (11/12) 279 (a) (PR) | 29-Nov-12 | Arrange for the agendas of key meetings to include an item to flag key risks that required addition into the Corporate Risk Register | SG-P | 28-Feb-13 | Will be undertaken when new Board and Committee structure launched | G |
| SWBTB(P)ACT.100 | Corporate Risk Register | SWBTB (11/12) 279 (PR)<br>SWBTB (11/12) 279 (a) (PR) | 29-Nov-12 | Amend the Board and Committee cover sheet to include a space to highlight where the report related to an entry on the Corporate Risk Register or should prompt the inclusion of an entry | SG-P | 28-Feb-13 | Will be undertaken when new Board and Committee structure launched | G |
| SWBTB(P)ACT.098 | External environment update | SWBTB (11/12) 277 (PR)<br>SWBTB (11/12) 277 (a) (PR) | 29-Nov-12 | Circulate details of the Board structure for the Clinical Commissioning Group | MS | 20-Dec-12 | Circulated as requested | B |
| SWBTB(P)ACT.101 | Significant Events report | SWBTB (11/12) 280 (PR)<br>SWBTB (11/12) 280 (a) (PR) | 29-Nov-12 | Present further information concerning incident 2 at the next meeting | KD | 20-Dec-12 | Included in Significant Evemts report presented at the December 2012 meeting | B |
| SWBTB(P)ACT.102 | Severe graded complaints report | SWBTB (11/12) 281 (PR)<br>SWBTB (11/12) 281 (a) (PR) | 29-Nov-12 | Arrange for the originating location of the complaint would be included in future versions of the severe graded complaints reports | KD | 20-Dec-12 | Included in the Serious Complaints report presented at the December 2012 meeting | B |

**KEY:**

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# TRUST BOARD

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|---|---|
| **REPORT TITLE:** | Execution of contract as a Simple Contract: building works for Gamma camera accommodation at City Hospital |
| **SPONSORING DIRECTOR:** | Graham Seager, Director of Estates/New Hospital Project |
| **AUTHOR:** | Richard Kinnersley, Head of Capital Projects |
| **DATE OF MEETING:** | 20 December 2012 |

## KEY POINTS:

It is proposed to sign the construction contract for building works for the refurbishment of facilities to accommodate the replacement of two Gamma Cameras at City Hospital

The contract sum is **£280,174.18** including VAT and the tender analysis report prepared by the Trust's Quantity Surveyor, Holbrow Brookes, recommended Harrabin Construction Ltd as the preferred contractor.

There is an option for construction contracts to be executed as a simple contract or as a deed (for contracts in excess of £1m). Under the law of contract, the period within which an action of breach of contract may be brought is limited to six years from the time of accrual of the cause of the action for contracts executed as a simple contract and twelve years for contracts executed as a deed.

This paper recommends the contract is signed as a Simple Contract.

## PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

| Approval | Receipt and Noting | Discussion |
|---|---|---|
| **X** | | |

## ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Trust Board is asked to:

- Approve the signing of the contract

Through the Trust Secretary, the Board is asked:

- Arrange for the contract to be signed at the indicated places
- Return the contracts and drawings to the Capital Projects department

**ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:**

| | |
|---|---|
| Strategic objectives | 21st Century Equipment and Facilities |
| Annual Priorities | To carry out refurbishment works to provide accommodation for two replacement Gamma Cameras |
| NHS LA accreditation | |
| CQC Core Standards | |
| Auditors' Local Evaluation | |

**IMPACT ASSESSMENT** *(Indicate with 'x' all those that apply in the second column)*:

| | | |
|---|---|---|
| Financial | **X** | To authorise the capital expenditure of £280,174.18 |
| Clinical | **X** | Improve diagnostic facilities |
| Workforce | **X** | To improve the working environment for the staff |
| Legal & Policy | **X** | No issues |
| Equality and Diversity | **X** | Improved patient privacy |
| Patient Experience | **X** | Improved clinical accommodation |
| Communications & Media | | No issues |
| Risks | | None |

**PRIOR CONSIDERATION:**

| |
|---|
| The replacement of two Gamma Cameras was agreed as part of the annual capital programme |

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# TRUST BOARD

| | |
|---|---|
| **REPORT TITLE:** | Execution of Contract as a Simple Contract – RFC Construction |
| **SPONSORING DIRECTOR:** | Graham Seager, Director of Estates and New Hospital Project |
| **AUTHOR:** | Richard Kinnersley, Head of Capital Projects |
| **DATE OF MEETING:** | 20 December 2012 |

**KEY POINTS:**

It is proposed to sign the construction contract for building works for the Endoscopy Decontamination Suite at Sandwell Hospital.

The contract sum is **£398,180.26** inc VAT and the Tender Analysis report prepared by the Trust's Quantity Surveyor, Holbrow Brookes, which recommended RFC Construction Ltd as the preferred contractor, is appended to this report

There is an option for Construction Contracts to be executed as a simple contract or as a deed (in excess of £1m). Under the law of contract, the period within which an action of breach of contract may be brought is limited to 6 years from the time of accrual of the cause of the action for contracts executed as a simple contract and 12 years for contracts executed as a deed

This paper recommends the contract is signed as a simple contract.

**PURPOSE OF THE REPORT** *(Indicate with 'x' the purpose that applies)*:

| Approval | Receipt and Noting | Discussion |
|---|---|---|
| **X** | | |

**ACTIONS REQUIRED, INCLUDING RECOMMENDATION:**

The Trust Board is asked to:

- approve the signing of the contracts

Through the Trust Secretary, the Board is asked to:

- arrange for contracts to be signed at the indicated places
- return Contracts and drawings to Capital Projects department

Sandwell and West Birmingham Hospitals NHS

NHS Trust

**ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:**

| | |
|---|---|
| Strategic objectives | 21st Century Centralised decontamination facilities. |
| NHS LA accreditation | To Carry our refurbishment to the Second floor at Sandwell to accommodate the Decontamination Suite. |
| CQC Essential Standards of Quality and Safety | |
| Auditors' Local Evaluation | |

**IMPACT ASSESSMENT** *(Indicate with 'x' all those that apply in the second column)*:

| | | |
|---|---|---|
| Financial | **x** | To authorise the expenditure of **£398,180.26** |
| Clinical | | |
| Workforce | **x** | To improve the working environment for Staff |
| Legal & Policy | **x** | To attach the Trust seal to Contracts |
| Equality and Diversity | | |
| Patient Experience | | |
| Communications & Media | | No issues |
| Risks | | None |

**PREVIOUS CONSIDERATION:**

| |
|---|
| The Endoscopy Decontamination Suite was agreed as part of the annual capital programme |

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# TRUST BOARD

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|---|---|
| **REPORT TITLE:** | Execution of Contract as a Deed: Blood Sciences Laboratory building works |
| **SPONSORING DIRECTOR:** | Graham Seager, Director of Estates/New Hospital Project Director |
| **AUTHOR:** | Richard Kinnersley, Head of Capital Projects |
| **DATE OF MEETING:** | 20 December 2012 |

## KEY POINTS:

It is proposed to sign the construction contract for building works for the Blood Sciences at Sandwell Hospital between the Trust and E Manton Building Contractors with a contract sum of **£2,995,000.00** including VAT.

There is an option for construction contracts to be executed as a simple contract or as a deed. Under the law of contract, the period within which an action for breach of contract may be brought is limited to 6 years from the time of accrual of the cause of the action for contracts executed as a simple contract and 12 years for contracts executed as a deed.

It is recommended that all construction contracts over £1m are executed as a deed.

This paper recommends the application of the Trust Seal to execute the contract as a deed.

## PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

| Approval | Receipt and Noting | Discussion |
|---|---|---|
| **X** | | |

## ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The Board is asked to:

- authorise the signing of the contract at the indicated places
- approve the application of the Trust Seal to the contract

**ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:**

| | |
|---|---|
| Strategic objectives | Reconfiguration of the existing vacant first floor of the Pathology Block to provide a Blood Sciences Integrated Automated Laboratory facility. |
| NHS LA accreditation | |
| CQC Core Standards | |
| Auditors' Local Evaluation | |

**IMPACT ASSESSMENT** *(Indicate with 'x' all those that apply in the second column)*:

| | | |
|---|---|---|
| Financial | **x** | Capital £2,995,000.00 |
| Clinical | **x** | To improve clinical space to provide a fully automated laboratory system |
| Workforce | **x** | To improve the working environment for Staff |
| Legal & Policy | **x** | To attach the Trust seal to Contract |
| Equality and Diversity | | |
| Patient Experience | **x** | To improve testing procedures for patients |
| Communications & Media | | |
| Risks | | |

**PRIOR CONSIDERATION:**

| |
|---|
| The Board was presented with the business case for the Blood Sciences Laboratory in October 2012 |

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# TRUST BOARD

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|---|---|
| **DOCUMENT TITLE:** | **Sandwell and West Birmingham Hospital NHS Trust Informatics Strategy 2012 to 20127. Version 0.2** |
| **SPONSOR (EXECUTIVE DIRECTOR):** | **John Adler, Chief Executive** |
| **AUTHOR:** | **Fiona Sanders, Interim Chief Information Officer (CIO)** |
| **DATE OF MEETING:** | **20 December 2012** |

**EXECUTIVE SUMMARY:**

The Sandwell and West Birmingham Hospitals NHS Trust Informatics Strategy has been revised following comments received from the SHA. The strategy was presented to the Trust Board in September 2012 and following the B2B review the following revisions have been made:

**Section 1**: Executive summary. This has been revised to emphasise our strategic vision.
**Section 2**: Has been re-expressed to reflect our review of key national and local initiatives. This includes Right Care Right Here and the Transformation plan.
**Sections 3, 4 and 5: I**ntroductions are signposted to our vision, as detailed in section 1.1

The SHA also suggested that further detail on financing should be included. This will only be possible once national negotiations around NPFIT funding are completed. A further addendum will be issued after that.

**REPORT RECOMMENDATION:**

It is recommended that the Board approves the revised strategy.

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

| Accept | Approve the recommendation | Discuss |
|---|---|---|
| | X | |

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

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

Comments:

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

The Sandwell and West Birmingham Hospital NHS Trust Informatics Strategy 2012 to 2017 Version 0.2 is aligned to:

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

**PREVIOUS CONSIDERATION:**

The Sandwell and West Birmingham Hospital NHS Trust Informatics Strategy 2012 to 2017 Version 0.1 was approved by the Trust Board in September 2012.

Sandwell & West Birmingham Hospitals NHS
NHS Trust

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

## Version 2.0 Final

# Health Informatics Service Strategy

| | | | |
|---|---|---|---|
| **Reference** | **HIS_ Strategy_v1.0** | **HIS Strategy** | |
| **Owner** | John Adler | **Version** | 2.0 |
| **Author** | Fiona Sanders | | |
| **Date** | 10th December 2012 | **Status** | Issued |

**Distribution** **This document has been distributed to:**

| Name | Date of issue | Version |
|---|---|---|
| Sue Wilson, Scott Paterson, Matthew Maguire, John Borland | 23/06/12 | V0.1 |
| Sue Wilson, Scott Paterson, Matthew Maguire, John Borland | 01/08/12 | V0.2 |
| Sue Wilson, Scott Paterson, Matthew Maguire, John Borland | 07/08/12 | V0.3 |
| Sue Wilson, Scott Paterson, Matthew Maguire, John Borland | 14/08/12 | V0.5 |
| The Trust Chair, Chief Executive, Health Informatics Steering Group, HIS Management Team, Divisional General Managers, Chief Executive. | 23/08/12 | V0.6 |
| Incorporating comments from Medical Director | 07/09/12 | V0.7 |
| Version 1.0 issued to Trust Board | 20/09/12 | 1.0 |
| Version 2.0 issued to the Trust Board incorporating comments from the SHA | 11/12/12 | 2.0 |

**Approvals** **This document requires the following approvals:**
**Health Informatics Steering Group**
**Chief Executive**

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

| | | | |
|---|---|---|---|
| 1.0 | Issued to Trust Board | Trust Board | 20th August 2012 |
| 2.0 | Incorporating comments from the Board to Board Review | Trust Board | 20th December 2012 |

## Contents

# 1 Executive Summary

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

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

This strategy sets out how we will continue to build upon our investment in technology and how our approach to information and IT across the Trust can lead to more joined up, safer, better care for us. The strategy spans information for patients, service users, clinicians and other care professionals. The strategy covers the requirements of clinical and no clinical users and embraces the challenge of integrated care pathways across our local health community. The NHS Information Strategy 2012 states that "Information can bring enormous benefits. It is the lifeblood of good health and wellbeing, and is pivotal to good quality care."[1]

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

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

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

[1] NHS Information Strategy, April 2012, Page 6

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

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

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

## 1.1 Our Strategic Vision

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

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

***The Trust will develop a connected and integrated healthcare system, supported across a modern and flexible infrastructure which will meet the needs of our local healthcare community and provide high quality patient information at the point of care. To achieve this we will:***

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

## 1.2 Delivery of the Strategy

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

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

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

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

[2] Dave Brailsford, Team GB Cycling Performance Director

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

***Informatics Delivery Approach***

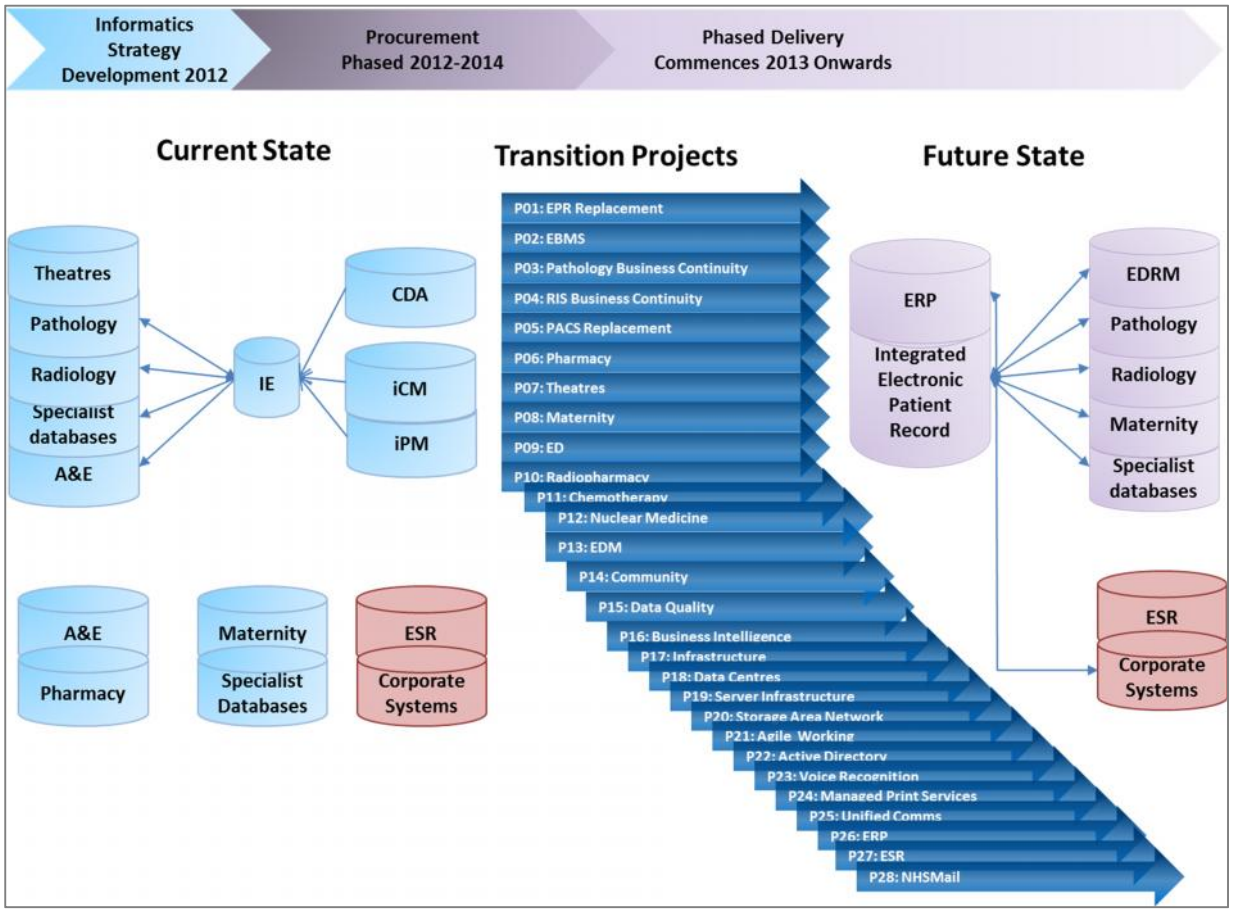
***The Trust will build upon the existing investment made by the Trust in informatics by:***

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

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

## 1.3 Purpose of Document

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



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

**Section 3** provides an overview of the current status of IT systems in the Trust and the plan for replacement, connection and/or integration to meet our vision;

**Section 4** describes the role and importance of information services in the Trust and its importance in delivering our vision;

**Section 5** describes the Trust's plans for infrastructure and telecommunications and how this will support our vision;

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

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

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

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

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

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

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

The Trust is operating in an environment of unprecedented change both politically and economically. The NHS Health and Social Care Act 2012 puts clinicians at the centre of commissioning, and frees up providers to innovate, empowers patients and gives a new focus to public health. This combined with significant changes in legislation and central informatics policy has informed the development of our informatics strategy. Whilst there are a number of demands placed upon our informatics requirements, which are from seemingly disparate and conflicting sources it is clear from both local and national initiatives that informatics is placed firmly at the centre of patient care in the 21st Century. As a result, NHS Informatics is increasing in profile and now informatics and the use of the computer and high quality patient informatics is essential to the delivery of patient care. Our informatics Strategy has been developed to ensure that all informatics initiatives are geared towards support of the Trust's strategic direction and providing a platform for future development.

Used effectively Information and IT will facilitate and drive integration across care settings, however to achieve this and generate the greater efficiencies and productivity required the Trust will need to maximise the technology it already has and ensure a cohesive and cogent approach to the development of the Health Informatics Service. In developing our informatics strategy we have taken into consideration key national and local initiatives.

## 2.1 National Drivers

In developing our strategy we reviewed the following key national strategies:

*"The Power of Information",* the NHS information Strategy advocates joined up care and access to patient information for healthcare professionals, patients and carers in care settings.

*"Quality, Innovation, Productivity and Prevention (QIPP) Programme"* a large scale transformational programme for the NHS, that involves all NHS staff, clinicians, patients and the voluntary sector. It will improve the quality of care the NHS delivers while making up to £20billion of efficiency savings by 2014-15, which will be reinvested in frontline care. Technology is a key enabler to QIPP.

*"Transforming Community Services"* the transfer of community services places additional demands on our informatics strategy. Whilst the programme concluded in April 2011, the requirements for care closer to home and joined up care informed the development of the Trust's informatics strategy. In developing this strategy we took

into consideration the six transformational attributes and subsequent guides. To meet the needs of clinicians in the community it is essential that we provide clinicians with appropriate technology and ensure that where safe and practical to do so clinical pathways are interlinked using shared records and joint care plans. In addition to application requirements we also need to provide a modern and mobile infrastructure including investment in mobile technology.

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

## 2.2 Local Drivers

The Trust is committed to *Right Here Right Care*, and is committed to improving health and the quality of health and social care services provided to local people in Sandwell and West Birmingham and bringing more health services to local community settings, so that elements of healthcare are closer to home. To meet our obligations to our patients and clinicians in the community it is essential that we provide clinicians with appropriate IT and ensure that where safe and practical to do so clinical pathways are interlinked using shared records and joint care plans. In addition to application requirements we also need to provide a modern and mobile infrastructure including investment in mobile technology.

Informatics and technology is a key enabler for the Trust's Transformation Plan. As the Trust initiates the enabling projects identified within the strategy, the Trust's capacity to enable service transformation will also increase. The Transformation work streams are enabled by the following informatics projects:

I. Patient Flow work stream is enabled by project 02 the eBMS
II. Theatre work stream is enabled by project 07 Theatres
III. Outpatient work stream is enabled by project 01 EPR
IV. Community work stream is enabled by project 014 Community
V. Urgent Care work stream is enabled by project 09 ED and project 01 EPR

As can be seen from the national and local drivers NHS Informatics is increasing in profile and now informatics and the use of the computer and high quality patient informatics is essential to the delivery of patient care. Used effectively Information and IT will facilitate and drive integration across care settings, however to achieve this and generate the greater efficiencies and productivity required the Trust will need to maximise the technology it already has and ensure a cohesive and cogent approach to the development of the Health Informatics Service.

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

We recognise that significant improvements to the quality of patient care and the needs of our community will be met by the provision ***of "connected and integrated healthcare information and systems"*** where we provide high quality clinical information to support the delivery of high quality safe patient care across a high quality and sustainable infrastructure.

To deliver our vision of a ***"connected and integrated healthcare system"*** to our local healthcare community we must balance competing needs, making the best use of limited resources and develop the optimum solution which builds on existing investments and provides a coherent road map for development of our vision. To deliver our vision we have identified primary infrastructure and application projects that will enable service transformation within our local health community. These guiding principles are detailed in section 2.1.

## 2.3 Guiding Principles

The vision for informatics in the Trust is to "***develop a connected and integrated healthcare system, supported across a modern and flexible infrastructure which will meet the needs of our local healthcare community and provide high quality patient information at the point of care."***

We will use health informatics to achieve operational efficiencies, tangible cost savings and improved patient outcomes. We will achieve this by providing a collaborative and

integrated environment, where critical patient and business information is available to employees and healthcare professionals. In order to provide this environment we will apply nine guiding principles:

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

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

In sections 3, 4 and 5 we have outlined the enabling projects which will support the delivery of the Trust's vision. Section 3 deals with system replacements and developments, section 4 deals with information services and section 5 deals with infrastructure and telecommunications.

# 3 Health System Projects

Our vision to develop and deliver ***"a connected and integrated healthcare system, supported across a modern and flexible infrastructure which will meet the needs of our local healthcare community and provide high quality patient information at the point of care"*** is dependent upon us delivering an integrated EPR solution. To achieve this and remain aligned with both our delivery approach and guiding principles the Trust must look at the informatics systems which are installed and establish a coherent and rolling improvement plan to meet the strategic needs of the Trust and migration to the future operating model.

To deliver our vision of a ***"connected and integrated healthcare system"*** to our local healthcare community we must balance competing needs, making the best use of limited resources and develop the optimum solution which builds on existing investments and provides a coherent road map for development of our vision. To deliver our vision we have identified application projects that will enable service transformation within our local health community and are aligned with guiding principles as detailed in section 2.3.

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

As stated in section 2.2 the Trust has previously committed to taking the NPfIT EPR solutions. As a result of the delays associated with the NPfIT, a number of departments have legacy systems, which are now approaching contract end dates. As part the system replacements plans the Health Informatics Strategy will co-ordinate and manage the replacement of every solution to ensure that it meets our vision for delivering "***a connected and integrated healthcare system, supported across a modern and flexible infrastructure which will meet the needs of our local healthcare community and provide high quality patient information at the point of care"***:

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

## 3.1 The Electronic Patient Record

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

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

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

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

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

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

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

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

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

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

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

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

2. **The final scope of Lorenzo Regional Care is agreed and its formal signing off under the Memorandum of Understanding (MOU) between CSC Alliance and NHS Connecting for Health.**
   The current position regarding the contract extension remains unclear. As of January 2012, it is expected that the CSC contract will not be renewed and no new sites will be added to the current implementation schedules. The Trust is waiting for confirmation of the position from the SHA.

3. **The Trust will not consider an implementation date until Care Pathways, Guidelines, Protocols and Advanced Clinical Decision Support are put back into the contract, even if it means they are at a reduced level of functionality from the original OBS/Contract.**
   With regard to care pathways, guidelines, protocols and advanced decision support. These were scheduled for delivery in release 4 of Lorenzo Regional Care. In light of the current status of the contract extension it is anticipated that the planned de-scoping of the release will remain. This has major implications for the Trust's HI plan.

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

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

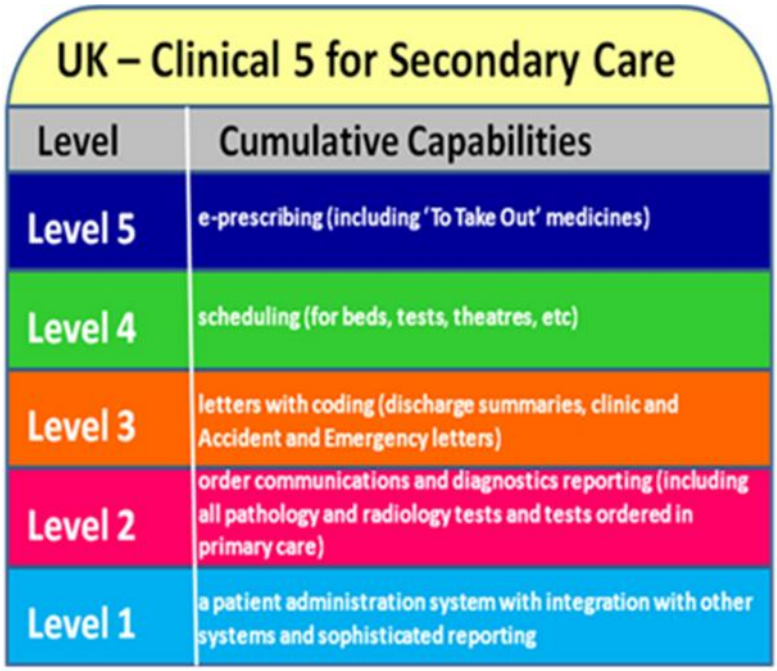
Clinicians are increasingly frustrated with the number of applications they need to access and also the amount of information held in silos within the Trust and across the health community. Integrated care beyond the boundaries of the Trust is becoming the accepted service model and this needs to be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

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

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

### 3.1.1 Options Appraisal

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




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

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

| Option | Positive | Negative |
|---|---|---|
| **Option 1**<br>**Do Minimum –** Stay with iCM and iSoft solution set | 1. Established system<br>2. No training or re-implementation costs<br>3. Annual support costs within current budget | 1. Poor levels of service delivery<br>2. Poor levels of support.<br>3. Antiquated system and architecture.<br>4. iCM product set is scheduled for "sunset" strategy. The timescales for this have yet to be confirmed<br>5. Does not include advanced decision support or protocol driven pathways, and clinical guidelines.<br>6. The products do not currently support prescribing or enterprise wide scheduling as an integrated product set.<br>7. The Trust will still be required to re-procure at the end of the contract in 2016<br>8. Trust will still be required to procure a number of core systems |
| **Option 2**<br>**Lorenzo Regional Care –** Take the previous NPfIT solution from CSC Alliance | 1. Significant financial incentives<br>2. Maintenance does not commence until 12 months after the implementation does not occur until 5 years after | 3. Poor levels of service delivery , though improved in past 2 years<br>4. Products not officially signed off at pilot sites<br>5. Poor levels of support, though improved in past 2 years |

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

| Option | Positive | Negative |
|---|---|---|
| could include a mix of supplier options and varying degrees of ROI depending on how advanced functionality is. | 2. Meets needs of Transformation programme now & in future<br>3. Integration of Enterprise wide scheduling with beds, Theatres, and resources for staff, equipment & locations.<br>4. Integration of ePrescribing, results reporting & full clinical decision support<br>5. Sound Implementation methodology and capacity to deliver | |
| **Option 5**<br>**Develop In-House** – develop the Clinical Data Archive (CDA) and eBMS to become a bespoke active Electronic Patient Record. | 1. Cost<br>2. Clinicians get the functionality they want, relatively when they want | 1. Requires significant in house development resource.<br>2. Will still be required to develop a procure a number of commercial solutions<br>3. Sustainability over long term keeping abreast with changes in health care – becomes too bespoke |
| **Option 6**<br>**UHB Solution** – Procure or outsource the Trust's Health | 1. Established solution liked by clinicians at UHB | 1. Strategic direction driven by UHB.<br>2. Solution based upon the CSC iPM |

| Option | Positive | Negative |
|---|---|---|
| Informatics Solution to University Hospital Birmingham | 2. Relatively low cost compared to more advanced fully integrated solutions<br>3. Junior Doctors & Consultants move between SWBH & UHB – same system, easier training, though they have to learn different systems at HEFT.<br>4. More cost effective than some other options on the market.<br>5. Could be a more attainable model in terms of affordability<br>6. Would not have to procure as many separate systems as some other "best of breed" offerings, which would reduce the annual support costs and technical infrastructure that could be incurred.<br>7. Could realize some key benefits such as drug savings | solution, already installed at SWBH NHS Trust<br>3. Does not support outpatient prescribing<br>4. Requirement to maintain and procure department systems<br>5. Does not support order entry, which is a core requirement for service departments<br>6. Does not support enterprise wide scheduling.<br>7. ROI far lesser degree than fully integrated solution<br>8. Product now with commercial supplier – competing priorities with other Trusts for development<br>9. Older architecture which is not supported on modern mobile devices such as iPADs |

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

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

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

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

### 3.1.2 Approach to Transition

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

The Trust would transition from the current systems to the new integrated solution at a pace that fits with the clinical and organisational requirements as well as the Trust's own capacity to change. Under this model, the Trust would only retain those specialist systems that cannot be delivered effectively through an EPR.
Based on best practice a typical implementation would take some 3 – 4 years from contract signing to being fully implemented Although timescales can be altered, it highlights the need to commence market testing for integrated solutions and for the Trust to commence planning for the replacement of the current EPR.

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

### 3.1.3 The Pan Birmingham Shared Care Record

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

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

## 3.2 Electronic Bed Management System

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

The patient journey through the hospital is a complex multi-disciplinary process from the point a patient is admitted to the point a patient is discharged there are multiple points in

the process where errors, inefficiencies and mis-communications can occur which cumulatively can result in the patient discharge being delayed. Often discharges are delayed through situations such as:

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

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

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

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

### 3.2.1 Electronic Bed Management System Product Plan

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

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

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

## 3.3 Pathology

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

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

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

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

Costs for this upgrade are currently awaited.

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

## 3.4 Radiology Information System (RIS)

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

| Project 4<br><br>RIS business continuity &<br><br>Replacement | High Level Requirements | Benefits |
|---|---|---|
| Year:<br><br>2013/14 | | |

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

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

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

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

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

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

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

## 3.5 PACS

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

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

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

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

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

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

## 3.6 Pharmacy

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

| Project 6<br><br>Pharmacy | High Level Requirements | Benefits |
|---|---|---|
| solution<br><br>Year:<br><br>2013/14 | | |

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

## 3.7 Theatres

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

| Project 7<br><br>Theatre Integration | High Level Requirements | Benefits |
|---|---|---|
| as part of the EPR solution<br><br>Year:<br><br>2013/14 | | |

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

## 3.8 Maternity

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

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

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

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

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

## 3.9 Emergency Department

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

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

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

## 3.10 Radiopharmacy

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

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

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

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

## 3.11 Chemotherapy prescribing

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

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

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

## 3.12 Nuclear Medicine

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

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

## 3.13 Electronic Document Management

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

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

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

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

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

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

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

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

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

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

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

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

## 3.14 Community Systems

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

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

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

### 3.14.1 Agile Working in Community

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

# 4 Information Services

Information Services are essential in the delivery of our vision. The provision of "…***high quality patient information at the point of care"*** is essential in the delivery of patient care. The Information Services team provide information to meet the operational needs of the Trust; this includes but is not limited to:

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

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

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

Information is a vital asset for the Trust, supporting both day to day clinical operations and the effective management of services and resources. The Trust requires accurate, timely

and relevant information to enable it to deliver the highest quality health care and to operate effectively. Having accurate relevant information available at the time and place where it is needed, is critical in all areas of the Trust's business and plays a key part in corporate and clinical governance, strategic risk, service and workforce planning and performance management.

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

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

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

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

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

## 4.1 Data Quality

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

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

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

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

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

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

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

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

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

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

## 4.2 Business Intelligence

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

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

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

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

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

## 4.3 Clinical Coding

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

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

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

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

1. The Trust should restructure the Clinical Coding Team.

2. Coding staff should cease to code radiology and diagnostic imaging that has already been electronically coded.

3. Introduce a systematic approach to the delivery and allocation of coding work.

4. Encoder software should be implemented.

5. To facilitate the introduction of encoder software two training seminars should be held, enabling staff to raise any concerns about the software.

6. Ensure greater engagement between clinicians and coding staff to help improve the coding process.

7. The Coding Department should reintroduce the appraisal process for all staff and ensure that staff has sufficient time and opportunity to undertake relevant training.

8. Reasonable time should be allocated to allow staff to update their coding books.

9. For future employees, coders should be awarded band 4 pay upon passing their qualification and being awarded Accredited Clinical Coder status.

10. Implement an income recovery coding review to assess the level of coding and the extent of any lost revenue

11. Reduce the quantity of coding checking and replace with an auditing framework.

12. Provide staff with greater autonomy over their workload and give personal responsibility for achieving deadlines.

13. Reduce the reliance on overtime and agency staff by recruiting the establishment, harmonising pay scales and training staff to deliver work efficiently at acceptable quality standards.

14. Staff at both sites should be brought under a single management structure with the head of coding managing both sites on a regular basis.

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

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

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

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

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

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

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

# 5 Infrastructure and Telecommunications

The Trust have a mature and well developed IT and telecommunications infrastructure that supports the delivery of IT systems to departments across the main sites and also to community sites and staff homes. A maturing and flexible infrastructure is essential to the Trust achieving its vision of our vision to develop and delivering ***"a connected and integrated healthcare system, supported across a modern and flexible infrastructure which will meet the needs of our local healthcare community and provide high quality patient information at the point of care"***

Investment in this core infrastructure is essential to allow rapid and reliable deployment of existing and new systems but extend our services into our local health community. Demand for access to systems and adequate resources to allow those systems to expand (storage capacity etc.) is continually increasing and the Trust must ensure that there is planned growth of all the key areas so that the reliability and resilience of these systems is not reduced or compromised and that we meet the needs of our local health care community. Our approach to this is outlined in section 5.1 to 5.8.

## 5.1 Network Infrastructure

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

| Project 17<br><br>Infrastructure | High Level Requirements | Benefits |
|---|---|---|
| | | improvements. |

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

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

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

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

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

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

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

## 5.2 Data Centres

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

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

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

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

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

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

## 5.3 Server Infrastructure

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

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

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

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

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

## 5.4 Storage Area Network Infrastructure

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

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

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

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

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

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

## 5.5 Agile Working

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

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

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

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

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

## 5.5 Active Directory

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

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

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

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

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

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

## 5.6 Medical Voice Recognition

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

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

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

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

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

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

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

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

## 5.7 Managed Print Services

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

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

The Trust requires the managed print service to provide:

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

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

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

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

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

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

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

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

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

### 5.8.1 Unified Communications

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

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

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

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

1. ***Presence awareness*** – IP Phones can be integrated with systems to determine if a particular member of staff is available (by virtue of the fact that they have logged into their phone), and potentially route calls to the most effective type of connection (voice, video, instant message).

2. ***Single number ID*** – individuals could be contacted using a single number incorporating multiple devices e.g. office number, mobile numbers, off-site numbers, home numbers (setup by the user and hidden to callers with rules supporting routing preferences). This supports the removal of multiple portable devices (mobile, Good technology, bleeps and pagers) carried by doctors, other clinicians and on-call teams. It would facilitate flexible working arrangements, reduce delays in routing calls and also re-route calls back through the Trust for charging and quality monitoring.

3. ***Reduction of bleep/pager and directory services*** - will reduce the demand for switchboard services and realise consequent savings, whilst reducing risk through

minimising delays in contacting the right clinical support team, on-call managers or individuals. This will require a change in current processes and working practices, including users more effectively managing their own call rosters.

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

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

### 5.8.2 Location Based Services

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

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

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

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

### 5.8.3 Patient Bedside Devices/Patient Access

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

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

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

### 5.8.4 Mobile Devices

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

### 5.8.5 Bring Your Own Device Policy

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

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

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

### 5.8.6 Telehealth

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

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

# 6 Corporate Systems

## 6.1 Electronic Staff Record

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

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

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

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

## 6.2 Enterprise Resource Planning

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

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

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

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

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

***Financial Management***

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

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

***Procurement***

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

***HR***

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

***CRM***

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

## 6.3 Email (NHSmail)

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

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

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

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

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

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

# 7 The Health Informatics Service

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

## 7.1 Organisational roles

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

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

I. Chief Information Officer

II. Head of Health Systems

III. Head of Customer Services

## 7.2 Chief Information Officer

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

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

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

### 7.3 Head of Information Technology

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

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

### 7.4 Head of Telecommunications

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

### 7.5 Head of Health Systems

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

I. The development of the vision and strategy for the EPR and subsequent requirements and procurement activity

II. Be responsible for HIS integration strategy.

III. Ensure compliance with the Trusts PPM standards

IV. Run the Trust's Health Informatics Programme Office, to plan and control all HI PPM activities ensuring compliance and integration with the TSO.

