Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 7 May 2015; 1330h – 1700h

Members attending

Mr R Samuda	(RSM)	[Chairman]
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	(RBA)	[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 R Goodby	(RG)	[Director of Workforce & OD]
Mrs C Rickards	(CR)	[Trust Convenor]

Guests

Patient for patient story [Item 3]

Mr A Tyagi	(AT)	[Group Director, Surgery A] [Item 5.2]
Mrs S Fitzpatrick	(SF)	[Head of Children's Services Community]

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	**Patient story (discussion to follow in private Board meeting)**	**Presentation**	**CO**
	4	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 2 April 2015 a true and accurate records of discussions*	**SWBTB (4/15) 055**	**Chair**
	5	**Update on actions arising from previous meetings**	**SWBTB (4/15) 055 (a)**	**SG-L**
	5.1	Pressure ulcer position in comparison to peer exemplars	SWBTB (5/15) 074 SWBTB (5/15) 074 (a)	CO
	5.2	Discussion about Never Event on April 27th 2015	SWBTB (5/15) 057 SWBTB (5/15) 057 (a)	RST
	6	**Questions from members of the public**	**Verbal**	**Public**
	7	**Chair's opening comments**	**Verbal**	**RSM**
	8	**Chief Executive's report, to include outstanding audit recommendations, annual plan 15-16 'top ten' format, and Safe and Sound 2**	**SWBTB (5/15) 058**	**TL**

	MATTERS FOR APPROVAL			
1415h	**9**	**Midland Met Appointment Business Case – to approve**	**SWBTB (5/15) 059 SWBTB (5/15) 059 (a) SWBTB (5/15) 059 (b)**	**TL**
1430h	**10**	**Trust's 2020 Vision – to approve final draft document**	**SWBTB (5/15) 060 SWBTB (5/15) 060 (a) SWBTB (5/15) 060 (b)**	**TL**
1445h	**11**	**TDA Annual plan 2015/16 submission – to note**	**SWBTB (5/15) 061 SWBTB (5/15) 061 (a) SWBTB (5/15) 061 (b)**	**TW**
1455h	**12**	**Board Assurance Framework 2015/16 – to approve**	**SWBTB (5/15) 062 SWBTB (5/15) 062 (a)**	**KD**
	13	**MATTERS FOR DISCUSSION – 2015-16**		
1510h	13.1	Trust Risk Register	SWBTB (5/15) 063 SWBTB (5/15) 063 (a)	KD
	a	- Oncology Service Level Agreement with UHB FT	Verbal	RSt
	b	- April consent non-compliance report	Verbal	RSt
	c	- Emergency care delivery and forward risks	Verbal	RB
1540h	13.2	Nurse staffing report	SWBTB (5/15) 064 SWBTB (5/15) 064 (a)	CO
1550h	13.3	Capacity plan for 2015-16	SWBTB (5/15) 065 SWBTB (5/15) 065 (a)	RB
1605h	**14**	**MATTERS FOR INFORMATION AND QUESTIONS – 2014-15**		
	14.1	Complaints – Quarter 4 update	SWBTB (5/15) 066 SWBTB (5/15) 066 (a)	KD
	14.2	Corporate integrated performance dashboard	SWBTB (5/15) 067 SWBTB (5/15) 067 (a)	TW
	14.3	Annual Plan 2014/15 delivery – end of year stocktake	SWBTB (5/15) 068 SWBTB (5/15) 068 (a)	TW
		PRESENTATION		
1615h	**15**	**Service presentation – vulnerable children and family service**	**Presentation**	**CO**
		UPDATES FROM THE COMMITTEES		
1640h	**16**	**Update from the meeting of the <u>Quality & Safety Committee</u> held on 24 April 2015 and minutes of the meeting held on 27 March 2015**	**SWBQS (3/15) 038**	**OD/ CO**
	17	**Update from the meeting of the <u>Workforce & OD Committee</u> held on 17 April 2015 and minutes of the meeting held on 19 December 2015**	**SWBWO (12/14) 066**	**HK/ RG**

	18	**Update from the meeting of the <u>Configuration Committee</u> held on 17 April 2015 and minutes of the meeting held on 19 December 2015**	**SWBCC (10/14) 046**	**RS/ TL**
	19	**Update from the meeting of the <u>Audit & Risk Management Committee</u> held on 30 April 2015 and minutes of the meeting held on 29 January 2015**	**SWBAR (1/15) 013**	**GH/ KD**
	20	**Any other business**	**Verbal**	**All**
	MATTERS FOR INFORMATION			
	21	**Details of next meeting** *The next public Trust Board will be held on 4 June 2015 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 Nishkam Centre, Soho Rd, Birmingham **Date** 2 April 2015

Present	In Attendance	Secretariat
Mr Richard Samuda [Chair]	Mr Mike Hoare	Mr Simon Grainger-Lloyd
Dr Sarindar Sahota OBE	Miss Kam Dhami	
Mrs Gianjeet Hunjan	Mrs Raffaela Goodby	
Mr Harjinder Kang	Mrs Chris Rickards	
Mr Toby Lewis		
Mr Colin Ovington		
Miss Rachel Barlow		
Dr Roger Stedman		
Mr Tony Waite		

Minutes	
1 Introductory remarks and apologies for absence	**Verbal**
Apologies for absence were received from Ms Dutton.	
2 Declaration of Interests	**SWBTB (4/15) 056**
Mr Grainger-Lloyd advised that there had been no further declarations made since the last meeting. The Board considered the refreshed version of the Register of Interests and approved it.	
3 Minutes of the previous meeting	**SWBTB (3/15) 054**
The minutes of the Trust Board meeting held on 5th March 2015 were presented for consideration and approval.	
4 Update on Actions arising from Previous Meetings	**SWBTB (3/15) 054 (a)**

The Board received the updated actions log. It was noted that the rolling slide deck of organisational change would be presented at the May Board informal session. Miss Dhami reminded the Board that it had previously considered the fit and proper persons test regulations. It was reported that any in year concerns could come from a variety of sources and stressed the importance of keeping those who raised a concern updated with progress. Should it appear that some action taken then an investigatory panel would be established which would be chaired by a NED. It was reported that the CQC would need to be notified of any concerns. It was noted that the management of Non Executive Directors concerns under these regulations would be managed by the Trust Development Authority. Mrs Hunjan suggested that a timeframe for the management of concerns raised needed to be set. Miss Dhami agreed that some timescales would be added into the process. It was also suggested that the documentation of the closure of any concerns raised needed to be robust. Mr Lewis noted that the previous Board had agreed that the regulations extended to all Executive Group attendees; not just Board members. Depending on the allegation of the concerns, the need to refer the concern to external bodies, such as professional bodies, should be included in the flow chart. Mr Lewis raised a series of questions about the position on falls and pressure ulcers, which had been reviewed in detail by the Quality and Safety Committee. Mr Ovington confirmed that the apparent rise in fall and pressure ulcers in prior months did reflect the correction of historic data errors. He further confirmed that he was now satisfied that our data was accurate, and that his team had no further 'review' data. Mr Ovington was then asked to compare our falls and pressure ulcer position to other organisations. He noted that 917 falls was a lower number than previous years at the Trust. He was asked if the 22 falls with harm was a reduction on previous years and was advised that this was also the case. In terms of the increase in pressure ulcers, it was noted that pressure ulcer incidence was reduced on previous years and the number of grade 4 ulcers was much reduced, which was a good change from previous years. Mr Lewis asked whether there was a sense of improvement in the Trust's position against some peer group of exemplars. It was agreed that this would be presented at the next meeting, so that the Trust could consider an aspiration for excellence in its forthcoming safety plan.	
ACTION: **Miss Dhami to update the Fit and Proper Persons test processes to include timescales for resolution and handling** **ACTION:** **Mr Ovington to present the Trust's position again peer exemplars in respect of pressure ulcers at the next meeting**	
5 Questions from members of the public	**Verbal**
A member of the public reported that she had raised some complaints and expressed concern that a lack of staffing might compromise the care of her	

daughter. She also noted that there were concerns about patient confidentiality based on the information on the publicly-available screens. A specific concern around a blood transfusion where there was a need to travel to London for an element of the procedure given that the machinery to do so was not available was also highlighted. Addressing these points, Mr Lewis noted that there was a willingness to buy the equipment, however commissioners would not currently pay the Trust to undertake this procedure in hospital. This was to be challenged as part of contract negotiations. The member of public was advised that the information displayed in public was the subject of Executive consideration at present, which would be considered by the Clinical Leadership Executive in April, with the new standards taking effect shortly afterwards. In terms of staffing, Mr Lewis advised that investigation did not concur with the allegations made but undertook to cover the subject in responding to the complaint raised under our formal complaints procedure. The Board was asked whether they were disappointed that there were shortcomings identified in the recent CQC report. The member of the public noted that good practice was also highlighted. He asked whether any action plans were in place to address the concerns. It was noted that the Trust had performed well in terms of the operation of the Emergency Care target over the winter and he offered to write a letter to the Chief Inspector of Hospitals to praise the soundness of the practice. Mr Lewis recognised the balance of comments made and drew attention to the improvement plan and he noted that there was no element of delay or denial in responding to the report. He stressed that the staffing levels were being consulted upon prior to and during the inspection, and changes had been implemented from January 2015. He stressed that the good practice should not be traded off against any unacceptable practice and work should continue to address matters such as hand washing.	
ACTION: **Mr Ovington to prepare a proposal for the display of public-facing patient information for discussion at the next meeting of the CLE**	
6 Patient story	**Presentation**
It was noted that the patient would present her story at the next meeting.	
7 Chair's opening comments and Chief Executive's report	**SWBTB (4/15) 058**
The Chairman paid tribute to the staff for handling of the impact of the CQC report. He noted that the view represented only one source of feedback and at the Quality Summit, where all external partners were present, it had been acknowledged that the Trust was well placed to address the concerns. He	

reiterated the commitment of the full Board to the Improvement Plan, and confirmed the changes to Board committee length in order to generate the time to have more patient facing visits by non-executive members. In addition to the items cited in his written report, Mr Lewis noted a pleasing performance in the CCGs Equality & Diversity award event recently. He noted that much work on equality & diversity was still needed and reminded the Board of the plan that we had approved in October 2014. The work on reconfiguration of cardiology and acute surgery was reported to be progressing well. It was noted that a further update would be presented on both at the next meeting. Dr Sahota asked whether any fines had been levied in respect of Delayed Transfers of Care and was advised that fines of £427k had been issued to Birmingham City Council for the prior year. Miss Barlow reported that access to some Local Authority enhanced assessment beds had been a particular issue because of closed beds in the community, where a number of patients had needed to occupy acute beds. In terms of Easter plan, Sandwell and West Birmingham has not provided full assurance, because of concerns about primary care and social care access over the period. Mr Lewis reported on the outstanding internal audit recommendations escalated to him, and highlighted huge improvement in the prior month with there now being 10 from an original position of 63. All 10 had intelligible delivery dates in the coming four months. Mrs Hunjan noted that this was a very positive move. She reminded all of the need to complete the Audit & Risk Management Committee self-assessment.	
8 To receive the Care Quality Commission's report and note the Trust's improvement plan	**SWBTB (4/15) 059** **SWBTB (4/15) 059 (a)** **SWBTB (4/15) 059 (b)**
Miss Dhami noted that the improvement plan had been published at the same time as the CQC report was published. It was reported that staff briefings had been held which had been well received. In terms of staff opinion, it was noted that there was a degree of disappointment but a willingness to work jointly to address the concerns. It was reported that most of the 13 actions due for completion in March had been progressed well and evidence would be sought to confirm success of the implementation. Dr Gill provided his own experience of attending a staff briefing. It was noted that in some instances there was a concern about what this meant for the Trust, however many patients had been positive about the position. It was noted that the GPs were supportive of the plans. The Chairman noted that there had some been some constructive feedback received on how the Trust had moved forward to date, however there was a feeling that learning lessons from incidents could be better. Miss Dhami reported that reports on incident reporting would be made more transparent and available. Secondly, from a practical point of view, a 'save for later' option had been agreed on the Safeguard database. Mr Lewis advised that feedback could be	

provided if the individual reporting chose to receive it, however the value of this feedback was the key concern of the staff. Learning was not robust from green and yellow incidents however, which needed to be addressed. It was also suggested that individuals needed to be given the opportunity to express the satisfaction with the response provided. Mrs Hunjan reported that the level of engagement with staff was pleasing. She agreed that learning from lower risk incidents needed to be themed.

Mr Kang noted that some of the issues raised centred on people rather than systems and processes. This was a common view expressed in discussion, responded to through the work being done on leadership, sickness and vacancies. Dr Stedman noted that behavioural changes needed to be given attention, including flattening hierarchies and promoting a culture of challenge among staff. Miss Barlow noted the need to change the arrangements for engagement in some cases including meeting arrangements. Dr Sahota noted that the engagement needed to extend to all staff groups; not just ward areas. Mr Lewis advised that work has been done to engage trainee doctors and facilities staff, although this had been difficult. Mr Kang noted that visibility was key and suggested that consideration needed to be given to make time to be more approachable. Mr Lewis noted that there was a need to ensure that enquiries by staff were responded to. He advised that this was a consideration for the Clinical Leadership Executive on 28 April. It was noted that the middle management were key to the success of the plans in addition to visibility of the accomplishments made.

In terms of the issues concerning training records in Imaging, it was reported that these would be in place imminently ready for the closure of the CQC enforcement notice during or before July.

A notes amnesty was reported to have been launched and a range of lockable trollies had been purchased. Mrs Rickards noted that this had been an ongoing issue and welcomed the work. Mr Lewis reported that the 'OK to Ask' initiative was showing some promise and highlighted work being undertaken to help wards to be self-sufficient to some degree, such as replenishing hand gel bottles. He emphasised the need for the work to be a whole-organisation effort.

Mr Lewis reported that the CQC had made a number of staffing-related observations, detailed in his report. He addressed each in turn and asked the Board to confirm that it was satisfied with the position reached. The largest factor by far remained vacancies and sickness, and consequent use of temporary staff.

- In responding to questions, attention was drawn by Miss Barlow to the draft policy for opening and closing capacity had been developed, which concerned consideration of the balance of risk. The detail of the Bradbury Day hospice nurse staffing was discussed, which was summarised as a patient experience matter rather than a patient safety issue. It was emphasised that discussion with the full multi-disciplinary team in the unit had identified no safety issues.

- The Board discussed the Leasowes staffing position, which is reflected in

the safe staffing report. During March 2015 there is clear progress with night staffing on the unit. • The ratios in community nursing were considered to be safe, however compromised on quality to some agree. The need to pay greater attention to contact time and caseloads was reflected in the annual plan elsewhere in the agenda. The five key priorities forming the Trust's response to the report were discussed: better learning; delivery of good basic care; addressing sickness and vacancy rates; addressing local management and leadership; and understand where issues are and addressing them. Attention was being given to ensuing that the care plans were coherent and refined. Dr Gill suggested that there was some basic work to ensure that records were simplified and were read by all disciplines. Dr Sahota noted that there were few surprises presented in the report. Dr Stedman noted that the improvement plan was the Trust's rather than the CQC' and that he felt it was important that we had and retained a sense of self-determination. Miss Dhami noted that maternity, critical care and end of life care were rated well. Community Children and Young people services did not get inspected and would be reviewed at the end of June.	
ACTION: **Mrs Goodby to present the sickness plan at the Board's informal session in May** **ACTION:** **Miss Dhami to present the CQC Improvement Plan to the Trust Board and Quality & Safety Committee at forthcoming meetings. The Executive to consider and present KPIs for the five themes in due course.**	
9 End of Year stocktake against recommendations in the Francis Report	**SWBTB (4/15) 060** **SWBTB (4/15) 060 (a)**
The Board reviewed progress against the Francis recommendations for the second time in 2014-2015. Although there was progress in many areas, overall we were behind where we wished to be, and a renewed focus, consistent with the Improvement Plan, was now needed. Each of the themes were discussed in turn. In terms of complaints handling it was reported that a devolved model had now been introduced. It was noted that the position had been approved however the target for responses had not been met as yet. More meetings with complainants were reported to be planned. The total number of complaints for 2014/15 was reported to be 915 complaints, a slight reduction on the prior year position. Dr Gill suggested that learning outcomes needed to be made more explicit, rather than lessons. Dr Sahota asked whether the devolved model had impacted on the number of outstanding complaints. It	

was reported that approvals process would be reviewed, however the current practice was useful for quality assuring the standard of complaints responses. The key success under the 'accurate, useful and relevant information' theme was the introduction of the kitemarking system, although it was noted that further effort was needed to use it better. The alignment of information with business intelligence was reported to be good and performance management was to be transferred into an advisory function. It was suggested that the Audit & Risk Management Committee needed to prioritise the DQ list. In terms of medical education and training, it was reported that better effort was made to harness the views of trainee doctors through a range of forums and ways. Mr Ovington reported that the actions under 'compassionate, caring and committed' theme had been delivered well and in some cases additional actions had been completed. He highlighted that the 'Rising Stars' initiative was well received and these staff would be used for specific purposes, such as improving care at night. He added that more work was needed in terms of appraisal and support of temporary staff. Miss Barlow reported that under the 'getting the fundamental standards right' theme, the seven day model was progressing and work was undertaken to reduce readmissions. It was noted that this needed to be applicable to community services as well as hospital services. Mr Lewis noted there needed to be specific focus on tackling readmission rates at Sandwell Hospital. In terms of 'care for the elderly' it was reported that work on focussed care had been a key success. It was agreed that elderly care patients being treated outside the elderly care wards needed to be better considered. The 'culture and values' element was discussed. Morale remains on par with the national average however there was a desire to improve this position. Into 2014/15, it was reported that patient and staff feedback was more mainstreamed as part of performance conversations. It was noted that this would be facilitated by the revisions around the performance management function. It was noted that more work was done to engage GPs in providing feedback. It was suggested that 'Choose and Book' could now be used to target a question to any service in the Trust. Mrs Goodby reported that all separate elements in this theme needed to be brought together. In terms of 'openness transparency and candour', it was noted that in private Board meetings, only critical elements were covered. The statutory duty of candour was now in place and in 97% of cases where there was moderate or severe harm, the open conversations had been held, although the quality of the conversations needed to be analysed. The whistleblowing policy remains unused and a meeting with the external company providing the Safecall reporting line had been held, at which a number of suggested improvements had been identified. Mrs Hunjan noted that there may be reticence of staff using the reporting line, however Mr Lewis suggested that there was more of a willingness to investigate	

concerns. Mrs Rickards confirmed that there was a markedly greater willingness to raise issues, particularly to and through the Chief Executive. She reported that middle management were not happy with their staff raising issues. The Chairman reiterated how unacceptable that dynamic was, and asked for greater effort to get across a single message to that effect.	
10 Trust risk register update	**SWBTB (4/15) 061** **SWBTB (4/15) 061 (a)**
10.1 Overview and any new considerations	
The Board was asked to review the Trust Risk Register. Miss Dhami reported that there was a proposal to add nine new risks to the Risk Register. Dr Stedman reported that some risks concerned fitness for purpose of the IT infrastructure, skills and security and also concerned the current EPR function. Mr Hoare supported the addition of the risks. It was noted that the pace of remedy would be discussed again at the Board in June after receipt of the infrastructure report. It was agreed that all risks would be added to the Trust Risk Register, including the amber risk around IT staffing, which post mitigation was a much lower risk. Miss Barlow reported that there had been a number of risks associated with the recent trauma peer review. It was highlighted that an immediate risk had been highlighted which concerned the capability of the local major trauma centre to perform the required function. Since this is UHB it did not feature on the Trust's risk register. The detail of the risks associated with the Trauma Peer Review was discussed and agreed. In terms of the interventional radiology risk, it was reported that 24/7 cover was challenging due to the small size of the team. Patients would be directed to the major trauma centre for any emergency work out of hours and a network solution would be worked up and that we were working with Dudley as well as UHB. Mrs Hunjan noted that a number of key risks seemed to frame around our relationship with UHB. Mr Lewis agreed that, despite attention, this was still the case. He agreed to examine what further engagement or escalation had merit. A significant risk around the operational management and financial management capacity was discussed. It was noted that an innovative campaign had been devised which would target recruitment into those posts. Miss Barlow highlighted the potential of this risk to compromise delivery in some Groups in quarters 1 and 2. It was agreed that the amber risks presented could be managed locally by the Clinical Groups however the red risks would be added to the Board level Trust Risk Register as proposed.	
10.2 Ophthalmology privacy and dignity risk	**Verbal**
Mr Lewis reported that a meeting had been arranged to resolve the issue at which there was optimism that the issue would be resolved.	

10.3 Oncology contract with University Hospitals Birmingham NHS FT	**Verbal**
Dr Stedman reported that a bilateral meeting was planned to sign off the proposed contract in April and resolve some outstanding issues.	
11 Nurse staffing levels	**SWBTB (4/15) 062** **SWBTB (4/15) 062 (a)**
Mr Ovington reported that a meeting had been held with the TDA at their instigation to discuss and challenge the nurse staffing report. This had not materially altered the position nor the presentation format. The Board's attention was drawn to the quality indicators supplied for each ward to try and provide an integrated view. Mr Ovington drew attention to the use of more temporary staffing usage at night, as we had increased establishments. In Medicine, it was noted that for some of the wards at City Hospital, there was a paucity in the data recorded which needed to be investigated, especially as this data flowed directly from VitalPacs. Mr Kang asked for details on the sickness position, noting that some wards were reporting very high rates of sickness. It was noted that this was being considered and some targeted work was being undertaken to understand this position. Mr Lewis asked if we could convert the percentages readily into real number on shift. He illustrated this point by reference to Ward D7, noting that unless some staff worked part shifts it was difficult to calculate back to the figure presented. Mr Ovington was again pressed to remove the 'specialling' position would be removed. It was noted that it was difficult to extract the 'specialling' influence, however this would be attempted. Mr Lewis highlighted that the staffing information was very nurse orientated as mandated nationally and that work would be undertaken to review the trainee doctor position, consistent with our view of 'ward clinical teams'.	
ACTION: Mr Ovington to present revised staffing data at the May Board meeting. **ACTION: Ms Goodby to examine by October how we can seek to create a broader Safe Staffing report for the Trust.**	
12 Corporate integrated performance report	**SWBTB (4/15) 063** **SWBTB (4/15) 063 (a)**
Mr Waite highlighted that the Trust did not meet the emergency care target, with a full year position being 92.52%. The plan to address delayed transfers of care was discussed. Performance against the 18 weeks RTT target was pleasing with the backlog of patients having been achieved. It was noted that Trauma and Orthopaedics speciality remained underachieving. The infection control targets were reported to have been met. One case of MRSA was noted to have been	

reported in March. There had been no breaches of mixed sex accommodation regulations and there was an improvement of the mortality review process. Theatre cancellations was discussed, where a downward improvement was reported. It was noted that the Cardiology information was included in the IPR. It was reported that in terms of diagnostic waits, the positon was to be validated, however this appeared to be a major improvement on performance during the previous quarter. It was agreed that the perinatal mortality rate should be considered by the Quality & Safety Committee.	
ACTION: Dr Stedman to present the position in terms of perinatal mortality at the next meeting of the Quality & Safety Committee	
13 Financial performance – Month 11 and end of year forecast outturn	**SWBTB (4/15) 064** **SWBTB (4/15) 064 (a)**
Mr Waite reported that the external finance limit would be undershot by c.£100k and the CRL would fall short by £470k. A £4.6m surplus was reported to be expected. The Board was advised that the risks associated with the income from NHSE were reported to have been managed and Quarter 4 performance was better than plan, with the pay bill also having reduced.	
14 Annual Plan 2015/16	**SWBTB (4/15) 065** **SWBTB (4/15) 065 (a)**
The Board was asked to approve the annual plan 2015/16. This had been developed on the back of a three month long local directorate process. Mr Lewis noted that we were setting more, and more stretching goals for the year ahead, and asked for confirmation that the 30 areas of focus for the coming year were appropriate. It was suggested that ten of these be given monthly Board focus – as a Top Ten. He also highlighted the big increase in community related areas of focus. Mr Kang asked whether there was further work to align the plan to the CQC improvement plan and the Francis plan. It was noted that the CQC work was included within the annual plan. The communications around the plans were agreed to need careful consideration, however it was suggested that key focus was needed on the top ten priorities. It was acknowledged that 'plan overload' was a material risk in the organisation. Dr Gill noted that vacancy rates and the term risks were not included. Mr Lewis agreed to undertake some redrafting to bring these points to the fore. Mr Waite had raised similar concerns prior to the meeting. Mrs Rickards noted the culture change needed to address the sickness absence position, including a management response. Mr Lewis reported that return to	

work interviews needed to occur as a priority which it was noted had been shown to be effective in other organisations. It was noted that this was an objective where some immediate impact was necessary. The Board approved the plan, and detailed action plans would be developed for each, aligned to the BAF. The plan will be publicised with May payslips.	
15 Financial Plan 2015/16	**SWBTB (4/15) 066** **SWBTB (4/15) 066 (a)**
Mr Waite presented the initial financial plan for 2015/16, which had been reviewed at the Finance and Investment Committee that morning. The plan proposed a surplus consistent with the ten year LTFM and OBC for Midland Met. We had yet to achieve settled 15-16 contractual arrangements. Miss Barlow outlined progress with CIP plans by Group. Of 8 Groups we have confidence around 4, including corporate, and from the other four the progress in medicine was highlighted. The greatest concern related to the two Surgical Groups, and clarity would be aided by the finalisation of the Capacity Plan. Mr Waite highlighted the non-recurrent nature of our surplus, and that therefore the year ahead was again a challenging one. We needed to secure pay reductions at close to full year effect and accordingly he felt that pressing ahead now with our final phase workforce changes was a priority. Dr Stedman concurred with that view stressing that the position was not unexpected to clinicians, having been deferred from February pending the CQC report. The plan retains investment for improvement and a modest contingency would be carried, which should be sufficient for remedying CQC-related actions, as well as our own investment and improvement plans. Dr Sahota asked when the CIP schemes for 2015/16 would be signed off. He was advised that up to £8m of our savings remained to absolutely confirmed. Work in May and June would finalise this, with some a phasing to plans, and non-recurrent cover consistent with the Trust level plan being presented.	
16 Update from the meeting of Quality & Safety Committee held on 27 March 2015 and minutes from the meeting held on 27 February 2015	**SWBQS (2/15) 030**
Given Ms Dutton's apologies, Mr Samuda presented an overview of the key discussions from the Quality & Safety Committee meeting held on 30 January 2015.	
17 Safeguarding update	**SWBTB (4/15) 072** **SWBTB (4/15) 072 (a)**
The Board was asked to receive and note the safeguarding update. In terms of the level of ambition, it was suggested that the indicators needed to be focussed on the relevant staff rather than a generic position and the safeguarding group needed to be clear on indicators beyond training in	

safeguarding. Miss Barlow noted that there were additional data sets that could feed into the dashboard.	
ACTION: **Mr Ovington to develop more ambitious safeguarding plan indicators and present this at the June meeting of the full Board**	
18 Any Other Business	**Verbal**
The Board was asked to note that in respect of the Midland Met project, authorisation to proceed on a single bidder basis had been received from HMT.	
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 7 May 2015 and would be held in the Anne Gibson Boardroom, City Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 7 May 2015, Anne Gibson Boadroom, City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

2 April 2015, Nishkam Centre, Soho Rd, Birmingham

Members present: Mr R Samuda (RSM), Mrs G Hunjan (GH), Mr H Kang (HK), Dr S Sahota (SS), Dr P Gill (PG), Mr T Lewis (TL), Miss R Barlow (RB), Mr C Ovington (CO), Dr R Stedman (RST), Mr T Waite (TW)

In Attendance: Mr M Hoare (MH), Miss K Dhami (KD), Mrs R Goodby (RG), Mrs C Rickards (CR)

Apologies: Ms O Dutton (OD)

Secretariat: Mr Simon Grainger-Lloyd (SGL)

Last Updated: 1 May 2015

	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.333	Learning plan 2014-17	SWBTB (10/14) 164 SWBTB (10/14) 164 (a)	02-Oct-14	Schedule a discussion about the rolling slide pack showing organisational change for a future Board Informal session	SG-L	~~12/12/2014~~ ~~16/01/2015~~ 22/05/2015	Scheduled for the ~~December January February~~ May meeting	R
SWBTBACT.349	Reaudit of consent	SWBTB (2/15) 022 SWBTB (2/15) 022 (a)	05-Feb-15	Undertake the 'April' consent project as suggested by Mr Lewis	KD/RST	30/04/2015	Update included on the agenda of the May meeting	G
SWBTBACT.339	Trust risk register update	SWBTB (11/14) 190 SWBTB (11/14) 190 (a)	06-Nov-14	Consider the means of better publicising the Trust's maternity services	RW	30/04/2015	A number of activities have taken place to promote services including open days, videos online and on YouTube and publication of good news stories in the local media.	G
SWBTBACT.346	Chair's opening comments and Chief Executive's report	SWBTB (2/15) 021	05-Feb-15	Consider the promotion of Never Events success within public areas of the Trust	RW	30/04/2015	Consideration has been given to promotion of never events success. Some publicity took place around the one year anniversary of no never events including online, on social media, in local media, and with staff and stakeholders. It is not intended to display never events data routinely within public areas of the Trust	G
SWBTBACT.359	Nurse staffing levels	SWBTB (3/15) 043 SWBTB (3/15) 043 (a)	05-Mar-15	Revise the nurse staffing report from April to take into account comments made at the meeting	CO	02/04/2015	Revised as requested and included on the agenda of the April & May meetings	G

SWBTBACT.360	Trust response to controls for revised Never Events	SWBTB (3/15) 042 SWBTB (3/15) 042 (a)	05-Mar-15	Present an update on controls to prevent Never Events at the September meeting	KD	03/09/2015	ACTION NOT YET DUE	G
SWBTBACT.362	2020 plan	Hard copy	05-Mar-15	Arrange for the amendments based on the feedback received on the 2020 plan to be incorporated where relevant	TL	02/04/2015	Included on the agenda of ~~April~~ May meeting	G
SWBTBACT.363	Workforce change: safe and sound 2014-16	SWBTB (3/15) 052 SWBTB (3/15) 052 (a)	05-Mar-15	Circulate a lessons learned document from the Phase 1 of the Safe and Sound work	TL	30/04/2015	Included on the agenda of the May Private Board meeting	G
SWBTBACT.366	Update on Actions arising from Previous Meetings	SWBTB (3/15) 054 (a)	02-Apr-15	Present the Trust's position again peer exemplars in respect of pressure ulcers at the next meeting	CO	07/05/2015	Included on the agenda of the May meeting	G
SWBTBACT.367	Questions from members of the public	Verbal	02-Apr-15	Prepare a proposal for the display of public-facing patient information for discussion at the next meeting of the CLE	CO	28/04/2015	Proposal prepared and discussed at the April meeting of CLE - agreement reached that it was sensible to have a ward patient map in place however care should be taken to limit the detail available on public facing screens. The use of white screens showing only name and bed details was agreed to be a sensible approach.	G
SWBTBACT.368	Care Quality Commission's report and the Trust's improvement plan	SWBTB (4/15) 059 SWBTB (4/15) 059 (a) SWBTB (4/15) 059 (b)	02-Apr-15	Present the sickness plan at the Board's informal session in May	RG	22/05/2015	ACTION NOT YET DUE	G
SWBTBACT.369	Care Quality Commission's report and the Trust's improvement plan	SWBTB (4/15) 059 SWBTB (4/15) 059 (a) SWBTB (4/15) 059 (b)	02-Apr-15	Present the CQC Improvement Plan to the Trust Board and Quality & Safety Committee at forthcoming meetings. The Executive to consider and present KPIs for the five themes in due course.	KD	24/05/2015	Plan presented to QSC in April and to be picked us as part of CEO update at May Board meeting	G

SWBTBACT.370	Nurse staffing levels	SWBTB (4/15) 062 SWBTB (4/15) 062 (a)	02-Apr-15	Present revised staffing data at the May Board meeting	CO	07/05/2015	Included on the agenda of the May meeting	G
SWBTBACT.373	Safeguarding update	SWBTB (4/15) 072 SWBTB (4/15) 072 (a)	02-Apr-15	Develop more ambitious safeguarding plan indicators and present this at the June meeting of the full Board	CO	04/06/2015	ACTION NOT YET DUE	G
SWBTBACT.371	Nurse staffing levels	SWBTB (4/15) 062 SWBTB (4/15) 062 (a)	02-Apr-15	Examine by October how we can seek to create a broader Safe Staffing report for the Trust	RG	01/10/2015	ACTION NOT YET DUE	G
SWBTBACT.372	Corporate integrated performance report	SWBTB (4/15) 063 SWBTB (4/15) 063 (a)	02-Apr-15	Present the position in terms of perinatal mortality at the next meeting of the Quality & Safety Committee	RST	24/04/2015	Position discussed and reported that each case had been reviewed and had not been identified as being avoidable	G
SWBTBACT.330	Francis Report action plan – mid-year review	SWBTB (10/14) 161 SWBTB (10/14) 161 (a)	02-Oct-14	Make an assessment of the adequacy of the proposed end year position against the actions raised in connection with the Francis Report	KD	~~05/03/2015~~ 02/04/2015	Included on the agenda of the April meeting	B
SWBTBACT.354	Trust risk register update	SWBTB (2/15) 026 SWBTB (2/15) 026 (a)	05-Feb-15	Provide an update on progress with resolving the Ophthalmology privacy and dignity risk at the next meeting	TL	05/03/2015	Included on the agenda of the ~~March~~ April 2015 meeting	B
SWBTBACT.352	Corporate integrated dashboard	SWBTB (2/15) 024 SWBTB (2/15) 024 (a)	05-Feb-15	Present an update on falls at the next meeting of the Quality & Safety Committee	CO	27/02/2015	Discussed at the March meeting of the Quality & Safety Committee and verbal update due at the Board meeting scheduled for 2/4/15	B

SWBTBACT.361	Corporate integrated performance dashboard	SWBTB (3/15) 039 SWBTB (3/15) 039 (a)	05-Mar-15	Present an update on performance against the falls and pressure sores measures at the next meeting of the Quality & Safety Committee, and then at April's full Board meeting	CO	02/04/2015	Discussed at the March meeting of the Quality & Safety Committee and verbal update given at the Board meeting scheduled for 2/4/15	B
SWBTBACT.364	Trust response to the Fit and Proper Person Test	SWBTB (3/15) 038 SWBTB (3/15) 038 (a)	05-Mar-15	Devise a process for handling in year concerns raised under the Fit and Proper Persons regulations	KD	02/04/2015	Included on the agenda of the April meeting	B
SWBTBACT.365	Update on Actions arising from Previous Meetings	SWBTB (3/15) 054 (a)	02-Apr-15	Update the Fit and Proper Persons test processes to include timescales for resolution and handling	KD	30/04/2015	Process flow chart updated to include metrics	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

TRUST BOARD

DOCUMENT TITLE:	Pressure Ulcer Incidence Comparative Data
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Lesley McDonagh - Clinical Lead Nurse Tissue Viability
DATE OF MEETING:	7th May 2015

EXECUTIVE SUMMARY:

The Board see the actual numbers of pressure ulcers developed in the trust on a monthly basis, this is showing a reducing trend over recent years. The enclosed report demonstrates how we compare to our peers and nationally. In summary we have made good progress in reducing the incidence of pressure ulcers, but our rate and position as a trust compared to the national picture is within normal confidence levels, but with room to improve further.

REPORT RECOMMENDATION:

The recommendation is that the Board is asked to note the plan to continue with our intensified efforts of recent months to tackle this problem where it is avoidable

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		X

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

Financial		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:

Relates to our safety objectives and BAF

PREVIOUS CONSIDERATION:

Report commissioned at the last Board meeting.

SWBTB (5/15) 074 (a)

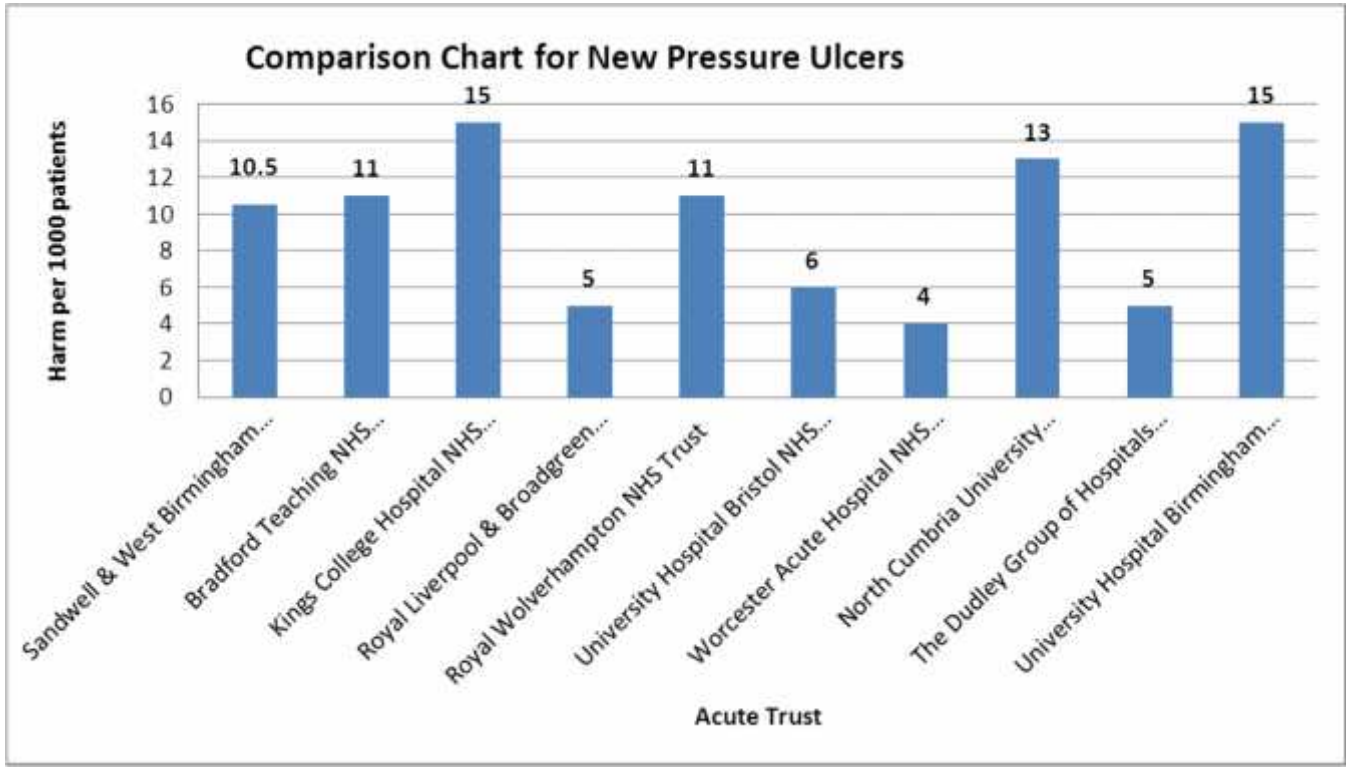
Sandwell and West Birmingham Hospitals NHS
NHS Trust

For Information

Pressure Ulcer Comparative Data
Report to Trust Board on 7th May 2015

- The Board will recall that we have been reducing numbers of pressure sores over quite some time.
- We submit our pressure ulcer data to the national safety thermometer on a monthly basis and the out put of this helps to inform our Integrated Performance Report, Harm Free Care dashboard
- Skin integrity is assessed using the Waterlow scoring system, in common with most trusts across the country, any pressure sores that develop, or are admitted to the Trust with an assessed grade of 3 or 4 from external sources are subject to detailed RCA and a table top review.
- We are starting a similar detailed review of grade 2 ulcers, on the basis that the severity of ulcers has reduced in number over all, and now there are more ulcers assessed at grade 2, an attempt to automate this assessment process using our safeguard system has also commenced, our aim in doing so is to have verified data within the month and reducing the month delay in reporting data ion the IPR.
- The first graph demonstrates the rate of ulcers reported by trusts per 1000 patients in a comparator group on the national safety thermometer over the last year
- All trusts are required to submit data to the safety thermometer, the second graph is a funnel ploy of all trusts over the last year, SWBH is clearly marked with a red dot. This demonstrates that we are within the normal confidence levels but at the upper end, and that more could be achieved to prevent ulcers from occurring.
- Our efforts to change to a new pressure relieving mattress and to ensure that all at risk patients have a robust care plan following their Waterlow assessment have intensified over recent months, this along with better reporting using safeguard will help us on this objective.

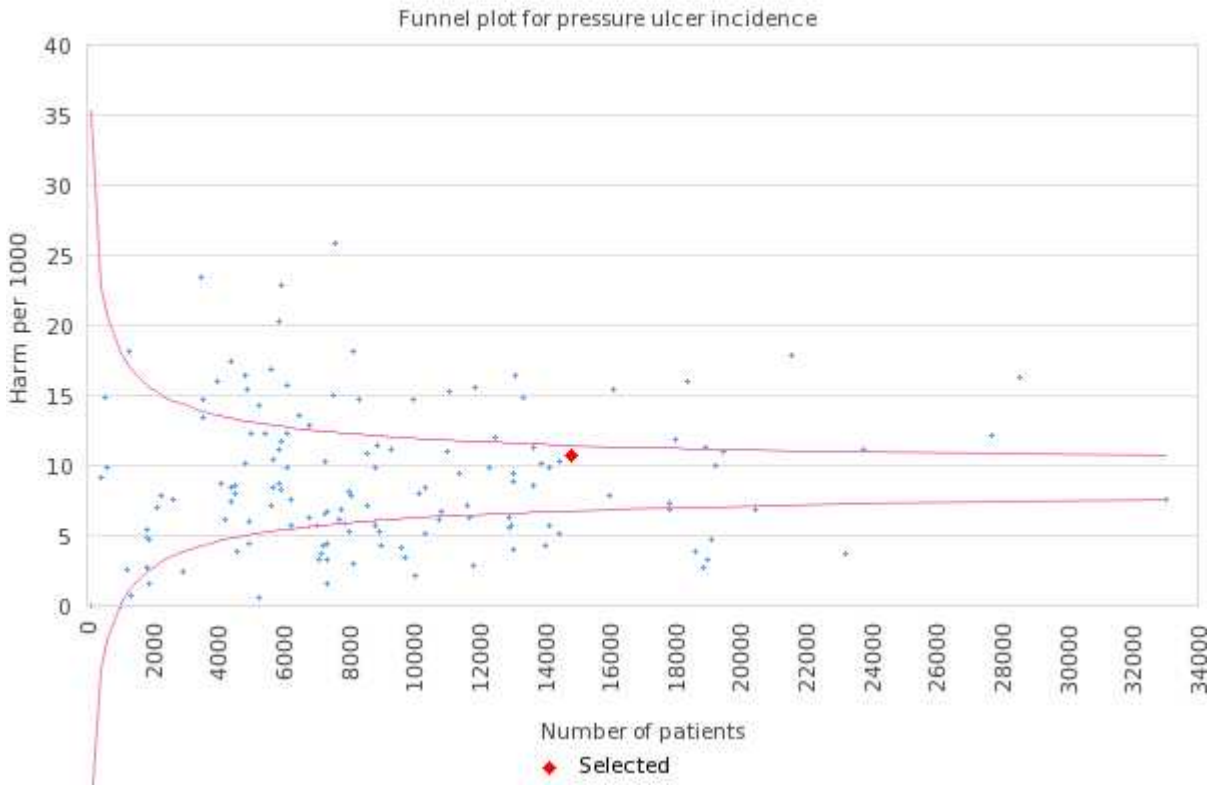
Graph 1 Comparison Chart for New Pressure Ulcers via Safety Thermometer Data Collection March 2014 –April 2015 Harm per 1000 patients



Sandwell & West Birmingham NHS Trust	10.5
Bradford Teaching NHS Foundation Trust	11
Kings College Hospital NHS Foundation Trust	15
Royal Liverpool & Broadgreen University NHS Foundation Trust	5
Royal Wolverhampton NHS Trust	11
University Hospital Bristol NHS Foundation Trust	6
Worcester Acute Hospital NHS Foundation Trust	4
North Cumbria University Hospitals NHS Trust	13
The Dudley Group of Hospitals NHS Trust	5
University Hospital Birmingham NHS Foundation Trust	15

Graph 2 Comparison Chart for New Pressure Ulcers via Safety Thermometer data collection March 2014 – April 2015

Sandwell & West Birmingham NHS Trust



Colin Ovington
Chief Nurse
30th April 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Never Event – Briefing Note**
SPONSOR (EXECUTIVE DIRECTOR):	**Dr Roger Stedman, Medical Director**
AUTHOR:	**Dr Roger Stedman, Medical Director**
DATE OF MEETING:	**7th May 2015**

EXECUTIVE SUMMARY:

A never event occurred on Monday 27th April 2015 in the BTC at City Hospital. Wrong site procedure for a patient undergoing extra corporeal shockwave lithotripsy.

The attached briefing note summarises the findings of the table top review which took place on Thursday 30th April 2015 – chaired by Dr Roger Stedman

REPORT RECOMMENDATION:

The Board is asked to receive and note the update.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Safe High Quality Care

PREVIOUS CONSIDERATION:

None

Briefing Note
Never Event – 27/04/2015
Wrong Site Extra Corporeal Shockwave Lithotripsy

Situation – On Monday 27th April 2015 a patient received 50 doses of extra corporeal shock wave lithotripsy (ESWL) therapy to the wrong side kidney. The error was caught and corrected and the patient went on to receive the remaining 1500 doses to the correct side. This has been classified as a no harm never event and reported on STEIS.

Background – ESWL is a procedure for treating kidney stones. It is a non-invasive procedure which involves focussing shockwaves on to the stones lodged in the kidney in order to shatter them without damaging the surrounding tissue. It is generally a very safe procedure although it is possible for tissue damage and bleeding to occur if excessive energies are used. It is normally carried out as an outpatient procedure under conscious sedation. At SWBH the procedure is carried out as a day case procedure in BTC in an operating theatre the equipment and operator are provided by a third party (Focus Medical Services Ltd). The procedure is overseen by nurses and doctors from the urology team and although takes place in theatres does not involve theatre staff. Kidney stones treated this way will normally be treated over a number of sessions (up to 4) over a period of time. Kidney stones can be a unilateral or bilateral disease, however only one side will be treated on any one occasion. If a patient has bilateral disease then the treatment course will be completed on one side before switching to the other for the remaining course. The decision to switch sides will be made on the day of treatment following check x-ray and ultrasound scan and discussion with the patient regarding symptoms.

Assessment – This incident involved a patient that has bilateral disease, they had already received two treatment episodes on the left side and the patient believed that he would be receiving treatment on the right side on this occasion. However following review of the x-rays it was decided by the clinical team that further treatment was required on the left side. The patient was informed and signed a consent form confirming that treatment was to be on the left side. On arrival in theatre at the 'sign in' and 'time out' stage (which are combined for procedures that don't involve anaesthetic) the patient said they were having treatment on the right side and was positioned on the table in order to receive right sided treatment. Treatment had commenced before it was realised by the attending nurse and registrar that the wrong side was being treated. At this point treatment was stopped, the patient was informed of the error, asked if they wished to continue treatment and re-positioned for treatment to continue on the correct side. A typical treatment involves between1500 and 2500 shocks delivered to the kidney over a 20 – 40 minute period, typically the energy of the shocks starts at a low level and is built up steadily as the patient tolerates. The error was spotted and corrected after 50 shocks which had been delivered at low energy levels – as a consequence of this the incident has been classified as a 'no harm' incident. The table top review has identified a number of contributory causes to this error for which a number of recommendations for change have resulted. A WHO checklist is carried out prior to the procedure – and was so on this occasion including the correct id check however it is clear from the table top review that not everyone in the treatment room (patient, nurse, doctor and operator) was aware of which was the correct side for the treatment in this case before treatment commenced.

Root Cause – Failure to carry out a sign in and time out procedure involving the whole team prior to commencing treatment.

Recommendations

1) Site marking – this is currently not widespread or normal practice – local policy will change with immediate effect to include site marking on the ward prior to moving the patient to theatre
2) Operating list information – With immediate effect the operating list on ORMIS will identify patients with bilateral disease and indicate if the decision of which side to operate will be made on the day of the procedure
3) Operating list order – currently patient admission is staggered and list order is changed as required throughout the day. It is recommended that all patients are admitted at the start of each session (am and pm) that lists on ORMIS are constructed with those requiring x-ray and laterlisation decisions towards the end of the session and that all patients are seen prior to team brief.
4) WHO checklist – it is recommended that a modified WHO checklist is developed for this procedure (as has been for other outpatient procedures) that combines sign in and time out and includes questions relevant to the procedure.
5) WHO checklist – with immediate effect the 'sign in' and 'time out' will be carried out with the patient sitting on a stool prior to positioning on the table and will involve all of the team, the patient and will be led by the ESWL machine operator.
6) Handover – It is recommended that a more robust handover process from ward to theatre is implemented for this procedure.
7) Duty of Candour – The patient has been informed and apologised to in person and a letter sent with a copy to the patient's GP.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE PUBLIC TRUST BOARD

Chief Executive's Report – May 2015

The Board's written agenda is dominated by two key long term decisions, which follow from last month's major decision to make a large Information Technology (IT) investment. We consider the final draft of our 2020 Vision, which we have been developing for the last year. In my view this synthesises our long term strategy and makes it explicit that bricks and mortar, and a new hospital, are a means to an end, not the end in itself.

Meanwhile, we face the latest approval hurdle for the new hospital in Smethwick – with submission to Whitehall departments of the final draft bid business case. We have until the end of June to receive permission to proceed. Meeting that timetable is consistent with the submission by Carillion of their planning application, and more importantly, with opening the new hospital in 2018-2019. Given the amount of change in the NHS, and turbulence in recent times, it is with some pride that the case is presented distinctively consistent with what we approved in November 2013. Delivery since of our finance and workforce plans, as well as maintenance of core standards, is the basis for our confidence in future implementation.

1. Our patients

After over a year without a never event, our meeting starts with discussion about one. The patient has not experienced harm, but we need to understand how this happened and how we can learn from it and prevent a similar incident happening again.

Following our discussions at the last public Board, we examine details of what would constitute outstanding performance in further reducing pressure ulcers. This discussion is, perhaps, a precursor to the safety plan that we will examine this summer, where in a number of areas we seek to identify ambitious, but feasible, specific goals for 2015-2018. Whilst setting such targets risks failure, their precision will concentrate our improvement efforts, and take us beyond the must dos that we explored in our Improvement Plan, arising from the CQC report.

During the last month the key step that we made towards that Improvement Plan's delivery, and the wider culture that we need, was our first Quality Improvement Half Day. Every service took time on the same afternoon to begin to discuss and plan, on a multi-professional basis, how services can be adapted and altered, often with small changes and incremental experiments, to drive up standards or improve patients' experience of care. These half days will happen monthly – and it must be encouraging that well over 1,500 employees participated in one last week, making this by some considerable distance one of the largest mobilisation activities in our Trust's history.

April has not seen improvement in waiting times in emergency care, and every conceivable effort continues to deliver what we achieved in April 2014. Sandwell wards closed norovirus, middle grade staffing issues, delayed transfers of care, and how we get the best from our teams working together remain the key factors in recent weeks. Rachel Barlow will outline the work that will begin on the ground in the week of May 18th to try to make concerted change in what can be delivered – but we

will not achieve sustainable change unless delayed transfers of care for Birmingham residents are significantly reduced.

When we look back at the end of 2015-2016 I very much hope that the detail behind our Capacity Plan, which we consider in the Board today, is seen to have been very important. This very detailed piece of work, using a methodology promoted nationally by the Intensive Support Team (IST), has been developed with clinical teams over the last three months. At a very granular level of detail this explains the changes we need to make and the scale we need to achieve if we are to (a) maintain current waiting times, which typically meet national standards (b) reduce first outpatient waiting times towards a guarantee of six weeks (c) support GPs who want to move care to the Trust from neighbouring organisation, especially for local residents.

2. Our workforce

The next month sees us begin a concerted drive to curb short term sickness in the organisation, consistent with our aim for the coming year to reduce rates of sickness by at least 1%. This is primarily a programme to create teams made up of our own staff, not temporary staff. It is also about fairness and about cost. The Board's workforce committee earlier this month explored the short and medium term actions needed to deliver, with a first step to ensure that return to work interviews are consistently delivered.

This month has seen us commence formal consultation on the final stage of our 2014 – 2016 workforce change programme, Safe and Sound. Though smaller than the work we consulted on last autumn, this second phase, which we delayed from its advertised date of February, is a significant undertaking. From our first phase we have successfully redeployed over 150 colleagues. We will work to achieve a similar success this spring and summer. In our first phase consultation, a quarter of proposed schemes were amended by feedback, and despite extensive pre-consultation with staff this year, I am sure we will see a similarly extensive and participative process. During May, our review of how the first phase schemes are going will be undertaken – testimony to our determination to change how we work, not simply to change our workforce.

NHS Employers, the umbrella organisation for health providers, profiled this month on its front page monthly briefing, the work this Trust is going on public health and health and wellbeing. The focus of their piece was on our projects and programmes to tackle mental health issues and stress among staff. Healthcare is inherently a challenging working environment, and we need to constantly endeavour to provide support to individuals and teams. Our widely praised conflict resolution training work, for example, is now being syndicated elsewhere.

3. Our partners

The Trust has achieved an agreed service contract for 2015-2016 with all major commissioners, including Sandwell and West Birmingham CCG. The arrangements in the year ahead are more akin to national terms and conditions than any previously entered into locally. Commissioners accept that the risk for demand side change sits with them. As a Trust we will look to implement the contract constructively, and with a clear focus on the long term sustainability of the local health and social care system. Our drive is not bringing in income, but going the right thing – so for example, we will continue to seek to redirect outpatient referrals that could be better provided in primary

care or with advice, despite the national incentives to simply accept the patient and see them in clinic.

The position for education contracts is not yet concluded, and no draft document has yet been put to the Trust by Health Education West Midlands. We do have an indicative idea about future funding, and are actively seeking to achieve the certainty that we have for services, and indeed for research projections.

The Trust is an initial stakeholder in the vanguard MCP which will cover several thousand patients in Handsworth, through Vitality. We are exploring with GP colleagues how this vehicle can be used, not only to tackle patterns of secondary care use, but also, critically, to address long term workforce issues in local general practice which are a crucial part of any 2020 vision or 2030 plan.

Constructive discussions continue with a range of local partner organisations, as we all seek to ensure that care integration locally is well delivered. We are working to provide support to a couple of under pressure services in Walsall, at the same time as working jointly with Dudley Group of Hospitals to secure a sustainable local interventional radiology service. This strong network ethos will be important to us as we aim to maintain local services, but ensure subspecialist care.

4. Our regulators

The Trust Development Authority visited our acute sites this month to undertake a hygiene standards visit. There were good practices identified, notably at Sandwell, however there were a number of areas for improvement, primarily but not exclusively in ward kitchens. Specific concern was raised about continued inconsistent hand hygiene and dust in high places. An action plan detailing actions has been developed, and indeed submitted. A large number of the improvements required were undertaken immediately on the day of the visit and the subsequent days. A revisit is planned for 18th May to provide an independent view of progress.

We continue discussions with the Care Quality Commission about our Improvement Plan, which we have formally submitted for approval as the requisite action plan that their processes require. Our children's community service, which the CQC could not rate last autumn because of errors in their process, will be inspected in late June 2015.

5. Our annual plan 2015/16 – top ten

The attached annex outlines the current state position with the highest priority items we agreed for the coming year in last month's annual plan. Whilst the overall programme will be reported quarterly and considered in detail at Board committees, the highest priorities should form a core part of our routine agenda.

Toby Lewis, Chief Executive
30 April 2015

ANNEX 1 - **Our annual plan 2015/16 – top ten**

Objective (listed by improvement quarter order)	Current state of planning	Improvement quarter	Success quarter	Likelihood of delivery assessment
Work within our agreed capacity plan for the year ahead	A detailed plan is in place, built bottom up, with significant clarity in most disciplines. Risks are well understood.	Q1	Q1-4	Planning Execution
Create balanced financial plan…	In the majority of teams we have a balanced plan, and understand how to deliver our pay savings. More clarity is needed on non-pay levers.	Q1	Q1-4	
Agree EPR OBC and initiate procurement process	We are on top of the position with the business case, but need to improve operational/IT integration in finalising the specifications next month.	Q1	Q1 and Q3	
Achieve the gains promised in our 10/10 programme	We can rapidly improve this position by concerted analysis of where this has succeeded and then replication of that learning in every ward.	Q2	Q2	
Implement our Rowley Regis expansion…	We have a consulted upon plan for the estate, with an identified number (2) of known unknowns to be resolved in the next two months.	Q2	Q3	
Cut sickness absence below 3.5%...	We think we know what works but cannot scale it to the impact required and need to embed an implementation plan	Q2	Q3 and Q4	
Reduce readmissions by 2% at Sandwell	We have made progress in 14-15 but need to scale our efforts and achieve operational grip	Q2	Q3-4	
Deliver our plans for significant improvements in our universal health visiting offer	We know the goal. We now need to scale the improvement at team level and adopt a clear change programme for year 1 and 2 review checks.	Q2	Q4	
Tackle caseload management in community teams	We have the tools to track DN, HV and midwife caseloads in place. We know need to agree on success and then frame trajectories.	Q3	Q4	
Reach financial close on the Midland Met	Our execution risk is amber because of the external interdependencies faced by this project.	Q4	Q4	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Midland Met Hospital - Appointment Business case
SPONSOR (EXECUTIVE DIRECTOR):	Toby Lewis, Chief Executive
AUTHOR:	Simon Cooke, Midland Met Project Manager
DATE OF MEETING:	7 May 2015

EXECUTIVE SUMMARY:

The Board is invited to consider and approve in principle the ABC.

The paper describes the key changes since OBC and invites the Board to consider four specific areas, focused both on the case itself and the coming months.

REPORT RECOMMENDATION:

The Board is recommended to approve the ABC, on the assurance that national approval conditions can be met, and that the conditions set out in our November 2013 approval remain extant. As such the Board is invited to:

(i) Agree that the ABC reflects the position of the Trust, within which negotiations with commissioners, partners and regulators should be progressed by the executive

(ii) That any changes to the ABC during regulatory consideration that vitiate the November 2013 conditions should be returned to the Board

(iii) That the Trust is committed to the timetable of approval and implementation outlined in the OBC and ABC, and sees significant risk for patient care were the timetable to be significantly delayed.

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	

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

21st century infrastructure

PREVIOUS CONSIDERATION:

Configuration Committee on 17 April 2015 and in private by the Board on 30 April 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Midland Metropolitan Hospital – Appointment Business Case

Report to the Trust Board – 7th May 2015

Overview:

The approval business case is a key stage in the journey to Midland Met opening in 2018.
The ABC has to be approved by the relevant authorities in June 2015, to permit us to proceed to final bid and approval of that stage in August 2015 – that then provides for financial close in January 2016, or the month before. The extant bid assumes some site access for works during both November and December 2015, consistent with the demolition and remediation work approved already by the Trust Board.

The attention of Board members is drawn to chapter 2 of the ABC. This sets out how the case meets the approval conditions sent to us by Government in July 2014, and revised in March 2015. It also explains the key changes since the Outline Business Case stage. A significant proportion of the ABC remains entirely consistent with the OBC.

The Configuration Committee of this Board has received and reviewed the ABC. The Workforce Committee of this Board has explored the delivery issues associated with our long term workforce plan.

The Board received a copy of the ABC on 30th April 2015. They were given assurance by the Director of Finance and Performance that the underlying financial assumptions remain unchanged.

Our financial and workforce assumptions have been adjusted to 2014-15 outturn and our plan for 2015-16.

The Board's attention is drawn to in particular:
- A CsRR of 3 is maintained throughout the base case.
- The level of CIP required over the decade remains a challenge for the Trust, with or without the MMH development.
- The parallel major investments in IT and workforce reform which are both essential and enabled by the case.
- The material retained estate investment on which Midland Met relies to provide community facilities for both local access and ambulatory outpatient care. Work on this is advanced at Rowley Regis and the City site, but further work is needed in 2015 to capture the final form for the 'Sandwell Treatment Centre'.

The New Hospital Project Director gave the Board assurance with regard to the Draft Final Bid received and evaluated in April. In particular

- The Bid was compliant in all key deliverables and is sufficiently robust to commence the process to close dialogue
- There had been significant progress and improvement in the Design Development since the interim submission in December

- A small number of issues were identified in the evaluation which requires further work prior to submission of the Final Bid.
- The bidder has received feedback on these issue and they have already commenced work to resolve.

A summary of the key project milestones was reported to the Board and is given below.

Milestone	Date
Submission of Generic Appointment Business Case	May 2015
Approval of Generic Appointment Business Case and Close Dialogue	June 2015
Receipt of Final Bid	July 2015
Submission of Specific Appointment Business Case	July 2015
Approval of Specific Appointment Business Case and Appoint Preferred Bidder	August 2015
Submission of Confirmatory Business Case	October 2015
Approval of Confirmatory Business Case	November 2015
Financial close	December 2015
MMH handed over to Trust	July 2018
MMH operational	October 2018

Our stakeholders continue to express strong support for the scheme.

The approval route in May and June is short. A stakeholder board has been convened which will oversee the process. The risk of delay is real.

The Evaluation report of the Draft Final Bid was also received and noted by the Board on 30th April 2015.

Having received the ABC and the Evaluation report the Board approved the recommendation to commence the process of closing dialogue.

Alan Kenny
New Hospital Project Director

SWBTB (5/15) 059 (b)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Midland Metropolitan Hospital

Appointment Business Case

May 2015

Where EVERYONE Matters

right care right here

DOCUMENT CONTROL SHEET

VERSION	DATE	COMMENTS
0.01	29/03/15	Andrea Graham's first draft to 29/03/15. Sections inserted, first edit and queries raised.
0.02	07/04/15	All sections inserted pending Chapters 14, 17 and 18. Simon Cook's edit included. First draft of Executive summary. Issued to Toby Lewis for comment.
0.03	10/04/15	Chapters 18 and 19 and content for Chapter 9 from Simon Cook added, Toby Lewis edit, appendices referenced. Issued to Configuration Committee (17 April 2015) for comment.
0.04	21/04/15	Simon Cook's addition of Chapters 18 and 19
0.05	21/04/15	Addition of Workforce Chapter, Andrea Graham restructure and early edit
0.06	22/04/15	Clean version for Simon Cook edit
0.07	22/04/15	Addition of Finance section, Andrea Graham format and edit
0.08	22/04/15	Tracked changes from Simon Cook and performance
0.09	26/04/15	Tracked changes from Simon Cook (activity and final adjustments)
0.10	27/04/15	Final team amendments

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1 Executive Summary

1.1 Introduction

1.1.1 This (Generic) version of the Appointment Business Case seeks approval for Closure of Dialogue subsequent to the satisfactory evaluation of a good Draft Final Bid from a single bidder. This would enable the procurement of the Midland Metropolitan Hospital to progress towards the next stage of appointing a Preferred Bidder under the Government's new Private Finance 2 arrangements.

1.1.2 The document demonstrates that the case presented by the Outline Business Case remains strong with increasing drivers to make the changes proposed by the Right Care, Right Here Programme and develop a new acute hospital without delay. The proposals align with the direction proposed in NHS England's Five Year Forward View published in October 2014 and local support for the project continues to be substantial.

1.1.3 Much of the document restates, where appropriate, the case made at Outline Business Case and demonstrates that the key drivers for the project, its scope, deliverability and affordability remain unaltered and in some instances are strengthened.

1.1.4 The key areas where the Appointment Business Case develops the Outline Business Case further are:

- The procurement route and strategy (in particular handling the implications of a single bidder from Interim Bid Submission);
- The bidder solution;
- Affordability (including a refresh of the long term financial model, activity and income projections, cost improvement plan and downside scenario); and
- The Workforce model.

1.2 The Strategic Context

1.2.1 The strategic context remains largely unaltered since the Outline Business Case in terms of the population needs, commissioner and provider landscape and national policy. Since Outline Business Case approval the NHS Five Year Forward View has been published, which emphasises the need for closer integration and the breaking down of barriers between care settings. The Right Care, Right Here Programme and the Midland Metropolitan Hospital Project closely align with this agenda. This is reflected in the Trust's plans to restrict the scale of its acute business and grow its community services.

The Population Served by the Trust

1.2.2 The total population served by Sandwell and West Birmingham Clinical Commissioning Group is expected to increase by 6% over the next 20 years. A 16% increase in the number of children and young people in Birmingham is forecast over the same period. The increase in people over 65 years of age will be markedly lower than England but the increase in local residents over 85 will be significant.

Diversity

1.2.3 The Trust delivers services to a population with a significantly higher proportion of black and minority ethnic and other minority ethnic groups than England as a whole. The Heart of Birmingham area has

the largest (68%) black and minority ethnic population in England, with the largest group being of Pakistani origin.

1.2.4 The Sandwell population is also becoming more ethnically diverse. In the ten years between 1991 and 2001 the black and minority ethnic population increased by 6% to 20%, with the rate of growth being most pronounced amongst the Asian communities.

1.2.5 The implications for the Trust are that services need to be culturally sensitive, accessible to all, tailored to specific needs, appropriate for different religious beliefs and supported by interpreting services where necessary.

1.2.6 The Trust will deliver services to people with increased levels of prevalence for certain conditions such as diabetes, eye disease and cardiovascular disease

1.2.7 The Trust has a strong track record in the management of long term conditions, for example:

- It is an award winning rheumatology centre of excellence;
- Both acute and community specialist respiratory services are provided by the Trust;
- The Diabetes Team has won the national innovation award for integrated care; and
- The King's Fund commends iCares, an admission avoidance older people's team, as a national exemplar.

Deprivation and Poor Health

1.2.8 The population served by the Trust is dominated by high levels of deprivation. When ranked on the English Indices of Deprivation - of 354 English local authorities, Birmingham is the 9th and Sandwell is the 12th most deprived. There are a significant number of wards in the worst 20% nationally.

1.2.9 In 2014 the Trust published its own three year Public Health Strategy which focuses on health and wealth in the local community and in the workforce. The Chief Executive of Public Health England has praised the approach and commended it to other provider organisations. A Board level committee, chaired by the Trust Chairman, oversees the public health and community development agenda.

1.2.10 The Trust's regeneration work extends beyond the procurement of the new hospital project into wider community activities across the hospital sites.

1.2.11 The table below gives a summary of key health and lifestyle indicators per 100,000 population. With the exception of the numbers of adults who smoke in Birmingham, all the figures are significantly worse than the average for England.

Table 1: Key Health and Lifestyle Indicators

Indicator (per 100,000 population)	Birmingham	Sandwell	England Average
Infant deaths	8.25	8.46	4.84
Deaths from smoking	248.10	280.50	206.80
Early deaths: heart disease and stroke	96.80	110.90	74.80
Early deaths: Cancer	123.20	135.10	114.00
People diagnosed with diabetes	5.12	5.63	4.30

Indicator (per 100,000 population)	Birmingham	Sandwell	England Average
Adults who smoke	22.50	27.50	22.20
Hospital stays due to alcohol	1,940	2,180	1,580
Obese adults	26.80	29.10	24.20
Obese children	10.80	12.90	9.60
Teenage pregnancies (under 18s)	52.10	59.10	40.90

National Context and Right Care, Right Here Programme

National Policy

1.2.12 The Francis Inquiry report (February 2013), examined the causes of the failings in care at the Mid Staffordshire NHS Foundation Trust between 2005 and 2009 making 290 recommendations, including the need for:

- Openness, transparency and candour throughout the healthcare system (including a statutory duty of candour), fundamental standards for healthcare providers; and
- Improved support for compassionate, committed care and stronger healthcare leadership.

1.2.13 A number of other reports including: the Berwick Report, 'A Promise to Learn a Commitment to Act', (August 2013), driving patient safety and 'Compassion in Practice' (December 2012) – the Vision for nurses, midwives and care-staff, have built on the recommendations of the Francis Report to embed a new focus on quality, safety and compassion in healthcare.

1.2.14 The Keogh Report: 'Transforming Urgent and Emergency Care Services in England, End of Phase One Report' (November 2013), was commissioned in response to concern that A&E Departments, associated acute hospital services and ambulance services are under intense, growing and unsustainable pressure.

1.2.15 The report describes the following vision:

- People with urgent but non-life threatening needs should receive highly responsive, effective and personalised services outside of hospital. These services should deliver care in, or as close to, people's homes as possible, minimising disruption and inconvenience for patients and their families.
- People with more serious or life threatening emergency needs should be treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery. Getting the out of hospital services right will relieve pressure on hospital based emergency services to enable delivery of this part of the vision.

1.2.16 The Better Care Fund provides an opportunity to transform local services so that people are provided with better integrated care supported by funding to help local areas manage pressures and improve long term sustainability. The Trust is represented on the Sandwell Integration Board and contributes to the West Birmingham sub-committee of the Birmingham Better Care Fund. Over the period to 2030 the Trust will to play a key role in avoiding admission and the business case for a new hospital is not predicated on net growth in admitted care.

1.2.17 The NHS Five Year Forward View, published in October 2014, sets out how the NHS needs to change proposing a more engaged relationship between patients, carers and staff in order to focus on wellbeing and prevention. The 3 main conclusions are:

- There should be more focus on prevention and public health;
- Patients need to be given more control over their own care; and
- Barriers need to be removed on how care is provided between primary care and hospitals; between physical and mental health; and between health and social care.

1.2.18 The report also emphasises that continued efficiencies of circa 2% per annum will be required and that new models of care will need to be developed to meet this challenge.

1.2.19 The Trust's 2020 Vision summary, developed collaboratively over the last 12 months, aligns well with this agenda. It reflects in full the plans for the new hospital. The outpatient improvement work in particular, overseen by a fortnightly board chaired by the Chief Executive, is implementing changes to the model of care designed to support a highly localised multi-site planned care strategy.

1.2.20 In 2013 the Trust changed the acute care model to make it identical on both hospital sites in preparation for a single site delivery system in 2018.

1.2.21 The 2020 Vision presented below has at its heart the definition of coordinated care consulted upon by National Voices.

'We will become renowned as the best integrated care organisation in the NHS by 2020.'

The Right Care Right Here Programme

1.2.1 The Trust is a founding member of the Right Care, Right Here Partnership. All partners have shown exceptional levels of commitment over the ten years of the programme. The current partners are:

- Sandwell and West Birmingham Clinical Commissioning Group;
- Sandwell and West Birmingham Hospitals NHS Trust;
- Black Country Partnership NHS Foundation Trust;
- Birmingham Community Healthcare NHS Trust;
- Birmingham and Solihull Mental Health NHS Foundation Trust;
- Birmingham City Council; and
- Sandwell Metropolitan Borough Council.

1.2.2 The Right Care, Right Here Programme continues to align with national policy with objectives to:

- Redesign services to meet the needs of the local populations;
- Ensure that people have the opportunity to benefit from healthier lifestyles;
- Expand services in community settings, bringing appropriate elements of care closer to home and integrating provision such that patients experience seamless care pathways;
- Develop new highly specialised acute hospital services to be provided in the Midland Metropolitan Hospital;

- Procure, build and commission the Midland Metropolitan Hospital on a brown field site in Smethwick; and
- Maximise opportunities for regeneration in the local area.

1.2.3 The programme governance of Right Care, Right Here has been fully reviewed over the last twelve months. The board now incorporates primary care providers including the local Vanguard Site.

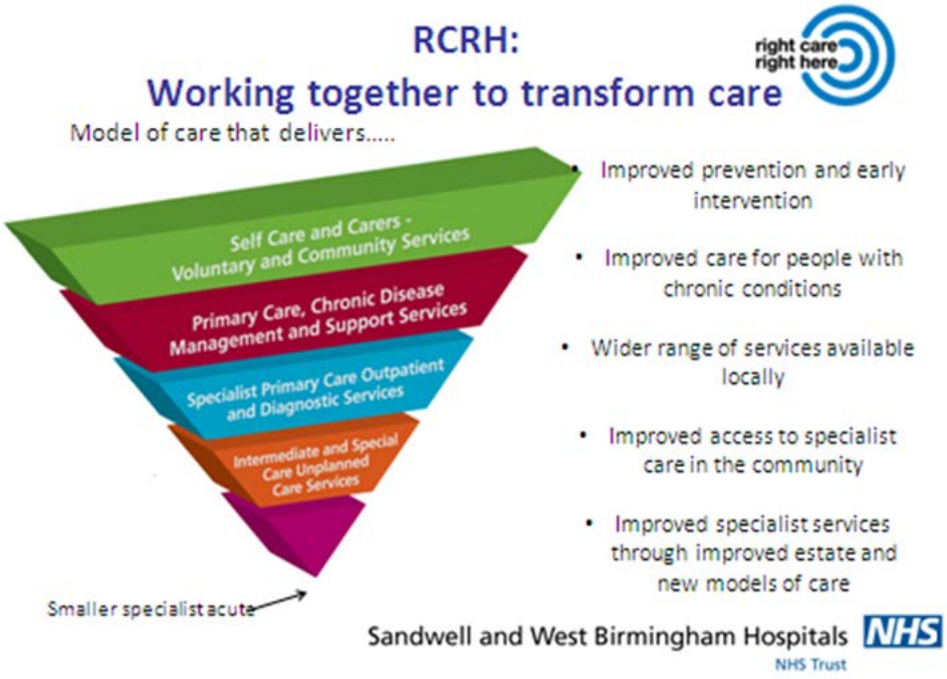
1.2.4 The Trust is meeting a significant portion of the cost of the Right Care, Right Here Programme because it is seen as instrumental in delivery of the changes required for the future.

1.2.5 The Right Care, Right Here Programme Board will act as the client for the 2017 Readiness Review in preparation for occupation of the new hospital site. All partners will consider together any mitigations needed to be ready to migrate to the new model of care in October 2018.

1.2.6 The approach and support the Trust has through Right Care, Right Here was described by the 2014 Gateway Review as a model for other schemes in the country.

1.2.7 The figure below presents an overview of the Right Care, Right Here model of care showing the important role the new hospital will have in the overall model of care.

Figure 1: Right Care, Right Here Model of Care



The Trust

1.2.8 Sandwell and West Birmingham Hospitals NHS Trust (the Trust) is an integrated care organisation dedicated to improving the lives of local people, to maintaining an outstanding reputation for teaching and education and to embedding innovation and research.

1.2.9 The table below summarises the key facts about the Trust.

Table 2: Key Facts about the Trust

Population served	530,000
Annual turnover	£447m million (2014/15)
Number of sites	Two acute sites and three main community locations
Current CQC Rating	'Requires improvement'
Current TDA Rating	Level 3

1.2.10 The Trust provides acute and specialist services from City Hospital in Birmingham and Sandwell General Hospital in West Bromwich. Emergency care, including A&E services is provided at both sites. In addition, the Trust provides comprehensive community services to over 300,000 people in the Sandwell area from more than 150 locations.

1.2.11 The Trust's strategic objectives, which align closely with national policy and the Right Care, Right Here vision, are presented in the table below.

Table 3: The Trust's Strategic Objectives

Strategic Objective	Description
Safe, high quality care	We will provide the highest quality clinical care. We will achieve the goals of safety, clinical effectiveness and patient experience set out in our quality strategy.
Accessible and responsive care	We will provide services that are quick and convenient to use and responsive to individual needs. They will be accessible to all ages and demographics. Patients will be fully involved in their design.
Care closer to home	Working in partnership with primary and social care we will deliver an increasing range of seamless and integrated services across hospital and community settings.
Good use of resources	We will make good use of public money. On a set of key measures we will be among the most efficient trusts of our size and type.
21st Century Infrastructure	We will ensure our services are provided from buildings fit for 21st century healthcare. We will make the most effective use of technology to drive improvements in quality and efficiency.
An engaged, effective organisation	An engaged and effective NHS organisation will underpin all we do. We will become an NHS foundation trust at the earliest opportunity. We will develop our workforce, promote education, training and research, and make the most effective use of technology to drive improvements in quality and efficiency.

1.3 The Case for Change

1.3.1 The case for change remains relevant and valid and has become more urgent with the increasing demands upon providers to raise standards of care against a backdrop of diminishing resources and increasing patient needs.

1.3.2 The Trust and local partners in the Right Care, Right Here Programme agree that there is a clear case for change as summarised below:

- First and foremost, the Trust cannot sustain services and can't meet Keogh recommendations on emergency care, operating acute services for adults and children from two sites.

- The poor health of the residents in the Trust's catchment area makes the case for change in the model of care to focus on prevention. The Right Care, Right Here Programme has developed plans to deliver these changes. A new single site acute hospital is central to successful delivery of these plans.
- Major changes in primary and community care make the case for development of a new acute hospital with capacity aligned to the activity model agreed by the Right Care, Right Here Programme.
- Due to the condition of the current estate the provision of a suitable environment for patients and staff will require investment in new hospital facilities.
- The preference for care closer to home and expansion of patient choice makes the case for delivering new services closer to home, building state of the art hospital facilities; and developing a high quality workforce.

1.4 The Future Service Requirement

1.4.1 The Right Care, Right Here vision for the future and the strong case for change have informed the development of a new model of care for the future underpinned by an activity and capacity model agreed by partners across the local health and social care economy.

1.4.2 The implications of the Right Care, Right Here vision for the Trust continues to be that:

- The majority of outpatient attendances and planned diagnostics will be provided outside the acute hospital in community locations. The existing two hospital sites will become community locations.
- A greater proportion of inpatient length of stay will be provided in the Trust's intermediate care beds. In the last twelve months the Trust has successfully won two tenders to deliver intermediate care services and operates the information hub through which all beds in Sandwell operate.
- There will be a significant reduction in average length of stay because we are able to deliver consultant based inpatient medicine.
- There will be a modest catchment loss for emergency inpatient activity related to the change in location of the acute hospital. The Trust's partnership with Dudley Group of Hospitals and Walsall Healthcare (the Black Country Alliance) will ensure that this transition is managed collaboratively and to time.
- There will be increased community-based urgent care and out-of-hours services to provide alternatives to attending the Emergency Department. The Trust will provide a major Urgent Care Centre (already built) on the Sandwell Hospital site.
- The Trust will also provide an Urgent Care Centre with the MMH co-located to the Emergency Department.
- There will be increased day surgery rates with the majority of adult day surgery being provided in dedicated day surgery units in the Birmingham Treatment Centre, Sandwell Treatment Centre and Birmingham and Midland Eye Centre.
- Better physical environments will be required for service users and staff which will encourage more rapid recovery and provide greater privacy and dignity.
- In partnership with our host CCG the service development plan includes repatriation of activity from other neighbouring trusts where clinically appropriate to provide a more local service for patients.

- The development of a new single site acute hospital is required allowing consolidation of acute emergency and inpatient services. This includes co-locating paediatric, neonatal, maternity and gynaecology services.

1.4.3 The greater proportion of patients attending for acute care will therefore be acutely unwell, have complex conditions or require the most specialist assessment and treatment. Development of a new acute hospital to meet these needs by bringing specialist staff together on one site is therefore an essential part of the model of care.

1.4.4 The activity and capacity model has formed the basis for calculating the clinical facilities required within the new hospital.

Table 4: Activity 2019/20

Category	Type	MMH	Community Facilities	Total
Admitted Patient Care	Elective Inpatients	8,142	0	8,142
	Day Cases	7,006	37,961	44,967
	Emergencies (inc intermediate care)	56,917	3,303	60,221
	Occupied Bed Days	211,535	51,257	262,793
Outpatients	New Outpatients	31,361	163,381	194,742
	Review Outpatients	27,888	317,857	345,745
	OP with Procedure	18,008	43,158	61,166
	Virtual Outpatients	1,928	22,214	24,142
	Maternity	18,739	0	18,739
Other	A&E Attendances	127,652	32,151	159,803
	Urgent Care	36,628	38,639	75,266
Capacity	Beds	669	148	817
Community	Contacts	0	880,805	880,805

1.4.5 The following summarises the key components that were specified to bidders as required for the Midland Metropolitan hospital:

1.4.6 A total of 669 beds, including:

- A 30 Bed Critical Care Unit (Level 2 and 3);
- 117 space Adult Acute Assessment Unit;
- 36 Neonatal Cots; and
- A 56 bed Children's Unit.

1.4.7 14 Generic Wards of 32 beds each, including:

- 14 Coronary Care Beds; and
- 16 distributed higher dependency monitored beds (Level 1);

1.4.8 13 Operating Theatres, comprising:

- 2 Trauma Theatres;
- 2 Emergency Theatres (including laparoscopic equipment);
- 2 Maternity Theatres in Delivery Suite; and
- 7 Elective Theatres;

1.4.9 Bespoke outpatient clinics for:

- Children;
- Urodynamics; and
- Antenatal services.

1.5 Project Objectives

1.5.1 The project objectives, summarised below, have not changed since approval of the Outline Business Case in July 2014:

- To move to a single acute hospital site;
- To develop a new high quality hospital building;
- To implement a new model of care to;
- To deliver the best possible quality of care; and
- To develop staff and provide an optimal working environment.

1.6 Economic Case

1.6.1 The economic case has not changed since the Outline Business Case was approved in July 2014.

The Options

1.6.2 The following four potential options were shortlisted to determine the strategic solution required to meet the strong case for change:

Option One: Do Minimum

1.6.3 This option would involve significant refurbishment of both the City and Sandwell Hospital sites resulting in a three-year delay as service provision would need to continue on the sites being redeveloped. Services would be delivered by splitting emergency care and elective inpatient care between the sites and would therefore continue to provide a dysfunctional model of care with significantly higher revenue costs.

Option Two: City Site Redevelopment

1.6.4 This option is similar to the Grove Lane option, although capital costs would be higher and build time would be two to three years longer in duration.

Option Three: Sandwell Site Redevelopment

1.6.5 This option is similar to Option Two, however, capital costs would be greater and the timescale would be one year longer due to the complexity inherent in a very confined site.

Option Four: New Build on the Grove Lane Site

1.6.6 This option required purchase of land through a compulsory purchase order to develop a new acute hospital. Limited refurbishment would be required on retained hospital estate.

1.6.7 A do nothing option was also described to serve as a baseline for assessment of costs.

Background to the Option Appraisal

1.6.8 The original non-financial appraisal was undertaken after the public consultation in April 2007.

1.6.9 Version 2 of the Outline Business Case, approved by the Department of Health in August 2009, contained a comprehensive economic appraisal across the four options to determine which option was the preferred solution. This approval enabled the decision to pursue a compulsory purchase order to facilitate acquisition of the Grove Lane site (Option Four). The Trust now owns the entire site.

1.6.10 The Trust refreshed the economic appraisal of the four options and the Do Nothing scenario for the Outline Business Case approved in July 2014. The conclusion was that Option 4 remained the preferred option. The procurement of the Midland Metropolitan Hospital was initiated on this basis.

1.6.11 Since the approval of the Outline Business Case in July 2014 there have been no changes in the underlying assumptions used to make the assessment and therefore the assessment still stands.

Economic Appraisal

1.6.12 The detailed appraisal in both non-financial and economic terms showed that the preferred solution was the development of a new acute hospital on the Grove Lane site. The results of the appraisal (at a 2013/14 price base) is summarised in the tables below.

Table 5: Combined Economic and Non-Financial Scores (Over 66 Years)

Economic Impact Appraisal Period 66 Years All Options	Option Do Nothing	Option 1 Do Minimum	Option 2 City Site	Option 3 Sandwell Site	Option 4 Grove Lane
EAC (£000)	599,081.7	614,812.6	611,470.9	612,962.3	607,221.2
Benefit Point	47.6	51.0	76.9	72.5	84.3
EAC per Benefit Point (£000)	12,581.10	12,044.52	7,954.31	8,453.71	7,204.79
Rank	5	4	2	3	1
Margin (%)	74.6%	67.2%	10.4%	17.3%	0.0%

Table 6: Combined Economic and Non-Financial Scores (Over 36 Years)

Economic Impact Appraisal Period 36 Years All Options	Option Do Nothing	Option 1 Do Minimum	Option 2 City Site	Option 3 Sandwell Site	Option 4 Grove Lane
EAC (£000)	532,386	545,388	543,444	544,612	539,577
Benefit Point	47.6	51.0	76.9	72.5	84.3
EAC per Benefit Point (£000)	11,180.5	10,684.5	7,069.4	7,511.1	6,402.2
Rank	5	4	2	3	1

Economic Impact Appraisal Period 36 Years All Options	Option Do Nothing	Option 1 Do Minimum	Option 2 City Site	Option 3 Sandwell Site	Option 4 Grove Lane
Margin (%)	74.6%	66.9%	10.4%	17.3%	0.0%

1.6.13 Both of the combined economic and non-financial scores show Grove Lane to be the preferred option by a margin of circa 10% compared with Option 2, City Site Redevelopment.

Health Economic Benefits Assessment

1.6.14 In 2011 the Trust undertook an exercise to quantify selected non-financial external health and regeneration benefits for the Do Nothing, Do Minimum and Grove Lane options.

1.6.15 The analysis was reviewed in February 2014 and concluded that the Option 4 Net Present Value is circa 1% favourable to Option 2. This is strengthened to 4% of Net Present Value once regeneration benefits are taken into account.

1.6.16 It also demonstrates that sufficient health and regeneration benefits are delivered to offset the additional net present costs incurred compared with either a Do Nothing or Do Minimum options.

Conclusion

1.6.17 This review and refresh of the economic case reconfirms the original conclusion that Option 4: Grove Lane is the appropriate preferred option.

1.6.18 There have been no changes in the underlying assumptions to this assessment since the Outline Business Case and therefore this analysis remains valid.

1.7 The Procurement Route

1.7.1 The Trust is procuring the Midland Metropolitan Hospital through the Government's new approach to the delivery of private finance into public infrastructure and services - Private Finance 2 (PF2). The Outline Business Case demonstrated this procurement route to be better value for money than using a public sector approach.

1.7.2 The Trust has followed the Competitive Dialogue procedure to enable it to work with Bidders in a competitive environment to develop high quality solutions that will meet the Trust's requirements and provide best value for money. This approach complies with European procurement law.

The Single Bidder Situation

1.7.3 The Invitation to Participate in Dialogue was issued to 3 bidders following the pre-qualification process. However, one bidder (Balfour Beatty) withdrew immediately after issue.

1.7.4 Although Momentum Healthcare (Laing O'Rourke / Interserve) engaged in the early part of dialogue it did not submit a response by the interim submission deadline and was therefore was deemed to have withdrawn.

1.7.5 This left Carillion, (The Hospital Company), as a single remaining bidder.

1.7.6 This presented the Trust with both a challenge and an opportunity:

- The lack of competition may compromise the ability to improve the quality of the bid at Preferred Bidder and may prevent the Trust from securing the best possible value for money;
- However, there was an opportunity to de-risk the programme by bringing financial close earlier, thus making the Oct 2018 hospital operational date more viable and enabling better value for money.

1.7.7 Although continuing with the Private Finance 2 procurement with a single bidder was legal, on 16th January 2015 the Trust Board reassessed which procurement options would best achieve its objectives and secure a value for money solution.

1.7.8 The option of re-procuring via Private Finance 2 was discounted given that this would be likely to result in a similar or worse outcome. The market appetite was unlikely to have improved significantly so recently after the current procurement. Therefore, in reappraising the procurement route, there were 2 main options available for the Trust, either to:

- Abort the existing procurement and re-procure with a conventional public sector approach such as ProCure 21+ (assuming that the Trust would purchase the Interim Bid design from The Hospital Company); or
- Continue with Private Finance 2 with additional measures to mitigate against the potential implications of a single bidder scenario.

1.7.9 The Trust tested which of the above two procurement routes was the best means of the Trust achieving its strategic objectives as summarised in the table below.

Table 7: Option Evaluation- PF2 versus P21+

Criteria	PF2	P21+
Quality of solution	Current solution evaluated as compliant and 'above the line' with plan in place to address Trust's 'red issues'. PF2 contract incentivises private sector to deliver integrated design which takes account of lifecycle and is inherently more efficient to run.	Reasonable to expect that the solution would be 'above the line'. Trust takes risk on functionality, ongoing maintenance and fabric of the building. Therefore incumbent on Trust to integrate the design with lifecycle considerations.
Delivery timescales	Operational by October 2018	Operational by October 2019
Affordability	Affordable with overall Continuity of Service Risk Rating (CSRR) of 4 and £11m surplus forecast in 2020/21	Affordable with overall CSRR of 4 and £8.3m surplus forecast in 2020/21

Criteria	PF2	P21+
Risks	The Trust may not be able to drive the quality of the solution to the extent that would have been possible under ongoing competition. However, the bid is currently 'above the line' and resolution of the outstanding areas of concern would be a condition of continuing the procurement. The Trust may not be able to secure and demonstrate that it has the best price. However, this would be largely mitigated through the additional measures proposed. There is a risk of the single bidder withdrawing / failing to provide a compliant bid. This is assessed as low given that the bidder already has sunk bid costs of £1.9m and is expecting to commit a further £3.8m before financial close.	There is a risk that the Trust would not secure the necessary public funding. There is a risk that more time would be required to address the design issues in the exemplar design, adding further delay, if the Trust did not buy the design from The Hospital Company. There is a risk that the construction programme would take longer than the assumed 31 months due to the lack of competitive pressure. Clearly the Trust would have the risk of the functionality and availability of the hospital and the ongoing maintenance. However, this has been priced into the VfM comparison below. There is a risk of needing to pay bid costs to the current bidder which is circa £1.9m. It is expected that the bidder would claim for costs given that its bid is compliant.
VfM	A quantitative analysis shows that the PF2 option is 19.1% better value for money than the P21+ option. The PF2 option has a total risk adjusted NPV of £366m.	A quantitative analysis shows that the PF2 option is 19.1% better value for money than the P21+ option. The P21+ option has a total risk adjusted NPV of £434m.

1.7.10 The Trust Board determined that it was in the Trust's best interests to continue the existing procurement with some additional mitigations to counter the issues described above. These mitigations drive quality, control cost and thereby safeguard value for money.

1.7.11 The Department of Health and HM Treasury were closely involved in the development and approval of the single bidder. The Trust set out the additional requirements of the bidder in procurement documentation which was approved by the DH and accepted by the bidder.

1.7.12 The assessment at Outline Business Case confirmed that both quantitatively and qualitatively it was better value for money to procure the Midland Metropolitan Hospital via Private Finance 2. A reassessment, taking into account the factors that have subsequently changed has reaffirmed this position.

1.7.13 In particular, the value for money of Private Finance 2 has improved considerably, mainly due to more favourable funding terms offered by funders and the underlying market rate. A sensitivity analysis has confirmed that Private Finance 2 is likely to remain better value for money against a range of potential future scenarios.

1.8 Project Scope

1.8.1 The scope of the project, which remains unchanged since approval of the Outline Business Case in July 2014, includes:

- Development of a new acute hospital on a brownfield site at Grove Lane which is now owned by the Trust;
- A design which responds to the Trust's design vision and clinical functionality as set out in the Functional Brief for Bidders at initiation of the procurement;

- A hard facilities management service to maintain the fabric of the hospital buildings and estate and ensure their lifecycle replacement for the duration of the Contract;
- The elective and minor maintenance services as specified in the draft contract at Outline Business Case stage;
- The same equipment classifications and responsibilities for installation as agreed at Outline Business Case – equipment management services continue to be outside the Private Finance 2 contract;
- A single integrated IM&T network delivering wired and wireless coverage to agreed criteria at completion and at the operational stage as agreed at Outline Business Case; and
- The same expectation for environmental sustainability and minimising energy costs as well as for supporting local regeneration.

1.8.2 As specified in the Outline Business Case the scope still does not include:

- Soft facilities management services; and
- Retail management (including retail catering).

1.8.3 It is now the intention to commence enabling works in November 2015 to prepare the site for the main construction in January 2016, after financial close. This brings part of the scope of the project forward before the Private Finance 2 contract has been signed. These enabling works will not prejudice the future of the site and are advantaged by a single bidder position.

1.9 Procurement Strategy

1.9.1 The procurement strategy presented in the Outline Business Case was for a structured and transparent Competitive Dialogue process, in line with underpinning regulations, to achieve the best outcome for the Trust without incurring unnecessary bid costs.

1.9.2 The draft Project Agreement was based on Department of Health Standard Form with subsequent amendments, including for the change to Private Finance 2, and it was tailored for the specific elements of this project. This alignment has stayed in place throughout the procurement process.

1.9.3 The Trust will Close Dialogue once a Draft Final Bid which includes all the elements required and necessary for the performance of the Project has been evaluated and assurance that all material issues relating to a Bidder's solution, in particular those impacting on price and risk, have been scoped and agreed. Approval of this (Generic) version of the Appointment Business Case from the Department of Health will be required before the Trust is able to Close Dialogue.

1.9.4 Delivery of the project under Private Finance 2 means that two separate Funding Competitions will be required. The first will be used to identify the Third Party Equity Provider and the second will be used to appoint the Senior Debt Provider. In each case these competitions are mandatory. The equity funding competition will be held prior to appointment of Preferred Bidder and the Senior Debt competition will be held at the Preferred Bidder stage. Due Diligence Advisors were appointed in March 2015 and will ensure that potential issues for Funders can be reviewed regularly through the procurement.

Single Bidder Treatment

1.9.5 In order to drive quality, the Trust has required that:

- All concerns identified at the evaluation of the Interim Bid submission have been addressed early in Competitive Dialogue Stage 4; and
- The quality scoring achieved at draft and final bids matches or exceeds that achieved at the Interim Bid submission.

1.9.6 The Trust has created a new metric of 'cost per benefit points' from The Hospital Company's interim submission. This is to be a product of the Net Present Value of the unitary payment and an assessment of the quality scored at bid evaluations. The Trust has required that this metric improves at each subsequent bid.

1.9.7 The approach to ensuring that costs are competitive is to request that The Hospital Company demonstrates what level of market testing is possible without delaying financial close.

1.9.8 78% of the value of the construction packages will be market tested using the following methods:

- True market lump sum;
- True market test rates;
- Subcontractor target cost / budget estimates;
- Quality / capability evaluation with all in rate for sample scope of works; and
- Market testing of rates using other schemes and adjusting for inflation.

1.9.9 It is intended that for each method 2 or 3 suppliers will be approached to provide a cost. As the scheme develops from the Draft Final Bid submission (April 2015) to the Final Bid submission (July 2015) an increasing number of work packages will have been subjected to a rigorous approach, resulting in The Hospital Company demonstrating that at least 78% of the construction cost has been tested.

1.9.10 The Trust's cost advisor will use a range of measures to support this process of mitigating the loss of competition within the PF2 procurement process.

Draft Final Bids

1.9.11 Evaluation of Draft Final Bids is required to determine whether the Trust is ready to Close Dialogue.

1.9.12 A Draft Final Bid was received on 2 April 2015. It was evaluated by the Evaluation Teams and reviewed by the Evaluation Moderation Committee.

1.9.13 Each Bid Deliverable was assessed using the scoring structure presented in the table below.

Table 8: Scoring of Bids

Score	General Definition	Criteria Based Definition
1	Unacceptable	Fails to meet requirements for almost all key criteria.
2	Very poor	Fails to meet requirements for many of the key criteria.
3	Poor	Fails to meet requirements for some key criteria.
4	Adequate	Meets requirements for all key criteria.
5	Good	Meets requirements / performs well for all key criteria and offers some additional benefits.

Score	General Definition	Criteria Based Definition
6	Excellent	Exceeds all project criteria and offers significant additional benefits.

1.9.14 The Trust has evaluated the Bidder through the application of the evaluation criteria, scoring and weightings set out below. The CD Stage 3 section weightings have been carried through to CD Stage 4 so that direct comparison of the scores from interim submission to Draft Final and Final Bid can be made.

Table 9: Weighting by Main Criterion / Work Stream

Main Criterion / Workstream	Weighting CD Stage 3	Weighting CD Stage 4/5
Cost	10%	10%
Clinical and Operational Functionality	34%	34%
Estates and Technical	24%	24%
Legal, Commercial and Finance	14%	14%
Hard FM	9%	9%
Subjective Assessment of Design Vision	9%	9%
Total	**100%**	**100%**

Price Compliance

1.9.15 The reference model that has been evaluated includes an assumption that there will be a capital contribution of £100m.

1.9.16 Bidders have been set a price target of a first year target Unitary Payment (UP) of less than £22 m and a Net Present Value (NPV) of the UP over the operational period of less than £262 m for their bid to be compliant.

1.9.17 The Bidder's base scheme proposes a first year UP of £21.95 m and a NPV of the UP over the operating period of £261.09m. The Bidder has therefore complied with the price hurdles.

Adherence to Single Bidder Mitigation Requirements

1.9.1 The Bidder has complied with the single bidder mitigations.

Standard Form Compliance

1.9.2 The Project Agreement and Schedules are compliant with HM Treasury's Standardisation of Private Finance 2 Contracts. Since this is the first hospital project to be procured under the Private Finance 2 model, the documents have been worked up in close consultation with the Department of Health and HM Treasury.

Technical Due Diligence Stage One Report

1.9.3 The Due Diligence Advisors' Stage One technical review of the draft Project Agreement and the ITPD demonstrates satisfactory findings at this stage of the project.

Final Bids

1.9.4 Following approval of this Generic Appointment Business Case to Conclude Dialogue the Trust will issue an Invitation to Submit Final Bids.

1.9.5 The Bidder will be required to submit a Final Bid based on the solution agreed prior to the Conclusion of Dialogue. Only minimal non-price sensitive issues will be addressed at Final Bid. Any new issues raised or previously withdrawn points re-raised at Final Bid stage will render the Bid non-compliant.

1.9.6 An update to this Appointment Business Case (Specific version) will be presented to seek approval for appointment of the Preferred Bidder.

Financial Close

Approach to Funding Competitions

1.9.7 The Due Diligence Advisors will be novated to the Preferred Bidder following approval of the Specific Appointment Business Case to enable preparation for Senior Debt the Funding Competition.

1.9.8 The Preferred Bidder will run a funding competition for the senior debt element of the project. This will be undertaken on an open book basis and overseen by the Trust, its advisors and the Department of Health / Infrastructure UK. The Preferred Bidder will select and recommend the winning funder(s) on a 'best value' basis in line with the agreed criteria and the Trust will confirm this selection.

1.9.9 One of the most significant changes under Private Finance 2 is the approach to the equity funding and ownership and make-up of the Special Purpose Vehicle/Project Co. A proportion of the equity is offered to the market in order to test market pricing and potentially secure a lower blended equity return. In addition, the public sector (Infrastructure UK) also takes a proportion of the equity under the same pricing and conditions as the selected equity funder.

1.9.10 The equity funding competition would normally take place post Preferred Bidder. However, as a result of the single bidder status, the Trust has been able to advance discussions around the process. Whilst appointment of the equity funder is expected to take place post preferred bidder, much of the process, evaluation and selection can be undertaken concurrently with the procurement.

1.9.11 Initial discussions indicate that the likely equity share of the SPV will be as follows:

- Preferred Bidder: 50%
- 3rd Party Equity provider: 40%
- Infrastructure UK: 10%

1.9.12 This split was determined to be sufficiently attractive to the market in terms of scale, but also maintained the appropriate balance of control and input for each party.

Planning Permission

1.9.13 The Bidder will commence preparation for the planning application after Conclusion of Dialogue and the full planning application will be launched in advance of appointment of Preferred Bidder.

1.9.14 The Preferred Bidder will take responsibility, and therefore accept risk, for amendments with cost implications arising from changes due to planning requirements which are identified at this stage.

1.9.15 Full Planning Approval and expiry of the judicial review period (6 weeks) will be completed prior to Financial Close.

Timescale for Financial Close

1.9.16 As a result of the opportunity afforded by the single bidder situation, Financial Close has been accelerated by 4 months and is scheduled for December 2015 in order to achieve a hospital handover in July 2018 as planned.

1.9.17 A Confirmatory Business Case will be agreed before Financial Close to provide confirmation to the Department of Health and HM Treasury that the conditions of Appointment Business Case approval (and any subsequent conditions) have been satisfied.

1.10 The Bidder Solution

1.10.1 This section outlines the solution developed by The Hospital Company and the Trust.

Design Vision

1.10.2 The design proposals fully support and enhance the Trust's design vision values (unchanged since Outline Business Case) which are for the Midland Metropolitan Hospital to be:

- Inspirational, attractive and imaginative;
- Welcoming;
- Reassuring;
- Light and airy;
- Clean without being clinical;
- Sympathetic to the environment;
- Fully accessible;
- Supportive to privacy and dignity; and
- A good place to work.

1.10.3 The Hospital Company has worked closely with the Trust to develop a hospital design which is characterised by:

- A clear, simple and legible building form which maximises the use of natural daylight.
- A building which focuses on the delivery of acute care only, concentrating staff specialist care on the acutely unwell.
- A building where there is clear separation of flows between staff, public and facilities management functions.
- A strong external landscaping strategy which looks to tie in with the existing features around the site such as the canal.
- A building which utilises the topography of the site to create safe and secure parking for staff and visitors without cluttering the external views.
- A central circulation floor which is visible from the outside as well as the inside.

- A building which looks to minimise travel distances for both patients and staff vertically and horizontally.
- Internal spaces which are clear, simple and in clinical areas repetitive allowing staff to work more efficiently.
- A building which induces civic pride.
- A building which utilises natural boundary lines allowing the public and the wider community to free flow across the external spaces.

1.10.4 Central to the design is *The Green* which will provide the building with a vibrant, landscaped setting and the *Winter Garden* which will form a highly visual and active main circulation floor.

1.10.5 The hospital sits on a main gateway site and, with its elevated position, will create a prominent feature against the skyline. Despite the size and massing of the building from a distance, the use of a variety of carefully selected, high quality materials and the change in form created by the ward floor plates means that on closer inspection the building will be less overpowering and its individual elements will be visible giving it a more reassuring and welcoming feel.

1.10.6 The figure below presents the design that has been developed.

Figure 2: MMH within a Landscaped Setting

1.10.7 The *Winter Garden* will provide much of the natural daylight into the ward spaces.

1.10.8 The Hospital Company has developed a solution which removes visitor parking from view, and places it all in a well-lit, secure and undercover location beneath the hospital. It provides easy access to the lifts, along with drop off, and is immediately adjacent to the hospital entrance and the main circulation hub.

Clinical Design

Clinical Involvement

1.10.9 The clinical design has been informed by comprehensive clinical engagement right from the beginning when clinical groups supported development of the brief (operational policies, PP&DDs – Planning, Policy and Design Description), PSC , ADR(Architecture Design Review) exemplar and the competitive dialogue process. The development of the brief involved circa 35 clinical leads with involvement from their wider teams whilst circa 100 clinical staff participated in the PSC and exemplar design. During Competitive Dialogue circa 60 clinical and operational leads have been involved in the formal boot camp design meetings including assessing drawings and proposals in preparation for evaluation of submissions.

Adjacencies, Flows and Generic Design

1.10.10 Clear separation of the public, ambulatory patients, inpatients and goods from the point of entering the hospital until the entrance into departments has been achieved. This promotes privacy and dignity for patients and the public.

1.10.11 Strong clinical adjacencies will support smooth patient pathways, especially for emergency and acute patients. There will be two podium floors which have co-located hot clinical areas to best facilitate acute patient and clinical staff flows.

1.10.12 Careful consideration has been given to meet the Trust's standards for bariatric care to meet the needs of the local community.

1.10.13 In addition to the isolation provision The Hospital Company has designed a high level of separation of clean and dirty flows in clinical departments to support effective infection control.

1.10.14 The Hospital Company has developed a robust approach to security in line with the Trust Brief.

1.10.15 Where clinically possible a generic design has been used for clinical accommodation to facilitate future change in use. For example: adult inpatient wards having a generic design and layout facilitates future flexibility in terms of which specialties can be accommodated in wards.

1.10.16 Internal strategically embedded soft expansion space has been included within or adjacent to key clinical departments to allow for future localised expansion or change of use. Flexibilities in operational practice have also been defined that could facilitate additional capacity in future.

1.10.17 The generic adult inpatient ward design provides 50% single bedrooms and 50% of beds in 4 bed bays. This meets the feedback received from patients in terms of having a choice of single rooms or 4 bed bays. The design will allow excellent observation into all bedrooms through the use of touch down spaces and viewing panels. This will allow patients good observation of staff and the corridors as well as facilitating staff to monitor and support groups of 4 or 8 beds in line with agreed staffing ratios.

Construction

1.10.18 The construction programme includes a two month period of advance works prior to financial close for site set up works and accommodation, cut and fill to create formation levels and laying of the piling mat to allow piling works to commence immediately post Financial Close. The extent of the works will not affect the value of the site in a no scheme situation

1.10.19 The overall construction period is for 33 months and includes beneficial access for the Trust to install and commission equipment and IT services

1.10.20 The building is designed to support a fast track construction by using pre-cast frame for the podium levels with a steel frame for the ward levels which allows both speed of construction and design flexibility. The plan is for multiple work areas to be created to allow parallel working to keep the construction programme as short as is practicable, bearing in mind this hospital will be one of the shortest build programmes in the UK.

Facilities Management

1.10.21 The approach to soft facilities management services has not changed since Outline Business Case and does not therefore form part of the scope of the contract. The Trust will, in 2018, have two private finance buildings – the Midland Metropolitan Hospital and the Birmingham Treatment Centre – as well as retained estate at City, Sandwell, Rowley Regis Hospitals and Leasowes. It is crucial that a consistent standard of service is offered across the organisation.

1.11 Financial Case

1.11.1 The scheme is aligned with commissioner plans including Better Care Fund aspirations and continues to be consistent with Right Care Right Here strategies.

1.11.2 The Long Term Financial Model has had its annual update to reflect subsequent actual performance since its last update and any changes in assumptions.

1.11.3 Whilst contracted income for 2015/16 has been agreed with commissioners at a higher level than was projected at OBC, future years realign with the Outline Business Case trajectory.

1.11.4 The trust delivered a 2014/15 surplus ahead of plan.

Key Assumptions

1.11.5 Changes since OBC approval include:

- Updating the base year of assessment to 2014/2015 and including the Financial Plan for 2015/2016 as year 1 within the LTFM;
- Incorporating an updated Unitary Charge assessment resulting from the preferred bidder submission; the improvement arising from this is retained as affordability headroom;
- Retains an assumption of £100m Public Dividend Capital (PDC) investment and with a revised profile aligned to the proposed build programme;
- Update of cost inflation and cost efficiency assumptions having regard to published regulator guidance; and
- Maintains delivery of a 3 Risk Rating under the Continuity of Service Risk Rating metric.

1.11.6 A coherence of top line income, revenue surpluses, capital investment and balance sheet management consistent with sustaining a Continuity of Service Risk Rating level 3 and providing for meaningful downside mitigation.

1.11.7 The financial planning parameters also include a necessary and sufficient non PF2 internal capital programme covering MMH equipment and refurbishment of the buildings that will become the Trust's

community facilities. A managed service contract provides for that investment necessary in fixed imaging equipment.

1.11.8 The financial models and assumptions used in support of the LTFM derive much of their input from the RCRH activity trajectories which are integrated with the Trust's operational plans. Coherence with RCRH principles and strategies has been reviewed and confirmed. The case confirms the approach to the build-up of a reserve. This reserve is applied non recurrently in the period to new hospital commissioning to enable transformation and then to underpin payment of the UP. By utilising these resources on a non-recurrent basis the Trust will be able to fund any additional costs during the transition. From 2018/19 the costs associated with the MMH, and in particular the PF2 unitary payment, are included within the model and are funded from within internally generated sources.

1.11.9 The LTFM demonstrates that the MMH is recurrently affordable and that the overall CIP requirement is marginally greater than current Monitor CIP assumptions.

The Cost Improvement Programme

1.11.10 The scale of the cost improvement plan is consistent with national efficiency requirements reflecting assumptions of cost inflation and price deflation. The additional net investment in the scheme is the equivalent of circa one additional year of that efficiency and is specifically enabled by delivery of the RCRH service changes. The trust contends that the scale of opportunity for operational productivity and service transformation driven cost change is consistent with that required to underpin scheme affordability.

1.11.11 The cost improvement plan is presented in the table below.

Table 10: Cost Improvement Plan

CIP savings by year and type, 2014/15 to 2024/24 Value at 2014/15 prices (£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)	2023/24 (£m)
Pay - Consultants	1.4	0.6	0.6	0.6	0.6	1.0	0.6	0.6	0.6	0.6
Pay - Junior Medical	0.1	1.2	1.0	1.1	1.1	0.9	1.3	1.3	1.3	1.3
Pay - Nursing, Midwifery and Health Visitors	2.2	3.1	2.6	2.9	2.9	2.5	1.8	1.8	1.8	1.8
Pay - Other Clinical	0.0	0.6	0.5	0.6	0.6	0.7	0.3	0.3	0.3	0.3
Pay - Community Nursing, Midwifery and Health Visitors	0.1	1.1	1.0	1.0	1.0	0.9	1.4	1.4	1.4	1.4
Pay - Scientific, Therapeutic and Technical	0.8	2.3	1.9	2.1	2.1	1.8	1.7	1.7	1.7	1.7
Pay - Non Clinical	2.8	4.6	3.8	4.2	4.2	3.9	3.6	3.6	3.6	3.6
Pay - Agency (Consultants)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pay - Agency (Junior Medical)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pay - Agency (Nursing, Midwifery and Health Visitors)	2.0	1.3	1.7	2.5	0.8	0.0	0.0	0.0	0.0	0.0
Pay - Agency (Scientific, Therapeutic and Technical)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pay - Agency (Non Clinical)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pay - TOTAL	**9.4**	**14.9**	**13.3**	**15.0**	**13.4**	**11.8**	**10.7**	**10.7**	**10.7**	**10.7**
Non Pay - Drugs	0.2	1.2	1.2	1.0	1.0	0.6	1.0	1.0	1.0	1.0
Non Pay - Clinical Supplies and Services	2.3	1.8	2.0	1.0	1.0	0.8	1.0	1.0	1.0	1.0
Non Pay - General Supplies and Services	0.7	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0
Non Pay - Establishment Expenditure	0.6	0.5	0.3	0.5	0.3	0.3	0.1	0.1	0.1	0.1
Non Pay - Premises and Fixed Plant	1.3	1.0	0.5	1.0	0.2	0.3	0.1	0.1	0.1	0.1
Non Pay - CNST	0.7	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0
Non Pay - Other	2.1	0.3	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0
Non Pay - TOTAL	**7.9**	**4.9**	**4.2**	**3.7**	**2.6**	**2.1**	**2.2**	**2.2**	**2.2**	**2.2**
Income improvements contributing to TSP target	**3.3**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
TOTAL TSP savings at 2014/15 prices (£m)	**20.6**	**19.8**	**17.5**	**18.7**	**16.0**	**13.9**	**13.0**	**13.0**	**12.9**	**12.9**

Affordability

1.11.12 The scheme is affordable as demonstrated by the consistent achievement of Continuity of Service Risk Rating level 3 ratings across the period of the LTFM. Estates costs are also consistent within the 12.5% test limit. The Continuity of Service Risk Rating in the base case PF2 LTFM is presented in the table below.

Table 11: Continuity of Service Risk Rating

CSRR in the base case PF2 LTFM		Forecast 2014/15	Forecast 2015/16	Forecast 2016/17	Forecast 2017/18	Forecast 2018/19	Forecast 2019/20	Forecast 2020/21	Forecast 2021/22	Forecast 2022/23	Forecast 2023/24
Liquidity ratio (days)											
	Current assets	62.5	48.2	45.9	91.5	136.6	55.8	53.4	48.6	53.7	60.8
	Inventories	3.3	3.5	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2
	PFI prepayments and assets held for sale	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Current liabilities	-66.2	-52.5	-53.4	-50.5	-71.7	-59.1	-57.7	-50.8	-51.2	-51.4
	Days	360.0	360.0	360.0	360.0	360.0	360.0	360.0	360.0	360.0	360.0
	Operating expenses	-415.5	-410.0	-406.9	-405.0	-406.3	-414.3	-425.5	-437.0	-446.1	-458.1
	Fully committed Working Capital Facility	-	-	-	-	-	-	-	-	-	-
	Derivatives and embedded financial assets	-	-	-	-	-	-	-	-	-	-
	Liquidity ratio (days) - opening liquidity	**-6.0**	**-6.8**	**-9.5**	**33.6**	**54.6**	**-5.7**	**-6.4**	**-4.5**	**-0.6**	**4.8**
Capital servicing capacity (times)											
	Interest payable (-ve)	-2.1	-2.1	-2.4	-2.0	-11.9	-15.1	-14.8	-15.0	-14.6	-14.2
	Debt repayment (-ve)	-3.0	-2.0	-1.3	-0.9	-104.9	-6.3	-5.6	-5.5	-5.1	-4.8
	PDC dividend (-ve)	-5.2	-6.0	-6.8	-6.9	-5.9	-5.8	-6.1	-6.4	-6.7	-7.1
	PDC repayment (-ve)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	EBITDA	25.2	26.3	28.2	29.8	39.6	40.8	40.9	41.4	42.2	42.7
	Interest receivable (+ve)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Surplus available	25.2	26.3	28.2	29.8	39.6	40.8	40.9	41.4	42.2	42.7
	Capital servicing capacity (times)	**2.4**	**2.6**	**2.7**	**3.0**	**0.3**	**1.5**	**1.5**	**1.5**	**1.6**	**1.6**
Scoring (uses opening liquidity)											
	Liquidity ratio score	3	3	2	4	4	3	3	3	3	4
	Capital servicing capacity score	3	4	4	4	1	2	2	2	2	2
	Overall Continuity of Service Risk Rating (CSRR)	**3**	**4**	**3**	**4**	**3**	**3**	**3**	**3**	**3**	**3**

1.11.13 The downside case stress tests the plan including with early years impact bias. Mitigation identified suggests that affordability stands that scrutiny with the impact of a reduction to Continuity of Service Risk Rating level 2 in the first two years of operation.

1.11.14 The downside case is presented in the table below.

Table 12: Downside Case

	ABC Downside: I&E Position								
	2015/16 Year 1 £m	2016/17 Year 2 £m	2017/18 Year 3 £m	2018/19 Year 4 £m	2019/20 Year 5 £m	2020/21 Year 6 £m	2021/22 Year 7 £m	2022/23 Year 8 £m	2023/24 Year 9 £m
Base Case	**3.4**	**4.3**	**6.5**	**9.6**	**5.0**	**4.2**	**3.9**	**4.3**	**4.1**
Downside Case	(7.7)	(12.4)	(16.7)	(21.1)	(25.5)	(29.9)	(33.9)	(37.3)	(41.3)
Revised Downside I&E Position	**(4.3)**	**(8.1)**	**(10.2)**	**(11.5)**	**(20.5)**	**(25.7)**	**(30.0)**	**(33.0)**	**(37.2)**
Mitigation Case	7.2	10.7	18.3	15.2	25.7	29.8	32.7	36.7	40.0
Net Impact of Interest and Inflation	0.1	0.6	0.8	(0.1)	0.3	3.2	2.1	1.9	3.0
Revised Mitigated I&E Position	**3.0**	**3.2**	**8.8**	**3.6**	**5.5**	**7.3**	**4.8**	**5.7**	**5.7**

	ABC Downside: Cash Position								
	2015/16 Year 1 £m	2016/17 Year 2 £m	2017/18 Year 3 £m	2018/19 Year 4 £m	2019/20 Year 5 £m	2020/21 Year 6 £m	2021/22 Year 7 £m	2022/23 Year 8 £m	2023/24 Year 9 £m
Base Case	**28.7**	**27.9**	**32.8**	**45.1**	**42.5**	**37.6**	**42.6**	**49.6**	**57.4**
Downside Case	(7.7)	(20.1)	(36.9)	(58.0)	(83.4)	(113.3)	(147.3)	(184.5)	(225.8)
Revised Downside Cash Position	**21.0**	**7.7**	**(4.1)**	**(12.8)**	**(40.9)**	**(75.8)**	**(104.7)**	**(135.0)**	**(168.5)**
Mitigation Case	7.9	18.6	37.1	52.5	78.6	108.5	141.2	177.9	217.7
Net Impact of Interest and Inflation	0.4	1.3	2.6	2.7	3.1	5.8	7.9	10.0	13.1
Revised Mitigated I&E Position	**29.3**	**27.6**	**35.6**	**42.3**	**40.7**	**38.5**	**44.5**	**52.9**	**62.4**

	ABC Downside: Continuity of Service Risk Rating								
	2015/16 Year 1	2016/17 Year 2	2017/18 Year 3	2018/19 Year 4	2019/20 Year 5	2020/21 Year 6	2021/22 Year 7	2022/23 Year 8	2023/24 Year 9
Base Case	4	3	4	3	3	3	3	3	3
Downside Case	3	2	3	3	1	1	1	1	1
Mitigation Case	4	3	4	3	2	2	3	3	3
Mitigation Case - OBC	**3**	**4**	**4**	**3**	**2**	**2**	**3**	**3**	**3**

1.11.15 The case includes necessary and sufficient investment in key enabling and supporting infrastructure and specifically informatics including electronic patient record, retained estate and medical equipment. Fixed imaging equipment investment is assumed to be delivered through a Managed Service Contract. The revenue costs are reflected in full in the long term financial model supporting the case.

1.11.16 The anticipated unitary payment reflects updated terms and represents a significant improvement on those at Outline Business Case. This case retains that improvement as affordability headroom.

1.11.17 The base case is predicated up on the provision of £100m of Public Dividend Capital investment as agreed with the NTDA and presented in the table below.

Table 13: Public Dividend Capital

	2016/17 £m	2017/18 £m	2018/19 £m	Total £m
PDC Drawdown	46.5	46.9	6.6	100.0

1.11.18 Land sale proceeds are specifically excluded from the base case and dealt with as potential mitigation in the downside case.

1.12 Management Case

Leadership and Project Management

1.12.1 The Chief Executive Officer (Senior Responsible Owner for this project) and Director of Finance and Performance both have considerable experience of delivering large Private Finance Initiative schemes. The Trust's Chairman has significant experience in property management. This level of capability will ensure strong leadership for the project.

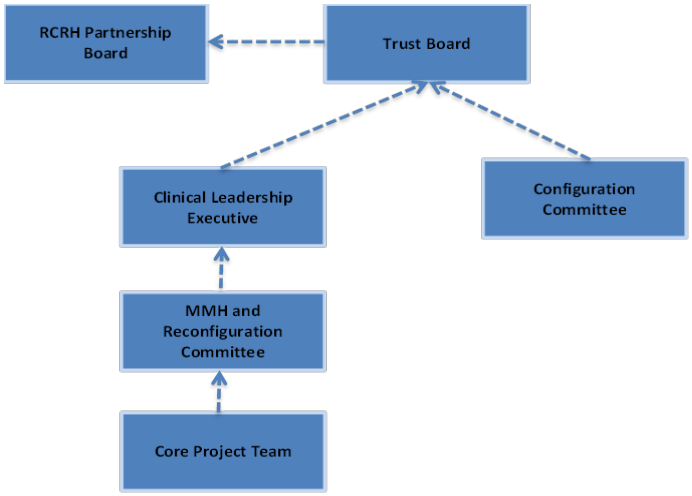
1.12.2 The Trust's in-house team also has significant experience of projects of this type and is supported by a team of external advisors who can build on learning from other successful schemes they have been involved in.

1.12.3 Three Gateway Reviews have been undertaken to date all resulting in a Green or Amber / Green outcome demonstrating the strong approach being taken to project management.

1.12.4 Strong governance has been put in place to ensure that the Trust Board, as investment decision maker, is assured that the proposals being made for the Midland Metropolitan Hospital and the intended procurement route represent a prudent, value for money and affordable course of action for the organisation.

1.12.5 The Governance Structure is presented in the figure below.

Figure 3: Governance Structure

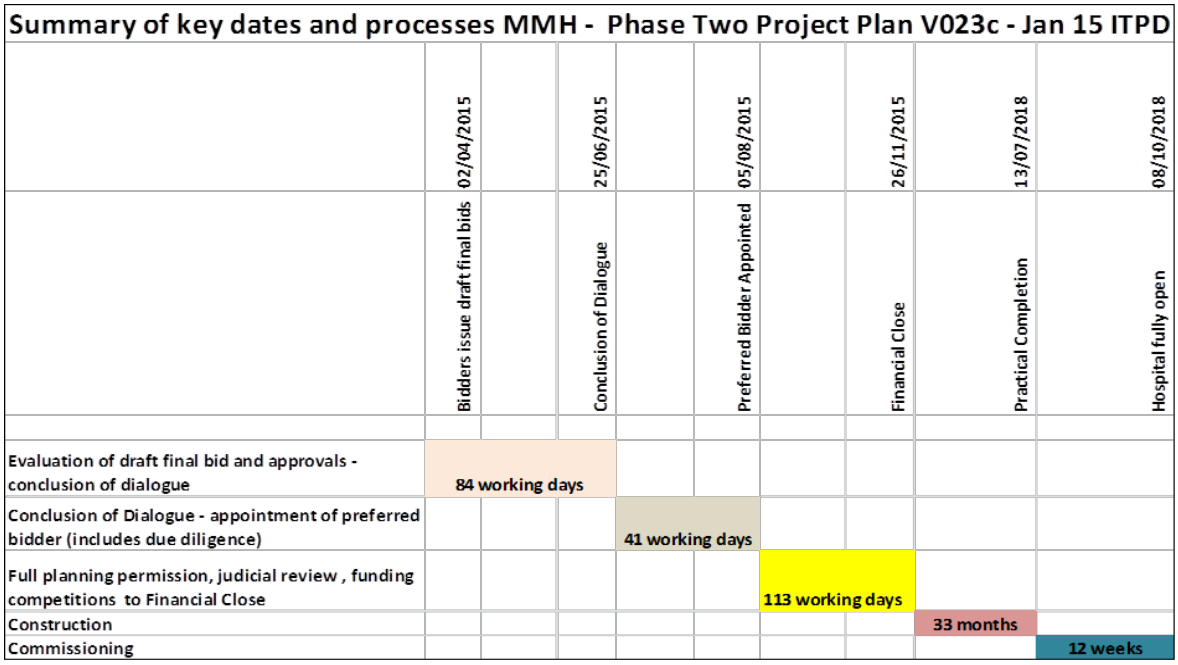


Project Plan and Timetable

1.12.6 The Single Bidder situation has provided the opportunity to reduce programme risk by bringing Financial Close earlier making the October 2018 hospital operational date more viable.

1.12.7 The figure below shows an overview of the key dates and steps to getting the Midland Metropolitan Hospital procured, built and opened.

Figure 4: Overview of the Steps to Opening the MMH in October 2018



The table below shows the key milestones that have been achieved and milestones to the Midland Metropolitan Hospital being operational.

Table 14: Key Milestones

Milestone	Date
Outline Business Case approved and OJEU Notice published	July 2014
Invitation to participate in dialogue issued	September 2014
Interim bid submission received	December 2014
Receipt of Draft Final Bids	April 2015
Submission of Generic Appointment Business Case	May 2015
Approval of Generic Appointment Business Case and Close Dialogue	June 2015
Receipt of Final Bid	July 2015
Submission of Specific Appointment Business Case	July 2015
Approval of Specific Appointment Business Case and Appoint Preferred Bidder	August 2015
Full planning consent granted	October 2015
Submission of Confirmatory Business Case	October 2015
Advanced works commence on site	November 2015
Approval of Confirmatory Business Case	November 2015
Financial close	December 2015

Milestone	Date
Commencement of main construction programme	January 2016
MMH handed over to Trust	July 2018
MMH operational	October 2018

1.13 Sustainability

1.13.1 Sustainability, regeneration and corporate citizenship are important aspects of the project. The work undertaken by The Hospital Company has strengthened the approach by providing a robust, measurable set of proposals to meet the Trust's specification.

1.13.2 Reducing the carbon footprint and energy consumption together with resulting emissions is of paramount importance to the Trust. A solution capable of achieving energy consumption of not greater than 42GJ/100m³ is required.

1.13.3 The BREEAM (Building Research Establishment Energy Assessment Model) assesses many criteria including sustainability management; waste from construction and in use, water, materials and transport. The mandated score of Excellent will drive out a fully comprehensive sustainability package including the reduction of admissions.

1.13.4 The Midland Metropolitan Hospital will make a positive difference to the development of Birmingham and Sandwell's local communities, enabling them to further thrive and prosper through a Supply Chain and Employment Framework.

1.13.5 The Hospital Company has great experience in creating employment and skills opportunities. 80% of construction expenditure will be local within the east and west midlands and70% of expenditure will be in the B postcode. Coupled with the Trust's understanding of the needs of local communities, the project will make a significant and positive contribution to the region's economic regeneration.

1.13.6 An equality impact assessment concluded that some frail and elderly patients / members of the public would have further to travel to the new hospital. This is addressed in the transport strategy which has been agreed with the Right Care, Right Here Programme Board.

1.14 Workforce

1.14.1 The Trust's Workforce and Organisational Development Strategy is underpinned by an affordable Long Term Workforce Model, a Workforce Change Plan and effective change management arrangements.

Long Term Workforce Model

1.14.2 The Long Term Workforce Model presented in the table below is aligned to the Long Term Financial model which has top down workforce assumptions aligned to activity and income.

Table 15: Long Term Workforce Model

		Outturn 2014/15 Wte	Plan 2015/16 Wte	Forecast 2016/17 Wte	Forecast 2017/18 Wte	Forecast 2018/19 Wte	Forecast 2019/20 Wte	Forecast 2020/21 Wte	Forecast 2021/22 Wte	Forecast 2022/23 Wte	Forecast 2023/24 Wte
BASELINE inc RCRH Change & CIP											
Pay - Consultants		289.2	289.2	289.7	290.0	290.8	291.6	293.5	299.3	302.0	304.5
Pay - Junior Medical		500.8	476.6	476.3	476.0	473.4	470.7	471.0	471.1	471.3	471.5
Pay - Nursing, Midwifery and Health Visitors		1,789.7	1,759.7	1,734.5	1,696.7	1,664.4	1,635.0	1,661.0	1,677.8	1,691.9	1,706.2
Pay - Community Nursing, and Health Visitors		473.4	465.5	472.9	482.8	495.9	505.0	513.1	519.6	536.7	544.0
Pay - Scientific, Therapeutic and Technical		1,131.7	1,078.7	1,088.9	1,097.3	1,108.5	1,129.8	1,144.9	1,156.7	1,169.4	1,180.6
PAY - OTHER CLINICAL		683.2	671.8	666.7	649.2	640.3	660.5	668.8	674.0	679.7	684.9
Pay - Non Clinical		2,127.3	1,980.0	1,978.2	1,972.5	1,903.7	1,834.1	1,829.7	1,834.3	1,840.0	1,845.1
Agency		240.0	240.0	227.1	205.7	188.8	195.6	197.1	192.3	193.6	195.1
Sub Total		*7,235*	*6,962*	*6,934*	*6,870*	*6,766*	*6,722*	*6,779*	*6,825*	*6,885*	*6,932*
Repatriation & Community Developments											
Pay - Consultants		-	2	3	3	4	6	7	8	9	10
Pay - Junior Medical		-	3	5	6	7	10	13	14	16	17
Pay - Nursing, Midwifery and Health Visitors		-	34	86	156	204	288	365	426	498	574
Pay - Community Nursing, and Health Visitors		-	-	-	-	-	-	-	-	-	-
Pay - Scientific, Therapeutic and Technical		-	12	18	19	22	33	42	46	47	47
PAY - OTHER CLINICAL		-	-	-	-	-	-	-	-	-	-
Pay - Non Clinical		-	4	5	6	6	9	12	13	13	13
Agency		-	-	-	-	-	-	-	-	-	-
Sub Total		-	55	117	190	244	347	439	508	582	661
CIP Impact											
Pay - Consultants		-	- 0	- 1	- 2	- 2	- 3	- 3	- 4	- 5	- 5
Pay - Junior Medical		- 24	- 12	- 22	- 33	- 44	- 53	- 66	- 79	- 92	- 105
Pay - Nursing, Midwifery and Health Visitors		- 30	- 48	- 88	- 132	- 176	- 214	- 241	- 269	- 296	- 323
Pay - Community Nursing, and Health Visitors		- 8	- 17	- 31	- 46	- 62	- 75	- 96	- 117	- 138	- 159
Pay - Scientific, Therapeutic and Technical		- 53	- 36	- 66	- 99	- 132	- 160	- 187	- 213	- 239	- 266
PAY - OTHER CLINICAL		- 11	- 24	- 44	- 66	- 88	- 107	- 120	- 133	- 145	- 158
Pay - Non Clinical		- 147	- 103	- 188	- 282	- 376	- 457	- 537	- 617	- 697	- 777
Agency		-	- 20	- 55	- 105	- 125	- 125	- 125	- 125	- 125	- 125
Sub Total		- 274	- 260	- 495	- 765	- 1,005	- 1,195	- 1,376	- 1,557	- 1,738	- 1,919
Net Trust Wide Position											
Pay - Consultants		289	290	291	292	293	295	298	304	306	309
Pay - Junior Medical		477	467	459	449	437	428	418	406	395	383
Pay - Nursing, Midwifery and Health Visitors		1,760	1,746	1,733	1,720	1,692	1,709	1,784	1,835	1,894	1,957
Pay - Community Nursing, and Health Visitors		466	449	442	437	434	430	417	402	398	385
Pay - Scientific, Therapeutic and Technical		1,079	1,055	1,040	1,018	999	1,002	1,000	989	976	962
PAY - OTHER CLINICAL		672	648	623	583	552	554	549	541	534	527
Pay - Non Clinical		1,980	1,881	1,795	1,696	1,534	1,386	1,305	1,230	1,156	1,081
Agency		240	220	172	101	64	71	72	67	69	70
Net Position	*7,221*	6,962	6,757	6,556	6,295	6,004	5,875	5,842	5,776	5,729	5,674
ABC Annual Movement		- 260	- 205	- 201	- 261	- 291	- 130	- 32	- 67	- 47	- 54
ABC Cummulative Movement		- 260	- 465	- 665	- 926	- 1,217	- 1,347	- 1,379	- 1,445	- 1,493	- 1,547

1.14.3 The model is consistent with the Outline Business Case trajectory reducing the workforce by 1,347 WTEs (against a 1,367 reduction within the Outline Business Case) between March 2014 and March 2020.

The Workforce Change Plan

1.14.4 The Trust has already made good progress in delivering the Workforce Change Plan set out in the OBC. Since OBC approval the Trust has:

- Successfully delivered the first wave (April 2014 – March 2015) of the Safe and Sound workforce change programme resulting in a reduction of 260 WTE;
- Launched the second wave of workforce change with the aim of achieving a reduction of 205 posts between April 2015 and March 2016;
- Made good progress in re-configuring existing services and developing more detailed plans for workforce changes to be delivered in 2016-2018 in readiness to work safely in the MMH; and

- Confirmed that clear safe staffing standards are currently in place and outlined plans to ensure that they will be maintained in 2018/19.

1.14.5 The workforce planning approach has been to develop strategic workforce change themes grouped within the following 3 drivers:

- Activity and pathway driven changes in workforce;
- Productivity driven reductions in workforce; and
- Reduction in the cost per WTE.

1.14.6 The rationale for this structured approach is to avoid double counting pay cost savings across schemes and years and to ensure a coherent transition to the Midland Metropolitan Hospital is achieved.

1.14.7 The table below outlines the approach.

Table 16: Workforce Change Plan

Key Drivers	Strategic workforce change theme	Transition phase (April 2016 – March 2018)	MMH phase (April 2018 – March 2020)
Activity and pathway driven changes in workforce	**Clinical Restructuring**	Fewer nurses and HCAs due to fewer outpatient sessions and reduction in beds Investment in community nursing	Fewer nurses and HCAs due to fewer outpatient sessions and reduction in beds Investment in community nursing Fewer emergency department staff as a result of single ED within MMH.
	Non-Clinical	Reduction in facilities staff due to greater cross functional working	
Productivity driven reductions in workforce	**Technology**	Fewer healthcare records staff due to introduction of EpR. Better use of consultant's time through telehealth enabling resources to be channelled into 7 day working. Introduction of mobile technology to improve productivity in community Fewer medical secretaries as a result of completing speech recognition technology.	Fewer porters and distribution staff as a result of introduction of automated guided vehicles
	Clinical Transformation	Medical and surgical bed reductions, shift to community settings, outpatients transformation, theatre utilisation, site reconfiguration, de-duplication of on-call rotas	Single site reconfiguration will result in transfer of hard FM staff to PF2 provider under TUPE.
	Scheduling	Reduction in theatre staff and outpatient staff as a result of improved scheduling and changing working practices to ensure optimal use of clinics and theatres.	

Key Drivers	Strategic workforce change theme	Transition phase (April 2016 – March 2018)	MMH phase (April 2018 – March 2020)
	Black Country Alliance	Collaboration of 3 NHS Trusts to share back office processes and reduce costs.	-
	Sickness Absence	Driving down sickness absence to ensure that the Trust is fully staffed.	
	User-Led	Empowering service users to carry out certain administrative tasks relating to their appointments e.g. booking and changing appointments, transport and tests.	
	Management de-layering	Completion of management de-layering pre MMH. Fewer corporate staff due to co-location into single head office site.	Further management de-layering as a result of single site configuration. Fewer corporate staff due to completion of co-location into single head office site at Sandwell General Hospital.
	Non-consultant Doctors	Improving senior medical cover / review of middle grade doctors against future requirements.	Reduction in medical staff due to de-duplication of medical rotas enabled by single site configuration.
	Skill mix and role redesign	A review of roles to introduce new more junior roles to reduce cost per WTE create a career path for progression from a wider range of backgrounds.	
	Premium Payments	Eliminating bank, agency, overtime and waiting list payments to reduce temporary staffing costs.	
	Intermediate Care is Cheaper	Shifting care from acute to community models of care.	

1.14.9 The leadership and governance arrangements are in place to drive the execution of the workforce plan to deliver the Long Term Workforce Model. Effective arrangements are in place to support management of change.

1.14.10 The benefits of the moving to the Midland Metropolitan Hospital configuration are vital to continue to improve quality and sustain safe services with a more productive workforce.

1.15 Consultation, Stakeholder Involvement and Approvals

1.15.1 Awareness of the scheme among local residents and the clinical community has been reborn since the publicity surrounding Outline Business Case approval. A specific section of the Trust's website has been dedicated to the project and local representatives through Healthwatch have been briefed on the project.

1.15.2 The Clinical Commissioning Group led listening exercise on Interventional Cardiology and Emergency Surgery, both of which move to single sites from August 2015, has afforded an important opportunity to restate the detail of the 2007 consultation and 2009 engagement activity. The Trust is satisfied that there is strong local awareness of the move to Midland Metropolitan Hospital tempered with some scepticism born of the decade plus journey to this point.

1.15.3 The Trust's work with local community groups, especially those adjacent to the site and along Dudley Road (which runs from the current City Hospital site to the Grove Lane site), has been extended in the last year. The Trust is in the process of creating a network of community contacts to support both clinical and charity work.

1.15.4 The Hospital Company will take the lead on engagement from late May to support the design and landscaping of the site relevant to the final planning consent.

1.15.5 Work is advanced in considering the transport connections vital to make the site work with minimal disruption to neighbours.

1.15.6 In 2013 and 2014 the Trust obtained support from the three local Clinical Commissioning Groups together with the local area team of NHS England. Both Health and Wellbeing Boards support the scheme. The Outline Business Case was approved by the National Trust Development Authority. Final approval to proceed was granted by the Department of Health and HM Treasury in July 2014.

1.15.7 These recent approvals reflect longstanding support for the project dating back to the Strategic Outline Case being agreed in 2004.

1.16 Conclusion

1.16.1 The Conclusion of this Generic Appointment Business Case is that:

- Since approval of the Outline Business Case the strategic context, case for change and economic case remain conclusive that the Midland Metropolitan Hospital is necessary and is fully supported by the local health economy.
- The subsequent refresh of activity, income and capacity projections demonstrate that the scope of Midland Metropolitan Hospital and its capacity remains unaltered from the Outline Business Case.
- A reassessment demonstrates that value for money has improved from 4.3% on a NPV basis to 27% mainly due to more favourable terms being offered by funders and the underlying market rate.
- The potential impact of the single bidder situation at Interim Bid Submission has been mitigated and the Trust Board has determined that continuing with the Private Finance 2 procurement is the best means of achieving the Trust's objectives;
- A refresh of the long term financial model, cost improvement programme, workforce plan and downside case demonstrates that the scheme remains affordable. The Trust's results in 2014/15 demonstrate the drive and capability locally to stick to the plans set out in this business case.
- The Trust is driving the procurement forward to ensure that the Midland Metropolitan Hospital opens in October 2018 in accordance with its strategic objective of delivering high quality and sustainable patient care.

2 Introduction

2.1 Purpose of the Appointment Business Case (ABC)

2.1.1 The purpose of the ABC is to secure agreement to appointing a 'Preferred Bidder' for the Midland Metropolitan Hospital (MMH) project. This is a key stage in the procurement where the Trust has received Final Bids and then selects a single provider to proceed towards Financial Close.

2.1.2 The ABC comes in 2 parts: the Generic ABC and the Specific ABC. This document, the Generic ABC, is based on the Draft Final Bid and its evaluation by the Trust. Approval of this Generic ABC is necessary before the Trust can 'Close Dialogue' in the procurement process.

2.1.3 The Specific ABC will be based upon the Final Bid and the Trust's evaluation. Approval of the Specific ABC will be necessary as part of the approvals to appoint Preferred Bidder.

2.2 Approach to the ABC

2.2.1 Given that very little has changed to the scheme since OBC approval, much of what was approved in the OBC remains unchanged and still valid. In these instances, the case made and approved in the OBC is re-stated for continuity. Thus, the key areas of the ABC are those that address the changes since the OBC.

2.3 Structure of the ABC

2.3.1 The ABC follows the 5 case model

2.3.2 Part A: Introduction and Strategic Case (Why does the Trust need to do anything - what is the problem?)

- 2. Introduction
- 3. Strategic Context
- 4. Case for Change
- 5. Future Service Requirement

2.3.3 Part B: Economic Case (What is the strategic solution?)

- 6. Background to the option appraisal7.
- 7. Benefit appraisal
- 8. Economic appraisal

2.3.4 Part C: Commercial Case (How does the Trust best procure the solution - MMH?)

- 9. Procurement route
- 10. Scope
- 11. Procurement Strategy
- 12. Bidder Solution

2.3.5 Part D: Financial Case (Can the Trust afford it?)

- 13. Affordability

2.3.6 Part E: Management Case (How does the Trust make it happen?)

- 14. Project timetable and management arrangements
- 15. Sustainability, regeneration and corporate citizenship
- 16. Workforce
- 17. Consultation, stakeholder involvement and approvals
- 18. Conclusion

2.3.7 The document comes in 2 volumes:

- Volume 1: The ABC Chapters
- Volume 2: The Appendices to the ABC

2.4 Outline Business Case (OBC) Approval

2.4.1 The OBC was approved in July 2014. The letter of approval from the Department of Health (DH) stipulated the following conditions as per the table below. Some of the conditions have already been agreed as 'closed' by the Stakeholder Board, which comprises the DH, the National Trust Development Authority (TDA) and Her Majesty's Treasury (HMT).

Table 17: Approval Conditions

No	Approval Condition	Outcome
1	Implement the Trust's existing recruitment plan to progress effective procurement and ensure that resourcing plans are sufficient.	The Trust has sufficiently resourced the procurement. Closed at Stakeholder Board 3rd December 2014.
2	Through dialogue identify whether delivery in July 2018 can be afforded within the Unitary Payment Cap set out in the OBC or whether savings could be made by adopting a different timetable.	It has been concluded that the delivering the hospital in July 2018 represents the optimal timescale. Closed at Stakeholder Board 3rd December 2014
3	The Unitary Payment (UP) must remain affordable and within the affordability cap identified within the OBC.	The UP remains affordable and is within the affordability cap identified within the OBC.
4	Need to develop a robust set of mitigation plans, supported by key commissioners, for a downside scenario before the Generic Appointment Business Case approval.	The Trust has an agreed downside plan. This has been briefed to stakeholders and comments are ongoing. This is detailed within the Affordability Chapter of this ABC.

No	Approval Condition	Outcome
5	Demonstrate Value for Money (VfM).	The VfM approach set out in the Procurement Approach chapter of this ABC was approved by Ben Masterson 26th March 2015. The Draft Final Bid received on 2nd April 2015 is compliant and there is a timetable to ensure that value for money continues to be demonstrated throughout the remainder of the procurement.
6	Work closely with the NTDA, DH and IUK throughout the procurement and provide regular updates against key approval parameters via a Stakeholder Board.	Future meetings dates have been confirmed.
7	Demonstrate that the value for money still favours PF2.	The VfM case has been re-affirmed in the Procurement Approach chapter of this Generic ABC.
8	Ensure no capital or revenue cost increases against the amounts identified in the OBC. DH capital cost cap set at £291m.	Off track against approval letter.
9	Submit a jointly agreed plan with commissioners for managing stranded fixed costs in the event of an income downturn at the Trust.	This is covered under condition 4.
10	Explore, before submission of Generic ABC the possibility of using land sales proceeds to improve affordability.	Modest land sales after scheme completion may improve the Trust's cash flow but the net receipt is not material to the sustainability rating.
11	Demonstrate that the scheme remains on track to deliver the significant workforce savings aligned to LTFM using evidence based plans to achieve full value of necessary savings.	This is detailed within the Workforce chapter of this Generic ABC. The Trust has removed the roles from its establishment required in 2014/15 and 2015/16. It has cut agency spend by a third compared with 2013/14.
12	Commissioner's support of Trust activity and income to be reconfirmed at each business case approval stage and income "actuals" to be evidenced. Plan to be congruent to OBC and underpinning LTFM.	Commissioner support remains to the income and activity plan underpinning Generic ABC.
13	Significant levels of productivity improvement to be delivered and affordability and efficiency to be kept under regular review.	The Trust ended 2014/15 at the correct 'run rate' and is on track for 2015/16 to be fully achieved.
14	Maintain strong performance against CQC and NTDA metrics of quality, safety, finance and performance in each financial year.	The Trust is rated A2 by the National Trust Development Authority in its Foundation Trust trajectory.
15	Achieve Capital and Cash plans in 2014-15 and satisfy the NTDA of its continuity of service risk rating for 2015-16 and 2016-17 and that it remains consistent with Long Term Financial Model (LTFM). This must include auditable visibility of the Right Care, Right Here reserve which services in 2018-19 the unitary payment.	On track
16	Maintain a gateway rating of amber-green or better.	On track to be complete prior to Specific Appointment Business Case submission All gateways to date are amber-green.

No	Approval Condition	Outcome
17	Achieve approval prior to Financial Close of IT Business Case or agree mitigation measures.	Midland Metropolitan Hospital Financial Close will occur before the Electronic Patient Record Final Business Case is approved. However, draft tender returns predate approval and the national stakeholder board confirmed in February 2015 that this timetable was acceptable. The EPR OBC was approved by the Trust Board on 2nd April 2015 and submitted to the TDA for approval.
18	Ensure that project continues to reflect accurately all aspects of PF2 policy.	On track

2.4.2 In addition to the conditions of OBC approval, another 3 conditions have subsequently been added by the Department of Health (26th March). These are detailed in the table below.

Table 18: Additional Conditions

No	Approval Condition	Outcome
19	Bidder to provide written assurance, in form approved by DH and HMT, that it accepts and complies with measures detailed within the ITPD 12 February 2015.	Written confirmation received from bidder 30th March 2015
20	Establish that the building envelope set out in the single bidder's design is adequate to meet the brief set out in the Trust Construction Requirements and provide supporting written evidence.	On track for reports to be provided by technical advisors (provided in an annex to this business case)
21	A representative from each of DH and HMT be appointed to the Trust's Project Board and attend relevant meetings as necessary.	A schedule of relevant meetings is being provided to the DH and HMT.

2.4.3 A report showing the progress against each of the above conditions is attached at ***Appendix 2a***

2.5 Key changes to the scheme since OBC approval

2.5.1 In terms of the Strategic Context, the operating environment has become more challenging. The drive to deliver higher standards of care and meet patient needs with diminishing resources has intensified, making the case for change more urgent.

2.5.2 The case for change for the scheme remains robust. The requirement for the MMH continues to be fully supported within the local health economy and forms a vital part of the Trust's strategy to deliver high quality care into the future. It remains a Trust priority to open the MMH in October 2018 in order to ensure the safety and sustainability of key services.

2.5.3 The project objectives developed in response to the case for change presented below have not changed since OBC approval:

- To move to a single acute hospital site;
- To develop a new high quality hospital building;

- To implement a new model of care;
- To deliver the best possible quality of care; and
- To develop staff and provide an optimal working environment.

2.5.4 Key changes arising from further development of the scheme and changes in the operating environment are detailed in the table below.

Table 19: Changes since OBC Approval

	Key change since OBC	Implications	Chapter(s) where addressed
Activity and income	Activity mapped to virtual outpatients A&E and UCC split out separately at MMH Activity and income projections have been refreshed to take account of the 2014/15 actual position and the expected contracted activity for 2015/16. New tariff deflators have been applied.	Activity projections remain in line with OBC assumptions for 2019/20. Income projections continue to align with Right Care Right Here assumptions agreed with commissioners. Therefore, the capacity requirements for MMH are unchanged from the OBC. However, the rate of change of transformation will need to increase in the interim.	5. Future service requirement 14. Affordability
Pay costs inflation	Pay cost inflation has been refreshed to take account of the most recent Monitor guidance.	Increased pay costs principally due to higher employer pension contributions.	14. Affordability
Capital programme	The capital programme has been refreshed and re-prioritised within the overall OBC envelope.	No impact on affordability or Continuity of Service Risk Rating (CSRR).	14. Affordability
Cost Improvement Programme (CIP)	The CIP has been refreshed through the business planning process to provide detail for 2015/16 – 2016/17. This has been reconciled to the LTFM and workforce plans. An outline plan has been created for the following 3 years.	Additional rigour to demonstrate affordability.	14. Affordability
Term sheets	Revised term sheets applied, reducing UP. The OBC assumed historic term sheets in accordance with the rates achieved at Alderhey plus a 50 basis point buffer. The ABC assumes current market rates with a 100 basis points buffer.	The current rates are significantly lower than assumed at OBC leading to a reduced UP.	14. Affordability

	Key change since OBC	Implications	Chapter(s) where addressed
Capex of scheme	The capital cost used in the shadow tariff for the OBC was £285m. The Trust's cost advisers have revised this to £312 to adjust for building cost inflation to date. The capital cost of the Draft Final Bid is £291.8m on an outturn cost basis. The scope is a like for like basis to the OBC except that the Trust will directly pay for remediation (circa £2m) and the bid now includes Active IM&T Infrastructure (circa £2m).	The Draft Final Bid is an affordable and efficient design and costs less than the estimate for the design at OBC in real terms. Furthermore, it meets the OBC approval criteria.	10. Procurement route
Procurement process	PF2 procurement conducted but only one bidder submitted Interim Bid Submission in December 2014. Therefore, single bidder in the procurement since that date. A revised Invitation to Participate in Dialogue has been issued to the bidder (and accepted) which sets out additional criteria to ensure that value for money is secured. The DH has approved approach to ensuring value for money in a single bidder procurement 26 March 2015	As a result of the additional criteria, the Trust is confident that the Draft Final Bid offers value for money for the Trust and that PF2 remains the preferred procurement route. As a result of the single bidder scenario, the Trust has been able to accelerate the procurement programme.	10. Procurement route 12. Procurement strategy
Public Sector Comparator (PSC)	The PSC has been refreshed to enable a proper comparison with the Bidder's Draft Final Bid. Updated to reflect same pricing index as Draft Final Bid and revised scope	Following these revisions to the PSC, a value for money assessment has been made which re-confirms the OBC conclusion that PF2 offers better value for money.	10. Procurement route
Programme	Financial Close has been brought forward from April 2016 to December 2015. It is now planned that enabling works (£2.47m) will commence in November 2015 with the main construction programme commencing January 2016. The OBC anticipated a construction period of 27 months. The Draft Final Bid anticipates a construction period (including enabling works) of 33 months.	The hospital is still due to be open October 2018. A reduced risk profile for the construction programme enabling better value for money.	12. Procurement strategy 15. Project management

	Key change since OBC	Implications	Chapter(s) where addressed
Scope	The Trust has stipulated a new requirement that the MMH will be 'Automated Guided Vehicles (AGV) ready'. Site remediation was included in the scope of the PF2 procurement at OBC but has subsequently been removed and the Trust will procure directly. Active IM&T infrastructure was outwith the PF2 procurement at OBC but has subsequently been included.	No impact on capital cost or timescales. The Trust provided with the option of using AGVs. The net cost impact of remediation and the IM&T infrastructure is insignificant. The risk to the Trust associated with the delivery a functional MMH on time has been reduced.	11. Project scope
Workforce plans	The Trust has commenced its workforce transformation programme and completed a statutory consultation for the first stage of the programme. An experienced Director of Organisational Development has been appointed to the Board who has a track record of large scale transformational change. More detail has been added to the Trust's workforce plan. This includes more definition and detail about how it will be delivered, given that the Trust has already delivered the first year of its workforce transformation.	More rigour and confidence in plans.	17. Workforce
Downside case	The downside case has been refreshed to reflect the risks identified in the Trust's Board Assurance Framework. The mitigations have been reviewed and improved to form a challenging but credible plan which is supported by commissioners.	More robust and credible downside case supported by commissioners.	14. Affordability
Long Term Financial Model (LTFM)	The annual update of the LTFM has been refreshed to reflect the above changes since OBC.	Continuity of Service Risk Rating (CSRR) remains at '3' or above throughout the period of the LTFM.	14. Affordability
Electronic patient record (EpR)	EpR was assumed to be fully implemented by October 2017 within the OBC. This has been reviewed and it is now planned that a 'Clinical wrap' of EpR will be fully implemented by October 2017.	The new hospital will be fully functional with the proposed solution	11. Project scope

2.6 Conclusion

2.6.1 The basis for the scheme has been refreshed with more recent information and validates that stated in the OBC. The key changes since the OBC which have a bearing on the scheme are outlined above and are addressed in detail in this ABC.

2.6.2 None of the changes identified challenge the requirement, scope, affordability or deliverability of the scheme. Rather, the changes emphasise the case for change and demonstrate better value for money than the OBC, thus making the business case more robust.

3 Strategic Context

3.1 Introduction

3.1.1 The strategic context outlined in this chapter continues to support the development of the MMH as outlined in Chapter 4: the Case for Change. It outlines the factors that come together to provide strategic context for the project including the:

- National context including policy, emerging guidance and financial conditions;
- Local context including: the needs of the population served by the Trust; commissioning intentions; the objectives of the Health and Wellbeing Boards and competition from other provider organisations;
- The Right Care Right Here (RCRH) vision for improving care in the local health and social care economy;
- The Trust's vision for the future and strategic objectives, and
- Conclusion and alignment with the national and local agenda.

3.2 National Context and Government Policy

3.2.1 This section summarises national policy and guidance as well as other factors that need to be taken into account in the Trust's plans for its future services and facilities.

The Francis Report

3.2.2 The Francis Inquiry report (February 2013), examined the causes of the failings in care at the Mid Staffordshire NHS Foundation Trust between 2005 and 2009 and makes 290 recommendations, including the need for:

- Openness, transparency and candour throughout the healthcare system (including a statutory duty of candour), fundamental standards for healthcare providers; and
- Improved support for compassionate, committed care and stronger healthcare leadership.

3.2.3 A number of other reports including: the Berwick Report, 'A Promise to Learn a Commitment to Act', (August 2013), driving patient safety and 'Compassion in Practice' (December 2012) – the Vision for nurses, midwives and care-staff, have built on the recommendations of the Francis Report to embed a new focus on quality, safety and compassion in healthcare.

The Keogh Report

3.2.4 The Keogh Report: 'Transforming Urgent and Emergency Care Services in England, End of Phase One Report' (November 2013), was commissioned in response to concern that A&E Departments, associated acute hospital services and ambulance services are under intense, growing and unsustainable pressure.

3.2.5 The report describes the following vision:

- People with urgent but non-life threatening needs should receive highly responsive, effective and personalised services outside of hospital. These services should deliver care in, or as close to, people's homes as possible, minimising disruption and inconvenience for patients and their families.

