Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Boardroom, Sandwell Hospital **Date** 25 April 2013; 1530h

Members

Mr R Samuda	(RSM)	[Chairman]
Dr S Sahota OBE	(SS)	[Non-Executive Director]
Mrs G Hunjan	(GH)	[Non-Executive Director]
Prof R Lilford	(RL)	[Non-Executive Director]
Ms O Dutton	(OD)	[Non-Executive Director]
Ms C Robinson	(CRO)	[Non-Executive Director]
Mr H Kang	(HK)	[Non-Executive Director]
Mr T Lewis	(TL)	[Chief Executive]
Mr R White	(RW)	[Director of Finance]
Dr R Stedman	(RST)	[Medical Director]
Miss R Overfield	(RO)	[Chief Nurse]
Miss R Barlow	(RB	[Chief Operating Officer]

In attendance

Mr M Sharon	(MS)	[Director of Strategy & OD]
Mr G Seager	(GS)	[Director of Estates & New Hosp Project]
Miss K Dhami	(KD)	[Director of Governance]
Mrs J Kinghorn	(JK)	[Head of Communications & Engagement]
Mrs C Rickards	(CRI)	[Trust Convener]

Guests

TBC

Secretariat

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

Time	Item	Title	Reference Number	Lead
1530h	1	**Apologies**	**Verbal**	**SGP**
	2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 28 March 2013 as a true and accurate record of discussions*	**SWBTB (3/13) 060**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (3/13) 060 (a)**	**SG-P**
	5	**Chair's opening comments and Chief Executive's report**	**SWBTB (4/13) 062** **SWBTB (4/13) 062 (a)**	**Chair/ CEO**
	6	**Questions from members of the public**	**Verbal**	**Public**
1545h		**PRESENTATION**		
	7	**Patient story**	**Presentation**	**LP**
1610h		**MATTERS FOR APPROVAL**		
	8	**Annual Plan 2013/14**	**SWBTB (4/13) 063** **SWBTB (4/13) 063 (a)**	**MS**
1625h		**MATTERS FOR CONSIDERATION AND NOTING**		
	9	**Safety, Quality and Governance**		

	9.1	Update from the meeting of the Quality & Safety Committee held on 19 April 2013 and minutes from the meeting held on 21 March 2013	SWBQS (3/13) 052	OD
	9.2	Quality report	SWBTB (4/13) 065 SWBTB (4/13) 065 (a)	RO/ KD/ RST
	9.3	Emergency Department Transformation Plan	To follow	RB
	9.4	Performance against Corporate Objectives – Quarter 4 update	SWBTB (4/13) 067 SWBTB (4/13) 067 (a)	MS
	9.5	Register of Seals 2012/13	SWBTB (4/13) 068 SWBTB (4/13) 068 (a)	SGP
1700h	**10**	**Performance Management**		
	10.1	Draft minutes from the meeting of the Finance & Performance Management Committee held on 19 April 2013	Hard copy	CRO
	10.2	Monthly finance report – Month 12	SWBTB (4/13) 069 SWBTB (4/13) 069 (a)	RW
	10.3	Monthly performance monitoring report	SWBTB (4/13) 070 SWBTB (4/13) 070 (a)	RW
	10.4	NHS Performance Framework & FT Compliance Framework report	SWBTB (4/13) 071 SWBTB (4/13) 071 (a)	RW
	10.5	Performance Management Regime – monthly submission	SWBTB (4/13) 072 SWBTB (4/13) 072 (a)	MS
	10.6	Update on the delivery of the Transformation Plan	SWBTB (4/13) 073 SWBTB (4/13) 073 (a)	RB
1730h	**11**	**Strategy and Development**		
	11.1	Foundation Trust application programme		
	▶	Monitoring report	SWBTB (4/13) 074 SWBTB (4/13) 074 (a)	MS
	12	**Any other business**	**Verbal**	**All**
	13	**Details of next meeting** *The next public Trust Board will be held on 30 May 2013 at 1530h in the Anne Gibson Boardroom, City Hospital* *Non-routine agenda items due to be considered at the meeting are:* • Health & Wellbeing update (DSOD) • Research strategy update (MD) • Assurance Framework update (Q4) (DG) • Committee annual reports (Committee Chairs) • Approve changes to the SOs/SFIs (DFPM) • Communications and engagement update (HCE) • Research strategy update (MD) • Staff survey report and action plan (CN)		

		• Directors' Register of Interests (DG)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 28 March 2013

Present		**In Attendance**	
Mr Richard Samuda	[Chair]	Miss Kam Dhami	
Ms Clare Robinson		Mr Graham Seager	
Mrs Gianjeet Hunjan		Mrs Jayne Dunn	
Dr Sarindar Sahota OBE		Mrs Jessamy Kinghorn	
Ms Olwen Dutton		Mrs Chris Rickards	
Mr Harjinder Kang		Mr John Cash	[Sandwell LINks]
Prof Richard Lilford			
Mr Mike Sharon		**Guest**	
Mr Robert White		Mrs Linda Pascall	[Assistant Director of Nursing]
Dr Roger Stedman		Ms Justine Irish	[Ward Sister]
Miss Rachel Overfield		Mrs Fiona Green	[Matron]
Miss Rachel Barlow			
		Secretariat	
		Mr Simon Grainger-Payne	

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
No apologies were received.	
2 Declaration of Interests	**Verbal**
There were no interests declared.	
3 Minutes of the previous meeting	**SWBTB (2/13) 037**
The minutes of the Trust Board meeting held on 28 February 2013 were	

approved.	
AGREEMENT: The minutes of the last meeting were approved	
4 Update on actions arising from previous meetings	**SWBTB (1/13) 019 (a)**
The Board reviewed the meeting action log and noted that there were no matters requiring escalation or that needed to be raised for the Board's attention.	
5 Chair and Chief Executive's opening comments	**Verbal**
The Chairman advised that he had met with several of the newly appointed Clinical Commissioning Group clinical leads during the month and that the session had been productive. The Board was advised that the Chairman had participated in the recent visit by the Department of Health to review the Trust's plans for the Midland Metropolitan Hospital. It was reported that the Chairman had opened the Learning Works facility, which he highlighted was a highly innovative idea which would encourage local people to work for their local hospital. Miss Overfield agreed that this was a very positive step for the Trust and that the current national agenda to engage public within the 14-18 age bracket had been supported by the opening of the facility. The Chairman advised that he had met with the Surgery B division management and also with Adrian Bailey, the MP for West Bromwich. Mr Sharon advised that a key activity with which he had been involved was the recent visit by the Permanent Secretary and Finance Director for the Department of Health, who had been guided through a patient journey to allow them to better understand the reason for the Trust's planned new hospital project. The Board was advised that during the month, the Trust had been awarded Trauma Unit status and that there had been a considerable amount of effort that had been directed into achieving this. It was highlighted that the reconfiguration of Stroke services had been completed and the opening of the acute stroke unit had been attended by a number of previous patients of the Trust and the media. It was highlighted that the stroke rehabilitation facility would be opened in June 2013. The Board was advised that the Trust had experienced unprecedented operational pressures which had resulted in longer than desired waiting times for patients to be seen in the Emergency Departments. Mr Sharon advised that staff had been thanked for their continued dedication during these circumstances. Ms Dutton and the Chairman added their thanks on behalf of the Board to these staff.	
6 Questions from members of the public	**Verbal**
Mr Cash noted that a number of national targets were not being met by the Trust and asked whether financial penalties would be incurred. Mr Sharon advised that no penalties had been incurred yet, however the Trust would be fined for failure to meet ambulance turnaround targets from April 2013. It was highlighted that underperformance against key targets had the potential to delay the Trust's application for Foundation Trust status. Mr Cash noted that following the recent 'Francis' review the Government was	

planning to introduce plans to ensure that trainee nurses worked initially as a Healthcare Assistant as part of their overall training programme. He asked whether this would be undertaken as a pilot within the Trust and how it would impact on the current Healthcare Assistant complement. Miss Overfield advised that there was little detail at present in terms of how the plans would work, however it was likely that the local universities would work with the Trust to modify the nurse training programmes. The Board was advised that the current training programme for nurses in the Trust was regarded as being sound, however the modified training programmes would be likely to require more ward-based training. It was reported that a joint party was working through the detail of revised training programmes. Mr Cash suggested that Robert Francis QC be invited to attend a Board meeting in future. Dr Stedman advised that the Trust Board through its committee structure was already focussed on the outcome of the 'Francis' report.	
7 Patient story	**Presentation**
Miss Overfield introduced the relatives of Margaret Eardley, a former patient of the Trust and a number of senior nursing staff who delivered a presentation which provided an overview of the care of Mrs Eardley during her time with the Trust. The presentation focussed on the experience of the patient on ward D17 at the end of her life, while the ward was closed due to an outbreak of Norovirus. Ms Dutton commented that the experience had been positive and she thanked the staff for the care they had shown Mrs Eardley. She asked whether there were any lessons learned for the Trust as a result of the experience. Ms Dutton was advised that in the circumstances when a ward was closed, although strict controls needed to be applied, discretion needed to be exercised to ensure each patient was treated appropriately and effectively. Mrs Pascall added that the closure of a ward could mean periods of tedium & isolation for patients and therefore the decision had been taken to provide complimentary access to television and telephones, however this had not been offered until towards the end of the outbreak. The Board was advised that a proactive approach had been taken to updating friends and relatives of patients. The Chairman thanked the staff on behalf of the Board for the informative and encouraging update.	
MATTERS FOR APPROVAL	
8 Trust Board cycle of business – 2013/14	**SWBTB (3/13) 046** **SWBTB (3/13) 046 (a)**
Mr Grainger-Payne presented the proposed cycle of business for the Trust Board for 2013/14, advising that the content and structure was largely unchanged from the previous year, being based on the Audit Commission's 'The Intelligent Board' publication and customised to include a number of local items. It was highlighted that the cycle of business had been refined to remove a number	

of items now considered by the committees of the Board according to their revised terms of reference. Mr Grainger-Payne also reported that there was likely to be a number of in-year changes to the cycle of business to reflect requirements arising from the recent 'Francis' report. Miss Overfield suggested that the remit of the new Workforce Assurance Committee needed to be built into the annual cycle of business. It was also suggested that an annual report from this Committee and the Charitable Funds Committee needed to be added to the reporting cycle. Subject to the amendments suggested, the Board approved its annual cycle of business.	
AGREEMENT: The Trust Board approved its annual cycle of business for 2013/14, subject to minor amendment	
9 Workforce and Organisational Development Assurance Committee terms of reference	**SWBTB (3/13) 047** **SWBTB (3/13) 047 (a)**
The Board was asked to resolve to establish a Committee of the Board to be known as the Workforce and Organisational Development Assurance Committee and to approve its terms of reference. Ms Robinson suggested that recruitment should be captured within the terms of reference and that the potential overlap and links with some of the audits undertaken that were discussed in other fora needed to be reflected. Subject to these minor amendments, the Trust Board approved the terms of reference for the Workforce and Organisational Development Assurance Committee.	
AGREEMEN: The Trust Board resolved to establish a Committee of the Board to be known as the Workforce and Organisational Development Assurance Committee and approved its terms of reference subject to minor amendment	
10 Use of the Trust Seal: contract supply of natural gas from 1 April 2013 to 31 March 2014	**SWBTB (3/13) 048**
The Board was asked to and approved the application of the Trust Seal to the gas supply contract that had been approved at the previous meeting.	
AGREEMENT: The Trust Board authorised the use of the Trust Seal to execute the contract with Eni Trading and Shipping Sp A (UK branch)	
11 Annual financial plan 2013/14	**SWBTB (3/13) 049** **SWBTB (3/13) 049 (a)**
Mr White presented the annual financial plan for 2013/14, which he highlighted had been considered by the Finance & Performance Management Committee at	

its previous meeting.

It was reported that the commissioning contract was usually settled by the end of February, however the changing arrangements concerning specialised commissioning had presented a delay to the process. The Board was advised that the contract settlement was anticipated by the end of April. Mr White advised that there was a prudent expectation that the income to be received would be £431m and that a net surplus of £4.6m would be set as an end of year target. It was reported that a reserve would be held for events that were not forecast as part of the usual plan.

The Board was advised that the financial plan included cost savings of £22.2m associated with the delivery of the Transformation Plan and that capital expenditure was anticipated to be £20.5m, including a higher balance towards medical equipment expense.

It was highlighted that there was an expectation that a shadow financial risk rating of 3 would be maintained throughout the year, the level at which the Trust could pursue its application for Foundation Trust status.

The Board was informed that a form of risk sharing arrangement would be pursued for financial penalties in 2013/14. Mr Kang asked whether the current year's scenario had been modelled in terms of fines and was advised that for the current year there would have been provision for any fines levied, however in 2013/14 the exposure was anticipated to be greater.

Prof Lilford asked whether assumptions had been built into the plan in terms of the required nurse staffing ratios. Mr White advised that the plan assumed that bed capacity would be kept open longer than originally anticipated and that nurse staffing budgets had, as a result, included an extra allocation.

Dr Sahota asked whether the IM & T requirements had been built into the plan. Mr White highlighted that an allocation of £1.2 - £2.0m had been allocated to HIS for this purpose. He was asked whether this amount was adequate for the plans proposed and the Board was advised that this was consistent with the requirements set out in the HIS strategy.

Mr Sharon asked the Board to note the risks associated with the absence of an agreed contract, however he advised that a series of high level meetings had been arranged to agree the final detail.

Mrs Hunjan asked whether the planned investment in statutory standards would retain the estates compliance at Level 2. Mr Seager confirmed that this was the case which complied with legislation.

Ms Robinson asked whether the financial plan took into account the bed reconfiguration plans. Miss Barlow advised that the 'bottom up' bed reconfiguration plan would be presented to the Quality & Safety Committee at a forthcoming meeting and the detail would be included in the financial plan. Ms Robinson asked whether it was likely that fewer beds would be open at the same

time in 2013/14. Miss Barlow confirmed that this was the case. Mrs Hunjan asked whether the forecast community bed position had been reflected in the plan. Mr White advised that these were included within the overall level of beds incorporated within the plan. The Board approved the financial plan for 2013/14, subject to agreement of the income position to be finalised with commissioners in April 2013.	
AGREEMENT: The Trust Board approved the financial plan for 2013/14, subject to agreement of the income position to be finalised with commissioners in April 2013	
12 Safety, Quality & Governance	
12.1 Update from the meeting of the Quality & Safety Committee held on 21 March 2013 and the minutes from the meeting held on 21 February 2013	**SWBQS (1/13) 012**
Ms Dutton's provided an outline of discussions that had occurred at the meeting of the Quality & Safety Committee. It was highlighted that the meeting of the Committee was the first at which feedback from the newly established Executive-led quality committees had been received. Key elements of the discussions at the meeting were reported to have been the lessons learned from mortality reviews; concerns over the length of time patients were waiting in Accident & Emergency Departments; potential penalties associated with under performance against the ambulance turnaround targets; concerns over the high usage of bank and agency staff use; safeguarding developments; deterioration against the indicators within the national inpatient survey and the Accident & Emergency survey. The Board was advised that the assessment against the Care Quality Commission's Essential Standard concerning 'care and welfare of people who use services' was currently at high red and that as such an investigation would be undertaken for discussion by the Executive Team and reported to the Board when concluded through the Quality Report.	
ACTION: Miss Dhami to report back on the reasons for the 'high red' status against CQC Essential Standard Outcome 2 at a forthcoming meeting	
12.2 Quality Report	**SWBTB (3/13) 051** **SWBTB (3/13) 051 (a)**
The Board was asked to consider the Quality Report, which it was advised had been discussed in detail at the Quality & Safety Committee on 21 March 2013. Miss Overfield highlighted that during the month, there had been a positive shift in terms of the number of falls and pressure sores. Overall, performance against a range of quality indicators on wards was reported to have improved. The Board's attention was drawn to performance against a number of areas rated as being at red status, however it was reported that there was an improvement from the	

previous month, mainly as a consequence of the continued recruitment of nurse staffing. One ward was reported to be closed due to an outbreak of Norovirus. Dr Stedman reported that compliance with the use of the World Health Organisation (WHO) checklist was currently pleasing and performance against the stroke targets was good. The Board was advised that a new acute stroke unit had opened at Sandwell General Hospital. Performance against the VTE assessment target was reported to be good. Dr Stedman advised that performance against the mortality review trajectory needed to be improved, however the distribution of the reviews was now more even across the specialities and overall there had been a reduction in the Trust's mortality levels. The Board was advised that a 'task and finish' group would be established to consider the differences in mortality levels between various parts of the Trust and that resources in addition to Dr Foster would be used to inform this view. Ms Dutton added that the work would also include consideration of the external influences on mortality, including public health matters. Prof Lilford cautioned against the use of statistical analysis to explain any variance but to look at individual cases. Dr Stedman agreed that there was a need to identify the particular deaths that needed to be reviewed in a targeted way. Ms Robinson suggested that the work on mortality should consider the clinical coding of palliative care cases. Dr Stedman advised that the Standardised Hospital Mortality Indicator (SHMI) did not include palliative care cases, whereas the Hospital Standardised Hospital Mortality Ratio (HSMR) did include these cases, however he agreed that consideration of the appropriate use of the palliative care code would be reviewed. Performance against the fractured neck of femur target was reported to be good at present. Ms Robinson advised that the Finance & Performance Management Committee had noted that the number of complaints being received into the Trust appeared to be in excess of responses being issued and therefore questioned the position in terms of a backlog of complaints. Ms Dutton advised that it was expected that some periods would experience a higher number of complaints being received than responses issued, however at present there was no backlog of complaints and therefore nothing of concern to highlight to the Board in this respect.	
12.3 Update on the performance of the Emergency Departments	**Hard copy paper**
Miss Barlow reported that the trend in the reduction in serious untoward incidents (SUIs) in the Trust's Emergency Departments (ED) continued to decline. It was highlighted that the dip in the number of open incidents was partly reflective of a number that at present remained unallocated to an investigating manager. The Board was assured however, that the Risk Management team had reviewed the incidents and had identified that there were none of serious concern. The Board was advised at the recent Emergency Care Assurance Group (ECAG) meeting, the directorate leadership team had presented a condition report which had brought closure to the application of Special Measures to the ED. It was reported that there remained further work to do however and therefore the ECAG would continue to meet for the foreseeable future and the actions required	

would be picked up by the delivery of the Integrated Development Plan.

In terms of overall performance, it was highlighted that all reporting trusts, with the exception of specialist organisations, were not meeting the waiting time target and that in terms of overall performance, the Trust was performing in line with the average position. It was reported however, that there had been an overall deterioration in the Trust's performance against the target, a situation which was currently exacerbated by a Norovirus outbreak and the associated ward closures. The Board was advised that recently a Level 4 status had been declared in terms of operational pressure, with the issue being compounded by the change in procedures used by ambulance trusts. It was reported that work was underway with the ambulance trust to pursue intelligent conveyancing, which would ensure that ambulance crews would deliver patients according to the trusts with capacity to handle them, rather than those that were within closest proximity.

The measures planned to achieve an improved level of performance in the ED were discussed and were highlighted to include decommissioning clinics in the ED and continuance of a GP service within the City Hospital ED. It was reported that the advertisement for the ED consultant posts would be issued shortly. The Board was advised that the ED team continued to operate a number of improvements, including some longer term actions focussed around estates and IT. In terms of capacity and flow, it was reported that the use of in-reach services and the iCARES model were being trialled, which was anticipated to improve patient experience. The Medicine & Emergency Care division was reported to have held an 'away day' and that there had been agreement that as from May 2013, the cover by medical consultants on site would be doubled. The Board was advised that the Trust had been encouraged to retain its current winter bed base until June 2013.

The 'soft' launch of the out of hours GP triage service (111) was discussed, which it was highlighted created a risk that the Trust would receive a higher level of people presenting in ED, therefore contingency plans had been put in place to mitigate this risk.

Miss Barlow advised that the proposed trajectory for achieving an improved level of performance against the ED target had been revisited and a view had been taken to end the trajectory to reach the 95% target to the end of Quarter 2. Mr Sharon advised that this proposal would be presented to the National Trust Development Authority for agreement. It was highlighted that the additional nurses currently being recruited would assist with the position. Miss Barlow advised that in terms of the future, leaders for the ED would be proactively sought.

Mr Kang asked for an indication of the proportion of the issue that was within the remit of the Trust to control. Miss Barlow advised that the position was partly reflective of circumstances both in Primary Care and within the wider Healthcare Economy. She was asked whether there was scope to collaborate with the ED of other trusts. Mr Sharon advised that there was scope for sharing the ambulance activity across the region in this respect. The Chairman emphasised the need for a

shared and co-operative approach to be adopted where possible. Dr Sahota asked by what magnitude activity had increased. Miss Barlow advised that as an indication, the levels of activity being experienced were currently higher than those of New Year's Eve, the time at which a peak in activity was generally seen. It was suggested that the levels of predicted activity should be shared at a future meeting. Prof Lilford commended the proposed plans to introduce weekend and out of hours cover by consultants. Miss Barlow advised that it was anticipated that the time of discharge would be brought to earlier in the day as a consequence. Ms Robinson observed that the trajectory for improvement was ambitious and asked what consequences would be incurred as a result of the commitment. Mr Sharon acknowledged that the trajectory was challenging, however he advised that the operational pressures in the first half of the financial year were traditionally less than in the latter. It was highlighted that the current performance had the potential to delay the Trust's application for Foundation Trust status if improvement was not achieved shortly.	
ACTION: **Miss Barlow to present an update on the delivery of the measures to improve performance of the Emergency Departments at the next meeting**	
12.4 Trust Board and Committee structure	**SWBTB (3/13) 052** **SWBTB (3/13) 052 (a)**
Mr Sharon presented the revised Board and Committee structure, which he asked the Board to receive and accept. Miss Dhami advised that a further version of the structure chart would be developed shortly to provide clarity on the remit of each of the new quality committees. Mrs Rickards commented that care needed to be taken to preserve the focus on Equality & Diversity and suggested that there was a need to ensure that Health & Safety was reflected in the remit of the committees. Miss Dhami advised that Health & Safety reported through the risk management structure which was reflected in the organisational chart. Miss Overfield advised that there was no plan to change the oversight of Equality & Diversity, despite some changes being forecast in terms of the staff supporting the area. The Board was advised in terms of these changes, that quality and safety assessments had been undertaken which confirmed that there were no likely adverse implications of the plans. Miss Overfield added that the Workforce area also handled Equality & Diversity matters.	
12.5 Board Assurance Framework	**SWBTB (3/13) 023** **SWBTB (3/13) 023 (a)**
Mr Grainger-Payne presented the Quarter 3 update on the plans to address the gaps in control and assurance against the risks to the delivery of the Trust's annual priorities.	

He reported that good progress has been made with addressing the gaps in control and assurance. The Board was asked to note that those risks rated as red, following the closure of the gaps in control and assurance related to: failure to deliver sustained improvement in safety and performance in the Trust's Emergency Departments as indicated in incident trends and performance and clinical indicators; underperformance against the Emergency Department four hour target; Data Quality in respect of reporting performance against the 18 week referral to treatment time target; and the impact on FT timescale regarding development & delivery of the Transformation Savings Plans & workforce reductions; the impact of lack of clear processes and agreement within the Clinical Commissioning Group (CCG) and reduced CCG engagement whilst new structure being established on the implementation of 'Right Care, Right Here' patient care pathways.	
13 Performance Management	
13.1 Draft minutes from the meeting of the Finance & Performance Management Committee held on 22 March 2013	**Hard copy**
Ms Robinson provided a summary of the discussions held at the meeting of the Finance & Performance Management Committee held on 22 March 2013. The Board was advised that the Committee had been made aware that the Trust's use of temporary nurse staff (agency and bank) was high at present, in response to the challenges with recovering the position caused by the delay in the delivery of the bed reconfiguration plan and the significant operational pressures faced by the Trust. It was reported that at the meeting, Mr White had advised the Committee that an agreed position regarding the funding settlement for 2013/14 had not been agreed with commissioners. It was reported that the Committee had been advised that the Transformation Savings Plans for the Medicine & Emergency Care division remained to be signed off. The Committee was reported to have been appraised of the significant operational pressures that the Trust and in particular, the Emergency Departments were experiencing at present. It was reported that the financial exposure as a result of fines associated with the current ambulance turnaround time position was potentially significant in 2013/14 had been highlighted. The consequential impact of the operational pressures on PDR rates, mandatory training and other performance metrics was reported to have been highlighted. It was reported that the Committee had been made aware that a number of Ophthalmology operations had been cancelled and that Miss Barlow was undertaking to assess the reasons behind this issue. The Board was advised that it had been reported that a revised format for the corporate performance report was under development, which would address the expectation that Trusts were routinely reviewing the Acute Trust Quality Dashboard. The Committee was reported to have been made aware that there was an expectation that the Trust would meet its statutory financial targets for 2012/13 and that the delivery of the Transformation Savings Plan for 2012/13 remained on track.	

A number of follow up actions were reported to have been commissioned at the meeting.	
13.2 Monthly finance report	**SWBTB (3/13) 054** **SWBTB (3/13) 054 (a)**
Mr White advised that there was an expectation that the Trust would deliver its revised forecast outturn position. It was highlighted that the Norovirus outbreak had impacted on both the Trust's operational and financial position.	
13.3 Monthly performance monitoring report	**SWBTB (3/13) 055** **SWBTB (3/13) 055 (a)**
Mr White presented the key exceptions in terms of performance across all major internal and external targets and asked the Board to receive and accept the performance and quality dashboard.	
13.4 NHS Performance Framework and FT Compliance Framework report	**SWBTB (3/13) 056** **SWBTB (3/13) 056 (a)**
Mr White advised that according to the NHS Performance Framework the Trust was classified as 'performing' and that the rating against the FT Compliance Framework was 'Amber/Green'. It was highlighted that the financial impact of any CQUINs not delivered in 2012/13 was expected to be minimal. Mr Kang asked whether the financial allocations for each CQUIN target were identical. Mr White advised that overall, the income attributed to the CQUINs was 2.5% of total resources, with some being allocated on a binary basis, with others being awarded on a gradient according to the level of achievement.	
13.5 Provider Management Regime monthly return	**SWBTB (3/13) 057** **SWBTB (3/13) 057 (a)**
Mr Sharon presented the proposed Provider Management Regime (PMR) return for submission to the Strategic Health Authority which the Board received and approved for submission.	
AGREEMENT: The Trust Board gave its approval to the submission of the Provider Management Regime return	
13.6 Update on the delivery of the Transformation Plan	**SWBTB (2/13) 028**
The Board was advised that the latest progress with the delivery of the Transformation Plan concerned reviewing the reporting processes and the Key Performance Indicators used to determine the progress with delivery of the Plan. The Board was advised that reporting would move to a quarterly basis in future, with the progress with the major workstreams being reported through the Finance & Performance Management Committee.	
14 Strategy & Development	
14.1 Foundation Trust application: programme director's report	**SWBTB (2/13) 030**

	SWBTB (2/13) 030 (a)
The Trust Board received and accepted the Foundation Trust programme director's report. Mr Sharon advised that the agreement of the milestones within the plan with the National Trust Development Agency would be reached through the current annual planning process.	
15 Any other business	**Verbal**
The Chairman, highlighting that the meeting would be the last at which Mr Sharon would be present in the capacity of Acting Chief Executive, thanked him for stepping into the role, particularly under such challenging operational circumstances.	
16 Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1530h on 25 April 2013 and would be held in the Boardroom at Sandwell Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 25 April 2013, Boardroom @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

28 March 2013, Anne Gibson Boardroom @ City Hospital

Members present: Mr R Samuda (RSM), Ms C Robinson (CR), Dr S Sahota (SS), Mr H Kang (HK), Mrs G Hunjan (GH), Prof R Lilford (RL), Ms O Dutton (OD), Mr M Sharon (MS), Mr R White (RW), Dr R Stedman (RST), Miss R Overfield (RO), Miss R Barlow (RB)

In Attendance: Mrs J Dunn (JD), Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Mr J Cash (JC) [Sandwell LINks]

Apologies: None

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 19 April 2013

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.233	Update on actions arising from previous meetings	SWBTB (9/12) 231 (a)	25-Oct-12	Present an update on the effectiveness of the ward leadership model at the December 2012 meeting of the Trust Board	RO	~~20/12/2012~~ ~~25/04/2013~~ 30/05/2013	To be presented firstly as part of a SIRG paper and then to the Board	Y
SWBTBACT.236	Workforce strategy	Hard copy paper	20-Dec-12	Provide an update on steps being taken to attract a greater number of apprentices into the Trust	RO	~~28/02/2013~~ ~~30/04/2013~~ 30/05/2013	Will be discussed at Workforce Assurance Committee as part of its cycle of business	Y
SWBTBACT.243	Monthly performance monitoring report	SWBTB (1/13) 005 SWBTB (1/13) 005 (a)	31-Jan-13	Arrange for open bed information to be reinstated within the corporate performance report	RW	~~28/03/2013~~ ~~25/04/2013~~ 30/05/2013	Format and content of corporate quality & performance dashboard is currently under review and a proposal is to be considered by the Finance & Performance Management Committee at its meeting scheduled for ~~April~~ May 2013	Y
SWBTBACT.235	Execution of a contract as a Simple Contract: building works for a Blood Sciences Laboratory at Sandwell Hospital	SWBTB (12/12) 287	20-Dec-12	Amend the SFIs/SOs to provide for more practical arrangements regarding contract signing	SG-P	~~14/02/2013~~ 09/05/2013	Included in version of SFIs presented to Audit Committee meeting on 14 February 2013 and due for ratification at the meeting of the Audit Committee planned for May 2013	G
SWBTBACT.245	Trust's initial response to the report of the Mid Staffordshire NHS Foundation Trust public inquiry	SWBTB (2/13) 032 SWBTB (2/13) 032 (a)	28-Feb-13	Present the baseline assessment against the recommendations within the 'Francis' report at the next meeting of the Quality & Safety Committee and Trust Board	KD	26/04/13	Handling of the Francis report response discussed at the Q & S Committee on 21/03/13. Agreed further work was needed to fully inform the response, particularly on those areas where a national positon needed to be agreed and soundings from staff needed to be taken. Further discussion about the response to the Francis report recommendations to be held at the Trust Board 'Time Out' session on 26/4/13. In the meantime, however work continues in parallel to address the areas that can be progressed, particularly those specific to professional groups.	G

SWBTBACT.246	Update from the meeting of the Quality & Safety Committee held on 21 March 2013 and the minutes from the meeting held on 21 February	SWBQS (1/13) 012	28-Mar-13	Report back on the reasons for the 'high red' status against CQC Essential Standard Outcome 2 at a forthcoming meeting	KD	30/05/13	Outcome 4 also now rated as being at 'high red' so investigation widened to include this. A discussion by the Executive Group is planned, after which time an update will be provided as part of the May 2013 Quality Report	G
SWBTBACT.247	Update on the performance of the Emergency Departments	Hard copy paper	28-Mar-13	Present an update on the delivery of the measures to improve performance of the Emergency Departments at the next meeting	RB	25/04/13	Included on the agenda of the April 2013 meeting	B

KEY:

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Chief Executive's Report
SPONSOR (EXECUTIVE DIRECTOR):	Toby Lewis, Chief Executive
AUTHOR:	Toby Lewis, Chief Executive
DATE OF MEETING:	25 April 2013

EXECUTIVE SUMMARY:

The attached is the first of a routine monthly update to the Trust Board from the perspective of the Chief Executive.

The report highlights the most important points contained within the Board's business for the month, to summarise the organisation's delivery and to indicate any specific priorities for the coming quarter, on which we need to focus additional attention, either as a Board or an Executive. The report highlights any particularly positive news for the Trust's patients, colleagues or the organisation as a whole.

REPORT RECOMMENDATION:

The Board is recommended to ACCEPT 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:

- The report alludes to a number of objectives, risks, standards and performance metrics that are picked up in further detail within a number of the Board reports.

PREVIOUS CONSIDERATION:

Routine monthly update to the Trust Board

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE PUBLIC TRUST BOARD

25th April 2013

Chief Executive's Report – April 2013

This is my first report to the Board, written after a mere nineteen days in post. The format of my monthly report will be adapted overtime, and feedback on it is welcome. My purpose is to highlight the most important points contained within the board's business for the month, to summarise the organisation's delivery at the time of writing, and to indicate any specific priorities for the coming quarter, on which we need to focus additional attention, either as a Board or an Executive. Finally, I will highlight any particularly positive news for our patients, colleagues or the organisation as a whole.

1. Patient care

Contained within the quality report is the falling friends and family test results we received last month. As with the gathering volume of other opinion survey material we collate and assess, it is important for us to understand what drives the views of respondents and what would persuade them to alter their views. Local understanding of that is crucial, and the Trust has some good practice examples of how local teams hear our patient's voices and act on the results. Whilst we will reflect on the Francis report (s) repeatedly over coming months, this pattern of listening and acting, both locally and organisation wide is a significant strength in keeping our care safe, if we can make it consistently the case.

Discussing where the care we have provided might not have been not good enough and being open when quality has fallen short is an important part of our commitment to learning. The latest data on completed mortality reviews within forty two days is disappointing, at only 49% of cases completed (a deterioration from prior performance in 1213). Dr Roger Stedman, aided by the newly in post associate medical director for clinical effectiveness and others, will work with teams to improve our quarter one compliance, and the results of that renewed focus will become clear at board level during quarter two.

There are three facets of care in April, and in March's data, which are highlighted in various reports and presentations in today's papers. Each form national minimum standards for quality (sometimes labelled targets) which we are committed to exceeding. As the review of 1213 shows we routinely did meet many of those standards but we need to discuss as a Board whether our

intended improvement plans in others are sufficient to remedy delivery. The three key issues for us presently are:

(I) non-compliance with the standard that nine out of ten patients or more should have a VTE assessment completed and recorded on our IT system

(ii) what lessons can be drawn from the patient with MRSA admitted to Sandwell Hospital in the second week of April and

(iii) our understanding of the key problems and solutions to our emergency care system's operational weaknesses, which have resulted in over 300 patients spending an hour prior to ambulance handover in March, and to four hour standard performance year to date in 1314 of 90.3%.

2. Workforce safety and employee engagement

By late June 2013 we will be ready to discuss as a Board our approach to future workforce numbers, the development of those colleagues, and our organisational development and leadership improvement model. The latter will form a key part of our Foundation Trust IBP. The former is a critical dependency in assessing our Long Term Financial model. Our immediate focus needs to be on tackling our vacancy rates in key professional groups and specific parts of the Trust. Vacancy rates, when combined with higher than anticipated sickness rates, place considerable strain on remaining colleagues in wards and departments, and bank/agency requests continue to grow, whilst fill rates do not. The Trust Management Board in the third week of May will devote the largest share of our cross-divisional and executive meeting to these issues to collectively understand what has worked best of the many local approaches tried over the last year, what has not yet been tried and needs reconsideration, and how rapidly we can ensure that our establishment levels on the ground match those risk-assessed as being appropriate in our funded plans.

April 19th saw the fifth anniversary of the Trust's award winning Listening into Action programme, and we held a celebratory event at St Andrews. This was well attended and gave us the opportunity to reflect on what has been achieved over time, both collectively and by some of our best performing teams. We will consider over coming weeks how we take forward the programme and ensure that it remains 'fresh' and effective in enabling colleagues to implement rapidly solutions to problems that they perceive in how their services work for our patients.

3. Regulatory compliance

As the main Board papers outline 1213 saw high level compliance with the NHS Trust performance framework. Increasingly we need to be able however to operate as a foundation trust, in advance of authorisation. As we begin quarter 1 of 1314 we have delivery concerns about elective wait times, not only in two key specialties, but also with the impact both of our backlog of

records previously reported to the board, and the cancellation and deferral effect of winter bed use planned care. Were our four hour emergency care performance to remain as poor as it has been in the opening three weeks of the month to date, we would experience an 'override' from Monitor on our rating later this quarter. This would take the form of swift escalated intervention with the chair and chief executive. Following the timetable for authorisation outlined in Mike Sharon's paper and submitted by Richard Samuda and I to the NTDA earlier this month, it is our 1314 quarterly performance operationally that will form a material part of the assessment of our organisation's fitness to proceed. The motivation for transforming our emergency care model is quality, but we cannot ignore the real impact continued failure would have on both the Midland Metropolitan Hospital and our foundation trust obligations.

The papers also highlight two areas of concern in the CQC tracking system, related to outcome four, arising from our inpatient survey results, and outcome two relating to consent. Whilst these matters will be discussed with the quality and safety committee, we should maintain a discussion within our Board about the sufficiency and pace of our plans to tackle the concerns raised. The new leadership team in our largest surgical division are fully focused on ensuring that consent follows in every case the process set out in law and guidance.

4. Partner alignment

Our Trust continues to enjoy a strong reputation in education, service and research for working in partnership with others. From April 1, new arrangements for the English NHS and in some regard for Local Authorities came into operation. These give us opportunities to further strengthen alignment. In particular Sandwell and West Birmingham CCG has appointed a large number of local principals to specialty and theme leadership roles. Our clinical directors in particular are being encouraged to work with these new leaders to take forward Right Care Right Here. The most recent partnership board accepted a proposal from accountable officers to develop a quantitative model for the changes that we need to make to out of hospital health and social care over coming years. This can only add resilience to our plans the midland metropolitan hospital. Meanwhile, our two key local authority partners face substantial financial challenges in 1314 and we are working with them, and with NHS partners across Birmingham and the Black Country, to implement changes to care that both enhance quality and reduce cost. In particular this is an opportunity for us to re examine how older people are looked after within our systems.

At the time of writing I am not able to confirm the status of the local area application for Academic Health Science Network (AHSN) authorisation. We are one of forty six partners within the bid proposal. I can confirm that the Trust submitted a strong supporting statement with match funding to the CLAHRC call for bids. Professor Lilford can advise the Board on the process followed from here and the benefits we seek locally.

5. Stroke services, gynaecology reconfiguration, and blood sciences

Since the Board last met, we have implemented the latest important changes to models of care across our two acute sites. We know that creating specialist high volume units for stroke care will save lives. In advance of any regional designation process this Trust reorganised all inpatient care onto our Sandwell site. The change has gone well and colleagues report, as do patients, very positively about both the new environment and the integrated team. From mid April the telemedicine solution to support remote working goes into place. The clinical director for stroke services is exploring how we take the opportunity of the changes to place more information about originality and morbidity in our service directly into the public domain.

Emergency gynaecology services have now been relocated onto the City site, after an extensive process of review and consultation internally and externally. As the service settles into its new location we will move to a truly seven day model of care with available diagnostic support. In July we will review audit data on the care of both patients transferred to gynaecology from Sandwell Hospital and those retained by general surgery on that site.

Further substantial investment has taken place on the Sandwell site over recent weeks with the relocation of blood sciences for the Trust to that campus. This location remains our intended plan alongside the midland metropolitan hospital. It further strengthens our pathology division to have singly located expertise, not least as we explore the range of partnerships available to us to ensure critical mass in pathology.

6. Feedback from clinical leaders across the Trust

The organisation has a simple and well developed internal communication model for talking and listening to senior leaders from departments, directorates and divisions, as well as corporate functions. At April's Hot Topics, I volunteered a commitment to précis for the Board the key issues of concern and debate raised with me at those monthly sessions by our leadership teams. The Board can hold the Executive to account for how we are tackling the subjects raised by those leading our teams. Over a hundred senior leaders attended sessions across three of our five principal sites.

- We heard continued suggestions that we have not yet reaped all of the benefits for patients of community health and acute care integration. This is recognised and plans will come to the May management board to reshape the structure of leadership in services to speed up improvements. At the same time we continue to discuss with CCG and LCG leaders how we work together to orientate community nursing resources to the needs of patients in partnership with GP practices.

- There was a strong message from leaders that we need to up the pace of change in implementing new IM&T solutions to improve quality and remove

paper processes. The Board is devoted a quarter of our upcoming timeout to this subject, and whilst we have an extensive implementation programme for 1314 including new systems in A and E and maternity services, we are also undertaking external visits to examine best practice in electronic patient records, conscious of the expiry of the national programme in three years time.

- A number of colleagues challenged us to be more explicit about how we intend to support innovation and reward excellence. The first round of beacon service designations takes place towards the end of May. I will launch the 2013 awards for colleagues at our Leadership Conference on April 30th. But the underlying issue is how many of our systems for managing performance can be amended to prioritise services that are succeeding. This should certainly form part of our discussions about how we operate as a foundation trust, and how we develop autonomy, accountability and pace in the way we lead the organisation 'from the middle'. These themes have already had some discussion within the executive, will feature in our own away day work in June, and will form part of the organisational development model cited above.

Toby Lewis
Chief Executive
April 19th 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Internal Annual Plan
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon (Director of Strategy and Organisational Development)
AUTHOR:	Jayne Dunn (Redesign Director RCRH) & Neetu Sharma (Head of Strategic Planning)
DATE OF MEETING:	25 April 2013

EXECUTIVE SUMMARY:

The Internal Annual Plan sets out the Trust's priorities for 2013/14 and provides a commentary on our current position, as well as a brief review of performance in 2012/13.

As part of the new monitoring arrangements, the Trust was required to submit annual planning documentation to the newly formed NHS Trust Development Authority (NTDA), to whom the Trust is now accountable. This annual planning document is consistent with the submission made to the NTDA in April 2013, and includes:

- **12/13 Performance and Key Achievements**
  - Developments within 'Safe, High Quality Care'
  - Performance against key standards and targets
  - Financial performance
  - Contractual performance
- **Planning Context**
  - Trust's long-term strategy
  - Review of external environment
- **Annual Priorities 2013/14**
  - Summary of Annual Plan
  - Key areas of focus (including FT and MMH)
  - Annual Priorities 13/14
  - Quality Improvement Priorities 13/14
  - Major developments
  - Enablers
- **Supporting Strategies**
- **Financial Plans 2013/14**
- **Risk Management**

We will monitor progress in delivering against the Internal Annual Plan through reporting to Trust Board and our stakeholders on a quarterly basis and by holding Directors and other staff to account for delivery through our individual performance management systems.

The Internal Annual Plan will be published on the staff intranet following approval from Trust Board. A short summary document will be provided for staff (attached to May 13 payslips) to provide key information regarding the Trust's priorities for 2013/14.

REPORT RECOMMENDATION:

The Board is recommended to APPROVE 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:

The Internal Annual Plan is aligned to the strategic objectives (see 'Summary Plan' for overview) and the corporate risk register, as well as national and local performance indicators.

PREVIOUS CONSIDERATION:

The NTDA Annual Plan submission was approved at March 2013 Trust Board.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

ANNUAL PLAN 2013/14

ANNUAL PLAN 2013/14

CONTENTS

Section 1 – Introduction

1.1 Introduction

The Trust has developed a five-year Integrated Business Plan (IBP) and supporting strategies to deliver our vision:

To improve the health and well-being of people in Sandwell, Western Birmingham and surrounding areas, working with our partners to provide the highest quality health care in hospital and closer to home.

In the context of our IBP this document sets out our plans for 2013/14 and provides a commentary on our current position. It sets out in detail our main priorities for action for the year ahead in order to achieve our strategic objectives. Our priorities can be summarised as:

- **Key Areas of Focus:** These highlight the significant overarching areas of focus for the organisation over the coming year, and underpin the Trust's annual priorities and major developments as outlined below:
    - **Annual Priorities**: The Trust Board has identified priorities for those areas that are considered important for the Trust to deliver this year. These have been shaped by the potential implications of changes in the external environment and have been developed with clinical leaders and senior managers .
    - **Quality Improvement Priorities**: A set of five quality improvement priorities have been identified based on areas where the Trust is a significant outlier in terms of performance benchmarks and relative position to comparative Trusts.
    - **Major Developments**: Key clinical and non-clinical service developments for 2013/14.

The following facilitate delivery of this plan:

- **Enablers**: Four key areas for support by the NHS Trust Development Authority (NTDA) in 2013/14.

- **Supporting Strategies**: the Trust's supporting strategies that underpin the delivery of the Trust's long-term strategy.

As part of the new structural arrangements in the NHS, the Trust was required to submit planning documentation for 2013/14 to the newly formed NHS Trust Development Authority (NTDA), to whom the Trust is now accountable. This document sets out our Annual Plan for 2013/14 and is consistent with the submission made to the NTDA in April 2013.

We will monitor progress in delivering on our priorities through reporting to our Board and our stakeholders on a quarterly basis and by holding Directors and other staff to account for delivery through our individual performance management systems.

Section 2 – Performance and Key Achievements in 2012/13

2.1 Developments within *'Safe High Quality Care'* - 2012/13

A detailed review of 2012/13 is included in the Trust's Annual Report 2012/13. Below is a selection of the key quality developments that have taken place during 2012/13.

Quality & Performance Indicators

- Delivered year 1 of the Quality & Safety Strategy
- Achieved Clinical Negligence Scheme for Trusts Level 2 (Maternity Services)
- Delayed Transfers Of Care: 2.3% for period April – December (5.7% corresponding period last year).
- Transient Ischaemic Attack (low risk) patients treated within 7 days of presentation: 78.4% for period April – December (16.0% for corresponding period last year).
- Hip Fractures (Operation within 24 hours of admission) for period April – December: 75.0% (69.4% for corresponding period last year).
- Stroke Patients (CT scan within 1 hour of arrival) for period April – December: 53.9% (44.4% for corresponding period last year).
- Out Patient Follow Up to New appointment ratio for period April – December: 2.25 (2.66 for corresponding period last year).

Clinical Service reconfigurations

- Trauma & Orthopaedics – all inpatients consolidated at Sandwell Hospital site to give a single inpatient unit, and confirmed validation as a Trauma Unit for both City and Sandwell Hospital sites.
- Stroke - consolidated all inpatient Stroke and Neurology services and Transient Ischemic Attack outpatient clinics at Sandwell Hospital with enhanced staffing levels that are in line with nationally recommended levels.
- Breast Surgery – all services now based in the Birmingham Treatment Centre allowing the best use of modern facilities, equipment and experienced staff and to facilitate the use of day surgery and ambulatory treatments.
- Gynaecology – all inpatient services consolidated at City Hospital alongside the Gynae-oncology Unit.
- Vascular Surgery- inpatient service transferred to the Queen Elizabeth Hospital in Birmingham as part of a single Vascular Network. Day case surgery & outpatient clinics still delivered locally at City & Sandwell hospitals.

Expansion of community services and integrated care

- We delivered Year 2 of our Health Visitor Strategy and related expansion in health visitor numbers in Sandwell, to reduce the caseload for each health visitor in line with national standards.

Specialist Services

- We established one of three national Centres for Behçet's Disease in partnership with specialist clinicians in neighbouring Trusts.