V. Be responsible for the development of the business case and OBS for the EPR replacement

VI. Lead the procurement of the EPR system

VII. Lead the transition and transformation to the new EPR and the paper light care model.

## 7.6 Head of Information Services

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

## 7.7 Head of Customer Services

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

## 7.8 Information Governance

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

# 8 Management Approach

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

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

## 8.1 Portfolio Management

The delivery of the Health Informatics Strategy will require a management of the programme and project delivery environment, the business as usual environment and the change in the operational environment. Portfolio management is increasingly being applied to organisations and corporate functions which are undertaking large-scales corporate change. The portfolio management function is "*increasingly becoming established as the interface between organizational ownership and the delivery of that change"* [3]

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

[3] Page3, Managing Portfolios of Change, Chris Venning, TSO

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

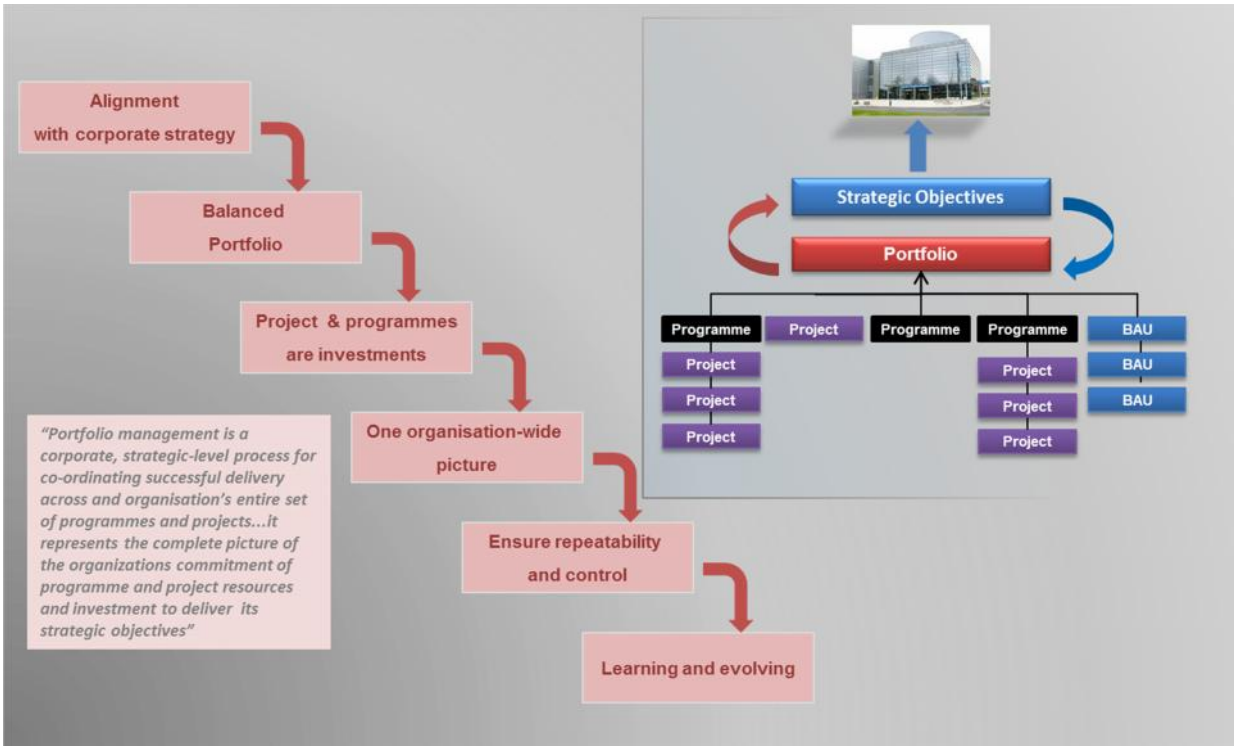



Figure 1 Portfolio Management

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

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

## 8.2 Programme and Project Management

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

## 8.3 Benefits Management

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

## 8.4 Service Management

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

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

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

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

# 9 Governance

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

## 9.1 Health Informatics Steering Group

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

## 9.2 Health Informatics Programme Board

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

## 9.3 Clinical Assurance Group

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

## 9.4 Informatics Futures Group

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

## 9.5 Health Informatics Programme Office

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

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

## 10 Key Risks

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

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

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

# 11 Costs

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

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

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

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

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

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

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

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

## 12 Feedback

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

| |
|---|
| **Section:** |
| **Submitted by:**<br><br>**Please submit this form to the CIO by email: fjsanders@nhs.net** |
| **Date :** |
| **Observation:** |

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# TRUST BOARD

| | |
|---|---|
| **DOCUMENT TITLE:** | **Emergency Care Quality and Performance** |
| **SPONSOR (EXECUTIVE DIRECTOR):** | **John Adler, Chief Executive** |
| **AUTHOR:** | **Rachel Barlow, John Adler, Kathryn Lennon** |
| **DATE OF MEETING:** | **20 December 2012** |

## EXECUTIVE SUMMARY:

This report summarises the latest position on emergency care quality and performance. It notes a continuing absence of red incidents in the Emergency Departments but also reports very poor performance on the 4 hour target. The report details key actions being taken to address this whilst not compromising quality and safety.

The report notes that the DH Intensive Support Team has visited the City site and that their report is awaited. It also presents a new dashboard which is designed to assist thinking as to the root cause of performance issues.

Following last month's agreement of a significant ED workforce investment plan, the report presents the proposed investment phasing for final approval.

## REPORT RECOMMENDATION:

The Trust Board is **recommended** to:

- Note the current position in terms of quality and performance
- Note that an update will be provided at the meeting on IST feedback and analysis of the new dashboard
- Confirm the workforce investment plan and the suggested phasing of this.

## 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 | |
| Clinical | **x** | Equality and Diversity | | Workforce | x |

Comments:

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

Trust Priority 2012/13 – Improve ED quality and performance

## PREVIOUS CONSIDERATION:

The Board received an update on performance and quality issues in the Emergency Departments at the November 2012 meeting

# SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

## TRUST BOARD

## December 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 Department Quality

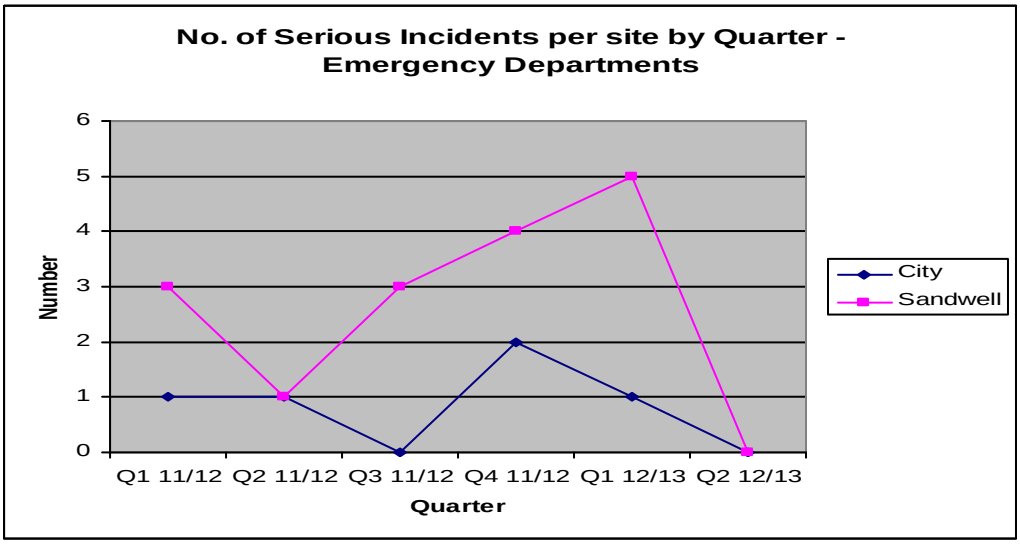
### 2.1 Incident Trends

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 table & graph below show 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 |
| Q3 2012/13 to date* | 0 | 0 |

* As at 10 December 2012




### 3.0 Emergency Department Performance

Emergency Department 4 hour performance continues at a very unsatisfactory level.

**Table 1: ED Performance – 4 hours**

| | 4 hour performance | | | |
|---|---|---|---|---|
| | **EYE** | **CITY** | **SGH** | **TRUST** |
| October 2012 | **99.2%** | **89.7%** | **91.1%** | **91.5%** |
| November 2012 | **99.1%** | **88.6%** | **92.6%** | **91.5%** |
| December 2012 (to 12 Dec) | **99.2%** | **88.5%** | **89.5%** | **89.4%** |
| | | | | |
| Q1 | **99.2%** | **93.7%** | **95.3%** | **95.1%** |
| Q2 | **99.5%** | **91.4%** | **94.7%** | **93.7%** |
| Q3 (to 12 Dec) | **99.1%** | **89.0%** | **91.2%** | **91.2%** |
| | | | | |
| YTD | **99.3%** | **91.6%** | **94.0%** | **93.6%** |

**Table 2: ED Clinical Quality Indictors**

| City | | November 2012 | YTD 12-13 |
|---|---|---|---|
| Dept wait (mins) | All | 344 | 316 |
| | Admitted | 485 | 442 |
| | Non-admitted | 240 | 238 |
| Assessment Wait (mins) | | 20 | 21 |
| Treatment Wait (mins) | | 65 | 75 |
| Left not seen (%) | | 4.61 | 5.76 |
| Unplanned reattendance (%) | | 8.09 | 8.21 |

| Sandwell | | November 2012 | YTD 12-13 |
|---|---|---|---|
| Dept wait (mins) | All | 312 | 285 |
| | Admitted | 440 | 432 |
| | Non-admitted | 235 | 233 |
| Assessment Wait (mins) | | 13 | 14 |
| Treatment Wait (mins) | | 49 | 57 |
| Left not seen (%) | | 3.89 | 4.45 |
| Unplanned reattendance (%) | | 8.28 | 8.52 |

In order to understand better the factors that may be driving the current poor level of performance, a new dashboard has been developed. The current version is attached. Careful thought has been given to the indicators and presentation that are likely to produce most added value. Analysis of what this information is telling us is in progress and this will be tabled at the meeting, together with any amendments to existing action plans which may be indicated by this analysis.

### 4.0 Emergency Care Assurance Group

The Emergency Care Assurance Group (ECAG) meets on 14 December 2012. ECAG oversees the quality and performance improvement work in the directorate of Emergency Medicine. The following update is being presented to the ECAG in December.

### Key Activities and Achievements

- The Emergency Department Escalation Policy was implemented on Monday 26 November 2012. The Shift Coordinator & Consultant set an escalation level for each area of the department, depending on pressure within the department and then ensure the required actions are taken and any issues escalated.

- The Emergency Department Workforce Proposal was presented to Trust Board on 29 November 2012 and it was agreed in principle to invest in the additional workforce which was requested. Further detail regarding the likely timetable for recruitment will go back to Trust Board for final approval in December 2012.

- The options appraisal and business case for the investment in a new IT system for ED will be presented to the HIS Steering Group on 20 December 2012. It has been discussed at the Emergency Department Task & Finish Group and there is support for the preferred option. Implementation is likely to be towards the end of Q4 2012/13 and there is provision in the HIS capital programme for this. The new system is seen as key to improving control of the ED flow, particularly at City where the current system does not facilitate this and the physical layout of the department is difficult.

**Issues for highlighting**

- The Intensive Support Team from the Department of Health visited City Hospital on Thursday 6 December 2012. The written report is expected within 10 days; feedback on the day highlighted the need for focus on rapid assessment, triage and see and treat models within the Emergency Department. These are existing actions on the Special Measures plan which are due for completion. There was also a clear need to develop stronger links between Acute Medicine and Emergency Medicine; A special meeting of the Task and Finish Group has been arranged for 17th December to address these key issues and a verbal update will be provided to the Board meeting.

- There has been a delay in the start of the programme to review and implement clinical guidelines in the EDs. It has been agreed that West Mercia guidelines will be used for Emergency Medicine. A start date for the localisation work is yet to be confirmed but will be expedited.

- There has been a delay in the completion of a competency assessment and gap analysis for leaders. This was scheduled to take place in October and November 2012 but has not yet taken place. The T&F Group will ensure that a new date is set at it's next meeting.

- The Governance Training Session at Sandwell was cancelled due to low levels of attendance. The Clinical Director and Assistant Head of Nursing will be reviewing the content on the training and secure a date which ensures good attendance from the multidisciplinary team.

**Next Steps**

- Review of Intensive Support Team recommendations and agree priority areas;

- Presentation of detailed workforce proposal and timeline at Trust Board December 2012 [see later in this paper];

- Completion of actions associated with Rapid Assessment and Fast-track / Minors Stream [sign off meeting 17 December]

- Implementation of Clinical Guidelines following review of BMJ and West Mercia guidelines;

- Presentation of IT system options appraisal and business case to the HIS Steering Group on 20 December 2012;

- Completion of competency assessment and gap analysis for nursing and medical staff;
- Delivery of Governance Training at Sandwell.

**5.0 Emergency Flow Project**

**Key Activities & Achievements**

- Professional clinical standards and capacity escalation standards launched pan Trust.
- Discharge meetings and real time use of EBMS improving.
- EBMS developed to support information flow for bed and discharge meetings.
- Observational focused site teams have provided intensive support to embed new standards and have identified several improvement areas as a result of observational work. This has informed a revised emergency flow programme plan.
- TSO programme support identified and governance structures revised for weekly project delivery team and executive fortnightly taskforce.

**Issues for Highlighting**

- Out of hours (OOH) capacity management, bed flow and escalation needs review. TSO will support operational team to work a late/early shift to review processes OOH.
- Revised project plan needs engagement of all key stakeholders.
- Red escalation level actions and outcomes need review by clinical reference group.
- Discharge rates from assessment units variable and require escalation standards to be agreed.

**Next Steps**

- PMO and visual management to be set up in Capacity room at City. Project support to be provided in real time.
- Agree and implement assessment unit escalation standards.
- Review red escalation capacity actions including weekend / OOH through a clinical reference group.
- Focus on increasing morning discharges and overall discharges though comprehensive development plan.

- Period of intensive support extended – but at risk of other workload.

**6.0 Workforce investment plan**

At its November meeting, the Trust Board agreed in principle a large scale plan for investment in the ED workforce. It was agreed that a schedule of the expected timelines for the various strands of investment would be brought back to the December meeting for final approval.

Attached to this report is a timeline for recruitment and associated costings and cash flow. This has been agreed between the Directorate team and Finance Department and is felt to be a realistic assessment. If anything, it may be somewhat optimistic in terms of recruitment, and therefore represents a "worst case" in terms of financial impact. In summary, cumulative additional expenditure is forecast to be:

| | |
|---|---|
| 2012/13: | £0.395m |
| 2013/14 | £1.806m |
| 2014/15 | £2.186m |

The Board will wish to be reminded that this significant investment is being agreed in advance of financial planning being completed for 2013/14. Although the Board is recommended to approve the investment as previously agreed, so that recruitment can begin, it is recommended to reserve the right to modify the investment plan in the event that it becomes unaffordable within the overall financial plan for next year. The aim, however, will be to protect the full investment. For the avoidance of doubt, this means that at this stage, all the additional posts will be established, with budgets profiled according to the agreed timeline. This approach is particularly important in order to assist with Consultant recruitment.

## 7.0 Summary, conclusions and recommendations

Given that the original concerns around the Emergency Department were based primarily on the high rate of red incidents, the continuing absence of such incidents is gratifying. Nevertheless, the very poor performance on the 4 hour target and the ED clinical indicators is a source of serious concern. The paper has detailed the extensive range of actions designed to improve this position whilst not compromising quality and safety.

The Trust Board is **recommended** to:

- Note the current position in terms of quality and performance
- Note that an update will be provided at the meeting on IST feedback and analysis of the new dashboard
- Confirm the workforce investment plan and the suggested phasing of this.

# Emergency Medicine Workforce Plan

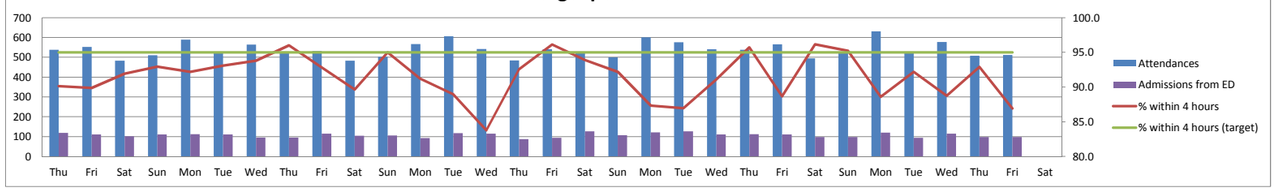
2013 - 2014

| Month | Nursing | Consultant | Middle-grade | Admin |
|---|---|---|---|---|
| Jan **2013** | 5.0 WTE Qualified<br>2.19 WTE Unqualified | | Current locum expenditure | 1 WTE B5 Gov Coordinator<br>7.22 WTE Clerk for Majors<br>Bank |
| Feb | 5.0 WTE Qualified | | Current locum expenditure | |
| March | 5.0 WTE Qualified | | Current locum expenditure | |
| | | | | |
| April | 4.2 WTE Qualified | | Current locum expenditure | |
| May | | 1 WTE Locum Consultant | Current locum expenditure | |
| June | | | 4 WTE Overseas | |
| July | | | | |
| August | | 2 substantive consultants (12 PA) | | 1.0 WTE Medical Secretary |
| Sept | | | | |
| Oct | | | | |
| Nov | | | | |
| Dec | | 2 substantive consultants (12 PA) | | 1.0 WTE Medical Secretary |
| Jan **2014** | | | | |
| Feb | | | | |
| Mar | | | | |
| | | | | |
| April | | | | |
| May | | | | |
| Jun | | | | |
| Jul | | | | |
| Aug | | 2 substantive consultants<br>(12 PA) | | |

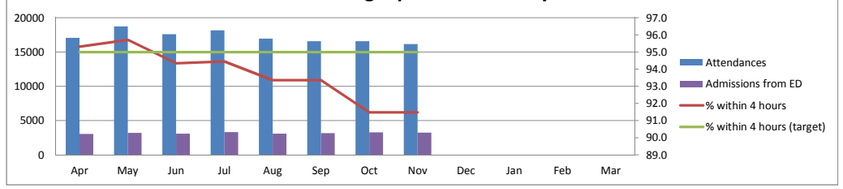
| | 2012/13 | | | 2012/13 | 2013/14 | | | | | | | | | | | | 2013/14 | 2014/15 | | | | | | | | | | | | 2014/15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan | Feb | Mar | Total | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
| **WTE's** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nursing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Trained Nursing | 5.00 | 10.00 | 15.00 | | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | 19.20 | |
| Untrained Nursing | 2.13 | 2.13 | 2.13 | | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | 2.13 | |
| Band 6 pay protection | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sub-total: Nursing | 7.13 | 12.13 | 17.13 | | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | 21.33 | |
| Medics | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Locum Consultant | | | | | | 1.00 | 1.00 | 1.00 | | | | | | | | | | | | | | | | | | | | | | |
| Substantive Consultant | | | | | | | | | 2.00 | 2.00 | 2.00 | 2.00 | 4.00 | 4.00 | 4.00 | 4.00 | | 4.00 | 4.00 | 4.00 | 4.00 | 6.00 | 6.00 | 6.00 | 6.00 | 6.00 | 6.00 | 6.00 | 6.00 | |
| Locum Middle Grades | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Substantive Middle Grades | | | | | | | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | |
| Sub-total: Medics | 0.00 | 0.00 | 0.00 | | 0.00 | 1.00 | 5.00 | 5.00 | 6.00 | 6.00 | 6.00 | 6.00 | 8.00 | 8.00 | 8.00 | 8.00 | | 8.00 | 8.00 | 8.00 | 8.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | 10.00 | |
| Admin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Band 5 Risk & Governance Co-ordinator | 1.00 | 1.00 | 1.00 | | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | |
| Majors Clerk | 7.22 | 7.22 | 7.22 | | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | 7.22 | |
| Medical Secretary | | | | | | | | | 1.00 | 1.00 | 1.00 | 1.00 | 2.00 | 2.00 | 2.00 | 2.00 | | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | 2.00 | |
| Sub-total: Admin | 8.22 | 8.22 | 8.22 | | 8.22 | 8.22 | 8.22 | 8.22 | 9.22 | 9.22 | 9.22 | 9.22 | 10.22 | 10.22 | 10.22 | 10.22 | | 10.22 | 10.22 | 10.22 | 10.22 | 10.22 | 10.22 | 10.22 | 10.22 | 10.22 | 10.22 | 10.22 | 10.22 | |
| **Grand-total** | **15.35** | **20.35** | **25.35** | | **29.55** | **30.55** | **34.55** | **34.55** | **36.55** | **36.55** | **36.55** | **36.55** | **39.55** | **39.55** | **39.55** | **39.55** | | **39.55** | **39.55** | **39.55** | **39.55** | **41.55** | **41.55** | **41.55** | **41.55** | **41.55** | **41.55** | **41.55** | **41.55** | |
| **£000's** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nursing | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Trained Nursing | 11 | 22 | 33 | 66 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 504 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 42 | 504 |
| Untrained Nursing | 7 | 7 | 7 | 21 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 85 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 85 |
| Band 6 pay protection | 15 | 15 | 15 | 46 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 185 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 185 |
| Sub-total: Nursing | 33 | 44 | 55 | 133 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 774 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 65 | 774 |
| Medics | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Locum Consultant | 0 | 0 | 0 | 0 | 0 | 12 | 12 | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 35 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Substantive Consultant | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 23 | 23 | 23 | 23 | 46 | 46 | 46 | 46 | 276 | 46 | 46 | 46 | 46 | 69 | 69 | 69 | 69 | 69 | 69 | 69 | 69 | 736 |
| Locum Middle Grades | 70 | 70 | 70 | 210 | 70 | 70 | | | | | | | | | | | 140 | | | | | | | | | | | | | 0 |
| Substantive Middle Grades | | | | 0 | | | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 350 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 35 | 420 |
| Sub-total: Medics | 70 | 70 | 70 | 210 | 70 | 82 | 47 | 47 | 58 | 58 | 58 | 58 | 81 | 81 | 81 | 81 | 801 | 81 | 81 | 81 | 81 | 104 | 104 | 104 | 104 | 104 | 104 | 104 | 104 | 1,156 |
| Admin | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Band 5 Risk & Governance Co-ordinator | 3 | 3 | 3 | 8 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 30 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 30 |
| Majors Clerk | 15 | 15 | 15 | 44 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 176 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 176 |
| Medical Secretary | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 2 | 2 | 4 | 4 | 4 | 4 | 25 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 50 |
| Sub-total: Admin | 17 | 17 | 17 | 52 | 17 | 17 | 17 | 17 | 19 | 19 | 19 | 19 | 21 | 21 | 21 | 21 | 231 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 21 | 256 |
| **Grand-total** | **121** | **132** | **142** | **395** | **152** | **163** | **128** | **128** | **142** | **142** | **142** | **142** | **167** | **167** | **167** | **167** | **1,806** | **167** | **167** | **167** | **167** | **190** | **190** | **190** | **190** | **190** | **190** | **190** | **190** | **2,186** |

# EMERGENCY DEPARTMENT & PATIENT FLOW DASHBOARD - November 2012 - TRUST

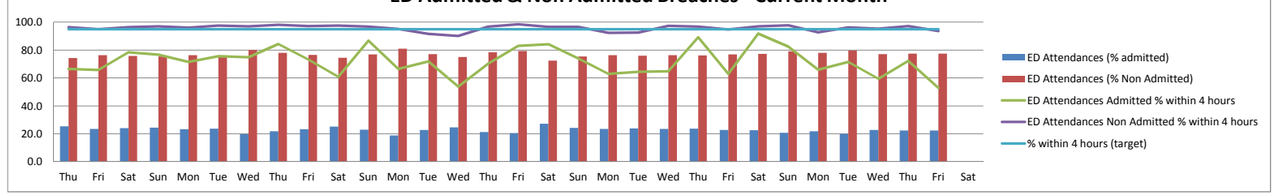
## Trust 4 hour target performance - Current Month



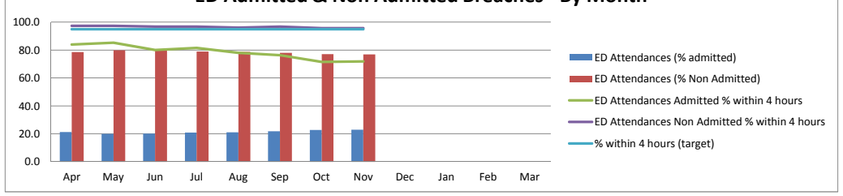

## Trust 4 hour target performance - By Month



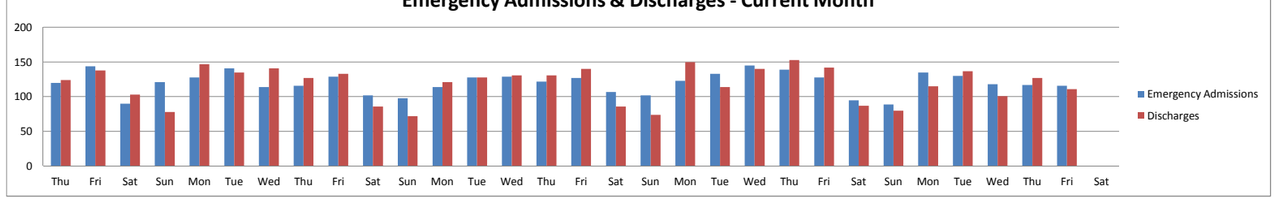

## ED Admitted & Non Admitted Breaches - Current Month



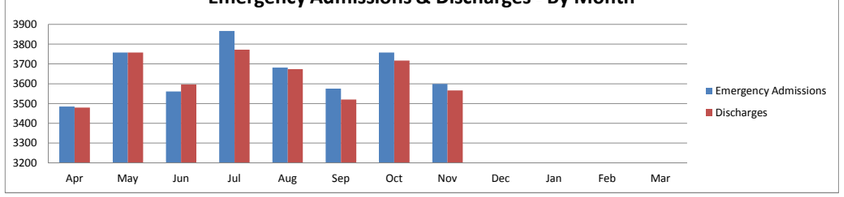

## ED Admitted & Non Admitted Breaches - By Month



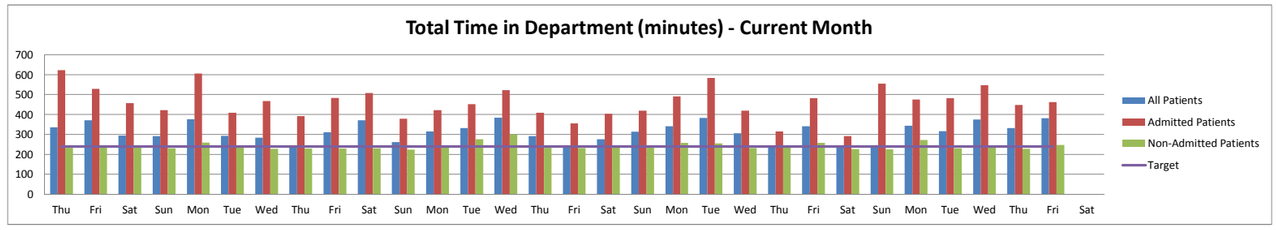

## Emergency Admissions & Discharges - Current Month



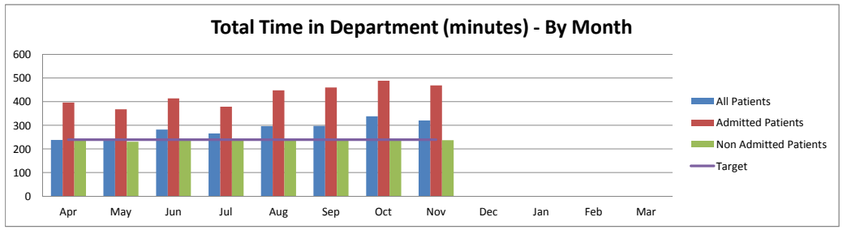

## Emergency Admissions & Discharges - By Month



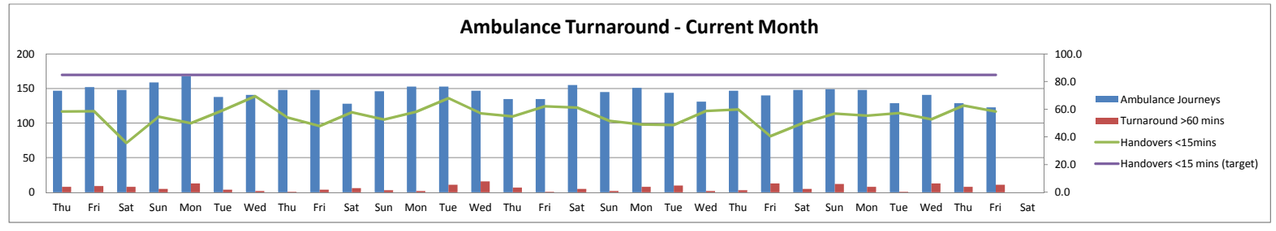

## Total Time in Department (minutes) - Current Month



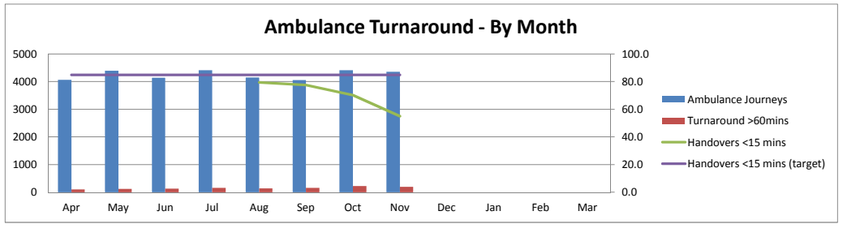

## Total Time in Department (minutes) - By Month



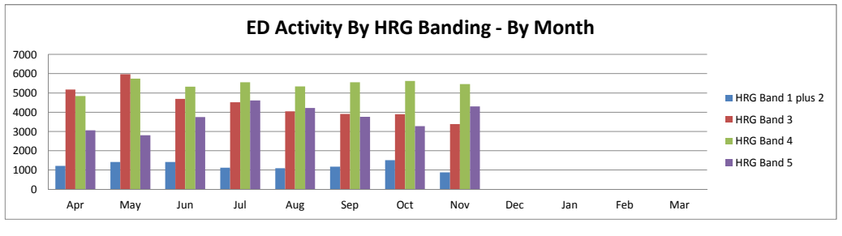

## Ambulance Turnaround - Current Month




## Ambulance Turnaround - By Month

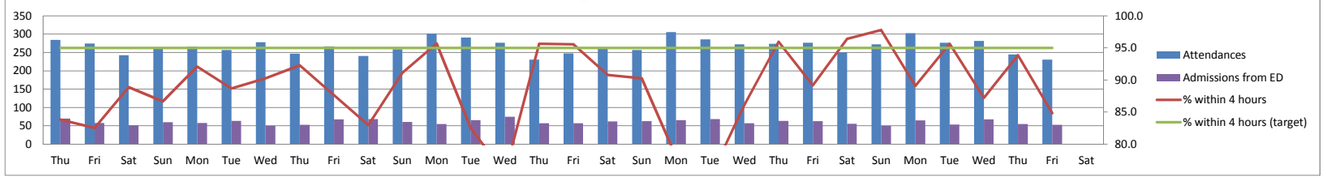



## ED Activity By HRG Banding - By Month

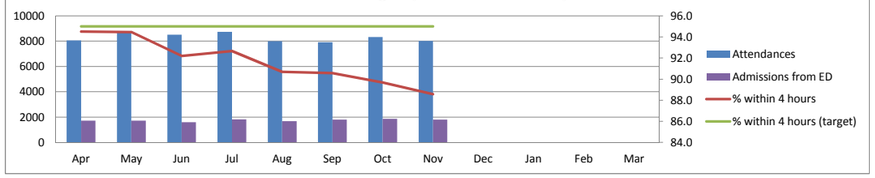


# EMERGENCY DEPARTMENT & PATIENT FLOW DASHBOARD - November 2012 - CITY HOSPITAL

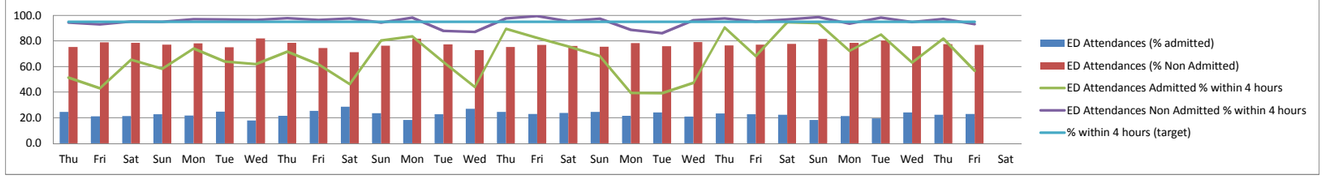
## Trust 4 hour target performance - Current Month



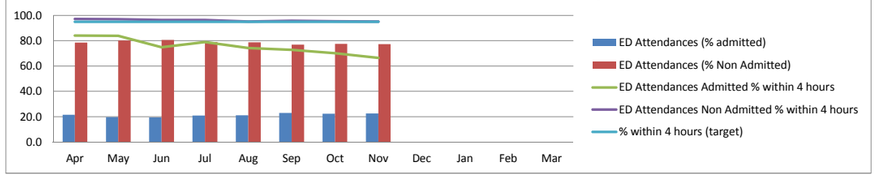

## Trust 4 hour target performance - By Month



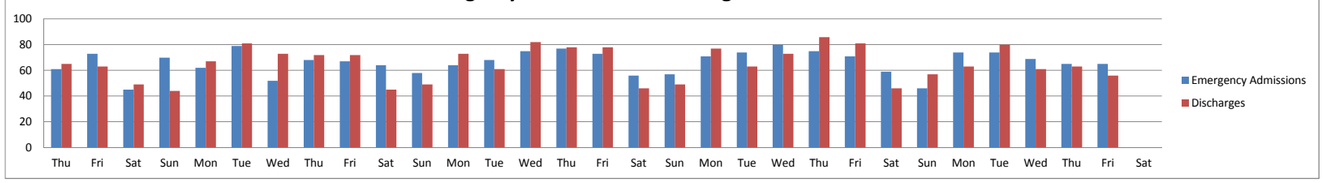

## ED Admitted & Non Admitted Breaches - Current Month



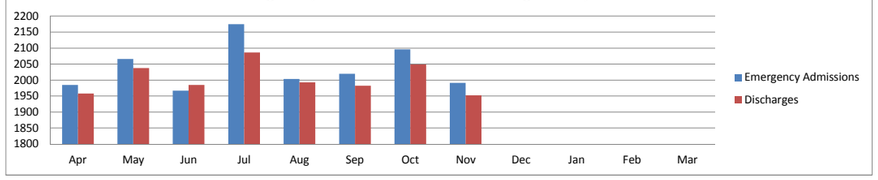

## ED Admitted & Non Admitted Breaches - By Month



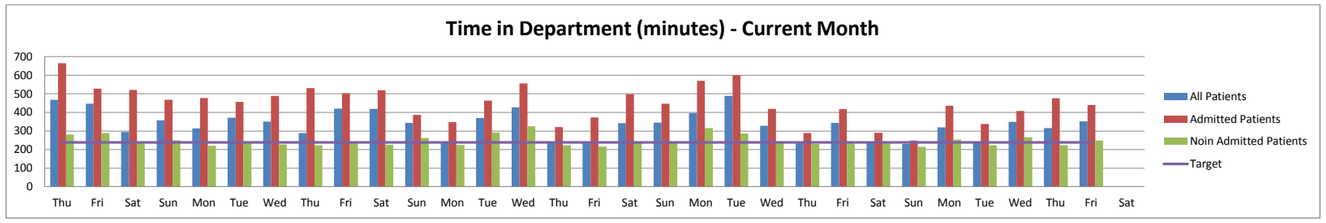

## Emergency Admissions & Discharges - Current Month



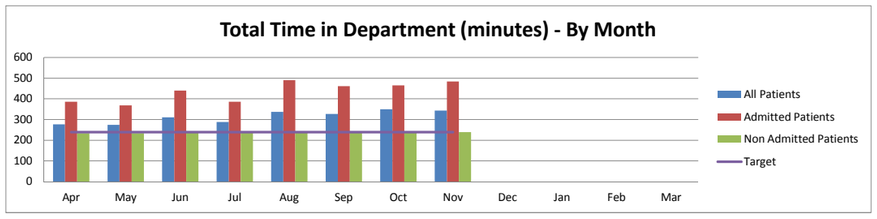

## Emergency Admissions & Discharges - By Month



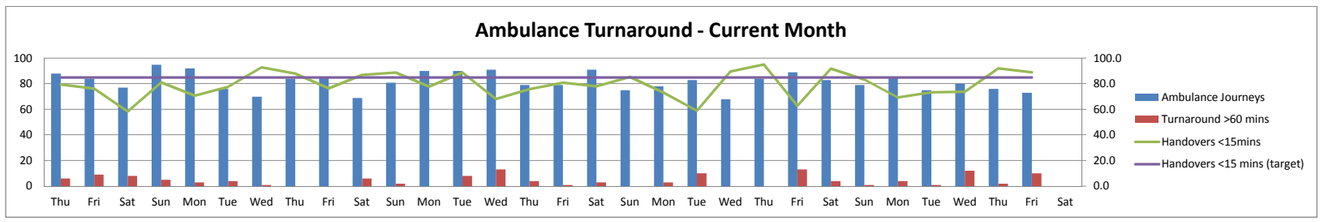

## Time in Department (minutes) - Current Month



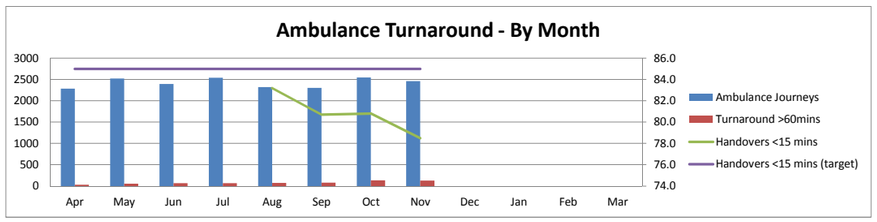

## Total Time in Department (minutes) - By Month




## Ambulance Turnaround - Current Month




## Ambulance Turnaround - By Month

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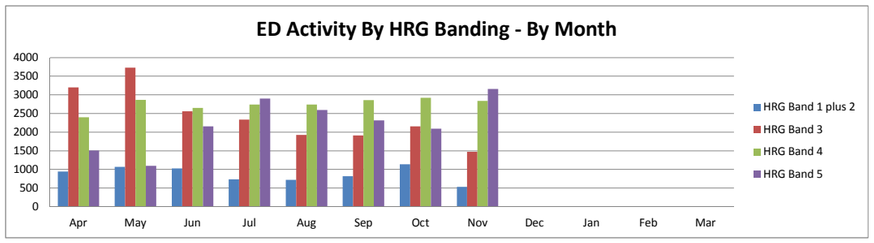
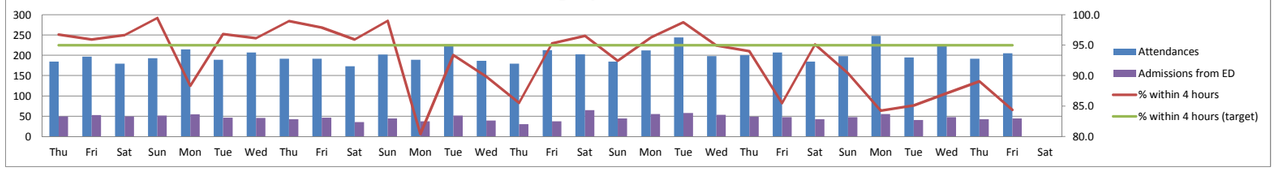
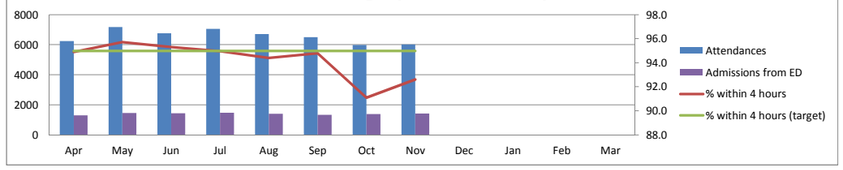


# EMERGENCY DEPARTMENT & PATIENT FLOW DASHBOARD - November 2012 - SANDWELL HOSPITAL

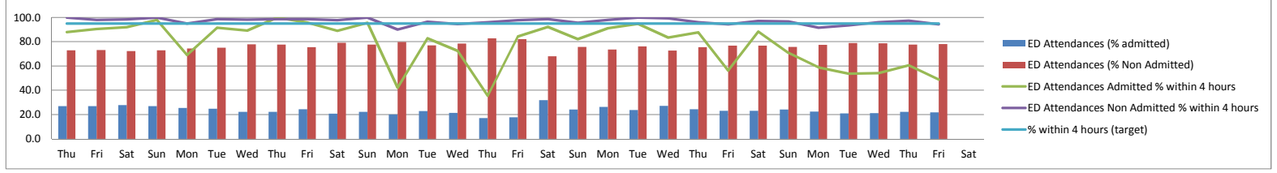
## Trust 4 hour target performance - Current Month




