Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Boardroom, Sandwell Hospital **Date** 28 February 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 M Sharon	(MS)	[Acting 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

Mrs J Dunn	(JD)	[Acting Director of Strategy]
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]
Mr B Hodgetts	(BH)	[Sandwell LINks]

Guests

Dr B Thompson (BT) [Consultant Radiologist]

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**
Pg 4	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 31 January 2013 as a true and accurate record of discussions*	**SWBTB (1/12) 019**	**Chair**
Pg 14	4	**Update on actions arising from previous meetings**	**SWBTB (1/13) 019 (a)**	**SG-P**
	5	**Chair and Chief Executive's opening comments**	**Verbal**	**Chair/ CEO**
	6	**Questions from members of the public**	**Verbal**	**Public**
1540h	**MATTERS FOR CONSIDERATION AND NOTING**			
Pg 16	7	**Acquisition of Leasowes Intermediate Care Centre**	**SWBTB (2/13) 021** **SWBTB (2/13) 021 (a) - SWBTB (2/13) 021 (c)**	**GS**
1550h	**MATTERS FOR CONSIDERATION AND NOTING**			
	8	**Safety, Quality and Governance**		
Pg 26	8.1	Update from the meeting of the Quality & Safety Committee held on 21 February 2013 and minutes from the meeting held on 25 January 2013	SWBQS (1/13) 012	GH

Pg 34	8.2	Quality report	SWBTB (2/13) 022 SWBTB (2/13) 022 (a)	RO/ KD/ RST
Pg 70	8.3	Trust's initial response to the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry	SWBTB (12/12) 032 SWBTB (12/12) 032 (a)	KD
	8.4	Update on performance of the Emergency Departments	To follow	RB
Pg 81	8.5	Radiation Protection annual report	SWBTB (2/13) 023 SWBTB (2/13) 023 (a)	BT
1630h	**9**	**Performance Management**		
	9.1	Draft minutes from the meeting of the Finance & Performance Management Committee held on 22 February 2013	Hard copy	CRO
Pg 86	9.2	Monthly finance report	SWBTB (2/13) 024 SWBTB (2/13) 024 (a)	RW
Pg 101	9.3	Monthly performance monitoring report	SWBTB (2/13) 025 SWBTB (2/13) 025 (a)	RW
Pg 108	9.4	NHS Performance Framework & FT Compliance Framework report	SWBTB (2/13) 026 SWBTB (2/13) 026 (a)	RW
Pg 111	9.5	Performance Management Regime – monthly submission	SWBTB (2/13) 027 SWBTB (2/13) 027 (a)	MS
Pg 125	9.6	Update on the delivery of the Transformation Plan	SWBTB (2/13) 028	RB
	10	**Strategy and Development**		
Pg 127	10.1	Clinical Reconfiguration Board update	SWBTB (2/13) 029	RL
Pg 136	10.2	Foundation Trust application programme		
	▶	Monitoring report	SWBTB (2/13) 030 SWBTB (2/13) 030 (a)	MS
	11	**Update from the Committees**		
	11.1	**Audit Committee**		
Pg 138	▶	Update from the meeting of the Audit Committee held on 14 February 2013 and minutes from the meeting held on 6 December 2013	SWBAC (12/12) 068	GH
	11.2	**Charitable Funds Committee**		
Pg 147	▶	Update from the meeting of the Charitable Funds Committee held on 14 February 2013 and minutes from the meeting held on 6 December 2013	SWBCF (12/12) 026	SS
Pg 153	▶	Revised terms of reference	SWBTB (12/12) 031 SWBTB (12/12) 031 (a)	SS
	12	**Any other business**	**Verbal**	**All**

	13	**Details of next meeting** *The next public Trust Board will be held on 28 March 2013 at 1530h in the Boardroom, Sandwell Hospital* *Non-routine agenda items due to be considered at the meeting are:* • Update on Medical Education (MD) • Board Assurance Framework update – Quarter 3 (DG) • Health & Wellbeing update (DSOD) • Research strategy update (MD) • Annual cycle of business for the Trust Board (DG) • Register of Interests (DG) • Annual corporate plan (DSOD) • Annual financial plan (DoF) • Equality & Diversity annual report (CN)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 25 January 2013

Present	**In Attendance**
Ms Clare Robinson (Vice Chair)	Mrs Jayne Dunn
Mr Harjinder Kang	Miss Kam Dhami
Mrs Gianjeet Hunjan	Mr Graham Seager
Dr Sarindar Sahota OBE	Mrs Jessamy Kinghorn
Mr Mike Sharon	Mrs Chris Rickards
Mr Robert White	Mr Bill Hodgetts
Miss Rachel Barlow	
Dr Roger Stedman	**Secretariat**
Miss Rachel Overfield	Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mr Richard Samuda, Ms Olwen Dutton and Prof Richard Lilford.	
2 Declaration of Interests	**Verbal**
There were no interests declared.	
3 Minutes of the previous meeting	**SWBTB (12/12) 310**
The minutes of the Trust Board meeting held on 20 December 2012 were approved.	
AGREEMENT: The minutes of the last meeting were approved	

4 Update on actions arising from previous meetings	SWBTB (12/12) 310 (a)
The Board reviewed the meeting action log and noted that there were no matters requiring escalation or needed to be raised for the Board's attention. The Board was advised that in terms of the action concerning the tabletop reviews for serious incidents, those scheduled had taken place as planned. The Board was advised that reviews were required to take place within 45 days of the incident occurring.	
5 Chair and Chief Executive's opening comments	**Verbal**
On behalf of Mr Samuda, Ms Robinson advised that he had met with the chairs of the local Mental Health and other regional acute trusts and that he had attended a presentation by the Health Minister. The Board was advised that the Chairman had presented at an event aimed at prospective governors, which it was highlighted had been poorly attended. It was reported that a dinner with research and teaching leads had been held. Dr Stedman advised that the event had prompted a productive discussion concerning the way in which the profile of research and teaching might be raised within the Trust. The Board was advised that the Trust Board walkabouts had been reinstated. Given that the next report from Robert Francis QC was due to be released imminently, Ms Robinson suggested that the Trust should have a clear response to the report ready to issue. Mrs Kinghorn advised that work would be undertaken to review the report and determine its applicability to the Trust. She advised that good improvements had been made over the last few years on information and alert systems, therefore the Board was aware of areas where quality was good or was of concern within the Trust. Mrs Kinghorn advised that a proactive approach would be adopted once the 'Francis' report was published, however there was an expectation that a connected number of Freedom of Information and media requests may be received. Miss Overfield advised that many of the messages anticipated to be contained within the report were already within the public domain. Dr Stedman advised that there was an expectation that scrutiny of clinical outcomes would be challenged and that the relationship between managers and clinicians would be given additional focus. Miss Dhami advised that an initial response to the recommendations would be presented to the Trust Board at its next meeting. Mr Kang underlined the need for a comprehensive question and answer briefing to be prepared in advance of the publication. He asked what key risks would be likely to present as a consequence of the 'Francis' report being published. Miss Overfield advised that it was possible that a number of retrospective complaints would be raised. She added that the situation concerning staffing on the Sandwell Hospital wards, combined with the recent operational pressures also presented a risk to the Trust at present. Mrs Kinghorn agreed to draft a briefing for Board members as soon as possible. Mr Sharon advised that the operational winter pressures were considerable at	

present and that the outbreak of diarrhoea and vomiting had presented a burden on staff. It was reported that many wards had been closed to admissions and that deployment of staff across the wards affected had been challenging. It was noted that the situation had resulted in poor performance across a number of national and local targets. The Board was advised that a daily call with the Clinical Commissioning Group and local area team Chief Operating Officer was held to discuss performance against the Emergency Department waiting time target. It was reported that an Urgent Care Summit had been arranged, which aimed to develop an Urgent Care strategy. Progress was reported to be continuing with the new hospital project and the approval process for the Outline Business Case. The Board was informed that a meeting had been held with the Department of Health which had confirmed the political support for the plans. Reaffirmed support was also reported to have been gained for the plans from the Clinical Commissioning Group leads. The Board was informed that Dr Hugh Bradby, former Medical Director, was due to retire that day and the Board congratulated and thanked him for 31 years of service to the Trust.	
ACTION: **Mrs Kinghorn to draft and circulate a briefing on the Trust's response to the 'Francis' report to all Board members**	
6 Questions from members of the public	**Verbal**
Mr Hodgetts advised that he understood that there were plans to change the operation of the PALS and asked for clarity on the position. Miss Dhami advised that the Trust was served by a single PALS function and that there were plans to strengthen this. Mr Hodgetts advised that he was aware that some key consultants and surgeons had left the Trust. Mr Sharon advised that some natural turnover of consultant staff could be expected, however he acknowledged that the departure of Dr Sturman and Mr Silverman to career progression opportunities was a loss of well regarded experience and skill from the Trust.	
7 Safety, Quality & Governance	
7.1 Update from the meeting of the Quality & Safety Committee held on 25 January 2013	**Verbal**
Mrs Hunjan, in Ms Dutton's absence, provided an outline of discussions that had occurred at the meeting of the Quality & Safety Committee. Miss Overfield advised that a debrief session following the recent Norovirus outbreak had been held and she advised that although it had been determined that the outbreak had been handled well, a number of lessons had been learned from the situation. Dr Stedman advised that performance against a number of quality indicators appeared to have been adversely impacted by the Norovirus outbreak. Miss Barlow advised that a system-wide debrief on the situation was	

planned. Miss Overfield advised that the Clinical Commissioning Group (CCG) had made an unannounced visit to Wards Newton 5 and Lyndon 4. The outcome of the visit reported that practice and care had been found to be exemplary.	
7.2 Quality Report	**SWBTB (1/13) 002** **SWBTB (1/13) 002 (a)**
The Trust Board was asked to receive and accept the Quality Report, noting that it had been discussed in detail by the Quality & Safety Committee and that the contents had been largely outlined as part of the report back from the Chair of the Committee. Miss Barlow presented an update on the operational position concerning Emergency Departments. In terms of performance against the four hour waiting time target, it was reported that good improvements had been delivered and a robust recovery plan was in place. It was highlighted that there were a number of areas under close focus to deliver further improvement, including leadership, ambulance turnaround and streamlining processes. Much effort was reported to be being directed into ensuring that as many patients were discharged prior to midday as possible. The Board was informed that emergency activity had been very high recently and that business continuity plans had been put in place to ensure that an improved performance was achieved. Ms Robinson asked that thanks be conveyed to all staff involved with the work for their efforts. Ms Robinson noted that although attention on achievement of the four hour target was good, it was not clear how the situation impacted on patient flow and patient experience and she asked how this view could be gained. Miss Barlow advised that performance against clinical quality indicators demonstrate the position against time to triage and time to treatment. It was agreed that these additional Key Performance Indicators should be included in the emergency flow dashboard. Mr Kang congratulated the Executives on the improved performance and asked whether any measures had been put into place to ensure performance was maintained once the pressure had reduced. Miss Barlow advised that the issues were multifactorial, however a number of measures had been implemented, including the rigour of a daily breach analysis and securing a Clinical Director for secondment into the area. It was highlighted that there remained a gap in general management within the area, however work was underway to devolve governance and accountability. Mr Kang asked when the oversight of the area could reduce to a less intensive level. Miss Barlow advised that close attention was needed for at least the remainder of the current quarter. Dr Stedman commented that a change in staff behaviour could not be delivered quickly. Dr Sahota asked whether adequate staffing levels were in place within the area. Miss Barlow reminded him that this was the intention of the investment business case that the Board had recently approved. She advised that the gaps in medical staffing that were in existence at	

present were currently being covered by locum staff. Dr Stedman advised that a further recruitment campaign would be launched shortly which was expected to generate a positive response. Mrs Hunjan observed that staff had appeared committed and dedicated when she had visited the area one evening recently. She asked whether any lessons could be learned from the analysis of breaches to the waiting time targets. Miss Barlow advised that much of the work underway would secure a reduction in the number of breaches, however she reported that in many cases there were a number of contributory factors to the breaches. It was highlighted that Mental Health-related issues could impact, therefore an alternative model of psychiatric treatment was planned. Mr Sharon underlined the complexity of the issues, noting that some 'quick fixes' could be delivered, however there were a number of matters which would take some time to improve sustainably. It was highlighted that some of the planning and strategic work in the area needed to cease on occasion to make time to address the immediate operational pressures. Ms Robinson asked whether there were any additional resources were needed to address the issues. She asked in particular whether the Non Executive Directors could offer any further support. Mr Sharon advised that the Clinical Commissioning Group was being asked for additional assistance. He also encouraged Board members to visit the area to offer moral support where possible. Ms Robinson asked that the Non Executive Directors were kept well briefed on the position, through for instance, the circulation of the position against some performance indicators on a regular basis.	
ACTION: **Miss Barlow to include a wider range of KPIs within the emergency flow dashboard** **ACTION:** **Miss Barlow to arrange for Non Executives to be regularly briefed on Emergency Department performance**	
7.3 Beacon services	**SWBTB (1/13) 003** **SWBTB (1/13) 003 (a)**
Dr Stedman presented a proposal for the introduction of Beacon services, a scheme designed to promote services for which the Trust was well regarded. It was reported that a competition would be organised which would result in a number of services across the Trust being awarded with Beacon status. The Board was advised that the status would be applied to the successful services for a period of three years and would be awarded on the basis of criteria such as innovation and reputation, alongside recognition of the service at a regional or national level and a track record in research and teaching. Dr Stedman advised that the service would also need to be able to demonstrate that it was well functioning and was well managed. It was highlighted that it was intended to include Non Executive Directors within the assessment panels. The benefits to which the service would be entitled as a result of the award were reported to	

include access to innovation funding, use of the Beacon logo and provision of some promotional material. Dr Sahota remarked that the concept was sound and suggested that it needed to be communicated to a wider external audience, including public and stakeholders. Mr Kang added that this plan would be likely to bond staff and he remarked that the use of competition was good and would motivate staff. Mr Sharon reminded the Board that the recognition of staff and teams was also undertaken using the annual staff awards process. Dr Stedman advised that the nomination of a service needed to from the division's triumvirate of Divisional Director, Divisional General Director and Head of Nursing or equivalent. Ms Robinson asked whether the process was in place in other organisations. Dr Stedman advised that he was aware that the concept had been discussed in other organisations within the region and that it was analogous to a number of schemes in place in the United States. Mr Kang remarked that care needed to be taken to ensure that the process was fair and open to all services and not just to those obvious candidates for the award. Mr White noted that the plans presented a financial implication, given that access to funds would be provided as part of the award.	
8 Performance Management	
8.1 Draft minutes from the meeting of the Finance & Performance Management Committee held on 25 January 2013	**Hard copy**
Ms Robinson provided a summary of the discussions held at the meeting of the Finance & Performance Management Committee held on 25 January 2013. As part of the discussion of the workforce dashboard, it had been noted that the recruitment process was overly lengthy and that sickness absence required further scrutiny, possibly through the use of Internal Audit. It was highlighted that the workforce dashboard contained a number of KPIs, which merited further discussion outside of the Committee meeting. Dr Sahota asked what confidence there was that spend on agency staff would not increase to a level seen previously. Mr White advised that a key issue at present concerned the number of medical staffing vacancies that needed to be filled by agency staff. Dr Sahota asked what measures could be put into place to prevent the use rising any further. Dr Stedman advised that the use of bank and agency staff could not be totally eliminated, however there were plans to introduce a medical bank, which would be analogous to the Trust's nurse bank. Miss Dhami advised that the Trust could also advertise for a speciality doctor to cover the vacancy, which would be a less costly option that using agency staff for a long term appointment. Miss Overfield added that the Trust had been required to use significant agency nurses to manage the winter beds that were open and to cope	

with the current operational pressures.	
8.2 Monthly finance report	**SWBTB (1/13) 004** **SWBTB (1/13) 004 (a)**
The Trust Board was asked to receive and accept the monthly finance report, detailing performance as at the end of Month 9, which it was highlighted had been discussed in detail at the recent meeting of the Finance & Performance Management Committee. Mr White advised that performance was ahead of plan and that an end of year surplus of £5.7m was forecast. It was highlighted that this had not been generated by holding reserves. The Board was informed that the cash position was currently strong and that the delivery of the Transformation Savings Plan was on track. A change in the capital programme to support a new transport system was noted.	
8.3 Monthly performance monitoring report	**SWBTB (1/13) 005** **SWBTB (1/13) 005 (a)**
Mr White presented the key exceptions in terms of performance across all major internal and external targets. It was highlighted that the report had been discussed in detail by the Finance & Performance Management Committee at its recent meeting. Performance against the stroke care performance was reported to have dipped, with the performance against the stay on a stroke ward unit being slightly above the 80% threshold. Miss Barlow advised that this reflected the recent bed closures and therefore there was an expectation that there would be a good recovery against this target. In terms of workforce metrics, it was reported that the number of appraisals being held had improved. The poor performance against the ambulance turnaround target was highlighted to reflect the pressure across the region at present, however the Trust's performance was noted to remain in line with that of other organisations locally. Performance against the 18 week referral to treatment time target was reported to be improving in the Plastic Surgery and Trauma & Orthopaedics areas. It was highlighted that recent operational pressures which had necessitated the use of surgical beds for medical patients had generated a number of cancelled operations within the month. Mrs Hunjan asked that the information concerning the number of open beds across the Trust be reinstated into the report.	
ACTION: Mr White to arrange for open bed information to be reinstated within the corporate performance report	
8.4 NHS Performance Framework report	**SWBTB (1/13) 005** **SWBTB (1/13) 005 (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 reported that consultation on the proposed new FT Compliance regime was underway. Ms Robinson advised that the Finance & Performance Management Committee would consider the Trust's performance against the new regime in shadow format shortly.	
8.5 Provider Management Regime monthly return	**SWBTB (1/12) 007** **SWBTB (1/12) 007 (a)**
Mr Sharon presented the proposed Provider Management Regime (PMR) return for submission to the Strategic Health Authority. It was reported that the Trust was currently declaring non-compliance with two Board Statements; one concerning meeting all key operational targets and the other relating to compliance with the IG toolkit. Miss Overfield advised that the pressure sore information included in the submission was not consistent with that included within the Quality Report. It was agreed that a system to enable Miss Overfield to review the information prior to inclusion in the PMR should be developed.	
ACTION: **Mr Sharon to arrange for a system to enable Miss Overfield to review the pressure damage information prior to inclusion in the PMR** **AGREEMENT:** **The Trust Board gave its approval to the submission of the Provider Management Regime return**	
8.6 Annual plan activity report – Quarter 3	**SWBTB (1/12) 008** **SWBTB (1/12) 008 (a)**
Mr Sharon presented a summary of progress with delivering the activities in the annual plan. The two areas at red status were highlighted to relate firstly to progress with the Trust's application for Foundation Trust status, where the revised Tripartite Formal Agreement suggested that there would be a 6-9 month delay. The other area of concern was highlighted to concern the progress with delivery of the 'Right Care, Right Here' programme, where the plan to deliver the required QIPP savings had not yet been identified and that the activity reduction forecast had not been achieved. The areas reported as being at amber status were highlighted to relate to workforce plans, due to the current higher than planned sickness absence and the achievement of all key access targets due to the issue with performance against the Accident & Emergency Department waiting time target.	
8.7 Update on the delivery of the Transformation Plan	**SWBTB (1/13) 011** **SWBTB (1/13) 011 (a)** **SWBTB (1/13) 011 (b)**
Miss Barlow asked the Board to receive and note the update with the delivery of the Transformation Plan and advised that a briefing session for Non Executive Directors was currently being arranged. It was reported that the plan was being delivered as expected and that planning	

for 2013/14 was underway.	
9 Strategy & Development	
9.1 Foundation Trust application: programme director's report	**SWBTB (1/13) 009** **SWBTB (1/13) 009 (a)**
The Trust Board received and accepted the Foundation Trust programme director's report. Mr Sharon advised that progress with the application for Foundation Trust continued to be made. It was reported that the Historical Due Diligence (2) report had been received, which presented a positive picture of progress made with the actions to address the recommendations raised during the first review.	
10 Any other business	**Verbal**
There was none	
11 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 28 February 2013 and would be held in the Boardroom at Sandwell Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 28 February 2013, Boardroom @ SandwellHospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

31 January 2013, Anne Gibson Boardroom @ City Hospital

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

In Attendance: Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK)

Apologies: Mr R Samuda (RSM), Ms O Dutton (OD), Prof R Lilford (RL)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 22 February 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	20/12/12	Deferred to the ~~January February~~ March 2013 meeting	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 ensure that only contracts of significant value require Trust Board approval	SG-P	14/02/13	Will be prepared for Audit Committee meeting in February 2013	G
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~~ 1/04/2013	Will be discussed at Workforce Assurance Committee	G
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	28/03/13	Verbal update at February meeting to be provided	G
SWBTBACT.235	Update on the delivery of the Transformation Plan	SWBTB (11/12) 270 SWBTB (11/12) 270 (a) SWBTB (11/12) 270 (b)	29-Nov-12	Revise the level of detail in the Transformation Plan update	RB	31/01/13	Revised level of detail now provided	B
SWBTBACT.237	Quality Report	Hard copy paper	20-Dec-12	Check the reason why no Tabletop Reviews had been held in November 2012	KD	31/01/13	Verbal update given at January 2013 meeting	B
SWBTBACT.238	Emergency Department performance update	SWBTB (12/12) 291 SWBTB (12/12) 291 (a) - SWBTB (12/12) 291 (d)	20-Dec-12	Share the report prepared by the Intensive Support Team (IST) into Emergency Department performance with the Board when available	RB	31/01/13	Included with the ED update presented at the Board meeting in January 2013	B

SWBTBACT.239	Update on the delivery of the Transformation Plan	SWBTB (12/12) 297 SWBTB (12/12) 297 (a) SWBTB (12/12) 297 (b)	20-Dec-12	Organise a specific briefing on the Transformation Plan for Non Executive Directors	RB	18/02/13	Briefing session organised for 22 March 2013	B
SWBTBACT.240	Chair and Chief Executive's opening comments	Verbal	31-Jan-13	Draft and circulate a briefing on the Trust's response to the 'Francis' report to all Board members	JK	06/02/13	Prepared and circulated as requested	B
SWBTBACT.241	Quality Report	SWBTB (1/13) 002 SWBTB (1/13) 002 (a)	31-Jan-13	Include a wider range of KPIs within the emergency flow dashboard	RB	28/02/13	Included in ED performance update	B
SWBTBACT.242	Quality Report	SWBTB (1/13) 002 SWBTB (1/13) 002 (a)	31-Jan-13	Arrange for Non Executives to be regularly briefed on Emergency Department performance	RB	28/02/13	Interim reports issued and NEDs copied into daily performance updates	B
SWBTBACT.244	Provider Management Regime monthly return	SWBTB (1/13) 005 SWBTB (1/13) 005 (a)	31-Jan-13	Arrange for a system to enable Miss Overfield to review the pressure damage information prior to inclusion in the PMR	MS	28/02/13	Information now provided by nursing rather than risk	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:	**Acquisition of Leasowes Intermediate Care Centre**
SPONSOR (EXECUTIVE DIRECTOR):	**Graham Seager - Director of Estates**
AUTHOR:	**Graham Seager - Director of Estates**
DATE OF MEETING:	**28 February 2013**

EXECUTIVE SUMMARY:

This report provides background to the acquisition of the Leasowes Intermediate Care Centre under the arrangements for the transfer of assets from former Primary Care Trusts.

REPORT RECOMMENDATION:

Accept the implications of the property becoming part of the Trust's asset base and agree the transfer.

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		Legal & Policy	X	Patient Experience	
Clinical		Equality and Diversity		Workforce	

Comments:

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

Accessible and Responsive Care

PREVIOUS CONSIDERATION:

None

1.0 INTRODUCTION AND BACKGROUND

Under the arrangements agreed nationally for the abolition of Primary Care Trusts following the Health and Social Care Act 2012, all existing property in the ownership of PCTs will transfer by 1st April 2013:

- To other local NHS bodies if they are the majority user of the site; or
- To a new national "NHS Property Company" for other properties.

As the Trust is the sole occupier and provider of services from the site, this will require the transfer of the site to the Trust.

This report has been prepared to summarise the nature of the services at Leasowes Intermediate Care Centre and the implications for the Trust of the transfer of the site to ownership of the Trust.

2.0 LEASOWES INTERMEDATE CARE CENTRE SITE

Leasowes Intermediate Care Centre is a purpose built Intermediate Care Facility with 20 beds, which was opened in January 2005 on Oldbury Road, Smethwick (postcode B66 1JE).

The site is currently in the ownership of Sandwell Primary Care Trust, and has a Net Book Value of £2.4m at 1st January 2013. Full Asset Register details of the site are attached as ***Appendix 1***.

3.0 THE SERVICE

To respond to these needs, Leasowes intermediate care service provides a community option for older people facing an avoidable acute hospital admission, It supports the transition between illness and recovery, with a timely response at the crucial point when independence is compromised, by acute illness, chronic illness and or frailty related to ageing. There are three elements to the service provided:

- Rapid response approach, to patients facing a potentially avoidable hospital admission;
- In patient care within Leasowes;
- Supported discharge from Leasowes.

Leasowes Intermediate Care Centre is a 20-bedded unit that is staffed by a dedicated nurse led multi disciplinary team. The expectation of the service is to provide a timely therapeutic bed based intervention, that responds to and contains crisis for older people in line with standard 3 of the National service framework for older people (2001). The aims and objectives of the Service are to:

- Support timely discharge from hospital;
- Reduce Readmission to Hospital;
- Avoid Hospital Admission where appropriate;
- Promote independence;

- Provide a safe, quality service that promotes dignity and supports choice for older people;
- Reduce Numbers of people entering Long Term Care;
- To be valued as a first class provider of intermediate care services.

4.0 INCOME AND EXPENDITURE POSITION IN 2012/13

The service has an overall direct operating budget in 2012/13 of £933,000, with 25.6 wte staff (see ***Appendix 2*** for the detailed budget and actual figures).

The costs of the facilities themselves are subsumed within the existing Transforming Community Services arrangements between the Trust and PCT. In summary:

- The costs are met by the PCT;
- A recharge is made to the Trust for the costs as an offset against service income under current contract arrangements.

Details of the overall site costs for 2012/13 (£476,911) are included as ***Appendix 3***.

Based on these costs, the overall I&E impact of the Leasowes Services can be summarised as follows:

	£000	
SLA Income - Intermediate Care Services	1,533	
Direct Costs		
Pay	(827)	
Non Pay	(106)	
Indirect Costs		
Rates	(30)	
Energy & Water	(47)	
Other Estate Related Costs	(10)	
Estates & Facilities SLA Value (with SWBH)	(270)	
Total Direct & Indirect Costs	(1,290)	
EBITDA	243	
Capital Charges		
Depreciation	(34)	
PDC Dividend	(86)	
Net Contribution to General Overheads	123	8%

5.0 THE SITE TRANSFER

The legal title to the Property will transfer to the Trust from the PCT by virtue of the PCTs Transfer Scheme. This will operate in the same way as Transfer Orders used previously where NHS bodies have been created, merged or split. No additional transfer documentation will be required to effect the transfer. The Trust will take the Property subject to all existing rights, liabilities and other matters affecting the Property as at 1st April 2013.

Under this arrangement, there will be a restriction placed on the Trust, preventing changes to the use of the Property without written consent from the Secretary of State for Health (SOSH). This restriction will be placed on the Land Registry title to this effect by the Trust as soon as possible following transfer, and this will be done by the Trust's Legal Advisers in April 2013.

The Trust has to notify SOSH where:

- SOSH resolves to dissolve the Trust or it otherwise became insolvent, had an administrator appointed etc;
- It stops using the land for health purposes or has its services contract terminated/expire with no intention to renew;
- It proposes to dispose* of the asset (*nb - includes leases/easements etc, not just sales but see below).

In such circumstances SOSH has discretion to ask for the land to be transferred to him or a third party but doesn't have to take it.

If it does transfer to SOSH the Trust's public dividend capital (PDC) is deemed to be repaid to net book value (NBV) as at date of transfer to SOSH but if that is higher than NBV on 1st April 2013 then SOSH may require the Trust to repay PDC to the value of the difference (in effect 100% overage)

Any other disposal would attract overage at 50% of any uplift between the sales receipt and the higher of a) NBV at sale and b) NBV at 1st April 2013.

Certain disposals are exempt from consent and overage - substation leases; wayleaves to statutory authorities; short term leases and licences where no security of tenure is created - but it is best to get SOSH consent if the position is unclear.

6.0 SITE OWNERSHIP CONSIDERATIONS

The default position of the Trust has always been that it should own the assets needed to deliver services, unless there are pressing reasons for an alternative arrangement.

Looking at the Leasowes Service, there are no plans to change the nature of the services currently delivered from the site; no known plans by commissioners to change the basis or nature of the existing contracts for services; and no over-riding reasons from an estates perspective for considering an alternative arrangement.

Having said that, it is important to note that there are risks inherent in taking ownership of the site:

- Transfer of Leasowes will increase the fixed costs of the Trust, and in the event that service contracts change, this could add to the burden on the overall CRES requirements of the Trust;

- The Trust will take on the responsibilities of ownership from the PCT, including those of a statutory nature (Health & Safety, etc.).

The alternative option is for Leasowes to transfer to the new national "NHS Property Company" and a lease entered into. The lease would require the Trust to accept all significant responsibilities associated with the land and property.

7.0 CONCLUSION AND RECOMMENDATION

Accept the implications of the property becoming part of the Trust's asset base and agree the transfer.