2.2 Performance against key targets and standards 2012/13

The Trust continues to monitor and report its performance against a wide range of national and local targets as well as the range of indicators associated with nationally mandated, and locally agreed CQUINs (Commissioning for Quality and Innovation). A summary of the Trust's performance to date during 2012/2013 against these key indicators is outlined in **Appendix A**.

The Trust continues consistently to meet the performance thresholds of the majority of indicators contained within the national performance assessment frameworks (i.e. the National Health Service Performance Assessment Framework and Monitor Compliance Framework). The principal exception to this is performance against the Accident and Emergency 4-hour wait target of 95%, where performance has fallen short of this during recent months. Additionally, although all high level Referral to Treatment Time pathway targets have been met for the year to date, delivery of the Admitted and Incomplete pathway targets within the specialty of Trauma and Orthopaedics remains problematic.

2.3 Financial Performance 2012/13

The Trust is forecasting a year end surplus of £5.7m which is £2m in excess of the original performance target set by the Department of Health.

The Trust achieved surpluses of £2.2m and £1.9m in the previous two financial years.

Table 1: Financial Performance 2010/11 – 2011/12 (projected)

£ million	2010/11 Outturn £m	2011/12 Outturn £m	2012/13 Plan £m	2012/13 Provisional Outturn £m
Income	387.9	422.4	422.8	428.1
Expenditure	(364.2)	(399.6)	(397.6)	(399.6)
Operating Surplus (EBITDA)	23.7	22.8	25.2	28.5
Financing Costs	(30.4)	(18.3)	(20.9)	(22.4)
Net surplus/(deficit)	(6.9)	4.5	4.3	6.1
DH technical adjustments	9.1	(2.6)	(0.6)	(0.4)
Surplus/(deficit) against DH target	2.2	1.9	3.7	5.7
Surplus as % of Income	0.6%	0.4%	0.9%	1.3%

For 2012/13, the Trust initially set a Transformation Programme target of £25.7m. Following an in year review of the Trust's financial performance and the impact of activity pressures on operational capacity, the Transformation Programme was revised downwards to £24.1m. This lower target remains in excess of the nationally required efficiency target inherent within PBR tariffs for the year. Based on current in year performance, the Trust remains on target to deliver the revised programme in full by the year end.

The projected outturn capital expenditure for 2012/13 is approximately £19.5m, primarily comprised of:

- £3.0m for further land acquisition in Grove Lane in preparation for the Midland Metropolitan Hospital;
- £4.7m of statutory standards and estates risk related expenditure,
- £3.2m of estates rationalisation schemes,
- £3.6m of medical and other equipment,
- £2.9m for service reconfiguration
- £1.2m of HIS and other IT projects.

2.4 Contractual Performance 2012/13

The Trust worked closely with commissioners in 2012/2013 to ensure that contracting intentions continue to align with Right Care Right Here (RCRH) trajectories, including the definition of £10m re-commissioning targets promoting the planned shift of activity out of the acute sector into community and primary care. The risk sharing approach agreed in 2011-2012 was rolled forward and modified to reflect the experiences of the previous contracting year. The table below summarises the Trust's high level activity for 2009/10 – 2011/12:

Table 2: Contract Delivery – Forecast Outturn 2010-13

Patient Type	2010-2011 Outturn	2011-2012 Outturn	2012-2013 Plan	2012-2013 Forecast Outturn	2012-2013 vs 2011-2012 %*
Admitted Patient Care (Spells):					
Day cases	50,425	53,657	46,483	46,345	-13.63
Electives	11,720	10,620	10,854	10,268	-3.31
Emergencies	61,163	57,404	55,986	61,375	6.92
Unbundled	21,034	16,530	15,653	16,879	2.11
Total	**144,342**	**138,211**	**128,976**	**134,867**	**-2.42**
Outpatients (attendances):					
New Consultant Led	157,789	154,136	144,954	155,392	0.81
Review Consultant Led	424,476	404,266	383,346	367,990	-8.97
Non Consultant Led		105,408	96,851	131,123	24.40
With Procedure	20,452	19,730	19,787	34,480	74.76
Total	**602,717**	**683,540**	**644,938**	**688,985**	**0.80**
A&E Attendances	218,211	214,744	207,352	203,143	-5.40
Rehabilitation OBDs	22,081	13,561	13,560	13,324	-1.75
Neonatal OCDs**	10,100	11,994	11,731	12,007	0.11
Birth Spells	6,128	5,560		5,999	7.90
Referrals	182,645	167,906		174,422	3.88
Community Contacts		636,563	671,215	739,559	16.18

NB. Births are also included in the emergency spells totals in the first section of the table

** Percentage changes from 2011-2012 outturn*

*** Transitional care cot days included in the contract from 2011-2012*

Reductions in planned admitted patient care demonstrate the continued movement along the RCRH trajectory, particularly emphasising the shift towards treatment within the outpatient environment as procedures carried out within outpatients increased significantly over previous years. Similarly, increases in community contacts demonstrate the shift of activity out of the secondary care arena. Forecast Accident and Emergency attendances reduced by more than 5% compared to 2011-2012, demonstrating the increased value of primary care triage and treatment interventions put in place during 2012-2013. An increase in births of almost 8% is indicative of the strengthening of the maternity service following reorganisation during 2011.

Section 3 – Planning context

3.1 Trust's long-term strategy

As set out in our IBP, the Trust's long –term strategy in summary is to further develop and sustain the highest quality integrated and seamless health care services for our local population, both in hospital and closer to home. In delivering this ambition, we will drive innovative solutions to achieve the best possible health outcomes for our population. Our aims, the intentions of our commissioners and the funding outlook for the NHS mean that in general terms our secondary care activity will reduce slightly, while our community based services will grow. However, in a small number of targeted areas, where we believe our position and market conditions permit, we intend to grow our activities for example in Ophthalmology and Gynae-oncology.

A key supporting strategy is the Right Care Right Here (RCRH) Programme which has been developed over the last eight years with our local partners including our main commissioners. The Programme aims to:

- Improve the ability of the health and social care system to support individuals to maintain their own health and well-being.
- Increase the proportion of health services provided in or closer to people's homes.
- Support the long term sustainability of the health economy through the development of modern, efficient and fit for purpose buildings both in acute and community settings.

One element of delivering the overall RCRH approach is the plan for the Midland Metropolitan Hospital (MMH): please see section 4.2 for further detail.

Acting consistently with a core set of values, we will pursue our vision through a set of six strategic objectives which will shape our long term direction and short term delivery through annual planning.

Table 3: SWBH Strategic Objectives

Six core strategic objectives	
Safe, High Quality Care	We will provide the highest quality clinical care. We will achieve the goals for 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 Facilities	We will ensure our services are provided from buildings fit for 21st century healthcare.
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.

3.2 Review of external environment

From April 2013, a number of structural changes within the health system as prescribed by the *Health and Social Care Act (2012)* will be implemented. This broader set of changes across both the commissioner and provider landscape will have implications for the Trust and it will be important that the Trust develops relationships with those new key partners.
Following the publication of the Francis Report, The Trust Board has provided an initial response to the recommendations made within the Report and will be ensuring the actions required are incorporated into the relevant Trust processes and strategies.

A summary of the key significant changes are highlighted below:

Changes to commissioning arrangements

From April 2013, NHS England will commission specialised services, primary care services, offender healthcare and some services for members of the armed forces. NHS England will have 4 regional and 27 local area teams. A Midlands Regional Office and Birmingham, Solihull and Black Country Local Area Team (LAT) have been established. The percentage of our income in 2013/14 that will be commissioned via NHS England and the respective Local Area Team is approximately 14%.

Clinical Commissioning Groups (CCGs) from April 2013 have taken on the majority of commissioning responsibilities previously undertaken by Primary Care Trusts. Sandwell and West Birmingham CCG (SWB CCG) will be the main commissioner for the Trust. This serves to benefit the Trust as the CCG catchment will be virtually co-terminus with the main population that the Trust serves. It will be important for the Trust going forward that strong relationships with SWB CCG are maintained. The percentage of our income in 2013/14 that will be commissioned by SWB CCG is approximately 64%.

A key feature of the changing commissioning landscape is the prospect of greater procurement and tendering of services by commissioners. This includes the use of Any Qualified Provider (AQP) which is now firmly established as another procurement tool that commissioners can choose to utilise to procure services. A number of our services are more susceptible to be subject to procurement by commissioners going forward, for example community services.

Changes to provider arrangements

NHS Trust Development Authority

From April 2013, the role of the NHS Trust Development Authority (NTDA) is to provide governance and accountability for NHS trusts in England and delivery of the foundation trust pipeline. The Trust will be accountable to the NTDA for both performance but also delivery of the FT timeline and the Tripartite Formal Agreement (TFA) which is summarised later in this annual plan. The Trust submitted its detailed plans for 2013/14 to the NTDA at the beginning of April.

Other Key Changes

Education and Training

A new National body, Health Education England (HEE) has been established as part of the health reforms. Local Training Boards (LETBs) have been developed with the intention to ensure the security of supply and on-going development of the multi-professional workforce. The West Midlands LETB (WMLETB) will execute these responsibilities through five Local Education and Training Councils (LETCs) that are the NHS provider led bodies responsible for ensuring the education, training and development of the workforce and that skills strategies are developed. The Trust is represented on both the Black Country LETC and the Birmingham and Solihull LETC.

Health and Well Being Boards/Healthwatch

Health and Wellbeing Boards (HWB) are due to take on their statutory roles from April 2013. Each HWB will have a local Healthwatch representative. Healthwatch is a new independent consumer champion for health and social care in England**.** There will be separate Heath and Well Being Boards for Birmingham and Sandwell.

Section 4 – Annual Priorities 2013/14

This Annual Plan sets out our priorities for 13/14 in order to achieve our strategic objectives.

4.1 Summary of Annual Plan 2013/14

A summary plan has been developed which looks at how the Annual Plan incorporates the strategic objectives at every level. This covers the following:

- Key Areas of Focus 2013/14
- Annual Priorities 2013/14
- Acute Quality Dashboard – Quality Improvement Priorities 2013/14
- Major Developments 2013/14

Further detail on each of these can be found in the following sections:

  - Detail on the Key Areas of Focus can be found in section 4.2;
  - Detail on how the annual priorities for 2013/14 relate specifically to the strategic objectives can be found in section 4.3.
  - More information about the Quality Improvement Priorities can be found in section 4.4
  - Section 4.5 provides more detail on the major developments we will be pursuing in 2013/14.
  - Further detail on the specific support requested from the NTDA with respect to areas of development in 2013/14 is included in section 4.6.
  - Section 5 provides more detail about 2013/14 plans for our supporting strategies.

Summary Plan – Internal Annual Plan (2013/14)

Sandwell and West Birmingham Hospitals NHS Trust

Key

- ✓ (filled) Strategic objective it makes biggest contribution to
- ✓ Other strategic objectives it contributes to

Our Vision

To improve the Health and Well-being of people in Sandwell, Western Birmingham and surrounding areas, working with our partners to provide the highest quality health care in hospital and closer to home.

	Safe, High Quality Care	Accessible and Responsive	Care Closer to Home	Good use of Resources	21st Century Facilities	An Engaged & Effective Organisation
Overarching Priorities						
Safe, High Quality Care	✓	✓				✓
Improvements to the way we provide care for emergency and acutely unwell patients	✓	✓				
Further delivery of the Transformation Programme & 2013/14 TSPs	✓	✓		✓		✓
Develop Health Informatics systems	✓			✓		✓
Make progress with Midland Metropolitan Hospital (MMH) and Foundation Trust application	✓	✓			✓	✓
Annual Priorities						
Deliver Year 2 of the Quality & Safety Strategy	✓	✓				✓
Deliver all CQUINs	✓			✓		
Improve emergency readmission rates	✓					
Consistently achieve the national A&E targets	✓	✓				
Waiting times in at least 90% of specialities will be at least as good as neighbours		✓				
Deliver year 1 of our Dementia Strategy and support to carers	✓	✓				
Increase our range of alternative models to face to face contact		✓	✓			
Pilot the process of developing GP letters with a view to providing patients and GPs with clinical letters within 2 working days		✓				
Develop comprehensive marketing plans for at least 3 services		✓				
Reconfigure a number of services across acute & community to provide integrated care			✓	✓		
Implement a number of RCRH pathways	✓	✓	✓	✓		
Implement a virtual ward in the community	✓		✓	✓		
Establishing 15 wte Health Visitors posts & reduce caseload	✓		✓			
To deliver year 2 of the Transformation Programme without compromising safety & quality of care	✓	✓		✓		
Deliver a 1-2% surplus				✓		
Enable clinically-led decision-making processes via SLR as part of SLM	✓			✓		✓

Key

✓ Strategic objective it makes biggest contribution to

✓ Other strategic objectives it contributes to

Our Vision

To improve the Health and Well-being of people in Sandwell, Western Birmingham and surrounding areas, working with our partners to provide the highest quality health care in hospital and closer to home.

Annual Priorities	Safe, High Quality Care	Accessible and Responsive	Care Closer to Home	Good use of Resources	21st Century Facilities	An Engaged & Effective Organisation
To refresh financial modelling for Midland Metropolitan Hospital via PF2	✓		✓		✓	✓
Maintain estates compliance with CQC outcome 10 ('Safety and suitability of premises') and 11 ('Safety, availability and suitability of equipment')	✓				✓	
Invest in the estate through capital schemes to support clinical strategy and in particular Pathology, Endoscopy & Stroke	✓				✓	✓
To deliver the milestones in the Foundation Trust timeline						✓
To improve our performance in the National Staff Survey	✓					✓
Review of Health Informatics systems and capabilities	✓			✓		✓
Attain 10% better than the national mean for sickness/absence rates	✓			✓		✓
Identify 3 beacon services	✓	✓				✓

Acute Quality Dashboard: Improvement Priorities	Safe, High Quality Care	Accessible and Responsive	Care Closer to Home	Good use of Resources	21st Century Facilities	An Engaged & Effective Organisation
• Emergency readmission rates	✓	✓				
• A & E re-attendance / patients seen within 4 hours	✓	✓				
• Complaints per 1000 episodes	✓	✓				✓
• VTE assessment rate	✓					
• Sickness/absence	✓					✓

Major Developments	Safe, High Quality Care	Accessible and Responsive	Care Closer to Home	Good use of Resources	21st Century Facilities	An Engaged & Effective Organisation
• Stroke	✓	✓				
• Pathology	✓			✓		
• Clinical Haematology	✓					✓
• Health Visitor Strategy	✓		✓			
• Cardiology: PPCI	✓			✓		
• Emergency Care	✓					✓
• Develop a model for Frail Elderly	✓	✓				
• Dementia	✓	✓				
• Community Respiratory services	✓		✓			
• End of life care provided 7 days a week	✓	✓	✓			
• Options: Medical Day Case Unit - Sandwell	✓			✓	✓	
• EPR	✓			✓	✓	✓
• Renewal of PACS	✓			✓		
• Electronic Chemotherapy Prescribing System	✓			✓		

4.2 Key Areas of Focus for 13/14

These highlight the significant overarching areas of focus for the organisation over the coming year in progressing our long term strategy and delivering our strategic objectives. They underpin the Trust's annual priorities and major developments.

Safe, High Quality Care

Providing safe, high quality care is critical to the delivery of all that we do. There are a number of key deliverables that support achievement of this. Key areas of focus include working with our staff to develop a culture that empowers and enables staff to deliver compassionate, safe high quality care and front line services.

Further priorities we have developed which contribute to delivering this aim are:

- Improvements to the way we provide care for emergency and acutely unwell patients
- Further delivery of the Transformation Programme & 2013/14 Transformation Saving Plans (TSPs)
- Developing our Health Informatics Systems
- Make progress with the Midland Metropolitan Hospital (MMH) & our Foundation Trust (FT) application.

Foundation Trust application

The Trust has revised the timeline for production of key documents as part of our FT application in view of the Treasury review of Private Finance Initiative (PFI) and the announcement of the Trust scheme as a possible example for implementation of the revised arrangements. The following table outlines the proposed timetable for the Trust's FT application:

Table 4: Revised FT timeline

Programme Stage/Activity	Proposed Timeline
1. Submission of updated New Hospital financial model to the Department of Health / NTDA	End of May 2013
2. Approval of the Outline Business Case financial model	October 2013
3. Repeat Board Governance Assurance Framework (BGAF) external assessment	End of October 2013
4. Historical Due Diligence (HDD) 2 refresh	Beginning of November 2013
5. Final external validation of Quality Governance self-assessment	End of November 2013
6. Fully revised IBP/Long TFM – submission (dependent on	End of November 2013

point 2 above)	
7. Submit Quality Governance external validation	End of December 2013
8. NTDA Board Readiness Assessment	End of January 2014
9. FT Quality visit/assessment	Beginning of February 2014
10. Final IBP/LTFM – submission	End of February 2014
11. Final Board 2 Board with NTDA [dependent on steps above]	April 2014

Midland Metropolitan Hospital

The Midland Metropolitan Hospital (MMH) Project forms part of the RCRH Programme which will address significant health inequalities and improve care across the local area.

The Outline Business Case (OBC) was originally approved by the Department of Health (DH) in August 2009 to clear the way for the Trust to acquire the land at Grove Lane. The Trust now owns the land.

The MMH project will be an early adopter of the Government's new Private Finance 2 (PF2) model. The Project Team is in the process of updating the financial model which underpins the OBC. This takes PF2 into account. It is anticipated that the updated financial modelling will be approved by the Department of Health, NTDA and Treasury later in 2013. The Trust is looking to gain approval to allow procurement for MMH to commence by December 2013.

4.3 Annual Priorities 13/14

In our five year IBP the Board has set out high level measures of progress for each of our six strategic objectives. This has been the starting point for identifying our annual priorities for 2013/14. As part of the Annual Planning process, the proposed priorities were communicated and discussed at a membership event as well as at meetings of senior clinicians and leaders across the organisation.

The tables overleaf set out for each strategic objective the high level measures of progress and the specific annual priorities for 2013/14.

Safe High Quality Care

High Level Measures of Progress

This means that we will:

- Deliver our Quality and Safety Strategy
- Achieve a year on year measurable reduction in preventable harm to patients
- Achieve a Net Promoter score for inpatient adults of 85 by March 2018
- Develop further our systems for reviewing mortality rates and making improvements

Related 2013/14 Priorities

- Deliver Year 2 of the Quality & Safety Strategy
- Deliver all CQUINs
- Improve emergency re-admission rates to achieve at least the national mean

Accessible & Responsive Care

High Level Measures of Progress

This means that we will:

- Meet all national access targets year on year
- Ensure that our services are perceived as at least as culturally sensitive as those of our neighbours and those measured by local and national patient surveys
- Be perceived by GPs as more responsive to their needs than our competitors
- Strengthen our reputation as a provider of safe, high quality care to those who access our services

Related 2013/14 Priorities

- Consistently achieve A&E target of 95% of patients seen within 4hrs, and reduce ambulance turnaround response times
- Waiting times in at least 90% of specialities will be at least as good as neighbours
- Deliver year 1 of our Dementia Strategy and support to carers (High Impact Innovation)
- Increase our range of alternative models to face to face contact: Digital First (High Impact Innovation)
- To pilot the process of developing GP letters to provide patients and GPs with clinical letters within 2 working days
- Develop comprehensive marketing plans for at least 3 services

Care Closer to Home

High Level Measures of Progress

This means that we will:

- Achieve greater integration of community services with both acute and primary care allowing seamless patient care and care closer to home in line with RCRH
- Meet RCRH activity projections for reducing demand for acute care through investment in alternative models of care
- Reduce Health Visitor caseloads in line with national recommendations by 2016
- Increase the proportion of our beds that are non-acute

Related 2013/14 Priorities

- Reconfigure a number of our services across acute & community to provide integrated care; i.e. Diabetes, Respiratory, Cardiology & MSK
- In partnership with the CCG and other partners, implement a number of RCRH pathways during 2013/14
- Implement a virtual ward in the community
- Establish 15 wte additional Health Visitor posts and reduce caseloads

Good Use of Resources

High Level Measures of Progress

This means that we will:

- Deliver our 5 year Transformation Programme of £125m TSPs
- Ensure we meet FT financial governance measures
- Use Service Line Management (SLM) to devolve decision making and inform corporate decisions

Related 2013/14 Priorities

- To deliver year 2 of the Transformation Programme without compromising safety and quality of care
- Deliver a 1-2% surplus
- Enable clinically-led decision-making processes via SLR as part of SLM with the aim of achieving Level 3 of Monitor's self-assessment criteria by March 2014

21st Century Facilities

High Level Measures of Progress

This means that we will:

- Deliver Midland Metropolitan Hospital (MMH) when circumstances allow
- Support compliance with Care Quality Commission (CQC) registration
- Invest in the estate through capital schemes to support clinical strategy

Related 2013/14 Priorities

- To refresh financial modelling for MMH via PF2 and submit to DH/NTDA by June. Subject to approval, commence procurement in December 2013
- Maintain estates compliance with CQC outcome 10 ('Safety and suitability of premises') and 11 ('Safety, availability and suitability of equipment')
- Invest in the estate through capital schemes to support our clinical strategy and in particular for 2013/14: Pathology, Endoscopy & Stroke

Engaged & Effective Organisation

High Level Measures of Progress

This means that we will:

- Become an NHSFT
- Develop a culture that empowers and enables staff to deliver compassionate, safe high quality care and front line services
- Develop our health informatics systems to reduce variability and ensure safe, error free and efficient care
- Identify and promote our 'beacon' or specialist services

Related 2013/14 Priorities

- To deliver the milestones in the Foundation Trust timeline including final submission by February 2014 (subject to progress with MMH)
- To improve performance in the National Staff Survey
- Review of our Health Informatics systems and capabilities as a basis for delivering the Health Informatics Strategy
- Attain 10% better than the national mean for sickness/absence rates

4.4 Acute Quality Dashboard – Quality Improvement Priorities 2013/14

The Acute Trust Quality Dashboard brings together indicators from various sources providing an indication of quality across the 5 domains of the NHS Outcomes Framework. As part of the NTDA annual plan submission, the Trust identified areas where we were significant outliers in terms of performance benchmarks and our relative position to comparative Trusts and set improvement targets for each.

The table below shows the five 'improvement priorities' included in the NTDA annual plan submission:

Table 5: NTDA 'Improvement Priorities'

No.	Improvement Priority	SWBH Sept 2012	National Mean	Improvement Plan
1	Emergency Re-admission - 30 days non-elective - 2 days non-elective - Babies within 30 days	 14.20% 3.18% 11.27%	 13.08% 2.50% 7.15%	Attain national mean for emergency re-admissions
2	A&E re-attendance A&E patients seen within 4 hours	7.6% 95% (YTD Q3 93.25%)	6.9% 94%	Improvement target: 5% Consistently attain national target: 95%
3	Rates of written complaints per 1000 episodes	5.14	4.43	Reduce by 5% year on year
4	VTE risk assessment rate	90.9%	93.3%	Attain national target: 95%
5	Sickness/absence – nurses & midwives	4.7% (Nurse) 6.1% (Midwife)	4.2% 4.5%	Attain 10% better than national mean for these groups

The Trust has developed an action plan for each of the areas of improvement listed above to ensure that individual targets are met in 2013/14.

4.5 Major Developments

The key service developments identified for 2013/14 fall into five broad categories. These are:

- **Clinical Service Reconfigurations** :
  In order to improve the quality of services with identified deficiencies, to ensure future clinical sustainability and in response to wider strategic drivers, we have undertaken a number of clinical services reconfigurations over the last 5 years. We have identified a number of other clinical services with the potential need for reconfiguration ahead of the opening of MMH.

- **Integrated Care including RCRH New Models of Care and expansion of our Community Services:**

  We will continue to be active partners in the RCRH Programme and will also work in partnership with primary care clinicians and SWB CCG to develop and implement new service models and innovative ways of working that deliver seamless patient care across different settings.

- **Improvements to Emergency Care and Care of the Frail Elderly:**

  We will develop our emergency care and frail elderly services in partnership with SWB CCG in order to ensure safe, high quality care, early senior assessment , alternative pathways to admission where clinically appropriate, integrated care and supported discharge.

- **Improvements to our Health Information System:**

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

- **Expansion of our Community Services**

Individual key service developments are described in more detail in Table 6 below.

Table 6: Key service developments for 2013/14

Service Development	Summary of the Development	Link To Strategic Aim	Impact on Activity, Income, Expenditure, Workforce and Capital	Commissioner Support	Key Risks	Progress in 2012/13	Expected Progress in: 2013/14 2014/15 2015/16	Link to Integrated Business Plan and LTFM
Clinical Service Reconfigurations:								
Stroke and TIA Services	Completion of our reconfiguration to consolidate Stroke, TIA and inpatient Neurology services at Sandwell Hospital. Extending the Sandwell Stroke Early Supported Discharge (ESD) Team to cover West Birmingham residents within S&WB CCG. Wider SHA Strategic Review	Safe High Quality Care	*Capital Cost:* £2.8m (across 2012/13 & 2013/14) *Revenue Cost:* Overall reduction in wte but increase in skill mix with additional cost of £103k per annum *Additional Revenue Cost:* £554k & £80k set up costs *Additional wte:* 7 wte health staff 10 wte care staff	SHA, PCT Cluster & local CCG support CCG support requested in contract discussions	Extended ESD not supported by CCG with resulting increased length of stays in hospital.	5 year Elderly Care and Stroke Services Strategy Developed. Single stroke service in SWBH. Embedding Sandwell stroke ESD service.	2013/14: Refurbishment of the rehabilitation ward (Newton 4) & the permanent location for the second CT scanner at Sandwell, embedding the new clinical pathways and service models and evaluating the outcomes. 2013/14: Expand the Trust's stroke ESD team.	Identified as a service development.

Table 6: Key service developments for 2013/14

Service Development	Summary of the Development	Link To Strategic Aim	Impact on Activity, Income, Expenditure, Workforce and Capital	Commissioner Support	Key Risks	Progress in 2012/13	Expected Progress in: 2013/14 2014/15 2015/16	Link to Integrated Business Plan and LTFM
	of Stroke Services commenced in 2012/13 and is expected to report early in 2013/14 with a recommendation for a reduced number of larger hyper-acute and acute stroke units. This is likely to be subject to public consultation on the recommendations followed by a process to identify the designated units. Our aim is to become a designated unit which will require further expansion of our new Acute Stroke and Neurology Unit at Sandwell.		To be confirmed following outcome of Strategic Review.		Not being designated a Hyper Acute and/or Acute Stroke Unit.	Participation in Strategic Review with submission of data.	Report from Strategic Review: early 2013/14 Public consultation: 2013/14 Designation of Hyper-Acute and Acute Stroke Units: 2013/14 Implementation : to be confirmed	Activity and financial impact will be included in IBP and LTFM when outcome of Strategic Review known.
Clinical Haematology – inpatient services	Review of inpatient services for Clinical Haematology to identify the best inpatient configuration ahead of the new single site Acute Hospital (MMH). Options include consolidation of Clinical Haematology inpatients on one site.	Safe High Quality Care	To be confirmed as part of Business Case	Will require CCG and LAT support	Potential loss of Level 2b designation for Clinical Haematology-Oncology. Adverse peer reviews	Review process initiated. Clinical Case for Change presented to Clinical Reconfiguration	2013/14: Development and short listing of options. Further staff and patient engagement. Formal public	Identified in IBP as potential clinical service development.

Table 6: Key service developments for 2013/14

Service Development	Summary of the Development	Link To Strategic Aim	Impact on Activity, Income, Expenditure, Workforce and Capital	Commissioner Support	Key Risks	Progress in 2012/13	Expected Progress in: 2013/14 2014/15 2015/16	Link to Integrated Business Plan and LTFM
						Programme Board with agreement to progress to next stage.	consultation (if considered appropriate) Business Case for Preferred Option 5 year Clinical Haematology Strategy to be developed. 2014/15: Implement preferred option	
Cardiology – Interventional Service	Review of Cardiology Interventional Service and in particular PPCI (Primary Percutaneous Cardiac Intervention)_to identify the best service model and configuration ahead of MMH. Options include consolidation of PPCI on one site.	Safe High Quality Care	To be confirmed as part of Business Case	Will require CCG and LAT support	Potential wider review of PPCI in Birmingham and reduction in the number of hospitals commissioned to provide PPCI.	5 year Cardiology Strategy Developed. Review project set up.	2013/14: Development and short listing of options. Further staff and patient engagement. Formal public consultation (if considered appropriate)	Identified in IBP as potential clinical service development.

Table 6: Key service developments for 2013/14

Service Development	Summary of the Development	Link To Strategic Aim	Impact on Activity, Income, Expenditure, Workforce and Capital	Commissioner Support	Key Risks	Progress in 2012/13	Expected Progress in: 2013/14 2014/15 2015/16	Link to Integrated Business Plan and LTFM
							Business Case for Preferred Option 2014/15: Implement preferred option	
Pathology	NHS Midlands and East SHA tender of Community GP Pathology Services.	Good Use of Resources	To be confirmed as part of project.	SHA led review with commissioner involvement	*Business:* Potential loss of community GP work . Potential impact on staff retention and recruitment whilst tender process underway.	Partnership developed with local NHS provider and a private provider in order to respond to the tender. PQQ submitted March 2013	2013/14 If successful PQQ submit to next stage of tender process. 2014/15: Implement outcome of tender.	Regional review of Pathology identified as a short/medium term development in IBP. Not included in LTFM as outcome of review not known.
	Rationalisation of Cytology Screening.	Good Use of Resources	Loss of service and income; TUPE of some staff	PCT Cluster led	Potential loss of Birmingham work	Agreement to centralise cytology services in the Black Country at Wolverhamp	Full implementation of Black Country centralisation. Similar process for Birmingham	

Table 6: Key service developments for 2013/14

Service Development	Summary of the Development	Link To Strategic Aim	Impact on Activity, Income, Expenditure, Workforce and Capital	Commissioner Support	Key Risks	Progress in 2012/13	Expected Progress in: 2013/14 2014/15 2015/16	Link to Integrated Business Plan and LTFM
	New integrated automated laboratory at Sandwell Hospital - first phase of an integrated pathology service for blood sciences and the long term plan to accommodate the main Pathology Services on the Sandwell Hospital site.	21st Century Facilities & Good Use of Resources	*Phase 1: Capital cost:* c£2.95 million *Net Savings:* 2013/14:£189k 2014/15:£516k 2015/16:£675k 2016/17:£752k	Not required	Uncertainty regarding future strategic configuration of Pathology Services.	ton Work on first phase commenced	2013/14: Completion of Capital work with new laboratory becoming operational in summer 2013	Identified as a medium term service development. Activity and financial impact included in LTFM
Integrated Care and expansion of our Community Services:								
Health Visiting Service	Development of Sandwell Health Visiting Service and expansion in numbers of Health Visitors in line with national standards for Health Visiting – reducing caseload for each Health Visitor from an average of 650-800 to 274.	Safe High Quality Care	*2012/13-2014/15: Total Additional Wte: 41* *Total Additional revenue costs:* £1.8m	Commissioners have agreed funding for an additional 15wte Health Visitors in 2013/14.	*Business:* Recruitment to additional posts. Location costs for additional posts. Identifying most appropriate location for Health Visitors to meet service and GP requirements.	Additional 15wte Health Visitors recruited	*Additional revenue costs:* £638k in 2013/14 and further £383k in 2014/15 *Additional wte:* *2013/14:* 15wte *2014/15:* Additional 11wte	Development and expansion of community services identified in IBP. Income to be reflected in LTFM.

Table 6: Key service developments for 2013/14

Service Development	Summary of the Development	Link To Strategic Aim	Impact on Activity, Income, Expenditure, Workforce and Capital	Commissioner Support	Key Risks	Progress in 2012/13	Expected Progress in: 2013/14 2014/15 2015/16	Link to Integrated Business Plan and LTFM
					Service to be commissioned by NCB from 2013/14			
Community Respiratory	Expansion of the Sandwell community respiratory team including further development of community spirometry service, integration of cardiac and pulmonary rehabilitation and bronchiectasis IV service	Care Closer to Home	*Additional revenue cost:* c.. £100k	CCG support requested in contract discussions	Failure to reduce hospital admissions	Introduction of extended hours and 7 day service	2013/14: Expansion of service	Development and expansion of community services identified in IBP.
Palliative & end of life care	Expansion of the palliative care team to provide 24/7 telephone advice and 7 day a week visiting service that will support patients in hospital and at home in Sandwell and West Birmingham.	Care Closer to Home	*Additional revenue cost:* £100k	CCG support requested in contract discussions	Failure to meet Cancer Peer Review Standards	5 year Palliative and End of Life Strategy developed.	2013/14: Introduce expanded team, 24/7 telephone advice and 7 day a week visiting service. 2014/15: Provide dedicated support for Care homes	Development and expansion of community services identified in IBP.
Emergency Care and Care of the Frail Elderly:								
Emergency Departments	Additional medical and nursing staff including	Safe, High Quality	*Additional revenue cost:*	Not required	Delays in recruitment	Recruitment started	2013/14 - 2014/15:	

Table 6: Key service developments for 2013/14

Service Development	Summary of the Development	Link To Strategic Aim	Impact on Activity, Income, Expenditure, Workforce and Capital	Commissioner Support	Key Risks	Progress in 2012/13	Expected Progress in: 2013/14 2014/15 2015/16	Link to Integrated Business Plan and LTFM
	improved skill mix and new roles to ensure high quality , safe services with extended on site senior cover, improved quality of care, new pathways of care and improved patient experience. Explore options to improve layout of City ED	Care	£2.28m *Additional wte:* 6 cons 4 middle grades 21.3 nurses 10.22 admin & clerical		Increased incidents Not meeting national A&E targets with related fines	Pilot CDU started at City Project set up to review options to improve layout of City ED	Recruit additional staff Set up CDU both sites (subject to outcome of pilot) Business Case to improve layout of City ED	
Medical Day Case Unit	To set up a medical day case unit at Sandwell in order to provide appropriate alternatives to inpatient admission.	Good Use of Resources	To be confirmed as part of Business Case	Will require CCG support	Failure to reduce admissions and use of inpatient beds for day cases		2013/14: Explore options and develop Business Case 2014/15: Implement approved option	Transfer of activity from inpatient to day case is included in the IBP.
Model of Care for Frail Elderly	Develop a model of care for frail elderly patients focused on reducing admissions, ensuring early specialist assessment and management post admission and reduced length of stay.	Safe, High Quality Care	To be confirmed as part of Business Case	May require CCG support	High emergency admissions, readmissions and longer length of stay.	5 year Elderly Care and Stroke Services Strategy Developed. Consultant Ortho	2013/14: Develop model of care and action plan. Develop any related Business Cases. Start to implement service redesign.	Reduced emergency admissions in IBP

Table 6: Key service developments for 2013/14

Service Development	Summary of the Development	Link To Strategic Aim	Impact on Activity, Income, Expenditure, Workforce and Capital	Commissioner Support	Key Risks	Progress in 2012/13	Expected Progress in: 2013/14 2014/15 2015/16	Link to Integrated Business Plan and LTFM
						Geriatrician appointed		
Dementia	Implement our Dementia Strategy to include environmental enhancements and workforce training to meet National Dementia strategy	Accessible and Responsive	*Capital Cost:* £50k	Bid submitted for external funding. SHA project money to be transferred from CCG to support project lead.	Funding not secured which will limit environmental improvements and exemplar wards	Dementia Strategy being developed	Finalise Dementia Strategy and deliver year 1 including exemplar wards and commence workforce training plan.	
Health Informatics System								
Delivery of our Informatics Roadmap	Review and stabilise core elements of the informatics infrastructure and commence the delivery of key systems identified for replacement.	Safe, High Quality Care	*Capital cost: Capital Cost in 2013/14:* £2m *Revenue:* Proportional review cost associated with system replacements	Commissioner support will be required when the Trust meets the needs of the Local Health community	Sustainability of IT infrastructure to support informatics roadmap. Capability and capacity of the organisation to take advantage of the new	Developed our Health Informatics Strategy and related Informatics Roadmap Delivery of the Informatics improvemen t plan	2013/14: Develop a strategic outline case for the Electronic Patient Record (EPR) replacement Replacement of the Radiology Information System/PACS.	The delivery of the Health Informatics Strategy is reflected in the IBP.

Table 6: Key service developments for 2013/14

Service Development	Summary of the Development	Link To Strategic Aim	Impact on Activity, Income, Expenditure, Workforce and Capital	Commissioner Support	Key Risks	Progress in 2012/13	Expected Progress in: 2013/14 2014/15 2015/16	Link to Integrated Business Plan and LTFM
					services offered. Data quality and real data entry management	Procurement of the maternity replacement solution Deployment of the Radiology and Pathology business continuity solutions	Replacement of Chemotherapy Prescribing System	

4.6 Enablers

As part of the NTDA Annual Plan submission, the Trust was asked to include suggested areas of development where the NTDA could provide support and further training opportunities. Each of these enablers were discussed and approved by the Board, with suggestions in italics as to how the NTDA can support the Trust:

- **Achieving Midland Metropolitan Hospital via the revised Private Finance Initiative (PFI) scheme 'PF2'** - e*arly engagement to determine role in approval process*
- **Emergency Department flow -** *Workforce and best practice assurance processes. Leadership development.*
- **Delivering Workforce Assurance Tool** - *Face to face training.*
- **Further development of Service Line Management (SLM)** - *Sharing best practice. Facilitating benchmarking clubs.*

Section 5 – Supporting Strategies

We have developed a range of strategies to facilitate the delivery of the Trust's IBP and ultimately facilitate delivery of our strategic objectives. Each supporting strategy has a number of annual targets and objectives. The key objectives to be delivered for each of these strategies in 2013/14 are now highlighted.

5.1 Quality & Safety Strategy and long-term Quality goals

The key objectives of the Quality & Safety Strategy (2011-2016) are as follows:

- To improve patient safety, ensure clinical effectiveness and to give patients a positive experience.
- To ensure the right quality mechanisms are in place so that standards of quality and safety are understood, met and effectively demonstrated.
- To provide assurance that quality and safety outcomes and benefits are being realised, and take priority action if the quality and safety of services provided is compromised.
- To promote the continuous improvement in the quality and safety of services provided.

The key objective for 2013/14 is to deliver Year 2 of the Quality & Safety Strategy, including delivery of the Trust's long-term quality goals. The Quality & Safety goals are grouped as follows:

Table 7: Long Term Quality goal groupings

Quality Goal: Patient Safety
• Reduce Healthcare Acquired Infections
• Improve care to vulnerable adults
• Improve care to patients with dementia / mental health illness/ learning disability
• Failure to rescue
• Improve medicines management
• Harm free care
Quality Goal: Effectiveness of Care
• Improve end of life care
• Improve general health of patients
• Reduce avoidable mortality
Quality Goal: Patient Experience
• Reduction in complaints and improvements to the complaints process • Outcomes from the national patient survey and improve Family Friendly Test (FFT) score

Monitoring of delivery of these long-term quality goals will be through reporting to the Quality & Safety Committee on a monthly basis. The detailed targets for 2013/14 relating to the quality goals can be found in **Appendix B.**

5.2 Workforce Strategy & Workforce Plan 2013/14

The key deliverables for the Workforce Strategy for 2013/14 are as follows:

- Improve workforce productivity and efficiency and deliver associated cost reductions
- Revise and enhance systems and processes for ensuring that staff have got the right knowledge, experience, qualifications and skills and behaviours to provide high quality care
- Enhance workforce governance arrangements
- Continue to improve levels of Mandatory Training across the Trust
- Continue to implement the Trust's Leadership Framework/Talent Management

Our workforce plan is driven by RCRH activity reductions, reducing workforce costs to meet national efficiency requirements and a change in staff whole time equivalents (WTEs) to support service developments. The forecast makes no assumptions about skill mix changes resulting from the impact of new ways of working or advances in technology. Wherever possible, job losses will be mainly absorbed by natural wastage, TUPE transfers and staff working for other employers therefore avoiding redundancies wherever possible.

Progress against the workforce plan is monitored by and reported to the Workforce & Organisational Development Assurance Committee on a bi-monthly basis.

The following workforce trajectory for the next 12 months is set out below and shows the projected changes to pay costs overall and the WTE impact by staff group over the period April 2013 to March 2014. The average cost per WTE rises during the period as a result of incremental drift and assumptions made about future pay awards.

Table 8: Actual and Forecast Outturn 2012/13

Workforce data item	Actual and Forecast Outturn 2012/13				
	Mar 12	Jun 12	Sep 12	Dec 12	Mar 13
Total number of contracted Full Time Equivalents	6685	6575	6447	6428.59	6488.59
Total Paybill (£000)	276523	67059	65306	65744	69536
Average cost per Full Time Equivalent 2012/13 (£000)					**41.25**

Table 9: Workforce Trajectory 2013/14

Workforce data item	Forecast 2013/14											
	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Total number of contracted Full Time Equivalents	6488.59	6379.64	6371.64	6371.64	6369.64	6366.31	6366.31	6366.06	6366.06	6366.06	6366.06	6366.06
Total Paybill (£000)	22690	22690	22690	22643	22643	22643	22596	22596	22596	22454	22454	22454
Forecast average cost per Full Time Equivalent 2013/14 (£000)												**42.51**

5.3 Clinical Strategy

Our Clinical Strategy: *Transforming Clinical Services 2012-18* sets out our clinical priorities and describes how we will develop our services over the next five years to ensure we can deliver our strategic vision. Our commitment to maintain and improve quality and safety for our patients will remain central to our clinical services and future strategy.

The key deliverables for our Clinical Strategy for 2013/14 will be:

- ***Clinical Leadership:*** Developing the leadership capability of our clinicians through delivery of our Clinical Leadership Development Strategy

- Establish and embed the new Associate Medical Director roles with their focus on Innovation and Transformation, System Integration and RCRH, Clinical Effectiveness and Patient Safety

- ***Beacon Services:*** Through the agreed competitive process, establish 3 Beacon Services which represent a particularly high standard of clinical quality, management, patient experience, innovation and delivery.

- ***Emergency Care:*** Implement the agreed expansion of Emergency Department workforce (nursing, medical and administrative), new roles and models of working. Implement the emergency pathway development project with the following work streams: Respiratory, Cardiology, Frail elderly, Emergency Surgery and Fractured Neck of Femur and development of ambulatory emergency care pathways.

- ***Long Term Conditions:*** Work in partnership with primary care colleagues to develop a new integrated approach (across secondary, community and primary care services) to care for people with long term conditions ensuring improved continuity, services which keep people well and out of hospital and care closer to home whenever possible.

- Develop a new service model for Frail Elderly.

- Develop a further ten 5 year clinical strategies at specialty or condition level.

Progress against the Clinical Strategy deliverables will be monitored by and reported to a number of committees based on the specific deliverable. These include the Clinical Development Board, the Emergency Department Task and Finish Group and the Medical Directors Team.

5.4 Estates Strategy

The Estates Strategy high level objectives, including specific actions, for 2013/14 are as follows:

- To analyse the estate condition and its performance:
  - Collate and submit information for Estates Return Information Collection (ERIC) (July)
  - Prepare reports on estates performance to inform estates strategy (July)

- To identify costs to achieve Estatecode Condition B for key facets of Condition Survey:
  - Cost update only (October)

- To prioritise capital investment in estate statutory compliance issues:
  - Update infrastructure risk assessments to inform investment in high and significant risk backlog items (May)

- To support compliance with Care Quality Commission registration:
  - Undertake external assurance review of estates compliance issues Outcome 10 and 11 (May)

- To achieve year-on-year improvement on performance in line with the Trust approved Carbon Management Plan:
  - Undertake actions identified in CMP (March 2014)

- To operate all Estate and Facilities services at a benchmark between the lower and upper quartiles of the Estates Return Information Collection (ERIC) returns of comparable Trusts and demonstrate value for money:
  - Following estates performance analysis (objective 1) develop plan to address any items that do not benchmark between upper and lower quartiles (October 2014)

- Maintain Patient Environment Action Team – "Good or Excellent Standards" status year on year:
  - *PEAT (now replaced with PLACE),* address any items of poor performance (March 2014)

- To have a formal system of control to ensure a robust Development Control Plan (DCP) to support clinical services:
  - On-going management of DCP (March 2014)

5.5 Health Informatics Strategy

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

To support the delivery of the informatics roadmap the priority is to review and stabilise core elements of the infrastructure and commence the delivery of key systems identified for replacement. The top 10 priorities for 2013 and 2014 are:

1. **Procurement:** Development of strategic outline case for the Electronic Patient Record (EPR) replacement
2. **Infrastructure:** Sizing review and investment in the network
3. **Infrastructure:** Upgrade to the data centre
4. **Infrastructure:** Unified Communications pilot
5. **Systems:** Digital dictation pilot
6. **Systems:** Delivery of a Trust wide A&E solution
7. **Systems:** Replacement of maternity system
8. **Systems:** Replacement of Radiology Information System
9. **Systems:** Replacement of chemotherapy prescribing system

10. **Service:** Service transformation based upon Information Technology Infrastructure Library (ITIL) service principles within the customer services function

Progress against these priorities are measured and reported to the Health Informatics Steering Group on a monthly basis.

5.6 Membership Strategy

The Membership Strategy high level objectives for 2013/14 are as follows:

Building the membership base:

- Increase the number of members from Rowley and Tipton by at least 153 to over 900 (increase of 20.5%)
- Increase the number of members from Ladywood by at least 30 to over 900 (increase of 3.4%)
- Review membership demographics using the 2011 census data which becomes available by ward in July 2013
- Following the review, set targeted recruitment measures to reduce inequalities in membership demographics.

Managing active membership:

- Prepare members for elections to the Council of Governors, ensuring enough public and staff candidates stand.
- Develop clear communication channels for Governors to communicate to members
- Arrange membership activities to increase the accessibility of the Trust Board to members
- Introduce clear route for member feedback to influence key decisions and strategy

Communicating with members:

- Involve members and shadow Governors in setting the annual priorities for 2014/15
- Continued increase of the number of membership activities from 2011/12, 2012/13 to 2013/14
- Continued engagement with staff members

Playing a key community role:

- Increase the number of members using 'www.swbhengage.com' by 25%
- Increase the number of schools signed up to our new schools membership scheme by 1 per quarter
- Continue to deliver programme of membership activities to promote healthy lifestyles and NHS careers
- Build on our programme of activities

Working with other membership organisations:

- Improve the link between membership and stakeholder organisations

5.7 Transformation Programme

The key objective for the Transformation Support Office (TSO) remains working with the Trust's Divisions in driving quality and efficiency improvements that will support their financial savings plans. All activities identified must also comply with the Trust's strategic objectives and will include:

- Supporting the development of TSP activities
- Facilitation of cross-cutting projects to improve the quality and safety of the Trust's services whilst meeting the demanding national efficiency targets
- Rigorous project planning and management to ensure change is co-ordinated and risks or deviations from target are mitigated

The cross cutting projects we will continue to undertake include;

- Outpatient efficiency
- Effective patient flow and bed utilisation
- Theatre Productivity
- Community.