## Trust 4 hour target performance - By Month




## ED Admitted & Non Admitted Breaches - Current Month

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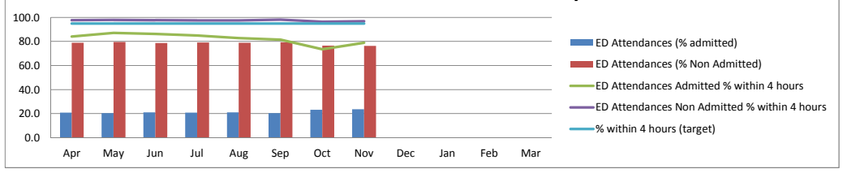
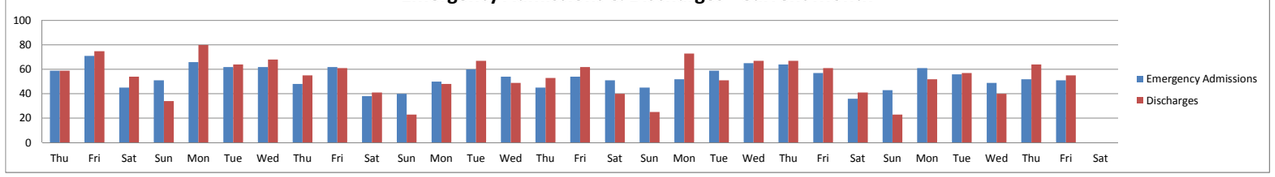
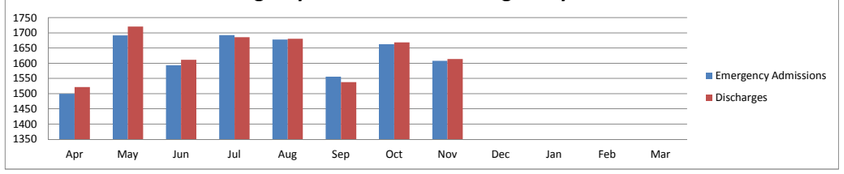


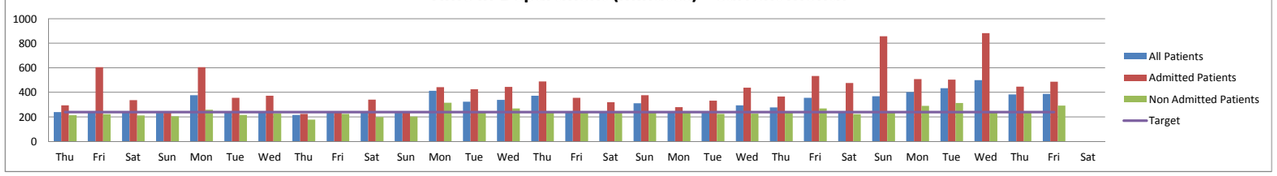

## Emergency Admissions & Discharges - Current Month




## Emergency Admissions & Discharges - By Month




## Time in Department (minutes) - Current Month

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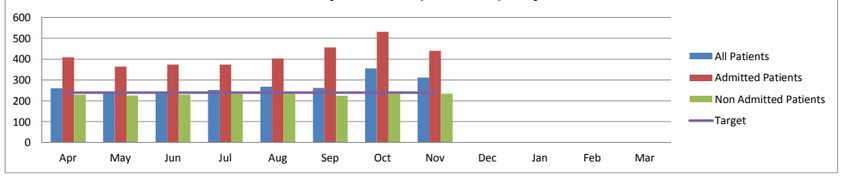
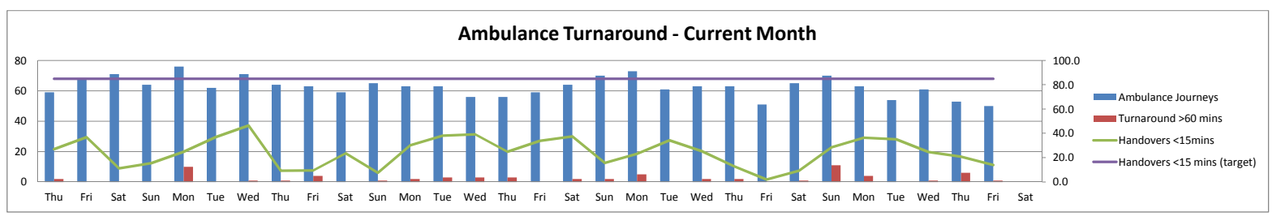
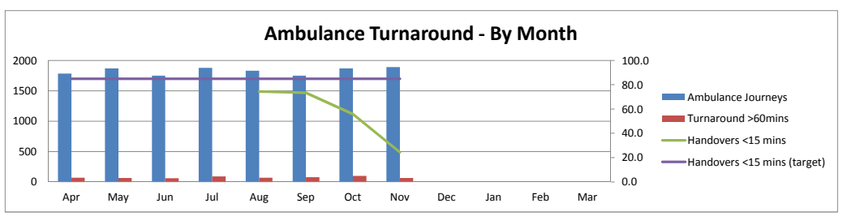



## Ambulance Turnaround - Current Month




## Ambulance Turnaround - By Month

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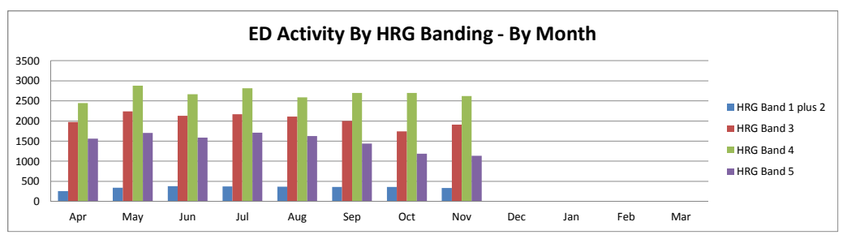


Sandwell and West Birmingham Hospitals NHS
NHS Trust

# TRUST BOARD

| | |
|---|---|
| **DOCUMENT TITLE:** | Annual Report on the Management of Fire Safety |
| **SPONSORING DIRECTOR:** | Graham Seager, Director of Estates/New Hospital Project Director |
| **AUTHOR:** | Rob Banks, Head of Estates |
| **DATE OF MEETING:** | 20 December 2012 |

**SUMMARY OF KEY POINTS:**

To provide the Trust Board with an annual update on all aspects of fire safety.

- Fire Safety Management
- Fire Safety Training
- Fire Safety Manuals
- Fire Precaution Works
- Fire Incidents and False Alarms
- Fire Safety Action Plan for 2011/12
- Fire Safety Action Plan for 2012/13
- Annual Statement of Fire Safety
- Recommendations

**PURPOSE OF THE REPORT** *(Indicate with 'x' the purpose that applies)*:

| Approval | Receipt and Noting | Discussion |
|---|---|---|
| **x** | **x** | |

**ACTIONS REQUIRED, INCLUDING RECOMMENDATION:**

The Board is asked to consider and approve the 2012 Annual report on the Management of Fire Safety. Annual statement of fire safety be duly completed, signed by the Chief Executive and forwarded to the Department of Health as required by the 31st January 2013

**ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:**

| | |
|---|---|
| Strategic objectives | Yes |
| Annual priorities | |
| NHS LA standards | Yes |
| Core Standards | Yes |
| Auditors' Local Evaluation | |

**IMPACT ASSESSMENT** *(Indicate with 'x' all those that apply in the second column)*:

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

**PREVIOUS CONSIDERATION:**

The Annual Report was considered and approved at the Trust Fire Safety Committee meeting in November 2012.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# 2012 Annual Report on the Management of Fire Safety

Rob Banks
Head of Estates
December 2012

# Table of Contents

**SUBJECT: Management of Fire Safety 2012**

## 1.0 INTRODUCTION

This report provides an overview of action taken in relation to the management of fire safety, fire safety training, fire precaution works, and a summary of fire incidents for the period 1st October 2011 to the 30th September 2012. It also identifies key issues facing the Trust and provides details of planned actions for the next twelve months.

We are pleased to report that once again a great deal of progress has been achieved during the reporting year and would like to recognise the continuing support of the Trust Fire Safety Committee and the efforts of the Fire Safety Team in the achievement of this progress.

## 2.0 FIRE SAFETY MANAGEMENT

### 2.1 Trust Fire Safety Management Arrangements

The Trust continues to work in line with the Department of Health Fire Code department (Fire Code – Fire Safety in the NHS, Health Technical Memorandum 05-01 "Managing Healthcare Fire Safety) and employs the services of an external Fire Safety Consultancy to fulfil the role of the Fire Safety Advisor.

### 2.2 Fire Safety Management Committee

Since its inauguration in September 2006, the Trust Fire Safety Committee has continued to meet on a regular basis. The Committee meet on a quarterly basis, having reduced from monthly frequency since September 2010..Monthly reports, including the detail of fire related incidents continue to be sent to FSC members, with written reports produced for each quarterly meeting.. All Fire Safety Committee meetings are formally recorded and resultant actions addressed.

### 2.3 Fire Safety Management Policy

The Trust's Fire Safety Management Policy was last reviewed in April 2012 and approved by the Trust Board in October 2012. The main changes to the policy were the inclusion of a section on the preparation of personal emergency evacuation plans for disabled persons and the restructuring of the document to meet the latest Trust standard for policies. The latest version of the Policy is available on the Trust Intranet.

The review process is in line with the Trust's policy approval and implementation process. The policy is next due for review in April 2015.

The Fire Safety Management Policy addresses many key issues including:-

- Trust organisation for fire safety
- Emergency Procedures
- Staff Training
- Specialist Role Fire Safety Training
- Fire Drills and Evacuation Simulation

2.4 West Midlands Fire Service (WMFS)

Attendance at false alarms

The WMFS continue to monitor the number of unwanted fire signals on Trust premises to which they receive calls, particularly at City Hospital. They are aware of the effort that the Trust puts in to investigating all fire calls and its commitment to reduce them. The WMFS have endorsed all of the preventative strategies employed by the Trust.

Last year, the fire and rescue service introduced a new approach to attending suspected false alarms. Their policy change was driven by the high number of false calls they received from all areas of the community, not just hospitals. While Sandwell General Hospital and Rowley Regis Hospital were unaffected by this policy change, at City Hospital, the fire service would only send an operationally effective response to confirmed fire calls or during the night-time. Rather than send fully crewed fire engines, they are sending only two fire-fighters in a light, non-operational vehicle. Their policy has now been extended to all of the Trust's inpatient sites.

Although the Fire Safety Committee had concerns that the fire and rescue service's failure to make a full operational attendance to one of our sites could, in certain circumstances, lead to difficulties, no such difficulties have so far been experienced. It remains essential that staff correctly identify the apparent cause of the operation of the fire alarm before passing information to switchboard who subsequently call the fire and rescue service.

Other matters

The Trust has continued to develop its close working relationship with the West Midlands Fire Service and has liaised frequently during the reporting period.

Though the Trust has had no audit visits from the WMFS during the reporting period, there have been several ad-hoc visits to site by WMFS officers at which they expressed their on-going satisfaction with our proactive approach to fire safety management and the standards of fire safety evident.

## 3.0 FIRE SAFETY TRAINING

The proactive approach to the management of Fire Safety within the Trust continues to be clearly demonstrated by its emphasis on staff training. Demanding targets were set for this reporting period and progress has been very good, however, achieving the targets has proven to be difficult.

The Fire Safety Team has maintained the range of training available to our staff, and our training content, delivery and effectiveness is kept under continual review.

3.1 The Structure of Fire Safety Training

Fire safety training in the Trust is heavily 'role' and 'location' based. All staff that could be in charge of a ward or department at the time of an incident receives role specific Fire Scene Manager training. Fire Response Team Leaders and Fire Safety Wardens also receive role specific training. All other staff must attend the general fire safety awareness training session.

Patient area staff must attend fire safety training annually. Following a review in 2010 of the frequency with which staff should attend fire safety training, it was agreed by the Fire Safety Committee (with the endorsement of Learning and Development) that non-patient area staff need only attend the general fire safety awareness and fire scene manager training once every 24 months. This allows the fire safety training team to concentrate more on the delivery of training to patient area staff.

The Estates fire safety training team deliver the following training modules:-

- Fire Safety Induction (mandatory)
- General Fire Safety Awareness (mandatory)
- Fire Scene Manager (mandatory)
- Fire Scene Manager Consolidation (non-mandatory)
- Fire Response Team Leader (mandatory)
- Fire Safety Warden (mandatory)
- Fire-fighting training for staff in very high dependency patient areas (non-mandatory)

Ad hoc induction and other training is provided for medical and nursing students, apprentices, and other groups that are not required to attend the Trust's formal induction training.

The transfer of staff from Sandwell PCT to SWBH as part of the Transforming Community Services has led to an additional training requirement. Former PCT staff are having their specific fire roles identified and training is being delivered at some of the PCT sites, concentrating on the larger more complex sites initially however training will be rolled out to all staff in due course.

Training is also provided to non-Trust staff (staff from other Trusts, for example) permanently based on the Trust's main sites.

3.2 Mandatory Fire Safety Training

Work continues with the Learning and Development Team to identify and develop the fire safety training requirements for all staff.

The following table indicates the number of staff having attended a mandatory training session during 2011/12 and compares attendance with 2009/10 and 2010/11.

| **Training module** | | **2009/10** | **2010/11** | **2011/12** |
|---|---|---|---|---|
| | | | | |
| Induction training | | 658 | 1022 | 610 |
| | | | | |
| General Fire Safety Awareness Training | | 3268 | 4490 | 4723 |
| | | | | |
| Fire Scene Manager Training | | 621 | 815 | 1073 |
| | | | | |
| Fire Response Team Leader Training | | 91 | 49 | 94 |
| | | | | |
| Fire Safety Warden Training | | 89 | 185 | 163 |
| | | | | |
| **TOTAL** | | **4727** | **6561** | **6592** |

With the exception of induction training, staff attendance at fire safety training increased last year by 10%, from 5539 (6561-1022) to 6053 (6592-610). The Trust's training compliance monitoring system (Safeguard) currently indicates a total of 5016 members of staff as being compliant, giving a compliance rate of 69%, this being a slight increase on last year's figure.

The table above indicates that 6592 staff attended a Trust fire safety training session, despite the system indicating a figure of only 5016 staff compliant. This variance is due to a number of staff having attended two training sessions within the reporting period, whilst others have attended a Fire Safety Awareness session rather than the higher level training required for their specific role.

The performance against targets for this reporting period is listed below:

| Training Module | Target No. | No. in date | % achievement |
|---|---|---|---|
| Fire Response Team Leader | 67 | 60 | 90 |
| Fire Scene Manager | 1360 | 1073 | 79 |
| Fire Safety Warden | 274 | 163 | 59 |
| General Fire Safety Awareness | 5982 | 5333 | 89 |

A separate risk assessment on the impact of this shortfall of training all of the patient area Fire Scene Managers has been conducted.

Of those staff undertaking the role of Fire Response Team Leader, 90% are within date regarding their training requirement. A further training session is scheduled to take place in November 2012 to involve those remaining out-of-date staff and those who have yet to attend their first such training session. Since August 2012 the range of staff undertaking the duty manager role has widened to include staff who have not previously acted in this role. Not all of these staff attended the courses that were available before the end of September, hence the additional training sessions being scheduled.

## 4.0 FIRE SAFETY MANUALS

4.1 Trust and Ward/Departmental Fire Safety Manuals

The Trust Fire Safety Manual and ward/department specific fire safety manuals continue to be developed and updated following their distribution throughout the Trust. The numerous departmental relocations taking place across the Trust's estate as part of the rationalization programme has made it difficult to keep up with the changes. As far as possible, fire safety manuals in patients areas are kept up to date and will continue to be amended as and when further relocations occur..

4.2 Fire Evacuation Strategy

An important part of the Fire Safety Manual is the Trust's Fire Evacuation Strategy. HTM05-01, Managing Healthcare Fire Safety, recommends the adoption of progressive horizontal evacuation for all inpatient and other critical areas.

Over recent years, the Trust has undertaken a considerable amount of structural work to provide the physical fire resisting sub-division within all of our buildings to facilitate horizontal evacuation of patients wherever possible. There are very few areas where further works are necessary

The local fire plans include evacuation procedures reflecting the individual needs of the patients.

## 5.0 FIRE PRECAUTION WORKS

Structural fire precautions

A prioritised schedule of fire precaution works to be undertaken during the reporting period was identified following detailed risk assessments.

Funding for these works was approved by SIRG from the Trust's capital programme statutory standards allocation and as a consequence the following works have been completed or are in progress and due for completion before 31st March 2013:

- New fire door sets installed to replace existing damaged/substandard door sets.
- Electromagnetic fire door hold open devices installed in various door locations.
- Replacement of contaminated smoke detectors and additional fire detection installed.
- Replacement of emergency lighting at City Hospital.
- New rear external fire escape to block 17 (former Theatres 4 and 5).

Operational measures

- Considerable work has been undertaken on replacing faulty or inappropriate automatic fire detectors at City Hospital and improving the Trust's fire alarm device disablement procedures. There are many reasons why detectors (and other fire alarm devices) have do be disabled, sometimes it is necessary to carry out construction work in areas covered by detectors, sometimes detectors go into fault towards the end of their operational life. The replacement of partially contaminated detectors and other disabled detectors has improved the reliability of the fire alarm system.

- Maintenance and testing procedures continue to be reviewed and improvements implemented.

## 6.0 FIRE INCIDENTS AND FALSE ALARMS

During this reporting period there have been 181 fire alarm activations across the Trust's main three sites compared with 170 for the previous period. (For the purpose of this report the guidance used by the Fire Service has been used to classify calls as either Fire Incidents or False Alarms). The Fire Service consider any fire event involving the production of flames, heat, or smoke which results in a financial or other loss; for example, the burning out of a light choke which did not result in the production of flames would be recorded by the fire and rescue service as a fire.

### Comparison of Fire Incidents and False Alarms 2009/10- 2010/11- 2011/12

| | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|
| False Alarms | 162 | 153 | 163 |
| Fire Incidents | 17 | 17 | 18 |
| **Total for Trust** | **179** | **170** | **181** |

6.1 Summary of false alarms

The figures above show a slight increase in the number of false alarms compared with the previous reporting period. This increase can be accounted for by the increase in accidental actuations of fire alarm call points, for which remedial action has recently been introduced.

Of the 163 false alarm calls in 2011/2012, the primary causes are as follows:-

| 2010/11 | 2011/2012 | Variation |
|---|---|---|
| 31 – accidental break glass | 44 – accidental break glass | +13 |

| | | |
|---|---|---|
| 31 – smell of burning | 39 – smell of burning | + 8 |
| 14 – contractors working practice | 8 – contractors working practice | -6 |
| 11 – deliberate actuation | 4 – deliberate actuation | -7 |
| 10 – cooking | 9 – cooking | -1 |
| 8 – cooking (toast) | 10 – cooking (toast) | +2 |

The Trust continued to be troubled by the accidental activation of fire alarm call points by patients or visitors attempting to leave the building by secure doors. Protective covers have now been provided at the most troublesome locations and initial indications point to this strategy proving successful in reducing accidental activations.

The number of false alarms due to cooking and the activity of contractors remain relatively low, but action is being taken to reduce them further (this includes staff training and the continued improvement of contractor management).

Staff are actively encouraged to raise the alarm if they smell smoke and our extensive Fire Safety Awareness training may result in staff being more proactive in reporting apparently minor events.

6.2 Summary of fire incidents

There were 18 fire incidents during the reporting period, compared with 17 last year.
Details of these are summarised as follows:-

Comparison table for 2010/11 and 2011/12

| 2010/2011 | 2011/2012 |
|---|---|
| • 7 – smoking related incidents (6 external, 1 internal) | • 4 – smoking related incidents (all external) |
| • 8 – related to a variety electrical equipment | • 6 – related to a variety electrical equipment |
| • 2 – related to cooking | • 2 – related to cooking |
| • 0 deliberately started fires | • 4 deliberately started fires |
| • | • 2 – related to the use of flammable liquids |

The Trust experiences only a very small number of minor fires. None of the incidents were significant or had an effect on patient care. None of the fires were reportable to the Department of Health. One of the small fires involving flammable liquids occurred in a theatre. The investigation into this incident continues.

All incidents are investigated thoroughly and monthly reports submitted to the Trust Fire Safety Committee.

6.3 Deliberately started fires (Arson)

One of the greatest risks to the Trust is the threat of deliberately started fires. Each year the main acute sites experience a small number of such fires. There were four deliberately started fires during the last reporting period – fortunately all were minor. The Trust adopts a number of arson avoidance strategies: avoiding arson is closely linked to building security, external storage of combustible materials is strictly controlled, and reducing the potential for arson is covered in our Fire Safety Awareness training. A Trust Health and Safety Notice: 'Reducing the Potential for Arson' was circulated to all senior managers for action in November 2011.

## 7.0 FIRE SAFETY ACTION PLAN FOR 2011/12

Performance against the planned targets was generally good with no significant shortfall. There was a small increase in the number of false alarms occurring on Trust premises. Fire safety training was delivered to a greater number of people than in previous years and good progress was made on fire safety improvements, detailed as follows:

- Improved awareness of fire safety management and practices throughout the Trust.
- Fire audits carried out in all patient areas.
- An increase in the number of Trust staff compliant with respect to fire safety training relating to their role.
- Completion of the structural and other fire improvements programme.
- Compliance with fire and rescue service expectations.
- Fire incidents continue to be fully investigated by a member of the Fire Safety Team

The Fire Safety Committee closely monitored performance against targets throughout the reporting period.

Whilst several of the issues continue as ongoing actions, the Fire Safety Action Plan for 2012/13 details the key fire safety issues facing the Trust in the coming year.

## 8.0 FIRE SAFETY ACTION PLAN FOR 2012/13

In addition to the appropriate and regular maintenance of fire precautions, there are a number of key fire safety issues facing the Trust in the coming year as can be seen in the following action plan for 2012/13, summarised as follows :-

- Review all fire training course content and objectives
- Deliver the general fire safety awareness training to all new staff at induction.
- Deliver the general fire safety awareness training at pre-booked twice weekly sessions.
- Deliver initial and refresher training to all Fire Safety Wardens.
- Deliver training to ‘patient’ and ‘non-patient’ area Fire Scene Managers.
- Deliver training to Fire Response Team Leaders as necessary.
- Investigate and report on all fire alarm activations
- Reduce false alarms.
- Reduce the number of fire incidents
- Develop and undertake further practical exercises at each hospital.
- Maintain and update Fire Safety Manuals
- Update fire safety audits.
- Continue with programme of fire precaution works.

# Fire Safety Action Plan 2012/13

| Task/Action | Key action(s) required | Completion date | Lead | Potential constraints and solutions | Intended outcome / measure of success | Status |
|---|---|---|---|---|---|---|
| Fire Training | Review of training<br><br>Review all fire safety training, making recommendations for improved measurable objectives, course content, and course duration. | March 2013 | PB | | Revised course objectives, contents, and duration.<br><br>Contribution to improved course attendance.<br><br>Improved fire safety procedures. | |
| | Induction training<br><br>Deliver the General Fire Safety Awareness training module to all induction courses. | Ongoing | PB | Fire safety trainer staffing levels to be maintained. | All new staff receive General Fire Safety Awareness training.<br><br>All new staff are aware of SWBH fire procedures. | |
| | General fire safety awareness training<br><br>To deliver general fire safety awareness training as required for the weekly Tuesday and Thursday pre-booked sessions and to respond to requests for the training to be delivered in workplaces as required. | Ongoing | PB | Fire safety trainer staffing levels to be maintained.<br><br>Trust staff to be released for training. | 90% of relevant staff to receive General Fire Safety Awareness training. | |

| Task/Action | Key action(s) required | Completion date | Lead | Potential constraints and solutions | Intended outcome / measure of success | Status |
|---|---|---|---|---|---|---|
| Fire Training | Fire Safety Warden Training<br><br>All fire safety wardens to receive initial or refresher training. | Ongoing | PB | Fire safety trainer staffing levels to be maintained.<br><br>Trust staff to be released for training. | 90% of relevant staff to receive General Fire Safety Warden training. | |
| | Fire Scene Manager Training<br><br>All patient area Fire Scene Managers trained as necessary within reporting year. | September 2013 | PB | Fire safety trainer staffing levels to be maintained.<br><br>Trust staff to be released for training. | 90% of patient area Fire Scene Managers trained as necessary. | |
| | All non-patient area Fire Scene Managers trained as necessary within reporting year. (Non-patient Fire Scene Managers receive training only every two years.) | September 2013 | PB | Fire safety trainer staffing levels to be maintained.<br><br>Trust staff to be released for training. | 45% of non-patient area Fire Scene Managers trained as necessary. | |
| | Fire Response Team Leader Training<br><br>To provide initial or refresher training to all Fire Response Team Leaders as necessary in order to fulfil duties in accordance with Fire Safety Management Policy. | September 2013 | PB | Fire safety trainer staffing levels to be maintained.<br><br>Trust staff to be released for training. | 100% of Fire Response Team Leaders trained as necessary. | |
| | Fire Fighting Training – Selected Staff<br><br>Staff in High Dependency Wards to receive refresher training in first action fire fighting techniques. | September 2013 | PB | Fire safety trainer staffing levels to be maintained.<br><br>Trust staff to be released for training. | 50% of all staff in High Dependency Wards received refresher training in first action fire fighting techniques. (This is not presently mandatory training) | |

| Task/Action | Key action(s) required | Completion date | Lead | Potential constraints and solutions | Intended outcome / measure of success | Status |
|---|---|---|---|---|---|---|
| False Alarms and Fires | Investigate and report on all fire alarm actuations. | Ongoing | PB | Incident report forms not completed by relevant staff. | Reduced risk to patients, staff, and visitors.<br><br>Fewer fires and false alarms.<br><br>Reduced attendances of fire and rescue service.<br><br>All fire related incidents reported to FSMC members on a monthly basis. | |
| | Reduce false alarms. | September 2013 | PB | Failure to influence behaviours of staff and contractors in avoiding unwanted fire signals through training and procedures. | A reduction by 10% of false alarms on previous reporting period. | |
| | Reduce the number of fire incidents | September 2013 | PB | Failure to influence behaviours of staff and contractors in avoiding fires through training and procedures.<br><br>Failure to manage equipment and services that can present an ignition source.<br><br>Failure to implement arson prevention strategy. | Reduced risk to patients, staff, and visitors.<br><br>Reduce fire incidents by 15% on previous reporting period.<br><br>Reduced attendances of fire and rescue service. | |

| Task/Action | Key action(s) required | Completion date | Lead | Potential constraints and solutions | Intended outcome / measure of success | Status |
|---|---|---|---|---|---|---|
| Fire Drill Exercises | Develop and undertake two practical exercises at City to test the Trust's fire response procedures. | September 2013 | PB | Resources; availability of ward areas for the exercise to be undertaken. | Fire drills and exercises undertaken and reviewed. | |
| | Develop and undertake two practical exercises at SGH to test the Trust's fire response procedures. | September 2013 | PB | Resources; availability of ward areas for the exercise to be undertaken. | Fire drills and exercises undertaken and reviewed. | |
| | Develop and undertake one practical exercises at RR to test the Trust's fire response procedures. | September 2013 | PB | Resources; availability of ward areas for the exercise to be undertaken. | Fire drills and exercises undertaken and reviewed. | |
| Ward/Department Fire Safety Manuals | Maintain and update Fire Safety Manuals to all wards/ departments as appropriate. | Ongoing. | PB | | Fire safety manuals maintained and updated. | |
| Fire Safety Audits | Update Fire Safety Audits of all Trust premises. | Sept 2013 | PB | | Fire safety audits updated. | |
| Fire Precaution Works | Continue with the Fire Precaution Works in accordance with the current Action Plans:-<br><br>2012/13 | Ongoing. | PF | Funding approved from capital programme<br><br>Access to ward and other patient areas to undertake works.<br><br>No ward decant facilities. | All planned works completed.<br><br>Report to FSC and SIRG. | |

The Fire Safety Manager and the Fire Safety Management Committee will monitor progress against all actions during the coming year

## 9.0 ANNUAL STATEMENT OF FIRE SAFETY

Following fire risk assessment the organisation has developed a programme of work to eliminate or reduce to a reasonably practicable level the significant fire risks identified by the fire risk assessment.

There is an annual requirement for all NHS organisations to submit a declaration of fire safety for all premises. This was completed, signed by the Chief Executive and submitted to the Department of Health by the 31st January 2012 as required.

The annual statement for this year is required to be submitted by the 31st January 2013, a copy of which is as follows:

# Annual Statement of Fire Safety 2012

| | | |
|---|---|---|
| NHS Organisation Code: | Sandwell & West Birmingham Hospitals NHS Trust | |
| I confirm that for the period 1st January 2012 to 31st December 2012, all premises which the organisation owns, occupies or manages, have fire risk assessments that comply with the Regulatory Reform (Fire Safety) Order 2005, and (*please tick the appropriate boxes*): | | |
| 1 | There are no significant risks arising from the fire risk assessments. | |
| **OR** 2 | The organisation has developed a programme of work to eliminate or reduce as low as reasonably practicable the significant fire risks identified by the fire risk assessment. | ✓ |
| **OR** 3 | The organisation has identified significant fire risks, but does **NOT** have a programme of work to mitigate those significant fire risks.* | |
| *Where a programme to mitigate significant risks **HAS NOT** been developed, please insert the date by which such a programme will be available, taking account of the degree of risk. Date: | | |
| 4 | During the period covered by this statement, has the organisation been subject to any enforcement action by the Fire & Rescue Authority? **(Delete as appropriate)** If Yes - Please outline details of the enforcement action in Annex A – **Part 1**. | No |
| 5 | Does the organisation have any unresolved enforcement action pre-dating this Statement? **(Delete as appropriate)** If Yes Please outline details of unresolved enforcement action in Annex A – **Part 2.** | No |
| **AND** 6 | The organisation achieves compliance with the Department of Health Fire Safety Policy, contained within HTM 05-01, by the application of Firecode or some other suitable method. | Yes |
| Fire Safety Manager | Name: Robert Banks | |
| | E-mail: rbanks@nhs.net | |
| Contact details: | Telephone: 0121 507 5342 | |
| | Mobile: | |
| Chief Executive Name: | | |
| Signature of Chief Executive: | | |
| Date: | | |
| Completed Statement to be forwarded to the NHS Information Centre to arrive no later than **31st January 2013** | | |

## 10.0 RECOMMENDATIONS

Board members are asked to:-

- Note and approve this Report
- Confirm that the Annual Statement of fire safety can be duly completed, signed by the Chief Executive and forwarded to the Department of Health as required by the 31st January 2013.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# TRUST BOARD

| | |
|---|---|
| **DOCUMENT TITLE:** | Financial Performance Report – November 2012 |
| **SPONSOR (EXECUTIVE DIRECTOR):** | Robert White, Director of Finance and Performance Management |
| **AUTHOR:** | Robert White/Tony Wharram |
| **DATE OF MEETING:** | 20 December 2012 |

**EXECUTIVE SUMMARY:**

The report presents the financial performance for the Trust and operational divisions for the period to 30th November 2012.

Measured against the DoH target, the Trust generated an actual surplus of £550,000 during November against a planned surplus of £470,000. For the purposes of its statutory accounts, the in month surplus was slightly higher at £579,000.

**REPORT RECOMMENDATION:**

The Finance & Performance Management Committee 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:**

Monthly at Performance Management Board and Finance & Performance Management Committee.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

# Financial Performance Report – November 2012

## EXECUTIVE SUMMARY

**• For the month of November 2012, the Trust delivered a "bottom line" surplus of £550,000 compared to a planned surplus of £470,000 (as measured against the DoH performance target).**

**• For the year to date, the Trust has produced a surplus of £2,251,000 compared with a planned surplus of £1,840,000 so generating an positive variance from plan of £411,000.**

**• 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 220 below planned levels. After taking account of the impact of agency staff, WTE's were 63 below plan. Total pay expenditure for the month, inclusive of agency costs, is £593,000 below the planned level.**

**• The month-end cash balance was approximately £23m 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 | 80 | 411 | >= Plan | > = 99% of plan | < 99% of plan |
| EBITDA Actual v Plan £000 | 97 | 371 | >= Plan | > = 99% of plan | < 99% of plan |
| Pay Actual v Plan £000 | 593 | 1,230 | <=Plan | < 1% above plan | > 1% above plan |
| Non Pay Actual v Plan £000 | (479) | (3,063) | <= Plan | < 1% above plan | > 1% above plan |
| WTEs Actual v Plan | 63 | 31 | <= Plan | < 1% above plan | > 1% above plan |
| Cash (incl Investments) Actual v Plan £000 | 23,138 | 23,138 | >= 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 | 1,840 | 2,251 |
| Capital Resource Limit | 11,135 | 4,601 |
| External Financing Limit | --- | 23,138 |
| Return on Assets Employed | 3.50% | 3.50% |

| 2011/2012 Summary Income & Expenditure Performance at November 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 | 383,695 | 32,799 | 33,067 | 268 | 256,879 | 258,952 | 2,073 | 388,220 |
| Other Income | 38,508 | 3,308 | 3,023 | (285) | 25,804 | 25,935 | 131 | 39,466 |
| Operating Expenses | (395,584) | (33,737) | (33,623) | 114 | (265,639) | (267,472) | (1,833) | (399,206) |
| EBITDA | 26,619 | 2,370 | 2,467 | 97 | 17,044 | 17,415 | 371 | 28,480 |
| Interest Receivable | 100 | 8 | 8 | 0 | 67 | 91 | 24 | 144 |
| Depreciation & Amortisation | (14,738) | (1,228) | (1,250) | (22) | (9,826) | (9,848) | (22) | (14,738) |
| PDC Dividend | (5,594) | (466) | (466) | 0 | (3,730) | (3,730) | 0 | (5,594) |
| Interest Payable | (2,157) | (185) | (180) | 5 | (1,479) | (1,441) | 38 | (2,162) |
| **Net Surplus/(Deficit)** | **4,230** | **499** | **579** | **80** | **2,076** | **2,487** | **411** | **6,130** |
| IFRS/Impairment/Donated Asset Related Adjustments | (353) | (29) | (29) | 0 | (236) | (236) | 0 | (353) |
| **SURPLUS/(DEFICIT) FOR DOH TARGET** | **3,877** | 470 | 550 | **80** | **1,840** | **2,251** | **411** | **5,777** |

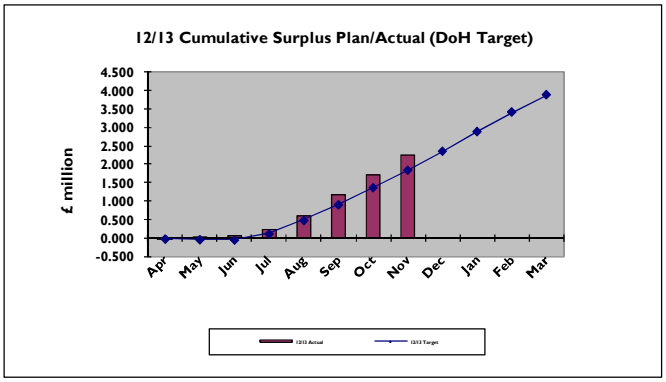
**The Trust's financial performance is monitored against the DoH target shown in the bottom line of the above table. IFRS and impairment adjustments are technical, non cash related items which are discounted when assessing performance against this target.**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# Financial Performance Report – November 2012

**Overall Performance Against Plan**

• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph. Net bottom-line performance delivered an actual surplus of £550,000 in November against a planned surplus of £470,000. The resultant £80,000 positive variance moves the year to date position to £411,000 above targeted levels.



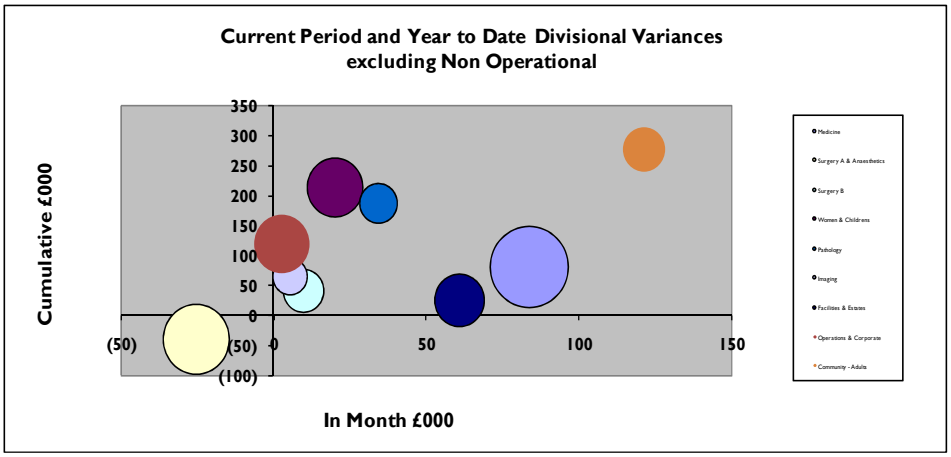

**Divisional Performance**

• For November, there are again no major variances from plan among operational divisions with only Surgery A posting a small in month deficit of £25k.

• 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 October 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 Surgery A and Facilities continue to have relatively small adverse variances.



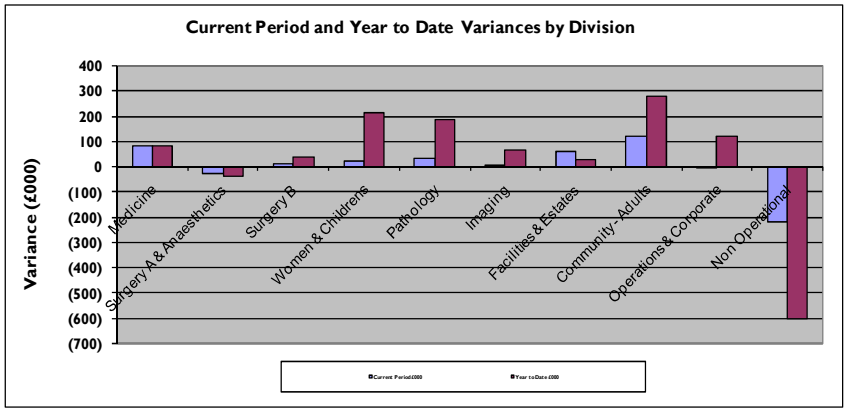

The tables adjacent and below show small adverse year to date variance for Surgery A and Facilities (although the latter is combined with Estates in the adjacent graph and shows a small year to date surplus).

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# Financial Performance Report – November 2012

**Divisional Variances from Plan**

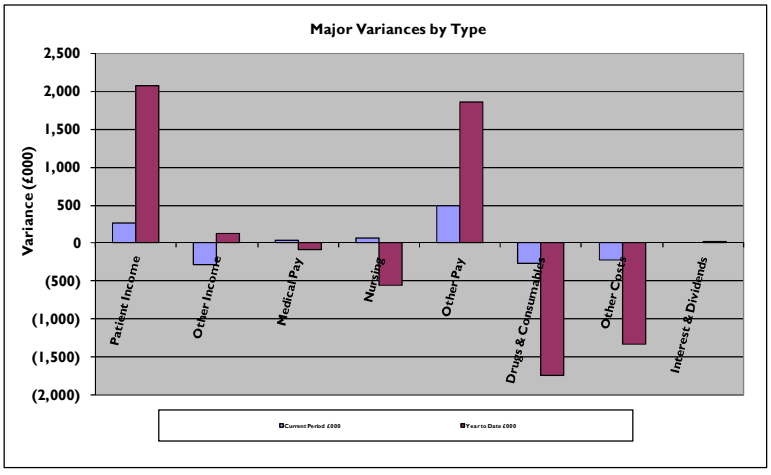
| | Current Period £000 | Year to Date £000 |
|---|---|---|
| Medicine | 84 | 81 |
| Surgery A & Anaesthetics | (25) | (39) |
| Surgery B | 10 | 41 |
| Women & Childrens | 20 | 213 |
| Pathology | 35 | 186 |
| Imaging | 6 | 65 |
| Facilities & Estates | 61 | 26 |
| Community - Adults | 121 | 278 |
| Operations & Corporate | 3 | 120 |
| Non Operational | (218) | (602) |




For November, patient related SLA income again shows a positive variation from plan . ICR charges also remain above plan. The small net adverse in month performance for income is largely the result of a one off adjustment in respect of donated asset income and the underlying performance remains strong. Overall pay expenditure is below planned levels particularly with the scientific, therapeutic & technical and HCA and support pay groups at £168k and £139k lower than plan respectively. Overall non pay expenditure is £479,000 higher than plan in month, largely in respect of drugs (which are largely matched by income), medical consumables and external services costs.