Graham Seager

Appendix 1: Asset Register Information

Appendix 2: Direct Service Budget 2012/13

Appendix 3: Site Costs 2012/13

Leasowes Estates Related Costs	
Direct Costs	**£**
Rates	30,000
Gas	24,000
Electricity	17,000
Water	5,500
Grounds Maintenance	1,500
Telephones	5,000
General Waste	1,000
Other (notional)	2,000
Total Direct Costs	**86,000**
Allocations	
Soft FM	237,267
Hard FM	32,854
Total Allocations	**270,121**
Capital Charges	
Buildings	33,854
Return on Assets	86,936
Total Capital Charges	**120,790**
Grand Total	**476,911**

SWBTB (2/13) 021 (b)

Asset Classification	Asset Code	Asset Title	Date Capitalised	CCA Purchase Cost	CCA GCRC	CCA YTD Depn	CCA Acc Depn	CCA NCRC	SWBH
Buildings - Owned	000191	Quantity Surveying Duties	01/04/2005	£2,000.00	£898.94	£16.05	£16.05	£882.89	Leasowes
Buildings - Owned	000208	Construction work	01/10/2005	£130,834.89	£110,980.13	£1,981.80	£1,981.80	£108,998.33	Leasowes
Buildings - Owned	000210	AUC	01/10/2005	£57,825.89	£49,050.56	£875.91	£875.91	£48,174.65	Leasowes
Buildings - Owned	000510	LEASOWES	01/01/2009	£1,816,593.33	£1,732,894.84	£30,944.55	£30,944.55	£1,701,950.29	Leasowes
Buildings - Owned	000541E	Leasowes	31/03/2009	£1,351.25	£1,042.72	£18.63	£18.63	£1,024.09	Leasowes
Buildings - Owned	000541F	Leasowes	31/03/2009	£1,207.50	£931.80	£16.65	£16.65	£915.15	Leasowes
Buildings - Owned Total				**£2,009,812.86**	**£1,895,798.99**	**£33,853.59**	**£33,853.59**	**£1,861,945.40**	
Land - Owned	000032	Leasowes - prep costs	31/03/2003	£18,571.00	£30,237.00	£0.00	£0.00	£30,237.00	Leasowes
Land - Owned	000034	leasowes prep costs	31/03/2003	£50,809.55	£82,727.27	£0.00	£0.00	£82,727.27	Leasowes
Land - Owned	000535	purchase of land-leasowes	31/03/2009	£274,561.00	£447,035.74	£0.00	£0.00	£447,035.74	Leasowes
Land - Owned Total				**£343,941.55**	**£560,000.01**	**£0.00**	**£0.00**	**£560,000.01**	

Financial Position at 31st December 2012: Intermediate Care - Leasowes

Expense Code	Expense Description	WTE Budget	WTE Actual	Annual Budget	CP Budget	CP Actual	CP Variance	YTD Budget	YTD Actual	YTD Variance
				£	£	£	£	£	£	£
Pay										
470010	Miscellaneous Income	0.00	0.00	0	0	46	-46	0	167	-167
502808	Senior Manager - Band 8	1.00	1.00	74,002	6,165	5,774	391	55,489	52,487	3,002
523001	Bank Nurse : Qualified	0.00	0.31	0	0	1,578	-1,578	0	4,560	-4,560
523205	Nursing & Midwifery Qual - Band 5	3.33	2.33	120,687	10,057	7,538	2,519	90,513	72,216	18,297
523206	Nursing & Midwifery Qual - Band 6	4.32	4.26	192,759	16,061	16,358	-297	144,553	141,655	2,898
523207	Nursing & Midwifery Qual - Band 7	1.30	0.06	75,697	6,306	238	6,068	56,756	31,268	25,488
525002	Nursing & Midwifery Unqual - Band 2	13.31	10.23	312,917	26,076	21,399	4,677	234,685	195,670	39,015
526401	Bank Nurse : Unqualified	0.00	0.79	0	0	1,400	-1,400	0	9,258	-9,258
565702	Admin and Clerical - Band 2	1.32	1.32	28,348	2,361	2,321	40	21,249	21,632	-383
565704	Admin and Clerical - Band 4	1.00	1.00	35,357	2,945	2,189	756	26,505	19,705	6,800
576330	Vacancy Factor - Nursing & Midwifery	0.00	0.00	-12,989	-1,082	0	-1,082	-9,738	0	-9,738
582501	Agency Nursing : Grade D	0.00	0.00	0	0	4,865	-4,865	0	39,991	-39,991
Total Pay		**25.58**	**21.30**	**826,778**	**68,889**	**63,707**	**5,182**	**620,012**	**588,609**	**31,403**
Non Pay										
700001	Drugs	0.00	0.00	32,500	2,025	2,104	-79	26,437	26,378	59
700501	Medical Gases	0.00	0.00	0	0	0	0	0	68	-68
701001	Dressings	0.00	0.00	0	0	0	0	0	368	-368
702001	Medical & Surgical Equipment : General	0.00	0.00	0	0	1,051	-1,051	0	4,990	-4,990
702701	Continence Products	0.00	0.00	0	0	842	-842	0	1,733	-1,733
702901	Contractual Clinical Services	0.00	0.00	18,063	1,505	1,350	155	13,545	12,150	1,395
708001	Patients Appliances : Purchase	0.00	0.00	0	0	22	-22	0	282	-282
712001	Laboratory Equipment	0.00	0.00	0	0	112	-112	0	255	-255
714001	Therapy Equipment & Materials	0.00	0.00	0	0	245	-245	0	570	-570
715001	Provisions	0.00	0.00	0	0	128	-128	0	1,033	-1,033
715401	Hardware & Crockery	0.00	0.00	0	0	0	0	0	458	-458
715601	Catering Equipment - Purchase	0.00	0.00	0	0	0	0	0	151	-151
717001	External Contracts : Catering	0.00	0.00	0	0	0	0	0	389	-389
718001	Staff Uniforms & Clothing	0.00	0.00	0	0	529	-529	0	872	-872
718201	Patients Clothing	0.00	0.00	0	0	0	0	0	75	-75
719001	Cleaning Equipment	0.00	0.00	0	0	637	-637	0	2,238	-2,238
720001	Bedding & Linen : Disposable	0.00	0.00	0	0	291	-291	0	1,385	-1,385
721001	Other General Supplies & Services	0.00	0.00	0	0	0	0	0	-1,708	1,708
722101	Stationery	0.00	0.00	0	0	28	-28	0	1,960	-1,960
727001	Travel & Subsistence	0.00	0.00	0	0	0	0	0	281	-281
727201	Regular Car User Allowance	0.00	0.00	1,200	100	0	100	900	63	837
735001	Furniture & Fittings	0.00	0.00	0	0	0	0	0	793	-793
735401	Computer Hardware Purchases	0.00	0.00	0	0	0	0	0	258	-258
738501	Building & Engineering Equipment Maintena	0.00	0.00	0	0	0	0	0	144	-144
738505	Build & Eng Maint - Annual Contracts	0.00	0.00	0	0	0	0	0	214	-214
748701	Miscellaneous Expenditure	0.00	0.00	0	0	0	0	0	612	-612
765108	SubHealthcare - External Healthcare	0.00	0.00	54,637	4,553	4,553	0	40,977	40,978	-1
770020	Recharge : Received - Tele-Communications	0.00	0.00	0	0	0	0	0	340	-340
Total Non Pay				**106,400**	**8,183**	**11,892**	**-3,709**	**81,859**	**97,332**	**-15,473**
Total Expenditure		**25.58**	**21.30**	**933,178**	**77,072**	**75,599**	**1,473**	**701,871**	**685,941**	**15,930**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue D29 meeting Room, City Hospital **Date** 25 January 2013; 0930h – 1130h

Members Present

Mrs G Hunjan [Chair]
Mr R Samuda
Dr S Sahota OBE
Prof R Lilford
Mr M Sharon
Miss K Dhami
Miss R Overfield
Dr R Stedman
Miss R Barlow
Mrs D Talbot

In Attendance

Mr S Parker

Guests

Mrs E Newell

Secretariat

Mr S Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies for absence from Olwen Dutton, Robert White and Allison Binns.	
2 Minutes of the previous meeting	**SWBQS (12/12) 112**
The minutes of the Quality and Safety Committee meeting held on 14 December 2012 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBQS (12/12) 112 (a)**
The updated actions list was noted by the Committee.	
4 Quality Report	**Hard copy**
Miss Overfield reported that the Safety Thermometer results had dipped slightly to	

92.5%. The number of falls incidents was highlighted to have risen slightly in November, with the trend being expected to continue into December. The Committee was advised that the position reflected the situation concerning staffing levels, with the number being higher at Sandwell Hospital given the greater difficulty with observing patients in bays as opposed to the Nightingale-style wards at City Hospital. The trend concerning pressure damage was reported to be pleasing and the usage of bank and agency staff was highlighted to have reduced, however the position was noted to remain higher then desired as a result of the additional beds being open than planned at present. Mrs Hunjan observed that the target for the Safety Thermometer audit was 95% and asked whether a penalty would be levied for not achieving this. She was advised that this was not the case at present and that the Trust's position remained in line with a number of peer organisations. Miss Overfield advised that reporting against some of the key metrics would need to be considered in the light of the next report from Robert Francis QC into the standards of care at Stafford Hospital. Mr Sharon advised that the Trust's position concerning pressure damage on the Acute Quality Dashboard was favourable. Prof Lilford commented that it was difficult to achieve a true comparison of performance in the absence of a network that provided a regional view.

The Committee was asked to consider a report concerning the recent outbreak of diarrhoea and vomiting, including the outcome of the debrief session that had been held on 17 January 2013. It was reported that during the outbreak 30 wards had closed, with the causative agent being identified as Norovirus in many, but not all, cases. It was highlighted that the number of ward closures included those that had closed but were quickly opened. It was highlighted that 300 patients had been affected by the outbreak and that 68 staff had reported diarrhoea and vomiting symptoms. The Committee was advised that it was difficult to determine the cost of the outbreak, however Miss Overfield advised that it was likely to have been costly. Miss Overfield advised that the debrief had identified that weekend arrangements needed to be more robust and that the situation had been burdensome for Microbiology staff. Mr Sharon advised that the planned closer working relationship with Dudley Group of Hospitals NHS Foundation Trust (DGOHFT) on Pathology matters would assist. Miss Overfield advised however, that the arrangements were unlikely to help with Infection Control handling. It was reported that during the period, it had been difficult to control the movement of doctors and that a number of staff had attended work, despite having symptoms of diarrhoea and vomiting which had exacerbated the situation. Mr Samuda asked whether a text message alerts system was in place to advise staff not to attend work should they be experiencing illness. Miss Overfield advised that this was not the case, however she acknowledged that this was a good suggestion. It was reported that the supply of laundry had been challenging and that mobile hand wash facilities were used, although their value was questionable overall. Handling visitors was reported to have been difficult and that appropriate decisions had been made, although there was a need to revisit these more rapidly that had been done. The Committee was advised that it was likely that a number of complaints from visitors might be received as a consequence of the ward closures. It was highlighted that the impact of the outbreak may be reflected in the ward quality dashboard. Dr Sahota asked how visiting End of Life patients had been handled.

Mrs Talbot reported that visitors had been accepted for these patients, in line with the discretionary arrangements outlined in the Visitors' Policy. Miss Overfield reported that better external support from GPs would have been welcome. Mr Samuda suggested that this issue should be raised through the appropriate channels. Miss Barlow advised that a system-wide briefing was planned. It was reported that a risk assessment process needed to have been in place which determined whether the admission needs were sufficient to allow admission to a ward on which patients and/or staff were experiencing diarrhoea and vomiting symptoms. Mr Sharon advised that during the outbreak, it had been suggested that the usual infection control policy should be lifted, however the Trust's commissioners had not been supportive of this. Mr Sharon suggested that all staff involved in handling the outbreak should be commended and that he appreciated the honesty of the debrief. Miss Overfield noted that the process had been jointly managed with Operations. Miss Barlow added that the pressure on the Operational procedures had been considerable and in particular the Trust's bed base had been stretched. Mrs Hunjan suggested that following the debrief, some follow up work was needed. Mr Sharon advised that there had been to date, little impact of the outbreak on the Trust's financial position. It was agreed that the action plan to address the follow up work would be presented at a future meeting of the Quality & Safety Committee. It was agreed that this would be presented in March 2013. Dr Sahota suggested that there was a need to link in with the regional partners on the follow up work where relevant. Miss Overfield advised that good links had already been made with external partners in this respect.

Dr Stedman reported that the performance against the fractured neck of femur target had deteriorated slightly. Compliance with the use of the World Health Organisation (WHO) checklist was reported to be at 99.8% and the root cause of cases where the checklist had not been used was being reviewed. It was reported that compliance against the other areas of the 'Five Steps to Safer Surgery' had improved and in particular the briefing and debriefing requirements. It was reported that performance against the stroke care target had suffered as a consequence of the ward closures due to the infection outbreak. It was reported that the VTE target was likely to increase to 95% for 2013/14. An improved performance on mortality reviews was reported to be anticipated. Miss Dhami advised that a specific item concerning mortality was due to be added to the agenda of the next Quality & Safety Committee. It was reported that the Trust's Hospital Standardised Mortality Ratio (HSMR) position continued to improve. Dr Sahota observed that mortality from the maternity area was not included and questioned whether this needed to be. Dr Stedman advised that the approach to mortality reporting by Dr Foster was inappropriate to apply to these deaths. Dr Sahota remarked that there needed to be assurance that mortality information from the maternity area was being reviewed. Mr Parker advised that the Trust also used Healthcare Evaluation Data (HED), which although only being freshly reviewed, could be used in future to set up an alert system, including for maternity information. Miss Dhami added that at present, a system was in place which ensured that deaths were reviewed to determine whether they were preventable. Mr Sharon asked whether the Care Quality Commission reviewed deaths on a Trustwide scale or on a site basis. Mr Parker advised that the CQC reviewed this both on a site and on a Trustwide basis, however the trigger alert was at a

Trustwide level. It was reported that compliance with the antibiotic stewardship target had improved. Miss Overfield reported that the Net Promoter Score had improved in December and that the Trust's performance was in line with the regional position. The Committee was advised that 'tally' boxes had been introduced into key locations. It was reported that the new Patient Experience Committee would meet shortly and would consider the Patient Experience strategy. It was highlighted that the resources supporting the Patient Experience agenda would be in place until the end of March 2013 at present, however it was likely that a request to fund the post would be submitted to extend the support into the new financial year. Miss Dhami advised that in terms of complaints handling, breaches against the failsafe targets were monitored on a weekly basis and the plan to devolve complaints handling would be presented at the February meeting of the Quality & Safety Committee.	
ACTION: **Dr Stedman to present an update on the Trust's mortality position at the February 2013 meeting of the Quality & Safety Committee** **ACTION:** **Miss Dhami to present the plan for devolving complaints handling at the February 2013 meeting of the Quality & Safety Committee**	
5 CQC mortality outlier – perinatal mortality	**SWBQS (1/13) 002** **SWBQS (1/13) 002 (a) - SWBQS (1/13) 002 (c)**
Mrs Newell joined the meeting to present an overview of the Trust's response to the alert received by the Care Quality Commission in respect of perinatal mortality. The Committee was advised that the alert had been received in December 2012, which had been triggered by 54 deaths, including still births and neonatal deaths. It was reported that the alert had not been anticipated, particularly given that perinatal deaths had reduced year on year. The Committee was advised that the level of perinatal mortality in the region was higher than in many other parts of the country, attributable in part due to the profile of the local demographic. Mrs Newell advised that deaths had been investigated since the alert for the period June 2011 – July 2012, which had identified 52 cases and in all instances, it had been identified that the appropriate procedures had been followed. It was highlighted however, that there it had been determined that coding could have been improved in some cases and that the assignment of neonatal deaths to a Paediatric death code had influenced the position to some degree. The Committee was advised that an instruction had now been issued to ensure that such deaths were coded to Obstetrics, rather than Paediatrics. It was reported that not all trusts in the region had adopted this approach however. The Committee was informed that the response to the alert had been issued to the Care Quality Commission within the required timeframe and that a response was awaited. Prof Lilford remarked that the report was good, however he highlighted the difficulty with replicating the calculation of adjusted perinatal mortality rates. He suggested that an alternative calculation be used in future. Mrs Newell advised	

that the calculation used was a standardised and recognised way of calculating perinatal mortality, which had been widely adopted regionally. She also advised that customised growth charts were also used to assist with determining whether a baby had grown appropriately. Dr Stedman added that the purpose of the perinatal mortality calculation was to detect abnormal variances and that it provided a consistent approach to this. It was agreed that when a response to the action plan had been received from the Care Quality Commission, this would be presented to the Quality & Safety Committee. Mr Sharon congratulated Mrs Newell on the recent award from the Royal College of Midwives for the promotion of normal births. Mrs Newell advised that the award had been given on the basis of clinical outcomes.	
6 Missed Downs Syndrome screening	**SWBQS (1/13) 003**
Mrs Newell advised that 6500 women had been audited and 74 instances of missed Downs Syndrome screening had been identified to date, 38 of which were patients of the Trust. It was reported that a number of measures to safeguard against any further cases of missed screening had been implemented. The Committee was advised that the prospective analysis would continue until a robust IT solution was available. It was highlighted that the development of a DVD to assist with the previously reported translation issues had not yet been developed in house and therefore consideration was being given to sourcing an external version. It was reported that it was the intention that the DVD would be shown in community locations. It was agreed that a further update on the missed Downs Syndrome screening action plan would be presented at the next meeting.	
ACTION: Mrs Newell to present an update on the missed Downs Syndrome screening action plan at the next meeting	
7 Action plans to address recommendations from the CQC inspection	**SWBQS (1/13) 004** **SWBQS (1/13) 004 (a)** **SWBQS (1/13) 004 (b)**
Miss Dhami presented the actions plans to address the recommendations following the unannounced visit to the Trust by the CQC in Autumn 2012. It was noted that the action plans covered Outcomes 2 and 16 and that the plans although site specific, were identical in terms of actions raised. It was reported that the action plans had been submitted to the CQC. The Committee was advised that a monthly update on the action plans would be presented and that when completed the CQC would be advised that this was the case. Miss Overfield advised that a significant number of the actions had already been completed.	
8 Medicine & Emergency Care division Transformation Savings Plan schemes	**SWBQS (1/13) 005** **SWBQS (1/13) 005 (a)** **SWBQS (1/13) 005 (b)**

Dr Stedman presented the Medicine & Emergency Care division's Transformation Savings Plan, however he advised that given that there was little detail behind the plan at present, the quality impact assessment of the schemes would be presented to the Committee in March 2013.	
ACTION: **Dr Stedman & Miss Overfield to present the quality impact assessment of the Medicine & Emergency Care transformation savings plan schemes at the meeting of the Quality & Safety Committee planned for March 2013**	
9 Corporate Performance report	**SWBQS (1/13) 006** **SWBQS (1/13) 006 (a)**
The Committee was asked to receive and accept the contents of the corporate performance report. It was highlighted that compliance with Information Governance training was currently 94.1%. Mr Sharon advised that the position would need to be reported to the Strategic Health Authority as part of the Provider Management Regime return. It was reported that the Trust Board at its last meeting, had considered a report on the Trust's Emergency Departments, which had identified that despite the challenges with meeting the national waiting time target, it did not appear that there was deterioration in quality of care. It was reported that a new Clinical Director was in place within the Emergency Care area for a six month secondment. Mrs Talbot suggested that as part of the assessment of the Emergency Department performance that national patient experience survey results needed to be considered. Dr Sahota noted that the performance against the admissions rate target was at red status. Mr Sharon advised that addressing the position was included as a priority within the 2013/14 annual plan. Prof Lilford advised that there was considerable literature available discussing readmission rates which might be of some assistance.	
10 Foundation Trust Quality Governance	**Verbal**
Miss Dhami reminded the Committee that the reassessment against the Quality Governance Framework had been postponed until end of February or early March 2013.	
11 Clinical Audit forward plan	**SWBQS (1/13) 007** **SWBQS (1/13) 007 (a)**
Mr Parker advised that the Clinical Audit plan report would be refreshed in future to provide an overview of the findings of the audits when completed. It was reported that there was some delay with the submission of information to the TARN audit and that feedback was awaited from the Trauma Network. It was highlighted however, that the conditional status of the Trust as a designated Trauma Unit had not been impacted by this delay however. Mr Parker was asked to check that this was in line with the reconfiguration plans for the area.	

Measures being taken to address the situations with the remaining delayed audits were presented. The Committee was asked to note that three audits had been completed during the period as expected and that there were no issues of significance to report.	
ACTION: Mr Parker to check that the submission of information for the TARN audit was in line for the plans to reconfigure the area	
12 Serious Incident report	**SWBQS (1/13) 008** **SWBQS (1/13) 008 (a)**
Miss Dhami asked the Committee to note that the serious incident report included ten ward closures due to the infection outbreak. Dr Sahota asked for further information on incidents 4 and 14. It was noted that the pressure damage information was not consistent with that included in the Provider Management Regime submission. Miss Overfield advised that this difference reflected the variation between the number of avoidable instances against the total number of pressure damage cases. It was agreed that further information on cases P1 and P3 should be provided in the next update.	
13 Serious graded complaints report	**SWBQS (1/13) 009** **SWBQS (1/13) 009 (a)**
Miss Dhami asked the Committee to note that there had been a reduction in the number of complaints received and that during the period there had been no red complaints reported. The Committee was advised that all eight amber complaints had been investigated.	
MINUTES FOR NOTING	
14 Minutes from Governance Board	**SWBGB (12/12) 177**
14.1 Minutes from the meeting held on 7 December 2012	
The Quality and Safety Committee received and noted the minutes from the Governance Board meeting held on 7 December 2012.	
15 Clinical Quality Review Group	**SWBQS (1/13) 010** **SWBQS (1/13) 011**
15.1 Minutes from the meeting held on 7 November 2012 and 5 December 2012	
The Quality and Safety Committee received and noted the minutes from the Clinical Quality Review Group meetings held on 7 November 2012 and 5 December 2012.	
16 Any other business	
There was none.	

17 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 21 February 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:	28 February 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 Board 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:

Quality & Safety Committee on 21 February 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

February 2013

Where EVERYONE Matters

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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 December decreased to 92.4% with increases in pressure damage, falls and new VTE on the day of the audit. It has improved to 94% in January.
- Falls incidents rose again in December but remain lower than at the same time in previous years. Rates at Sandwell continue to be higher than at City.
- Infection rates continue to be within target and reported MRSA screening rates meet the SHA target.
- Pressure Damage – trend continues downwards
- Bank/agency (nursing) increased slightly during January and is higher than in previous years.
- Staffing ratios are concerning on a number of wards mainly due to winder beds being open and difficulty staffing wards.

CLINICAL EFFECTIVENESS

- Fractured Neck of Femur operated on within 24 hours of admission during January was 79%, exceeding the local target of 70%.
- Compliance with the use of the World Health Organisation (WHO) checklist is 99.72%. Work has been commenced on spot check notes audits and qualitative reviews.
- Stroke Care- Performance has recovered against the stroke indicators with 83.02% patients spending 90% of their stay on the stroke unit.
- VTE performance remains above 90% during January for all admitted patients.
- Mortality Reviews Performance for November was 63% which is below the target of 71%. This is an improvement on October's performance but still behind trajectory. A plan has been put in place to recover and restore target achievement.
- In the light of the Francis Report2, a separate document on mortality management in the Trust has been written and is on the Q&S Committee Agenda.

PATIENT EXPERIENCE

- The Net Promoter score in January increased to 67 achieving the SHA 10 point improvement target. The SHA average is currently at 70.
- The first report on the national inpatient survey result is subject to a separate report for Q&S Committee
- The first results of FFT in our A&E departments is included this month.
- 74 complaints were received in December and 54 final responses were sent out.

WORKFORCE QUALITY

- The Trust is currently meeting its overall mandatory training target – 88.74% (85%). PDR rates however, are lower than our target rate at 70.64%.
- Sickness absence is 4.41% (December)

3 TARGETED AREAS OF SUPPORT

- Many of the Trust's medical wards are giving rise for concern especially with regard to staffing arrangements – we are taking additional steps to try to resolve this issue including using Spanish agency staff.

4 EMERGING TRENDS/NOTICEABLE PATTERNS

- None specifically

5 OF SPECIFIC NOTE

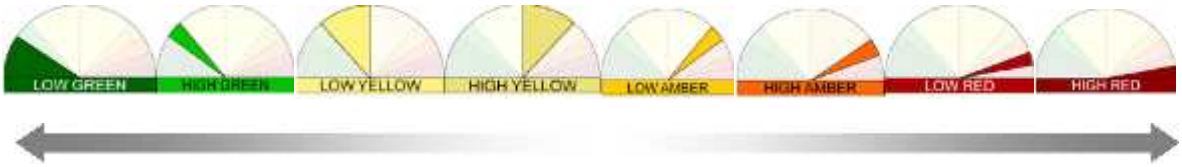
- There is nothing specific to note over and above the other matters highlighted above.

6 KEY CLINICAL RISKS

- Variable standards/leadership EDs
- Staffing levels as a result of 'paused' bed closure plan

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 current risk estimates for the essential standards of quality and safety for the Trust published by the CQC on 6th February 2013 are:

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

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 contributes towards the risk estimate for Outcome 4.

	Quantitative Items: 262							Qualitative Items: 56	
	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*	**14** (9)	**7** (6)	**11** (7)	**185** (162)	**18** (17)	**6** (8)	**21** (13)	**40** (38)	**16** (20)

* The figure in brackets indicates the number of items in the November version of the QRP

The indicators where the Trust's position is shown to be worse than compared with the expected or moving in that direction are currently under review. 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 estimate are based on data that relates to a period some way in the past (e.g. September 2010) with the most recent being September 2012. In light of this local intelligence will be used, together with that available in the QRP, to establish the up-to-date position. If this has not improved priority action will be taken and reported to the Quality and Safety Committee in March.

8 CQuINs

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

Exec Lead				PATIENT SAFETY			Sept	Oct	Nov	Dec			Jan			To Date (*=most recent month)	TARGET		Note	THRESHOLDS			12/13 Forward Projection
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13					
RS	A	3	Acute CQUIN	VTE Risk Assessment (Adult IP)	396	%	91.0 ■	91.5 ▲	91.7 ▼	→		90.2 ▼	→		91.1 ▲	91.1*	90	90	a	=>90		<90	●
RB	K	20		Appropriate Use of Warfarin	372		Compliant	→	→	→		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 ▲	→	→	→		→	→			83	70	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	%	99.8 ■	99.8 ■	99.8 ■	→		99.8 ■	→		99.8 ■	99.8	99	100		No variation		Any variation	●
RS	H	9		Safe Surgery - Other Areas		%	100 ▲	99.8 ▼	99.5 ▼	→		99.5 ■	→		99.5 ■	99.5	98	98		No variation		Any variation	●
RS	H	10		Stroke Care	743	%	Met Q2 req's	→	→	→			→		→	Met Q2 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	●
EFFECTIVENESS OF CARE																							
RO	H	8	Acute CQUIN	Dementia	396	%	Met Q2 req's	Meeting Q3 req's	Meeting Q3 req's	→		Met Q3 req's	→		Not Meeting Q4 req's	Not Meeting Q4 req's	90	90	a	No variation		Any variation	●
RS	H	3		Mortality Review	743	%	68.9 ▲	53.9 ■	63.9 ▲	→			→			63.9	71	80		No variation		Any variation	●●
RO	H	11	Community CQUIN	Dementia	44	%	Met Q2 req's	Not Meeting Q3 req's	Not Meeting Q3 req's	→		Met Q3 req's	→			Met Q3 req's	80	90		No variation		Any variation	●
PATIENT EXPERIENCE																							
RO	H	8	Acute CQUIN	Personal Needs	396	%	→	→	→	→		→	→		→	66.9	71.6	71.6	a	No variation		Any variation	
RO	H	8		Net Promoter	372	No.	63 ▲	64 ▲	65 ▲	→		67 ▲	→			67	63	65		No variation		Any variation	●
RO	H	8		End of Life Care	372	%	60 ▲	59 ▼	65 ▲	→		62 ▼	→			62	52	53		No variation		Any variation	●
RS	H	10		Every Contact Counts - Alcohol	372	%	57 ■	→	61 ▲	→		→	→			61	66	80		No variation		Any variation	●
RO	H	12		Every Contact Counts - Smoking	372	%	Baseline established	→	→	→		→	→			Baseline established				No variation		Any variation	●
RO	H	11	Community CQUIN	Pt. (Community) Exp'ce - Personal Needs	44	Score	91.5 ▼	96.0 ▲	93.0 ▼	→		94.0 ▲	→			94.0	90	90		No variation		Any variation	●
RO	H	11		Net Promoter	88	No	81 ■	88 ▲	86 ▼	→		85.0 ▼	→			85	75	75		No variation		Any variation	●
RO	H	11		Every Contact Counts	132	%	Baseline established	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	%	Baseline established	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		Q2 Return Submitted	→	→	→		Q3 Return Submitted	→		→	Q3 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●
RS	H	13		Neonatal - Hypothermia Treatment	73	%	Q2 Return Submitted	→	→	→		Q3 Return Submitted	→		→	Q3 Return Submitted	Derive Base	Derive Base		No variation		Any variation	●
RS	H	13		Neonatal - Discharge Planning / Family Experience and Confidence	122	%	Q2 Return Submitted	→	→	→		Q3 Return Submitted	→		→	Q3 Return Submitted	Derive Base	Derive Base		Met		Not Met	●
RS	H	12		HIV - Optmum Therapy	147	%	Q2 Return Submitted	→	→	→		Q3 Return Submitted	→		→	Q3 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●

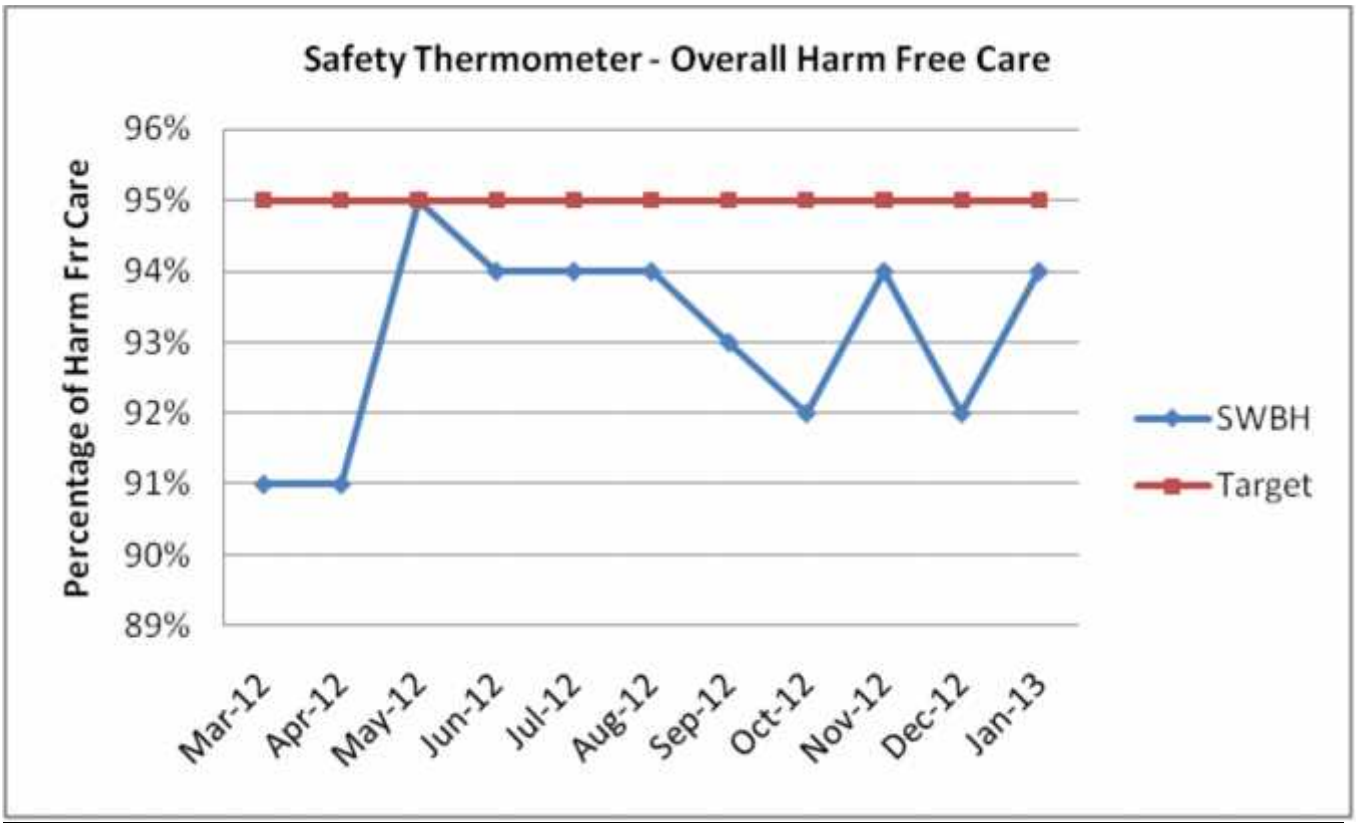
9 PATIENT SAFETY

9.1 Safety Thermometer

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

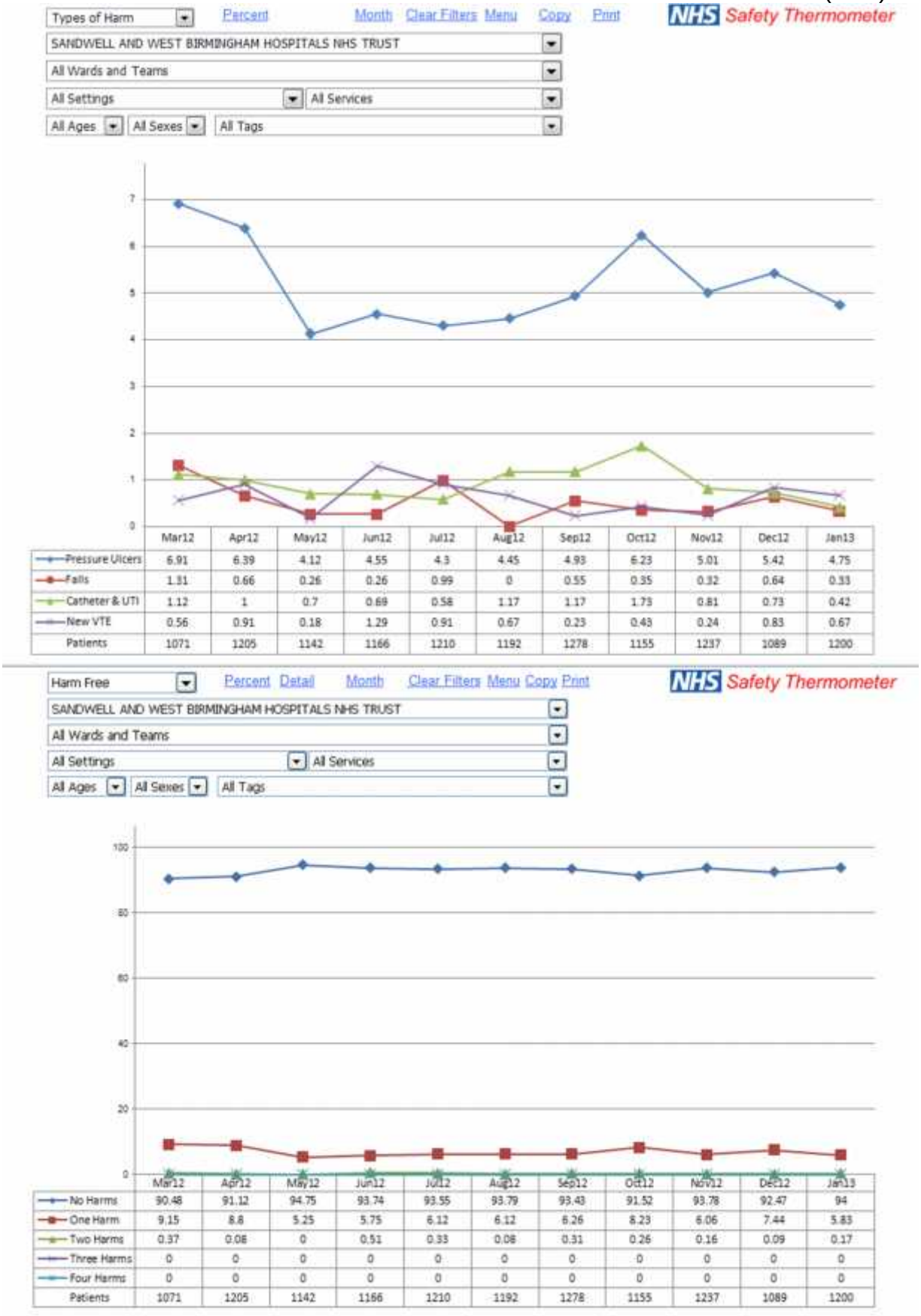
Conducting monthly whole Trust census of patients for 4 harm events (falls, pressure damage, CAUTI and VTE) continues to go well with good engagement of nursing staff. Work has commenced to add other harm measures to the tool, eg avoidable weight loss.

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



Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
90.48%	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

Figure 1: *Harm free care trend*



Figures 2 & 3: *Number of patients by type and number of harm incidents*

Acute Divisions **11** patients experienced **1 new harm**. **No** patients experienced **2, 3 or 4 harms**
Community Division **7** patients experienced **1 new harm** and **0** patients experienced **2, 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.