Success in all these areas will be assessed by continuous review of the Transformation Scorecard, which contains a set of balanced Key Performance Indicators (KPI's) in the categories of People, Quality, Milestone achievement and Financial measures. We will also review the achievement of work stream and division TSPs.

To drive the achievement of Transformation within the Trust, a number of enabling projects have also been identified such as;

- Developing the capability of TSO staff – to date the Trust has enjoyed the support of an external provider in key areas of transformation. Whilst knowledge transfer has taken place, this will be accelerated during 2013/14 to provide a stronger basis for a stand-alone team. This will be measured by development of an enhanced TSO capability and development framework.

- Commence developing the capability of Operational Trust staff in the use of Continuous Improvement techniques so that such thinking becomes an integrated part of everyday activities. In addition we will work with Trust Leadership at all levels to promote those behaviours that support engagement and drive effective decision making.

- Creation of a 'Model Area,' which encompasses all elements of future working we hope to achieve for the Trust. Currently being selected, this area will be the subject of intensive support from TSO to define, trial and implement elements of sustainable best practise and continuous improvement.

- Working with the CCG and other external organisations to ensure Transformation activities are aligned with our wider organisation, and that all projects are aligned, collaborative and mutually supportive. The success of this work will be evidenced through our Transformation Scorecard and achievement of TSPs.

Section 6 – Financial Plan 2013/14

6.1 Income and Expenditure Plans 2013/14 to 2015/16

The Trust is planning to achieve a surplus in 2013/14 of £4.6m, 1.1% of turnover (income). The surplus is planned to increase over the two subsequent years to meet the financial performance requirements of the Foundation Trust regime and to establish a position prior to the new hospital development. Table 10 summarises the planned position. The Trust's plans generate a Monitor financial risk rating (FRR) score of 3 out of 5 which is satisfactory.

Table 10: Summary Financial Plan 2013/14 – 2015/16

Category	2012/13 Provisional Outturn	2013/14 Plan	2014/15 Plan	2015/16 Plan
	£m	£m	£m	£m
Total Income	428.1	**431.0**	429.5	428.2
Total Costs	(399.6)	**(403.3)**	(401.4)	(399.5)
Operating Surplus (EBITDA)	28.5	**27.7**	28.1	28.7
Financing Costs	(22.4)	**(23.1)**	(23.4)	(24.1)
Net Surplus / (Deficit)	6.1	**4.6**	4.7	4.8
DH Technical Adjustments	(0.4)	**-**	-	-
Net Surplus/(Deficit) for DoH Target	5.7	**4.6**	4.7	4.8
Surplus as % of Income	1.3%	**1.1%**	1.1%	1.1%

The Trust enters the year not having agreed contract values with its main commissioners SWB CCG and its Associates, and the Specialised Commissioning Team, in the context of uncertainty about CCG allocation changes in relation to specialised commissioning. The Trust's detailed financial and operational plans are subject to finalisation of contracts in the early part of the financial year.

6.2 Transformation Programme Targets 2013/14

The Trust's original savings target for 2013/14 was £22.2m. To date divisions have identified savings totalling £20.9m as shown in the table. The programme is made up of over 300 individual schemes. Each scheme is subject to a Quality Impact Assessment and an Equality Impact Assessment by the Medical Director and the Chief Nurse.

Table 11: Transformation Programme 2013/14 by Division

Division	TSP Target £000	Schemes Identified 2013/14 £000
Medicine & Emergency Care	3,480	2,169
Surgery A, Anaesthetics & Critical Care	3,269	3,269
Surgery B	1,767	1,767
Women's & Child Health	2,799	2,799
SCHS: Adult Services	1,771	1,771
Pathology	1,444	1,444
Imaging	1,224	1,224
Nursing & Therapies	712	712
Operations/Strategy	1,043	1,043
Facilities	1,556	1,556
Estates	658	658
Postgraduate Centre	68	68
Chief Executive	181	181
Finance	341	341
Governance	229	229
Workforce	267	267
Health Informatics	347	347
Corporate - Other	1,084	1,084
Total	**22,241**	**20,930**

This multi-year Transformation Plan is broken down into workstreams which themselves are made up of a number of individual schemes. The aim is to continue the process commenced in 2012/13 of moving away from what might be regarded as a more traditional and fragmented approach to CIPs and consider the operations of the Trust on a wider and more "whole system" basis.

Table 12: 2 Year Transformation Programme by Workstream

Workstream	TSP Target £000	Schemes Identified 2013/14 £000
Workforce Efficiency	5,731	5,413
Medical Workforce Efficiency	1,093	1,093
Patient Flow & Bed Day Utilisation	1,432	1,432
Urgent Care	86	86
Outpatient Efficiency	2,037	908
Theatre Productivity	556	556
Diagnostics	211	211
Community Service Efficiency	1,771	1,771
Estates Rationalisation	271	271
Strategic IT Enablement	347	347
Corporate Services & Facilities	690	690
Procurement	3,175	3,311
SLR Improvement	4,548	4,548
Other	294	294
Total	**22,241**	**20,930**

6.3 Capital Programme 2013/14

The table below summarises the Trust's Capital Programme for 2013/14. The capital programme totals £17.5m. The Trust has sufficient internally generated cash to fund the proposed programme and does not require any loans from the DH.

Table 13: Capital Programme 2013/14

	£000
Capital Resources	
Internally Generated Cash	15,054
Additional Capital Resource Limit	5,453
Total Resources	**20,507**
Capital Expenditure	
Right Care, Right Here - Land Acquisition and Clearance	1,886
Statutory Standards/Fire/DDA/ Estates/ Security	4,870
Medical & Other Equipment	4,853
IT Programmes	2,000
Strategic Investment/Service Reorganisation	2,900
Capitalised Salaries	475
Schemes continuing from 2012/13	522
Contingency	3,000
Total Expenditure	**20,506**
Under/(Over) Commitment against CRL	**0**

6.4 Delivery of contractual standards & targets

During 2013 / 2014 performance monitoring and reporting arrangements to the Trust Board and to the other various Boards and Committees will continue. At this stage the exact composition of the NHS Performance Assessment Framework and Monitor's Compliance Framework is not finalised, but the Trust will respond to whatever format they may take. The Trust will also continue to monitor and report its performance to West Midlands NTDA Local Area Team through the Provider Management Regime as part of its progress towards attainment of Foundation Trust Status.

During 2013 / 2014 performance against national and local contractual quality requirements will also be a fundamental part of the Trust's performance monitoring and reporting process. Additionally, systems are currently being set up to ensure the appropriate mechanisms are in place to monitor local performance against the range of quality indicators which comprise the Acute Trust Quality Dashboard. The dashboard which is currently published quarterly by the Midlands and East Quality Observatory contains a wide range of indicators, the majority of which are aligned to the 5 domains of the NHS Outcomes Framework.

We will work with SWB CCG to deliver the agreed QIPP (Quality, Innovation, Productivity and Prevention) Schemes for 2013/14. These are expected to deliver circa £3m savings and at a high level will focus on:

- alternatives to outpatient appointments, a reduction in new to follow up ratios and implementation of RCRH care pathways
- reduction in procedure of limited clinical value
- improvement to emergency and urgent care systems

6.5 Financial Risks

The Trust has assessed its financial plans using the risk rating tool used by Monitor, the Foundation Trust regulator. The unweighted Monitor risk score is 3.3 out of 5, which is satisfactory. Monitor is consulting on a revised risk rating tool known as the Continuity of Service risk rating. The Trust's plans score 3 out of 4 which is satisfactory.

The key financial risks facing the Trust have been identified as follows:

- contract agreement with commissioners
- contract penalties
- operational capacity plans, including for winter
- savings targets not yet identified
- slippage on the capital programme
- financing arrangements for the Midland Metropolitan Hospital

Each of these risks has been assessed and actions have been identified to mitigate their possible impact.

Section 7 – Risk Management

The Trust operates a comprehensive risk management system and Assurance Framework. The Trust's risk management strategy has been reviewed and approved for the period 2012-2015.

The Trust has a Board Assurance Framework, a document which sets out the key risks to our strategic and corporate objectives, the key controls to manage these risks and the level of assurance on the effectiveness of the controls. It also highlights where gaps in controls and assurance have been identified and the progress with implementing the actions required to address this shortfall.

The Assurance Framework is considered on a quarterly basis by the Trust Board and twice yearly by the Audit Committee. The Assurance Framework informs the declarations made in the Annual Governance Statement. Where gaps in controls and assurance of the management of the risks associated with the delivery of any of the Trust's objectives are identified, the remedial action to address them is reported in the quarterly update of the Assurance Framework.

Appendix A: 12/13 Performance

NATIONAL AND LOCAL PRIORITY INDICATORS			Actual 12/13	Data Period	12/13 Target	11/12 Out-turn
Cancer	2 weeks	%	94.6	M1-11	=>93	94.8
	2 weeks (Breast Symptomatic)	%	96.1	M1-11	=>93	95.8
	31 Day (diagnosis to treatment)	%	99.5	M1-11	=>96	99.5
	31 Day (second/subsequent treatment – surgery)	%	99.2	M1-11	=>94	100
	31 Day (second/subsequent treatment – drug)	%	99.8	M1-11	=>98	99.2
	31 Day (second/subsequent treatment – radiotherapy)	%	100	M1-11	=>94	100
	62 Day (urgent GP referral to treatment)	%	86.5	M1-11	=>85	86.9
	62 Day (referral to treatment from screening)	%	96.6	M1-11	=>90	98.5
	62 Day (referral to treat from hosp specialist)	%	93.7	M1-11	=>85	91.6
Cancelled operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.7	M1-12	<0.8	0.6
	28 day breaches	No.	1	M1-12	=>3	1
DTOC	Acute	%	2.9	M1-12	<3.5	5.2
A&E 4-hour waits	4-hour waits	%	92.21	M1-12	=>95	95.38
A&E timeliness	Total Time in Department (95th centile)	h:m	5:12	M1-12	=<4hrs	3:59
	Time to Initial Assessment (=<15mins) (95th centile)	Mins	17	M1-12	<15	21
	Time to treatment in department (median)	Mins	58	M1-12	=<60	59

A&E Patient Impact	Unplanned re-attendance rate	%	7.82	M1-12	=<5.0	8.60
	Left Department without being seen rate	%	4.71	M1-12	=<5.0	4.83
Ambulance Turnaround	Clinical Handovers completed within 15 minutes	%	71.30	M1-12	=>85.0	n/a
	Average Turnaround Time	m:s	34.24	M1-12	=<30:00	29.23
	In Excess of 60 minutes	No.	2354	M1-12	0	1256
Stroke Care	Patients spending >90% stay on Acute Stroke Unit	%	87.6	M1-11	=>83.0	85.9
	Patients receiving CT Scan within 24 hours of arrival	%	92.21	M1-11	100	100
	Patients receiving CT Scan within 1 hour of arrival	%	52.2	M1-11	=>50.0	37.5
	TIA (High Risk) Treatment within 24 hours of initial presentation	%	69.5	M1-12	=>60.0	53.2
	TIA (Low Risk) Treatment within 7 days of initial presentation	%	76.8	M1-12	=>60.0	30.4
Infection Control	C. Difficile	No.	37	M1-12	57	95
	MRSA Bacteraemia	No.	1	M1-12	2	2
	MRSA Screening (Elective) – Patient Not Matched	%	138.9	M12	85	n/a
	MRSA Screening (Non-Elective) – Patient Not Matched	%	76.8	M12	85	n/a
RTT 18 week Milestones	Admitted Care (RTT<18 weeks)	%	94.0	M11	=>90.0	93.2
	Non-Admitted Care (RTT<18 weeks)	%	99.3	M11	=>95.0	97.5
	Incomplete Pathway (RTT<18	%	95.4	M11	=>92.0	97.2

	weeks)					
	Acute Diagnostic Waits greater than 6 weeks	%	0.88	M11	=>1.0	0.99
Same Sex Accomm. breaches	Total Number of Breaches (% of completed FCEs)	%	0.00	M1-12	0	0.07
Mortality in Hospital (12 month cumulative data)	Hospital Standardised Mortality Rate	HSMR	89.1	Dec '11–Nov '12		90.5
	Peer (SHA) HSMR	HSMR	97.0	Dec '11–Nov '12		95.8
	Summary Hospital-level Mortality Indicator	SHMI	94.4	Dec '11–Nov '12		96.8
Readmission Rates (to any speciality) within 30 days of discharge	Following initial Elective Admission	No.	1582	M1-12	No.only	
	Following initial Elective Admission	%	1.24	M1-12	No.only	
	Following initial Non-Elective Admission	No.	7471	M1-12	No.only	
	Following initial Non-Elective Admission	%	5.87	M1-12	No.only	
Workforce	Total Sickness Absence	%	4.52	M10-11	<3.15	3.90
	Mandatory Training Compliance	%	88.10	M12	=>95.0	71.9
GUM 48 hrs	Patients offered app't within 48 hrs	%	100	M1-12	=>98	100
Infant Health & Inequalities	Maternal Smoking Rates	%	10.1	M1-09	<11.5	11.9
	Breast Feeding Initiation Rates	%	72.1	M1-09	>63.0	65.6
Data Quality	Valid Coding for Ethnic Category (FCEs)	%	94.0	M1-12	=>90	94.5

Appendix B: Long-Term Quality Goals

Quality Goal: Patient Safety	2013/14
Reduce Healthcare Acquired Infections	
MRSA	**2**
C Difficile	**46**
MSSA	**10**
E Coli	**200**
Blood culture contaminant	**3%**
Achieve MRSA screening targets	**90%**
Improve care to vulnerable adults	
Pressure damage	**90**
Falls	**672**
Weight loss	**4%**
Improve care to patients with dementia / mental health illness/ learning disability	
Increase use of memory test and referral to dementia services	**95%**
Increase training to appropriate staff – Level 1 Level 2	**95%** **30%**
Failure to rescue	
Reduce the number of preventable cardiac arrests	**TBC**
Increase number of appropriate staff trained to ILS standard	**1500**
Increase use of sepsis bundle	**30%**
Improve medicines management	
Reduce medication errors - increase overall reporting - reduce proportion causing serious harm	**5%**↑ **20%**
Improve standards for safe storage medication	**85%**
Reduce unnecessary antibiotic use – duration recorded/indication recorded	**90%**
Harm free care	

Increase the amount of harm free care measured via Safety Thermometer	**98%**
Reduce adverse events causing serious harm - increase overall reporting - reduce proportion causing serious harm	**5%** ↑ **30%**
Improved evidence of 'Being Open' with patients and families involved in events resulting in at least moderate harm.	**60%**
Achieve NHSLA Risk Management Standards for: Acute Trusts	**Level 2**
Quality Goal: Effectiveness of Care	
Improve end of life care	
Increase number of appropriate patients on supportive care pathway – acute/community	**90**
Reduce readmission rates of patients at end of life	**35**
Increase the number of patients who achieve their choice of where to die.	**70**
Improve appropriate application of DNACPR decisions	**50% eligible staff**
Improve general health of patients	
Achieve smoking cessation targets/alcohol cessation targets/breast feeding targets	
Achieve health visiting staff numbers	**+10**
Reduce avoidable mortality	
Achieve a mortality performance in the top quartile of the national peer group	**Upper 2nd quartile**
Reduce variation in mortality – City - Sandwell	**85** **90**
Reduce incidence of hospital related VTE	**95%**
Reduce harm from elective surgical care	**TBC**
Quality Goal: Patient Experience	
Improve outcomes from national patient survey	**TBC**
Improve 'family friendly test' score	**TBC**
Reduction in formal complaints	**5%**
Reduction in link complaints	**3%**
Improve the proportion of complaints responded to within set time limits	**80%**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 21 March 2013; 0930h – 1130h

Members Present

Mrs O Dutton [Chair]
Mr R Samuda
Dr S Sahota OBE
Mr M Sharon
Miss K Dhami
Miss R Overfield
Dr R Stedman
Miss R Barlow
Mr R White
Mrs D Talbot

In Attendance

Ms A Binns
Mr S Parker

Secretariat

Mr S Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies for absence from Richard Lilford and Gianjeet Hunjan.	
2 Minutes of the previous meeting	**SWBQS (2/13) 031**
Subject to minor amendment, the minutes of the Quality and Safety Committee meeting held on 21 February 2013 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 (2/13) 031 (a)**
The updated actions list was noted by the Committee. The Committee was advised that the sign off of the Medicine & Emergency Care Transformation Savings Plan (TSP) schemes from a quality and safety perspective	

was currently underway. It was agreed that a close view of the ongoing quality and safety impact of the schemes should be maintained.	
REPORT BACK FROM THE QUALITY COMMITTEES	
4 Patient Safety Committee	**Verbal**
Dr Stedman advised that at the meeting of the Patient Safety Committee held on 1 March 2013, the terms of reference for the Committee had been approved. Progress with the Patient Safety 'Listening into Action' work was reported to have been discussed. An issue concerning a large number of unassigned incidents being held centrally was reported to have been highlighted to the Committee. The Committee was advised that the 'Being Open' policy had been discussed. Ms Dutton asked when the policy would be reviewed next. Miss Dhami advised that this would be according to the planned review date, however the issue with the policy related to the organisation's understanding of the contents. It was reported however, that embedding this within the Trust had been included within the action plan to devolve the complaints handling process. Miss Overfield added that the matter also linked into the Duty of Candour obligations that were due to be introduced by the Department of Health in line with one of the recommendations from the 'Francis' report. It was suggested that 'Being Open' should be included within the discussion topics at the forthcoming Leadership Conference.	
ACTION: Mr Sharon to consider the inclusion of 'Being Open' within the agenda for the Leadership Conference	
5 Patient Experience Committee	**Verbal**
Miss Overfield reported that the major discussions at the Patient Experience Committee that had been held on 1 March 2013, had concerned the set up and operation of the Committee and the development of the Patient Experience strategy. The Committee was advised that the planned presentation of patient stories to the Board had also been discussed.	
6 Clinical Effectiveness Committee	**Verbal**
Dr Stedman reported that the reporting cycle for the Committee had been discussed at the meeting held on 1 March 2013. Other items discussed were reported to include the development of the mortality review system and the Clinical Audit forward plan. The outcome of the national audit on epilepsy was reported to have been discussed, which it was highlighted had presented a variable picture. Ms Dutton asked whether this report suggested that the Trust had issues in this respect. She was advised that this was not the case, however the report highlighted the opportunities available related to specialist nurse input into clinics. The VTE policy was reported to have been considered and approved. It was reported that the Trust's performance in relation to a number of indicators considered as part of the thrombosis audit was poorer than desired.	
7 Compliance & Assurance Committee	**Verbal**

Miss Dhami advised that the Compliance & Assurance Committee had held its inaugural meeting on 20 February 2013, at which the Committee's terms of reference had been discussed. It was highlighted that the Committee's remit was broad and that it would take responsibility for checking that action plans were being delivered robustly, including those relating to external assessments. It was reported that the Committee would also take a role with ensuring that governance arrangements at a divisional and directorate level were in place. It was highlighted that the Committee would report indirectly to the Audit Committee in respect of risk management arrangements.	
MATTERS FOR APPROVAL	
8 Compliance & Assurance Committee terms of reference	**SWBQS (3/13) 033** **SWBQS (3/13) 033 (a)**
The Committee asked for and gave its approval to the terms of reference for the Compliance & Assurance Committee.	
AGREEMENT: The Quality & Safety Committee approved the terms of reference for the Compliance & Assurance Committee	
MATTERS FOR DISCUSSION/DEBATE	
9 Emergency Department assurance update	**Verbal**
Miss Barlow reported that a primary concern in relation to the Emergency Departments at present concerned the prevention of breaches to the 12 hour decision to admission target. It was highlighted that a number of other trusts in the region were facing similar pressures at present. The Committee was advised that the soft launch of the out of hours (111) GP triage service had been undertaken which had exacerbated the position. It was reported that much work was currently underway to establish a Clinical Decision Unit (CDU) which would be staffed by Emergency Department nurses and medics, with the aim of relieving the pressure on the Accident & Emergency departments and the Medical Assessment Unit. It was reported that work was underway to establish a Medical Discharge Unit. Miss Overfield highlighted the ongoing concerns regarding nurse staffing and reported that nurses working in corporate areas had been asked to work a clinical shift where possible. Dr Stedman reported that the hours covered by medics in the Emergency Departments would be extended from May 2013 on a permanent basis, however a pilot would arranged in the interim. The Committee noted that there appeared to be a higher number of patients that were taking longer to discharge. Miss Barlow advised that this was reflective of the higher level of acuity of patients being treated by the Trust at present. Mr White advised that additional capacity would be created in the Trust's financial position in 2013/14 given the potential fines which would be levied in respect of underperformance against the ambulance turnaround target. The Committee was advised that a penalty of £200 would be imposed in the case of ambulance crews being detained for over 30 minutes and £1000 for delays of 60 minutes and over. Mrs Talbot asked whether nursing and care homes were accepting patients. She was advised that this was the case, although one care home in the region had been closed. The Committee was	

advised that daily calls with the Clinical Commissioning Group (CCG) continued to discuss performance against the Emergency Department waiting time target. It was highlighted that a number of elective operations had been cancelled as a result of the operational pressures. Miss Overfield advised that the Care Quality Commission (CQC) had been briefed on the issues. The Committee was advised that Trust Board would be appraised of the position at its forthcoming meeting. Dr Stedman reported that the level of incidents in the area remained largely stable and that systems were in place to monitor the safety of the Emergency Departments. Mrs Talbot asked what communication was planned to promulgate the position and the key issues to the Trust. Mr Sharon reported that the key messages needing to be communicated to the public had been discussed with the CCG. It was reported that staff working in the Emergency Departments had been thanked for their continued dedication in the face of the difficulties. It was highlighted that the need to adhere to infection control stipulations needed to be underlined. Ms Dutton asked whether the issue was likely to be short term. Mr Sharon advised that there was an expectation of a trend of peaks and troughs of activity over a period of time, however the predicted pattern in the short term was unclear, therefore at present the response needed to be considered in the longer term.	
10 Board and Committees – structure chart	**SWBQS (3/13) 034** **SWBQS (3/13) 034 (a)**
The revised Board and Committee structure chart was considered. Miss Dhami drew the Board's attention to the inclusion of the new quality committees within the structure. It was suggested that a further version of the structure should be prepared which omitted the Trustwide governance committees and instead included the remit of the main boards and committees. Mr Sharon highlighted that the Clinical Service Development Board was not an interim committee and therefore it was agreed that this body should be removed from the structure. It was highlighted that the Health & Safety Committee should be included as reporting to the Compliance & Assurance Committee.	
ACTION: Mr Grainger-Payne to make the suggested revisions to the structure and prepare an additional version which highlights the remit of each Board or Committee	
11 Quality Report	**SWBQS (3/13) 034** **SWBQS (3/13) 034 (a)**
Miss Overfield reported that results of the Safety Thermometer audit had improved and that the no Grade 4 pressure sores had been reported for ten months. It was reported that the trend of falls at Sandwell Hospital had improved. Continued issues concerning Norovirus infections in the Trust were highlighted. It was reported that cases of 'flu were also being seen in the Trust and that there was a possibility that a ward may need to be shut as a consequence eventually. The level of nutrition assessments was reported to be good. It was highlighted that the Trust continued to use a high level of bank and agency nursing staff, which was	

reported to be partly reflective of the need to dedicate specific resources to some patients given the higher level of patient acuity being handled. The Committee was advised that there was a high level of patients being treated in areas in which they would not be usually treated (outliers). The Committee was pleased to learn that the nurse staffing ratio position had improved and that performance against a number of the quality metrics had improved. Dr Stedman reported that a new acute stroke unit had been opened at Sandwell Hospital. Mr Sharon added that the finish and furnishing of the unit was impressive. It was reported that the 2013/14 target for undertaking VTE assessments was 95% and that there was an expectation that this would be met using available IT and workflow solutions. Ms Dutton noted that the use of the World Health Organisation (WHO) checklist had taken some time to implement and asked whether there were any lessons learned which could be applied to better handling of Norovirus infections. Dr Stedman suggested that there was a need to adopt the use of more checklists. Dr Sahota noted that there was a large quantity of reported incidents that awaited assignment to an appropriate manager to investigate. Ms Binns advised that the position was not new, however the information was now routinely monitored and would be reported within the Quality Report on a regular basis. Miss Overfield reported that 'tally' boxes had been introduced into Accident & Emergency Departments to collect 'Friends and Family Test' information. Dr Stedman advised that performance against the mortality review target was behind trajectory at present, however the reviews were being distributed more evenly throughout the consultant workforce.	
12 Corporate Quality & Performance dashboard	**SWBQS (3/13) 036** **SWBQS (3/13) 036 (a)**
Mr White advised that the substance of the report had been covered within discussions about other agenda items. He reported that the Trust was classed as 'performing' against the NHS Performance Framework and 'Amber/Green' against the FT Compliance Framework.	
13 Francis inquiry – Trust's initial response	**Verbal**
Miss Dhami reminded the Committee that at the previous Board meeting, the initial response to the 'Francis' report had been considered and it had been agreed that a plan would be developed in terms of how the response to the recommendations would be taken forward. It was highlighted that there had been an agreement that a further update would be presented to the Trust Board at its next meeting, however the Committee was advised that the national position against some of the recommendations remained outstanding and was not expected shortly for a number of areas. In addition, the Committee was advised that further views from the Trust's staff needed to be gathered to inform the response. On this basis, it was suggested that further consideration of the report's recommendations should be postponed until the Trust Board 'Time Out' on 26 April 2013.	

Mr Samuda emphasised the need for the Board to lead on executing the actions to address the recommendations and to set the overall tone for the response. Ms Dutton noted that some changes had been introduced already which were consistent with the recommendations from the 'Francis' report. She suggested that a considered and measured response needed to be delivered. Mr Sharon agreed and suggested that key messages in respect of the actions planned could be incorporated within the discussions at the forthcoming Leadership Conference. The Committee agreed that in the meantime, the actions that could be delivered should be progressed, however the national context should be awaited for other elements of the response. Miss Overfield advised that actions specific to some professional groups were being delivered.	
14 Mortality reviews interim analysis report	**SWBQS (3/13) 050** **SWBQS (3/13) 050 (a)**
Dr Stedman presented the analysis of mortality reviews which had been undertaken over several months. Ms Dutton asked for what reason deaths in Accident & Emergency had been excluded from the reviews. Dr Stedman reported that Accident & Emergency was regarded as a transitional area and that a regular report on deaths in this area was received by the Mortality & Quality Alerts Committee. The current mortality review process was outlined. It was highlighted that the review of deaths during 2012 had identified that some patients had experienced either a delayed diagnosis or misdiagnosis of a condition and that 21 of the deaths were classed as being preventable. The lack of feedback within the mortality review process was highlighted. Dr Stedman agreed that the process needed to be made more systematic and meaningful. He also suggested that it would be beneficial to set a tolerance level. In terms of next steps, the Committee was advised that the reviews would be undertaken by division and directorate and those common themes, including the prevalence of sepsis, would be identified and acted upon using a corporate approach. Dr Sahota observed that the issue concerning sepsis had been discussed previously and asked what timescales were applied to handling the position corporately. Miss Overfield advised that investment in appropriate resources to support the sepsis work was needed. Dr Stedman reported that the handling of sepsis was an evolving process and approach and that there was a need to learn lessons from patient deaths. Ms Dutton asked whether the revised mortality review process would assist with identifying the reasons behind the differences in the mortality rates in different areas of the Trust. Dr Stedman advised that this analysis was being undertaken separately, however the mortality rates were reducing on both sites at present. Mr Sharon asked whether the mortality position in other organisations had been reviewed. Dr Stedman advised that this was the case, however there was a need to gain assurance internally that the position and the data was accurate.	

Ms Dutton asked whether consideration of the system influences on mortality rates, such as late presentation of patients, would be incorporated within the remit of the revised mortality review system. She was advised that this was the case.	
15 Complaints Development Plan	**SWBQS (3/13) 037** **SWBQS (3/13) 037 (a)**
The Committee was asked to receive the plan to remodel the complaints handling process. The Committee was advised that a summary of progress with the action plan would be presented on a routine basis. It was highlighted the plan incorporated a number of measures which would address the 'Francis' recommendations. It was reported that the action plan incorporated the interactions with the Trust's stakeholders. The Committee was advised that the detail of the action plan would be considered by the Patient Experience Committee.	
16 CNST report	**SWBQS (3/13) 049** **SWBQS (3/13) 049 (a)** **SWBQS (3/13) 049 (b)**
Ms Binns advised that the Trust had successfully achieved accreditation against Level 2 CNST risk management standards for maternity. It was reported that the assessment against Level 3 risk management standards was booked for 2014. The Committee was pleased with the update and suggested that congratulations be communicated to the maternity and risk management teams. Mr Samuda asked whether there were clear plans to address the areas where a shortfall had been identified. He was advised that an action plan to address these areas would be developed shortly.	
17 CQC Quality & Risk profile update	**Verbal**
Miss Dhami advised that some responses to the Quality & Risk Profile (QRP) update remained outstanding, however since the report had been commissioned, the assessment against Outcome 4 had deteriorated to high red. It was reported that the basis of this score included the PROMs position, the outcome of the Accident & Emergency patient survey and some national audit results. The Committee was advised that the position would be discussed further by the Executive Team at its meeting on 26 March 2013.	
18 Safeguarding	
18.1 Child safeguarding Section 11 audit and action plan – progress report – February 2013	**SWBQS (3/13) 038** **SWBQS (3/13) 038 (a)** **SWBQS (3/13) 038 (b)**
18.2 Adult safeguarding	**SWBQS (3/13) 038 (c)**
Miss Overfield advised that the Trust was represented on both Sandwell and	

Birmingham Safeguarding Boards. The Committee was asked to receive the self assessment against Section 11 of the Safeguarding Vulnerable Groups Act. It was highlighted that flagging children on a child protection plan was a challenge given that 'at risk' lists were not issued centrally. The Committee was advised that there were no issues of significance to highlight. It was reported that both Safeguarding Boards were classified as being failing. In terms of adult safeguarding, it was reported that the complexity of the policies and processes was increasing particularly in respect of the community element, including the neglect agenda. It was reported that the Trust performed well in relation to Court of Protection orders. Mock assessments were reported to have been undertaken for the assessment of capacity and safety. Miss Overfield advised that although some safeguarding expertise was in place within the Trust, this was not available out of hours unless the Safeguarding Units in the Police and Social services was accessed. Miss Dhami advised that out of hours legal advice could be accessed through the Trust's solicitors if required. Miss Overfield advised that handling patients lacking capacity was challenging. She reported that 'Prevent' training was underway, however this was challenging in terms of resource. The Committee was advised that much work had been undertaken following the concerns raised by the 'Saville' case. Miss Dhami advised that a complaint had been received questioning the reason why the Trust was not registered with the CQC in relation to mental health. It was reported that further investigation of this position had identified that the Trust needed to be registered in this respect and that this was being undertaken shortly.	
19 Patient Experience strategy and action plan	**SWBQS (3/13) 039** **SWBQS (3/13) 039 (a)** **SWBQS (3/13) 039 (b)**
All were asked to provide comments on the Patient Experience strategy and action plan to Miss Overfield. The Committee was advised that the delivery of the action plan needed to be resourced and funded.	
20 Patient stories for the Trust Board – 'Hear All About It'	**SWBQS (3/13) 040** **SWBQS (3/13) 040 (a)**
Miss Overfield presented the process developed for presenting patient stories to the Trust Board on a routine basis. She advised that a patient story was planned for the Trust Board meeting scheduled for 28 March 2013 which reflected the experience of a patient on ward which had been required to close due to an outbreak of Norovirus.	
21 National inpatient survey results	**SWBQS (3/13) 041** **SWBQS (3/13) 041 (a)** **SWBQS (3/13) 041 (b)** **SWBQS (3/13) 041 (c)**
Miss Overfield presented a summary of the national inpatient survey results. She advised that a comparison of internal intelligence against the national report was undertaken. In terms of CQUIN requirements, the Committee was advised that	

there was a need to introduce the use of the Friends and Family Test (FFT) by the end of 2012/13 and that a ten point improvement in the FFT score should be achieved. It was reported that the results would need to include those from the Emergency Departments. The Committee was advised that an additional requirement concerned the need to achieve a two point improvement against five key questions in the national inpatient survey, however it was highlighted that there had been deterioration in performance against two of the indicators. The Committee noted that the internal inpatient survey results presented a more positive picture than those reported externally. It was suggested that this variance might reflect that the external survey was completed by more relatives than patients. The local surveys however, were reported to be more readily completed by patients, given that the forms were more accessible. Ms Dutton noted that performance against the 'sharing same sex accommodation' and the 'assistance at mealtime' indicators had deteriorated. Miss Overfield advised that the performance against the first indicator might reflect the configuration of the wards at Sandwell Hospital, where although the patients are treated in separate bays, there might be a perception that they were being treated in a same sex environment. It was highlighted that Cardiac and Stroke Care wards also remained mix sex. In terms of the assistance at mealtimes, it was highlighted that relatives' perception of the amount of help provided to patients was sometimes different to the reality. Dr Stedman added that many patients who were unwell lost appetite and therefore refused the offer of food.	
22 Accident & Emergency Department patient survey results	**SWBQS (3/13) 042** **SWBQS (3/13) 042 (a)**
Miss Overfield presented to Accident & Emergency Department patient survey results, which she highlighted offered a disappointing picture. It was highlighted that the Trust was within the bottom 20% of trusts in relation to a range of indicators. The Committee was advised that some of the issues raised by the survey were already being acted upon. Mr Sharon asked whether the results could be distinguished between Sandwell and City Hospital Accident & Emergency Departments. He was advised that this was not clear.	
23 Serious Incident report – format review	**SWBQS (3/13) 043** **SWBQS (3/13) 043 (a)**
Miss Dhami advised that following discussions at the last meeting of the Trust Board, it had been agreed that the Serious Incident report would again be presented as a standalone item. Given that it was clear that a more focussed discussion at the Trust Board meeting was required, it was agreed that consideration needed to be given to the format of the report in future.	
24 Serious Incident webholding update	**SWBQS (3/13) 048** **SWBQS (3/13) 048 (a)**
Ms Binns advised that the webholding status update was considered by the Risk	

Management Group on a monthly basis. It was reported that a target was set for the management of a reported incident within 21 days, however the Committee was asked to note that this aim was not being met at present. It was highlighted that the position had been discussed at the recent meeting of the Patient Safety Committee where it had been agreed that incidents would be batched and sent to the relevant manager to process urgently. The Committee was advised that a contributory factor to the large number of incidents being held in webholding was the migration between Datix to Safeguard risk management systems. Miss Overfield cautioned that given the operational pressures being experienced by the Trust at present, there was less staff time than usual to handle matters such as this.	
25 Serious graded complaints report – format review	**SWBQS (3/13) 044** **SWBQS (3/13) 044 (a)**
It was agreed that further consideration needed to be given to the most appropriate format for the serious graded complaint report that was presented to the Trust Board.	
MATTERS FOR RECEIPT	
26 CQC action plan update	**SWBQS (3/13) 051** **SWBQS (3/13) 051 (a)** **SWBQS (3/13) 051 (b)**
It was agreed that the Committee should receive and accept the report. Miss Dhami advised that delivery of the action plan was largely on track.	
27 Foundation Trust Quality Governance	**Verbal**
Miss Dhami advised that there was nothing on which to update the Committee at present.	
28 Clinical Audit forward plan: monitoring report	**SWBQS (3/13) 045** **SWBQS (3/13) 045 (a)**
Mr Parker provided an update on the issues and progress with the Clinical Audit forward plan. He advised that the detail of the Sentinel Stroke audit was to be reported within the Quality Account and that data needed to be collected across the entire episode of care, however at present there was difficulty with identifying resources to input the information. It was highlighted that the matter was being discussed by the Stroke Action Team. In terms of the National Bowel Cancer audit, it was reported that the outcome suggested that the Trust was an outlier. The Committee was advised that the position had been investigated and it had been determined that the quality of data needed to be improved, particularly in terms of that concerning the premorbid status of patient prior to surgery, where the data used initially was incorrectl Mr Parker reported that an audit had been completed concerning compliance with antibiotics guidance, which had suggested that the Trust's level of compliance was disappointing. It was noted however that the data was historical given that it had	

been collected in May/June 2012. An action plan to address the position was reported to be under development.	
MINUTES FOR NOTING	
29 Minutes from the Clinical Quality Review Group	**SWBQS (3/13) 046**
29.1 Minutes from the meeting held on 4 February 2013	
The Quality and Safety Committee received and noted the minutes from the Clinical Quality Review Group meeting held on 4 February 2013.	
30 Any other business	**Verbal**
Miss Dhami advised that a Rule 43 letter had been received from Sandwell coroner in connection with a matter reported in early March 2013. It was highlighted that the Rule 43 letter concerned the application of a DNAR order having been placed without involving the patient or the patient's relatives. The Committee was advised that the Trust had 56 days to respond to the coroner. It was reported that the relevant managers had been approached to agree the actions needed to robustly communicate the requirements of placing DNAR orders. Dr Stedman advised that there was a need to look at the practicality and logistics of making decisions that involved the right people. Ms Dutton agreed that there was a need to consider how DNAR orders should be applied, including the policy for so doing, as a priority. Dr Stedman advised that the response needed to be proportionate and that resuscitation should not be expected when it was not clinically appropriate.	
31 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 19 April 2013 at 0930h in the D29 (Corporate Suite) Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Quality Report
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Overfield (Chief Nurse), Dr Roger Stedman (Medical Director) and Kam Dhami (Director of Governance)
AUTHOR:	Various
DATE OF MEETING:	25 April 2013

EXECUTIVE SUMMARY:

The attached report presents a composite picture of performance against a number of key Quality metrics and qualitative information, responsibility for which currently sits within the remits of three members of the Executive Team.

- The Committee is invited to accept the report, noting in particular the key points highlighted in Section 2 of the report.

REPORT RECOMMENDATION:

The Board is recommended to ACCEPT 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 incidents.
- NHSLA Acute and Community risk management standards – 'Learning from experience'
- Includes performance against a number of CQuIN targets and national & local targets and priorities
- Aligned to the priorities set out within the Quality Account

PREVIOUS CONSIDERATION:

Trust Management Board on 16 April 2013 and Quality & Safety Committee on 19 April 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY REPORT

A monthly report presenting an update on Patient Safety, Clinical Effectiveness and Patient Experience in the Trust

April 2013

Where EVERYONE Matters

CONTENTS

QUALITY REPORT

1 INTRODUCTION

This report presents a composite picture of the performance against the various key Quality metrics to which the Trust works, both in terms of those mandated at a national or regional level and those set by the organisation.

The report has been populated with latest performance information for the period up until this Board meeting, across a range of areas within three domains: patient safety, clinical effectiveness and patient experience.

2 KEY POINTS TO NOTE

The Trust Board's attention is drawn to the following this month:

PATIENT SAFETY

- Safety Thermometer results in March achieved 95% harm free care. 1 patient experienced 2 new harms in the Community.
- Falls in February continued to reduce with 42 in the acute and 8 in the community and more un-avoidable following RCA
- Infection rates – Norovirus continues to affect both sites into March. *C diff* and MRSA remain within trajectory for the year.
- Pressure Damage – There were 10 avoidable hospital acquired pressure sores reported in January. Of these there were no grade 4 sores and a total of 3 grade 3 sores. This represents a continuing improving picture over the year.
- Assessment of nutritional risk reduced slightly but other aspects of nutritional care maintained.
- Quality Audits illustrated 34 wards recorded improved results from Nov, 10 deteriorated and 2 remained the same.
- Bank/agency (nursing) increased in March to 8,500 shifts.
- Staffing ratios – No information available at the time of writing the report.

CLINICAL EFFECTIVENESS

- Compliance with the use of the World Health Organisation (WHO) checklist was 98.96%.
- Validated VTE performance information was not available for March.
- Mortality Reviews Performance for January was 49% which is below the target of 74% in month. The year to date performance is 63%.
- Fractured Neck of Femur being operated on within 24 hours of admission during March was 70%. The year to date performance is 68.28%.

PATIENT EXPERIENCE

- The Net Promoter decreased to 63, the first time the Trust has been below target (65) since October last year.
- Preferred place of death for patients increased to 62% in February, exceeding the joint hospital/community target of 53%

WORKFORCE QUALITY

- The Trust is currently meeting its overall mandatory training target at 86.41% (target 85%).
- PDR rates however, are lower than our target rate at 69.16 (target 85%).
- Sickness absence was 4.47% in February, which remains above the target (3.5%) but is a similar figure to the same time last year (4.39%).

3 TARGETED AREAS OF SUPPORT

- Wards targeted for specific divisional and corporate support as a result of audits and other indicators are :D7,P3,D30, N1,D41 and N5

4 EMERGING TRENDS/NOTICEABLE PATTERNS

- None specifically

5 OF SPECIFIC NOTE

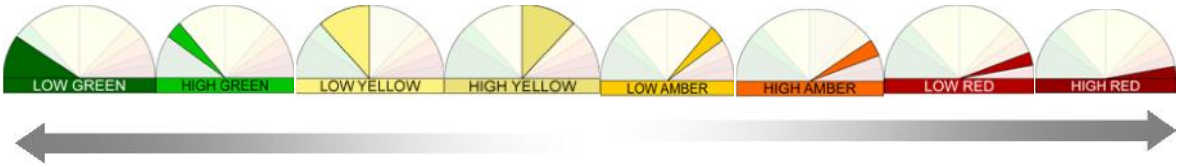
- There is nothing specific to note over and above the other matters highlighted above.

6 KEY CLINICAL RISKS

- Staffing arrangements on some wards

7 CARE QUALITY COMMISSION'S QUALITY AND RISK PROFILE

The Care Quality Commission (CQC) publishes a QRP for each registered provider which is used to support the day to day work of CQC Inspectors. The QRP provides the Trust with a risk estimate for each outcome of the 16 Essential Standards of Quality and Safety. These risk estimates are produced by the CQC using a statistical model that aggregates individual pieces of information which the CQC holds about the Trust. The risk estimates are displayed as dials as shown below:



The risk estimates for the essential standards of quality and safety for the Trust published by the CQC on 6th March 2013 are shown below:

Risk estimate	Frequency	Outcomes
No Data	-	-
Insufficient data	-	-
Low Green	2	11 and 21
High Green	1	8 and 14
Low Yellow	10	1, 5, 6, 7, 9, 10, 12, 13, 16, and 17
High Yellow	1	2
Low Amber	-	-
High Amber	-	-
Low Red	1	-
High Red	1	4

There are currently no outcome risk estimates in Amber and one in Red. This shows the Trust as being at a low risk of non-compliance with the CQC's 16 essential standards of quality and safety, with the exception of **Outcome 4** which relates to the '*care and welfare of people who use services*'.

These are details of the individual pieces of data that contribute towards the risk estimate for **Outcome 4**.

	Quantitative Items: 270							Qualitative Items: 60	
	Much worse than expected	Worse than expected	Tending towards worse than expected	Similar to expected	Tending towards worse than expected	Better than expected	Much better than expected	Negative Comment	Positive Comment
Number of items*	**16** (14)	**7** (7)	**11** (11)	**187** (185)	**19** (18)	**7** (6)	**23** (21)	**44** (40)	**16** (16)

* The figure in brackets indicates the number of items in the previous version of the QRP published in February 2013

The indicators where the Trust's position is shown to be worse than compared with the expected or moving in that direction are under review and further details will be presented to the Quality & Safety Committee. The data sources include the Stroke Improvement National Audit Programme, PROMs (groin hernia surgery and knee replacement), the CQC A&E Survey and Dr Foster Intelligence.

In the majority of cases the risk estimates are based on data that relates to a period some way in the past (e.g. September 2010). In light of this local intelligence is being used to establish the up-to-date position. If this has not improved corrective action will be taken and reported to the Quality and Safety Committee.

NOTE: At the time of writing, the CQC has published the April version of the QRP. This shows an adverse movement in the risk estimate for **Outcome 2**, which covers '*consent to care and treatment'*, from a High Yellow to a High Red. The reasons for this changed position are being investigated and corrective action will be taken, as indicated.

