Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 1 May 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]
Dr P Gill	(PG)	[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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Guests

Patients for patient story & service presentation

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 3 April 2014 a true and accurate records of discussions*	**SWBTB (4/14) 059**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (4/14) 059 (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 (3/14) 030**	**RSM/ TL**
		MATTERS FOR DISCUSSION AND APPROVAL		
1415h	8	**Financial plan 2014 - 16**	**To follow**	**TW**
1435h	9	**Financial performance report – Month 12**	**SWBTB (5/14) 061** **SWBTB (5/14) 061 (a)**	**TW**
1445h	10	**Corporate performance dashboard**	**SWBTB (5/14) 062** **SWBTB (5/14) 062 (a)**	**TW**
	10.1	Rapid access chest pain performance	Verbal	RB

	10.2	Performance against the 18 week referral to treatment time target	SWBTB (5/14) 063	RB
1510h	**11**	**Safe staffing**	**SWBTB (5/14) 064** **SWBTB (5/14) 064 (a)**	**CO**
1525h	**12**	**Trust Risk Register update**	**SWBTB (5/14) 065** **SWBTB (5/14) 065 (a)**	**KD**
1540h	**13**	**Quarter 4 2013/14 annual plan update**	**SWBTB (5/14) 066** **SWBTB (5/14) 066 (a)**	**TL**
		PRESENTATION		
1550h	**14**	**Community and Therapies Group – rapid response team update**	**Presentation**	**RB**
1610h	**15**	**Update from the meeting of the <u>Audit & Risk</u> Committee on 24 April 2014 and minutes of the meeting held on 30 January 2014**	**SWBAR (1/14) 011**	**GH/ KD**
	16	**Update from the meeting of the <u>Quality & Safety</u> Committee on 25 April 2014 and minutes of the meeting held on 28 March 2014**	**SWBQS (3/14) 035**	**OD/ CO**
	16	**Update from the meeting of the <u>Configuration</u> Committee held on 25 April 2014 and minutes of the meeting held on 28 February 2014**	**SWBCC (2/14) 010**	**RSM/ TW**
	16	**Any other business**	**Verbal**	**All**
		MATTERS FOR INFORMATION		
1620h	**17**	**Midland Metropolitan Hospital project: monitoring report**	**SWBTB (5/14) 067**	
1652h	**18**	**Foundation Trust application programme: monitoring report**	**SWBTB (5/14) 068**	
	19	**Details of next meeting** *The next public Trust Board will be held on 5 June 2014 at **1330h** in the Churchvale/Hollyoak Rooms, Sandwell Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.1

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

Present	**In Attendance**
Mr Richard Samuda [Chair]	Mr Mike Hoare
Ms Clare Robinson	Miss Kam Dhami
Dr Sarindar Sahota OBE	Mrs Chris Rickards
Mrs Gianjeet Hunjan	Mr Bill Hodgetts [Healthwatch]
Mr Harjinder Kang	
Ms Olwen Dutton	
Mr Toby Lewis	**Guests**
Mr Tony Waite	Patient 's daughter
Mr Colin Ovington	Patient's granddaughter
Miss Rachel Barlow	Dr Muninder Lotay
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**
There were no declarations received since the last meeting.	
3 Minutes of the previous meeting	**SWBTB (3/14) 045**
The minutes of the Trust Board meeting held on 6th March 2014 were presented	

for consideration and approval. It was agreed that section 12.1 needed to be rephrased to reflect that the quality of complaints handling had been improved.	
4 Update on Actions arising from Previous Meetings	**SWBTB (3/14) 045 (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. It was highlighted that the whistleblowing considerations had not yet concluded and that work would continue over the next few weeks in readiness for implementation.	
5 Questions from members of the public	**Verbal**
Mr Cash observed that it was pleasing that patient stories were presented at the Board. He suggested however that resources needed to be better directed to handling patients affected by dementia. Mr Cash asked what progress was made with the application for Foundation Trust status. Mr Lewis advised that a change with the regulatory regime following the Francis enquiry had introduced a pause in the approval of FTs nationally, however the new timetable now identified that authorisation as an FT was likely by summer 2015. Mr Cash asked whether there was a further inspection was needed prior to this. Mr Lewis advised that a scheduled inspection by the Chief Inspector of Hospitals was due within the next six months and that there was a possibility that there might be an unannounced inspection in the meantime or subsequent to this. Mr Cash asked what plans were in place to reconfigure stroke services further. Mr Lewis advised that there was an internal reconfiguration of stroke some time ago, however across the West Midlands there was a possibility that the infrastructure around Hyper Acute Stroke Units (HASUs) might be changed, with deliberations being underway to consider how many of the existing HASUs were needed based on travel times within the considerations. Mr Hodgetts noted that there was good feedback on the recent internal reconfiguration of stroke services and noted that to further reconfigure them may not be helpful or welcome. Mr Lewis advised that the decision was within the remit of the Commissioners and that any changes would be based on the need to save further lives. Mr Hodgetts asked whether reconfiguration of Cardiology was planned. He was advised that there was a possibility that plans would be developed to centralise Cardiology on one site.	
6 Patient story	**Presentation**
The Board was addressed by the daughter of a patient who had been cared for on Newton 1 and Lyndon 4. The Board agreed that the experience has been significantly short of expectations and Mr Samuda apologised on behalf of the Trust for the care that the patient	

had received. Dr Sahota echoed the apology and underlined the requirement for the patient's nutritional needs to be met at all times. The patient's daughter outlined the difficulty with making the presentation to the Board, particularly given that she was a member of staff. Mr Lewis asked for views as to the measures the Trust could undertake to provide assurance that learning had been gained from the poor patient experience. The patient's daughter advised that systems and processes need to be put into place to prevent a reoccurrence of the situation, in addition to an apology. It was highlighted that there had not been an apology to date. The Board collectively expressed its sincere apologies for the experience and its extreme discomfort at the situation. It was noted that the relatives would be making a formal complaint about the matter in due course. The guests were thanked for their attendance and for sharing the experience with the Board.	
7 Chair's opening comments and Chief Executive's report	**SWBTB (4/14) 047**
Mr Samuda advised that an announcement on the appointment of a new Non Executive Director was due to be made shortly, the individual having a background in primary care and research. The Board was advised that meetings had been held with local MPs and with representatives from the Health & Wellbeing Board. A meeting with the Chairman and Chief Executive of Healthwatch was reported to have been held which had created a closer relationship. Mr Lewis reported that a third MRSA bacteraemia case had been reported in March. It was reported that work would be undertaken with staff and patients of different ethnic backgrounds in the forthcoming months as part of the plans to strengthen the Trust's equality & diversity framework. The Board was advised that trainee accreditation would not be withdrawn from Sandwell A & E, following the concerns aired at the last meeting over the allocations made by the Deanery. It was suggested that further focus was needed to provide oversight on education at Board level which would be provided by the Director of Organisational Development when in post. The leadership develop process was reported to have commenced on 31 March and would continue for another two years with investment in a middle management cadre of c. 150 staff.	
7.1 Car parking update	**SWBTB (4/14) 048** **SWBTB (4/14) 048 (a)**

Mr Ovington reminded the Board that changes to car parking charges had been discussed at the February Board meeting and that the update highlighted how car parking would be addressed for patients delayed in clinic. The Committee noted the update, including the number of car parking spaces for disabled individuals, which was over and above that required. Mr Ovington advised that a standard operating procedure was being developed that provided the steps to take when a patient was delayed in clinic at the fault of the Trust.	
7.2 Complaints handling KPIs	**SWBTB (4/14) 049** **SWBTB (4/14) 049 (a)**
Miss Dhami presented an update on the KPIs that had been developed to assess the effectiveness of the complaints handling process. It was reported that the current suite of KPIs remained largely valid. Since November it was noted that the issuing of complaints was required within 30 working days. Proposed changes to the KPIs were highlighted to relate to the indicator concerning responses sent out, where it was proposed that this be replaced by the number of responses sent out that month. Additionally, the indicator concerning those responses issued outside the failsafe target of 90 days be replaced by those issued after 30 days. The average response time was noted to be 33 days. An update on the effectiveness of the devolution of complaints was presented. It was highlighted that some of the Clinical Groups were more impacted than others by the process. The Chairman asked whether the training in complaints handling had been well accessed. He was advised that training and had been taken up by all Groups and that areas were being targeted where needed. The training was reported to be ongoing. Ms Dutton asked what could be done to make contact with the complainants informally in an attempt to address the complaints quickly. Miss Dhami advised that this was in place in some areas with senior clinicians either arranging meetings with the complainants or telephoning them. It was suggested that this practice should be encouraged. Dr Sahota suggested that there was a need to start handling complaints and issues at source to prevent matters escalating into formal complaints. Miss Dhami advised that this practice was in place and further work would be directed to capturing the activity formally. Mr Kang suggested that the target response time should be 30 days or below. Miss Dhami advised that some complaints were handled more speedily than this target already and that conversations were occurring to discuss and negotiate the time for the responses. It was highlighted that a Group-level sitrep was produced outlining performance in terms of issuing complaints. Mr Lewis suggested that there was a need to balance quality responses with timeliness and in this respect	

he added that the quality of responses was much improved from previous months and was more timely. Mr Lewis asked that data for linked complaints to be separated from original complaints in future reports to the Board. Ms Robinson highlighted that the KPIs needed to set expectations for implementing practice from the learning. Ms Dutton suggested that a quick learning point around food and nutrition could be implemented. Mr Lewis advised that determination of a patient's mental capability was necessary and the associated working with the family also needed to be given attention. It was agreed that a full response to the issues highlighted through the patient story needed to be shared with the Board at a future meeting.	
ACTION: Mr Ovington to provide an update on the measures to address the issues highlighted in the patient story at a future meeting **ACTION: Miss Dhami to provide an update on performance against the Complaints handling KPIs at a future meeting**	
8 2014/15 annual corporate plan	**SWBTB (4/14) 050** **SWBTB (4/14) 050 (a)**
Mr Lewis advised that the plan was consistent with the version of the plan and targets discussed with the Board previously, including workforce redesign. It was noted that the TDA assessment was that the Trust was a low-medium status in terms of the submission and that the 10 year annual plan was amber based on the new framework set out by the TDA. Dr Sahota highlighted an inconsistency with the workforce reductions in the annual plans. It was agreed that these would be addressed. The proposed changes to the VAT rules for the public sector were agreed that have been considered, in terms of the contracted out of service elements. Mr Waite advised that this was intended to harmonise the practice in health with other public sector arms. It was reported however that the matter nationally remained to be approved. Miss Barlow suggested that the photos used in the annual plan needed to be more representative of the staff demographic, including the use of male staff. Ms Dutton highlighted that the diversity and cultural considerations needed to be reflected in the annual plan. Mr Lewis agreed that this suggestion would be given due consideration. The plan was approved.	
9 2014/15 TDA annual plan	**SWBTB (4/14) 051** **SWBTB (4/14) 051 (a)** **SWBTB (4/14) 051 (b)**
The Board considered and approved the TDA annual plan noting its coherence with the previously agreed annual corporate plan.	

10 Corporate performance dashboard	**SWBTB (4/14) 052** **SWBTB (4/14) 052 (a)**
Mr Waite provided the key highlights of the corporate performance report. It was reported that performance against the Emergency Care target was in excess of 95% during February and that performance against the cancelled operations target had been 1.1%. It was reported that Trauma and Orthopaedics and Urology performance had improved significantly. Performance against the Medicines management target was reported to be mixed. Ten mixed sex accommodation breaches were reported to have occurred during the last month. Ms Dutton expressed her disappointment at the performance against the medicines management target. Mr Ovington advised that much targeted focus was being given to addressing this. Mrs Hunjan advised that the matter had also been considered at the Quality & Safety Committee. Mr Lewis asked what the rapid access chest pain performance had been during February. Miss Barlow offered to determine the position. Mr Lewis asked why the position in terms of feedback from Friends and Family was poor in maternity. Mr Ovington suggested that the speed of maternity services might be contributing. It was suggested that feedback might need to be canvassed after the Mums had returned home.	
ACTION: Miss Barlow to determine the rapid access chest pain performance and report back at the next meeting	
10.1 Emergency Care waits in March	**Verbal**
Miss Barlow reported that performance against the Emergency Care target appeared to be more sustained and was much better than the position at the same time in 2013/14. She advised that a robust care of the elderly model and psychiatric assessment needed to be introduced to deliver further improvement. It was reported that a community hub showing availability across community beds was in place and that a project to deliver an electronic bed management system would be introduced. In terms of the funding for GPs in the Emergency Departments, it was reported that the Trust had taken over the contract for this work.	
11 Financial performance report – Month 11	**SWBTB (4/14) 053** **SWBTB (4/14) 053 (a)**
Mr Waite presented the financial performance for month 11. He advised that there was confidence that the external resourcing limit had been met. It was reported that the expected surplus was anticipated to be £6.7m. Mrs Rickards left the meeting.	

Continuity of Service Risk Rating was expected to be 4. In terms of income, all key matters had been settled with the local Clinical Commissioning Group. Pay expenditure was reported to have been within budget, despite the high use of temporary staff during the period. It was noted that oversight of the capital plan would be provided by the Finance & Investment Committee in future. Contracts for 2014/15 were reported to be signed shortly, subject to addressing some minor points, which would secure a level of income in line with the Long Term Financial Model.	
12 Trust Risk Register	**SWBTB (4/14) 054** **SWBTB (4/14) 054 (a)**
Miss Dhami reminded the Board of the approach to refreshing the risk management approach, including the more robust completion of risk assessments and risk identification at a Group and directorate level. The timing of the refresh was reported to coincide with the recent considerations by the Investment Advisory Group and that it was likely that the decisions from this process might be reflected in future versions of the risk register. It was reported that the risk register would be presented on a monthly basis in future. The Board was asked to note the key risks included in the risk register and the proposed handling of each. It was reported that the Audit and Risk Management Committee would consider the internal audit plan at its next meeting, which would be aligned to the risks in the Trust Risk Register. Work was reported to be underway to refocus the Board Assurance Framework on the key matters on which the Board sought assurance as opposed to the Trust Risk Register. Mr Hoare suggested that the containment measures for risks to be tolerated could be included in the risk register. Mr Kang added that the parameters for acceptance or the risk needed to be set. It was noted that the methodology to risk management had been discussed with Internal Audit. It was noted that there was a specific scrutiny process through the Risk Management Committee and that the risk registers would be published from June 2014. Miss Dhami advised that this sharing process was necessary to identify risk interdependencies and to identify aggregate risks such as falls and IT risks. Each risk was discussed in turn. In terms of the MMH risk, it was suggested that the risk should be tolerated for 28 days, subject to the containment measures. In terms of workforce reduction risk, it was agreed that the levers and deployment of these might not match clearly the need to deliver the paybill	

reduction required. The detail of the risk around the loss of the Hyper Acute Stroke Unit status was discussed. It was agreed that a treatment plan assuming that the facility was lost was needed. The Board considered the risk around the Pathology sample archiver technology. It was noted that the equipment was being provided by a commercial source at present assuming that the technology was robustly working and that consideration was needed around the contractual matters in due course. It was agreed that a briefing from the Group Director for Pathology was needed in readiness for the next meeting. It was agreed that the risk should continue to be treated. Regarding the risk around the 18 weeks performance and processes associated with this, it was noted that the delays to the availability of the data were highlighted to be key considerations. The final risk concerned delayed transfers of care were articulated by Miss Barlow. It was agreed that this needed to be treated through partnership working. It was suggested that the risks with a post mitigation status of less than red may not need to be discussed by the Board. Ms Robinson disagreed with this view on the basis that some of the mitigation plans might take some time to implement. It was agreed that the assurance process needed to be scrutinised by the Audit & Risk Management Committee to assure the Board that the appropriate risks were raised to the Board. Ms Dutton suggested that she would expect a risk around security checks to feature on the risk register. She was advised that it was likely that matters such as these would be considered through the Executive-led Risk Management Committee. Mr Hoare stressed the importance of clearly articulated risks, particularly in view of the proposal to publish all risks. It was agreed that the risk register should be a regular feature of the Board. Ms Dutton left the meeting.	
ACTION: **Miss Dhami to present the updated risk register at the next meeting** **ACTION:** **Miss Dhami to arrange for the detail of the Pathology risk to be presented at the next meeting**	
13 Homeless patient pathway	**Presentation**
Mr Lewis presented an overview of the Homeless initiative and the future plans, including the Trust's involvement with supporting the homeless patient pathway. Dr Muninder Lotay joined the meeting and presented an overview of the	

homeless patient pathway, including the improved access for these individuals who were reported to often present with comorbidities and were more likely to need to access hospital services than other individuals. It was reported that onward referral to services such as mental health support and drug & alcohol abuse services was provided through GPs as part of the homeless patient pathway. Through the homeless initiative, it was reported that readmission and reattendance rates were greatly reduced and quality of care was improved. Dr Stedman confirmed that high readmission rates and reattendances related to homeless patients and that the interventions by the homeless patient pathway would have a significant impact. Dr Sahota asked how the local authority was being engaged with the plans. Dr Lotay advised that the plans were being underpinned by local authorities and that Social Services would be engaged with making assessments. He added that weekly Multi Disciplinary Teams would meet which included Social Services. It was reported that targeting patients in the community where there were areas of known individuals that would benefit from access to healthcare was planned. Miss Barlow highlighted that there was good opportunity to work together. It was noted that there would be work to link with vulnerable families. Mr Kang asked whether there was any joint working with the homeless initiative being undertaken within the Trust. Mr Lewis confirmed that this was the case, including the consideration of hostels. He asked Dr Lotay how the partnership working with the Trust had been received. He was advised that the proposals had been well embraced and that the provision for homeless individuals had been well received by ward staff. Clothing donations were reported to have been particularly successful. It was noted that work was underway to ensure that the homeless pathway was sustainable. Dr Lotay was thanked for his attendance.	
14 Update from the meeting of the Quality & Safety Committee held on 28 March 2014 and minutes from the meeting held on 28 February 2014	**SWBQS (2/14) 023**
Ms Hunjan presented an overview of the key discussions from the Quality & Safety Committee held on 28 March 2014. Mr Ovington suggested that a greater focus was needed on Safeguarding children in future. It was noted that a best practice model for this was needed. It was noted that the Clinical Audit plan and internal audit plan would be approved by the Clinical Executive Committee prior to presentation to the Audit & Risk Management Committee. Dr Stedman reported that assurances over palliative care coding would be	

developed in response to the recent media interest around this matter.	
15 Update from the meeting of the Finance & Investment Committee held on 28 March 2014 and minutes from the meeting held on 31 January 2014	**SWBFI (1/14) 011**
Ms Robinson presented an overview of the key discussions from the Finance & Investment Committee held on 28 March 2014 and minutes from the meeting held on 31 January 2014. The financial plan for 2014/15 including the risks around this was noted to have been discussed. The Board was advised that a special meeting of the Committee would be organised for May to look at the development of the Transformation Savings Plan.	
16 Update from the meeting of the Workforce & OD Committee held on 28 March 2014 and minutes from the meeting held on 16 December 2014	**SWBWO (12/13) 037**
Mr Kang presented an overview of the key discussions from the Workforce & OD Committee meeting held on 28 March 2014 and minutes from the meeting held on 16 December 2014. The target for the appointment of the new Organisational Development Director was reported to be by the end of May 2014.	
17 Any Other Business	**Verbal**
There was none.	
Matters for Information	
The Board received the following for information: • Midland Metropolitan Hospital Project: Monitoring Report • Foundation Trust Application Programme: Monitoring Report	**SWBTB (4/14) 055** **SWBTB (4/14) 056**
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 1st May 2014 and would be held in the Anne Gibson Boardroom, City Hospital.	

Signed: ……

Name: ……

Date: ……

Next Meeting: 1 May 2014, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

3 April 2014, Churchvale/Hollyoak Rooms @ 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), Mr C Ovington (CO)

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: 25 April 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 arranged for May 2014	G
SWBTBACT.277	Complaints handling KPIs	SWBTB (4/14) 049 SWBTB (4/14) 049 (a)	03-Apr-14	Provide an update on the measures to address the issues highlighted in the patient story at a future meeting	CO	01/05/14	Update to be provided to the private session of the Trust Board in May pending a more detailed update in public at a later meeting	G
SWBTBACT.278	Complaints handling KPIs	SWBTB (4/14) 049 SWBTB (4/14) 049 (a)	03-Apr-14	Provide an update on performance against the Complaints handling KPIs at a future meeting	KD	04/09/14	ACTION NOT YET DUE Update to Quality & Safety Committee arranged for August 2014	G
SWBTBACT.279	Corporate performance dashboard	SWBTB (4/14) 052 SWBTB (4/14) 052 (a)	03-Apr-14	Determine the rapid access chest pain performance and report back at the next meeting	RB	01/05/14	Included as a verbal update on the agenda of the May 14 meeting	G
SWBTBACT.280	Trust Risk Register	SWBTB (4/14) 054 SWBTB (4/14) 054 (a)	03-Apr-14	Present the updated risk register at the next meeting	KD	01/05/14	Included as an update on the agenda of the May 14 meeting	G
SWBTBACT.281	Trust Risk Register	SWBTB (4/14) 054 SWBTB (4/14) 054 (a)	03-Apr-14	Arrange for the detail of the Pathology risk to be presented at the next meeting	KD	01/05/14	Update to be presented at the May meeting of the Trust Board	G

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

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – P12 March 2014
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Management
AUTHOR:	Chris Archer, Associate Director of Finance - Corporate
DATE OF MEETING:	1 May 2014

EXECUTIVE SUMMARY:

- All key financial targets delivered for the year ended 31 March 2014:
  - Surplus for performance reporting purposes £6.751m being in line with revised plan and representing 1.5% of total income
  - External Finance Limit under-shoot £3.9m being £(0.9)m external financing requirement vs. £3.0m approved EFL.
  - Capital Resource Limit under-shoot £0.8m being £21.0m relevant capital expenditure vs. £21.8m approved CRL.
  - Continuity of Service Risk Rating of 4 [vs. level 3 considered to be acceptable]
- Other matters of note
  - The year-end I&E position includes impairments to fixed assets of £8.9m. This is treated as a technical adjustment and does not affect delivery against the revised DH target surplus of £6.7m.
  - The year-end cash balance was £41.8m being £3.5m above plan
  - The capital spend for the year was £21.4m against a plan of £21.9m.

REPORT RECOMMENDATION:

The Board is requested to RECEIVE the contents of the report.