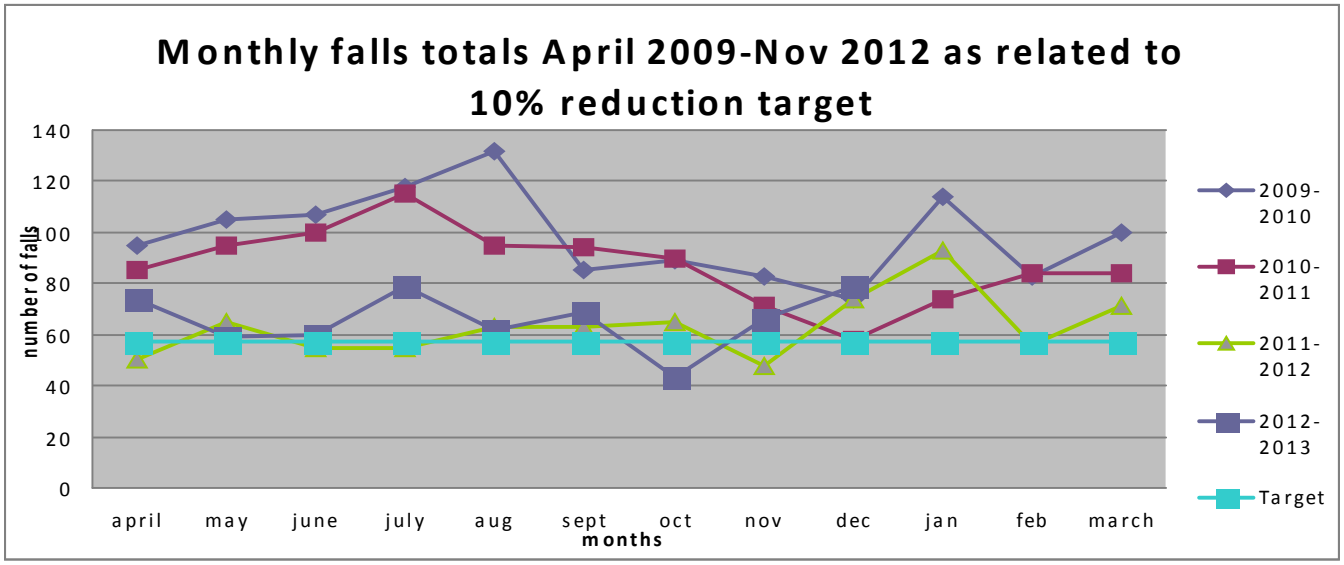


Figure 4: *Trend of falls*

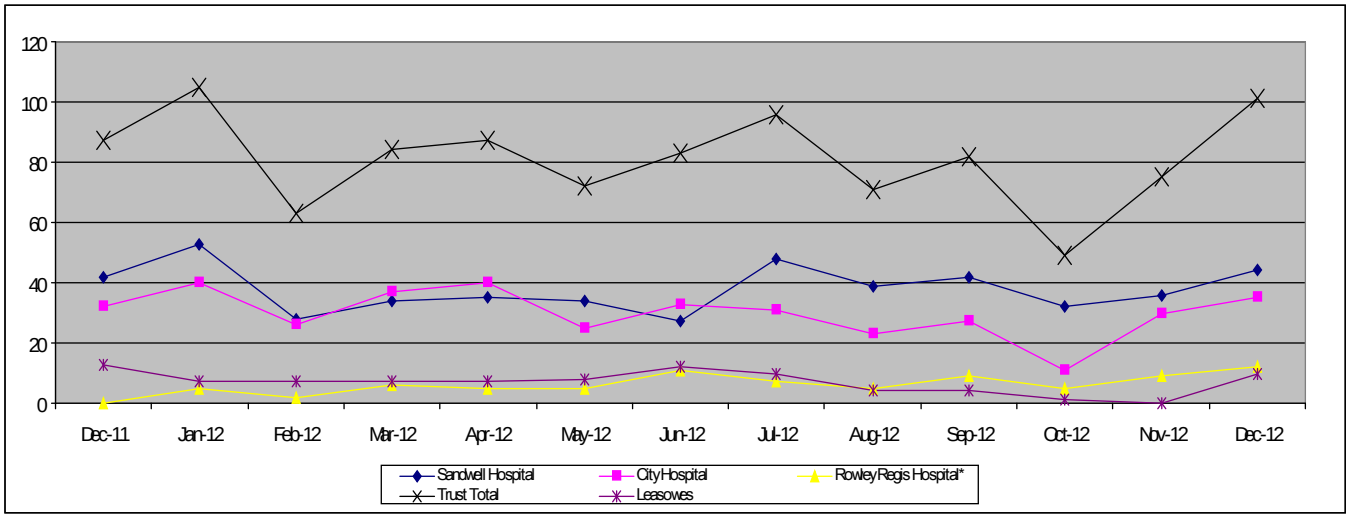


Figure 5: *Incidence of falls per 1000 bed days across Acute Inpatient Divisions*

Sandwell continues to have a higher number of falls compared to City.

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.

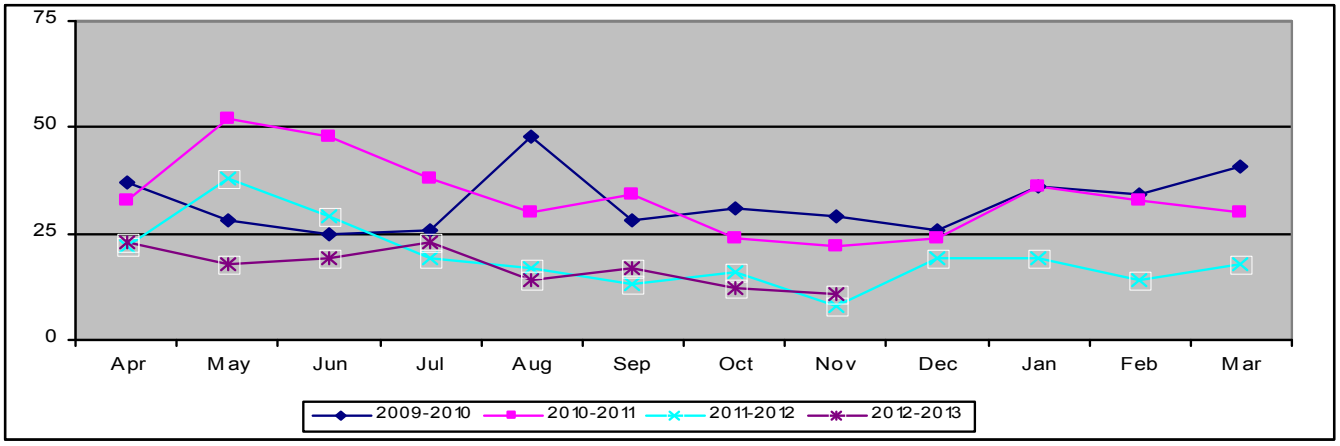


Figure 6: *Number of hospital acquired pressure damage Grade 2, 3 & 4, April 2009 - July 2012*

New pressure ulcers (reported on ST):
January – 4

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 January was 91.29% has met the required 90% standard. *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*

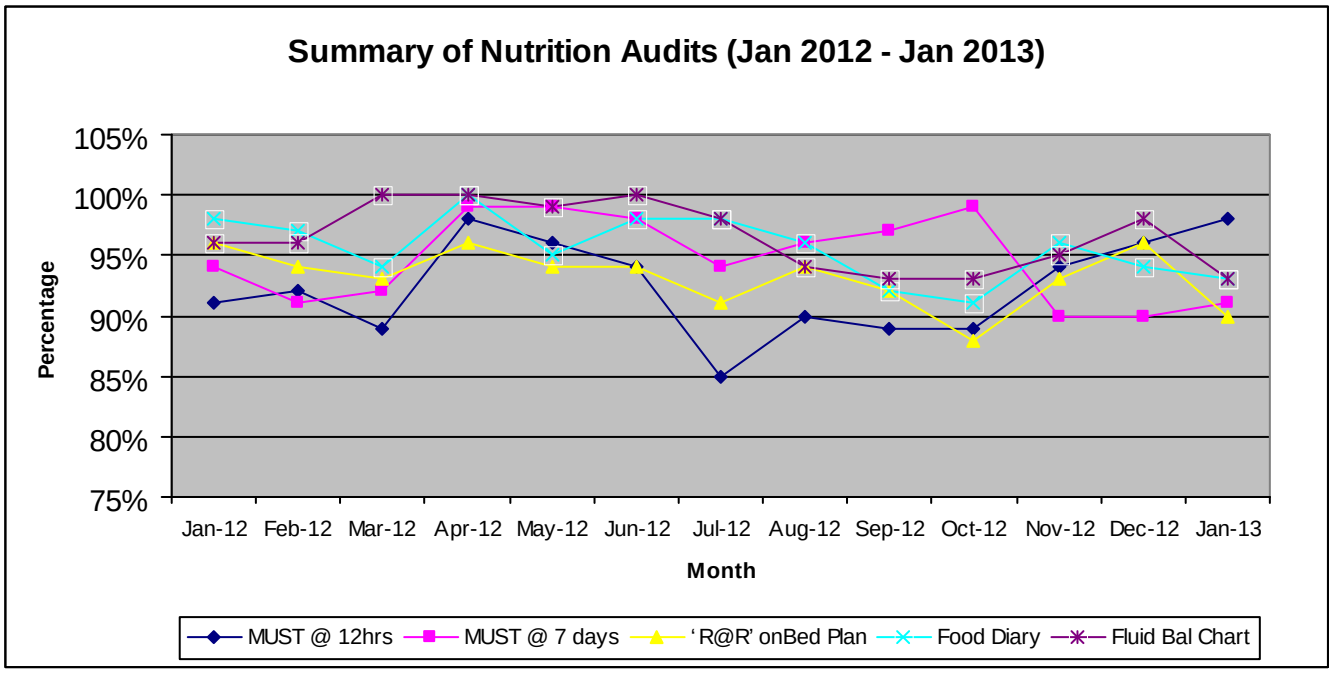


Figure 7: *Nutrition Audit Results*

9.3 Infection Control – report expected on Wednesday

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

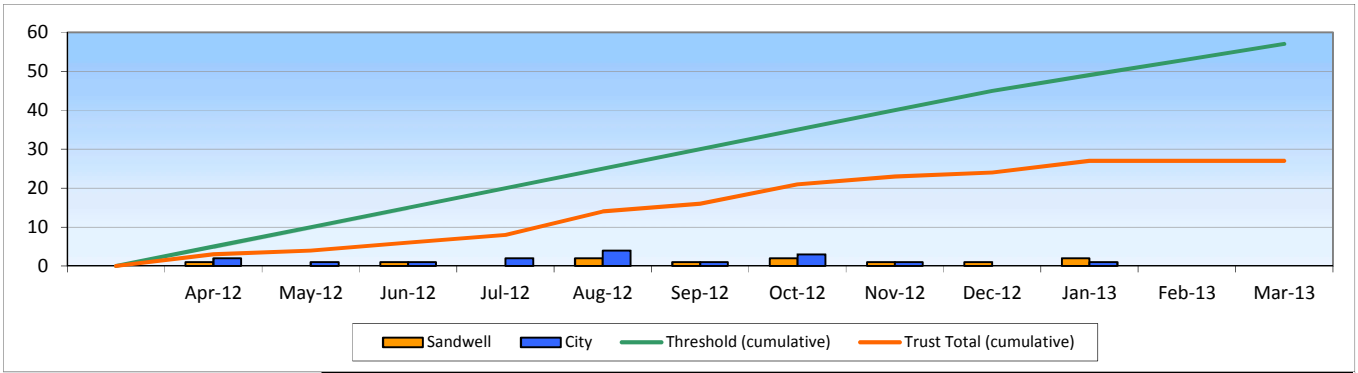
There were no post-48 hour MRSA bacteraemia for January. The total number of MRSA bacteraemias against the Trust target to date is 1.

MRSA Screening

Target: 85% eligible patients by March 2013.

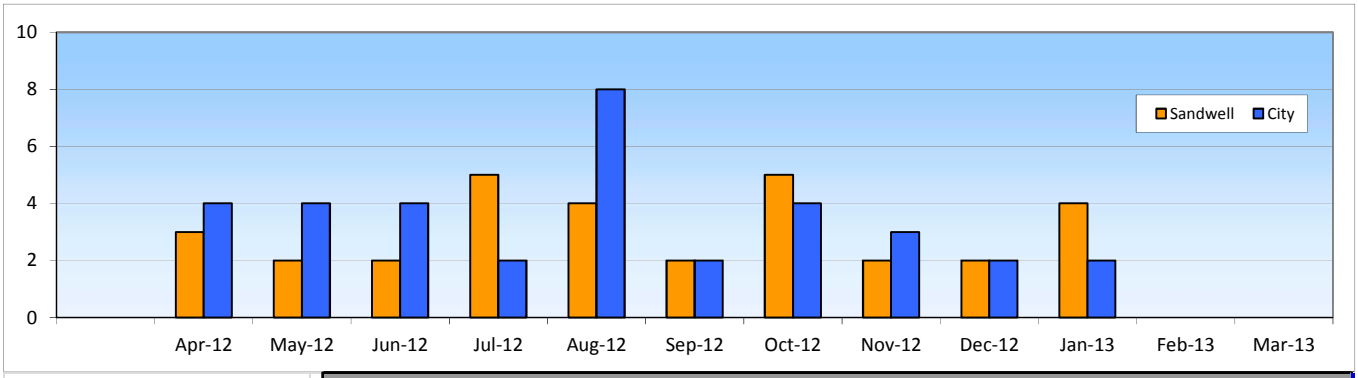
			To Date (*=most recent month)	TARGET YTD	TARGET 12/13
MRSA Screening - Elective	Patient Not Matched	%	130.9*	75	85
	Best Practice - Patient Matched	%	59.8*	75	85
MRSA Screening - Non Elective	Patient Not Matched	%	80.7*	75	85
	Best Practice - Patient Matched	%	67.3*	75	85

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			**11**
City	2	1	1	2	4	1	3	1	0	1			**16**
Trust	3	1	2	2	6	2	5	2	1	3	0	0	**27**
Intermediate Care	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	27	27	-
Threshold (cumulative)	5	10	15	20	25	30	35	40	45	49	53	57	-

Figure 8: *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			**31**
City	4	4	4	2	8	2	4	3	2	2			**35**
Trust	7	6	6	7	12	4	9	5	4	6	0	0	**66**
Intermediate Care	0	0	0	0	0	0	0	0	0	0			**0**
Trust Total (cumulative)	7	13	19	26	38	42	51	56	60	66	66	66	-

Figure 9: *Trust Best Practice Data*

Blood Contaminants

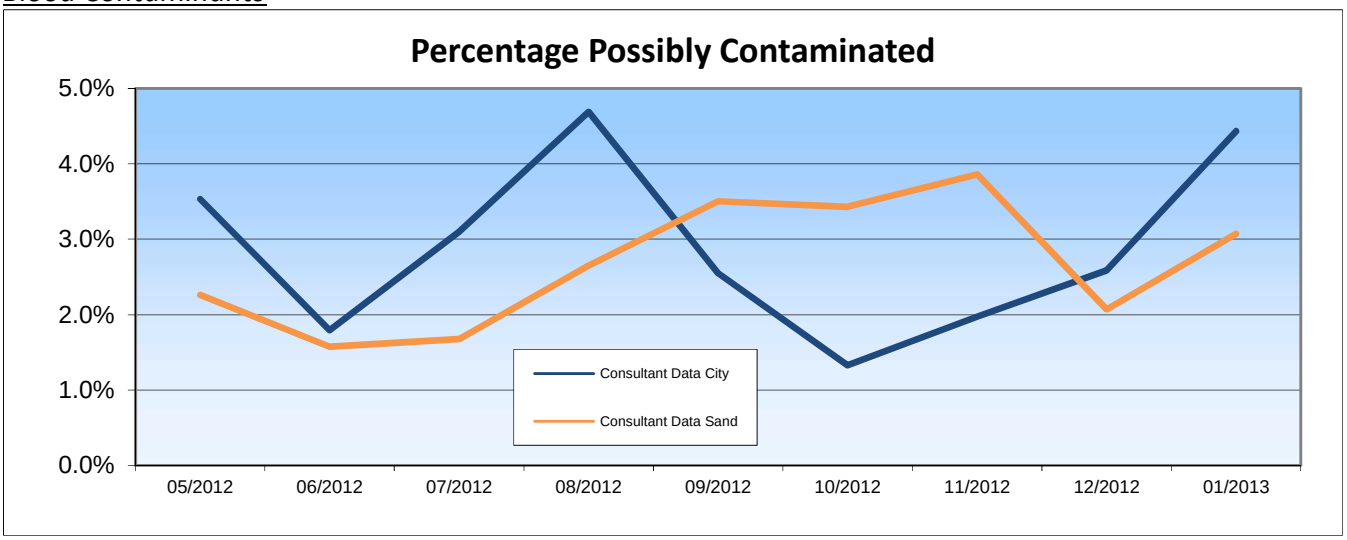


Figure 10: *Blood Contaminants*

E Coli Bacteraemia

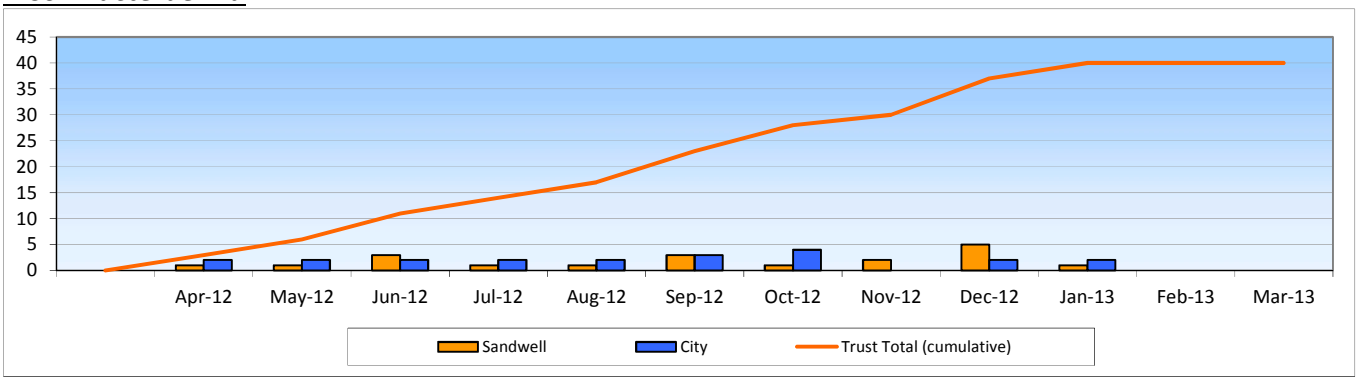


Figure 11: *E Coli Bacteraemia*

MSSA

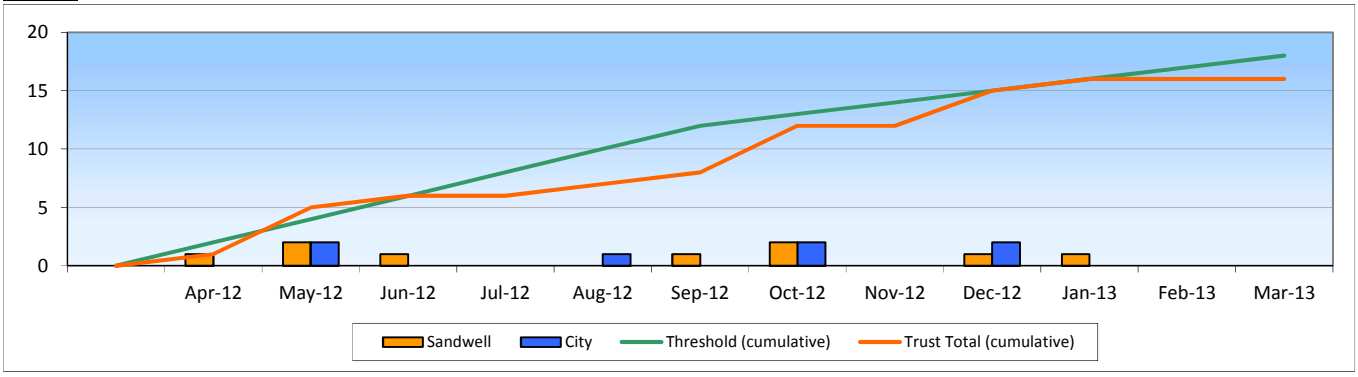


Figure 12: *MSSA*

Outbreak and Other Infection Control Activity

During January 10 wards were affected by diarrhoea and vomiting, 2 of which were confirmed to be due to norovirus. 7 of the 10 wards were completely closed.

PEAT

National Standards of Cleanliness average scores 96%.

9.4 Maternity

The Obstetric Dashboard is produced on a monthly basis. Of note:

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

Adjusted Perinatal Mortality Rate (per 1000 babies): the adjusted perinatal mortality rate for December was 7.2 which was below the trajectory (8) and was lower than the previous month. 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 December was 24.7%, which is below the trajectory of 25% over the year and higher than the previous month.

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

Community Midwife Caseload (bi-monthly): The community midwife caseload in December reduced to 134 from the previous month (138), which is below the trajectory of 140.

Vacancies: Vacancy rates were not available for December at the time of writing the report.

9.5 Emergency Department highlights

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

9.6 Safeguarding

A Safeguarding Update is not due in this month's report.

9.7 Medicine Management – as per update in the January version of the Quality Report

Antibiotic CQUIN

The results of the antibiotic audits carried out in December are summarised in the table below.

The 97% target for documenting allergy status on the prescription was achieved in for the first time December, 98.4% compliance was achieved.

Compliance with recording of stop or review dates has declined in December (77.7%), compared to November (79.4%), but remains marginally above the baseline assessment (77.1%)

Recording of the indication for antibiotics on the drug chart has declined to 66.5% for the trust, compared to 72.5% in November, but remains well above the baseline of 8.8%.

Compliance with the trust guideline needs to be achieved in ≥90% of antibiotic prescriptions; this was achieved both at City and Sandwell.

Indicator	SWBH	Baseline	CQUIN target
Number of patients	626	-	
% with allergy status documented	98.4%	91.7%	>97%
% on antibiotics	28%	30.8%	
% on IV antibiotics	14.2%	14.6%	
% on IV antibiotics for more than 48 hours	55.1%	61.4%	Maintain at baseline level
% on antibiotics for >5 days	10.7%	9.7%	
% with stop/review date documented on drug chart	77.7%	77.1%	>95%
% with indication documented on drug chart	66.5%	8.8%	>95%
% with antibiotics in line with guidelines	98.9%	87.5%	>90%

Warfarin CQUIN.

An 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 December. Compliance of 100% was achieved.

Drug Storage Audits

Drug storage audits were cancelled in December due to operational pressures.

9.8 Never Events

There were no Never Events reported in January 2013.

9.9 National Patient Safety Agency (NPSA) alerts

1. Overdue alerts: NPSA 2011/PSA001 – Safer spinal (intrathecal) epidural and regional devices. This alert will continue to remain as "ongoing" on the Central Alert System until all of the components we require to safely convert to the new neuraxial devices are available.

2. New alerts: No new alerts have been received.

9.10 Medical Devices Agency (MDA) alerts

1. Overdue alerts: MDA 096 – Resuable laryngoscope handles All Models, All Manufacturers. Process have been put in place to address this alert but a final solution for ongoing compliance is being discussed currently.

2. New alerts: 003 – Ambulatory insulin infusion pumps. Manufactured by Animas. Animas IR200, Animas IR1250 and Animas 2020. all serial numbers.

Two further alerts were received in January but were immediately signed off as requiring no action.

9.11 Lessons Learned

The key to a positive safety culture within the organisation is to learn from incidents through sustainable actions.

During January there was one serious incident review. Had the learning disability nurse been made aware of the patient then staff may have found better ways to communicate and work with the patient. Further advertisement of the availability of the Learning Disability nurse has taken place.

9.12 Significant Risks

Significant risks are presented on a monthly basis at the Risk Management Group (RMG). These risks are being proposed for inclusion onto the Corporate Risk Register (CRR).

A summary report of progress in implementing the treatment plans for existing risks on the CRR is presented monthly to the Trust Board.

No new risks were presented to the Trust Board for inclusion on CRR in January 2013.

9.13 Patient & Staff Safety: Listening into Action

- Further work is being undertaken to improve the quality of feedback provided both to individuals and across the Trust from incident reporting.
- A snapshot audit shows that incident and risk issues are being discussed at 70% of staff meetings. There is some concern that some staff do not have team meetings and this will further be addressed through a Hot Topics questionnaire.
- Risk user group forums have been cancelled through lack of attendance. Staff are advised to contact Risk Management personnel should they require any assistance.

9.14 Nurse Staffing Levels

The Trust aims to have staffing ratios at around 1 WTE:1 bed (unless guidance specifically states otherwise) and a qualified to unqualified ratio of 60:40.

Key

▯	No previous score available
➲	Stayed the same/on target
🡅	Improved
🡇	Deteriorated
	Off Plan
	Significantly off plan
Data in blue	Indicates previous months data
Red text	Of concern

Medicine & Emergency Care- DHoN comments

- D7 data is showing bed compliment split of 13 base ward beds and 12 winter beds.
- Lyndon 4 data is showing bed compliment of 13 base ward beds and 20 winter beds.
- Lyndon 5 data has been split to show base beds (14) and winter beds (20) The ward has relocated from Priory 4.
- D30 is purely winter beds.
- Winter bed compliment across division=64.
- Please note the rise in bed usage on Newton 4/1 is becoming a regular pattern.
- Also note within Eau 4 extra beds used in Bay E, funding matches use.
- Newton 2 was used by medicine for 3 weeks of January (21 beds)and was staffed by Medicine staff (substantive and bank)

- **Surgery A -DHoN comments**
- SAU/D42- Please note funding decreased alongside established trolley numbers- this is now being addressed within Division. The Division are also collating Average Occupancy and for this month that is 160%, thus adding pressure to current staffing.

- Lyndon and Priory 2 are planned to be working at 20 beds, a reduction from budgeted beds. This is a Divisional plan in response to Quality and Risk issues which are being reviewed on a monthly basis. However both areas have had increase in bed usage associated with accommodation of medical outliers and the use by medicine of Newton 2. This is as a direct response to pressures for capacity across the Trust primarily related to Medicine. The Division have collated the number of cancelled operations in this time.
- Lyndon 3 is funded for 18 elective beds and 15 post acute beds- the area has been collecting data on bed use to demonstrate the actual use of the beds compared to the plan.

Jan-13	Budgeted Posts & Funded Beds				Actual Bed Usage		Actual In Post				Sickness	SNCT	Bed Occupancy	Complaints	Falls	Pressure sores	MUST	ST (Target 95%)	FFT (Target 65)
Medicine	Total WTE	% Trained Staff	No. Funded Beds	Budgeted Staff per bed	Average Actual Bed Usage	Budgeted Staff: Actual Bed Ratio	Total WTE In Post	% Trained Staff	% Bank & Agency Staff	Actual Staff:Bed Ratio	% (previous Month)	Most Recent SNCT Ratio	%	Number	Number	Number	%	%	Score
D5 (CCU/PCCU)	39.65	92.43%	17	2.33	17	2.33	39.2	86.56%	8.34%	2.31	10.61%	46.4	98	0	2	1	100	88	60
CCU Sandwell	19.17	85.76%	10	1.92	10	1.92	18.67	72.33%	19.91%	1.87	3.94%	18.43	93	0	0	0	90	90	83
D7 (13base/12 ww)	42.81	49.64%	25	1.71	25	1.71	38.77	45.44%	15.35%	1.55	0.00%	42.81	88	0	1	0	100	100	40
D11	32.61	58.66%	21	1.55	21	1.55	28.29	55.50%	11.45%	1.35	10.82%	27.43	94	1	2	2	95	94	59
D12	17.12	64.95%	10	1.71	10	1.71	15.04	65.82%	8.91%	1.50	7.90%	11.76	85	0	2	0	100	100	84
D15	26.45	58.41%	24	1.10	24	1.10	28.24	50.63%	21.05%	1.18	6.44%	29.9	95	1	0	0	100	95	66
D16	32.71	41.94%	23	1.42	23	1.42	32.4	40.49%	19.82%	1.41	10.76%	18.62	92	0	0	0	81	81	0
D17	29.64	64.44%	26	1.14	26	1.14	30.03	56.81%	12.89%	1.16	0.00%	19.62	70	0	2	0	95	88	100
D18	23.59	46.12%	16	1.47	16	1.47	26.79	35.43%	33.63%	1.67	5.71%	21.07	100	0	4	0	100	100	65
D41	29.94	74.95%	19	1.58	19	1.58	26.2	66.16%	14.79%	1.38	1.35%	29.99	91	0	1	0	100	88	46
D43	35.69	51.02%	28	1.27	24	1.49	27.82	39.86%	28.50%	1.16	8.20%	34.98	93	0	4	0	100	100	100
MAU	65.2	64.98%	28	2.33	28	2.33	71.13	60.32%	12.87%	2.54	6.61%	NA	NA	2	1	0	80	100	62
PRIORY 3	31.08	51.54%	29	1.07	29	1.07	30.41	46.96%	7.27%	1.05	5.38%	27.83	87	0	4	0	97	100	75
EAU	63.54	47.78%	28	2.27	32	1.99	61.85	42.31%	36.96%	1.93	4.27%	NA	NA	1	7	0	90	100	76
NEWTON 4	30.82	43.45%	22	1.40	24	1.28	38.51	28.23%	40.27%	1.60	8.36%	42.97	100	1	8	0	100	100	58
NEWTON 1	21.82	79.47%	12	1.82	14	1.56	21.86	67.73%	18.32%	1.56	10.70%	19.15	89	0	9	1	100	92	0
LYN5 (base med)	16.3	55.89%	14	1.16	14	1.16	16.52	53.87%	9.33%	1.18	1.08%	40.95	99	1	1	3	nil	na	na
LYN5 (winter)	22.35	58.26%	20	1.12	20	1.12	24.77	34.32%	31.36%	1.24	1.08%	40.95		0		0		na	na
LYN4(13 base,20ww	39.05	56.67%	33	1.18	33	1.18	36	43.86%	19.36%	1.09	12.98%	NA	NA	0	0	0	89	96	0
NEWTON 5	22.43	69.73%	15	1.50	15	1.50	23.43	68.92%	16.36%	1.56	1.91%	15.37	91	0	3	0	100	100	na
D30 (winter)	23.77	61.42%	19	1.25	19	1.25	26.79	39.65%	27.58%	1.41	16.60%			0	4	0	100	100	86
PRIORY 5	37.53	51.29%	34	1.10	34	1.10	43.59	44.97%	19.08%	1.28	5.12%	68.99	99	0	2	0	100	85	100

Lyndon 5 is being used as part Base Medicine beds (14) and part winter capacity (20)

***Newton 2 was used for 3 weeks of January and staffed by a mixture of Substantive and Bank staff. Divisional Actual Staff:Actual bed Ratio= 1.39*

Figure 13: *Medicine*

Jan-13	Budgeted Posts & Funded Beds				Actual Bed Usage		Actual In Post				Sickness	SNCT	Bed Occupancy	Complaints	Falls	Pressure sores	MUST	ST (Target 95%)	FFT (Target 65)
Surgery	Total WTE	% Trained Staff	No. Funded Beds	Budgeted Staff per bed	Average Actual Bed Usage	Budgeted Staff: Actual Bed Ratio	Total WTE In Post	% Trained Staff	% Bank & Agency Staff	Actual Staff:Bed Ratio	% (previous Month)	Most Recent SNCT Ratio	%	Number	Number	Number	%	%	Score
D21(was D30)	28.84	56.80%	23	1.25	23	1.25	29.5	44.24%	15.76%	1.28	11.92%	NA	92	0	5	0	100	89	76
D25	28.28	60.04%	19	1.49	19	1.49	26.03	56.59%	8.44%	1.37	5.58%	NA	83	1	0	1	100	100	66
SAU/D42	22.98	73.89%	14	1.64	14	1.64	22.53	65.90%	8.49%	1.61	17.17%	NA		0	2	0	100	100	67
ASU	24.6	72.36%	20	1.23	29	0.85	23.28	70.53%	4.55%	0.80	13.38%	NA		1	0	0		na	25
LYNDON 2	27.93	56.57%	26	1.07	26	1.07	30.57	41.96%	20.75%	1.18	19.03%	NA	93	1	1	0	100	89	36
LYNDON 3	39.8	58.27%	33	1.21	33	1.21	38.38	48.04%	10.79%	1.16	4.22%	NA	81	2	3	0	90	96	49
PRIORY 2	26.87	61.11%	26	1.03	26	1.03	31.47	43.59%	22.48%	1.21	5.05%	NA	97	0	0	3	92	92	69
NEWTON 3	41.27	57.98%	33	1.25	33	1.25	42.15	51.99%	8.06%	1.28	3.46%	NA	93	1	3	0	100	100	73

Figure 14: *Surgery A*

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.

