Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 3 July 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]

Guests

Patients for patient story & service presentation

Mr M Lewis	(ML)	[Group Director – Medicine & EC]
Mrs J Malpass	(JM)	[Head of Anticoagulation Services]
Ms R Clarke	(RC)	[Deputy Head of Anticoagulation Services]

Secretariat

Mr S Grainger-Lloyd (SGL) [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**	**SG-L**
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 5 June 2014 a true and accurate records of discussions*	**SWBTB (6/14) 096**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (6/14) 096 (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 (7/14) 098**	**RSM/ TL**
	MATTERS FOR DISCUSSION AND APPROVAL			
1410h	8	**Never Event in Medicine & Emergency Care**	**Presentation**	**RST**
1420h	9	**Never Events controls assurance**	**SWBTB (7/14) 099** **SWBTB (7/14) 099 (a)**	**KD**
1430h	10	**Corporate integrated performance dashboard**	**SWBTB (7/14) 100** **SWBTB (7/14) 100 (a)**	**TW**
	10.1	Plans for remedying constitutional deviations	Verbal	RB

	10.2	18 weeks RTT position and plans to improve	SWBTB (7/14) 101 SWBTB (7/14) 101 (a)	RB
	10.3	Emergency Care recovery plan	SWBTB (7/14) 102 SWBTB (7/14) 102 (a)	RB
	10.4	CQC intelligent monitoring	Verbal	KD
	10.5	Publication of safety on NHS Choices	SWBTB (7/14) 103 SWBTB (7/14) 103 (a)	KD
1500h	**11**	**Financial performance – Month 2**	**SWBTB (7/14) 104 SWBTB (7/14) 104 (a)**	**TW**
	11.1	Two year financial view	Presentation	TW/ TL
1520h	**12**	**Trust Risk Register update**		
	12.1	Update on actions agreed at the June meeting	SWBTB (7/14) 105 SWBTB (7/14) 105 (a)	KD
	12.2	New considerations		
1530h	**13**	**Five year plan**	**SWBTB (7/14) 106 SWBTB (7/14) 106 (a)**	**TL**
1540h	**14**	**Nurse staffing levels**	**SWBTB (7/14) 107 SWBTB (7/14) 107 (a)**	**CO**
1550h	**15**	**Annual Report on the Implementation of Medical Appraisal**	**SWBTB (7/14) 108 SWBTB (7/14) 108 (a) - SWBTB (7/14) 108 (e)**	**RST**
	PRESENTATION			
1600h	**16**	**Service update – Anticoagulation services**	**Presentation**	**RB**
	UPDATES FROM THE COMMITTEES			
1615h	**17**	**Update from the meeting of the <u>Configuration</u> Committee on 27 June 2014 and minutes of the meeting held on 25 April 2014**	**SWBCC (4/14) 019**	**RSM/ TL**
	18	**Update from the meeting of the <u>Finance & Investment</u> Committee held on 26 June 2014 and minutes of the meeting held on 30 May 2014**	**SWBFI (5/14) 031**	**CR/ TW**
	19	**Update from the meeting of the <u>Workforce & OD</u> Committee held on 27 June 2014 and minutes of the meeting held on 28 March 2014**	**SWBWO (3/14) 044**	**HK/ TL**
	20	**Any other business**	**Verbal**	**All**
	MATTERS FOR INFORMATION			
1625h	**21**	**Midland Metropolitan Hospital project: monitoring report**	**SWBTB (7/14) 109**	
	22	**Foundation Trust application programme: monitoring report**	**SWBTB (7/14) 110**	
	23	**Annual Plan 2014/15 monitoring template**	**SWBTB (7/14) 111**	

			SWBTB (7/14) 111 (a)
	24	**Details of next meeting** *The next public Trust Board will be held on 7 August 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** 5 June 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 Harjinder Kang	**Guests**
Dr Paramjit Gill	Ms Stephanie Herilihy
Ms Olwen Dutton	Ms Marion Long
Mr Toby Lewis	Mr Peter Cook
Mr Tony Waite	
Mr Colin Ovington	**Secretariat**
Miss Rachel Barlow	Mr Simon Grainger-Lloyd
Dr Roger Stedman	

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
No apologies were received.	
2 Declaration of Interests	**SWBTB (6/14) 074**
The Committee was asked to receive and approve the updated register of interests, which it was highlighted included new Board members. It was agreed that Dr Gill's GP practice work needed to be included.	
ACTION: Mr Grainger-Lloyd to update the register of directors' interests to reflect Dr Gill's GP practice work	
3 Minutes of the previous meeting	**SWBTB (5/14) 072**
The minutes of the Trust Board meeting held on 1st May 2014 were presented for	

consideration and approval. They were accepted as a true and accurate record of the discussions held.	
4 Update on Actions arising from Previous Meetings	**SWBTB (5/14) 072 (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. Mr Lewis asked that we ensure that all recorded actions from our minutes are logged into the action log, so that Board members have confidence that items are not slipping from view.	
5 Questions from members of the public	**Verbal**
Mr Hodgetts reported that a review at Sandwell General Hospital had been undertaken by Healthwatch and that the report would be prepared and shared with the Board in due course. The staff involved with the visit were thanked on behalf of Healthwatch. Mr Hodgetts shared a letter which had been issued to his GP which presented an incorrect diagnosis. It was agreed that the matter would be followed up subsequent to the Board by Miss Barlow. Mr Lewis reiterated that this underlined the importance of copying letter to GPs to patients, as it allowed errors to be spotted. Ms Dutton suggested that an entry should be made in the letters which suggested a point of contact should the letter contain inaccuracies from the patient's point of view. It was agreed that this should be a matter that required action. Mr Lewis emphasised the need to implement robust controls and in the light of the digital dictation plans, the signing off of letters being by clinical rather than administrative staff.	
ACTION: Miss Barlow to introduce a contact point into patient letters that may be accessed should there be a need to raise any inaccuracies	
6 Patient story	**Presentation**
Stephanie Herilihy and Marion Long joined the Board to present the story of a patient who had been treated on Henderson Reablement unit. The story was noted be of successful treatment, and the patient was noted to be maintaining good progress since leaving the care of the Trust. It was reported that following the treatment, advice had been given as to ongoing management of the lifestyle of the patient. Dr Stedman asked whether there could have been better arrangements from the transfer between critical care and the reablement facility. It was agreed that a more lengthy rehabilitation in an acute setting initially would have been beneficial to the overall care in this case or alternatively, that the Henderson Unit needed to be better equipped with the means to treat patients of this nature. Ms Dutton asked in terms of the emotional support, what therapies had been provided. She was advised that having spent three months in ITU, motivation and	

encouragement to become independent had been necessary, including interaction with family. Dr Gill asked whether the communication experience with the GP had been effective. He was advised that there was little ongoing input from the GP in this case, except that which related to wound management. It was reported that comprehensive discharge summary had been provided. The Board was also advised that there was no need for a care package to be provided given than the patient was functional when she left. Ms Long reported that Icares was provided to support the process. The staff were thanked for their attendance and story.	
7 Chair's opening comments and Chief Executive's report	**SWBTB (6/14) 075**
The Chairman reported that the 'Trust's Got Talent' event had been well received. All were thanked for their attendance at the Leadership Conference on 5 June 2014 and the success of the event was highlighted. Mr Lewis reported that the process of defining the Top Leadership Cadre was proving occasionally controversial, but he remained of the view that it was important to define the structure of the organisation. It was noted that colleagues' endorsement around integrated care had been received at the recent leadership conference and there had been pleasing traction with the launch of the whistleblowing policy and the 2020 vision. Ms Robinson highlighted that there was a need to change the Board's working as part of the plans and that there had been a suggestion that the Board should go out to visit patients, in addition to receiving patients. This was agreed and we are holding a Board meeting in a GP surgery in November. Mr Lewis reported that he had attended the Sandwell Peoples' Parliament meeting where a number of opportunities for engaging with young people had been identified through this partnership. It was suggested that the Board be appraised of our work for patients with Learning Disabilities at a forthcoming Board meeting, and consider agreeing some organisation wide pledges for improvement. It was reported that practice around adult level psychiatry had deteriorated, with two patients having waited 24 hours for care, with one waiting in excess of 12 hours in Accident & Emergency. It was proposed that a discussion with the mental health trusts' senior management was needed with a view to address the deterioration. In terms of the mixed sex breaches, it was reported that new technology had been introduced to improve the robustness of reporting. The majority of the breaches reported related to stroke services, therefore additional focus had been given to resolving the issues in this area in relation to 'step down' arrangements. It was noted that in some instances where clinical care was of prime importance, single sex breaches were permitted. Spot audits were reported to be continuing to demonstrate that the measures to prevent this were working effectively. Dr	

Stedman noted that the work was tied into the clinical review process to define Level 1 as opposed to Level 2 patients. Mr Lewis encouraged Board members to visit the area if they were available. Mr Lewis reflected on the care of Mrs Greenhill and her family. He reiterated the apology he had given personally. He noted that the family had specifically requested that the issues raised be dealt with in private by the Board because of the unwanted media attention. The Board resolved to discuss the matter later that day. Dr Sahota noted that a new Director for Research & Development had been appointed. He suggested that the brief of the individual be widened to incorporate a number of further areas. Mr Lewis advised that the Research & Development strategy needed to be brought back to the Board prior to September, which would pick up these suggestions. It was noted that the Sickle Cell research was picked up robustly with the local universities. It was reported that check in kiosks would ask whether patients would be happy to be approached to join clinical trials and research. Dr Sahota emphasised that every effort should be directed into accessing European funding for the research. It was noted that an alternative model to the Learning Centre in the West Midlands needed to be considered.	
ACTION: **Mr Grainger-Lloyd to arrange for the Board to be appraised of the Trust's capacity to handle patients with learning difficulties at a future meeting** **ACTION:** **Dr Stedman to present the revised research & development strategy to the Board in October**	
8 Annual Accounts – Year ended 31 March 2014	**SWBTB (6/14) 076** **SWBTB (6/14) 076 (a)** **SWBTB (6/14) 076 (b)**
Mr Waite advised that the annual accounts had been previously considered by the Audit & Risk Management Committee and that all financial duties had been met. It was noted that inventories needed to be considered outside of the meeting. The Board agreed to adopt the annual accounts.	
9 2013/14 audit memorandum	**SWBTB (6/14) 077**
The Board was advised that the external auditors provided a clean opinion of the Trust's annual accounts and that the unadjusted balance differences were not judged to be material. Two points on the accounts were reported to be have been raised at the Audit & Risk Management Committee, which related to an error that had been identified and an additional disclosure needed to cross reference the remuneration	

overview with the remuneration report in the Annual Report.	
10 Letter of representation	**SWBTB (6/14) 078**
The Board was asked to review the representations in the Letter of Representation and approve the signing of the letter on behalf of the Board. Agreeing that the representations contained in the letter were justified and accurate, the Board approved the signing of the letter.	
11 2013/14 Annual Governance Statement	**SWBTB (6/14) 079** **SWBTB (6/14) 079 (a)**
The Board reviewed the Annual Governance Statement, to be issued by the accountable officer. Mr Lewis was asked colleagues to note three issues of control lapse in terms of Data Quality, noting however that there had been much effort directed to improving the integrity of data quality during the year. It was suggested that a re-audit of the controls to prevent Never Events should be presented at a forthcoming meeting of the Quality & Safety Committee. It was reported that there was continued concern around the non-pay controls, although these were reservations rather than being an extant issue. Ms Dutton noted that the focus of the Never Events was concentrated on theatres, rather than on other areas and suggested that a broader view be adopted, taking into account outpatients. Mr Lewis agreed to reword his statement. Mr Lewis invited comment on information governance and whether the AGS was clear enough. Miss Dhami reported that a Limited Assurance had been received from the Information Commissioners Office (ICO) following a Trust-instigated audit, however the Trust was not an outlier in this respect in comparison to most peer organisations. Notwithstanding this, work was reported to be underway to address the position. It was noted that Information Governance was part of the mandatory training suite. Mr Lewis reported that some site differences were the main concern of the ICO as part of the report, with the discrepancies being resolved by the end of the summer. It was agreed that the Board would receive an update on the progress with the delivery of the ICO development plan at a future meeting. Subject to the changes suggested, the Board noted the AGS.	
ACTION: Miss Dhami to present an update on the Never Events controls audit at the next meeting of the Quality & Safety Committee **ACTION: Miss Dhami to arrange for an update on the progress with the delivery of the ICO action plan to be presented to the Board**	
12 Quality Account 2013/14	**SWBTB (6/14) 080** **SWBTB (6/14) 080 (a) - SWBTB (6/14) 080 (c)**
Dr Stedman presented the draft Quality Account, which he noted would be published alongside the Annual Report. It was reported that the opinion provided	

by the external auditors was as expected. The Board was advised that there were some further external assurances were awaited. Subject to the receipt of the further external assurances, the Board agreed to adopt the Quality Account.	
13 Capital Plan 2014/15	**SWBTB (6/14) 081** **SWBTB (6/14) 081 (a)**
Mr Waite presented the Capital Plan for 2014/15. It was noted that the plan had been received and challenged by the Finance & Investment Committee at its last meeting. The Board was advised that the IM&T and estates priorities featured significantly in the plan. It was highlighted that an arrangement for the monitoring of the plan was designed to provide a more robust view. The risks associated with the plan were highlighted which it was noted would be kept under review by the Finance & Investment Committee. Mr Lewis provided strong support for the plan caveated by the requirement that the estates costs do not breach austerity measures in terms of minor works. Given the risk statements, it was agreed to seek verbal confirmation that the risks are captured in the risk register openly. Confirmation was sought that the financing costs of the capital were already provided in the annual budget and that maintenance revenue costs will be provided for in the financial year. Mr Waite reported that the financial costs were consistent with those in the strategic plan as were the revenue consequences of the scheme, with some allowances having been made within the strategic plan. It was reported that in 2015/16 some machinery going out of warranty would be picked up. It was agreed that through the Performance Management Committee any applied revenue implications on in year investment arrangements needed to be presented and monitored. Subject to these points, the plan was approved.	
ACTION: Mr Waite to ensure that the any revenue implications on in-year investment arrangements is monitored by the PMC	
14 Financial performance report – Month 1	**SWBTB (6/14) 082** **SWBTB (6/14) 082 (a)**
Mr Waite presented the financial position for Month 1. He highlighted that the deficit incurred was more significant than anticipated, largely associated with the under delivery of TSP schemes. Much attention was reported to be being directed to addressing the financial position. It was noted that the Finance & Investment Committee would meet monthly from now onwards. The balance of the TSP together with a line of sight in 2015/16 was reported to be the subject of the Executive in the short term. The level of agency expenditure was reported to remain of concern, with the Finance & Investment Committee providing due focus on this. The cash position was noted to be significantly below plan, which it was	

highlighted reflected a delay in the receipt of income associated with specialist services and the learning & development agreement funding which would be settled by the end of June. Payments in respect of non-pay creditors were noted to be being given attention at present. It was noted that there are no matters of significance in this respect that had been identified however, suggesting that the matter was a working capital timing issue. The pattern of spend in April 2014 was noted to mirror that in 2013. The Board was assured that the cash position would be addressed in due course when the creditor payments were normalised. Ms Robinson added that agency spend was in excess of budget and therefore further work was being undertaken to better understand the reasons for this. Mr Lewis advised that a trajectory of agency spend would be presented to the Finance & Investment Committee. Mr Kang advised that there was a budget phasing issue and balance sheet tracking that needed to be addressed. Mr Lewis noted that the Trust had not reduced expenditure as planned and significant attention would be directed to run rate analysis. Dr Sahota suggested that payment rate to bank staff needed to be considered as part of the work. Mr Ovington advised that the use of Thornbury non-framework agency presented a significant issue and that the use of temporary staff from this agency was being closely monitored. Ms Dutton suggested that the messages around the financial position needed to be embedded within front line clinical teams. Mr Ovington advised that there was mixed picture in terms of nursing leadership focus on finance and work was being undertaken to address this. Ms Robinson reported that there was a sense that more data needed to be provided for managers to demonstrate the implication in sickness absence for instance. She added that work should be undertaken to understand the ownership arrangements of Thornbury. Mrs Hunjan asked what arrangements were in place to fill Paediatrics and Neonatal nursing gaps. She was advised that there was a reliance on existing staff working additional shifts given the special nature of their roles. Mr Lewis advised that the matter was represented on the Trust Risk Register. Mrs Hunjan suggested that the delay to the recruitment through agency was a concern which was agreed to be a matter needing to be investigated. Mr Lewis advised that work was underway to develop the communication around the Trust's finances.	
15 Corporate integrated dashboard	**SWBTB (6/14) 083** **SWBTB (6/14) 083 (a)**
Mr Waite presented the corporate integrated dashboard which he advised continued to be an evolving report. An indication of the quality of data in the report against the various indicators was highlighted to be included in the report, as was a measure of peer comparison. Some areas of shortfall and positivity were highlighted. A further breach of the cancelled operations guarantee was noted to have been	

reported and the performance against the emergency care target was noted to have deteriorated within May and June. Miss Barlow noted that achievement of the emergency care target on a quarterly basis remained possible however, with non-admitted breaches being a key area of focus. It was noted that the surges in attendances needed to be recognised earlier to arrange the necessary support. Meetings with the CCG and Local Authorities were reported to have been held with a common commitment to deliver improvement and reduction in delays. Ms Robinson asked what work was being done in the community in respect of discharges. Miss Barlow reported that delayed transfers were reviewed twice daily which was delivering some good decreases in delayed transfers of care. Mr Lewis underlined the positive view of internal staff of the need to achieve a better position in respect of eliminating delays. It was highlighted that fines would be levied should they be needed as per the Board's previous mandate, however there was merit in awaiting the outcome of the current positive discussions. Mr Lewis added that some delays related to CCGs due to continuing care in addition to the Local Authority influences. Mr Lewis asked for the reasons why serious incident information was missing from the report, in addition to Cardiac data. It was agreed that the reasons for this needed to be understood. Ms Dutton suggested that the papers needed to be issued in good time for the consideration of the report by the Board Committees. Ms Robinson suggested that consideration needed to be given to understand the limitations to populating the data. Mr Lewis advised that there was an inherent lead time for some of the pieces of information. Mr Waite asked the Board to note the Group dashboard.	
15.1 18 weeks improvement plan	**Verbal**
Miss Barlow provided an overview of the current position in respect of performance against the 18 weeks referral to treatment time target. It was reported that some specialities were performing poorly against the target, although at an overall level the target was being met. The Board was informed that in May eleven areas underperformed against the target. Cardiology, T & O and Oral Surgery were notably underperforming. In April overall waiting lists were above where they expected to be, because of poor cashing up and some rise in demand. The Board was advised that there were a number of measures underway to catch up with the shortfall and further validation was underway. A new plan was reported to have been developed, although this needed to be validated further. The financial implications of the position were outlined at circa 500k, including the use of temporary medical staff to address waiting times. Ms Robinson asked in relation to the additional funding required, whether the cost pressure had been provided for. She was advised that this was within the list due to be set against central reserves. Mr Lewis advised that the process of scrutiny was within the remit of the Executive and clarity on non-recurrent investment including the exit	

plans from this commitment was needed. Ms Robinson asked whether there was an understanding of the reasons why the plans were not being achieved. She was advised that for those areas where there was a shortfall, theatre utilisation would need to be improved and clinics would be more robustly 'cashed up'. Mr Kang asked how the funding aligned to the areas' TSP targets. It was reported that unanticipated overspend was added to the cost savings, which was different to the previous practice. Mr Hodgetts expressed his concern with the safety of cardiology. Dr Stedman advised that the issue did not concern emergency access, but elective treatment. Mr Lewis advised that there was further work planned to understand the reasons for performance and the feasibility of delivery across the piece, in addition to at an individual speciality-level. He added that there needed to be focus on understanding the non-admitted risk better. It was agreed that a further update should be provided to the Board at the next meeting.	
ACTION: Miss Barlow to provide an update on performance against the 18 week referral to treatment time target at the next meeting	
16 Trust risk register update	**SWBTB (6/14) 085** **SWBTB (6/14) 085 (a) -** **SWBTB (6/14) 085 (c)**
Miss Dhami presented the updated risk register which proposed the addition of a further four red risks. The Committee was asked to note the updates to the treatment of the risks already included. The pre-mitigated red risks in summary were presented. It was highlighted that the risks presented for addition had been considered by the Risk Management Committee and the Clinical Leadership Executive. It was suggested that a discussion of the risks by the Board was needed to decide if they should be added. Mr Lewis advised that it was unclear as to the reasons for the reduction in the severity of the Pathology risk. He was advised that the response time for the engineers was much better and that a robust manual process was in place should the track equipment breakdown. He accepted that logic. The new risks were discussed in turn. In terms of the Ophthalmology outpatient risk, Ms Dutton expressed her concern that the mitigation in place did not reduce the severity of the risk. Mr Lewis advised that the rating of the risk was perhaps overstated having personally visited the department that day. It was agreed that the plans to address the current position would be outlined at the July Board meeting. The risk around the HDU Paediatric nurses was outlined. Dr Stedman reported that the staffing levels were assessed on an ongoing basis and that children needing high dependency care would receive this. Mr Lewis noted that there was no instance when the risk had crystallised. Mr Ovington noted that the rest of the	

Paediatric ward would be depleted should there be a high number of HDU patients. It was agreed that work that Mr Ovington and Miss Barlow would identify a proposed solution by the August Board meeting. The risk around the provision of tier four care for Paediatric patients was discussed. Mr Ovington reported that this was a national issue. Mr Lewis suggested that this may need to feature in the risk register for some time, and the Board accepted after discussion that there was no Trust driven remedy that was foreseeable. The risk around acute oncology services was discussed, where there was reported to be a risk that seven day cover for acute oncology services could not be provided jointly with University Hospital Birmingham FT. It was noted that the matter reflected a number of separate risks with various severities. Mr Lewis highlighted that the absence of a Pharmacist presented a significant risk. It was agreed that a solution would be investigated and timelined. Mr Cooke advised that an alert from the MHRA had been received in respect of the recent baby drips media publicity, although he highlighted that this did not appear to present an immediate issue for the Board.	
ACTION: **Miss Barlow to update the Board on the solution identified to addressing the Ophthalmology outpatient risk at the next meeting** **ACTION:** **Mr Ovington to investigate what financial solution was available to addressing the Paediatrics HDU risk in August** **ACTION:** **Miss Barlow to investigate and report back on the solutions available to addressing the acute oncology risks**	
17 Annual plan 2013/14 update – red and amber areas	**SWBTB (6/14) 086** **SWBTB (6/14) 086 (a)**
The Board was asked to receive and accept the update. It was agreed that the assessments represented a fair and accurate reflection of progress. Mr Lewis noted the 2014-15 annual plan, agreed in April for which the monitoring format would be visible at the July Trust Board.	
18 Timetable for the sign off of the five year plan submissions to the Trust Development Authority	**SWBTB (6/14) 087** **SWBTB (6/14) 087 (a)**
The Board was asked to receive and note the update and to note that the LTFM and IBP would be recurring items for the consideration of the Board at future meetings. Ms Robinson asked to what extent the Finance & Investment Committee could be involved in the scrutiny of the documents prior to submission. Mr Waite noted that the LTFM had had LFIC scrutiny but agreed to advise the committee chair of any material adjustments to the previously approved plan. The five year plan and IBP were being submitted in draft form. This was agreed.	

19 Pharmacy – Service update	**Presentation**
Mr Cooke joined the Board to provide an overview of the Pharmacy service. Mr Kang noted the continuity of medication as part of the integrated care plans and asked how the Trust was embracing this. Mr Cooke advised that better medicines management between the Trust and GPs needed to be improved to ensure waste was minimised for instance. Dr Stedman advised that the Drugs and Therapeutics Committee was efficient and that there was a move towards a local area formulary was planned. It was noted that the CQUIN targets incorporated Pharmacy-related elements. Mr Cooke was thanked for his report.	
20 Update from the meeting of Public Health, Community Development and Equality Committee held on 29 May 2014 and minutes from the meeting held on 27 February 2014	**SWBPH (2/14) 005**
The Chairman presented an overview of the key discussions from the Public Health, Community Development and Equality Committee held on 29 May 2014, which it was highlighted included volunteering and development of the equality & diversity framework. Mr Lewis reminded the Board that it would receive equality and diversity training at the informal meeting scheduled for 13 June 2014.	
21 Update from the meeting of the Quality & Safety Committee held on 30 May 2014 and minutes from the meeting held on 25 April 2014	**SWBQS (4/14) 036**
Ms Dutton presented an overview of the key discussions from the Quality & Safety Committee held on 25 April 2014 and minutes from the meeting held on 28 March 2014. She highlighted that the focus of the Committee had include the future workplan.	
22 Update from the meeting of the Finance & Investment Committee held on 30 May 2014 and minutes from the meeting held on 28 March and 16 May 2014	**SWBFI (3/14) 019** **SWBFI (5/14) 020**
Ms Robinson presented an overview of the key discussions from the Finance & Investment Committee held on 30 May 2014. It was reported that the Committee would meet monthly to retain a focus on the financial position and the delivery of the TSPs. The Board was advised the Ms Robinson would become the Trust's Board champion for procurement. It was noted that the national procurement plans provided a risk as well as an opportunity.	
23 Any Other Business	**Verbal**
It was highlighted that the lead for Whistleblowing would be the Chair of the Audit and Risk Management Committee for the oversight of the process.	
Matters for Information	

The Board received the following for information: • Midland Metropolitan Hospital Project: Monitoring Report • Foundation Trust Application Programme: Monitoring Report	**SWBTB (6/14) 088** **SWBTB (6/14) 089**
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 5th June 2014 and would be held in the Churchvale/Hollyoak Rooms, Sandwell Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 3 July 2014, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

5 June 2014, Churchvale/Hollyoak Rooms @ Sandwelll Hospital

Members present: Mr R Samuda (RSM), Ms C Robinson (CR), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr H Kang (HK), Dr Paramjit Gill (PG), 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)

Apologies: None

Secretariat: Mr Simon Grainger-Lloyd (SGL)

Last Updated: 27 June 2014

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
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	13/06/14	Included on the agenda of the private session on 3 July 2014	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	31/08/14	ACTION NOT YET DUE Update to Quality & Safety Committee arranged for August 2014	G
SWBTBACT.288	Questions from members of the public	Verbal	05-Jun-14	Introduce a contact point into patient letters that may be accessed should there be a need to raise any inaccuracies	RB	31/07/14	ACTION NOT YET DUE	G
SWBTBACT.289	Chair's opening comments and Chief Executive's report	SWBTB (6/14) 075	05-Jun-14	Arrange for the Board to be appraised of the Trust's capacity to handle patients with learning difficulties at a future meeting	SGL	07/08/14	Scheduled for August meeting of the Trust Board	G
SWBTBACT.290	Chair's opening comments and Chief Executive's report	SWBTB (6/14) 075	05-Jun-14	Present the revised research & development strategy to the Board in October	RST	02/10/14	ACTION NOT YET DUE	G
SWBTBACT.294	18 weeks improvement plan	Verbal	05-Jun-14	Provide an update on performance against the 18 week referral to treatment time target at the next meeting	RB	03/07/14	Included on the agenda of the Trust Board meeting of 3 July 2014	G
SWBTBACT.295	Trust risk register update	SWBTB (6/14) 085 SWBTB (6/14) 085 (a) - SWBTB (6/14) 085 ©	05-Jun-14	Update the Board on the solution identified to addressing the Ophthalmology outpatient risk at the next meeting	RB	03/07/14	Included within the risk management discussion included on the agenda of ther meeting being held on 3 July 2014	G

SWBTBACT.296	Trust risk register update	SWBTB (6/14) 085 SWBTB (6/14) 085 (a) - SWBTB (6/14) 085 ©	05-Jun-14	Investigate what financial solution was available to addressing the Paediatrics HDU risk in August	CO	03/07/14	Included within the risk management discussion included on the agenda of ther meeting being held on 3 July 2014	G
SWBTBACT.297	Trust risk register update	SWBTB (6/14) 085 SWBTB (6/14) 085 (a) - SWBTB (6/14) 085 ©	05-Jun-14	Investigate and report back on the solutions available to addressing the acute oncology risks	RB	03/07/14	Included within the risk management discussion included on the agenda of ther meeting being held on 3 July 2014	G
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	13/06/14	Training delivered at the June informal session	B
SWBTBACT.284	Rapid access chest pain performance	Verbal	01-May-14	Present an update on the Cardiology receiver plan at the next private Board session	RB	05/06/14	Included on the agenda of the meeting planned for 5 June 2014	B
SWBTBACT.285	Performance against the 18 week referral to treatment time target	SWBTB (5/14) 063	01-May-14	Prepare an analysis to highlight the number of patients who would be treated under the 18 weeks pathways and the likely waiting times expected	RB	05/06/14	Included on the agenda of the meeting planned for 5 June 2014	B
SWBTBACT.286	Quarter 4 2013/14 annual plan update	SWBTB (5/14) 066 SWBTB (5/14) 066 (a)	01-May-14	Present the detail of the 2013/14 Quarter 4 annual plan update red and amber actions at the next meeting	TW	05/06/14	Included on the agenda of the meeting planned for 5 June 2014	B
SWBTBACT.287	Declaration of Interests	SWBTB (6/14) 074	05-Jun-14	Update the register of directors' interests to reflect Dr Gill's GP practice work	SGL	06/06/14	Changes made and updated version included on the internet	B
SWBTBACT.291	2013/14 Annual Governance Statement	SWBTB (6/14) 079 SWBTB (6/14) 079 (a)	05-Jun-14	Present an update on the Never Events controls audit at the next meeting of the Quality & Safety Committee	KD	27/06/14	Quality & Safety Committee cancelled. Update at Trust Board on 3/7/14	B
SWBTBACT.292	2013/14 Annual Governance Statement	SWBTB (6/14) 079 SWBTB (6/14) 079 (a)	05-Jun-14	Arrange for an update on the progress with the delivery of the ICO action plan to be presented to the Board	KD	03/07/14	ICO action plan circulated	B
SWBTBACT.293	Capital Plan 2014/15	SWBTB (6/14) 081 SWBTB (6/14) 081 (a)	05-Jun-14	Ensure that the any revenue implications on in-year investment arrangements is monitored by the PMC	TW	30/06/14	Included within considerations of the PMC agenda	B

KEY:

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

CHIEF EXECUTIVE'S REPORT

Report to the Public Trust Board – July 2014

Last month at the Board we received our first Integrated Performance Report. This was an important step in my view because we were examining issues of workforce, safety, quality, national standards and other matters alongside each other. This reflects the real balance that colleagues and leaders face daily. This month's Board papers once again are anchored in that report. Inevitably, we focus attention on some areas of non-compliance - as is the case nationally we face challenges in delivering the emergency care standard and in sustaining elective care compliance. Although these issues have great media and political scrutiny, our motivation remains the promise we have made to local patients that these are quality standards we should meet routinely.

1. Our patients

In May we had an increase in waits for diagnostic services. Although the increase was modest, we are working hard to ensure that by August we can again ensure 99% of waits are below six weeks and in time we can have no breaches of this standard. Diagnostic waits are clearly periods of uncertainty for the patient and a degree of uncalibrated clinical risk, other than the urgency marker applied by the referring clinician.

We discussed as a Board last month the sharply increasing volume of long wait mental health patients in our A&E departments. Since that time we have seen some incremental improvement. Productive discussions have taken place with both mental health providers locally. We have in mind a very different model of care, based on each of our sites, which might offer a more suitable clinical environment, together with staff trained for the conditions presenting. I am confident that by the time of the next Trust Board we will have a firm proposition. As can be seen in out Emergency Care Recovery Plan in the board papers, we are clear that resolving issues of mental ill health are central to ensuring a short wait culture in our A&E departments.

It is extremely frustrating to once again begin our Board meeting with an exploration of a Never Event. Review suggests this occurred last year. Colleagues within the Trust have worked very hard over recent months to change our control regime to try and eliminate never events. That work continues and is reflected in the latest audit paper which we examine today. On a related matter, it is pleasing to continue to see the Trust performing well against peers for incident reporting rates. With employee payslips this month we again promote our new Whistle-blowing Policy, and I believe we are making progress with work to promote a open and just culture.

2. Our colleagues

I am pleased that our recent work to raise the profile of thanks for the work that teams do is being widely commented upon. Richard Samuda's note was welcomed, as was last month's Heartbeat. Nomination numbers are going moderately well for staff awards which close on July 4th and we still hope for the usual last minute rush. Meanwhile, a number of teams are into the final stages of

nomination for national awards, including pathology with the HSJ awards, and Occupational Health as a finalist in the Nursing Times, Excellence in Staff Health & Wellbeing awards.

Special mention should go to Lucy Titcomb in pharmacy, who has been recognised by the Royal Pharmaceutical Society as a new Fellow. Professor Lip has once again been recognised for his research work on atrial fibrillation. Board members are aware of the developing R&D Plan for the Trust being led by Karim Raza. Encouragingly, the Trust's beacon award winning Gynae-Oncology Service has just been awarded a very large NIHR grant - beating off national competition to do so. Our congratulations have been passed to Sean Kehoe and Sudha Sahota.

I am pleased to report considerable attention and praise for the work we have done our Public Health Plan 2014-2017, which we launched at our Leadership Conference. Public Health England have kindly agreed to visit us and explore how the plan came about and anything that they can do to support the work. The plan does contain controversial elements and towards the end of this summer we will implement the changes to Trust food pricing across our sites. This will cut prices for healthier food and increase closer to the local high street rate prices for less healthy options. Meanwhile, our ground-breaking work to fund Nicotine Replacement Therapy for employees has seen a very very good rate of quit success in the first fifty volunteers. The project is now being expanded further.

As you will know the NHS marks its sixty sixth anniversary on Saturday July 5th. To celebrate this, a mobile party is being arranged which will visit the staff on the Trust's wards and departments.

3. Our partners

Healthwatch in Birmingham launched their annual report at Edgbaston cricket ground on June 26th. I had the opportunity to present some thoughts from our organisation about how we are putting the voices of our patients at the heart of the Trust. We want to ensure that we do this using modern technology, such as the opinion widget that Healthwatch oversee which is now on the front page of our website feeding in comments on our services. But that also we take the opportunity to support specialty and condition specific groups whereby expert patients can contribute to service planning and design. The Clinical Leadership Executive has proposed that that should be a key component of our twenty Integrated Care Pioneer services within our 2020 vision.

Discussions continue around avoiding the delay of patient's discharge from our care (so called DTOCs). The Board had considered taking the significant step of invoking fines of Local Authority organisations for extended stays. We agreed last month to defer that step pending further progress with exciting proposals to completely change the model of social work support to our hospitals. Targeting change not later than early August, in time for the trainee handover, and with time to perfect the model before winter, we have reached agreement with the CCG and Sandwell Metropolitan Borough Council introducing an acute medicine unit based multi-disciplinary team. This will suspend section 2 and 5 paperwork and hand principle decision making authority over Continuing Health Care needs to that MDT. Crucially expected date of discharge plans, agreed with patients and all agencies, will govern the work of each team. Birmingham City Council are also a key partner in these plans and we are optimistic of reaching a similar agreement with them. This would rely on a clear platform for services in west Birmingham.

We end our partnership with Hospedia at City Hospital this summer. Our contract at Sandwell Hospital continues to 2017-18. Over coming days we will confirm the arrangements to introduce

patient available wifi services on our sites this autumn. Although there will therefore be a gap between one service ending and another beginning, we ought to be in a position to provide a clear timescale and plan to our staff and patients during July. We will endeavour to find an interim entertainment option for the three to four month gap. We will clearly need to keep both the pricing of the wifi option and the impact on internet speed site-wide under consistent review.

4. Our regulators

Consistent with national expectations, we have produced recovery plans for emergency care, and a response plan for diagnostic waits. These have been considered by the TDA and feedback is awaited. Government has allocated additional funds to CCGs to support further investment in emergency care and elective waits, and we are progressing proposals in both areas. National policy now proposed a pause in commissioner fines for non-compliance in elective care. We are exploring with commissioners how this will be enacted.

Publication is awaited of the latest CQC Intelligent Monitoring data, covering the period to June 2014. We are cautiously optimistic of another strong review consistent with the good rating we would require to be nominated for further progress as a Foundation Trust.

Considerable effort and diligence has gone into the latest planning submissions made through the TDA. We discussed in our last Board those proposals, based on the LTFM and LTWM we aged in autumn 2013. Two year plan submissions have been rated low-medium risk, which is both encouraging and broadly consistent with our own view. We believe a similar conclusion should be reached in respect of our five year plan, notwithstanding the additional implementation bandwidth required to deliver our EPR and Midland Metropolitan Hospital plans.

Similar plans have been proposed across the Unit of Planning (Sandwell, Birmingham and Solihull). Review across that landscape suggests congruence on the scale of financial challenge across provider and commissioner assumptions. Over that medium term period radical change is needed in what we do and how we do it if we are to operate within the funding regime now expected in the rest of this decade. We believe that the implementation of Right Care, Right Here, including our closure of 2 A&E departments, and rationalisation of acute services, makes a material contribution to that reform project.

5. Hot Topics

Discussions in Hot Topics were dominated by two issues during June. Firstly the launch of our Whistleblowing Policy, and then secondly, the always difficult choices around financial balance. As we discussed last month changes to our restaurants have occasioned much discussion, as has changes to reserved car parking. Upcoming alterations to staff accommodation rents after a three year cap may well drive discussion. Medical staff committee and other bodies are being used to ensure that we have the widest possible discussion about service changes and the choices that we need to make in finalising our savings plans for 2014-2016. I was pleased to note the feedback of that body that the leadership team, led by Rachel Barlow, had revised theatre scheduling, and annualisation, plans after extensive clinical feedback in February and March. The tone we are seeking to achieve remains one where everyone who works with us, and who serve, has a voice in what we do, but no-one has a veto over change and reform.

By way of a reminder to the Board, the next meeting will be held at Rowley Regis Hospital on 7 August.

Toby Lewis
Chief Executive
27 June 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**'Never Events': Assurance plan Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami – Director of Governance**
AUTHOR:	**Allison Binns, Assistant Director of Governance**
DATE OF MEETING:	**3 July 2014**

EXECUTIVE SUMMARY:

This report provides an update on 'Never Events' assurance processes; focusing on any outstanding audit results and conclusions.

There remains continued concern regarding the documentation of swab counts and site marking, together with the documentary evidence on the consent form that a patient has received written information.

As at reporting, a serious incident investigation has confirmed that a Never Event occurred at the Trust in relation to a guidewire left in situ; the incident occurred between 29 January and 3 March 2014. (This was notified by a neighbouring Trust when they saw the patient on 9 June 2014 when attending for a peripherally inserted central catheter (PICC) line insertion. The neighbouring Trust has since removed the guidewire and held discussions with the patient.) The investigation report is still being finalised; learning outcomes and investigation actions will be monitored through the Patient Safety Committee.

The proposal for a Never Events Assurance Committee (NEAC) has been planned for some time; however the re-occurrence of a Never Event and ongoing assurances required across the Trust give rise to the immediate establishment of this group, which will report to the Patient Safety Committee.

REPORT RECOMMENDATION:

The Trust Board is asked to **DISCUSS** and **APPROVE** the conclusions.

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

Accept	Approve the recommendation	Discuss
X		

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

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

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

High Quality Care

PREVIOUS CONSIDERATION:

Executive Group and Clinical Leadership Executive (28 January 2014)

'Never Events': Controls Audit Report

1. Introduction

Audits were undertaken across diverse specialties and directorates to provide assurance on processes which contributed to the Trusts recent Never Events. Variable practices were apparent which prompted a number of recommendations in targeted areas followed by re-audits.

This report provides an update on the results and what has been concluded from them (ongoing / further actions to be monitored by the Never Event Assurance Committee are highlighted in bold font within the table).

The assurance level for each issue has been assigned based on the results of the audits undertaken and on the conclusions drawn from the initial audits.