**Variance From Plan by Expenditure Type**

| | Current Period £000 | Year to Date £000 |
|---|---|---|
| Patient Income | 268 | 2,073 |
| Other Income | (285) | 131 |
| Medical Pay | 34 | (82) |
| Nursing | 67 | (555) |
| Other Pay | 492 | 1,867 |
| Drugs & Consumables | (264) | (1,739) |
| Other Costs | (215) | (1,324) |
| Interest & Dividends | 0 | 24 |



Sandwell and West Birmingham Hospitals NHS
NHS Trust

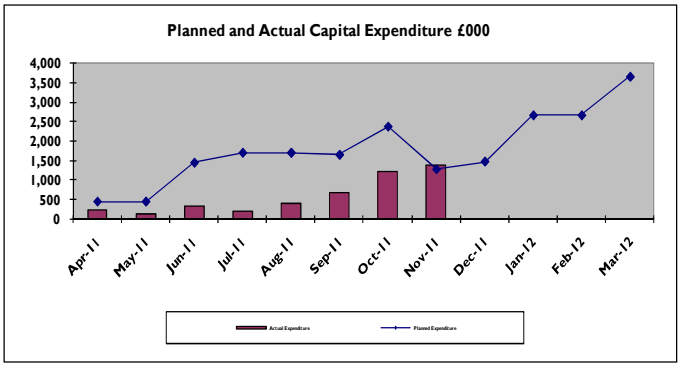
# Financial Performance Report – November 2012

## Capital Expenditure

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

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

• For the year to date, actual expenditure is approximately £4.6m primarily related to statutory standards , estates rationalisation , pathology reconfiguration and medical equipment.

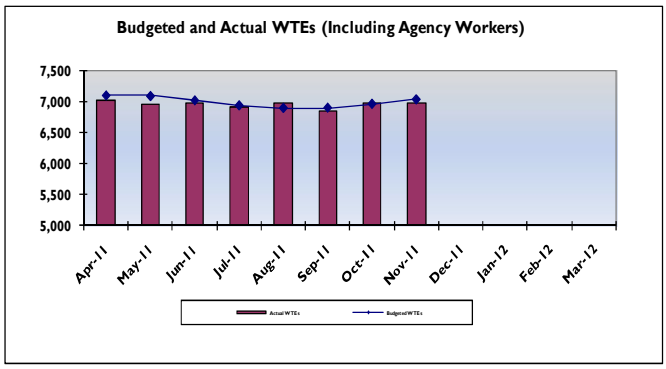


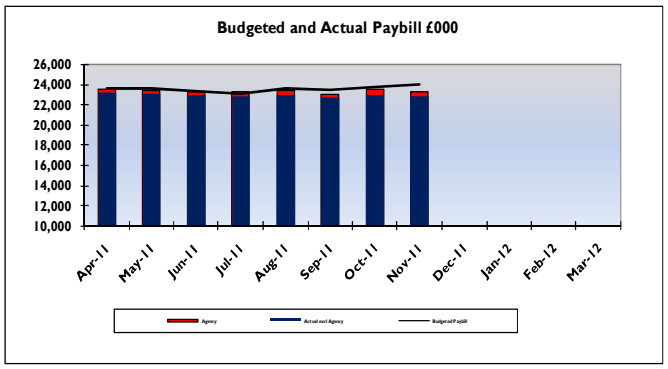

## Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 63 below plan compared with 16 above plan for October. Excluding the impact of agency staff, wte numbers are around 220 below plan. Actual wte's have fallen by 7 compared with October and the widening of the gap between planned and actual expenditure reflects the addition of resources, particularly into the Medicine and Emergency Care budget, to reflect additional capacity and winter pressures but which has not yet been matched by the same level of expenditure.

• Total pay costs (including agency workers) are £593,000 lower than budgeted levels for the month , particularly within the scientific, therapeutic & technical and HCA and support pay groups.

• Expenditure for agency staff in November was £573,000 compared with £552,000 in October, an average of £526,000 for 2011/12 and a November 2011 spend of £316,000. The biggest single group accounting for agency expenditure remains medical staffing.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

# Financial Performance Report – November 2012

## Pay Variance by Pay Group

• The table below provides an analysis of all pay costs by major staff category with actual expenditure analysed for substantive, bank and agency costs.

**Analysis of Total Pay Costs by Staff Group**

| | Year to Date to November | | | | | |
|---|---|---|---|---|---|---|
| | | Actual | | | | |
| | Budget £000 | Substantive £000 | Bank £000 | Agency £000 | Total £000 | Variance £000 |
| Medical Staffing | 50,104 | 48,106 | | 2,080 | 50,186 | (82) |
| Management | 10,313 | 9,562 | | 0 | 9,562 | 751 |
| Administration & Estates | 20,702 | 19,223 | 899 | 342 | 20,465 | 237 |
| Healthcare Assistants & Support Staff | 20,889 | 19,031 | 1,852 | 14 | 20,897 | (8) |
| Nursing and Midwifery | 57,133 | 54,363 | 2,500 | 825 | 57,688 | (555) |
| Scientific, Therapeutic & Technical | 29,052 | 27,809 | | 411 | 28,220 | 832 |
| Other Pay | 69 | 14 | | | 14 | 55 |
| Total Pay Costs | 188,262 | 178,109 | 5,250 | 3,673 | 187,032 | 1,230 |

**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 30th November are approximately £47m which is around £12.5m higher than at 31st March and £3.0m lower than in October, primarily the result of the receipt of a number of one off payments in October rather than spread over a longer period.

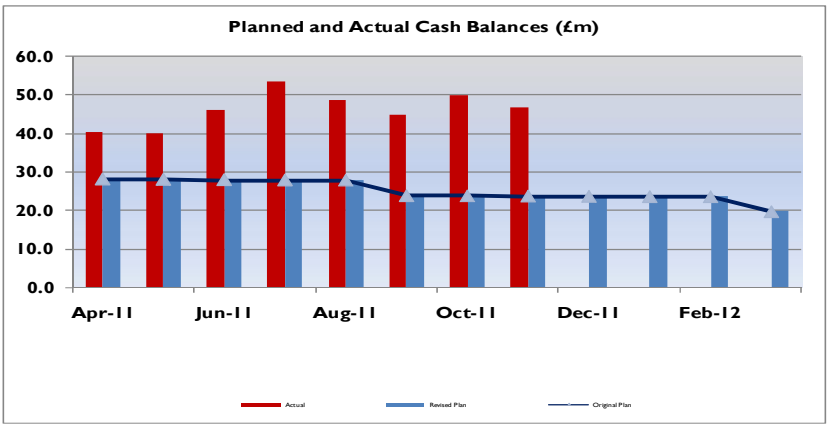
**Sandwell & West Birmingham Hospitals NHS Trust**
**STATEMENT OF FINANCIAL POSITION 2012/2013**

| | | Opening Balance as at 1st April 2012 £000 | Balance as at end November 2012 £000 | Forecast at 31st March 2013 £000 |
|---|---|---|---|---|
| **Non Current Assets** | Intangible Assets | 1,075 | 955 | 1,125 |
| | Tangible Assets | 227,072 | 221,322 | 228,882 |
| | Investments | 0 | 0 | 0 |
| | Receivables | 865 | 865 | 950 |
| **Current Assets** | Inventories | 4,065 | 4,055 | 4,050 |
| | Receivables and Accrued Income | 14,446 | 16,583 | 13,500 |
| | Investments | 0 | 0 | 0 |
| | Cash | 34,465 | 46,961 | 26,310 |
| **Current Liabilities** | Payables and Accrued Expenditure | (33,751) | (45,608) | (32,488) |
| | Loans | (2,000) | (2,000) | (2,000) |
| | Borrowings | (1,166) | (1,166) | (1,221) |
| | Provisions | (15,649) | (12,672) | (10,389) |
| **Non Current Liabilities** | Payables and Accrued Expenditure | 0 | 0 | 0 |
| | Loans | (5,000) | (4,000) | (3,000) |
| | Borrowings | (29,995) | (29,356) | (28,969) |
| | Provisions | (2,532) | (2,532) | (1,600) |
| | | 191,895 | 193,407 | 195,150 |
| **Financed By** | | | | |
| **Taxpayers Equity** | Public Dividend Capital | 160,231 | 160,231 | 160,231 |
| | Revaluation Reserve | 41,228 | 40,253 | 40,253 |
| | Other Reserves | 9,058 | 9,058 | 9,058 |
| | Income and Expenditure Reserve | (18,622) | (16,135) | (14,392) |
| | | 191,895 | 193,407 | 195,150 |

Sandwell and West Birmingham Hospitals NHS

NHS Trust

# Financial Performance Report – November 2012




## 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 November 2012**

| ACTUAL/FORECAST | 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 | Nov-13 £000s |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Receipts | | | | | | | | | | | | | |
| SLAs: Black Country Cluster | **16,459** | 17,747 | 17,165 | 17,165 | 17,165 | 16,993 | 16,993 | 16,993 | 16,993 | 16,993 | 16,993 | 16,993 | 16,993 |
| Birmingham & Solihull Cluster | **11,334** | 11,341 | 11,341 | 11,341 | 11,341 | 11,228 | 11,228 | 11,228 | 11,228 | 11,228 | 11,228 | 11,228 | 11,228 |
| Other Clusters | **429** | 629 | 629 | 629 | 629 | 623 | 623 | 623 | 623 | 623 | 623 | 623 | 623 |
| Pan Birmingham LSCG | **1,944** | 1,944 | 1,944 | 1,944 | 1,944 | 1,925 | 1,925 | 1,925 | 1,925 | 1,925 | 1,925 | 1,925 | 1,925 |
| Education & Training | | | 4,347 | | | 4,300 | 0 | 0 | 4,300 | 0 | 0 | 4,300 | 0 |
| Loans | | | | | | | | | | | | | |
| Other Receipts | **767** | 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 | **30,933** | 34,561 | 38,326 | 33,979 | 33,979 | 37,968 | 33,668 | 33,668 | 37,968 | 33,668 | 33,668 | 37,968 | 33,668 |
| Payments | | | | | | | | | | | | | |
| Payroll | **13,699** | 13,215 | 13,215 | 13,215 | 13,214 | 13,068 | 13,068 | 13,068 | 13,068 | 13,068 | 13,068 | 13,068 | 13,068 |
| Tax, NI and Pensions | **9,332** | 9,556 | 19,111 | 9,556 | 9,555 | 9,455 | 9,455 | 9,455 | 9,455 | 9,455 | 9,455 | 9,455 | 9,455 |
| Non Pay - NHS | **2,500** | 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 | **6,904** | 5,361 | 8,995 | 8,314 | 8,202 | 8,000 | 7,500 | 7,500 | 7,500 | 7,500 | 7,500 | 7,500 | 7,500 |
| Non Pay - Capital | **915** | 1,775 | 1,975 | 4,665 | 4,970 | 1,750 | 1,750 | 500 | 500 | 500 | 500 | 500 | 500 |
| PDC Dividend | | | | | 2,797 | | | | | | 2,700 | | |
| Repayment of Loans | | | | | 1,000 | | | | | | 1,000 | | |
| Interest | | | | | 25 | | | | | | 20 | 20 | 20 |
| BTC Unitary Charge | **387** | 416 | 416 | 416 | 832 | 430 | 430 | 430 | 430 | 430 | 430 | 430 | 430 |
| Other Payments | **175** | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 | 175 |
| Total Payments | **33,912** | 32,998 | 46,387 | 38,841 | 43,270 | 35,378 | 34,878 | 33,628 | 33,628 | 33,628 | 37,348 | 33,648 | 33,648 |
| Cash Brought Forward | **49,940** | 46,961 | 48,524 | 40,463 | 35,601 | 26,310 | 28,901 | 27,691 | 27,732 | 32,073 | 32,114 | 28,434 | 32,755 |
| Net Receipts/(Payments) | **(2,979)** | 1,563 | (8,061) | (4,862) | (9,291) | 2,591 | (1,209) | 41 | 4,341 | 41 | (3,679) | 4,321 | 21 |
| Cash Carried Forward | **46,961** | 48,524 | 40,463 | 35,601 | 26,310 | 28,901 | 27,691 | 27,732 | 32,073 | 32,114 | 28,434 | 32,755 | 32,776 |

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# Financial Performance Report – November 2012

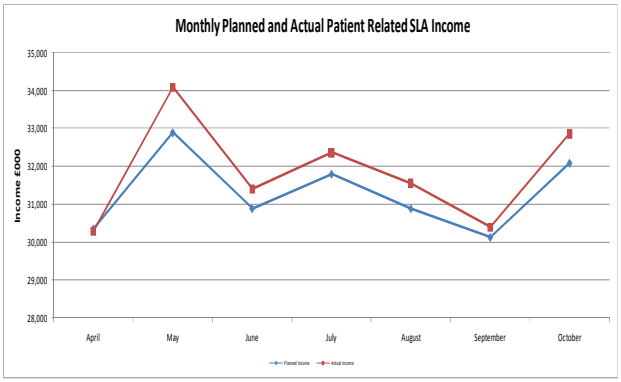
| Risk Ratings | | | |
|---|---|---|---|
| **Measure** | **Description** | **Value** | **Score** |
| EBITDA Margin | Excess of income over operational costs | 6.5% | 3 |
| EBITDA % Achieved | Extent to which budgeted EBITDA is achieved/exceeded | 102.2% | 5 |
| Net Return After Financing | Surplus after dividends over average assets employed | 1.8% | 3 |
| I&E Surplus Margin | I&E Surplus as % of total income | 0.9% | 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 November.
• 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 – October. 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.



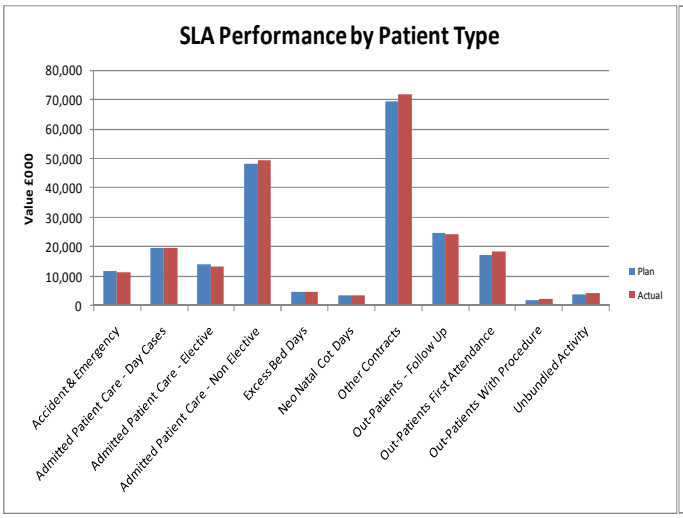

| Month | Planned Income £000 | Actual Income £000 | Variance £000 |
|---|---|---|---|
| April | 30,356 | 30,296 | (61) |
| May | 32,897 | 34,084 | 1,187 |
| June | 30,895 | 31,409 | 514 |
| July | 31,805 | 32,365 | 560 |
| August | 30,893 | 31,560 | 666 |
| September | 30,134 | 30,399 | 265 |
| October | 32,095 | 32,865 | 770 |
| **Total** | **219,075** | **222,977** | **3,901** |

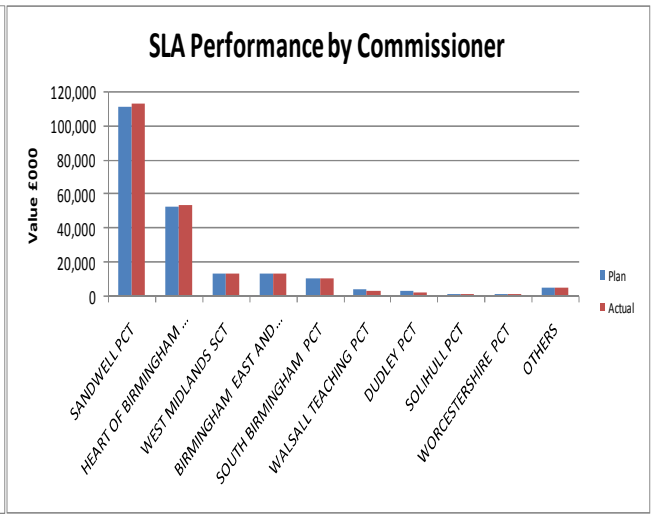
Sandwell and West Birmingham Hospitals NHS
NHS Trust

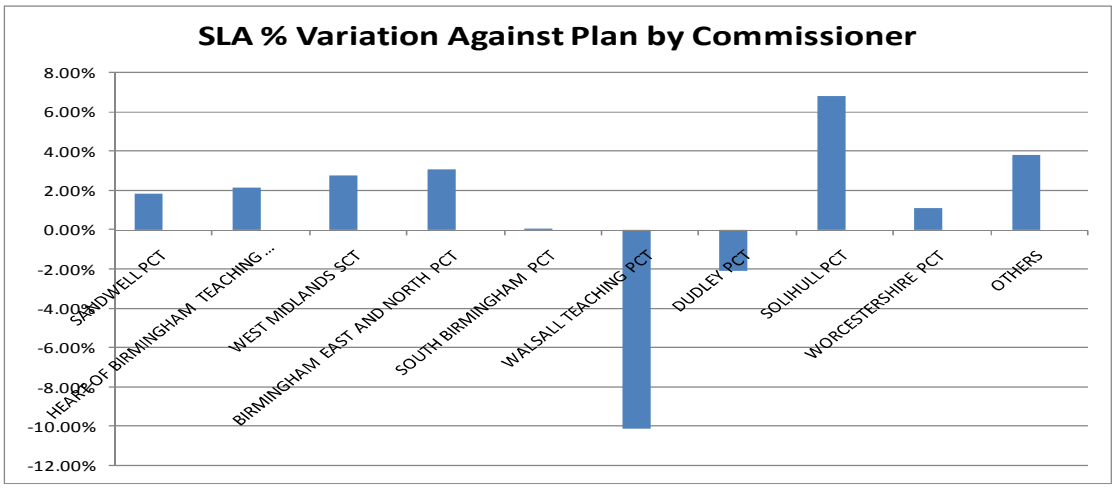
# Financial Performance Report – November 2012

**Performance by Activity Type and Commissioner**

• The following graphs show performance by activity type and commissioner comparing planned and actual financial values for the year to date and the percentage variance from plan for each type of activity and commissioner.

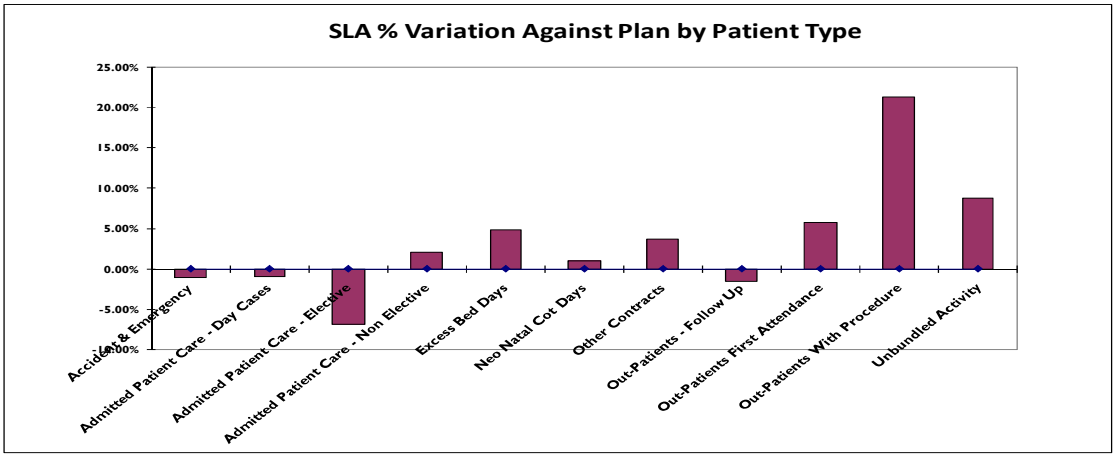


Sandwell and West Birmingham Hospitals NHS
NHS Trust

# Financial Performance Report – November 2012

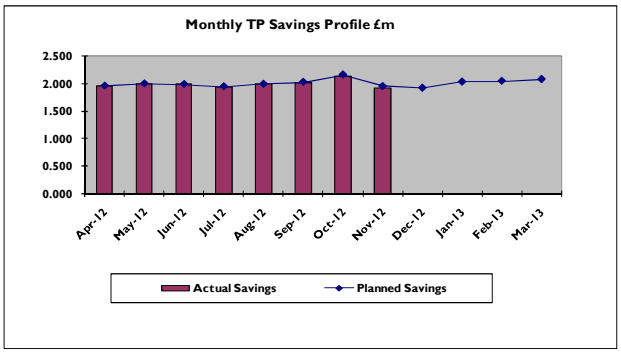


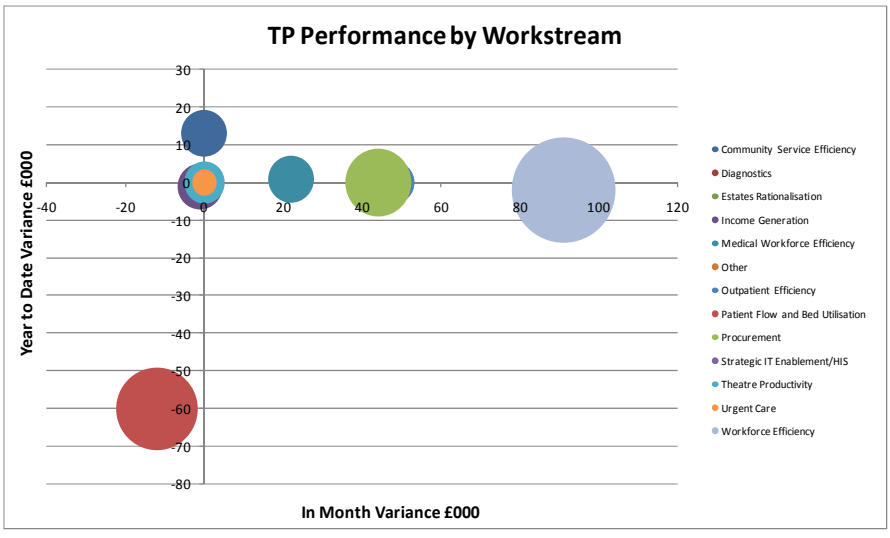

## Transformation Programme

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

• At 30th November and against the revised target, actual savings were £48,000 or 0.3% lower than planned levels although the full year effect is maintained at the level of the revised plan.

• The forecast outturn for the programme remains in line with 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 November, only the Patient Flow and Bed Utilisation workstream has a material adverse variance against plan and this is wholly related to the secondary impact within the Facilities Division.

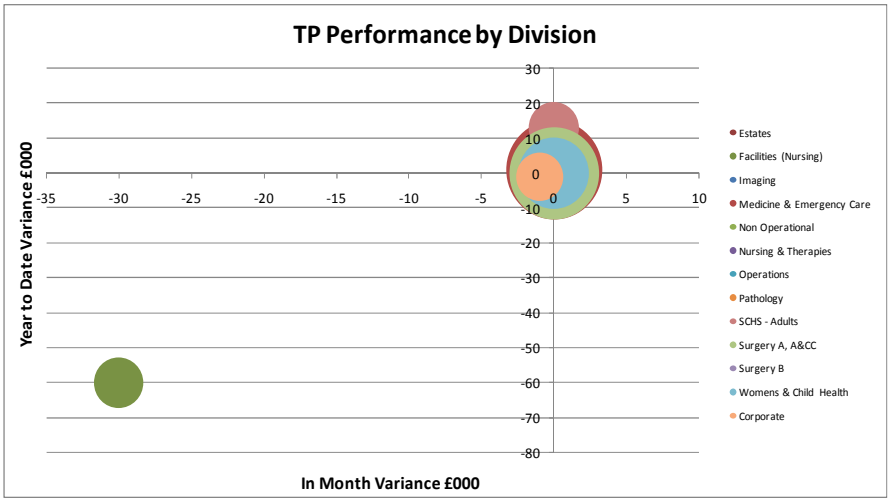
Sandwell and West Birmingham Hospitals NHS
NHS Trust

# Financial Performance Report – November 2012

**Transformation Programme**

•At the end of November, only the Facilities Division is reporting a material deficit 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 across the Trust. 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 Office for Budget Responsibility has forecast that the UK economy will contract by 0.1% this year (a substantial reduction from the forecast made in March) and growth forecasts for the next 5 years have been cut. Meanwhile, the European Central Bank expects the Eurozone economy to shrink by 0.5% this year and the Bundesbank has cut its forecast growth for 2013 for the German economy to 0.4%.

• Further significant concerns continue to be expressed regarding the financial health of the NHS and individual organisations within it including the following:

- a £50m contingency fund being set up to cover a projected deficit in Wales with the Wales Audit Office warning of a worst case scenario of a £130m deficit by April;
- a warning from the Nuffield Trust in its report Decade of Austerity of a £54bn funding gap for the English NHS if it fails to meet its efficiency targets and government spending remains constrained; and
- a warning that hospitals operating at near to full capacity create potential dangers for patient care.

• A Kings Fund review of NHS performance has expressed significant concerns around A&E waits and the financial position as well as the ability of the service to maintain standards of quality in the face of annual 5% savings at the same time as demand is rising.

SWBTB (12/12) 293 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# Financial Performance Report – November 2012

**Conclusions**

**• Measured against the DoH target, the Trust generated an actual surplus of £550,000 during November against a planned surplus of £470,000. For the purposes of its statutory accounts, the in month surplus was slightly higher at £579,000. 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 £550,000 surplus in November is £80,000 better than planned for the month.**

**• For the year to date, the Trust has generated a surplus (as measured against the DoH target) of £2,251,000 which is £411,000 better than the planned position.**

**• In month capital expenditure is £1.4m which represents a further material increase on previous months but the year to date position remains significantly 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 30th November, cash balances are approximately £23m higher than the cash plan and around £12.5m 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.**

**• The review of the current and forecast financial position has resulted in an increase in the projected year end surplus to approximately £5.8m (as measured against the DoH control total) as some risks have not materialised. Any additional surplus is retained within the organisation.**

**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

# 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:** | 20 December 2012 |

**EXECUTIVE SUMMARY:**

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – November 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 and Finance & Performance Management Committee

# SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST CORPORATE DASHBOARD - NOVEMBER 2012

## EXECUTIVE SUMMARY AND KEY EXCEPTIONS

### KEY EXCEPTIONS

a

**Stroke Care** - provisional data for November indicates that the proportion of patients admitted with Stroke who spent 83% or more of their time in hospital on an Acute Stroke Unit reduced to 75.1%, year to date performance remains in excess of the operational threshold. The percentage of patients admitted to an acute Stroke Unit within 4 hours and the percentage of patients receiving a CT Scan within 1 hour of arrival remain below locally identified targets, although 95.5% of patients during the month did receive a CT scan within 24 hours of arrival.

c

**Workforce** - **PDR** (12-month rolling) compliance improved further during November to 69.3%, with 5178 staff reported as having received a PDR within the last 12 months. **Mandatory training** compliance also improved to 87.4% as at the end of November. Divisions remain focused 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. Current performance against the Information Governance modules is 90.5%.

d

**Emergency Department & Patient Flow** - performance against the **A&E 4-hour maximum wait** target remained at 91.5% during November, and reduced to 93.76% for the year to date. The Trust continues to meet 2 of the 5 **A&E Clinical Quality Indicators**, 1 in each of the Timeliness and Patient Impact sections, both of which are also being met for the year to date. Reporting Times of **Imaging Requests** from the Emergency Department show further improvement, with the current performance trajectory of 80% 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 75%. Other elements of Patient Flow; Delayed Transfers of Care, Elective Admission Cancellations, Day of Surgical Admission Rate and Length of Stay remain within operational thresholds.

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. The percentage of Clinical Handovers completed within 15 minutes reduced overall to 55.0% (target 85%) during the month, with site specific performance of 24.5% and 78.5% for Sandwell and City respectively. The average turnaround time improved slightly to 34 minutes 40 seconds, compared with a target of 30 minutes or less. There were a total of 201 instances reported where ambulance turnaround was in excess of 60 minutes, 134 of which were at City (target 0).

### CQUIN PERFORMANCE

b

| | Patient Safety | | | Effectiveness 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 | | 1 | 7 |
| Specialised | | | | | | | | | 4 | | | 4 |

**CQUIN** - the Dementia Community CQUIN requirements for the month of October were not fully met. Performance and payment will be assessed across the Quarter, which will require improved performance during the months of November and December.

### 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 | 5637 | 5176 | 461 | 8.9 | 42199 | 39334 | 2865 | 7.3 | 42960 | 42199 | -761 | -1.8 |
| IP Non-Elective | 4841 | 4774 | 67 | 1.4 | 38278 | 37084 | 1194 | 3.2 | 35975 | 38278 | 2303 | 6.4 |
| OP New | 15435 | 12938 | 2497 | 19.3 | 115598 | 98142 | 17456 | 17.8 | 106718 | 115598 | 8880 | 8.3 |
| OP Review | 32451 | 38130 | -5679 | -14.9 | 261317 | 292588 | -31271 | -10.7 | 281650 | 261317 | -20333 | -7.2 |
| OP Review:New | 2.10 | 2.95 | -0.84 | -28.7 | 2.26 | 2.98 | -0.72 | -24.2 | 2.64 | 2.26 | -0.38 | -14.4 |
| AE Type I | 13609 | 14289 | -680 | -4.8 | 118481 | 118250 | 231 | 0.2 | 119130 | 118481 | -649 | -0.5 |
| AE Type II | 2055 | 2632 | -577 | -21.9 | 18869 | 21781 | -2912 | -13.4 | 25445 | 18869 | -6576 | -25.8 |
| Adult Community | 51293 | 40664 | 10629 | 26.1 | 328152 | 289761 | 38391 | 13.2 | 283935 | 328152 | 44217 | 15.6 |
| Child Community | 15078 | 10561 | 4517 | 42.8 | 89668 | 90819 | -1151 | -1.3 | 82115 | 89668 | 7553 | 9.2 |

f

Overall Elective activity for the month and year to date remains in excess of the plan by 8.9% and 7.3% for the periods respectively. Non Elective activity exceeded the plan for the month by 1.4%, and exceeds the plan for year to date by 3.2%. Month and year to date New and Review Outpatient performance is such that the Follow Up : New Outpatient Ratio for the year to date further improved (reduced) to 2.26 which compares favourably with a ratio derived from plan of 2.98. A&E Type I activity (+0.2%) is essentially on plan for the year to date although Type II (BMEC) activity (-13.4%) remains well below plan. Adult Community activity is currently 13.2% above plan for the year to date. Child Community activity is 1.3% below plan.

### NATIONAL PERFORMANCE FRAMEWORKS

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

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' and 6-week Diagnostic Waits. The Trust is projected to meet all high level RTT targets and Cancer targets. The overall weighted score for service delivery is 2.64, which attracts a **PERFORMING** classification.

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

The Trust failed to meet A&E 4-hour wait operational threshold during the month. The Trust is projected to meet all high level RTT targets and Cancer targets. 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 - NOVEMBER 2012

| Exec Lead | PATIENT SAFETY | | | | | July | August | September | October | | | November | | | To Date (*=most recent month) | TARGET | | 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 | | | | | | | |
| RS | H | 3 | Stroke Care | Pts spending >90% stay on Acute Stroke Unit | % | 85.1 ▼ | 88.9 ▲ | 87.2 ▼ | → | | 88.7 ▲ | → | | 76.1 ■ | 88.2 | 83 | 83 | a | No Variation | 0 - 2% Variation | >2% Variation | ● | 72.8 | 85.9 |
| | K | | | Pts admitted to Acute Stroke Unit within 4 hrs | % | 65.3 ▼ | 68.7 ▲ | 65.1 ▼ | → | | 51.1 ▼ | → | | 50.0 ▼ | 66.2 | 90 | 90 | | No Variation | 0 - 2% Variation | >2% Variation | ● ● | | 68.7 |
| | K | | | Pts receiving CT Scan within 24 hrs of arrival | % | 94.0 ▲ | 93.8 ▼ | 100 ■ | → | | 93.3 ■ | → | | 95.5 ▲ | 95.5 | 100 | 100 | | No Variation | 0 - 2% Variation | >2% Variation | ● | | 100 |
| | K | | | Pts receiving CT Scan within 1 hr of arrival | % | 51.3 ▼ | 53.1 ▲ | 61.5 ▲ | → | | 42.9 ■ | → | | 47.6 ▲ | 55.3 | 50 | 50 | | No Variation | 0 - 2% Variation | >2% Variation | ● | | 37.5 |
| | H | | | TIA (High Risk) Treatment <24 h from initial presentation | % | 66.7 ▼ | 80.0 ■ | 60.0 ▼ | 75.0 ■ | 100.0 ▲ | 84.6 ▲ | 62.5 ▼ | 88.9 ▼ | 76.5 ▼ | 71.2 | 60 | 60 | | No Variation | 0 - 2% Variation | >2% Variation | ● | 46.15 | 53.2 |
| | K | | | TIA (Low Risk) Treatment <7 days from initial presentation | % | 58.3 ■ | 82.5 ■ | 83.9 ▲ | 100.0 ▲ | 80.0 ▲ | 86.5 ▲ | 100.0 ▲ | 100.0 ▲ | 100.0 ▲ | 78.3 | 60 | 60 | | No Variation | 0 - 2% Variation | >2% Variation | ● | | 30.4 |
| R0 | A | 4 | Infection Control | C. Difficile (DH Reportable) | No. | 2 ▼ | 6 ■ | 2 ■ | 2 ▼ | 3 ▼ | 5 ▼ | 1 ▲ | 1 ▲ | 2 ▲ | 23 | 40 | 57 | | No variation | | Any variation | ● | 120 | 95 |
| | K | | | C. Difficile (Best Practice Numbers) | No. | 7 ▼ | 12 ■ | 4 ■ | 5 ▼ | 4 ▼ | 9 ▼ | 2 ▲ | 3 ▲ | 5 ▲ | 50 | 64 | 95 | | | | | ● | 120 | 95 |
| | A | | | MRSA Bacteraemia | No. | 0 ■ | 0 ■ | 0 ■ | 0 ■ | 0 ■ | 0 ■ | 0 ■ | 0 ■ | 0 ■ | 1 | 2 | 2 | | No variation | | Any variation | ● | 5 | 2 |
| | | | | MSSA Bacteraemia | No. | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 13 | No. Only | No. Only | | | | | | 22 | 12 |
| | | | | E Coli Bacteraemia | No. | 3 | 3 | 6 | 1 | 4 | 5 | 2 | 0 | 2 | 30 | No. Only | No. Only | | | | | | 73 | 50 |
| | F | 3 | | MRSA Screening - Elective — Patient Not Matched | % | 113.3 ▼ | 110.6 ▼ | 115.0 ▲ | Numerator = 3020 | Denominator = 2886 | 104.6 ▼ | Numerator = 2794 | Denominator = 2905 | 96.2 ▼ | 96.2* | 65 | 85 | | No variation | | Any variation | ● | 40.3 | 40.6 |
| | F | | | MRSA Screening - Elective — Best Practice - Patient Matched | % | 42.1 ■ | 39.5 ▼ | 38.7 ▼ | Numerator = 1277 | Denominator = 2379 | 53.7 ▲ | Numerator = 1640 | Denominator = 2905 | 56.5 ▲ | 56.5* | 65 | 85 | | No variation | | Any variation | ● ● | 40.3 | 40.6 |
| | F | | | MRSA Screening - Non Elective — Patient Not Matched | % | 67.7 ▲ | 69.2 ▲ | 66.4 ▼ | Numerator = 2476 | Denominator = 3751 | 66.0 ▼ | Numerator = 2322 | Denominator = 2956 | 78.6 ▲ | 78.6* | 65 | 85 | | No variation | | Any variation | ● | 18.9 | 26.0 |
| | F | | | MRSA Screening - Non Elective — Best Practice - Patient Matched | % | 68.2 ▼ | 69.1 ▲ | 66.1 ▼ | Numerator = 2344 | Denominator = 3537 | 66.3 ▲ | Numerator = 2458 | Denominator = 3706 | 66.3 ■ | 66.3* | 65 | 85 | | No variation | | Any variation | ● | 18.9 | 26.0 |
| RS | A | 3 | Acute CQUIN | VTE Risk Assessment (Adult IP) — 396 | % | 91.4 ▲ | 87.5 ■ | 91.0 ■ | → | | 91.7 ▲ | → | | 91.2 ▼ | 91.2* | 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 | Data Submitted | Monthly data collection | | | No variation | | Any variation | ● | | |
| RB | H | 20 | | Antibiotic Use — 743 | Score | → | → | 83 ▲ | → | | → | → | | → | 83 | 70 | 80 | | No variation | | Any variation | ● | | |
| RO | D | 8 | | Reducing Avoidable Pressure Ulcers — 372 | No. | Compliant | Compliant | Compliant | → | | Compliant | → | | Compliant | Compliant | Comply with audit | | | No variation | | Any variation | ● | | |
| RO | H | 8 | | Nutrition and Weight Management — 743 | | Compliant | Compliant | 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 ■ | → | | 99.8 ■ | 99.8 | 99 | 100 | | No variation | | Any variation | ● | | |
| RS | H | 9 | | Safe Surgery - Other Areas — 743 | % | → | 99.6 ■ | 100 ▲ | → | | 99.8 ▼ | → | | 99.5 ▼ | 99.8 | 98 | 98 | | No variation | | Any variation | ● | | |
| RS | H | 10 | | Stroke Care — 743 | % | → | → | 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 | | Compliant | Compliant | Compliant | → | | Compliant | → | | | Compliant | Comply with audit | | | No variation | | Any variation | ● | | |
| KD | F | 14 | Never Events - in month | | No. | 1 ■ | 0 ■ | 1 ■ | → | | 0 ■ | → | | 0 ■ | 0* | 0 | 0 | | No variation | | Any variation | ● | | |
| | F | | Open Serious Incidents Requiring Investigation (SIRI) | | No. | 10 | 4 | 2 | → | | 3 | → | | 1 | 1* | No. Only | No. Only | | | | | | | |
| | F | | Open Central Alert System (CAS) Alerts | | No. | 14 | 9 | 10 | → | | 8 | → | | 5 | 5* | No. Only | No. Only | | | | | | | |
| DS | D | | 100% Compliance WHO Surgical Checklist | | Y / N | N ■ | N ■ | N ■ | → | | N ■ | → | | N ■ | No | Y | Y | | Y | | N | ● | | N |
| RO | D | | Falls Resukting In Severe Injury or Death | | No | 1 ■ | 2 ▼ | 6 ▼ | → | | 0 ■ | → | | 2 ■ | 2* | 0 | 0 | | No variation | | Any variation | ● | | |
| RO | | 8 | High Impact Nursing Actions | Inpatient Falls reduction | % | 79 ▼ | 62 ▲ | 69 ▼ | → | | 43 ■ | → | | | 446 | 456 | 684 | | =<57/m | | >57/m | ● | 1024 | 763 |
| | | | | Nutritional Assessment (MUST) | % | 85 ■ | 90 ■ | 91 ▲ | → | | 89 ■ | → | | 94 ■ | 94* | 90 | 90 | | =>90 | | <90 | ● | | 89.0 |
| | | | | Fluid Balance Chart Completion | % | 98 | 94 | 93 | → | | 93 | → | | 95 | 95* | | | | | | | | | 100 |