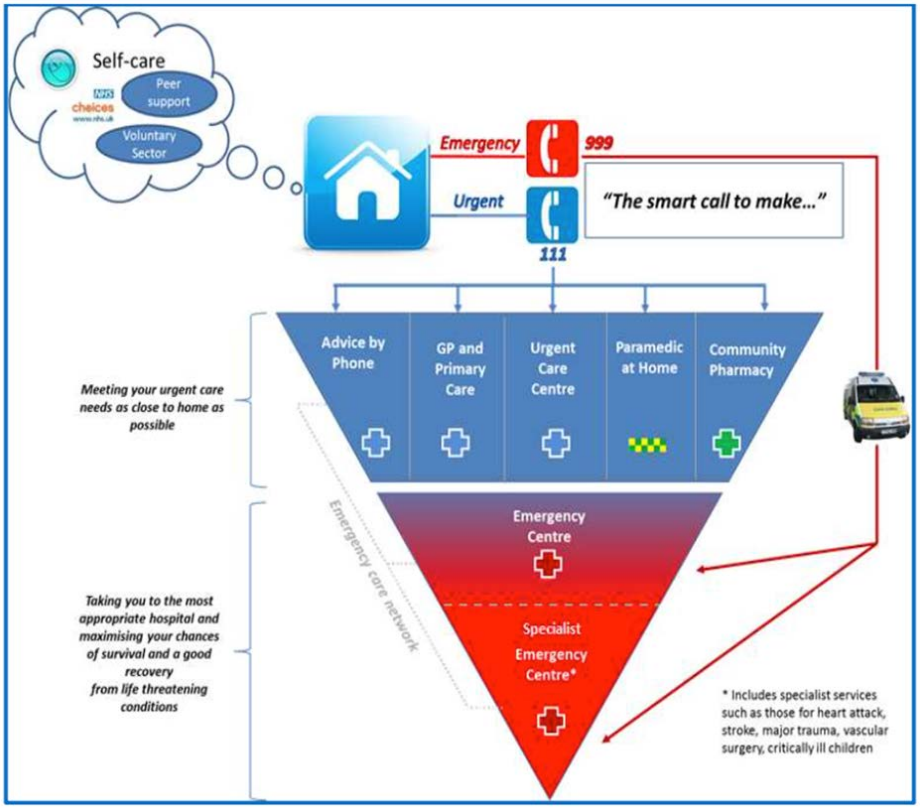
- People with more serious or life threatening emergency needs should be treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery. Getting the out of hospital services right will relieve pressure on hospital based emergency services to enable delivery of this part of the vision.

3.2.6 The proposals emphasise that the NHS must:

- Provide better support for people to self-care;
- Help people with urgent care needs get the right advice in the right place, first time;
- Provide highly responsive urgent care services outside of hospital so that people no longer choose to queue in A&E;
- Ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and good recovery; and
- Connect all urgent and emergency services together so that the overall system becomes more than just a sum of its parts.

3.2.7 The vision is summarised in the figure below.

Figure 5: Keogh: Vision for Urgent and Emergency Care



The Better Care Fund

3.2.8 The Better Care Fund was announced in June 2013. It provides an opportunity to transform local services so that people are provided with better integrated care and support. A substantial level of funding is being provided to help local areas manage pressures and improve long term sustainability. The Fund is an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change. The Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life. The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings.

3.2.9 Commissioner support for the scheme, and approval of it, post-dates the initiation of the Better Care Fund and, at Outline Business Case stage, specifically confirmed the congruence of the project with the Better Care Fund.

3.3 The NHS Five Year Forward View

3.3.1 The NHS Five Year Forward View was published in October 2014. It sets out how the NHS needs to change proposing a more engaged relationship between patients, carers and staff in order to focus on wellbeing and prevention. The 3 main conclusions are:

- There should be more focus on prevention and public health;
- Patients need to be given more control over their own care; and
- Barriers need to be removed on how care is provided between primary care and hospitals; between physical and mental health; and between health and social care.

3.3.2 The report emphasises that continued efficiencies of circa 2% per annum will be required and that new models of care will need to be developed to meet this challenge. Such models may include:

- Primary and Acute Care systems, bringing together GPs and hospitals; and
- Multi-Speciality Community Providers, whereby primary care, community care and hospital specialists come together to create integrated out of hospital care.

3.3.3 The Trust is a partner in the local Vanguard Scheme being developed through the Vitality GP partnership.

3.4 Financial Environment

3.4.1 As referred to in the NHS Five Year Forward View, funding constraints and real terms tariff reductions lead to the requirement for high levels of cost improvement plans compared with historic levels. Funding constraints for commissioners will add to the pressures being felt locally.

3.4.2 This is reflected in the changes to efficiency assumptions and expectations under Monitor's Compliance Regime along with the requirement (set by the Trust's Board) for the base case to deliver a level 3 Risk Rating under Monitor's Continuity of Service Risk Rating metric.

3.4.3 This results in the Trust needing to make significant savings leading up to the new hospital opening and to realise further financial benefits when the facility opens in October 2018. The vast majority of the savings are required with or without the new build, and, as the Workforce Chapter explains, these are efficiencies that can only be accessed via reconfiguration.

National Context: Conclusion

National context dictates that significant change driven by clinical leaders and supported by public engagement will be required to meet the higher standards of care expected in future.

Investing in integrated care and shift of activity away from the acute setting will be central to future plans supported by development of high quality, safe and sustainable services for patients requiring acute care in hospital.

Services will need to become increasingly productive and cost effective to ensure that the NHS continues to meet the needs of patients.

3.5 Local Context and Health Strategy

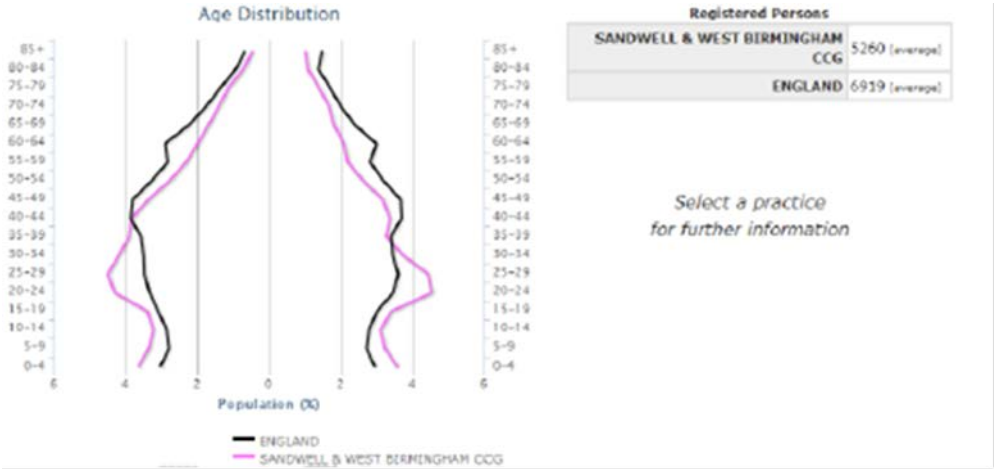
Population Served by the Trust

3.5.1 This section outlines the needs of the population that the Trust serves.

Demographic Change

3.5.2 The total population served by Sandwell and West Birmingham Clinical Commissioning Group (SWB CCG) is expected to increase by 6% over the next 20 years. A 16% increase in the number of children and young people in Birmingham is forecast over the same period. The increase in people over 65 years of age will be markedly lower than England (approximately only a third of the England trend). This is highlighted by the population pyramid presented in the figure below.

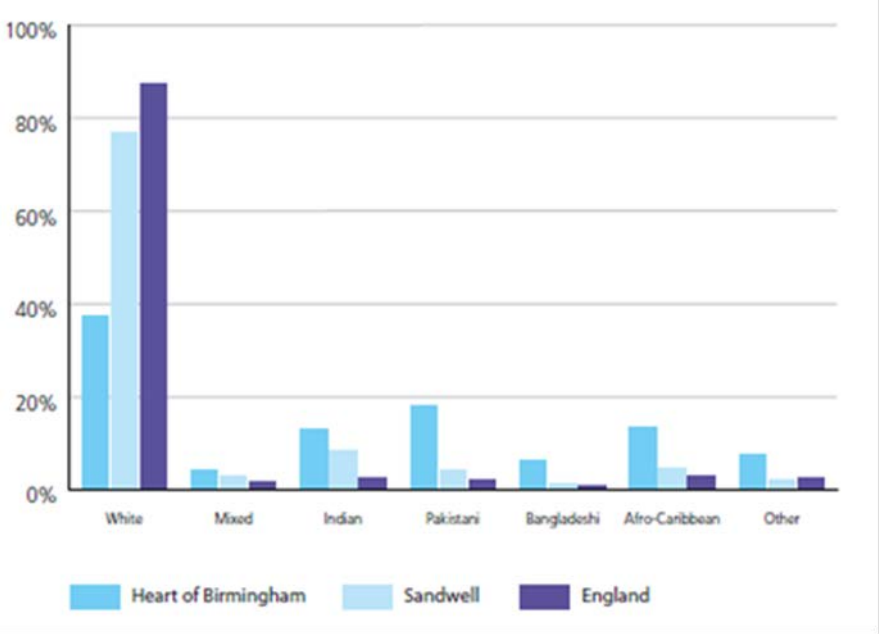
Figure 6: Age Distribution



Ethnicity

3.5.3 The Trust delivers services to a population with a significantly higher proportion of black and minority ethnic (BME) and all other ethnic groups than England as a whole. This is illustrated in the figure below.

Figure 7: Ethnicity



3.5.4 The Heart of Birmingham area of SWB CCG has the largest (68%) black and minority ethnic population in England, with the largest group being of Pakistani origin. There is a further increase in the BME population predicted to 2016 (40% increase in the Pakistani and Bangladeshi population and a 130% increase in the number of Black Africans to 18,000).

3.5.5 The Sandwell population of SWB CCG is also becoming more ethnically diverse. In the ten years between 1991 and 2001 the BME population increased by 6% to 20%, with the rate of growth being most pronounced amongst the Asian communities. It is estimated that by 2025, people from BME communities will comprise 30% of the Sandwell population in the SWB CCG.

3.5.6 The implications for the Trust are that:

- Services need to be culturally sensitive and accessible to all;
- Health promotion or lifestyle management may need to be tailored for the specific needs of this group;
- Plans for the future need to ensure that the Trust has facilities which are appropriate for different religious beliefs and which make interpreting services available where necessary; and
- The Trust will deliver services to people with increased levels of prevalence for certain conditions such as diabetes, eye disease and cardiovascular disease.

Deprivation

3.5.7 The population served by the Trust is dominated by high levels of deprivation. When ranked on the English Indices of Deprivation (IMD) - of 354 English local authorities, Birmingham is the 9th and Sandwell is the 12th most deprived. There are a significant number of wards in the worst 20% nationally.

3.5.8 The most deprived areas of Sandwell have a life expectancy of 10.1 years lower for men and 5.9 years lower for women in 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.

3.5.9 The overall Birmingham unemployment rate (as measured by the percentage of the population claiming job seekers allowance) is 12.6%, more than double that of the UK at 5.6%, with electoral wards in the Birmingham area being the most severely affected at over 20%. Sandwell's rate is currently 7.2%. Such social and economic deprivation has an adverse impact on health at all levels. The Trust therefore serves a population with lower life expectancies and higher than average rates of mortality and disease.

Health Status

3.5.10 As expected for a population with high levels of deprivation, life expectancy for both men and women is significantly lower than the England average. Men have a life expectancy of 75.9 years for Birmingham as a whole and 74.3 years for men in Sandwell, in comparison to an England average of 77.9 years. Female life expectancy in Birmingham is 81 years, compared to 80 in Sandwell, and 82 years for the England average. It is important to note that these figures are for Birmingham as a whole, and that indicators for the heart of Birmingham area are assumed to be significantly worse as a result of the high levels of deprivation.

3.5.11 The table below gives a summary of key health and lifestyle indicators per 100,000 population. With the exception of the numbers of adults who smoke in Birmingham, all the figures are significantly worse than the average for England.

Table 20: Key Health and Lifestyle Indicators

Indicator (per 100.000 population)	Birmingham	Sandwell	England Average
Infant deaths	8.25	8.46	4.84
Deaths from smoking	248.10	280.50	206.80
Early deaths: heart disease and stroke	96.80	110.90	74.80
Early deaths: Cancer	123.20	135.10	114.00
People diagnosed with diabetes	5.12	5.63	4.30
Adults who smoke	22.50	27.50	22.20
Hospital stays due to alcohol	1,940	2,180	1,580
Obese adults	26.80	29.10	24.20
Obese children	10.80	12.90	9.60
Teenage pregnancies (under 18s)	52.10	59.10	40.90

3.5.12 Additional analysis of key health conditions shows that:

- Incidence rates for some cancers are significantly higher for the local population than for the rest of the West Midlands;
- Levels of prevalence for certain health conditions are projected to increase largely in line with the national average rates for the heart of Birmingham area, but at a higher rate for Sandwell which is projected to have the highest rates of stroke, CVD, CHD and hypertension in the local health economy; and

- Birth rates for the local populations are higher than the England average, with Sandwell having the highest rate within the West Midlands (77.6 live births per 100,000), and Birmingham the third highest (73.3).

The Population Served by the Trust: Conclusion

Population growth, local diversity, high levels of deprivation and consequent poor health means that there is a need to rebalance resources, to shift activity away from the acute setting and invest in services that will improve the health of local people and reduce health inequalities.

3.6 The Local Health and Social Care Economy

3.6.1 This section describes the local health and social care economy outlining the objectives of local partners and commissioners as well as summarising the impact of competition from other providers in the area.

The Local Councils

3.6.2 The Trust delivers services to a core population of circa 530,000 which is served by two local authorities:

- Sandwell Metropolitan Borough Council; and
- Birmingham City Council.

3.6.3 The borough of Sandwell spans a densely populated part of the Black Country and the West Midlands conurbation, encompassing the urban towns of Blackheath, Cradley Health, Oldbury, Rowley Regis, Smethwick, Tipton, Tividale, Wednesbury and West Bromwich.

3.6.4 Bordering Sandwell to the east is the Heart of Birmingham area of the City of Birmingham. This area includes some of the poorest, most deprived neighbourhoods as well as the affluent shopping and business districts of the City Centre. The Trust predominantly serves the Handsworth Wood, Ladywood, Aston, Lozells, Nechells, New Oscott, Perry Barr and Soho wards in the Heart of Birmingham area.

The Commissioning Organisations

3.6.5 The regional team of NHS England covers the Midlands and East of England. This benefits the Trust, as it is now geographically at the heart of this one body as opposed to being on the periphery of two separate clusters as it was in the early days.

3.6.6 The Trust now provides services for three main Clinical Commissioning Groups (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); and
- NHS Birmingham South and Central CCG (accounts for circa 5% of Trust activity).

Sandwell and West Birmingham Clinical Commissioning Group

3.6.7 Sandwell and West Birmingham Clinical Commissioning Group (SWB CCG) is responsible for a population of 530,000, largely drawn from the Sandwell and Heart of Birmingham geographical areas. The CCG population is aligned to the catchment population that the Trust serves.

3.6.8 SWB CCG includes all but three of the practices that sit within the Trust's natural boundary. The three remaining practices, which have a practice population of around 28,000, are part of the NHS Cross City CCG, which accounts for circa 13% of the Trust's activity. The configuration of local practices is presented in the table below.

Table 21: Local GP Practice Configuration

	Local Consortium	Number of Practices	Approx. list Size	No. of practices in top 20 referrers to SWBH
SWB CCG	Healthworks	10 12	54,000 77,000	0 7
	Black Country Commissioning Group	20	112,000	5
	Sandwell Healthcare Alliance	31	127,000	6
	Pioneers for Health (P4H)	10	46,000	0
	Intelligent Commissioning Forum (ICOF)	27	107,000	0
NHS Cross City Clinical Commissioning Group		1 2	4,000 24,000	0 2
Total		**113**	**551,000**	**20**

3.6.9 The strategic priorities for Sandwell and West Birmingham CCG are to:

- **Initiate** – intervening early to prevent illness and being proactive in providing care, using high quality information and empowering patients to make choices and manage their care;
- **Integrate** – putting the patient at the centre of everything, improving communications to ensure seamless transitions between primary, secondary and community care, and across health and social care;
- **Innovate** – scaling up good practice, changing the way we do things to deliver more with less, creating new models of delivery to provide more care in community settings;
- **Improve** – focusing on the quality and safety of services in all parts of the system, ensuring that this is reflected in the patient experience, valuing and acting on their feedback; and,
- **Influence** – playing a full role in local partnerships to affect the wider determinants of health, engaging directly with patients and our communities to facilitate change.

3.6.10 Given the nature of the health needs of the SWB CCG population, five domains or high level outcomes have been identified:

- Preventing people from dying prematurely;
- Enhancing the quality of life for people with long-term conditions;
- Helping people recover from ill health or following injury;
- Ensuring people have positive experiences of care; and
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

3.6.11 A further key priority for SWB CCG includes building on the successful partnership arrangements as part of the RCRH Programme. SWB CCG has not only confirmed commitment to the programme, but

has also expressed an intention to accelerate this work. The CCG recognises that the RCRH Programme is critical to the successful delivery of the objectives of the local health economy.

3.6.12 Other key CCG priorities include improving the quality of clinical services commissioned, increasing efficiency of all providers and decreasing dependency on the acute sector. These priorities are aligned to delivery of the RCRH strategy.

Local Health and Wellbeing Boards

3.6.13 The local Health and Wellbeing Boards for Sandwell and Birmingham have identified their priorities for improving health. There is significant congruence in their priorities, particularly those focussed around:

- Early years and adolescent health;
- Long term conditions and integration of care;
- Frail elderly and dementia;
- Alcohol;
- Healthy and sustainable communities; and
- Maximising the capability of individuals to lead healthy lives.

3.6.14 During 2014/15 the Health and Wellbeing Board for Sandwell refreshed its medium term plans. The Midland Metropolitan Hospital is now one of the named priorities of the board.

3.6.15 The Trust is responding to local challenges through the development of a Public Health Plan supported by local partners that contributes to the local Health and Wellbeing priorities.

3.6.16 In addition to the specific commitments the Trust gives to improving health and wellbeing, the plans for a new hospital will support the physical regeneration of a large part of the area. Construction and procurement of local products / services will also create local jobs.

Other Providers in the Local Area

3.6.17 There are five other general acute hospital trusts (including three NHS Foundation Trusts) within the Birmingham and Black Country area, three of which also provide community health services. There are also three specialist NHS Foundation Trusts and a large Community Services Trust. The Trust has established a joint Partnership Board for collaboration with both Walsall and Dudley Group of Hospitals. The types of services provided by these organisations are presented in the table below.

Table 22: NHS Organisations in Birmingham and the Black Country

Organisation	Acute Service Provider	Community / Health and Social Care Provider	Catchment Area
Dudley Group of Hospitals NHS Foundation Trust (DGH)	✓	✓	Dudley
Heart of England NHS Foundation Trust (HEFT)	✓	✓	Birmingham Solihull
University Hospital Birmingham NHS Foundation Trust (UHB)	✓		Birmingham

Organisation	Acute Service Provider	Community / Health and Social Care Provider	Catchment Area
Walsall Healthcare NHS Trust (WHT)	✓	✓	Walsall
Royal Wolverhampton Hospitals NHS Trust (RWT)	✓	✓	Wolverhampton
Birmingham Community Healthcare NHS Trust		✓	Birmingham
Black Country Partnership NHS Foundation Trust (SMHSCT)		✓	Sandwell Dudley, Walsall
Birmingham and Solihull Mental Health NHS Foundation Trust			Birmingham and Solihull
The Royal Orthopaedic Hospital NHS Foundation Trust	✓		West Midlands Specialist Trust
Birmingham Children's Hospital NHS Foundation Trust	✓		West Midlands Specialist Trust
Birmingham Women's NHS Foundation Trust	✓		West Midlands Specialist Trust

Competition and Acute Market Share

3.6.18 The Trust is in the centre of a complex and competitive local healthcare market, reinforcing the need for the Trust to deliver excellent care that meets patient needs and is convenient to access. The situation also provides opportunities for the Trust to encourage a greater flow of patients from the local population.

3.6.19 A summary of the Trust's market share by CCG is summarised in the table below.

Table 23: Market Share

		OP: new attendances	Non-elective admissions	Elective admissions
SWB CCG	Activity	261,602	49,451	43,805
	% of Trust total	75	76	70
	% SWB CCG total	80	64	70
Cross City	Activity	46,529	6885	9,472
	% of Trust total	13	11	15
	% Cross city total	15	6	11
South Birmingham CCG	Activity	16,120	2653	3074
	% of Trust total	5	4	5
	% South Birmingham total	17	8	13
Walsall CCG	Activity	4347	711	1298
	% of Trust total	1	1	2
	% Walsall CCG total	7.9	6.1	9.3

Dudley CCG	Activity	4735	676	1082
	% of Trust total	1	1	2
	% Dudley CCG total	4	1	2

The Local Health and Social Care Economy: Conclusion

The Trust maintains strong alignment with the local context including the need to develop services that prevent poor health, integrate care, develop care closer to home and increase focus on quality and safety.

Healthy competition from a range of other providers requires proactive shift of activity to community services and development of sustainable, high quality, acute and specialist services.

3.7 Right Care Right Here (RCRH) Programme

3.7.1 This section summarises the implications of the RCRH objectives and model of care on the plans of the Trust.

The RCRH Partners

3.7.2 The Trust is a key member of the RCRH Partnership. All partners have shown exceptional levels of commitment over the 10 years of the programme.

3.7.3 The current RCRH partners are:

- Sandwell and West Birmingham Clinical Commissioning Group (SWB CCG);
- Sandwell and West Birmingham Hospitals NHS Trust (The Trust);
- Black Country Partnership NHS Foundation Trust (BCP FT);
- Birmingham Community Healthcare NHS Trust (BCH);
- Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT).
- Birmingham City Council (BCC); and
- Sandwell Metropolitan Borough Council (SMBC).

RCRH Objectives and Outcomes

3.7.4 The RCRH objectives are to:

- Redesign services to meet the needs of the local populations;
- Ensure that people have the opportunity to benefit from healthier lifestyles;
- Expand services in community settings, bringing appropriate elements of care closer to home and integrating provision such that patients experience seamless care pathways;
- Develop new highly specialised acute hospital services to be provided in the MMH;
- Procure, build and commission the MMH on a brown field site in Smethwick; and
- Maximise opportunities for regeneration in the local area.

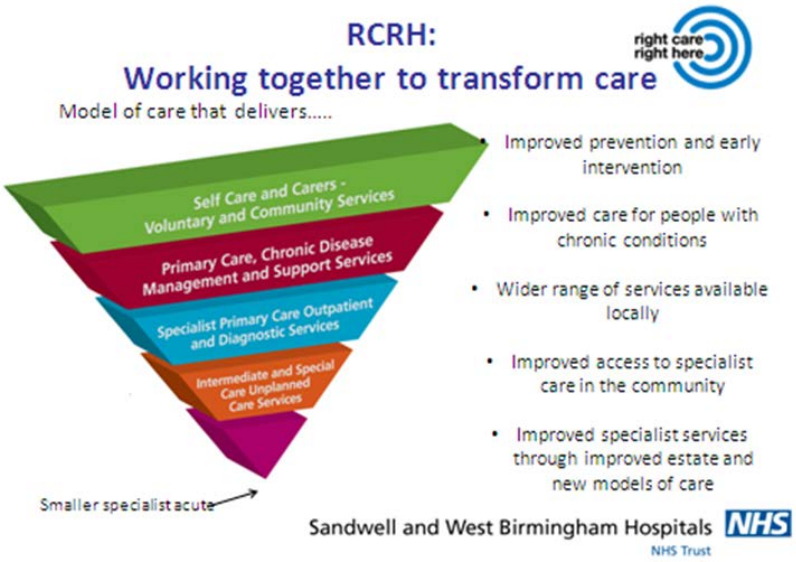
3.7.5 The expected outcomes of the RCRH Programme are significant. Local people will have improved physical, mental and social well-being through:

- Prevention of ill health and promotion of healthy lifestyles through education and leisure activities;
- Earlier treatment of specific conditions to improve life expectancy and chance of recovery;
- Development of a single pathway of care and integration of services - with agencies working together facilitated by information sharing;
- Support to enable people to stay in their own homes;
- Delivery of care closer to people's homes;
- Re-organisation of services to reduce professional isolation, achieve greater critical mass, deliver better quality of care and achieve long term clinical sustainability;
- Better physical environments for service users and staff to encourage more rapid recovery and provide greater privacy and dignity;
- Involvement of local people as active participants in the development of services which are culturally sensitive and convenient;
- More effective use of staff resources and greater diversity in the workforce that reflects local communities; and
- Integration of health plans with local regeneration developments.

Overview of the RCRH Model of Care

3.7.6 The RCRH Programme has developed a new model of care for the local population summarised in the figure below.

Figure 8: The RCRH Approach



3.7.7 The model of care includes interdependent components that deliver:

- Improved prevention and early intervention;
- Improved care for people with long term conditions;

- A wider range of services available locally;
- Improved access to specialist care in the community; and
- Improved specialist services through improved estate and new models of care.

3.7.8 Implementation of the RCRH Programme has now been underway for some years with a growing range of traditional secondary care services now being provided via new models of care in community locations.

3.7.9 The Trust is developing a new model of patient care in line with the RCRH vision outlined above. Within this service model the Trust will deliver clinical services in multiple locations including:

- Patients' own homes;
- Primary care and health centre settings;
- The Trust's community facilities including Rowley Regis Hospital, Sandwell Treatment Centre, Birmingham Treatment Centre, Birmingham and Midlands Eye Centre, the adjacent Sheldon Block and Leasowes Intermediate Care Facility; and
- A new single site acute hospital.

3.7.10 This vision requires a major step change in service provision across the health economy through service redesign and investment with a re-balancing of capacity to reflect a greater focus on delivering care in community and primary care settings and clinically sustainable acute hospital services operating at maximum productivity.

3.7.11 Where quality, safety and outcome are improved by care closer to home the Trust will deliver care in community settings and will integrate services both internally and with external partners in order to provide seamless care.

3.7.12 The RCRH vision will be enabled by:

- Transformation of the estate including development of primary care facilities, community facilities and development of a new acute hospital;
- Development of information management and technology (IM&T) functionality that will facilitate pathways of care across all local healthcare settings; and
- A redesigned workforce that is able to deliver high quality care across reconfigured services and in a range of different settings.

Right Care Right Here Programme: Conclusion

The RCRH Programme requires the Trust to shift care out of acute facilities to enable investment in prevention and care closer to home.

The RCRH model of care proposes a single site new acute hospital to deliver those high quality sustainable clinical services that need to be delivered within a hospital.

3.8 The Trust Context

Introduction to the Trust

3.8.1 Sandwell and West Birmingham Hospitals NHS Trust (the Trust) is an integrated care organisation. The Trust is dedicated to improving the lives of local people, to maintaining an outstanding reputation for teaching and education and to embedding innovation and research. The table below summarises the key facts about the Trust.

Table 24: Key Facts about the Trust

Population served	530,000
Annual turnover	£447m million (2014/15)
Number of sites	Two acute sites and three main community locations
Current CQC Rating	Requires improvement
Current TDA Rating	Level 3

3.8.2 The Trust provides acute and specialist services from City Hospital in Birmingham and Sandwell General Hospital in West Bromwich. Emergency care, including A&E services is provided at both sites. In addition, the Trust provides comprehensive community services to over 300,000 people in the Sandwell area from more than 150 locations. Of these three are registered through the Trust. Those being:

- Rowley Regis Community Hospital;
- Leasowes Intermediate Care Centre; and
- Halcyon Midwife-led Birth Centre.

3.8.3 In April 2011 the Trust acquired Sandwell PCT's Community Services Provider Arm, resulting in the Trust providing community based care for circa 60% of its local catchment population.

3.8.4 The Trust is a teaching hospital Trust of the University Of Birmingham. It also delivers undergraduate and specialist education for nurses and professions allied to medicine for the University of Birmingham, the University of Wolverhampton and Birmingham City University. A number of clinical specialties have a long and distinguished record of contribution to academic research.

Trust Vision

3.8.5 Taking into account the local health economy context and the Trust's inherent strengths, the Trust has set the following vision for the future of its services:

'We will become renowned as the best integrated care organisation in the NHS by 2020.'

3.8.6 In the short term the Trust will:

- Relentlessly improve the quality of care provided to patients, achieving ever higher levels of safety, effectiveness and patient satisfaction;
- Recruit, engage and develop passionate and committed people;

- Integrate specialist community services with acute services to ensure that pathways focused on prevention and swift rehabilitation are developed;
- Integrate district nursing, community midwifery and health visiting services as closely as possible with primary health care teams to ensure that patients receive a comprehensive proactive health promoting service;
- Work with partners to actively identify and care for patients who are most at risk of hospital admission, developing virtual wards to keep patients out of hospital and swiftly able to be discharged;
- Actively build on the success of the Trust's acute specialist services;
- Meet all statutory and regulatory obligations;
- Ensure that plans will be based on a sophisticated understanding of the health needs of local communities driven by active dialogue and engagement; and
- Explore new contractual and funding partnerships to create a system with clear and comprehensive incentives to keep patients well and out of hospital.

3.8.7 In the longer term, 2020 ambitions mean that:

- The Trust will consistently deliver safe, reliable care that patients value highly;
- Patients will say that they do not perceive organisational barriers to accessing the care they seek;
- Staff engagement and leadership programmes will be recognised as among the best in the NHS;
- The Trust will be widely recognised as a ground breaking organisation that takes responsibility for meeting the health and wellbeing needs of the population - providing and organising care in a systematic way;
- The Trust will make innovative use of analytics and technology to make services more accessible and responsive;
- The Trust will develop a more comprehensive set of services to manage the health of the local population working with local communities, the voluntary and statutory sectors;
- The population will hold and use its own integrated health record;
- The Trust will invest more in alternatives to hospital care, reducing the acute services footprint so that the MMH will be a new smaller centre for the most acute inpatient treatment;
- The MMH will be open to provide the highest quality acute specialist services from pleasant, clean, fit for purpose facilities; and
- The Trust will drive innovation in the local health economy, using membership of the West Midlands Academic Health Science Network and building on research strengths and position as a large employer to create local employment opportunities.

Trust Values

3.8.8 The Trust values underpin everything it does as an organisation and reflect what it believes are most important to its patients, their relatives and their carers. The table below outlines what the Trust values will mean to patients, carers, relatives and staff.

Table 25: Trust Values

The Trust will be	What this will mean to patients, carers, relatives and staff
Caring and Compassionate	The Trust sees patients, their carers and relatives as individuals and listens to their needs The Trust cares for patients, their carers and relatives as they want it to The Trust will treat all the patients with dignity and respect
Accessible and Responsive	The Trust's services are accessible to all The Trust identifies and responds to the diverse needs of the patients and communities that it serves The Trust involves patients in decisions about their care.
Professional and Knowledgeable	The Trust demonstrates high levels of competence and professionalism in all that it does The Trust provides safe, high-quality services The Trust pursues opportunities for innovation in the way it provides services
Open and Accountable	The Trust is open about what it does The Trust is accountable to patients and local people for the decisions in takes and the services it provides
Engaging and Empowering	The Trust values the experience and knowledge of all its staff and listens to their ideas The Trust works together across boundaries to provide the very best care The Trust provides an environment in which staff can flourish and grow

3.8.9 Combined with the Trust's vision for the future delivery of healthcare to the distinct and diverse population that it serves, the Trust's values have helped it to develop a set of long term strategic objectives.

Strategic Objectives

3.8.10 The Trust's strategic objectives are presented in the table below.

Table 26: The Trust's Strategic Objectives

Strategic Objective	Description
Safe, high quality care	We will provide the highest quality clinical care. We will achieve the goals of safety, clinical effectiveness and patient experience set out in our quality strategy.
Accessible and responsive care	We will provide services that are quick and convenient to use and responsive to individual needs. They will be accessible to all ages and demographics. Patients will be fully involved in their design.
Care closer to home	Working in partnership with primary and social care we will deliver an increasing range of seamless and integrated services across hospital and community settings.
Good use of resources	We will make good use of public money. On a set of key measures we will be among the most efficient trusts of our size and type.
21st Century Infrastructure	We will ensure our services are provided from buildings fit for 21st century healthcare. We will make the most effective use of technology to drive improvements in quality and efficiency.
An engaged, effective organisation	An engaged and effective NHS organisation will underpin all we do. We will become an NHS foundation trust at the earliest opportunity. We will develop our workforce, promote education, training and research, and make the most effective use of technology to drive improvements in quality and efficiency.

Range of Services

3.8.11 The Trust provides a full range of secondary care services for the local population, some more specialist services to a wider population and comprehensive community services in Sandwell.

3.8.12 City Hospital (shown in the figure below) was built in 1887 as the Infirmary for the Birmingham Workhouse. The majority of the estate, including the main inpatient facilities, still dates from this time. More recent additions include the £35m Birmingham Treatment Centre which provides state of the art facilities for one-stop diagnosis and treatment. It includes an Ambulatory Surgical Unit with six theatres, extensive imaging facilities, an integrated breast care centre and teaching accommodation.

3.8.13 Specialist services / departments at City Hospital include:

- The Birmingham and Midland Eye Centre (BMEC), a supra-regional specialist facility;
- The Pan-Birmingham Gynaecological Oncology Centre;
- The Sickle Cell and Thalassaemia Centre; and
- The regional base of the National Poisons Information Service.

Figure 9: City Hospital

3.8.14 Sandwell General Hospital's (shown in the figure below) main clinical facilities were rebuilt in the 1970s. In 2005 a new £18m Emergency Services Centre opened on the Sandwell site, incorporating a comprehensive Emergency Department, Emergency Assessment Unit and Cardiac Care Unit.

Figure 10: Sandwell Hospital

3.8.15 Rowley Regis Community Hospital (shown in the figure below) was opened in 1994 and provides continuing care and rehabilitation services. It also has a range of outpatient and diagnostic facilities.

Figure 11: Rowley Regis Community Hospital

3.8.16 Clinical Directorates serve as the main focus for both operational management and planning, supported by a clinical group management structure which integrates performance, business, quality and financial management with operational delivery. The seven groups are as follows:

- Medicine and Emergency Care;

- Women and Child Health;
- Imaging;
- Surgery A (General Surgery, Trauma and Orthopaedics, Urology, Vascular), Anaesthetics and Critical Care;
- Surgery B (BMEC, Oral and Maxillo-facial surgery, ENT and Audiology);
- Pathology; and
- Community and Therapies.

3.8.17 The table below gives an overview of services across the hospital sites.

Table 27: Services by Site

	Service	City	Sandwell	Rowley
WOMEN AND CHILD HEALTH	Paediatrics	OP and PAU	✓	
	Obstetrics	✓		
	Midwifery led care	Serenity birth centre and OP	OP	
	Neonatal	IP (level 2 units) and OP		
	Gynaecology	✓	DC and OP	OP
	Gynae- oncology	✓	OP	
	Genito-urinary Medicine/ HIV		OP	
	Children's therapists		✓	OP
	Health Visiting			
	Family planning			OP
SURGERY A	General surgery	DC and OP	✓	OP
	Breast surgery	✓		
	Trauma and orthopaedics	SAU,DC and OP	✓	
	Vascular surgery (I P at UHB)	DC and OP	DC and OP	
	Urology	✓	TC and OP	OP
	Plastic surgery	✓	✓	OP
	Paediatric surgery	TC and OP	✓	
	Emergency surgery	SAU	✓	
SURGERY B	Ophthalmology	✓	DC and OP	OP
	Behcet's	OP		
	Ear, nose and throat	✓	OP	OP
	Oral surgery	DC and OP	OP	
	Dental surgery (Host)		DC and OP	OP
	Audiology	DC and OP	OP	OP
	New-born hearing	✓		

	Service	City	Sandwell	Rowley
MEDICINE	Emergency medicine	A&E and MAU	A&E and MAU	
	Acute medicine	IP and OP	✓	
	Elderly care	✓	✓	OP and DC
	Stroke (Including TIA)		✓(Including HASU)	
	Neurology	OP	✓	OP
	Cardiology	✓	✓	OP
	Gastroenterology	✓	✓	OP
	Respiratory	✓	✓	
	Dermatology	✓	DC and OP	
	Diabetes and renal	IP and OP	IP and OP	OP
	Lipid clinic		OP	OP
	Rheumatology and immunology	✓	✓	OP
	Haematology (non-oncology)	✓(sickle cell and thalassemia unit)	OP	OP
	Haematology (oncology)	DC and OP	✓ (level 2b care)	
	Anticoagulation	OP	OP	OP
	Oncology	OP and chemo (DC)	OP and chemo (DC)	
CLINICAL SUPPORT	Anaesthetics & pain	DC and OP	DC and OP	
	Critical care	IP and OP	IP and OP	
	Imaging	✓	✓	OP (ultrasound and x-ray
	Pathology	Some laboratories	Main laboratories	
COMMUNITY SERVICES	Phlebotomy	IP and OP	IP and OP	IP and OP
	Intermediate care and re-enable meant	IP at City		IP
	Foot health	OP	OP	OP
	Musculoskeletal service	OP	OP	OP
	Community TB team		OP	
	Nutrition and dietetics	IP and OP	IP and OP	OP
	Icares		In reach	
	Primary care assessment and treatment centre			OP
	Physiotherapy and occupational therapy	IP and OP	IP and OP	IP and OP
	Speech and language therapy	IP and OP	IP and OP	IP and OP
	Palliative care	IP support	IP support	
	Continence	OP	OP	

Changes to SAU and Cardiology as a result of interim reconfiguration are likely to be approved by August 2015

3.8.18 A broad range of community services in Sandwell are provided from four main community sites including rehabilitation at the Leasowes Intermediate Care Centre, a range of outpatient activity from the Lyng Centre for Health and Social Care and Rowley Regis Hospital and midwife-led births delivered at the Halcyon Birth Centre.

Activity

3.8.19 Activity delivered at each of the three hospitals is presented in the table below.

Table 28: Activity by Site 2014/15

Activity	City Hospital	Sandwell Hospital	Rowley Regis	Community Services Sites	Henderson & Leasowes (Beddays)	Total
Elective Admissions	32,660	15,976	15			48,651
Emergency Admissions	48,122	9,896	3		13,825	71,848
Outpatients (total)	470,027	253,078	18,277			741,383
Outpatients (A&E)	113,210	107,348				220,558
Community Contacts				721,068		721,068

3.8.20 The table below shows activity by specialty in 2014/15.

Table 29: Activity by Specialty

Speciality	Elective inpatients	Day cases	Elective and day cases	Emergency admissions	Outpatient attendances
General surgery	783	2,967	3,750	4,999	19,420
Urology	1,287	1,632	2,919	1,207	20,008
Breast surgery	59	836	895	50	11,029
Colorectal surgery	1	-	1	1	-
Vascular surgery	7	311	318	16	4,431
Trauma & Orthopaedics	1,522	1,832	3,354	3,134	28,523
ENT	349	692	1,041	861	16,456
Ophthalmology	501	7,254	7,755	553	134,833
Oral surgery	21	3,043	3,064	4	5,648
Plastic surgery	319	1,033	1,352	35	6,660
Accident & Emergency	1	-	1	91	96
Pain management	12	1,880	1,892	9	6,076
General medicine	- 10	- 1,342	- 1,353	39	-
Acute Internal Medicine	48	- 897	- 849	17,097	10,560
Gastroenterology	142	1,809	1,951	1,966	16,836
Clinical haematology	248	2,881	3,129	240	17,160
Diabetic medicine		1	1	169	8,687
Cardiology	418	1,431	1,849	2,358	30,676
Anticoagulant Service	1	-	1		65,417
Stroke Medicine	3	- 3	- 1	1,001	349
Dermatology	24	2,167	2,191	37	25,347
Respiratory medicine	55	228	283	1,908	9,632
GUM			-	-	7,839
Medical oncology	636	5,068	5,705	- 6	8,425
Neurology	12	141	153	99	9,039
Rheumatology	29	2,442	2,472	29	25,729
Paediatrics	477	317	795	7,564	12,320
Geriatric Medicine	18	- 3	14	2,946	3,957
Obstetrics	9	5	15	5,811	65,560
Gynaecology	651	1,367	2,017	1,943	14,748
Gynaecological Oncology	636	181	817	176	3,089
Clinical Oncology	88		88	1	5,867
Midwife Episode			-	1,779	15,007
Others	386	2,645	3,031	1,904	132,601
Total	**8,732**	**39,919**	**48,651**	**58,022**	**742,025**

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Quality and Safety

3.8.21 The Trust Board regularly reviews all key quality indicators, considers a monthly integrated quality report and has recently approved a new five year Quality and Safety strategy to formalise and provide a local framework for quality and safety. The vision for 'Safe, High Quality Care' is that all clinical care is measured appropriately for safety, effectiveness and patient experience and that increasing attention is given to the outcomes of care. Information on quality and safety is acted upon rapidly and effectively to ensure continual improvement.

3.8.22 The four key objectives articulated in the Quality and Safety strategy are to:

- Improve patient safety, clinical effectiveness and patient experience;
- Ensure the right quality mechanisms are in place so that standards of quality and safety are understood, met and effectively demonstrated;
- Provide assurance that quality and safety outcomes and benefits are being realised, and take action if quality or safety is compromised; and
- Promote the continuous improvement in the quality and safety of services provided.

3.8.23 The Quality and Safety strategy includes three ambitious Trust-wide quality priorities covering safety, clinical outcomes and patient experience which drive year-on-year improvement. These were selected to have the highest possible impact on improving patient care across the organisation. The top three quality and safety related priorities are presented in the table below.

Table 30: Top Three Quality and Safety Related Priorities

Patient Safety	To reduce adverse events which result in avoidable harm	=	We do no harm to patients
Clinical effectiveness	To reduce avoidable mortality and morbidity	=	Fewer patients dying and fewer having complications
Patient experience	To increase the % of patients who would recommend the Trust to family and friends	=	Improve patient satisfaction

3.8.24 Specific, measurable quality improvement goals will be set out each year through the annual planning process. Performance will be reported through public Board reports and through the Quality Account.

Research

3.8.25 The Trust is committed to delivering high quality research to improve patient care and treatment. It has a long history of delivering research in the fields of Cancer, Cardiology, Diabetes, Rheumatology, Ophthalmology and Neurology. More recently, there has been increased research activity in other disciplines including Gastroenterology, Stroke, Dermatology and Paediatrics. Research teams at the Trust have developed large, well-characterised clinical cohorts from the local ethnically mixed patient population in order to support on-going research activity.

3.8.26 The research portfolio includes a range of both academic and commercially funded studies, and also supports undergraduate and postgraduate student educational projects. The Trust has strong ties with local universities and hosts a number of academic units which deliver both basic and translational research (applying findings to influence practice and improve outcomes). Income streams include the Department of Health through the National Institute for Health Research (NIHR), clinical research networks, research councils, charities, and commercial companies.

In 2014/15 the Trust published a three year Research and Development Plan. This commits the organisation to seeking to treble trial recruitment and move towards the top of local recruitment performance. The organisation plays an increasingly active role in the Clinical Research Network. Research facilities are incorporated across the future hospital sites, recognising that the majority of trial activity is outpatient derived.

Education

3.8.27 The Trust's hospitals are part of the University of Birmingham Teaching Programme and are responsible for training 300 medical students every year, including military trainees. Quality of training

has been consistently rated as excellent, following visits from both the West Midlands Workforce Deanery and the Royal Colleges.

3.8.28 Trainee nurses from both Wolverhampton and Birmingham City Universities are based in the Trust and at any one time up to 300 students are working to complete their adult nursing course across all three sites at both degree and diploma levels. Placements are also offered to a range of trainee clinical scientists and Allied Health Professionals (AHPs) as part of their undergraduate and post-graduate studies including: Audiology, Pharmacy, Biomedical Sciences, Physiotherapy, Dietetics, Speech and Language Therapy, Occupational Therapy, Radiology (both diagnostic and therapeutic), Clinical Physics, Clinical Physiology and Medical Physics.

3.8.29 Educational facilities are provided across the future hospital sites. The current education centre at Sandwell Hospital will be retained. Lecture, meeting and library facilities are also provided within the Midland Metropolitan Hospital.

Public Health Plan

3.8.30 The Trust has developed its first Public Health Plan to improve health across the Sandwell and West Birmingham Health Economy. It has been developed in consultation with local stakeholders and sets out how the Trust proposes to improve the health and wellbeing of its patients, visitors, our staff, Trust members and the local community. By taking a co-ordinated approach the entire organisation will be able reinforce consistent health-promoting messages.

Finance

3.8.31 The Trust has a forecast level of annual income in 2014/15 of £441m which will generate a surplus of £4.3m. The table below shows that the Trust has a history over the last three years of strong financial performance, achievement of statutory financial targets and delivery of circa £65m of cost improvement savings.

Table 31: Summarised Statement of Comprehensive Income Position

Statement of Comprehensive Income	2011/12	2012/13	2013/14	2014/15
	£m	£m	£m	£m
NHS Clinical income	382.8	391.4	394.1	397.2
Non NHS Clinical income	41.4	41.6	43.5	43.5
Total Income	**424.1**	**433.0**	**437.6**	**440.7**
Total Operating Expenses	**(401.2)**	**(406.3)**	**(410.6)**	**(415.7)**
Surplus/(Deficit) from operations	**23.0**	**26.7**	**27.0**	**25.0**
Surplus (deficit) from operations margin	*5.4%*	*6.2%*	*6.2%*	*5.7%*
Adjustment for donated asset income	(0.5)	(0.0)	(0.2)	(0.1)
EBITDA	22.5	26.7	26.8	25.0
EBITDA margin	*5.3%*	*6.2%*	*6.1%*	*5.7%*
Non - Operating Income	(0.2)	(0.1)	(0.2)	(0.0)
Non - Operating Expenses	(18.3)	(30.0)	(29.3)	(17.9)
Surplus/(deficit)	**4.5**	**(3.4)**	**(2.5)**	**7.1**
IPAQ Technical adjustments - impairment lossess (reversals)	2.4	(8.7)	(8.9)	2.8
Replace Surplus/(deficit)	**2.1**	**5.3**	**6.4**	**4.3**
Replace Surplus margin	*1.1%*	*-0.8%*	*-0.6%*	*1.6%*

Performance

3.8.32 The Trust has a strong track record of performing well against the national standards for acute hospital trusts including achieving national targets.

3.8.33 The table below provides more detail on the Trust's performance against key targets over the period 2012/13 to 2014/15. The key area of underperformance continues to be emergency care. Detailed partnership arrangements are in place to support improvement. The Midland Metropolitan Hospital will offer a better environment and configuration from which to sustain improvement.

Table 32: Summary of Performance against Targets

	Measure	2012/13	2013/14	2014/15	2014/15 Target
Access Metrics					
Cancer two weeks GP referral to first outpatient	%	94.7	95.0	Data due May	=>93.0
Cancer two weeks GP referral to first outpatient (breast symptoms)	%	95.9	96.7	Data due May	=>93.0
Cancer 31 date diagnosis to treatment for all cancers	%	99.5	99.2	Data due May	=>96.0
Cancer 62 day urgent GP referral to treatment for cancers	%	87.1	87.0	Data due May	=>85.0
Emergency care four hour waits	%	92.54	94.5	92.52	=>95.0
Referral to treatment time admitted <18 weeks	%	93.7	90.1	92.45	=>90.0
Referral to treatment time non-admitted <18 weeks	%	98.6	96.5	95.49	=>95.0
Referral to treatment time incomplete pathway <18 weeks	%	95.3	92.7	94.88	=>92.0
The acute diagnostic waits > six weeks	%	0.88	0.75	0.23	<1.00
Cancelled operations	%	0.7	1.1	0.8	=<0.8
Cancelled operations (breach 28 day guarantee)	%	0.004	0.02	0.89	0
Delayed transfers of care	%	2.9	3.1	3.7	=<3.5
Outcome Metrics					
MRSA bacteraemia	No.	1	1	4	0
C Difficile	No	37	39	29	<37
Mortality reviews within 42 days	%	72.9	83.0	89	=>80.0
Risk Adjusted Mortality rate	RAMI	88.9	86.9	88	<100
Summary hospital level mortality index	SHMI	95.9	96.3	94.2	<100
Caesarean section rate	%	23.6	24.9	25	=<25.0
Patient safety thermometer - harm free care	No.	94.2	94.4	93.5	=>95.0
Never events	No.	2	5	0	0
VTE risk assessment (adult IP)	%	90.8	98.7	97.8	=>95.0
WHO safer surgery checklist	%	99.2	99.9	99.9	=>98.0
Quality Governance Metrics					

	Measure	2012/13	2013/14	2014/15	2014/15 Target
Mixed Sex Accommodation Breaches	No.		124	107	0
Patient Satisfaction (FFT) - Response Rate (IP Wards and Emergency Care)	%		20.5	43.2/21.9	>28/>20.0
Patient Satisfaction (FFT) - Score (IP Wards and Emergency Care)	No		68	72/52	>68/>40
Staff Sickness Absence	%	4.38	4.33	4.69	=<3.15
Staff Appraisal	%	69.2	96.7	90.5	=>95.0
Medical Staff Appraisal and Revalidation	%	77.0	97.9	92.8	=>95.0
Mandatory Training Compliance	%	86.4	87.2	87.6	=>95.0
Commissioning for Quality & Innovation (CQUIN)					
VTE Risk assessment (adult IP)	%		98.7	97.8	100
NHS Safety Thermometer - Reduction in Pressure Sores	No.		Achieved	Achieved	Base less 10%
Dementia - Find, Investigate and Refer	No.		Not met	Achieved	Meet 3 components
Dementia - Patient Stimulation			Achieved	Achieved	Comply
Safe Storage of Medicines	%		81	N/a	90
Use of Pain Care Bundles	%		Achieved	Achieved	Improve on base
Use of Sepsis Care Bundles	%		Achieved	Achieved	Improve on base
Community Risk Assessment & Advice	%		Achieved	Achieved	Improve on base
Recording DNAR Decisions	%		Achieved	n/a	Improve on base
Clinical Quality and Outcomes					
Stroke Care Patients who spend > 90% stay on Stroke Unit	%	85.6	91.3	91.9	=>83.0
Stroke Care Patients admitted to an Acute Stroke Unit < 4 hours	%	59.1	76.4	79.5	=>90.0
Stroke Care - Patients receiving a CT Scan < 1 hour of presentation	%	52.0	71.9	71.6	=>50.0
Stroke Care Admission to Thrombolysis Time (% within 60 minutes)	%		51.2	80.3	=>85.0
Stroke Care Swallowing Assessments within 24 hours of admission	%		98.6	99.6	=>98.0
TIA (High Risk) Treatment within 24 hours of presentation	%	69.8	70.9	98.1	=>70
TIA (Low Risk) Treatment within 7 days of presentation	%	75.9	84.5	97.11	=>75.0
MRSA Screening Elective	%	60	92.6	87.26	=>80.0
MRSA Screening Non Elective	%	65	94.2	82.52	=>80.0
Inpatient Falls Reduction - Acute	No.	737	617	811	<660

	Measure	2012/13	2013/14	2014/15	2014/15 Target
Inpatient Falls Reduction - Community	No.		112	184	<144
Hip Fractures - Operation within 24 hours	%	75.7	70.3	69.5	=>85.0
Patient Experience					
Complaints Received - Formal and Link	No.	724	948	941	
Patient Average Length of Stay	Days	3.8	3.4	3.7	=<4.3
Coronary Heart Disease - Primary Angioplasty (<150 minutes)	%	91.2	92.5	Data due May	=>80.0
Coronary Heart Disease - Rapid Access Chest Pain (<2 weeks)	%	95.7	96.3	98.2	=>98.0
GU Medicine - Patients Offered Appointment <48 hours	%	100	100	100	n/a

3.8.34 The Estate

3.8.35 The Estates Strategy was updated in September 2013 (see ***Appendix 3a***). The strategy identifies significant issues with the suitability of large parts of the Trust's current estate. Parts of City Hospital, including the main hospital building, are over 100 years old and the Trust has one of the highest backlog maintenance levels in the NHS in England. The Estates Strategy sets out these issues in more detail.

3.8.36 There have, however, been some fairly recent capital developments in the Trust's hospitals. In 2005 the Trust opened a £18.7m Emergency Services Centre at Sandwell Hospital (following the destruction of the former A&E by fire) and the £30m PFI-financed Birmingham Treatment Centre (BTC) at City Hospital also opened in that year.

3.8.37 Detailed condition surveys of the two main sites were undertaken in 2002. A desktop update of the surveys was carried out in August 2007 and the surveys were updated again in June 2012 to identify where condition had deteriorated due to age or improved as a result of capital investment in the estate. Backlog maintenance figures are amended annually to take account of any capital investment required for the High and Significant risk items from revised risk assessments and an allowance for inflation.

3.8.38 The table below identifies the estimated cost to achieve Estate Code Condition B at 31st March 2013. The Trust has used DH methodology for measuring risk in relation to substandard assets so that investments can be prioritised. The DH definition of Condition B is: 'Sound, operationally safe and exhibits only minor deterioration'.

Table 33: Cost to Achieve Condition B

Risk Level	Cost (£)		
	Sandwell	City	Trust
High Risk	0	0	0
Significant risk	1,415,000	1,825,000	3,430,000
Moderate risk	38,126,562	43,617,055	82,250,017
Low risk	3,779,969	6,265,212	10,973,383
Total backlog	43,321,531	51,707,267	96,653,400

Risk adjusted	3,161,105	3,903,427	7,638,640

3.8.39 The Trust aims to reduce its backlog maintenance levels through the development of the new hospital. The strategy also summarises the following plans:

- Upgrade to some parts of the existing accommodation to manage High and Significant estates risks on current sites;
- Reconfiguration of the City Hospital site to support the acute, community and primary care services not transferring to the MMH; and
- Reconfiguration of the Sandwell Hospital site to support the acute, community and primary care services not transferring to the MMH.

3.8.40 The services that will be provided from the reconfigured retained estate sites are outlined in Chapter 5.

The Trust's Current Status and Strategic Objectives: Conclusion

The Trust's successful track record of delivery despite the unsustainable configuration of services across two acute hospital sites and the poor condition of its estate means that it is in a good position to move forward.

The organisation's strategic objectives are in alignment with national and local context.

3.9 Conclusion and alignment with national and local agenda

3.9.1 The table below summarises and brings together the themes explored in this chapter to demonstrate how the RCRH vision for change and Trust plans for the future continue to align with national and local strategic context to provide for the needs of the local population.

Table 34: Strategic Themes

Strategic Themes	RCRH and MMH Alignment
High Quality, Safe Care Increased focus on the need to change the culture of the NHS to provide consistently high quality, safe care that meets rising patient expectations as a result of the Francis Enquiry, Berwick and other reports.	Concentrating a critical mass of specialist expertise on one acute site to facilitate right care, at the right time, at the right place. Supporting the delivery of high quality, safe care through better building design, clinical adjacencies, consistent environments, easy to clean surfaces etc. Improved working environment and more sustainable clinical teams working together and developing a sense of professional pride in delivering high quality care
Funding Restraints The need to make step change improvements in efficiency and productivity as a result of continuing pressure on resources.	Reduction in number of patients accessing expensive acute care unnecessarily. Efficiencies gained from moving to a single site acute hospital, reduction in duplication and focussing investment in clinical rather than back office services. Productive clinical environments support improvement in length of stay and other improvements in efficiency. OBC modelling is integrated into the LTFM to ensure that the long term planning horizon is understood and efficiency improvements required prior to the opening of the MMH will be delivered to plan.

Strategic Themes	RCRH and MMH Alignment
Sustainable Clinical Care Drive to ensure that services are clinically safe and sustainable needs to be led by clinicians underpinned by local engagement.	Concentration of acute inpatient services on a single site. Bringing teams together on one site to help cover rotas in specialties with limited supply in key professional roles. Development of excellent children's care by concentrating expertise on one site and providing for the specific needs of children and younger people. Improvement in reputation gained from new facilities support recruitment and retention of key staff.
Prevention and Reducing Health Inequalities Continuing drive to reduce inequalities and improve population health supported by partnership working in the Health and Well Being Boards.	RCRH rebalancing of resources to focus on prevention and health improvement. Partnership working through RCRH has been strong over the last decade. Engagement of representative service users has improved MMH plans.
Integrated Care The need to provide care that is more integrated around the needs of patients, offering care closer to home when appropriate and delivered seamlessly across organisation boundaries.	RCRH facilitates a devolved model of care that shifts services closer to patients' homes. RCRH model of care for patients with long term conditions to ensure that their conditions are managed effectively to avoid hospital admission. A smaller acute footprint allowing resources to be diverted to keeping people well and out of hospital. Opportunities offered by the Better Care Fund to build on these achievements.
Patient Choice and Competition Responding to increasing public expectations supported by growing sources of information to guide their choices.	RCRH will provide choice of a range of community facilities. MMH will provide a significantly improved acute care environment for patients and their carers - this will encourage them to choose the new hospital. Patients will be able to choose a single room or a 4 bedded bay. Improvements to patient experience, privacy and dignity will be facilitated by the new facilities.

4 Case for Change

4.1 Introduction

4.1.1 Chapter 3 outlines local health needs, strategic context, and the development of a new model of care agreed by the local health economy.

4.1.2 This chapter presents the case for the development of the MMH as part of the wider RCRH model of care and concludes that there is a need to develop a new system of healthcare that addresses the changing needs of patients and enables delivery of high quality services.

4.1.3 Since the Outline Business Case was approved in July 2014 the Trust has continued with a programme of reconfiguration aiming to bring primary cardiac intervention services onto the City Hospital Site and Emergency Surgery onto the Sandwell site to provide more sustainable care until the MMH opens. This strengthens the case for change due to the impacts of separation of specialties across sites.

4.1.4 Apart from that there have been no changes - the case for change continues to grow as presented in the following sections.

4.1.5 The case for change is presented under five main headings:

- Poor health in the area the Trust serves;
- Major changes in primary and community care;
- Sustaining top quality acute services;
- Old and unsuitable hospital buildings; and
- Care closer to home and patient choice.

4.1.6 The following sections detail the evidence supporting the case for change.

4.2 Poor Health in the Area the Trust Serves

4.2.1 The areas of Birmingham and Sandwell that the Trust serves have some of the highest levels of deprivation and poorest levels of health in the UK. Poor health has persisted in the area for many years and is improving more slowly than in the rest of England.

Health indicators

4.2.2 Chapter 3 outlines the impact of deprivation on the health of the population served by the Trust showing that the Trust's catchment has poor life expectancy, high levels of infant mortality and a high level of households with one or more persons with a long term illness. These outcomes require major change in the way health and social care services are provided. Health indicators demonstrate the following:

- Low overall levels of life expectancy;
- Early deaths from heart disease and strokes;
- High level of deaths from smoking;
- High levels of hospital stays due to alcohol;

- High levels of low birth weight babies; and
- High levels of infant mortality.

Long Term Conditions

4.2.3 There are a high percentage of households with one or more persons with a limiting long term condition. The current default for these patients is to access acute services for their care resulting in higher than expected use of non-elective care.

The Need to Rebalance Resources

4.2.4 As described in the NHS Five Year Forward View, redesigning services to focus on prevention and health promotion will be essential to improving outcomes for the community. The RCRH strategy is to invest in the prevention of ill health which means that it will be necessary to move specialist expertise and resources from the acute sector into primary care.

4.2.5 In order to support this shift, there needs to a rebalancing of resources resulting in the need for a smaller, but more effective and highly specialised acute facility. Length of stay will be shorter due to the provision of more productive, high quality care which will enable patient needs to be met through reduced capacity. It follows that this more concentrated acute care requires appropriate facilities suitable for the needs of 21st century healthcare. Achieving this across two hospital sites would be very expensive and clinically unsustainable due to the duplication of infrastructure and specialist staffing.

4.2.6 The RCRH Programme model of care summarised in Chapter 3 will ensure that patients are able to access:

- Health promotion services;
- Services supporting self-care and care at / closer to home to avoid unnecessary admission to hospital; and
- 21st century healthcare provided in a single site, new acute hospital when they do require admission to an acute hospital.

Conclusion

The poor health of the residents in the Trust's catchment area makes the case for change in the model of care to focus on prevention. The RCRH Programme has developed plans to deliver these changes. A new single site acute hospital is central to successful delivery of these plans.

4.3 Major Changes in Primary and Community Care

4.3.1 Some major investments in buildings and services in primary and community care have already been delivered with more on the way. Examples of changes already being implemented are:

- Development of primary care facilities;
- Development of intermediate care services;
- Expansion of hospital at home schemes;
- Transfer of outpatient services to community settings; and

- Development of urgent care services to reduce pressure in the Emergency Departments.

4.3.2 The shape and size of the local acute hospital service will need to change in response to this because:

- Specialist expertise will be required in the community as well as in the acute environment. It will be difficult to provide sustainable highly specialist cover on two acute sites as well as a range of community facilities in the new model.
- Planned developments in community and primary care will result in the requirement for fewer acute hospital beds and reduction in outpatient and diagnostic capacity in the acute hospital.

Conclusion

Major changes in Primary and Community Care make the case for development of a new acute hospital with capacity aligned to the activity model agreed by the RCRH Programme.

4.4 Sustaining Top Quality Acute Services

4.4.1 Following the recommendations of the Keogh Review the Trust is concerned about the stability of current acute care configuration which is sustained by a very high proportion of temporary staff. This situation is not sustainable in the longer term and the Keogh recommendations would be impossible to implement in the current configuration.

4.4.2 There is increasing evidence that large, more specialist units, deliver better outcomes than smaller units unable to specialise sufficiently. For example: the importance of improving clinical outcomes through greater sub-specialisation with appropriate critical mass has been highlighted in: ‘Getting it Right First Time’ (Tim Briggs, September 2012). The main reasons for change in this area are:

- The changing way in which doctors are trained;
- The effect of the European Working Time Directive on working hours;
- Strong evidence that specialist centres are more effective because they concentrate clinical expertise where it is needed to improve sustainable cover across services; and
- The challenge of attracting and retaining the best staff in a competitive market.

4.4.3 It is becoming increasingly difficult to provide top quality, sustainable acute hospital services for a population of circa 530,000 in a relatively small geographical area from two hospitals that are only 4-5 miles apart. This section provides examples of the impact of this issue on the Trust and makes the case for developing a new single site hospital.

Specialist Services

4.4.4 The Trust has already made changes to some specialist services e.g. paediatrics, neo-natal services, stroke services and surgery. These reconfigurations will go some way to improving the sustainability of services pending the opening of the MMH.

4.4.5 The Trust is currently consulting on a proposal to locate cardiology services, including a 24 hour Primary Cardiac Intervention Service, on a single site at the City Hospital. Direct admission to the interventional cardiac suite is difficult to do on two sites given the range of staff involved and proposals indicate that a higher quality and more sustainable service can be provided on a single site.

4.4.6 Similarly, the Trust is also consulting on a proposal to locate to locate SAU for emergency surgery and trauma assessment onto a single site. This also ensures that a sustainable and high quality service is provided to patients.

Critical Care

4.4.7 Step up and down arrangements for patients requiring critical care are currently quite limited with resultant risks to quality of care. Patients requiring level 1 care are therefore either accommodated in the Critical Care Unit longer than clinically required or transferred to a general ward earlier than is ideal. It is proposed to introduce defined Level 1 Care beds on appropriate wards and extended hours of operation for the Critical Care Outreach Team to address this. Development of these services across two sites would require significant investment in difficult to recruit staff. This would present issues around affordability and may not be achievable.

Consultant Led Services

4.4.8 Development of 7 day per week / 24 hour consultant led services in the Emergency Department, Adult Acute Assessment Unit and other key areas would improve speed of senior assessment and quality of care. To achieve this on two sites will require significant increase in consultant numbers, which will not be affordable. In addition, recruiting to specialist medical posts in the Emergency Department is likely to be difficult. Meeting national standards and requirements will be more difficult across two sites, whereas on a single site the Trust will comfortably match expectations.

Separation of Clinical Specialties across Sites

4.4.9 There is strong scientific evidence that surgical outcomes are substantially better when procedure rates exceed 100 per annum. For example a specialist interventional cardiologist should have the opportunity to perform a minimum of 100 Percutaneous Cardiological Interventions per year Delivering the service across 2 sites requires more interventional cardiologists making it not only less productive but also more difficult for clinicians to maintain minimum levels.

4.4.10 Interim reconfiguration was approved in the context of the change being a medium term plan to improve clinical specialisation and sustainability - the long term plan being to bring it all onto one site in the MMH. If plans for the new hospital do not progress this would result in long term separation of specialties across sites with the following impact:

- The on-going requirement to transfer patients who require inpatient admission in paediatrics, emergency general surgery, trauma and gynaecology;
- Practical problems organising training for junior doctors;
- The requirement for clinicians to maintain cover across sites in the context of the reconfigured services; and
- The risk involved when acutely ill patients may be on one site while the specialist team is undertaking clinical care on the other.

4.4.11 The average journey time between the two hospitals is 20 – 30 minutes but can be quite a bit longer. This has impact on patients travelling by ambulance, relatives and also on staff, putting pressure on the working day.

4.4.12 Where the Trust has restructured to focus specialities onto one of the sites this has sometimes caused more issues with clinical adjacencies further complicating the situation outlined below.

4.4.13 In some of the very acute specialities such as critical care, anaesthesia and emergency surgery the Trust has to divert scarce consultant resource away from elective care because of the need to staff 24 hour cover rotas on two sites. The activity does not always justify this.

Duplication of Departments across Two Sites

4.4.14 Duplication of departments across two sites reduces the efficiency and sustainability of services due to staffing requirements and skill mix as well as the running costs of expensive equipment. Examples of departments that would benefit from integration onto one site are:

- Interventional Imaging;
- Pharmacy;
- Inpatient Operating Theatres;
- Critical Care;
- Emergency Department;
- Acute Adult Assessment; and
- Cardiology (CCU and Cardiac Catheter Labs in particular).

Conclusion

The examples above demonstrate the case for the move to a single site acute hospital to sustain top quality acute services.

4.5 Old and Unsuitable Hospital Buildings

4.5.1 Many of the buildings at both City and Sandwell Hospitals are old and unsuitable for the provision of 21st century healthcare.

Age of the Estate

4.5.2 Much of the existing estate is of significant age and does not comply with the DH aspiration for 40% of the NHS estate to be less than 15 years old by 2010. The table below shows the age profile of City, Sandwell and Rowley Regis Hospitals.

Table 35: Building Age Profile

Age profile	Sandwell %	City %	Rowley %
2005 to present	0	21.29	0
1995 to 2004	0	9.31	0
1985 to 1994	0	3.98	100
1975 to 1984	88.87	5.12	0
1965 to 1974	4.28	7.27	0
1955 to 1964	0	3.11	0
1948 to 1954	0	0.41	0

Age profile	Sandwell %	City %	Rowley %
pre1948	6.85	49.5	0
total	**100**	**100**	**100**

4.5.3 In summary:

- More than 70% of the City Hospital site is more than 30 years old;
- More than 90% of Sandwell Hospital site is more than 20 years old; and
- Almost 50% of the City Hospital site was built pre 1948.

Some of the Trust's clinical services are housed in sub-optimal portacabins and other temporary buildings.

Backlog Maintenance

4.5.4 The Trust has one of the largest backlog maintenance problems in the country. The current estimated cost to achieve Estatecode condition 'B' is in the region of £100 million. When compared to other large acute Trusts outside of London the Trust lies well above the upper quartile. Significant investment has been utilised from the Capital Programme to address High and Significant Risk backlog and minimise risk to the organisation. It is accepted that the Trust will continue to have very high backlog maintenance levels until the MMH is open. The emphasis will continue to be to keep High and Significant Risk backlog to a minimum.

Condition Surveys

4.5.5 Condition surveys have been undertaken across the range of categories defined in Estatecode. These include Physical Condition, Statutory Compliance, Energy Performance and Space Utilisation. Overall the outcome of all of these criteria is that the Trust is in need of complete modernisation and improvement and the only way to realistically achieve this is through the development of a new acute hospital.

Management of Asbestos

4.5.6 The presence of asbestos, whilst managed in accordance with statutory regulations, still presents major problems for refurbishments and major new works. The need to carry out destructive / invasive surveys to determine the full extent of its presence presents operational difficulties for clinical and non-clinical services.

Engineering Infrastructure

4.5.7 The age of the engineering infrastructure, including services and medical gases, means that although they are serviceable, they will need long term replacement. The age and construction of much of the engineering services does not allow easy adaptation and expansion to facilitate the development of new and improved clinical services.

Energy Performance

4.5.8 72% of the City Hospital site and 77% of Sandwell Hospital site requires improvement to increase energy performance.

Functional Suitability

4.5.9 At City Hospital, only 29% is deemed acceptable with over 70% being either tolerable or intolerable.

4.5.10 At Sandwell Hospital, only 18% is deemed tolerable with approximately 70% being either tolerable or intolerable.

4.5.11 The following sections outline the clinical impact of poor functional suitability.

Empty Buildings

4.5.12 Since 2012 ten medium / small buildings on the City Hospital site and the old Maternity Unit at Sandwell Hospital have been closed for the following reasons:

- Poor condition and utilisation;
- Vacant facilities following clinical reconfigurations; and
- The need to make estate efficiencies.

4.5.13 Closure of the buildings has provided savings and increased estate efficiency in the short term, but results in an unsightly hospital environment. It will not be appropriate to continue to hold empty buildings in the long term.

Lack of flexibility

4.5.14 The age and piecemeal construction of the hospitals has resulted in lack of flexibility – there is very little generic space that could be used to support changes in services and models of care over time. This means that changes to service require expensive and suboptimal capital developments that have to fit in around existing buildings. This limits the potential for future service development as well as the potential for new technology and innovation.

Care Environment

4.5.15 Patient Led Assessments of the Care Environment (PLACE) audits were held between April and June 2014. Feedback from the audits was that overall standards continue to be very good and the majority of the detailed checks were passed. The audits covered cleanliness, food, privacy and dignity and condition appearance and maintenance. Whilst a high standard has been achieved, both patients' expectations and the Trust's aspirations continue to rise. However, an aging estate will make further improvements increasing hard to achieve.

4.5.16 The Trust has developed an Art in Hospital Strategy prior to the opening of the new hospital. The Art Steering Group has facilitated a number of community and staff engagement art projects and commissioned some collections of art loan pieces from 'Painting in Hospitals'. This artwork has enhanced some of the corridors and clinical areas in both City and Sandwell Hospitals. However, it is difficult to place / hang pictures in many areas because of poor lighting, engineering pipes and other issues that affect the aesthetic.

Fragmented Adjacency of Departments

4.5.17 Ad hoc development of the hospitals over the years has resulted in a number of poor adjacencies between departments. The impact of this has been reduced through rationalisation of the estate and

by moving several services to more central locations. This includes the Sickle Cell and Thalassemia (SCAT) Centre and services for older people previously located in the Sheldon Building. However, there are still a number of issues caused by fragmented adjacency:

- To transfer an emergency patient from the Emergency Department to Theatres or Critical Care entails taking patients along public corridors. This is particularly difficult at City Hospital where the route is along the main spine corridor. This increases the length of the patient journey, with consequent clinical risk, and provides no privacy or dignity. The figure below shows the length of the corridor and the lack of separation between patients being transferred, visitors and deliveries / FM services.

Figure 12: City Hospital Main Spine Corridor

- The length of the spine corridors causes problems for patients and visitors needing to walk long distances, particularly if they have mobility problems or are unwell.
- Access to wards from the Adult Emergency Assessment Units on both sites is also along public corridors.
- Maternity and Rheumatology are also disconnected from the corridor on the City Hospital site. Ambulance transport is therefore required to access main hospital services with potential for clinical risk.

4.5.18 The impact of poor adjacency is:

- Less than ideal patient journeys;
- Increased cost for porters or use of ambulances; and
- Increase in clinical risk

Inpatient Facilities

4.5.19 Out-dated ward configurations have been improved as much as possible in the current estate; however, they are no longer suitable for modern care. The figure below shows an example of an unsuitable ward configuration.

Figure 13: Unsuitable Ward Configuration

4.5.20 Current ward templates are such that the number of single rooms that can be designed into the space available is insufficient to deliver a service. This limits the improvement possible in the current estate. The current percentage of single room accommodation available across the two hospital sites is less than 15% which is not ideal, particularly given the prevalence of serious infectious diseases such as TB in the local population. These rooms are widely dispersed across the existing estate which makes it more expensive to bring them up to the standards likely to be required over the next ten years.

4.5.21 The impact of this is:

- Poor privacy, dignity and patient experience;
- Only a minority of patients have the choice of a single room – this may have particular impact on some groups of patients and limits choice to all patients admitted;
- Infection control is hampered by the lack of isolation facilities;
- Poor ability to use space flexibly due to issues with access to toilet facilities; and
- Large bays in typical wards are difficult to clean without major impact on bed availability.

Fragmentation of Inpatient Theatres

4.5.22 Inpatient theatres are spread between two sites in configurations which reduce efficiency both in terms of space utilisation and staffing. In addition, at Sandwell Hospital theatres are split across 2 floors with 4 theatres on the first floor and 4 theatres on the third floor. This fragmented configuration reduces the Trust's ability to implement the following modernised service improvements:

- The development of a central admissions unit for elective surgical cases;
- Integrated recovery facilities;
- Effective staffing structures and skill mix; and
- Flexibility in use of staff and equipment.

Lack of Dedicated Departmental Facilities

4.5.23 There is currently a dedicated Medical Day Case Unit on the City hospital site but not at Sandwell with the result that treatments take place across many different unsuitable ward and outpatient environments. The impact of this is:

- Patients are admitted to wards unnecessarily reducing efficient use of ward resources;
- Reduced ability to share recovery areas with other departments (Medical Day Case Unit and Interventional Radiology share in the preferred solution);
- Reduced potential for development of effective skill mix across clinical areas; and
- Reduced ability to respond to the increase in demand over time for day case rather than inpatient treatments.

Poor Functional Performance within Departments

4.5.24 Many departments are no longer suitable for the provision of modern services, for example:

- The Medical Admissions Unit at City Hospital is hampered by poor access arrangements and movement around the department is limited by pillars and disjointed circulation space;
- Lack of training and meeting facilities close to working departments means that staff have to leave the department for routine continuing professional development, departmental meetings etc.; and
- Changing facilities are often not available making implementation of a uniform policy more difficult.

Movement around Hospital Sites

4.5.25 Way finding especially at City Hospital is made difficult by:

- Distance between buildings;
- The existence of many entrances across the site; and
- The fact that car parking is spread across a wide area.

4.5.26 The impact of this is:

- Poor patient and visitor experience caused by anxiety when they are unable to find departments;
- Patients find walking between departments difficult because of the distances involved; and
- Long walks across uneven terrain in all weather conditions from car parks and bus stops.

Lack of a Clear Main Entrance

4.5.27 The Hospitals do not have clear main entrances, particularly at City Hospital, but present a sprawling, disjointed and untidy front door. The figure below shows the difficulty for patients trying to find the main corridor at City Hospital. The car park is some distance away and the signage can often be hidden by delivery vehicles.

Figure 14: Entrance to the Main Spine Corridor at City Hospital

4.5.28 This has the following impact on the Trust:

- Poor way finding as described above;
- Inability to concentrate resources such as wheelchairs, payphones etc.
- Inability to focus customer care resources where help is needed;
- Poor image for the Trust resulting in potential lack of confidence from patients and their families;
- Limited ability to present patient information and health messages;
- Limited ability to host community activities, exhibitions etc.; and
- Reduced ability to enhance well-being through the use of airy, comfortable places for service users or staff to wait or meet.

Poor Working Environments

4.5.29 Staff are still working in poor clinical environments with impact on morale and ability to provide best patient care. Some examples of this are presented below:

- Lack of single rooms make it operationally more difficult to manage infection control;
- The Emergency Department at City Hospital has developed in an ad hoc basis within available space. The layout does not lend itself to efficient patient flow or organisation.
- The Medical Assessment Unit at City Hospital is in an area with disjointed layout as described above, poor facilities and no natural daylight; and
- The Trust has difficulty in maintaining national standards for patient flow and segregation in Endoscopy due to size and lay out constraints.

Integration of Health Plans with Regeneration Developments

4.5.30 Full integration of health plans with local regeneration developments is not possible under current circumstances because the poor condition of current estate does nothing to improve local neighbourhoods. The Trust cannot support wider regeneration objectives without making substantial changes.

Conclusion

Due to the condition of the current estate the provision of a suitable environment for patients and staff will require investment in new hospital facilities. This provides the case for the development of a new high quality hospital building.

4.6 Care Closer to Home and Patient Choice

Reasons for Developing Care Closer to Home

4.6.1 Many patients prefer to receive care closer to home as has been evidenced by evaluation of the RCRH exemplar projects. They value the convenience and find venues easy to get to. Other reasons for moving care closer to home or community settings are:

- Acute hospitals are not ideal environments for the frail or elderly because the expertise of clinical staff may often be focused on the short term management of acute patient care;
- The expertise for planning and delivering rehabilitation and the management of long term needs may not be as well developed in acute hospitals as it is in community environments; and
- On-going management of long term conditions when the acute treatment is completed should be managed by the GP / community team who should know the patient well.

Delivery of Care Closer to Home

4.6.2 Patients and GPs increasingly expect care to be provided as close to home as possible. Responding to this, where clinically possible, will strengthen the Trust's links with primary care and the population that the Trust serves in an area where patients have real choices about where to go for specialist

treatment. Effective development of community services is the essential component of care closer to home. For example:

- Limited out of hours community respiratory service means that patients with long term respiratory conditions, who have an acute episode out of hours, are more likely to present to the Emergency Department, and then get admitted for further assessment;
- Patients with a fractured neck of femur currently stay in hospital longer than necessary because of a lack of rehabilitation service in community locations or at home; and
- Many patients requiring end of life care are currently admitted to hospital due to a lack of hospice beds or home support services.

4.6.3 Development of these services is dependent on achieving shift of activity out of acute care. In addition, implementation of a new model of care across the interface with acute services is a very important enabler of this change. It will not be possible to deliver care closer to home with current acute bed capacity and the current approach to clinical care. The reasons for this are as follows:

- Current acute capacity supports a higher level of activity than the model predicts – failure to reduce acute activity will reduce the resources available for delivery of community services;
- Current variation in acute assessment processes and poorly developed streaming can mean that patients are admitted unnecessarily. This means that care that could have been managed in patients' own homes defaults to acute admission; and
- Current variation in care and discharge processes means that patients are not yet consistently having the opportunity to access early discharge to a community setting or to their own homes.

Patient Choice

4.6.4 Extension of patient choice and the range of providers mean that the Trust will need to be able to respond to patients' needs and involve them in decisions about their care. The Trust will need to ensure that it responds to patient requirements in a highly competitive market place because patients in the Trust's catchment area have easy access to a number of other local hospitals. The Trust will be responding to patient choice by:

- Delivering services that offer care closer to home;
- Ensuring that the patient experience is supported by providing the best quality services in the best facilities; and
- Delivering the best customer care with staff that are focused on patient centred care.

Conclusion

The preference for care closer to home and expansion of patient choice makes the case for delivering new services closer to home, building state of the art hospital facilities; and developing a high quality workforce.

4.7 The Conclusion of the Case for Change

4.7.1 The overall case for change draws on the need to respond to changing local health needs with modernised services as described by the RCRH Programme.

4.7.2 **The poor health of the residents in the Trust's catchment area** makes the case for change in the model of care to focus on prevention. The RCRH Programme has developed plans to deliver these changes. A new single site acute hospital is central to successful delivery of these plans.

4.7.3 **Major changes in Primary and Community Care** make the case for development of a new acute hospital with capacity aligned to the activity model agreed by the RCRH Programme.

4.7.4 The move to a single site acute hospital is necessary to **sustain top quality acute services.**

4.7.5 Due to the **condition of the current estate** the provision of a suitable environment for patients and staff will require investment in new hospital facilities.

4.7.6 The preference for **care closer to home and expansion of patient choice** makes the case for delivering new services closer to home, building state of the art hospital facilities; and developing a high quality workforce.

4.7.7 Since the approval of the Outline Business Case in July 2014 there have been few changes, but the need for delivery without delay has intensified in the context of

- On-going challenges to clinical sustainability;
- Increasing financial pressures requiring improvements to efficiency;
- Increasing population and needs of the community; and
- Growing expectations of NHS services.

5 Future Service Requirements

5.1 Introduction

5.1.1 This chapter sets out the model of care that has been agreed by partners within the local health economy. It details the activity projections and the capacity requirements to deliver that activity.

5.1.2 Activity projections have been refreshed to take account of a revised actual position for 2014/15 and contracted activity for 2015/16. The outcome of this refresh, presented at ***Appendix 5a***, is that the capacity requirements for MMH remain unaltered.

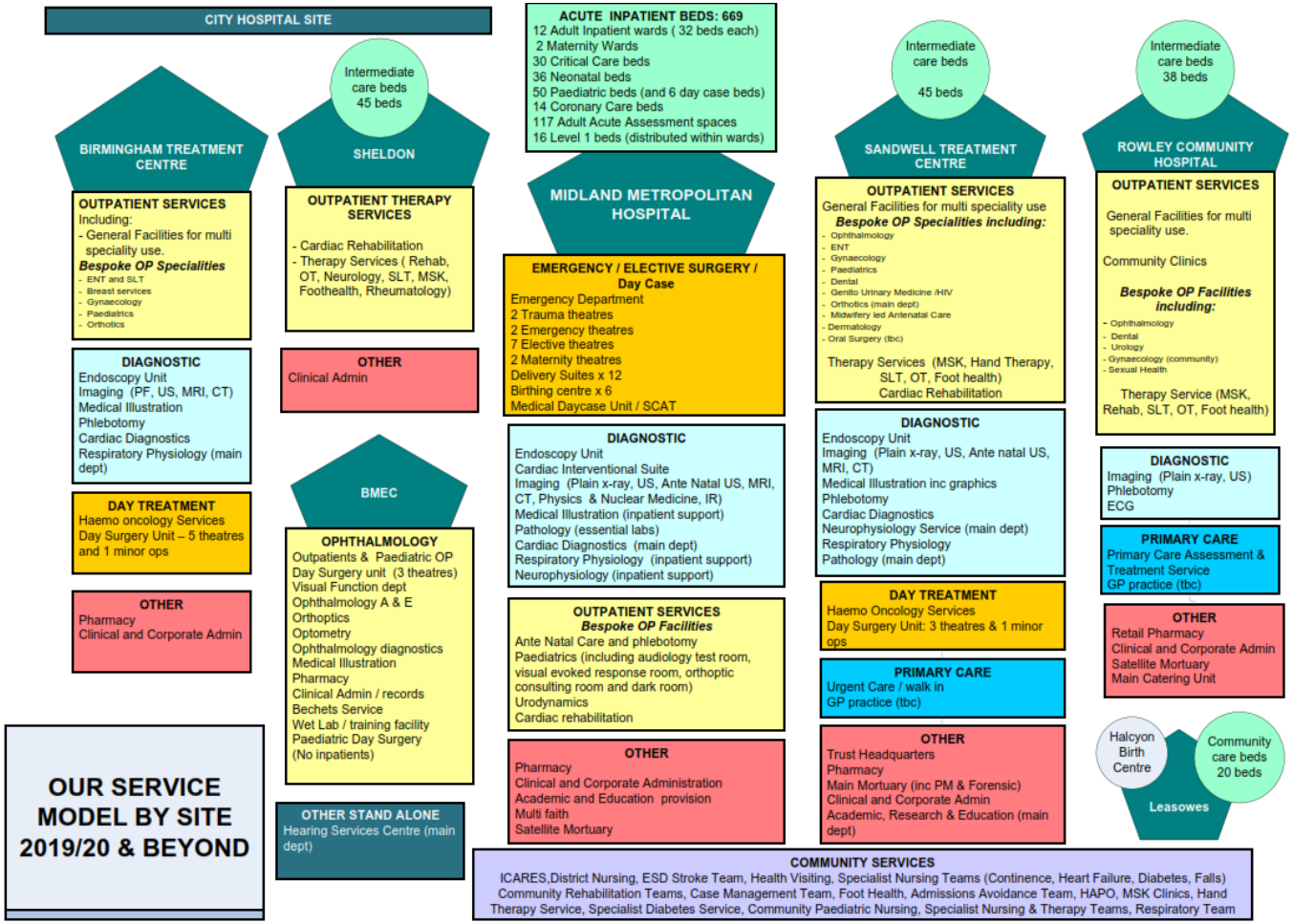
5.2 Right Care Right Here (RCRH) Model of Care

5.2.1 The RCRH Programme has developed a new model of care, as presented in Chapter 3, for the local population.

5.3 Trust Service Configuration

5.3.1 The figure below summarises the services that will be offered at each of the locations to support the RCRH model of care.

Figure 15: Model of Care



5.3.2 The Trust's service configuration aligns to the RCRH model. Most of the Trust's services will be provided either in the community or from one of its community facilities. The principles behind these decisions agreed with the Trust's Clinical Leadership Committee were to:

- Ensure the vision for the RCRH Programme is maintained;
- Transfer additional appropriate out patient, day case and support services to community facilities;
- Deliver acute inpatient care on a single site hospital;
- Accommodate corporate administration functions on the community sites; and
- Plan future service locations with the departments involved.

The Community Facilities

5.3.3 The community facilities will serve populations of about 150,000 and provide accommodation for a range of services including:

- Urgent care;
- Outpatients and diagnostics;
- Day surgery and day services;
- Intermediate care beds;
- Specialist community services; and
- Primary care.

5.3.4 The exact mix of services provided in each of the facilities will vary according to local circumstances. A range of provider organisations including the Trust, primary care and community service providers will operate from the community facilities.

5.3.5 The buildings to be retained and developed (if required) for the Trust's community facilities are:

- The Birmingham Treatment Centre (BTC) on the City Hospital site;
- Part of Sandwell General Hospital, which will become the Sandwell Treatment Centre (STC);
- Rowley Regis Hospital (RRH);
- Sheldon Block on the City Hospital site, which will become the Dudley Road Intermediate Care Centre;
- The Birmingham and Midlands Eye Centre (BMEC), which will continue to accommodate all Ophthalmology services with the exception of inpatient elective care; and
- Leasowes Intermediate Care Centre.

5.3.6 The necessary investment will be delivered through the Trust's Capital Programme.

The New Acute Hospital Facility

5.3.7 A new acute hospital is the final part of the set of facilities that will support the RCRH model of care. The Trust's aspiration for the hospital is that patients attending services for investigation or treatment will receive excellent care with timely availability of clinical expertise at all points of their individual care

pathways. It will provide modern purpose built facilities in which to deliver acute care. As a single site acute hospital it will allow consolidation of acute emergency and inpatient services with a critical mass of patients, staff and equipment. This will enable delivery of:

- High quality care 24/7 and 365 days per year;
- Continuity of care through multidisciplinary teams working to pathways and protocols agreed by expert led teams;
- Initial assessment and treatment of patients requiring emergency care by experienced specialist clinicians working extended hours 7 days a week.
- in the most acute specialities and on-site 12 hours, 7 days a week for a number of others;
- Sub-specialty expertise across the entire range of specialties available to in-patients in a timely fashion;
- High-level diagnostic support, including imaging and pathology available 24/7;
- Separation of acute unplanned and elective patient flows with individuals responsible for elective care of patients not being simultaneously responsible for the delivery of emergency care; and
- Leadership at the point of care delivery e.g. wards, departments and theatres will be provided by experienced clinicians with sufficient time to lead and supervise staff and standards.

5.3.8 This will also mean:

- A greater proportion of patients attending the acute hospital will be acutely unwell, have complex conditions or require specialist assessment.
- The smooth transfer of patients to a community location or primary care once this level of acute care is no longer required will be essential.
- Clear patient pathways that cross organisations and professional groups will be essential to ensure seamless patient care without duplication or gaps and to ensure patients receive the right service in the right place at the right time.
- Smooth, timely flow of information, ideally in the form of an integrated health care record, between professionals and across locations and providers will be important.
- Changes to the workforce will be required to ensure staff with the right competencies are available at the right time in the right place.
- The Trust will continue to provide and develop a range of more specialist services to the local population, to the wider population within the West Midlands and in some cases further afield. This includes Gynae-oncology, specialist Ophthalmology, Sickle Cell and Thalassaemia and specialist Rheumatology services.

5.3.9 A detailed breakdown of activities being provided by the Trust at each of these facilities is presented in the Service Model presented at ***Appendix 5b***.

5.4 Activity Projections

5.4.1 The RCRH Programme has developed a jointly owned Activity and Capacity Model which is used by the partners to underpin future healthcare development. It provides activity forecasts for the Trust's catchment area across all commissioners.

5.4.2 The RCRH Activity and Capacity Model was originally developed in 2004 for the Strategic Outline case (SOC) and has since been developed through a series of versions. In summary the most significant versions have been:

- Version 4.2 (2008) formed the basis of the first version of the OBC (2008).
- Version 5.1 (2010) developed by the RCRH Programme as part of a wider review linked to change in financial conditions within the NHS. Version 5.1 included revised forecast activity and capacity for the MMH.
- Version 5.3 (2010) developed by the Trust following a value engineering exercise for the MMH to recognise the changes in version 5.1 and also given the changes to NHS financial conditions to reduce the size of the MMH and improve affordability. In particular this resulted in a change in the split of activity between MMH and the Trust's future community facilities (retained estate).
- Version 5.7 adjusted (2013). Over the last few years the Trust has amended the Activity and Capacity Model to support its long term financial model (LTFM) submissions. Version 5.7 adjusted (V5.7a) forms the basis of the LTFM submitted in November 2013 as part of the assurance work and preparation for proceeding to the procurement phase for MMH. All modelling in V5.7 is based on 10/11 outturn. The main adjustment has been to identify the difference between the 2013/14 contracted (LDP) plan and the modelled activity for 2013/14 in the earlier version 5.7 and then to apply the % difference to the future years trajectory. The model assumes MMH becomes fully operational from October 2018.
- The LTFM approved by the Board, updated to include revised activity detail provided by the relevant CCGs (version 5.7b).

5.4.3 The current version of the model starts from a baseline of the first 10 months of actual activity plus 2 months forecast in f 2014/15 and produces a detailed year by year forecast over the ten years to 2023/24.

5.4.4 ***Appendix 5a*** presents comprehensive detail about the assumptions underpinning the activity assumed for the Trust. This includes productivity, length of stay, day case rates, bed occupancy, theatre minutes and utilisation, outpatient new to review ratios and throughput etc. It has also been supplemented by additional analysis and modelling for Pathology and Imaging.

5.4.5 The model produces activity projections for the Trust aligned to location as presented in the table below.

Table 36: Projected Trust Activity in 2019/20 by Location

Category	Type	MMH	Community Facilities	Total
Admitted Patient Care	Elective Inpatients	8,142	0	8,142
	Day Cases	7,006	37,961	44,967
	Emergencies (inc intermediate care)	56,917	3,303	60,221
	Occupied Bed Days	211,535	51,257	262,793
Outpatients	New Outpatients	31,361	163,381	194,742
	Review Outpatients	27,888	317,857	345,745
	OP with Procedure	18,008	43,158	61,166
	Virtual Outpatients	1,928	22,214	24,142
	Maternity	18,739	0	18,739
Other	A&E Attendances	127,652	32,151	159,803
	Urgent Care	36,628	38,639	75,266
Capacity	Beds	669	148	817
Community	Contacts	0	880,805	880,805

5.4.6 The model produces trajectories for how activity will change over the years to the opening of the new hospital as summarised in the table below.

Table 37: Activity Trajectory

Activity Trajectories	Actual 31/03/12	Actual 31/03/13	Actual 31/03/14	Forecast 31/03/15	Forecast 31/03/16	Forecast 31/03/17	Forecast 31/03/18	Forecast 31/03/19	Forecast 31/03/20	Forecast 31/03/21	Forecast 31/03/22	Forecast 31/03/23	Forecast 31/03/24
Elective	58,534	57,310	52,642	48,651	49,540	50,528	51,452	52,253	53,109	53,979	54,767	55,416	56,082
Non elective	61,163	57,404	57,838	58,022	59,582	60,175	59,943	59,388	60,221	61,488	62,618	63,530	64,463
Outpatients	683,540	690,550	730,364	742,025	751,849	708,593	669,414	634,267	644,535	656,076	666,709	675,890	685,306
A&E and Urgent Care	210,094	196,250	174,928	220,558	219,340	223,324	227,209	230,038	235,069	239,195	242,377	244,247	246,151
Other clinical - Non Tariff	60,612	76,820	53,703	1,414,134	1,460,561	1,467,195	1,485,499	1,505,792	1,533,467	1,558,305	1,583,429	1,608,872	1,634,638
Community Contacts	636,500	717,180	748,088	720,759	723,980	768,995	800,957	843,297	880,805	918,705	946,397	963,893	981,811

5.4.7 The activity and capacity model has been used to calculate bed, theatre, outpatient, imaging, endoscopy, cardiac intervention room and birthing room capacity. It also informs the income assumptions presented in the LTFM as presented in Chapter 13.

5.5 Performance assumptions

5.5.1 The productivity implications of the RCRH Vision for the Trust are that:

- The majority of outpatient attendances and planned diagnostics will be provided outside the acute hospital in community locations by a mixture of secondary care specialists and primary care professionals.
- A greater proportion of inpatient length of stay will be provided in the Trust's intermediate care beds.
- A significant reduction in average length of stay, reducing in the acute hospital to 3.1 days and within the intermediate care beds to 17 days.
- A catchment loss for Emergency Department and emergency inpatient activity related to the change in location of the acute hospital.
- Increased community-based urgent care and out-of-hours services to provide alternatives to attending the Emergency Department.
- Increased day surgery rates (to 85%) with the majority of adult day surgery being provided in dedicated day surgery units in the BTC, STC and BMEC.
- Better physical environments for service users and staff which will encourage more rapid recovery and provide greater privacy and dignity.
- The development of a new single site acute hospital is required allowing consolidation of acute emergency and inpatient services.

5.5.2 The impact of the RCRH model of care is presented in the table below.

Table 38: Impact of the RCRH Model of Care

	SWBH in Midland Met	SWBH in Community Facilities	Other Providers
Outpatient Attendances	*13%* *(Antenatal & Paediatrics)*	74% will be provided by SWBH in community locations 24% being Ophthalmology attendances in BMEC 4% being attendances provided via virtual clinics	6% will be provided by new providers in community locations 7% will be absorbed in to primary care as part of routine working in primary care.
Beds & Length of Stay	671 beds Average length of stay of 3.08 days	Circa 148 beds Average length of stay of 17.01 days	
Catchment Loss	3% adult emergency inpatient admissions	None assumed	Emergency catchment loss primarily flows to:

	SWBH in Midland Met	SWBH in Community Facilities	Other Providers
			Walsall UHBT DGoHFT HEFT
Emergency Department	70% total ED & Urgent Care attendances	30% delivered in Urgent Care Centres (STC) & BMEC (45 % in BMEC)	Excludes Urgent Care activity in existing primary care Urgent Care Centres (e.g. Summerfield)
Day Case Rate 85%	48% including: Children's day surgery * Medical Day Case Unit Interventional Cardiology	100% Day surgery in BTC, BMEC & STC Medical day cases (including chemotherapy) in BTC & STC	

5.6 Capacity requirement

5.6.1 In order to develop an understanding of capacity requirements it has been necessary to consider the level of throughput possible given the planned case-mix of the Trust and a set of performance and productivity assumptions.

5.6.2 ***Appendix 5a*** presents the activity / performance / capacity parameters underpinning the functional requirements. These models were used as the starting point for discussing capacity with lead clinicians within the Trust and for developing the functionality of the new acute hospital and the community facilities.

Inpatient Beds

5.6.3 The tables below summarise the functionality requirements of significant departments within the new acute hospital and the community facilities, comparing these with current provision and highlighting any key performance factors or other issues.

Table 39: Inpatient Beds

	2014/15	2019/20 Planned Capacity	Other Comments
Critical Care (levels 2 &3)	30 funded beds (32 physical bed spaces)	30	2014/15: Bed numbers vary as staffed on points basis.

	2014/15	2019/20 Planned Capacity	Other Comments
Children's	51	50	2014/15: In addition: 5 medical day case beds; 9 surgical day case beds open 2-3 days per week; ability to open up to 12 winter/flexible beds) 2019/20: Includes Assessment Unit, adolescent beds (up to the age of 16) & capacity for children in all specialties. In addition there are 6 day case spaces.
Neonatal	29 funded cots (37 physical cot spaces)	36	Some transitional care will take place on the maternity wards (see below).
Maternity	44 (inc. transitional care, HDU beds on Delivery Suite, antenatal & post-natal care)	60* (inc. transitional care, HDU beds on Delivery Suite, antenatal & post-natal care)	2014/15: In addition - 6 ADAU spaces & 6 discharge lounge spaces 2019/20: *includes circa 10 transitional care beds although actual no. vary according to demand and flexible use with maternity beds In addition there is a Foetal Medicine & Antenatal Day Assessment Unit (6 spaces) & Transfer Lounge (6 spaces – can be flexed to beds at peak demand)
Adult Acute Assessment	103 Medical (includes 21 trollies) 21 Surgical	117 (94 medical & 23 surgical)	2019/20: Reduced capacity to reflect direct admission from ED or ambulance to a number of specialties including stroke, trauma (fractured neck of femur), interventional cardiology etc. Also move to ambulatory pathways and use of chaired area and consult/exam rooms for this. Adult Acute Assessment will comprise: Medical Assessment Unit with: 56 medical assessment beds 14 medical monitored beds 24 trollies medical ambulatory assessment (in addition to a chaired area for up to 30 patients) Surgical Assessment Unit with: 6 beds and 17 trollies
Medical Adult Beds	318	224 (inc. 14 CCU beds)	2014/15: Includes extra beds across medicine and surgery opened in 2013/14 & 2014/15 but planned to reduce by 2017/18. Includes 51 '*ready to go'* beds 2019/20: Capacity reflects earlier transfer to intermediate care beds.

	2014/15	2019/20 Planned Capacity	Other Comments
Surgical Adult Beds	208	154	In addition there will be an Emergency Gynaecology Assessment Unit (6 trolley spaces) and Emergency Pregnancy Assessment Unit (6 trolley spaces)
Sub Total	**804**	**671**	
Intermediate Care	42	148	
SWBH Total	**846**	**816**	

Bed Capacity Modelling Methodology

5.6.4 To derive the bed groupings the future adult bed days were analysed by HRG and HRG Chapter and then grouped on the basis of conditions that were agreed with clinical leads to give the bed numbers in the table below. It should be noted that generic wards were planned as units of 32 beds, arranged in clusters of 3 so at an operational level there will be some flexibility in use of these beds.

Table 40: Inpatient Beds by Condition Grouping

Condition Groupings	Specialties	Bed Numbers
Medicine	Respiratory: Includes 4 level 1 beds & 10 isolation rooms	32
Medicine	Acute Elderly: Includes acute elderly & mental illness	32
Medicine	GI: Includes medical, acute GI bleeding,4 level 1 beds	32
Medicine	Haematology oncology, Haemoglobonopathy Dermatology & Rheumatology	32
Medicine	Stroke & neurology Includes 4 level 1 beds	32
Medicine	Short stay, frail elderly, poisons (monitored beds)	32
Musculoskeletal	Orthopaedics & Trauma	64
Maternity	Ante- and post-natal, HDU (level 2). In addition there is a Foetal Medicine & Antenatal Day Assessment Unit (6 spaces) & Transfer Lounge (6 spaces – can be flexed to beds at peak demand)	60
Gynaecology & Gynaeoncology	In addition a collocated EGAU (6 spaces) & EPAU (6 spaces)	24
Surgical Specialties	Long stay, Colorectal Surgery includes 4 level 1 beds	32
Surgical Specialties	Short stay, Urology, ENT, Interventional Radiology, Plastic Surgery, Breast Surgery & Ophthalmology	32
Cardiology	Includes 14 CCU beds & cardiology step down beds	32
Sub Total		***436***
Adult Acute Assessment	All adult emergency inpatients (except maternity, fracture of femur, stroke, & acute chest pain): • 56medical assessment beds • 14 medical monitored beds • 24 trollies medical ambulatory assessment (in addition to a chaired wait) • 23 Surgical Assessment Unit trollies/beds	117
Critical Care (ICCU) level 2 & 3	All adult	30
Neonatal	Intensive Care, High Dependency and Special Care	36
Children	Includes Paediatric Assessment Unit, Adolescents, High Dependency. In addition there are 6 day case spaces.	50
Sub Total		***233***
Total		**669**
Condition Groupings	**Specialties**	**Bed Numbers**

Theatres

5.6.5 Operating theatre capacity requirements are presented in the table below.

Table 41: Operating Theatres

	2019/20	2019/20 - Other
Emergency (including trauma)	4	Includes: 2 Trauma; 1 Laproscopic & 1 General
Elective Inpatient	7	Includes: 2 Orthopaedic; 2 Laproscopic; 1 IR capacity; 1 Ophthalmic &ENT capacity and I gynae-oncology
Maternity	2	In Delivery Suite
MMH Sub-total	**13**	
BTC	5	And 1 minor op
BMEC	3	
Sandwell	3	And 1 minor op
Community Sub-total	**11**	
Total	**24**	

Outpatients

5.6.6 Outpatient capacity requirements are presented in the table below.

Table 42: Outpatients Consulting Rooms

Specialty	SWBH 2014/15	2019/20 Midland Met	2019/20 Community	Community Locations	2014/15 Total	2019/20 Total
Generic Adult	35 BTC 21 SGH 5 RRH	0	35 BTC 36 STC 9 RRH	BTC, STC & RRH will have suites of generic adult consulting rooms for use by all specialties (apart from those requiring bespoke accommodation)	61	80
T&O	4 cubicles & 4 rooms SGH 6 cubicles & 2 rooms City	0	Use of generic adult rooms		16	Use of generic adult rooms
Breast	5 BTC	0	5	Bespoke accommodation: BTC	5	5
ENT	6 BTC 5 SGH	0	3 STC 6 BTC	Bespoke accommodation: BTC & STC	11	9
Oral Surgery	3 City	0	4	Bespoke accommodation: STC&RRH	3	4
Dental	3 SGH	0	2	Bespoke accommodation: STC&RRH	3	2
Diabetes	6 City 7 SGH	0	Use of generic adult rooms		13	Use of generic adult rooms
Dermatology	6 Sheldon	0	6	Bespoke accommodation: STC	6	6
Antenatal	5 City 3 SGH	7	6	Bespoke accommodation for Midwifery led antenatal clinics: STC	8	13
Fetal Medicine	1 City	0	0		1	Use of antenatal clinic
Respiratory	5 SGH	0	5	Bespoke accommodation: STC	5	5
Oncology	6 BTC (at SGH use generic adult rooms)	0	6 BTC 4 STC	Bespoke accommodation: BTC & STC (adjacent to chemotherapy day units)	6 BTC & use of generic adult rooms	10
Ophthalmology	27 BMEC 5 SGH Archer Ward	1*	39 BMEC 6 STC 4 RRH	Bespoke accommodation: BMEC, BTC & STC	32 & Archer Ward	49

5.6.7 For the majority of specialities all adult outpatient activity will be undertaken in community facilities with no outpatient activity in the MMH. The exception to this is Maternity where all consultant led and high risk antenatal outpatient activity will be undertaken in the MMH. Low risk and midwifery led outpatient activity will continue to be offered in community locations.

Imaging

5.6.8 Imaging capacity is presented in the table below.

Table 43 Imaging Capacity

Department	New Acute Hospital	BTC	STC	RRH
Imaging	2 Plain Film x-ray 2 Plain Film x-ray in ED 4 Ultrasound rooms 2 MRI 2 CT 2 Fluoroscopy room Interventional Radiology Suite (with x 2 flourscopy, barium and 1 ultrasound room) 4 Gamma Cameras	1 MRI 1 CT 1 Dexa Scanner 2 Plain x-ray rooms 4 Ultrasound rooms	1 MRI 1 CT 2 Plain Film x-ray 3 Ultrasound rooms (1 to be used as a vascular room)	1 Plain Film x-ray 2 Ultrasound rooms
Cardiac Diagnostics	1 Stress ECHO TOE room 2 ECHO rooms 1 Ambulatory monitoring room 1 ECG rooms 1 Pacing room3 Cath Labs	1 Exercise stress testing room 1 Ambulatory monitoring room 2 ECG rooms	1 Exercise stress testing room 2 ECG rooms 1 Ambulatory monitoring room 1 Device testing room	1 ECG/ECHO room
Respiratory Physiology	1 Respiratory testing 1 Sleep diagnosis/therapeutic assessment room	4 Respiratory testing rooms	2 Respiratory testing rooms 1 Sleep room	N/A
Neurophysiology	1 Nerve Conduction Studies 1 EEG Recording room	N/A	1 Ambulatory EEG room 2 NSC/EMG rooms 2 EMG/NCS & EP rooms 4 EEG sleep rooms	N/A

Note: No Imaging capacity in BMEC or the Sheldon Block

Sensitivity Analysis and Expansion / Reduction Strategy

5.6.9 Sensitivity analysis has been undertaken for the activity and capacity model. This work has informed the Trust's Expansion / Reduction Strategy.

5.7 Expansion Strategy

5.7.1 The Trust's brief has identified expansion space within the MMH sufficient for up to an additional 96 adult generic beds (using the generic ward template). In addition some additional bed capacity could be created though further improved productivity in length of stay and / or additional bed days provided in intermediate care or contacts in the community (as an appropriate alternative to admission or step down from acute care). The generic ward design within MMH will enable easy change in use of ward between specialties.

5.7.2 In relation to specialist areas:

- **Critical Care:** within the ADR there is soft expansion space that could be used for additional critical care bed capacity possibly through a central Level 1/ step down area.
- **Neonatal Unit:** if additional capacity was required the first option would be transfer of cases within the Neonatal Network (as is current practice). There would also be the option to use the 4 transitional care rooms as single cot nurseries either on a temporary or permanent basis.
- **Children's Inpatient Unit:** there is flexibility in capacity between inpatient beds, the Paediatric Assessment Unit and day case area (all co-located on the unit).
- **Delivery Suite:** there is flexibility in capacity within Delivery Suite between high risk delivery rooms, the birthing centres and the bereavement rooms (as is current practice).

5.7.3 In relation to Operating Theatres:

- **For emergency cases**: the capacity already exists within the emergency theatres planned for MMH as demand for these was rounded up to ensure adequate 24/7 capacity and hence there is a lower utilisation rate.
- **For elective cases**: there is some flexibility within the planned capacity as there was a rounding up rather than down of number of theatres compared to the number indicated by the modelling work (to allow flexibility for longer lists as complexity of surgery increases e.g. in Gynaecology Oncology and to ensure the required range of specialist theatres). Additional capacity of 49 elective sessions per week can be created by introducing routine three session days Monday-Friday and two sessions on a Saturday.

5.7.4 There is some soft expansion space within the MMH between the Operating Theatre Department and Critical Care Unit that could be used to create additional capacity in either department including support accommodation such as recovery spaces for additional theatre lists.

5.7.5 In relation to outpatient clinics

- Additional capacity for antenatal clinics and paediatric clinics can be created through planning routine weekend sessions (3 additional sessions per room per week in each department).
- The remaining outpatient activity is planned to be provided in Community Facilities. If however, there was a change in service model resulting in the need to provide additional adult outpatient clinics in the MMH some of the expansion space could be converted to outpatient rooms rather than beds.

5.7.6 In relation to other areas:

- Most Imaging modalities and Endoscopy (apart from Nuclear Physics and Bronchoscopy) are also provided in the Community Facilities (BTC and STC) and so additional capacity for these can be created by transferring any routine work from MMH to these sites and increasing their capacity

by use of 3 routine sessions per day Monday to Friday and up to 4 routine sessions at the weekend. Within MMH there is also the option of increasing from a 16 session routine working week up to 22 sessions (3 session days on Saturday and Sunday).

- Within Interventional Cardiology and Bronchoscopy (only delivered in MMH) there is the option of increasing capacity from a 16 session routine working week up to 22 sessions (3 session days on Saturday and Sunday).
- If further temporary capacity is required there is the option of commissioning mobile or temporary facilities and locating these in the planned temporary facility docking station on the ground floor of MMH adjacent to the facilities area.

5.7.7 Within the future Community Facilities the following expansion capacity is planned:

- Additional theatre sessions from increasing day case theatres from 10 sessions per week to 16 sessions per week.
- Additional outpatient clinics from increasing routine sessions from 16 sessions per week to 19 sessions per week.

Reduction Strategy

5.7.8 If the MMH capacity was too great the Trust could use its estate flexibly. In the scenario where clinical space in the acute hospital was surplus, and there really was no clinical function that could be delivered from it, the space could be converted to corporate administration offices to allow relocation of corporate functions from Trust estates allowing a consequent disposal.

Ensuring Delivery to Plan

5.7.9 As outlined above activity trajectories have been agreed with partners. Ambitious targets have been set for service changes and improvements in performance. It is important that progress against trajectory is monitored to ensure that the Trust is on track to move into the new hospital and the refurbished community facilities. This will allow time to implement mitigating actions if there is a significant variance from plan.

5.7.10 A governance process to monitor delivery has been agreed. Progress is overseen by the Clinical Leadership Executive via the MMH and Reconfiguration Clinical Leadership Executive (CLE) Committee. The following measures will ensure delivery:

- The ABC Version 1 trajectories inform the Trust's Transformation Plan which is currently being refreshed into an Integrated Transformation Programme;
- Trust and Clinical Group level Annual Plans take the activity and capacity levels in ABC Version 1 trajectories into consideration;
- Bi-annual review of progress against trajectory at Clinical Group and specialty level is undertaken at Clinical Group performance review meetings;
- The Executive will report whole system progress to deliver the trajectories along with any material future system planning documents to the Trust Board on a quarterly basis from April 2014; and
- Additional reviews are undertaken at key project milestones including appointment of preferred bidder and financial close,

5.7.11 A formal review of progress with demand figures, bed numbers and outpatient supply will be concluded no later than 15 months before the opening of the new hospital. The results of this should

trigger mutual provider and commissioner formal re-confirmation of the safety of those assumptions for the due date, together with any actions agreed to mitigate risk. This overall assessment of risk will be made publically available.

Key Activity and Capacity Measures

5.7.12 Activity and capacity measures have been proposed for the monitoring process as presented below:

- Emergency Care: A&E attendances and Non-elective admissions;
- Elective Care: Elective admissions and day cases;
- Outpatients: first attendances and review attendances;
- Bed Capacity: bed days (split emergency, elective and intermediate care) and bed numbers; and
- Community Contacts: outpatient and bed alternative contacts.

5.7.13 Monitoring for each of the above measures will include:

a) LTFM / RCRH trajectory – at least current year and end point (2019/20);

b) LDP / Contract trajectory – current year; and

c) Actual performance – current year.

Other Trust Capacity Requirements

5.7.14 The table below presents the other Trust capacity requirements.

Table 44: Other Facilities

Service	2014/15	2020/21 New Acute Hospital	Key Performance Factors	2020/21 Community Sites	2020/21 Total
Endoscopy	7	2	16 sessions per week and 24 hour access for emergencies	6 endoscopy rooms: 3 in BTC 3 in STC 10 sessions per week	8
Cardiac Interventional rooms	2 and access to interventional imaging room	3	16 sessions per week and 24 hour access for emergencies	None	3
Birth Rooms	20	18 (12 high risk and 6 midwifery led)	In addition within Delivery Suite there are 6 Induction spaces	3 birth rooms in Halcyon Birthing Centre (stand-alone midwifery led centre)	21

5.8 Summary of Requirements of MMH

5.8.1 The specification for the new acute hospital can be split into two parts: the Design Vision and the Functional Content; the two coming together to form the core of the Design Brief. The aim of the Design Brief is to describe the Trust's aspirations and expectations as well as providing a clear framework for the development of a design.

Design Vision

5.8.2 The Trust developed the Design Vision with a Design Group chaired by the Trust Design Champion. The group included members of the Trust, Local Government and PCT partners led by the Design Champion, Sue Davis, who was the previous Trust Chair.

5.8.3 The Design Vision developed by this group reflects the requirement to create a landmark hospital, which will be an asset to the local community and will support local regeneration. The design should be enduring and take account of the diverse needs of the population it serves.

5.8.4 The key elements of the Design Vision are that the hospital will be:

- Inspirational, attractive and imaginative;
- Welcoming;
- Reassuring;
- Light and airy;
- Clean without being clinical;
- Sympathetic to the environment;
- Fully accessible;
- Supportive to privacy and dignity; and
- A good place to work.

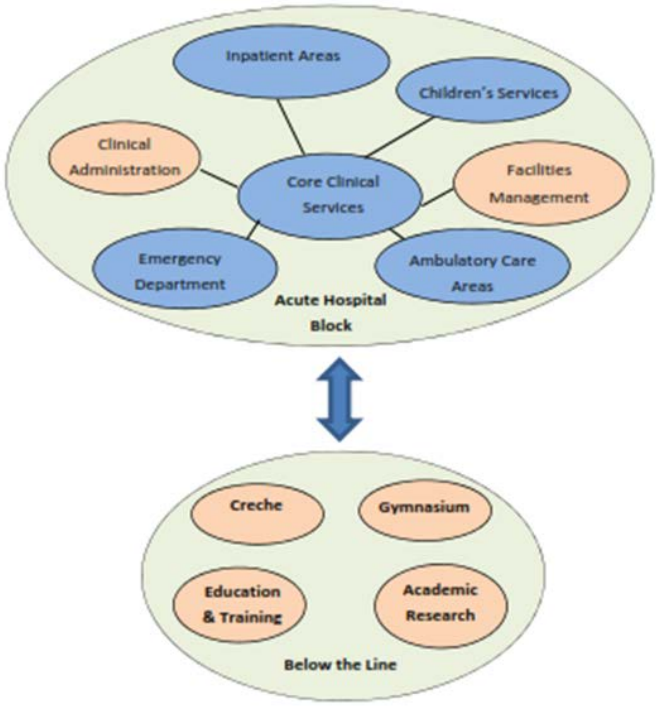
The Functional Content

5.8.5 Prior to the procurement the Trust developed a Functional Brief which consisted of the Whole Hospital Operational Overview and individual Departmental Planning Policies and Design Descriptions (PPDDs).

5.8.6 A philosophy of zoning to facilitate co-ordination of associated services was developed ensuring that physical adjacency will support the patient journey.

5.8.7 Space for a crèche, gymnasium; research and training facilities was included in the site plan. However, they were not included in brief for the PF2 bidders and are therefore presented below the line in the model summarised in below:

Figure 16: Design Solution



5.9 New Hospital Clinical Requirements

5.9.1 The Activity and Capacity Model (ABC Version 1) has formed the basis for calculating the clinical facilities required within the new hospital. The following summarises the key components specified to bidders as required for the acute hospital:

5.9.2 A total of 669beds, including:

- A 30 Bed Critical Care Unit (Level 2 and 3);
- 117 space Adult Acute Assessment Unit;
- 36 Neonatal Cots; and
- A 56 bed Children's Unit.

There will be 14 Generic Wards of 32 beds each, including:

- 14 Coronary Care Beds; and
- 16 distributed higher dependency monitored beds (Level 1);

5.9.3 13 Operating Theatres, comprising:

- 2 Trauma Theatres;
- 2 Emergency Theatres (including laparoscopic equipment);
- 2 Maternity Theatres in Delivery Suite; and

- 7 Elective Theatres;

5.9.4 Bespoke outpatient clinics for:

- Children;
- Urodynamics; and
- Antenatal services.

5.10 The MMH Service Solution

Capacity Modelling and Clinical Engagement

5.10.1 The activity and capacity model, informed by high levels of clinical engagement, forms the basis for an understanding of the clinical facilities required. The capacity requirements for the MMH are presented in the sections above.

5.10.2 The service model is also underpinned by a set of detailed operational policies covering all of the departments in the MMH. These informed the development of the Planning Policy and Design Descriptions (PPDDs) which specified departmental requirements in the new hospital for Bidders.

5.10.3 Each of the PPDDs and operational policies has an identified clinical lead who has worked with clinical colleagues and operational staff in developing the documents. This work was co-ordinated throughout the process via clinical leadership groups including the Clinical Leadership Executive.

5.10.4 The Architectural Design Review (ADR), undertaken with clinicians during autumn 2013 provided the opportunity for update to the clinical brief for the MMH prior to commencing the procurement phase of the project. It also prepared them for the procurement to ensure no surprises and keep them engaged in the process. The Trust's Medical Director confirmed clinician support for the MMH at OBC.

Other Factors Influencing Development of the Service Solution

5.10.5 The following key issues were also considered when developing the Operational Policies and PPDDs:

- Adjacencies between departments to facilitate patient flows;
- Separating flows of public and ambulatory patients, inpatients and goods from the point of entering the hospital until at least the entrance into departments;
- Ease of access for patients;
- Future flexibility in use of space;
- Responding to national, regional and local policy;
- Improving efficiency of service provision;
- Dealing with major incidents and business continuity; and
- Provision of the facilities and support required to develop the more specialist services (that have a regional or national profile) provided by the Trust in a way that integrates them with other services within the hospital but also retains their specialist identity.

Emergency and Urgent Care

5.10.6 Circa 30% of patients requiring urgent care will be able to attend one of the community-based urgent care services or be managed in primary care through an out-of-hours service. The largest of these functions will be delivered from the Sandwell Hospital site delivered on an integrated basis by the Trust. As a result a smaller percentage of emergency attendances will take place in the Emergency Department (ED) within MMH. These patients will typically have injuries and conditions requiring the level of specialist assessment, diagnosis and treatment that will only be available in an acute setting.

5.10.7 Most patients attending the ED will be assessed, diagnosed, treated and discharged from the ED by the team of clinical staff based within the Department. To facilitate this dedicated Imaging facilities and near patient testing will be required within the Department.

5.10.8 A significant number of patients will require further assessment by specialty teams and / or admission. The flow for adult patients will primarily be from the ED to the adult Acute Assessment Unit which will therefore need to be located immediately adjacent (vertical or horizontal) to the ED. For children and young adolescents the flow will be from the dedicated children's area in the ED to the Paediatric Assessment Unit which is part of the Children's Inpatient Unit.

Admitted Patient (Specialist Services)

5.10.9 A number of specialist services are required to support the patient pathway for admitted care including the adult Acute Assessment Unit (AAU), Critical Care, Interventional Cardiology, Coronary Care, Operating Theatres, Children's inpatient services, the Delivery Suite and Neonatal services. In many cases patients will need interventions and care in more than one of these services and so easy, quick access between services will be required to facilitate rapid assessment and diagnosis or on-going treatment. These services will be operational or at least accessible 24 hours a day.

5.10.10 The Adult Assessment Unit will comprise of a Surgical Assessment Unit and a Medical Assessment Unit (with ambulatory, assessment and monitored bed zones).

5.10.11 The Delivery Suite and Neonatal Unit will be co-located and adjacent to the antenatal clinic with ground floor access. The Delivery Suite will have a low risk, midwifery led birth centre collocated with a high risk consultant led area including 2 dedicated operating theatres, high dependency beds and a dedicated bereavement suite.

5.10.12 The Children's Inpatient Unit will include a Paediatric Assessment Unit (PAU), day case area and adolescent area as well as inpatient Paediatric beds including high dependency care. The Unit will be located away from adult inpatient facilities and will be adjacent to the Children's Outpatient Department.

Admitted Patient Care – Generic Adult Inpatients

5.10.13 Adult inpatients (apart from those requiring care in one of the specialist areas above) will be accommodated in generic inpatient beds. The majority of emergency admissions will be admitted to these beds via the adult AAU (with 117 assessment spaces) and the majority of elective surgical inpatients will be admitted following surgery via the Operating Theatre Department (which includes the central admissions area).

5.10.14 An important element of the new service model is a reduced length of stay facilitated by new pathways which include a streamlined admissions process, early initial diagnosis, rapid assessment and timely treatment. These will be supported by early senior medical assessment and decision making with 24/7 on site consultant presence in key specialties.

5.10.15 In the MMH there will be 376 generic adult inpatient beds. These will be accommodated in 12 wards each with 32 beds. The wards will be based on a generic design and primarily located in clusters of 3 in order to facilitate future flexibility in use. In addition there will be 64 maternity beds located across 2 wards (in a generic ward design).

5.10.16 The future service requires generic wards with 50% single rooms and en-suite bathrooms and the remaining 50% of beds will be in bays of 4 (each bay having a dedicated bathroom). This arrangement will improve patient privacy and dignity, facilitate infection control and offer patient choice between a single room and a bay of 4 beds in line with feedback from public engagement work.

Outpatients

5.10.17 The vast majority of outpatient attendances will be provided outside the MMH in the Trust's community facilities and will be delivered by a mixture of secondary care specialists, community staff and primary care professionals. This includes specialist Ophthalmology attendances which will continue to be provided at BMEC. The aim will be to provide rapid access with a one stop approach, and where required, follow up in the community or primary care. Many staff will work in multiple locations across the MMH, the Trust's Community Facilities and other community locations including primary care and patient's homes.

5.10.18 Within the MMH the main outpatient services delivered will be in the Antenatal Clinic (for high risk women and consultant care) and the Children's outpatient department.

5.10.19 There will also be a Medical Day Case Unit in MMH for the provision of day cases that need to be delivered on an acute hospital site with the full clinical back up that this offers. Examples include biologic infusions, Sickle Cell and Thalassemia treatments.

Diagnostics

5.10.20 Diagnostic services are key to the rapid assessment, diagnosis and treatment of patients in all specialities and settings and so need to form part of the patient pathway at the right time and in the right place. Where possible a one stop approach will be developed.

5.10.21 Diagnostic services, as far as possible, will be provided in the Trust's Community Facilities as well as in the MMH. The Trust will be a provider for many of the community based services. The exceptions to this service model will be where specialist equipment and technology is required but with insufficient demand to justify duplicating this in multiple locations or where there is only a small team of staff with specialist skills (for example: Bronchoscopy and Nuclear Medicine will be based in the MMH and Breast Surgery services in the BTC).

5.10.22 The Trust's main pathology service will continue to be based in STC with an 'essential laboratory' (including Blood Bank) in the MMH to support emergency and urgent inpatient care.

Clinical Support Services

5.10.23 The majority of clinical support services will be located in the Community Facilities as most patients access these on an ambulatory basis. They will provide an in-reach service to inpatients in the MMH (where appropriate this will include some bespoke accommodation). There will however be some clinical support services with their main base in the MMH because their service has a significant contribution to inpatient pathways. These include Pharmacy and Cardiac Diagnostics. These services will provide an outreach service to the Community Facilities. The main mortuary will continue to be located in STC (adjacent to the main pathology department) with a body store located in the MMH to support emergency and inpatient care.

Non-Clinical Support Services

5.10.24 There are a range of non-clinical services within the MMH. Some of these closely support clinical services and are therefore located adjacent to the relevant clinical service in hubs or admin zones. Others do not so directly support clinical services and are located further away from clinical areas e.g. the receipts and distribution centre.

Research and Education

5.10.25 Research and education are important to the Trust's future success and the wider health economy. The Trust has a good track record for delivery of research and education and they play a significant part in attracting the best staff, with consequent impact on quality of care and reputation as well as attracting related income. The main base for these departments will be at STC. However, high quality facilities for the elements that relate to inpatient care will provided in the MMH. These facilities will be developed in a way that gives a clear identity to research and education.

5.10.26 When the MMH opens the Trust expects to provide most of the essential research and education facilities in retained estate with small satellites for essential services in the MMH.

5.11 Conclusion

5.11.1 The model of care, activity assumptions and capacity requirements have been developed jointly with the RCRH Programme Board following extensive engagement in the community and with clinicians. A service model has been developed to inform the requirements of the new acute hospital.

5.11.2 Activity projections have been refreshed and agreed with RCRH partners. The activity expected in 2019/20 remains consistent with the OBC in all areas except for outpatients. Outpatient activity has increased by circa 40,000 cases per year due to more procedures taking place in an outpatient setting and due to the introduction of 'virtual outpatients'.

6 Background to the Option Appraisal

6.1 Introduction

6.1.1 The purpose of this chapter is to outline:

- The back ground to the option appraisal which shows how the Grove Lane solution, Option 4, has been reconfirmed over several iterations of the MMH business case; and
- A description of the shortlisted options.

6.1.2 The conclusion of the evaluation conducted for the OBC was that the Grove Lane solution represented the best economic solution to achieve the objectives of the project.

6.1.3 Since the approval of the OBC there have been no changes in the underlying assumptions used to make that assessment and therefore the assessment still stands.

6.2 Background: Reconfirmation of Option 4

Option 4 approved in OBC 2009

6.2.1 The original non-financial appraisal was undertaken after the public consultation in April 2007. The outcome of this work is presented in Chapter 7.

6.2.2 Version 2 of the OBC approved by the Department of Health (DH) in August 2009 contained a comprehensive economic appraisal across four options to determine which option was the preferred solution. Chapter 6 presents the development and evaluation of options undertaken at that time along with a subsequent economic update undertaken in March 2011.

6.2.3 Following approval of the OBC in August 2009 the DH approved the decision to pursue a Compulsory Purchase Order (CPO) to facilitate acquisition of the Grove Lane site. The Trust now owns the entire site.

Option 4 reconfirmed by Trust Board 2013

6.2.4 In 2013 the Trust Board discussed, in a series of workshop settings, whether the original option appraisal in 2009 remained valid. In doing that specific consideration has been given to:

- The changed financial circumstances for public services notwithstanding the strong performance of the Trust in recent years;
- Revised population expectations including changes in the migrant patterns of the area;
- Enhanced expectations of care integration with local GP practices; and
- Considerably revised expectations of critical mass of acute care service infrastructure.

6.2.5 The conclusion was that the case for change remains overwhelming and that only a new build acute hospital can deliver change at the pace required.

Option 4 reconfirmed in the Non-Financial Appraisal February 2014

6.2.6 In February 2014 the Trust and its advisors undertook a review of each option to consider the changes to the options and to identify which, if any, of the scores and weightings should be revised. The main difference to the 2009 option appraisal is that the new build options would include less new build and additional retained estate at Sandwell and at City. The conclusion of the review was that no scorings were altered and thus the economic analysis that option 4 was the preferred option remained valid.

Option 4 reapproved in OBC 2014

6.2.7 In 2014 the Trust reviewed and refreshed the economic appraisal of the original four options and a Do Nothing option. The conclusion of this was that option 4 remained the preferred option and this was approved within the OBC in July 2014.

Changes since the OBC approval July 2014

6.2.8 There have been no changes to the key underlying assumptions since the OBC was approved and therefore the conclusion that option 4 is the preferred option remains valid.

6.3 Identification of the Shortlist of Options

6.3.1 The four options considered were:

- Option 1: Do Minimum;
- Option 2: City Site re-development;
- Option 3: Sandwell Site re-development; and
- Option 4: A new build on the Grove Lane Site.

6.4 Description of the Shortlisted Options

Option 0: Do Nothing

6.4.1 Although, the Do Nothing option is non-viable in the long-term, it serves as a baseline assessment of the costs needing to be incurred. It demonstrates the forecast costs for which no additional quantitative benefits will accrue. All subsequent options costs and benefits are assessed against this outcome. The core assumptions for Do Nothing are:

- Revenue costs are based upon 2013/2014 costs as presented within the Trust's LTFM and then adjusted to reflect differences for this option.
- The Trust has a major backlog maintenance need which would need to be addressed as well as a refurbishment across a long timeline at circa £15m additional investment per annum.
- Small capital investments are included within the Capital Programme representing schemes which will take place irrespective of option chosen.
- The lifecycle replacement trajectory would bring forward the need for earlier significant additional lifecycle expenditure. Adopting consistent Trust accounting practices would see most of this cost being incurred against capital resources and the remaining adding to the Trust's revenue cost base.

- Equipment replacement is consistent with capital programme routine maintenance investment levels. Priorities will be formed from these stable investment levels.
- The land owned by the Trust, valued at April 2013, is determined as an opportunity cost as, technically, this land may be used for alternative purposes.
- The residue of land the Trust is committed to purchase at Grove Lane is included and then sold later in the timeline.
- Building asset residual values have been calculated for new builds taking new asset values, adding capital additions, deducting depreciation to arrive at a view of the building values at the end of both appraisal periods, years 36 and 66.

Option 1: Do Minimum

6.4.2 This option involves significant refurbishment of both the City Hospital site and the Sandwell Hospital site. The refurbishment would take place over a longer time period as service provision continues on the sites being redeveloped. This would inevitably slow down the delivery of the Right Care Right Here service model as hospital facilities would not be in place to enable the full service delivery.

6.4.3 Services would be delivered by splitting emergency care and elective inpatient care between City and Sandwell Hospital sites. Once the full model of care is operational, activity volumes undertaken will be consistent with the Grove Lane option.

6.4.4 This would create a three year delay in the roll out of the full service model with full delivery not occurring until 2021/2022 at the earliest.

6.4.5 The general approach to assessing the cash flows inherent within this option is consistent with the Do Nothing Option. Additional characteristics specific to Do Minimum are detailed below:

- The Do Minimum option considers to what extent the approach would change the costs identified under Grove Lane. A full list of these annual changes is included within ***Appendix 13a*** and includes for example:
  - Additional bed capacity on the Sandwell site to allow for peaks in demand;
  - Additional critical care beds, one per site, are required; and
  - Additional tiers of medical staffing cover are required to enable safe practice.
- Additional Soft FM needs have been included recognising the two site strategy.
- Refurbishment costs of both sites are significant and cover an extended timeline.
- New capital expenditure and associated revised lifecycle estimates have been considered and included within the modelling.
- New residual building values will be derived through alternative refurbishment costs and revised lifecycle estimates.
- A small element of land within the City site will be sold as well as the Grove Lane site.

6.4.6 The Do Minimum option delivers the service model but in a dysfunctional manner with annual revenue costs being significantly greater.

Option 2: New Build on the City Hospital Site

6.4.7 The characteristics of this option are similar to Grove lane although capital forecast costs are higher and build time would be 2-3 years longer.

6.4.8 This would mean the Trust is unable to realise efficiencies from a single acute site and will have to:

- Incur additional on call and 24/7 medical staff cover;
- Lose soft FM savings;
- Keep greater bed coverage for longer; and
- Land sales would apply to Grove Lane and part of the Sandwell site.

Option 3: New Build on the Sandwell Hospital Site

6.4.9 This option is similar to Option 2 in outline. However, capital costs are greater and timelines are one year longer. Decanting costs are greater due to the complexity inherent with the build as Sandwell is a very confined site.

Option 4: New Build on the Grove Lane Site

6.4.10 The details of this option are presented in Chapter 5, which outlines how the Midland Metropolitan Hospital will be supported by community facilities developed on retained estate. The characteristics of this option are:

- The purchase of land by Compulsory Purchase Order to build the Midland Metropolitan Hospital;
- A new build discounted capital expenditure consistent with GEM principles;
- Limited refurbishment of retained hospital estate;
- New medical and IT equipment required in preparation for the new acute hospital;
- Lifecycle costs are charged 30% to capital and 70% to revenue;
- Detailed revenue cost modelling has been included in the economic modelling;
- Transition costs have been included recognising that one off costs will be incurred as the option gets closer to fruition and dual running costs are forecast as Grove Lane becomes operational;
- Consideration has been given to activities, currently being provided by the Trust, which will, under future service models, be delivered by third parties e.g. GPs; and
- Significant disposal of land occurs when large parts of City and Sandwell sites are sold.

6.5 Conclusion

6.5.1 The following 4 options for evaluation are:

- Option 1: Do Minimum;
- Option 2: City Site re-development;
- Option 3: Sandwell Site re-development; and
- Option 4: A new build on the Grove Lane Site.

7 Benefits Appraisal

7.1 Introduction

7.1.1 The non-financial benefits appraisal process and outcome is presented at ***Appendix 8a***. This chapter summarises the methodology, results and conclusions reached. Chapter 6 outlines how the results were reconfirmed in 2014 and that there have been no changes since OBC approval in 2014.

7.2 Methodology

7.2.1 Benefit criteria were identified, weightings applied and then scored against each of the options. A sensitivity analysis was conducted to test the conclusion.

7.3 Benefit Criteria

7.3.1 The following benefit criteria were used to assess the options:

- Clinical quality;
- Environmental quality;
- Development of existing services;
- Strategic fit, including regeneration;
- National, Regional and local policy;
- Training, Teaching and Research;
- Effective use of resources; and
- Ease of delivery.

7.4 Non-Financial Benefit Scores

7.4.1 The table below shows the raw scoring by option by criteria as well as the two sets of weights assigned to each criterion.

Table 45: Raw Scores and Range of Weights

Criteria Covered	Weight %	Option 0 Do Nothing	Option 1a Do Minimum SGH Hot / CH Cold	Option 1b Do Minimum CH Hot / SGH Cold	Option 2 Build / Refurbish City	Option 3 Build / Refurb. SGH	Option 4 New Build Grove Lane
Better Access	15%	55	55	60	60	55	70
Clinical quality	17-19%	35	45	45	85	80	90
Environmental quality	13-8%	30	45	40	85	80	90
Development of existing services	8-9%	65	70	70	90	90	90
Strategic fit, inc. regeneration	8-10%	25	30	30	70	70	90

Criteria Covered	Weight %	Option 0 Do Nothing	Option 1a Do Minimum SGH Hot / CH Cold	Option 1b Do Minimum CH Hot / SGH Cold	Option 2 Build / Refurbish City	Option 3 Build / Refurb. SGH	Option 4 New Build Grove Lane
National, Regional and local policy	7-6%	50	60	60	90	90	90
Training, Teaching and Research	12-7%	60	60	60	80	80	80
Effective use of resources	14-15%	70	70	70	90	90	90
Ease of delivery	7-11%	20	20	25	40	15	70
Total	**15%**	**410**	**455**	**460**	**690**	**650**	**760**

7.4.2 The table below shows the average weighted scoring by option by criteria.

Table 46: Average Weighted Scores

Criteria Covered	Option 0 Do Nothing	Option 1a Do Minimum SGH Hot / CH Cold	Option 1b Do Minimum CH Hot / SGH Cold	Option 2 Build / Refurbish City	Option 3 Build / Refurb SGH	Option 4 New Build Grove Lane
Better Access	8.2	8.2	8.9	8.9	8.2	10.4
Clinical quality	6.2	7.9	7.9	15.0	14.1	15.8
Environmental quality	3.6	4.7	4.2	8.9	8.3	9.4
Development existing services	5.7	6.2	6.2	7.9	7.9	7.9
Strategic fit, including regeneration	2.3	2.8	2.8	6.5	6.5	8.3
National, Regional, local policy	3.1	3.7	3.7	5.5	5.5	5.5
Training, Teaching, Research	5.7	5.7	5.7	7.6	7.6	7.6
Effective use of resources	10.1	10.1	10.1	13.0	13.0	13.0
Ease of delivery	2.7	1.8	2.2	3.6	1.3	6.2
Total	**47.62**	**51.05**	**51.71**	**76.87**	**72.51**	**84.28**

7.5 Results of the Non-Financial Option Appraisal

7.5.1 The resultant outcome clearly demonstrates the significant variance between the Do Nothing, Do Minimum and Grove Lane solutions and reflects the view that investment in the Grove Lane option will generate significantly higher non-financial benefits.

7.5.2 The benefit point scores are critical to the choice of the preferred option as they affect the ranking and relative by benefit point option scores significantly.

7.5.3 The table below shows the ranking and the percentage difference between the options, showing Grove Lane option as the highest in terms of qualitative score.

Table 47: Results Based on Average Weighted Scores

	Option 0 Do Nothing	Option 1a Do Minimum SGH Hot / CH Cold	Option 1b Do Minimum CH Hot / SGH Cold	Option 2 Build / Refurbish City	Option 3 Build / Refurb SGH	Option 4 New Build Grove Lane
Average Score	47.62	51.05	51.71	76.87	72.51	84.28
Rank Order	5	5	4	2	3	1
Difference	-44%	-39%	-39%	-9%	-14%	0%

7.6 Sensitivity Analysis

7.6.1 A sensitivity analysis was undertaken which:

- For access: reduced the score for the Grove Lane option from 70 to 68;
- For environmental quality: reduced the score for the 3 new build options by 2 points each; and
- For effective use of resources: reduced the score for all 3 new build options by 2 points each.

7.6.2 The table below shows the ranking and the percentage difference between the options as a result of this sensitivity, showing no material change to the score and no change to the ranking or the percentage difference between the scores.

Table 48: Non-Financial Appraisal Sensitivity Analysis

	Option 1a Do Minimum SGH Hot / CH Cold	Option 1b Do Minimum CH Hot / SGH Cold	Option 2 Build / Refurbish City	Option 3 Build / Refurb SGH	Option 4 New Build Grove Lane
Average Score	51.05	51.71	76.37	72.01	83.48
Rank Order	5	4	2	3	1
Difference	-39%	-38%	-9%	-14%	0%

7.6.3 A further stress test is to consider how much the Grove Lane scores would need to reduce in order for the next best solution which is the refurbishment and new build on the City site. Each score on the Grove Lane option would need to be reduced by 10% in order for the preferred option to switch to the City site (1% difference in average score).

7.7 Conclusion

7.7.1 Option 4, the Grove Lane New Build, scores highest in the non-financial appraisal even with a sensitivity analysis where its scores for access, environmental quality and effective use of resources were reduced.

8 Economic Appraisal

8.1 Introduction

8.1.1 This chapter presents an economic appraisal of the options identified in Chapter 6. As outlined in Chapter 6 there have been no changes to the economic appraisal (summarised in ***Appendix 8a***) since OBC approval in 2014.

8.2 Methodology

8.2.1 A Do Nothing option is non-viable in the long-term. It serves however as a baseline to assess the net benefit of each option. This option will therefore be known as Option 0.

8.2.2 All five options have been developed by applying technical guidance consistent with the Treasury Green Book, and Generic Economic Model (GEM) Investment Appraisal Guidance. In particular the following is of note:

- The base year and price base is 2013/2014;
- Prices quoted exclude VAT;
- Cash flows are discounted by 3.5% per annum to year 30 and 3% per annum thereafter;
- Affordability cash flows have been amended to exclude capital charges and provisions for redundancy costs;
- Although, build / refurbishment timelines are different a 66 year appraisal period has been used, which reflects the re-development period plus 60 years of operation; and
- An alternate period of 36 years is also included.

8.3 Costs

Cash Flows

8.3.1 There are a number of steps involved in arriving at a preferred economic option. Traditional discounted cash flows across the following categories are considered for each option:

- **Opportunity Costs**: these are costs identified for areas which may be used for alternative means, (i.e. what opportunity has been foregone by using this resource in the option being considered). In most NHS cases, opportunity costs are restricted to land values.
- **Capital Outlays:** for new builds or refurbishment (net of vat and discounted by a 2.5% GDP deflator) are applied by year of spend.
- **Land or building sales** - recorded in the year(s) in which they are estimated to be realised.
- **An estimate of the residual value of an asset** - at the end of the lifespan to represent an estimate of an assets value at that time, i.e. 36 and 66 years.
- **Capital and revenue lifecycle costs** - of maintaining estate assets.
- **The Trust's capital programme** - for new and replacement assets.
- **Revenue cost cash flows** - across clinical, non-clinical and estates costs across the lifetime. For non-Grove Lane options, the Grove Lane revenue streams have been taken as a baseline and adjusted for dysfunctional expenditure incurred in the alternative options.

- **Transitional costs** - declared separately and consider non-recurrent or ad-hoc spends.
- **Externalities** - require an assessment of lost activities to the host provider and consideration to where this work goes in future.

8.3.2 An adjustment is made for the assessment of risk relevant to each option and sensitivity is considered against criteria of each option.

8.3.3 The sum of these discounted results creates a net present cost (NPC) and an Equivalent Annual Cost (EAC) by option. A ranking occurs with the lowest NPC receiving the preferred option status.

Revenue Cost Forecasts

8.3.4 The Grove Lane option revenue costs have been driven from the cost projections in the Trust's LTFM. Capital charges and restructuring costs have been removed in line with guidance.

8.3.5 All other options have been considered to assess the degree to which they might be different to the LTFM expected position. Typically areas considered include:

- Additional revenue costs due to needing to maintain two acute sites;
- The additional build timeline leading to savings not being realised as quickly as hoped;
- Different transitional costs, for project management, decanting, soft FM, and non-recurring costs;
- Additional ward requirements;
- Different dual running assumptions;
- Revenue lifecycle estimates over a 65 year lifespan; and
- Beyond the ten year LTFM time horizon, a stable 1% growth has been applied to all revenue costs in all options.

8.3.6 ***Appendix 8a*** presents the revenue costs by option.

Capital Cost Forecasts

8.3.7 Capital cash-flow is specific to each option and includes:

- Estimates for new capital build;
- Major refurbishment estimates;
- Land acquisition and disposal;
- Capital lifecycle trajectories;
- Internal replacement capital programme forecasts; and
- Internal new and replacement equipment requirements.

8.3.8 Each option has been considered discretely. External advisors have updated new capital build forecasts and refurbishment in the Do Minimum option which takes account of circa £130m of backlog maintenance as well as a capital build over a significant timeline.

Residual Value Calculations

8.3.9 An estimate of the value of new build assets has been included to discount costs over 36 and 66 years. Due to time limitations it has not been possible to model retained estate residual values or equipment lifecycle replacement residual values. Land residual values have also been calculated adjusted for additions and estimated disposals.

Transition Costs

8.3.10 Non-recurring, project and dual running forecasts have been modelled. Also, where revenue forecasts are different to the LTFM position the differences are reflected in this section to allow them to be identified discretely.

Externalities

8.3.11 In each option a headlines review has considered how different the outflow of activity to other providers might be as catchment activity loss might change depending upon the site of the main acute hospital.

8.3.12 Different build timelines affect the timing of activity changes. A delay in realising some changes has been applied to some options. In do nothing the activities have been repatriated to the Trust, rather than other providers.

8.4 Risk Assessment

8.4.1 An exercise has been undertaken to update the risk assessment underpinning the economic appraisal. The risks identified in the OBC approved by the DH in August 2009 were re-examined for this appraisal. This included:

- An updated assessment of cost drivers;
- A review of the likelihood of events occurring; and
- An assessment of a revised timeline of occurrence.

Risks Associated with Delay

8.4.2 Options 1, 2 and 3 are associated with two to three year delay in service model delivery depending on the option. This is because of revisions that will be required to reconfiguration plans already consulted on and implemented. These were consulted upon in the context of being interim changes until the opening of a single site new acute hospital.

8.4.3 The plans for emergency surgery reconfiguration were approved by the Secretary of State following referral to the Independent Reconfiguration Panel. This approval included a recommendation that the NHS West Midlands Strategic Health Authority, Heart of Birmingham and Sandwell Primary Care Trusts and Sandwell and West Birmingham Hospitals NHS Trust should ensure that plans for future healthcare provision, including buildings, are delivered as rapidly as possible.

8.4.4 This is a conservative estimate for delay considering the complexity of the changes required to the model and the strength of local support for the Grove Lane solution. It will involve the following detailed work:

- For the Do Minimum there is a requirement to develop new reconfiguration plans to achieve a clinically effective 'hot' and 'cold' site model.
- For new build on the City / Sandwell sites there will be a requirement to seek new planning consents.
- For all options there will be a requirement to repeat a consultation process that previously strongly supported the Grove Lane solution, with the potential for public concern.
- There will be a requirement to resolve issues and concerns caused by not following the plans put forward to support the compulsory purchase order which was approved following an unopposed inquiry indicating public support for the Grove Lane solution.
- There will be a requirement to develop new delivery plans and business cases to initiate the new solutions.

8.4.5 These delays would have an inevitable impact upon capital costs. It would also create local concerns about the sustainability of services. This risk is shown in the following tables as NHS Consultation. The tables below present a summary of the risk analysis.

Table 49: EAC of Risk Retained Under Each Option

	Option 0	Option 1	Option 2	Option 3	Option 4
Risk Category	**EAC £000**	**EAC £000**	**EAC £000**	**EAC £000**	**EAC £000**
NHS Consultation	717.7	1,152.5	1,225.4	534.7	350.4
Scale of Facilities	0.0	0.0	0.0	0.0	0.0
Planning Costs	81.2	158.7	175.6	121.7	0.0
Acquisition Costs	0.0	0.0	0.0	(16.4)	0.0
Site Development Costs	2.3	36.0	20.8	102.2	124.7
Sale Valuations	2.5	15.3	15.5	19.3	0.2
Land Holding	0.0	0.0	0.0	6.0	6.0
Project termination	0.0	0.0	0.0	3.9	0.0
Judicial Review	58.4	79.2	99.1	65.7	0.0
Total	**862.1**	**1,441.6**	**1,536.4**	**837.1**	**481.3**

Table 50: NPC of Risk Retained Under Each Option

	Option 0	Option 1	Option 2	Option 3	Option 4
Risk Category	**EAC £000**	**EAC £000**	**EAC £000**	**EAC £000**	**EAC £000**
NHS Consultation	19,411.9	31,172.0	33,143.6	14,462.1	9,476.8
Scale of Facilities	0.0	0.0	0.0	0.0	0.0
Planning Costs	2,195.4	4,291.5	4,749.6	3,291.8	0.0
Acquisition Costs	0.0	0.0	0.0	(443.0)	0.0
Site Development Costs	62.0	974.8	562.0	2,764.0	3,372.0
Sale Valuations	68.6	412.9	419.7	521.8	5.1

Risk Category	Option 0 EAC £000	Option 1 EAC £000	Option 2 EAC £000	Option 3 EAC £000	Option 4 EAC £000
Land Holding	0.0	0.0	0.0	163.0	163.0
Project termination	0.0	0.0	0.0	105.0	0.0
Judicial Review	1,578.6	2,141.0	2,681.6	1,776.2	0.0
Total	**23,316.5**	**38,992.3**	**41,556.5**	**22,640.9**	**13,016.9**

8.5 Net Present Cost and Equivalent Annual Cost Analysis

8.5.1 Once the Non-financial benefit scores are considered against the economic results a revised ranking is generated. The EAC by Benefit Point clearly changes the ranking demonstrating the Grove Lane solution to be the preferred option. The margin of preference is significant, with Grove Lane achieving a 68.5% lower EAC by Benefit Point compared with the next best option: Do minimum.

8.5.2 Taking the economic GEM results the table below demonstrates the relative economic position and relative ranking. The table demonstrates Do Nothing as the preferred option, with Grove Lane second.

Table 51: Economic Cost of Options (Including Impact of Risk)

Economic Impact Appraisal Period 66 Years All Options	Option Do Nothing £m	Option 1 Do Minimum £m	Option 2 City Site £m	Option 3 Sandwell Site £m	Option 4 Grove Lane £m
NPC	16,315.4	16,747.6	16,608.7	16,638.0	16,479.1
EAC	599.1	614.8	611.5	613.0	607.2
EAC Variance	+0.0	+15.7	+12.4	+13.9	+8.1
Rank	1	5	3	4	2

8.5.3 The table below considers the impact of the qualitative benefit scores on the option ranking over 36 years.

Table 52: Combined Economic and Non-Financial Scores (Over 66 Years)

Economic Impact Appraisal Period 66 Years All Options	Option Do Nothing	Option 1 Do Minimum	Option 2 City Site	Option 3 Sandwell Site	Option 4 Grove Lane
EAC (£000)	599,081.7	614,812.6	611,470.9	612,962.3	607,221.2
Benefit Point	47.6	51.0	76.9	72.5	84.3
EAC per Benefit Point (£000)	12,581.10	12,044.52	7,954.31	8,453.71	7,204.79
Rank	5	4	2	3	1
Margin (%)	74.6%	67.2%	10.4%	17.3%	0.0%

8.5.4 The table below considers the impact of the qualitative benefit scores on the option ranking over 36 years.

Table 53: Combined Economic and Non-Financial Scores (Over 36 Years)

Economic Impact Appraisal Period 36 Years All Options	Option Do Nothing	Option 1 Do Minimum	Option 2 City Site	Option 3 Sandwell Site	Option 4 Grove Lane
EAC (£000)	532,386	545,388	543,444	544,612	539,577
Benefit Point	47.6	51.0	76.9	72.5	84.3
EAC per Benefit Point (£000)	11,180.5	10,684.5	7,069.4	7,511.1	6,402.2
Rank	5	4	2	3	1
Margin (%)	74.6%	66.9%	10.4%	17.3%	0.0%

8.6 Determining the Preferred Option

8.6.1 Both of the Combined Economic and Non-financial scores show Grove Lane to be the preferred option by a margin of circa 10% compared with Option 2, City site development.

8.7 Health Economic Benefits Assessment

8.7.1 The next step demonstrates that sufficient health and regeneration benefits are delivered to offset the additional net present costs incurred compared with either a Do Nothing or Do Minimum.

8.7.2 In 2011 the Trust undertook an exercise to quantify selected non-financial external health benefits for each of the Do Nothing, Do Minimum and Grove Lane options. In February 2014, the Trust convened a workshop to review this analysis.

Approach

8.7.3 The 2011 workshops were held to identify which of the benefits identified in the Benefits Realisation Plan had already been quantified and included within the revenue cash flows in the economic appraisal. It was agreed that these would be excluded to avoid double count of benefits. The excluded benefits are primarily those resulting in internal efficiencies such as reduction in length of stay, reduced capacity etc.

8.7.4 For the remaining health benefits a method of quantification was identified focusing on the benefit to the individuals and the wider economy rather than to the Trust. The exception to this was the reduced level of did not attend (DNA) rates which had not previously been included in the affordability model.

8.7.5 A number of meetings and discussions were then held with the Trust's Medical Director, senior clinicians and the Directors of Public Health to confirm the measures, the level of benefit anticipated between the options and to identify potential sources of evidence. In looking at the level of benefits anticipated the Trust's ability to contribute to the RCRH Programme outcomes was also considered. This is because of the strong interdependencies between the wider RCRH Programme and the project.

8.7.6 The detailed work on quantifying the health benefits is presented at ***Appendix 8b.*** The outcome of the work on the economic analysis is presented below.

External Health Benefit Outcomes

8.7.7 The outcome of this analysis is contained in the table below and which shows a NPC of the benefits from the Grove Lane investment amounts to £794m whereas the Do Minimum shows £325m with the Do Nothing being zero, given zero investment.

Table 54: Summary of External Health Benefit Quantification

External Benefit Considered	Do Nothing		Do Minimum		Option 2: City Option 3: Sandwell Option 4: Grove Lane	
	NPC £000s	EAC £000s	NPC £000s	EAC £000s	NPC £000s	EAC £000s
Transport related services	0	0	-7,793	-288	65,285	2,414
Reduction in mortality rate	0	0	-	-	-100,296	-3,708
Reduction in discharges to nursing homes	0	0	-52,515	-1,942	-122,411	-4,526
Reduction in DNA costs	0	0	-31,946	-1,181	-103,262	3,818
Increased day case rates	0	0	-140,821	-5,206	-164,126	6,068
Public health benefits: Stroke	0	0	-92,023	-3,402	-368,623	13,629
Increased public health benefits: reduced levels of heart disease	0	0	-35	-1	-122	5
Total External Health Benefits	**-**	**-**	**325,133**	**12,021**	**793,555**	**29,339**

8.8 Quantification of Regeneration Benefits

8.8.1 The position is strengthened further if the impact of regeneration benefits is incorporated into the case.

8.8.2 Regeneration benefits were also presented in the Benefits Realisation Plan. Understanding of the impact of these benefits to the local community has been developed further and can be summarised as follows:

- The direct and indirect creation of additional jobs within an area of higher than average unemployment.
- The re-skilling of a portion of the local labour force.
- Increased economic activity in the local construction industry and support services.
- The project enables developers to generate enhanced property rental values that would otherwise have been unachievable in this area. Hence re-enabling an active local property market to meet pent up demand for quality building stock.
- A decreased level of unemployment in the local economy due to the attraction of inwards investment by companies that would otherwise have located elsewhere.
- The project enables developers to generate enhanced property rental values that would otherwise have been unachievable in this area. Hence ensuring the supply of suitable modern buildings to the area.
- A decreased level of unemployment in the local economy due to the attraction of inwards investment by companies that would otherwise have located elsewhere.

- Post construction benefits profiled to 20% in Construction +1 to rising 20% p.a. until 100% of benefit is realised in Construction + 5 years.
- The opportunity cost of investment in regenerative terms.

8.8.3 This work was first undertaken for the OBC approved in August 2009. The analysis has been updated for assumptions about land sales, accepted economic norms and impact on the wider Smethwick regeneration plans.

8.9 Impact of Incorporating the External Health and Regeneration Benefits

8.9.1 The table below draws the external health and regeneration benefits together and extends the economic option appraisal to determine the options with the greatest Net Present Value (NPV). This shows the option which generates the best economic outcome when comparing all costs and benefits identified.

8.9.2 The table below reflects this outcome and clearly demonstrates the NPV of the Grove Lane option is the preferred outcome against a do nothing baseline.