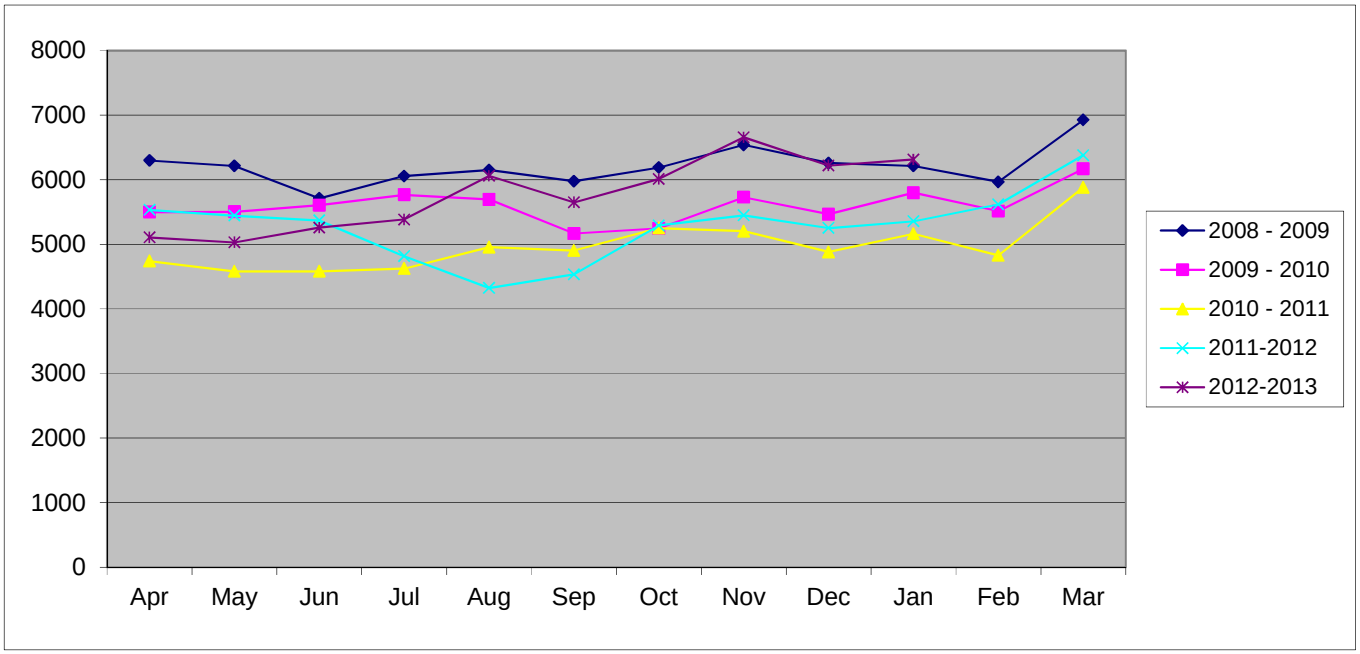


Figure 16: *Total Bank & Agency Use Nursing April 2008 –date.*

10 CLINICAL EFFECTIVENESS

10.1 Mortality

CQUIN Target

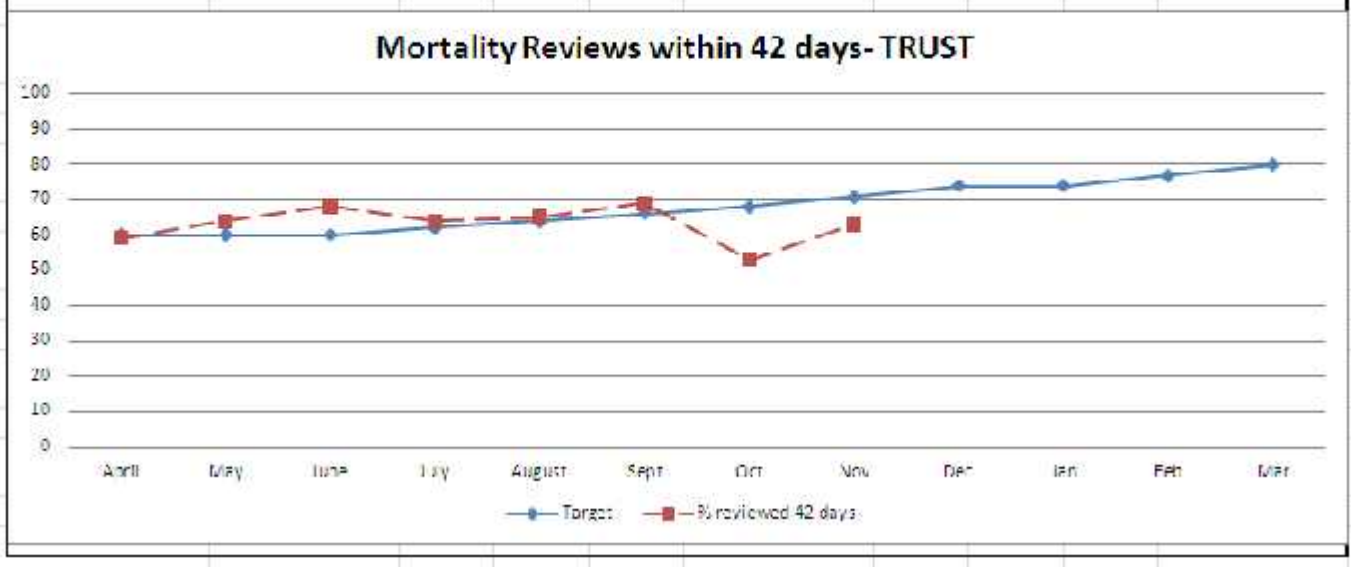
As part of the Trust's annual contract agreement with the commissioners the Trust has agreed a CQUIN scheme with an end year target to review 80% of hospital deaths within 42 working days.

During the most recent month for which complete data is available (November) the Trust reviewed 63% of deaths compared with a target trajectory for the period of 71.0%. The Trust has failed to meet the trajectory for November. The CQUIN payment is calculated across the quarter. The Trust has set a plan in motion to meet the required quarter performance. This includes communicating with CDs and DDs to performance manage their teams to meet their targets, and close scrutiny by the Medical Director's Team.

In addition, the Trust has developed an improved Mortality Review System which will spread the burden of carrying out reviews more equitably across the medical specialities. This is planned to result in more deaths being reviewed as required.

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	66	64	65	69	53	63				
DEATHS (all trust)	133	146	126	121	132	121	139	108	136			



Data from QMF dashboard, CDA 13/2/12

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 (90.4) remains below 100, and is less than the lower statistical confidence limit and continues to remain lower than that of the SHA Peer (96.4). The in-month (November 12) HSMR for the Trust has decreased to 64.2 (Figure ( ).

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'

Further 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'

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 95.6.

Mortality table 2012/13

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

Figure ( ) Mortality Statistics

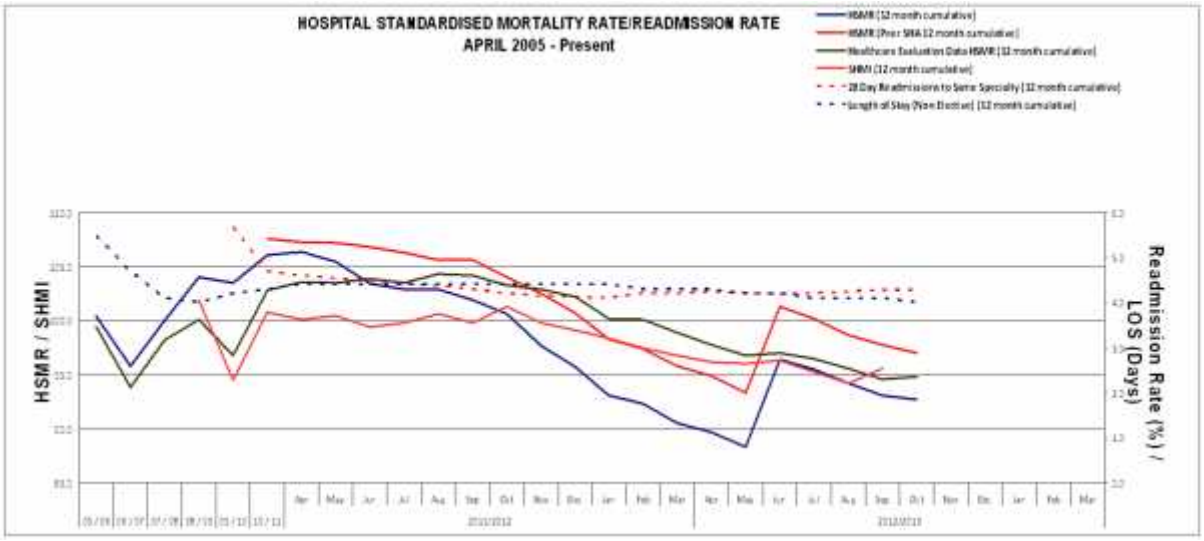


Figure ( ) : *HSMR/Readmission rate data April 05 - October 12*

CQC Mortality Alerts received in 2012/13

No new alerts have been received.

A response from the CQC to the investigation report that was submitted by the Trust in relation to perinatal mortality is awaited.

Dr Foster generated alerts (RTM)

There were no new diagnoses or procedures alerting with significant variation in terms of mortality when the data period December 2011 – November 2012 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	40588	1466	3.6%	1621.3	4.0%	90.4	85.9	95.2		7
ALL	Acute and unspecified renal failure	314	45	14.3%	62.4	19.9%	72.1	52.6	96.5		1
ALL	Acute bronchitis	1375	28	2.0%	39.6	2.9%	70.7	46.9	102.1		1
ALL	Acute cerebrovascular disease	612	100	16.3%	115.0	18.8%	87.0	70.7	105.8		1
ALL	Aspiration pneumonitis, food/vomitus	158	48	30.4%	54.5	34.5%	88.1	65.0	116.8		1
ALL	Cancer of prostate	705	6	0.9%	10.1	1.4%	59.7	21.8	129.9		1
ALL	Congestive heart failure, nonhypertensive	819	77	9.4%	101.6	12.4%	75.8	59.8	94.7		3
ALL	Diabetes mellitus with complications	392	9	2.3%	15.0	3.8%	59.8	27.3	113.6		2
ALL	Nonspecific chest pain	3877	1	0.0%	3.6	0.1%	27.6	0.4	153.6		1
ALL	Other psychoses	185	9	4.9%	5.4	2.9%	165.4	75.5	314.0	1	
ALL	Pulmonary heart disease	288	23	8.0%	13.7	4.8%	167.8	106.3	251.8	1	
ALL	Residual codes, unclassified	642	4	0.6%	6.7	1.0%	59.6	16.0	152.6		1
ALL	Septicemia (except in labour)	108	14	13.0%	22.5	20.9%	62.2	34.0	104.3		1
ALL	Short gestation, low birth weight, and fetal growth retardation	794	8	1.0%	18.7	2.3%	42.9	18.5	84.5		1
Mortality (in-hospital 30 days) - Procedures										**Alert**	
Team	Procedures	Superspells	Deaths	%	Expected	%	Relative Risk	Low	High	-	+
ALL	Puncture of joint	493	3	0.6%	4.0	0.8%	74.5	15.0	217.8		1
ALL	Reduction of fracture of bone (upper/lower limb)	827	2	0.2%	3.8	0.5%	53.2	6.0	191.9		1

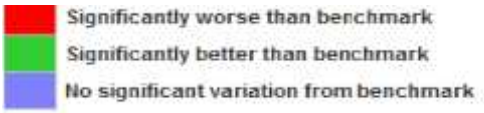


Figure ( ) Mortality in hospital diagnoses

National Clinical Audit Supplier – Potential Outlier Alerts

The Trust has not been notified of any new potential outlier alerts.

3.2 Patient Related Outcome Measures (PROMs)

Provisional data in the form of experimental statistics was published on 17/01/13 for the 2011/12 financial year and also for the period April 12 to August 12 for the current financial year. The data is being interrogated to determine the differences between the pre and post -op scores for individual questions and to compare these with the national benchmark. This data will then be forwarded to the relevant specialties to assist them in identifying more specific areas for improvement.

3.3 Clinical Audit

Clinical Audit Forward Plan 2012/13

The Clinical Audit Forward Plan for 2012/13 contains 83 audits that cover the key areas recognised as priorities for clinical audit. These include both the 'external must do' audits such as those included in the National Clinical Audit Patient Outcomes Programme (NCAPOP), as well as locally identified priorities or 'internal must do' audits.

Status as at end of December 2012	Total
0 - Information requested	10
1 - Audit not yet due to start	1
2- Significant delay	2
3- Some delay - expected to be completed as planned	3
4- On track - Audit proceeding as planned	41
5- Data collection complete	16
6- Finding presented and action plan being developed	2
7- Action plan developed	5
A - Abandoned	3
Grand Total	83

The status of the audits that have been included in the plan as at the end of January 2013 is shown in the table above. No further audits have been indicated as experiencing significant delay.

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 January 2013 is shown in the table below (data source CDA Dashboard) .

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

Figure 21: *WHO checklist compliance (data source CDA Dashboard 13/2/13)*

The WHO Checklist Steering Group continues to meet monthly. Work is in progress to carry out qualitative reviews focussing on the culture of patient safety in areas where interventions take place. A communication plan has been drawn up and in under constant updating. Focus is on improving completion of the debrief section of the 5 steps.

A spot check of records of the WHOCL in the notes is in progress. The intention is to review 50 sets of notes per month.

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 13/2//13	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**
% 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 %▲
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%
CQUIN: % pts receiving brain imaging in 24 hrs	94.74% ■	98.11% ▲	98.33% ▲	95.00% ▼	88.37% ▼	96.23%▲	100.00% ▲	91.84% ▼	92.31▲	100

of admission										
Pts scanned within 24 hrs of hospital arrival	96.67% ▲	100.00% ▲	92.16% ▼	93.88% ▲	93.75% ▼	100.00% ▲	91.67% ▼	91.84% ▲	92.31% ▲	95% ▲
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 ▲
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 %
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 %▼

Figure 22: *Performance against stroke care targets (data Stroke Project update report 13/2/13/13)*

Progress update on the Stroke Reconfiguration

1. The Bed reduction plan in preparation for the reconfiguration onto one site in March was approved by the Executive Team on 15th January 2013. This involves beds closing every week on D11 and 43 to achieve the new bed availability at Sandwell on the newly refurbished ward P4.This was delayed due to the bed pressures resulting from Infection control issues. New acute unit and transfer of patients will occur on 11th March 2013.

2. Number of stroke patients across both sites is fitting in to the new total of 55 patients. However, as beds on D43/D11 are vacated by stroke patients they are being filled with medical outliers. The Executive Team has been asked for permission to co-locate patients from D43 to D11 over the next 4 weeks.

3. A task and finish group has been re established to manage the SNapp data requirements as this has stalled due to changes in personnel.

4. Outpatient reorganisation at Sandwell to accommodate Stroke services is being finalised. Space constraint is the main challenge. 1 room identified on a Monday and Tuesday afternoon. 2 rooms on a Wednesday and Thursday will have to remain on a morning.

5. A proposal for investment to support ESD in West Birmingham has been produced to match the provision for Sandwell residents in order to deliver the community end of the service to the required specification and facilitate a reduction in LOS. This will be discussed with commissioners to gain their support.

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. Provisional data for November (Source CDA –QMF Dashboard 13/2/13) indicates 79.31% of patients with a Fractured Neck of Femur received an operation within 24 hours of admission, resulting in a year to date performance of 68.23%. Performance has improved significantly throughout the year from 45.83% in April 2012. *Internal Priority*

10.7 Ward Reviews

The ward reviews will be reported March.

10.8 Quality Audits

The Quality Audits are not due for reporting this month.

11 PATIENT EXPERIENCE

11.1 Net Promoter

The Trust's overall Net Promoter Score (NPS) increased to 65, achieving the SHA target. *CQUiN* % returns decreased by 4% - this may be attributed to pressures of D&V outbreak on many wards and other patient surveys happening on the wards at the same time.

SHA ambition requires both the improvement on score plus weekly reporting.

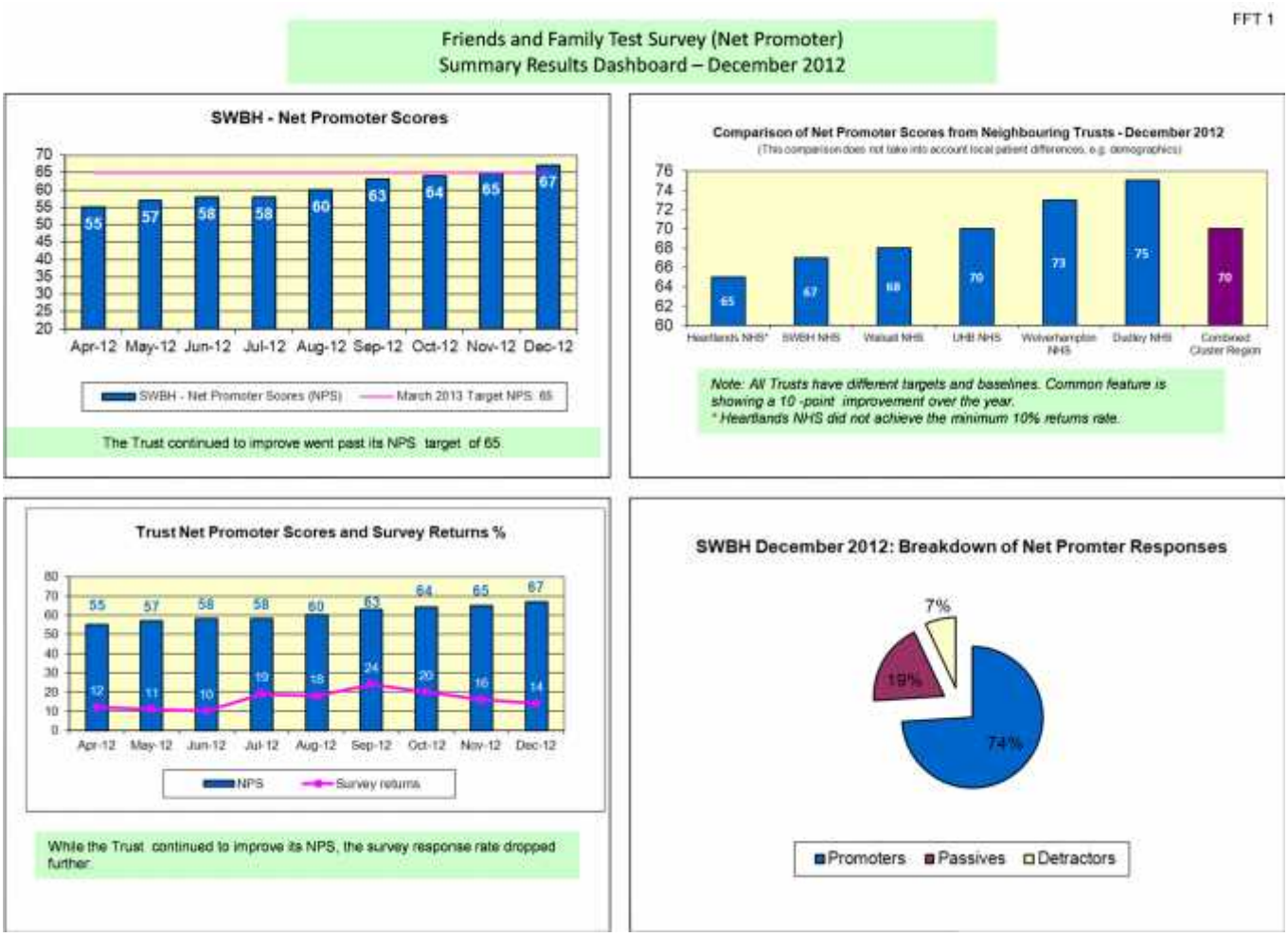


Figure 28: *Net Promoter position*

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					
Hospital Site name	1 - Extremely Likely	2 - Likely	3 - Neither likely or unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know
Birmingham Midland Eye Centre (Bmec) - RXK03	125	42	12	5	5	1
City Hospital - RXK02	57	10	7	0	1	1
Sandwell General Hospital - RXK01	44	19	3	5	9	3
Total	226	71	22	10	15	5

11.2 Complaints/PALS

a) Complaints Data

Complaints: The following table sets out the complaints data for January 2013 with reference to previous months where relevant.

MONTH	Complaint type: RECEIVED			Complaint type: SENT		
	First contact*	Link*[2]	TOTAL	First contact*	Link*[2]	TOTAL
Oct 2012	62	12	74	97	19	116
Nov 2012	68	11	79	113	15	128
Dec 2012	39	5	44	76	17	93
Jan 2013	60	14	74	47	7	54

**First Contact complaint*: where the Trust's substantive (i.e. initial) response has not yet been made.*

*[2]**Link complaint**: the complainant has received the substantive response to their complaint but has returned as they remain dissatisfied/or require additional clarification.*

Pilot

Since 1 January 2013 the Complaints Team has been undertaking a pilot that involves responding to all complaints received after this as soon as practicable but certainly within 40 working days. This means using the capability of acknowledging complaints by telephone and at the same time confirming the issues which need to be addressed.

This will ensure that the response answers the query that the complainant is raising, where it isn't obvious. By doing this, it will enable a more targeted answer from staff and aims to reduce any dissatisfaction about the complaint response.

The pilot will last 2 months and feedback will be provided in March 2013.

Complaints Review

Following the external review of the Trust's complaints handling arrangements, a decision has been made to devolve a proportion of complaints to divisions and directorates. A development plan is currently being drawn up to progress this which will be shared with the Quality & Safety Committee in February 2013.

Breach cases

Some complaints continue to accrue "active" days as they have not yet been concluded and closed. These are generally out of the control of the Trust and as at the time of this report these include:

Correction position as at 1 February 2013 was 20 cases in breach. The breakdown is as follows:

3 cases where the complaint is progressing to a meeting
2 cases where the complainant is considering next steps
10 cases where the response is at the final stages of the complaints process
5 cases at early stage of the complaints process

Parliamentary and Health Service Ombudsman (PHSO) cases

- The NHS Complaints Procedure comprises 2 stages. The first or 'local resolution' stage involves the Trust investigating the complaint and providing a substantive response to the complainant. Where the complainant remains dissatisfied with the Trust's response given at the local resolution stage, the complainant can progress their complaint to the second stage, that is, referral to the Parliamentary and Health Service Ombudsman (PHSO). The PHSO provides a service to the public by undertaking independent investigations into complaints that the NHS has not acted properly fairly or has provided a poor service.

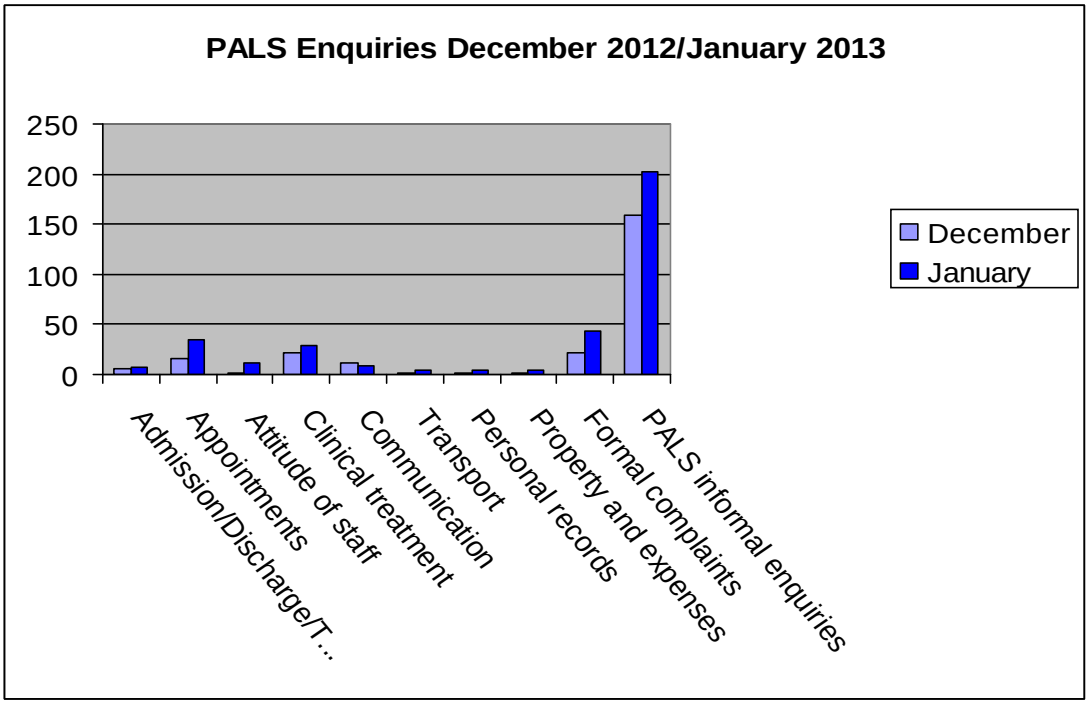
- The Trust currently has 9 active cases with the PHSO.

b) PALS Data

- **Contacts and general enquiries:** In January 2013 PALS recorded 196 PALS enquiry contacts and 203 general enquiry contacts. In comparison to December 2012 where we received 109 PALS enquiry contacts and 159 general enquiry contacts. The general informal enquiries are not captured on the PALS database but relate to enquiries taken at the PALS reception desk.

- Chart A provides a **breakdown of the themes** identified via PALS contacts in January 2013. The main categories reported during the month of January 2013, were issues relating to :
    - Clinical Treatment: PALS received 29 this month in comparison to 21 issues reported during December 2012. These relate to queries, comprising the categories of clinical care, low staffing levels, and medicines. In addition, issues relating to a delay in the following: investigations, results, surgery, treatment and xray/scan.
    - During January 2013 there was a significant increase in the number of appointment enquiries where 34 were reported this month, in comparison to 16 enquiries during December 2012. Appointment enquires relate to appointments cancelled, delay, notification and time.
    - There has also been a significant rise in the number of formal complaint issues which comprise the categories of handling, advice, process, referral and response time from 44 enquiries received this month in comparison to 22 enquiries reported during December 2012.

CHART A – Breakdown of top 10 issues



11.3 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%.

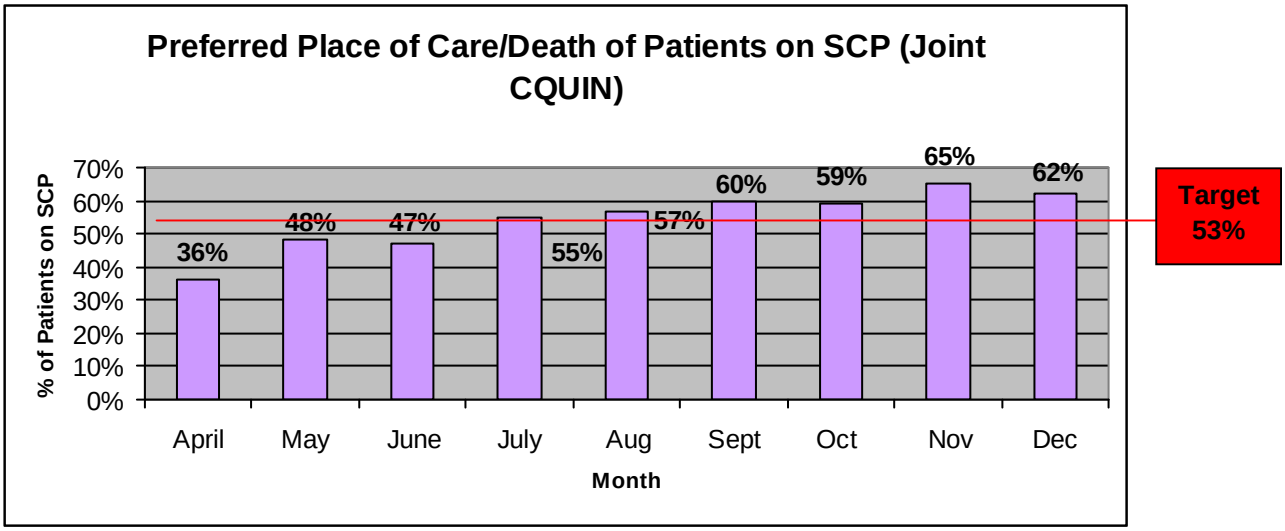


Figure 29: *Preferred place of death/death of patients on SCP*

12 WORKFORCE QUALITY

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

	% Trust
Mandatory Training	88.74% (85%)
PDR	70.64% (85%)
Turnover (leavers)	10.31%
Sickness absence	4.41% (3.5%) December

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:	Initial response to the Report of the Mid Staff NHS Foundations Trust Public Inquiry
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance and Rachel Overfield, Chief Nurse
DATE OF MEETING:	28 February 2013

EXECUTIVE SUMMARY:

This report summarises the 290 recommendations made in the Francis Report by theme. It provides the Trust's initial response and sets out how the Board intends to take forward the recommendations that apply to provider organisations.

The key messages emanating from the Francis Report have been reflected upon, and in particular how they relate to this organisation. As a result and by way of an opening response a number of areas, which already have the Board's attention, have been identified for early action. These relate to: culture; mortality rates; frail elderly; complaints handling; patient experience; and nurse staffing.

A comprehensive position statement against the recommendations that apply to the Trust will be presented to the public Board meeting in March, together with a plan for taking forward any areas requiring action.

REPORT RECOMMENDATION:

1. **DISCUSS** and **APPROVE** the Trust's proposed approach to responding to the recommendations made in the Francis Report; and

2. **CONSIDER** and **APPROVE** the areas identified for early improvement / development.

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:

'Safe High Quality Care'

PREVIOUS CONSIDERATION:

Quality and Safety Committee – 21 February 2013

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Initial response to the
Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

1. Introduction

1.1 Following an extensive public inquiry into the failings at Mid Staffordshire NHS Foundation Trust, Robert Francis QC published his final report on 6 February 2013.

1.2 Although the public inquiry was focused on one organisation, it highlights a whole system failure. A system which should have had checks and balances in place, and working, to ensure that patients were treated with dignity, and suffered no harm.

1.3 This report provides the Trust's initial response to the Francis Report and sets out how the Board intends to take forward the recommendations that apply to provider organisations.

2. Recommendations from the Francis Report

The 1,782 page report has 290 recommendations which cut across and have major implications for all levels of the health service across England. They are focussed on the following themes:

2.1

A STRUCTURE OF FUNDAMENTAL STANDARDS AND MEASURES OF COMPLIANCE

NHS Constitution and values:

- Strengthen NHS Constitution to place patients first as an 'overriding value' and to articulate fundamental standards of staff behaviour;

Development of fundamental standards – of behaviour, safety and quality:

- List of clear, fundamental quality and safety standards, which any patient is entitled to expect, and to permit any hospital service to continue;
- NICE should produce standard procedures and guidance to enable organisations and individuals to comply with these fundamental standards. They should work with professional and patient organisations to do so, and cover clinical outcomes as well as staff mix and cultural outcomes;
- 'Enhanced standards' should be developed and made available to commissioners to raise standards. Clear focus on the role of commissioners in driving standards;
- Non-compliance should not be tolerated and any organisation not able to consistently comply should be prevented from continuing a service;
- Causing death or serious harm to a patient by non-compliance without reasonable excuse of the fundamental standards should be a criminal offence.

Regulation of standards:

- CQC should become the single regulator dealing with corporate governance, financial competence, viability and compliance with patient safety and quality for all trusts (i.e. combining CQC's current role with Monitor's previous role as an FT regulator);
- Consider transferring the regulation of governance, and fitness of persons to be directors,

governors etc. from Monitor to CQC;

- CQC should have a duty for monitoring the accuracy of the data providers supply and to require providers to provide a fuller narrative about patient complaints. Provision of misleading information to a regulator should become a criminal offence;
- CQC should expand its work with overview and scrutiny functions and foundation trust governors as a valuable source of intelligence and feedback;
- Routine and risk based monitoring, notably inspection, is advocated as a key source of regulatory information and regulators are encouraged to adopt 'zero tolerance' and 'a low threshold of suspicion.' Regulators must have policies in place to intervene to protect patients and to repeatedly review if intervention is necessary;
- CQC must develop well trained, specialist inspectors, integrate patient representation into its structures and consider formalising partnership input from professional bodies such as the GMC;
- Government should look at moving responsibility for conducting criminal prosecutions in the NHS away from the Health and Safety Executive to CQC;
- Providers to comply with risk schemes of equal rigour to the NHS LA. Various recommendations for the NHS LA to consider how it evaluates elements of risk, including staffing levels;
- All regulators to improve information sharing;
- National Patient Safety Agency and Health Protection Agency functions to be protected and potentially transferred to another regulator;
- Transfer of FT authorisation process to CQC with support from TDA in developing quality of care as a pre-condition for authorisation. Inspection should be strengthened as part of the authorisation process. Aspirant trusts should be subject to a 'duty of utmost good faith';
- However, any evolution of the CQC should be gradual and staged. The report explicitly states the CQC should not be dissolved and replaced by another organisation.

2.2 **OPENNESS, TRANSPARENCY AND CANDOUR THROUGH THE SYSTEM, UNDERPINNED BY STATUTE**

- A statutory duty to be truthful to patients where harm has or may have been caused;
- Staff to be obliged by statute to make their employers aware of incidents in which harm has been or may have been caused to a patient;
- Trusts have to be open and honest in their quality accounts which will be consistent, publicly available. Quality and risk profiles should also be made public;
- The deliberate obstruction of the performance of these duties and the deliberate deception of patients and the public should be a criminal offence;
- It should be a criminal offence for the directors of trusts to give deliberately misleading information to the public and the regulators;
- Proposals for strengthening support for governors, and for strengthening the role of governors and NEDs including their accountability to the public;
- Complaints handling must be improved nationally and locally;
- There should be a consistent structure for local Healthwatch across the country;
- Each provider board should have a member responsible for information;
- The CQC should be responsible for policing these obligations.