| Exec Lead | | | | PATIENT SAFETY (Continued) | | July | August | September | October | | November | | | 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 | | | | | | | |
| RS | | 3 | Obstetrics | Post Partum Haemorrhage (>2000 ml) | No. | 0 ■ | 1 ▼ | 3 ▼ | → | | 3 ■ | → | | 0 ▲ | 10 | 32 | 48 | | =<2 | 3 - 4 | >4 | ● | 9 | 7 |
| | | | | Admissions to Neonatal ICU | % | 10.5 ▼ | 8.7 ■ | 9.4 ▼ | → | | 8.8 ▲ | → | | | 9.8 | =<10 | =<10 | | =<10 | 10.0-12.0 | >12.0 | ● | 7.2 | 10.7 |
| | | | | Adjusted Perinatal Mortality Rate (per 1000 babies) | /1000 | 7.6 ■ | 7.1 ▲ | 7.9 ▼ | → | | 3.8 ▲ | → | | | 3.8* | <8.0 | <8.0 | | <8 | 8.1 - 10.0 | >10 | ● | 6.5 | 11.9* |
| | | | | Caesarean Section Rate | % | 23.9 ▼ | 27.1 ■ | 21.4 ■ | → | | 22.6 ▼ | → | | 26.6 ■ | 23.3 | <25.0 | <25.0 | | =<25.0 | 25-28 | >28.0 | ● | 23.6 | 22.2 |
| | H | | | Early Booking (Completed Assessment <12+6 weeks) | % | 84 ▲ | 84 ■ | 80 ▼ | → | | 80 ■ | → | | | 80* | =>90 | =>90 | | =>90 | 75-89 | <75 | ● ● | | 76.0 |
| RO | | 2 | Infant Health & Inequalities | Maternal Smoking Rates | % | → | → | 9.5 ▲ | → | | → | → | | → | 9.9 | <11.5 | <11.5 | | <11.5 | 11.5 - 12.5 | >12.5 | ● | 11.9 | 9.8 |
| | | | | Breast Feeding Initiation Rates | % | → | → | 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. (%) | 4805 (65.0) ▼ | 4836 (65.4) ▲ | 4904 (65.6) ▲ | → | | 5087 (68.2) ▲ | → | | 5178 (69.3) ▲ | 5178 (69.3) | 7389 (100) | 7389 (100) | c | 0-15% variation | 15 - 25% variation | >25% variation | ● ● | 4635 | 5348 |
| RS | | | | Medical Appraisal and Revalidation | % | 71 | 79 | 84 | → | | 83 | → | | 87 | 87 | No. Only | No. Only | | | | | | | |
| RO | K | 3 | | Mandatory Training Compliance | % | 79.4 ■ | 80.8 ■ | 83.3 ■ | → | | 85.1 ■ | → | | 87.4 ▲ | 87.4 | 100 | 100 | | =>90 | 85 - 89 | <85 | ● | 86.8 | 71.9 |
| **EFFECTIVENESS OF CARE** | | | | | | | | | | | | | | | | | | | | | | | |
| RO | H | 8 | Acute CQUIN | Dementia | 396 | % | Met Q2 req's | Met Q2 req's | Met Q2 req's | → | | Meeting Q3 req's | → | | Meeting Q3 req's | 80 | 90 | b | No variation | | Any variation | ● | | |
| RS | H | 3 | | Mortality Review | 743 | % | 63.6 ▼ | 64.9 ▲ | 68.9 ▲ | → | | → | → | | 68.9 | 66 | 80 | | No variation | | Any variation | ● | | 66.9 |
| RO | H | 11 | Community CQUIN | Dementia | 44 | % | Met Q2 req's | Met Q2 req's | Met Q2 req's | → | | Not Met Q2 req's | → | | Not Met Q2 req's | 80 | 90 | | No variation | | Any variation | ● | | |
| RS | | 6 | Mortality in Hospital (12-month cumulative data) | Hospital Standardised Mortality Rate | | HSMR | 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 | → | 94.2 Sep'11 to Aug'12 | 94.2 | | | | | | | | | |
| | | | | Peer (SHA) HSMR | | HSMR | 94.9 | 93.3 | 101.3 | → | | 100.2 | → | 98.7 | 98.7 | | | | | | | | | |
| | | | | Peer (National) HSMR - Quarterly | | HSMR | → | → | 97.0 | → | | → | → | → | 97.0 | | | | | | | | | |
| | D | 19 | | SHMI | | SHMI | 96.2 May'11-Apr'12 | 96.0 Jun'11-May'12 | 96.3 Jul'11-Jun'12 | → | | 95.3 Aug'11-Jul'12 | → | 94.2 Sep'11-Aug'12 | 94.2 | | | | | | | | | |
| RB | | 3 | Readmission Rates (to any specialty) within 30 days of discharge - Operating Framework Definition effective April 2011 | Following initial Elective Admission | | No. | 140 ■ | 141 ▼ | 138 ▲ | → | | 124 ■ | → | 152 ■ | 1115 | 975 | 1463 | | No Variation | 0 - 5% Variation | >5% Variation | ● | | 1463 |
| | | | | Following initial Elective Admission | | % | 1.26 ■ | 1.34 ▼ | 1.36 ▼ | → | | 1.10 ■ | → | 1.37 ■ | 1.30 | 1.15 | 1.15 | | No Variation | 0 - 5% Variation | >5% Variation | ● | | 1.15 |
| | | | | Following initial Non-Elective Admission | | No. | 727 ▼ | 648 ▲ | 613 ▲ | → | | 620 ▼ | → | 561 ■ | 5078 | 4561 | 6842 | | No Variation | 0 - 5% Variation | >5% Variation | ● | | 6842 |
| | | | | Following initial Non-Elective Admission | | % | 6.57 ▼ | 6.17 ▲ | 6.04 ▲ | → | | 5.48 ■ | → | 5.07 ■ | 5.92 | 5.38 | 5.38 | | No Variation | 0 - 5% Variation | >5% Variation | ● | | 5.38 |
| RB | K | 3 | Hip Fractures | Operation <24 hours of admission | | % | 80.0 ■ | 76.2 ▼ | 80.0 ▲ | → | | 90.0 ▲ | → | 85.7 ▼ | 73.8 | 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) | | % | 95 ▲ | 95 ■ | 95 ■ | → | | 95 ■ | → | 94 ▼ | 95 | 90 | 90 | | >/=90 | 89.0-89.9 | <89 | ● | 94.5 | 95 |
| | | 3 | | Maternity HES | | % | 6.4 ▼ | 6.3 ▲ | 6.2 ▲ | → | | 6.4 ▼ | → | 6.9 ▼ | 6.3 | <15 | <15 | | =<15 | 16-30 | >30 | ● | 5.4 | 6.0 |
| | G | 11 | | Data Completeness Community Services | | % | No Data | No Data | No Data | → | | >50 | → | >50 | >50 | =>50 | =>50 | | =>50 | | <50 | ● | | |
| | H | 2 | | SUS Altered Data | | % | | | | → | | | → | | | | | | | | | | | |
| **PATIENT EXPERIENCE** | | | | | | | | | | | | | | | | | | | | | | | |
| RB | A | 2 | A&E 4-hour waits | 4-hour waits | | % | 94.5 ■ | 93.4 ▼ | 93.9 ▲ | 91.1 ■ | 91.6 ▼ | 91.5 ▼ | 92.6 ▲ | 90.8 ▼ | 91.5 ■ | 93.76 | =>95 | =>95 | d | =>95 | | <95 | ● ● ● | 96.99 | 95.38 |
| | D | 3 | A&E Timeliness | Total Time in Department (95th centile) | | h : m | 4 : 34 ▲ | 4 : 37 ▼ | 4 : 58 ▼ | → | | 5 : 38 ▼ | → | 5 : 21 ▲ | 4 : 50 | =<4hrs | =<4hrs | | =<4hrs | | =<4hrs | ● ● | | 3 : 59 |
| | D | | | Time to Initial Assessment (=<15 mins)(95th centile) | | mins | 17 ■ | 18 ▼ | 18 ■ | → | | 19 ▼ | → | 17 ▲ | 17 | <15 | <15 | | <15 | | <15 | ● ● | | 21 |
| | D | | | Time to treatment in department (median) | | mins | 66 ▲ | 60 ■ | 53 ▲ | → | | 54 ▼ | → | 52 ▲ | 60 | =<60 | =<60 | | =<60 | | >60 | ● | | 59 |
| | D | | A&E Patient Impact | Unplanned re-attendance rate | | % | 8.26 ▲ | 8.25 ▲ | 7.88 ▲ | → | | 7.59 ▲ | → | 7.79 ▼ | 7.95 | =<5.0 | =<5.0 | | =<5.0 | | >5.0 | ● ● ● | | 8.66 |
| | D | | | Left Department without being seen rate | | % | 5.26 ▲ | 4.91 ■ | 4.23 ▲ | → | | 4.77 ▼ | → | 4.06 ▲ | 4.84 | =<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 | | % | 11 | 14 | 46 | → | | 63 ■ | → | 75 ▲ | 75* | 80 | 90 | | No variation | | Any variation | ● | | |
| | | | | Ultrasound | | % | 97 | 100 | 100 | → | | 98 ■ | → | 100 ▲ | 100* | 80 | 90 | | No variation | | Any variation | ● | | |
| | | | | MRI | | % | 82 | 60 | 60 | → | | 76 ■ | → | 91 ▲ | 91* | 80 | 90 | | No variation | | Any variation | ● | | |
| | | | | CT | | % | 98 | 98 | 99 | → | | 99 ■ | → | 99 ■ | 99* | 80 | 90 | | No variation | | Any variation | ● | | |

| Exec Lead | | | PATIENT EXPERIENCE (Continued) | | | | July | August | September | October | | | November | | | To Date (*=most recent month) | TARGET | | Exec Summary Note | THRESHOLDS | | | 12/13 Forward Projection | 10/11 Outturn | 11/12 Outturn |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Trust | Trust | Trust | S'well | City | Trust | S'well | City | Trust | | YTD | 12/13 | | | | | | | |
| RB | H | | Ambulance Turnaround | Clinical Handovers completed within 15 minutes | | % | | 79.4 ■ | 77.6 ▼ | 55.9 ▼ | 80.8 ▲ | 70.3 ▼ | 24.5 ▼ | 78.5 ▼ | 55.0 ▼ | 55.0* | =>85 | =>85 | e | =>85 | | <85 | ● ● | | |
| RB | H | 18 | | Average Turnaround Time | | m : s | 32:44 ▼ | 32:37 ▲ | 33.07 ▼ | 35:40 ▼ | 36:07 ▼ | 35:56 ▼ | 34:36 ▲ | 34:42 ▲ | 34:40 ▲ | 32:57 | =<30:00 | =<30:00 | | =<30:00 | | >30:00 | ● | | 29:23 |
| | H | | | In Excess of 60 minutes | | No. | 166 ▼ | 149 ▲ | 163 ▼ | 98 ▼ | 134 ▼ | 232 ▼ | 67 ▲ | 134 ■ | 201 ▲ | 1270 | 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. | 62 | 79 | 56 | → | | 62 | → | | 68 | 499 | No. Only | No. Only | | | | | | | 834 |
| RO | H | 8 | Acute CQUIN | Personal Needs | 396 | % | → | → | → | → | | → | → | | → | 67.9 | 67.6 | 71.6 | | No variation | | Any variation | ● | | |
| RO | H | 8 | | Net Promoter | 372 | No. | 58 ■ | 60 ▲ | 63 ▲ | → | | 64 ▲ | → | | | 64 | 61 | 65 | | No variation | | Any variation | ● | | |
| RO | H | 8 | | End of Life Care | 372 | % | 55 ▲ | 57 ▲ | 60 ▲ | → | | 59 ▼ | → | | | 59 | 49 | 53 | | No variation | | Any variation | ● | | |
| RS | H | 10 | | Every Contact Counts - Alcohol | 372 | % | → | → | → | → | | → | → | | | 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 ▼ | → | | 96.0 ▲ | → | | | 96.0 | 90 | 90 | | No variation | | Any variation | ● | | |
| RO | H | 11 | | Net Promoter | 88 | No | 91 (H'son) & 80 (L'wes) | 71 ■ | 81 ■ | → | | 88 ▲ | → | | | 88 | 75 | 75 | b | No variation | | Any variation | ● | | |
| RO | H | 11 | | Every Contact Counts | 132 | % | Base data being captured | Base data being captured | Baseline established | → | | Met Monthly requirement | → | | | Met Monthly requirement | | | | No variation | | Any variation | ● | | |
| RO | H | 11 | | Smoking Cessation | 132 | % | Base data being captured | Base data being captured | Baseline established | → | | Met Monthly requirement | → | | | Met Monthly requirement | | | | No variation | | Any variation | ● | | |
| RS | H | | Specialised Commissioners | Clinical Quality Dashboards | 49 | | → | → | Q2 Return Submitted | → | | → | → | | → | Q2 Return Submitted | Submit Data | Submit Data | | No variation | | Any variation | ● | | |
| RS | H | 13 | | Neonatal - Hypothermia Treatment | 73 | % | → | → | 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 | % | → | → | Q2 Return Submitted | → | | → | → | | → | Q2 Return Submitted | Derive Base | Derive Base | | Met | | Not Met | ● | | |
| RS | H | 12 | | HIV - Optmum Therapy | 147 | % | → | → | 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. | 12755 | 12090 | 11492 | → | | 13408 | → | | 12725 | 97403 | No. Only | No. Only | | | | | | 137824 | 111793 |
| | | | | Average Length of Queue | | mins | 0.34 ▲ | 0.29 ▲ | 0.39 ▼ | → | | 0.37 ▲ | → | | 0.39 ▼ | 0.39* | <1.0 | <1.0 | | <1.0 | 1.0-2.0 | >2.0 | ● | 0 | 0.21 |
| | | | | Maximum Length of Queue | | mins | 12.4 ■ | 9.1 ▲ | 13.2 ▼ | → | | 33.2 ▼ | → | | 10.1 ■ | 10.1* | <6.0 | <6.0 | | <6.0 | 6.0-12.0 | >12.0 | ● ● | 6.3 | 10 |
| | | | Telephone Exchange | Number of Calls Received | | No. | 74174 | 75331 | 70935 | → | | 83144 | → | | 78030 | 598167 | No. Only | No. Only | | | | | | 909301 | 849502 |
| | | | | Calls Answered | | % | 92.4 | 89.8 | 90.7 | → | | 89.4 | → | | 91.5 | 91.2 | No. Only | No. Only | | | | | | 90.5 | 90.2 |
| | | | | Answered within 15 seconds | | % | 57.0 | 54.6 | 64.4 | → | | 54.3 | → | | 60.6 | 57.1 | No. Only | No. Only | | | | | | 52.4 | 52.5 |
| | | | | Answered within 30 seconds | | % | 72.9 | 70.1 | 77.1 | → | | 69.5 | → | | 75.3 | 72.3 | No. Only | No. Only | | | | | | 68.4 | 68.1 |
| | | | | Average Ring Time | | Secs | 21.6 | 25.3 | 19.5 | → | | 25.8 | → | | 20.5 | 20.5* | No. Only | No. Only | | | | | | 21.2 | 25 |
| | | | | Longest Ring Time | | Secs | 780 | 1173 | 734 | → | | 782 | → | | 615 | 615* | No. Only | No. Only | | | | | | 731 | 718 |
| **TRANSFORMATION PLAN** | | | | | | | | | | | | | | | | | | | | | | | | | |
| RB | | 2 | Spells | Elective IP | | No. | 1113 ■ | 1034 ▼ | 672 ■ | → | | 721 ▼ | → | | 836 ▲ | 6839 | 7452 | 10981 | f | No Variation | 0 - 2% Variation | >2% Variation | | 11748 | 10610 |
| | | | | Elective DC | | No. | 4278 ▲ | 4017 ▼ | 4213 ▲ | → | | 4893 ▼ | → | | 4801 ▲ | 35360 | 31883 | 46983 | | No Variation | 0 - 2% Variation | >2% Variation | | 53959 | 53685 |
| | | | | Total Elective | | No. | 5391 ▼ | 5051 ▼ | 4885 ▲ | → | | 5614 ▼ | → | | 5637 ▲ | 42199 | 39335 | 57964 | | No Variation | 0 - 2% Variation | >2% Variation | ● | 65707 | 64295 |
| | | | | Total Non-Elective | | No. | 4937 ▲ | 4732 ▲ | 4618 ▼ | → | | 5016 ▲ | → | | 4841 ▼ | 38278 | 37084 | 57105 | | No Variation | 0 - 2% Variation | >2% Variation | ● | 59000 | 55675 |
| | | | Outpatient Attendances | New | | No. | 15147 ▲ | 13634 ▼ | 13605 ▲ | → | | 15781 ▲ | → | | 15435 ▼ | 115598 | 98142 | 144072 | | No Variation | 0 - 2% Variation | >2% Variation | ● | 163493 | 159051 |
| | | | | Review | | No. | 33831 ▲ | 31369 ▼ | 30151 ▲ | → | | 34608 ▼ | → | | 32451 ▼ | 261317 | 292588 | 430846 | | No Variation | 0 - 2% Variation | >2% Variation | ● | 440812 | 421494 |
| | | | A/E Attendances | Type I (Sandwell & City Main Units) | | No. | 15819 ▲ | 14293 ▼ | 13076 ■ | 5802 ▼ | 8082 ▲ | 13884 ▲ | 5814 ▲ | 7795 ■ | 13609 ▲ | 118481 | 118250 | 175107 | | No Variation | 0 - 2% Variation | >2% Variation | ● | 181494 | 177201 |
| | | | | Type II (BMEC) | | No. | 2359 ▲ | 2143 ▼ | 1973 ▼ | → | 2158 ▲ | 2158 ▲ | → | 2055 ▲ | 2055 ▲ | 18869 | 21781 | 32254 | | No Variation | 0 - 2% Variation | >2% Variation | ● ● ● | 36756 | 36362 |
| | | 16 | Community | Adult - Aggregation of 18 Individual Service Lines | | No. | 49385 ▲ | 47984 ▼ | 45297 ▼ | → | | 51293 ▲ | → | | | 328152 | 289761 | 492472 | | No Variation | 0 - 2% Variation | >2% Variation | ● | 461797 | 493163 |
| | | | | Children - Aggregation of 4 Individual Service Lines | | No. | 12909 ▲ | 10284 ▼ | 12435 ▲ | → | | 15076 ■ | → | | | 89668 | 90819 | 158876 | | No Variation | 0 - 2% Variation | >2% Variation | ● | 102773 | 143400 |
| | | 2 | Outpatient Efficiency | New : Review Rate | | Ratio | 2.23 ▲ | 2.30 ■ | 2.22 ▲ | 2.57 ▲ | 2.03 ■ | 2.19 ▲ | 2.46 ▲ | 1.95 ▲ | 2.10 ▲ | 2.26 | 2.30 | 2.30 | | No Variation | 0 - 5% Variation | >5% Variation | ● | 2.70 | 2.65 |
| | | | | DNA Rate - New Referrals | | % | 11.8 ▲ | 12.6 ▼ | 11.9 ▲ | → | | 12.0 ▼ | → | | 12.8 ▼ | 11.3 | 10.0 | 10.0 | | No variation | | Any variation | ● ● | 13.1 | 11.8 |
| | | | | DNA Rate - Reviews | | % | 11.4 ▼ | 10.9 ▲ | 11.0 ▼ | → | | 11.1 ▼ | → | | 11.1 ■ | 10.2 | 10.0 | 10.0 | | No variation | | Any variation | ● | 11.9 | 10.5 |

| Exec Lead | | | TRANSFORMATION PLAN (Continued) | | | July | August | September | October | | | November | | | 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 | % | 94.5 ■ | 93.4 ▼ | 93.9 ▲ | 91.1 ■ | 91.6 ▼ | 91.5 ▼ | 92.6 ▲ | 90.8 ▼ | 91.5 ■ | 93.76 | =>95 | =>95 | d | =>95 | | <95 | ● ● ● | 96.99 | 95.38 |
| | C | | | Acute Delayed Transfers of Care | % | 2.6 ▲ | 2.5 ▲ | 3.6 ■ | 2.1 ▲ | 2.8 ■ | 2.5 ■ | 2.0 ▲ | 4.8 ■ | 3.4 ▼ | 3.2 | <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 | % | 0.7 ▼ | 0.4 ▲ | 0.7 ▼ | 0.3 ▲ | 0.7 ■ | 0.5 ▲ | 0.7 ▼ | 0.9 ■ | 0.8 ■ | 0.6 | <0.8 | <0.8 | | <0.8 | 0.8 - 1.0 | >1.0 | ● | 0.8 | 0.6 |
| | | | | Average Length of Stay | Days | 3.4 ▲ | 3.5 ▼ | 3.6 ▼ | 4.0 ■ | 3.4 ▼ | 3.6 ■ | | | | 3.7 | 4.3 | 4.3 | | No Variation | 0 - 5% Variation | >5% Variation | ● | 4.3 | 4.2 |
| | | | | Day of Surgery (IP Elective Surgery) | % | 92.4 ▲ | 91.6 ▼ | 86.5 ▼ | 91.4 ▲ | 93.4 ▲ | 92.6 ▲ | 93.6 ▲ | 95.0 ▲ | 94.4 ▲ | 91.6 | 82.0 | 82.0 | | No Variation | 0 - 5% Variation | >5% Variation | ● | 88.7 | 89.5 |
| | | | | Daycase Rate - All Procedures | % | 78.3 ■ | 78.4 ▲ | 85.0 ■ | 88.1 ▲ | 84.6 ▲ | 86.0 ▲ | 84.5 ▼ | 83.8 ▼ | 84.1 ▼ | 83.1 | 80.0 | 80.0 | | No Variation | 0 - 5% Variation | >5% Variation | ● | 81.5 | 82.7 |
| RO | | 7 | Sickness Absence | Long Term (> 28 days) | % | 3.26 ▲ | 3.34 ▼ | 3.28 ▲ | → | | 3.43 ▼ | → | | | 3.43 (Q3) | <2.15 | <2.15 | | <2.15 | 2.15-2.50 | >2.50 | | 3.12 | 2.95 |
| | | | | Short Term (<28 days) | % | 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 | % | 4.16 ▲ | 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 | % | 89.1 | 86.9 | 87.0 | → | | 83.2 | → | | 83.8 | 86.4 | No. Only | No. Only | | | | | | 86.2 | 87.2 |
| | | | | Nurse Bank Shifts covered | No. | 4898 ▼ | 5389 ▼ | 5007 ▲ | → | | 4904 ▲ | → | | 5399 ▼ | 39196 | 31320 | 46980 | | 0 - 2.5% Variation | 2.5 - 5.0% Variation | >5.0% Variation | ● ● ● | 54952 | 56396 |
| | | | | Nurse Agency Shifts covered | No. | 495 ▲ | 703 ▼ | 642 ▲ | → | | 1101 ▼ | → | | 1159 ▼ | 5901 | 2553 | 3830 | | 0 - 5% Variation | 5 - 10% Variation | >10% Variation | ● ● ● | 4550 | 6948 |
| **KEY ACCESS TARGETS** | | | | | | | | | | | | | | | | | | | | | | | | |
| RB | A | 1 | Cancer | 2 weeks | % | 95.6 ▲ | 94.4 ▼ | 93.0 ▼ | → | | 95.2 ▲ | → | | | 94.6 | =>93 | =>93 | | No variation | | Any variation | ● | 94.5 | 94.8 |
| | A | | | 2 weeks (Breast Symptomatic) | % | 100 ▲ | 98.0 ▼ | 93.3 ▼ | → | | 97.9 ▲ | → | | | 97.0 | =>93 | =>93 | | No variation | | Any variation | ● | 94.7 | 95.8 |
| | A | | | 31 Day (diagnosis to treatment) | % | 100 ■ | 98.8 ▼ | 98.7 ▼ | → | | 99.4 ▲ | → | | | 99.5 | =>96 | =>96 | | No variation | | Any variation | ● | 99.7 | 99.5 |
| | A | | | 31 Day (second/subsequent treatment - surgery) | % | 100 ■ | 97.8 ▼ | 97.6 ▼ | → | | 99.0 ▲ | → | | | 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) | % | n/a | 100 ■ | 100 ■ | → | | n/a | → | | | 100 | =>94 | =>94 | | No variation | | Any variation | ● | 100 | 100 |
| | A | | | 62 Day (urgent GP referral to treatment) | % | 86.4 ▲ | 93.7 ▲ | 80.2 ■ | → | | 85.4 ■ | → | | | 86.4 | =>85 | =>85 | | No variation | | Any variation | ● | 88.0 | 86.9 |
| | A | | | 62 Day (referral to treat from screening) | % | 90.0 ▼ | 92.9 ▲ | 96.0 ▲ | → | | 93.5 ▼ | → | | | 97.3 | =>90 | =>90 | | No variation | | Any variation | ● | 99.2 | 98.5 |
| | H | | | 62 Day (referral to treat from hosp specialist) | % | 84.4 ■ | 97.9 ■ | 96.0 ▼ | → | | 94.7 ▼ | → | | | 93.7 | =>85 | =>85 | | No variation | | Any variation | ● | 95.6 | 91.6 |
| RB | A | 2 | RTT 18-Weeks | Admitted Care (RTT <18 weeks) | % | 94.3 ▲ | 95.3 ▲ | 93.3 ▼ | → | | 93.5 ▲ | → | | | 93.5* | =>90.0 | =>90.0 | | =>90.0 | 85-90 | <85.0 | ● | 92.7 | 93.2 |
| | A | | | Non-Admitted Care (RTT <18 weeks) | % | 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) | % | 97.5 ▲ | 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. | 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 |
| RB | E | 2 | Diagnostic Waits | Acute Diagnostic Waits greater than 6 weeks | % | 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 | % | 2.6 ▲ | 2.5 ▲ | 3.6 ■ | 2.1 ▲ | 2.8 ■ | 2.5 ■ | 2.0 ▲ | 4.8 ■ | 3.4 ▼ | 3.2 | <3.5 | <3.5 | | <3.5 | 3.5 - 5.0 | >5.0 | ● | 4.6 | 5.2 |
| | | | | Pt's Social Care Delay | No. | 3 ▲ | 11 ▼ | 11 ■ | 6 ▲ | 3 ■ | 9 ▲ | 7 ▼ | 6 ▼ | 13 ▼ | 13* | <18 | <18 | | No Variation | 0 - 10% Variation | >10% Variation | | 23 | 13 |
| | | | | Pt.'s NHS & NHS plus S.C. Delay | No. | 4 ■ | 8 ▼ | 10 ■ | 2 ■ | 5 ■ | 7 ■ | 3 ▼ | 3 ▲ | 6 ▲ | 6* | <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 | % | 0.7 ▼ | 0.4 ▲ | 0.7 ▼ | 0.3 ▲ | 0.7 ■ | 0.5 ▲ | 0.7 ▼ | 0.9 ■ | 0.8 ■ | 0.6 | <0.8 | <0.8 | | <0.8 | 0.8 - 1.0 | >1.0 | ● | 0.8 | 0.6 |
| | H | | | 28 day breaches | No. | 0 ■ | 0 ■ | 1 ■ | → | | 0 ■ | → | | 0 ■ | 1 | 1 | 3 | | 3 or less | 4 - 6 | >6 | ● | 1 | 1 |
| | | | | Sitrep Declared Late Cancellations by Speciality | No. | 34 ■ | 17 ■ | 34 ■ | 5 ▲ | 23 ▲ | 28 ■ | 17 ■ | 36 ▼ | 53 ■ | 232 | 213 | 320 | | 0-5% variation | 5 - 15% variation | >15% variation | ● | 500 | 363 |
| RB | | 10 | Cardiology | Primary Angioplasty (<150 mins) | % | 100 ▲ | 92.3 ▼ | 76.9 ■ | | | | | | | 91.9 | =>80 | =>80 | | =>80 | 75-79 | <75 | ● | 90.7 | 88.4 |
| | | | | Rapid Access Chest Pain | % | 93.6 ■ | 96.0 ▲ | 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:** | 20 December 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 (November):**
There was 1 area of actual underperformance during the month of November; A&E 4-hour waits performance of 91.5% and 2 areas of projected underperformance; RTT Delivery in all specialties and Diagnostic Waits in excess of 6 weeks.

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

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

**Foundation Trust Compliance Summary report (November):**

Within the Service Performance element of the Risk Rating for the month of November the Trust underperformed against the A&E 4-hour wait target.

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

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

## REPORT RECOMMENDATION:

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

## ACTION REQUIRED *(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 Mgt Board and Finance & Performance Mgt 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 | November 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 | 91.50% | 0 | 0.00 |
| MRSA Bacteraemia | 1.00 | 0 | | >1.0SD | 1 | 3 | 3.00 | 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 | 2 | 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 | >90.0%* | 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 | >95.0%* | 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 | >92.0%* | 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 | 1 - 5* | 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 | 1.00 - 5.00%* | 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 | 95.2% | 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 | 97.9% | 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 | 99.4% | 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 | 99.0% | 3 | 0.75 | >94.0%* | 3 | 0.75 |
| Cancer - 31 day second or subsequent treatment (drug) | 0.25 | 98.0% | 93.00 - 98.00% | 93.0% | 100.0% | 3 | 0.75 | 100.0% | 3 | 0.75 | 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 | n/a | 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 | 85.4% | 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 | 93.5% | 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 | 3.40% | 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 | 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 | 91.70% | 3 | 3.00 | 91.20% | 3 | 3.00 |
| **Sum (all weightings)** | **14.00** | | | | | | | | | | | | | | | |
| **Average Score (Integrated Performance Measures)** | | | | | | | **2.86** | | | **2.64** | | | **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** | | | **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

| Criteria | Metric | Weight (%) | | SCORING 3 | SCORING 2 | SCORING 1 | 2012 / 2013 September | Score | Weight x Score | 2012 / 2013 October | Score | Weight x Score | 2012 / 2013 November | 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 | **0.28%** | **3** | **0.6** | **0.40%** | **3** | **0.6** | **0.58%** | **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. | **5.85%** | **3** | **0.15** | **6.01%** | **3** | **0.15** | **6.11%** | **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** | **6.21%** | **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** | **6.21%** | **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 | **91.00%** | **2** | **0.05** | **96.00%** | **3** | **0.075** | **93.00%** | **2** | **0.05** |
| | Better Payment Practice Code Volume (%) | | 2.5 | 95% or more of the volume of NHS and Non NHS bills are paid within 30days | Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days | Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days | **95.00%** | **3** | **0.075** | **94.00%** | **2** | **0.05** | **95.00%** | **3** | **0.075** |
| | 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 | **12.99** | **3** | **0.15** | **13.19** | **3** | **0.15** | **14.89** | **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 | **36.87** | **2** | **0.1** | **41.81** | **2** | **0.1** | **41.50** | **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:** | 20 December 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 November 2012 are as follows:

| Key Area for rating / comment by Provider | Score / RAG rating* |
|---|---|
| **Governance Risk Rating** (RAG as per SOM guidance) | AG |
| **Financial Risk Rating** (Assign number as per SOM guidance) | 3 |
| **Contractual Position** (RAG as per SOM guidance) | Not required by SHA |

Key Features of the return for November are:

- TFA Progress – agreement not to submit Final IBP / LTFM to SHA, pending further discussion on TFA milestones.
- Governance – A&E performance for the month of November is 91.5%, below the operational threshold of 95.0%.

Contractual – A number of areas are subject to performance improvement notices received during November. 2 relating to local quality requirements; Maternity Early Booking and Ambulance Turnaround Times. 4 notices relating to A&E 4-hour wait, 6-week diagnostic waits, RTT Admitted Care (T&O and Plastic Surgery) and 62-day Urgent GP to Treatment Cancer waits. There was 1 Never Event during September which also attracted a performance notice.

## 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

| SELF-CERTIFICATION RETURNS |
| --- |
| |
| **Organisation Name:** |
| **Sandwell & West Birmingham Hospitals NHS Trust** |
| **Monitoring Period:** |
| **November 2012** |

# NHS Trust Over-sight self certification template

**Returns to provider.development@westmidlands.nhs.uk by the last working day of each month**

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

| Name of Organisation: | Sandwell & West Birmingham Hospitals NHS Trust | Period: | November 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) | AG |
| **Normalised YTD Financial Risk Rating** (Assign number as per SOM guidance) | 3 |

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

**Governance Declarations**

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

**Supporting detail is required where compliance cannot be confirmed.**

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

## Governance declaration 1

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

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

## Governance declaration 2

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

| | | | |
|---|---|---|---|
| Signed by : | | 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:**

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

| | |
|---|---|
| **Target/Standard:** | **12. Achieved a minimum of Level 2 of the IG Toolkit.** |
| **The Issue :** | |
| **Action :** | |

| | |
|---|---|
| **Target/Standard:** | |
| **The Issue :** | |
| **Action :** | |

| | |
|---|---|
| **Target/Standard:** | |
| **The Issue :** | |
| **Action :** | |

| | |
|---|---|
| **Target/Standard:** | |
| **The Issue :** | |
| **Action :** | |

| | |
|---|---|
| **Target/Standard:** | |
| **The Issue :** | |
| **Action :** | |

# Board Statements

## Iwell & West Birmingham Hospitals NHS T

November 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 SOM's Oversight Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients. | Yes |
| 2 | The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements. | Yes |
| 3 | The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements. | Yes |
| | **For FINANCE, that:** | **Response** |
| 4 | The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months. | Yes |
| 5 | The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time. | Yes |
| | **For GOVERNANCE, that:** | **Response** |
| 6 | The board will ensure that the trust at all times has regard to the NHS Constitution. | Yes |
| 7 | All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner | Yes |
| 8 | The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of occurrence and the plans for mitigation of these risks. | Yes |
| 9 | The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily. | Yes |
| 10 | An Annual Governance Statement is in place , and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk). | Yes |
| 11 | The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the Governance Risk Rating; and a commitment to comply with all commissioned targets going forward . | 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, and that any elections to the shadow board of governors are held in accordance with the election rules. | Yes |
| 14 | The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability. | Yes |
| 15 | The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan. | Yes |

| | *Signed on behalf of the Trust:* | *Print name* | *Date* |
|---|---|---|---|
| **CEO** | **TO BE ADDED** | **John Adler** | **20/12/2012** |
| **Chair** | **TO BE ADDED** | **Richard Samuda** | **20/12/2012** |

# QUALITY

**Information to inform the discussion meeting**

**Sandwell & West Birmingham Hospitals NHS Trust**

**Insert Performance in Month**

Refresh Data for new Month

| | Criteria | Unit | Dec-11 | Jan-12 | Feb-12 | Mar-12 | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Sep-12 | Oct-12 | Nov-12 | Board Action |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | SHMI - latest data | Score | 99.1 | 98.4 | 97.5 | 96.8 | 96.2 | 96.0 | 96.3 | 95.3 | 94.2 | 94.2 | 94.2 | 94.2 | SHMI data relates to period September 2011 - August 2012 which is the most recent period for which data is available (source HED). |
| 2 | Venous Thromboembolism (VTE) Screening | % | 90.8 | 92.9 | 92.4 | 92.6 | 92.4 | 92.9 | 91.0 | 91.4 | 87.5 | 91.0 | 91.7 | 91.2 | |
| 3a | Elective MRSA Screening | % | 42.5 | 40.2 | 39.4 | 40.8 | 38.1 | 39.9 | 40.7 | 42.0 | 39.5 | 38.7 | 104.6 | 96.2 | Data reported is screens not matched with patients. Screens matched to patients for the month is 56.5%. |
| 3b | Non Elective MRSA Screening | % | 54.2 | 50.5 | 58.7 | 61.7 | 70.3 | 64.1 | 66.3 | 68.0 | 69.1 | 66.1 | 66.0 | 78.6 | 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 | 8 | 0 | 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 | 1 | None of the November incidents were in excess of 45 days at month end |
| 6 | "Never Events" occurring in month | Number | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 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 | 2 alerts overdue at the end of the month |
| 9 | RED rated areas on your maternity dashboard? | Number | 4 | 4 | 4 | 4 | 2 | 1 | 2 | 4 | 3 | 3 | 2 | 4 | October - Midwifery Staff Vacancies (10.5%), Midwiferyt Staff Sickness Absence (6.3%), Neonatal Mortality Rate (3.8 / 1000 babies) and Clinical Incidents (Amber) (27). |
| 10 | Falls resulting in severe injury or death | Number | 4 | 2 | 6 | 2 | 3 | 0 | 1 | 1 | 2 | 6 | 0 | 2 | |
| 11 | Grade 3 or 4 pressure ulcers | Number | 5 | 14 | 5 | 7 | 12 | 4 | 2 | 2 | 3 | 3 | 1 | 1 | Figures since June 12 have been amended to show total number of hospital acquired avoidable grade 3 and 4 pressure sores in month. |
| 12 | 100% compliance with WHO surgical checklist | Y/N | No | No | No | No | No | No | No | No | No | No | No | No | Compliance was 99.82% in November (3842 records compliant of 3849 total). All list and individual checklists are checked for completeness by staff at the end of the session and then entered onto a database. |
| 13 | Formal complaints received | Number | 51 | 59 | 69 | 72 | 60 | 51 | 61 | 62 | 79 | 56 | 62 | 68 | |
| 14 | Agency as a % of Employee Benefit Expenditure | % | 1.5 | 1.7 | 1.8 | 2.5 | 1.7 | 1.4 | 1.9 | 1.9 | 2.2 | 1.8 | 2.3 | 2.45 | |
| 15 | Sickness absence rate | % | 4.28 | 4.34 | 4.39 | 4.13 | 4.06 | 4.51 | 4.23 | 4.16 | 4.10 | 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 | 87 | 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. |

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:** | 20 December 2012 |

**EXECUTIVE SUMMARY:**

**Please refer to attached documents for detail**

**Urgent Care:**

- Review underway to structure Transformation activity with Emergency Flow Recovery Project.
- Emergency Pathway project now setting up project structure for the roll out / adaptation of West Mercier clinical pathway model.
- Practical Problem Solving activity started in City ED, with TSO support, to resolve day to day concerns has commenced.

**Theatres:**

- Centralised Booking approved to run pilot with T&O. SOPs now being prepared and trained in readiness for January pilot.
- Theatres project organisation chart agreed with allocated leads against each project (see attached)
- First meeting held for Step-Down project and TOR agreed. Performance Management project board go-live on 10th December.