8 CQuINs

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST CORPORATE DASHBOARD - MARCH 2013

Exec Lead				PATIENT SAFETY			November	December	January	February		March			To Date (*=most recent month)	TARGET	
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13
RS	A	3		VTE Risk Assessment (Adult IP)	396	%	91.7 ▼	90.2 ▼	91.5 ▲	→		91.0 ▼	→		86.1 ■	86.1*	90	90
RB	K	20		Appropriate Use of Warfarin	372		→	Compliant	→	→		→	→			Compliant	Comply with audit	
RO	H	8		Safety Thermometer	396	%	Data Submitted	Data Submitted	Data Submitted	→		Data Submitted	→		Data Submitted	Data Submitted	Monthly data collection	
RB	H	20		Antibiotic Use	743	Score	→	→	→	→		→	→		→	83	80	80
RO	D	8	Acute CQUIN	Reducing Avoidable Pressure Ulcers	372	No.	Compliant	Compliant	Compliant	→		Compliant	→		Compliant	Compliant	Comply with audit	
RO	H	8		Nutrition and Weight Management	743		Compliant	Compliant	Compliant	→		Compliant	→		Compliant	Compliant	Comply with audit	
RS	H	9		Safe Surgery - Operating Theatres	743	%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	100	100
RS	H	9		Safe Surgery - Other Areas		%	99.5 ▼	99.5 ■	99.5 ■	→		99.7 ▲	→		99.7 ■	99.7	98	98
RS	H	10		Stroke Care	743	%	→	Met Q3 req's	→	→		→	→			Met Q3 req's	Comply	Comply
RO	H			Safety Thermometer	88	%	Data Submitted	Data Submitted	Data Submitted	→		Data Submitted	→			Data Submitted	Monthly data collection	
RO	D	11	Community CQUIN	Reducing Avoidable Pressure Ulcers	176		Compliant	Compliant	Compliant	→		Compliant	→			Compliant	Comply with audit	
RO	H			Nutrition and Weight Management	176		Compliant	Compliant	Compliant	→		Compliant	→			Compliant	Comply with audit	
				EFFECTIVENESS OF CARE														
RO	H	8	Acute CQUIN	Dementia	396	%	Meeting Q3 req's	Met Q3 req's	Meeting Q4 req's	→		Meeting Q4 req's	→		Met Q4 req's	Met Q4 req's	90	90
RS	H	3		Mortality Review	743	%	63.9 ▲	65.4 ▲	49.0 ▼	→			→			49.0	74	80
RO	H	11	Community CQUIN	Dementia	44	%	Not Meeting Q3 req's	Met Q3 req's	Meeting Q4 req's	→		Meeting Q4 req's	→			Meeting Q4 req's	80	90
				PATIENT EXPERIENCE														
RO	H	8		Personal Needs	396	%	→	→	→	→		→	→		→	66.9	71.6	71.6
RO	H	8		Net Promoter	372	No.	65 ▲	67 ▲	66 ▼	→		69 ▲	→			69	65	65
RO	H	8	Acute CQUIN	End of Life Care	372	%	65 ▲	62 ▼	56 ▼	→		62 ▲	→			62	53	53
RS	H	10		Every Contact Counts - Alcohol	372	%	61 ▲	→	→	→		57 ▲	→		89 ■	89	80	80
RO	H	12		Every Contact Counts - Smoking	372	%	→	→	Compliant	→		→	→			Compliant	Comply with audit	
RO	H	11		Pt. (Community) Exp'ce - Personal Needs	44	Score	93.0 ▼	94.0 ▲	93.5 ▼	→		92.0 ▼	→			92.0	90	90
RO	H	11	Community CQUIN	Net Promoter	88	No	86 ▼	85.0 ▼	86.0 ▲	→		50.0 ■	→			50	75	75
RO	H	11		Every Contact Counts	132	%	Met Monthly requirement	Met Monthly requirement	Met Monthly requirement	→		Met Monthly requirement	→			Met Monthly requirement	Comply with KPI trajectories	
RO	H	11		Smoking Cessation	132	%	Met Monthly requirement	Met Monthly requirement	Met Monthly requirement	→		Met Monthly requirement	→			Met Monthly requirement	Comply with KPI trajectories	
RS	H			Clinical Quality Dashboards	49		→	Q3 Return Submitted	→	→		→	→			Q3 Return Submitted	Submit Data	Submit Data
RS	H	13	Specialised Commissioners	Neonatal - Hypothermia Treatment	73	%	→	Q3 Return Submitted	→	→		→	→			Q3 Return Submitted	Derive Base	Derive Base
RS	H	13		Neonatal - Discharge Planning / Family Experience and Confidence	122	%	→	Q3 Return Submitted	→	→		→	→			Q3 Return Submitted	Derive Base	Derive Base
RS	H	12		HIV - Optmum Therapy	147	%	→	Q3 Return Submitted	→	→		→	→			Q3 Return Submitted	Submit Data	Submit Data

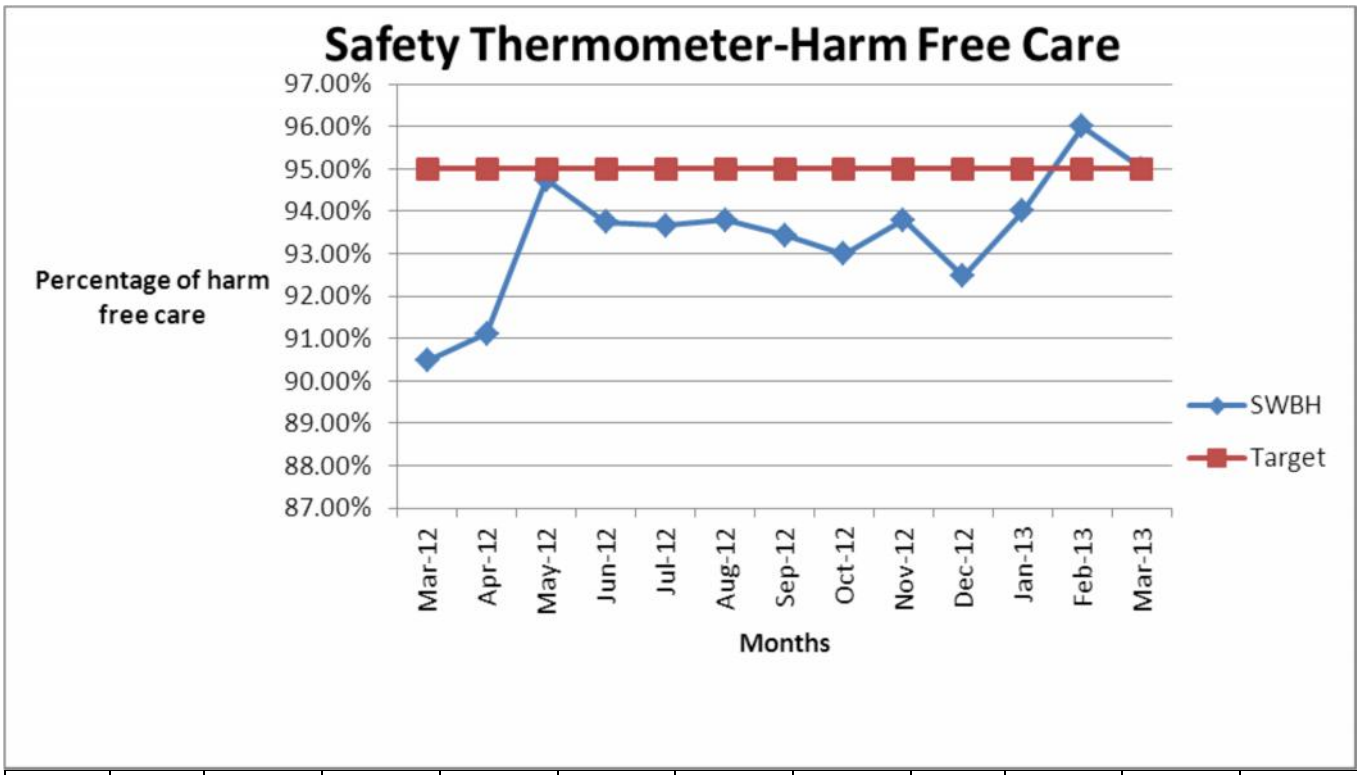
9 PATIENT SAFETY

9.1 Safety Thermometer

CQUiN for 2012/13 – requires introduction of the tool in acute and community in patient areas. *CQUiN*

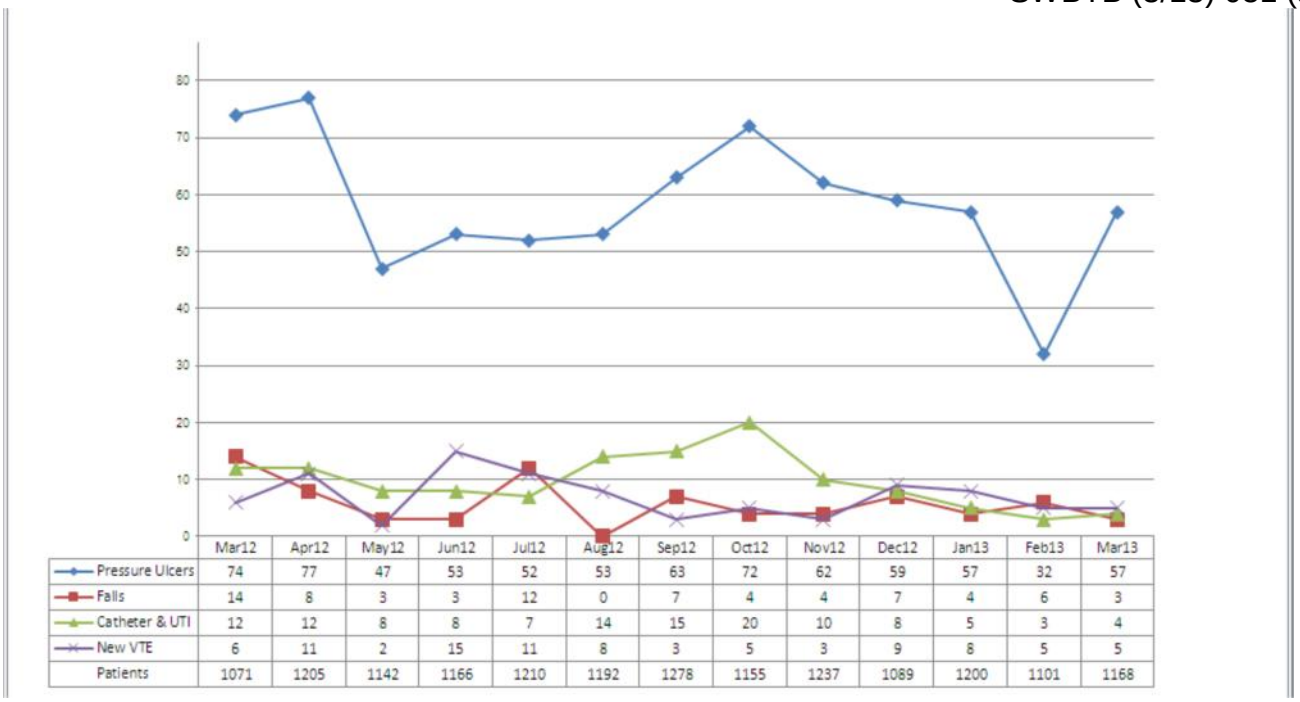
Conducting monthly whole Trust census of patients for 4 harm events (falls, pressure damage, CAUTI and VTE) continues to go well with good engagement of nursing staff. Work has commenced to add other harm measures to the tool, eg avoidable weight loss.

The SHA ambition is for Trusts to achieve 95% harm free care.



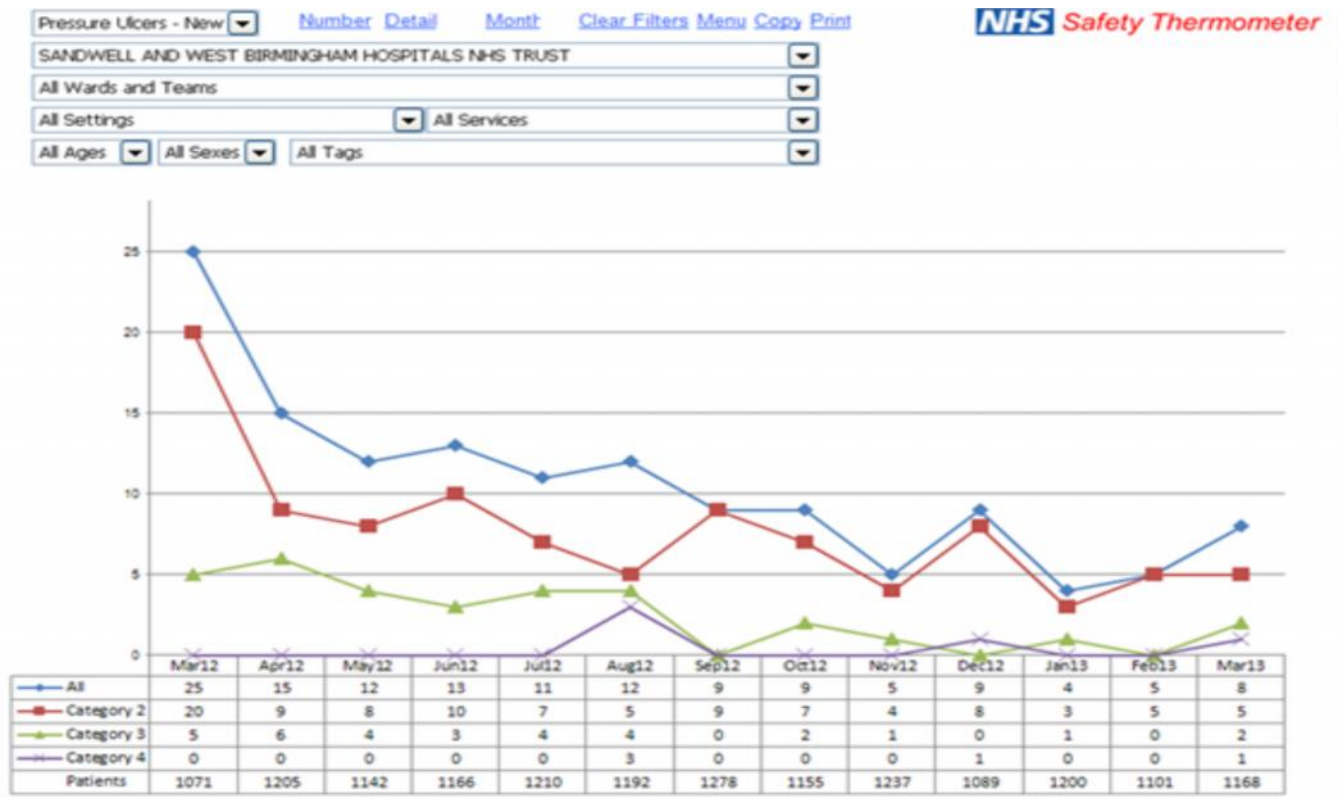
Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
91.12% ë	94.75% ë	93.74% í	93.55% í	93.79% ë	93.43% í	91.52% í	93.78% ë	92.47% í	94% ë	96% ë	95% í

Figure 1: *Harm free care trend*



	Mar12	Apr12	May12	Jun12	Jul12	Aug12	Sep12	Oct12	Nov12	Dec12	Jan13	Feb13	Mar13
Pressure Ulcers	74	77	47	53	52	53	63	72	62	59	57	32	57
Falls	14	8	3	3	12	0	7	4	4	7	4	6	3
Catheter & UTI	12	12	8	8	7	14	15	20	10	8	5	3	4
New VTE	6	11	2	15	11	8	3	5	3	9	8	5	5
Patients	1071	1205	1142	1166	1210	1192	1278	1155	1237	1089	1200	1101	1168

Figure 2: *Number of patients by type*



	Mar12	Apr12	May12	Jun12	Jul12	Aug12	Sep12	Oct12	Nov12	Dec12	Jan13	Feb13	Mar13
All	25	15	12	13	11	12	9	9	5	9	4	5	8
Category 2	20	9	8	10	7	5	9	7	4	8	3	5	5
Category 3	5	6	4	3	4	4	0	2	1	0	1	0	2
Category 4	0	0	0	0	0	3	0	0	0	1	0	0	1
Patients	1071	1205	1142	1166	1210	1192	1278	1155	1237	1089	1200	1101	1168

Figure 3: *Trust overall numbers (new pressure ulcers which developed 72 or more hours after the patient was admitted to a ward)*

Acute Divisions **8** patients experienced **1 new harm**. **No** patients experienced **2, 3 or 4 harms**
Community Division **8** patients experienced **1 new harm**. **1** patient experienced **2 harms.** **No** patients experienced **3 or 4 harms.**

a) Falls

There are no formal targets set for falls for 2012/13 other than the safety thermometer but we will continue to aim to reduce avoidable falls across the Trust by a further 10%. Our audits will continue to monitor risk assessment compliance, appropriate use of care bundles and numbers of falls. Falls with injury continue to be reported as adverse incidents and TTRs conducted.

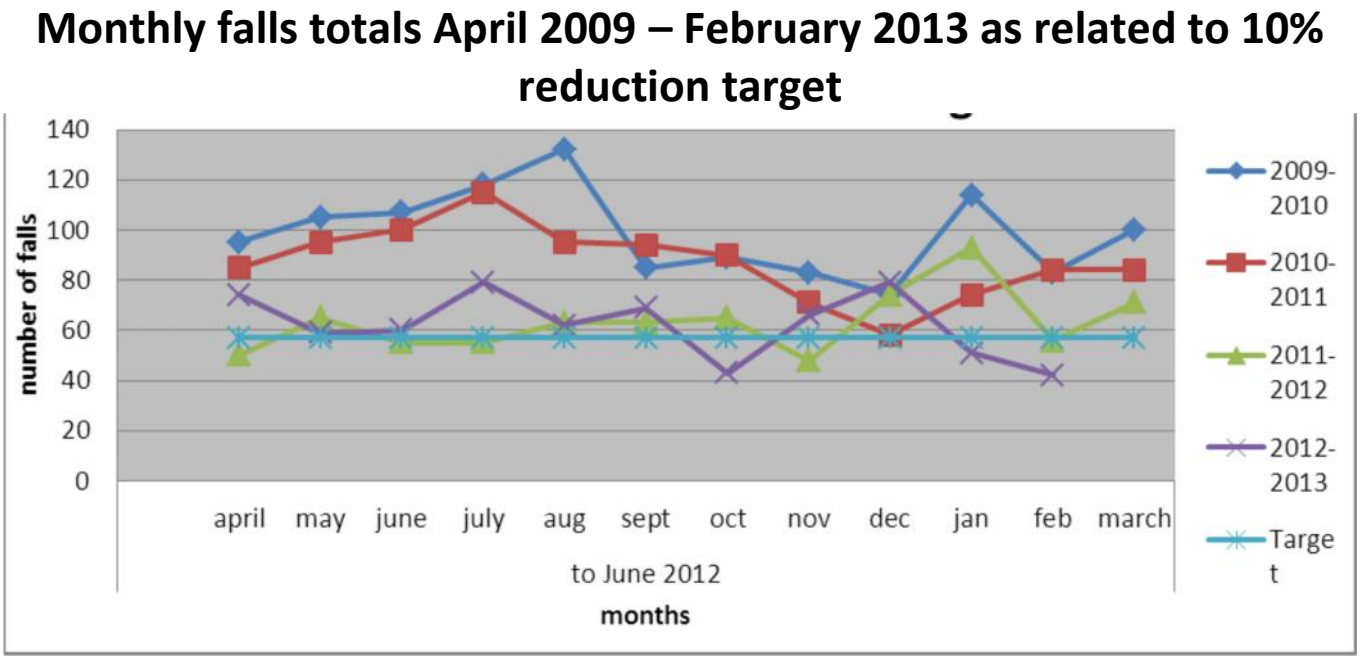


Figure 4: *Trend of falls*

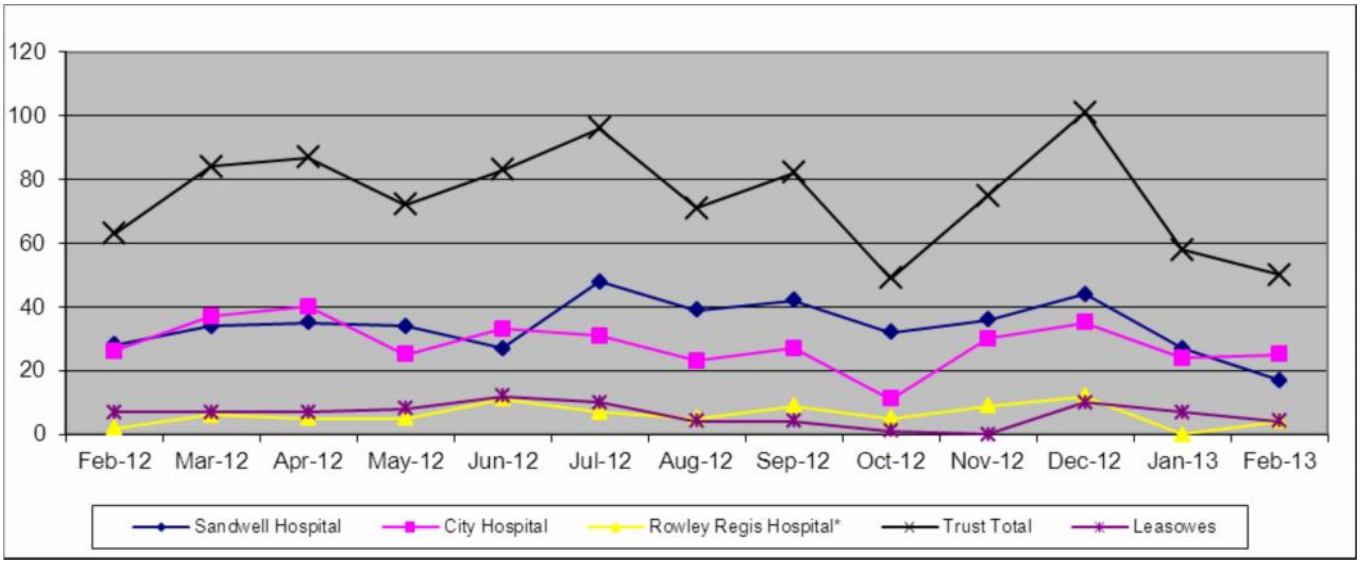


Figure 5: *Incidence of falls per 1000 bed days across Acute Inpatient Divisions*

b) Pressure Damage

Target 2012/13: Eradication of all avoidable pressure damage *SHA Priority and CQUiN.*
Target to assess patients for risk, introduce appropriate care bundle and conduct TTRs on all grade 3 and 4 sores.

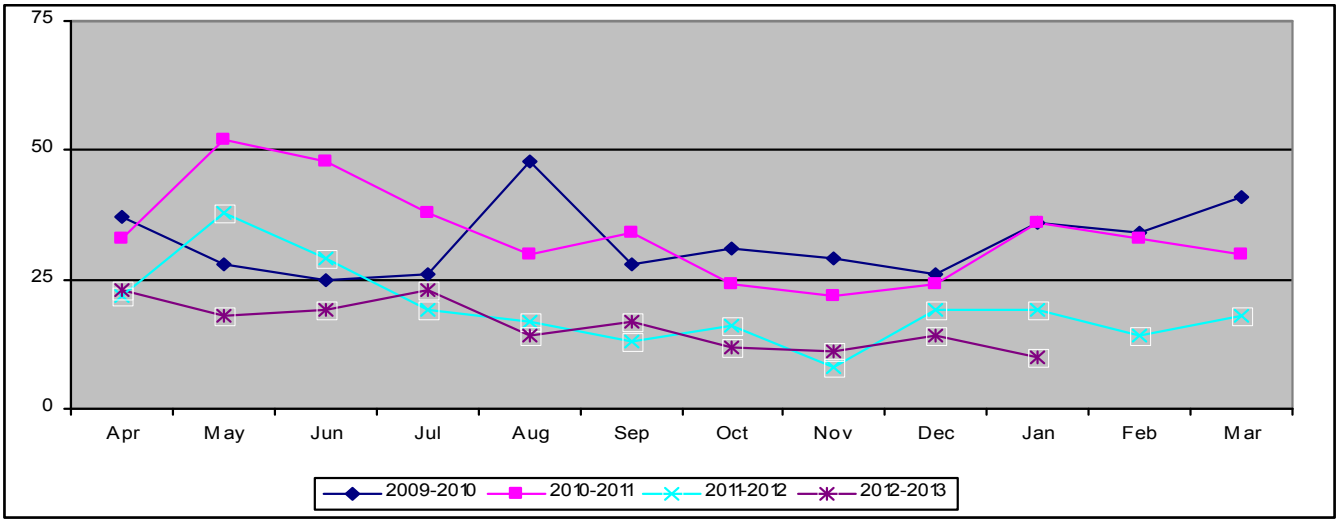


Figure 6: *Number of hospital acquired pressure damage Grade 2, 3 & 4, April 2009 - July 2012*

Grade of Sore	2012-2013												
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	12/13 Total
Grade 2	21	16	17	21	11	14	11	11	11	7			140
Grade 3	2	2	2	2	3	3	1	0	3	3			21
Grade 4	0	0	0	0	0	0	0	0	0	0			0
Trust Total	**23**	**18**	**19**	**23**	**14**	**17**	**12**	**11**	**14**	**10**			**161**

Figure 7: *Table of avoidable hospital acquired pressure ulcers by grade*

c) VTE Risk Assessment

The VTE Risk Assessment CQUIN target continued from 2011/12. Performance of at least 90% each month is required to trigger payment. Performance during March was not available at the time of writing. *CQUiN*

9.2 Nutrition/Fluids

Target 2012/13: Reduction of avoidable weight loss in patients on 8 Trust wards where vulnerable adults are nursed. *CQUiN*
90% patients MUST assessed within 12 hours admission *Internal Priority*

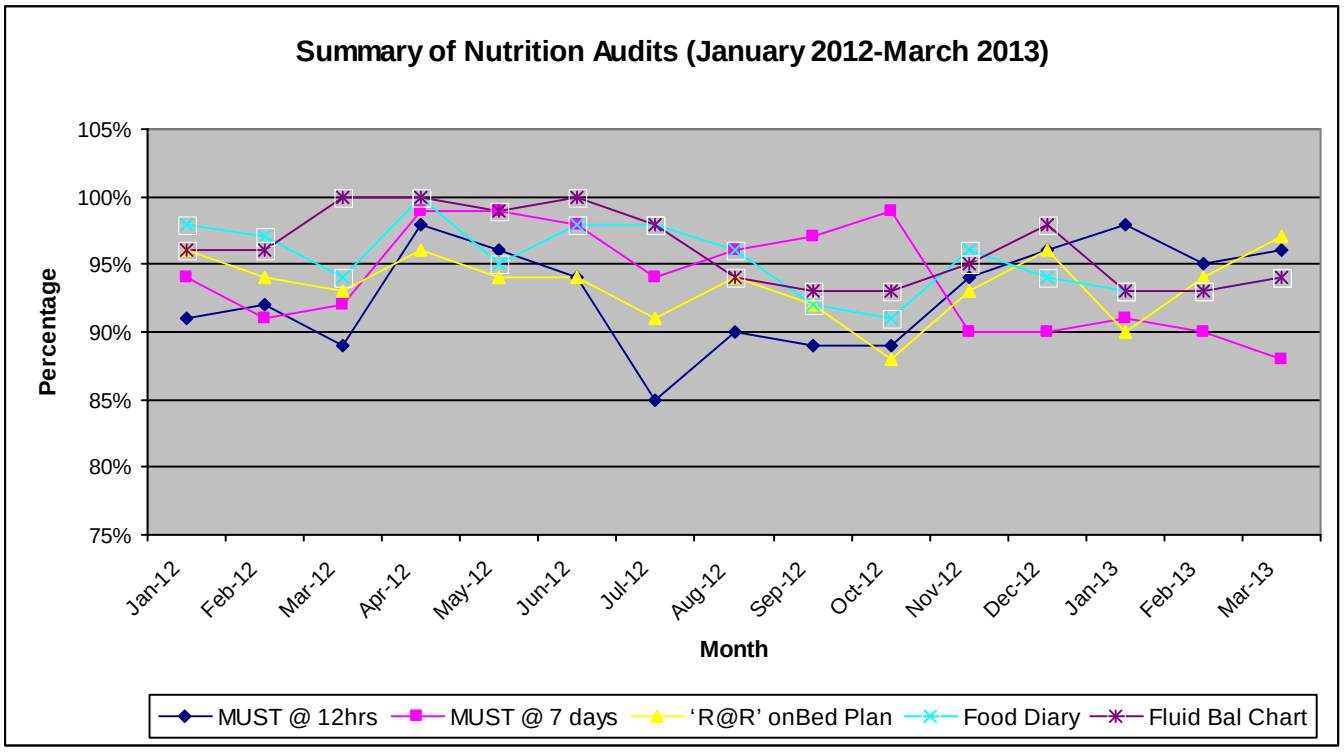


Figure 8: *Nutrition Audit Results*

9.3 Infection Control

Targets 2012/13:	*C difficile* – 57 cases (post 48 hours, using SHA testing methodology)
(National Priority	MRSA – 2 cases (post 48 hours)
Local contract)	MRSA Screening – 85% eligible patients
	Blood culture contaminants – 3% or less
	E Coli and MSSA – Continue to record and TTR device related infections
	National cleanliness standards – 95%

MRSA

There were no post-48 hour MRSA bacteraemia for March. The total number of MRSA bacteraemias against the Trust target to date is 1.

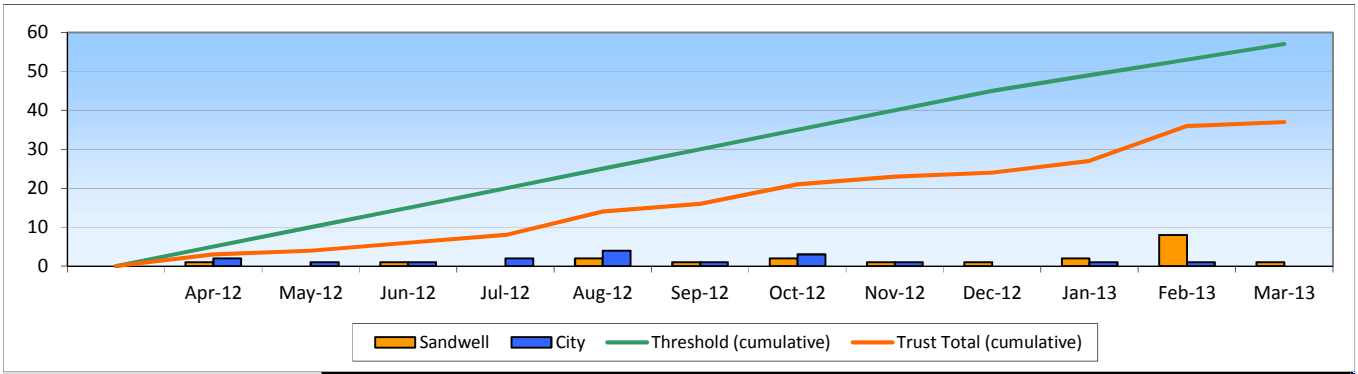
MRSA Screening

Target: 85% eligible patients by March 2013.

			To Date (*=most recent month)	TARGET YTD	TARGET 12/13
MRSA Screening - Elective	Patient Not Matched	%	138.9*	85	85
	Best Practice - Patient Matched	%	59.5*	85	85
MRSA Screening - Non Elective	Patient Not Matched	%	76.8*	85	85
	Best Practice - Patient Matched	%	64.9*	85	85

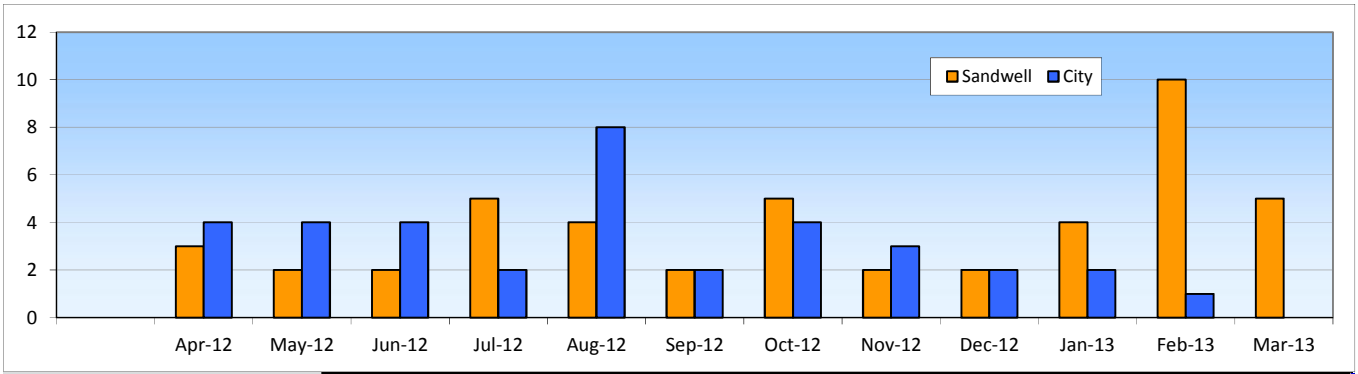
Figure 9: *MRSA screening eligibility*

Clostridium difficile



	2012-2013												
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Total
Sandwell	1	0	1	0	2	1	2	1	1	2	8	1	**20**
City	2	1	1	2	4	1	3	1	0	1	1	0	**17**
Trust	3	1	2	2	6	2	5	2	1	3	9	1	**37**
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0	**0**
DoH Trajectory	5	5	5	5	5	5	5	5	5	4	4	4	**57**
Trust Total (cumulative)	3	4	6	8	14	16	21	23	24	27	36	37	-
Threshold (cumulative)	5	10	15	20	25	30	35	40	45	49	53	57	-

Figure 10: *SHA Reportable CDI*



	2012-2013												
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Total
Sandwell	3	2	2	5	4	2	5	2	2	4	10	5	**46**
City	4	4	4	2	8	2	4	3	2	2	1	0	**36**
Trust	7	6	6	7	12	4	9	5	4	6	11	5	**82**
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Trust Total (cumulative)	7	13	19	26	38	42	51	56	60	66	77	82	-

Figure 11: *Trust Best Practice Data*

Blood Contaminants

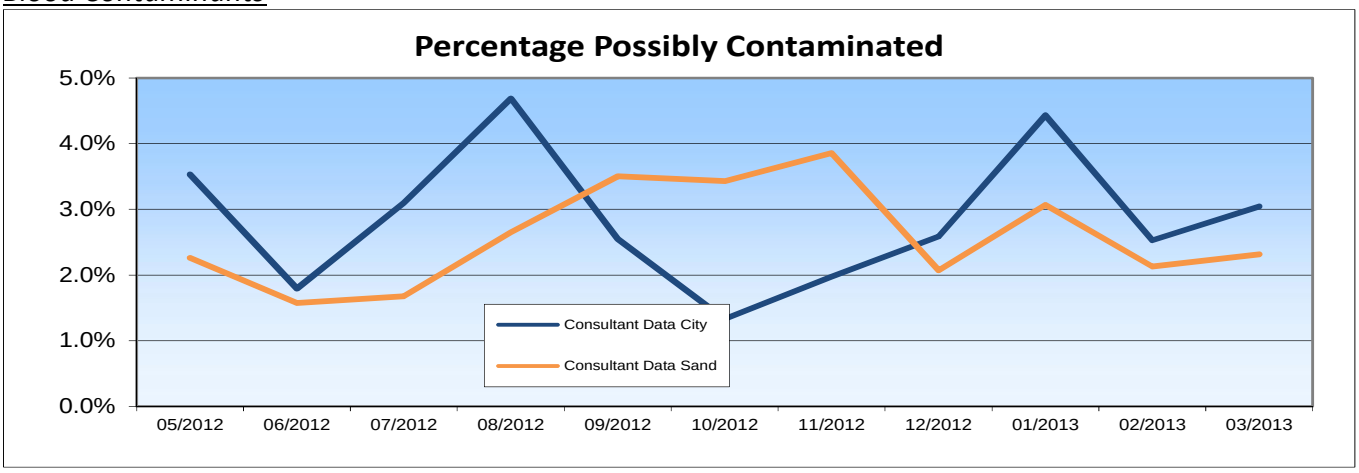


Figure 12: *Blood Contaminants*

E Coli Bacteraemia

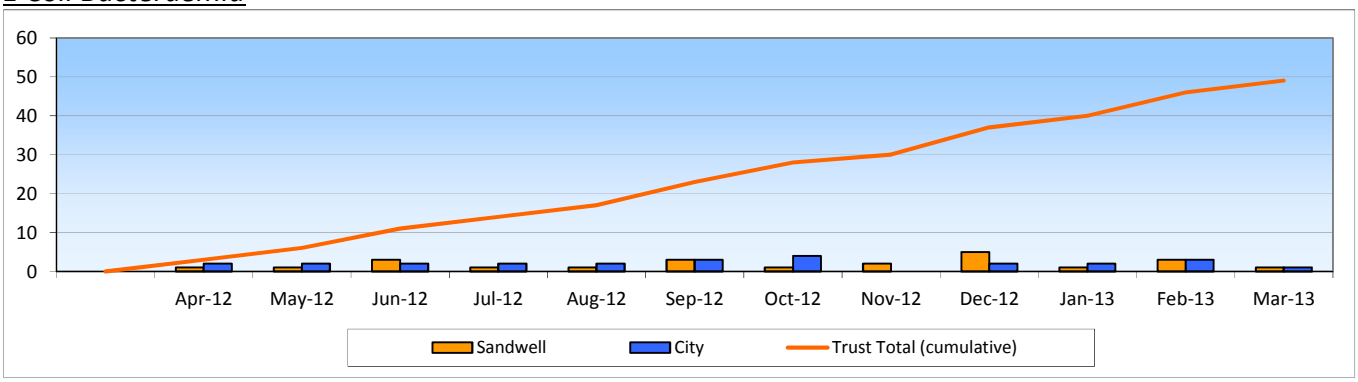


Figure 13: *E Coli Bacteraemia*

MSSA

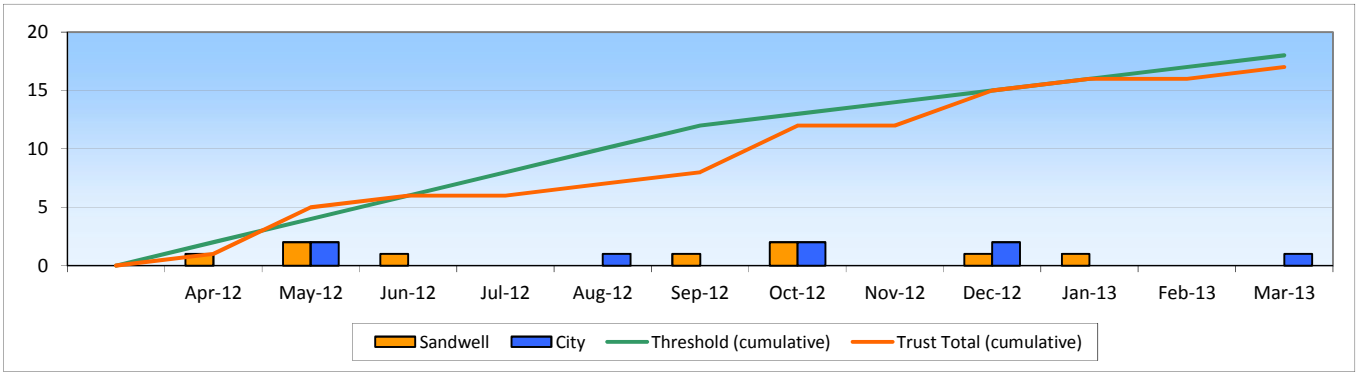


Figure 14: *MSSA*

Outbreak and Other Infection Control Activity

- Norovirus continues to be a problem both within our trust and the community. This is thought to be due to a more virulent strain of the virus, and is causing an unprecedented number of incidents both within the community and in many trusts across the country.

- Staff have been working really well given that we have now had over 6 months worth of ward closures due to norovirus; however, the outbreaks do not appear to be reducing and staff are reminded to continue to use the visitor/patient checklist on all visitors and patients admitted to the trust.
- The number of confirmed cases of Influenza A tailed off during March; however, many patients are still requiring Critical Care. The majority of cases are due to H3N2, not H1N1 (swine flu), and young people, and pregnant woman, are being affected. This is very late in the season compared to usual and staff are advised to be alert to symptoms suggestive of influenza when assessing patients so that they can be isolated and treated appropriately.

Please note that a further summary of infection prevention and control incidents is included in the papers of the meeting as a separate report.

PEAT

National Standards of Cleanliness average scores 96%.

9.4 Maternity

The Obstetric Dashboard is produced on a monthly basis. Of note:
(Please note the February data was not available at the time of writing the report)

*Post Partum Haemorrhage (PPH)(>2000ml): t*here were 0 patients recorded to have had a PPH of >2000ml in January

Adjusted Perinatal Mortality Rate (per 1000 babies): the adjusted perinatal mortality rate for January was 4 which was below the trajectory (8) and was lower than the previous month (7.2). Perinatal mortality rates must be considered as a 3 year rolling average due to the small numbers involved and the significant variances from month to month.

Caesarean Section Rate: the number of caesarean sections carried out in January was 22.7%, which is below the trajectory of 25% over the year and lower than the previous month.

Delivery Decision Interval (Grade I, CS) >30 mins: the delivery decision interval rate for January was 4% which is below the trajectory (15).

Community Midwife Caseload (bi-monthly): The community midwife caseload in January reduced to 128 from the previous month (134), which is below the trajectory of 140.

9.5 Emergency Department highlights

A separate report is provided for the Trust Board this month.

9.6 Medicine Management

Antibiotic Stewardship CQUIN

Monthly point prevalence audits of antibiotic prescribing across all inpatient areas are carried out; the results for February and March are summarised below:

February 2013

Indicator	SWBH	City	Sandwell	Baseline
Number of patients	624	314	310	-
% with allergy status documented	**97.9%**	97.1%	98.7%	**91.7%**
% on antibiotics	34.6%	30.3%	39.0%	30.8%
% on IV antibiotics	17.5%	17.2%	17.7%	14.6%
% on IV antibiotics for more than 48 hours	63.3%	66.7%	60.0%	61.4%
% on antibiotics for >5 days	11.1%	11.1%	11.0%	9.7%
% with stop/review date documented on drug chart	**84.7%**	81.1%	87.6%	**77.1%**
% with indication documented on drug chart	**73.1%**	69.5%	76.0%	**8.8%**
% with antibiotics in line with guidelines	**95.8%**	97.9%	94.2%	**87.5%**

March 2013

Indicator	SWBH	City	Sandwell	Baseline
Number of patients	617	275	342	-
% with allergy status documented	**97.2%**	97.1%	97.4%	**91.7%**
% on antibiotics	34.2%	36.4%	32.5%	30.8%
% on IV antibiotics	14.7%	14.2%	15.2%	14.6%
% on IV antibiotics for more than 48 hours	58.2%	56.4%	59.6%	61.4%
% on antibiotics for >5 days	10.9%	13.1%	9.1%	9.7%
% with stop/review date documented on drug chart	**83.4%**	81.0%	85.6%	**77.1%**
% with indication documented on drug chart	**70.1%**	68.0%	72.1%	**8.8%**
% with antibiotics in line with guidelines	**92.9%**	95%	91%	**87.5%**

Compliance with recording of stop or review dates declined slightly in March (83.4%) compared to February (84.7%) but remained above the baseline assessment (77.1%).

Recording of the indication for antibiotics on the drug chart fell slightly to 70.1% compared to the February figure of 73.1%, but remains well above the baseline of 8.8%.

Compliance with the trust guidelines fell to 92.9% compared to 95.8% in February, but remains above the target (≥90%).

Warfarin CQUIN

The quarterly audit of patients admitted taking warfarin with an INR above 5 whose dosage had been adjusted or reviewed prior to the next dose, was carried out over a 1 week period in March. Compliance of 100% was achieved.

Drug Storage Audits

Ward drug storage audits are carried out monthly; the results for January, February and March are summarised below:

General Drugs

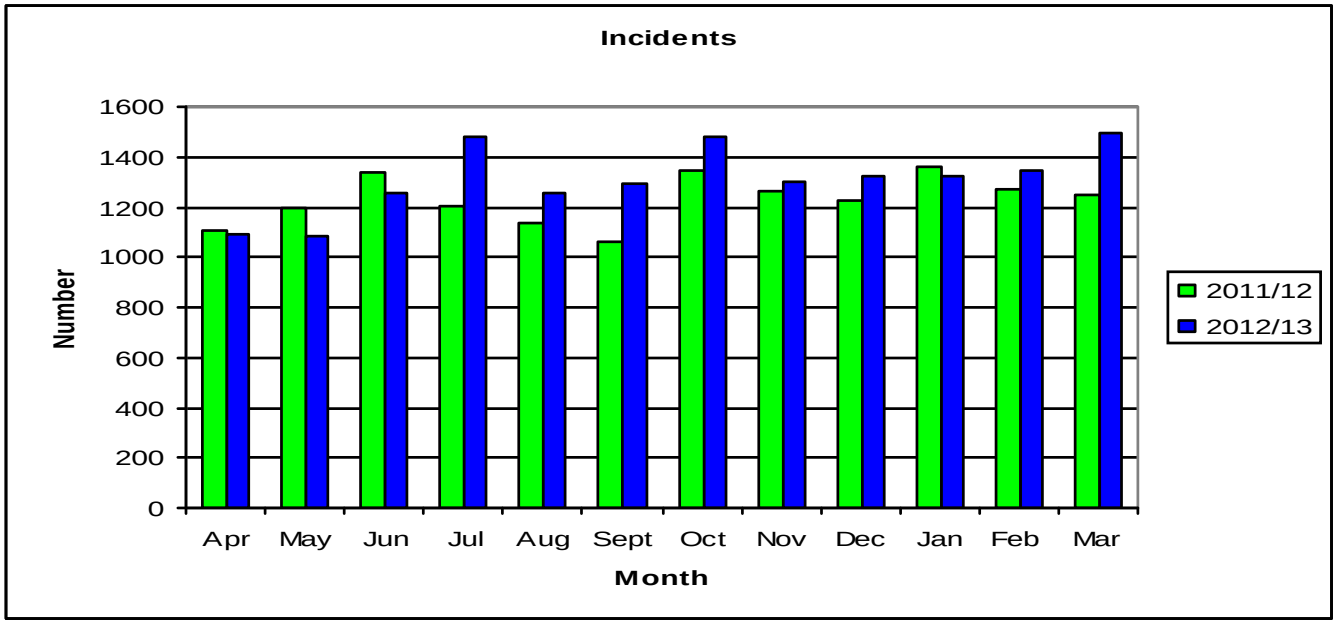
Compliance	January	February	March
90-100%	93%	80%	75%
70-89%	100%	100%	100%

Controlled Drugs

Compliance	January	February	March
90-100%	80%	80%	80%
70-89%	90%	85%	90%
50-69%	100%	100%	100%

There has been a reduction in compliance with performance against general drug standards; action plans are in place to address the issues (including purchase of new drug cupboards / fridges).

9.7 Incidents



Incidents in March 2013

Total Number of Incidents reported		**1499**
Of the total: *(* incidents still under investigation)*		
Near miss		225
No Harm		730
Low (minimal harm)		451
Moderate		84
Severe (permanent or long term harm)		5
*Death (related to the patient safety incident)		4
"Top 5" Reporters (Acute)		
1	Emergency Departments (both)	257
2	Priory 5	86
3	Labour Ward	65
4	Emergency Assessment Unit	50
5	Lyndon 4	44
"Top 3" Reporters (Community)		
1	Leasowes Intermediate Care	21
2	Community Nurses Mesty Health Visiting	15
3	VHC	12
"Top 5" Type**		
1	Medication lost/discrepancy/not available	57
2	Organisational issues	56
3	Verbal abuse (patient on staff)	47
4	Pressure sores -community acquired	41
5	Communication failure - with patient/team	34

*** 344 incidents are not yet assigned to a causative group*

Issue / Risk	Action to take / taken	Who by	When by
There are a large number of incidents that have been awaiting a management response for more than 4 weeks which could potentially lead to delays in recognising a rising trend or more serious incidents.	• Managers and Risk coordinators to systematically clear any "overdue" incidents. • Risk Team to print all "overdue" incidents on paper for managers as an alternative to using electronic systems. • Continued production of the "web holding" report advising of monthly status of incidents.	Managers and Risk coordinators Head of Risk	July 2013

Incident reporting

Reporting of incidents across the Trust continues to rise year on year which evidences an improving safety culture. This has been shown in the latest benchmarking report from the National Reporting and Learning System (NRLS) when compared against similar sized acute organisations in the West Midlands.