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

Accept	Approve the recommendation	Discuss
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:

Considered by the Performance Management Committee.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – March 2014

EXECUTIVE SUMMARY

- **All key financial targets delivered for the year ended 31 March 2014:**
  - **Surplus for performance reporting purposes £6.751m being in line with revised plan and representing 1.5% of total income**
  - **External Finance Limit under-shoot £3.9m being £(0.9)m external financing requirement vs. £3.0m approved EFL.**
  - **Capital Resource Limit under-shoot £0.8m being £21.0m relevant capital expenditure vs. £21.8m approved CRL.**
  - **Continuity of Service Risk Rating of 4 [vs. level 3 considered to be acceptable]**
- **Other matters of note**
  - **The year end I&E position includes impairments to fixed assets of £8.9m. This is treated as a technical adjustment and does not affect delivery against the revised DH target surplus of £6.7m.**
  - **The year-end cash balance was £41.8m being £3.5m above plan**
  - **The capital spend for the year was £21.4m against a plan of £21.9m.**

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	1,071	2,151	>= Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	602	1,153	>= Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	(416)	739	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	2,219	(1,123)	<= Plan	<= Plan	>1% above plan
WTEs Actual v Plan	(307.9)	(90.3)	<= Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000	3,473	3,473	>= 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	4,600	6,751
Capital Resource Limit	21,815	21,011
External Financing Limit	3,015	(915)
Return on Assets Employed	3.50%	3.50%

2013/14 Summary Income & Expenditure Performance at March 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
Income from Activities	395,159	34,075	32,311	(1,764)	395,159	395,634	475
Other Income	41,095	3,356	3,919	563	41,095	42,157	1,062
Operating Expenses	(410,245)	(34,830)	(33,027)	1,803	(410,245)	(410,629)	(384)
EBITDA	26,009	2,601	3,203	602	26,009	27,162	1,153
Interest Receivable	100	8	10	2	100	129	29
Impairment of Fixed Assets	0	0	(8,922)	(8,922)	0	(8,922)	(8,922)
Depreciation, Amortisation & Profit/(Loss) on Disposal	(14,138)	(1,498)	(1,423)	75	(14,138)	(13,867)	271
PDC Dividend	(5,027)	(419)	(365)	54	(5,027)	(4,717)	310
Interest Payable	(2,344)	(195)	(191)	4	(2,344)	(2,290)	54
Net Surplus/(Deficit)	**4,600**	**497**	**(7,688)**	**(8,185)**	**4,600**	**(2,505)**	**(7,105)**
IFRIC12/Impairment/Donated Asset Related Adjustments	0	0	9,256	9,256	0	9,256	9,256
SURPLUS/(DEFICIT) FOR DOH TARGET	**4,600**	**497**	**1,568**	**1,071**	**4,600**	**6,751**	**2,151**

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

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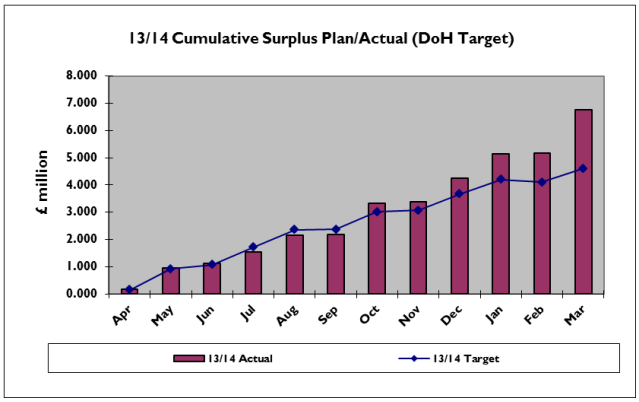
Overall Performance against Plan

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 £1,568,000 in March against a planned surplus of £497,000. The resultant £1,071,000 favourable variance results in a year to date return on income of 1.5%, exceeding the plan of a 1.1% return.

The Trust achieved its forecast surplus of £6.7m.



Performance of Clinical Groups / Corporate Areas

•Medicine overspent by £0.3m in the month mainly in ward areas reflecting winter capacity.

•Women & Child health reflects continuing shortfall on income.

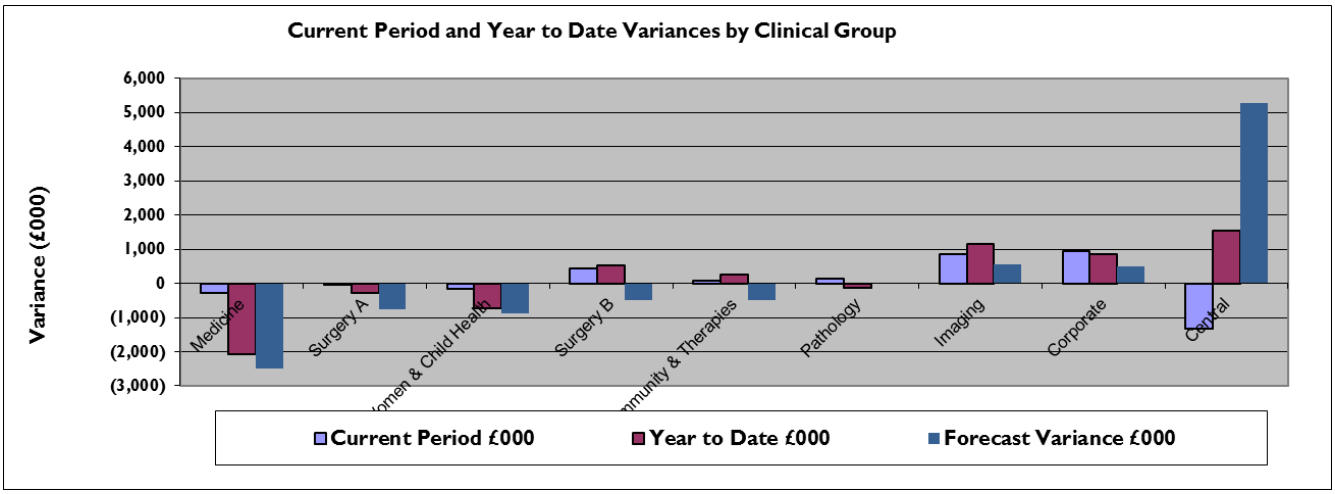
•Surgery B year end ophthalmology income benefit £0.6m.

•Imaging NHS and other income benefit £0.5m in month with continued staffing underspends.

Group Variances from Plan (Operating income and expenditure)	**Current Period £000**	**Year to Date £000**
Medicine	(283)	(2,061)
Surgery A	(55)	(290)
Women & Child Health	(168)	(729)
Surgery B	438	522
Community & Therapies	70	266
Pathology	132	(116)
Imaging	871	1,158
Corporate	934	858
Central	(1,336)	1,545

•Corporate directorates continue to underspend on management costs; position reflects funding for consultancy support.

•The Central position reflects year end SLA income adjustments, particularly for Specialised Services.



Sandwell and West Birmingham Hospitals NHS
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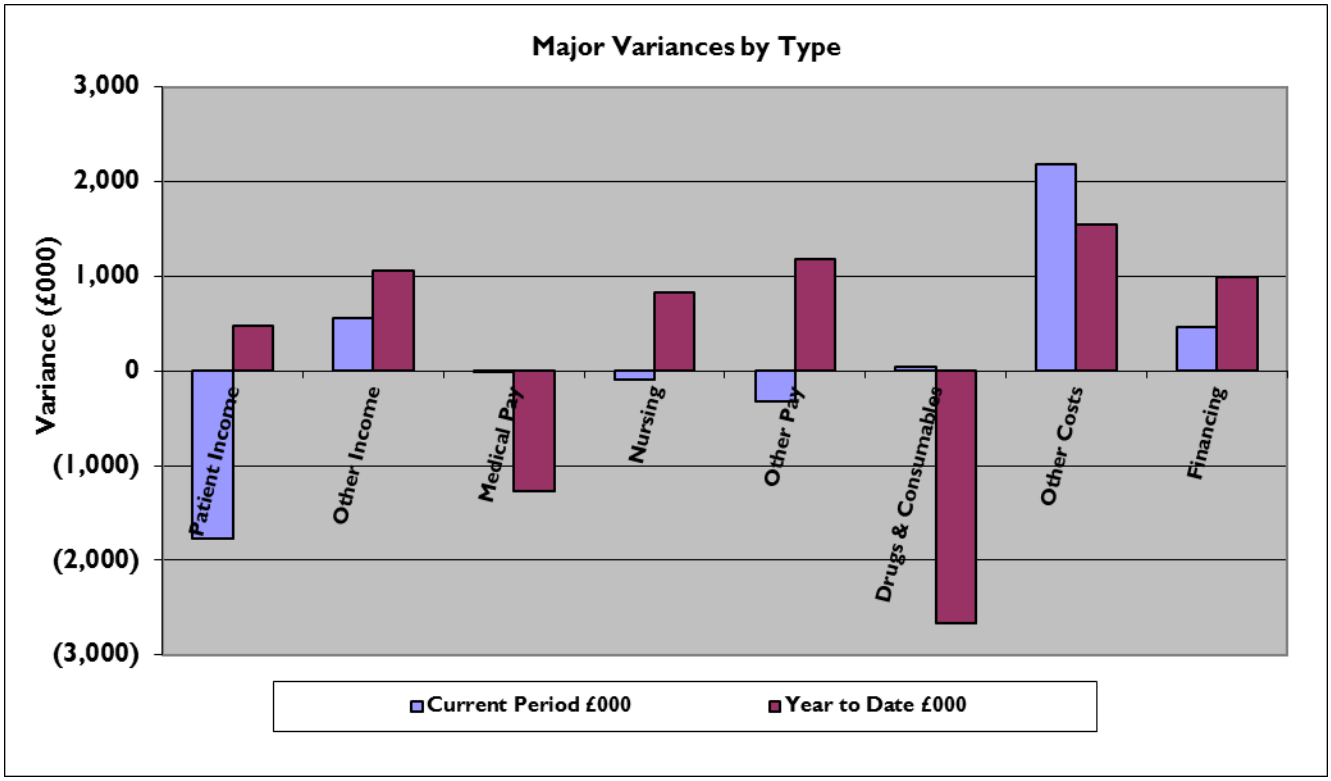
The Trust-wide in-month favourable variance is £1,071,000.

Contract income performance includes necessary deferral of £1.5m re antenatal pathway and the impact of contract settlement with SWB CCG.

Other costs includes movement on provisions.

Financing costs are below plan.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	(1,764)	475
Other Income	563	1,062
Medical Pay	(1)	(1,266)
Nursing	(92)	826
Other Pay	(323)	1,179
Drugs & Consumables	39	(2,669)
Other Costs	2,180	1,546
Financing	469	998



Sandwell and West Birmingham Hospitals NHS
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Financial Performance Report – March 2014

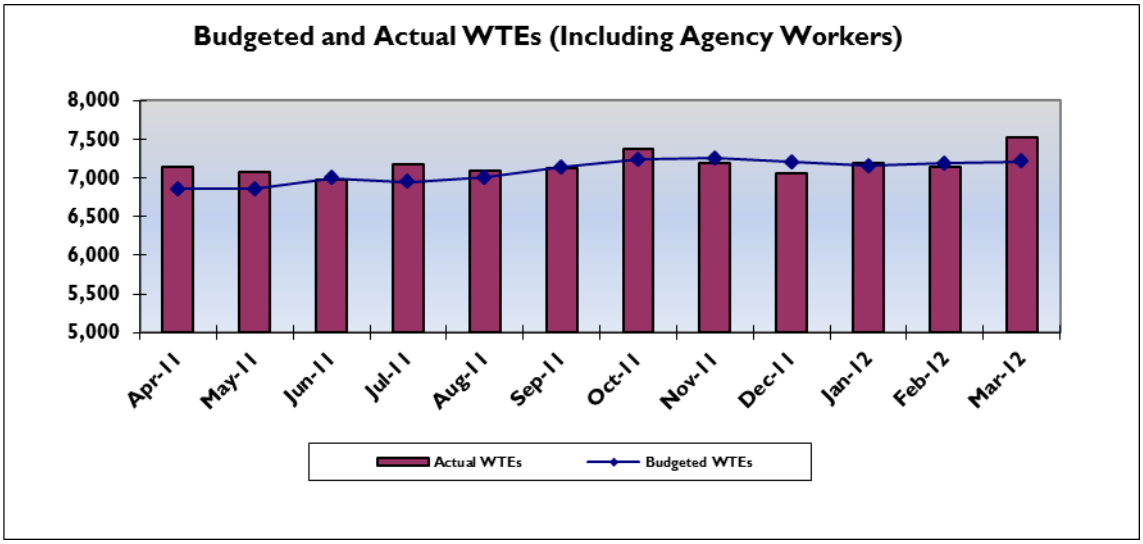
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are 308 above plan . Excluding the impact of agency staff, whole time equivalent (WTE) numbers are 59 below plan.

• Total pay costs (including agency workers) are £416,000 above budgeted levels for the month.

•Overspending on healthcare assistants continues with management, administrative and scientific and therapy staffing groups underspending.

•Gross expenditure for agency staff in March was £1.3m which is above trend for the year.



Analysis of Total Pay Costs by Staff Group

	Year to Date to March					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	77,067	74,611	0	3,722	78,333	(1,266)
Management	15,545	14,139	0	0	14,139	1,406
Administration & Estates	32,010	28,627	2,459	1,178	32,264	(254)
Healthcare Assistants & Support Staff	31,872	28,130	4,260	1,148	33,538	(1,666)
Nursing and Midwifery	91,971	82,044	4,392	4,709	91,145	826
Scientific, Therapeutic & Technical	44,045	41,538	0	561	42,099	1,946
Other Pay / Technical Adjustment	(231)	22	0	0	22	(253)
Total Pay Costs	292,279	269,111	11,111	11,318	291,540	739

Sandwell and West Birmingham Hospitals NHS

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Financial Performance Report – March 2014

Balance Sheet

•Cash balances at 31st March stood at £41.8m, £3.5m higher than the planned figure. The forecast cash flow for the next twelve months is shown overleaf.

•The balance sheet includes impairment in the value of tangible assets also reflected in the I&E statement and the year end 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	Balance as at end March 2014
		£000	£000	£000	£000
Non Current Assets	Intangible Assets	924	525	539	886
	Tangible Assets	216,669	215,237	215,724	226,403
	Investments	0			
	Receivables	1,048	966	966	1,011
Current Assets	Inventories	3,604	3,470	3,383	3,272
	Receivables and Accrued Income	10,432	23,355	28,368	16,177
	Investments	0	0	0	
	Cash	42,448	45,189	43,173	41,808
Current Liabilities	Payables and Accrued Expenditure	(43,040)	(52,703)	(56,029)	(53,867)
	Loans	(2,000)	(2,000)	(2,000)	(2,000)
	Borrowings	(914)	(861)	(659)	(1,064)
	Provisions	(10,355)	(8,209)	(7,931)	(8,036)
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)	(27,915)
	Provisions	(3,168)	(2,789)	(2,807)	(2,562)
		183,385	191,872	192,321	193,113
Financed By					
Taxpayers Equity	Public Dividend Capital	160,231	160,231	160,231	161,640
	Revaluation Reserve	34,356	33,659	33,321	41,899
	Other Reserves	9,058	9,058	9,058	9,058
	Income and Expenditure Reserve	(20,260)	(11,075)	(10,289)	(19,484)
		183,385	191,872	192,321	193,113

Financial Performance Report – March 2014

CASH FLOW

12 MONTH ROLLING FORECAST AT March 2014

ACTUAL/FORECAST	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	Mar-15 £000s
Receipts													
SLAs: SWB CCG	**21,142**	21,121	21,121	21,121	21,121	21,121	21,121	21,121	21,121	21,121	21,121	21,121	21,121
Associates	**6,152**	6,534	6,534	6,534	6,534	6,534	6,534	6,534	6,534	6,534	6,534	6,534	6,534
Other NHS income	**2,780**	1,016	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,050
Specialised Service (LAT)	**5,843**	4,052	4,052	4,052	4,052	4,052	4,052	4,052	4,052	4,052	4,052	4,052	4,052
Education & Training	**1,409**	4,434			4,434			4,434			4,434		499
Public Dividend Capital		72											
Loans													
Other Receipts	**4,386**	1,587	1,588	1,588	1,588	1,588	1,588	1,588	1,588	1,588	1,588	1,588	1,593
Total Receipts	**41,712**	38,816	34,349	34,349	38,783	34,349	34,349	38,783	34,349	34,349	38,783	34,349	34,849
Payments													
Payroll	**13,773**	14,431	14,377	14,358	14,288	14,275	14,275	14,241	14,241	14,241	14,239	14,239	14,239
Tax, NI and Pensions	**9,660**	9,621	9,584	9,572	9,525	9,517	9,517	9,494	9,494	9,494	9,493	9,493	9,493
Non Pay - NHS	**4,196**												
Non Pay - Trade	**7,626**	10,009	10,009	9,996	9,946	9,937	9,937	9,912	9,912	9,912	9,911	9,911	9,911
Non Pay - Capital	**3,980**	2,610	2,466	2,899	2,957	1,707	1,315	1,963	1,963	2,836	2,775	2,656	1,660
PDC Dividend	**2,253**						2,610						2,610
Repayment of Loans	**1,000**						1,000						1,000
Interest	**15**	178	178	178	178	178	178	178	178	178	178	178	178
BTC Unitary Charge		83	83	83	83	83	83	83	83	83	83	83	83
Other Payments	**574**												4,810
Total Payments	**43,077**	36,932	36,697	37,086	36,977	35,697	38,915	35,871	35,871	36,744	36,679	36,560	43,984
Cash Brought Forward	**43,173**	41,808	43,692	41,344	38,607	40,413	39,065	34,499	37,411	35,889	33,494	35,598	33,387
Net Receipts/(Payments)	**(1,365)**	1,884	(2,348)	(2,737)	1,806	(1,348)	(4,566)	2,912	(1,522)	(2,395)	2,104	(2,211)	(9,135)
Cash Carried Forward	**41,808**	43,692	41,344	38,607	40,413	39,065	34,499	37,411	35,889	33,494	35,598	33,387	24,252

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2014

Capital Expenditure

• Capital spending for the year was £21.4m against plan of £21.9m.

•Spending on Grove Lane was £4.9m in line with the revised plan. The planned accelerated spending on medical equipment was achieved, totalling £3.1m.

• Capital Resource Limit under-shoot £0.8m being CRL charge of £21.0m vs. approved CRL £21.8m

•The capital plan for 2014/15 takes into account planned movements in spending between 2013/14 and 2014/15.

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 year end score, using the TDA methodology, shows as 4.

1) Financial Risk Ratings	Financial Metric	2012/13 Full Year Accounts	Current Year to Date	Forecast Outturn
			Actual	Forecast
		£000s	£000s	£000s
2) Continuity of Service Rating				
Liquidity Ratio (days)	Working Capital Balance	(3,726)	(6,982)	(6,982)
	Annual Operating Expenses	405,860	411,889	411,889
	Liquidity Ratio Days	(3.3)	(6.1)	(6.1)
	Liquidity Ratio Metric	**3**	**3**	**3**
Capital Servicing Capacity (times)	Revenue Available for Debt Service	27,063	27,071	27,071
	Annual Debt Service	10,296	10,082	10,082
	Capital Servicing Capacity (times)	**2.6**	**2.7**	**2.7**
	Capital Servicing Capacity metric	**4**	**4**	**4**
Continuity of Services Rating	**Continuity of Services Rating for Trust**	**4**	**4**	**4**

Transformation Programme

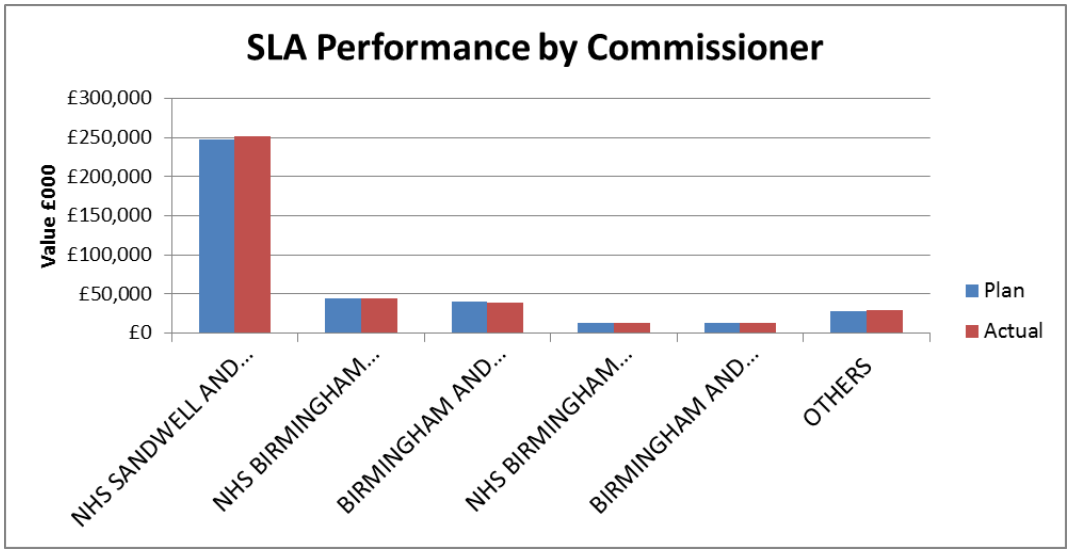
•Progress against 2013/14 TSPs is reported separately. The Trust achieved £21.8m of savings against the internal target of £22.3m, a £0.5m shortfall. Full year effect £19.8m being £2.4m under plan.