Table 1

Grade	Assurance Level	
4	High	Good compliance
3	Medium/high	Reasonable compliance
2	Medium	Average compliance
1	Low	Poor/no compliance

	Issue requiring assurance	Action taken	Results/Practice changes	Conclusion / Comments	Assurance level
1.	The number of cases reviewed in Urology was not adequate to provide assurance that surgical site marking and swab / instrument counts were robustly carried out.	Urology carried out a retrospective audit of swab and instrument counts of 40 sets of notes.	The audit results showed: **Surgical Site:** - On who checklist 87.5% - On theatre care plan 86% **Swab count:** - On who checklist 85% - On theatre care plan 97.5%	The level of compliance is commensurate with the results from the first audit of all surgical specialties. However, the expectation for all specialties would be that this is closer to 100%.	**3**

	Issue requiring assurance	Action taken	Results/Practice changes	Conclusion / Comments	Assurance level
				Incident forms will be completed for all cases where the site (if bilateral organ) is not marked or swab checks not documented. **This will now be included as a monitoring tool in the appropriate policy.**	
2.	Assurance on surgical site marking in Ophthalmology following a further Never Event despite having 100% compliance with this audit previously.	Surgical site marking audit undertaken in a) Theatre b) Laser treatments in OPD	Theatre: 60/60 cases marked. Laser OPD: 12/12 cases marked.	Continued maximum compliance has been gained through these re-audits, giving continued assurance that there are robust processes in place now.	**4**
3.	Assurance on consent taking in Ophthalmology following a further Never Event despite having 100% compliance with this audit previously.	The consent process for 10 laser patients and 10 intravitreal injection patients was audited.	Result for both audits was 100%		**4**
4.	100% was achieved on the audit of the Lens protocol, but a further Never Event showed that errors could occur by not using paper records which have been matched to the patient.	Biometry to be printed and secured within the Healthcare records. This will then be the check for correct lens placement. Protocol updated and disseminated.	Healthcare records checked and this shows 100% compliance with protocol. A recent near miss also identified that checking procedures are working.	Reassuringly the protocol put in place since the last Never Event has prevented a further one from occurring. Surgery B to ensure continued control of sessions where	**4**

	Issue requiring assurance	Action taken	Results/Practice changes	Conclusion / Comments	Assurance level
				company reps are in theatres though.	
5.	Although tissue is x-rayed post removal in breast surgery and reviewed at the MDT documentation of this review is not consistent.	Stamp purchased for theatres (care plan) until this can be added into the next theatre care plan print (e.g. guide wire removed Yes ☐ No ☐, Guidewire removal confirmed – date/name)	The Directorate look at the images for every guided case in the MDT and check the specimen X-rays to ensure the guide wire is present. If it is not present the notes are checked to ensure that the disposal of the wire is recorded. There have been no unrecorded wires since this way of doing it was introduced.	Breast have a robust method for checking that their wires are removed but both the stamp and the amended theatre care plan are available for their use.	**4**
6.	Vascular surgery do not routinely document that the guide wire has been removed following Radio Frequency Ablation vein removal.	To audit current practice and use the stamps as above.	A pre stamp audit (baseline) showed that 17% of 23 spot checked cases were compliant for documentation. Stamp use has since been introduced.	The use of the stamp commenced in June 2014 following their baseline audit. **They will monitor their own compliance with a further audit in Q2 and share with NEAC.**	**None assigned**
7.	In defining actions it was identified that T&O also use guide wires and that no information has been sought on their compliance of documenting removal	T&O to undertake an audit showing that 100% of eligible cases will be documented as having the guide wire removed following surgery.	A prospective audit of the documentation and use of the guidewire stamps started in June 2014, data collection will continue for a one month period. Results will be collated in July 2014	**The results of the audit will be shared with NEAC and further actions advised as appropriate.**	**None assigned**
8.	The protocol used in Maternity requires swab and instrument counts to	The protocol was amended at the time of the initial audit and all staff advised that swab and instrument	Data collection was delayed due to operational reasons but is planned to start in July 2014.	The directorate recognised that their protocol was inaccurate during their first audit and	**4**

	Issue requiring assurance	Action taken	Results/Practice changes	Conclusion / Comments	Assurance level
	be recorded in; the WHO checklist or the maternity theatre care plan rather than either for instrumental deliveries and C sections which are carried out in theatres.	counts are to be recorded in both sets of documentation		amended it halfway through. Compliance at the previous audit was 94% and this review audit is to reassure that the policy change is embedded.	
9.	Documentation of the provision of information leaflets to assist patients with making an informed decision about undergoing a procedure was variable.	All specialties to review the available leaflets provided by EIDO, through CONNECT. Processes to be put in place to improve the provision of information and its documentation for each specialty. - Ophthalmology - T&O Full review of available EIDO information leaflets taking place within all specialties of Surgery A. Discussions with IT to link leaflets to electronic record	The February / March 2014 consent data shows a marginal improvement in the provision of information leaflets documented on the consent form of 32% from 28% in October / November 2013. Not an IT priority.	The monthly audits will continue to be reviewed to ensure the use of leaflets is evidenced on consent form. Each specialty will be required to provide an improvement trajectory. **Consent and its components will be monitored though NEAC.**	**1**
10.	All specialties to ensure that they have a robust method of taking consent prior to procedure day	T&O already shared message to consent in clinic but will also review BOA consent and information protocols and explore	Audit results show that 103 patients were not consented prior to the day of the procedure. The auditor opinion is that of these 103	This element is collected through the monthly consent audits. All directorates will be required to contribute monthly and to have	**2**

	Issue requiring assurance	Action taken	Results/Practice changes	Conclusion / Comments	Assurance level
	except in direct access cases.	the use of pre-printed labels. All surgery A directorates told to take consent in clinic and then re-audit	cases, there were 29 where there were opportunities to take consent prior to the admission.	an improving trajectory. **This will be monitored through NEAC**	
11.	Improvement in numbers of nurses in 'high risk' areas having completed training for NGT insertion.	CCS and Stroke staff completing NGT competencies Changes made to the NGT training. Awareness raising of issues relating to NGTs	Majority of specialist staff are fully competent (practical and theory/ cross site) New starters are booked on NGT study days 2 signatures now required for x ray sticker Training / shadowing Nutrition Nurses has commenced and will be on going	There is a corporate steer for NGT and those responsible for the NGT policy, practices and training are very receptive to the changes required through national alerts and local incidents. They review the processes and are very quick to react if there needs to be additional safety steps or training to improve safety.	**4**
12. 4	Following an incorrect dental extraction a process required defining to reassure that it wouldn't happen again.	Teeth to be extracted are marked on the x-ray in clinic ahead of the procedure.	Marking was carried out in 82% of cases (27/33)	Oral surgery advise that there is no absolute failsafe but will continue to mark x-rays.	**3**
13.	Assurance that robust processes are in place for relevant Never Event list.	A review of guidelines/protocols and SOPs relevant to the listed never events.	All relevant policies etc. have been identified. Leads are being asked to provide audits or the monitoring results as advised by the policy. The controls will then be assessed.	**The NEAC will aim to have reviewed/tested the controls for relevant never events and made the required changes in practice within Q3 and Q4.**	**None assigned**

	Issue requiring assurance	Action taken	Results/Practice changes	Conclusion / Comments	Assurance level
14.	Robust processes are in place to ensure patient safety where consent on the day of procedure is required e.g. T&O, Gastro	Review direct access procedures, define audit methodology and undertake.	A survey has been designed which will be released to all specialties and analysed in Q2.	**The NEAC will require all areas identified as taking consent on the day as having safe processes in place.**	**None assigned**

In addition to those audits carried out, **Ophthalmology** checked to ensure that **patients were being positively identified**. This was a survey of 25 patients who were asked if both the nursing staff and medical staff asked them to provide identification information. 100% of nurses requested this information and 23/25 doctors asked for it. The information requested of the patients was name, address and date of birth. This shows **reasonable compliance**.

2. Conclusion

a. On the whole the results of the targeted audits are encouraging in that there are good results which provide a high level of assurance. Areas which continue to cause concern are those which relate to documented evidence of compliance with processes, such as swab counts and provision of information leaflets.

b. Anecdotally when asked if processes are followed the answers is affirmative. However, proof that this has occurred is often not easily seen within healthcare records and thus leaves the Trust open to criticism but more importantly identifies significant questionable safety practices, leaving patients exposed.

c. Despite a run of never events and the undertaking of this assurance process the challenges identified in the initial assurance plan remain. Whilst there are pockets of proactive patient safety assessments the culture is still one of reactivity with continued under reliance on the need for accurate and timely documentation.

d. A recent incident also proved to be a never event regarding the retention of a guidewire. The use of guidewires and the processes for ensuring full removal will be reviewed within the survey to be launched regarding consent undertaken on the day of the procedure.

e. The WHO checklist group is being disbanded to be superseded by a new committee to be known as the Never Events Assurance Committee (NEAC). This committee will report quarterly to the Patient Safety Committee and be responsible, with the membership from clinical groups, for monitoring processes which have contributed to our Never Events.

3. Recommendations

The Trust Board is asked to **DISCUSS** and **APPROVE** the conclusions and the formation of the NEAC.

Kam Dhami
Director of Governance

June 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Performance Report
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance & Performance Management
AUTHOR:	Gary Smith, acting Head of Performance Management
DATE OF MEETING:	3 July 2014

EXECUTIVE SUMMARY:

This report is to inform the Board of the summary performance of the trust for the period May 2014.

REPORT RECOMMENDATION:

The Board members are asked to consider the content of this 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

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 good value for money.

PREVIOUS CONSIDERATION:

Finance & Investment Committee; Workforce & OD Committee

Sandwell and West Birmingham Hospitals
NHS Trust

Integrated Quality and Performance Report

May 2014

Contents

At A Glance

Infection Control

The number of cases of C Diff reported during the month was 2, both in Gastroenterolgy one in D26 and one in PR5,compared with a trajectory of 3 for the period. There were no cases of MRSA Bacteraemia reported during the month. The incidence of MSSA and E. Coli, both expressed per 100,000 bed days are within TDA identified operational thresholds.

MRSA Screening for Elective and Non-Elective patients is reported as 83% and 98% respectively for the month.

Harm Free Care

All Groups met each of the 3 components reported for the WHO Surgical Checklist, with Trust performance for all elements exceeding operational thresholds.

There were 5 Open CAS Alerts reported, 1 of which was overdue at the end of the reporting period (May), but subsequently closed on 4 June 2014.

The number of Grades 2-4 avoidable pressure sores fell to 4 cases for April (the latest data). All were at grade 2 level with 2 occuring in Medicine, 1in Surgery A and one in Community.

Obstetrics

The overall Caesarean Section rate for May (25.98%) is similar to April. The Elective rate for the month was 7.91% and Non-Elective rate 18.02%.

Admissions to Neonatal Intensive Care reduced to 4.59% for the month of May, and 5.22% for the year to date.

Data for Puerperal Sepsis and other puerperal infections is included in the report, aligned to CQC definitions.

Mortality & Readmissions

The Trust's HSMR for the most recent 12-month cumulative period is 89.3, which remains beneath that of the SHA Peer. The City site HSMR remains beneath lower statistical confidence limits (75.3), with the Sandwell site HSMR (102.5), within statistical confidence limits for the most recent 12-month cumulative period.

Mortality rates for weekday and weekend, low risk diagnoses and CQC diagnosis groups are within or beneath statistical confidence limits.

During the most recent month for which complete data is available (March) the overall Trust performance for review of deaths within 42 days improved to 83%.

Stroke Care & Cardiology

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 an improvement in the proportion of patients spending 90% or more of their stay on an Acute Stroke Unit (92.7%) and also an improvement in the proportion of patients admitted to an Acute Stroke Unit within 4 hours (89.1%). Other reported Stroke Care metrics all met the identified operational thresholds with the exception of stroke admission to thrombolysis time that dropped to 69.2% against a 85% target.

Cardiology Primary Angioplasty data for March indicates variable performance by site. Door to Balloon performance is 58% and 90% for City and Sandwell respectively. Call to Balloon performance is 60% and 100% for City and Sandwell respectively. Targets for both are equal to or greater than 80%. RACP performance for March is reported as 91.6% (95.6% year to date), compared with a target of equal to or greater than 98%.

Cancer Care

The Trust continues to meet, for month (April) and year to date all high level Cancer Treatment targets.

Exceptions at Group level were; Medicine (92.7%) and Women & Child Health (85.5%) both failed to meet the 93.0% operational threshold for the 2-week maximum cancer wait, and Women & Child Health (72.0%) failed to meet the 85.0% operational threshold for 62-day urgent GP referral to treatment.

Patient Experience - MSA & Complaints

A total of 43 Mixed Sex Accommodation breaches were reported during the month of May comprising; Coronary Care Sandwell (14), Priory 4 Sandwell (21) and AMU A Sandwell (8). Fines levied by commissioner (£250 / occupied bed day) are c.£29K for the year to date.

An expectation of zero tolerance of MSA breaches has been communicated to Clinical Group Management. Solutions to eliminate such breaches are expected. Daily capacity discussions will in future include mixed sex accommodation as an item. Spot checks at ward level are also to be undertaken.

Patient Experience - Cancelled Operations

Cancelled Operatons - a breach of the 28-day late cancelled operation guarantee was reported for the month of May. The breach related to the specialty of Cardiology, and is attributed to the lack of an available bed. A Root Cause Analysis of the circumstances has been requested and an assurance requested by the Chief Operating Officer on processes, escalation and zero tolerance.

Cancelled Operations - the proportion of SitRep declared late cancellations during the month of May remained at 0.9%. Numerically late cancellations increased from 38 to 43 during the month, and by Group were attributed to; Medicine (2), Surgery A (16), Surgery B (22) and Women and Child Health (3).

Emergency Care

The Trust did not meet the 4-hour ED wait target during the month of May with performance of 93.5%. Performance for the Quarter to date (as at 25th June 2014) is 94.2%. The Quarter is predicted to outturn at 93.0% as the number of breaches for the month has been exceeded. Submission of a recovery plan by Tuesday 17 June has been requested by the NTDA. Internally focus is on earlier escalation informed by on-going reference to demand and capacity data, set daily transfer / discharge targets for admission units and improving patient turnover from MFFD wards. A number of Middle Grade doctors and ENPs are set to commence employment with the Trust soon to improve workforce availability.

Fractured Neck of Femur - the proportion of patients who received an operation within 24 hours of admission during May improved considerably to 90.0%, also improving performance for the year to date to 74.1%.

Referral To Treatment

Data for May is showing 2 patients that have breached 52 weeks, one in ENT and one in general Surgery.

A number of specialties are 'off trajectory' in terms of improving RTT performance. A 'lock down' discussion with the Chief Executive and Chief Operating Officer is scheduled for any specialty off plan, to identify factors influencing this, what plans are to retrieve performance and future adherance to plans.

Acute diagnostic waits in excess of 6 weeks has exceeded the <1% threshold at 1.4%. 6 types of test have failed target in May. The NDTA have requested a recovery plan by June 30th.

Staff

PDR overall compliance as at the end of May reduced to 91.5% overall (range by Group 88 - 96%).

Mandatory Training compliance remains stable at 87% with with performance by Group ranging between 82% - 95%.

Sickness Absence during May is reported as 3.94% (range 2.7 - 5.5%), and 4.28% for the 12-month cumulative period.

CQUIN

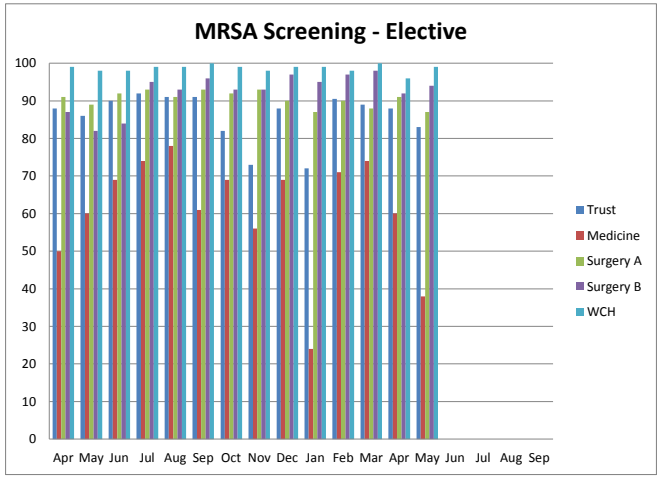
The Trust is contracted to deliver a total of 22 CQUIN schemes during 2014 / 2015. 9 schemes are nationally mandated, a further 10 have been agreed locally, with the remaining 4 identified by the West Midlands Specialised Commissioners. The collective financial value of the schemes is c.£8.3m.

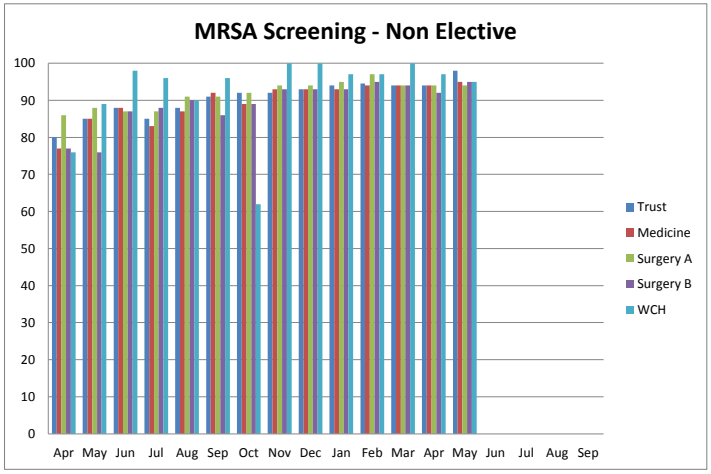
A significant number of the schemes require an initial baseline assessment during quarter 1, following which an improvement trajectory willl be agreed with commissioners.

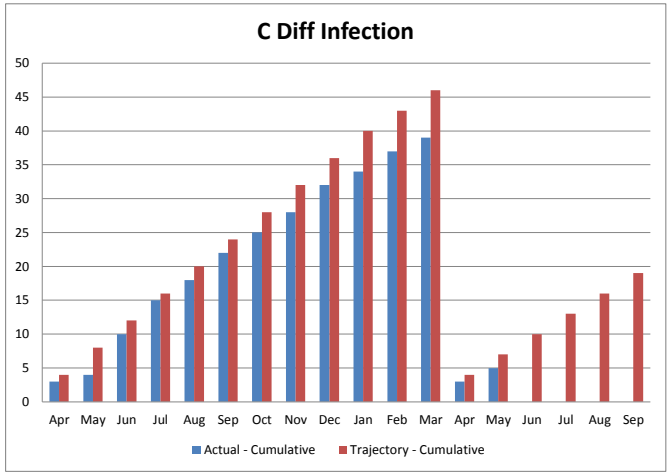
Of schemes with performance reported to date, Dementia screening failed to meet 90% in all 3 components (Find (97%), Assess (69%) and Refer (100%)). Contractual requirements are to deliver 90% in each component for each month during the quarter.

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A M J J A S O N D J F M A M J J A S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
4			C. Difficile	37	4		May-14	2	0	0	0					2	5			
4			MRSA Bacteraemia	0	0		May-14	0	0	0	0					0	0			
4			MSSA Bacteraemia (rate per 100,000 bed days)	<9.42	<9.42		May-14									4.4	4.5			
4			E Coli Bacteraemia (rate per 100,000 bed days)	<94.9	<94.9		May-14									17.48	13.6			
3			MRSA Screening - Elective	80	80		May-14	38	87	94	99					82.8				
3			MRSA Screening - Non Elective	80	80		May-14	95	94	95	95					97.8				

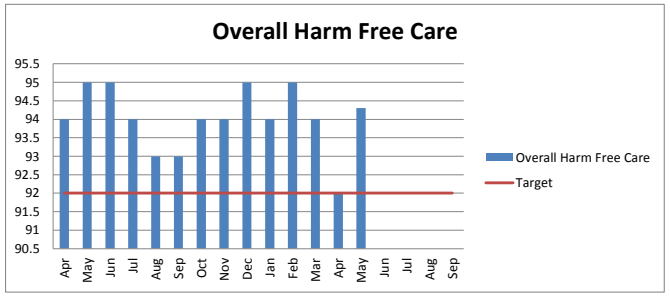


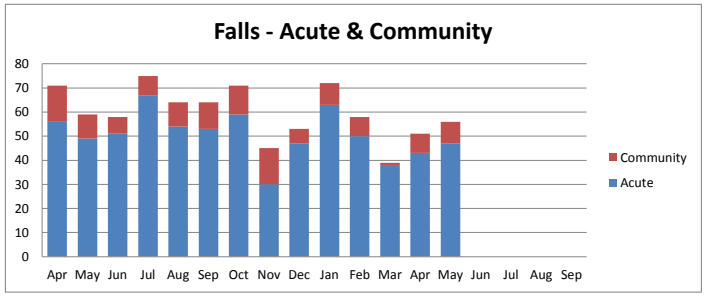


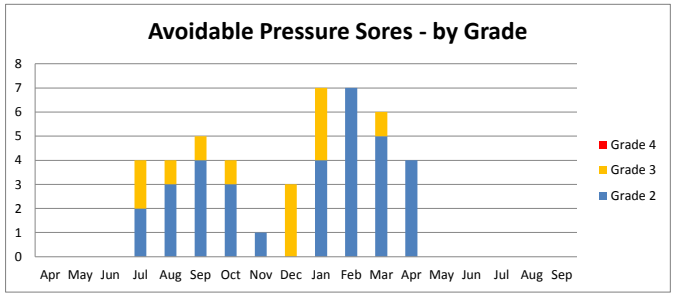


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		d	Patient Safety Thermometer - Overall Harm Free Care (%)	=>92	=>92	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14									94.9		●		
8			Falls	804	67	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	40	7	0	0			9		56	107	●		
9			Falls with a serious injury	0	0	3	3	4	●	●	1	6	2	6	2	1	2	1	4					May-14	2	0	0	0		0	2		4	5	●		
8			Grade 2,3 or 4 Pressure Ulcers (avoidable)	0	0	14	16	13	4	4	5	4	1	2	7	8	7	4					Apr-14	2	1	0	0			1		4	4	●		
3		d	Venous Thromboembolism (VTE) Assessments	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	99	98	98	92					98		●		
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	98	98	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	100	100	99.4	100					99.77		●		
3			WHO Safer Surgery - 3 sections and brief (% lists where complete)	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	100	100	98	100					99.3		●		
3			WHO Safer Surgery - Audit - 3 sections, brief and debrief (% lists where complete)	85	85	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	100	100	98	100					99.0		●		
9		d	Never Events	0	0	●	●	1	●	1	●	●	2	●	1	●	●	●	●					May-14	0	0	0	0	0	0	0		0	0	●		
9		d	Medication Errors causing serious harm	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	0	0		0	0	●		
9		d	Serious Incidents	0	0	0	5	3	10	7	5	1	4	0	2	0	1	3	2					May-14	2	0	0	0	0	0	0		2	5	●		
9			Open Central Alert System (CAS) Alerts			5	5	3	6	6	8	7	6	9	9	8	11	9	5					May-14									9		●		
9		d	Open Central Alert System (CAS) Alerts beyond deadline date	0	0														1					May-14									1		●		

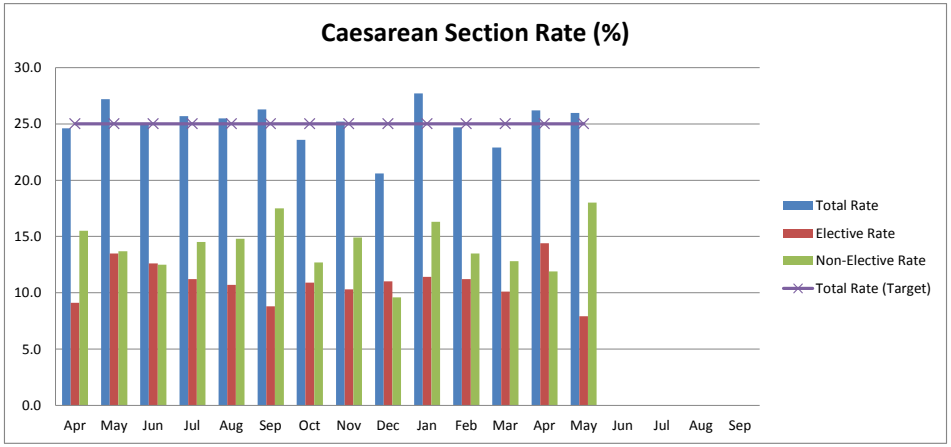


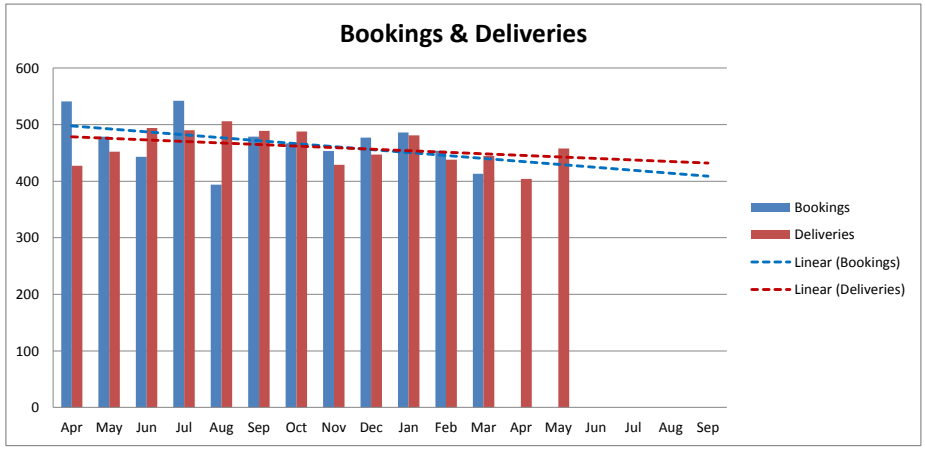




Patient Safety - Obstetrics

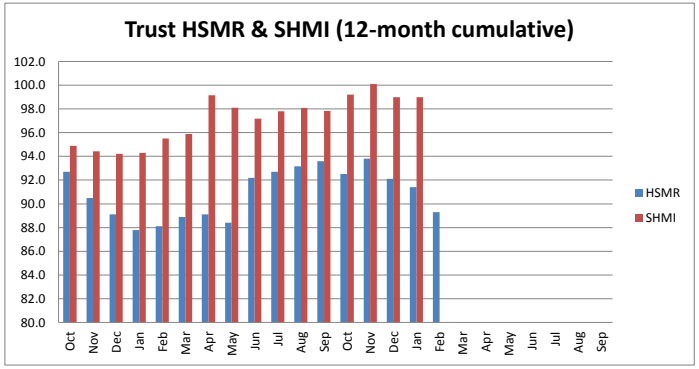
Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Caesarean Section Rate - Total (%)	=<25.0	=<25.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	25.98	26.1	●		
3		●	Caesarean Section Rate - Elective (%)			9	14	13	11	11	13	11	10	11	12	11	10	14	8					May-14	7.91	9.0			
3		●	Caesarean Section Rate - Non Elective (%)			16	14	13	15	15	16	13	15	10	16	14	13	12	18					May-14	18.02	17.1			
2		●d	Maternal Deaths	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	0	0	●		
3			Post Partum Haemorrhage (>2000ml)	48	4	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	0	0	●		
3			Admissions to Neonatal Intensive Care (%)	=<10.0	=<10.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	4.59	5.22	●		
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<8.0	<8.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14	11.3		●		
12			Early Booking Assessment (<12 + 6 weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14	134		●		
2			Breast Feeding Initiation (Quarterly) (%)	=>77.0	=>77.0			●			●			●			●							Mar-14	75.4	76.2	●		
2		●	Puerperal Sepsis and other puerperal infections (variation 1) (%)			4.2	7.0	2.3	5.1	4.3	2.4	1.9	1.9	3.4	1.3	2.3	0.7	2.0	1.0					May-14	1.0	1.6			
2		●	Puerperal Sepsis and other puerperal infections (variation 2) (%)			1.5	1.9	0.6	1.7	1.4	1.3	1.0	0.5	1.4	0.2	1.6	0.5	1.3	1.0					May-14	1.01	1.16			
2		●	Puerperal Sepsis and other puerperal infections (variation 3) (%)			0.5	0.9	0.0	0.9	0.6	0.9	0.2	0.2	0.5	0.2	0.2	0.0	0.5	0.7					May-14	0.67	0.58			

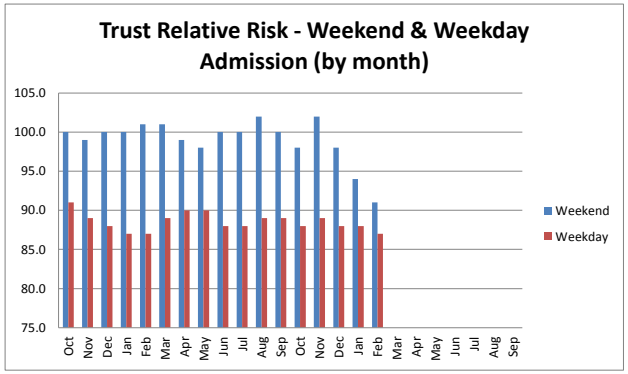


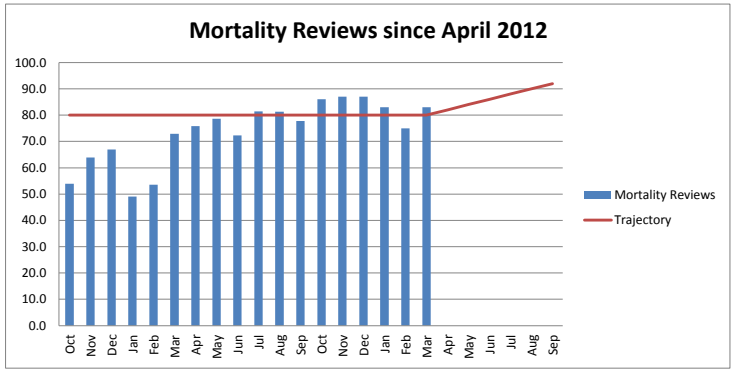


Clinical Effectiveness - Mortality & Readmissions

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
5		C	Hospital Standardised Mortality Rate - Overall (12-month cumulative)	Below Upper CI	Below Upper CI	89	88	92	93	93	94	93	94	92	91	89									Feb-14										89.3	●		
5		C	Hospital Standardised Mortality Rate - Weekday (12-month cumulative)	Below Upper CI	Below Upper CI	90	90	88	88	89	89	88	89	88	88	87									Feb-14										86.9	●		
5		C	Hospital Standardised Mortality Rate - Weekend (12-month cumulative)	Below Upper CI	Below Upper CI	99	98	100	100	102	100	98	102	98	94	91									Feb-14										90.8	●		
6		C	Summary Hospital-level Mortality Index (12-month cumulative)	Below Upper CI	Below Upper CI	99	98	97	98	98	98	99	100	99	99										Jan-14										99.0	●		
5		C	Deaths in Low Risk Diagnosis Groups	Below Upper CI	Below Upper CI	●	●	●	●	●	●	●	●	●	●	●									Feb-14									96.4		●		
3			Mortality Reviews within 42 working days	100	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●								Mar-14	81	91	100	100					83		●		
5		C	Emergency Readmissions (within 30 days) - Overall (%) (12-month cumulative)			9.1			8.9			8.9													Jan - Dec 13									8.9				
5			Emergency Readmissions (within 30 days) - Following Initial Elective Admission (%) (12-month cumulative)			4.1			4.2			4.1													Jan - Dec 13									4.1				
5			Emergency Readmissions (within 30 days) - Following Initial Non Elective Admission (%) (12-month cumulative)	=<10.9	=<10.9	13.7			13.3			13.4													Jan - Dec 13									13.4		●		

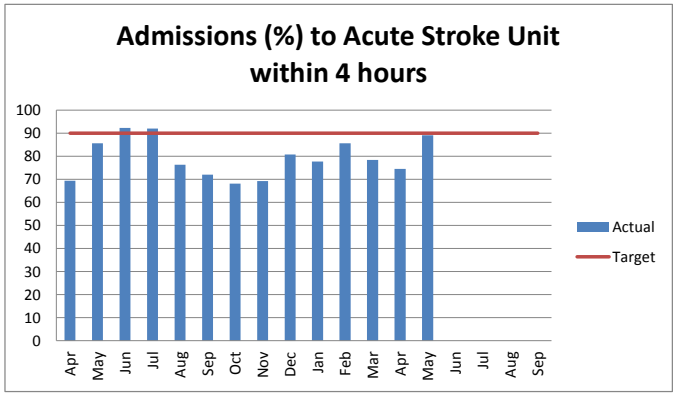


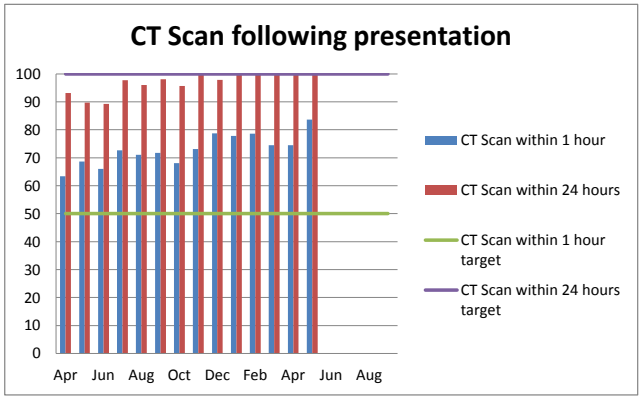


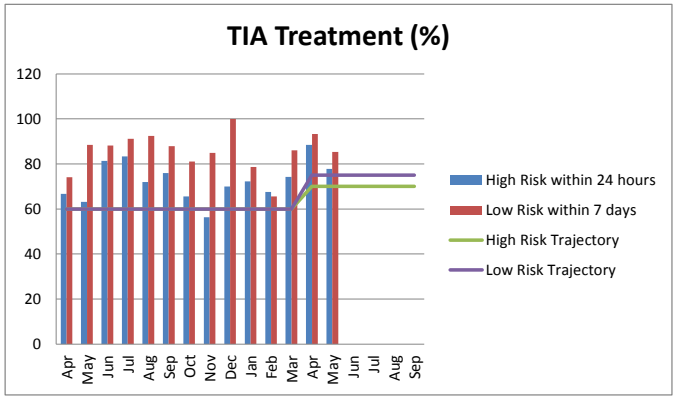


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Pts spending >90% stay on Acute Stroke Unit (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	92.7	84.1	●		
3			Pts admitted to Acute Stroke Unit within 4 hrs (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	89.1	82.6	●		
3		●	Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	83.6	77.7	●		
3			Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	100.0	100.0	●		
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	69.2	84.6	●		
3			Stroke Admissions - Swallowing assessments (<24h) (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	100.0	100.0	●		
3			TIA (High Risk) Treatment <24 Hours from initial presentation (%)	=>70.0	=>70.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	77.8	81.6	●		
3			TIA (Low Risk) Treatment <7 days from initial presentation (%)	=>75.0	=>75.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	85.3	89.3	●		
9			Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14	58 (C) & 90 S)		●		
9			Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14	60 (C) & 100(S)		●		
9			Rapid Access Chest Pain - seen within 14 days (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14	91.6	95.6	●		

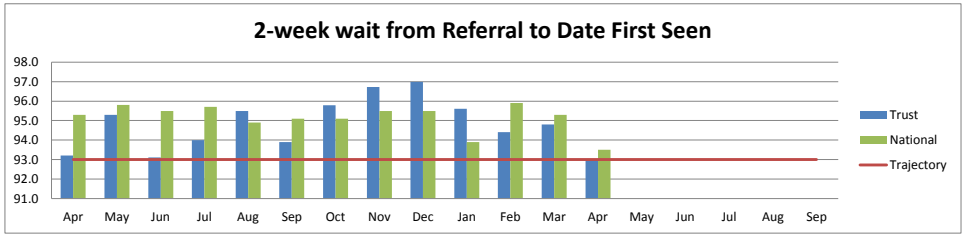


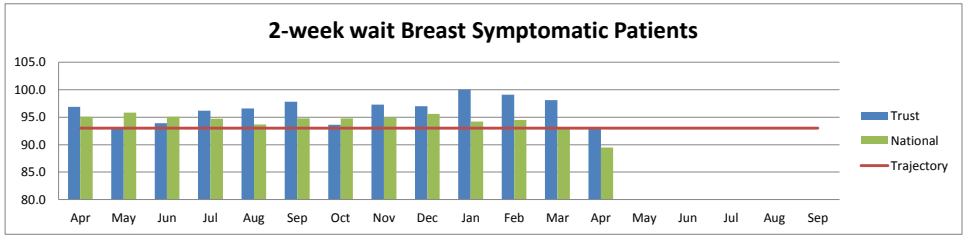


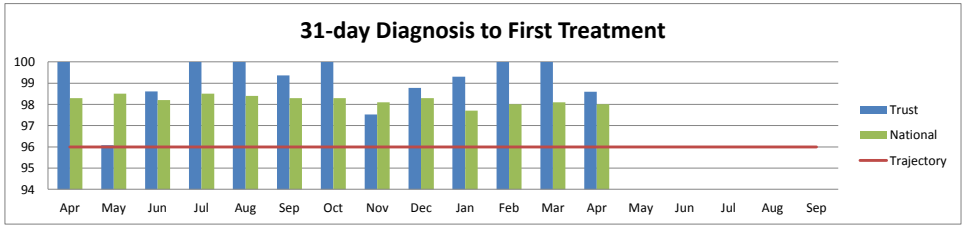


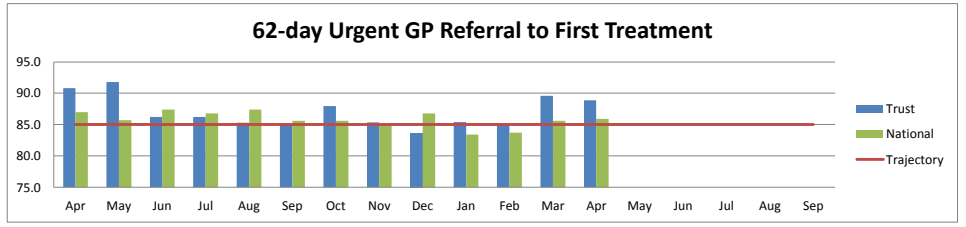
Clinical Effectiveness - Cancer Care

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
1			2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	92.7	93.9	95.4	85.7					93.0	93.0	●		
1			2 weeks (Breast Symptomatic)	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14		93.2							93.2	93.2	●		
1			31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	100	99	100	97					98.6	98.6	●		
1			31 Day (second/subsequent treatment - surgery)	=>94.0	=>94.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14									97.9	97.9	●		
1			31 Day (second/subsequent treatment - drug)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14									100	100	●		
1			31 Day (second/subsequent treat - radiotherapy)	=>94.0	=>94.0	n/a	n/a	n/a	n/a	n/a	n/a	n/a	●	n/a	n/a	n/a	●	n/a						Apr-14											●		
1			62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	96.7	91.9		72					88.9	88.9	●		
1			62 Day (referral to treat from screening)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14		100							100	100.0	●		
1			62 Day (referral to treat from hosp specialist)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	100	100		100					100	100.0	●		