2.3 **IMPROVED SUPPORT FOR COMPASSIONATE, CARING AND COMMITTED NURSING**

- Nurses should be assessed for their aptitude to deliver and lead proper care, and their ability to commit themselves to the welfare of patients;
- Training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard;
- Nurses need a stronger voice with suggestions NMC strengthens its role;

- Healthcare workers should be regulated by a registration scheme, with a uniform description of their role;
- Patients should be allocated a key nurse for each shift. Ward leaders should not be office-bound. Particular attention should be given to care for the elderly.

2.4

STRONGER HEALTHCARE LEADERSHIP

- An NHS leadership college to offer potential and current leaders the chance to share in a common form of training to exemplify and implement a common culture, code of ethics and conduct;
- It should be possible to disqualify those guilty of serious breaches of the code of conduct or otherwise found unfit from eligibility for leadership posts;
- A registration scheme and a requirement need to be established that only fit and proper persons are eligible to be directors of NHS organisations;
- Requirements on FTs to provide adequate training for directors;
- Strengthened role for training organisations in providing safety information, for instance recommended skill mix and staff ratios;
- Professional regulators to play a tougher role in relation to protecting patients and the public;
- Health Education England should have a medical director and a lay person on its board. LETBs should have a post of medically qualified post graduate dean.

3. SWBH response to the Francis Report : Our approach

3.1 The first recommendation of the Francis Report is that:

> All commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work.

The next recommendation made is that:

> Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted and, thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions.

3.2 The Board welcome Robert Francis's comprehensive report which rightly looks across the whole system. His emphasis on developing the right culture within the NHS, through better leadership, training, information and transparency is the right approach. It is clear that the causes of the Mid Staffs scandal are deep and complex and the solutions are equally diverse.

3.3 Even if the 290 recommendations were implemented now, the fundamental shift in culture can only be achieved if patient care is put top of the agenda for boards and is the first responsibility of professionals working in the NHS. That will take time and commitment over many years.

3.4 Every Trust can learn lessons from what happened at Mid Staffs and our Trust is no exception.

The Board's vision for 'High Quality Care' is one where all clinical care provided is appropriately measured for its safety, effectiveness and patient experience, where we can increasingly measure the ultimate outcomes of care, and where information on quality and safety is acted upon rapidly and effectively to ensure continual improvement.

The Trust strives to improve year on year from the position against all key measurable benchmarks. Our ambition is to be in the top quartile of comparable trusts within all key measurable benchmarks.

We know that within our own Trust the vast majority of patients have a positive patient experience, but that doesn't mean we are perfect and that there isn't more we can do to improve standards and make sure quality and safety are our absolute focus every day.

3.5 The Trust's proposed approach for responding to the recommendations is set out in **Appendix 1**.

3.6 A comprehensive position statement against the recommendations that apply to the Trust will be presented to the public Board meeting in March, together with a plan for taking forward any areas requiring action.

4. Areas identified for early improvement / development

The key messages emanating from the Francis Report have been reflected upon, and in particular how they relate to this organisation. As a result and by way of an opening response a number of areas, which already have the Board's attention, have been identified for early action. These are detailed below.

4.1

Culture
Issue: The Trust and a positive track record of delivering high quality care and performance delivery, robust staff engagement and a history of strong partnership working. Over recent months, however, Trust pressures and uncertainties have exposed some vulnerability. These include: different management approaches across the two acute hospital sites; local intelligence indicating some lack of staff engagement; variable quality of leadership; inconsistent decision-making processes; and differing levels of 'buy in' to the Trust vision and values. The 2012 NHS Staff Survey results show that the majority of the 28 key findings (23) show no significant change since the 2011 survey results. Whilst overall performance is unchanged, there has been some pleasing positive shifts but beneath this several questions areas that show a worrying deteriorating trend.

Response:
A revised workforce and organisational development structure and assurance arrangements are currently under development and will be launched soon. This will result in greater oversight and performance management of issues such as: leadership development and performance; staff development; education and training and workforce planning

Further analysis of the NHS Staff Survey results is being prepared and action will be taken to address the areas that staff highlighted as in need of improvement.

The staff survey action plan will be agreed, overseen and monitored by the Trust's Workforce and OD Committee once established.

4.2	**Mortality rates**

Issue:
Mortality performance is published nationally by Dr Foster and is available for all hospital Trusts through their website. There are two measures of mortality that are widely used to compare hospitals in the NHS - **HSMR** (Hospital Standardised Mortality Ratio) and **SHMI** (Summary Hospital Mortality Index). The available information shows that there are deviations from 'expected' mortality both for the City Hospital (lower than expected) and Sandwell (higher than expected).

Mortality is scrutinised by the Mortality and Quality Alerts Committee (MQuAC), chaired by the Medical Director. MQuAC meets monthly and conducts a 'deep dive' into the monthly mortality figures. Mortality by hospital site, diagnostic category, division, directorate and day of the week are studied and action plans are commissioned where differences cannot be easily explained.

Response:
In addition to MQuAC there are a number of initiatives within the Trust aimed at tackling and reducing mortality. These include: mortality reviews; stroke reconfiguration; management of subarachnoid haemorrhage; implementation of sepsis bundles; and emergency care pathway development. Funding has been identified to appoint an individual to support this programme of work.

The Trust could be classed as 'performing' with respect to mortality, but has the potential to do a great deal better. There is concern regarding the difference in mortality between the two hospitals and work is underway to investigate the causes of this. There are mechanisms in place to monitor and scrutinise mortality but these could be strengthened.

4.3	**Frail elderly**

Issue:
A large part of the patient population is frail elderly and this presents particular challenges in an acute hospital environment where their needs are not necessarily immediately catered for. A subset of this group is a large proportion of patients with varying degree of mental ill-health. Our own local intelligence highlights a need to see

our frail elderly patients as more of a specialty in their own right, with staff and environments that better meet these needs.

Response:

The Trust has recently launched a project for improvements in dementia care. A business plan is under development to secure funding to deliver the action plan. The work of the Adult Safeguarding team is being revitalised. The Elderly Care Directorate is reviewing its working arrangements to ensure that their specialist advice is available to all elderly patients experiencing our services. A bid has been submitted to the Department of Health to secure funding to improve the environments to make the ward settings elderly care/dementia friendly. Work is underway with third-sector partners to enhance this work.

4.4 **Complaints handling**

Issue:

Last year the Trust experienced a situation where a backlog in significantly overdue complaint responses developed. The target date set to resolve the problem was December 2012; this was achieved. To better understand the cause of the difficulties experienced and to prevent a recurrence, the Trust commissioned an independent consultancy to conduct a review of the complaints process, identify blockages that prevent complaints being handled on time and make recommendations on how to improve the process and engage stakeholders to support improvements. The review highlighted problems with the current centralised complaints process and recommended a new devolved arrangement.

Response:

A plan has been developed to achieve an improved response to patient concerns. It sets out the improvements necessary to ensure that the Trust provides patients, their families and the public with appropriate means to give feedback about their experiences; raise a concern or complaint; equip staff with the skills and knowledge to effectively respond and for this to be done in a proportionate and timely manner. Achievement of the objectives in the plan will also result in the feedback received being widely shared and robustly scrutinised at all levels across the organisation as well with external stakeholders. As a result the learning from complaints will lead to improvements in the quality of care and service delivery.

In creating the plan it was decided to amalgamate the actions required to progress the 'live' complaints related work streams looking at introducing a predominantly devolved model of complaints investigation and response drafting; ,maintaining and improving compliance with Outcome 17 of the Essential Standards of Quality and Safety; and responding to recommendations made in the Mid Staffordshire NHS Trust Public Inquiry Report (February 2013)

The plan was approved by the Quality and Safety Committee on 22 February 2013.

4.5

Patient experience
Issue: Based on external benchmarks and local intelligence the Trust's patient satisfaction results are average. The Trust has internal systems for seeking patient views but these have been fairly fragmented and results not well co-ordinated and acted upon. Up until very recently there was no identified team for facilitating and co-ordinating patient experience activities. This resulted in a fairly ad hoc approach to patient experience improvement activity. **Response:** A decision was made to transfer responsibility for seeking and acting upon patient views to the Chief Nurse and along with this the funding for the rest of this financial year for a Patient Experience lead. A Patient Experience Strategy has been developed covering the period 2013 – 2016, plus a high level implementation plan. The strategy describes the Trust direction of travel to improve the patient experience by engaging patients, collecting and measuring feedback and taking action to make improvements. The strategy includes key national guidance, the CCG position, the Trust position, compliance with relevant CQUINs and sources of patient feedback. The Strategy and plan will require further refinement in response to recommendations from the Francis Report. The Patient Experience and supporting implementation plan were approved by the Quality and Safety Committee on 22 February 2013.

4.6

Nurse staffing
Issue: Well established systems exist for reviewing and monitoring our nurse staffing arrangements, including information in the monthly Quality Report presented at the public Trust Board. In recent years there has been considerable investment by the Board into many areas of nursing, including some wards, the Emergency Admissions Unit, Emergency Departments and ward leadership. The Trust has also invested in an e-rostering system and acuity measurement tools to enable more real-time assessment of staffing arrangements. However, there remain some nursing areas where further adjustment to establishments is required in order to satisfy professional guidelines and ensure quality of care is provided. For the first time in several years, for a variety of reasons, planning for the current pressures posed by winter have proved challenging.

Response:
The current establishment reviews will continue to highlight any staffing needs and any corrective action required will be presented to the Executive Team. This will include a review of numbers as well as trained to untrained ratios.

The established central nurse recruitment process will continue to provide a 'supply' of nurses into approved vacancies.

4.7 Progress in taking forward the work required to address the issues of concern will be monitored by the Quality and Safety Committee, with regular updates provided to the Board.

5. Recommendations

The Trust Board is recommended to:

5.1 **DISCUSS** and **APPROVE** the Trust's proposed approach to responding to the recommendations made in the Francis Report (Appendix 1);

5.2 **CONSIDER** and **APPROVE** the areas identified for early improvement / development (Section 4); and

Kam Dhami
Director of Governance

February 2013

Appendix 1

SANDWELL AND WEST BIRMINGHAM HOSPITAL NHS TRUST

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

SWBH Response: Our Approach

WHO	HOW	WHEN
The Board	◆ **A report to the public Board meeting that:** - Distils the recommendations that apply to providers - Includes a statement on the extent to which the Board accepts the recommendations and what it intends to do to implement them - Initial areas identified where the Trust needs to improve / develop - Immediate and longer term actions - The nomination of required Board roles	**28 February 2013**
	◆ **A report to the public Board that:** - Provides a baseline assessment against the relevant recommendations, supporting evidence and a plan to address areas for improvement / development identified.	**28 March 2013**
	◆ **A Board 'timeout' to discuss and debate the impact on the Trust of the findings and recommendations**	**26 April 2013**
Quality and Safety Committee	◆ **To consider the relevant recommendations and receive reports on:** - Mortality, Compassionate Care, Complaints Handling, Whistleblowing, Patient Experience Strategy, Dementia Action Plan and the National In-patient Survey and Staff Survey results	**21 February 2013**
	◆ **Receive and check the report proposed for presentation at the February public Board**	**21 February 2013**

WHO	HOW	WHEN
Managers and Staff	◆ **Special Hot Topics Briefings to discuss the Report and the key learning points for the Trust** - Every team to send a representative to one of the **five** sessions. Attendance registers to be kept - In order to ensure the information is cascaded throughout the organisation, questions will be set for discussion with staff in the workplace. For the first time, the Trust is mandating that feedback *is returned by all teams.* - Responses to the questions received from staff to be distilled and considered by the Executive Team and shared widely across all levels in the organisation. - Front page article in the March edition of Heartbeat	**13** (x2)**, 14** (x2) and **15** (x1) **February 2013** **2 April 2013** **(closing date for feedback)** **9 April 2013** **(Executive Team)** **March 2013**
Senior Leaders	◆ **A quality theme to the 2013 Leadership Conference**	**30 April 2013**
Stakeholders	◆ CEO to issue a briefing to stakeholders ◆ Discuss the Trust's approach to the Report with Commissioners at the next available Clinical Quality Review Meeting	**5 February 2013** **4 March 2013**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Annual Radiation Safety Report 2012
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Barlow, Chief Operating Officer
AUTHOR:	Bill Thomson, Consultant Physicist and RPA
DATE OF MEETING:	28 February 2013

EXECUTIVE SUMMARY:

To provide the Trust Board with an annual report on radiation safety within the Trust , including:

- Staff Radiation safety
- Patient radiation safety
- Routine equipment monitoring
- Radiation incidents
- Radiation protection training
- Research

REPORT RECOMMENDATION:

Trust Board members are asked to accept this 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		Environmental	X	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:

Relates to radiation protection standards for staff (HSE) , patients (CQC) , radioactive transport (DofT) , and training (Clinical Governance).

PREVIOUS CONSIDERATION:

Radiation Safety Committee members

Sandwell and W Birmingham Hospitals NHS Trust

Radiation Safety Report 2012

The main issues in 2012 relate to continued routine monitoring of the radiation doses received by staff, particularly those staff designated as Classified workers, and to several Inspections that occurred throughout the year.

The CQC carried out an Inspection specifically under the Ionising Regulations (Medical Exposure) Regulations [IRMER] . A summary of the aspects of review that have followed from that Inspection is given, however a full report has been presented to the Clinical Governance Board by Dr Claire Keaney, the IRMER lead for the Trust.

In addition there were inspections carried out by the Environment Agency of the nuclear medicine facilities at City site and Sandwell site. There were only a few very minor points raised, and the opportunity was taken to discuss the arrangements for the closure of the Sandwell nuclear medicine facility. With two new gamma cameras being installed on City site, the service is being rationalised onto this site in 2013. There are formal procedures for the removal of the licensing arrangements for the Environment Agency.

Staff Doses

All staff doses (both whole body doses and also extremity doses) are reviewed centrally for any trends and for compliance with the Ionising Radiation Regulations.

Monitoring is carried out routinely for staff working regularly with ionising radiation. The monitoring period is 2 months, and the dosemeters record a value above 0.2mSv. Specialist dosemeters are used to record the dose to the fingertips, mainly from handling procedures in Radiopharmacy, nuclear medicine and for the krypton generator service. In addition, the finger dose and eye dose is monitored of certain medical staff carrying out regular X-ray fluoroscopy work in theatres or for Interventional Radiology.

If doses exceed, or are likely to exceed, 3/10ths the annual dose limits then staff are designated as classified workers. They receive annual medical checks and working practices are reviewed to ensure working practices comply with the ALARP princviple (As Low As Reasonably Practical).

Currently there are 5 classified workers in Radiopharmacy. The Radiopharmacy staff receive higher finger doses due to the need for syringe and vial manipulations required in the preparation of radiopharmaceuticals. Reviews of practices have taken place to ensure all appropriate dose reduction measures are in place. Dr Thomson has also given a refresher talk in dose reduction techniques to the Radiopharmacy staff.

The Krypton generator service involves high activities of high energy gamma emitting radionuclides. Although shielding is incorporated into the dispensing area, whole body doses received by staff are at the threshold level which requires classification. During 2012, the loading rig was rebuilt and improvements were made to the shielding. Of note is that the lead technologist for the krypton service, Peter Childs, retired having been appointed at the inception of the service in 1981.

Nearly all other recorded doses were for staff within nuclear medicine and at the threshold level for detection (0.2mSv).

Imaging Equipment

SWBH has one of the largest inventories of ionising imaging equipment in the region. These are all subject to a regular programme of quality assurance by Physics staff, as required by the Ionising Radiations Regulations. The following summarises equipment issues that were resolved.

- 6 minor mechanical and misalignment faults
- 4 dose meter or detector dose indicator readings inaccurate (no effect on patient dose or image quality, but does affect dose audits)
- A noticeable increase in patient dose in the cath lab; - detector replaced
- Cath lab tube also replaced after failure
- 1 anti-scatter grid damaged and causing artefacts on image; replaced
- Two lead aprons found to be damaged; new lead aprons purchased which have a better ergonomic design, distributing weight to spare the wearer's back

Gamma Camera Systems

- A uniformity issue occurred with the 6 years old GE camera which required the company to completely rebuild the camera heads.
- The two older gamma cameras at City had continued unreliability issues. However SIRG agreed a £1.4m replacement programme which started in October 2012. This programme will provide two new SPECT/CT and SPECT gamma camera systems and upgrade the imaging, reception and waiting areas.

IRMER Issues

There was an inspection by the CQC of the IRMER procedures within the Trust. There were a number of changes recommended to the IRMER procedures within the Trust, and these are listed below with the progress in implementation.

recommendation	**progress**
improve awareness of practitioners and operators of IRMER procedures	internal: complete external: in progress
improve Trust-level recognition of IRMER procedures	procedures: complete protocols: in progress
update IRMER procedures and examination protocols	complete
improve incident reporting and investigation systems	complete
audit non-medical referrers	ongoing, as planned
remove radiographers as referrers in theatre	complete
make referral criteria available to referrers	complete
remove student radiographers as referrers	complete
clarify justification and authorisation of expsoures, especially in CT	complete
formalise arrangements for referrer evaluations of images	outstanding*
keep up-to-date records of practitioner and operator training	ongoing, as planned

*This refers to situations in which a radiologist's report of an examination is not necessary, e.g. fracture clinic and oral surgery. The practice is acceptable and long-standing, but the inspectors recommended a service-level agreement structure.

Training

Several training courses were held throughout 2012 covering the following areas –

- IRMER Training for Cardiologists (course offered nationally)
- IRMER Training for non-medical referrer staff.
- Driver Training for Radioactive Goods Transport.

- Training Course for Sentinel Lymph Node Procedures (contains radiation protection advice for staff and radioactive waste aspects)
- Laser Safety Training for new medical staff in the Eye Centre.
- Clinical Use of SPECT V/Q with Kr81m, including radiation protection aspects. (course offered nationally).

Other Aspects

Dr Thomson helped run a national training day for Endocrinologists for I131 Therapy

Dr Thomson has been asked to chair a working party reviewing the National Physical Laboratory's Good Practice Guide for Radionuclide Calibrators.

Dr Thomson lectured on a National Physical Laboratory training day for radionuclide calibrators.

Dr Thomson presented work at the BNMS meeting entitled "Guidance on the Guidance Notes for Restrictions following I131 Therapy for Thyrotoxicosis" .

Dr Thomson presented work at a European nuclear medicine meeting entitled "EXCEL Programs to Optimise the Cost and Choice of generator schedules for radiopharmacies and to provide daily 99mTc activity information"

WH Thomson
Consultant Physicist and RPA

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – January 2013
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	28 February 2013

EXECUTIVE SUMMARY:

The report presents the financial performance for the Trust and operational divisions for the period to 31st January 2013.

Measured against the DoH target, the Trust generated an actual surplus of £1,146,000 during January against a planned surplus of £527,000. For the purposes of its statutory accounts, the in month surplus was slightly lower at £1,129,000. This performance is consistent with the revised target agreed with the Strategic Health Authority of £6,330,000.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
x		

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

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

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

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

PREVIOUS CONSIDERATION:

Performance Management Board and Trust Management Board on 19 February 2013 and Finance & Performance Management Committee on 22 February 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – January 2013

EXECUTIVE SUMMARY

• For the month of January 2013, the Trust delivered a "bottom line" surplus of £1,146,000 compared to a planned surplus of £527,000 (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 to date, the Trust has produced a surplus of £4,701,000 compared with a planned surplus of £2,880,000 so generating an positive variance from plan of £1,821,000, again in line with the Trust's revised target.

• At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 276 below planned levels. After taking account of the impact of agency staff, WTE's were 137 below plan. Total pay expenditure for the month, inclusive of agency costs, is £307,000 below the planned level.

• The month-end cash balance was approximately £25.4m above the planned level.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	619	1,821	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	665	1,398	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	307	2,189	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(328)	(3,735)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	137	46	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	25,389	25,389	>= 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	2,880	4,701
Capital Resource Limit	15,175	7,913
External Financing Limit	---	25,389
Return on Assets Employed	3.50%	3.50%

2011/2012 Summary Income & Expenditure Performance at January 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	Forecast Outturn £000's
Income from Activities	383,961	32,214	32,761	547	321,257	324,406	3,149	389,540
Other Income	39,064	3,159	3,298	139	32,712	32,507	(205)	38,563
Operating Expenses	(396,406)	(32,946)	(32,967)	(21)	(332,085)	(333,631)	(1,546)	(399,382)
EBITDA	26,619	2,427	3,092	665	21,884	23,282	1,398	28,721
Interest Receivable	100	8	12	4	83	120	37	136
Depreciation, Amortisation & Profit/(Loss) on Disposal	(14,738)	(1,228)	(1,349)	(121)	(12,282)	(12,427)	(145)	(14,971)
PDC Dividend	(5,594)	(466)	(466)	0	(4,662)	(4,662)	0	(5,594)
Interest Payable	(2,157)	(185)	(160)	25	(1,849)	(1,782)	67	(2,162)
Net Surplus/(Deficit)	**4,230**	**556**	**1,129**	**573**	**3,174**	**4,531**	**1,357**	**6,130**
IFRIC12/Impairment/Donated Asset Related Adjustments	(353)	(29)	17	46	(294)	170	464	200
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,877**	527	**1,146**	**619**	**2,880**	**4,701**	**1,821**	**6,330**

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

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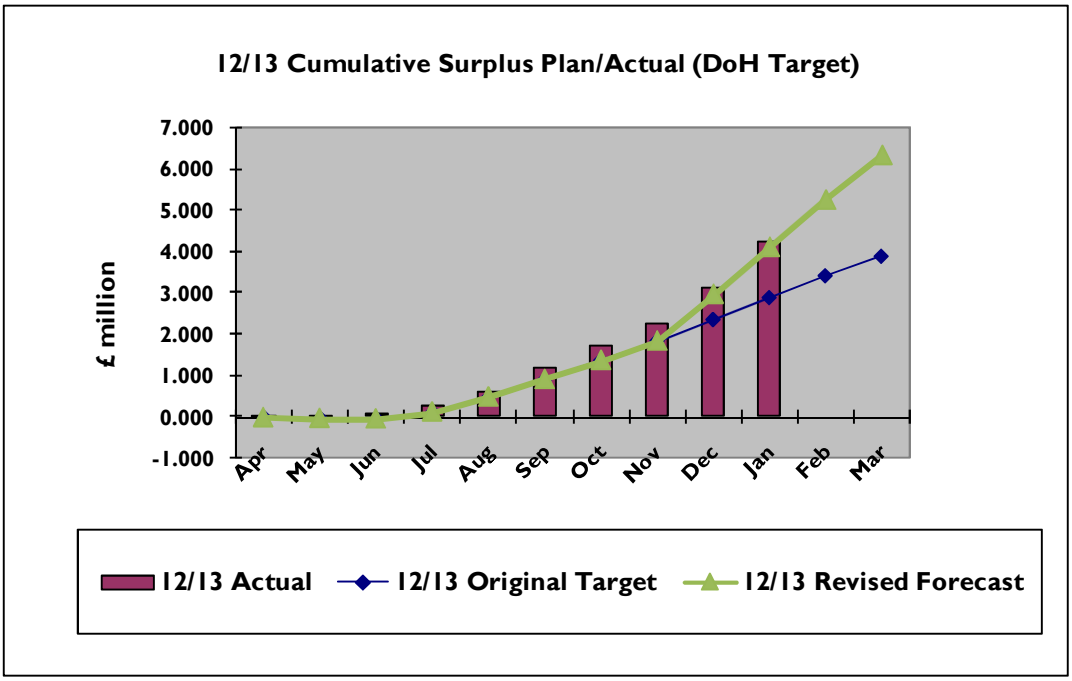
Overall Performance Against Plan

• 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 £1,146 in January against a planned surplus of £527,000. The resultant £619,000 positive variance moves the year to date position to £1,821,000 above targeted levels which is consistent with the revised target agreed with the Strategic Health Authority.



Divisional Performance

• For January, only Imaging and Corporate Services have posted in month deficits against plan and these deficits are relatively small when viewed against overall performance or the planned position.

• Performance in non operational areas reflects a cautious view of a number of uncertain items, including patient related SLA income where appropriate.

• SLA performance which is based on fully costed information for December shows an ongoing significant overall positive variation from plan particularly within Medicine (although a significant element of this relates to high cost drugs for which there is an equivalent higher level of expenditure) and some smaller variations in other areas.

• There continues to be no material year to date adverse variances from plan although Surgery A and Facilities continue to have relatively small adverse variances.

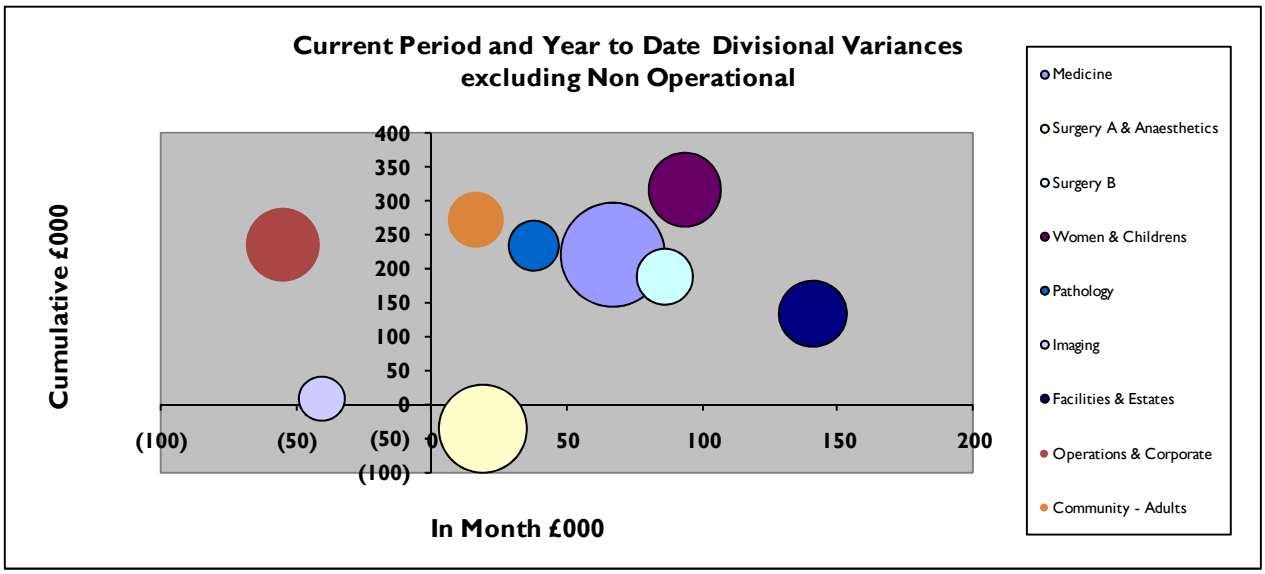
Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – January 2013

The adjacent table and graph below show small adverse year to date variances for Surgery A and Facilities (although the latter is combined with Estates in the adjacent graph and shows a year to date surplus).

Divisional Variances from Plan

	Current Period £000	Year to Date £000
Medicine	67	221
Surgery A & Anaesthetics	19	(37)
Surgery B	86	188
Women & Childrens	93	316
Pathology	38	234
Imaging	(40)	8
Facilities & Estates	141	133
Community - Adults	17	272
Operations & Corporate	(55)	235
Non Operational	298	(171)



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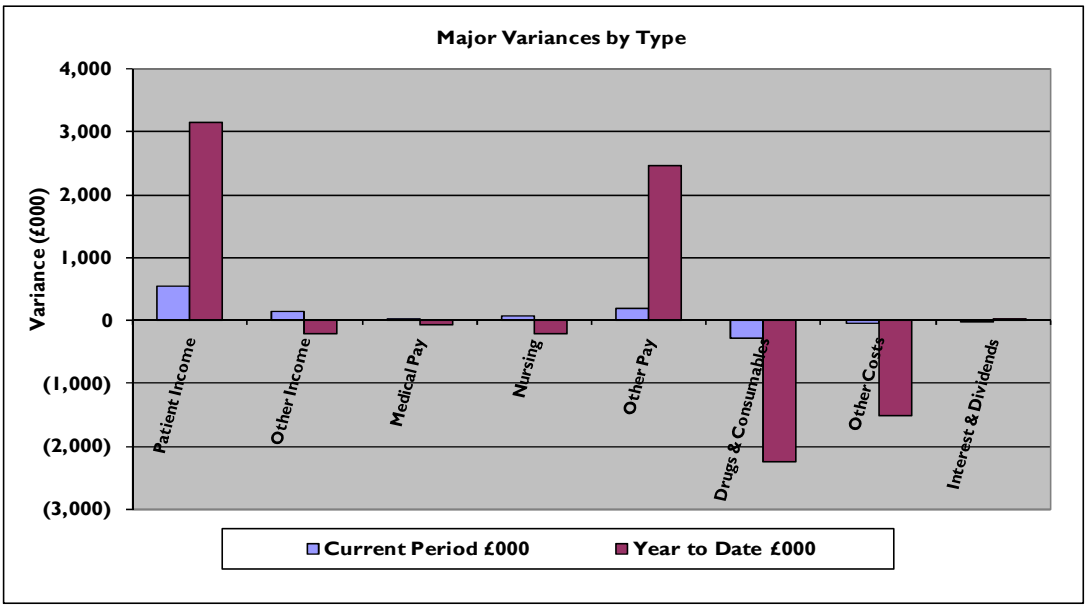
For January, patient related SLA income again shows a positive variation from plan . Overall pay expenditure is below planned levels particularly with the administration & estates, scientific and therapeutic & technical pay groups. Overall non pay expenditure is £328,000 higher than plan in month, mainly in respect of drugs (including rechargeable high cost drugs), patient related consumables and equipment and IT equipment and maintenance (including significant one off expenditure on enhanced systems and hardware within corporate areas and the Community – Adults Division).

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	547	3,149
Other Income	139	(205)
Medical Pay	32	(59)
Nursing	74	(217)
Other Pay	201	2,465
Drugs & Consumables	(287)	(2,234)
Other Costs	(41)	(1,501)
Interest & Dividends	4	37



Capital Expenditure

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

• Year to date expenditure remains fairly low and lower than the planned position for the month which reflects and expectation of increased spend in the final quarter, consistent both with experience in previous years and with the revised planned phasing of spend.

• A review of expected forecast outturn shows a current expectation of an underspend against the original plan of almost £3m although it should be noted that, for some months, a planned in year shortfall of approximately £2.3m has been included within the programme which is reflected within the draft plan for 2013/14 for committed programmes and schemes.

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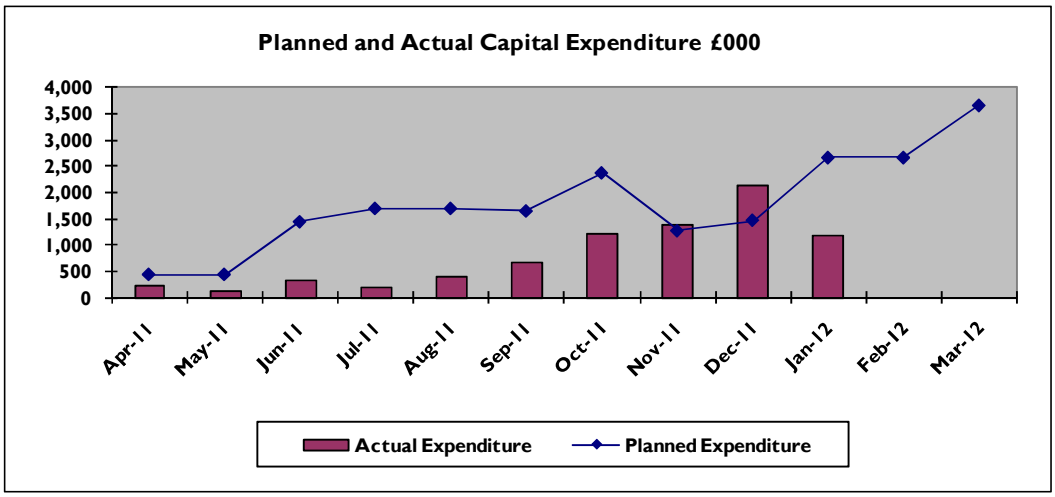
Financial Performance Report – January 2013

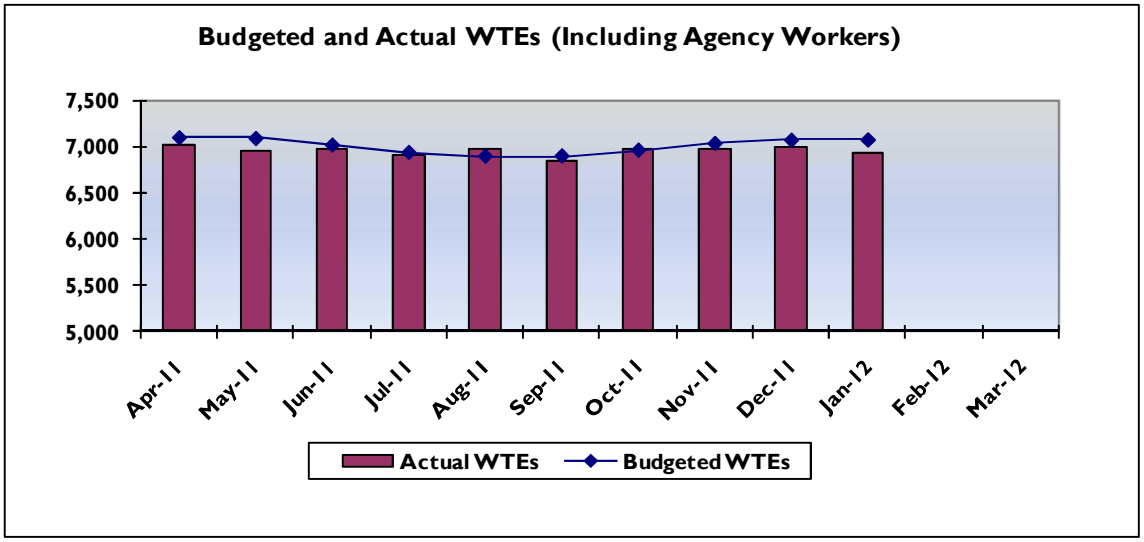


Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 137 below plan compared with 70 below plan for December. Excluding the impact of agency staff, whole time equivalent (wte) numbers are around 276 below plan. Actual wte's have fallen by 65 compared with December although this is mainly the result of a reduction in bank and agency numbers with substantive wte's showing a net fall of approximately 12 in month.