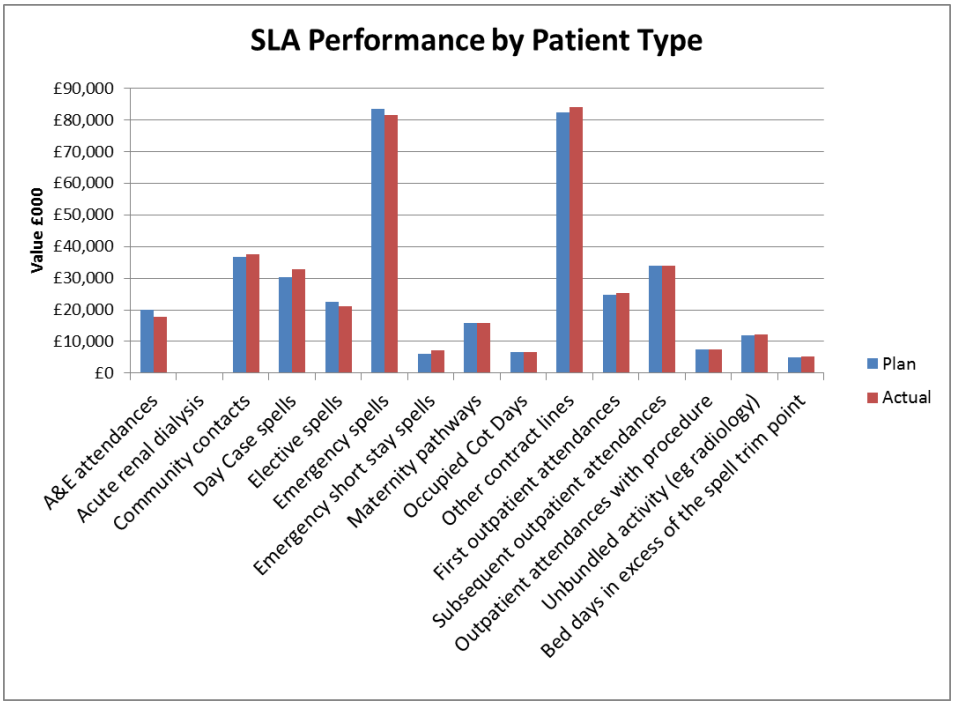
•Continued emphasis is being place on identification of full year TSP for 2014/15. A review of timings of schemes has been undertaken in order to ensure the programme is able to be delivered in full in the year.

Financial Performance Report – March 2014

Performance Against Service Level Agreement Target

•The position reflects year end agreements with commissioners. It includes deferring £1.5m of income into 2014/15 for antenatal pathways where the income for all the pathway is received at the time of first scan.





Financial Performance Report – March 2014

Key risks

• At £6.7m, the Trust has achieved more than its originally planned surplus of £4.6m by some margin. The revised surplus was notified to the Trust Development Authority around the turn of the calendar year.

•The surplus against the Department of Health target is after technical adjustments principally relating to impairment of fixed assets.

•However the year end position is underpinned by material one-off items which benefit the position, including release of balance sheet flexibility and holding of vacancies to achieve recurrent cost improvement plans. This means that the Trust's starting underlying position for 2014/15 includes risks which are being managed as part of the financial plan implementation programme for the first quarter of the new financial year.

External Focus

•The NHS can improve care for patients and get better value by looking at quality and costs together, according to clinical, managerial and financial leaders. A group of bodies, including the HFMA, NHS Confederation, Academy of Medical Royal Colleges and Faculty of Medical Leadership and Management, have issued a report, 'Two sides of the same coin'. It said all three professions must come together to solve quality and care issues. It added that the NHS was too often used as a 'political football' and urged politicians to be candid with the public about the quality and level of services that can be realistically achieved with the money available.

•Finance directors are less confident about their organisations' future financial position, according to the latest King's Fund quarterly monitoring report. The survey said that one in eight trusts and clinical commissioning groups will overspend their budgets in 2013/14. Though this was an improvement on the previous quarter, only 40% of provider finance directors believed their organisations would achieve financial balance in 2014/15. The figure reduced still further for 2015/16 – down to 16%. While CCG chief finance officers were more optimistic, only a third were confident of achieving balance in 2015/16. The fund said the lack of confidence was due to the commencement of the better care fund in 2015/16.

•The Department of Health has highlighted the need to change NHS pay contracts so that they 'reward most those staff who make the greatest contribution and end incremental pay rises based on time served'. In its response to the Commons health committee's report on health and social care expenditure, it welcomed changes that mean Agenda for Change progression is now based on meeting locally agreed appraisal and performance standards. However it said AFC needed to change further to reform and simplify progression arrangements and support seven day services.

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:	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:	1 May 2014 (Report prepared 24 April 2014)

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April 2013 – March 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 - MARCH 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 met the 4-hour wait operational threshold of 95% during the month of March with performance of 95.1%. Performance for the last quarter (4) was 94.4% and for the year was 94.5%. Performance for April 2014 to date (as of 21dt April) is 95.86%.

Cancelled Operatons - a breach of the 28-day late cancelled operation guarantee was reported for the month of March. The breach related to the specialty of Trauma & Orthopaedics at Sandwell. A Root Cause Analysis of the circumstances relating to the breach has been requested.

Referral To Treatment - the Trust met each high-level RTT operational threshold for the month of March, there were however a total of 15 treatment functions underperforming during the month. There is one patient reported as waiting in excess of 52 weeks in Ophthalmology at month end. Diagnostic waits further improved during the month to 0.75% (operational threshold =<1.00%).

Outcome Metrics:

Infection Control - The total number of cases of C Diff reported during the year was 39, within the trajectory for the period of 46. There was a total of 1 MRSA Bacteraemia reported during the year. The incidence of MSSA and E. Coli, both expressed per 100,000 bed days are within TDA identified operational thresholds for the year. The C Diff target for 2014 / 2015 for the Trust, set externally, is 37, with zero tolerance for MRSA Bacteramia.

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 within statistical confidence limits, with values of 92.1 and 100.1 respectively.

Quality Governance:

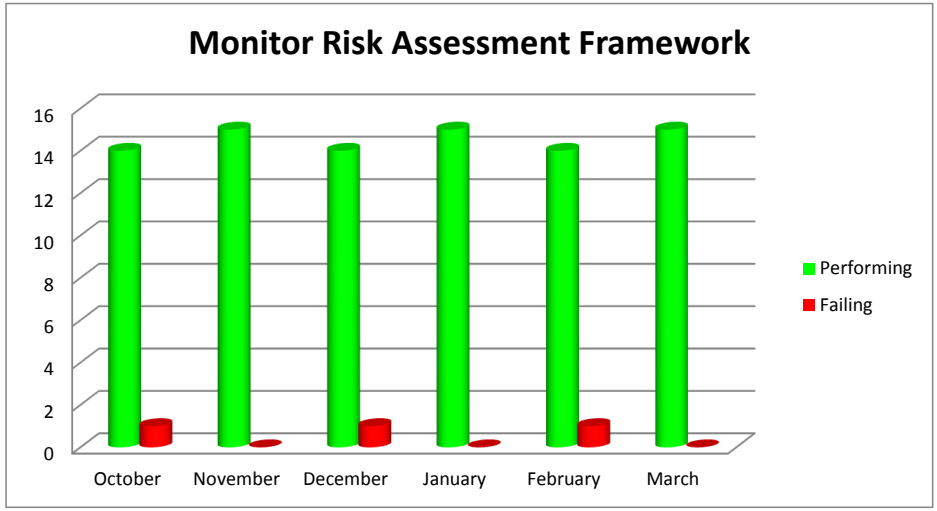
A total of 21 **Mixed Sex Accommodation** breaches were reported during the month of March comprising; Coronary Care Sandwell (4) and Priory 4 Sandwell (17). The introduction of the Trust's Electronic Bed Management System (eBMS) provides more active monitoring of mixed sex accommodation breaches. During the year a total of 124 breaches have been declared across the Trust.

PDR overall compliance as at 4 April 2014 stood at 96.7%, with 7188 staff recorded as having a valid PDR within the most recent 12-month period. The range of performance by Group was 94.64% - 99.36%. Medical Appraisal compliance stood at 97% at the end of March.

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.

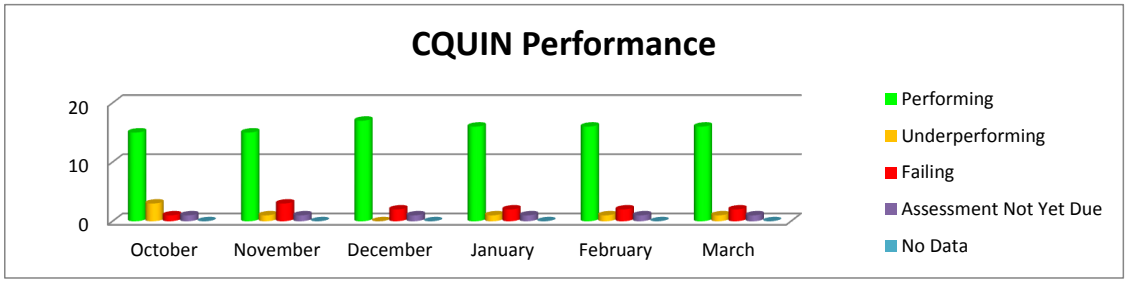
Access and Outcome metrics are formally monitored quarterly. A potential governance concern is triggered by; an aggregate weighted score is 4.0 or more, **or** by failing the same indicator for at least 3 consecutive quarters **or** by breaching the A&E waiting times target in two quarters over any four-quarter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



During the month of March the Trust met / is projected (Cancer targets) to meet the required thresholds for each of the Access and Outcomes indicators. This would attract an overall weighted score for the month of 0.0 with a GREEN Governance Rating.

During the Quarter (4) the Trust met / is projected (Cancer targets) to meet the required thresholds for each of the Access and Outcomes indicators, other than the Emergency Care 4-hour waits, which was 94.43% for the quarter. This would attract an overall weighted score for the quarter 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 schemes have either been met or are currently performing, 2 have not been met for the year, 1 is underperforming, with results for the remaining scheme, Annual Staff Survey, awaited.

Friends and Family Test to Maternity - performance during March was 9.30%. The end year target of a 65% response rate was not met.

Medicines Management (Storage) - final validated audit data from Q4 identifies 8 of 42 wards which were not fully (100%) compliant with the requirements of this CQUIN. The 81% overall level of wards compliant falls short of the Quarter 4 CQUIN target of 90%. Group Director's of Operations have been provided with a copy of the report and advised of the non-compliant areas.

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.

Dementia (Find, Assess and Refer) CQUIN scheme - although contractual delivery of this scheme is now complete, performance during March was such that only 2 of the 3 components of the scheme were met; Find (99%) and Assess (100%), Referral however is reported as 83%.

Clinical Quality & Outcomes

Stroke Care - performance against the range of stroke care related indicators is contained within the main body of this report. The main features to highlight are a reduction in the proportion of patients admitted to an Acute Stroke Unit within 4 hours to 78.4% and an improvement in the proportion of eligible patients receiving thrombolysis within 60 minutes of admission to 87.5% (6 of 8 patients).

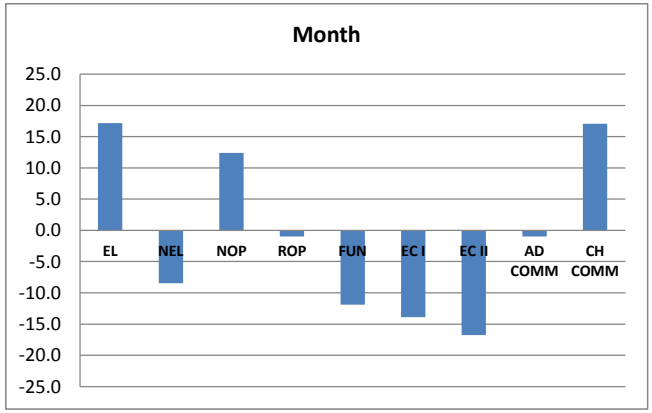
Fractured Neck of Femur - the proportion of patients who received an operation within 24 hours of admission is reported as 60.0% (12 of 20 patients). Performance for the year is reported as 70.33%, compared with an internal operational threshold of 85.0%.

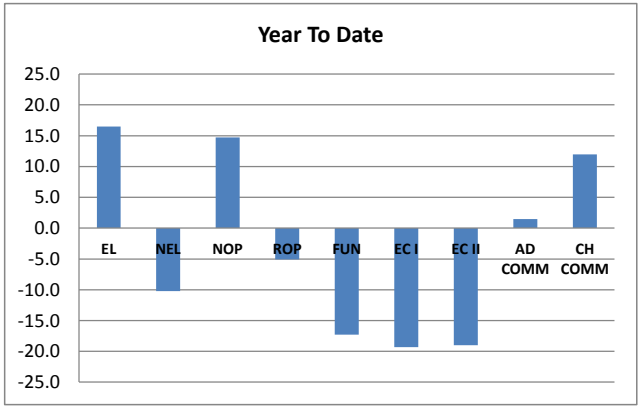
Patient Experience

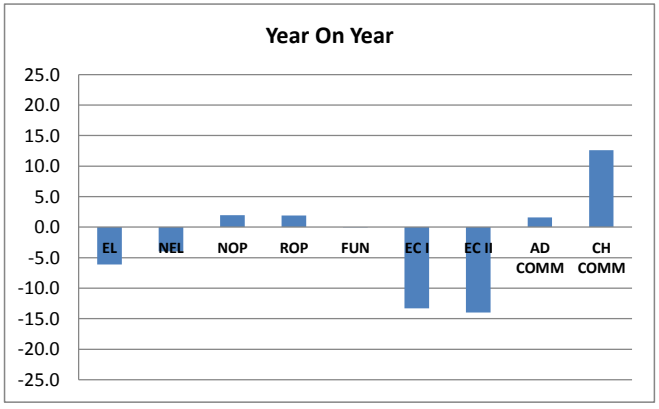
Cancelled Operations - the proprtion of SitRep declared late cancellations during the month of March was 1.1%, a reduction from 1.6% during February. Numerically late cancellations also reduced from 66 to 56 during the month, and were spread across a number of different specialties. No patients were subject to last minute cancellation on more than one occasion during the period.

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 exceeds the plan for the year by 16.5%, although is (6.1%) less than that delivered during the corresponding period last year. Non-Elective activity is 10.2% less than the plan for the year, and 4.0% less than the corresponding period last year. Overperformance against the New Outpatient activity plan for the year (+14.7%) and an underperformance against the Review OP activity plan for the year (-5.1%), gives a Follow Up:New OP Ratio of 2.23 for the year, significantly less than the ratio derived from plan (2.69). Type I and Type II Emergency Care activity for the year is 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 1.5% and 12.0% respectively.







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

Exec Lead	KPI Source	Data Source	Category / Indicator			November	December	January	February		March			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	%	96.7 ▲	97.0 ▲	95.6 ▼	→		94.4 ▼	→			95.0	=>93	=>93	No variation		Any variation	●	94.8	94.7
	B*			2 weeks (Breast Symptomatic)	%	97.3 ▲	97.0 ▼	100 ▲	→		99.1 ■	→			96.5	=>93	=>93	No variation		Any variation	●	95.8	95.9
	B*			31 Day (diagnosis to treatment)	%	97.5 ▼	98.8 ▼	99.3 ▲	→		100 ▲	→			99.1	=>96	=>96	No variation		Any variation	●	99.5	99.5
	B*			31 Day (second/subsequent treatment - surgery)	%	96.3 ▼	98.1 ▲	98.8 ▲	→		100 ▲	→			98.5	=>94	=>94	No variation		Any variation	●	100.0	99.2
	B*			31 Day (second/subsequent treatment - drug)	%	100 ■	100 ■	100 ■	→		100 ■	→			100	=>98	=>98	No variation		Any variation	●	99.2	99.8
	B*			31 Day (second/subsequent treat - radiotherapy)	%	100 ■	n/a	n/a	→		n/a	→			100	=>94	=>94	No variation		Any variation	●	100	100
	B*			62 Day (urgent GP referral to treatment)	%	85.4 ▼	83.7 ■	85.4 ■	→		85.2 ▼	→			86.7	=>85	=>85	No variation		Any variation	●	86.9	87.1
	B*			62 Day (referral to treat from screening)	%	98.0 ▲	100 ▲	94.7 ▼	→		100 ▲	→			98.1	=>90	=>90	No variation		Any variation	●	98.5	96.9
	A*			62 Day (referral to treat from hosp specialist)	%	97.3 ▼	100 ▲	90.2 ▼	→		95.6 ▲	→			91.9	=>85	=>85	No variation		Any variation	●	91.6	93.2
RB	B*	2	Emergency Care 4-hour waits		%	95.2 ■	95.4 ▲	95.4 ■	92.5 ■	92.5 ▼	92.5 ■	95.4 ■	94.9 ▲	95.1 ■	94.5	=>95	=>95	=>95		<95	●	95.38	92.54
RB	B*	2	Referral To Treatment	Admitted Care (RTT <18 weeks)	%	90.9 ▼	92.4 ▲	90.1 ▼	→		90.0 ▼	→		90.0 ■	90.0*	=>90.0	=>90.0	=>90.0	85-90	<85.0	●	93.2	93.7
	B*			Non-Admitted Care (RTT <18 weeks)	%	96.2 ■	96.9 ▲	97.0 ▲	→		96.5 ▼	→		96.4 ▼	96.4*	=>95.0	=>95.0	=>95.0	90 - 95	=<90.0	●	97.5	98.6
	B*			Incomplete Pathway (RTT <18 weeks)	%	93.8 ■	93.0 ▼	92.9 ▼	→		93.0 ▲	→		92.7 ▼	92.7*	=>92.0	=>92.0	=>95.0	87 - 92	=<87.0	●	97.2	95.3
				Treatment Functions Underperforming	No.	13 ▼	12 ▲	13 ▼	→		16 ▼	→		15 ▲	15*	0	0	0 / month	1 - 6 / month	>6 / month	●	10 (Q4)	11 (Q4)
	A			Waits >52 weeks	No.	36 ▲	12 ▲	3 ▲	→		1 ▲	→		1 ■	1*	0	0	<0		>0	●		
RB	A*	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks	%	0.85 ▼	1.56 ■	1.44 ▲	→		0.89 ■	→		0.75 ▲	0.75*	<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 ■	→		1 ■	12	0	0	3 or less	4 - 6	>6	● ●	1	2
	A	2		No. of second or subsequent urgent operations cancelled	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0	<0		>0	●		0
			Outcome Metrics																				
CO	B*	4	Infection Control	C. Difficile (DH Reportable)	No.	3 ▼	4 ▼	2 ▲	1 ▼	2 ■	3 ▼	2 ▼	0 ▲	2 ▲	39	46	46	No variation		Any variation	●	95	37
	A*			MRSA Bacteraemia	No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	1	0	0	No variation		Any variation	●	2	1
	A			MSSA Bacteraemia (rate per 100,000 bed days)	No.	4.5 ■	9.5 ■	4.4 ■	→		0.0 ▲	→		8.8 ▼	5.7	=<9.02	=<9.02	No variation		Any variation	●		
	A			E Coli Bacteraemia (rate per 100,000 bed days)	No.	35.9 ▼	19.0 ▲	35.1 ▼	→		14.3 ▲	→		26.5 ▼	20.8	=<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	→	→		→	→		8.92	8.92*								
	A			Following an initial Elective Admission	%	→	4.06 Apr'13 - Jun'13	→	→		→	→		4.18 Jul'13 - Sep'13	4.18*								
	A			Following an initial Non-Elective Admission	%	→	13.69	→	→		→	→		13.26	13.26*	10.9	10.9	No variation		Any variation	● ●		
RS		3	Mortality Reviews within 42 working days		%	87 ▲	87 ■	83 ▼	→			→			83*	80	80	No variation		Any variation	●	66.9	
RS	A	6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate	HSMR	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	→		92.1 Jan'13 to Dec '13	92.1	100	100	No variation		Any variation	●	88.9	90.5
				Peer (SHA) HSMR	HSMR	101.4	100.9	101.5	→		100.5	→		98.8	98.8								
				Peer (National) HSMR - Quarterly	HSMR	→	96.4	→	→		→	→		93.5	93.5								
	A	19		SHMI	SHMI	98.1 Sep'12-Aug'13	97.8 Oct'12-Sep'13	99.2 Nov'12-Oct'13	→		100.1 Dec'12 - Nov'13	→			100.1	100	100	No variation		Any variation	●	96.8	95.9
RS	A	12	Obstetrics	Caesarean Section Rate - Elective and Non-Elective	%	25.2 ■	20.6 ■	27.7 ■	→		24.7 ■	→		22.9 ▲	24.9	<25.0	<25.0	=<25.0	25-28	>28.0	●	22.2	23.6
	A			Caesarean Section Rate - Elective	%	10.3	11.0	11.5	→		11.2	→		10.1	11.0								
	A			Caesarean Section Rate - Non-Elective	%	14.9	9.6	16.2	→		13.5	→		12.8	13.9								
	A			Maternal Deaths	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0	No variation		Any variation	●		
CO	A*	8	Patient Safety Thermometer - Harm Free Care		%	93.7 ▼	94.5 ▲	94.0 ▼	→		94.8 ▲	→		94.4 ▼	94.4*	=>92	=>92	=>92		<92	●		

Exec Lead	KPI Source	Data Source	Category / Indicator				November	December	January	February			March			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.	6 ▲	7 ▼	6 ▲	→		1 ▲	→		4 ▼	4*	0	0	No variation		Any variation	●		2
KD	A		Never Events - in month			No.	2 →	0 →	1 →	→		0 →	→		0 →	5	0	0	No variation		Any variation	●		2
KD	A		Open Central Alert System (CAS) Alerts			No.	6 ▲	9 ▼	9 →	→		8 ▲	→		11 ▼	11*	0	0	No variation		Any variation	●		10
RS	A*	3	VTE Risk Assessment			%	94.2 →	95.5 →	97.6 ▲	→		98.6 ▲	→		98.7 ▲	98.7*	95	95	=>90		<90	●	92.4	90.8
RS	A	3	WHO Safer Surgery Checklist	Audit - 3 sections (% pts where all sections complete)		%	99.7 ▲	99.8 ▲	99.8 →	→		99.4 ▼	→		99.9 ▲	99.9*	100	100	=>98		<98	●		
RS		3		Audit - 3 sections and brief (% lists where complete)		%	94.5 ▲	97.2 →	90.2 →	→		89.4 ▼	→		99.0 →	99.0*	100	100	=>95		<95	●		
		3		Audit - 3 sections, brief and debrief (? Lists where complete)		%	85.9 →	86.1 →	74.4 →	→		82.1 ▲	→		97.5 →	97.5*	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		%	0.07 ▲	0.03 ▲	0.05 ▼	→		0.08 ▼	→		0.16 ▼	0.08	0.0	0.0	0.00		>0.00	●		
RB	A*	2		Numerical		No.	9 ▲	4 ▲	6 ▼	→		10 ▼	→		21 ▼	124	0	0	0		>0	●		
				Chargeable Days		No.	17 ▲	7 ▲	10 ▼	→		22 ▼	→		36 ▼	200	0	0	0		>0	●		
CO	B	8	Patient Satisfaction (Friends & Family)	Response Rate	Inpatient Wards	%	31.4	29.0	31.0	→		33.5	→		36.2	36.2*								
CO	B				Emergency Care Department	%	17.1	15.0	15.0	→		15.6	→		15.1	15.1*								
CO	B*				IP Wards plus Emergency Care Department	%	21.0	19.0	19.0	→		20.4	→		20.3	20.3*								
CO	B			Score	Inpatient Wards	No.	70	73	71	→		75	→		73	73*								
CO	B				Emergency Care Department	No.	47	44	47	→		48	→		48	48*								
CO	B*				IP Wards plus Emergency Care Department	No.	56	57	57	→		60	→		60	60*								
RB	B	7	Sickness Absence	Long Term (> 28 days)		%	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)		%	1.56 ▼	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		%	4.23 ▲	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. (%)	5975 (79.9) ▲	6193 (82.7) ▲	6337 (84.8) ▲	→		6639 (88.6) ■	→		7188 (96.7) ▲	7188 (96.7)	7490 (100)	7490 (100)	0-15% variation	15 - 25% variation	>25% variation	●	5348	5127
RS	A	14		Medical Appraisal and Revalidation		%	87 ■	89 ▲	91 ▲	→		94 ▲	→		97 ▲	97*	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 ■	10.87 ■	11.00 ■	→		11.14 ▼	→			11.14	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)