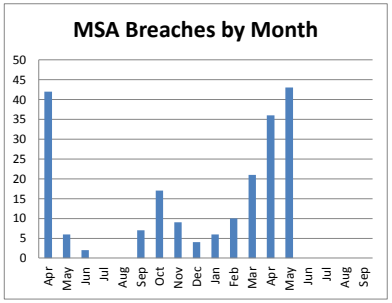


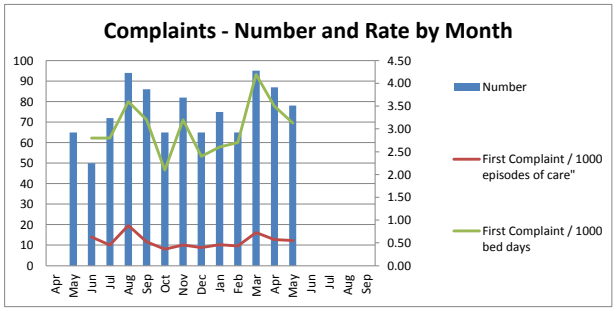


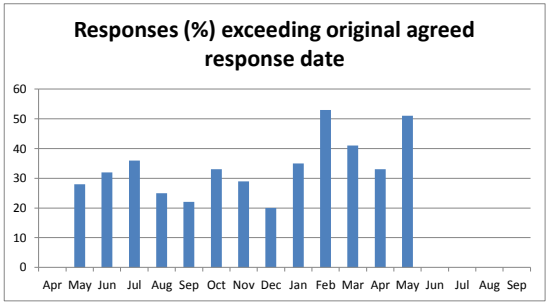


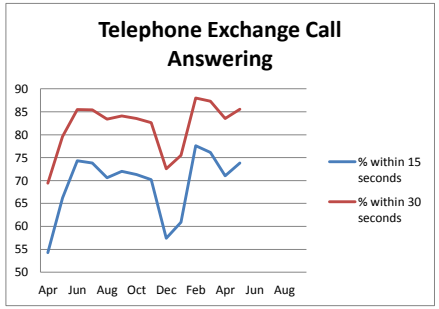
Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		b	FFT Response Rate - Inpatients	=>30.0	=>30.0	31	40	30	35	31	19	29	31	29	31	34	36	36	44					May-14									43.8		●		
8		a	FFT Score - Inpatients	=>60.0	=>60.0	66	66	67	68	37	72	71	70	73	71	75	73	74	74					May-14									74.0		●		
8		b	FFT Response Rate Emergency Department	=>20.0	=>20.0	2.2	3.7	9.6	5	5.3	12	21	17	15	15	16	15	15	16					May-14	16								16.1		●		
8		a	FFT Score - Emergency Department	=>46.0	=>46.0	55	49	50	49	50	51	46	47	44	47	48	48	47	49					May-14	49								49.0		●		
13		a	Mixed Sex Accommodation Breaches	0	0	42	6	2	0.5	0.4	7	17	9	4	6	10	21	36	43					May-14	43	0	0	0		0	0		43	79	●		
9			No. of Complaints Received (formal and link)			63	65	50	72	94	56	65	52	65	75	65	95	87	78					May-14	38	12	9	4	0	4	3	8	78	78			
9			No. of Active Complaints in the System (formal and link)				302	336	272	254	238	201	201	190	188	188	210	194	245					May-14	117	50	31	15	1	5	10	16	245				
9		a	No. of First Formal Complaints received / 1000 bed days					2.8	2.8	3.6	3.2	2.1	3.2	2.4	2.6	2.7	4.2	3.5	3.1					May-14									3.13	3.13			
9			No. of First Formal Complaints received / 1000 episodes of care					0.6	0.5	0.9	0.5	0.4	0.5	0.4	0.5	0.4	0.7	0.6	0.6					May-14									0.55	0.55			
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	100	100		97	78	94	97	75	97	99	98	97	95	99	100	100					May-14	100	100	100	100	100	100	100	100	100		●		
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	0	0		28	32	36	25	22	33	29	20	35	53	41	33	51					May-14	67	50	58	47	100	0	40	50	51		●		
9			No. of responses sent out				17	5	128	73	78	109	59	79	81	58	67	117	30					May-14	10	10	3	4	0	1	0	2	30				
9			Oldest' complaint currently in system (days)				197	155	165	147	150	107	174	91	112	118	127	104	124					May-14	124	124	117	61	91	19	94	69	124				
14		e	Access to healthcare for people with Learning Disability (full compliance)	Yes	Yes	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	Y	Y	Y	Y	Y	Y	Y	Y	Yes		●		



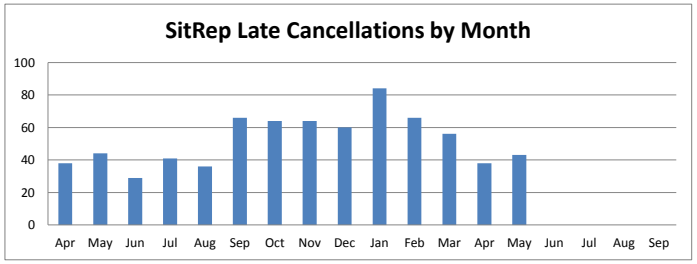


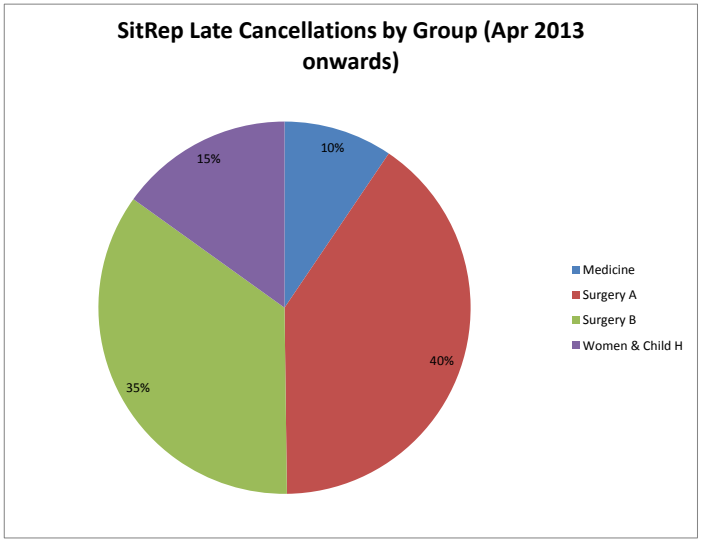


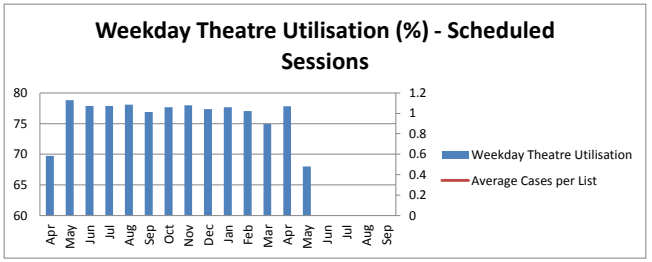


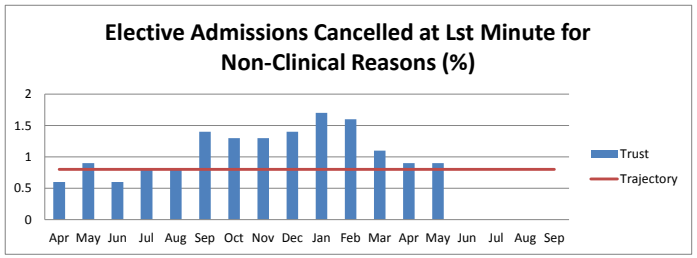
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2		●	Elective Admissions Cancelled at last minute for non-clinical reasons (%)	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	0.11	1.23	2.17	1.17					0.9	0.8	●		
2		●e●	28 day breaches	0	0	4	1	5	1	0	0	0	0	0	0	0	1	1	1					May-14	1	0	0	0					1	2	●		
2		●e	No. of second or subsequent urgent operations cancelled	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	0	0	0	0					0	0	●		
2			Sitrep Declared Late Cancellations	320	27	38	44	29	41	36	66	64	64	60	84	66	56	38	43					May-14	2	16	22	3					43	81	●		
3			Sitrep Declared Late Cancellations (Pts. >1 occasion)	0	0	5	6	6	2	9	10	7	5	7	13	13	0	0	1					May-14	0	0	1	0					1	1	●		
3			Multiple Cancellations experienced by same patient (all cancellations) (%)	0	0	18	13	17	12	19	14	12	13	13	13	13	11	12	7					May-14	5.7	6.7	7.3	8.8					6.9		●		
3			All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	3.1	3.1	7	6	6	6	5	6	6	6	5	8	6	6	5	6					May-14	2.3	8.1	9.0	6.7					6.0		●		
3			Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14									68		●		



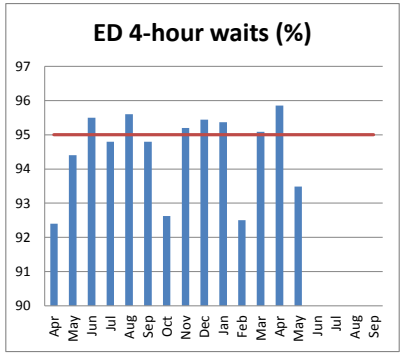


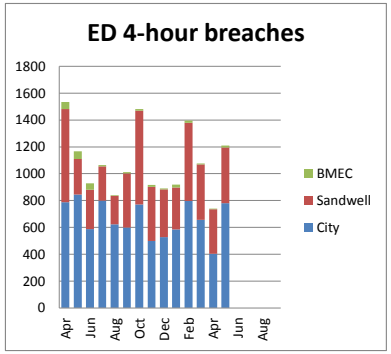


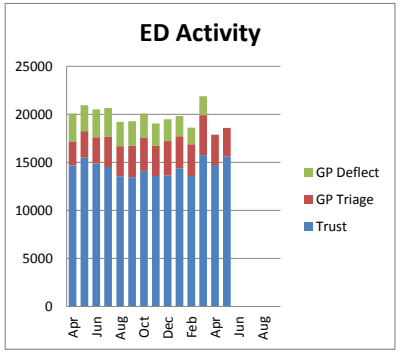


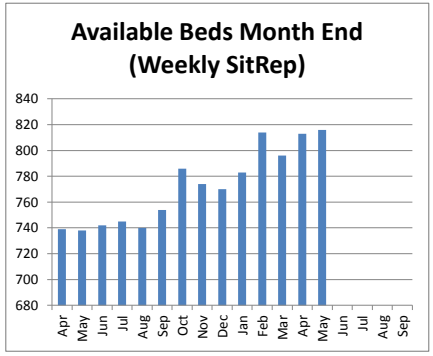
Access To Emergency Care & Patient Flow

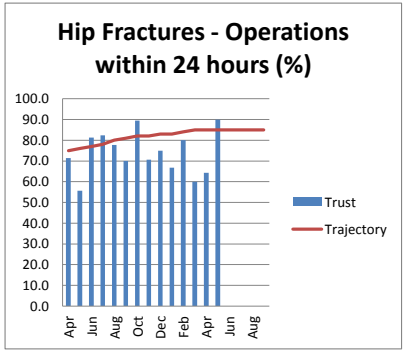
Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend	Next Month	3 Months
2			Emergency Care 4-hour waits (%)	=>95.0	=>95.0																			May-14	98.5	91.4	99.3	93.49	94.37			
2			Emergency Care Trolley Waits >12 hours	0	0	1																		May-14	0	0	0	0	0			
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins																			May-14	16	23	10	19	19			
3			Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins																			May-14	55	68	18	54	50			
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0																			May-14	7.58	6.10	3.32	6.35	5.97			
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0																			May-14	3.89	5.90	1.14	4.48	3.93			
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	0	0																			May-14	47	89		136	252			
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	0	0																			May-14	1	7		8	23			
11			WMAS - Turnaround Delays > 60 mins (% all journeys)	=<0.02	=<0.02																			May-14	0.3	0.9		0.65				
2			Delayed Transfers of Care (Acute) (%)	=<3.5	=<3.5																			May-14				3.3	3.3			
2			Delayed Transfers of Care (Acute) (No.)	<10 per site	<10 per site																			May-14	7	6		13				
2			Patient Bed Moves (10pm - 8am) (No.)																522	578				May-14				578	1100			
3			Hip Fractures - Operation < 24 hours of admission (%)	=>85.0	=>85.0																			May-14				90.0	74.07			





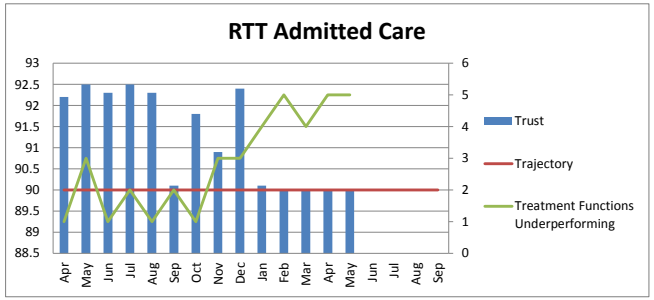


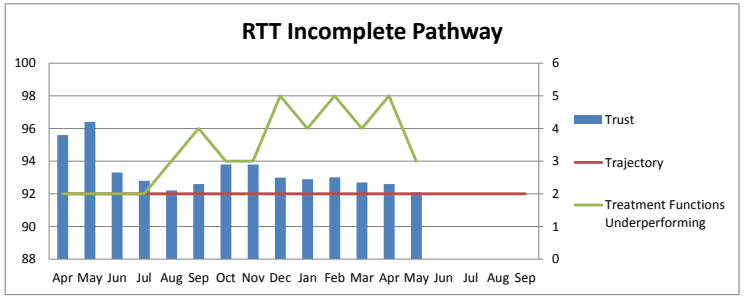


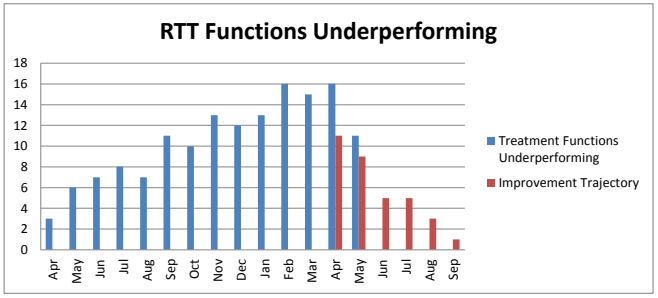


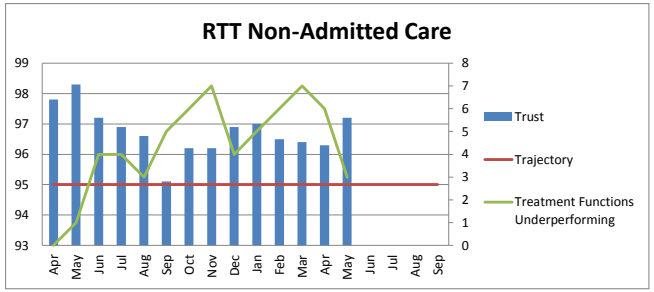
Referral To Treatment

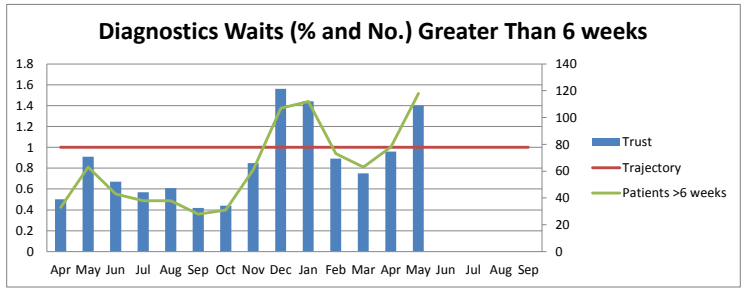
Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2			RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0																			May-14	95.3	82.1	87.8	95.0					90.02				
2			RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0																			May-14	94.4	96.7	97.2	97.6					97.20				
2			RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0																			May-14	92.0	88.6	93.5	98.1					92.08				
2			Patients Waiting >52 weeks	0	0	8	28	50	57	29	20	66	36	12	3	1	1	1	2					May-14	0	1	1	0					2				
2			Treatment Functions Underperforming	0	0	3	6	7	8	7	11	10	13	12	13	16	15	16	11					May-14	3	4	4	0					11				
2			Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0																			May-14	4.48	13.7	0.51	0.00		0.35			1.4				

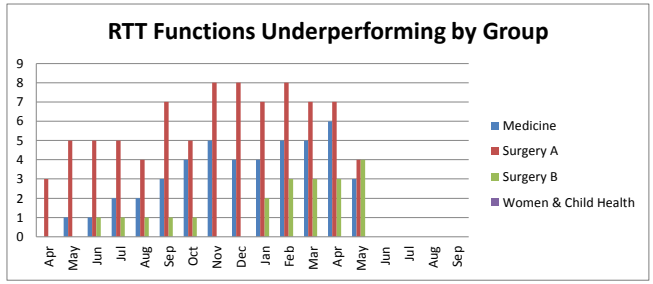












Data Completeness

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Data Completeness Community Services	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14								>50	>50		●		
2		●	Percentage SUS Records for AE with valid entries in mandatory fields	=>99.0	=>99.0																																
2		●	Percentage SUS Records for IP care with valid entries in mandatory fields	=>99.0	=>99.0																																
2		●	Percentage SUS Records for OP care with valid entries in mandatory fields	=>99.0	=>99.0																																
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=>99.0	=>99.0	99.3	99.3	99.2	99.2	99.1	99.1	99.1	98.9	99.2	98.9	98.9	98.7	98.7	96.8					May-14								96.8	97.7	●		
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	=>99.0	=>99.0	99.7	99.8	99.7	99.7	99.7	99.7	99.7	99.7	99.7	99.7	99.6	99.5	99.5	99.5					May-14								99.5	99.5	●		
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=>95.0	=>95.0	97.8	97.3	97.4	97.2	97.4	97.3	97.5	97.2	97.1	97.6	96.8	95.9	96.3	95.8					May-14								95.8	96.0	●		
2			Ethnicity Coding - percentage of inpatients with recorded response	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14								92.91	92.82	●		
2		●b●	Data Quality of Trust Returns to the HSCIC																																		
2			Maternity - Percentage of invalid fields completed in SUS submission	=<15.0	=<15.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14								6.78	6.78	●		

Staff

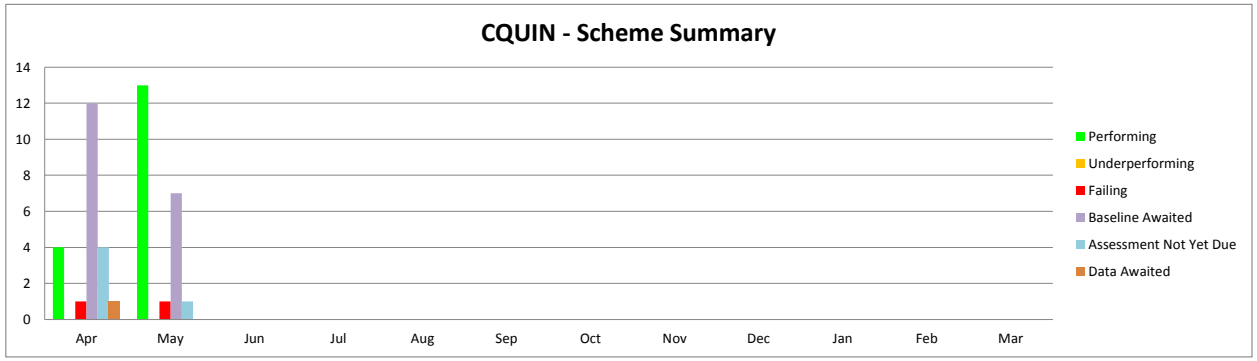
Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
7		b	WTE - Actual versus Plan			312	456	465	458	511	610	643	626	572	541	567								Feb-14	163	76	37	34	33	28	34	162	567	567				
3		b	PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	92	89	93	88	96	92	90	93		91.45	●			
7		b	Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	98	96	87	93	100	97	100	100		95.0	●			
3		b	Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	3.9	5.5	2.7	3.9	3.1	5.2	3.8	3.4	3.94	4.28	●			
3			Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	82	86	86	85	95	91	90	92		87.05	●			
3			Mandatory Training - Health & Safety (% staff)	=>75.0	=>75.0											●	●	●	●					May-14	97	98	97	98	99	99	100	100		98.45	●			
7		b	Staff Turnover (rolling 12 months) (%)	2.7 - 18.8	2.7 - 18.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14									11.95	11.80	●			
7			New Investigations in Month			4	5	8	9	1	4	3	1	4	2	4	5	1	4					May-14	1	0	0	0	0	2	0	1	4					
7			Vacancy Time to Fill (weeks)			15	19	18	18	18	18	18	17	18	20	18	19	18	20					May-14									20					
7			Professional Registration Lapses	0	0	3	0	0	1	0	4	7	0	0	0	0	0	0						May-14	0	0	0	0	0	0	0	0	0	0	●			
7			Qualified Nursing Variance (FIMS) (FTE)			26	108	138	143	181	236	177	199	210	163	162								Feb-14									162	162				
10			Nurse Bank Fill Rate			72	77	75	77	78	76	75	76	71	73	75	76	76	82					May-14									81.7	78.5				
10			Nurse Bank Use (shifts)	46980	3915	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	2851	824	212	477	0	9	276	134	4832	9537	●			
10			Nurse Agency Use (shifts)	3830	319	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	1874	352	76	17	0	157	267	10	2826	6116	●			
15			Your Voice - Response Rate														19.8							May-14	7	12	19	14	30	27	33	29						
15			Your Voice - Overall Score														3.63							May-14	3.6	3.5	3.7	3.7	3.4	3.8	3.8	3.6						

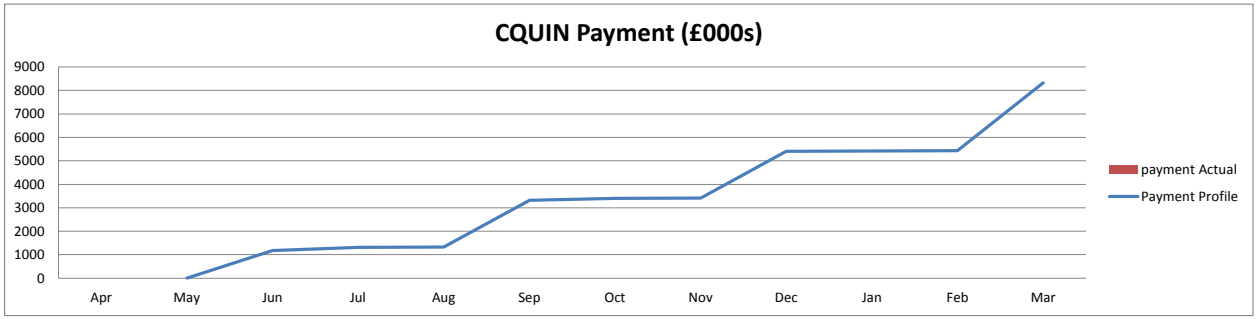
CQUIN (I)

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8			FFT - Implementation of Staff FFT	Implement by end July		●	●											May-14									On Track	On Track			
8			FFT - Early Implementation of Patient FFT in OP / DC Departments	Implement by end Oct		●	●											May-14									On Track	On Track			
8			FFT - Increase and / or Maintain Response Rate in ED areas	>Q1 rate		●	●											May-14									16		●		
8			FFT - Increase and / or Maintain Response Rate in IP areas	>Q1 rate		●	●											May-14									44		●		
8			FFT - Reduce Negative Responses (ED, IP and Mat'y) (%)	0		Derive base data												May-14									On Track	On Track			
8			NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	50% reduction		Derive base data												May-14									On Track	On Track			
8			Dementia - Find, Assess and Refer	=>90	=>90	●	●											May-14									3 of 3 met	2 of 3 met	●		
8			Dementia - Clinical Leadership and Staff Training			Confirm training req's												May-14									Clinician in place	Clinician in place	●		
8			Dementia - Supporting Carers of People with Dementia	Monthly Audit	Monthly Audit	●	●											May-14									On Track	On Track			
9			Learning From Safeguarding Concerns	Quarterly report to Board																										
2			Quality of Outpatient and Discharge Letters			Derive base data																								
4			Sepsis - Use of Sepsis Care Bundles			Derive base data																								
8			Pain Relief - Use of Pain Care Bundles			Derive base data												May-14									On Track	On Track	●		
9			Medication and Falls			Derive base data																								
9			Serious Untoward Incidents			Derive base data																								
14			Community Therapies - Effective Referral Management			Derive base data																								

CQUIN (II) and summary

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Community Therapies - Community Dietetics			Derive base data																									
12			Maternity - Low Risk Births	Quarterly audit / action plan		Base data																									
16			Bechet's Disease	Submit Quarterly return		Quarterly Return																					On Track	On Track			
17			HIV Home Delivery Medicines (% patients receiving)	70		Derive base data																					On Track	On Track			
17			Retinopathy of Prematurity Screening (%)	95		Derive base data																					On Track	On Track			
17			Timely Administration of TPN for preterm infants	95		Derive base data																					On Track	On Track			

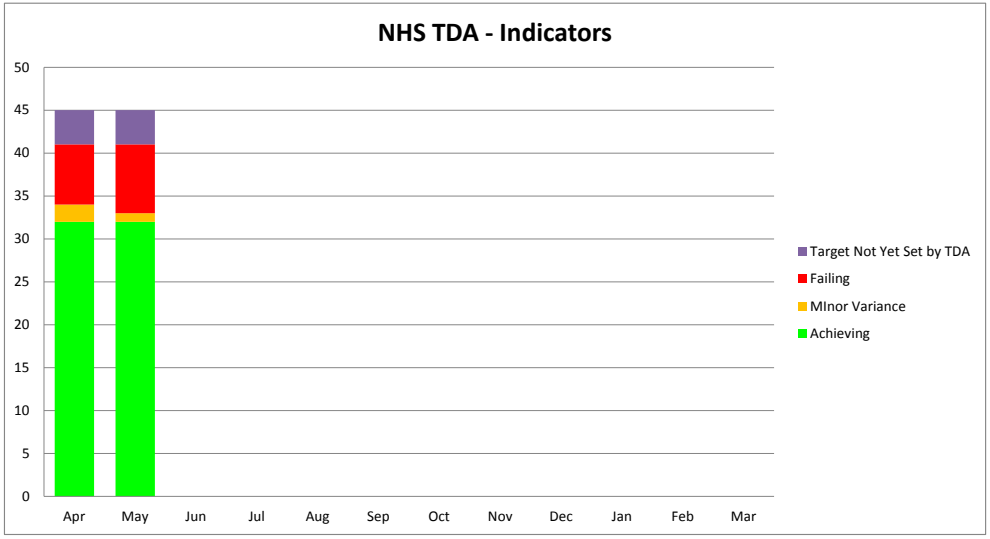




The Trust is contracted to deliver a total of 22 CQUIN schemes during 2014 / 2015. 9 schemes are nationally mandated, a further 9 have been agreed locally, with the remaining 4 identified by the West Midlands Specialised Commissioners. The collective financial value of the schemes is c.£8.3m.

A significant number of the schemes require an initial baseline assessment during quarter 1, following which an improvement trajectory willl be agreed with commissioners.

External Assessment Frameworks



NHS TDA Accountability Framework

NHS TDA Accountability Framework for 2014 / 2015 comprises 3 principal elements; Quality Score, Finance RAG Assessment and Sustainability Score, each of which contribute to the derivation of an Overall Escalation Score. The Quality Score comprises 5 component scores; Caring, Effective, Response, Safe and Well-led, each of which comprise a variable number of metrics. It is intended that individual organisations will be able to score their own performance, although how to do this, and the thresholds for a number of individual metrics have not yet been published.

Metrics within the framework which are currently identified as outside of operational thresholds are:

- There were 1 CAS Alert at the end of May beyond the deadline date, susequently closed early June.

- There were 2 Serious Incidents reported during May.

- The Trust's FFT Response Rate and Score in ED is 14.8% and 47.0 respectively

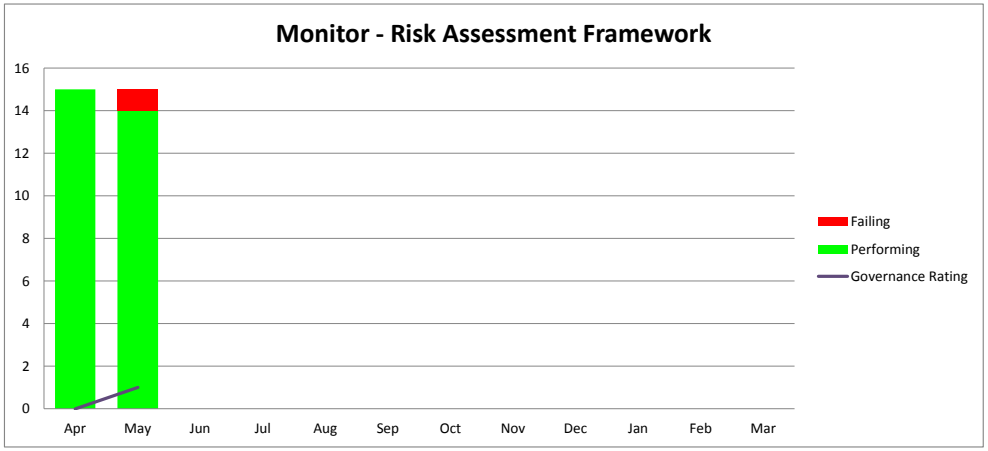
- A total of 43 Mixed Sex Accommodation Breaches were reported during the month

- There was a breach of the 28-day cancelled operation guarantee in Cardiology

- At the end of May an ENT patient wait for treatment exceeded 52 weeks

- Overall Sickness Absence for the 12-month cumulative period is 4.30% (4.11% in April)

- ED 4-hour performance of 93.49%



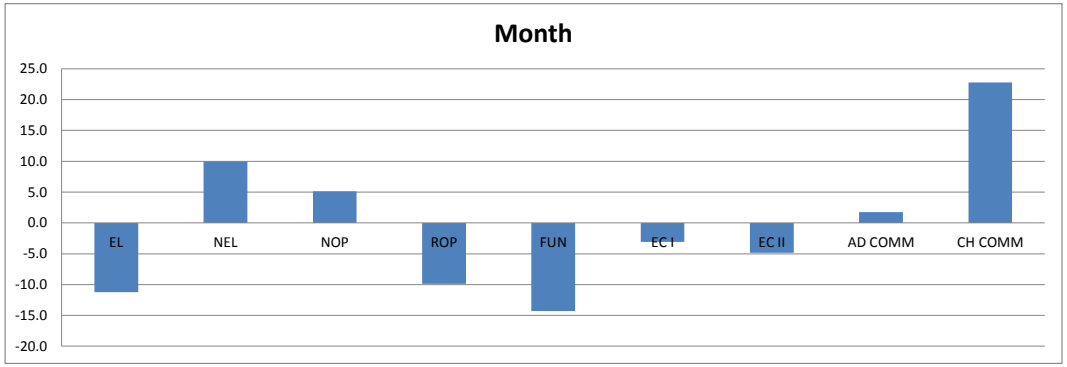
Monitor Risk Assessment Framework

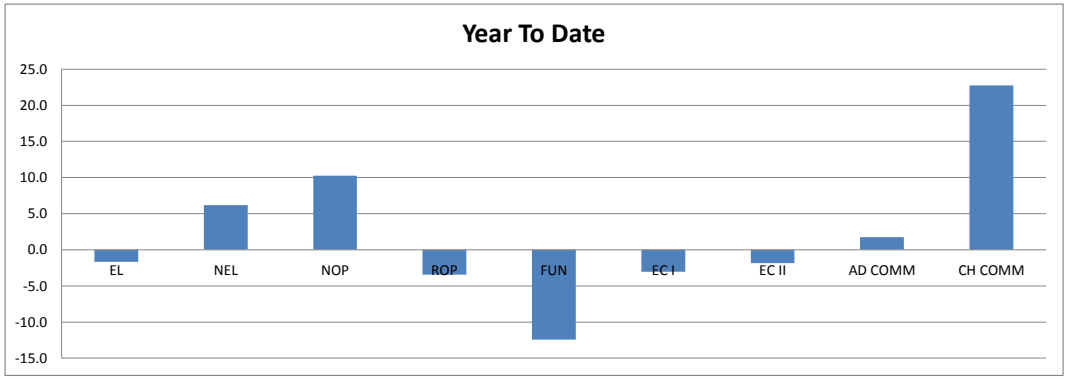
Monitor introduced its ***Risk Assessment Framework*** for NHS Foundation Trusts with effect from 1 October 2013, which replaced its previous Compliance Framework. The range of indicators utilised by Monitor within this framework is less extensive than those used by the NHS TDA. The Access and Outcome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

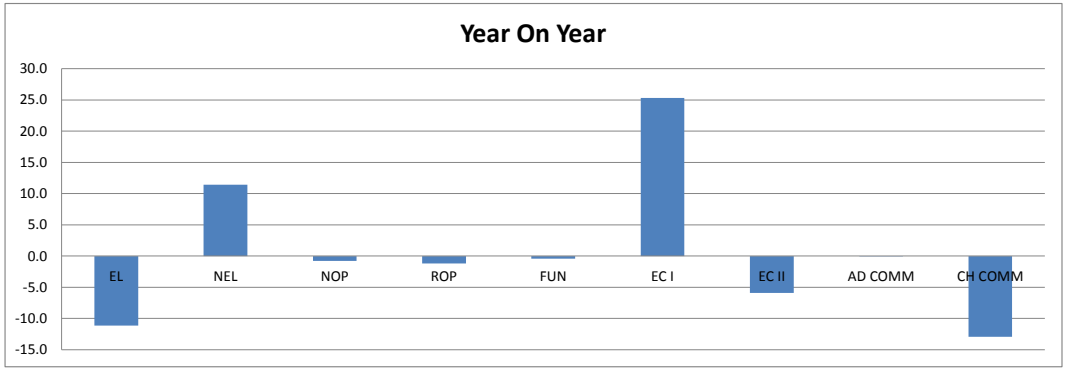
During the month of May the Trust met, or is projected (Cancer and RTT targets) to meet the required thresholds for each of the Access and Outcomes indicators. The Trust failed to meet the ED 4-hour target, with performance during the month of May reported as 93.49%. This would attract an overall weighted score for the month of 1.0 with a AMBER / GREEN Governance Rating.

Governance Rating	Green (0.0)		Amber / Green (1.0 - 1.9)	
	Amber / Red (2.0 - 3.9)		Amber / Red (>3.9)	

Activity Summary







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 opposite. Additionally, there is a year on year comparison of current year with previous year for the corresponding period of time. High level Elective activity is beneath the plan for the month by 11.2%, but is essentially on plan for the year to date. Non-Elective activity during the month is 10.0% greater than plan, is 6.2% higher for the year to date, and 11.4% higher than the corresponding period last year. New outpatient attendance numbers are similar in number to those delivered for the corresponding period last year, but are ahead of plan by 10.2% for the year to date. With OP Review attendances 3.4% below plan for the year to date, the Follow-Up to New OP Ratio for the period to date has reduced to 2.26, compared with a plan derived from contracted activity of 2.58. Type I Emergency Care activity for the month and year to date is c.3.0% less than plan, although considerably higher than the corresponding period last year, due to the inclusion within plan of GP Triage Activity. Type II activity is 4.9%, 1.9% and 5.9% less than plan for month, year to date and last year respectively. Adult Community and Child Community activity exceeds plans for April by 1.7% and 22.8% respectively.