8.9.3 Grove Lane has a net benefit of £1,116m.

Table 55: Impact of Incorporating External Health and Regeneration Benefits

External Benefit Considered	Do Nothing		Do Minimum		Option 2		Option 3		Option 4: Grove Lane	
	NPC £000s	EAC £000s	NPC £000s	EAC £000s	NPC £000s	EAC £000s	NPC £000s	NPC £000s	NPC £000s	NPC £000s
Appraisal Outcome	16,316,745	599,130	16,750,199	614,909	16,613,532	611,650	16,642,457	613,129	16,482,198	607,335
Variance to Do Nothing	-	-	433,453	15,778	296,786	12,520	325,712	13,998	165,453	8,204
External Health Benefit Quantification	0	0	-325,133	-12,021	-793,555	-29,339	-793,555	-29,339	-793,555	-29,339
Health Benefits Compared to Additional Costs	0	0	108,320	3,758	-496,768	-16,820	-467,843	-15,341	-628,102	-21,135
Ranking on NPV Position	**5**		**4**		**2**		**3**		**1**	
Consideration of Regeneration Benefit Impact	0	0	14,060	520	10,756	398	325	12	-488,347	-18,055
Net Cost and All Benefits Position	0	0	122,381	4,277	-486,012	-16,422	-467,518	-15,329	-1,116,449	-39,190

8.10 Conclusions of the Economic Case

8.10.1 It can be concluded that the Option 4 NPV is circa 1% favourable to the Option 2 NPV. This is strengthened to 4% of NPV once Regeneration Benefits are taken into account.

8.10.2 This review and refresh of the economic case reconfirms the original conclusion that option 4: Grove Lane is the appropriate preferred option.

8.10.3 There have been no changes in the underlying assumptions to this economic assessment since the OBC and therefore this analysis remains valid.

9 Procurement Route

9.1 Introduction

9.1.1 An assessment was made in the Outline Business Case (OBC) to establish the optimal procurement approach; whether to procure using a public sector procurement route or to use Private Finance 2 (PF2). The conclusion of this assessment was that PF2 offered better value for money (VfM) than the Public Sector Comparator (PSC)

9.1.2 This section reassesses the VfM case made and approved in the OBC to procure the Midland Metropolitan Hospital using PF2. It evaluates the impact of any relevant changes in determining whether or not PF2 remains the optimal procurement route for the Trust.

9.2 Background and Advent of Single Bidder Scenario

9.2.1 The OBC approved in July 2014 presented a quantitative and qualitative assessment demonstrating that the PF2 procurement route demonstrated best value for money (VfM).

9.2.2 Following approval of the OBC the Trust commenced a PF2 process to procure the Midland Metropolitan Hospital (MMH). The Competitive Dialogue phase started with 3 bidders. However, one of the bidders withdrew following the issue of the Invitation to Participate in Dialogue (ITPD). Only one bidder (Carillion, referred to as The Hospital Company) submitted an interim bid, under competitive conditions, by the deadline of 12th December 2014. This interim bid submission was evaluated by the Trust as compliant and 'above the line'.

9.2.3 The PF2 procurement process relies upon competition to drive and demonstrate VfM. Therefore, whilst noting that continuing with the PF2 procurement with a single bidder was legal, the Trust Board reassessed (on 16th January 2015) which procurement options would best achieve its objectives and secure a value for money solution.

9.2.4 The Trust worked closely with the MMH Stakeholder Board (comprising the DH, HMT and TDA) in developing and agreeing an approach to mitigating against the potential effects of a single bidder so early in the procurement process.

9.3 Trust Board Reappraisal of the Procurement Options – January 2015

9.3.1 The Trust Board made a full reassessment of the procurement options available to the Trust. This re-assessment is presented at ***Appendix 9a***. The key points from the reassessment are set out in this section.

9.3.2 The MMH is critical to the Trust's strategy of concentrating complex care, acute inpatients and emergency services into a single acute inpatient hospital. The Trust's key objectives in procuring this effectively are to:

- Procure a hospital which is fully functional, high quality and enables delivery of the Trust's strategy and service model;
- Ensure that the MMH is operational by 2018 so that the clinical and financial benefits are secured in accordance with the Trust's long term plan;
- Procure the hospital within the Trust's affordability envelope; and

- Conduct the procurement within an acceptable risk profile, managing risks such as construction delay, cost inflation, securing approvals and funding.

Assessment Criteria

9.3.3 Given the Trust's procurement objectives, the criteria used to assess which procurement route is most advantageous were:

- The quality of the solution, including functionality, build quality and design – which is fit for purpose for the long term;
- Timescales for delivery – to enable sustainability in the short term;
- Affordability, taking into account both project costs and operational costs impacted by the scheme e.g. costs of running two Emergency Departments;
- The risks to the Trust - other than those that would transfer to a private sector partner (these will be taken into account in the Value for Money (VfM) assessment); and
- VfM of the PF2 procurement route compared with a public sector procurement route.

Procurement Options

9.3.4 The option of re-procuring via PF2 was discounted given that this would be likely to result in a similar or worse outcome. The market appetite was unlikely to have improved significantly so recently after the current procurement. Therefore, in reappraising the procurement route, there were 2 main options available for the Trust, either to:

- Abort the existing procurement and re-procure with a conventional public sector approach such as P21+ (assuming that the Trust would purchase the Interim Bid design from The Hospital Company); or
- Continue with PF2 with additional measures to mitigate against the potential implications of a single bidder scenario.

Mitigations to Support PF2 VfM

9.3.5 The following mitigations were proposed to ensure that VfM was demonstrated, achieved and maintained in the event that the Trust chose to continue with the remainder of the PF2 procurement:

- Requiring increased quality of bids from interim submissions through to Preferred Bidder;
- Cost modelling and benchmarking of separable cost streams (e.g. construction cost, lifecycle and facilities management);
- Monitoring of bidder's cost plans;
- Open book accounting; and
- Supply chain competition.

9.4 Option Evaluation PF2 versus P21+ (Using The Hospital Company's Design)

9.4.1 The Trust robustly tested which procurement route was the best means of the Trust achieving its strategic objectives despite the single bidder scenario: whether to procure via P21+ using The Hospital Company design solution or whether to continue with the existing PF2 procurement with mitigations.

9.4.2 The table below presents the appraisal which was made of PF2 versus P21+ (using The Hospital Company design) against the criteria outlined above to meet the Trust's procurement objectives.

Table 56: Option Evaluation- PF2 versus P21+

Criteria	PF2	P21+
Quality of solution	Current solution evaluated as compliant and 'above the line' with plan in place to address Trust's 'red issues'. PF2 contract incentivises private sector to deliver integrated design which takes account of lifecycle and is inherently more efficient to run.	Reasonable to expect that the solution would be 'above the line'. Trust takes risk on functionality, ongoing maintenance and fabric of the building. Therefore incumbent on Trust to integrate the design with lifecycle considerations.
Delivery timescales	Operational by October 2018	Operational by October 2019
Affordability	Affordable with overall Continuity of Service Risk Rating (CSSR) of 4 and £11m surplus forecast in 2020/21	Affordable with overall CSRR of 4 and £8.3m surplus forecast in 2020/21
Risks	The Trust may not be able to drive the quality of the solution to the extent that would have been possible under ongoing competition. However, the bid is currently 'above the line' and resolution of the outstanding areas of concern would be a condition of continuing the procurement. The Trust may not be able to secure and demonstrate that it has the best price. However, this would be largely mitigated through the additional measures proposed. There is a risk of the single bidder withdrawing / failing to provide a compliant bid. This is assessed as low given that the bidder already has sunk bid costs of £1.9m and is expecting to commit a further £3.8m before financial close.	There is a risk that the Trust would not secure the necessary public funding. There is a risk that more time would be required to address the design issues in the exemplar design, adding further delay, if the Trust did not buy the design from The Hospital Company. There is a risk that the construction programme would take longer than the assumed 31 months due to the lack of competitive pressure. Clearly the Trust would have the risk of the functionality and availability of the hospital and the ongoing maintenance. However, this has been priced into the VfM comparison below. There is a risk of needing to pay bid costs to the current bidder which are circa £1.9m. It is expected that the bidder would claim for costs given that its bid is compliant.
VfM	A quantitative analysis shows that the PF2 option is 19.1% better value for money than the P21+ option. The PF2 option has a total risk adjusted NPV of £366m.	A quantitative analysis shows that the PF2 option is 19.1% better value for money than the P21+ option. The P21+ option has a total risk adjusted NPV of £434m.

Option Evaluation Commentary

Quality Comparison

9.4.3 The Hospital Company submitted a compliant interim bid to the Trust which would be required to improve further given that would be a condition of continuing the procurement. However, a P21+ approach could yield a similar quality scheme and so the consideration regarding quality was inconclusive.

Timescale Comparison

9.4.4 Analysis identified that a P21+ procurement route was likely to deliver an operational MMH by October 2019. This delay from the Trust's procurement objective of October 2018 would create significant operational, clinical and financial challenges.

Affordability Comparison

9.4.5 Affordability as measured by reference to the Continuity of Service Risk Rating (CSRR) was not a differentiating factor between an updated PF2 and prospective P21+ route. Each route provided for an affordable solution and improved affordability over the extant PF2 model all other things being equal.

Risk Comparison

9.4.6 The risks of the 2 procurement options were distinct. The main risk of continuing with PF2 was that the Trust would not be able to demonstrate a fully competitive price despite the mitigations. However, the Trust would not be able to demonstrate a fully competitive price in a P21+ procurement either. Furthermore, there were additional risks of being able to secure the level of public funding or a private sector partner to deliver the scheme. Overall, the risk profile of the Public Sector Procurement was assessed as higher than that of continuing the existing PF2 procurement.

VfM Comparison

9.4.7 The VfM assessment showed that the PF2 option was 19.1% better value than the P21+ option on a Net Present Value (NPV) basis. This reflected the value to the Trust of the risk transfer to The Hospital Company. It also showed that the adjusted PF2 option was VFM compared to the PSC by 19%.

Qualitative Analysis

9.4.8 A qualitative analysis was undertaken by the Trust's advisor, Deloitte, for the OBC and this was reviewed to establish the extent to which it had relied upon market competition. The analysis highlighted that in 1 out of the 40 sections, additional measures would be required to compensate for the lack of competitive pressure. This related to the desire to introduce innovation into the design and the provision of services. Innovation had already been evidenced in the interim bid submission and the Trust would require all of the remaining concerns regarding the design and service provision to be addressed in order for subsequent bids to be compliant.

Conclusion

9.4.9 The PF2 option was assessed in January 2015 as meeting all of the Trust's procurement objectives. Whilst not as favourable as a competitive situation through to Preferred Bidder, the mitigations were expected to secure and demonstrate a sufficiently competitive price and drive a quality solution.

9.4.10 The P21+ option would not meet the Trust's objective of delivering an operational hospital by October 2018. Furthermore, such a procurement would have a higher risk profile than PF2 and the value for money analysis demonstrated that it was not as favourable as the PF2 approach. P21 is a framework model which creates a single partner position at an earlier stage than a single bid PF2 solution.

9.4.11 The conclusion of the analysis was that the PF2 option was preferable due to a lower procurement risk profile, better VfM and an earlier delivery timescale, which met the Trust's requirement of October 2018.

9.4.12 Based on the above analysis, the Trust Board made a decision on 16 January 2015 that the Trust should continue with the procurement and apply the mitigations referred to above. It was considered that this decision would be the best means of achieving the Trust's procurement objectives.

9.4.13 The additional requirements that the mitigations imposed on the Bidder were detailed in the Invitation to Participate in Dialogue (ITPD) Volume 4 of the procurement documentation which was approved by the DH on 26 March 2015. The ITPD made it clear that adherence to and fulfilment of these conditions would be a requirement for both the Draft Final Bid and Final Bid to be compliant. The Hospital Company accepted the terms of the ITPD on 30 March 2015.

9.4.14 The quantitative analysis which was undertaken in January 2015 based on the Interim Bid Submission has been updated following receipt of the Draft Final Bid with the result that the PF2 option is 18.9% better value for money than the P21+ option. This analysis is presented at ***Appendix 9b.***

9.5 Trust's Exemplar (PSC) via P21+ versus The Hospital Company Solution via PF2

9.5.1 The purpose of this comparison is to review the assessment made in the OBC to establish whether it is still better VfM to procure the Trust's exemplar (PSC) via a public sector procurement route (P21+) or to procure using PF2. The assessment in the OBC concluded that PF2 offered better VfM. This assessment focuses on the changes since the OBC and whether these alter the outcome of the OBC assessment.

Quantitative assessment

The results arising from the VfM assessment at OBC stage are summarised in the table below demonstrating that the PF2 option offered better value for money than the PSC route.

Table 57: VfM Assessment at OBC Stage

Option	NPV* of Project Cost £m	NPV* of risk retained by Trust £m	Total risk adjusted NPV* £m
PF2 (£100m capital contribution)	392.1	18.3	410.4
PSC	323.2	105.4	428.6
VfM	-	-	4.2%

** NPVs discounted to April 2013*

9.5.2 The key relevant facts / underlying assumptions that have changed and have a potential impact on the VfM assessment are shown in the table below.

Table 58: Change in Assumptions Impacting on VfM Assessment

Fact / assumption	OBC	Generic ABC Based on Draft Final Bid
1. Funding term sheet	A term sheet was drafted to reflect market conditions at the time of OBC drafting. This formed the basis of the shadow tariff model and also the basis on which the bidder submitted the interim solution.	The term sheet issued was updated to reflect current market conditions and those seen on similar, recent projects in the sector. The bidder was instructed to use this revised term sheet as the basis for the final submission. The funding market has improved considerably since OBC hence there has been a significant reduction in the terms outlined. The term sheet included instruction to use a 100bps (1.0%) buffer to mitigate against any adverse future market movement.
2. Lifecycle costs	Assumed at £20/m^2 in the PSC.	The Trust has recognised that £20/m^2 is below market rates. Revised to £23.53/m^2 in the revised exemplar PSC. The Draft Final Bid assumes £22.13/m^2
3. Schedule of accommodation	Design based upon exemplar developed and costed at this point in time. The schedule of accommodation of the PSC at OBC stage was 79,828m^2. The gross internal floor area (GIFA) of the exemplar drawn solution at OBC was 83,628m^2.	The PSC SoA has been refined to reflect the outcome of the dialogue. The SoA of the PSC at ABC stage is now 80,047m^2 The drawn solution is still assumed to be 83,628m^2. The Draft Final Bid SoA was 78,743m^2 and the drawn solution was 82,257m^2.
4. Construction programme/phasing	Construction programme based upon exemplar plan developed at this point in time. Per OBC the construction programme was estimated at 27 months.	Construction programme based upon bidder design and feedback from dialogue with the Trust. Per draft final bid the total construction programme outlined is 33 months.
5. Facilities Management costs	Costing at OBC based upon exemplar design and provided by Trust/Trust's technical advisor in line with industry benchmarks. £30/m^2 (25.2% of capex)	FM costs provided within bidder submission and benchmarked against similar projects and Trust's technical advisor database. £30/m^2 (25.1% of capex)
6. Risk transfer	The Trust's project team undertook a detailed exercise to assess the level of risk and probability of occurrence for each procurement route investigated making use of prior project experience, empirical data and industry benchmarks.	The risk assessment exercise was reviewed and updated where necessary as a result of any significant changes implemented post OBC. Examples include changes in price bases/inflation, phasing of costs and impact of using P21+ as the PSC route.

9.5.3 The Trust's exemplar costings have been refreshed to reflect the key factors above and thus enable a more robust comparison with the PF2 option. Additionally, the exemplar has been re-costed at the same price index as The Hospital Company bid. A summary of how these changes have altered the capital costs is presented in the table below.

Table 59: Summary of Capital Cost Changes

	OBC PSC (£m) (price base April 17 – midpoint construction)	OBC PSC (current price base – PUBSEC index 223 Jan 2015)	Revised PSC (current price base – PUBSEC index 223 Jan 2015)
2015/16	41.3	45.3	45.0
2016/17	114.9	125.9	125.1
2017/18	112.9	123.7	122.9
2018/19	16.0	17.5	17.4
Total Capex	**285.0**	**312.3**	**310.4**

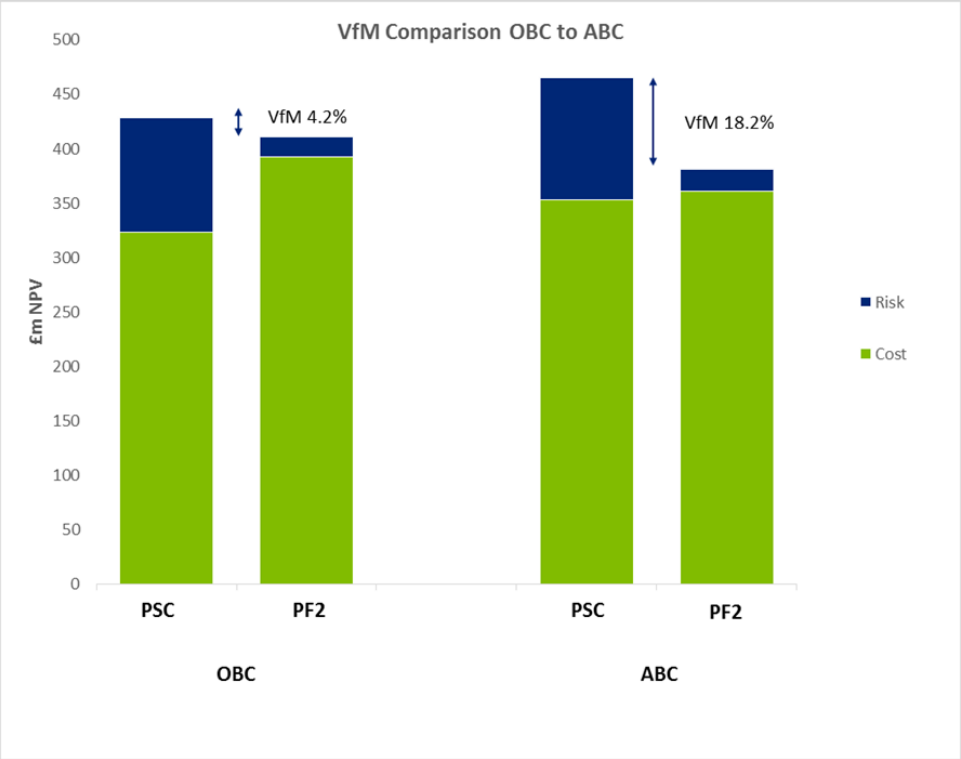
9.5.4 The movement in capex from OBC to ABC is as a result of the following:

- Refinement of the exemplar design and schedule of accommodation leading to an increase in the gross internal floor area (GIFA);
- Revised costing of the building materials and process as the design has developed; and
- A significant increase in the construction inflation indices.

9.5.5 A review of the risk transfer was made comparing the risk assessment exercise undertaken at OBC with the current scenario and procurement option. This exercise was updated where necessary as a result of any significant changes implemented post OBC. Examples include changes in price bases / inflation and phasing of costs.

9.5.6 The impact of changes in the above factors has been quantified and is shown in the figure below which compares the Net Present Values (NPVs) of the two potential procurement routes at OBC and ABC stages highlighting the VFM differential at each stage. In addition it highlights the movement in the constituent cost streams at each stage.

Figure 17: VfM Comparison OBC to ABC

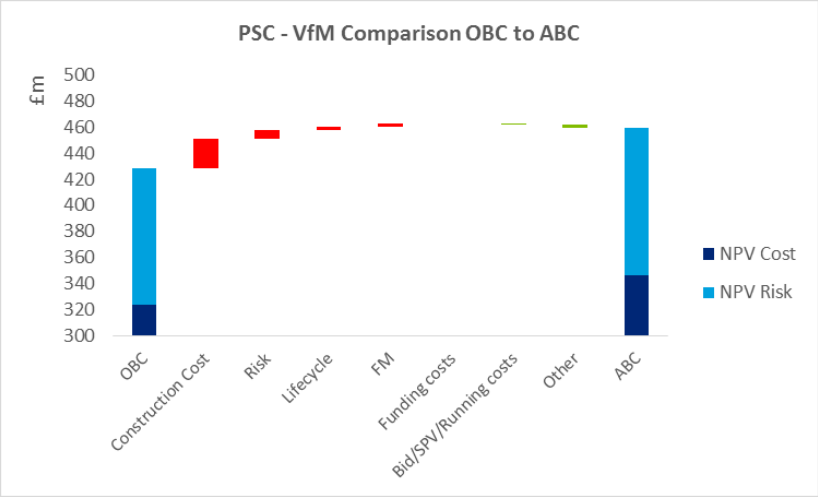


9.5.7 Key changes from OBC to ABC are:

- PF2 costs have decreased as a result of a significant improvement in the senior debt funding terms and underlying swap market position;
- The estimated construction costs for the PSC exemplar have increased significantly, largely as a result of construction inflation; and
- The income stream arising from the public sector's 10% equity stake in the SPV has been factored into the ABC VfM calculation. The income has been included within 'Other'.

9.5.8 The waterfall charts presented in the figures below illustrate the increase / decrease in each of the constituent parts for each procurement route from OBC to ABC. They highlight that the most significant movement from OBC to ABC is due to the improvement in funding terms available. This change only has impact on the PF2 option hence this is largely the reason for the significant improvement in the VfM position.

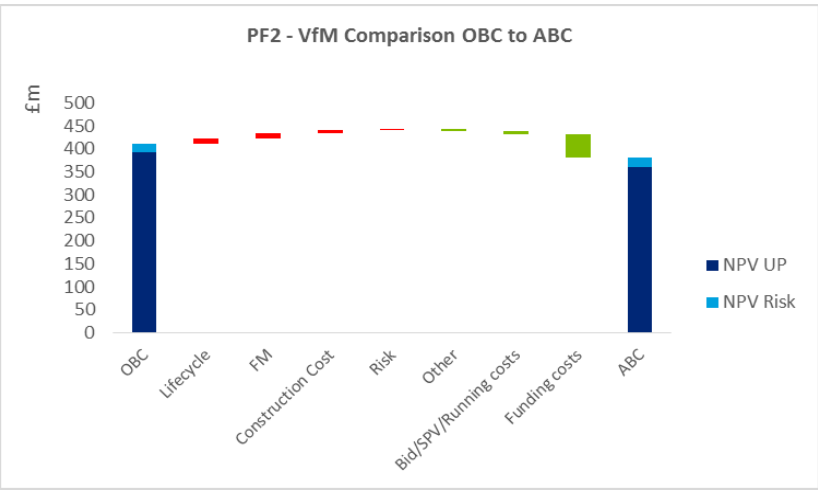
Figure 18: Comparison OBC to ABC for PSC



9.5.9 Key changes from OBC to ABC for the PSC solution are:

- Significant increase in the construction costs as a result of inflation / indices;
- Many of the risks identified are directly linked to construction cost hence as a result of the above the risks associated also increased;
- Increases in the GIFA of the building in turn increase the FM / Lifecycle costs which are based upon a £/m^2 metric; and
- Changes in the Schedule of Accommodation and construction costs as a result of dialogue and refinement of the solution and costs.

Figure 19: Comparison OBC to ABC for PF2



9.5.10 Key changes from OBC to ABC PF2 solution/bid are:

- Funding costs decreased significantly as a result of improvements in the funding market and underlying rates. This change was captured within the analysis at this stage and is reflected in the term sheets issued to Bidders.
- Changes in the Schedule of Accommodation and construction costs as a result of dialogue and refinement of the solution and costs.
- Changes in the Schedule of Accommodation and construction costs as a result of dialogue and refinement of the solution and costs.

9.5.11 The quantitative assessment presented in the table below demonstrates that the Draft Final Bid submission is 18.2% better value for money procured via PF2 than the PSC being procured through P21+.

Table 60: Quantitative Assessment

Option	NPV of Project Cost £m	NPV of risk retained by Trust £m	NPV of Equity Return as a result of 10% stake in SPV	Total risk adjusted NPV £m
PF2 – Final Bid	361.2	20.3	(0.9)	380.6
PSC – ABC Stage	352.8	112.4	-	465.2
VfM	-	-		18.2%

Sensitivity Analysis

9.5.12 A sensitivity analysis (presented at ***Appendix 9c***) has been conducted to establish the switching point at which the 2 routes represent equivalent VfM as well as the impact of potential future changes such as European Investment Bank (EIB) funding; construction cost increase and sensitivity to funding terms.

9.5.13 This analysis has shown that:

- The NPV of the cost and risk retained under the PSC solution would need to reduce by £84.6m (75%) in order for the PF2 solution to cease being value for money.
- The PF2 solution still demonstrates value for money (11.7%) when the risk transferred / UP NPV metric is adjusted in line with the Midland Metropolitan Hospital OBC metric of 16%.
- The construction cost of the PF2 solution would need to increase by £64.0m in order for the PF2 solution to cease being value for money.
- The underlying swap rate or funding margins would need to increase by 3.76%, making a total 'All in' funding rate of 8.59%, in order for the PF2 option to cease being value for money.
- The PF2 solution still demonstrates value for money (17.4%) when the optimism bias is completely removed from the PSC cost estimate (a reduction in PSC capex of £4.3m).

Qualitative Assessment

9.5.14 A qualitative assessment was undertaken at OBC. This has been reviewed to reflect any new information since OBC and a summary of the changes are shown in the table below.

Table 61: Changes in the Qualitative Assessment

Description of Change from OBC	Commentary
Quality of Competition At ABC stage the procurement process is well underway hence focus is on ensuring that a robust competitive process is in place to fully deliver the expected benefits.	The project team is satisfied that there was competitive tension up to the point that the Interim Bid was submitted. As a result of the single bidder status the Trust is putting in place measures to ensure maximum competitive tension and value for money for the remainder of the procurement including market testing, cost / benefit ratios and financial and quality hurdles.
Efficiency of Procurement Process At ABC stage the procurement is well underway and efficient process is required in order to sustain market interest and drive towards the best overall solution	The project plan has been agreed as appropriate by approval bodies. The plan has remained on track since OJEU without any undue delays. The procurement process could have an impact on VfM given that there is now a single bidder. Hence, the Trust has developed a series of mitigations to drive and demonstrate VfM in the absence of another bidder. The Trust Board is satisfied that this approach will deliver better value for money than the alternative procurement options.
Risk Transfer Reassessment at the ABC stage to ensure that the selected procurement route is delivering the expected risk transfer as anticipated from a robust competitive process.	The Interim Bid Submission received 12 December 2014 from The Hospital Company is on the basis of accepting the risk transfer as per the standard contract. The Trust Board 16 January 2015 confirmed that the deal is suitable for delivery through PF2 and that the Trust's objectives are best met through that route. Risk transfer is achievable and that has formed the basis of the Interim Bid Submission. The Trust and The Hospital Company are proceeding on the basis that the risk transfer remains as per the standard contract. If The Hospital Company subsequently does not meet required standards or affordability hurdles on future submissions then those bids will be non-compliant and the Trust will have the option of terminating the procurement and not paying The Hospital Company any bid costs.

The detailed qualitative assessment is presented at ***Appendix 9d.***

9.5.15 In summary the qualitative assessment shows the following:

9.5.16 **Quality of competition -** The Trust was satisfied that competitive tension existed up to the point that the Interim Bid was submitted. For the Draft Final Submission and Final Submissions, the Trust has implemented measures to ensure maximum competitive tension has been maintained and that VfM has been delivered for the remainder of the procurement.

9.5.17 **Efficient procurement process -** The procurement process could have an impact on VfM given that there is now a single bidder. Hence, the Trust has developed a series of mitigations to drive and demonstrate VfM in the absence of another bidder.

9.5.18 **Risk transfer -** Risk transfer is achievable and has formed the basis of the Interim and Draft Final Bid Submissions. Risk transfer remains as per the standard contract.

9.6 Conclusion

9.6.1 The VfM assessment at OBC confirmed that both quantitatively and qualitatively it was better VfM to procure the MMH via PF2.

9.6.2 In January 2015 The Trust Board made a robust re-appraisal of procurement route options given that only a single bidder submitted an Interim Bid in December 2014. The conclusion of this re-appraisal was that continuing with the PF2 route and was the best means of achieving the Trust's procurement

objectives. This was on the basis that additional mitigations would be applied to ensure that value for money was delivered and evidenced.

9.6.3 The VfM assessment has been refreshed to compare the Trust's exemplar with the Draft Final Bid. The key changes are: a revised PSC to enable a like for like comparison; revised funding terms; revised lifecycle costs; revised schedule of accommodation; and revised risk transfer. The most significant of these changes in terms of the VfM assessment are the revised funding terms.

9.6.4 A reassessment, taking into account the key factors that have subsequently changed has confirmed that the PF2 route remains value for money with it increasing from 4.3% on a NPV basis to 18.2%.

9.6.5 The VfM of PF2 has improved mainly due to more favourable funding terms offered by funders and the underlying market rate. A sensitivity analysis has confirmed that PF2 is likely to remain better VfM against a range of potential future scenarios.

10 Project Scope

10.1 Introduction

10.1.1 This chapter sets out the scope of the project requirements as briefed to bidders in the Invitation to Participate in Dialogue documentation. It covers:

- An overview of the site;
- The design approach;
- Planning;
- The site strategy;
- Energy and sustainability;
- The ICT Strategy;
- The equipment strategy;
- The hard FM services strategy;
- Soft FM services strategy; and
- Income generation opportunities.

10.2 Overview of the site

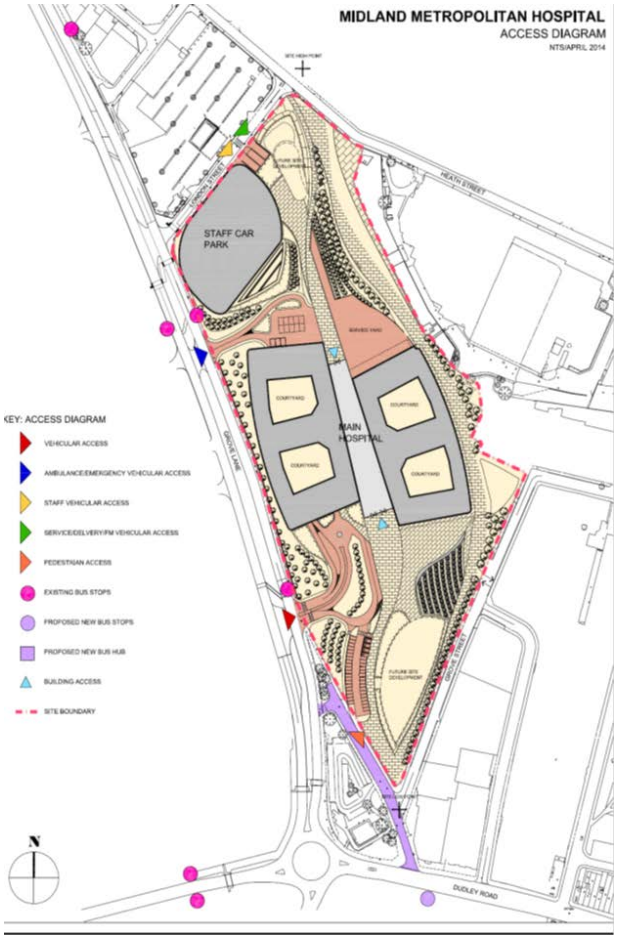
10.2.1 The schedule of area required for the new hospital development and the activities laid out in the Functional Brief dictated that a substantial area of land was required for the new MMH. A 6.76 hectare brownfield site that meets this requirement has been identified at Grove Lane. The Trust has compulsorily purchased the freehold.

10.2.2 The Grove Lane site is bounded by the Grove Lane dual carriageway to the west, London Street to the north, Cranford Street to the north east, Cape Arm canal to the east, Grove Street to east and old Grove Lane to the south west. It was previously in industrial use and located just within the local authority boundary of Sandwell Metropolitan Borough Council (SMBC) and adjacent to the boundary with Birmingham City Council.

10.2.3 An aerial view and plan view of the site showing the PSC are presented on the next page.

Figure 20: Aerial View of the Site

Figure 21: Plan View



10.3 The Design Approach

Clinical Engagement

10.3.1 The clinical design has been informed by comprehensive clinical engagement right from the beginning when clinical groups supported development of the operational policies, specification documents and public sector comparator / exemplar design. In this way the Project Scope has been clinically led.

Design Vision

10.3.2 The design vision was summarised by the following statements in the Functional Brief which emphasise the human impact of the building which is required to be:

- Inspirational, attractive and imaginative;
- Welcoming;
- Reassuring;
- Light and airy;
- Clean without being clinical;
- Sympathetic to the environment;
- Fully accessible;
- Designed with privacy and dignity at the centre of patient flows; and
- A good place to work.

10.4 Planning

10.4.1 The brief for bidders included the planning arrangements laid out in this section.

10.4.2 There has been extensive engagement with planning officers from Sandwell Metropolitan Borough Council (SMBC), the wider public, Trust employees, landowners to be affected by the proposals and local MPs/Councillors through the Public Consultation events.

10.4.3 On completion of the Public Consultation an outline planning application, complete with Design and Access Statement, was submitted to SMBC on the 4th April 2008.

10.4.4 This outline planning application was for the redevelopment of the Grove Lane site to provide a new acute hospital (Use Class C2) and a supporting education, research and administration centre (Use Class B1 (a) and (b)), together with a gym (D2), crèche (D1) and car parking.

10.4.5 Sandwell Metropolitan Borough Council granted outline planning approval on 29th October 2008. This was renewed in July 2013 and remains valid for a further six years from that date.

10.5 Site strategy

The Functional Make-up of the MMH

10.5.1 The service requirement was defined in Chapter 5. As a result, a functional make up and operations of the MMH has been derived to form the scope. This has been divided into the following areas, each of which are summarised below:

- Emergency and Urgent Care;
- Admitted Patient Care – Specialist Services;
- Admitted Patient Care – Generic Adult Inpatients;
- Outpatients;
- Diagnostics;
- Clinical Support Services; and
- Non-clinical Support Services.

10.5.2 The functional content of the MMH is presented in the table below.

Table 62: Functional Content

Department	Functional Content
Emergency	Initial assessment areas, Minors, Majors, Children's, Resuscitation and 2 plain film x-ray
Inpatients	14 generic 32 bed wards (including 14 Coronary Care Beds), 117 Adult Assessment Beds, 56 Children's Beds, 30 level 2 / 3 Critical Care beds
Maternity Delivery Suite	2 theatres, Delivery Suite, Birth Centre
Neonatal	36 cots
Operating Theatres	11 theatres, Central Admissions Area and Recovery
Outpatients	Bespoke Antenatal Clinic (including ultrasound), bespoke Paediatric Clinic and Urodynamics
Interventional Cardiology	3 Cardiology Catheterisation Laboratories and support accommodation including Day Case Area
Imaging	2 CT and MRI scanners, 2 plain film, 5 Ultrasound, Interventional Radiology Suite, 4 gamma cameras and Radio-Pharmacy
Clinical Support	Therapy Suites (including physiotherapy), Pathology Essential Laboratory, Pharmacy, Endoscopy, Medical Day Case Unit including Sickle Cell and Thalassemia, Cardiac Diagnostics, Cardiac Rehabilitation, Neurophysiology, Respiratory Physiology, Mortuary (No PM facilities), Medical Illustration
Administration / Non Clinical support	Multifaith Centre, Clinical / Corporate Administration, Education and Training, Academic Research, Medical Engineering, Facilities, IM&T and Energy Centre, Relatives Overnight Stay

Phasing

10.5.3 The Trust expects that the MMH will open by October 2018. Given the availability of a clear site, the Trust expects that the development will be achieved in a single phase.

10.5.4 It is the intention to commence enabling works in November 2015 to prepare the site for the main construction in January 2016, after financial close. These enabling works will not prejudice the future of the site. Therefore, project specific works such as the piling will commence in January 2016.

10.5.5 The concession period of 30 years will apply from the scheduled end of this single phase completion date.

Car Parking

10.5.6 Construction, maintenance and lifecycle of car parking infrastructure (excluding barrier equipment) will be included in the PF2 contract. Car park management (including supply and maintenance of barrier equipment) will remain the responsibility of the Trust.

Remediation

10.5.7 The Trust is taking responsibility for remediating the site. The site was cleared and buildings demolished to slab level by the end of February 2015. Foundation works and building slabs are due to be removed in preparation for future hospital redevelopment by the end of July 2015. Following remediation and handover of the site, the Hospital Company will take responsibility for site contamination.

Retained Estate

10.5.8 The Estates Strategy has been updated to show the approach to developing the community facility model described in Chapter 5. Development will be managed through the Trust's capital programme.

10.5.9 It will still be possible to release the remaining land / buildings for primary care use if required. The land not being used for health purposes will be released for investment in regeneration projects. This is part of the comprehensive regeneration strategy described below.

10.6 Energy, Sustainability and Regeneration

10.6.1 The Trust is committed to ensuring that the new development is environmentally sustainable to the maximum extent possible and will contribute to longer term affordability by minimising energy costs.

10.6.2 Bidders were required to consider sustainability and the design vision together ensuring that a sustainable future is fully integrated into the design. The Trust has required that technology, materials and policies that promote sustainability are developed in relation to:

- Energy use in the building;
- Minimising pollution;
- Water use in the building;
- The materials used in construction;
- Land use and ecology;
- Travel plans for the new hospital;
- The equipment used by the Trust;
- Recycling and waste management;

10.6.3 It is essential that any carbon reduction or energy saving measures adopted are sustainable in the long term. Bidders were required to demonstrate the sustainable credentials over the whole life cycle of any low carbon or renewable technology employed. The analysis includes the supply chain and all aspects of the associated infrastructure.

10.6.4 Bidders were required to demonstrate sustainable proposals both in terms of the completed scheme and during the construction process. These include the use of manufactured materials, recycled materials and the embodied energy held within these materials. Throughout the construction

programme, under the requirements of BREEAM Healthcare, Bidders were required to demonstrate sustainable transport options for construction traffic and illustrate suitable disposal method for both site waste and consequential waste generated by the development. A BREEAM Healthcare 'Excellent' rating is a fundamental Trust requirement and achievement of the final rating as detailed above will be part of the building acceptance procedure.

Energy

10.6.5 It is a requirement of the Trust to raise the profile of operational energy and environmental management in order to improve performance in these areas. As the impact of the new facility will be influenced by both the activities of those operating the building and those occupying the building, it is recognised that the minimisation of such impacts will be as a result of partnerships.

10.6.6 Therefore, the Trust required bidders to deliver a solution capable of achieving energy consumption not greater than 42GJ/100m³ whilst achieving a BREEAM 'Excellent' score under ENE01.

Regeneration

10.6.7 The community served by the Trust is one of the most deprived in England and suffers from high levels of chronic ill health. Bearing in mind the strong links between poverty and ill health the Trust is committed to local regeneration as a key strand in the RCRH Programme and intends that the scheme will act as a catalyst for development in Sandwell and west Birmingham.

10.6.8 The Trust therefore required bidders to present proposals that will:

- Generate employment and training opportunities during construction and ongoing management;
- Provide opportunities for local suppliers when sourcing goods and services; and
- Engage with local social and economic regeneration initiatives.

10.7 IM&T Strategy

10.7.1 The Trust has developed an Informatics Strategy (presented at ***Appendix 11a***) to inform the development of a Digital Hospital.

10.7.2 The vision for Health Informatics is to

Develop an integrated health care system which connects and shares information across our community, supported across a modern and flexible infrastructure which will meet the needs of our local healthcare community and provide high quality patient information at the point of care.

10.7.3 The Strategy (presented at ***Appendix 10a***) sets out the vision in more detail including a five-year framework for transforming IM&T capability and capacity in the Trust.

The Current Situation

10.7.4 The Trust's electronic patient record (EPR) currently consists of the CSC iPM PAS solution with iCM providing clinical functionality. Various departments have stand-alone systems installed as part of Connecting for Health which currently contribute to the EPR e.g. Radiology, Maternity and Theatres.

10.7.5 The Trust has also developed the Clinical Data Archive (CDA) which is a repository of clinical reports, letters and clinical results. The EPR has been closely integrated with other key systems, such as

Radiology, Pathology and the clinical letter system. This has been crucial to supporting improved working practices and greater efficiencies.

10.7.6 The organisation is also in the process of transferring non-clinical records to electronic formats. The Trust has already made significant progress in the transition to efficient office working processes to maximise the utilisation of current estate.

The Strategic Plan

10.7.7 In alignment with national policy the Trust is investing in new systems over the next five years. The funding for this is shown in the long term financial model (LTFM). IM&T is a major enabler for the successful transition to the services to be delivered from the MMH.

10.7.8 The Trust plans to build upon and consolidate existing systems to deliver the enhanced capability required of the full EPR. This will enable improved integration of care records and reduce the complexity of managing multiple systems and interfaces.

10.7.9 A document management solution that combines data held electronically across multiple systems with an electronic view of paper based records will support the migration to a paperlite operating model by the time the MMH opens.

10.7.10 The Electronic Patient Record Outline Business Case was approved by the Trust Board on 2nd April 2015 and has been submitted to the NTDA for approval. The business case sets out a timeline (presented at ***Appendix 10b***) which will deliver a 'Clinical Wrap' solution by October 2017, thus enabling the migration to a paperlite environment prior to the opening of the MMH.

10.7.11 Migration to agile working in office environments will continue until the MMH opens.

Impact of the IM&T Strategy on the Scope of the MMH

10.7.12 The impact of the Informatics Strategy is summarised below:

- Minimal space for holding medical records has been planned into the MMH assuming significant progress to a paper-lite operating model; this will be enabled by the EPR Programme and associated Document Management solutions (hosted externally to the MMH).
- Office / administration capacity in the MMH and other Trust facilities is based on efficient assumptions driven by well tested agile working models;
- Technology that can support voice over IP (VoIP) and agile desktop functionality will be required; this will be enabled by the Infrastructure Programme.
- A requirement to support connectivity between the MMH and the Trust's community facilities has been specified, this will be enabled by the Infrastructure Programme; and
- The need to build in sufficient capacity to support incremental growth of functionality and implementation of new technology over time has been included in scope.

Trust Requirements Specified in the PF2 Contract

10.7.13 The management of Informatics services and systems has a very different risk profile to the rest of the services being considered in the PF2 contract. The future requirements and systems of the Trust are extremely difficult to forecast for the duration of the contract (around 30 years) and is therefore impossible to price on any realistic basis.

10.7.14 Given this, the only aspect of IT services proposed to be included within the PF2 contract is the network infrastructure within the facilities including the relevant connections to the external environment. The requirements for this have been documented in the recently modified Schedules. The full impact of these schedules will be agreed prior to submission of final bids.

10.7.15 The fixed network cabling and containment systems will be designed to ensure that the capacity and connectivity provided can support the Informatics Strategy.

10.7.16 The Trust's hardware, software, systems and management services remain outside the scope of the scheme.

10.7.1 The Trust required Bidders to design a single integrated network delivering wired and wireless coverage to agreed criteria at completion and at the operational stage. The Trust will manage the single integrated network across the site after completion and requires that the successful bidder will utilise that network for building management and other systems.

10.7.2 The brief was for the PF2 partner to be responsible for the supply, installation, and lifecycle of the network infrastructure. Maintenance of the passive element of the network will be provided throughout the operational phase of the contract.

10.7.3 In addition, a short term hardware maintenance service for the active network will also be provided as an elective service for the first 5 years of the contract. The Trust will be responsible for the procurement, installation, maintenance and lifecycle of the hardware / equipment needed to enable voice and data transmission across the network infrastructure.

Internal Fixed Cable Networking

10.7.4 The configuration of network cabling and components would depend on the design of the building; however certain minimum requirements were specified as follows:

- Core network components will be dual connected to provide alternate routing;
- Physical network cabling to operational areas should be provided from more than one location so that, in the event of failure of one network location, an entire operational area is not impacted; and
- Networks should have sufficient bandwidth and resilience to support images, VoIP, data and wireless mobile technologies and communications.

Wireless Network

10.7.5 Full wireless access to the single integrated network was specified. Arrangements for testing the wireless network after commissioning were set out in Schedule 8 of the Project Agreement to ensure that good levels of performance are maintained when the hospital is fully operational.

Incoming Network

10.7.6 Incoming network services will be provided through diverse routes (primary N3 links etc.) to reduce the risk of duct damage / building work etc. causing complete failure of service.

10.7.7 Robust high capacity network links will be required to Trust's community facilities from the MMH prior to opening. These links will be required to support clinical care between these sites.

Not Included in the Scope of the PF2 Contract

10.7.8 The following have not been included in scope:

- IT software / platforms / systems and other hardware and peripheral requirements, such as PCs and servers – these will be funded from the Trust's Capital Programme.
- The main Data Centre – this will be externally located and Informatics will determine the design and required supplier within the time period of the current Strategy. It is highly probable that this Data Centre will be N3 hosted and it is therefore important that the MMH site has dual resilient N3 connections. However, Informatics requirements are for small local computer rooms in which to host racks containing locally required service provision e.g. Active Directory services / locally specific clinical services.

10.8 Equipment Strategy

10.8.1 The Trust defined which equipment types would be best managed by the Trust or by the PF2 Partner. The PF2 Partner is required to provide, install, maintain and replace certain items of fixed medical equipment which have been specified and selected by the Trust. The provision, installation, maintenance and replacement of all other equipment will be the responsibility of the Trust.

10.8.2 The Trust will be procuring a managed equipment service (MES) for certain large items of medical equipment in parallel to the MMH procurement.

10.8.3 The Trust will require beneficial access to the facilities prior to Practical Completion for the purpose of installing and commissioning these items of fixed medical equipment.

10.8.4 The Trust's approach has therefore been to define equipment into detailed classifications to reflect the proposed responsibilities. These classifications are shown in the Equipment Responsibility Matrix presented at ***Appendix 10c*** which outlines the responsibility for the procurement, transfer, fit, maintenance, and lifestyle for each category in the classification matrix.

10.8.5 1:50 designs have been completed for all repeatable and those which are likely to have a potential significant cost. All rooms will have been designed at 1:50 by financial close and will be populated into a database of equipment requirements.

10.9 Hard FM Services Strategy

10.9.1 The Trust has specified a hard FM service to maintain the fabric of the MMH buildings and estate and ensure their lifecycle replacement for the duration of the PF2 Contract. The Trust also requires elective and minor maintenance services

10.9.2 Hard FM services to Trust retained estate will not be required within the PF2 contract.

10.9.3 The required standards for the hard FM service are set out in the Project Agreement. The Trust intends the full payment mechanism to apply.

10.9.4 It is proposed to transfer some members of the Trust's hard FM staff using TUPE arrangements. Some staff will be retained to maintain the retained estate. The Trust has engaged with Estates staff regarding the most appropriate way of identifying staff that will transfer to the hard FM provider within the PF2 contract.

10.10 Soft FM Services Strategy

10.10.1 Soft FM services are not included within the scope of requirements and will be provided by the Trust directly or by a third party.

In House Soft FM Services

10.10.2 The Trust's preferred solution for Soft FM is in accordance with PF2. Management of services will stay within the hospital where there are strong interdependencies with clinical services for example:

- Domestic/ ward services;
- Patient catering;
- Portering;
- Postal services and receipt and distribution services (due to the close operational links and shared capacity with portering); and
- Security (and therefore also car parking due to synergies between the two services).

10.10.3 Outsourced Soft FM Services

10.10.4 The Trust may outsource the following services that do not have strong interdependencies with clinical services however it will not do so through the PF2 contract:

- Retail Catering; and
- Linen and Laundry Services (the Trust will continue to outsource this service).

10.11 Income Generation Opportunities

10.11.1 The Trust does not expect the PF2 partner to manage retail opportunities (including retail catering) within the hospital. The Trust will deliver retail catering services.

10.11.2 The Trust has specified an amount of retail space within the MMH atrium which it expects to manage itself or sublet to an independent third party.

10.11.3 The Trust will require that internet access through the single integrated IM&T network will be available to visitors and patients and reserves the right to charge for this access.

10.12 Conclusion

10.12.1 The project has a clearly defined scope which reflects the Trust's requirements which were detailed in the Invitation to Participate in Dialogue procurement documentation.

11 Procurement Strategy

11.1 Introduction

11.1.1 This chapter describes the procurement strategy, the process and outcome of commercial negotiations to date.

11.2 The Procurement Strategy

Underpinning Regulations

11.2.1 The Trust is procuring the MMH through the Government's new approach to the delivery of private finance into public infrastructure and services, Private Finance 2 (PF2) route.

11.2.2 The procurement is following the Competitive Dialogue (CD) procedure under Article 29 of directive 2004/18/EC (the Directive) and Regulation 18 of the Public Contracts Regulations 2006 (SI 2006/5) (as amended).

11.2.3 The purpose of Dialogue is for the Trust to work with Bidders to develop solutions that will meet the Trust's requirements.

11.2.4 The rules of CD require that Final Bids will contain all the elements required and necessary for the performance of the project. This means that a high level of detail will be required such that price and commercial certainty has been achieved prior to 'Closure of Dialogue'.

Summary of Trust Approach

11.2.5 It was originally planned for the Dialogue process to follow a 3:2:1 pattern.

11.2.6 The aim has been to make the Dialogue process as structured and transparent as possible to achieve the best outcome for the Trust without incurring unnecessary bid costs. The process has been controlled by the Core Project Team to retain an overview of all issues and ensure consistency of approach.

11.2.7 The draft Project Agreement was based on Department of Health (DH) Standard Form (Version 3, as amended July 2004, February 2006, November 2006) ('DHSF') and has been tailored to reflect SOPC4 amendments, HM Treasury's Standardisation of PF2 Contracts which was issued in December 2012 and the specific elements of this project. It was prepared with comprehensive bespoke drafting to reflect the Trust's commercial position as outlined in ITPD Volume Three.

11.2.8 Delivery of the Project under PF2 means that two separate Funding Competitions will be required. The first will be used to identify the third party Equity Provider and the second will be used to appoint the Senior Debt Provider. In each case these competitions are mandatory. The equity funding competition will be held prior to appointment of Preferred Bidder and the Senior Debt competition will be held at the Preferred Bidder stage. Due Diligence Advisors were appointed in March 2015 and will ensure that potential issues for Funders can be reviewed regularly through the procurement.

11.2.9 The Due Diligence Advisors Stage One technical review of the draft Project Agreement and the ITPD is presented at ***Appendix 11d***.

11.2.10 The Trust will only Close Dialogue once they have received and evaluated a Draft Final Bid which includes all the elements required and necessary for the performance of the Project and assurance

that all material issues relating to a Bidder's solution, in particular those impacting on price and risk, have been scoped and agreed. Approval from DH will be required before the Trust is able to close Dialogue. One of the pre-requisites for this closure will be approval of this Appointment Business Case from NHS Trust Development Authority, Department of Health and HM Treasury. No changes to the basic features of the Bid involving changes to cost or which would otherwise potentially distort competition or result in discrimination will be permitted following Closure of Dialogue.

Impact of Single Bidder at CD Stage 4

11.2.11 The Trust set out a procurement plan following OBC approval which commenced with the OJEU publication in July 2014. Due to only 1 bidder proceeding to the 4th stage of Competitive Dialogue the Trust has been able to shorten the remainder of the procurement period, enabling financial close to be accelerated by 4 months. The Trust is on track to appoint Preferred Bidder within 13 months of OJEU.

11.2.12 The key stages are summarised in the table below:

Table 63: Procurement Stages

Procurement Milestones	Post OBC plan	Single bidder plan
OJEU	14th July 2014	14th July 2014
Prequalification Stage Selection of 3 Bidders and one reserve	4th September 2014	4th September 2014
Invitation to Participate in Dialogue Issued	5th September 2014	5th September 2014
CD Stage 1: ITPD Clarification Induction activities	8th - 19th September 2014	8th - 19th September 2014
CD Stage2/3: Dialogue to Interim Submissions Interim submissions Appointment of Single Bidder	12th December 2014 8th January 2014	12th December 2014 11 March 2015
CD Stage 4: Dialogue with Single Bidder Submission of Draft Final Bid Closure of Dialogue	9th April 2015 30th July 2015	2nd April 2015 25th June 2015
CD Stage 5: Final Bid Final Bid submitted Appointment Preferred Bidder	31st July 2015 22nd October 2015	3rd July 2015 5th August 2015
Preferred Bidder to Financial Close Financial Close	15th April 2016	9th December 2015
Construction Handover Hospital Opening	20th July 2018 12th October 2018	13th July 2018 8th October 2018

11.3 Official Journal of the European Union (OJEU)

11.3.1 The Project is being procured under the UK Government's new PF2 scheme and follows the Competitive Dialogue procedure set out in the Public Contracts Regulations 2006. The Project was advertised by way of a contract notice published in the OJEU on 17 July 2014 (OJEU ref. 2014/S 135-242757). A copy of the OJEU notice is at ***Appendix 11a.***

11.4 Pre-Qualification Stage

11.4.1 A Memorandum of Information, Pre-Qualification Questionnaire (PQQ) and PQQ Evaluation Methodology were made available to all interested candidates through the NHS Sourcing Electronic Procurement Portal.

11.4.2 The PQQ was intended to shortlist three bidders with a potential reserve bidder to shadow the early stages of the procurement. There were 3 responses to the PQQ:

- Balfour Beatty;
- Carillion (The Hospital Company);
- Laing O'Rourke / Interserve (Momentum Healthcare);

11.4.3 The constitution of these bidders is at ***Appendix 11b***.

11.4.4 These responses were scored and the sum of the weighted scores in each case was in excess of the minimum score defined in the PQQ Evaluation Methodology (50%). All three bidders were therefore shortlisted to receive the Invitation to Participate in Dialogue (ITPD).

11.5 CD Stage 1 - ITPD Clarification

11.5.1 The aims of this stage were to:

- Initiate the CD process with the Bidders selected;
- Provide the information Bidders need to proceed effectively;
- Allow Bidders to test their understanding of the Trust's brief;
- Respond effectively to queries and requests for clarifications;
- Acknowledge the approach to the Senior Debt Funding Competition;
- Facilitate discussion of the intended approach to the Equity Funding Competition;
- Initiate the appointment of the due diligence advisors; and
- Establish effective lines of communication and rules of engagement.

11.5.2 The ITPD was issued to 3 bidders. However, one bidder (Balfour Beatty) withdrew immediately after issue.

11.5.3 The two remaining Bidders were required to deliver short presentations to demonstrate their understanding of the Project. These presentations did not form part of the evaluation process and covered:

- Opportunities – understanding of Trust requirements and aspirations;
- Constraints – understanding of site issues, planning etc.; and
- Innovations – first ideas on innovation at sketch outline level.

11.5.4 The Core Project Team provided feedback to help the Bidders develop understanding of the Trust's design and commercial principles.

11.6 CD Stage 2 and 3 - Preliminary Proposals and Dialogue to Interim Submissions

11.6.1 These stages were merged in order to reduce the programme length. The aims of these stages were for:

- Bidders to indicate how and in what way they would seek to improve the Exemplar Design;
- Bidders to have an early opportunity to test their developing ideas and approaches;
- Provision of full feedback on the proposals;
- Bidders to work with the Trust to continue development of their design;
- Bidders to develop an Interim Bid Submission for evaluation;
- The Trust to manage requests for information and to resolve issues raised during the process;
- The Trust to evaluate Interim Bid Submissions to shortlist two Bidders; and
- The Trust Board to consider the evaluation report and approve the two Bidders going forward into CD Stage 4.

Interim Bid Evaluation

11.6.2 Although Momentum Healthcare engaged in the early part of dialogue it did not submit a response by the interim submission deadline of 12.00pm, 12 December. Consequently, Momentum Healthcare was deemed to have effectively withdrawn from the competition.

11.6.3 There was one response from The Hospital Company. The submission met the price targets and that was complete. The submission was evaluated by the MMH Project Team and other relevant staff and advisors in accordance with the published Evaluation Methodology in the ITPD.

11.6.4 The groups met and achieved consensus scores which were recorded contemporaneously together with relevant evidence as to why that score was appropriate on the Trust's electronic procurement portal Bravo.

11.6.5 Other non-scoring activities included a Design Quality Indicator (DQI) presentation from the bidder and a full day of meetings with the departmental clinical design groups. Views from both sources formed part of the evidence reviewed during the Clinical Design scoring session.

11.6.6 The Evaluation Moderation Committee met to review the scoring and as a consequence the scores in four clinical questions were increased from 4 to 5. All other scores remained as originally recorded.

11.6.7 Detailed below are summaries of each of the interim submission responses by section, together with the Bidder's overall weighted score of 71.76.

Table 64: Interim Submission Weighted Scores

Section		Current Weighted Score	Maximum Weighted Score	Percentage
Design Vision Total		6.75	9	75.00
Estates & Technical Total		14.10	24	58.75
Clinical Total		23.80	34	70.01
Legal & Commercial Total		3.50	5	70.02

Section		Current Weighted Score	Maximum Weighted Score	Percentage
Financial Total		4.00	5	80.02
Facilities Management Total		6.19	9	68.82
Project Management Total		1.58	2	79.15
Regeneration Total		1.83	2	91.60
Pricing Total		10.00	10	100.00
Grand Total		**71.76**	**100**	

11.6.8 The bid was compliant in terms of quality scores because it achieved an overall score of 50% and no questions were scored as 1 (unacceptable).

11.6.9 The overall weighted score of 71.76 positions the Bid between adequate and good. Only one section – Estates and Technical – had an average score below adequate. However all issues were felt to be resolvable in the next stage of dialogue.

11.6.10 There were a number of questions where the bidder scored either 2 (very poor) or 3 (poor). These were captured to be resolved early in the next stage of Dialogue.

11.6.11 The Trust Board met on 8th January 2015 and agreed that the submission was compliant and should proceed to the next stage of Dialogue. However, the fact that there was only one bid raised concerns about the ability to drive and demonstrate value for money. The approach to managing this issue is covered below.

11.7 Single Bidder Implications and Treatment

The Issue

11.7.1 The consequence of a single bidder at the end of CD3 presented the Trust with both a challenge and an opportunity:

11.7.2 The lack of a competitive lever could compromise the ability to improve quality of the interim bid through to Preferred Bidder;

11.7.3 Additionally, the absence of competition might prevent the Trust from securing and demonstrating the best possible price;

11.7.4 However, there was an opportunity to de-risk the programme by bringing financial close earlier, thus making the October 2018 hospital operational date more viable and enabling better value for money.

11.7.5 An option appraisal was undertaken by the Trust Board to determine the best way forward given that only a single bidder submitted an Interim Bid Submission. This appraisal has been detailed in Chapter 9. The Trust Board determined that it was in the Trust's best interests to continue the existing procurement, albeit with some additional mitigations to counter the issues described above. These mitigations drive quality and control cost, thereby safeguarding value for money.

Approach to driving quality

11.7.6 In order to drive quality, the Trust has required that all concerns identified at the evaluation of the interim bid submission have been addressed early in the CD Stage 4.

11.7.7 Additionally, the Trust has required that the quality scoring achieved at the draft and final bids matches or exceeds that achieved at the interim submission.

11.7.8 The Trust has created a new metric of 'cost per benefit points' from The Hospital Company's interim submission. This is the product of the NPV of the unitary payment and an assessment of the quality, scored at bid evaluations. The Trust has required that this metric improves at each subsequent bid.

Approach to ensuring that costs are competitive

11.7.9 The Trust has requested that The Hospital Company provides a market testing strategy to demonstrate what level of market testing is possible without the market testing becoming part of the critical path of the procurement and thus delaying financial close. 78% of the value of the construction packages will be market tested using the following methods:

- True market lump sum;
- True market test rates;
- Subcontractor target cost / budget estimates;
- Quality / capability evaluation with all in rate for sample scope of works; and
- Market testing of rates using other schemes and adjusting for inflation.

11.7.10 The deliverables required from The Hospital Company to evidence the above are presented in the updated ITPD Volume 4 presented at ***Appendix 11c.***

11.7.11 It is intended that for each method 2 or 3 suppliers will be approached to provide a cost. As the scheme develops from the draft final bid submission (April 2015) to the final bid submission (July 2015) an increasing number of work packages will have been subjected to a rigorous approach, resulting in The Hospital Company demonstrating that at least 78% of the construction cost has been tested.

11.7.12 The Hospital Company is required to demonstrate market testing as described above at both draft final bid submission and final submissions.

11.7.13 The Trust's cost advisor is providing support by:

- Cost modelling to compare with the Public Sector Comparator and / or another relevant scheme such as the Royal Liverpool Hospital (also being constructed by The Hospital Company).
- Monitoring the bidder's cost plans to ensure that costs were contained within the limits set out in the interim bid.
- Using open book accounting to ensure that movements in elemental costs are transparent understood and accepted.
- Providing assurance that at least 78% of the value of the scheme had been market tested through having sight of market testing and tendering information.

11.7.14 Additionally, the Trust has a financial hurdle in place based on the first year Unitary Payment (UP) and net present value of the UP over the contract life. The Hospital Company is required to pass the hurdle at both draft final bid submission and final bid submissions in order to submit a compliant bid.

11.7.15 FM and lifecycle costs in the unitary payment will be benchmarked prior to Preferred Bidder. Lifecycle costs will be subject to early review by the technical due diligence advisors. The Trust requires an amendment to clause 28 of the Project Agreement to require The Project Company to competitively tender lifecycle costs.

11.7.16 The Hospital Company will be required to competitively procure equipment and other non-pay items during the operational period in accordance with the Trust Standing Financial Instructions or some other agreed protocol and to evidence that.

11.7.17 The above mitigations were detailed in a revised ITPD which was issued to The Hospital Company on 11 March 2015. The Hospital Company confirmed acceptance of the terms in full in a letter to the Trust dated 30 March 2015.

11.8 Competitive Dialogue Process Stage 4

11.8.1 The aims of CD Stage 4 were for:

- The Bidder to complete development of their proposals;
- The Bidder to resolve all project specific commercial requirements with the Trust;
- Costings and the financial model to be completed ensuring that all price sensitive issues have been resolved;
- The Trust to manage the process ensuring that meetings, requests for information (RFI), issues etc. are managed effectively and without incurring unnecessary costs and pressures on Bidders and Trust staff;
- Development of all items required for the Bidder to prepare the Draft Final Bid;
- The Trust to prepare an Appointment Business Case in draft and seek approval as a condition of Closure of Dialogue;
- Submission and evaluation of Draft Final Bids; and
- Approval for Closure of Dialogue.

11.9 Submission and Evaluation of the Draft Final Bid

Compliance Testing

11.9.1 The full evaluation report for CD Stage 4 which was approved by the Trust Board is presented at ***Appendix 11e***. Compliance tests have been applied to assess the Draft Final Bid which have confirmed that:

- All specified deliverables are included;
- Those deliverables specified as compliant are fulfilled e.g. a bid which demonstrates compliance with the set price targets;
- All deliverables are in the required formats and the prescribed pro-formas have been used;
- Sufficient information at the required standard has been provided to enable a full evaluation; and

- Compliance with instructions regarding Reference and Variant Bids has been followed.

Evaluation Approach

11.9.2 The evaluation of the Draft Final Bid is one of the factors which determine whether the Trust is ready for Closure of Dialogue.

11.9.3 Scoring of all Draft Final Bid was undertaken by the Evaluation Teams and then reviewed by the Evaluation Moderation Committee.

11.9.4 Each Bid Deliverable was assessed for the extent to which the Trust's requirements were met and any additional benefits offered using the scoring structure presented in the table below. Cost is scored separately as described later in this chapter.

Table 65: Scoring of Bids

Score	General Definition	Criteria Based Definition
1	Unacceptable	Fails to meet requirements for almost all key criteria.
2	Very poor	Fails to meet requirements for many of the key criteria.
3	Poor	Fails to meet requirements for some key criteria.
4	Adequate	Meets requirements for all key criteria.
5	Good	Meets requirements / performs well for all key criteria and offers some additional benefits.
6	Excellent	Exceeds all project criteria and offers significant additional benefits.

Weighting

11.9.5 The Trust has evaluated the Bidder through the application of the evaluation criteria, scoring and weightings set out below. The Trust has decided to carry the CD stage 3 weights through to CD stage 4 (at a work stream level) so that direct comparison of the scores from interim submission to Draft Final and Final Bid can be made.

11.9.6 The Trust has required the quality score for the solution is achieved during evaluation at Draft Final and Final Bid stage to equal or exceed the quality score achieved at Interim Submission. Each main criterion corresponds with a workstream and has been allocated an overall weighting shown in the table below.

Table 66: Weighting by Main Criterion / Work Stream

Main Criterion / Workstream	Weighting CD Stage 3	Weighting CD Stage 4/5
Cost	10%	10%
Clinical and Operational Functionality	34%	34%
Estates and Technical	24%	24%
Legal, Commercial and Finance	14%	14%
Hard FM	9%	9%
Subjective Assessment of Design Vision	9%	9%

Main Criterion / Workstream	Weighting CD Stage 3	Weighting CD Stage 4/5
Total	**100%**	**100%**

Evaluation of the Draft Final Bid

11.9.7 The evaluation report presented to the Trust Board is at ***Appendix 11e***. This section summarises the findings.

11.9.8 The Draft Final Bid was received on 2nd April 2015 and it was agreed that it met the price hurdles and that it was complete.

11.9.9 The bid was evaluated in accordance with the methodology outlined in the ITPD. Consensus scores were achieved which were recorded contemporaneously together with relevant evidence as to why that score was appropriate on the Trust's electronic procurement portal Bravo.

11.9.10 Other non- scoring activities included two presentations (one for clinical staff and one for the public) from the bidder on 17th April 2015 and two full days of meetings with the departmental clinical design groups. Views from both sources formed part of the evidence reviewed during the clinical design scoring session.

11.9.11 The Evaluation Moderation Committee amended one score - all other scores remained as originally recorded.

11.9.12 The table below summarises the weighted evaluation scores at Draft Final Bids.

Table 67: Draft Final Bid - Weighted Evaluation Scores

Section	Current Weighted Score	Maximum Weighted Score	%
Design Vision	7.050	9	78.33
E&T	17.368	24	72.37
Clinical	25.217	34	74.17
Legal	4.167	5	83.33
Finance	4.500	5	90.00
FM	7.476	9	83.07
Project Management	1.667	2	83.33
Regeneration	2.000	2	100.00
Pricing	10.000	10	100.00
Grand Total	**79.444**	**100**	

11.9.13 The bid is compliant in terms of quality scores because it has achieved an overall score of more than 50% and has no questions scored as 1 (unacceptable).

11.9.14 The overall weighted score of 79.444 positions the Bid well above adequate (66.67) but not quite at good (83.33). All sections have improved since the interim submission and only 8 deliverables were scored as poor (50.0) with no very poor or unacceptable scores. The remaining poor issues are all felt to be resolvable prior to submission of Final Bids.

Price Compliance

11.9.15 The Trust has scored Cost as a Bid Deliverable.

11.9.16 The reference model that has been evaluated a capital contribution of £100m.

11.9.17 Bidders have been set a price target of a first year target Unitary Payment (UP) of less than £22 m and a Net Present Value (NPV) of the UP over the operational period of less than £262 m for their bid to be compliant.

11.9.18 Provided that the Bidder complies with the hurdle the Bidder will score 100% on price.

11.9.19 The Bidder's base scheme proposes a first year UP of £21.95 m and a NPV of the UP over the operating period of £261.09 m. The Bidder has therefore complied with the price hurdles.

Adherence to Single Bidder Mitigation Requirements

11.9.20 The Bidder has complied with the single bidder mitigations. The detail is presented in the evaluation report presented at ***Appendix 11e***.

Technical Due Diligence Stage One Report

11.9.21 The Due Diligence Advisors Stage One technical review of the draft Project Agreement and the ITPD are presented at ***Appendix 11d*** demonstrating satisfactory findings at this stage of the project.

11.10 Competitive Dialogue Process Stage 5

11.10.1 The aims of CD Stage 5 will be for:

- The Bidder to submit a Final Bid;
- The Trust to evaluate the Final Bid;
- The due diligence advisors to review the changes from Draft Final Bids and comment on any effect on their report;
- The Trust to update the Appointment Business Case (ABC); and
- The Trust to coordinate approvals leading to approval of the Preferred Bidder.

Final Bid

11.10.2 The Trust will issue an Invitation to Submit Final Bids (ITFB) to the Bidder at the Conclusion of Dialogue. This document will include addenda to the ITPD, which will capture changes to the brief that have been raised and addressed during the Dialogue process.

11.10.3 The ITFB will specify:

- Confirmation of changes to requirements set out in the ITPD which have arisen from the Dialogue process.

- Reference to previous amendments or addenda which recorded these changes throughout the process;
- The detailed content required for the Final Bid;
- The deadline for submission of the Final Bid; and
- Any specific terms agreed with the Bidder during the CD process.

11.10.4 The Bidder will be required to submit a Final Bid based on the solution identified and agreed prior to the Closure of Dialogue.

11.10.5 The Trust will have discussed and resolved all commercial and price sensitive issues before Closure of Dialogue. The Project Agreement will therefore be agreed in respect of this position with only minimal non-price sensitive issues left to be addressed at Final Bid. Any new issues raised or previously withdrawn points re-raised at Final Bid stage will render the Bid non-compliant.

11.10.6 Only items that have changed since the Draft Final Bid will be submitted by the Bidder in Final Bid. A schedule of items submitted as part of the Draft Final Bid and that remain unchanged will also be required for completeness.

11.10.7 Only Bid Deliverables that have changed since the Draft Final Bid will be evaluated at the Final Bid. The scores will then be combined with the Draft Final Bid Scores of the remaining deliverables to complete the evaluation.

11.11 Evaluation and Selection of Preferred Bidder

11.11.1 The Core Project Team will first check bid compliance.

11.11.2 Evaluation of items that have changed since the Draft Final Bid will then be undertaken as described and the Core Project Team will produce an Evaluation Report.

11.11.3 The Core Project Team will also consider whether there is any potential for changes to items submitted at Final Bid to impact on the Draft Final Bid previously issued. The Trust is only permitted to “clarify, specify and fine tune” Bidder Submissions at this stage.

11.11.4 The Evaluation Report will confirm (or otherwise) that the Bidder should be appointed as Preferred Bidder by application of the evaluation criteria identified. The report will be considered by the Trust Board to confirm the provisional appointment subject to approval of the ABC.

11.11.5 The Trust will inform the Bidder of the outcome of its Final Bid evaluation.

11.11.6 A review of the due diligence report will be commissioned by the Trust after receipt of the Final Bid. This report will review any risks that have arisen since the full review conducted at Draft Final Bid stage. It will also inform the Funding Competition.

11.12 Financial Close

11.12.1 This phase will allow for clarification of aspects of the bid and confirming commitments in the Final Bid, provided that this does not have the effect of changing substantial aspects.

11.12.2 A Confirmatory Business Case will be agreed before Financial Close to provide confirmation to the DH and HMT that the conditions of ABC approval (and any subsequent conditions) have been satisfied.

11.13 Key Project Milestones

11.13.1 These are set out in Chapter 14.

11.14 Procurement Documentation

11.14.1 The procurement process and supporting information is presented in four volumes of the ITPD. These were issued prior to the commencement of the Competitive Dialogue process and refreshed as required during the process.

Volume 1 – Executive Summary

11.14.2 This provides an executive summary of the ITPD suite of documents and additionally includes:

- Background to the Trust;
- Content for change;
- Right Care, Right Here model of care;
- MMH acute model of care; and
- Activity assumptions.

Volume 2 - Design Specification

11.14.3 This provides detail on:

- Clinical and functional brief;
- Architectural design requirements;
- Quality of construction; and
- Technical information.

Volume 3 - Commercial Document

11.14.4 This provides detail on the Trust's commercial position, the Project Agreement and its schedules and includes:

- Facilities management;
- Interim services;
- Retail opportunities;
- Car parking; and
- Regeneration strategy.

Volume 4 - Procurement Process

11.14.5 This provides detail on the competitive dialogue process including:

- The competitive dialogue strategy;

- The procurement timetable;
- The evaluation process;
- Approach to reference and variant bids; and
- Price and value for money assessment.

11.14.6 The updated version of Volume 4 is presented at ***Appendix 11c***.

11.15 Standard Form Compliance

11.15.1 The Project Agreement and Schedules are compliant with HM Treasury's Standardisation of PF2 Contracts. Since this is the first hospital project to be procured under the PF2 model, the Project Agreement and Schedules have been worked up in close consultation with the Department of Health and HM Treasury. Some project specific drafting has been included and is summarised in the following sections.

Clause 17.1A (Advance Works)

11.15.2 The base Draft Final Bid assumes that certain Advance Works will be carried out by The Hospital Company Construction Limited (the Advance Works Contractor) at the Site under the terms of an Advance Works Agreement. The Project Agreement acknowledges this and includes drafting stating that the Advance Works are deemed to be part of the Works and to have been carried out by Project Co under the Project Agreement. The Advance Works Contractor is also listed as a Project Co Party under the Project Agreement. Confirmation of the precise contractual structure will be established before Final Bids.

Clause 35.11 - 35.13 (Capital Payments)

11.15.3 The Trust will make capital payments of up to £100,000,000 funded by PDC as agreed with the DH towards the Constructions Costs. Drafting has been included to describe how these payments will be made, the timing of such payments and the conditions which must be satisfied before such payments are made.

Schedule 14 (Service Requirements)

11.15.4 The draft Schedule 14 provided by HM Treasury was used as the base for the MMH Schedule 14 and the MMH document is compliant with that document. Due to the fact that this is a health project and certain health specific elements are required, the schedule has been adapted in certain areas to ensure it works well in the health context. The draft Schedule 14 is well worked up at this stage and has been reviewed and signed off by both the Department of Health and HM Treasury (against the template version provided).

11.15.5 Project specific drafting in relation to IM&T arrangements has also been included.

Schedule 18 (Payment Mechanism)

11.15.6 The draft Schedule 18 provided by HM Treasury was used as the base for the MMH Schedule 18 and the MMH Schedule 18 is compliant with that document. Due to the fact this is a health project and certain health specific elements are required, this has been adapted slightly in order to ensure it works well in the health context. The draft Schedule 18 is well worked up at this stage and has been reviewed and signed off by both the Department of Health and HM Treasury (against the template version provided).

Schedule 22 (Variation Procedure)

11.15.7 Whilst this Schedule is compliant with PF2, some work has been done in order to seek to ensure that the schedule is as effective as possible. Single Stage Variations for less complex variations and Two Stage Variations for more involved variations have been introduced in order to seek to streamline the process where appropriate but to ensure enough time is given and detail worked up where the variation is more complex.

Retail

11.15.8 PF2 does not contain drafting in relation retail arrangements. The Trust will be managing its own retail tenants and they will be included within the definition of Trust Party in the Project Agreement. Drafting will be added setting out Project Co's, the Trust's and the tenants' responsibilities in relation to the relevant areas of the MMH.

11.16 Approach to Funding Competitions and Due Diligence

11.16.1 The project is to be procured via PF2 therefore there is a requirement for two funding competitions to take place as follows:

- Debt funding competition; and,
- Equity funding competition.

11.16.2 The approach to each of these exercises is set out below:

Debt Funding Competition (DFC)

11.16.3 Historically, funders have commissioned due diligence following the appointment of the Preferred Bidder. This often resulted in the re-opening of commercial terms and as a consequence, delays to the project programme. In addition, the re-opening of commercial positions is at odds with the legal requirements of Competitive Dialogue and the ABC process.

11.16.4 In order to provide potential participants in the DFC with an appropriate level of understanding to limit the re-opening of any commercial points, the Trust has adopted a strategy to work with the single bidder in appointing the due diligence advisors.

11.16.5 The strategy outlined the roles and responsibilities of each of the appointed advisors and required agreement to the timetable and funding protocol. Advisors were also required to acknowledge that they owed a duty of care to not only the debt provider but also the equity provider.

11.16.6 Due diligence advisors (legal, technical and insurance) were appointed by the Trust (acting in an administrative capacity only and as trustee for the due diligence advisor duty of care to the debt/equity providers) and the single bidder. The procurement process was undertaken in January 2015.

11.16.7 The single bidder situation allowed for the bidder to be more involved and engaged in this process - their involvement included:

- Contribution to the list of firms invited to tender;
- Agreement to the scope of services to be provided and terms and conditions of appointment; and
- Participation in the evaluation of tender responses, face to face interviews and decision making process.

11.16.8 Following the evaluation exercise appointments were made in March 2015. Payment to the appointed advisors will be made by the senior debt funders following financial close and fees have been factored into the financial model.

11.16.9 The stages within the due diligence scope of services are as follows:

- **Stage 1 - Due diligence report.** This stage is based upon ITPD documentation to allow funders to have an informed early consideration of project specifics and issues which may be of concern. In order to accelerate the programme, due diligence advisors have also received the draft final bid and been asked to raise comments on them. Stage 1 reports relating to 'Legal', 'Technical' and 'Insurance' issues have been received from the Shadow Due Diligence Advisors and are presented at ***Appendix 12d***. No major funder issues have been identified.
- **Stage 2 - Due diligence report.** This stage is initially based upon the draft final bidder submission. It is expected that a review for changes in the project only will be required at final bid stage. This report will inform the funding competition and allow the bidder to resolve any questions in order to finalise pricing (it is not expected that there will be any refinement to the Project Agreement or other commercial positions). The due diligence process will run in parallel with the final ABC Department of Health review and approval processes.

11.16.10 Due diligence appointments will be novated to the Preferred Bidder at the time that they are appointed as Preferred Bidder.

11.16.11 The Preferred Bidder will run a funding competition for the senior debt element of the project. This will be undertaken on an open book basis and overseen by the Trust, its advisors and the Department of Health / Infrastructure UK (IUK). The Preferred Bidder will select and recommend the winning funder(s) on a 'best value' basis in line with the agreed criteria and the Trust will confirm this selection.

11.16.12 Due diligence appointments will be novated to the selected funder(s) at the time that they are appointed as preferred funder(s) and will continue their remit up to financial close and beyond.

Equity Funding Competition (EFC)

11.16.13 One of the most significant changes under PF2 in comparison to PFI is the approach to the equity funding and ownership and make-up of the SPV/Project Co. Under PF2 a proportion of the equity is offered to the market in order to test market pricing and potentially secure a lower blended equity return. In addition, the public sector (IUK) also takes a proportion of the equity under the same pricing and conditions as the selected equity funder. Typically, the EFC is envisaged to take place post preferred bidder appointment however, as a result of the single bidder status, the Trust has been able to advance discussions around the process. Whilst appointment of the equity funder is expected to take place post preferred bidder, much of the process, evaluation and selection can be undertaken concurrently with the procurement.

11.16.14 Initial discussions indicate that the likely equity share of the SPV will be as follows:

- Preferred Bidder: 50%
- 3rd Party Equity provider: 40%
- IUK: 10%

11.16.15 This split was determined to be sufficiently attractive to the market in terms of scale, but also maintained the appropriate balance of control and input for each party.

11.16.16 The due diligence advisor appointment outlined above also provides information to the equity provider. The technical advisor to the senior debt funders will also owe a duty of care to the equity funders.

11.16.17 The Bidder has produced a protocol for the funding competition for the equity element of the project and a list of firms to be invited to tender – this list has been reviewed by both the Trust and IUK. The competition will be undertaken on an open book basis and overseen by the Trust, its advisors and DH/IUK. The Bidder will select and recommend the winning funder(s) on a 'best value' basis in line with the agreed criteria and the Trust will confirm this selection.

11.17 Due Diligence

11.17.1 The due diligence advisors will be novated to the Preferred Bidder following approval of the ABC to enable preparation for the Funding Competition.

11.18 Planning Permission

11.18.1 The Trust will expect the Bidder to commence preparation for the planning application after Closure of Dialogue. The full planning application will be launched in advance of appointment of Preferred Bidder.

11.18.2 The planning process will continue to be taken forward with Sandwell Metropolitan Borough Council (SMBC) at this stage.

11.18.3 The Preferred Bidder will take responsibility, and therefore risk, for amendments with cost implications arising from changes due to planning requirements which are identified at this stage. This is particularly important as the Trust and SMBC have an agreed Section 106 and 278 agreement which sets out the costs the Trust will contribute. Any additional costs associated with the design will be the responsibility of the Bidder.

11.18.4 Full Planning Approval and expiry of the judicial review period (6 weeks) will be completed prior to Financial Close.

11.19 Certificate of Title

11.19.1 The Trust has prepared a report on Title which was included within the data room for the information of the Bidders and which Bidders could review and raise queries on. The Trust also provides a "Trust Title Warranty" to Project Co in Clause 7.2.4 of the Project Agreement. The Trust warrants and undertakes (save as disclosed in the Specific Title Matters) that throughout the Project Term:

- The Site will be in the sole legal and beneficial ownership of the Trust;
- The Site will not be subject to any Adverse Rights;
- No one will be in adverse possession of the Site or has acquired or is acquiring any Adverse Rights affecting the Site;
- There will be no disputes, claims, actions, demands or complaints in respect of the Site that are outstanding or that are expected by the Trust and that would prevent or disrupt the carrying out of the Services; and
- No person, other than the Trust will have any right (actual or contingent) to possession, occupation or use or interest in the Sites.

11.19.2 The Specific Title Matters are still under discussion.

11.20 Transfer of Undertakings and Protection of Employment (TUPE)

11.20.1 It is anticipated there will be a TUPE transfer of staff from the Trust to Project Co. This will be a Service Provision Change type TUPE transfer under Regulation 3 of the TUPE Regulations.

11.20.2 The Trust currently carries out the relevant Hard FM services itself across all of its sites using a directly employed workforce. Under the Project Agreement, Project Co will have responsibility for delivering those services at MMH, although the Trust will continue to deliver those services directly at other sites.

11.20.3 Between now and the transfer date, the Trust will establish this organised grouping of employees by "splitting" the current workforce into two "teams" – "team A" who will continue to be employed by the Trust and "Team B" which is the group of staff who will transfer. This will be done as far as possible on a voluntary basis but could be achieved on a compulsory basis if required. Those employees who volunteer or are selected will be expressly designated as the grouping of staff whose purpose is to deliver the relevant services at the MMH site from the date of the transfer onwards.

11.20.4 There will be a single transfer of staff from the Trust to Project Co. The services to be provided after the transfer are the same as those currently carried out by the Trust itself. The services will be provided to the same legal entity - the Trust - which currently employs those staff to carry out the activities in question.

11.20.5 The drafting in the Project Agreement is compliant with the PF2 standard form drafting.

11.21 Conclusion

11.21.1 The procurement process has run to time. However, the key issue that has arisen is that only a single bidder submitted an interim bid submission at CD Stage 3.

11.21.2 The Trust has undergone a rigorous option appraisal, with input from TDA / DH / HMT of the best way forward given that only a single bidder remains in the procurement process. This has been to ensure that the Trust meets the project objectives, including achieving value for money.

11.21.3 The conclusion of the option appraisal was that the procurement should continue, albeit with mitigations to ensure that the bid continues to improve in quality, that costs are controlled and value for money secured.

11.21.4 The Draft Final Bid submitted on 2nd April 2015 is compliant with all of the Trust's requirements.

11.21.5 As a result of the opportunity afforded by the single bidder situation, Financial Close has been accelerated by 4 months and is scheduled for December 2015 in order to achieve a hospital handover in July 2018 as planned.

12 Bidder Solution

12.1 Introduction

12.1.1 This section outlines the solution developed by The Hospital Company and the Trust including the:

- Design vision values maintained by the Trust;
- Design proposed for the MMH;
- Approach to construction;
- Facilities management arrangements; and
- Sustainability strategy.

12.2 Design Vision

12.2.1 The Trust has a strong vision and key set of values which have been maintained throughout the design process. The MMH aims to implement new ways of delivering healthcare across Sandwell and west Birmingham to an increasing population, which is currently around 530,000. The Trust's aspiration is that this achieved within a notable and high quality healthcare environment. The core requirement for the Trust is to create a landmark hospital which will be an asset to the local community and will support local regeneration. The design will be enduring and reflect the needs of the population it serves.

12.2.2 The design proposals fully support and enhance the Trusts design vision values which are for the MMH to be:

- Inspirational, attractive and imaginative;
- Welcoming;
- Reassuring;
- Light and airy;
- Clean without being clinical;
- Sympathetic to the environment;
- Fully accessible;
- Supportive to privacy and dignity; and
- A good place to work.

12.3 Design

Key Attributes

12.3.1 The Hospital Company has worked closely with the Trust to develop a hospital design which is characterised by:

- A clear, simple and legible building form which maximises the use of natural daylight.

- A building which focuses on the delivery of acute care only, concentrating staff specialist care on the acutely unwell.
- A building where there is clear separation of flows between staff, public and facilities management functions.
- A strong external landscaping strategy which looks to tie in with the existing features around the site such as the canal.
- A building which utilises the topography of the site to create safe and secure parking for staff and visitors without cluttering the external views.
- A central circulation floor which is visible from the outside as well as the inside.
- A building which looks to minimise travel distances for both patients and staff vertically and horizontally.
- Internal spaces which are clear, simple and in clinical areas repetitive allowing staff to work more efficiently.
- A building which induces civic pride.
- A building which utilises natural boundary lines allowing the public and the wider community to free flow across the external spaces.

12.3.2 Key to the heart of the design is *The Green* which will provide the building with a vibrant, landscaped setting and the *Winter Garden* which will form a highly visual and active main circulation floor. The hospital sits on a main gateway site and, with its elevated position, will create a prominent feature against the skyline. Despite the size and massing of the building from a distance, the use of a variety of carefully selected, high quality materials and the change in form created by the ward floor plates means that on closer inspection the building will be less overpowering and its individual elements will be visible giving it a more reassuring and welcoming feel.

Figure 22: MMH within a Landscaped Setting

A Good Neighbour

12.3.3 Grove Lane sits within a key area of regeneration and development by the local authority. The building of the MMH will provide the catalyst for growth in the immediate surrounding areas and act as a gateway into Birmingham from the west side of the City.

Natural Light

12.3.4 The *Winter Garden* will provide much of the natural daylight into the ward spaces. Despite its deep plan appearance within the clinical floor plates, pockets of courtyards have been formed to allow natural daylight into spaces with a focus on areas which will be heavily occupied. All of this supports the Trust's design vision value to create a building which is 'light and airy'.

Healing Environment

12.3.5 The principal purpose of the hospital is to provide a safe, healing and reassuring environment to all users of the building. The design will inspire and promote clinical staff providing a learning and development platform for those entering into the health environment.

12.3.6 The quality of inpatient accommodation is a key feature within the overall design and the single rooms will enjoy pleasant views to support recovery and patient amenity.

12.3.7 The design of the single bedrooms will provide the patient and visitor with privacy and dignity when required, but also supports maximum staff observation.

12.4 Clinical Design

12.4.1 Throughout the development of the clinical design for Midland Met there has been comprehensive clinical engagement. In summary this has included:

- 2006 onwards - development of the service model, PP&DDs and clinical operational policies – 37 clinical leads with involvement from their wider teams.
- 2007/08 onwards - Public Sector Comparator (PSC) Design - via work on 1:500, 1:200, exemplar room drawings and involvement in the AEDET review of the PSC) – 37 clinical leads and representatives from their wider clinical teams.
- 2010 - Value engineering work for Midland Met (identifying additional activity that could appropriately be delivered closer to home in community facilities, updated clinical brief etc)- meetings with circa 40 clinical leads. In addition regular updates were given to the Clinical Executive Team.
- 2013 -The Architecture Design Review (ADR) for Midland Met undertaken autumn 2013 –
  - Open sessions for staff held in September 2013 - attended by circa 80 staff.
  - FT members sessions held in September & October 2013.
  - Boot camp design meetings which involved – circa 100 clinical participants.
  - Monthly updates to the Clinical Leadership Executive attended by Executive Team and Clinical Group Management Teams. Issues were presented to allow senior clinical engagement in managing these and also in agreeing the whole hospital layout (1:500 drawings).

- 20014/15 - Competitive Dialogue as part of procurement phase of the project. Clinical leads reviewed and updated the brief (Operational Policies and PP&DDs) prior to the start of dialogue and during the dialogue process with circa 60 clinical and operational leads participating in the boot camp design meetings including feedback on the proposed design in preparation for evaluation. In addition there have been a number of clinical department meetings outside of the boot camps including with wider teams including Critical Care, Emergency Department, Operating Theatres, Acute Adult Assessment, Sickle Cell and Thalassemia Unit.

12.4.2 The MMH will provide clinical teams with modern purpose built facilities in which to deliver a single site acute hospital. It will allow consolidation of acute emergency and inpatient services with a critical mass of patients, staff and equipment.

12.4.3 The Trust's aspiration is that patients attending services for investigation or treatment, whether for planned elective care or unplanned acute care, will have excellence in clinical care with rapid availability of clinical expertise at all points in their individual care pathways.

12.4.4 The Hospital Company has worked closely with the Trust and engaged with a range of senior clinical teams, with a single-minded focus on delivering the best clinical planning to deliver the service model.

12.4.5 In respect to clinical flows and planning the hospital is characterised by:

Separation of Flows

12.4.6 Clear separation of the public, ambulatory patients, inpatients and goods from the point of entering the hospital until the entrance into departments has been achieved. This promotes privacy and dignity for patients and the public.

12.4.7 The public will arrive on clinical floors at a visitor hub (there will be 4 on each podium floor and 3 on the ward floors) and then enter the right clinical department without having to travel far from the visitor hub. The design delivers this separation but still achieves clinical adjacencies that allow efficient use of staff and facilities.

Clinical Adjacencies

12.4.8 Strong clinical adjacencies will support smooth patient pathways, especially for emergency and acute patients. There will be two podium floors which have co-located hot clinical areas to best facilitate acute patient and clinical staff flows;

12.4.9 At Level 2 the first of these floors will provide a co-located Emergency Department, Imaging, an Acute Assessment Unit (AAU) (with capacity to accommodate patients for up to 48 hours) and a Surgical Assessment Unit. Many emergency patients will have all of their care, from arrival to discharge, provided on this level. In addition the Cardiac Unit including the Cardiac Catheterisation Laboratory Unit will be on this floor to facilitate direct access for emergency patients.

12.4.10 At Level 3, the second of these floors will provide a co-located Operating Theatre Suite and Integrated Critical Care Unit immediately above the Emergency Department and Imaging with a hot lift.

12.4.11 The Delivery Suite (with a high risk zone and a Midwifery Led Unit) and Neonatal Unit will also be located on this floor. Women arriving in labour will access the Delivery Suite via a dedicated ground floor entrance and lift. The high risk antenatal facilities (Clinic, Day Assessment Unit and Foetal Medicine) are located on this level. The maternity wards will be located on the floor above.

Dedicated Children's Unit

12.4.12 Children's services will be located on Level 4 in a dedicated Children's Unit that accommodates distinctive, but co-located, zones for paediatric acute assessment, inpatient beds (including level 2 high dependency beds), adolescent beds, day-case facilities and outpatients.

Therapy Zones

12.4.13 Therapy zones will be co-located with the relevant clinical ward / department (including stroke, musculoskeletal and Acute Assessment Unit (AAU) to facilitate early access for patients who require therapy as well as strengthening wider team working.

Bariatric Provision

12.4.14 Whilst the Trust does not provide specialist bariatric care or surgery it is recognised that a significant proportion of our local population has bariatric support requirements which need to be accommodated when they are admitted to hospital for other conditions. All departments will accommodate patients up to 300 kg. In addition facilities will be provided for patients up to 380 kg in key departments to allow delivery of the most likely pathways, e.g. emergency attendance to the Emergency Department resulting in admission to the Acute Medical Unit and then the respiratory ward.

Isolation Provision

12.4.15 The Hospital Company has met the Trust's brief for 50% single rooms in generic inpatient wards.

12.4.16 In addition the Trust's brief for isolation facilities in each ward with additional clustering on the respiratory and medicine / haematology ward has been achieved in the design. This distributed approach to isolation facilities will allow patients requiring isolation to receive care on the relevant specialty ward with appropriately trained clinical teams as well as providing zones for cohort nursing in the event of an outbreak requiring greater isolation facilities (over and above the 50% single bedroom provision).

12.4.17 The isolation rooms have been designed based on the generic single inpatient bed room and en-suite with the addition of a lobby. The layout of the ward single bedroom zones is such that additional lobbies could be added (with addition of the required engineering) at a future date if required. In addition rooms in key clinical departments will also have isolation facilities e.g. the Emergency Department and the Integrated Critical Care Unit. This provision reflects the health needs profile of the local population including the high prevalence of TB.

Infection Control

12.4.18 In addition to the isolation provision The Hospital Company has achieved in the design a high level of separation of clean and dirty flows in clinical departments (including Theatres, Endoscopy and Cardiac Catheter Laboratories). This principle has also been applied within the design of the facilities hubs and automatic guided vehicle routes.

Waste Flows

12.4.19 Within clinical wards and departments staff will place waste in local disposal holds within the ward or department. These will be located close to the goods entrance to the ward so that facilities staff won't have to travel far with waste from the disposal hold to the facilities management (FM) lift. This will also

reduce double handling of waste as the disposal hold is designed with containers that will be taken directly (via automatic guided vehicles from the facilities hub) to the FM yard.

12.5 Staff and Visitor Experience

12.5.1 The *Winter Garden* will provide a focal point for visitors on their journey through the hospital. It will also provide a central space for staff to meet and relax in which is away from their respective clinical departments. One of the Trust's key requirements is the provision of a good place to work and this impressive space will encourage staff to leave their intense, highly acute, working environments and enjoy different sights and sounds. As well as the use of the *Winter Garden*, staff rest and change facilities will be provided within each clinical floor plate at every level

Figure 23: Winter Garden

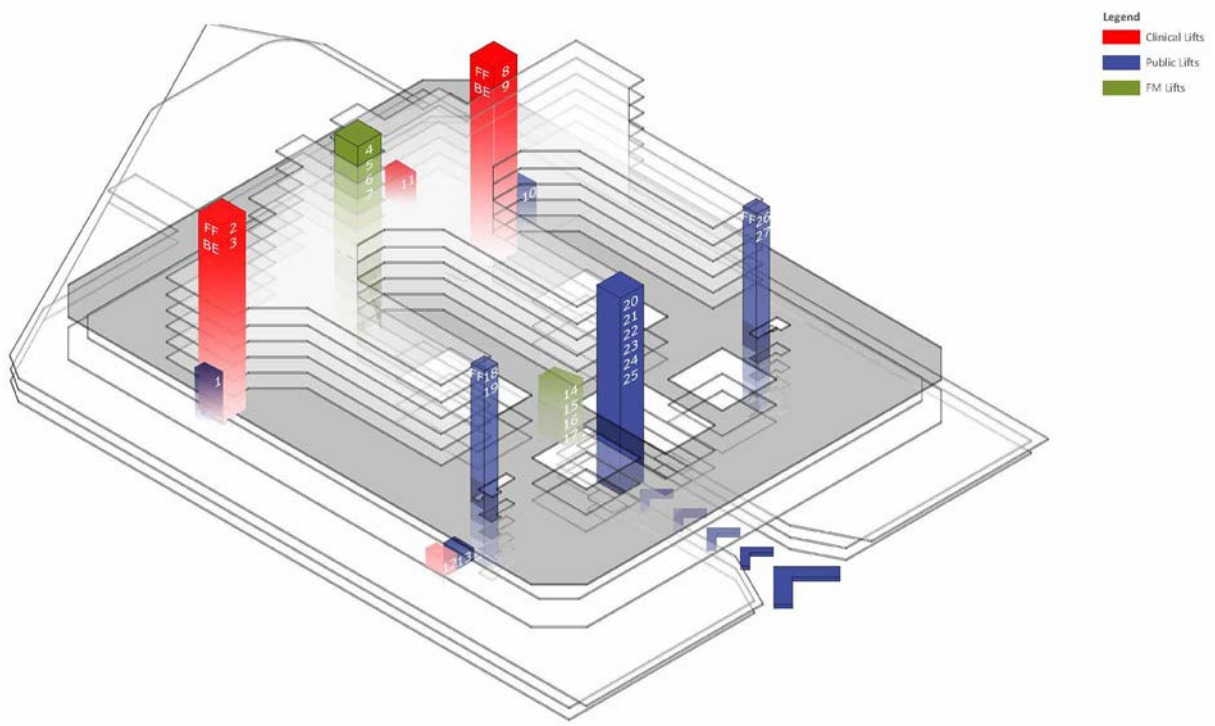
Winter Garden, Way Finding and Separation of Flows

12.5.2 The Trust has placed great importance on way finding within the scheme and is keen to ensure that it will be clear and intuitive. The general flows of staff, visitors and facilities management have therefore been separated providing greater efficiency for staff moving in between clinical spaces and reduces the risk of visitors becoming lost and disorientated in what will be a highly complex building.

12.5.3 With a single and direct route up from the under croft car park below, the *Winter Garden* will provide the starting point for visitors and patients to begin the decision making process of their journey. With clearly defined lifts up to the ward floors and specific public lifts down to the clinical floors the reduced choices should make journeys easier and less stressful.

12.5.4 The Trust is working closely with The Hospital Company to ensure that the way finding ties in with the arts strategy for the hospital, allowing more illustrative and graphic depictions to represent routes rather than presenting visitors and patients with wordy signage which can often be more confusing.

Figure 24: Separation of Flows



12.5.5 The separation of flows will improve patient privacy and dignity and remove the need to travel in lifts alongside back of house activities.

12.6 Safety and Security

12.6.1 The Hospital Company has developed a robust approach to security in accordance with the Trust Brief.

Site-wide Security

12.6.2 Vehicle and pedestrian signage and control systems around the site will ensure that areas which are accessible by the public and those which are intended for staff / authorised personnel are clearly identifiable and demarcated.

12.6.3 Access to the Emergency Department forecourt via Grove Lane will be a blue light route for emergency vehicles. Emergency public drop-off to the department and the Delivery Suite will be also be provided. These drop-off areas will be strictly controlled and monitored.

12.6.4 Landscaping has been designed to act as a deterrent to unauthorised access using defensive planting in lieu of barbed wire to provide an equally effective but less aggressive approach. The selection and position of trees and low level planting will be designed such that there are no hiding places or blind spots in the security and CCTV system.

12.6.5 The building has been designed to support safety and security as follows:

- The number of entrance / egress points has been reduced to a minimum;

- Isolated areas, recesses and hiding places have been avoided to promote natural surveillance and create a feeling of safety for building users; and
- Low lying flat roofs and scalable facades with exposed rainwater pipes have been avoided.

12.6.6 The design meets security standards for access / egress / escape points, windows and alarm systems.

12.6.7 Out of hours access will be controlled by the security base adjacent to the Emergency Department reception area.

Staff and Visitor Car Park

12.6.8 The staff and visitor car parks will be accessible 24 hours a day.

12.6.9 Staff and public parking will be segregated and will be controlled via access barrier systems and separate entrances. CCTV coverage will be provided throughout the car parks.

12.6.10 Car parking has been designed to create an environment that is well lit, non-threatening and with clear and direct way finding methodology.

12.6.11 Cycle parking / stores are also designed to be safe, secure, undercover and with natural surveillance

External Access Controls

12.6.12 The main entrance will be accessed through automatic opening doors from the car park during normal operating hours. Video entry linked to the security room will be used for out of hours access and proxy card access will be used for staff. CCTV will be provided with link back to Security Room.

12.6.13 The Emergency Department entrance will be accessed through automatic opening doors 24 hours a day. CCTV will be provided with link back to the security room.

12.6.14 The Maternity entrance will be accessed through access controlled doors with video entry linked to the Maternity Department and proxy card access will be used for staff. CCTV will be provided with link back to the security room.

Security Zoning

12.6.15 Five security categories have been defined as follows:

- **Public spaces,** freely accessible to the staff and public including the visitor car park and emergency department entrance;
- **Public spaces which will be access controlled out of hours** including the *Winter Garden*, public circulation cores etc.;
- **Semi-public spaces,** which will be access controlled public areas;
- **Semi-private spaces,** which will be controlled / escorted access for visitors and patients; and
- **Private spaces**, which will be controlled access, staff only, areas.

12.6.16 This has facilitated design of robust and proportionate security arrangements in all areas of the hospital. Access control systems utilising proximity readers will be installed at the entrances to key areas / departments in line with zoning arrangements.

12.7 Accessibility

12.7.1 The master plan has been developed to focus on the simplicity of the routes into the building from both the car park and t*he Green* directly into the *Winter Garden*. The *Winter Garden* provides the main circulation hub from where lifts, which are clearly visible from within the space, will take visitors and patients to their intended destination. The intention is that from the *Winter Garden* by looking up visitors will be able to see routes to the wards and other areas, making the return journey easier.

12.7.2 Having a single point of access up to the *Winter Garden* has allowed drop off positions to be located close by and in most cases undercover. The whole ingress and egress strategy for the building should be simple to understand and remember.

12.8 Future Proofing and Flexibility

12.8.1 Where clinically possible a generic design has been used for clinical accommodation to facilitate future change in use. This includes adult inpatient wards having a generic design and layout. This approach allows future flexibility in terms of which specialties can be accommodated in wards.

12.8.2 Within the Operating Theatre Department The Hospital Company has worked with the Trust's team to demonstrate how three of the operating theatres can be converted to fully integrated theatres including use of robotic surgery.

12.8.3 Internal strategically embedded soft expansion space has been included within or adjacent to key clinical departments to allow for future localised expansion or change of use. This includes:

- An expansion floor template on Level 9 that can be converted to 3 generic wards but could also be used for other functionality such as outpatients.
- Two areas of expansion within the Imaging Department have been provided - one for more general imaging e.g. plain film and one for specialist modality expansion such as magnetic resonance imaging (MRI) or computerised tomography (CT). Externally, but immediately adjacent to the Imaging Department is provision for mobile clinical vehicles such as CT scanners. This allows not only for future use whilst static equipment is being replaced but also use of mobile equipment as technology develops or becomes more available e.g. mobile positron emission tomography (PET) scanner.
- Adjacent to recovery within the Operating Theatre Suite but in close proximity to the Integrated Critical Care Unit is expansion space that could be used for an additional operating theatre and support rooms, recovery expansion or an 8 bed level 1 unit.
- Within the Delivery Suite is space that can be used for additional delivery rooms in the future.
- Clinical administration zones are provided on all floors and on clinical floors located in zones such that in the future they could be converted to clinical use facilitating expansion of neighbouring clinical departments e.g. Integrated Critical Care Unit.

12.8.4 In all of these areas The Hospital Company has demonstrated how the space can be laid out or converted for operational use.

Operational Flexibility

12.8.5 There are additional flexibilities in operational practice that could facilitate additional capacity as described in the following sections.

Neonatal Unit

12.8.6 If additional neonatal capacity was required the first option would be transfer of cases within the Neonatal Network (as is current practice). There would also be the option to use the four transitional care rooms as single cot nurseries either on a temporary or permanent basis.

Children's Inpatient Unit

12.8.7 There is flexibility in capacity between paediatric inpatient beds, the Paediatric Assessment Unit and day case area (all co-located on the Children's Inpatient Unit).

Delivery Suite

12.8.8 There is flexibility in capacity within the Delivery Suite between high risk delivery rooms, the birthing centres and the bereavement rooms (as is current practice).

Operating Theatres

12.8.9 For emergency cases there is some flexibility within the planned capacity as demand was rounded up in the modelling to ensure adequate 24/7 capacity and hence there is a lower utilisation rate.

12.8.10 For elective cases there is some flexibility within the planned capacity as there was a rounding up in the modelling to allow flexibility for longer lists as the complexity of surgery increases and to ensure the required range of specialist theatres. An additional capacity of 49 elective sessions per week can also be created by introducing routine three session days Monday-Friday and two sessions on a Saturday.

Outpatient Clinics

12.8.11 Additional capacity for Antenatal Clinics and Paediatric Clinics can be created through planning routine weekend sessions (3 additional sessions per room per week in each department).

Medical Day Case, Interventional Radiology, Endoscopy and Sickle Cell and Thalassemia Unit

12.8.12 In recognition of the evolving nature of clinical practice within these departments and the on-going shift from inpatient to ambulatory care (including for emergency conditions), these departments have been collocated in a way that will allow them to function in any one of these ways:

- As discreet departments;
- As one integrated department; or
- Flexible use of facilities in line with changing demand.

12.8.13 In particular, the admissions and recovery rooms are based on a generic design and are co-located to allow flexibility in use between the zones. In addition these rooms have the required bed head provision to support Integrated Critical Care Unit (Level 2) patients if required for temporary additional capacity or as a decant facility.

Emergency Department / Surgical Assessment Unit /Ambulatory Zone of the Acute Medicine Unit

12.8.14 These departments have been co-located and designed to allow flexibility in use of the capacity. The ambulatory zone of the Acute Assessment Unit can be used as a temporary minors facility for the

Emergency Department (e.g. if required to segregate flows in a pandemic influenza scenario or a major incident). In addition The Hospital Company has demonstrated how the chaired wait in the ambulatory zone could be converted into a bed or trolley assessment area (based on the generic 4 bed bay template with en-suite).

Option for installation of Automated Guided Vehicles (AGVs)

12.8.15 The Trust has required that the bidder solution is such that AGVs can be used for the movement of goods and waste without crossing public flows and minimising cross over with clinical flows. The brief was that the solution is 'AGV ready' to leave the Trust with the option of fitting AGVs should it wish to do so. The design solution can therefore be used with or without AGVs.

12.8.16 The Trust is evaluating whether or not to procure AGVs. Potential benefits of AGVs include:

- Reduced manpower requirement for moving supplies, materials and waste (back of house logistics) around the hospital;
- Availability of AGVs can be 24 hours a day, 7 days per week;
- They enable FM activities to be scheduled outside normal working hours at no additional cost to improve the Trust's operational efficiency; and
- Reduced risk of accidental damage to the hospital fabric as AGVs will not collide with doors or walls.

12.8.17 Planning for the future allows for changes and unforeseen events in operational requirements over the longer term.

12.8.18 The bidder has provided an additional variant bid to accompany the Draft Final Bid which includes the provision of AGVs and the associated infrastructure. This provides the Trust with the option of a fully integrated design which ensures that a working solution will be available from day one of operations. The additional capital cost of this variant bid is £3.65m and the increase in the first year UP is £287K per annum. There would be an additional ongoing maintenance charge of circa £100K per annum which the Trust would pay directly.

12.8.19 A value for money assessment is being undertaken by the Trust, taking into account the above benefits, the investment required and the training implications for FM staff. In addition the Trust is testing that the solution is compliant with the latest guidance on stock control from the DH.

12.8.20 If the Trust decides that the AGV variation is value for money, the scope will be changed for the Final Bid.

12.9 The Generic Ward

12.9.1 The generic adult inpatient ward design provides the Trust's brief of 50% single bedrooms and 50% of beds in 4 bed bays. This also meets the feedback received from patients in terms of having a choice of single rooms or 4 bed bays especially for older patients who might feel isolated in single rooms. The design will allow excellent observation into all bedrooms through the use of touch down spaces (as opposed to central staff bases) and viewing panels. This will allow patients good observation of staff and the corridors as well as facilitating staff to monitor and support groups of 4 or 8 beds in line with agreed staffing ratios.

12.9.2 The retention of a generic ward layout follows lean principles for staff and, in particular, staff with transient work patterns, e.g. junior medical staff, therapists and facilities staff, in terms of locating room types etc.

12.9.3 Each inpatient bed will have an adjacent vertical medi-rail for attaching monitoring and clinical equipment (such as infusion pumps) so allowing flexibility in use of the bed and reducing the need for additional mobile equipment adjacent to the bed. Each inpatient bed space will have an overhead H-track for patient hoists allowing the Trust flexibility to add a hoist in any bed location.

12.9.4 The majority of generic adult inpatient wards will be located on levels 6-8 with 3 on each of these levels. The clinical lifts for bed transfers / movements will be located at one end of these wards allowing easy access. The facilities lifts will also be located at this end of the ward but in a dedicated zone away from the clinical lifts. Similar principles apply to the generic adult wards located on podium floors.

12.9.5 Each generic ward will have good access to local shared staff facilities including changing rooms, seminar room and staff rest room with the latter having external views. Entrance to these zones on levels 6-8 will be via the clinical and facilities entrance to the ward and so separate to the public entrance.

12.9.6 The design will also facilitate the experience for visitors to wards. Each ward will have a dedicated visitor hub (on levels 6-8) or access to a shared visitor hub with similar clinical departments (on podium floors). Each hub will be centred around a public lift with signposting to this from the *Winter Garden* on level 5. Each visitor hub will include toilet provision, a water dispenser and seating. At the entrance to each ward there will be a welcome point for visitors. Visitor entrances will be at the opposite end of the ward to the clinical and facilities entrance.

12.9.7 As shown in the figure below the internal ward corridors will have an open feeling as a result of the recessed entrances to the single rooms. In addition to the quiet day room the design has delivered a recess / breakout area in the middle of the ward with an external view which also allows external light into the corridor.

Figure 25: Generic Ward: Recessed Room Entrances

12.9.8 Some wards require a suite of specialist rooms. These rooms will follow generic design principles (e.g. based on a procedure room) and will be located at the clinical and facilities entry end of the ward so allowing future flexibility in use of the ward.

12.9.9 On the Gynaecology (for the Emergency Gynaecology Assessment Unit) and Stroke (for Transient Ischaemic Attack (TIA) patients) Wards these specialist rooms will require access for ambulatory patients and their carers / relatives often as a result of an urgent or emergency referral. These wards will therefore be located on level 6 to allow the podium public lifts to extend to the wards. The lifts will arrive in an additional small visitor hub for each of these zones. This location will also allow easy access to these facilities for patients referred from the Emergency Department, Acute Assessment Unit or Surgical Assessment Unit and (for Transient Ischaemic Attack (TIA) patients) easy access to imaging facilities.

Standard Bedroom Design

12.9.10 The single bedrooms will be located along a main internal corridor to the ward. The layout of the single bedroom, with the bed head at an angle, will allow patients easy views into the internal ward corridor and externally. This will reduce the feeling of isolation for patients within these rooms whilst retaining privacy and dignity.

Figure 26: Standard Bedroom Design

12.9.11 The entrance to the en-suite bathroom will be located on the same side as the bed head with a grab rail between the bed and en-suite door. This should reduce the risk of patient falls.

12.9.12 This layout has been used for all single bed rooms even if the ward layout has varied (including children's inpatient beds and the Acute Assessment Unit).

12.9.13 The single room and en-suite layout has been mocked up at various stages during dialogue to enable testing with a wider group of clinical and facilities staff. The level of mock-up has developed from taping out at initial stage to full physical mock up prior to draft final submission.

12.9.14 The Trust brief is for a single room at 17 m^2. This is below the current HBN recommendation of 19 m^2. The Trust constructed a mock up to test the functionality prior to going to market and it was agreed as clinically functional by clinicians.

12.9.15 The Hospital Company proposal is for a room at 15.7 m^2. Their initial proposal was rejected by the Trust because of poor observation. The current design, although a further derogation on HBN, has

excellent observation. The Hospital Company has mocked up a single room in this design and over fifty clinical staff have viewed it. The consensus is that it is well liked and functional.

12.10 Car Parking

12.10.1 The Hospital Company has developed a solution which removes visitor parking from view, and places it all in a well-lit, secure and undercover location beneath the hospital. It provides easy access to the lifts, along with drop off, and is immediately adjacent to the hospital entrance and the main circulation hub.

12.10.2 Therefore, the only vehicles accessing the main entrance will be buses which will give an unobstructed view of the hospital.

12.10.3 Integrated parking is a feature of many overseas hospitals, but is not frequently seen in the UK. However, it is a recognised feature of many contemporary airport and shopping centre designs and therefore familiar to the public.

12.10.4 A key benefit to an integrated car park is that it provides both staff and patients with parking close to the hospital, whilst retaining separate entrances for each. It also automatically creates a vertical focus for staff and visitor movement. To aid orientation, in the MMH this vertical circulation will be deliberately highlighted from both outside and inside the hospital. The design also enables flexibility in designating staff and visitor parking numbers.

12.10.5 The Trust will be responsible for parking payment, access and barrier systems.

12.11 Open Spaces

12.11.1 The *Green* at the front of the hospital offers an opportunity for a variety of events and activities, encouraging the wider community to come together and populate the space.

Figure 27: Open Spaces

12.12 Technical Design confirmation

12.12.1 The Trusts' advisors have reviewed all aspects of the design including those described in this chapter and technical issues such as the adequacy of plant space. At the request of DH they have produced a report which concludes that:

'The Trust's Technical Advisory Team is comfortable that the building envelope set out in the single bidder's design is adequate to meet the brief set out in the Trust Construction Requirements.'

That report is included at ***Appendix 12a***.

12.13 Construction

12.13.1 The construction programme includes a two month period of advanced works prior to financial close for site set up works and accommodation, cut and fill to create formation levels and laying of the piling mat to allow piling works to commence immediately post Financial Close. The extent of the works will not affect the value of the site in a no scheme situation

12.13.2 The overall construction period is 33 months and includes beneficial access for the Trust to install and commission equipment and IT services

12.13.3 The building is designed to sit within the natural contours of the site which may require a substantial amount of ground works, which the bidder is seeking to reduce by adjusting levels accordingly. The agreed section 106 and 278 agreements with Sandwell Metropolitan Borough Council planning department will remain unchanged from the outline planning approval.

12.13.4 The building is designed to support a fast track construction by using pre-cast frame for the podium levels with a steel frame for the ward levels which allows both speed of construction and design flexibility. The plan is for multiple work areas to be created to allow parallel working to keep the construction programme as short as is practicable, bearing in mind this hospital will be one of the shortest build programmes in the UK.

12.13.5 Off-site component manufacture will be maximised to:

- Support the construction programme by craning in completed components e.g. bathroom pods and services units;
- Reduce on-site activity to minimise the impact of the construction works on the local community; and
- Allow robust quality control systems to be used in the factory setting.

12.13.6 The location of the new hospital occupies a site which is served by dual carriageway from junction 1 of the M5 which further reduces the impact of the construction works on the local community.

12.13.7 Detailed work will be undertaken to develop the beneficial access arrangements as a coordinated programme with the equipment supply.

12.14 Facilities Management

Soft Facilities Management (FM) Services Strategy

12.14.1 The approved OBC set out the outcome of the VfM assessment undertaken in respect of the soft FM services. The overall conclusion was that to achieve the same specification in respect of core soft FM services, including cleaning, catering and portering the PF2 route does not provide VfM or flexibility of the service. Soft FM services do not therefore form part of the scope of the contract.

12.14.2 All of the soft FM services are currently managed in-house with the exception of the Laundry and Linen Service. The Trust construction requirements set out the PF2 partner's responsibilities for the facilities required for these services and the equipment responsibility matrix provides this information for equipment.

12.14.3 The Trust is aware of the potential for issues to arise at the interface between soft FM services and the PF2 partner. The Trust will work with The Hospital Company to ensure respective responsibilities are clearly set out. For example, domestic cleaning services will be carried out in accordance with accepted practice. The Hospital Company will be expected to identify any specific considerations that their solution may require and how these may be managed.

12.14.4 The Hospital Company has developed design solutions that allow for installation of an Automated Guided Vehicle (AGV) System. The system delivers a return on investment by reducing labour and inventory costs, eliminating time wasted looking for supplies, and improving efficiency. The automated transportation of materials and supplies in the hospital frees up staff time, allowing them to spend more time in direct contact with patients.

12.15 Sustainability

12.15.1 It is a requirement of the Trust to raise the profile of operational energy and environmental management in order to improve performance in these areas. As the impact of the new facility will be influenced by both the activities of those operating the building and those occupying the building, it is recognised that the minimisation of such impacts will be as a result of partnerships.

12.15.2 Reducing the carbon footprint and energy consumption together with resulting emissions is of paramount importance to the Trust. The Trust requires a solution capable of achieving energy consumption of not greater than 42GJ/100m^3.

12.15.3 The BREEAM (Building Research Establishment Energy Assessment Model) assesses many criteria including sustainability management; waste from construction and in use, water, materials and transport. The mandated score of Excellent will drive out a fully comprehensive sustainability package including the ENE01 reduction of admissions standard.

12.15.4 Combined heat and power and ground source cooling using the local aquifer will form the basis of sustainable energy.

12.15.5 The planning application is accompanied by a Green Travel Plan which is required to generate modal shifts in transport to support sustainability. The local bus operator, Centro, have agreed to divert bus routes onto the site and the site is also served by public footpaths and cycle ways linked to the wider Birmingham and Sandwell network

Community

12.15.6 The MMH is a once in a lifetime opportunity to boost the economic prospects of the Smethwick and wider Sandwell and Birmingham area. It will make a positive difference to the development of Birmingham and Sandwell's local communities, enabling them to further thrive and prosper through a

Supply Chain and Employment Framework. The Hospital Company has great experience in creating employment and skills opportunities. Coupled with the Trust's understanding of the needs of local communities, the project will make a significant and positive contribution to the region's economic regeneration.

12.15.7 The Hospital Company's supply chain will act as a catalyst for long term employment and economic regeneration in the local region. They will achieve 80% of project spend with supply chain and will achieve 70% local employment on the MMH from within the Midlands and achieve 50% from the B postcode.

12.15.8 Diversifying and localising the supply chain benefits the area through:

- Monitoring supplier diversity and local supply chain performance;
- Making diverse and local suppliers aware of relevant opportunities to provide services;
- Removing barriers that prevent local or diverse suppliers applying for work;
- Encouraging the supply chain to use local and diverse suppliers; and
- Maximising local spend and employment, including spend with small and medium sized enterprises (SMEs) measured as a percentage of contract turnover.

12.15.9 The Hospital Company is a signed up member of the Birmingham Business Charter for Social Responsibility and are committed to achieve positive outcomes against the following standards:

- Local Employment;
- Buy Birmingham First;
- Partners in the Community;
- Good Employer;
- Green and Sustainable;
- Ethical Procurement.

12.15.10 They will procure local first and most importantly pay the National Living Wage. They will encourage subcontractors to promote work opportunities in the region. Each section of The Hospital Company's operations and the supply chain will commit to this from contract award to completion.

The Virtual Hospital Portal Tool

12.15.11 The Virtual Hospital Portal Tool is vital to promoting, pricing and giving access to the supply chain partners to facilitate development of comprehensive quotes. The tool will complement The Hospital Company's approach to:

- Attracting local businesses and suppliers within the community; and
- Gathering information on who has registered interest, their geographic location and scope of provision.

12.15.12 The Hospital Company will impose upon the Tier 1 (with NG Bailey the mechanical and electrical (M&E) partner in full support) subcontractors that they use the Virtual Hospital Portal Tool both for their pre-contract pricing, but also as a tool for recruitment of local Tier 2 and 3 supply chain partners.

Supply Chain Support:

12.15.13 The Hospital Company is committed to working in partnership with the Trust and the local authorities by inviting a minimum of 2 organisations from the region to be included on the list of organisations invited to tender or submit a price for works, services or supplies, where suitable organisations exist.

12.15.14 From the outset localism in procurement and supply within the Midlands will be promoted. The Hospital Company will consider each package individually and establish the most appropriate route of procurement whether this be a labour, plant and materials (full package), labour only, supply only etc. through interaction with the market in *Meet the Buyer* events. Having such a procurement strategy ensures a healthy supply chain which engages niche local specialists.

Procurement Efficiency Workshops for Small and Medium Sized Enterprises (SMEs)

12.15.15 To develop the local supply chain The Hospital Company is seeking to host workshops for Small and Medium Sized Enterprises on procurement efficiency in the supply chain led by a Chartered Institute of Procurement and Supply (CIPS) expert.

Job Creation

12.15.16 The Planning Manager, Community Regeneration Manager and subcontractors will provide labour forecasts highlighting all vacancies and training opportunities on site. Through the Talent Match initiative, the Employment Steering Group will work with:

- Birmingham City Council's *Building Jobs for Birmingham*;
- Sandwell Metropolitan Council's *Think Sandwell*; and
- The Trusts Learning Works on Unett Street to recruit locally to the site.

12.16 Conclusion

12.16.1 The Bidder Solution presents an exciting landmark building that responds to the Design Vision and Functional Brief. Clinical staff have been involved in every stage of the design process to ensure that the MMMH will deliver the model of care with flexibility for future use.

12.16.2 The design has maximised the use of a constrained site and The Hospital Company has engaged with the planning department to ensure that it has retained good fit with local plans.

12.16.3 The construction timescales have been minimised through the use of advanced works and use of fast track construction methodologies.

12.16.4 This solution will deliver the full range of benefits anticipated for the project and represents a bright future for acute healthcare in Sandwell and west Birmingham.

13 Affordability

13.1 Introduction

Key Messages

13.1.1 The scheme is affordable as demonstrated by the consistent achievement of Continuity of Service Risk Rating (CoSRR) level 3 ratings across the period of the LTFM. Estates costs are also consistently within the 12.5% test limit.

13.1.2 The trust delivered a 2014/15 surplus ahead of plan.

13.1.3 The downside case stress tests the plan including with early years impact bias. Mitigation identified suggests that affordability stands that scrutiny with impact of a reduction to CoSRR level 2 in the first two years of operation

13.1.4 The scheme is aligned with commissioner plans including Better Care Fund aspirations and remains consistent with RCRH strategies

13.1.5 CIP is consistent with national efficiency requirements reflecting assumptions of cost inflation and price deflation. The additional net investment in the scheme is the equivalent of circa one additional year of that efficiency and is specifically enabled by delivery of the RCRH service changes. The trust contends that the scale of opportunity for operational productivity and service transformation driven cost change is consistent with that required to underpin scheme affordability

13.1.6 The case includes necessary and sufficient investment in key enabling and supporting infrastructure and specifically informatics including EPR, retained estate and medical equipment. Fixed imaging equipment investment is assumed to be delivered through a Managed Service Contract. The revenue costs are reflected in full in the LTFM supporting the case.

13.1.7 The anticipated unitary payment reflects updated terms and represents a significant improvement on those at OBC. This case retains that improvement as affordability headroom.

13.1.8 The base case assumes £100m of Public Dividend Capital investment.

13.1.9 Land sale proceeds are specifically excluded from the base case and dealt with as potential mitigation in the downside case.

13.2 Key assumptions

13.2.1 Changes since the OBC was approved in July 2014 include:

- Updating the base year of assessment to 2014/2015 and including the Financial Plan for 2015/2016 as year 1 within the LTFM;
- Incorporating an updated Unitary Charge assessment resulting from the preferred bidder submission; the improvement arising from this is retained as affordability headroom;
- Retains an assumption of £100m Public Dividend Capital (PDC) investment and with a revised profile aligned to the proposed build programme;
- Update of cost inflation and cost efficiency assumptions having regard to published regulator guidance; and

- Maintains delivery of a 3 Risk Rating under the "Continuity of Service Risk Rating" metric.

13.2.2 A coherence of top line income, revenue surpluses, capital investment and balance sheet management consistent with sustaining a CoSRR level 3 and providing for meaningful downside mitigation.

13.2.3 The financial planning parameters also include a necessary and sufficient non PF2 internal capital programme covering MMH equipment and refurbishment of the buildings that will become the Trust's community facilities. A managed service contract provides for that investment necessary in fixed imaging equipment.

13.2.4 The financial models and assumptions used in support of the LTFM derive much of their input from the RCRH activity trajectories which are integrated with the Trust's operational plans. Coherence with RCRH principles and strategies has been reviewed and confirmed.

13.2.5 The case confirms the approach to build up of a reserve which is applied non recurrently in the period to new hospital commissioning to enable transformation and then to underpin payment of the Unitary Charge. By utilising these resources on a non-recurrent basis the Trust will be able to fund any additional costs during the transition. From 2018/19 the costs associated with the MMH, and in particular the PF2 unitary payment, are included within the model and are funded from within internally generated sources.

13.2.6 The LTFM demonstrates that the MMH is recurrently affordable and that the overall CIP requirement is marginally greater than current Monitor CIP assumptions.

13.3 MMH Capital Costs

The bidder cost of construction of £291.8m, (including recovery of bidder costs) in contained within the Unitary Payment. The PF2 solution provides for a GIFA of 78,828 m2.

Capital Charge Implications

13.3.1 Capital charges for the existing estate are forecast to reduce commensurate with the intended disposal of most of the City Hospital site and some of the Sandwell Hospital site. This is compensated by the depreciation charge for MMH reflecting the capital cost of the new hospital and the need to equip the new facilities to appropriate standards.

13.3.2 In calculating the capital charges within both the PSC and PF2 options a judgement of a revised 10% impairment of the initial MMH capital build cost has been included. This is consistent with Trust past experience in District Valuer (DV) valuations of significant capital builds including the BTC and the Emergency Care Facility at Sandwell Hospital and is more cautious than the OBC position given the upward trend in asset valuations witnessed in 2014/2015.

13.3.3 Depreciation within the affordability assessment has been calculated based upon an impaired asset value of £269m and PDC interest calculations have been undertaken assuming £100m drawn down of Public Dividend Capital. The table below analyses forecast depreciation movements by site in 2014/15 and from 2017/18 to 2019/20.

Table 68: Depreciation by Site

Depreciation by site		Year			
Site	Asset Type	2014/15	2017/18	2018/19	2019/20
BMEC Sheldon	Buildings	(390)	(515)	(505)	(611)
	Information Technology	0	0	0	0
	Intangible Assets	0	0	0	0
	Plant and Machinery	0	(157)	(166)	(184)
	Subtotal	**(390)**	**(673)**	**(671)**	**(795)**
BTC	Buildings	(552)	(608)	(625)	(671)
	Information Technology	0	0	0	0
	Intangible Assets	0	0	0	0
	Plant and Machinery	0	(100)	(100)	(146)
	Subtotal	**(552)**	**(708)**	**(725)**	**(818)**
City Hospital	Buildings	(2,575)	(2,922)	(201)	(307)
	Dwellings	(11)	(11)	0	0
	Furniture and Fittings	(138)	(152)	(52)	(50)
	Information Technology	(944)	(871)	(426)	(420)
	Intangible Assets	(179)	(9)	(3)	0
	Plant and Machinery	(3,447)	(2,732)	(885)	(942)
	Transport and Equipment	(13)	(7)	(7)	(4)
	Subtotal	**(7,307)**	**(6,703)**	**(1,572)**	**(1,724)**
MMH (Grove Lane)	Buildings	0	0	(3,700)	(4,933)
	Furniture and Fittings	0	0	0	(50)
	Information Technology	0	0	(150)	(300)
	Plant and Machinery	0	0	0	(64)
	Project Cost	0	(59)	0	0
	Subtotal	**0**	**(59)**	**(3,850)**	**(5,348)**
Rowley Regis	Buildings	(387)	(452)	(467)	(530)
	Information Technology	0	0	0	0
	Plant and Machinery	(29)	(60)	(95)	(131)
	Subtotal	**(416)**	**(512)**	**(562)**	**(661)**
Sandwell	Buildings	(2,894)	(2,855)	(2,110)	(2,098)
	Dwellings	(33)	(33)	0	0
	Furniture and Fittings	(15)	(15)	(15)	(15)
	Information Technology	(523)	(1,794)	(2,242)	(2,914)
	Intangible Assets	(58)	(42)	(33)	0
	Plant and Machinery	(1,019)	(911)	(447)	(462)
	Transport and Equipment	(155)	(175)	(129)	(78)
	Subtotal	**(4,698)**	**(5,825)**	**(4,976)**	**(5,567)**
TOTAL	Buildings	(6,799)	(7,352)	(7,607)	(9,150)
	Dwellings	(44)	(44)	0	0
	Furniture and Fittings	(154)	(168)	(67)	(116)
	Information Technology	(1,467)	(2,665)	(2,818)	(3,634)
	Intangible Assets	(237)	(51)	(35)	0
	Plant and Machinery	(4,495)	(3,961)	(1,693)	(1,930)
	Transport and Equipment	(168)	(182)	(135)	(82)
	Project Cost	0	(59)	0	0
	Total	**(13,363)**	**(14,481)**	**(12,356)**	**(14,911)**

13.3.4 The table below shows the change in estate footprint in 2014/15 and 2019/20.

Table 69: Change in Area by Site

Change in area by site, 2014/15 to 2019/20								
Site		City	Sandwell	Rowley	BMEC / Sheldon	BTC Incl Archway	Grove Lane	TOTAL
Area (m^2)	2014/15	65,727	60,726	8,736	11,761	12,600	0	**159,550**
	2019/20	1,254	28,000	8,000	11,736	12,600	78,828	**140,418**
Change in area	Area (m^2)	-64,473	-32,726	-736	-25	0	78,828	**-19,132**
	Percentage	**-98%**	**-54%**	**-8%**	**0%**	**0%**	-	**-12%**

Impairment

13.3.5 The existing fixed asset bases of the City, Sandwell and Rowley sites are reduced via impairment to reflect the change in area. A proportion of this write down is charged to the Trust Revaluation Reserve and the balance forms a charge against expenditure in 2017/2018 (circa £84m).

13.3.6 City and Sandwell site land assets are assumed to be retained across the period of the LTFM. Any prospective land sales in respect of that retained estate are excluded from the base case and likely modest with any realisation necessarily post hospital opening..

13.3.7 The impairment value (presented in the table below) in 2018/2019 reflects the reduction in asset valuation based upon the PF2 scenario. In this case, the construction cost is assessed at a lower value to the PSC as the PF2 contractor is able to reclaim VAT.

Table 70: Forecast Impairments by Site

	Site	Year 2017/18	Year 2018/19
Impairment Charges to the Expenditure Position	City Hospital	(43,024)	0
	MMH (Grove Lane)	(7,514)	(29,700)
	Rowley Regis	(655)	0
	Sandwell	(33,448)	0
	TOTAL	(84,641)	(29,700)
Impairment Charges to the Revaluation Reserve	City Hospital	(11,879)	0
	MMH (Grove Lane)	0	0
	Rowley Regis	(719)	0
	Sandwell	(9,006)	0
	TOTAL	(21,603)	0

Trust Capital Programme

13.3.8 The plan includes necessary and sufficient capital investment in key enabling and supporting infrastructure and specifically informatics including EPR, retained estate and medical equipment. Fixed imaging equipment investment is assumed to be delivered through a Managed Service Contract.

13.3.9 The table below summarises the Trust's Capital Investment Plans across the next ten years.

Table 71: Capital Investment Plan

Maximum Capital Investment Trajectory	2015/2016 MMH Modelled	2016/2017 MMH Modelled	2017/2018 MMH Modelled	2018/2019 MMH Modelled	2019/2020 MMH Modelled	2020/2021 MMH Modelled	2021/2022 MMH Modelled	2022/2023 MMH Modelled	2023/2024 MMH Modelled	Modelled Timeline
Slippage of 2014-2015 Schemes	2,000	0	0	0	0	0	0	0	0	2,000
Land	1,600	500	0	0	0	0	0	0	0	2,100
Capitalised Salaries & Slippage	500	500	500	500	500	250	250	250	250	3,500
Statutory Standard	1,500	1,500	1,000	550	1,000	1,000	1,550	1,550	1,550	11,200
Strategic Investment - CQC Related Implementation Plan	750	0	0	0	0	0	0	0	0	750
Contingency	0	0	0	0	0	0	1,000	1,000	1,500	3,500
Sub Total	6,350	2,500	1,500	1,050	1,500	1,250	2,800	2,800	3,300	23,050
Retained Estate Refurbishment	3,287	2,087	2,087	2,739	7,877	6,218	-	-	-	24,295
Site Demolitions	780	780	1,830	780	-	-	1,050	-	-	5,220
City Site Demolitions before Sale.	-	-	-	-	-	-	-	-	-	0
Sub Total Retained Estate	4,067	2,867	3,917	3,519	7,877	6,218	1,050	0	0	29,515
IM&T Investment Routine	4,490	525	800	750	500	350	0	0	0	7,415
IM&T-EPR & MMH	606	6,622	8,099	1,366	100	1,122	1,309	1,000	900	21,124
Sub Total IM&T	5,096	7,147	8,899	2,116	600	1,472	1,309	1,000	900	28,539
Medical Equipment	2,326	3,076	3,585	3,007	4,126	4,126	4,126	4,426	4,426	33,224
MMH Specifics	2,169	1,653	1,818	1,848	-	-	-	-	-	7,488
Discount for Imaging MES	-	(1,500)	(1,133)	(1,940)	(0)	(1,780)	(80)	(70)	(700)	(7,203)
Sub Total Medical Equipment	4,495	3,229	4,270	2,915	4,126	2,346	4,046	4,356	3,726	33,509
Revised Capital Programme Position	20,008	15,744	18,586	9,600	14,103	11,286	9,205	8,156	7,926	114,612

13.3.10 The Imaging equipment targeted to be provided under MES conditions includes the following.

Table 72: Imaging MES

	2016/2017 MMH Modelled £000's	2017/2018 MMH Modelled £000's	2018/2019 MMH Modelled £000's	2019/2020 MMH Modelled £000's	2020/2021 MMH Modelled £000's	2021/2022 MMH Modelled £000's	2022/2023 MMH Modelled £000's	2023/2024 MMH Modelled £000's	Modelled Timeline £000's
Imaging Equipment Supplied via MES (Inc BTC MRI)	2,300.0	3,000.0	10,800.0	-	1,800.0	70.0	80.0	800.0	18,850.0

13.3.11 The depreciation forecasts include the consequences of the Trust's internal Capital Programme.

13.4 Approach to Affordability Modelling

The Affordability Assessment Process

13.4.1 The affordability modelling starts from a refreshed baseline of the Trust's operational forecast outturn for 2014/2015 based upon final service delivery plans and LDP agreements with CCGs. Alongside this outturn the Trust has developed its detailed plans for 2015/2016. It is from this base that future activity, investment, cost and workforce models have been projected.

13.4.2 The process has been developed to dovetail with Monitor's Long-Term Financial Model (LTFM) such that three LTFMs have been developed:

- A version that translates the effect of the PF2 process and reflects affordability under PF2 conditions;
- A Downside PF2 Position; and
- A Mitigated Downside PF2 Position.

13.4.3 The Trust has a well-developed activity and capacity model which enables granular interpretation of future activity behaviour to create future patterns of activity. From this an assessment of future income streams and capacity requirements is generated.

13.4.4 Cost and workforce models are developed by taking a granular view of the Trust forecast outturn and modelling an assessment of how different areas will change with changes in assumed activity and capacity. Developments and efficiency are then layered on top of this baseline.

13.4.5 The affordability assessment process has included an evaluation of how each currently provided function might change for acute and / or community services. This has been achieved by the application of cost drivers (e.g. activity change, income, space, bed days, theatre minutes, and outpatient minutes), which most accurately forecast the likely long term impact on each function or service. Consideration is also given to the nature of current service costs and how these might vary with changes in service provision.

13.4.6 Specialised costs such as capital charges have been assessed separately to reflect both the impact of the MMH and the costs of developing and operating the community facilities on retained estate.

13.4.7 The Service Development Tabs (SDEVs) within the LTFM have been used to isolate key areas of development change fundamental to the case. Each analysis focuses on one key developmental theme, as follows

SDEV1 – Repatriation Opportunities

13.4.8 SDEV1 focuses upon market research opportunities assessed by the Trust and its host commissioner as activities, currently presenting at other providers, will be attracted to the Trust pre and post service reconfiguration. These activities will be blended within the core activities of the Trust and therefore a significant marginal investment gain is targeted.

13.4.9 This gain contributes to the affordability of the scheme over the timeline. Plans for 2015/2016 include a major step in this repatriation objective with £3m of investment targeted to be delivered at a 33% margin.

13.4.10 The trust has undertaken detailed demand and capacity modelling such that it should be confident this activity fits within planned capacity can reasonably be expected to be processed at the necessary level of productivity.

13.4.11 The table below summarises SDEV1.

Table 73: SDEV1 - Repatriation Opportunities

SDEV 1 - Repatriation Opportunities	2015/16 £000's	2016/17 £000's	2017/18 £000's	2018/19 £000's	2019/20 £000's	2020/21 £000's	2021/22 £000's	2022/23 £000's	2023/24 £000's
Total revenue	3,000	5,937	7,568	10,505	14,031	17,033	18,665	18,665	18,665
Employee Benefit Expenses	(1,784)	(2,454)	(2,576)	(2,868)	(4,321)	(5,631)	(6,072)	(6,072)	(6,072)
Drug expenses	(90)	(178)	(227)	(315)	(421)	(511)	(560)	(560)	(560)
Clinical supplies and services expenses	(90)	(178)	(227)	(315)	(421)	(511)	(560)	(560)	(560)
Other expenses	(36)	(71)	(91)	(126)	(168)	(204)	(224)	(224)	(224)
Total Expense	**(2,000)**	**(2,881)**	**(3,120)**	**(3,625)**	**(5,331)**	**(6,857)**	**(7,416)**	**(7,416)**	**(7,416)**
Margin	**1,000**	**3,055**	**4,448**	**6,880**	**8,700**	**10,175**	**11,249**	**11,249**	**11,249**

SDEV2 – Community Developments

13.4.12 SDEV2 reflects the expected significant service developments in community related services to underpin the RCRH strategy of care closer to home and significantly more of it provided in community locations. Priority areas will evolve over time to enable seamless integration between a reduced acute and an emerging community service. The table below summarises SDEV2.

Table 74: SDEV2 - Community Developments

SDEV 2 - Community Developments	2015/16 £000's	2016/17 £000's	2017/18 £000's	2018/19 £000's	2019/20 £000's	2020/21 £000's	2021/22 £000's	2022/23 £000's	2023/24 £000's
Total revenue	0	2,400	6,573	9,823	11,823	14,423	17,523	19,673	23,672
Employee Benefit Expenses	0	(1,940)	(4,890)	(6,837)	(8,740)	(9,913)	(11,739)	(14,196)	(16,874)
Drug expenses	0	0	(123)	(491)	(473)	(577)	(876)	(787)	(1,065)
Clinical supplies and services expenses	0	0	(123)	(491)	(473)	(577)	(876)	(787)	(1,065)
Other expenses	0	0	(432)	(982)	(946)	(1,875)	(2,278)	(1,967)	(2,367)
Total Expense	**0**	**(1,940)**	**(5,569)**	**(8,801)**	**(10,631)**	**(12,942)**	**(15,769)**	**(17,737)**	**(21,371)**
Margin	**0**	**460**	**1,004**	**1,022**	**1,192**	**1,481**	**1,754**	**1,936**	**2,301**

SDEV3 – Imaging Managed Equipment Service

13.4.13 One of the keys to success in enabling the RCRH Clinical Strategy is the provision of effective diagnostic services. A significant investment need has been highlighted in replacing and adding Imaging equipment. Since the MMH OBC was developed, an OBC Managed Equipment Service Business Case has been approved by the TDA. The aim of this case is to pass the provision of Imaging equipment to a third party through an MES contract and thus spread the investment need over a longer time frame, yet still ensuring the approach provides good value for money through the transference of risk and training. The model assumes an MES contract will be in existence from the beginning of 2016/2017. The table below summarises SDEV3.

Table 75: SDEV3 - Imaging Managed Equipment Service

SDEV 3 - Imaging Managed Equipment Service	2015/16 £000's	2016/17 £000's	2017/18 £000's	2018/19 £000's	2019/20 £000's	2020/21 £000's	2021/22 £000's	2022/23 £000's	2023/24 £000's
Clinical supplies and services expenses	0	(971)	(1,464)	(3,019)	(3,068)	(3,247)	(3,247)	(3,511)	(3,602)
Other expenses	0	0	0	(900)	(900)	(900)	(900)	(900)	(900)
Total Expense	**0**	**(971)**	**(1,464)**	**(3,919)**	**(3,968)**	**(4,147)**	**(4,147)**	**(4,411)**	**(4,502)**

SDEV4 – IM&T Investment Strategy

13.4.14 A further cornerstone to enable the Trust's objectives is 21st century informatics and support solutions, including a paperlite philosophy. Current IM&T infrastructure requires a significant overhaul to meet these objectives. An IM&T Strategy establishes a route to these objectives by analysing the steps into four components:

- Infrastructure resilience;
- EPR (including Clinical Wrap) replacement;
- MMH Specific Networking and hardware needs; and
- Other IM&T hardware and software solutions for business integrity.

13.4.15 The table below summarises SDEV4.

Table 76: SDEV4 - IM&T Investment Strategy

SDEV 4 - IM&T Investment Strategy	2015/16 £000's	2016/17 £000's	2017/18 £000's	2018/19 £000's	2019/20 £000's	2020/21 £000's	2021/22 £000's	2022/23 £000's	2023/24 £000's
Employee Benefit Expenses	(55)	(55)	(205)	(205)	(55)	(55)	(55)	(27)	(27)
Other expenses	(647)	(1,320)	(2,840)	(3,177)	(3,177)	(2,957)	(3,047)	(3,015)	(3,009)
Total Expense	**(702)**	**(1,375)**	**(3,045)**	**(3,382)**	**(3,232)**	**(3,012)**	**(3,102)**	**(3,042)**	**(3,036)**
Non Maintenance Capex									
Networking & Stabilisation	(4,490)	(525)	(800)	(750)	(500)	(350)	0	0	0
EPR Related	(556)	(3,872)	(5,959)	(416)	0	(1,122)	(1,309)	0	0
Non Direct EPR Related	(50)	(2,750)	(440)	0	0	0	0	(1,000)	(900)
MMH	0	0	(1,700)	(950)	(100)	0	0	0	0
Total Capex	**(5,096)**	**(7,147)**	**(8,899)**	**(2,116)**	**(600)**	**(1,472)**	**(1,309)**	**(1,000)**	**(900)**
Grand Total	**(5,798)**	**(8,522)**	**(11,944)**	**(5,498)**	**(3,832)**	**(4,483)**	**(4,411)**	**(4,042)**	**(3,936)**

13.4.16 The Trust Board has recently approved an EPR Business Case which is currently with the TDA for scrutiny. The additional cost need to enable this and the other three components of the strategy are outlined in SDEV4. Significant additional capital and revenue resources are built into overall affordability to enable delivery in this key area.

SDEV5 – Internal Developments

13.4.17 SDEV5 has been used to isolate those developments and contingencies where the trust has discretion. This includes the headroom generated as a consequence of the improved funding terms reducing the unitary charge.

Table 77: SDEV5 - Internal Developments

SDEV 5 - Contingencies including UP	2015/16 £000's	2016/17 £000's	2017/18 £000's	2018/19 £000's	2019/20 £000's	2020/21 £000's	2021/22 £000's	2022/23 £000's	2023/24 £000's
Employee Benefit Expenses	(750)	(750)	(750)	(750)	(2,000)	(3,750)	(4,500)	(5,250)	(6,000)
Clinical supplies and services expenses	(750)	(750)	(750)	(750)	(1,500)	(2,750)	(3,750)	(5,250)	(6,575)
Other expenses	0	0	0	(500)	(2,000)	(4,500)	(5,500)	(4,500)	(4,500)
Total Expense	**(1,500)**	**(1,500)**	**(1,500)**	**(2,000)**	**(5,500)**	**(11,000)**	**(13,750)**	**(15,000)**	**(17,075)**

13.5 Factors Influencing Affordability

13.5.1 The key factors influencing the affordability model in relation to acute services are summarised below:

- A&E services reflect RCRH activity predictions and the introduction of Urgent Care Centres within retained estate which relocates significant attendances. The Emergency Departments at City and Sandwell Hospitals have received significant new investment in 2013/2014. This investment will be maintained across the timeline until the two A&E functions merge within Midland Met. Thereafter economies of scale are modelled to reduce direct costs across medical staffing and nursing areas.
- Critical care services are predicted to remain stable, but with enhanced support for outreach functions.

- Rehabilitation and intermediate care services are provided in community retained estate based facilities and bed models grow as new pathways discharge patients from acute to community based facilities at an early length of stay.
- The costs associated with admitted patient care services change in line with activity projections.
- Admitted Patient Care requirements are consistent with OBC modelled expectations with the potential for 10 fewer Intermediate care beds by 2019/2020.
- From Midland Met opening in 2018/2019 most surgical day cases with the exception of children's day surgery remain at Sandwell (STC), the BTC or for ophthalmology BMEC and are thus no longer provided within an acute setting.
- Medical day cases are provided from a number of sites rather than all categorised as acute activity.
- Paediatric services are assumed to remain as local services with no significant expectation of referral pattern change.
- Maternity services are assumed to see a repatriation of births from other Black Country acute providers as a result of the Delivery Suite and collocated Midwifery Birth Centre within Midland Met being located in Sandwell MBC and therefore births being registered in the Black Country rather than Birmingham.
- The planned reductions in length of stay reduce the forecast bed requirements within the acute hospital and this is reflected within the cost projections. Over the next few years as length of stay and improved models of care impact on bed provision. A net reduction of circa c100 beds is modelled to occur by 2019/20, with c160 fewer acute beds and c60 more Intermediate care beds compared with today's model of care.
- A significant majority of future outpatient volumes are provided from Community based estate, with only approx. 13% of outpatients attending the acute setting. Overall volumes of outpatients are targeted to reduce and therefore direct operating costs are forecast to reduce in correlation to this.
- Diagnostic services are predicted to grow as demand increases and trends move towards an enriched case mix and an increasing range of tests/scans, although significant imaging work will also be undertaken within community retained estate facilities.
- Non-clinical support functions are modelled to fit within the new service configuration recognising efficiencies that will be achieved through service integration within one acute hospital site;
- The costs of hard and soft FM services have been individually modelled taking into account the reduction in the overall space requirement for acute hospital services compared to the current position and including an updated assessment of energy and rates costs.
- The Trust is planning a major new investment in IM&T infrastructure and support over the next few years to update PAS systems and move towards a paperlite operating model. This features in both additional revenue costs in operational expenditure and significant provision within the capital programme explained within the service development analysis.

13.5.2 The key factors influencing the affordability model in relation to services provided in the community retained estate facilities are:

- The provision of a significant majority of outpatient activity in community retained estate facilities;
- Provision of the majority of surgical day case activity in the community facilities based in the BTC, BMECSTC sites;

- Pathology main laboratories and all direct access work undertaken from a community retained estate setting;
- Outpatient ophthalmology, dermatology and oral surgery will be fully provided from STC and BMEC locations;
- The provision of Community Services from community retained estate facilities and other community based locations including patients own homes;
- In-patient facilities for intermediate care are provided by the Trust within Sheldon, STC and Rowley Regis Hospital facilities; and
- Fixed estate related costs relevant to the facilities in use.

13.6 Activity & Income

Patient Related Activity and Income

13.6.1 Sandwell and West Birmingham CCG together with the two Birmingham CCGs make up 80% of the Trusts clinical income. Sandwell and West Birmingham CCG is 65.5%, Birmingham Cross City CCG (11%), Birmingham South & Central CCG (3.5%), with the balance from other CCGs. This is an important metric in terms of securing strategic alignment and / or support from commissioning bodies. A high level summary of activity by CCG is presented in the table below.

Table 78: High Level Summary of Income and Activity by CCG

HIGH LEVEL SUMMARY OF INCOME & ACTIVITY BY CCG	Sandwell & West Birmingham CCG		Bham Cross City CCG		Bham South & Central CCG		Specialised Commissioners		All Other CCGs		ALL CCGs Total	
Category	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
	FOT 14/15	19/20	FOT 14/15	19/20	FOT 14/15	19/20	FOT 14/15	19/20	FOT 14/15	19/20	FOT 14/15	19/20
INCOME												-
A&E Incl Urgent Care	13.8	15.7	2.6	2.8	1.0	1.1	-	-	1.9	2.1	19.3	21.6
Day Cases	20.4	20.1	4.1	4.6	1.2	1.3	3.6	4.5	3.0	3.1	32.2	33.6
Elective IP	13.8	12.4	2.1	2.1	0.6	0.7	0.6	0.6	2.1	1.7	19.3	17.5
Elective Sub total	*34.2*	*32.5*	*6.2*	*6.7*	*1.8*	*2.0*	*4.2*	*5.2*	*5.1*	*4.8*	*51.5*	*51.1*
Non Electives	72.7	72.9	9.4	9.6	3.6	3.4	4.9	5.1	5.3	4.4	95.8	95.4
OCL	55.3	54.5	10.8	11.6	3.0	3.1	29.5	30.9	6.8	6.3	105.3	106.5
OP First	15.8	13.7	4.1	3.9	1.2	1.2	1.5	1.5	2.9	2.9	25.5	23.2
OP Follow Up	19.1	13.7	5.3	4.0	1.7	1.3	3.0	2.8	3.3	2.4	32.4	24.1
OPPROC	4.9	6.7	1.0	1.0	0.3	0.3	0.2	0.3	0.5	0.5	6.8	8.8
OP Virtual	0.1	0.4	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.5
Maternity Pathway	11.3	13.8	2.5	2.5	0.5	0.4			0.3	0.3	14.6	17.0
Outpatient Sub total	*51.2*	*48.2*	*12.9*	*11.5*	*3.6*	*3.2*	*4.7*	*4.6*	*7.0*	*6.1*	*79.4*	*73.7*
Community (TCS)	23.6	25.1	1.1	1.2	0.0	0.0	6.3	6.8	1.8	1.6	32.8	34.8
Sub-total Total Income Excluding MFF	**250.8**	**248.9**	**43.0**	**43.5**	**13.0**	**12.8**	**49.5**	**52.6**	**28.0**	**25.2**	**384.2**	**383.0**
Adjustments to the above												
MFF	6.4	6.2	1.1	1.1	0.4	0.3	0.6	0.6	0.7	0.6	9.1	8.8
Developments	-	19.2	-	2.7	-	1.3	-	3.7	-	0.3	-	27.3
Sub-total Income Adjustments	**6.4**	**25.4**	**1.1**	**3.8**	**0.4**	**1.7**	**0.6**	**4.4**	**0.7**	**0.9**	**9.1**	**36.1**
TOTAL CONTRACTED INCOME	**257.1**	**274.3**	**44.1**	**47.4**	**13.4**	**14.5**	**50.1**	**56.9**	**28.6**	**26.1**	**393.3**	**419.2**
Other Income												
Taper Relief	-	-	-	-	-	-	-	-	-	5.9	-	5.9
Other Income (Non-contracted)	0.4	0.3	-	-	-	-	-	0.8	47.1	44.1	47.4	45.1
Sub-total Other Income	**0.4**	**0.3**	**-**	**-**	**-**	**-**	**-**	**0.8**	**47.1**	**50.0**	**47.4**	**51.0**
TOTAL INCOME BEFORE TARIFF DEFLATOR	**257.5**	**274.6**	**44.1**	**47.4**	**13.4**	**14.5**	**50.1**	**57.7**	**75.7**	**76.1**	**440.7**	**470.2**
Tariff Deflator	-	**(9.8)**	-	**(1.7)**	-	**(0.5)**	-	**(2.1)**	-	**(1.0)**	-	**(15.1)**
INCOME AFTER TARIFF DEFLATOR	**257.5**	**264.8**	**44.1**	**45.7**	**13.4**	**14.0**	**50.1**	**55.6**	**75.7**	**75.1**	**440.7**	**455.1**
CCG share as a percentage of Total Contracted Income		**65.5%**		**11.0%**		**3.5%**						
Total for S&WB and Bham CCGs												**80.0%**
	000's	000's	000's	000's	000's	000's	000's	000's	000's	000's	000's	000's
Activity												
A&E Incl Urgent Care	156.1	168.3	30.6	31.9	11.0	11.3	-	-	22.9	23.6	220.6	235.1
Day Cases	24.9	27.2	5.4	6.0	1.6	1.8	4.2	6.1	3.7	3.8	39.9	45.0
Elective IP	5.8	5.7	1.0	1.0	0.3	0.3	0.8	0.4	0.8	0.7	8.7	8.1
Elective Sub total	30.7	33.0	6.4	6.9	2.0	2.1	5.1	6.5	4.5	4.5	48.7	53.1
Non Electives	44.7	46.9	6.0	6.2	2.3	2.2	1.6	1.8	3.4	3.1	58.0	60.2
OP First	134.1	122.1	35.3	34.4	9.1	9.0	10.5	10.7	18.8	18.6	207.8	194.7
OP Follow Up	283.0	210.2	74.3	53.5	21.0	16.8	38.8	35.6	38.8	29.7	455.9	345.7
OPPROC	36.6	46.2	6.1	7.1	2.0	2.1	1.3	2.2	3.1	3.5	49.0	61.2
OP Virtual	8.8	17.6	2.1	3.4	0.6	0.9	0.0	0.7	1.1	1.6	12.6	24.1
Maternity Pathway	13.2	15.2	2.6	2.6	0.5	0.5			0.4	0.4	16.8	18.7
Outpatient Sub total	475.7	411.4	120.4	101.0	33.1	29.3	50.5	49.1	62.2	53.8	742.0	644.5
Community (TCS)	524.4	662.7	22.4	24.2	0.7	0.7	136.7	157.4	36.6	35.7	720.8	880.8
TOTAL ACTIVITY	**1,231.6**	**1,322.3**	**185.9**	**170.3**	**49.1**	**45.7**	**193.9**	**214.8**	**129.6**	**120.7**	**1,790.0**	**1,873.7**

13.6.2 The activity modelling addresses the following factors:

- Amendments to model results across the future timeline, reflecting latest LDP contract performance (2015/16) compared with historic modelled expectations for this period - in effect, restating the activity baseline and thus any impact across the future eight year period.
- Some growth in activity as a result of increasing demand for the Trust's population, i.e. assumption of increased demand for short stay emergencies and as a result of demographic change.
- An anticipated transfer (loss) of activity (especially outpatient activity) to new primary care-based provider organisations. However a proportion is assumed to be retained by the Trust, but in a community rather than an acute setting. New pathways including "Virtual" Outpatients are being developed which are forecast to expand significantly.
- A loss of emergency catchment to other local acute providers reflecting the change in location due to transfer to the Midland Met (circa 11% of affected specialties).
- The provision by the Trust of a range of services (outpatients, diagnostics, day surgery, urgent care and intermediate care) in settings outside of an acute hospital. Many of these services will be covered by national PBR arrangements (e.g. outpatients, day surgery) and where appropriate national tariff has been used to forecast future income. Others (e.g. intermediate care, urgent

care) have been the subject of local discussions and the Trust's base case includes income assumptions agreed with the Trust's main commissioners.