• Total pay costs (including agency workers) are £307,000 lower than budgeted levels for the month , particularly within the scientific, therapeutic & technical and administration & estates pay groups.

• Expenditure for agency staff in January was £623,000 compared with £688,000 in December, an average of £526,000 for 2011/12 and a January 2012 spend of £404,000. The biggest single group accounting for agency expenditure remains medical staffing.



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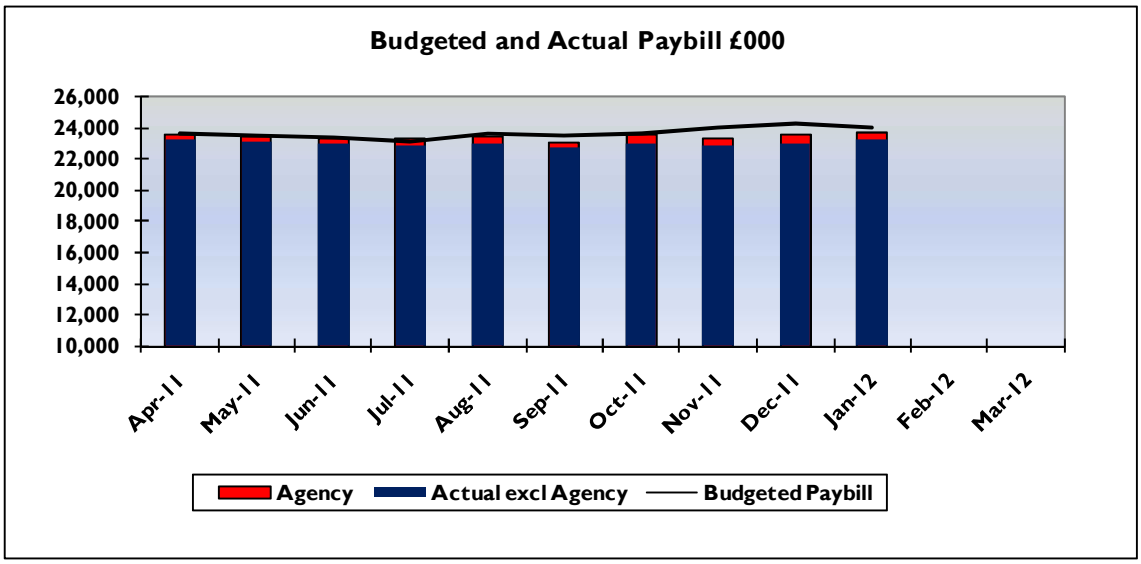


Pay Variance by Pay Group

• 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 January					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	62,991	60,378		2,672	63,050	(59)
Management	12,730	12,003		0	12,003	727
Administration & Estates	26,255	23,969	1,156	473	25,598	657
Healthcare Assistants & Support Staff	26,079	23,678	2,447	18	26,143	(64)
Nursing and Midwifery	72,226	67,968	3,145	1,330	72,443	(217)
Scientific, Therapeutic & Technical	36,265	34,656		490	35,146	1,119
Other Pay	44	18			18	26
Total Pay Costs	236,590	222,669	6,748	4,984	234,401	2,189

NOTE: Minor variations may occur as a result of roundings

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – January 2013

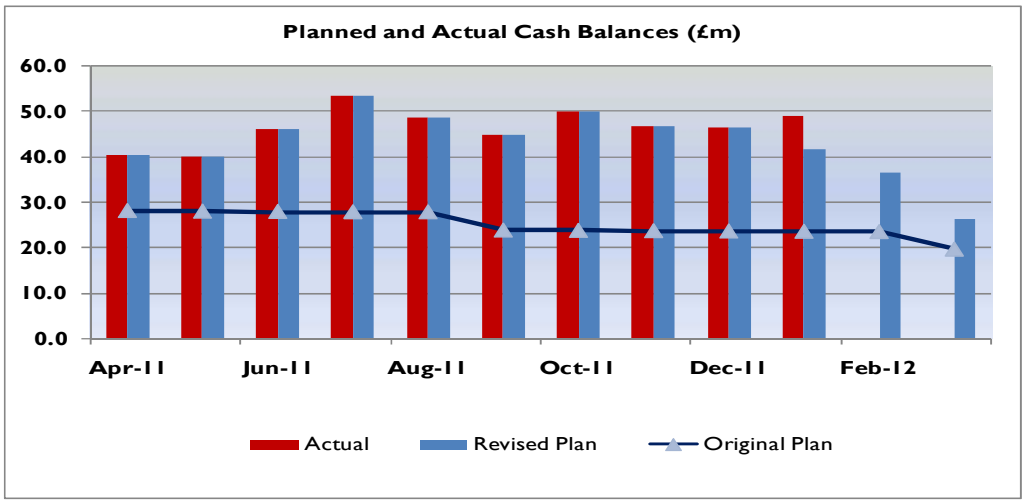
Balance Sheet

• 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.

• Cash balances at 31st January are approximately £49.1m which is around £14.6m higher than at 31st March 2012 and £2.6m higher than at 31st December.

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

		Opening Balance as at 1st April 2012 £000	Balance as at end January 2013 £000	Forecast at 31st March 2013 £000
Non Current Assets	Intangible Assets	1,075	998	1,025
	Tangible Assets	227,072	222,554	226,371
	Investments	0	0	0
	Receivables	865	865	950
Current Assets	Inventories	4,065	3,920	4,050
	Receivables and Accrued Income	14,446	15,089	13,500
	Investments	0	0	0
	Cash	34,465	49,092	26,310
Current Liabilities	Payables and Accrued Expenditure	(33,751)	(45,554)	(32,491)
	Loans	(2,000)	(2,000)	(2,000)
	Borrowings	(1,166)	(977)	(914)
	Provisions	(15,649)	(11,669)	(9,489)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	0
	Loans	(5,000)	(4,000)	(3,000)
	Borrowings	(29,995)	(29,362)	(29,262)
	Provisions	(2,532)	(2,530)	(2,500)
		191,895	196,426	192,550
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	160,231
	Revaluation Reserve	41,228	40,253	35,753
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	(18,622)	(13,116)	(12,492)
		191,895	196,426	192,550



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Financial Performance Report – January 2013

Cash Forecast

• A forecast of the expected cash position for the next 12 months is shown in the table below. The significant increase in capital related payments towards the year end reflects the expected payment profile for the current capital programme (and is dependent on the programme being delivered) and the experience of actual payments in previous years.

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT January 2013

ACTUAL/FORECAST	Jan-13 £000s	Feb-13 £000s	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
Receipts													
SLAs: Black Country Cluster	**17,724**	17,165	17,165	16,993	16,993	16,993	16,993	16,993	16,993	16,993	16,993	16,993	16,993
Birmingham & Solihull Cluster	**11,341**	11,341	11,341	11,228	11,228	11,228	11,228	11,228	11,228	11,228	11,228	11,228	11,228
Other Clusters	**565**	575	575	569	569	569	569	569	569	569	569	569	569
Pan Birmingham LSCG	**1,944**	1,944	1,944	1,925	1,925	1,925	1,925	1,925	1,925	1,925	1,925	1,925	1,925
Education & Training	**4,444**			4,300	0	0	4,300	0	0	4,300	0	0	0
Loans													
Other Receipts	**1,580**	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	**37,598**	33,925	33,925	37,915	33,615	33,615	37,915	33,615	33,615	37,915	33,615	33,615	33,615
Payments													
Payroll	**13,862**	13,700	13,700	13,068	13,068	13,068	13,068	13,068	13,068	13,068	13,068	13,068	13,068
Tax, NI and Pensions	**9,089**	14,950	9,150	9,455	9,455	9,455	9,455	9,455	9,455	9,455	9,455	9,455	9,455
Non Pay - NHS	**2,231**	2,650	2,650	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Non Pay - Trade	**8,045**	8,314	9,041	8,000	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500
Non Pay - Capital	**992**	5,415	5,642	1,750	1,750	500	500	500	500	500	500	500	500
PDC Dividend			2,797						2,700				
Repayment of Loans			1,000						1,000				
Interest			25						20	20	20	20	20
BTC Unitary Charge	**416**	416	832	430	430	430	430	430	430	430	430	430	430
Other Payments	**330**	175	175	175	175	175	175	175	175	175	175	175	175
Total Payments	**34,965**	45,620	45,012	35,378	34,878	33,628	33,628	33,628	37,348	33,648	33,648	33,648	33,648
Cash Brought Forward	**46,459**	49,092	37,397	26,310	28,847	27,585	27,572	31,859	31,846	28,114	32,381	32,348	32,315
Net Receipts/(Payments)	**2,633**	(11,695)	(11,087)	2,537	(1,263)	(13)	4,287	(13)	(3,733)	4,267	(33)	(33)	(33)
Cash Carried Forward	**49,092**	37,397	26,310	28,847	27,585	27,572	31,859	31,846	28,114	32,381	32,348	32,315	32,283

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

Risk Ratings

•The table overleaf shows the Monitor risk rating score for the Trust based on performance at January.
• 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. This changes the Liquid Ratio score from 1 to 3.
•I&E Surplus Margin remains at a 3 which reflects the profiling of surpluses growing towards the year end.
• Formal reporting of overall performance would be rounded to a score of 3.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

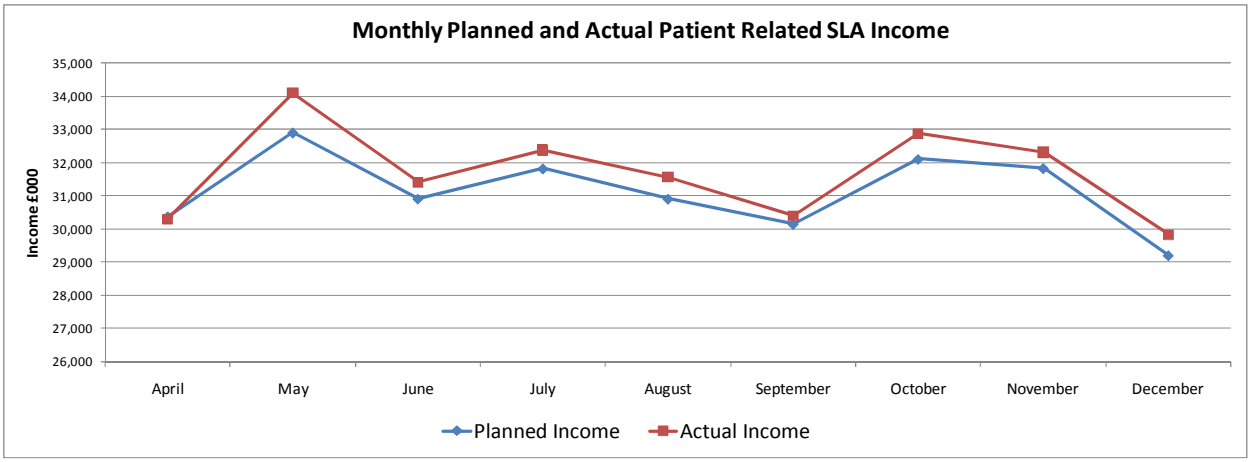
Financial Performance Report – January 2013

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	7.0%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	106.4%	5
Net Return After Financing	Surplus after dividends over average assets employed	2.7%	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	26.5	4
Overall Rating			**3.7**

Performance Against Service Level Agreement Target

•The graph and table below and overleaf show an overview of financial performance against the Trust's Service Level Agreements with Commissioners.

• Fully costed data is only available one month in arrears and this data therefore only covers the period April – December. For the purpose of financial reporting for the current period, a prudent estimate is made of SLA income. This adjustment together with the aforementioned timing difference does not permit a direct comparison with performance incorporated within the main financial statements.



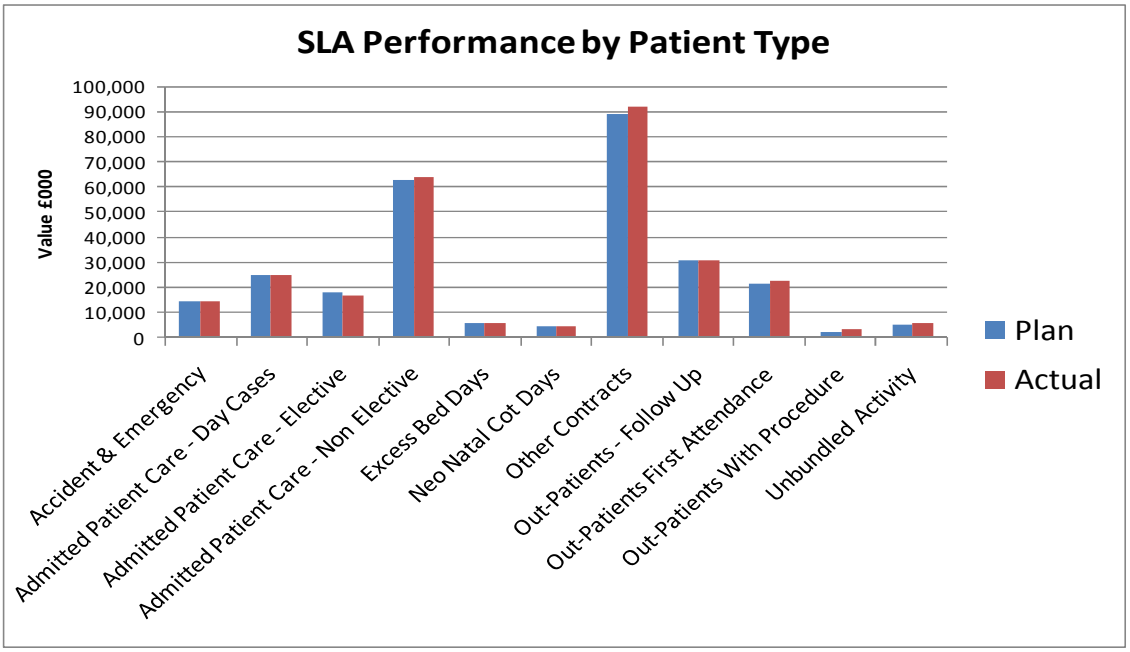
Month	Planned Income £000	Actual Income £000	Variance £000
April	30,356	30,296	(61)
May	32,897	34,084	1,187
June	30,895	31,409	514
July	31,805	32,365	560
August	30,893	31,560	666
September	30,134	30,399	265
October	32,095	32,863	768
November	31,820	32,301	481
December	29,182	29,830	648
Total	**280,077**	**285,105**	**5,028**

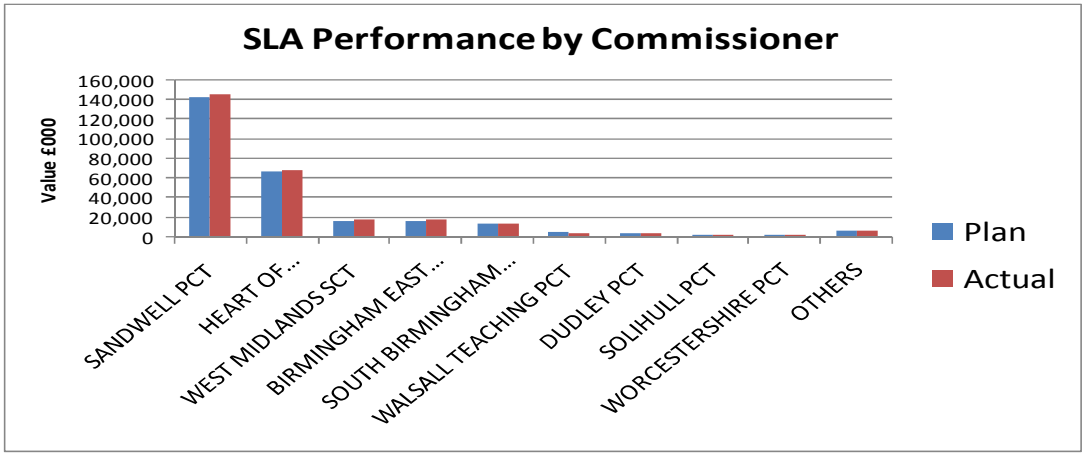
Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – January 2013

Performance by Activity Type and Commissioner

• The following graphs show performance by activity type and commissioner comparing planned and actual financial values for the year to date and the percentage variance from plan for each type of activity and commissioner.





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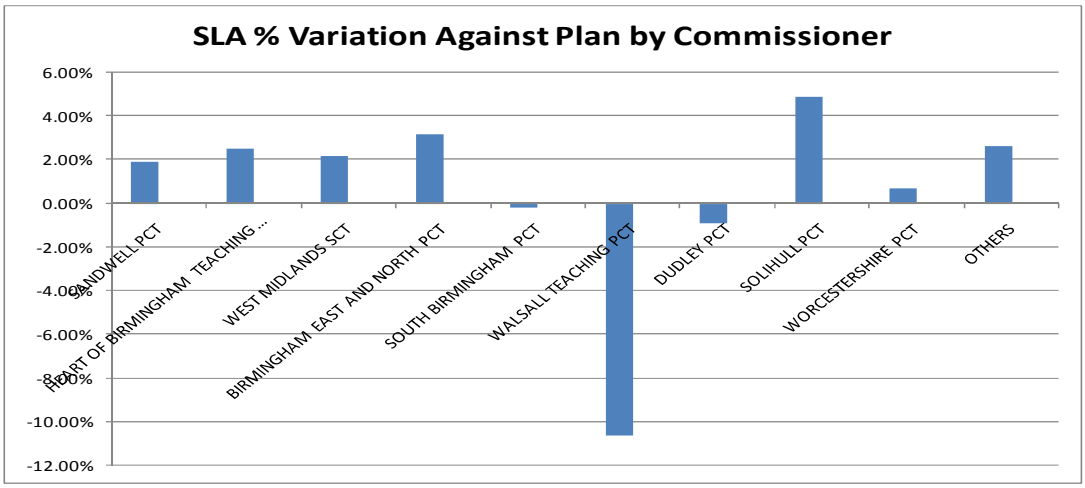
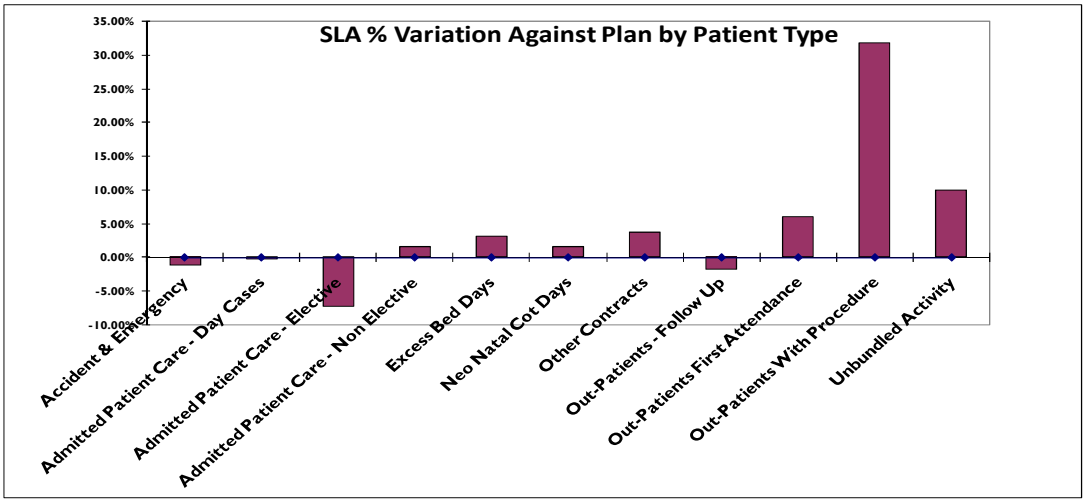
NHS Trust

Financial Performance Report – January 2013





Transformation Programme

•The graph overleaf shows actual progress against the Trust's Transformation Programme for 2012/13, inclusive of RCRH related changes.

• At 31st January and against the revised target, actual savings were £6,000 or 0.03% higher than planned levels and the full year effect is maintained at the level of the revised plan.

• The forecast outturn for the programme remains in line with plan and the full year recurrent effect of the programme remains in excess of the 2012/13 requirement.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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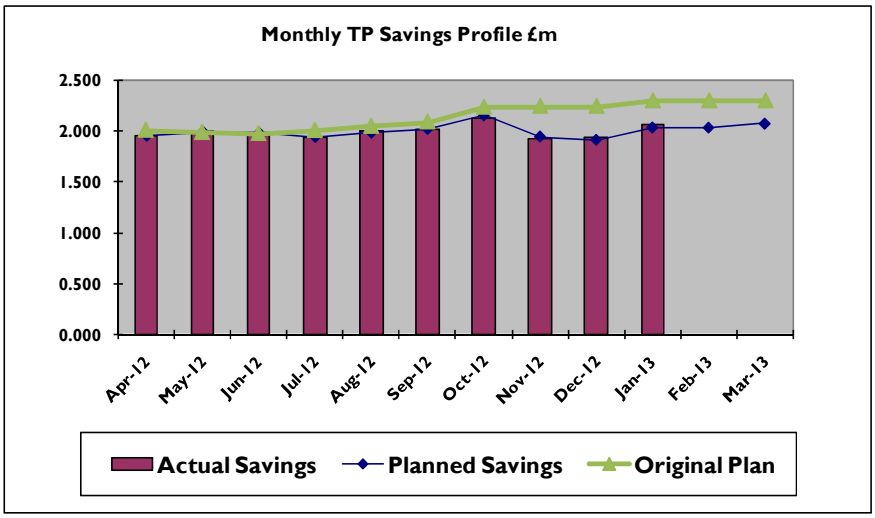
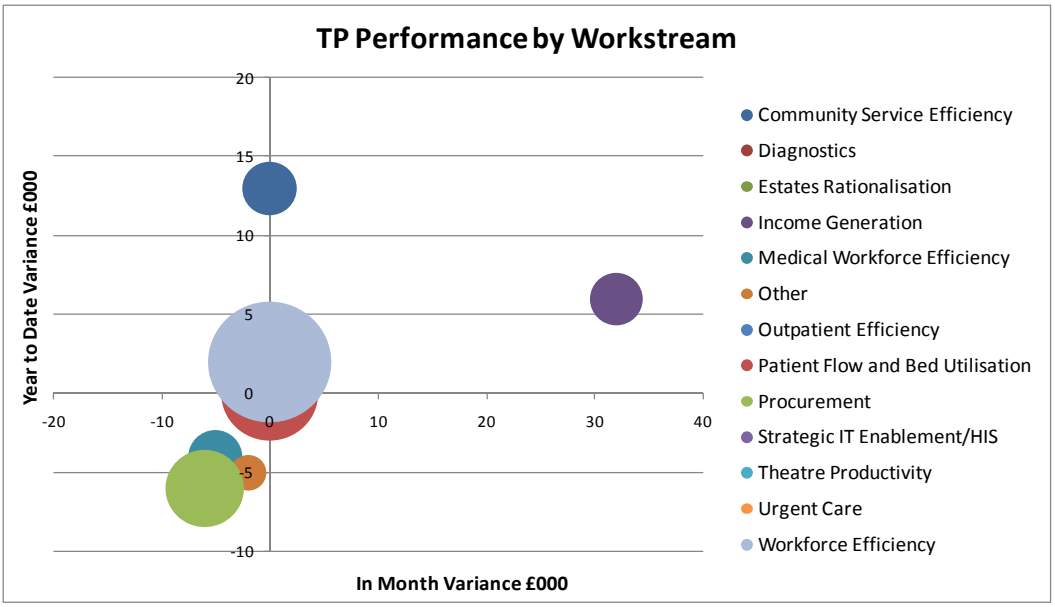


Transformation Programme cont

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

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



Transformation Programme cont

•At the end of January, there are no significant adverse variances from plan.

• Mitigating strategies remain in place for the position to date with a detailed assessment of risk management and actions planned as part of the ongoing performance management regime across the Trust. The Performance Management Board will continue to recommend appropriate actions to the F&PMC sub-committee of the Board

Sandwell and West Birmingham Hospitals NHS
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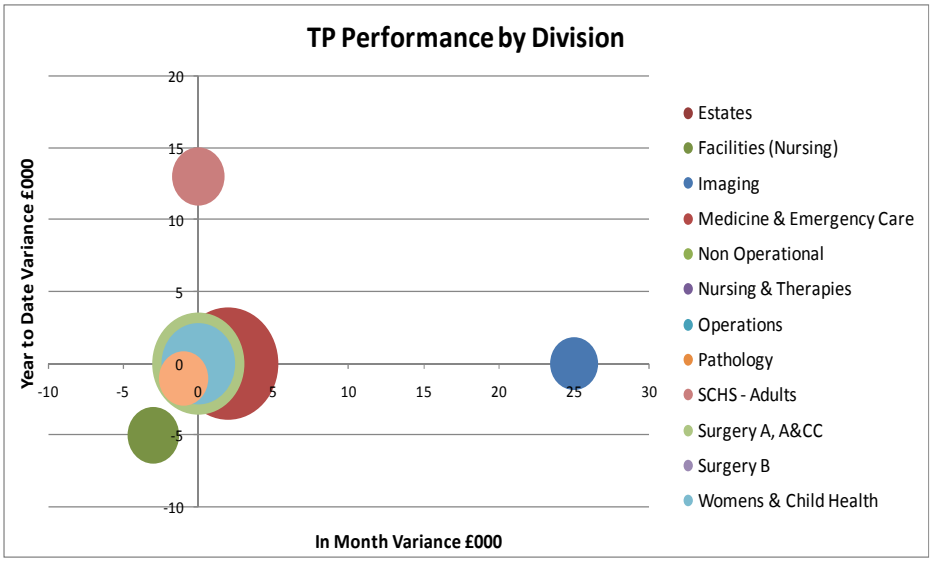

External Focus

• The general economic situation continues to be weak. The UK economy shrank by 0.3% in the last three months of 2012, further fuelling fears that the economy could re-enter recession. The economy had grown by 0.9% in the previous quarter and for the whole year, net growth was flat.

• A Kings Fund study has suggested that overall health and social care costs could consume half of government spending in 50 years' time compared with around 9% today, driven by population changes, wealth increases, medical advances and the ageing population.

• The Secretary of State for Health has confirmed the break up of South London Healthcare which will be dissolved by October 1 with its three hospitals taken over by neighbouring trusts.

• The National Audit Office has confirmed that while there have been benefits from the introduction of the consultant contract in 2003, it said value for money could still be boosted and performance assessed more widely and that further gains could be delivered from the changes.

• The publication of the Francis report on Mid Staffordshire will have both operational and financial impacts on the whole NHS, including Sandwell & West Birmingham Hospitals. However, until the detail of the recommendations are worked through, it is not possible to assess with any degree of accuracy what the financial impact might be on the Trust.

Sandwell and West Birmingham Hospitals NHS
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Conclusions

• Measured against the DoH target, the Trust generated an actual surplus of £1,146,000 during January against a planned surplus of £527,000. For the purposes of its statutory accounts, the in month surplus was slightly lower at £1,129,000. This represents a further increase in the year to date surplus and is consistent with the revised bottom line position agreed with the Strategic Health Authority.

• The £1,146,000 surplus in January is £619,000 better than originally planned for the month.

•For the year to date, the Trust has generated a surplus (as measured against the DoH target) of £4,701,000 which is £1,821,000 better than the originally planned position.

• In month capital expenditure is £1.2m which still leaves year to date capital expenditure significantly lower than plan. The most significant reason for the variance from plan is the delay in Grove Lane land purchase although the Trust has a liability under GVD1 and GVD2 to acquire the land and this position will be reflected in the Trust's accounts for 2012/13.

•At 31st January, cash balances are approximately £25.4m higher than the cash plan and around £14.6m greater than the balance held at 31st March.

• Although there are some minor adverse bottom line in month performances by operational divisions, none is material and this has not affected the overall ability of the Trust to perform in line with its revised forecast agreed with the Strategic Health Authority. Monitoring of divisional positions continues with action being taken as necessary to rectify any potential and/or actual variances with performance of the Transformation Programme remaining a key component of this.

Recommendations

The Trust Board is asked to:

i. RECEIVE the contents of the report; and

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

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:	28 February 2013

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April 2012 – January 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 - JANUARY 2013

(a)

EXECUTIVE SUMMARY AND KEY EXCEPTIONS

KEY EXCEPTIONS

b

Emergency Department - performance against the **A&E 4-hour maximum wait** target improved to 92.2% during January, although remained below the operational threshold of 95.00%. Inclusion of the Sandwell site non-chargeable GP Triage data improves performance for the month and year to date to 92.8% and 93.3% respectively, with added inclusion of BMEC fast-track OP attendances, improving this further to 93.1% and 93.5% respectively. The Trust continues to meet 2 of the 5 **A&E Clinical Quality Indicators**, 1 in each of the Timeliness and Patient Impact sections, for the year to date, although performance against 4 of the 5 indicators has improved during the month.

A breakdown of recent ED 4-hour breaches related or not to capacity constraints has ben undertaken and this information is being used to inform discussions with various specialties / services for the purpose of improving patient flow. A GP triage service at City, similar to the one in operation at Sandwell is scheduled to commence on 18 February 2013. A root-cause analysis of any BMEC breaches has been initiated. The intensive support tean are scheduled to visit Sandwell site ED on 1 March 2013.

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. Performance against each of the 3 indicators improved during the month; the percentage of Clinical Handovers completed within 15 minutes improved on both sites to 74.8% overall (target 85%), the average turnaround time improved to c.35 minutes overall (target 30 minutes or less) and the number of instances where ambulance turnaround was in excess of 60 minutes also reduced to 182 overall (target 0).

The improvement in clinical handover data at Sandwell has been contributed to by an improvement in the quality of data capture and reporting by the West Midlands Ambulance Service.

e

Cancer - the 31-day subsequent treatment (drug) target of 98% was not met during the month of December, with actual performance of 97.4% (1 of 39 patients treated during the period). The patient who saw an Oncologist at the end of November, agreed and consented to chemotherapy, for which an appointment within the 31-days was made. The patient subsequently decided not to commence chemotherapy until after Christmas. The appointment to commence chemotherapy was rescheduled for 31 December 2012, unfortunately this fell outside of the 31-day target period. All other high level cancer targets were met during the month and all continue to be met for the year to date.

A number of patients requested to defer appointments and / or treatment during the Christmas period through 'Patient Choice'. Any actions which may be implemented to cope with potential similar issues during future holiday periods are being explored. The Chief Operating Officer has requested escalation of any issues which may require support / intervention to be highlighted in future.There remains a need for patients to be made fully aware by their GP of the importance of keeping appointments and commencement of treatment as soon as is practically possible.

f

Referral to Treatment Time & Diagnostic Waits - each high level, Admitted, Non-Admitted and Incomplete Pathway RTT target was met during the month. There remain 2 specialities which failed to meet the operational threshold of 90% for Admitted Care, Trauma & Orthopaedics where performance reduced to 79.4% (81.3% previous month) and Plastic Surgery where performance remained stable at 86.6%. Trauma & Orthopaedics also failed to meet the RTT Incomplete Pathway threshold of 92%, with performance for the month of 81.3%, a reduction from the previous month's performance of 84.3%. Diagnostic Waits in excess of 6-weeks at the end of January increased from 1.85% in December to 1.98%, with a similar number (103 (99 of whom were waiting for an Endoscopy)) of patients waiting.

The specialties of Trauma & Orthopaedics and Plastic Surgery remain on improvement trajectories to meet the relevant RTT operational thresholds. Diagnostic Waits performance is not meeting a previously determined improvement trajectory, and a rectification plan to address this has been produced. It is expected that performance will meet the required 1.0% maximum performance threshold before the end of the current financial year.

g

Cancelled Operations - the proportion and number of Elective Admisisons cancelled at the last minute for non-clinical reasons increased during the month of January. A total of 65 cancellations were made, 36 at Sandwell and 29 at City, across a range of specialties.

The number of cancellations and range of specialties affected reflect the demand for emergency admissions during the month, particularly the early part of the month when a number of wards were closed due to Norovirus, particularly at Sandwell. Recovery plans in the affected areas have been implemented, with the recognition of the need to ensure each affected patient is offered a new date within 28 days of the original date.

CQUIN PERFORMANCE

a

	Patient Safety			Effectiveness of Care			Patient Experience			ALL		
	R	A	G	R	A	G	R	A	G	R	A	G
Acute			9	2			2		3	4		12
Community			3			1			4			8
Specialised									4			4

CQUIN - the Acute Dementia CQUIN target comprises 3 elements, 2 of which were not met during the month of January. Overall performance for this CQUIN is assessed across the quarter. The proportion of Mortality Reviews which were undertaken within 42 days of death improved from 53.9% during October to 63.9% during November, although is not currently meeting the trajectory of 71.0%. The Personal Needs Acute CQUIN, based upon responses to 5 Patient Experience questions, has not been met for the year. The Trust has been advised that its aggregate score is 66.9, compared with a target score based upon improvement from previous years, of 71.6.The most recent data (November) for the Alcohol Screening CQUIN identified 61% compliance compared with a trajectory for the period of 66%.