**Community:**

- Developing input from SPARTIC & STAR to feed into Discharge Board Review Meetings
- Review of all processes at Leasowes Unit undertaken in first week of December. Follow up meeting to be set with DGM, Workstream leads and TSO to prioritise future actions / projects.

**Outpatients:**

- Deep dive + process completed for 5 specialities, with General Surgery and Rheumatology still to complete.
- Pathway redesign process started with first 3 areas (Urology, BMEC & Medicine). Target is to have new pathway pilots running in April 13.
- Roll out on plan for partial booking of all FU appointments, in the New Year.

**Patient Flow:**

- Daily Discharge Reviews – hand-over, standard and peer review monitoring in place.
- Near patient Pharmacy – (L2/L4) GO LIVE 3rd December (P5&L3&N3). – Some delays due to new equipment availability.
- Links established with Emergency Flow Recovery Project:
  - Implementation of standards in Emergency Departments and Wards
  - Internal Professional Standards
  - ED Escalation Standards
  - Capacity and Patient Flow Escalation Standard
- Impact of Daily Discharge Review meetings now showing sustained impact in terms of discharge KPI (see attached).

**7 day working:**

- Discussion held during TSPG on 30th Nov to review Trust approach to 7 day working.
- Key points were:
  - Most existing 7 day working fits into level 1 & 2 of the NHS Improvement, 4 level guide – ie local to individual service (see attached).
  - 7 day working should be reviewed under the following 4 headings
    1. Best for quality of care
    2. To make best use of Trust assets
    3. To optimise capacity management
    4. To meet patient requests
- A working group will be established, with the objective of feeding back to TPSG, in the New Year, on current "7 day working" activities across the trust, and a proposal on how the Trust should approach "7 day working" in future.

The TSO are reviewing the format for Trust Board reports for 2013.

**REPORT RECOMMENDATION:**

The Board is asked to receive and note 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:**

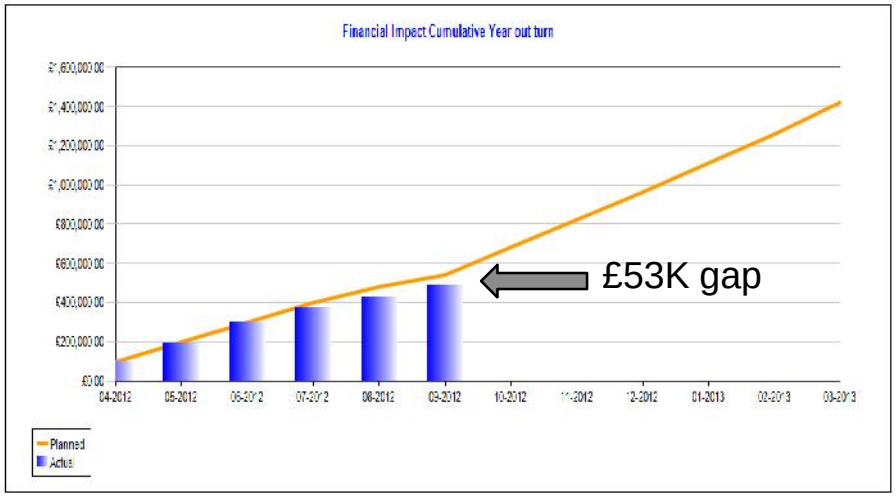
Delivery of the Transformation Plan

**PREVIOUS CONSIDERATION:**

Routine monthly update.

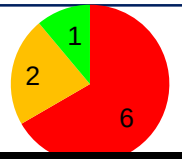
# Work stream: Outpatients

## 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 | £53K miss on September TSP target | Manage through Divisional leads at COO |

## Next steps

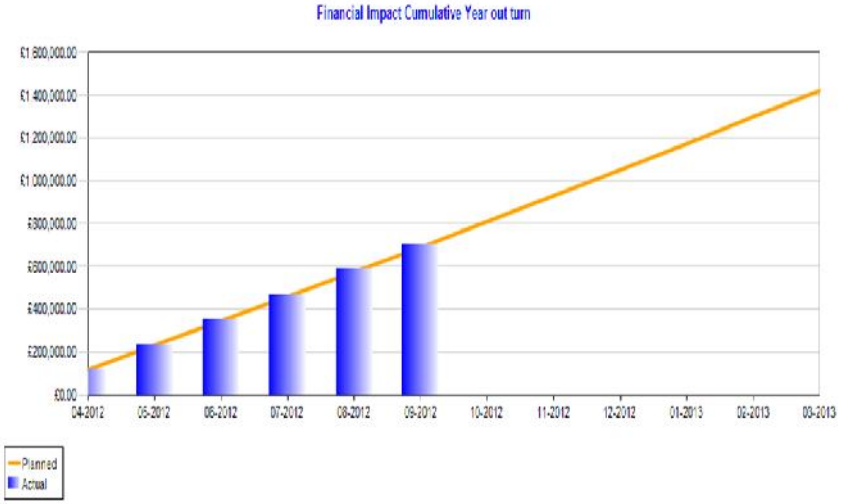
- Clinical pathway redesign- initial meetings with some directorates held, but limited progress. Need to formulate plan to launch pathway redesign early in New Year.
- Five directorates have completed Deep Dive plus and exec task force review- T&O, Cardiology, Urology , Gastro and Geriatrics. With General Surgery still to attend the Exec task force. Rheumatology analysis on-going.
- Focus on LiA identified quick wins through the Outpatients Operational Group- action plan devised.
- Roll out partial booking for all FU appointments in the New Year.
- Implement 'Blue Prism' in OP early in 2013 it gets prioritised to the top of Matthew Maguire's list. This will achieve some savings in medical records and anti-coag initially.

## Risks / Issues / Escalation

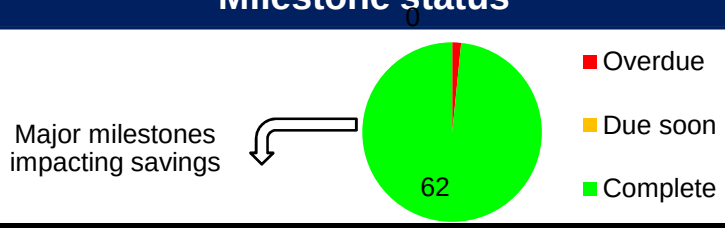
- Slow/limited progress on engagement with directorates in pathway redesign.
- Lack of clarity on how much outpatient activity the CCGs will agree to provide in primary care
- Resource implications within divisions which may result in a delay in the decommission of clinics or failure to progress projects
- Specialities do not have a clear strategy for OP activities

# Workstream: COMMUNITY

## Financial status




## Milestone status




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

## Next steps

- Week commencing 3rd December review of all processes at Leasowes Unit begins
- Develop input from SPARTIC & STAR to feed into Discharge Board Review Meetings
- Continue to work with STAR to release time to assist in timely processing of referrals
- Feedback findings from Sexual Health review
- Review admission and discharge processes at Leasowes & Henderson to inform requirements within Systmone for data collection

## 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

Rehab Workstream

- Meeting held to discuss data collection on Henderson & Leasowes and way forward with recording data on Systmone. Exploring the possibility of developing a bed unit within system for accurate recording of data and possible use of eBMS to assist discharge and planning.

- Prep work started in readiness for observation week commencing 3rd December. Objective to review all processes with a view to improvement and pushing forward some of the work already identified within the workstream i.e. nurse handover, MDT, Discharge Board Review Meetings etc

Integrated Teams

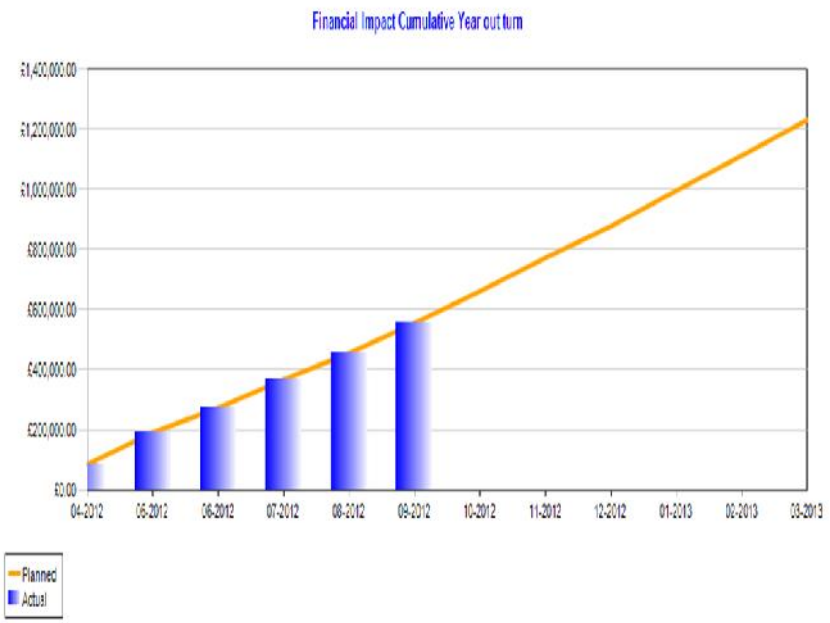
- Work still ongoing re review of Single Referral Form and referral into other community services other than beds
- SPARTIC element of ICARES team have joined Discharge Board Review conference calls. Going forward discussions started on developing a symbol for eBMS to assist wards when patient referred to Intermediate Care
- Review of STAR processes - working together to try and release sometime to enable quicker processing of referrals. Discussions started re development of information on eBMS to update wards re progress of STAR referrals

PCS

- “Deep Dive” into DN service at Neptune completed –feedback to DN team to take place next Thursday
- Review of Sexual Health Service complete – presentation in process of preparation to feedback to DGM and Sexual Health Service staff

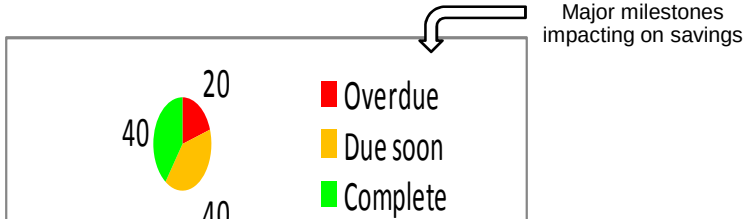
# Workstream: Theatres

## Financial status




## Milestone status

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




## Next steps

**CB:** Go out to bank for 2 band 3 to support T&O centralised booking pilot
Finalise and validate first draft SOP's
Implement training to support SOP adherence.
**Pre-OP**: Clarify rotas
Templates to be built
EDTA training being undertaken
**Scheduling**: Liaise with team leads to determine opportunities which will be tested and trialled
Test what if scenarios with the demand capacity model

## 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

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# Theatre Workstream Project: Org Chart

**Clinical/Management Leads:**
Zoe Huish
Bethan Downing

**Transformation:**
Leann Coughlan
Paul Woodhead

**T&O Clinical/Management Leads:**
Yvette Moore
Mr Roy

## BOOKING RULES

**Lead**: Louise Pickering

-Exploring the use of a Point system that will be used for scheduling and monitoring productivity. This will be driven by throughput targets and BOA baseline standards.
-Core scheduling rules to be developed e.g. No patients to be cancelled without authorisation (cancellation policy endorsed by DGM) First patient locked down OPCS generated procedure times

## THEATRE WARD FLOW

**Lead**: TBD by Bethan
-Determine the line and process of communication between ward & theatre
-Theatre planning board will support this process
-Clarify teams roles and responsibilities
-Use Ormis to clarify the order of the days list
-Review the footfall to promote a seamless theatre session.

## PERFORMANCE MANAGEMENT

**Lead**: Derek Norman
-The use of performance management board in theatres
-Use of new theatre dashboard in current systems & structures
-Clear process in place for reporting and escalating performance
-Theatre Planning board
-The use of Exec Reinforcement?

## STEP DOWN

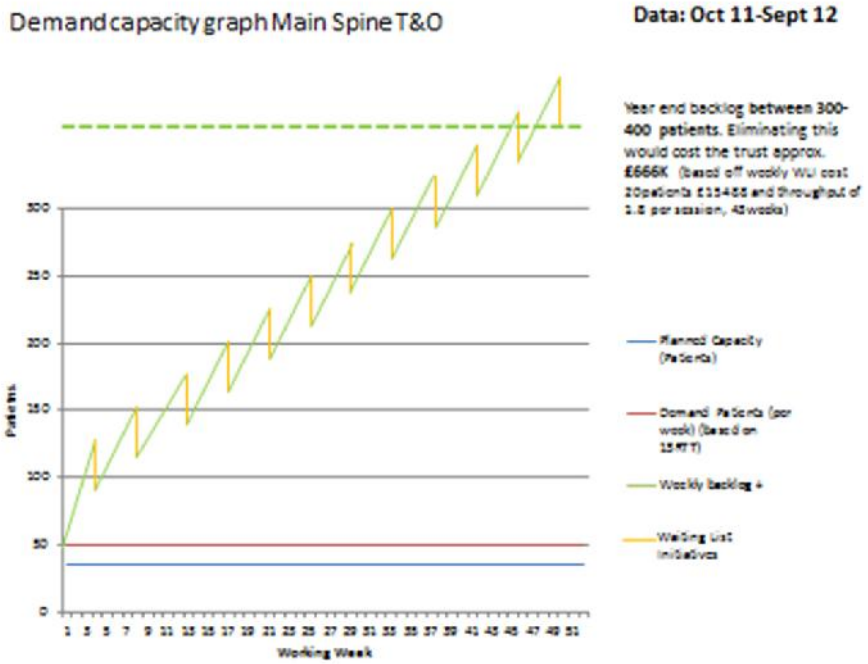
**Lead**: Lesley Hodgkinson
-Admission Suite at SGH
-23 hour stay ward at SGH
-Utilise BTC ASU 23 hour stay
-Extended hours in SDU – to remain open until 10.00p.m.
-Minor Ops at SGH
-Community/GP services – procedures currently done as an outpatient being performed in health centres either by our staff or by specialist trained GP's/nurses.
-Planned flexible working

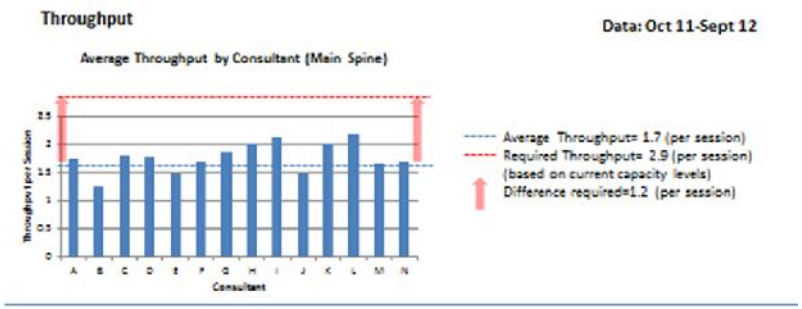
## FLEXIBLE WORKING

# Workstream: Theatres

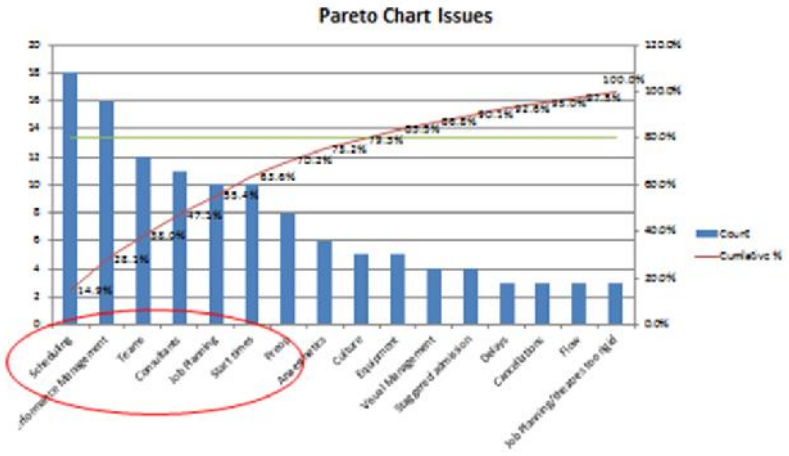
## Delivery status

**Scheduling Workout 7th Nov: Deep Dive Presentation**



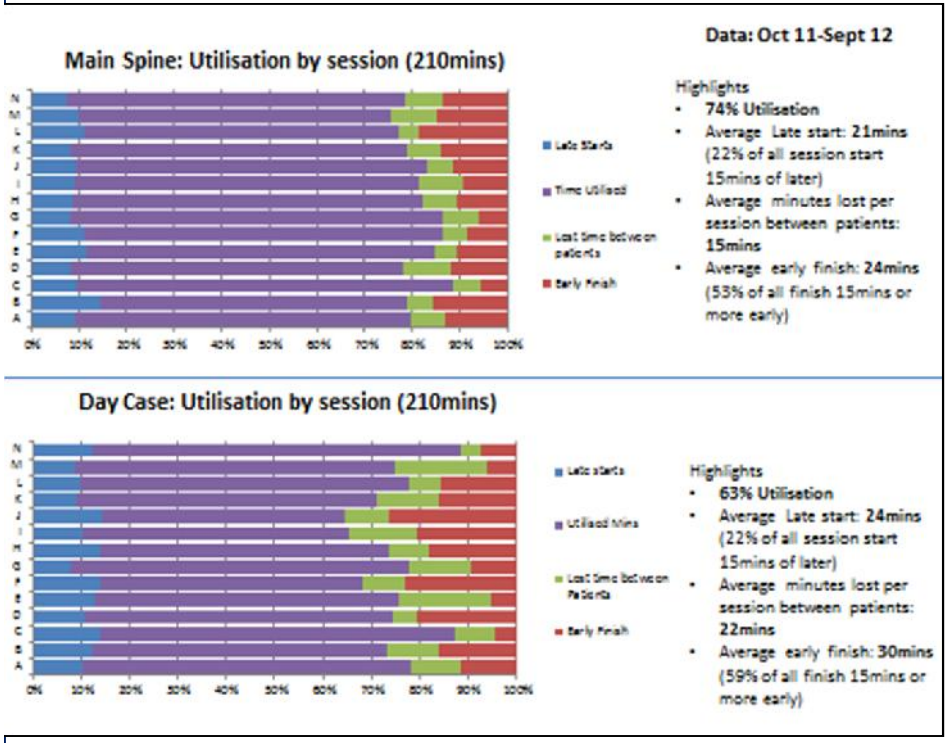



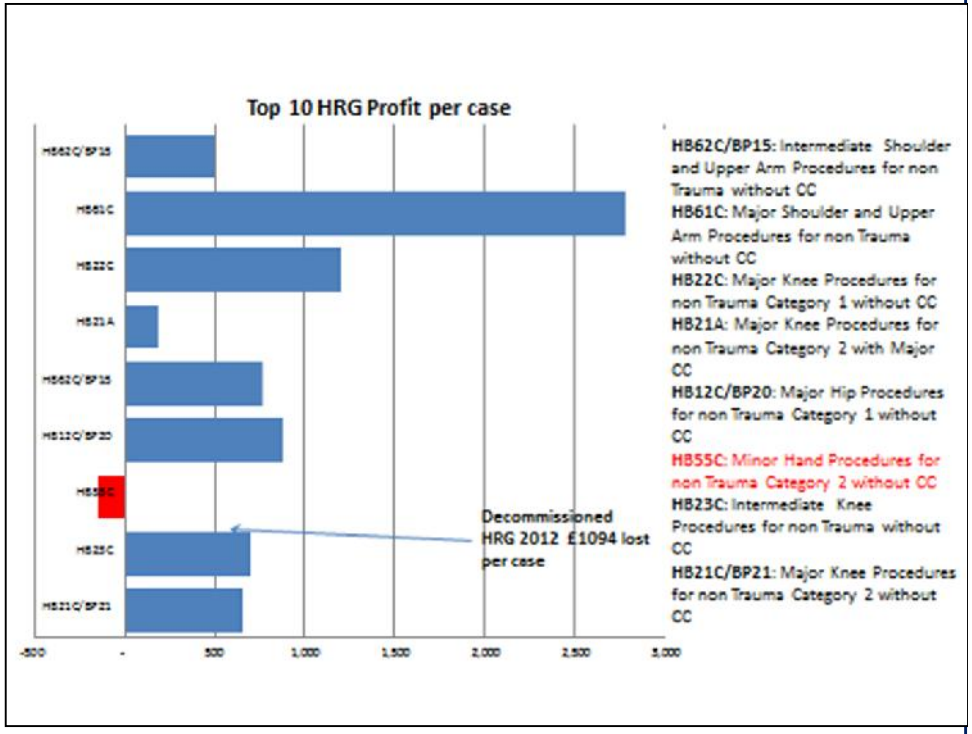




# Delivery status

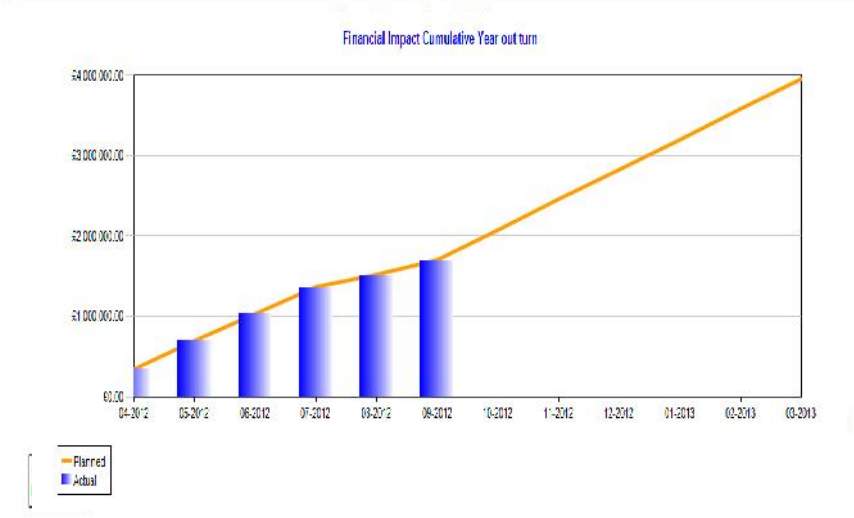
## Scheduling Workout 7th Nov: Deep Dive Presentation



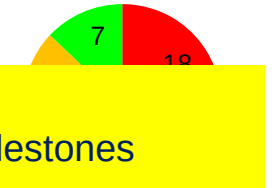



# Patient Flow Workstream:

## Financial status




## Milestone status




Major r
impacti

TPRS milestones need to be reviewed in light of changed Bed Reconfiguration Programme

| RAG | M | | ctions |
|---|---|---|---|
| | Phas<br>Curre<br>still o | | next steps |
| | Phas<br>deper<br>of str | | next steps |
| | Phase 3 (25 beds) | Delay in proposed nursing establishment | As per next steps |

## Next steps

- Board Round Peer Review monitoring in place.
- Daily Discharge Reviews – hand-over, standard and peer review monitoring in place.
- Near patient Pharmacy – (L2/L4) GO LIVE 3rd Dec (P5&L3&N3).
- Transport – embed practice.
- Improved hand-over and criteria-led discharges.
- Ongoing developments in eBMS.

{ ? External partners inc. NH, STAR, SW }

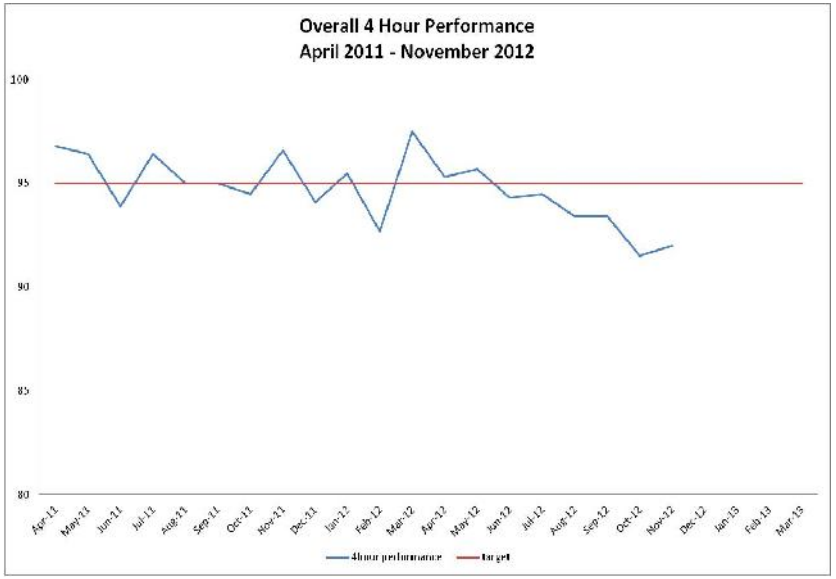
**Links to Emergency Flow Recovery Project**

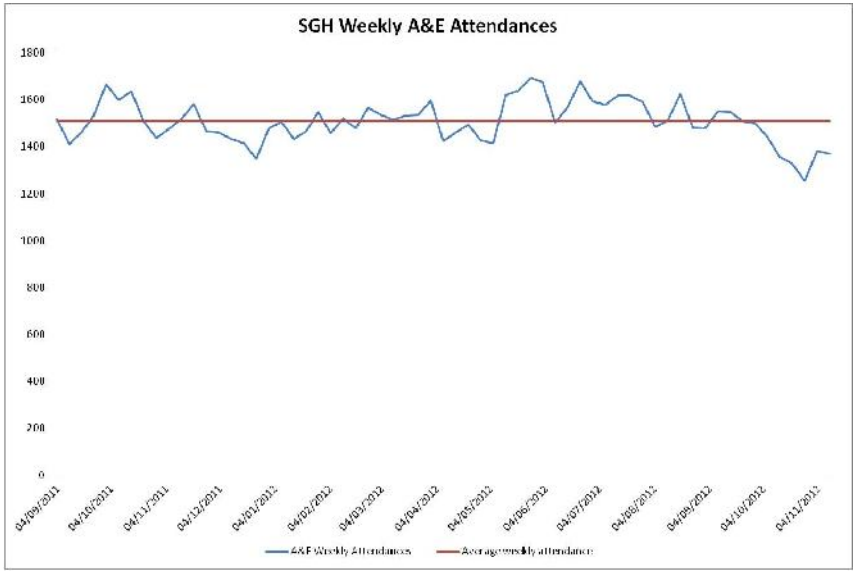
- Implementation of standards in Emergency Departments and Wards (launched 26th November).
- Internal Professional Standards - expectations for day-to-day clinical working.
- ED Escalation Standards - actions within our EDs to cope with pressures.
- Capacity and Patient Flow Escalation Standard - actions across the Trust to cope with pressures.

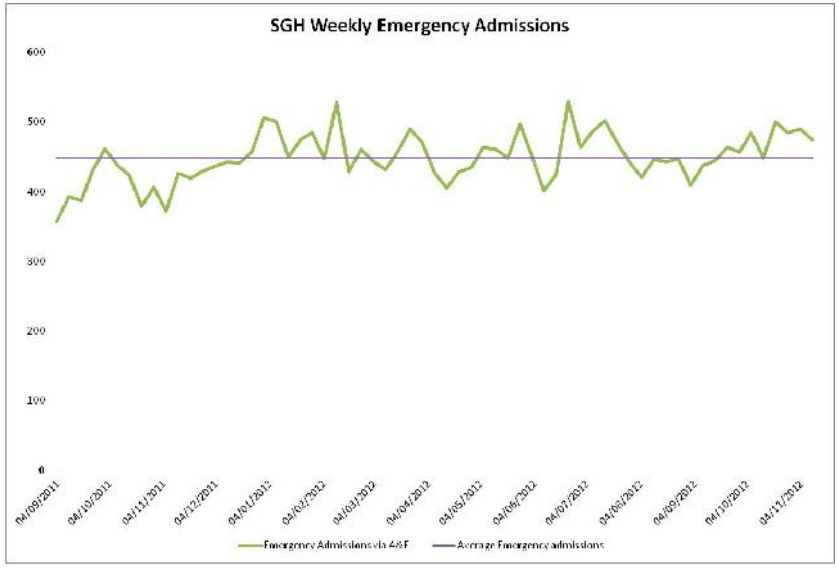
## Risks / Issues / Escalation

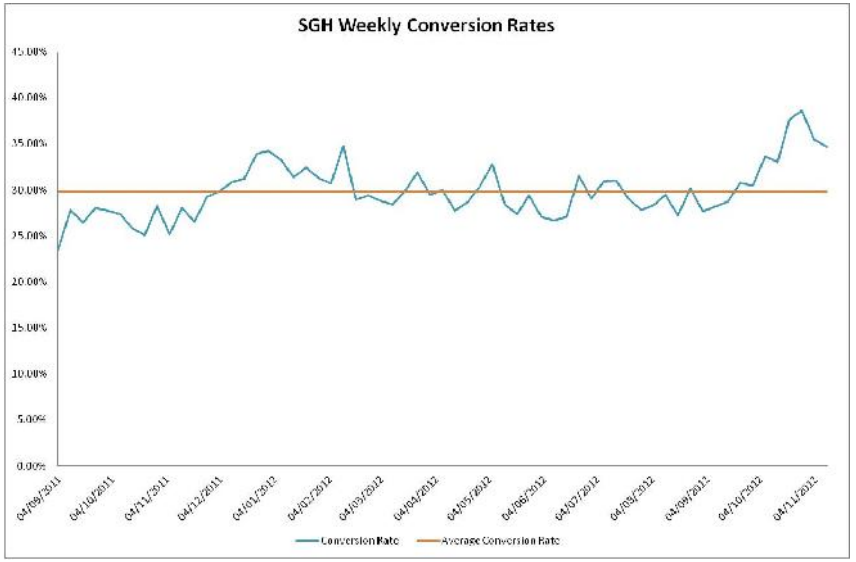
- Potential increase in A&E attendances +/- conversion rates to emergency admissions
- Winter pressures and closures of wards due to infection
- Less 'easy opportunities' for additional discharges at times of escalation
- Challenges with some wards changing their daily practice

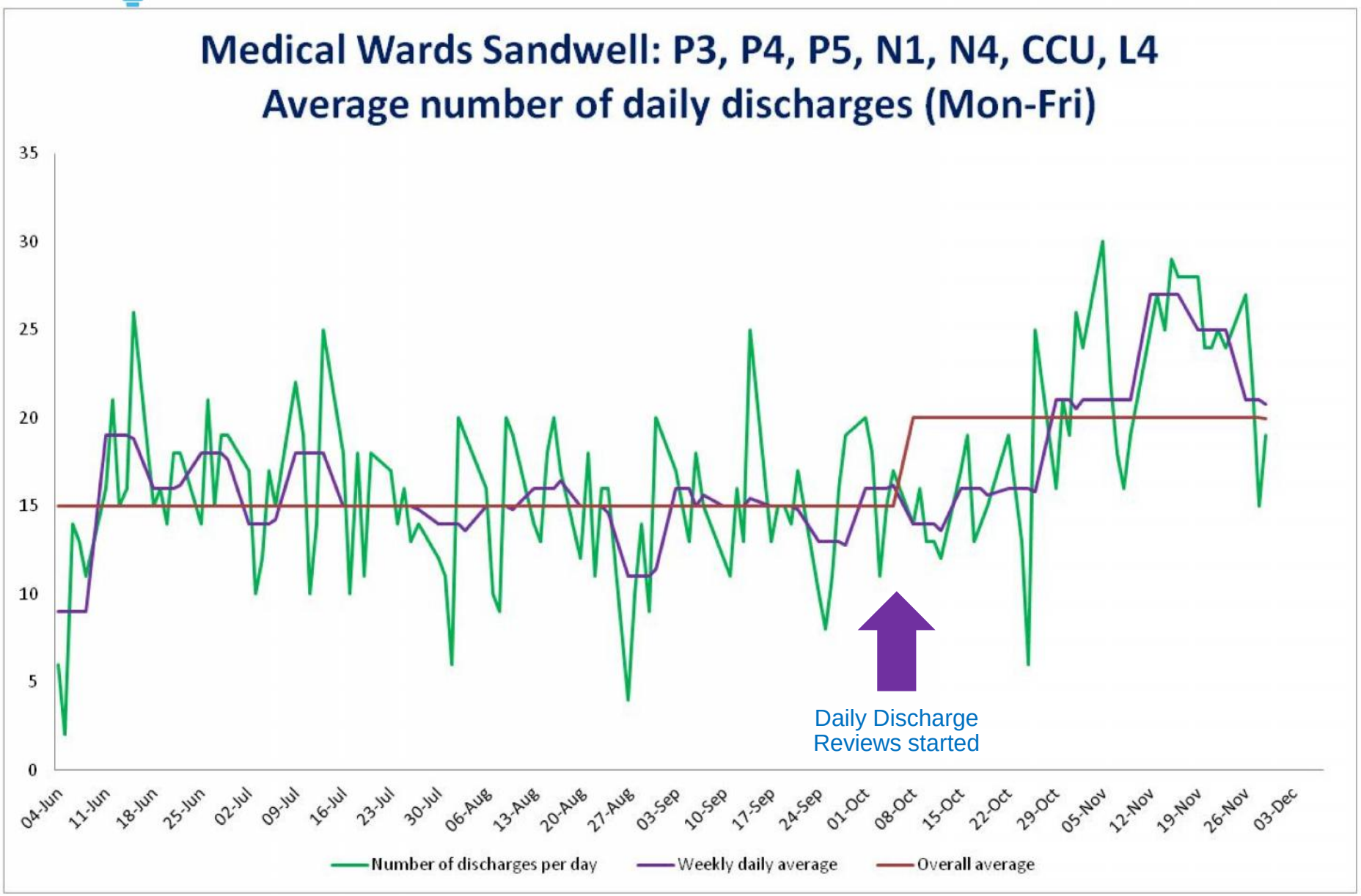
# Emergency Access Indicators




Medical Wards Sandwell: P3, P4, P5, N1, N4, CCU, L4
Average number of daily discharges (Mon-Fri)
35
30
25
20
15
10
5
0
04-Jun
11-Jun
18-Jun
25-Jun
02-Jul
09-Jul
16-Jul
23-Jul
30-Jul
06-Aug
13-Aug
20-Aug
27-Aug
03-Sep
10-Sep
17-Sep
24-Sep
01-Oct
08-Oct
15-Oct
22-Oct
29-Oct
05-Nov
12-Nov
19-Nov
26-Nov
03-Dec
Daily Discharge Reviews started
Number of discharges per day
Weekly daily average
Overall average

# Transformation Plan
# 7 day working discussions

# "7 day working"

- How we've managed 7 day working to date
- Work done in Imaging for "New Ways of Working"
- Feedback on:
  - How areas are impacted by lack of 7 day working
  - How areas could benefit from 7 day working
  - What enabling services would be required to facilitate 7 day working
- How should we approach 7 day working going forward

# NHS Improvement

**Level 1** – Services limited to one department or a service that is beginning to deliver some services beyond the 8am - 6pm Monday to Friday service. This could be extended working days and some weekend services, however, does not deliver equitable services irrespective of the day of the week. (e.g. radiotherapy case study, three session elective surgery).

**Level 2** - Services that are delivered seven days per week, but not always offering the full range of services that are delivered on week days. This limited range of services goes beyond "on call" and emergencies only and facilitates some clinical decision making and discharge, though is likely to be one service and not integrated with other service delivery. (e.g. pharmacy services offering a limited range of services, with several staff available, radiology offering weekend lists for in patients).

**Level 3** - A whole service approach to seven day service delivery that requires several elements to work together in order to facilitate clinical decision making or treatment, often covering more than one work force group. (e.g. stroke services integrating acute stroke clinicians, imaging, specialist nurses, TIA clinics, thrombolysis).

**Level 4** - A whole system approach to seven day service delivery by integrating the requirements for elements of seven day services across more than one specialty area (e.g. across several departments and services within an acute trust, integration of several services across health and social care to reduce admission to the acute sector).

**Level 1**

Some local Services delivering outside the normal Mon-Fri 8am-6pm

**Level 2**

Some local Services delivering 7 days / week

**Level 3**

A whole service 7 days / week requiring other services to do the same

**Level** 4

Whole system 7 day working across several services

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# TRUST BOARD

| | |
|---|---|
| **DOCUMENT TITLE:** | Clinical Services Reconfiguration Programme: Minutes from the Programme Board Meeting on 6th December 2012 |
| **SPONSOR (EXECUTIVE DIRECTOR):** | Mike Sharon, Director of Organisational Development and Strategy |
| **AUTHOR:** | Jayne Dunn, Redesign Director – RCRH |
| **DATE OF MEETING:** | 20 December 2012 |

**EXECUTIVE SUMMARY:**

The attached presents the minutes from the Clinical Services Reconfiguration Programme Board meeting held on 6th December 2012.

The minutes cover an update of progress with each area of clinical service reconfiguration projects that the Trust is involved in, including a range of wider SHA/health economy plans for clinical service consolidation. In summary the minutes provide details of:

1. The service reconfigurations we have recently implemented.
2. The peer review visit in early October to validate our Trauma Unit status.
3. Progress with delivering the implementation phase of our stroke reconfiguration project which will consolidate all inpatient Stroke and Neurology services along with TIA services at Sandwell Hospital from early March 2013. There has been a slight delay of a week to the opening date for the new Hyper Acute Stroke Unit (HASU) due to a delay in starting refurbishment work on Priory 4 ward. There has also been a delay in resolving the consultant on call rota which needs to be resolved promptly and there is a need to review the refurbishment and relocation arrangements for the second CT scanner at Sandwell which will now require the use of a temporary scanner whilst this work is undertaken. Neither of these should delay the opening of the new HASU.
4. In addition it outlines the latest progress with the NHS Midlands and East strategic review of stroke services.