October 2011 to March 2012	SWBH ranked 4th from the top of the middle 50% of reporters with a reporting rate of 6.7 per 100 incidents against a median of 5.9
April 2012 to September 2012	SWBH ranked 4th from top of the top 25% of reporters. We reported 9.4 incidents per 100 against a median of 6.2.

We also continue to improve the rate at which we are reporting incidents, but there is more work to be done to improve this position.

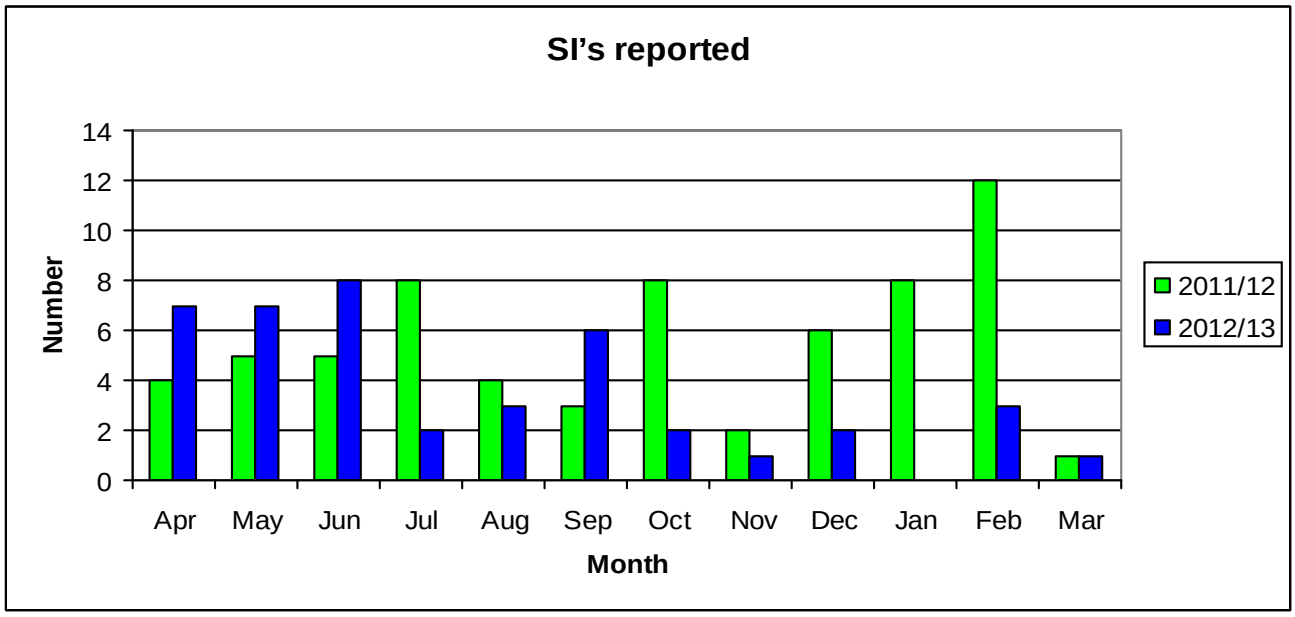
The degree of harm is also reported to the NRLS and we continue to show a higher or a similar rate of incidents resulting in moderate or severe harm or death attributed to the incident. However, in the latest report the consistent application of the NPSA definitions of harm has had the effect of reducing our reporting rates from nearly double in the moderate and severe categories.

	Moderate harm		Severe harm		Death caused by the Patient Safety Incident	
	All large acute organisations	SWBH	All large acute organisations	SWBH	All large acute organisations	SWBH
October 2011 – March 2012	5.9%	12.1%	0.6%	1.0%	0.1%	0.2%
April 2012 – September 2012	5.3%	6.7%	0.6%	0.6%	0.1%	0.2%

9.8 Serious Incidents (SIs)

In **March 2013** there was **1** new SI reported to CCG/SHA

- **2013/9239 – Multiple Departments**
  Sub optimal care of an acutely unwell patient

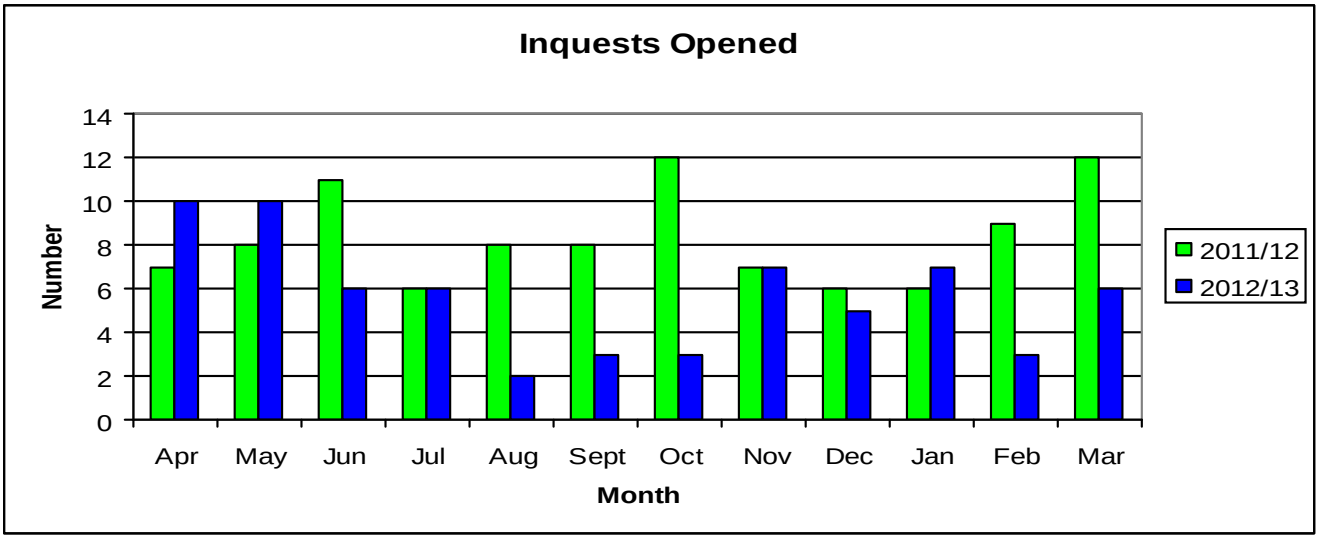


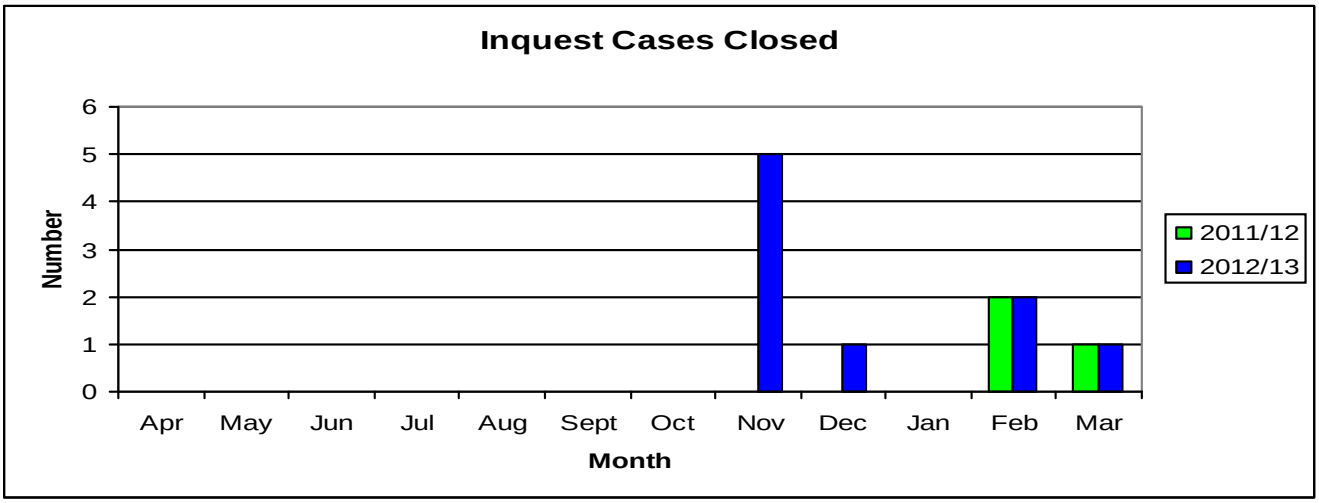
NB: The serious incidents reported in the graph above do not include pressure sores, fractures resulting from falls, ward closures, some infection control issues or health and safety incidents.

Issue / Risk	Action to take / taken	Who by	When by
Delays in closing pressure sore incidents reported to the CCG due to a change in internal process.	Reports for avoidable pressure sores to be sent to risk team to ensure adequate information to enable closure with CCG.	Assistant Director of Nursing (Quality)	May 2013
Some incidents remaining open on the CCG database past the 45 day deadline.	Patient Safety Manager assigned to manage and monitor closures. Process discussion with CCG to ensure timely closure.	Head of Risk	March 2013

9.9 Inquests

During March 2013 **6** new inquest cases were notified to the Trust.





During March 2013 **1** Inquest case was closed.

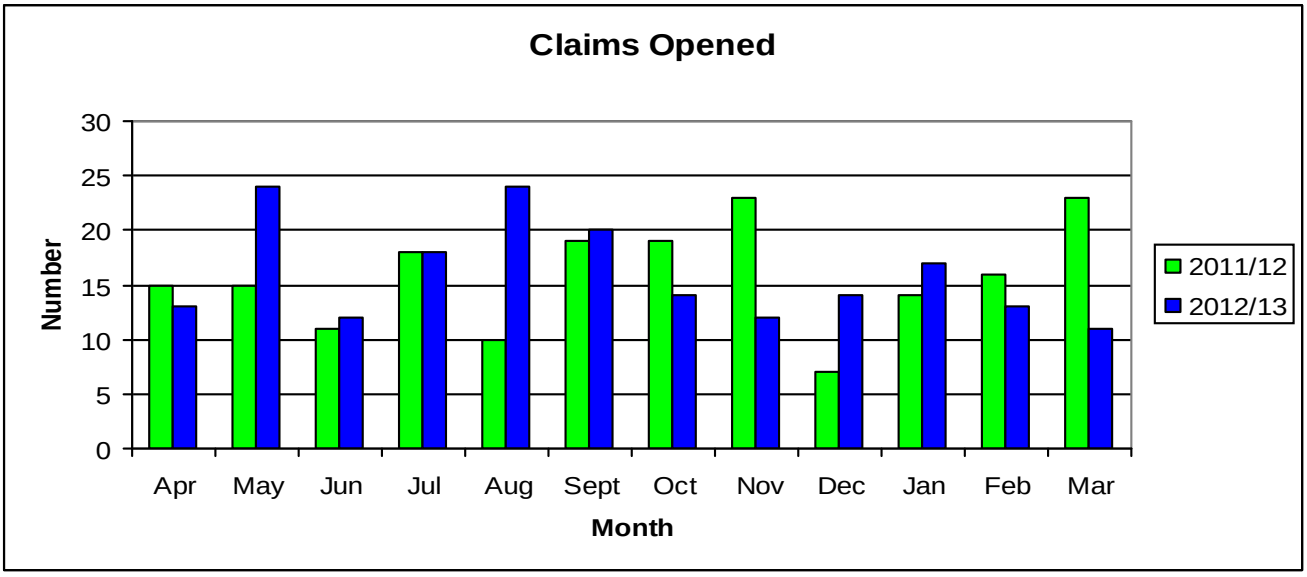
- This case was originally opened in February 2012. The outcome was a narrative verdict with no issues for the Trust.

Issue / Risk	Action to take / taken	Who by	When by
A large number of Inquests have not yet been held and a continued flow of Inquests being received.	• Systematic process to be defined with use of checklists. • Use of a centralised diary to ensure timely follow-up of clinician statements for the Coroner.	Legal Services Manager	May 2013

9.10 Claims

There are **8** new claims opened in March 2013.

The claims opened in March were 2 employer liability and 9 clinical negligence cases. 2 employer liability cases were closed during the month.



Issue / Risk	Action to take / taken	Who by	When by
A large number of clinical negligence cases remain open due to delays in notifying solicitors where no action has taken place.	• Review of all open files. • Close all previously advised cases on the database. • Write to all solicitors where no activity has occurred for 6-12 months.	Legal Services Manager	July 2013

9.11 Nurse Staffing Levels

This data summary was not available at the time of writing the report.

Bank & Agency

The Trust's nurse bank/agency rates are detailed in the tables below and show year on year comparison from 2008/9 to date. Notably we are now using more nurse bank/agency than we have for the past 4 years.

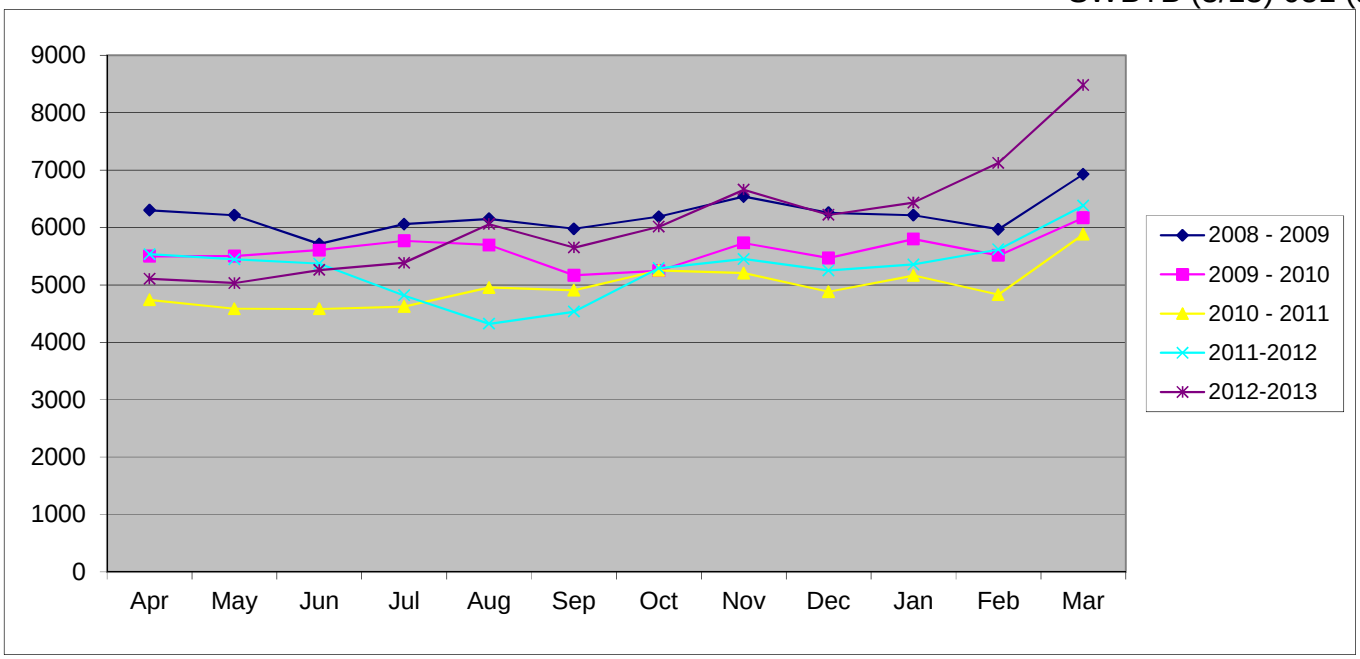


Figure 15: *Total Bank & Agency Use Nursing April 2008 –date.*

10 CLINICAL EFFECTIVENESS

10.1 Mortality

CQUIN Target

As part of the Trust's annual contract agreement with the commissioners the Trust has agreed a CQUIN scheme with an end year target to review 80% of hospital deaths within 42 working days.

During the most recent month for which complete data is available (January) the Trust reviewed 49% of deaths compared with a target trajectory for the month of 74%. The Trust has failed to meet the trajectory for January. Operational pressures within the trust have had effects on many parts of the organisation and carrying out mortality reviews has not escaped. Performance is looking more encouraging for February as 49% of deaths have already been reviewed at this early stage in the month.

In addition, the Trust has developed and implemented a revised Mortality Review System which will spread the burden of carrying out reviews more equitably across the medical specialities. The impact of this new system will not be seen until reporting of the march figures takes place.

The Medical Director's Team is working closely with the Medical Clinical Managers to reinforce the importance of carrying out mortality reviews and learning from the findings.

The value of this CQUIN for 2012 / 2013 is approximately £743K.

2012/13	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Target	60	60	60	62	64	66	68	71	74	74	77	80
% reviewed 42 days	59	64	68	64	65	69	53	63	66	49		
DEATHS (all trust)	133	146	126	121	132	121	139	108	136	150	143	181

Figure 16: *Data from QMF dashboard, CDA 9/4/12*

HSMR (Source: Dr Foster)

The Hospital Standardised Mortality Ratio (HSMR) is a standardised measure of hospital mortality and is an expression of the relative risk of mortality. It is the observed number of in- hospital spells resulting in death divided by an expected figure.

The Trusts 12-month cumulative HSMR (87.8) remains below 100, and is less than the lower statistical confidence limit and continues to remain lower than that of the SHA Peer (96.7). The in-month (January 13) HSMR for the Trust has decreased to 81.4 (Figure ( ))

12 month cumulative site specific HSMR's are 76.2 and 99.7 for City and Sandwell respectively, neither of which are currently in excess of upper statistical confidence limits.

Summary Hospital – Level Mortality Indicator (SHMI)

The SHMI is a national mortality indicator launched at the end of October 2011. The intention is that it will complement the HSMR in the monitoring and assessment of Hospital Mortality. One SHMI value is calculated for each trust. The baseline value is 1. A trust would only get a SHMI value of 1 if the number of patients who die following treatment was exactly the same as the number expected using the SHMI methodology. SHMI values have also been categorised into the following bandings.

1	where the Trust's mortality rate is 'higher than expected'
2	where the trust's mortality rate is 'as expected'
3	where the trust's mortality rate is 'lower than expected'

The last SHMI data was published on 24/01/13 for the period July 11 – June 12. For this period the Trust has a SHMI value of 0.97 and was categorised in band 2.

- 11 trusts had a SHMI value categorised as 'higher than expected'
- 16 trusts had a SHMI value categorised as 'lower than expected'
- 115 trusts had a SHMI value categorised as 'as expected'

Further SHMI data for the period October 2011 – September 2012 is due to be published this month. In addition, the UHBT Healthcare Evaluation Data (HED) tool provides data in month based on the SHMI criteria. The SHMI includes all deaths up to 30 days after hospital discharge. The Trust SHMI for the most recent period for which data is available is 94.4.

Mortality table 2012/13

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan
Internal Data:										
Hospital Deaths	133	146	126	121	132	121	139	106	140	157
Dr Foster 56 HSMR Groups:										
Deaths	110	129	111	100	113	101	124	89	126	132
HSMR (Month)	84.6	89.2	89.7	85.5	83.9	84.8	91.1	64.2	83.3	81.4
HSMR (12 month cumulative)	89.7	88.3	96.4	95.5	94.2	93.1	92.5	90.4	89.1	87.8
HSMR (Peer SHA 12 month cumulative)	94.9	93.3	101.3	100.2	98.7	97.8	96.7	96.4	96.8	96.7
Healthcare Evaluation Data (HED) SHMI (12 month cumulative)	96.2	96.0	96.3	95.3	94.2	95.6	94.9	94.4	-	-

Figure (17) Mortality Statistics

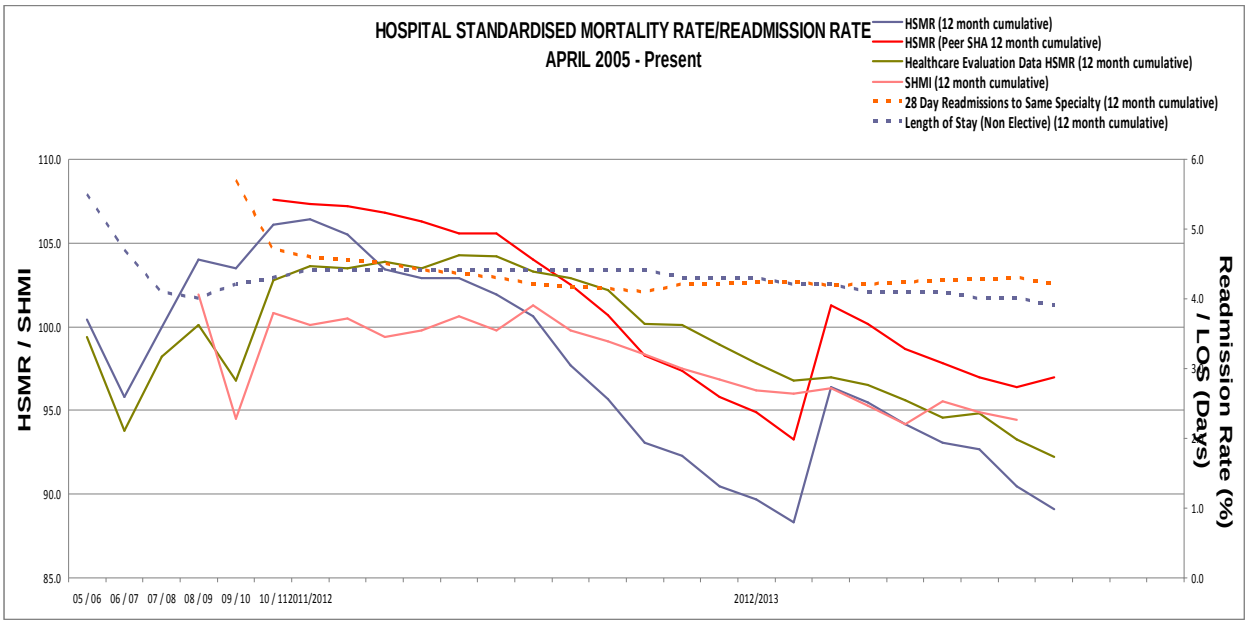


Figure (18) : *HSMR/Readmission rate data April 05 - December 12*

CQC Mortality Alerts received in 2012/13

No new mortality outlier alerts have been received.

Dr Foster generated alerts (RTM)

There were no new diagnoses or procedures alerting with significant variation in terms of mortality when the data period February 2012 – January 2013 is considered (see table below).

Mortality (in-hospital) - Diagnoses										Alert	
Team	Diagnoses	Superspells	Deaths	%	Expected	%	Relative Risk	Low	High	-	+
ALL	HSMR Basket of 56 Diagnosis Groups	40113	1426	3.6%	1623.6	4.0%	87.8	83.3	92.5		8
ALL	Acute and unspecified renal failure	332	45	13.6%	63.1	19.0%	71.3	52.0	95.4		2
ALL	Acute bronchitis	1338	28	2.1%	39.7	3.0%	70.5	46.8	101.9		1
ALL	Acute cerebrovascular disease	616	92	14.9%	114.6	18.6%	80.2	64.7	98.4		1
ALL	Aspiration pneumonitis, food/vomitus	172	59	34.3%	62.1	36.1%	95.0	72.3	122.6		1
ALL	Congestive heart failure, nonhypertensive	825	73	8.8%	102.9	12.5%	70.9	55.6	89.2		4
ALL	Diabetes mellitus with complications	361	8	2.2%	12.1	3.3%	66.4	28.6	130.8		1
ALL	Nonspecific chest pain	3723	1	0.0%	3.7	0.1%	27.2	0.4	151.4		1
ALL	Pneumonia	1744	323	18.5%	356.8	20.5%	90.5	80.9	101.0		1
ALL	Pulmonary heart disease	282	18	6.4%	13.4	4.8%	134.1	79.4	211.9	1	
ALL	Residual codes, unclassified	613	3	0.5%	6.5	1.1%	46.1	9.3	134.8		1
ALL	Septicemia (except in labour)	142	19	13.4%	30.4	21.4%	62.6	37.7	97.7		1
ALL	Short gestation, low birth weight, and fetal growth retardation	798	8	1.0%	18.7	2.3%	42.9	18.5	84.4		2
Mortality (in-hospital 30 days) - Procedures										**Alert**	
Team	Procedures	Superspells	Deaths	%	Expected	%	Relative Risk	Low	High	-	+
ALL	Puncture of joint	488	2	0.4%	4.1	0.8%	48.9	5.5	176.4		1
ALL	Reduction of fracture of bone (upper/lower limb)	865	3	0.3%	4.4	0.5%	67.5	13.6	197.2		1

Significantly worse than benchmark
Significantly better than benchmark
No significant variation from benchmark

Figure (19): Mortality in hospital diagnoses

National Clinical Audit Supplier – Potential Outlier Alerts

The Trust was notified on 19/03/13 by the National Bowel Cancer Audit of being a potential outlier with a higher than expected rate of 2 year mortality. A review is being undertaken to determine the reasons for the potential outlier status.

10.2 Patient Related Outcome Measures (PROMs)

Further provisional data in the form of experimental statistics was published on 14/02/13 for the period April 12 to October 12. This data is being discussed with the Divisional Director for Surgery A to determine further action to be taken to improve scores.

10.3 Clinical Audit

Clinical Audit Forward Plan 2013/14

The Clinical Audit Forward Plan for 2013/14 covering the key priority areas for audit is being submitted for approval by the Clinical Effectiveness Committee at the meeting to be held on 12/04/13. A summary of the outputs from the 2012/13 plan will be presented to the committee in May.

10.4 Compliance with the 'Five Steps for Safer Surgery'

Compliance with the "Five Steps to Safer Surgery" process is reported using the Clinical Systems Reporting Tool (CSRT).

The reported compliance with the 3 sections in the checklist for March 2013 is shown in the table below (data source CDA) .

2012/13	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
WHO Checklist Safer Surgery Audit - 3 Sections (All areas)	99.45 %■	99.65% ▲	99.83 %▲	99.46% ▼	99.82 %▲	99.80 %▼	99.72 %▼	99.83 %▲	99.38 %▼
WHO Checklist Safer Surgery Audit - 3 Sections and Brief	92.89 %■	93.90% ▲	93.50 %▼	93.55% ▲	94.17 %▲	96.75 % ▲	95.27 %▼	95.81 %▲	95.29 %▼
WHO Checklist Safer Surgery Audit - 3 Sections, Brief and Debrief	80.61 %■	80.67% ▲	76.33 %▼	81.71% ▲	81.61 %▼	89.19 %▲	84.32 %▼	83.71 %▼	82.07 %▼

Figure 20: *WHO checklist compliance (data source CDA SHA submission and CQUIN Compliance Report 9/4/13)*

The WHO Checklist Steering Group will be meeting quarterly from March 2013 onwards. The qualitative reviews focussing on the culture of patient safety in areas where interventions will be tested by the Theatre Matrons during the next month. The Clinical Effectiveness Team is scheduling audits of theatre care plans for WHOCL compliance during 13/14.

Performance management of non-compliant lists continues.

10.5 Stroke care

Performance against the principal stroke care targets to which the Trust is working in 2012/13 is outlined in the table below.

Stroke Care- Source- CDA Dashboard 13/3//13	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
% Spending >= 90% of stay on stroke unit	91.18 %▼	93.88 %▲	94.12 %▲	85.11 %▼	85.19 %▲	86.96% ▲	84.91 %▼	86.79% ▲	80.70 %▼	83.02 %▲	82.14 %▼
Admitted to stroke unit within 4 hrs of arrival at hospital	76.67 %▲	72.22 %▼	72.55 %▲	65.31 %▼	68.75 %▲	67.44% ▼	52.08 %▼	60.87% ▲	44%▼	50%	41.38
CQUIN: % pts receiving brain imaging in 24 hrs of admission	94.74 %■	98.11 %▲	98.33 %▲	95.00 %▼	88.37 %▼	96.23% ▲	100.00 %▲	91.84% ▼	92.31 ▲	100	93.33 % ▼
Pts scanned within 1 hr of arrival at hospital	70.00 %▲	61.11 %▼	58.33 %▼	52.63 %▼	53.13 %▲	58.97% ▲	45.45 %▼	55.%32 ▲	56.00 %▲	51.52 ▲	48.15 %▼
TIA - ABCD2 >= 4 treated within 24 hours	61.54 %▼	50.00 %▼	100.00 %▲	66.67 %▼	80.00 %▲	60.00% ▼	84.62 %▲	76.47% ▼	57.89 %▼	66.67 %	54.14 %▼
TIA - ABCD2 < 4 treated within 7 days	57.14 %▼	48.15 %▼	68.42 %▲	66.67 %▼	88.37 %▲	96.77% ▲	86.49 %▼	100.00% ▲	87.50 %▼	77.23 %▼	91.67 %▲

Figure 21: *Performance against stroke care targets (data CDA Stroke & TIA Dashboard 13/3/13)*

The Stroke Unit opened at Sandwell on 11th March 2013.It is anticipated that the new unit will facilitate an even higher quality of stroke care and patient experience.

10.6 Treatment of Fractured Neck of Femur within 48 hours

The Trust has an internal Clinical Quality target whereby 70% of patients with a Fracture Neck of Femur receive an operation within 24 hours of admission. Data for March (Source CDA –QMF Dashboard 13/3/13) indicates 70% of patients with a Fractured Neck of Femur received an operation within 24 hours of admission, resulting in a year to date performance of 68.28%. Performance has improved significantly throughout the year from 45.83% in April 2012. *Internal Priority*

10.7 Ward Reviews

The Ward Reviews are not due for reporting this month.

10.8 Quality Audits

These audits include:

- Essence of care standards (DoH)
- Same sex standards
- Observations of care
- Patient ID and uniform audits

Audits are conducted twice yearly in all adult in patient areas.

Trust Wide Clinical Care Compliance (comparison of data from June 2012 to February 2013)					
Clinical Care Component	June 2012	November 2012		February 2013	
	Percentage compliance	Percentage compliance		Percentage compliance	
Promoting Health and wellbeing	83%	77%	↓	79%	↑
Generic	95%	86%	↓	94%	↑
Orientation to ward (inc bed board compliance)	-	86%	-	92%	↑
Privacy and Dignity	88%	87%	↓	96%	↑
Bladder and Bowel	98%	82%	↓	95%	↑
Eating and drinking	98%	83%	↓	96%	↑
Safety	96%	90%	↓	93%	↑
Individualised/ self care	97%	85%	↓	94%	↑
Environment and staff	96%	85%	↓	88%	↑
Observations of Care	98%	89%	↓	96%	↑
Overall Compliance	94%	83%	↓	94%	↑

Figure 22: Observation of Care Trust Wide data comparison from June 2012 to February 2013

6.18 Trust Wide Documentation Compliance: risk assessments (comparison of data from June 2012 to February 2013)					
Risk Assessment	June 2012 (Base: 622 patients)	November 2012 (Base: 522 patients)		February 2013 (Base: 632 patients)	
	Percentage compliance	Percentage compliance		Percentage Compliance-CQUIN 95%	
Tissue Viability	97%	97%	↔	91%	↓
Falls	98%	97%	↓	92%	↓
Bladder and Bowel	96%	94%	↓	99%	↑
Communication	96%	96%	↔	98%	↑
Patient Hygiene	96%	97%	↑	92%	↓
Moving and Handling	97%	96%	↓	92%	↓
Pain	96%	95%	↓	98%	↑
Oral Hygiene	94%	97%	↑	91%	↓
Record keeping	89%	86%	↓	92%	↑
Mental Health	95%	92%	↓	91%	↓
Nutrition	93%	92%	↓	89%	↓
Overall Compliance	95%	95%	↔	92%	↓

Figure 23: Patients being risk assessed against prescribed benchmarks: comparison of Trust wide data

'Care Rounds' were implemented on Adult inpatient areas in 2012 for patients who do not require high levels of intervention, whereby a nurse visits the patient either hourly or two hourly to attend to comfort needs (pain relief, positioning, toileting, food/ fluids etc) and follows prescribed standards of care. Those patients whose clinical condition dictates a higher level of intervention, the care standards are replaced with detailed care plans.

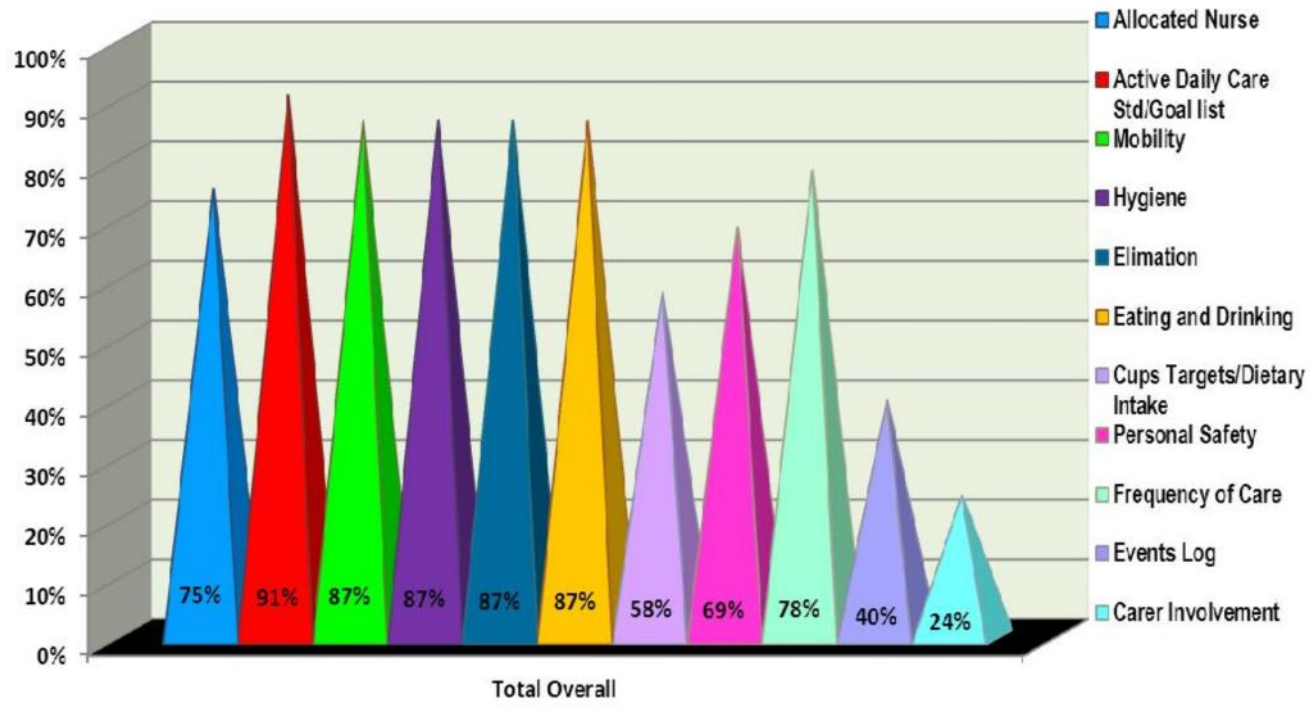


Figure 24: Compliance of 2 hourly patient checks

11 PATIENT EXPERIENCE

11.1 Net Promoter

The Trust's overall Net Promoter Score (NPS) decreased to 63, and was below the SHA target of 65 for the first time since October. *CQUiN* SHA ambition requires both the improvement on score plus weekly reporting.

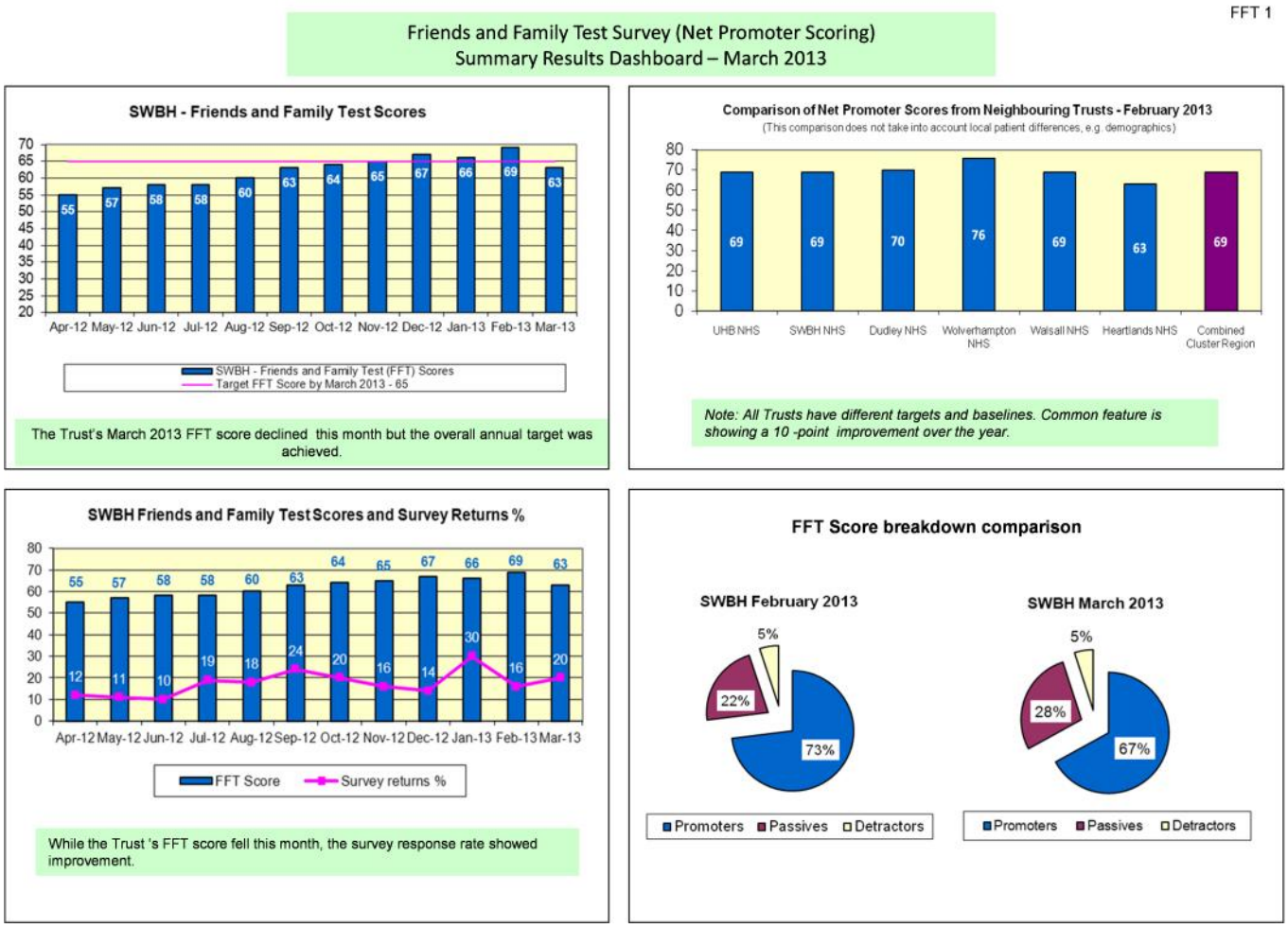


Figure 25: *Net Promoter position*

Resources have now been identified to expand the Patient Experience Team which will enable a more robust and co-ordinated approach to improvements in patient experience and bringing patient experience to the Trust Board.

Friends and Family test Accident and Emergency

Hospital Site Details		Total responses in each category for A&E Department								
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name	1 - Extremely Likely	2 - Likely	3 - Neither likely or unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know	Total Number of people eligible to respond	Total number of responses for each A&E department	Response rate for each A&E department
	City Hospital - RXK02	21	6	4	5	0	0	5177	36	0.7%
	Sandwell General Hospital - RXK01	27	5	0	3	0	0	4328	35	0.8%
	Birmingham Midland Eye Centre (Bmec) - RXK03	56	6	3	4	0	1	1968	70	3.6%
	Total	104	17	7	12	0	1	11473	141	1.2%

Figure 26: Friends & Family Test results for A&E

11.2 Complaints

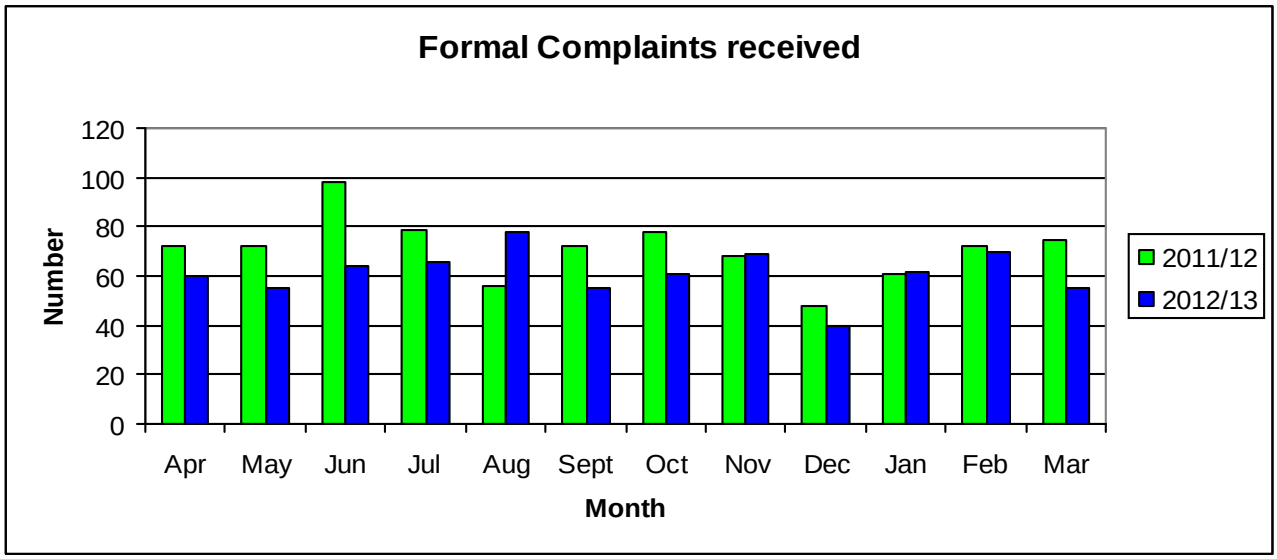


Figure 27: Formal complaints received

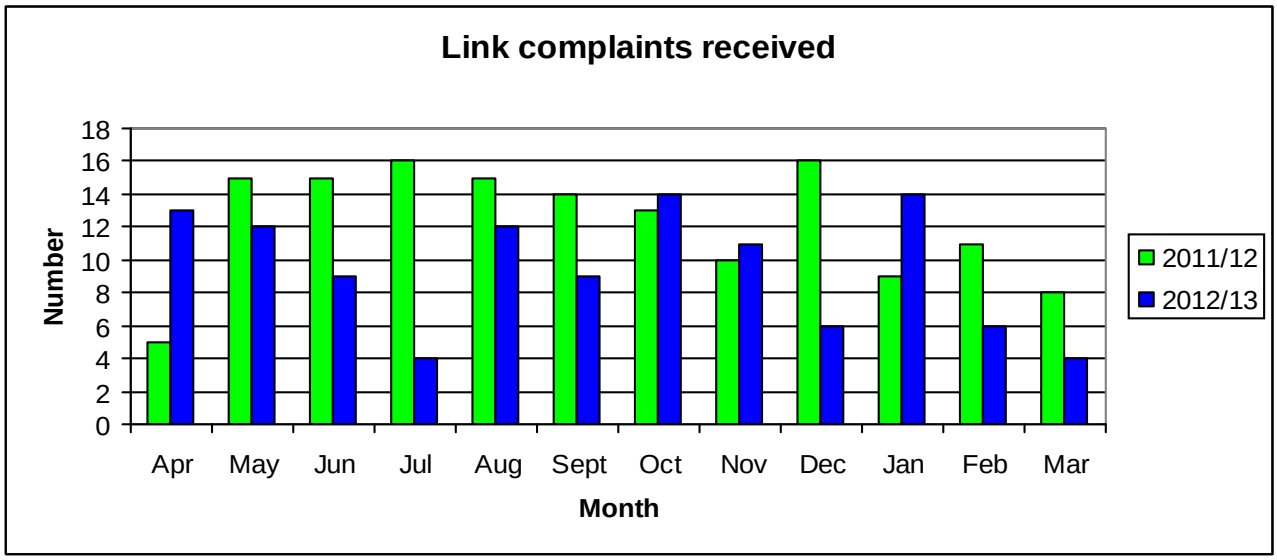


Figure 28: Link complaints - *the complainant has received the substantive response to their complaint but has returned as they remain dissatisfied and/or require additional clarification.*

Complaints comparative data

Context

The total formal and link complaints received requiring a response in March 2013 (n = 59) has fallen significantly when compared with February 2013 (n = 76).

March 2013 shows a 29% decrease compared with the same month last year (n = 83).

Categorisation

The 55 formal complaints received in March 2013 were graded as follows:

Red	1	Amber	6	Yellow	33	Green	15

Themes	Learning
The top 5 themes are: • Dissatisfaction with medical treatment (n = 27) • Dissatisfaction with nursing care (n = 24) • Attitude of nursing staff (n = 9) • Long waits in clinics and departments (n = 8) • Failure or delay in diagnosis (n = 5)	All complaints received in March are in the process of being investigated. Learning from complaints closed in February include: • Ensure that future cancellation letters are issued in a timely matter if appointments are cancelled. • Nursing staff on the Day Surgery Unit have been reminded of the correct procedures to follow when placing any patient belongings into safekeeping, both to ensure clear labelling of the belongings and to place these items into the ward safe. • Matron has arranged training for her staff in insulin management.

