Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 3 April 2014; 1330h

Members

Mr R Samuda	(RSM)	[Chairman]
Ms C Robinson	(CRO)	[Vice Chair]
Dr S Sahota OBE	(SS)	[Non-Executive Director]
Mrs G Hunjan	(GH)	[Non-Executive Director]
Ms O Dutton	(OD)	[Non-Executive Director]
Mr H Kang	(HK)	[Non-Executive Director]
Mr T Lewis	(TL)	[Chief Executive]
Mr C Ovington	(CO)	[Chief Nurse]
Miss R Barlow	(RB)	[Chief Operating Officer]
Mr T Waite	(TW)	[Director of Finance]
Dr R Stedman	(RST)	[Medical Director]

In attendance

Mr M Hoare	(MH)	[Non Executive Director]
Miss K Dhami	(KD)	[Director of Governance]
Mrs C Rickards	(CR)	[Trust Convenor]

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Secretariat

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

Time	Item	Title	Reference Number	Lead
1330h	**1**	**Apologies**	**Verbal**	**SG-L**
	2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 6 March 2014 a true and accurate records of discussions*	**SWBTB (3/14) 045**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (3/14) 045 (a)**	**SG-L**
	5	**Questions from members of the public**	**Verbal**	**Public**
1340h	**6**	**Patient story**	**Presentation**	**CO**
1400h	**7**	**Chair's opening comments and Chief Executive's report**	**SWBTB (4/14) 047**	**RSM/ TL**
	7.1	Car parking update	SWBTB (4/14) 048 SWBTB (4/14) 048 (a)	CO
	7.2	Complaints handling KPIs	SWBTB (4/14) 049 SWBTB (4/14) 049 (a)	KD
	MATTERS FOR DISCUSSION AND APPROVAL			
1415h	**8**	**2014/15 annual corporate plan**	**SWBTB (4/14) 050 SWBTB (4/14) 050 (a)**	**TL**

1435h	**9**	**2014/15 TDA annual plan**	**SWBTB (4/14) 051 SWBTB (4/14) 051 (a) SWBTB (4/14) 051 (b)**	**TW/ TL**
1445h	**10**	**Corporate performance dashboard**	**SWBTB (4/14) 052 SWBTB (4/14) 052 (a)**	**TW**
	10.1	Emergency Care waits in March	Verbal	RB
1505h	**11**	**Financial performance report – Month 11**	**SWBTB (4/14) 053 SWBTB (4/14) 053 (a)**	**TW**
1515h	**12**	**Trust Risk Register**	**SWBTB (4/14) 054 SWBTB (4/14) 054 (a)**	**KD**
		PRESENTATION		
1530h	**13**	**Homeless initiative update**	**Presentation**	**TL**
1550h	**14**	**Update from the meeting of the Quality & Safety Committee on 28 March 2014 and minutes of the meeting held on 28 February 2014**	**SWBQS (2/14) 023**	**OD/ CO**
	15	**Update from the meeting of the Finance & Investment Committee held on 28 March 2014 and minutes of the meeting held on 31 January 2014**	**SWBFI (1/14) 011**	**CR/ TW**
	16	**Update from the meeting of the Workforce & OD Committee held on 28 March 2014 and minutes from the meeting held on 16 December 2013**	**SWBWO (12/13) 037**	**HK/ TL**
	17	**Any other business**	**Verbal**	**All**
		MATTERS FOR INFORMATION		
1610h	**18**	**Midland Metropolitan Hospital project: monitoring report**	**SWBTB (4/14) 055**	
1615h	**19**	**Foundation Trust application programme: monitoring report**	**SWBTB (4/14) 056**	
	20	**Details of next meeting** *The next public Trust Board will be held on 1 May 2014 at **1330h** in the Anne Gibson Boardroom, City Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 6 March 2014

Present	**In Attendance**
Mr Richard Samuda [Chair]	Mr Mike Hoare
Ms Clare Robinson	Miss Kam Dhami
Dr Sarindar Sahota OBE	Mr Mike Sharon
Mrs Gianjeet Hunjan	Mrs Chris Rickards
Mr Harjinder Kang	Mr Bill Hodgetts [Healthwatch]
Ms Olwen Dutton	
Mr Toby Lewis	**Guests**
Mr Tony Waite	Ms Sharon Reynolds [Matron]
Mr Colin Ovington	Patient
Miss Rachel Barlow	Patient's husband
Dr Roger Stedman	

Secretariat

Mr Simon Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
No apologies for absence were received.	
2 Declaration of Interests	**Verbal**
Mr Kang advised that he had taken on a new role as a management consultant with PA Consulting Group since the Board had last met.	
3 Minutes of the previous meeting	**SWBTB (2/14) 028**

The minutes of the Trust Board meeting held on 6th February 2014 were presented for consideration and approval. It was agreed that there were some amendments to sections 19 and 20 before the minutes could be approved. Mr Grainger-Lloyd agreed to make the changes suggested.	
4 Update on Actions arising from Previous Meetings	**SWBTB (2/14) 028 (a)**
The Board received the updated actions log. It was noted that there were no actions outstanding or requiring escalation to the Board for resolution.	
5 Questions from members of the public	**Verbal**
Mr Cash asked how the Twitter site was being received and used. Mr Lewis advised that the Trust's and his own site was being well followed, with reasonable penetration into some staff groups. He advised that a process was underway to make the communications more interactive with those using social media to express views. Mr Cash noted that some trusts were reporting a financial deficit and asked how the Trust was progressing against its five year cost improvement plans. Mr Waite advised that although the current year's plans were progressing ahead of trajectory there was further work to finalise the plans for reducing costs over the next few years. It was highlighted that to do this was a key challenge and that engaging all the organisation was necessary to ensure it was delivered. Mr Cash noting that membership events were being held, asked how the Trust would involve patients and carers in the work of the Trust in future. The Chairman advised that the Trust was ambitious with community engagement and that this would inform the Trust's contribution to public health in the area. He added that a new Board-level Committee had been established specifically to discuss Public Health, Community Development and Equalities. Mr Cash thanks the Chairman for this information and advised that this would be fed back to patients as part of his role. Mr Ovington added that by taking forward the patient experience strategy that the Board had considered at its last meeting, this would engage patients further.	
6 Patient story	**Presentation**
The Board was addressed by a patient who had been cared for on the Surgical Assessment Unit (SAU) at City Hospital and later postoperatively on Ward D25. Mr Ovington noted that there had appeared to be a contrast between the experiences on the different ward environments during the various inpatient spells in hospital. The patient advised that the nursing care on D27 was of a more compassionate standard and the staff appeared to be enjoying their roles, which	

was of contrast to the SAU and D25. The Board was advised that in the patient's opinion, the D27 staff had better respected the personal requirements of the patient in contrast to the experience on D25. Mr Sharon observed that the patient understood better what was expected and there was greater explanation of the planned care on D27. Ms Barlow asked how Matron Reynolds had fed back to staff on the issues raised by the patient. She was advised that the messages were communicated through the weekly team meetings and in particular the management of pain issue that had been raised. It was reported that the 'care and comfort' round now included pain consideration and that there was an acknowledgement that the staff had not delivered care in the manner expected on this occasion. Dr Stedman identified that there may have been a failure to communicate the plan of care and asked at which point a medic had discussed the plan and the situation with the patient. He was advised that the trainee doctor could only present all the options but was unaware of the plan for the patient. Dr Stedman expressed his concern that the reason for medication being prescribed had not been explained. Ms Robinson asked how easy it had been for the patient to complain. She was advised that the process was not problematic. The Board was advised that the patient's friends and family had been advised that the Trust was willing to listen should patients raise concerns. The patient and her husband were thanked for their attendance and illuminating story. It was noted that there were a significant number of lessons learned from the story.	
7 End of Life Care update	**Presentation**
Dr Anna Lock joined the Board to present an overview of the End of Life Care service provided by the Trust and the future plans for the development of this service. Dr Sahota noted that there had been good improvement in the delivery of palliative care in terms of compassion and dignity over the years. He asked how friends and family's needs were taken into consideration as part of the plans. Ms Hall advised that a survey was issued to relatives and carers, which was used to delivered continuous improvement and provide feedback to the teams on bereavement. It was reported that condolence cards were also issued to family, following the death of a loved one. Dr Lock advised that there was a set of competencies which aimed to deliver good bereavement services, in addition to palliative care. Mr Lewis agreed that the service had been transformed over recent years and asked how children were taken into account as part of the plans. Dr Lock advised that the Trust's interventions were limited mainly to older children, which was clearly different to that of younger children and babies. Mr Lewis suggested that	

children of all ages needed to be taken into account as part of future planning. Mr Lewis asked in terms of application of Do Not Attempt Cardiopulmonary Resuscitate (DNACPR) orders, what progress had been made with making the process more consistent and robust. Dr Lock advised that there were currently complexities in the interface between primary care and acute care in this respect. Ms Hall advised that a single form would be the most sensible approach. It was reported that the robust completion of DNACPR forms was linked to the plans for improving communication, with frank and open discussions being needed to make the completion of the forms more meaningful. It was noted that the auditing of the forms was being taken through the Mortality and Quality Alerts Committee (MQAC). Dr Stedman noted that it was counter cultural in some respects to embrace dying as opposed to making every effort to keep patients alive. Ms Dutton asked whether mortality reviews would be picked up via the cultural change programme. Dr Stedman advised that there was potential for a review of the last year of life for a subset of patient deaths that could inform this work. Ms Dutton suggested that consideration needed to be given to the most appropriate time for the intervention of palliative care services. She was advised that late presentation was a key issue faced by the teams and that to ensure good planning for death could be undertaken then an early intervention was important. Mr Hodgetts noted that there appeared to be difficulty with supply of pharmaceuticals when a patient lived on a border of a region. Ms Hall acknowledged that this was the case and that work was needed to ensure that responsibilities were clarified further. Mr Ovington suggested that an End of Life Care Champion on the Board should be identified and he was then nominated and accepted for the role. Ms Dutton added that she would also be happy to support him as the Non Executive voice. Dr Lock and Ms Hall were thanked for their attendance and informative presentation.	
8 Chair's Opening Comments and Chief Executive's report	**SWBTB (3/14) 030**
The Chairman advised that since the last meeting the Patient Safety Summit had been held, which had discussed a safety tool (MaPSaf). He added that he had attended the Healthwatch conference which had been a valuable event attended, particularly in terms of taking forward membership events and governor development. In addition, it was reported that a member event around Quality and Safety had been held. The Chairman noted that he had been appraised recently and that it had been evident as part of this that there was a support for the Trust and of the Trust's improvement priorities. Mr Lewis introduced his report. He noted the importance of environmental issues and suggested that the Public Health, Community Development and Equality	

Committee would consider the sustainability update in future on the Board's behalf. This was agreed. A successful MMH bidder day had been held, with potential partners for the Trust's PF2. The Chairman, CEO, Finance Director and Director of Estates had led the discussions. The 'Big Decision Day' event was reported to have been held on Monday 3 March 2014, at which support had been given to adopting the 'Hello my name is…' approach as a Trust wide model. This was also reflected in the Patient Experience Plan. It was reported that the CCG was planning to reconfigure its work into around 35 decision making units and the impact of these plans on the Trust would be thought through. The Board was advised that CNST Level 3 accreditation had been awarded to the Maternity Unit. Ms Dutton noted that a clear expectation on admission was part of the '10 out of 10' standards and asked whether this would form part of discharge communications. Mr Lewis advised that further work would be undertaken on this, however, the currently set standards did not cover this at present because they are focused on the first twelve hours after admission. Mr Kang asked what reception the 'First Friday' concept had received by the Trust's managers. Mr Lewis advised that the issue had been extensively debated by the Clinical Leadership Executive and that it would be trialled for a year. It was highlighted that this would require some support for managers not comfortable to enter clinical areas. Ms Dutton asked whether this would cover community locations. She was advised that this was the case. Ms Robinson asked what outcomes were expected and how the undertaking would be monitored. Mr Lewis advised that the useful metrics of success would be canvassed in July from the leaders undertaking the visits once the process was embedded. The Chairman noted that the purpose intended was to be light touch and listening rather than expanding our audit arm.	
9 2014/15 annual corporate plan	**SWBTB (3/14) 031** **SWBTB (3/14) 031 (a) - SWBTB (3/14) 031 (c)**
Mr Sharon advised that the second version of the TDA annual plan had been submitted prior to the meeting of the Board. He advised that the Board was presented with a draft of the majority of the final plan, with the completed version due for submission on 4 April 2014. It was highlighted that further drafting would continue in readiness for final submission. Ms Robinson noted that there had been little opportunity for Board members to comment on the plan. She added that lessons learned was a key theme throughout the plan and suggested that an overarching plan for undertaking this listening and learning approach was needed. Ms Dutton noted that this was a recurrent theme that had been raised previously. Miss Dhami advised that the	

work around lessons learned would be delivered in Quarter 2 of 2014/15. The next staging post on the development of the annual plan was highlighted to be at the beginning of April and Board members would be asked to comment again prior to submission.	
10 Whistleblowing policy	**SWBTB (3/14) 032** **SWBTB (3/14) 032 (a)**
Miss Dhami presented the draft whistleblowing policy for comment. It was reported that the existing whistleblowing policy had been revised and refreshed to better encourage staff to speak up. It was noted that the policy had been prepared taking into account best practice and national guidance and would be a dynamic and active approach. A step by step procedure for the handling of whistleblowing concerns was reported to be under development, including the use of a helpline which needed to be established alongside an external hotline, the detail of which needed to be agreed. Mr Kang asked whether the policy would be launched proactively and was advised that this was the case. He suggested that the use of all Non Executives could be used, rather than a single Non Executive colleague. Mr Lewis noted that a single Non Executive colleague would have oversight of whistleblowing in its entirety however staff could refer to any of the Non Executives as part of the procedure. It was reported that the whistleblowing policy would be reinforced during mandatory training. Ms Robinson suggested that whistleblowing should be a last resort and therefore it was critical that an independent person, such as the Non Executive be used early in the process. She added that there should be an obligation in terms of timescales for handling the concerns to be included in the process. Miss Dhami advised that the timing would be negotiated with the person training the concern and that the procedural guidance would include the suggested response times. Ms Robinson noted that acknowledgement was needed shortly after the concern was reported. It was highlighted that the steps were not needed in a sequential basis, so that a concern could be raised directly with a Non Executive immediately if wished, however individuals were encouraged to adopt a step by step approach in line with practice nationally and elsewhere. It was reported that the Non Executive lead would be made aware when the policy was invoked. Mrs Rickards noted that the policy would be considered by the JCNC given its profile and that it would be considered by the PPAC en route. The Chairman asked whether whistleblowing was covered as part of the patient safety walkabouts. He was advised that this was included within the prompts already in place. It was noted that anonymous whistleblowing presented a challenge in terms of handling. Ms Dutton suggested detailed and credible concerns raised in this manner should be investigated. Mr Kang asked how staff would be protected when they were faced with an	

allegation. It was agreed that further consideration would be given to strengthening this section, including when the most appropriate timing was for disclosure to the individuals cited. It was agreed that sign off of the policy should be delegated to the Chief Executive and lead Non Executive Director.	
11 National patient and staff survey results	**SWBTB (3/14) 033** **SWBTB (3/14) 033 (a) - SWBTB (3/14) 033 (c)**
Mr Ovington presented the annual patient survey results, which it was noted were not significantly different from those of the previous year. As such it was hoped that the 'patient knows best' approach and patient experience plan would assist with improving the results. He added that the implementation of the ten out of ten standards may also create a shift. Mr Sharon reported that again there had not been a significant change in the staff survey results, although there had been a pleasing change in the number of staff regarding safety as being as the organisation's top priority. Mr Kang questioned whether this reflected whether safety was actually a top priority or this reflected the significant exposure to discussions around this. Mr Sharon advised that this was due to a number of different aspects. Mr Lewis added that the 'Your Voice' concept would be used to assist with understanding the position and that a comparison to other organisations would be undertaken. Mr Lewis reminded the Board that clear goals had been added in response to the Francis report which would address some of the actions needed to improve the position. He added that shortly, all questions in the patient and staff survey would be considered through the Patient and Staff Experience Committee to understand what actions were being taken to address each. Miss Barlow highlighted the need to link the actions through to the staff delivering the care, such as those responsible for discharge. Dr Sahota noted that the position on discharge did not appear to be improving year on year, particularly in relation to delays caused in Pharmacy for drugs to take home. Ms Dutton noted that there was further work to do to improve the position around morale and staff feeling that they were making a difference through their work. Mr Lewis advised that this was linked into the appraisal process which was being given greater focus at present. Ms Dutton noted that the 'Winter Must Be Better' pledges were useful and could be used in the same way to reinforce the difference that individual staff make to the Trust's operation. Mr Kang supported the approach for placing the onus of appraisal on the individual being appraised. Mrs Hunjan noted that there remained the need for managers to be held to account for appraisals, however.	
12 Corporate performance dashboard	**SWBTB (3/14) 034** **SWBTB (3/14) 034 (a)**

Mr Waite reported that there were a number of areas of positive results to highlight, including VTE assessment and the CQUIN for dementia. Other areas where February showed an improvement on previous months included performance against the fractured neck of femur target and safe surgery checklist completion. Cancelled operations were noted to be a concern as were residual concerns over non-compliance against the medicines management CQUIN target. Miss Barlow expressed her disappointment with the performance against the cancelled operations target, however she advised that a new process had been implemented which was delivering an improvement, particularly in Surgery B. A new approach to theatre scheduling was reported to be in place which would also assist the position. Ms Robinson noted that the performance against the target response times to complaints had been poor and asked whether the position had reversed since the report had been prepared. Miss Dhami acknowledged that the position against the overall target had not improved, however the majority of the complaints processed through the devolved model were ready for final sign off. It was reported that the devolution process was working well generally however. Ms Dutton advised that she was reviewing some sample complaints and would report back to the Board at the next meeting. It was agreed that a trajectory for achieving an acceptable performance against the target should be presented at the same time. Mr Lewis suggested that KPIs would be retained but work would be directed to improving the quality of the complaints and reducing the number of linked complaints.	
12.1 Site differences in performance against rapid access chest pain target	**Verbal**
Miss Barlow reported that the deterioration in performance against the rapid access chest pain target related to a change to the administration system for appointments, however a SOP had been implemented and a dedicated resource for the work was now in place which should rectify the position. It was reported that the reason for the underperformance was being evaluated in terms of risk assessment.	
12.2 Unacceptable Emergency Care waits in February	**Verbal**
Miss Barlow advised that the results against the Emergency Care target remained disappointing. Attendances and admissions were reported to be stable however ambulance arrivals had increased significantly for the Trust and regionally. It was reported that there remained a risk around the Black Country in this respect at present. The Board was advised that there were not significant capacity issues at City Hospital and therefore the poorer than planned resource was impacting on the position at the site. In terms of consultant recruitment, acute medical consultants had been shortlisted for interview which could assist with improving performance in the area. Other areas of challenge were reported to include the higher level of beds than planned that remained open and work was needed to address discharge. It was noted that the contract for the current GP 'front end' would terminate in Quarter 1 and work was underway to understand how this	

could be replaced. Partnership work with the ambulance service was reported to be being considered. The bed base in the community was being considered in the near future, given that a number of beds had been closed for admissions due to safety concerns and infection control. It was reported that a number of focus areas for the CCG had been highlighted such as the management of chronic illnesses and conditions and the measures to divert patients away from acute services. Mr Kang asked what risk was around the future plans for the Mid Staffordshire NHS FT. It was acknowledged that this was a risk due to the knock on effect from other local trusts affected. It was reported that additional rigour would be applied to manage intermediate care beds, in addition to the management of the acute beds. It was noted that this represented an additional opportunity to manage the position in terms of Emergency Care. Mr Lewis reported that almost every part of the West Midlands was running at levels of activity at a level that did not allow the minimum standards in relation to Emergency Care to be met. He added that handover from ambulances represented a significant risk and that the number of patients waiting more than 60 minutes before handover had increased. It was highlighted that there was a triage service that was applied. Mr Lewis advised that from 1 April, patient identifiable information for GP triaged patients would need to be reported and there was insufficient confidence at present that this could provided, meaning that there was a possibility that the overall position reported might be impacted. It was noted that solving the City Hospital position was a key priority. Mr Lewis advised that the emergency care staffing model remained unstable, although not unsafe, and it was anticipated that confirmation of the new hospital plans should and must make a material difference to the recruitment of the medical staff needed.	
13 Financial performance report – Month 10	**SWBTB (3/14) 035** **SWBTB (3/14) 035 (a)**
Mr Waite reported that it was anticipated that the required end of year forecast position would be met and that ongoing contract negotiations continued to settle the position in 2014/15. It was reported that there was a low risk around the expected shortfall against capital spend. It was highlighted that there was further work to do to set the plan for 2014/15 at present and the 'Big Decision Day' had set out the plans for allocating funds internally in the future. The handling of reserves was discussed. Mr Waite reported that there had been overspend in a number of key areas during the year, which had been addressed using central reserves, however there was a keenness to avoid a perpetuity of this practice. Mr Lewis advised that a key change was the prospective handling rather than retrospective handling of reserves.	

It was highlighted that the non-pay expenditure was a key concern. Mr Waite reported that a focus on directorates rather than groups would assist with understanding the position at a granular level.	
14 Board Assurance Framework – Quarter 3 update	**SWBTB (3/14) 036** **SWBTB (3/14) 036 (a)**
Miss Dhami presented the Quarter 3 update of the Board Assurance Framework for receipt and noting. It was highlighted that the approach would be refreshed for 2014/15.	
15 Update from the meeting of the Quality & Safety Committee held on 28 February 2014 and minutes from the meeting held on 31 January 2014	**SWBQS (1/14) 014**
Ms Dutton presented an overview of the key discussions from the Quality & Safety Committee held on 28 February 2014. Ms Dutton noted that clear focus should be given to the Safeguarding Children work. The risk associated with the transfer of the school health nursing contract was raised by the Dr Stedman. Mr Lewis noted that there was a planned shortfall in the number of trainees provided by the Deanery, which the Board was advised might necessitate a reconfiguration of services should the position not be addressed. It was reported that the Trust was to challenge the position with the Deanery and a legal intervention may be required should this be deemed necessary.	
16 Update from the meeting of the Public Heath, Community Development and Equalities Committee held on 27 February 2014	**Verbal**
Mr Samuda presented an overview of the key discussions from the Public Heath, Community Development and Equalities Committee held on 27 February 2014. The Chairman advised that more focus would be given around equality and diversity in future. It was reported that Dr Middleton attended the Committee to present an overview of Public Health matters.	
17 Update from the meeting of the Configuration Committee held on 28 February 2014	**SWBCC (12/13) 013**
Mr Samuda presented an overview of the key discussions from the Configuration Committee meeting held on 28 February 2014, which had included further discussion of the evaluation criteria for the MMH contractors.	
18 Any Other Business	**Verbal**
It was noted that the meeting was Mr Sharon's last and he was thanked for his service to the Trust during his tenure.	
Matters for Information	

The Board received the following for information: • Midland Metropolitan Hospital Project: Monitoring Report • Foundation Trust Application Programme: Monitoring Report • Sustainability update	**SWBTB (3/14) 038** **SWBTB (3/14) 039** **SWBTB (3/14) 040**
Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1330h on 3rd April 2014 and would be held in the Churchvale/Hollyoak Rooms, Sandwell Hospital.	

Signed: ……

Name: ……

Date: ……

Next Meeting: 3 April 2014, Churchvale/Hollyoak Rooms @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

6 March 2014, Boardroom @ Sandwell Hospital

Members present: Mr R Samuda (RSM), Ms C Robinson (CR), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr H Kang (HK), Ms O Dutton (OD), Mr T Lewis (TL), Miss R Barlow (RB), Mr T Waite (TW), Dr R Stedman (RST)

In Attendance: Mr M Hoare (MH), Miss K Dhami (KD), Mr M Sharon (MS), Mrs C Rickards (CR), Mr B Hodgetts (BH)

Apologies: None

Secretariat: Mr Simon Grainger-Lloyd (SGL)

Last Updated: 27 March 2014

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.273	Equality & diversity – interim position statement	SWBTB (12/13) 255 SWBTB (12/13) 255 (a)	19-Dec-13	Include equality and diversity within the business of a future Board Development session	SG-L	30/04/14	ACTION NOT YET DUE Training slot to be arranged for May 2014	G
SWBTBACT.272	Proposals for external support for 'Never Events' assurance	SWBTB (12/13) 251 SWBTB (12/13) 251 (a) SWBTB (12/13) 251 (b)	19-Dec-13	Ensure that the programme model for 2014 onwards be presented as part of Annual Plan finalisation	TL	31/03/14	Presented as the Transforming Transformation update presented at the meeting in March	B
SWBTBACT.275	Chair's Opening Comments and Chief Executive's report	SWBTB (2/14) 003 SWBTB (2/14) 003 (a)	06-Feb-14	Present a briefing note concerning car parking facilities and City and Sandwell Hospitals at the Board meeting in April	TL	03/04/14	Included on the agenda of the meeting on 3 April 2014	B
SWBTBACT.276	Corporate performance dashboard	SWBTB (2/14) 007 SWBTB (2/14) 007 (a)	06-Feb-14	Circulate a note explaining the site difference in terms of rapid access chest pain performance	RB	06/03/14	Verbal update presented at the meeting on 6 March 2014	B

KEY:

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

CHIEF EXECUTIVE'S REPORT

Report to the Public Trust Board – April 2014

The Board meets to reflect on delivery for patients in February 2014, but with a clear eye to the challenges of the financial year 2014-15. That year sees a continuation of many of the improvement programmes and projects that we have developed over the last twelve months. But with an expectation that we find out the final decision on the Midland Metropolitan Hospital from Whitehall officials and that we undertake our CQC and TDA assessments of the organisation's present state and future potential. The next two years will see significant financial challenges across the NHS and we have to continue to work to maintain our strong financial position, which allows us to invest in successful departments.

The Board considers today the risk register and the latest complaints performance. Both appear to me improvements on what we had before but do not yet drive transformation within the Trust in the manner that we would wish. The intent shortly to publish our risk registers widely on Connect may help to raise their profile as a vehicle for tracking concerns. I think we have further to go to ensure that complaints drive change in how we work Trust-wide, rather than solely improve care in the department directly affected. The work we have done on learning from never events illustrates how potentially powerful experiences can be applied horizontally across the organisation.

1. Our patients

February saw weaker performance on some key indicators. More specialties than previously fell short of the 18 week waiting time standard. Our cancelled operations performance has not yet responded to efforts to halve cancellations. And we had one of our weakest three months of the year for emergency care delivery (along with April and October). We have to ensure in quarter one of 2014-15 that 'grip', or the precision of our efforts to improve for patients, is felt across a range of areas of service delivery. As we add in additional programmes, such as 10/10 and year of outpatients, they cannot be at the expense of core standards. At the end of the quarter one, we need to review the sufficiency of our arrangements to track delivery – by then we will have in place the new performance reporting model that is being built to integrate all data points.

There were areas of continued strength in February. We have now received the TDA assessment of our infection control practices, which is exceptionally positive. We achieved a third successive month of dementia success against our CQuIn, and wider CQuIn performance suggests continued good focus on quality improvement in a range of spheres. In 2014-15, these projects will be managed directly by clinical directorates, rather than 'special-ed' by corporate departments and we need to ensure that this shift adds to delivery, rather than leading to a loss of focus.