Finance Summary

Data Source	Data Quality	PAF	Indicator	Trajectory		Previous Months Trend												Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
				Year	Month	A	M	J	J	A	S	O	N	D	J	F	M		M	A	B	W	P	I	C	CO						
18		•f	Bottom Line Income & Expenditure position - Forecast compared to plan																												
18		•f	Bottom Line Income & Expenditure position - Year to Date Actual compared to plan																												
18		•f	Actual efficiency recurring / non-recurring compared to plan - Year to Date actual compared to plan																												
18		•f	Actual efficiency recurring / non-recurring compared to plan - Forecast compared to plan																												
18		•f	Forecast underlying surplus / deficit compared to plan																												
18		•f	Forecast year end charge to capital resource limit																												
18		•f	Is the Trust forecasting permanent PDC for liquidity purposes?																												
18		•b	Temporary costs and overtime as % total paybill																												

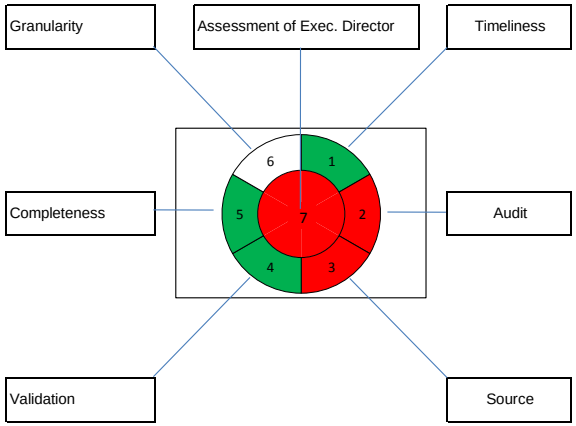
Legend

Data Sources	
1	Cancer Services
2	Information Department
3	Clinical Data Archive
4	Microbiology Informatics
5	Dr Foster
6	Healthcare Evaluation Data (HED) Tool
7	Workforce Directorate
8	Nursing and Facilities Directorate
9	Governance Directorate
10	Nurse Bank
11	West Midlands Ambulance Service
12	Obstetric Department
13	Operations Directorate
14	Community and Therapies Group
15	Strategy Directorate
16	Surgery B
17	Women & Child Health
18	Finance Directorate

Indicators which comprise the External Performance Assessment Frameworks		
●		NHS TDA Accountability Framework
	a	Caring
	b	Well-led
	c	Effective
	d	Safe
	e	Responsive
	f	Finance
●		Monitor Risk Assessment Framework
●		CQC Intelligent Monitoring

Groups	
M	Medicine & Emergency Care
A	Surgery A
B	Surgery B
W	Women & Child Health
P	Pathology
I	Imaging
C	Community & Therapies
CO	Corporate

Data Quality - Kitemark



Each outer segment of indicator is colour coded on kitemark to signify strength of indicator relative to the dimension, with following key:

Red	Insufficient
Green	Sufficient
White	Not Yet Assessed

The centre of the indicator is colour coded as follows:

Red / Green	As assessed by Executive Director
White	Awaiting assessment by Executive Director

If segment 2 of the Kitemark is Blank this indicates that a formal audit of this indicator has not yet taken place

Medicine Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
C. Difficile	30	3	●	●	●	●	●	●	●	●					May-14	0	0	2	2	3	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	●		
MRSA Screening - Elective (%)	80	80	●	●	●	●	●	●	●						May-14	50	90	19	38		●		
MRSA Screening - Non Elective (%)	80	80	●	●	●	●	●	●	●						May-14	90	96	93	95		●		
Falls	0	0							33	40					May-14	12	23	5	40	73	●		
Falls with a serious injury	0	0	5	2	5	1	1	1	1	2					May-14	2	0	0	2	3	●		
Grade 3 or 4 Pressure Ulcers (avoidable)	0	0	3	0	0	2	3	3	2						Apr-14				2	2	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				May-14	100	100	99	99.6		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●					May-14	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●						May-14	100	100	100	100		●		
Never Events	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	●		
Serious Incidents	0	0					●	●	●	●					May-14	2	0	0	2	3			
Mortality Reviews within 42 working days	=>80.0	=>80.0	●	●	●	●	●	●							Mar-14	87.0	80.0	80.0	81.0		●		
Pts spending >90% stay on Acute Stroke Unit (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●					May-14		92.7		92.7	84.1	●		
Pts admitted to Acute Stroke Unit within 4 hrs (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●					May-14		89.1		89.1	82.6	●		
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●					May-14		83.6		83.6	77.7	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●					May-14		100		100.0	100.0	●		
Stroke Admission to Thrombolysis Time (% within 60 mins)	=>85.0	=>85.0	●	●	●	●	●	●	●	●					May-14		69		69.2	84.6	●		
Stroke Admissions - Swallowing assessments (<24h) (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●					May-14		100		100.0	100.0	●		
TIA (High Risk) Treatment <24 Hours from initial presentation (%)	=>70.0	=>70.0	●	●	●	●	●	●	●	●					May-14		77.8		77.8	81.6	●		
TIA (Low Risk) Treatment <7 days from initial presentation (%)	=>75.0	=>75.0	●	●	●	●	●	●	●	●					May-14		85.3		85.3	89.3	●		
Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●							Mar-14		58(C) 90(S)		58 (C) & 90 (S)		●		
Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●							Mar-14		60(C) 100(S)		60 (C) & 100 (S)		●		
Rapid Access Chest Pain - seen within 14 days (%)	=>98.0	=>98.0	●	●	●	●	●	●							Mar-14		91.6		91.6	95.6	●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●						Apr-14			93	92.7		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●						Apr-14			100	100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●						Apr-14			97	96.7		●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
FFT Response Rate																						
FFT Score																						
Mixed Sex Accommodation Breaches	0	0	5	4	2	3	7	21	36	43					May-14	8	35	0	43	79	●		
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●					May-14	0.00	1.31	0.00	0.11		●		
28 day breaches	0	0	●	●	●	●	●	●	●	1					May-14	0	1	0	1	1	●		
Sitrep Declared Late Cancellations	0	0	13	2	2	7	7	4	10	2					May-14	0	2	0	2	12	●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	94.5 (s)	91.3 (c)		93.5	94.7	●		
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●					May-14	0 (s)	0 (c)		0	0	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●					May-14	16 (s)	23 (c)		19	19	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●					May-14	55 (s)	68 (c)		54	50	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●					May-14	7.58 (s)	6.10 (c)		6.35	5.97	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●					May-14	3.89 (s)	5.90 (c)		4.48	3.93	●		
WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	0	0	●	●	●	●	●	●	●	●					May-14	47 (s)	89 (c)		136	252	●		
WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	0	0	●	●	●	●	●	●	●	●					May-14	1 (s)	7 (c)		8	23	●		
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●					May-14	###	93.0	96.5	95.3		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	###	90.2	96.4	94.4		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●					May-14	###	88.7	94.2	92.0		●		
Patients Waiting >52 weeks	0	0	17	6	4	0	0	0	0	0					May-14	0	0	0	0		●		
Treatment Functions Underperforming	0	0	4	5	4	4	5	5	6	3					May-14	0	2	1	3		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●					May-14	0.00	0.88	###	4.48		●		
WTE - Actual versus Plan			176	158	165	135	163								Feb-14				163				
PDRs - 12 month rolling (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	92	92	93		92	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	95	96	100		98	●		
Sickness Absence (%)	=<3.15	=<3.15	●	●	●	●	●	●	●	●					May-14	4.16	3.56	3.84	3.89	4.10	●		
Mandatory Training (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	81	83	81		82	●		
New Investigations in Month			2	0	0	0	0	1	1	1					May-14				1				
Nurse Bank Use	34560	2880	●	●	●	●	●	●	●	●					May-14				2851	5620	●		
Nurse Agency Use	7423	619	●	●	●	●	●	●	●	●					May-14				1874	4051	●		
Your Voice - Response Rate (%)			11		8			7							May-14	7	6	10	7				
Your Voice - Overall Score			3.73		3.68			3.58							May-14	3.5	3.7	3.6	3.58				

Surgery A Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
C. Difficile	7	1	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	2	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●					May-14	91	99	75	0	87		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●					May-14	95	93	99	100	95		●		
Falls	0	0							9	7					May-14	1	3	3	0	7	16	●		
Falls with a serious injury	0	0	1	0	1	1	0	1	0	0					May-14	0	0	0	0	0	0	●		
Grade 3 or 4 Pressure Ulcers (avoidable)	0	0	1	0	2	0	1	0	1						Apr-14					1	1	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	97	99	100	100	98.2		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●					May-14	100	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	100	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●					May-14	100	100	100	100	100		●		
Never Events	0	0	●	1	●	●	●	●	●	●					May-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	0	●		
Serious Incidents	0	0				●	●	●	●	●					May-14	0	0	0	0	0	1	●		
Mortality Reviews within 42 working days	=>80.0	=>80.0	●	●	●	●	●	●							Mar-14	100	100	100	87	91.0		●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●						Apr-14	94		94		93.9		●		
2 weeks (Breast Symptomatic)	=>93.0	=>93.0	●	●	●	●	●	●	●						Apr-14	93.2				93.2		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●						Apr-14	98		100		99.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●						Apr-14	90		95.2		91.9		●		
FFT Response Rate																								
FFT Score																								
Mixed Sex Accommodation Breaches	0	0	12	5	2	3	3	●	●	●					May-14	0	0	0	0	0	0	●		
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●						May-14	0.7	4.1	0.6	0.0	1.23		●		
28 day breaches	0	0	0	0	0	0	0	1	1	0					May-14	0	0	0	0	0	1	●		
Sitrep Declared Late Cancellations	0	0	28	35	25	28	37	18	13	16					May-14	4	10	2	0	16	29	●		
Hip Fractures - Operation < 24 hours of admission (%)	85	85	●	●	●	●	●	●	●	●					May-14		90.0			90.0	74.1	●		

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●					May-14	88.1	62.4	91.0		82.1		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	99.0	94.5	99.0		96.7		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●					May-14	93.1	82.7	93.0		88.6		●		
Patients Waiting >52 weeks	0	0	28	13	3	3	0	0	1	1					May-14	1	0	0	0	1	2	●		
Treatment Functions Underperforming	0	0	5	8	8	7	8	7	7						May-14	1	3	0	0	4		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●					May-14	###	0.00	0.0	0.00	13.72		●		
WTE - Actual versus Plan			70	71	72	88	76								Feb-14					76				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	95	76	93	87		89	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●						May-14	95	93	100	98		96	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●					May-14	5.85	6.18	5.06	5.53	5.46	5.3	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	82	82	89	89		86	●		
New Investigations in Month			0	0	2	1	1	1	0	0					May-14					0				
Nurse Bank Use	9908	826	●	●	●	●	●	●	●	●					May-14					824	1592	●		
Nurse Agency Use	1144	95	●	●	●	●	●	●	●	●					May-14					352	835	●		
Your Voice - Response Rate			16		13			12							May-14	15	5	6	13	12				
Your Voice - Overall Score			3.03		3.55			3.53							May-14	3.5	3.4	3.6	3.6	3.53				

Surgery B Group

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		O	E					
C. Difficile	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●					May-14	95	89	94		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●					May-14	95	95	95		●		
Falls	0	0							1	0					May-14	0	0	0	1	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0					May-14	0	0	0	0	●		
Grade 3 or 4 Pressure Ulcers (avoidable)	0	0	0	0	0	0	0	0							Apr-14	0	0	0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●						May-14	99	96	97.7		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●					May-14	99.4	99.4	99.4		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	98.7	97.4	98.4		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●					May-14	98.7	94.9	97.7		●		
Never Events	0	0	●	1	●	●	●	●	●	●					May-14	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	●		
Serious Incidents	0	0				●	●	●	●	●					May-14	0	0	0	0	●		
Mortality Reviews within 42 working days	=>80.0	=>80.0	●	●	●	●	●	●							Mar-14		100	100		●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●						Apr-14		95.4	95.4		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●			●	●	●						Apr-14		100	100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0		●	●	●	●	●							Apr-14					●		
FFT Response Rate																						
FFT Score																						
Mixed Sex Accommodation Breaches	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	●		
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●					May-14	2.1	2.3	2.17		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0					May-14	0	0	0	0	●		
Sitrep Declared Late Cancellations	0	0	19	14	19	36	15	22	3	22					May-14	13	9	22	25	●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		O	E					
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	99		99.3	99.5	●		
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●					May-14	0		0	0	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●					May-14	10		10	13	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●					May-14	18		18	19	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●					May-14	3.32		3.32	2.96	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●					May-14	1.1		1.14	1.26	●		
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●					May-14	88	88	87.8		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	99	94	97.2		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●					May-14	95	91	93.5		●		
Patients Waiting >52 weeks	0	0	9	9	2	0	1	1	0	1					May-14	0	1	1	1	●		
Treatment Functions Underperforming	0	0	1	0	0	2	3	3	3	4					May-14	1	3	4		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●					May-14	0.00	0.51	0.51		●		
WTE - Actual versus Plan			31	24	23	27	37								Feb-14			37				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	91	99		93	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●						May-14	85	100		87.0	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●					May-14	3.1	1.9	2.66	3.01	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	83	94		86	●		
New Investigations in Month			0	0	0	1	0	0	0	0					May-14			0				
Nurse Bank Use	2796	233	●	●	●	●	●	●	●	●					May-14			233	444	●		
Nurse Agency Use	71	6	●	●	●	●	●	●	●	●					May-14			76	149	●		
Your Voice - Response Rate			17		18			19							May-14	13	31	19				
Your Voice - Overall Score			3.66		3.72			3.73							May-14	3.8	3.7	3.73				

Women & Child Health Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
C. Difficile	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●					May-14	99				99		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●					May-14	100	94			95		●		
Falls	0	0							0	0					May-14	0	0	0	0	0	0	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0					May-14	0	0	0	0	0	0	●		
Grade 3 or 4 Pressure Ulcers (avoidable)	0	0	0	0	0	0	0	0							Apr-14	0	0	0	0	0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	98	87			91.8		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●					May-14	100		100		100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	100		100		100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●					May-14	100		100		100		●		
Never Events	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	0	●		
Serious Incidents	0	0				●	●	●	●	●					May-14	0	0	0	0	0	2			
Caesarean Section Rate - Total (%)	=<25.0	=<25.0	●	●	●	●	●	●	●	●					May-14		26			25.98	26.1	●		
Caesarean Section Rate - Elective (%)			11	10	11	12	11	10	14	8					May-14		8			7.91	9.0			
Caesarean Section Rate - Non Elective (%)			13	15	10	16	14	13	12	18					May-14		18			18.02	17.1			
Maternal Deaths	0	0	●	●	●	●	●	●	●	●					May-14		0			0	0	●		
Post Partum Haemorrhage (>2000ml)	48	4	●	●	●	●	●	●	●	●					May-14		0			0	0	●		
Admissions to Neonatal Intensive Care (%)	=<10.0	=<10.0	●	●	●	●	●	●	●	●					May-14		4.6			4.59	5.22	●		
Adjusted Perinatal Mortality Rate (per 1000 babies)	<8.0	<8.0	●	●	●	●	●	●							Mar-14		11			11.3		●		
Early Booking Assessment (<12 + 6 weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●							Mar-14		134			134		●		
Mortality Reviews within 42 working days	=>80.0	=>80.0	●	●	●	●	●	●							Mar-14	100				100		●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●						Apr-14	86				85.7		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●						Apr-14	97				97.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●						Apr-14	72				72.0		●		
FFT Response Rate																								
FFT Score																								
Mixed Sex Accommodation Breaches	0	0	●	●	●	●	●	●	●	●					May-14	0				0	0	●		

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●					May-14	1.2				1.17		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0					May-14	0				0	0	●		
Sitrep Declared Late Cancellations	0	0	4	13	14	13	7	12	12	3					May-14	3				3	15	●		
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●					May-14	95				95.0		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	97.6				97.6		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●					May-14	98				98.1		●		
Patients Waiting >52 weeks	0	0	4	4	2	0	0	0	0	0					May-14	0				0	0	●		
Treatment Functions Underperforming	0	0	0	0	0	0	0	0	0	0					May-14	0				0		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●					May-14	0.0				0.0		●		
WTE - Actual versus Plan			64	39	42	41	34								Feb-14					34				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	87	86	93	88		88	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	100	85	100			93	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●					May-14	1.25	4.34	5.19	3.63	3.85	4.44	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	88	85	86	88		85	●		
New Investigations in Month			1	0	0	0	0	0	0	0					May-14					0				
Nurse Bank Use	6852	571	●	●	●	●	●	●	●	●					May-14					751	1074	●		
Nurse Agency Use	184	15	●	●	●	●	●	●	●	●					May-14					17	94	●		
Your Voice - Response Rate			17		11			14							May-14	21	7	22	20	14				
Your Voice - Overall Score			3.74		3.79			3.74							May-14	3.9	3.9	3.6	3.6	3.74				

Pathology Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate					Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		HA	HI	B	M	I					
Never Events	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	0	0	●		
WTE - Actual versus Plan			31	32	30	37	33								Feb-14						33				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	98	98	91	97	100		96	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	100	100	100	100	100		100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●					May-14	4.80	2.20	2.24	4.30	0.00	3.11	4.16	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	95	93	94	95	98		95	●		
New Investigations in Month			0	0	0	0	0	0	0	0					May-14						0				
Your Voice - Response Rate			17		36			30							May-14	38	34	20	32	56	30				
Your Voice - Overall Score			3.31		3.6			3.43							May-14	3	3.4	3.9	3.4	3.8	3.43				

Imaging Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		DR	IR	NM	BS					
Never Events	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	0	0	●		
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●					May-14			83.6		83.6	77.7	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●					May-14			###		100.0	100.0	●		
Mixed Sex Accommodation Breaches	0	0	●	●	●	●	●	●	●	●					May-14	0	0	0	0	**0**	**0**	●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●					Apr-14	0.4				0.35		●		
WTE - Actual versus Plan			26	20	21	18	28								Feb-14					28				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	89	91	97	95		92	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●						May-14	96		100			97.0	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●					May-14	3.5	3.4	1.80	8.2	5.22	4.48	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	89	93	93	94		91	●		
New Investigations in Month			0	0	1	0	0	0	0	2					May-14					2				
Nurse Bank Use	288	24	●	●	●	●	●	●	●	●					May-14					9	28	●		
Nurse Agency Use	752	63	●	●	●	●	●	●	●	●					May-14					157	289	●		
Your Voice - Response Rate			30		19		27								May-14	25	18	43	27	27				
Your Voice - Overall Score			3.73		3.72		3.79								May-14	3.6	4.6	4.2	3.8	3.79				

Community & Therapies Group

Indicator	Trajectory Year	Trajectory Month	Previous Months Trend O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Directorate	Month	Year To Date	Trend	Next Month	3 Months
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●					May-14		100		●		
Patient Safety Thermometer - Overall Harm Free Care	=>92	=>92	91	90	92	94	93	92	90	94					May-14		94.31		●		
Falls	=<0.4	=<0.4	0.4	0.2	0.0	0.0	0.2	0.0	0.6	0.0					May-14		0.0	0.3	●		
Pressure Ulcers	=<7.0	=<7.0	8.9	9.5	7.5	5.6	6.9	8.7	9.5	5.7					May-14		5.69	7.6	●		
Never Events	0	0	●	●	●	●	●	●	●	●					May-14		0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●					May-14		0	0	●		
FFT Response Rate - Wards	=>28.0	=>28.0	19	13	15	13	6	22	16	19					May-14		19	35	●		
FFT Score - Wards	=>68.0	=>68.0	94	100	93	85	83	82	81	95					May-14		95	88	●		
Mixed Sex Accommodation Breaches	0	0	●	●	●	●	●	●	●	●					May-14		0	0	●		
WTE - Actual versus Plan			55	70	32	34	34								Feb-14		34				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14			90.3	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14			100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●					May-14		3.82	3.98	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14			90	●		
New Investigations in Month			0	0	1	0	1	1	0	0					May-14		0				
Nurse Bank Use	5408	451	●	●	●	●	●	●	●	●					May-14		276	549	●		
Nurse Agency Use	3282	273	●	●	●	●	●	●	●	●					May-14		267	536	●		
Your Voice - Response Rate			28		18		33								May-14		33				
Your Voice - Overall Score			3.71		3.75		3.78								May-14		3.78				
DVT numbers	730	>61			30	40	57	53	53	62					May-14		53	58	●		
Therapy DNA rate OP services (%)	=<9	=<9					11	12	12	16					May-14		62	14	●		
FEES assessment	>100	>8.3						1	7	10					May-14		10	8.5	●		
ESD Response time	<48 hrs	<48 hrs				●	●	●	●	●					May-14				●		
STEIS	0	0			2	0	0	1	0	2					May-14		2	2	●		
Rapid response to AMU, RRTS	<60 mins	<60 mins			77	75	75	75	75	71					May-14		71	73	●		
Avoidable weight loss	<20%	<20%		●	●	●	●	●	●	●					May-14		0	9	●		
Green Stream Community Rehab response time for treatment (days)	=<11	=<11					15	11	12	7.9					May-14		7.9	9.95	●		

Corporate Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate							Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		CEO	F	W	M	E	N	O					
WTE - Actual versus Plan			191	215	187	161	164								Feb-14								164				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	89	89	88	94	96	96	87		93	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14			100						100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●					May-14	3.33	0.74	2.63	2.41	1.05	4.21	3.66	3.41	4.13	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●					May-14	95	92	95	88	99	88	92		90	●		
Nurse Bank Use	1088	91	●	●	●	●	●	●	●	●					May-14								134	264	●		
Nurse Agency Use	55	5	●	●	●	●	●	●	●	●					May-14								10	19	●		
New Investigations in Month			0	1	0	0	2	2	0	1					May-14								1				
Your Voice - Response Rate					26			29							May-14	63	45	38	30	21	28	19	29				
Your Voice - Overall Score					3.56			3.57							May-14	3.70	3.65	3.65	3.52	3.34	3.51	3.66	3.57				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**18 week update**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow Chief Operating Officer**
AUTHOR:	**Rachel Barlow Chief Operating Officer**
DATE OF MEETING:	**3 July 2014**

EXECUTIVE SUMMARY:

This paper provides an update on the plan to meet 18 weeks both in terms of access to services and quality of care particularly;

The paper covers at specialty level for those areas that need to deliver improvements across the 18 week pathways a focus on:

- Outpatient waits over 6 weeks
- Inflow and outflow through specialities

With a recent national directive to stabilise the national 18 week position this summer, all Trusts have been asked to provide plans to clear waits over 16 weeks. The paper outlines

- Waiting times over 16 weeks for treatment by specialty
- Challenges to deliver clearance at pace over the summer period
- Timelines for key steps to revise plans to deliver this backlog clearance

REPORT RECOMMENDATION:

The Board is asked to consider the briefing and discuss the challenges related to 18 weeks

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

A key national performance metric

PREVIOUS CONSIDERATION:

Considered at the last public meeting of the Trust Board

Sandwell and West Birmingham Hospitals NHS
NHS Trust

18 Referral to Treatment update

1. Introduction

The Board have previously received updates on the referral to treatment performance and delivery plans. These highlighted a number of specialties that are challenged in terms of the access standard:

- ENT
- General surgery
- Ophthalmology
- Oral
- T&O
- Urology
- Cardiology
- Respiratory

The operational leads for these specialties attend the CEO lock in meeting in June. This paper summarises the areas covered through that meeting and the new challenge nationally to stabilise the national performance position and rapidly reduce the longest waiting patients over the summer period.

2. Patients waiting on a non-admitted pathway

Last month the Board was informed of the pending completion of cardiology validation. This validation exercise has now been completed and no clinical or safety concerns were identified by the clinical team.

The time to out-patients appointment in an 18 week pathway for most specialties should be a 6 week wait. This allows for a diagnostic period and treatment period of 6 weeks respectively, following the outpatient episode. Non-admitted outpatient pathways lasting more than 6 weeks potentially take up a disproportionate time of the total 18 week pathway particularly for those pathways requiring in patient admission. For those non admitted outpatient pathways waiting a long time, patients may be waiting for diagnostics to take place, results of tests to be considered and a treatment plan to be set. The table below summaries the position for those specialties outlined in section 1:

Outpatient waits over 6 weeks:

Row Labels	Under_Six_week_wait	Six_week_Plus_waiter	Grand Total	% At 6 Weeks And Above
100-General Surgery	1049	712	1761	40.43%
101-Urology	517	609	1126	54.09%
110-Trauma & Orthopaedics	1250	1080	2330	46.35%

120-ENT	965	840	1805	46.54%
130-Ophthalmology	2790	2916	5706	51.10%
140-Oral Surgery	303	208	511	40.70%
320-Cardiology	576	1048	1624	64.53%
340-Thoracic Med	425	552	977	56.50%

As part of the recovery plan, clinical teams are required to reduce the time to out-patients through a number of initiatives:

- Direct access diagnostics , reducing the need to see a consultant
- Increased utilisation and standardisation of clinic templates across services
- Effective management and discharge of patients who do not attend – which will be standardised through introduction of partial booking this year.
- In some areas increased capacity, possibly though redistribution of job plans, will address demand and capacity mismatch where this is identified

A trajectory for reduction of >6 week waits will be set over the coming month as part of the delivery plan at specialty level.

3. Inflow and outflow

For those specialties where a reduction in waiting times will be delivered, the 3 monthly inflow (new out patients) and outflow (numbers of patients with a clock stop) is summarised below.

	New Attended Appts(3 Month Average)	Total Clockstops(3month average)
100-General Surgery	570	922
101-Urology	570	415
110-Trauma & Orthopaedics	1288	844
120-ENT	643	579
130-Ophthalmology	1565	2067
140-Oral Surgery	291	384
320-Cardiology	461	320
340-Thoracic Med	276	170

In Urology, Trauma and orthopaedics, ENT, respiratory and cardiology the clock stops are less than the referrals in a rolling 3 month period. The variance will either be attributed to uncashed up clinics (uncompleted administration episodes) or demand and capacity mismatch. Both aspects are being validated and enhanced performance management of uncashed up clinics put in place – against the

electronic management of this introduced late this year will strengthen the real time management of this issue.

4. Patients waiting over 16 weeks

National compliance with the 18 weeks standard continues to underperform. In the last fortnight, there has been announcement nationally of the Secretary of States expectation for a reduction in waiting times across the country, particularly reducing the backlog of patients over 16 weeks. The national expectation is that Trust headline level performance will be achieved by end of August (reflected in September data). It is acknowledged that some specialties such as T&O may present a greater local challenge and that actions to bring these into line with performance standards at specialty level may require a longer recovery plan to be agreed. The overall goal is to aim for the cohorts of patients on incomplete pathways to be reduced at least to May 2010 levels or below.

The current number of patients waiting over 16 weeks is:

Admit	
	16+ weeks (Admit)
100- GENERAL SURGERY	85
101- UROLOGY	58
110- TRAUMA AND ORTHOPAEDICS	437
120- ENT	52
130- OPHTHALMOLOGY	198
140- ORAL SURGERY	174
160- PLASTIC SURGERY	44
300- GENERAL MEDICINE	1
301- GASTROENTEROLOGY	27
320- CARDIOLOGY	69
330- DERMATOLOGY	34
340- Respiratory Medicine	1
400- NEUROLOGY - ACUTE	2
502- GYNAECOLOGY	27
X01- Other Specialties	242
X02- Trust Total	**1451**
Non Admit	
	16+ weeks (Non Admit)
100- GENERAL SURGERY	168
101- UROLOGY	161
110- TRAUMA AND ORTHOPAEDICS	277
120- ENT	185
130- OPHTHALMOLOGY	679
140- ORAL SURGERY	67
160- PLASTIC SURGERY	34
170- CARDIOTHORACIC SURGERY	2
300- GENERAL MEDICINE	17
301- GASTROENTEROLOGY	98
320- CARDIOLOGY	375
330- DERMATOLOGY	117
340- Respiratory Medicine	157

400- NEUROLOGY - ACUTE	80
410- RHEUMATOLOGY	25
430- GERIATRICS	31
502- GYNAECOLOGY	30
X01- Other Specialties	927
X02- Trust Total	**3430**

The clearance of patients waiting over 16 weeks is a significant challenge. There is some recognition across the system that this will require intense acceleration of workload over the summer period and funding has been made available to support this . The realism of accelerating high volumes of activity requires additional capacity internally or externally and patient agreement. Our experience of outsourcing elective work is that i) capacity, ii) patient choice and iii) acuity of case mix, make this a 'part' of a capacity solution but will not be enough to meet the full ambition set. The timing of the year also coincides with the 'holiday season' which will prove another challenge to deliver accelerated activity over the next 2 months.

The CCG are determining outsourcing capacity in the independent sector and the Trust are reviewing what additional internal capacity can be generated.

Dependant on the rate of work and volume of work, the plan may affect Trust level delivery for a few months. Delivery plans will be finalised over the coming weeks and this impact determined.

5. Next steps

Continuing the work at specialty level to reduce waiting times and the challenge of the CEO lock in meeting in June, the key specialities are completing bottom up a capacity/ demand exercise and productivity challenge for meeting 18 weeks. Over and above that, in the next 2 weeks the teams will complete the demand and capacity review and scope out the delivery plan for the 16 week challenge. Much of the future plan relies on 'doing things differently' and clinical engagement will be key; to this point the Associate Medical Director for Transformation is now supporting this process.

The Board are asked to note the above position and current work in train to model backlog clearance to 16 weeks.

The timeline for securing plans to clear 16 week backlog position is rapid.

- 2.7.14 Agree funding plan with CCG
- 4.7.14 Complete scaling the 16 week plus position by speciality
- 11.7.14 Finalise solution by specialty

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Emergency Care recovery plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Rachel Barlow – Chief Operating Officer**
DATE OF MEETING:	**3 July 2014**

EXECUTIVE SUMMARY:

The attached documentation is the ED recovery plan the Trust were required to submit to the NTDA in June.

Key points:
Our failings reflect:

- City ED with major on-going staffing issues and mental health pressures and Sandwell ED with major capacity pressures, and mental health pressures. We drop below Trust 95% when the latter hits.
- We have the wrong configuration with 2 EDs; Single site with a new hospital is important and approval would will make a material difference to recruitment and performance.

We have good multi-professional working in place. The four things that will make a difference in the next three months are:

- Improving staffing cover at City : From July 1 we have got a temporary fix for the City staffing deficits at City. These were not an issue in April when we performed well, so we know this will make a difference.
- Reducing delayed transfers of care: We have almost got agreement to restructure how we work with social services to introduce on-site MDTs focused on EDDs – the intention is to start a pilot in July
- The Trust continues attempt to mitigate current high levels of DTOC by opening additional beds.
- Decreasing waits for mental health patients: Chairs and CEOs have met to discuss mental health issues last week. This areas is probably the least scoped in terms of a sustainable solution but a productive meeting and agreement made on provider workshops to streamline current ways of working and to work in partnership to provide a proposal for moderate and long term solution to commissioners

The recovery trajectory is summarised by month and quarter below:

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Month:	**95.0**	**95.5**	**96.3**	**96.3**	**96.3**	**96.3**	**95.5**	**95.3**	**95.1**
Quarter:			**95.6**			**96.3**			**95.3**
Year (Cumulative):	**94.5**	**94.7**	**95.0**	**95.2**	**95.3**	**95.4**	**95.4**	**95.4**	**95.4**

REPORT RECOMMENDATION:

The Board is asked to discuss the recovery trajectory and key issues affecting performance.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Objectives: Safe and high quality care, accessible and responsive services, performance indicators

PREVIOUS CONSIDERATION:

Urgent Care Board - Requirement for plan jointly signed by CCG Chief Accountable Officer

A&E Performance Diagnostic and Recovery Action Plan

Trust Development Authority
Quality. Delivery. Sustainability.

Submission Details

TDA area name	Midlands & East
Trust Name (please choose from drop down list)	Sandwell And West Birmingham Hospitals NHS Trust
Trust Contact Number	0121 5074790
Trust Contact Email	rachel.barlow2@nhs.net
Date of Submission	17.6.14
Trust Chief Executive signature:	Toby Lewis Chief Executive
Return To (email address):-	TDA.MidlandsEast@nhs.net return by 17th June 2014
Queries should be addressed to:-	deborah.poxon@nhs.net

TDA Area Director of Delivery & Development:
Midlands & East

Dale Bywater (dale.bywater@nhs.net)

Midlands & East Current Performance, agreed delivery dates and trajectory

Sandwell And West Birmingham Hospitals NHS Trust

2013/14 A&E Performance

Trust	Trust Code	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14	YE 2013/14
Sandwell And West Birmingham Hospitals NHS Trust	RXK	94.15%	95.07%	94.40%	94.32%	94.48%

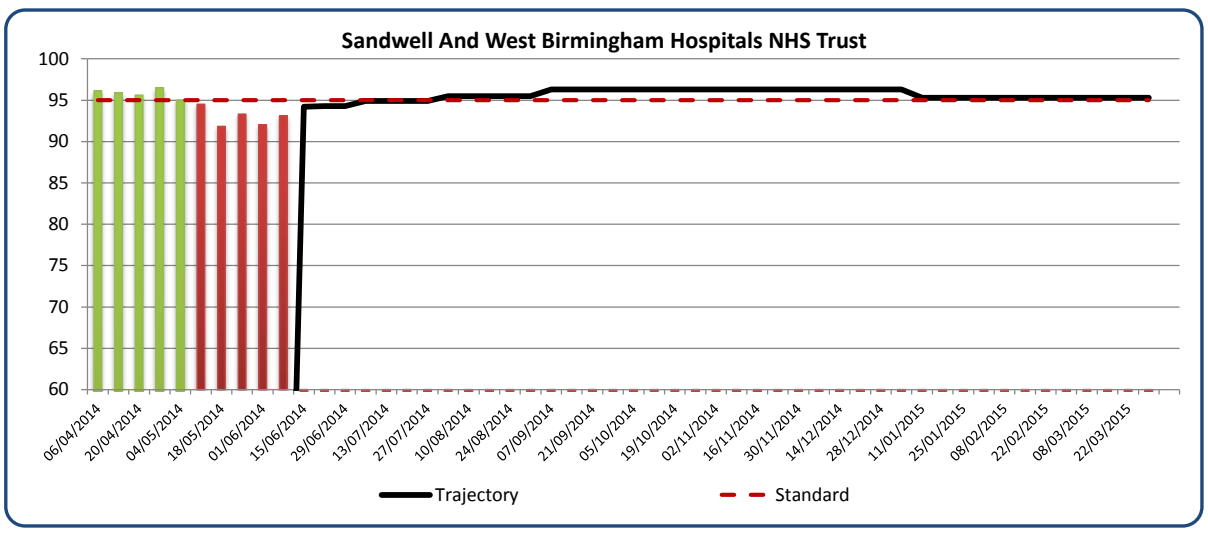
2014/15 A&E Recovery Trajectory

Please populate the highlighted (blue) section below with your proposed recovery trajectory

Week Ending	Trajectory	Actual Performance	Standard
06/04/2014		96.11	95.00
13/04/2014		95.90	95.00
20/04/2014		95.60	95.00
27/04/2014		96.50	95.00
04/05/2014		95.00	95.00
11/05/2014		94.50	95.00
18/05/2014		91.83	95.00
25/05/2014		93.31	95.00
01/06/2014		92.00	95.00
08/06/2014		93.10	95.00
15/06/2014	94.20		95.00
22/06/2014	94.30		95.00
29/06/2014	94.30		95.00
06/07/2014	94.90		95.00
13/07/2014	94.90		95.00
20/07/2014	94.90		95.00
27/07/2014	94.90		95.00
03/08/2014	95.50		95.00
10/08/2014	95.50		95.00
17/08/2014	95.50		95.00
24/08/2014	95.50		95.00
31/08/2014	95.50		95.00
07/09/2014	96.30		95.00
14/09/2014	96.30		95.00
21/09/2014	96.30		95.00
28/09/2014	96.30		95.00
05/10/2014	96.30		95.00
12/10/2014	96.30		95.00
19/10/2014	96.30		95.00
26/10/2014	96.30		95.00
02/11/2014	96.30		95.00
09/11/2014	96.30		95.00
16/11/2014	96.30		95.00
23/11/2014	96.30		95.00
30/11/2014	96.30		95.00
07/12/2014	96.30		95.00
14/12/2014	96.30		95.00
21/12/2014	96.30		95.00
28/12/2014	96.30		95.00
04/01/2015	96.30		95.00
11/01/2015	95.30		95.00
18/01/2015	95.30		95.00
25/01/2015	95.30		95.00
01/02/2015	95.30		95.00
08/02/2015	95.30		95.00
15/02/2015	95.30		95.00
22/02/2015	95.30		95.00
01/03/2015	95.30		95.00
08/03/2015	95.30		95.00
15/03/2015	95.30		95.00
22/03/2015	95.30		95.00
29/03/2015	95.30		95.00

Please complete the highlighted sections (blue) below with your forecasted quarterly positions for 2014/15

Q1 2014/15		Q2 2014/15		Q3 2014/15		Q4 2014/15	
Forecast	Actual	Forecast	Actual	Forecast	Actual	Forecast	Actual
	94.83	95.60		96.30		95.30	



Performance Diagnostic and Recovery plan information

Sandwell And West Birmingham Hospitals NHS Trust

Diagnostic

Diagnostic	Can you explain what the specific reasons are for the Trusts' A&E Q1 14/15 underperformance?	leave commitments there is difficulty covering the second consultant middle shift from 10am - 6pm at the City site, reducing senior decision maker capacity. In April the shift was covered and performance targets were met. Progress on recruitment allows mitigation of this issue from 23rd June. 2. Growth in number of DTOCs and Medically Fit for Discharge patients impacts on flow and bed capacity in the assessment units. There is a demonstrable correlation between high DTOC numbers and ED under performance. 3. Mental Health: the increasing number and length of time spent in ED for this group impacts on ED capacity and flow. Our target is to clear a cubile every 120 minutes.The gearing effect on space and staffing is significant is significant.
	Could you please provide details and data on : * What is the change in A&E attendees (in-year and yr-on-yr)? * Actual 14/15 attendees vs. plan/outturn for 2013/14. * Emergency Admissions 14/15 vs. plan/outturn for 2013/14. * What is change in Non-elective activity (in-year and yr-on-yr)? * Has your A&E conversion rate changed and what is it (in-year and yr-on-yr)? * Are there any bed capacity constraints currently (staffing / norovirus)? * If the level of acuity has changed -could the Trust evidence this? * Has the Trust had any workforce challenges (A&E staffing)?	Please see attached trend on areas below: * What is the change in A&E attendees (in-year and yr-on-yr)? there was a 16% increase in ED attendnaces between 2012/13 and 2013/14. The out of hours profile (particluarly at city) is challenging and most breaches OOH. * Actual 14/15 attendees vs. plan/outturn for 2013/14. see attached * Emergency Admissions 14/15 vs. plan/outturn for 2013/14. see attached * What is change in Non-elective activity (in-year and yr-on-yr)? see attached * Has your A&E conversion rate changed and what is it (in-year and yr-on-yr)? our converison rat eto admsision is 20% * Are there any bed capacity constraints currently (staffing / norovirus)? There no current infection control issues but DTOC are increasing to a level that has significant impact on capacity and flow through acute beds. Currently 40-50 DTOC per day. * If the level of acuity has changed -could the Trust evidence this? VC to feedback * Workforce challenge: vacancy rate of ED consultants 34%, and up to 50% vacancies in middle grades over winter. The number of trainees allocated is drastically reduced this year, which will have ongoing longer term impact on recruitment.
	Is there any other issues to highlight which is impacting on A&E performance? If so, could you quantify that impact and its effect on your A&E performance?	Mental Health waits: the number of patients waiting a very long time in ED is increasing. In January the Trust recorded 40 patents waiting over 4 hours for treatment. In May this has increased by over 70% to 73 breaches . The number of patients waiting over 20 hours from arrival for assessment and treatment is increasing. These longest of waits take up ED capacity which would otherwise be available to assess and treat the equivalent of 40 patients on a non-admitted pathway. The DTOC position both in the acute Trust and in intermediate care beds is the other major contributor to underperformance due to the impact it has on flow. The Trust open additional bed capacity unfunded to mitigate risk associated with lack of capacity to accommodate emergency medical admission. The Trust work with 2 social service providers, both have continued investment in 7 day services. There are inherent delays in the process and ways of working and the Trust, CCG and social services are working to introduce a new innovate assessment model in July as a pilot.
	Could the Trust quantify both the number of 8hr and 12hr trolley waits/ breaches that have taken place during 13/14 and 14/15? Could you confirm that the Trust is adopting a zero tolerance approach to 12hr breaches?	The profile of 8 and 12 hour trolley waits is attached from arrival to the department. The Trust has shown demonstrable improvement in decreasing trolley waits since April 13. The remaining long trolley waits are exclusively mental health waits. The Trust has a zero tolerance to 12 hour trolley waits. One patient has waited over 12 hours from DTA this year for admission to an external mental health bed. This has had a table top review. Chairs and Chief Executives are due to meet later in June to examine remedy.
	Could the Trust outline if there have been any quality & patient safety issues (SUIs)raised in A&E (in-year)? What actions have the Trust taken to minimise and mitigate avoidable harm?	There have been 2 SUIs reported this year. 1. MRSA bacteremia; TTR completed; learning training and awareness raising; continued audit.2. Fall with fracture; TTR yet to be finalised.
Breach Analysis	Could the Trust confirm and provide evidence that 7 day breach analysis is being used?	The Trust has a daily breach analysis and validation process. See attached example. This is shared with the Urgent Care Forum weekly which includes membership of CCG, LAT, social services, NTDA and regional capacity team.
	What are the key features/ Themes that have or are appearing from the breach analysis?	Key themes include 1. late assessment and review by ED, 2.Mental health breaches 3.Capacity isuses related to slow patient flow and discharge.
External Support	Has the IST visited the hospital and if so when?	[illegible] strategy. The Urgent Care Board examined the IST recommendations across organisations in September 2013 and concluded they were met, with the exception of the elderly care pathway - which is now addressed in this plan from August 2014.
	Have you fully implemented the IST recommendations made? If not when will this be completed?	All recommendations completed, with the exception of 'Develop frail elderly pathway'; the Trust has an elderly care strategy and development plan. Compliance with the recommendation is recruitment dependant. Recruitment is in progress for 3 consultants. The pilot of the acute older people assessment model over the summer along with the Frail Safe Pilot the Trust has been selected for will see compliance with this recommendation.
	What further support is required (TDA/IST)?	Support is required from the NTDA to reduce mental health delays through a robust 7 day crisis service and additional bed capacity for mental health assessment. thsiis required for both adult and children's mental health. Also support is sought for the NTDA to engage social services in a new model of early assessment and integrated working from the assessment unit, a leaner patient pathways and more timely interventions to enable earlier discharge and avoid delays.
Winter	Has your winter contingency capacity and/or escalation remained open? If so, how many beds?	Additional bed capacity has been opened over Q1 across both sites; largely in correlation to DTOC pressures. The Trust expects this to be a first call on released winter pressure funding announced last Friday.
	Could the Trust quantify the amount of winter monies received in 2013/14?	[illegible] invested £6million last year in emergency care including the establishment of 2 Medically Fit for Discharge wards. However, it is important to be clear that the Trust and CCG co-invest the emergency threshold sums.
	Outline how the winter monies were deployed and what impact this had on A&E performance?	Winter monies were spent on DVT and OPAT service, a primary care assessment pilot at Rowley Regis Hospital, increased transport and additional medical staff. Together with a combination of other significant initiatives including a new ambulance assessment model, an expansion of acute medical assessment beds and the medically fit for discharge wards, performance improved with the Trust achieving 5/6 months performance standards between November and April inclusive. Full Urgent Care Board Winter plan attached.
Flow	What is the current level of DTOCs (Q1 to date)?	Across a week there is variance in the number of DTOC which are increasing to 40 - 50 patients delayed daily. Our SITREP reported position is 3.7%. But in practice this is almost 10% of the medical bed base.
	What is the maximum and minimum number of DTOCs? And what is the average compared to the same period last year?	The maximum number of discharges varies little this year compared to last year (24 and 25 respectively) , but the minimum number has increased from 15 - 19. In 13/14 was DTOC has increased by 6.79% in average numbers this year as compared to the same period last year - the weekly SITREP reported average is 22; but this varies within the week and is often much higher. Current DTOC is 33.
	What are the actions you are taking to improve flow through your adult inpatient bed capacity during the period?	The Trust have introduced a home for lunch project aimed at achieving 40% ward discharges by 12pm - current performance is 23%. An operational hub in the acute Trust has improved the coordination of flow with beds being available in the assessment unit to receive the medical take on a majority of occasions. A similar hub is in development for community and social care beds at Sandwell. The Trust aspire a single model across Sandwell and Birmingham. The CCG, community Trust, and SMBC have committed to this. Birmingham City Council have yet to.
	What actions have you put in place to improve the rate of discharge of simple and complex discharges?	All patients have a EDD on admission. Multi professional board rounds take place on all wards by 9.30am. ICARES (the Trust Integrated Community Reablement service in reaches to the Sandwell site to support discharge flow. The Trust would like to see a replica ICARES service in West Birmingham and this will be our priority one bid to the winter monies, after net of escalation funding..
	How are you working with social care and commissioners to reduce your DTOCs and improve flow?	The Trust , CCG and Social services are currently working towards a new integrated way of working across 7 days. This includes a team based in the medical assessment units to start discharge assessment and planning on admission, with a trusted assessment approach amongst partner organisations for decisions for placement in real time, that are no longer dependant on panel authorisation. The final proposals will be in place for mid-July with an ambition to pilot over the summer.
	What is the average weekly pattern of discharges by day and against plan for Q4?	We aim to discharge 88 emergency medical patients a day . The goals are attributed 50% to the AMUs and 50% to the base wards. Weekend discharge rates are increasing. With 7 day working initiatives. Profile atached.
Partnership working	What actions is the urgent care group undertaking to improve performance?	[illegible] evaluation of the Primary Care Assessment and Treatment Serivce at Rowley Regis Hospital. Considerable investment continues in reducing attendance rates but this has yet to drive absolute reductions in foot-fall.
	What are the arrangements with commissioners in terms of: * Level of mutual support (financial/other) provided by commissioners? * Do you share breach analysis with commissioners? * Are their local health system TCs when required? * What is the current status regarding community bed capacity? * What additional support has been provided by IS or other providers i.e. mutual support during Q3 and Q4?	There is a weekly conference call or meeting between Trust, CCG, Social Services, regional capacity team, LAT and NTDA. Breach analysis is shared along with an urgent care score card. Availability of bed capacity in the community is limited, particularly dementia beds and residential placements. Support is required in 2 areas; 1. Improving the provision of mental health assessment and bed capacity. The current serivce is intolerable for patients and impacts significantly on ED capacity. 2. Support for redesigning an integrated team with social serivces which is lean and responsive and actively plans discharge on admission.