- The development of alternative treatment pathways in community services to avoid hospital bed days and outpatient follow up attendances within the acute setting. This is a service model which is intended to grow over time to avoid work in the acute setting and enable on-going treatment closer to patients' homes. This mirrors national and local commissioning strategies.
- The inclusion of community services integrated within the Trust should lead to long-term investment in this area as an enabling strategy to change/reduce demand on secondary care.
- The inclusion of health economy wide QiPP schemes to reflect commissioning intent, e.g. improving new to review follow up ratios, decommissioning of certain elective procedures and minimising the impact of future emergency admissions by targeting reductions in average length of stay.
- Modest development growth for new service provision. This covers service areas where the Trust is confident, and has received commissioner agreement, that resources will be targeted, e.g. Health Visitor growth, Behçet's Centre, Gynae-oncology and Stroke. In addition the Trust will be seeking, with support from its host commissioner, to repatriate some activities currently delivered by alternative providers across most points of delivery.

Activity in 2019/2020

13.6.3 The tables below summarise the activity and income split between Midland Met and the Trust's community facilities.

Table 79: Activity Split between MMH and Retained Estate

	Activity		
	MMH	Ret Estate	TOTAL
Outpatients	97,924	546,611	644,535
Electives	14,666	38,442	53,109
Emergencies	56,917	3,303	60,221
A&E	127,652	32,151	159,803
Urgent Care	36,628	38,639	75,266
Total	**333,788**	**659,146**	**992,934**

Table 80: Income Split between MMH and Retained Estate (Excluding Community Services)

	Income (£'000s)		
	MMH	Retained Estate	TOTAL
Outpatients	22,611	54,954	77,565
Electives	24,644	30,537	55,181
Emergencies	90,926	10,187	101,112
A&E	18,664	4,633	23,297
OCL	110,667	0	110,667
Total	**267,512**	**100,312**	**367,823**

13.6.4 The pie charts below show in the first full year of site reconfiguration (2019/2020) by point of delivery (POD) the proportions of activity and income undertaken in acute and retained estate settings.

Figure 28: MMH Activity and Income

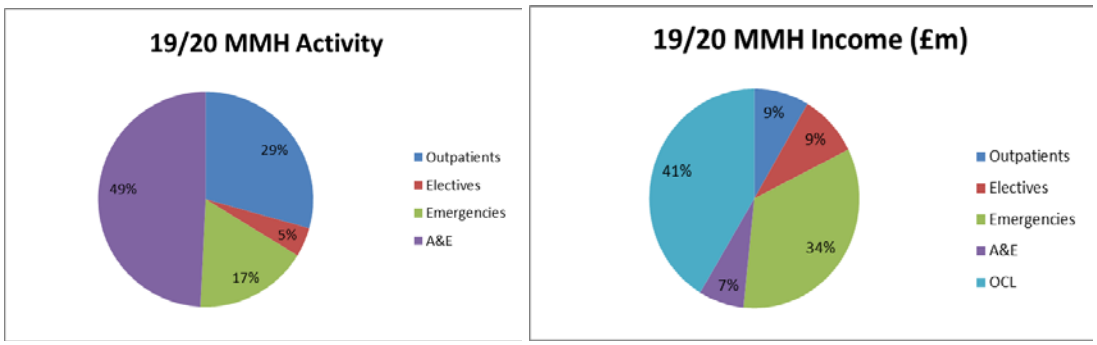
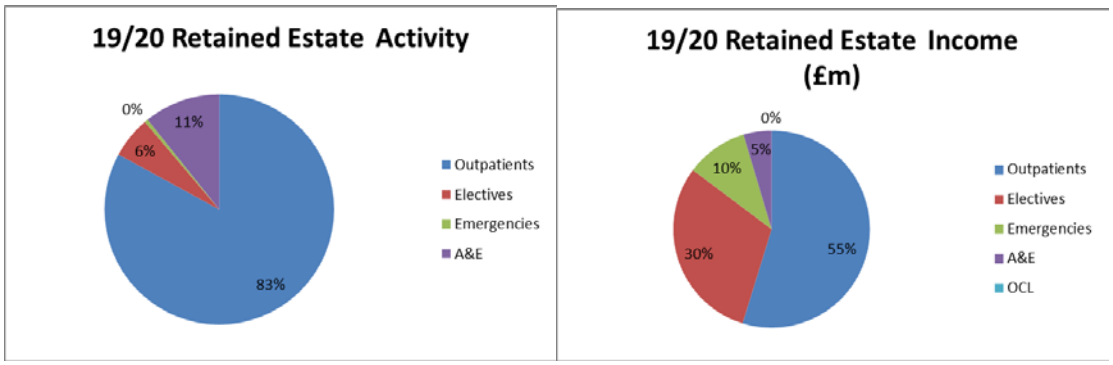


Figure 29: Retained Estate Activity and Income



13.6.5 The total activity and income trajectory expressed at point of delivery level (POD) is outlined in the table below.

Table 81: Total Activity and Income Position

	2013/14 Activities	2014/15 Activities	2015/16 Activities	2016/17 Activities	2017/18 Activities	2018/19 Activities	2019/20 Activities	2020/21 Activities	2021/22 Activities	2022/23 Activities	2023/24 Activities
Elective	52,642	48,651	49,540	50,528	51,452	52,253	53,109	53,979	54,767	55,416	56,082
Non elective	57,838	58,022	59,582	60,175	59,943	59,388	60,221	61,488	62,618	63,530	64,463
Outpatient	730,364	742,025	751,849	708,593	669,414	634,267	644,535	656,076	666,709	675,890	685,306
A&E	174,928	220,558	219,340	223,324	227,209	230,038	235,069	239,195	242,377	244,247	246,151
Other clinical - Tariff	53,703	1,414,134	1,460,561	1,467,195	1,485,499	1,505,792	1,533,467	1,558,305	1,583,429	1,608,872	1,634,638
Service Developments included in above:											
Acute											
Spells			613	1,227	1,619	2,233	3,133	3,779	4,171	4,171	4,171
A&E Attendances			-	2,323	3,669	5,993	8,316	10,639	11,985	11,985	11,985
Outpatients			1,234	4,027	5,708	8,501	11,294	14,087	15,768	15,768	15,768
Community			-	21,218	31,827	53,045	74,263	95,481	106,090	106,090	106,090
Non electives made up of:											
Non elective	57,838	58,022	57,075	57,431	56,812	55,574	55,517	56,352	57,206	58,078	58,970
Intermediate Care			2,507	2,382	2,531	2,852	3,094	3,132	3,171	3,211	3,251
Repatriation				362	600	962	1,610	2,004	2,242	2,242	2,242
Total Non electives	**57,838**	**58,022**	**59,582**	**60,175**	**59,943**	**59,388**	**60,221**	**61,488**	**62,618**	**63,530**	**64,463**

	2013/14 £000's	2014/15 £000's	2015/16 £000's	2016/17 £000's	2017/18 £000's	2018/19 £000's	2019/20 £000's	2020/21 £000's	2021/22 £000's	2022/23 £000's	2023/24 £000's
Electives	54,311	53,528	50,985	50,331	49,838	49,783	50,337	51,007	51,849	52,711	53,647
Non elective	93,585	99,445	95,551	95,736	94,457	93,649	93,559	94,958	96,673	98,431	100,329
Outpatient	82,416	81,807	87,578	81,187	75,695	71,415	72,184	73,194	74,451	75,737	77,134
A&E	18,074	20,070	21,977	21,633	21,362	21,075	21,271	21,484	21,765	22,053	22,367
Community Core Contacts	36,765	32,836	31,779	32,305	32,671	33,347	33,994	34,727	35,588	36,468	37,412
Other Contract Lines	108,945	109,537	102,865	103,037	104,386	107,119	110,341	113,632	117,322	121,206	125,373
Sub Total	394,096	397,223	390,735	384,229	378,408	376,387	381,686	389,002	397,648	406,607	416,262
Service Developments	-	-	3,000	8,145	13,526	19,249	24,482	29,846	34,507	36,739	40,816
Patient Related Income	**394,096**	**397,223**	**393,735**	**392,373**	**391,935**	**395,636**	**406,168**	**418,848**	**432,154**	**443,346**	**457,078**
MMH Related	-	-	-	-	-	7,425	5,940	4,455	2,970	1,485	-
Cummulative Position	**394,096**	**397,223**	**393,735**	**392,373**	**391,935**	**403,061**	**412,108**	**423,303**	**435,124**	**444,831**	**457,078**
Cat C Income	43,509	43,513	42,660	42,802	42,962	43,000	43,030	43,207	43,386	43,590	43,776
Trust Wide Position	**437,605**	**440,736**	**436,395**	**435,175**	**434,896**	**446,062**	**455,138**	**466,510**	**478,511**	**488,421**	**500,854**

13.6.6 Key activity movements by POD have been analysed into key change themes which summarise the trajectory behaviour.

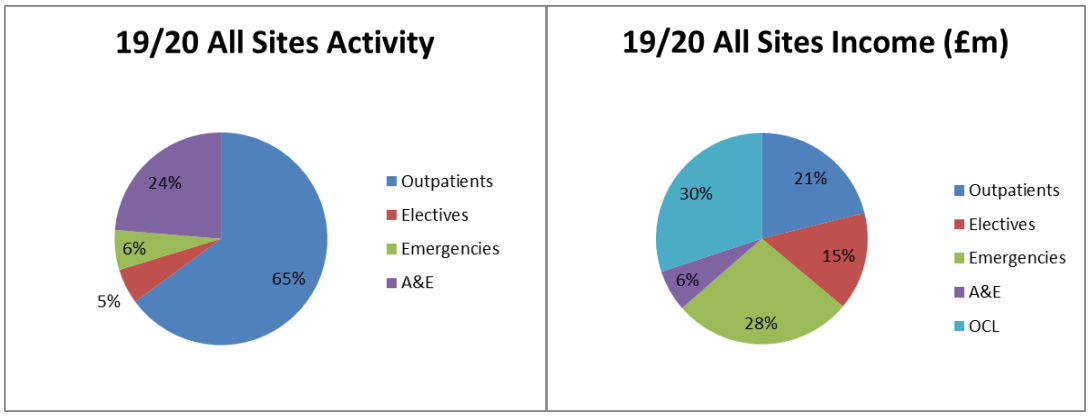
13.6.7 The table below presents these movements by POD to illustrate the annual trajectory changes predicted to occur until 2020/2021.

Table 82: Activity Movements

POD	CHANGE THEME	2014/2015 000's	2015/2016 000's	2016/2017 000's	2017/2018 000's	2018/2019 000's	2019/2020 000's	2020/2021 000's	2021/2022 000's	2022/2023 000's	2023/2024 000's	Grand Total £'000
Electives	Baseline Steps	53	49	50	51	51	52	53	54	55	55	53
	Baseline Changes	(4)	0	0	0	0	0	0	0	0	0	(4)
	Demography & Demand	0	0	1	1	1	1	1	1	1	1	5
	Alternative Service Pathway	0	0	(0)	(0)	(0)	(0)	(0)	0	0	0	(0)
	Alternative Service Provider	0	0	0	0	0	0	0	0	0	0	0
	Catchment Loss	0	0	0	0	0	0	0	0	0	0	0
	Change Site	0	0	0	0	(0)	0	0	0	0	0	0
	Peer Productivity	0	0	(0)	0	(0)	0	0	0	0	0	(0)
	Repatriation	0	1	0	0	0	0	0	0	0	0	2
	Electives Total	**49**	**50**	**51**	**51**	**52**	**53**	**54**	**55**	**55**	**56**	**56**
Emergencies	Baseline Steps	58	58	60	60	60	59	60	61	63	64	58
	Baseline Changes	0	2	(1)	(1)	(0)	0	0	(0)	0	0	(0)
	Demography & Demand	0	0	1	1	1	1	1	1	1	1	8
	Alternative Service Pathway	0	0	(1)	(1)	(0)	0	0	0	0	0	(2)
	Alternative Service Provider	0	0	0	0	0	0	0	0	0	0	0
	Catchment Loss	0	0	0	(1)	(2)	(1)	0	0	0	0	(4)
	Change Site	0	(0)	(0)	(0)	(0)	0	0	0	0	0	(1)
	Peer Productivity	0	0	1	1	1	0	0	0	0	0	3
	Repatriation	0	0	0	0	0	1	0	0	0	0	2
	Emergencies Total	**58**	**60**	**60**	**60**	**59**	**60**	**61**	**63**	**64**	**64**	**64**
Outpatients	Baseline Steps	730	742	752	709	669	634	645	656	667	676	730
	Baseline Changes	0	0	0	0	0	0	0	0	0	0	0
	Demography & Demand	12	9	14	14	10	9	9	9	9	9	103
	Alternative Service Pathway	0	0	(8)	(7)	(7)	0	0	0	0	0	(22)
	Alternative Service Provider	0	0	(37)	(33)	(28)	(1)	0	0	0	0	(99)
	Catchment Loss	0	0	0	0	0	0	0	0	0	0	0
	Change Site	0	0	(0)	0	0	0	0	0	0	0	0
	Peer Productivity	0	0	(15)	(14)	(13)	0	0	0	0	0	(42)
	Repatriation	0	1	3	2	3	3	3	2	0	0	16
	Outpatients Total	**742**	**752**	**709**	**669**	**634**	**645**	**656**	**667**	**676**	**685**	**685**
A&E	Baseline Steps	175	221	219	223	227	230	235	239	242	244	175
	Baseline Changes	0	0	0	0	0	0	0	0	0	0	0
	Demography & Demand	46	(1)	2	6	6	6	2	2	2	2	70
	Alternative Service Pathway	0	0	0	0	0	0	0	0	0	0	0
	Alternative Service Provider	0	0	0	0	0	0	0	0	0	0	0
	Catchment Loss	0	0	0	(3)	(5)	(3)	0	0	0	0	(11)
	Change Site	0	0	0	0	(0)	(0)	0	0	0	0	(0)
	Peer Productivity	0	0	0	0	0	0	0	0	0	0	0
	Repatriation	0	0	2	1	2	2	2	1	0	0	12
	A&E Total	**221**	**219**	**223**	**227**	**230**	**235**	**239**	**242**	**244**	**246**	**246**
Community Contract	Baseline Steps	748	721	724	769	801	843	881	919	946	964	748
	Baseline Changes	0	0	0	0	0	0	0	0	0	0	0
	Demography & Demand	(27)	3	15	16	16	16	17	17	17	18	108
	Alternative Service Pathway	0	0	3	1	1	0	0	0	0	0	5
	Alternative Service Provider	0	0	5	4	4	0	0	0	0	0	14
	Catchment Loss	0	0	0	0	0	0	0	0	0	0	0
	Peer Productivity	0	0	0	0	0	0	0	0	0	0	0
	Change Site	0	0	0	0	0	0	0	0	0	0	1
	Repatriation	0	0	21	11	21	21	21	11	0	0	106
	Community Contract Total	**721**	**724**	**769**	**801**	**843**	**881**	**919**	**946**	**964**	**982**	**982**

13.6.8 Overall POD activity, excluding community services, provided by the Trust is represented in the figure below.

Figure 30: All Sites Activity and Income 2019/20



Non-Patient Related Income

13.6.9 Non-patient related income is largely divided into two categories:

- Education and training related, including national levies; and
- General Category C income for activities or services provided by various departments within the Trust.

13.6.10 Each area has been individually considered to determine the likely impact of the planned changes on individual income streams. Training income streams have been assumed to generally remain stable across the period, while Category C income accruing to service departments fluctuates depending on individual circumstances. The Category C Income profile is presented in the table below.

Table 83: Category C Income

2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
43,513	42,660	42,802	42,962	50,425	48,970	47,662	46,356	45,075	43,776

13.7 Costs Underpinning PF2 Affordability

Characteristics of the Affordability Model

13.7.1 The overall projections demonstrate that the Trust maintains a bottom line surplus, after adjusting for technical issues, across the period.

13.7.2 This position includes the following key features:

- In order to afford the forecast unitary charge and generate support for transitional costs, an internal cost improvement programme has been developed which exceeds expected national efficiency requirements and the impact of activity cessation. In the intermediate years, the savings are set aside to deal with non-recurrent transitional costs so that, by 2018/19, they can be fully released to meet the affordability demands of the project.
- The PF2 solution model assumes £100m support is granted through PDC in support of funding the scheme and this is paid over to the Special Purpose Vehicle at defined completion stages which maximises risk transfer. The profile contained within the forecast Unitary Payment structure is shown below.
- Future modelling forecast surpluses of around 1% of turnover are successfully maintained across the period. Surpluses are required to grow significantly prior to MMH opening to enable a strong liquidity position to be established which assists in generating a 3 CsRR score.

13.7.3 The Statement of Comprehensive Income is presented below incorporating the PF2 based Unitary Charge from mid-year 2018/2019. Surpluses grow as the maximum opportunities are gained from preparedness for single acute site working.

Headline Summary Position		10 Year Timeline									
Statement of Comprehenisve Income		Forecast Outturn									
		2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Main Income		440.7	436.4	435.2	434.9	438.6	449.2	462.1	475.5	486.9	500.9
Taper Relief						7.4	5.9	4.5	3.0	1.5	-
	Total Income	**440.7**	**436.4**	**435.2**	**434.9**	**446.1**	**455.1**	**466.5**	**478.5**	**488.4**	**500.9**
Expenditure											
Pay		(285.0)	(283.0)	(276.0)	(267.0)	(260.6)	(257.9)	(261.6)	(263.8)	(267.0)	(270.5)
Non Pay		(125.1)	(122.6)	(124.7)	(129.1)	(137.7)	(144.8)	(157.5)	(167.7)	(175.4)	(185.6)
Transition Reserves		(5.4)	(4.3)	(6.1)	(9.0)	(2.8)	(6.3)	(2.0)	(2.0)	(2.0)	(2.0)
Dual Running		-	-	-	-	(5.2)	(5.4)	(4.5)	(3.5)	(1.7)	-
	Operating Expenditure	(415.5)	(410.0)	(406.9)	(405.0)	(406.3)	(414.3)	(425.5)	(437.0)	(446.1)	(458.1)
EBITDA		25.3	26.4	28.3	29.9	39.7	40.9	41.0	41.5	42.3	42.7
Non Operating Costs		(20.7)	(23.0)	(23.9)	(23.4)	(30.2)	(35.9)	(36.8)	(37.6)	(38.0)	(38.7)
Net Surplus (discounting Impairments)		**4.6**	**3.4**	**4.3**	**6.5**	**9.5**	**5.0**	**4.2**	**3.9**	**4.3**	**4.1**

13.7.4 The years to the MMH opening in 2018/2019 have non-recurring expenditure covering transition and restructuring contingencies. Post MMH opening a contingency for dual running exists over a three year time horizon. This contingency is funded by the major capital investment revenue relief support offered to PF2 schemes.

13.7.5 The table below summarises the impact of these contingencies and presents a headline view of surplus if these elements were discounted from the annual positions to arrive at an underlying assessment of financial performance.

Table 84: Normalised I&E Position

Normalised I&E Position	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	2023/24 £m
Net Surplus / (Deficit)	**4,321**	**3,434**	**4,322**	**(78,130)**	**(20,151)**	**4,983**	**4,213**	**3,909**	**4,306**	**4,062**
Taper Relief	-	-	-	-	(7,425)	(5,940)	(4,455)	(2,970)	(1,485)	-
Reserves / TWT	-	-	-	-	-	-	-	-	-	-
Transition - RCRH	3,000	3,000	1,870	1,250	-	-	-	-	-	-
MMH Orientation / Backfill	-	-	-	-	2,000	2,000	-	-	-	-
Restructuring Reserve	-	-	1,000	4,000	-	2,250	-	-	-	-
Section 106 Infrastructure for MMH	-	-	1,750	2,250	-	-	-	-	-	-
Contingency Bed Flexibility/ Winter Pressures	-	-	1,500	1,500	760	2,010	2,000	2,000	2,000	2,000
Winter Resilence	-	1,300	-	-	-	-	-	-	-	-
Dual Running Costs	-	-	-	-	5,239	5,396	4,501	3,510	1,729	-
Fixed Asset impairments	263	-	-	84,641	29,700	-	-	-	-	-
Normalised Net Surplus / (deficit)	**7,584**	**7,734**	**10,442**	**15,511**	**10,123**	**10,699**	**6,259**	**6,449**	**6,549**	**6,062**
Normalised Net Surplus Margin	*1.7%*	*1.8%*	*2.4%*	*3.6%*	*2.3%*	*2.4%*	*1.3%*	*1.3%*	*1.3%*	*1.2%*

Pay Forecast Trajectory

13.7.6 The table below presents the pay forecast trajectory by major staff group incorporating the impact of cost improvement efficiencies, service developments, and new ways of working including RCRH behavioural change. Pay cost also includes an annual assessment of incremental drift and an estimate of future annual pay awards.

Table 85: Pay Forecast Trajectory by Staff Group

	10 Year Timeline: Pay Spend vs Workforce									
	2014/15 £m's	2015/16 £m's	2016/17 £m's	2017/18 £m's	2018/19 £m's	2019/20 £m's	2020/21 £m's	2021/22 £m's	2022/23 £m's	2023/24 £m's
Pay Forecast Expenditure: *(Real)*	**(285.0)**	**(278.2)**	**(270.0)**	**(259.3)**	**(248.2)**	**(240.5)**	**(238.7)**	**(235.6)**	**(233.3)**	**(230.6)**
Analysed Across Pay Headings										
Consultants	(42.7)	(41.5)	(41.7)	(41.9)	(42.1)	(41.7)	(42.2)	(42.8)	(43.3)	(43.7)
Junior Medical Staff	(32.5)	(32.1)	(32.1)	(31.8)	(31.3)	(29.1)	(28.7)	(28.2)	(27.7)	(27.2)
Nursing - Acute	(71.0)	(72.0)	(69.6)	(66.1)	(62.8)	(61.7)	(64.1)	(64.6)	(64.8)	(65.1)
Nursing - Community	(17.8)	(17.1)	(18.4)	(20.7)	(22.1)	(23.6)	(23.7)	(24.4)	(26.1)	(27.6)
Other clinical staff (include HCAs)	(16.6)	(15.5)	(14.9)	(13.9)	(13.1)	(12.9)	(12.7)	(12.5)	(12.3)	(12.1)
Scientific / Prof & Tech	(40.8)	(39.4)	(38.5)	(37.2)	(36.0)	(35.8)	(35.4)	(34.7)	(33.9)	(33.0)
Non Clinical	(56.6)	(54.4)	(50.9)	(46.9)	(41.3)	(35.8)	(32.0)	(28.9)	(25.7)	(22.4)
Agency	(6.9)	(6.2)	(4.0)	(0.9)	0.5	0.2	0.1	0.5	0.5	0.5
Total Pay Spend	**(285.0)**	**(278.2)**	**(270.0)**	**(259.3)**	**(248.2)**	**(240.5)**	**(238.7)**	**(235.6)**	**(233.3)**	**(230.6)**
Wte's including Developments	**6,962**	**6,757**	**6,556**	**6,295**	**6,004**	**5,875**	**5,842**	**5,776**	**5,729**	**5,674**
Forecast Average Cost Per Wte (£'000's)	**(40.9)**	**(41.2)**	**(41.2)**	**(41.2)**	**(41.3)**	**(40.9)**	**(40.9)**	**(40.8)**	**(40.7)**	**(40.6)**

13.7.7 The average cost per WTE is presented in the table below.

Table 86: Average Cost per WTE

	10 Year Timeline: Average Cost Per WTE									
	2014/15 £000's	2015/16 £000's	2016/17 £000's	2017/18 £000's	2018/19 £000's	2019/20 £000's	2020/21 £000's	2021/22 £000's	2022/23 £000's	2023/24 £000's
Average Cost Per WTE (Nominal)										
Consultants	(147.6)	(145.2)	(146.2)	(147.5)	(150.6)	(151.3)	(154.7)	(157.3)	(160.9)	(165.1)
Junior Medical Staff	(68.2)	(69.9)	(71.4)	(72.9)	(75.1)	(72.8)	(75.1)	(77.5)	(80.1)	(83.0)
Nursing - Acute	(40.4)	(41.8)	(42.1)	(42.2)	(42.9)	(43.6)	(44.6)	(45.6)	(46.6)	(47.8)
Nursing - Community	(38.3)	(38.8)	(38.4)	(38.1)	(38.3)	(38.7)	(38.4)	(37.9)	(37.4)	(36.8)
Other clinical staff (include HCAs)	(24.7)	(24.4)	(24.4)	(24.5)	(24.9)	(25.0)	(25.4)	(25.9)	(26.4)	(27.0)
Scientific / Prof & Tech	(37.8)	(38.1)	(37.9)	(37.7)	(38.0)	(38.4)	(38.9)	(39.4)	(39.8)	(40.4)
Non Clinical	(28.6)	(29.4)	(28.9)	(28.4)	(28.1)	(27.6)	(26.8)	(26.1)	(25.3)	(24.2)

Operational Non Pay Forecast

13.7.8 The operational non-pay trajectory is outlined in the table below. Clinical non-pay costs are forecast to rise due in part to inflation but also recognising volume changes in high cost drugs in particular. Non-pay efficiencies are assumed as part of the cost improvement programme. Other expenses rise over the timeline as this contains:

- Support for IM&T development;
- The introduction of an Imaging MES arrangement from 2016/2017;
- Restructuring contingencies;
- Reserve contingencies; and
- Section 106 enabling costs.

Table 87: Operational Non-Pay Forecast Expenditure

	10 Year Timeline: Non Pay Spend v Workforce									
	Forecast Outturn 2014/15 £m's	LTFM Modelled Future Years								
		2015/16 £m's	2016/17 £m's	2017/18 £m's	2018/19 £m's	2019/20 £m's	2020/21 £m's	2021/22 £m's	2022/23 £m's	2023/24 £m's
Operational Non Pay Forecast Expenditure (Nomi	**(130.5)**	**(126.9)**	**(130.9)**	**(138.1)**	**(145.7)**	**(156.4)**	**(164.0)**	**(173.2)**	**(179.2)**	**(187.6)**
Drug expenses	(34.9)	(33.7)	(34.8)	(35.8)	(37.4)	(39.2)	(40.8)	(42.6)	(44.0)	(46.0)
Clinical supplies and services expenses	(46.3)	(47.8)	(47.7)	(49.2)	(51.8)	(54.8)	(58.9)	(63.0)	(67.8)	(72.8)
CNST Premium	(6.7)	(6.7)	(7.0)	(7.3)	(7.6)	(8.0)	(8.4)	(8.9)	(9.6)	(10.1)
Other expenses	(41.4)	(37.5)	(40.4)	(44.1)	(39.0)	(42.5)	(43.5)	(46.7)	(46.6)	(48.5)
PFI specific expenses:										
- Operating charge element of Unitary Payment	(1.2)	(1.3)	(1.0)	(1.7)	(4.7)	(6.5)	(7.9)	(8.4)	(9.4)	(10.1)
- Other Expenses	0.0	0.0	0.0	0.0	(5.2)	(5.4)	(4.5)	(3.5)	(1.7)	0.0
Total Operational Non Pay Spend	**(130.5)**	**(126.9)**	**(130.9)**	**(138.1)**	**(145.7)**	**(156.4)**	**(164.0)**	**(173.2)**	**(179.2)**	**(187.6)**

13.7.9 The PFI elements within the table refer to the existing PFI scheme for the BTC and subsequent dual running costs for the PSC/PF2 project.

13.8 Approach to PF2 Affordability

13.8.1 This section moves on to consider the impact of PF2 on affordability.

Unitary Charge based Upon Partial Indexation and IFRIC 12 Consequences

13.8.2 The Unitary Charge modelled within the affordability position updates the ceiling value that was included in the OBC against which the public sector comparator was measured. The updated unitary charge position reflects an improvement in the annual charge and falls well within the ceiling set at OBC stage.

The Maximum Affordable Unitary Charge

13.8.3 The Unitary Charge in the draft bid has improved significantly from OBC as a direct consequence of updated funding terms. That improvement is retained as affordability headroom in this case. That is, the affordability case presented here is consistent with the OBC Unitary Charge affordability ceiling of £27m.

13.8.4 The OBC allowed for a maximum first full year affordability ceiling of circa £27m. Bidder submissions suggest a revised value of £21.9m, excluding potential EIB funding support. Most components of the OBC Unitary Payment assessment have proven to be close benchmarks. A pressure is created by a differing view of lifecycle costs but this is insignificant in comparison to the forecast change in funding terms currently available within the market. These revised improved terms drive the improvement in the forecast Unitary Charge.

13.8.5 The table below presents the statement of comprehensive income for PF2.

13.8.6 This demonstrates that top line income and revenue surpluses which, when taken together with capital investment and balance sheet management are consistent with sustaining a CoSRR level 3 and providing for meaningful downside mitigation.

Table 88: Statement of Comprehensive Income (PF2)

Statement of Comprehensive Income	Forecast Outturn 2014/15	Forecast 2015/16	Forecast 2016/17	Forecast 2017/18	Forecast 2018/19	Forecast 2019/20	Forecast 2020/21	Forecast 2021/22	Forecast 2022/23	Forecast 2023/24
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income										
NHS Clinical income	397.2	393.7	392.4	391.9	395.6	406.2	418.8	432.2	443.3	457.1
Non NHS Clinical income	43.5	42.7	42.8	43.0	43.0	43.0	43.2	43.4	43.6	43.8
Other Operating income	-	-	-	-	7.4	5.9	4.5	3.0	1.5	-
Total Operating Income	**440.7**	**436.4**	**435.2**	**434.9**	**446.1**	**455.1**	**466.5**	**478.5**	**488.4**	**500.9**
Expenditure										
Pay	(285.0)	(283.0)	(276.0)	(267.0)	(260.6)	(257.9)	(261.6)	(263.8)	(267.0)	(270.5)
Non Pay	(130.5)	(126.9)	(130.9)	(138.1)	(145.7)	(156.4)	(164.0)	(173.2)	(179.2)	(187.6)
Total Operating Expenses	**(415.5)**	**(410.0)**	**(406.9)**	**(405.0)**	**(406.3)**	**(414.3)**	**(425.5)**	**(437.0)**	**(446.1)**	**(458.1)**
Operational Surplus	**25.3**	**26.4**	**28.3**	**29.9**	**39.7**	**40.9**	**41.0**	**41.5**	**42.3**	**42.7**
Profit / loss on asset disposal	(0.0)	(0.0)	(0.0)	-	-	-	-	-	-	-
Impairment losses	(0.3)	-	-	(84.6)	(29.7)	-	-	-	-	-
Depreciation	(13.4)	(14.9)	(14.7)	(14.5)	(12.4)	(14.9)	(15.8)	(16.2)	(16.7)	(17.4)
Total interest receivable / (payable)	0.1	0.1	(0.1)	0.2	0.2	0.2	0.2	0.1	0.2	0.3
Total interest payable on loans / leases	(2.2)	(2.2)	(2.3)	(2.1)	(12.2)	(15.4)	(15.1)	(15.1)	(14.8)	(14.6)
PDC Dividend	(5.2)	(6.0)	(6.8)	(6.9)	(5.9)	(5.8)	(6.1)	(6.4)	(6.7)	(7.1)
Non Operating Costs	(21.0)	(23.0)	(23.9)	(108.0)	(59.9)	(35.9)	(36.8)	(37.6)	(38.0)	(38.7)
Surplus / (deficit) before tax	4.3	3.4	4.3	(78.1)	(20.2)	5.0	4.2	3.9	4.3	4.1
Add back technical adjustments	0.3	-	-	84.6	29.7	-	-	-	-	-
Revised Surplus / (deficit) before tax	**4.6**	**3.4**	**4.3**	**6.5**	**9.5**	**5.0**	**4.2**	**3.9**	**4.3**	**4.1**
Net Margin %	**1.04%**	**0.79%**	**0.99%**	**1.50%**	**2.14%**	**1.09%**	**0.90%**	**0.82%**	**0.88%**	**0.81%**

13.9 Balance Sheet

13.9.1 The Trust starts from a solid balance sheet base. The table below shows how the balance sheet is forecast to move over the time period.

Table 89: Balance Sheet

BALANCE SHEET	Outturn Mar-15	Forecast Mar-16	Forecast Mar-17	Forecast Mar-18	Forecast Mar-19	Forecast Mar-20	Forecast Mar-21	Forecast Mar-22	Forecast Mar-23	Forecast Mar-24
ASSETS, NON CURRENT										
Property, Plant and Equipment and intangible assets, Net	213,891	223,490	229,260	132,353	136,817	145,244	150,104	152,584	153,659	153,936
Property, plant & equipment (PFI)	20,094	19,544	18,983	18,374	281,350	275,745	270,127	264,496	258,850	253,191
PFI Other Assets	0	0	0	0	0	0	0	0	0	0
Investments, Non-Current	0	0	0	0	0	0	0	0	0	0
Trade and Other Receivables, Net, Non-Current (including prepayme	890	890	890	890	890	890	890	890	890	890
Other Assets, Non-Current	0	0	0	0	0	0	0	0	0	0
Assets, Non-Current, Total	**234,875**	**243,924**	**249,133**	**151,618**	**419,057**	**421,879**	**421,122**	**417,970**	**413,399**	**408,016**
ASSETS, CURRENT										
Inventories	3,467	3,217	3,217	3,217	3,217	3,217	3,217	3,217	3,217	3,217
NHS Trade Receivables, Current	14,124	12,270	12,264	6,532	6,594	6,769	6,981	7,203	7,389	7,618
Non NHS Trade Receivables, Current	395	119	122	(863)	(669)	(641)	(693)	(858)	(953)	(911)
Other Receivables, Current	1,799	1,549	1,549	1,549	1,549	1,549	1,549	1,549	1,549	1,549
Other Financial Assets, Current (e.g. accrued income)	0	0	0	0	0	0	0	0	0	0
Prepayments, Current, PFI related	0	0	0	0	0	0	0	0	0	0
Prepayments, Current, non-PFI related	0	0	46,496	93,352	0	0	0	0	0	0
Cash and Cash Equivalents	28,382	28,705	27,881	32,767	45,133	42,494	37,568	42,594	49,552	57,353
Other Assets, Current	(0)	(1)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)
Assets, Current, Total	**48,167**	**45,860**	**91,527**	**136,552**	**55,822**	**53,387**	**48,621**	**53,703**	**60,752**	**68,825**
ASSETS, TOTAL	**283,042**	**289,784**	**340,660**	**288,169**	**474,879**	**475,266**	**469,742**	**471,673**	**474,151**	**476,841**
LIABILITIES, CURRENT										
Interest-Bearing Borrowings , Current (including accrued interest)	(1,000)	0	0	0	0	0	0	0	0	0
Deferred Income, Current	0	0	0	0	0	0	0	0	0	0
Provisions, Current	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)
Trade payables, Current	(19,555)	(20,361)	(17,920)	(15,340)	(16,189)	(17,379)	(13,663)	(14,430)	(14,930)	(15,631)
Other payables, Current	(3,252)	(3,252)	(3,252)	(3,252)	(3,252)	(3,252)	(3,252)	(3,252)	(3,252)	(3,252)
Capital payables, Current	(8,035)	(8,035)	(8,035)	(8,035)	(13,035)	(11,035)	(8,035)	(8,035)	(8,035)	(8,035)
Accruals, Current	(15,109)	(15,909)	(15,909)	(15,909)	(15,909)	(15,909)	(15,909)	(15,909)	(15,909)	(15,909)
Payments on Account	0	0	0	0	0	0	0	0	0	0
Finance Leases, Current	0	0	0	0	0	0	0	0	0	0
PFI leases, Current	(1,017)	(1,306)	(903)	(24,690)	(6,253)	(5,607)	(5,457)	(5,079)	(4,773)	(5,595)
PDC dividend payable, Current	0	0	0	0	0	0	0	0	0	0
Other Liabilities, Current	0	0	0	0	0	0	0	0	0	0
Interest payable	0	0	0	0	0	0	0	0	0	0
Liabilities, Current, Total	**(52,470)**	**(53,366)**	**(50,522)**	**(71,728)**	**(59,140)**	**(57,684)**	**(50,819)**	**(51,207)**	**(51,401)**	**(52,923)**
NET CURRENT ASSETS (LIABILITIES)	**(4,303)**	**(7,506)**	**41,005**	**64,824**	**(3,318)**	**(4,298)**	**(2,198)**	**2,496**	**9,351**	**15,902**
LIABILITIES, NON CURRENT										
Interest-Bearing Borrowings, Non-Current	0	0	0	0	0	0	0	0	0	0
Deferred Income, Non-Current	0	0	0	0	0	0	0	0	0	0
Provisions, Non-Current	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)
Trade and Other Payables, Non-Current	0	0	0	0	0	0	0	0	0	0
Finance Leases, Non-current	0	0	0	0	0	0	0	0	0	0
PFI leases, Non-Current	(26,897)	(25,592)	(24,690)	0	(210,492)	(204,885)	(199,428)	(194,349)	(189,576)	(183,981)
Other Liabilities, Non-Current	**(29,883)**	**(28,578)**	**(27,675)**	**(2,986)**	**(213,478)**	**(207,871)**	**(202,414)**	**(197,335)**	**(192,562)**	**(186,967)**
TOTAL ASSETS EMPLOYED	**200,689**	**207,841**	**262,463**	**213,456**	**202,261**	**209,710**	**216,510**	**223,131**	**230,188**	**236,951**
TAXPAYERS' EQUITY										
Public dividend capital	162,210	162,210	208,706	255,561	262,210	262,210	262,210	262,210	262,210	262,210
Retained Earnings (Accumulated Losses)	(15,170)	(11,737)	(7,414)	(85,544)	(105,695)	(100,711)	(96,499)	(92,589)	(88,284)	(84,222)
Charitable Funds	0	0	0	0	0	0	0	0	0	0
Donated asset reserve	0	0	0	0	0	0	0	0	0	0
Revaluation reserve	44,591	48,309	52,113	34,381	36,687	39,153	41,740	44,452	47,204	49,905
Miscellaneous Other Reserves	9,058	9,058	9,058	9,058	9,058	9,058	9,058	9,058	9,058	9,058
TOTAL TAXPAYERS EQUITY	**200,689**	**207,841**	**262,463**	**213,456**	**202,261**	**209,710**	**216,510**	**223,131**	**230,188**	**236,951**

13.9.2 Key features include:

- Liquidity growth over time driven from cash backed surpluses;
- Management of working capital to optimise the trust's liquidity position
- Land and Buildings have been indexed between 1-2% per annum and
- The existing estate fixed assets are impaired as they fall out of use based upon a granular review of the Trust's asset base.

13.9.3 The £100 Public Dividend Capital is phased into the position. The annual values are treated as prepayments until the full asset comes on stream in 2018/2019 where the prepayment is then released to offset the capital contribution:

Table 90: Public Dividend Capital

	2016/17 £m	2017/18 £m	2018/19 £m	Total £m
PDC Drawdown	46.5	46.9	6.6	100.0

13.9.4 MMH is estimated to be revalued on commissioning with a consequent 10% impairment.

13.10 Cost Improvement Savings (CIP) 2014/2015

13.10.1 The Trust has a strong track record of delivering efficiency requirements consistent with planning assumptions. The Trust delivered a cost improvement programme (CIP) of circa £20.6m in 2014/15 across a number of transformational themes, as identified in the table below.

Table 91: Cost Improvement Programme Savings 2014/15

CIP Delivery 2014/2015 Theme	£000's
Clinical services non-pay efficiencies	868
Community Service Efficiency	318
Corporate Services | Facilities	4,855
Diagnostics	1,010
External marketing of clinical services	189
Medical Workforce Efficiency	1,146
Other schemes covered by FYE of in year schemes	5,404
Outpatient Efficiency	65
Patient Flow | Bed Day Utilisation	983
Procurement	648
SLR Improvement	366
Strategic IT Enablement	69
Theatre Productivity	76
Use of non-recurrent flexibilities	2,787
Workforce Efficiency	1,820
Total Value Realised	**20,604**

13.10.2 For future years the cost improvements modelled within the trajectory are presented in the table below at subjective cost heading.

Table 92: Cost Improvement Plan by Year and Type

CIP savings by year and type, 2014/15 to 2024/24 Value at 2014/15 prices (£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)	2023/24 (£m)
Pay - Consultants	1.4	0.6	0.6	0.6	0.6	1.0	0.6	0.6	0.6	0.6
Pay - Junior Medical	0.1	1.2	1.0	1.1	1.1	0.9	1.3	1.3	1.3	1.3
Pay - Nursing, Midwifery and Health Visitors	2.2	3.1	2.6	2.9	2.9	2.5	1.8	1.8	1.8	1.8
Pay - Other Clinical	0.0	0.6	0.5	0.6	0.6	0.7	0.3	0.3	0.3	0.3
Pay - Community Nursing, Midwifery and Health Visitors	0.1	1.1	1.0	1.0	1.0	0.9	1.4	1.4	1.4	1.4
Pay - Scientific, Therapeutic and Technical	0.8	2.3	1.9	2.1	2.1	1.8	1.7	1.7	1.7	1.7
Pay - Non Clinical	2.8	4.6	3.8	4.2	4.2	3.9	3.6	3.6	3.6	3.6
Pay - Agency (Consultants)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pay - Agency (Junior Medical)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pay - Agency (Nursing, Midwifery and Health Visitors)	2.0	1.3	1.7	2.5	0.8	0.0	0.0	0.0	0.0	0.0
Pay - Agency (Scientific, Therapeutic and Technical)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pay - Agency (Non Clinical)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pay - TOTAL	**9.4**	**14.9**	**13.3**	**15.0**	**13.4**	**11.8**	**10.7**	**10.7**	**10.7**	**10.7**
Non Pay - Drugs	0.2	1.2	1.2	1.0	1.0	0.6	1.0	1.0	1.0	1.0
Non Pay - Clinical Supplies and Services	2.3	1.8	2.0	1.0	1.0	0.8	1.0	1.0	1.0	1.0
Non Pay - General Supplies and Services	0.7	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0
Non Pay - Establishment Expenditure	0.6	0.5	0.3	0.5	0.3	0.3	0.1	0.1	0.1	0.1
Non Pay - Premises and Fixed Plant	1.3	1.0	0.5	1.0	0.2	0.3	0.1	0.1	0.1	0.1
Non Pay - CNST	0.7	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0
Non Pay - Other	2.1	0.3	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0
Non Pay - TOTAL	**7.9**	**4.9**	**4.2**	**3.7**	**2.6**	**2.1**	**2.2**	**2.2**	**2.2**	**2.2**
Income improvements contributing to TSP target	**3.3**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
TOTAL TSP savings at 2014/15 prices (£m)	**20.6**	**19.8**	**17.5**	**18.7**	**16.0**	**13.9**	**13.0**	**13.0**	**12.9**	**12.9**

13.10.3 The Trust has developed detailed plans for 2015/2016 and outline themes for future years under the umbrella transformational schemes approach. This recognises that there are a number of elements which make up the gross savings requirements for the Trust which are:

- Meeting the nationally driven CIP objectives laid down by DH / Monitor for any given period. Presently this is largely driven by the impact of tariff deflation and meeting cost inflation.
- Clinical Transformation which defines the impact of RCRH change on capacity and infrastructure, e.g. fewer beds, fewer outpatient clinics and improved theatre utilisation.
- The impact of site reconfiguration which affects hard and soft FM environments but also bringing together clinical models on to one acute site provides the opportunity for savings in on call, medical rota management and intensity banding payments.

13.10.4 The table below shows the transitional Right Care Right Here change and national CIP expectations.

Table 93: RCRH Change and National Efficiency Expectations

Transitional RCRH Change & National CIP Expectations	Outturn 2014/15 £m	Forecast 2015/16 £m	Forecast 2016/17 £m	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m	Forecast 2022/23 £m	Forecast 2023/24 £m	*Across Period 19/20 to 14/15 £m*	*Across Period 19/20 to 15/16 £m*
Efficiency Driven Expectations (CIP)												
Income	3.3	-	-	-	-	-	-	-	-	-	3.3	-
Pay	9.4	14.9	13.3	15.0	13.4	11.8	10.7	10.7	10.7	10.7	77.7	68.3
Non Pay	5.9	4.9	4.2	3.7	2.6	2.1	2.2	2.2	2.2	2.2	23.5	17.6
Non Recurring	2.0	-	-	-	-	-	-	-	-	-	2.0	-
Sub Total	**20.6**	**19.8**	**17.5**	**18.7**	**16.0**	**13.9**	**13.0**	**13.0**	**12.9**	**12.9**	**106.5**	**85.9**
	-	-	-	-	-	-	-	-	-	-	-	-
Transformational Change Driven by RCRH & Site	-	-	-	-	-	-	-	-	-	-	-	-
	-	-	-	-	-	-	-	-	-	-	-	-
Medical & Surgical Bed Reductions	-	1.2	1.8	2.2	1.6	-	-	-	-	-	6.9	6.9
Theatre Utilisation	-	-	0.4	0.2	0.3	-	-	-	-	-	0.9	0.9
A&E Removal of 13/14 Stepped Investment	-	-	-	-	0.4	1.2	-	-	-	-	1.7	1.7
Review of On Call	-	-	-	-	-	0.3	-	-	-	-	0.3	0.3
Review of Junior Medical Bandings	-	-	-	-	-	1.9	-	-	-	-	1.9	1.9
Outpatient Environments	-	-	0.6	0.6	0.8	0.7	-	-	-	-	2.7	2.7
Reduce Premium Rate Working	-	-	0.1	0.1	0.2	0.2	0.2	-	-	-	0.6	0.6
Sub Total	**-**	**1.2**	**3.0**	**3.1**	**3.3**	**4.3**	**0.2**	**-**	**-**	**-**	**14.9**	**14.9**
Hard and Soft FM	-	-	-	-	-	-	-	-	-	-	-	-
Estates Pay Transfer to PF2 Provider (TUPE)	-	-	-	-	0.5	0.5	-	-	-	-	1.0	1.0
Utilities Avoided	-	-	-	-	2.5	1.5	-	-	-	-	4.0	4.0
Estate Hard FM Avoided - Non Pay	-	-	-	-	0.6	0.5	-	-	-	-	1.0	1.0
Estate Soft FM Reductions - Pay	-	-	-	-	0.8	0.7	-	-	-	-	1.5	1.5
Estate Soft FM Avoided - Non Pay	-	-	-	-	0.8	0.4	-	-	-	-	1.2	1.2
Sub Total	**-**	**-**	**-**	**-**	**5.2**	**3.6**	**-**	**-**	**-**	**-**	**8.8**	**8.8**
	-	-	-	-	-	-	-	-	-	-	-	-
Total Transformational Changes Modelled	**20.6**	**21.0**	**20.5**	**21.9**	**24.5**	**21.7**	**13.2**	**13.0**	**12.9**	**12.9**	**130.2**	**109.6**

13.10.5 ***Appendix 13a*** provides further details of savings plans for 2015/16, together with the outline opportunities for 16/17 to 19/20. This demonstrates a scale of opportunity and approach to delivery consistent with credible cost reduction.

13.11 Affordability – Transformational Journey

The table below presents a summarised source and applications view of the LTFM journey necessary to and consistent with the achievement of a sustainable CoSRR level 3 rating.

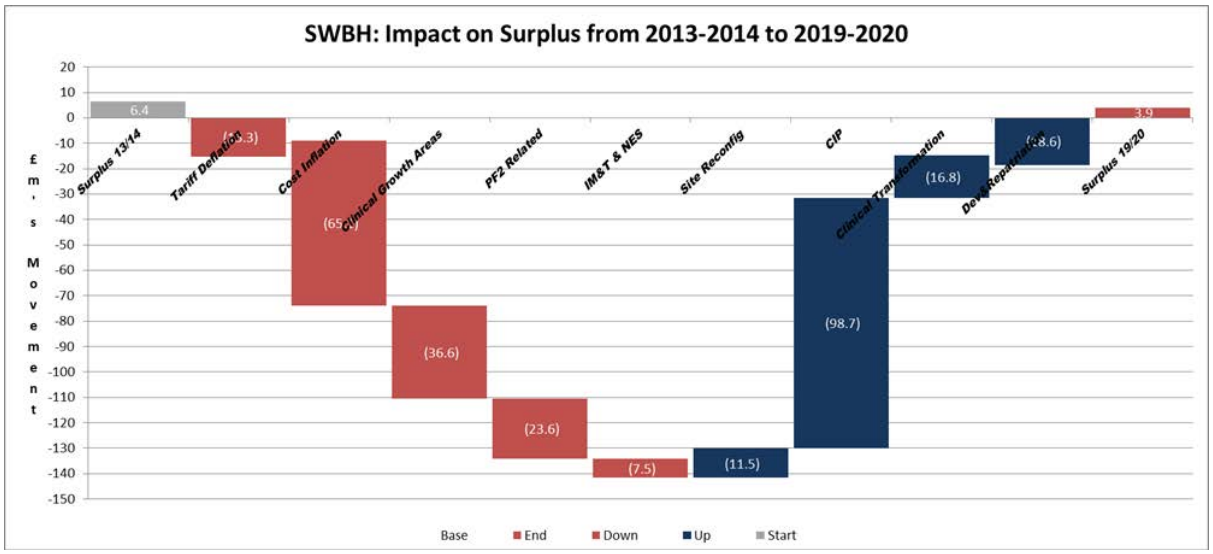
13.11.1 The table shows annual change across many themes, transformation, efficiency savings, inflation issues, development changes and the implications of site change. It represents an affordability "roadmap" which presents a route across the years as change is delivered.

Table 94: Affordability and Transformation

		PERIOD MOVEMENT			ANNUAL MOVEMENTS						PERIOD
		2013/14 £m	2019/20 £m	Movem't £m	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	Movem't £m
Modelled Surplus Movement		**6**	**5**	**(1)**	**5**	**3**	**4**	**7**	**10**	**5**	**(1)**
Total Income		**438**	**455**	**18**	**441**	**436**	**435**	**435**	**446**	**455**	**18**
Explained By:											
Net RCRH Themes / Activity Movements				10	12	(7)	(0)	1	0	4	10
Future Service Developments				26	0	3	5	6	6	6	26
Tariff Impact				(24)	(9)	0	(6)	(7)	(3)	1	(24)
PFI Taper Relief				6	0	0	0	0	7	(1)	6
Income Movement Over Period				**18**	**3**	**(4)**	**(1)**	**(0)**	**11**	**9**	**18**
Total Operating Expenditure :	Pay	**(292)**	**(258)**	**34**	**(285)**	**(283)**	**(276)**	**(267)**	**(261)**	**(258)**	**34**
Explained By:											
Pay											
Net RCRH Themes / Activity Movements				3	1	(3)	(0)	1	0	5	3
AfC Inc Drift & ConCon & Merit Awards				(19)	(3)	(3)	(3)	(3)	(3)	(3)	(19)
Medical & Surgical Bed Reductions inc Agency				9	2	1	2	2	2	(1)	9
IM&T Development				(0)	0	(0)	0	(0)	0	(0)	(0)
Theatres Transformaion				1	0	0	0	0	0	0	1
Future Service Developments				(15)	0	(3)	(3)	(3)	(2)	(4)	(15)
Investment Advisory Panel				(2)		(1)				(1)	(2)
Outpatient Transformation				3	0	0	1	1	1	1	3
A&E Transformation				2	0	0	0	0	0	1	2
Medical Staffing Rotas				2	0	0	0	0	0	2	2
Premium Rate Working				1	0	0	0	0	0	0	1
Hard & Soft FM				3	0	0	0	0	1	1	3
Inflation				(20)	(3)	(5)	(1)	(2)	(5)	(5)	(20)
CIP				78	9	15	13	15	13	12	78
Icare Growth				(8)	0	0	(2)	(1)	(1)	(5)	(8)
Community Growth				(2)			(0)	(0)	(1)	(0)	(2)
Diagnostics Growth				(1)			(0)	0	(0)	(0)	(1)
Pay Movement Over Period Sub Total				**34**	**7**	**2**	**7**	**9**	**6**	**3**	**34**
Non Pay		**(119)**	**(156)**	**(37)**	**(130)**	**(127)**	**(131)**	**(138)**	**(146)**	**(156)**	(37)
Non Pay Inflation				(25)	(6)	(1)	(4)	(4)	(4)	(5)	(25)
CIP & Transformation Agenda				23	6	5	4	4	3	2	23
Repatriation				(1)	(0)	(0)	(0)	(0)	(0)	(0)	(1)
Future Community Developments				(2)	0	0	0	(1)	(1)	0	(2)
Other Non Pay Net Movements				0	0	0	(0)	0	0	(0)	0
Dual Running Contingency				(5)					(5)	(0)	(5)
PFI Operating Charge				(11)	(0)	(0)	0	(1)	(8)	(2)	(11)
Imaging MES				(4)			(1)	(0)	(2)	(0)	(4)
IM&T Strategy				(3)	0	(1)	(1)	(2)	(0)	0	(3)
Net RCRH Themes / Activity Movements	Drugs			(5)	(2)	1	(1)	(1)	(1)	(1)	(5)
	Clinical Supplies			(4)	(2)	(2)	1	(0)	0	(0)	(4)
Site Changes	Other Expenses			9	(2)	2	(0)	0	7	2	9
Non Recurring Assigned				(6)	(5)	1	(2)	(3)	6	(4)	(6)
Investment Advisory Panel				(3)	0	(1)	0	0	(1)	(2)	(3)
Non Pay Movement Over Period Sub Total				**(39)**	**(13)**	**3**	**(4)**	**(7)**	**(8)**	**(11)**	**(39)**
Non Operational Costs		**(21)**	**(36)**	**(15)**	**(21)**	**(23)**	**(24)**	**(23)**	**(30)**	**(36)**	**(15)**
Depreciation: New MMH				(6)					(4)	(1)	(6)
Depreciation: Other Movements				4	0	(2)	0	0	6	(1)	4
PDC Dividend : £100m				(4)			(1)	(2)	(1)		(4)
PDC Dividend : Other Movements				2	(1)	(1)	(0)	2	2	0	2
Loss on Disposal				0	0						0
PFI Interest MMH & BTC				(13)	(0)	0	(0)	0	(10)	(3)	(13)
Non Operating Costs Movement Over Period Sub Total				**(15)**	**(0)**	**(2)**	**(1)**	**1**	**(7)**	**(6)**	**(15)**
Summary											
Income		438	455	18	441	436	435	435	446	455	18
Operating Expenditure		(411)	(414)	(4)	(415)	(410)	(407)	(405)	(406)	(414)	(4)
Non Operating Expenditure		(21)	(36)	(15)	(21)	(23)	(24)	(23)	(30)	(36)	(15)
Net Position		**6**	**5**	**(1)**	**5**	**3**	**4**	**7**	**10**	**5**	**(1)**

13.11.2 This is represented graphically below:

Figure 31: Impact on Surplus



13.12 Affordability and Sustainability

Inflation Assumptions

13.12.1 Tariff assumptions within the LTFM suggest a period of deflation will continue until 2019-2020 as part of the delivery of annual efficiency. Thereafter, tariff will stabilise and start to increase towards the end of the trajectory.

13.12.2 Pay-related inflation is modelled at relatively low levels, reflecting current trends. The Trust assumes the national pay award will grow but remain below the underlying rate of RPI until 2019-2020. Thereafter pay awards may increase more in line with a circa 2.5% RPI expectation.. Other pay increases associated with incremental uplift and consultant discretionary awards are modelled as cost pressure adjustments and therefore do not feature in the inflationary calculations, but do feature in consideration of the implied efficiency. This typically adds circa 1% per annum to the annual pay bill.

13.12.3 Although the Health Service Cost Index (HSCI), suggests minimal inflationary pressure on drugs (September 2013 compared with September 2012) the Trust has modelled a growth of 4.55% per annum. This is additional to a volume growth of 2-3% built into baseline income forecasts. Taken together, this represents a material annual increase in income and cost to cover inflation, volume and latest NICE prescribing guidance.

13.12.4 Other areas of non-pay cover a broad spectrum of non-pay costs with differing component judgments of cost inflation. For example:

- Medical and Surgical purchases are running at an annual rate of circa 4% growth; and
- Utilities, a growth of circa 5%.

13.12.5 The Trust has modelled a blended position which takes these elements into account. Future years assumptions predict reductions in non-pay cost inflation, although, levels remain relatively high.

13.12.6 PFI estimated inflation has been applied to the unitary charge for expenditure in respect of the BTC, as contractually the Trust is obliged to pay RPI indexation each year. Future RPI levels of 2.5% have been modelled for the Unitary Payment (UP).

13.12.7 The actual Inflation indices used in developing the base case of the Trust's LTFM are presented in the table below.

Table 95: Inflation Indices used for the LTFM Base Case

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
	Income									
Elective	-1.32%	0.00%	-2.30%	-2.10%	-1.00%	0.00%	0.20%	0.50%	0.50%	0.60%
Non Elective	-1.32%	0.00%	-2.30%	-2.10%	-1.00%	0.00%	0.20%	0.50%	0.50%	0.60%
Outpatients	-1.32%	0.00%	-2.30%	-2.10%	-1.00%	0.00%	0.20%	0.50%	0.50%	0.60%
A&E	-1.32%	0.00%	-2.30%	-2.10%	-1.00%	0.00%	0.20%	0.50%	0.50%	0.60%
Other Clinical Tariff	-1.32%	0.00%	-2.30%	-2.10%	-1.00%	0.00%	0.20%	0.50%	0.50%	0.60%
Other Clinical Non Tariff	-1.32%	0.00%	-2.30%	-2.10%	-1.00%	0.00%	0.20%	0.50%	0.50%	0.60%
Other Block Cost & Volume (Community Services)	-1.32%	0.00%	-2.30%	-2.10%	-1.00%	0.00%	0.20%	0.50%	0.50%	0.60%
Other Income - Private Patients	-1.32%	0.00%	-0.90%	-2.10%	-1.80%	0.30%	0.30%	0.30%	0.80%	0.80%
Other Income - Education & Training	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other Income - Research & Development	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Other Income - Other	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Expenditure									
Pay	0.42%	1.72%	0.50%	0.70%	2.00%	2.10%	2.20%	2.20%	2.20%	2.50%
Drugs	5.00%	1.85%	4.50%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%	3.00%
Clinical Supplies & Services	2.75%	1.00%	3.00%	3.00%	3.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Shared Services	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
CNST Premium	2.75%	1.00%	3.00%	3.00%	3.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Other Costs	2.75%	1.00%	3.00%	3.00%	3.00%	3.50%	3.50%	3.50%	3.50%	3.50%
PFI Indexation	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%
Capex Inflation	2.00%	1.00%	1.50%	1.50%	2.00%	2.00%	2.00%	2.00%	2.00%	2.00%

Implied Efficiency

13.12.8 The Trust is required to form its own view of future inflation trends / indices. Guidance is typically issued at the end of quarter 3 each year indicating expectations for the forthcoming year. The inflation / deflation assessments must deliver an overall implied efficiency rate consistent with national expectations. The Trust is working to long range implied efficiency levels as directed by Monitor in 2014 for the period to 2017/2018 of circa 4% per annum base case. Thereafter expectations are reflected between 3.5-3% annually.

13.12.9 The case has been built upon assumptions generated ahead of the latest guidance for 2014/2015 which reduced efficiency assumptions for 2014/15 to a net 4%. The inflation assumptions outlined above, plus cost pressures including PF2 elements creates an implied efficiency trajectory as outlined in the table below.

Table 96: LTFM Implied Annual Efficiency Assessment (Base Case)

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2021/22	2022/23	2023/24
LTFM Implied Efficiency Assessment (Annual): BASE	3.2%	3.0%	4.0%	4.0%	4.0%	3.5%	3.4%	3.2%	3.2%

13.13 The 12.5% Test

13.13.1 The test seeks to confirm that estates costs do not exceed 12.5% of the Trust annual normalised income. The precise definition of costs to be included in this metric has not been independently stated therefore, two measures have been developed in consideration of the test.

13.13.2 Firstly, to assess the proportion of the full unitary charge compared to normalised turnover, and secondly, to include the unitary charge, non-MMH depreciation, PDC dividend and estates hard FM costs in comparison to normalised turnover. In both instances the Trust is able to meet the test successfully. The table below demonstrates the components of the test and the result of the two approaches.

Table 97: 12.5% Test

Calculation of 12.5%	18/19 £000's	19/20 £000's	20/21 £000's	21/22 £000's	22/23 £000's	23/24 £000's
Turnover:						
Recurrent	449,342	460,232	472,822	484,995	497,117	511,561
Non Recurrent	-	-	-	-	-	-
Total	**449,342**	**460,232**	**472,822**	**484,995**	**497,117**	**511,561**
Maximum value of estates costs (12.5% of Total Turnover)	*56,168*	*57,529*	*59,103*	*60,624*	*62,140*	*63,945*
Maximum value of estates costs (12.5% of Recurrent Turnover)	*56,168*	*57,529*	*59,103*	*60,624*	*62,140*	*63,945*
Total Estates Costs						
Facilities Management (Operating Charge)						
PFI Interest	12,174	15,388	15,066	15,081	14,791	14,563
Capital Repayment	4,944	6,253	5,607	5,457	5,079	4,773
Facilities Management (Operating Charge)	4,713	6,537	7,871	8,381	9,434	10,116
Total PFI Charges	**21,831**	**28,177**	**28,544**	**28,919**	**29,304**	**29,452**
Expressed as a % of turnover	***4.86%***	***6.12%***	***6.04%***	***5.96%***	***5.89%***	***5.76%***
In Excess of recommended 12.5%	-	-	-	-	-	-
Group 2 : Estates Costs Excl Soft FM						
PFI Interest	12,174	15,388	15,066	15,081	14,791	14,563
Capital Repayment	4,944	6,253	5,607	5,457	5,079	4,773
Facilities Management (Operating Charge)	4,713	6,537	7,871	8,381	9,434	10,116
Depreciation Excluding MMH Build	3,714	4,137	4,413	4,737	4,982	5,127
PDC Dividend	5,875	5,836	6,129	6,439	6,752	7,075
Estates Building Related	530	335	335	335	335	335
Estates Engineering Related	1,694	1,145	1,145	1,145	1,145	1,145
Estates General Related	401	209	209	209	209	209
Estates Grounds Related	194	85	85	85	85	85
Total Group 2 : Estates Costs Excl Soft FM	**34,239**	**39,924**	**40,860**	**41,869**	**42,812**	**43,428**
Expressed as a % of turnover	***7.62%***	***8.67%***	***8.64%***	***8.63%***	***8.61%***	***8.49%***
In Excess of recommended 12.5%	-	-	-	-	-	-

13.14 Continuity of Service Risk Rating (CsRR)

13.14.1 The Trust is able to secure a minimum Risk Rating of at least 3 in its base case affordability position. This is achieved in the early trajectory years by strong performance against the Capital Service Capacity component of the test. As the MMH PF2 scheme is introduced performance against this component deteriorates placing a greater emphasis on the liquidity position.

13.14.2 The liquidity position improves across the timeline to strengthen the underlying rating. This is generated by annual cash backed surpluses across each year of the trajectory. The position does not rely upon a working capital facility under FT conditions. The Trust estimates a working capital facility of circa £30m. If this were to be included into the metric the liquidity position would be greatly strengthened as would the overall rating position. The Trust is not relying on this facility to meet the rating assessment. The continuity of service risk rating is presented in the table below.

Table 98: Continuity of Service Risk Rating in the Base Case LTFM

CSRR in the base case PF2 LTFM		Forecast 2014/15	Forecast 2015/16	Forecast 2016/17	Forecast 2017/18	Forecast 2018/19	Forecast 2019/20	Forecast 2020/21	Forecast 2021/22	Forecast 2022/23	Forecast 2023/24
Liquidity ratio (days)											
	Current assets	62.5	48.2	45.9	91.5	136.6	55.8	53.4	48.6	53.7	60.8
	Inventories	3.3	3.5	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2
	PFI prepayments and assets held for sale	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Current liabilities	-66.2	-52.5	-53.4	-50.5	-71.7	-59.1	-57.7	-50.8	-51.2	-51.4
	Days	360.0	360.0	360.0	360.0	360.0	360.0	360.0	360.0	360.0	360.0
	Operating expenses	-415.5	-410.0	-406.9	-405.0	-406.3	-414.3	-425.5	-437.0	-446.1	-458.1
	Fully committed Working Capital Facility	-	-	-	-	-	-	-	-	-	-
	Derivatives and embedded financial assets	-	-	-	-	-	-	-	-	-	-
	Liquidity ratio (days) - opening liquidity	**-6.0**	**-6.8**	**-9.5**	**33.6**	**54.6**	**-5.7**	**-6.4**	**-4.5**	**-0.6**	**4.8**
Capital servicing capacity (times)											
	Interest payable (-ve)	-2.1	-2.1	-2.4	-2.0	-11.9	-15.1	-14.8	-15.0	-14.6	-14.2
	Debt repayment (-ve)	-3.0	-2.0	-1.3	-0.9	-104.9	-6.3	-5.6	-5.5	-5.1	-4.8
	PDC dividend (-ve)	-5.2	-6.0	-6.8	-6.9	-5.9	-5.8	-6.1	-6.4	-6.7	-7.1
	PDC repayment (-ve)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	EBITDA	25.2	26.3	28.2	29.8	39.6	40.8	40.9	41.4	42.2	42.7
	Interest receivable (+ve)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Surplus available	25.2	26.3	28.2	29.8	39.6	40.8	40.9	41.4	42.2	42.7
	Capital servicing capacity (times)	**2.4**	**2.6**	**2.7**	**3.0**	**0.3**	**1.5**	**1.5**	**1.5**	**1.6**	**1.6**
Scoring (uses opening liquidity)											
	Liquidity ratio score	3	3	2	4	4	3	3	3	3	4
	Capital servicing capacity score	3	4	4	4	1	2	2	2	2	2
	Overall Continuity of Service Risk Rating (CSRR)	**3**	**4**	**3**	**4**	**3**	**3**	**3**	**3**	**3**	**3**

Downside and Sensitivity

13.14.3 The trust has developed a downside case and then a sensitivity to that case which stretches the scale and accelerates the timing of risk. Mitigations have then been identified which are over & above those cost and productivity improvements represented in the base case.

- The downside case from OBC has been subject to significant review and hardened in presentation of this ABC. The base case now shows risks to £41m by year 9 being some 25% higher than at OBC. This ABC now also includes a stress test sensitivity with risks to £62m and with an accelerated impact in the early years.
- The trust contends that it can reasonably mitigate against the base downside fully through a range of credible yet challenging actions and which provide for a minimum CoSRR level 2. In the downside base case this recovers to a level 3 by 2021.22 but remains at level 2 in the stress test sensitivity.
- The downside case tackles risk through cost reduction with minimal reliance on additional income expectations. That cost reduction specifically includes a review of workforce terms and conditions and is necessarily aggressive in that in the stress test sensitivity.

- The trust has been explicit with commissioners that its final stage mitigation would see site retrenchment. It is recognised that any such plan would require consultation and robust quality and equality impact assessment.

13.14.4 ***Appendix 13b*** explains further the approach to downside modelling and considers in more depth the risks generated from the Trust's Risk Register and mitigation available to the Trust under these circumstances.

13.14.5 The table below summarises the downside and sensitivity results.

Table 99: Downside case

	ABC Downside: I&E Position								
	2015/16 Year 1 £m	2016/17 Year 2 £m	2017/18 Year 3 £m	2018/19 Year 4 £m	2019/20 Year 5 £m	2020/21 Year 6 £m	2021/22 Year 7 £m	2022/23 Year 8 £m	2023/24 Year 9 £m
Base Case	**3.4**	**4.3**	**6.5**	**9.6**	**5.0**	**4.2**	**3.9**	**4.3**	**4.1**
Downside Case	(7.7)	(12.4)	(16.7)	(21.1)	(25.5)	(29.9)	(33.9)	(37.3)	(41.3)
Revised Downside I&E Position	**(4.3)**	**(8.1)**	**(10.2)**	**(11.5)**	**(20.5)**	**(25.7)**	**(30.0)**	**(33.0)**	**(37.2)**
Mitigation Case	7.2	10.7	18.3	15.2	25.7	29.8	32.7	36.7	40.0
Net Impact of Interest and Inflation	0.1	0.6	0.8	(0.1)	0.3	3.2	2.1	1.9	3.0
Revised Mitigated I&E Position	**3.0**	**3.2**	**8.8**	**3.6**	**5.5**	**7.3**	**4.8**	**5.7**	**5.7**

	ABC Downside: Cash Position								
	2015/16 Year 1 £m	2016/17 Year 2 £m	2017/18 Year 3 £m	2018/19 Year 4 £m	2019/20 Year 5 £m	2020/21 Year 6 £m	2021/22 Year 7 £m	2022/23 Year 8 £m	2023/24 Year 9 £m
Base Case	**28.7**	**27.9**	**32.8**	**45.1**	**42.5**	**37.6**	**42.6**	**49.6**	**57.4**
Downside Case	(7.7)	(20.1)	(36.9)	(58.0)	(83.4)	(113.3)	(147.3)	(184.5)	(225.8)
Revised Downside Cash Position	**21.0**	**7.7**	**(4.1)**	**(12.8)**	**(40.9)**	**(75.8)**	**(104.7)**	**(135.0)**	**(168.5)**
Mitigation Case	7.9	18.6	37.1	52.5	78.6	108.5	141.2	177.9	217.7
Net Impact of Interest and Inflation	0.4	1.3	2.6	2.7	3.1	5.8	7.9	10.0	13.1
Revised Mitigated I&E Position	**29.3**	**27.6**	**35.6**	**42.3**	**40.7**	**38.5**	**44.5**	**52.9**	**62.4**

	ABC Downside: Continuity of Service Risk Rating								
	2015/16 Year 1	2016/17 Year 2	2017/18 Year 3	2018/19 Year 4	2019/20 Year 5	2020/21 Year 6	2021/22 Year 7	2022/23 Year 8	2023/24 Year 9
Base Case	4	3	4	3	3	3	3	3	3
Downside Case	3	2	3	3	1	1	1	1	1
Mitigation Case	4	3	4	3	2	2	3	3	3
Mitigation Case - OBC	**3**	**4**	**4**	**3**	**2**	**2**	**3**	**3**	**3**

Table 100: Downside Sensitivity

	ABC 10% Downside Sensitivity: I&E Position								
	2015/16 Year 1 £m	2016/17 Year 2 £m	2017/18 Year 3 £m	2018/19 Year 4 £m	2019/20 Year 5 £m	2020/21 Year 6 £m	2021/22 Year 7 £m	2022/23 Year 8 £m	2023/24 Year 9 £m
Base Case	**3.4**	**4.3**	**6.5**	**9.6**	**5.0**	**4.2**	**3.9**	**4.3**	**4.1**
Downside Case	(8.7)	(17.4)	(26.1)	(35.7)	(45.5)	(49.9)	(54.0)	(58.0)	(62.0)
Revised Downside I&E Position	**(5.3)**	**(13.1)**	**(19.6)**	**(26.1)**	**(40.5)**	**(45.7)**	**(50.0)**	**(53.6)**	**(57.9)**
Mitigation Case	7.2	11.0	19.1	16.6	42.0	49.8	54.8	60.7	66.0
Net Impact of Interest and Inflation	0.1	0.4	0.2	(1.2)	(1.6)	(1.6)	(2.2)	(2.1)	(0.8)
Revised Mitigated I&E Position	**2.0**	**(1.6)**	**(0.3)**	**(10.7)**	**(0.1)**	**2.5**	**2.5**	**5.0**	**7.3**

	ABC 10% Downside Sensitivity : Cash Position								
	2015/16 Year 1 £m	2016/17 Year 2 £m	2017/18 Year 3 £m	2018/19 Year 4 £m	2019/20 Year 5 £m	2020/21 Year 6 £m	2021/22 Year 7 £m	2022/23 Year 8 £m	2023/24 Year 9 £m
Base Case	**28.7**	**27.9**	**32.8**	**45.1**	**42.5**	**37.6**	**42.6**	**49.6**	**57.4**
Downside Case	(8.7)	(26.1)	(52.2)	(87.9)	(133.4)	(183.3)	(237.3)	(295.2)	(357.2)
Revised Downside Cash Position	**20.0**	**1.8**	**(19.5)**	**(42.8)**	**(90.9)**	**(145.8)**	**(194.7)**	**(245.7)**	**(299.9)**
Mitigation Case	7.9	18.9	38.3	54.8	97.0	145.9	199.7	259.3	324.2
Net Impact of Interest and Inflation	0.5	1.2	2.5	1.8	0.5	(0.7)	(2.0)	(2.9)	(2.7)
Revised Mitigated I&E Position	**28.4**	**21.9**	**21.3**	**13.8**	**6.6**	**(0.6)**	**3.1**	**10.7**	**21.7**

	ABC 10% Downside Sensitivity: Continuity of Service Risk Rating								
	2015/16 Year 1	2016/17 Year 2	2017/18 Year 3	2018/19 Year 4	2019/20 Year 5	2020/21 Year 6	2021/22 Year 7	2022/23 Year 8	2023/24 Year 9
Base Case	4	3	4	3	3	3	3	3	3
Downside Case	3	1	3	3	1	1	1	1	1
Mitigation Case	3	3	4	3	2	2	2	2	2

13.15 Affordability Conclusions

13.15.1 The affordability conclusions are that:

- The scheme is affordable as demonstrated by the consistent achievement of CoSRR level 3 ratings across the period of the LTFM. Estates costs are also consistently within the 12.5% test limit.
- The trust delivered a 2014.15 surplus ahead of plan
- The downside case stress tests the plan including with early years impact bias. Mitigation identified suggests that affordability stands that scrutiny with impact of a reduction to CoSRR level 2 in the first two years of operation
- The scheme is aligned with commissioner plans including Better Care Fund aspirations and remains consistent with RCRH strategies
- CIP is consistent with national efficiency requirements reflecting assumptions of cost inflation and price deflation. The additional net investment in the scheme is the equivalent of circa one additional year of that efficiency and is specifically enabled by delivery of the RCRH service changes. The trust contends that the scale of opportunity for operational productivity and service transformation driven cost change is consistent with that required to underpin scheme affordability
- The case includes necessary and sufficient investment in key enabling and supporting infrastructure and specifically informatics including EPR, retained estate and medical equipment. Fixed imaging equipment investment is assumed to be delivered through a Managed Service Contract. The revenue costs are reflected in full in the LTFM supporting the case.

- The anticipated unitary payment reflects updated terms and represents a significant improvement on those at OBC. This case retains that improvement as affordability headroom.
- The base case assumes £100m of Public Dividend Capital investment.
- Land sale proceeds are specifically excluded from the base case and dealt with as potential mitigation in the downside case.

14 Project Timetable and Management Arrangements

14.1 Introduction

14.1.1 This chapter sets out how the project will be successfully managed through the remainder of the procurement to ensure that it delivers the project objectives required by the Trust.

14.1.2 A project plan is being followed to enable financial close to be achieved by December 2015 and MMH to be operational by October 2018.

14.1.3 Robust project management arrangements are in place to drive project delivery.

14.1.4 Risks have been actively managed and a benefits realisation plan produced.

14.2 Project Plan and Timetable

14.2.1 The key milestones already achieved for the project are set out in the table below along with subsequent dates showing the aim to achieve Financial Close in December 2015 and MMH to be operational by October 2018.

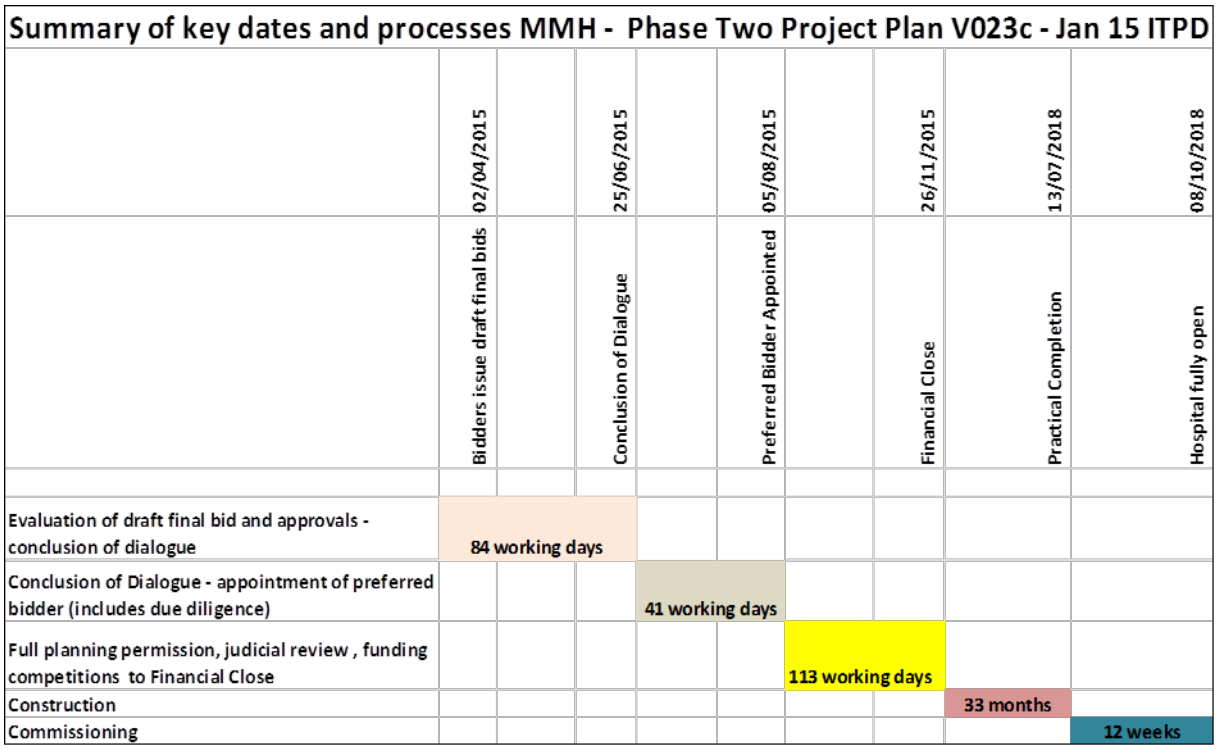
Table 101: Key Milestones to Financial Close

Milestone	Date
Strategic Outline Case approved	July 2004
Outline Planning Consent granted	October 2008
Trust purchased Grove Lane site	September 2012
Refreshed Outline Planning Consent	June 2013
Vacant possession of the Grove Lane site	November 2013
Outline Business Case approved	July 2014
OJEU Notice published	July 2014
Expressions of interest received	August 2014
Pre-Qualification Evaluation	August 2014
Invitation to participate in dialogue issued	September 2014
Interim bid submission received	December 2014
Receipt of Draft Final Bids	April 2015
Submission of Generic Appointment Business Case	May 2015
Approval of Generic Appointment Business Case and Close Dialogue	June 2015
Receipt of Final Bid	July 2015
Submission of Specific Appointment Business Case	July 2015
Approval of Specific Appointment Business Case and Appoint Preferred Bidder	August 2015
Full planning consent granted	October 2015
Submission of Confirmatory Business Case	October 2015
Advanced works commence on site	November 2015

Milestone	Date
Approval of Confirmatory Business Case	November 2015
Financial close	December 2015
Commencement of main construction programme	January 2016
MMH handed over to Trust	July 2018
MMH operational	October 2018

14.2.2 The key dates and processes for the next phase of the project are presented in the figure below and a detailed project plan is presented in ***Appendix 14a.***

Figure 32: Key Dates and Processes



14.3 Project Management

14.3.1 The Trust places particular importance on effective project management arrangements across all its development activities, and has significant in-house experience.

14.3.2 A comprehensive Project Management approach was established by the Trust for this project prior to entering the OBC Phase of the project and these arrangements and structures have continued with ongoing refinement and expansion into the Procurement Phase of the Project.

14.3.3 Details of the Project Structure are set out in the Project Execution Plan (PEP) presented at ***Appendix 14b***. This document has been updated to ensure that all participants are aware of their roles and responsibilities and understand the project approach.

14.4 Capability and Best Practice

14.4.1 The Chief Executive Officer (Senior Responsible Owner for this project) and Director of Finance and Performance both have considerable experience of delivering large PFI schemes. The Trust's Chairman has significant experience in property management. This level of capability will ensure strong leadership for the project.

14.4.2 The Project Team is supported by a fully resourced Project Office, of appropriately experienced and qualified individuals. Details are set out within the PEP presented at ***Appendix 14b.***

14.4.3 The project is managed in line with best practice ensuring that roles and responsibilities are clearly defined. Decision making is transparent and is documented to ensure a robust audit trail is maintained.

14.5 Organisational Structure and Governance

Roles and Responsibilities

The Senior Responsible Owner (SRO)

14.5.1 The Chief Executive Officer undertakes the SRO role for this project. The SRO is personally accountable for the success of the project ensuring that the project meets its objectives and delivers benefits. The SRO will ensure that the project maintains business focus in a changing healthcare context and that risks are managed effectively.

The Project Director

14.5.2 The Project Director is responsible for day to day decision making on behalf of the SRO and setting high standards for delivery of the project.

The Project Manager

14.5.3 The Commercial Manager / Senior Project Manager is a full time post and coordinates the activities of the Core Project Team on a day to day basis and is responsible for ensuring that:

- The Competitive Dialogue process runs smoothly;
- Requests for information, issues and changes are managed appropriately;
- Project standards are maintained; and
- The project budget is managed effectively.

Governance Arrangements

The Trust Board

14.5.4 The Trust Board is the investment decision maker for the project ensuring that the project has a viable and affordable business case. The Board will require evidence that the project can deliver value for money and best quality healthcare for the local community through effective management of the procurement process.

14.5.5 The project is managed through two key Trust Sub-Committees to ensure that proper scrutiny and oversight is maintained during transition and to ensure effective alignment with planning across all the years of the project. This avoids the risks of silo-working and ensures that new ways of working are developed well before MMH opening.

The Configuration Subcommittee

14.5.6 The purpose of the Configuration Committee is to provide the Board with assurance concerning strategic direction ensuring on-going alignment of the MMH and the programme of interim reconfigurations. The committee holds the executive to account for delivering the estates strategy and the full business case. The LTFM is tracked by the Board's Finance Committee on a bimonthly basis.

14.5.7 The membership includes:

- The Trust Chair (Chair);
- Two Non-Executive Directors;
- The Chief Executive Officer (SRO);
- The Medical Director;
- The Director of Finance and Performance Management;
- The Director of Estates and New Hospital Project.

A quorum is at least 4 members, of which there must be at least one Non-Executive Director.

14.5.8 The full terms of reference are presented in the PEP presented at ***Appendix 14b***. A brief summary of the MMH related duties of the Committee are presented below. The committee:

- Oversees the competitive dialogue process ensuring that best practice is carried out in line with EU regulations;
- Approves project plans and monitor progress against plan;
- Approves and sign off the key outputs and decisions at each stage of the project;
- Reviews and acts on factors affecting the successful delivery of the project;
- Reviews serious issues, which have reached threshold level, considering requirement for changes to the project scope, budget or timescale if required;
- Brokers relationships with stakeholders within and outside the project to maintain positive support for the acute hospital development; and
- Maintains awareness of the broader perspective advising the SRO on how it may affect the project.

14.5.9 The Configuration Subcommittee delegates authority, to the MMH and Reconfiguration Committee of the Clinical Leadership Executive and Core Project Team to ensure that the project meets its objectives.

MMH and Reconfiguration Committee

14.5.10 The MMH and Reconfiguration Committee is a committee of the Clinical Leadership Executive comprising a group of SWBH Executive Directors and representatives of the seven Clinical Groups who manage the operational services of the Trust. They provide leadership within the organisation to ensure successful delivery of the project and assurance to the Clinical Leadership Executive and Trust Board about the project. The group provides guidance to the Project Director and ensures that Trust resources are available to support the project. The group:

- Provides leadership, mandate and focus within the Trust ensuring that Clinical Group objectives will drive effective delivery of the competitive dialogue process;
- Provides advice to the Project Director, Configuration subcommittee and Trust Board, raising any concerns and providing expert opinion to support decision making;
- Resolves issues at organisational level when the Core Project Team requires assistance;
- Resolves issues which impact on SWBH involving senior external stakeholders, the press; Government, arm's length bodies etc.;
- Provides assessment of serious issues;
- Manages changes to the project where required ensuring tight control of cost;
- Ensures that project plans are achievable and facilitate delivery as required; and
- Reviews the risk register on a quarterly basis / at key milestones, advise the Configuration subcommittee prior to approval and help the Core Project Team mitigate risks at organisational level.

14.5.11 The membership of the MMH and Reconfiguration Committee includes:

- Chief Executive Officer (Chair);
- All Executive Directors;
- The Commercial Manager;
- Deputy Chief Operating Officer / Transformation Director; and
- Representatives of each Clinical Group.

14.5.12 Issues exceeding the delegated authority of the MMH and Reconfiguration Committee are referred to the Clinical Leadership Executive or the Trust Board.

Core Project Team

14.5.13 The Core Project Team is the group of individuals with appropriate and complementary professional, technical or specialist skills who, under the direction of the Project Director and coordinated by the Project Manager, are responsible for carrying out the work detailed in the project plan.

14.5.14 The Core Team is responsible for:

- Planning and delivering the Competitive Dialogue and bid evaluation process and all other activities to financial close;
- Developing, maintaining and implementing project plans;
- Co-ordinating working groups and evaluation teams as required;

- Monitoring progress and reporting to the MMH and Reconfiguration Committee and Configuration Subcommittee;
- Managing issues as they arise in line with the issue management policy and escalating those above threshold to the MMH and Reconfiguration Committee;
- Managing change control;
- Managing project advisors, ensuring that their contribution is well understood and that the Trust obtains best advice and value;
- Managing risks in line with project risk management strategy; and
- Ensuring effective development and delivery of the Engagement and Communications Plan

14.5.15 The Core Team membership includes the:

- Director of Estates and New Hospital Project;
- Commercial Manager;
- Deputy Chief Operating Officer / Transformation Director;
- Head of Estates;
- Deputy Director of Workforce;
- Head of Facilities
- Senior Project Accountant; and
- Project Manager.

14.5.16 The Core Team meets weekly, or as required, to co-ordinate the work required by the project. It reports to the MMH and Reconfiguration Committee.

14.5.17 The Core Team coordinates the working groups as required by the procurement Process.

The Clinical Leadership Executive

14.5.18 The Clinical Leadership Executive maintains an overview of the clinical brief and the activity and financial parameters set by the MMH and Reconfiguration Committee. It provides clinical leadership in relation to the design process and will inform evaluation of bidders' proposals in the PF2 process. The Clinical Leadership Executive includes the management teams of the Trust's seven Clinical Groups and the Executive Directors of the Trust.

Land Acquisition Group

14.5.19 The Land Acquisition Group was formed during Phase One of the project to acquire the land required to build the hospital. This group will continue to meet until the final amounts due for the land acquired under compulsory purchase have been agreed and paid and the remediation of the site is complete.

14.5.20 The group is responsible for:

- Completing purchase of land required for the hospital site;
- Arranging agreed demolition works on the land acquired;
- Ensuring that this work is completed to timeframe; and

- Managing budget in line with the capital programme
- Overseeing the remediation of the site prior to handover to the PF2 contractor.

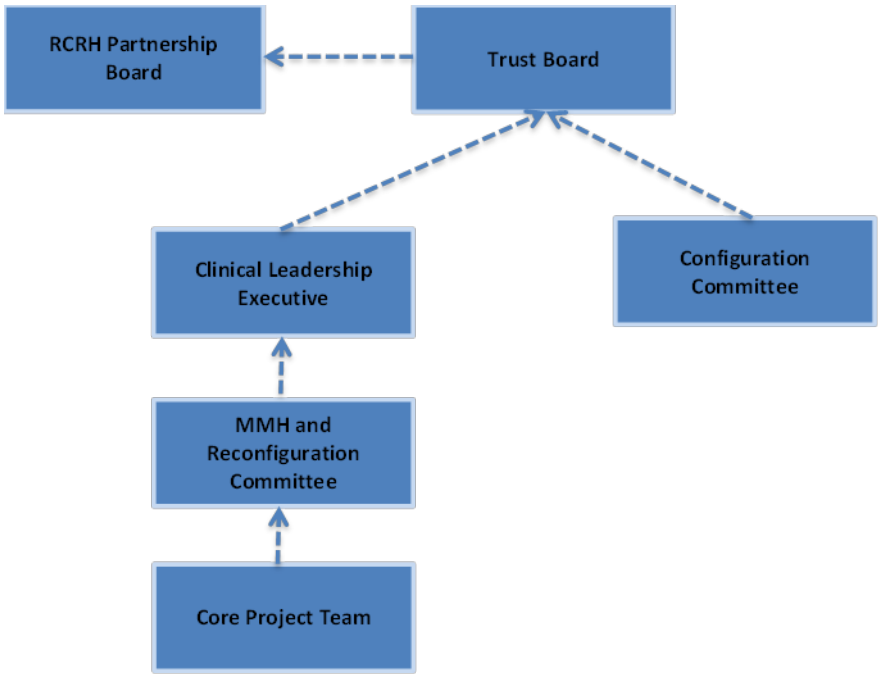
14.5.21 Membership of the group includes the:

- Director of Estates and the New Hospital Project;
- Director of Finance;
- Head of Estates;
- Commercial Manager; and
- Legal, land and other advisors as required

The Project Structure

14.5.22 The project structure is shown in Figure [XX] below.

Figure 33: Project Structure



14.5.23 A more detailed structure chart showing individual roles is presented at ***Appendix 14c***.

14.6 External Advisors

14.6.1 The project advisors are listed in table below.

Table 102: Project Advisors

Advice requirement	Company
Legal advisors	Pinsent Masons
Financial Advisors	Deloitte
Co-ordination of technical advice	Capita Consulting
Health Planning	Capita Consulting
Facilities Management	Capita Consulting
Equipping	MTS
Architecture	IBI Nightingales
Town Planning	IBI Nightingales
Engineering	Hulley & Kirkwood
Traffic & Transport	Hulley & Kirkwood
Quantity Surveying	Cyril Sweett Limited (incorporating Nisbet)
Life Cycle Analysis	Cyril Sweett Limited (incorporating Nisbet)
Health & Safety	Cyril Sweett Limited (incorporating Nisbet)
Costing Services	Cyril Sweett Limited (incorporating Nisbet)
Insurance	Willis Ltd.

14.6.2 Project advisors have been appointed on a terms of reference which includes all work required from pre-OJEU to Financial Close. The tender documentation outlines the work programme and deliverables anticipated. The Core Team and work streams co-ordinate delivery of work or advice as required.

14.6.3 The project advisors meet with the Core Team as required to:

- Plan and co-ordinate work across working groups;
- Maintain communication;
- Report on progress and issues; and
- Provide advice as required.

14.7 Project Procurement Costs and Funding

14.7.1 The table below presents the staff funded by the project.

Table 103: Posts Funded by the Project

Staffing	WTE
Project Director	0.8 WTE
Commercial Manager	1 WTE
Project Manager	1 WTE
Workforce Lead	1 WTE
Accountants / Commercial	3 WTE

Staffing	WTE
Change Team Lead	0.4 WTE
Service Development Managers	2 WTE
Head of Estates	0.65WTE
Project Manager Capital Projects	1WTE
Equipping Manager	1 WTE
Estates Managers	2 WTE
Facilities Managers	1 WTE
Project Administrators:	2 WTE

14.7.2 The Trust has established a specific budget for the remaining stages of the Project as set out in the table below.

14.7.3 The budget is managed by the Project Director, with clear delegated powers within the overall budgetary arrangements of the Trust.

Table 104: Project Budget

MMH /Community Facilities		Budget 2014/15 to 2019/20					
	13/14	14/15	15/16	16/17	17/18	18/19	19/20
	£	£	£	£	£	£	£
Pay							
Project Office	342,500	382,000	382,000	317,000	317,000	317,000	317,000
Human Resources	46,000	46,000	46,000	106,000	106,000	106,000	46,000
Finance	180,000	180,000	180,000	130,000	130,000	130,000	130,000
Redesign	155,000	405,000	230,000	170,000	350,000	350,000	260,000
Estates	271,000	366,000	366,000	446,000	446,000	466,000	295,000
Total Pay	**994,500**	**1,379,000**	**1,204,000**	**1,169,000**	**1,349,000**	**1,369,000**	**1,048,000**
MMH Project Office Non Pay							
Engagement and Comms	20,000	30,000	20,000	10,000	10,000	30,000	30,000
Boot Camp expenses	50,000	50,000	50,000				
Market Engagement	30,000						
Misc (stationery,printing,travel etc)	40,000	40,000	40,000	40,000	40,000	40,000	40,000
Sub-Total Project Office NonPay	**140,000**	**120,000**	**110,000**	**50,000**	**50,000**	**70,000**	**70,000**
Advisor Costs							
OBC							
Development of workforce model	20,000						
Development of activity model	30,000						
External Assurance	50,000						
Update Outline Planning Permission	50,000						
Business Case Production	15,000	15,000	15,000				
PSC refresh	265,000						
Sub-Total - OBC	**430,000**	**15,000**	**15,000**	-	-	-	-
PFI PROCUREMENT							
Insurance Advisor		3,000	900				
Estates & Technical Against Tender	131,000	300,000	188,000	104,000	39,000	39,000	
Estates & Technical Out of Scope							
Legal Advice Against Tender	20,000	100,850	80,000				
Legal Advice Outside Scope	96,100	100,850	80,000				
Corporate Finance Advice Against Tender	20,000	109,850	60,000				
Corporate Finance Advice Outside Scope	94,700	109,850	60,000				
Business, Finance, Activity & Project Management	500		4,800				
IT Advisor	20,000	20,000	20,000				
Regeneration Advisor	5,000	5,000	5,000				
Warranty of Title -legal costs			50,000				
Independent Tester				50,000	100,000	150,000	
Due Diligence Advisors							
Bidder Costs							
Advisor Contingency	127,925	260,000	220,925	210,000	210,000	150,000	210,000
Sub-Total - PFI Procurement	**515,225**	**1,009,400**	**769,625**	**364,000**	**349,000**	**339,000**	**210,000**
Total Advisor Costs	**945,225**	**1,024,400**	**784,625**	**364,000**	**349,000**	**339,000**	**210,000**
Total Non Pay	**1,085,225**	**1,144,400**	**894,625**	**414,000**	**399,000**	**409,000**	**280,000**
Total Pay and Non Pay	**2,079,725**	**2,523,400**	**2,098,625**	**1,583,000**	**1,748,000**	**1,778,000**	**1,328,000**

14.8 Project Execution Plan

14.8.1 A Project Execution Plan was initially written in 2008 and has been refreshed at key stages of the project. The document has been updated for the next stage of the project and is now known as the Project Execution Plan (PEP). The document is presented at ***Appendix 14b***.

14.9 Audit and Review

Integrated Assurance and Approvals Plan

14.9.1 The MMH has been identified as a 'Major Project' by the Major Projects Authority (MPA) within the Cabinet Office. It is mandatory for all Major Projects to have an Integrated Assurance and Approvals Plan (IAAP). Integrated assurance and approval is the planning, coordination and provision of assurance activities and DH / HMT approval points through the life of the project. The IAAP is presented in ***Appendix 14d***. The MPA undertakes quarterly monitoring of the project.

Gateway Review

14.9.2 The Right Care, Right Here Programme has undertaken regular Gateways Reviews and a Strategic Health Authority Review to oversee the programme.

14.9.3 The MMH Gateway Review process was initiated with a Risk Potential Assessment (RPA) in 2008 which indicated a score of 51. This put the project within the high risk threshold. The Gateway reviews to date and planned are shown in the table below.

Table 105: Gateway Review Dates and Outcomes

Date	Gateway	Purpose	Delivery Confidence	Actions outstanding
November 2008	Gate 1	To confirm that the business case is robust – that is, in principle it meets the business need, is affordable, achievable with appropriate options explored and likely to achieve value for money.	Green	None
December 2010	Gate 2	To confirm the Outline Business Case now that the project is fully defined and ensure that the delivery strategy and procurement is robust and appropriate.	Amber Green	None
March 2014	Second Gate 2	To reconfirm the above in the light of PF2.	Amber Green	None
May 2015	Gate 3	Prior to submission of the Specific ABC and appointment of Preferred Bidder.	TBC	TBC
June 2018	Gate 4	'Readiness for Service' prior to practical completion.	TBC	TBC
March 2019	Gate 5	Post project review	TBC	TBC

A summary of the second Gate 2 (March 2014) report and the completed actions is presented at ***Appendix 14e***.

Trust Board Assurance

14.9.4 New members were appointed to the Trust Board during 2013, including a new Chief Executive Officer. The Board therefore undertook a review of project assumptions during the period of update for PF2. This enabled robust project validation to be undertaken including a clinical review of the Public Sector Comparator design. This process provided assurance for the Board to support the OBC approval process during 2014.

14.10 Risk Management

14.10.1 A risk register was established at the beginning of the project. The register records:

- A description of each risk and the scope of its potential impact;
- The probability of each risk occurring (with a score of between 1-5, 5 being the highest, 1 the lowest);
- The level of impact (with a score of between 1-5 as above); and
- Risk management arrangements to minimise the probability and / or impact.

14.10.2 Risk workshops involving all members of the Core Project Team and lead Directors have been undertaken regularly throughout the project. As a result all of the risks have been actively managed at each stage.

14.10.3 The risk register for the procurement stage of the project has been reviewed by the team and risks are being actively managed. A copy of the risk register is presented at ***Appendix 14f*.**

14.11 Benefits Realisation and Evaluation

14.11.1 A benefits realisation plan has been written and is presented at ***Appendix 14g***. The key benefit themes identified are:

- Improved clinical quality and sustainability of clinical services;
- Improved customer care;
- More effective use of staff resources;
- Improved patient flows;
- Improved accessibility of services for the local population;
- Improved flexibility and quality of accommodation;
- Improved ability to develop / sustain services and respond to commissioner intentions;
- Financial benefits; and
- Local area regeneration.

14.12 Conclusion

14.12.1 The project management arrangements have proved robust to date. Strong leadership and effective issue and risk management have ensured that the procurement has remained on track for MMH to be operational by October 2018.

15 Sustainability, Regeneration and Corporate Citizenship

15.1 Introduction

15.1.1 Sustainability, regeneration and corporate citizenship are important aspects of the project stated clearly in the:

- Project objectives and benefits presented in the Outline Business Case; and
- The specification for bidders contained within the Functional Brief.

15.1.2 The Trust required bidders to demonstrate how they would deliver these objectives. Chapter 12 (Bidder Solution) outlines the approach The Hospital Company has taken to meet the Trust's requirements. This work has strengthened the approach by providing a robust measurable set of proposals to meet the specification.

15.1.3 This chapter builds on Chapter 12 to set out the overarching approach to sustainability, regeneration and corporate citizenship.

15.2 Approach to Sustainability for the New Hospital

BREEAM

15.2.1 BREEAM is the Building Research Establishment Environmental Assessment Method for buildings and large scale developments. It sets the standard for best practice in sustainable design and has become the de facto measure used to describe environmental performance of buildings and communities. A BREEAM Assessment was undertaken in November 2008. The public sector comparator achieved a BREEAM score of 78.7%, achieving a rating of Excellent. As outlined in Chapter 12 The Hospital Company will be required to achieve a rating of Excellent in the MMH.

Energy Use of the Facilities

15.2.2 The Trust will raise the profile of operational energy and environmental management in order to improve performance in these areas. As the impact of the new facility will be influenced by both the activities of those operating the building and those occupying the building, it is recognised that the minimisation of such impacts will be as a result of partnerships. An energy use performance target will be set for a maximum of 42GJ/100m^3.

Travel Plans for the New Hospital

15.2.3 The Trust's Travel Plan investigates the potential for providing alternative means of transport to and from the site in order to reduce reliance upon the car and sets actions and targets for the minimisation of pollution and congestion. It is supported by a detailed transport assessment, including staff surveys and makes recommendations on travel to work.

15.2.4 As outlined in Chapter 12 the Bidder Solution has prepared a planning application supported by a Green Travel Plan to generate shifts in transport.

15.2.5 The RCRH Programme has formed a Transport Group which aims to develop effective transport routes to the MMH and other healthcare facilities. The Trust will liaise with local public transport providers and the local authority to ensure good accessibility from all town and community centres in the catchment area.

Water Use of the Facilities

15.2.6 Water consumption will be minimised as much as possible given that clinical risks and requirements are to be a clear priority.

Materials Used in Construction

15.2.7 The Trust aims to ensure that the materials and construction techniques used are classified as A rated in the Green Guide to Specification ([Ref]). Use of recycled 'aggregate' materials (crushed masonry for example) for use in foundations and under road surfaces is also to be incorporated where possible and where such materials can be found within a sensible distance for transport.

Land Use and Ecology

15.2.8 Whilst the Trust recognises that the current use of the proposed site is urban / industrial the Trust aims that the site should be developed to benefit the people, environment and ecology in the locality.

Pollution

15.2.9 The development will limit the emission of carbon dioxide through the significant use of low / zero carbon energy technologies (LZC). LZC should deliver no less than a 30% reduction of carbon dioxide emissions. Operational pollution will be reduced through the application of good practice design of the site, buildings and services.

Operational Waste Management

15.2.10 The MMH will support minimisation of waste and maximal recycling. Dedicated facilities will be incorporated for storage and collection of recyclable material in conjunction with adequate segregation.

15.3 Regeneration and Urban Renewal

15.3.1 The development of a new hospital in this area will have substantial regenerative and health benefits which are mutually supportive. It represents a big step forward in the achievement of the Council's policy objectives set out in the Smethwick AAP to regenerate the Grove Lane area of Smethwick.

15.3.2 A detailed report on the many regeneration opportunities provided by the MMH can be provided if required (this report provides part of the proof of evidence for the compulsory purchase order public Inquiry). A number of the significant social, economic and environmental regeneration benefits of the scheme are outlined below:

15.3.3 The health and social benefits are that:

- The MMH will provide improved delivery of acute health services in Sandwell and west Birmingham;
- The RCRH programme has established links with the Learning and Skills Council, colleges and local partnerships to develop initiatives to train local people for health employment;
- The flagship building will become the civic heart of the area and a point of pride for the community;
- The MMH will act as a catalyst for new, mixed use regeneration helping to inspire new confidence in the area and major new public and private investment; and

- The regeneration potential of the City Hospital site will be maximised as a 'gateway' link to Jewellery Quarter.

15.3.4 The economic, regeneration and skills benefits are summarised below:

- Working with partners across the borough the Project Team specified a commitment to ensuring that local people will be given equal opportunities for training and employment. As outlined in Chapter 12 The Hospital Company has now made clear proposals about how this can be achieved.
- To optimise the employment and training benefits arising from significant investment that will take place in the program.
- Temporary jobs will be created in the demolition and remediation of the site, and in the subsequent construction of the hospital with estimated impact of circa 500 full time construction jobs.
- The hospital will directly employ skilled and unskilled people who will be relocated from the existing sites thus creating a concentration of health professionals within the Grove Lane area of Smethwick.
- New health activity in the area is likely to demand locally produced goods and services which will result in indirect jobs. Using a conservative multiplier it is anticipated that the new hospital could generate in the region of 220 jobs indirectly and 440 induced jobs.
- A new hospital will add an additional dimension to the mixed use development proposed on these sites. It will provide a catalyst for new types of economic activity associated with hospital research and services.
- The hospital may attract related economic activities and need for key worker housing.
- The development of a new acute hospital at Grove Lane will release land at City and Sandwell Hospitals for comprehensive regeneration to provide major new investment opportunities.

15.3.5 The environmental benefits are summarised below:

- The hospital will be one of Sandwell's most significant development projects and will help to transform a largely derelict and run down part of the Borough.
- The MMH makes efficient use of land opening up a run down private industrial area for public use.
- The majority of existing buildings are not appropriate for modern industrial use and a large part of the site is derelict with a low density of employment. A new hospital will regenerate the site and bring it back into productive use.
- The MMH will be set within a landscaped context and will provide a high quality building of design that will dramatically improve the visual appearance of the area.
- The position of the hospital next to the canal will enable public access to this part of the waterways network, which was previously inaccessible.
- The site will be permeable and accessible whilst ensuring security for staff, visitors and patients.
- The proposals include a substantial area of public realm, which will be available to staff, visitors and patients.
- A key regenerative benefit will be the comprehensive remediation of a large area, rather than piecemeal remediation of individual sites.

- Public transport access to the site will be catered for with dedicated bus and taxi drop-off facilities located directly adjacent to the main entrance.

Trust Activities to Support Regeneration

15.3.6 Since the first OBC approval in August 2009 the Trust has actively worked with partners to maximise the regeneration benefits of the MMH, which will act as a catalyst for development in the area. The following activities have taken place:

- The Trust has participated in a workshop on the vision for regeneration for the RCRH Programme. A vision group has since formed and continues to coordinate work with the two councils and other stakeholders to ensure joined up approaches to regeneration.
- The Trust ran an event for regeneration group professionals, the councils and other interested parties to develop plans for ensuring that the impact of the new hospital will be to realise real benefits for local communities. This event was led by the Chair of the Trust and resulted in the development of an action plan. Work has already begun in response to the plan and there is a high level of commitment for joint working in the future.
- Members of the team have presented at and participated in activities for the residential led neighbourhood regeneration of the Windmill Eye estate, which is adjacent to the Grove Lane site.
- Members of the team are involved in the Western Growth Corridor regeneration programme.

15.3.7 The Trust is working with Find it in Sandwell and Find it in Birmingham on innovative new ways of ensuring that the new hospital will provide opportunities for local businesses before, during and after the construction phase of the project. This involves the linking of the new acute hospital website to the 'Find it' sites to lead local companies expressing an interest in the scheme to the 'Find it' web pages. They can then register on the sites and access training to help them prepare their business for the new opportunities. The website will then provide a resource for the PF2 bidders (and eventually Project Co) to identify highly capable local companies to provide products and services for the scheme.

15.3.8 Working with the 'Find it' initiative the Trust plans to run a supply chain engagement event to ensure that local companies continue to be involved and to provide opportunities for them to link with architects and potential PF2 partner organisations.

15.3.9 The RCRH Partnership Board has agreed a vision for regeneration and the Vision Group has completed a detailed mapping exercise of regeneration initiatives, over the next 20 years

Corporate Citizen Checklist

15.3.10 A Good Corporate Citizen Checklist has been completed which makes reference to how the project will support sustainable development and tackle health inequalities. This self-assessment tool addresses:

- Transport;
- Procurement;
- Facilities Management;
- Employment and Skills;
- Community Engagement; and

- New buildings.

Regeneration Objectives for the PF2 Partner

15.3.11 The Hospital Company is required to actively work to generate opportunities for:

- Local employment and apprenticeships;
- Work for local companies in the PFI supply chain for provision of products and / or services; and
- Other benefits for the local community.

15.3.12 The Hospital Company have presented a strong regeneration strategy in its Draft Final Bid submission. It has committed to:

- 80% construction spend within East and West Midlands
- 70% employment within 20 miles of MMH
- 50% employment within B postcode

15.3.13 A dedicated Community Regeneration manager will work with the Trust and local authorities to develop a community needs plan for MMH. This would be combined with local spend and employment initiatives to ensure a lasting local legacy.

15.3.14 The Hospital Company are working towards National Skills Academy for Construction "centre of excellence "status for MMH. They have committed to a high level of work experience, apprenticeship and other training posts.

15.3.15 In turn the Trust will work with local partners to ensure that local companies and colleges are able to respond to demand when products, services and workforce are required.

15.4 Equality Impact Assessment

15.4.1 An equality impact assessment is a careful examination of a proposed policy, project or service to see if it could affect some groups unfavourably.

15.4.2 The Trust has developed a framework (presented at ***Appendix 15a***) to tackle discrimination in a proactive way, ensuring that equality considerations are consistently integrated into day-to-day business through equality impact assessment. This ensures legal compliance, but also helps to ensure that Trust services best support the healthcare needs of the local population.

15.4.3 The framework was used to make an assessment in November 2013 of the potential impact on the following 'protected characteristics':

- Age;
- Disability;
- Race;
- Sex;
- Gender;
- Reassignment;

- Sexual Orientation;
- Religion or Belief;
- Pregnancy & Maternity;
- Marriage & Civil Partnership; and
- Other socially excluded groups.

15.4.4 The conclusion of the assessment was that some frail and elderly patients / members of the public would have further to travel to the new hospital. This is addressed in the transport strategy which has been agreed with the RCRH board.

16 Workforce

16.1 Introduction

16.1.1 This Chapter builds on work undertaken for the OBC as part of an ongoing process of robust planning and delivery of the workforce changes required for service reconfiguration in readiness for the opening of the MMH. It presents the current workforce profile and outlines the Trust's successful track record for delivery of workforce change.

16.1.2 The LTWM embeds the rigor of top down modelling through integration with the Long Term Financial Model (LTFM) as well as addressing bottom up design of the future workforce in line with activity trajectories, productivity improvements and safe staffing standards.

16.1.3 The trust has already successfully delivered the 'Safe and Sound Phase 1' – the first stage of the trust's workforce change plan. This has resulted in the reduction of 260 whole time equivalents (WTEs).

16.1.4 The trust has a clear plan to deliver the remainder of the workforce change plan by March 2020 which will be a combination of a further reduction of 1,087 WTEs and a reduction in the cost per WTEs in the future establishment.

16.1.5 The trust has made the necessary changes and investments in safe staffing and now meets all of the standards agreed by the Trust Board. A robust approach is in place to ensure that these standards are maintained.

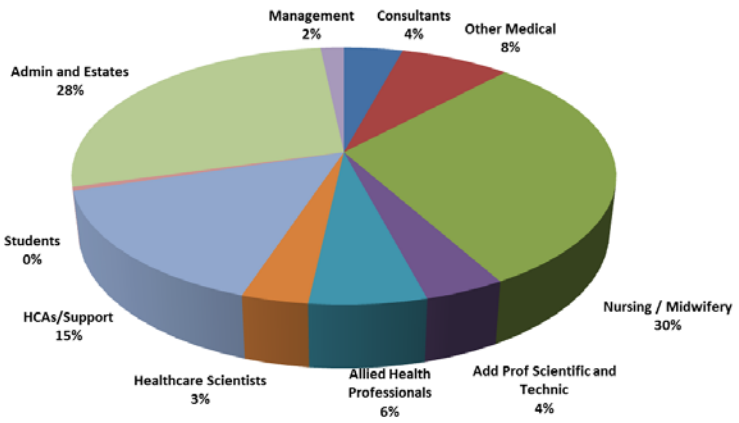
16.1.6 The workforce change plan has clear governance and the trust has recently appointed an experienced Director of Workforce and Organisational Development to the Trust Board to lead its implementation.

16.2 Current Workforce Profile

16.2.1 The Trust is one of the largest teaching Trusts in the country employing circa 7,000 staff for the delivery of acute and community services.

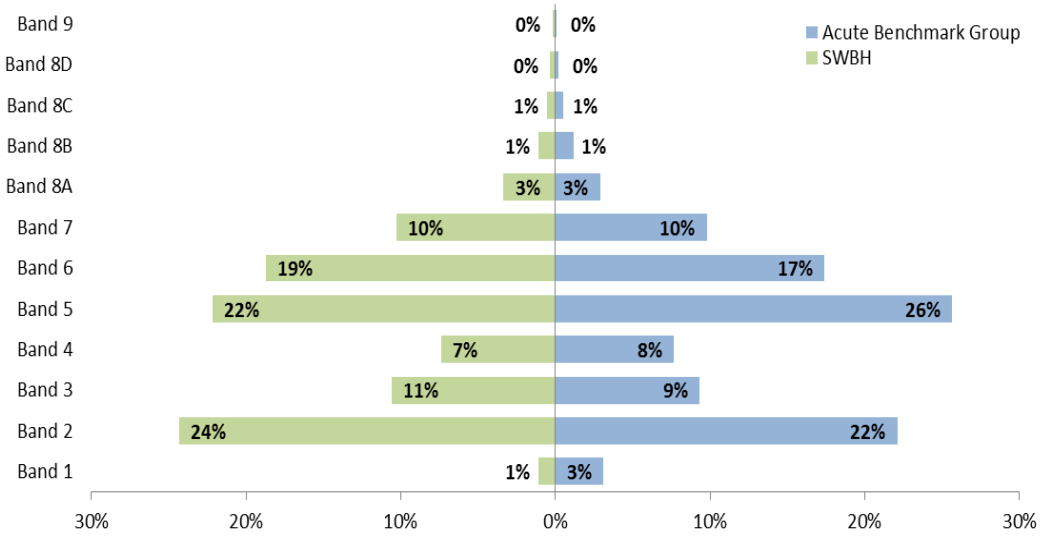
16.2.2 Approximately 70% of the workforce has a clinical role. The current workforce as at February 2015 is represented in the pie chart below.

Figure 34: Current Workforce by Job Role



16.2.3 88% of the current workforce is employed on Agenda for Change (AfC) terms and conditions with the remainder being Trust directors and medical staff. The majority of the workforce (83%) is paid on AfC band 7 or below. When compared with the regional acute benchmark group the Trust's AfC banding profile has slightly more band 1 to 4 and slightly fewer band 5 posts (as at February 2015) as reflected in the figure below. This is reflective of the Trust's plans to continue to alter the skill mix in line with new working practices.

Figure 35: Current Workforce: AfC Band Against Benchmark Group



16.2.4 The gender of the workforce is fairly typical of most NHS provider organisations with females making up 78% of the workforce.

16.2.5 Analysis shows a typical spread of staff in each age bracket with an average age of 42 years. The average age of consultant and middle grade medical staff is 48. The Trust actively maps retirement forecast patterns across professions to inform succession plans and create opportunities to profile the workforce in line with the long term workforce model.

16.2.6 The workforce profile as at February 2015 is set out in the table below:

Table 106: Workforce Profile - Snapshot in February 2015

ABC Workforce Profile								
Staff Category	**HC**	**WTE**	**Full Time %**	**Part Time %**	**Male %**	**Female %**	**Average Age**	**Sickness %**
Registered Nursing, Midwifery and Health visiting staff	**2083**	**1,896.36**	**68.55**	**31.45**	**6.72**	**93.28**	**41**	**5.44**
Qualified Scientific, Therapeutic and Technical Staff	**921**	**819.93**	**66.99**	**33.01**	**28.66**	**71.34**	**39**	**3.29**
Allied Health Professionals	437	375.74	60.18	39.82	20.37	79.63	38	2.95
Other Scientific, Therapeutic and Technical Staff	213	191.12	66.67	33.33	34.74	65.26	42	4.19
Healthcare Scientists	271	253.08	78.23	21.77	37.27	62.73	40	3.11
Qualified Ambulance Staff	**1**	**0.92**	**0.00**	**100.00**	**100.00**	**0.00**	**25**	**0.00**
Other Qualified Ambulance Staff	1	0.92	0.00	100.00	100.00	0.00	25	0.00
Support to clinical staff	**1970**	**1,696.10**	**57.11**	**42.84**	**13.40**	**86.60**	**43**	**6.35**
Support to nursing	860	752.49	59.19	40.81	11.86	88.14	43	7.63
NHS Infrastructure Support	**1353**	**1,100.51**	**50.33**	**49.67**	**32.52**	**67.48**	**46**	**4.29**
Managers & senior managers	110	104.69	84.55	15.45	39.09	60.91	46	1.46
Admin and Estates staff	501	456.20	72.46	27.54	35.73	64.27	44	3.46
Other Infrastructure & Support Staff	742	539.62	30.32	69.68	29.38	70.62	48	5.56
Medical Staff Group	**788**	**755.50**	**88.71**	**11.29**	**58.63**	**41.37**	**38**	**0.80**
Career/Staff Grades	84	74.00	75.76	24.24	66.67	33.33	46	1.63
Trainee Grades	425	417.60	95.19	4.81	49.52	50.48	30	0.59
Consultant	279	263.90	83.52	16.48	69.60	30.40	49	0.88
Others	**47**	**45.85**	**89.36**	**8.51**	**19.15**	**80.85**	**27**	**3.86**
Total	**7163**	**6,315.17**	**64.11**	**35.86**	**22.06**	**77.94**	**42**	**4.65**

16.2.7 42% of employees have worked in the organisation for more than 10 years and 12% of the workforce has less than 12 months service.

16.2.8 Employee turnover in February 2015 was running at 12.46% (excluding medical staff) and shows an increasing trend since April 2013 (10 - 11%). The leavers rate is higher than local benchmark groups (9 and 11%). This is influenced by plans to reduce workforce numbers.

16.2.9 The ethnicity profile is broadly representative of the local population with the exception of the Asian ethnic group which is under-represented. The Trust has been successful in reducing the number of staff that choose not to disclose their ethnicity from 18% to 9% over the last few years and continues to improve this data source.

16.3 Best Practice and Key Successes

16.3.1 The Trust is developing the workforce for the future through a range of best practice approaches which are summarised in this section.

16.3.2 The Trust is in the second year of a comprehensive 3 year leadership development programme developed and supported by recognised industry experts (Hay group). This is in recognition of the need to ensure that the cadre of leaders in the Trust are capable of leading large scale service and workforce redesign to deliver its future ambitions.

16.3.3 The organisation is widely acknowledged for its long term commitment to employee engagement and currently acts on staff feedback through one of the most comprehensive real-time staff feedback systems in the country known as '*Your Voice'*.

16.3.4 In 2014 the NHS Staff Survey showed improvement in key areas related to team working, feeling valued and agreeing that their role makes a difference to patients. Staff ability to contribute towards improvements at work is ranked as in the best 20% of all acute Trusts and staff motivation at work is ranked as above average.

16.3.5 The Trust is ranked with the best 20% in the 2014 National Staff Survey for the number of employees (87%) responding that they have had an appraisal in the last 12 months. The Trust has a target of 100% was 90% at the end of March

16.3.6 The Trust's new appraisal process is designed improve the appraisal experience and on driving high performance through clarity of role, 'SMART' objectives, performance assessment and talent development. The outputs of the new process will link more systematically to succession planning and career development.

16.3.7 The Trust has a proactive employee health and well-being service linked to its Public Health Plan which includes improving employee health data used to offer tailored support on risk issues such as being overweight, smoking and high alcohol consumption. An employee counselling service is also provided and the Trust and is working towards being recognised as a leader in workplace mental health provision.

16.3.8 The Trust's approach to flu vaccination has been recognised nationally for achieving vaccinations for 80% of front line staff.

16.3.9 Workforce initiatives that will support the long term economic well-being of the area in line with the aims outlined in Chapter 15 include:

- **The Learning Works** which is a community based initiative developed in partnership with Sandwell Metropolitan Borough Council and Job Centre Plus to provide access to training and employment opportunities for local people.
- **The Live and Work Programme** which tackles homelessness by offering people from the local community access to work through the Trust's apprenticeship programme and provides on-site accommodation.

16.4 Key challenges and Opportunities

16.4.1 Having commenced its workforce change programme, the Trust will need to make further significant whole time reductions in line with the long term workforce model of 1,087 WTE by March 2020.

16.4.2 Significant workforce change will be required to deliver the new model of care in line with RCRH including shifts of activity to more community based services. This also provides an opportunity for skill mix review to contribute to an expected reduction in cost per WTE.

Vacancy rates in some staff groups, e.g. medical ward nursing (band 5) and emergency care, continue to be high. The Trust actively reviews management of hard to fill and hard to retain posts. The table below presents the current 'hot-spots' and the Trust's approach to managing these vacancies.

Table 107: Management of Hard to Fill Posts

Posts	Action Planned
Medical workforce Consultants in the following specialties: ▪ Interventional radiology ▪ Acute medicine ▪ Emergency medicine ▪ Elderly care	Working in partnership with Health Education West Midlands through the Black Country LETC and there is an established task force driving approaches to targeted recruitment and increasing the use of advanced practice roles Targeted recruitment search and advertising campaign The long term solution is consolidating emergency and inpatient services on to the new MMH single site hospital
Non-medical workforce ▪ Sonographers ▪ Advanced nursing practitioners ▪ General nursing	Working in partnership with Health Education West Midlands through the Black Country LETC who are engaging the Health Education Institutions in a review of the content and duration of the training and is commissioning more education places to increase supply. In-house there are plans in place to enable other healthcare professionals to obtain the sonography competencies. Focus on attracting and retaining named nursing commissions students Overseas recruitment
Management and Leadership Difficulty in recruiting high calibre candidates to clinical group senior management positions	Targeted attraction, recruitment and retention strategy 3 year leadership development programme in place (year 2 in 2015/16) New appraisal system rolling out with systematic link to succession planning

16.4.3 Typically between 700 and 800 staff leave the Trust each year, in addition to medical staff. This provides opportunities for reducing pay costs through the disestablishment of vacancies where the role is not required in the future or redesign of the role. The Trust has been successful in redeploying staff who may occupy a post that will be disestablished into new roles to avoid redundancies.

16.4.4 The Trust has demonstrated its ability to manage and reduce premium rate pay costs. The Trust's agency spend has reduced its agency spend from £1.2m in June 2014 to £862k in February 2015 (a reduction of 26%). The Trust has also enhanced its utilisation of nursing bank and recently established a medical bank. This is a sound base from which to further progress reductions in cost / WTE through avoidance of premium payments. In support of this the trust has implemented the following measures:

- Trust bank pay rates have been revised to encourage Trust employees to work on the internal bank to reduce reliance on agency staffing;
- The nurse staffing review has resulted in additional registered nurses being rostered on nights from January 2015 to help to reduce reliance on temporary staffing when additional capacity is required;
- Plans to reduce sickness absence to 3.5% or less in 2015/16 and recruitment plans to staff 'hard to fill' vacancies are in place and will drive down reliance on temporary staffing further.

16.4.5 Sickness absence levels are relatively high at 5.27% for February 2015 and 4.65% for the 12 month rolling period, costing £9 m each year on salary costs for time lost alone. A challenging target has been set at 3.5% with a range of measures and a detailed action plan in place designed to make improvements.

16.4.6 The Trust's current configuration of split site working across the two acute hospitals continues to create cost pressures for premium rate working, poor economies of scale and duplication of rotas as

well as exacerbating the Trust's ability to resource 'hard to fill' posts, particularly in the Trust's Emergency Departments.

16.4.7 This section has presented examples of the main challenges being faced by the Trust in the broader context of pay inflation, incremental drift and requirement for future investment in staffing new services.

16.5 Workforce and Organisational Development Strategy

Strategic Aims and Objectives

16.5.1 The Workforce and Organisational Development Strategy is a key enabler for achieving the Trust's vision:

'to be renowned as the best integrated care organisation in the NHS'

16.5.2 In support of the Trust's vision the workforce aims are to:

- Develop and retain a high quality workforce that enables the Trust to provide the very best patient care;
- Become the employer of choice in the region; and
- Ensure that the workforce is highly productive and affordable.

16.5.3 In order to achieve these strategic aims, the Trust has 5 key strategic workforce objectives to:

- Deliver the Long Term Workforce Model;
- Develop the Trust's leadership capacity and capability;
- Ensure that the workforce has the necessary development, skills and training;
- Become a truly effective and engaged organisation; and
- Address recruitment and retention issues.

16.6 The Long Term Workforce Model (LTWM)

16.6.1 As outlined above delivery of the Long Term Workforce Model (LTWM) is a key objective in the Workforce and Organisational Development Strategy. This section outlines how it has been developed and presents the model from 2014/15 – 2023/14.

Alignment with the Long Term Financial Model (LTFM)

16.6.2 The LTWM is consistent with the long term financial model (LTFM) which has top down workforce assumptions aligned to activity and income.

16.6.3 The LTWM is consistent with the OBC trajectory and reduces WTEs by 1,347 (against a 1,367 reduction within the OBC) between March 2014 and March 2020. In addition to WTE reduction the Trust expects to achieve a reduction in cost / WTE of £/ WTE. The key drivers to reduce the pay bill are threefold:

- Activity and pathway driven changes in workforce e.g. fewer beds in the acute setting leading to a reduction in nursing staff but more care closer to home resulting in an increase in community nursing;
- Productivity driven reductions in workforce, leading to fewer WTE to deliver a given quantity of activity e.g. use of technology and improved processes;
- Reduction in the cost per WTE of the future establishment e.g. ensuring that staff spend a greater proportion of their time conducting tasks appropriate to their grade through role re-design and the introduction of more junior roles.

16.6.4 The above threefold approach will mean that not only will the workforce establishment in terms of WTE be reduced but also the average cost per WTE, although this will be focussed on certain staff groups rather than universally applied. The drivers and how they will be applied are described in more detail in the Workforce Change Plan.

16.6.5 The Trust has undertaken detailed workforce modelling with service and clinical leads for circa 90% of staff. This work is being refined regularly. The nursing models have been refreshed following the Trust's review of nursing establishments to ensure that the nurse staffing models in 2018/19 will meet the Trust's safe minimum staffing standards.

Table 108: Long Term Workforce Model [DN: ensure is latest version consistent with LTFM]

		Outturn 2014/15 Wte	Plan 2015/16 Wte	Forecast 2016/17 Wte	Forecast 2017/18 Wte	Forecast 2018/19 Wte	Forecast 2019/20 Wte	Forecast 2020/21 Wte	Forecast 2021/22 Wte	Forecast 2022/23 Wte	Forecast 2023/24 Wte
BASELINE inc RCRH Change & CIP											
Pay - Consultants		289.2	289.2	289.7	290.0	290.8	291.6	293.5	299.3	302.0	304.5
Pay - Junior Medical		500.8	476.6	476.3	476.0	473.4	470.7	471.0	471.1	471.3	471.5
Pay - Nursing, Midwifery and Health Visitors		1,789.7	1,759.7	1,734.5	1,696.7	1,664.4	1,635.0	1,661.0	1,677.8	1,691.9	1,706.2
Pay - Community Nursing, and Health Visitors		473.4	465.5	472.9	482.8	495.9	505.0	513.1	519.6	536.7	544.0
Pay - Scientific, Therapeutic and Technical		1,131.7	1,078.7	1,088.9	1,097.3	1,108.5	1,129.8	1,144.9	1,156.7	1,169.4	1,180.6
PAY - OTHER CLINICAL		683.2	671.8	666.7	649.2	640.3	660.5	668.8	674.0	679.7	684.9
Pay - Non Clinical		2,127.3	1,980.0	1,978.2	1,972.5	1,903.7	1,834.1	1,829.7	1,834.3	1,840.0	1,845.1
Agency		240.0	240.0	227.1	205.7	188.8	195.6	197.1	192.3	193.6	195.1
Sub Total		*7,235*	*6,962*	*6,934*	*6,870*	*6,766*	*6,722*	*6,779*	*6,825*	*6,885*	*6,932*
Repatriation & Community Developments											
Pay - Consultants		-	2	3	3	4	6	7	8	9	10
Pay - Junior Medical		-	3	5	6	7	10	13	14	16	17
Pay - Nursing, Midwifery and Health Visitors		-	34	86	156	204	288	365	426	498	574
Pay - Community Nursing, and Health Visitors		-	-	-	-	-	-	-	-	-	-
Pay - Scientific, Therapeutic and Technical		-	12	18	19	22	33	42	46	47	47
PAY - OTHER CLINICAL		-	-	-	-	-	-	-	-	-	-
Pay - Non Clinical		-	4	5	6	6	9	12	13	13	13
Agency		-	-	-	-	-	-	-	-	-	-
Sub Total		-	55	117	190	244	347	439	508	582	661
CIP Impact											
Pay - Consultants		-	- 0	- 1	- 2	- 2	- 3	- 3	- 4	- 5	- 5
Pay - Junior Medical		- 24	- 12	- 22	- 33	- 44	- 53	- 66	- 79	- 92	- 105
Pay - Nursing, Midwifery and Health Visitors		- 30	- 48	- 88	- 132	- 176	- 214	- 241	- 269	- 296	- 323
Pay - Community Nursing, and Health Visitors		- 8	- 17	- 31	- 46	- 62	- 75	- 96	- 117	- 138	- 159
Pay - Scientific, Therapeutic and Technical		- 53	- 36	- 66	- 99	- 132	- 160	- 187	- 213	- 239	- 266
PAY - OTHER CLINICAL		- 11	- 24	- 44	- 66	- 88	- 107	- 120	- 133	- 145	- 158
Pay - Non Clinical		- 147	- 103	- 188	- 282	- 376	- 457	- 537	- 617	- 697	- 777
Agency		-	- 20	- 55	- 105	- 125	- 125	- 125	- 125	- 125	- 125
Sub Total		- 274	- 260	- 495	- 765	- 1,005	- 1,195	- 1,376	- 1,557	- 1,738	- 1,919
Net Trust Wide Position											
Pay - Consultants		289	290	291	292	293	295	298	304	306	309
Pay - Junior Medical		477	467	459	449	437	428	418	406	395	383
Pay - Nursing, Midwifery and Health Visitors		1,760	1,746	1,733	1,720	1,692	1,709	1,784	1,835	1,894	1,957
Pay - Community Nursing, and Health Visitors		466	449	442	437	434	430	417	402	398	385
Pay - Scientific, Therapeutic and Technical		1,079	1,055	1,040	1,018	999	1,002	1,000	989	976	962
PAY - OTHER CLINICAL		672	648	623	583	552	554	549	541	534	527
Pay - Non Clinical		1,980	1,881	1,795	1,696	1,534	1,386	1,305	1,230	1,156	1,081
Agency		240	220	172	101	64	71	72	67	69	70
Net Position	*7,221*	6,962	6,757	6,556	6,295	6,004	5,875	5,842	5,776	5,729	5,674
ABC Annual Movement		- 260	- 205	- 201	- 261	- 291	- 130	- 32	- 67	- 47	- 54
ABC Cummulative Movement		- 260	- 465	- 665	- 926	- 1,217	- 1,347	- 1,379	- 1,445	- 1,493	- 1,547

16.6.6 The LTWM shows that a net 1,087 fewer WTEs will be required arising from a pay-bill reduction of £86m by March 2020 as shown in the table below. Of the £86m savings, £54m is targeted to come from a reduction in WTEs, with the balance to be achieved from new working practices that will see new skill mix profiles, new ways of working and a reduction in premium rate payments including: on-call, overtime and consultant PAs.

Table 109: Staff / Pay Savings Forecasts

	Outturn 2014/15 £m	Forecast 2015/16 £m	Forecast 16/17 to 17/18 £m	Forecast 18/19 to 19/20 £m	Forecast Over Timeline £m	15/16v19/20 Over Timeline £m
Pay Target Savings	11.4	16.1	34.4	35.2	97	86
Costs Saved by WTE	- 11.4	- 10.3	- 23.1	- 21.0	- 66	- 54
New Ways of Working	- 0.0	- 5.9	- 11.3	- 14.2	31	31

16.6.7 During the same timeframe the community workforce will grow by 347 posts to support the Trust's strategy of delivering care closer to home through enhancing community based services and intermediate care provision.

16.7 Workforce Change Plan

16.7.1 This section presents the Workforce Change Plan which outlines how the changes will be delivered between now and 2020.

16.7.2 The Trust is in the second year of a 6 year Workforce Change Plan which will deliver in three distinct phases. This is designed to achieve the ambition to deliver the best integrated services, maintain safe staffing levels and to prepare for the transition into MMH.

16.7.3 The three phases are:

- Safe and Sound (April 2014 – March 2016);
- Workforce Transition (April 2016 to March 2018)
- Operational MMH (April 2018 to March 2020)

16.7.4 The table below presents WTE reduction and savings targets for each of the phases.

Table 110: WTE reduction and Savings Targets

Phase	Year	Net WTE reduction	Net £m reduction
Safe and Sound 1	Apr 14 - Mar 15	260	11.4
Safe and Sound 2	Apr 15 - Mar 16	205	16.1
Transition	Apr 16 - Mar 18	462	34.4
MMH	Apr 18 - Mar 20	420	35.3
TOTAL		**1,347**	**97.2**

16.7.5 The workforce planning approach to deliver the LTWM has been to develop strategic workforce change themes grouped within the following 3 drivers:

- Activity and pathway driven changes in workforce;
- Productivity driven reductions in workforce; and
- Reduction in the cost per WTE.

16.7.6 The rationale for this structured approach is to avoid double counting pay cost savings across schemes and years and ensure a coherent transition to MMH is achieved. These strategic workforce change themes deliver across all 3 phases of the Change Plan.

16.7.7 Definitions for the Key Drivers and Strategic Workforce Change Themes are presented in the table below.

Table 111: Key Drivers and Strategic Workforce Change Themes

Drivers	Driver Description	Strategic workforce change theme
Activity and pathway driven changes in workforce	Changes in the workforce in response to activity changes in line with RCRH and the transition to the new model of care in the MMH.	**Clinical Restructuring** Change in clinical staffing as a result of a change in activity e.g. staffing numbers and ratios
		Non-Clinical Review of support functions e.g. estates and facilities
Productivity driven reductions in workforce	Building upon the activity driven modelling described above the next stage is to model productivity opportunities which will result in the requirement for fewer WTEs. Workforce reductions will be delivered by changes to ways of working.	**Technology** Use of technology to improve productivity and reduce waste, including EPR, speech recognition, automation, robots, telehealth and mobile working in community
		Clinical Transformation Medical and surgical bed reductions, shift to community settings, outpatients redesign, theatre utilisation, site reconfiguration, de-duplication of on-call rotas
		Scheduling Improving scheduling and changing working practices to ensure optimal use of clinics and theatres.
		Black Country Alliance Collaboration of 3 NHS Trusts to share back office processes and reduce costs.
		Sickness Absence Driving down sickness absence to ensure that the Trust is fully staffed.
		User-Led Empowering service users to carry out certain administrative tasks relating to their appointments e.g. booking transport and tests.
		Management de-layering Review of management structures to ensure fit for purpose and efficient, i.e. spans of control and consolidation of disparate corporate functions
Reduction of cost per WTE	In addition to the activity driven modelling and reductions in WTEs through productivity presented above this driver is to reduce costs per WTE. This will principally be achieved through reviewing the skill mix and conducting role re-design The resultant reduction in cost per head will allow additional efficiencies to be made without further reduction in WTEs.	**Skill mix and role redesign** A review of roles to introduce new more junior roles to reduce cost per WTE create a career path for progression from a wider range of backgrounds. This will enable staff to spend a greater proportion of their time working to their grade and maximising the use of their skills and experience.
		Non-consultant Doctors Improving senior medical cover / review of middle grade doctors against future requirements. **Assistant grades** Review of junior doctors intensity payments

Drivers	Driver Description	Strategic workforce change theme
		Premium Payments Eliminating bank, agency, overtime and waiting list payments to reduce temporary staffing costs.
		Intermediate Care is Cheaper Shifting care from acute to community models of care.

Workforce Change Plan

16.7.8 The workforce change plan is presented in the table below.

Table 112: Workforce Change Plan

Driver	Strategic change theme	13/14 March 14	Ave Annual Year 2014/2015	2015-2016 WTE reduction/	2016-2018 WTE reduction/	2018-2020 WTE reduction/	2019-2020 Resultant WTE Establishment
	Opening WTE Position		6,962	6,962	6,757	6,295	
Activity & Pathway driven change	Clinical Functions		822.1	- 41.4	- 103.2	7.8	685
	Intermediate Care Development		207.1		77.4	48.0	332
	Community Pathway Redesign		679.7	55.0	16.6	26.8	778
	Non Clinical		619.5		0.7	- 138.8	481
Productivity driven reduction	Technology			-	- 43.9	- 43.2	- 87
	Clinical Transformation		2,584.0	- 13.4	- 104.3	- 100.0	2,366
	Scheduling		1,253.7	- 69.3	- 190.7	- 122.0	872
	Black country alliance		470.7	- 27.2	- 32.6	- 44.0	367
	Sickness absence			- 40.0	- 20.0	- 20.0	- 80
	Premium Payments			- 5.2	-	-	- 5
	User-led		205.3	- 25.7	- 53.4	- 28.6	98
	Management delayering		174.5	- 37.7	- 8.2	- 5.9	123
Total WTE CHANGES			260	- 205.0	- 461.8	- 420.0	5,875
Total WTE		7,221	6,962	6,757	6,295	5,875	- 1,346

16.8 Safe and Sound Phase 1 April 2014 – March 2015

Overview of Phase 1 of Safe and Sound

16.8.1 The first phase of the Workforce Transformation Plan, Safe and Sound, was launched in October 2014 and is now complete.

16.8.2 The aims of Safe and Sounds Phase 1 were to:

- Eliminate the use of agency work other than in disciplines where a national shortage exists;

- Significantly reduce the use of overtime; extra hours and bank work; and
- Reduce staffing numbers through productivity without compromising on safety and quality.

Delivery approach for Phase 1 of Safe and Sound

16.8.3 The Trust has engaged in an open and extensive consultation with Trade Unions and with staff. Every change scheme has been visible, providing the opportunity for staff to test the operational impact and to influence change proposals. This resulted in improvements being made to scheme proposals.

16.8.4 The changes were implemented in line with the Trust's organisational change policy and included statutory consultation. The WTE reduction has been achieved through:

- Natural turnover;
- A comprehensive redeployment plan that matched staff at risk of redundancy to vacancies; and
- Skills development programmes for staff redeployed into new or different roles.

16.8.5 Examples of schemes delivered to enable the reduction in WTE are:

- **Clinical Transformation:** changing staffing models in outpatients nursing and in the Birmingham and Midland Eye Centre;
- **Scheduling:** improved productivity in imaging sessions;
- **Technology:** adjustments to roles and administrative processes in outpatients including, introduction of self check-in kiosks and major changes to receptionist roles; and
- **Management delayering:** revised structures in finance, pharmacy and facilities.

16.8.6 The average cost per WTE has also been reduced, for example through:

- **Restructuring the medical secretary function:** this has resulted in the removal of band 3 junior medical secretary roles and the introduction of a band 2 administrative assistant.

Outcomes of Phase 1 of Safe and Sound

16.8.7 Phase 1 delivered a WTE reduction of 260 WTEs with an attendant reduction in pay costs of £11.4m.

16.8.8 The Trust has strengthened its quality and safety standards. Investment has been made in 20 WTE more registered nurses in addition to converting a further 20 WTE unregistered posts to registered posts. This has been to meet minimum safe staffing levels.

16.8.9 In addition the Trust has invested significantly in an additional 60 WTE nursing posts in community based services enabling the opening of 2 new intermediate care wards.

16.8.10 Redundancies have been minimised.

16.8.11 Lessons have been learnt from Safe and Sound 1 which will improve the effectiveness of Safe and Sound 2.

16.9 Safe and Sound Phase 2 April 2015 – March 2016

Overview of Phase 2 'Safe and Sound'

16.9.1 The second phase of the Workforce Change Plan, Safe and Sound was launched in April 2015.

16.9.2 Its overall aims are the same as Safe and Sound Phase 1 with the objective of reducing the workforce by a further 205 WTE and reducing pay costs by £16.1.

Delivery approach of Phase 2 'Safe and Sound'

16.9.3 A statutory consultation process will commence in May for affected staff groups. Circa 260 staff will be affected by the changes proposed. As was the case in 'Safe and Sound' phase 1, a significant amount of posts will be released through the disestablishment of vacant posts and re-deployment.

16.9.4 Specific schemes from the Change Plan for Safe and Sound Phase 2 to reduce WTEs include:

- **Technology:** improving productivity in the medical secretary group through new working practices including 1:2 medical secretary to consultant ratios, new ways of working and the introduction of speech recognition; and
- **Clinical transformation:** reducing circa 22 band 5 nursing posts due to bed reductions.

16.9.5 Schemes to reduce the cost per WTE include:

- **Assistant grades:** systematic review of all clinical departments and specialist nurse roles to make optimal use of specialist nursing skills in the management of long-term conditions including tasks that are currently undertaken by medical staff;
- **Assistant practitioner roles**: using more (band 4) assistant practitioners in place of band 5 registered nurses and AHPs in outpatients, imaging, rehabilitation services;
- **Advanced practitioner roles**: using advanced practitioners in place of middle grade doctors for some tasks and 2nd on-call rotas;
- **Non-clinical:** re-configuration of administrative services and further skill mix revision in facilities and estates.

16.10 Workforce Transition and Realising MMH benefits (April 2016 to March 2020)

Opportunities Unlocked by MMH

16.10.1 Whilst the majority of the Trust's workforce change plan can be delivered pre-MMH, there remain significant benefits which can only be realised once MMH is operational and the site reconfiguration is complete.

16.10.2 Operating a single emergency services department is the most sustainable solution to responding to the severe recruitment and retention shortages that continue to threaten to compromise the safe running of the Trust's current two emergency departments. The Trust's emergency departments continue to experience difficulties in being fully staffed to deliver safe high quality care and are reliant on long term locum temporary staffing. Whilst quality has been maintained, this is being achieved at a high price and the staffing model is fragile. Proactive attempts have been made to recruit high calibre medics but to date this has proved unsuccessful. Solutions such as consultant secondments from other NHS organisations have been trialled but have not proved to be a sustainable solution.

16.10.3 In light of the national consultant shortage, for which it is recognised that reconfiguration of services is the only solution in many of cases, the Trust acknowledges that the staffing arrangements in the ED departments will remain fragile until such time it can operate with one emergency department. This is unlikely to happen until it has all inpatient services on one acute hospital site thus creating the critical mass to ensure resilience and permanent staffing which is sustainable both clinically and financially.

16.10.4 All acute inpatient services will be consolidated onto the single site resulting in a concentration of clinical staff which will enable a greater level of senior medical cover throughout the day, 7 days per week. This forms a core part of the trust's strategy to improve quality and continue to ensure safety.

16.10.5 Productivity driven reductions in workforce will be realised through economies of scale and bringing staff together onto one acute site to achieve more effective ways of working. De-duplication of clinical and operational rotas, including on call and out of hours will enable a reduction in WTE and release resources to ensure resilience and 7 day working.

16.10.6 Corporate reductions will be enabled through the consolidating teams onto a single head office site at Sandwell General Hospital. Completion of this will only be possible once acute services have been relocated to MMH. This will facilitate greater team working and joined up business intelligence support to clinical groups through maximising the use of standardising data and information and operating systems.

16.10.7 Optimal scheduling and consultant job planning that will ensure that clinical staff do not undertake unnecessary travel to deliver care between the new MMH hospital and community locations.

16.10.8 MMH will enable new effective working practices and effective team working arising through new workflows in the new hospital design e.g. ward layouts, optimal location and co-location of services and departments.

16.10.9 Greater use of technology will be made possible by the move to the MMH. For example: a new IM&T infrastructure will enable tasks to be undertaken more easily by patients / service users or robots through assistive technology in the workplace e.g. self-check in, stores and distribution and robots cleaning.

16.10.10 Multi-site working across acute and community environments will be made productive through through minimising staff movement and exploiting the time saving opportunities that new technology offers e.g. docking technology, teleconferencing, tele-health and videoconferencing.

16.10.11 Further terms and conditions driven reductions will be made possible by consolidating staff on one acute hospital site. For example: a reduction in trainee doctors intensity payments, reduction in non-medical on-call payments and a reduction in premium rate working.

16.10.12 The transition phase (April 2016 – March 2018) will continue to drive productivity to the full extent possible in advance of the delivery MMH.

Overview of Key Changes April 2016 to March 2020

16.10.13 The key changes are shown in the table below.

Table 113: Overview of Key Workforce Changes April 2016 - March 2020

Key Drivers	Strategic workforce change theme	Transition phase (April 2016 – March 2018)	MMH phase (April 2018 – March 2020)
Activity and pathway driven changes in workforce	**Clinical Restructuring**	Fewer nurses and HCAs due to fewer outpatient sessions and reduction in beds Investment in community nursing	Fewer nurses and HCAs due to fewer outpatient sessions and reduction in beds Investment in community nursing Fewer emergency department staff as a result of single ED within MMH.
	Non-Clinical	Reduction in facilities staff due to greater cross functional working	
Productivity driven reductions in workforce	**Technology**	Fewer healthcare records staff due to introduction of EpR. Better use of consultant's time through telehealth enabling resources to be channelled into 7 day working. Introduction of mobile technology to improve productivity in community Fewer medical secretaries as a result of completing speech recognition technology.	Fewer porters and distribution staff as a result of introduction of automated guided vehicles
	Clinical Transformation	Medical and surgical bed reductions, shift to community settings, outpatients redesign, theatre utilisation, site reconfiguration, de-duplication of on-call rotas	Single site reconfiguration will result in transfer of hard FM staff to PF2 provider under TUPE.
	Scheduling	Reduction in theatre staff and outpatient staff as a result of improved scheduling and changing working practices to ensure optimal use of clinics and theatres.	
	Black Country Alliance	Collaboration of 3 NHS Trusts to share back office processes and reduce costs.	-
	Sickness Absence	Driving down sickness absence to ensure that the Trust is fully staffed.	
	User-Led	Empowering service users to carry out certain administrative tasks relating to their appointments e.g. booking and changing appointments, transport and tests.	
	Management de-layering	Completion of management de-layering pre MMH. Fewer corporate staff due to co-location into single head office site.	Further management de-layering as a result of single site configuration. Fewer corporate staff due to completion of co-location into single head office site at Sandwell General Hospital.

Key Drivers	Strategic workforce change theme	Transition phase (April 2016 – March 2018)	MMH phase (April 2018 – March 2020)
	Non-consultant Doctors	Improving senior medical cover / review of middle grade doctors against future requirements.	Reduction in medical staff due to de-duplication of medical rotas enabled by single site configuration.
	Skill mix and role redesign	A review of roles to introduce new more junior roles to reduce cost per WTE create a career path for progression from a wider range of backgrounds.	
	Premium Payments	Eliminating bank, agency, overtime and waiting list payments to reduce temporary staffing costs.	
	Intermediate Care is Cheaper	Shifting care from acute to community models of care.	

16.11 Safe staffing

Nurse Staffing Establishment Review

16.11.1 A nurse staffing establishment review, led by the Trust's Chief Nurse, was undertaken of outpatient, community and ward areas in November 2014. Group directors and nurse leadership teams were engaged and external benchmarking and best practice were taken into account. The review was published on the Trust's intranet site to enable all staff to review the proposal and feedback any issues or concerns.

16.11.2 The outcome of the review was:

- An agreed ward leadership model;
- Minimum standards for nurse: bed ratio; and
- The normal balance between registered and non-registered practitioners for early, late and night shifts.

16.11.3 The recommendations of the review were agreed by the Trust Board in December 2014.

Safe Staffing Standards

16.11.4 The minimum safe staffing standards are as follows:

- A ward should have 1 ward manager (band 7) supported by two deputy ward managers;
- A registered nurse should have no more than eight patients in their care as a minimum;
- No acute ward should have fewer than 2 registered nurses despite the number of patients; and
- The normal balance between registered nurses and non-registered HCAs should be 60-70% registered and 30-40% non-registered

16.11.5 The Trust has subsequently changed nursing establishment levels such that the minimum safe staffing level standards have been fully met.

Monitoring of Safe Staffing Standards

16.11.6 The BRAD assessment tool (an acuity and dependency tool) is currently used on the wards to determine daily adjustments required to staffing levels based on patient acuity and occupancy levels. The Trust plans to introduce the use of the Safer Nursing Care Tool.

16.11.7 Compliance against safe staffing levels, comparisons with the national reporting system, fill rates and use of temporary staffing are scrutinised by the Trust Board every month.

Staffing for MMH Configuration

16.11.8 As outlined in Chapter 12 the design of generic wards will facilitate observation into all bedrooms through the use of touch down spaces (as opposed to central staff bases) and viewing panels. This will enable monitoring and support of groups of 4 or 8 beds in line with agreed staffing ratios. The generic design supports implementation of lean principles.

16.11.9 The Trust's nursing model for the MMH has been revised for the staffing impact of different ward configuration with 50% single rooms. The workforce model has identified additional nurse staffing requirements associated with 50% single rooms. The staffing model includes the requirement for an additional health care assistant across all wards to work at night to ensure safe observation of patients and to minimise the risk of patient falls. This nursing establishment of an additional 70 WTEs has been informed by learning from other trusts which already have a 50% single room ratio.

16.12 Management of Change

16.12.1 This section outlines the how the Trust is supporting staff through transition as well as the governance, leadership and assurance arrangements that have been put in place to deliver the change.

Supporting Staff through Transition

16.12.2 The Trust has put in place a number of support measures to equip and prepare staff for change and to work effectively in the future and maximise the opportunity to redeploy staff and reduce the risk of redundancies. These include:

- A 3 year education plan to develop a workforce that is fit, safe and effective to practice in their roles now and in the future;
- Communication and engagement with staff affected through sharing ideas about changes with staff and publishing proposals on the Trust's intranet;
- Joint working with trade union colleagues to effectively manage change and minimise the need for redundancies; and
- Using vacancies to redeploy staff with associated trial periods and 12 months skills development programmes.

Clinical Leadership and Involvement in Workforce Redesign

16.12.3 The Chief Nurse and Medical Director have guided and signed off the Trust's bottom up staffing models for the MMH. A range of clinicians and service leads were involved for each of the models developed.

16.12.4 A series of development days with clinical groups are being planned for June 2015 where the Trust's workforce change plans for 2016-2020 will be worked up further.

16.12.5 The Trust has a lead clinician, who is a Consultant Acute Assessment Physician, working with the MMH planning team with a particular focus on workforce planning.

16.12.6 Both the Chief Nurse and the Medical Director are active contributors to the Trust's annual education commissioning plan designed to ensure that the trust has a workforce with the skills for the future.

16.13 Governance and Leadership

16.13.1 In recognition of the scale and importance of the Workforce Change Plan the Trust has appointed an experienced board level Director of Workforce and OD. The appointee has extensive experience in leading major workforce change programmes including one of the most significant local authority workforce reductions in the UK.

16.13.2 The Trust has successfully delivered a range of large scale workforce changes associated with significant clinical service reconfigurations including: surgery, maternity, pathology and stroke services.

16.13.3 The Trust's organisational change policy has been revised and the processes for how workforce change is managed have been made more robust. This includes a rigorous tracking of the implementation of changes and new working practices.

16.13.4 The Workforce Delivery Committee (a sub-committee of the Clinical Leadership Executive) is the main body for involving group representatives and lead clinicians in formulating the Trust's workforce strategy and plan and oversees progress against delivery. This Committee is chaired by the Executive Director of Workforce and Organisational Development. Other members comprise the Medical Director, Chief Nurse, Chief Operating Officer and representatives from each of the Clinical Groups.

Assurance

16.13.5 Board level assurance of the execution of the Trust's Workforce and Organisational Development Strategy is provided by the Workforce and OD Committee. This is chaired by a non-executive director and meets quarterly.

16.13.6 The Trust has engaged with the NTDA in the workforce assurance meetings. The Trust's approach to safe staffing, working modelling and the scope of the workforce component of the ABC has been shared with the TDA to ensure that it meets the requirements of approval bodies.