Emergency care continues to dominate much system wide discussion across health and social care. Performance in March is almost returning to our successes of the winter. This is despite considerable bed closures across Sandwell in the out of hospital sector. Over coming weeks we will re-open our ward at Leasowes. Discussions continue about how the system can best support mental health patients, and the Trust has provided a financial bridge for a further two weeks to support these services. The future of the unit we provide at Rowley remains uncertain, but will be determined

within our wider contract negotiation with the CCG. Overall, we are not succeeding in reducing either demand or delayed transfers of care and this must create considerable anxiety for the future, in terms of the Better Care Fund and its expectations of reduced acute demand in 2015-16.

2. Our colleagues

I am pleased to report that we will end the year with our best appraisal position on record. The 350 employees not appraised will be tracked individually by the HR Department. We are determined that appraisal will benefit everyone, and determined too that obligations held by individuals in the Trust are discharged – an intention we will apply to the stubborn 10% of mandatory training compliance which still eludes us.

The new financial year will see some significant changes in how employees are managed. During 2013-14 we have seen some improvement in the management of long-term sickness. Regular clinics with Occupational Health have been introduced to support managers in delivering a package of support to individuals. We agreed with our JCNC that we would take further steps to try and tackle short term sickness rates, including making the data on sickness days much more visible internally. This is an evidence based approach to tackling absenteeism and distinguishing it from underlying ill health. Our investment to better support mental health and wellbeing at work, which is part of our agreed Public Health strategy, will complement those efforts. In addition, we are almost ready to launch our changes to how investigations are conducted, bringing in a distinct investigations unit to take up the role previously undertaken by managers working in peer departments. I think this is a potentially important project to change the pace at which concerns are investigated and acted upon.

In May the whistleblowing policy we agreed last time will go live. Within that we will purchase for the first time a whistleblowing 'hot line' from outside the Trust. This will give staff the full suite of options available to them to raise concerns. As we enter a period of financial austerity across the NHS, and within our Trust a period of change and restructuring, it is immensely important that whispered voices are heard.

Over recent weeks, a number of Board members, including me, have been involved in listening activities within the Trust, on top of our routine safety visits. On May 2nd, we start the first Friday project for middle managers. These events for me have included a number of discussions with staff from minority ethnic backgrounds, most notably the Unison Black Self-Organising Members Group. These have contributed to work we will present to the equality committee on how we support leadership development and professional development for staff from all backgrounds. We will develop a partnership with NHS Employers in this field and are currently actively seeking out the best performing organisations within the sector in this field to do what they are doing. The Trust ought to be one where diversity is actively celebrated, and we have further to go to make that the reality for everyone who works in the Trust.

3. Our partners

The aspirations of our CCG partners are well reflected in their contract proposals for 2014-15. These set out a raft of quality indicators (40+), as well as a fining and incentive scheme. The translation from these contracts to the behaviour of individual referrers needs further work. We interview for our Director of Primary Care in mid-May and we will look to that post-holder, aided by the practice

support team, to try and see how we construct more meaningful bilateral relationships with practices.

The NHS England contract structure is more traditional, but we are aware of their ambitions to publish a specialist services strategy this summer. It will be important that the separation of commissioning responsibilities for secondary and tertiary services does not drive unwarranted differences to strategy unless aggregation has evidenced merit, as in the case of stroke care.

The transfer of school nursing to Birmingham Community Trust took place on April 1. Unfortunately the new provider was not fully ready, specifically in respect of IT, and so this Trust has agreed some arrangements for April to secure services. The learning from this process needs to heard within the Local Authority as it is all too clear that transition risk was weakly considered within the framework of contract tendering.

4. Our regulators

The Trust Development Authority's Winter Report cited the Trust as one of the highest performing organisations in the sector. Our risk rating has improved from 2/5 to 1/5. Similarly, Board members will be aware that the Intelligent Monitoring Report from the CQC was published in mid-March, and our rating has improved from 4/6 to 5/6.

Health Education West Midlands continues to meet with the Trust to discuss its programme to reduce hospital-based trainee numbers, both as part of an overall reduction and because of a need to see further trainees in general practice (each one requiring the removal of two hospital based post-holders). The initial reduced allocation to the Trust has been reduced and capped. We await the formal report from HEWM from their level 3 visit to A&E at Sandwell, but informal feedback suggests that the posts accredited there will be retained subject to a successful revisit this summer. We need to ensure that our revised performance reporting captures educational data points including trainee feedback. CLE considers when it next meets how we can be one of the first Trusts in the country to appoint Chief Residents among our trainees, which is an RCP recommendation.

5. Feedback from our middle managers

Attendance continues to be strong at our monthly team brief, with over 150 staff attending and 30-40 teams feeding back each month. The conversations tend to follow a consistent pattern, with a yearning for more effective IT, and a concern that the pace of expectation for change can sometimes seem overwhelming. New features this month included a lively discussion about NHS Property Services, where the behaviour of this body in seeking to charge for use of community real estate seems potentially at odds with the strategy to transfer care into more local settings.

This month sees the start of our Top Leaders' Cadre work, with the leading 160 clinicians and non-clinical managers in the Trust, starting our Hay Group supported programme for personal and team development. Responsibility for tracking that work sits with the Executive, and we agreed that the Board's Organisational Development Committee would receive feedback on the effectiveness of the programme. We will bring to the next committee in June an overview of all leadership development work within the Trust, including how we can better support leaders from all backgrounds coming into management roles.

"Hello My Name Is…" dominated Hot Topics in March. This is a social media inspired campaign, led by Dr Kate Granger, a cancer patient in Yorkshire, to try and introduce some basic courtesy into how health professionals meet with those in their care. The campaign is a key part of our own Patient Experience strategy.

Toby Lewis,
Chief Executive
30th March 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Car Parking update
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington, Chief Nurse
AUTHOR:	Steve Clarke, Deputy Director - Facilities
DATE OF MEETING:	3 April 2014

EXECUTIVE SUMMARY:

The following paper seeks to provide further details around the enquiries raised when the Board was presented with the proposed revised approach to car parking charges at its meeting in February 2014.

REPORT RECOMMENDATION:

The Board is recommended to receive and ACCEPT the update.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
✓		

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

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

Comments:

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

None specifically

PREVIOUS CONSIDERATION:

Trust Board on 6 February 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Car Parking Update

REPORT TO THE TRUST BOARD – 3 APRIL 2014

1.0 Introduction

1.1 The following paper seeks to provide further details around the enquiries raised when the Board was presented with the proposed revised approach to car parking charges at its meeting in February 2014.

2.0 Patients Delayed in Clinics

2.1 The following details the system being introduced from Monday 14th April 2014 to administer refunds for car park charges if clinics run late and subsequently delays the patient appointment and the patient incurs additional car parking fees.

2.2 Refund System

- Where a patient appointment is delayed and the delay has incurred additional car parking costs a claim form will be completed by the agreed authorised person in the Outpatient Department.
- The form is then taken by the patient to the relevant Reception desk – (BTC Reception desk at City, General Enquiries Desk at Sandwell).
- The form is checked by Reception staff and the minimum charge is paid by the patient.
- The patient hands in the ticket received at entry (ticket to be attached to the form).
- Reception staff give the patient a receipt for the payment and a one shot release ticket to enable them to leave the car park without further payment.
- If a patient cannot claim at the time of the appointment, a retrospective claim can be made, by post. However a one shot ticket will be offered in preference to postal order/cheque.

2.3 Car Parking Concessions

The following concessions are available to all patients and visitors (prices from 1/4/14).
(NB. Only available for pay on foot (barriered car parks)

One shot tickets	4 for £10
Season tickets	£9 for 3 days unlimited usage (plus £5 refundable deposit)
	£18 for 7 days unlimited usage (plus £5 refundable deposit)
	£42 for 3 months unlimited usage (plus £5 refundable deposit)

A system of scratch cards is to be introduced for the 'pay & display' car parks (City only) to mirror the one shot ticket concession – 4 for £10

3.0 Allocated Space – Blue Badge Holders

3.1 Blue Badge Ratio

Guidance refers to BS8300 which recommends that there is an allowance of 5% for disabled spaces and 5% for enlarged spaces, planning regulations can also state up to 6% for car parks with more than 34 bays, but this is specific to the individual local authorities.

Hospital	Total Visitor Bays	Disabled Visitor Bays	%
Sandwell	258	37	14.3
City	534	140	26.2
Rowley	60	10	16.7
Total	**852**	**187**	**21.9**

Note: Staff blue badge holders are allowed to use visitor disabled bays.

4.0 Rowley Cost Comparison

4.1 There has always been a separate cost base for the Rowley car parking charge, the main differentials between the Rowley site and the City and Sandwell site is the infrastructure. City and Sandwell have extensive CCTV coverage on all car parks and manned security teams covering 24/7.

4.2 If the charges at Rowley were introduced across the Trust the impact on income would be a reduction of circa. 300k.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Key Performance Indicators – Complaints Handling
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Allison Binns, Assistant Director of Governance
DATE OF MEETING:	3 April 2014

EXECUTIVE SUMMARY:

This report sets out details of the Key Performance Indicators used to inform the Corporate Performance report about complaints handling currently.

Data shows that comparisons with the same time period for most of the indicators may not be beneficial as responses are set a time frame of 30 days and we have changed the way we manage complaints across the organisation.

However, the data shows that we have more than halved the average response time to resolve complaints.

The complaints handling process continues to be dynamic as it embeds into the clinical groups and corporate directorates routine. There remains some issues which are affecting the ability to meet agreed response dates, but work is on-going to ensure that the process is right for each directorate and seamless.

REPORT RECOMMENDATION:

The Board is recommended to DISCUSS and NOTE the contents.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		✓

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

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

Comments:

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

Inclusion of metrics within the corporate performance dashboard

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 28 March 2014

Sandwell & West Birmingham Hospitals NHS Trust

Key Performance Indicators: Complaints Handling

1.0 Introduction

1.1 Prior to 4 November 2013 complaints were handled through a corporate team with the assistance of colleagues within the Clinical Groups and Corporate Directorates. Following an external review the complaints handling process was devolved to the Clinical Groups and Corporate Directorates, with a small proportion of the more complex multi organisational complaints remaining with the corporate team for management.

1.2 There were two main drivers for change, firstly to improve the complaint timeliness to ensure that we responded to complainants within agreed time limits. Secondly, so that service improvements were identified and implemented by the staff within the service.

1.3 There was a discussion at the March Trust Board about the key performance indicators (KPIs) relating to complaints within the Corporate Performance Report. Further information was requested to gain a better understanding of the data presented. This paper provides commentary on the KPIs, an explanation on recent performance and action taken / planned where improvement is required.

2.0 Monitoring

2.1 To monitor complaints handling KPIs are included in the monthly Corporate Performance Report. These are outlined in section 3.0. The data since October 2013 can be found at **Appendix 1**.

2.2 Since implementation of the devolved model of complaints handling the KPIs have not changed as they remain valid at this point. It is however, suggested that some amendments are made to two of the KPIs and these are outlined in section 3.0.

2.3 It is worth noting that the timeframe for responding to complainants was set at 30 working days in November 2013, having previously been 40 working days. This does cause some difficulty with previous years comparisons.

3.0 Key Performance Indicators

3.1 The following KPIs are monitored monthly:

	Indicator	Measure	Improvement target
a)	The number of active complaints in the system (new and re-opened)	Total number	A declining trend of total numbers
b)	Then number of new complaints received (new and re-opened)	Total number	A decreasing number of both
c)	The number of days to acknowledge a new and re-opened complaint	3 working days after receipt[1]	100%

	Indicator	Measure	Improvement target
d)	The number of responses which have gone over their original agreed response date	Number as a percentage of total active complaints	A declining number to achieve 0%
e)	Total number of responses sent out	Total number	-
f)	Oldest complaint	Days	-
g)	Number of first formal complaints received per 1000 episodes of care	Number	-

[1] Statutory requirement

3.2 The number of active complaints includes all cases at any stage of complaints handling, excluding those which are with the Parliamentary Health Service Ombudsman (PHSO). The PHSO cases are excluded as we are unable to influence their management.

By providing more proportionate and timely responses the number of complainants who return and their cases requires re-opening will reduce. Equally, through the resolution of complaints through meetings with key staff, it is hoped that re-opened cases will reduce. In future we will capture complaints and concerns which have been resolved locally with the aim of seeing this number increasing and the number of new formal complaints reducing. These will have a positive impact on the first two KPI measures.

3.3 Acknowledgement of complaints remains the only statutory requirement for NHS complaints handling. This KPI is set and cannot be amended. This is a basic function and should not be less than the stated target.

3.4 KPI (d) above was originally introduced due to the number of overdue cases within the system in 2013. There remain challenges in providing responses within agreed time limits so this KPI continues to be monitored. The improvement target of 0% does not relate to cases which go over their agreed date as requested by the complainant.

3.5 'Responses sent out' (e) was initially chosen as a KPI to monitor and capture the numbers sent against the trajectory to address the previous overdue cases. Going forward this KPI requires amendment to show the number of responses sent out as a percentage of those due out in the same month.

At the time when complaints were taking longer than the failsafe time limit of 90 days, this KPI provided important information. However, this has reduced since the introduction of the devolved model, but requires continued monitoring until the norm is 30 days or less. This KPI will then be ceased.

3.6 The TDA currently measures complaints per 1000 bed days, so this KPI was introduced and provides some proportionality of the extent of complaints received.

4.0 Data Comparisons

4.1 A review of all cases received and closed in the period since the devolved model (04.11.13 to 19.03.14) shows an average response of 33 days. This is admittedly still over the agreed 30 day time limit set for the new process and work is on-going to address this. 82 days is the longest it has taken a response to be sent since the change in process. This case was passed over from an agency member of staff and required a further review prior to finalising a response.

This compares with the same time frame in the previous year (04.11.12 to 19.03.13) with an average response of 77 days and the longest response time was 205 days.

5.0 Issues and Solutions

5.1 Assignment of too many Investigation Leads (ILs) by some Clinical Groups has caused confusion about who complaints were to go to and difficulty for the Group to monitor progress.

Response: In discussions with the Clinical Group management teams, amendments have and are being made to the IL lists. This has meant that complaints are sent to the correct person more promptly.

5.2 Currently the approval process allows 10 working days for management approval, CEO check and CEO validation. This takes away a third of the time for the complaint to be investigated.

Response: Speedier notifications to ILs is assisting in limiting the delays in them having the information they require to commence their investigations. Once the approval processes are embedded, the time required for these will reduce. Emailing of responses to the Chief Executive has commenced to assist in the turnaround time at validation.

5.3 Opportunities to discuss and clarify issues with the complainant are not utilised as often as they could, possibly leading to responses which don't directly respond to the complainants primary issues and missing the chance to resolve the issue at the time.

Response: Complaints Co-ordinators are encouraging staff to make contact sooner and a 'bite size' training session on making telephone contact with complainants is being developed.

5.4 The human resources within the Corporate Complaints team have seen a reduction in workforce due to resignations.

Response: An interim solution is in place for the Complaint Co-ordinator posts and appointments have been made. Staff will be in post by May and will commence training. The Head of PALS and Complaints post is also vacant and whilst interim arrangements have been made the new post holder starts on 28 April.

5.5 Complaints not acknowledged within the 3 day statutory period.

Response: The corporate complaints team have been reminded that this is a basic 'must do.' However, reviews of administration time for the team are taking place to identify a rota for undertaking this work on a daily basis.

6.0 Conclusion

6.1 There is still work to be done to ensure that we achieve and maintain the set KPIs. More importantly that we provide a timely, proportionate and effective response to complainants in the most appropriate manner for them.

6.2 Weekly 'SitReps' are being used to highlight to the Clinical Groups and Corporate Directorates where the delays in the complaints handling exist. Complaints Co-ordinators are meeting weekly with Investigation Leads to assist with those cases which are delayed at the investigation point.

The number of active complaints in the system will be vastly reduced when all those complaint responses currently overdue to their agreed response date are finalised.

7.0 Recommendation

7.1 The Board is asked to **DISCUSS** and **NOTE** the contents of the report.

Allison Binns
Assistant Director of Governance

25 March 2014

Appendix 1

Extract from the Corporate Performance Report

FEBRUARY 2014	PATIENT EXPERIENCE

Exec Lead	KPI Source	Data Source	Indicator			October	November	December	January			February			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
KD	D	14	Complaints	No. of Complaints Received formal and link)	No.	65	82	65	→		75	→		65	853	No. Only	No. Only					834	724
				No. of Active Complaints in the System (formal and link)	No.	201	201	190	→		188	→		188	188*	No. Only	No. Only						
				No. of First Formal Complaints received / 1000 episodes of care	No.	0.36	0.45	0.40	→		0.46	→		0.43	0.43*	No. Only	No. Only						
				No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	%	97 ▲	99 ▲	98 ▼	→		97 ▼	→		95 ▼	95*	100	100	100		<100	●		
				No. of responses which have exceeded their original agreed response date (% of total active complaints)	%	33 ▼	29 ▲	20 ▲	→		35 ▼	→		53 ▼	53*	0	0	0		>0	●●		
				No. of responses sent out	No.	109	59	79	→		81	→		58	58*	No. Only	No. Only						
				Oldest' complaint currently in system	Days	107	174	91	→		112	→		118	118*	No. Only	No. Only						

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Trust Annual Plan 2014/15**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Mike Sharon, Director of Strategy and Organisational Development**
DATE OF MEETING:	**3 April 2014**

EXECUTIVE SUMMARY:

The attached draft Annual Plan sets out the start point context and the priority areas for the Trust in 2014/15.

The intended audience is staff and local stakeholders.

It is consistent with the TDA planning submission and the emerging Quality Account.

The format in which it is provided is draft and it is intended to revise the format for publication and circulation.

REPORT RECOMMENDATION:

The Board is therefore asked to:

- **Approve** the Trust Annual Plan for 2014/15

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	x

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

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

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

Aligned to all strategic objective and Trust performance metrics

PREVIOUS CONSIDERATION:

December 2013, March 2014

SWBTB (4/14) 050 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Annual Plan 2014/15

Where EVERYONE Matters

Introduction

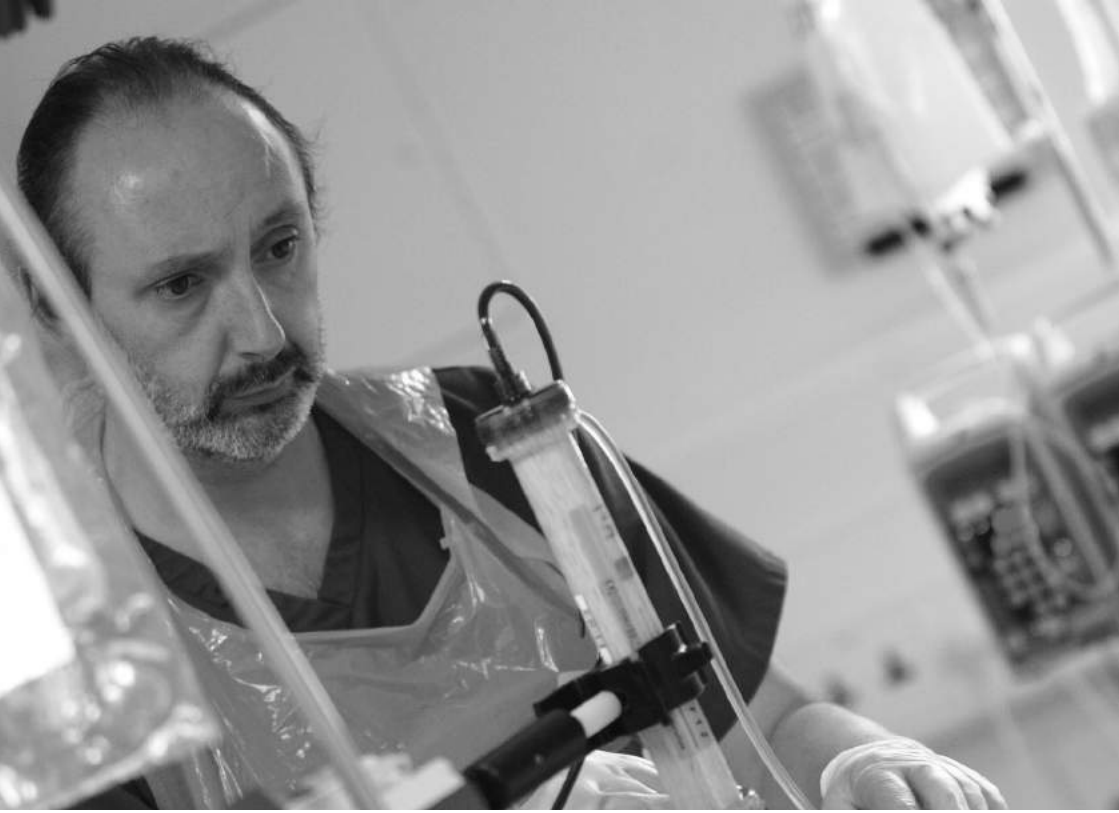
Strategic Context and Direction

The Trust serves half a million people. We have the lowest acute mortality in Birmingham. We provide integrated adult and paediatric care to 300'000 people. We are rated at 1 (a provider with no significant concerns) by the TDA and 5 (out of 6 bands - with 6 being best) by the CQC. Over the next three /six years we are investing in leadership, in a new EPR (Electronic Patient Record), and in reconfiguration. A new Board and Executive team are 'bedding down' and building on a tradition of partnership strength with some local stakeholders. Tackling a poor acute readmission rate, ensuring seven day care continuity, and improving patient satisfaction into the 80s+ are critical goals for us.

75% of staff think safety is our top priority, and as we make data quality, risk management, and peer learning more transparent that figure will improve further. We want patients to view us as an integrated care provider; renowned as the best in the NHS.

Context of Plan Delivery 2013/14

We reduced amenable mortality further, delivered ED standards in midwinter, outperformed our surplus projection and achieved over £20m+ of savings once again. We did this whilst assimilating a new NED, CEO, DOF, and CNO. Our Board is supported by Deloitte in our FT journey. We faced five never events, material data quality issues, had two MRSA cases and one grade 4 pressure ulcer. Each are a call to action to improve, and specifically to learn better internally from one team to another – this led our quality self-assessment to be more self critical than other submissions made in January. Our CCG relationships are strong, though that organisation too is changed, and we have sought to find a new partnership around community nursing services. Both relevant LAs have the poorest rating for children's services and we are actively engaged in improvement work.



75% of staff think safety is our top priority, and as we make data quality, risk management, and peer learning more transparent that figure will improve further.

Narrative on 2 Years Ahead (2014/15 and 2015/16)

In Q4 15-16 we will reach financial close on MMH and will have agreed an EPR replacement FBC (Full Business Case). By then outpatient transfer into community settings will be advanced in line with our RCRH trajectories. Equally advanced will be our integrated care provision in support of the BCF (Better Care Fund).

Preparing for those second year goals, will be of equal importance to the Board in 14-15 as the immediate drive to secure sustained improvement in readmissions, harm free care, employee morale, mandate standards, and another £20m+ cost reduction plan. SWBH is well placed for the new NHS, but only if we galvanise the talents of our 7500 employees.

Safe, High Quality Care

Our ambition is to provide the safest, highest quality care possible. To achieve this ambition we will wholeheartedly adopt the lessons from the Francis and Berwick reports. This means that our approach will deliver:

- An organisation that continuously learns from the best in the world, from our patients and from our experience.
- A strong patient voice from ward to board, driving our key discussions and our key actions.
- Over 7,000 staff living our values every day.
- A leadership cadre with the values and improvement science skills effectively to put quality of care and patient safety as their highest priority.
- A completely open and transparent way of doing business underpinned by confidence in the quality of our data and using data intelligently.

We have already decided to make a significant investment in leadership development over the next two years because delivering ever higher quality and safety while meeting our financial challenges requires extraordinary talent, extraordinarily well led.

We have a Quality and Safety Strategy (2012-2016) which provides an overarching framework for quality governance across the Trust. This defines, at a high-level, the improvements in the quality of care we intend to achieve over a 4 year period. Our specific long-term quality goals are currently being reviewed.

The Trust's Quality & Safety Committee (a sub-committee of the Trust Board) provides assurance on the delivery of the Trust's long term quality goals as set out in the Quality & Safety strategy. It also monitors and provides assurance to the Board that clinical services are appropriately delivered, in terms of quality, effectiveness and safety. Where quality and performance falls below acceptable standards, it ensures that action is taken to bring it back in line with expectations, and to promote improvement and excellence.

Sitting underneath the Trust's Clinical Leadership Executive (CLE) are 3 sub-committees focused on quality:

- Patient Safety Committee.
- Clinical Effectiveness Committee.
- Patient Experience Committee.

In addition we have a Risk Management Committee.

Our overarching quality priorities for 2014/15 are:

- Reducing preventable deaths.
- Reducing readmissions.
- Improving emergency department waiting times.
- Improving our Friends and Family test score.
- Implementing our Public Health Plan.
- Reducing the number of complaints per 1000 episodes of care.
- Improving Outpatient processes and the patient experience in outpatients.

During Q1 we will introduce a new programme called 10/10. In effect a right every time pledge for inpatients.

Our proposed standards to prevent harm:

- We will use Positive patient identification using three unique identifiers.
- We will assess every patient for their risk of developing a pressure ulcer and put in place the appropriate preventative measures.
- We will assess every patient for their risk of falling and ensure that the correct preventive measures are in place.
- We will assess every patient for the risk of developing venous thrombo-embolism and ensure the correct prophylaxis is prescribed where appropriate.
- We will ensure every patient has a base line set of observations carried out by a registered nurse including at least one record of height and weight.
- Every patient will have their medicines checked and reconciled against a definitive list and have any allergies clearly documented on their prescription chart.
- Every patient will have their mental capacity assessed and where required referral for further assessment.
- Every patient will have their pain assessed against a visual analogue scale and offered analgesia if required.
- Every patient will be screened for MRSA and given decolonisation treatment if required.
- Every patient will have their nutrition and fluid needs assessed and given access to appropriate nutritional advice.

Proposed CQUIN targets for 2014/15:

- Safety thermometer.
- Pressure sore prevention.
- Blood clot prevention.
- Falls – linked to sedation and blood pressure medicine.
- Sepsis.
- Referral time to treatment for therapy services.
- Friends and family test.
- Dementia.
- Pain.
- Speed up sending letters to GPs after an outpatient appointment.
- Letters to GPs after an inpatient discharge.
- Safeguarding referral patterns.

Accessible & Responsive

The Trust has in 2013-14 performed well on national standards. We have identified some in-year and prior year discrepancies in performance. This suggests some frailty in systems and in data quality. A taskforce is supporting the Board on data quality, against a plan agreed with commissioners, and aligned with our new Internal Auditor.

The areas of deviation in 13-14 saw us:

- Not deliver VTE assessment at 95% every month, though we are YTD compliant. We believe that our technology-enabled mitigation (deployed since January) provides a secure forward plan.
- Have increased on-the-day cancelled operations. New practices have been deployed during February and we believe that by Q2 14-15 these will be embedded and robust. Our goal is to achieve 0.5% or better.
- Miss the 62-day cancer standard for one month (December). This is highly unusual and we believe that our standard control regime will enable delivery consistently.

We also identified longstanding mixed sex non-compliance in a specified number of departments. From March 2014 our data for this standard will flow directly from our PAS system. The areas of potential small-scale non-compliance will remain. We expect to remain within national standards on a quarterly basis.

Diagnostic compliance is being achieved. Pressures and demands mount as patterns of referral change. We are working through a specific project to try and achieve five week compliance to provide a measure of headroom on our current arrangements.

In eleven months, the Trust has achieved 95% compliance five times. Our ambulance turnaround position is consistently averaging below 30 minutes. Yet we still have over 45 minute turnarounds (there remain some data issues within that) and our emergency care resilience (and ability to deliver on both sites) is not yet demonstrated. We have a cogent care model which we introduced in May 2013. Our forward plans are more of the same, augmented by a whole community bed control centre run from the Trust. This will give us improved capability to tackle the 5% of our medical bed base consistently occupied by patients who are 'labelled' delayed transfer of care.