MARCH 2014	CQUINs

Exec Lead	KPI Source	Data Source	Indicator				November	December	January	February			March			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	%	94.2 ■	95.5 ■	97.6 ▲	→		98.6 ▲	→		98.7 ▲	98.7*	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	%	1 ▲	3 ▼	4 ▼	→		5 ▼	→			70	10% reduction on aggregate 6-month base (Oct 2012 - March 2013) of 81 (68 Acute + 13 Comm)					●		
CO	D				224	%	1 ■	0 ▲	3 ■	→		2 ▼	→			9						●		
CO	D	8	Dementia	Find, Investigate and Refer	269	%	1 of 3 met	3 of 3 met	3 of 3 met	→		3 of 3 met	→		2 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	Survey Undertaken	Monthly Audit		No variation		Any variation	●		
CO	D	8	Friends & Family Test	Phased Data Collection Expansion - Maternity	137	%	12.30	7.00	8.00	→		16.40	→		9.30	9.30	65	65				● ●		
CO	D			Increased Response Rate (Emergency Care plus All Wards)	175	%	21.0	19.0	19.0	→		20.4	→		20.3	20.3	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 ■	→	→		→	→		81 ▲	81	90	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	On Trajectory	Off Trajectory	→		On Trajectory	→		Achieved	Achieved	Improvement Trajectory agreed		No variation		Any variation	●		
RS	D	4	Use of Sepsis Care Bundles		1105	%	Base identified	→	Off Trajectory			→				Off Trajectory	5% improvement trajectory		No variation		Any variation	●		
CO	D	11	Community Risk Assessment & Advice		1105	%	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	Compliant	Compliance		No variation		Any variation	●		
RS	D	22		Behcets Highly Specialised Service	60		→	On Track	→	→		→	→		On Track	Compliant	Compliance		No variation		Any variation	●		
RS	D	12		HIV - Communication with GPs	180		→	Compliant	→	→		→	→		Compliant	Compliant	Compliance		No variation		Any variation	●		
RS	D	12		Neonatal - Retinopathy Of Prematurity (Screening)	180		→	Compliant	→	→		→	→		Compliant	Compliant	Compliance		No variation		Any variation	●		

Exec Lead	KPI Source	Data Source	Indicator				November	December	January	February		March		To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
							Trust	Trust	Trust	S'well	City	S'well	City		YTD	13/14						
RS	D	3	Stroke Care	Pts spending >90% stay on Acute Stroke Unit		%	92.3 ▲	88.5 ▼	88.5 ■	→		→		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		%	69.2 ▲	80.8 ▲	77.8 ▼	→		→		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		%	100.0 ■	97.9 ■	100.0 ■	→		→		95.8	100	100	No Variation	0 - 2% Variation	>2% Variation	●	100	92
	D			Pts receiving CT Scan within 1 hr of presentation		%	73.1 ▲	78.7 ▲	77.8 ▼	→		→		71.9	50	50	No Variation	0 - 2% Variation	>2% Variation	●	37.5	52.0
	D			Admission to Thrombolysis Time (% within 60 mins)		%	50.0 ▲	50.0 ■	66.7 ▲	→		→		51.2	85	85	=>85		<85	● ● ●		
	D			Admission to Thrombolysis Time (% over 90 mins)		%	50.0 ▲	0.0 ■	0.0 ■	→		→		20.9	0	0	0		>0	● ●		
	D			Stroke Admissions - Swallowing assessments (<24h)		%	100.0 ■	100.0 ■	100.0 ■	→		→		98.6	100	100	=>98		<98	●		
	D			TIA (High Risk) Treatment <24 h from initial presentation		%	56.3 ■	70.0 ■	72.2 ▲	→		→		70.9	60	60	No Variation	0 - 2% Variation	>2% Variation	●	53.2	69.8
	D			TIA (Low Risk) Treatment <7 days from initial presentation		%	84.9 ▲	100.0 ▲	78.6 ▼	→		→		84.5	60	60	No Variation	0 - 2% Variation	>2% Variation	●	30.4	75.9
RB		3	Infection Control	MRSA Screening - Elective	Patient Not Matched	%	227 ▼	221 ▼	302 ▲	Numerator = 3587	Denominator = 1164	308 ▲	Numerator = 3846	Denominator = 1181	326 ▲	326*	90	90	No variation		Any variation	●		138.9
					Best Practice - Patient Matched	%	73 ■	88 ■	87 ▼	Numerator = 1042	Denominator = 1164	90 ▲	Numerator = 1086	Denominator = 1181	92 ▲	92*	80	80	No variation		Any variation	●		59.5
				MRSA Screening - Non Elective	Patient Not Matched	%	92 ▲	89 ▼	90 ▲	Numerator = 2213	Denominator = 2405	92 ▲	Numerator = 2299	Denominator =2527	91 ▼	91*	90	90	No variation		Any variation	●		76.8
					Best Practice - Patient Matched	%	92 ▲	93 ▲	94 ▲	Numerator = 2213	Denominator = 2354	94 ■	Numerator = 2299	Denominator = 2440	94 ■	94*	80	80	No variation		Any variation	●		64.9
CO		14	Falls Requiring Serious Incident Investigation			No	2 ▲	4 ▼	2 ▲	→		1 ▲	→		2 ▼	29	0	0	No variation		Any variation	● ●		22
CO		8	Grade 3 or 4 pressure ulcers - avoidable			No	0 ■	1 ■	2 ▼	→		1 ▲	→		1 ■	11	0	0	No variation		Any variation	●		
CO		8	High Impact Nursing Actions	Inpatient Falls reduction	Acute	No	30 ■	47 ▼	63 ▼	→		50 ▲	→		38 ▲	607	605	660	=<55/m		>55/m	●		737
CO					Community	No	15 ■	6 ■	9 ▼	→		8 ▲	→		1 ▲	119	132	144	=<12/m		>12/m	●		
RS		3	Obstetrics	Post Partum Haemorrhage (>2000 ml)		No.	1 ▼	0 ■	0 ■	→		0 ■	→		0 ■	3	48	48	=<2	3 - 4	>4	●	7	10
				Admissions to Neonatal ICU		%	12.4 ▼	8.3 ■	11.6 ■	→		12.3 ■	→			10.4	=<10	=<10	=<10	10.0-12.0	>12.0	●	10.7	10.2
				Adjusted Perinatal Mortality Rate (per 1000 babies)		/1000	16.3 ▼	2.2 ■	0.0 ▲	→		6.8 ▼	→			6.8*	<8.0	<8.0	<8	8.0 - 10.0	>10	●	11.9*	4.5
	D			Early Booking (Completed Assessment <12+6 weeks)	National Definition	%	158.0 ▼	152.0 ▼	152.0 ■	→		145.0 ▼	→			145.0*	=>90	=>90	=>90	75-89	<75	●	76.0	78.0
	D				SWBH Early Booking (Bookings > Births)	%	83.5 ▲	84.5 ▲	79.0 ▼	→		81.0 ▲	→			81.0*	=>90	=>90	=>90	75-89	<75	● ●	76.0	78.0
CO		2	Infant Health & Inequalities	Maternal Smoking Rates		%	→	8.12 ▼	→	→		→	→		10.4 ▼	8.9	<11.5	<11.5	<11.5	11.5 - 12.5	>12.5	●	9.8	9.9
CO				Breast Feeding Initiation Rates		%	→	76.4 ▼	→	→		→	→		75.4 ▼	76.2	>63.0	>63.0	>63.0	61-63	<61.0	●	73.0	72.6
RB		3	Hip Fractures	Operation <24 hours of admission		%	70.6 ■	75.0 ▲	66.7 ▼	→		80.0 ▲	→		60.0 ▼	70.3	85.0	85.0	No Variation	0 - 2% Variation	>2% Variation	●	66.4	76.7
RB	D	3	Data Quality	Valid Coding for Ethnic Category (FCEs)		%	92 ▼	92 ■	92 ■	→		93 ▲	→		92 ▼	93	90	90	>/=90	89.0-89.9	<89	●	95	93
		3		Maternity HES		%	9.2 ▼	7.2 ▲	8.5 ▼	→		6.9 ▲	→		7.0 ▼	7.2	<15	<15	=<15	16-30	>30	●	6.0	6.6
	D	3	Emergency Care Timeliness	Total Time in Department (95th centile)		h : m	4:46 ▲	4:48 ▼	4:38 ▲	→		5:35 ▼	→		4:43 ▲	5:03	=<4hrs	=<4hrs	=<4hrs		=<4hrs	● ●	3 : 59	5 : 15
	D			Time to Initial Assessment (=<15 mins)(95th centile)		mins	17 ▲	17 ■	17 ■	→		18 ▼	→		17 ▲	17	=<15	=<15	<15		<15	●	21	17
	D			Time to treatment in department (median)		mins	43 ▲	42 ▲	45 ▼	→		52 ▼	→		54 ▼	47	=<60	=<60	=<60		>60	●	59	58
	D		Emergency Care Patient Impact	Unplanned re-attendance rate		%	6.09 ▲	6.37 ▼	5.74 ▲	→		5.92 ▼	→		5.19 ▲	6.48	=<5.0	=<5.0	=<5.0		>5.0	● ●	8.66	7.81
	D			Left Department without being seen rate		%	2.96 ▲	3.16 ▼	2.73 ▲	→		3.76 ▼	→		3.78 ▼	3.59	=<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 ■	1	0	0	0		>0	●		
RB	D	18	Ambulance Turnaround	Clinical Handovers recorded		%	89.7 ▲	89.2 ▼	89.7 ▲	90.5 ▲	90.2 ▲	90.3 ▲	86.4 ▼	89.9 ▼	88.5 ▼	88.5*	=>85	=>85	=>85		<85	●		71.3
	D			Average Turnaround Time		m : s	26:59 ▲	27:19 ▼	26:59 ▲	28:28 ▼	27:19 ▲	27:50 ▼	27:29 ▲	28:09 ▼	27:46 ▲	27:46*	=<30:00	=<30:00	=<30:00		>30:00	●	29:23	34:24
	D			30 - 60 minutes	All Journeys	No.	1253 ▲	1385 ▼	1242 ▲	523 ▼	767 ▼	1290 ▼	584 ▼	905 ▼	1489 ▼	16274	0	0	0		0	● ● ●		22089
	D				Hospital Fines (WMAS report)	No.	122 ▲	159 ▼	127 ▲	68 ▼	96 ▼	164 ▼	101 ▼	70 ▲	171 ▼	2815	0	0	0		0	● ● ●		
	D			In Excess of 60 minutes	All Journeys	No.	5 ▲	18 ▼	7 ▲	12 ▼	23 ▼	35 ▼	6 ▲	10 ▲	16 ▲	427	0	0	0		0	● ● ●	1256	2354
	D				Hospital Fines (WMAS report)	No.	2 ▲	10 ▼	1 ▲	4 ■	10 ▼	14 ▼	5 ▼	4 ▲	9 ▲	237	0	0	0		0	● ● ●		

MARCH 2014	PATIENT EXPERIENCE

Exec Lead	KPI Source	Data Source	Indicator				November	December	January	February		March		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	%		100 ▲	99 ▼	100 ▲	→		100 ■	→		90 ▼	90*	90	90	No variation		Any variation	●		99
				Ultrasound	%		100 ■	100 ■	100 ■	→		100 ■	→		99 ▼	99*	90	90	No variation		Any variation	●		100
				MRI	%		93 ▼	81 ■	77 ▼	→		93 ■	→		72 ■	72*	90	90	No variation		Any variation	●		84
				CT	%		100 ▲	99 ▼	99 ■	→		100 ▲	→		97 ▼	97*	90	90	No variation		Any variation	●		99
KD	D	14	Complaints	No. of Complaints Received formal and link)	No.		82	65	75	→		65	→		95	948	No. Only	No. Only					834	724
				No. of Active Complaints in the System (formal and link)	No.		201	190	188	→		188	→		210	210*	No. Only	No. Only						
				No. of First Formal Complaints received / 1000 episodes of care	No.		0.45	0.40	0.46	→		0.43	→		0.73	0.73*	No. Only	No. Only						
				No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	%		99 ▲	98 ▼	97 ▼	→		95 ▼	→		99 ▲	99*	100	100	100		<100	●		
				No. of responses which have exceeded their original agreed response date (% of total active complaints)	%		29 ▲	20 ▲	35 ▼	→		53 ▼	→		41 ▲	41*	0	0	0		>0	● ●		
				No. of responses sent out	No.		59	79	81	→		58	→		67	67*	No. Only	No. Only						
				Oldest' complaint currently in system	Days		174	91	112	→		118	→		127	127*	No. Only	No. Only						
RB		15	Elective Access Contact Centre	Number of Calls Received	No.		12590	10032	13318	→		12338	→		13534	150110	No. Only	No. Only					111793	150454
				Average Length of Queue	mins		0.24 ▲	0.20 ▲	0.25 ▼	→		0.35 ▼	→		0.30 ▲	0.30*	<1.0	<1.0	<1.0	1.0-2.0	>2.0	●	0.21	0.25
				Maximum Length of Queue	mins		7.2 ■	8.3 ▼	12.3 ■	→		12.4 ▼	→		9.0 ■	9.0*	<6.0	<6.0	<6.0	6.0-12.0	>12.0	●	10.1	14.2
			Telephone Exchange	Number of Calls Received	No.		73295	71451	80266	→		65814	→		69708	862361	No. Only	No. Only					849502	901987
				Calls Answered	%		91.2	89.4	90.8	→		92.6	→		92.5	91.1	No. Only	No. Only					90.2	90.7
				Answered within 15 seconds	%		70.2	57.4	60.9	→		77.6	→		76.1	69.1	No. Only	No. Only					52.5	58.2
				Answered within 30 seconds	%		82.6	72.6	75.5	→		88.0	→		87.3	81.1	No. Only	No. Only					68.1	73.0
				Average Ring Time	Secs		14.1	22.0	19.7	→		10.4	→		11.2	11.2*	No. Only	No. Only					25	18
				Longest Ring Time	Secs		476	526	492	→		523	→		533	533*	No. Only	No. Only					718	349
RB		2	Patient Flow	Average Length of Stay	Days		3.8 ▼	3.8 ■	3.7 ▲	4.2 ▼	3.1 ▲	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)	%		94.1 ▼	95.9 ▲	96.3 ▲	96.3 ▼	92.0 ▼	93.5 ▼	96.7 ▲	95.8 ▲	96.2 ▲	94.5	82.0	82.0	No Variation	0 - 5% Variation	>5% Variation	●	89.5	92.0
				Daycase Rate - All Procedures	%		81.8 ▼	83.1 ▲	84.3 ▲	83.3 ▼	83.2 ▼	83.2 ▼	82.0 ▼	84.2 ▲	83.4 ▲	84.5	80.0	80.0	No Variation	0 - 5% Variation	>5% Variation	●	82.7	83.9
				Available Beds at Month End	No.		774	770	783	→		814	→		796	796*								
RB		2	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%		1.3 ■	1.4 ▼	1.7 ▼	2.3 ▼	1.1 ▲	1.6 ▲	1.2 ▲	1.0 ■	1.1 ▲	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 ■	→		1 ■	12	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 ■	60 ▲	84 ▼	35 ▼	31 ▲	66 ▲	25 ▲	31 ■	56 ▲	648	320	320	0-5% variation	5 - 15% variation	>15% variation	● ●	363	425
				Sitrep Declared Late Cancellations (Pts. >1 occasion)	No.		5 ▲	7 ▼	13 ▼	6 ▲	7 ▼	13 ■	0 ■	0 ■	0 ■	0*	0	0	No variation		Any variation	●		60
				Multiple Cancellations experienced by same patient (all cancellations)	%		13.3 ▼	13.3 ■	12.7 ▲	→		13.4 ▼	→		10.5 ▲	10.5*	0.0	0.0	No variation		Any variation	● ●		13.6
				All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	%		5.5 ▲	5.4 ▲	7.9 ▼	→		6.3 ▲	→		5.5 ▲	5.5*	3.1	3.1	No variation		Any variation	●		6.2
RB		10	Cardiology	Primary Angioplasty – Door To Balloon Time (90 mins)	%		75.0 (S) ▼			→			→			85.6	=>80	=>80	=>80	75-79	<75	●	80.1	85.4
				Primary Angioplasty – Call To Balloon Time (150 mins)	%		85.7 (S) ▼			→			→			92.5	=>80	=>80	=>80	75-79	<75	●	88.4	91.2
				Rapid Access Chest Pain	%		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

Exec Lead	KPI Source	Data Source	Indicator			November	December	January	February		March		To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	S'well	City	Trust	YTD	13/14						
MS	D	7	Staff in Post	Establishment	wte	7252	7204	7152	→		→		7184							7184*		
				Staff In Post (contracted)	wte	6626	6632	6612	→		→		6617							6617*		
				Staff In Post (headcount)	no.	7610	7617	7589	→		→		7597							7597*		
				Staff In Post - FTE / Headcount ratio	Ratio	1.15	1.15	1.15	→		→		1.15							1.15*		
				Variance (Establishment - Staff In Post)	wte	626	572	540	→		→		567							567*		
				Qualified Nursing Variance (FIMS)	wte	199	211	163	→		→		162							162*		
				Posts Advertised in Month (NHS Jobs)	wte	146	139	91	→		→		92							91*		
			Induction		%	95 ▼	98 ▲	91 ▼	→		→									91*		91.3
RB	D	7	Learning & Development	PDRs (12-month rolling)	No. (%)	5975 (79.9) ▲	6193 (82.7) ▲	6337 (84.8) ▲	→		→		6639 (88.6) ■							7188 (96.7)	5348	5127
RS		14		Medical Appraisal and Revalidation	%	87 ■	89 ▲	91 ▲	→		→		94 ▲							97*		77
MS		3		Mandatory Training Compliance	%	86.6 ▲	86.6 ■	86.3 ▼	→		→		87.2 ▲							86.6	71.9	86.4
RB		7	Sickness Absence	Long Term (> 28 days)	%	2.67 ▲	2.62 ▲	2.52 ▲	→		→		2.81 ▼							2.70	2.95	3.39
				Short Term (<28 days)	%	1.56 ▼	1.47 ▲	1.94 ▼	→		→		1.70 ▲							1.60	0.95	0.99
	D			Total	%	4.23 ▲	4.10 ▲	4.46 ▼	→		→		4.51 ▼							4.31	3.90	4.38
RB		17	Bank & Agency Use	Nurse Bank Fill Rate	%	76.0	71.2	73..0	→		→		74.6							75.1	87.2	82.9
				Nurse Bank Shifts covered	No.	5193 ▲	4360 ▲	4931 ▼	→		→		5304 ▼							60920	56396	60463
				Nurse Agency Shifts covered	No.	2656 ▼	2651 ▲	3174 ▼	→		→		3360 ▼							31039	6948	12874

MARCH 2014	ACTIVITY & CONTRACTUAL

Exec Lead	KPI Source	Data Source	Indicator			November	December	January	February		March		To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	S'well	City	Trust	YTD	13/14						
RB		2	Spells	Elective IP	No.	802 ▲	648 ▼	725 ▼	→		→		684 ▲	665 ▼	8561	10141	10141	No Variation	0 - 2% Variation	>2% Variation		10610	9596
				Elective DC	No.	4141 ▼	3645 ▲	4356 ▲	→		→		3831 ▼	4094 ▲	50071	40198	40198	No Variation	0 - 2% Variation	>2% Variation		53685	52875
				Total Elective	No.	4943 ▼	4293 ▲	5081 ▲	→		→		4515 ▼	4759 ▲	58632	50339	50339	No Variation	0 - 2% Variation	>2% Variation	●	64295	62471
				Total Non-Elective	No.	4562 ▼	4642 ▼	4738 ▼	→		→		4306 ▲	4797 ▲	54715	60931	60931	No Variation	0 - 2% Variation	>2% Variation	●	55675	56982
			Outpatient Attendances	New	No.	14642 ▼	12949 ▲	15327 ▲	→		→		13610 ▲	14996 ▼	174898	152466	152466	No Variation	0 - 2% Variation	>2% Variation	●	159051	171540
				Review	No.	30360 ▼	27239 ▲	33655 ▼	→		→		30131 ▲	32514 ■	389497	410406	410406	No Variation	0 - 2% Variation	>2% Variation	●	421494	382248
			Emergency Care Attendances	Type I (Sandwell & City Main Units)	No.	11760 ▲	11886 ▲	12502 ▲	5430 ▲	6392 ▲	6156 ▼	7556 ▲	11822 ▲	13712 ▲	148856	184483	184483	No Variation	0 - 2% Variation	>2% Variation	● ●	177201	171701
				Type II (BMEC)	No.	1847 ▲	1778 ▼	1882 ▲	→	1759 ▼	→	2038 ▲	1759 ▼	2038 ▲	22922	28304	28304	No Variation	0 - 2% Variation	>2% Variation	● ●	36362	26649
				All - Contracted plus Non-Contracted	No.	19080 ▲	19514 ▲	19838 ▲	7791 ▲	10850 ▲	8941 ▲	12960 ▲	18641 ▲	21901 ▲	239761	207126	207128						207128
		16	Community	Adult - Aggregation of 18 Individual Service Lines	No.	46207 ■	40222 ▼	46825 ▼	→		→		42542 ■		504497	497249	540982	No Variation	0 - 2% Variation	>2% Variation	●	493163	538147
				Children - Aggregation of 4 Individual Service Lines	No.	17407 ▲	13173 ▼	18181 ▲	→		→		15441 ▼		170556	152327	165757	No Variation	0 - 2% Variation	>2% Variation	●	143400	155412
			Contract	Improvement Notices	No.	0 ■	0 ■	0 ■	→		→		0 ■	0 ■	0*	0	0				●		
RB	D	2	Delayed Transfers of Care	Acute	%	2.6 ■	3.2 ▼	3.2 ■	2.8 ■	3.0 ■	2.2 ▲	3.1 ▼	2.9 ▲	2.6 ▼	3.1	<3.5	<3.5	<3.5	3.5 - 5.0	>5.0	●	5.2	2.9
				Pt's Social Care Delay	No.	10 ▼	8 ▲	7 ▼	2 ▲	2 ▲	3 ▼	10 ■	4 ▲	13 ▼	13*	<18	<18	No Variation	0 - 10% Variation	>10% Variation		13	7
				Pt.'s NHS & NHS plus S.C. Delay	No.	9 ■	10 ■	13 ■	3 ■	0 ■	7 ■	4 ▼	3 ■	11 ■	11*	<10	<10	No Variation	0 - 10% Variation	>10% Variation		20	8
RB		2	Outpatient Efficiency	New : Review Rate	Ratio	2.07 ▼	2.10 ▼	2.20 ▼	2.33 ■	2.16 ▲	2.23 ■	2.14 ▲	2.21 ▼	2.17 ▲	2.23	2.30	2.30	No Variation	0 - 5% Variation	>5% Variation	●	2.65	2.23
				DNA Rate - New Referrals	%	12.2 ▲	12.7 ▼	12.5 ▲	→		→		11.6 ▲	10.8 ▲	11.4	10.0	10.0	No variation		Any variation	● ●	11.8	11.3
				DNA Rate - Reviews	%	12.5 ▲	13.5 ▼	12.4 ▲	→		→		12.6 ▼	12.4 ▲	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)