Risk Management

16.13.7 The key risks associated with the Workforce Change Programme and the approach to mitigation is summarised in the table below:

Table 114: Workforce Risks

Workforce risk	Approach to mitigation
There is a risk that genuine change does not occur and that the Trust does not make sustainable workforce changes leading to inability to change and develop services whilst achieving pay cost reductions	Improving productivity through changing the ways of working (working smarter, introduction of technology, reducing duplication) Removing posts where there is less work to do (activity reductions) Workforce change proposals will clearly set out new work flow/new working practices Greater connectivity between service redesign and opportunities for pay cost reductions Auditing outcomes to ensure sustainable changes to working practices
There is a risk that the Trust will not control temporary staffing expenditure leading to increased financial pressure	Continued use of in-house medical staff bank Full use of e-rostering to ensure minimum staffing levels Executive led bank/agency approval procedures Stringent management of vacancies and time lost through sickness absence
There is a risk that uncertainty for staff leads to low morale and inability to retain key skills	Ensuring that changes to structures and roles create opportunities for career development and progression Involving staff in change proposals and decisions that affect the way that they work Managing change well and without unnecessary delay Monitoring levels of staff engagement and taking corrective action where necessary
There is a risk that services can be delivered in 2018/19	Staffing models for operating in the MMH to be developed with service and clinical leads Workforce reduction plans will ensure safe minimum staffing levels are maintained Quality and safety impact assessments for all workforce change proposals are reviewed by Chief Nurse and Medical Director and discussed at the Quality and Safety Committee Safe staffing governance and reporting linked to clinical outcomes

16.14 Conclusion

16.14.1 This chapter sets out the Trust's Workforce and OD Strategy which is underpinned by an affordable Long Term Workforce Model, Workforce Change Plan and change management arrangements.

16.14.2 The Trust has already made good progress in delivering the workforce plan that it set out in the OBC. Since OBC approval the Trust has:

- Successfully delivered the first wave (April 2014 – March 2015) of the Safe and Sound workforce change programme resulting in a reduction of 260 WTE;
- Launched the second wave of workforce change with the aim of achieving a reduction of 205 posts between April 2015 and March 2016;
- Made good progress in re-configuring existing services and developing more detailed plans for workforce changes to be delivered in 2016-2018 in readiness to work safely in the MMH; and
- Confirmed that clear safe staffing standards are currently in place and outlined plans to ensure that they will be maintained in 2018/19.

16.14.3 The benefits of the moving to the MMH configuration are vital to continue to improve quality and sustain safe services with a more productive workforce.

16.14.4 The leadership and governance arrangements are in place to drive the execution of the workforce plan to deliver the Long Term Workforce Model.

17 Consultation and Stakeholder Involvement

17.1 Introduction

17.1.1 The MMH project has been underpinned by strong stakeholder involvement and support since its inception. This chapter sets out consultation and engagement to date and the Trust's plan to continue to work with its key stakeholders.

17.2 Consultation and Engagement

17.2.1 A formal public consultation was undertaken in 2007 as part of the Right Care, Right Here proposals (the RCRH Consultation Documents can be found at ***Appendix 17a***). This set out the scope of the MMH project, including the implications for City Hospital and Sandwell General Hospital. Since then there has been significant on-going engagement regarding the design development of the scheme.

17.3 Staff and Patient Involvement in Design Development

Engagement in the Design Brief

17.3.1 Staff and patients have contributed to the design brief and to the subsequent design development. The scheme is unusual in that an exemplar was developed with significant clinical involvement at 1:200 scale. This enabled the Trust to issue a design brief which enjoyed strong clinical support and reduced the risk of issues being surfaced during the Competitive Dialogue itself.

Engagement in Competitive Dialogue

17.3.2 In advance of the Competitive Dialogue Process Clinical Leads were identified who were able to:

- Dedicate time to Competitive Dialogue and ensure consistency throughout the process;
- Represent their clinical team and other teams in related departments / services;
- Engage with wider clinical teams between meetings; and
- Have a good understanding of the clinical brief, MMH project and whole hospital function.

17.3.3 'Boot camps' have been an effective means for concentrated and focussed staff involvement both pre OJEU and during the Competitive Dialogue. The format of these has typically been in blocks of two days centred around key areas such as 'theatres', 'facilities management' and the 'emergency floor'. Clinicians have been provided with additional time away from their clinical duties to enable sufficient focus to be given to the design development.

17.3.4 Each team consisted of 6-8 people depending on the specific departments in each group, typically teams included:

- A member of the capital projects team;
- A member of the service redesign team; and
- For clinical department groups typically: 1-2 medical clinical leads, 1-2 nursing clinical leads, 1 therapy lead and 1-2 corporate function leads (e.g. facilities team, infection control team).

17.3.5 Consistent membership was maintained through the series of boot camps and training was provided prior to Competitive Dialogue. All team members were familiar with the brief documents and relevant whole hospital policies.

17.3.6 Clinical leads represented all the departments in the group they were allocated to and actively engaged with the relevant clinical teams between boot camps and meetings.

17.3.7 Community, patient and public representatives have been involved in workshops and focus groups to comment on the design development for the new hospital.

17.4 Stakeholder Engagement and Communications

17.4.1 Regular communications have been maintained with staff and the public. The channels used for internal communications are:

- Chief Executive Officer weekly message to all staff;
- Corporate Team Brief;
- 'Hot Topics' (the monthly team discussion forum);
- Focus groups and events;
- 'Heartbeat' (the Trust Magazine);
- Staff Communications (daily staff briefing);
- The intranet; and
- The RCRH Newsletter.

17.4.2 Public facing media / channels used for communications are:

- The RCRH Newsletter;
- The Acute Hospital Brochure;
- The website;
- Press releases;
- Public meetings / focus groups;
- Trust Members newsletter;
- 'GP Focus' (GP magazine);
- A DVD which explains the RCRH Programme to the public;
- Twitter and Facebook; and
- Stakeholder update.

17.5 Outline Communications and Engagement Plan

17.5.1 The Outline Communications and Engagement Plan is presented at ***Appendix 17b***.

17.6 Commissioner and Council Support

Commissioner Support

17.6.1 The MMH is vital to the delivery of the RCRH Programme. A strong partnership of commissioners and providers has developed since approval of the Strategic Outline Case (SOC) in July 2004 and a local health economy activity and capacity model has been developed. GPs have been involved in the programme from the beginning. The Trust provides services for three main CCGs:

- NHS Sandwell and West Birmingham (SWB) CCG (accounts for circa 75% of Trust activity);
- NHS Cross City CCG (accounts for circa 13% of Trust activity); and
- NHS Birmingham South and Central CCG (accounts for circa 5% of Trust activity).

17.6.2 SWB CCG, the largest commissioner for the Trust, is represented on the RCRH Partnership Board. All three of the CCGs continue to support RCRH and the development of the MMH.

17.6.3 The Trust's lead commissioners signed a Commissioner Support Letter at the OBC stage. The commissioners have now reaffirmed their support at this stage.

17.6.4 The CCG support letters for this stage and at OBC approval in 2014 are presented at ***Appendix 18c*** demonstrating the long term support from commissioners from the early days of the MMH Project.

Engagement with Overview and Scrutiny Committees

17.6.5 Regular presentations have been made to both Overview and Scrutiny Committees (OSCs). The approach to this has been a joint presentation led by the RCRH Programme in which regular updates on the progress of the acute hospital development are also presented. Feedback from the OSCs has been positive and the Trust and other partners have been keen to respond to questions / requests for information.

Support from the Local Health and Wellbeing Boards

17.6.6 The RCRH Programme has facilitated the support of local stakeholders throughout the years of the programme. Sandwell Metropolitan Borough and Birmingham City Councils are both represented on the RCRH Partnership Board and have worked closely with the Trust on many aspects of the MMH Project. Their continued support is evidenced by the support letters from the Local Health and Well Being Boards presented at ***Appendix 17d***.

17.7 Conclusion

17.7.1 The endorsement letters from the CCGs and the local Health and Wellbeing Boards demonstrate a high level of support for RCRH and specifically the development of the MMH. They are all actively involved in the RCRH Programme and see the benefits for their local communities. They also point to on-going public support for the scheme. The lead commissioner SWB CCG also commits to working closely with the Trust to ensure delivery of the business case.

17.7.2 Reappraisal of the financial and activity model has taken place in April 2015 and is aligned with commissioner intentions.

17.8 Stakeholder Board Engagement

17.8.1 A Stakeholder Board was established following the OBC approval in order to expedite the approval process for the ABC, recognising that the timescales for ABC production and approval were relatively short. The Stakeholder Board comprises representatives from the DH, HMT, TDA and the Trust.

17.8.2 The Stakeholder Board has met regularly since December 2014 and has already agreed that some of the OBC approval conditions have been met.

18 Conclusion

18.1 Purpose

18.1.1 This Generic Appointment Business Case has been prepared to request approval to Close Dialogue in the procurement of the Midland Metropolitan Hospital (MMH).

18.2 The foundations for the scheme remain robust

18.2.1 The MMH OBC was approved in July 2014. The approval letters for the scheme to date are presented at ***Appendix 18a***.

18.2.2 The case for change remains strong and there is an increasing urgency for the scheme in order to secure the sustainability of acute services – hence the requirement for a newly commissioned hospital by October 2018.

18.2.3 The project remains aligned with the national strategic context and will support delivery of local strategic plans for the RCRH Programme.

18.2.4 The project remains on track to deliver the following benefits to the local health economy:

- **Improved quality and sustainability of clinical services** resulting in improved clinical outcomes, reduced mortality and ability to deliver excellent clinical care;
- **Improved customer care** so that that patients are treated with respect, are involved in decisions about their treatment and can be confident in the quality of their care;
- **More effective use of staff resources**, ensuring that staff are trained to deliver a new sustainable model of care, are productive and satisfied with their experience at work;
- **More effective patient flows** to maximise use of resources and improve patient experience;
- Improved accessibility of services for the local population, so that patients can access a good range of local services, with faster access to treatment, at times convenient to them;
- **Improved flexibility and quality of accommodation** which will improve the patient and staff experience, maintain the best environment for clinical care and provide greater privacy and dignity for patients;
- **Improved ability to develop / sustain services and respond to commissioning intentions**, so that the Right Care, Right Here vision is achieved and new services can develop and be sustained over time;
- **Financial benefits** from services which are affordable, financially sustainable in the long-term and achieve budget forecasts;
- **Contribution to local community regeneration as new developments** are built around the hospital and the local community have opportunities to find work in the hospital.

18.2.5 The strategic solution of MMH being delivered on the Grove Lane site remains valid.

18.2.6 The Trust's annual update of the LTFM has confirmed that the scheme remains affordable and demonstrates that the Trust will achieve a CsRR of at least 3 throughout the LTFM horizon.

18.2.7 Activity and capacity assumptions remain consistent with the OBC.

18.2.8 Given the continuity in the factors above, the scope of the scheme remains unchanged.

18.3 Key changes since OBC approval have strengthened the case

18.3.1 There is an increasing urgency to consolidate acute care onto a single site in order to sustain the provision of high quality, safe services.

18.3.2 The PF2 procurement route represents strong value for money (increased from 4.2% at OBC to 18.2%), principally due to an increase in costs of the Public Sector Comparator and a subsequent reduction in the funding terms of the PF2;

18.3.3 Due to the reduction in funding terms, the UP has reduced to £21.95m.

18.4 Significant progress has been made since the OBC

18.4.1 Since the OBC, the PF2 procurement has commenced and financial close is now scheduled for December 2015 rather than April 2016 as originally planned.

18.4.2 Design development has progressed successfully with comprehensive clinical involvement, culminating in a draft final bid being submitted on time and being evaluated by the Trust as fully compliant in all respects.

18.4.3 The Trust has worked closely with the DH and HMT to ensure that sufficient robust mitigations have been put in place to secure value for money given that only a single interim bid was received.

18.4.4 Demolition on the Grove Lane site has been completed and the site has been cleared ready for site preparations works to commence prior to the main construction programme.

18.4.5 All of the conditions of OBC approval (and subsequent DH conditions) have been met in so far as that is possible at this stage in the procurement process. All conditions are on track to be met by the timescales stipulated by the DH.

18.4.6 Local commissioners and stakeholders continue to endorse this project as a key enabler for the RCRH Programme, aligned with commissioning intentions, and affordable within the local health economy.

18.4.7 The Trust's workforce transformation programme is well underway. Statutory consultation has already taken place on circa 400 posts on the 'Safe and Sound' phase. The first stage of Safe and Sound has been delivered on time in 2014/15 with the second stage to be delivered during 2015/16.

18.4.8 The EpR OBC has been approved by the Trust Board and a procurement plan is in place to deliver a paperless solution by October 2017.

18.5 The project is on track for MMH to open by October 2018

18.5.1 This Generic ABC is being submitted on schedule in order to meet the programme timescales and to open the MMH by October 2018.

18.5.2 The Trust is driving the procurement forward to Financial Close which is now scheduled for December 2015 with the main construction programme due to commence in January 2016.

18.6 Approval is now requested to enable 'Closure of Dialogue'

18.6.1 The ABC checklist has been completed and is presented at ***Appendix 18b***.

18.6.2 Approval is requested from the Department of Health and HM Treasury to enable this much needed development of service to take place.

19 Appendices

Appendix Number	Document Name	Document Status since OBC Approval in July 2014
2a	Approval Letters	New at OBC approval
3a	Estates Strategy	Updated
5a	Activity, Performance and Capacity Assumptions	Updated
5b	Clinical Service Model	Updated
7a	Economic Appraisal from OBC	Unchanged
8a	Revenue Costs for Economic Appraisal from OBC	Unchanged
8b	External Health Benefits	Unchanged
9a	Trust Board Procurement Options Appraisal	New document
9b	Quantitative assessment of P21+ vs PF2 (both using Hospital Company design	New document
9c	VfM Sensitivity Analysis	New document
9d	Qualitative Assessment	Updated
10a	IM&T Strategy	Updated
10b	Electronic Patient Record Procurement Timeline	New document
10c	Equipment Responsibility Matrix	New document
11a	OJEU Notice	Unchanged
11b	Constitutions of Consortia	New document
11c	Updated ITPD Volume 4	Updated
11d	Stage One Due Diligence Reports	New documents
11e	Draft final bid evaluation	New documents
12a	Technical advisors report	New documents
13a	Cost improvement programme	Updated
13b	Downside case	Updated
14a	Project Plan	Updated
14b	Project Execution Plan	Updated
14c	Project Structure	Updated
14d	Integrated Approvals and Assurance Plan	Updated
14e	Gateway 2 Action Plan	Updated
14f	Risk Register	Updated
14g	Benefits Realisation Plan	Unchanged
15a	Equality Impact Assessment	Updated
17a	RCRH Consultation Documents	New document
17b	Outline Communications and Engagement Plan	Unchanged

17c	Letters of Support from Commissioners	New document
17d	Letters of support from local Health and Wellbeing Board	New document
18a	Previous Approval Letters	Unchanged
18b	ABC Checklist	New document

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	2020 Plan
SPONSOR (EXECUTIVE DIRECTOR):	Toby Lewis, Chief Executive
AUTHOR:	Toby Lewis, Chief Executive
DATE OF MEETING:	7 May 2015

EXECUTIVE SUMMARY:

The Board has seen repeatedly a document which we began building a year ago. Our 2020 Vision. As we have considered it we have debated what it is for, and how it is phrased. It remains in place as a single simple overview of our long term plans, framed in delivery of the definition of integrated care that we agreed last summer. The document will form the headpiece of a suit of plans, some of which we have already developed (public health and R&D), some of which are nearing completion, and some of which will follow over the next 18 months. The 2020 Vision is not meant to be everything, but it meant to be something that is our strategy, and which, quite deliberately takes us beyond Midland Met.

REPORT RECOMMENDATION:

The Board is asked to formally endorse:

- That it agrees the 2020 Vision as a long term strategy document for the Trust subject to
- The engagement process described in the attached paper being concluded
- And the creation of a portfolio of Integrated Care Pioneer services over the year ahead

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**

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

Aligned to all Trust's strategic objectives

PREVIOUS CONSIDERATION:

Trust Board in March 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Communicating our 2020 vision

REPORT TO THE TRUST BOARD – 7 MAY 2015

Sandwell & West Birmingham Hospitals NHS Trust is in the process of approving its 2020 plan to set the strategy of the Trust for the next five years. As the overarching vision for development of services it is important that employees, patients, stakeholders and the wider community have the opportunity to learn about the vision and to contribute.

During June, Sandwell & West Birmingham Hospitals NHS Trust will publish the 2020 plan document and communicate this both internally and externally, seeking feedback.

Internal communications

Groups and directorates have all been involved in building the vision that began with work at the leadership conference in June 2014. Information has also been included in the Trust's newsletter, Heartbeat; so many employees will have some level of awareness of the 2020 vision, although more detailed understanding of its content will differ.

In June 2015 we will:

- Use our monthly briefing session, Hot Topics, to inform teams of the 2020 plan and ask them to discuss how their team fits into the vision and offer feedback;
- Publish the 2020 plan on our intranet, Connect, and highlight it through our Staff Comms daily bulletin;
- Publish via staff screensavers;
- Present at the 2015 leadership conference; and
- Arrange staff drop-in sessions to find out more and provide feedback.

External communications

Stakeholders, patients and the public may also want the opportunity to learn and comment on the vision.

During June 2015 we will:

- Publish the plan on the Trust website;
- Use social media to raise awareness of the plan with a short introductory film that will be shown on Trust TV screens;
- Distribute the plan to stakeholders including Healthwatch, Local Authority leaders and officers, Scrutiny Committees, Right Care Right Here partners, local voluntary and community groups seeking views; and
- Present the plan at the Trust Annual General Meeting on 25th June, inviting stakeholders, patients and the public to attend. This presentation will also include a summary of feedback comments received.

Ruth Wilkin, Director of Communications

Our **2020** Vision

Contents

Who is this document for?

This is for **everyone** involved with local care. Patients, carers, professionals, other organisations, Trust staff, members, volunteers, funders, suppliers, and students. Each may need more detail that differs to meet their particular interests. But a common thread is crucial too. And that is what our 2020 vision sets out.

1. What is the 2020 vision for?

The purpose of our 2020 vision is to summarise how services will change as we develop the organisation towards this ambition. The Trust provides research and educational services, and we have published long term growth plans for those vital functions separately. This 2020 vision, described mainly through the eyes of our patients, outlines what services will be like in five years time, what will be different, and what will stay the same. The strategy shows you the highlights, not every detail, but it **makes firm commitments to improvement**.

We are not starting from scratch nor is this something radically different for the Trust. We have a strong track record and reputation for placing integrated care at the heart of what we do: Whether it is in our work to help patients and staff make healthy lifestyle choices, or in offering more locally accessible outpatient clinics in community centres and GP practices. **The focus is now on this becoming the way we do things across every part of the Trust**, not just in diabetes or anti-coagulation, but across our portfolio.

Our goal is to become renowned as the best integrated care organisation in the NHS. That is a big ambition. It comes at a time when all organisations are making a similar claim or stating a similar commitment. Sandwell and West Birmingham will be distinctive is that it is the daily experience patients have of what we do. And that is why the single measure of success we are setting is the opinion of those we care for: Our patients.

It is clear that our Trust cannot achieve these plans alone. We have important partnerships in place already with the voluntary sector, with local schools, with GPs, dentists, optometrists, and pharmacies. We work with other hospitals, and expect to do that much more actively, especially across the Black Country, in coming years. We are deeply involved in educational excellence locally, and have high ambitions to develop research further at the Trust. We believe our plans fit well with those of other partners, especially those providing mental health care on which our work always depends. The 2020 Vision **gives those partners clarity about our aims and ambitions**.

How we have developed our 2020 vision?

We have been working on this document for twelve months. It has been built 'bottom up'. The plan has been developed in close partnership with our clinicians and managers. Every clinical group has had time to consider their role in supporting each others' plans. Starting with our leadership conference in 2014, workshops, surveys and other tools have allowed us to test and refine the ideas of our staff, and to engage patients in developing ideas.

This work has led us not just to choices about priorities but also to a descriptive series of patient stories. These stories show how care models will change. In many cases most care will be delivered in the same way, and certainly to high quality standards. But in all sorts of ways we expect to change the coordination of care - joining up more effectively with patients and their relatives, with GPs and other care partners, and across our own organisation, between sites and specialties. This coordination is a seven day a week ambition.

Our detailed plans will evolve as time moves on. But the direction of travel should be clear and consistent - In line with this 2020 Vision. We want to take a lead role in disease prevention. We aim to provide long-term conditions care in different ways and in partnership with general practice. Acute care will be specialised and centralised for excellence. And long-term rehabilitation and social care will be part of what we do, working alongside others to meet the changing needs of our population.

2. What do we mean by integrated care?

Sandwell and West Birmingham Hospitals NHS Trust provides care to over half a million local residents. One and a half million times each year someone has contact with one of our 7,000 staff. But we are not the biggest provider of care locally, nor the biggest provider of NHS care. We work in partnership with primary care, and with families and voluntary groups who support people in their own homes. Their role has to be enhanced by what we do.

Integrated care can mean different things to different people. It is for this reason, at the outset of developing our 2020 vision, that we felt it important to adopt one definition which clearly describes what integrated care means and which forms the basis of how we see care developing over the coming months and years. Central to this is working to put the patient at the centre of care - informing the outcome, with our services coordinating care on their behalf.

National Voices, a national coalition of health and social care charities in England, were tasked with developing a definition for person-centred coordinated care in 2013. This definition has been developed to take away the jargon of integration, and describe what this really means, feels and looks like from a patient's point of view. It is this definition we adopted in 2014 to form the basis of our Trust. This definition clearly puts patients, their families and carers in the driving seat when it comes to their care.

"*I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me*"

Importantly, this definition makes clear that location alone is not enough. Simply moving services "out of hospitals" does not deliver integrated working and it does not orientate services around the patient's needs. Location **can** be very important, especially where repeated consultation is needed. That is why the Right Care, Right Here focus in on local provision for long term conditions. In our chapter on location in this vision, we make clear that long-term outpatients under our care should expect that their postcode plays a part in co-deciding where their treatment will take place. In many cases we would want to be able to support care in a GP practice - as we do now for diabetes, on a scale not seen elsewhere in the NHS.

Co-ordinated care **does** depend on connections made through technology. The Trust is investing over £50million in technology in coming years. We want to be able to work across locational boundaries and organisational boundaries. We strongly support Your Care Connected, which provides access to a summary care record. And we are working to improve patient access to data that is information that belongs to the person whose care we are involved with.

Skilled, motivated people provide the best care. Teamwork is **always** at the heart of what we do, and increasingly care, both complex and personal care, relies on inter-disciplinary working. Traditionally, NHS staff choose a career discipline, a job location, and a 'sector' to work in. We are working with our staff and our students to understand how to work best when we organise what we do differently, and how to prepare and prosper professionally when a vertically and horizontally integrated model of care becomes our norm. These changes are exciting, but also daunting. We need to involve people, be clear with them, and support them in making the changes that, typically, we are agreed need to be made. This is a Trust "where everyone matters".

3. Does our plan fit the bigger picture?

The NHS has to meet changing needs in years to come, and has to do so more efficiently as demand will rise faster than funding. Our vision to integrate care is consistent with national policy and evidence. We will play our part through the Right Care, Right Here partnership in delivering care without boundaries in the years ahead.

In the next five years we expect the local population to:

- grow by xx,xxx people, which is round x% more than now, and age, with x% living past 85 years of age
- continue to be among the most ethnically diverse in England, including additional immigration from Eastern Europe and Sub-Saharan Africa
- see rising and changing patterns of need, with diabetes and dementia increasing among local people

At the same time, the care that the NHS can provide will change. Genetic medicine will make a big difference to how we personalise care. Treatments for a host of diseases, including cancer, are changing and we need to be able to provide the most modern interventions for local people. More of our patients live with a number of long term conditions such as arthritis and respiratory disease. These mean they have much more frequent contact with healthcare services over extended periods of time, but also that they themselves become an expert in managing their own care. It is right that healthcare services become more tailored to their requirements and to those who care for and support them. And of course, changes in technology and treatments allow much more healthcare to be self-managed or delivered in people's homes.

The NHS Five Year Forward view, published in October 2014, summarised a vision for the future of the NHS. In order to respond to changes in health needs, addressing the widening health gap and responding to the development of new technologies, there is a need to fundamentally consider how the NHS is structured to deliver the best care to patients to meet their future needs.

We believe that the NHS in West Birmingham and in Sandwell is well placed to meet the challenges of the Forward View. We have a tradition of innovation across organisations, and of partnership. This ranges from new care models, like our work with GPs on diabetes, through to supporting local people with employment opportunities. We have over 100 apprentices in the Trust, and work with partners like St Basils to target employment opportunities for traditionally vulnerable groups. Our plans for the Midland Met Hospital in 2018, and longer term work as part of the Right Care Right Here programme, will help to ensure we are at the fore-front of this transformation. The single most critical step to change is to reform the traditional outpatient visit model, retaining it only where it is the right approach for a specific patient, and replacing it in other cases with consultation through technology, support to local GPs, and group consultation models in which long term therapy is delivered to large number of patients.

It is important that we sustain outstanding partnerships with primary care. But we must also ensure that specialist acute services are improved and sub-specialisation is developed locally. It is in that context that we are strengthening traditional ties with Walsall Manor and Russell's Hall in Dudley. These important acute centres, each of which also offers community based care, are both essential to the Midland Metropolitan Hospital as emergency models change, and can form a wider and deeper network that will seek to develop specialist excellence local to the communities that we serve. We expect to formalise that alliance in the coming twelve months.

Icares

Seen as a model of national as well as local best practice, our Integrated Care Service or Icares places coordinating care at the heart of what they do.

Icares delivers admission avoidance, care management and community rehabilitation to anyone aged 16 or over who needs care from both nurses and therapists.

This service is not about working in a set way with rigid pathways, or expecting our patients to fit into the way we deliver care, it is about wrapping our community services and those we interlink with, around each and every individual person referred to us to provide them with what they need to be safe, be well and be happy with life.

The team are made up of community specialists delivering care both in and out of people's homes. The team work on behalf of patients to help them navigate moving between different boundaries and organisations for their care, so that from a patient's point of view their care is joined up and they have one point of contact.

DiCE Service

The DiCE teams truly are an example of how integrated care really can make a difference.
Our diabetes specialist nurses and consultants have teamed into pairs to form the DiCE teams. Through close collaboration with Sandwell and West Birmingham Clinical Commissioning Group each team has been linked with 111 GPs.

Each DiCE team has committed to spend at least half a day, every two months with the GPs providing diabetes support.

In some cases they attend clinics within the GP surgeries where they see patients face-to-face, examples are brought to case discussions or conversations are held either over the telephone or by email.

The aim is to increase primary care expertise and management to enable a greater percentage of diabetes care for type 2 and stable type 1 diabetics to take place within the GP practice with the support of the DiCE team.

It enables primary care clinicians and diabetes specialists to work together in the best interests of the patient and improves the patient experience with more care delivered locally.

Add specialist network for sickle cell care?

4. Our super-diverse population

The NHS offers a defined standard of service - or aims to. The Constitution of the NHS, reinforced through the Mandate issued by Parliament, specifies what must be done. But the people we serve locally have diverse, as well as common, needs. So we have to respond differently to achieve the same outcomes.

Our population is dominated by high levels of deprivation and poor health when compared with the rest of England, with Sandwell ranked as the 12th most deprived local authority in England and Birmingham ranked 9th.

Whilst comparatively, we serve a relatively young population, we estimate the number of people of pensionable age in Sandwell is expected to increase by 33% between 2008 and 2033 (more than double that of other age groups). This is coupled with an expectation that late onset dementia is expected to rise by 50% between 2006 to 2030.

We serve an ethnically diverse population, including those from an Indian, Pakistani and Black and Caribbean background. As migration patterns change, we anticipate an even greater ethnic mix in the population we serve. Such diversity is associated with certain specific health needs, and therefore future services would need to ensure they meet the needs of these population groups and remain culturally sensitive.

The lifestyle factors and choices that our local population makes have a major bearing on their health needs. The number of smokers, obese adults and people admitted to hospital as a result of alcohol is well above the average for England. Housing status, and employment, are both determinants of health status, and use of NHS services.

This means **three principles** for our future:

1. We have to play our part of *tackling poverty and exclusion* in the communities we serve. We can do that through how we spend NHS resources. And by the partnerships we develop and support.

2. We have to *address health behaviours*, starting with the wellbeing of our staff, but also helping those we care for to make lifestyle changes that can be sustained. Every service we provide needs to make every contact count.

3. We have to offer services suitable to need, delivering *diversity not uniformity* that addresses cultural difference to make sure that our services are clinically effective.

In 2014 we published our three year Public Health Plan for the Trust. That sets out specific commitments for improvement by 2017. A further three year plan will follow, taking us towards 2020. However, unless we work with partners to address the three principles by 2020, then services locally by 2030 will face severe difficulties as underlying needs will rise beyond our funding, workforce and service plans - and beyond what is foreseeable achievable. Success is entirely possible, but we must act now.

Multiple Long Term Conditions

Long term conditions is a term used to describe health problems that cannot be cured but can be controlled by medication or other therapies. It is estimated that more than 15 million people in England have a long term condition. Examples of long term conditions range from high blood pressure and coronary heart disease to depression, dementia and arthritis. Many of us call these diseases, chronic conditions.

As populations get older, the number of people with a long term condition increase, and the proportion of a population with several long term conditions increases too. It is estimated that the number of people with a long term condition is set to increase significantly over the next ten years, particularly the prevalence of people with 3 or more conditions at once. Long term conditions can affect many parts of a person's life, from their ability to work and have relationships, to housing and education opportunities. Care of people with long term conditions accounts for 70% of the money that is spent on health and social care across the whole of England.

The best of what we already do at the Trust tries to "wrap" services around our patients. In simple terms to focus on the person not on the diseases or diseases being discussed. But that needs to become routinely our approach if we are to meet the rising demand in our population, and if we are to match the definition of integrated, coordinated care we set out in Chapter 2. To do this, we will need to undertake more of what we do in multi-specialty clinics, and more of what we do in circumstances coordinated through general practices. In turn this requires major changes in how primary care functions, at a time when that system is faced with major workforce issues, both with retirement and recruitment. The Trust can play an important role in helping to address those issues - making the experience of providing primary care locally a simpler, easier, more rewarding one.

In 2020…Mary's story

Mary is an 81 year old lady who lives alone. She was previously independent and mobile. She enjoyed doing her own shopping, and socialising with her neighbours. She had a fall at home while preparing a meal in the kitchen and, after pressing her STAY Telecare alarm button, was taken to hospital by ambulance.

Doctors found that Mary had not broken anything, but was bruised and sore. She was assessed by the Rapid Response Therapy Team in A&E. They found that Mary's confidence was now low and she was very unsteady on her feet. As Mary lives alone with minimal support, it was decided in discussion with Mary and her family that a short period of rehabilitation was required before returning home.

She was transferred from A&E to an intermediate care bed where she received a short period of rehabilitation. At this point, Mary was still lacking confidence when getting out of bed and walking around, and she required some support when getting something to eat and drink. It was decided with Mary and her family, that Mary could return home with an increased level of support and ongoing rehabilitation to assist in her return to complete independence. Mary was therefore referred to the Own Bed Instead (OBI) Service for a period of rehabilitation and support in her own home. After a short period of support from the OBI service, Mary regained her independence and confidence and was able to continue living in her home, to Mary & her family's delight.

5. Not everything has to change - can we maintain current strengths?

The vast majority of people who use services offered by the Trust rate them highly. Our outcomes are good when compared to other local Trusts. So it is important that in adapting to meet the challenges of the future, described in this document, we do not lose sight of those strengths.

Our workforce

In many parts of our Trust engagement and morale are high, sickness and turnover are low, and there is a very strong commitment to the local NHS. Almost half of our staff have worked for the Trust for over ten years, and 92% of staff report in anonymised surveys that their roles makes a positive difference to care. Appraisal is consistently in evidence across the Trust, and mandatory, compulsory training is undertaken consistently.

We want to maintain that strength. But we want to make it consistently true across our organisation, in every team, developing a clear plan for the potential of every employee, as roles change and as individuals want to develop.

In support of that ambition we believe that we must:

- Achieve morale and employee engagement scores that are among the best in the NHS, rather than results which are better than average. We will do this by developing local leaders and managers who have the skills to work with their teams to achieve quality improvements;
- Reduce sickness rates and vacancy rates in our Trust, whilst reducing turnover rates - especially among employees who have been with us for less than two years. We will do this by making career pathways more explicit and supporting training and development;
- Create clear job roles for individuals to work across community and hospital practice, whilst retaining the job satisfaction of working in a defined team, and the work/life balance that comes with a base and a routine.

Our patients

96% of those who are admitted to our Trust rate their care as good or outstanding. Over 30,000 local residents have fed back their views on outpatient services, and more than 19 out of 20 are very satisfied with the way that they were cared for. Individual services offered by the Trust consistently undertake patient feedback surveys, focus groups and other methods to gather opinions and ideas.

This feedback matters - for example, during 2015 we have completely changed the arrangements across our sites for visitors to come and see friends and family in our wards, by moving to what we call 'open visiting'. This reflects patient feedback, but also our commitment to making sure that we do isolate people when they are in our care by creating unreasonable processes.

We do have clear feedback on what people want us to change, and we are acting on that:

- Our communication could be better, especially ensuring that patients are always involved in conversations about their care and are not talked about;
- Our communication could be better, because we could improve the notice we give for appointments and cancel fewer operations at the last minute;

- Our communication could be better, when patients are cared for by several teams, during an admission or over several visits to our services;
- Our communication cold be better, with more information in multiple languages and better availability of translation services that reflect the super-diversity of our communities

All of these wants and needs reflect a search for co-ordination and a consistent excellence. That Is what our 2020 Vision commits the Trust to work to deliver.

Our partners

Our annual GP survey suggests that some current services are especially valued, including our breast service, the regional eye hospital, and diabetes and pain management. Other strengths include our gastroenterology advice and guidance service which allows GPs to request email advice from hospital consultants. Similar services are being introduced Trust-wide during 2015. GPs tell us that they want better communication and integration with hospital teams.

Work with local optometrists, pharmacists, dentists and other contractors is very important to the Trust. By 2020 we want to have clear networked partnerships in place with both independent and commercial local organisations, whose care is a vital part of local High Street NHS provision.

Research undertaken on our behalf independently highlights the strong tradition the Trust has of partnership working. Statutory partnerships with local authority and other NHS bodies, are reinforced by specific joint working initiatives with the third sector and a collaborative openness with Healthwatch. We have private sector partnerships in a number of clinical fields, as well as through our Birmingham Treatment Centre contract.

Our 2020 vision expects the scale, breadth and depth of those partnerships to grow. We will maintain links with existing educational partners at Birmingham University, BCU and Wolverhampton. We work collaboratively with both Birmingham Community Healthcare and the city's regional Children's Hospital. As services become more specialised in any number of clinical fields, we need to find the right balance of local provision, and rationalisation of services into larger specialist centres, such as the Queen Elizabeth, or federated specialist services across Trusts such as Walsall Healthcare, Dudley Group of Hospitals, and ourselves, together serving a population of over one million people.

How we manage change

The Trust is a large organisation. We already work from over 150 sites and have teams based in many different places. That makes it immensely important that local team leaders are connected to those people that they are supporting and coaching, and that those leaders retain a close connection to the Trust as a whole - able to translate system wide projects into local quality improvements. That is the culture we are seeking to make our norm.

From our workforce, our patients and our partners, what is clear is that we do many things well. But that there is room for improvement, and we need to achieve consistency. We have to do that without standing in the way of innovation, but creating standards that apply wherever a patient has contact with us. This mix of local ideas and Trust-wide discipline is essential to our 2020 Vision: We describe in Chapters 7, 8 and 9, three levers which are key to success.

6. Our 2020 Vision: Clinical & corporate services

* Please refer to the PDF for all 8 plans

Services cut across all of our teams. A patient may have contact with multiple services, many times, across several sites. The teams within our Trust are organised into care groups, and we have organised the ideas put forward about our future on that basis. But for many patients, it will be helpful to summarise what you can expect on a pathway basis - from home onwards.

Our Vision expects that general practice remains the fundamental unit of care within our NHS. We will ensure that our community based teams are organised to fit alongside and within the extended primary healthcare team. That integration may be geographical, as in the case of district nursing, or may reflect local authority teams for services where that is most appropriate.

Where a GP refers a patient to our care, we will provide expert advice. **More commonly than at present that advice will not require a patient to come to a hospital clinic**. Where it makes sense to do so, we will undertake diagnostic tests before a clinic visit or on the same day. The scale of same day services will be larger than it is today. More planned care services will be open in the evening and at weekends.

Planned care services will be offered through our two Treatment Centres, on Dudley Road and in West Bromwich: Birmingham and Sandwell. In some cases we will be able to provide outpatient procedures even more locally than that. Follow up from care will take place, if it is long term, closer to home.

Emergency care will be focused on the Midland Metropolitan Hospital, but only where being admitted to a bed is the next step for care. We will work to **prevent admission** wherever we can do so, by both providing and supporting alternatives to admission that sustain home or nursing home care.

These alternatives, as well as step down facilities from acute provision, form the basis for our **intermediate and rehabilitative care model**, which will be delivered from at least four locations - Leasowes, Dudley Road, Sandwell and Rowley Regis.

The Trust is committed to providing **care on a long term basis to local residents**. Over the next five years we would expect to become much more involved in delivering extended social care services. This reflects the changing needs of our population.

Finally, and crucially, our **preventative care services** are being expanded, and developed alongside traditional NHS provision. We expect this part of what we do to grow, because we know that by 2030 we have to tackle the underlying determinants of ill-health in our local communities.

7. Care transformation locally: Technology

The trust is undertaking a major investment in information technology between now and 2020. This will not only provide our staff with the tools to deliver better and more reliable care with access to better and more up to date information about you. It will also transform the way you access your care from us and enable you to better care for yourself with our support.

Safer and more reliable

Technologies such as VitalPacs and Electronic Prescribing will mean that the care that we provide will be safer than ever. Our systems will know when your condition changes whilst in hospital and enable clinical teams to respond more rapidly. Doctors and nurses will be able to ensure you are taking the right medicines, that you always get them on time and that they are the most appropriate medicines for you. Our systems will be able to ensure that you have always had the right tests and are always ready for your appointment or operation.

Information always available everywhere

Mobile technology and the Electronic Patient Record means that your health record will, with your permission, be available to any doctor or nurse caring for you wherever you are - whether it is your GP in their surgery, a community nurse visiting you at home or an A&E doctor when you come to hospital. Your Care Connected enables hospitals, community services and GPs to share the information they have. This will reduce unnecessary repeat tests, repeat appointments and vital information about you will not be lost or forgotten.

Keeping you informed showing you the way

You will be able to monitor your own progress as you pass through our systems - make and see your appointments online. See your own test results and even ask questions of your clinical team. Our self check in kiosks will welcome you when you arrive at hospital, they will help you find your way to your appointment on time, make sure the information we keep about you is up to date and will even let you know if there is an opportunity for you to take part in one of the many research studies we carry out.

Empowering you through technology to care for yourself

We are pioneering the use of smartphone and tablet technology that provide apps that will help you take control of your condition. Patients Know Best is an app that helps you set goals, track your condition, communicate with your clinical team and learn about your condition - so that you become your own expert. Other devices such as home blood pressure monitoring, heart rate monitors, blood sugar measurement and much more will mean that you can track your own condition and share it with your doctor. You will have access to your own healthcare record and you will be able to take it with you wherever you go. You can even communicate with other patients just like you.

Telling you how we are doing

Technology will make information available to you about the quality of care we provide. We will be able to tell you how safe and clean our wards are, how our services compare to other hospitals and what others think about the services we provide. Information is power and we will use our technology to give you the power to manage your own care and make your own choices to receive the best care possible.

A FURTHER PAGE WILL BE ADDED WITH A CASE STUDY ON TECHNOLOGY - a community or IC one

8. Care transformation locally: Locations

The Trust provides care from 150 locations in 2015. We expect the number of locations to remain similar, but the scale of services provided at home, in general practice, in leisure centres and elsewhere within our communities to grow. Meanwhile, we are investing in all of our 4 hospital sites, and in 2018 will add a fifth site: The Midland Metropolitan Hospital in Smethwick, at the top of the Dudley Road.

Local care lies at the heart of our 2020 vision. That responsive, accessible model was important when predecessor organisations consulted local people in 2007. Most local care can be provided in the home of a patient or in a nearby general practice. During the last eighteen months, we have significantly expanded care in such settings.

Rowley Regis Hospital

The site is vital to local people and services have expanded over the last two years. In March 2015 we undertook a consultation exercise on the final state of the site and further expansion. During 2015 and 2016 we are committed to implementing changes to:

- Ensure intermediate and day hospital care is sufficient, and can support discharges from our hospitals and Russell's Hall, where many local people get their emergency care
- Transfer more outpatient services onto the site, to support long term conditions care close to home, in partnership with GPs and the multi-disciplinary primary healthcare team
- Make sure that our changes do not impose a burden on local residents, for example through car park overspill - while trying to create local amenities on the site.

Leasowes in Oldbury

We provide intermediate care through this centre, as well as offering some end of life and our current midwife led birth centre in the adjacent Halcyon facility. Our strategy remains to support intermediate care beds both on our sites and, where appropriate elsewhere as well. Over the next five years we plan to maintain the centre and to support its use for rehabilitation and out of hospital long term care. The future of the Bradbury Day Hospice will be driven by commissioner decision about the long term strategy for end of life care in our area.

City Hospital on Dudley Road

In 2018, the A&E at City Hospital, and the majority of bed based services will close and transfer to the Midland Metropolitan Hospital. The Birmingham and Midland Eye Centre (BMEC) will remain use at City, alongside the Birmingham Treatment Centre (BTC). Current plans retain hearing services on the site, but this is subject to ongoing review. In addition, we are developing the Sheldon Block as our intermediate care base for Ladywood and Perry Barr. That transformation began in 2014 and will continue progressively over the next five years.

Midland Metropolitan Hospital

This new hospital brings together specialist acute services for adults and children. It allows us to offer seven day a week excellence and team based care. With more diagnostic and interventional facilities this major new hospital for the next century is an essential part of the local health landscape. It is a major change in how care is delivered, as well as where care is delivered. It requires a separation between planned and emergency work, and between community-based care, including outpatients, and admitted care.

Developing the Sandwell Treatment Centre by 2020

The future of our site in West Bromwich - Sandwell General - is secure. But the site sees considerable change from 2017 to 2020. These changes are in line with the prior public consultation but seek to provide ***more*** services on the site that previously envisaged. Of course over the next five years the position is a changing one, and commissioner intent may require adjustment to our plans.

Outpatient services will be the heart of the new Sandwell Treatment Centre model. Both new and follow up care in most adult and childrens' specialties will be provided through the site. We expect to invest in improving the outpatient environment, and this forms part of the approved long term financial model for the Trust, which underpins the agreed Midland Metropolitan Hospital business case. Only emergency outpatients and antenatal care will take place inside Midland Met. There may be a small number of specialties where it does not make sense to duplicate clinics on multiple sites. This restriction would be more likely to apply to complex multi-disciplinary care.

- Day surgery and investigative procedures such as planned endoscopy care will be maintained at Sandwell, exactly as we currently do within the Birmingham Treatment Centre. This will allow local provision to be maintained. This was always the intention of Right Care, Right Here. If some surgical procedures are transferred by commissioners into primary care, then we will need to maintain an assessment of the viability of services.

- 35,000 patients are expected to be able to use the new Urgent Care Centre which will replace the existing A&E department. The CCG have begun an engagement exercise on the future shape of emergency care, and subject to that work maintaining the agreed system wide strategy, the Trust will offer with partners this vital service from 2018. The exact clinical exclusions from attending an Urgent Care Centre, as against an A&E department, are well understood nationally. Most ambulance transferred patients will by-pass the Urgent Care Centre and be looked after within an A&E department.

- Intermediate and long term care will be offered at Sandwell. This is the type of care we presently provide in Leasowes and Rowley Regis. We know that local delivery of such a service helps to integrate our care with the support of friends and family.

- Over the course of the next five years, we expect to transfer to majority of our corporate services onto the Sandwell site. Trust Headquarters relocated there in April 2014. Key support departments, which help us to run safe, and develop higher quality services, will locate there. This will include important aspects of our Research and our Education portfolios. These investments both confirm the central role that the site will continue to play in the life of the Trust, but also ensure local employment opportunities, as more than 15% of our workforce are within corporate teams.

We do expect to see some land sales. This is in line with our long term published plans, and we continue to explore with partners such as the Local Authority how these intentions can best meet both local need and economic obligations on the Trust. Taking the re-used property and the excess property we remain able to develop some of our estate with local partner organisations, including the third sector. We are exploring the creation, for example, of a general practice service on the site.

9. Care transformation locally: Our workforce

Everything in our 2020 vision depends on the skills, talents and teamwork of our workforce. That is why we are committed to educating the next generation of NHS staff. And why we are investing heavily in research and development, to ensure that the most innovative care Is delivered by the Trust, and those with a passion for excellence are recruited to local service.

In the future we will employ over 6,000 people. We want to sustain that workforce as a high-skill, high-wage, multi-site, flexible group. Able to meet the health challenges faced by local people, as well as to themselves live healthy lifestyles. Every employee will have not only an appraisal and training plan, but a clear indication of their potential career trajectory. Whether in full time or part time work with us, our workforce will be supported to become ambassadors for the local NHS - implementing their own ideas to improve care within our organisation and with partners beyond it.

A great place to work

Working for the NHS is a privilege. But the dedication of staff must be rewarded with opportunity, consistency of leadership, and unwavering support to do difficult and challenging jobs. Our investment plans ringfence training expenditure, and provide for support to make major shifts in care. To work in teams requires that we support work-life balance. And that we act to cut sickness and reduce turnover. The Board, and wider leadership, understand that without success in those basics, the Vision outlined in this and other documents, cannot be achieved.

The next generation of employees

Whether it is school leavers through our association with the Sandwell UTC, apprentices through our ground-breaking work on enrolling young people from our communities, or the skills training and long term we provide to older adults re-entering employment, the organisation knows that part of our contribution to health lies in the jobs that we create and nurture for local people.

Preparing our teams for change

Our care model requires different skills. More reliance on technology. The capability to work across different teams and various sites. These are big changes. 60% of our employees who have worked for us for more than five years. Around 10% of our staff change each year. For both longstanding and newly enrolled staff the future is different to the present and we need to prepare carefully for that, with time, investment and collaboration.

Improvement and leadership skills

In 2015 we launched a major Improvement Plan for care. At the same, we created ring-fenced dedicated time across our services for one half day each month, to be reserved for development, support and quality improvement. That time to talk is crucial to our 2020 Vision. Individual teams need chance to identify opportunities for change, and to reflect on organisation wide learning. At the same time, the skills to improve services, to bring about and evaluate change are critical, and we will develop a model of routine implementation methodology during 2016. This supports the three year investment in leadership that we made in 2014. Across our directorates and Groups we are working to core leadership competencies, which we need to consistently apply throughout the Trust.

Add LEARNING WORKS CASE STUDIES

10. Judging our level of integration – you must decide in 2020

Successful integration is not easy to measure. As part of our plans, and those of the wider Right Care, Right Here partnership, there are agreed metrics which set expected levels of service change. But the real test is the opinion of each patient about their experience of our care. Have we changed who controls care outcomes? Because that is our aim.

Getting your feedback on care co-ordination

During 2015-2016 we will be changing how we gather feedback in our surveys and focus groups. We will make sure that the co-ordination of care across settings and services is a dominant feature of local data capture. Over the next five years that dataset will build a picture of where we are succeeding and where we are falling short of our vision. In 2020 we will undertake a much larger scale study of patient opinion in order to both assess the delivery of our plans and frame our strategy to 2030.

Making this 2020 Vision happen day to day

We will be establishing a series of patient panels to help us evaluate the plans put forward by our clinical groups, and test with you whether they deliver the level of coordination and joined up care you want to see from our services.

The delivery of this vision matters. It is for this reason that this will be governed through our Trust Board, with progress reported to our Clinical Leadership Executive, which has representation from each of our clinical Groups, as well as the full Trust Executive. Our membership, and the member's leadership group will also be appraised and involved in overseeing our work.

We will report within our annual plan and at our Annual General Meeting on our progress. In particular we will provide commentary on the future state models outlined by each of our Groups, and provide a straightforward assessment of the progress of our Integrated Care Pioneers: These services which will embody the change in how we provide care in 2020 and the decade that follows.

Taking the lead - our Integrated Care Pioneers

During 2015 we will be selected 20 services that form our Pioneers programme. These are the services that we believe have to be at the forefront, in vanguard of change, in order to accomplish both our 2020 Vision, and the wider Right Care, Right Here programme.

We would expect our pioneers to include services providing integrated models of care, such as diabetes, as well as those where we recognise that the care model needs to change, such as respiratory services. The pioneers are not only current Trust services, but services where we now we need to develop improved provision both to support care at home and to ensure that the Midland Metropolitan Hospital is supported by consistent models and standards of care regardless of the postcode of the person using its services.

INSIDE COVER TO BE TIMELINE FOR 2020 VISION and WIDER PLANS

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**TDA Annual Plans 2015/16 submission**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite, Director of Finance**
AUTHOR:	**Tony Waite, Director of Finance**
DATE OF MEETING:	**7th May 2015**

EXECUTIVE SUMMARY:

Attached are:

- TDA annual plan summary
- Summary finance schedules as an appendix to the plan summary

The Finance and Investment Committee will specifically routinely consider, inter alia, the following

- group & directorate level financial performance information
- non-pay CIP delivery
- CQUIN delivery assurance
- quarterly contract reconciliation oversight

REPORT RECOMMENDATION:

The Board is asked to receive and note the submission.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Good use of resources

PREVIOUS CONSIDERATION:

The Board received a summary financial plan at the April meeting.

SWBTB (4/15) 061 (a)

Annex A: Summary of One Year Operational Plan 2015/16

NHS Trust…Sandwell & West Birmingham Hospitals NHS Trust……

Strategic context and direction To include: Outline of plan delivery in 2014/15 and narrative on the progress anticipated in 2015/16, within the context of the Trust's previously submitted five year plan to 2018/19. To include the impact of strategic commissioning intentions, service changes, local health economy factors, competitive position, strategic developments, transactions and organisational sustainability.	**Outline of 2014/15 and progress to be made in 2015/16** **(Including strategic context and developments, transactions, organisational sustainability)** 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 6 by the CQC. Our CsRR is 3 – 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 (two NED replacements are due in 2015-16) and Executive team are in place and are beginning to develop a way of working and leading which can develop in the year ahead – grounded in a commitment to openness and candour. In Q4 2014-15 we welcomed a new director of Organisational Development (the Trust's first HR director in over five years), and a new director for the New Hospital project. Tackling a poor acute readmission rate, ensuring seven day care continuity, and improving patient satisfaction into the 80s+ are critical goals for us in the year ahead – as they have been in 2014-15. Although we have taken step in the last twelve months to make data quality, risk management, and peer learning more transparent we are seeing a fall in the number of staff who think safety is our top priority at the Trust – and that has to change in the year ahead. 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. We recognize that large scale workforce change has damaged morale and produced anxiety. Our commitment remains to meet our obligations and our timing promises, and thereby to create confidence that we will be open and do what we say we will. **Impact of strategic commissioning intentions and service changes** The Right Care, Right Here partnership is seeking to develop shared organisational resilience locally and alternatives to traditional tendering, alongside local authority colleagues. This creates opportunities to mitigate the significant risks created by GP led and Better Care Fund required changes. Trust led service reconfiguration will see us relocate interventional cardiology onto one site in spring 2015, and acute surgery likewise. Unless we face issues of safety or service sustainability we do not envisage reconfiguration of other services. We are developing a cardiac MRI unit at City, and will work to move a measure of secondary work for local people back onto our sites from UHB and Dudley.

	The CCG have confirmed that they do not intend to contract in 2015-16 on the basis of their better care fund trajectories. **Local health economy factors, competitive position** The Trust delivers services to a core population of c.500,000 serviced by two local authorities (Sandwell Metropolitan Borough Council and Birmingham City Council). The Trust is commissioned in the main from three CCGs; Sandwell and West Birmingham CCG, which accounts for c.75% of the Trust's activity and Birmingham Cross City and Birmingham South Central CCGs which account for c.18% of the Trust's activity combined. The population we serve is dominated by high levels of deprivation and poor health compared with the rest of England. 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. The Trust also serves some of the most diverse communities in the region, with large proportions of people from the black and minority ethnic communities within our catchment which 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. 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 undertaken considerable work to consolidate our presence across our geographic patch through 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.

Approach taken to improve quality and safety To include: The approach to quality improvement, the methodology used and the key improvements to be delivered over the next year across the five CQC domains of quality: safe, caring, effective, responsive and well-led. Consistent with information contained within the Trust's published Quality Account.	The challenges set in the Five year plan continue as we work to redesign care pathways to make them responsive to the needs of the population. The CQC visit highlighted some issues that need addressing urgently. Medicines Management being one such item which has needed the focus of all to change behaviours. Difficulties with discharge planning continue with the added effect of capacity problems and delays in patients being admitted. There has been and continues to be robust plans put in place to ensure timely discharge dates are set and all supporting discharge needs are met with improved links with the community and social services. Taken together we have 30 priority metrics for the year ahead. These span our long-term objectives, which have underpinned our plans for several years. The goals reflect ambitions set out in Group and Directorate business plans submitted between January and March 2015. Of these 30 priority metrics, we have five specific quality and safety improvement priorities: **1. <u>Reducing readmissions:</u>** **Safe:** By introducing a specially adapted scoring tool based upon length of stay, acuity of admissions, co-morbidity and number of previous admissions we aim to reduce the number of readmissions by putting in place plans of care to support the patient at home. **Caring:** A taskforce has been developing pathways to identify how patients can be supported. Patients have been asked what they want/need to help them stay at home. **Effective:** For the respiratory 'frequent flyers' a multi-disciplinary team will meet monthly to discuss patient care and to ensure the appropriate care package will be put in place. A holistic approach is being implemented with input from psychologists, dieticians, GP's and community support. A database similar to that used in cancer services is being developed. **Responsive:** The taskforce had been meeting regularly and pathways developed. Community services have been extended until 8pm at night. To see if the proposed pathway would meet the needs of the patients a patient who was a known 'readmitter' was interviewed while on the ward. **Well Led:** The multi-disciplinary team (MDT) meetings are being set up as a direct response to the needs she highlighted and by a realization that most of the admissions/discharges happen out of hours. The MDT meetings are being led by a respiratory consultant supported by a member of the Change Team. **<u>2. Improving Outpatients by implementing phase 2 of our Year of Outpatients programme</u>** **Safe:** 2014 has been the 'year of out patients' seeing projects developed that improve access to services ensuring patients are seen in a timely manner. Developments have included the role out of electronic clinic outcome forms and decision to admit forms. This project ensures that patients are not missed from follow up appointments or off waiting lists. **Caring:** By improving access we are ensuring our patients are seen at the right time and by the right person

Effective: '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.

Responsive: Self-check in desks are being installed in all outpatient areas. They are already in use in BMEC and will eventually help us to ask questions that time at reception desks often does not allow e.g.

- whether someone is happy to be contacted
- by researchers for a future R&D trial, completion of family and friends questionnaires.

Another project that we are developing is voice recognition for letter dictation. This will enable us to turn the clinic letters around within the required timeframes so GP's and the patients are kept informed about developments/changes in care.

The quality of our discharge/clinic letters is currently being audited against agreed standards by the CCG as part of the 2014/15 CQUIN.

Well Led: The Year Of Outpatients Programme is led by the Chief Operating Officer supported by the Change Team. All Groups have representation on the steering groups to support the future developments.

3. Achieving the gains promised within our 10/10 programme

Safe: 'Ten out of Ten' is our patient safety checklist. It is our commitment that each and every patient admitted on to our wards is taken through these standards within 24 hours of admission

Effective: As well as improving the quality of care and ensuring all appropriate assessments are done this initiative is intended to keep patients free from harm and involve them in the standard of their own healthcare

Caring: The initiative is to ensure that all assessments such as VTE, MUST, mental capacity, falls, MRSA etc are undertaken so appropriate referral/ treatment can be initiated

Responsive: The check list was launched in respond to the under achievement of targets. Since implementation/promotion there has been an increased awareness especially with the use of stamps for the patient records. Further work to be done to align outputs of 10/10 to the KPIs set across the Trust (e.g. VTE assessment).

Well Led: Led by the Chief Nurse to improve the quality and safety of care

4. Meeting the improvement requirements agreed with the Care Quality Commission

The Trust published its improvement plan on 26th March 2015, identifying 69 areas of improvement by the end of October 2015. Each of these priorities will be implemented in full and will be reported monthly to the Trust Board. In addition, the Trust is seeking to tackle underlying cultural themes which have been implied in the response to the CQC report.

	The five themes from our Improvement Plan are: i. Better at learning across our organization and spreading best practice ii. Consistently delivering the basics of great care iii. A visible reduction in sickness and vacancy rates iv. Best practice evident around local management and leadership v. Further evidence of incident reporting and risk management **5. Tackling caseload management in community teams** **Safe:** Considerable work has been completed in 14-15 on caseload management. We understand the baseline position. **Effective:** As we embed primary health multi-disciplinary working we need to consider the most effective and dynamic model with which to meet need **Caring:** We recognize that caseload management is a qualitative as well as a quantitative objective. Contact time needs to be incorporated into our calculations and considerations as part of the CNO's recent initiative. **Responsive:** We need to ensure that we can meet our standard across 52 weeks, and within constraints across 7 days. **Well Led:** The Trust expects to implement new IT tools to make caseload management more visible as part of our active management of performance
Delivery of operational performance standards Including contractual and national targets and standards.	**Achievements in 2014/15** The Trust has performed well on national targets in 2014/15. Towards the end of 2013/14, we identified key areas of improvement for the year, and have made considerable progress in the following areas: • Never Events: 0 Never Events this year. We have learned from the Never Events in 2013/14 and reviewed the processes we have in place. We are keeping awareness raised in surgical specialties in particular and have commenced work to review controls of <u>all</u> appropriate Never Events. • Mixed sex accommodation: Significant reduction in breaches in Q2 and Q3 of 2014/15 and zero breaches in Q4 • Infection Control – consistent reduction year on year of reported cases of C Diff – for 2014/15, 27 actual cases versus nationally set trajectory of 37 • Mortality rates consistently lower than our peers • Met the cancer, cardiac, diagnostic and elective waiting times standards We continue to meet all cancer targets, and our MRSA screening and VTE assessments rates are consistently compliant

	(97.0% and 97.4% respectively). **Areas of deviation** • Patients admitted to Acute Stroke Unit within 4 hours –79.5% YTD against 90% target • Patients waiting >52 weeks • Emergency care 4hr waits – our performance in 14/15 sees us with a final 2014-15 position of 92.52% • Serious Incidents • Some specialties underperforming against elements of the 18 week RTT trajectories • Diagnostic waits of 6 weeks **Key areas of improvement for 2015/16:** • Consistently meet waiting time targets: 18 week RTT, cancer waiting times and six week wait for first OPD • Double safe discharges each morning and reduce DTOCs • Reduce DNA rates, cancelled clinics/operations • Cut sickness absence below 3.5% with a focus on reducing days lost to short term sickness • All first outpatient appointments within 6 weeks
Workforce plans Including proposed changes, quality impact, staff engagement and support.	Our long term workforce model requires us to significantly change the shape of our workforce, employing fewer staff in 2020 than our current establishment of around 7,000 in 2015. A modelled figure of 1,087 fewer WTEs from 2015/16 is the estimate arising from a pay-bill reduction of £86m by March 2020. In 2015/16 we will reduce our pay costs by £16.1m through the delivery of our workforce change programme Safe and Sound phase 2. This will include a 205 WTE workforce reduction through schemes designed to reduce WTEs and schemes aimed at reducing the cost per WTE, including: • Improving productivity in the medical secretary group through new working practices 1:2 medical secretary to consultant ratio and skill mix changes and further WTE reductions driven by the introduction of speech recognition • Reducing circa 22 band 5 nursing posts due to planned bed reductions • Assistant grades: using more band 4 assistant practitioners in place of band 5 registered nurses and AHPs in

	outpatients, imaging and rehabilitation services • Advanced practitioner roles: using APs in place of middle grade doctors for tasks typically undertaken by doctors and out of hours cover • Re-configuration of administrative services and further skill mix revision in facilities and estates functions Our plans for staff engagement include continuing to build upon our local real time staff feedback survey 'Your Voice' by improving team participation rates, the percentage of the team who report that they are aware of the results of their local survey and those that report that they are aware of changes that are made as a result of staff feedback. We are now twelve months into our Top Leadership development programme and from April 2015 we commenced the roll out of our new approach employee appraisal and talent management system for all employees.
Financial and investment strategy To include: One year financial plan, financial sustainability, cost improvement programme, QIPP/BCF, capital and key risks and risk mitigation.	The finance & investment plan for 2015/16 is consistent with the Trust's medium term plan and which underpins the proposed investment in new hospital facilities and the further development of SWBH as an integrated care organisation. Headline financial metrics for 2015.16 include a modest in year surplus and continuity of service risk level 3 rating consistent with on-going financial sustainability. Activity and income expectations are aligned to the Trust's medium term plan and trajectory to service models underpinning a new hospital in 2018. These expectations are underpinned by commissioner commitments made through the RCRH partnership. Contracts for 2015.16 have moved significantly to a PbR based arrangement supplemented by local pricing where appropriate. There is no transitional financial support and which marks an acceleration of the intended move to a more standard contract infrastructure. The plan for elective and community services is reliant on repatriation of work and effective management of the distribution of services subject to the Better Care Fund and in particular those where there is prospective market testing by CCGs. For 2015.16 income from repatriation is planned at £3m and is underpinned by a granular market share analysis. CQUIN income is assumed at £9m for 2015.16. The specific schemes are well defined and delivery plans are in place. The trust expects significant scrutiny from commissioners in respect of that delivery at risk of not securing the planned level of income. The trust has adopted the Enhanced Tariff Option model for contract pricing. The consequent marginal rate of 70% payment on specialised services represents a financial risk particularly in respect of pas through costs and the trust has been candid with NHSE that it will manage demand as appropriate to mitigate any substantial risk. BCF plans in respect of non-elective admissions are considered to be aspirational with minimal meaningful impact in 2015/16. There are no specific QIPP proposals from commissioners although they have expressed an intent to manage demand consistent with their BCF aspirations. Both are expected to be managed within trust plan volumes and income. Key hospital service configuration changes anticipated in 2015/16 are in respect of acute cardiology and acute surgical

	assessment. These are the subject of on-going public engagement and are financially neutral at worst. Potential proposed changes in respect of stroke services remain to be finalised by commissioners. It is likely that any changes would require additional resources to meet prospective service standards. Capital expenditure totals £20m for 2015.16 and is focussed on key strategic objectives related to EPR/IM&T infrastructure development and retained estate transformation in line with medium term plans. Routine statutory maintenance and equipment replacement is also provided for. Internally generated resources provide the source of capital funding with the exception of a first tranche of PDC funding in respect of the proposed new hospital development in line with the approved OBC. It is anticipated that c£2m of CRL cover shall be required to be carried forward from 2014/15. This reflects a revised scheduling of capital developments. Risk comes from the scale and pace of necessary EPR/IM&T development. Significant cost reduction is necessary to deliver national efficiency gains and to support service change and investment consistent with medium term plans. The overall scale of cost reduction at £21m is consistent with medium term plans and which provides a modest stretch on national efficiency requirements. This cost reduction necessarily focuses on workforce and pay bill reduction. The Trust has concluded an initial workforce change consultation and a second process has recently commenced. Delivery of that workforce and pay reduction in a manner consistent with sustaining safe services represents a key challenge and risk. This is in particular having regard to recent system pressures and emergent conclusions of a CQC inspection. CIP delivery in 2015.16 will see an enhanced focussed on non-pay constraint and reduction. This will be underpinned by work to secure excellence in the operation of underlying transaction processes and systems. Mitigation and contingency is provided by way of specific discretionary development and general risk reserves and an expected upside on inflation assumptions. A downside risk and mitigation assessment has been undertaken as part of the ABC submission. The plan builds on 2014/15 which was necessarily a period of significant adjustment to accelerate cost reduction and workforce change capability and with consequent reliance on substantial non-recurrent measures to deliver financial plans. Building effective change capability across the organisation represents a key risk and which is planned to be mitigated by continuation of a formal leadership development programme with specialist support and effective early recruitment to key senior managerial vacancies. The finance team is undergoing a fundamental change such that there is enhanced support and influence to front line business.
Longer term financial sustainability, income, costs, activity, capital and risk mitigation.	The trust delivered a financial result in 2014.15 ahead of plan. The medium term plan is represented by the LTFM underpinning the ABC for new hospital development. That 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. The plan identifies that capital investment necessary and sufficient to enabling and supporting infrastructure and in particular informatics including EPR, retained community estate and medical equipment replacement. Fixed imaging equipment is proposed to be delivered through a Managed Service Contract. A robust assessment of the downside case, including sensitivity with stretched and accelerated risk, has been undertaken. It is the trust's contention that there are credible if challenging mitigations consistent with financial sustainability. The detail of this downside assessment is represented in the ABC.
Plans to improve efficiency and productivity through the more effective use of information and technology.	The Trust has a portfolio of projects planned for 2015/16 which improve productivity and efficiency. These include a range of projects to support the Trusts Year of Outpatients Programme including internal eReferrals Management, eOutcomes, eDTA, Self-Check In Kiosks, partial booking, internal development's to support the patient quality and CQuins agenda, enhancements to the Trusts eBed Management and Clinical data Archive solution, new PACS/VNA solution and Speech Recognition.
Organisational relationships and capability To include: Patient and public engagement, relationships with stakeholders and leadership development.	**Organisational Relationships** Sandwell & West Birmingham Hospitals NHS Trust is committed to the population it serves and recognises its role as a key contributor to the local economy. The Board members are active in developing and continuing relationships with local stakeholders in the commercial, health and social care, housing, education, justice, community and faith sectors. Our Non-executive directors are from a range of professional backgrounds including education, primary care and industry,

	and they each have dedicated links with stakeholders that they manage closely on a formal and informal basis. The Trust is an integral part of the Right Care Right Here partnership that is driving local healthcare service transformation, delivering care closer to people's homes and preparing for the new Midland Met Hospital in Smethwick. We have positive relationships with Sandwell & West Birmingham Clinical Commissioning Group at all levels of both organisations. Evidence of our mutually beneficial relationship can be seen through our shared approach to tackling extreme demand pressures during winter 2014/2015. 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. As a provider of community services in Sandwell, the Trust has strong links with local service providers. We have a dedicated relationship manager for the GP community, engaging regularly with primary care clinicians through meetings, events and bulletins. 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. We engage with the scrutiny committees in our service plans and developments as well as having close links with both Healthwatch organisations, a member of which has a place at the public Trust Board meetings. The Trust has a developing volunteering base through the Royal Voluntary Service and is looking to re-energise it's volunteering programme for 2015/16, allowing opportunities for members of the public to contribute to the work of the Trust in a variety of different ways. In 2014 the Trustees of the SWBH Charity set a new strategic direction for the charity and engaged with our workforce to bid for funding for innovative projects that improved the health and wellbeing of our population. One of our strategic priorities was to fund schemes that supported the local community and we will in 2015 begin implementing some large and small schemes to that end. These include a partnership with a local Women's Aid to support domestic abuse victims in our Emergency Departments and a TB screening service for homeless people. We have over 8000 members who engage with the Trust in a number of ways, including a monthly events programme, patient / public involvement groups, and engagement with the Midland Met new hospital development programme. During 2014 we have worked with members to identify people who may be interested in being part of a shadow board of governors and are looking to establish that group robustly in 2015. 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. During 2015/2016 we will: • Increase number and diversity of the Trust membership, developing opportunities to engage and get involved, as well as benefits of membership

- Work with partners to renew the Right Care Right Here partnership enabling us to work jointly towards our vision to be renowned as the best integrated care organisation
- Ensure regular communication to the public and stakeholders about progress in developing the Midland Met Hospital in Smethwick.
- Undertake public engagement activity around proposed changes to urgent and emergency cardiology services and emergency trauma assessment
- Carry out listening events for potential service developments at Rowley Regis Hospital to further develop the facility into a vibrant health care hub for primary and secondary care services
- Develop the Shadow Board of Governors to prepare the organisation for Foundation Trust status as well as providing some valuable opportunity for meaningful engagement and accountability with patient representatives
- Increase public and patient involvement in clinical trials
- Continue delivering community projects in partnership with local groups through our charitable funds
- Develop our corporate engagement offer to businesses, enabling them to support the SWBH Charitable Funds as their chosen charity
- Initiate our stakeholder tracking survey to gain a baseline measure of reputation
- Establish a SWBH volunteering programme to engage a wide range of patients, the public and members in the work of the Trust
- Continue to develop our apprenticeship programme helping people get the training and experience they need to get jobs. During the year we are working in partnership with St Basils to offer our specially refurbished hospital accommodation to apprentices with no fixed abode.
- Support both Healthwatch organisations in their activities, enabling access to information and visits to Trust services. We will continue to work in collaboration with them where there are recommendations to improve patient care.

Patient engagement

SWBH is committed to ensuring that patients in our care receive the best experience we can provide. To do this we need to be sure we actively involve our patients in their care and listen and learn from the feedback they give us. We do this in a variety of ways but essential to this is having staff who genuinely care about the service they deliver and truly place the patient at the heart of all they do.

We make sure we are measuring and improving the quality of the services we provides to patients, the key aim being to ask, monitor and act upon patient feedback ensuring that we make sustainable service improvements in the areas that the patients say matter to them the most. We continue to gather feedback on our services through national Friends and Family Test (FFT) using IT solutions that patients can use easily. Currently we obtain feedback from Inpatients, Out Patient

	Departments, Maternity Services and Emergency Departments, with more than 20,000 surveys completed each year. Further plans are to rollout the FFT to all departments in 2015. The current tools used to collect data are, iPad, SMS messaging, paper surveys and tokens. Plans for 2015 include introduction of an app for smartphones, this will prove an added alternative advantage to obtain patient feedback. A pilot for improved visiting times commenced 1st January 2015. The visiting policy will be reviewed in June 2015 following the pilot and be responsive to patient and staff feedback. There will be a continued patient 'voice' at Trust Board through the 'Hear all about it ' programme. Each month a patient and/or their carer attend the board to share their experience of our care by telling their 'story'. This will be expanded to other key decision making committees deeper inside the Trust during the forthcoming year. At SWBH we recognise that the relationship between leadership capability, culture and performance is demonstrated in the evidence of highly performing organisations. The mark of good leadership is felt at every level and by every patient. SWBH will be investing in developing outstanding leadership within our workforce, leaders who will be given an opportunity to create a climate of innovation, leaders who can flourish in order to improve people's health and their experiences of the NHS. We aim to do this by encouraging staff to attend: • 'Putting Patient First' Workshops: The Patient Journey • Patient Experience Conference during 2015-16 • Patient Experience campaigns: #Any Questions? **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. The Leadership Development portfolio is being further enhanced by the introduction of 1-1 and group coaching for individuals and teams and MBTI preference type. The introduction of these development programmes will (we believe) significantly improve our leadership development support at all levels of the organisation.

Development priorities and actions that the Trust is taking to meet its development needs.	**Development Priority 1** Description: The Trust continues to develop its learning model. This development need is reflected in our answers to two year plan queries from the NTDA in relation, notably, but not exclusively, to quality and safety. We are confident of our own local learning but want to implement a whole Trust model. Extensive discussions over twelve months and work to look at other NHS organisations have identified few role models operating with this consistently in place. Latest state: We have an agreed plan for learning, grounded in our Quality Improvement half days. During 2015-16 we need to test the effectiveness of our work ensure learning happens horizontally and vertically in our Trust, from the good work done as well as from error. **Development Priority 2** Description: The Trust delivers elective wait times through heroic effort and considerable validation. We have the key components of a change plan to automate our work and transfer planned care management onto a firmer footing. This will require dedicated effort in coming months as we look to maintain performance but succeed in delivering real change. Intent: • By end of Q1 2-15-16 • Removal of validation expenditure in excess of £0.5m • Wait times consistently <6 weeks Specialty level compliance with 18 week standard **Development Priority 3** Description: We will deploy Ten Out Of Ten through our wards over the coming two quarters. This demands multi-professional working. But also local leadership to challenge delays or silos. As we change our ward structures and staffing this will be enabled. Intent: Consistent delivery in most wards during Q1 2015-16. **Development Priority 4** Description: Elimination of Delayed Transfers of Care from our inpatient beds and the provision of safe care for those people in the right environment: Currently nearly 10% of our medical base contains patients officially classified as having social or health care needs.

	Current state: The Trust has to see improvement in Q1 and Q2. The Trust will not reach its financial control total in 2015-16 without either a supply subsidy or achievement of this goal.

Sandwell and West Birmingham Hospitals NHS Trust

Financial Plan 2015/16: Appendices

Sandwell & West Birmingham Hospitals NHS Trust

Appendix 1 Main Financial Statements

Sandwell and West Birmingham Hospitals NHS Trust

Appendix 1A

Key Data Item	2014/15 Full Year FOT (mc 01) £000s	2015/16 Full Year Plan (mc 02) £000s
Continuity of Services Risk Ratings		
Liquidity Ratio (days)	3	2
Capital Servicing Capacity (times)	3	4
Overall Continuity of Services Risk Rating	3	3
Key Metric P7 - Continuity of Services Risk Rating	**GREEN**	**GREEN**

Sandwell & West Birmingham Hospitals NHS Trust

SUMMARY INCOME & EXPENDITURE 2015/16

Outturn 2014/15 £000's	TDA Plan 2015/16 £000's	TRUST	TDA Plan WTE	TDA Plan £000's	April 2015 £000's	May 2015 £000's	June 2015 £000's	July 2015 £000's	August 2015 £000's	September 2015 £000's	October 2015 £000's	November 2015 £000's	December 2015 £000's	January 2016 £000's	February 2016 £000's	March 2016 £000's
		INCOME														
403,189	400,356	Total Patient Related Income		400,356	33,647	33,642	33,642	33,642	33,642	33,163	33,163	33,163	33,163	33,163	33,163	33,163
43,401	34,752	Other Income		34,752	2,896	2,896	2,896	2,896	2,896	2,896	2,896	2,896	2,896	2,896	2,896	2,896
446,590	**435,108**	**TOTAL INCOME**		**435,108**	**36,543**	**36,538**	**36,538**	**36,538**	**36,538**	**36,059**	**36,059**	**36,059**	**36,059**	**36,059**	**36,059**	**36,059**
		EXPENDITURE														
(292,253)	(283,270)	Total Pay Costs	6,757	(283,270)	(24,576)	(24,576)	(24,576)	(24,084)	(24,084)	(23,686)	(23,194)	(23,194)	(23,194)	(22,702)	(22,702)	(22,702)
(128,952)	(125,537)	Total Non-Pay Costs		(125,537)	(10,035)	(10,029)	(10,029)	(10,433)	(10,433)	(10,343)	(10,746)	(10,746)	(10,746)	(10,699)	(10,649)	(10,649)
		Total Reserves		0												
(421,205)	**(408,807)**	**TOTAL EXPENDITURE**	**6,757**	**(408,807)**	**(34,611)**	**(34,605)**	**(34,605)**	**(34,517)**	**(34,517)**	**(34,029)**	**(33,940)**	**(33,940)**	**(33,940)**	**(33,401)**	**(33,351)**	**(33,351)**
25,385	**26,301**	**EBITDA**		**26,301**	**1,932**	**1,933**	**1,933**	**2,021**	**2,021**	**2,030**	**2,119**	**2,119**	**2,119**	**2,658**	**2,708**	**2,708**
		P&L on Disposal of Fixed Assets														
(13,362)	(14,880)	Depreciation		(14,880)	(1,240)	(1,240)	(1,240)	(1,240)	(1,240)	(1,240)	(1,240)	(1,240)	(1,240)	(1,240)	(1,240)	(1,240)
		Impairment of Fixed Assets														
(5,326)	(5,976)	PDC Dividend		(5,976)	(498)	(498)	(498)	(498)	(498)	(498)	(498)	(498)	(498)	(498)	(498)	(498)
(2,112)	(2,016)	Interest Recievable / Payable and Other Finance		(2,016)	(168)	(168)	(168)	(168)	(168)	(168)	(168)	(168)	(168)	(168)	(168)	(168)
4,585	**3,429**	**SURPLUS/(DEFICIT)**		**3,429**	**26**	**27**	**27**	**115**	**115**	**124**	**213**	**213**	**213**	**752**	**802**	**802**
68	(72)	IFRIC12/Impairment/Donated Asset Related Adjustments/Gains on Absorption		(72)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)
4,653	**3,357**	**SURPLUS/(DEFICIT) FOR DH TARGET**		**3,357**	**20**	**21**	**21**	**109**	**109**	**118**	**207**	**207**	**207**	**746**	**796**	**796**
5.7%	**6.0%**	**EBITDA Margin %**		**6.0%**	**5.3%**	**5.3%**	**5.3%**	**5.5%**	**5.5%**	**5.6%**	**5.9%**	**5.9%**	**5.9%**	**7.4%**	**7.5%**	**7.5%**
1.0%	**0.8%**	**Surplus Margin %**		**0.8%**	**0.1%**	**0.1%**	**0.1%**	**0.3%**	**0.3%**	**0.3%**	**0.6%**	**0.6%**	**0.6%**	**2.1%**	**2.2%**	**2.2%**
20,604	***20,992***	***MEMO: COST IMPROVEMENT PROGRAMME***		***20,992***	***700***	***699***	***699***	***1,401***	***1,401***	***1,401***	***2,099***	***2,099***	***2,099***	***2,798***	***2,798***	***2,798***

Sandwell & West Birmingham Hospitals NHS Trust

SUMMARY BALANCE SHEET 2015/16

Outturn End 2014/15 £000's	TDA Plan End 2015/16 £000's	BALANCE SHEET	April 2015 1 £000's	May 2015 2 £000's	June 2015 3 £000's	July 2015 4 £000's	August 2015 5 £000's	September 2015 6 £000's	October 2015 7 £000's	November 2015 8 £000's	December 2015 9 £000's	January 2016 10 £000's	February 2016 11 £000's	March 2016 12 £000's
		NON-CURRENT ASSETS												
233,309	243,034	Property, Plant and Equipment	234,429	234,874	235,318	235,763	236,207	236,651	237,096	237,540	237,984	238,429	238,873	243,034
677		Intangible Assets												
890	890	Trade and Other Receivables	890	890	890	890	890	890	890	890	890	890	890	890
234,876	**243,924**	**TOTAL NON-CURRENT ASSETS**	**235,319**	**235,764**	**236,208**	**236,653**	**237,097**	**237,541**	**237,986**	**238,430**	**238,874**	**239,319**	**239,763**	**243,924**
		CURRENT ASSETS												
3,467	3,217	Inventories	3,467	3,467	3,467	3,467	3,467	3,467	3,467	3,467	3,467	3,467	3,467	3,217
16,318	13,937	Trade and Other Receivables	16,064	14,187	14,187	14,187	14,187	14,187	14,187	14,187	14,187	14,187	14,187	13,937
28,382	28,705	Cash and Cash Equivalents	28,848	28,849	29,184	29,460	29,762	26,569	26,780	26,995	27,215	27,437	27,868	28,705
48,167	**45,859**	**TOTAL CURRENT ASSETS**	**48,378**	**46,503**	**46,838**	**47,114**	**47,416**	**44,223**	**44,434**	**44,649**	**44,869**	**45,091**	**45,522**	**45,859**
283,043	**289,783**	**TOTAL ASSETS**	**283,698**	**282,267**	**283,046**	**283,766**	**284,513**	**281,764**	**282,420**	**283,079**	**283,743**	**284,410**	**285,285**	**289,783**
		CURRENT LIABILITIES												
(45,951)	(47,557)	Trade and Other Payables	(46,450)	(44,769)	(45,266)	(45,756)	(46,248)	(43,747)	(44,240)	(44,735)	(45,235)	(45,736)	(46,443)	(47,557)
(4,502)	(4,502)	Provisions	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)	(4,502)
(1,017)	(1,306)	Borrowings	(1,306)	(1,306)	(1,306)	(1,306)	(1,306)	(1,306)	(1,306)	(1,306)	(1,306)	(1,306)	(1,306)	(1,306)
(1,000)	0	DH Capital Loan	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(500)	(500)	(500)	(500)	(500)	(500)	0
(52,470)	**(53,365)**	**TOTAL CURRENT LIABILITIES**	**(53,258)**	**(51,577)**	**(52,074)**	**(52,564)**	**(53,056)**	**(50,055)**	**(50,548)**	**(51,043)**	**(51,543)**	**(52,044)**	**(52,751)**	**(53,365)**
(4,303)	**(7,506)**	**NET CURRENT ASSETS (LIABILITIES)**	**(4,880)**	**(5,074)**	**(5,236)**	**(5,450)**	**(5,640)**	**(5,832)**	**(6,114)**	**(6,394)**	**(6,674)**	**(6,953)**	**(7,229)**	**(7,506)**
		NON-CURRENT LIABILITIES												
(2,986)	(2,986)	Provisions	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)	(2,986)
(26,898)	(25,592)	Borrowings	(26,523)	(26,439)	(26,354)	(26,269)	(26,185)	(26,100)	(26,015)	(25,931)	(25,846)	(25,761)	(25,677)	(25,592)
0		DH Capital Loan												
(29,884)	**(28,578)**	**TOTAL NON-CURRENT LIABILITIES**	**(29,509)**	**(29,424)**	**(29,340)**	**(29,255)**	**(29,171)**	**(29,086)**	**(29,001)**	**(28,917)**	**(28,832)**	**(28,747)**	**(28,663)**	**(28,578)**
200,689	**207,840**	**TOTAL ASSETS EMPLOYED**	**200,931**	**201,266**	**201,632**	**201,948**	**202,286**	**202,623**	**202,871**	**203,119**	**203,368**	**203,619**	**203,871**	**207,840**
		TAXPAYERS' EQUITY												
162,210	162,210	Public Dividend Capital	162,210	162,210	162,210	162,210	162,210	162,210	162,210	162,210	162,210	162,210	162,210	162,210
(13,758)	(11,737)	Retained Earnings reserve	(14,928)	(14,594)	(14,228)	(13,911)	(13,573)	(13,236)	(12,988)	(12,740)	(12,491)	(12,240)	(11,988)	(11,737)
43,179	48,309	Revaluation Reserve	44,591	44,591	44,591	44,591	44,591	44,591	44,591	44,591	44,591	44,591	44,591	48,309
9,058	9,058	Other Reserves	9,058	9,058	9,058	9,058	9,058	9,058	9,058	9,058	9,058	9,058	9,058	9,058
200,689	**207,840**	**TOTAL TAXPAYERS' EQUITY**	**200,931**	**201,266**	**201,632**	**201,948**	**202,286**	**202,623**	**202,871**	**203,119**	**203,368**	**203,619**	**203,871**	**207,840**

Sandwell & West Birmingham Hospitals NHS Trust

SUMMARY CASH FLOW 2015/16

Outturn 2014/15 £000's	TDA Plan 2015/16 £000's	CASH FLOW	ANNUAL 2015/16 £000's	April 2015 M01 £000's	May 2015 M02 £000's	June 2015 M03 £000's	July 2015 M04 £000's	August 2015 M05 £000's	September 2015 M06 £000's	October 2015 M07 £000's	November 2015 M08 £000's	December 2015 M09 £000's	January 2016 M10 £000's	February 2016 M11 £000's	March 2016 M12 £000's
41,808	**28,382**	**CASH BROUGHT FORWARD**	**28,382**	**28,382**	**28,848**	**28,849**	**29,184**	**29,460**	**29,762**	**26,569**	**26,780**	**26,995**	**27,215**	**27,437**	**27,868**
		CASH FLOWS FROM OPERATING ACTIVITIES													
12,022	11,528	Operating Surplus/(Deficit)	11,528	918	1,009	1,042	992	1,012	1,008	923	923	924	926	927	924
13,363	14,880	Depreciation and Amortisation	14,880	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240
(263)	0	Impairments and Reversals	0	0	0	0	0	0	0	0	0	0	0	0	0
(51)	(72)	Donated Assets received credited to revenue but non-cash	(72)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)
(2,221)	(2,184)	Interest Paid	(2,184)	(182)	(182)	(182)	(182)	(182)	(182)	(182)	(182)	(182)	(182)	(182)	(182)
(5,170)	(5,994)	Dividend (Paid)/Refunded	(5,994)						(2,997)						(2,997)
(195)	250	(Increase)/Decrease in Inventories	250												250
1,201	2,380	(Increase)/Decrease in Trade and Other Receivables	2,380	253	1,877										250
0	0	(Increase)/Decrease in Other Current Assets	0												
(11,193)	1,607	Increase/(Decrease) in Trade and Other Payables	1,607	(1)	(2,181)	(3)	(12)	(6)		(8)	(4)			208	3,614
(3,331)	0	Provisions Utilised	0												0
185	0	Increase/(Decrease) in non Cash Provisions	0												
4,347	**22,395**	**TOTAL OPERATING ACTIVITIES**	**22,395**	**2,222**	**1,757**	**2,091**	**2,032**	**2,058**	**(937)**	**1,967**	**1,971**	**1,976**	**1,978**	**2,187**	**3,093**
		CASH FLOWS FROM INVESTING ACTIVITIES													
109	84	Interest Received	84	7	7	7	7	7	7	7	7	7	7	7	7
(15,388)	(20,136)	(Payments) for Property, Plant and Equipment	(20,136)	(1,678)	(1,678)	(1,678)	(1,678)	(1,678)	(1,678)	(1,678)	(1,678)	(1,678)	(1,678)	(1,678)	(1,678)
0	0	(Payments) for Intangible Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
(15,279)	**(20,052)**	**TOTAL INVESTING ACTIVITIES**	**(20,052)**	**(1,671)**	**(1,671)**	**(1,671)**	**(1,671)**	**(1,671)**	**(1,671)**	**(1,671)**	**(1,671)**	**(1,671)**	**(1,671)**	**(1,671)**	**(1,671)**
(10,932)	**2,343**	**NET CASH FLOW BEFORE FINANCING**	**2,343**	**551**	**86**	**420**	**361**	**387**	**(2,608)**	**296**	**300**	**305**	**307**	**516**	**1,422**
		CASH FLOWS FROM FINANCING ACTIVITIES													
570	0	New Public Dividend Capital received in year: PDC Capital	0												
0	0	New Public Dividend Capital received in year: PDC Revenue	0												
(2,000)	(1,000)	Loans repaid to DH - Capital Investment Loans Repayment of Principal	(1,000)						(500)						(500)
(1,064)	(1,020)	Capital element of payments relating to PFI, LIFT Schemes and finance leases	(1,020)	(85)	(85)	(85)	(85)	(85)	(85)	(85)	(85)	(85)	(85)	(85)	(85)
0	0	Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	0												
(2,494)	**(2,020)**	**TOTAL FINANCING ACTIVITIES**	**(2,020)**	**(85)**	**(85)**	**(85)**	**(85)**	**(85)**	**(585)**	**(85)**	**(85)**	**(85)**	**(85)**	**(85)**	**(585)**
(13,426)	**323**	**NET INCREASE (DECREASE) IN CASH IN PERIOD**	**323**	**466**	**1**	**335**	**276**	**302**	**(3,193)**	**211**	**215**	**220**	**222**	**431**	**837**
28,382	**28,705**	**CASH AT END OF PERIOD**	**28,705**	**28,848**	**28,849**	**29,184**	**29,460**	**29,762**	**26,569**	**26,780**	**26,995**	**27,215**	**27,437**	**27,868**	**28,705**

Sandwell & West Birmingham Hospitals NHS Trust

SUMMARY CAPITAL PROGRAMME 2015/16

CAPITAL PROGRAMME	ANNUAL 2015/16 £000's	April 2015 £000's	May 2015 £000's	June 2015 £000's	July 2015 £000's	August 2015 £000's	September 2015 £000's	October 2015 £000's	November 2015 £000's	December 2015 £000's	January 2016 £000's	February 2016 £000's	March 2016 £000's
CAPITAL FINANCING													
Depreciation	14,880	1,120	1,127	1,129	1,041	1,041	1,360	1,353	1,351	1,439	1,439	1,240	1,240
I & E Surplus - current year surplus attributed to financing of capital expenditure	3,357	20	21	21	109	109	118	207	207	207	746	796	796
Unspent cash from previous financial years	2,695						526	578	580	511	89	206	206
Proceeds from Disposals													
Grants & Donations	76	10	6	6	6	6	6	6	6	6	6	6	6
PDC	0												
Less: Loan repayments	(1,000)						(1,000)						
TOTAL CAPITAL FINANCING	**20,008**	**1,150**	**1,154**	**1,156**	**1,156**	**1,156**	**1,010**	**2,144**	**2,144**	**2,163**	**2,280**	**2,248**	**2,248**
CAPITAL PROGRAMME													
Slippage and retentions	800	600	100	100									
Land and remediation	1,600	87	89	89	89	89	89	178	178	178	178	178	178
Statutory Standards	1,500	83	83	83	83	83	83	167	167	167	167	167	167
Retained Estate Refurbishment	3,287	182	183	183	183	183	183	365	365	365	365	365	365
Other Estate Related	780	43	43	43	43	43	43	87	87	87	87	87	87
CQC improvement plan	750	125	125	125	125	125	125						
Medical Equipment	2,250	125	125	125	125	125	125	250	250	250	250	250	250
IM&T	5,096	281	281	283	283	283	283	567	567	567	567	567	567
MMH Project costs capitalised	2,169	181	181	181	181	181	181	181	181	181	181	181	181
Capitalised Salaries	500	24	28	28	28	28	28	56	56	56	56	56	56
Contingency	1,200							200	200	200	200	200	200
Donated assets	76	10	6	6	6	6	6	6	6	6	6	6	6
TOTAL CAPITAL PROGRAMME	**20,008**	**1,741**	**1,245**	**1,247**	**1,147**	**1,147**	**1,147**	**2,056**	**2,056**	**2,056**	**2,056**	**2,056**	**2,056**
CAPITAL SOURCES LESS PROGRAMME	**0**	**(591)**	**(91)**	**(91)**	**9**	**9**	**(137)**	**88**	**87**	**106**	**224**	**191**	**191**
Cumulative expenditure		9%	15%	21%	27%	33%	38%	49%	59%	69%	79%	90%	100%

Sandwell & West Birmingham Hospitals NHS Trust

Appendix 2 Income and Expenditure by Group

Appendix 2A

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST
Current Group Control Totals

		REVISED TARGETS			
	Pay	Pay	Non Pay	Income	Net
	£000's	£000's	£000's	£000's	£000's
CLINICAL GROUPS					
Medicine & Emergency Care	1,539.09	-71,061	-31,452	408	**-102,105**
Surgery A	988.59	-45,835	-11,057	718	**-56,174**
Women's & Child Health	895.14	-36,484	-9,534	563	**-45,455**
Surgery B	367.36	-16,392	-9,756	1,455	**-24,693**
Community & Therapies	662.60	-21,888	-6,041	1,056	**-26,872**
Pathology	313.75	-11,623	-6,968	4,318	**-14,273**
Imaging	289.37	-12,321	-4,376	2,433	**-14,264**
CLINICAL GROUPS	**5,055.90**	**-215,604**	**-79,184**	**10,951**	**-283,836**
CORPORATE DIRECTORATES					
Chief Executive	117.34	-5,217	-1,363	924	**-5,657**
Finance	99.26	-3,010	-1,254	88	**-4,176**
Medical Director	161.81	-6,104	-2,018	2,091	**-6,031**
Operations	372.52	-12,186	-2,633	1,698	**-13,122**
Workforce	95.30	-2,926	-239	1,180	**-1,985**
Estates & New Hospital Project	92.77	-2,973	-10,941	480	**-13,434**
Corporate Nursing & Facilities	824.99	-20,591	-6,747	5,571	**-21,766**
CORPORATE DIRECTORATES	**1,763.99**	**-53,007**	**-25,196**	**12,031**	**-66,172**
GROUPS AND DIRECTORATES	**6,819.89**	**-268,611**	**-104,380**	**22,983**	**-350,008**
CENTRAL excl reserves					
Central excl reserves	0.00	-100	-9,690	1,326	**-8,464**
Trust wide SLA income				396,522	**396,522**
Other central income				18,351	**18,351**
Financing			-22,965		**-22,965**
CENTRAL excl reserves	**0.00**	**-100**	**-32,655**	**416,199**	**383,444**
RESERVES					
SLA income				-4,075	**-4,075**
RCRH / IAP			-4,500		**-4,500**
Pay inflation	0.00	-8,000			**-8,000**
Non-Pay inflation			-1,500		**-1,500**
Resilience	0.00	-1,988	-204	0	**-2,192**
Savings targets	0.00	0	0		**0**
Developments	0.00	0	-3,354		**-3,354**
Contingency	0.00	-4,500	-1,500		**-6,000**
Other			0		**0**
Other		-71	-316	1	**-384**
RESERVES	**0.00**	**-14,559**	**-11,374**	**-4,074**	**-30,005**
TRUST TOTAL	**6,819.89**	**-283,270**	**-148,409**	**435,108**	**3,431**

Sandwell & West Birmingham Hospitals NHS Trust

Appendix 3 SLA Income

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST
BUDGET BOOKLET 2015/2016

Appendix 3A

TABLE: INCOME BY COMMISSIONER

Commissioning Body	2014/2015 OUTTURN £000's	2015/2016 CONTRACT £000's	Movement £000's	MAIN MOVEMENTS
NHS SANDWELL AND WEST BIRMINGHAM CCG	257,320	258,618	1,298	Repatriation of activity from specialised contract and other Trusts, plus growth, offset in part by removal of transitional finance
NHS BIRMINGHAM CROSSCITY CCG	43,587	44,060	474	
WEST MIDLANDS SPECIALISED COMMISSIONING GROUP	39,158	36,901	-2,257	Repatriation of activity from specialised contract to CCGs
BIRMINGHAM AND THE BLACK COUNTRY AREA TEAM	14,431	10,924	-3,507	Transfer of Health Visiting commissioning to Local Authority (Oct-15)
NHS BIRMINGHAM SOUTH AND CENTRAL CCG	13,244	13,051	-192	
NHS WALSALL CCG	5,364	5,486	123	
NHS DUDLEY CCG	4,875	4,886	10	
NHS SOLIHULL CCG	3,063	3,266	203	
NON CONTRACTED ACTIVITY	2,568	2,777	209	
SANDWELL METROPOLITAN BOROUGH COUNCIL	1,926	4,964	3,038	Transfer of Health Visiting commissioning from NHS England (Oct-15)
NHS REDDITCH AND BROMSGROVE CCG	1,638	1,694	57	
NHS SOUTH EAST STAFFS AND SEISDON PENINSULAR CCG	1,602	1,593	-10	
NHS WOLVERHAMPTON CCG	962	956	-6	
NHS SOUTH WORCESTERSHIRE CCG	693	680	-13	
BIRMINGHAM CITY COUNCIL	623	107	-517	14/15 figure includes DTOC invoice, not assumed in 15/16
NHS WYRE FOREST CCG	565	558	-7	
NHS COVENTRY AND RUGBY CCG	442	446	4	
NHS SOUTH WARWICKSHIRE CCG	412	402	-9	
NHS CANNOCK CHASE CCG	392	364	-28	
NHS WARWICKSHIRE NORTH CCG	367	412	45	
CAPE HILL MEDICAL CENTRE	237	237	-0	
NHS SHROPSHIRE CCG	236	233	-3	
NHS TELFORD AND WREKIN CCG	226	259	33	
NHS HEREFORDSHIRE CCG	186	201	15	
NHS STAFFORD AND SURROUNDS CCG	169	149	-20	
NHS EAST STAFFORDSHIRE CCG	161	151	-11	
SMETHWICK MEDICAL CENTRE	157	39	-117	
NHS STOKE ON TRENT CCG	151	139	-11	
ARDEN, HEREFORDSHIRE AND WORCESTERSHIRE AREA TEAM	117	83	-34	
NHS NORTH STAFFORDSHIRE CCG	103	85	-19	
POWYS TEACHING LHB	70	47	-23	
BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	29	29	-0	
TOTAL	**395,072**	**393,798**	**-1,274**	

* Note - 2014.15 out turn values represent final settlements with commissioners and which is net of fines & penalties

ACTIVITY BY POD

POD	2014/2015 Activity Plan	2014/2015 Outturn Activity	2015/2016 Activity Plan	Difference Plan to Plan	Difference Plan to Outturn
Accident and Emergency	220,578	218,725	219,669	-909	944
Acute Renal Dialysis	544	614	556	12	-58
Community	580,955	586,421	582,262	1,307	-4,159
Day Cases	44,783	39,194	41,682	-3,101	2,488
Elective	8,687	8,511	9,108	421	597
Emergency	40,450	40,166	41,491	1,042	1,325
Emergency Same Day	11,936	10,258	13,639	1,704	3,381
Maternity – Antenatal and Postnatal pathways	14,096	17,660	18,896	4,800	1,236
Occupied Cot Days	11,521	11,563	11,517	-4	-46
Other Contract Lines	3,392,744	3,148,921	3,185,152	-207,591	36,231
Outpatient First Attendance	185,996	182,633	180,207	-5,788	-2,426
Outpatient Follow Up	415,805	442,860	446,203	30,398	3,343
Outpatient Procedures	37,650	40,623	49,606	11,956	8,983
UNBUNDLED	62,942	63,111	62,381	-561	-730
Excess Bed Days	21,034	19,651	16,566	-4,469	-3,085

INCOME BY POD

POD	2014/2015 Plan £000's	2014/2015 Outturn £000's	2015/2016 Plan £000's	Difference Plan to Plan £000's	Difference Plan to Outturn £000's
Accident and Emergency	20,353	20,040	21,710	1,358	1,670
Acute Renal Dialysis	68	80	68	0	-12
Community	35,985	35,959	35,194	-790	-765
Day Cases	33,218	33,411	32,364	-853	-1,046
Elective	19,504	19,231	20,745	1,241	1,513
Emergency	79,577	80,279	77,661	-1,916	-2,618
Emergency Same Day	8,230	7,992	9,132	902	1,140
Maternity – Antenatal and Postnatal pathways	14,220	15,310	17,985	3,765	2,675
Occupied Cot Days	6,000	5,941	5,929	-71	-11
Other Contract Lines	94,426	96,792	90,060	-4,366	-6,731
Outpatient First Attendance	26,343	26,258	26,393	49	134
Outpatient Follow Up	33,407	33,502	35,198	1,791	1,696
Outpatient Procedures	7,336	7,109	9,178	1,842	2,069
UNBUNDLED	9,520	9,981	8,556	-964	-1,425
Excess Bed Days	5,313	5,245	3,624	-1,689	-1,621
Grand Total	**393,499**	**397,130**	**393,798**	**298**	**-3,332**

* Note income figures for all years are stated gross of fines & penalties

ACTIVITY BY POD AND GROUP

POD	GROUP									
	Medicine & Emergency Care	**Surgery A**	**Women's & Child Health**	**Surgery B**	**Community & Therapies**	**Pathology**	**Imaging**	**Corporate**	**Central**	**TOTAL**
Accident and Emergency	190,313	0	0	29,356	0	0	0	0	0	219,669
Acute Renal Dialysis	0	556	0	0	0	0	0	0	0	556
Community	5,059	0	24,935	0	537,348	0	0	14,919	0	582,262
Day Cases	15,283	11,680	2,211	12,259	0	118	131	0	0	41,682
Elective	1,517	4,549	1,860	1,157	0	23	2	0	0	9,108
Emergency	19,233	7,278	13,694	1,287	0	0	0	0	0	41,491
Emergency Same Day	9,314	2,882	1,142	300	0	0	0	0	0	13,639
Excess Bed Days	0	0	18,896	0	0	0	0	0	0	18,896
Maternity – Antenatal and Postnatal pathways	0	0	11,517	0	0	0	0	0	0	11,517
Occupied Cot Days	34,482	0	184	10,094	0	3,037,847	97,560	0	4,986	3,185,152
Other Contract Lines	42,181	42,505	12,382	80,907	558	1,627	47	0	0	180,207
Outpatient First Attendance	157,225	60,543	20,076	141,094	5,418	61,819	29	0	0	446,203
Outpatient Follow Up	15,531	12,391	12,253	9,404	0	26	0	0	0	49,606
Outpatient Procedures	36,250	18,430	4,327	3,272	0	101	1	0	0	62,381
UNBUNDLED	11,001	3,816	1,302	447	0	0	0	0	0	16,566

INCOME BY POD AND GROUP

POD	GROUP									
	Medicine & Emergency Care £000's	**Surgery A £000's**	**Women's & Child Health £000's**	**Surgery B £000's**	**Community & Therapies £000's**	**Pathology £000's**	**Imaging £000's**	**Corporate £000's**	**Central £000's**	**TOTAL £000's**
Accident and Emergency	19,672	0	0	2,038	0	0	0	0	0	**21,710**
Acute Renal Dialysis	0	68	0	0	0	0	0	0	0	**68**
Community	359	0	9,400	0	24,187	0	253	995	0	**35,194**
Day Cases	9,546	11,747	1,470	9,406	0	65	132	0	0	**32,364**
Elective	2,310	12,747	4,022	1,650	0	11	5	0	0	**20,745**
Emergency	42,286	15,782	17,527	2,066	0	0	0	0	0	**77,661**
Emergency Same Day	6,542	1,778	643	169	0	0	0	0	0	**9,132**
Excess Bed Days	0	0	17,985	0	0	0	0	0	0	**17,985**
Maternity – Antenatal and Postnatal pathways	0	0	5,929	0	0	0	0	0	0	**5,929**
Occupied Cot Days	29,956	9,203	8,339	8,657	736	8,301	9,156	2,521	13,191	**90,060**
Other Contract Lines	8,997	6,008	2,161	8,872	42	308	3	0	0	**26,393**
Outpatient First Attendance	14,228	4,944	2,558	10,894	275	2,298	1	0	0	**35,198**
Outpatient Follow Up	2,903	3,522	1,612	1,137	0	4	0	0	0	**9,178**
Outpatient Procedures	6,222	1,642	324	359	0	7	0	0	0	**8,556**
UNBUNDLED	2,325	822	370	107	0	0	0	0	0	**3,624**
TOTAL	**145,348**	**68,262**	**72,340**	**45,355**	**25,239**	**10,994**	**9,551**	**3,517**	**13,191**	**393,798**

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST **Appendix 3D**

BUDGET BOOKLET 2015/2016

CQUIN TARGETS: Sandwell & West Birmingham & Associates

Goal Number	Goal Name	Goal Weighting (% of relevant income)	Expected Financial Value of Goal £
1	National 1 - AKI	0.25%	£796,048
2a	National 2 - Sepsis	0.13%	£398,024
2b	National 2 - Sepsis	0.13%	£398,024
3	National 4 - Dementia	0.25%	£796,048
4	National 3 - MH/A&E	0.50%	£1,592,096
5b	Dietetics - Communication	0.13%	£406,452
6	Safeguarding	0.50%	£1,592,096
7	Dementia Moves	0.31%	£987,099
8	Out of Hours Transfers	0.31%	£987,099
		2.50%	**£7,952,987**

CQUIN Scheme: NHSE Specialised Services	Weighting	Indicative Value
OPA follow ups	20%	£117,984
HIV : reducing unnecessary CD4 monitoring	20%	£117,984
Haemoglobinopathy Networks	20%	£117,984
ODX: Eligible breast cancer patients receiving a NICE DG10 compliant	20%	£117,984
HSS Clinical outcome collaborative audit workshop	20%	£117,984
TOTAL	**100%**	**£589,921**

CQUIN Scheme: NHSE Other		Indicative Value
Uptake in breast screening services	27%	£94,310
Uptake in bowel screening services	28%	£96,501
Health Visiting (combined value)	45%	£154,156
TOTAL	100%	**£344,967**

Key contract terms and conditions

Contract	Notes
SWBCCG	Standard tariff payment rules apply Local prices applicable at marginal rates for under/over-performance Fines ceiling £2m Block elements £24m CQUINS cover national (AKI, Sepsis, Dementia, MH/A&E) and local (Dietetics, safeguarding, dementia moves, OOH transfers)
Birmingham Cross City	Standard tariff payment rules apply Local prices applicable at marginal rates for under/over-performance Block elements £1.7m
Birmingham South Central	Standard tariff payment rules apply Local prices applicable at marginal rates for under/over-performance Block elements £0.3m
Other Associates	As above
Specialised Services	Standard tariff payment rules apply Local prices applicable at marginal rates for under/over-performance Fines ceiling £2m Block elements CQUINS cover (OP follow ups, HIV, haemoglobinopathy, Cancer, Behcets)
NHS Public Health	Block Contract comprising screening, HV and CHIS
NHS Dental	Standard tariff payment rules apply Secondary care dental services
Sandwell MBC Public Health	Local tariff principally sexual health (GUM and CaSH). HV from October 2015
Others	NCA, Powys, PMS+GP practices

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework 2015/16**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Executive Group**
DATE OF MEETING:	**7 May 2015**

EXECUTIVE SUMMARY:

Attached is the Board Assurance Framework for 2015/16.

The BAF was initially populated by the Executive Group, who took a view on the major risks to the delivery of the Trust's annual priorities for the year as outlined in the annual plan seen by the Board at the April meeting. The controls in place to manage the risks and the assurances that the controls are working effectively are also included as key elements of the BAF, alongside any action plans to address any gaps in control or weak /absent assurance.

The draft BAF was reviewed by the Board at the April informal session on 17 April and the version attached reflects the points of discussion or amendments suggested.

Work is also underway to better embed the discussions around the BAF into routine meetings across the Trust, including Clinical Leadership Executive, the Board Committees and the Trust Board, a process which will be developed over the coming Quarter.

REPORT RECOMMENDATION:

The Trust Board is asked to review and accept the Board Assurance Framework and note the plans to strengthen the way in which the BAF is used to drive discussions and set agendas within the organisation.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

The BAF is aligned to all strategic objectives and annual priorities.

PREVIOUS CONSIDERATION:

The development of the BAF was informed by discussions at the Board Informal session on 17 April and has been the subject of several discussions by the Executive Group. The BAF was also reviewed by the Audit & Risk Management Committee at its meeting on 30 April 2015.

Sandwell and West Birmingham Hospitals NHS Trust
BOARD ASSURANCE FRAMEWORK 2015/16

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
COO	001 -SHQC	Reducing readmissions **MF**	There is a risk that re-admission rates for the Trust remain significantly in excess of national norms, particularly at Sandwell Hospital, as result of poor coding or failure to deliver pathway changes accessing urgent acute or community assessment and ambulatory care. This not only represents poor care for patients but also carries a significant financial risk where tariff rules are strictly applied.	Q&SC	5	3	15	The readmissions task force has been introduced and implemented targeted specialty specific measures to tackle the root causes of readmissions. Each high volume, high rate specialty has a target absolute reduction of readmission; this is accompanied by a delivery plan. The measures to demonstrate controls are working will be delivery of these trajectories and sustained performance. Targeted specialties are Acute Medicine, Elderly Care medicine, Respiratory medicine, Cardiology, Gastroenterology and General Surgery. Plans to be delivered over Q1 and Q2. Reporting arrangements are in place to Quality & Safety Committee and Trust Board.	Internal: Overall trust readmission rates are reported in the IPR as well as by Clinical Group. The readmissions task force meets monthly and reports by specialty holding each specialty lead accountable for delivery of practice as well as re-admission rate. Quarterly report to Quality & Safety Committee.	3	3	9		The full impact of certain actions from the task force has yet to be realised; significant practice change requires embedding throughout the organisation. Certain IT developments are required to support those behaviours	Q4 15/16	2	3	6
COO	002-SHQC	Improving outpatients by implementing phase 2 of our Year of Outpatients programme	There is a risk that the intended benefits of the projects in Year of Out Patients (YOOP) do not realise their full benefits due to failure to deliver technical infrastructure or change the workforce and organisational delivery model which may lead to long waits, poor patient experience and wasted capacity	Q&SC	3	4	12	YOOP delivery programme in place. Focus is on completion implementation of Self Check In Kiosks, Partial Booking and other developments in line with YOOP programme. This is overseen by a Year of Out Patients programme Board. Reporting into CLE, Q&SC and Trust Board. Control measures through OP dashboard include Patient surveys aiming at 98% satisfaction, no avoidable hospital clinic cancellations, reduce DNA rates by 4%.	Internal: IPR, programme exception report and minutes and action trackers from CLE, Q & SC and Trust Board. Patient satisfaction results. DNA rates. Communications on intended changes and benefits.	3	4	12		Work to strengthen staff and user engagement	Sep-15	2	4	8
CN	003 -SHQC	Achieving the gains promised within our 10/10 programme **MF**	There is a risk that patient safety could be compromised as a result of not delivering fundamental checks and baseline assessments within the first 24 hours after admission to hospital which could lead to poor planning.	Q&SC	3	3	9	An ongoing training programme has been implemented and a monthly KPI dashboard has been introduced to report compliance. A set of smarter KPIs to be introduced from which assurance can be drawn	Internal and peer: Audit of compliance with 10/10	1	3	3		Introduction of a review of KPIs at Clinical Group review meetings	Sep-15	1	3	3

Sandwell and West Birmingham Hospitals NHS Trust
BOARD ASSURANCE FRAMEWORK 2015/16

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DG	004-SHQC	Meeting the improvement requirements agreed with the Care Quality Commission	There is a risk that the scale of the task leads to inconsistent implementation of the required standards and practices across the organisation leading to a statutory breach of the fundamental standards of care,	Q&SC	3	4	12	Clearly defined outcomes set for each action. Planned and spot audits and unannounced visits to validate compliance. Evidence vault. Protected time for discussions at a local level at QIHDs. Monitoring and oversight of delivery by the CLE, QSC and Trust Board.	Internal: Observed practice during walkabouts and First Friday. Audit findings and action plans. Staff and patient feedback e.g. Your Voice, FFT, complaints. Incident data.	2	4	8		Improvement Plan evidence vault to be created and launched (May 2015).	Oct-15	1	4	4
COO	005 -SHQC	Tackling caseload management in community teams MF	There is a risk that a caseload of community nursing teams remains too high and above benchmark as a result of poor management systems, too many patients being admitted to the case load, poor discharge patterns or the absence of team members leading to short appointments or too few appointments to be effective	Q&SC	4	3	12	Workload dependency tool (GEL) has been introduced for monitoring the position. Evaluation of outputs and confirmation of intended service redesign to be undertaken. Arrangements in place to monitor the financial consequences of the priority.	Internal and peer: Results of audit of caseload management and data monitoring from GEL. Group reviews.	2	3	6		Complete the implementation of GEL and staff training across all teams. Development and delivery of service redesign plan to a timescale to be agreed. Control measures to be agreed to track assurance	May-15	2	3	6
COO	006-AR	Meet national waiting time standards and deliver from October a guaranteed maximum six week outpatient wait	There is a risk that speciality compliance of the standards are not met due to failure to implement demand and capacity plans and associated workforce plans which may lead to unforecast underperformance, poor patient experience and financial penalties.	Q&SC	4	4	16	1. Demand and capacity plans are in development 2. A balanced scorecard has been introduced to track delivery in design 3. Job planning to be completed in line with capacity plan. 4. Tracking tool to be introduced. 5. Monitoring arrangements through Group Reviews, OMC, Q&SC and Trust Board.	Internal: IPR scorecard monitoring discussions. The minutes of Group reviews, OMC, Q&S, Trust Board. Balanced scorecard. Peer: CCG contract review meeting and TDA performance review	3	4	12		Tracking and delivery of weeks work and other assurance KPIs as implemented in Q1	Sep-15	2	4	8
COO	007-AR	Double the number of safe discharges each morning and reduce by at least a half the number of delayed transfers of care in Trust beds	There is a significant risk that the volume of patient discharges from hospital beds each morning is insufficient as a result of poor understanding of expected date of discharge, poor discharge planning or the coordination of activities to effect a safe discharge leading to not enough beds available to admit patients with an emergency or urgent requirement for hospital care and financial penalties	Q&SC	4	4	16	1. An Urgent Care Board has been established and standard operating procedures for 7 day safe discharge across all Clinical Groups have been developed 2. Full realisation of benefits of ADAPT pathway. 3. Arrangements for delivery and monitoring of associated KPI daily / weekly are in place 4. Monitoring through Capacity meeting.	Internal: CLE discussions, Q&S reports up to Trust Board Peer: CCG contract review meeting, System Resilience Group and TDA performance review	4	4	16		On going training and reinforcement of good discharge practices Focused project on Expected Date of Discharge	Jul-15	2	4	8

Sandwell and West Birmingham Hospitals NHS Trust
BOARD ASSURANCE FRAMEWORK 2015/16

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
MD	008-AR	Implement advice and guidance support for GPs in all specialities and expand the use of video technology to consult with patients	There is a risk that we fail to meet contractual requirements to implement A&G and lose engagement and reputation with our primary care partners. There are financial penalties in the contract if we fail to implement A&G	Q&SC	3	3	9	Implementation of advice and guidance is a key objective of the Year of Outpatients change program. At a national level the new electronic referral management system will be implemented on 15th June 2015	Each Clinical group has reported back to YOOP services that have made available A&G through current systems that are commensurate with requirements	2	3	6		New National ERMS (choose and book 2) to become available June 2015	Q3 15/16	1	3	3
CN	009-AR	Deliver our plans for significant improvements in our universal Health Visiting offer MF	There is a significant risk that children and families may not have adequate access to a comprehensive range of NHS, Local Authority and voluntary services as a result of lack of knowledge or poor co-ordination by health visitors which could lead to physical, mental or social developmental delay, or poor use of safeguarding facilities	Q&SC	3	4	12	1. A recruitment programme into health visitor vacancies is in place. 2. Leadership development programme 3. Portfolio of accessible services	Internal and peer: 1. Report describing improvements in Universal Health Visiting 2. Annual report of performance	2	4	8		Portfolio of services to be developed	Jul-15	2	4	8
COO	010-AR	Work within our agreed capacity plan for the year ahead, thereby cutting Do Not Attend rates, cancelled clinic and operation numbers, largely eliminate use of premium rate expenditure and accommodating patients declined NHS care elsewhere MF	There is a risk that sustainable demand and capacity plans are not delivered as a result of failure to resolve capacity gaps and / or optimise resources both workforce and service assets eg; theatres or out patients. This may leads to unplanned costs and activity .	FIC	4	4	16	1. Demand and capacity plans in development to be completed in Q1 2. Balanced scorecard to track delivery in design to be completed for May 3. Job planning to be completed in line with capacity plan in Q1 4. CCG contract review meeting and TDA performance review	Internal: Project group review and via IPR and direct update reports via Group reviews, OMC, FIC to Trust Board.	3	4	12		Tracking and delivery of weeks work and other assurance KPIs as implemented in Q1	Apr-15	2	4	8
COO	011-CCH	Expand iCares and heart failure services to provide improved provision in West Birmingham, by agreement with local practices	There is a risk that expansion of services fails lack of commissioning and a shortfall in workforce and marketing of new services which may lead to SWBH patients receiving varying levels of access to community services resulting in longer length of stay, readmission and differing satisfaction levels	Q&SC	4	4	16	1. Business case development to expand services in Q1. 2. Bid for resilience funding to expand Ibeds inreach team to be confirmed in April . 3. Ongoing recruitment campaign in train.	Internal: CLE scorecards and minutes , Group review External; CCG contract meeting	3	4	12		delivery plan to be developed in Q1. Marketing and engagement with selected GP practices	Dec-15	2	4	8

Sandwell and West Birmingham Hospitals NHS Trust
BOARD ASSURANCE FRAMEWORK 2015/16

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
COO	012-CCH	Implement our Rowley Regis expansion plans (Rowley Max) so that by March 2016 we have in place our RCRH model on the site MF	There is a risk that the infrastructure required to deliver the plan is not in place as a result the delivery of the RCRH model for the Rowley site is delayed resulting in loss of market share and demand and the inability to redesign clinical service provision on the residual acute sites	CC	3	4	12	1. Developing a plan to be approved during spring 2015-16 2. Board Committee oversight	Internal: Board Committee minutes	3	4	12		Engagement and communication of final plan	Apr-16	2	4	6
CN	013-CCH	Ensure that we improve the ability of patients to die in a location of their choosing, including their own home	There is a risk that patients are not given a choice about the place they would prefer to die as a result of the Trust's inability to co-ordinate services in a timely manner which could lead to patients dying in one of our hospitals leading to high levels of dissatisfaction or complaints	Q&S	3	3	9	1. An End of life strategy is in place 2. An End of Life group has been established 3. A set of KPIs to monitor the position have been developed, with arrangements in place to monitor these on a monthly basis	Internal and peer: An audit of preferred place of death	2	3	6		Develop the pathway of services that require co-ordinating to help a patient to return home as smoothly and efficiently as possible Train staff in the use of the pathway	Aug-15	2	3	6
CEO	014-CCH	Support agreed GP partners through the CCG's 'push sites' initiative, designed to fit care models to local population	Diverse projects, structures and relationships militate against sufficient successful delivery in 11 months that 16-17 decisions can be made by Trust and commissioners	TB	4	2	8	Primary care liaison team to track projects, in liaison with CCG, reporting monthly to the Chief Executive, and through him to EG and CLE. Quarterly formal stocktake from July 2015.	Assurance via senior involvement, escalated to formal review with CCG at mid year if off track.	3	2	6		Focus detailed project plans developed for key impact schemes by end of Q2	Oct-16	2	2	4
COO	015-CCH	Respiratory medicine service sees material transfer into community setting, in support of GPs	There is a risk that the clinical service model remains with too much Direct Clinical Care time committed to routine clinic work in the acute hospital which will potentially result in late intervention on community patient pathways, which may result in a continued rate of readmissions	Q&SC	4	4	16	1. Community respiratory service in place across Sandwell (now part of iCares) 2. Respiratory pathways and service redesign through readmissions project and demand and capacity plan to be clarified by July.	Internal: Readmissions reports to Clinical Effectiveness Committee, Demand and Capacity reports to FIC, New clinical model through Group review is reported to CLE	3	4	12		Current work to be pulled together through project group to deliver the respiratory medicine equivalent of the DiCE project is in place. Further work to do to understand GP push sites	Oct-15	2	4	8
CEO	016-GUR	Implement successfully and safely the new tariff regime (ETO) as the Trust moves to a PBR system with all commissioners by 2017	Marginal rate for specialist services in ETO necessitates active rationing of care and care modalities. Risk that this creates inequity, and reduces quality of care offered (as distinct from safety).	QSC	3	4	12	Explicit approach with Board oversight, supported by written policy taken through CLE. Escalation to CCG CQMS meeting in Q3/4 as active rationing begins.	Patient level tracking of any delayed care decisions	3	4	12		Explicit approach to 16-17 contract form negotiation to seek to remove pass through marginal rate from national arrangements. This materially reduces risk of accumulated delays over years as distinct from brief 'year end' issue.		3	2	6

Sandwell and West Birmingham Hospitals NHS Trust
BOARD ASSURANCE FRAMEWORK 2015/16

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOF	017a-GUR	Create financial balanced plans for all directorates and deliver Group-level I & E balance on a full year basis [2015.16 financial year] **MF**	There is a risk that the identified opportunity for financial improvement is insufficient to deliver balanced financial plans across each and all directorates. This could result in a failure to generate those financial surpluses necessary to underpin the approval & delivery of key strategic investments.	FIC	3	5	15	Effective use of comparative information including peer benchmarking, best practice review and expert scrutiny. Market share analysis to identify repatriation opportunity. Focussed executive support to directorates to develop plans. Transparent & explicit process for plan sign off.	Management assurance. Routine reporting of historic and prospective financial performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning, budgetary control, CIP delivery and data quality. External audit review of arrangements for securing VFM. Regulator scrutiny of safe, effective, financially viable services.	2	5	10		Complete demand and capacity work to confirm financial margin generated is in line with financial plan requirements. Development & execution of tailored marketing plan with GPs to secure referrals in line with repatriation requirement. Confirm budget control totals and delivery plans through CEO sign off process. Confirm downside contingency plan to deliver group level I&E balance on a full year basis.	Jun-15	2	4	8
DOF	017b-GUR	Create financial balanced plans for all directorates and deliver Group-level I & E balance on a full year basis [2015.16 financial year] **MF**	There is a risk that the scale & pace of financial improvement delivered is insufficient. This is caused by a lack of necessary capacity and capability. This could result in a failure to generate those financial surpluses necessary to underpin the approval & delivery of key strategic investments.	FIC	4	5	20	Expedited recruitment to fit for purpose senior management structures and follow through on senior leadership development programme. Utilisation of expert support as necessary and appropriate. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective financial performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning, budgetary control, CIP delivery and data quality. External audit review of arrangements for securing VFM. Regulator scrutiny of safe, effective, financially viable services.	3	5	15		Completion of necessary recruitment and leadership development programme. Embedding PMO arrangements in Group management teams & alignment of Change Team resources to support critical improvement projects. Review & amendment of SOPS for TPRS such that it is effective tool for monitoring and managing change programmes. Progression and conclusion of Safe & Sound 2 programme consistent with necessary scale of workforce and paybill change. Confirm downside contingency plan to deliver trust level I&E balance on a full year basis.	Jun-15	2	5	10

Sandwell and West Birmingham Hospitals NHS Trust
BOARD ASSURANCE FRAMEWORK 2015/16

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOF	017c-GUR	Create financial balanced plans for all directorates and deliver Group-level I & E balance on a full year basis [2015.16 financial year] **MF**	There is a risk that the scale & pace of financial improvement delivered is insufficient. This is caused by a risk of compromise to the safety and quality of services provided. This could result in a failure to generate those financial surpluses necessary to underpin the approval & delivery of key strategic investments.	FIC	3	4	12	Fit for purpose QIA / EIA assessment and approval process.	Management assurance. Routine reporting through TPRS of QIA / EIA status of individual change projects. Management review through PMO and performance management structures. Independent assurance. Internal audit review of core systems & processes including financial planning, budgetary control, CIP delivery and data quality. External audit review of arrangements for securing VFM. Regulator scrutiny of safe, effective, financially viable services.	2	4	8		Confirmation of QIA / EIA sign off in advance of project imnplementation. Embed routine ex-post monitoring of KPIs related to QIA / EIA assessments.		1	3	3
DOF	017d-GUR	Create financial balanced plans for all directorates and deliver Group-level I & E balance on a full year basis [2016.17 financial year] **MF**	There is a risk that the identified opportunity for financial improvement is insufficient to deliver balanced financial plans across each and all directorates. There is a risk that the scale & pace of financial improvement delivered is insufficient. This is caused by a lack of necessary capacity and capability and risk of compromise to the safety and quality of services provided. This could result in a failure to generate those financial surpluses necessary to underpin the approval & delivery of key strategic investments.	FIC	4	5	20	Effective use of comparative information including peer benchmarking, best practice review and expert scrutiny. Expedited recruitment to fit for purpose senior management structures and follow through on senior leadership development programme. Effective QIA / EIA process. Transparent & explicit process for plan sign off. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective financial performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning, budgetary control, CIP delivery and data quality. External audit review of arrangements for securing VFM. Regulator scrutiny of safe, effective, financially viable services.	3	5	15		Completion of necessary recruitment and leadership development programme. Focussed executive support to directorates to develop plans. Utilisation of expert support as necessary and appropriate.	Sep-15	2	5	10

Sandwell and West Birmingham Hospitals NHS Trust
BOARD ASSURANCE FRAMEWORK 2015/16

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOF	018a-GUR	Develop our capital plan and execute in line with that plan on a quarter by quarter basis [2015.16 financial year]	There is a risk that the capital plan is constrained by the requirement to secure key financial metrics and which compromises the timely progression of key estate development and necessary equipment replacement without compromise to key statutory standards. There is a risk that the scale and pace of capital programme delivery is delayed as a result of lack of necessary capacity and capability and which compromises the timely progression of key estate development and necessary equipment replacement.	FIC	3	5	15	Detailed review of absolute and sequenced capital requirements in particular for imaging, medical equipment replacement and retained estate development. IM&T programme confirmed. Routine consideration of full range of financing options to optimise flexibility within financial plan. Appropriate focus and development of senior leadership. Transparent & explicit process for plan sign off. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective capital plan performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning & budgetary control. External audit review of arrangements for securing VFM. Regulator scrutiny of arrangements for compliance with statutory standards.	2	5	10		Confirm absolute and sequenced capital requirements for imaging, medical equipment and retained estate. Confirm £2m capital contingency in financial plan sufficient to meet those requirements. Confirm named scheme executive / project lead for all schemes. Confirm inclusion of capital programme as standing item on group / directorate performance management agendas.	Jun-15	2	4	8
DOF	018b-GUR	Develop our capital plan and execute in line with that plan on a quarter by quarter basis [2016.17 financial year]	There is a risk that the capital plan is constrained by the requirement to secure key financial metrics and which compromises the timely progression of key estate development and necessary equipment replacement without compromise to key statutory standards. There is a risk that the scale and pace of capital programme delivery is delayed as a result of lack of necessary capacity and capability and which compromises the timely progression of key estate development and necessary equipment replacement.	FIC	4	5	20	Detailed review of absolute and sequenced capital requirements in particular for imaging, medical equipment replacement and retained estate development. IM&T programme confirmed. Routine consideration of full range of financing options to optimise flexibility within financial plan. Appropriate focus and development of senior leadership. Transparent & explicit process for plan sign off. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective capital plan performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning & budgetary control. External audit review of arrangements for securing VFM. Regulator scrutiny of arrangements for compliance with statutory standards.	3	5	15		Conclusion of MES contract during 2015.16 for delivery of key fixed equipment from 2016.17. Confirm retained estate investment programme. Establish and confirm necessary & sufficient management resources to deliver critical elements of the programme. Confirm financial plan for 2016.17 consistent with delivery delivery of necessary surplus to underpin capital programme investment [see risk 017d above].	Dec-15	2	5	10

Sandwell and West Birmingham Hospitals NHS Trust
BOARD ASSURANCE FRAMEWORK 2015/16

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
COO	019-GUR	Reform how corporate services support frontline care, ensuring information is readily available to teams from ward to Board	The risk is that we do not achieve a performance cycle that drives changes required to delivery the annual and long term plan supported by an intelligent suite of business information . The impact is that may result in failure or delay to fully deliver efficiency, effectiveness in clinical services, with sound governance and assurance from board to ward	TB	4	4	16	1. A project team is in place to create standard cycle of directorate, Group and Trustwide reports. 2. Recruitment in train for BIU lead and Head of Performance 3. Procurement of an intelligent dashboard front end	Internal: Trust Board, CLE, Group review reports. A reporting tool is in place at frontline service level and standard reports are visible monthly to support performance improvement cycle	3	4	12		Specify and procure dashboard information system	Oct-15	2	4	8
DOF	020-GUR	Reform how corporate services operate to create efficient transactional services by April 2016 that benchmark well against peers within the Black Country Alliance	There is a risk that corporate functions provide an inadequate level of support to front line teams as a result of an extended period of significant change and which may lead to a delay in service and financial improvement and failure to secure middle & back office efficiency at necessary scale.	TB	3	4	12	Recruitment to residual gaps in corporate team infrastructure. Routine reporting & coherent performance management arrangements. Transactional excellence improvement to be effected through robust programme management arrangements and with expert support as necessary and appropriate.	Management assurance. Routine reporting of transactional KPIs at performance review meetings. Independent assurance. Internal audit review of core systems and processes including performance management and data quality assurance programme. Regulator scrutiny of 'well led' assessment.	3	4	12		Establishment & implementation of effective transactional excellence improvement programme. Undertake baseline assessment and pilot diagnostic to include definition of what excellence looks like. Procure delivery partner to implement full diagnostic, solution design and change programme delivery.	Sep-15	2	4	8
MD	021-21CF	Agree EPR outline business case and initiate procurement process, whilst completing infrastructure investment programme MF	There is a risk that due to inadequate IT infrastructure and lack of management capacity and capability within the IT team that we fail to achieve or fully realise the benefits of the procurement and implementation of the EPR prior to the move to midland Met	FIC	5	4	20	External contractors have been brought in to conduct a deep dive review of IT infrastructure across the entire estate. A remedial investment and action plan will result from the deep dive which will be actioned in advance of the implementation phase of the EPR project. A departmental workforce review will take place during 15/16 in order to ensure a team structure fit for purpose	Internal: Progress on these will be reported regularly through IT committee and thence to CLE. Direct reporting to FIC on progress of the EPR procurement and to Configuration Committee on infrastructure and EPR implementation.	3	4	12		Until deep dive infrastructure review complete and work force review complete the risk remains	Q2 15/16	2	4	8

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOF	022-21CF	Reach financial close on the Midland Met Hospital MF	There is a risk that approving bodies [TDA, DH, HMT] delay or fail to approve the business case. This may be as a result of lack of confidence in the business case or trust ability to deliver, political or policy change, absence of a compliant bid, withdrawal of commissioner support or other significant reason. This would give rise to delay or absence of financial close an with potential requirement for expedient service change to secure safe, effective & financially viable services. There is a risk that the senior debt funding competition fails to secure sufficient funds as a result of lack of market appetite and which may cause the case to fail.	CC	4	5	20	Delivery of coherent appointment business case consistent with OBC evidenced with sufficient cost improvement and workforce plans. Ongoing delivery against approval conditions. Confirmation of compliant bid through conclusion of evaluation process. Effective engagement with EIB to secure their commitment to [part-] funding of the development. Routine oversight and management through Stakeholder Board and trust Reconfiguration Committee.	Management Assurance. Routine oversight and assurance through trust Configuration Committee. Independent assurance. Due diligence using external advisors of bid and key elements of business case.	3	5	15		Further development of cost reduction and workforce plans and commissioner confirmation of downside plans.		2	5	10
COO	023a-21CF	Complete consultation on, implement and evaluate the reconfiguration of interventional cardiology and acute surgery between our acute sites	The risk is that the patient pathways and intended benefits of reconfiguration are delayed through late delivery of estates infrastructure or not realised due to pathway or clinical service model implementation resulting in unintended outcomes such as increased LOS and negative impact on patient / staff experience	CC	3	4	12	1. Public engagement successfully completed. 2. Estates plans and procurement identified and approved. 3. Detail of patient pathways in development and supporting clinical infrastructure in development 4. CCG Configuration / RCRH Partnership Board	Internal: Estates plans, pathway and clinical infrastructure via Group Review, project group and configuration committee reports.	2	4	8		Pathways to be confirmed and signed off. Provision of support services eg imaging model and transport to be implemented. Initial evaluation to be post 1.8.15	Aug-15	2	4	8
COO	023b-21CF	**Cardiology**	The risk is that the patient pathways and intended benefits of reconfiguration are delayed through late delivery of estates infrastructure or delays in procurement resulting in continue risk and down time from aging equipment and the challenge of dual site rotas	CC	3	4	12	1. Business case and procurement pathways agreed. 2. Project group and plan in place to deliver. 3.Assurance and control measures include key milestones in delivery programme and benefits identified post reconfiguration in business case.	Internal: Estates plans, pathway and clinical infrastructure via Group Review, project group and configuration committee reports.	2	4	8			Aug-15	2	4	8

Sandwell and West Birmingham Hospitals NHS Trust
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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
COO	023c-21CF	**Acute surgery**	The risk is that the patient pathways and intended benefits of reconfiguration are delayed because of a lack of complete multiprofessional engagement and ownership to deliver a standardised workforce and clinical model. This may result in delay in implementation resulting in unintended outcomes such as increased LOS and negative impact on patient / staff experience	CC	4	4	16	1.Change case and public engagement completed 2. Project group and plan in place to deliver. 3. job plans to be agreed - process in place 4. Estates work to be completed as per delivery plan 5. Assurance and control measures include key milestones in delivery programme and benefits identified post reconfiguration in business case.	Internal: Estates plans, pathway and clinical infrastructure via Group Review, project group and configuration committee reports.	3	4	12		Further staff engagement, finalisation of GP pathways and imaging model to support new acute surgery model	Aug-15	2	4	8
DENHP	024-21CF	Develop, agree and publicise our final location plans for services in the Sandwell Treatment Centre	There will remain a risk that the final location plans may need to change in response to service need, business plans funding constraints.	CC	3	4	12	Monitoring arrangements are in place through the Board and sub committee structures reports and risk registers. Draft plan to be available June 2015.	Reports to MMH Reconfiguration Committee. Inclusion in Group/service business plans. Outcomes inform 2016/17/18 capital programmes.	3	4	12		Current plans will be reviewed to confirm assumptions remain valid and identify material gaps/omissions. This work will inform preparation of the draft plan by June 2015.	Jun-15	3	3	9
COO	025-21CF	Finalise and begin to implement our RCRH plan for the current Sheldon Block as an intermediate care and rehabilitation centre for Ladywood and Perry Barr	The risk is that the commissioning of intermediate care is neither timely nor adequate for the demand and implementation. This may result in delay of gap in this level of care which may lead to increased delayed discharges and negatively impact on patient experience and outcomes	CC	3	4	12	1. Secure contract fro activity. 2. With Estates working to identify estates plans and capital investment in agreed timeframe. This will include decant programme from Sheldon block for other services that are not located their in the RCRH model. 3. Community workforce strategy includes workforce model for Sheldon services with supporting recruitment plan.	Internal: Confirmed estates plans. Workforce scorecard discussed at Clinical Group Review. Signed contract to provide service discussed at Clinical Group Review External; Contract meetings	3	3	9		Delivery of successful recruitment campaign (Community Clinical Group working jointly with Medicine on recruitment plan) supported by corporate recruitment and communications expertise. Assess any further implementation requirements based on contract.	Mar-16	2	2	4

Sandwell and West Birmingham Hospitals NHS Trust
BOARD ASSURANCE FRAMEWORK 2015/16

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOD	026-EEO	Cut sickness absence below 3.5% with a focus on reducing days lost to short term sickness MF	High levels of sickness absence may persist which may adversely affect the development of high performing, cohesive teams to support the delivery of high quality care	W&ODC	5	3	15	Provision management information. Group focus. Sickness absence training programme. Monthly case review of long term cases. Counselling and health and well being services.	Internal: Assessed through sickness absence data, Your Voice and national staff survey results	4	3	12		Development if a cohesive plan, embracing effective leadership, group ownership, Health and wellbeing use of business intelligence, coupled with consistent application of sickness absence management process		3	3	9
DOD	027-EEO	Finalise our long terms workforce plan, explaining how we will safely remove the paybill equivalent of 1000 posts between 2016 and 2019	There is a risk that future staffing models will not be well enough defined to enable the identification of sufficient posts to be removed leading to an inability to formulate a robust workforce plan which may lead to the non delivery of the required workforce and pay cost savings between 2016 to 2019	W&ODC	4	4	16	LTWM sets out 5 year workforce forecast linked to clinical activity changes. Annual business planning template requires groups/directorates to describe workforce change requirements. Strategic workforce change themes are developed. Monthly oversight of Workforce Delivery and quarterly oversight at board level Workforce and OD Committee. Bottom-up workforce models/scenarios developed for MMH	Workforce change schemes tracked through TPRS. Exec led PMO. TDA workforce returns	3	4	12		Closer alignment of workforce transformation with service transformation. Further refinement on bottom up workforce modelling/scenario generation required		2	4	8
DOC	028-EEO	Create time to talk within our Trust so that engagement is improved. This will include implementing Quality Improvement half days, revamping Your Voice, Connect and Hot topics and committing more energy to First Fridays	Poor staff engagement levels that could be contributed to by ineffective internal communications systems and visibility, leading to lack of understanding of the Trust's vision and objectives, lack of ability to share good practice and improve services, low staff morale and high turnover.	W&ODC	4	3	12	Internal communications strategy in place and approved by June 2015. Quality Improvement Half Days implemented from April 2015. Improved engagement with Your Voice including how teams change and improve as a result of staff feedback. Increased attendance and team feedback at Hot Topics monthly briefings. Increased visibility of senior leaders. New intranet system for sharing information across the organisation.	Internal: Engagement scores on Your Voice and improved feedback rates on internal communications systems Independent: National staff survey results	2	3	6		Publish internal communications strategy - June 2015; Implement Quality Improvement Half Days - April 2015, Relaunch Connect intranet site; December 2015,	Jun-15	2	3	6
DOD	029-EEO	Agree and begin to implement our three year Education Plan	The loss of highly skilled staff is a problem. The inability to recruit highly qualified staff is also a problem. The perception of staff is that there is no money to support training. The lack of visibility around who accesses the funding and the lack of clarity about Education Training and Development does affect staff morale and retention.	W&ODC	3	3	9	A draft strategy has been developed for agreement by the E,L&D Committee (April 15). Trust training plan has been collated and developed to show all Trust staff accessing development support and funding. Revision of the study leave policy is being progressed to address the issue of staff leaving upon completion of higher level education and training programmes.	Internal: Minutes from the E, L & D Committee	1	3	3		Publish the strategy in June 15. Publish Trust Training plan in May 15. Monitor via E,L&D committee.	Jul-15	1	3	3

Sandwell and West Birmingham Hospitals NHS Trust
BOARD ASSURANCE FRAMEWORK 2015/16

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOD	030-EEO	Complete the second year of our leadership development programme, providing clinical leaders with the skills and expertise to lead the organisation forward	There is a risk of lack of engagement from staff due to delays in communicating the list of participants. Lack of engagement from the provider and willingness to continue with the programme delivery.	W&ODC	4	3	12	The list of participants is to be agreed and distributed. Promotional materials to be produced based on the success of the first year's programme. Increased involvement with the provider and assurances agreed.		1	3	3			Jun-15	1	3	3

KEY

Safe high quality care	Q&SC - Quality & Safety Committee
Accessible and Responsive	FIC - Finance & Investment Committee
Care closer to home	CC - Configuration Committee
Good use of resources	W&ODC - Workforce & OD Committee
21st Century facilities	TB - Trust Board
Engaged and effective organisation	**MF** - Annual priorities which will be given monthly focus

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Risk Registers
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Mariola Smallman, Head of Risk Management
DATE OF MEETING:	7 May 2015

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 was presented to the Board at its April meeting and Executive Director updates are highlighted where these were provided.

The Trust risk Register was discussed at the last meeting of the Clinical Leadership Executive where it was agreed that the Trust Board should be asked to approve the addition of the four new risks arising from the Women and Child Health Group.

REPORT RECOMMENDATION:

- **RECEIVE** monthly updates on progress with treatment plans from risk owners for high (red) risks on the Trust Risk Register.
- **REVIEW and AGREE** whether the proposed four additional risks should be included on 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:

Clinical Leadership Executive on 28 April 2015.

RISK MANAGEMENT COMMITTEE REPORT TO CLINICAL LEADERSHIP EXECUTIVE

Report on Trust Risk Register

1 INTRODUCTION

The Trust Risk Register compromises high (red) risks that have been through the validation processes at directorate / group and Executive Committee levels. 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) and medium (amber) risks by RMC provides the initial Trust-wide validation stage ("confirm and challenge") to ensure consistency and identify duplicates, etc.

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.

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.

2 TRUST RISK REGISTER

The Trust Risk Register was reported to the Board at its April meeting and Executive Director updates are highlighted where these were provided for the Board meeting. Trust Board approved the addition of the following risks which are now included on the Trust Risk Register at **Appendix A**:

1. There is a risk that a not fit for purpose IT infrastructure will result in a failure to achieve strategic objectives and significantly diminishes the ability to realise benefits from related capital investments. e.g. successful move to paperlite MMH, successful implementation of Trust Wide EPR.
2. There is a risk of failure of a trust wide implementation of a new EPR due to insufficient skilled resources in Informatics, significant time constraints (programme should have started earlier) and budgetary constraints (high risk that in adding the full costs of an EPR into the LTFM that there is insufficient capital for related and pre-requisite schemes - e.g. Infrastructure Remediation / MMH Infrastructure preparation / Business Plan schemes)
3. There is a risk of a breach of patient or staff confidentiality due to inadequate information security systems and processes which could result in regulatory and statutory non-compliance.
4. Not all shifts have an appropriately trained trauma nurse on duty due to a lack of nurses trained in ATNC or equivalent which could compromise the quality of care.
5. Reduced ability to provide an Interventional Radiology service as a result of difficulties in recruiting Interventional Radiology consultants, results in delays for patients and loss of business.
6. Clinical Groups are unable to transact basic business processes because of key person gaps resulting in performance delays and failures.

There are four additional risks for the Board to review and decide whether to support the CLE's recommendation for these to be added to the Trust Risk Register:

1. Current capacity is restricted and is resulting in a number of women having dating USS performed > 12/40 and some being out with the screening window and therefore not receiving screening as per National NSC guidelines- inequitable service for those women choosing to book at SWBH.
2. Provision of ultra sound support for Gynaecology services at risk due to difficulties in

recruitment and retention of ultra-sonographers which results in potential for delayed diagnosis and failure to achieve 31day cancer investigation targets.

3. BadgerNet connectivity problems associated with the use of I Pads is affecting Community Midwives' (CMW) ability to access/ update patient live records.
4. National shortage of intradermal BCG vaccination leading to a potential increase in babies affected with TB.

See risk assessments at **Appendix B.**

3 ELECTRONIC RISK REGISTER

The Risk Team are currently piloting the Safeguard electronic risk module using risk assessments and risk register data for the Chief Executive's Directorate. Some system amendments are being worked on to improve the "look and feel" so that it mirrors Trust approach and terminology.

The electronic risk system will follow the same format as the incident reporting module, which staff are familiar with. The system will be based on the Trust's existing risk assessment and register approach and terminology as well as prompts and "help notes" included within the risk forms.

A phased implementation is planned, commencing with W&CH and then Medicine. Roll out will be co-ordinated by the Risk Team, who will liaise with existing directorate risk leads. Directorate risk leads will cascade to their wards / departments and provide advice / support as per existing process.

The risk system will provide an integrated risk register which will be able to report on risk themes, by different management levels, by risk scores, etc., which be visible to all staff from the Incident Reporting Icon on Connect.

Reporting of the Trust Risk Register to the Board will continue throughout the implementation of the electronic risk register system.

4 RECOMMENDATION

Trust Board is asked to:

- **RECEIVE** monthly updates on progress with treatment plans from risk owners for high (red) risks on the Trust Risk Register
- **REVIEW** and **AGREE** whether the proposed four additional risks should be included on the Trust Risk Register.

Kam Dhami
Director of Governance

Appendix A: Trust Risk Register (version as at April 2015)

Reference No	Source of Risk	Clinical Grp / Corp. Dir.	Specialty / Ward/Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Executive Lead	Expected Date of Completion	Date of Latest Review	Review Frequency	Likelihood	Severity	Residual risk rating	Change since last mth
414MARWK03		Chief Executive	Workforce Strategy	Organisational (Strategic)	Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment reduction of 1400 wtes, 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. Previous 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. Update: Detailed plans for 14/15 and 15/16 in development due for implementation during Q3 and Q4 of 2014. Key planning assumptions for 2016 onwards in development.	Chief Executive pending appointment of Director of OD.	Mar-20	Jun-14	bi-monthly	3	5	15	=
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. Previous updates: 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. Feedback received from Stroke Review Advisory panel to be considered to strengthen position as preferred provider. Update 21.11.2014 - outcome of review has been put on hold and no definitive outcome has been received due to data validation issue. No current timeline. Update 12.2.2015 Awaiting final decision from CCG Commissioners and the independent panel that has been set up to review the whole process. CCG have not confirmed a timeline or completion date.	Chief Operating Officer	TBC - Commissioner led review	Feb 15	Monthly	4	3	12	=

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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. Previous 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. Progress: Timelines for assessment and training September to December and SOP / policy review in September	Chief Operating Officer	Jul-14	Sep-14	Jul-14	2	4	8	=

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TRR1401COO02	Management review	Corporate Operations		Operational	Sustained high Delayed Transfers of Care (DTOC) patients remaining in acute bed capacity.	4	4	16	Joint working through joint discharge teams on both acute sites established; 7 day working pilot; Weekly urgent care call with Chief Executives and Chief accountable officers from LAT, CCG, NTDA, acute Trust and social services includes DTOC review, strategic and operational work; Commissioning plans for 7 day working in 2014 in train. Previous update: Additional capacity closed end July although DTOC remains high. Plan will remain in place to re-open additional beds if required and triggers are agreed and activated through Operations Centre and authorised by COO or on call Executive Directors. Resilience System Plan (winter) submissions includes additional beds in community and social care – outcome of funding decision to be agreed in July. This will impact on DTOC reduction. Work to establish a Joint Health Social Care assessment and discharge team continues – now in training phase for go live at Sandwell in August and then at City. Progress: DTOC numbers remain high. The System Resilience plan awaits clarification from Birmingham City Council on aspects of plan workforce and the re-ablement bed plan for the locality. New joint team with Sandwell is in implementation phase with good engagement.	Chief Operating Officer	Jun-14	Sep-14	Jul-14	2	4	8	=

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0907SOP15	Inspections: H&S and PEAT	Surgery B	Ophthalmology	Clinical	Risk of Breach of Privacy and Dignity Standard, Information Governance Risk and Infection Control Risk at SGH Outpatient Department as a consequence of poor building design in SGH Ophthalmology OPD. Clean/dirty utility failings cannot be addressed without re-development of the area.	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. Previous update: Rowley Max has been scoped and will be delivered in Year of Out Patients programme on track for completion Q2. Plans for relocation of oral surgery OP to enable ophthalmology to meet privacy and dignity standards in development with intention to complete in Q3. SGH outpatients privacy and dignity risk treatment plan stalled as dependant on Oral Surgery being relocated, which is still to be resolved Update 24.2.2015 Continuing to seek potential solution through re-location of Oral Surgery either off-site or to another SWBH location.	Chief Operating Officer	31/12/2015	Feb 15	GBM	3	3	9	=
1103PAE02	Risk Assessment	Women's 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. Previous updates: 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. Current review of budgets and redeployment of resources. Monthly activity and staffing review of HDU care to be carried out and reported to paediatric clinical governance. Update: Monitoring in place; monthly reports to Clinical Directorate Governance Group and activity monitored through monthly directorate meeting	Chief Operating Officer	TBC	Dec-14	Monthly	3	4	12	=

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1103PAN01	Risk Assessment	Women's 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. Mental health commissioners report that they are working up enhanced assessment service for children's mental health which intends to reduce numbers of children needing admission. Impact expected in autumn. Confirmed new assessment service and intended benefits will enable review of residual risk. The Trust continues working closely to support this work. Agreed with both adult providers access to mental health bank to support specialist staffing. Guidance on booking process to be agreed in July. Previous Update: Direct access to agency booking approved by Chief Nurse 11.08.14 Update: Continue to monitor any incidents as they arise. Funding identified by the Mental Health Trust to provide both a Crisis Team and a Home Treatment team – both due to be in place January 2015, however funding is currently only available until end on March 2015.	Chief Operating Officer	TBC	Dec-14	Monthly	4	4	16	=
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Oncology Service is currently unable to treat approx. 120 patients a month due to workforce issues.	5	4	20	Previous update: SLA with Royal Wolverhampton Hospital NHS FT to provide consultant AOS – 2 sessions to augment the 2 sessions provided by UHB Update: Provision of replacement locum through New Cross Hospital, Wolverhampton to provide Consultant AOS - 2 sessions to augment the 2 sessions provided by UHB. Update 12.2.2015. Locum secured through agency. Clinic modelling re: breast and lung taking place as per actions through Cancer Taskforce Group.	Chief Operating Officer	TBC	Feb 15	Monthly	3	4	12	=

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	Oncology Peer Review	Medicine	Scheduled Care	Operational	Trust non-compliant with Oncology Standards.	5	4	20	Previous update: Workforce and service design issues (hot clinics) to be negotiated through enhanced SLA with oncology provider. Meeting scheduled with QE for September. Intention is to agree model of service and agree workforce model and SLA for Q3. Developing nurse led services to see pre-chemotherapy patients – to mitigate oncology demand issues. Previous Update: Clinic Modelling and AOS proposal completed as a pre-requisite to negotiations with UHBFT re: SLA provision. Pilots to commence re: oral chemotherapy pharmacist role and rescheduling of chemotherapy in BTC. Update12.2.2015: Interviews for x 2 Band 6 AOS nurses taking place. IAP being completed for 7 day service through business planning process.	Chief Operating Officer	TBC	Feb 15	Monthly	1	4	4	=
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Trust has inconsistent cancer pathways between its sites and mixed visiting oncology MDT attendance patterns.	3	5	15	Previous update: Trust has extended discussions with UHB and executive led cancer futures workshop now scheduled for early September. Update: Workshop has taken place and proposal for oncology clinic model has been submitted to UHBFT. Update 12.2.2015: Awaiting reply from UHBFT re: model proposal. Cancer Action Taskforce Group working through actions and proposed model.	Chief Operating Officer	TBC	Feb 15	Monthly	1	5	5	=
201109DEL30	Risk Assessment	Womens and Child Health	Maternity	Clinical	The existing provision of a 2nd theatre team for an obstetric emergency.	2	5	10	Process to request opening of a second theatre in and out of hours for obstetrics is in place. Ongoing monitoring of any second theatre team issues through the incident reporting process. (Risk initially RED, downgraded to AMBER due to reduced frequency). Previous Update: TB has previously reviewed the risk and agreed it is to be tolerated. Update: Continued monitoring	COO	TBC	Nov 14	Monthly	2	5	10	=

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TBC	Risk assessment	Women and Child Health	Maternity	Financial	Unpredictable birth activity and the impact of cross charging from other providers against the AN / PN tariff is significantly affecting the financial position of the service impacting on the affordability and quality provision of the service.	4	4	16	Previous Update: Maximise tariff income through robust electronic data capture. Review of activity and income data 6 months post BadgerNet roll out. Comprehensive review of maternity pathway payment system underway for presentation to FD. Update: Options appraisal from finance in progress which will be discussed between the Clinical Group Director of Operations and Director of Finance	Chief Operating Officer	Ongoing	Oct-14	Monthly	3	4	12	=
201501NYOBS02	Incidents	Women and Child Health	Maternity	Clinical	Breakdown of lifts risk delay in transfer in an emergency situation which could result in a catastrophic event for either a pregnant woman / unborn baby.	4	5	20	• A& E type stretcher in Delivery suite & ward available at all times. • When both lifts out try to utilise M1 as opposed to M2. • Notice displayed clearly when lift out of use. • Ensure frequent maintenance of each lift. • Ensure incident reporting to indicate frequency of lifts out of action. Update: Lift 11 repair completed; Lift 20 upgrade works will commence 7 April.	Chief Operating Officer	Ongoing	Mar 15	Monthly	2	3	6	n/a

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INFORMATICS002	Departmental Review	Medical Director's Office	Informatics Service	Organisational (Strategic)	There is a risk that a not fit for purpose IT infrastructure will result in a failure to achieve strategic objectives and significantly diminishes the ability to realise benefits from related capital investments. e.g. successful move to paperlite MMH, successful implementation of Trust Wide EPR.	5	4	20	Causes: - A not fit for purpose IT infrastructure including network, compute and storage. - The existing infrastructure has been poorly managed and maintained over the years. - A lack of in-house technical IT expertise. - A lack of strategic technical IT investment. Risk Controls; - Infrastructure Stabilisation Programme - Phase 1: deep dive commenced to identify detailed IT infrastructure issues – network element to be completed by May 2015. - Phase 2: a programme of work to address and upgrade to 21st Century IT infrastructure. Timetable tbc: current estimate April 2016. - Appropriate benefits realisation in the programme - Clear identification of dependency linkage between key programmes e.g. EPR, business objectives and underlying IT enablement.	MD	Apr-16	Jan-15	Monthly	5	4	20	na

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INFORMATICS003	Departmental Review	Medical Director's Office	Informatics Service	Organisational (Strategic)	There is a risk of failure of a trust wide implementation of a new EPR due to insufficient skilled resources in Informatics, significant time constraints (programme should have started earlier) and budgetary constraints (high risk that in adding the full costs of an EPR into the LTFM that there is insufficient capital for related and pre-requisite schemes - e.g. Infrastructure Remediation / MMH Infrastructure preparation / Business Plan schemes)	4	4	16	Cause - Significant time pressure to carry out a full EPR procurement and implementation in given time period prior to MMH opening - Significant dependency on underlying Infrastructure - Significant dependency on Informatics resource - Significant dependency on LTFM budget and capital allocation between EPR costs and other required capital schemes Risk Control - Recruitment of suitably skilled staffing resource for the EPR Programme and associated infrastructure programme. - Informatics LTFM will be prioritised to ensure appropriate funding is allocated to EPR and necessary dependencies. - Completion of the formal procurement process – SOC / OBC / OBS at speed in attempt to claw back time required for implementation - Managerial and Board support for programme ensuring investment in infrastructure dependencies and required resource is given priority. - Management time will be given for programme elements (benefit realisation / change processes etc.) - Setup of appropriately manned programme board with strict governance and TORs - Development of contingency plans in relation to clinical IT systems will be established to ensure that if there is any slippage (for example a TDA query / Legal challenge) there is an alternative and fully considered option.	MD	Nov-18	Jan-15	Monthly	4	4	16	na

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INFORMATICS004	Departmental Review	Medical Director's Office	Informatics Service	Organisational (Strategic)	There is a risk of a breach of patient or staff confidentiality due to inadequate information security systems and processes which could result in regulatory and statutory non-compliance.	4	4	16	Cause: - Not fit for purpose Security Infrastructure which has been poorly managed and maintained - Poor skill sets within Informatics regarding Security / Information Security - No dedicated security manager within Informatics - Lack of time and resource spent on IGTK compliance within Informatics Risk Control - Increased investment required across security infrastructure – determinant on LTFM review. - Security manager recruited to bring immediate focus to upgrades, improvements and IGTK and best practice activities. - Review all NHS National mandates for Informatics and clinical systems and ensure compliance - Deep discovery activities required to bring out any 'under the cover' issues - End of XP and Windows 2003 support to be given higher priority to ensure issue is mitigated (windows 7 migration). This could involve the use of external consultancy companies to speed up the process.	MD	Oct-15	Jan-15	Monthly	2	4	8	na
COO1503001	Trauma peer review	Medicine and Emergency Care	ED	Clinical	Not all shifts have an appropriately trained trauma nurse on duty due to a lack of nurses trained in ATNC or equivalent which could compromise the quality of care.	5	3	15	All shift coordinators have ATLS qualifications. The Staff running the resus area particularly do not necessarily have trauma qualifications. The peer review team advised that these staff should have the Advanced Trauma Nurse Course (ATNC) or equivalent. The staff will be scheduled to attend training. In the meantime local trauma teaching will take place as a re-fresher session.	COO	30.5.15		monthly	2	3	6	na

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COO1503004	Clinical and operational	Imaging	Interventional radiology	Operational	Reduced ability to provide an Interventional Radiology service as a result of difficulties in recruiting Interventional Radiology consultants results in delays for patients and loss of business.	4	3	12	Service covered weekdays resulting in potential delays for patients presenting out of hours. Clinically these cases may be appropriate to manage in a scheduled service. If clinically required urgent patients will be transferred to another local centre with 24/7 cover. The intention is to secure alternative and robust 24/7 cover arrangements through recruitment, and partnership arrangements through a network approach with other providing organisations. Current recruitment includes extending the search for locums; also consider recruitment from abroad. Develop collaboration with Dudley - supports service resilience and potentially better chances of joint recruitment. Immediate potential for joint appointment of fellow or specialist doctor. Explore options to develop extended roles for radiographer or nurse to cover some procedures. Revisit previous plans to consolidate services onto one site to make cover easier to manage.	COO	Appointment of fellow / specialist doctor; clear plans agreed for other actions - end Q1 15/16	19/03/2015	Fortnightly	2	3	6	na
CEO1503001		Corporate Operations		Operational	Clinical Groups are unable to transact basic business processes because of key person gaps resulting in performance delays and failures.	4	4	16	Executive Group weekly monitoring of recruitment processes; investing in high quality agency staff to cover gaps; peer support network set up by COO for existing staff to buddy with high quality agency staff. Interview timetable for Director of Operations scheduled for mid may conclusion.	COO	30/06/2015	Mar 15	Weekly	4	3	12	na
PROPOSED ADDITIONAL RISKS																	

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201503NYOBS01		Women's and Child Health	Maternity	Operational	Current capacity is restricted resulting in a number of women having dating USS performed > 12/40 and some being outwith the screening window and therefore not receiving screening as per National NSC guidelines which results in the potential for an inequitable service for those women choosing to book at SWBH.	3	5	15	Existing Controls: • Implemented alternative ways of providing services to minimise impact. ✓ Bank / Agency Sonographers / scanning midwives ✓ Additional Clinics • Task group established to monitor and manage. • HR/Recruiting policies designed to support managers to recruit where there are difficulties to recruit. • Ongoing review of referrals to ensure inappropriate scans are not being undertaken and requests are in line with best practice guidance. Additional Controls: • Link action to workforce planning methodologies. • Support Groups to link in with Recruitment to support "Open Days" and other innovative methods to recruit.	COO	01/06/2015	Mar 15	Monthly	2	5	10	na

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		Women's and Child Health	Gynaecology	Clinical	Provision of ultra sound support for Gynaecology services is at risk due to difficulties in recruitment and retention of ultra-sonographers which results in the potential for delayed diagnoses, failure to achieve 31day cancer investigation targets plus impacts on the one-stop community service contract.	3	4	12	Existing Controls: • Ultra sound services currently actively recruiting externally. • Training provided to support the development of sonographers in house. • Developing pathways for other multi professional to take up elements of sonographers role. (i.e midwives completing dating scan service.) • Prioritising work and concentrating on high risk areas i.e. EPAU and Emergency Gynaecology, PMB. • Use of agency staff to cover gaps in the current service. Additional Controls: • Radiology directorate considering more 'creative' advertising, offering incentives. • Consider consolidating CGS to 2 venues at City and Sandwell where scan provision can be utilised more appropriately. Update: Due to the continued attrition of sonographers the Group lacks confidence that the sonography team will be able to maintain attendance at all community gynae clinics given the low priority a one stop outpatient clinic will have compared to urgent / emergency activity. A worsening position is anticipated.	COO	01/06/2015	Apr 15	Monthly	3	4	12	na

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201409NYOBS02		Women's and Child Health	Community Midwifery	Operational	BadgerNet connectivity problems associated with the use of I Pads is affecting Community Midwives' (CMW) ability to access/ update patient live records.	4	4	16	Existing controls: • Connectivity issues reported to EPR team via the IT Service Desk for investigation. • A proforma has been developed to enable CMW to send critical information to the IT service desk. • Utilisation of local super users and dedicated midwife for day- to- day support. Additional controls: • IT Service Desk exploring solutions, e.g. enable access onto GP computers, establish uninterrupted WIFI 4G connection.	COO	01/06/2015	Apr 15	Monthly	3	4	12	na

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	Operational issue	Women's and Child Health	Maternity and neonatal	Clinical	National shortage of intradermal BCG vaccination leading to a potential increase in babies affected with TB.	5	4	20	Existing Controls: • Pooling all available vaccines from other areas in the Trust including the Paediatric Clinic BTC and Occupational Health. • Getting the maximum number of doses out of each vial when opened to prevent unnecessary wastage. • A vial is not opened unless there are a sufficient number of infants to vaccinate. • All the community midwives informed that infants will be discharged without being vaccinated. Additional Controls: • Record all infants who are discharged from Maternity and Neonates who qualify but don't receive the vaccine. • Pharmacy locating other areas in the Trust that they distribute BCG vaccine to and sending them to Maternity. • To inform all parents of eligible infants of the shortage of the vaccine and how to raise any concerns with relevant agencies. • Clinics to be set up from May 2015 onwards to enable infants to return and be vaccinated when the BCG vaccine is available. • Advise community midwives and parents to be extra vigilant in observing and referring infants where necessary. • Inform Paediatrics and the HV of potential admissions.	COO	30/06/2015	Apr 15	Monthly	4	4	16	na

Ref: **201503NYOBS01** **Obstetrics Scanning Capacity RISK ASSESSMENT**

DIVISION	Women & Children's	WARD/DEPARTMENT	Obstetrics		
ASSESSOR	Nicola Robinson / Elaine Newell	ASSESSMENT DATE	19.03.15	REVIEW DATE	
SCOPE OF ASSESSMENT	Current capacity is restricted and is resulting in a number of women having dating USS performed > 12/40 and some being out with the screening window and therefore not receiving screening as per National NSC guidelines- inequitable service for those women choosing to book at SWBH.				