**REPORT RECOMMENDATION:**

The Trust Board is recommended to:

1. ACCEPT this progress report regarding our ongoing clinical service reviews and reconfiguration projects.

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

The receiving body is asked to receive, consider and:

| Accept | Approve the recommendation | Discuss |
|---|---|---|
| X | | |

| **KEY AREAS OF IMPACT** *(Indicate with 'x' all those that apply):* | | | | | |
|---|---|---|---|---|---|
| Financial | x | Environmental | | Communications & Media | X |
| Business and market share | x | Legal & Policy | x | Patient Experience | X |
| Clinical | x | Equality and Diversity | x | Workforce | X |
| Comments: | | | | | |

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

This report aligns to our Corporate Objective 2: High Quality Care and the following priorities for 2012/13:

- Delivering the quality priorities set out in our Quality Account
- Delivering the Transformation Plan
- Progressing the "Right Care Right Here" vision of service change

**PREVIOUS CONSIDERATION:**

September 2012: Progress report relating to Clinical Service Reconfiguration

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# MINUTES

# Clinical Service Reconfiguration Programme Board

**Venue** Meeting Room, Corporate Suite (D29) **Date** 6th December 2012

**Present:**

Mrs. G Hunjan (Chair) Mr J Adler (part) Dr J Berg (part)
Mrs J Dunn Professor R Lilford Mr M Sharon (part)

**Secretariat:**

Mrs L Broadway

| MINUTES | PAPER REFERENCE |
|---|---|
| **1. Apologies for absence** | |
| Apologies were received from Miss R Barlow, Mrs A Geary, Mr H Kang, Mr G Seager and Mr R Stedman. | |
| **2. Introduction** | |
| Mrs Hunjan introduced Professor Lilford, recently appointed Non-Executive Director, and reported that he would be taking over as Chair of the Clinical Service Reconfiguration Programme Board from February 2013. | |
| **3. Minutes of the previous meeting** | **SWBRB (12/12) 74** |
| The minutes of the meeting held on 13th September 2012 were accepted as a true and accurate record. | |
| **4. Matters Arising** | |
| **4.1 Process for Reconfiguration** | |
| Mrs Dunn reported that the updated Process for Reconfiguration document had been circulated to Divisional Directors, Clinical Directors and Divisional General Managers. The background to this document was explained to Professor Lilford. | |
| **5. Emergency Gynaecology Reconfiguration** | **SWBRB (12/12) 83** |
| The Quarter 2 SWBH Emergency Gynaecology Services progress report was received and presented by Mrs Dunn. It was noted that the EGAU would | |

| MINUTES | PAPER REFERENCE |
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| be accommodated within the Surgical Assessment Unit and funding had now been agreed. It was expected that the unit would be up and running by end of March 2013. Liaison was taking place with Surgery A to agree theatre and bed capacity transfer to City site. Transition arrangements were in place to support safe clinical care during the transition period and an engagement and communications plan had been agreed. Mrs Geary is leading on the actions identified in the report.<br><br>The key service change would be for all elective and emergency inpatient admissions to be at City Hospital. Patients from Sandwell Hospital requiring inpatient care would be transferred from EAU to City Hospital. Those patients requiring emergency surgery who were not stable enough to transfer to City would be operated on at Sandwell.<br><br>Mrs Hunjan expressed the hope that arrangements would be put in hand to monitor the number of transfers from Sandwell to City and any adverse incidents that may arise. The Board should be kept up dated. | |
| **6. Surgical Services Update** | **SWBRB (12/12) 77** |
| Mrs Dunn presented the progress report for Vascular Surgery, Breast Surgery and Orthopaedic Reconfiguration. | |
| **6.1 Orthopaedic Reconfiguration** | |
| It was noted that arrangements were in hand to finalise staffing rotas. In answer to a query from Professor Lilford, it was explained that discussions were taking place with commissioners to explore opportunities for the Trust to send patients who were suitable for early discharge to the Norman Power Centre for rehabilitation. | |
| **6.2 Breast Surgery Reconfiguration** | |
| It was noted that no issues of concern had arisen following the reconfiguration of Breast Surgery services to City Hospital, primarily in the Birmingham Treatment Centre (BTC), which had taken place on 30th July 2012. SIRG had approved the development of VAC assisted biopsy as a procedure which would substitute a surgical procedure for a radiological intervention, thus improving patient pathway.<br><br>A post-reconfiguration evaluation planned for March 2013 was discussed and it was agreed this would be better undertaken 12 months after implementation. Following a request from Mrs Hunjan, Mrs Dunn agreed to ascertain whether there had been any adverse events since reconfiguration and include her findings in a report for the next Board meeting. | |
| **ACTION: Mrs Dunn to ascertain any adverse/events arising from reconfiguration and include in update report to next meeting of the Board. Mr Beverdige to arrange for the post-reconfiguration evaluation to b eundertaken 12 months after implementation.** | |

| MINUTES | PAPER REFERENCE |
|---|---|
| **6.3 Vascular Surgery** | |
| Inpatient vascular surgery and vascular interventional radiology had transferred to UHBFT (Queen Elizabeth Hospital) on 10th September 2012. This had enabled the closure of D30 by transferring and integrating male urology with male ENT on D21. The Trust's consultant contracts, together with all radiology nursing and medical staff had been retained by SWBHT. Some staff that had not been eligible to transfer under TUPE had been appointed by UHBFT to help manage the vascular service. Outpatients and day cases would continue to be seen at City and Sandwell Hospitals. The SLA had not yet been signed. It was agreed that a post-reconfiguration review should be undertaken after six months and after 12 months.<br><br>No further progress had been made on plans to upgrade Ward D21. In answer to a query from Mr Adler, Mrs Dunn advised that the upgrade of D21 had not been included in the original plans for vascular reconfiguration. She agreed to liaise with Mr Seager and Mr Beveridge to ascertain the current position.<br><br>It was noted that new specialised commissioning arrangements had been introduced and the Trust would need to become a specialised commissioning centre (except for varicose veins) for Vascular Surgery day cases from 1st April 2013. The Trust would wish to be a designated centre. Mrs Dunn would liaise with Mr Beveridge and Mr Ian Kendall. | |
| **ACTION: Mrs Dunn to liaise with Mr Seager and Mr Beveridge to ascertain position with regard to update of D21 and would liaise with Mr Beveridge and Mr Kendall about the implications of the new specialised commissioning arrangements.** | |
| **7. Stroke Services Reconfiguration** | **SWBRB (12/12) 82** |
| Mrs Dunn presented the Progress Report for the Stroke and TIA Reconfiguration Project. It was noted that the project status was shown as 'red'. The main reasons for this were:<br>• Delay in commencing refurbishment work on Priory 4<br>• Delay in resolving consultant on call rotas<br>• Issues recently raised about arrangements for the second CT scanner at Sandwell Hospital.<br><br>***Delay in commencing refurbishment work on Priory 4*** - this was because as a result of the revised Trust bed configuration plan, additional beds being open for the winter, and the need to relocate Priory 3 for deep cleaning, there had been a delay in vacating Priory 4 ward and thus the commencement of the refurbishment work required for stroke configuration. This had resulted in a delay of a week to the overall project plan with the planned opening date of the new HASU moving from 25th February 2013 to 4th March 2013.<br><br>***Delay in resolving consultant on call rotas*** - unfortunately the issues | |

| **MINUTES** | **PAPER REFERENCE** |
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| regarding consultant rotas for stroke being aligned with the acute medical consultant rota and to establish specialist cover out of hours for stroke had not yet been resolved. It was agreed that Mrs Dunn would liaise with Dr Stedman regarding this as this was an important issue that required resolution as soon as possible.<br><br>Following a query from Professor Lilford, Mrs Dunn explained the background to medical cover, training and issues in respect of the rota. It was anticipated that consultants would be expected to undertake 7 day ward rounds. Thrombolysis rates were not as high as they could be but were expected to increase post reconfiguration. It was planned that post-reconfiguration there would be stroke alert nurses in post who will meet patients in ED who have been assessed by WMAS as FAST positive and alerted to the team prior to arrival. The use of telemedicine would enhance the service. However there was a need to monitor this post reconfiguration to ensure thrombolysis rates increase.<br><br>The relocation of all stroke and neurology services to Sandwell would impact on junior doctor training experience in Medicine and other specialties such as ED. Liaison was taking place with College tutors.<br><br>The work being carried out in respect of early supported discharge was explained. This is important to help reduce length of stay and support the reduced bed numbers. This service covers Sandwell residents with 30% of patients who have had a stroke and are Sandwell residents being discharged to the Early Supportive Discharge Team (national target is 40%). Currently there is not such a team for West Birmingham residents and so there have been discussions with Birmingham Community Health FT, the CCG and Sandwell Adult Community Division about options to develop such a team.<br><br>***Issues had arisen in respect of the CT scanner at Sandwell.*** Despite the Imaging Division having signed off plans in August, staff were now raising concerns about what had been signed off and so further accommodation changes would be required. This may cause a delay to the operational date for the permanent CT scanner. The money allocated in the business case for a temporary scanner may now need to be used for these changes.<br><br>It was noted that LIA events had been held and staff were keen to proceed with the reconfiguration and performance within the specialty had improved.<br><br>In answer to a query from Mr Sharon, Mrs Dunn advised that there would not initially be a direct admission model for stroke following reconfiguration but this was still under discussion for the medium term.<br><br>The SHA review of stroke services, and in particular the number of Hyper Acute Stroke Units (HASU) was still on-going and the report would be issued by end of March 2013. A further template return was required in December but this may be delayed until the middle of January. There had been issues with the model developed by Deloitte and this had been | |

| MINUTES | PAPER REFERENCE |
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| queried with them. Networks are working together regarding this but they have differing view of what is required and the numbers that should be used to model. If only 4 HASUs were established across Birmingham and the Black Country 2 Trust's currently providing HASU services would need to no longer provide these. It was looking unlikely that a decision would be made before the end of March.<br><br>The Reconfiguration Board expressed concern regarding the delays and Mrs Hunjan expressed the hope that the reconfiguration would be back on track by the beginning of March and that the SHA would have more information available at that stage. | |
| **ACTION: Mrs Dunn to discuss issues in respect of the consultant rotas with Dr Stedman.** | |
| **8. Trauma Centres and Units** | |
| **8.1 Progress Report** | **SWBRB (12/12) 84** |
| The November progress report in respect of Trauma Unit Designation was received and the key milestone were noted. | |
| **8.2 Trauma Unit Validation Visit** | **SWBRB (12/12) 75** |
| The draft report following the Trauma Unit validation visits to Sandwell and City Hospitals in October was received. Initial feedback seemed positive. Informal feedback was received at the Trauma Network meeting on 21st November but a formal response had not yet been received. It is understood that all Trauma Units will be awarded conditional status with a further action plan required within a month. The conditional status was understood to be primarily due to issues with TARN data submission and the absence of a SLA with Birmingham Community Healthcare Trust for Rehabilitation Consultant support. This would be discussed at the Steering Group meeting on 10th December. There had been as significant drop in trauma activity at the Trust as expected as many trauma cases came to City Emergency Department as either walk-in patients or by own transport rather than via WMAS. It was noted that UHBFT had been discharging patients directly rather than repatriating them back to SWBH. Mrs Hunjan expressed the hope that there was supporting documentation/policies to record relevant activity. | |
| **9. Pathology Update** | |
| A copy of the pathology update was received and presented by Dr Berg. It was noted that discussions were still on-going between SWBH and Dudley Group of Hospitals in respect of joint working in pathology and were progressing well. It was hoped that the Trust would be in a position to jointly tender (with Dudley Group) for any community pathology work. It is anticipates that an announcement would be made next week. The LTS process engineering study would be completed early in the New Year and their report would be presented to both Boards.<br><br>The cytology screening contract had been awarded to Royal Wolverhampton Hospitals. As a consequence some SWBH staff may | |

| MINUTES | PAPER REFERENCE |
|---|---|
| transfer there. Discussions had commenced about the transfer of work from the Trust to Royal Wolverhampton; however this was unlikely to take place before June 2013.<br><br>The building work for the blood sciences laboratory was on course. Phase 1 was due for handover on 28th January 2013. Trust Board had given approval for the haematology Sysmex track and an order had been placed.<br><br>It was reported that the closure of Guys & St Thomas drug laboratory had seen an increase in requests to SWBH's Toxicology Department. The Trust had tendered for urine testing work. It was also proposed that the Trust would tender for oral fluid drug testing work for Edinburgh.<br><br>Professor Lilford was pleased to note that the Pathology Department was working in a positive and encouraging manner. | |
| **10. Future Clinical Reconfigurations** | **SWBRB (12/12) 76** |
| A paper outlining the services where potential clinical reconfiguration had been identified was received and presented by Mrs Dunn. | |
| **10.1 Clinical Haematology** | |
| Following an external peer view of the haematology-oncology service in March 2012 it had been recommended that the Trust consider providing all inpatient care on one site. A haematology steering group had been set up and the Terms of Reference were received. It was hoped to hold an LIA event for patients in January 2013. It was likely that public consultation would be required if a decision was agreed to proceed with reconfiguration. Professor Lilford felt there would be little benefit in this reconfiguration proceeding. It was agreed that the clinical case for change would be presented at the next Reconfiguration Board meeting in February. Concern was expressed that patients may not be willing to travel from Sandwell catchment area to City Hospital and therefore this activity may be lost to Dudley Group of Hospitals. Mrs Dunn advised that "do nothing" options would also be explored. | |
| **10.2 Interventional Radiology** | |
| Currently Interventional Radiology (IR) was provided at both City and Sandwell Hospitals but there was no dedicated 24/7 IR rota on either site. It was likely that national recommendations will be published in the next year recommending all acute hospital should have a 24/7 IR service. A Steering Group would be set up to review future options for the service. The Terms of Reference were received. Professor Lilford expressed concern that there was no Consultant Surgeon representative on the group. It was suggested that a Consultant Obstetrician should also be included in the membership for wider meetings. Recruitment to Consultant IR vacancies had proved extremely difficult and the service was currently understaffed. The service review would need to identify which configurations would make the | |

| MINUTES | PAPER REFERENCE |
|---|---|
| service more attractive to potential applicants. | |
| **10.3 Cardiology – Percutaneous Cardiac Intervention (PCI)** | |
| The background to this proposed service review was noted. It was felt that it may not be necessary to go out to public consultation. However Consultant Cardiologists were divided in opinion about one site working. Initial discussions had taken place with UHBFT about the possibility of combining PCI out-of-hours but it appeared that UHBFT would expect the service to be based at QE Hospital. It was agreed that an update report would be provided at a future Reconfiguration Board meeting. | |
| **11. REPORTS FOR INFORMATION** | **SWBRB (12/12) 78-81** |
| The following reports/notes were received for information. Mrs Hunjan advised Professor Lilford that the notes were brought to Reconfiguration Board to strengthen the governance arrangements for the meeting:<br><br>• Notes from the Stroke Reconfiguration Project Board - 30th August and 1st November 2012.<br>• Notes from Stroke Clinical Implementation Group – 10th August, 24th August and 2nd November 2012<br>• Notes from SWBH Vascular Surgery Reconfiguration Project Team – 5th September 2012<br>• Notes from Trauma Steering Group – 13th August and 10th September 2012<br>• Notes from Haematology/Oncology Inpatient Review Steering Group – 15th October 2012 | |
| **12 ANY OTHER BUSINESS** | |
| **12.1 February Meeting** | |
| Professor Lilford highlighted that the February meeting of the Reconfiguration Board clashed with the proposed date for a Board-to-Board FT meeting. It was agreed that if a final decision had not been made regarding the Board to Board meeting by end of December 2012, an alternative date for the Reconfiguration Board would be sought and notified. | |
| **ACTION: Mrs Broadway would ascertain whether an alternative date would be required for the next Reconfiguration Board meeting and make the necessary if so required.** | |
| **12 DATE & TIME OF NEXT MEETING** | |
| Thursday 7th February 2013, from 1 pm to 3.00 pm in the Meeting Room, Ward D29. | |

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:** | 20 December 2012 |

**EXECUTIVE SUMMARY:**

The paper provides a progress report on the work of the *Right Care Right Here* Programme as at December 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 reports to Trust Board

# SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

# RIGHT CARE RIGHT HERE PROGRAMME: PROGRESS REPORT DECEMBER 2012

**Introduction**

The purpose of this paper is to provide an update on progress with the Right Care Right Here (RCRH) Programme and the QIPP (Quality Innovation Productivity and Prevention) Schemes.

**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 October (month 1-7) shows that against these contract lines activity are above plan (and therefore below QIPP savings) by circa £2.69 million. This is a significant deterioration from last month's report partly because last month's report was against the £6.3 million whereas this month is against the full £10million QIPP savings but also because of significant activity increases in month for non elective admissions and new outpatients. The table in Appendix 1 summarises performance to date against plan and against 2011/12 actual income levels. It should be noted that part of the performance below plan for elective admissions is as a result of some day case activity now being undertaken and coded as outpatient with procedure (this activity type is therefore above plan).

As reported last month there are ongoing 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.

**Pathway redesign activity**

Pathway redesign activity will recommence in a number of areas as the CCG is able to identify leads for this work. The Musculo-Skeletal Pathway Group met and agreed a plan to introduce the new pathways for hip, knee and shoulder joint replacements. This means:

- From January 2013 all patients referred to Orthopaedics for this surgery should have been triaged in primary care, had diagnostic tests arranged by their GP along with management of any other conditions, have received information and had a discussion about the proposed operation. From a patient's perspective this will mean fewer trips to hospital and reduced waiting times. For our Orthopaedic service this will mean more patients are fit for surgery when referred and a reduction in waiting times with less pressure to undertake additional clinics.
- From June 2013 the 6 month and 12 month follow up appointments will be undertaken in a community location by a Surgical Care Practitioner or MSK therapist who has been assessed as meeting the required competencies. For patients this will mean receiving their follow up care closer to home. For our Orthopaedic service this will mean less demand for consultant follow up appointments again reducing waiting times.
- Introduction of a training programme for SWBH staff and primary care clinicians.
- Our Orthopaedic clinicians will be attending the Local Commissioning Groups to present the new pathways with a plan to return 6 months later to discuss progress.

**RCRH Partnership**

The RCRH Partnership meeting structure has been revised as follows:

- The RCRH Partnership Executive has a first meeting scheduled for 13th December.
- In relation to the subgroups, initial meetings have been held for :
    - Implementation of Pathways and Redesign
    - Regeneration

- Dates in mid December have been arranged for:
    - Finance and Performance
    - Communications and Engagement

**Recommendations:**

The Trust Board is asked to:

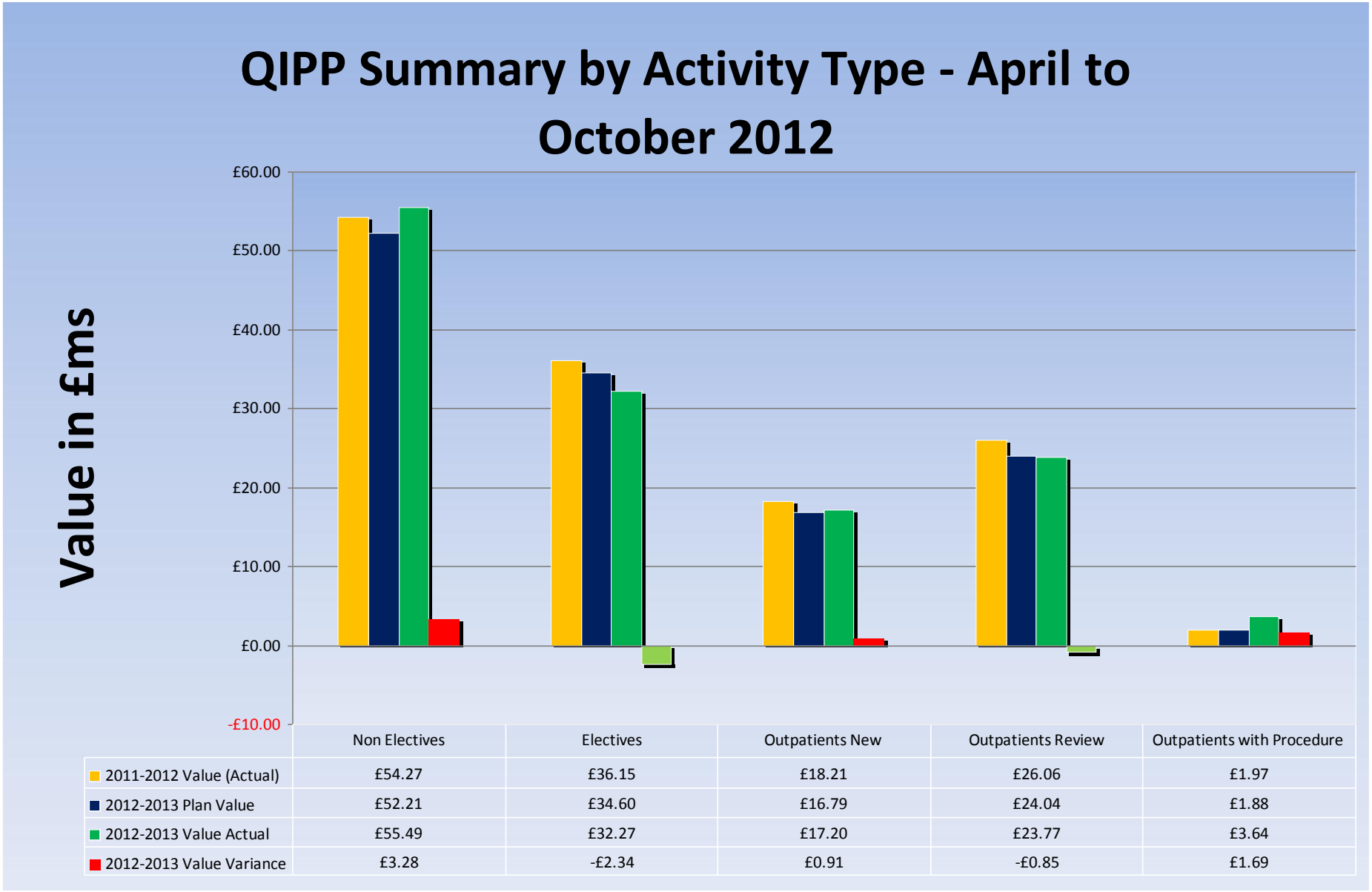
- ACCEPT the progress made with the Right Care Right Here Programme.

Jayne Dunn

Redesign Director – Right Care Right Here

11th December 2012

**APPENDIX 1**




| | Non Electives | Electives | Outpatients New | Outpatients Review | Outpatients with Procedure |
|---|---|---|---|---|---|
| 2011-2012 Value (Actual) | £54.27 | £36.15 | £18.21 | £26.06 | £1.97 |
| 2012-2013 Plan Value | £52.21 | £34.60 | £16.79 | £24.04 | £1.88 |
| 2012-2013 Value Actual | £55.49 | £32.27 | £17.20 | £23.77 | £3.64 |
| 2012-2013 Value Variance | £3.28 | -£2.34 | £0.91 | -£0.85 | £1.69 |

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# TRUST BOARD

| | |
|---|---|
| **DOCUMENT TITLE:** | **Communications and Engagement Update** |
| **SPONSOR (EXECUTIVE DIRECTOR):** | **Jessamy Kinghorn, Head of Communications and Engagement** |
| **AUTHOR:** | **Jessamy Kinghorn, Head of Communications and Engagement** |
| **DATE OF MEETING:** | **20 December 2012** |

**EXECUTIVE SUMMARY:**

This report summarises progress against the communications and engagement strategy action plan and provides details of communications and engagement activity over the last 6 months.

**REPORT RECOMMENDATION:**

The Board is asked to note 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 | | **X** |

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

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

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

Relates the Trust's Strategic Objective to be an engaged, effective organisation.

**PREVIOUS CONSIDERATION:**

Bi-annual update.

# Communications and Engagement

# Trust Board Report

# Paper by the Head of Communications and Engagement

# December 2012

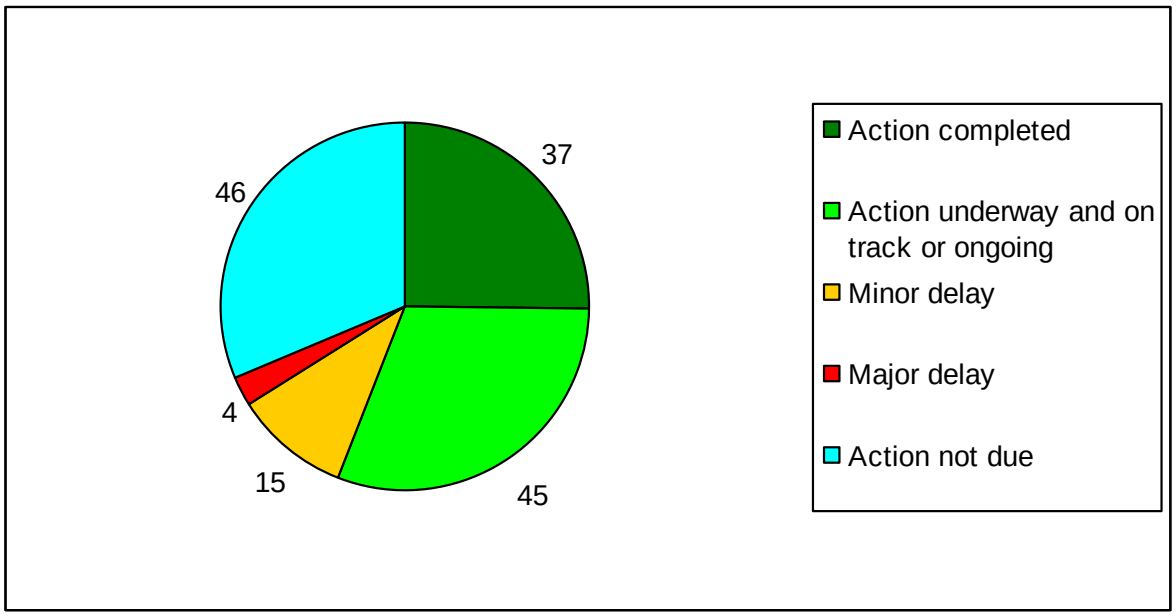
A Communications and Engagement Strategy for 2012-2017 was approved by the Trust Board in June 2012. This report includes a high level update on delivery of the strategy and associated actions. The day to day communications and engagement performance of the Trust, where it can be measured, is reported in appendix one.

Since the development and approval of the Communications and Engagement Strategy, a further set of key communication and engagement actions was identified as part of the Integrated Development Plan (IDP).

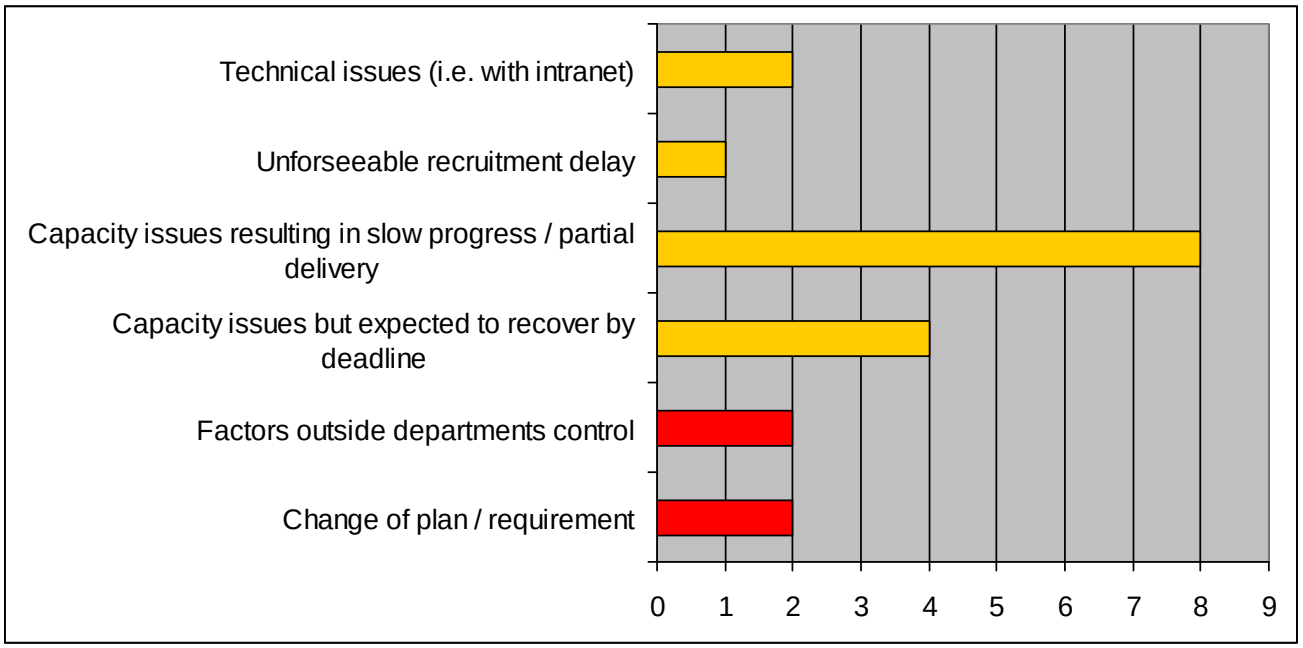
A single integrated action plan (IAP) supports delivery of both the communications and engagement strategy and the relevant actions in the IDP.

This IAP is monitored monthly by the Communications and Engagement team at a meeting chaired by the Head of Communications and Engagement and is discussed at the OD Steering Group chaired by the Chief Executive.

**Status of IAP actions:**




Of the Red and Amber actions, reasons for the delay are given below, with detail provided for actions rated ‘red.’




| | | |
|---|---|---|
| Develop a communications approach to close the loop with regard to feedback from complaints, incidents and audits | Many of those required to achieve this were involved with dealing with outstanding complaints, which was prioritised. Now the complaints backlog has been cleared, a date is being arranged to look at taking this forward to deliver by the year end. | |
| Presentation to Sandwell LINk on quality reports following sending of reports for info | A meeting specifically about the quality reports has not yet taken place, although Executive team members have attended the LINk for discussions on reconfiguration, patient transport and incidents. | |
| Relay patient stories told at the Board to staff through internal communications, such as Heartbeat | Individual patient stories have not been heard at the Board during this time. Other feedback has been provided through Heartbeat, such as features on Board walkabouts. | |
| Board review of Trust values | No formal review has taken place but Board are keeping the current values which were consulted on as part of the FT application. A Hot Topics session on the values as taken place to see if these could be further embedded. | |

All but two of the actions directly relating to the delivery of the strategy are on track or complete. Two are slightly behind schedule and rated amber.

## 5.0 Recommendations

The Trust Board is asked to NOTE the report

# Communications and Engagement Performance – appendix 1

## 1.0 Highlights

Some of the highlights of the last six months include:

The launch of engage website – a social engagement website aimed primarily at members and those with an interest in the Trust or the local area. The launch as been a soft launch (i.e. not widely publicised) and the site has 169 users to date. The most recent feature to be added is a section on the history of the Trust.

### Infection Control

We continue to work closely with our colleagues in infection control and pathology to support them with communications advice following outbreaks such as norovirus, and public health messages about not coming into hospital with D&V symptoms. We are also supporting occupational health colleagues with internal messaging for staff about getting their flu vaccination.

### Ward Team Challenge

The press office supported the nursing division with their annual 'ward Team Challenge' on Wednesday 27th June by testing the media skills and awareness of our nursing teams.

### Olympic Torch relay

Communications staff worked on Saturday 30th June to provide a 'fun day' for the public who were in the vicinity of City Hospital in anticipation of seeing the Olympic Torch pass down Dudley Road. Various activities were organised including displays of Irish and Bangra dancing, art and crafts and medical themed fun 'tests'. The public came together to produce a huge super sized banner wishing Team GB good luck in the Olympics, which was attached to our railings in time for the procession.

### Reconfigurations

The team has provided communications support to the reconfiguration of our breast and vascular services. This has included patient engagement where we have asked our patients what changes they would like to see to improve the service we provide.

### Awards

The team were shortlisted in four categories at this year's national AHCM awards – best engagement, best media handling (which the Trust was highly commended for), best use of digital media, and Abigail Parkin was selected as the Communicator of the Future.

## 2.0 Internal Communications

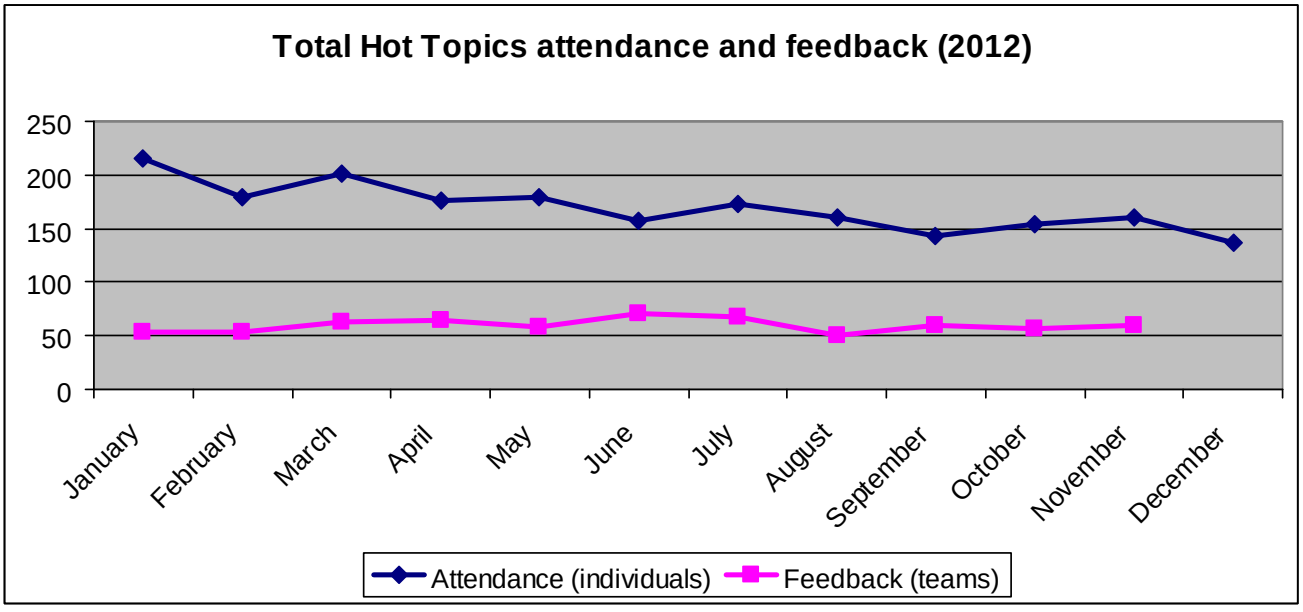
Regular internal communications methods include the Trust's newsletter, Heartbeat which includes 'Your Right To Be Heard', Hot Topics, daily e-bulletins, monthly Chief Executive's Key Messages, daily updating of the intranet and use of posters and displays. Listening into Action and Owning the Future are further methods used to engage with frontline staff.

**Hot Topics:** Each month a topic is discussed by teams throughout the Trust through the monthly team briefing session, Hot Topics. Each team feeds back the outcome of their discussion and the feedback is shared with teams the following month. It is also used to influence policy, strategy and planning in the organisation. Recent subjects are:

July 2012 – Staff Appraisal (non-medical)
August 2012 – Quality and Safety
September 2012 – Our Priorities (Trust objectives 2013/14)
October 2012 – Trust Values
November 2012 – Corporate Services TP workstream
December 2012 – Visibility of senior leadership

The briefing starts with a core brief, held by the Chief Executive each month at City, Sandwell and Rowley Regis Hospitals. Attendance figures, together with the number of teams providing feedback on the 'hot topic' each month are below:

| Month | Rowley Attendance | Sandwell Attendance | City Attendance | Total Attendance | Total Feedback |
|---|---|---|---|---|---|
| June | 12 | 66 | 79 | 157 | 70 |
| July | 19 | 72 | 82 | 173 | 67 |
| August | 15 | 66 | 79 | 160 | 51 |
| September | 13 | 62 | 68 | 143 | 60 |
| October | 15 | 67 | 72 | 154 | 56 |
| November | 15 | 68 | 77 | 160 | 59 |
| December | 15 | 58 | 64 | 137 | - |
| Average | 15 | 65 | 74 | 154 | 59 |



The introduction of Hot Topics in 2009 saw average attendance at core brief increase from just 62 across the three meetings in 2006/07 to more than 130 in 2009/10.

The main difference made by Hot Topics was in opening up the core brief to any member of staff nominated by their manager. More than a third of the total attendance at core brief meetings since March 2009 has been made up of people who are not on the Hot Topics Managers list.

The addition of Sandwell's community health services in April, 2011 has seen core brief attendance increase to an average 185 in the first 6 months of the year, but attendance has fallen since the summer and average 155 in the last 6 months of 2012.

Feedback has remained steady during the year at an average of 59 teams, but this is still well below the 95 average of 2009. Numbers fell away in late 2010 and have not recovered since.

Some of the teams with the best feedback records include:

Audiology
Cancer Services
City and Sandwell Day Nurseries
Communications
Community Children's
Community Respiratory
EPR
Hearing Services
Human Resources
ICARES
Newborn Hearing Screening
Nutrition & Dietetics
Occupational Health
Orthoptics
Patient Transport
Physiotherapy/Occupational Therapy
Recruitment
Security
Speech and Language

Attendance at core brief is still much higher than it was in the old Team Brief days, but the fall this year suggests we need to have another look at how we might refresh the format. The layout was changed in July to better reflect the Trust's key priorities, but otherwise there has been no change to the format since the beginning of 2009.

**Your Right To Be Heard:** On average 12 letters have been published published in the Your Right To Be Heard section of Heartbeat in each issue during the last six months, along with a response from the relevant manager.

186 nominations were received for the staff awards 2012. As well as the prizes for the winning entries, all teams and individuals nominated have received certificates.

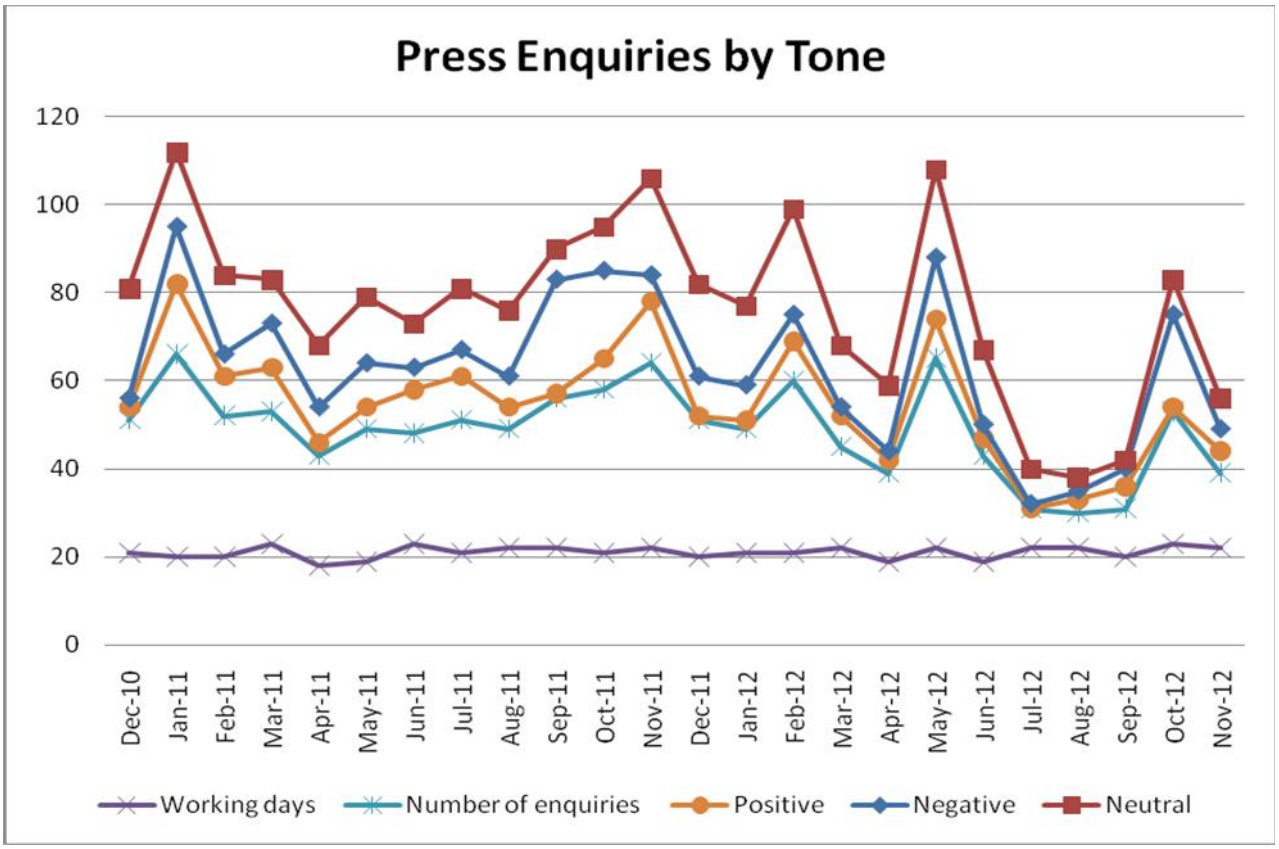
For the November draw 684 tickets were sold for the staff lottery. Staff can apply for grants of £500 for initiatives to benefit staff or patients.