Recovery Plan

Recovery Plan	Is there a Board agreed Recovery Action Plan in place? (If so please attach with your response)	This recovery plan will be submitted to the Trust Board. The Emergnecy Care performance is regaulrly reported and discussed monhtly.
	If yes, when was it agreed and could you confirm this has been agreed with commissioners?	
	What date does the Trust expect to be back on track and achieving A&E safely and sustainably?	see trajectory
	If no RAP is in place, when will one be agreed?	

Could you briefly provide in the box below details on the current short/medium and more longer term actions to address A&E underperformance. In addition, based on the recovery trajectory outlined on the "Trust Summary" tab, could you quantify (where possible) the impact of these actions on A&E performance:

Short/ Medium term:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Patient safety data on NHS Choices
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	3 July 2014

EXECUTIVE SUMMARY:

New data published today (24 June 2014) will for the first time allow the public the opportunity to compare key safety measures across NHS trusts in England.

The patient safety information on NHS Choices allows you to compare hospitals and find out how they are doing in terms of cleanliness and infections such as MRSA, preventing blood clots, or reporting incidents. It also shows if a hospital has enough nursing and midwifery staff to provide safe care to patients.

No data can provide certainty about how safe the care of an individual patient was, is or will be, or determine whether hospitals are safe or not. But it is an important tool that allows patients, the public and the NHS to ask questions and encourage continuous improvement.

The patient safety data published on NHS Choices for our locations has been extracted and is provided in **Appendix A**. **In all areas published a good position is shown for the Trust**. This is not the case for some organisations where indicators are described as "*amongst the worst*" or "*some standards not met*". Maintenance and improvement of our performance against the indicators will continue through our established monitoring and assurance arrangements.

To assist the public, a glossary is available on the website which provides a description of the each indicator and explains the data sources that inform the ratings. This can be found at **Appendix B**.

REPORT RECOMMENDATION:

1. **Board members are asked to DISCUSS** the Trust's position against the patient safety indicators published on NHS Choices.

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:

To provide Safe, High Quality Care

PREVIOUS CONSIDERATION:

None

Appendix A

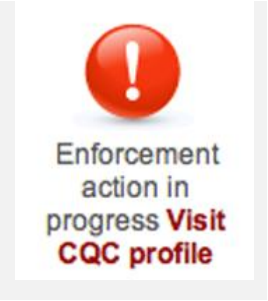
Patient Safety Data on NHS Choices for Sandwell and West Birmingham Hospitals NHS Trust

Hospital	Infection control and cleanliness	Care Quality Commission national standards	Recommended by staff	Safe Staffing	Patients assessed for blood clots	NHS England patient safety notices	Open and honest reporting
Sandwell General Hospital	As expected	All standards met	Within expected range with a value of 59.02%	121% of planned level	98.30% of patients assessed	Good - All alerts signed off where deadline has passed	As expected
City Hospital	As expected	All standards met	Within expected range with a value of 59.02%	114% of planned level	98.30% of patients assessed	Good - All alerts signed off where deadline has passed	As expected
Rowley Regis Hospital	As expected	All standards met	Within expected range with a value of 59.02%	121% of planned level	98.30% of patients assessed	Good - All alerts signed off where deadline has passed	As expected
Bradbury Day Care Centre	n/a Data not available	All standards met	Within expected range with a value of 59.02%	n/a Data not available	98.30% of patients assessed	Good - All alerts signed off where deadline has passed	As expected
Birmingham Treatment Centre	n/a Data not available	n/a Data not available	Within expected range with a value of 59.02%	n/a Data not available	98.30% of patients assessed	Good - All alerts signed off where deadline has passed	As expected

Appendix B

Glossary of patient safety indicators

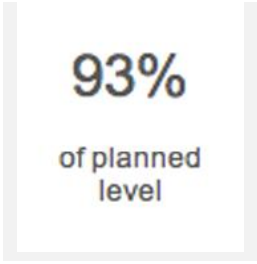
Care Quality Commission: national standard



The Care Quality Commission (CQC) is the independent regulator for health and adult social care in England. CQC checks whether services meet national standards of quality and safety. The indicator on NHS Choices shows you whether a hospital is meeting safety standards as expected.

Hospitals are rated as either meeting the required standards or not. This is the most authoritative view of the safety of a hospital and is the most meaningful source of data on patient safety available.

Safe staffing: nursing hours filled as planned hide



Find out how well a hospital's nursing and midwifery staffing requirements are being met.

Nurses, midwives and care staff are part of a wider team of healthcare professionals providing patient care. Often working alongside therapists, specialist nurses and psychologists, they play an important role in providing high quality and safe care to patients.

Safety of care relates to a number of factors, including the skills and experience of staff and the different needs of patients in their care. Each ward manager works closely with the director of nursing to make decisions about staff requirements for each shift, and ensure patient needs can be met. The number of staff required at any time is called the planned staffing number.

The data is presented in two ways on NHS Choices:

1. You can see if a hospital's nursing and midwifery staffing requirements are being met overall.
2. For each hospital, you can also see as a percentage of hours in a day or night whether the actual number of nurses on duty met what was planned in a hospital or ward. We will present a result for both registered and unregistered nurses.

Sometimes the actual staffing number is below the planned number. This may be the result of staff sickness, or because there is a lower number of patients on the ward than usual, so staff have been moved to work in another area.

Sometimes the actual staffing number will be higher than the planned number. This may be because there are a lot of patients on the ward who need extra care because of their physical or mental health condition.

Some hospitals will be unable to meet their staffing needs with permanent staff all of the time on every shift.

% of registered nurse day hours filled as planned (Hospital)	94% of planned level Ward level breakdown
% of non registered nurse day hours filled as planned (Hospital)	92% of planned level Ward level breakdown
% of registered nurse night hours filled as planned (Hospital)	94% of planned level Ward level breakdown

Information about staffing levels alone cannot tell you whether a hospital is safe or unsafe, but a regular lower percentage of the planned staff being in place is a cause for concern.

What is the difference between an unregistered and a registered nurse?

A registered nurse is a member of the registered nursing or midwifery staff on the duty rota dedicated to the inpatient wards. This includes supervisory ward managers, sisters, charge nurses, midwives and staff nurses.

An unregistered nurse is a member of staff on the duty rota dedicated to the inpatient wards whose work is supervised by a registered nurse.

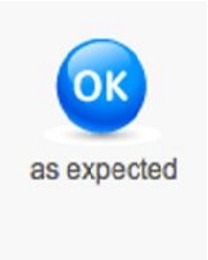
Infection control and cleanliness

Find out how well an organisation performs in terms of infection control and cleanliness.

The indicator you can see on this website is constructed from the existing data displayed about the number of Clostridium difficile (C. difficile) and MRSA infections, and patients' views on the cleanliness of wards.

The patient safety indicator combines this information with additional data to provide an overall rating for preventing infection and cleanliness.

The results are displayed with different coloured icons:



- green = good
- blue = OK
- red = poor

The rating does not describe whether a hospital is safe, but it does give an indication of how it is performing in terms of cleanliness and infections.

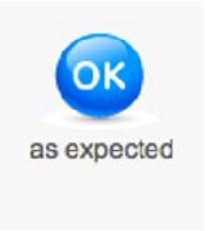
Open and honest reporting

You can now find out how well your hospital performs in open and honest reporting of patient safety incidents. This indicator gives an overall picture of whether the hospital has a good patient safety incident reporting culture.

A good reporting culture means that the hospital reports incidents frequently – serious incidents as well as those with low or no harm to patients. Reporting even these less serious incidents shows that an organisation understands that these are opportunities to learn and improve.

A good reporting culture is also indicated when members of staff can say their organisation has a fair and effective incident reporting procedure.

The ratings for this indicator are displayed with different coloured icons:



- green = good
- blue = OK
- red = poor

This does not describe whether a hospital is safe, but it does give an indication of how well developed the hospital's patient safety incident reporting culture is.

Patients assessed for risk of blood clots hide

Deep vein thrombosis (DVT) and pulmonary embolism are collectively known as venous thromboembolism (VTE), a condition where blood clots form in the veins. Anyone can develop VTE, but people are more at risk when they are less mobile and unwell. This means that the risk of VTE increases with acute medical illness, long-term health problems, and some surgical operations.

Hospitals are expected to assess the patients they admit for the risk of VTE. All hospitals should risk-assess at least 95% of inpatients when they are admitted. A value above 95% is good and fewer than this is poor.

NHS England patient safety reporting

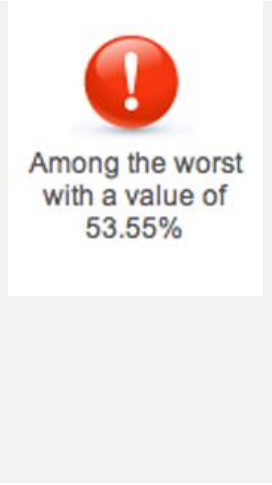
Patient safety alerts are sent out by NHS England to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death.

Alerts are key in helping hospitals to improve the quality of care they provide. They also demonstrate a hospital's accountability for the safety of their patients. All hospitals should respond to patient safety alerts in the timeframe given to them by NHS England. Any delay in taking the relevant actions required is a cause for concern.

The performance of your hospital is shown on NHS Choices in two ways:

- poor = the hospital has not completed one or more safety alerts for which the deadline has passed
- good = the hospital has dealt with all patient safety alerts within the given timeframe

Recommended by staff



This indicator shows the percentage of staff (as measured by the NHS Staff Survey) happy to recommend the hospital if a friend or relative needed treatment. It is based on the standard of care the hospital provides.

The indicator is displayed on three ways on this site. It shows if the hospital is performing:

- as expected
- worse than average
- better than average

The rating does not describe whether a hospital is safe, but staff opinion of the quality of care provided by an organisation is an important indicator about the safety of care and the quality of care in general.

NHS Safety Thermometer data on pressure ulcers and falls with harm

% of patients who have been hurt in a fall in the last 3 days	0.30%
% of patients being treated for a bed sore (pressure ulcer)	4.42

The NHS Safety Thermometer is a point of care survey instrument. It is used in hospitals and other organisations to check how many patients in their care have suffered one or more of a defined list of "harms" associated with patient safety. It allows teams to measure harm and the proportion of patients that are "harm free" during their working day.

For more detailed information, visit either the NHS Safety Thermometer or the Health and Social Care Information Centre(HSCIC) website.

On NHS Choices we display two "harms" measured by the NHS Safety Thermometer on each hospital's overview page profile. You can see:

- the number of patients being cared for who have a pressure ulcer (bed sore)
- the number of patients being cared for who have been hurt by a fall in the last three days

You'll also be able to see the percentage of patients surveyed each month.

Note: NHS Safety Thermometer data should not be used to compare hospitals or make judgments about which hospitals are safer than others.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – P02 May 2014
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Management
AUTHOR:	Chris Archer, Associate Director of Finance - Corporate
DATE OF MEETING:	3 July 2014

EXECUTIVE SUMMARY:

Key messages:

- Year to date I&E £323k behind plan driven by CIP delivery below plan & pay cost run rate
- Forecast remains delivery of £3.1m plan surplus in line with LTFM commitment – requires discipline in living within budget
- CIP delivery below plan and underlying over spending notably on temporary pay – not sustainable
- Reported position moderated by benefit of £683k reserves – intended for development
- Capex modest and requires confirmation of plan & expedited delivery
- Cash below plan due to timing differences

Key actions:

- Secure net expenditure within budget including as necessary continuation of expedient measures to contain and control expenditure with emphasis on reduction of premium rate agency and medical staff premium rate working.
- Secure extant CIP scheme delivery & confirm route to resolution of residual balance.
- Secure service delivery to operational & CQUIN standards to minimise avoidable income losses
- Complete work to confirm detailed capital programmes for IM&T, Estates and medical equipment.

Key numbers:

- Month surplus £297k being £155k adverse to budget; YTD surplus £48k being £323k adverse.
- CIP delivery to date £920k being £420k adverse to revised plan & £1.1m adverse to TDA plan
- Forecast surplus £3.1m in line with financial plan.
- Capex YTD £479k being £414k below plan.
- Cash at £1 May £36.3m being £5.3m below plan due to timing difference on receipt of E&T income
- CoSRR 4 to date as plan; forecast 3 as plan

REPORT RECOMMENDATION:

The Board is requested to RECEIVE the contents of the report and ENDORSE any actions taken to ensure that the Trust secures its key financial targets.

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:
To be considered by Finance & Investment Committee members and Performance Management Committee.

SWBTB (7/14) 104 (a)

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – May 2014 (month 2)

EXECUTIVE SUMMARY

- For the **month** of May 2014, the Trust delivered a **"bottom line" surplus of £297,000 being £155,000 adverse** to a flex budget surplus of £452,000. The year to date surplus of £48,000 is £323,000 adverse to flex budget to the end of May.
- The year to date adverse variance consists of £420,000 shortfall against savings targets, up to £683,000 benefit of release of central reserves (some of which may be offsetting Group overspends on particular initiatives) leaving a **net underlying overspend of £586,000 in Groups** after the benefit of pass through cost funding of £405,000.
- Forecast anticipates that the position will be recovered and the annual surplus target of £3.146m will be met through CIP development and delivery with uncommitted reserves as contingency.
- Actual **savings delivery is assessed at £920,000 being £420,000 behind the Trust phased plan**.
- At month end there were 6,933 whole time equivalent (WTE) staff in post (excluding use of agency), 185 below the currently planned level (which may not reflect final savings or investment plans). After taking account of the impact of agency staff, **WTE's were 84 above plan**. Total **pay expenditure** for the month, including agency costs, **is £295,000 above the planned level.** Agency spend is up 15% in month driven by medical staffing.
- Key risks include management of costs pressures and income recovery compromised by shortfalls in delivery of operational standards. Additional resources have been announced nationally to address system resilience issues in emergency care and in achieving referral to treatment time standards.

Financial Performance Indicators - Variances					
Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	(155)	(323)	>= Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	(154)	(324)	>= Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	(295)	(813)	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	(236)	27	<= Plan	<= Plan	>1% above plan
WTEs Actual v Plan	(84)	(368)	<= Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000		(5,077)	>= Plan	>=95% of plan	<95% of plan
Note: positive variances are favourable, negative variances unfavourable					

- **The month-end cash balance was £36.3m, £5.1m lower than revised cash plan**. This reflects the late receipt of Education and Training funding which is anticipated in June. This should restore cash balances to planned levels.
- Year to date spend on capital is £479,000 being £413,000 below plan.

2014/15 Summary Income & Expenditure Performance at May 2014	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	389,862	32,536	32,937	401	65,010	65,557	547	389,862
Other Income	41,301	3,460	3,436	(24)	6,897	6,811	(85)	41,301
Pay Expenses	(282,136)	(24,123)	(24,417)	(295)	(48,627)	(49,440)	(813)	(282,136)
Non-Pay Expenses	(124,400)	(9,626)	(9,862)	(236)	(19,329)	(19,301)	27	(124,400)
EBITDA	**24,628**	**2,248**	**2,094**	**(154)**	**3,951**	**3,627**	**(324)**	**24,628**
Depreciation	(13,962)	(1,161)	(1,161)	0	(2,327)	(2,327)	0	(13,962)
PDC Dividend	(5,220)	(451)	(451)	0	(870)	(870)	0	(5,220)
Net Interest Receivable / Payable	(2,150)	(171)	(172)	(1)	(358)	(357)	1	(2,150)
Other Finance Costs / P&L on sale of assets	(150)	(13)	(13)	0	(25)	(25)	0	(150)
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,146**	**452**	**297**	**(155)**	**371**	**48**	**(323)**	**3,146**
Surplus / (Deficit) against TDA plan	3,374	68	297	229	6	48	42	3,374

TDA annual plan differs by £228k IFRIC 12 adjustment; in year Trust .phasing of budgets reflects updated local plans

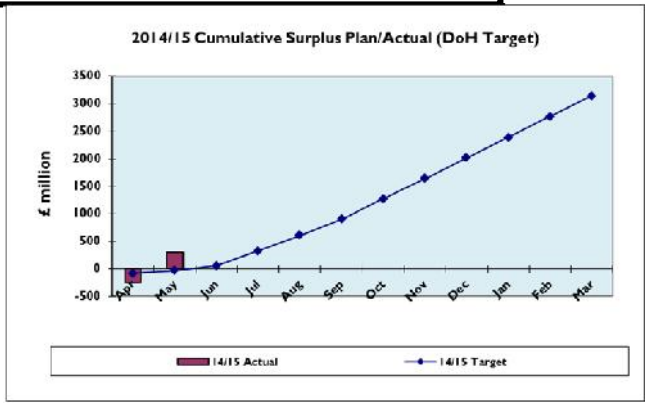
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – May 2014

Overall Performance against Plan

The Trust delivered an actual surplus of £297,000 against a planned surplus of £452,000 in May. It is anticipated that this will be recovered in order to achieve the year end surplus target of £3.146m surplus.

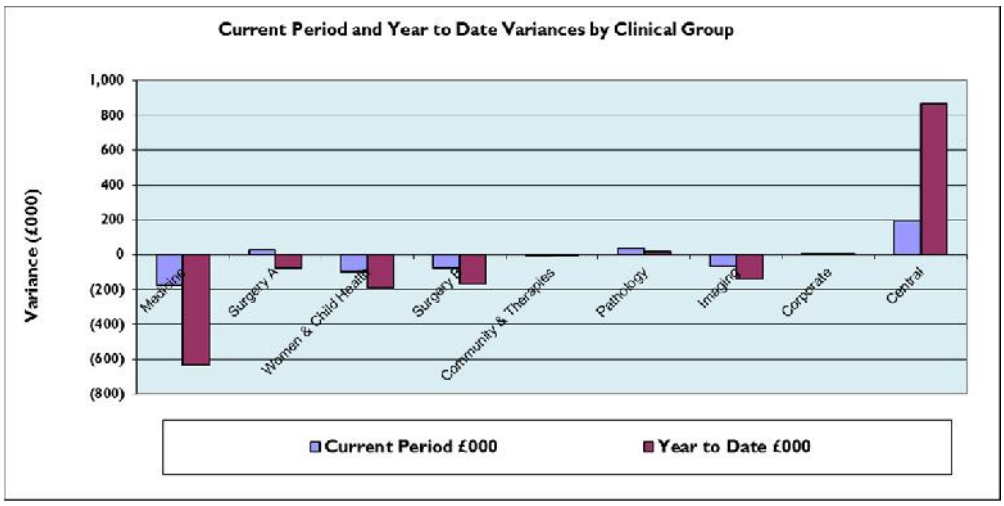


Performance of Clinical Groups / Corporate Areas

- Medicine pay overspend includes £100k on HCA support to patients assessed as having enhanced care needs. Additional beds remain open. Drugs and cardiology non-pay spends offset by additional income.
- Surgery A underspend nursing vacancies.
- Women & Child overspend is mainly anticipated costs of antenatal pathways at other providers.
- Surgery B overspend medical staff premium rate working. Additional income received to cover some costs of Lucentis, though SWB contract is capped.
- Imaging premium rate working and additional costs of mobile scanner contracts.

Group Variances from Plan (Operating income and expenditure)	**Current Period £000**	**Year to Date £000**
Medicine	(175)	(635)
Surgery A	30	(77)
Women & Child Health	(95)	(194)
Surgery B	(78)	(167)
Community & Therapies	(8)	(4)
Pathology	37	18
Imaging	(65)	(138)
Corporate	5	4
Central	195	868

- Underlying Group year to date position is £420k CIP not delivered and £586k of other underlying overspends having taken account of £405k additional income to cover pass through drugs. This is moderated by impact of unallocated central reserves of £683k.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – May 2014

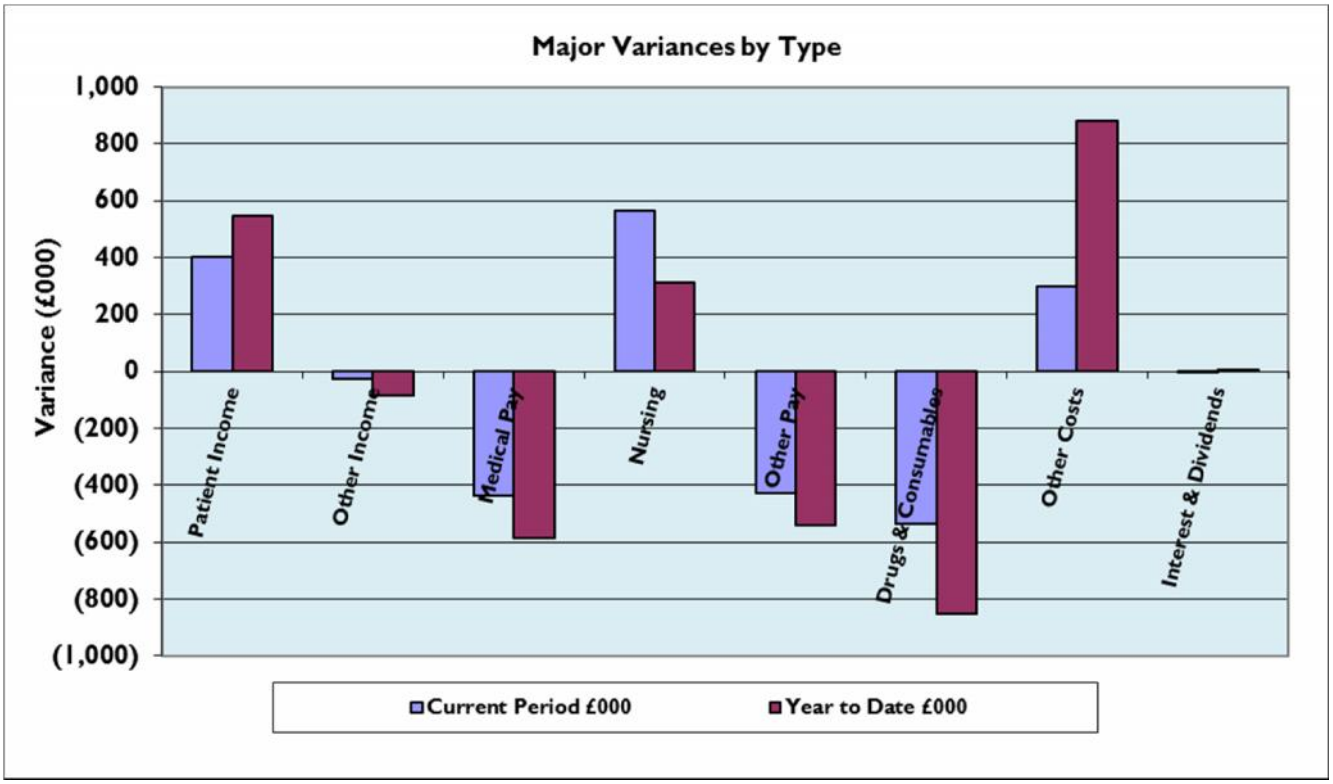
Overall headline adverse variance to plan £155k in May (£323k year to date). There is still some movement of budgets between expenditure type headings to reflect savings and investment plans and distribution of inflation funding. Against current targets however:

Patient income over-performed reflecting pass through drugs arrangements and cardiology activity.

Medical pay overspend is mainly premium rate working. Other pay includes outstanding budget adjustments and savings targets.

Other costs reflects release of inflation and investment reserves.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	401	547
Other Income	(24)	(85)
Medical Pay	(437)	(586)
Nursing	567	313
Other Pay	(426)	(541)
Drugs & Consumables	(536)	(852)
Other Costs	301	880
Interest & Dividends	(1)	1



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – May 2014

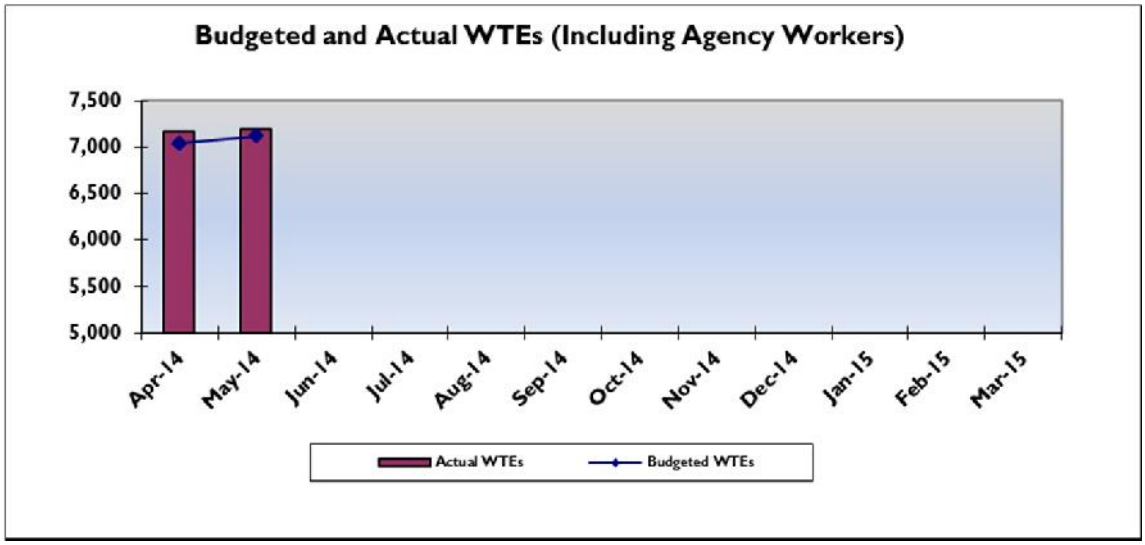
Paybill & Workforce

• There were 6,933 WTE in post in May plus an estimated 270 WTE of agency staffing across the month. In total this is 84 WTE above planned establishments, though these are subject to change as savings and investment plans are finalised.

•Total pay costs (including agency workers) at £24.4m are £295,000 above budget for the month, £813,000 above budget for the year to date.

•Principal overspending is for medical staff premium rate working and for healthcare assistants providing enhanced care support to vulnerable patients.

•Gross expenditure for agency staff in May was £1,154,000 which shows no movement from the recent run rate.



Analysis of Total Pay Costs by Staff Group

	Year to Date to May 2014					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	12,986	12,667	0	905	13,572	(586)
Management	2,612	2,350	0	0	2,350	262
Administration & Estates	5,306	4,769	355	128	5,253	53
Healthcare Assistants & Support Staff	5,399	4,946	719	156	5,820	(422)
Nursing and Midwifery	15,611	13,739	757	802	15,298	313
Scientific, Therapeutic & Technical	7,577	6,914	0	168	7,082	495
Other Pay / Technical Adjustment	(865)	65	0	0	65	(930)
Total Pay Costs	48,627	45,451	1,830	2,159	49,440	(813)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – May 2014

Balance Sheet

- Cash balances at 31st May stood at £36.3m, an increase of £7.8m over the month and £5.1m lower than plan.
- This is principally because of the delay in receipt of £4.5m Education funding which is now due in June.
- The revised forecast cash flow for the next twelve months is shown overleaf.

STATEMENT OF FINANCIAL POSITION 2014/15

	Balance at 31st March 2014	Balance as at 30th April 2014	Balance as at 31st May 2014	Forecast at 31st March 2015
	£000	£000	£000	£000
Non Current Assets				
Property, Plant and Equipment	226,403	225,355	224,640	228,768
Intangible Assets	886	886	886	562
Trade and Other Receivables	1,011	1,295	1,295	700
Current Assets				
Inventories	3,272	3,213	3,426	3,600
Trade and Other Receivables	16,177	23,852	20,548	11,610
Cash and Cash Equivalents	41,808	28,520	36,325	24,388
Current Liabilities				
Trade and Other Payables	(53,867)	(48,168)	(52,250)	(43,546)
Provisions	(8,036)	(7,548)	(7,324)	(3,724)
Borrowings	(1,064)	(1,059)	(1,059)	(1,029)
DH Capital Loan	(2,000)	(2,000)	(2,000)	(1,000)
Non Current Liabilities				
Provisions	(2,562)	(2,562)	(2,570)	(2,522)
Borrowings	(27,915)	(27,921)	(27,757)	(27,884)
DH Capital Loan	(1,000)	(1,000)	(1,000)	
	193,113	**192,863**	**193,160**	**189,923**
Financed By				
Taxpayers Equity				
Public Dividend Capital	161,640	161,640	161,640	162,211
Retained Earnings reserve	(19,484)	(19,827)	(19,437)	(10,255)
Revaluation Reserve	41,899	41,992	41,899	28,909
Other Reserves	9,058	9,058	9,058	9,058
	193,113	**192,863**	**193,160**	**189,923**

Financial Performance Report – May 2014

CASH FLOW

12 MONTH ROLLING FORECAST AT May 2014

ACTUAL/FORECAST	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	Apr-15 £000s	May-15 £000s
Receipts														
SLAs: SWB CCG	21,328	21,084	21,165	21,165	21,165	21,165	21,165	21,165	21,165	21,165	21,165	21,165	21,165	21,165
Associates	6,176	6,698	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417
Other NHS income	1,549	260	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461
Specialised Service (LAT)	99	8,892	3,260	3,260	3,260	3,260	3,260	3,260	3,260	3,260	3,260	3,260	3,260	3,260
Over/(Under) Performance Payments		3,959												
Education & Training			4,608	4,608			4,608			4,608			4,608	
Public Dividend Capital						72						499		
Loans														
Other Receipts	1,651	3,173	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755
Total Receipts	30,803	44,066	38,666	38,666	34,058	34,130	38,666	34,058	34,058	38,666	34,058	34,557	38,666	34,058
Payments														
Payroll	13,895	13,711	14,512	14,025	14,007	14,007	13,616	13,616	13,616	13,613	13,613	13,613	13,613	13,613
Tax, NI and Pensions	9,567	9,518	9,675	9,350	9,338	9,338	9,077	9,077	9,077	9,076	9,076	9,076	9,076	9,076
Non Pay - NHS	4,186	1,905	1,905	2,034	2,034	2,034	2,148	2,148	2,148	2,148	2,148	2,148	2,148	2,148
Non Pay - Trade	12,144	8,942	7,309	7,826	7,825	7,825	8,282	8,281	8,281	8,282	8,281	8,281	8,282	8,282
Non Pay - Capital	2,895	1,342	2,899	2,957	1,707	1,315	1,963	1,963	2,836	2,775	2,656	1,660	2,775	2,775
PDC Dividend						2,610						2,610		
Repayment of Loans						1,000						1,000		
Interest			178	178	178	178	178	178	178	178	178	178	178	178
BTC Unitary Charge	428	439	375	375	375	375	375	375	375	375	375	375	375	375
Other Payments	975	405										4,810		
Total Payments	44,090	36,262	36,853	36,744	35,463	38,681	35,638	35,637	36,510	36,446	36,326	43,750	36,446	36,446
Cash Brought Forward	41,808	28,521	36,325	38,138	40,059	38,654	34,102	37,129	35,550	33,097	35,317	33,048	23,854	26,074
Net Receipts/(Payments)	(13,287)	7,804	1,813	1,922	(1,406)	(4,552)	3,027	(1,580)	(2,453)	2,220	(2,269)	(9,194)	2,220	(2,389)
Cash Carried Forward	28,521	36,325	38,138	40,059	38,654	34,102	37,129	35,550	33,097	35,317	33,048	23,854	26,074	23,685

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – May 2014

Capital Expenditure

- Year to date capital expenditure is £479,000 vs. plan £892k.
- Detailed capital plans are being developed for estates, IM&T and capital equipment.

Continuity of Service Risk Rating

•The rating for May is 4 which is consistent with the planned position of 3 for the year.

Memorandum	Current Month Metrics			Forecast Outturn Metrics		
Continuity of Services Risk Ratings	Plan	Actual / Forecast	Variance	Plan	Actual / Forecast	Variance
	(mc 01)	(mc 02)	(mc 03)	(mc 04)	(mc 05)	(mc 06)
	£000s	£000s	£000s	£000s	£000s	£000s
Liquidity Ratio (days)						
Working Capital Balance	(7,230)	(5,760)	1,470	(13,301)	(13,301)	(0)
Annual Operating Expenses	68,031	68,794	763	405,044	406,847	1,803
Liquidity Ratio Days	(6)	(5)	1	(12)	(12)	0
Liquidity Ratio Metric	**3.0**	**3.0**	**0.0**	**2.0**	**2.0**	**0.0**
Capital Servicing Capacity (times)						
Revenue Available for Debt Service	3,584	3,593	9	24,842	24,566	(276)
Annual Debt Service	1,422	1,436	14	10,532	10,616	84
Capital Servicing Capacity (times)	2.5	2.5	(0.0)	2.4	2.3	(0.0)
Capital Servicing Capacity metric	**4.0**	**4.0**	**0.0**	**3.0**	**3.0**	**0.0**
Continuity of Services Rating for Trust	**4**	**4**	**0**	**3**	**3**	**0**

Service Level Agreements

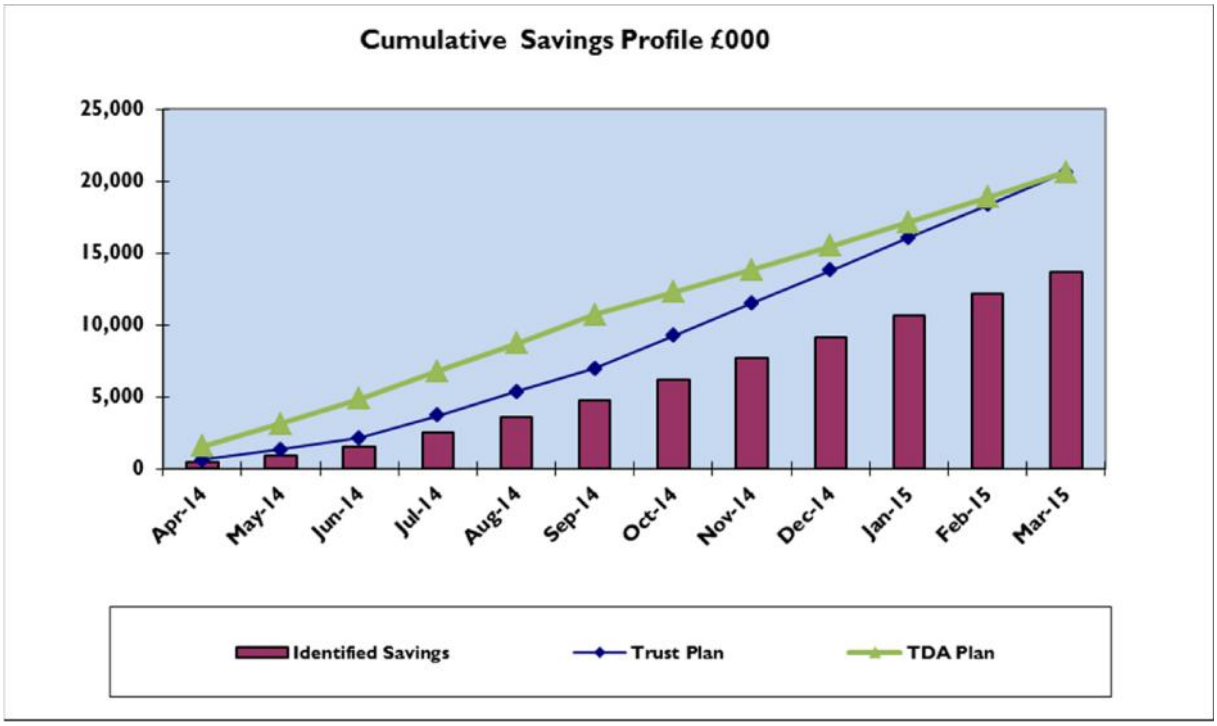
•SLA targets have now been devolved. Activity and income data for April indicates an over performance before fines of £293,000. Fines notices have been received for April and are within the agreed fines cap levels. The CCG is indicating that it will withhold an element of the monthly payment pending receipt of remedial action plans to deliver RTT & MSA targets. The cash flow statement assumes no such payment deferral on assumption of delivery of said action plans.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – May 2014

Savings Programme

- The Trust has identified £13.7m of savings against the annual target of £20.6m. These have a full year effect of £18.0m.
- The forecast profile of savings delivery is shown below together with the original plan against which the TDA continues to monitor the Trust
- Detailed work continues with Groups and Corporate Directorates to identify the balance of the programme using benchmark information where appropriate, to ensure savings do not adversely impact quality or safety and to deliver the savings plans identified.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – May 2014

Key risks

- **CQUIN targets** mainly require setting of baselines for Q1. However the Q1 target for dementia care has not been met and will result in a loss of £65,000 for the quarter.
- **Delivery of savings** is slower than the conservative plan for May. Finance and Investment Committee have received a separate detailed report on how the plan is to be delivered.
- **Overspending on ward staffing.** Detailed work is going on to agree ward establishments consistent with safety requirements and enforce procedures and controls around deviation from agreed levels.
- **Premium rate waiting list work** is continuing in a number of specialties. More robust controls are being implemented along side work better to understand capacity constraints that mean demand is not consistently met.
- An emerging key cost pressure from **maternity payments to other providers** is anticipated in the May results. Plans to manage this pressure will be developed in order to mitigate the financial risk estimated at £1.0m for the year.
- National funding for system resilience has been announced by NHS England to address emergency care and waiting list performance. More details and local arrangements are yet to be agreed. Such funding will help to mitigate operational and financial risks at least in year.

External Focus

- NHS England has highlighted guidance for area teams on the transfer of funds to social care in 2014/15. This year, NHS England will transfer £1.1bn to local authorities, including £200m that is earmarked as the first part of the better care fund. As well as the area team guidance, it also provides details of the transfer to individual councils by area team.
- The NHS England Chief Executive Simon Stevens has said that new models of reimbursement for some elective conditions, long-term conditions, including year-of-care, and urgent and emergency care would be piloted. Incentives, including CQUIN, the quality and outcomes framework and the quality premium, would also be examined. He would be pushing for a steady increase in the proportion of payments tied to performance, quality and outcomes for all NHS-funded services. And there would be a spectrum of approaches to sharing utilisation risk for particular services – from volume-based payments to delegated capitated budgets.
- NHS Employers has published a questions and answers document on safe staffing guidance. The document includes information on the data required, how it will be communicated and which services should provide the information.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – May 2014

Recommendations

The Trust Board is asked to:

i. RECEIVE the contents of the report; and

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

Tony Waite

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

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

EXECUTIVE SUMMARY:

The Trust Risk Register compromises high (red) risks that have been through the validation processes at directorate / group and Executive Committee levels. The Clinical Leadership Executive is responsible for reviewing and approving high (red) risks validated by Risk Management Committee, which are proposed for inclusion on the Trust Risk Register reported to Trust Board.

The Trust Risk Register is reported to the Board to ensure oversight of the high red risks managed by the Clinical Groups, Corporate Directorates and Corporate Project Teams under the direction of Executive Leads.

The Trust Risk Register was reported to the Board at its June meeting. As at writing there is one proposed addition and an amendment: Women and Child Health risk - no on-site 2nd Obstetric theatre team out of hours; the Acute Oncology Service overarching risk is amended to feature as three individual risks to better reflect the individual elements being addressed. The Trust Risk Register, including the proposed additional risk and amended oncology risk is at Appendix A.

High (red) risks that have been reviewed by the Risk Management Committee and continue to be managed at Clinical Group, Corporate Directorate or Project levels but are not proposed for inclusion on the Trust Risk Register have previously been reported to the Board. This high (red) risk summary log is available on request; however there have not been any notable changes to report since the last update to the Board.