We have strong seven-day provision already and are working through the priorities to improve further.

Our patient experience strategy has been developed to ensure that we deliver on our nine Customer Care Promises that will deliver significantly improved patient satisfaction. Our Francis ambition on satisfaction is to be over three years the best in the West Midlands.

2014/15 will be the Year of Outpatients. This means we will improve processes to reduce unnecessary activities, rethink models of delivery and create a faster, more responsive service for patients and GPs, based on clear standards and protocols.

Care Closer to Home

The Trust has a long term activity and capacity model (which underpins our LTFM (Long Term Financial Model) which includes the configuration of the new hospital and residual service models at City, Sandwell and community locations as part of our health economy wide Right Care Right Here vision.

The model is based on activity and efficiency assumptions on a year by year trajectory (in line with our LTFM). Our capacity and service development plans for the next two years aim to meet these trajectories and as such key features include:

- Shift from acute bed capacity to intermediate care and other community services.
- A focus on outpatient transformation in 2014/15 to include new pathways that deliver improved patient experience, reduced follow up appointments, alternatives to face to face consultant contacts and care closer to home.
- New community based models of care for long term conditions delivered in partnership with primary care colleagues
- Greater integration of acute and community services along care pathways.
- Growth in our community services to support the transfer of activity from acute care, admission avoidance, greater integration with primary care.
- Increased day case rates.

We will continue our programme of the last five years of service reconfiguration to ensure safe high quality sustainable clinical services. This is likely to include inpatient cardiology reconfiguration with consolidation on one site.

We will also develop our proposals for a community beds hub which will provide an overview of available capacity across the health and care system.

Good Use of Resources

Financial sustainability

The route to financial sustainability consistent with clinical & operational sustainability is described in our LTFM (Long Term Financial Model).

That medium term strategy is to maintain income and to improve profitability by reducing costs. That improvement in profitability is represented by EBITDA (earnings before interest) growth from an existing 6% to a prospective 11% by 2019/20. This growth affords the investment in new facilities and models of care necessary to service sustainability and improvement in liquidity, consistent with sustaining a minimum level 3 Continuity of Service Risk Rating as representative of financial sustainability.

The maintenance of income is consistent with the Trust's position as an integrated care provider and consequent intent to secure relevant income under the Better Care Fund. That intent is shared by its principle commissioner SWBCCG.

Detailed activity & income has been agreed with SWBCCG for 2014/15 as has a forward trajectory of activity, capacity and income consistent with commissioner support for new hospital development. This forward trajectory includes necessary & appropriate assessments of the impact of demographic growth and localisation of services.

The reduction of costs is necessarily focussed on sustained & significant real terms reductions in the pay bill. This is to be achieved through securing a permanent workforce to mitigate premium costs and a c200 wte per annum reduction in workforce numbers. A robust prospective and on-going Quality Impact Assessment process will ensure these changes are consistent with safe, high quality services delivering key standards. A step change in benefit from improved procurement on both a strategic and tactical level is also anticipated and underpinned by greater visibility and engagement at a granular level across the organisation.

The forward capital expenditure programme necessarily has a focus on retained estate refurbishment to underpin new service models [£25m over six years to 2019/20] and IM&T infrastructure and systems [£27m]. The programme provides for appropriate investment to sustain statutory standards and equipment replacement. The programme for imaging replacement & development assumes the effective use of off balance sheet managed service contract arrangements.

Proposed workforce changes

Overall WTE reduction of circa 200 posts per annum (2014/15 and 2015/16):

- Increasing our substantive nursing establishment (funded through converting temporary staffing spend).
- Reduction in support roles and management /administrative roles.

Significant reduction in temporary staffing pay spend (primarily agency costs) as:

- We improve our 'time to hire' for recruitment.
- Strengthen controls on when additional staff are required.
- Introduce an 'in-house' medical staffing bank.
- Re-job plan our medical teams to ensure capacity and fit.
- Address medical ward nursing staff turnover.

21st Century Infrastructure

The main focus on 2014/15 will be in two areas:

- To achieve final approvals for procurement of the new Midland Metropolitan Hospital.
- To procure an Electronic patient record (EPR).

Both of these are important building blocks to creating a sustainable and successful future for our organisation.

They are also linked. The design for the new hospital will assume that we have an EPR. We need to embed and start to use the benefits of an EPR before we make the move into MMH.


OLYMPUS
JAPAN

An Engaged & Effective Organisation

We introduced monthly staff surveys ('Your Voice') in September 2013 at team level to measure staff engagement levels 'real time' and improve working lives and we start 2014/15 with some encouraging signs on staff engagement:

- The Trust's overall level of staff engagement showing an improving trend and in line with national average (3.67 to 3.73).
- A significant increase in NHS staff recommending their hospital from 3.53 to 3.71.

In 2014/15 our priorities are to:

- Develop further our senior leaders through our new Leadership Development Programme.
- Use the Autonomy and Accountability Framework to reward success and target support where it is most needed.
- Increase the uptake of patients on clinical trials.
- Achieve 100% compliance on mandatory training and PDRs for all eligible staff.
- Begin to deliver the objectives set out in our Public Health Plan.
- Have passed all of the NHS Trust Development Authority tests for becoming a Foundation Trust.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Annual Plan 2014/15

Where EVERYONE Matters

Annual Plan 2014/15
AP01

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**NTDA Planning Submission: 4th April 2014**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Mike Sharon, Director of Strategy and Organisational Development**
DATE OF MEETING:	**3 April 2014**

EXECUTIVE SUMMARY:

The Trust is required to submit a **final** two year plan to the TDA on 4 April 2014, which includes:

- Two year plan summary
- Financial plan
- Activity plan
- Workforce plan
- Planning checklist

On 24th March 2014, the TDA provided feedback on the draft submission of the above documents (submitted: 5th March 2014). Specific feedback on the finance & workforce plans have been sent to the relevant leads and the TDA will be liaising directly with those teams to answer any queries. No feedback was received on the activity plan.

Feedback on the draft two year summary plan requested the following:

- A statement in the 2 year plan that describes the work the Trust is doing to prepare for Foundation Trust status, for example the routine refresh of their QGAF work and their work on board development.

This has been included in the two year summary plan, which is included at **Appendix A.**

In addition, the TDA provided feedback on the planning checklist ('Annex E') which required a small number of updates to compliance statements

These compliance statements are included in **Appendix B** with updated responses from the relevant Executive lead.

REPORT RECOMMENDATION:

The Board is therefore asked to:

- Review the two-year summary **(Appendix A)** and note the additional information provided on our preparation for FT status
- Review the non-compliant statements at **Appendix B**
- Approve both documents ahead of final submission Friday 4th April 2014

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:					
Aligned to all strategic objective and Trust performance metrics					
PREVIOUS CONSIDERATION:					
March 2014					

Summary of Two Year Plan 2014/15 to 2015/16

NHS Trust: Sandwell & West Birmingham Hospitals NHS Trust

Strategic context & direction

Strategic Context and Direction

The Trust serves half a million people. We have the lowest acute mortality in Birmingham. We provide integrated adult and paediatric care to 300k people. We are rated at 1 by the TDA and 5 by the CQC. Our CsRR is 4 – and we have a 10 year LTFM at 3. Over the next three /six years we are investing in leadership, in a new EPR, and in reconfiguration. A new Board and Executive team are 'bedding down' and building on a tradition of partnership strength with some local stakeholders. Tackling a poor acute readmission rate, ensuring seven day care continuity, and improving patient satisfaction into the 80s+ are critical goals for us. 75% of staff think safety is our top priority, and as we make data quality, risk management, and peer learning more transparent that figure will improve further. We want patients to view us an integrated care provider; renowned as the best such in the NHS.

Impact of strategic commissioning intentions and service changes

- SWBH will seek to provide an element of BCF community capability building and care management and enabling
- Activity and capacity model agreed with SWBCCG as reasonable strategic financial planning assumptions
- MMH supports reduction of 15% in emergency activity
- B&BC Shared care record supports integrated care across all providers
- Regaining work lost to other providers, notably QE and DGH
- The Trust is a specialist eye, cancer, cardiac, haematology and rheumatology centre

Context of Plan Delivery 2013/14

We reduced amenable mortality further, delivered ED standards in midwinter, outperformed our surplus projection and achieved over £20m+ of savings once again. We did this whilst assimilating a new NED, CEO, DOF, and CNO. Our Board is supported by Deloitte in our FT journey. We faced five never events, material data quality issues, had 2 MRSA cases and one grade 4 pressure ulcer. Each are a call to action to improve, and specifically to learn better internally from one team to another – this led our quality self-assessment to be more self critical than other submissions made in January. Our CCG relationships are strong, though that organisation too is changed, and we have sought to find a new partnership around community nursing services. Both relevant LAs have the poorest rating for childrens' services and we are actively engaged in improvement work.

Narrative on 2 Years Ahead (2014/15 and 2015/16)

In Q4 15-16 we will reach financial close on MMH and will have agreed an EPR replacement FBC. By then outpatient transfer into community settings will be advanced in line with our RCRH trajectories. Equally advanced will be our integrated care provision in support of the BCF. Preparing for those second year goals, will be of equal importance to the Board in 14-15 as the immediate drive to secure sustained improvement in readmissions, harm free care, employee morale, mandate standards, and another £20m+ cost reduction plan. SWBH is well placed for the new NHS, but only if we galvanise the talents of our 7500 employees.

We are continuing to work towards Foundation Trust status. The Trust Board is undertaking self-assessments against the Quality Governance Assurance Framework (QGAF) metrics, as well as progressing our Board Development programme through one-to-one coaching with Deloitte. Our IBP is being refreshed in line with the MMH OBC, and will be submitted to the TDA in June 2014 along with our 10 year LTFM. We are holding a number of membership engagement events throughout April and May to generate public awareness of the role of a Foundation Trust governor. The Trust is awaiting confirmation from the TDA/CQC as to the date of the Chief Inspector of Hospitals visit which will allow us to progress with further external assessment processes (e.g. HDD).

Approach taken to improve quality and safety

Our ambition is to provide the safest, highest quality care possible. To achieve this ambition we will wholeheartedly adopt the lessons from the Francis and Berwick reports. This means that our approach will deliver:

- An organisation that continuously learns from the best in the world, from our patients and from our experience
- A strong patient voice from ward to board, driving our key discussions and our key actions
- Over 7,000 staff living our values every day
- A leadership cadre with the values and improvement science skills effectively to put quality of care and patient safety as their highest priority
- A completely open and transparent way of doing business underpinned by confidence in the quality of our data and using data intelligently

We have already decided to make a significant investment in leadership development over the next two years because delivering ever higher quality and safety while meeting our financial challenges requires extraordinary talent, extraordinarily well led.

Our patient experience strategy has been developed to ensure that we deliver on our nine Customer Care Promises that will deliver significantly improved patient satisfaction. Our Francis ambition on satisfaction is to be over three years the best in the West Midlands.

We also have a Quality and Safety Strategy (2012-2016) which provides an overarching framework for quality governance across the Trust. This defines, at a high-level, the improvements in the quality of care we intend to achieve over a 4 year period. Our specific long-term quality goals are currently being reviewed.

The Trust's Quality & Safety Committee (a sub-committee of the Trust Board) provides assurance on the delivery of the Trust's long term quality goals as set out in the Quality & Safety strategy. It also monitors and provides assurance to the Board that clinical services are appropriately delivered, in terms of quality, effectiveness and safety. Where quality and performance falls below acceptable standards, ensures that action is taken to bring it back in line with expectations, and to promote improvement and excellence.

Sitting underneath the Trust's Clinical Leadership Executive (CLE) are 3 sub-committees focused on quality:

- Patient Safety Committee
- Clinical Effectiveness Committee

- Patient Experience Committee

In addition we have a Risk Management Committee.

The priorities identified in our current Quality Account and current Annual Plan are:

- Reducing preventable deaths
- Reducing readmissions
- Improving emergency department waiting times
- Improving our Friends and Family test score
- Becoming a Health Promoting hospital
- Reducing the number of complaints per 1000 episodes of care
- Improving VTE assessment rates

Most of these priorities will be continued into 2014/15 and 2015/16

During Q1 we will introduce a new programme called 10/10. In effect a right every time pledge for inpatients.

Our proposed standards to prevent harm:

- We will use Positive patient identification using three unique identifiers
- We will assess every patient for their risk of developing a pressure ulcer and put in place the appropriate preventative measures
- We will assess every patient for their risk of falling and ensure that the correct preventive measures are in place
- We will assess every patient for the risk of developing venous thrombo-embolism and ensure the correct prophylaxis is prescribed where appropriate
- We will ensure every patient has a base line set of observations carried out by a registered nurse including at least one record of height and weight
- Every patient will have their medicines checked and reconciled against a definitive list and have any allergies clearly documented on their prescription chart
- Every patient will have their mental capacity assessed and where required referral for further assessment
- Every patient will have their pain assessed against a visual analogue scale and offered analgesia if required
- Every patient will be screened for MRSA and give decolonisation treatment if required
- Every patient will have their nutrition and fluid needs assessed and given access to appropriate nutritional advice

Proposed CQUIN targets for 2014/15:

- Safety thermometer
    - Pressure sore prevention

- Blood clot prevention
- Falls – inked to sedation and blood pressure medicine

- Sepsis
- Referral time to treatment for therapy services
- Friends and family test
- Dementia
- Pain
- Speed up sending letters to GPs after an outpatient appointment
- Letters to GPs after an inpatient discharge
- Safeguarding referral patterns

Service capacity & developments

The Trust has a long term activity and capacity model (underpins our LTFM) which includes the configuration of the new hospital and residual service models at City, Sandwell and community locations as part of our health economy wide *Right Care Right Here* vision.

The model is based on activity and efficiency assumptions on a year by year trajectory (in line with our LTFM). Our capacity and service development plans for the next 2 years aim to meet these trajectories and as such key features include:

- Shift from acute bed capacity to intermediate care and other community services
- A focus on outpatient transformation in 2014/15 to include new pathways that deliver improved patient experience, reduced follow up appointments, alternatives to face to face consultant contacts and care closer to home
- New community based models of care for Long Term Conditions delivered in partnership with primary care colleagues
- Greater integration of acute and community services along care pathways
- Growth in our community services to support the transfer of activity from acute care, admission avoidance, greater integration with primary care
- Increased day case rates

We will continue our programme of the last 5 years of service reconfiguration to ensure safe high quality sustainable clinical services. This is likely to include inpatient cardiology reconfiguration with consolidation on one site.

Mitigations (should no transitional support be available)

The plan provides for year on year surpluses.

Recurrent surpluses are consistent with the requirement for minimum 1% net margin; headline plan net margins are 0.7% [2014/15] & 0.8% [2015/16] and which reflect

entirely the application of resources on a non-recurrent basis in support of strategic change & development objectives.

The delivery of 1% headline net margin would require additional cost improvement such that the annual requirement exceeds 5% of operating costs and a pace of change which may add undue risk to the delivery of those objectives.

There is a stated determination to deliver maximum savings at a scale & pace consistent with safe services and key service standards.

Delivery of operational performance standards

The Trust has in 2013-14 performed well on national standards. We have identified some in-year and prior year discrepancies in performance. This suggests some frailty in systems and in data quality. A taskforce is supporting the Board on data quality, against a plan agreed with commissioners, and aligned with our new Internal Auditor. This group, chaired by the Chief Executive, has introduced a data quality kite-mark, new sign-off standards for data, a new mandatory training programme for all employees and the visible publication of key data within the Trust on large public view television screens. Together this package is a strategy to ensure our data is highly accurate.

The areas of deviation in 13-14 saw us:

- Not deliver VTE assessment at 95% every month, though we are YTD compliant. We believe that our technology-enabled mitigation (deployed since January) provides a secure forward plan.
- Have increased on-the-day cancelled operations. New practices have been deployed during February and we believe that by Q2 14-15 these will be embedded and robust. Our goal is to achieve 0.5% or better.
- Miss the 62-day cancer standard for one month (December). This is highly unusual and we believe that our standard control regime will enable delivery consistently.

We also identified longstanding mixed sex non-compliance in a specified number of departments. From March 2014 our data for this standard will flow directly from our PAS system. The areas of potential small-scale non-compliance will remain critical care (beyond 12 hours at level 1) on occasion. Performance on this element has transformed in year. But pressures remain. And some front door and coronary care unit pressures – the former associated with flow choices to preserve safety and the latter a consequence of poor estate design. We expect to remain within national standards on a quarterly basis.

Diagnostic compliance is being achieved. Pressures and demands mount as patterns of referral change. We are working through a specific project to try and achieve five week compliance to provide a measure of headroom on our current arrangements.

The Trust remains RTT compliant. In 2013-14 we have surmounted the longstanding reporting issues faced by non-admitted patients. The IST is reviewing with us in Q4 our new arrangements. We project continued Trust compliance through 2014-15 and specialty compliance from the end of Q2. A specific plan for those specialties is going to be managed alongside commissioners through Q1.

In eleven months, the Trust has achieved 95% compliance five times. Our ambulance turnaround position is consistently averaging below 30 minutes. Yet we still have

over 45 minute turnarounds (there remain some data issues within that) and our emergency care resilience (and ability to deliver on both sites) is not yet demonstrated. We have a cogent care model which we introduced in May 2013. Our forward plans are more of the same, augmented by a whole community bed control centre run from the Trust. This will give us improved capability to tackle the 5% of our medical bed base consistently occupied by patients who are 'labelled' delayed transfer of care.

We have strong seven-day provision already and are working through the priorities to improve further.

Our most significant areas of risk to delivery of the TDA standards (set out in the updated Accountability Framework) in 2014/15 are:

- Never Event incidence – there have been a total of 5 Never Events in 2013/14 against a target of '0'. In addition there have been a total of 8 CAS alerts in 2013/14. New approaches are being introduced to share learning across the organisation e.g. issuing 'learning alerts' via video messages.
- Emergency care 4hr waits – our performance throughout 2013/14 sees us with a YTD average of 94.4%. Recovery plan submitted to TDA in Q2/3 of 2013/14.
- Cancelled operations – the Trust's cancelled ops rate is above the current target of >0.8% (current performance = 1.1% - see improvement plan outlined above)
- Referral to Treatment times – although currently compliant, there are pressures in a small number of specialties

Workforce plans

PROPOSED CHANGES

Overall WTE reduction of circa 200 posts per annum (2014/15 and 2015/16):

- Increasing our substantive nursing establishment (funded through converting temporary staffing spend)
- Reduction in support roles and management / administrative roles

Significant reduction in temporary staffing pay spend (primarily agency costs) as:

- We improve our 'time to hire' for recruitment
- Strengthen controls on when additional staff are required
- Introduce an 'in-house' medical staffing bank
- Re-job plan our medical teams to ensure capacity and fit
- Address medical ward nursing staff turnover

STAFF ENGAGEMENT AND SUPPORT

- Trust's overall level of staff engagement showing an improving trend and in line with national average (3.67 to 3.73)

- Significant increase in NHS staff friends and family test from 3.53 to 3.71
- Trust is ranked as in best 20% of Trusts for 9 of the 28 key findings including those qualities required for effective change management i.e.
- Satisfaction with the quality of care delivered
- Work pressure felt by staff
- Well structured appraisal
- Staff suffering from work related stress
- Good communication between senior management and staff
- Trust –wide decision day to input to annual priorities for 2014/15 prior to annual business plan being agreed
- Monthly staff surveys 'Your Voice' introduced in September 2013 at team level to measure staff engagement levels 'real time' and improve working lives
- Trust's staff engagement methodology 'Listening into Action' well established and monthly CEO 'hot-topics' introduce key change programmes for discussion and staff feedback
- Well established organisational change management policy, processes and track record of successfully delivering large scale change (service re-configuration, workforce reduction programmes)
- Staff Health and Wellbeing Programme and support mechanisms for career advice, coping with change, counselling etc.
- Healthy employee relations climate

Financial and investment strategy

Headline messages

- The financial plan is consistent with the financial trajectory agreed with the NTDA and as represented in the LTFM which underpins the OBC for new hospital development.
- The plan demonstrates the delivery of all statutory financial duties and a level 3 Continuity of Service Risk Rating.
- The financial plan is consistent with the delivery of key operational standards and safe, high quality services.
- The financial plan is dependent on significant savings being c5% of costs in each year and with necessary focus on pay and workforce reduction. This scale of savings is intended to provide some scope for development consistent with changes necessary for on-going service & financial sustainability.
- Recurrent surpluses are consistent with the requirement for minimum 1% net margin; headline plan net margins are 0.7% [2014/15] & 0.8% [2015/16] and which reflect entirely the application of resources on a non-recurrent basis in support of strategic change & development objectives.

Income

Detailed activity & income has been agreed with SWBCCG for 2014/15 as has a forward trajectory of activity, capacity and income consistent with commissioner support for new hospital development. The proposed contract uses NHS Standard Contract terms and National Tariff subject to local variations and modifications including relevant and effective risk sharing arrangements. CQUIN is assumed recoverable at 2.5% of relevant income and to be delivered at minimal additional cost. The application of funds in respect of marginal rate emergency tariff and emergency readmissions is transparent and effective in supporting the delivery of key operational

standards. The plan includes provision for exposure to financial penalties of £2.0m and which is the level capped in the contract with main commissioners.

Expenditure

Cost inflation is consistent with that assessed in national planning assumptions as uprated for local experience. The plan recognises investment consistent with the national assumptions of 0.4% of tariff inflation being targeted for safety and quality improvement. The plan reflects the full year impact of investment and cost reduction in 2013/14 and the recurrent impact of utilising reserves and corporate savings to underpin front line cost pressures.

Savings required in 2014/15 total £26m [being 6% OPEX] including specific cost reductions, eliminating the premium from temporary staffing and generating financial margin through productivity improvement and on services with volume growth. Savings in 2015/16 total a minimum of £22m on a similar basis. The cost improvement opportunity is scaled as being in excess of plan requirements and is the focus of work to translate into realisable cost reduction at necessary scale & pace.

The plan includes £2.5m for investment in change & improvement. This is linked to a robust Accountability & Autonomy Framework.

Contingencies

The main contract has downside risk in respect of volume demand risk being carried by the trust assessed at £2m and a further potential downside of £1m from a performance related incentive scheme. Upside opportunity exists in respect of a determination to avoid contract fines of up to £2.0m and £1m from the performance related incentive scheme. Plan includes recognised contingencies of a minimum 0.5%. Such contingency may be drawn from planned non-recurrent expenditure £1.4m, likely excess on pay inflation to £1.5m and uncommitted reserves to £3.0m. In addition the trust has significant residual balance sheet flexibility which could be applied on a non-recurrent basis but which may erode cash balances & liquidity.

Capital

Plan capex totals £40m over the two years of the plan. This is in excess of depreciation and represents a use of cash balances in support of strategic objectives for retained estate refurbishment to underpin new service models [£7m] and IM&T infrastructure and systems [£12m] in addition to completing the acquisition and preparation of land for new hospitals development [£5m]. Appropriate provision is also made for compliance with statutory standards and equipment replacement.

Additional capex & CRL cover in respect of potential slippage from 2013/14 to 2014/15 of up to £2m is included in the plan. This is intended to reflect a downside view and consistent with securing a prudent level of CRL cover. The resource for this capex is entirely from trust cash balances.

Cash

Cash balances remain positive and significant over the two years of the plan. There is a modest planned reduction from current c£30m to c£18m by 2016 consistent with strategic capex profiling.

Financial sustainability

The route financial sustainability consistent with clinical & operational sustainability is described in the LTFM.

That medium term strategy is to maintain income and to improve profitability by reducing costs.

That improvement in profitability is represented by EBITDA growth from an extant 6% to a prospective 11% by 2019/20. This growth affords the investment in new facilities and models of care necessary to service sustainability and improvement in liquidity consistent with sustaining a minimum level 3 Continuity of Service Risk Rating as representative of financial sustainability.

The maintenance of income is consistent with the trust's position as an integrated care provider and consequent intent to secure relevant income under the Better Care Fund. That intent is shared by its principle commissioner SWBCCG.

Detailed activity & income has been agreed with SWBCCG for 2014/15 as has a forward trajectory of activity, capacity and income consistent with commissioner support for new hospital development. This forward trajectory includes necessary & appropriate assessments of the impact of demographic growth and localisation of services.

Cost inflation is consistent with that assessed in national planning assumptions as uprated for local experience.

The reduction of costs is necessarily focussed on sustained & significant real terms reductions in the pay bill. This is to be achieved through securing a permanent workforce to mitigate premium costs and a c250 wte per annum reduction in workforce numbers. A robust prospective and on-going QIA process will ensure these changes are consistent with safe, high quality services delivering key standards. A step change in benefit from improved procurement on both a strategic and tactical level is also anticipated and underpinned by greater visibility and engagement at a granular level across the organisation.

The forward capital expenditure programme necessarily has a focus on retained estate refurbishment to underpin new service models [£25m over six years to 2019/20] and IM&T infrastructure and systems [£27m]. The programme provides for appropriate investment to sustain statutory standards and equipment replacement. The programme for imaging replacement & development assumes the effective use of off balance sheet managed service contract arrangements.

Cash balances remain positive and significant over the medium term. There is a modest planned reduction from current c£30m to c£18m over the first two years to 2015/16 consistent with strategic capex profiling. In subsequent years cash balances are planned to grow to c£39m by 2020 to improve liquidity consistent with sustaining a minimum level 3 Continuity of Service Risk Rating in the face of increased capital / debt servicing costs arising from new hospital development under PF2.

Cost Improvement Plans

Savings in 2014/15 total a minimum of £26m including specific cost reductions, eliminating the premium from temporary staffing and generating financial margin on services with volume growth. Savings in 2015/16 total a minimum of £22m on a similar basis.

The target level of those specific cost reductions & against which directorate level savings plans are being tracked is currently assessed at £20.6m [2014/15] & £19.9m [2015/16]. There is a recognised and significant level of under-developed / unidentified cost savings at the time of writing. This arises from, inter alia, some schemes being budget reductions not real cost reductions and a revised assessment of the part-year effect in 2014/15 of schemes which cannot all become effective from 1 April. Some parts of the business remain to identify schemes to fulfil their savings requirement. This is the subject of urgent & focused attention and will be remedied for 2014/15 by 30 May & for 2015/16 by Q2 of 2014. An austerity programme has been introduced with immediate effect to provide downward pressure on costs during the period of this remedial work.

Work is progressing to secure necessary confidence in the savings proposals consistent with a robust Operating Plan as follows:

- Expert support engaged from 7 April to jump start cost reduction
- Expert support engaged from 7 April to consolidate & strengthen service improvement & change management capability into single transformation PMO
- Expert support engaged from 7 April to establish sustainable activity / capacity planning and granular clinical & operational performance improvement diagnostic capability including specifically peer comparison
- The trust has commenced implementation of trust wide leadership development programme linked to new Accountability & Autonomy Framework

QIPP

The QIPP programme remains in development led collaboratively by primary and secondary care clinicians.

The QIPP programme proposed by SWBCCG is set out below:

QIPP	14/15	15/16	16/17
	£'000s	£'000s	£'000s
ACS Chronic conditions	0	1,685	663
Vaccine preventable admissions	520	520	960
Medically unexplained symptoms	0	1,108	539
Zero LOS, no procedure	1,079	1,079	2,350

Readmissions	0	3,659	2,149
OP New:FUP - Medical Specialties	3,000	885	2,940
A&E - Patients leave without being seen	102	102	240
A&E Low cost attendance	0	860	1,029
A&E Frequent attenders	512	512	1,846
Total	5,212	10,409	12,715

The programme is derived from Commissioning for Value and specific local benchmarked performance and represents a prioritised programme. Over the two years 2014-16 the programme aims to achieve West Midlands average performance and 2016/17 moves to top quartile.