## 3.0 Media activity

We have experienced a dip in the number of enquiries we have received through the Trust press office, however other factors may have affected our numbers since an office move in early August gave us some technical problems with our telephones. This meant that we did not capture all our telephone calls. The problem has since resolved, although we do experience dips in service occasionally.

### 3.1 Press enquiries

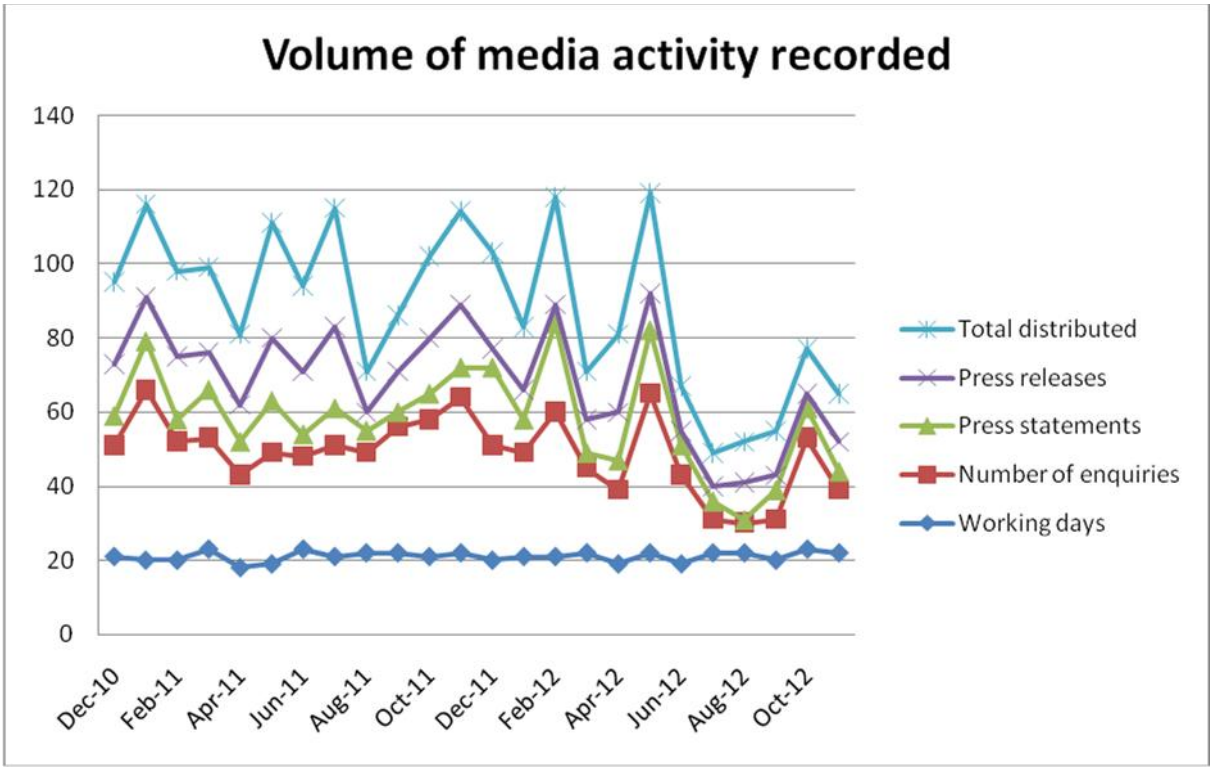
| | Month | Working days | Number of enquiries | Positive | Negative | Neutral |
|---|---|---|---|---|---|---|
| 2012 | *January* | *21* | *28* | *2* | *8* | *18* |
| | *February* | *21* | *39* | *9* | *6* | *24* |
| | *March* | *22* | *23* | *7* | *2* | *14* |
| | *April* | *19* | *20* | *3* | *2* | *15* |
| | *May* | *22* | *43* | *9* | *14* | *20* |
| | **June** | **19** | **24** | **4** | **3** | **17** |
| | **July** | **22** | **9** | **0** | **1** | **8** |
| | **August** | **22** | **8** | **3** | **2** | **3** |
| | **September** | **20** | **11** | **5** | **4** | **2** |
| | **October** | **23** | **30** | **1** | **21** | **8** |
| | **November** | **22** | **17** | **5** | **5** | **7** |



The number of enquiries received, and statements and press releases issued, is recorded below. This indicates the volume of work undertaken by the press office, but does not reflect the different levels of complexity this activity generates.

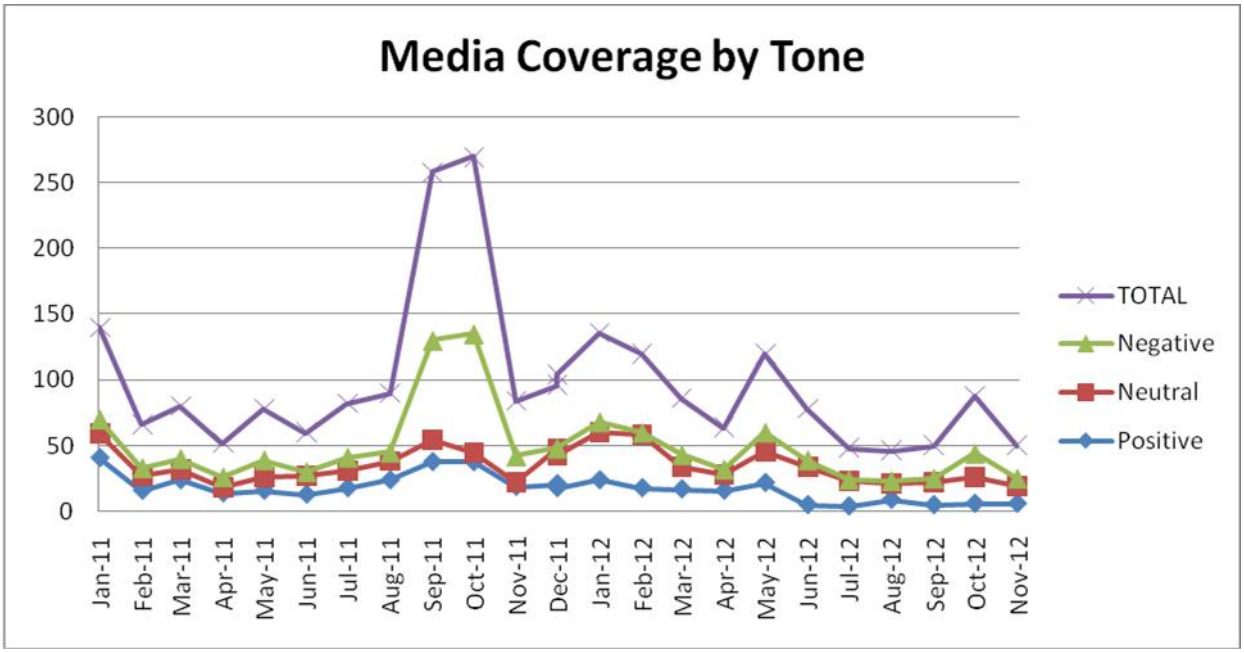
### 3.2 Media Activity

| | Month | Working days | Number of enquiries | Press statements | Press releases | Total distributed |
|---|---|---|---|---|---|---|
| 2011 | *December* | *20* | *31* | *21* | *5* | *26* |
| 2012 | *January* | *21* | *28* | *9* | *8* | *17* |
| | *February* | *21* | *39* | *24* | *5* | *29* |
| | *March* | *22* | *23* | *4* | *9* | *13* |
| | *April* | *19* | *20* | *8* | *13* | *21* |
| | *May* | *22* | *43* | *17* | *10* | *27* |
| | **June** | **19** | **24** | **8** | **4** | **12** |
| | **July** | **22** | **9** | **5** | **4** | **9** |
| | **August** | **22** | **8** | **1** | **10** | **11** |
| | **September** | **20** | **11** | **8** | **4** | **12** |
| | **October** | **23** | **30** | **8** | **4** | **12** |
| | **November** | **22** | **17** | **5** | **8** | **13** |



### 3.3 Actual Press Coverage

| | | Media articles | | | |
|---|---|---|---|---|---|
| | **Month** | **Positive** | **Neutral** | **Negative** | **TOTAL** |
| **2011** | *December* | *18* | *24* | *6* | *56* |
| **2012** | *January* | *24* | *36* | *8* | *68* |
| | *February* | *18* | *40* | *2* | *60* |
| | *March* | *17* | *17* | *9* | *43* |
| | *April* | *16* | *12* | *4* | *32* |
| | *May* | *22* | *23* | *15* | *60* |
| | **June** | **5** | **29** | **5** | **39** |
| | **July** | **4** | **19** | **1** | **24** |
| | **August** | **9** | **12** | **2** | **23** |
| | **September** | **5** | **17** | **3** | **25** |
| | **October** | **6** | **20** | **18** | **44** |
| | **November** | **6** | **13** | **6** | **25** |
| | | | | | |




The big story in June was that of a positive work experience scheme organised by the Trust which was misrepresented by a popular blogger who was confused about the details. The blogger inspired a large number of negative press cuttings which in turn whipped up a small number of campaigners to 'protest' outside Sandwell Hospital. The national doctors' strike inspired some neutral coverage regarding how the Trust would cope on 21st June, whilst meeting our infection control target and investing in state-of the art liver testing equipment at Sandwell generated a number of positive reports.

August saw neutral coverage on delays to our new hospital, whilst an invitation to the health correspondent of the Birmingham Mail to attend a tour of pathology generated a great positive article on some new drugs testing equipment recently installed at City Hospital. The launch of a new national service at the Birmingham and Midland Eye Hospital – the Behcets clinic – was covered positively in August, alongside stories about the appointment of Dr Roger Stedman as new Medical Director, and a positive piece on hot desking.

September saw negative stories on the rise in the number of complaints we received, and in the rise in car parking fees, whilst our Chief Executive's impending move to Leicester was covered alongside a radio phone-in featuring Neurologist Dr David Nicholl who explained that millions of headaches are caused by painkillers. This was followed up with a twitter chat hosted by our headache specialist nurse who was able to respond immediately online to queries from the public on how to deal with persistent headaches.

We had a big spike in negative coverage in October regarding the case of a young mum with a fatal cancer who was not diagnosed for some time. Then at the end of the month and continuing into November we saw negative coverage of a local angle on the national story concerning the Liverpool Care Pathway. We then had lift with some positive coverage around a massive investment in heart scanning equipment at Sandwell Hospital that will improve the diagnostic service of heart complaints for local people.

### 3.4 Staffing

On top of an existing vacancy and the Senior Communications Manager taking up a role in the TSO at the start of the year, we lost a full time permanent press officer (band 5) on 31st August, who left for a new job out of the NHS. We took the opportunity to improve our digital skill set by rewriting the job description for the band 5 with a marked emphasis on digital communications. Subsequently we have successfully recruited a new Digital Communications Officer (band 5) and two communications support officers (band 3) who will focus on either internal or external communications. It is anticipated they will take up their positions in January 2013.

### 3.5 Emergency Planning

The West Midlands Conurbation Resilience Forum has not met since the last update, however Press and PR Manager Vanya Rogers remains a member. We have developed a staff action sheet of what to do in an emergency and will progress it through sign off and print at the next internal emergency planning meeting.

### 3.6 Media Training

We ran a media training course on 12th July for six senior members of staff; namely Richard Samuda, Chairman, Rachel Barlow, Chief Operating Officer, Roger Stedman, Medical Director, Deva Situnayake, Deputy Medical Director, Jonathan Berg, Clinical Director of Pathology and Jenny Marshall, Head of Procurement. We are currently looking at a further course to be held in spring 2013.

### 3.7 Documentaries

The Communications team receive many approaches to participate in documentaries. Whilst the Trust is not always able to take part, several have gone ahead since the last report in June:

The Trust has facilitated filming for documentaries including a gynaelogical procedure for 'Embarassing Bodies' and one looking at first time parents, Sebrina and Steve Miller, following them right up to the birth of their daughter Zella for Channel 5 which is due to screened in early in 2013.

The Channel 5 'Making Faces' documentary was screened in October, showing the amazing advances in medical science that mean doctors can rebuild faces. Staff from BMEC were featured.

The One Show (BBC1) came into City Hospital on Wednesday 17th October to film national charity 'Kissing it Better' as they challenged the show to find volunteers to come to the hospital and make patients feel better by offering their skills for free. We were delighted to welcome ballet dancers from the Birmingham Royal Ballet, cub scouts, beauticians, a magician, gospel singers and bhangra dancers.

The show 'Surprise Surprise' aired on 12th November featuring Upper GI Blues fundraiser Brian Childs and staff from Sandwell Hospital. The extended segment took a full day to film at Sandwell Hospital, and had to be done without alerting Brian to what was really going on.

The Trust is due to feature in the first 'Tonight' programme of 2013 with a look at how maternity services are gearing up for the forecast population boom. Filming at Halcyon Midwife-led Birth Centre in Smethwick has been set up along with an interview of Kathryn Gutteridge, Consultant Midwife, new mums who have used the facility and prospective mums viewing the unit for the first time.

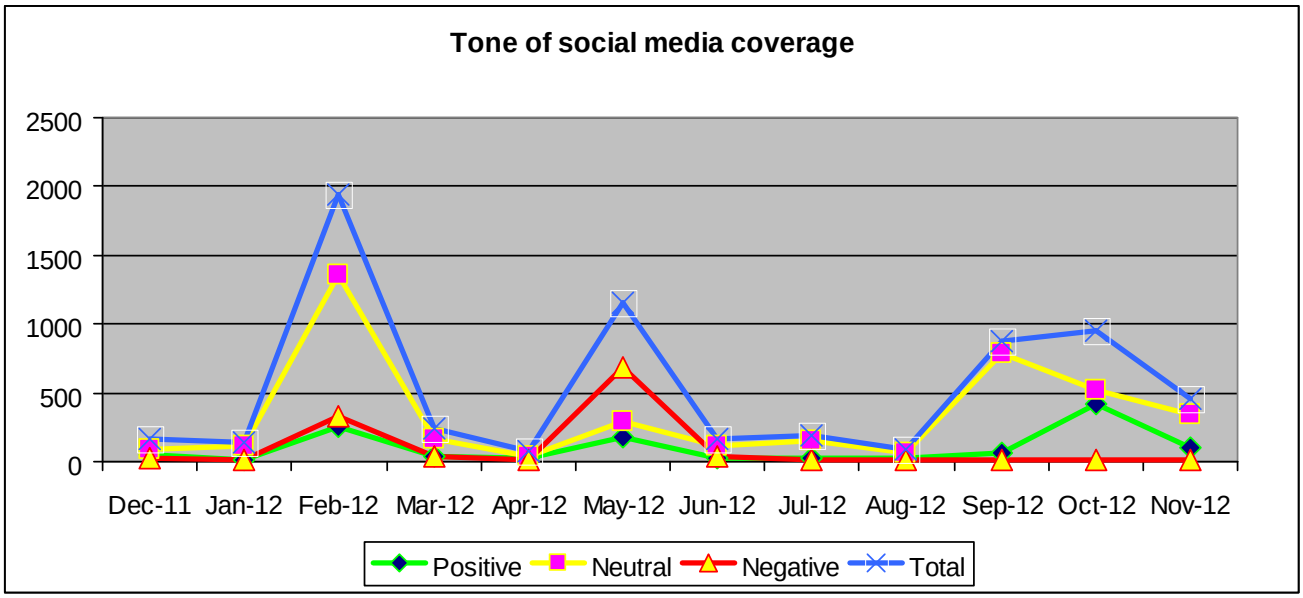
The Trust is also involved in making a film with the Department of Health, looking at how the NHS provides care from the cradle to the grave. We are currently talking to the television soap 'Doctors' about potentially providing a location for filming in 2013.

## 4.0 Social Media

The Trust collects data on social media activity, where there is public access to it. The data captured excludes comments left on news websites relating to articles about the Trust or our services, (which can comprise significant numbers for high profile stories), or the number of times comments, news articles or blogs are 'liked' or 'shared' on social networking platforms.

Data for 2012 shows that large spikes in activity can occur due to a single news story. However, the increase in activity towards the end of the year is more sustained.

| Outlet | Dec-11 | Jan-12 | Feb-12 | Mar-12 | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Sep-12 | Oct-12 | Nov-12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Twitter** | 151 | 127 | 1172 | 220 | 69 | 379 | 158 | 167 | 87 | 563 | 619 | 356 |
| **Blog** | 4 | 0 | 3 | 2 | 2 | 7 | 3 | 2 | 0 | 1 | 2 | 2 |
| **Facebook** | 7 | 18 | 677 | 13 | 3 | 21 | 2 | 23 | 5 | 262 | 267 | 89 |
| **Forums** | 3 | 0 | 135 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| **Other** | 0 | 0 | 305 | 0 | 1 | 750 | 0 | 0 | 0 | 35 | 64 | 4 |
| **Total** | 165 | 145 | 2292 | 235 | 75 | 1157 | 164 | 192 | 92 | 876 | 952 | 451 |
| | | | | | | | | | | | | |
| **Tone** | | | | | | | | | | | | |
| **Positive** | 54 | 16 | 251 | 39 | 21 | 177 | 20 | 30 | 21 | 69 | 415 | 101 |
| **Neutral** | 91 | 120 | 1361 | 160 | 41 | 290 | 112 | 151 | 63 | 790 | 519 | 341 |
| **Negative** | 20 | 9 | 331 | 36 | 13 | 690 | 32 | 11 | 11 | 17 | 18 | 9 |
| **Total** | 165 | 145 | 1943 | 235 | 75 | 1157 | 164 | 192 | 95 | 876 | 952 | 451 |




**Highlights (June – November) – The top most talked about SWBH social media activity.**

375 – Staff Awards
187 - #SWBHsex (Twitter chat on sexual health with Dartmouth clinic)
140 - #SWBHmigraine (Twitter chat on migraines with Julie Edwards, CNS)
121 - #SWBHmenopause (Twitter chat on menopause with Moira mukherjee, CNS)
95 – Engage content (particularly engage blogs)
92 – Stoptober (part of a national smoking cessation campaign)
75 – Health Service Journal awards
68 - #SWBHeye (Twitter chat on eye health with Mohd. Tallouzi, Advanced nurse practitioner)
67 – The One Show
66 – Fundraising and charitable donations
61 - #SWBHstress (Twitter chat on stress awareness and reduction with Jenny Wright, Health and Wellbeing Facilitator)
45 – News re midwifery led units
36 – Flu fighters
35 – compliments from members of the public

The numbers relate to the number of mentions on Twitter, Facebook and Pinterest combined.

Planned social media activity for the coming month includes:

- Week before Xmas (the party week) 17th December – 23rd December – focus is on alcohol awareness – 1 x message a day including a quiz to see if you know your alcohol units and limits

- Over Xmas and New Year 24th December – 31st December – focus is on sexual health over the party season – 1 x message a day

- New Year's Day – 1st January – focus is on smoking cessation as a new year's resolution – 12 messages spread across the day

- January 2013 1st January – 31st January – focus on healthy eating throughout January – a new healthy recipe will be added to engage everyday throughout January which will also then be added to the Trust Pinterest, Twitter and Facebook accounts, promoting engage at the same time.

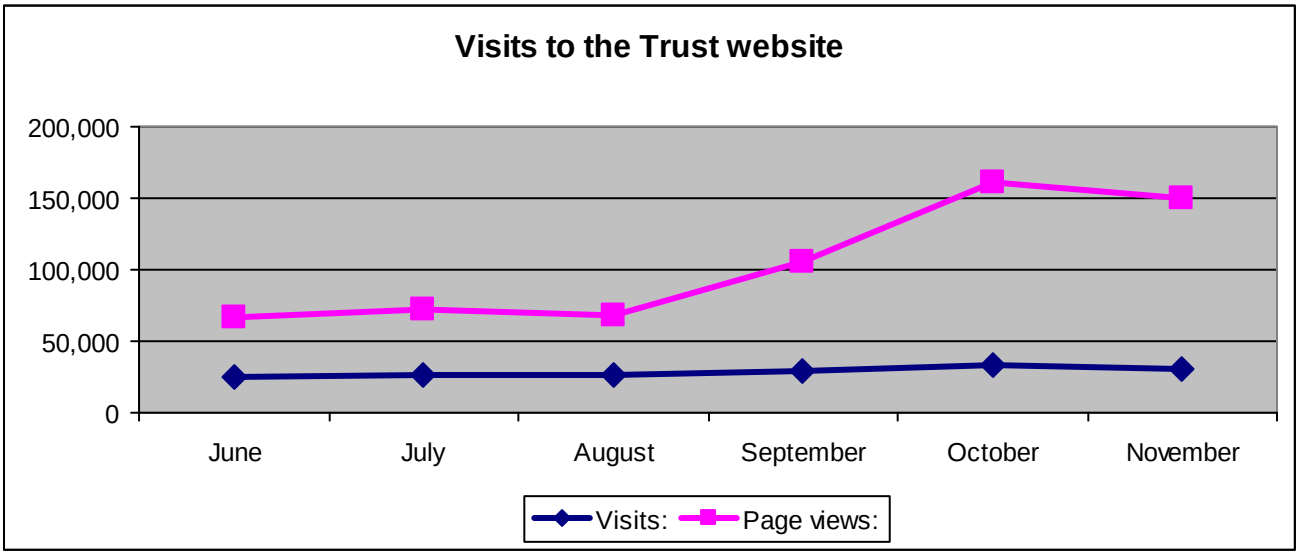
- I have also anticipated the 12 days of #NHSXmas is likely to be rerun again this year to discourage unnecessary attendance to A&E over the Xmas season this runs from 25th December to 5th of January with two messages sent daily in close succession from each other.

## 5.0 Website

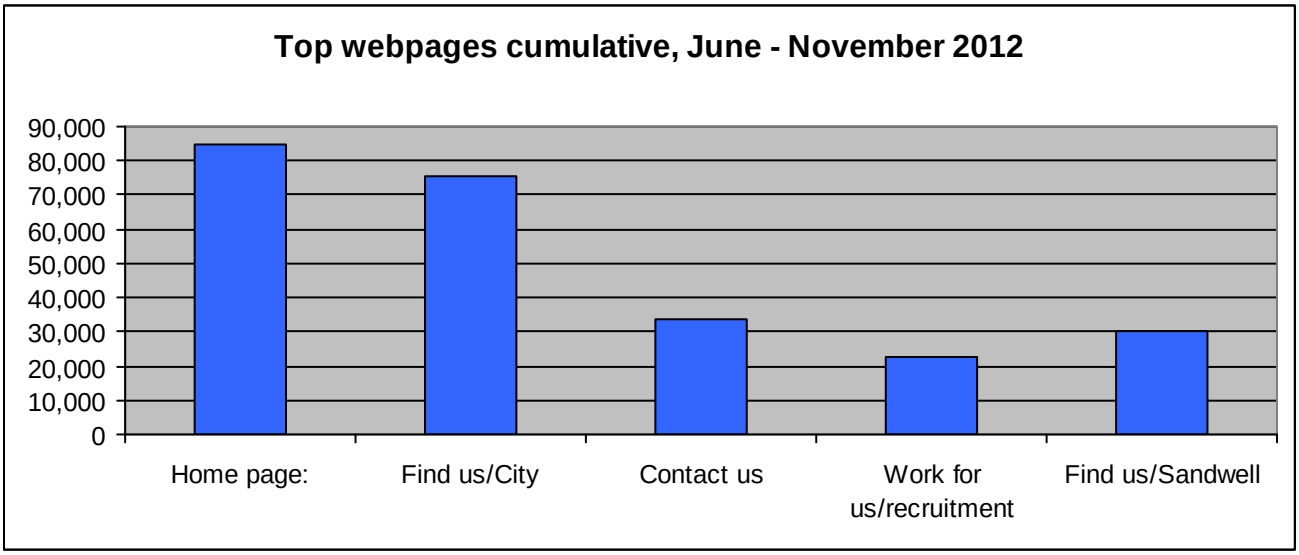
Over the last six months there have been 171,202 visits to the Trust website compared to 105,315 visits over the previous six months. The average number of daily visits to the website has increased from 577 to 936, an increase of 62%.

In the last six months, 622,036 pages have been viewed.

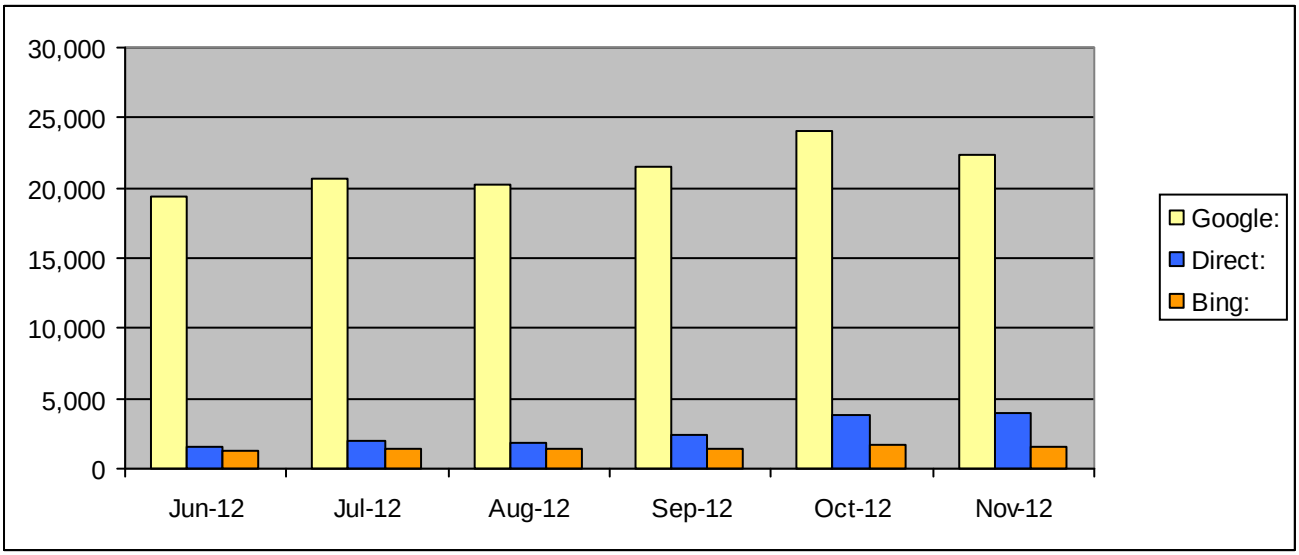
On average, 64.95% of visitors were new visitors to the site.




The most popular pages accessed on the site are:




Google remains the most popular search engine to access the Trust website from. However, there has been a steady increase in the number of people accessing the website directly.




## 6.0 Patient Information

Following the successful retention of the Information Standard earlier this year, 140 patient information leaflets have been completed, with a further 153 in active development. In addition there is an extremely large number of leaflets with a review due in the next six months, or that need to be brought in line with the Trust policy. Following some difficulties recruiting to the substantive patient information post, a new patient information manager is due to start early in the new year to help ensure the Trust meets its NHSLA obligations for patient information and consent.

## 7.0 Membership:

The Trust has an active shadow membership and continues to engage members in a range of activities, including a series of health talks, and the now annual discussion on Trust priorities. Attendance from members at events has dropped and a member survey is being

carried out to determine the best way forward as part of the development of the membership strategy. Work is also underway to create a social networking / web platform for members.

Total membership numbers at December:
2009: 7,488 2010: 7,487 2011: 7,556 2012: 7,297

Membership recruitment activities reduced during the year, although the return of the Membership Manager from maternity leave in November is expected to reverse that trend. There was also an increase in the number of elderly members who withdrew their membership through ill health or who had since passed away. Since the generation of the membership report, numbers are recovered and on target to increase the membership to 8,000 by 31st March 2013.

As part of the actions to ensure membership numbers return to anticipated levels, it is planned to take more frequent membership reports to the FT Programme Board.

Membership reports are shown against 2001 census data. Local data from the 2011 census will not be available until July 2013. Membership at December 2011 is broken down by constituency below at figure 12. A demographic breakdown of the membership follows at figure 13.

| Constituency | Governor seats | Minimum member target | Members | Population | Change since last report |
|---|---|---|---|---|---|
| Ladywood | 3 | 900 | **829** | 94538 | ↓ |
| Edgbaston and Sparkbrook | 1 | 300 | **369** | 96388 | ↓ |
| Perry Barr | 3 | 900 | **1053** | 100476 | ↓ |
| Erdington | 1 | 300 | **304** | 90654 | ↓ |
| Wednesbury and West Bromwich | 3 | 900 | **1077** | 105770 | ↓ |
| Oldbury and Smethwick | 3 | 900 | **1278** | 94969 | ↓ |
| Tipton and Rowley Regis | 3 | 900 | **725** | 82165 | → |
| The Wider West Midlands | 2 | 600 | **1654** | 4602348 | ↓ |
| Not Specified | 0 | | **8** | | |
| Total | 19 | | **7297** | 5267308 | |

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

| Public constituency | Members 2009 | Members 2011 | **Members 2012** | Number | **Proportion of membership 2012** | Eligible members 2011 | Over / Under represented 2009 | Over / Under represented 2011 | Over / Under represented 2012 | Excl. wider West Midlands |
|---|---|---|---|---|---|---|---|---|---|---|
| Age (years): | | | | | | | | | | |
| 0-16 | 253 | **432** | **423** | → | **5.80%** ↑ | 428612 | -6.08% | -3.7% | **-3.7%** | **-6.2%** |
| 17-21 | 442 | **486** | **470** | ↓ | **6.40%** → | 332660 | -1.44% | -0.9% | **-0.9%** | **-4.4%** |
| 22+ | 6,435 | **6,638** | **6,404** | ↓ | **87.80%** ↓ | 3768599 | 2.74% | 4.70% | **4.6%** | **10.6%** |
| Ethnicity: | | | | | | | | | | |
| White | 4,494 | **4,379** | **4,215** | ↓ | **57.8%** ↓ | 4674296 | -28.73% | -30.8% | **-31.0%** | **-11.2%** |
| Mixed | 40 | **128** | **125** | → | **1.7%** → | 73225 | -0.86% | 0.30% | **0.3%** | **-1.3%** |
| Asian or Asian British | 1,584 | **1,744** | **1,708** | ↓ | **23.4%** ↑ | 385573 | 13.83% | 15.8% | **16.1%** | **3.2%** |
| Black or Black British | 808 | **805** | **770** | ↓ | **10.6%** ↓ | 104032 | 8.82% | 8.70% | **8.6%** | **4.1%** |
| Other | 266 | **191** | **179** | ↓ | **2.5%** → | 30182 | 2.98% | 2.00% | **1.9%** | **1.2%** |
| Socio-economic groups: | | | | | | | | | | |
| ABC1 | 2,820 | **2,827** | **2,730** | ↓ | **37.10%** ↓ | 1913858 | -9.09% | -9.6% | **-9.6%** | **-3.2%** |
| C2 | 1,235 | **1,230** | **1,208** | → | **16.40%** ↓ | 685541 | -0.25% | -0.6% | **-0.3%** | **-0.5%** |
| D | 1,560 | **1,602** | **1,548** | ↓ | **21.0%** ↑ | 794461 | 1.43% | 1.6% | **1.6%** | **-2.1%** |
| E | 1,873 | **1,924** | **1,839** | ↓ | **25.0%** ↑ | 700084 | 7.91% | 8.2% | **7.9%** | **5.3%** |
| Gender analysis: | | | | | | | | | | |
| Male | 2,946 | **2,923** | **2,820** | ↓ | **38.60%** ↓ | 2575111 | -9.55% | -10.2% | **-10.2%** | **-9.4%** |
| Female | 4,386 | **4,483** | **4,334** | ↓ | **59.40%** ↑ | 2692197 | 7.46% | 8.2% | **8.3%** | **7.5%** |

Sandwell and West Birmingham Hospitals NHS
NHS Trust

# TRUST BOARD

| | |
|---|---|
| **DOCUMENT TITLE:** | **'Listening into Action' update** |
| **SPONSOR (EXECUTIVE DIRECTOR):** | **John Adler, Chief Executive** |
| **AUTHOR:** | **Nick Howells, Senior Communications Manager** |
| **DATE OF MEETING:** | **20 November 2012** |

**EXECUTIVE SUMMARY:**

This report summarises activity within the Listening into Action programme, highlighting recent exemplars and detailing revised support arrangement.

**REPORT RECOMMENDATION:**

The Board is asked to note 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 | | **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** |

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

Relates the Trust's Strategic Objective to be an engaged, effective organisation. Used in implementation of Trust Priorities 2012/13 on improving quality and safety and the Transformation Plan. Monitored via Staff Survey metrics.

**PREVIOUS CONSIDERATION:**

Usual quarterly update

Sandwell and West Birmingham Hospitals NHS
NHS Trust

**Briefing on Staff Engagement for the Trust Board**

**Trust Board – 20 December 2012**

**Introduction**

The Trust started using the 'Listening into Action' [LiA] approach for staff engagement in April 2008.

LiA is a tried and tested methodology which provides a structure for effective staff engagement. Since its introduction, the Trust has seen significant movement on a number of key indicators in the National Staff Survey for improved engagement and communication.

**Future support for LiA**

Until this summer LiA activity in the Trust had been supported by a part-time LiA Facilitator. It had always been the intention that this support would cease at a point when it was felt that LiA as a way of working was sufficiently embedded in the Trust. It is now felt that we have reached that stage, although it is recognised that support will still be needed where teams are unfamiliar with the methodology.

In order to provide this support an appeal was put out via email and Hot Topics for new LiA Champions, who will support the small number of champions we have at the moment. Divisions have also been asked to make nominations, with the aim of having at least two champions available in every division. There have been 20 volunteers to date.

A training programme has been developed which will be delivered to the new champions in January and February, 2013.

At present there is a range of LiA activity going on in the Trust. Experience has shown that LiA is most effective when it sticks closely the original methodology. The aim is that the new champions should support LiA in their divisions and ensure that future LiA activity follows as closely as possible to the proper methodology.

It is hoped that the additional support capacity provided by the extra champions will also enable the Trust to extend its engagement activity, which will be an important element of delivering the Transformation Plan.

**LiA activity**

LiA continues to be a powerful tool in helping to deliver positive change in the Trust. Some of the best recent examples of the use of LiA include Microbiology, which won the 2012 staff award for engagement. The success of this LiA shows the potential power of the LiA approach.

In this case the original engagement event was held at Edgbaston Cricket Ground and staff were taken there in a hired double decker bus. All of this helped to create a real enthusiasm among staff which was carried though into subsequent work and that positive atmosphere has continued 12 months on. Achievements include staff designing and agreeing their own 7 day working arrangements.

Another example of the successful application of LiA techniques is the setting up of Integrated Care Services (ICARES) in the Adult Community Division in October.

This was a complex transformation project involving moving over 100 staff working in eight teams into four new teams. It meant staff changing bases, line managers, and their working hours to provide an 8am to 8pm service on seven days a week. It was launched with an LiA in April and staff have been involved throughout in designing how the service would work.

But LiA can be equally effective on a smaller scale. SDU/Theatres and Newton 2 ran an event on improving patient experience in day care and short stay surgery sat around a trolley in the Sandwell Day Hospital.

We have also increasingly been using LiA as a way of engaging with patients. The Inflammatory Bowel Disease Service ran an event for patients who, due to the nature of the disease, can be reluctant to discuss their problems. This forum gave them a chance to feedback on the service and offer ways to improve things.

**Engagement Sponsor Group**

The Engagement Sponsor Group, chaired by the Chief Executive, has continued to meet monthly. It receives reports on a rolling 3 month basis from each division and updates on engagement activity associated with the Transformation Plan, like the recent event on the future of Outpatients. It has also discussed papers on the future of staff engagement and the engagement lessons learnt from the introduction of a centralised reception in the BTC.

**HSJ Award**

In November the Trust won a prestigious Health Service Journal Award for Staff Engagement for Listening into Action.

**Owning the Future**

Based on the staff involvement model developed by John Lewis, Owning the Future is seen as a natural extension of Listening into Action, providing a permanent structure for engagement in the Trust.

The approach has been piloted in the Adult Community Division and Pathology since the summer of 2011. It involves an ambassador being elected by each team, whose responsibility is to:

- Be the voice of their team
- Bring forward the team's ideas for improvements to day to day working practices
- Work with their manager to support and develop the team's understanding about the Trust
- Ensure effective mechanisms are in place to feedback to their team
- Identify items for divisional level discussion
- Develop links with other ambassadors and share best practice.

Ambassadors were initially elected for a two year period, so will be due for re-election in 2013.

Owning the Future has proved to be effective in improving communication in the pilot areas. The cost of the support needed would make it prohibitive to roll out the same model as is used by John Lewis, but we are looking to develop an alternative model which would need less central support.

**Recommendation**

The Trust Board is asked to RECEIVE and NOTE the update.

**Nick Howells**
**Senior Communications Manager**
**December 2012**

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:** | **20 December 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 20 December 2012

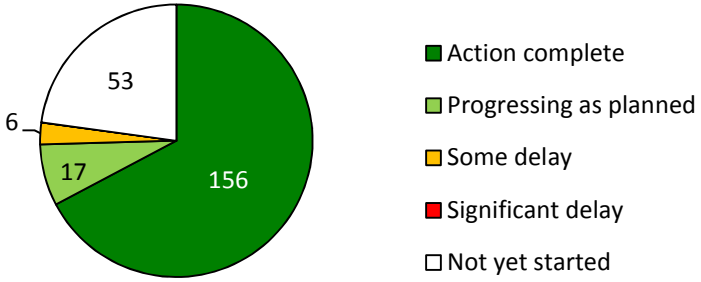
Sandwell and West Birmingham Hospitals NHS
NHS Trust

# FT Programme Monitoring Status Report

**Amber**

## Milestone status

**Milestone Deliverables**




## Activities Last Period

- 8th draft IBP/LTFM and supporting documentation developed for submission to SHA on 14/12/12.
- Formal sign-off of downside modelling and mitigation strategies.
- HDD 2 process underway (3.12.12 – 14.12.12).
- Presentations to staff on IBP/LTFM content commenced.
- Preparation commenced ahead of Quality and Safety visit on 15/01/13.
- Formal independent assessment of BGM completed and report received.

## Issues for Resolution/Risks for Next Period

- Clarity required on timescale and process for recommencing OBC approval and impact on FT timeline and actions

## Planned Next Period

- Submission of final outstanding documentation to SHA by end of January 2013 ahead of final B2B.
- HDD 2 report from PwC expected during January 2013.
- Board self-assessment against quality governance domains to be completed at January FT seminar.
- Independent assessment of progress against quality governance action plan to be undertaken by Deloitte.
- Appointment of election advisors.
- SHA Quality and Safety visit – 15/01/13.
- Mock B2B session ahead of final SHA B2B.
- Final SHA B2B – 07/02/13.
- Continue programme of raising staff awareness of FT issues.