REPORT RECOMMENDATION:

1. **DISCUSS** the proposed high (red) risk and **AGREE** if it is to be added to the Trust Risk Register.

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
NHS Trust

Trust Risk Register

Report to the Trust Board on 3 July 2014

1. EXECUTIVE SUMMARY

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

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

1.3 The Clinical Leadership Executive is responsible for reviewing and approving high (red) risks validated by Risk Management Committee, which are proposed for inclusion on the Trust Risk Register reported to Trust Board.

1.4 The Trust Risk Register is reported to the Board to ensure oversight of the high red risks managed by the Clinical Groups, Corporate Directorates, and Corporate Project Teams under the direction of Executive Leads.

1.5 Management of individual risks continues at each level of risk register they feature; escalation of risks through management reporting structures does not transfer all ownership of the risk.

1.6 Updates to the existing risks on the Trust Risk Register and the proposed addition were received by CLE at its meeting on 25 June 2014. Following discussion, it was agreed to escalate the additional risk to the Board for consideration. As a reminder, the options available for handling these risks are:

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

2. Trust Risk Register Update

2.1 The Trust Risk Register was reported to the Board at its June meeting. As at writing there is one risk being put forward by CLE for consideration by the Trust Board and another for amendment:

- New risk: Women and Child Health risk in relation to no **on-site 2nd Obstetric theatre team out of hours**. The CLE's view is that the unmitigated risk score (4 x 5) is too high and that the RMC should revisit the mitigation / action plans and associated costs.

- Amendment: The **Acute Oncology Service** overarching risk is amended to feature as three individual risks to better reflect the separate elements being addressed.

The Trust Risk Register, including the proposed additional risk and amended oncology risk is at **Appendix A.**

2.2 High (red) risks that have been reviewed by the Risk Management Committee and continue to be managed at Clinical Group, Corporate Directorate or Project levels but are not proposed for inclusion on the Trust Risk Register have previously been reported to the Board. This high (red) risk summary log is available on request; however there have not been any notable changes to report since the last update to the Board.

2.3 The RMC will review and report High (red) risks to CLE on a monthly basis and highlight new risks or changes to existing risks. The CLE will update the Board on existing risks and escalate 'new' risks.

3. RECOMMENDATION(S)

The Board is recommended to:

3.1 **REVIEW** the Trust Risk Register and updates provided by Executive Directors.

3.2 **DISCUSS** the proposed additional high (red) risk (no on-site obstetric theatre team out of hours) and **DECIDE** if it is to be added to the Trust Risk Register.

Kam Dhami
Director of Governance
26 June 2014

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	Executive 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	Jun-14	Quarterly	3	5	15
1414MARWK03		Chief Executive	Workforce Strategy	Organisational (Strategic)	Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment reduction of 1300 wte's, leading to excess pay costs.	4	5	20	Review of existing policy levers to ensure options are maximised and are executed sufficiently early. Strong governance oversight by the Trust Board. Update: A more detailed plan is being developed through CLE workforce committee, led personally by the Chief Executive. Will culminate in review at Board's Workforce and OD committee in September 2014.	Chief Executive pending appointment of Director of OD.	Mar-20	Jun-14	bi-monthly	3	5	15

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	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
2013HASU01	CCG	Medicine	Stroke/Admitted Care	Operational	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. Update: Standard operating procedure agreed and in place for data collection and validation. KPI improving new pathways, e.g., thrombolysis pathways direct from ambulance to CT scanner and strengthened capacity planning to ensure availability of gender specific beds to support timely admission.	Chief Operating Officer	TBC - Commissioner led review	Jun-14	Monthly	4	3	12
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. Update: New Waiting List Manager recruited and starting in July. Year of Out Patients programme will deliver automation to strengthen real time data. Plans to centralise elective access team in Q2. Data Validation Team still required - funding until end Q2. perceived knowledge deficit in some services regarding 18 weeks - New Elective Access Manager to assess competency of teams and provide re-training in Q2.	Chief Operating Officer	Jul-14	Jun-14	Jul-14	2	4	8

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	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
TRR1401CCO02	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 DTOC review, strategic and operational work; Commissioning plans for 7 day working in 2014 in train. Update: Joint work with CCG and social services in train to agree a new, leaner model of assessment and discharge delivery which will start on admission, with trusted assessors conducting single assessments. The authorisation to fund will sit with the assessor and there will be no delay in out of hospital funding decisions. The intention is to reach a work flow and team function agreement to start a pilot in July. Current mitigation of high DTOC includes additional capacity.	Chief Operating Officer	Jun-14	Jun-14	Jul-14	2	4	8
0907SOP15	Inspections: H&S and PEAT	Surgery B	Ophthalmology	Clinical	Sandwell Outpatient Department: Risk of Breach of Privacy and Dignity Standard as a consequence of poor building design in; Information Governance Risk; Infection Control Risk re. clean/dirty utility requirements.	5	4	20	Trust Solution fitting in with RCRH required; Compliance with Medical Device and ICOC standards; Service Improvement application to Sandwell OPD; Greater use of Rowley facilities. Update: Rowley Max has been scoped and will be delivered in Year of Out Patients programme.	Chief Operating Officer	31/12/2015	Jun-14	GBM	5	4	20

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	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
1103PAE02	Risk Assessment	Womens and Child Health	Paediatrics	Clinical	Children that require but may not receive HDU 1:1 care - due to unpredictable demand, inadequate funding, poor staffing levels. Quality of care compromised for these and non HDU children due to inadequate staffing levels.	4	4	16	IAP submitted for HDU funds secured 12-13 to staff areas. Additional IAP submitted 13-14 for Paediatric Outreach team. Awaiting outcome from November IAP submission. Update: Local escalation process is in place to ensure care is provided to HDU patients. Tracking occurrences to further quantify risk to those non-HDU patients.	Chief Operating Officer	TBC	Jun-14	Monthly	4	4	16
1103PAN01	Risk Assessment	Womens and Child Health	Paediatrics	Clinical	Lack of Tier 4 beds for C&YP with Mental Health problems means that they are admitted to the paediatric ward. There is no specialist medical or nursing mental health team to care for their needs with limited access to in / out of hours CAMHS support. Care for these children is compromised and impacts also on other children and parents.	4	4	16	Bank and agency staff utilised where available. Incidents to be escalated to the Health Forum / SSCB / PAB LA. Monthly report to be developed and reviewed at Paediatric Governance meeting and information provided to risk, Health Forum / SSCB / PAB. Honorary contracts for psychiatrists to be explored. Update: There is no strategic plan to address this risk externally; although the inadequate provision of mental health services continues to be raised at the highest level by the Trust. The Trust is exploring opportunities to access mental health bank staff via Mental Health Trusts.	Chief Operating Officer	TBC	Jun-14	Monthly	4	4	16

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	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Acute Oncology Service is currently unable to treat approx. 120 patients a month due to workforce issues.	5	4	20	Locum appointed to cover the consultant oncologist retirement and to provide some elements for the AOS peer review recommendations	Chief Operating Officer	TBC	Jun-14	Monthly	5	4	20
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Trust non-compliant with Acute Oncology Standards.	5	4	20	Investment pending through IAP.	Chief Operating Officer	TBC	Jun-14	Monthly	5	4	20
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Trust has inconsistent cancer pathways between its sites and mixed visiting oncology MDT attendance patterns.	5	4	20	Trust is extending discussions with UHB and executive led cancer futures workshop now scheduled for early September.	Chief Operating Officer	TBC	Jun-14	Monthly	5	4	20
PROPOSED ADDITION:																
201109del30	Serious incident review	Women and Child Health	Clinical	Clinical	Risk of an adverse outcome for mother and baby caused by no on site 2nd obstetric theatre team out of hours.	3	5	15	Policy for 'City site overnight emergency theatre'; Escalation procedures in and out of hours; Provision of staff support – raise awareness of potential situations; Theatre manager maintaining a log each time 2nd theatre team requested; Incidents monitored and managed by the Group.	Chief Operating Officer		Jun-14	Monthly	2	5	10

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Five year TDA plan summary**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Director of Finance & Performance Management**
AUTHOR:	**Neetu Sharma – Head of Strategic Planning**
DATE OF MEETING:	**3 July 2014**

EXECUTIVE SUMMARY:

The Trust submitted a five year plan summary to the TDA on 23rd June 2014, one of the required submission documents as part of the TDA's planning cycle.

The five year plan builds upon the two year plan that was submitted in April 2014, including further detail on the Trust's clinical strategy, organisational relationships and financial sustainability. It is closely aligned to the Trust's ten year IBP, also submitted to the TDA in June 2014.

REPORT RECOMMENDATION:

The Board is asked to note the contents of the five year plan.

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Alignment to all Trust objectives, Trust risk register and LTFM

PREVIOUS CONSIDERATION:

TDA planning submissions previously discussed at 6 March 2014, 3 April 2014 and 5 June 2014 Trust Board meetings

Summary of Five Year Plan 2014/15 to 2018/19

NHS Trust: Sandwell & West Birmingham Hospitals NHS Trust

Strategic context & direction

Strategic Context and Direction

The Trust serves half a million people. We have the lowest acute mortality in Birmingham. We provide integrated acute and community adult and paediatric care to 320k people. We are rated at 1 by the TDA and 5 by the CQC. Our CsRR is 4 – and we have a 10 year LTFM that is not below3. Over the next five years we are investing in leadership, in a new EPR, and in reconfiguration. A new Board and Executive team are in place and building on a tradition of partnership strength with some local stakeholders. Tackling a poor acute readmission rate, ensuring seven day care continuity, and improving patient satisfaction into the 80s+ are critical goals for us. 75% of staff think safety is our top priority, and as we make data quality, risk management, and peer learning more transparent that figure will improve further. We want patients to view us an integrated care provider; renowned as the best such in the NHS. The confidence of local people, including our staff, we see as central to our plans – we are describing significant change and need to sustain public trust during that process of transformation.

Impact of strategic commissioning intentions and service changes

Local commissioners have indicated that they want to strengthen vertical partnerships between primary care and other sectors. As part of that they expect to see a greater proportion of care for SWBCCG residents taking place within the boundary of the CCG. Meanwhile, significant pressure continues on DGH, Walsall Healthcare, and UHB. This Trust's strategy aims to respond to those intentions and pressures. Acting routinely in partnership we will look to continue to develop out of hospital care, whilst creating capacity to support acute and specialist care. We recognise that upward trends on emergency activity will need to be reversed to meet commissioning allocations. The Trust will respond creatively to that, and is prepared to explore a significant measure of demand side risk share in return for an instrumental role in supply side redesign. The Trust recognises the forthcoming specialist services strategy. As a major provider of specialist eye, rheumatology, haematology and cardiac care, we look forward to engaging in discussions on future service shape. We want to provide outstanding quality and will work with all parties to achieve improvement. Our gynae-oncology unit, with the best outcomes in England, is a role model in what can be achieved by team building, talent management, and ruthless focus, which we consider to be more significant drivers of change that reconfiguration. Where we are not best placed to deliver a service we will explore models to divest ourselves of provider status, although typically our governance model will be that on-site services operate with our organisation in the prime provider contract role. Given the significant turnover/debt ratio in our LTFM this is a commercial necessity, but more importantly it ensures governance accountability matches public perception of responsibility. We are concerned that local strategies for both children's services and mental health care create unwise fragmentation between mainstream primary and acute provision and intended future service models. We are a major provider of children's services (one in six of our patients are children) and we necessarily provide and liaise to provide significant volumes of organic and behavioural mental health care. We will look to develop better joint working both with other providers and with those commissioning these services in order to achieve care coordination and integration.

Local health economy factors, competitive position, strategic developments, transactions and organisational sustainability

Following the Health and Social Care Act (2012) the Trust is now commissioning in the main from three CCGs:

- NHS Sandwell and West Birmingham CCG (accounts for circa 75% of Trust activity)

- NHS Cross City CCG (accounts for circa 13% of Trust activity)
- NHS Birmingham South and Central CCG (accounts for circa 5% of Trust activity)

A key benefit of the changed commissioning arrangements for the Trust is that the configuration of commissioning arrangements have been organised around the catchment population the Trust serves, as opposed to separate configurations for both the previous Sandwell and HoB areas respectively. This is further supported by the Right Care, Right Here partnership, which celebrates its tenth year in 2014.

There are a range of wider local health economy factors that will need to continue to form an integral part of our plans. We serve a growing population, which has significantly higher than average BME rates (and the rates will grow over the next decade). Such diversity is associated with specific health needs and, in general terms, higher levels of ill health and therefore demand. All other ethnic groups have a higher than average representation when compared to the rest of England, emphasizing the importance of culturally sensitive services tailored to the specific needs of these groups. The population served by SWBH is dominated by high levels of deprivation. Of the 354 English local authorities, when ranked on deprivation score (IMD), Birmingham is the 9th most deprived and Sandwell is the 12th most deprived. In Sandwell, life expectancy is 10.1 years lower for men and 5.9 years lower for women in the most deprived areas of Sandwell than in the least deprived areas. For the Birmingham population of SWB CCG, the corresponding figures are comparable with a 10.3 years and 5.6 years gap respectively.

An integrated provider of acute and community services, we face competition from a range of other providers. Within the wider Birmingham and the Black Country area there are five other general acute hospital trusts (including three NHS Foundation Trusts), three of which also provide community health services; three specialist NHS Foundation Trusts and a large Community Services Trust. We have established a favourable competitive position within our Local Health Economy area. We seek to further consolidate our presence across our geographic patch by revitalising our Rowley site to the West of our patch, and extending some of our work and examples of best practice in Sandwell across the wider Birmingham area. More detail can be found in our assessment of our market position within our ten year integrated business plan (Chapter 4). We began these changes in 2013/14 with the opening of new wards at Rowley, a new acute care service, and a sexual health unit. Meanwhile, we extended our early supported discharge service into West Birmingham.

Context of Plan Delivery 2013/14

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

Narrative on 5 Years Ahead (2014/15 to2018/19)

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

7500 employees.

The Trust faces a complex and challenging agenda. We have set a clear planning horizon across the organisation. Our '2020' long-term plan, informed by a clear set of three year delivery plans will help us develop, outline and track delivery of our service developments and key changes over the coming period. This will be collated into a single Change Plan and programme. Through this we intend to agree trajectories for a series of plans which support each of our six strategic objectives. A dedicated change team has been developed to support this process.

The organisation is continuing our work towards becoming a Foundation Trust, which remains a key priority. Our IBP has been refreshed in line with the MMH OBC, and is submitted in support of this planning return along with our 10 year LTFM. The Trust has discussed a revised timetable with the TDA. This involves progressing with a view to a CIH inspection in Q3 14/15, for which the organisation has commenced preparations. Other notable activities include our routine refresh of the QGAF assessment, with a further planned refresh of the self-assessment in July 14. The Trust Board is also progressing our Board Development programme through one-to-one coaching with Deloitte LLP.

In year 4 and 5 (2018/20) we will be closing two A&E departments, exiting the Dudley Road hospital, and rationalising our Sandwell estate, whilst opening a major Urgent Care Centre. This is a massive service change project. Active improvement activity is already in hand to ensure that we have the productivity and service delivery models in place to support the ambitions of our population and partners. We understand that the Midland Metropolitan Hospital is not a bricks and mortar project. It is a catalyst to service changes both before, during and after the move, which we foresee occurring in October 2018.

One of the acknowledged risks of hospital re-development work is that it distracts the organisation and stands in the way of other priorities. That is in part a work bandwidth issue. But it also arises because the post-opening future is ill-defined. That is why in June 2014 we have launched our four month programme to define our 2020 vision. This short, summative statement will highlight for public, partners and our own people, what results we expect to achieve as we enter the next decade. In line with our mission statement, we will look to profile around twenty Integrated Care Pioneer services. These are service lines within our Trust that we pledge will achieve the full measure of success by 2020 in meeting the Trust's adopted definition of integrated care success, first drafted by National Voices:

'I want to plan my care with people who work with me and my carer(s), to allow me control, and who coordinate services to achieve the outcomes that are important to me'

Within our annual reports from 2015/16 we will specifically report on our success in delivering this vision, and in responding to the patients' voice in assessing our success.

Approach taken to improve quality and safety

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

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

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

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

The Trust's Quality & Safety Committee (a sub-committee of the Trust Board) provides assurance on the delivery of the Trust's long term quality goals as set out in the Quality & Safety strategy. It also monitors and provides assurance to the Board that clinical services are appropriately delivered, in terms of quality, effectiveness and safety. Where quality and performance falls below acceptable standards, ensures that action is taken to bring it back in line with expectations, and to promote improvement and excellence. Sitting underneath the Trust's Clinical Leadership Executive (CLE) are 3 sub-committees focused on quality:

Patient Safety Committee	Achieving 'zero harm' through our 10/10 approach; a universal learning model for the organisation - learning from Never Events, incidents, errors and complaints and sharing learning - assuring processes designed to prevent harm.
Clinical Effectiveness Committee	Reducing avoidable mortality (VitalPacs, Sepsis, Mortality review); reducing avoidable re-admissions - through integrated care, improving reliable care in stroke, cardiology and emergency care; implementing best evidence based practice in all areas; Trebling the number of patients participating in clinical trials.
Staff and Patient Experience Committee	Ensuring that we deliver on our nine Customer Care Promises that will deliver significantly improved patient satisfaction. Our Francis ambition on satisfaction is to be the best in the West Midlands over three years.

In addition we have a Risk Management Committee.

The priorities for 2014/15 identified in our 13/14 Quality Account are:

- Reducing emergency re-admissions
- Reducing preventable deaths
- The patient Experience in Outpatient departments
- Publication and implementation of the first year of our three year public health strategy

- Improving the safety of patients in hospital through our 10/10 campaign

Our 10/10 campaign is, in effect, a right every time pledge for inpatients:

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

CQUIN targets for 2014/15:

- Friends & Family Test
  - *Implementation of staff FFT*
  - *Early Implementation*
  - *Increased or maintained Response Rate in Acute Providers*
  - *Reduction in Negative Responses in Acute Providers*
- NHS Safety Thermometer - *Improvement Goal Specification (Pressure Sores)*
- Dementia
  - *Find, Assess, Investigate, Refer*
  - *Clinical Leadership & Appropriate Training for Staff*
  - *Supporting Carers of People with Dementia*
- Learning from Safeguarding Concerns - *Ensure safeguarding practices are embedded into practice*
- Outpatient and Discharge Letters - *Assess the quality of outpatient and discharge letters*
- Sepsis - Reducing mortality due to sepsis - *Implementation of Sepsix 6*
- Pain Care bundles - *Eliminate pain review process that leads to variation in patient experience of pain relief.*
- Medication & Falls - *Examines actions taken to prevent falls through multifactorial interventions - focusing on the impact of medications.*

- SUI Incidents - *Eradicate these incidents and improve patient Safety.*
- Community Therapies
  - *Effective referral management across community services.*
  - *Community Dietetics*
- Maternity - *Evidencing women deemed low risk are having low risk births at time of delivery.*

Our clinical strategy including service line management, clinical networks and clinical sustainability

We have set our long-term vision and strategy as being renowned as the best integrated care organisation in the NHS. This forms the basis of the development of our clinical strategy and model for wider healthcare delivery to our local population. This involves a significant shift in the way in which we deliver services, with us not only providing services more locally and either in or closer to people's homes, but also systematically integrating the way in which we deliver that care. This builds on the platform of our Right Care Right Here health economy plan, which looks to improve the ability of the health and social care system to support individuals to maintain their health and well-being and deliver more care locally supported by our intentions to concentrate secondary care services to one purpose-built, modern acute site. More information is included as part of our 10 year IBP.

In support of this plan, key areas of focus over the coming period include working with partners to implement redesigned care pathways that transfer activity from acute to primary and community care services, growing our community services in Sandwell and where appropriate West Birmingham and reshaping our clinical capacity (including reduction in acute beds) and repatriating acute work for our local population in line with the redesigned care pathways.
We intend to strengthen our acute service offering and to also ensure critical mass and clinical service sustainability in the context of developing national standards and clinical networks, while maintaining a 24/7 emergency department on both the City Hospital and Sandwell Hospital sites over the next four years until the opening of MMH as a single acute site.

We will also develop our specialist services where we have a regional or national reputation. This will allow us to recruit and retain excellent clinical staff both within these services but also more widely. Further detail can be found in our 10 year IBP, which accompanies this submission.

The Trust is an active partner of key clinical networks and has made a commitment to become an active partner in the Academic Health Science Network. The Trust is currently a member organisation of the West Midlands Clinical Research Network and actively participates in both commercial and non-commercial research across a full range of disease areas for the benefit of the local population. We are active partners in the CLARHC 2 Programme. We have agreed to co-host a number of themed events on patient safety and clinical quality, out of which a number of research ideas have come, including an evaluation of the implementation of our 10/10 safety campaign; an evaluation of the impact of readmissions risk assessments with multi-modal intervention.

Service capacity & developments

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

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

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

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

Mitigations (should no transitional support be available)

The plan provides for year on year surpluses. Recurrent surpluses are consistent with the requirement for minimum 1% net margin; headline plan net margins are 0.7% [2014/15] & 0.8% [2015/16] and which reflect entirely the application of resources on a non-recurrent basis in support of strategic change & development objectives. The delivery of 1% headline net margin would require additional cost improvement such that the scale and pace of change may add undue risk to the delivery of those objectives. There is a stated determination to deliver maximum savings at a scale & pace consistent with safe services and key service standards.

Delivery of operational performance standards

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

The areas of deviation in 13-14 saw us:

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

consistently.

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

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

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

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

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

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

- Never Event incidence – there have been a total of 5 Never Events in 2013/14 against a target of '0'. In addition there have been a total of 8 CAS alerts in 2013/14. New approaches are being introduced to share learning across the organisation e.g. issuing 'learning alerts' via video messages.
- Emergency care 4hr waits – our performance in 14/15 sees us with a YTD position below 95% (success in April, fail in May and June).
- Cancelled operations – the Trust's cancelled ops rate is above the current target of >0.8% (current performance = 0.9% - see improvement plan outlined above)
- Referral to Treatment times – although currently compliant, there are pressures in ten specialties

Workforce plans

Our Long Term Workforce Model

Underpinning our workforce plan is our Long Term Workforce Model (LTWM). This is consistent with our Long Term Financial Model (LTFM) and sets out our long range

forecast for our WTE movements between now and 2022.

Our model has been refined to reflect the 2013/14 outturn position in the LTFM. This has resulted in an additional 132 WTEs at our start point than previously forecast (albeit it our year end pay spend was under budget). This in the main reflects our higher than planned temporary staffing utilisation. Our forecast and our plans to more stringently manage temporary staffing show this coming back into line during 14/15 and 15/16.

This means that our WTE movement profile remains largely unchanged throughout the remaining years, save for a difference of circa 30 WTEs. This arises as a result of WTEs reducing by that amount due to our school nurses transferring to Birmingham Community Healthcare NHS Trust.

The LTWM predicts that our WTE movement from now until 2018/19 when our new single site acute hospital is scheduled to open is forecast to change from 7,180 to 5,750. This means that by 2018/19 we will be running our services with circa 1,430 fewer posts. This is driven by the following:

Driver	**WTE Change**
National efficiency expectations	- 1,319
Service Developments	+ 317
Net RCRH /other reductions relating to: acute hospital bed reductions reduction in outpatient attendances move of all in-patient services to a single site (allowing a single emergency front door and assessment units and single out of hours rotas Transfer of Hard FM estates staff to the PFI provider	- 428
Total WTE Reduction	1,430

Our Workforce Plan

Our workforce plan is one of the Trust's delivery plans that make up our Single Change Plan that is overseen by the Transformation Executive. Our plan is as follows:

- To work with circa 1,430 fewer people as we reduce the overall size of our workforce in response to our plans for site reconfiguration through our new smaller single site acute hospital (Midland Metropolitan Hospital), scheduled to open in 2018/19, new RCRH models of care and greater workforce efficiency
- To attract and retain highly skilled, trained and empowered staff to work differently – in more flexible but tightly connected teams across multiple locations, drawing on more transferable skills, including maximising the use of new technologies. This requires us to develop re-skilling programmes, tightly manage performance and develop new roles and career paths
- Develop our clinical and non-clinical leaders and operational managers to lead our organisation well and to understand future skills needs among their teams and

respond constructively to new roles and new ways of working

We will be reducing our WTEs by circa 200 posts in 2014/15 and in 2015/16 as per plan. :

- Improving our recruitment 'time to hire'
- Additional controls in place for when temporary staffing is required
- Introduction of our 'in-house' medical staffing bank
- Re-job plan our medical teams to ensure capacity and fit
- Addressing medical ward nursing staff turnover

Staff Engagement and Support

In September 2013 we introduced our monthly on line, real time staff survey 'Your Voice' to give our leaders rapidly turned around data on local engagement, motivation and ideas for improvement and an insight into whether the things we do by way of a response are making enough of a difference. This asks every employee for their views every 3 months. We believe that the scale of this is the largest and most comprehensive in the NHS currently.

Listening into Action (LiA), our pioneering and nationally recognised staff engagement methodology continues to be important in our range of approaches to improving levels of engagement through involving staff in driving daily improvements and in decision making.

The Trust's results in the 2013 national NHS staff survey show our overall level of staff engagement improving (from 3.67 to 3.73), around the national average. We have seen a significant improvement increase in the NHS Staff Friends and Family test key findings from 3.53 to 3.71. We are ranked in the best 20% of Trusts for 9 of the 28 key findings, including those qualities required for delivering large scale and effective change management. Our results showed that 3 out of 4 staff responding believe that the 'care of patients is our top priority' a significant increase of 10% compared with the previous year. Our focus is on finding out what made 75% of staff believe this and what worried the other 25% of participants or what they think the Trust values more highly.

Our staff health and well-being strategy is shaped by employee feedback, sickness absence statistics and evaluation of health needs of the Trust's workforce. We are introducing two strands for employee health to align the work of the Prevention Champion to tackle the big health issues in employees and patients and use Trust intelligence to formulate responses to trends and issues specifically affecting employees.

Financial and investment strategy

Headline messages

- The financial plan is consistent with the financial trajectory agreed with the NTDA and as represented in the LTFM which underpins the OBC for new hospital development.

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

Income

Detailed activity & income has been agreed with SWBCCG for 2014/15 and has a forward trajectory of activity, capacity and income consistent with commissioner support for new hospital development. The proposed contract uses NHS Standard Contract terms and National Tariff subject to local variations and modifications including relevant and effective risk sharing arrangements. CQUIN is assumed recoverable at 2.5% of relevant income and to be delivered at minimal additional cost. The application of funds in respect of marginal rate emergency tariff and emergency readmissions is transparent and effective in supporting the delivery of key operational standards. The plan includes provision for exposure to financial penalties of £2.0m and which is the level capped in the contract with main commissioners.

Contract income	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m
SWB CCG	254.8	255.3	259.4	260.0	260.2
BXC CCG	43.8	44.1	44.8	44.9	45.1
BSC CCG	13.1	13.2	13.5	13.5	13.5
NHSE	50.0	49.7	50.1	49.9	49.8
Other	29.3	28.5	29.7	30.6	32.1
	---	---	---	---	---
Total	391.0	390.8	397.5	398.9	400.7

Expenditure

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

Savings required & cost pressures to be managed in 2014/15 total £26m [being 6% OPEX]. This will be addressed by way of specific cost reductions, eliminating the premium from temporary staffing, generating financial margin through productivity improvement and on services with volume growth. Savings in 2015/16 total a minimum of £22m on a similar basis. The cost improvement opportunity is scaled as being in excess of plan requirements and is the focus of work to translate into realisable cost reduction at necessary scale & pace. The plan includes £2.5m for investment in change & improvement. This is linked to a robust Accountability &

Autonomy Framework.

Contingencies

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

Capital

Plan capex totals £40m over the two years of the plan. This is in excess of depreciation and represents a use of cash balances in support of strategic objectives for retained estate refurbishment to underpin new service models [£7m] and IM&T infrastructure and systems [£12m] in addition to completing the acquisition and preparation of land for new hospitals development [£5m]. Appropriate provision is also made for compliance with statutory standards and equipment replacement. Additional capex & CRL cover in respect of potential slippage from 2013/14 to 2014/15 of up to £2m is included in the plan. This is intended to reflect a downside view and consistent with securing a prudent level of CRL cover. The resource for this capex is entirely from trust cash balances.

Cash

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

Financial sustainability

- The route financial sustainability consistent with clinical & operational sustainability is described in the LTFM.
- That medium term strategy is to maintain income and to improve profitability by reducing costs.
- That improvement in profitability is represented by EBITDA growth from an extant 6% to a prospective 11% by 2019/20. This growth affords the investment in new facilities and models of care necessary to service sustainability and improvement in liquidity consistent with sustaining a minimum level 3 Continuity of Service Risk Rating as representative of financial sustainability.
- The maintenance of income is consistent with the trust's position as an integrated care provider and consequent intent to secure relevant income under the Better Care Fund. That intent is shared by its principle commissioner SWBCCG.
- Detailed activity & income has been agreed with SWBCCG for 2014/15 as has a forward trajectory of activity, capacity and income consistent with commissioner support for new hospital development. This forward trajectory includes necessary & appropriate assessments of the impact of demographic growth and localisation of services.

- Cost inflation is consistent with that assessed in national planning assumptions as uprated for local experience.
- The reduction of costs is necessarily focussed on sustained & significant real terms reductions in the pay bill. This is to be achieved through securing a permanent workforce to mitigate premium costs and a reduction of c200 posts per annum (2014/15 and 2015/16). A robust prospective and on-going QIA process will ensure these changes are consistent with safe, high quality services delivering key standards. A step change in benefit from improved procurement on both a strategic and tactical level is also anticipated and underpinned by greater visibility and engagement at a granular level across the organisation.
- The forward capital expenditure programme necessarily has a focus on retained estate refurbishment to underpin new service models [£25m over six years to 2019/20] and IM&T infrastructure and systems [£27m]. The programme provides for appropriate investment to sustain statutory standards and equipment replacement. The programme for imaging replacement & development assumes the effective use of off balance sheet managed service contract arrangements.
- Cash balances remain positive and significant over the medium term. There is a modest planned reduction from current c£30m to c£18m over the first two years to 2015/16 consistent with strategic capex profiling. In subsequent years cash balances are planned to grow to c£39m by 2020 to improve liquidity consistent with sustaining a minimum level 3 Continuity of Service Risk Rating in the face of increased capital / debt servicing costs arising from new hospital development under PF2.

Cost Improvement Plans

- Savings in 2014/15 total a minimum of £26m including specific cost reductions, eliminating the premium from temporary staffing generating financial margin through productivity improvement and on services with volume growth. Savings in 2015/16 total a minimum of £22m on a similar basis.
- The target level of those specific cost reductions & against which directorate level savings plans are being tracked is currently assessed at £20.6m [2014/15] & £19.9m [2015/16]. There is a recognised and significant level of under-developed / unidentified cost savings at the time of writing. This arises from, inter alia, some schemes being budget reductions not real cost reductions and a revised assessment of the part-year effect in 2014/15 of schemes which cannot all become effective from 1 April. Some parts of the business remain to identify schemes to fulfil their savings requirement. This is the subject of urgent & focused attention and will be remedied for 2014/15 by 30 May & for 2015/16 by Q3 of 2014.

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

Productivity and efficiency including benchmarked position and cost improvements

Scale of efficiency requirement

The overall scale of financial challenge is no greater than that faced by similar NHS organisations with the exception of the equivalent of one year's additional efficiency improvement to afford the net investment in new hospital & IT infrastructure. Demonstrably the change & improvement facilitated by that investment is self-financing in meeting that additional challenge.

Efficiency savings are of 5% per annum through to 2019/20 then 2.7% thereafter being consistent with Monitor base case assumptions and differential local investment. This includes the financial impact of changes arising from the RCRH transformation and is summarised in the table below:

TSP TRAJECTORY	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 £m	Period £m
Income	4.97	2.04	1.00	1.00	-	-	-	-	-	-	9.0
Pay	9.1	10.6	15.7	13.8	14.0	13.9	12.0	9.4	9.5	9.3	117.4
Non Pay	5.8	7.9	1.3	4.2	5.4	5.5	7.9	3.6	3.5	3.6	48.7
CCG Tariff Adjustment											-
Sub Total	**19.9**	**20.6**	**18.0**	**19.0**	**19.4**	**19.4**	**19.9**	**13.0**	**13.0**	**13.0**	175.1
Other Movements inc RCRH / Bed Plan Disinvestment / EDAT,Agency Reductions and Tariff Adjustment	**0.2**	**-**	**3.7**	**2.5**	**2.4**	**2.6**	**0.1**	**0.1**	**-**	**-**	11.6
											-
Baseline View of TSP Implications	**20.1**	**20.6**	**21.7**	**21.5**	**21.8**	**22.0**	**20.0**	**13.1**	**13.0**	**13.0**	**186.7**
% of Turnover	**4.6%**	**4.8%**	**5.0%**	**4.9%**	**5.0%**	**4.9%**	**4.4%**	**2.8%**	**2.7%**	**2.7%**	

Strategic approach to cost improvement

The approach to cost improvement over the period of plan is by necessity one that challenges the fundamental scope, nature and organisation of services delivered by the Trust. Accordingly, reference is to transformational savings programmes and which are aligned to the trust's stated vision and strategic objectives. Design and delivery is in the context of the trust as a business partner in the local health & economic community.

Strategic themes for transformation & cost improvement may be summarised as follows:

- Service model & pathway change
- Operational excellence and productivity optimisation
- Leveraging value from procurement
- Middle & back office as customer relationship managers and value adding business partners
- Service portfolio and leveraging margin from education & research development

Scope of opportunity – a benchmarking led approach where relevant

The trust is clear that safe services are cost effective services and that high quality services can be the most cost effective services.
The financial plan includes that investment in estate & IM&T infrastructure to provide effective enablement of transformational change and improvement. This is further underpinned by committed investment in organisational development to secure that capacity & capability to deliver change at necessary scale and pace.
It is the trust's view that the scale of opportunity is consistent with the scale of CIP required and the identification of CIP opportunity is underpinned by a benchmarking led approach. For example, a headline view of scope for benefit from operational excellence is summarised in the tables below:

Operational improvement opportunity [CHKS benchmark led] 1

Core Indicators	Women's & Child Health			Medicine & Emergency Care			Surgery A				Surgery B	
	Gynaecology, Gynaeoncology and GUM	Maternity & Perinatal Medicine	Paediatrics	Emergency & Acute Medicine	Admitted Care	Scheduled Care / Long term Conditions	General, Breast & Plastics Surgery	Trauma & Orthopaedics	Theatres, Vascular & Urology	Anaesthetics & Critical Care	Ophthalmology	ENT and Oral Surgery
Average Length of Stay	1.2	2.6	1.5	4.7	3.8	1.8	1.4	3.8	1.2	0.114	0.256	0.61
Risk Adjusted Length of Stay Index 2013	75	156	114	106	105	92	81	97	63	86	77	81
Day Case Rate	55.00%	34.40%	53.60%	58.10%	81.10%	96.90%	84.60%	58.40%	69.50%	99.90%	94.00%	81.50%
Basket of 25 Day Case Rate	86.30%	-	-	0.00%	20.00%	0.00%	78.80%	81.20%	56.30%	-	98.30%	52.30%
Readmissions 28 days	11.80%	3.30%	8.40%	14.50%	11.40%	8.10%	8.00%	5.90%	6.10%	1.50%	1.70%	2.90%
Outpatient DNA Rate	9.60%	7.90%	15.30%	16.20%	10.60%	11.10%	8.90%	11.30%	10.40%	11.90%	12.00%	14.80%
Outpatient New to Follow-up Ratio	1:1.0	1:1.1	1:2.7	1:2.5	1:2.5	1:3.5	1:1.8	1:1.4	1:1.6	1:0.91	1:2.9	1:1.0
Data Quality	95.4	97.5	91.3	94.8	94.5	97.3	96.4	96.3	97.9	99	98.6	97.3
Complication Rate Attributed	2.20%	0.04%	0.02%	0.21%	0.59%	0.22%	2.40%	1.60%	0.96%	0.00%	0.76%	1.30%
Complication Rate Treated	3.90%	0.18%	0.31%	1.10%	1.50%	0.62%	4.70%	4.70%	1.50%	0.25%	2.10%	1.60%
Misadventure Rate	0.41%	0.00%	0.01%	0.01%	0.03%	0.03%	0.07%	0.00%	0.26%	0.00%	0.37%	0.14%
Mortality	0.26%	0.16%	0.05%	3.27%	2.82%	2.40%	0.65%	0.60%	0.10%	0.60%	0.02%	0.12%
Risk Adjusted Mortality Index 2013	57	0	17	92	81	87	91	68	26	121	54	67
SHMI - In-Hospital 2013	40	57	48	71	73	75	69	51	12	337	46	36

Key

- Lower 5%
- Lower Quartile
- Inter-quartile range
- Upper Quartile
- Upper 5%
- No data

Note

Activity has not been directly attributed to the directorates of Community Children and Cancer Services.

Operational improvement opportunity [CHKS benchmark led] 2

	Surgery A	Surgery B	Women's & Child Health	Medicine & Emergency Care	Trust wide totals
Theatres	Reduce number of elective theatres by 5		Consolidate work of 3 theatres into 2		Reduce number of theatres by 6
O/P DNA	Reduce number of sessions by 3 per week by 2019/20	Reduce number of sessions by 8 per week by 2019/20	Reduce number of sessions by 4 per week by 2019/20	Reduce number of sessions by 5 per week by 2019/20	Reduce number of sessions by 20 per week by 2019/20
O/P New/Fup	negligible	negligible	Potentially13 fewer sessions per week by 2019/20	Potentially 57 fewer sessions per week	Potentially 70 fewer sessions per week
Beds/LOS	£6.9m cost reduction cumulative over 6 years Lower bed base by 38 beds	£1.2 m cost reduction cumulative over 6 years Lower bed base by 7	£6.9m cost reduction cumulative over 6 years Lower bed base by 34 beds by 2019/20	£12.8m cost reduction cumulative over 6 years Lower bed base by 40 beds	£27.7m cost reduction cumulative over 6 years Lower bed base by 119 by 2019/20
Readmissions (patient experience)	350 fewer readmissions per annum	45 fewer readmissions per annum	700 fewer readmissions per annum	1500 fewer readmissions per annum	2500 fewer readmissions per annum
Readmissions (£)	£125k per year saving			£460k per year saving	£600k per year saving
Coding	T&O = £1.5m annual income opportunity			Income opportunity of £4.8M in General Medicine	Income generation opportunity of £6.3m per annum
Cons Workforce	Save up to 15.5 PAs per week in OP				

Robust CIP governance

Development and delivery of transformational cost savings is through the trust's organisational structure. This puts an emphasis on directorates as the core unit of business and makes for clear line accountability driving ownership and responsibility in that delivery.
Financial success for directorates is defined by reference to the delivery of safe services to recognised operational standards within their recognised budget control total. The delivery of cost improvement at a level consistent with that then forms part of that success. The trust has an integrated performance reporting framework which aligns dimensions of safety, quality, operational standards, patient & staff satisfaction and money. This rounded approach is also embedded in the trust's accountability & autonomy framework.

The development & delivery of transformational savings programmes is supported by a single integrated change team. This team includes a PMO and change management expertise and is aligned to business intelligence capability and supporting corporate functions.

The PMO provides effective arrangements for the monitoring and management of the transformational cost improvement programmes. This includes the provision of systems, processes & tools to enable this. TPRS is the trust's bespoke application for monitoring, reporting and control at a granular level. PMO functions are being established within clinical groups to further embed excellence in CIP governance. The trust's Finance & Investment Committee provides a basis for assurance of the effectiveness of these arrangements and consequent financial success.

Each and every cost improvement proposal is subject to ex-ante and routine ex-post assessment for quality and equality impact. The trust's normal risk management arrangements provide for on-going recognition and assessment of any significant risk arising from cost improvement. The trust's Quality and Safety Committee provides a basis for assurance of the effectiveness of these arrangements.

The development of schemes consistent with the full value of the CIP requirement for these years and future years of the plan is being progressed through the change team and in line with the strategic themes described above.