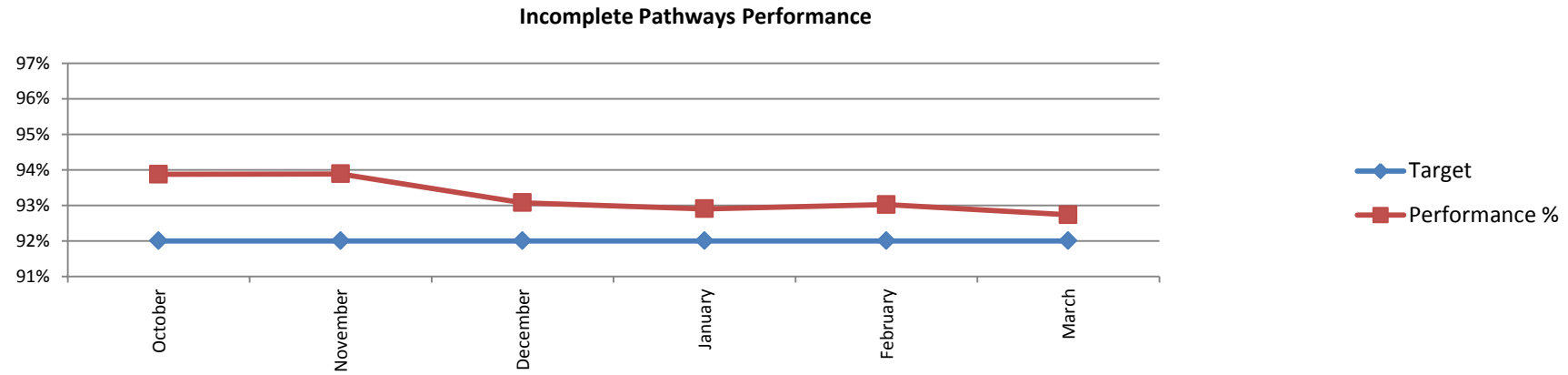
FORWARD PROJECTION ASSESSMENT	
●	Maintain (at least), existing performance to meet target
●	**Improvement** in performance required to meet target
● ●	**Moderate Improvement** in performance required to meet target
● ● ●	**Significant Improvement** in performance required to meet target
XXX	**Target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

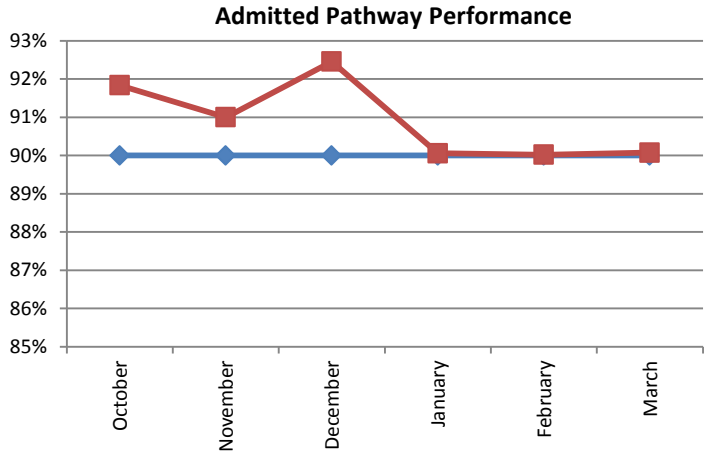
PERFORMANCE ASSESSMENT SYMBOLS	
▲	Fully Met - Performance continues to improve
■	Fully Met - Performance Maintained
▼	Met, but performance has deteriorated
▲	Not quite met - performance has improved
■	Not quite met
▼	Not quite met - performance has deteriorated
▲	Not met - performance has improved
■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

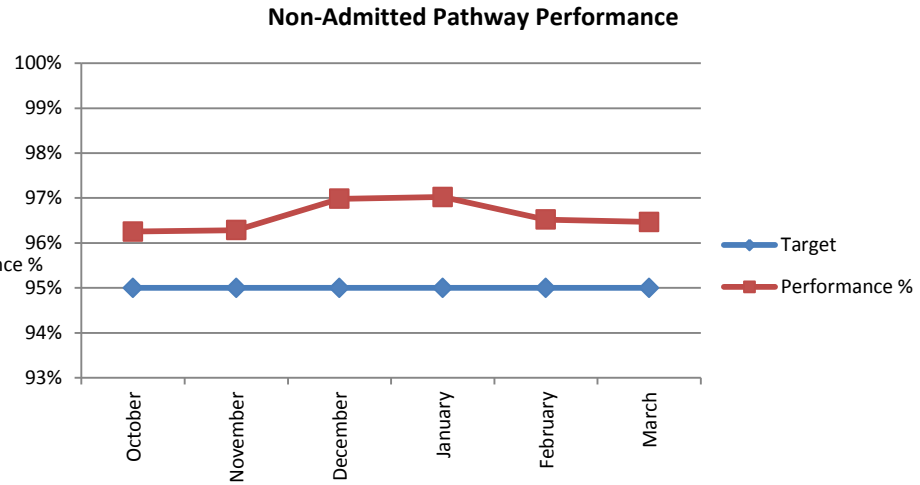
18week referral to treatment plan

Rachel Barlow
Chief Operating Officer

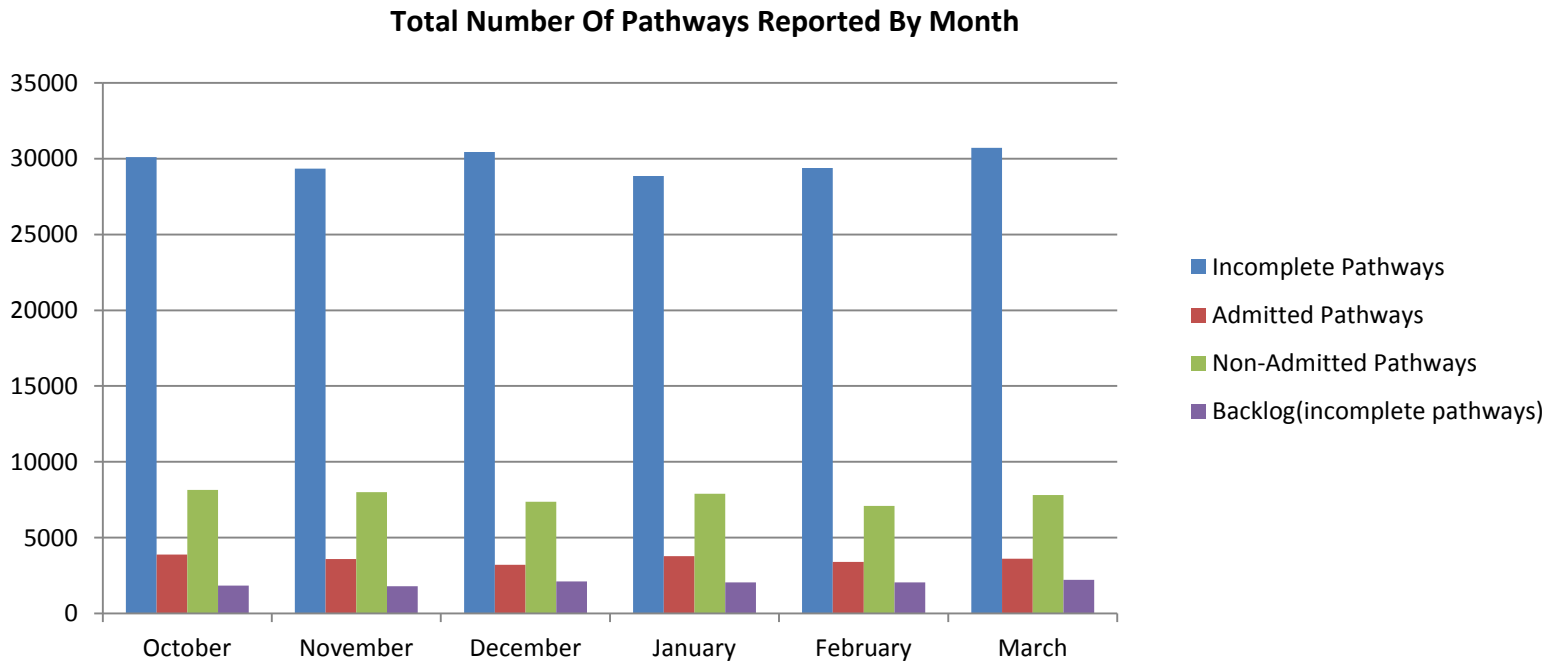
Performance: At Trust level we have maintained compliance with treating patients within 18 weeks







The waiting list has remained in the region of 30000 patients waiting for treatment.

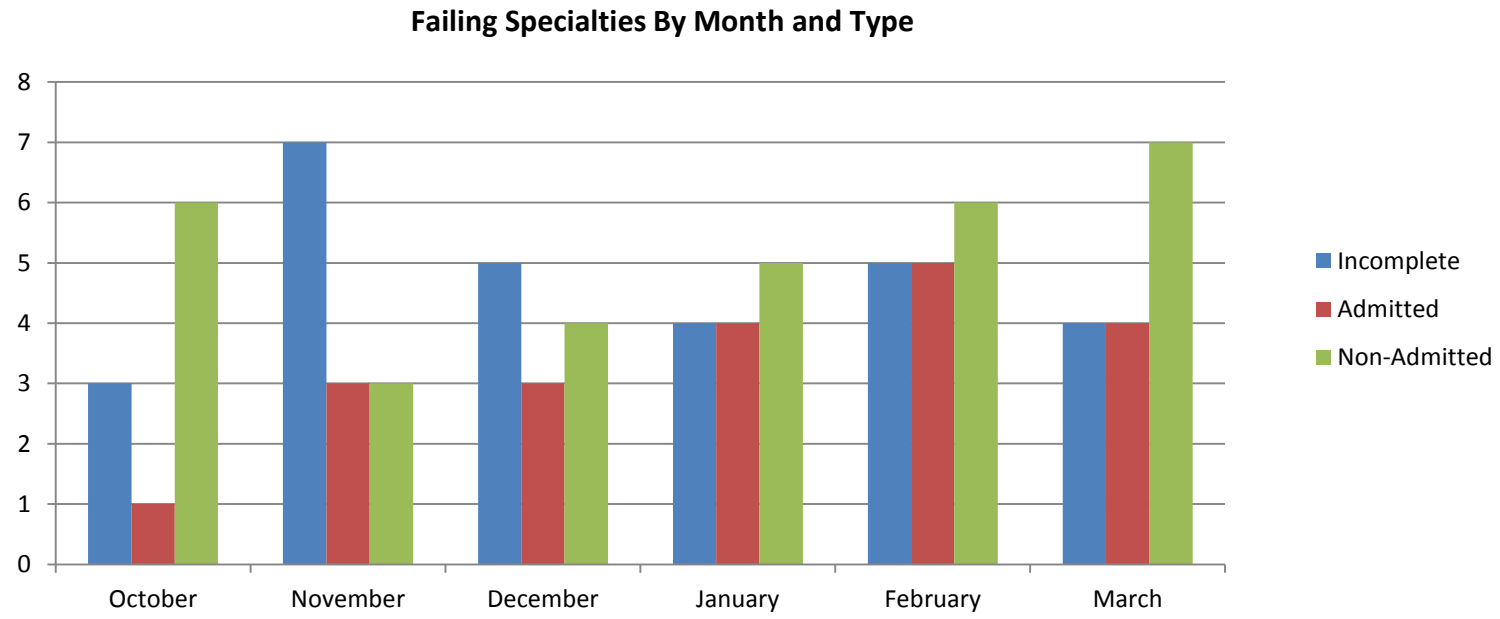


	October	November	December	January	February	March
Incomplete Pathways	30089	29333	30443	28844	29378	30709
Admitted Pathways	3882	3591	3220	3791	3396	3606
Non-Admitted Pathways	8142	8005	7362	7891	7099	7809
Backlog(incomplete pathways)	1843	1794	2109	2047	2051	2231

We planned to under deliver in some specialties during Q3 and 4 (shaded below); this was to decrease the backlog of patients waiting over 18 weeks

Specialty	Q3	Q4	Q1
Cardiology			
Respiratory			
T&O			
General Surgery			
Urology			
Plastics			
Opthalmology			
ENT			

The numbers of specialty level actually underperforming has been higher then planned. This is due in 50 % of key specialties being ahead of recovery plan and reducing the backlog at a quicker rate than intended. Of the areas with un-forecast under delivery against plan, the Directorates have committed assurance to delivery in Q1. There are 4 specialties planned to underperform in Q1.



Looking ahead in 2014/15 to deliver 18 weeks referral to treatment standards within all specialities

- We have capacity to meet contracted activity in OP and theatres – but dependant on optimising utilisation in some areas

- We have completed an annualised theatre review with resources agreed across the year through annualised scheduling and job planning

- The Year of Out Patients Change Programme starts in May which will provide an improved electronic (e) infrastructure for tracking referral to treatment pathways reducing time of administration and some decision making processes;
    - e- (clinic) outcome
    - e-Decision to Admit (DTA)
    - DOCMAN; a system that enables electronic triage and record keeping
    - Digital dictation

- Area of current underperformance which remain forecast in Q1 as the waiting list size is decreased and the longest of our waiting patients are treated include:
    - Cardiology
    - Orthopaedics
    - Plastics
    - Ophthalmology

During Q1 we will reduce the waiting list size and backlog in the following specialties : Orthopaedics, Cardiology, Plastics and Ophthalmology

Orthopaedics

- Have made good progress on redesign of OP pathways and reduction of waiting times. In patent waiting list will reduce in Q1/2
- Direct access diagnostic pathway in place – but referral trend has not reduced- we will offer a new advice and guidance service to primary care to enable appropriate patients treatment pathways to remain under their GPs and reduce the demand on OP
- Further demand management will be achieved through strengthening the referral triage process; audit with CCG
- The Specialty have a plan to deliver capacity within week and stop reliance on weekend initiatives
- A community enhanced recovery service is intended to decrease LOS, support recovery at home and release bed capacity
- The above initiatives and demand management will reduce the size of the waiting list and the backlog of work will reduce over Q1/2

Cardiology

- Failed to deliver trajectory to date, partly due to failure to recruit locum. New consultants recently recruited. Locum support will enable quicker reduction of the waiting list size.
- The waiting list will undergo a clinical validation to ensure our patients are booked according to clinical need
- Direct access in place – yet to see impact on decrease in referrals.
- There is scope for significant utilisation opportunities for Out Patients and Cardiac Catheter Lab through working differently.
- Intensive support team to be commissioned for this specialty

Across planned care a continuous focus on redesign of leaner patient pathways is key to reducing waiting time, provide a better patient experience and potentially release capacity to treat more patients is important

Earlier diagnostics:

- Direct access diagnostics in cardiology and orthopaedics will decrease demand on outpatients and enable primary care to manage less complex conditions in the community. Those patients with more complex requirements referred to a specialist will have tests before the 1st OPA

- Annualised job plans and resource scheduling - Full PA contribution over an annualised basis

- Agreeing annualised job plans in theatres and schedules of theatres across a year enables improved utilisation of assets and optimisation of clinical time
- Specialities can utilise 'down time ' due to leave across the organisation improving over all utilisation

Following patient up in a different way

- Not all patients need to come to hospital for follow up visits or to receive normal test results. There is service redesign to be completed across a number of specialties to reduce the need for follow up appointments and make capacity to reduce waiting times
- Workforce redesign – developing staff or teams to deliver care thereby increasing capacity

Getting the administration and operational processes right

- Full cashing up of clinic outcomes
- Most paper will become defunct in Q1 /2 as we go electronic with real time view of clinical outcomes
- Grip on waiting list management

Key messages

- Focus on getting the administration and operational processes right every time, through automation and operational grip day to day, week to week
- Utilisation - optimise use of our staff resources and clinical assets
- Full PA contribution over an annualised basis
- Service redesign – decrease demand (New and Review) , direct access, leaner pathways taking less time, and improving the patient experience
- Utilise support to accelerate change: Intensive Support Team and Change Programme – Year of Out Patients
- We have capacity to deliver the contract

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Nurse Staffing
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington, Chief Nurse
AUTHOR:	Colin Ovington, Chief Nurse
DATE OF MEETING:	1 May 2014

EXECUTIVE SUMMARY:

'Hard Truths – the journey to putting patients first', DoH, January 2014 is the Government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry and one of the key actions from their response is to ensure safe staffing and for data about nurse staffing numbers on hospital wards to be was to publish by the end of June 2014 the very latest.

Additionally, Trust Boards will be expected to receive six monthly nurse staffing reports, in order to be assured about the safety of staffing and to be able to ensure that appropriate actions are being taken to resolve risks to patient safety which has resulted from gaps in staffing compliments.

REPORT RECOMMENDATION:

The Board is asked to support the proposal to publish patient to Registered Nurse ratios on our public web site on a monthly basis

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		x

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

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

Comments:

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

High Quality Care and Good Use of Resources.

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

SWBTB (5/14) 064 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAFE STAFFING

Report to Trust Board on 1st May 2014

1 EXECUTIVE SUMMARY

1.1 Hard Truths – the journey to putting patients first. DoH, January 2014 is the Government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry.

1.2 One of the key actions from their response is to ensure safe staffing and for data about nurse staffing numbers on hospital wards to be was to publish by the end of June 2014 the very latest.

1.4 Trust Boards will be expected to receive six monthly nurse staffing reports, in order to be assured about the safety of staffing and to be able to ensure that appropriate actions are being taken to resolve risks to patient safety which has resulted from gaps in staffing compliments.

2 NURSE STAFFING AT SANDWELL & WEST BIRMINGHAM HOSPITALS TRUST

2.1 Hard Truths does not give any recommendation about methodology for calculating safe staffing numbers or ratios but does indicate that the National Institute for Health and Care Excellence will produce guidance by the summer of 2014. Additional work will then be produced to give similar guidance for non-acute settings which include community services.

2.2 Nurse staffing has been calculated on a monthly basis for a number of years using Bed Ratio Acuity Dependency (BRAD) methodology. There is no inter-rater reliability test on this methodology and is subject to wide variation in the results for individual wards.

2.3 A review of ward nursing establishments has been undertaken by the Chief Nurse, using accepted norms and professional judgement alongside the BRAD methodology.

2.4 The ward establishment of registered nurses (RN) and health care assistants (HCA) are deployed using an e-rostering system; gaps in rosters are filled by staff working additional hours or by using temporary staff from our internal nurse bank or via external commercial agencies.

2.5 Senior nurses have been publishing their deployment of staff and the ratio of patients to RN's per shift every day of the week since February 2014. The standard that we aspire to is to be better than eight patients to an RN.

2.6 Overall the balance of patients to RNs per shift on the planned rosters for each of the Groups is as follows

Table 1.

Group	Early	Afternoon	Night
Medicine & Emergency care	5	5	8
Surgery A	5	6	12
Surgery B	5	5	5

These figures are masked by specialist units and assessment units who have out of clinical necessity slightly higher numbers of RN's. Two areas of concern exist for the Trust one is specific to Priory 5 and the other relates to night shift rota's.

2.7 Priory 5

This ward currently can only achieve a patient to RN ratio of 9 in the morning, 9 in the afternoon and 11 at night. The Group have been requested to balance the deployment of staff across their wards to ensure that this ward is brought into the required parameters.

2.8 Night Shift Patterns

The trust has a fairly traditional pattern of night shifts in common with most other trusts. This tradition means that there are fewer RN's on duty, primarily because most patients will be asleep, fewer investigations can take place and routine parts of the organisation are closed down during the evening until the following morning. This pattern of working has been changing over a number of years and staffing deployment has not always kept pace with this change although to a large extent there is still a similar closing down of non-urgent services out of hours. The real change that has occurred is the increase in acuity and dependency of individual patients and this has impacted on the requirement for additional staff resource e.g. to supervise patients who are at risk of falling. The ratio numbers in table 1 do not take account of this variable.

3 CURRENT ISSUES

3.1 Turnover of nurses within the first two years of becoming registered is 40%

3.2 Vacancy rates across the trust are 11%

3.3 Rotational posts are being put into place to help address retention issues, these are attractive and allow new registrants to consolidate and gain experience in a number of wards or departments.