RISK TREATMENT PLAN

ACTION (inc Cost/Resource implications)	BY WHEN	BY WHOM	DATE ACHIEVED
Link action to workforce planning methodologies.	01.06.15	DGM/ HOS /	
Support Groups to link in with Recruitment to support "Open Days" and other innovative methods to recruit	01.06.15	Clinical group	

HAZARD	WHO/WHAT COULD BE HARMED/ DAMAGED?	EXISTING CONTROLS	L	S	RR	ADDITIONAL CONTROLS	L	S	RRR	FI
Scan capacity is currently restricted which could result in women being denied a dating scan before <12/40 & combined screening within the recommended timeframe as per NSC screening guideline.	• Mom Unborn babies Staff Trust	• Implemented alternative ways of providing services to minimise impact. ✓ Bank / Agency Sonographers / scanning midwives ✓ Additional Clinics • Task group established to monitor and manage. • HR/Recruiting policies designed to support managers to recruit where there are difficulties to recruit. • Ongoing review of referrals to ensure inappropriate scans are not being undertaken and requests are in line with best practice guidance	3	5	15	• Link action to workforce planning methodologies. • Support Groups to link in with Recruitment to support "Open Days" and other innovative methods to recruit.	2	5	10	

Appendix B: WCH risk assessments

RISK ASSESSMENT: Provision of ultra sound support for Gynaecology services is at risk due to difficulties in recruitment and retention of ultra-sonographers which results in the potential for delayed diagnoses, failure to achieve 31day cancer investigation targets plus impacts on the one-stop community service contract.

GROUP	Women's and Child Health	**WARD/DEPARTMENT**	Emergency Gynaecology, Community Gynaecology, PMB service, Gynae Oncology, In patient gynaecology.		
ASSESSOR	Lis Hesk	**ASSESSMENT DATE**	9.4.15	**REVIEW DATE**	
SCOPE OF ASSESSMENT	• To consider the impact of ultra sonographer cover in Emergency Gynaecology, provision of service to EPAU / EGAU • Currently Ultra sound provide support to the 6 Community Gynae Clinics to provide a one stop service, as commissioned by CCG's • Post Menopausal Bleeding pathway requires a one stop service including ultra sound support, for all women presenting with PMB. This is part of the 2 week referral pathway. • Provision of ultra sound support for Gynaecology services at risk due to difficulties in recruitment and retention of ultra sonographers				

	RISK	WHO OR WHAT COULD BE HARMED OR DAMAGED?	EXISTING CONTROLS	CURRENT RISK RATING	ADDITIONAL CONTROLS	RESIDUAL RISK RATING
1.	Ultra sound scan support is a key investigation in making a gynaecological diagnosis and formulating a treatment plan for all aspects of emergency and elective gynaecology and Gynae oncology. Provision of a 'one stop' gynaecology service both in Community Gynaecology and PMB service are recommendations according to NICE guidance and compliant with the RCRH philosophy. Failure to provide ultra sound support to gynaecology services could result in delayed diagnosis and failure to achieve 31day cancer investigation targets.	Patients due to potential delay in diagnosis. Trusts reputation due to failure to achieve cancer diagnosis within the required 31 day pathway. Financial implications due to inability to achieve required cancer 31 day targets. Potential to withdraw service for Community Gynaecology when this is re tendered due to inability to provide a one stop service.	• Ultra sound services currently actively recruiting externally. • Training provided to support the development of sonographers in house. • Developing pathways for other multi professional to take up elements of sonographers role. (i.e midwives completing dating scan service.) • Prioritising work and concentrating on high risk areas i.e. EPAU and Emergency Gynaecology, PMB. • Use of agency staff to cove gaps in the current service.	3 X 4 = 12	• Radiology directorate considering more 'creative' advertising, offering incentives. • Consider consolidating CGS to 2 venues at City and Sandwell where scan provision can be utilised more appropriately.	3 x 4 = 12

	ACTION	BY WHEN	BY WHOM	DATE ACHIEVED
1.	Radiology directorate considering more 'creative' advertising, offering incentives.			
2.	Use of agency staff to cove gaps in the current service.			
3.	Consider consolidating CGS to 2 venues at City and Sandwell where scan provision can be uterlised more appropriately.			

Ref: 201409NYOBS02

Community Badger net access (MIS) RISK ASSESSMENT

DIVISION	Women & Children's	**WARD/DEPARTMENT**	Community Midwifery Service		
ASSESSOR	Nicola Robinson	**ASSESSMENT DATE**	18.09.14	**REVIEW DATE**	18.03.15
SCOPE OF ASSESSMENT	With the implementation of the Badger Net system , there is evidence from Community Midwives that there are technical problems associated with the use of I Pads in particular to do with connectivity i.e.: Wi-Fi, 4G and access via VPN. This is affecting access to the system due to loss of connectivity which in turn is affecting CMW ability to access/ update patient live records.				

RISK TREATMENT PLAN

ACTION (inc Cost/Resource implications)	**BY WHEN**	**BY WHOM**	**DATE ACHIEVED**
To enable upload of Badger net onto GP computers for easier access for CMWs	31.01.15	IT / EPR Team	
To establish uninterrupted WIFI 4 G connection.	31.03.15	IT / EPR team	

HAZARD	**WHO / WHAT COULD BE HARMED / DAMAGED?**	**EXISTING CONTROLS**	**L**	**S**	**RR**	**ADDITIONAL CONTROLS**	**L**	**S**	**RRR**	**FI**
Loss of connectivity within the community setting for midwives affecting the record keeping of live patient notes, which could lead to essential information not being available in real time or indeed not at all.	• *Patients* • *Staff* • *Trust*	• Connectivity issues reported to EPR team via the IT Service Desk for investigation. • A proforma has been developed to enable CMW to send critical information to the IT service desk. • Utilisation of local super users and dedicated midwife for day- to- day support.	4	4	16	• *IT Service Desk exploring solutions, e.g. enable access onto GP computers, establish uninterrupted WIFI 4G connection.*	3	4	12	

BCG Obstetric RISK ASSESSMENT

DIVISION	Women and children	**DEPARTMENT**	Inpatient Services		
ASSESSOR	Esther Rackley	**ASSESSMENT DATE**	07/04/2015	**REVIEW DATE**	Mid May 2015
SCOPE OF ASSESSMENT	Maternity and Neonatal. National shortage of intradermal BCG vaccination leading to a potential increase in babies affected with TB				

ACTION PLAN

ACTION	BY WHEN	BY WHOM	DATE ACHIEVED
Making a comprehensive list of all infants who are discharged from Maternity and Neonates who qualify but don't receive the vaccine in order to facilitate recall at a later date.	April 2015	E Rackley	07/04/2015
Pharmacy to locate other areas in the Trust that they distribute BCG vaccine to and redirect supply to Maternity.	April 2015	John Persaud	
To inform all parents of eligible infants of the shortage of the vaccine and what arrangements have been put in place in order to ensure that vaccination is given at a later date.			
Clinics to be set up from May 2015 onwards to enable infants to return and be vaccinated when the BCG vaccine is available.	June 2015	Head of Service Paeds and Childrens Services	
Advise community midwives and parents to be extra vigilant in observing and referring infants where necessary.	April 2015	Lydia Nestor	
Inform Paediatrics and the HV of potential admissions.	April 2015	. Head of Service Paeds and Childrens Services	

HAZARD	WHO/WHAT COULD BE HARMED/DAMAGED?	EXISTING CONTROLS	CURRENT RISK RATING	ADDITIONAL CONTROLS	RESIDUAL RISK RATING
National shortage of the BCG Vaccine at least until the beginning of May.	All infants born at SWBH who meet the WHO criteria for Vaccination.	• Pooling all available vaccines from other areas in the Trust including the Paediatric Clinic BTC and Occupational Health. • Getting the maximum number of doses out of each vial when opened to prevent unnecessary wastage. • A vial is not opened unless there are a sufficient number of infants to vaccinate. • All the community midwives Informed that infants will be discharged without being vaccinated	5x4=20	• Record all infants who are discharged from Maternity and Neonates who qualify but don't receive the vaccine. • Pharmacy locating other areas in the Trust that they distribute BCG vaccine to and sending them to Maternity. • To inform all parents of eligible infants of the shortage of the vaccine and how to raise any concerns with relevant agencies. • Clinics to be set up from May 2015 onwards to enable infants to return and be vaccinated when the BCG vaccine is available. • Advise community midwives and parents to be extra vigilant in observing and referring infants where necessary. Inform Paediatrics and the HV of potential admissions.	4x4= 16

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:	7th May 2015

EXECUTIVE SUMMARY:

This report is an update using the data collected during March 2015.
The data from the national reporting system has been applied to our own expected staffing data to help understand our nurse staffing position.
Our information team have undertaken a random audit on three wards to check for any reliability or integrity problems in the data, none have been identified. The Group Directors of Nursing are undertaking a deep dive into the data to help with increasing validity and organisational understanding.
Quality indicators collected in ward based dashboards are attached from Medicine and Emergency care, and Surgery A in addition the ward review dialogue from Community and therapies. No real trends can be observed at this point in time but continued work on this will monitor any trending in the longer term.

REPORT RECOMMENDATION:

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 June 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		Patient Experience	X
Clinical	**X**	Equality and Diversity		Workforce	X

Comments:

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

Relates to our safety objectives and BAF

PREVIOUS CONSIDERATION:

Considered monthly.

FOR INFORMATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAFE NURSE STAFFING

Report to Trust Board on 7th May 2015

1 EXECUTIVE SUMMARY

1.1 This report is an update using the data collected during March 2015.

1.2 The data this month has also had a number of quality indicators applied to the Medicine and Emergency Care group, and Surgery A.

1.3 The data from the national reporting system has been applied to our own expected staffing data to help understand our nurse staffing position.

1.4 Three wards were randomly selected by the information team to re test the staffing data for accuracy.

2 MARCH 2015 POSITION

2.1 Table 1. is the output data from the national data collection for March 2015 which demonstrates that we achieve higher fill rates against our rota's in most areas. The quarterly summary figures in table 1. demonstrate that there are no major variation in actual staffing of the wards over the period. Higher levels of additional Registered Nurses and Health Care Assistants staff are consistently being used at night.

Table 1.

	Safe Staffing data return - Summary (Mar15)		Day				Night							
			Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Day		Night	
	Site Code	Site 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	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Jan-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2123.25	2227.333	505.5	492.25	582.75	555	129.5	157.5	104.9%	97.4%	95.2%	121.6%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
	RXK02	CITY HOSPITAL	30328.5	30574.63	15962.5	15937.82	18989.5	20653.42	7731	8767.25	100.8%	99.8%	108.8%	113.4%
	RXK10	ROWLEY REGIS HOSPITAL	2919	3183.5	3472.5	3411.5	1333	1558.5	1429	1542.25	109.1%	98.2%	116.9%	107.9%
	RXK01	SANDWELL GENERAL HOSPITAL	29286.5	30702.12	17609.5	19883.43	16561.5	18341	8455	11660.25	104.8%	112.9%	110.7%	137.9%
			64657	66688	37550	39725	37467	41108	17745	22127	103.1%	105.8%	109.7%	124.7%
Feb-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1867.25	2053.5	464.5	462	490.25	518	129.5	101.75	110.0%	99.5%	105.7%	78.6%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
	RXK02	CITY HOSPITAL	27390.25	27677.75	14544.5	14620.48	17409.5	18193.92	6915.5	7414.25	101.0%	100.5%	104.5%	107.2%
	RXK10	ROWLEY REGIS HOSPITAL	2542	2743.25	3000.5	3185.5	1194.5	1192	1457.5	1407	107.9%	106.2%	99.8%	96.5%
	RXK01	SANDWELL GENERAL HOSPITAL	25298.5	27136.1	14521.5	16240.82	14720	16798	7292	9867.25	107.3%	111.8%	114.1%	135.3%
			57098	59611	32531	34509	33814	36702	15795	18790	104.4%	106.1%	108.5%	119.0%
Mar-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2353.25	2352.417	501.5	447	573.5	565.25	148	139.5	100.0%	89.1%	98.6%	94.3%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
	RXK02	CITY HOSPITAL	29823.73	30744.15	16727.5	15515.32	18670	21136.23	7507.5	7752	103.1%	92.8%	113.2%	103.3%
	RXK10	ROWLEY REGIS HOSPITAL	2702.5	3084.9	3546.75	3896.583	1211.5	1717.75	1670.5	2067	114.1%	109.9%	141.8%	123.7%
	RXK01	SANDWELL GENERAL HOSPITAL	28133.5	30365.28	15989.5	17373.25	15995	20147.07	7760.517	10975.02	107.9%	108.7%	126.0%	141.4%
			63013	66547	36765	37232	36450	43566	17087	20934	105.6%	101.3%	119.5%	122.5%
3-month Avges	*RXK03*	*BIRMINGHAM MIDLAND EYE CENTRE (BMEC)*	*2114.583*	*2211.083*	*490.5*	*467.0833*	*548.8333*	*546.0833*	*135.6667*	*132.9167*	104.9%	95.3%	99.8%	98.1%
	RXKTC	*BIRMINGHAM TREATMENT CENTRE*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0.0%	0.0%	0.0%	0.0%
	RXK02	*CITY HOSPITAL*	*29180.83*	*29665.51*	*15744.83*	*15357.87*	*18356.33*	*19994.52*	*7384.667*	*7977.833*	101.6%	97.7%	108.8%	108.0%
	RXK10	*ROWLEY REGIS HOSPITAL*	*2721.167*	*3003.883*	*3339.917*	*3497.861*	*1246.333*	*1489.417*	*1519*	*1672.083*	110.4%	104.8%	119.5%	109.4%
	RXK01	*SANDWELL GENERAL HOSPITAL*	*27572.83*	*29401.17*	*16040.17*	*17832.5*	*15758.83*	*18428.69*	*7835.839*	*10834.17*	106.7%	111.1%	116.9%	138.2%
	Total	*Latest 3 month average====>*	61589	64282	35615	37155	35910	40459	16875	20617	104.4%	104.4%	112.6%	122.1%

Table 2 and 3 demonstrate the expected numbers of Registered Nurses and Health Care Support staff we plan to be on our rosters over the 24 hour day using the agreed nursing and midwifery staffing establishments. 2% of additional shifts for Registered nurses and 4% of additional shifts for Healthcare Support staff are used for focused care, based on the declaration of why additional staff are required on the Trust nurse bank data base.

Table 2

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon/Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during March 2015	Percentage night time fill rate during March 2015	Morning HCSW expected	Afternoon/Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during March 2015	Percentage night time fill rate during March 2015
Medicine & Emergency care	D5	City	13	5	5	5	see	D7	1	1	0	see	D7
	D7	City	19	3	3	3	97	94.5	1	1	0	89.6	169.6
	D11	City	21	3	3	3	109	124.7	2	2	1	91.6	103.6
	D12	City	10	2	2	2	74	84.2	1	1	1	90.7	92.7
	D15	City	24	3.5	3.5	3	99.3	183.5	2	2	1	112.9	100
	D17	City	25	3.5	3.5	3	126.8	164.8	2	2	1	98.7	149.5
	D26	City	21	3	3	3	81.4	88.3	2	2	1	89.1	61.7
	AMU 1	City	41	10	10	10	108.8	143.7	4	4	4	92.9	108
	AMU 2	City	19	5	5	5	105.7	125.3	1	1	1	100.6	103.7
	CCU Sandwell	Sandwell	10	3	3	3	102.8	118.2	0	0	0	78.9	0
	PR4	Sandwell	25	7	7	7	89.5	108.4	3	3	3	82.3	119.1
	PR5	Sandwell	34	5	5	4	97.9	103.6	3	3	2	95.1	101.9
	NT4	Sandwell	28	4	4	4	130.7	171.2	3	3	3	178.2	195.9
	LY 4	Sandwell	34	5	5	4	156.2	263.6	3	3	2	125.4	145.6
	LY5	Sandwell	29	4	4	4	89.6	95.8	4	4	2	87.7	107
	N5	Sandwell	15	5	5	2	102.6	101.8	1	1	1	134.3	0
	AMU A	Sandwell	32	11	11	11	112.4	118.1	4	4	3	102.4	151.7
	AMU B	Sandwell	20	3.5	3.5	3	111	140.9	3	3	3	111.7	135.2

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon/Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during March 2015	Percentage night time fill rate during March 2015	Morning HCSW expected	Afternoon/Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during March 2015	Percentage night time fill rate during March 2015
Surgery A	D21	City	23	4	4	2	103.9	108.1	2	2	2	93.6	82.9
	D25	City	19	4	4	2	91.9	126.9	2	2	2	85.7	107.9
	SAU	City	14	4	4	3	151.2	152.9	1	1	1	98.6	0
	N2	SGH	24	4	3	2	107.9	131.8	2	2	1	88.4	165.2
	L2	SGH	20	6	6	4	102.3	142.7	3	3	2	92.8	115.4
	P2	SGH	20	4	4	2	104	128.1	3	3	2	110.6	166.6
	N3	SGH	33	6	6	3	117.1	125.4	4	4	3	123.2	146.8
	L3	SGH	33	6	6	3	107.3	123.9	4	4	3	105.1	119.4
	CCS	City		Staff flexed to the dependency/number of patients in the units			114.3	112.5	Staff flexed to the dependency/number of patients in the units			91.8	200
	CCS	SGH					101.6	121.3				126.2	0

Table 3

Community & Therapies	Ward	site	No. Beds	Morning shift RN's expected	Afternoon/Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during March 2015	Percentage night time fill rate during March 2015	Morning HCSW expected	Afternoon/Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during March 2015	Percentage night time fill rate during March 2015
	Henderson	RH	24	3	3	2	143.1	195.5	3.5	3.5	2.5	112	165.7
	Elisa Tinsley	RRH	24	3	3	2	100.7	112.4	3.5	3.5	2.5	113.9	107.1
	D43	City	24	6	6	4	119.3	322.4	5	5	2	102.2	103.1
	Leasowes	RH	20	3	3	2	107	139.1	3	3	2	104.3	112.2

Surgery B	Ward	site	No. Beds	Morning shift RN's expected	Afternoon/Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during March 2015	Percentage night time fill rate during March 2015	Morning HCSW expected	Afternoon/Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during March 2015	Percentage night time fill rate during March 2015
	Eye ward	City	10	2	2	2	100	98.6	1	1	0	89.1	94.3

Women's and Children's	Ward	site	No. Beds	Morning shift RN's expected	Afternoon/Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during March 2015	Percentage night time fill rate during March 2015	Morning HCSW expected	Afternoon/Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during March 2015	Percentage night time fill rate during March 2015
	L G	SGH	14	3	3	2	135.7	155	1	1	1	143.2	0
	L1	SGH	26	5	5	4	124.3	136.2	3	3	2	86.1	130.6
	D19	City	8	3	3	2	105.6	110.2	1	1	0	109.5	0
	D27	City	18	4	3	2	102.9	106.3	2	2	1	94.5	143.4
	Maternity	City	42	6	5	4	95.7	99.2	4	4	2	73.6	91.1

Group Directors of Nursing have been re-energising ward reviews, taking into account multidisciplinary team working, analysis of ward dash boards is part of this process, I have attached dashboards for Medicine, Surgery A and the ward review report for Community and Therapies which gives an account from the leadership team about their range of indicators. Ward level data, group level summary and ward by ward reviews demonstrate the governance process that is undertaken by the clinical teams, this information is also presented by the Group Directors of Nursing at the Chief Nurse business meeting, where results are challenged by the team and actions agreed to seek improvement.

3 RECOMMENDATION(S)

3.1 To continue to develop the application of quality indicators alongside the staffing data, and over time identify trends

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

3.2 To receive an update at the June Trust Board meeting

Colin Ovington

Chief Nurse

30th April 2015

Appendix 1 – Medicine & Emergency Care Dashboard

Nursing Quality, Safety and Patient Experience Dashboard

Leading the Culture of Compassionate Care

	Area	Unit	CITY									Sandwell								
			D11	D12	D15	D17	D26	AMU1	AMU2	D5	D7	L4	P4	N4	L5	N5	P5	CCU	AMU A	AMU B
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100	100	60	78	100	70	100	100	100	87.5	100	100	100	100	100	100	100	100
	Nutrition Audit (MUST)	Score %	96	100	60	44	100	70	100	100	91	77.5	100	100	96	100	98	100	100	66.6
	Fluid Balance Audit	Score %	100	100	100	100	100	70	100	90	100	60	100	100	80	100	100	100	93	0
	Pain Audit (CQUIN)	Score %	100	No data	No Data	100	100	100	94	N/A	N/A	100	100	100	100	100	100	100	100	62.5
	Safe storage of drugs audit	Score %	100	a/w data	a/w data	76.4	100	No data	No data	N/A	N/A	Pass	88	98	100	100	80	No data	98	94.74
	Compliance against drug safety cross	Score %	87.09	87	77.4	1	71	No data	No data	100	93	67	93.5	98	97	81	100	93.5	70.9	92.31
	Observation Chart Audit	Score %	97	99	100	100	99	Vitalpac	Vitalpac	100	100	81	100	100	100	100	100	N/A	71	62.5
	Falls Risk Assessment Audit	Score %	100	N/A	20	74	100	90	100	100	82	86.6	100	100	93	100	80	100	100	100
	Safety/Privacy & Dignity	Score %	73	100	100	98	100	100	100	N/A	N/A	90	100	100	90	100	100	No data	0	0
	Pressure Ulcers Avoidable (none hospital acquired)	Score %	0	0	0	0	0	0	0	1	2	0	0	0	0	0	3	0	0	3
	Pressure Ulcers Avoidable (hospital acquired)	Score %	1 (Grade 2)	0	0	0	1 (Grade 2)	4	2	0	0	0	0	2	0	0	0	0	4	0
	Falls (target <) no harm	Score %	3	1	1	1	1	2	2	1	1	3	5	3	0	0	3	0	0	3
	Falls (target <) resulting in harm	Score %	0	0	0	0	0			0	0	1	0	0	0	0	0	0	0	0
	Dementia screening audit	Score %	0	N/A	N/A	100	100	100	100	100	100	100	100	100	100	100	100	100	98	91.67
	Safety Thermometer (No new harm)	Score %	0	100	100	100	0	100	100	100	100	0	100	100	100	100	100	100	100	100
	Incidents Total (inc Falls)	No of	22	4	6	26	11	25	32	8	13	23	38	12	15	2	20	14	41	24
	Incidents (red)	No of	0	0	0	0	0	0	0	0	0	1	0	0	1	1	0	0	0	0
	Incidents (amber)	No. of	0	0	1	0	1	1	1	4	7	4	1	0	1	0	1	4	15	4
	PALS Queries	No of	0	0	0	1	0	1	0	0	0	0	1	0	1	0	1	0	1	2
	Compliments	No. of	6	6	5	10	5	4	6	No data	No data	5	25	34	12	76	16	3	6	8
	Complaints	No. of	0	0	0	0	0	1	0	0	0	0	2	0	1	0	2	0	1	2
	Likely to/Extremely Likely to Recommend our Hospital	Score (%)	71	100	100	100	68	96.61	91.3	100	100	93	100	100	No data	No data	60	87.5	78	60
	Mixed Sex Breaches	No. of	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	10/10 Standard	Score (%)	100	100	100	0	100	No data	No data	100	100	100	80	100	90	100	100	100	83	100
Infection Prevention and Control	MRSA	Total Eligible Screened w ithin 28 days (%)	0	0	0	0	0	93.17	93.82	0	1	0	0	1	0	1	82	92.86	92.1	89.47
	C Diff	No. of	0	0	0	0	0	0	0	0	1	1	0	5	0	0	0	0	0	2
	E-Coli	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
		No. of Bloodstream YTD	0	0	0	0	0	100	0	0	0	0	0	0	0	1	0	0	0	0
	Hand Hygiene	Score (%)	96	98	98	100	100	No data	No data	100	100	96	100	100	97	100	96	No data	100	90
	ESBL	Score (%)	0	0	0	0	0	No data	No data	0	0	0	0	1	0	0	0	0	0	0
	VRE	No of	0	0	0	0	0	No data	No data	No data	0	0	0	0	0	0	0	0	0	0
	Ward Cleanliness	Score (%)	100	100	51.6	48	100	No data	No data	No data	No data	Pass	100	100	No data	92	100	96.2	100	100
	Compliance against environmental standards	Score (%)	100	99	a/w data	78	100	0	0	No data	No data	Pass	89	95	100	100	80	35.4	100	0
	Outbreaks	No. of	0	0	0	0	0	No data	No data	0	0	0	0	1	0	0	0	0	0	0
	Post infection reviews	No. of	0	0	0	0	0	94.7	No data	0	1	0	0	4	0	1	0	N/A	0	0
	Cannulas (VIP), (CAUTI's)	Score (%)	98 VIP	100	100	20	100	No data	No data	80	80	77	100	100	90	100	100	100	87	100
Patient Flow	No of days daily discharge goals achieved No of days where 16 beds are available at 9pm (AMUs)	No. of	8	15	9	9	7	0	3	39%	55%	No data	6/31	7/30	No data	4	17	15	No data	No Data
	No of days where patient discharged before lunch	No. of	11	3	17	15	1			11	3	No data	4	8	No data	2	7	14	N/A	N/A
	Vacancies Band 7	No. of	0	0	0	0	0			1	1	0	0	0	0	0	0	0	0	0
	Vacancies Band 6	No. of	0	0	0	1	0			2.57	2.57	0	1	0	0	0	1	0.5	0.39	0
	Vacancies Band 5	No. of	4.73	1.78	5.31	7.1	4.81	2.9	3.87	0	0	No data	1	3.3	3.35	0	3	0	6	5
	Vacancies Band 2	No. of	3.83	0.2	0	0	3.83	2.52	1.13	0	0	0	3	2.23	0	0.4	0	0	-1	-0.92
	Sickness long term	%	No data	13.08	11.6	1.36	2.93	5.42	5	0	0	10.6	2	0.4	5.76	3.95	2.5	1.45	0	0
	Sickness short term	%	No data	4.09	0.27	1.22	4.38	Y	Y	3.6	3.6	2.3	5.46	5.64	6.9	0	2.5	1.78	2.46	17.3
Staffing	Sickness total	%	No data	8.27	12.56	5.56	7.31	No data	No data	3.6	3.6	12.9	7.46	0.6	12.66	3.95	5	3.23	2.46	17.3
	No of specials used	No. of	No data	0	0	0	2.18	84.31	100	1	0	53	49	27.6	124 hrs	0	0	0	N/A	N/A
	Is the ward compliant with Erostering rules?	Y/N?	Y	Y	Y	Y	Y	82.48	86.5	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Brad Score		No data	a/w data	a/w data	No data	No data	No data	No data	No data	No data	No data		Total WTE 1680.42 Rec WTE 64.07 Actual WTE 31.90 Budgeted WTE 36.59	No data	No data	95.85	100	n/a	n/a
	PDR %	%	93.55	26.6	12.5	39.29	93.1	N	N	72	72	100	100	100	93.31	100	95	100	87	72.73
	Mandatory Training %	%	90.69	87.6	80.5	84	81.02			89	89	79	83.11	88.19	78	92.19	80	92.31	81.4	82
Finance	Is the ward in budget? (Record overall position)	Y/N	N -£74,182	Y	N	N	N (-£234,160)			N (-£71,120 end Feb 15)	N (-£71,120 end Feb 15)	N -£59,236	Y (income generation +£5813)	No actions in place	N	N	N (-£160k)	N (-£4325)	Y	N
	Did monthly finance meeting take place?	Y/N	N	N	N	N	N			N	N	Y	N	N	N	N	N	N	N	N

Appendix 2 – Surgery A Dashboard

WARD ASU

Leading the Culture of Compassionate Care

	Area	Unit	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	NA	NA	NA	NA	100%	100%	100%	100%	100%		100%
	Documentaion Audit	Score %											#DIV/0!
	Pain Audit (CQUIN)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%
	Missed Dose Audit	Score %					100%	100%	100%	100%	100%		100%
	Medicine Audit	Score %											#DIV/0!
	Drugs Storage	Score %					100%	100%	100%	100%	100%		100%
	CD Audit	Score %				72%	100%	100%	100%	100%	100%		95%
	Falls Risk Assessment Audit	Score %	NA	NA	NA	NA	100%	100%	100%	100%	100%		100%
	Safety/Privacy & Dignity	Score %	NA	NA	NA	NA	100%	100%	100%	100%	100%		100%
	Falls (target =0)	No. of	NA	NA	NA	NA	0	0	0	0	0		0%
	10 Out of 10	Score %					NA	100%	100%	95%	100%		99%
	Incidents Total (inc Falls)	No of	7	11	6	14	15	1	8	11	9		9.11
	Incidents (red)	No of	0	0	0	0	0	0	0	0	0		0
	Incidents (amber)	No. of	1	3	1	3	1	0	3	2	0		2
Patient Experience	PALS Queries	No of	0	0	0	2	1	0	0	1	0		0
	Compliments	No. of	2	3	3	2	3	5	3	6	4		3
	Complaints	No. of				0	1	0	1	0	0		0
	FFT Overall Results	Score (%)	0%	100%	100%	99%	98.25%	92%	100%	78%	77%		83%
	FFT Response Rate	Score (%)	100%	100%	25%	100%	100%	100%	100%	100%	100%		92%
	Mixed Sex Breaches	No. of	0	0	0	0	0	0	0	0	0		0
Infection Prevention and Control	MRSA	Screening % Emergency	0%	0	0	0	0	0	0	0	0		0
		Screening % Elective	93.44%	93.66%	94.52%	97%	96%	95%	98%	97.37%			96%
		No. of Bloodstream	0	0	0	0	0	0	0	0	0		0
		No. of Clinicals	0	0	0	0	0	0	0	0	0		0
	C Diff	No. of	0	0	0	0	0	0	0	0	0		0
	MSSA	No. of Bloodstream	0	0	0	0	0	0	0	0	0		0
	E-Coli	No. of Bloodstream	0	0	0	0	0	0	0	0	0		0
	Hand Hygiene	Score (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%
	Ward Cleanliness	Score (%)	99%	99%	99%	98%	99%	99%	99%	99%	99%		99%
	Outbreaks	No. of	0	0	0	0	0	0	0	0	0		0%
	Cannulas (VIP)	Score (%)	NA	NA	NA	NA	40%	88%	98%	95%	100%		84%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)			1.2	1.2	1.2	0.2	0.6	0.6	1.6		0.84
	Sickness in Month with Trajectory of management	ST/LT Added Together %	13.23%	15.24%	20.90%	10.79%	12.96%	10%	5%	6.71%			12%
	Sickness long term	%	3.47%	10.24%	19.26%	5.68%	10.54	2.81		4.17%			197%
	Sickness short term	%	9.75%	4.99%	1.64%	5.10%	2.42	7.46		2.53%			145%
	Did monthly HR meeting take place?		?	?	?	?	YES	YES	YES	YES	YES		
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs			minu 157.5								
		No. of HCA's in Hrs	*	*	*	*							
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?				YES	YES	YES	YES	YES	YES		
	Documentation		NA	NA	NA	NA	80%	85%	90%	95%	100%		85%
	PDR %				80.00%	76.00%	66.60%	62.50%	84%	96%	100%		81%
	Mandatory Training % by Month		89.26%	88.87%	88.25%	90.70%	90.74%	92.14%	91.28%	95.98%	96.65%		92%
	Uniform Audit		NA	NA	NA	NA	80%	100%	100%	100%	100%		96%
Finance	Is the ward in budget? This month, last month, projection	Y/N				YES	YES	YES	YES	YES	YES		
	Did monthly finance meeting take place?	Y/N				YES	YES	YES	YES	YES	YES		

WARD CPAU

Leading the Culture of Compassionate Care

	Area	Unit	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	NA	NA	NA	NA	85.71%	100%	100%	100%	100%	97%
	Nutrition Audit (MUST)	Score %	NA	NA	NA	NA	20%	100%	100%	100%	100%	84%
	Drugs Storage	Score %	NA	NA	NA	NA	90%	100%	100%	100%	100%	98%
	Falls Risk Assessment Audit	Score %	NA	NA	NA	NA	80%	100%	100%	100%	100%	96%
	Safety/Privacy & Dignity/ Documentation Audit	Score %	NA	NA	NA	NA	100%	100%	100%	100%	100%	100%
	Falls (target =0)	No. of	0	0	0	0	0	0	0	0	0	0
	Wasted clinic slots	No. of	95	178	132	9	74	233	17	40	103	881
	Incidents Total (inc Falls)	No of				5	4	3		6		18
	Incidents (red)	No of			0	0	0	0	0	0	0	0
	Incidents (amber)	No. of			0	0	0	0	0	0	0	0
Patient Experience	PALS Queries	No of	0	0	1	0	0	0	0	0	0	1
	Compliments	No. of	3	1	1	0	1	0	1	1	1	9
	Complaints	No. of	0	0	0	0	0	0	0	0	0	0
	FFT Overall Results	Score (%)			NA	NA	NA	NA	NA	NA	NA	#DIV/0!
Infection control	MRSA	Screening % Elective			100%	100%	100%	100%	100%	100%	100%	100%
	CRO	Screening % Elective	NA	NA	NA	NA	NA			100%	100%	100%
	Hand Hygiene	Score (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ward Cleanliness	Score (%)	95%	98%	97%	95%	98%	96%	98%	98%	98%	97%
Staffing	Vacancies (Exclude Ward Clerks)	No. of			2.8	2.8	0.8	0.8	0.8	0.8	1.8	10.6
	Sickness in Month with Trajectory of management	ST/LT Added Together %	10.61%	7.07%	8.51%	14.23%	14.29%	19.73%	22.76%	15.45%		14%
	Sickness long term	%	5.81%	5.81%	5.81%	5.81%	12.39%	15.07%	19.46%	12.19%		10%
	Sickness short term	%	4.80%	1.26%	2.70%	8.42%	1.90%	4.66%	3.30%	3.26%		4%
	Did monthly HR meeting take place?	Y/N	Yes	Yes	Yes	Yes	Yes	Yes	Y	Yes	Yes	
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs			0	0	0	0	0	0	0	0
		No. of HCA's in Hrs			0	0	0	0	0	0	8	8
	PDR %		90%	94.70%	94.70%	96.40%	100.00%	94.12%	100%	100%	100%	97%
	Mandatory Training % by Month		93.75%	92.97%	96.80%	96.34%	97.45%	96.63%	94.72%	96.24%	94.35%	95%
	Uniform Audit						97.61%	100%	100%	100%	100%	100%
Finance	Is the ward in budget? This month, last month, projection	Y/N			Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	Did monthly finance meeting take place?	Y/N	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

WARD CPAU Sandwell

Leading the Culture of Compassionate Care

	Area	Unit	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average
Patient Safety	Tissue Viability Audit (Waterlow)	Score %										100%	100%	100%	
	Nutrition Audit (MUST)	Score %										100%	100%	100%	
	Drugs Storage	Score %										n/a	n/a	n/a	
	Falls Risk Assessment Audit	Score %										100%	100%	100%	
	Safety/Privacy & Dignity/ Documentation Aud	Score %										100%	100%	100%	
	Falls (target =0)	No. of											0	0	
	Wasted clinic slots	No. of										42			
	Incidents Total (inc Falls)	No of											0	2	
	Incidents (red)	No of											0	0	
	Incidents (amber)	No. of											0	0	
Patient Experienc	PALS Queries	No of										0	0	0	
	Compliments	No. of										0	0	0	
	Complaints	No. of										0	0	0	
	FFT Overall Results	Score (%)										n/a	n/a	n/a	
Infection control	MRSA	Screening % Elective													
	CRO	No. screened	NA	NA	NA	NA	NA	NA	NA	NA					0
	Hand Hygiene	Score (%)										100%	100%	97%	
	Ward Cleanliness	Score (%)													
Staffing	Vacancies (Exclude Ward Clerks)	No. of										0.8	0.8	0.8	
	Sickness in Month with Trajectory of management	ST/LT Added Together %									19.73%	21.40%	15.23%		
	Sickness long term	%									15.07%	18.42%	12.19%		
	Sickness short term	%									4.66%	2.97%	3.05%		
	Did monthly HR meeting take place?	Y/N										Yes	Yes	Yes	
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs										0	0	0	
		No. of HCA's in Hrs										0	0	28.5	
	PDR %											88.24%	88.89%	77.78%	
	Mandatory Training % by Month												95.64%	92.71%	
	Uniform Audit											100%	100%	100%	
Finance	Is the ward in budget? This month, last month, projection	Y/N										Yes	Yes	Yes	
	Did monthly finance meeting take place?	Y/N										Yes	Yes	Yes	

WARD D6

		Area	Unit	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	Average
Leading the Culture of Compassionate Care	Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%
		Nutrition Audit (MUST)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%
		Documentation Audit	Score %									100%		100%
		Pain Audit (CQUIN)	Score %	N/A	N/A	N/A	N/A	100%	100%	100%	100%	100%		100%
		Missed Dose Audit	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%
		Medications Audit	Score %									80%		80%
		Drugs Storage	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%
		CD Audit		100%	100%	96%	100%	100%	100%	100%	100%	100%		99.6%
		Falls Risk Assessment Audit	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%
		Safety/Privacy & Dignity	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%
		Falls (target =0)	No. of	0	0	0	0	0	0	0	0	0		0
		Dementia screening audit results	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%
		Incidents Total (inc Falls)	No of	0	9	5	3	8	7	20	20	20		92
		Incidents (red)	No of	0	0	0	0	0	0	0	0	0		0
		Incidents (amber)	No. of	0	0	0	0	0	1	0	0	0		1
		Number of amended theatre lists on the day	No of	6	4	6	9	7	6	11	9	18		76
	Patient Experience	PALS Queries	No of	0	0	0	0	0	0	0	0	0		0
		Compliments	No. of	5	6	2	2	2	3	2	4	3		29
		Complaints	No. of	0	0	0	0	0	0	0	0	0		0
		Patient Experience	Score (%)									100%		
		FFT Overall Results	Score (%)	N/A	N/A	N/A	N/A	N/A	N/A	75%	80%	100%		
		FFT Reponse Rate		N/A	N/A	N/A	N/A	N/A	N/A					
		Mixed Sex Breaches	No. of	0	0	0	0	0	0	0	0	0		0
	Infection Control	MRSA	Screening % Elective	95.48%	95%	90%	95%	95%	96.61%	92.75%	96.39%	97.44%		95%
		CRO	No Screened	NA	NA	NA	NA	NA	NA	8	8	4		20
		Hand Hygiene	Score (%)	100%	100%	96%	98%	95%	97%	96%	95%	95%		97%
		Ward Cleanliness	Score (%)	98%	98%	97%	99%	100%	99%	99%	95%	95%		98%
		Cannulas (VIP)	Score (%)	N/A	N/A	N/A	N/A	100%	100%	100%	100%	100%		100%
		Vacancies (Exclude Ward Clerks)	No. of	0	0	0	0	0	0	0	0	0.2		0.2
		Sickness in Month with Trajectory of management	ST/LT Added Together %	13.23%	19.85%	21.79%	23.16%	12.05%	16.96%	14.06%	4.58%	2.48%		14.24%
		Sickness long term	%	12.82%	18.61%	16.67%	22.75%	10.34%	12.82%	12.82%	1.83%	0%		12%
		Sickness short term	%	0.41%	1.24%	5.13%	0.41%	1.71%	4.14%	1.24%	2.75%	2.48%		2%
	Staffing	Did monthly HR meeting take place?		Y	Y	Y	Y	Y	Y	Y	Y	Y		
		No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	15	0	0	0	0	9.5	7.5	9.5	0		41.5
			No. of HCA's in Hrs	7.5	0	76	28.5	38	57	0	0	6		213
		Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y	Y	Y	y	y	y	y	y		
		PDR %		100%	87.50%	87.50%	100.00%	100%	100%	100%	100%	100%		97%
		Mandatory Training % by Month		94.55%	90.30%	89.09%	91%	92.91%	94.49%	95.24%	98.31%	99.04%		94%
		Uniform Audit		100%	100%	100%	100%	100%	100%	100%	100%	100%		100%
	Finance	Is the ward in budget? This month, last month, projection	Y/N	Y	Y	Y	N	N	N	N	N	N		
		Did monthly finance meeting take place?	Y/N	Y	N*	Y	Y	Y	N	Y	Y	Y		

WARD D21

Leading the Culture of Compassionate Care

	Area	Unit	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%	100%	100%	100%	100%	75%	90%	96%
	Nutrition Audit (MUST)	Score %	100%	100%	100%	100%	100%	100%	100%	92%	100%	99%
	Documentation Audit	Score %	NR	NR	NR	NR	NR	NR	NR	97%	98%	98%
	Fluid Balance Audit	Score %	100%	100%	100%	100%	100%	100%	100%	78%	96%	97%
	Pain Audit (CQUIN)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Protected Meal Time Audit		100%	100%	100%	97%	100%	100%	100%	97%	100%	99%
	Missed Dose Audit	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Medications Audit	Score %	NR	NR	NR	NR	NR	NR	NR	100%	100%	100%
	Drugs Storage	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	CD Audit		100%	100%	100%	100%	90%	100%	100%	100%	100%	99%
	Falls Risk Assessment Audit	Score %	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%
	Safety/Privacy & Dignity	Score %	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%
	Pressure Ulcers Avoidable	No. of	0	0	0	0	0	0	0	0	0	0
	Pressure Ulcers Unavoidable	No.of	0	0	0	0	0	0	0	0	0	0
	Falls (target =0)	No. of	2	1	4	2	1	1	0	0	0	10
	Dementia screening audit results	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Safety Thermometer (No new harm)	Score %	95%	100%	95%	100%	100%	95%	100%	100%	100%	98%
		No. of Harms	0	0	0	0	0	0	0	0	0	0
	Incidents Total (inc Falls)	No of				11	7	12	9	11		50
	Incidents (red)	No of	0	0	0	0	0	0	0	0	0	0
	Incidents (amber)	No. of	0	0	1	0	0	0	1	0	0	2
Patient Experience	PALS Queries	No of	0	1	0	3	1	0	0	1	1	7
	Compliments	No. of	14	6	16	14	16	20	18	10	11	125
	Complaints	No. of	0	0	0	0	0	1	0	1	1	3
	Pateint Experience	Score (%)	NR	NR	NR	NR	NR	NR	NR	100%	100%	100%
	FFT Overall Results	Score (%)	71%	71%	82%	84%	81%	65%	67%	79%	78%	75%
	FFT Respose Rate	Score (%)	46%	30%	27%	57%	59%	30%	51%	46%	27%	41%
	Mixed Sex Breaches	No. of	0	0	0	0	0	0	0	0	0	0
Infection Prevention and Control	MRSA	Screening % Emergency	75%	100%	83%	70%	70%	66%	86%	100%	88	1050%
		Screening % Elective	100.00%	100.00%	100.00%	100%	100%	100%	100%	100%	100%	100%
		No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
		No. of Clinicals	0	0	0	0	0	0	0	0	0	0
	CRO	No Screened	NA	NA	NA	NA	NA	NA	0	1	0	1
	C Diff	No. of	0	1	0	0	0	1	0	0	0	2
	MSSA	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
	E-Coli	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
	Hand Hygiene	Score (%)	97%	98%	97%	97%	98%	99%	99%	98%	98%	98%
	Ward Cleanliness	Score (%)	97%	98%	99%	99%	100%	99%	98%	97%	96%	98%
Staffing	Outbreaks	No. of	0	0	0	0	0	0	0	0	0	0
	Cannulas (VIP)	Score (%)	100%	100%	100%	100%	100%	100%	100%	69%	97%	96%
	Vacancies (Exclude Ward Clerks)	No. of (in wte)	3	3	3	3	2	2.3	2.3	2.3	2.3	
	Sickness in Month with Trajectory of management	ST/LT Added Together %	2.81%	3.30%	3.34%	3.56%	4%	2.70%	6.06%	11.65%	4.76%	5%
	Sickness long term	%	0.00%	0.00%	0.12%	0.38%	3%	0.00%	0%	6.58%	4.07%	2%
	Sickness short term	%	2.21%	3.30%	3.22%	3.18%	0.65%	2.70%	6.06%	5.07%	0.69%	3.01%
	Did monthly HR meeting take place?		y	y	y	y	y	Y	y	y	y	
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	0	0	0	0	0	0	0	0	0	
		No. of HCA's in Hrs	0	0	0	0	0	0	0	0	0	
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y	Y	y	y	y	y	y	y	
	Brad Score	Reccommended						29.22	25.99	25.94	27.64	
		Actual						24.14	24.05	24.39	24.05	
		Budgeted						28.84	25.64	25.64	25.64	
	PDR %		96%	94%	94%	100%	100%	100%	96%	100%	92.31%	97%
Finance	Mandatory Training % by Month		97.00%	97.17%	97.37%	97.53%	100%	94.81%	98.84%	99.23%	99.74%	98%
	Uniform Audit		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Is the ward in budget? This month, last month, projection	Y/N	Y	Y	Y	y	y	y	y	n		
	Did monthly finance meeting take	Y/N	Y	Y	Y	y	y	y	y	y	y	

Leading the Culture of Compassionate Care

WARD D25

	Area	Unit	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%	100%	100%	100%	100%	80%	100%	98%
	Nutrition Audit (MUST)	Score %	100%	100%	100%	100%	100%	100%	100%	89%	100%	99%
	Documentation Audit	Score %	NA	NA	NA	NA	NA	NA		100%	91%	96%
	Fluid Balance Audit	Score %	100%	100%	100%	100%	100%	100%	100%	97%	75%	96.89%
	Pain Audit (CQUIN)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Protected Meal Time Audit		100%	100%	94%	100%	100%	96%	100%	94%	97%	98%
	Missed Dose Audit	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Medications Audit	Score %	NA	NA	NA	NA	NA	NA		100%	100%	100%
	Drugs Storage	Score %	100%	100%	100%	100%	100%	100%	80%	100%	100%	98%
	CD Audit		100%	100%	100%	100%	80%	100%	95%	95%	100%	97%
	Falls Risk Assessment Audit	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Safety/Privacy & Dignity	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Pressure Ulcers Avoidable	No. of	0	0	0	0	0	0	0	0	0	0
	Pressure Ulcers Unavoidable	No.of	0	0	0	0	0	2	0	2	0	4
	Falls (target =0)	No. of	2	1	0	1	0	0	0	1	0	5
	Dementia screening audit results	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Safety Thermometer (No new harm)	D25 Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		No. of Harms	0	0	0	0	0	0	0	0	0	0
	Incidents Total (inc Falls)	No of	18	15	17	14	16	13	12	9		114
	Incidents (red)	No of	0	0	0	0	0	0	0	0	0	0
	Incidents (amber)	No. of	0	0	0	0	0	0	0	0	0	0
Patient Experience	PALS Queries	No of	0	0	0	0	1	0	0	0	0	1
	Compliments	No. of	13	8	10	8	6	10		14	16	85
	Complaints	No. of	1	0	2	0	0	2	0	0	0	5
	Patient Experience	Score (%)	na	na	na	na	na	na		100%	100%	100%
	FFT Overall Results	Score (%)	76%	68%	66%	70%	60%	53%	59%	73%	57%	65%
	FFT Reponse Rate		96%	73%	68%	50%	49%	37%	95%	90%	88%	71.78%
	Mixed Sex Breaches	No. of	0	0	0	0	0	0	0	0	0	0
Infection Prevention and Control	MRSA	Screening % Emergency	67%	100%	75%	100%	100%	100%	100%	100%	100%	94%
		Screening % Elective	100%	100%	0%	67%	75%	100%	100%			77%
		No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
		No. of Clinicals	0	0	0	0	0	0	0	0	0	0
	CRO	No. screened	NA	NA	NA	NA	NA	NA	NA	NA	0	0
	C Diff	No. of	0	0	0	0	0	0	0	0	1	1
	MSSA	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
	E-Coli	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
	Hand Hygiene	Score (%)	100%	100%	100%	100%	100%	100%	93%	86%	96%	97%
	Ward Cleanliness	Score (%)	94%	88%	90%	99%	99%	99%	98%	96%	95%	95%
	Outbreaks	No. of	0	0	0	0	0	0	0	0	0	0
	Cannulas (VIP)	Score (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	3.28	4.28	4.08	3	3	3	3	3	0.44	3.66
	Sickness in Month with Trajectory of management	ST/LT Added Together %	9.35%	13.47%	7.26%	7.44%	9.19%	13.76%	13.31%	15.05%	11.49%	11%
	Sickness long term	%	8.12%	10.30%	6.55%	6.30%	3.95%	10.58%	12.05%	9.83%	7.27%	8%
	Sickness short term	%	1.23%	3.17%	0.71%	1.14%	5.24%	3.18%	1.26%	5.22%	4.22%	3%
	Did monthly HR meeting take place?		Y	Y	Y	Y	Y	Y	Y	Y	Y	
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	0	0	0	356	207.5	311.5				356
		No. of HCA's in Hrs				251.5	338.5	328.5				251.5
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y	Y	Y	Y	Y	y	Y	Y	
	Brad Score	Reccommended				1.4	1.2	27.32		30.89	32.36	
		Actual						24.14		27.11	27.11	
		Budgeted						29.41		29.41	29.41	
	PDR %		96%	92.86%	96.55%	96.43%	88.89%	88.89%	98%	79.31%	82.76%	91%
	Mandatory Training % by Month		92.50%	93.30%	91.61%	92.07%	88.83%	89.83%	89.82%	90.07%	88.92%	91%
	Uniform Audit		100%	100%	100%	100%	100%	100%	92%	100%	100%	99%
Finance	Is the ward in budget? This month, last month, projection	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	
	Did monthly finance meeting take place?	Y/N	Y	N*	Y	Y	Y	Y	Y	Y	Y	

Lyndon 2

Leading the Culture of Compassionate Care

	Area	Unit	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average/ YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	NR	NR	NR	NR	NR	100%	100%	66%	100%	92%
	Nutrition Audit (MUST)	Score %	100%	100%	94%	100%	100%	100%	72%	82%	100%	94%
	Documentation Audit	Score %	New audit started Feb 15							84%	79%	82%
	Fluid Balance Audit	Score %	NR	NR	NR	NR	NR	100%	100%	80%	98%	95%
	Pain Audit (CQUIN)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Protected Meal Time Audit	Score %	97%	100%	96%	100%	100%	100%	86%	96%	100%	97%
	Missed dose Audit	Score %	NR	NR	NR	NR	NR	100%	100%	60%	100%	90%
	Medications	Score %	New audit started Feb 15							78%	97%	88%
	Drugs Storage	Score %	NR	NR	NR	PASS	NR	100%	60%	100%	100%	90%
	CD Audit	Score %	NR	NR	NR	NR	FAIL	100%	NR	90%	85%	92%
	Falls Risk Assessment Audit	Score %	NR	NR	NR	NR	NR	100%	100%	50%	100%	88%
	Safety/Privacy & Dignity	Score %	NR	NR	NR	NR	100%	100%	0%	90%	95%	77%
	Pressure Ulcers Avoidable	No. of	0	0	0	0	0	0	0	0	0	0
	Pressure Ulcers Unavoidable	No.of	0	0	0	0	0	0	0	0	0	0
	Falls (target =0)	No. of	1	0	1	1	0	1	0	0	1	5
	Dementia screening audit results	Score %	100%	100%	100%	100%	100%	100%	100%	100%	89%	99%
	Safety Thermometer (No new harm)	Score %	100%	100%	100%	95%	100%	100%	100%	100%	100%	99%
		No. of Harms	0	0	0	1	0	0	0	0	0	1
	Incidents Total (inc Falls)	No of	11	10	16	12	9	7	14	9	7	95
	Incidents (red)	No of	0	0	0	0	0	0	0	0	0	0
	Incidents (amber)	No. of	0	1	3	0	0	1	0	0	0	5
Patient Experience	PALS Queries	No of	0	1	1	2	0	0	0	2	3	9
	Compliments	No. of	31	25	24	25	31	49	29	21	27	262
	Complaints	No. of	0	1	0	0	1	0	1	0	0	3
	Patient Experience	Score (%)	New audit started Feb 15							83%	95%	89%
	FFT Overall Results	Score (%)	63%	71%	58%	65%	73%	61%	58%	53%	51%	61%
	FFT Response Rate	No. of	67%	38%	51%	25%	46%	61%	45%	62%	53%	50%
	Mixed Sex Breaches	No. of	0	0	0	0	0	0	0	0	0	0
Infection Prevention and Control	MRSA	Screening % Emergency	93%	93.55%	93.10%	80.43%	91.89%	92%	88%	90.91%	93.55%	91%
		No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
		No. of Clinicals	0	0	0	0	0	0	0	0	0	0
	C Diff	No. of	0	0	2	0	0	0	0	0	0	2
	MSSA	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
	E-Coli	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
	Hand Hygiene	Score (%)	98%	97%	95%	95%	98%	99%	72%	95%	91%	93%
	Ward Cleanliness	Score (%)	99%	99%	98%	99%	97%	98%	99%	88%	98%	97%
	Outbreaks	No. of	0	0	0	0	0	0	0	0	0	0
	Cannulas (VIP)	Score (%)	85%	100%	100%	97%	97%	100%	100%	66%	100%	94%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	4.8	5.8	5.8	5.8	4.6	4.6	2.1	2.1	2.1	
	Sickness in Month with Trajectory of management	ST/LT Added Together %	4.32%	1.88%	1.32%	4.27%	3%	3.21%	1.79%	6.37%	7.37%	4%
	Sickness long term	%	2.11%	0.00%	0.08%	0.00%	0%	2.23%	0	2.61%	2.69%	
	Sickness short term	%	2.21%	1.88%	1.24%	4.27%	3%	1.21%	1.79%	3.75%	4.67%	
	Did monthly HR meeting take place?		Y	Y	Y	N	N	N	Y	N	Y	
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	NR	NR	NR	NR	-77	-502	-106.4	153.1	62	
		No. of HCA's in Hrs	NR	NR	NR	NR	124.5	133.5	156	60.8	262.5	
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y	Y	Y	Y	Y	Y	Y	Y	
	Brad Score	Reccommended	19.94	24.3	25.42	30.29	26.15	29.96	30.34	33.07	34.58	
		Actual	29.71	29.5	29.79	26.87	29.73	26.64	30.45	27.76	26.21	
		Budgeted	30.73	30.73	30.73	30.73	30.73	29.41	28.01	26.01	26.01	
	PDR %		100%	100.00%	96.43%	100.00%	92.59%	92.31%	92.86%	92.86%	96.43%	96%
	Mandatory Training % by Month		NR	NR	NR	86.30%	87.88%	87.93%	89.28%	91.61%	93%	89%
	Uniform Audit		100%	96%	93%	93%	100%	100%	100%	100%	75%	95%
Finance	Is the ward in budget? This month, last month, projection	Y/N	y	Y	Y	Y	Y	Y	Y	N	N	
	Did monthly finance meeting take place?	Y/N	y	Y	Y	N	N	Y	Y	Y	N	

Leading the Culture of Compassionate Care

WARD Lyndon 3

	Area	Unit	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%	100%	100%	100%	100%	88%	62%	100%
	Nutrition Audit (MUST)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	80%	100%
	Documentation Audit	Score %	Audit commenced from February 2015							81%	71%	76%
	Fluid Balance Audit	Score %								89%	61%	75%
	Pain Audit (CQUIN)	Score %	100%	100%	100%	100%	100%		100%	100%	100%	100%
	Protected Meal Time Audit	Score %				98%	98%	96%	96%	100%		98%
	Missed Dose Audit	Score %								100%	100%	100%
	Medications Aduit	Score %	Audit commenced from February 2015							100%	100%	100%
	Drugs Storage	Score %								100%	100%	
	CD Audit	Score %					96%			100%	100%	96%
	Falls Risk Assessment Audit	Score %	100%	100%	100%	100%	100%	100%	100%	100%	88%	99%
	Safety/Privacy & Dignity	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Pressure Ulcers Avoidable	No. of	0	1	0	0	0	0	0	0	0	1
	Pressure Ulcers Unavoidable	No.of	0	0	0	0	0	0	0	0	0	0
	Falls (target =0)	No. of	0	1	1	0	0	1	0	1	1	5
	Dementia screening audit results	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Safety Thermometer (No new harm)	Score %	100%	100%	100%	96%	100%	100%	100%	100%	98%	99%
		No. of Harms	0	0	0	4.35	0	0	0	0	2%	4.37
	Incidents Total (inc Falls)	No of								11	8	
	Incidents (red)	No of	0	0	1	0	0	0	0	0	0	1
	Incidents (amber)	No. of	0	0	0	0	0	0	0	0	0	0
Patient Experience	**PALS Queries**	No of	0	0	0	0	1	0	0	1	1	3
	Compliments	No. of	19	7	8	5	19	44	40	13	21	20
	Complaints	No. of	0	3	0	5	0	0	0	0	0	8
	Patient Experience	Score (%)	Audit commenced from February 2015							100%	100%	100%
	FFT Overall Results	Score (%)	63%	74%	87%	87%	80%	100%	76%	72%		80%
	FFT Response	Score (%)	48%	41%	37%	23%	13%	14%	17%	39%		29%
	Mixed Sex Breaches	No. of	0	0	0	0	0	0	0	0	0	0
Infection Prevention and Control	MRSA	Screening % Emergency	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Screening % Elective	100%	100%	100%	100%	100%	100%	100%	100%	100	1200%
		No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
		No. of Clinicals	0	0	0	0	0	0	0	0	0	0
	C Diff	No. of	0	0	0	0	1	0	0	0	0	1
	MSSA	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
	E-Coli	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
	Hand Hygiene	Score (%)	97%	98%	97%	97%	98%	99%	100%	99%	100	1198%
	Ward Cleanliness	Score (%)	94%	98%	98%	96%	98%	99%	95%	84.62%		95%
	Outbreaks	No. of	0	0	0	0	0	0	0	0	0	0
	Cannulas (VIP)	Score (%)							96.40%	97%	85%	93%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)			3.3	2.4	2.4	1.85	0	0	0	1.42
	Sickness in Month with Trajectory of management	ST/LT Added Together %	3.58%	5.27%	7.81%	2.88%	2.65%	12.11%	13.01%	9.03%	7.37%	7%
	Sickness long term	%	1.59%	2.14%	4.43%		0%	2.52%	5.56%	5.70%	2.08%	3%
	Sickness short term	%	1.99%	3.12%	3.38%		2.65%	9.59%	7.45%	3.32%	5.29%	5%
	Did monthly HR meeting take place?		YES	YES	YES	YES	YES	YES	YES	YES	YES	
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	0	0	0	0	0	0	0	0	0	0
		No. of HCA's in Hrs										#DIV/0!
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y	Y	Y	Y	y	Y	Y	Y	
	Brad Score	Reccommended	37.02	39.09	38.57	38.92	42.98	47.03	37.19	40.03	40.47	
		Actual	27.88	26.03	27.13	28.05	25.56	24.3	25.16	26.51	34.39	
		Budgeted	40.17	40.17	40.17	40.17	40.17	40.17	40.17	40.17	39.98	
	PDR %	Score %			73.81%	80.00%	76.09%	73.91%	82.61%	82.61%	87.5	1317%
	Mandatory Training % by Month	Score %			87.44%	82.75%	82.32%	84.12%	85.73%	84.93%	83.95	1272%
	Uniform Audit	Score %				100%	100%	100%	100%	100%	100	1750%
Finance	Is the ward in budget? This month, last month, projection	Y/N	Y	Y	Y	Y	Y	y	Y	Y	Y	
	Did monthly finance meeting take place?	Y/N	Y	Y	Y	Y	Y	y	Y	Y	Y	

Leading the Culture of Compassionate Care

WARD Newton 2

	Area	Unit	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Nutrition Audit (MUST)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Document Audit	Score %	Audit commenced from February 2015								86.25%	
	Fluid Balance Audit	Score %	N/A	N/A	N/A	N/A	100%	100%	100%	100%	86.25%	100%
	Pain Audit (CQUIN)	Score %	100%	100%	100%	100%	100%	100%	100%	92%	100%	100%
	Protected Meal Time Audit	Score %	100%	97%	93%	87%	100%	100%	100%	100%	93%	95%
	Missed Dose Audit	Score %					11%	100%	100%	100%	90%	11%
	Medications Audit	Score %	Audit commenced from February 2015								97.70%	
	Drugs Storage	Score %							80%			
	CD Audit	Score %					19/11/2014					
	Falls Risk Assessment Audit	Score %	100%	100%	100%	100%		100%	100%	100%	100%	100%
	Safety/Privacy & Dignity	Score %					100%	100%	100%	100%	100%	100%
	Pressure Ulcers Avoidable	No. of						0	0	0	0	0
	Pressure Ulcers Unavoidable	No.of						0	0	0	0	0
	Falls (target =0)	No. of	0	0	2	0		0	0	0	0	2
	Dementia screening audit results	Score %	100%	100%	100%		100%	100%	100%	100%	100%	100%
	Safety Thermometer (No new harm)	Score %	100%	100%	100%	92%	100%	100%	100%	100%	100%	98%
		No. of Harms	0	0	0	0	0	0	0	0	0	0
	Incidents Total (inc Falls)	No of	0	10	5	15	7	4	7	4		1
	Incidents (red)	No of	0	0	0	0	0	0	0	0		0
	Incidents (amber)	No. of	0	1	1	1	0	1	1	0		3
Patient Experience	PALS Queries	No of	1	1	1	0	3	0	0	0	1	7
	Compliments	No. of	12	9	16			12		16	20	37
	Complaints	No. of	0	0	0	2	0	0	0	0	0	2
	Patient experience	Score (%)	Audit commenced from February 2015								100%	
	FFT Overall Results	Score (%)	75%	69%	86%	100%	60%	20%	33%	56%	60%	83%
	FFT Response Rate	Score (%)	33%	27%	28%	10%	24%	23%	41%	23%		26%
	Mixed Sex Breaches	No. of	0	0	0	0	0	0	0	0	0	0
Infection Prevention and Control	MRSA	Screening % Emergency	93%	83.98%	90.76%	94.51%						90%
		Screening % Elective	96.24%	96.24%	96.24%	97%		99%		95.33%		97%
		No. of Bloodstream	0	0	0	0	0	0	0	0		0
		No. of Clinicals	0	0	0	0	0	0	0	0		0
	C Diff	No. of	0	0	0	0	0	0	0	0		0
		No. of YTD	0	0	0	0	0	0	0	0		0
	MSSA	No. of Bloodstream	0	0	0	0	0	0	0	0		0
		No. of Bloodstream YTD	0	0	0	0	0	0	0	0		0
	E-Coli	No. of Bloodstream	0	0	0	0	0	0	0	0		0
		No. of Bloodstream YTD	0	0	0	0	0	0	0	0		0
	Hand Hygiene	Score (%)	100%	99%	97%	99%	97%	100%	97%	NR	100%	98%
	Ward Cleanliness	Score (%)	96%	100%	99%	97%	0	99%	94%		99%	85.52%
	Outbreaks	No. of	0	0	0	0	0	0	0	0	0	0
	Cannulas (VIP)	Score (%)	100%	95%			92%	100%	94%			96%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	0	1 HCA	1 HCA	1 HCA	1 HCA	1	1	1	1	0.00
	Sickness in Month with Trajectory of management	ST/LT Added Together %	10.45%	16.30%	9.49%	9.15%	6.46%	25.35%	29.66%	12.84%		11%
	Sickness long term	%	8.16%	10.34%	6.63%	7.11%	5.12%	16.23%	23.57%	11.92%		8%
	Sickness short term	%	2.29%	5.97%	2.86%	2.03%	1.34%	9.12%	6.09%	0.92%		4%
	Did monthly HR meeting take place?		N0	YES	YES	YES	YES	YES	YES	y	Y	#DIV/0!
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs										#DIV/0!
		No. of HCA's in Hrs										#DIV/0!
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y	Y	Y	Y	Y	Y	y		
	Brad Score	Reccommended						21.15		22.54		
		Actual						11.33		15.18		
		Budgeted						17.73		17.54		
	PDR %					65.22%	56.52%	65.22%	NR	45.95%	50%	65%
	Mandatory Training % by Month		79.00%			79.28%	79.67%	80.99%	81.76%	54.55%	81.88%	79%
	Uniform Audit			99%				100%	100%	100%	100%	99%
Finance	Is the ward in budget? This month, last month, projection	Y/N	N	N	N	N	N	N	Y	N	N	
	Did monthly finance meeting take place?	Y/N	Y	N	Y	N	Y	N	Y	y	Y	

Leading the Culture of Compassionate Care

WARD Newton 3

	Area	Unit	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	New Audit Commenced from February 2015							79%	100%	90%
	Nutrition Audit (MUST)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Documentation Audit	Score %	New Audit Commenced from February 2015							85%	89%	87%
	Fluid Balance Audit	Score %	New Audit Commenced from February 2015							76%	84%	80%
	Pain Audit (CQUIN)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Protected Meal Time Audit		100%			100%	98%	100%	100%	100%	100%	99.71%
	Missed Dose	Score %	New Audit Commenced from February 2015							100%	100%	100%
	Medications Audit	Score %	New Audit Commenced from February 2015							100%	78%	89%
	Drugs Storage	Score %		100%	100%	100%	100%		100%	100%	100%	100%
	CD Audit			100%	100%			95%	100%	100%	100%	99.17%
	Falls Risk Assessment Audit	Score %	New Audit Commenced from February 2015							70%	100%	85%
	Safety/Privacy & Dignity	Score %	New Audit Commenced from February 2015							85%	83%	84%
	Pressure Ulcers Avoidable	No. of	0	0	0	0	0	0	1	0	0	1
	Pressure Ulcers Unavoidable	No.of	0	0	0	1	1		0	0	0	2
	Falls (target =0)	No. of	1	0	0	2	0	1	0	1	0	5
	Dementia screening audit results	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Safety Thermometer (No new harm)	Score %	100%	96.30%	96.67%	96.55%	96.67%	96.67%	96.15%	92%		97.66%
		No. of Harms	0	0	3.33	0	0	0	0	8		7.03
	Incidents Total (inc Falls)	No of	21	10	10	24	20	24	19	24		41
	Incidents (red)	No of	0	0	0	0	0	0	1	0	0	0
	Incidents (amber)	No. of	1	1	0	0	0	0	0	0	0	2
Patient Experience	PALS Queries	No of				2	2	1	3	4	1	13
	Compliments	No. of	10	15	11	15	12	22	15	13	1	63
	Complaints	No. of	0	1	0	0	0	0	1	1	0	3
	Patient Experence	Score (%)	New Audit Commenced from February 2015							100%	100%	100%
	FFT Overall Results	Score (%)	76%	58%	73%	71%	39%	50%	73%	76%	60%	64%
	FFT Response Rate	Score (%)	33%	27%	14%	11%	13%	8%	13%	14%	42%	19%
	Mixed Sex Breaches	No. of	0	0	0	0	0	0	0	0	0	0
Infection Prevention and Control	MRSA	Screening % Emergency			92.5%	92%						92%
		Screening % Elective	91.41%	95.29%	100%	100%	84.09%	83.53%	91.75%	97.10%		93%
		No. of Bloodstream	0	0	0	0	0	0	0	0		0
		No. of Clinicals	0	0	0	0	0	0	0	0		0
	C Diff	No. of	0	0	1	0	0	0	0	1	0	2
	MSSA	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
	E-Coli	No. of Bloodstream	0	0	0	0	0	0	0	1	0	1
	Hand Hygiene	Score (%)	98%	96%	99%	0%	100%	0%	98%	99.50%	60%	72%
	Ward Cleanliness	Score (%)	98%	97%	99%	95%	98%	96%	89%	94%	71%	93%
	Outbreaks	No. of	0	0	0	0	0	0	0	0	0	0
	Cannulas (VIP)	Score (%)	98%	97%	98%	97%	100%	100%	100%	100%	100%	98%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)			3.3				1.92	1.92	0.92	3.30
	Sickness in Month with Trajectory of management	ST/LT Added Together %	5.68%	4.98%	3.18%	3.02%	11.93%	11.19%	10%	4.81%		5%
	Sickness long term	%	4.53%	2.40%	0.00%	0.70%	4.20%	6.28%	4.33%	2.15%		3%
	Sickness short term	%	1.26%	2.71%	3.27%	2.30%	7.73%	4.91%	5.74%	2.66%		67%
	Did monthly HR meeting take place?				Y	N	Y	N	Y	Y	Y	
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	0	0	0	0	0	0	0	0	0	0
		No. of HCA's in Hrs	0	0	0	0	0	0	0	0	0	0
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?				Y		Y	N			
	Brad Score	Reccommended	49.72	51.14	50.32	50.93	50.22	NR	NR	62.08		
		Actual	38.46	38.45	38.95	38.8	38.85	NR	NR	37.15		
		Budgeted	41.64	41.64	41.64	41.64	41.64	NR	NR	41.64	41.64	
	PDR %			84.42%	84.42%	69.77%	74.34%	56.83%	59.09%	63.64%	91.49%	78%
	Mandatory Training % by Month				86.84%	86.06%	85.00%	83.10%	85.19%	86.06%	83.30%	85%
	Uniform Audit						100%	100%	100%	100%	100%	100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	Y	Y	Y	y	y	y	y	y	Y	
	Did monthly finance meeting take place?	Y/N	Y	Y	Y	y	y	N	N	N	y	

Leading the Culture of Compassionate Care

WARD Priory 2

	Area	Unit	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%	100%	100%	100%	100%	85%	100%	98%
	Nutrition Audit (MUST)	Score %	100%	100%	100%	100%	100%	100%	95%	100%	100%	99%
	Documentation Audit	Score %	New Audit Commenced from February 2015							78%	100%	89%
	Fluid Balance Audit	Score %	100%	100%	100%	100%	100%	100%	100%	95%	98%	99%
	Pain Audit (CQUIN)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Protected Meal Time Audit	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Missed Dose Audit	Score %	100%	100%	100%	100%	100%	100%	100%	83%	96%	98%
	Medications Audit	Score %	New Audit Commenced from February 2015							100%	100%	100%
	Drugs Storage	Score %	NR	NR	NR	NR	100%	NR	100%	100%	100%	100%
	CD Audit	Score %	NR	85%	NR	NR	NR	NR	NR	95%	100%	93%
	Falls Risk Assessment Audit	Score %	100%	100%	100%	100%	100%	100%	100%	88%	100%	99%
	Safety/Privacy & Dignity	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Pressure Ulcers Avoidable	No. of	0	0	0	0	0	0	0	0	0	0
	Pressure Ulcers Unavoidable	No.of	0	0	0	0	0	0	0	0	0	0
	Falls (target =0)	No. of	2	0	0	0	0	1	0	0	1	4
	Dementia screening audit results	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Safety Thermometer (No new harm)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	89%	99%
		No. of Harms	0	0	0	0	0	0	0	0	3	0
	Incidents Total (inc Falls)	No of	15	8	8	5	7	6	7	13	7	56
	Incidents (red)	No of	0	0	0	0	0	0	0	0	0	0
	Incidents (amber)	No. of	0	0	2	1	1	0	0	0	1	0.6
Patient Experience	PALS Queries	No of	0	3	0	0	0	3	0	1	1	0.89
	Compliments	No. of	26	22	15	26	20	42	33	42	45	30
	Complaints	No. of	2	0	0	1	0	0	0	0	0	0
	Patient Experience	Score (%)	New Audit Commenced from February 2015							100%	100%	100%
	FFT Overall Results	Score (%)	75%	89%	83%	50%	65%	72%	40%	69%	71%	74%
	FFT Reponse Rate	No, of	32%	12%	23%	13%	32%	27%	26%	71%	68%	33.8%
	Mixed Sex Breaches	No. of	0	0	0	0	0	0	0	0	0	0
	MRSA	Screening % Elective	93.75%	88.24%	95.00%	100%	92.31%	95.24%	88.24%	100%	100%	95%
		No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
		No. of Clinicals	0	0	0	0	0	0	0	0	0	0
	C Diff	No. of	0	2	0	0	0	0	0	1	0	3
	MSSA	No. of Bloodstream	0	0	0	0	0	1	0	0	0	1
	E-Coli	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
	Hand Hygiene	Score (%)	100%	NR	100%	100%	NR	100%	98%	58%	46%	75%
	Ward Cleanliness	Score (%)	99%	94%	96%	99%	98%	98%	95%	98%	85%	96%
	Outbreaks	No. of	0	0	0	0	0	0	0	0	0	0
	Cannulas (VIP)	Score (%)	100%	100%	100%	100%	100%	100%	90%	71%	95%	95%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	NR	NR	0.8	1.6	1.6	1.6	4.4	4.4	4.4	
	Sickness in Month with Trajectory of management	ST/LT Added Together %	5.99%	8.86%	4.91%	6.84%	5.69%	12.10%	5.80%	12.84%	14.39%	7%
	Sickness long term	%	4.92%	6.07%	3.50%	3.75%	1.87%	5.26%	3.22%	11.92%	11.46%	5%
	Sickness short term	%	1.07%	2.79%	1.41%	3.09%	3.82%	6.84%	2.58%	0.92%	2.93%	2%
	Did monthly HR meeting take place?		Y	Y	Y	Y	Y	N	Y	N	Y	
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	NR	NR	157.5	291.5	159	590.5	596.4	346.7		2141.6
		No. of HCA's in Hrs	NR	NR	450.5	783.8	560.4	557	422.9	188.4		2963
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y	Y	Y	Y	Y	Y	Y	Y	
	Brad Score	Reccommended	33.03	36.5	39.58	39.95	37.04	40.91	38.57	36.81	39.21	37.96
		Actual	28.09	27.52	28.58	31.69	30.02	30.14	31.06	33.52	58.4	33.22
		Budgeted	26.87	26.87	26.87	26.87	26.87	26.87	29.59	30.73	29.6	27.90
	PDR %		NR	NR	NR	86.67%	96.43%	96.43%	96.43%	93.10%	100%	95%
	Mandatory Training % by Month		NR	NR	NR	80.99%	84.06%	85.37%	85.90%	84.05%	85.02%	84%
	Uniform Audit		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	N	N	N	N	N	N	N	N	N	
	Did monthly finance meeting take place?	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	N	

Leading the Culture of Compassionate Care

WARD SAU

	Area	Unit	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%	100%	100%	100%	100%	80%	100%	100%
	Nutrition Audit (MUST)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Documetnation Audit	Score %	New audit started March 15								88%	88%
	Fluid Balance Audit	Score %	NR	NR	NR	NR	NR	NR	100%	81%	91%	91%
	Pain Audit (CQUIN)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Missed Dose Audit	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Medications Audit	Score %	New audit started March 15								98%	98%
	Drugs Storage	Score %	100%	NR	NR	100%	100%	100%	90%	100%	100%	99%
	CD Audit		NR	NR	NR	NR	80%	100%	100%	95%	90%	93%
	Falls Risk Assessment Audit	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Safety/Privacy & Dignity	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Pressure Ulcers Avoidable	No. of	100%	100%	100%	100%	0	0	0	0	0%	0
	Pressure Ulcers Unavoidable	No.of	100%	100%	100%	100%	0	0	0	0	0	0
	Falls (target =0)	No. of	0	1	0	2	1	2	0	0	0	3
	Dementia screening audit results	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Safety Thermometer (No new harm)	Score %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		No. of Harms	0	0	0	0	0	0	0	0	0	0
	Incidents Total (inc Falls)	No of	5	10	8	8	7	9	8	20	6	9.0
	Incidents (red)	No of	0	0	0	0	0	0	0	0	0	0
	Incidents (amber)	No. of	0	0	0	0	0	0	0	0	0	0
Patient Experience	PALS Queries	No of	0	0	0	1	1	0	0	0	0	2
	Compliments	No. of	0	5	3	3	5	4	3	5	15	11
	Complaints	No. of	0	0	0	0	1	0	1	0	0	2
	Patient Experience	Score (%)	New audit started March 15								100%	100%
	FFT Overall Results	Score (%)	59%	56%	57%	82%	75%	67%	47%	56%	50%	61%
	FFT Response Rate	Score (%)	80%	33%	25%	74%	15%	11%	65%	100%	87%	54%
	Mixed Sex Breaches	No. of	0	0	0	0	0	0	0	0	0	0
Infection Prevention and Control	MRSA	Screening % Emergency	86%	84%	96%	94%	82.76%	86%	98.80%	97.78%	85.71%	90%
		No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
		No. of Clinicals	0	0	0	0	0	0	0	0	0	0
	C Diff	No. of	0	0	0	0	0	0	0	0	0	0
	MSSA	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
	E-Coli	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0
	Hand Hygiene	Score (%)	99%	98%	99%	99%	99%	98%	99%	99%	89%	97.67%
	Ward Cleanliness	Score (%)	98%	95%	76%	97%	98%	97%	97%	91%	93%	94%
	Outbreaks	No. of	0	0	0	0	0	0	0	0	0	0
	Cannulas (VIP)	Score (%)	0	0	0	0	0	100%	83%	92%	94%	0
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	2.0	2.0	2.0	2.0	3.45	3.45	3.45	2.45	2.45	
	Sickness in Month with Trajectory of management	ST/LT Added Together %	8.37%	11.19%	13.07%	7.87%	14.23%	16.76%	8.81%	6.54%	5.24%	10.23%
	Sickness long term	%	4.47%	8.64%	8.71%	7.17%	8.71%	14.19%	6.87%	6.54%	3.03%	8%
	Sickness short term	%	3.90%	2.55%	4.36%	0.70%	5.52%	2.57%	1.94%	0%	2.20%	3%
	Did monthly HR meeting take place?		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	NR	NR	NR	-35.5	106	-23.5	-375.8	-302.2	-345.2	-162.7
		No. of HCA's in Hrs	NR	NR	NR	104	9	128.5	291	217	223	162
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y	Y	Y	Yes	Yes	Yes	Yes	No	
	Brad Score	Reccommended	NA	NA	NA	NA	NA	NA	NA	NA	NA	
		Actual	NA	NA	NA	NA	NA	NA	NA	NA	NA	
		Budgeted	NA	NA	NA	NA	NA	NA	NA	NA	NA	
	PDR %		NR	95.87%	NR	96%	88%	88%	95.83%	100%	92%	95.94%
	Mandatory Training % by Month		100.0%	100.0%	100.0%	97.00%	96.63%	95.14%	93.93%	93.81%	93.35%	99%
	Uniform Audit		100%	100%	100%	100%	100%	100%	100%	75%	75%	94%
Finance	Is the ward in budget? This month, last month, projection	Y/N	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	Did monthly finance meeting take place?	Y/N	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	

Leading the Culture of Compassionate Care

WARD SDU

	Area	Unit	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	Average
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	n/a	75%	50%	40%	100%	83%		
	Nutrition Audit (MUST)	Score %	n/a	n/a	n/a	n/a	n/a	n/a		
	Fluid Balance Audit	Score %	n/a	n/a	n/a	n/a	n/a	n/a		
	Pain Audit (CQUIN)	Score %	100%	100%	100%	100%	85%	100%		
	Documentation Audit	Score %	n/a	98%	53%	97.50%	85%	92%		
	Medication Audit (missed doses)	Score %	n/a	100%	84%	100%	80%	100%		
	Drugs Storage	Score %	n/a	100%	100%	100%	100%	100%		
	CD Audit		n/a	100%	100%	100%	100%	100%		
	Falls Risk Assessment Audit	Score %	n/a	n/a	n/a	n/a	n/a	n/a		
	Safety/Privacy & Dignity/ Documentation Audit	Score %	n/a	98%	53%	97.50%	85%	92%		
	Pressure Ulcers Avoidable	No. of	0	0	0	0	0	0		
	Pressure Ulcers Unavoidable	No.of	0	0	0	0	0	0		
	Falls (target =0)	No. of	0	0	0	0	0	0		
	Proms			91%						
	Measures Board	internal		100%	100%	100%	100%	100%		
		external		100%	100%	100%	100%	100%		
	Incidents Total (inc Falls)	No of	1	1	6	2	3	6		
	Incidents (red)	No of	0	0	0	0	0	0		
	Incidents (amber)	No. of	0	0	0	0	0	1		
Patient Experience	PALS Queries	No of	1	1	0	0	0	0		
	Compliments	No. of	1	1	0	1	1	1		
	Complaints	No. of	0	0	0	0	0	0		
	FFT Overall Results	Score (%)	n/a	100%	100%					
	Mixed Sex Breaches	No. of	0	0	0	0	0	0		
Infection Prevention and Control	MRSA	Screening % Emergency	n/a	n/a	n/a	n/a	n/a	n/a		
		Screening % Elective	95.06%	88.75%	95.16%	93.02%	96.67%	98.04%		
		No. of Bloodstream	0	0	0	0	0	0		
		No. of Clinicals	0	0	0	0	0	0		
	C Diff	No. of	0	0	0	0	0	0		
		No. of YTD	0	0	0	0	0	0		
	MSSA	No. of Bloodstream	0	0	0	0	0	0		
		No. of Bloodstream YTD	0	0	0	0	0	0		
	E-Coli	No. of Bloodstream	0	0	0	0	0	0		
		No. of Bloodstream YTD	0	0	0	0	0	0		
	Hand Hygiene	Score (%)	100%	100%	100%	100%	100%	100%		
	Ward Cleanliness (Green Book completed)	Score (%)	100%	100%	100%	100%	100%	100%		
	Outbreaks	No. of	0	0	0	0	0	0		
	Cannulas (VIP)	Score (%)	100%	66.60%	67%	100%	100%	83%		
Staffing	Vacancies (Exclude Ward Clerks)	No. of	1	1	1	1	0	0		
	Sickness in Month with Trajectory of management	ST/LT Added Together %	6.53%	4.16%	5.25%	5.25%	2.80%	8.25%		
	Sickness long term	%	5.83%	0	0	0	0	3.3		
	Sickness short term	%	0.70%	4.16	5.25	6.24	2.80%	4.95		
	Did monthly HR meeting take place?		no	yes	yes	yes	Yes	Yes		
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	0	0	0	0	0	0		
		No. of HCA's in Hrs	0	0	0	0	0	0		
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	n/a	n/a	n/a	n/a	n/a	n/a		
	Brad Score		n/a	n/a	n/a	n/a	n/a	n/a		
	PDR %			68.75%	68.75%	87.50%	82.35%	84.60%		
	Mandatory Training % by Month			94.64%	95.09%	93.56%	93.44%	92.71%		
	Uniform Audit		No	100%	100%	97.60%	93.87%	95.92%		
Finance	Is the ward in budget? This month, last month, projection	Y/N	Yes	Yes	Yes	Yes	Yes	Yes		
	Did monthly finance meeting take place?	Y/N	Yes	yes	Yes	Yes	Yes	Yes		

Leading the Culture of Compassionate Care

WARD SSAU

	Area	Unit	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average/YDT
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	NR	100%	100%	100%	100%	100%	100%
	Doccummentation Audit	Score %	New Audit Commenced from March 2015					88%	88%
	Nutrition Audit (MUST)	Score %	NR	100%	100%	100%	100%	100%	100%
	Fluid Balance Audit	Score %	NR	100%	100%	100%	100%	100%	100%
	Pain Audit (CQUIN)	Score %	NR	100%	100%	100%	100%	100%	100%
	Protected Meal Time Audit	Score %	NR	100%	100%	86%	96%	100%	96%
	Missed Doses Audit	Score %	NR	100%	100%	100%	100%	100%	100%
	Medications Audit	Score %	New Audit Commenced from February 2015					93%	93%
	Drugs Storage	Score %	NR	100%	100%	100%	80%	100%	96%
	CD Audit	Score %	NR	100%	100%	NR	85%	85%	93%
	Falls Risk Assessment Audit	Score %	NR	100%	100%	100%	100%	100%	100%
	Safety/Privacy & Dignity	Score %	NR	100%	100%	0%	100%	100%	80%
	Pressure Ulcers Avoidable	No. of	NR	0	0	0	0	0	0
	Pressure Ulcers Unavoidable	No.of	NR	0	0	0	0	0	0
	Falls (target =0)	No. of	1	0	0	0	0	0	1
	Dementia screening audit results	Score %	NR	100%	100%	100%	100%	100%	100%
	Safety Thermometer (No new harm)	Score %	100%	100%	100%	100%	100%	100%	100%
		No. of Harms	0	0	0	0	0	0	0
	Incidents Total (inc Falls)	No of	5	2	1	2	8	2	20
	Incidents (red)	No of	0	0	0	0	0	0	0
	Incidents (amber)	No. of	0	0	0	0	0	0	0
Patient Experience	PALS Queries	No of	NR	0	1	0	0	0	1
	Compliments	No. of	NR	NR	NR	16	13	12	41
	Complaints	No. of	0	0	0	1	0	1	2
	Patient Experience	Score (%)	New Audit Commenced from March 2015					100%	100%
	FFT Overall Results	Score (%)	NR	80%	75%	67%	59%	73%	71%
	FFT Response Rate	No. of	NA	53%	24%	100%	100%	100%	75%
	Mixed Sex Breaches	No. of	0	0	0	0	0	0	0
Infection Prevention and Control	MRSA	Screening % Emergency	94%	82.89%	94%	96.84%	95.80%	93.37%	93%
		No. of Bloodstream	0	0	0	0	0	0	0
		No. of Clinicals	0	0	0	0	0	0	0
	C Diff	No. of	0	0	0	0	0	0	0
	MSSA	No. of Bloodstream	0	0	0	0	0	0	0
	E-Coli	No. of Bloodstream	0	0	0	0	0	0	0
	Hand Hygiene	Score (%)	NR	NR	95%	72%	95%	91%	88%
	Ward Cleanliness	Score (%)	NR	97%	98%	95%	88%	93%	94%
	Outbreaks	No. of	0	0	0	0	0	0	0
	Cannulas (VIP)	Score (%)	100%	NR	100%	100%	100%	83%	97%
Staffing	Vacancies (Exclude Ward Clerks)	No. of	NR	2.68	2.68	2.68	2.68	2.68	
	Sickness in Month with Trajectory of management	ST/LT Added Together %	4.34%	5.73%	2.27%	1.58%	3.23%	3.38%	3%
	Sickness long term	%	0%	0%	0%	0%	0%	0%	0%
	Sickness short term	%	4.34%	5.73%	2.27%	1.58%	3.23%	3.38%	3%
	Did monthly HR meeting take place?		No	Yes	Yes	Yes	No	Yes	
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	NR	NR	-51.5	-180.75	12	14	-52
		No. of HCA's in Hrs	NR	NR	13.5	285.8	0	0	75
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Yes	Yes	Yes	Yes	Yes	Yes	
	PDR %		75%	53.85%	53.85%	90%	77.78%	100%	75%
	Mandatory Training % by Month		84.58%	87.61%	88.07%	87.65%	85.16%	93.35%	88%
	Uniform Audit		100%	100%	100%	100%	100%	100%	100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	N	N	N	N	N	Yes	
	Did monthly finance meeting take place?	Y/N	Yes	Yes	Yes	Yes	Yes	Yes	

Appendix 3 - Community & Therapies Dashboard March 2015

1.0 Dashboard data

The use of the dashboards has been commenced and currently we are using the template developed by Surgery and Medicine but is being reviewed for any amendments to reflect the nature of care provided in C&T in-patient areas.

Overview of findings:

Ward	Positive results	Areas for improvement	Key actions
Leasowes	• Safety audits 100% compliance • Compliments av. 15 per month; only I PALS enquiry in last 12 months and no complaints	• Avoidable PU's 4 in last 9 months * • Falls – av. 2.4 per month with ^ Jan-March, mainly due to specific patients. • Hygiene – 96% hand hygiene, 97% ward cleanliness • Staff sickness 7% (5% LTS, 2% short) • Use of temp staffing to cover vacancies and sickness	• Improved personalised care planning with follow up care actions • Improve local hygiene awareness and standards • Reduce staff sickness • Recruit to outstanding vacancies
D43	• Safety audits 100% compliance • No complaints	• March ward cleanliness ˅ to 78% • Staff sickness –short term 14.4 • Use of temporary staffing – having to cover D47 • Mandatory training 81% • PDR's 87%	• Liaise with facilities to improve ward cleanliness. • Recruit to vacancies • Agree future for D47 with CCG and care model

D47	• No complaints	• Use of temporary staffing	• Improve systems for monitoring and reporting compliance with the required standards
ET	• Safety audits 100% compliance • Avoidable PU's- 0 for 12 months • Compliments av. 6.3 per month • MRSA screening 100% • Use of focussed care - 0	• Re-admissions within 7 days av. 8 per month – need to establish if included internal transfers • Complaints – 3 in last 12 months • Staff sickness, LTS 6.72 • PDR's 59% • Mandatory training 82%	• Recruit to vacancies • Agree future model of care for McCarthy /ET with CCG • Review of re-admissions
Henderson *	• Safety audits 100% compliance • Complaints – 0 • Compliments av. 3 per month • FFT- 95% satisfaction • IPC audit - 100%	• Staff sickness • Mandatory training • PDR's	• Reduce staff sickness • Increase compliance with mandatory training and PDR's with the completion of recruitment to vacancies.
Community - The icares Directorate are currently developing the community nursing dashboard; this will be an electronic version that will be accessible on desk tops. Once available this will be reported, it is expected by end of Q1 2015. It may be possible in future to roll out the electronic version to our in-patient areas.			

*Data prior to completion of avoidability template and decision made by TVS based on incident reported detail

**A different dashboard is in use based on the more extensive CCG KPI requirements. The two requirements are being mapped for reporting from 1.4.15 to ensure this is not burdensome to the staff

A recommended change is the additional use of rates across all in-patient areas based on occupied days (or an agreed denominator) so there is comparison between all wards for all indicators where applicable in particular - falls, avoidable pressure damage, unavoidable pressure damage and UIT's.

2.0 Ward Reviews

Ward reviews have also commenced and all wards will have undertaken a baseline quarterly review by 1.5.15 based on the revised Trust template. Results to date for Q1 are:

- **D43 April 2015**

Objective	1 Environment and IPC	2 Essential care	3 Effective use of resources	4 Admission and discharge	5 Patient experience	6 Privacy and dignity in care	7 Safeguarding in care	8 Learning environment	9 Managing the deteriorating patient
Rag rating For elements within standard	7 green 2 amber	7 green 3 amber	7 amber 3 green	3 green 1 amber	4 amber 3 green	8 green 2 amber	green element	3 green 2 amber	5 green

D43 Summary of review from 2014-15 Q3 review	D43 Summary current review as above 2015-16 Q1
The service transferred to community and therapies in Q3, this is the first ward review of the unit within the clinical group, using the new tool, so will be used as a baseline. From the 69 assessed elements, 52% were considered Green – where full compliance demonstrated	This review in Q1 shows an improving position with 73% of the assessed elements showing green (as opposed to 52% on previous review) there are still some key fundamental areas that are amber that need to show some significant improvement by next review, in relation to

42% of elements were unable to be assessed as compliant, largely due to lack of systems to report compliance The service is operating with high levels of vacancies, and have the additional pressure of supporting D47 so using a high rate of sessional staff. The unit manager is supporting both units. The long term sickness rate is over 18% which also brings additional challenges. The service has key areas where improvements need to be evidenced, and the review will be repeated in April 2015	• Environment • Personalised approach to planning care • Patients day • Bedding in of a quality assurance programme However it must be acknowledged the unit currently has 11 band 5 vacancies and is too reliant on bank and agency, the relative success of the McCarthy and D47 model is directly disadvantaging D43 However even in this context the changes discussed at length pre and during review can largely be actioned with current resources The review will be repeated again in Q1

❖ **ET April 15**

Objective	**1 Environment and IPC**	**2 Essential care**	**3 Effective use of resources**	**4 Admission and discharge**	**5 Patient experience**	**6 Privacy and dignity in care**	**7 Safeguarding in care**	**8 Learning environment**	**9 Managing the deteriorating patient**
Rag rating **For elements within standard**	**8 green** **1 amber**	**9 green** **2 amber**	**7 green** **3 amber**	**3 green** **1 amber**	**6 green** **1 amber**	**8 green** **2 amber**	**green**	**4 green** **1 amber**	**4 green** **1 amber**
ET Summary of review 2014-15 Q1									

Eliza Tinsley ward transferred to community and therapies clinical group Dec 2014, this is the first formal ward review post transfer and will allow for a baseline, on the whole a positive review, with 80% of assessed elements green, there is more work to be done in relation to falls prevention, personalised care planning, and enriching the patient experience.
This will largely be addressed through the new model of care being proposed.
Again it must be acknowledged the unit manager has taken on oversight of three wards in last three months, with an acting B7 on McCarthy, which no doubt has diluted her impact and visibility on ET. The future management responsibilities will be management of Henderson and ET

- **D47 April 2015**

Objective	1 Environment and IPC	2 Essential care	3 Effective use of resources	4 Admission and discharge	5 Patient experience	6 Privacy and dignity in care	7 Safeguarding in care	8 Learning environment	9 Managing the deteriorating patient
Rag rating For elements within standard	7 green 2 amber	8 green 3 amber	6 green 4 amber	3 green 1 amber	6 green 1 amber	7 green s 3 amber	1 amber	3 green 2 amber	4 green 1 amber

D47 Summary of review 2014-15 Q1

Unit has been operating now for four months, it is a partnership approach with Midland Heart, who were unable to fully recruit to team until Q3 2014/15
It has been a challenging winter, in terms of developing and growing a team, in context of a busy winter, and the lack of a

stable, dedicated nursing service for the unit; initially based on one nurse model but on occasion had to flex to two nurses to meet patient flow requirements.
This on the whole was a positive review, the service is clearly demonstrating how patients are at the heart of service delivery, with a greater attention on therapeutic activity than previously observed, patient's on the unit speak highly of the unit and the staff approach. The team demonstrated they understand the discharge process, and need to be holistic in relation to impact on carer support.
The challenges of ensuring the shared governance framework between Midland Heart and SWBH is robust remains, and the clinical model has been recognised internally as needing to be strengthened to a two nurse model to support the patient flow requirements identified through the pilot.
Midland heart needs greater access to SWBH systems in relation to training.
The quality audit programme needs bedding in, with systems to evidence compliance.
The review will be repeated in 6 weeks, where it is envisaged a greater number of green standards will be evidenced

3.0 Other

The general risks for the group are:

- The current levels of vacancy across both in-patient areas and community teams. Despite several advertisements all posts have not been filled and repeat advertisements are pursued. This has been exacerbated by maternity leave with no backfill agreement for community posts. The high level of vacancy has negatively impacted upon other parameters of workforce indicators - staff sickness, PDR's and Mandatory training, especially for those areas where there is not ease of access to temporary staff cover.
- Time form offer of post to complete the recruitment process.
- Access to some mandatory training e.g. safeguarding adults training.
- Safer staffing community nursing – awaiting full role out of dependency tool to identify what the staffing and patient dependency profile is. In addition there is a long standing challenge of balancing scheduled work and incoming unscheduled work for community nurses and GP desire that their aligned nurses cover both types of work which is not maintainable with current staffing levels and does not provide a good patient experience; proposals are being discussed with the CCG.
- Staff working at low levels – an ergonomic assessment has been undertaken with regards to clinical workload tasks in patients homes and the impact on staff in working at low levels in the home. Based on the external report a business case is being finalised as to what actions and equipment needs to be pursued by the trust.
- Time taken to complete required audits and dashboards as not automated from the various data sources.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Demand and capacity summary report**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Rebecca Buswell – Project Manager**
DATE OF MEETING:	**7 May 2015**

EXECUTIVE SUMMARY:

The Trust has undertaken a review of demand and capacity for out patients and inpatient activity. The work takes into account the following annual priorities:

- To achieve a maximum 6 week wait for all specialties by October
- To meet our obligation for access targets for elective care at speciality level
- To eradicate reliance at speciality level on premium rate working
- To repatriate local activity in line with long term activity plan

All specialties in Medicine, Women's and Children's and Surgery A have a demand and capacity balanced plan with a route to clear waits to a maximum of 6 weeks by end of October based on contracted activity for this year. Capacity has also been identified for anticipated growth of local work. The only minor exception to this is paediatric new OP which has a gap of 6 appointments week. The specialty is doing further work at sub specialty level to reconcile this. Surgery B have not finalised their plans at the time of writing. There is an Executive sponsored Accelerated Support and Delivery week for the Clinical Group to finalise the service delivery model which concludes on the 7th May.

The approach used has standardised demand and capacity planning across all specialities using the Department of Health Intensive Support Team capacity planning tools. The project involved operational and clinical leaders at speciality level and was supported at a project level by Rebecca Buswell, Project Manager.

The Board heard previously from Cardiology of the improvement work they have completed last year reducing waits and working within a capacity footprint that met demand. This was entirely achieved by pathway redesign, demand management and efficiency improvements with no additional costs. Likewise all specialties have reviewed the opportunities for redesign, the outcome of which improves access and timeliness for patient pathways. Examples of developments to deliver a balanced demand and capacity plan include:

Dermatology

- Enhanced triage and advice and guidance , supporting GPs to care for patients in the community
- Increased capacity for patch testing utilising our specialist nursing team skills better
- Increased productivity and standardisation of clinic templates
- These plans take an anticipated deficit position of 103 appointments a week to a surplus position which enables opportunities for growth

Orthopaedics

- Implementation of enhanced triage and advice and guidance supporting GPs to care for patients in the community
- 1 stop MRI diagnostic pathway

- Reducing patent cancellations for surgery through improved pre assessment communication
- Extension of theatre time on selected lists (within capacity to enable scheduling of more joint work)
- Job planning changes and compliance
- These plans closed a gap of 133 OP appointments and 34 surgical procedures a week to a small surplus position

Paediatrics

- At subspecialty level, the team focus on allergy and cardiology pathways. An investment case for increasing allergy nurses is a proposal to close the capacity and demand gap for paediatrics.
- Improved advice and guidance
- Pilot telephone follow up for patients with neuro disabilities
- Development work on autism pathways
- These plans will close the gap of 83 OP slots in Q3 after reducing the 10 week OP wait to 6 weeks

Trust wide initiatives impacting on demand and capacity include:

- Advice and guidance – all specialties now provide advice and guidance via choose and book with a 72 hour response
- Partial booking which will be implemented later this summer will reduce DNA rates and minimise cancellations of clinics
- Job planning needs to be completed to ensure the capacity provided is wholly utilised
- A communication, engagement and marketing campaign will support the promotion of our redesigned patient pathways, reduced waiting times and clinical support through advice and guidance

Risk to delivery:

- Mismatch in capacity plans and job plans which will be mitigated by job plan and capacity plan sign off through at Group and Executive level
- Delay in partial booking role out which is being overseen by the YOOP Programme Board

Assurance on delivery:
The improvement and development work supporting the demand and capacity plan will be delivered by end of June in the main; this and the repatriation and marketing programme will be overseen by a project group led by the Chief Operating Officer with operational and clinical representation from all Clinical Groups.

REPORT RECOMMENDATION:

The Board is invited to discuss report

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

Accept	Approve the recommendation	Discuss
		x

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

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Accessible and responsive care, safe and high quality care, good use of resources
PREVIOUS CONSIDERATION:
Discussed by Executive Group

Medicine

Specialty name	Demand/ Capacity gap (to deliver service at 85th percentile)	Additional slots required to get to 6 weeks (clearing non recurrent backlog by OCTOBER 2015)	Anticipated growth in demand (based on 15-16 contracted activity)	TOTAL GAP	Actions to address the gap/continued improvement	Quantification (no. of slots)	Quantification (COST)	IAP submitted? (Y/N)	Delivery deadline	Lead	Remaining gap
Cardiology (NEW OP)	**0**	**0**	**8**	**8**	Surplus new capacity of +17 following standardisation of clinic templates	17	N/A	N/A	Ongoing	JB	**+9**
					Total number of additional slots available	**17**					
Cardiology (FUP)	**0**	**0**	**13**	**13**	New consultant recruitment, minimum he can see 30 patients with 1 reg	30					**+17**
					Should additional FUP capacity be required, actions in place:		N/A	N/A	Recruitment pending	JB	
					DNA = 3.66 patients average per week - monitoring of DNA rate to reduce	N/A	N/A	N/A	31/03/2016	JB	
					9 new can be convert into FU	N/A	N/A	N/A	If required	JB	
					Advise and Guidence to GP service	N/A	N/A	N/A	Ongoing	JB	
					Cancellation appointment = 1.33 patients per week - look to reduce if capacity compromised	N/A	N/A	N/A	Ongoing	JB	
					Review of discharge rates by consultant to take place	N/A	N/A	N/A	30/06/2015	JB	
					Total number of additional slots available	**30**					
Cardiology (ADMITTED)	**0**	**6**	**2**	**8**	Unreliable out dated Catheter Lab equipment on a number of occassions has resulted in the catheter lab on either site being unavailable which has resulted in cancelled procedures - circa 24 procedures YTD. Scheduling of catheter sessions is not as robust as it could be and needs to include cross site planning ahead of the cardiology reconfiguration, which will maximise efficeny and enable the planned growth in complex procedures when the new catheter labs come on line on the City site.	N/A	N/A	N/A	31/07/2015	JB	**+2**
					Surplus admitted capacity of +10	10	N/A	N/A	N/A	N/A	
					Total number of additional slots available	**10**					
Elderly Care (NEW OP)	**13**	**1**	**11**	**25**	All DNA's to be referrered back to GP exception for Parkinsons Patients	6	N/A	N/A	31/05/2015	S Naqvi / R Narwain	**0**
					Utilisation of clinics to ensure they are fully booked - close monitoring	0	N/A	N/A	30/06/2015	S Naqvi / R Narwain	
					Close monitoring and promotion of Choose & Book Advice & Guidance	0	N/A	N/A	Ongoing	S Naqvi / R Narwain	
					Communication will be sent by speciality lead to all consultants in Elderly care to reduce the number of follow-ups	7	N/A	N/A	31/05/2015	S Naqvi / R Narwain	
					Letters will be sent to GPs and patients with all positive results. Only patients with abnormal results will be booked back as follow up	0	N/A	N/A	31/05/2015	S Naqvi / R Narwain	
					Additional capacity identified (not previously included in IST model) which will address potential additional demand in 2015-16 due to increased contracted activity (also 12 per week)	12	N/A	N/A	Complete	S Naqvi / R Narwain	
					Total number of additional slots available	**25**					
Elderly Care (FUP)	**11**	**3**	**-2**	**12**	Reduce demand by 1 patient per clinic - communication sent to all Elderly Care physicians 27.4.15. Increase discharge rates per consultant.	**20**					**+8**
					Total number of additional slots available	**20**					
Neurology (New OP)	**0**	**0**	**-4**	**-4**	All DNA's referred back to GP. Look at booking processes to address high DNA rate.	N/A	N/A	N/A	31/05/2015	JB	**+4**
					Surplus capacity of +26 new slots - to be converted to address FUP gap				30/06/2015	JB	
					Utilisation of clinic to ensure they are fully booked, close monitoring.				Ongoing	JB	
Neurology (FUP)	**11**	**0**	**9**	**20**	Conversion of new slots to FUP	26			30/06/2015	JB	**+6**
					Total number of additional slots available	**26**					

Specialty name	Demand/ Capacity gap (to deliver service at 85th percentile)	Additional slots required to get to 6 weeks (clearing non recurrent backlog by OCTOBER 2015)	Anticipated growth in demand (based on 15-16 contracted activity)	TOTAL GAP	Actions to address the gap/continued improvement	Quantification (no. of slots)	Quantification (COST)	IAP submitted? (Y/N)	Delivery deadline	Lead	Remaining gap
Dermatology (NEW OP)	**68**	**24**	**11**	**103**	Cutaneous Allergy management: Triage pathway - (actioned) Patch Testing Meeting 05/03 for Forward Plan to increase capacity by 10 slots/week & flexibility of cover for leave/BH -	10	N/A	N/A	Complete	SV / MA / LR / TC / SC	**+37**
					New Consultant - 5 extra slots/week for Patch Testing	15	N/A	N/A	Complete		
					Paediatrics: SLA - BCH x 1 clinic	10	N/A	N/A	Complete		
					Phase 2: Clinic template standardisation	52	N/A	N/A	30/06/2015		
					Enhanced triage - 30% reduction in demand	53	N/A	N/A	30/06/2015		
					Total number of additional slots available	**140**					
Dermatology (FUP)	**362**	**31**	**2**	**395**	Cutaneous Allergy management (as above)	20	N/A	N/A	Complete	SV/MA/LR/TC/ SC	**+12**
					2 additional PA's (already in existence)	15	N/A	N/A	Complete		
					Dr Ogboli FUPs (SLA)	10	N/A	N/A	Complete		
					Walkin capacity	24	N/A	N/A	Complete		
					CNS existing capacity	181	N/A	N/A	Complete		
					Phase 2 (Clinical Effectiveness & Efficiency)						
					Additional CNS FUP	21	N/A	N/A	30/06/2015		
					Additional FUP per consultant	28	N/A	N/A	30/06/2015		
					30% reduction in demand through enhanced triage	108	N/A	N/A	30/06/2015		
					Total number of additional slots available	**407**					
Dermatology (ADMITTED)	**33**	**4**	**0**	**37**	Full utilisation of theatre space (490 minutes) - first audit **complete** and shared with clinical team. Second audit to take place to validate - agree way forward with clinical team. Locums, dermatologists and nurses covering simple surgery.	25	N/A	N/A	Complete	S Velangi/L Rea / T Crutchley	**+6**
					Adjust Mr Salahuddin job plan - 2 extra PA to meet demand	8	N/A	N/A	Complete	J Grabham/ L Rea / T Crutchley	
					Reduction in demand as per enhanced triage programme	10	N/A	N/A	30/06/2015	L Rea/ T Crutchley / D Campbell / M Anderson / S Murray	
					Total number of additional slots available	**43**					
Gastroenterology (NEW OP)	**84**	**12**	**0**	**96**	Review Endoscopy Service regarding increase of productivity from 65 to 85% - Meeting to map capacity and demand and action plan	20	N/A	N/A	26/02/2015	S Cooper	**+4**
					Review Booking Schedules		N/A	N/A	01/04/2015		
					Stage 1 clinic template review: standardise=increase of 16 new slots at SGH (non admit)	16	N/A	N/A	31/03/2015	L Rea/ T Crutchley/ M Anderson	
					Stage 2 clinic template review: = increase of 14 new slots	14	N/A	N/A	30/06/2015	L Rea/ T Crutchley/ M Anderson	
					Devise SOP for escalation process & enforce	0	N/A	N/A	31/03/2015	L Rea/ T Crutchley / D Campbell / M Anderson / S Murray	
					Enhanced Triage- 30% reduction in demand	50	N/A	N/A	01/05/2015	M Anderson/ L Rea	
					Review job plans to accommodate virtual triage	0	N/A	N/A	01/05/2015	M Anderson/ L Rea	
					Total number of additional slots available	**100**					
Gastroenterology (FUP)	**87**	**6**	**-16**	**77**	Enhanced triage - 30% reduction in demand	58	N/A	N/A	30/06/2015	LR/TC/DC/MA	**+1**
					CNS existing capacity	20	N/A	N/A	Complete		
					Total number of additional slots available	**78**					
					Stage 1: Increase slots by 4 new per consultant per week	28	N/A	N/A	17/04/2015	LR/TC/DC/MA	
					Stage 2: Increase slots by 3 new per consultant per week	21	N/A	N/A	31/05/2015		

Specialty name	Demand/ Capacity gap (to deliver service at 85th percentile)	Additional slots required to get to 6 weeks (clearing non recurrent backlog by OCTOBER 2015)	Anticipated growth in demand (based on 15-16 contracted activity)	TOTAL GAP	Actions to address the gap/continued improvement	Quantification (no. of slots)	Quantification (COST)	IAP submitted? (Y/N)	Delivery deadline	Lead	Remaining gap
Respiratory (NEW OP)	**47**	**6**	**5**	**58**	Devise SOP with escalation process and enforce	o	N/A	N/A	31/03/2015	ER/TC/DC/MA	**+15**
					Enhanced triage - 25% reduction in demand	24	N/A	N/A	31/05/2015		
					Total number of additional slots available	**73**					
Respiratory (FUP)	**25**	**4**	**6**	**35**	Enhanced triage - 25% reduction in demand	35					**0**
					Total number of additional slots available	**35**					
Immunology (NEW OP)	**9**	**7**	**-4**	**12**	Decide where greatest proportion of activity sits - Medicine/Pathology - data requested 20/02	0	N/A	N/A	01/04/2015	ML/SC/JB/SR	**+1**
					Review job plans and clinic scheduling to ensure that capacity meets demand. Create new slots.	9	N/A	N/A	01/05/2015		
					Decrease in activity for 2015-16	4	N/A	N/A	Ongoing		
					Devise SOP for escalation process and enforce	0	N/A	N/A			
					Total number of additional slots available	**13**					
Immunology (FUP)	**11**	**3**	**-1**	**13**	Reduction in contracted activity - focused reduction on demand (10% increase in discharge rates)	14	N/A	N/A	Ongoing	?	**0**
					Total number of additional slots available	**14**					

Surgery A

Specialty name	Demand/ Capacity gap (to deliver 85th percentile)	No. of additional slots required to get to 6 weeks (clearing non recurrent backlog by OCTOBER 2015)	Anticipated growth in demand (based on 15-16 contracted activity)	TOTAL GAP	Actions to address the gap/continued improvement	Quantification (no. of slots)	Quantification (COST)	IAP submitted? (Y/N)	Delivery deadline	Lead	Remaining gap
General Surgery (New OP)	68	6	0	74	Improved access to nurse led clinics	2	N/A	N/A	31/03/2015	SC	0
					Focus on reducing demand into service (2.5% per week)	6	N/A	N/A	Ongoing	SC	
					Reduction in DNA rate (Improve discharge rate to 80%-increase ROTT)	11	N/A	N/A	30/06/2015	SC/JG/EH	
					Defined pathways and capacity for cancer activity	5	N/A	N/A	30/05/2015	JG/EH	
					PTL validation	0	N/A	N/A	31/03/2015	SC	
					Evidence of the model to be used to inform job planning review	25	N/A	N/A	30/05/2015	EH/JG	
					Use of SCP to increase 2 x clinics to 50 weeks per year	15	N/A	N/A	30/04/2015	SC	
					Additional PF nurse clinic	10	N/A	N/A	30/05/2015	SC	
					Total number of additional slots available	**74**					
General Surgery (FUP)	19	0	-2	17	Create virtual clinics to reduce clinic appointment times	3	N/A	N/A	30/06/2015	SC/JG/EH	+2
					Reduction in DNA rate (improve discharge rate to 80% - increase ROTT)	3	N/A	N/A	30/06/2015	SC/JG/EH	
					PTL validation	0	N/A	N/A	31/03/2015	SC	
					Evidence of the model to be used to inform job planning review	3	N/A	N/A	30/05/2015	EH/JG	
					Improve patient pathway redesign to ensure GP/community input focus (Laps, Hernia, Pelvic floor, rectal bleed)	10	N/A	N/A	30/06/2015	SC/JG/EH	
					Total number of additional slots available	**19**					
General Surgery (ADMITTED)	18	5	-7	16	PTL validation	0	N/A	N/A	31/03/2015	SC	+2
					Evidence of the model to be used to inform job planning review	5	N/A	N/A	30/05/2015	EH/JG	
					Use of Breast theatre lists	2	N/A	N/A	31/03/2015	SC	
					Improve Utalisation to 85%	2	N/A	N/A	30/05/2015	EH/JG	
					PA Increase by 4 extra	9	N/A	N/A	Ongoing	EH/JG	
					Total number of additional slots available	**18**					
Plastic Surgery (NEW OP)	12	1	8	21	Coding of Walsall Activity to Inpt only	2	N/A	N/A	31/03/2015	SC	0
					Implementation of 6 week rota to ensure capacity is where current demand is	6	N/A	N/A	01/04/2015	SC	
					Reduction in DNA rate (Improve discharge rate to 80%)	2	N/A	N/A	02/04/2015	SC	
					Reduction in OP demand (10% per week)	11	N/A	N/A	Ongoing	SC	
					PTL validation	0	N/A	N/A	31/03/2015	SC	
					Total number of additional slots available	**21**					
Plastic Surgery (FUP)	34	0	7	41	Create community discharge process for dressing clinics and post op	20	N/A	N/A	30/06/2015	SC	0
					Improve DNA discharge rate	10	N/A	N/A	01/06/2015	SC	
					Standardise clinic templates	5	N/A	N/A	02/05/2015	SC	
					Reduction in follow up demand (5% per week)	6	N/A	N/A	30/06/2015		
					Total number of additional slots available	**41**					
Plastic Surgery (ADMITTED)	11	4	0	15	Implementation of 6 week rota to ensure capacity is where current demand is	2	N/A	N/A	31/03/2015	SC	-4
					Compliance with EA policy	3	N/A	N/A	31/03/2015	SC	
					MDT attendance via Teleconference	1	N/A	N/A	30/04/2015	SC	
					Theatre utalisation to 85%, improve late starts/early finishes	5	N/A	N/A	30/04/2015	SC/GS	
					Total number of additional slots available	**11**					

Specialty name	Demand/ Capacity gap (to deliver 85th percentile)	No. of additional slots required to get to 6 weeks (clearing non recurrent backlog by OCTOBER 2015)	Anticipated growth in demand (based on 15-16 contracted activity)	TOTAL GAP	Actions to address the gap/continued improvement	Quantification (no. of slots)	Quantification (COST)	IAP submitted? (Y/N)	Delivery deadline	Lead	Remaining gap
Breast Surgery (NEW OP)	**27**	**3**	**3**	**33**	Implementation of SCP f/u clinics to release consultants	10	N/A	N/A	30/06/2015	SC/JG/MS	**-3**
					Release of breast surgeons from on call rota	20	N/A	N/A	30/06/2015	SC/JG/MS	
					Total number of additional slots available	**30**					
Breast Surgery (FUP)	**2**	**0**	**2**	**4**	Implementation of SCP f/u clinics to release consultants	4	N/A	N/A			**0**
					Total number of additional slots available	**4**					
Breast Surgery (ADMITTED)	**2**	**2**	**-1**	**3**	Theatre utalisation to 85%, improve late starts/early finishs	1	N/A	N/A	30/04/2015	MS/SC	**0**
					Audit of oncoloplastic throughput required to ensure estimation is accurate potential to increase throughput	1	N/A	N/A	30/06/2015	SC	
					Use of General Surgery capacity to ensure no shortfall	1	N/A	N/A	01/07/2015	SC	
					Total number of additional slots available	**3**					
Urology (NEW OP)	**51**	**5**	**8**	**64**	Recruitment of 7th Consultant with additional outpatient sessions	12	£100k	Y	01.09.2015	Ugo Otite	**0**
					SCP and Nurse new appointments	12	N/A	N/A	Completed	Bethan Downing	
					Increase Haematuria capacity by 4 per week	4	N/A	N/A	01.06.15	Ugo Otite	
					Management of DNAs (improve discharge rate / implement partial booking)	4	N/A	N/A	01..06.2015	Bethan Downing	
					Referral management - advice and guidance	4	N/A	N/A	01.04.2015	Ugo Otite	
					Referral management - duplicate referrals	2	N/A	N/A	completed	Mo Nawaz	
					Assess capacity and best use of junior doctors	10	N/A	N/A	01.04.2015	Mo Nawaz	
					Streamline clinic tempates including junior doctor support for clinics	16	N/A	N/A	01.06.2015	Bethan Downing	
					Total number of additional slots available	**64**					
Urology (FUP)	**7**	**5**	**-5**	**7**	Communication of 'normal' results - virtual/letter and guidance to GPs on further management and triggers for re-referral	3	N/A	N/A	01/06/2015	UO	**+3**
					Pathway redesign (raised PSA normal biopsy/surveillance)	3	N/A	N/A	01/06/2015	UO	
					Management of DNAs (improve discharge rate / implement partial booking)	4	N/A	N/A	01/06/2015	UO	
					Total number of additional slots available	**10**					
Urology (ADMITTED)	**11**	**4**	**3**	**18**	Increase pool of pre-assessed patients	1	N/A	N/A	01/06/2015	B Downing	**-7**
					Review all admissions where post op currently require overnight admission for AM catheter removal	2	N/A	N/A	01/09/2015	UO	
					Moving D/C to appropriate environment	0	N/A	N/A	01/06/2015	B Downing	
					Improve Utilisation of daycase lists	8	N/A	N/A	01/06/2015	B Downing	
					Total number of additional slots available	**11**					
Vascular Surgery					Re-align job plan capacity to OP capacity - requires outpatient room	0	N/A	N/A	01.06.2015	Bethan Downing	
					SCP/CNS review	9	N/A	N/A	Completed	Bethan Downing	
					Management of DNAs (improve discharge rate / implement partial booking)	2	N/A	N/A	01.06.2015	Ugo Otite	

Specialty name	Demand/ Capacity gap (to deliver 85th percentile)	No. of additional slots required to get to 6 weeks (clearing non recurrent backlog by OCTOBER 2015)	Anticipated growth in demand (based on 15-16 contracted activity)	TOTAL GAP	Actions to address the gap/continued improvement	Quantification (no. of slots)	Quantification (COST)	IAP submitted? (Y/N)	Delivery deadline	Lead	Remaining gap
Vascular Surgery (NEW OP)	22	0	-1	21	Referral management - promote advice and guidance	1	N/A	N/A	01.06.15	Ugo Otite	0
					Streamline clinic templates	2	N/A	N/A	01.06.2015	Bethan Downing	
					Realign follow up capacity	7	N/A	N/A	Completed	Bethan Downing	
					Total number of additional slots available	**21**					
Vascular Surgery (FUP)	6	0	0	6	Pathway redesign (one stop access to diagnostics)	2	N/A	N/A	01/09/2015	BD	0
					Streamline clinic capacity	2	N/A	N/A	01/06/2015	UO	
					Management of DNAs (improve discharge rate / implement partial booking)	2	N/A	N/A	01/06/2015	UO	
					Total number of additional slots available						
Vascular Surgery (ADMITTED)	4	0	1	5	Improve throughput per list - 3 cases per list	2	N/A	N/A	01/06/2015	UO/PN	0
					Move LA vein procedures to minor ops	1	N/A	N/A	01/06/2015	B Downing	
					Improve LA/GA ratio	0	N/A	N/A	01/06/2015	UO/PN	
					Pathway standardisation for veins ensuring consultant apply pathway across specialty	2	N/A	N/A	01/06/2015	UO/PN	
					Develop method of picking up sessions (all sessions are on QI days) - loss of 10 sessions per year	0	N/A	N/A	01/06/2015	UO/PN	
					Total number of additional slots available	**5**					
Trauma & Orthopaedics (NEW OP)	124	0	9	133	Fracture clinics to be deliverd by consultant on call during on call week, this will give 200 slots per week which is 134 slots per week more than now (over 52 weeks)	134	N/A	N/A	30/06/2015	YJ/JJ/SR	+28
					Separate out out urgent hands, upper limb and P & P	20	N/A	N/A	30/06/2015	YJ/JJ/SR	
					New job plans will include number of clinics as now but with fracture capacity removed (see above). Therefore dedicated first outpatient capacity. No increased slots	0	N/A	N/A	30/06/2015	YJ/JJ/SR	
					Referral management, eg Advice and Guidance, duplicate referrals, fixed templates	2	N/A	N/A	TBC	YJ/JJ/SR	
					Standardise pathways for all consultants, eg, Ensure all consultants are working to pathways already implemented and checking results and discharging where possible. No additional capacity but will reduce 18 week pathway	0	N/A	N/A	On going	YJ/JJ/SR	
					1 stop MRI 6 patient slots per week. 3 on each site. Discussing with imaging. Will reduce 18 week pathway but not provide additional capacity	0	N/A	N/A	TBC	YJ/JJ/SR	
					Reduce DNA rates - Partial Booking of New appointments	5	N/A	N/A	01/06/2015	YJ/JJ/SR	
					Total number of additional slots available	**161**					
Trauma & Orthopaedics (FUP)	0	0	-12	-12	Surplus capacity of +24 - flexibility to convert to admitted	N/A	N/A	N/A	Ongoing	YJ/JJ/SR	+36
					Total number of additional slots available	**0**					
					Improved discharge of patient initiated cancellations (3 weeks notice / 2 reasonable offers) in line with Access Policy	2	N/A	N/A	01/06/2015	YJ/JJ/SR	
					Flexible theatre sessions. Extend all whole day sessions by one hour to deliver 4 joints per list	4	N/A	N/A	01/08/2015	YJ/JJ/SR	

Specialty name	Demand/ Capacity gap (to deliver 85th percentile)	No. of additional slots required to get to 6 weeks (clearing non recurrent backlog by OCTOBER 2015)	Anticipated growth in demand (based on 15-16 contracted activity)	TOTAL GAP	Actions to address the gap/continued improvement	Quantification (no. of slots)	Quantification (COST)	IAP submitted? (Y/N)	Delivery deadline	Lead	Remaining gap
Trauma & Orthopaedics (ADMITTED)	**27**	**10**	**-3**	**34**	Maximise DC capacity to improve throughput of genuine DC. Flexing usage of BTC theatres between all T & O consultants as necessary via annualised job planning	3	N/A	N/A	01/06/2015	YJ/JJ/SR	**-4**
					Remove shoulders from Day case facilities and undertake surgery in theatre 3 - Enabling higher numbers to go through SDU DC sessions.Available Thursday afternoon and Friday unless other specialties displaced (plastics)	3	N/A	N/A	01/06/2015	YJ/JJ/SR	
					Add elective IP onto P & P lists when demand is low	2	N/A	N/A	01/05/2015	YJ/JJ/SR	
					Additional 3 theatre sessions (IAP case) for trauma to be used for elective patients when trauma is low	2	N/A	N/A	TBC	YJ/JJ/SR	
					Increase pool of pre assessed patients to fill late cancellations slots	2	N/A	N/A	01/06/2015	YJ/JJ/SR	
					Additional consultant Based on 12 PA job plan to undertake 6 theatre sessions. Distribution of DCC to be established and may involve other consultants.	12	£100k	No	TBC	YJ/JJ/SR	
					Redistribution of outpatients sessions to theatre sessions as improvements made	TBC	N/A	N/A	TBC	YJ/JJ/SR	
					Total number of additional slots available	**30**					
Pain Management (NEW OP)	**25**	**6**	**8**	**39**	F/up DNA high, will discharge and review capacity to create new OP appt. (13%+)	1	N/A	N/A	30/05/2015	DLS	**-14**
					40 % of our appointments will be given C&B from May 2015 - if this reduces DNA to 10% will increase capacity	1	N/A	N/A	01/05/2015	DLS	
					Review of clinic templates to implement standardisation	2	N/A	N/A	30/04/2015	DLS/AK	
					Full establishment of nursing staff to enable reinstatement of T/F clinics (member of staff resigned)	6	N/A	N/A	01/07/2015	DLS/YJ/LH	
					Transfer of work from UHB OP 1.3 additional patients per week. Additional capacity needed One consultant, one qualified nurse and one physio per session. Costs to be determined Pain management - support and funding needed for 1.5 clinics per week extra Currently unfunded	15	TBC	No	TBC	DLS/YJ/LH	
					Total number of additional slots available	**25**					
Pain Management (FUP)	**38**	**5**	**6**	**49**	Follow up capacity significantly reduced in response to CCG request to amend NFUP ratio	0					**-28**
					Impovement in FUP DNA rate	5					
					Focus on reducing demand into service	15					
					Total number of additional slots available	**20**					
Pain Management (ADMITTED)	**0**	**4**	**5**	**9**	Surplus capacity of +4 admits per list	4	N/A	N/A	Ongoing	D Lloyd-Smith	**-5**
					UHB transfer of work: will lead to 6 additional lists per year currently unfunded. 61 day cases Costs to be determined. Creatig a capacity shortfall once work transfers	0	TBC	No	TBC	D Lloyd-Smith	
					Total number of additional slots available	**4**					

W&CH

Specialty name	Demand/ Capacity gap (to deliver 85th percentile)	No. of additional slots required to get to 6 weeks (clearing non recurrent backlog by OCTOBER 2015)	Anticipated growth in demand (based on 15-16 contracted activity)	TOTAL GAP	Actions to address the gap/continued improvement	Quantification (no. of slots)	Quantification (COST)	IAP submitted? (Y/N)	Delivery deadline	Lead	Remaining gap
Gynaecology & Gynae Oncology (NEW OP)	**19**	**0** ***Target = 4 weeks***	**1**	**20**	Standardise clinics in outpatients.*	0	0	N/A	Complete	S Kehoe	**+5**
					Review of Directory of services	0	0	N/A	Complete	S Kehoe	
					Starting up a 2 week wait triage clinic.*	0	0	N/A	01/06/2015	S Kehoe	
					Review DNA Rates	1	0	N/A	01/06/2015	S Kehoe	
					Review discharge rates by Consultant	0	0	N/A	Complete	S Kehoe	
					New vulva research clinic (to release FUP capacity)	5	0	N/A	01/08/2015	S Kehoe	
					Convert 1x FUP per General Gynae clinic to New	8	0	N/A	01/08/2015	S Kehoe	
					Choose and book directly bookable clinics.**	0	0	N/A	Complete	S Kehoe	
					Additional consultant (already agreed)	10	0	N/A	01/09/2015	G Downey	
					Total number of additional slots available	**24**					
Gynaecology (FUP)	**0**	**0**	**1**	**1**	Audit of follow ups by consultant	1	0	N/A	01/08/2015	S Kehoe	**+11**
					Surplus FUP capacity	6	0	N/A	Complete		
					Conversion of FUP slots to news	-8	0	N/A	01/06/2015	J Mills	
					Review of discharge rates by consultant	1	0	N/A	01/08/2015	S Kehoe	
					Additional consultant (already agreed)	10	0	N/A	01/09/2015	G Downey	
					Review DNA Rates	1	0	N/A	01/08/2015	S Kehoe	
					Total number of additional slots available	**11**					
Gynaecology (ADMITTED)	**0**	**0** ***Target = 3 weeks***	**0**	**0**	Capacity currently meeting delivery of 85th percentile exactly (42 DTAs per week)	N/A			N/A	N/A	**0**
					Total number of additional slots available	**0**					
Gynae Oncology (FUP)	**6**	**0**	**1**	**7**	Audit of follow ups by consultant	0	0	N/A	complete	S Kehoe	**+17**
					New vulva research clinic (to release FUP capacity)	10	0	N/A	01/08/2015	S Kehoe	
					Review of Directory of services	0	0	N/A	Complete	S Kehoe	
					Review of discharge rates by consultant	0	0	N/A	Complete	S Kehoe	
					Review DNA Rates	1	0	N/A	01/08/2015	S Kehoe	
					Total number of additional slots available	**11**					
Gynae Oncology (ADMITTED)	**7**	**0** **Target = 3 weeks**	**2**	**9**	Ongoing review of out of area referrals	0	0	N/A	ongoing	S Kehoe	**0**
					Refine referral pathways from units - reduction in number of breaches	0	0	N/A	01/09/2015	S Kehoe	
					Additional theatre list needed to cover the proven 10% increase in Gynae Onc patients	2	£12,000 & associated theatre costs	N (£12k within group budget)	TBC	S Kehoe	
					2 x extended theatre lists per week	2	0	N/A	Surgery A to confirm	S Kehoe	
					Improved theatre utilisation:		0	N/A	01/07/2015	S Kehoe	
					Surgical approach	1	0	N/A	01/06/2015	S Kehoe	
					Review of training in theatres	2	0	N/A	01/06/2015	S Kehoe	
					Total number of additional slots available	**7**					
Paediatrics (NEW OP)	**34**	**21** ***(Currently performing at 10 weeks)***	**7**	**62**	Creation of additional capacity (CD to review)	10	0	N/A	01/08/2015	C Agwu	**-28**
					Continue to work through standardisation of clinic templates to include specialist clinics	0	0	N/A	ongoing	C Agwu	
					Pilot telephone follow up clinic for neuro-disability service with aim to create capacity within CDC clinics for new patients	2	0	N/A	01/09/2015	C Agwu	
					Reduce follow up of children where main concern is behavioural issues by referral to alternative services	2	0	N/A	01/08/2015	C Agwu	
					Improve autism pathway by reduction in multiple follow up appointments	2	0	N/A	01/08/2015	C Agwu	
					Develop the role of an allergy nurse specialist to create capacity in consultant led clinics.	14	£50.5k	Y	01/08/2015	H Bennett	
					Robust management of patient cancellations for allergy and weight management services by automatic discharge back to GP's for cancelled new appointments	2	0	N/A	01/05/2015	L Eyre	
					Improved marketing of advice and guidance services offered within paediatrics.	2	0	N/A	01/07/2015	Trust	
					Total number of additional slots available	**34**					
Paediatrics (FUP)	**5**	**14**	**2**	**21**	Audit of follow ups by consultant	0	0	N/A	01/08/2015	C Agwu	**-15**
					3 month Pilot telephone follow up clinic for neuro-disability service with aim to create capacity within CDC clinics for new patients (starts June 2015)	2	0	N/A	01/09/2015	C Agwu	
					Reduce follow up of children where main concern is behavioural issues by referral to alternative services to release capacity for new patients	2	0	N/A	01/09/2015	C Agwu	
					Review DNA Rates	0	0	N/A	Ongoing	C Agwu	
					Improve autism pathway by reduction in multiple follow up appointments	2	0	N/A	01/08/2015	C Agwu	
					Total number of additional slots available	**6**					

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Complaints & PALS report: 2014/15 quarter 4
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Karen Beechey, Head of PALS & Complaints
DATE OF MEETING:	7 May 2015

EXECUTIVE SUMMARY:

This report sets out details of Complaints and PALS enquiries received between January and March 2015 (Quarter 4).

The report provides high level data on PALS and Complaints, demographics of the subject of the complaint if a patient and the reasons those complaints were made.

The report also details some of the lessons learned and the changes which have been made in wards/departments as a result of the enquiry or complaint.

REPORT RECOMMENDATION:

The Board is recommended to DISCUSS and NOTE the contents of the report.

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

Accept	Approve the recommendation	Discuss
✓		✓

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:

Improve and heighten awareness of the need to report and learn from complaints.

PREVIOUS CONSIDERATION:

Quality & safety Committee on 24 April 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Complaints and PALS Report

2014/15: Quarter 4

COMPLAINTS MAKING A DIFFERENCE

Complaints provide a learning opportunity for individuals as well as changes in practices or procedures which may not have been evident without the patient or their representative raising the issue. Below are some improvements made as a direct result of this feedback.

What we were told	Our response	The difference
Following a foot operation the complainant had to return several times as they felt that they were not healing appropriately. They went for physio but the consultant later advised that they would not have recommended this. The complainant then felt that the consultant was unhappy that they had attended physio, and that we did not provide enough information after surgery, and we did not listen to them.	Consultant will in future check that his patients understand his explanations around their conditions and treatment and encourage them to ask more questions if they feel this is necessary.	Patients will be better informed in an environment that is welcoming of questions, at the time of their consultation.
The patient had to chase their own MRI results and had to have the scan re done. The bicep rupture wasn't identified in the first MRI and now the patient will either have to have two corrective procedures, or chose not to be treated, leaving them with only 85% arm movement.	It was identified that the root cause of this issue was the delay in reporting, and this occurred because only two members of staff had access to these MRI results. Access has now been granted to all departmental secretaries and now results can be managed more effectively.	Effective management of results will reduce the risk of delayed reporting and further reduce the chances of there being long term health implications for patients.
Patient was waiting 2 hours for the on-call Gynaecologist to treat her whilst suffering haemorrhaging following a gynaecological operation that was carried out a few days before. The on-call Gynaecologist was ready to treat her but felt that a shift handover delayed her being treated.	When the consultant requested that the on call team be contacted (as the patient came in via A&E very early in the morning) this was not acted upon straight away. By the time this had been identified, the day shift was about to commence. It was decided to wait for this shift to start, and treatment then commenced. Whist not detrimental to the patients' health or recovery, it is recognised that this delay in contacting the on call team, and waiting for the day shift to start, did delay this patient's treatment which was not acceptable.	In future when on call teams are requested this action will be carried out immediately in order to ensure such delays do not occur. If there is a reason to query the request this will be discussed after the call out has been actioned, not before.
Patient had to claim travel expenses and the finance office was closed for lunch. The Patient had to wait 50 minutes for staff to return. Patient has suggested staggered lunch breaks.	As a result of this complaint, the finance office has introduced a staggered lunch roster enabling the office to stay open throughout the working day.	No one will have to wait to claim travel or other expenses; the service is now more in line with our Care Promises and the opening hours more reflective of when patients need their services.

What we were told	Our response	The difference
Patient's scan results were not available for discussion with the Consultant and having been promised that this would be the case, the complainant felt misled.	The scan was marked as urgent, and the patient reassured that the 'reporting day' (the day per week that is put aside to report such results) would work in with the consultation appointment. Unfortunately there was a delay in the reporting day that staff were unaware of. This meant that the results were missing at the time of the consultation. As a result of the complaint, the system for reporting has changed. There is no longer a specific day for reporting, rather results are reported straight away, and the team has been reminded to ensure that urgent requests are more explicit	This will reduce the risk of consultations taking place without important information to hand, and will instil confidence that patients have in our ability to keep our promises.
Patient attended A&E with a possible fracture following a fall. Following an x-ray he was diagnosed with a pulled muscle and prescribed co-codamol for pain relief. The patient's carer was concerned there may have been a misdiagnosis because the patient was still in extreme pain and his on-going kidney condition had deteriorated which she thinks may have been due to the prescribed pain relief. This patient was also treated at another hospital in the days following for a fracture.	We acknowledge that there was a delay in identifying the fracture, but the correct procedure relating to x-ray reporting were followed. Assurance was also given regarding the dosage of pain relief in a patient with a kidney condition. There was a delay in the consultant review of the x-ray, (which did identify the fracture) as we don't routinely review x-rays over the weekend. We have reviewed our missed x-ray policy and a named consultant now reviews all reports on a daily basis to avoid any delays in contacting patients.	This will allow us to ensure patients receive any follow up treatment required in timely manner.
Issues regarding the opening visiting times at Sandwell were raised in this complaint. The patient states they had no privacy or dignity during personal conversations with consultants and with visitors in and out all day.	It was acknowledged that changes to the visiting hours will on the whole have a positive impact on patients' experience. The Chief Nurse has reviewed open visiting times at the end of the trial (end March 2015), and it is planned that the results will be shared in a further response (planned for April/ May) and sent to the complainant detailing these findings.	Some changes to open visiting have already been made in response to feedback from patients, relatives and staff, such as changing the start time from 10 to 11am, and others will follow to further improve the patient experience.

COMPLAINTS AND PALS: 2014/15

Quarter 4 highlights

1.	The total number of PALS concerns registered was 554, down by 84, which was largely due to the reduction in the continence calls that have all but ceased in the quarter. This figure does not include an additional 74 calls about appointments. (page 18)
2.	The total number of Complaints logged was 207, a decrease of 28 across the quarter compared to Q3 2014. 17 of these were withdrawn by the complainant at some point during the quarter leaving 190 to manage. There were 3 less complaints made in January 2014 compared to January 2015, 10 less complaints made in February 2014 compared to February 2015, and 20 more made in March 2014 compared to March 2015. (page 6)
3.	The total number of compliments collected for Q4 2014/15 was 354 compared to 397 in Q3 2014/15 and 504 in Q2 2014/15. It is not clear whether this is a genuine drop in compliments or the reporting and collection method itself as some of the wards and other clinical areas that reported compliments in the last quarter returned none this quarter. (Appendix 11 page 33)
4.	The average number of days taken to resolve complaints saw a decrease of 13 days from 75 (Q3 2014/15) down to 62 (Q4 2014/15). This decrease can be attributed to the resolution of fewer older complaints as well as a higher proportion of newer complaints being managed within their target dates. (page 8)
5.	Complaints per 1000 bed days have decreased when compared to the previous quarter, with an average rate of 3.1 against 4.5 in the previous quarter. This increase has nearly flattened the trend line, with an overall rolling average over the last 12 months of 3.5. (page 7)
6.	When looking at the complaints rate per 1000 FCE it is still Surgery B that has the highest complaints rate, and Woman and Child with the lowest. Women and Child have seen an increase in rate from 2.5 to 3.61 with Medicine on slightly higher at 3.66. (page 8 and page22)
7.	'Not Upheld' complaints made up 26% of closed complaints against 20% in Q3 2014/15 and 33% in Q2 2014/15 but with no emerging trends in terms of Groups or themes. (page 14)
8.	The three themes that emerged out of complaints this quarter are Attitude of Staff, Clinical Care and Appointments, the same as the previous two quarters. Surgery B has again had the highest number of complaints about their management of appointments than any other Clinical Group, and PALS enquiries about the same theme featured Surgery B but at a reduced rate of 27% compared to 47% in Q3 2014/15. (page 12)
9.	Reopened cases totalled 44 and 5 of those re opened were due to not all the issues being answered in our first response. This compares to 23 reopened with 5 where not all issues were addressed in Q3 2014/15 and 34 reopened, 9 with outstanding issues from Q2 2014/15. There has been a steady reduction in the % of those reopened where not all issues were addressed, from 26% in Q2 2014/15, to 22% in Q3 2014/15, halving to just 11% in Q4 2014/15. (page 15)
10.	There were 2 new PHSO enquiries of the Trust in this quarter, and 3 previous enquiries were closed off. Of those closed, 1 was not upheld, 1 was partially upheld and the other was upheld with financial penalty. (pages 16)
11.	Complaints satisfaction survey return rate was similar to last month at 19% compared to 20% for Q3 2014/15 and 14% for Q2 2014/15. The overall satisfaction rate improved to 46% compared to 33% in Q3 but still has a way to go to the 60% rate of Q2 2014/15. (page 10)
12.	There is still disproportionality of the ethnicity of the subjects of complaints verses the general populous of our patients, particularly in Pakistani's and Black Caribbean's with work planned to investigate this with a view to ensuring accessibility equally across all ethnic groups. (page 11)

COMPLAINTS AND PALS: 2014/15

Index

INTRODUCTION

Concerns and complaints raised by patients and visitors must be viewed positively as an unsolicited form of feedback. These are opportunities to improve our services and the care we provide based on user experience.

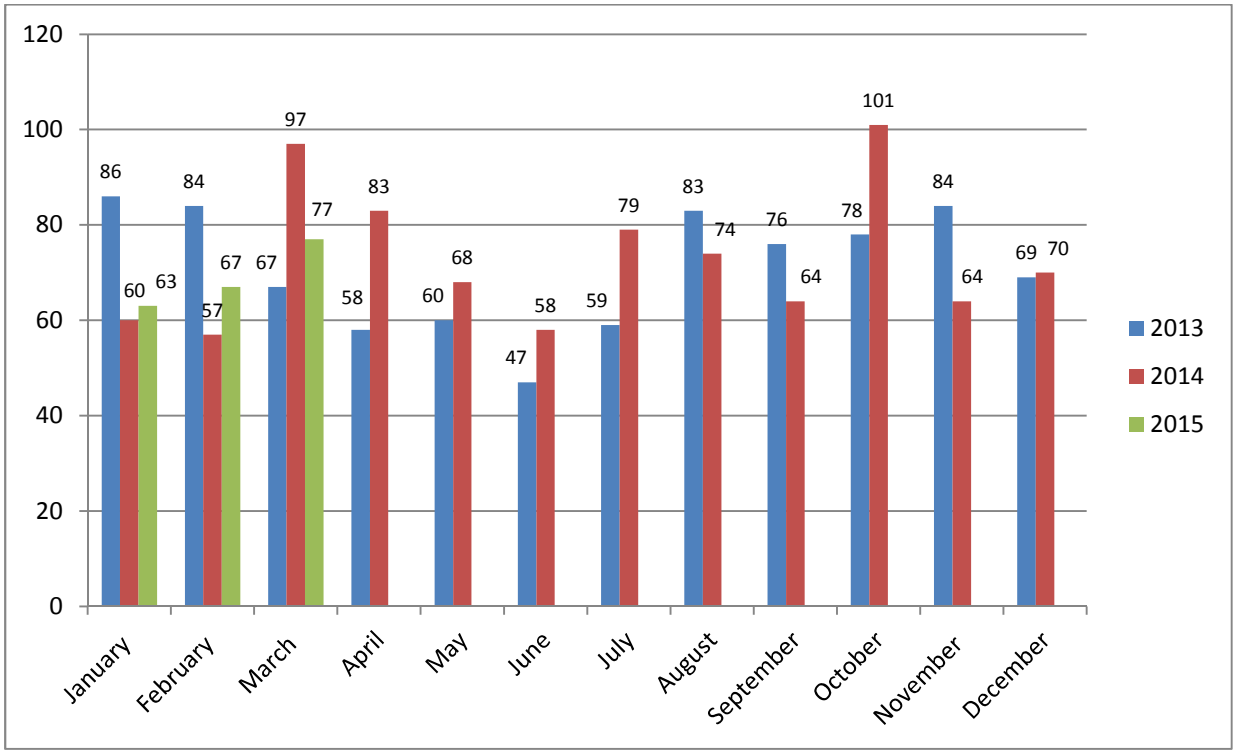
This report sets out and provides commentary on the complaints, PALS enquiries, local departmentally resolved concerns and compliments, the way they were managed, who they were made against and what about. The important learning opportunities are evidenced and the subjects of the complaints are also profiled.

COMPLAINTS

1. Complaints Management

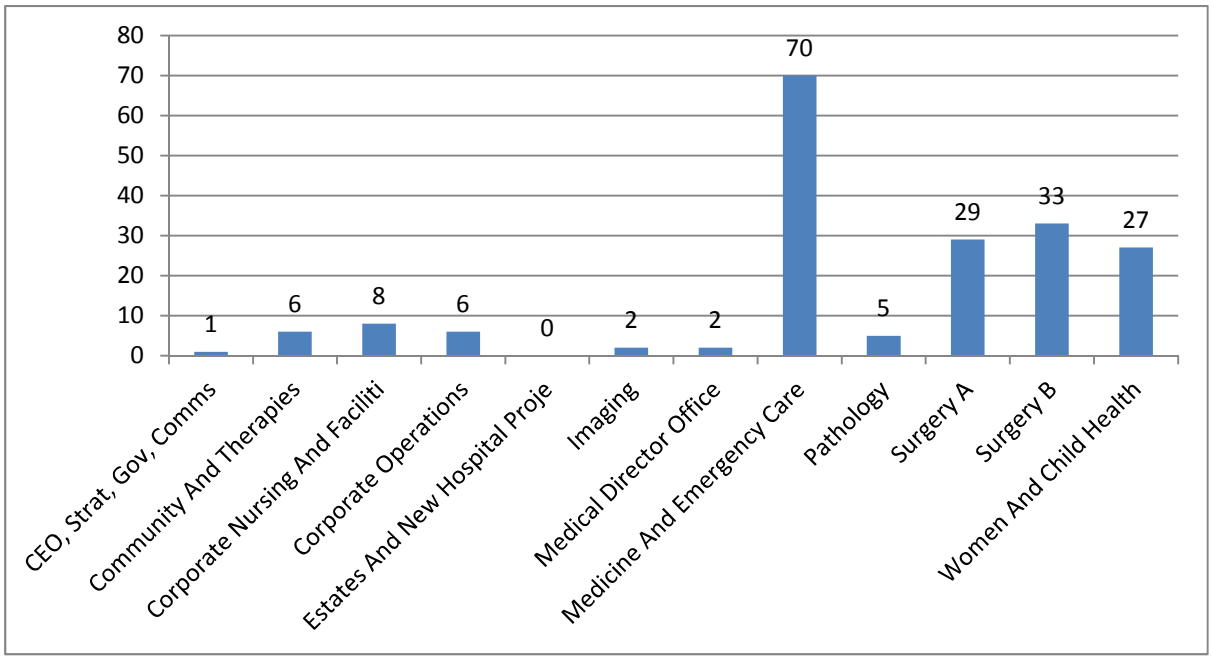
1.1 Total received

The total number of complaints received in Q4 2014/15 was 207, 28 less than in Q3 2014/15 and 32 less than in Q2 2014/15. In the same period the previous year, Q4 2013/14 214 complaints were made. When broken down by month, year on year, there were 3 more complaints made in January 2015 compared to January 2014, 10 more complaints made in February 2015 compared to February 2014 and 20 less made in March 2015 compared to March 2014. It should also be noted that 17 complaints were withdrawn in this quarter, slightly less than in the previous quarter leaving 190 actively managed this quarter.