The figures set out above cross all relevant providers to SWBCCG. It is proposed that the QIPP programme the trust agrees with SWBCCG is the programme it shall be expected to deliver for all relevant commissioners.

The agreed contract indicates a gross QIPP savings expectation underpinned by £2m of transitional financial support.

Plan capex totals £40m over the two years of the plan.

This is in excess of depreciation and represents a use of cash balances in support of strategic objectives for retained estate refurbishment to underpin new service models [£7m] and IM&T infrastructure and systems [£12m] in addition to completing the acquisition and preparation of land for new hospitals development [£5m]. Appropriate provision is also made for compliance with statutory standards and equipment replacement.

Additional capex & CRL cover in respect of anticipated slippage from 2013/14 to 2014/15 of £2m is included in the plan. This is intended to reflect a downside view and consistent with securing a prudent level of CRL cover. The resource for this capex is entirely from trust cash balances.

Risk	Mitigation
Unable to secure necessary & sufficient staff consistent with safe & sustainable services	Eliminate reliance on temporary staff through move to full permanent establishment. Implement trust wide organisation development programme to make SWBH employer of choice. Develop service specific clinical network & partnership models of care delivery.
Unable to transact savings programme at necessary scale & pace with consequent risk to financial performance & CoSRR.	Consolidation & strengthening of service improvement & change management capacity & capability into single transformation PMO. Implementation of trust wide leadership development programme linked to new Accountability & Autonomy Framework to drive development & delivery of savings. Strengthening of executive level capacity & capability to progress workforce change through appointment of Director of Workforce & OD. Development of Service Line Management capability to identify & crystalise granular level savings.
Service portfolio eroded as clinical standards drive move to delivery through specialised centres and hospital consolidation. Consequent risk to clinical critical mass for sustainability, surplus estate & financial performance.	Progress relevant service re-configuration within extant SWBH services & hospitals. Review & determine SWBH role in delivery of specialised services where can be clinically & financially sustainable; plan & progress market exit where not. Deliver MMH which provides for hospital capacity consolidation and is scaled on basis consistent with health economy strategy for step change in out of hospital. Develop organisational level network & partnership models of care delivery. Position SWBH as hub of integrated care provision for health economy to sustain financial scale.
MMH not approved and inability to address backlog maintenance on extant estate at necessary scale & pace without compromise to service delivery capability.	Secure MMH business case as being fit for purpose & best value option. Confirm 'plan B' estate development requirements and implementation programme. Secure confirmation of necessary funding. Develop organisational level network & partnership models of care delivery. Position SWBH as hub of integrated care provision for health economy to sustain financial scale.

NHS Trust Development Authority
Planning checklist: Quality and workforce
CIH Domains: Safe, Effective, Caring, Responsive to people's needs, Well-led

Most of the following requirements for assurance in the checklist apply to all Trusts, others to specific types of Trusts e.g. Acute Trusts. The note in brackets indicates whether it applies to all or only some e.g. "where applicable").

Please provide for each individual requirement:

- confirmation that requirements are in place (yes/no)
- a Trust assurance statement against each of the individual requirements (no more than 1 -2 paragraphs) either to support your confirmation of compliance (including how you could further evidence that if necessary, e.g. by referencing web links, key documents) or, in the case of non-compliance describe the mitigating actions/plan/timeline in place to achieve compliance.

Please also indicate against any requirements where you may benefit from support/signposting to best practice/linkages with other Trusts and any areas within the checklist where you are demonstrating good practice you are willing to share

Name of NHS Trust: Sandwell & West Birmingham Hospitals NHS Trust

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (24th March 2014)
1.	**Context** All NHS Trusts need to make demonstrable progress towards reducing avoidable deaths in our hospitals. This requires all NHS Trusts to have robust systems to identify and escalate deteriorating patients, in particular at weekend and out of hours, as well as robust governance systems of mortality surveillance and review. **(All)** **Trusts to confirm the following are in place:**			
	1.3 All deaths where aspects of care were judged to be suboptimal should undergo a thorough review by a multi-disciplinary team, including Doctors (Consultants/GPs and junior doctors), Nurses, Pharmacists/other AHPs as appropriate with outcomes reported to a Mortality	No	We operate an electronic mortality review system that currently ensures over 80% of ALL (not just sub-optimal care) deaths are reviewed within 42 days. We have a trajectory to improve this to 100% of eligible deaths by the	Statement does not support all deaths - 80% as per CCG contract.

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (24th March 2014)
	Review Committee (or equivalent) and any further action taken e.g. case note reviews, which should take into account national guidance		end of 14/15. We deliberately exclude deaths that are identified as on supportive care pathways as we have identified that review of these is un-productive. However as a quality assurance check for supportive care pathway patients 1:4 of these deaths are reviewed by one of our palliative care consultants. Any death where sub-optimal care is identified is subjected to full case note review and where appropriate table top review. Mortality reviews are discussed monthly at Mortality and Quality Alerts Committee and a quarterly report is reviewed at the Quality and Safety Board committee. The same report is fed back to Clinical Group and Directorate Governance meetings for the sharing of learning. The trust is taking part in the national PRISM2 study - a sample of 100 deaths will be subjected to external review through this process. We are making a number of improvements and adaptations to the mortality review system - including the adoption of the Hogan/Likert scale in the review process (part of the methodology of the PRISM study), linking of mortality review to coroners referral process and death certification - all death certificates will as a result be subject to consultant review. The mortality review system specifically examines the quality of in-patient care during the last two admissions - however our work on	

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (24th March 2014)
			re-admissions has identified that on average patients are admitted to hospital three or more times in the last six months of life, in many cases significantly more than this. We will be conducting an audit of the 'Last Year of Life' with the express purpose of looking at avoidable admissions, predictable deaths, missed opportunities for community and home based end of life care.	
2.	**Context** All Trusts should have an open and transparent culture in which serious incidents are routinely reported, investigated and learned from **(All)** **Trusts to confirm the following are in place:**			
	2.1 The Trust has systems in place to ensure reporting, investigation, closure rates and learning of all Serious Incidents, Never Events, CAS (Central Alerting System) Alerts, and the National Reporting and Learning System, in line with national requirements (SIRI Policy 2010, Never Events Policy Framework 2012, National Patient Safety Warning System, Care Quality Commission (CQC), 2009/10, Core Standards C1b: Safety Notices)**.** There should be regular reports to the Trust public Board	No	High level information is currently provided in the Quality Report that is presented monthly to the Board. From February 2014 KPIs for the requirements stated have been included in the refreshed Integrated Quality, Performance and Finance report (the Quality Report will be discontinued). Organisation wide learning is variable and actions are in place to strengthen this. A patient safety summit was held in February 2014, as a launch platform for increasing awareness. An external review of theatre safety has been commissioned. New approaches are being introduced to share	Trust declared non compliant but plan in place to address with milestones/timescales

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (24th March 2014)
			learning across the organisation e.g. issuing 'Learning Alerts' via video messages. The Patient Safety Summit launched on 13 Feb 14. A safety culture exercise commenced here and is being rolled out. The first learning alert video was sent to all Trust mobiles and via the intranet in Jan 14. KPIs are incorporated into the dashboard already. Reports of non- closure of alerts and incidents are reported through the Patient Safety Committee and with the CCG. Escalation processes have been refined.	
3c	**Workforce in-year monitoring and reporting:**			
	3.7 Every six months, the Trust board will undertake a detailed review of staffing using evidence based tools. The first of these will take place in June 2014 and Trusts will be required to set out what evidence they have used to reach their conclusions. The second review, to be undertaken by December 2014, will use National Institute for Health and Care Excellence accredited tools	No	Not currently in place. Plan will be drawn up by June 2014.	Trust declared non compliant - plan in development
	3.8 The Trust should have a register of risks against the workforce plan, underpinned by a reliable system for monitoring CIP schemes in-year assessing the quality impact in line with NQB Guidance on CIPs.	Yes	A risk register for the workforce plan has been developed. This includes workforce risks around the planned change delivery programme and hard to fill posts, captured in the Workforce Directorate risk register and the Chief Executive risk register respectively.	Trust declared non compliant - plan in development

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (24th March 2014)
			All CIP schemes are quality impact assessed by the Chief Nurse and Medical director. The Trust has agreed not to develop a separate set of metrics for measuring the quality impact of CIPs. Therefore the any adverse quality impact of CIPs is identified through the routine integrated performance reporting system.	
8.	**Context** The move towards an NHS staffed with senior decision makers 24/7 is critical in supporting the provision of high quality services			
	As set out by NHS England, on 7-day working, local contracts for 2014/15 should include an Action Plan to deliver the clinical standards within the Service Development and Improvement Plan Section	No	The Trust has implemented a number of developments for 7 day working this year. The partnership Urgent Care Board has agreed to take on the partnership programme approach for 7 day service development. Contract rounds in process and action plan to be included.	Declared non compliant - partnership arrangements in place.
11.	**Context** It is important to have effective systems in place to collect, measure and respond to patients, relatives and carer feedback to ensure they are equal partners in care, treated with dignity and understand what is going to happen to them and why at each stage of their treatment **(All)** **Trusts to confirm the following are in place:**			
	11.1 Trusts should have clear plans in place to meet national CQUINs response rates for the Friends and Family test (FFT) in all areas required by the national guidance on FFT. The FFT already applies to Acute in-patient, A and E and maternity services and Trusts should have plans in place where applicable to roll out in Mental	Yes	This CQUIN is established in our programme of work with increasing trends in performance across all areas. Multiple methods are used to collect information and our efforts continue to ensure that this is grown and sustained in the coming year.	More information required re frequency of use of patient stories, and What are the trusts plans to engage effectively

No.	Supporting Safe Services	Confirmation of compliance (Yes/No)	Trust assurance statement (Either to support compliance or to explain actions in place to achieve compliance)	TDA feedback (24th March 2014)
	Health services by the end of December 2014 in line with national guidance. The Trust can provide evidence that it is using the learning from FFT to drive improvement in the quality of patient care **(Where applicable)**		FFT response rates and scores are monitored through the Assurance and Accountability Framework. Results and learning are discussed in the Group Performance reviews to ensure learning and actions are picked up A new Patient experience Group of our Clinical Leadership Executive provides a focus for all activities designed to address improved patient experience. The Trust Board at each monthly meeting hears a patient story in public session and has a session to reflect on lessons learned from the story at the private session immediately following the public meeting. The Chief Executive and Chief Nurse recently met the CEO of HealthWatch Sandwell. A similar meeting will be arranged for Birmingham. The discussion explored how the two organisations will work together in the future	with Health Watch

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Corporate Performance Monitoring Report
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Performance Management
DATE OF MEETING:	3 April 2014 (Report prepared 27 March 2014)

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April 2013 – February 2014.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

Performance Management Committee, Clinical Leadership Executive and Finance & Investment Committee

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST INTEGRATED PERFORMANCE CORPORATE DASHBOARD - FEBRUARY 2014

EXECUTIVE SUMMARY

External Assessment Frameworks

Performance against metrics contained within the NHS TDA Accountability Framework:

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

Access Metrics:

Emergency Care - the Trust performance against the 4-hour wait operational threshold of 95% during February reduced to 92.5% for each site, and Trust wide, with year to date performance for the period April 2013 - February 2014 inclusive at 94.4%.

An ED Performance Risk Summit has been held recently with CCG, LAT and Social Services partners. A range of actions was identified for each organisation including; Improving WMAS Turnaround Times, Reducing Preventable ED Attendances / Admissions, Referral Pathways from ED to all specialties to improve timeliness of referral as well as speedier transit of blood specimens to Pathology and transfer of patients requiring Imaging.

High Level **Referral To Treatment Time** performance thresholds were met for each pathway during the month of February, although the number of treatment functions underperforming increased to 16. There is one patient reported as waiting in excess of 52 weeks in Ophthalmology. Diagnostic waits improved overall during the month to 0.89% (73 patients).

Outcome Metrics:

Infection Control - The number of cases of C Diff reported during the month was 3, with 36 for the year to date, both values within the respective trajectories of 3 and 43. Reported cases of MSSA and E. Coli for the year to date continue to remain within operational thresholds.

Mortality - both the Hospital Standardised Mortality Rate (HSMR) and Summary Hospital level Mortality Indicator (SHMI) for the most recent 12-month cumulative period for which data is available, remain below 100 for the Trust, with values of 93.8 and 99.2 respectively.

WHO Safer Surgery Checklist - compliance against the checklist whereby all 3 sections, brief and debrief were completed improved to 82.1% (January 74.4%) during the month of February. Compliance against the other 2 components of the checklist; all 3 sections and 3 sections plus brief were both at a similar level to the previous month.

Quality Governance:

A total of 10 **Mixed Sex Accommodation** breaches were reported during the month of February comprising; Coronary Care Sandwell (7) and Critical Care Sandwell (3). A total of 103 have been reported to date. An electronic monitoring / reporting system is being introduced, initially into 'higher risk' areas with effect from the end of April.

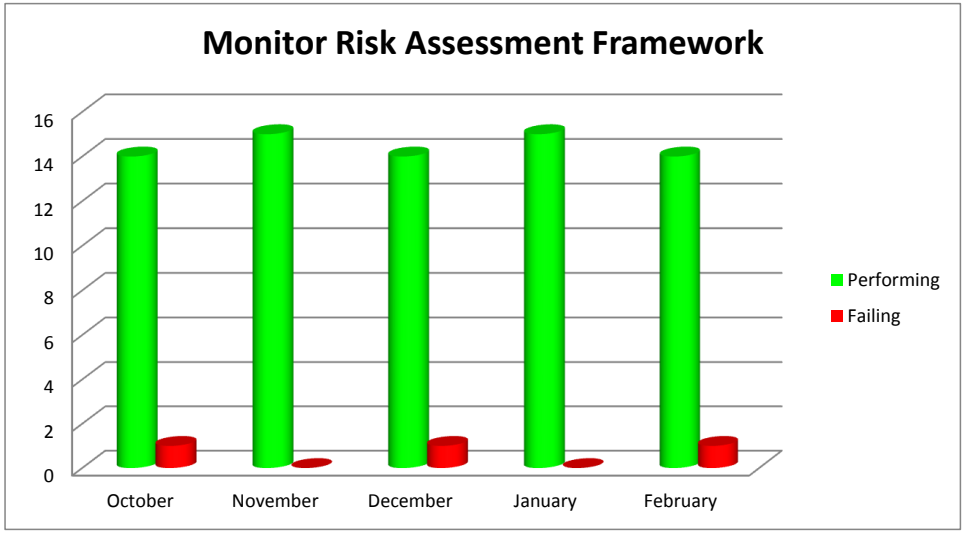
Overall **Sickness Absence** during the month of February is 4.51% (4.31% year to date). Range by Group is 2.90% (Pathology) to 5.53% (Surgery A).

PDR overall compliance further improved to 88.6%, with 6639 staff now recorded as having a valid PDR during the most recent 12-month period. Clinical Group Range 83 - 96%. Corporate Directorate Range 76 - 100%. Medical Appraisal and Revalidation also increased to 94%.

Performance against metrics contained within the Monitor Risk Assessment Framework

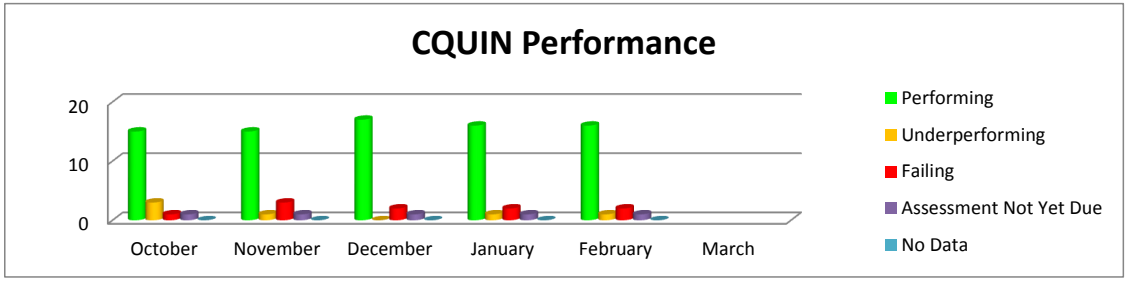
Monitor introduced its ***Risk Assessment Framework*** for NHS Foundation Trusts with effect from 1 October 2013, which replaces its previous Compliance Framework. The range of indicators utilised by Monitor within this framework is less extensive than those used by the NHS TDA. The metrics are identified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

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



During the month of February the Trust met / is projected to meet (Cancer targets) the required thresholds for each of the Access and Outcomes indicators with the exception of ED 4-hour waits, which during he month was 92.5%. This would attract an overall weighted score for the month of 1.0 with an AMBER / GREEN Governance Rating.

CQUIN



CQUIN - A summary of the current performance against the various acute, community and specialised CQUIN schemes is reflected in the table above. Of the 20 summary schemes,16 are performing, with either year to date targets being met or progress in accordance with plan, 1 scheme underperforming and 2 schemes currently failing, with the remaining scheme, Annual Staff Survey, not yet due for assessment.
Dementia (Find, Assess and Refer) CQUIN scheme - exceeded 90% for each of the 3 components for the third consecutive month. Contractual delivery of this scheme is now complete, the focus on the quality of care aspects of the scheme continues.

Friends and Family Test to Maternity - most recent performance, although much improved (16.4%) remains well short of the end of year 65% target. Use of i-pads within the Community is intended to further improve performance.

Medicines Management (Storage) - results from a complete audit of compliance for all wards against this CQUIN are due during week commencing 24 March 2014.

Use of Sepsis Care Bundles - the scheme comprises 3 elements; the percentage of patients with triggers of sepsis who are screened with the sepsis tool, of these patients the percentage who have the sepsis bundle commenced and finally those patients where the bundle is fully deployed within 1 hour. Preliminary data indicates a reduction in performance in the first and third element from the baseline position. The formal CQUIN assessment period is Quarter 4. This report will be updated as further data for the quarter becomes available.

Clinical Quality & Outcomes

Stroke Care - data for February identifies improved performance in a number of areas, particularly admission to an Acute Stroke Unit within 4 hours and the proportion of patients receiving thrombolysis within 60 minutes. The latter is supported by a revised pathway, established with WMAS to take Stroke patients direct to CT where thrombolysis can be administered and reduce time to thrombolysis.

MRSA Screening - both Elective and Non Elective screening rates are at 90% or above for the month of February. Screening of Elective patients in Medicine improved considerably to 71% (75 of 106), from 50% in January.

Fractured Neck of Femur - the percentage of patients receiving an operation within 24 hours of admission during February increased to 80% (16 of 20 patients), from 66.7% during the previous month. Performance for the year to date is 72.4%.

Patient Experience

The percentage of **Imaging Requests** from Emergency Care reported within 24-hours, for each of the 4 modalities; Plain Radiography, Ultrasound, MRI and CT exceeded the operational threshold of 90%, with MRI reporting during the month increasing to 93%, with the other modalities at 100%.

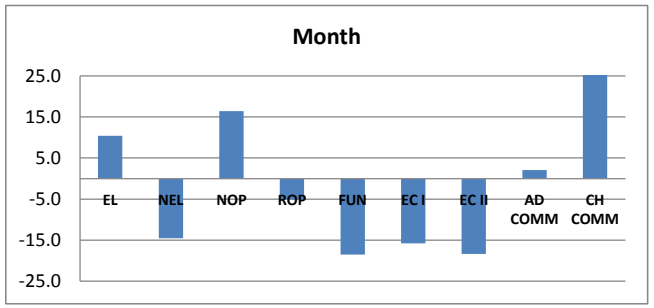
Cancelled Operations - there is no demonstrable improvement in the proportion of SitRep declared late cancellations during the month, which are reported as 1.6%. Numerically 66 were reported, with cancellations across the majoity of surgical specialties. There were no breaches of the 28-day guarantee following cancellation, reported during the month.

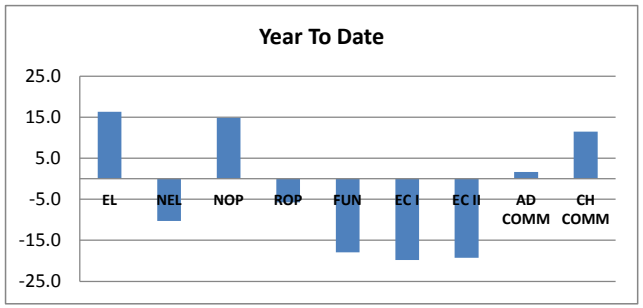
The Task and Finish Group has formulated a policy to ensure that patients are not cancelled on the day of admission or procedure without first ensuring that all opportunities to prevent cancellation have been exhausted. An escalation process to support the policy is also in place.

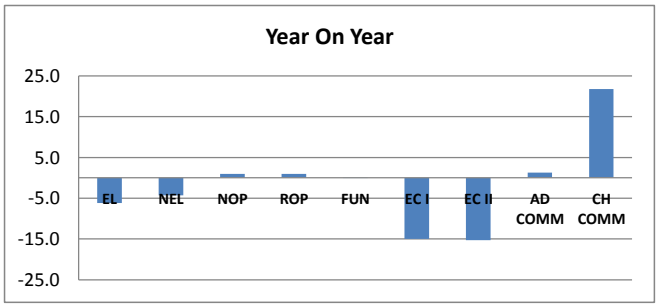
Cardiology Data - an additional interim data clerk has been appointed to Cardiology to address the current backlog of cardiology data input. A Standard Operating Procedure has been established to ensure all Rapid Access Chest Pain referrals receive appointments within 2 weeks of urgent referral.

Activity & Contractual

Activity - Variance expressed as a percentage between actual activity and planned (contracted) activity is reflected for the month and year to date in the graphs below. Additionally, there is a year on year comparison of current year with previous year for the corresponding period of time. High level Elective activity continues to exceed the plan for the year to date by 16.3%, although remains (6.2%) less than that delivered during the corresponding period last year. Non-Elective activity is currently 10.3% less than the plan for the year to date, and 4.3% less than the corresponding period last year. Overperformance against the New Outpatient activity plan for the year to date (+14.8%) and an underperformance against the Review OP activity plan for the year to date (-5.8%), gives a Follow Up:New OP Ratio of 2.23 for the year to date, significantly less than the ratio derived from plan (2.71). Type I and Type II Emergency Care activity to date remains significantly less than plan and for the corresponding period in 2012 / 2013. Adult Community and Child Community activity is currently exceeding plans for the year to date by 1.7% and 11.5% respectively.







FEBRUARY 2014	EXTERNAL ASSESSMENT FRAMEWORKS - TDA ACCOUNTABILITY FRAMEWORK & MONITOR RISK ASSSESSMENT FRAMEWORK

Exec Lead	KPI Source	Data Source	Category / Indicator				October	November	December	January			February			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
			Access Metrics				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RB	B*	1	Cancer	2 weeks		%	95.8 ▲	96.7 ▲	97.0 ▲	→		95.6 ▼	→			95.1	=>93	=>93	No variation		Any variation	●	94.8	94.7
RB	B*	1	Cancer	2 weeks (Breast Symptomatic)		%	93.6 ▼	97.3 ▲	97.0 ▼	→		100 ▲	→			96.2	=>93	=>93	No variation		Any variation	●	95.8	95.9
RB	B*	1	Cancer	31 Day (diagnosis to treatment)		%	100 ▲	97.5 ▼	98.8 ▼	→		99.3 ▲	→			99.0	=>96	=>96	No variation		Any variation	●	99.5	99.5
RB	B*	1	Cancer	31 Day (second/subsequent treatment - surgery)		%	100 ▲	96.3 ▼	98.1 ▲	→		98.8 ▲	→			98.4	=>94	=>94	No variation		Any variation	●	100.0	99.2
RB	B*	1	Cancer	31 Day (second/subsequent treatment - drug)		%	100 ■	100 ■	100 ■	→		100 ■	→			100	=>98	=>98	No variation		Any variation	●	99.2	99.8
RB	B*	1	Cancer	31 Day (second/subsequent treat - radiotherapy)		%	n/a	100 ■	n/a	→		n/a	→			100	=>94	=>94	No variation		Any variation	●	100	100
RB	B*	1	Cancer	62 Day (urgent GP referral to treatment)		%	88.0 ▲	85.4 ▼	83.7 ■	→		85.4 ■	→			86.9	=>85	=>85	No variation		Any variation	●	86.9	87.1
RB	B*	1	Cancer	62 Day (referral to treat from screening)		%	96.3 ▲	98.0 ▲	100 ▲	→		94.7 ▼	→			98.4	=>90	=>90	No variation		Any variation	●	98.5	96.9
RB	A*	1	Cancer	62 Day (referral to treat from hosp specialist)		%	100 ▲	97.3 ▼	100 ▲	→		90.2 ▼	→			91.3	=>85	=>85	No variation		Any variation	●	91.6	93.2
RB	B*	2	Emergency Care 4-hour waits			%	92.6 ▼	95.2 ■	95.4 ▲	96.2 ▲	94.7 ■	95.4 ■	92.5 ■	92.5 ▼	92.5 ■	94.4	=>95	=>95	=>95		<95	●	95.38	92.54
RB	B*	2	Referral To Treatment	Admitted Care (RTT <18 weeks)		%	91.8 ▲	90.9 ▼	92.4 ▲	→		90.1 ▼	→		90.0 ▼	90.0*	=>90.0	=>90.0	=>90.0	85-90	<85.0	●	93.2	93.7
RB	B*	2	Referral To Treatment	Non-Admitted Care (RTT <18 weeks)		%	96.2 ▲	96.2 ■	96.9 ▲	→		97.0 ▲	→		96.5 ▼	96.5*	=>95.0	=>95.0	=>95.0	90 - 95	=<90.0	●	97.5	98.6
RB	B*	2	Referral To Treatment	Incomplete Pathway (RTT <18 weeks)		%	93.8 ▲	93.8 ■	93.0 ▼	→		92.9 ▼	→		93.0 ▲	93.0*	=>92.0	=>92.0	=>95.0	87 - 92	=<87.0	●	97.2	95.3
			Referral To Treatment	Treatment Functions Underperforming		No.	10 ▲	13 ▼	12 ▲	→		13 ▼	→		16 ▼	16*	0	0	0 / month	1 - 6 / month	>6 / month	●	10 (Q4)	11 (Q4)
RB	A	2	Referral To Treatment	Waits >52 weeks		No.	66 ▼	36 ▲	12 ▲	→		3 ▲	→		1 ▲	1*	0	0	<0		>0	●		
RB	A*	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks		%	0.44 ▼	0.85 ▼	1.56 ■	→		1.44 ▲	→		0.89 ■	0.89*	<1.0	<1.0	<1.0	1.0 - 5.0	>5.0	●	0.99	0.88
RB	A	2	Cancelled Operations	28 day breaches		No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	11	0	0	3 or less	4 - 6	>6	● ●	1	2
RB	A	2	Cancelled Operations	No. of second or subsequent urgent operations cancelled		No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0	<0		>0	●		0
			Outcome Metrics																					
CO	B*	4	Infection Control	C. Difficile (DH Reportable)		No.	2 ▲	3 ▼	4 ▼	0 ▲	2 ■	2 ▲	1 ▼	2 ■	3 ▼	36	43	46	No variation		Any variation	●	95	37
CO	A*	4	Infection Control	MRSA Bacteraemia		No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	1	0	0	No variation		Any variation	●	2	1
CO	A	4	Infection Control	MSSA Bacteraemia (rate per 100,000 bed days)		No.	17.6 ■	4.5 ■	9.5 ■	→		4.4 ■	→		0.0 ▲	5.4	=<9.02	=<9.02	No variation		Any variation	●		
CO	A	4	Infection Control	E Coli Bacteraemia (rate per 100,000 bed days)		No.	30.7 ▼	35.9 ▼	19.0 ▲	→		35.1 ▼	→		14.3 ▲	20.2	=<94.9	=<94.9	No variation		Any variation	●		
RB	A	6	Emergency Readmissions (all Diagnostic Groups) within 30 days - CQC definition - QUARTERLY	Following an initial Elective or Non-Elective Admission		%	→	→	9.06	→		→	→		→	9.06*								
RB	A	6	Emergency Readmissions (all Diagnostic Groups) within 30 days - CQC definition - QUARTERLY	Following an initial Elective Admission		%	→	→	4.06 Apr'13 - Jun'13	→		→	→		→	4.06*								
RB	A	6	Emergency Readmissions (all Diagnostic Groups) within 30 days - CQC definition - QUARTERLY	Following an initial Non-Elective Admission		%	→	→	13.69	→		→	→		→	13.69*	10.9	10.9	No variation		Any variation	● ●		
RS		3	Mortality Reviews within 42 working days			%	86 ■	87 ▲	87 ■	→			→			87*	80	80	No variation		Any variation	●	66.9	
RS	A	6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate		HSMR	92.7 Aug'12 to Jul'13	93.2 Sep'12 to Aug'13	93.6 Oct'12 to Sep'13	→		92.5 Nov'12 to Oct'13	→		93.8 Dec '12 to Nov '13	92.5	100	100	No variation		Any variation	●	88.9	90.5
RS		6	Mortality in Hospital (12-month cumulative data)	Peer (SHA) HSMR		HSMR	101.7	101.4	100.9	→		101.5	→		100.5	101.5								
RS		6	Mortality in Hospital (12-month cumulative data)	Peer (National) HSMR - Quarterly		HSMR	→	→	96.4	→		→	→		→	96.4								
RS	A	19	Mortality in Hospital (12-month cumulative data)	SHMI		SHMI	97.8 Aug'12-Jul'13	98.1 Sep'12-Aug'13	97.8 Oct'12-Sep'13	→		99.2 Nov'12-Oct'13	→			99.2	100	100	No variation		Any variation	●	96.8	95.9
RS	A	12	Obstetrics	Caesarean Section Rate	Elective and Non-Elective	%	23.6 ■	25.2 ■	20.6 ■	→		27.7 ■	→		24.7 ■	25.0	<25.0	<25.0	=<25.0	25-28	>28.0	●	22.2	23.6
RS	A	12	Obstetrics	Caesarean Section Rate	Elective	%	10.9	10.3	11.0	→		11.5	→		11.2	11.1								
RS	A	12	Obstetrics	Caesarean Section Rate	Non-Elective	%	12.7	14.9	9.6	→		16.2	→		13.5	13.9								
RS	A	12	Obstetrics	Maternal Deaths		No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0	No variation		Any variation	●		
CO	A*	8	Patient Safety Thermometer - Harm Free Care			%	94.0 ▲	93.7 ▼	94.5 ▲	→		94.0 ▼	→		94.8 ▲	94.8*	=>92	=>92	=>92		<92	●		