Longer term financial sustainability, income, costs, activity, capital and risk mitigation

Overview

The plan demonstrates sustainable finances as measured by a minimum CSRR of 3 across the period of the plan. Critically, it embodies the service improvement and infrastructure investment consistent with becoming renowned as the best integrated care organisation in the NHS and the year on year efficiency gains which drive the financial margins that afford that change and investment. Income and activity are aligned with key commissioner commitments and expected transformation through the health economy RCRH programme which is embedded in the financial plan.

The overall scale of financial challenge is no greater than that faced by similar NHS organisations with the exception of the equivalent of one year's additional efficiency improvement to afford the net investment in new hospital & IT infrastructure. Demonstrably the change & improvement facilitated by that investment is self-financing in meeting that additional challenge.

The plan indicates the build-up of resources driven by EBITDA margin improvement and which are applied non-recurrently to enable necessary change & improvement. Those resources are then applied recurrently in support of the unitary payment for investment in new hospital facilities.

The trust is committed to the management of service delivery and development through its devolved organisation structure, moving from a top down dominated model to one of an empowered, enabled and accountable middle supported and coached by the executive. The development of this organisational model, whilst on-going, is entirely consistent with Monitor's four dimensional model of Service Line Management.

Headline financials across 10 year LTFM

- CSRR of minimum 3 across the period of the plan
- EBITDA margin improvement from 6% in 2014/15 to 11% in 2019/20 affording new hospital investment provided through PF2 with £100m PDC contribution

- Efficiency savings of 5% per annum through to 2019/20 then 2.7% thereafter being consistent with Monitor base case assumptions and differential local investment
- Net workforce reduction of 1724 wte (24%) across period of the plan with differential focus on middle and back office functions to maximise resources aligned to front line care
- Direct capital investment £128m [excluding MMH new hospital development] across the plan including £34m investment in IM&T and £26m in retained estate to enable transformation & improvement. On balance sheet PF2 funded development of new hospital including £100m PDC contribution & £16m 'big ticket' imaging through off balance sheet managed service contract
- Shadow base unitary charge on PF2 hospital £27.0m in first full year of operation being compliant with recognised 12.5% proportion of turnover test as an indicator of affordability
- Cash balances initially utilised to supplement capital investment then grow on basis consistent with delivery of necessary liquidity component of CSRR

Risk & mitigation

The trust has modelled downside risks and mitigations across four key themes:

- Implied Efficiency and Inflationary Risk
- Sustainability and Transformation of Services
- Workforce
- Estate Infrastructure Management

A financial summary across the prospective years of the LTFM is summarised overleaf:

	Income and Expenditure Impact (I&E)								
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income and Expenditure (I&E)									
Base LTFM	3.1	3.5	6.0	8.7	6.5	6.1	4.2	3.3	5.3
Downside	0.0	(2.6)	(5.9)	(9.2)	(18.1)	(26.9)	(35.1)	(43.4)	(48.3)
Mitigated	0.1	1.0	3.9	1.6	(6.0)	(0.4)	6.8	11.8	13.0
Cash									
Base LTFM	22.6	18.6	24.1	33.0	35.5	39.9	40.4	45.1	53.9
Downside	18.9	8.1	1.4	(8.3)	(31.1)	(61.1)	(101.0)	(142.9)	(187.5)
Mitigated	20.6	15.4	19.5	22.3	13.2	19.1	29.2	34.4	45.0
CsRR									
Base LTFM	3	3	4	4	3	3	3	3	3
Downside	3	2	3	3	3	1	1	1	1
Mitigated	3	3	4	4	3	2	2	3	3

The mitigated downside provides for a CSRR of level 2 during the first two years of operation of the new hospital and then a return to level 3.

The key mitigation schemes are as set out below:

- **Estate Infrastructure Management:** Schemes identified, reduce or delays non-essential capital programme expenditure, with little or no disruption to direct patient care. These schemes will enable cash to be retained within the financial year.
- **Sustainability and Transformation of Services**: The mitigation schemes identified aims to review capacity and current service provision, with a view to rationalise clinical services over and above current CIP and RCRH plans. The mitigation scheme also considers the impact of service development deferrals where unavoidable or agreed with Commissioners.
- **Workforce Management**: The Trust will seek to implement a range of short term controls on workforce within the constraints of ensuring that safe and high quality services are maintained at all times. Within these controls, specific attention will be focussed on the use of non- essential temporary staff, particularly where it is considered that the value for money obtained from these staff is not optimal.
- **Employees Terms and Conditions**: Review of terms and conditions under Agenda for Change. The requirement will be to transfer to local pay conditions. It is anticipated consultation and agreement with relevant bodies would be required which has been reflected in the timing of when these mitigations have been introduced.
- **Commercial Opportunities**: Analysis carried out to maximise the Trust's commercial opportunities and ensure value for money.

- **Corporate Contingency**: Levels of corporate contingencies has been identified, in the form of Reserves. These reserves have resources earmarked for change over the LTFM timeline. Temporary reprioritisation will enable these contingencies to be drawn against as a buffer against adverse risks.
- **Accelerated Technological Advancement**.
- **Implied Efficiency**: Target greater efficiency measures post introductions of MMH

Organisational relationships and capability including patient and public engagement, relationships with stakeholders and leadership development

Organisational Relationships

The Trust has traditionally been well-regarded by others for the calibre of our joint working. We intend to build on that tradition and individual Board members have responsibility for progressing and overseeing specific partnerships. This is reviewed quarterly by the Board. We work closely with both Healthwatch organisations, and value the joint work we are beginning to do with them. A healthwatch representative has standing speaking rights in our Board meetings.

The commissioning partnership is a strong one, albeit further work will be needed to ensure that this collaboration remains coherent with the SWBCCG devolved commissioning model. Through the Right Care, Right Here partnership we work with the mental health, community and LA systems. This has led to a well-supported Better Care Fund plan for Sandwell. Whilst the SWB trajectories in the Better Care Fund plan for Birmingham are consistent with our plans, and all partners avow support for MMH, we have been unable to support the plan itself, as it duplicates CIP proposals, and because the current one-size governance model we consider unlikely to succeed. Ourselves and SWBCCG continue to support a distinct West Birmingham BCF, or one blended with Sandwell.

In education, we have good working systems with the University of Birmingham, as well as with Wolverhampton and BCU. We are key partners in the proposed Aston Medical School. With the appointment of a new Trust R&D director we are increasingly active in the CLRN and our stated ambition is to treble trial recruitment numbers by 2020.

Our appointment of a local GP as our director of primary care reflects an intention in 2014-15 to develop more direction relationships with provider GPs, probably through strategic alliances with existing GP chains. Conscious of national work on partnership, chains and networks, we continue to develop our own views of which services might be best delivered in a network across parts of the Black Country where the population would regard collaboration as in their best interests. The initial focus of such work is likely to be in areas where sub-specialisation is increasing and where it makes sense for different sites to hold different sub specialist interests for planned care.

Patient engagement

Our Patient Experience plan is interested in patient satisfaction. It does matter to us whether we meet expectation, made up of every single interaction and communication. Yet the plan is also part of our safety campaign, because there is not a single study of safety in healthcare published in any reputable journal that does not suggest that the patient's voice matters, and matters far more than we tend to assume. We extend that idea to hear too the carer's voice and understand better the continuity of care offered by family and friends. That continuity is something we need in what we do, and as care delivery becomes sometimes fragmented we need to find new ways to create it.

'Patient Knows Best' is an IT system we are piloting in some of our specialties. We are keen to see if we can give data and knowledge back to the patient who gave it to us, rather than securing someone's case notes in our own password protected place. That idea, of course demands a paradigm shift in how the NHS works with patients. That shift is one that this plan will contribute to. If we all make sense of how we can contribute to delivering the ideas described within it. Some parts of our Trust do this already and do it better than other parts. Our plan builds on that variation and seeks to reduce it massively. We want the best of SWBH now to be what we do consistently across SWBH in the near future.

At SWBH we are passionate about our services and care deeply about the quality of care our service users, their carer's and families receive. We know that we don't always get it right but it is our intention, with the help of the Patient Experience strategy, to implement a culture where we continually listen and learn from patient, staff and carer feedback so that we work together to achieve sustainable service improvement. The Trust continues to gather feedback on our services through the national Friends & Family Test, with approximately 10,000-15,000 surveys completed each year. The Trust also issues a detailed patient experience survey on a quarterly basis as well as annual surveys including maternity (national), inpatient, OP, and A&E surveys.

Public engagement & relationships with stakeholders

Sandwell and West Birmingham Hospitals NHS Trust already has a strong sense of shared purpose with our local commissioners, local authorities and other local health organisations. We will seek to build on this to strengthen our relationships with other local organisations that have similar aims to us in a number of ways, including:

- Utilising formed links with voluntary and third sector organisations
- Interaction with younger members of the public through school liaison
- Ensuring Faith groups, employment services, local councils are made aware of membership
- Working with local and national partners to identify added value offerings to membership and identifying best practice via local Trusts and FTN
- Working closely with the local universities over the development of roles and opportunities within the Trust, and ensure the university governor roles are effective
- Engaging closely with commissioners to improve communication and ensure the Clinical Commissioning Group governor roles are effective
- Developing closer relationships with the local authorities, supporting their governors to ensure the governor role is effective
- Continuing to prioritise partnership working through the Right Care Right Here programme
- Undertaking some of our membership activity in conjunction with the two local mental health NHS foundation trusts
- Working with a local social media partnership to develop the membership website

Leadership development

The Trust has commissioned a leadership development programme that will support the development of the top leaders within the Trust (450). The programme will complement the current leadership development training opportunities available to staff and will also see the release of a new leadership competency framework that will be adopted throughout the organisation. These commissioned programmes will also support the development of newly appointed medical staff, ensuring they develop their leadership and management skills to match their medical knowledge.

Contained within the leadership development programme is a bespoke 360-degree tool based on SWBH leadership competencies and two 180 tools relating to leadership styles and organisational climate. Action Centred Leadership forms the framework that all our leadership development is based upon. This methodology continues to prove effective in creating improved team and operational leadership.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Safe Nurse Staffing
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Colin Ovington – Chief Nurse
DATE OF MEETING:	3rd July 2014

EXECUTIVE SUMMARY:

The board last received an update on nurse staffing at the May 2014 meeting. The board are expected to receive a monthly update on the safety of nurse staffing on wards with a six monthly review of the establishments. This paper gives an update on the data from May 2014 in relation to nurse staffing across the trust which is now collected nationally and published on NHS Choices

The output from the new data collection system gives a fill rate against expected ward staffing. By implication anything at or over 100% would indicate that there were sufficient numbers of nursing staff to deliver safe care. An analysis of the data is given in the enclosed paper.

REPORT RECOMMENDATION:

To support the proposal to publish patient to RN ratios on our public web site and on NHS Choices on a monthly basis as per national requirement.

To receive an update at the August Trust Board meeting

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			
Clinical		Equality and Diversity		Workforce	X

Comments:

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

Staffing on the neonatal unit is subject to national problems in recruiting nurses qualified within the specialty and is on the Group risk register

PREVIOUS CONSIDERATION:

May 2014 Trust Board

FOR INFORMATION

SWBTB (7/14) 107 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAFE NURSE STAFFING

Report to Trust Board on 3rd July 2014

1 EXECUTIVE SUMMARY

1.1 The board last received an update on nurse staffing at the May 2014 meeting. The board are expected to receive a monthly update on the safety of nurse staffing on wards with a six monthly review of the establishments.

1.2 During June 2014 a new monthly national data collection on nurse staffing numbers has commenced with the outputs being available on NHS Choices and our own web site.

1.3 The output from the new data collection system gives a fill rate against expected ward staffing. By implication anything at or over 100% would indicate that there were sufficient numbers of nursing staff to deliver safe care. The converse does not however mean that care was unsafe but does warrant explanation.

2 NURSE STAFFING AT SANDWELL & WEST BIRMINGHAM HOSPITALS TRUST

2.1 Every ward has a permanent establishment of Registered Nurses (RN) and health care assistant staff (HCA). Duty rosters are planned to ensure that there is a compliment of staff for each shift in the roster period and to ensure that there are no more than eight patients per registered nurse where ever possible. Typically our rosters will have more staff on during day time shifts than night time shifts.

2.2 The output from the data collection is at appendix 1. and demonstrates that almost all wards are operating at over 100% staffing against plan. This also means above budget allocation. The assessment provided for the board in May showed that the nurse staffing ratios as planned were within a safe range and our ability to have no more than eight patients to an RN during day time shifts was achievable. I also highlighted that we allocate more of our resources during the day which consequently meant that the ratio was more patients per RN at night. This is a typical way of staffing hospital wards in the NHS and not out of kilter and the accepted norm. There is no additional guidance to alter this model.

2.3 The data from our peer benchmark group is presented in table 1. And clearly demonstrates that we achieve a higher fill rate against planned staffing on our wards. The explanations of this relate to use of temporary staff to provide care for individual patients when they are at risk of falls, or are in a high level of agitation requiring closer supervision.

Peer benchmark group	Average of Avg fill % - nurses/midwives (Day)	Average of Avg fill % - care staff (Day)	Average of Avg fill % - nurses/midwives (Night)	Average of Avg fill % - care staff (Night)
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	110%	119%	133%	129%
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	82%	95%	96%	135%
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	94%	110%	97%	112%
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS T	92%	95%	94%	99%
THE ROYAL WOLVERHAMPTON NHS TRUST	93%	100%	93%	122%
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	94%	99%	96%	107%
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	94%	104%	99%	94%

Table 1.

2.4 Analysis of the data and implies that we are more richly staffed compared to benchmark trusts. We have seen a huge growth in the use of temporary staff across the trust since 2011. The explanation of this relates to filling gaps on rotas because of absence and to help with the care of individual patients who are at risk of falling. This last factor is exercising many trusts and we are currently exploring alternative ways to ensure patients are kept occupied and supported and reducing the requirement for one to one supervision. We have three dementia coordinators who are beginning to demonstrate a real benefit in helping patients to reminisce and keep occupied.

2.5 Wards have been requested to ensure that rota's are completed eight weeks in advance. The nurse bank has been requested to look at the rosters at the time of completion to check for gaps and to begin to fill using our own nurse back. Experience dictates that the longer notice we have about the need to fill gaps on rosters the more likely it is that they can be filled with internal resource. Conversely the shorter the notice period the less likely that an internal bank will be able to fill the gap necessitating the requirement of external agency usage. Permission to use external agency staff will require Chief Nurse sign off from July in an effort to better understand the nuisances of the requirement for more staff and to exert an element of control.

3 CURRENT ISSUES

3.1 The neonatal unit shows the widest deficit on the data collection. There is a national shortage of neonatal trained nursing staff. The data presented demonstrates variation from plan. The plan is to always staff for a full ward. However in this specialty the number of babies requiring care at any one time is very unpredictable and during the timeframe (May 2014) the staffing was not unsafe and all babies on the unit were given good care with no serious complaints or incidents. This is kept under scrutiny by the matron and workloads are actively managed to ensure that staff are brought into shifts when they are needed and not simply because the plan demonstrates a shortfall.

3.2 Student Nurse about to qualify as RN's have been taken through a new values based recruitment process to ensure that we recruit the cream. Successful candidates will be joining a rotational scheme to help them consolidate their training and for us to help identify their particular skills. This also has the benefit of developing flexibility in their skills

to work in different areas of the trust when increased pressure requires us to move staff to meet patient demand.

4 RECOMMENDATION(S)

4.1 To publish patient to RN ratio's on our public web site and on NHS Choices on a monthly basis as per national requirement.

4.2 To receive an update at the August Trust Board meeting

Colin Ovington

Chief Nurse

25th July 2014

APPENDICES:

Appendix 1 – Data from the national Nurse Staffing return

Appendix 1 – Data from the national Nurse Staffing return

	Day				Night				Day		Night	
	Registered midwives/ nurses		Care Staff		Registered midwives/ nurses		Care Staff		Average fill rate - registered nurses/mid wives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/mid wives (%)	Average fill rate - care staff (%)
Ward name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Coronary Care Unit - Sandwell	1057	1249	38	111	835	1076.5		23	118.20%	292.10%	128.90%	
Critical Care - Sandwell	3438.5	3275.5	733.33	596.5	2069	2564		22	95.30%	81.30%	123.90%	
AMU A - Sandwell	2861	3403.5	1952	2594	1614.5	2169	914.5	1414	119.00%	132.90%	134.30%	154.60%
Neonatal Unit - City	1320	1014.25	256.5	256.5	1320	1014.25	0	0	76.80%	100.00%	76.80%	#DIV/0!
Lyndon 1 - Paediatrics	1212	1362	629.5	948	671	1056	217	293	112.40%	150.60%	157.40%	135.00%
Lyndon 2 - Surgery	1208.5	1551	1258	1572	497	656.5	506.5	721.5	128.30%	125.00%	132.10%	142.40%
Lyndon 3 - T&O/Stepdown	1652.25	1719.5	1605.5	1567.5	816.5	1023	885.5	1057	104.10%	97.60%	125.30%	119.40%
Lyndon 5 - Cardiology/General Medicine	1515	1544	1493	1473	575	506	782	782	101.90%	98.70%	88.00%	100.00%
Lyndon Ground - PAU/Adolescents	1103	1161	281	360	693	798	198	318	105.30%	128.10%	115.20%	160.60%
AMU B - Sandwell	1761	1761	622.5	730	632.5	758	552	666	100.00%	117.30%	119.80%	120.70%
Newton 2 - General Surgery	1100.25	1289	707.5	958	315.5	449	142.5	277	117.20%	135.40%	142.30%	194.40%
Newton 3 - T&O	1481.5	1607.5	1435.5	1796.5	770.5	1034	506	1079.5	108.50%	125.10%	134.20%	213.30%
Newton 4 - Stepdown/Stroke/Neurology	1596.25	1826	1660	2364	770.5	860	540.5	1703	114.40%	142.40%	111.60%	315.10%
Newton 5 - Haematology	1685.25	1667	595	668	644	690		281	98.90%	112.30%	107.10%	
Priory 2 - Colorectal/General Surgery	1329.5	1608.5	909	1310.5	416.02	653.5	522.5	626.5	121.00%	144.20%	157.10%	119.90%
Priory 3 - General Medicine	1448.5	1604.5	1557.75	1435	863.5	1045.5	771.5	989	110.80%	92.10%	121.10%	128.20%
Priory 4 - Stroke/Neurology	3128	3366.5	1339	1836	1564	1848	264.5	942	107.60%	137.10%	118.20%	356.10%
Priory 5 - Gastro/Resp	1794	2089	1776.5	2078	908.5	1093	1046.5	1499.5	116.40%	117.00%	120.30%	143.30%
SAU - Sandwell	663.75	832	349.5	351	304.5	314	154	251	125.30%	100.40%	103.10%	163.00%
CCS - Critical Care Services - City	3363.5	3329.5	804.5	897	2301	2552		0	99.00%	111.50%	110.90%	
D5 - Cardiology (Male)	3414.5	3691.75	751.5	1015.5	1299.5	1922.5	11.5	11.5	108.10%	135.10%	147.90%	100.00%
D11 - General Medicine (Male)	925.5	974	1342.5	1665.5	805	931	644	1044.5	105.20%	124.10%	115.70%	162.20%
D12 - Isolation	812.5	715	439.5	447	385	670	231	396	88.00%	101.70%	174.00%	171.40%
D15 - Gastro/Resp/Haem (Male)	1141.5	957.5	688.5	742.5	407	522	275	650	83.90%	107.80%	128.30%	236.40%
D16 - Male General Medicine	671	803	1183	1323.5	586.5	597.5	598	735.5	119.70%	111.90%	101.90%	123.00%
D17 - Gastro/Resp/Haem (Female)	999	1391	1220	1256	805	1035	460	874	139.20%	103.00%	128.60%	190.00%
D19 - Paediatric Medicine	813	907	79.5	67.5	506	648		0	111.60%	84.90%	128.10%	
D21 - Male Urology / ENT	1215.5	1262.5	1407.25	1176	425.5	643.5	678.5	653.5	103.90%	83.60%	151.20%	96.30%
D25 - Surgical (Female)	1309	1542	695	785.5	662	799	519	704.5	117.80%	113.00%	120.70%	135.70%
D26 - Acute Geriatrics (Female)	1276	1446	1507	1971	461	725	1001	1125.5	113.30%	130.80%	157.30%	112.40%
D27 - Oncology	1543	1569	918	1083	696.5	707.5	352	363	101.70%	118.00%	101.60%	103.10%
AMU 2 & West Midlands Poisons Unit - City	1865.5	1956.5	604.75	657.25	923	1120.5	310.5	402.5	104.90%	108.70%	121.40%	129.60%
Surgical Assesment Unit - City	1157.5	1221	733.25	758	643	720	297	374	105.50%	103.40%	112.00%	125.90%
D43 - Medically Fit for Discharge	1201.5	1524	1464.5	1614.5	655.5	931	678.5	814	126.80%	110.20%	142.00%	120.00%
AMU 1 - City	3566	3929	2646	3089.5	2756.5	3416.5	1202	1321	110.20%	116.80%	123.90%	109.90%
Ophthalmology Main Ward - City	1925.08	1971.25	522.92	698.5	324.5	471.75	18.5	18.5	102.40%	133.60%	145.40%	100.00%
Eliza Tinsley Ward - MFFD	970.5	1435	1271	1473.5	471.5	942.5	642.5	709.5	147.90%	115.90%	199.90%	110.40%
Henderson	927	945	1184	1501	552	672	324	706	101.90%	126.80%	121.70%	217.90%
Leasowes	630	723	1597	1555	318	276	754.5	694.5	114.80%	97.40%	86.80%	92.00%

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Report on the Implementation of Medical Appraisal**
SPONSOR (EXECUTIVE DIRECTOR):	**Dr Roger Stedman, Medical Director**
AUTHOR:	**Philip Andrew, Head of Medical Staffing**
DATE OF MEETING:	**3rd July 2014**

EXECUTIVE SUMMARY:

Medical Revalidation has been in place since December 2012 and is well established within the Trust. Approximately 80 doctors have now been through the revalidation process. The Medical Director acting as the Responsible Officer (RO) has a statutory duty to ensure that the requirements of revalidation are met. To be revalidated a doctor has to demonstrate that they have been participating in annual appraisal (assessed against the requirements of the GMC's Good Medical Practice) and have undertaken at least one patient and colleague multisource feedback exercise prior to their revalidation date.

This report provides a summary of the medical appraisal and revalidation activity within the Trust in the period 1st April 2013 to 31 March 2014. It includes information on the number of doctors that the RO is responsible for (371), the number of appraisals undertaken (360) and the number of revalidation recommendations made (77).

The report sets out the governance arrangements around revalidation, provides details on how the performance of doctors is monitored and how concerns with doctors are responded to.

The report seeks to assure the Board that the Trust is compliant with the requirements of medical revalidation.

REPORT RECOMMENDATION:

To accept this report and to note that it will be shared (along with the annual audit) with the higher level RO.

To approve the `statement of compliance' confirming that the Trust, as a designated body, is in compliance with the regulations (see Appendix 4).

To agree that a report on medical revalidation be presented to the Trust on an annual 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	
Business and market share		Legal & Policy	X	Patient Experience	
Clinical	**X**	Equality and Diversity		Workforce	X
Comments:					

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

Well led organisation

PREVIOUS CONSIDERATION:

Workforce & OD Committee on 27 June 2014

FOR DECISION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Annual Report on the Implementation of Medical Appraisal

Report to Trust Board on 3rd July 2014

1 EXECUTIVE SUMMARY

1.1 Medical Revalidation has been in place since December 2012 and is well established within the Trust. Approximately 80 doctors have now been through the revalidation process. The Medical Director acting as the Responsible Officer (RO) has a statutory duty to ensure that the requirements of revalidation are met. To be revalidated a doctor has to demonstrate that they have been participating in annual appraisal (assessed against the requirements of the GMC's Good Medical Practice) and have undertaken at least one patient and colleague multisource feedback exercise prior to their revalidation date.

1.2 This report provides a summary of the medical appraisal and revalidation activity within the Trust in the period 1st April 2013 to 31 March 2014. It includes information on the number of doctors that the RO is responsible for (371), the number of appraisals undertaken (360) and the number of revalidation recommendations made (77).

1.3 The report sets out the governance arrangements around revalidation, provides details on how the performance of doctors is monitored and how concerns with doctors are responded to.

1.4 The report seeks to assure the Board that the Trust is compliant with the requirements of medical revalidation.

2 BACKGROUND

2.1 Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Previous Board Reports on Medical Revalidation were presented to the Trust Board in May 2012 and November 2012.

Trusts have a statutory duty to support their Responsible Officers (RO) in discharging their duties under the Responsible Officer Regulations(`The Medical Profession (Responsible Officers) Regulations 2010 as amended in 2013' and `The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012') and it is expected that Trust Boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their

organisations;

- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

3 GOVERNANCE ARRANGEMENTS

3.1 A Medical Revalidation Implementation Group (MRIG), chaired by the RO, was established in 2012 and continues to be the main forum for ensuring the various components of medical appraisal and revalidation are being adhered to and that the Trust keeps up to date with new requirements and developments.

3.2 The medical appraisal and revalidation process is clearly set out in the Trust Appraisal Policy for Career Grade Medical Staff which was implemented in 2012 and further revised in October 2013.

3.3 An IT system, PReP, was acquired in 2012 that fully documents the appraisal process. The Consultant or SAS Doctor completes their appraisal input form on PReP with the necessary supporting information uploaded for each domain under the GMC's Good Medical Practice document. The appraiser then has access to the input form on PReP and can reject the form in advance of the appraisal meeting if it is felt that that the input form does not meet the necessary requirements. The PDP and Output form is completed as part of and after the appraisal meeting and signed off on PReP by both appraiser and appraisee. The PReP system provides the RO with access to all the appraisal input and output information for all the doctors he has responsibility for. There is also an RO dashboard and a suite of reports available on the system.

3.4 The operational management of the PReP system and the revalidation process is undertaken by the Medical Workforce Project Manager who has weekly meetings with the Head of Medical Staffing to report progress and/or concerns.

3.5 The process for ensuring the Trust maintains an accurate of list of prescribed connections is relatively straightforward as the Medical Workforce Project Manager is within the Medical Staffing department so has access to the details of all new starters and leavers. New Consultant starters are trained on the PReP system and we obtain confirmation of their current appraisal and revalidation status when they commence.

3.6 The ROs have established a regional network to share concerns about doctors who work in their Trust. The SWBH RO has also set up meetings with the main private healthcare providers to ensure that any concerns that might have been flagged in private practice are fedback to the Trust.

3.7 The RO has to provide regular self assessments for the Revalidation Support Team of NHS England. This has been in the form of quarterly Organisational Readiness Self Assessments (ORSAs) which have now been replaced by Annual Organisational Audits (AOAs).

4 MEDICAL APPRAISAL

4.1 Appraisal and Revalidation Performance data

As at 31st March 2014 the Trust had a prescribed connection with 371 doctors (295 Consultants, 60 SAS Doctors, 15 Temporary or short term contract holders and 1 other doctor with a prescribed connection to this designated body)

In the period 1 April 2013 to 31st March 2014 the number of completed appraisals was 360 (286 Consultants, 59 SAS Doctors and15 Temporary or short term contract holders). A summary of the reasons for missed or incomplete appraisals is contained in Appendix 1 (`Other doctor reasons' account for the majority of missed appraisals (6) and 5 of those would best be described as `underestimation of preparation and workload involved in appraisal process leading to delay in appraisal' . Of the 11 appraisals that were missed 9 have now taken place. Of the 2 remaining, 1 doctor is on long term sickness absence and the other is a doctor not involved in clinical practice.)

In the period 1 April 2013 to 31st March 2014 there were 2 doctors in remediation and/or disciplinary processes. In addition there were 16 GMC referrals that the Trust was involved with (mostly complaints made by patients and includes 3 referrals made by the Trust. The Trust referrals were conduct concerns raised about 2 agency locums and an ex-employee).

As part of the appraisal and revalidation process all doctors that have a prescribed connection to the Trust will undertake a colleague and patient multisource feedback (360 degree feedback) every three years. The doctor is required to evidence reflection on the results of this feedback with their appraiser in advance of their revalidation date.

4.2 Appraisers

As at 31st March 2014 there are 118 medical appraisers within the Trust, all of whom have undertaken Strengthened Appraisal Training. In the period 1st April 2013 to 31st March 2014 71 of those trained appraisers undertook at least one appraisal. This training is a one day training session that the Trust has commissioned (the objectives of the training include: Be familiar with SWBH appraisal policy for medical staff; Understand the purpose of the medical appraisal and how it relates to other management and regulatory processes; Be aware of the General Medical Council (GMC), British Medical Association (BMA) and Department of Health's guidance on appraisals in line with Good Medical Practice; Understand the role of the appraisal in the revalidation process, based on the most current information from the Revalidation Support Team (RST) and the Trust; Understand what preparatory work needs to be done by the appraiser and appraisee before the appraisal interview and the timescales; Have examined the appraisal process and what supporting

information should be included under each section in terms of evidence; Have explored the role of the appraiser and the skills required to conduct an effective appraisal interview; Know how to complete the summary of appraisal form and PDP sections with the appraisee, using SMART objectives; Be able to handle difficult appraisals which may include: performance or capability issues; inadequate evidence; reluctance to agree the need for further development; health and probity issues and who to communicate concerns to within the Trust; Have practised the skills required to carry out appraisals by appraising a colleague(s) during the workshop.)

An Appraiser Forum has been established which meets quarterly and his chaired by Dr Santhana Kannan (Medical Appraisal Lead). Items that have been discussed include the following: improvements required on PReP system (both from an appraiser and appraisee perspective), reflection, discussions re appraiser feedback, PDP and SMART Objectives).

We would like to improve attendance at the Appraiser Forum by having a development programme that is valued by the group. There are issues of discussion that should make attendance of at least a proportion of the forum meetings mandatory.

A regional appraiser network has been established in parallel to the Responsible Officers network so that good practice and experience can be shared.

4.3 **Quality Assurance**

The Quality Assurance Process has three strands to it – the appraisal portfolio, the individual appraiser and the organisation.

For the appraisal portfolio an audit of 40 anonymised input forms and output forms has been undertaken by the RO (Medical Director), Associate Medical Directors and Medical Appraisal Lead. This audit reviewed electronic appraisal folders to provide assurance that the appraisal inputs (pre- appraisal declarations and supporting information) provided is available and appropriate; that the appraisal outputs (Personal Development Plan (PDP), summary and signoffs) are complete and to an appropriate standard and any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs.

The summary of the audit is contained in Appendix 2.

Each individual medical appraiser will be required to provide an annual record of their reflections as an appraiser on appropriate continuing professional developments and an annual record of their participation in appraisal calibration events such as reflection on Appraisal Forum meetings.

The Medical Appraisal process is all captured on the PReP IT system and before the appraisee is able to countersign the output form on PReP they have to complete the feedback questionnaire which includes ratings on how the appraisal was undertaken and the skills of the appraiser. It has been agreed that this feedback will be shared at the

Appraisers Forum but will only be done so once there have been a sufficient number of appraisals undertaken to provide robust data and to minimise issues of confidentiality.

4.4 **Access, security and confidentiality**

The PReP system limits access of appraisal information to only those who need such access. The appraisee has access to their own appraisal inputs and outputs; an appraiser has access to their appraisees appraisal inputs and outputs. The RO has access to all the doctors appraisal input and outputs. The only others with access are the administrators of the PReP system (Head of Medical Staffing and Medical Workforce Project Manager). The system is web based and has a high level of data security. All users of PReP have to sign an undertaking that the information is used and stored in accordance with Data Protection legislation and must not contain any patient identifiable data.

4.5 **Clinical Governance**

There is an expectation that individual Consultants and SAS Doctors should already be aware of the complaints and Serious Untoward Incidents (SUIs) that they have been involved in and that reflection on these should not be left until appraisal. It is recognised however that complaints and incident information is not always available to every Consultant and SAS Doctor so every quarter the Medical Workforce Project Manager provides the Risk Department with a list of doctors whose appraisal is due in the quarter so an individual summary containing the complaint and SUI information can be sent to those people being appraised (the appraiser is copied into this report too).

There have been occasions where the RO has chaired a Table Top Review (TTR) and as part of the outcomes of the TTR process a doctor has been required to ensure that their learning and reflections on the event have been captured on PReP. There is a specific section on PReP which asks the individual doctor to confirm whether or not they have been required by the RO to ensure that information is discussed at appraisal. This has to be completed and a failure to complete correctly would be seen as a potential disciplinary issue.

5 REVALIDATION RECOMMENDATIONS

5.1 During the period 1st April 2013 to 31st March 2014 there were 77 revalidation recommendations made to the GMC by the Trust. All of the recommendations were made on time. There were 76 positive recommendations, 1 deferral requests and 0 non engagement notifications

5.2 The revalidation recommendations are usually made no later the third week of the preceding month and there is a robust process managed by the Medical Workforce Project Manager to ensure timescales are always kept to. The Head of Medical Staffing and the Medical Workforce Project Manager work together to action the recommendations jointly on behalf of the Medical Director. The Head of Medical Staffing escalates any concerns to the Medical Director.

6 RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

7.1 All staff employed by SWBH undergo the necessary pre-employment checks in accordance with NHS Employers and Trust policy. An ongoing audit of pre-employment checks is now being undertaken and has replaced the spot check audit that was previously undertaken each quarter.

7.2 All locums engaged via locum agencies are procured via either the Health Trust Europe (HTE) or Crown framework agreements which have a stringent requirement on pre-employment checks and are independently audited to ensure compliance. Every locum booked via an agency would have been first screened by a Consultant in the specialty to ensure that the qualifications and experience are suitable for the post.

7 MONITORING PERFORMANCE

8.1 The RO and Head of Medical Staffing meet every week and as part of that meeting issues relating to doctors performance are routinely discussed. There is also a regular Decision Making Group which is attended by the RO, Associate Medical Directors, Deputy Director of Workforce, Deputy Director of Governance and the Head of Medical Staffing where a summary of current concerns is presented. There is a detailed discussion of the approach being taken in each case and challenge is encouraged to ensure the RO is managing the issues appropriately. New concerns or issues are also raised at this meeting. The Deputy Director of Governance has the opportunity to bring to the groups attention any issues with complaints data, SUI data, trends etc that might indicate poor practice or learning and development needs of individual doctors and/or teams.

8.2 The RO and Head of Medical Staffing meet the GMC Employer Liaison Adviser every quarter and the current GMC issues with our doctors are discussed. This meeting also provides the RO with the opportunity to discuss any other matters that have not yet been notified to the GMC or are low level concerns.

8.3 The RO regularly discusses clinical outcome data with Group Directors and Clinical Directors and areas of concern or further investigation are identified.

8 RESPONDING TO CONCERNS AND REMEDIATION

9.1 Where there are concerns raised then the Trust Disciplinary Policy for Medical Staff is used (this incorporates the national framework Maintaining Higher Professional Standards in the NHS (MHPS) document). The policy covers the process for dealing with issues relating to doctors conduct, capability and health. This policy also outlines the process for exclusion of a doctor.

9.2 An important component of responding to concerns is effective investigation. A need has been identified for more people to be trained in case investigation within the Trust. The aim is for all the Associate Medical Directors and Group Directors to be trained along with a number of HR Managers.

9.3 The processes within the disciplinary policy are well established however more work is required to develop remediation, re-skilling and rehabilitation options within the Trust.

9.4 The RO and Head of Medical Staffing have established good links with the National Clinical Assessment Service (NCAS) and the GMC (via the aforementioned Employers Liaison service) to obtain specialist advice when concerns are raised.

12 DEVELOPMENTS REQUIRED/ NEXT STEPS

12.1 The medical appraisal and revalidation systems within the Trust have worked effectively since revalidation was introduced in 2012. The main areas to be developed now are:

- Further Appraiser development and improvement: through ongoing training, reflection, feedback and performance review. The Appraisal Forum needs to be integral to this improvement process and attendance at the forum must become a mandatory requirement for ongoing status as a medical appraiser.
- Develop processes for remediation, re-skilling and rehabilitation of doctors within the Trust;
- Improved case investigation resource so that the skills and experience of case investigation is spread more widely across the Trust
- Explore greater patient involvement in the medical appraisal process over and above the patient feedback exercises.

13 RECOMMENDATIONS

13.1 To accept this report and to note that it will be shared (along with the annual audit) with the higher level RO.

13.2 To approve the `statement of compliance' confirming that the Trust, as a designated body, is in compliance with the regulations (see Appendix 4).

13.3 To agree that a report on medical revalidation be presented to the Trust on an annual basis

[Dr Roger Stedman, Executive Lead]
[Medical Director/Responsible Officer]
[23rd June 2014]

APPENDICES:

Appendix 1 – Summary of Missed or Incomplete appraisals 2013-14

Appendix 2 – Quality assurance audit of appraisal inputs and outputs 2013-14

Appendix 3 – Audit of revalidation recommendations 2013-14

Appendix 4 – Statement of Compliance

Appendix 1 Summary of missed or incomplete appraisals 2013-14

Audit of all missed or incomplete appraisal in period 1 April 2013 -31 March 2014

Doctor factors [total]	**Number**
Maternity leave during the majority of the 'appraisal due window'	0
Sickness absence during the majority of the 'appraisal due window'	1
Prolonged leave during the majority of the 'appraisal due window'	0
Suspension during the majority of the 'appraisal due window'	0
New starter within the 3 month of appraisal due date	1
New starter more than 3 months from appraisal due date	2
Postponed due to incomplete portfolio/insufficient supporting information	1
Appraisal outputs not signed off by the doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors	6
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors [describe]	0
[describe]	0
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors [describe]	0
Total	**11**

Appendix 2

Quality assurance audit of appraisals inputs and outputs

Total number of appraisals completed		Number
	Number of appraisal portfolios sampled [to demonstrate adequate sample size]	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs	40	
Scope of work: has a full scope of practice been described.		38
Continuing Professional Development [CPD]: Is CPD compliant with GMC requirement?		35
Quality improvement activity: Is quality improvement activity compliant with GMC requirement?		29
Patient feedback exercise: Has a patient feedback exercise been completed?		12
Colleague feedback exercise: Has a colleague feedback exercise been completed?		13
Review of complaints: Have all complaints been included?		36
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?		36
Is there sufficient supporting information from all the doctor's role and places of work?		27
Has any patient identifiable evidence been submitted		0
Is the portfolio sufficiently completed for the stage of the revalidation cycle year [year 1 to year 4]		24
Appraisal Outputs	40	
Appraisal summary present		40
Appraisal statements present		40
PDP		38

Audit of revalidation recommendations

Revalidation recommendation between 1 April 2013 to 31 March 2014	**Number**
Recommendations completed on time [within the GMC recommendation window].	77
Late recommendations [completed, but after the GMC recommendation window closed]	0
Missed recommendations [not completed]	0
TOTAL	77
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified.	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resource or support for the responsible officer role	0
Other	0
Describe other	
TOTAL [sum of [late] + [missed]	0

Appendix 4 – Statement of Compliance

Designated Body Statement of Compliance

The board/executive management team –[delete as applicable] of [Insert official name of designated body] has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments:

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments:

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments:

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments:

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments:

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments:

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

[1]Doctors with a prescribed connection to the designated body on the date of reporting.