A system has been introduced designed to equalise the work involved with undertaking mortality reviews, which it is anticipated will improve the turnaround time of the reviews. Areas of poorer performance of Alcohol Screening are to be targeted and audit periods have been identified for Alcohol Screening for the remainder of the year. It is intended that the forthcoming 'Leadership Conference' is structured around Patient Experience.

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	5460	5147	313	6.1	52286	48609	3677	7.6	53127	52286	-841	-1.6
IP Non-Elective	4783	5259	-476	-9.1	47887	47471	416	0.9	45906	47887	1981	4.3
OP New	15090	13082	2008	15.3	143955	120920	23035	19.0	131519	143955	12436	9.5
OP Review	32549	39250	-6701	-17.1	322284	363031	-40747	-11.2	350696	322284	-28412	-8.1
OP Review:New	2.16	3.00	-0.84	-28.1	2.24	3.00	-0.76	-25.4	2.67	2.24	-0.43	-16.0
AE Type I	13086	14499	-1413	-9.7	146502	146670	-168	-0.1	148479	146502	-1977	-1.3
AE Type II	1831	2671	-840	-31.4	22722	27016	-4294	-15.9	30912	22722	-8190	-26.5
Adult Community	39919	33985	5934	17.5	410566	367092	43474	11.8	363229	410566	47337	13.0
Child Community	10571	11613	-1042	-9.0	112939	117505	-4566	-3.9	105279	112939	7660	7.3

d

Overall Elective activity for the month and year to date remains in excess of the plan by 6.1% and 7.6% for the periods respectively. Non Elective activity was 9.1% less than plan for the month, but continues to exceed the plan for the year to date by 0.9%. Month and year to date New and Review Outpatient performance is such that the Follow U : New Outpatient Ratio for the year to date further improved (reduced) to 2.24 which compares favourably with a ratio derived from plan of 3.00. A&E Type I activity (-0.1%) remains essentially on plan for the year to date although Type II (BMEC) activity (-15.9%) remains well below plan. Adult Community activity is currently 11.8% above plan fc the year to date. Child Community activity is 3.9% below plan.

NATIONAL PERFORMANCE FRAMEWORKS

NHS PERFORMANCE FRAMEWORK - Summary						
	August	September	October	November	December	January
Performing	16	14	16	16	15	16
Underperforming	2	4	2	2	3	2
Failing	1	1	1	1	1	1
Weighted Score	**2.64**	**2.54**	**2.64**	**2.64**	**2.57**	**2.64**

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

The Trust failed to meet the A&E 4-hour wait operational threshold during the month and underperformed against the indicators 'RTT Delivery in all specialities' and 6-week Diagnostic Waits. The Trust is projected to meet all high level Cancer targets. The overall weighted score for service delivery is 2.64, which attracts a**PERFORMING** classification.

The Trust failed to meet A&E 4-hour wait operational threshold during the month. The Trust is projected to meet all high level 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 - JANUARY 2013

PATIENT SAFETY

Exec Lead								September	October	November	December			January			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		%		87.2 ▼	88.7 ▲	86.5 ▼	→		80.8 ■	→		83.0 ■	86.9	83	83		No Variation	0 - 2% Variation	>2% Variation	●	72.8	85.9
	K			Pts admitted to Acute Stroke Unit within 4 hrs		%		65.1 ▼	51.1 ▼	60.9 ▲	→		51.3 ▼	→		48.4 ▼	61.7	90	90		No Variation	0 - 2% Variation	>2% Variation	● ●		68.7
	K			Pts receiving CT Scan within 24 hrs of presentation		%		100 ■	93.3 ■	91.8 ▼	→		95.0 ▲	→		100.0 ■	93.9	100	100		No Variation	0 - 2% Variation	>2% Variation	●		100
	K			Pts receiving CT Scan within 1 hr of presentation		%		61.5 ▲	42.9 ■	55.3 ■	→		61.5 ▲	→		51.5 ▼	52.4	50	50		No Variation	0 - 2% Variation	>2% Variation	●		37.5
	H			TIA (High Risk) Treatment <24 h from initial presentation		%		60.0 ▼	84.6 ▲	76.5 ▼	55.6 ■	60.0 ▼	57.9 ■	57.1 ▲	70.6 ▲	66.7 ■	68.8	60	60		No Variation	0 - 2% Variation	>2% Variation	●	46.15	53.2
	K			TIA (Low Risk) Treatment <7 days from initial presentation		%		83.9 ▲	86.5 ▲	96.3 ▲	88.9 ▼	85.7 ▼	87.0 ▼	60.0 ▼	71.0 ▼	67.4 ▼	76.8	60	60		No Variation	0 - 2% Variation	>2% Variation	●		30.4
R0	A	4	Infection Control	C. Difficile (DH Reportable)		No.		2 ■	5 ▼	2 ▲	1 ■	0 ▲	1 ▲	2 ▼	1 ▼	3 ▼	27	49	57		No variation		Any variation	●	120	95
	K			C. Difficile (Best Practice Numbers)		No.		4 ■	9 ▼	5 ▲	2 ■	2 ▲	4 ▲	4 ▼	2 ■	6 ▼	60	80	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.		1	0	0	0	0	0	1	0	1	14	No. Only	No. Only						22	12
				E Coli Bacteraemia		No.		6	5	2	5	2	7	1	2	3	40	No. Only	No. Only						73	50
	F	3		MRSA Screening - Elective	Patient Not Matched	%		115.0 ▲	104.6 ▼	96.2 ▼	Numerator = 2251	Denominator = 2009	112.0 ▲	Numerator = 3036	Denominator = 2319	130.9 ▲	130.9*	75	85		No variation		Any variation	●	40.3	40.6
	F				Best Practice - Patient Matched	%		38.7 ▼	53.7 ▲	56.5 ▲	Numerator = 1109	Denominator = 2009	55.2 ▼	Numerator = 1387	Denominator = 2319	59.8 ▲	59.8*	75	85		No variation		Any variation	● ●	40.3	40.6
	F			MRSA Screening - Non Elective	Patient Not Matched	%		66.4 ▼	66.0 ▼	78.6 ▲	Numerator = 2250	Denominator = 2869	78.4 ▼	Numerator = 2092	Denominator = 2594	80.7 ▲	80.7*	75	85		No variation		Any variation	●	18.9	26.0
	F				Best Practice - Patient Matched	%		66.1 ▼	66.3 ▲	66.3 ■	Numerator = 2392	Denominator = 3571	67.0 ■	Numerator = 2240	Denominator = 3329	67.3 ▲	67.3*	75	85		No variation		Any variation	●	18.9	26.0
RS	A	3	Acute CQUIN	VTE Risk Assessment (Adult IP)	396	%		91.0 ■	91.5 ▲	91.7 ▼	→		90.2 ▼	→		91.1 ▲	91.1*	90	90	a	=>90		<90	●	92.3	92.4
RB	K	20		Appropriate Use of Warfarin	372			Compliant	→	→	→		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 ▲	→	→	→		→	→			83	70	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	%		99.8 ■	99.8 ■	99.8 ■	→		99.8 ■	→		99.8 ■	99.8	99	100		No variation		Any variation	●		
RS	H	9		Safe Surgery - Other Areas		%		100 ▲	99.8 ▼	99.5 ▼	→		99.5 ■	→		99.5 ■	99.5	98	98		No variation		Any variation	●		
RS	H	10		Stroke Care	743	%		Met Q2 req's	→	→	→		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.		1 ■	0 ■	0 ■	→		0 ■	→		0 ■	0*	0	0		No variation		Any variation	●		
	F		Open Serious Incidents Requiring Investigation (SIRI)			No.		2	3	1	→		2	→		0	0*	No. Only	No. Only							
	F		Open Central Alert System (CAS) Alerts			No.		10	8	5	→		4	→		3	3*	No. Only	No. Only							
RO	D		Falls Resukting In Severe Injury or Death			No		6 ▼	0 ■	2 ■	→		2 ■	→		1 ▲	1*	0	0		No variation		Any variation	●		
RO		8	High Impact Nursing Actions	Inpatient Falls reduction		%		69 ▼	43 ■	66 ■	→		79 ▼	→			591	513	684		=<57/m		>57/m	●	1024	763
				Nutritional Assessment (MUST)		%		91 ▲	89 ■	94 ■	→		96 ▲	→		98 ▲	98*	90	90		=>90		<90	●		89.0
				Fluid Balance Chart Completion		%		93	93	95	→		98	→		93	93*									100

Exec Lead			PATIENT SAFETY (Continued)			September	October	November	December		January		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.	3 ▼	3 ■	0 ▲	→		0 ■	→		0 ■	10	40	48		=<2	3 - 4	>4	●	9	7
				Admissions to Neonatal ICU	%	9.4 ▼	8.8 ▲	10.8 ■	→			→			9.9	=<10	=<10		=<10	10.0-12.0	>12.0	●	7.2	10.7
				Adjusted Perinatal Mortality Rate (per 1000 babies)	/1000	7.9 ▼	3.8 ▲	10.3 ■	→		7.2 ■	→			7.2*	<8.0	<8.0		<8	8.1 - 10.0	>10	●	6.5	11.9*
				Caesarean Section Rate	%	21.4 ■	22.6 ▼	26.6 ■	→		24.7 ■	→		22.7 ▲	23.4	<25.0	<25.0		=<25.0	25-28	>28.0	●	23.6	22.2
	H			Early Booking (Completed Assessment <12+6 weeks)	%	80 ▼	80 ■	81 ▲	→		81.5 ▲	→			81.5*	=>90	=>90		=>90	75-89	<75	● ●		76.0
RO		2	Infant Health & Inequalities	Maternal Smoking Rates	%	9.5 ▲	→	→	→		10.5 ▼	→		→	10.1	<11.5	<11.5		<11.5	11.5 - 12.5	>12.5	●	11.9	9.8
				Breast Feeding Initiation Rates	%	72.8 ▲	→	→	→		71.5 ▼	→		→	72.1	>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. (%)	4904 (65.6) ▲	5087 (68.2) ▲	5178 (69.3) ▲	→		5282 (71.0) ▲	→		5267 (70.6) ▼	5267 (70.6)	7389 (100)	7389 (100)		0-15% variation	15 - 25% variation	>25% variation	● ●	4635	5348
RS				Medical Appraisal and Revalidation	%	84	83	87	→		86	→		88	86	No. Only	No. Only							
RO	K	3		Mandatory Training Compliance	%	83.3 ■	85.1 ■	87.4 ▲	→		88.1 ■	→		88.7 ▲	88.7	100	100		=>95	90 - 95	<90	●	86.8	71.9
EFFECTIVENESS OF CARE																							
RO	H	8	Acute CQUIN	Dementia	396	%	Met Q2 req's	Meeting Q3 req's	Meeting Q3 req's	→		Met Q3 req's	→		Not Meeting Q4 req's	Not Meeting Q4 req's	90	90	a	No variation		Any variation	●		
RS	H	3		Mortality Review	743	%	68.9 ▲	53.9 ■	63.9 ▲	→			→			63.9	71	80		No variation		Any variation	● ●		66.9
RO	H	11	Community CQUIN	Dementia	44	%	Met Q2 req's	Not Meeting Q3 req's	Not Meeting Q3 req's	→		Met Q3 req's	→			Met Q3 req's	80	90		No variation		Any variation	●		
RS		6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate		HSMR	96.4 Jul'11 to Jun'12	95.5 Aug'11 to Jul'12	94.2 Sep'11 to Aug'12	→		93.1 Oct'11 to Sep'12	→		92.7 Nov'11 to Oct'12	92.7								
				Peer (SHA) HSMR		HSMR	101.3	100.2	98.7	→		97.8	→		97.0	97.0								
				Peer (National) HSMR - Quarterly		HSMR	97.0	→	→	→		95.4	→		→	95.4								
	D	19		SHMI		SHMI	96.3 Jul'11-Jun'12	95.3 Aug'11-Jul'12	94.2 Sep'11-Aug'12	→		95.6 Oct'11-Sep'12	→		93.2 Nov'11-Oct'12	93.2								
RB		3	Readmission Rates (to any specialty) within 30 days of discharge - Operating Framework Definition effective April 2011	Following initial Elective Admission		No.	138 ▲	124 ■	146 ■	→		100 ■	→		112 ▼	1215	1219	1463		No Variation	0 - 5% Variation	>5% Variation	●		1463
				Following initial Elective Admission		%	1.36 ▼	1.10 ■	1.32 ■	→		0.98 ■	→		1.03 ▼	1.30	1.15	1.15		No Variation	0 - 5% Variation	>5% Variation	●		1.15
				Following initial Non-Elective Admission		No.	613 ▲	620 ▼	591 ■	→		613 ■	→		564 ■	5696	5702	6842		No Variation	0 - 5% Variation	>5% Variation	●		6842
				Following initial Non-Elective Admission		%	6.04 ▲	5.48 ■	5.33 ■	→		6.03 ■	→		5.21 ■	5.94	5.38	5.38		No Variation	0 - 5% Variation	>5% Variation	● ●		5.38
RB	K	3	Hip Fractures	Operation <24 hours of admission		%	80.0 ▲	90.0 ▲	92.9 ▲	→		70.6 ▼	→		77.8 ▲	74.7	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)		%	95 ■	95 ■	94 ▼	→		94 ■	→		94 ■	94	90	90		>/=90	89.0-89.9	<89	●	94.5	95
		3		Maternity HES		%	6.2 ▲	6.4 ▼	6.9 ▼	→		6.6 ▲	→		6.7 ▼	6.4	<15	<15		=<15	16-30	>30	●	5.4	6.0
	G	11		Data Completeness Community Services		%	No Data	>50	>50	→		>50	→		>50	>50	=>50	=>50		=>50		<50	●		
PATIENT EXPERIENCE																							
RB	A	2	A&E 4-hour waits	4-hour waits		%	93.4 ▲	91.5 ▼	91.5 ■	86.5 ▼	90.2 ▼	88.9 ▼	91.9 ▲	92.4 ▲	92.2 ▲	93.00	=>95	=>95	b	=>95		<95	XXX	96.99	95.38
	A	2		4-hour waits (inc. Sandwell on-site GP Triage activity)		%	93.4 ▲	92.0 ▼	92.0 ■	89.0 ▼	90.2 ▼	89.6 ▼	93.3 ▲	92.4 ▲	92.8 ▲	93.30	=>95	=>95		=>95		<95	● ● ●		
	A	2		4-hr waits (inc. S'well GP Triage & BMEC OP Fast Track)		%	93.7 ▲	92.3 ▼	92.4 ▲	89.0 ▼	90.6 ▼	90.0 ▼	93.3 ▲	92.9 ▲	93.1 ▲	93.50	=>95	=>95		=>95		<95	● ● ●		
	D	3	A&E Timeliness	Total Time in Department (95th centile)		h : m	4 : 58 ▼	5 : 38 ▼	5 : 21 ▲	→		6 : 14 ▼	→		5 : 06 ▲	5 : 00	=<4hrs	=<4hrs		=<4hrs		=<4hrs	● ●		3 : 59
	D			Time to Initial Assessment (=<15 mins)(95th centile)		mins	18 ■	19 ▼	17 ▲	→		21 ▼	→		14 ■	17	<15	<15		<15		<15	● ●		21
	D			Time to treatment in department (median)		mins	53 ▲	54 ▼	52 ▲	→		54 ▼	→		52 ▲	58	=<60	=<60		=<60		>60	●		59
	D		A&E Patient Impact	Unplanned re-attendance rate		%	7.88 ▲	7.59 ▲	7.79 ▼	→		7.46 ▲	→		7.57 ▼	7.87	=<5.0	=<5.0		=<5.0		>5.0	● ● ●		8.66
	D			Left Department without being seen rate		%	4.23 ▲	4.77 ▼	4.06 ▲	→		4.60 ▼	→		3.78 ▲	4.72	=<5.0	=<5.0		=<5.0		>5.0	●		4.83
RB		21	Reporting Times of Imaging Requests from ED - **pecentage reported within 24 hours / next day**	Plain Radiography		%	46	63 ■	75 ▲	→		98 ■	→		99 ▲	99*	90	90		No variation		Any variation	●		
				Ultrasound		%	100	98 ■	100 ▲	→		99 ▼	→		100 ▲	100*	90	90		No variation		Any variation	●		
				MRI		%	60	76 ■	91 ▲	→		100 ▲	→		75 ■	75*	90	90		No variation		Any variation	● ●		
				CT		%	99	99 ■	99 ■	→		99 ■	→		100 ▲	100*	90	90		No variation		Any variation	●		

Exec Lead							September	October	November	December			January			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	H	18	Ambulance Turnaround	Clinical Handovers completed within 15 minutes		%	77.6 ▼	70.3 ▼	55.0 ▼	47.1 ▲	75.9 ▼	63.7 ▲	70.4 ▲	78.2 ▲	74.8 ▲	74.8*	=>85	=>85	c	=>85		<85	● ● ●		
	H			Average Turnaround Time		m : s	33.07 ▼	35:56 ▼	34:40 ▲	38:41 ▼	37:29 ▼	38:00 ▼	35:43 ▲	34:28 ▲	35:02 ▲	33:42	=<30:00	=<30:00		=<30:00		>30:00	●		29:23
	H			In Excess of 60 minutes		No.	163 ▼	232 ▼	201 ▲	128 ▼	195 ▼	323 ▼	74 ▲	108 ▲	182 ▲	1775	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.	56	62	68	→		38	→		60	597	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.	63 ▲	64 ▲	65 ▲	→		67 ▲	→			67	63	65		No variation		Any variation	●		
RO	H	8		End of Life Care	372	%	60 ▲	59 ▼	65 ▲	→		62 ▼	→			62	52	53		No variation		Any variation	●		
RS	H	10		Every Contact Counts - Alcohol	372	%	57 ■	→	61 ▲	→		→	→			61	66	80		No variation		Any variation	●		
RO	H	12		Every Contact Counts - Smoking	372	%	Baseline established	→	→	→		→	→			Baseline established				No variation		Any variation	●		
RO	H	11	Community CQUIN	Pt. (Community) Exp'ce - Personal Needs	44	Score	91.5 ▼	96.0 ▲	93.0 ▼	→		94.0 ▲	→			94.0	90	90		No variation		Any variation	●		
RO	H	11		Net Promoter	88	No	81 ■	88 ▲	86 ▼	→		85.0 ▼	→			85	75	75	a	No variation		Any variation	●		
RO	H	11		Every Contact Counts	132	%	Baseline established	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	%	Baseline established	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		Q2 Return Submitted	→	→	→		Q3 Return Submitted	→		→	Q3 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●		
RS	H	13		Neonatal - Hypothermia Treatment	73	%	Q2 Return Submitted	→	→	→		Q3 Return Submitted	→		→	Q3 Return Submitted	Derive Base	Derive Base		No variation		Any variation	●		
RS	H	13		Neonatal - Discharge Planning / Family Experience and Confidence	122	%	Q2 Return Submitted	→	→	→		Q3 Return Submitted	→		→	Q3 Return Submitted	Derive Base	Derive Base		Met		Not Met	●		
RS	H	12		HIV - Optmum Therapy	147	%	Q2 Return Submitted	→	→	→		Q3 Return Submitted	→		→	Q3 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●		
RB		15	Elective Access Contact Centre	Number of Calls Received		No.	11492	13408	12725	→		9812	→		18309	125524	No. Only	No. Only						137824	111793
				Average Length of Queue		mins	0.39 ▼	0.37 ▲	0.39 ▼	→		0.27 ▲	→		3.19 ■	3.19*	<1.0	<1.0		<1.0	1.0-2.0	>2.0	●	0	0.21
				Maximum Length of Queue		mins	13.2 ▼	33.2 ▼	10.1 ■	→		8.5 ▲	→		29.0 ■	29.0*	<6.0	<6.0		<6.0	6.0-12.0	>12.0	●	6.3	10
			Telephone Exchange	Number of Calls Received		No.	70935	83144	78030	→		75409	→		80912	754488	No. Only	No. Only						909301	849502
				Calls Answered		%	90.7	89.4	91.5	→		88.1	→		88.5	90.6	No. Only	No. Only						90.5	90.2
				Answered within 15 seconds		%	64.4	54.3	60.6	→		54.4	→		54.5	56.6	No. Only	No. Only						52.4	52.5
				Answered within 30 seconds		%	77.1	69.5	75.3	→		69.6	→		69.4	71.7	No. Only	No. Only						68.4	68.1
				Average Ring Time		Secs	19.5	25.8	20.5	→		24.3	→		24.4	24.4*	No. Only	No. Only						21.2	25
				Longest Ring Time		Secs	734	782	615	→		977	→		692	692*	No. Only	No. Only						731	718
TRANSFORMATION PLAN																									
RB		2	Spells	Elective IP		No.	672 ■	721 ▼	836 ▲	→		643 ▼	→		726 ▼	8189	9209	10981	d	No Variation	0 - 2% Variation	>2% Variation		11748	10610
				Elective DC		No.	4213 ▲	4893 ▼	4801 ▲	→		3960 ▲	→		4734 ▼	44097	39400	46983		No Variation	0 - 2% Variation	>2% Variation		53959	53685
				Total Elective		No.	4885 ▲	5614 ▼	5637 ▲	→		4603 ▲	→		5460 ▼	52286	48609	57964		No Variation	0 - 2% Variation	>2% Variation	●	65707	64295
				Total Non-Elective		No.	4618 ▼	5016 ▲	4841 ▼	→		4858 ■	→		4783 ▼	47887	47471	57105		No Variation	0 - 2% Variation	>2% Variation	●	59000	55675
			Outpatient Attendances	New		No.	13605 ▲	15781 ▲	15435 ▼	→		12523 ▲	→		15090 ▼	143955	120920	144072		No Variation	0 - 2% Variation	>2% Variation	●	163493	159051
				Review		No.	30151 ▲	34608 ▼	32451 ▼	→		27199 ▲	→		32549 ▼	322284	363031	430846		No Variation	0 - 2% Variation	>2% Variation	●	440812	421494
			A/E Attendances	Type I (Sandwell & City Main Units)		No.	13076 ■	13884 ▲	13609 ▲	5647 ▼	7950 ■	13597 ▲	5438 ▼	7648 ■	13086 ▼	146502	146670	175107		No Variation	0 - 2% Variation	>2% Variation	●	181494	177201
				Type II (BMEC)		No.	1973 ▼	2158 ▲	2055 ▲	→	1847 ▼	1847 ▼	→	1831 ▼	1831 ▼	22722	27016	32254		No Variation	0 - 2% Variation	>2% Variation	● ● ●	36756	36362
		16	Community	Adult - Aggregation of 18 Individual Service Lines		No.	45297 ▼	51293 ▲	42495 ■	→		39919 ■	→			410566	367092	492472		No Variation	0 - 2% Variation	>2% Variation	●	461797	493163
				Children - Aggregation of 4 Individual Service Lines		No.	12435 ▲	15076 ■	12700 ■	→		10571 ▲	→			112939	117505	158876		No Variation	0 - 2% Variation	>2% Variation	●	102773	143400
		2	Outpatient Efficiency	New : Review Rate		Ratio	2.22 ▲	2.19 ▲	2.10 ▲	2.58 ▼	2.00 ▼	2.17 ▼	2.48 ▲	2.02 ▼	2.16 ▲	2.24	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	●	2.70	2.65
				DNA Rate - New Referrals		%	11.9 ▲	12.0 ▼	12.8 ▼	→		12.1 ▲	→		13.1 ▼	11.4	10.0	10.0		No variation		Any variation	● ●	13.1	11.8
				DNA Rate - Reviews		%	11.0 ▼	11.1 ▼	11.1 ■	→		11.1 ■	→		12.2 ▼	10.3	10.0	10.0		No variation		Any variation	●	11.9	10.5

Exec Lead			TRANSFORMATION PLAN (Continued)			September	October	November	December			January			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	A&E 4-hour waits	%	93.9 ▲	91.5 ▼	91.5 ■	86.5 ▼	90.2 ▼	88.9 ▼	91.9 ▲	92.4 ▲	92.2 ▲	93.00	=>95	=>95		=>95		<95	XXX	96.99	95.38
	C			Acute Delayed Transfers of Care	%	3.6 ■	2.5 ■	3.4 ▼	1.6 ▲	1.8 ■	1.7 ▲	0.8 ▲	4.5 ■	2.7 ▼	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	%	0.7 ▼	0.5 ▲	0.8 ■	0.4 ▲	0.5 ■	0.4 ■	1.9 ■	0.9 ■	1.3 ■	0.6	<0.8	<0.8		<0.8	0.8 - 1.0	>1.0	●	0.8	0.6
				Average Length of Stay	Days	3.6 ▼	3.6 ■	3.4 ▲	4.4 ■	3.4 ▼	3.8 ▼				3.7	4.3	4.3		No Variation	0 - 5% Variation	>5% Variation	●	4.3	4.2
				Day of Surgery (IP Elective Surgery)	%	86.5 ▼	92.6 ▲	94.4 ▲	92.9 ▼	95.2 ▲	94.2 ▼	94.3 ▲	92.9 ▼	93.5 ▼	91.9	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	●	88.7	89.5
				Daycase Rate - All Procedures	%	85.0 ■	86.0 ▲	84.1 ▼	85.7 ▲	84.5 ▲	85.0 ▲	87.0 ▲	84.9 ▲	85.7 ▲	83.7	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	●	81.5	82.7
RO		7	Sickness Absence	Long Term (> 28 days)	%	3.28 ▲	3.43 ▼	3.29 ▲	→		3.45 ▼	→		3.58 ▼	3.58 (Q4)	<2.15	<2.15		<2.15	2.15-2.50	>2.50		3.12	2.95
				Short Term (<28 days)	%	0.91 ▼	1.08 ■	1.18 ▼	→		1.13 ▲	→		1.28 ■	1.28 (Q4)	<1.00	<1.00		<1.00	1.00-1.25	>1.25		1.05	0.95
	D			Total	%	4.19 ▼	4.51 ▼	4.47 ▲	→		4.58 ▼	→		4.86 ▼	4.86 (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	%	87.0	83.2	83.8	→		77.9	→		76.3	84.6	No. Only	No. Only						86.2	87.2
				Nurse Bank Shifts covered	No.	5010 ▲	4908 ▲	5437 ▼	→		4839 ▲	→		4899 ▼	48983	39150	46980		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	● ● ●	54952	56396
				Nurse Agency Shifts covered	No.	642 ▲	1094 ▼	1219 ▼	→		1379 ▼	→		1371 ▲	8704	3192	3830		0 - 5% Variation	5 - 10% Variation	>10% Variation	● ● ●	4550	6948
KEY ACCESS TARGETS																								
RB	A	1	Cancer	2 weeks	%	93.0 ▼	95.2 ▲	94.8 ▼	→		94.0 ▼	→			94.5	=>93	=>93	e	No variation		Any variation	●	94.5	94.8
	A			2 weeks (Breast Symptomatic)	%	93.3 ▼	97.9 ▲	93.7 ▼	→		93.3 ▼	→			96.3	=>93	=>93		No variation		Any variation	●	94.7	95.8
	A			31 Day (diagnosis to treatment)	%	98.7 ▼	99.4 ▲	100 ▲	→		99.3 ▼	→			99.5	=>96	=>96		No variation		Any variation	●	99.7	99.5
	A			31 Day (second/subsequent treatment - surgery)	%	97.6 ▼	99.0 ▲	100 ▲	→		100 ■	→			99.3	=>94	=>94		No variation		Any variation	●	99.5	100.0
	A			31 Day (second/subsequent treatment - drug)	%	100 ■	100 ■	100 ■	→		97.4 ■	→			100	=>98	=>98		No variation		Any variation	●	100	99.2
	A			31 Day (second/subsequent treat - radiotherapy)	%	100 ■	n/a	n/a	→		n/a	→			100	=>94	=>94		No variation		Any variation	●	100	100
	A			62 Day (urgent GP referral to treatment)	%	80.2 ■	85.4 ■	90.7 ▲	→		85.2 ▼	→			86.7	=>85	=>85		No variation		Any variation	●	88.0	86.9
	A			62 Day (referral to treat from screening)	%	96.0 ▲	93.5 ▼	100 ▲	→		94.1 ▼	→			97.2	=>90	=>90		No variation		Any variation	●	99.2	98.5
	H			62 Day (referral to treat from hosp specialist)	%	96.0 ▼	94.7 ▼	91.3 ▼	→		95.2 ▲	→			93.6	=>85	=>85		No variation		Any variation	●	95.6	91.6
RB	A	2	RTT 18-Weeks	Admitted Care (RTT <18 weeks)	%	93.3 ▼	93.5 ▲	93.1 ▼	→		94.9 ▲	→		93.9 ▼	93.9*	=>90.0	=>90.0	f	=>90.0	85-90	<85.0	●	92.7	93.2
	A			Non-Admitted Care (RTT <18 weeks)	%	96.5 ▼	98.4 ▲	98.8 ▲	→		98.5 ▼	→		98.8 ▲	98.8*	=>95.0	=>95.0		=>95.0	90 - 95	=<90.0	●	96.7	97.5
	A			Incomplete Pathway (RTT <18 weeks)	%	97.0 ▼	97.1 ▲	96.9 ▼	→		96.4 ▼	→		96.0 ▼	96.0*	=>92.0	=>92.0		=>95.0	87 - 92	=<87.0	●		97.2
	E			Treatment Functions Underperforming	No.	4 ▼	6 ▼	3 ▲	→		3 ■	→		3 ■	3*	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	●		100
RB	E	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks	%	1.47 ■	1.98 ▼	1.68 ▲	→		1.85 ▼	→		1.98 ▼	1.98*	<1.0	<1.0		<1.0	1.0 - 5.0	>5.0	●		0.99
RB	C	2	Delayed Transfers of Care	Acute	%	3.6 ■	2.5 ■	3.4 ▼	1.6 ▲	1.8 ■	1.7 ▲	0.8 ▲	4.5 ■	2.7 ▼	2.9	<3.5	<3.5		<3.5	3.5 - 5.0	>5.0	●	4.6	5.2
				Pt's Social Care Delay	No.	11 ■	9 ▲	13 ▼	0 ▲	2 ▲	2 ▲	1 ▼	5 ▼	6 ▼	6	<18	<18		No Variation	0 - 10% Variation	>10% Variation		23	13
				Pt.'s NHS & NHS plus S.C. Delay	No.	10 ■	7 ■	6 ▲	2 ▲	4 ▼	6 ■	1 ▲	8 ■	9 ▼	9	<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	%	0.7 ▼	0.5 ▲	0.8 ■	0.4 ▲	0.5 ■	0.4 ■	1.9 ■	0.9 ■	1.3 ■	0.6	<0.8	<0.8	g	<0.8	0.8 - 1.0	>1.0	●	0.8	0.6
	H			28 day breaches	No.	1 ■	0 ■	0 ■	→		0 ■	→		0 ■	1	2	3		3 or less	4 - 6	>6	●	1	1
				Sitrep Declared Late Cancellations by Speciality	No.	34 ■	28 ■	53 ■	7 ■	12 ■	19 ■	36 ■	29 ■	65 ■	316	267	320		0-5% variation	5 - 15% variation	>15% variation	● ●	500	363
RB		10	Cardiology	Primary Angioplasty (<150 mins)	%	76.9 ■	84.2 ■	88.2 ▲	100 ■	100 ■	100 ▲				90.8	=>80	=>80		=>80	75-79	<75	●	90.7	88.4
				Rapid Access Chest Pain	%	97.7 ■	97.0 ▲	98.5 ■	100 ■	66.7 ▼	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 ■	→		100 ■	→		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, Deputy Director of Finance
DATE OF MEETING:	28 February 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 (January):
There were 3 areas of underperformance during the month of January; A&E 4-hour waits, RTT Delivery in all specialties and Diagnostic Waits in excess of 6 weeks.

The overall average weighted score for service performance for the month is 2.64. CQC Registration Status remains Unconditional. As such the Trust continues to attract a **PERFORMING** classification.

Financial Performance (January):
The weighted overall score is 2.90 with underperformance reported in 3 areas; Better Payment Practice Code (Value), Better Payment Practice Code (Volume) and Creditor Days. The classification for the month of January remains **PERFORMING.**

Foundation Trust Compliance Summary report (January):

Within the Service Performance element of the Risk Rating for the month of January the Trust underperformed against the A&E 4-hour wait target.

The overall score for the month remains 1.0 which attracts an **AMBER / GREEN** Governance Rating.