Exec Lead	KPI Source	Data Source	Category / Indicator				October	November	December	January			February			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
			Outcome Metrics (Cont'd)				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
KD	A	14	Medication Errors causing serious harm			No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0	No variation		Any variation	●		
KD	A		Open Serious Incidents Requiring Investigation (SIRI)			No.	9 ▼	6 ▲	7 ▼	→		6 ▲	→		1 ▲	1*	0	0	No variation		Any variation	●		2
KD	A		Never Events - in month			No.	0 ■	2 ■	0 ■	→		1 ■	→		0 ■	5	0	0	No variation		Any variation	●		2
KD	A		Open Central Alert System (CAS) Alerts			No.	7 ▲	6 ▲	9 ▼	→		9 ■	→		8 ▲	8*	0	0	No variation		Any variation	●		10
RS	A*	3	VTE Risk Assessment			%	95.0 ▼	94.2 ■	95.5 ■	→		97.6 ▲	→		98.6 ▲	98.6*	95	95	=>90		<90	●	92.4	90.8
RS	A	3	WHO Safer Surgery Checklist	Audit - 3 sections		%	99.5 ▼	99.7 ▲	99.8 ▲	→		99.8 ■	→		99.4 ▼	99.4*	100	100	=>98		<98	●		
RS		3		Audit - 3 sections and brief		%	91.7 ▲	94.5 ▲	97.2 ■	→		90.2 ■	→		89.4 ▼	89.4*	100	100	=>95		<95	●		
RS		3		Audit - 3 sections, brief and debrief		%	80.2 ▲	85.9 ■	86.1 ■	→		74.4 ■	→		82.1 ▲	82.1*	100	100	=>85		<85	●		
RB	C	11	Data Quality	Data Completeness Community Services		%	>50	>50	>50	→		>50	→		>50	>50	=>50	=>50	=>50		<50	●		>50
CO	C	8	Access to healthcare for people with Learning Disability (full compliance)			Y / N	Y ■	Y ■	Y ■	→		Y ■	→		Y ■	Yes	Full	Full	Y		N	●	N	Y
			Quality Governance																					
RB	A	2	Mixed Sex Accommodation Breaches	As percentage of completed FCEs		%	0.13 ▼	0.07 ▲	0.03 ▲	→		0.05 ▼	→		0.08 ▼	0.07	0.0	0.0	0.00		>0.00	●		
RB	A*	2		Numerical		No.	17 ▼	9 ▲	4 ▲	→		6 ▼	→		10 ▼	103	0	0	0		>0	●		
RB				Chargeable Days		No.	29 ▼	17 ▲	7 ▲	→		10 ▼	→		22 ▼	200	0	0	0		>0	●		
CO	B	8	Patient Satisfaction (Friends & Family)	Response Rate	Inpatient Wards	%	29.2	31.4	29.0	→		31.0	→		33.5	33.5*								
CO	B				Emergency Care Department	%	21.1	17.1	15.0	→		15.0	→		15.6	15.6*								
CO	B*				IP Wards plus Emergency Care Department	%	23.4	21.0	19.0	→		19.0	→		20.4	20.4*								
CO	B			Score	Inpatient Wards	No.	71	70	73	→		71	→		75	75*								
CO	B				Emergency Care Department	No.	46	47	44	→		47	→		48	48*								
CO	B*				IP Wards plus Emergency Care Department	No.	54	56	57	→		57	→		60	60*								
RB	B	7	Sickness Absence	Long Term (> 28 days)		%	2.78 ▲	2.67 ▲	2.62 ▲	→		2.52 ▲	→		2.81 ▼	2.70	<2.15	<2.15	<2.15	2.15-2.50	>2.50		2.95	3.39
RB	B			Short Term (<28 days)		%	1.54 ▼	1.56 ▼	1.47 ▲	→		1.94 ▼	→		1.70 ▲	1.60	<1.00	<1.00	<1.00	1.00-1.25	>1.25		0.95	0.99
RB	B			Total		%	4.32 ▼	4.23 ▲	4.10 ▲	→		4.46 ▼	→		4.51 ▼	4.31	<3.15	<3.15	<3.15	3.15-3.75	>3.75	● ● ●	3.90	4.38
RB	A	7	Staff Appraisal	PDRs (12-month rolling)		No. (%)	5925 (79.7) ▲	5975 (79.9) ▲	6193 (82.7) ▲	→		6337 (84.8) ▲	→		6639 (88.6) ■	6639 (88.6)	7490 (100)	7490 (100)	0-15% variation	15 - 25% variation	>25% variation	●	5348	5127
RS	A	14		Medical Appraisal and Revalidation		%	84 ▲	87 ■	89 ▲	→		91 ▲	→		94 ▲	94*	100	100	0-15% variation	15 - 25% variation	>25% variation	●		77
CO	A		Nursing Staff	Registered Nurses as percentage of Nurses		%	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
CO	A			Nurse : Bed Ratio		Ratio	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
MS	B		Staff Turnover	All Staff (Excluding Medical & Dental) - rolling 12 months		%	10.90 ■	10.90 ■	10.87 ■	→		11.00 ■	→			11.00	2.7 - 18.8	2.7 - 18.8	2.7 - 18.8		<2.7 or >18.8			

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

FEBRUARY 2014	CQUINs

Exec Lead	KPI Source	Data Source	Indicator				October	November	December	January			February			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RS	D	3	VTE	Risk Assessment	224	%	95.0 ▼	94.2 ■	95.5 ■	→		97.6 ▲	→		98.6 ▲	98.6*	95	95	=>90		<90	●	92.4	90.8
RS	D	5		Root Cause Analysis	224	%	→	→	100	→		→	→		→	100	100	100	100		<100	●		
CO	D	8	NHS Safety Thermometer	Reduction in Prevalence of Pressure Ulcers (Acute plus Community)	224	%	4 ▲	1 ▲	3 ▼	→		4 ▼	→			65	10% reduction on aggregate 6-month base (Oct 2012 - March 2013) of 81 (68 Acute + 13 Comm)					●		
CO	D				224	%	1 ▼	1 ■	0 ▲	→		3 ■	→		2 ▼	9						●		
CO	D	8	Dementia	Find, Investigate and Refer	269	%	2 of 3 met	1 of 3 met	3 of 3 met	→		3 of 3 met	→		3 of 3 met	3 of 3 met	90% (F, I and R) for 3 consec. months		No variation		Any variation	●		
CO	D			Clinical Leadership	45		→	→	→	→			→			Identified	In Place	In Place	No variation		Any variation	●		
CO	D			Supporting Carers of People with Dementia	135		Survey Undertaken	Survey Undertaken	Survey Undertaken	→		Survey Undertaken	→			Survey Undertaken	Monthly Audit		No variation		Any variation	●		
CO	D	8	Friends & Family Test	Phased Data Collection Expansion - Maternity	137	%	9.04	12.30	7.00	→		8.00	→		16.40	16.40	65	65				● ●		
CO	D			Increased Response Rate (Emergency Care plus All Wards)	175	%	23.4	21.0	19.0	→		19.0	→		20.4	20.4	19	>20				●		
CO	D			Improve Performance on Staff FFT	137	Score	→	→	→	Autumn Annual Staff Survey			Autumn Annual Staff Survey				Improvement from 12/13							
RB	D	20	Safe Storage of Medicines		1105	%	→	→	59 ■	→		→	→			59	75	90	No variation		Any variation	● ●		
CO	D	8	Dementia Patient Stmulation		1138		On Track	On Track	On Track	→		On Track	→		On Track	On Track	Compliance		No variation		Any variation	●		
RS	D	9	Use of Pain Care Bundles		1138	%	Base identified	Base identified	On Trajectory	→		Off Trajectory	→		On Trajectory	On Trajectory	Improvement Trajectory agreed		No variation		Any variation	●		
RS	D	4	Use of Sepsis Care Bundles		1105	%	On Track	Base identified	→			Off Trajectory				Off Trajectory	5% improvement trajectory		No variation		Any variation	●		
CO	D	11	Community Risk Assessment & Advice		1105	%	On Track	On Trajectory	On Trajectory	→		On Trajectory	→		On Trajectory	On Trajectory	10% improvement trajectory		No variation		Any variation	●		
RS	D	8	Recording DNAR Decisions		1105	%	→	→	→	→		→	→		→	On Track	Improvement on Q2 base by Q4		No variation		Any variation	●		
RS	D	Oct-13	Specialised Commissioners (Quarterly Returns)	Clinical Quality Dashboards	60		→	→	Compliant	→		→	→		→	Compliant	Compliance		No variation		Any variation	●		
RS	D	22		Behcets Highly Specialised Service	60		→	→	On Track	→		→	→		→	Compliant	Compliance		No variation		Any variation	●		
RS	D	12		HIV - Communication with GPs	180		→	→	Compliant	→		→	→		→	Compliant	Compliance		No variation		Any variation	●		
RS	D	12		Neonatal - Retinopathy Of Prematurity (Screening)	180		→	→	Compliant	→		→	→		→	Compliant	Compliance		No variation		Any variation	●		

Exec Lead	KPI Source	Data Source	Indicator				October	November	December	January			February			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RS	D	3	Stroke Care	Pts spending >90% stay on Acute Stroke Unit		%	90.5 ▼	92.3 ▲	88.5 ▼	→		88.5 ■	→		93.3 ▲	91.3	83	83	No Variation	0 - 2% Variation	>2% Variation	●	85.9	85.6
	D			Pts admitted to Acute Stroke Unit within 4 hrs		%	68.1 ▼	69.2 ▲	80.8 ▲	→		77.8 ▼	→		85.7 ▲	76.4	90	90	No Variation	0 - 2% Variation	>2% Variation	●	68.7	59.1
	D			Pts receiving CT Scan within 24 hrs of presentation		%	95.7 ▼	100.0 ■	97.9 ■	→		100.0 ■	→		100.0 ■	95.4	100	100	No Variation	0 - 2% Variation	>2% Variation	●	100	92
	D			Pts receiving CT Scan within 1 hr of presentation		%	68.1 ▼	73.1 ▲	78.7 ▲	→		77.8 ▼	→		78.6 ▲	71.8	50	50	No Variation	0 - 2% Variation	>2% Variation	●	37.5	52.0
	D			Admission to Thrombolysis Time (% within 60 mins)		%	0.0 no pts	50.0 ▲	50.0 ■	→		66.7 ▲	→		75.0 ▲	42.9	85	85	=>85		<85	● ● ●		
	D			Admission to Thrombolysis Time (% over 90 mins)		%	0.0 no pts	50.0 ▲	0.0 ■	→		0.0 ■	→		0.0 ■	22.8	0	0	0		>0	● ●		
	D			Stroke Admissions - Swallowing assessments (<24h)		%	100.0 ■	100.0 ■	100.0 ■	→		100.0 ■	→		100.0 ■	98.5	100	100	=>98		<98	●		
	D			TIA (High Risk) Treatment <24 h from initial presentation		%	65.5 ▼	56.3 ■	70.0 ■	→		72.2 ▲	→		67.6 ▼	70.5	60	60	No Variation	0 - 2% Variation	>2% Variation	●	53.2	69.8
	D			TIA (Low Risk) Treatment <7 days from initial presentation		%	81.1 ▼	84.9 ▲	100.0 ▲	→		78.6 ▼	→		65.6 ▼	84.4	60	60	No Variation	0 - 2% Variation	>2% Variation	●	30.4	75.9
RB		3	Infection Control	MRSA Screening - Elective	Patient Not Matched	%	250 ▼	227 ▼	221 ▼	Numerator = 4060	Denominator = 1345	302 ▲	Numerator = 3587	Denominator = 1164	308 ▲	308*	89	90	No variation		Any variation	●		138.9
					Best Practice - Patient Matched	%	82 ▼	73 ■	88 ■	Numerator = 1167	Denominator = 1345	87 ▼	Numerator = 1042	Denominator = 1164	90 ▲	90*	78	80	No variation		Any variation	●		59.5
				MRSA Screening - Non Elective	Patient Not Matched	%	90 ▲	92 ▲	89 ▼	Numerator = 2257	Denominator = 2506	90 ▲	Numerator =	Denominator =	92 ▲	92*	89	90	No variation		Any variation	●		76.8
					Best Practice - Patient Matched	%	92 ▲	92 ▲	93 ▲	Numerator = 2257	Denominator = 2403	94 ▲	Numerator =	Denominator =	94 ■	94*	78	80	No variation		Any variation	●		64.9
CO		14	Falls Requiring Serious Incident Investigation			No	7 ▼	2 ▲	4 ▼	→		2 ▲	→		1 ▲	27	0	0	No variation		Any variation	● ●		22
CO		8	Grade 3 or 4 pressure ulcers - avoidable			No	0 ■	0 ■	1 ■	→		2 ▼	→		1 ▲	10	0	0	No variation		Any variation	●		
CO		8	High Impact Nursing Actions	Inpatient Falls reduction	Acute	No	59 ■	30 ■	47 ▼	→		63 ▼	→		42 ▲	561	605	660	=<55/m		>55/m	●		737
CO					Community	No	12 ▼	15 ■	6 ■	→		9 ▼	→		8 ▲	118	132	144	=<12/m		>12/m	●		
RS		3	Obstetrics	Post Partum Haemorrhage (>2000 ml)		No.	0 ■	1 ▼	0 ■	→		0 ■	→		0 ■	3	44	48	=<2	3 - 4	>4	●	7	10
				Admissions to Neonatal ICU		%	12.1 ■	12.4 ▼	8.3 ■	→		11.6 ■	→			10.2	=<10	=<10	=<10	10.0-12.0	>12.0	●	10.7	10.2
				Adjusted Perinatal Mortality Rate (per 1000 babies)		/1000	12.2 ■	16.3 ▼	2.2 ■	→		0.0 ▲	→			0.0*	<8.0	<8.0	<8	8.0 - 10.0	>10	●	11.9*	4.5
	D			Early Booking (Completed Assessment <12+6 weeks)	National Definition	%	178.0 ▲	158.0 ▼	152.0 ▼	→			→			152.0*	=>90	=>90	=>90	75-89	<75	●	76.0	78.0
	D				SWBH Early Booking (Bookings > Births)	%	81.0 ■	83.5 ▲	84.5 ▲	→			→			84.5*	=>90	=>90	=>90	75-89	<75	● ●	76.0	78.0
CO		2	Infant Health & Inequalities	Maternal Smoking Rates		%	→	→	8.12 ▼	→		→	→		→	8.4	<11.5	<11.5	<11.5	11.5 - 12.5	>12.5	●	9.8	9.9
CO				Breast Feeding Initiation Rates		%	→	→	76.4 ▼	→		→	→		→	76.7	>63.0	>63.0	>63.0	61-63	<61.0	●	73.0	72.6
RB		3	Hip Fractures	Operation <24 hours of admission		%	89.5 ▲	70.6 ■	75.0 ▲	→		66.7 ▼	→		80.0 ▲	72.4	84.0	85.0	No Variation	0 - 2% Variation	>2% Variation	●	66.4	76.7
RB	D	3	Data Quality	Valid Coding for Ethnic Category (FCEs)		%	93 ■	92 ▼	92 ■	→		92 ■	→		93 ▲	93	90	90	>/=90	89.0-89.9	<89	●	95	93
		3		Maternity HES		%	6.8 ▲	9.2 ▼	7.2 ▲	→		8.5 ▼	→		6.9 ▲	7.2	<15	<15	=<15	16-30	>30	●	6.0	6.6
	D	3	Emergency Care Timeliness	Total Time in Department (95th centile)		h : m	5:45 ▼	4:46 ▲	4:48 ▼	→		4:38 ▲	→		5:35 ▼	5:06	=<4hrs	=<4hrs	=<4hrs		=<4hrs	● ●	3 : 59	5 : 15
	D			Time to Initial Assessment (=<15 mins)(95th centile)		mins	20 ▼	17 ▲	17 ■	→		17 ■	→		18 ▼	17	=<15	=<15	<15		<15	●	21	17
	D			Time to treatment in department (median)		mins	48 ▼	43 ▲	42 ▲	→		45 ▼	→		52 ▼	47	=<60	=<60	=<60		>60	●	59	58
	D		Emergency Care Patient Impact	Unplanned re-attendance rate		%	6.16 ▼	6.09 ▲	6.37 ▼	→		5.74 ▲	→		5.92 ▼	6.47	=<5.0	=<5.0	=<5.0		>5.0	● ●	8.66	7.81
	D			Left Department without being seen rate		%	3.47 ▼	2.96 ▲	3.16 ▼	→		2.73 ▲	→		3.76 ▼	3.57	=<5.0	=<5.0	=<5.0		>5.0	●	4.83	4.67
	D		Emergency Care Trolley Waits >12 hours			No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	1	0	0	0		>0	●		
RB	D	18	Ambulance Turnaround	Clinical Handovers recorded		%	87.7 ■	89.7 ▲	89.2 ▼	89.6 ▲	89.8 ▲	89.7 ▲	90.5 ▲	90.2 ▲	90.3 ▲	90.3*	=>85	=>85	=>85		<85	●		71.3
	D			Average Turnaround Time		m : s	29:02 ▼	26:59 ▲	27:19 ▼	26:17 ▲	27:46 ▲	26:59 ▲	28:28 ▼	27:19 ▲	27:50 ▼	27:50*	=<30:00	=<30:00	=<30:00		>30:00	●	29:23	34:24
	D			30 - 60 minutes	All Journeys	No.	1505 ▼	1253 ▲	1385 ▼	491 ▲	751 ▲	1242 ▲	523 ▼	767 ▼	1290 ▼	14785	0	0	0		0	● ● ●		22089
	D				Hospital Fines (WMAS report)	No.	290 ▼	122 ▲	159 ▼	49 ▲	78 ▲	127 ▲	68 ▼	96 ▼	164 ▼	2644	0	0	0		0	● ● ●		
	D			In Excess of 60 minutes	All Journeys	No.	71 ▼	5 ▲	18 ▼	1 ▲	6 ▲	7 ▲	12 ▼	23 ▼	35 ▼	411	0	0	0		0	● ● ●	1256	2354
	D				Hospital Fines (WMAS report)	No.	54 ▼	2 ▲	10 ▼	0 ■	1 ▲	1 ▲	4 ■	10 ▼	14 ▼	228	0	0	0		0	● ● ●		

FEBRUARY 2014	PATIENT EXPERIENCE

Exec Lead	KPI Source	Data Source	Indicator				October	November	December	January			February			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RB		21	Reporting Times of Imaging Requests from Emergency Care - % **reported within 24 hours / next day**	Plain Radiography	%		99 ▲	100 ▲	99 ▼	→		100 ▲	→		100 ■	100*	90	90	No variation		Any variation	●		99
				Ultrasound	%		100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100*	90	90	No variation		Any variation	●		100
				MRI	%		100 ■	93 ▼	81 ■	→		77 ▼	→		93 ■	93*	90	90	No variation		Any variation	●		84
				CT	%		99 ■	100 ▲	99 ▼	→		99 ■	→		100 ▲	100*	90	90	No variation		Any variation	●		99
KD	D	14	Complaints	No. of Complaints Received formal and link)	No.		65	82	65	→		75	→		65	853	No. Only	No. Only					834	724
				No. of Active Complaints in the System (formal and link)	No.		201	201	190	→		188	→		188	188*	No. Only	No. Only						
				No. of First Formal Complaints received / 1000 episodes of care	No.		0.36	0.45	0.40	→		0.46	→		0.43	0.43*	No. Only	No. Only						
				No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	%		97 ▲	99 ▲	98 ▼	→		97 ▼	→		95 ▼	95*	100	100	100		<100	●		
				No. of responses which have exceeded their original agreed response date (% of total active complaints)	%		33 ▼	29 ▲	20 ▲	→		35 ▼	→		53 ▼	53*	0	0	0		>0	● ●		
				No. of responses sent out	No.		109	59	79	→		81	→		58	58*	No. Only	No. Only						
				Oldest' complaint currently in system	Days		107	174	91	→		112	→		118	118*	No. Only	No. Only						
RB		15	Elective Access Contact Centre	Number of Calls Received	No.		13978	12590	10032	→		13318	→		12338	136576	No. Only	No. Only					111793	150454
				Average Length of Queue	mins		0.27 ▲	0.24 ▲	0.20 ▲	→		0.25 ▼	→		0.35 ▼	0.35*	<1.0	<1.0	<1.0	1.0-2.0	>2.0	●	0.21	0.25
				Maximum Length of Queue	mins		13.0 ▲	7.2 ■	8.3 ▼	→		12.3 ■	→		12.4 ▼	12.4*	<6.0	<6.0	<6.0	6.0-12.0	>12.0	●	10.1	14.2
			Telephone Exchange	Number of Calls Received	No.		76416	73295	71451	→		80266	→		65814	792653	No. Only	No. Only					849502	901987
				Calls Answered	%		90.5	91.2	89.4	→		90.8	→		92.6	91.0	No. Only	No. Only					90.2	90.7
				Answered within 15 seconds	%		71.3	70.2	57.4	→		60.9	→		77.6	68.5	No. Only	No. Only					52.5	58.2
				Answered within 30 seconds	%		83.5	82.6	72.6	→		75.5	→		88.0	80.5	No. Only	No. Only					68.1	73.0
				Average Ring Time	Secs		13.1	14.1	22.0	→		19.7	→		10.4	10.4*	No. Only	No. Only					25	18
				Longest Ring Time	Secs		341	476	526	→		492	→		523	523*	No. Only	No. Only					718	349
RB		2	Patient Flow	Average Length of Stay	Days		3.6 ▲	3.8 ▼	3.8 ■	4.1 ▲	3.4 ▼	3.7 ▲				3.7	4.3	4.3	No Variation	0 - 5% Variation	>5% Variation	●	4.2	3.8
				Day of Surgery (IP Elective Surgery)	%		94.4 ▼	94.1 ▼	95.9 ▲	96.7 ▲	96.1 ▼	96.3 ▲	96.3 ▼	92.0 ▼	93.5 ▼	94.4	82.0	82.0	No Variation	0 - 5% Variation	>5% Variation	●	89.5	92.0
				Daycase Rate - All Procedures	%		83.7 ▼	81.8 ▼	83.1 ▲	83.5 ▲	84.7 ▲	84.3 ▲	83.3 ▼	83.2 ▼	83.2 ▼	84.5	80.0	80.0	No Variation	0 - 5% Variation	>5% Variation	●	82.7	83.9
				Available Beds at Month End	No.		786	774	770	→		783	→		814	814*								
RB		2	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%		1.3 ▲	1.3 ■	1.4 ▼	1.6 ▲	1.7 ■	1.7 ▼	2.3 ▼	1.1 ▲	1.6 ▲	1.1	<0.8	<0.8	<0.8	0.8 - 1.0	>1.0	●	0.6	0.7
	D			28 day breaches	No.		0 ■	0 ■	0 ■	→		0 ■	→		0 ■	11	0	0	3 or less	4 - 6	>6	● ●	1	2
	D			No. of second or susequent urgent operations cancelled	No.		0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0	<0		>0	●		0
				Sitrep Declared Late Cancellations	No.		64 ▲	64 ■	60 ▲	27 ▲	57 ▼	84 ▼	35 ▼	31 ▲	66 ▲	592	293	320	0-5% variation	5 - 15% variation	>15% variation	● ●	363	425
				Sitrep Declared Late Cancellations (Pts. >1 occasion)	No.		7 ▲	5 ▲	7 ▼	8 ▼	5 ■	13 ▼	6 ▲	7 ▼	13 ■	13	0	0	No variation		Any variation	●		60
				Multiple Cancellations experienced by same patient (all cancellations)	%		12.4 ▲	13.3 ▼	13.3 ■	→		12.7 ▲	→		13.4 ▼	13.4*	1.0	0.0	No variation		Any variation	● ●		13.6
				All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	%		5.7 ▼	5.5 ▲	5.4 ▲	→		7.9 ▼	→		6.3 ▲	6.3*	3.3	3.1	No variation		Any variation	●		6.2
RB		10	Cardiology	Primary Angioplasty	Door To Balloon Time (90 mins)	%	76.9 ■	75.0 (S) ▼		→			→			85.6	=>80	=>80	=>80	75-79	<75	●	80.1	85.4
					Call To Balloon Time (150 mins)	%	100.0 ▲	85.7 (S) ▼		→			→			92.5	=>80	=>80	=>80	75-79	<75	●	88.4	91.2
				Rapid Access Chest Pain		%	96.4 ■	90.9 ■	91.7 ▲	→		89.2 ▼	→			96.3	100	100	=>98	96.0 - 97.9	<96	●	99.1	95.7
RB		12	GU Medicine	Patients offered app't within 48 hrs		%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	=>98	=>98	=>98	95-98	<95	●	100	100