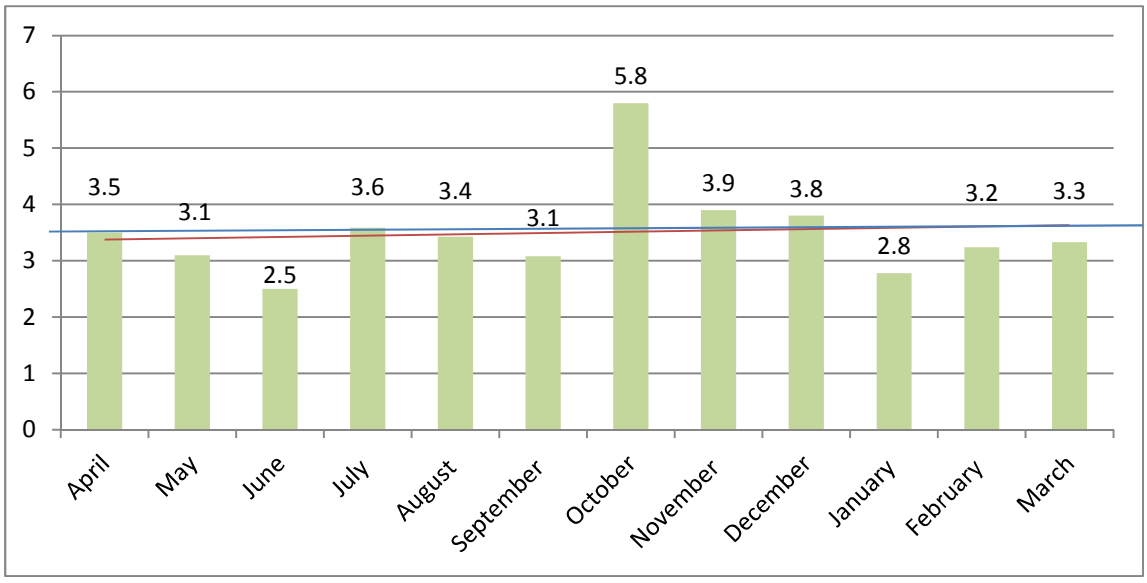
1.2 Complaints by Group

When analysing the complaints received in Q4 2014/15, by Clinical Group and Corporate Directorate, Medicine continue to receive the most complaints. **Appendix 1a** shows how these figures compare with the last 4 quarters. **Appendix 1b** shows how this is broken down by ward (where applicable)



1.3 Complaints by 1000 bed days

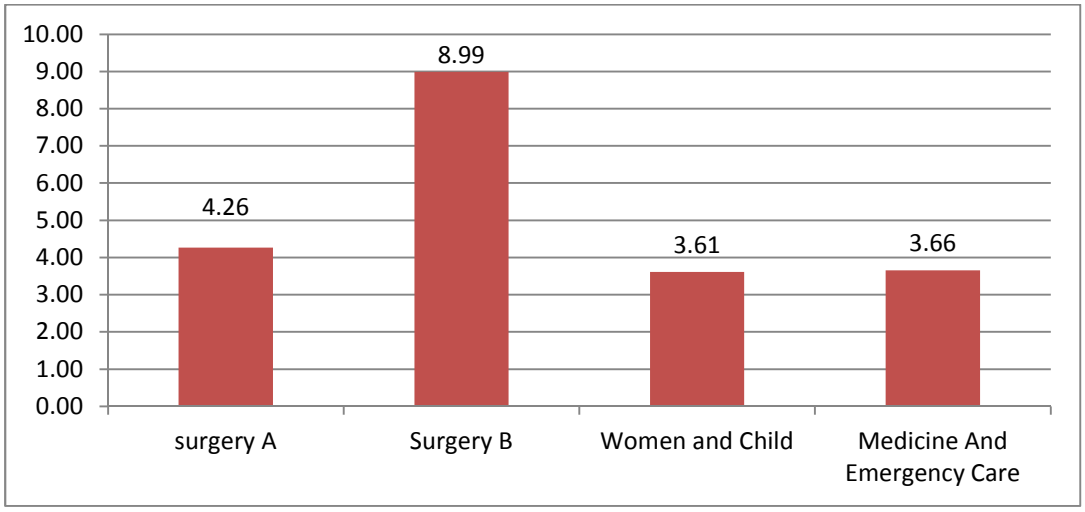
The complaints rate, calculated as complaints per 1000 bed days for Q4 2014/15 is lower than the previous two quarters. This has flattened the trend line slightly, but not affected the 12 month rolling average of 3.6, which has remained the same for this quarter. The trend line is shown in red and the rolling average is shown in blue.



1.4 Complaints received per 1000 FCE (Finished Consultant Episodes)

To more accurately compare which Clinical Group is receiving the most complaints, it is important to represent these not just as numbers of complaints, but as a proportion of the patients that have received care in these areas. This then puts these numbers into context. By comparing the numbers of complaints with FCE we can gauge better whether one service or another is attracting more dissatisfaction and once understood, drill down further into what aspect of that service needs to improve. This analysis was only applied to the largest of the Clinical Groups, as they contribute to 83% of the complaints. This is a small increase from the 81% proportion from Q3 2014/15 and a decrease from the 86% of Q2 2014/15.

Complaints received per 1000 FCE (Finished Consultant Episodes)



Although the majority of complaints received are still made about Medicine, it is again Surgery B that has the highest number of complaints per 1000 FCE and as shown in **appendix 2** this rate is slightly lower than it was in Q3 2014/15. Reference is also made to the theme of complaints in section 2.2 and **appendix 6** In order to better understand the types of complaints made against Surgery B.

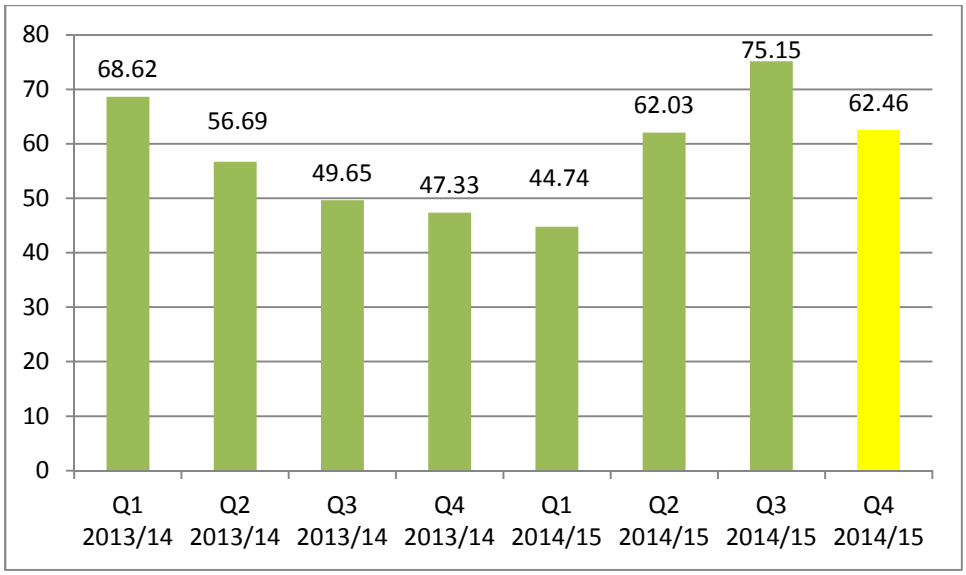
1.5 Timeliness of Responses

As previously reported, Q2 and Q3 2014/15 saw an increase in the average days taken to respond to complaints, and this was largely due to the volume of older cases that had been finalised. With work continuing to complete older complaints, and as predicted in last quarters report, the average has started to fall.

Amendments to the sign off process has seen a larger number of complaints being finalised but importantly, has seen them finalised in shorter timeframes. We are further enhancing the reporting and monitoring process of all complaints made against the Trust with a continued focus on ensuring

that no complaint breaches its target response date. With some older complaints still to be finalised, this will not see the average reduce to 30 days immediately but it is predicted that the decline in average days will continue over the next quarter.

Average days to respond by quarter

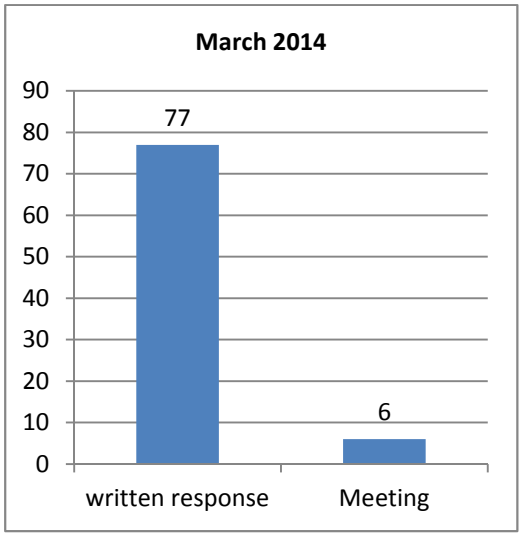


Appendix 3 shows a further breakdown of this data by Clinical Group. It should be noted that this is the total time that the complaint took to respond to and includes all stages of the process. Future reports (starting with Q1 2015/16) will be able to break down each stage of the process so that feedback can be targeted. Once the data is broken down in this way, it will also be easier to direct attention to the specific stages of concern.

1.6 Complaints managed by resolution meeting

It is recognised that for some complaints, a resolution meeting, as opposed to a written response can be more effective in addressing concerns. Commonly, those complaints relating to the death of a patient, where the patient is a child, or where there may be concerns around how well a written response could be comprehended, are best resolved through a resolution meetings. Some complainants will also express a preference to meet with the Trust, and it remains an important aspect of the complaints resolution process. In Q4 2014/15 a system for recording when a complaint was resolved through a meeting was developed and implemented in mid February.

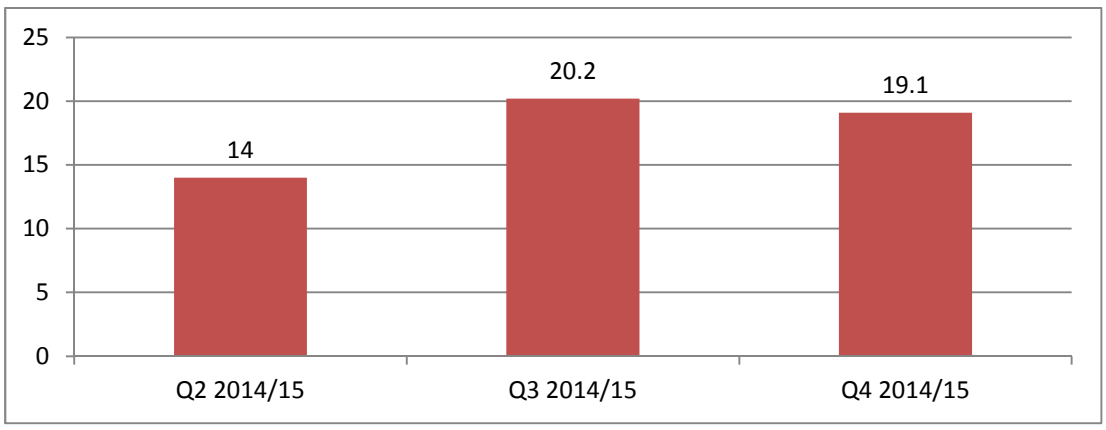
Comparison of complaints managed in March 2015 with a meeting, against a written response.



1.7 Complaint satisfaction survey

Everyone who makes a complaint is given the opportunity to provide feedback on how they found their experience via completion of a questionnaire that is sent with the final response. There was a slight decrease in returns with a response rate of 19.1% on Q4 2014/15 (which equates to 36 actual returns.)

Complainant satisfaction return rate

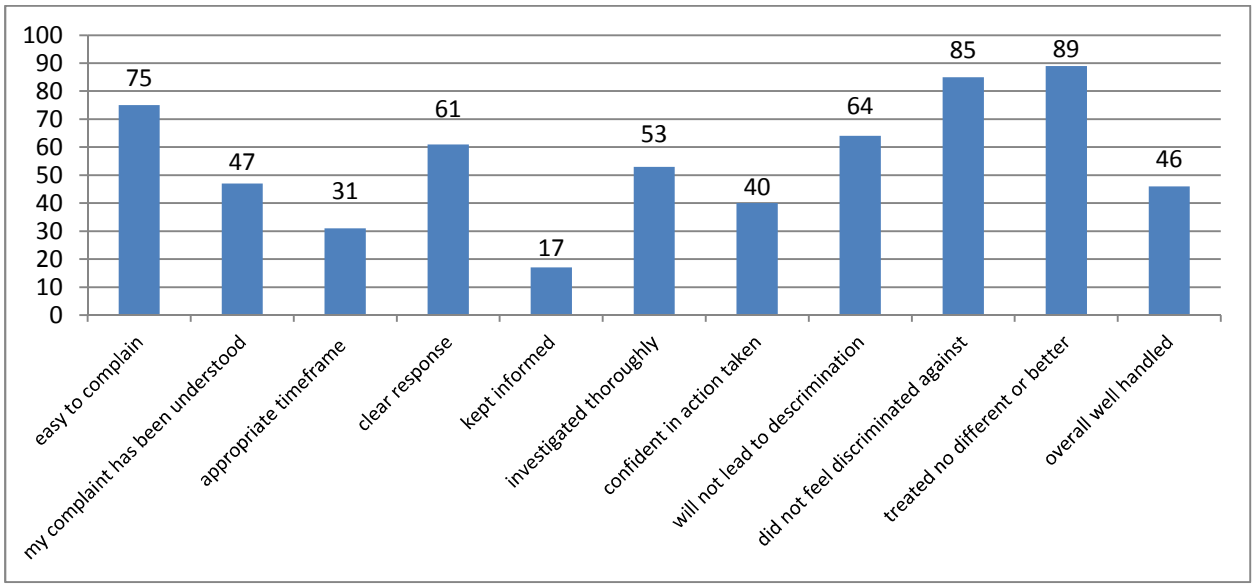


Appendix 4 covers all results in detail, and shows that there is still work to be done to improve how satisfied complainants are with many aspects of the process, particularly when compared with the results reported in Q2 and Q3 2014/15.

There has been a slight increase complainants reporting that how easy it was to make their complaint, along with an increasing satisfaction with the timeframe taken to respond, the clarity of the response, the thoroughness of the investigation, and that the complaint will not lead to discrimination. How satisfied complainants felt about the over handling of their complaint also

increased. Work continues to improve the number of respondents who felt that their complaint was well handled. Whilst work is already underway to ensure that respondents whose complaint response may go over the target date, are always kept informed that should in turn see this score improve also.

Compliant survey results as a % of respondents Q4 2014/15



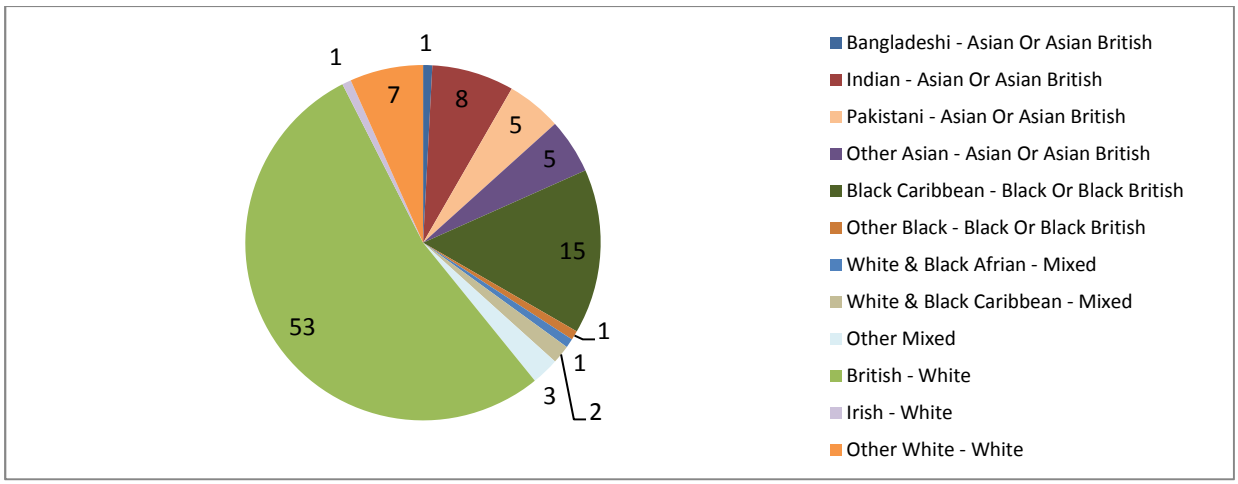
Appendix 5 shows a profile (where given) of the respondents in terms of their gender, age and ethnicity.

2. Complaints in detail

2.1 Profile of the subject of complaints

In order to check that our complaints process is accessible to all, it is important to understand the profile of complainants by certain protected characteristics. Gender, age and ethnicity are recorded and then compared to our hospital population and also the population of the geographic area that we serve in **Appendix 6**.

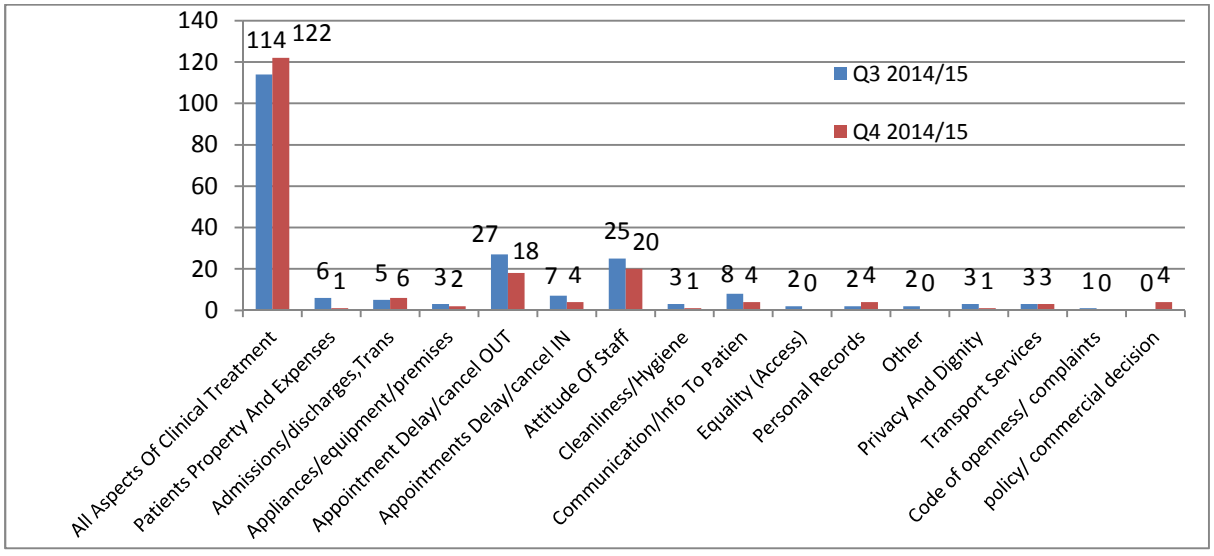
Subject of complaint by Ethnicity



In Q2 and Q3 2014/15 there was disproportionality in the ethnic mix of complainant's versus our patient population. This trend has continued into Q4 2014/15 with a lower rate of complaints from Asian complainants (mainly Pakistani with 10% patient population and a 5% complaints rate) and a higher rate for Black Caribbean with a 4% patient population and a 16% complaints rate. This disproportionality has remained the same over the last nine months, and work will continue to identify any barriers in making a complaint. During Q4 2014/15, complaints posters were displayed in the Emergency Departments in both Sandwell and City, and all entrances to the hospital (including Rowley Regis.) These posters, and the corresponding complaints leaflets are also now available on the intranet in 5 other languages.

2.2 Formal complaints by theme

This table shows the broad themes that our complaints fell into in Q4 2014/15 compared to Q3 2014/15.



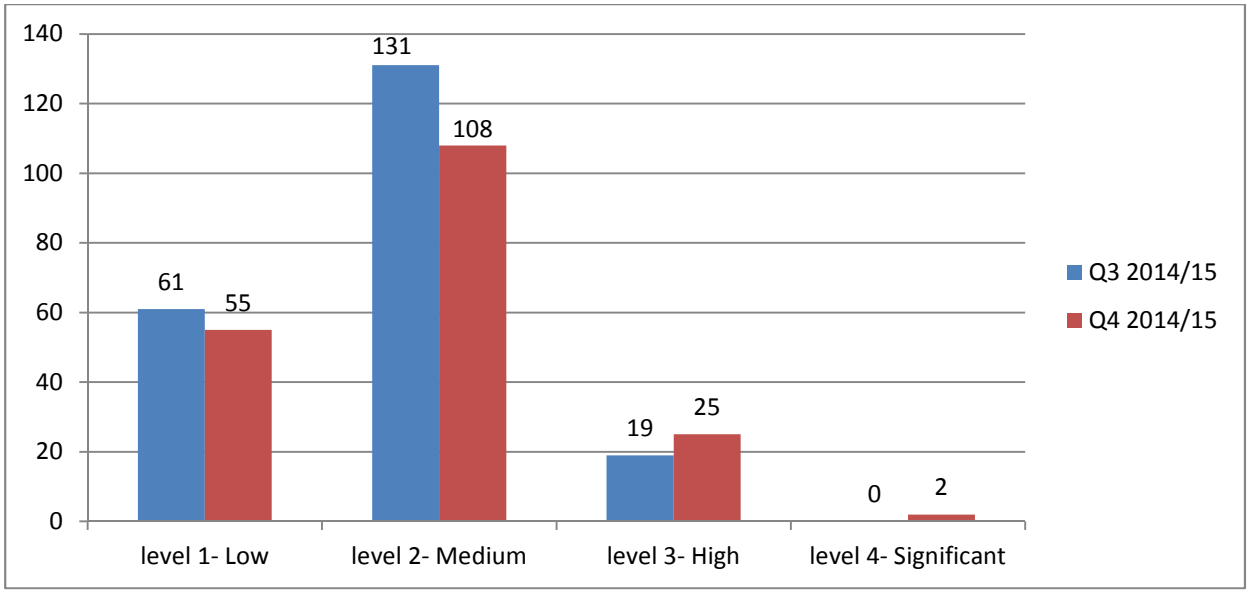
When analysing the top three themes complained about, these remain 'all aspects of clinical treatment', 'appointment delays', and 'staff attitude'. **Appendix 7** breaks down the themes of complaints by Group, profession and department for the most complained about themes.

In Q2 and Q3 2014/15 it was reported that Surgery B had a disproportionately higher rate of complaints about their management of appointments. This is still the case in Q4 2014/15, although this has fallen from 32% (Q3 2014/15) to 26% this quarter.

2.3 Formal complaints by severity

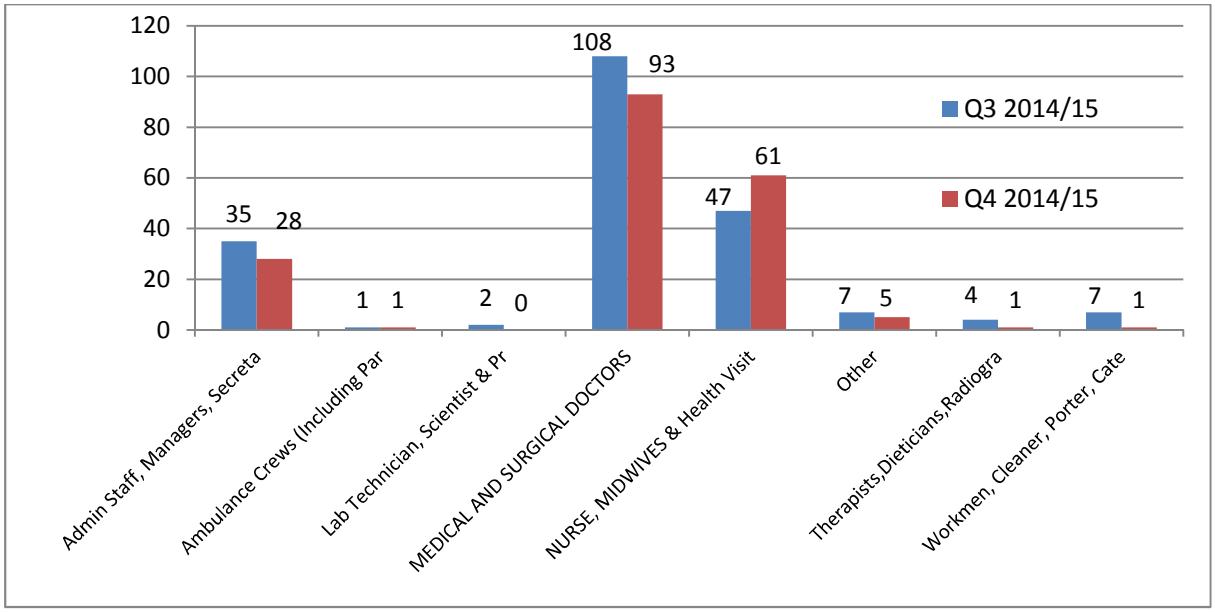
The following is a breakdown of the 190 actively managed complaints by severity and shows that once again complaints considered high or significant (Levels 3 and 4) remain in the minority. This quarter, Level 1 and 2 complaints made up 86% (163) those received which was 5% lower than the last quarter and only slightly higher (2%) than the quarter before. Unlike the previous quarter, there were 2 Level 4 complaints, both of which involved the death of a patient, (one new born baby and one elderly man.)

A breakdown the severity grade of complaint



2.4 Formal complaints by profession

There was a decrease in complaints made involving all but one professional group this quarter, this being Nursing, Midwives and Health Visitors. This increase was most prevalent in Community and Therapies having 6 complaints about this staff group compared to 2 from the previous quarter. Complaints involving medical staff continue to feature as the highest profession complained about (as the complaint the complaint often relates to their clinical care) and is consistent with the previous two quarters.



3. Formal complaints outcomes

3.1 Resolved complaints

The focus from Q3 2014/15 on resolving all complaints within their target response dates has continued. Feedback is still provided regularly to Investigation Leads about the quality of the complaint responses. Q3 2014/15 saw 202 complaint responses sent out compared to 187 for this quarter. Work continues to ensure that complaints stay on track and do not breach their target date, or the 30 day limit set for the majority of complaints from 1 April 2015.

3.2 Formal complaints upheld.

At the conclusion of a complaint, we categorise the outcome as one of the following three categories.

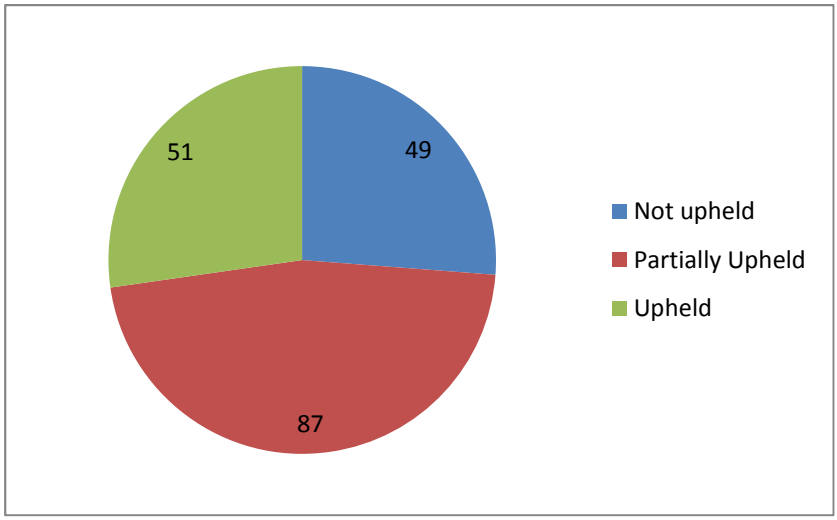
Upheld – we agreed that the complainant was found to have experienced poor care/ treatment/ customer service.

Partially upheld- elements of the complaint were found to be the case, but not all.

Not upheld- The investigation did not uncover any failings on behalf of the Trust.

The outcome of complaint responses remain mostly either upheld or partially upheld, but there was a slight decrease, at 74% of responses in Q4 2014/15 compared to 80% in Q3 2014/15. This compares to 67% in Q2 2014/15 and 75% in Q1 2014/15. This high percentage for these outcomes does demonstrate a continued commitment to 'Being Open' and integrity in general in complaints management. There was however no significant work group, or complaint trends in those that were not upheld.

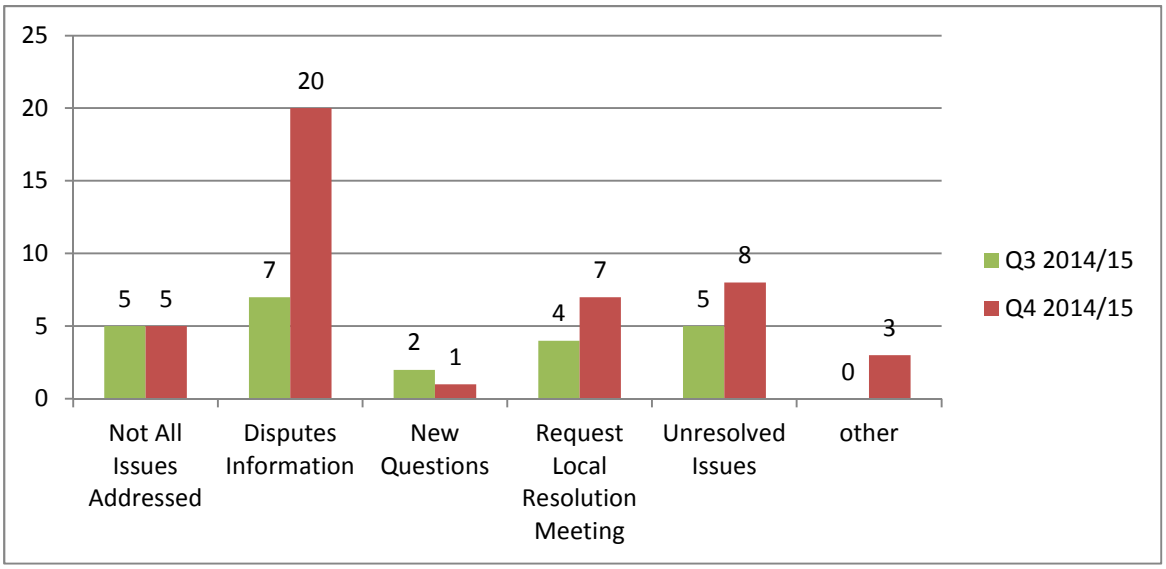
Q4 2014/15 complaint outcomes



3.2 Reopened cases

Reopened cases totalled 44 and 5 (11%) of these were because not all the issues were addressed in our first response. This compares to 51% in Q1 2014/15, 26% in Q2 2014/15 and 22% in Q3 2014/15. So whilst the total number that were reopened is higher than in Q3 2014/15, the rate that complainants come back to us concerned about the thoroughness of investigation has halved. It should be noted that there has been an increase in the number of complaints that have been finalised in both Q3 and Q4 2014/15. Whilst our overall aim is to reduce the amount of complaints disputing their response, an increased number in finalised complaints can impact on the reopen rate.

Total number of cases reopened and why



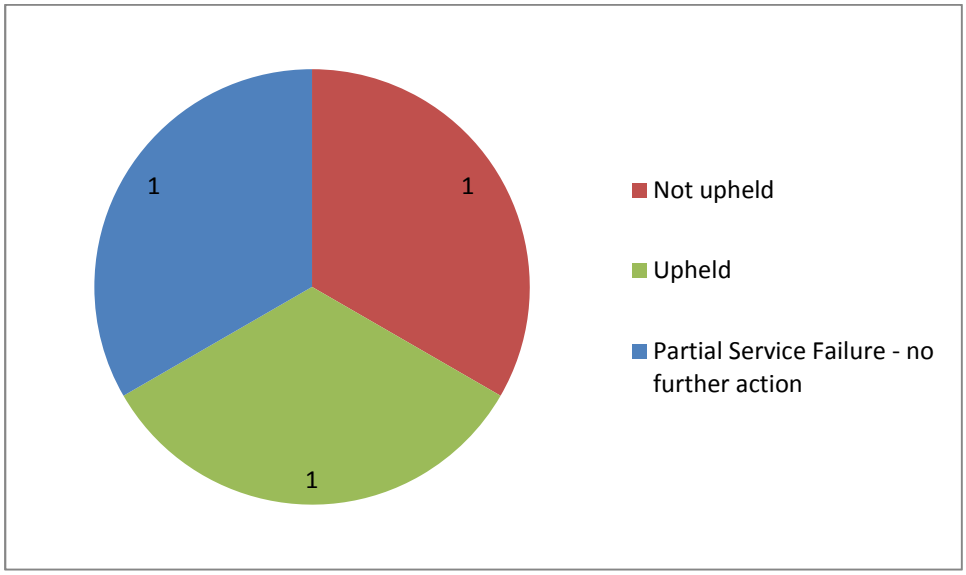
Of those complaints that were reopened because we had not addressed issues first time, there continues to be no particular Group that has contributed to this level of dissatisfaction. Even when the two quarters (the last 6 months) data are added together, nothing disproportionate is apparent. **Appendix 8** shows all reopened complaints by Group and Grade, and does also conclude that it is the medium grade (Level 2) complaints that are most likely to be reopened. There is also a breakdown of the Medicine and Emergency care Group as this remains the group that received the most reopened cases. This breakdown is shown by both reason and grade.

3.3 Parliamentary and Health Services Ombudsman enquiries.

When the local complaints process is exhausted, any complainant who remains dissatisfied can have their complaint reviewed independently by the Parliamentary and Health Services Ombudsman (PHSO).

Two new PHSO complaints were logged in the three months of this quarter, and three enquiries completed during this same period. These are shown below.

The outcome of the 3 cases closed in Q4 2014/15



The following is a summary of the action that was taken as a result of the complaint where the PSHO upheld the complainant's complaint.

The patient's mother had complained about a number of issues that related to his care, and this complaint had been responded to, reopened, and we had met with the complainant also. As the complaint had not been managed to her satisfaction, the complainant contacted the PHSO in order that they review the complaint and the way it was managed. The PHSO concluded that the delivery

of the patient's care had not sufficiently considered his learning difficulties, and that compensation should have been offered to the patient's mother through the complaints process, which was denied her at the time. The time it took to manage the complaint was also criticised. As a result, the Trust were asked to pay £1000 compensation for

- The failing of our care in relation to the patients special needs.
- The complainant's distress, caused by the failings of our care.
- The Trust's management of the complaint.

The Trust was also asked to produce an action plan of how it intended to remedy the failings identified.

Appendix 9 details this action plan which confirms that the majority of these actions have already been completed. It should also be noted that the complainant also received the recommended compensatory payment of £1000.

New PHSO cases

Case 1

The complainant's concern centres on the care given to his father and the actions of the Trust after his father had died. The family are looking for an acknowledgement of our failings, and apology and financial compensation (although the PHSO advisory letter does not detail what the compensation is for.)

This complaint was made against the Trust in February 2013 and the original response was disputed in October 2013. We met with the family of the patient in April 2014, to discuss the issues that remained outstanding. A copy of this recording and a summary of our discussion was sent to the complainant in May 2014.

Case 2

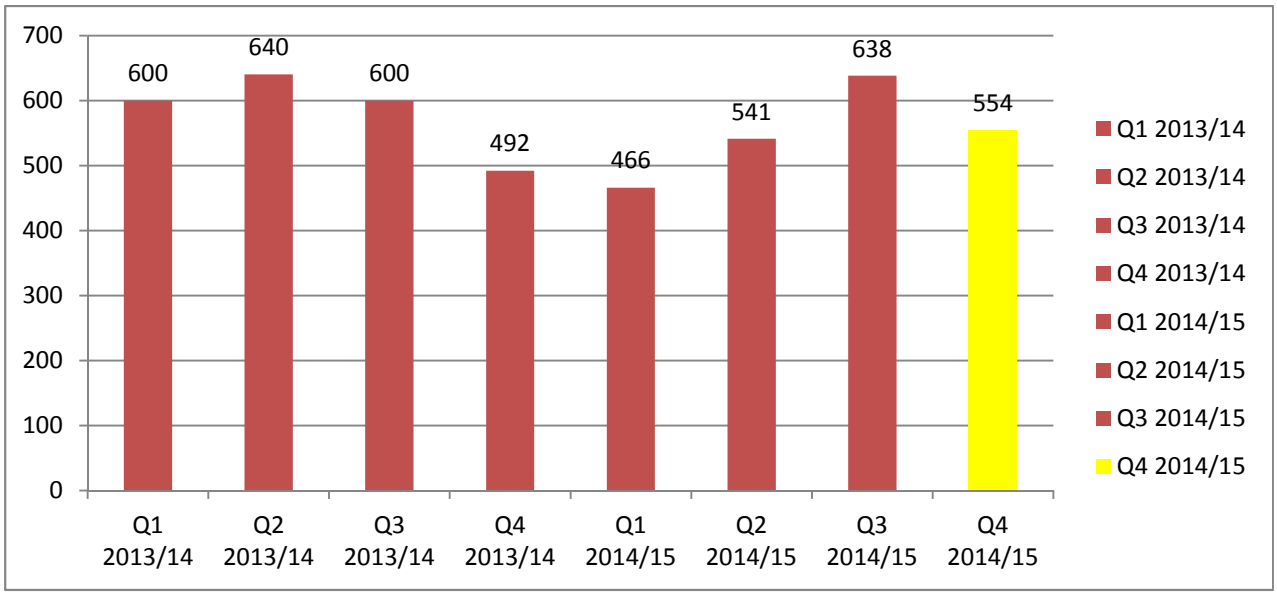
The complainant has approached the PHSO seeking financial redress for the health issues he now suffers from as a result of the stroke (that he holds the Trust responsible for). He also says the handling of his complaint has been poor.

We first responded to his complaint in July 2014 and this was disputed in August 2014. We met with the patient in November and sent a copy of the meeting and a summary of our discussion to the complainant in December 2014.

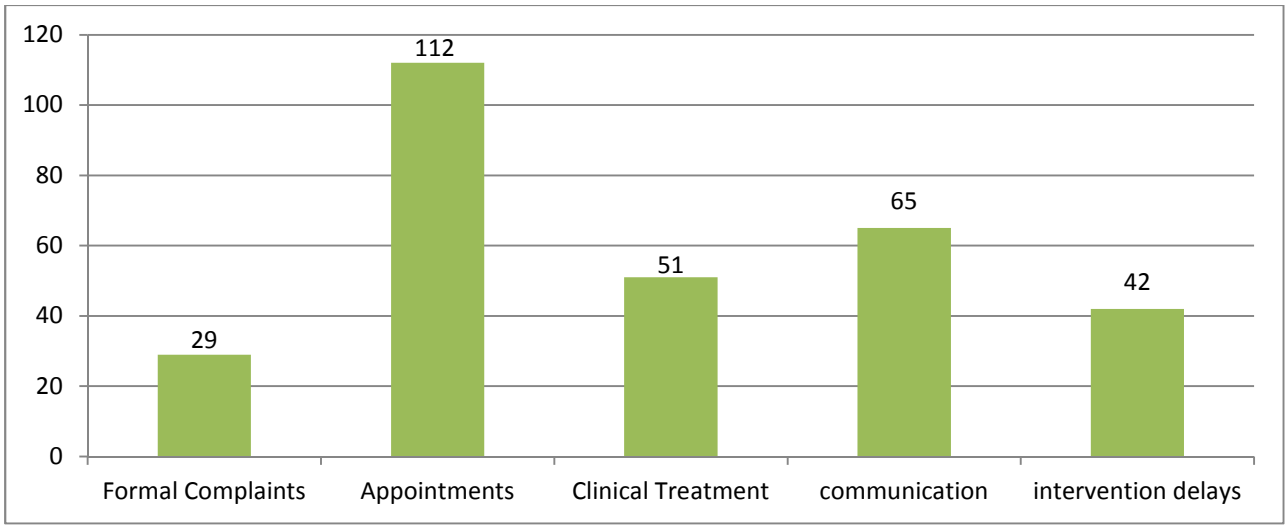
PALS

PALS continue to play a vital role in providing patients with a local advocate who can investigate concerns. As well as reporting the standard enquiries, work has continued in the collection of compliments for this quarter; Clinical Groups also reported how many concerns were addressed at departmental level (those that were resolved by the Trust without the need to escalate to PALS or Complaints). These concerns are often well managed with effective and caring solutions.

The total number of PALS enquiries made for Q4 2014/15 was 554 compared to 638 in Q3 2014/15 and 541 in Q2 2014/15 and the following graph shows the number of enquiries of PALS by quarter over the past 2 years. Of note was the additional 73 calls taken in the month of March, not recorded on Safeguard that related to assisting the appointments team with signposting, following a new initiative regarding appointment enquiries. It was established that the letter only quoted the PALS telephone number for anyone with enquiries. The letter has since been amended and these calls have now all but ceased.



The following are the top five enquiries taken by PALS in Q4 2014/15



In past reports, the top 5 enquiry types have made up approximately 2/3 of enquiries, but this quarter saw a far wider mix of enquiry types. The top 5 themes this quarter made up just over half (54%) of the overall PALS enquiries. This makes a quarter on quarter analysis in **Appendix 10** more difficult as there are categories that appear in this quarter that haven't in the past. Transversely, an improved reporting and data capture accuracy has seen the category 'General Enquiries' disappear.

Appendix 10 reports these enquiries by Group and how the top issues resolved by PALS compare to the previous quarter.

Appendix 11 shows the compliments collected this quarter. There is also a breakdown of locally resolved concerns, however there were very few concerns reported in Q4 2014/15 that had been locally resolved. An important part of devolving complaints management to clinical groups/ corporate directorates is to encourage on the spot resolution reducing the need to make formal complaints in the first place. Anecdotally, it is felt that this local management of concerns is indeed taking place. Complaints rates are declining and there is evidence of staff taking advice from the complaints team about how to best manage local meetings and discussions. For this reason, the collection of departmentally resolved complaints for the purposes of this report will cease from Q1 2015/16, on the assumption that this is now an embedded part of the way clinical and nursing staff deal with local concerns.

Summary

The total number of complaints logged during Q4 2014/15 was **207**, with 17 being withdrawn to date, and includes two new cases has been referred to the PHSO by a complainant. This number compares to 235 complaints received for Q3 2014/15 (with 211 managed once 24 were withdrawn.) **359** compliments were recorded alongside just 2 departmentally resolved concerns. PALS received **554** enquiries, a reduction of 84 for the same period last quarter.

The average days to complete a complaint has decreased to an average of 62 days, however Q1 2015/16 should see a continued decrease as complaints are kept in date, with fewer older complaints left to resolve. It is apparent from the satisfaction survey that complainants feel they were not kept as well informed than those giving feedback in Q3 2014/15 but the overall satisfaction rate improved in this quarter.

Of the Clinical Groups, Medicine continues to attract the highest number of complaints, and Women and Child Health the lowest (of the four Clinical Groups that make up the majority of complaints). Surgery B still has the highest complaints rate with many of these concerns still attributed to appointment issues, but at a lower rate than in previous quarters.

PALS enquiries have decreased, as they are no longer receiving enquiries about the continence service. They did field an additional 74 calls about appointments in support of an initiative from the Appointments Team.

Development work from previous quarters.

- A system for recording complaints that have been resolved by a meeting was developed in February 2015 and will be reported on, quarter on quarter to monitor our success in increasing the number of resolution meetings held.

- An 'Action Tracker' will be used for all complaints from Q1 2015/16. This will be reported on, in terms of compliance to the action that was agreed following a complaint, and how this was communicated to the complainant.

Key areas for focus in Quarter 1 2015/16

- A new process for triaging complaints is to be established in Q1 2015/16 to ensure they are categorised as one of the following types of complaints.

    1. Fast track complaints - telephone or face to face meetings where issues are resolved quickly (likely level 1 and some level 2 grade complaints.)
    2. Standard complaints in need of investigation and in need of a written response (letter or report.)
    3. Complaints involving the death of a patient, where a specific pathway for the management of the compliant will be developed.

- A recent development in the Safeguard database has enabled us to record how long each stage of a complaint takes rather than just reporting the time taken for the whole complaint. By understanding this, more work and coaching can be concentrated on the right part of the process to further improve the time it takes to manage a complaint. Whilst the fields on Safeguard have now been implemented, the reporting mechanism has not yet been finalised, so this is on hold until Ulysses complete this work.

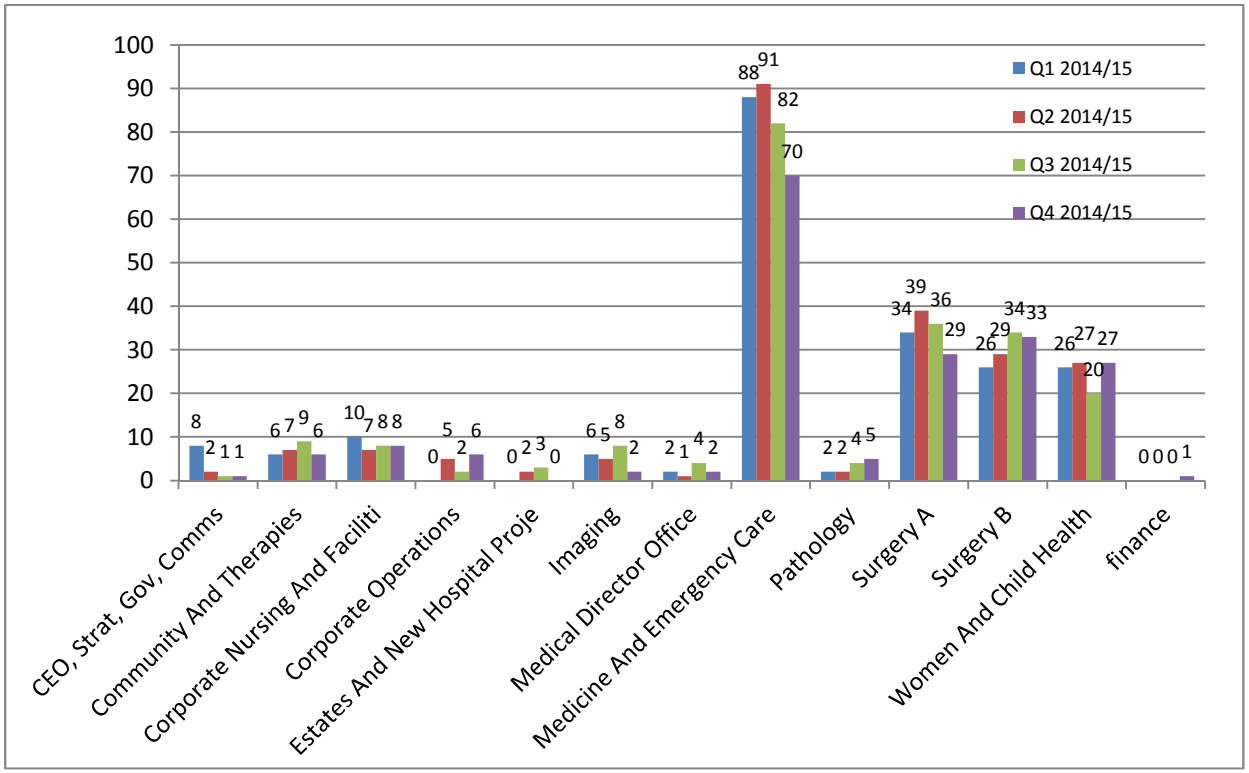
- Reaching out to certain ethnic communities to investigate how to redress complainant imbalance.

- Integrate across Governance in order to better understand the link between an incident that results in a complaint and in turn may result in a legal claim.

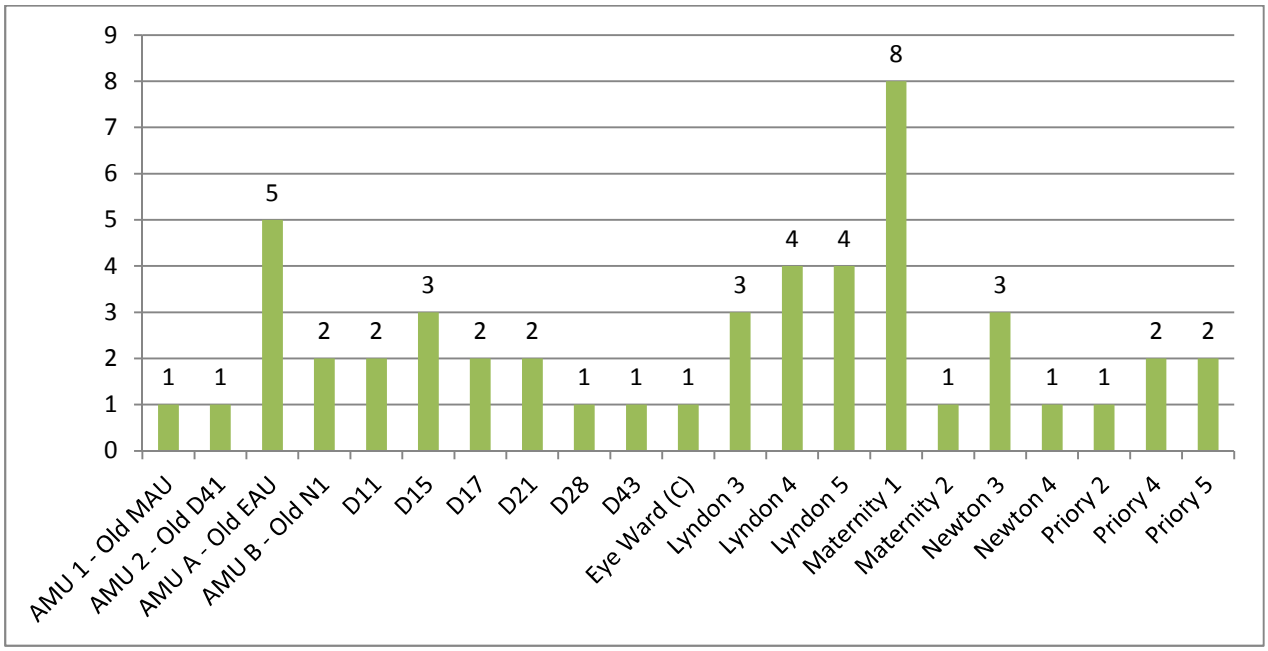
- Redefining the process for managing and reporting the stages of a complaint in order to ensure the target date is not missed in 2015/16

Appendix 1a

Complaints received by Clinical Group and Corporate Directorate for Q4 2014/15, compared to Q3 2014/15, Q2 2014/15 and Q1 2014/15

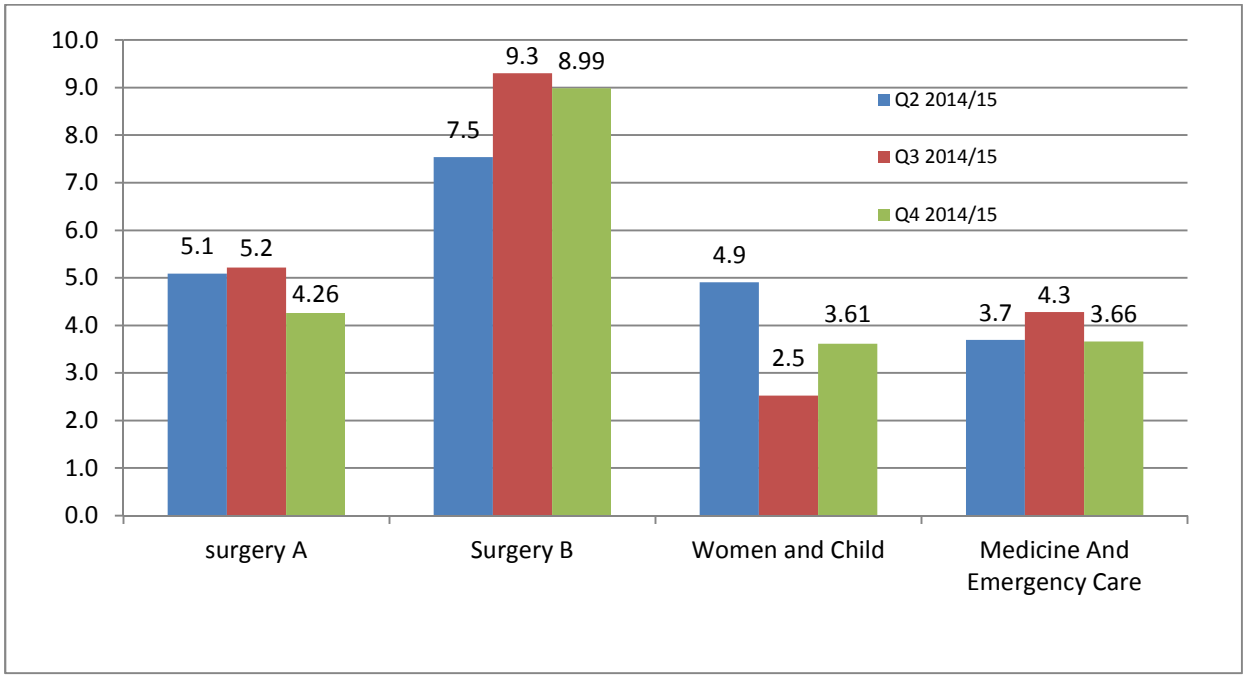


Appendix 1b



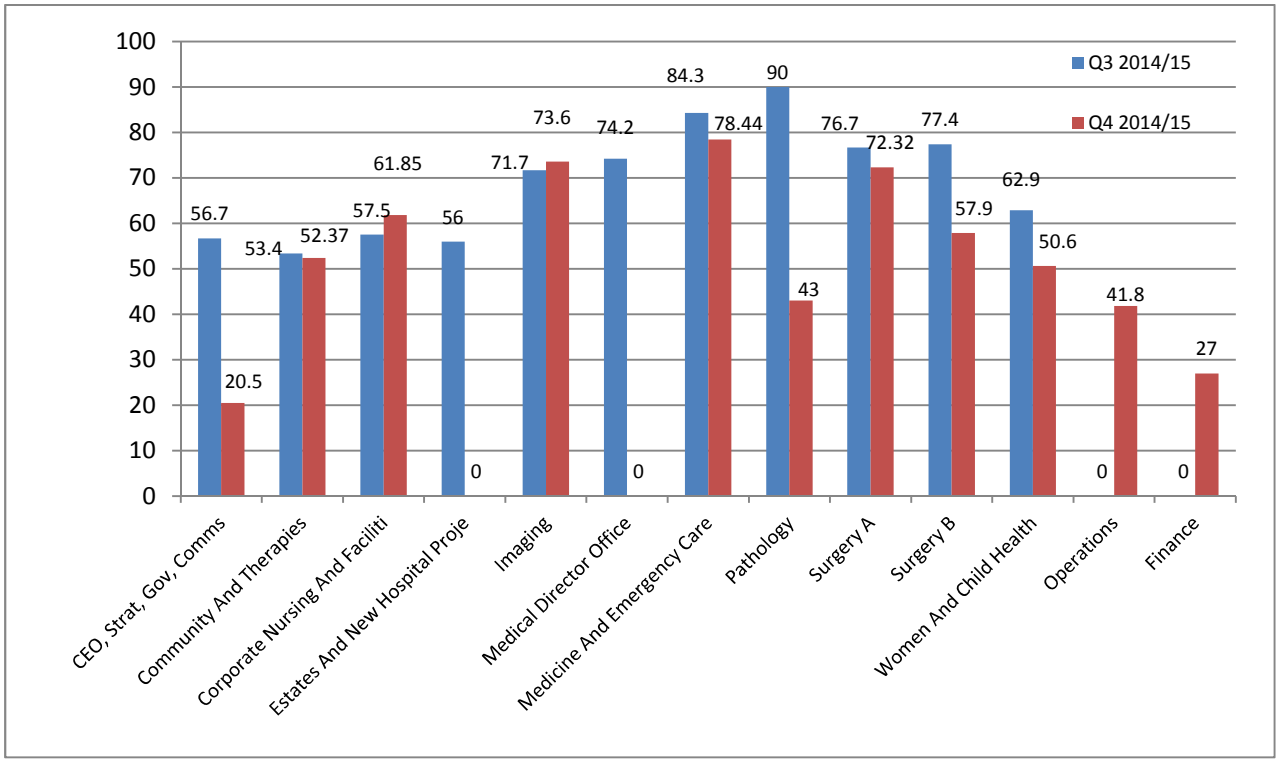
Appendix 2

Complaints rates by FCE for Q1 2014/15, Q2 2014/15 and Q4 2014/15 by the top four Clinical Groups



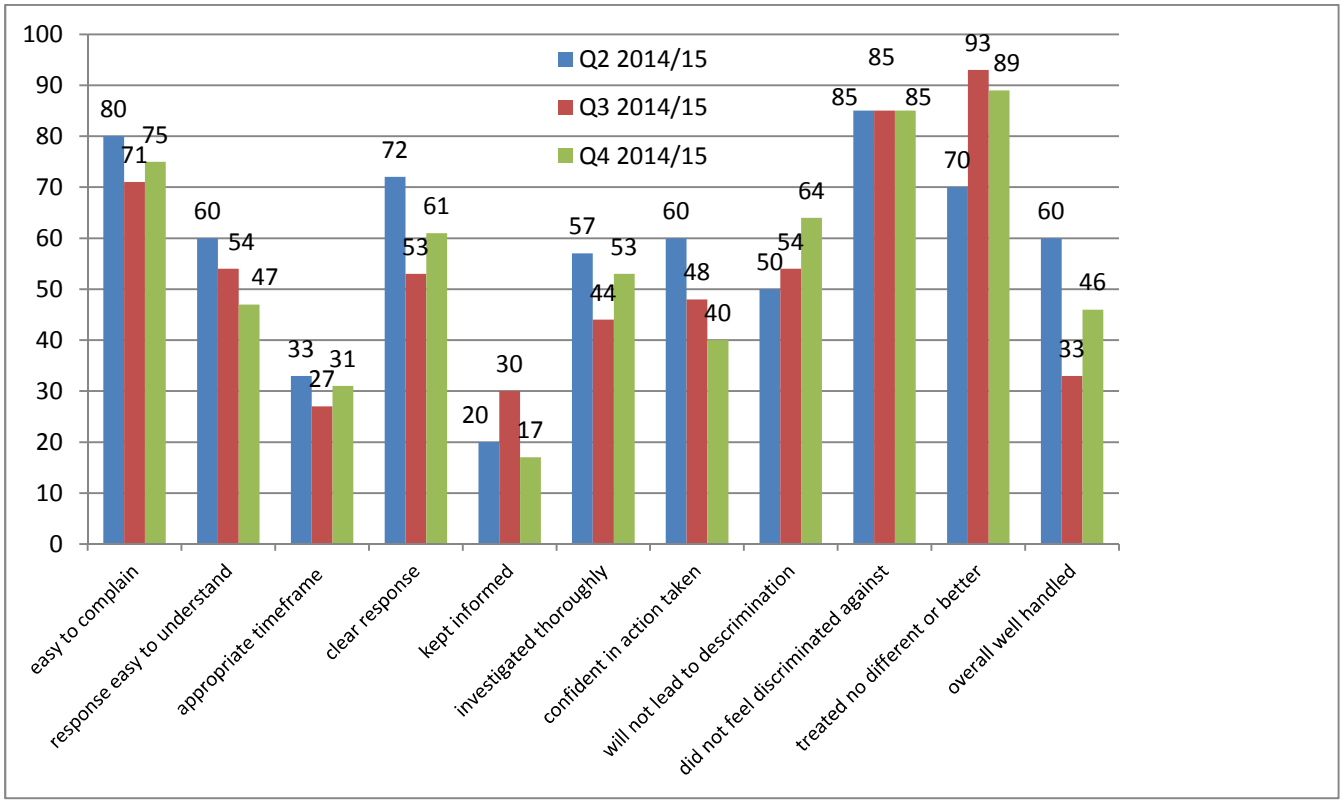
Appendix 3

Complaints turn around by Clinical Group for Q3 2014/15, showing the number of days that each new, or reopened complaint took to close from the time it was received by the Complaints team to the time that it was signed off.



Appendix 4

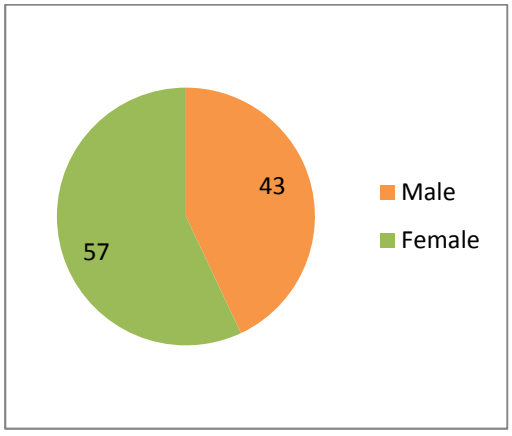
The Complaints satisfaction survey questions for Q4 2014/15 compared to Q2 2014/15 and Q2 2014/15 (and the % of respondents that answered in the positive to each question.)



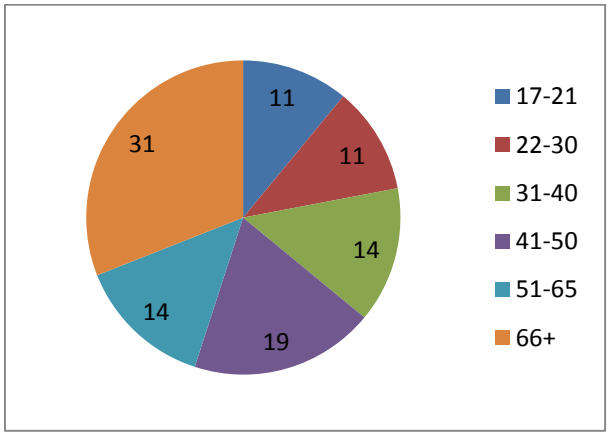
Appendix 5

The profile of respondents to the Complaints satisfaction survey for Q4 2014/15

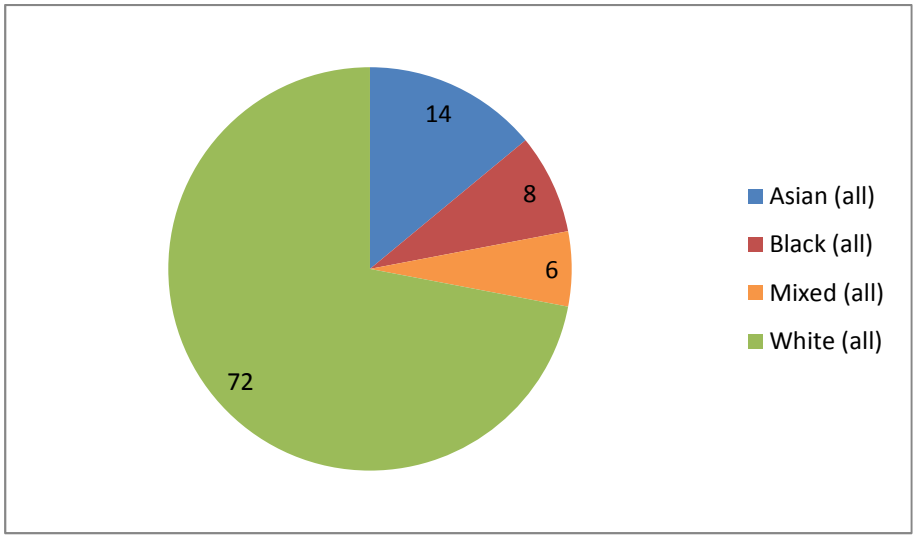
Gender (%)



Age (%)

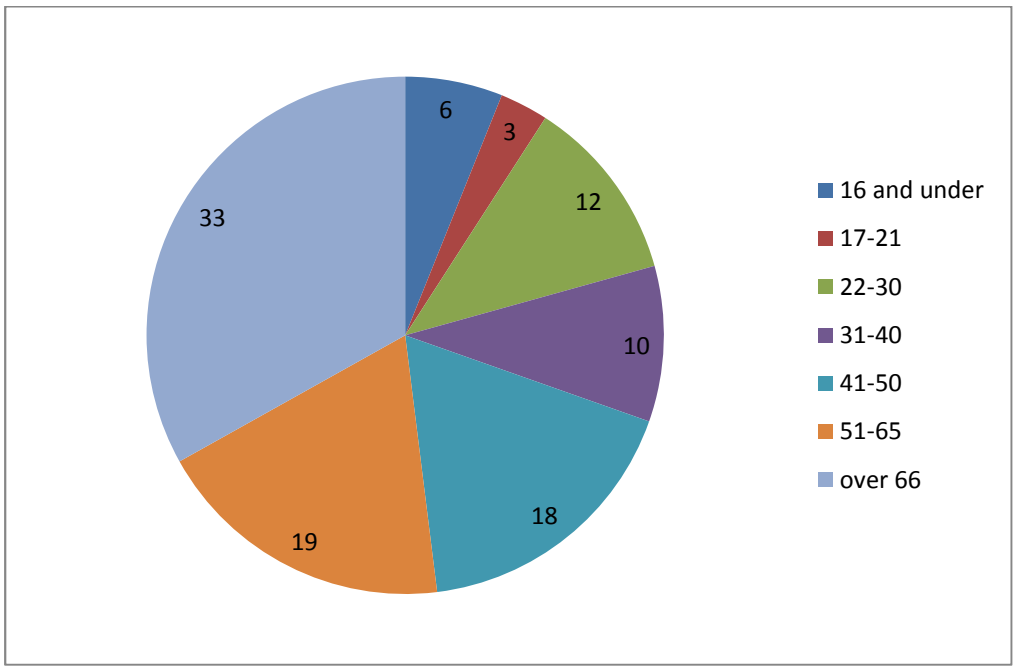


Ethnicity (%)

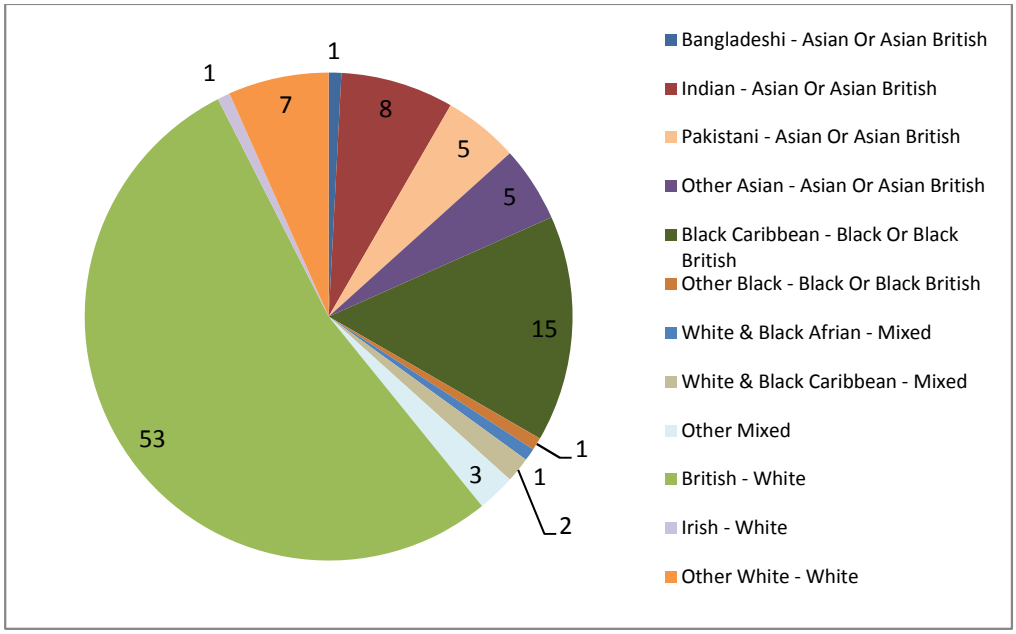


Appendix 6

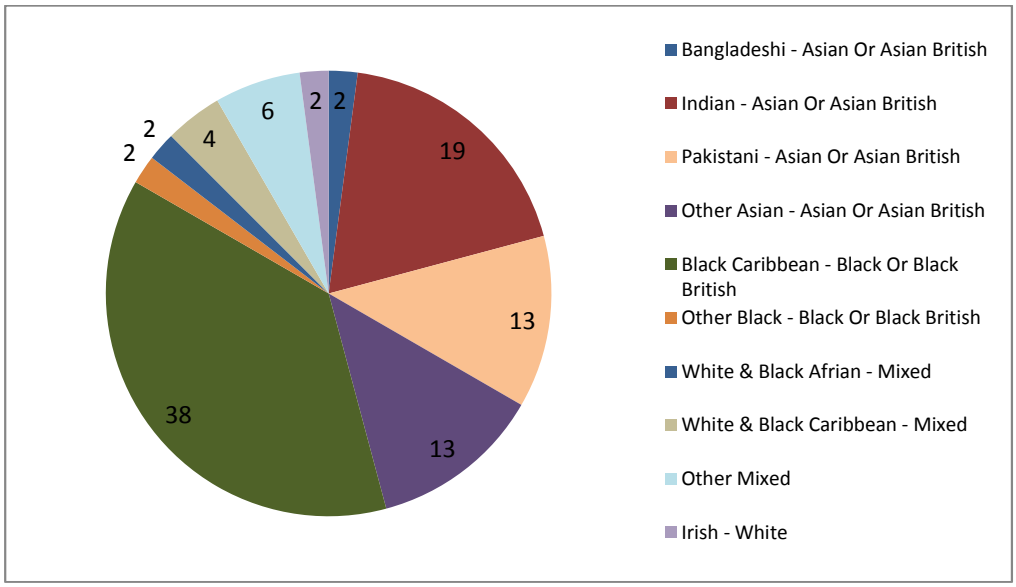
A breakdown of all complainants by % by age where specified (165 complainants) for Q4 2014/15



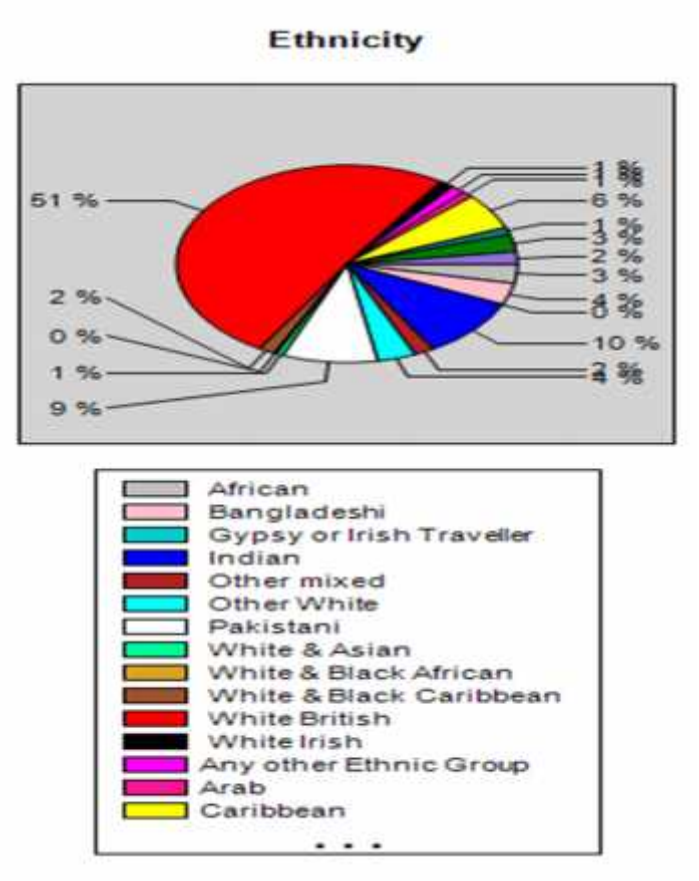
A breakdown of all complainants by % of those where ethnicity was recorded (120 complainants) for Q4 2014/15



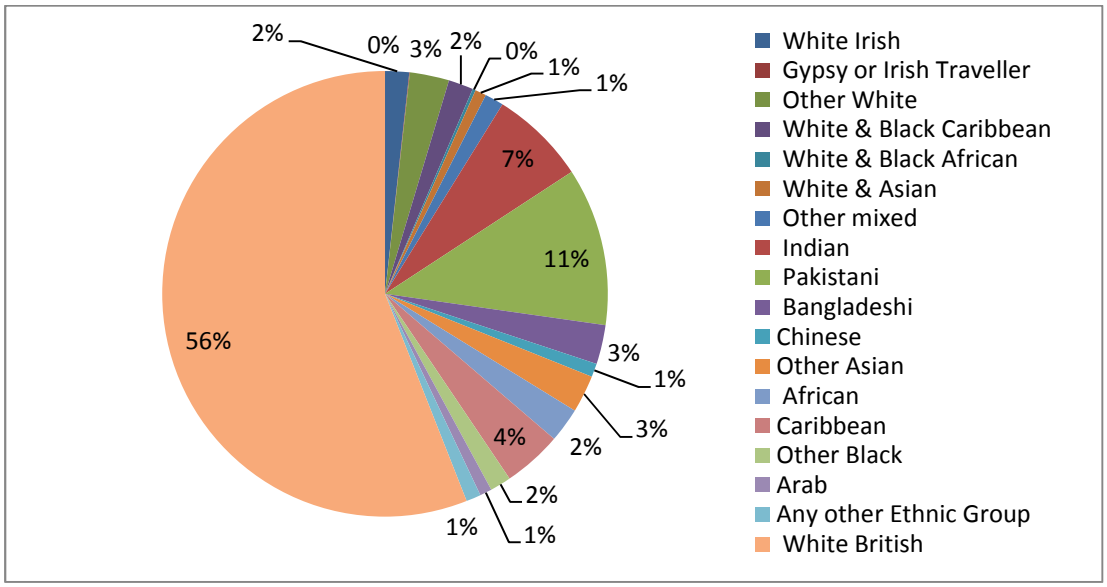
A breakdown of all complainants by % of those where ethnicity was recorded (120 complainants) taking out those White British for Q4 2014/15



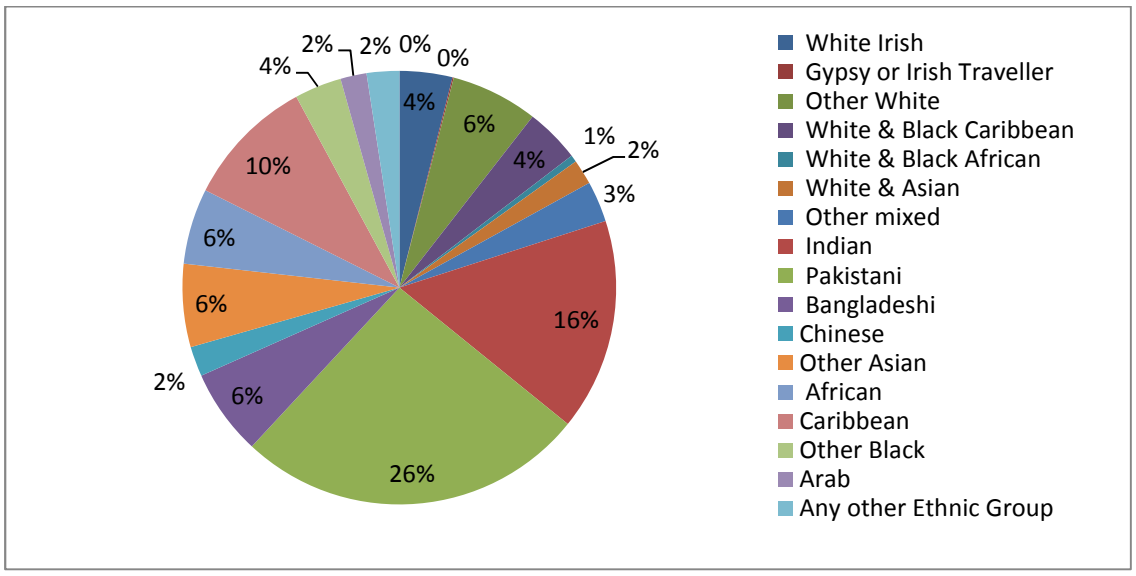
Ethnicity split of patient population



Ethnicity split by Sandwell and West Birmingham Population as taken from the 2011 census and quoted out to the Local Demography report prepared by the Trusts Equality and Diversity team in 2013.



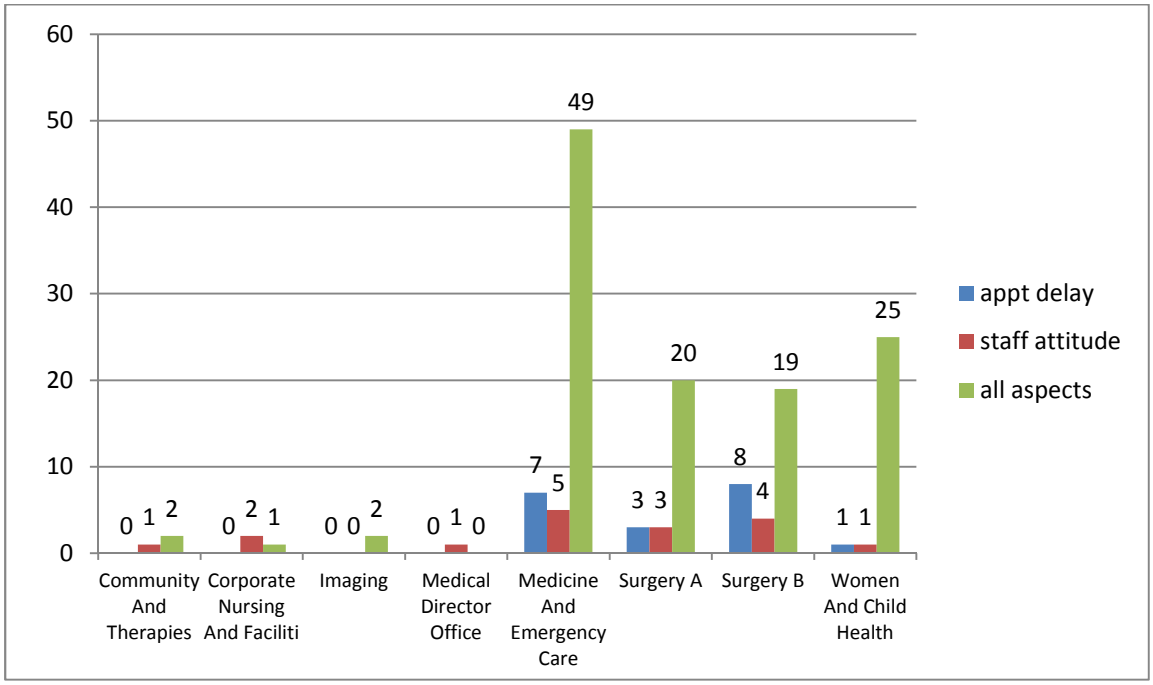
Ethnicity split by Sandwell and West Birmingham Population as taken from the 2011 census and quoted out to the Local Demography report prepared by Equality and Diversity in 2013, without White British.



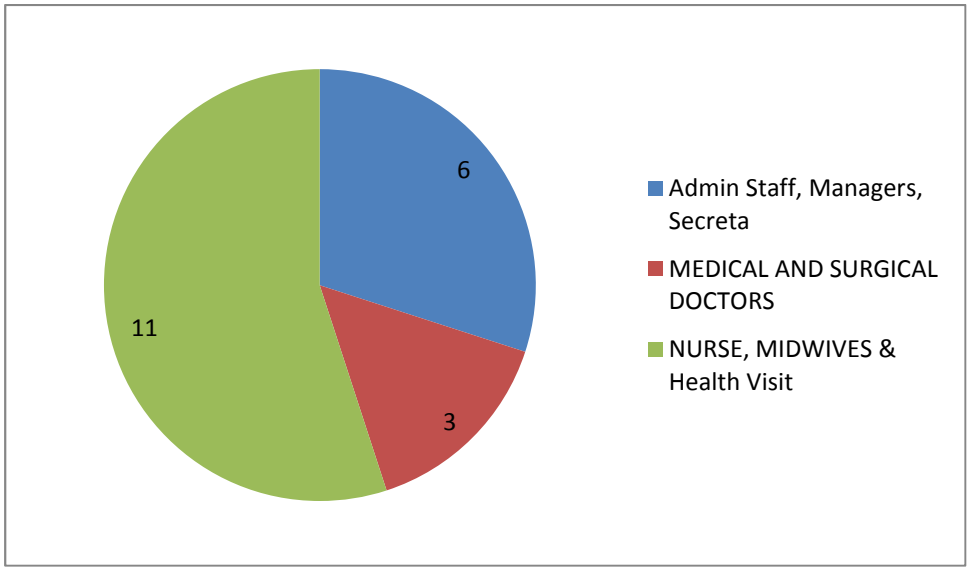
Appendix 7

A breakdown of the top three themes complained about, broken down by Clinical Group or Corporate Directorate for Q4 2014/15. Where there were no complaints for this theme for a Clinical Group or Corporate Directorate, then they are not featured in this breakdown.

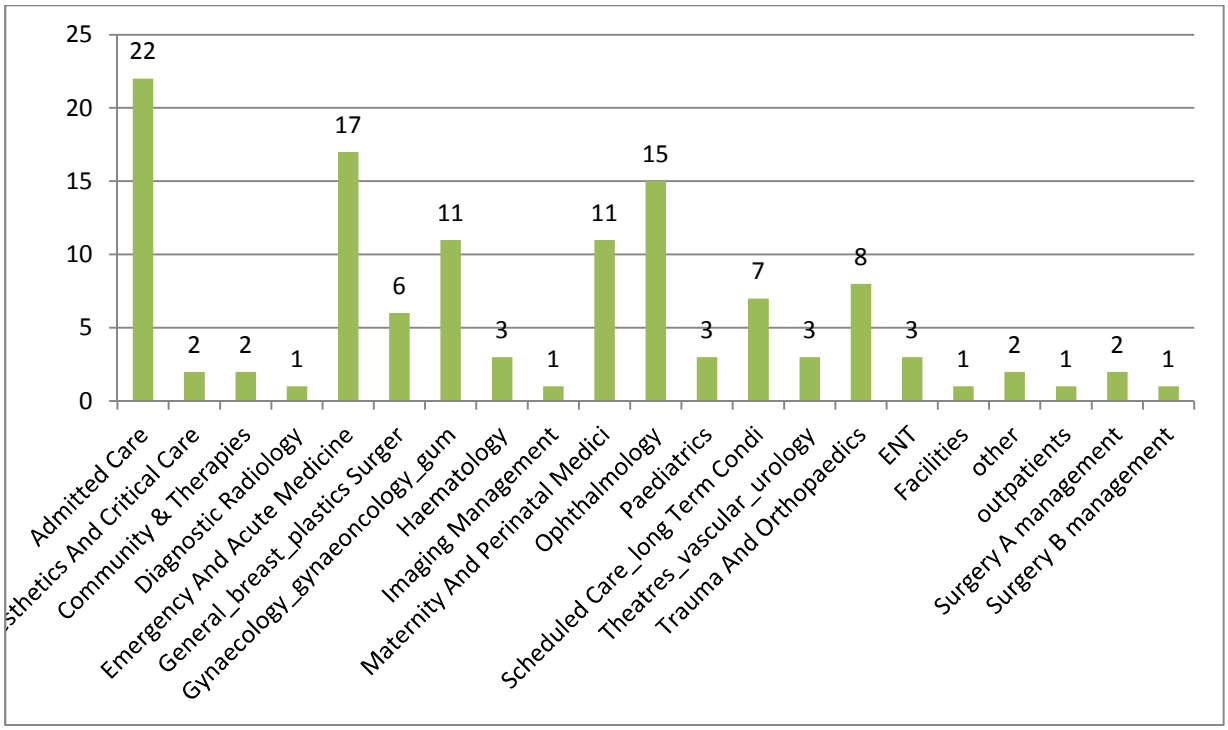
A breakdown of the top three themes by groups for Q4 2014/15



A breakdown of the 'attitude of staff' theme by staff groups for Q4 2014/15

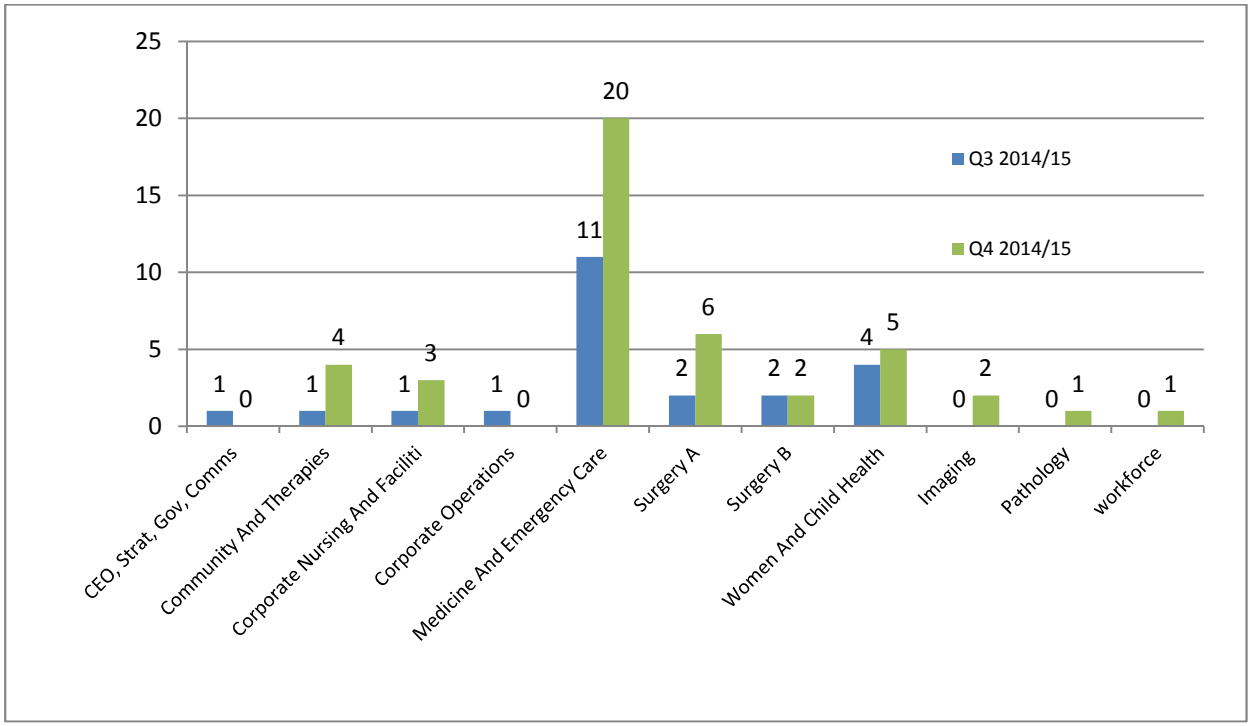


A breakdown of the 'all aspects of clinical treatment' theme by Trust wide clinical directorate Q4 2014/15

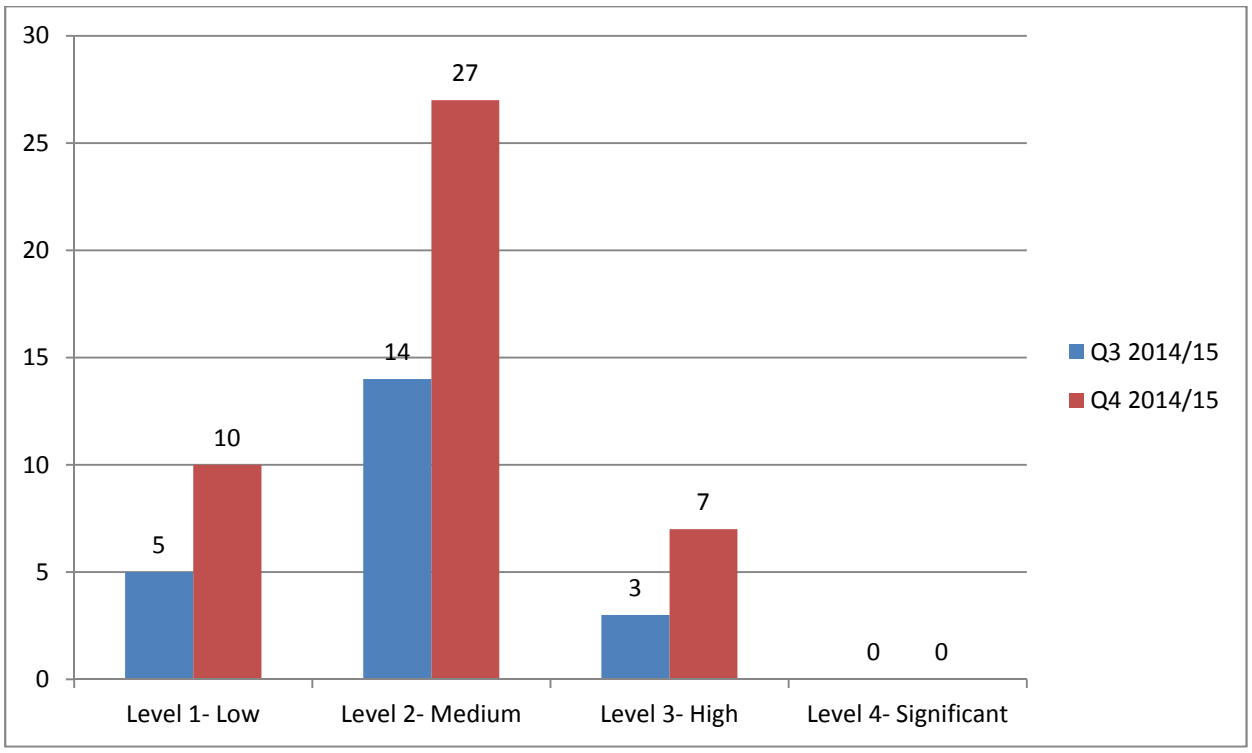


Appendix 8

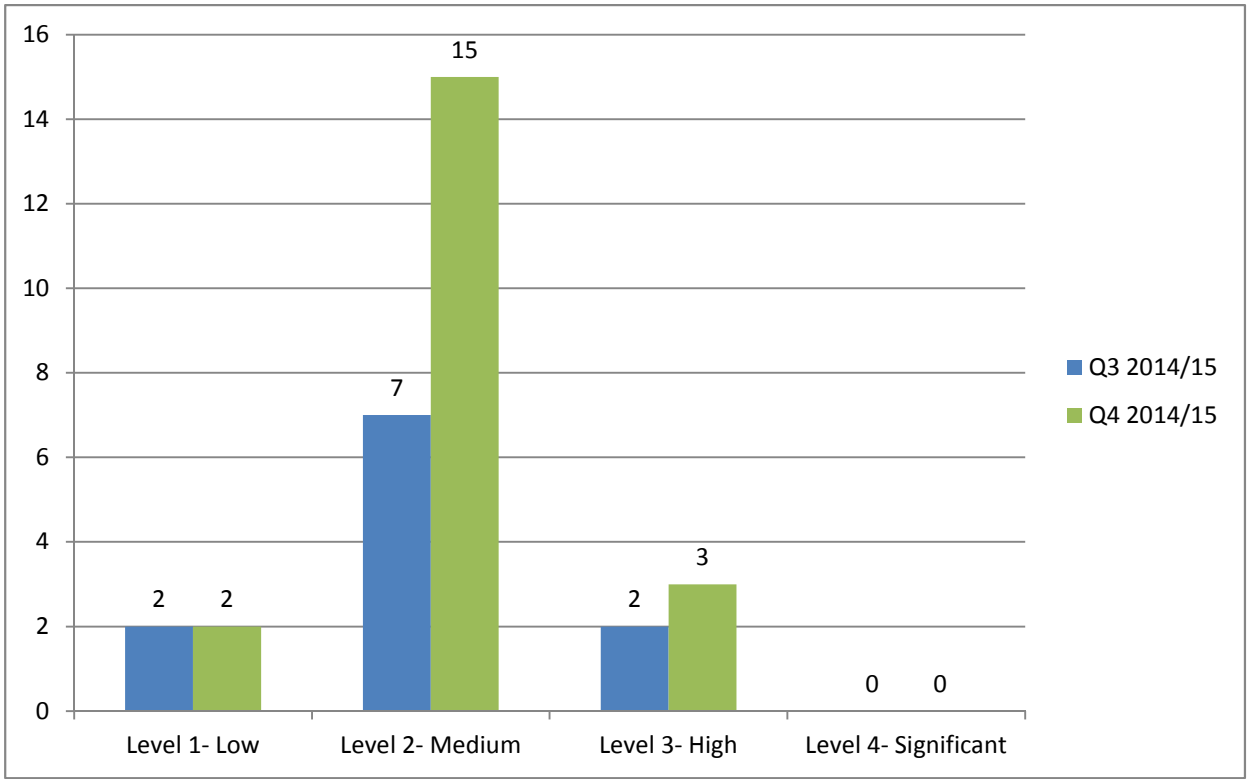
Complaints that have been reopened in Q4 2014/15 by Clinical Group and Corporate Directorate



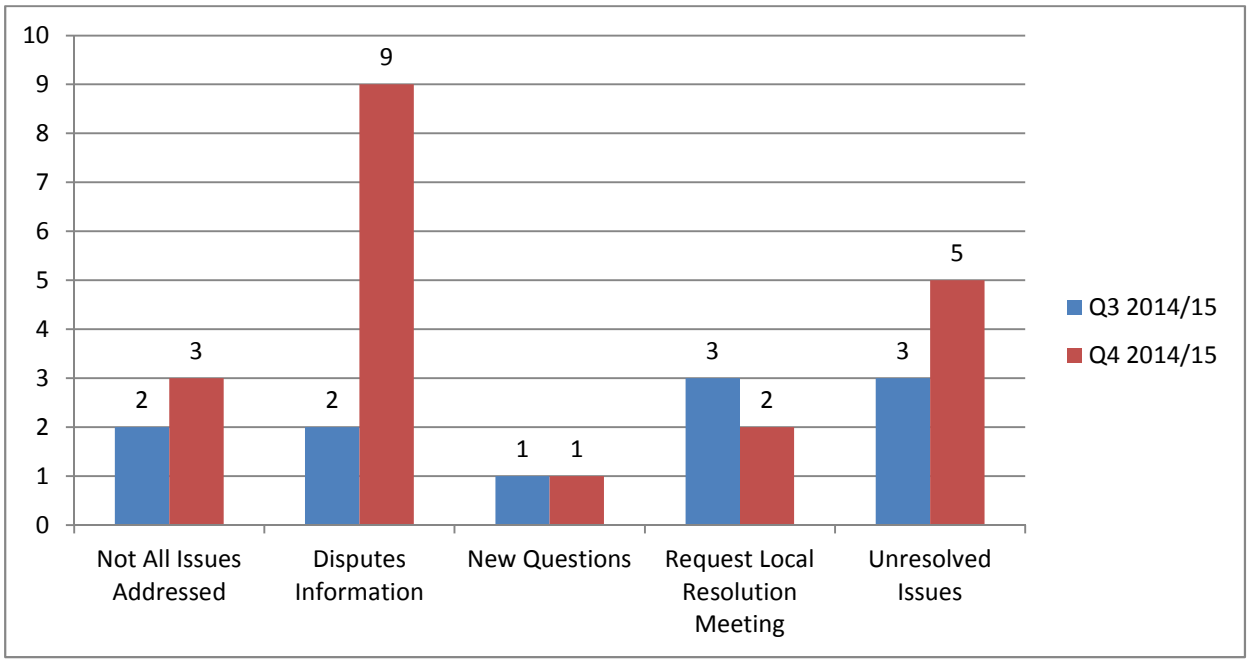
Complaints that have been reopened in Q4 2014/15 by Grade



Reopened complaints for Medicine and Emergency Care by grade



Reopened complaints for Medicine and Emergency Care by reason



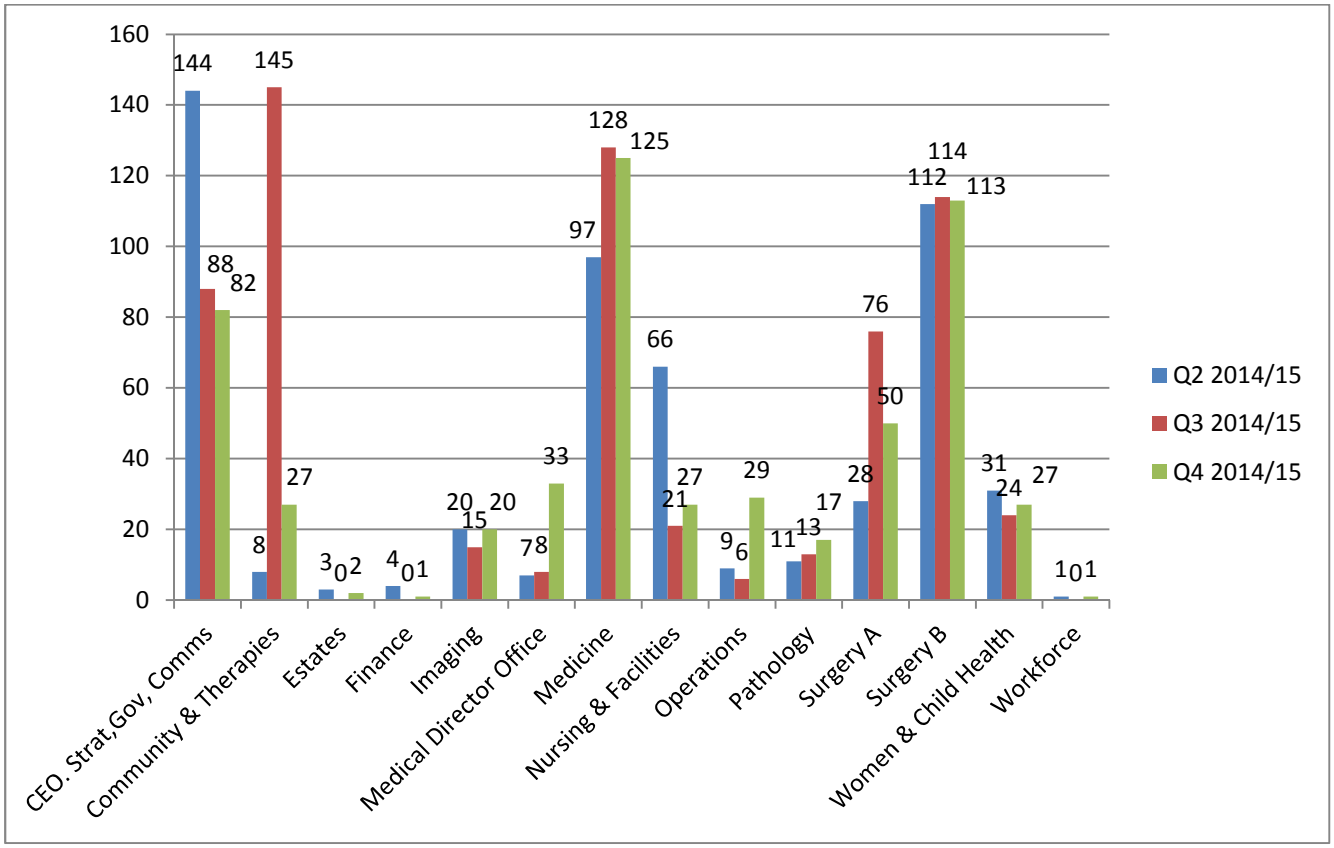
Appendix 9

Improvement actions required as a result of a PHSO investigation that found partial service failure. All actions have been completed.

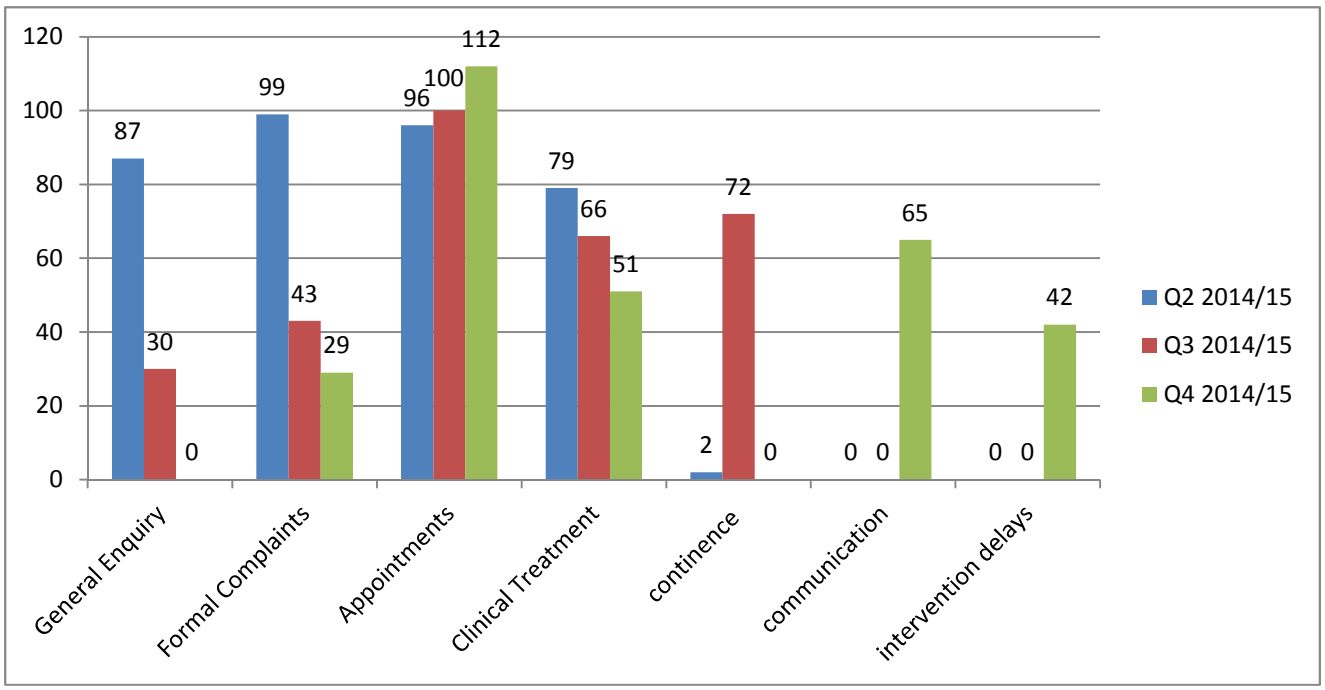
Improvement actions
▸ A patient with LD will be identified on both the patient management system, and the electronic bed management system ▸ The casualty card and the patient assessment record to include the identification of a patient with LD ▸ Pathways for referral to the LD liaison nurse and both Sandwell and City Hospital ▸ Reasonable adjustments to include longer appointment times, and the facility for carers to attend anaesthetic and recovery areas. ▸ Easy read information developed by LD Nurse and given to patients ▸ LD web page with a library of easy read information ▸ A specialist training package rolled out across both Sandwell and City Hospital, to include nurses and FY1 doctors at ward and departmental level. ▸ Information days held at both Sandwell and City Hospitals on LD, specifically on how to access services in the local areas ▸ Patient survey provided to all patients including those with LD ▸ Opportunity for feedback from families and carers of patients with LD - through audit and attending provider and carer meetings ▸ Working with Sandwell Peoples Parliament to better understand the needs of LD community in terms of Acute Healthcare provision

Appendix 10

PALS enquiries broken down by group

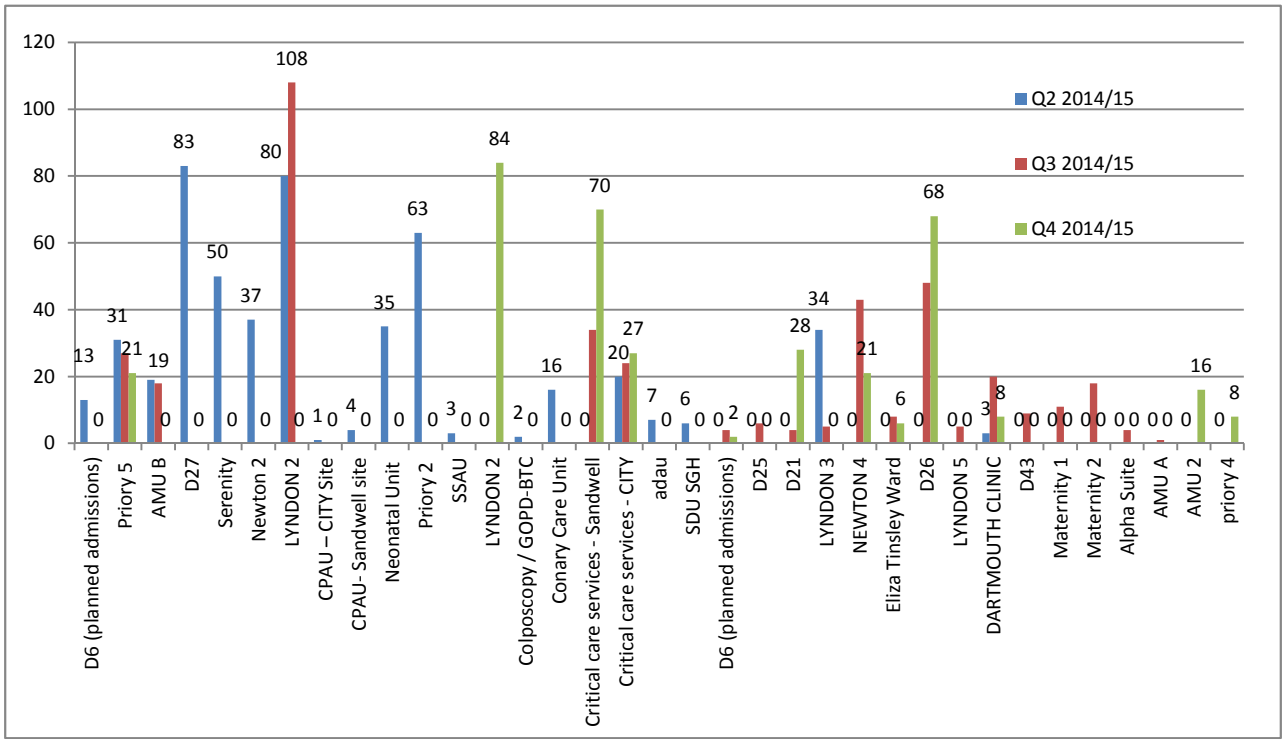


The Top PALS enquiries over the last 3 quarters are shown below.



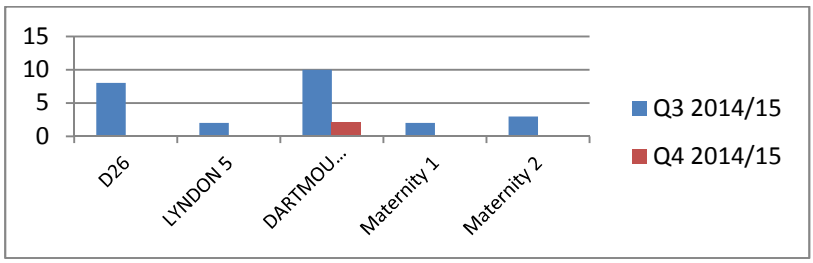
Appendix 11

Compliments



This shows the breakdown of compliments collated by the wards that responded for Q4 2014/15. It was reported in Q2 2014/15 that during Q3 and Q4, Wards within Clinical Groups will be more consistently collecting all compliments to report more comprehensively in the Q4 2014/15 report. However this still does not appear to have been the case. The total number of compliments, when we started collecting the data in Q2 2014/15 was 507, against 397 in Q3 2014/15 and 359 in Q4 2014/15. Without a more comprehensive reporting tool (as opposed to the manual tick sheet currently in use) it is still not clear whether this is a drop in compliments, or a lack of commitment in reporting this activity.

Departmentally resolved concerns



The same can be said for the reporting of the departmentally managed concerns. This table shows that dispute finding a manual method of capture, only 2 departmentally resolved complaints were reported in Q4 2014.

Karen Beechey
Head of PALS & Complaints

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Quality, Performance & Finance Report
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Mgt
AUTHOR:	Gary Smith, Acting Head of Performance Monitoring
DATE OF MEETING:	7 May 2015 (Report finalised 30th April 2015)

EXECUTIVE SUMMARY:

The report is intended to inform the Trust Board of the summary performance of the Trust for the period April 2014 – March 2015.

REPORT RECOMMENDATION:

The Trust Board is 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
		x

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

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

Comments: V4

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

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

PREVIOUS CONSIDERATION:

Operational Management Committee and Quality & Safety Committee

Sandwell and West Birmingham Hospitals
NHS Trust

Integrated Quality and Performance Report

March 2015

Contents

At A Glance

Infection Control

There were 5 cases of C. Diff reported during the month of March, 4 in Medicine and 1 in Surgery A. The number of cases for the month exceeded the trajectory, but the numbers for the year remain within the trajectory.

There was 1 case of post-48 hour MRSA Bacteraemia reported during the month of March at Sandwell (Clinical Haematology).

The incidence of MSSA Bacteraemia and E. Coli (both expressed per 100,000 bed days) for the month of March and year remain with the operational threshold.

Both MRSA elective and non-elective screening remain above the 80% target at 97% and 95% respectively for March.

Harm Free Care

Overall Harm Free Care as assessed through the NHS Safety Thermometer indicates a level of Harm Free Care of 93.53% for March, beneath the 95.0% operational threshold.

There were 78 falls reported in March, an increase from the previous month (64).

The total number of hospital acquired, avoidable pressure ulcers decreased to 7 (5 Grade 2 and 2 grade 3) during the month of February.

There is 1 medication incident resulting in serious harm reported for March which is under investigation.

There were 4 Open CAS Alerts reported at the end of March, 1 of which was overdue at the end of the reporting period.

Obstetrics

The overall Caesarean Section rate for March of 24.6% remained beneath the target of 25.0%. Elective and Non-Elective rates for the month were 8.7% and 15.9% respectively. The overall rate for 2014 / 2015 was 25.0%.

Adjusted perinatal mortality rate (per 1000 births) increased during the month of February to 13.7, in excess of the target of 8.0 or less.

Breast feeding initiation for the quarter was above the 77% target at 77.5%. The year figure was 75.9%

Mortality & Readmissions

The Trust's RAMI for the most recent 12-month cumulative period is 88, similar to that of the National HES Peer (87). City and Sandwell site RAMIs are 69 and 103 respectively.

Mortality rates for weekday and weekend and low risk diagnoses remain within statistical confidence limits. RAMI values for all CQC diagnosis groups are also within or beneath statistical confidence limits.

During the most recent month for which complete data is available (January) the overall Trust performance for review of deaths within 42 days was 89%, a reduction from the previous month's performance of 92%. The trajectory for the period is 98%.

The Crude Mortality Rate for March is 1.5%. 12 month figure is 1.4%

Stroke Care & Cardiology

Stroke data for the month of march indicates Patients spending >90% of their time on a stroke ward remains above the 90% operational threshold at 94.6% for the month, Admittance to a stroke unit within 4 hours remains relatively stable at 80.95% (90% target) and 85.7% eligible patients received thrombolysis within 60 minutes of admission (target 85%). Patients receiving a CT scan within 24 hours of presentation was 98.5% against a 100% target, with 67.16% patients receiving a CT Scan within 1hour of presentation.

Primary Angioplasty (Door to balloon time <90 minutes %) was 88.5% for March against an 80% target. Primary Angioplasty (Call to balloon time <150 minutes %) was 89.8% for March against an 80% target. RACP percentage for March was 100% above the 98% target. 98.2% for the year.

Cancer Care

The Trust continues to meet all, in month (February) and year to date high level Cancer Treatment targets, and compare well against national benchmark data.

2 Groups, Medicine and Women & Child Health, failed to meet 93.0% operational threshold for the 2-week maximum cancer wait with performance for the month of 89.4% and 91.9% respectively.

All Groups met the 31 day diagnosis to treatment target of 96% during February.

Surgery B failed to meet the 62 day urgent GP referral to treatment target (85%) with performance in 'Head and Neck' cancer of 40% (1.0 of 2.5 accountable patients treated within 62 days). Medicine also failed to meet the 62 day referral to treatment target of 90% from a hospital specialist (0.0 of 0.5 accountable patients treated within the timescale).

Patient Experience - MSA & Complaints

There were no mixed sex accommodation breaches reported during the month of March.

In March the Inpatient and ED Response Rates both remain above the operational threshold at 43% and 22% respectively, FFT Scores in both areas improved to 72 and 52 respectively.

100% of complaints received during the month were acknowledged within 3 days of receipt.

The percentage of complaints exceeding the original agreed response date has increased (worsened) to 54% in March.

The oldest complaint currently in the system is in Surgery A at 234 days

Patient Experience - Cancelled Operations

The number of Last Minute Cancelled Operations increased during March to 41, equivalent to 0.9%, against a 0.8% target. The majority of cancellations (17) were seen in Surgery A spread across the 4 Clinical Directorates.

There was one second or subsequent urgent operation cancellations in March in Women and Children's Group in the Gynaecology Directorate.

There were no breaches of the 28 day late cancelled operation guarantee reported during the month of March.

Emergency Care

The Trust's performance against the 4-hour ED wait target of 95.0% during the Month (March), Quarter (4) and Year was 91.27%, 91.99% and 92.52% respectively. Current performance (as at 29th April) for April is 91.72% .

Delayed Transfers of Care for the month of March reduced quite significantly from 4.2% (February) to 3.1% overall, although the rate for City remains high at 4.8% (Sandwell is 1.8%).

The proportion of patients admitted with a Fractured Neck of Femur who received an operation within 24 hours of admission during March was 60.0% (3 of 5 patients) and 69.5% for the year.

Referral To Treatment

Trust level Admitted, Non-Admitted and incomplete RTT Pathway targets were all met for the month of March.

1 patient waited more than 52 weeks for commencement of treatment on the RTT Admitted Pathway (1 x Neurology), 2 patients on the Non Admitted pathway (1x ophthalmology, 1x Cardiology) and 1 patient was waiting for commencement of treatment on the RTT Incomplete Pathway in Urology.

6 Treatment Functions failed the respective RTT pathway performance thresholds for the month.

Diagnostic waits (March) beyond 6 weeks were 0.23%, compared with an upper operational threshold of 1.00%. The majority (20) of the 21 patients waiting in excess of 6 weeks were in Imaging.

Data Completeness

The Healthcare and Social Care Information Centre (HSCIC) assess the percentage of Trust submitted records for A&E, Inpatients and Outpatients to the Secondary Uses Service (SUS) for completeness of valid entries in mandatory fields. All three parameters are above target. (latest data provided January)

The Trust's internal assessment of the completion of valid NHS Number Field within inpatient data sets remains below the 99.0% operational threshold, with actual performance (completeness) during March reported as 96.6%.

The Trust's internal assessment of the percentage of invalid fields completed in the SUS submission for Maternity records remains in excess of the operational threshold of =<15.0%, with a value for March of 38.77%.

Staff

PDR overall compliance as at the end of March improved to 90.5%. The range by Group is 84 - 98%. The Medical Appraisal / Revalidation Rate for the month is 92.8%.

Mandatory Training at the end of March remained stable at 87.6% overall. The range by Group is 85 - 94%.

The most recent 'Your Voice' data shows a decline in score from 3.57 to 3.55 (Lowest Finance 2.77 to highest Immunology and Maternity at 3.98). Response rate stayed the same at 12.7% (Lowest Maternity 3% to highest Governance 52%)

Sickness Absence still remains high at 5.05% for March, and 4.69% for the 12-month rolling period. (Range by Clinical Group during March is 2.1% to 5.9% and by Corporate Directorate 1.08% to 6.66%).

The Return to Work interview rate following Sickness Absence is 45.4% for the 12-month cumulative period.

Data on the number of Unfilled Bank shifts is now included in the report.

CQUIN

In summary, 20 schemes are classified as performing, with the remaining 2 underperforming.

Underperforming schemes are; 1) Medication and Falls - an e-BMS development, with a scheduled implementation during February, will provide continuous audit data on the number of admissions at high risk of falling, which should improve compliance. CCG agreement to a contract variation to reflect this has been obtained: 2) The Community Dietetics scheme is now back on track to an agreed revised implementation plan. Subject to delivery during Q4, the Trust will receive 75% of the original scheme value. Final data for March / Quarter 4 for both schemes is awaited.

To date three confirm and challenge meetings have been held with scheme leads. Community Dietetics has been subject to detailed discussion with CCG leads, with a revised implementation plan and payment profile having now been agreed. Confirmation has been received from Specialised Commissioners that all 4 schemes have been fully achieved for Q3, and payment criteria satisfied.

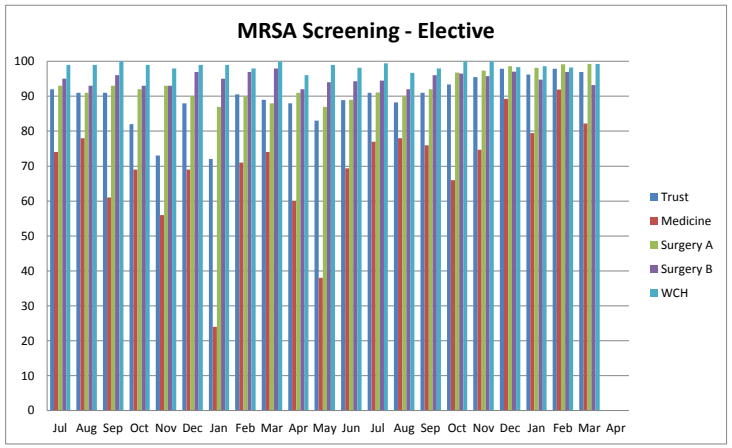
External Assessment Frameworks

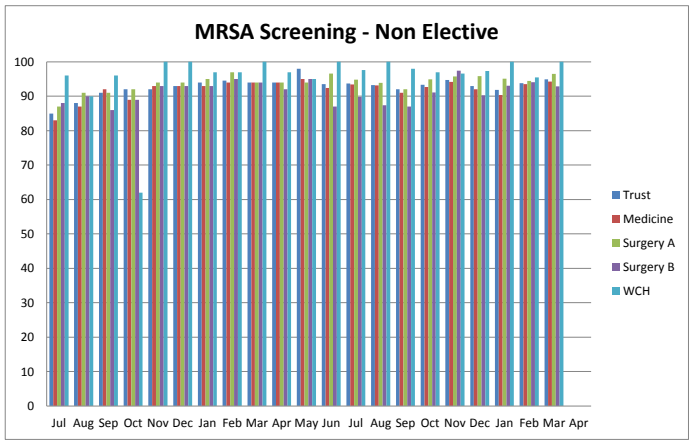
TDA Accountability Framework - Quality Scores for each of the 5 domains which comprise the framework are indicated in the main body of this report, with the areas of 'adverse' performance against each domain identified. The sum of the domain scores are used to derive the overall quality score which for the most recent period is 2 (1 is highest risk rating and 5 is lowest risk rating). The overall score is also influenced by the application of any override rules which may be applied, which during March related to ED 4-hour performance of 91.27%.

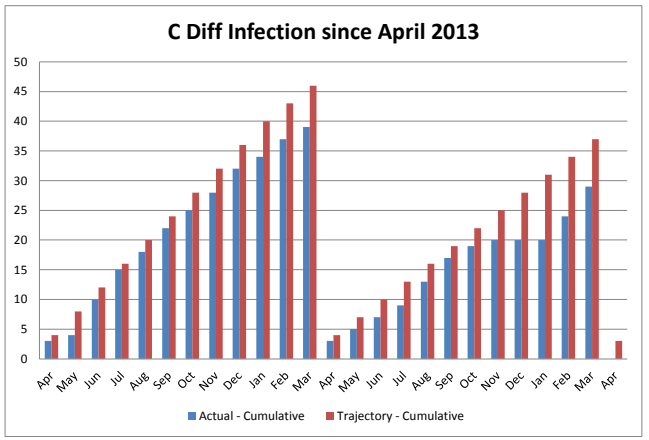
Monitor Risk Assessment Framework - compliance against this framework is also indicated. For the month of March performance (actual and projected) attracts a Governance Rating of 1.0 (Amber / Green), influenced adversely by ED 4-hour wait performance.

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
4			C. Difficile	No.	37	3	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	4	1	0	0					5	29	●	●	●
4			MRSA Bacteraemia	No.	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	1	0	0	0					1	4	●	●	●
4			MSSA Bacteraemia (rate per 100,000 bed days)	Rate	<9.42	<9.42	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15									8.7	5.7	●	●	●
4			E Coli Bacteraemia (rate per 100,000 bed days)	Rate	<94.9	<94.9	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15									17.34	17.9	●	●	●
3			MRSA Screening - Elective	%	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	82	99	93	99					97.0		●	●	●
3			MRSA Screening - Non Elective	%	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	94	97	93	100					95.0		●	●	●

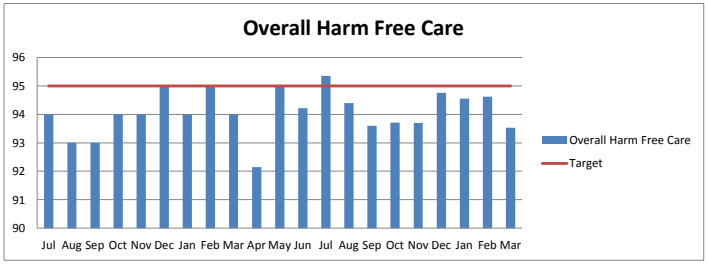


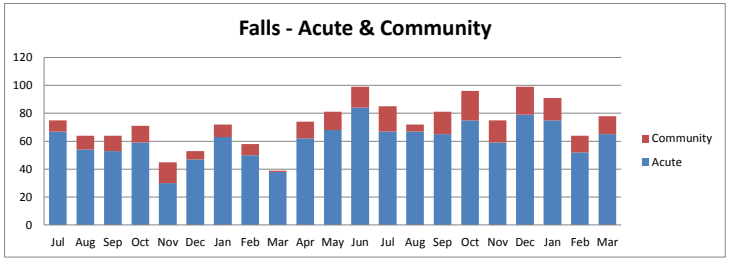


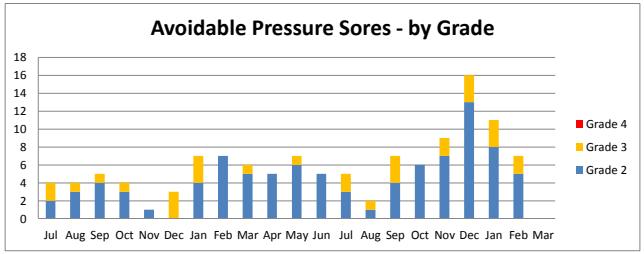


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	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	%	=>95	=>95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15									93.5		●		
8		d	Patient Safety Thermometer - Catheters & UTIs	%			0.72	0.52	0.69	0.43	0.43	0.53	0.48	0.51	0.49	0.42	0.41	0.40	0.25	0.31	0.41	0.40	0.64		Mar-15									0.64				
8			Falls	No.	804	67	45	53	72	58	39	74	81	99	85	72	81	96	75	99	91	64	78		Mar-15	52	4	0	0	0	0	13		78	995	●		
9			Falls with a serious injury	No.	0	0	2	6	2	1	2	1	5	4	1	5	1	1	2	1	1	0	1		Mar-15	1	0	0	0		0	0		1	25	●		
8			Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	No.	0	0	1	2	7	8	7	5	7	5	5	2	7	6	9	16	11	7			Feb-15	4	0	0	2			1		7	80	●		
3		d	Venous Thromboembolism (VTE) Assessments	%	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	98.8	98.9	97.6	88.7					97.4		●		
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	%	98	98	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	99.8	99.8	99.9	99.3		100			99.9		●		
3			WHO Safer Surgery - 3 sections and brief (% lists where complete)	%	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100	100	100	100		100			99.9		●		
3			WHO Safer Surgery - Audit - 3 sections, brief and debrief (% lists where complete)	%	85	85	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100	99.0	100	100		100			99.9		●		
9		d	Never Events	No.	0	0	2	●	2	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	99.3	0	0	0	0	0	0		0	0	●		
9		d	Medication Errors causing serious harm	No.	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	1		Mar-15	1	0	0	0	0	0	0		1	1	●		
9		d	Serious Incidents	No.	0	0	4	0	2	0	1	3	2	2	2	2	1	1	2	3	4	4	6		Mar-15	3	0	0	2	0	0	1	0	6	32	●		
9			Open Central Alert System (CAS) Alerts	No.			6	9	9	8	11	9	5	7	5	6	5	5	15	17	10	9	4		Mar-15									9		●		
9		d	Open Central Alert System (CAS) Alerts beyond deadline date	No.	0	0							1	1	1	0	0	0	4	0	1	0	1		Mar-15									1		●		

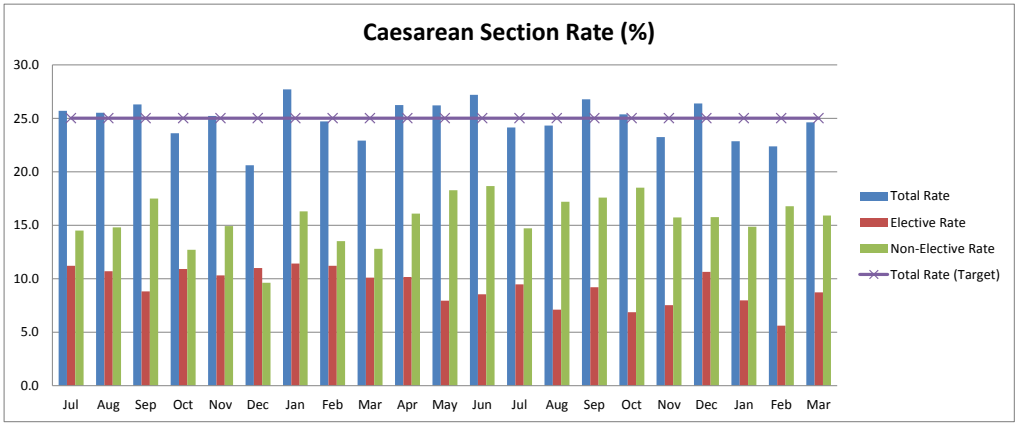


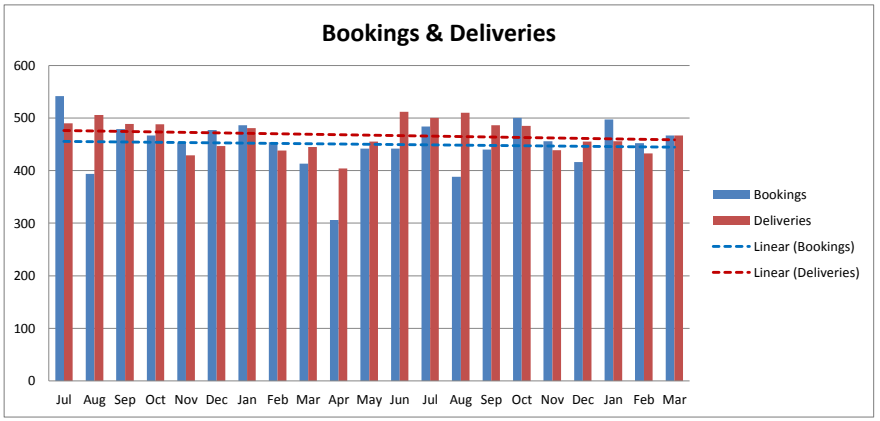




Patient Safety - Obstetrics

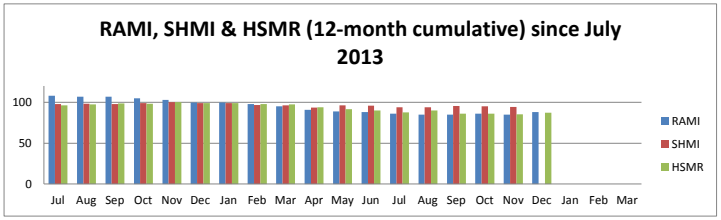
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Caesarean Section Rate - Total	%	=<25.0	=<25.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	24.6	25.0	●		
3		●	Caesarean Section Rate - Elective	%			10	11	12	11	10	10	8	9	9	7	9	7	8	11	8	6	9		Mar-15	8.7	8.3			
3		●	Caesarean Section Rate - Non Elective	%			15	10	16	14	13	16	18	19	15	17	18	19	16	16	15	17	16		Mar-15	15.9	16.7			
2		●d	Maternal Deaths	No.	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	1	●	●	●		Mar-15	0	1	●		
3			Post Partum Haemorrhage (>2000ml)	No.	48	4	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	6	●		
3			Admissions to Neonatal Intensive Care	%	=<10.0	=<10.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	1.28	2.23	●		
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	Rate	<8.0	<8.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Feb-15	13.7		●		
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	76.02		●		
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Feb-15	190		●		
2			Breast Feeding Initiation (Quarterly)	%	=>77.0	=>77.0			●		●			●			●			●			●		Mar-15	77.52	75.86	●		
2		●	Puerperal Sepsis and other puerperal infections (variation 1) (%)	%			1.9	3.4	1.3	2.3	0.7	2.3	1.8	2.6	1.8	0.9	0.9	0.7	1.5	1.2	1.4	0.5	2.1		Mar-15	2.1	1.7			
2		●	Puerperal Sepsis and other puerperal infections (variation 2) (%)	%			0.5	1.4	0.2	1.6	0.5	1.5	1.8	1.6	1.6	0.7	0.3	0.7	1.3	0.8	0.3	0.5	1.5		Mar-15	1.5	1.2			
2		●	Puerperal Sepsis and other puerperal infections (variation 3) (%)	%			0.2	0.5	0.2	0.2	0.0	0.8	0.7	0.4	0.4	0.2	0.0	0.0	1.0	0.4	0.0	0.0	1.2		Mar-15	1.2	0.5			

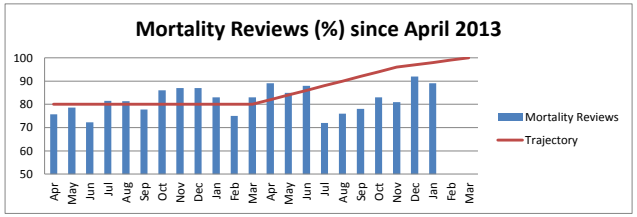


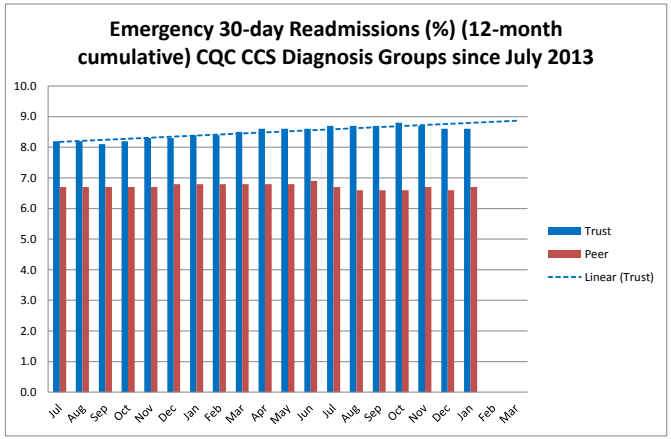


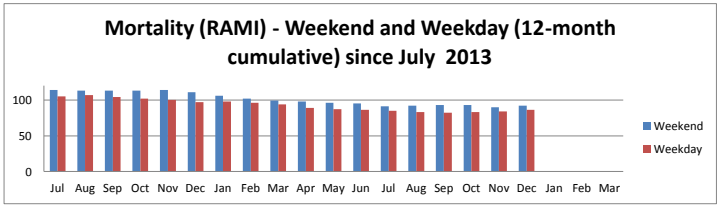
Clinical Effectiveness - Mortality & Readmissions

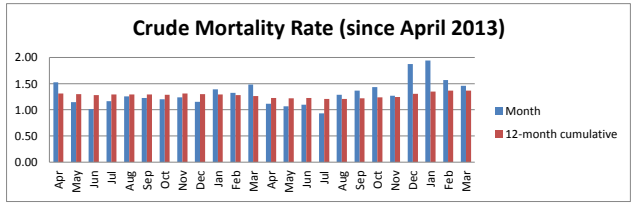
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	103	100	100	98	95	91	89	88	86	85	85	86	85	88					Dec-14										88			
5		C	Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	100	97	98	96	94	89	87	86	85	83	82	83	84	86					Dec-14										86			
5		C	Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	114	111	106	102	99	98	96	95	91	92	93	93	90	92					Dec-14										92			
6		C	Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	100	99	99	97	96	94	96	96	94	94	95	95	94						Nov-14										94.2			
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			100	99	99	98	97	94	92	90	88	90	86	86	85	87					Dec-14										87.4			
5			Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	67	104	78	73	106	66	75	47	51	71	89	80	76	111					Dec-14									111				
3			Mortality Reviews within 42 working days	%	100	=>98	●	●	●	●	●	●	●	●	●	●	●	●	●	●					Jan-15	90	88							89			
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			1.2	1.2	1.4	1.3	1.5	1.1	1.1	1.1	0.9	1.3	1.4	1.4	1.3	1.9	1.9	1.6	1.5		Mar-15									1.46				
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.3	1.3	1.3	1.3	1.3	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.3	1.4	1.4	1.4		Mar-15										1.36			
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month - internal data	%			7.3	7.7	7.3	7.4	7.5	8.1	8.2	7.3	7.6	7.9	7.4	7.8	7.6	8.2	8.7	8.4	8.5		Mar-15									7.86				
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative - internal data	%								8.1	8.2	7.9	7.8	7.8	7.7	7.7	7.7	7.7	7.9	8.0	8.2		Mar-15										7.69			
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative) - CHKS data	%			8.3	8.3	8.4	8.4	8.5	8.6	8.6	8.6	8.7	8.7	8.7	8.8	8.7	8.6	8.6				Jan-14										8.6			





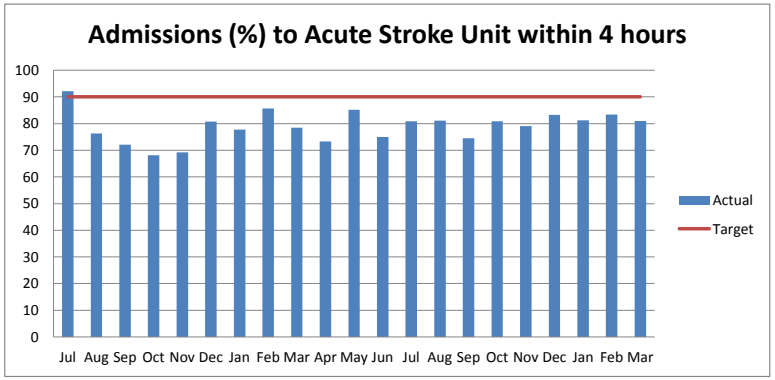


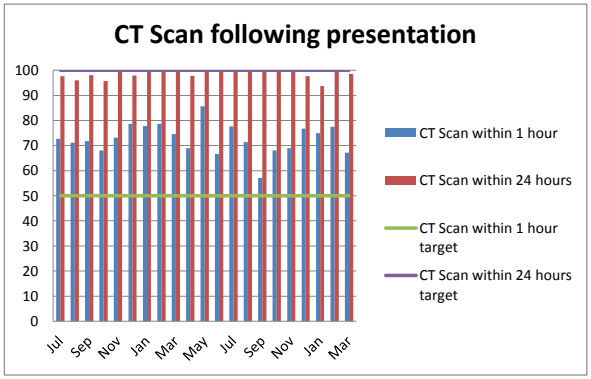


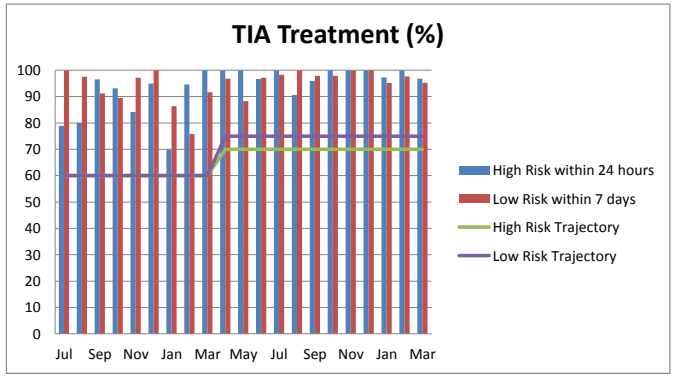


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Pts spending >90% stay on Acute Stroke Unit	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	94.6	91.9	●		
3			Pts admitted to Acute Stroke Unit within 4 hrs	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	81.0	97.5	●		
3		●	Pts receiving CT Scan within 1 hr of presentation	%	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	67.2	71.6	●		
3			Pts receiving CT Scan within 24 hrs of presentation	%	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	98.5	98.8	●		
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	%	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	85.7	80.3	●		
3			Stroke Admissions - Swallowing assessments (<24h)	%	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100.0	100.0	●		
3			TIA (High Risk) Treatment <24 Hours from receipt of referral	%	=>70.0	=>70.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	96.8	98.1	●		
3			TIA (Low Risk) Treatment <7 days from receipt of referral	%	=>75.0	=>75.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	95.2	97.1	●		
9			Primary Angioplasty (Door To Balloon Time 90 mins)	%	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	88.2	88.5	●		
9			Primary Angioplasty (Call To Balloon Time 150 mins)	%	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	85.7	89.8	●		
9			Rapid Access Chest Pain - seen within 14 days	%	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100.0	98.2	●		

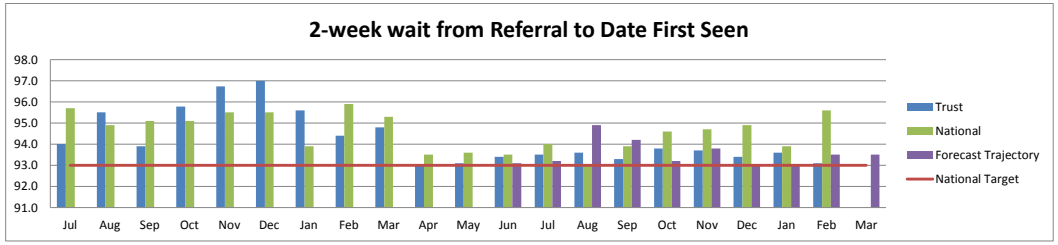


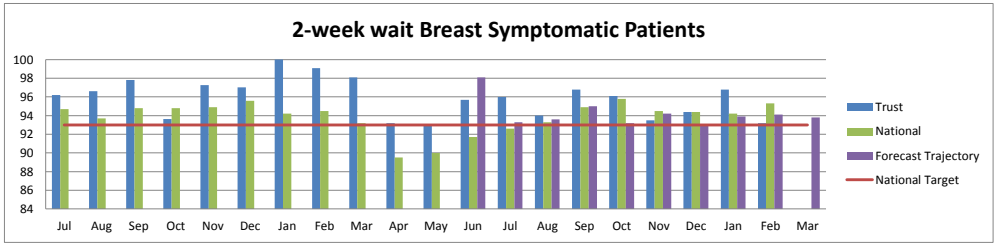


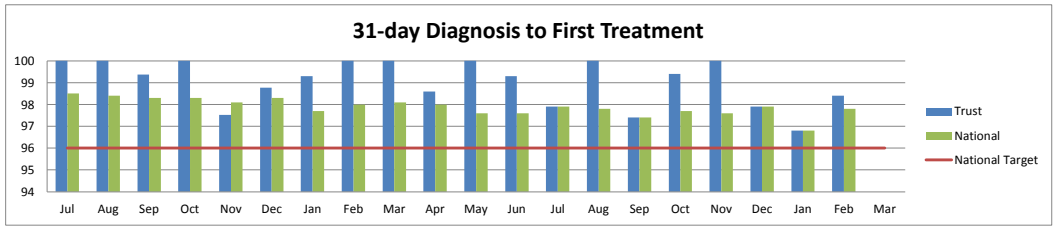


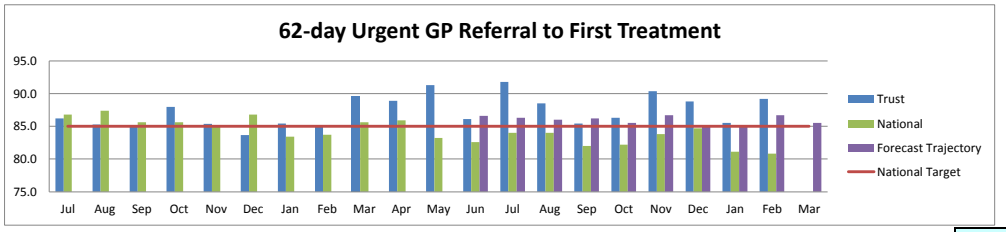
Clinical Effectiveness - Cancer Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	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	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	89.4	94.0	100	91.9					93.1	93.4	●		
1			2 weeks (Breast Symptomatic)	%	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		93.2							93.2	94.7	●		
1			31 Day (diagnosis to treatment)	%	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	97.3	100	96.2					98.4	98.7	●		
1			31 Day (second/subsequent treatment - surgery)	%	=>94.0	=>94.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15									97.5	97.9	●		
1			31 Day (second/subsequent treatment - drug)	%	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15									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	n/a	●			Feb-15									100	100	●		
1			62 Day (urgent GP referral to treatment)	%	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	92.3	90.7	40.0	90.0					89.2	88.4	●		
1			62 Day (referral to treat from screening)	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		100		100					100	97.6	●		
1			62 Day (referral to treat from hosp specialist)	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	50	100		100					96.0	94.4	●		



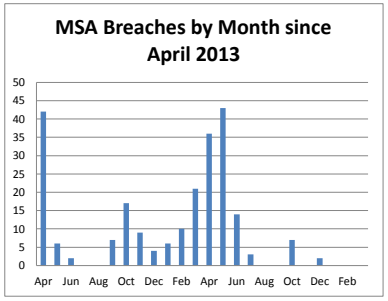


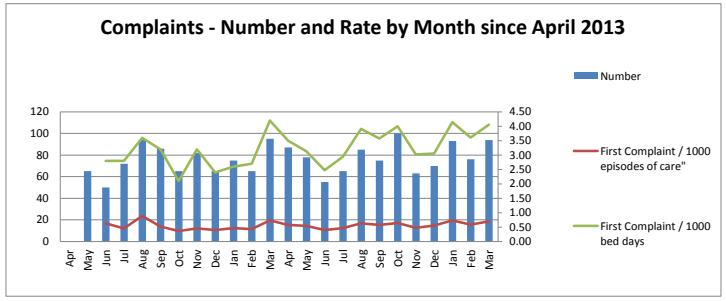


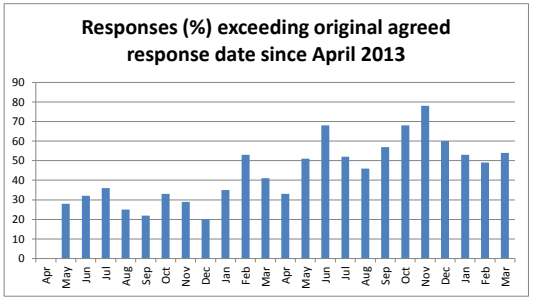


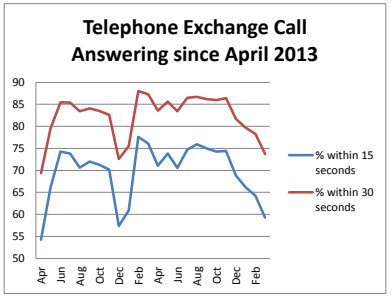
Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	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	29	31	34	36	36	44	45	41	32	31	28	31	28	33	43	43		Mar-15									43.2				
8		a	FFT Score - Inpatients	No.	=>60.0	=>60.0	70	73	71	75	73	74	74	70	73	76	74	73	73	69	70	68	72		Mar-15									72.0				
8		b	FFT Response Rate Emergency Department	%	=>20.0	=>20.0	17	15	15	16	15	15	16	16	16	17	17	17	18	17	18	21	22		Mar-15	22								21.9				
8		a	FFT Score - Emergency Department	No.	=>46.0	=>46.0	47	44	47	48	48	47	49	48	47	49	47	48	49	50	50	44	52		Mar-15	52								52.0				
13		a	Mixed Sex Accommodation Breaches	No.	0	0	9	4	6	10	21	36	43	14	3	0	0	7	0	2	0	0	0		Mar-15	0	0	0	0		0	0		0	107			
9			No. of Complaints Received (formal and link)	No.			52	65	75	65	95	87	78	55	65	85	75	100	63	70	93	76	94		Mar-15	38	16	16	11	5	1	1	6	94	941			
9			No. of Active Complaints in the System (formal and link)	No.			201	190	188	188	210	194	245	270	219	258	282	324	359	219	249	266	265		Mar-15	117	45	36	32	6	5	6	18	265				
9		a	No. of First Formal Complaints received / 1000 bed days	Rate			3.2	2.4	2.6	2.7	4.2	3.5	3.1	2.5	2.9	3.9	3.6	4.0	3.0	3.1	4.1	3.6	4.1		Mar-15	3.1	2.9	24.7	2.6					4.06	3.58			
9			No. of First Formal Complaints received / 1000 episodes of care	Rate			0.5	0.4	0.5	0.4	0.7	0.6	0.5	0.4	0.5	0.6	0.6	0.6	0.5	0.6	0.7	0.6	0.7		Mar-15	1.0	1.7	0.9	0.5			0.0		0.70	0.60			
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	%	100	100	99	98	97	95	99	100	100	100	99	99	100	99	100	99	99	98	100		Mar-15	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	29	20	35	53	41	33	51	68	52	46	57	68	78	60	53	49	54		Mar-15	55	51	47	56	50	60	58	60	54				
9			No. of responses sent out	No.			59	79	81	58	67	117	30	4	138	66	42	35	26	198	59	52	84		Mar-15	32	15	13	7	4	2	4	7	84				
9			Oldest' complaint currently in system	Days			174	91	112	118	127	104	124	145	127	133	131	174	161	182	192	213	234		Mar-15	230	234	144	94	138	96	103	138	234				
14		e	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	Y	Y	Y	Y	Y	Y	Y	Y	Yes				



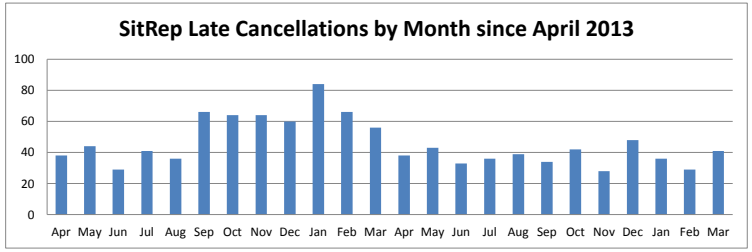


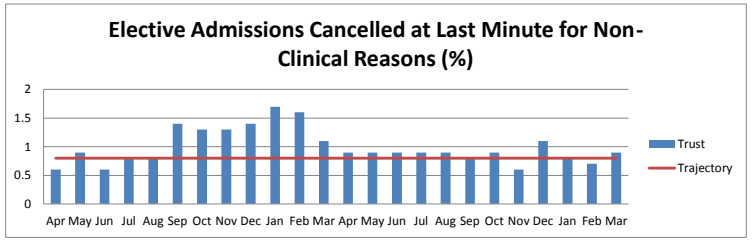


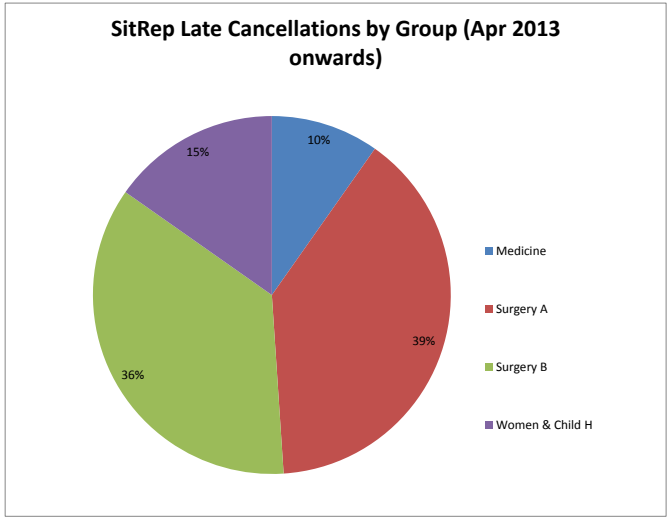


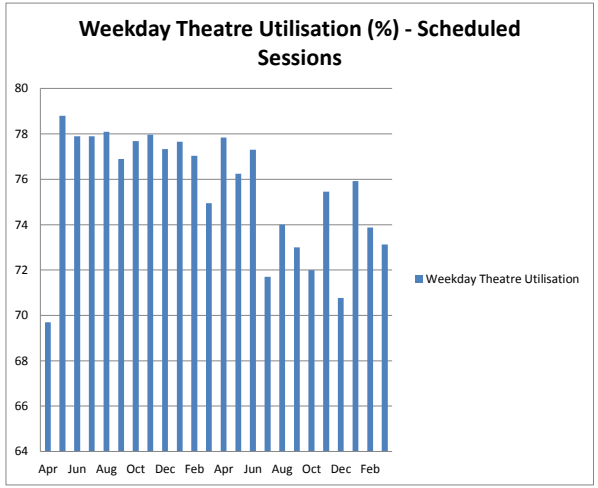
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	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	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0.46	1.54	0.72	2.35					0.9	0.8	●		
2		●e●	Number of 28 day breaches	No.	0	0	0	0	0	1	1	1	0	0	0	1	0	0	1	0	0	0			Mar-15	0	0	0	0					0	4	●		
2		●e	No. of second or subsequent urgent operations cancelled	No.	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1				Mar-15	0	0	0	1					1	3	●		
2			No. of Sitrep Declared Late Cancellations	No.	320	27	64	60	84	66	56	38	43	33	36	39	34	42	28	48	36	29	41			Mar-15	9	17	8	7					41	447	●		
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	No.	0	0	5	7	13	13	0	0	1	0	0	0	0	0	0	0	0	0	0			Mar-15	0	0	0	0					0	1	●		
3			Multiple Cancellations experienced by same patient (all cancellations)	%	0	0	13	13	13	13	11	12	7	10	12	11	13	11	14	10	11	13	12			Mar-15	9.6	15.8	9.4	15.2					11.79		●		
3			All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	%	3.1	3.1	6	5	8	6	6	5	6	5	5	6	7	6	6	8	6	7	5			Mar-15	1.9	6.5	8.6	7.1					5.1		●		
3			Weekday Theatre Utilisation (as % of scheduled)	%	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Mar-15	48.3	75.4	75.3	79.2					73.1		●		



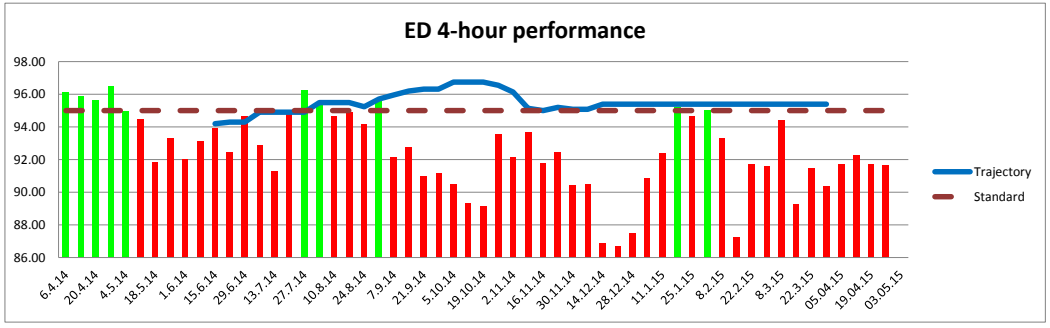


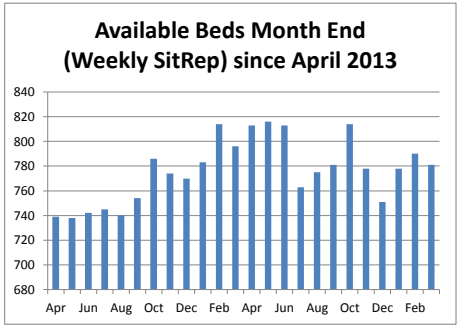


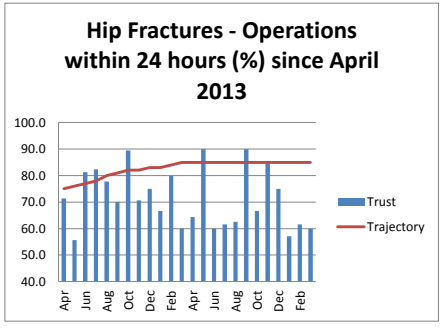


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend	Next Month	3 Months
2		e	Emergency Care 4-hour waits	%	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	93.5	87.7	98.6	91.27	92.52	●		
2			Emergency Care 4-hour breach (numbers)	No.								741	1210	1277	1122	876	1460	1636	1440	2234	1054	1481	1695		Mar-15	512	1154	29	1695	16226			
2		e	Emergency Care Trolley Waits >12 hours	No.	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	●		
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	mins	=<15	=<15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	15	19	15	18	18	●		
3			Emergency Care Timeliness - Time to Treatment in Department (median)	mins	=<60	=<60	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	54	70	20	54	51	●		
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	%	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	7.94	7.68	3.55	7.27	6.89	●		
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	%	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Mar-15	2.73	6.22	1.90	4.24	4.09	●		
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	No.	0	0	●	●	●	●	●	119	136	125	145	51	136	219	159	282	185	149	164		Mar-15	40	124		164	1870	●		
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	No.	0	0	●	●	●	●	●	13	8	8	8	1	13	21	14	31	7	6	8		Mar-15	6	2		8	138	●		
11		●	WMAS - Handover Delays > 60 mins (% all emergency conveyances)	%	=<0.02	=<0.02	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0.33	0.08		0.16	0.29	●		
11			WMAS - Emergency Conveyances (total)	No.			3927	4122	4009	3826	4271	4044	4227	4093	4278	3994	4067	4193	4168	4470	4001	3829	4182		Mar-15	1798	2384		4182	49546			
2			Delayed Transfers of Care (Acute) (%)	%	=<3.5	=<3.5	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	1.8	4.8		3.1	3.7	●		
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	No.	<10 per site	<10 per site						●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	5	6		11		●		
2			Patient Bed Moves (10pm - 8am) (No.) -ALL	No.								668	751	722	751	694	681	720	646	806	651	683	743		Mar-15				743	8516			
2			Patient Bed Moves (10pm - 8am) (No.) - exc. Assessment Units	No.								312	331	330	329	339	276	353	293	323	250	302	293		Mar-15				293	3731			
3			Hip Fractures - Operation < 24 hours of admission (%)	%	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15				60.0	69.5	●		

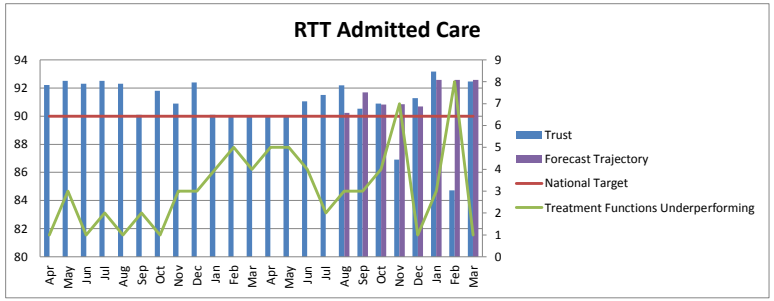


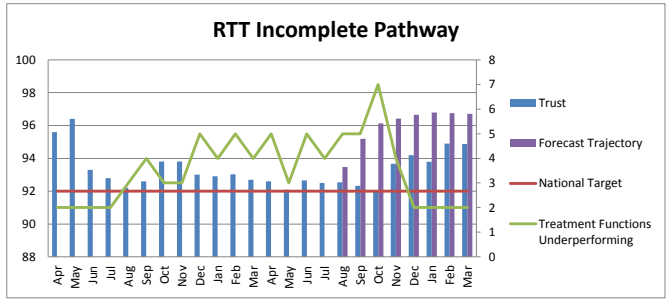


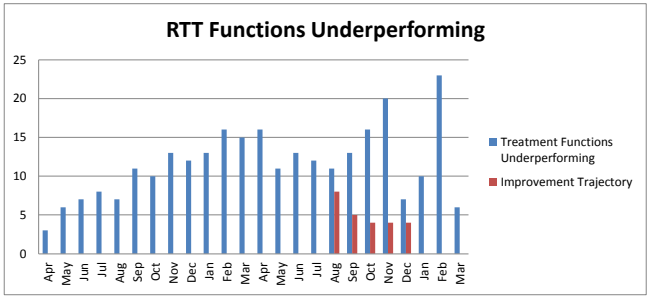


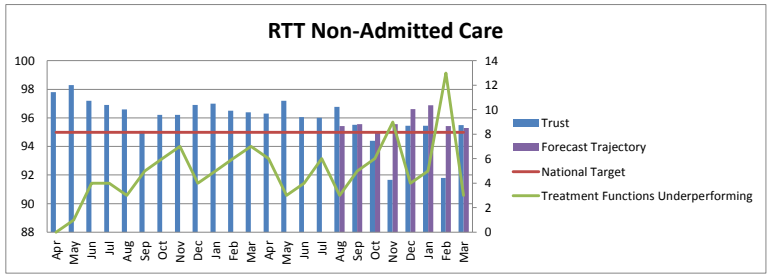
Referral To Treatment

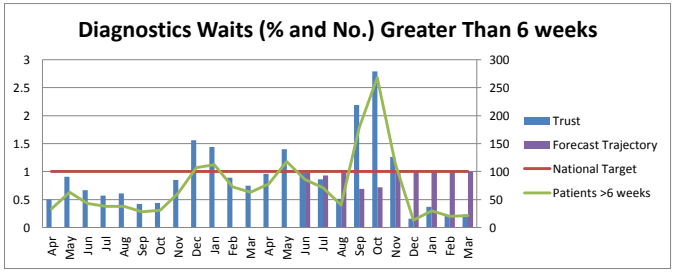
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2			RTT - Admittted Care (18-weeks)	%	=>90.0	=>90.0																			Mar-15	94.8	89.9	91.5	96.4					92.45				
2			RTT - Non Admittted Care (18-weeks)	%	=>95.0	=>95.0																			Mar-15	95.5	95.1	95.6	97.2					95.49				
2			RTT - Incomplete Pathway (18-weeks)	%	=>92.0	=>92.0																			Mar-15	97.3	92.2	93.8	98.6					94.88				
2			Patients Waiting >52 weeks	No.	0	0	36	12	3	1	1	1	2	2	3	4	4	3	3	0	4	3	4		Mar-15	1	2	1	0					4				
2			Treatment Functions Underperforming	No.	0	0	13	12	13	16	15	16	11	13	12	11	13	17	20	7	10	23	6		Mar-15	1	4	1	0					6				
2			Acute Diagnostic Waits in Excess of 6-weeks	%	=<1.0	=<1.0																			Mar-15	0.1	0.0	0.0	0.0		0.3			0.23				

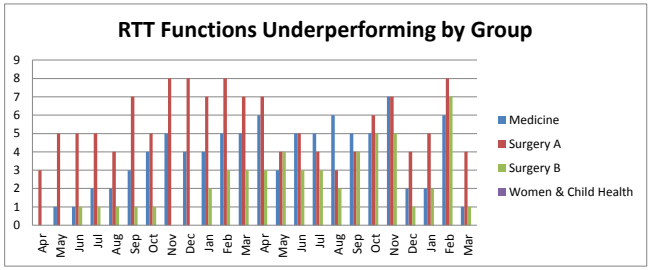










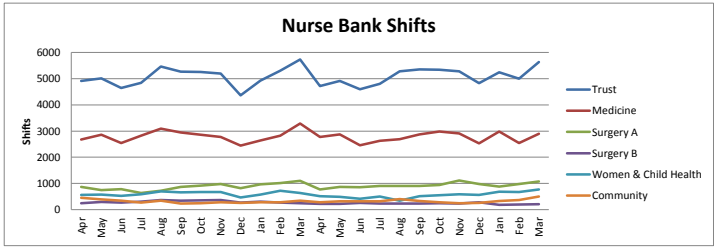


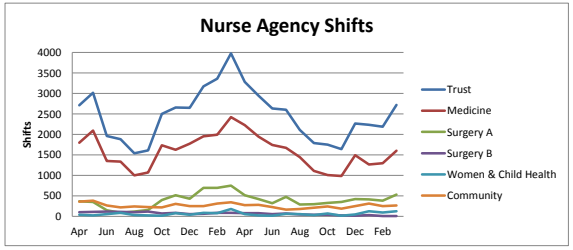
Data Completeness

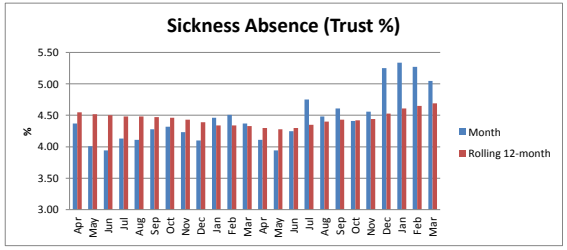
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Data Completeness Community Services	%	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15								>50	>50		●		
2		●	Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	%	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					Jan-15									99.49		●		
2		●	Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	%	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					Jan-15									99.56		●		
2		●	Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	%	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					Jan-15									99.45		●		
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	%	=>99.0	=>99.0	98.9	99.2	98.9	98.9	98.7	98.7	97.0	95.6	95.4	95.2	95.7	95.3	95.7	96.0	96.5	96.9	96.6		Mar-15									96.6	96.5	●		
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	%	=>99.0	=>99.0	99.7	99.7	99.7	99.6	99.5	99.5	99.5	99.5	99.5	99.4	99.4	99.5	99.5	99.5	99.6	99.6	99.6		Mar-15									99.6	99.5	●		
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	%	=>95.0	=>95.0	97.2	97.1	97.6	96.8	95.9	96.3	95.8	96.3	96.1	96.1	96.2	96.4	96.6	96.2	97.0	96.7	96.8		Mar-15									96.8	96.7	●		
2			Ethnicity Coding - percentage of inpatients with recorded response	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15									92.49	92.19	●		
2		●b●	Data Quality of Trust Returns to the HSCIC (provided by TDA)	%	=>96.0	=>96.0			94.9	94.9	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.5	98.7					Dec-14									98.7		●		
2			Maternity - Percentage of invalid fields completed in SUS submission	%	=<15.0	=<15.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15									38.77	35.85	●		

Staff

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	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 (FTE)	No.			626	572	541	567	567	531	558	580	584	626	608	628	674	685	701	732	807		Mar-15	328	71	32	70	18	40	15	234	807				
3		b	PDRs - 12 month rolling	%	=>95.0	=>95.0																			Mar-15	84	90	98	94	97	85	90	93		90.52			
7		b	Medical Appraisal and Revalidation	%	=>95.0	=>95.0																			Mar-15	96	89	97	83	100	97		100		92.8			
3		b	Sickness Absence	%	=<3.15	=<3.15																			Mar-15	5.1	5.2	2.1	5.9	5.9	4.7	4.7	5.2	5.05	4.69			
3			Return to Work Interviews following Sickness Absence	%	100	100																			Mar-15	17.7	29.0	39.0	46.2	69.7	49.4	64.3	68.0		45.40			
3			Mandatory Training	%	=>95.0	=>95.0																			Mar-15	85	90	88	85	94	87	91	90		87.6			
3			Mandatory Training - Health & Safety (% staff)	%	=>95.0	=>95.0																			Mar-15	96	96	93	96	99	98	99	99		97.1			
7		b	Staff Turnover (rolling 12 months)	%	=<10.0	=<10.0																			Mar-15									12.06	12.17			
7			New Investigations in Month	No.			1	4	2	4	5	1	4	6	5	2	15	3	1	0	3	4	5		Mar-15	2	2	0	1	0	0	0	0	5				
7			Vacancy Time to Fill	weeks			17	18	20	18	19	19	20	19	18	19	19	20	21	20	20	23	22		Mar-15									22				
7			Professional Registration Lapses	No.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Mar-15	0	0	0	0	0	0	0	0	0	0			
7			Qualified Nursing Variance (FIMS) (FTE)	No.			199	210	163	162	162	161	169	173	177	201	200	188	200	228	238	247	263		Mar-15									263.4	200.1			
10			Nurse Bank Fill Rate	%	100	100	76	71	73	75	76	76	82	82	80	77	78	78	82	73	78	78	78		Mar-15	72	76	100	90	100	87	93	100	78.3	78.5			
10			Nurse Bank Shifts Not Filled	No.	0	0	1882	1610	1983	1781	1627	1723	969	919	1087	1802	1370	1036	1440	1727	1716	1432	1487		Mar-15	###	335	1	81	0	2	36	1	1487	16708			
10			Nurse Bank Use (shifts)	No.	46980	3915																			Mar-15	2896	1079	206	774	7	14	495	161	5632	58090			
10			Nurse Agency Use (shifts)	No.	0	0																			Mar-15	1601	525	4	122	0	121	261	82	2716	26100			
10			Admin & Clerical Bank Use (shifts)	No.	0	0																			Mar-15	791	222	193	72	603	177	247	3968	6271	67208			
10			Admin & Clerical Agency Use (shifts)	No.	0	0																			Mar-15	55	22	29	38	0	0	0	17	161	1540			
			Medical Staffing - Number of instances when junior rotas not fully filled	No.	0	0																																
15			Your Voice - Response Rate	%							19.8		18.2		17.4		12.6		12.7						Feb-15	6	9	14	9	12	18	28	15					
15			Your Voice - Overall Score	No.							3.63		3.68		3.65		3.57		3.55						Feb-15	3.6	3.4	3.5	3.5	3.8	3.3	3.8	3.5					





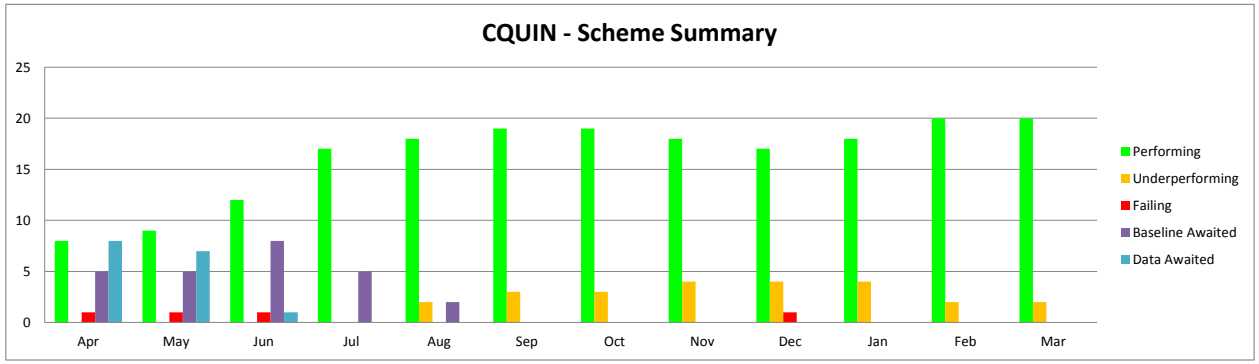


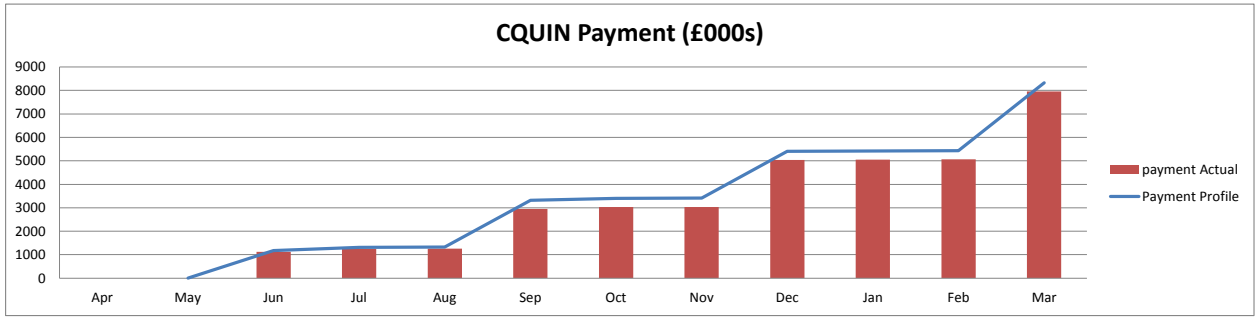
CQUIN (I)

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		●	●	●	●	●	●	●	●	●	●	●	●	Mar-15									Met	Met	●	●	●
8			FFT - Early Implementation of Patient FFT in OP / DC Departments	Implement by end Oct		●	●	●	●	●	●	●	●	●	●	●	●	Mar-15									Met	Met	●	●	●
8			FFT - Increase and / or Maintain Response Rate in ED areas	>Q1 rate		15	16	16	16	17	17	17	18	17	18	21	22	Mar-15									Met	Met	●	●	●
8			FFT - Increase and / or Maintain Response Rate in IP areas	>Q1 rate or at least 25% Q4		36	44	45	41	32	31	28	31	28	33	43	43	Mar-15									Met	Met	●	●	●
8			FFT - IP Response Rate (March 2015 target 40%) - replaces Reduce Negative Responses	40		●	●	●	●	32	31	28	31	28	33	43	43	Mar-15									Met	Met	●	●	●
8			NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers (community avoidable)	10% reduction		●	●	●	●	●	●	●	●	●	●	●	●	Mar-15									On Track	On Track	●	●	●
8			Dementia - Find, Assess and Refer	=>90	=>90	●	●	●	●	●	●	●	●	●	●	●	●	Mar-15									3 of 3 met	3 of 3 met	●	●	●
8			Dementia - Clinical Leadership and Staff Training			●	●	●	●	●	●	●	●	●	●	●	●	Mar-15									Met	Met	●	●	●
8			Dementia - Supporting Carers of People with Dementia	Monthly Audit	Monthly Audit	●	●	●	●	●	●	●	●	●	●	●	●	Mar-15									Met	Met	●	●	●
9			Learning From Safeguarding Concerns	Quarterly report to Board			●			●			●			●		Mar-15									On Track	On Track	●	●	●
2			Quality of Outpatient and Discharge Letters	Trust/CCG to agree assess. criteria			●		●	●	●	●	●	●	●	●	●	Mar-15									On Track	On Track	●	●	●
4			Sepsis - Use of Sepsis Care Bundles	Informed by base data target 65%			●		●	●	●	●	●	●	●	●	●	Mar-15									Met	Met	●	●	●
8			Pain Relief - Use of Pain Care Bundles	Informed by base data			●		●	●	●	●	●	●	●	●	●	Mar-15									On Track	On Track	●	●	●
9			Medication and Falls	Informed by base data			●		●	●	●	●	●	●	●	●	●	Mar-15									actions in place	actions in place	●	●	●
9			Serious Untoward Incidents (Never Events)	Informed by base data			●			●			●			●		Mar-15									On Track	On Track	●	●	●
14			Community Therapies - Effective Referral Management	Informed by base data			●			●			●		●	●	●	Mar-15									On Track	On Track	●	●	●

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	Informed by base data														Mar-15									actions in place	actions in place			
12			Maternity - Low Risk Births	Quarterly audit / action plan														Mar-15									On Track	On Track			
16			Bechet's Disease	Submit Quarterly return		Met (Q1)			Met (Q2)			Met (Q3)			Met (Q4)			Mar-15									Met (Q4)	Met			
17			HIV Home Delivery Medicines (% patients receiving)	70	Quarterly	Met (Q1)			Met (Q2)			Met (Q3)			Met (Q4)			Mar-15									Met (Q4)	Met			
17			Retinopathy of Prematurity Screening (%)	95	Quarterly	Met (Q1)			Met (Q2)			Met (Q3)			Met (Q4)			Mar-15									Met (Q4)	Met			
17			Timely Administration of TPN for preterm infants	95	Quarterly	Met (Q1)			Met (Q2)			Met (Q3)			Met (Q4)			Mar-15									Met (Q4)	Met			





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.