3.4 Single interview process for newly qualified nurses to gain employment within the trust to replace multiple interviews until they are successful

4 RECOMMENDATION(S)

4.1 To publish patient to RN ratio's on our public web site on a monthly basis.

4.2 To receive a nurse staffing report six monthly.

Colin Ovington

Chief Nurse

24th April 2014

APPENDICES:

Appendix 1 – Current ward establishments and ratios

Appendix 1 – Current ward establishments and ratios

Medicine & Emergency care

Ward	site	No. Beds	budget establishment includes 22% uplift	RN WTE	HCSW WTE	Percentage RN's on the funded establishment	Morning shift RN's expected	Afternoon/Evening shift RN's expected	Night shift RN's expected	Morning HCSW expected	Afternoon/Evening HCSW expected	Night Shift HCSW expected	Ratio of patients per RNs early shift	Ratio of patients per RN's afternoon/ evening	Ratio of patients per RN's night shift
D11 (moved from D18)	City	21	26.18	15.87	10.30	60.6	4	3	2	2	2	2	5	7	11
D12	City	10	16.53	11.38	5.15	68.8	2	2	2	1	1	1	5	5	5
D15	City	24	26.88	16.58	10.30	61.7	3	3	2	2	2	2	8	8	12
D16	City	23	27.87	17.57	10.30	63.0	4	4	2	2	2	2	6	6	12
D17	City	25	29.56	18.47	11.09	62.5	5	4	2	2	3	2	5	6	13
D26 (moved from D7)	City	21	26.18	15.87	10.30	60.6	4	3	2	2	2	2	5	7	11
AMU 1	City	41	73.71	52.95	20.76	71.8	11	11	10	4	4	4	4	4	4
AMU 2 (D41)	City	19	29.69	24.38	5.31	82.1	6	6	4	1	1	1	3	3	5
D43 (MFFD)	City	24	29.64	15.08	14.56	50.9	4	3	2	4	3	2	6	8	12
CCU Sandwell	Sandwell	10	18.33	15.76	2.58	86.0	3	3	2	0	0	1	3	3	5
P3 (ARU)	Sandwell	29	30.45	18.47	11.98	60.6	5	4	2	2	3	2	6	7	15
PR4	Sandwell	25	48.68	40.17	8.51	82.5	8	8	5	2	2	1	3	3	5
PR5	Sandwell	34	32.25	18.92	13.33	58.7	4	4	3	3	3	2	9	9	11
NT4	Sandwell	28	35.15	21.49	13.66	61.1	5	4	3	3	3	2	6	7	9
LY5	Sandwell	34	37.31	21.07	16.24	56.5	5	4	3	3	3	3	7	9	11
N5 (inc day unit)	Sandwell	15	21.03	16.78	4.26	79.8	4	4	2	1	0	1	4	4	8
AMU A	Sandwell	40	71.61	50.56	21.05	70.6	10	10	8	5	5	3	4	4	5
AMU B (NT1)	Sandwell	20	30.36	19.78	10.58	65.2	5	4	2	2	3	2	4	5	10
Rowley (MFFD)	RRH	24	29.64	15.08	14.56	50.9	4	3	2	4	3	2	6	8	12
TOTAL		**467**	**641.05**	**426.21**	**214.8395**	66.5	**96**	**87**	**60**	**45**	**45**	**37**	**5**	**5**	**8**

Surgery A

Ward	site	No. Beds	budget establishment includes 22% uplift	RN WTE	HCSW WTE	Percentage RN's on the funded establishment	Morning shift RN's expected	Afternoon/Evening shift RN's expected	Night shift RN's expected	Morning HCSW expected	Afternoon/Evening HCSW expected	Night Shift HCSW expected	Ratio of patients per RNs early shift	Ratio of patients per RN's afternoon/ evening	Ratio of patients per RN's night shift
D21		23	28.49	16.38	12.11	57.5	4	4	2	2	2	2	6	6	12
D25		19	28.28	16.98	11.30	60.0	4	4	2	2	2	2	5	5	10
SAU D42		14	22.98	16.98	6.00	73.9	3	3	0	1	1	0	5	5	#DIV/0!
SDU		12	0.00			#DIV/0!	4.5	2	0	1	1	0	3	6	#DIV/0!
N2		24	17.73	11.23	6.50	63.3	4	3	2	2	2	1	6	8	12
L2		20	30.73	17.20	13.53	56.0	3	3	2	3	2	2	7	7	10
P2		20	26.87	16.42	10.45	61.1	4	3	2	3	2	2	5	7	10
N3		33	40.65	23.93	16.72	58.9	6	6	3	4	4	3	6	6	11
L3		33	39.17	23.19	15.98	59.2	6	6	3	4	4	3	6	6	11
TOTAL		**198**	234.90	**142.31**	**92.59**	60.6	**38.5**	**34**	**16**	**22**	**20**	**15**	**5**	**6**	**12**

Rowley Regis Hospital

Ward	site	No. Beds	budget establishment includes 0% uplift	RN WTE	HCSW WTE	Percentage RN's on the funded establishment	Morning shift RN's expected	Afternoon/Evening shift RN's expected	Night shift RN's expected	Morning HCSW expected	Afternoon/Evening HCSW expected	Night Shift HCSW expected	Ratio of patients per RNs early shift	Ratio of patients per RN's afternoon/ evening	Ratio of patients per RN's night shift
Henderson	RH	24	26.83	11.90	14.93	44.4	2	2	2	2	2	2	12	12	12
Leasowes	RH	20	23.03	8.03	15.00	34.9	2	2	1	4	3	2	10	10	20
Eliza Tinsley	RH	24	29.80	14.90	14.90	50.0	4	4	3	4	4	2	6	6	8

Surgery B

Ward	site	No. Beds	budget establishment includes 0% uplift	RN WTE	HCSW WTE	Percentage RN's on the funded establishment	Morning shift RN's expected	Afternoon/Evening shift RN's expected	Night shift RN's expected	Morning HCSW expected	Afternoon/Evening HCSW expected	Night Shift HCSW expected	Ratio of patients per RNs early shift	Ratio of patients per RN's afternoon/ evening	Ratio of patients per RN's night shift
Eye ward	City	10	14.22	10.86	3.36	76.4	2	2	2	1	1	0	5	5	5

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:	1 May 2014

EXECUTIVE SUMMARY:

The Trust Risk Register compromises high (red) risks that have been through the validation processes at directorate / group and Risk Management Committee 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.

The Trust Risk Register was accepted by the Board at its April meeting (**Appendix 1, Section A**). As at writing there have not been any significant developments reported; any changes arising between now and the meeting will be verbally reported. Trust Board will receive the Trust Risk Register on a monthly basis and where there is a significant development a narrative will be provided. At the last Trust Board meeting, Pathology colleagues were asked to provide a narrative on the archiver machine risk, which will be provided at the meeting.

Risks that have been reviewed by the Risk Management Committee and continue to be managed at Clinical Group, Corporate Directorate or Project levels are provided as a Summary Risk Log at **Appendix 1, Section C**, which was requested by the Trust Board at its last meeting to ensure the Board has an oversight of all high risks across the Trust.

REPORT RECOMMENDATION:

The Board is recommended to NOTE the report.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	✓	✓

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:

The Board receives regular risk register updates.

Sandwell and West Birmingham Hospitals NHS Trust
Trust Risk Register

APPENDIX 1, SECTION A

Reference Number	Source of Risk	Corporate Directorate / Clinical Group / Corporate Project	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
1401MMH001	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	Oct-18	Feb-14	Quarterly	3	5	15
1414MARWK03		Chief Executive	Workforce Strategy	Organisational (Strate	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-20	Mar-14	bi-monthly	3	5	15
2013HASU01	CCG	Medicine	Stroke/Admitted Care	Operational/Business	Potential loss of the Hyper Acute Stroke Unit which is subject to an external commissioner led review.	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; Implement action plans to improve data capture and accuracy.	Clinical Group Director Medicine	TBC - Commissioner led review	Feb-14	Monthly	4	3	12
14-01-PATH-36	Incidents	Pathology	Pathology/Microbiology/Clinical	Operational/Business	Unpredicted downtime on archival/retrieval unit due to equipment failure. Patient management could be compromised/delayed due to a repeat sample being required.	4	4	16	Working with archive machine supplier to resolve issue. Contingency measures in place involving manual archiving. See Appendix A, Section B.	Clinical Group Director Pathology		Mar-14	Monthly	3	3	9
TRR1401COO01	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; SOP to be agreed and implemented in March for new processes; Elective access team structure to be reviewed; Central booking process to be strengthened to ensure real time data quality management; 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.	4	4	16	Joint working through joint discharge teams on both acute sites established; 7 day working pilot; 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

Number	Ref	Summary of Risk	Probability	Severity	Risk Rating (PxS)	Lead Director responsible for risk treatment plan	Group / Directorate	Expected date of completion	Source of internal review	Frequency of Review	Probability	Severity	Residual risk rating	↑ ↓
Risk category: CLINICAL														
1	201207Mat01	Failure to follow up antenatal screening results (Downs) could result in women being denied screening and/or appropriate action being taken which could subsequently lead to a baby born with congenital abnormalities. Increased risk of mortality or morbidity.	3	5	15	Womens and Child Health Group Director	Maternity and Perinatal Medicine	2014/15	WCH Group Management	Monthly	2	5	10	
Risk category: FINANCIAL														
2		Failure to develop robust 3 year outline CIP plans as part of the FT application (16/17, 17/18, 18/19)	4	4	16	Director of Finance	Finance	2014/15	FT Project	Monthly	3	3	9	
3		Failure to develop robust rolling 2 year detailed CIP plans as part of the FT application (14/15 & 15/16)	4	5	20	Director of Finance	Finance	2014/15	FT Project	Monthly	3	4	12	
4	1402FIN03	Loss of WEBDE on 31st August 2014 will disrupt payroll processing.	5	4	20	Director of Finance	Payroll	2014/15	Finance Management	Monthly	3	2	6	
Risk category: NON-CLINICAL / ENVIRONMENTAL														
5	14-03-PATH-03	Extremely noisy / cramped laboratories (Trace Elements laboratory and Vitamins laboratory) not considered a safe working environment for staff.	5	3	15	Pathology Group Director	Biochemistry	2014/15	Pathology Management	Monthly	2	3	6	
6	201302OBS01	Risk of Baby abduction - the current baby tagging system is not fit for purpose.	3	5	15	Womens and Child Health Group Director	Maternity and Perinatal Medicine	2014/15	WCH Group Management	Monthly	2	5	10	
Risk category: OPERATIONAL														
7		The validity and reliability of reports produced for management of the Trust key activities are bespoke, variable and lack controls on release. This results in variability in multiple reports and potential data quality issues.	4	4	16	Chief Operating Officer	COO	2014/15	COO	Monthly	2	4	8	
8	1414MARWK	High levels of staff turnover in localised areas impeding the development of coherent high performing teams and consequent adverse impact on the safe delivery care.	5	4	20	Medicine Group Director / Workforce Directorate Lead	HR Manager from Medicine and Medicine Group Leadership	2014/15	Workforce & Organisational Development Assurance Committee	Monthly	3	4	12	
9	14-03-PATH-02	Insufficient staff over the long term in the TPMT and Vitamins labs which is adversely impacting on both operational service delivery and the workforce.	5	3	15	Pathology Group Director	Biochemistry	2014/15	Pathology Management	Monthly	2	3	6	
10	13-12-PATH-30	Blood Sciences and Blood Transfusion Blood Testing Services at City and Sandwell Hospitals turnaround times are not always met due to inadequate staffing levels.	4	4	16	Pathology Group Director	Blood Sciences	2014/15	Pathology Management	Monthly	2	2	4	
11	0314SB03	Business risk due to lack of appropriate Levels of management support for Group B. Currently only GDO and GM to support all of Group B, this is exacerbated during periods of planned and unplanned leave	5	3	15	Surgery B Group Director	Ophthalmology	2014/15	Group B Management	Monthly	2	3	6	

Number	Ref	Summary of Risk	Probability	Severity	Risk Rating (PxS)	Lead Director responsible for risk treatment plan	Group / Directorate	Expected date of completion	Source of internal review	Frequency of Review	Probability	Severity	Residual risk rating	↑ ↓
12	0314SB01	Business (IG) risk due to possible loss of data. Data storage capacity for ophthalmic imaging has been exceeded; data stored locally on some machines contavening IG Standards; OCT equipment no longer able to function.	5	4	20	Surgery B Group Director	Ophthalmology	2014/15	Group B Management	Monthly	2	2	4	
13	201309NEO01	High vacancy rates in the neonatal unit and non compliance to BAPM standards for nursing staff - potential compromise to care in times of high activity.	4	5	20	Womens and Child Health Group Director	Obstetrics and Neonates	2014/15	WCH Group Management	Monthly	2	3	6	
14	1209WKF02	High levels of sickness absence adversely affecting the development of high performing cohesive teams supporting the delivery of high quality care.	5	3	15	Workforce	Workforce	2014/15	Workforce & Organisational Development Assurance Committee	Monthly	3	3	9	
Risk category: ORGANISATIONAL / STRATEGIC														
15	201403FTP2	Inability to achieve external validation of QGAF / BGAF standards would adversely affect the FT application.	3	5	15	Director of Governance	Director of Governance	2014/15	FT Project	Monthly	2	5	10	
16	201403FTP3	Organisation is unable to design and implement arrangements for the body of the organisation to be well-led which undermines FT process.	4	5	20	CEO / Director of OD when appointed	Director of OD	2014/15	FT Project	Monthly	2	5	10	
17	201403STRBD1	Failure to achieve a successful outcome from prospective tender processes resulting in a loss of income /reputation as a result of lack of capacity, skills and capability to respond successfully to procurement opportunities for existing and new services.	4	4	16	CEO / Director of OD when appointed	Strategy	2014/15	Strategy Management	Monthly	3	4	12	
18	201403STRBD4	The Practice Support/BD team fail to maintain relationships with Practices, CCG's and other Primary Care Services both to identify intelligence as well as to preserve and maintain relationships with the Trust	4	4	16	CEO / Director of OD when appointed	Strategy	2014/15	Strategy Management	Monthly	2	4	8	
19	201403FTP1	Failure to achieve FT status within TDA agreed timescales as a result of inability to meet the requirements of the assessment process.	5	4	20	Director of Finance	Finance	2014/15	FT Project	Monthly	3	4	12	
20		Inability to comply with the PAF framework, Monitor Compliance Framework and NHS Performance Assessment Framework leading to adverse knock-on impact on reported progress within the TFA.	5	4	20	Director of Finance	Finance	2014/15	FT Project	Monthly	3	4	12	
21		Sustain the opportunities to Income Generate: Failure to reach projected contract numbers or perform to the contractual obligations of our Funding Broker could result in the loss of income generation funding that supports apprenticeships development and also funds other wider Trust development activities from any under spend available.	5	3	15	Workforce	L&D	2014/15	Workforce & Organisational Development Assurance Committee	Quarterly	1	5	5	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Plan Delivery Report 2013/14 – Final Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Director of Finance & Performance Management**
AUTHOR:	**Neetu Sharma – Head of Strategic Planning**
DATE OF MEETING:	**1 May 2014**

EXECUTIVE SUMMARY:

The document provides an update on progress of delivery for the key activities and objectives included in the Trust Annual Plan for 2013/14.

A summary has been provided of those actions currently rated amber or red which have not been completed and will be carried forward into 2014/15.

The overall status for the 120 actions included within the annual plan is as follows:

RAG	Description	Q1	Q2	Q3	Q4
5	**Action complete**	**9**	**9**	**19**	**42**
4	**On-going action***	**79**	**83**	**63**	**49**
3	**Action underway – delayed into early 14/15**	**30**	**25**	**30**	**20**
2	**Action significantly delayed**	**2**	**3**	**7**	**9**
1	**Action not yet started**	**1**	**1**	**1**	**0**

REPORT RECOMMENDATION:

To discuss progress against achievement of the key activities outlined in the Trust Annual Plan for 2013/14.

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:

Relates to all annual priorities

PREVIOUS CONSIDERATION:

January 2014 (Q3 update)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

13/14 Annual Plan: Final Monitoring Report

1. Introduction

The Trust's internal Annual Plan (2013/14) was structured around the Trust's strategic objectives and informed by the NTDA annual planning process. Five key areas of focus emerged which underpin all developments and priorities for 2013/14.

This report outlines overall progress against a list of actions included within the 13/14 annual plan, focusing on those that were not met by the end of 13/14 and those actions which will continue to be measured in 14/15.

2. Q4 position

The status of the 120 actions included within the 13/14 annual plan is illustrated below:

RAG	Description	Q1	Q2	Q3	Q4
5	**Action complete**	**9**	**9**	**19**	**42**
4	**On-going action**	**79**	**83**	**63**	**49**
3	**Action underway – delayed into early 14/15**	**30**	**25**	**30**	**20**
2	**Action significantly delayed**	**2**	**3**	**7**	**9**
1	**Action not yet started**	**1**	**1**	**1**	**0**

This paper will focus on those actions now classified as categories 4,3 and 2 above.

The majority of 'on-going actions' (category 4) are long-term quality goals from the Trust's Quality and Safety Strategy. These goals originally span a five year period (2012-2017) and therefore weren't restricted to delivery in 13/14 alone. A list of the key on-going actions can be found in section 3.

The objectives rated as 'action underway' (category 3) reflect those actions which have been partially completed during 13/14 however have been delayed/carried over into 2014/15. These actions can be found in section 4.

The objectives rated as 'action significantly delayed' (category 2) reflect those actions which have been significantly delayed and will require further work to be carried out in 2014/15 in order to meet the objective. These actions can be found in section 5.

3. Key 'on-going actions' for 2014/15

N.B. The long-term quality goals have been grouped under their main heading (rather than by sub-objective).

Objective	Exec Lead	Q4 RAG	Key 13-14 achievements/actions for 2014/15
LONG TERM QUALITY GOALS			
Reduce Healthcare acquired infections	CN	4	• Continue to improve the number of patients who are MRSA screened. Sustained improvement over several months is still required to meet the definitive target of 100% and maintain at this level.
Improve care to vulnerable adults	CN	4	• Falls reduction in hospital but increase in falls with harm – themed review undertaken – action plan submitted to patient safety and CQRM – fallsafe to be implemented in 14/15 and CQUIN re. medication /falls. • A focused project is to be scoped to identify any actions above the falls care bundle that may help prevent falls.
Improve care to patients with dementia/ mental health illness/ disability	CN	4	• Memory screening CQUIN achieved in Q4 2013/14 • Training of 1st cohort of Dementia Champions complete. 2nd cohort commenced training. • 3 activity co-ordinators commenced in Q4 and are working with patients with dementia in terms of distraction and reminiscence therapy using DTRS equipment purchased earlier in the year • Enhancing the environment DOH project almost complete • Profile of wards included in above project commenced to review KPI including falls, V&A, staff trained etc.
Failure to rescue	MD	4	• Continuing with the work to improve the recognition and response to patients with sepsis. • Increasing the percentage of patients screened positive for sepsis receiving sepsis six bundle to 50%.
Improve medicines management	COO	4	• Final validated audit data from Q4 identifies 8 of 42 wards which were not fully (100%) compliant with the requirements of this CQUIN. The 81% overall level of wards compliant falls short of the Quarter 4 CQUIN target of 90%. Group Directors of Operations have been provided with a copy of the report and advised of the non-compliant areas.
Harm free care	CN	4	• 94% harm free care achieved • 'Being Open' policy - policy reviewed and Incident database being used more frequently to

Objective	Exec Lead	Q4 RAG	Key 13-14 achievements/actions for 2014/15
			document. Further work to implement this process needs to take place due to the contractual obligation of the duty of candour.
Improve end of life care	CN	4	• Acute – 61% of patients achieved preferred place of care & Community – 46% • 7/7 visit service and 24/7 telephone advice delivered from December 2013 (nursing and consultant advice)
Improve general health of patients	Various	4	• Achieved health visiting staff numbers • Public Health Plan launched in early 2014 • Clear objectives set around smoking & alcohol cessation, physical activity and healthy eating
Reduce avoidable mortality	MD	4	• Achieved 2013/14 VTE target of 95% • Continue to monitor mortality rates using HSMR as a measure. HSMR for SWBH (Nov 12-Oct 13) was 92.1 with the national average being at 100. West Midlands average is currently at 98.8. • Having set up a Task and Finish Group to investigate differences in mortality rates between the two main hospital sites, this piece of work is continuing to be monitored through MQuAC
ADDITIONAL ON-GOING ACTIONS			
Deliver all CQUINs	Various	4	• Of the 20 summary schemes, 16 schemes have either been met or are currently performing, 2 have not been met for the year, 1 is underperforming, with results for the remaining scheme, Annual Staff Survey, awaited.
Actively incorporate the recommendations of the Report of the Children and Young People's Outcomes Forum	CN	4	• Training event held with the Women's and Children's group on the outcomes framework • A self-assessment against the outcomes framework was undertaken in May 2013 and a local action plan put in place for the actions which relate to the Trust • Work has been established with the trust to ensure that safeguarding is a key priority during 2013/14 and moving into 2014/15 there are a number of areas of good practice however, teenage pregnancy, youth work and transition to adult services for children with long term conditions, and adolescent care remain within our immediate focus
Strengthen partnership working with GPs	CEO	4	• Monthly newsletter 'First Contact' now firmly established, with distribution of GPs now also expanding to other CCGs. • Twice monthly clinical symposia programme established from January 2014.