FEBRUARY 2014	STAFF EXPERIENCE

Exec Lead	KPI Source	Data Source	Indicator			October	November	December	January			February			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
MS	D	7	Staff in Post	Establishment	wte	7188	7252	7204	→			→			7204*								
				Staff In Post (contracted)	wte	6545	6626	6632	→		6612	→			6612*								
				Staff In Post (headcount)	no.	7527	7610	7617	→		7589	→			7589*								
				Staff In Post - FTE / Headcount ratio	Ratio	1.15	1.15	1.15	→		1.15	→			1.15*								
				Variance (Establishment - Staff In Post)	wte	643	626	572	→			→			572*								
				Qualified Nursing Variance (FIMS)	wte	177	199	211	→			→			211*								
				Posts Advertised in Month (NHS Jobs)	wte	158	146	139	→		91	→			91*								
			Induction		%	98 ▲	95 ▼	94 ▼	→			→			94*	100	100	=>85		<85			91.3
RB	D	7	Learning & Development	PDRs (12-month rolling)	No. (%)	5925 (79.7) ▲	5975 (79.9) ▲	6193 (82.7) ▲	→		6337 (84.8) ▲	→		6639 (88.6) ■	6639 (88.6)	7389 (100)	7389 (100)	0-15% variation	15 - 25% variation	>25% variation	●	5348	5127
RS		14		Medical Appraisal and Revalidation	%	84 ▲	87 ■	89 ▲	→		91 ▲	→		94 ▲	94*	100	100	0-15% variation	15 - 25% variation	>25% variation	●		77
MS		3		Mandatory Training Compliance	%	85.2 ▼	86.6 ▲	86.6 ■	→		86.3 ▼	→		87.2 ▲	87.2	100	100	=>95	90 - 95	<90	● ●	71.9	86.4
RB		7	Sickness Absence	Long Term (> 28 days)	%	2.78 ▲	2.67 ▲	2.62 ▲	→		2.52 ▲	→		2.81 ▼	2.70	<2.15	<2.15	<2.15	2.15-2.50	>2.50		2.95	3.39
				Short Term (<28 days)	%	1.54 ▼	1.56 ▼	1.47 ▲	→		1.94 ▼	→		1.70 ▲	1.60	<1.00	<1.00	<1.00	1.00-1.25	>1.25		0.95	0.99
	D			Total	%	4.32 ▼	4.23 ▲	4.10 ▲	→		4.46 ▼	→		4.51 ▼	4.31	<3.15	<3.15	<3.15	3.15-3.75	>3.75	● ● ●	3.90	4.38
RB		17	Bank & Agency Use	Nurse Bank Fill Rate	%	75.0	76.0	71.2	→		73..0	→		74.6	75.0	No. Only	No. Only					87.2	82.9
				Nurse Bank Shifts covered	No.	5260 ▲	5193 ▲	4351 ▲	→		4906 ▼	→		5236 ▼	55091	43065	46980	0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	● ● ●	56396	60463
				Nurse Agency Shifts covered	No.	2497 ▼	2655 ▼	2643 ▲	→		3154 ▼	→		3235 ▼	26898	3511	3830	0 - 5% Variation	5 - 10% Variation	>10% Variation	● ● ●	6948	12874

FEBRUARY 2014 | **ACTIVITY & CONTRACTUAL**

Exec Lead	KPI Source	Data Source	Indicator			October	November	December	January			February			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RB		2	Spells	Elective IP	No.	764 ▼	802 ▲	648 ▼	→		725 ▼	→		684 ▲	7889	9323	10141	No Variation	0 - 2% Variation	>2% Variation		10610	9596
				Elective DC	No.	4452 ▼	4141 ▼	3645 ▲	→		4356 ▲	→		3831 ▼	45927	36954	40198	No Variation	0 - 2% Variation	>2% Variation		53685	52875
				Total Elective	No.	5216 ▼	4943 ▼	4293 ▲	→		5081 ▲	→		4515 ▼	53816	46277	50339	No Variation	0 - 2% Variation	>2% Variation	●	64295	62471
				Total Non-Elective	No.	4742 ▲	4562 ▼	4642 ▼	→		4738 ▼	→		4306 ▲	49944	55690	60931	No Variation	0 - 2% Variation	>2% Variation	●	55675	56982
			Outpatient Attendances	New	No.	15991 ▼	14642 ▼	12949 ▲	→		15327 ▲	→		13610 ▲	159760	139125	152466	No Variation	0 - 2% Variation	>2% Variation	●	159051	171540
				Review	No.	32500 ▼	30360 ▼	27239 ▲	→		33655 ▼	→		30131 ▲	355700	377574	410406	No Variation	0 - 2% Variation	>2% Variation	●	421494	382248
			Emergency Care Attendances	Type I (Sandwell & City Main Units)	No.	12201 ▼	11760 ▲	11886 ▲	5796 ▲	6706 ▼	12502 ▲	5430 ▲	6392 ▲	11822 ▲	135143	168562	184483	No Variation	0 - 2% Variation	>2% Variation	● ●	177201	171701
				Type II (BMEC)	No.	1944 ▼	1847 ▲	1778 ▼	→	1882 ▲	1882 ▲	→	1759 ▼	1759 ▼	20884	25861	28304	No Variation	0 - 2% Variation	>2% Variation	● ●	36362	26649
				All - Contracted plus Non-Contracted	No.	20120 ▲	19080 ▲	19514 ▲	8345 ▲	11493 ▲	19838 ▲	7791 ▲	10850 ▲	18641 ▲	217880	189317	207128						207128
		16	Community	Adult - Aggregation of 18 Individual Service Lines	No.	49810 ■	46207 ■	40222 ▼	→		46825 ▼	→			461955	454295	540982	No Variation	0 - 2% Variation	>2% Variation	●	493163	538147
				Children - Aggregation of 4 Individual Service Lines	No.	17857 ▲	17407 ▲	13173 ▼	→		18181 ▲	→			155114	139139	165757	No Variation	0 - 2% Variation	>2% Variation	●	143400	155412
			Contract	Improvement Notices	No.	1 ■	0 ■	0 ■	→		0 ■	→		0 ■	0*	0	0				●		
RB	D	2	Delayed Transfers of Care	Acute	%	3.6 ▲	2.6 ■	3.2 ▼	2.8 ▼	3.6 ▲	3.2 ■	2.8 ■	3.0 ■	2.9 ▲	3.2	<3.5	<3.5	<3.5	3.5 - 5.0	>5.0	●	5.2	2.9
				Pt's Social Care Delay	No.	9 ▲	10 ▼	8 ▲	3 ■	4 ▼	7 ▼	2 ▲	2 ▲	4 ▲	4*	<18	<18	No Variation	0 - 10% Variation	>10% Variation		13	7
				Pt.'s NHS & NHS plus S.C. Delay	No.	10 ■	9 ■	10 ■	6 ■	7 ■	13 ■	3 ■	0 ■	3 ■	3*	<10	<10	No Variation	0 - 10% Variation	>10% Variation		20	8
RB		2	Outpatient Efficiency	New : Review Rate	Ratio	2.03 ▲	2.07 ▼	2.10 ▼	2.21 ■	2.19 ▼	2.20 ▼	2.33 ■	2.16 ▲	2.21 ▼	2.23	2.30	2.30	No Variation	0 - 5% Variation	>5% Variation	●	2.65	2.23
				DNA Rate - New Referrals	%	12.9 ▼	12.2 ▲	12.7 ▼	→		12.5 ▲	→		11.6 ▲	11.6	10.0	10.0	No variation		Any variation	● ●	11.8	11.3
				DNA Rate - Reviews	%	12.6 ▼	12.5 ▲	13.5 ▼	→		12.4 ▲	→		12.6 ▼	10.4	10.0	10.0	No variation		Any variation	●	11.9	10.3

LEGEND

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

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

FORWARD PROJECTION ASSESSMENT	
●	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:	Financial Performance Report – P11 February 2014
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Management
AUTHOR:	Chris Archer, Associate Director of Finance - Corporate
DATE OF MEETING:	3 April 2014

EXECUTIVE SUMMARY:

Key messages:

- Trust £1.0m ahead of original plan to date, consistent with £6.7m forecast outturn.
- Position reflects £0.3m of provisions released into the position in month and £0.7m of site clearance spend transferred to the capital programme.
- Clinical Groups continuing to overheat, including pay and non-pay overspends as well as shortfalls in some areas of income.
- Significant capital spend required in March to hit Capital Resource Limit.

Key actions:

- Review & confirm forecast positions and escalate financial controls as necessary
- Identify cost reduction measures consistent with recurrent TSP delivery at full target value & remedy of residual recurrent budget over spending
- Responsible officer / accountable director to confirm capex forecast for each & all schemes

Key numbers:

- In month surplus £49k being £152k better than plan after further release of provisions of £1.0m
- Year to date surplus £5.2m being £1.0m better than plan after the release of an additional £0.3m from provisions and £0.7m transferred to the capital programme.
- Forecast surplus £6.7m being in line with revised plan declared to TDA
- Capex £9.8m [45% of annual programme] remaining to be spent in two months.
- Cash balance of £43.2m is £3.2m higher than plan as at 3^{1st} January.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
x		

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

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Good use of Resources
PREVIOUS CONSIDERATION:
Performance Management Committee and Finance & Investment Committee

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – February 2014

EXECUTIVE SUMMARY

• For the month of February 2014, the Trust delivered a "bottom line" surplus of £49,000 compared to a planned deficit of £103,000 (as measured against the DoH performance target). Actual in month performance includes the release of an additional £0.3m from reserves and the transfer of £0.7m of site clearance work to the capital programme and remains consistent with the year end revised surplus.

• For the year to date, the Trust has produced a surplus of £5,180,000 compared with a planned surplus of £4,103,000 so generating a favourable variance from plan of £1,077,000. This includes the impact of £1.3m being released to date from provisions as well as £0.7m of site clearance work transferred to the capital programme. Both the year to date position and the forecast outturn remain consistent with the revised target agreed with the Trust Development Authority.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 278 below planned levels. After taking account of the impact of agency staff, WTE's were 36 below plan. Total pay expenditure for the month, inclusive of agency costs, is £25,000 below the planned level (£1,154,000 year to date), the year to date position includes release of non-recurrent provisions to improve the position.

• The month-end cash balance was £43.2m. Year to date spend on capital is £9.0m.

•The forecast year end I&E position includes an estimate of impairments to fixed assets. This is treated as a technical adjustment and does not affect delivery against the revised DH target surplus of £6.7m.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	152	1,077	>=Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	225	533	>=Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	25	1,154	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	(736)	(3,359)	<=Plan	<=Plan	>1% above plan
WTEs Actual v Plan	36.0	(70.6)	<=Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000	3,203	3,203	>=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	4,103	5,180
Capital Resource Limit	18,706	18,706
External Financing Limit	---	3,203
Return on Assets Employed	3.50%	3.50%

2013/14 Summary Income & Expenditure Performance at February 2014	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	393,770	32,957	33,734	777	361,084	363,323	2,239	395,746
Other Income	41,029	3,895	4,054	159	37,739	38,238	499	42,303
Operating Expenses	(408,965)	(35,185)	(35,896)	(711)	(375,564)	(377,769)	(2,205)	(411,240)
EBITDA	25,834	1,667	1,892	225	23,259	23,792	533	26,809
Interest Receivable	100	8	10	2	92	118	26	131
Impairment of Fixed Assets	0	0	0	0	0	0	0	(2,500)
Depreciation, Amortisation & Profit/(Loss) on Disposal	(13,962)	(1,164)	(1,120)	44	(12,490)	(12,279)	211	(13,390)
PDC Dividend	(5,027)	(419)	(492)	(73)	(4,609)	(4,352)	257	(4,616)
Interest Payable	(2,344)	(195)	(241)	(46)	(2,149)	(2,099)	50	(2,198)
Net Surplus/(Deficit)	**4,601**	**(103)**	**49**	**152**	**4,103**	**5,180**	**1,077**	**4,236**
IFRIC12/Impairment/Donated Asset Related Adjustments	0	0	0	0	0	0	0	2,500
SURPLUS/(DEFICIT) FOR DOH TARGET	**4,601**	**(103)**	**49**	**152**	**4,103**	**5,180**	**1,077**	**6,736**

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

Sandwell and West Birmingham Hospitals NHS

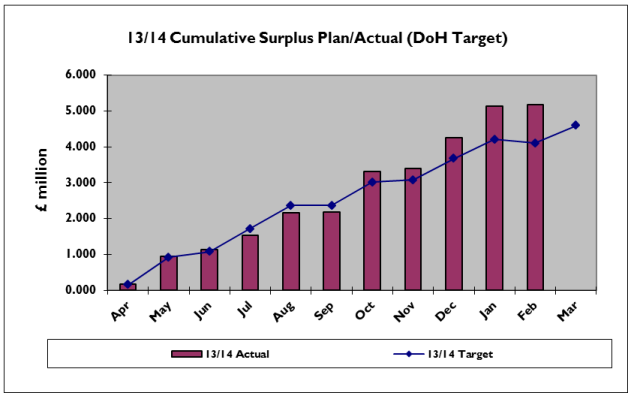
NHS Trust

Financial Performance Report – February 2014

Overall Performance against Plan

The overall performance of the Trust against the DoH planned position is shown in the graph. Net bottom-line performance delivered an actual surplus of £49,000 in February against a planned deficit of £103,000. The resultant £152,000 favourable variance results in a year to date return on income of 1.3%, exceeding the plan of a 1.1% return.

The Trust's forecast is now a surplus of £6.7m.



Performance of Clinical Groups / Corporate Areas

•Medicine overspent by £0.6 mainly in ward areas reflecting winter capacity.

•Surgery A overspend caused by a number of non pay issues, the largest of which is the transfer of orthopaedic cases to the private sector.

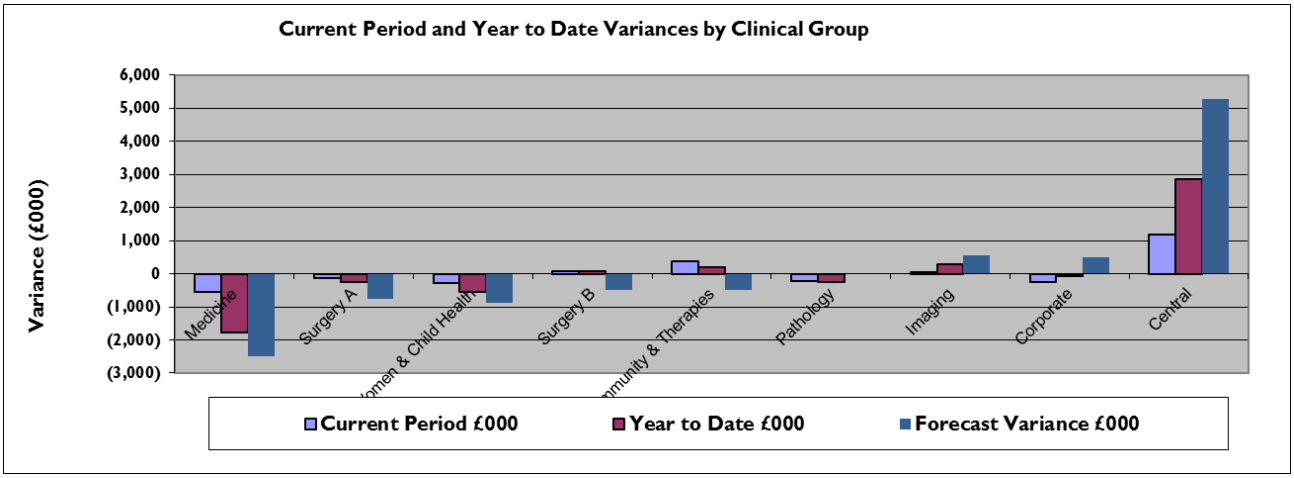
•Women & Child health continuing shortfall on income and overspend on medical consumables.

•Pathology have met the one-off costs of resolving a consumables contract issue.

Group Variances from Plan (Operating income and expenditure)	Current Period £000	Year to Date £000	Forecast Variance £000
Medicine	(553)	(1,779)	(2,481)
Surgery A	(126)	(235)	(746)
Women & Child Health	(282)	(561)	(889)
Surgery B	65	84	(503)
Community & Therapies	387	196	(482)
Pathology	(235)	(248)	2
Imaging	36	287	555
Corporate	(248)	(76)	489
Central	1,180	2,865	5,270

•Corporate directorates continue to underspend on management costs.

•The Central position reflects release of provisions to support the general position.



Sandwell and West Birmingham Hospitals NHS

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Financial Performance Report – February 2014

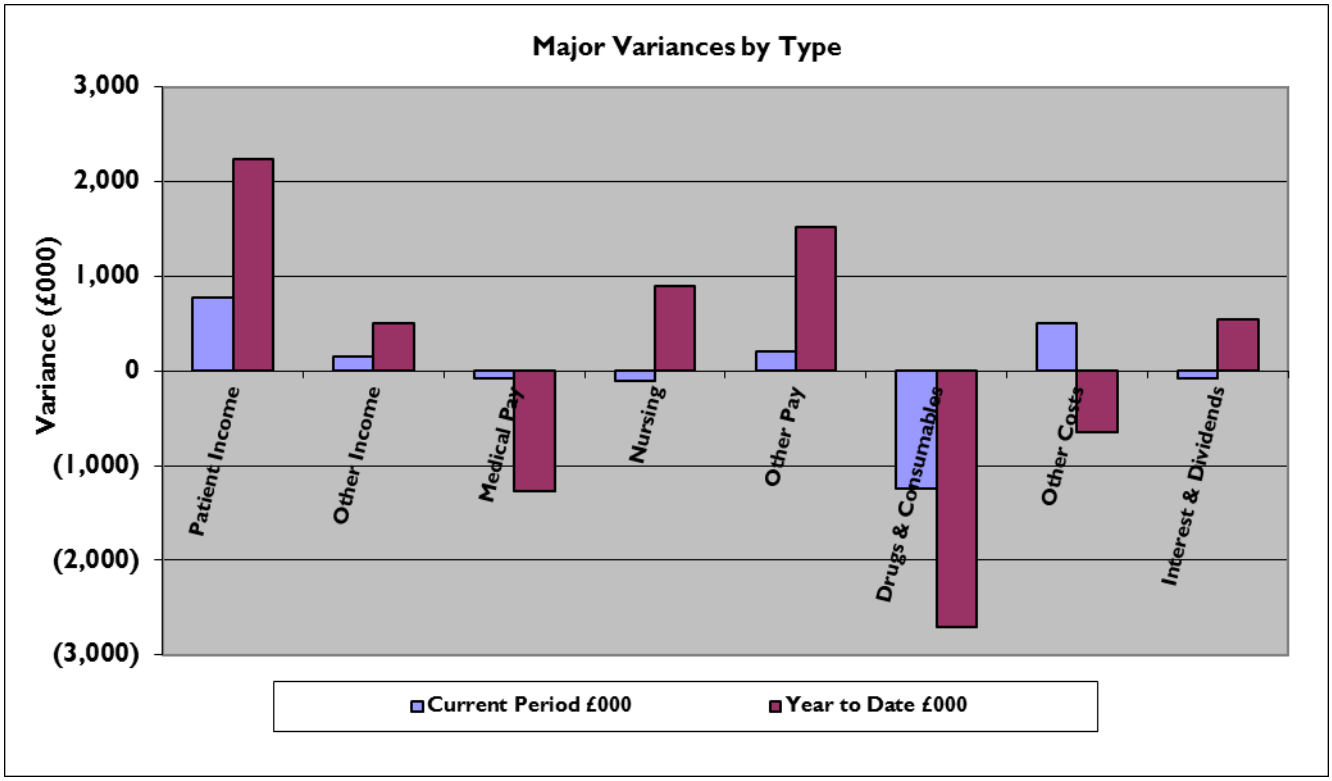
The Trust-wide in-month favourable variance is £152,000.

Contract income overperformed in the month, including pass through drugs which is also reflected in the drugs overspend.

Other costs includes £1.0m release of provisions to support the overall position.

Financing costs are below plan.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	777	2,239
Other Income	159	499
Medical Pay	(81)	(1,265)
Nursing	(100)	893
Other Pay	206	1,526
Drugs & Consumables	(1,246)	(2,707)
Other Costs	510	(652)
Interest & Dividends	(73)	544



Sandwell and West Birmingham Hospitals NHS

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Financial Performance Report – February 2014

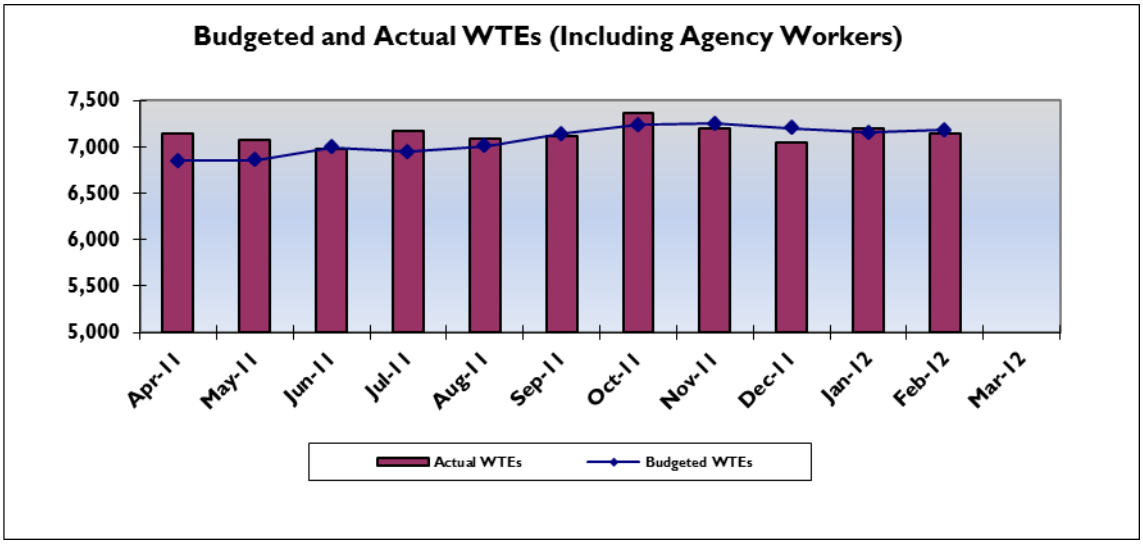
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are 36 below plan . Excluding the impact of agency staff, whole time equivalent (WTE) numbers are 278 below plan.

• Total pay costs (including agency workers) are £25,000 below budgeted levels for the month.

•Overspends on healthcare assistants and medical staff continue which are partly offset by underspending management and scientific staff budgets.

•Gross expenditure for agency staff in February was £914,000 which shows no movement from the average year to date.



Analysis of Total Pay Costs by Staff Group

	Year to Date to February					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	70,554	68,356	0	3,463	71,819	(1,265)
Management	14,237	12,980	0	0	12,980	1,257
Administration & Estates	29,371	26,341	2,191	1,122	29,654	(283)
Healthcare Assistants & Support Staff	29,184	25,699	3,796	1,035	30,530	(1,346)
Nursing and Midwifery	84,150	75,387	3,864	4,006	83,257	893
Scientific, Therapeutic & Technical	40,292	38,296	0	401	38,697	1,595
Other Pay / Technical Adjustment	323	20	0	0	20	303
Total Pay Costs	268,111	247,079	9,851	10,027	266,957	1,154

Sandwell and West Birmingham Hospitals NHS

NHS Trust

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Balance Sheet

•Cash balances at 28th February stood at £43.2m, £3.2m higher than the planned figure. The forecast cash flow for the next twelve months is shown overleaf.

•The forecast balance sheet assumes impairment in the value of tangible assets also reflected in the I&E statement and the revised forecast I&E surplus of £6.7m.

STATEMENT OF FINANCIAL POSITION 2013/14

		Opening Balance as at 1st April 2013	Balance as at end January 2014	Balance as at end February 2014	Forecast at 31st March 2014
		£000	£000	£000	£000
Non Current Assets	Intangible Assets	924	525	539	874
	Tangible Assets	216,669	215,237	215,724	220,477
	Investments	0			
	Receivables	1,048	966	966	700
Current Assets	Inventories	3,604	3,470	3,383	3,600
	Receivables and Accrued Income	10,432	23,355	28,368	12,300
	Investments	0	0	0	
	Cash	42,448	45,189	43,173	37,944
Current Liabilities	Payables and Accrued Expenditure	(43,040)	(52,703)	(56,029)	(46,361)
	Loans	(2,000)	(2,000)	(2,000)	(2,000)
	Borrowings	(914)	(861)	(659)	(1,029)
	Provisions	(10,355)	(8,209)	(7,931)	(7,654)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	0	0
	Loans	(3,000)	(2,000)	(2,000)	(1,000)
	Borrowings	(29,263)	(28,306)	(28,406)	(27,884)
	Provisions	(3,168)	(2,789)	(2,807)	(3,262)
		183,385	191,872	192,321	186,705
Financed By					
Taxpayers Equity	Public Dividend Capital	160,231	160,231	160,231	162,139
	Revaluation Reserve	34,356	33,659	33,321	28,909
	Other Reserves	9,058	9,058	9,058	9,058
	Income and Expenditure Reserve	(20,260)	(11,075)	(10,289)	(13,401)
		183,385	191,872	192,321	186,705

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CASH FLOW

12 MONTH ROLLING FORECAST AT February 2014

ACTUAL/FORECAST	Feb-14 £000s	Mar-14 £000s	Apr-14 £000s	May-14 £000s	Jun-14 £000s	Jul-14 £000s	Aug-14 £000s	Sep-14 £000s	Oct-14 £000s	Nov-14 £000s	Dec-14 £000s	Jan-15 £000s	Feb-15 £000s
Receipts													
SLAs: SWB CCG	**20,706**	20,700	20,978	20,978	20,978	20,978	20,978	20,978	20,978	20,978	20,978	20,978	20,978
Associates	**6,437**	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600	6,600
Other NHS income	**1,852**	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100	1,100
Specialised Service (LAT)	**4,417**	4,400	4,400	4,400	4,400	4,400	4,400	4,400	4,400	4,400	4,400	4,400	4,400
Education & Training			4,700	0	0	4,700	0	0	4,700	0	0	4,700	0
Public Dividend Capital		1,409											
Loans													
Other Receipts	**1,630**	2,600	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800
Total Receipts	**35,042**	36,809	39,578	34,878	34,878	39,578	34,878	34,878	39,578	34,878	34,878	39,578	34,878
Payments													
Payroll	**13,831**	13,800	14,100	14,100	14,100	14,100	14,100	14,100	14,100	14,100	14,100	14,100	14,100
Tax, NI and Pensions	**9,649**	9,500	9,650	9,650	9,650	9,650	9,650	9,650	9,650	9,650	9,650	9,650	9,650
Non Pay - NHS	**1,622**	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Non Pay - Trade	**8,873**	9,320	7,825	7,825	7,825	7,825	7,825	7,825	7,825	7,825	7,825	7,825	7,825
Non Pay - Capital	**1,695**	3,400	1,308	1,308	1,308	1,308	1,308	1,308	1,308	1,308	1,308	1,308	1,308
PDC Dividend		2,075						2,750					
Repayment of Loans		1,000						1,500					
Interest		15	0	0	15	0	0	15	0	0	15	0	0
BTC Unitary Charge	**376**	428	225	225	225	225	225	225	225	225	225	225	225
Other Payments	**1,012**	500	92	92	92	92	92	92	92	92	92	92	92
Total Payments	**37,058**	42,038	35,200	35,200	35,215	35,200	35,200	39,465	35,200	35,200	35,215	35,200	35,200
Cash Brought Forward	**45,189**	43,173	37,944	42,322	42,000	41,663	46,041	45,719	41,132	45,509	45,187	44,850	49,228
Net Receipts/(Payments)	**(2,016)**	(5,229)	4,378	(322)	(337)	4,378	(322)	(4,587)	4,378	(322)	(337)	4,378	(322)
Cash Carried Forward	**43,173**	37,944	42,322	42,000	41,663	46,041	45,719	41,132	45,509	45,187	44,850	49,228	48,906

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Capital Expenditure

- Year to date capital expenditure is £9.0m, with £12.9m left to spend of the Trust's Capital Resource Limit.
- Significant spending is happening in March including bringing forward expenditure on Grove Lane.
- There remains a risk of capital programme (and thus capital resource limit) underspend. The programme is under review to appropriately manage the programme taking one year with another.