Figure 29: Complaint themes and lessons learned

11.3 Parliamentary and Health Service Ombudsman (PHSO)

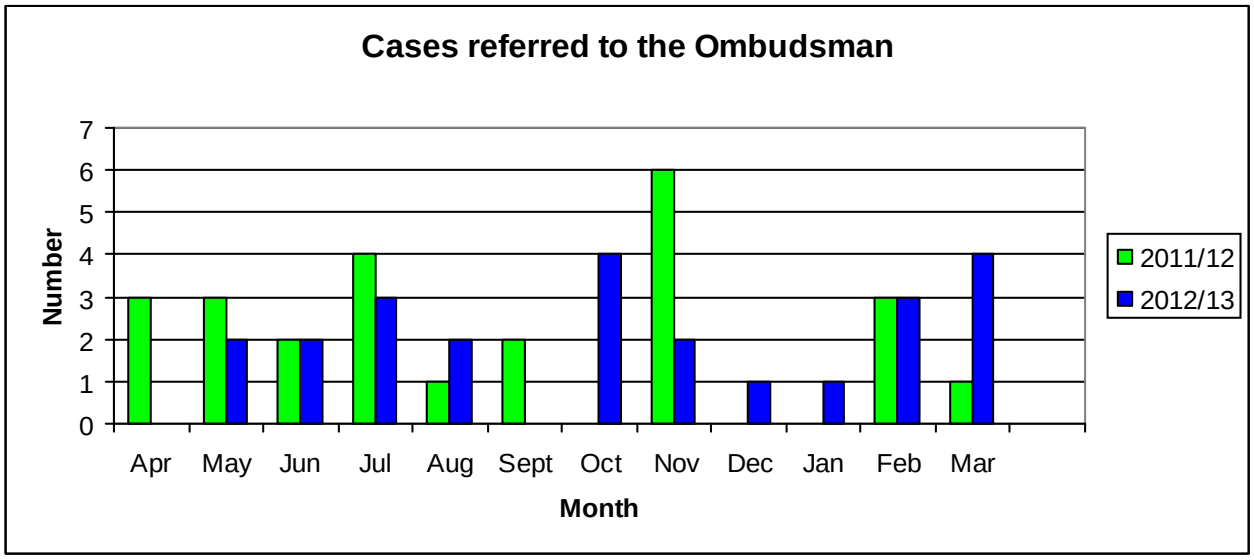


Figure 30: Cases referred to the PHSO

The Trust currently has 13 active cases with the PHSO

11.4 PALS

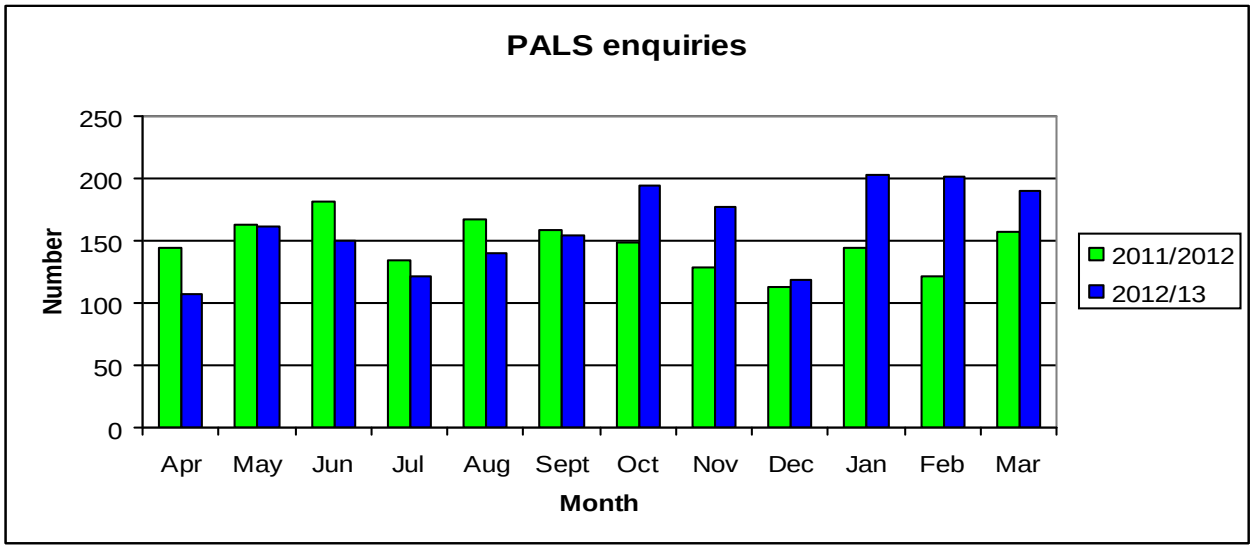


Figure 31: PALS enquiries

PALS comparative data

Context

Total PALS enquiries received in March 2013 (n = 190) have fallen marginally when compared with February 2013 (n = 202). 3 of the PALS cases were related to the community and the rest related to acute services.

March 2013 shows an increase compared with the same month last year (n = 157). However, the Patient Support Centre also deals with general enquiries and these were significantly increased (2011/12 n = 171 compared with 2012/13 n = 289).

Themes	Learning
The top 5 themes are: • Issues relating to clinical treatment • Cancellation of appointments, mainly relating to lack of communication. • Issues relating to the request for formal complaints advice • Lack of communication, mainly with relatives. • Delays or inappropriate discharge and transfer arrangements.	In March, PALS have investigated concerns and have assisted with a number of initiatives to improve the patient experience including: • Manager agreed to allocate appointment slots further apart to avoid the same delay happening again. • Staff member apologised for being rude and explained the usual Trust process to the patient. • Equipment supplies for community catheter care have been enhanced and staff advised of the correct follow up care procedures.

Figure 32: PALS themes and lessons learned

11.5 End of Life

End of Life Report

Targets/Metrics: *CQuIN* 10% increase in number of patients achieving preferred place of death who are on a supportive care pathway – Acute and Community. This is also a national nursing high impact action and nurse sensitive indicator. The target for this year is 53%.

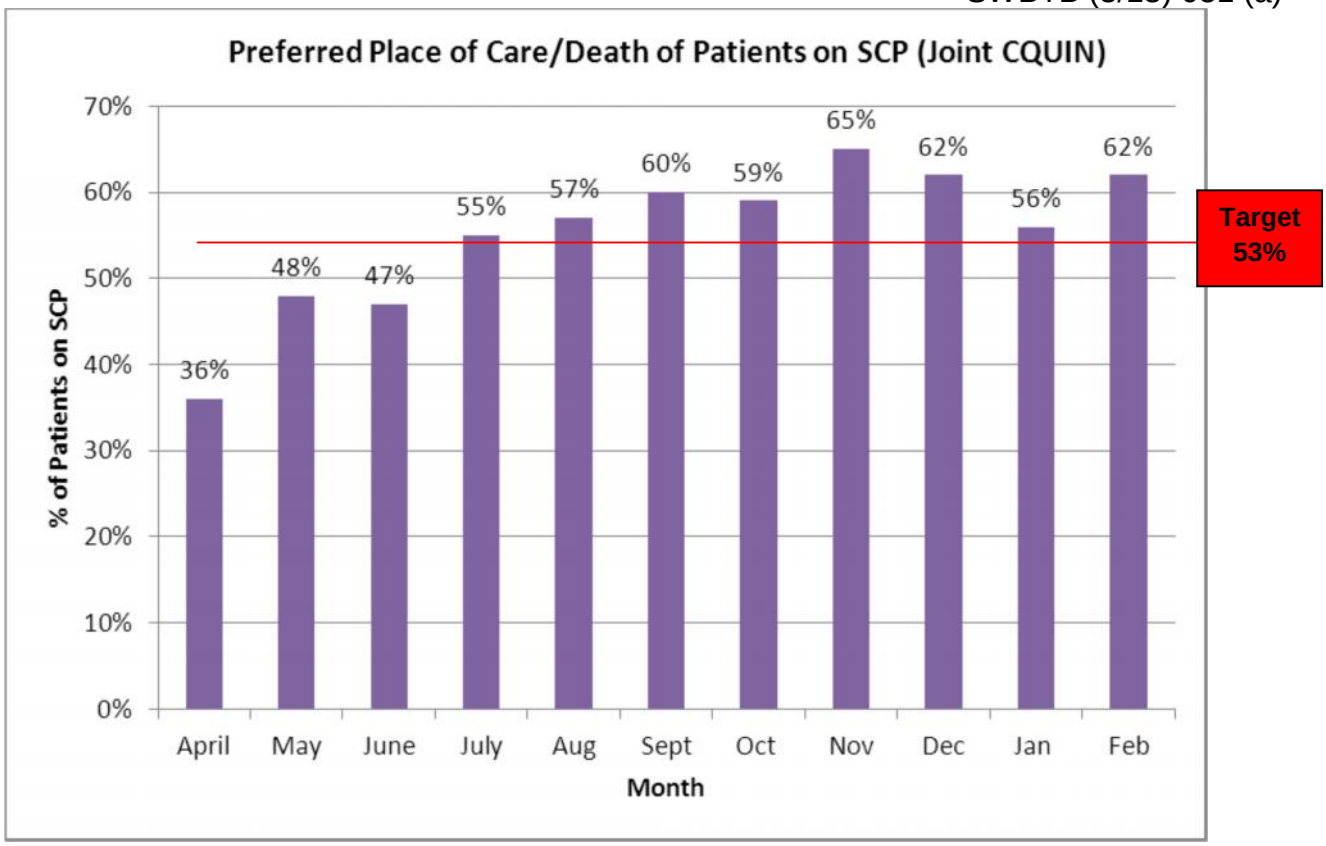


Figure 33: *Preferred place of death/death of patients on SCP*

12 WORKFORCE QUALITY

The Board is asked to note key headlines from the workforce dashboard for March 2013.

	% Trust	% Target
Mandatory Training	86.41%	(85%)
PDR	69.16%	(85%)
Turnover (leavers)	10.33%	-
Sickness absence	4.47% (compared to the same time last year 4.39%)	(3.5%)

13 RECOMMENDATION

The Trust Board is asked to:

- **NOTE** in particular the key points highlighted in Section 2 of the report and **DISCUSS** the contents of the remainder of the report.

APPENDIX 1

Glossary of Acronyms

Acronym	Explanation
CAUTI	Catheter Associated Urinary Tract Infection
C Diff	*Clostridium difficile*
CRB	Criminal Records Bureau
CSRT	Clinical Systems Reporting Tool
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
ED	Emergency Department
DH	Department of Health
HED	Healthcare Evaluation Data
HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
ID	Identification
LOS	Length of Stay
MRSA	Methicillin-Resistant Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NPSA	National Patient Safety Agency
OP	Outpatients
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
RAID	Rapid Assessment Interface and Discharge
RTM	Real Time Monitoring
SHA	Strategic Health Authority
SHMI	Summary Hospital-level Mortality Indicator
TIA	Transient Ischaemic Attack ('mini' stroke)
TTR	Table top review
UTI	Urinary tract infection
VTE	Venous thromboembolism
Wards:	
EAU	Emergency Assessment Unit
MAU	Medical Assessment Unit
D	Dudley
L	Lyndon
N	Newton
P	Priory
A&E	Accident & Emergency
ITU	Intensive Therapy Unity
NNU	Neonatal Unit
WHO	World Health Organisation
WTE	Whole time equivalent
YTD	Year to date

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Plan Delivery Report 2012/13 – Q4 Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon – Director of Strategy and OD**
AUTHOR:	**Neetu Sharma – Head of Strategic Planning**
DATE OF MEETING:	**25 April 2013**

EXECUTIVE SUMMARY:

The document provides an update on progress of delivery for the key activities and objectives included in the Trust Annual Plan for Q4.

This report provides a summary of progress against each of the five Trust priority areas for the year as well as the sections of the Annual Plan that were required by the SHA at the time. It covers the following themes:

- Delivering the Quality priorities set out in our quality account and annual plan
- Workforce Plans
- Progressing towards becoming a Foundation Trust
- Achieving key access targets
- Right Care Right Here
- Service Developments (other than RCRH)
- Sustainability
- Delivering the Transformation Plan

Of the eight summary themes; **4 are GREEN**, **2 are AMBER** and **2 are RED**.

The **red** actions and a brief description are as follows:

- **Progress towards becoming a Foundation Trust** – the timelines in the Tripartite Formal Agreement (TFA) require further negotiation in light PF2. A proposed trajectory has been submitted to the NTDA as part of the annual plan submission.
- **Right Care Right Here** - QIPP saving activity reductions only identified at a high level and to the value of £6.3million against the LDP agreement of £10 million. Activity to date for 2012/13 is above plan particularly for non-elective (emergency) admissions and so the expected QIPP activity reductions have not been realised

The **amber** actions and a brief description are as follows:

- **Workforce plans** - sickness absence continues to be off trajectory; E-rostering has been delayed in roll out due to ward closure/opening issues and there are issues around the detail of TSP's to enable identification of potential WTE effect.
- **Achieving key access targets** - ED Performance continued to deteriorate in Q4; Trajectory for improvement for T&O and plastics 18 weeks improvement impacted by bed closures due to infection control issues which continue

REPORT RECOMMENDATION:

To discuss progress against achievement of the key activities outlined in the Trust Annual Plan for Q4.

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:

Relates to all annual priorities

PREVIOUS CONSIDERATION:

January 2013 Public Trust Board (Q3 update)

Trust Board – 25th April 2013

Annual Plan – Quarter 4 Update

1.0 Introduction

The purpose of this report is to provide an update on delivery of each of the key priorities identified in the 2012/13 Annual Plan.

2.0 Delivery against Priorities

This report provides a summary of progress against each of the five Trust priority areas for the year as well as the sections of the Annual Plan that were required by the SHA at the time. This report therefore covers the following summary themes:

- Delivering the Quality priorities set out in our quality account and annual plan
- Workforce Plans
- Progressing towards becoming a Foundation Trust
- Achieving key access targets
- Right Care Right Here
- Service Developments (other than RCRH)
- Sustainability
- Delivering the Transformation Plan

It provides a summarised analysis of progress and informs the Board where more detailed reporting of individual objectives takes place.

Of the eight summary themes; **4** are GREEN , **2** are AMBER and **2** are RED (FT and RCRH).

3.0 Recommendations

The Board is asked to:

- Accept progress against delivery of each of the key priorities identified in the 2012/13 Annual Plan.
- Consider the key issues outlined for the attention of the Board for each key priority area.

Update Against Key Priorities – Q4	
Key Priority Area	**Delivering quality priorities set out in our quality account and annual plan.**
Executive Lead	Chief Nurse/Director of Governance/Medical Director
Summary of position	Details of our current position are set out in the Quality Report which is reported to Q&S Committee and Trust Board every month. In summary: • CQuINs are all on target for end of year achievement with exception of inpatient survey results and mortality reviews. • Infection Control targets are being achieved. • Safety Thermometer is currently registering 96% harmfree care (target 95%). • ED action plan (special measures) is progressing well • Pressure damage rates are continuing to reduce • Patient experience continues to be measured predominantly by the Friends and Family Test and is currently showing a score of 69 (on target). • A Patient Experience Strategy and action plan went to Quality & Safety in March and was approved. • Due to operational pressures and transitioning to a new IT system mortality reviews are behind trajectory – final year figures will not be available until May. • VTE risk assessments are achieving >90% target • WHO checklist compliance is on target • HSMR and SHMI remain on a downward trajectory with significant closure of the gap between two sites.
Key issues to flag to the attention of the Board	The considerable capacity pressures in recent weeks have put a strain on maintaining quality standards in some areas. This has been compounded by an extensive and prolonged norovirus outbreak.
Current Reporting Process	All of the quality priorities are included in the Trust monthly Quality report which currently goes to Governance Board/Quality & Safety Committee and Trust Board.
RAG rating – Q4	**4**

Update Against Key Priorities – Q4 Template	
Key Priority Area	**Workforce Plans**
Executive Lead	Chief Nurse
Summary of position	• Workforce Efficiency Programme is currently delivering according to plan and includes: -WTE reduction (TSP) - Sickness absence reduction action plan - Roll out e-rostering and acuity tools - Management review - Bank/agency monitoring/controls - Best use of APC framework • HR dashboard continues to be reported. • The new Workforce Assurance Tool is currently in process of being adopted. • Currently on track with NHSLA standards. • A new HR Department structure has been developed and is now being consulted upon. • A new Trust Workforce Assurance structure has been approved and is now in the process of implementation.
Key issues to flag to the attention of the Board	• Sickness absence continues to be off trajectory. The action plan has been revised with some new initiatives included. • E-rostering delayed in roll out due to ward closure/opening issues. • Management review is complete but will not produce the anticipated savings. • Issues around detail of TSP's to enable identification of potential WTE effect. • National renegotiation of some AFC terms and conditions.
Current Reporting Process	• The workforce and medical efficiency programmes are reported via the Transformation Programme structures. • HR dashboard is reported at F&PC but will move to Workforce Assurance • Some key workforce measures are in the Quality Report and Performance report. • Various reports go to TMB.
RAG rating – Q4	**3**

Update Against Key Priorities – Q4	
Key Priority Area	**Progressing towards becoming a Foundation Trust**
Executive Lead	Director of Strategy and Organisational Development
Summary of position	In the last quarter the Trust has completed the following stages of the FT application: • Historical Due Diligence (HDD) stage 2 report sign-off and submission The announcement with regards to the development of PF2 will have implications for the Trust's FT timetable and Tripartite Formal Agreement (TFA). A revised TFA timeline has been developed and included in the Trust's annual plan return to the TDA. It is understood that it will be as part of this process that the TFA timeline will be renegotiated with the NTDA.
Key issues to flag to the attention of the Board	Given the work now required on the Trust's new Hospital plans, this will result in an approximate 13 month extension to our FT timetable, with our final submission to the National Trust Development Authority now due in April 2014. In spite of this delay, the Trust has a number of activities related to the FT application that will require delivery and improvement over the coming months. The Integrated Development Plan sets a number of challenging timescales for the Trust.
Current Reporting Process	FT Programme Director's Report to the Trust Board.
RAG rating – Q4	**2**

Update Against Key Priorities – Q4	
Key Priority Area	**Achieving key access targets**
Executive Lead	Chief Operating Officer
Summary of position	• Overall good performance with the exception of ED performance and 18 weeks at specialty level (Plastics and Orthopaedics): o ED 89.91% Q4 and 92.55% FYE (inclusive of GP activity) o March performance 18 weeks: orthopaedics admitted: 85.48% and Plastics 87.79% (unvalidated). • Sustained improvements in Delayed Transfers of Care (2.9%YTD) and continued delivery of Cancer targets. • Stroke: Variable performance in Stroke and TIA services with challenges in Q4 with stroke ward closed to infection control. Reconfiguration of services to Sandwell in March. *(performance relates to position as at 17.4.13)*
Key issues to flag to the attention of the Board	**Emergency Department Performance:** Sustained reduction in trend of serious incidents over this period and delivery of key aspects of special measures plan completed. Special measures concluded in March. Performance continued to deteriorate in Q4. Key issues include : • Workforce and leadership capability • Recruitment to new funded/ increased establishment • Development of processes and systems in ED including Health Informatics (IT) system • Capacity and flow: significant impact with closed capacity due to infection control issues over this period. • DTOC Despite progress against initiatives in ED and patient flow including those listed below, there remains underperformance against the ED targets: • Ambulance assessment model • GP service at both ED's • See and treat • Development of the clinical leadership role • Pilot of a clinical decision unit • Implementation of escalation standards • Development of eBMS to manage patient flow through bed base • Agile pharmacy and transport improvements 18 weeks**:** Trajectory for improvement for T&O and plastics impacted by bed closures due to infection control issues which continue. Recovery plan in revision.

Current Reporting Process	Performance reporting is via PMB to Trust Board. The Trust Board receives a monthly update on performance. Emergency Care Assurance Group Exceptional reporting on areas of risk are via individual agenda items e.g. ED updates and Stroke Reconfiguration Business Case.
RAG rating – Q4	**3**

Update Against Key Priorities – Q4	
Key Priority Area	**Right Care Right Here**
Executive Lead	Mike Sharon, Director of Strategy and Organisational Development
Summary of position	**RCRH Programme:** The new Programme meeting structure has been established. Waheed Saleem has been appointed as the new Programme Chair. **Implementation of Redesigned Care Pathways:** Progress continues to be made with implementation of the Musculo-Skeletal Pathways for elective joint replacement surgery. The CCG continue with their evaluation of a number of new community service models that have been implemented and that link to the pathways. This may result in new specifications being issued and for some of these services new commissioning arrangements (e.g. tendering or AQP) may follow. **QIPP Savings:** Of the £10million income reduction related to QIPP Savings and agreed as part of the LDP, high level plans were identified with activity reductions equating to circa £6.3million. Monthly activity and income monitoring continues to show overall activity is above plan particularly for non-elective (emergency) admissions and so the expected QIPP activity reductions have not been realised.
Key issues to flag to the attention of the Board	Whilst progress has been made in quarter 4 with implementing the RCRH redesigned care pathways, full implementation is now expected to take place during 2013/14. Through contract discussions with the CCG it is anticipated that the income reduction target related to QIPP savings will be circa £3million. At a high level the focus of schemes will be around reducing review outpatient attendances though revised pathways or alternative forms of follow up and reduction in procedures of limited clinical value. Benchmarking work is underway to compare SWBH performance with that of other Trusts in the West Midlands in order to identify specialities and procedures with the most opportunity for service redesign.
Current Reporting Process	Monthly RCRH Implementation Board meeting with quarterly progress report to Trust Board
RAG rating – Q4	**2**

Update Against Key Priorities – Q4	
Key Priority Area	**Service Developments (other than RCRH)**
Executive Lead	Mike Sharon, Director of Strategy and Organisational Development
Summary of position	Clinical Service Reconfigurations: • ***Vascular Surgery*** – transfer of inpatient service to UHBFT completed 10/9/12 • ***Stroke and Transient Ischaemic Attack (TIA) Services*** – consolidation of service at Sandwell in new Stroke and Neurology Unit from 19/3/13. Returns submitted to Network as part of SHA Strategic Review of Stroke Services. • ***Orthopaedic Inpatient Services*** – transfer to Sandwell Hospital completed 24/8/12 • ***Pathology*** - The Blood Sciences Laboratory phase 1a work completed on time, within budget and became operational early April 2013. Phase 1 b starts 1st May with a completion date at the end of September. The LTS study of our and Dudley Group of Hospitals Pathology Laboratories is ongoing, with additional work undertaken as requested by Dudley Group of Hospitals - final report due early May. The SHA tendering of GP direct access work continues. The tender exercise started at the end of January 2013 and the Trust submitted a PQQ return at the beginning of March. We expect to hear the outcome of this and whether we are invited to progress to the next stage in May. Following the Black Country tender for Cytology services and decision to consolidate Cytology services in Wolverhampton a similar consolidation has been agreed for Birmingham which will result in Cytology Services in Birmingham being provided by Heart of England Foundation NHS Trust. A number of staff will be transferred via TUPE to these services by 1st June, after which the Trust will no longer provide this service. Major Capital Redevelopments: • ***Endoscopy Unit Upgrade*** – This project is on track. Phase 1, (Endoscopy washers and decontamination) will be operational by the end of April 2013. Phase 2, (the Endoscopy unit works) will commence on 1st April 2013 (in line with the Capital Programme). Expansion of Specialist Services: • ***National Behçet's Syndrome Centre*** – The Centre was established in July with clinics starting slightly ahead of plan. Most of the staff have been recruited including the Lead Nurse who started in post in November. Recruitment for the Consultant Ophthalmologist post is ongoing. The clinics have been transferred to a dedicated area within the Clinical Research Facility (adjacent to BMEC). A number of patients have been transferred from other specialities and new referrals are starting to increase. Nurse led telephone clinics are

	being established. • ***Gynae-Oncology Service*** - work is ongoing within the speciality to develop pathways with referring units, rollout the Survivorship Programme to include cancer unit patients, identify any further opportunities to convert open surgery to minimal access surgery, develop an outpatient ascitic drainage service and explore an 'at home service'. An External Peer Review visit took place on 29th October 2012 with excellent feedback received. The specialty has developed a 5 year Clinical Strategy which was presented to the Executive team in February 2013. <u>Expansion of our Community Services:</u> • ***Health Visiting Service*** - Additional 15wte training posts. We increased Heath Visitor numbers by 15 wte additional posts in 2012/13. We have extensively re-shaped the way we train Health Visitors and there are 16 due to qualify 2013. In addition a recent care plan audit showed improvements in all of our Health Visiting teams; a Health Visitor Service Rapid Appraisal was undertaken by the SHA in August. An Integrated Development Plan has been produced along with an action plan and monthly progress report.
Key issues to flag to the attention of the Board	**Clinical Service Reconfigurations:** • SHA Strategic Review of Stroke Services ongoing. The aim is to have a preferred configuration of Stroke Services across the SHA by end of March 2013. The Birmingham, Black Country and Solihull CCGs are working together to identify a preferred option locally.
Current Reporting Process	**Clinical Service Reconfigurations:** Reported Quarterly to Clinical Services Reconfiguration Programme Board, quarterly progress report to Trust Board and specific project updates/Business Cases to Trust Board at key milestones. **Major Capital Redevelopments:** Progress reported to Strategic Investment and Review Group (SIRG). **Expansion of Specialist Services:** Divisional Performance Reviews (by exception). **Expansion of our Community Services:** Directorate Meetings & Divisional Performance Reviews (by exception).
RAG rating – Q4	**Clinical Service Reconfigurations: 4** **Major Capital Redevelopments: 4** **Expansion of Specialist Services: 4** **Expansion of our Community Services: 4**

Update Against Key Priorities – Q4	
Key Priority Area	**Sustainability**
Executive Lead	Director of Estates/New Hospital Project Director
Summary of position	**Carbon emissions reduction in line with Carbon Trust Carbon Management Plan (CMP)** The Trust is now working towards the CMP revised baseline and target - a 15% reduction in carbon emissions by 2016/17 (from 2011/12 levels). Recently undertaken projects include LED energy efficient lighting in the Sheldon Block and LED energy efficient lighting with controls (daylight dimming and motion detectors) in both of the Trust libraries. The library schemes are estimated to save 51,700 kWh in electricity and 28 tonnes of carbon per annum (equating to circa £7,000 in cost savings). Planned future projects include further LED lighting/control schemes and air conditioning controls in the Pathology department. The Trust is also exploring a water borehole pre-cooling system for the air handling units at Sandwell Hospital to save energy, carbon and costs. **Target reduction of 5% for total site energy consumed per 100m3 heated volume (i.e. reduction to 925kWh per 100m3)** The Trust is working to reduce energy consumption through the schemes above. The Trust is also investing in a new steam boiler (March 2013) with an economiser at Sandwell that will save circa 6% on gas consumption. The Trust is continuing with site rationalisation work to reduce energy consumption from buildings (see below). The Trust has also recently submitted an application for energy efficiency funding from the DH for LED lighting works across the Trust and the borehole water pre-cooling scheme at Sandwell. **Site rationalisation / agile work implementation as part of Estates TSP** Site rationalisation work is progressing well. This programme will greatly reduce the Trust's energy consumption and help us towards our carbon management target of 15% reduction in carbon emissions by 2016/17 (from 2011/12 levels).
Key issues to flag to the attention of the Board	To note that the energy (and carbon) savings from site rationalisation / agile working will be heavily impacted by any changes to the planned areas for closure and also the timeframes. From the end of March 2013, there will be no designated Sustainability Officer in post until Jan 2014 due to maternity leave.
Current Reporting Process	Sustainability progress is reported to the Trust Board on a quarterly basis with regards to recently implemented and planned/future projects.
RAG rating – Q4	**4**

Update Against Key Priorities – Q4	
Key Priority Area	**Delivering the Transformation Plan**
Executive Lead	Chief Operating Officer
Summary of position	**2012/13 Transformation Savings delivered.** **Transformation Programme established in year.** **Developing an expert level Transformation Support Office (TSO) function within the Trust to improve capacity and capability to deliver large-scale change.** • KMT continue advising and supporting development of TSO as part of commissioned work. • KMT contracted extended until end May. TSO team development programme in progress. • Development of TSO team on track with a balance of formal training and continuous "on-the-job" coaching. • TPRS now providing a complete view of projects for the current year as well as FY13/14 & FY14/15. Next phase includes a balance score card approach to reporting for 2013/14. **Recruitment to key posts:** • Transformation Associate Director commenced in post in Q4. **Delivery of workforce plan related to all transformation projects.** • Workforce elements of all transformation projects are now managed centrally through TPRS. Workforce team manage HR functions within TPRS with have a direct link to individual projects. **Impact on other organisations (e.g. primary and community care) to enable change to be identified and delivered, e.g. decommissioning and commissioning of pathway changes to reduce acute hospital activity.** • Q4 work with Birmingham Social services to establish a joint discharge team and joint protocols slow to progress, escalated to Director of Social Services. • Joint scoping workshops completed for urgent care with CCG and social services. This will inform a joint transformational programme in 2013/14 across the urgent care system. **IT strategy and plan to identify key enablers to projects.** • eBMS (electronic bed management system) development has continued and has been key to the progress in the patient flow project.
Key issues to flag to the attention of the Board	• As a relatively new way of working in a 5 year approach to Transformation, the capacity and capability of teams to apply and deliver transformational thinking to future planning. This will be addressed through organisational development plan encompassing transformation. This work remains in a planning phase and linked

	with the overall organisational development agenda. • Clinical engagement –A new associate medical director post appointed to in Q4. This role will be developed in Q1of 13/14. • Impacts of external commissioning structure changes: Uncertainty still remains particularly at a specialty level in Q4. The Trust is working with key CCG leaders through the RCRH Programme Board and local forums to establish infrastructure to support transformation plan. • Moving to 2 year planning, a strategic programme of transformation now needs to be identified in line with delivering TSP plans for future years.
Current Reporting Process	Transformation Plan Programme update: via TPSG to Trust Board monthly Transformation Plan financial update: via F&PC to Trust Board monthly.
RAG rating – Q4	**4**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Register of sealed documents**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Payne, Trust Secretary**
AUTHOR:	**Kam Dhami, Director of Governance**
DATE OF MEETING:	**25 April 2013**

EXECUTIVE SUMMARY:

An application for use of the Trust Seal is made when required. The Trust's Standing Orders (section 8) require a register to be kept of all documents to which the Trust Seal has been affixed.

Details of all documents that have been made under seal during the period 1st April 2012 to 31st March 2013 is attached.

REPORT RECOMMENDATION:

The Trust Board is asked to **RECEIVE**, **CONSIDER** and **ACCEPT** the list of sealed documents.

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments: Accrds with requirements of the Trust's standing orders

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

None specifically

PREVIOUS CONSIDERATION:

The Board considers the register of sealed documents on an annual basis and is timed for presentation in the Board cycle of business for April.

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

REGISTER OF SEALED DOCUMENTS

Detailed below is a summary of the documents sealed by the Trust during the period 1st April 2012 to 31st March 2013.

Register Ref. No.	Description of Document	Date Sealed
175	Lease contract documents for WRVS at City Hospital and Sandwell Hospital	3/4/12
176	GVD2 (Part II) in connection with Compulsory Purchase Order 2009	31/5/12
177	Chapel Lease at Sandwell Hospital	23/10/12
178	Phase III: Section 106 agreements for Midland Metropolitan Hospital. Application No.: DC/08/49418	1/2/13
179	Possession Order under CPO – Plot 35	1/3/13
180	Possession Order under CPO – Plot 54	1/3/13
181	Possession Order under CPO – Plot 24	1/3/13
182	Possession Order under CPO – Plot 14	1/3/13
183	Possession Order under CPO – Plot 26	1/3/13
184	Possession Order under CPO – Plot 55 (Ref SG)	1/3/13
185	Possession Order under CPO – Plot 55 (Ref SP)	1/3/13
186	Possession Order under CPO – Plot 39	1/3/13

April 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – March 2013
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	25 April 2013

EXECUTIVE SUMMARY:

The report presents the financial performance for the Trust and operational divisions for the year ended 31st March 2013.

Measured against the DoH target, the Trust generated an actual surplus of £639,000 during March against a planned surplus of £467,000. For the purposes of its statutory accounts, an in month deficit of (£9,138,000) was generated, wholly the result of the impairment of fixed assets which is treated as a technical offset for the purpose of measuring performance against the DoH target. Performance remains consistent with the revised target agreed with the Strategic Health Authority.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

Good use of Resources (under 12/13 OfE, key Strategies & Programmes)

PREVIOUS CONSIDERATION:

Finance & Performance Management Committee on 19 April 2013

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – March 2013

EXECUTIVE SUMMARY

• For the month of March 2013, the Trust delivered a "bottom line" surplus of £639,000 compared to a planned surplus of £467,000 (as measured against the DoH performance target). Actual in month performance is consistent with the revised year end target agreed with the Strategic Health Authority of 1.3% of turnover.

• For the year ended 31st March 2013, the Trust has produced a surplus against the DoH target of £6,523,000 compared with a planned surplus of £3,877,000 so generating an positive variance from plan of £2,646,000, again in line with the Trust's revised target.

• The month-end cash balance was approximately £22.7m above the initially planned level.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	172	2,646	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	(1,901)	116	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	270	2,176	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(4,992)	(8,364)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	(409)	1	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	16,138	16,138	>= Plan	> = 95% of plan	< 95% of plan

Note: positive variances are favourable, negative variances unfavourable

Performance Against Key Financial Targets

Target	Year to Date Plan £000	Year to Date Actual £000
Income and Expenditure	3,877	6,523
Capital Resource Limit	21,498	17,678
External Financing Limit	---	16,138
Return on Assets Employed	3.50%	3.50%

2012/2013 Summary Income & Expenditure Performance at March 2013	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
Income from Activities	384,736	30,992	33,784	2,792	384,736	390,952	6,216
Other Income	40,414	4,553	4,582	29	40,414	40,502	88
Operating Expenses	(398,531)	(33,240)	(37,962)	(4,722)	(398,531)	(404,719)	(6,188)
EBITDA	26,619	2,305	404	(1,901)	26,619	26,735	116
Interest Receivable	100	8	12	4	100	146	46
Depreciation, Amortisation & Profit/(Loss) on Disposal	(14,738)	(1,228)	(9,438)	(8,210)	(14,738)	(23,096)	(8,358)
PDC Dividend	(5,594)	(466)	(26)	440	(5,594)	(5,154)	440
Interest Payable	(2,157)	(123)	(90)	33	(2,157)	(2,072)	85
Net Surplus/(Deficit)	**4,230**	**496**	**(9,138)**	**(9,634)**	**4,230**	**(3,441)**	**(7,671)**
IFRIC12/Impairment/Donated Asset Related Adjustments	(353)	(29)	9,777	9,806	(353)	9,964	10,317
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,877**	**467**	**639**	**172**	**3,877**	**6,523**	**2,646**

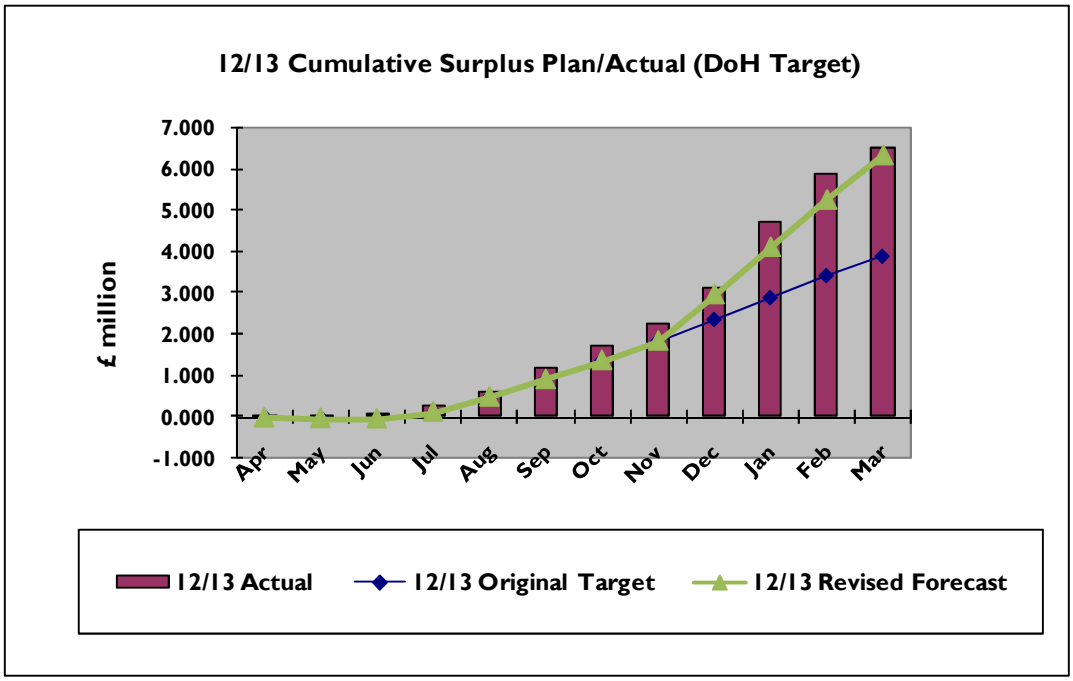
The Trust's financial performance is monitored against the DoH target shown in the bottom line of the above table. Some adjustments are technical, non cash related items which are discounted when assessing performance against this target.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2013

Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the graph below. Net bottom-line performance delivered an actual surplus of £639,000 in March against a planned surplus of £467,000. The resultant £172,000 positive variance moves the year to date position to £2,646,000 above targeted levels which is consistent with the revised target agreed with the Strategic Health Authority.



Divisional Performance

• At the year end, all operational divisions generated bottom line financial performance which was consistent with or better than their target break even position.

• Significantly better than planned performance was delivered by the Medicine & Emergency Care and Women & Childrens Services Divisions, predominantly generated by higher than planned patient related income levels. At the same time, significant additional investment was made, particularly within the Medicine & Emergency Care Division, on opening and maintaining additional capacity in response to high levels of demand and issues generated by loss of capacity through unplanned events such as the Norovirus outbreak.

• The other major area of better than planned performance was in corporate services, a combination of better than planned income and savings generated through ongoing vacancies in a number of departments.

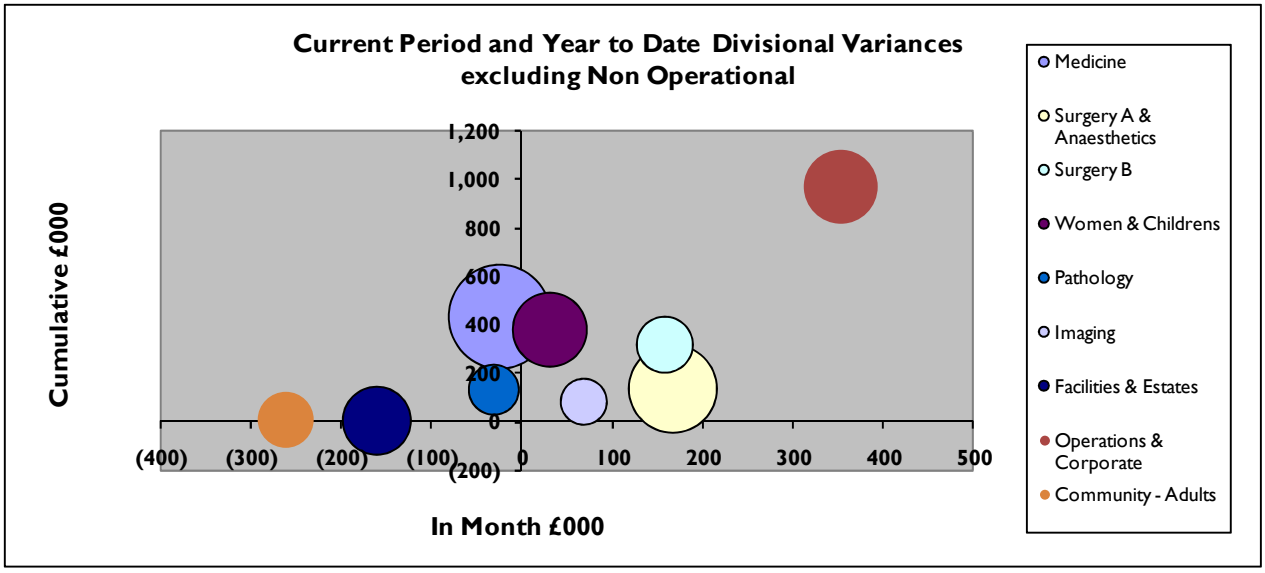
Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2013

The adjacent table and graph below show positive year end variances across all operational divisions although these vary significantly in size from almost zero to almost £1m for corporate services.

Divisional Variances from Plan

	Current Period £000	Year to Date £000
Medicine	(24)	432
Surgery A & Anaesthetics	167	137
Surgery B	158	316
Women & Childrens	32	381
Pathology	(32)	133
Imaging	69	81
Facilities & Estates	(160)	3
Community - Adults	(262)	7
Operations & Corporate	353	973
Non Operational	2,018	1,871



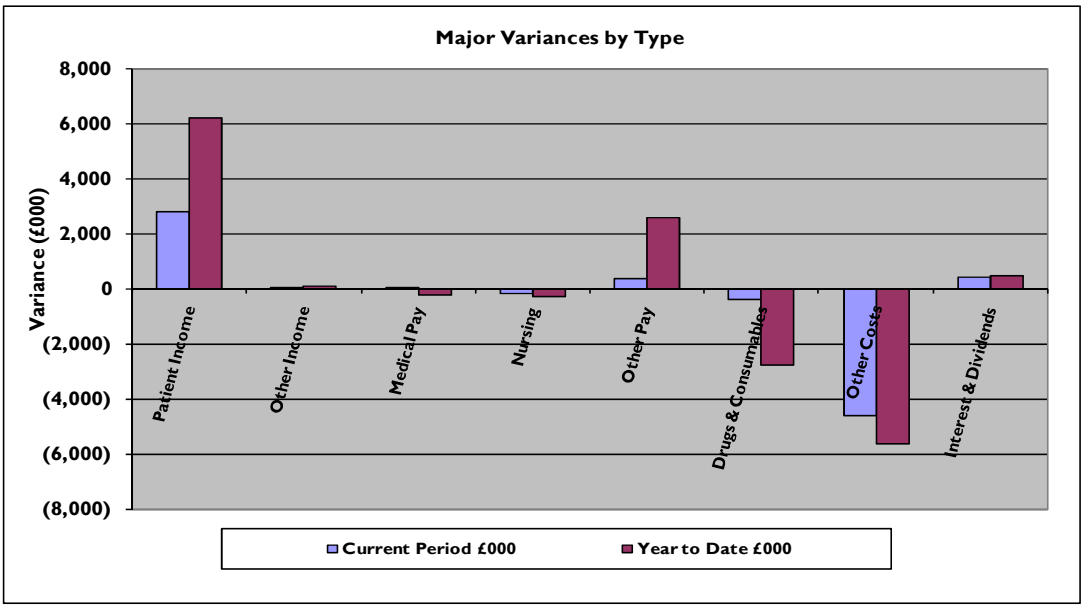
Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2013

For March, patient related SLA income again shows a positive variation from plan . Overall pay expenditure is lower than planned levels although this is significantly affected by one off changes in pay budgets to reflect year additional investment in capacity.

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	2,792	6,216
Other Income	29	88
Medical Pay	53	(200)
Nursing	(142)	(244)
Other Pay	359	2,620
Drugs & Consumables	(398)	(2,730)
Other Costs	(4,606)	(5,645)
Interest & Dividends	444	486



Capital Expenditure

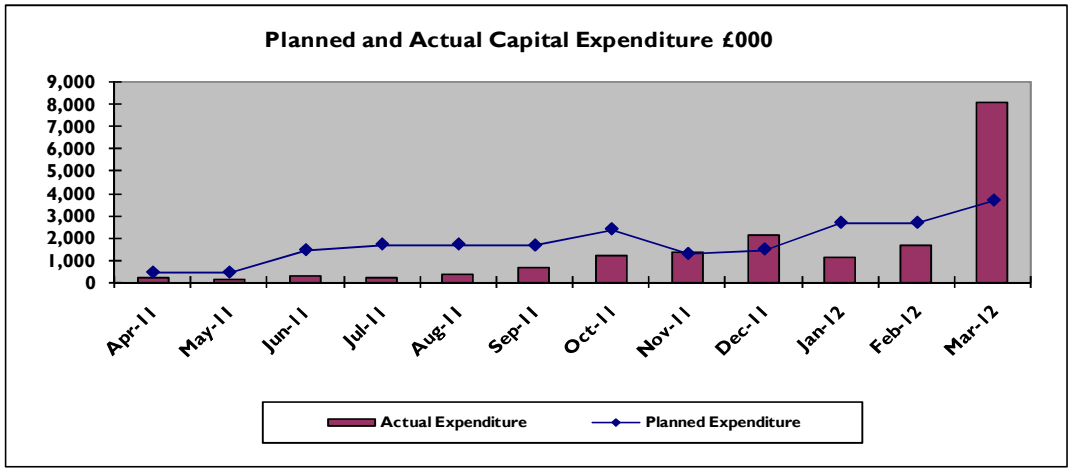
• Planned and actual capital expenditure by month is summarised in the graph overleaf.

• Although there was a very substantial increase in spend in March, capital expenditure at the year end fell some £3.8m below plan.

• The largest single variance from plan relates to expenditure on Grove Lane land where there have been significant delays in the programme.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2013

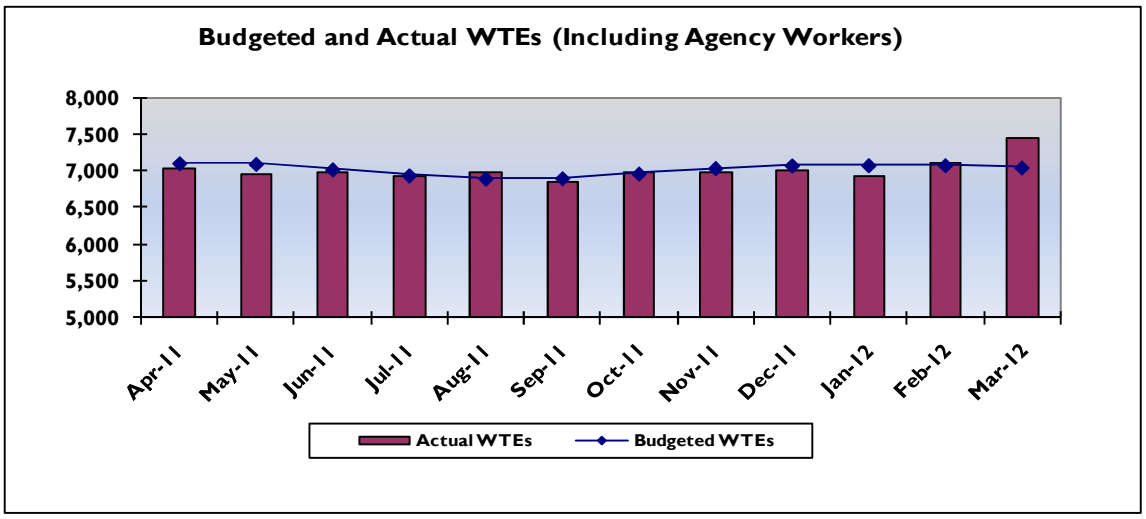


Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 400 above plan. Excluding the impact of agency staff, whole time equivalent (wte) numbers are marginally below plan. A very significant element of this higher level relates to non permanent staff covering additional capacity and the impact of other operational pressures such as the ongoing Norovirus problem.

• Total pay costs (including agency workers) are £270,000 lower than budgeted levels for the month although this is significantly impacted by the release of additional non recurrent funding to cover additional capacity related costs.

• Expenditure for agency staff in March was £1,601,000 compared with £1,097,000 in February.