Objective	Exec Lead	Q4 RAG	Key 13-14 achievements/actions for 2014/15
			• Practice visit programme continues, with key projects arising from this feedback (revised discharge summary template and OP template) working groups established. • Director of primary care interviews to be held in May 2014
Pilot new process for GP letters	CEO	4	• Outpatient letter standards and template are approved and implemented across Trust • EPR working on development of discharge summary template in iCM. • Discharge summary template to be agreed by working group in May 2014 (following a cost benefit analysis) and process for developing within iCM take 3-6 months.
Move to a 7 day working model to support treatment & discharge	COO	4	• Investment into diagnostics 7 day service • Winter pilot scheme of 7 day social services continued in 14/15 • Operational hub 7 days working well • Discharges increasing at weekends 7 day clinical standards published by Bruce Keogh will be part of a longer term delivery programmes
Reconfigure number of services across acute and community to provide integrated care	COO	4	• The CCG are working with the Trust's clinical team and Birmingham Community Health Trust to implement the Community Diabetes specification in a phased way from April 2014. This will include: o delivery of diabetes care requiring specialist input as joint clinics in primary care, in order to help transfer skills to the primary care team o A system of 'link' consultants/specialist teams working closely with clusters of practices. o Developing connected health tools (digital healthcare) to deliver advice and guidance for practice teams.
Further delivery of the Transformation Programme and 2013/14 TSPs	DF	4	• Delivered £21,757,000 savings against plan of £22,267,000. £510k shortfall - 2.3%. 13/14 surplus was 1.5%. Delivered overall financial plan.
Develop leadership capability of our clinicians through delivery of Clinical Leadership Development Strategy	DSOD	4	• Continuing programme of development with initial development centres held in April/May 2014.
Building the membership base & manage active membership through communicating with members and	Head of Comms	4	• Public membership continues to grow. In the last year the Trust recruited 1697 new members through plans that use a range of online, face to face and written communication • Targeted recruitment campaigns have been launched to ensure the number of members

Objective	Exec Lead	Q4 RAG	Key 13-14 achievements/actions for 2014/15
playing key community role			within constituencies is at least 300 members per governor within that constituency
On-going provision of a broad ranging evidenced based Health and Well Being Programme	CN	4	• Broad range of services offered to staff including staff health screening, NHS health checks, eye screening, comprehensive counselling service and a robust stress support programme.
Regular sickness/absence case management review and improving management information to support effective and timely management of absence.	DSOD	4	• Ongoing monthly case conferences with Occupational Health to discuss sickness absence cases 3 months and over. • Pilot case conference for N+M absent for 28+ days started in Nov 2013. • Table Top Reviews arranged for any sickness absence case 9 months and over in duration commenced 15.01.14

4. Actions underway – delayed into early 2013/14

Objective	Exec Lead	Q4 RAG	Reason for non-completion	Key actions required to fulfil objective
Attain national mean for emergency re-admissions	COO	3	• Current underperformance against goal but improvements seen in 2013/14.	• Q1 (14/15) trajectories to be set at specialty level for improvement. • Prediction tool implemented to predict risk of readmissions. • Project manager appointed to support taskforce; key work streams include coding, discharge plans and communications. • GP and social care representative invited to join group and participate in audit.
Improvements to the way we provide care for emergency and acutely unwell patients / Consistently achieve national A&E targets	COO	3	• Below target performance earlier in 13/14 • 13/14 overall performance 94.4% • Performance improved with 5/6 last month's performing against 95% standard	• Ensuring continued engagement of social care in Birmingham and Sandwell Capacity and flow through community social care and health beds particularly access to long term placement beds

Objective	Exec Lead	Q4 RAG	Reason for non-completion	Key actions required to fulfil objective
Review of PALS function and resources	DG	3	• Review of PALS function being undertaken nationally • Review once this has been completed and new Head of Department in post.	• Additional resources identified and interviews to take place by May 2014.
Compliance with all QGAF domains	DG	3	• Anticipation that QGAF framework would be revised nationally as part of Monitor review of external assurance processes for aspirant FTs. New guidance now indicated that QGAF will continue during 14/15 until new framework issued.	• Revised FT timetable in development which will inform the specific requirements for completion of the QGAF formal self-assessment and external validation process.
Establish a base line of current usage of intra-operative goal fluid therapy & explore potential for expansion of use through mapping of HRGs identified that may benefit against our activity profile	MD	3	• Baseline audit data has not been shared.	• Baseline audit completed and usage has expanded across the trust (based on theatre stock levels). • Guidelines for usage to be completed by October 2014.
Waiting times in at least 90% of specialities will be as good as neighbours	COO	3	• Waiting times for a majority of specialities are competitive in comparison to neighbours. Exceptions include cardiology and oral surgery.	• Cardiology turn-around project to improve operational standards including key access in train. • Surgery A striving to reduce waiting times to max. 6 weeks in all specialties by May 2014. • Trajectories for all specialities requiring decrease in waiting times monitored though elective access meetings.
Develop alternative models of face to face contact including Digital First	COO	3	• Secondary care elements that are yet to be implemented across the organisation include: ○ Pre-operative screening online ○ Post-surgical remote follow up ○ Remote follow up in Secondary Care ○ Remote delivery of test results	• Increased provision of specialties providing advice and guidance via email/Choose and Book • Working group for Choose & Book Directory of Services to be updated (to increase appointment booking online)

Objective	Exec Lead	Q4 RAG	Reason for non-completion	Key actions required to fulfil objective
			○ Secondary Care clinic letters	• Small scale telemedicine pilots have taken place in Sandwell Social and Community services • Appointment reminders via text implemented e.g. MSK at Sandwell. • Some specialties delivering remote test results and remote follow up but need standardising in 2014/15
Develop comprehensive marketing plans for at least 3 of our services	DSOD	3	• Marketing plans developed for both Gastroenterology and Breast services. • Gynae Oncology marketing plan delayed	• Expected that Gynae Oncology marketing plan developed by July 2014. Dependent on securing replacement marketing/comms support.
Implement redesigned care pathways and other QIPP schemes		3	• Some delay in CCG evaluation of pilots, decisions on forward commissioning approach and confirming approved list of Procedures of Limited Clinical Value (now approved & list circulated to Clinical Groups). • Some delay in Clinical Groups identifying specific schemes to reduce OP follow up ratios. CCG set up implementation groups for a number of redesigned pathways with SWBH representation but progress slow.	• Engage in joint work with CCG once QIPP priorities for 2014/15 agreed. • CCG have shared draft commissioning specification for Dermatology but not formally issued and commissioning process and timescales unclear.
Implement a virtual ward in the community	COO	3	• PCAT service based at RRH set up. • PCAT continuation dependent on evaluation at end of Q1 2014/15. Evaluates well from patient experience perspective.	• CCG level decision required. ICARES continues to develop - further integration with DN planned as part of DN specification (1st April 2014).
Procure Business Intelligence system	CII	3	• Lack of funding	• Funding has been identified by finance for the recruitment of a project management and technical resource to

Objective	Exec Lead	Q4 RAG	Reason for non-completion	Key actions required to fulfil objective
				support the delivery of service line management.
Enable clinically-led decision making processes via SLR	MD	3	• SLR Technical Group in place during 13/14 – awaiting software to launch new reporting framework.	• The SLR Technical Group chaired by the Associate Medical Director (Innovation) has implemented a new service line reporting framework. To be introduced to Clinical Groups in 2014-15.
Make progress with MMH	DE	3	• TDA Board approved MMH financial model • DH and HMT approval to come	• Pursue DH/HMT approval and respond promptly to queries
Undertake external assurance review of estates compliance issues outcomes 10 & 11	DE	3	• External Assurance exercise undertaken, however, the draft report needs further work.	• Report expected to be presented to Audit & Risk Management Committee in May 2014.
Staff engagement: development of focused action plans in response to 'Hot Spot' areas.	DSOD	3	• Only 50% of group action plans have been developed. Further engagement from groups required. • Issues with the data quality from Quality Health.	• Data quality issue has been resolved. • Groups are being chased for action plans and would expect to have a full set by the end of May 2014.
Develop strategic outline case for the EPR replacement	CII	3	• Procurement	• The Trust are engaging with CSC to complete a pre-due diligence of the CSC Lorenzo solution.
Upgrade to data centre	CII	3	• Planning underway to relocate telecomms and the computer room to be developed under estate rationalisation.	• Remedial work on the City computer room scheduled for 14/15
Conduct digital dictation pilot	COO	3	• Procurement	• Business case to be resubmitted for approval. Supplier identified. • This scheme has been replaced by the VitalPACS digital surveillance scheme
Replacement of chemotherapy prescribing system	CII	3	• Phase 1 of project went live 24 March 2014.	• Project will complete by October 2014.

5. Actions significantly delayed

Objective	Exec Lead	Q4 RAG	Reason for non-completion	Key actions required to fulfil objective
Develop further five 5 year clinical strategies at speciality or condition level	DSOD	2	• PSC, MMH OBC, preparation for MMH procurement, and TSP/PMO work is a higher priority	• Deferred due to MMH & other team commitments.
Reduce rate of written complaints per 1000 episodes by 5%	DG	2	• Original target of 5% reduction not met	• Complaints in May 2013 were 67 per 1000 episodes. This data has only been collected since then and is variable month on month and has not been achieved in 3 months of the past 10.
Reduction in link complaints	DG	2	• This is variable and complainant centred. No reduction seen.	• Part of the devolution plan is to offer more meetings in the first place which will have the effect of reducing Link complaints. • Currently still receiving some cases which were handled pre devolution.
Innovative wireless communication systems for emergency MDT	COO	2	• Scheme not prioritised in winter 2013 improvement plan.	• Work on handover and board rounds to improve communication on the shop floor in train.
Develop a new service model for Frail Elderly	COO	2	• Recruitment key to expand on work.	• EIST provided critical recommendations on our services which have been presented to clinicians/AHPs/nursing involved in older adults' care. Action plan devised for care of older adults • In process of writing combined JDs for geriatric and acute medicine to provide older adult consultant leadership from the front door.
Submit FT application in line with revised TFA milestones	DF	2	• No formal timeline agreed with TDA • TDA/CQC to confirm date of CIH visit which	• IBP being re- developed. • Board development Plan on-going.

Objective	Exec Lead	Q4 RAG	Reason for non-completion	Key actions required to fulfil objective
			is key milestone in FT application	• Clinical Group governance baseline audit. FT Development Committee engaging with clinical and corporate groups ahead of the CIH visit.
Implementation of revised appraisal system including skills development & objective-setting training programme	DSOD	2	• New policy developed & will be reviewed by EG and considered by CLE in May 2014.	• Implementation period extended and working assumption is August 2014
Attain 10% better than the national mean for sickness absence rates	DSOD	2	• Overall sickness absence levels have started to increase and levels of absence in nursing and midwifery staff groups remaining higher than the acute benchmark groups in the West Midlands.	• Sickness absence is being closely managed at Group level with support from HR and Occupational Health Depts. • Monthly case conference review of all long-term sickness absence cases, now includes all nursing and midwifery absences of greater than 1 months duration.
Unified communications pilot	CII	2	• Removed from capital 13/14 plan to accommodate Vital PAC.	• To be carried forward to 14/15.

6. Recommendations

The Board is asked to:

- Accept the progress against the overall action plan for 2013/14.
- Discuss those objectives carried forward into 2014/15 and agree any actions required to ensure successful delivery.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit Committee – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 30 January 2014

Members Present		In Attendance	Guests
Mrs G Hunjan	[Chair]	Mr R Chidlow	Mr M Dodd
Ms C Robinson		Mr P Capener	
Dr S Sahota		Mrs R Chaudary	
Mr H Kang		Mr G Palethorpe	
Ms O Dutton [Part]		Mr G Ball	
		Mr A Hussain	
		Miss K Dhami	
Secretariat		Mr T Waite	
Mr S Grainger-Lloyd		Mr C Ovington	
		Mr T Wharram	

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Mr Andy Bostock. It was noted that greater effort should be directed to issuing papers in a more timely way in future.	
2 Minutes of the previous meeting	**SWBAR (10/13) 060**
The minutes of the meeting held on 25 October 2013 were approved as a true and accurate reflection of discussions held. Mr Grainger-Lloyd was asked to determine when and to where the next iteration of the data quality handling would be presented.	
ACTION: Mr Grainger-Lloyd to arrange for a further update on data quality handling to be presented at the next meeting **AGREEMENT: The minutes of the meeting held on 25 October 2013 were**	

Minutes	Paper Reference
approved as an accurate record	
3 Matters arising	**SWBAR (10/13) 060 (a)**
The Audit and Risk Management Committee received and noted the updated actions log.	
4 Data Quality – 18 weeks open pathway update	**Hard copy**
Mr Dodd provided an update on the background to the 18 weeks data validation issue. A number of approaches were reported to have been adopted to auditing the open pathways, including issuing of 76,000 letters. The outcome of the audit was reported to reflect a live database. The various groups of patients audited were outlined. In total 104,436 pathways were reported to have been reviewed. It was noted that there were a number of patients that remained in the system. Mrs Hunjan noted that this matter had been of interest for the Trust for a number of months. She asked whether any follow up with patients not replying to letters had been undertaken and was advised that a dialogue with the CCG and GPs had been undertaken prior to sending the letter out. She was also advised that a view had been taken as to whether to pursue cases where addresses had been changed and in a number of cases after all reasonable efforts, the cases had been closed. Mrs Hunjan asked what mitigation had been taken to prevent a reoccurrence of the data quality issue. Mr Dodd advised that a weekly meeting was arranged to look at all the cases and tracking all live patients and monitoring how long they had been waiting. Regular reports to the CCG were reported to be being prepared. Mrs Hunjan suggested that the work on data quality more widely was also being tracked through the CQN meeting. Ms Robinson asked what residual risks remained following all the mitigation applied. Mr Dodd advised that all root cause analyses were completed which had addressed as many issues as could be identified. Ms Robinson asked what potential issues might arise from closing patient pathways from those patients who had not replied to the letters. Mr Dodd advised that the view had been taken that any concerns would have been raised by complaints to the Trust and GPs. It was reported that the lists of patients written to were issued to GPs which were expected to be followed up in the case that a reply had not been received. Mr Dodd advised that patients had been encouraged to contact the Trust or GPs if there was concern and that there was a degree of onus on patients who were aware that they had not been seen as they would have expected. Dr Sahota highlighted that there was a high proportion of people in the	

Minutes	Paper Reference
local area that changed addresses regularly and asked how many letters had been returned that had indicated this. Mr Dodd advised that this was not clear, however of the 3,600 responses received from the 176,000 letters, only 0.2% of the patients responded had needed to be seen. Mrs Hunjan noted that there had not been an apparent increase in harm or complaints that could be connected with the issue. It was noted that the data quality matter would be reported back through routine update in future.	
5 Risk management plans	**SWBAR (1/14) 003** **SWBAR (1/14) 003 (a)**
Miss Dhami provided an overview of the current risk management situation. She advised that for a while discussions had been held regarding the need to improve the processes for risk management and developing the risk register further. The Committee advised that development of the Trust Risk Register was underway and at a Group level work was underway to make risk management more robust where needed. It was reported that a new Risk Management Committee had been established with the specific remit of strengthening risk management. In addition, work was reported to be underway to develop the Board Assurance Framework (BAF), to ensure that scrutiny and discussion of the BAF would be enhanced and made more meaningful. Miss Dhami reported that work was underway to encompass clinical audit within the annual planning process and the internal audit framework. The key actions to improve the risk management culture and processes were highlighted. Mrs Hunjan noted that the internal audit plan previously had been based on high levels of risk. Ms Robinson noted that the concerns would need to be reflected in the Annual Governance Statement for 2013/14. Mr Chidlow advised that there was a set of mandatory statements within the AGS and that the overall position in respect of risk would also be reviewed by the external audit process. Mr Capener noted the importance of communicating the measures to strengthen the risk management framework as part of the internal audit opinion. Mr Palethorpe suggested that the AGS will need to reflect the additional elements of assurance provided usually by the BAF that were in place. It was noted that the AGS needed to be drafted by early April. He suggested that the BAF provided a uniform or central source of assurance and therefore this needed to be developed robustly for 2014/15. Ms Dutton noted that the work planned to standardise and cleanse the risk registers and encourage managers to participate in the ownership and use of the risk register was pleasing. She noted however, that given the degree	

Minutes	Paper Reference
of work to embed the risk register process, managers should be involved now in cleansing the risk registers ready for the start of 2014/15. Miss Dhami advised that the various functions and departments were engaged in this activity, albeit the degree of involvement was at present patchy. Mrs Hunjan asked how the clinical audit agenda was driven externally. Miss Dhami advised that there was an element of externally mandated audits, alongside some internal priorities, clinical interest and some audits at the discretion of the Groups. It was reported that a discussion at the Executive-level was planned shortly to agree the balance and content of the audit plan. Ms Dutton asked how much influence the Trust had on including only the external audits that were of most relevance. She was advised that there remained a degree of mandatory audit, however the remainder of the plan needed to remain dynamic. It was suggested that it should be the remit of the various Board Committees to monitor the relevant element of risk. It was highlighted that there was a potential to use software to enhance the management of risk. Mr Waite suggested that the use of Safeguard had proved useful to some degree in embedding risk management. Mr Waite suggested that work was needed to ensure that the processes being deployed in terms of the AGS and risk management framework needed to be fit for purpose and that consideration needed to be given to the self-assessment measures that could be needed. It was agreed that a further update on the plans to refresh the risk management framework needed to be presented at the next meeting.	
ACTION: **Miss Dhami to present an update on progress with the plans to refresh the risk management framework at the next meeting**	
6 External Audit matters	
6.1 External Audit progress report	**SWBAR (1/14) 004**
Mr Chidlow reported that since October 2013, the Charitable Funds audit had been completed, with the remainder of the work being planning for the April – June 2014 audit of the statutory annual accounts. The Committee was asked to receive and note the technical updates provided. It was highlighted that the interim audit work would commence in February and that work was in place to review the work of Internal Audit. The mandatory indicator testing on the Quality Report was also reported to be planned at a time earlier than had been previously.	
6.2 External Audit Plan 2013/14	**SWBAR (1/14) 005**

Minutes	Paper Reference
Mr Chidlow provided an overview of the external audit plan, which involved audit of the financial statements, a review of the arrangements for economy, efficient and effectiveness and an audit of the quality report. The Committee was advised that a key risk concerned the management override of controls which would be given specific focus. In terms of deferred income and balances, it was highlighted that there had been a difference of view between the auditors and the Trust. The valuation of the fixed assets was reported to be another risk worthy of highlighting, although a full valuation of assets was planned within the current year. Fraud risk from revenue recognition was reported to be a standard area of focus as part of the audit, although this had been rebutted for the Trust.	
6.3 Matters of accounting judgement – statutory accounts 2013/14	**Hard copy**
Mr Waite reported that the matters of accounting judgement had arisen from the recent discussion of the statutory accounts, which it was highlighted were consistent with the matters being raised by external audit at present. All were asked to review the paper and report back to Mr Grainger-Lloyd to refer to Mr Waite and Mrs Hunjan with a view to reporting back at a later date. Ms Robinson asked what impact of the different accounting treatments in recognition of revenue. Mr Wharram reported that this would impact on the Trust's 'bottom line'. Mr Chidlow highlighted that the formalisation of the decision not to consolidate the Charitable Funds was needed as soon as convenient.	
7 Internal Audit matters	
7.1 Internal Audit progress report, including recommendation tracking update and Data Quality update	**SWBAR (1/14) 006** **SWBAR (1/14) 006 (a)**
Mrs Chaudary reported that 165 days of the Internal Audit plan had been completed, with a significant element of the work comprising data quality reviews. In terms of the recommendation tracking, 98.5% of actions had been completed. Mrs Hunjan noted that in terms of the theatre utilisation review, Executive-level sign off was required and asked for the reasons for this delay. It was reported that some of the management responses had needed to be revised. Mrs Hunjan suggested that a maximum turnaround for sign off	

Minutes	Paper Reference
needed to be stipulated, noting that in this case there was considerable delay. Ms Robinson suggested that operational representation was needed to be able to challenge outcomes from the reviews. It was agreed that a more robust escalation processes for delays was needed. Dr Sahota supported this view. Ms Robinson asked for further detail on the issues concerning the use of the Key Skills Framework (KSF). She urged that further work was needed to resolve delays in implementing recommendations such as in this case. Mr Capener provided a summary of the issues and suggested that a stocktake of the current position was needed. Mr Kang suggested that an integrated set of documentation and recommendation tracking was needed which could flag issues and delays. Ms Dutton highlighted that the matters needed to be reported to the Committees by exception to prevent consideration of insignificant issues. The Committee discussed the merits of the use of an integrated recommendation tracking mechanism and it was agreed that the requirement would be largely addressed through the approach that would be deployed by Internal Audit.	
7.2 Internal Audit reviews	**SWBAR (1/14) 006 (b) - SWBAR (1/14) 006 (g)**
Mr Capener reported that in terms of the theatre utilisation review, there was clear evidence that action had been taken to implement the recommendations and achieve a higher level of utilisation. The concern about emergency sessions was reported to have been addressed. Mrs Hunjan noted that the impact of cancelled operations on patient experience could be adverse. Mrs Chaudary reported that planned cancellations required notification of six weeks. Mr Capener advised that the use of the vacated sessions had not been used as effectively as possible. Miss Dhami advised that there were few complaints concerning cancelled operations. Mr Kang asked how a check was made that the recommendations and actions were delivered in a timely way. He was advised that management responses agreed a set of actions against which a report is made routinely and that a revisit to the area was undertaken where needed. Miss Dhami advised that the actions should be given sufficient focus by the relevant Group and Senior Management and that the recommendations should be considered as part of the Group performance reviews. In terms of the report on the Accident & Emergency waiting times internal report, Mr Capener highlighted a number of concerns and that the information had been revised to take into account feedback from the Chief Executive following the last meeting. The Committee was asked to note the letter to the Chief Executive which set out the additional work that had	

Minutes	Paper Reference
been undertaken and had resulted in a difference in assurance levels to that provided initially. It was highlighted that agreement as to how community data should be handled needed to be reached. Ms Robinson noted that a further update on the approach to data quality needed to be presented at the next meeting of the Audit & Risk Management Committee. It was also noted that an update would be presented by the Chief Executive to the Trust Board at its meeting on 6 February 2014.	
7.3 Fraud risk assessment report	**SWBAR (1/14) 007**
Mr Ball drew the Committees attention to the action plan within the risk assessment report which would provide the focus for the plan from April 2014 onwards, including the review of existing policies and protocols. It was noted that a redress and sanctions policy might need to be introduced. Mr Kang suggested that there was a need to understand best practice in this area with a view to adopting a sensible and practical approach. It was reported that the risk assessment featured within the counterfraud workplan. Mr Kang asked who within the HR function Counterfraud would link. He was advised that this would usually be the HR Director and the sharing protocol would include information sharing. Mrs Hunjan asked how the risk assessment outcome correlated to the previous assessments made of the Counter Fraud position. She was advised that it was consistent, although there was a possibility of a further assessment within the year. Mrs Hunjan suggested that further work was needed to understand the impact of Counterfraud interventions within the Trust, particularly part of the induction programme. She suggested that a dashboard needed to be developed with a view to monitoring progress with addressing the actions. It was agreed that this needed to be built into future reports. Mr Waite welcomed the balance between strategic and immediate focus in the plan. He encouraged a risk-based and proportionate response be developed to the local risk of fraud.	
ACTION: Mr Ball to include a dashboard to show progress with addressing the actions arising from the counter fraud work in future	
7.4 Draft interim Counter Fraud workplan January – March 2014	**SWBAR (1/14) 008**
Mr Ball presented the overall workplan for Counterfraud until March 2014, covering 33 days and was weighted to awareness raising focus. It was	

Minutes	Paper Reference
highlighted that the work was proactive rather than reactive and that any adjustments would need to be agreed with the Director of Finance. Dr Sahota encouraged that the good practice being delivered by the previous provider be continued rather than be replaced. Mr Waite advised that the risk assessment would reflect this and set the baseline. The Committee agreed that the plan represented a risk-based and proportionate response to the local risk of fraud.	
7.5 CW Audit counterfraud investigation report	**SWBAR (1/14) 009**
The Committee received and noted the report. It was highlighted that three investigations continued to be handled. Mr Kang asked whether these cases represented a typical representation of counter fraud in the Trust. Mr Ball suggested that as an initial view, it appeared that these were relatively typical of comparable organisations. It was highlighted that proactive work would seek to undercover the level of risk associated with fraud. Mr Glenthorpe advised that external context would be provided to inform this view on an ongoing basis. Ms Robinson highlighted the tension between disciplinary and fraud matters. Mr Waite suggested that it would be integral to the work of counterfraud to link in with HR and identify line management responsibilities where relevant.	
7.6 Progress to date with the handover from CW Audit	**Verbal**
Mr Ball reported that Baker-Tilly had completed a number of handover meetings with CW Audit and the relevant internal notifications and linkage into induction programmes had started.	
8 Governance matters	
8.1 Changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation	**SWBAC (1/14) 010** **SWBAC (1/14) 010 (a)**
Mr Grainger-Lloyd advised that a number of non-contentious changes had been made to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation to reflect the new naming convention for senior managers and to reflect that a number of new Board Committees had been established. He was asked to reflect the role of a new Non Executive Designate role within the document.	
ACTION: Mr Grainger-Lloyd to amend the Standing Orders as suggested	

Minutes	Paper Reference
9 Updates from the Chairs of the Trust Board Committees	**Verbal**
Ms Robinson reported that procurement best practice was being considered by the Finance & Investment Committee and that a future focus would be provided on the risk register and Board Assurance Framework to understand the relevant risks within the remit of the Committee. Mr Kang advised that recruitment and retention had been a focus of the Workforce & OD Committee and in particular the risk of a high turnover. The high level of sickness absence was also reported to be a concern. Dr Sahota advised that the investment protocol had been extended to exclude investment in alcohol and arms in addition to tobacco.	
10 Any Other Business	**Verbal**
There was none.	
11 Date and time of next meeting	**Verbal**
It was noted that the date and time of the next meeting would be 24 April 2014 at 1400h in the Anne Gibson Boardroom, City Hospital	

Signed:……..