Comments:

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments:

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Comments:

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments:

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

[2]Doctors with a prescribed connection to the designated body on the date of reporting.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Configuration Committee – Version 0.2

Venue D29 Meeting Room, City Hospital **Date** 25 April 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 Waite		Ms D Lewsley	
Mrs G Hunjan			

Minutes	Paper Reference
1 Apologies	**Verbal**
Apologies for absence were received from Mr Lewis and Dr Stedman.	
2 Minutes of the previous meetings	**SWBCC (2/14) 010**
The minutes of the meeting of the Configuration Committee held on 28 February 2014 were approved.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meeting	**SWBCC (2/14) 010 (a)**
The Committee received and noted the updated actions log. It was agreed that a fact sheet should be prepared which summarised the key space allocations, in addition to the Gateway Review fact sheet that had already been prepared. It was agreed that the communications plan oversight would need to be provided at the next meeting.	
4 MMH Project status update	**SWBCC (4/14) 012**
Mr Seager asked the Committee to note the MMH project status update. It was reported that in terms of the GVD3, it was reported that discussions were ongoing concerning the future ownership of the land recently acquired and the	

associated access rights. The potential for a judicial review was reported to remain a possibility, which it was agreed needed to be captured as a risk. Ms Robinson asked what reputational impact the closure of the canal would cause when the bridge link was removed. She was advised that this did not present a significant risk given the configuration of the canal at this point. Mr Waite reported that the case remained with the Department of Health which would next submit it to HM Treasury. It was reported that a meeting between the Trust Development Authority and the Department of Health was arranged for 7 May to discuss affordability of the scheme. The options and implications of launching the procurement phase prior to approval of the business case was discussed, including the impact of timing of the opening of the new hospital. Mrs Hunjan asked whether it was likely that the forthcoming General Election might impact. She was advised that this was a possibility. The options around starting construction at an early stage were discussed. It was agreed that the Chief Executive's input to the decision-making needed to be canvassed at an early stage.	
5 Gateway review	**SWBCC (4/14) 013** **SWBCC (4/14) 013 (a)** **SWBCC (4/14) 013 (b)**
The Chairman noted the Gateway Review report presented a positive view of the project. The recommendations from the report were reviewed. It was noted that the terms of reference for the committees needed to be re-defined to include a regular oversight of all projects with which the MMH has interdependencies in order to clarify their purpose and avoid potential confusion. It was agreed that the schedule of matters being considered by the Executive-led as opposed to the Board-level Committee should be circulated. It was agreed that the Recommendation 4, in that a more detailed work plan should be developed and the Project Director should focus resources to the next stage plan and identify any skill gaps and resource shortfall was linked to the approvals process. The Committee agreed that the progress with addressing the recommendations would be considered as a regular item by the Committee.	
6 Premarket engagement	**SWBCC (4/14) 014** **SWBCC (4/14) 014 (a)**
The Committee was asked to receive and note the outcome of the recent premarket engagement. Mr Seager reported that feedback from the exercise was being built into plans and considerations where appropriate. Liability for bidder cost was discussed. It was noted that there was legal precedent for this, with the claim being on the Trust in the event of delays, in the first	

instance. In the terms of the land demolition, the Chairman asked for assurance that the most appropriate contractors would be engaged. He was advised that local knowledge was a key consideration as part of this and that the contractors identified were credible in this respect.	
7 BTC lessons learned	**SWBCC (4/14) 015** **SWBCC (4/14) 015 (a)**
The lessons learned from the BTC contract were discussed which were focussed predominantly on ambiguities in the contract. It was reported that every effort had been made to address these ambiguities as part of the MMH plans. It was reported that legal advice had been taken on these matters.	
8 PQQ comparison	**SWBCC (4/14) 016** **SWBCC (4/14) 016 (a)**
The Committee was asked to note the analysis comparing the SWBH PQQ percentages against a standard PQQ.	
9 Clinical reconfiguration summary update	**SWBCC (4/14) 017** **SWBCC (4/14) 017 (a)**
Mrs Dunn presented a progress report on the clinical reconfigurations ongoing at present. She provided a detailed update on the Cardiology reconfiguration. It was reported that a final case for change would be presented to the Executive Group in June 2014. It was suggested that the plans be reviewed by the Trust's legal team. Mrs Dunn advised that the guidelines for undertaking a public consultation were clear and therefore there was little further benefit to undertaking a legal review. Mrs Hunjan noted that the Cardiology speciality was subject to recovery, however it was noted that this was beyond the scope of the PCI service that was associated with the reconfiguration plans.	
10 'Right Care, Right Here' activity and capacity assumptions monitoring report including bed capacity	**SWBCC (4/14) 018** **SWBCC (4/14) 018 (a)**
The Committee was asked to receive and note the progress update, highlighting that work would be undertaken to provide the analysis at a speciality level. Ms Robinson urged the consideration of this work to be linked into the Year of Outpatients, including setting appropriate trajectories. It was noted that the work being undertaken by Capita would inform this work. Mrs Hunjan noted that a previously prepared report presented an overview of the transfer of activity into the community and asked how the lessons learned from this would be harnessed. She was advised that this was part of the Year of Outpatients work and that there would be greater visibility of the trajectories by the next meeting.	
11 Matters to raise to the Board	**Verbal**
It was agreed that progress with the MMH Department of Health decision needed to be raised to the Board. Ms Robinson suggested that the original time line and	

the key milestones, decision points needed to be presented alongside the current expectations and potential impact on the October 2018 timescale for opening.	
12 Any other business	**Verbal**
There was none.	
13 Details of the next meeting	**Verbal**
The next meeting is to be held on 27 June 2014 at 0800h in the D29 (Corporate Suite) Meeting Room, at City Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance & Investment Committee – Version 0.1

Venue Anne Gibson Committee Room, City Hospital **Date** 30 May 2014; 0800 – 1000h

Present	**In attendance**	**Secretariat**
Ms Clare Robinson	Mr Chris Archer	Mr Simon Grainger-Lloyd
Mr Richard Samuda		
Mr Harjinder Kang		
Mr Tony Waite		
Mr Toby Lewis [Part]		

Minutes	**Paper Reference**
1 Apologies for Absence	**Verbal**
Miss Barlow's apologies were tendered.	
2 Minutes from the previous meeting	**SWBFI (3/14) 019** **SWBFI (5/14) 020**
The minutes of the meeting held on 28 March 2014 and 16 May 2014 were accepted, subject to minor amendment, as a true and accurate record of discussions held.	
AGREEMENT: The minutes of the previous meeting were accepted as a true and accurate reflection of the discussions held	
3 Matters arising from previous meeting	**SWBFI (3/14) 020 (a)**
The Committee was asked to receive and note the action tracker. It was agreed that the matters arising and actions from the meeting held on 16 May needed to be drawn out explicitly, them being: • The need for the Executive to identify the risks of deferring other work • The need for a joined up communication plan in connection with the finances to be developed • It was agreed that there was a difference in the reports that the Board needed to see on finances as opposed to the oversight needed by the Finance & Investment	

Committee • Focus would be 2014/15 and 15/16 together and look at the progress towards 2015/16	
3.1 Payment against the Better Payment Practice Code	**SWBFI (5/14) 021** **SWBFI (5/14) 021 (a)**
Mr Waite reported that at present the target performance against the Better Payment Practice Code was not being met, although there were few issues with external agencies as a result of this position. It was reported that internal audit was undertaking a review of the situation. Mr Archer reported that a movement of £85k was required to achieve the 85% target. Mr Lewis suggested in the interests of best practice by managers, there needed to be a drive for improvement in this respect and suggested that the areas where there were particular issues needed to be identified. He added that managers needed to be made aware of performance in their area for the 'three way match' through the use of an Oracle report. Ms Robinson suggested that the matter needed to be considered as part of the wider procurement work and the efficiency of the invoicing system. Mr Waite advised that the standard term of payment was 30 days and from a supplier perspective there were no issues presented by the current position at present for suppliers downstream.	
ACTION: Mr Waite to provide an update of performance against the Better Payment Practice Code as part of his next update on procurement plans	
4 2014/15 Month 1 financial update	**SWBFI (5/14) 022** **SWBFI (5/14) 022 (a)** **SWBFI (5/14) 022 (b)**
Mr Archer reported that against a planned deficit of £81k, a deficit of £249k had been incurred. It was highlighted that lack of planned delivery of TSP schemes was a significant factor in this position. The income was reported to be as planned. The Committee was advised that budgets were currently settling at present. The position in terms of inflationary issues was discussed, including the influences posed by pay awards and energy costs. It was reported that an inflationary reserve was set and that this may need to be released during the year if needed. Mr Lewis suggested that there was a need to present actual spend month on month at each meeting of the Committee. It was reported that spend did not reduce as planned. Mr Kang suggested that run rates needed to be published to provide this clarity. Mr Archer reported that pay spend was flat during the month. Ms Robinson noted that the effect of the initiatives to address agency spend did not appear to be delivering a reduction in expenditure. Mr Lewis suggested that the position was being monitored by the TDA and offered to bring back an analysis of agency spend highlighting where there was a difficulty in recruiting, such as A & E and Critical Care, as opposed to waiting list initiatives and the other spending that needed to be handled. Mr Lewis advised that the information in	

this respect needed to be made available on a weekly basis to inform the position. Mr Lewis agreed that there needed to be clear line of sight on systemic as opposed to incidental spend. Ms Robinson suggested there was a need to forecast forward. She added that it was clear that addressing expensive staffing costs needed to be integral to the delivery of the budgetary positions required. She asked whether any additional resources were needed to provide the extra analyses suggested. Mr Lewis advised that this was not necessary and that the practice would be put into place in time for the next meeting. Mr Waite underlined the key message that a permanent workforce was preferable to one that was composed of a high level of temporary staff and outlined the procurement implications of this.

It was agreed that the integrated dashboard should be included in the papers considered by the Committee in future.

Mr Lewis advised that a medical staff bank was being created at present to address the inefficiency in the temporary staffing system.

It was highlighted that short term sickness presented an issue at the moment and therefore there was a focus on addressing this in a number of areas across the Trust. The Committee was advised that there was a desire to reduce sickness absence to less than 3%. Mr Lewis reported that this was linked to the plans to change the nurse staffing model over the coming months.

Mr Lewis asked how the Month 1 income position was derived. Mr Archer reported that the fundamental assumption was that the activity and income was in line with the contract. It was reported that this position included the expected fines levied. It was requested that the May income position needed to clarify the element that represented an adjustment made to the prior month's position as a result of agreeing the coding position. It was reported that the information needed to demonstrate whether the income received was adequate to pay for the complexity of the patients seen. Ms Robinson suggested that on a month by month basis, a forecast income line was necessary. Mr Kang offered to share a report that might provide a visual representation of the position in this respect. Mr Waite advised that for the biggest contract, there was no forecast adjustment needed in terms of income as a result of residual issues. It was agreed that this position needed to be clarified in readiness for the Board meeting planned for 5 June. Mr Archer advised that the situation needed to reflect antenatal pathways straddling the financial years and the patients who underwent a 12 week scan but went elsewhere for the remaining antenatal care.

Mr Samuda noted that the cash position was not as expected. It was reported that there had been a significant amount of payments made in the last month, which was a pattern seen in previous years. Mr Waite reported that there were some congruent working capital movements that were also influencing position. It was reported that there had been no obvious missed payments or accruals as evidenced by the recent external audit of the annual accounts and therefore this did not appear to be a concern. It was highlighted that a reconciliation on the cash position against the plan was necessary which should be presented to the next meeting to set out the variances influencing the cash position.

The financial issues were considered, which it was highlighted included a set of

cost pressures, such as settling the 18-week position and the antenatal pathways that straddled the two financial years. Mr Lewis underlined the need, should risks be presented, to harmonise the presentation with that of the trust risk register and the Board Assurance Framework. Mr Waite agreed to look at nomenclature of the risks and issues being presented.	
ACTION: **Mr Waite to present an analysis of agency spend at the July meeting, including a forecast position** **ACTION:** **Mr Waite to present a month on month view of expected income at the July meeting** **ACTION:** **Mr Waite to clarify the impact of the residual income issues on the financial position** **ACTION:** **Mr Waite to present an analysis of the cash position against budget at the July meeting**	
5 Transformation Savings Plan	
5.1 Update on TSP 2014/15 plan and delivery	**SWBFI (5/14) 023** **SWBFI (5/14) 023 (a)** **SWBFI (5/14) 023 (b)**
Mr Waite reported that there were significant savings opportunities that had been identified for 2014/15 which would be delivered and that attention was being given to identifying how savings could be delivered in 2015/16. It was reported that individual project leads were being engaged to identify meaningful milestones and actions to deliver the schemes. Mr Kang asked whether the delivery of the plans was incorporated within staff objectives. Mr Waite advised that the discipline was applied through a PMO approach and accountability came through this arrangement. Mr Lewis advised that at present there was little accountability outside the Executive Group, however work was underway to ensure that accountability was taken on by directorate managers. Mr Kang underlined the need for the accountability for delivery to be built into the set of leaders' responsibility as part of a cultural shift. It was agreed that the position should continue to be monitored, with a further consideration in detail at a future meeting. Mr Lewis suggested that budgetary accountability below directorate level needed to monitored and considered in the context of a rewards and consequences approach. Mr Waite reported that there was an intention to translate the current approach into a directorate PMO which would include necessary accountabilities. On a line by line basis, the schemes were reviewed to assess whether in May, the progress planned had been achieved. It was reported that £13.9m of the 2014/15 total TSP target had been identified, with significant residual challenge related to the clinical groups' positions. It was agreed that the shortfall against the profile against the year should be monitored on a monthly basis. Ms Robinson asked when the end date for the completion of the scheme	

identification was planned. She was advised that there were a number of actions at an Executive-level that needed to be completed in order to facilitate the identification of the schemes. It was noted that there was no sense that additional resource was needed, including the finalisation of the nurse staffing model. Mr Lewis left the meeting. The Committee reviewed the outcome of the CHKS benchmarking work which identified that there was an opportunity to generate significant efficiencies. It was noted that a number of the schemes required cultural changes which would extend into 2015/16. It was noted that the benchmarking information was made available at a consultant-level. It highlighted the need to reduce readmissions and improve quality of care as part of the measures, which would inform the TSP strategy in the future. The Service Line Reporting position was considered which would signpost areas where additional scrutiny was needed in terms of cost efficiency by a speciality level. Mr Samuda underlined the need for the skills of the external consultants to be transferred into the Trust. Mr Waite advised that this was the clear intention, including the use of a capacity planning tool and PMO methodology. It was suggested that careful consideration was needed to ensure that the retention of skills and change management was secured as part of the designing of the overall approach to transformation. Ms Robinson noted the tension between delivery of 'day roles' and the delivery of change management and therefore urged consideration be given to only releasing the expert consultants when sufficient skills and capability was identified in the Trust. It was agreed that a proposal around this should be presented at the next meeting. It was suggested that a communications element should be added into the project plan. It was reported that KM & T would exist at the end of June, with the work to embed the benchmarking tool being completed shortly.	
ACTION: **Miss Barlow to provide an update on the plans to release the change management expertise at the next meeting**	
5.2 Self-assessment against Monitor's goals and action plan	**SWBFI (5/14) 024** **SWBFI (5/14) 024 (a)**
Mr Waite presented a self-assessment against Monitor's and Audit Commission's guidance in delivering sustainable cost improvement plans. It was agreed that the position should be revisited in July. It was noted that the internal audit resource needed to be appropriate when necessary.	
6 Capital plan 2014/15	**SWBFI (5/14) 026** **SWBFI (5/14) 026 (a)** **SWBFI (5/14) 026 (b)**
Mr Waite presented the capital plan for 2014/15 which was noted to be previously included in the budget book as a cost of £19.155m.	

The structure of the programme was reported to be grounded within the LTFM. It was noted that some spend would be delivered ahead of plan, including that on medical equipment. The IT spend was reported to be in line with the previously agreed spend. Mr Lewis asked whether the estates element of the plan was congruent with previous discussions. He was advised that this was the case. The investment and contingency of £2m was uncommitted at present. Mr Samuda noted that digital dictation was late in the programme and Mr Lewis asked that this be prioritised to be completed by October. The capitalisation position was reported to be consistent with broadly in line with that of other organisations. It was agreed that the policy for capitalisation needed to be considered by the Audit & Risk Management Committee. Demolition costs for Grove Lane were reported to have been capitalised. It was noted that the capital plans included the management of the Trust's transport fleet and that the matter had been considered and was practice was being reviewed. It was noted that the Trust Board would be asked to approve the capital plan at its meeting on 5 June. Ms Robinson suggested that the monitoring of the capital plan spend needed to be considered by the Committee at each meeting, with a detailed review on a quarterly basis. Mr Samuda highlighted the need to include post project evaluation. The Committee agreed to the recommendation that the Trust Board should be asked to approve the Capital Plan. It has become clear that minor works austerity measures had not been applied to basic works, such as painting. Where small sums of money were required to enable the delivery of schemes, staff are able to call on funds for this purpose.	
ACTION: **Mr Waite to ensure that the delivery of the capital plan be considered at each meeting**	
7 Financial risks to the organisation	**SWBFI (5/14) 027** **SWBFI (5/14) 027 (a)**
The risks from the risk register were considered, which it was noted included a change in the payroll system although this was highlighted to be well mitigated.	
8 Committee workplan	**SWBFI (5/14) 028**
The Committee was asked to receive and note the annual workplan and would be used to inform the agenda setting in future.	
9 Matters for information	
9.1 Procurement national work	**SWBFI (5/14) 029** **SWBFI (5/14) 030**
The information was presented for information. It was highlighted that the role of	

Non Executive Director for Procurement would be taken on by Ms Robinson. Mr Samuda encouraged innovation in this arena. It was reported that Key Performance Indicators around procurement would be presented at the next meeting. Mr Kang suggested that a structured arrangement needed to be put into place to consider how procurement might be taken forward.	
10 Matters to highlight to the Board	**Verbal**
It was noted that Month 1 and TSP summary should be presented. It was agreed that the cash position needed to be raised to the Board. The benchmarking work needed to be raised.	
11 Meeting effectiveness feedback	**Verbal**
It was agreed that the meeting had included some productive discussions.	
12 Any Other Business	**Verbal**
There was none. It was agreed that a monthly schedule of meetings was necessary.	
13 Details of the next meeting	
The next meeting of the Finance and Investment Committee was noted to be scheduled for 25 July 2014 at 0800h at City Hospital.	

Signed: …….

Name: …….

Date: ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Workforce & Organisational Development Committee – Version 0.1

Venue D29 (Corporate Suite) Meeting Room, Sandwell Hospital **Date** 28 March 2014 at 1330h

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

Minutes	Paper Reference
1 Apologies	**Verbal**
Apologies were received from Mr Samuda.	
2 Minutes of the previous meetings	**SWBWO (12/13) 037**
The minutes of the meeting held on 16 December 2013 were approved.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meeting	**SWBWO (12/13) 037 (a)**
The Committee received and noted the updated actions log. It was noted that there were no matters outstanding or of significance to escalate to the Committee.	
4 Staff retention	**Verbal**
Mrs Barnett advised that there were a number of actions in train to address the staff retention issues, including identification of a directorate lead and robust monitoring. It was reported that the pursuance of development opportunities and nursing staff moving into alternative professions were highlighted to be the key reasons for leaving based on early indications from staff polls. Mrs Barnett advised that the exit questionnaire process would be strengthened and all leavers were being offered an exit interview. A process to address development requirements was reported to have been devised. Mr Ovington advised that	

rotations for nursing staff between specialities was included as part of this. Mr Lewis observed that there was a sense that the location of the medical wards were in a constant state of flux and therefore effort was being directed to addressing this and managing flow through of nursing staff through these wards. Mrs Barnett advised that the accident & emergency area was particularly affected by staff retention, with the overall staff turnover being c. 11%. She added that the exit interview take up was low at around 5%. It was highlighted that within the first two years of employment the nurse turnover was 40% annually. Mr Sharon asked how this measured against other professions in the NHS. He was advised that there was difficulty with obtaining benchmarking information. It was agreed that plans would be put into place to robustly address this performance, even if it was identified that the position was comparable to other NHS organisations. Mr Lewis asked that the work needed to include the reasons for staff staying in the Trust. Mr Sharon suggested that the use of 'Your Voice' could be used to inform this work. Mr Ovington reported that there was a degree of complacence that the turnover was high from middle managers in the organisation.	
ACTION: **Mrs Barnett to present a robust action plan to address the high level of turnover at a future meeting**	
5 Operational workforce report	**SWBWO (3/14) 039** **SWBWO (3/14) 039 (a)**
Mrs Barnett presented an overview of performance against the key workforce metrics. Mr Kang asked for further information against the time to hire target. Mrs Barnett advised that 14 weeks was an internal target set and there was an ambition to reduce this to 12 weeks. The Committee was advised that the new NHS Jobs service allowed benchmarking against other trusts. Overall, it was highlighted that the vacancy approval process presented a current delay in the process. In terms of the pre-employment check stage, the use of an electronic DBS assisted with reducing this stage of the process. Work was reported to be underway with occupational health to speed up the recruitment process for Women and Child Health workers. It was reported that work was planned to adopt practice for transferring checks between organisations. NHS Employers was reported to be being lobbied to accept measures that would reduce the pre-employment check bureaucracy. The lead in time for some posts was reported to be overly long if students and trainees were secured ahead of time. Mr Kang asked whether the access to bank and agency staff was influencing behaviours. He was advised that this was the case to some degree and that there may not be sufficient accountability on managers for recruiting to key positions in a timely way. Mrs Barnett added that competing priorities for recruiting managers also influenced the speed of filling vacancies. Mr Lewis commented that there appeared to be a lack of inertia directed to recruiting to posts that were non-nursing. Mr Pollitt advised that the current talent pool could be used in some circumstances to fill the vacancies.	

Mr Lewis asked for further details about appraisal plans. It was highlighted that 353 individuals were outstanding for appraisal. The Committee was advised that consideration was being given to providing managers with the tools to make an appraisal effective. It was reported that a meeting with HR would be organised should the outstanding appraisals not be conducted or arranged as planned and that increments, study leave or clinical excellence awards may be withheld where possible. It was noted that a cultural shift to conducting appraisals was needed. Mr Kang noted the high level of customer feedback on Occupational Health. It was noted that the feedback was based on a detailed customer survey. The 'paperlite' approach was reported to be reflective of the transfer of the paper records into electronic means. Miss Barlow asked whether electronic job planning was being implemented and how the use of e-rostering would be developed. Mrs Barnett advised that the systems were being developed at present and it was agreed that the tool should be used by staff managing doctors. It was further agreed that the ongoing work to implement job planning should incorporate the views of the Chief Operating Officer. In terms of e-rostering, Mr Ovington reported that this would be linked into payroll and would be used to monitor the use of temporary staff and controlling mandatory training. It was noted that the contents of the operational report would be fed into the integrated quality, finance and performance report in future.	
6 JCNC feedback	**Verbal**
Mr Lewis reported that JCNC attendance by managers and Trade Unions was stabilising. It was highlighted that a workplan for the Committee was currently being developed, which would include sickness absence and equality & diversity. The role of the governors was also planned for inclusion as part of the JCNC work.	
7 Learning & education report to include leadership development programme	**Verbal**
Mr Sharon reported that the leadership development programme would commence on 31 March. It was noted that 160 staff forming the top leaders cadre had been invited.	
8 Mandatory training plans	**SWBWO (3/14) 041** **SWBWO (3/14) 041 (a)**
Mr Pollitt provided an overview of the definition and inclusions within the suite of mandatory training. Mr Lewis noted that the current commitment on individuals as a result of the way in which the courses were organised was overly demanding and therefore work had been undertaken to consider ways of executing it differently while taking care to ensure that the key elements were maintained. It was noted that there were a number of options to delivering the training	

including e-learning, new technology and the more traditional face to face. It was agreed that a further update would be presented at the next meeting.	
ACTION: **Mr Pollitt to present an update on the plans to revise the approach to mandatory training at the next meeting**	
9 Strategic workforce report	**SWBWO (3/14) 042** **SWBWO (3/14) 042 (a)**
Mr Sharon introduced the action plan to deliver the Trust's workforce strategy. Mr Lewis noted that the plans needed to be aligned with delivering an engaged and effective organisation and delivering the workforce reduction plans required. Mrs Deakin asked the Committee to note the key priorities that were set within the workforce plan. The Committee considered the key objectives in turn. It was agreed that the values based recruitment should be pursued which would be delivered by 2014. The pay progression policy was highlighted to clarify the means by which staff payrises were awarded which was a matter that required further discussion in a forum that was yet to be decided, potentially that being the Workforce Delivery Committee. Sickness absence to be reduced to less than 3% was noted to be a further objective, with the current position being c. 4% (related to contractual hours lost). The actions to reduce the sickness absence to 3% were reported to be developed, however not applied consistently at present. Short terms sickness was noted to have the most significant impact on the operational position. It was agreed that a person identifiable list of sickness absence should be published. The Committee discussed the sensitivity and presentation of this information. The plans for succession planning, it was agreed that talent management needed to be built in with the intention of this work being completed by August 2014. It was noted that strategy also incorporated the introduction of the appraisal policy. It was agreed that the approach to appraisal should be discussed again at the next meeting.	
ACTION: **Mrs Barnett to consider the means of making person-identifiable sickness absence information more visible** **ACTION:** **Mrs Deakin to present the appraisal policy at the next meeting**	
10 Workforce change programme as part of the LTFM	**SWBWO (3/14) 043** **SWBWO (3/14) 043 (a)**
Mr Sharon reported that work had been implemented to identify the required workforce reductions, however much work was still needed to provide confidence with the delivery of the work. It was noted that work was needed to introduce measures in 2014/15 to deliver pay savings in the forthcoming years. It was agreed that there was a good degree of focus on this in the coming months.	

11 Matters to raise to the Board	**Verbal**
It was agreed that retention issues needed to be flagged in addition to leadership development the plans to reduce the quantum of mandatory training; JCNC and the strategic workforce update.	
12 Any Other Business	**Verbal**
It was noted that this meeting would be Mr Sharon's last meeting and he was thanked for his contributions and input.	
13 Details of the next meeting	**Verbal**
The next meeting is to be held on 27 June 2014 at 1330h in the D29 (Corporate Suite) Meeting Room, at City Hospital.	

Signed ……..

Print ……..

Date ……..

Midland Metropolitan Hospital Status Report June 2014

Activities Last Period

- Approval process –DH OBC /commercial
- Continue fine tuning procurement documents

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

- Meeting with TDA confirmed expected date of CIH visit is Q3 2014/15, with application anticipated to reach Monitor in Q1 2015/16
- 10 year IBP & LTFM submitted to the TDA along with 5 year workforce and activity planning templates
- BGAF & QGAF self-assessments scheduled for July Trust Board informal session (11.07.14)

Planned Next Month

- Respond to TDA feedback on IBP & LTFM and incorporate into updated versions
- Engagement with clinical groups on CIH visit
- Discussion with independent accounting firm to confirm Independent Financial Review (IFR) requirements as part of the revised FT process

Issues for Resolution/Risks for Next Month

- Confirmation of plan FT timeline with TDA – aligned to MMH timeline (in response to Monitor queries)
- Confirmation required from CQC as to timing of CIH visit
- Confirmation required from DH / HMT re MMH

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Plan 2014/15 monitoring template**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite, Director of Finance & Performance Management**
AUTHOR:	**Neetu Sharma, Head of Strategic Planning**
DATE OF MEETING:	**3 July 2014**

EXECUTIVE SUMMARY:

This template will be used to monitor delivery of the objectives set out within the 2014/15 annual plan. These are aligned to the Trust's strategic objectives and will be monitored and reported on a more regular basis via the relevant Board or committee. This template will be submitted to Trust Board on a quarterly basis providing detail on progress made against the 2014/15 plan.

REPORT RECOMMENDATION:

- Note the reporting template for the objectives within the 2014/15 annual plan

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

All annual plan actions are aligned to the Trust's strategic objectives.

PREVIOUS CONSIDERATION:

The Board approved the Annual Plan at its meeting in April 2014.

Annual Plan Monitoring 2014-15

RAG Code:

5	**Action complete**
4	**Progressing as planned**
3	**Some delay but expect to be completed as planned**
2	**Significant delay - unlikely to be completed as planned**
1	**Action not yet due to start**

Ref	Strategic Objective	Priority	Exec Lead	Currently reported	RAG	Current status	Key actions to progress & expected date of completion
S1	Safe, High Quality Care	Reducing preventable deaths, in particular by focusing on the Sepsis Six Care Bundle					
S2	Safe, High Quality Care	Reducing readmissions by 1%, through integrating care and better managing risk					
S3	Safe, High Quality Care	Meeting the emergency care waiting time standard, as we did in April 2014					
S4	Safe, High Quality Care	Improving our Friends and Family results, towards being the best in the region					
S5	Safe, High Quality Care	Implementing year one of our Public Health plan, making every contact count					
S6	Safe, High Quality Care	Reducing the number of complaints, especially repeat complaints					
S7	Safe, High Quality Care	Delivering our Year of Outpatient programme, to reach 98% patient satisfaction					
AR1	Accessible & Responsive Care	No mixed sex breaches of our privacy and dignity standard, now reported from eBMS					
AR2	Accessible & Responsive Care	By October 2014, specialty delivery of 18 week wait standards, and introducing these standards into therapy services					
AR3	Accessible & Responsive Care	Cutting cancelled operations numbers, and eliminating repeat cancellations					
AR4	Accessible & Responsive Care	Delivering national cancer wait times, even where other Trusts deliver part of the care					
AR5	Accessible & Responsive Care	Achieving the emergency care standard, and meeting our own ambitions around mental health care in an acute setting					
AR6	Accessible & Responsive Care	Complying with both the letter and the spirit of the Safe Staffing promise made after the Francis Inquiry					
C1	Care Closer to Home	Develop further our model of intermediate care at Leasowes, Rowley Regis and in Sheldon					
C2	Care Closer to Home	Complete the transfer of 27 clinics into Rowley Regis, as agreed by the Clinical Leadership Executive					
C3	Care Closer to Home	Reform another long term conditions specialty into general practice, year two of what we have achieved with Diabetes					
C4	Care Closer to Home	Implement our pacesetting project to change the shape of district nursing delivery, making our services part of the primary health care team					
C5	Care Closer to Home	Resolve the long term configuration of midwifery services for 2015-16, with our CCG partners, local families and the Local Authorities					

C6	Care Closer to Home	Ensure that our plans for winter 2014 are supported by consistent models of our of hospital care in nursing homes and the other settings of risk					
G1	Good Use of Resources	Cut our reliance on agency, overtime and bank staffing, on which last year we spent over £25m					
G2	Good Use of Resources	Standardise our equipment, especially in theatres to reduce the costs and safety risks of variation					
G3	Good Use of Resources	Make sure that the way we work is productive and efficient, across the week and in every month of the year, making smarter use of technology					
G4	Good Use of Resources	Reduce overheads in our system, so that more of every pound is spent on patient care					
G5	Good Use of Resources	Eliminate the costs of poor quality care, where patients need more expensive treatment because of errors or omissions that we have contributed to					
G6	Good Use of Resources	Improving our 'time to hire' from vacancy to recruitment					
G7	Good Use of Resources	Introducing an in-house medical bank					
G8	Good Use of Resources	Providing extra support to high-turnover departments and those with long-term vacancies					
G9	Good Use of Resources	Investing in our occupational health services counselling teams to tackle workplace stress					
G10	Good Use of Resources	Ensure that our training expenditure supports career and skill development					
F1	21st Century Infrastructure	Invest in estate that we are keeping for the long-term including Sandwell General Hospital, Rowley Regis and Sheldon					
F2	21st Century Infrastructure	Resolve issues with the Birmingham Treatment Centre to ensure better staff and patient experience					
F3	21st Century Infrastructure	Proceed with MMH					
E1	An Engaged & Effective Organisation	Achieve 100% PDR and mandatory training compliance by March 2015	DSOD				
E2	An Engaged & Effective Organisation	Cut sickness rates from their current 4.5% by focusing on our fifty hot spots	DSOD				
E3	An Engaged & Effective Organisation	Improve employee wellbeing by implementing our Public Health plan	CEO				
E4	An Engaged & Effective Organisation	Invest in our leaders, through partnership with Hay Group and others	DSOD				
E5	An Engaged & Effective Organisation	Introduce 360-degree appraisal into all leadership roles	DSOD				

Annual Plan Monitoring 2013-14

v8 31.01.14
Q3

RAG Code:

5	**Action complete - no update required**
4	**Progressing as planned - no update required**
3	**Some delay but expect to be completed as planned - please complete columns H & I**
2	**Significant delay - unlikely to be completed as planned - please complete columns H & I**
1	**Action not yet due to start - no update required**

Strategic Objective	Priority	Exec Lead	Currently reported	RAG	Reason for delay
Safe, High Quality Care	Develop leadership capability of our clinicians through delivery of Clinical Leadership Development Strategy	DSOD	CLE	4	
	Reduce Healthcare acquired infections	CN	Integrated Quality & Performance Report		
	MRSA	CN	Integrated Quality & Performance Report	4	
	E coli	CN	Integrated Quality & Performance Report	4	
	Blood culture contaminant	CN	Patient Safety Committee/Quality Report	4	
	Achieve MRSA screening targets	CN	Integrated Quality & Performance Report	4	
	Improve care to vulnerable adults	CN	Integrated Quality & Performance Report		
	Pressure damage	CN	Integrated Quality & Performance Report	4	
	Falls	CN	Integrated Quality & Performance Report	4	
	Weight loss	CN	Quality Report	4	
	Improve care to patients with dementia/ mental health illness/ disability	CN	Dementia Action Plan		

Increase use of memory test and referral to dementia services	CN	Dementia Action Plan	5	
Increase training to appropriate staff	CN	Dementia Action Plan	4	funding agreed to support 2 degree modules annually
Failure to rescue	MD	Patient Safety Committee/Quality Report	4	
Reduce number of preventable cardiac arrests	MD	Patient Safety Committee/Quality Report	4	
Increase number of staff trained to ILS standard	MD	Patient Safety Committee/Quality Report	4	
Increase use of sepsis bundle	MD	Patient Safety Committee/Quality Report	4	
Improve medicines management	COO	Patient Safety Committee/Quality Report / Medicines Safety group / Drug & Therapeutics Committee	4	
Reduce medication errors	COO	Patient Safety Committee/Quality Report / Medicines Safety group / Drug & Therapeutics Committee	4	
Improve standards for safe storage of medicine	COO	Patient Safety Committee/Quality Report / Medicines Safety group / Drug & Therapeutics Committee	3	Trajectory not currently being hit Number of incidents relating to safe storage
Reduce unnecessary antibiotic use	COO	Patient Safety Committee/Quality Report / CQRM	4	
Harm free care	CN	Patient Safety Committee/Quality Report		
Increase amount of harm free care measured by safety thermometer	CN	Patient Safety Committee/Quality Report	4	
Reduce adverse events causing serious harm	CN	Patient Safety Committee/Quality Report	4	
Improved evidence of 'being open' with patients and families	DG	Patient Safety Committee/Quality Report	4	(*Although want to introduce use of Safeguard for this too.)*
Achieve NHSLA risk management standards for acute trusts	DG	Patient Safety Committee/Quality Report		No further mandatory assessments can be undertaken until the NHSLA has devised new standards and a new process.
Improve end of life care	CN	Quality Report		
Increase number of appropriate patients on supportive care pathway	CN	Quality Report	4	
Reduce readmission rates of patients at end of life	CN	Quality Report	3	Subject to a review of readmission rates as part of COO work.

Increase the number of patients who achieve their choice of where to die	CN	Quality Report	4	
Improve appropriate application of DNACPR decisions	MD	Quality Report	4	
Improve general health of patients	Various	Corporate Performance Dashboard/Trust Board/ Finance & Performance Committee	4	
Achieve smoking cessation targets/alcohol cessation targets/breast feeding target	MD	Corporate Performance Dashboard/Trust Board/ Finance & Performance Committee	4	
Achieve health visiting staff numbers	COO	Corporate Performance Dashboard/Trust Board/ Finance & Performance Committee	5	
Reduce avoidable mortality	Various	Quality & Safety Committee/ Mortality & Quality Alerts Committee	4	
Achieve a mortality performance in the top quartile of the national peer group	MD	Quality & Safety Committee/ Mortality & Quality Alerts Committee	4	
Reduce variation in mortality	MD	Quality & Safety Committee/ Mortality & Quality Alerts Committee	4	
Reduce harm from elective surgical care	MD	Quality & Safety Committee/ Mortality & Quality Alerts Committee	4	
Improve outcomes from national patient survey	CN	Patient Experience Committee/Quality Report		N/A - no longer completed nationally
Improve 'family friendly test' score	CN	Patient Experience Committee/Quality Report	4	
Deliver all CQUINs	CN	Quality Report/Finance & Performance Committee		
Use of pain care bundles	COO	Quality Report/Finance & Performance Committee	4	

	Safe, High Quality Care	*Use of sepsis care bundles*	MD	Quality Report/Finance & Performance Committee	4	
		Community risk assessment (falls and pressure ulcers)	CN	Quality Report/Finance & Performance Committee	5	
		Recording DNAR decisions	MD	Quality Report/Finance & Performance Committee	4	
	Care Closer to Home	Continue to implement the Health Visitor strategy and reduce HV caseload	COO	Quality & Safety Committee	5	
	An Engaged & Effective Organisation	Building the membership base & manage active membership through communicating with members and playing key community role	HOC	Trust Board	4	
	An Engaged & Effective Organisation	On-going provision of a broad ranging evidenced based Health and Well Being Programme	CN	Workforce & OD Assurance Committee	4	
	Safe, High Quality Care	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
	Accessible & Responsive Care	Strengthen partnership working with GPs	DSOD	?	4	
	Accessible & Responsive Care	Pilot new process for GP letters	COO		4	• Outpatient letter standards and template are approved and implemented across Trust

	Care Closer to Home	Reconfigure number of services across acute and community to provide integrated care	COO	MMH & Reconfiguration CLE Committee	4	
	Accessible & Responsive Care	Deliver year 1 of Dementia Strategy and support to carers	CN	Quality & Safety Committee/Patient Experience Committee	4	• The Dementia action plan is detailed and comprehensive – there are a number of domains that require further work into 14/15
	Good Use of Resources	Move to a 7 day working model to support treatment & discharge	COO		4	• Interdependencies with social services, mental health and community services. • Access to nursing and residential homes 7 days a week.
	21st Century Facilities	Invest in estate through capital schemes	DE		4	
	21st Century Facilities	Update infrastructure risk assessments to inform investment in high and significant risk backlog items (May 13)	DE	Trust Board	4	

An Engaged & Effective Organisation	Improving management information to support effective and timely management of absence.	CN	Workforce & OD Assurance Committee	4	Work has been on-going to use the Trust's e-rostering system to support the provision of management 'reminders' with respect to the management of sickness absence. Initial discussions with the e-rostering system provider were positive, but are now less so.
An Engaged & Effective Organisation	Regular case management review.	CN	Workforce & OD Assurance Committee	4	
Safe, High Quality Care	Deliver long-term quality goals for 13-14	DG	Quality & Safety Committee	4	
	Deliver Year 2 of the Quality & Safety Strategy	Various	Quality & Safety Committee	4	
Good Use of Resources	Further delivery of the Transformation Programme and 2013/14 TSPs	COO	Finance & Performance Committee/Trust Board	4	
Good Use of Resources	Develop integrated community teams based on clinical pathways	COO		4	

Key actions required to rectify & expected date of completion
Continuing programme of development with initial development centres held in April/May 2014.
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.
79 avoidable pressure ulcers in 13/14 one grade 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 implanted 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 fall.

Memory screening cquin achieved in Q4
2nd cohort commenced . 1st cohort on wards as dementia champions
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%.

Weekly audits and action tracking

94% harm free care achieved
Policy reviewed and Incident database being used more frequently to document. Further work to implement this process needs to take place due to the contractual obligation of the duty of candour.
No longer taking place, so no further action possible.

Acute – 61% of patients achieved preferred place of care C0mmunity – 46%
As member of WHO Health Promoting Hospital we endeavour to promote good health practices amongst our patient groups. The HPH network publishes a list of 40 standards for a member organisation, applied over 5 domains to include management policy, standard patient assessment, patient information, workforce health and cooperation with the community.
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

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%
Risk assessments and advice in community – 85% compliant –CQUIN achieved
Work ongoing. Membership plan in development.
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
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. 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
• 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.

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: • delivery of diabetes care requiring specialist input as joint clinics in primary care, in order to help transfer skills to the primary care team • A system of 'link' consultants/specialist teams working closely with clusters of practices. • Developing connected health tools (digital healthcare) to deliver advice and guidance for practice teams.
• 3rd uni cohort commenced in Q4 and 2 cohorts annually financed • 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 • Carers surveys added to Ipad – still small response • 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 • Memory screening cquin achieved in Q4
• 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 clincial standards published by Bruce Keogh will be part of a longer term delivery programmes

• One further meeting scheduled for February ’13 but if outcome is not positive it will be necessary to identify an alternative solution.
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.