Sandwell and West Birmingham Hospitals NHS
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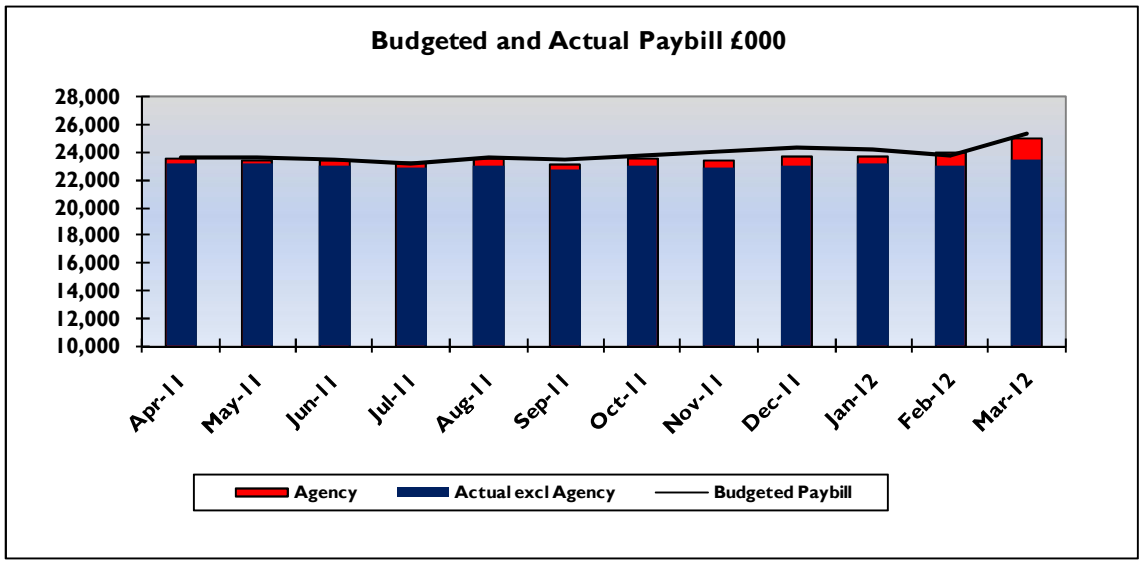
Financial Performance Report – March 2013



Pay Variance by Pay Group

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

Analysis of Total Pay Costs by Staff Group

	Year to Date to March					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	75,797	72,367		3,630	75,997	(200)
Management	14,856	14,452		0	14,452	404
Administration & Estates	31,795	28,734	1,461	708	30,903	892
Healthcare Assistants & Support Staff	31,339	28,302	3,227	53	31,582	(243)
Nursing and Midwifery	87,944	81,441	4,105	2,642	88,188	(244)
Scientific, Therapeutic & Technical	43,769	41,595		649	42,244	1,525
Other Pay	63	21			21	42
Total Pay Costs	285,563	266,912	8,793	7,682	283,387	2,176

NOTE: Minor variations may occur as a result of roundings

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – March 2013

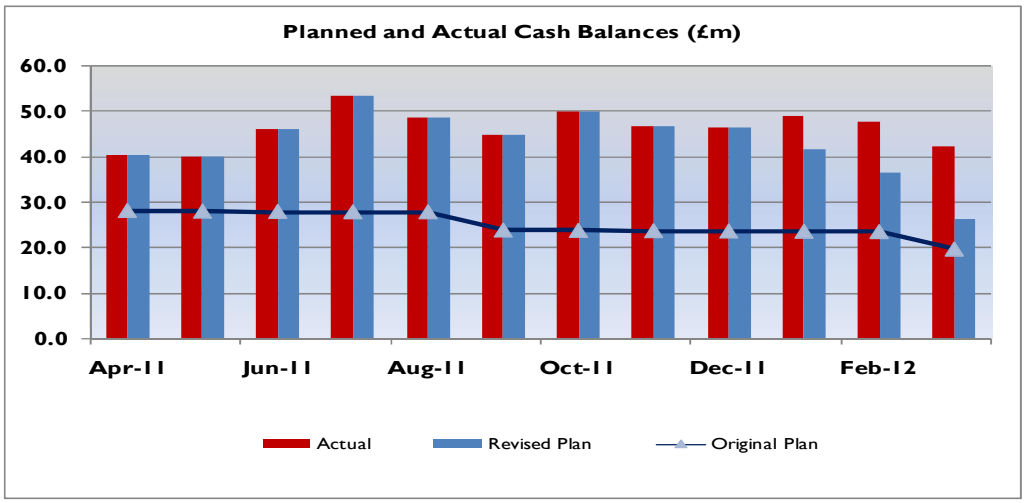
Balance Sheet

• The opening Statement of Financial Position (balance sheet) for the year at 1st April reflects the statutory accounts for the year ended 31st March 2012. The position at 31st March 2013 reflects the draft statutory accounts for the year.

• Cash balances at 31st March 2013 are around £42.4m which is almost £8m higher than at 31st March 2012.

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

		Opening Balance as at 1st April 2012 £000	Actual at 31st March 2013 £000
Non Current Assets	Intangible Assets	1,075	924
	Tangible Assets	227,072	216,669
	Investments	0	0
	Receivables	865	1,048
Current Assets	Inventories	4,065	3,604
	Receivables and Accrued Income	14,446	10,448
	Investments	0	0
	Cash	34,465	42,448
Current Liabilities	Payables and Accrued Expenditure	(33,751)	(43,056)
	Loans	(2,000)	(2,000)
	Borrowings	(1,166)	(914)
	Provisions	(15,649)	(10,355)
Non Current Liabilities	Payables and Accrued Expenditure	0	0
	Loans	(5,000)	(3,000)
	Borrowings	(29,995)	(29,263)
	Provisions	(2,532)	(3,168)
		191,895	183,385
Financed By			
Taxpayers Equity	Public Dividend Capital	160,231	160,231
	Revaluation Reserve	41,228	34,356
	Other Reserves	9,058	9,058
	Income and Expenditure Reserve	(18,622)	(20,260)
		191,895	183,385



Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – March 2013

Cash Forecast

• A forecast of the expected cash position for the next 12 months is shown in the table below.

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT March 2013

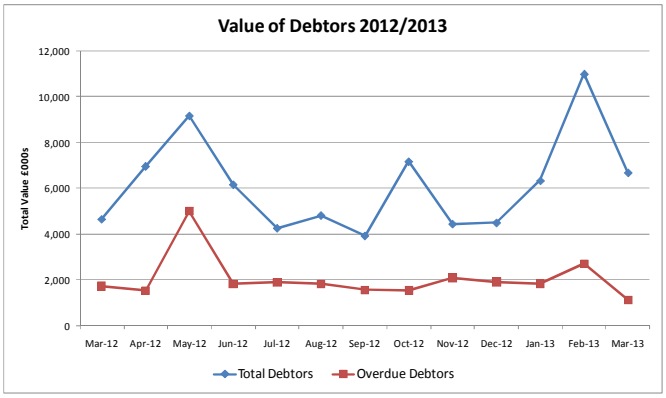
ACTUAL/FORECAST	Mar-13 £000s	Apr-13 £000s	May-13 £000s	Jun-13 £000s	Jul-13 £000s	Aug-13 £000s	Sep-13 £000s	Oct-13 £000s	Nov-13 £000s	Dec-13 £000s	Jan-14 £000s	Feb-14 £000s	Mar-14 £000s
Receipts													
SLAs: Black Country Cluster	**17,576**	17,400	17,400	17,400	17,400	17,400	17,400	17,400	17,400	17,400	17,400	17,400	17,400
Birmingham & Solihull Cluster	**11,448**	11,334	11,334	11,334	11,334	11,334	11,334	11,334	11,334	11,334	11,334	11,334	11,334
Other Clusters	**620**	614	614	614	614	614	614	614	614	614	614	614	614
Pan Birmingham LSCG	**1,944**	1,925	1,925	1,925	1,925	1,925	1,925	1,925	1,925	1,925	1,925	1,925	1,925
Education & Training	**0**	4,300	0	0	4,300	0	0	4,300	0	0	0	0	0
Loans													
Other Receipts	**5,039**	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900	2,900
Total Receipts	**42,554**	38,472	34,172	34,172	38,472	34,172	34,172	38,472	34,172	34,172	34,172	34,172	34,172
Payments													
Payroll	**13,655**	13,464	13,464	13,464	13,464	13,464	13,464	13,464	13,464	13,464	13,464	13,464	13,464
Tax, NI and Pensions	**11,553**	9,455	9,455	9,455	9,455	9,455	9,455	9,455	9,455	9,455	9,455	9,455	9,455
Non Pay - NHS	**680**	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Non Pay - Trade	**14,246**	8,250	7,750	7,750	7,750	7,750	7,750	7,750	7,750	7,750	7,750	7,750	7,750
Non Pay - Capital	**3,185**	1,750	1,750	500	500	500	500	500	500	500	500	500	500
PDC Dividend	**2,797**						2,700						2,700
Repayment of Loans	**1,000**						1,000						1,000
Interest	**25**						20	20	20	20	20	20	20
BTC Unitary Charge	**823**	430	430	430	430	430	430	430	430	430	430	430	430
Other Payments	**120**	175	175	175	175	175	175	175	175	175	175	175	175
Total Payments	**48,084**	36,024	35,524	34,274	34,274	34,274	37,994	34,294	34,294	34,294	34,294	34,294	37,994
Cash Brought Forward	**47,978**	42,448	44,897	43,545	43,444	47,642	47,541	43,720	47,898	47,777	47,656	47,534	47,413
Net Receipts/(Payments)	**(5,530)**	2,449	(1,351)	(101)	4,199	(101)	(3,821)	4,179	(121)	(121)	(121)	(121)	(3,821)
Cash Carried Forward	**42,448**	44,897	43,545	43,444	47,642	47,541	43,720	47,898	47,777	47,656	47,534	47,413	43,591

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

Debtors

• The adjacent graph shows the movement in both total and overdue debtors for the year. There has been a significant fall in both total and overdue debts in March, largely linked with NHS organisations clearing outstanding balances before the year end.

• The table overleaf shows changes in debtor performance compared with prior periods.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2013

Measure	31st March 2011	31st March 2012	31st January 2012	28th February 2013	31st March 2013
Total Debtors as % of Turnover	2.20%	1.10%	1.50%	2.57%	1.55%
Overdue Debtors as % of Turnover	0.60%	0.40%	0.60%	0.63%	0.26%
Debtor Days	8.1 days	4.0 days	5.5 days	8.5 days	5.7 days

Risk Ratings

•The adjacent table shows the Monitor risk rating score for the Trust based on performance at March.
• An adjustment has now been made to the liquidity ratio to reflect an uncommitted overdraft facility (which would be in place as an FT) as this more accurately reflects performance against the Monitor risk rating regime.

Risk Ratings

Measure	Description	Value	Score
EBITDA Margin	Excess of income over operational costs	6.6%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	100.4%	5
Net Return After Financing	Surplus after dividends over average assets employed	2.8%	4
I&E Surplus Margin	I&E Surplus as % of total income	1.3%	3
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	18.9	3
Overall Rating			**3.4**

Continuity of Service Rating

• Monitor are currently proposing the introduction of a revised risk rating measure based on continuity of service. The performance of the Trust against this measure is shown in the table below.

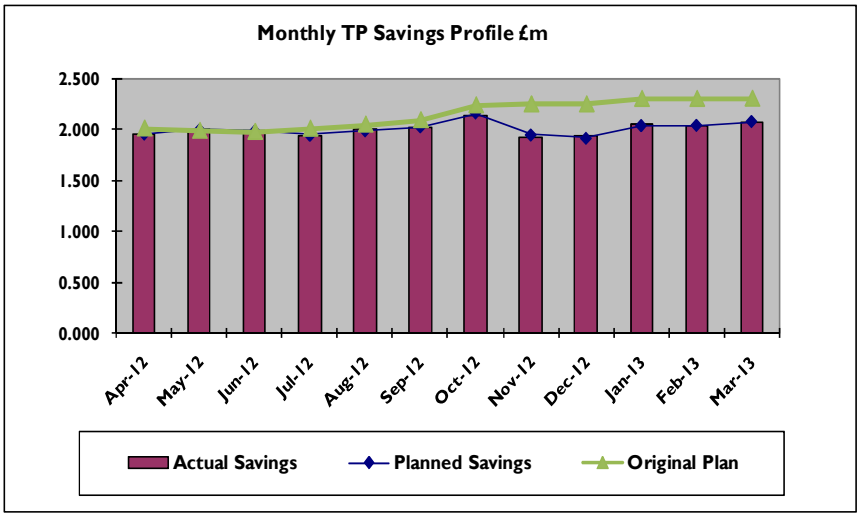
Risk Ratings	Current Month		Year to Date		Forecast Outturn	
Measure	**Value**	**Score**	**Value**	**Score**	**Value**	**Score**
Capital Service Capacity	27.554	4	3.595	4	2.703	4
Liquidity	-3.874	3	-3.874	3	-3.099	3
Overall Rating		**3**		**3**		**3**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2013

Transformation Programme

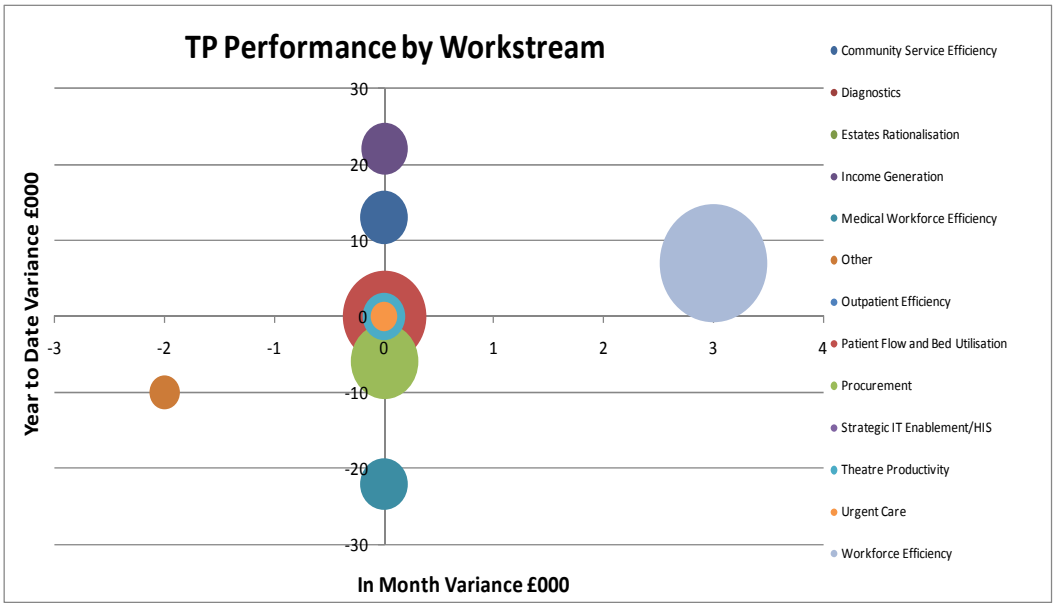
•The graph overleaf shows actual progress against the Trust's Transformation Programme for 2012/13, inclusive of RCRH related changes.
• At the year end and against the revised target, actual savings were £4,000 higher than planned levels.



Transformation Programme cont

•The chart below shows in month and year to date performance of the Transformation Programme by workstream.

• At the year end, there are no material variances from plan at either a workstream or divisional level.

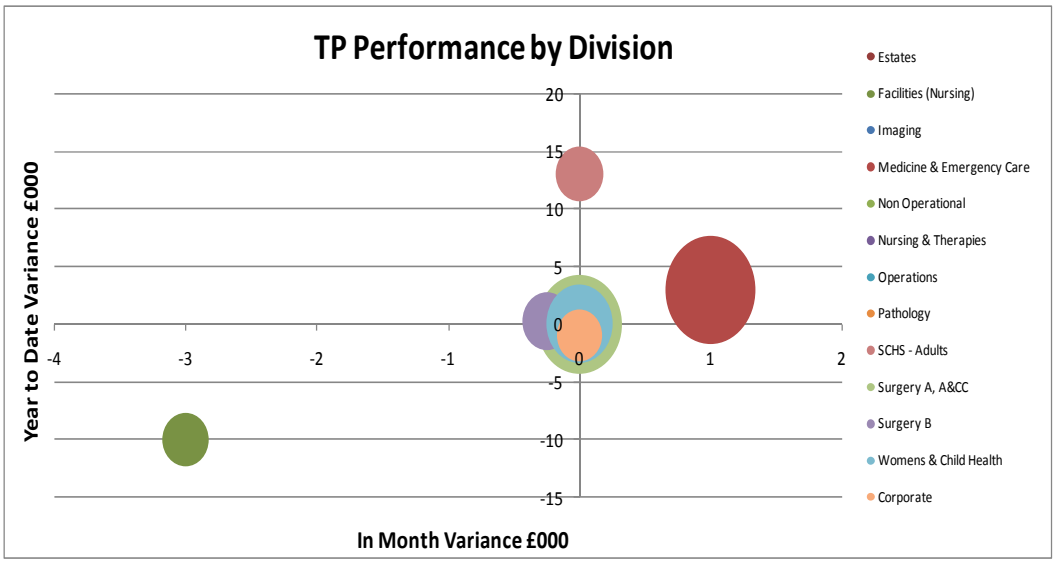


Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – March 2013

Transformation Programme cont'd

• The graph below shows performance by division at the year end. Again, there are no material variances from targets.



Conclusions

• Measured against the DoH target, the Trust generated an actual surplus of £628,000 during March against a planned surplus of £467,000. For the purposes of its statutory accounts, the Trust generated a deficit of (£9,150,000) in month which is wholly the result of an impairment of fixed assets which is treated as a technical adjustment for the purpose of measuring performance against the DoH target. This is consistent with the revised bottom line position agreed with the Strategic Health Authority.

• For the year to date, the Trust has generated a surplus (as measured against the DoH target) of £6,513,000 which is £2,636,000 better than the originally planned position.

•At 31st March 2013, cash balances are approximately £22.7m higher than the original cash plan and almost £8m greater than the balance held at 31st March 2012.

Recommendations

The Trust Board is asked to:

i. RECEIVE the contents of the report.

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Corporate Performance Monitoring Report
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Planning & Performance Management
DATE OF MEETING:	25 April 2013 (Report prepared 17 April 2013)

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April 2012 – March 2013.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
		x

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

Performance Management Board, Trust Management Board and Finance & Performance Management Committee

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST CORPORATE DASHBOARD - MARCH 2013

EXECUTIVE SUMMARY AND KEY EXCEPTIONS

KEY EXCEPTIONS

b

Emergency Department - performance against the **Emergency Care 4-hour maximum wait** target reduced to 82.9% during March and 92.21% for the year to date. Inclusion of the non-chargeable GP Triage data improves performance for the month and year to date to 85.5% and 92.5% respectively. The Trust met 1 of the 5 Emergency Care **Clinical Quality Indicators** during the month, and continues to meet 2, 1 in each of the Timeliness and Patient Impact sections, for the year to date.

Actions identified as part of a recovery plan are focused upon increasing workforce numbers (recruitment to additional Consultant and Nursing posts in progress), improving systems and processes, such as the introduction of a new I.T. System during the early part of May, which will support improvement to patient flow, and evaluating options to improve the overall environment, the latter to be considered by SIRG, during Quarter 1. Other actions designed to improve overall patient flow include retaining winter bed capacity during Quarter 1, development of a longer-term bottom-up medical bed plan and the introduction of a Capacity Management Team for both acute sites.

c

Ambulance Turnaround - the indicators within the report reflect those contained in the Quality section of the Trust's 2012 / 2013 contract with its commissioners, which will also feature as nationally mandated targets for 2013 / 2014. Performance against the percentage of Clinical Handovers completed within 15 minutes reduced on both, and overall to 71.3% from 75.6% last month (target 85%). The average turnaround time also worsened to approximately 40 minutes for each site (target 30 minutes or less), and the number of instances where ambulance turnaround was in excess of 60 minutes also increased to 351 (target 0).

Specific targets, and financial penalty for non-compliance, for handovers between ambulance and the Emergency Department that fall between 30 - 60 minutes and those in excess of 60 minutes, are nationally mandated and form part of the 2013 / 2014 contract with commissioners. As reported above there were 351 instances of delays in excess of 60 minutes during March, and in addition a further 2177 instances reported by WMAS of delays between 30 - 60 minutes. Actions identified to improve performance form part of a multi-faceted action plan, which includes to need to ensure all staff have full awareness of the targets and the reason for them, as well as joint working with the ambulance service to ensure that data quality is of a high standard.

e

Cancelled Operations - the proportion and number of Elective Admissions cancelled at the last minute for non-clinical reasons reduced during the month of March. A total of 44 cancellations were made, 18 at Sandwell and 25 at City, across a range of specialties. During the last Quarter (4), a total of 174 late cancellations have occurred, compared with a total of 74 for the corresponding period last year.

Again the number of cancellations and range of specialties affected during the month reflect the demand for emergency admissions, when a number of wards were closed due to Norovirus. There will be a need to ensure each affected patient is offered a new date within 28 days of the original date.

CQUIN PERFORMANCE

	Patient Safety			Effectiveness of Care			Patient Experience			ALL		
	R	A	G	R	A	G	R	A	G	R	A	G
Acute	1		8	1		1	1		4	3		13
Community			3			1	1		3	1		7
Specialised									4			4

a

CQUIN - there are currently 4 CQUIN targets which are not being met. The percentage of VTE assessments undertaken during the month of March is currently reported as 86.1% (target 90%, which increases to 95% for 2013 / 2014), the proportion of Mortality Reviews which were undertaken within 42 days of death reduced to 49.0% during the month of December, compared with a trajectory of 74% for the period, the Community Net Promoter Score is reported as 50.0 for the month of February (target 75.0), and the Personal Needs Acute CQUIN, based upon responses to 5 Patient Experience questions, has not been met for the year, as reported previously.

The percentage of VTE assessments undertaken during March was adversely affected by a major I.T. failure, resulting in a period of 5 days when it was not possible to electronically record assessments. Performance for the month exclusive of this period of downtime was 90.5%. The system introduced to equalise the work amongst consultant staff involved with undertaking mortality reviews, is anticipated to improve the turnaround time of the reviews reported towards the latter part of the year. The Community Net Promoter score has been adversely influenced by negative responses within a relatively small sample size, with the anticipation that performance during March will show improvement, such that the target score of 75 across the quarter will be met.

CONTRACTED ACTIVITY PLAN

	Month				Year to Date				Year on Year Comparison (to date)			
	Actual	Plan	Variance	%	Actual	Plan	Variance	%	2011/12	2012/13	Variance	%
IP & DC Elective	5085	4799	286	6.0	62471	57964	4507	7.8	64295	62471	-1824	-2.8
IP Non-Elective	4810	4911	-101	-2.1	56982	57105	-123	-0.2	55675	56982	1307	2.3
OP New	13214	11900	1314	11.0	171540	144072	27468	19.1	159051	171540	12489	7.9
OP Review	29442	34468	-5026	-14.6	382248	430846	-48598	-11.3	421494	382248	-39246	-9.3
OP Review:New	2.23	2.90	-0.67	-23.1	2.23	2.99	-0.76	-25.5	2.65	2.23	-0.42	-15.9
ED Type I	12703	15112	-2409	-15.9	171701	175107	-3406	-1.9	177201	171701	-5500	-3.1
ED Type II	1986	2784	-798	-28.7	26649	32254	-5605	-17.4	36362	26649	-9713	-26.7
Adult Community	40519	40518	1	0.0	496666	448333	48333	10.8	449317	496666	47349	10.5
Child Community	14059	12962	1097	8.5	141449	143524	-2075	-1.4	130384	141449	11065	8.5

d

Overall Elective activity for the month and year exceeded the plans by 6.0% and 7.8% for the periods respectively. Non Elective activity was 2.1% less than plan for the month, but is essentially (-0.2%) on plan for the year. New and Review Outpatient performance is such that the Follow Up : New Outpatient Ratio for the year is 2.23, compared with a ratio derived from plan of 2.99. ED Type I activity for the year was 1.9% below plan, although 15.9% below plan for the month, and is influenced (reduced) by patients seen by the GP Triage Service. Type II (BMEC) activity remained well below plan for the month and year to date. Adult Community activity, on plan for the month, was 10.8% above plan for the year. Child Community activity, 8.5% higher than plan for the month, outturned at 1.4% below plan.

NATIONAL PERFORMANCE FRAMEWORKS

NHS PERFORMANCE FRAMEWORK - Summary						
	October	November	December	January	February	March
Performing	16	16	15	16	17	16
Underperforming	2	2	3	2	1	2
Failing	1	1	1	1	1	1
Weighted Score	**2.64**	**2.64**	**2.57**	**2.64**	**2.71**	**2.64**

The Trust failed to meet the Emergency Care 4-hour wait operational threshold during the month, underperformed against the VTE assessment target and is projected to underperform against the indicator 'RTT Delivery in all specialities'. The Trust is projected to meet all high level RTT and Cancer targets. The overall weighted score for service delivery is 2.64, which attracts a **PERFORMING** classification.

MONITOR COMPLIANCE FRAMEWORK - Summary						
	October	November	December	January	February	March
Performing	13	15	14	15	15	15
Failing	2	1	2	1	1	1
No Data	1	0	0	0	0	0
Governance Rating	**3.0**	**1.0**	**2.0**	**1.0**	**1.0**	**1.0**

The Trust failed to meet Emergency Care 4-hour wait operational threshold during the month. The Trust is projected to meet all high level RTT and Cancer targets. The overall governance score for the month is 1.0 which attracts an **AMBER / GREEN** Governance Rating.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST CORPORATE DASHBOARD - MARCH 2013

Exec Lead			PATIENT SAFETY				November	December	January	February			March			To Date (*=most recent month)	TARGET		Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13							
RS	H	3	Stroke Care	Pts spending >90% stay on Acute Stroke Unit		%	86.5 ▼	80.8 ■	86.0 ■	→		88.1 ▲	→			87.6	83	83		No Variation	0 - 2% Variation	>2% Variation	●	72.8	85.9
	K			Pts admitted to Acute Stroke Unit within 4 hrs		%	60.9 ▲	51.3 ▼	54.0 ▲	→		43.8 ▼	→			60.6	90	90		No Variation	0 - 2% Variation	>2% Variation	● ●		68.7
	K			Pts receiving CT Scan within 24 hrs of presentation		%	91.8 ▼	95.0 ▲	100.0 ■	→		93.3 ■	→			92.1	100	100		No Variation	0 - 2% Variation	>2% Variation	●		100
	K			Pts receiving CT Scan within 1 hr of presentation		%	55.3 ■	61.5 ▲	57.7 ▼	→		48.2 ■	→			52.2	50	50		No Variation	0 - 2% Variation	>2% Variation	●		37.5
	H			TIA (High Risk) Treatment <24 h from initial presentation		%	76.5 ▼	57.9 ■	66.7 ■	66.7 ■	50.0 ■	57.1 ■	87.5 ▲	80.0 ■	84.6 ■	69.5	60	60		No Variation	0 - 2% Variation	>2% Variation	●	46.15	53.2
	K			TIA (Low Risk) Treatment <7 days from initial presentation		%	96.3 ▲	87.0 ▼	67.4 ▼	91.7 ▲	73.7 ▲	80.7 ▲	73.7 ▼	71.4 ▼	72.7 ▼	76.8	60	60		No Variation	0 - 2% Variation	>2% Variation	●		30.4
R0	A	4	Infection Control	C. Difficile (DH Reportable)		No.	2 ▲	1 ▲	3 ▼	8 ■	1 ■	9 ■	1 ■	0 ▲	1 ■	37	57	57		No variation		Any variation	●	120	95
	K			C. Difficile (Best Practice Numbers)		No.	5 ▲	4 ▲	6 ▼	10 ■	1 ▲	11 ■	5 ▲	0 ▲	5 ■	76	95	95					●	120	95
	A			MRSA Bacteraemia		No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	1	2	2		No variation		Any variation	●	5	2
				MSSA Bacteraemia		No.	0	0	1	0	0	0	0	1	1	15	No. Only	No. Only						22	12
				E Coli Bacteraemia		No.	2	7	3	3	3	6	1	1	2	48	No. Only	No. Only						73	50
	F	3		MRSA Screening - Elective	Patient Not Matched	%	96.2 ▼	112.0 ▲	130.9 ▲	Numerator = 2655	Denominator = 1371	193.6 ▲	Numerator = 2633	Denominator = 1896	138.9 ▼	138.9*	85	85		No variation		Any variation	●	40.3	40.6
	F				Best Practice - Patient Matched	%	56.5 ▲	55.2 ▼	59.8 ▲	Numerator = 992	Denominator = 1371	72.4 ▲	Numerator = 1128	Denominator = 1896	59.5 ▼	59.5*	85	85		No variation		Any variation	● ●	40.3	40.6
	F			MRSA Screening - Non Elective	Patient Not Matched	%	78.6 ▲	78.4 ▼	80.7 ▲	Numerator = 2490	Denominator = 3024	82.3 ▲	Numerator = 2064	Denominator = 2686	76.8 ■	76.8*	85	85		No variation		Any variation	●	18.9	26.0
	F				Best Practice - Patient Matched	%	66.3 ■	67.0 ■	67.3 ▲	Numerator = 2083	Denominator = 3225	64.6 ▼	Numerator = 2381	Denominator = 3668	64.9 ▲	64.9*	85	85		No variation		Any variation	● ●	18.9	26.0
RS	A	3	Acute CQUIN	VTE Risk Assessment (Adult IP)	396	%	91.7 ▼	90.2 ▼	91.5 ▲	→		91.0 ▼	→		86.1 ■	86.1*	90	90	a	=>90		<90	●	92.3	92.4
RB	K	20		Appropriate Use of Warfarin	372		→	Compliant	→	→		→	→			Compliant	Comply with audit			No variation		Any variation	●		
RO	H	8		Safety Thermometer	396	%	Data Submitted	Data Submitted	Data Submitted	→		Data Submitted	→		Data Submitted	Data Submitted	Monthly data collection			No variation		Any variation	●		
RB	H	20		Antibiotic Use	743	Score	→	→	→	→		→	→		→	83	80	80		No variation		Any variation	●		
RO	D	8		Reducing Avoidable Pressure Ulcers	372	No.	Compliant	Compliant	Compliant	→		Compliant	→		Compliant	Compliant	Comply with audit			No variation		Any variation	●		
RO	H	8		Nutrition and Weight Management	743		Compliant	Compliant	Compliant	→		Compliant	→		Compliant	Compliant	Comply with audit			No variation		Any variation	●		
RS	H	9		Safe Surgery - Operating Theatres	743	%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	100	100		No variation		Any variation	●		
RS	H	9		Safe Surgery - Other Areas		%	99.5 ▼	99.5 ■	99.5 ■	→		99.7 ▲	→		99.7 ■	99.7	98	98		No variation		Any variation	●		
RS	H	10		Stroke Care	743	%	→	Met Q3 req's	→	→		→	→			Met Q3 req's	Comply	Comply		No variation		Any variation	●		
RO	H	11	Community CQUIN	Safety Thermometer	88	%	Data Submitted	Data Submitted	Data Submitted	→		Data Submitted	→			Data Submitted	Monthly data collection			No variation		Any variation	●		
RO	D			Reducing Avoidable Pressure Ulcers	176		Compliant	Compliant	Compliant	→		Compliant	→			Compliant	Comply with audit			No variation		Any variation	●		
RO	H			Nutrition and Weight Management	176		Compliant	Compliant	Compliant	→		Compliant	→			Compliant	Comply with audit			No variation		Any variation	●		
KD	F	14	Never Events - in month			No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0*	0	0		No variation		Any variation	●		
	F		Open Serious Incidents Requiring Investigation (SIRI)			No.	1	2	0	→		4	→		2	2*	No. Only	No. Only							
	F		Open Central Alert System (CAS) Alerts			No.	5	4	3	→		10	→		10	10*	No. Only	No. Only							
RO	D		Falls Resukting In Severe Injury or Death			No	2 ■	2 ■	1 ▲	→		2 ▼	→		2	2*	0	0		No variation		Any variation	●		
RO		8	High Impact Nursing Actions	Inpatient Falls reduction		%	66 ■	79 ▼	51 ■	→		42 ▲	→			684	693	756		=<63/m		>63/m	●	1024	763
				Nutritional Assessment (MUST)		%	94 ■	96 ▲	98 ▲	→		95 ▼	→		96 ▲	96*	90	90		=>90		<90	●		89.0
				Fluid Balance Chart Completion		%	95	98	93	→		93	→		94	94*									100

Exec Lead			PATIENT SAFETY (Continued)			November	December	January	February		March		To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13						
RS		3	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	0 ▲	0 ■	0 ■	→		0 ■	→		0 ■	10	48	48		=<2	3 - 4	>4	●	9	7
				Admissions to Neonatal ICU	%	10.8 ■	8.1 ■	10.6 ■	→			→			9.8	=<10	=<10		=<10	10.0-12.0	>12.0	●	7.2	10.7
				Adjusted Perinatal Mortality Rate (per 1000 babies)	/1000	10.3 ■	7.2 ■	4.0 ▲	→		13.2 ■	→		4.5 ■	4.5*	<8.0	<8.0		<8	8.1 - 10.0	>10	●	6.5	11.9*
				Caesarean Section Rate	%	26.6 ■	24.7 ■	22.7 ▲	→		24.7 ▼	→		25.4 ■	23.6	<25.0	<25.0		=<25.0	25-28	>28.0	●	23.6	22.2
	H			Early Booking (Completed Assessment <12+6 weeks)	%	81.0 ▲	81.5 ▲	78.0 ▼	→		77.0 ▼	→		78.0 ▲	78.0*	=>90	=>90		=>90	75-89	<75	● ●		76.0
RO		2	Infant Health & Inequalities	Maternal Smoking Rates	%	→	10.5 ▼	→	→		→	→		9.3 ▲	9.9	<11.5	<11.5		<11.5	11.5 - 12.5	>12.5	●	11.9	9.8
				Breast Feeding Initiation Rates	%	→	71.5 ▼	→	→		→	→		74.4 ▲	72.6	>63.0	>63.0		>63.0	61-63	<61.0	●	65.6	73.0
RB		5	Cervical Cytology	Diagnostic Report Turnaround	Days	<9 days ■	<9 days ■	<9 days ■	→		<9 days ■	→		<9 days ■	<9 days	<9 days	<9 days		<9 days	9-12 days	>12 days	●	<9 days	<9 days
RO		7	Learning & Development	PDRs (12-month rolling)	No. (%)	5178 (69.3) ▲	5282 (71.0) ▲	5267 (70.6) ▼	→		5195 (69.5) ▼	→		5127 (69.2) ▼	5127 (69.2)	7389 (100)	7389 (100)		0-15% variation	15 - 25% variation	>25% variation	● ●	4635	5348
RS				Medical Appraisal and Revalidation	%	87	86	88	→		81	→		77	77	No. Only	No. Only							
RO	K	3		Mandatory Training Compliance	%	87.4 ▲	88.1 ■	88.7 ▲	→		not available	→		86.4 ▼	86.4	100	100		=>95	90 - 95	<90	●	86.8	71.9
EFFECTIVENESS OF CARE																							
RO	H	8	Acute CQUIN	Dementia	396	%	Meeting Q3 req's	Met Q3 req's	Meeting Q4 req's	→		Meeting Q4 req's	→		Met Q4 req's	Met Q4 req's	90	90		No variation		Any variation	●		
RS	H	3		Mortality Review	743	%	63.9 ▲	65.4 ▲	49.0 ▼	→			→			49.0	74	80	a	No variation		Any variation	● ● ●		66.9
RO	H	11	Community CQUIN	Dementia	44	%	Not Meeting Q3 req's	Met Q3 req's	Meeting Q4 req's	→		Meeting Q4 req's	→			Meeting Q4 req's	80	90		No variation		Any variation	●		
RS		6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate		HSMR	94.2 Sep'11 to Aug'12	93.1 Oct'11 to Sep'12	92.7 Nov'11 to Oct'12	→		90.5 Dec'11 to Nov'12	→		89.1 Jan'12 to Dec '12	89.1								
				Peer (SHA) HSMR		HSMR	98.7	97.8	97.0	→		96.4	→		97.0	97.0								
				Peer (National) HSMR - Quarterly		HSMR	→	95.4	→	→		→	→		94.6	94.6								
	D	19		SHMI		SHMI	94.2 Sep'11-Aug'12	95.6 Oct'11-Sep'12	94.9 Nov'11-Oct'12	→		94.4 Dec'11-Nov'12	→			94.4								
RB		3	Readmission Rates (to any specialty) within 30 days of discharge - Operating Framework Definition effective April 2011	Following initial Elective Admission		No.	146 ■	100 ■	114 ▼	→		128 ■	→		124 ■	1582	1463	1463		No Variation	0 - 5% Variation	>5% Variation	●		1463
				Following initial Elective Admission		%	1.32 ■	0.98 ■	1.05 ▼	→		1.28 ■	→		1.18 ■	1.24	1.15	1.15		No Variation	0 - 5% Variation	>5% Variation	●		1.15
				Following initial Non-Elective Admission		No.	591 ■	613 ■	606 ▲	→		550 ■	→		572 ■	7471	6842	6842		No Variation	0 - 5% Variation	>5% Variation	● ●		6842
				Following initial Non-Elective Admission		%	5.33 ■	6.03 ■	5.59 ■	→		5.50 ▲	→		5.46 ▲	5.87	5.38	5.38		No Variation	0 - 5% Variation	>5% Variation	● ●		5.38
RB	K	3	Hip Fractures	Operation <24 hours of admission		%	92.9 ▲	70.6 ▼	81.5 ▲	→		71.4 ▼	→		83.3 ▲	76.2	70.0	70.0		No Variation	0 - 2% Variation	>2% Variation	●	64.7 (Q4)	66.4
RB		3	Data Quality	Valid Coding for Ethnic Category (FCEs)		%	94 ▼	94 ■	94 ■	→		94 ■	→		93 ▼	94	90	90		>/=90	89.0-89.9	<89	●	94.5	95
		3		Maternity HES		%	6.9 ▼	6.6 ▲	6.7 ▼	→		6.5 ▲	→		6.6 ▼	6.4	<15	<15		=<15	16-30	>30	●	5.4	6.0
	G	11		Data Completeness Community Services		%	>50	>50	>50	→		>50	→		>50	>50	=>50	=>50		=>50		<50	●		
PATIENT EXPERIENCE																							
RB	A	2	Emergency Care 4-hour waits	4-hour waits (Type I and II only)		%	91.5 ■	88.9 ▼	92.2 ▲	90.1 ▼	91.2 ▼	90.8 ▼	81.8 ▼	83.6 ▼	82.9 ▼	92.21	=>95	=>95	b	=>95		<95	XXX	96.99	95.38
	A	2		4-hr waits (inc. S'well & City GP Triage)		%	92.0 ▲	89.6 ▼	92.8 ▲	91.7 ▼	91.1 ▼	91.4 ▼	85.3 ▼	85.7 ▼	85.5 ▼	92.50	=>95	=>95		=>95		<95	XXX		
	D	3	Emergency Care Timeliness	Total Time in Department (95th centile)		h : m	5 : 21 ▲	6 : 14 ▼	5 : 06 ▲	→		5 : 43 ▼	→		7 : 19 ▼	5 : 12	=<4hrs	=<4hrs		=<4hrs		=<4hrs	● ●		3 : 59
	D			Time to Initial Assessment (=<15 mins)(95th centile)		mins	17 ▲	21 ▼	14 ■	→		17 ■	→		18 ▼	17	<15	<15		<15		<15	● ●		21
	D			Time to treatment in department (median)		mins	52 ▲	54 ▼	52 ▲	→		55 ▼	→		54 ▲	58	=<60	=<60		=<60		>60	●		59
	D		Emergency Care Patient Impact	Unplanned re-attendance rate		%	7.79 ▼	7.46 ▲	7.57 ▼	→		7.61 ▼	→		7.18 ▲	7.82	=<5.0	=<5.0		=<5.0		>5.0	● ● ●		8.66
	D			Left Department without being seen rate		%	4.06 ▲	4.60 ▼	3.78 ▲	→		4.35 ▼	→		5.08 ■	4.71	=<5.0	=<5.0		=<5.0		>5.0	●		4.83
RB		21	Reporting Times of Imaging Requests from Emergency Care % **reported within 24 hours / next day**	Plain Radiography		%	75 ▲	98 ■	99 ▲	→		100 ▲	→		99 ▼	99*	90	90		No variation		Any variation	●		
				Ultrasound		%	100 ▲	99 ▼	100 ▲	→		100 ■	→		100 ■	100*	90	90		No variation		Any variation	●		
				MRI		%	91 ▲	100 ▲	75 ■	→		57 ▼	→		84 ▲	84*	90	90		No variation		Any variation	●		
				CT		%	99 ■	99 ■	100 ▲	→		100 ■	→		99 ▼	99*	90	90		No variation		Any variation	●		

Exec Lead			PATIENT EXPERIENCE (Continued)				November	December	January	February		March		To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13						
	H			Clinical Handovers completed within 15 minutes		%	55.0 ▼	63.7 ▲	74.8 ▲	65.8 ▼	82.2 ▲	75.6 ▲	59.7 ▼	79.9 ▼	71.3 ▼	71.3*	=>85	=>85		=>85		<85	● ● ●		
RB	H	18	Ambulance Turnaround	Average Turnaround Time		m : s	34:40 ▲	38:00 ▼	35:02 ▲	34:33 ▲	36:38 ▼	35:48 ▼	40:37 ▼	39:55 ▼	40:13 ▼	34:24	=<30:00	=<30:00	c	=<30:00		>30:00	●		29:23
	H			In Excess of 60 minutes		No.	201 ▲	323 ▼	182 ▲	74 ■	154 ▼	228 ▼	144 ▼	207 ▼	351 ▼	2354	0	0		0		>0	● ● ●		1256
RB	B	2	Mixed Sex Accommodation (Total Number of Breaches)			%	0.00 ■	0.00 ■	0.00 ■	→		0.00 ■	→		0.00 ■	0.00	0.0	0.0		0.00	0.00 - 0.50	>0.50	●		0.07
KD	F	14	Complaints	First Formal Complaints Received		No.	68	38	60	→		70	→		57	724	No. Only	No. Only							834
RO	H	8	Acute CQUIN	Personal Needs	396	%	→	→	→	→		→	→		→	66.9	71.6	71.6		No variation		Any variation			
RO	H	8		Net Promoter	372	No.	65 ▲	67 ▲	66 ▼	→		69 ▲	→		63 ■	66 (Q4)	65	65		No variation		Any variation	●		
RO	H	8		End of Life Care	372	%	65 ▲	62 ▼	56 ▼	→		62 ▲	→			62	53	53		No variation		Any variation	●		
RS	H	10		Every Contact Counts - Alcohol	372	%	61 ▲	→	→	→		57 ▲	→		89 ■	89	80	80		No variation		Any variation	●		
RO	H	12		Every Contact Counts - Smoking	372	%	→	→	Compliant	→		→	→			Compliant	Comply with audit			No variation		Any variation	●		
RO	H	11	Community CQUIN	Pt. (Community) Exp'ce - Personal Needs	44	Score	93.0 ▼	94.0 ▲	93.5 ▼	→		92.0 ▼	→			92.0	90	90		No variation		Any variation	●		
RO	H	11		Net Promoter	88	No	86 ▼	85.0 ▼	86.0 ▲	→		50.0 ■	→			50	75	75	a	No variation		Any variation	● ● ●		
RO	H	11		Every Contact Counts	132	%	Met Monthly requirement	Met Monthly requirement	Met Monthly requirement	→		Met Monthly requirement	→			Met Monthly requirement	Comply with KPI trajectories			No variation		Any variation	●		
RO	H	11		Smoking Cessation	132	%	Met Monthly requirement	Met Monthly requirement	Met Monthly requirement	→		Met Monthly requirement	→			Met Monthly requirement	Comply with KPI trajectories			No variation		Any variation	●		
RS	H		Specialised Commissioners	Clinical Quality Dashboards	49		→	Q3 Return Submitted	→	→		→	→		Q4 Return Submitted	Q4 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●		
RS	H	13		Neonatal - Hypothermia Treatment	73	%	→	Q3 Return Submitted	→	→		→	→		Q4 Return Submitted	Q4 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●		
RS	H	13		Neonatal - Discharge Planning / Family Experience and Confidence	122	%	→	Q3 Return Submitted	→	→		→	→		Q4 Return Submitted	Q4 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●		
RS	H	12		HIV - Optmum Therapy	147	%	→	Q3 Return Submitted	→	→		→	→		Q4 Return Submitted	Q4 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●		
RB		15	Elective Access Contact Centre	Number of Calls Received		No.	12725	9812	18309	→		12421	→		12509	150454	No. Only	No. Only						137824	111793
				Average Length of Queue		mins	0.39 ▼	0.27 ▲	3.19 ■	→		1.06 ■	→		0.25 ■	0.25*	<1.0	<1.0		<1.0	1.0-2.0	>2.0	●	0	0.21
				Maximum Length of Queue		mins	10.1 ■	8.5 ▲	29.0 ■	→		26.6 ▲	→		14.2 ▼	14.2*	<6.0	<6.0		<6.0	6.0-12.0	>12.0	●	6.3	10
			Telephone Exchange	Number of Calls Received		No.	78030	75409	80912	→		69754	→		77745	901987	No. Only	No. Only						909301	849502
				Calls Answered		%	91.5	88.1	88.5	→		91.5	→		91.2	90.7	No. Only	No. Only						90.5	90.2
				Answered within 15 seconds		%	60.6	54.4	54.5	→		67.9	→		64.2	58.2	No. Only	No. Only						52.4	52.5
				Answered within 30 seconds		%	75.3	69.6	69.4	→		80.3	→		78.0	73.0	No. Only	No. Only						68.4	68.1
				Average Ring Time		Secs	20.5	24.3	24.4	→		16.2	→		18.0	18.0*	No. Only	No. Only						21.2	25
				Longest Ring Time		Secs	615	977	692	→		403	→		349	349*	No. Only	No. Only						731	718
TRANSFORMATION PLAN																									
RB		2	Spells	Elective IP		No.	836 ▲	643 ▼	726 ▼	→		671 ▲	→		723 ▲	9596	10981	10981	d	No Variation	0 - 2% Variation	>2% Variation		11748	10610
				Elective DC		No.	4801 ▲	3960 ▲	4734 ▼	→		4409 ▲	→		4362 ▼	52875	46983	46983		No Variation	0 - 2% Variation	>2% Variation		53959	53685
				Total Elective		No.	5637 ▲	4603 ▲	5460 ▼	→		5080 ▲	→		5085 ▼	62471	57964	57964		No Variation	0 - 2% Variation	>2% Variation	●	65707	64295
				Total Non-Elective		No.	4841 ▼	4858 ■	4778 ▼	→		4310 ▲	→		4810 ▲	56982	57105	57105		No Variation	0 - 2% Variation	>2% Variation	●	59000	55675
			Outpatient Attendances	New		No.	15435 ▼	12523 ▲	15090 ▼	→		13514 ▲	→		13214 ▼	171540	144072	144072		No Variation	0 - 2% Variation	>2% Variation	●	163493	159051
				Review		No.	32451 ▼	27199 ▲	32549 ▼	→		29500 ▲	→		29442 ▼	382248	430846	430846		No Variation	0 - 2% Variation	>2% Variation	●	440812	421494
			Emergency Department Attendances	Type I (Sandwell & City Main Units)		No.	13609 ▲	13597 ▲	13086 ▼	5036 ▲	7455 ■	12491 ▲	5663 ▼	7040 ■	12703 ▼	171701	175107	175107		No Variation	0 - 2% Variation	>2% Variation	●	181494	177201
				Type II (BMEC)		No.	2055 ▲	1847 ▼	1831 ▼	→	1854 ▲	1854 ▲	→	1986 ▼	1986 ▼	26649	32254	32254		No Variation	0 - 2% Variation	>2% Variation	● ● ●	36756	36362
		16	Community	Adult - Aggregation of 18 Individual Service Lines		No.	42495 ■	39919 ■	45582 ▼	→		40519 ▼	→			496666	448333	492472		No Variation	0 - 2% Variation	>2% Variation	●	461797	493163
				Children - Aggregation of 4 Individual Service Lines		No.	12700 ■	10571 ▲	14450 ■	→		14059 ▼	→			141449	143524	158876		No Variation	0 - 2% Variation	>2% Variation	●	102773	143400
		2	Outpatient Efficiency	New : Review Rate		Ratio	2.10 ▲	2.17 ▼	2.16 ▲	2.52 ▼	2.04 ▼	2.18 ▼	2.51 ▲	2.11 ▼	2.23 ▼	2.23	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	●	2.70	2.65
				DNA Rate - New Referrals		%	12.8 ▼	12.1 ▲	13.1 ▼	→		11.9 ▲	→		13.1 ▼	11.3	10.0	10.0		No variation		Any variation	● ●	13.1	11.8
				DNA Rate - Reviews		%	11.1 ■	11.1 ■	12.2 ▼	→		11.2 ▲	→		12.7 ▼	10.3	10.0	10.0		No variation		Any variation	●	11.9	10.5