Name:……

Date:…….

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

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

Present

Ms G Hunjan [Chair]
Mr R Samuda
Dr S Sahota OBE
Dr R Stedman
Mr C Ovington

In Attendance

Ms A Binns
Mrs D Talbot
Mrs L Barnett [Item 3.1 only]

Secretariat

Mr S Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies for absence were received from Ms Dutton, Miss Dhami, Mr Waite and Mr Harding.	
2 Minutes of the previous meeting	**SWBQS (2/14) 023**
The minutes of the Quality and Safety Committee meeting held on 28 February 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 (2/14) 023 (a)**
The updated actions list was received and noted by the Committee.	
3.1 CRB/DBS checking process update	**SWBQS (3/14) 025** **SWBQS (3/14) 025 (a)** **SWBQS (3/14) 025 (b)**
Mrs Barnett presented the latest update against the CRB/DBS checking process. It was reported that a number of priority departments were being targeted for CRB/DBS checks to be undertaken, namely those which were considered the most risky areas. The Committee was advised that a significant number of staff had moved from areas where checks were not needed into areas where a check was	

now needed. Notwithstanding this, the Committee was asked to note that the position reported most likely represented the worst case scenario. It was reported that there were few concerns associated with the CRB/DBS process and the Committee was asked to note the few issues that had been encountered during the recent years. Assurance from the checking process was highlighted to be confined to the time at which checks were completed only. In terms of DBS, it was noted that this was a voluntary scheme and therefore the uptake was relatively low at present. An electronic DBS system was reported to have been introduced which had speeded up the application process. It was suggestion that a subscription service to the DBS may need to be considered. It was noted that there would be limited liability on the Trust should there be issues that arose from undeclared change in status. Dr Sahota shared his experience from other organisations where CRB checks were mandatory. It was noted that CRB checks were only portable for junior doctors at present in line with the requirements set out by NHS Employers. Mrs Barnett provided assurance that a consistent approach to security clearance was being taken across the Trust. It was agreed that a further update needed to be presented to the Safeguarding Committee prior to being presented to Board Committee. It was suggested that the matter should be better presented at a future meeting of the Workforce & OD Committee.	
ACTION: **Mr Grainger-Lloyd to arrange for an update on the CRB/DBS checking process to be considered by the Workforce & OD Committee**	
MATTERS FOR DISCUSSION/DEBATE	
4 Quality & safety ambitions 2014 – 17/18	**SWBQS (3/14) 026** **SWBQS (3/14) 026 (a)**
Mr Ovington presented the proposed quality and safety ambitions for the forthcoming years for any final comments and suggestions. It was noted that the proposals had been shared with and supported by the Trust's members. Mrs Hunjan asked how the achievement of the ambitions would be captured and that lessons had been learned along the way. Mr Ovington advised that the progress would be captured through the integrated dashboard and Quality Account although it needed to be harmonised with other work underway, such as the focus on the actions arising from the Francis enquiry. Dr Sahota suggested an exceptions report would be appropriate to consider in respect of delivery of the quality & safety ambitions. Dr Stedman highlighted that an amendment to the readmissions target was needed. It was highlighted that the management of safeguarding actions needed to be	

devolved across the Trust. Ms Binns noted that the framework for the management of this needed to be implemented which would assist with cascading and acting on the learning. Mr Ovington reported that further updates would be provided through the integrated quality, finance and performance dashboard. Dr Sahota encouraged the targets set to be more challenging where possible.	
4.1 Shaping the Committee agenda for the future	**Verbal**
Mr Ovington suggested that consideration needed to be directed to the future model of operation for the Committee. Dr Stedman suggested that the agenda of future meetings should be structured around the quality priorities within the quality strategy. Mr Samuda suggested that the discussions needed to focus on peer comparisons and proposed improvements suggested internationally and nationally. It was reported that the Executive processes for driving improvement relied mainly on the Group performance reviews. It was agreed that consideration was needed to receiving clinicians at the Board in future to discuss plans for achieving excellence in some key areas.	
5 Draft integrated quality, finance and performance dashboard	**SWBQS (3/14) 027** **SWBQS (3/14) 027 (a)**
The Committee received and noted the revised integrated quality, finance and performance dashboard, which Miss Barlow advised had been considered at the recent meeting of the Finance & Investment Committee. Mr Samuda welcomed the layout and proposed content of the report and in particular the inclusion of the data quality mark attached to each indicator. He suggested that work related to GP liaison could be included, in addition to some softer indicators, such as the number of bed moves a patient had to make, telephone answering times and cancellations on the day of surgery. Mrs Hunjan asked the open beds needed to be included in the new report. Mr Ovington suggested that there may be some indictors were more seasonally applicable than others. The Committee welcomed the trending information. All were asked to feed further comments back to Mr Waite.	
6 Corporate performance dashboard including performance against CQUINs 2013/14 and targets for 2014/15	**SWBQS (3/14) 028** **SWBQS (3/14) 028 (a)**
Miss Barlow presented the key highlights from the corporate performance dashboard, including the Emergency Department performance, the quarterly target for which it was highlighted was possible to achieve by the month end. It was reported that improvement plans against the 18 week target at Group level had been scrutinised recently. It was noted that there was an expectation that it was anticipated that the 18 weeks plan in Trauma & Orthopaedics would be delivered by August 2014. It was agreed that a special measures report into the Cardiology speciality be presented at the next meeting.	

Ten breaches against the single sex accommodation requirements were reported to have been incurred, which it was acknowledged was unacceptable, however an electronic means of monitoring breaches was being trialled. Against the CQUIN targets, it was reported that the Trust was failing against the Medicines Management indicator. Mr Ovington advised that a zero tolerance approach to this was being adopted. Miss Barlow reported that in terms of cancelled operations, it was reported that a robust approach to this was being taken. Dr Sahota noted that there had been some cancellation of consultant appointment panels and asked how this was impacting. Dr Stedman advised that a continuous recruitment drive for Accident & Emergency consultants was underway and in terms of Interventional Radiology, sharing arrangements offered by the Trust were not compelling therefore negotiations were underway with local Trusts on an agreement that would make these positions more attractive. It was highlighted however, that overall consultant recruitment was successful, with 35-40 being appointed within the last twelve months. Miss Barlow advised that securing middle grade consultants into Accident & Emergency had been successful.	
ACTION: **Miss Barlow to present the Cardiology recovery plan at the next meeting**	
7 2014/15 TSP – Quality Impact Assessment update	**Verbal**
It was reported that there had been a limited number of schemes that had been signed off since the last meeting and there were no issues to highlight.	
8 Complaints handling – Key Performance Indicators	**SWBQS (3/14) 029** **SWBQS (3/14) 029 (a)**
Miss Binns presented a set of proposed key performance indicators which were used to monitor the effectiveness of the complaints handling process. Miss Binns answered a number of specific queries from Mr Samuda about the details of the complaints handling process, including the process for handling informal complaints. She highlighted that the devolved process was working well, with good engagement at a local level and performance was significantly better than that of previous years. Dr Sahota asked what training was being put in place to ensure that staff were equipped to handle complaints. Mrs Talbot advised that good programmes were in place and had been ongoing for a number of years. Mr Ovington reported that informal complaints rarely needed Executive intervention or sign off proving that the system was working well. He added that a trajectory should be set that was challenging to ensure that performance was adjusted to being more acceptable. Miss Binns advised that by April, there was an intention that the performance would be back on track. Mrs Talbot advised that there appeared to be a culture of empowerment though	

the devolved approach. Dr Stedman reported that there was a national requirement to embrace the Duty Of Candour and that fines would be levied in the event that it could be demonstrated that this duty had not been complied with. Ms Binns added that this was built into the complaints process through the Being Open requirements. Mrs Hunjan asked whether performance was measured in working days for specific complaints included in the report. Ms Binns offered to check whether this was the case. It was noted that performance against the KPIs would be included in the corporate performance dashboard. Ms Binns offered to bring an update on performance against the KPIs at the meeting in August 2014. It was suggested that learning points from claims needed to be considered by the Committee.	
ACTION: **Ms Binns to provide an update on performance against the complaints handling KPIs at the August meeting of the Quality & Safety Committee** **ACTION:** **Miss Binns to arrange for a report into learning points from claims to be presented at a future meeting**	
9 Serious Incident report	**SWBQS (3/14) 031** **SWBQS (3/14) 031 (a)**
The Committee was asked to receive and note the serious incident report. Dr Sahota noted that there was an increase in sharps incidents. Mr Ovington suggested that further information would be needed to better understand the position. Dr Stedman offered to share the detail behind the Information Governance issues with Mrs Hunjan outside the meeting.	
10 Clinical audit forward plan: monitoring report	**SWBQS (3/14) 032** **SWBQS (3/14) 032 (a)**
The Committee was asked to receive and note the progress with the clinical audit forward plan. Mr Samuda observed that there might be a gap in the clinical effectiveness matters that were reported up to the Committee. Dr Stedman outlined the wider remit of the Clinical Effectiveness team. It was agreed that this would be picked up as part of a report against the long term goals for the Executive-led Clinical Effectiveness Committee.	
11 CQC Intelligent Monitoring report	**SWBQS (3/14) 034** **SWBQS (3/14) 034 (a)**
The Committee was asked to receive and note the latest version of the CQC intelligent monitoring report.	
12 Committee observations by Deloitte	**SWBQS (3/14) 033**

The Committee was asked to receive and note the recommendations from the Deloitte observation report.	
OTHER MATTERS	
13 Matters of topical or national media interest	
13.1 Implications of the Professor Black mortality review	**Verbal**
Dr Stedman reported that a study had been undertaken which looked at quality of care and death rates which showed that there was little correlation, which lead to the recommendation that mortality reviews should be undertaken. The Committee was advised that these reviews were already underway and that the Trust would be participating in Prof Black's future work. It was reported that it was the intention to aim for a review of 100% of deaths by the year end and that an audit would be commissioned to review whether there was a possibility that admissions could have been avoided during the last year of life. Mrs Talbot asked that learning disabilities be considered as part of this work. Dr Stedman presented an overview of the changes in coding of palliative care coding which had generated recent national publicity, which he highlighted to be reflective of the increased reporting of deaths coded as palliative care as a result of the employment of additional consultants in this area. It was reported that the Supportive Care Pathway was used by the Trust, rather than the Liverpool Care Pathway.	
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 25 April 2014 at 1030h in the D29 (Corporate Suite) Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Configuration Committee – Version 0.2

Venue D29 Meeting Room, City Hospital **Date** 28 February 2014 at 0800h

Members present		In attendance	Secretariat
Mr R Samuda	[Chair]	Mr G Seager	Mr S Grainger-Lloyd
Ms C Robinson		Mrs J Dunn	
Mr T Lewis		Ms D Lewsley	
Mr T Waite			
Dr R Stedman			
Mrs G Hunjan			

Minutes	Paper Reference
1 Apologies	**Verbal**
Apologies for absence were received from Mr Sharon.	
2 Minutes of the previous meetings	**SWBCC (12/13) 013**
The minutes of the meeting of the Configuration Committee held on 12 December 2013 were approved.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meeting	**SWBCC (12/13) 013 (a)**
The Committee received and noted the updated actions log.	
4 MMH Project status update	**SWBCC (2/14) 002** **SWBCC (2/14) 002 (a)**
Mr Seager presented a summary overview of the work underway on the MMH project. In terms of the GVD, it was reported that notice had been served, with no response having being received to date, therefore the land would come under the ownership of the Trust on 1 March 2014. Mr Lewis underlined the need to confirm the possession of the land once the notice period had elapsed. It was noted that construction on the land could commence thereafter. Should objections be received, then a potential land tribunal may need to be entered into. It was confirmed that permission had been sought to remove the bridge link.	

It was reported as part of PF2 a pre-market engagement day with potential bidders would be held in readiness for the later OJEU process. Mr Seager advised that the notice for this had been placed, the matter being a decision of the Trust. Mr Lewis asked whether all of the 1:200 design schemes had been received. He was advised that this was the case being based on an active service space of 74,000 square feet. It was noted that there was a degree of flexibility (optimism bias) that had been incorporated within the plans at a level of 7%. Ms Robinson suggested that a key fact sheet needed to be developed to ensure consistency of communications. It was agreed that this would be useful for Board members.	
ACTION: Mr Seager to develop a 'fact sheet' detailing the key messages relating to the new hospital project	
5 Evaluation model for MMH	**SWBCC (2/14) 003** **SWBCC (2/14) 003 (a)**
Mr Seager reminded the Committee that the Board had considered the evaluation model previously in February. It was agreed that the weightings would be developed further and Ms Lewsley drew the Committee's attention to the addendum to the report which set out the Trust's proposed split for the evaluation criteria. Ms Robinson suggested that the reasons behind the variance from the recommended valuation template needed to be clearly set out. Mr Lewis advised that there was no justification of the weightings to the bidders but these would be published at the outset of the process. Mr Seager advised that there was no significant departure (2% overall) from the Pre Qualification Questionnaire criteria, with the majority of the variance reflecting the focus on regeneration as part of the scheme. It was agreed that the detail of this variance needed to be set out. Ms Robinson suggested that there was a need for Board members to fully understand the scrutiny and validation processes that had been employed to review the weightings and evaluation criteria that had been set. The remaining stages of the evaluation process were discussed, including the scoring process for each. It was noted that clarity was needed as to whether criteria could be rescored. Mr Lewis suggested that there was a need for continuity of deliverables and a consistency of the panel evaluating the bids was needed to ensure that the final decision was based on the financial basis of the offering. Ms Lewsley guided the Committee through the complexities of the evaluation process. Ms Robinson asked how care was taken to ensure that equal information was disclosed to the different bidders. Mr Lewis noted that care needed to be taken to safeguard against disclosing the details of a bidders scheme to other contenders. It was highlighted that the provision of feedback to a particular bidder to all other bidders represented a challenge in this respect. It was agreed that the team providing the feedback needed to be making decisions and providing information back to the bidders that was harmonised with the evaluation panel. It was agreed that a summary on the PQQ was to be developed and that a summary of the bid deliverables was also needed. An overview of the process	

demonstrating the rigour that had been placed on the decisions made was agreed to be needed which would be considered alongside the proposed bid deliverables. It was suggested that the composition of the evaluation committee needed to be finalised, although it was suggested that this should include the Chief Executive, Medical Director, Director of Finance & Performance Management, Chairman and two Non Executive Directors. Mr Lewis noted that financial credibility of the bidders needed to be established as part of the PQQ. Ms Lewsley guided the Committee through the process that would be used for this purpose, including turnover threshold. The independent credit score was highlighted to be part of the initial assessment. A series of ratio tests would be performed by Deloitte and checked by the Trust to confirm the financial robustness of the organisations. Dr Stedman asked whether a 'track record' test for organisations that would potentially work together could be applied. Ms Lewsley advised that this would be part of the review of the organisations historic delivery but only on an individual basis. Ms Robinson suggested that the evaluation needed to include future commitments planned. Mr Lewis agreed that this was a reasonable suggestion however highlighted that this information needed to be provided by the bidders rather than being sourced outside of the process. Ms Robinson suggested that the viability and track record of subcontractors needed to be considered. It was noted that this was included in the evaluation of the consortia. Mr Lewis asked who had reviewed the IT specification to ensure that it was future proof. He was advised that an independent advisor had been commissioned to review this and it was agreed that Mr Lewis would review the report. Ms Robinson suggested that a requirement for self-certification of the information from the bidding firms needed to be requested. It was agreed however that the duty of care in this respect needed to fall on the Trust. It was noted that the process allowed for references to be taken up. It was agreed that PQQ responses needed to be sent to the Trust Headquarters at Sandwell General Hospital.	
ACTION: **Mr Seager to arrange for a summary of the PQQ process to be prepared**	
6 MMH procurement documentation	**SWBCC (2/14) 004** **SWBCC (2/14) 004 (a)**
The Committee received and noted the MMH procurement documentation. It was suggested that the new internal auditors needed to be reflected in the documentation. A glossary of the documents for the procurement process was reported to have been developed and the documents will be lodged centrally on the Executive directory. It was noted that the documents had been signed off by the Chief Executive and that the information was provided for the Committee information only.	

7 MMH procurement PEP	**SWBCC (2/14) 005** **SWBCC (2/14) 005 (a)**
The Committee received and noted the MMH procurement PEP. It was noted that there was no reporting line between the MMH Project Team and the Configuration Committee. Ms Robinson asked what progress on the communications and engagement plans had been made. Mr Lewis advised that the plan was being developed at present.	
8 Draft Outline Business Case	**SWBCC (2/14) 009** **SWBCC (2/14) 009 (a)**
The Committee received and noted the draft Outline Business Case for the MMH and it would be published at an appropriate time of the project. It was noted that there was little opportunity to make changes to the document at this stage.	
9 Clinical reconfiguration summary update	**SWBCC (2/14) 006** **SWBCC (2/14) 006 (a)**
Mrs Dunn provided a general update on progress with clinical reconfiguration across the Trust. The key highlights of the report were drawn out for the Committee. It was reported that a letter concerning the issues arising from the vascular services reconfiguration would be issued to commissioners shortly. Mrs Hunjan asked in terms of the interventional radiology whether staff had transferred across to UHBFT. She was advised that staff had not transferred fully, however a number of staff worked some sessions at UHBFT. Mr Samuda asked in relation to diabetes, what progress had been made with allocating link teams to practices Mrs Dunn advised that an introductory email has been sent to the 80% of practices with which the Trust was linking and at the time of writing the report 25% of these have already made contact with the link teams.	
10 Stroke reconfiguration update	**SWBCC (2/14) 007** **SWBCC (2/14) 007 (a)**
Mrs Dunn advised that there remained no clarity from commissioners on the Hyper Acute Stroke Units (HASUs) that would be in place in future although it was expected that there would be a reduction on the number currently in existence at present. It was reported that a financial return had been submitted and a clinical quality return was due shortly. As part of this, the Trust had been asked what size capacity the Trust would expect and views on working in partnership. The Committee discussed the future options and expectations. It was noted that the locations for the HASUs were being based on 30 minutes	

travel time for patients. Mrs Hunjan asked how the thrombolysis target would be incorporated within the changes planned. Mrs Dunn advised that the pathways planned facilitated this requirement. In terms of the number of strokes handled by neighbouring trusts, it was noted the position was largely equal with the exception of UHBFT which handled a lower number. It was noted that the plans would be considered by the Executive Group shortly. Mr Lewis advised that should the Trust not be designated a HASU then there would be little impact in terms of loss of other business, although there would be a limited effect on the delivery of elderly care services. Ms Robinson suggested that the financial consequences needed to be understood.	
11 'Right Care, Right Here' activity and capacity assumptions monitoring report including bed capacity	**SWBCC (2/14) 008** **SWBCC (2/14) 008 (a)**
Mrs Dunn presented a summary of the 'Right Care, Right Here' activity and capacity trajectories. It was highlighted that outpatient attendances was expected to reduce and dovetailed into the 'Year of the Outpatient' plans. A decrease in Emergency Department attendances was reported to have been seen. Mr Samuda asked whether this was linked to the plans for the MMH. Mrs Dunn advised that this was the case and Mr Lewis added that the activity arrangements were included within the proposition but needed to be monitored by speciality level. Ms Robinson asked what confidence was placed on the quality of the data underpinning the performance and in particular data on beds. Mrs Dunn advised that there was an expectation that bed data might vary to some degree but some validation had been undertaken. It was agreed that the information would be presented bimonthly.	
12 Matters to raise to the Board	**Verbal**
It was agreed that information on the GVD, procurement and stroke needed to be raised to the Board at the next meeting. Mrs Robinson acknowledged the huge amount of work that had been undertaken on the MMH project.	
13 Any other business	**Verbal**

There was none.	
14 Details of the next meeting	**Verbal**
The next meeting is to be held on 25 April 2014 at 0800h 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
- GVD 3

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 18
- 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

FT Programme Monitoring Status Report

Activities This Month

- TDA published new FT guidance (Accountability Framework – March 2014) outlining revised FT application process.
- Prospective FT Project Plans with timeline options to 05/2015 & 05/2016 & coherent with prospective MMH obligations.
- On-going work on re-development of IBP

Planned Next Month

- IBP chapters re-developed in line with OBC in readiness for submission to the TDA in June 2014
- Determine timing of & external support required for BGAF & QGAF assessments
- 'Get Involved in Leading the Trust' events planned for April & May (membership)

Issues for Resolution/Risks for Next Month

- Confirmation required from CQC as to likely timing of CIH visit
- Confirmation required from DH / HMT re MMH