Continuity of Service Risk Rating

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

	Financial Metric	2012/13 Full Year Accounts	Current Year to Date	Forecast Outturn
			Actual	Forecast
		£000s	£000s	£000s
Continuity of Service Rating				
Liquidity Ratio (days)	Working Capital Balance	(3,726)	4,922	(6,800)
	Annual Operating Expenses	405,995	377,769	411,240
	Liquidity Ratio Days	(3.3)	4.3	(6.0)
	Liquidity Ratio Metric	**3**	**4**	**3**
Capital Servicing Capacity (times)	Revenue Available for Debt Service	26,928	23,910	26,940
	Annual Debt Service	10,296	9,228	9,843
	Capital Servicing Capacity (times)	**2.6**	**2.6**	**2.7**
	Capital Servicing Capacity metric	**4**	**4**	**4**
Continuity of Services Rating	**Continuity of Services Rating for Trust**	**4**	**4**	**4**

Transformation Programme

- Progress against 2013/14 TSPs is reported separately.
- Continued emphasis is being place on identification of full year TSP for 2014/15. A review of timings of schemes has been undertaken in order to ensure the programme is able to be delivered in full in the year.

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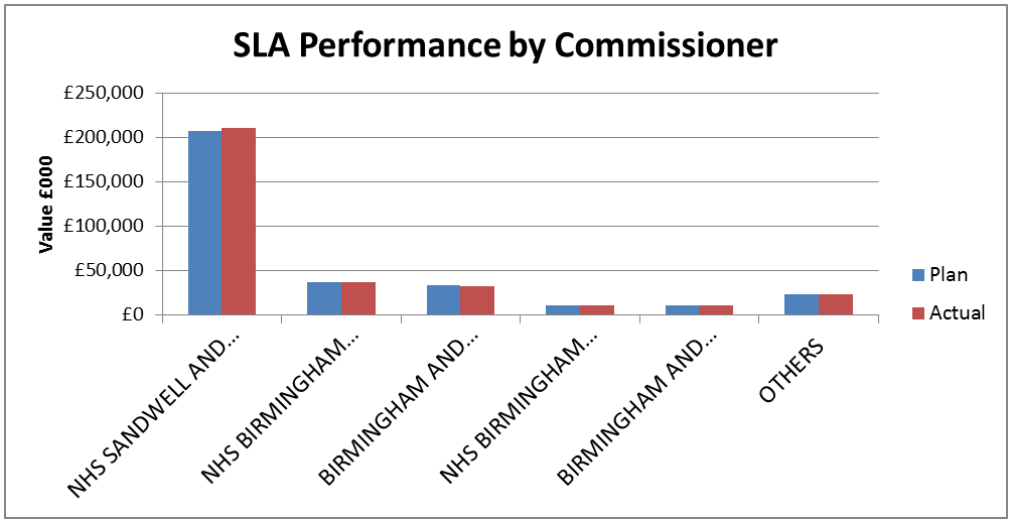
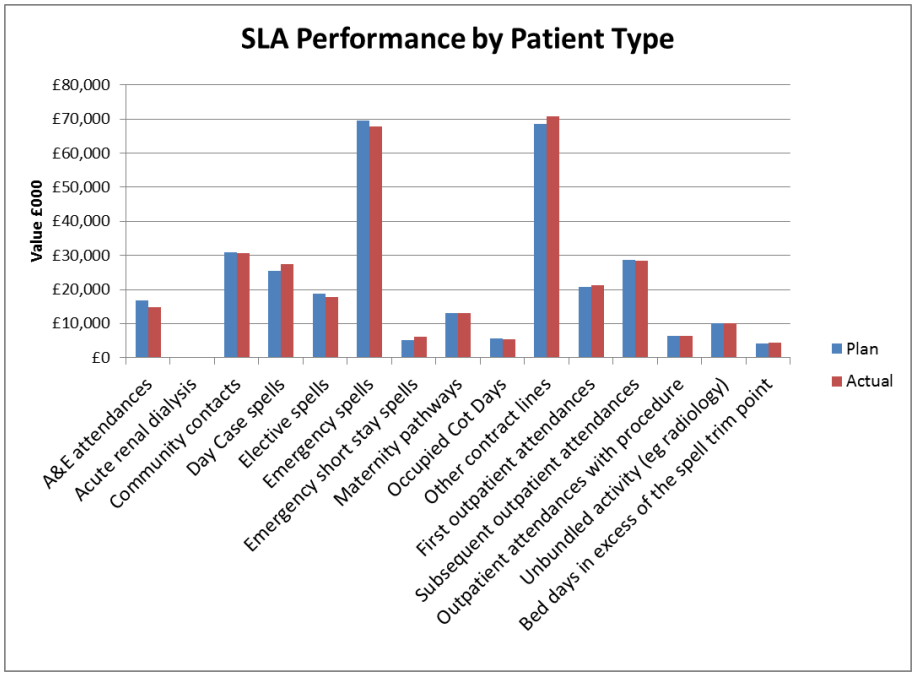
Performance Against Service Level Agreement Target

•Performance for April to January remains ahead of plan overall , including pass through high cost drugs and direct access imaging and pathology work for GPs. A&E activity is below plan as is the number of births.

•Dialogue continues with commissioners with a view to closing down year end positions in a mutually satisfactory way.





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Key risks

•Dialogue with commissioners about the likely year end income position is proceeding with the intention of securing respective financial stability and retention of resources for local services.

•Winter plans are continuing in conjunction with commissioners. Capacity continues to be run at a premium cost within Medicine.

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

•The year end surplus has been revised upwards to £6.7m which reflects the movement in balance sheet items including provisions.

External Focus

•NHS staff due a pay increment in 2014/15 will receive just this increment (typically worth over 3%), while all other staff will get a 1% payment. The plans were announced as part of the government's response to the pay review bodies' recommendations for public sector workers. The 1% increase will be non-consolidated and non-pensionable, meaning the consolidated pay scales remain unchanged. The same approach will apply in 2015/16 with staff not eligible for a pay increment receiving a 2% payment (equivalent to 1% a year). GPs will receive a 1% increase. After business expenses, this represents a 0.28% increase in GP contract payments

•The Employee pension contribution increases will go ahead as planned from 1 April, the government has confirmed. This is the third of three rises planned in the NHS pension scheme before the move to the career average revalued earnings (Care) scheme in 2015/16. In its response to the consultation on the year three proposals, the government said the rationale for the rise still stood and, despite warnings to the contrary, there has only been a small increase in the number of members opting out of the scheme.

•Monitor has amended documents supporting its national tariff publication for 2014/15. It said the changes reflect the latest OPCS codes, which were not available for inclusion in the consultation grouper or the '2014/15 National tariff payment system' published in December. The latest OPCS classifications (version 4.7) are included in the 2014/15 payment grouper, released by the Health and Social Care Information Centre earlier this week.

•The Department of Health has published details of the education and training tariff for 2014/15. 'Education and training tariffs: tariff guidance for 2014/15' sets out payments for non-medical placements and medical undergraduate and postgraduate placements in secondary care. It also covers how tariffs will be implemented and when and how tariffs can be varied.

Recommendations

The Trust Board is asked to:

i. RECEIVE the contents of the report; and

ii. ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

Tony Waite

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Risk Registers
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Mariola Smallman, Head of Risk Management
DATE OF MEETING:	3 April 2014

EXECUTIVE SUMMARY:

The Trust Board received a report earlier this year setting out progress with the risk register refresh, which was initiated partly to revitalise the process and to reflect the new management and committee structure. This report provides a further progress update and presents the current Trust Risk Register for consideration.

REPORT RECOMMENDATION:

Trust Board is asked to:

- **RECEIVE and DISCUSS** the Trust Risk Register;
- **APPROVE** the risk recommendations of individual risk owners;
- **NOTE** the progress made with the risk register refresh.

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

Accept	Approve the recommendation	Discuss
	✓	✓

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

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

Comments:

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

Aligned to BAF, quality and safety agenda and requirement for risk register process as part of external accreditation programmes.

PREVIOUS CONSIDERATION:

Risk Management Committee

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Risk Register Development

1. Introduction

1.1 The Trust Board received a report earlier this year setting out progress with the risk register refresh, which was initiated partly to revitalise the process and to reflect the new management and committee structure. This report provides a further progress update and presents the current Trust Risk Register for consideration.

2. Background

2.1 The Trust Board received a report earlier this year setting out progress with the risk register refresh, which was initiated partly to revitalise the process and to reflect the new management and committee structure. This report provides a further progress update.

2.2 Earlier this year the Risk Team collated all risk registers held at corporate directorate, clinical group, clinical directorate and corporate project levels to identify key improvements required and to transfer them all onto a standardised format. This exercise had identified a variety of risk register formats in use and variable risk register maturity.

2.3 To assist risk register owners a Risk Register Condition Checklist was developed and circulated to Risk Management Committee members; of particular note was that most responses identified the following areas for improvement:

- Integration of registers maintained at higher or lower management levels, where applicable. i.e. a department identifies an amber risk which should be managed locally as well as escalated to the directorate register for review and monitoring.

- Controls (or treatment plans in progress) need to identify interdependencies with other internal and/or external services and appropriate notification / joint working is documented.

2.4 Over the last quarter the Risk Team provided advice and information to assist colleagues with risk register reviews, including one to one meetings with risk leads and the production of a risk register summary (crib sheet at **Appendix B**) which reinforces risk register standardised methodology, responsibilities and escalation/reporting processes.

3. Validation process for risks rated High (Red) at Pre-mitigation Stage

3.1 Locally held risk registers are validated through directorate management / governance structures through to the Risk Management Committee. However there is a need to synchronise the scheduling of reviews/updates for both committees and performance reviews. The timing of the refreshed risk register process also coincided with the

2014/15 annual planning cycle and the Investment Advisory Panel (IAP) bidding process, both of which will inform risk register developments, including the identification of new risks.

3.2 The Risk Management Committee is responsible for overseeing the development of risk registers across the Trust utilising a consistent methodology and standardised format. Review of high (red) risks by RMC provides the initial Trust-wide validation stage ("confirm and challenge") to ensure consistency and identify duplicates, etc.

3.3 This validation stage also identifies which high (red) risks are to be reported to Clinical Leadership Executive as the Trust Risk Register, accepting that all high (red) risks continue to be managed by directorates / groups. Where risks are considered to be high (red) risks but need more information or need to be redefined, they will remain in a virtual holding area until they are re-submitted and reviewed by RMC.

3.4 Clinical Leadership Executive (CLE) will receive a regular Trust Risk Register report to review and consider adequacy of controls, identify interdependencies and inform senior operational decisions and interventions. It should be noted that by virtue of their roles CLE members will already be well aware of their high (red) risks and associated mitigation plans. Similarly CLE members will be informed of cross-cutting risks through various sub-committees and project boards, e.g. Patient Safety, Workforce Assurance, MMH, FT, etc.

3.5 Trust Board receives the Trust Risk Register as a validation process to gain assurances on the adequacy of controls and approve the risk recommendation of individual risk leads. The risk recommendation is based on Trust policy as set out in the table below:

Terminate	Cease doing the activity likely to generate the risk
Treat	Reduce the probability or severity of the risk by putting appropriate controls in place
Tolerate	Accept the risk or tolerate the residual risk once treatments have been applied
Transfer	Redefine the responsibility for managing the risk e.g. by contracting out a particular activity.

4. Trust Risk Register

4.1 Currently the Trust Risk Register compromises high (red) risks that have been through the validation processes at directorate / group and RMC levels. The Trust Risk Register is therefore expected to have additional entries over the coming months as these validation processes take place as well as new risks identified through annual planning and IAP processes.

4.2 The Trust Risk Register is attached at **Appendix A** with lead Director updates and risk treatment recommendations as follows:

Risk Title	Update
Midland Metropolitan Hospital Executive Lead: Director of Estates and New Hospital Project Risk Owner: As above	The MMH project is currently going through the DH and Treasury approval process and is expected to be approved by 24 April 2014. The Trust has responded to all questions raised by DH. The MMH Project Team ensures robust control across all work streams associated with the project and report through both the MMH and Reconfiguration Committee and Trust Configuration Committee. **Risk Recommendation: Tolerate**
Trust workforce reduction of 1300 WTEs Executive Lead: Chief Executive Risk Owner: Pending appointment of Director of Organisational Development	Proposal submitted to Workforce Delivery Committee. Scrutiny will be through the Workforce and OD Assurance Committee. **Risk Recommendation: Treat**
Potential loss of the Hyper Acute Stroke Unit Executive Lead: Chief Operating Officer Risk Owner: Group Director of Medicine and Emergency Care	The Commissioner led Stroke Services Review is ongoing; SWBH Stroke leads are engaged. The outcome is awaited. **Risk Recommendation: Tolerate**
Unpredicted downtime of laboratory sample archiver due to equipment failure Executive Lead: Chief Operating Officer Risk Owner: Group Director of Pathology	The Pathology Service is currently managing this risk when it arises through a practical workaround contingency that requires additional staff and ceasing add-on tests. A robust contingency is being sought from the archiver supplier. **Risk Recommendation: Treat**
Lack of assurance of standard process and data quality approach to 18 weeks Executive Lead: Chief Operating Officer Risk Owner: Chief Operating Officer	An 18 week performance and data quality scorecard is in place and reviewed weekly. A task and finish group is overseeing implementation of revised real time data management and quality processes in Q1. This will include centralisation of some administration functions across the organisation with regard to elective access. Electronic solutions to be delivered through the HIS delivery plan include electronic referral management and electronic outcome recording, which will enable better real time management of the system with less reliance on paper and the

Risk Title	Update
	associated risks of a paper dependant system. The Trust is also working with the DH Elective Access Intensive Support Team. **Risk Recommendation: Treat**
Sustained high Delayed Transfers of Care (DTOC) patients remaining in acute bed capacity Executive Lead: Chief Operating Officer Risk Owner: Chief Operating Officer	Joint working with partner organisations in place with weekly governance meeting with Chief Officers from LAT, CCG, Social Services and NTDA. The creation of an operational hub for health and social care community beds is in train for delivery in Q1. This will give benefit of a real time view of patient flow and pathways in all community beds. A fining regime has been put in place via contracts for 2014/15 as penalty for high levels of DTOC. **Risk Recommendation: Treat**

5. Conclusion

5.1 The risk register refresh is progressing well and there are some assurances that improvements are being made in areas where risk registers were not fully embedded and being actively managed through management and governance structures. This approach is strengthening synergies with the Board Assurance Framework which is also being progressed.

5.2 Further progress will necessitate the continued commitment of directorates / groups as well as the support of the Risk Team.

5.3 The approach has been shared with Internal Audit, who will incorporate the adequacy of high (red) risk controls into the 2014/15 Audit Programme.

6. Recommendations

Trust Board is asked to:

- **RECEIVE and DISCUSS** the Trust Risk Register;
- **APPROVE** the risk recommendations of individual risk owners;
- **NOTE** the progress made with the risk register refresh.

Mariola Smallman
Head of Risk Management

26 March 2014

Appendix A: Trust Risk Register (version as at 21 March 2014)

Source of Risk	Corporate Directorate	Clinical Group	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
Project Risk Assessment	MMH Project Board			Organisational (Strategic)	Increase in cost of Midland Metropolitan Hospital if approval delayed, then restarts approval cycle.	4	5	20	Involvement of Chair and Chief Executive with Department of Health and HM Treasury officials.	Director of Estates and New Hospital Project	Jun-18	Feb-14	Quarterly	3	5	15
	Chief Exec, Strategy, Governance and Comms		Workforce Strategy	Organisational (Strategic)	Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment reduction of 1300 WTE's, leading to excess pay costs.	4	5	20	Review of existing policy levers to ensure options are maximised and are executed sufficiently early. Strong governance oversight by the Trust Board.	Chief Executive pending appointment of Director of OD.	Mar-18	Mar-14	bi-monthly	3	5	15

CCG		Medicine	Stroke/Admitted Care	Operational/Business	The commissioner led strategic review of Stroke Services may result in the loss of the Hyper Acute Stroke Unit. Impacts: clinical services including geriatric, general medical, neurology, emergency department and imaging; difficulty in recruitment and retention of specialised staff (potential for lack of development and / or deskilling); may prompt the Deanery to downgrade the training experience offer for junior doctors. National figures show varying times for these patients to self-present, with SWBH patients presenting later than average for a variety of reasons. Approx. 20% of patients currently accessing HASU services at SWBH self-present through A & E and are therefore at a higher risk of delays to treatment. Maintaining the 7 day High Risk TIA and ASU model of care will be adversely affected without the HASU service which is also linked to the risk of losing specialised consultants. There is a net financial impact if the HASU service ceases.	4	4	16	Trust representatives on Strategic Review sub groups • SWBH Stroke Action Team continues to monitor stroke activity and performance on a monthly basis and to develop actions plans for service improvement. Timely submission of info and data returns relating to the Review. • • As part of SWBH stroke reconfiguration the evaluation of service options indicated that reconfiguring stroke services to the Sandwell site would offer the best opportunity to retain HASU status in a strategic review • Current specification for the reconfigured stroke service and for future stroke services & HASU are based closely on the London Model of care for stroke and RCP guidelines which SWBH reconfigured services were also modelled on (e.g. staffing ratios) • SWBH stroke reconfiguration was approved by PCT/CCG with support from SHA in the context of the Strategic Review • WMAS involved in planning travel times for SWBH stroke reconfiguration and similar WMAS travel times will be used in the Strategic Review • Implement action plans to improve data capture and accuracy • SWBH is in top 29 of UK Trusts for SSNAP performance	Clinical Group Director Medicine	Aug 14 - Commissioner led review	Mar 14	Monthly	4	3	12

14-01-PATH-36	Incidents	Corporate Operations	Pathology	Pathology/Microbiology/Clinical Biochemistry	Operational/Business	Unpredicted downtime on archival/retrieval unit. Sample discarded before requests are completed for reasons listed below. Any stored samples are inaccessible for any outstanding or add on tests. Patient management could be compromised/delayed due to a repeat sample being required.	4	4	16	Engineer response is 'next working day'. In reality issues are not often resolved in one visit. If parts are required, often from abroad, resolution can take a significant number of days. Continue with the current approach with a robust contingency plan involving manual archiving. Work with supplier to have better approaches to the clinical risk when the equipment fails, and a more robust response to equipment downtime. Review use of unit (store only for 1-2 days), discard flox and urine samples immediately on completion. Real time samples are still most at risk in the archiver. Remove archiver and adopt a standalone system of sample archiving from a third party supplier. Not in our control, due to contract in place.	Clinical Group Director Pathology		Mar-14	Monthly	3	3	9
1401COO01	Management review	Corporate Operations			Operational	Lack of assurance of standard process and data quality approach to 18 weeks.	4	4	16	Task and Finish Group established to oversee rapid improvement programme. Work programme includes: 1. SOP to be agreed and implemented in March for new processes. 2. Elective access team structure to be reviewed. 3. Central booking process to be strengthened to ensure real time data quality management. 4. IST visit will inform work programme content.	Chief Operating Officer	Jul-14	Jan-14	Jul-14	2	4	8
TRR1401COO02	Management review	Corporate Operations			Operational	Sustained high Delayed Transfers of Care (DTOC) patients remaining in acute bed capacity due to lack of nursing and residential care placements and social services capacity to provide timely support at home. The decrease in acute available bed capacity is a risk potentially to patients' outcomes due to the unnecessary lengthened stay in an acute hospital environment and the Emergency Care Target.	4	4	16	Joint working through joint discharge teams on both acute sites established. 7 day working pilot over winter in place. Weekly urgent care call with Chief Executives and Chief accountable officers from LAT, CCG, NTDA, acute Trust and social services includes weekly DTOC review and strategic and operational work . Commissioning plans for 7 day working in 2014 in train.	Chief Operating Officer	Jun-14	Jan-14	Jul-14	2	4	8

Appendix B: Risk Register Summary

1. Introduction

The following information summarises Trust Risk Management Policy for Risk Registers. Risk Registers should be maintained at each level of the organisation, utilising the standard Corporate Template in MS excel format, which is available from the Risk team on x 5712 or email Swb-tr.riskmanagement@nhs.net

2. Risk Register Responsibilities

Table 1

Risk Register's (RR) maintained at each mgmt level	Type of risks on each Risk Register (RR) level	Responsibilities
Ward / Department	• Low (Green) • Moderate (Yellow) • Medium (Amber) • High (Red)	• Review and revise risk assessments regularly • Maintain summary of risk assessments on Risk Register and review/update regularly • Manage risks locally • Moderate and above risks are copied onto Directorate RR, but local ownership and actions / mitigation measures continue
Directorate Governance Group / Directorate Management Team	• Moderate (Yellow) • Medium (Amber) • High (Red)	• Maintain and monitor Directorate RR (yellow, amber and reds) through regular review • Approve / initiate actions / mitigation measures • Add any new risks with associated risk assessments • Carry out directorate confirm and challenge • Ensure Directorate RR includes risks from all service areas
Clinical Group / Corporate Directorate / Corporate Project	• Medium (Amber) • High (Red)	• Maintain and monitor Clinical Group / Directorate / Corporate Project RR • Initiate actions / mitigation measures • Add any new risks with associated risk assessments • Carry out Clinical Group / Corporate Directorate / Corporate Project - confirm and challenge. • Identify and agree significant operational interventions • Upload RR by third Friday of each month onto **s:\Risk Registers** in the relevant folder in standard spreadsheet format as: **YYMM_*<add Clinical Group name here>* Risk Register.xls**

3. Trust-wide risk register review and oversight processes

Table 2

Trust-wide committee	Type of risks reviewed	Responsibilities
Risk Management Committee (RMC)	All High (Red) pre mitigation risks from clinical groups / corporate directorates	• Review all risks rated High (Red) at pre-mitigation stage, collated and presented as the Interim Trust Risk Register. • Carry out confirm and challenge of risk ratings and controls / mitigation measures. • Agree which of the High (Red) risks, that continue to be managed locally by Clinical Groups / Corporate Directorates, will be forwarded to Clinical Leadership Executive for review.
Clinical Leadership Executive	High (Red) pre mitigation risks reviewed / agreed by RMC	• Reviews High (Red) risks and receives assurance that operational and strategic interventions are either adequately managing the risks or is informed of new risks that may be unmitigated. • Confirms which risks will be reported to Trust Board.
Trust Board	High (Red) pre mitigation risks reviewed / agreed by RMC	• Receives Trust Risk Register report to ensure the Board is aware of and has an oversight of the Trust's high risks. • Reviews and agrees: o Which risks require further mitigation measures. o Which risks will be accepted or tolerated by the Trust Board, including the frequency of their review.

4. Assurance

Risk registers are reviewed locally and corporately as part of management and audit processes, e.g., internal governance processes such as Performance Reviews, external inspections, audits and accreditation programmes, etc. It is understood that the forthcoming Internal Audit review programme will include risk register controls and action plan reviews to ascertain adequacy of controls.

5. Risk Register Checklist

Identification of risks will be from various sources. The following are examples of information sources from which risks can be identified:

- Annual Plan
- Corporate Review and Performance Dashboards
- Legislation / Regulation / Accreditation schemes / Inspections / Audits
- Trust Strategic Objectives
- Incidents / Complaints / Claims / H&S Risk Assessments
- Review of Business Continuity Plans / Disaster Recovery Plans for critical functions

6. Risk Register "sense check":

1. Does the risk register include all service areas and cover all types of risks – clinical, financial, operational, organisational and environmental?
2. Are there associated risk assessments for each risk register entry? The Risk Assessment Template can be found in the Trust Risk Management Policy, published on Connect or from Swb-tr.riskmanagement@nhs.net.
3. The risk register should be a summary of more detailed information maintained on the associated risk assessment. (The risk register does not need to show the review/amendment audit trail in detail – this needs to be maintained locally perhaps in the "Notes" column as well as updating the associated risk assessment).
4. Does the risk scoring adhere to the Trust Risk Assessment Matrix for both existing (pre-mitigation) and residual risk scores? This is available from Swb-tr.riskmanagement@nhs.net and within the Trust Risk Management Policy, published on Connect.
5. Ensure the risk register does not detail every function in the Service that could otherwise be viewed as operational day to day business activities? i.e., is the RR a list of issues rather than risks?
6. Is the risk clearly defined - what is the risk and impact? The risk register should state how the risk is currently being managed. (**N.B. risk registers must be in plain English as they will be published on the Trust's website as well as on Connect.)**
7. Are all risks still in date or can some be archived?
8. The review frequency should state weekly/monthly/quarterly, etc., not "ongoing".
9. Risk Register entries should have the standard Trust risk register reference (i.e., YYMMLLLNN(LLL = department / cost code, NN = individual number allocated to each risk)
10. Risk registers must not include patient or staff initials other than in the "*Who is responsible for implementing plan*?" column.