Exec Lead			TRANSFORMATION PLAN (Continued)			November	December	January	February			March			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13							
RB	A	2	Patient Flow	Emergency Care 4-hour waits	%	91.5 ■	88.9 ▼	92.2 ▲	90.1 ▼	91.2 ▼	90.8 ▼	81.8 ▼	83.6 ▼	82.9 ▼	92.21	=>95	=>95		=>95		<95	XXX	96.99	95.38
	C			Acute Delayed Transfers of Care	%	3.4 ▼	1.7 ▲	2.7 ▼	1.7 ▼	3.3 ■	2.5 ▲	2.1 ▼	3.1 ▲	2.6 ▼	2.9	<3.5	<3.5		<3.5	3.5 - 5.0	>5.0	●	4.6	5.2
	H			Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.8 ■	0.4 ■	1.3 ■	1.4 ▲	1.0 ▼	1.2 ▲	0.9 ■	1.1 ■	1.0 ■	0.7	<0.8	<0.8		<0.8	0.8 - 1.0	>1.0	●	0.8	0.6
				Average Length of Stay	Days	3.4 ▲	3.8 ▼	3.7 ▲	4.6 ■	3.6 ▼	4.0 ▼				3.8	4.3	4.3		No Variation	0 - 5% Variation	>5% Variation	●	4.3	4.2
				Day of Surgery (IP Elective Surgery)	%	94.4 ▲	94.2 ▼	93.5 ▼	93.4 ▼	92.1 ▼	92.6 ▼	93.4 ■	93.7 ▲	93.6 ▲	92.0	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	●	88.7	89.5
				Daycase Rate - All Procedures	%	84.1 ▼	85.0 ▲	85.7 ▲	86.6 ▼	84.4 ▼	85.3 ▼	86.2 ▼	83.8 ▼	84.8 ▼	83.9	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	●	81.5	82.7
RO		7	Sickness Absence	Long Term (> 28 days)	%	3.29 ▲	3.45 ▼	3.58 ▼	→		3.38 ▲	→		3.58 ▼	3.51 (Q4)	<2.15	<2.15		<2.15	2.15-2.50	>2.50		3.12	2.95
				Short Term (<28 days)	%	1.18 ▼	1.13 ▲	1.28 ■	→		1.04 ■	→		0.96 ■	1.09 (Q4)	<1.00	<1.00		<1.00	1.00-1.25	>1.25		1.05	0.95
	D			Total	%	4.47 ▲	4.58 ▼	4.86 ▼	→		4.42 ▲	→		4.54 ▼	4.60 (Q4)	<3.15	<3.15		<3.15	3.15-3.75	>3.75	● ● ●	4.17	3.90
RO		17	Bank & Agency Use	Nurse Bank Fill Rate	%	83.8	77.9	76.3	→		76.4	→		75.5	82.9	No. Only	No. Only						86.2	87.2
				Nurse Bank Shifts covered	No.	5437 ▼	4839 ▲	4978 ▼	→		5210 ▼	→		6186 ▼	60463	46980	46980		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	● ● ●	54952	56396
				Nurse Agency Shifts covered	No.	1222 ▼	1381 ▼	1454 ▼	→		1910 ▼	→		2153 ▼	12874	3830	3830		0 - 5% Variation	5 - 10% Variation	>10% Variation	● ● ●	4550	6948
KEY ACCESS TARGETS																								
RB	A	1	Cancer	2 weeks	%	94.8 ▼	94.0 ▼	94.7 ▲	→		95.7 ▲	→			94.6	=>93	=>93		No variation		Any variation	●	94.5	94.8
	A			2 weeks (Breast Symptomatic)	%	93.7 ▼	93.3 ▼	97.4 ▲	→		94.9 ▼	→			96.1	=>93	=>93		No variation		Any variation	●	94.7	95.8
	A			31 Day (diagnosis to treatment)	%	100 ▲	99.3 ▼	98.9 ▼	→		100 ▲	→			99.5	=>96	=>96		No variation		Any variation	●	99.7	99.5
	A			31 Day (second/subsequent treatment - surgery)	%	100 ▲	100 ■	98.1 ▼	→		100 ▲	→			99.2	=>94	=>94		No variation		Any variation	●	99.5	100.0
	A			31 Day (second/subsequent treatment - drug)	%	100 ■	97.4 ■	100 ■	→		100 ■	→			99.8	=>98	=>98		No variation		Any variation	●	100	99.2
	A			31 Day (second/subsequent treat - radiotherapy)	%	n/a	n/a	n/a	→		n/a	→			100	=>94	=>94		No variation		Any variation	●	100	100
	A			62 Day (urgent GP referral to treatment)	%	90.7 ▲	85.2 ▼	85.7 ▲	→		85.6 ▼	→			86.5	=>85	=>85		No variation		Any variation	●	88.0	86.9
	A			62 Day (referral to treat from screening)	%	100 ▲	94.1 ▼	95.0 ▲	→		91.7 ▼	→			96.6	=>90	=>90		No variation		Any variation	●	99.2	98.5
	H			62 Day (referral to treat from hosp specialist)	%	91.3 ▼	95.2 ▲	85.7 ▼	→		100 ▲	→			93.7	=>85	=>85		No variation		Any variation	●	95.6	91.6
RB	A	2	RTT 18-Weeks	Admitted Care (RTT <18 weeks)	%	93.1 ▼	94.9 ▲	93.9 ▼	→		94.0 ▲	→			94.0*	=>90.0	=>90.0		=>90.0	85-90	<85.0	●	92.7	93.2
	A			Non-Admitted Care (RTT <18 weeks)	%	98.8 ▲	98.5 ▼	98.8 ▲	→		99.3 ▲	→			99.3*	=>95.0	=>95.0		=>95.0	90 - 95	=<90.0	●	96.7	97.5
	A			Incomplete Pathway (RTT <18 weeks)	%	96.9 ▼	96.4 ▼	96.0 ▼	→		95.4 ▼	→			95.4*	=>92.0	=>92.0		=>95.0	87 - 92	=<87.0	●		97.2
	E			Treatment Functions Underperforming	No.	3 ▲	3 ■	3 ■	→		4 ▼	→			4*	0	0		0 / month	1 - 6 / month	>6 / month	●		10 (Q4)
	H			Audiology D.A Patients seen in <18 weeks	%	100 ■	100 ■	100 ■	→		100 ■	→			100	100	100		100		<100	●		100
RB	E	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks	%	1.68 ▲	1.85 ▼	1.98 ▼	→		0.88 ■	→			0.88*	<1.0	<1.0		<1.0	1.0 - 5.0	>5.0	●		0.99
RB	C	2	Delayed Transfers of Care	Acute	%	3.4 ▼	1.7 ▲	2.7 ▼	1.7 ▼	3.3 ■	2.5 ▲	2.1 ▼	3.1 ▼	2.6 ▼	2.9	<3.5	<3.5		<3.5	3.5 - 5.0	>5.0	●	4.6	5.2
				Pt's Social Care Delay	No.	13 ▼	2 ▲	6 ▼	7 ▼	11 ■	18 ■	4 ▲	3 ■	7 ■	7*	<18	<18		No Variation	0 - 10% Variation	>10% Variation		23	13
				Pt.'s NHS & NHS plus S.C. Delay	No.	6 ▲	6 ■	9 ▼	4 ▼	1 ■	5 ▲	3 ▲	5 ▼	8 ▼	8*	<10	<10		No Variation	0 - 10% Variation	>10% Variation		22	20
RB	H	2	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.8 ■	0.4 ■	1.3 ■	1.4 ▲	1.0 ▼	1.2 ▲	0.9 ■	1.1 ■	1.0 ■	0.7	<0.8	<0.8	e	<0.8	0.8 - 1.0	>1.0	●	0.8	0.6
	H			28 day breaches	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	1	2	3		3 or less	4 - 6	>6	●	1	1
				Sitrep Declared Late Cancellations by Speciality	No.	53 ■	19 ■	65 ■	36 ■	30 ▼	66 ▼	18 ▲	25 ▲	43 ▲	425	320	320		0-5% variation	5 - 15% variation	>15% variation	● ●	500	363
RB		10	Cardiology	Primary Angioplasty (<150 mins)	%	88.2 ▲	100 ▲	100 ■							91.5	=>80	=>80		=>80	75-79	<75	●	90.7	88.4
				Rapid Access Chest Pain	%	98.5 ■	85.1 ■								96.1	=>98	=>98		=>98	96 - 97.9	<96	●	100.0	99.1
RB		12	GUM 48 Hours	Patients offered app't within 48 hrs	%	100 ■	100 ■	100 ■	→		99.8 ▼	→		100 ▲	100	=>98	=>98		=>98	95-98	<95	●	100.0	100
RO	G	8	Access to healthcare for people with Learning Disability (full compliance)		Y / N	Y ■	Y ■	Y ■	→		Y ■	→		Y ■	Yes	Full	Full		Y		N	●		N

KEYS TO DATA SOURCES, PERFORMANCE ASSESSMENT SYMBOLS AND INDICATORS WHICH COMPRISE NATIONAL & LOCAL PERFORMANCE ASSESSMENT FRAMEWORKS

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

INDICATORS WHICH COMPRISE THE PERFORMANCE ASSESSMENT FRAMEWORKS	
A	NHS Performance F'work, Monitor Compliance F'work, SHA Provider M'ment Return & Local Priority / Contract.
B	NHS Performance F'work, SHA Provider M'ment Return & Local Priority / Contract.
C	NHS Performance Framework & Local Priority / Contract.
D	SHA Provider Management Return & Local Priority / Contract.
E	NHS Performance Framework only
F	SHA Provider Management Return only
G	Monitor Compliance Framework only
H	Local & Contract (inc. CQUIN)
K	Local

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Performance Framework Monitoring Report and summary NHS FT Governance Risk Rating (FT Compliance Report)
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Mike Harding, Head of Performance Management and Tony Wharram, Associate Director of Finance
DATE OF MEETING:	25 April 2013

EXECUTIVE SUMMARY:

The report provides an assessment of the Trust's performance mapped against the indicators which comprise the **NHS Performance Framework**.

Service Performance (March):
There were 2 areas of underperformance during the month of March; Emergency Care 4-hour waits performance of 82.90% and VTE Assessment performance of 86.10%. There is a further 1 area of projected underperformance, RTT Delivery in all specialties. The overall average weighted score for service performance for the month is projected as 2.64. CQC Registration Status remains Unconditional. As such the Trust is projected to continue to attract a **PERFORMING** classification.

The average weighted service performance score for the Quarter (4) is 2.57 (**PERFORMING CLASSIFICATION**), with underperformance against Emergency Care 4-hour waits, VTE Assessments, RTT Delivery in all specialties and projected underperformance against 6-week diagnostic waits.

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

Foundation Trust Compliance Summary report (March):

Within the Service Performance element of the Risk Rating for the month of March and Quarter 4 the Trust underperformed against the Emergency Care 4-hour wait target. The overall score for the month and quarter is 1.0 which attracts an **AMBER / GREEN** Governance Rating.

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

REPORT RECOMMENDATION:

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

ACTION REQUIRED - The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		x

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

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

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

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

PREVIOUS CONSIDERATION:

Performance M'ment Board, Trust M'ment Board and Finance & Performance M'ment Committee

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2012/13

QUALITY OF SERVICE

Integrated Performance Measures

Indicator	Weight	Performance Thresholds: Performing (Score 3)	Score 2	Underperforming (Score 0)	January 2012/13	Score	Weight x Score	February 2012/13	Score	Weight x Score	March 2012/13	Score	Weight x Score	Quarter 4 2012/13	Score	Weight x Score
Emergency Care Waits less than 4-hours	1.00	95.00%	94.00 - 95.00%	94.00%	92.20%	0	0.00	90.80%	0	0.00	82.90%	0	0.00	88.70%	0	0.00
MRSA Bacteraemia	1.00	0		>1.0SD	1	3	3.00	1	3	3.00	1	3	3.00	1	3	3.00
Clostridium Difficile	1.00	0		>1.0SD	3	3	3.00	9	3	3.00	1	3	3.00	13	3	3.00
18-weeks RTT 90% Admitted	1.00	=>90.0%	85.00 - 90.00%	85.0%	93.9%	3	3.00	94.0%	3	3.00	=>90.0%*	3	3.00	=>90.0%*	3	3.00
18-weeks RTT 95% Non -Admitted	1.00	=>95.0%	90.00 - 95.00%	90.0%	98.8%	3	3.00	99.3%	3	3.00	=>95.0%*	3	3.00	=>95.0%*	3	3.00
18-weeks RTT 92% Incomplete	1.00	=>92.0%	87.00 - 92.00%	87.0%	96.0%	3	3.00	95.4%	3	3.00	=>92.0%*	3	3.00	=>92.0%*	3	3.00
18-weeks RTT Delivery in all Specialities (number of treatment functions)	1.00	0	1 - 20	>20	3	2	2.00	4	2	2.00	1 - 6*	2	2.00	>0 and <20*	2	2.00
Diagnostic Test Waiting Times (percentage 6 weeks or more)	1.00	<1%	1.00 - 5.00%	5%	1.98%	2	2.00	0.88	3	3.00	<1.00%*	3	3.00	1.00-5.00%*	2	2.00
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.00 - 93.00%	88.0%	94.7%	3	1.50	95.7%	3	1.50	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms	0.50	93.0%	88.00 - 93.00%	88.0%	97.4%	3	1.50	94.9%	3	1.50	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers	0.25	96.0%	91.00 - 96.00%	91.0%	98.9%	3	0.75	100.0%	3	0.75	>96.0%*	3	0.75	>96.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (surgery)	0.25	94.0%	89.00 - 94.00%	89.0%	98.1%	3	0.75	100.0%	3	0.75	>94.0%*	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)	0.25	98.0%	93.00 - 98.00%	93.0%	100.0%	3	0.75	100.0%	3	0.75	>98.0%*	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)	0.25	94.0%	89.00 - 94.00%	89.0%	100.0%	3	0.75	100.0%	3	0.75	>94.0%*	3	0.75	>94.0%*	3	0.75
Cancer - 62 day urgent referral to treatment for all cancers	0.50	85.0%	80.00 - 85.00%	80.0%	85.7%	3	1.50	85.6%	3	1.50	>85.0%*	3	1.50	>85.0%*	3	1.50
Cancer - 62 day referral to treatment from screening	0.50	90.0%	85.00 - 90.00%	85.0%	95.0%	3	1.50	91.7%	3	1.50	>90.0%*	3	1.50	>90.0%*	3	1.50
Delayed Transfers of Care	1.00	<3.5%	3.5 - 5.00%	>5.0%	2.70%	3	3.00	2.50%	3	3.00	2.60%	3	3.00	2.60%	3	3.00
Mixed Sex Accommodation Breaches (as percentage of completed FCEs)	1.00	0.0%	0.0 - 0.5%	0.5%	0.00%	3	3.00	0.00%	3	3.00	0.00%	3	3.00	0.00%	3	3.00
VTE Risk Assessment	1.00	90.0%	80.00 - 90.00%	80.0%	91.50%	3	3.00	91.00%	3	3.00	86.10%	2	2.00	89.58%	2	2.00
Sum (all weightings)	**14.00**															
Average Score (Integrated Performance Measures)							**2.64**			**2.71**	* projected		**2.64**	* projected		**2.57**

CQC Registration Status

		Unconditional or no enforcement action by CQC	The assessment of non-compliance / outstanding conditions from the initial registration	Enforcement action by CQC			**Performing**			**Performing**			**Performing**			**Performing**

Overall Quality of Service Rating

Performing

Assessment Thresholds for Integrated Performance Measures Average Score	
Underperforming if less than	2.1
Performance Under Review if between	2.1 and 2.4
Performing if greater than	2.4

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Provider Management Regime Return
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Strategy & Organisational Development & Kam Dhami, Director of Governance
AUTHOR:	Mike Harding, Head of Performance Management & Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	25 April 2013

EXECUTIVE SUMMARY:

The Provider Management Regime (PMR) return is to be submitted to the SHA on a monthly basis and comprises a dashboard of performance against key quantifiable targets, together with a declaration of compliance against a series of Board Statements.

The organisational risk ratings as reported for March 2013 are as follows:

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

Key Features of the return for March are:

- TFA Progress
  – Submission of FT application to DH – Not Fully Achieved - agreed with SHA to delay pending further discussion on TFA milestones.
- Governance – Emergency Care (4-hour waits) performance for the month of March is 82.9% (operational threshold 95.0%).
- Contractual – A number of areas remain subject to performance improvement notices received during year.

REPORT RECOMMENDATION:

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

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

The PMR covers performance against a number of the Trust's objectives, standards and metrics

PREVIOUS CONSIDERATION:

Performance Management Board on 16 April 2013

SELF-CERTIFICATION RETURNS
Organisation Name:
Sandwell & West Birmingham Hospitals NHS Trust
Monitoring Period:
March 2013

NHS Trust Over-sight self certification template

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

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

Name of Organisation:	Sandwell & West Birmingham Hospitals NHS Trust	Period:	March 2013

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	AG
Normalised YTD Financial Risk Rating (Assign number as per SOM guidance)	3

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

Governance Declarations

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

Supporting detail is required where compliance cannot be confirmed.

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

Governance declaration 1

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

Signed by:		Print Name:	Toby Lewis
on behalf of the Trust Board	Acting in capacity as:	Chief Executive	
Signed by:		Print Name:	Richard Samuda
on behalf of the Trust Board	Acting in capacity as:	Chairman	

Governance declaration 2

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

Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		
Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		

If Declaration 2 has been signed:

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

Target/Standard:	**11. Plans in place to ensure ongoing compliance with all existing targets.**
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Board Statements

Iwell & West Birmingham Hospitals NHS T

March 2013

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SOM's Oversight Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes

	For FINANCE, that:	Response
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	Yes
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes

	For GOVERNANCE, that:	Response
6	The board will ensure that the trust at all times has regard to the NHS Constitution.	Yes
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	Yes
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of occurrence and the plans for mitigation of these risks.	Yes
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the Governance Risk Rating; and a commitment to comply with all commissioned targets going forward.	No
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies, and that any elections to the shadow board of governors are held in accordance with the election rules.	Yes
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.	Yes

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO	**TO BE ADDED**	**Toby Lewis**	**25/04/2013**
Chair	**TO BE ADDED**	**Richard Samuda**	**25/04/2013**

QUALITY

Information to inform the discussion meeting

Sandwell & West Birmingham Hospitals NHS Trust

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Dec-12	Jan-13	Mar-13	Board Action
1	SHMI - latest data	Score	99.1	98.4	97.5	96.8	96.2	96.0	96.3	95.3	94.2	95.6	94.9	94.4	SHMI data relates to period December 2011 - November 2012 which is the most recent period for which data is available (source HED).
2	Venous Thromboembolism (VTE) Screening	%	92.4	92.9	91.0	91.4	87.5	91.0	91.5	91.7	90.2	91.5	91.0	86.1	A major internal I.T failure adversely impacted upon performance for a period of 5 days during the month, when it was not possible to record VTE assessments electronically.
3a	Elective MRSA Screening	%	38.1	39.9	40.7	42.0	39.5	38.7	104.6	96.2	112.0	130.9	193.6	138.9	Data reported is screens not matched with patients. Screens matched to patients for the month is 59.5%.
3b	Non Elective MRSA Screening	%	70.3	64.1	66.3	68.0	69.1	66.1	66.0	78.6	78.4	80.7	82.3	76.8	Data reported is screens not matched with patients. Screens matched to patients for the month is 64.9%.
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	8	7	9	10	4	2	3	1	2	0	4	2	No incidents are overdue for completion
6	"Never Events" occurring in month	Number	0	0	0	1	0	1	0	0	0	0	0	0	
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number	20	19	17	14	9	10	8	5	4	3	10	10	3 open alerts. Spinal needles remain a manufacturing problem. Risk assessment undertaken and decision made regarding Laryngoscope handles. 1 alert deadline of 21/03 just being rechecked but first indications are that none in Trust.
9	RED rated areas on your maternity dashboard?	Number	2	1	2	4	3	3	2	4	4	2	2	3	February - Midwifery Staff Sickness Absence (6.5%), Adjusted Perinatal Mortality Rate (13.2 / 1000 babies) and Neonatal Mortality Rate (2.2 / 1000 babies).
10	Falls resulting in severe injury or death	Number	3	0	1	1	2	6	0	2	2	1	2	2	
11	Grade 3 or 4 pressure ulcers	Number	12	4	2	2	3	3	1	1	6	1	2	2	There were 2 avoidable grade 3 pressures sores reported for the month of March. A further 5 unavoidable pressures sores were reported.
12	100% compliance with WHO surgical checklist	Y/N	No	No	No	No	No	No	No	No	No	No	No	No	Compliance was 99.4% in March (3063 records compliant of 3082 total). All list and individual checklists are checked for completeness by staff at the end of the session and then entered onto a database.
13	Formal complaints received	Number	60	51	61	62	79	56	62	68	38	60	70	57	
14	Agency as a % of Employee Benefit Expenditure	%	1.7	1.4	1.9	1.9	2.2	1.8	2.3	2.45	2.91	2.62	4.57	6.41	
15	Sickness absence rate	%	4.06	4.51	4.23	4.16	4.10	4.18	4.51	4.47	4.58	4.86	4.42	4.55	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	74	78	69	71	79	84	83	87	86	88	81	77	These figures indicate the percentage of Consultant Appraisals that were completed at that time without reference to completed PDPs which are seen as a more dynamic document.

FINANCIAL RISK RATING

Sandwell & West Birmingham Hospitals NHS Trust

			Risk Ratings					Insert the Score (1-5) Achieved for each Criteria Per Month				
								Reported Position		Normalised Position*		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	3	3	3	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	5	5	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	4	4	4	4	
	I&E surplus margin %	20%	3	2	1	-2	<-2	3	3	3	3	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	Includes effect of assumed working capital facility
Weighted Average		**100%**						**3.4**	**3.4**	**3.4**	**3.4**	
Overriding rules												
Overall rating								**3**	**3**	**3**	**3**	

Overriding Rules :

Max Rating	Rule	
3	Plan not submitted on time	No
3	Plan not submitted complete and correct	No
2	PDC dividend not paid in full	No
2	Unplanned breach of the PBC	No
2	One Financial Criterion at "1"	
3	One Financial Criterion at "2"	
1	Two Financial Criteria at "1"	
2	Two Financial Criteria at "2"	

* Trust should detail the normalising adjustments made to calculate this rating within the comments box.

FINANCIAL RISK TRIGGERS

Sandwell & West Birmingham Hospitals NHS Trust

Insert "Yes" / "No" Assessment for the Month

Refresh Triggers for New Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	No	No	No	
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	No	No	No	No	No	
3	Working capital facility (WCF) agreement includes default clause	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Escalation processes in place and reported to Finance Committee which is monitoring progress.
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No	No	No	
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	No	No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	No	No	
8	Quarter end cash balance <10 days of operating expenses	No	No	No	No	No	No	No	
9	Capital expenditure < 75% of plan for the year to date	No	No	No	Yes	Yes	No	No	Significant acceleration in programme in Q4 and particularly in March.
10	Yet to identify two years of detailed CIP schemes	Yes	Yes	No	No	No	No	No	

GOVERNANCE RISK RATINGS

Sandwell & West Birmingham Hospitals NHS Trust

Insert YES, NO or N/A (as appropriate)

Refresh GRR for New Quarter

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Current Data: Jan-13	Current Data: Feb-13	Current Data: Mar-13	Current Data: Qtr to Mar-13	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	No	No	Yes	Yes	Yes	Yes	Yes	Status Changed October 2012
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		No	No	Yes	Yes	Yes	Yes	Yes	Status Changed October 2012
			Patients dying at home / care home	50%		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Status changed June 2012
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	February 2013 performance confirmed from National Cancer Waiting Times system report. March performance projected.
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	February 2013 performance confirmed from National Cancer Waiting Times system report. March performance projected.
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	February 2013 performance confirmed from National Cancer Waiting Times system report. March performance projected.
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	February 2013 performance confirmed from National Cancer Waiting Times system report. March performance projected.
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	Yes	No	No	No	No	No	No	Performance in March was 82.9%. Performance inclusive of GP Triage activity was 85.5% for the month.
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3j	Category A call –emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0								
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No	No	No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No	No	No	
			TOTAL			**1.0**	**2.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	
		RAG RATING :				AG	AR	AG	AG	AG	AG	AG	

GOVERNANCE RISK RATINGS

Sandwell & West Birmingham Hospitals NHS Trust

Insert YES, NO or N/A (as appropriate)

Refresh GRR for New Quarter

See 'Notes' for further detail of each of the below indicators

GREEN	**= Score less than 1**
AMBER/GREEN	**= Score greater than or equal to 1, but less than 2**
AMBER / RED	**= Score greater than or equal to 2, but less than 4**
RED	**= Score greater than or equal to 4**

	Overriding Rules - Nature and Duration of Override at SHA's Discretion		**Historic Data**			**Current Data**				
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and breaches the cumulative year-to-date trajectory for three successive quarters								
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.								
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter								
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.								
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter								
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter either Red 1 or Red 2 targets for a third successive quarter								
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter								
viii)	Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.								
		Adjusted Governance Risk Rating	**1.0**	**2.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	
			AG	AR	AG	AG	AG	AG	AG	

CONTRACTUAL DATA

Information to inform the discussion meeting

Sandwell & West Birmingham Hospitals NHS Trust

Insert "Yes" / "No" Assessment for the Month

Refresh Data for new Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	
1	Are the prior year contracts* closed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	No	No	No	No	No	No	No	
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
5	Are there any disputes over the terms of the contract?	No	No	No	No	No	No	No	
6	Might the dispute require third party intervention or arbitration?	No	No	No	No	No	No	No	
7	Are the parties already in arbitration?	No	No	No	No	No	No	No	
8	Have any performance notices been issued?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Performance against 2 local quality requirements; Maternity Early Booking Target and Average Ambulance Turnaround time, as well as performance against A&E 4-hour waits, 6-week diagnostic waits and 18-weeks RTT Admitted Care in T&O and Plastic Surgery, have all attracted Performance Notices recently. With the exception of 6-week Diagnostic Waits, all remain below operational performance thresholds.
9	Have any penalties been applied?	No	Yes	Yes	Yes	Yes	Yes	Yes	

*All contracts which represent more than 25% of the Trust's operating revenue.

TFA Progress

Apr-13

Sandwell & West Birmingham Hospitals NHS Trust

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Due or Delivered Milestones	Future Milestones	Board Action
1	Draft IBP and LTFM submitted	Aug-11	Fully achieved in time		
2	Assess and challenge IBP/LTFM	Sep-11	Fully achieved in time		
3	HDD stage 1	Dec-11	Fully achieved in time		
4	8 week public engagement completed	Mar-12	Fully achieved in time		
5	First cut Quality Governance self-assessment	May-12	Fully achieved in time		
6	BGAF process	Sep-12	Fully achieved in time		
7	Submit IBP/LTFM to SHA for review	Sep-12	Fully achieved in time		
8	Final cut Quality Governance self-assessment	Sep-12	Fully achieved in time		
9	Submission of key FT application documentation for review	Sep-12	Fully achieved in time		
10	External validation of final Quality Governance sef-assessment	Oct-12	Fully achieved in time		
11	FT readiness review with SHA	Oct-12	Fully achieved in time		
12	Final IBP/LTFM - SHA submission	Nov-12	Fully achieved but late		Agreed with SHA not to submit at this stage pending further discussion on TFA milestones.
13	BGAF validation	Nov-12	Fully achieved in time		
14	Board able to certify compliance with IG toolkit	Dec-12	Fully achieved but late		
15	SHA approval review	Dec-12	Fully achieved but late		Agreed with SHA pending further discussion on TFA milestones
16	HDD Stage 2	Dec-12	Fully achieved in time		
17	SHA FT quality assessment	Jan-13	Not fully achieved		Agreed with SHA to delay at this stage pending further discussion on TFA milestones
18	Final submission of all key outstanding documentation to SHA	Jan-13	Not fully achieved		Agreed with SHA to delay at this stage pending further discussion on TFA milestones
19	Final SHA Board to Board	Feb-13	Not fully achieved		Agreed with SHA to delay at this stage pending further discussion on TFA milestones
20	Submission of FT application to DH	Mar-13	Not fully achieved		Agreed with SHA to delay at this stage pending further discussion on TFA milestones
21					
22					
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40					

Notes

Ref	Indicator	Details
Thresholds	The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.	
1a	Data Completeness: Community Services	Data completeness levels for trusts commissioned to provide community services, using Community Information Data Set (CIDS) definitions, to consist of: - Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community; - Community treatment activity – referrals; and - Community treatment activity – care contact activity. While failure against any threshold will score 1.0, the overall impact will be capped at 1.0. Failure of the same measure for three quarters will result in a red-rating. **Numerator:** all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems). **Denominator:** all activity data required by CIDS.
1b	Data Completeness Community Services (further data):	The inclusion of this data collection in addition to Monitor's indicators (until the Compliance Framework is changed) is in order for the SHA to track the Trust's action plan to produce such data. This data excludes a weighting, and therefore does not currently impact on the Trust's governance risk rating.
1c	Mental Health MDS	Patient identity data completeness metrics (from MHMDS) to consist of: - NHS number; - Date of birth; - Postcode (normal residence); - Current gender; - Registered General Medical Practice organisation code; and - Commissioner organisation code. **Numerator:** count of valid entries for each data item above. (For details of how data items are classified as VALID please refer to the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq) **Denominator:** total number of entries
1d	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** the number of adults in the denominator whose employment status is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Accommodation status: **Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Having a Health of the Nation Outcome Scales (HoNOS) assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. **Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.
2a-c	RTT	Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the threshold on a monthly basis. Consequently, any failure in one month is considered to be a quarterly failure. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process. Will apply to consultant-led admitted, non-admitted and incomplete pathways provided. While failure against any threshold will score 1.0, the overall impact will be capped at 2.0. The measures apply to acute patients whether in an acute or community setting. Where a trust with existing acute facilities acquires a community hospital, performance will be assessed on a combined basis. The SHA will take account of breaches of the referral to treatment target in 2011/12 when considering consecutive failures of the referral to treatment target in 2012/13. For example, if a trust fails the 2011/12 admitted patients target at quarter 4 and the 2012/13 admitted patients target in quarters 1 and 2, it will be considered to have breached for three quarters in a row.
2d	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008): a) Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: - treatment options; - complaints procedures; and - appointments? c) Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each month. Failure to do so will result in the application of the service performance score for this indicator.
3a	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter.. Will apply to any community providers providing the specific cancer treatment pathways
3b	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. National guidance states that for patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided the SHA receive evidence of written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA. In the absence of any locally-agreed contractual arrangements, the SHA encourages trusts to work with other providers to reach a local system-wide agreement on the allocation of cancer target breaches to ensure that patients are treated in a timely manner. Once an agreement of this nature has been reached, the SHA will consider applying the terms of the agreement to trusts party to the arrangement.
3c	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways.
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Notes

Ref	Indicator	Details
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist units; - internal transfers of service users between wards in a trust and transfers from other trusts; - patients recalled on Community Treatment Orders; or - patients on leave under Section 17 of the Mental Health Act 1983. The indicator applies to users of working age (16-65) only, unless otherwise contracted. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face-to-face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA may apply a score.
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation

Sandwell and West Birmingham Hospitals NHS
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TRUST BOARD

DOCUMENT TITLE:	**Transformation Plan Status Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow, Chief Operating Officer**
AUTHOR:	**Mike Banbury, Associate Director of Transformation**
DATE OF MEETING:	**25 April 2013**

EXECUTIVE SUMMARY:

Reporting process review:

- KPI's dashboard modifications are in place, work continuing to capture the required data
- Revised format for TPSG has been trialled and adopted

Community:

- Draft Business Case for OPAT (IV Therapies) completed
- Bed Matrix attached to eBMS
- Policy for IV Therapies in community agreed
- Principles for ICARES "in-reach" pilot have been agreed
- Development of a patient contract for Leasowes & Henderson underway
- Acute community group meeting to review processes/communications re referrals for community beds
- Current state mapping in Sexual Health to begin w/c 8/4/13
- Re-launch of cellulitis IV therapy in community pathway w/c 8/4/13 developing pathway for UTI for Sandwell
- Development of an algorithm with ICARES for escalation purposes
- Collaborative LiA to define Community 5 year strategy cancelled by SWBH at short notice

Urgent Care and ED support

- MSS on track for Phase 1 completion by 7th May
- ED Redesign on track - estates drawing up plans
- IT scoped Daily Operations and Data board – Planned release date 7th May
- CDU Opened
- Development of PMO and performance reviews ongoing
- Continued level of pressure on ED affects ability to deliver change
- AEC network site visit due 16th April, launch event 23rd April
- Standard Clinical Pathways – clinical lead to be identified

Outpatients:

- Workstream focus to switch emphasis to pathway redesign, looking to set clear performance targets for all clinics.
- Further engagement workshops to ensure Partial Booking can progress and concerns understood
- Trust-wide OP quality standards –performance management system and engagement programme being designed with clinical lead and new Clinical AD for Transformation
- OP Benchmarking analysis continues to understand how SWBH compares with NHS best practise, and prioritise future Transformation projects
- BMEC self check-in desks, dates set for 'super user' training, business case for building works to improve flow due at SIRG

Cardiology workshop held to understand issues with Cath Labs scheduling

Theatres:

- **Booking Rules** –throughput of 4 cases on all lists for T&O being verified. General/colo rectal rollout of T&O model to commence April
- **Centralised Booking –** SIRG approval being revisited at next meeting,
- **Theatre Utilisation** – work to progress VSM wastes has been hampered by staff availability
- **Performance Management** - Roll out of performance continues across whole of SGH, City Site and BTC
- **Step Down** – Further work hampered by current capacity issues
- **Pre-Op 'One Stop** – Surgical Day Unit preop to move to Centralised pre op 1st May

Patient Flow:

- Focus remains targeting Emergency Flow to support current ED performance priorities.
- Flow Coordination huddles 'Go-Live' at City site
- Near Patient Pharmacy standard and nursing checklist launched
- Improved real-time use of eBMS (confirmed & potential discharges, patient level notes)
- Improved use of Discharge Lounge at City, business case for SGH due at SIRG
- Clinical Leadership identified for Frail Elderly Project
- Patient 'Guide to Discharge' and 'Ticket Home' agreed and in final stages of printing ready for implementation
- Capacity Team model and timescale to be confirmed (to enable Operations Centre implementation)
- Developing an integrated approach to the workstream in conjunction with Community and Urgent Care

TPRS focus:

- Intensive support has continues in Medicine to show detail of 2013/14 TSPs
- Work on 2015/16 TSP generation continues
- Work to define TSO future strategy continues

REPORT RECOMMENDATION:

The Board is recommended to receive and accept the report.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		X

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

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

Comments:

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

Delivery of the Transformation Plan

PREVIOUS CONSIDERATION:

Trust Management Board on 16 April 2013

Work stream: Outpatients

Date – 05/04/13

Project Status

Recovery Actions / Escalations

Concern	Impact	Countermeasure	Resp	Date	Status
Concerns raised by consultants about the impact of partial booking on their areas	Roll out will be phased by division/speciality	Meet with directorates individually to engage and address concerns	CD/SH	Starting 30th March	Open
Lack of general manager structure for outpatients services across the organisation	Impact on speed of progress for making operational changes, lack of ownership and responsibility by teams	Outpatient Operational Group established. Daily huddles for OP areas to PPS. Concerns about lack of operational structure have been raised to RB and MB	CD	2012	Open – and an ongoing issue yet to be resolved
BMEC self check in desks require capital investment for pilot	Delay with agreement through SIRG will impact on Go-Live date for pilot	Develop contingency plan for kiosks in the event that business case is declined by SIRG	SH	12th April 2013	

Next steps

1. Arrange directorate meetings with all areas re – process for partial booking
2. Present 8 Quality OP standards at CET
3. Design performance management for 8 quality OP standards
4. Validate KPIs for work stream with MC
5. Train the Trainer ‘super user’ for self check in kiosks roll out BMEC training plan
6. Medicine- Continue to facilitate PMO and project tracking. Review TOR for PMO. Meet with senior managers to ensure that teams keep on track and have ownership of TSPs. Chase areas which are not tracking progress in TSPs ie ED, areas with no GM

Key successes

Vascular surgery keen to start pathway redesign work.

Urology partial booking commenced 2.4.13

8 quality standards validated with OP steering group

Approach to roll out 8 Quality standards agreed with Deva Situnayake and Hamish Brown

Commenced action plan fro PPS from SGH OPD ie process for aligning resources to new clinic set up

Cardiology workshop to identify issues with cath lab scheduling facilitated and action plan owned by speciality

Work stream: ED / Urgent Care

Date – 05/04/13

Project Status

RAG	AREA
	People
	Quality
	Money
	Milestones

Recovery Actions / Escalations

Concern	Impact	Countermeasure	Resp	Date	Status
Consultants not fully engaged with development of ED	Delays in Best practice roll out across ED	Clinical Director Mark Poulson to engage with consultants	CD	30th March	Open
Lack of project management and ownership.	Overall quality of delivery not being met for ED	PMO control and reporting to be implemented	WB/MW	30th March	Closed
Continued level of pressure on ED detracting from ability to deliver change	Delays in delivery	More proactive delivery of project actions through focus from senior team	MP/MW/AF	30th March	Closed
Project & operational communications not consistent through ED	Project delivery fragmented / Breach escalations not reported consistently	Communication plan to be formed and escalations to be standardised	MP/MW/AF/WB	30th March	Open

Next steps

1. Ongoing use & development of PMO
2. Daily performance review and project update briefings
3. ED Processes to be mapped
4. Sign off for Daily Operations and Data Electronic Board
5. Complete Stakeholder analysis
6. Complete Communications plan
7. Develop and Issue A3 communications to ED/Wider Trust

Key successes

MSS on track for Phase 1 completion by 7th May
ED Redesign on track estates drawing plans
IT scoped Daily Operations and Data board – Planed release date 7th May
CDU Opened

Work stream: Community

Date – 05/04/13

Project Status

RAG	AREA
	People
	Quality
	Financial
	Milestones

Recovery Actions / Escalations

Concern	Impact	Countermeasure	Resp	Date	Status
LIA's arranged for March/April to develop 5 year strategy for community cancelled	Understanding service requirements to develop plans to shape future services	Establish understanding of next steps	SL/FS	TBC	Open
Phase 2 of review at Leasowes still incomplete	Observations required to develop action plan incomplete	JH to complete work at Leasowes	SL	12/04/13	Open
Single Referral Form not rolled out	Extra paperwork for wards	Meeting called for w/c 15/4 to reach agreement	TC/SK/ ICARES	25/04/13	Open
Some work not as far progressed due to leads being unavailable, sickness, a/l, and capacity	Some work falling behind – no updates from workstream leads	Meeting arranged with Matron to plan how we bring work back on track	JH	11/04/13	Open

Next steps

1. Outstanding work at Leasowes to be completed over next few weeks
2. Development of a patient contract for Leasowes & Henderson underway
3. Acute community group meeting to review processes/communications re referrals for community beds
4. Current state mapping in Sexual Health to begin next week
5. Re-launch of cellulitis IV therapy in community pathway next week developing pathway for UTI for Sandwell
6. Development of an algorithm with ICARES for escalation purposes
7. Patient leaflets developed for community bed bases to be attached to Intranet

Key successes

Draft Business Case for OPAT (IV Therapies) completed
Bed Matrix attached to eBMS
Policy for IV Therapies in community agreed
Principles for ICARES "in-reach" pilot have been agreed

Work stream: Patient Flow

Date – 05/04/13

Project Status

RAG	AREA
	People
	Quality
	Financial
	Milestones

Recovery Actions / Escalations

Concern	Impact	Countermeasure	Resp	Date	Status
Ward closures due to infections	Increased pressure on flow	Maintain focus on discharges in particular those patients waiting for external agencies	CR/RB		Open
Moves from MAU to inpatient wards too slow	4 hour breaches due to beds	Introduction of transfer team Pilot f daily huddles to commence	CR/EF	02.04.13	Closed
Lack of Capacity Management Team resource	Too few people to undertake the role	Business Case to SIRG for introduction of restructured team (12hrs a day 7 days per week)	CR/RB		open
Number of medical admissions and outliers	Cancellation of elective activity – 18 weeks pathway performance				

Next steps

1. Evaluate Flow Coordination pilot (end April)
2. Fully operationalise Flow Dashboard (end April)
3. Complete roll-out of Near patient pharmacy at both sites
4. Confirm Capacity Team model and timescale (to enable Operations Centre implementation)
5. Focus on ‘preparing for the weekend’ project.
6. Launch Frail Elderly Project (initial wshop – end April)
7. Develop an integrated approach to the workstream in conjunction with Community and Urgent Care
8. Launch Ambulatory Assessment Pathway project
9. Business Case for Discharge Lounge at Sandwell site to be submitted to SIRG

Key successes

1. Flow Coordination huddles ‘Go-Live’ at City site
2. Near Patient Pharmacy standard and nursing checklist launched
3. Improved real-time use of eBMS (confirmed & potential discharges, patient level notes)
4. Improved use of Discharge Lounge – City
5. Clinical Leadership identified for Frail Elderly Project
6. Patient ‘Guide to Discharge’ and ‘Ticket Home’ agreed and in final stages of printing ready for implementation

Work stream: Theatres

Date – 05/04/13

Project Status

RAG	AREA
	People
	Quality
	Financial
	Milestones

Recovery Actions / Escalations

Concern	Impact	Countermeasure	Resp	Date	Status
Low staff numbers in theatres	Cancelled operations and theatre sessions	Bethan to review staffing model	BD	ongoing	Open
Cannot meet T&O demand (backlog) due to insufficient bed capacity	Continued increase of backlog	Exploring 5 bedded bay on P3 and additional funding (other options being reviewed). Finance plan submitted	M.Bev.		Open
Centralised Booking - SIRG approval	Unable to roll out across Trust	Waiting for decision	HF	9/4/13	Open
Ability to measure impact of initiatives introduced – cancellations plus data availability	Unable to understand impact of program initiatives	1. Clear communication to stakeholders of current issues 2. Exploring alternatives			

Next steps

1. Start specialty, phased roll out – General/colorectal surgery to commence April 2013
2. Agree start up policy and roles and responsibilities
3. If SIRG approval for CB – discussions with HR re redeployment opportunities. Commence recruitment process. Commence specialty engagement.
4. Location move for Pre-op – contingency arrangements identified
5. SDU preop to move to Centralised pre op 1st May
6. Engagement discussion with Preop staff re preop service vision for 13/14
7. Send performance board output to key stakeholders

Key successes

Roll out of performance board across City Site and BTC on 2nd April 2013. Also roll out across BMEC agreed.

BMEC meeting organised with key stakeholders on 24th April

Performance board dashboard developed

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TRUST BOARD

DOCUMENT TITLE:	**Foundation Trust Programme Monitoring and Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Mike Sharon, Director of Strategy and Organisational Development**
DATE OF MEETING:	**25 April 2013**

EXECUTIVE SUMMARY:

The report gives an update on:

- Activities this period
- Activities next period
- Issues for resolution and risks in next period (corresponding to red risks on the FT risk register)

REPORT RECOMMENDATION:

To review the planned activities and issues that require resolution as part of the FT Programme

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		x

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

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

Comments:

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

'Becoming an effective organisation' and 'Achieving FT Status'

PREVIOUS CONSIDERATION:

FT Programme Board on 25 April 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FT Programme Monitoring Status Report

Amber

Activities Last Month

- Revised TFA timeline included in final TDA Annual Plan submission. Proposed date of FT application submission to TDA: April 2014
- Development of 9th draft IBP has commenced
- Updated LTFM completed
- Board Governance to be discussed at April FT Development Seminar
- Trust Strategy & priorities to be presented at April Leadership Conference
- Timetable for 2015/16 TSP issued

Planned Next Month

- Submission of updated MMH financial model to DH
- Continue programme of raising staff awareness of FT issues.

Issues for Resolution/Risks for Next Month

- Agreement from TDA on revised TFA milestones
- Make progress on A&E target in line with rectification plan to NTDA
- Outline 15/16 TSPs to be developed
- New processes designed for 18 weeks reporting data – pilot work and Trust wide implementation scheduled in April/May.