In summary, 20 schemes are classified as performing, with the remaining 2 underperforming. No schemes are currently failing.

Underperforming schemes are; 1) Medication and Falls - an e-BMS development, with a scheduled implementation during February, will provide continuous audit data on the number of admissions at high risk of falling, which should improve compliance. CCG agreement to a contract variation to reflect this has been obtained: 2) The Community Dietetics scheme is now back on track to an agreed revised implementation plan. Subject to delivery during Q4, the Trust will receive 75% of the original scheme value. Final data for March / Quarter 4 for both schemes is awaited.

To date three confirm and challenge meetings have been held with scheme leads. Formal submission of CQUIN performance to commissioners has been made for the first 2 Quarters. Initial feed back from Commissioning (29th Dec) showed concern for 3 areas; FFT inpatients, Community Dietetics and Maternity. Maternity and FFT inpatients have subsequently been cleared for payment. Community Dietetics has been subject to more detailed discussion, with a revised implementation plan and payment profile having now been agreed. Confirmation has been received from Specialised Commissioners that all 4 schemes have been fully achieved for Q3, and payment criteria satisfied.

External Assessment Frameworks

TRUST DEVELOPMENT AUTHORITY (TDA) ACCOUNTABILITY FRAMEWORK - SUMMARY

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
QUALITY SCORE		5	3	3	3	3	2	2	2	2	3	2	2
Domain													
Responsiveness	Initial Score	5	4	4	4	4	4	4	3	5	5	3	5
	Override Rules Applied	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Revised Score	5	3	3	3	3	2	2	2	2	3	2	2
	Indicators Not Achieving TDA Standard	RTT >52weeks 28 day canc. Ops	RTT >52weeks 28 day canc. Ops Diagnostic Waits ED 4-hours	RTT >52weeks ED 4-hours DTOC	RTT >52weeks ED 4-hours DTOC	RTT >52weeks ED 4-hours DTOC	28-day canc. Op. ED 4-hours Diagnostic Waits	ED 4-hours DTOC Diagnostic Waits RTT >52weeks Non-Ad RTT	ED 4-hours DTOC Diagnostic Waits RTT >52weeks Admitted RTT Non-Ad RTT	ED 4-hours 28 day canc. Ops Urgent Op - canc x2	ED 4-hours DTOC	ED 4-hours DTOC Urgent Op - canc x2 RTT >52weeks Admitted RTT Non-Ad RTT	ED 4-hours Urgent Op - canc x2 RTT >52weeks
Effectiveness	Initial Score	5	5	5	5	5	5	5	5	5	5	5	5
	Override Rules Applied	No	No	No	No	No	No	No	No	No	No	No	No
	Revised Score	5	5	5	5	5	5	5	5	5	5	5	5
	Indicators Not Achieving TDA Standard												
Safe	Initial Score	4	5	4	5	5	4	5	5	5	5	5	3
	Override Rules Applied	No	No	No	No	No	No	No	No	No	No	No	No
	Revised Score	4	5	4	5	5	4	5	5	5	5	5	3
	Indicators Not Achieving TDA Standard	Pt. Safety Incidents Open CAS Alerts Harm Free Care	Pt. Safety Incidents Open CAS Alerts	Pt. Safety Incidents Open CAS Alerts Harm Free Care	Pt. Safety Incidents Open CAS Alerts	Pt. Safety Incidents Harm Free Care	Harm Free Care MRSA Bact.	Harm Free Care	Harm Free Care Open CAS Alerts	Harm Free Care Maternal Death	Harm Free Care Open CAS Alerts	Harm Free Care	MRSA Bacteraemia Open CAS Alerts Harm Free Care Medication Error
Caring	Initial Score	5	5	5	5	5	5	5	5	5	5	3	5
	Override Rules Applied	No	No	No	No	No	No	No	No	No	No	No	No
	Revised Score	5	5	5	5	5	5	5	5	5	5	3	5
	Indicators Not Achieving TDA Standard	MSA Breaches	MSA Breaches	MSA Breaches	MSA Breaches			MSA Breaches		MSA Breaches		ED FFT Score	
Well Led	Initial Score	3	3	3	3	3	3	2	2	2	3	4	4
	Override Rules Applied	No	No	No	No	No	No	No	No	No	No	No	No
	Revised Score	3	3	3	3	3	3	2	2	2	3	4	4
	Indicators Not Achieving TDA Standard	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	IP FFT Resp. Rate ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	IP FFT Resp. Rate ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	DQ Returns to HSCIC Temp. Staff Costs	DQ Returns to HSCIC Temp. Staff Costs
FINANCE SCORE		AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER

Override Rules

Metric	Override Rule	Domain	Domain Score Affected	Max Domain Score Achievable	Quality Score Affected	Max Quality Score Achievable
RTT - Admitted	Below 90%	Responsiveness	Yes	3	Yes	3
Accident & Emergency	Between 92% and 95%	Responsiveness	Yes	3	Yes	3
Accident & Emergency	Below 92%	Responsiveness	Yes	2	Yes	2
Cancer 62-day Standard	Below 85%	Responsiveness	Yes	3	Yes	3
HSMR or SHMI	High Outlier for 1 Quarter	Effectiveness	Yes	3	No	n/a
HSMR or SHMI	High Outlier for 1 Quarter	Effectiveness	Yes	2	No	n/a
HSMR or SHMI	High Outlier for 2 Quarters or more	Effectiveness	Yes	2	Yes	3
HSMR or SHMI	High Outlier for 1 Year or more	Effectiveness	Yes	2	Yes	2
HSMR and / or SHMI	High Outlier for 2 Years	Effectiveness	Yes	1	Yes	1

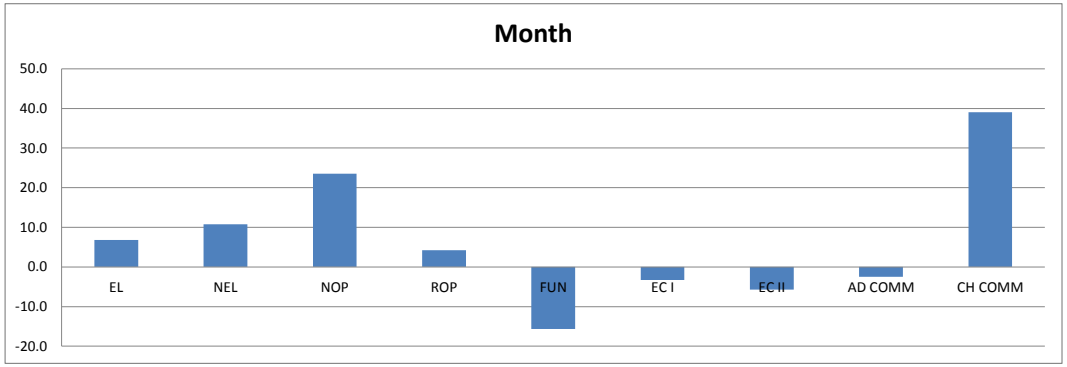
MONITOR RISK ASSESSMENT FRAMEWORK - SUMMARY

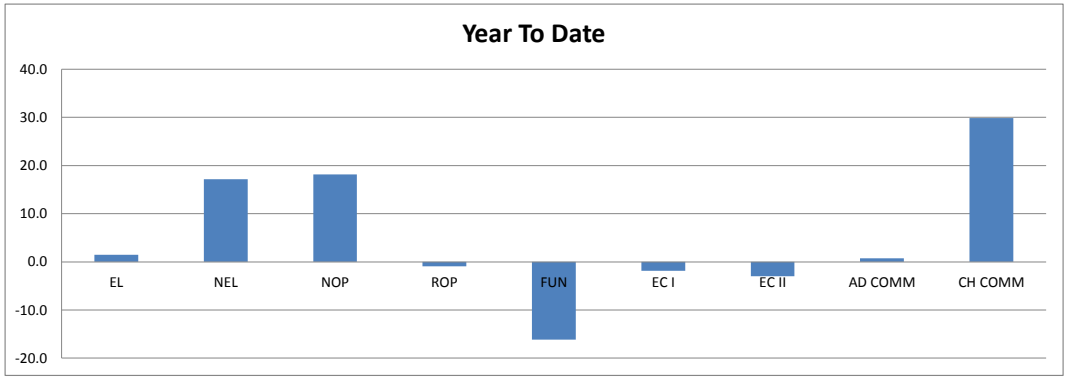
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Indicators Achieving Monitor Standard	15	14	14	14	14	14	13	12	14	14	12	14
Indicators Not Achieving Monitor Standard	0	1	1	1	1	1	2	3	1	1	3	1
		ED 4-hours	ED 4-hours	ED 4-hours	ED 4-hours	ED 4-hours	ED 4-hours RTT Non-Admitted	ED 4-hours RTT Admitted RTT Non-Admitted	ED 4-hours	ED 4-hours	ED 4-hours RTT Admitted RTT Non-Admitted	ED 4-hours
GOVERNANCE RATING	0.0	1.0	1.0	1.0	1.0	1.0	2.0	3.0	1.0	1.0	3.0	1.0

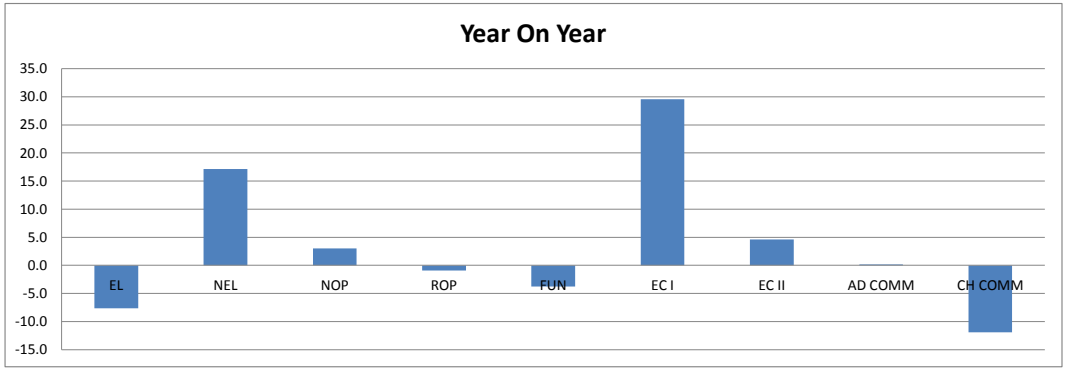
PLEASE NOTE:

For both Frameworks - Performance is projected where data is not available for the period of assessment (e.g. RTT and Cancer)

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 was 6.8% higher than plan for the month and 1.4% higher than plan for the year. Non-Elective activity during the month is 10.8% greater than plan, is 17.2% higher than plan for the year, and also 17.2% higher than the corresponding period last year. New outpatient attendance numbers exceeded the plan for the year by 18.2%, and with outpatient review attendances just below plan (-0.9%) for the year, the Follow-Up to New OP Ratio for the year is 2.14, compared with a plan derived from contracted activity of 2.56, and a ratio of 2.23 for last year. Type I Emergency Care activity for the month is 3.3% behind plan, and is 1.8% less than plan for the year, well in excess of the activity delivered for last year due to the inclusion of GP Triage activity in plan and actual. Type II Emergency Care activity is 5.78% below plan for the month, and 3.0% less than plan for the year. Adult Community and Child Community activity exceeds plans for the year by 0.7% and 29.8% respectively.

Finance Summary

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend O	N	D	J	F	M	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
18		f	Bottom Line Income & Expenditure position - Forecast compared to plan £m	£0.0		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Mar-15										£1,279k	●	●	●
18		f	Bottom Line Income & Expenditure position - Year to Date Actual compared to plan £m	£0.0	£0.0						●	●	●	●	●	●	●	●	●	●	●	●	●	Mar-15	-2.6	-2.9	-2.8	-1.6	0.1	-1.9	0.7	0.0		£1,279k	●	●	●
18		f	Actual efficiency recurring / non-recurring compared to plan - Year to Date actual compared to plan	£0.0	£0.0						●	●	●	●	●	●	●	●	●	●	●	●	●	Mar-15											●	●	●
18		f	Actual efficiency recurring / non-recurring compared to plan - Forecast compared to plan	£0.0							●	●	●	●	●	●	●	●	●	●	●	●	●	Mar-15											●	●	●
18		f	Forecast underlying surplus / deficit compared to plan	£0.0							●	●	●	●	●	●	●	●	●	●	●	●	●	Mar-15											●	●	●
18		f	Forecast year end charge to capital resource limit	£22.8							●	●	●	●	●	●	●	●	●	●	●	●	●	Mar-15										-£35k	●	●	●
18		f	Is the Trust forecasting permanent PDC for liquidity purposes?	No		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Mar-15										No	●	●	●
18		b	Temporary costs and overtime as % total paybill	2.6%	2.6%	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Mar-15	9.0%	4.2%	1.4%	1.5%	0.0%	1.8%	3.7%	1.2%	6.2%	4.1%	●	●	●
18			Continuity of Service Risk Rating - Year to Date	2.5							●	●	●	●	●	●	●	●	●	●	●	●	●	Mar-15										3.0	●	●	●

Contractual Requirements - Operational Standards (OS) / National Quality Requirements (NQR)

Data Source	Data Quality	OS / NQR	Indicator	Threshold	QUARTER 1 (£000s)									QUARTER 2 (£000s)									QUARTER 3 (£000s)								
					M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		OS	RTT Admitted Care (£400 per breach by specialty)	=>90.0%	0.0	94.8	10.4	0.0					105.2	1.6	72.4	9.2	0.0						83.2	0.0	98.4	13.2	0.0					111.6
2		OS	RTT Non-Admitted Care (£100 per breach by specialty)	=>95.0%	12.9	6.4	0.0	0.0					19.3	19.8	2.9	0.0	0.0						22.7	30.4	15.9	5.2	0.0					51.5
2		OS	RTT Incomplete Pathway (£100 per breach by specialty)	=>92.0%	36.5	76.4	22.0	0.0					136.9	53.0	75.1	20.5	0.0						153.6	19.4	26.5	7.4	0.0					69.7
2		OS	Diagnostic Waits (£200 per breach)	=>99.0%	0.0	5.4	0.0	0.0		1.4			6.8	16.8	2.6	0.0	0.0		0.0				19.4	37.8	1.2	0.0	0.0		18.0			57.0
2		OS	ED Waits >4 hours (£200 per breach between 92.0% and 95.0%)	=>95.0%	123.2		0.0						123.2	145.8		0.0						145.8	330.2		0.0						330.2
1		OS	Cancer Waits (2 weeks, 31 days and 62 days - £200, £1000 and £1000 per breach respectively)	Various	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0
13		OS	Mixed Sex Accommodation Breaches (£250 per day per Service User affected)	0	32.8	0.0	0.0	0.0					32.8	0.0	1.3	0.0	0.0						1.3	2.3	0.5	0.0	0.0					2.8
2		OS	Cancelled Operations 28-day (non-payment of rescheduled episode of care)	0	1.8	1.3	0.0	0.0					3.1	0.0	1.3	0.0	0.0						1.3	0.0	1.3	0.0	0.0					1.3
4		NQR	MRSA Bacteraemia (£10,000 per incidence)	0	20.0	0.0	0.0	0.0			0.0		20.0	10.0	0.0	0.0	0.0			0.0			10.0	0.0	0.0	0.0	0.0			0.0		0.0
4		NQR	C Diff (differential impact if annual target exceeded)	37	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0			0.0	0.0	0.0	0.0	0.0			0.0		0.0
2		NQR	RTT Waits >52 weeks Incomplete Pathway (£5,000 per breach)	0	0.0	5.0	5.0	5.0					15.0	0.0	20.0	0.0	0.0						20.0	0.0	10.0	10.0	0.0					20.0
11		NQR	WMAS Handovers to ED (£200 per breach 30 - 60 minutes)	0	76.0								76.0	66.4									66.4	132.0								132.0
11		NQR	WMAS Handovers to ED (£1000 per breach >60 minutes)	0	29.0								29.0	22.0									22.0	66.0								66.0
2		NQR	ED Trolley Waits >12 hours (£1,000 per breach)	0	0.0								0.0	0.0									0.0	0.0								0.0
2		NQR	Cancelled Operations - no urgent operation cancelled for second time (£5,000 per breach)	0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	5.0					5.0
3		NQR	VTE Risk Assessment (£200 per breach)	=>95.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0
13		NQR	Publication Of Formulary (withholding of 1% of actual monthly contract value for non publication)	0							0.0	0.0	0.0							0.0	0.0	0.0							0.0	0.0	0.0
9		NQR	Duty Of Candour (Non-payment for cost of care or £10,000 if cost of care unknown / indeterminate)	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
2		NQR	Completion of valid NHS Number in Acute Commissioning Data Set (£10 per breach)	=>99.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0
2		NQR	Completion of valid NHS Number in A&E Commissioning Data Set (£10 per breach)	=>95.0%	0.0		0.0						0.0	0.0		0.0							0.0	0.0		0.0						0.0
			ALL		324.2	189.3	37.4	5.0	0.0	1.4	0.0	0.0	567.2	335.4	174.7	35.0	0.0	0.0	0.0	0.0	0.0	0.0	545.7	638.1	162.8	35.0	5.0	0.0	18.0	0.0	0.0	847.1

Data Source	Data Quality	OS / NQR	Indicator	JANUARY (£000s)									FEBRUARY (£000s)									MARCH (£000s)								
				M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		OS	RTT Admitted Care (£400 per breach by specialty)	0.0	9.2	0.4	0.0					9.6	0.0	28.4	32.8	0.0					61.2	0.0	4.0	0.0	0.0					4.0
2		OS	RTT Non-Admitted Care (£100 per breach by specialty)	3.0	0.5	0.0	0.0					3.5	10.8	6.3	7.9	0.0					25.0	1.3	2.2	0.0	0.0					3.5
2		OS	RTT Incomplete Pathway (£100 per breach by specialty)	0.0	7.9	4.7	0.0					12.6	0.0	8.8	2.4	0.0					11.2	0.0	11.0	5.6	0.0					16.6
2		OS	Diagnostic Waits (£200 per breach)	0.0	0.0	0.0	0.0		0.0			0.0	0.0	0.0	0.0	0.0		0.0			0.0	0.0	0.0	0.0	0.0		0.0			0.0
2		OS	ED Waits >4 hours (£200 per breach between 92.0% and 95.0%)	41.6		0.0						41.6	98.8		0.0			0.0			98.8	116.5		0.0						116.5
1		OS	Cancer Waits (2 weeks, 31 days and 62 days - £200, £1000 and £1000 per breach respectively)	Assessed Quarterly									Assessed Quarterly																		
13		OS	Mixed Sex Accommodation Breaches (£250 per day per Service User affected)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2		OS	Cancelled Operations 28-day (non-payment of rescheduled episode of care)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
4		NQR	MRSA Bacteraemia (£10,000 per incidence)	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0	10.0	0.0	0.0	0.0			0.0		10.0
4		NQR	C Diff (differential impact if annual target exceeded)	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0
2		NQR	RTT Waits >52 weeks Incomplete Pathway (£5,000 per breach)	0.0	5.0	0.0	0.0					5.0	0.0	5.0	0.0	0.0					5.0	0.0	5.0	0.0	0.0					5.0
11		NQR	WMAS Handovers to ED (£200 per breach 30 - 60 minutes)	37.0								37.0	29.8								29.8	32.8								32.8
11		NQR	WMAS Handovers to ED (£1000 per breach >60 minutes)	7.0								7.0	6.0								6.0	8.0								8.0
2		NQR	ED Trolley Waits >12 hours (£1,000 per breach)	0.0								0.0	0.0								0.0	0.0								0.0
2		NQR	Cancelled Operations - no urgent operation cancelled for second time (£5,000 per breach)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	5.0					5.0	0.0	0.0	0.0	5.0					5.0
3		NQR	VTE Risk Assessment (£200 per breach)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
13		NQR	Publication Of Formulary (withholding of 1% of actual monthly contract value for non publication)								0.0	0.0								0.0	0.0								0.0	0.0
9		NQR	Duty Of Candour (Non-payment for cost of care or £10,000 if cost of care unknown / indeterminate)	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
2		NQR	Completion of valid NHS Number in Acute Commissioning Data Set (£10 per breach)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2		NQR	Completion of valid NHS Number in A&E Commissioning Data Set (£10 per breach)	0.0		0.0						0.0	0.0		0.0						0.0	0.0		0.0						0.0
			ALL	88.6	22.6	5.1	0.0	0.0	0.0	0.0	0.0	116.3	145.4	48.5	43.1	5.0	0.0	0.0	0.0	0.0	242.0	168.6	22.2	5.6	5.0	0.0	0.0	0.0	0.0	201.4

Data Source	Data Quality	OS / NQR	Indicator	YEAR TO DATE (£000s)								
				M	A	B	W	P	I	C	CO	ALL
2		OS	RTT Admitted Care (£400 per breach by specialty)	1.6	307.2	66.0	0.0					374.8
2		OS	RTT Non-Admitted Care (£100 per breach by specialty)	79.2	33.3	14.0	0.0					125.5
2		OS	RTT Incomplete Pathway (£100 per breach by specialty)	110.9	214.7	67.4	0.6					401.1
2		OS	Diagnostic Waits (£200 per breach)	54.6	9.2	0.0	0.0		19.4			83.2
2		OS	ED Waits >4 hours (£200 per breach between 92.0% and 95.0%)	856.1		0.0						856.1
1		OS	Cancer Waits (2 weeks, 31 days and 62 days - £200, £1000 and £1000 per breach respectively)	0.0	0.0	0.0	0.0					0.0
13		OS	Mixed Sex Accommodation Breaches (£250 per day per Service User affected)	35.1	1.8	0.0	0.0					36.9
2		OS	Cancelled Operations 28-day (non-payment of rescheduled episode of care)	1.8	3.9	0.0	0.0					5.7
4		NQR	MRSA Bacteraemia (£10,000 per incidence)	40.0	0.0	0.0	0.0			0.0		40.0
4		NQR	C Diff (differential impact if annual target exceeded)	0.0	0.0	0.0	0.0			0.0		0.0
2		NQR	RTT Waits >52 weeks Incomplete Pathway (£5,000 per breach)	0.0	50.0	15.0	5.0					70.0
11		NQR	WMAS Handovers to ED (£200 per breach 30 - 60 minutes)	374.0								374.0
11		NQR	WMAS Handovers to ED (£1000 per breach >60 minutes)	138.0								138.0
2		NQR	ED Trolley Waits >12 hours (£1,000 per breach)	0.0								0.0
2		NQR	Cancelled Operations - no urgent operation cancelled for second time (£5,000 per breach)	0.0	0.0	0.0	15.0					15.0
3		NQR	VTE Risk Assessment (£200 per breach)	0.0	0.0	0.0	0.0					0.0
13		NQR	Publication Of Formulary (withholding of 1% of actual monthly contract value for non publication)	0.0						0.0	0.0	0.0
9		NQR	Duty Of Candour (Non-payment for cost of care or £10,000 if cost of care unknown / indeterminate)	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
2		NQR	Completion of valid NHS Number in Acute Commissioning Data Set (£10 per breach)	0.0	0.0	0.0	0.0					0.0
2		NQR	Completion of valid NHS Number in A&E Commissioning Data Set (£10 per breach)	0.0		0.0						0.0
			ALL	1090.2	620.1	162.6	20.0	0.0	19.4	0.0	0.0	2920.3

Contractual Requirements - Local Quality Requirements

Data Source	Req	Indicator	Threshold	QUARTER 1 (£000s)									QUARTER 2 (£000s)								
				M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
3	LQR	Maternity - various (8)	Various									0.0									0.0
3	LQR	Stroke - thrombolysis (non payment for any >30 hours if 3 consecutive months of failure)	=>50.0%	0.0								0.0	0.0								0.0
3	LQR	Stroke - >90% stay on ASU (non payment for breach if 3 consecutive months of failure)	=>90.0%	0.0								0.0	0.0								0.0
3	LQR	Stroke - CT Scan <1 hr presentation (non payment for any >2 hours if 3 consec. months failure)	=>50.0%	0.0					0.0			0.0	0.0					0.0			0.0
3	LQR	Stroke - CT Scan <24 hr presentation (non pay't for any >30 hours if 3 consec. months failure)	100%	0.0					0.0			0.0	0.0					0.0			0.0
3	LQR	ED - Time to Initial Assessment <15 mins (£50 per breach between 92.0% and 95.0%)	=>95.0%	44.0		0.0						44.0	34.9		0.0						34.9
3	LQR	ED - Unplanned Reattendance within 30 days (£50 per breach between 5.00% and 8.00%)	=<5.00%	29.5		0.0						29.5	49.9		0.0						49.9
3	LQR	ED - Left Without Being Seen (lower £23 pay't per pt., & £15 per breach between 5.00% and 8.00%)	=<5.00%	0.0		0.0						0.0	0.0		0.0						0.0
2	LQR	DTOC - Less than 10 (provider responsible) per site (non pay't XS bed days)	<10 per site	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2	LQR	Letters for Evictions from Wards (non pay't XS bed days)	100%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2	LQR	Morning Discharges (< m'day) (no conseq. breach, traj. Q1(23%),Q2(27%),Q3(31%),Q4(35%))	Q1 (23%) - Q4 (35%)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2	LQR	DTA (delay in unplanned admiss. to clinically appro. bed) (8 hr(£250),10hr(£500),12hr(£1000)	0	0.0	0.0	0.0	0.0					0.0	0.3	0.0	0.0	0.0					0.3
19	LQR	Pt's with small-cell lung cancer have t'ment initiated =<2w path. diagnosis (non pay't for breach)	=>80.0%	6.3								6.3	2.1								2.1
2	LQR	Paeds. have OP F/U app't <6 w discharge post meningoccal septicaemia (non pay't OP app't >6w)	100%				0.1					0.1				0.1					0.1
19	LQR	Pts. Admit. with MI presc. antiplatelet,statin or b. blocker(non pay for breach if 3 consec. m'ths fail.)	=>98.0%	0.0								0.0	0.0								0.0
8	LQR	EOL Care (pt's (on SCP) achieving pref. place of death) (Consec. Fail triggers contract clause)	=>75.0%	0.0	0.0		0.0					0.0	0.0	0.0		0.0					0.0
3	LQR	WHO Safer Surgery Checlkist Compliance (3 components) (Consec. Breaches £1000 / month)	98%, 95% and 85%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
3	LQR	MRSA Screening (EL and NEL) (£1000 per month after 4 months consecutive breaches)	=>80.0% matched	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
4	LQR	Appro. Antimicrobial Stewardship (Q'ly Reporting (cc. CCG) (£1000 / Q'ter after 2 Q'ters breaches)	Submit Report					0.0				0.0					0.0				0.0
19	LQR	HbA1c (pt's achieved target <6 m after being set) (non pay't for breach after 3 m'ths fail)	=>75.0%	Assessed 6-monthly									0.0								0.0
19	LQR	HbA1c (pt's receiving written care plan with agreed targets) (£50 per breach)	=>90.0%	Assessed 6-monthly									0.0								0.0
2	LQR	Ethnicity Coding (£1000 per month after 2 months failure)	=>90.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
		ALL		79.8	0.0	0.0	0.1	0.0	0.0	0.0	0.0	79.9	87.2	0.0	0.0	0.1	0.0	0.0	0.0	0.0	87.3

Indicator	QUARTER 3 (£000s)									JANUARY (£000s)								
	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
Maternity - various (8)									0.0									
Stroke - thrombolysis (non payment for any >30 hours if 3 consecutive months of failure)	0.0								0.0	0.0								0.0
Stroke - >90% stay on ASU (non payment for breach if 3 consecutive months of failure)	0.0								0.0	0.0								0.0
Stroke - CT Scan <1 hr presentation (non payment for any >2 hours if 3 consec. months failure)	0.0					0.0			0.0	0.0					0.0			0.0
Stroke - CT Scan <24 hr presentation (non pay't for any >30 hours if 3 consec. months failure)	0.0					0.0			0.0	0.0					0.0			0.0
ED - Time to Initial Assessment <15 mins (£50 per breach between 92.0% and 95.0%)	47.5		0.0						47.5	14.7		0.0						14.7
ED - Unplanned Reattendance within 30 days (£50 per breach between 5.00% and 8.00%)	41.0		0.0						41.0	13.9		0.0						13.9
ED - Left Without Being Seen (lower £23 pay't per pt., & £15 per breach between 5.00% and 8.00%)	0.3		0.0						0.3	0.0		0.0						0.0
DTOC - Less than 10 (provider responsible) per site (non pay't XS bed days)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
Letters for Evictions from Wards (non pay't XS bed days)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
Morning Discharges (< m'day) (no conseq. breach, traj. Q1(23%),Q2(27%),Q3(31%),Q4(35%))	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
DTA (delay in unplanned admiss. to clinically appro. bed) (8 hr(£250),10hr(£500),12hr(£1000)	0.5	0.0	0.0	0.0					0.5	0.8	0.0	0.0	0.0					0.8
Pt's with small-cell lung cancer have t'ment initiated =<2w path. diagnosis (non pay't for breach)	8.4								8.4	0.0								0.0
Paeds. have OP F/U app't <6 w discharge post meningoccal septicaemia (non pay't OP app't >6w)				0.0					0.0				0.0					0.0
Pts. Admit. with MI presc. antiplatelet,statin or b. blocker(non pay for breach if 3 consec. m'ths fail.)	0.0								0.0	0.0								0.0
EOL Care (pt's (on SCP) achieving pref. place of death) (Consec. Fail triggers contract clause)	0.0	0.0		0.0					0.0	0.0	0.0		0.0					0.0
WHO Safer Surgery Checlkist Compliance (3 components) (Consec. Breaches £1000 / month)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
MRSA Screening (EL and NEL) (£1000 per month after 4 months consecutive breaches)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
Appro. Antimicrobial Stewardship (Q'ly Reporting (cc. CCG) (£1000 / Q'ter after 2 Q'ters breaches)					0.0				0.0	Assessed Quarterly								
HbA1c (pt's achieved target <6 m after being set) (non pay't for breach after 3 m'ths fail)	Assessed 6-monthly									Assessed 6-monthly								
HbA1c (pt's receiving written care plan with agreed targets) (£50 per breach)	Assessed 6-monthly									Assessed 6-monthly								
Ethnicity Coding (£1000 per month after 2 months failure)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
ALL	97.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	97.7	29.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	29.3

Indicator	FEBRUARY (£000s)									MARCH (£000s)								
	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
Maternity - various (8)																		0.0
Stroke - thrombolysis (non payment for any >30 hours if 3 consecutive months of failure)	0.0								0.0	0.0								0.0
Stroke - >90% stay on ASU (non payment for breach if 3 consecutive months of failure)	0.0								0.0	0.0								0.0
Stroke - CT Scan <1 hr presentation (non payment for any >2 hours if 3 consec. months failure)	0.0					0.0			0.0	0.0					0.0			0.0
Stroke - CT Scan <24 hr presentation (non pay't for any >30 hours if 3 consec. months failure)	0.0					0.0			0.0	0.0					0.0			0.0
ED - Time to Initial Assessment <15 mins (£50 per breach between 92.0% and 95.0%)	14.8		0.0						14.8	14.2		0.0						14.2
ED - Unplanned Reattendance within 30 days (£50 per breach between 5.00% and 8.00%)	17.1		0.0						17.1	18.2		0.0						18.2
ED - Left Without Being Seen (lower £23 pay't per pt., & £15 per breach between 5.00% and 8.00%)	0.0		0.0						0.0	0.0		0.0						0.0
DTOC - Less than 10 (provider responsible) per site (non pay't XS bed days)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
Letters for Evictions from Wards (non pay't XS bed days)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
Morning Discharges (< m'day) (no conseq. breach, traj. Q1(23%),Q2(27%),Q3(31%),Q4(35%))	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
DTA (delay in unplanned admiss. to clinically appro. bed) (8 hr(£250),10hr(£500),12hr(£1000)	0.5	0.0	0.0	0.0					0.5	0.8	0.0	0.0	0.0					0.8
Pt's with small-cell lung cancer have t'ment initiated =<2w path. diagnosis (non pay't for breach)	4.2								4.2									0.0
Paeds. have OP F/U app't <6 w discharge post meningoccal septicaemia (non pay't OP app't >6w)				0.0					0.0				0.0					0.0
Pts. Admit. with MI presc. antiplatelet,statin or b. blocker(non pay for breach if 3 consec. m'ths fail.)	0.0								0.0	0.0								0.0
EOL Care (pt's (on SCP) achieving pref. place of death) (Consec. Fail triggers contract clause)	0.0	0.0		0.0					0.0	0.0	0.0		0.0					0.0
WHO Safer Surgery Checlkist Compliance (3 components) (Consec. Breaches £1000 / month)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
MRSA Screening (EL and NEL) (£1000 per month after 4 months consecutive breaches)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
Appro. Antimicrobial Stewardship (Q'ly Reporting (cc. CCG) (£1000 / Q'ter after 2 Q'ters breaches)	Assessed Quarterly													0.0				0.0
HbA1c (pt's achieved target <6 m after being set) (non pay't for breach after 3 m'ths fail)	Assessed 6-monthly									0.0								0.0
HbA1c (pt's receiving written care plan with agreed targets) (£50 per breach)	Assessed 6-monthly									0.0								0.0
Ethnicity Coding (£1000 per month after 2 months failure)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
ALL	32.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	32.4	33.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	33.1

Indicator	YEAR TO DATE (£000s)								
	M	A	B	W	P	I	C	CO	ALL
Maternity - various (8)				0.0					0.0
Stroke - thrombolysis (non payment for any >30 hours if 3 consecutive months of failure)	0.0								0.0
Stroke - >90% stay on ASU (non payment for breach if 3 consecutive months of failure)	0.0								0.0
Stroke - CT Scan <1 hr presentation (non payment for any >2 hours if 3 consec. months failure)	0.0					0.0			0.0
Stroke - CT Scan <24 hr presentation (non pay't for any >30 hours if 3 consec. months failure)	0.0					0.0			0.0
ED - Time to Initial Assessment <15 mins (£50 per breach between 92.0% and 95.0%)	170.1		0.0						170.1
ED - Unplanned Reattendance within 30 days (£50 per breach between 5.00% and 8.00%)	169.5		0.0						169.5
ED - Left Without Being Seen (lower £23 pay't per pt., & £15 per breach between 5.00% and 8.00%)	0.3		0.0						0.3
DTOC - Less than 10 (provider responsible) per site (non pay't XS bed days)	0.0	0.0	0.0	0.0					0.0
Letters for Evictions from Wards (non pay't XS bed days)	0.0	0.0	0.0	0.0					0.0
Morning Discharges (< m'day) (no conseq. breach, traj. Q1(23%),Q2(27%),Q3(31%),Q4(35%))	0.0	0.0	0.0	0.0					0.0
DTA (delay in unplanned admiss. to clinically appro. bed) (8 hr(£250),10hr(£500),12hr(£1000)	2.8	0.0	0.0	0.0					2.8
Pt's with small-cell lung cancer have t'ment initiated =<2w path. diagnosis (non pay't for breach)	21.0								21.0
Paeds. have OP F/U app't <6 w discharge post meningoccal septicaemia (non pay't OP app't >6w)	0.0			0.2					0.2
Pts. Admit. with MI presc. antiplatelet,statin or b. blocker(non pay for breach if 3 consec. m'ths fail.)	0.0								0.0
EOL Care (pt's (on SCP) achieving pref. place of death) (Consec. Fail triggers contract clause)	0.0	0.0		0.0					0.0
WHO Safer Surgery Checlkist Compliance (3 components) (Consec. Breaches £1000 / month)	0.0	0.0	0.0	0.0					0.0
MRSA Screening (EL and NEL) (£1000 per month after 4 months consecutive breaches)	0.0	0.0	0.0	0.0					0.0
Appro. Antimicrobial Stewardship (Q'ly Reporting (cc. CCG) (£1000 / Q'ter after 2 Q'ters breaches)					0.0				0.0
HbA1c (pt's achieved target <6 m after being set) (non pay't for breach after 3 m'ths fail)	0.0								0.0
HbA1c (pt's receiving written care plan with agreed targets) (£50 per breach)	0.0								0.0
Ethnicity Coding (£1000 per month after 2 months failure)	0.0	0.0	0.0	0.0					0.0
ALL	363.6	0.0	0.0	0.2	0.0	0.0	0.0	0.0	363.8

Contractual Requirements - CQUIN (CQ)

Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	QUARTER 1 (£000s)								QUARTER 2 (£000s)								QUARTER 3 (£000s)								JANUARY (£000s)								FEBRUARY (£000s)								MARCH (£000s)								YEAR TO DATE (£000s)							
						M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
8		CQ	FFT - Implementation of Staff FFT	125	Implement by end July	0.0	0.0	0.0

Contractual Requirements - Outcome Thermometer (OT) Incentive Scheme

Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	QUARTER 1 (£000s)									QUARTER 2 (£000s)									QUARTER 3 (£000s)									QUARTER 4 (£000s)									YEAR TO DATE (£000s)								
						M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		OT	ED Waits >4 hours (=>95.0% each Quarter)	400	=>95.0%	100.0		0.0						100.0	100.0		0.0								100.0	100.0		0.0							100.0	100.0		0.0							100.0	400.0		0.0							400.0
2		OT	RTT Admitted Care (0 failing specialties after Q1)	200	0	na	na	na	na					0.0	8.3	25.0	33.3	0.0					66.6	0.0	33.3	33.3	0.0					66.6	0.0	66.6	0.0	0.0					66.6	8.3	124.9	66.6	0.0					199.8
2		OT	RTT Non-Admitted Care (0 failing specialties after Q1)	200	0	na	na	na	na					0.0	42.9	14.3	9.5	0.0					66.7	22.2	22.2	22.2	0.0					66.6	22.2	44.4	0.0	0.0					66.6	87.3	80.9	31.7	0.0					199.9
1		OT	Cancer Waits (2 weeks)	400	=>93.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0									0.0	0.0							0.0
19		OT	Urgent & Emergency Care - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0									0.0	0.0							0.0
19		OT	Lipid Management in OP Clinics - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0									0.0	0.0							0.0
2		OT	Community Nursing (Quality & Info Requirements) - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0									0.0	0.0							0.0
14		OT	Dev'ment of Advice & Guidance Service and Map of Medicine - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0									0.0	0.0							0.0
2		OT	Cardiology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.61	0.0								0.0	0.0								0.0	14.3								14.3	14.3								14.3	28.6							28.6
2		OT	Paediatrics - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.64				0.0					0.0				14.3					14.3				14.3					14.3				14.3					14.3	0.0			42.9					42.9
2		OT	Dermatology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<2.48	14.3								14.3	14.3								14.3	14.3								14.3	14.3								14.3	57.2							57.2
2		OT	Geriatric Medicine - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.76	0.0								0.0	14.3								14.3	14.3								14.3	14.3								14.3	42.9							42.9
2		OT	Rheumatology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<4.99	14.3								14.3	14.3								14.3	0.0								0.0	14.3								14.3	42.9							42.9
2		OT	Gastroenterology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.45	14.3								14.3	0.0								0.0	0.0								0.0	0.0								0.0	14.3							14.3
2		OT	General Medicine - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<2.38	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0	0.0							0.0
9		OT	Never Events (reduced incentive available (1 = 85% available, 2 (65), 3 (40), 4 (10), 5 (0)	-2000	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
			ALL			142.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	142.8	194.1	39.3	42.8	14.3	0.0	0.0	0.0	0.0	290.5	165.1	55.5	55.5	14.3	0.0	0.0	0.0	0.0	290.4	179.4	111.0	0.0	14.3	0.0	0.0	0.0	0.0	304.7	681.4	205.8	98.3	42.9	0.0	0.0	0.0	0.0	####

Contractual Requirements - Price Activity Matrix (PAM)

Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	QUARTER 1 (£000s) M	A	B	W	P	I	C	CO	ALL	QUARTER 2 (£000s) M	A	B	W	P	I	C	CO	ALL
2		PAM	Elective (IP and DC)	52721	Contract Plan	48	75	-62	-26	2	0			37	116	6	91	-83	10	-2			138
2		PAM	Non-Elective	82299	Contract Plan	167	-17	-45	3					108	184	121	-46	21					280
2		PAM	Excess Bed Days	20352	Contract Plan	74	25	-21	-60					18	112	-12	-18	-44					38
2		PAM	Accident & Emergency	20352	Contract Plan	-11		-86						-97	37		-68						-31
2		PAM	Outpatient New	26337	Contract Plan	23	5	-20	-36	-3	0	0		-31	16	6	8	-38	-1	0	0		-9
2		PAM	Outpatient Review	33208	Contract Plan	59	-34	-10	-27	-1	0	-1		-14	30	-25	102	-29	4	0	-2		80
2		PAM	Outpatient with Procedure	7336	Contract Plan	-22	44	-138	12					-104	24	53	-155	22					-56
2		PAM	Outpatient Telephone Conversation	196	Contract Plan	3	0							3	3	0							3
2		PAM	Maternity	14219	Contract Plan				72					72				300					300
2		PAM	Occupied Cot Days	6000	Contract Plan				18					18				-117					-117
2		PAM	Unbundled Activity	9520	Contract Plan	28	1	-8	6	0	0			27	185	-13	4	3	0	0			179
2		PAM	Other Contract Lines	89552	Contract Plan	119	-6	331	11	-8	-78	0		369	419	7	172	-40	-13	-81	0		464
2		PAM	Community	36003	Contract Plan	0	0		-8		0	0		-8	0	0		-12		0	4		-8
			ALL			488	93	-59	-35	-10	-78	-1	0	398	1126	143	90	-17	0	-83	2	0	1261

Indicator	QUARTER 3 (£000s) M	A	B	W	P	I	C	CO	ALL	JANUARY (£000s) M	A	B	W	P	I	C	CO	ALL
Elective (IP and DC)	74	-85	-89	-37	16	10			-111	29	-74	-22	-29	3	2			-91
Non-Elective	218	-68	-66	-30					54	219	-42	-24	-22					131
Excess Bed Days	-30	-6	-30	-45					-111	16	10	-7	-11					8
Accident & Emergency	64		-85						-21	-13		-38						-51
Outpatient New	66	14	-82	-57	-3	0	0		-62	14	-5	-30	-16	-1	0	0		-38
Outpatient Review	-24	-40	47	-26	2	0	0		-41	5	-14	15	-17	1	0	1		-9
Outpatient with Procedure	6	38	-111	20					-47	1	10	-27	1					-15
Outpatient Telephone Conversation	2	0							2	0	0							0
Maternity				391					391				128					128
Occupied Cot Days				27					27				-7					-7
Unbundled Activity	130	-35	-1	3	0	0			97	59	-6	-1	0					52
Other Contract Lines	762	7	6	-45	-39	-59	0		632	284	4	-21	24	-12	-23			256
Community	1	0		-7		0	1		-5	0	0		2		0	0		2
ALL	1269	-175	-411	194	-24	-49	1	0	805	614	-117	-155	53	-9	-21	1	0	366

Indicator	FEBRUARY (£000s) M	A	B	W	P	I	C	CO	ALL	YEAR TO DATE (£000s) M	A	B	W	P	I	C	CO	ALL
Elective (IP and DC)	22	-32	26	-12	3	5			12	289	-110	-56	-187	34	15			-15
Non-Elective	72	2	-42	55					87	860	-4	-223	27					660
Excess Bed Days	6	-12	-8	5					-9	178	5	-84	-155					-56
Accident & Emergency	-13		-44						-57	64		-321	0					-257
Outpatient New	33	8	3	-9	0	0	1		36	152	28	-121	-156	-8	0	1		-104
Outpatient Review	-12	-12	27	-8	-1	0	1		-5	58	-125	181	-107	5	0	-1		11
Outpatient with Procedure	19	14	-21	6					18	28	159	-452	61					-204
Outpatient Telephone Conversation	0	0							0	8	0							8
Maternity				111					111				1002					1002
Occupied Cot Days				11					11				-68					-68
Unbundled Activity	45	-7	-2	-1	0	0			35	447	-60	-8	11	0	0			390
Other Contract Lines	255	-2	9	-55	-14	-23	0		170	1839	10	497	-105	-86	-264	0		1891
Community	0	0		-3		0	-1		-4	1	0		-28		0	4		-23
ALL	427	-41	-52	100	-12	-18	1	0	405	3924	-97	-587	295	-55	-249	4	0	3235

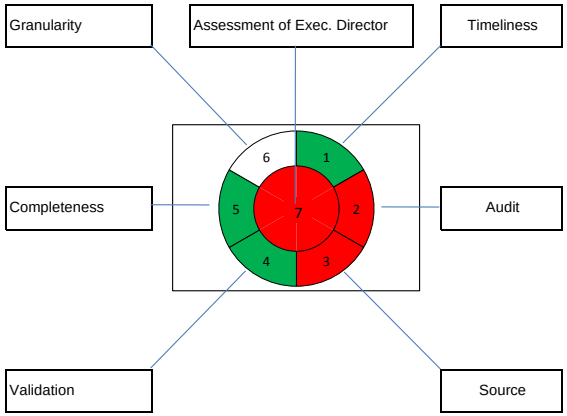
Legend

Data Sources	
1	Cancer Services
2	Information Department
3	Clinical Data Archive
4	Microbiology Informatics
5	CHKS
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
19	Medicine & Emergency Care Group
20	Change Team (Information)

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	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		EC	AC	SC					
C. Difficile	30	3	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	3	1	4	20	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	1	1	2	●		
MRSA Screening - Elective (%)	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	64	96	63	82.2		●		
MRSA Screening - Non Elective (%)	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	94	94	93	94.28		●		
Falls	0	0						33	40	61	42	44	41	67	50	66	63	42	52		Mar-15	12	32	8	52	601	●		
Falls with a serious injury	0	0	2	5	1	1	1	1	3	3	1	4	1	1	2	0	1	0	1		Mar-15	0	1	0	1	19	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	0	0	2	3	3	2	3	3	3	0	5	3	6	7	10	4			Feb-15	1	3	0	4	46	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	99	99.4	98	98.815		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100	99.4	99.0	99.8		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100	100	100	100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	1		Mar-15	1	0	0	1	1	●		
Serious Incidents	0	0				●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	1	1	1	3	18	●		
Mortality Reviews within 42 working days	100	=>98	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15	89	94	87	90		●		

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		EC	AC	SC					
Pts spending >90% stay on Acute Stroke Unit (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		94.6		94.6	91.9	●		
Pts admitted to Acute Stroke Unit within 4 hrs (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		81.0		81.0	79.5	●		
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		67.2		67.2	71.6	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		95.6		95.6	96.2	●		
Stroke Admission to Thrombolysis Time (% within 60 mins)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		86		85.7	80.3	●		
Stroke Admissions - Swallowing assessments (<24h) (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		100		100.0	100.0	●		
TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=>70.0	=>70.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		96.8		96.8	98.1	●		
TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=>75.0	=>75.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		95.2		95.2	97.1	●		
Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		88		88.2	88.5	●		
Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		86		85.7	89.8	●		
Rapid Access Chest Pain - seen within 14 days (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		100		100.0	98.2	●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15			89	89.4		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15			100	100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15			92.3	92.3		●		
Mixed Sex Accommodation Breaches	0	0	4	2	3	7	21	36	43	14	0	0	0	7	0	0	0	0	0		Mar-15	0	0	0	0	100	●		
No. of Complaints Received (formal and link)									38	28	28	32	36	48	18	31	30	36	38		Mar-15	9	13	7	38	363			
No. of Active Complaints in the System (formal and link)									##	##	##	##	##	##	##	93	##	126	117		Mar-15	46	45	17	117				
Oldest' complaint currently in system (days)									##	##	##	##	##	##	##	##	##	209	230		Mar-15				230				

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		EC	AC	SC					
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0.00	4.80	0.00	**0.46**		●		
28 day breaches	0	0	●	●	●	●	●	●	1	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	**0**	**1**	●		
Sitrep Declared Late Cancellations	0	0	2	2	7	7	4	10	2	7	7	3	2	5	4	1	0	0	9		Mar-15	0	9	0	**9**	**50**	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0										61	54	57	60	62	61	49	48		Mar-15	59		37.6	**48.33**		●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	93.5 (s)	87.7 (C)		**90.4**	**91.7**	●		
Emergency Care 4-hour breach (numbers)								570	1003	1016	907	736	1201	1390	1181	1913	940	1242	1412		Mar-15	###	4	47	**1412**	**13511**			
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0 (s)	0 (c)		**0**	**0**	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	15 (s)	19 (c)		**18**	**18**	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	54 (s)	70 (c)		**63**	**58**	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	7.94 (s)	7.68 (c)		7.8	7.34	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	2.73 (s)	6.22 (c)		4.24	4.3	●		
WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	0	0	●	●	●	●	●	119	136	125	145	51	136	219	159	282	185	149	164		Mar-15	40	124		164	1870	●		
WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	0	0	●	●	●	●	●	13	8	8	8	1	13	21	14	31	7	6	8		Mar-15	6	2		8	138	●		
WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	=<0.02	=<0.02	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0.33	0.1		0.16	0.29	●		
WMAS - Emergency Conveyances (total)			3927	4122	4009	3826	4271	4044	4227	4093	4278	3994	4067	4193	4168	4470	4001	3829	4182		Mar-15	1798	2384		4182	49546			

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		EC	AC	SC					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		91.2	96.9	94.8		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		94.5	96.0	95.5		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		94.7	98.7	97.3		●		
Patients Waiting >52 weeks	0	0	6	4	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1		Mar-15	0	1	0	1		●		
Treatment Functions Underperforming	0	0	5	4	4	5	5	6	3	5	5	6	5	5	7	2	2	6	1		Mar-15	0	1	0	1		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0.0	0.1	0.0	0.06		●		
WTE - Actual versus Plan			158	165	135	163	163	171	161	157	151	166	160	166	197	232	242	244	328		Mar-15				328				
PDRs - 12 month rolling (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	81	86	85		83.8	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	95	100	93		95.8	●		
Sickness Absence (%)	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	4.75	5.38	5.22	5.09	4.57	●		
Return to Work Interviews (%) following Sickness Absence	100	100																	●		Mar-15	6.4	18.8	43.9		17.7	●		
Mandatory Training (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	85	85	85		84.7	●		
New Investigations in Month			0	0	0	0	1	1	1	1	2	1	2	1	0	0	1	2	2		Mar-15				2				
Nurse Bank Fill Rate	100	100																	72		Mar-15				72		●		
Nurse Bank Shifts Not Filled	0	0																	1031		Mar-15				1031		●		
Nurse Bank Use	34560	2880	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15				2896	32185	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15				1601	15436	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15				791	7932	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15				55	478	●		
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																											

Your Voice - Response Rate (%)				8	7	9	9	6		Feb-15	5	4	12	**6**					
Your Voice - Overall Score				3.68	3.58	3.76	3.76	3.57		Feb-15	3.6	3.7	3.5	**3.57**					

Surgery A Group

Indicator	Trajectory		Previous Months Trend																	Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		A	B	C	D					
C. Difficile	7	1	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	1	0	0	0	1	8	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	99	100	99	0	99.2		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	97	97	94	100	96.5		●		
Falls	0	0						9	7	4	8	3	9	9	6	6	0	4	4		Mar-15	2	1	0	1	4	69	●		
Falls with a serious injury	0	0	0	1	1	0	1	0	0	0	0	0	0	0	0	1	0	0	0		Mar-15	0	0	0	0	0	1	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	0	2	0	1	0	1	0	0	0	1	1	0	0	4	0	0			Feb-15	0	0	0	0	0	7	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	98.7	98.9	99.1	99.5	98.894		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	99.4	100	99.1	100	99.8		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	98.0	100	100	100	99.0		●		
Never Events	0	0	1	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	0	●		
Serious Incidents	0	0			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	3	●		
Mortality Reviews within 42 working days	100	=>98	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15	50	100		92	88		●		

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		A	B	C	D					
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	95.8		92.2		94.0		●		
2 weeks (Breast Symptomatic)	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	93.2				93.2		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	96.6		100		97.3		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	89.5		94.7		90.7		●		
Mixed Sex Accommodation Breaches	0	0	5	2	3	3	0	0	0	0	3	0	0	0	0	2	0	0	0		Mar-15	0	0	0	0	0	5	●		
No. of Complaints Received (formal and link)									12	11	8	19	15	13	13	7	15	9	16		Mar-15	3	7	2	1	16	129			
No. of Active Complaints in the System (formal and link)									50	50	34	39	49	57	78	53	45	40	45		Mar-15	8	17	7	4	45				
Oldest' complaint currently in system (days)									124	131	118	99	109	133	143	171	192	213	234		Mar-15					234				
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	2.3	1.5	1.2	0.5	1.54		●		
28 day breaches	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	1	0	0	0		Mar-15	0	0	0	0	0	3	●		
Sitrep Declared Late Cancellations	0	0	35	25	28	37	18	13	16	5	6	16	10	18	6	33	11	13	17		Mar-15	9	4	3	1	17	164	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0										76	78	75	77	71	78	79	75		Mar-15	75.4	74.3	77.2		75.4		●		
Emergency Care 4-hour breach (numbers)								81	100	100	119	52	103	118	94	121	43	108	127		Mar-15	66	53	8		127	1166			
Hip Fractures - Operation < 24 hours of admission (%)	85	85	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		69.5			60.0	69.5	●		

Indicator	Trajectory		Previous Months Trend																	Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		A	B	C	D					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	90.8	86.1	93.3		89.9		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	97.5	92.8	94.4		95.1		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	96.4	87.9	93.9		92.2		●		
Patients Waiting >52 weeks	0	0	13	3	3	0	0	1	1	0	2	4	2	1	2	0	3	1	2		Mar-15	0	0	2	0	2		●		
Treatment Functions Underperforming	0	0	8	8	7	8	7	7	5	5	4	3	4	6	7	4	5	8	4		Mar-15	0	3	1	0	4		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0.0		0		0.00		●		
WTE - Actual versus Plan			71	72	88	76	76	64	71	77	78	71	71	71	76	66	62	70	71		Mar-15					70.87				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	88.4	85.5	92.5	92.2		90.2	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	84	69	100	95		89.0	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	5.40	3.83	5.97	4.13	5.16	5.36	●		
Return to Work Interviews (%) following Sickness Absence	100	100																	●		Mar-15	10.2	5.8	51.3	13.2		29.0	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	85	83	94	91		89.5	●		
New Investigations in Month			0	2	1	1	1	0	0	0	0	0	2	0	1	0	1	1	2		Mar-15					2				
Nurse Bank Fill Rate	100	100																	76		Mar-15					76		●		
Nurse Bank Shifts Not Filled	0	0																	335		Mar-15					335		●		
Nurse Bank Use	9908	826	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15					1079	10816	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15					525	4320	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15					222	2889	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15					22	105	●		
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																											
Your Voice - Response Rate				13			12			11			11			9					Feb-15	13	5	7	7	9				

Your Voice - Overall Score				3.55	3.53	3.57	3.57	3.41		Feb-15	3.35	3.42	3.45	3.43	**3.41**				

Surgery B Group

Indicator	Trajectory Year	Trajectory Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate O	Directorate E	Month	Year To Date	Trend	Next Month	3 Months
C. Difficile	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	88	87	93.2		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	94	96	92.9		●		
Falls	0	0						1	0	0	2	0	0	0	0	1	1	0	0		Mar-15	0	0	0	5	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Mar-15	0	0	0	0	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			Feb-15	0	0	0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	97.94	97.07	97.6		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100	99.9	99.9		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100	100	100		●		
Never Events	0	0	1	●	1	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	●		
Serious Incidents	0	0			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	2	●		
Mortality Reviews within 42 working days	100	=>97	●	●	●	●	●	●	●				●								Jan-15					●		

Indicator	Trajectory		Previous Months Trend																	Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		O	E					
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		100	100		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●			●	●	●	●	●	●	●	●	●	●		●	●			Feb-15		100	100		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●		●	●	●	●		●	●	●	●	●			Feb-15		40.0	40.0		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Mar-15	0	0	0	0	●		
No. of Complaints Received (formal and link)									9	3	10	11	8	12	11	14	14	12	16		Mar-15	12	4	16	120			
No. of Active Complaints in the System (formal and link)									31	40	34	37	36	37	47	33	35	35	36		Mar-15	28	8	36				
Oldest' complaint currently in system (days)									117	100	103	129	98	63	138	109	102	123	144		Mar-15			144				
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0.9	0.49	0.72		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Mar-15	0	0	0	0	●		
Sitrep Declared Late Cancellations	0	0	14	19	36	15	22	3	22	17	16	14	16	12	11	7	24	11	8		Mar-15	6	2	8	161	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0										72	74	72	73	68	74	72	75		Mar-15	76	73	75.3		●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	98.63		98.6	98.99	●		
Emergency Care 4-hour breach (numbers)								7	14	72	6	25	29	5	25	21	8	8	39		Mar-15	29	10	39	249			
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0		0	0	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	15		15	14	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	20		20	20	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	3.55		3.55	3.29	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	1.90		1.90	1.72	●		

Indicator	Trajectory		Previous Months Trend																	Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A							
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	90.9	92.5	91.5		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	95.8	95.1	95.6		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	94.8	91.7	93.8		●		
Patients Waiting >52 weeks	0	0	9	2	0	1	1	0	1	1	0	0	2	2	1	0	0	1	1		Mar-15	1	0	1		●		
Treatment Functions Underperforming	0	0	0	0	2	3	3	3	4	3	3	2	4	5	5	1	2	7	1		Mar-15	0	1	1		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0.0	0.0	0.00		●		
WTE - Actual versus Plan			24	23	27	37	37	28	34	38	33	32	28	30	27	30	32	29	32		Mar-15			32.03				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	98.25	99.09		98.3	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	97	100		97.0	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	2.17	2.05	2.13	3.24	●		
Return to Work Interviews (%) following Sickness Absence	100	100																	●		Mar-15	25.3	77.9		39.0	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	85	92		86.7	●		
New Investigations in Month			0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Mar-15			0				
Nurse Bank Fill Rate	100	100																	100		Mar-15			100		●		
Nurse Bank Shifts Not Filled	0	0																	1		Mar-15			1		●		
Nurse Bank Use	2796	233	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15			206	2593	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15			4	457	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15			193	2282	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15			29	353	●		
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																									
Your Voice - Response Rate				18			19			17			17			14					Feb-15	7	29	14				

Your Voice - Overall Score				3.72	3.73	3.52	3.52	3.54		Feb-15	3.65	3.49	**3.54**						

Women & Child Health Group

Indicator	Trajectory		Previous Months Trend																	Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		G	M	P	C					
C. Difficile	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	1	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	99.2				99.2		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		100			100		●		
Falls	0	0						0	0	2	0	1	0	0	0	0	0	0	0		Mar-15	0	0	0	0	0	3	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Mar-15	0	0	0	0	0	0	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2			Feb-15	0	0	2	0	2	4	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	99.1	80.4	100		88.7		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	99.0	100			99.3		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100	100	100		100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100	100	100		100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	0	●		
Serious Incidents	0	0			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	2	0	0	2	6	●		

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		G	M	P	C					
Caesarean Section Rate - Total (%)	=<25.0	=<25.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		24.6			24.6	25.0	●		
Caesarean Section Rate - Elective (%)			10	11	12	11	10	10	8	9	9	7	9	7	8	11	8	6	9		Mar-15		8.71			8.7	8.3			
Caesarean Section Rate - Non Elective (%)			15	10	16	14	13	16	18	19	15	17	18	19	16	16	15	17	16		Mar-15		15.9			15.9	16.7			
Maternal Deaths	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		0			**0**	1	●		
Post Partum Haemorrhage (>2000ml)	48	4	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		0			**0**	**6**	●		
Admissions to Neonatal Intensive Care (%)	=<10.0	=<10.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		1.3			**1.28**	**2.33**	●		
Adjusted Perinatal Mortality Rate (per 1000 babies)	<8.0	<8.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		13.7			**13.7**		●		
Early Booking Assessment (<12 + 6 weeks) (%) - SWBH Specific	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15		76			76.02		●		
Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		190			**190**		●		
Mortality Reviews within 42 working days	100	=>97	●	●		●	●	●	●	●		●	●	●	●	●					Jan-15							●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	91.8		100		91.9		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	96.2				**96.2**		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	90.0				**90.0**		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Mar-15	0				**0**	**0**	●		
No. of Complaints Received (formal and link)									4	6	11	8	8	8	12	7	11	9	11		Mar-15	5	5	1		**11**	**95**			
No. of Active Complaints in the System (formal and link)									15	21	21	24	29	29	33	12	21	27	32		Mar-15	16	13	3		**32**				
Oldest' complaint currently in system (days)									61	82	52	66	87	104	123	151	52	73	94		Mar-15					**94**				

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		G	M	P	C					
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	2.9		0.0		2.35		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Mar-15	0				0	0	●		
Sitrep Declared Late Cancellations	0	0	13	14	13	7	12	12	3	4	7	6	6	7	7	7	1	5	7		Mar-15	7				7	72	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0										78	76	77	77	80	77	78	79		Mar-15	79.2				79.2		●		
Emergency Care 4-hour breach (numbers)								18	14	14	18	14	30	23	36	82	5	30	16		Mar-15	8	0	8	0	16	300			
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	96.4				96.4		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	97.2				97.2		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	98.6				98.6		●		
Patients Waiting >52 weeks	0	0	4	2	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0		Mar-15	0				0		●		
Treatment Functions Underperforming	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Mar-15	0				0		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0.0				0.0		●		

Indicator	Trajectory		Previous Months Trend																	Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		G	M	P	C					
WTE - Actual versus Plan			39	42	41	34	34	48	58	60	67	81	61	60	59	66	67	69	70		Mar-15					**69.87**				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	95.4	90.7	95.7	96.1		**93.7**	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100	80	85	0		**83.3**	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	3.35	7.72	4.18	5.99	**5.9**	**5.21**	●		
Return to Work Interviews (%) following Sickness Absence	100	100																	●		Mar-15	22.0	49.0	35.3	66.7		**46.2**	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	92	83	88	87		**85.2**	●		
New Investigations in Month			0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	1	1		Mar-15					**1**				
Nurse Bank Fill Rate	100	100																	90		Mar-15					**90**				
Nurse Bank Shifts Not Filled	0	0																	81		Mar-15					**81**				
Nurse Bank Use	6852	571	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15					**774**	**6474**	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15					**122**	**532**	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15					**72**	**886**	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15					**38**	**84**	●		
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																													
Your Voice - Response Rate				11			14			12			12			9					Feb-15	17	3	15	12	**9**				
Your Voice - Overall Score				3.79			3.74			3.65			3.65			3.53					Feb-15	3.44	3.98	3.2	3.78	**3.53**				

Pathology Group

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate					Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		HA	HI	B	M	I					
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	**0**	**0**	●		
No. of Complaints Received (formal and link)									0	1	0	1	1	3	0	2	3	1	5		Mar-15						**5**	**17**			
No. of Active Complaints in the System (formal and link)									1	2	1	2	3	6	5	5	8	7	6		Mar-15						**6**				
Oldest' complaint currently in system (days)									91	112	27	46	68	92	111	90	96	117	138		Mar-15						**138**				
WTE - Actual versus Plan			32	30	37	33	33	30	32	31	32	29	27	25	27	27	24	16	18		Mar-15						**18.02**				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	92.4	100	96.1	100	100		**97.3**	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	100	100	100	100	100		**100**	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	4.17	1.76	8.24	2.44	14.4	**5.86**	**4.17**	●		
Return to Work Interviews (%) following Sickness Absence	100	100																	●		Mar-15	85.3	86.5	63.6	92.7	100		**69.7**	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	90	97	95	98	94		**94.0**	●		
New Investigations in Month			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Mar-15						**0**				
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15						**603**	**6372**	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15						**0**	**0**	●		
Your Voice - Response Rate				36		30		31			31			12							Feb-15	18	24	15	27	36	**12**				
Your Voice - Overall Score				3.6		3.43		3.74			3.74			3.76							Feb-15	3.29	3.77	3.74	3.85	3.98	**3.76**				

Imaging Group

Indicator	Trajectory Year	Trajectory Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate DR	IR	NM	BS	Month	Year To Date	Trend	Next Month	3 Months
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	0	●		
Unreported Tests / Scans																														
Outsourced Reporting																														
IRMA Instances																														
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15			67.7		67.7	71.6	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15			100		98.5	98.8	●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Mar-15	0	0	0	0	0	0	●		
No. of Complaints Received (formal and link)									4	2	3	3	0	4	2	2	3	2	1		Mar-15					1	26			
No. of Active Complaints in the System (formal and link)									5	7	8	5	5	8	10	8	9	7	5		Mar-15					5				
Oldest' complaint currently in system (days)									19	40	59	30	52	76	72	75	83	75	96		Mar-15					96				
Emergency Care 4-hour breach (numbers)								30	39	41	32	34	49	50	52	45	41	49	51		Mar-15	51				51	513			
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0.3				0.31		●		
WTE - Actual versus Plan			20	21	18	28	28	15	13	11	13	22	14	16	15	21	21	33	40		Mar-15					39.68				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	79	100	94	100		84.9	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	97		100			96.9	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	4.3	1.6	3.26	7.7	4.70	4.63	●		
Return to Work Interviews (%) following Sickness Absence	100	100																	●		Mar-15	49.8	###	60.5	29.9		49.4	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	85	86	92	90		87.0	●		
New Investigations in Month			0	1	0	0	0	0	2	2	0	0	6	0	0	0	0	0	0		Mar-15					0				
Nurse Bank Use	288	24	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15					14	182	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15					121	1146	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15					177	1439	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15					0	0	●		
Your Voice - Response Rate				19		30			33			33			18						Feb-15	16		31	16	18				
Your Voice - Overall Score				3.72		3.73			3.73			3.73			3.28						Feb-15	3.1		3.3	3.9	3.28				

Community & Therapies Group

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		AT	IB	IC					
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15				100		●		
Falls	0	0						8	9	11	13	4	14	20	17	21	22	16	13		Mar-15	0	13	0	13	168	●		
Falls with a serious injury	0	0						0	2	0	0	1	0	0	0	0	0	0	0		Mar-15	0	0	0	0	3	●		
Grade 2,3 or 4 Pressure Ulcers (avoidable)	0	0						2	4	2	2	1	1	1	3	5	2	1			Feb-15		1		1	24	●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	0	0	0	0	●		
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	1		Mar-15	0	1	0	1	1	●		
FFT Response Rate - Wards	>25%	>25%						39	68	43	60	59	57	47	38	33	33	41	59		Mar-15				58.5		●		
FFT Score - Wards	=>68.0	=>68.0	100	93	85	83	82	81	95	87	83	91	82	88	73	87	100	95	90		Mar-15				90		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Mar-15	0	0	0	0	0	●		
No. of Complaints Received (formal and link)									3	0	0	5	2	5	1	1	2	1	1		Mar-15				1	21			
No. of Active Complaints in the System (formal and link)									10	8	3	8	8	10	12	3	4	3	6		Mar-15				6				
Oldest' complaint currently in system (days)									94	##	75	38	60	64	81	75	61	82	##		Mar-15				103				
WTE - Actual versus Plan			70	32	34	34	34	27	36	45	45	62	65	67	71	75	76	72	15		Mar-15				15.02				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	95	91	88		90.1	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	4.8	3	5.5	4.66	4.93	●		
Return to Work Interviews (%) following Sickness Absence	100	100																	●		Mar-15	93.0	74.2	53.9		90.6	●		

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		AT	IB	IC					
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	95	93	88		90.6	●		
New Investigations in Month			0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0		Mar-15				0				
Nurse Bank Fill Rate	100	100																	93		Mar-15				93				
Nurse Bank Shifts Not Filled	0	0																	36		Mar-15				36				
Nurse Bank Use	5408	451	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15				495	3869	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15				261	2492	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15				247	2905	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15				0	0	●		
Your Voice - Response Rate				18			33		32			32			28						Feb-15	21	36	26	28				
Your Voice - Overall Score				3.75			3.78		3.88			3.88			3.76						Feb-15	3.7	3.7	3.8	3.76				
DVT numbers	730	>61		30	40	57	53	53	62	87	39	33	70	35	42	47	54	53	55		Mar-15				55	630	●		
Therapy DNA rate OP services (%)	=<9	=<9				11	12	12	16	11	11	11	11	12	14	12	12	14	13		Mar-15				12.9	12.3	●		
FEES assessment	>100	>8.3					1	7	10	3	4	4	5	5	3	2	14	1	3		Mar-15				3	61	●		
ESD Response time	<48 hrs	<48 hrs			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15						●		
STEIS	0	0		2	0	0	1	0	2	1	0	1	0	0	0	1	0	0	1		Mar-15				1	6	●		
Rapid response to AMU, RRTS	<60 mins	<60 mins		77	75	75	75	75	71	72	73	68	81	79	82	86	79	98			Feb-15				98	78.5	●		
Avoidable weight loss	<20%	<20%	●	●	●	●	●	18	0	8	0	0	0	0	0	9	0	0	8		Mar-15				8.1	3.6	●		
Green Stream Community Rehab response time for treatment (days)	=<11	=<11				15	11	12	7.9	11	16	16	17	14	12	13	9.5	12	14		Mar-15				13.7	12.9	●		

Indicator	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		AT	IB	IC					
DNA/No Access Visits		%										3.3	0.9	0.7	0.9	0.9	0.9	0.8	0.9		Mar-15				0.85				
Falls Assessments - DN service only		%										72	58	49	45	45	62	54	65		Mar-15				64.6				
Pressure Ulcer Assessment - DN service only		%										73	61	50	48	46	63	57	65		Mar-15				65.1				
Healthy Lifestyle Assessments - DN Service only		%										61	54	48	39	43	58	54	56		Mar-15				56.2				
At risk of Social Isolation Referrals to 3rd sector DN service only		%										46	75	67	57	65	95	77	53		Mar-15				53.3				
MUST Assessments - DN Service only		%										9.4	11	9.9	11	9.8	19	18	36		Mar-15				36.1				
Incident Rates		per 1000 charge										3.6	4.8	4.9	3.5	3.5	5.1	4.1	4.9		Mar-15				4.9				
Dementia Assessments - DN Service only		%										72	62	55	52	51	61	62	62		Mar-15				61.9				
48 hour inputting rate		%										91	83	81	85	86	89	83	88		Mar-15				87.5				

Corporate Group

Indicator	Trajectory		Previous Months Trend																Data Period	Directorate							Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		CEO	F	W	M	E	N	O					
No. of Complaints Received (formal and link)									8	4	5	6	5	7	6	6	15	5	6		Mar-15								6	73			
No. of Active Complaints in the System (formal and link)									16	13	12	13	21	21	25	12	21	16	18		Mar-15								18				
Oldest' complaint currently in system (days)									69	90	77	99	121	106	104	104	123	145	138		Mar-15								138				
WTE - Actual versus Plan			215	187	161	164	164	149	154	162	176	162	183	194	203	168	175	200	234		Mar-15								234.22				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	88	88	94	90	94	96	86		92.5	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15			100						100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	3.19	1.08	2.20	3.31	2.70	6.36	6.66	5.20	4.46	●		
Return to Work Interviews (%) following Sickness Absence	100	100																	●		Mar-15	48.8	65.1	39.1	83.7	52.8	71.3	70.0		68.0	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15	91	96	95	92	95	89	89		90.1	●		
New Investigations in Month			1	0	0	2	2	0	1	3	1	0	5	0	0	0	1	0	0		Mar-15								0				
Nurse Bank Use	1088	91	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15								161	2082	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Mar-15								82	193	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15	74	89	45	28	0	3064	666	3966	39032	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●	●		Mar-15	0	17	0	0	0	0	0	17	479	●		
Your Voice - Response Rate				26			29			24			21			15					Feb-15	52	28	28	20	12	10	11	15				
Your Voice - Overall Score				3.56			3.57			3.6			3.49			3.48					Feb-15	3.81	2.77	3.85	3.49	3.24	3.52	3.37	3.48				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Plan Delivery Report 2014/15 – Final Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Director of Finance & Performance Management**
AUTHOR:	**Rebecca Buswell – Project Support Manager**
DATE OF MEETING:	**7 May 2014**

EXECUTIVE SUMMARY:

The document provides an update on progress of delivery for the key activities and objectives included in the Trust Annual Plan for 2014/15.

A summary has been provided of those actions we achieved in 2014/15, and any ongoing work to further improve on these achievements. Additionally, there are a number of objectives we did not deliver, and an update has been provided as to the key actions required for 2015/16 to meet each of these objectives.

REPORT RECOMMENDATION:

To discuss progress against achievement of the key activities outlined in the Trust Annual Plan for 2014/15.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		x

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

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

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

Relates to all annual priorities

PREVIOUS CONSIDERATION:

February 2015 (Q3 update)

Annual Plan 2014/15 – Final Monitoring Report (April 2015)

Complete: *These objectives have been completed. Ongoing work is as a result of successful delivery/part of longer term Trust plans.*

	2014-15 Objective	What we achieved	What we will continue to work on
✓	**Implement year one of our Public Health plan**, making every contact count	• New traffic light system for food introduced in October 2014 with accompanying 'Choose Green' campaign • Huge improvement in number of midwives carrying out carbon monoxide monitoring & smoking cessation advice • Nicotine Replacement Therapy programme implemented • Use of landfill ended	• Implementing year two of the plan • MECC training dates confirmed for April 2015
✓	**Reduce preventable deaths**, in particular by focusing on the Sepsis Six Care Bundle	• 2014-15 aim was to increase the percentage of patients being screened positive for sepsis receiving the sepsis six bundle of care to 50%. This was also a CQUIN for 14/15 and the CCG set an exit trajectory of 65%. The trajectory was achieved. • Meeting trajectory for RAMI (deaths in low risk diagnosis groups)	• There remains work to be done and the CQUIN for 15/16 focuses on the Emergency Department as well as the Acute Medical Units • Improvement in performance against target of 98% of mortality reviews within 42 days
✓	**Cut cancelled operations numbers,** and eliminating repeat cancellations	• 0.8% for 2014-15 as compared to 1.1% in 2013-14	• Reduce avoidable cancellations in BMEC to sustain trajectory
✓	**Deliver national cancer wait times,** even where other Trusts deliver part of the care specification	2014-15 overall performance: • 2 weeks – 93.4% (target =>93%) • 31 Day – 98.7% (target =>96%) • 62 Day – 88.4% (target =>85%)	• Ensure that there are no variations in monthly performance both at Trust and specialty level • Reduce diagnostic waiting times further • Cancer Taskforce in place chaired by Medical Director to deliver common standard of excellence in providing information & support to patients with cancer.
✓	**Comply with both the letter and the spirit of the Safe Staffing**	• All daily requests for additional staffing are reviewed by Group Directors of Nursing to ensure productive use of existing workforce.	• Chief Nurse has discussed with Group Directors of Nursing & Deputies the option of moving to the Association of UK University Hospitals safer staffing

Complete: *These objectives have been completed. Ongoing work is as a result of successful delivery/part of longer term Trust plans.*

	2014-15 Objective	What we achieved	What we will continue to work on
	promise made after the Francis Inquiry	• Review of NICE guidance has taken place. Applied guidance to revised nursing establishments and made amendments to ensure compliance. • Monthly board reports produced on nurse safe staffing compliance.	tool as our assessment method. • We will test out the method in the coming months and begin using the tool to do our six month reviews from early 2015. • Further NICE guidance expected in 2015
✓	**Achieve the emergency care standard,** and **meeting our own ambitions around mental health care** in an acute setting	• Mental Health assessment suites outside of ED established in December 2014. • Significant reduction in the length of time mental health patients stay in ED	• Efficiency of diagnostic and assessment pathway
✓	**Develop further our model of intermediate care at Leasowes, Rowley Regis and in Sheldon**	• PCAT based at Rowley Day Hospital continues ahead of formal evaluation • 20 flexible level 2 intermediate care beds opened on D47 in Sheldon on schedule following significant investment from the Trust • McCarthy Ward opened in February 2015	• Continue to improve the assessment and transition process from acute to intermediate care beds
✓	**Implement our pacesetting project to change the shape of district nursing delivery,** making our services part of the primary health care team	• District Nursing Teams have been divided into 25 alignments with GP Practices – all GP's have a named team • MDT meetings have now started on average a 2 monthly basis. • Quarterly Operational Group meetings are held with CCG, SWBH and BCHC providers, information from this is passed on to Pace Setting Board. • KPI's have been agreed and signed off with CCG and SWBH. • Each team/GP Practice have now met and agreed their own personalised Standard Operating Procedure	• Continue to Monitor KPI to measure benefits realisation and identify if any amendments are required to the pilot community nursing service • Develop services specification to reflect the integrated services strategy above. • Re-profile staff competencies to deliver the integrated services and unscheduled care/hospital avoidance priorities • Recruitment to vacancies once revised staffing model agreed • Complete leadership development of top team.

Complete: *These objectives have been completed. Ongoing work is as a result of successful delivery/part of longer term Trust plans.*

2014-15 Objective	What we achieved	What we will continue to work on
✓ 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	• Two additional consultant geriatricians recruited • Expanded level of support provided to nursing homes • Additional intermediate care beds opened on D47	• Plans for 15-16 in development and monitored elsewhere
✓ **Complete the transfer of 27 clinics into Rowley Regis,** as agreed by the Clinical Leadership Executive	• GUM clinics are being delivered as well as clinics delivered by Surgical Care Practitioners. • Pelvic Floor clinics are also now being delivered at Rowley • T&O clinics commenced in January 2015 with potential for plaster technicians to hold sessions there two days a week • Modifications required at Rowley to allow for additional clinics to be transferred (including Respiratory Oxygen Assessment & General Surgery)	• Estates plans finalised at Rowley Regis to allow for further clinics to be transferred (infection control risk due to carpet)
✓ Ensure that our **training expenditure supports career and skill development**	• Group training plans submitted via the business planning process in Feb 2015 and quality assured by L&D department and Workforce planning. • 2015/16 TNA presented to the EL&D Committee on 20/04/15 for scrutiny against workforce and business plans and to provide assurance on investment • Additional £230,000 committed to training in 2015-16	• Monitoring against TNA at specialty level
✓ **Providing extra support to high-turnover departments** and those with long-term vacancies	• Focused work on medical and surgical staff nurses (Band 5) – 20% reduction in staff leaving within 2 years of commencement • Improved exit questionnaires – specific group management feedback sought through Your Voice and exit questionnaires • Enhanced management structure in Medicine	• Plan to develop rotational schemes (different specialties and into community) • Continue to provide support to those teams affected by workforce change programmes

Complete: *These objectives have been completed. Ongoing work is as a result of successful delivery/part of longer term Trust plans.*

2014-15 Objective		What we achieved	What we will continue to work on
✓	**Standardise our consumables & equipment,** especially in theatres to reduce the costs and safety risks of variation	• Product Standardisation Group operated and effected reduction in range of products used at demonstrable reduced costs. • Database of contracts and forward procurement work plan established and which provides line of sight to future standardisation opportunities.	• Enhanced focus on non-pay control and optimisation to include greater product standardisation, supplier rationalisation and catalogue management. • Secure Managed Service Contract for fixed imaging equipment.
✓	**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**	• EPR OBC presented to Trust Board in January 2014 • Demand and capacity modelling completed across 20 specialties using NHS IMAS tool – bridging gaps between demand & capacity through efficiencies and pathway redesign • TSP programme designed to include schemes to improve productivity through effective production planning • Progress made against 7 day standards	• Create fit for purpose contracting/business development function to better align corporate and devolved activity and capacity plans • Establish business intelligence function • Approved business case for EPR • Embed capability to assess, plan and manage demand and capacity across the year
✓	**Investing in occupational health services counselling teams**	• £20k investment in counselling service provision in 2014	• Mental health training for managers to commence in X 2015
✓	**Introducing an in-house medical bank**	• In house medical bank launched in X 2015 and rolled out across all areas	• Managing any issues as they arise to ensure ongoing success
✓	**Cut our reliance on agency, overtime and bank staffing,** on which last year we spent over £25m	• Chief Nurse implemented new controls from July – Dec 2014 ensuring agency used in the most appropriate way and to control expenditure • Agency expenditure has reduced from X to X • Bank staffing spend has reduced from X to X • Reduction in overtime spend of 8.6%	• Eliminate premium rate working through balanced demand and capacity plans – focused work within Surgery B at end of April/early May will identify minimal investment required to bridge gap between demand and capacity
✓	**Eliminate the costs of poor quality care,**	• 0 Never Events in 2014-15 • MRSA screening – consistently meeting target (2014-15	• Further implementation and embedding of our 10/10 programme in 2015-16

Complete: *These objectives have been completed. Ongoing work is as a result of successful delivery/part of longer term Trust plans.*

	2014-15 Objective	What we achieved	What we will continue to work on
	where patients need more expensive treatment because of errors or omissions that we have contributed to	performance = • C Diff cases = 27 (maximum = 37)	
✓	**Reduce overheads** in our system, so that **more of every pound is spent on patient care**	• Safe and Sound workforce change programme including re-design and cost reduction in corporate functions. • Optimisation of treasury management arrangements to minimise PDC dividend charges.	• Progress programme to secure excellence in delivery of middle & back of transaction functions, systems and processes. • Progress development of retained estate consistent with medium term plans and to reduce m2 from the operational footprint. • Component revaluation of retained estate to minimise depreciation costs.
✓	**Resolve issues with the Birmingham Treatment Centre** to ensure **better staff and patient experience**	• Deed of Settlement and Variation to Project Agreement has been finalised and engrossed following Trust Board approval	• Confirm receipt of Lump Sum Deduction payment
✓	**Proceed with MMH**	• Competitive Dialogue CD Stage 4 has been completed with Carillion, draft final bid submission received on 2nd April 2015, as per programme. • Evaluation of the bid submission has commenced with recommendation to be presented to Moderation Committee on 24th April 2015 • Department of Health and HM Treasury have formally agreed to proceeding with a single bidder, (Carillion).	• ABC to be reviewed at extraordinary Trust Board meeting on 30th April 2015
✓	**Invest in estate that we are keeping for the**	• Almost £1m invested in intermediate care beds at Sheldon D47 now complete and fully operational	• The Development Control Plans for community locations are in the process of being updated.

Complete: *These objectives have been completed. Ongoing work is as a result of successful delivery/part of longer term Trust plans.*

	2014-15 Objective	What we achieved	What we will continue to work on
	long-term including Sandwell General Hospital, Rowley Regis and Sheldon	• Refresh & update of Development Control Plans for Community Estates, Sandwell, City & Rowley has commenced. • Consultation/Communication about to commence regarding proposed changes to Rowley has been completed and evaluation of the feedback commenced. • IAP bids for capital funding from 2015/2016 capital programme were submitted as part of the Business Planning process	• Agree final proposals for Rowley following feedback from public consultation. • Confirmation of funding for IAP bids from 2015/2016 capital programme to be confirmed by end April 2015
✓	**Improve employee wellbeing** by implementing our Public Health plan	• Implemented staff nicotine replacement programme– 29% quit rate over 12 weeks. • Phase 1 of mental health support for managers launched from 7th August. • From Sept 2014, all new inductees complete assessment for lifestyle behaviours. • Vending machines have undergone change with regards to sugary drinks being removed and the lunch time service for patient meals has also changed. • Food traffic light system introduced with promotional campaign early Q3. • Night-workers have been surveyed to get feedback on provision of food at night	• Nicotine Replacement Programme will be evaluated, in its entirety, at the end of January 2015. • Mental health training to be rolled out following initial pilot (received positive feedback) • Developing gym at Sandwell delayed into 15/16 – waiting on capital projects
✓	**Invest in our leaders**, through partnership with Hay Group and others	• 7 cohorts of the first top leader programme have commenced – 150+ leaders on programme. • Consultant leadership development programme up and running. • Top leaders cadre continue with 1:1 coaching and peer support • 17 staff enrolled on NHS Leadership Academy national	• Next TLC will begin in May 2015 • 360 degree appraisal scheduled to be rolled out for all leaders on a 3 year cycle • We need to continue to develop our leadership brand • Broaden the scope of the coaching provision/ network

Complete: *These objectives have been completed. Ongoing work is as a result of successful delivery/part of longer term Trust plans.*

	2014-15 Objective	What we achieved	What we will continue to work on
		programmes • ACL programmes continues to be delivered. The functional leadership approach is becoming embedded in the organisation. • Leadership Competence Framework developed	
✓	**Introduce 360-degree appraisal into all leadership roles**	• 150 leaders have had 360 degree appraisal introduced into their role	• In April 2015, an additional 150 on the leadership programme will commence the leadership programme and undertake 360 appraisal • Plans are being developed in house to ensure that the remaining trust leaders undertake 360 appraisal
	Achieve 100% PDR and mandatory training compliance	• PDR overall compliance for 2014-15 is 90.52% • Mandatory training compliance for 2014-15 is 87.6%	• A new Trust wide process commenced rollout in April 2015 and the new arrangements are being put in place in Governance, Community & Therapies and Medicine

Objectives we did not meet in 2014-15: *these objectives require significant further work and will remain a focus throughout 15/16*

	2014-15 Objective	Progress made in 2014-15	What we need to achieve in 2015-16
X	**Reduce readmissions** by 1%, through integrating care and better managing risk	• Trust readmission rate - 8.17% (2014/15) compared with X% in 2013/14 • Sandwell readmission rate - 9.71% (2014/15) compared with 8.8% in 2013/14 • City readmission rate - 7.09% (2014/15) compared with X% in 2013/14 • LACE Tool usage at only 19.7% across Trust.	• Reducing readmissions remains key Trust priority in 2015-16 • Trial on 2 wards at Sandwell for patients with high LACE score, ICARES triaging patients on discharge and offered support to try and prevent re-admission • Audit of ED patients on both sites looking at average age of patient and condition of admissions/re-admissions over one month to identify areas for focused work • Commencement of work to develop strategy for Advance Care Planning • Geriatrician working with GP's in Care Homes to reduce admissions/re-admissions • Development of an MDT model for patients with COPD • Development and roll out of new discharge summary to assist with care plans in the community - ongoing
X	**Meet the emergency care waiting time standard as we did in April 2014**	• The Trust did not meet the 4-hour ED wait target during 2014-15 (apart from in April 2014). Overall performance was 92.52%, with performance of 91.27% in March 2015.	Recovery approach includes: • ED development programme • Establishing WMAS boundaries • Increasing morning discharges • Reducing DTOC through new ways of working • Reducing health delays agreeing a system wide choice policy • Reducing mental health delays through new assessment suites • Recruitment of ED consultants
X	**Deliver our Year of Outpatient programme**, to reach 98% patient satisfaction	• Most specialities are using electronic outcomes and cold appointing 6 weeks in advance to reduce hospital cancellations • Patients can request to cancel their appointment via email – cancel or change my appointment form is now on the Trust Website with mandatory fields	• Improving outpatients remains a key Trust priority in 2015-16 • Complete roll out of electronic outcomes (1st week in May) • Complete roll out of self-check-in kiosks and introduce patient calling screens • Develop workflow in the electronic referral management system (WinDip) to support electronic triaging • Demand & capacity plans to be signed off at specialty level by

Objectives we did not meet in 2014-15: *these objectives require significant further work and will remain a focus throughout 15/16*

	2014-15 Objective	Progress made in 2014-15	What we need to achieve in 2015-16
		• Self-check-in kiosks have gone live at Rowley Regis, Alpha Suite, Pain, Diabetes and Physio at City. BMEC are now on new software • Electronic referral management system (WinDip) procured and training received • A&G has been set up for all the specialities • Consultant Advice and Triage Service model further tested in Gastroenterology and Respiratory • Patient Experience Survey carried out in March and April 2015 • Introduced virtual clinics – review of normal test results and discharge by phone consultation • Reviewed of diagnostic pathways – scheduling tests before 1st outpatient appointment • Direct access diagnostics – avoiding hospital outpatient appointments for normal test results and introducing primary care pathways • Demand and capacity model developed for 20 specialties across the organisation	both clinical and operational leads • Implement follow up partial booking • Implement speech recognition
X	**Improve our Friends and Family results**, towards being the best in the region	• **Inpatients FFT score: 70** (Q4 Avg) This was -2 points below our Q3 score. However, the Trust's Q4 score is same as the regional average score (Jan – Feb 2015). The Trust's response rate rose from 33% (Jan 2015) to 43% (Mar 2015). • **Emergency Department FFT score: 49** (Q4 Avg) It was same as the Q3 score. This score is, however, +1 over the regional average score	• Response rate target is now 50% • Clinical Groups/teams taking responsibility and ownership of their FFT score and making improvements. • FFT programme Awareness: Renewed Marketing/publicity campaign. • More Patient Experience/Customer Care training for frontline staff. • Make FFT 'inclusive' for all groups of patients and carers. • Medium and long term planning in terms of investment to

Objectives we did not meet in 2014-15: *these objectives require significant further work and will remain a focus throughout 15/16*

	2014-15 Objective	Progress made in 2014-15	What we need to achieve in 2015-16
		(Jan – Feb 2015). The Trust's response rate rose from 18% (Jan 2015) to 22% (Mar 2015) • **Maternity Services –** Response rates have dropped below 10%. • FFT programme extended to **Outpatients**, **Day cases and ED Walk-in** areas.	update patient feedback and reporting systems using emerging interactive technologies, e.g., Apps, crowd sourcing, etc,
X	**Reduce the number of complaints**, especially repeat complaints	• The total number of Complaints logged in Q3 was 207, a decrease of 28 across the quarter. • 17 of these were withdrawn by the complainant at some point during the quarter leaving 190 to manage. • There were 3 fewer complaints made in January 2014 compared to January 2015, but 10 fewer complaints made in February 2014 compared to February 2015, with 20 more made in March 2014 to March 2015.	• Development of a systematic way to monitor how many complainants are offered resolution meetings, to assess the impact on rate of reopened cases. This will be reported in Q1 of 2015/16. • A new process for of the triaging of complaints is to be established in Q1 2015 to ensure they are categorised as one of the following types of complaints. 1. Fast track complaints - telephone of face to face meetings where issues are resolved quickly (likely level 1 and some level 2 grade complaints.) 2. Standard complaints in need of investigation and in need of a written response (letter or report.) 3. Complaints involving the death of a patient, where a specific pathway for the management of the compliant will be developed. • An 'Action Tracker' is in development to monitor achievement of actions resulting from complaints. This will be tested in Q4 2014 and fully introduced in Q1 2015/16.
X	**No mixed sex breaches of our privacy and dignity standard,** now reported from eBMS	• Considerable progress made– sustained compliance demonstrated • 93 mixed sex breaches in Q1 2014-15, followed by 3 breaches in Q2, 9 breaches in Q3 and 0 breaches in Q4.	• More to do to improve privacy and dignity in outpatients

Objectives we did not meet in 2014-15: *these objectives require significant further work and will remain a focus throughout 15/16*

	2014-15 Objective	Progress made in 2014-15	What we need to achieve in 2015-16
X	By October 2014**, specialty delivery of 18 week wait standards,** and introducing these standards into therapy services	• National requirements to reduce national backlog has required several revisions to the in-year profile • Trust did not meet target for Admitted & Non-Admitted Care in November 2014 and February 2015 and has a number of treatment functions underperforming due to requirement to contribute to national backlog clearance	• Key priority for 2015-16 is for all new OP appointments within 6 weeks, and demand and capacity plans are based on reduction in waiting time to 6 weeks, both for new and admitted pathways
X	**Resolve the long term configuration of midwifery services** for 2015-16 with our CCG partners, local families and the local authorities	• Significant delay to timetable due to number of meetings being cancelled with CCG	• Re-establish detailed programme with timescales for delivery
X	**Reform another long term conditions specialty into general practice**, year two of what we have achieved with diabetes	• Diabetes model continues to progress • Delay in reforming second LTC specialty	• Plans in place for Respiratory in 2015-16
X	**Improving our 'time to hire'** from vacancy to recruitment	• Reduced pre-employment check part of process • Improved reporting mechanism to identify delays • Time to hire has increased to 22 weeks at the end of 2014-15 as compared with 19 weeks at the end of 2013-14. • Affected by the workforce change (all vacancies held until redeployment complete)	• Completion of 'Safe & Sound' programme (started in April 2015) • Redeployment process refined following lessons learned in Phase 1

Objectives we did not meet in 2014-15: *these objectives require significant further work and will remain a focus throughout 15/16*

	2014-15 Objective	Progress made in 2014-15	What we need to achieve in 2015-16
X	**Cut sickness rates from their current 4.5% by focusing on our fifty hotspots**	• Sickness absence rates have increased to 4.65% for 2014-15	• Cut sickness absence below 3.5% with a focus on reducing days lost to short term sickness (Trust priority for 2015-16 and reported monthly to Trust Board) • A clear reduction starting from Q2 in sickness rate within Trust • Delivery of trajectories for input measures that we know work, specifically return to work interviews, and referral to formal procedures for majority of staff who appear to breach thresholds in our policy • Individual target dates for return to work in place for all individuals off work for 6 months+

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 27 March 2015; 1030h – 1130h

Present

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

In Attendance

Ms A Binns
Mr G Smith
Mrs D Talbot

Secretariat

Mr S Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies for absence were received from Ms Claire Parker and Mr Tony Waite.	
2 Minutes of the previous meeting	**SWBQS (2/14) 030**
The minutes of the Quality and Safety Committee meeting held on 27 February 2015 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBQS (2/15) 030 (a)**
The updated actions list was received and noted by the Committee.	
MATTERS FOR DISCUSSION/DEBATE	
4 Ward concerns	**SWBQS (3/15) 032** **SWBQS (3/15) 032 (a)**
Mr Ovington presented an overview of the Ward D26 audit which had been undertaken since the last meeting. It was reported that the CQC had also visited the ward as part of the inspection and the issues raised had been investigated. The	

audit was reported to have covered the month of January and a review of all of the case notes of patients treated. It was highlighted that although the ward had addressed some of the issues raised, there was further work to do around some aspects of basic care. Mr Ovington reported that the staff on the ward were committed to making the changes needed speedily. The Committee was asked to note the summary of conclusions from the audit. Ms Dutton asked whether this 'deep dive' would be followed up and rolled out across the organisation. She was advised that this was the case, although cautioned that to do this audit on wards where there was greater throughput then the scale of the audit would be significantly higher. Mrs Talbot reported that the review of D17 would follow a similar process. It was noted that the methodology was excellent, however was very labour intensive. Mr Ovington reported that the standard of care needed to be targeted towards good and excellent. Mr Samuda asked what the key difficulties were to achieving this and was advised that lack of complete documentation was an issue. It was noted that this was the responsibility of all permanent and temporary staff. Mrs Hunjan noted that there was an issue with not being able to save electronic reports in draft format which could be reaccessed if interrupted, which Miss Dhami advised was being considered at present. Dr Sahota suggested that better work was needed to ensure that the patients were informed of when medicines needed to be taken before or after food. Mrs Talbot reported that some drugs rounds coincided with meal times. Ms Dutton asked how day care record completion was to be handled. Mr Ovington reported that audit practice was being considered to provide a more accurate picture. Mr Samuda suggested that there was a need to learn from practice and audits such as these. It was noted that the learning would be shared as part of the quality improvement half days. Miss Dhami suggested that a prospective look of the performance was needed and triggers were needed in a real time basis. It was noted that this was linked to the embedding of the Ten out of Ten initiative. Dr Stedman noted the burden of these audits, counting of information and recording and that this should not be at the expense of delivering good quality care, therefore the capturing of information needed to be smarter, including real time capture. Mr Ovington agreed to bring an example of ward dashboard and the trigger tool to a future meeting.	
ACTION: **Mr Ovington to bring an example of the ward dashboard & trigger tool to a future meeting**	
5 Model for closing and opening capacity	**Hard copy paper**
Miss Barlow presented an overview of the considerations for opening and closing beds. It was reported that opening beds would be triggered by the planned need for additional capacity. It was reported that if there was a major incident, then the relevant plans would be invoked which would ensure that the bed base was cleared quickly. Miss Barlow reported that there was flexible capacity available on both sites, which included required equipment, although she noted that flexibility	

to open additional beds would not be available in the new hospital. Closure of the beds was noted to be more difficult than opening beds. The checklist used and risk assessment was noted and it was reported that the decisions to be taken involved discussion by the Executive triumvirate. Mr Samuda emphasised the need to ensure that communication and the provision of adequate staff ratios to be planned into the flexing of capacity. Mr Ovington agreed that safely staffing these areas was a consideration. Dr Stedman reported that the medical team would be allocated a bay when additional capacity was opened or locum staff would be engaged if sufficient beds were opened. Mrs Hunjan noted that there would be impact on support staff, such as catering and other facilities services. It was agreed that any feedback on the draft policy needed to be directed to Miss Barlow.	
6 Falls and pressure ulcers update	**SWBQS (3/15) 034** **SWBQS (3/15) 034 (a)** **SWBQS (3/15) 034 (b)**
Mr Ovington reminded the Committee that at March's Board meeting a discussion had been held which highlighted that the falls position reported previously had not reflected those held for review within the Safeguard database. It was noted that the position remained better than the national average. Mrs Talbot reported that the falls collection method was through the safety thermometer, although this was highlighted to provide a limited picture. It was reported that the supplementary method was through the Safeguard incident database, which had been retrospectively been adjusted to take into account those held in the pending section of the database. Falls associated with the community beds was noted to reflect the demographic of patients treated in these intermediate beds. It was reported that avoidable vs. unavoidable falls and pressure ulcers were determined by national guidance and that patients were risk assessed on admission to determine the care plan for the patient individually. A root cause analysis was reported to be undertaken when a fall incurring injury occurred. Common factors with the avoidable falls were noted to be associated with out of hours transfers, within toilets where privacy and dignity was prioritised, dementia and medication. Learning from tabletop reviews and care plans information was reported to be shared, including through means such as mandatory training. In terms of pressure sores, it was noted that the position was deteriorating. Mrs Talbot reported that the eradicate campaign had been successful previously, although this now needed to be prioritised and learning would be shared from areas where there had not been any pressure ulcers. Miss Barlow reported that a check needed to be made to ensure that the additional beds in community services D47 ward had been added into the position.	

She asked whether the avoidable falls were fed back to patients. Mrs Talbot advised that this was the case prior to tabletop review. Ms Dutton asked for clarity on the linkages to the Safeguarding Boards. Mrs Talbot provided the details of this and further processes needed to be developed to share learning across the organisation. Dr Sahota noted that in a large number of cases the age of the patients was not known. It was reported that this reflected the omission of this information in the incident forms. It was noted that sharing from other organisations was needed where possible.	
7 Patient story	**Verbal**
Mr Ovington provided the detail of the patient story which would be presented to the Board at its next meeting.	
8 Integrated Performance Report	
Mr Smith provided the key highlights from the Integrated Performance Report. Ms Dutton noted that sickness absence had risen; delayed transfers of care had also risen and the longest complaint in the system was 213 days old. It was noted that the complaint was currently within the approval process. Ms Binns noted that the complaints position was pleasing overall however. Miss Barlow reported that discussions had been held with Birmingham City Council which revealed that a number of enhanced assessment beds had been closed which had significantly impacted on the available placements. It was reported that a fines notice had been issued and a daily briefing with the Council was held. Dr Sahota noted the financial pressures on the Council at present. Mr Ovington reported that there was wide variation in sickness absence between wards at present. In terms of infection control, it was reported that some cases of *C difficile* had been reported and a MRSA bacteraemia infection had been reported in March. The performance against mortality review target was reported to be improving, although there was further work to do to generate an even better position. Mrs Hunjan noted that the population of the data quality kite mark information was not as complete as desired and suggested that this should be addressed and a trajectory set. Ms Dutton noted that there was an increase in red ratings on the data quality assessments.	
MATTERS FOR RECEIPT AND ACCEPTANCE	
8 Serious Incident report	**SWBQS (3/15) 035** **SWBQS (3/15) 035 (a) - SWBQS (3/15) 035 (b)**
The Committee received and noted the report.	

9 Clinical audit forward plan: monitoring report	**SWBQS (3/15) 036** **SWBQS (3/15) 036 (a)**
The Committee received and noted the report.	
10 Forward plan for the Committee	**SWBQS (3/15) 037** **SWBQS (3/15) 037 (a)**
The Committee received and noted the report.	
OTHER MATTERS	
11 Matters of topical or national media interest	**Verbal**
It was noted that the CQC had recently published its report on the Trust following the inspection in autumn 2014, a matter which the Board and Executive were currently directing much attention. Mr Samuda reported that the staff briefings around the recent publicity following the publication of the Care Quality Commission's report had been well received. It was noted that it had been identified that additional support might be needed for staff who would work regularly for the Trust on bank staff terms. Mr Ovington reported that further work was needed more fundamentally for bank staff as a whole. Ms Dutton suggested that this needed to be considered as a priority, including equality of pay rates for instance and a better means of incentivising staff. Mr Samuda reported that staff were embracing well the plans for quality improvement half days.	
ACTION: Mr Ovington to discuss plans to strengthen the development and management of bank staff with the Corporate Nursing team and the Director of Workforce & OD and to bring back a report summarising the plans in July 2015	
12 Meeting effectiveness	**Verbal**
It was noted that the meeting had been productive and some good discussions had been held.	
13 Matters to raise to the Board and Audit & Risk Management Committee	**Verbal**
It was noted that there were several matters to raise to the Board.	
14 Any other business	**Verbal**
There was none. Ms Binns reported that as an interim the Welsh National Chart would be implemented to address the position with controls to prevent the occurrence of a Never Event concerning maladministration of insulin.	
15 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to	

be 24 April 2015 at 1030h in the Anne Gibson Committee Room, City Hospital.	

Signed ……

Print ……

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** 19 December 2014 at 1330h

Members Present

Mr H Kang [Chair]
Dr P Gill [Part]
Mr T Lewis
Miss R Barlow
Mr C Ovington

In attendance

Mrs L Barnett
Mrs G Deakin
Mr J Pollitt
Mr J McGee (Hay Group)

Secretariat

Mr S Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies for absence were received from Richard Samuda.	
2 Minutes of the previous meetings	**SWBWO (9/14) 059**
The minutes of the meeting held on 26 September 2014 were approved subject to minor amendment.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meeting	**SWBWO (9/14) 059 (a)**
The Committee received and noted the updated actions log.	
3.1 DBS checks	**Verbal**
Mrs Barnett advised that the three year check would be suspended and work would be undertaken around the annual staff declaration to include a declaration around DBS.	
3.2 Junior doctors' conflict resolution training	**Verbal**

Mr Pollitt reported that in the revised matrix, a risk assessment would be undertaken and he had discussed the matter with the undergraduate tutors to pursue the matter. He reported that all junior doctors, particularly those in high risk areas continued to be trained in conflict resolution. It was agreed that a further update would be provided at the next meeting.	
ACTION: Mr Pollitt to present an update on Junior Doctor conflict resolution training at the next meeting	
4 Sickness absence hot spots – trajectories for reduction	**Hard copy**
Mrs Barnett reported that monthly case conferences continued and that overall sickness absence continued to be a concern. In terms of hot spot areas, there was mixed performance, with some areas performing and others deteriorating. It was noted that there were a number of contributory factors, including capacity and workforce review. Overall, it was noted that high sickness was the norm in some areas and therefore this would be a big focus for 2015/16. Surgery B was noted to have maintained a good level. Mr Kang noted the assertion that there was a link between leadership and sickness absence. Mrs Barnett agreed that this was the case and was evident through the case management approach. Mr Kang asked whether the latest position reported was as expected. He was advised that this was not the case, particularly in the Women & Child Health Group. It was noted that the Imaging Group was experiencing a significant pressure as a result of the workforce review, particularly as this covered all levels of seniority. Miss Barlow provided an overview of the workforce challenges and progress in the area and suggested that there was no anticipation that sickness absence would fall further. Long term sickness in the area was reported to be being addressed. Mr Pollitt noted the link to the performance management processes, where poor management appeared to be the delay behind some of the issues. Mr Kang noted that he had received some thanks from staff who had received a letter thanking them for not taking any time off sick. It was highlighted that this was contrasted with the feedback concerning cost of the initiative which had also been received. Mr Kang asked whether sickness absence was displayed outside ward areas. Mr Ovington advised that this was the case, although this was consistent or not updated routinely. Mrs Barnett advised that it appeared that this measure was effective initially, however this waned after time. It was noted that the greater effect would come from conversations about this on an ongoing basis. It was agreed a significant focus was needed on the matter in 2015/16, particularly given that the Trust's performance had deteriorated. Mr Kang asked what the link was to the work to address bank and agency. Mrs Barnett reported that there was some feedback that bank fill was difficult at present. Mr Ovington reported that filling vacancies had assisted with addressing bank and agency and also the work to implement a revised focussed care system which meant that ther	

way staff were used had changed. The big users of bank surgery were highlighted to be the big bed-holding Groups. It was agreed that sickness absence should be included on the agenda of the next meeting.	
ACTION: Mrs Barnett to provide an update on progress with addressing sickness absence at the next meeting	
5 Time to hire by professional group	**SWBWO (12/14) 062** **SWBWO (12/14) 062 (a)**
Mrs Barnett reported that for November, the data had been impacted by the workforce review, where vacancies were deliberately being carried pending conclusion of the redeployment process. The key measure of significance was closing date and interview date, which had improved, although needed to be a continued area of focus. Pre-employment check time was reported to have improved. It was reported that a local initiative was underway to improve the pre-employment checking process. It was reported that budgets were devolved in some areas, which included responsibility for filling vacancies. It was noted that there would be benefit of working from one finance and HR system for budgets and headcount. Mr Kang highlighted the need for this to be in place to facilitate accountability. It was noted that the turnover positon had risen to 12%. The proposal to issue the interview dates with the advert were reported to be delaying the vacancy approval process, therefore not all managers did this at present. It was suggested that KPIs needed to be set for parts of the vacancy approval process. Mr Kang asked whether the process for the vacancy approval could commence prior to the receipt of notice. Mrs Barnett advised that this needed to be considered for some generic roles, particularly in nursing. Mr Ovington reported that over recruitment was low risk, given the natural churn and therefore there was little harm in progressing with a generic recruitment initiative. It was suggested that the trends would be mapped going forward. Dr Gill joined the meeting. It was agreed that time to hire should be revisited at the March meeting.	
ACTION: Mrs Barnett to present the time to hire positon at the March meeting	
6 Proposal to increase notice periods for key staff groups	**Verbal**

Mr Lewis reported that the Board had asked the Committee to consider the plan to extend notice periods, particularly for some nursing staff in key positions, where notice periods were currently only four weeks. Mr Kang asked whether there was freedom to make this change. Mrs Barnett reported that the notice period was set locally. It was suggested that the practice in Walsall and Dudley be considered, with a view to discussing the proposal to make the change in early 2015 with the staff side. Mrs Barnett highlighted the potential cost implications of the suggestion in that bank and agency may need to be used, should staff finish their notice period with sickness.	
ACTION: Mrs Barnett to present an update on increasing notice periods at the next meeting	
7 JCNC feedback	**Verbal**
Mrs Barnett reported that a stocktake had been undertaken on the workforce review, which highlighted that the process had been acceptable overall, however the application Trustwide was inconsistent. Mr Kang asked whether there had been any follow up with managers where performance had been poorer than desired. He was advised that these discussions had been undertaken where necessary and development needs in this respect had been highlighted. Mr Lewis joined the meeting. He advised that a specific development process would be implemented in Facilities and that a wider view would be taken as to the development needs for the managers required to manage the process. Mr Lewis noted that the process had fallen down in areas where managers and their team did not meet regularly. It was noted that the process had generated a number of lessons learned, including making use of the workforce sessions mandatory future. It was reported that the formal proposals for Phase 2 would be discussed at the next JCNC meeting, including the use of a criteria-based selection process. It was noted that intense support was needed around Phase 2. Mr Pollitt reported that there was further consideration around the redeployment process and the training of individuals who were not fully 'up to speed' when first in post. It was reported that candidates were provided with assistance with their applications. Mr Lewis suggested that there was a need to publicise successfully redeployed individuals. Mrs Barnett reported that the process had provided a number of opportunities for individuals who would not normally have been shortlisted for some posts. Mr Lewis reported that work was needed to mainstream the process by which staff could offer themselves up for alternative roles in the organisation. Dr Gill highlighted that this approach could promote a positive view of opportunity and development in the organisation.	
8 Leadership development programme	**SWBWO (12/14) 063** **SWBWO (12/14) 063 (a)**
Mr McGee was welcomed to the meeting who provided an update on leadership	

development. Mr Pollitt presented the overview of progress with the leadership development programme to date, with the programme to be concluded in May 2015. It was reported that some of the cohorts had developed plans to bring around transformational change, including some that had made an application for the use of Charitable Funds. Mr Kang asked whether the changed behaviours were captured. He was advised that individuals were regularly canvassed about their changed behaviours and progress with their projects. It was reported that using the leadership competency framework would be used to run another 360 degree exercise to quantify changes as a result of the process. Mr McGee provided an overview from his perspective. Mr Lewis noted that the leadership development of medics and nurse leaders was well advanced and that the programme aimed to improve leadership in non-clinicians. Mr Pollitt reported that the feedback on the programme had been positive from those attending it. Mr Pollitt reported that alongside the programme, the new medical staff development programme was also running. Miss Barlow suggested that in additional to specialist leads, attention needed to be given to cancer lead roles and other medical roles. Mr Lewis agreed and suggested that work was needed to handle those that had not been included in the leadership programme. He added that much attention was needed to developing the corporate deputies and work was needed to plan to sequential development over and beyond the formal leadership development programme. He added that a view also needed to be taken as to how development was either aligned to current roles or for the next step for the individuals. Miss Barlow asked how the programme supported the integrated care ambitions. Mr McGee reported that the programme had originally been designed with this in mind, however the set up in teams had not prompted a focus on integration, a matter in hindsight was maybe a situation that was not as productive as possible. Mr Lewis reported that the governance improvement days would assist with this to a large degree. Mr Lewis asked how nursing leadership was progressing. Mr Ovington suggested that targeted programmes were needed through the internal programme and for others more specialised programmes were needed which prevented silos developing.	
9 Draft appraisal policy	**Hard copy**
Mrs Deakin presented the proposed revised approach to appraisal which included the plans to improve performance and develop potential. It was noted that the policy did not currently include 360 degree feedback consistently and it was	

proposed that this be mainstreamed for all team leaders and above. It was reported that completion of this would be monitored and the roll out process needed to ensure that the same people were not asked to complete the 360 degree feedback each time. It was reported that performance ratings were not included at present or potential target identified. Mr Kang noted that the communications around this needed to be carefully crafted to ensure that staff knew what good looked like. Directors were reported to be key sponsors around the plans and champions would be identified within the groups. Mr Kang asked whether ratings would be relative or absolute. He was advised that it was planned that these should be absolute. It was noted that a calibration process would be integral to the process and would also pick up diversity and other checks. Mr Kang asked whether there was a link to reward and development. Mrs Deakin reported that this was the case, although the detail was yet to be developed and there needed to be recognition that some individuals wanted excellence in their current role as opposed to other ambitions. Mr Lewis reported that a large number of staff did not have objectives and that the culture needed to change to achieve this. Dr Gill suggested that this needed to be tailored according to the role but needed to be aligned to the overall objectives of the organisation. It was reported that roll out would be from April 2015.	
10 Long term workforce plan	**SWBWO (12/14) 061** **SWBWO (12/14) 061 (a)**
Mrs Deakin outlined the progress with the long term workforce plan to achieve a reduction of 1400 WTEs. She provided an overview of the entire plan. The Committee was advised that at present the key focus was to support the Midland Met plans where an independent workforce review had been undertaken to reduce workforce costs and create integrated working. It was reported that over six weeks this project would be mobilised and would involve taking the benchmarking and brainstorming ideas. Mr Lewis reported that there was a need to ensure that there was no double counting and clarity on from where the next 600 WTE reductions would be derived. Mr Kang asked when the level of detail to get to the final ambition could be produced. He was advised that the short term plan needed to be confirmed as robust, after which the focus on the next 600 WTE reduction needed to be achieved. It was suggested that this element needed to be identified using a desk top approach.	
11 Update on the workforce consultation programme	**Verbal**
It was noted that this mater had been covered as part of other items.	
12 Workforce elements of the Board Assurance Framework	**SWBWO (12/14) 064** **SWBWO (12/14) 064 (a)**

The Committee received and noted the update.	
13 Integrated performance, quality and finance dashboard	**SWBWO (12/14) 065** **SWBWO (12/14) 065 (a)**
The report was received and noted.	
14 Matters to raise to the Board and Audit & Risk Management Committee	**Verbal**
Sickness process, leadership development, appraisal and workforce plans wpuld be raised to the Trust Board.	
15 Meeting effectiveness	**Verbal**
This item was not discussed.	
16 Any Other Business	**Verbal**
There was none.	
17 Details of the next meeting	**Verbal**
The next meeting is to be held on 27 March 2015 at 1330h in the D29 (Corporate Suite) Meeting Room, at City Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Configuration Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 31 October 2014 at 0800h

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

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies for absence were received from Dr Stedman.	
2 Minutes of the previous meetings	**SWBCC (9/14) 035**
The minutes of the meeting of the Configuration Committee held on 3 September 2014 were approved. It was noted that Mrs Hunjan was in attendance at the last meeting. Mr Lewis noted that the GP front end had been redesigned in the Midland Met. In terms of stroke care, it was reported that there was not expected to be a stroke tendering exercise at present. It was noted that the Trust incurred a significant loss on stroke at present, therefore the funding mechanism for this needed to be agreed.	
AGREEMENT: The minutes of the previous meetings were approved subject to minor amendment	
3 Matters arising from the previous meeting	**SWBCC (9/14) 035 (a)**
The Committee received and noted the updated actions log. In terms of the insolvency risk, Mr Lewis asked whether any insurance against insolvency of the subcontractors had been pursued. He was advised that this was not the case. Ms Robinson noted the risk of delay with the project should a	

subcontractor go into administration.	
4 Project Director status updates	
4.1 Midland Met update	**SWBCC (10/14) 038**
Mr Seager reported that the MMH plans were progressing well. The discussions and state of play in terms of the relationships with the bidders was outlined. Mr Lewis provided an update on the discussions with the Treasury. Financial close was reported to be by April 2016. Legal advice was reported to be being taken in terms of the position concerning the bidders. It was noted that it was likely that a proposition would be received from the bidders which satisfied the financial requirements of the Trust in this respect. Mr Seager reported that the demolition at the Grove Lane site was well underway and remediation was being prepared. It was noted that all of the surveys would be posted and a remediation plan would be devised which would be shared with the advisers and executed subsequently.	
4.2 Community Facilities	**SWBCC (10/14) 039**
Mr Seager reported that the community facilities work was progressing well in terms of agreeing the configuration of the retained estate.	
4.3 Managed Equipment Services	**SWBCC (10/14) 040**
The Committee was asked to receive and note the update.	
5 Midland Met business case process	**SWBCC (10/14) 041** **SWBCC (10/14) 041 (a)** **SWBCC (10/14) 041 (b)**
The process leading up to the final approval of the OBC was given by Mr Seager in outline. It was noted that the actual business case needed to be approved. It was reported that an interim had been appointed to project manage the business case development. It was noted that a stakeholder board would be established and consideration was needed as to the composition of this body.	
6 Gateway action plan	**SWBCC (10/14) 042** **SWBCC (10/14) 042 (a)**
The Committee received and noted the update.	
7 Midland Met project risk register	**SWBCC (10/14) 043** **SWBCC (10/14) 043 (a)**
Ms Lewsley guided the Committee through the Midland Met project risk register which had been revised in line with comments at the last meeting. It was suggested that the document needed to be aligned to the overall Trust Risk Register, including the way in which assurances are listed and cited. Ms Robinson suggested	

that the sources of independent assurance needed to be reflected. It was suggested that the alignment with the BAF was also needed. Ms Robinson asked that the wording of the TSP targets needed to be updated to reflect the current position.	
ACTION: Ms Lewsley to revise the MMH risk register in line with comments made at the meeting	
8 Managed Equipment Services business case	**SWBCC (10/14) 044** **SWBCC (10/14) 044 (a)**
Ms Lewsley reported that in July 2014, the detail of the managed equipment service had been considered and the aim was to get to the point for a preferred bidder for MES so that two bidders could discuss contract conditions and to get them involved in the design of the rooms that the equipment would be housed in. It was noted that the assumptions in the OBC for the equipment had been reviewed as part of the process and the scope of the equipment needed from an operational perspective had been considered, which identified that the OBC for the MES showed a moderate increase in cash flow and that the MES showed better value for money than other routes of equipment purchase. It was reported that the approvals process for the MES OBC had been reviewed, with the underlying capital cost of the equipment being c. £18m and a whole life cost of £47m. It was reported that the business case would be presented to Trust Board in due course. Mr Waite reported that the approval by the Trust Board would allow the procurement to be progressed expeditiously. He asked the Committee to note the addendum which was prepared as a result of a further review of the assumptions. In terms of affordability, it was noted that any issues were likely to be resolved as a result of a competitive procurement process. It was noted that a commercial joint venture was needed to support equipment in the BTC and that an extension would be needed to the current facility. Ms Robinson asked what procurement expertise was being sought to support this work. Ms Lewsley advised that two advisers were being used, including Pinsent Masons. It was reported that the transfer arrangements for the MMH, in terms of the fit out of the new hospital and service close down was needed to be established. The risks associated with this were discussed and the management of the mitigation was reported to be being managed by the Project Director. Ms Robinson suggested that additional commercial advice should be taken if needed. It was highlighted that the framework included all credible suppliers for the work. Mr Samuda asked whether VAT had been considered as part of the business case. He was advised that this was the case and the standard form contract and business case met the VAT regulations. Mr Waite reported that the economic analysis was dependent on the risk retention and there would be a series of scenarios for consideration. It was noted that the Board would be asked to approve the business case for	

submission to the TDA for approval which would allow the procurement process to commence. Ms Robinson noted the intention to establish a project group for the work and asked how the post project evaluation would work. Ms Lewsley advised that there was a need for a different set of individuals to make a judgement as to whether the objectives of the project had been met. It was suggested that this type of scrutiny was needed as part of the procurement process. It was noted that the reliance of the change management team needed to be considered into planning the workload of the individuals. The alignment between the Cath lab business case and the MES business case was outlined. Both were reported to be being channelled through the same procurement process and the governance requirements were shared. It was suggested that the business case needed to be presented in overview for the Board meeting, with the full document being available from the Trust Secretary.	
9 Clinical reconfiguration summary update	**SWBCC (10/14) 045** **SWBCC (10/14) 045 (a)**
Mrs Dunn reported that the revised diabetes model was now in place. Mr Lewis asked whether there was any formal evaluation intended of the model and was advised that it was likely that the CCG would undertake this. In terms of the impact of the new model, it was noted that some clinics had been closed as a result of this. In terms of Cardiology, it was noted that the key issue concerned engagement. Mr Lewis reported that agreement had been secured with the CCG that there was acceptance that we would reconfigure to a single interventional Cardiology unit. It was noted that plans would be discussed by the Overview and Scrutiny Committee with a view to agreeing whether public consultation was needed. The impact of any public consultation on the number of Cath labs was discussed. It was noted that a review of Cardiology by the Royal College of Physicians had been undertaken which would provide a view on the proposed configuration of the speciality.	
10 Surgical reconfiguration	**Hard copy**
The plans for surgical reconfiguration were discussed, with a single site for surgery at Sandwell Hospital being proposed. It was noted that there was a possibility that the CQC might provide a view on the current arrangements as a result of the recent inspection. The current model was outlined including the current arrangement of having a Surgical Assessment Unit at City Hospital. It was proposed that the SAU was to be decommissioned and patients would be diverted to Sandwell Hospital instead. It was noted that consideration was needed as to what service would be provided at City Hospital, including the provision for gynaecology patients. In terms of the key challenges, the Committee was advised that there was a proposal that female patients under 45 arriving with abdominal pain would be treated as gynaecology patients. The quality impact assessment for the plans was reported to be completed imminently. It was reported that the plans had been discussed with the	

CCG and the discussion would be furthered at the forthcoming meeting of the Overview and Scrutiny Committee. It was reported that the plans would be progressed with implementation in spring or summer of 2015. It was noted that approximately a third of patients arriving at the SAU we received by ambulance, which would need to be addressed with the ambulance service when the plans were implemented. A inter hospital transfer service was reported to be needed for patients who arrived by foot as part of the plans. Mrs Hunjan asked whether the gynaecology reconfiguration had needed public consultation. Mrs Dunn advised that this had not been needed. She asked with the risks associated with transferring patients between sites had been fully considered. Mr Lewis advised that there were clear transfer arrangements between Emergency Departments at present, which would need to be amended to provide greater robustness to support the plans, including out of hours provision. Mrs Hunjan asked whether provision for transport for family members had been considered. She was advised that this had been considered and it had been decided that this would not be provided. Mrs Hunjan asked what volumes of transfers were envisaged. Mr Lewis advised that this was c. 50 patients per month. Ms Robinson asked how the communications would be managed to ensure that the proposals were seen positively externally. Mr Lewis advised that the communications would centre on the provision of more rapid access to the service. In terms of other trusts, it was noted that there would be explicit communications with other local trusts. Ms Robinson asked how the plans impacted on flow through the Emergency Departments. Mr Lewis advised that when the transfers were arranged, then they would not need to be received through the Sandwell Hospital Emergency Department. The interdependency with the stroke reconfiguration plans was discussed and the decant facilities required. In terms of the space currently occupied by the current City Hospital SAU, it was reported that this would be 'stood down' or used to move Paediatric Assessment Unit closer to the Emergency Department. It was reported that any decisions would be made in early 2015. It was noted that there was solidity around the plans from the Clinical Leadership Executive. It was noted that the Overview and Scrutiny Committee's responsibility was to confirm that a reasonable consultation process had been undertaken, rather than to direct the plans. Mr Lewis reported that the financial implications had been thought through, which related to differences in on call arrangements and the level 1A beds.	

11 Meeting effectiveness	**Verbal**
It was noted that the meeting had over run. An additional item was to be added to the agendas of future meetings concerning matters to raise to the Audit & Risk Management Committee.	
12 Matters to raise to the Board	**Verbal**
It was reported that the MES business case, the project directors report and the plans for surgical configuration plans would be presented to the Trust Board. In terms of matters for the Audit and Risk Management Committee the alignment between the risk register to the Trust Risk Register and BAF was to be strengthened.	
13 Any other business	**Verbal**
There was none.	
14 Details of the next meeting	**Verbal**
The next meeting is to be held on 19 December 2014 at 0800h in the D29 (Corporate Suite) Meeting Room, at City Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit and Risk Management Committee – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 29 January 2015; 1400h

Members Present		**In Attendance**
Mrs G Hunjan	[Chair]	Mr A Bostock
Dr S Sahota		Mr G Palethorpe
Mr H Kang		Ms E Sims
		Mr A Hussain
		Miss K Dhami
		Mr T Waite
Secretariat		Mr T Lewis
Mr S Grainger-Lloyd		Mr M Zaman

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Ms Clare Robinson, Ms Olwen Dutton, Mr Bradley Vaughan, Mr Rob Chidlow and Mr Colin Ovington.	
2 Minutes of the previous meeting	**SWBAR (10/14) 058**
The minutes of the meeting held on 30 October 2014 were considered and approved as a true and accurate reflection of discussions held. It was noted that the reflection of the private meeting with the auditors needed to be highlighted.	
3 Matters arising	**SWBAR (10/14) 058 (a)**
The Audit and Risk Management Committee received and noted the updated actions log.	
4 Risk management and governance matters	

Minutes	Paper Reference
4.1 Amended Terms of Reference	**SWBAR (1/15) 002** **SWBAR (1/15) 002 (a)**
The Committee accepted the revisions to the terms of reference.	
4.2 Board Assurance Framework update	**Verbal**
Miss Dhami reported that an initial session to discuss the Board Assurance Framework (BAF) had been held, however further time needed to be set aside to discuss the way in which the BAF was to work in future. It was noted that the Q3 position needed to be developed and the BAF was to be prepared for 2015/16 which would be a refreshed version of the framework. Mr Palethorpe asked whether the Committees' feedback would be provided at the next meeting. Miss Dhami advised that this was the case and that the Committee agendas already included the BAF and discussed relevant entries. Mrs Hunjan suggested that consideration needed to be given to presenting a formal note of Committee discussions at the Audit & Risk Management Committee. Mr Lewis suggested that the BAF needed to considered in an informal board session and the linkages between the BAF, the annual plan and the risk register needed to identified and that this relationship was clear. It was noted that this work needed to be completed in April 2015.	
ACTION: Miss Dhami to arrange a further session to discuss the way in which the BAF would operate in 2015/16	
4.3 Audit and Risk Management Committee – self-assessment of effectiveness	**SWBAR (1/15) 003** **SWBAR (1/15) 003 (a)**
Miss Dhami reported that a self-assessment of the Committee's effectiveness featured in the annual cycle of business and a checklist had been circulated, however the response had not been good to date. It was suggested that the analysis of the results and the measures to improve the effectiveness would be highlighted. Mr Grainger-Lloyd was asked to recirculate the questionnaire.	
ACTION: Mr Grainger-Lloyd to recirculate the self-assessment questionnaire and arrange for the outcome to be presented at the next meeting	
4.4 Overseas visitors – write offs and new process	**Verbal**
Mr Waite reported that the actions raised at the last meeting would be	

Minutes	Paper Reference
progressed by Mr Zaman and that these would be completed by the end of Quarter 1. It was agreed that a note would be circulated outlining the scale of fees recovered from overseas visitors. Dr Sahota advised that sometimes it was difficult to identify patients that needed to reimburse the Trust when they had left. Miss Dhami advised that work was underway to include a check for all patients arriving at the Trust for treatment as a mandatory requirement. It was reported that a policy on overseas visitors would be presented for approval at the next Clinical Leadership Committee. It was reported that a pilot had been run for a short period to date. Mr Zaman reported that in his experience deposits would be taken from individuals and good measures could be put in place to ensure that recovery was as easy as possible. Miss Dhami advised that the Trust's consultants had a role in supporting the arrangements. Mr Kang returned to the recent patient story where the individual did not have the mental capacity to reimburse the Trust. Miss Dhami advised that in an emergency, care was automatically given, however with planned care measures could be taken to make family members and individuals aware of the need to make payment. Mr Lewis reported that the situation related more to elective care and he underlined that the matter was not a top priority for the Trust at present although work would progress. Mrs Hunjan noted that the number of write offs were significant however it was noted that this was not a major issue for the financial performance of the Trust overall. It was noted that changes to the EEA reciprocal arrangements was planned, which might impact on receipts by the Trust.	
ACTION: **Miss Dhami to provide an update on progress with embedding the overseas visitor policy at the next meeting**	
4.5 Data quality update	**SWBAR (1/15) 007** **SWBAR (1/15) 007 (a)**
Mr Waite reported that work had been done to strengthen data quality in the Trust although there was further work to do which would be picked up in part by the Internal Audit plan and through the finance team. It was noted that the kite marking work was pleasing. Mr Lewis reported that there were a number of actions that still needed to be completed and that the Performance Management Committee would take a hand in reviewing the work. Miss Dhami reported that a series of top tips on Data Quality had been developed and circulated. It was noted that progress with addressing data quality associated with RTT and single sex performance was not as would have been desired at present. It was noted that the e-outcome system roll out would assist with the RTT position and that the 52 week breach patients were still reported, which were people not on the active	

Minutes	Paper Reference
waiting list and therefore this needed to be a key area of focus. It was noted that there was little risk of harm as a result of this however. Mrs Hunjan asked whether other trusts were experiencing similar issues. Mr Palethorpe advised that this was the case elsewhere and as such, an extended disclosure needed to be referenced in the Annual Governance Statement 2014/15. It was suggested that further assurances would be reviewed after the roll out of e-outcome. Mr Bostock reported that data quality indicators and early warning mechanisms, using available technology, was of significant interest to Monitor as part of the assessment process.	
4.6 Governance pack: waived tenders; payment overpayments; losses & special payments	**SWBAR (1/15) 004** **SWBAR (1/15) 006**
Mr Zaman reported that a fuller governance pack would be prepared for the next meeting. It was reported that for April – December 2014, there had been 510 tender waivers, the majority being associated with single source tendering. Mr Waite reported that in line with the requests of the Committee and the review of procurement, a new single source form had been introduced which provided better recognition of categories and allowed better scrutiny by procurement and identification of instances when single source tendering was the only option, which was anticipated to show a benefit when next reported. Mr Palethorpe reported that better planning for contracts was an associated benefit of this work. It was reported that breaches of SOs/SFIs would be provided at the next meeting. Mr Kang suggested that instances of tendering where competition should have been undertaken needed to be made clear. Mr Waite agreed and advised that this practice would take some time to embed. Mr Lewis reported that some of instances were CEO approved, such as Meridian, and therefore some drafting amendments in the report were needed to avoid any misapprehension. It was also noted that the use of 'divisions' needed to be replaced by clinical groups and corporate directorates. Mr Bostock noted that the arrangement with the KPMG also needed to be removed. It was noted that further work was needed specifically with the Estates directorate to improve the position. In terms of salary overpayments, it was noted that 117 payments had been made, valued at £140k, although it was noted that this was relatively modest in overall payroll terms. Mr Zaman reported that recovery was usually swift and successful. It was highlighted that late notification of change in terms and work patterns and terminations was a key reason for the overpayments. Mr Kang noted that there was no automation of termination and he encouraged the team to consider a process improvement in this respect. Mr Zaman suggested that this could be	

Minutes	Paper Reference
included in a starter pack. Losses and special payments were discussed, of which there had been 232 cases totalling £341,000. It was noted that this included some write offs associated with overseas visitors. Mr Zaman reported that stock loss was minimal. Mrs Hunjan noted that good work had been undertaken to alleviate this issue over recent years.	
5 External Audit matters	
5.1 External Audit progress report and annual plan 2014/15	**SWBAR (1/15) 008** **SWBAR (1/15) 008 (a)**
Mr Bostock reported that the interim audit was due to commence in February 2015. It was reported that guidance around the quality accounts had not yet been received however it was likely that assurance around 18 weeks referral to treatment time performance would be included. The Committee was guided through the proposed plan for 2015/16, and the risks which included value of tangible assets, income recognition & associated fraud risk, management of override controls and reduction of paybill & restructuring costs. It was noted that the management of override of controls was a standard item in the annual audit. In terms of Value for Money, it was reported that the PFI and new hospital plans would be reviewed. Mr Waite reported that the VFM for the PFI arrangements including procurement were supported by Deloitte. Mr Lewis asked whether this decision had been reviewed in the prior year's audit and was advised that this was undertaken within a wider framework including financial resilience, efficiency and effectiveness. It was noted that the consideration of PF2 vs. other funding options was not within the remit of KPMG audit. Mrs Hunjan asked what progress had been made with pulling the process for the development of the annual accounts, quality account and AGM to a place earlier in the year. Mr Zaman reported that regular meetings with KPMG were held and a detailed plan for the annual report (including quality account) and annual accounts were in place. It was noted that the AGM would be held in June this year rather than September.	
5.2 Key accounting judgements 2014/15	**SWBAR (1/15) 009** **SWBAR (1/15) 009 (a)**
Mr Waite reported that there were a number of key areas of judgement around the development of the annual accounts and the Committee was asked to challenge and confirm these matters. It was reported that the matters concerned: consolidation of charitable funds, where the funds were noted to not be material to the Trust's accounts and therefore there was no need to consolidate them. In terms of the judgement around the	

Minutes	Paper Reference
treatment of provisions for repayment of transitional funding, it was proposed that a consistent accounting treatment be adopted and significant use of the balances had been seen during the year. Further judgements were highlighted to include valuation of fixed assets and recognition of Midland Met project costs as an asset under construction. The Committee supported the judgements proposed.	
6 Internal Audit matters	
6.1 Internal audit progress report and recommendation tracking	**SWBAR (1/15) 010** **SWBAR (1/15) 010 (a)**
Mr Palethorpe outlined progress made with the delivery of the internal audit progress report. It was noted that the Being Open review raised the issue of consistency of the application of the accepted process. In terms of recommendation tracking, it was noted that a number of actions remained open. It was reported that discussions were underway at an Executive level to address this position. Where recommendations had been completed, it was noted that follow up to confirm that this was the case had been undertaken. Mrs Hunjan noted that in some instances there had been no response received. Mr Lewis reported that the position would be presented to the Board as an enhanced means of oversight. It was suggested that the importance of the actions needed to tie into the organisation's risk matrix and registers. It was noted that the majority were already being tracked. Dr Sahota noted that time had moved on and some actions might no longer be relevant. Mr Palethorpe noted that this was picked up in discussions with the Executive. It was noted that some draft reports needed to be finalised by the Executive Leads. Mr Lewis reported that an escalation process needed to be implemented to flag this to himself should there be undue delay in agreeing the reports. Mr Lewis asked for the specification for the WHO checklist review to be sent to him. Mr Waite reported that the ledger review suggested that a number of areas needed to be revisited in terms of basic control areas as part of the next internal audit plan.	
ACTION: Mr Lewis to present the position concerning open internal audit actions to the Trust Board	
6.2 Counter fraud progress report	**SWBAR (1/15) 011**

Minutes	Paper Reference
Ms Sims presented an overview of the work of counterfraud since the last meeting. A proactive exercise was reported to be underway with respect of whistleblowing. Mr Lewis suggested that this needed to be tied into existing staff survey methodology. Mr Waite reported that the intention of the work was to baseline the position. Mrs Hunjan asked how community sites were targeted. Ms Sims advised that this was a matter she would discuss with her colleagues and report back at the next meeting.	
ACTION: Mr Vaughan to update the Committee on the method by which counterfraud activities extended to community staff at the next meeting	
6.3 Clinical audit – exceptions to report	**SWBAR (1/15) 012** **SWBAR (1/15) 012 (a)**
Miss Dhami presented the position on the 80 clinical audits in the plan. It was reported that the Trust was in a good positon against a number of national audits and the tracking was considered at Clinical Effectiveness Committee.	
7 Matters for information	
7.1 Reference costs	**SWBAR (1/15) 013**
The Committee received and accepted the report.	
8 Updates from the Chairs of the Trust Board Committees	**Verbal**
Mr Kang reported that the key matters of interest for the Workforce & OD Committee included sickness absence, which did not appear to be being addressed. Time to hire was also discussed, as was turnover and the workforce review and learnings from this. Dr Sahota reported that a bidding process for funds had been undertaken at the Charitable Funds Committee. It was noted that the reporting back process would strengthen in future.	
9 Any Other Business	**Verbal**
It was reported that Mr Palethorpe was leaving and was thanked for his contributions during his tenure.	
10 Date and time of next meeting	**Verbal**
It was noted that the date and time of the next meeting would be 23 April	

Minutes	Paper Reference
2015 at 1400h in the Anne Gibson Boardroom, City Hospital	

Signed:……..

Name:……

Date:……