More information

If you have any queries about the development of your risk register contact the Risk Team on x5712 or email Swb-tr.riskmanagement@nhs.net

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 28 February 2014; 1030h – 1230h

Present

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

In Attendance

Ms A Binns
Mr M Harding
Mrs D Talbot
Dr H Grindulis [Item 6 only]
Ms S Manu [Item 6 only]

Secretariat

Mr S Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies for absence were received from Miss Barlow and Mr Waite.	
2 Minutes of the previous meeting	**SWBQS (12/13) 014**
The minutes of the Quality and Safety Committee meeting held on 31 January 2014 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBQS (12/13) 014 (a)**
The updated actions list was received and noted by the Committee.	
MATTERS FOR DISCUSSION/DEBATE	
4 Proposed future quality priorities and CQUIN targets	**SWBQS (2/14) 016** **SWBQS (2/14) 016 (a)**
Mr Ovington asked the Committee to note the presentation that had been previously delivered to the Trust's members around quality and safety. The Committee was asked to note the performance against the quality improvements identified in the Trust's annual plan. It was noted that the position had improved against emergency readmission rates, complaints per 1000 episodes	

and VTE assessment rate, however performance against the target to see patients within 4 hours of arrival at the Trust's Emergency Departments and the sickness absence rates was poorer than desired. Sickness absence performance was noted to be integral to the success against TDA accountability framework. The Committee was asked to note the ten targets that would form the overall approach to preventing harm. Miss Dhami highlighted that the members were supportive of the targets. Mr Ovington advised that although the list of standards would apply primarily to inpatients, it would also be amended for patients being seen through other routes. Ms Binns suggested that in terms of communications, it should be reinforced that the standards were not solely nursing-related. It was reported that the standards would be published in key departments. Mr Ovington presented the proposed CQUIN targets for 2014/15, the discussion of which was reported to have been held with commissioners. In terms of the speed of sending letters to GPs after an outpatient appointment it was suggested that it would be of interest to see performance by speciality. Mrs Hunjan noted that some of the services took an overly long time to issue responses and asked if the performance would be monitored at the Committee. She was advised that this was the case through the consideration of the integrated finance, quality and performance dashboard. Mrs Hunjan asked whether a standard letter would be prepared, however she was advised that the letters needed to take account speciality-specific content. The Committee was reminded that the patient experience strategy had been approved in draft by the Board at the February meeting and work would be undertaken to embed the promises within this over the coming year. Mr Samuda suggested that Healthwatch would assist with disseminating messages and information through membership and to the wider public.	
5 Internal Audit report – Data Quality of Friends and Family Test	**SWBQS (2/14) 017** **SWBQS (2/14) 017 (a)**
Mr Ovington presented the Internal Audit report Data Quality of Friends and Family Test. It was highlighted that multiple methods were used to canvas views, including the use of tally boxes and the possibility of these being subject to misuse. It was reported that a standard operating procedure would be developed to introduce controls where possible. Ms Dutton asked whether the take up of this facility was pleasing. She was advised that this was variable and therefore consideration as to the continuance of this facility was needed.	
6 Child Protection update	**SWBQS (2/14) 018** **SWBQS (2/14) 018 (a)** **SWBQS (2/14) 018 (b)**
Ms Sindy Manu presented an overview of the Trust's position in terms of Child Protection and in particular compliance against Section 11 of the Children's Act 2004. It was noted that 1500 children in Birmingham were flagged as having a Child Protection Plan which were registered with the Trust. Other key areas for action were reported to include: developing patient information, refreshing the	

Safeguarding strategy, preparing an annual report for 13/14, delivering the audit programme response and the development of a risk register. It was highlighted that the referral mechanism for child protection cases to the local authority had changed to be more multidisciplinary in future. A Multi Agency Screening Hub (MASH) was reported to have been set up in November which also considered domestic abuse matters. A number of actions in readiness for the planned CQC visit were reported to have been delivered, including mock inspections, the development of a Level 1 leaflet, policy refresh & development. As part of the mock inspections all areas were reported to have been asked a standard set of questions and the responses were noted to be variable between areas. Ms Dutton asked whether the Child Protection framework incorporated School Nurses and was advised that this was the case until end March 2014. Dr Sahota asked whether all staff working with children had undergone Vetting & Barring Checks. It was agreed that an update should be presented at the next meeting. Dr Grindulis presented an overview of the safeguarding incidents, the majority of which were classified as yellow incidents. It was reported that as of 24 February, there were 31 inpatients who were associated with safeguarding concerns. The Committee was appraised of the detail of some of these individuals. The action plan for the forthcoming year was discussed. Dr Grindulis highlighted the risk of the school nursing contract move from the perspective of the information sharing requirements. It was reported that the Chief Executive was working to discuss and resolve this issue.	
ACTION: **Mrs Barnett to present an update on the position concerning DBS/CRB checks for staff working with children**	
7 Theatre safety report	**Verbal**
Dr Stedman reported that a draft report had been received following the theatre safety visit recently. He outlined the key highlights from the report which were largely positive. It was noted however, that the atmosphere in theatres was somewhat informal however which had the potential to compromise the rigour of the processes. 'Lock down' of theatre lists 24 hours before start and the quality of service provided by the externally contracted sterilisation provider were reported to be further concerns. Dr Sahota asked whether any concerns by junior staff were being taken into account. Dr Stedman highlighted that this was evident as part of the last Never Event in Ophthalmology. He added that the Team Brief prior to the theatre list starting would also assist. Miss Dhami reported that the confidence to speak up	

had been found to be good as part of the review. Ms Binns asked what reasons lay behind the continuing occurrence of Never Events and was advised that this could be associated with the poorer than desired score on team working. It was agreed that full report would be presented to the Committee in due course.	
8 Corporate quality and performance dashboard	**SWBQS (2/14) 019** **SWBQS (2/14) 019 (a)**
Mr Harding advised that performance against the 62 day cancer target had not been met for December, however the position for the quarter and year to date remained acceptable. It was reported that work was underway to improve the performance against the cancelled operations target. The performance against the Emergency Care target was reported to have deteriorated during February and was less than 95% for the quarter to date. It was reported that attendances into Emergency Department had been very high recently. Compliance with the WHO checklist completion was reported to have deteriorated and areas contributing to this position were investigating the reasons behind this. Dr Stedman advised that use of the checklist was embedded, however documentation completion was not good and therefore evidence that the checklist had been used was unavailable on occasions. A number of mixed sex accommodation breaches were reported. The CQUIN target for dementia was reported to have been met. A fall back against the pain care target was reported, although there was an expectation that the position would improve. Mr Ovington reported that he would investigate whether IV paracetamol was available widely. It was highlighted that an ongoing audit of medicines management and security of medicines was underway. Mr Ovington advised that he was taking a personal interest in ensuring this position was improved. Performance against the VTE assessment target was reported to be pleasing, whereas deterioration in the performance against the fractured neck of femur target had been seen. The number of operations cancelled on the day of surgery was reported to be disappointing. In terms of the integrated quality, finance and integrated report, it was highlighted that this would be discussed with the Non Executives and Executive Directors during March. Dr Sahota suggested that the report needed to include indicators such as theatre utilisation and late starts/early finishes in theatre.	
9 MRSA bacteraemia update	**SWBQS (2/14) 020**
Mr Ovington provided an overview to the background behind the recent MRSA bacteraemia case. It was noted that although the case was preventable, it did occur at the fault of the hospital.	

10 2014/15 TSP – Quality Impact Assessment update	**Verbal**
It was reported that there had been no more QIA work undertaken since the last meeting.	
11 Serious Incident report	**SWBQS (2/14) 021** **SWBQS (2/14) 021 (a)**
The Committee was asked to receive and note the serious incident report. It was noted that there had been a peak in reporting in July and October, although the reasons for this were noted to be unclear.	
13 Clinical audit forward plan: monitoring report	**SWBQS (2/14) 022** **SWBQS (2/14) 022 (a)**
The Committee received and accepted the report.	
OTHER MATTERS	
13 Matters of topical or national media interest	**Verbal**
It was noted that there had been recent publicity around mortality rates led by Professor Black. Dr Stedman advised that the implications of this would be shared at the next meeting. Dr Sahota asked what effect the training plans developed by the deanery would have on the Trust. Dr Stedman advised that a number of trainees would be lost from the Trust's complement and therefore one of the options to address this would require non-training grade staff would need to fill these posts at a financial cost to the organisation.	
14 Matters to raise to the Board	**Verbal**
It was noted that there were several matters to raise to the Board.	
15 Any other business	**Verbal**
There was none.	
16 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 28 March 2013 at 1030h in the D29 (Corporate Suite) Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance & Investment Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 31 January 2014; 0800 – 1000h

Present	**In attendance**	**Secretariat**
Ms Clare Robinson	Mr Chris Archer	Mr Simon Grainger-Payne
Mr Richard Samuda	Mr Tony Wharram	
Mr Harjinder Kang		
Mr Tony Waite		
Ms Rachel Barlow		
Mr Mike Sharon		

Minutes	**Paper Reference**
1 Apologies for Absence	**Verbal**
There were no apologies tendered.	
2 Minutes from the previous meeting	**SWBFI (11/13) 102**
The minutes of the meeting held on 22 November 2013 were accepted as a true and accurate record of discussions held. It was highlighted that the Board Assurance Framework would be developed such that it lent itself to the robust monitoring of risks relevant to the remit of the various Board Committees. Mr Waite highlighted that the current Service Line Reporting plans would be discussed by the Executive Group before any further updates to the Committee. It was noted that there was a clear link to the development of the future Transformation Savings Plan. It was agreed that a discussion of the Transformation Plan should be scheduled for the future.	
AGREEMENT: The minutes of the previous meeting were accepted as a true and accurate reflection of the discussions held	
3 Matters arising from previous meeting	**SWBFI (11/13) 102 (a)**

The Committee was asked to receive and note the action tracker.	
3.1 Monitoring of Social Services performance	**Verbal**
Miss Barlow reported that good progress was being made in terms of joint working with Social Services. It was reported that an operation hub was being established for joint working with the Local Area Team, CCGs and community which was being hosted by the Trust. Discharge goals each day and delays in the pathways were reported to be being given due focus through this way of working. It was noted that Winter monies from the CCG would be used to support the IT element of the work. Ms Robinson asked what impact the work would have on the Trust's performance and cost base. Miss Barlow advised that the delayed transfers of care would be expected to reduce significantly as a result of the seven day working. Mr Sharon agreed that there were good benefits from this joint working and that the impact could be monitored through the delayed transfers of care position and the way in which the seven day working was working.	
3.2 Progress with updating the contracts database	**SWBFI (1/14) 002** **SWBFI (1/14) 002 (a)**
Mr Waite asked the Committee to note the update. He advised that the database had been well populated. As a next step, the Committee was advised that the influence of the Procurement team on the Trust would be reviewed with a view to providing a commercial perspective. It was noted that there might be a further set of contracts that needed to be added, although a number of these may not be of a level of significant materiality. Ms Robinson suggested that these should be risk assessed to determine which should be given attention. In terms of the plans for procurement development, the operational focus and value for money aspect would feed into the transformation plan. It was agreed that the control and governance arrangements should be reported back to the Committee in six months' time and that in the meantime a baseline should be established and best practice from elsewhere should be determined.	
ACTION: Mr Waite to present the procurement strategy as part of the Transformation Plan at a future meeting of the Finance & Investment Committee	
3.3 Outcome of the review of the Pathology contracts	**Verbal**
It was agreed that the lessons learned from the review of Pathology contracts would be encompassed as part of the wider Procurement review.	
3.4 Effectiveness of the revised bed model	**Verbal**
Miss Barlow highlighted that the revised bed model had contributed to an improved performance against the Emergency Care target. It was reported that work was planned to review all community beds for the next year, including the	

use of Medically Fit for Discharge beds as part of this. Miss Barlow advised that the costs of the individual wards could be determined. Mr Archer reported that staffing the wards remained problematic due to the acuity of patients on these wards and the inability to recruit staff substantively which lead to the budgets for the wards showing an overspend to address this through temporary staffing. Ms Robinson suggested that a view should be taken as to whether the Winter funding had covered the provision of the additional capacity in this respect. It was agreed that this should be presented at the next meeting, based on the budgets for the wards being designated for winter pressures, including the influences on 2014/15. Mr Waite advised that a wider review of the influence of the Trust's finances on the operational running of the Trust was being undertaken. He added that the effectiveness of the bed model could also be evidenced by a view of the quality of care being delivered and performance against key indicators.	
ACTION: **Mr Waite to present an update at the next meeting to demonstrate whether the Winter funding had sufficiently covered the capacity that had been open during the period**	
3.5 Use of bank medical staff	**SWBFI (1/14) 009** **SWBFI (1/14) 009 (a)**
The Committee received and noted the update. It was highlighted that there were a number of measures being taken to reduce the reliance on medical bank staff. Mr Kang asked whether there were any training needs that had been identified which might prevent the need to employ medical bank staff. Mr Sharon advised that agencies supplied medical staff and that in the short term it was not likely that the responsibilities of these temporary staff could be undertaken by other staff in post, such as nurse consultants. It was reported that a medical staff bank would be established by the end of 2014/15 Quarter 2. Mr Kang asked how locum fees would be reduced. He was advised that this needed to be considered at a speciality level and debates were being held with the Clinical Directors. Mr Waite advised that there might be some scope for prior fee arrangements with key suppliers which would handle this requirement to some degree. Mr Kang suggested that there may be a need to engage some medical staff on a longer term basis. Ms Robinson suggested that there might be a need to establish opportunities for collaboration with other Trusts in the region. Miss Barlow advised that it was the intention to develop some strategic partnerships around Interventional Radiology and Plastic surgery. It was agreed that the delivery of financial impact of the work programme should be presented at a future meeting. Mr Waite advised that this could be covered within the future Transformation Plan as part of the development of a sustainable and effective workforce.	

3.6 Cost of turnover	**SWBFI (1/14) 010**
Miss Barlow presented an overview of the fixed costs associated with turnover of staff, in addition to an element of expenditure related to backfilling positions. It was noted that the cost to the organisation for 2012/13 was £620,828. Ms Robinson suggested that a view of recruitment times and processes in other organisations, including private sector, should be reviewed to determine whether there was any good practice that could be applied. It was agreed that there was a need to review recruitment processes as a matter of priority, including the use of internal audit where needed. It was agreed that the matter needed to be considered as part of the remit of the Workforce & OD Committee.	
4 Transformation Plan	
4.1 Progress update 2013/14 and plans for 2014/15	**Verbal**
Mr Waite presented an overview of the key messages concerning the 2014/15 TSPs. It was highlighted that the savings proposals needed to be built into the operating plan for 2014/15 to the Trust Development Authority. It was reported that 91% of directorate savings proposals had been identified, with a further 12% central savings proposals being added, which reflected additional potential opportunities that could be invoked. It was noted that some of the schemes would not take effect from 1 April and therefore the risks associated with this needed to be assessed. Ms Robinson noted that there was little means of identifying income generation schemes. Mr Waite advised that there was a reliance on SLR improvement to generate an improvement in income. He offered to circulate the breakdown of schemes by theme to provide this overview. It was highlighted that there remained a c. £2m gap of schemes from directorates to reach the planned £20.6m target savings. Ms Robinson suggested that consideration should be given to the means by which the savings should progress while service and clinical developments were undertaken conjointly. It was noted that this was the essence of the planned change programme that would be developed by March 2014. Mr Waite offered to present an overview of the impact of the schemes at the next meeting, together with the arrangements that were put into place to ensure that the programme was delivered efficiently and effectively.	
ACTION: Mr Waite to present an overview of the TSP for 2014/15 including the measures being put into place to ensure robust delivery	
4.2 TSP delivery report 2013/14	**SWBFI (1/14) 003** **SWBFI (1/14) 003 (a)** **SWBFI (1/14) 003 (b)**
It was reported that overall the delivery of the 2013/14 TSP was as expected at present.	

5 Procurement	
5.1 Procurement dashboard	**SWBFI (1/14) 005** **SWBFI (1/14) 005 (a)**
The Committee was asked to receive and note the report. Ms Robinson commented that the report was a useful summary.	
5.2 Outline of contract pricing using catalogue management approach	**Verbal**
The Committee was asked to receive and note the report.	
5.3 Measures in place to ensure benefits of purchasing in volume are harnessed	**Verbal**
The Committee was asked to receive and note the report.	
6 Trust financial management	
6.1 2013/14 Month 9 financial position, including year-end forecast	**Hard copy**
Mr Waite reported that the forecast outturn headline surplus had been amended upwards, which was principally driven by the release of reserves and a view of forecast income. It was reported that there was a likelihood that the Capital Resource Limit may be undershot for 2013/14, although the risks associated with this for future years were reported to be low. Mr Archer added that the underlying forecast position reflected a reduction in emergency activity and an increase in planned activity which could inform the next year plan. Ms Robinson noted that the adjustment to the outturn position had been reported to the Trust Development Authority (TDA) previously and asked whether this was a further adjustment. It was highlighted that the TDA would welcome the planned improved surplus forecast. Mr Waite noted that the communication of the revised forecast needed to be considered carefully in terms of external views and staff perception in the light of the Transformation Plan. It was highlighted that the forecast position had been made clear to the CCG despite the revised end year position for 2013/14. The details of the contract negotiations were discussed. It was agreed that the timing of the presentation of the contract and financial plan needed to be considered by Mr Waite.	
6.2 Financial risks to the organisation	**Verbal**
Ms Robinson underlined the reliance on the Trust Risk Register and Board Assurance Framework to drive the discussion on the financially-based risks.	
7 Matters for information	
7.1 Integrated quality, finance and performance monitoring report	**SWBFI (1/14) 008**

	SWBFI (1/14) 008 (a)
The Committee received and noted the report. All were asked to comment on the draft report. Mr Samuda suggested that heavy NED input to the development of the dashboard was required.	
8 Matters to highlight to the Board	**Verbal**
It was agreed that the revised forecast and realignment of the Transformation plan and the arrangements needed to deliver an effective plan needed to be raised with the Board at the next meeting.	
9 Meeting effectiveness feedback	**Verbal**
It was noted that the meeting had overrun and that there needed to be a focus on some of the key aspects in the finance report. Mr Waite noted that consideration needed to be given to how to change the presentation of material to show the consequences and interpretation rather than focussing on clarification. Mr Samuda suggested that a clear cycle of business needed to provide a forward view of discussions and focus and direct focus on matters that would provide due assurance for the Board.	
10 Any Other Business	**Verbal**
There was none.	
11 Details of the next meeting	
The next meeting of the Finance and Investment Committee was noted to be scheduled for 28 March 2014 at 0800h in the D29 (Corporate Suite) meeting room at City Hospital.	

Signed: …….

Name: …….

Date: ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Workforce & Organisational Development Committee – Version 0.1

Venue D29 (Corporate Suite) Meeting Room, Sandwell Hospital **Date** 16 December 2013 at 1400h

Members Present		**In attendance**
Mr H Kang	[Chair]	Mrs L Barnett
Mr R Samuda		Mrs G Deakin
Mr M Sharon		Mr J Pollitt
Mr C Ovington		
Miss R Barlow		**Secretariat**
		Mr S Grainger-Payne

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Mr Lewis and Mr Ovington.	
2 Minutes of the previous meetings	**SWBWO (9/13) 030**
The minutes of the meeting held on 30 September 2013 were approved.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meeting	**SWBWO (9/13) 030 (a)**
The Committee received and noted the updated actions log. Mr Sharon reported that an updated workforce strategy was currently under development and that the assurance process would continue. In terms of the revised HR dashboard, Mrs Barnett advised that further comments had been received on the proposed revisions. It was highlighted that agreement needed to be reached as to what indicators would be included in the integrated performance and quality dashboard. Mr Sharon underlined the need for the focus of the Committee to be directed to the long term workforce view, however the operational performance data would be provided as supplementary information through a regular exception report. Until the integrated dashboard was refined	

however, it was agreed that the existing HR dashboard be continue to be considered. Mr Pollitt advised that the Trust's induction programme had been reviewed and a system known as Quizdom, would be implemented to create a more interactive delivery and automated register. Mr Kang asked what measures were undertaken should a session be rated poorly. Mr Pollitt advised that the system was not sophisticated enough to be able to rate performance at present, however the new model would allow greater granularity on performance. Mr Samuda highlighted that the consideration of induction needed to be extended to the process for junior doctors. Mr Pollitt advised that at present local induction for junior doctors was effective, with the feedback being directed to the Deanery and assessed by the NHS Litigation Authority. It was reported that a meeting was held routinely with the Deanery to discuss junior doctor induction. Mrs Barnett highlighted that the induction was greatly improved on that in place during previous years. Mr Sharon reported that a list of trusts' HSMR rates had been collated and that the Trust's current rate was favourable, especially in the light of consultant to bed ratios. Mrs Deakin advised that in terms of workforce optimisers, there remained a risk that there was double counting.	
4 Workforce Change Programme	**SWBWO (12/13) 034** **SWBWO (12/13) 034 (a)**
Mr Sharon reported that the long term workforce model had been developed in line with the Long Term Financial Model. He added that an outline scope for each of the project areas was being developed, with the oversight and detail of these being considered by the Workforce Delivery (Executive) Committee. Mrs Deakin advised that charters had been developed for the enabling workstreams to describe their set up for discussion and debate in readiness for final project plans. It was reported that the MMH project methodology would be adopted, including the creation of an overarching project plan. It was reported that a meeting of the Workforce Delivery Committee was planned for 19 December. It was noted that there was likely to be a different executive lead for each workstream, although these were still to be decided. Mr Kang asked whether there had been external review of the plans. Mr Sharon advised that there had been external scrutiny of the opportunities for workforce change, but not of the model created *per se*. Mr Sharon advised that discussions had been held with the Executive Group on the totality of change required and the resources needed to deliver this. Mr Kang suggested that the Committee should consider itself with three primary aspects of the workforce plan: the timescale for the plan; an overview of the plan itself; and the outcome of any validation work and external scrutiny. Mrs Deakin advised that the project governance was anticipated to be in place by the time that the Committee next met.	

The Chairman asked whether there might be any matters of such significance that they would need to be raised to the Board. Mrs Deakin advised that this was likely to be the case.	
5 24/7 working – current situation and future intentions	**SWBWO (12/13) 036** **SWBWO (12/13) 036 (a)**
Mr Sharon advised that resources were being identified to gather together a view of the Trust's approach to 24 hour/7 day working. He advised that a baseline assessment would be developed shortly and the plans needed to address the requirement in the context of the MMH would be considered. Mrs Deakin advised that the information presented to the Committee set out the worst case scenario, however a more granular view would be developed shortly. Mr Samuda asked whether the Trust was accessing any national working groups on this matter. He was advised that there were no specific national working groups, although it was possible that this would be created through the LETBs and LETCs on a regional basis in due course. Mr Kang noted that some work had been undertaken to determine the financial impact of the plans nationally, which was based on the recent HFMA work. Mr Sharon highlighted that it was possible that additional funding to the value of c. £4m might be needed to support the plans. He added that should minimum national standards be set then there was a requirement to understand the gap that needed to be addressed. It was agreed that an understanding of the likely position by 2015/16 and the impact of the MMH plans on the requirements was needed. Mr Sharon advised that the matter would be discussed by the Executive Group. Mrs Deakin advised that a clear plan would be developed in readiness for the meeting of the Workforce Delivery Committee in January 2014.	
6 Strategic workforce report	**SWBWO (12/13) 033**
Mrs Deakin presented the Quarter 3 update of the annual workforce programme. She advised that overall, the work planned was on track. It was highlighted that 'Your Voice' real time staff polling had been introduced and that a full cycle of polling had been completed. Mrs Deakin advised that much work had been undertaken with staff who could not access PCs to provide their views. It was reported that in April 2014, a staff 'Friends and Family Test' would be introduced nationally, although the linkage to the national survey was as yet unclear. Mrs Deakin reported that on the leadership aspect, some commitment around leadership development was being worked through. The Committee was advised that stringent sickness absence management was reported to be being given clear focus at present. It was reported that the strategy would be refreshed in the next few months.	

7 Learning & education report to include leadership development proposal	**SWBWO (12/13) 035** **SWBWO (12/13) 035 (a) - SWBWO (12/13) 035 (d)**
Mr Pollitt outlined the current activity underway on learning and education. The issues and measures being faced at present were outlined, including poor mandatory training compliance in some areas despite the overall pleasing level. Medical devices refresher training was reported to be a key area of concern, although the plans to address this were outlined. It was noted that the Medical Devices Committee provided oversight of the issue. Mr Pollitt advised that in terms of Mandatory Training, work was underway to transform the Mandatory Training using competency based assessment and local training delivery. A key issue was reported to concern 'Learning Beyond Registration', which represented an income of £300k, however this did not address the training need fully for matters such as CPD, some mandatory training and for allied healthcare professionals. It was reported that the funding would be used on a priority basis. Mr Kang asked whether the fund would be likely to increase and he was advised that it was likely that the system would be refined to better align the funding. Mr Kang asked whether current attendance by medics at training events was acceptable. He was advised that the attendance at the events would be likely to increase in line with the development programme for leaders. It was highlighted that all new consultants were required to undertake a tailored development course. Mr Sharon advised that a tender had been issued through OJEU for the provision of a development programme, which was required to include 360 degree feedback and a talent management framework, which would be delivered before the end of March 2014. It was reported that the development programme would include medical staff. Mr Pollitt reported that work was underway to evaluate e-learning and using a survey tool, the view appeared to be positive to date. It was noted that good developments were underway specifically in the Ophthalmology area. Mr Samuda asked whether the work of the Trust was in line with the requirements of the new CQC inspection regime. Mr Sharon advised that this was the case.	
8 Operational workforce report	**SWBWO (12/13) 035** **SWBWO (12/13) 035 (a) - SWBWO (12/13) 035 (h)**
Mrs Barnett provided an overview of performance against key operational workforce measures. Mr Kang asked how long term sickness was managed on the basis that many of these cases related to anxiety or stress. Mrs Barnett advised that in excess of 28 days absence was classified as long term sickness and that the majority of anxiety	

cases fell within the definition of short term sickness absence. It was reported that there was a correlation between good leadership and sickness absence. The Committee was asked to note the key actions being undertaken to address sickness absence. The Committee reviewed the workforce TSP for 2013/14 and was advised that a paper would be prepared for the JCNC outlining the workforce implications of the 2014/15 schemes. It was highlighted that given a number of schemes had been withdrawn there was a gap in terms of the workforce adjustments required. It was agreed that the Performance Management Committee (Executive level) should take oversight of these plans. Mr Sharon highlighted that development of the workforce policies was key to refocusing new workforce practice in future. It was noted that the new Appointment Advisory Committee process for the recruitment of consultants would be introduced in the new year. Mrs Barnett highlighted that offer acceptance to post commencement was c.75%, contrary to the position allegedly reported to the Finance & Investment Committee. It was noted however, that retention of new recruits was an issue. It was agreed that a clear understanding of the reasons behind this issue was needed. It was highlighted that measures were being undertaken to avoid the use of agency staff where possible and was agreed that the competitiveness of current the Trust's bank rates needed to be reviewed. The use of agency nurses through the Thornbury Nursing Services agency was expressed as a particular concern and a risk to the management of agency staff expenditure. It was agreed that a further update would be presented at the next meeting. The Committee was asked to review the diversity information concerning Trust staff, which highlighted some marked differences in some areas particularly in terms of pay groups. It was suggested that this information should be presented to the Trust Board as part of the Board Development work. Mr Samuda suggested that the opportunity to engage the newly appointed legal team for the Trust in the work should be considered.	
ACTION: **Mrs Barnett to present an update on the Trust's retention rate at the next meeting** **ACTION:** **Mr Ovington to arrange for an update on Equality & Diversity to be presented to the Board**	
9 JCNC feedback	**Verbal**
There was no feedback to provide.	
10 Recruitment	**Verbal**

It was agreed that this matter would be discussed at the next meeting.	
11 Any Other Business	**Verbal**
It was agreed that the workforce risk register would be presented at the next meeting.	
12 Details of the next meeting	**Verbal**
The next meeting is to be held on 28 March 2014 at 1330h in the D29 (Corporate Suite) Meeting Room, at City Hospital.	

Signed ……..

Print ……..

Date ……..

Midland Metropolitan Hospital Status Report April 2014

Activities Last Period

- Approval process –DH OBC /commercial
- Pre Market Engagement Day
- Pre Market Engagement with individual bidders
- Gateway Review

Planned Next Period

- Secure Site
- Agree the procurement documentation with the Board
- Agree a communications plan with the executive
- Ensure project resourcing is in place to October 1
- Mobilise the new clinical procurement team
- Progress the City site “separation for disposal” plan

Issues for Resolution/Risks for Next Period

Finalise Approvals before agreement to advertise scheme

SWBTB (4/14) 056

FT Programme Monitoring Status Report

Activities This Month

- Clinical Group Governance audit paper discussed at March FT Development Committee – agreement that a standardised agenda will be used for all group governance meetings
- Awaiting confirmation of CIH visit – confirmed that this will not take place in Q1 (14/15)
- FT Risk Register re-defined following feedback from Risk Management Committee

Planned Next Month

- IBP chapters redeveloped in line with OBC in readiness for submission to the TDA in June 2014
- 'Get Involved in Leading the Trust' events planned for April & May (membership)
- TDA to publish new FT guidance (with details of CIH visit process)

Issues for Resolution/Risks for Next Month

- Confirmation required from CQC as to date of CIH visit
- Continue to make progress on A&E target in line with rectification plan to NTDA
- MMH approval