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

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		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)	Quarter 1 2012/13	Score	Weight x Score	Quarter 2 2012/13	Score	Weight x Score	Quarter 3 2012/13	Score	Weight x Score	January 2012/13
A/E Waits less than 4-hours	1.00	95.00%	94.00 - 95.00%	94.00%	95.14%	3	3.00	93.91%	0	0.00	90.60%	0	0.00	92.20%
MRSA Bacteraemia	1.00	0		>1.0SD	1	3	3.00	1	3	3.00	1	3	3.00	1
Clostridium Difficile	1.00	0		>1.0SD	6	3	3.00	10	3	3.00	8	3	3.00	3
18-weeks RTT 90% Admitted	1.00	=>90.0%	85.00 - 90.00%	85.0%	93.8%	3	3.00	94.3%	3	3.00	93.6%	3	3.00	93.9%
18-weeks RTT 95% Non -Admitted	1.00	=>95.0%	90.00 - 95.00%	90.0%	98.4%	3	3.00	98.0%	3	3.00	98.5%	3	3.00	98.8%
18-weeks RTT 92% Incomplete	1.00	=>92.0%	87.00 - 92.00%	87.0%	97.1%	3	3.00	97.4%	3	3.00	96.8%	3	3.00	96.0%
18-weeks RTT Delivery in all Specialities (number of treatment functions)	1.00	0	1 - 20	>20	11	2	2.00	11	2	2.00	12	2	2.00	3
Diagnostic Test Waiting Times (percentage 6 weeks or more)	1.00	<1%	1.00 - 5.00%	5%	0.87%	3	3.00	0.90%	3	3.00	1.84%	2	2.00	1.98%
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.00 - 93.00%	88.0%	94.5%	3	1.50	94.4%	3	1.50	94.7%	3	1.50	>93.0%*
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms	0.50	93.0%	88.00 - 93.00%	88.0%	96.2%	3	1.50	98.1%	3	1.50	95.3%	3	1.50	>93.0%*
Cancer - 31 day diagnosis to treatment for all cancers	0.25	96.0%	91.00 - 96.00%	91.0%	99.8%	3	0.75	99.1%	3	0.75	99.6%	3	0.75	>96.0%*
Cancer - 31 day second or subsequent treatment (surgery)	0.25	94.0%	89.00 - 94.00%	89.0%	99.7%	3	0.75	98.5%	3	0.75	99.7%	3	0.75	>94.0%*
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	99.2%	3	0.75	>98.0%*
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	100.0%	3	0.75	>94.0%*
Cancer - 62 day urgent referral to treatment for all cancers	0.50	85.0%	80.00 - 85.00%	80.0%	86.4%	3	1.50	86.7%	3	1.50	87.1%	3	1.50	>85.0%*
Cancer - 62 day referral to treatment from screening	0.50	90.0%	85.00 - 90.00%	85.0%	100.0%	3	1.50	93.2%	3	1.50	95.5%	3	1.50	>90.0%*
Delayed Transfers of Care	1.00	<3.5%	3.5 - 5.00%	>5.0%	3.50%	2	2.00	<3.50%	3	3.00	<3.50%	3	3.00	2.70%
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%
VTE Risk Assessment	1.00	90.0%	80.00 - 90.00%	80.0%	92.13%	3	3.00	89.96%	2	2.00	91.08%	3	3.00	91.10%
Sum (all weightings)	**14.00**													
Average Score (Integrated Performance Measures)							**2.86**			**2.64**	* projected		**2.64**	* projected

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

Quarter 1 2012/13	Quarter 2 2012/13	Quarter 3 2012/13	January 2012/13
Performing	**Performing**		**Performing**

Overall Quality of Service Rating

Quarter 1 2012/13	Quarter 2 2012/13	Quarter 3 2012/13	January 2012/13
Performing	**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 TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2012/13

Financial Indicators				SCORING			2012 / 2013			2012 / 2013			2012 / 2013			2012 / 2013	
Criteria	**Metric**	**Weight (%)**		**3**	**2**	**1**	**October**	**Score**	**Weight x Score**	**November**	**Score**	**Weight x Score**	**December**	**Score**	**Weight x Score**	**January**	**Score**
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	**0.00%**	**3**	**0.15**	**0.00%**	**3**	**0.15**	**0.00%**	**3**	**0.15**	**0.57%**	**3**
Year to Date	YTD Operating Performance	25	20	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	**0.40%**	**3**	**0.6**	**0.58%**	**3**	**0.6**	**0.98%**	**3**	**0.6**	**1.32%**	**3**
	YTD EBITDA		5	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	**6.01%**	**3**	**0.15**	**6.11%**	**3**	**0.15**	**6.29%**	**3**	**0.15**	**6.52%**	**3**
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	**0.00**	**3**	**0.6**	**0.00**	**3**	**0.6**	**0.00**	**3**	**0.6**	**0.01**	**3**
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	**6.21%**	**3**	**0.15**	**6.21%**	**3**	**0.15**	**6.66%**	**3**	**0.15**	**6.71%**	**3**
	Rate of Change in Forecast Surplus or Deficit		15	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	**0.00%**	**3**	**0.45**	**0.00%**	**3**	**0.45**	**0.00%**	**3**	**0.45**	**0.00%**	**3**
Underlying Financial Position	Underlying Position (%)	10	5	Underlying breakeven or Surplus	An underlying deficit that is less than 2% of underlying income.	An underlying deficit that is greater than 2% of underlying income	**0.91%**	**3**	**0.15**	**0.91%**	**3**	**0.15**	**0.91%**	**3**	**0.15**	**1.48%**	**3**
	EBITDA Margin (%)		5	Underlying EBITDA equal to or greater than 5% of underlying income	Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income	Underlying EBITDA less than 1% of underlying income	**6.21%**	**3**	**0.15**	**6.21%**	**3**	**0.15**	**6.22%**	**3**	**0.15**	**6.71%**	**3**
Finance Processes & Balance Sheet Efficiency	Better Payment Practice Code Value (%)	20	2.5	95% or more of the value of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the value of NHS and Non NHS bills are paid within 30days	Less than 60% of the value of NHS and Non NHS bills are paid within 30 days	**96.00%**	**3**	**0.075**	**93.00%**	**2**	**0.05**	**95.00%**	**3**	**0.075**	**88.00%**	**2**
	Better Payment Practice Code Volume (%)		2.5	95% or more of the volume of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days	Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days	**94.00%**	**2**	**0.05**	**95.00%**	**3**	**0.075**	**94.00%**	**2**	**0.05**	**92.00%**	**2**
	Current Ratio		5	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	**1.10**	**3**	**0.15**	**1.10**	**3**	**0.15**	**1.11**	**3**	**0.15**	**1.13**	**3**
	Debtor Days		5	Debtor days less than or equal to 30 days	Debtor days greater than 30 and less than or equal to 60 days	Debtor days greater than 60	**13.19**	**3**	**0.15**	**14.89**	**3**	**0.15**	**12.95**	**3**	**0.15**	**13.60**	**3**
	Creditor Days		5	Creditor days less than or equal to 30	Creditor days greater than 30 and less than or equal to 60 days	Creditor days greater than 60	**41.81**	**2**	**0.1**	**41.50**	**2**	**0.1**	**39.03**	**2**	**0.1**	**41.63**	**2**
						Weighted Overall Score			**2.93**			**2.93**			**2.93**		

*Operating Position = Retained Surplus/Breakeven/deficit less impairments

Assessment Thresholds	
Performing	> 2.40
Performance Under Review	2.10 - 2.40
Underperforming	< 2.10

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:	28 February 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 January 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)	4
Contractual Position (RAG as per SOM guidance)	Not required by SHA

Key Features of the return for January are:

- TFA Progress
  – January TFA milestones (2) – agreement with SHA to delay at this stage, pending further discussion on TFA milestones – both indicated as Not Fully Achieved.
- Governance – A&E performance for the month of January is 92.2% (operational threshold 95.0%).
- Financial Risk Triggers – actual Capital Expenditure is less than 75% of plan for the year to date.
- Contractual – a number of areas remain subject to performance improvement notices received during November. 2 relating to local quality requirements; Maternity Early Booking and WMAS Turnaround Times. 3 notices relating to A&E 4-hour wait, 6-week diagnostic waits and RTT Admitted Care (T&O and Plastic Surgery).

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.

SELF-CERTIFICATION RETURNS
Organisation Name:
Sandwell & West Birmingham Hospitals NHS Trust
Monitoring Period:
January 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:	January 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)	4

*** 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:	TO BE ADDED	Print Name:	Mr R Samuda
on behalf of the Trust Board	Acting in capacity as:	Chairman	
Signed by:	TO BE ADDED	Print Name:	Mr M Sharon
on behalf of the Trust Board	Acting in capacity as:	Acting CEO	

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

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January 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**	**Mr M Sharon**	**28/02/2013**
Chair	**TO BE ADDED**	**Mr R Samuda**	**28/02/2013**

QUALITY

Information to inform the discussion meeting

Sandwell & West Birmingham Hospitals NHS Trust

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Board Action
1	SHMI - latest data	Score	97.5	96.8	96.2	96.0	96.3	95.3	94.2	94.2	94.2	94.2	95.6	93.2	SHMI data relates to period November 2011 - October 2012 which is the most recent period for which data is available (source HED).
2	Venous Thromboembolism (VTE) Screening	%	92.4	92.6	92.4	92.9	91.0	91.4	87.5	91.0	91.5	91.7	90.2	91.1	
3a	Elective MRSA Screening	%	39.4	40.8	38.1	39.9	40.7	42.0	39.5	38.7	104.6	96.2	112.0	130.9	Data reported is screens not matched with patients. Screens matched to patients for the month is 59.8%.
3b	Non Elective MRSA Screening	%	58.7	61.7	70.3	64.1	66.3	68.0	69.1	66.1	66.0	78.6	78.4	80.7	Data reported is screens not matched with patients. Screens matched to patients for the month is 67.3%.
4	Single Sex Accommodation Breaches	Number	8	0	0	0	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	8	2	8	7	9	10	4	2	3	1	2	0	No incidents were reported in January
6	"Never Events" occurring in month	Number	1	1	0	0	0	1	0	1	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	19	23	20	19	17	14	9	10	8	5	4	3	3 open alerts. Spinal needles remain a manufacturing problem. Risk assessment undertaken and solution close for Laryngoscope handles. Awaiting ackowledgment on chlorhexidene alert.
9	RED rated areas on your maternity dashboard?	Number	4	4	2	1	2	4	3	3	2	4	4	2	December - Midwifery Staff Sickness Absence (5.4%) and Number of Deliveries 555 (ideal <520).
10	Falls resulting in severe injury or death	Number	6	2	3	0	1	1	2	6	0	2	2	1	
11	Grade 3 or 4 pressure ulcers	Number	5	7	12	4	2	2	3	3	1	1	6		Figures since June 12 have been amended to show total number of hospital acquired avoidable grade 3 and 4 pressure sores in month.
12	100% compliance with WHO surgical checklist	Y/N	No	No	No	No	No	No	No	No	No	No	No	No	Compliance was 99.83% in January (3613 records compliant of 3619 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	69	72	60	51	61	62	79	56	62	68	38	60	
14	Agency as a % of Employee Benefit Expenditure	%	1.8	2.5	1.7	1.4	1.9	1.9	2.2	1.8	2.3	2.45	2.91	2.62	
15	Sickness absence rate	%	4.39	4.13	4.06	4.51	4.23	4.16	4.10	4.18	4.51	4.47	4.58	4.86	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	78	72	74	78	69	71	79	84	83	87	86	88	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	4	4	4	4	Includes effect of assumed working capital facility
Weighted Average		**100%**						**3.7**	**3.7**	**3.7**	**3.7**	
Overriding rules												
Overall rating								**4**	**4**	**4**	**4**	

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				
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				
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				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				
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No				
7	Interim Finance Director in place over more than one quarter end	No	No	No	No				
8	Quarter end cash balance <10 days of operating expenses	No	No	No	No				
9	Capital expenditure < 75% of plan for the year to date	No	No	No	Yes				Programme expected to accelerate in Q4 as projects near completion. The timing of land transactions are however expected to continue to contribute to slippage but these are committed in the medium term.
10	Yet to identify two years of detailed CIP schemes	Yes	Yes	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				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				Status Changed October 2012
			Patients dying at home / care home	50%		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				
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	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				
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	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				December performance (drug treatments) was 97.4% (38 of 39 patients). Performance for the quarter was 99.2%. Other 31 day targets were met for each month during the quarter. January 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				December 2012 performance confirmed from National Cancer Waiting Times system report. January 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				December 2012 performance confirmed from National Cancer Waiting Times system report. January performance projected.
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes				December 2012 performance confirmed from National Cancer Waiting Times system report. January 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				Performance in January was 92.2%. Performance inclusive of Sandwell GP Triage activity was 92.8% 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				
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes				
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		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				
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	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				
				TOTAL		**1.0**	**2.0**	**1.0**	**1.0**	**0.0**	**0.0**	**0.0**	
		RAG RATING :				AG	AR	AG	AG	G	G	G	

GOVERNANCE RISK RATINGS

Sandwell & West Birmingham Hospitals NHS Trust

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

Historic Data	Current Data

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

GOVERNANCE RISK RATINGS

Sandwell & West Birmingham Hospitals NHS Trust

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

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

Refresh GRR for New Quarter

			Historic Data			Current Data				
Overriding Rules - Nature and Duration of Override at SHA's Discretion										
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**	**0.0**	**0.0**	**0.0**	
			AG	AR	AG	AG	G	G	G	

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				
2	Are all current year contracts* agreed and signed?	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				
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes				
5	Are there any disputes over the terms of the contract?	No	No	No	No				
6	Might the dispute require third party intervention or arbitration?	No	No	No	No				
7	Are the parties already in arbitration?	No	No	No	No				
8	Have any performance notices been issued?	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, all of which have attracted Performance Notices recently, remain below operational performance thresholds.
9	Have any penalties been applied?	No	Yes	Yes	Yes				

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

TFA Progress

Feb-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	Not fully achieved		
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			
20	Submission of FT application to DH	Mar-13			
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.

Notes

Ref	Indicator	Details
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
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 Department of Health's website.
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
NHS Trust

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:	**28 February 2013**

EXECUTIVE SUMMARY:

Reporting process review:

- KPI's have been reviewed with each work stream
- Presented to TPSG 8/2/13 (earlier than planned)
- On target for feedback to Trust Board 28/2/13

Theatres:

- **Booking Rules** – policy completed, crib sheets validated by 70% consultants, theatre booking policy to be agreed at divisional governance group
- **Theatre Utilisation** – initial analysis completed, amendment of theatre utilisation policy has commenced. Waste walk and workout to begin on Feb 12th
- **Performance Management** - analysis of causes of delay to start times completed, start-up protocol has been proposed, process mapping exercise completed, areas identified for roll out of performance board
- **Step Down** - Analysis completed, scheduling meetings standardised across site, Lithotripsy to move to EPAU from April
- **Pre-Op 'One Stop Shop' -** Funding approved for relocation of preoperative assessment at SGH, One stop shop on-going, all consultants/registrars trained in eDTA. Next step - relocation of centralised preoperative assessment at SGH
- **Centralised Booking -** 95% of SOPs signed off by Elective access manager
- **Capacity Strategy -** First draft model for general surgery and colorectal surgery created

Community:

- SPARTIC in process of developing a waiting list
- Pilot SPARTIC updating discharge planning with bed and waiting list status began this week
- Work complete around prep for eBMS at Henderson & Leasowes information with EPR
- Amputee Pathway complete taken to Steering Group for sign off

Urgent Care

- Ambulance Assessment Unit trial successful and adopted
- Visualisation and performance review format within ED ongoing
- Standardised Clinical Pathways project ongoing using West Mercia guidelines
- Started to implement MSS Patient First computer system
- ED/MAU – joint approach to establishing a CDU location and process
- ED daily beach analysis to target and improve root causes
- Ambulance assessment 4 trolley bay (nurse led) implemented
- 6 month process improvement plan identified

Outpatients:

- Deep Dive + review of clinic productivity to continue with emphasis to be placed on final review meetings with Exec sponsors.
- Workstream focus to switch emphasis to pathway redesign, looking to set clear performance targets for all clinics.
- Roll out partial booking for follow ups from end of February 2013
- Trust-wide 7xOP quality standards presented to CD away day and TPSG

Patient Flow:

- Focus remains targeting Emergency Flow to support current ED performance priorities.
- Shift in emphasis from beds to named patients with high focus on delayed discharges
- Working to embed good practice; board rounds, daily discharge reviews, medically fit etc. patients, use of eBMS
- Reduction in length of stay; 3.8 days to 3.5 days

TPRS focus:

- Intensive support now being provided in Medicine to show detail of 2013/14 TSP's and aid affective decision making
- TSO currently reviewing all future year TSP submissions to identify true Transformation projects to ensure alignment of TSO workstream support.
- Work has commenced through COO to prepare for 2015/16 TSP generation

REPORT RECOMMENDATION:

The Board is asked 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		

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 19 February 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Clinical Service Reconfiguration Programme Board

Venue Meeting Room, Corporate Suite (D29) **Date** 7th February 2013

Present:

Dr J Berg (part)	Mrs G Hunjan	Mrs J Dunn
Ms G Gadd	Mrs A Geary	Mrs J Kinghorn
Professor R Lilford (Chair)	Mr M Sharon	Mr R White

In Attendance:

Mr P Hazle
Dr C Wright

Secretariat:

Mrs L Broadway

MINUTES	PAPER REFERENCE
1. APOLOGIES FOR ABSENCE	
Apologies were received from Miss R Barlow, Mr M Beveridge, Mr H Kang, Mrs S Murray, Mr G Seager and Dr R Stedman.	
2. CHAIRMANSHIP	
Professor Lilford reminded the Board that he had taken over as Chair of the Board from Mrs Hunjan with immediate effect.	
3. MINUTES OF THE PREVIOUS MEETING	**SWBRB (07/02) 02**
The minutes of the meeting held on 6th December 2012 were accepted as a true and accurate record.	
4. MATTERS ARISING NOT ON THE AGENDA	
4.1 Adverse Incidents/Events/Complaints relating to Recent Reconfiguration	
Mrs Dunn reported that she had ascertained from the Risk Management Department that no complaints or adverse incidents had been received/recorded that linked to reconfiguration of clinical services.	
4.2 Updated Terms of Reference	**SWBRB (07/02) 09**

MINUTES	PAPER REFERENCE
The Terms of Reference of the Board Version 3 (Draft 1) were received. It was noted that the membership had been updated to reflect staff changes and current reconfigurations. It was explained that named lead clinicians would change according to live reconfiguration projects. It was proposed that Dr Christine Wright be included as a member of the Board in view of the potential reconfiguration of clinical haematology services. This was agreed. Following a query from Professor Lilford, it was noted that the Programme Board had been re-established in June 2011 and would continue to meet until 18 months after delivery of reconfiguration (to ensure that 12 month evaluation was undertaken and resulting action was developed). Mr Sharon advised that this could be re-assessed in light of other circumstances (e.g. MMH) but that the Board would be required to continue to meet for the foreseeable future. It was noted that reference to PCT/CCGs would need to be updated from April 2013. The Terms of Reference would be relevant for the next 12 months.	
ACTIONS: Mrs Dunn to update Terms of Reference in respect of reference to PCTs. Dr Wright to be added as a member of the Board.	
5 CLINICAL HAEMATOLOGY – POTENTIAL RECONFIGURATION	
Dr Wright and Mr Hazle were in attendance for this item to present the clinical case for change for clinical haematology services. A copy of the Clinical Case for Change document and a presentation hand-out were received and discussed. It was noted that a review of inpatient services currently provided on both hospital sites had commenced in 2012 following issues raised by the clinical team and a recommendation from a peer review follow up visit. Haematology Oncology inpatients were currently based at Sandwell Hospital (Level 2b) and haemoglobinopathy inpatients were primarily based at City Hospital. A peer review recommendation made in March 2012 had advised that a strategic discussion needed to take place between the Directorate and the Trust Board to explore the feasibility of locating all inpatients on one site. It was felt that this way forward would improve patient care, strengthen the consultant body and provide better junior doctor support. Clinical quality was another important driver for change. The haematology oncology service served the local district population and haemoglobinopathy service served the local population and surrounding areas and took Regional and supra-regional referrals. It was anticipated that referrals to the haemaglobinopathy service would increase significantly over the next few years as a result of demographics changes to our local population. It was also noted that the Trust's	

MINUTES	PAPER REFERENCE
haemoglobinopathy service is the second biggest haemoglobinopathy service in the country (London being the biggest) largely as a result of the demographics of our population particularly in Birmingham. Professor Lilford commented that this was an important point that should be included in the consideration of future options and that it should not be assumed at this stage that any consolidation would necessarily be on the Sandwell site. There were currently five consultants (with sub-specialisation) working a cross-site rota for inpatient work covering both sites at weekends and inpatient cover mainly by phone in weekdays (out of hours) which was challenging. Both haematology oncology and haemoglobinopathy services had to undergo peer reviews. A steering group has been established to progress the proposed reconfiguration and the clinical team were supportive of the proposal to have inpatients on one hospital site. The majority of haematology oncology inpatient work was done on an elective basis and haemoglobinopathy on an emergency basis. The key drivers for a single inpatient site were noted and discussed. Mr Sharon felt that the increase in demand for the haemoglobinopathy service was not translated into the drivers. Dr Wright felt that although this was important it did not significantly influence the change as many of these patients would be managed on an ambulatory day case or outpatient basis e.g. pain management was done on a day case basis and much was done to support and provide care to people at home. The increase in numbers would have more of an impact on day case rates than on inpatients (bed days). The model of care had changed. The implications for nursing/medical staffing were discussed. It was considered whether, if the service was expanding, it would be more relevant to continue the service across both sites. This could be a driver for keeping the status quo. Dr Wright advised that support was being given to care in the community and plans were in hand to strengthen community working. Dr Wright advised that the current service ran the risk of compromising the care provided and the risk of not meeting national standards for haemoglobinopathy (partnership working with other organisations). Focusing patients on one site would strengthen the team and free up time for greater partnership working. Detail from peer reviews had not been included as it was assumed these had been shared through other forum after such reviews had taken place. Mr Sharon and Professor Lilford felt the clinical case for change would be strengthened by the inclusion of relevant detail and recommendations from peer reviews and explanation of how reconfiguration of inpatient services would help address these.	

MINUTES	PAPER REFERENCE
Following a query from Mr White, the implications for undergraduate and postgraduate training were discussed. Dr Wright advised that junior doctors currently worked across sites and feedback from the deaneries was that training was of a high standard. Mr Sharon felt that this should be included to strengthen the drivers for change. The efficiency of consultant time was discussed. Dr Wright advised that reconfiguration of inpatient services to one site would free up more consultant time to undertake research. The number of consultant WTE was less now than a few years ago. Haemoglobinopathy was a significant income generator for the Trust. It was agreed that the Review should move to the next stage of undertaking an option appraisal and risk assessment. There should be further patient and staff engagement in the next stage of work. The Clinical Case for Change should be strengthened by the inclusion of research in the document, inclusion of the growth in demand for Haemoglobinopathy, inclusion of relevant detail and recommendations from peer reviews and explanation of how reconfiguration of inpatient services would help address these and by the expansion of information in the key drivers. The strengthened Clinical Case for Change could be included in the report from the next stage which would either be a Case for Consultation with a set of short listed options or a Case for Preferred Option (if formal public consultation is not considered appropriate). Part of the next stage of the Review will be assessing whether formal public consultation is appropriate. It was agreed that the advice of the Joint Health Scrutiny team should be sort as to whether this reconfiguration would require public consultation. Mr Sharon felt that this was likely. It was noted that the timescales for the next stage of the Review would depend partly upon whether formal public consultation is required and that a progress report will be presented to the next meeting of the Programme Board.	
ACTION: Mrs Dunn and Dr Wright to provide feedback to the Steering Group that the Review should move to the next stage of an option appraisal and risk assessment with further staff and patient engagement, and that the Clinical Case for Change should be strengthened as suggested. Mrs Dunn to obtain advice of the Joint Health Scrutiny Committee as to whether public consultation for the reconfiguration of inpatient clinical haematology services would be required.	
6 EMERGENCY GYNAECOLOGY RECONFIGURATION	**SWBRB (07/02) 08**
The Quarter 3 Emergency Gynaecology Services report was received and presented by Mrs Geary. It was noted that the reconfiguration now relates to all inpatient Gynaecology services and not just the emergency element. It was noted that the final stage of reconfiguration was on schedule to commence on 1st April. The EPAU would be based as part of a new	

MINUTES	PAPER REFERENCE
Emergency Gynaecology Assessment Unit (EGAU) on the Surgical Assessment Unit at City Site. There was enabling work still to do and a request was going to SIRG on 12th February for the £60,000 for the work. There was a mitigation plan in place in case the work was not completed by 1st April. The communications and engagement plan was on track. Following a query from Professor Lilford, it was noted that there should not be any problems with recruitment of Clinical Nurse Specialists to increase the current team to support the EGAU as there were already 3 CNS as part of the team and there was a group of staff to choose from. Recruitment was tight but doable. Work was still on on-going to resolve the issue with pathways for walk-in patients at Sandwell. This depended on good triage and the team was working with the medical and nursing staff to resolve this matter. In answer to a query from Mrs Hunjan, Mrs Geary confirmed that any transfers would be recorded on the system and records maintained.	
7 SURGICAL SERVICES UPDATE	
The January progress report for T&O, breast surgery and vascular reconfiguration was received.	
7.1 Trauma & Orthopaedics	
It was noted that there were no significant issues. A post-reconfiguration review would be undertaken 12 months after implementation. Mrs Dunn advised that this would be undertaken using operational factors such as length of stay etc and would be an internal review. The Division would be monitoring performance on a rolling programme. Professor Lilford felt it would be useful to have some data about activity etc ahead of the 12 month review and that this should be incorporated as part of the regular updates. Mrs Kinghorn suggested that information could be drawn from the patient survey. It was agreed that Mr Beveridge should include this as part of his next Programme Board report.	
ACTION: Mrs Dunn to request Mr Beveridge to give an update on post-reconfiguration activity etc in the next Surgical Services Update report for the May Reconfiguration Board.	
7.2 Vascular Surgery	
It was noted that following the transfer of inpatient vascular surgery and vascular interventional radiology on 10th September 2012 to UHBFT, there had been no adverse events reported. Revised consultant job plans had been agreed and implemented to ensure availability at SWBHT Monday to Friday. The upgrade of Ward D21 remained a priority for the Division. Discussion took place regarding the awareness of GPs regarding reconfiguration of services and implications. There was uncertainty as to	

MINUTES	PAPER REFERENCE
what work was undertaken to ascertain GPs views. Mr Sharon felt that this was normally taken into account through market share reporting. Mrs Hunjan queried whether there was information on the web site advising patients which site they would need to attend for their treatment. Mrs Kinghorn advised that GPs could access this information from the web site and more internal work was being done to expand this information for GPs/CCGs. It was noted that liaison did take place with the deaneries but sometimes it was not until later that issues were raised. Mr Sharon reported that he had been advised that Cardiology Physiologists were attending UHB for vascular training now that the service is no longer provides at SWBH. Assurances regarding this would be required.	
8 STROKE SERVICES RECONFIGURATION	**SWBRB (07/02) 07**
The January Stroke and TIA reconfiguration project report was received. It was noted that the project was currently showing an amber status. The new hyper-acute and acute stroke and neurology ward (Priory 4) at Sandwell Hospital would become operational on 11th March 2013. Some on-going refurbishment work was scheduled until June 2013. The following key issues were noted: *Bed Capacity* – There was a risk of increased demand from medical emergency admissions and/or issues such as an infection outbreak, preventing the required reduction in bed numbers in time to open the new hyper-acute and acute ward with the correct staffing levels. *Outpatients* – Mrs Dunn reported that this issue had now been resolved. *Consultant Rotas* - Agreement had since been reached in respect of consultant rotas and additional hours of cover for dedicated middle grades. Telemedicine would be introduced thus negating the need for consultants to always be on site. This would need to be evaluated either by an internal or external review. *Discharge Arrangements* – The unit had been modelled on an average length of stay of 21 days. Work continued to explore the options for extending the admission criteria for the Sandwell ESD team and to identify the resources that would be required to extend the Sandwell ESD team to cover the whole CCG area. It was noted that Birmingham currently does not have an ESD team. Such a team was essential to support the reduced length of stay and bed numbers. Mr Sharon expressed concern about putting beds at Sandwell with no discharge support at the Birmingham end and no decant plan. There would be a significant risk in not having enough medical beds as a whole. Mrs Dunn felt it would take at least six months for a Birmingham ESD team to be up and running. However there was still support from community teams for Birmingham patients. More complex stroke patients tended to fall within the Sandwell team catchment area.	

MINUTES	PAPER REFERENCE
It was noted that the Division of Medicine was working on mitigation plans in respect of medical outliers, bed capacity and staffing. Mr Sharon felt that this plan should be available within the next two weeks to enable stroke reconfiguration to move forward. The SHA's strategic review of stroke services was still on-going but it was noted that no firm proposals/decisions had yet arisen. The Birmingham, Solihull and Black Country CCGs had established a commissioning group to oversee the plans and submissions for their areas. This group was expected to develop a preferred commissioner model for Birmingham, Solihull and the Black Country. SWBH could be vulnerable if the number of stroke admissions required for a HASU is increased (currently a minimum of 600). Mrs Kinghorn felt that a review of stroke services reconfiguration should be undertaken as soon as possible rather than waiting a year after introduction. The stroke dashboard and mortality rates would be reviewed on a monthly basis via the Stroke Action Team. The SHA would be able to monitor the Trust's performance via SSNAP.	
9 TRAUMA CENTRES AND UNITS	**SWBRB (07/02) 07**
The January progress report in respect of Trauma Unit Designation was received. It was noted that the formal outcome of validation was expected 11th February 2013. Mrs Hunjan reported that the CQC had advised that TARN data was required by May 2013. Mrs Dunn advised that the Trust was now much more up-to-date in respect of submitted data and therefore the May deadline should not be a problem. One item of concern was that a recent CT audit had shown that the Trust did not hit its 30 minute maximum time to CT from request for all patients in ED but there were clinical reasons (e.g. requiring anaesthesia or sedation) in a number of cases. This was under review.	
10 FUTURE CLINICAL RECONFIGURATIONS	**SWBRB (07/02) 11**
The February paper outlining the services where potential clinical reconfiguration had been identified was received.	
10.1 Clinical Haematology	
This was not discussed further.	
10.2 Interventional Radiology	
The main area of concern was that there was currently no formal dedicated IR 24/7 rota on either site and it was likely that national recommendation would be published in the next year recommending all acute hospitals should have a 24/7 IR service. Options were being considered to draw up a partnership with a neighbouring Trust (likely to be	

MINUTES	PAPER REFERENCE
UHB) to provide this service. Problems were being experienced in recruiting to Consultant vacancies due to "supply and demand". The formation of a partnership may attract more applicants. Options were being considered and a strategy being drawn up. It was agreed that the Reconfiguration Board would be kept advised of progress.	
10.3 Cardiology – Percutaneous Cardiac Intervention (PCI)	
A proposal was under discussion to provide 24/7 PPCI from one central hospital with patients requiring PPCI being taken directly there by the ambulance service or transferred if self-presenting at A&E with one consultant covering both sites. Options were still being considered. Time from onset of symptoms to PPCI was critical to patient outcomes and was therefore a key performance indicator. This was broken down to time from onset of systems to arrival in hospital (call to door time) and time from arrival in hospital to PPCI (door to balloon time). It had been noted by CLARHC that there was a need for the Trust to improve its door to balloon times. It was hoped that options and a plan would be available by May 2013. It was agreed that appropriate representatives would attend a future meeting of the Reconfiguration Board to discuss.	
ACTION: Mrs Dunn to request appropriate representatives to attend a future meeting of the Reconfiguration Board to present the plan and options.	
10.4 Community Project Strategy	
Mrs Dunn reported that it was likely that some form of reconfiguration of community services would commence in the future. This would be an agenda item for the next Reconfiguration Board meeting.	
11 PATHOLOGY UPDATE	**SWBRB (07/02) 10**
The latest pathology update report and a copy of Pathology News were received and presented by Dr Berg. The SHA tendering process of GP pathology had commenced. The bidders meeting had taken place on 5th February. It was the largest tender for pathology services that had been issued and would lead to the closure of pathology departments. A response was being put together with a privet provider and Dudley Group of Hospital FT. The privet provider would oversee the IT and GP service and would run the service if the bid was successful. The deadline for the PQQ return was 1st March. Only 4-5 bids would proceed from that point so there was a 25% chance of success. Decisions were being made to ensure that SWBH pathology department had options to ensure its continuity. These included contract length of leased equipment and managed service contracts (aiming for 5 year periods rather than 10 years).	

MINUTES	PAPER REFERENCE
Work was progressing to provide an integrated pathology department with Dudley Group of Hospital FT. It was hoped that the LTS report would be considered by the Trust Board in March. Mr Sharon had given a verbal report at the last Trust Board meeting in January. It was important that appropriate communications were given to staff in view of the on-going changes to pathology working. Work was continuing to ensure the successful implementation of the centralisation of the cytology service to Wolverhampton. A number of staff had been identified for TUPE across to Wolverhampton. Birmingham now wished to proceed with a change in service and discussions with them were on-going but again it was likely this would move away from SWBH (possibly to HEFT). The building work for the blood sciences laboratory was on course. The installation of equipment was awaited but should be up and running in April 2013. It was likely that more pathology services would be run by private companies in the future. Retained estate costs were very high and were an issue.	
12 REPORTS FOR INFORMATION	
The following reports/notes were received for information: • Haematology/Oncology Inpatient Review Steering Group – 14th January 2013 • Notes from the Stroke Reconfiguration Project Board – 20th December 2012 • Notes from Stroke Clinical Implementation Group – 16th and 30th November 2012 and 4th January 2013	**SWBRB (07/02) 04** **SWBRB (07/02) 06** **SWBRB (07/02) 03a-c**
13 ANY OTHER BUSINESS	
There was no further business.	
14 DATE & TIME OF NEXT MEETING	
Thursday 9th May 2013, from 1.00 pm to 3.00 pm in the Meeting Room, Corporate Suite (Ward D29).	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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:	**28 February 2013**

EXECUTIVE SUMMARY:

The report gives an update on:

- Activities this period
- Activities next period
- Issues for resolution and risks in next period

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 28 February 2013

SWBTB (2/13) 030 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FT Programme Monitoring Status Report

Red

Activities Last Period

- High level milestones from the revised TFA have been included in the NTDA Annual Plan submission
- HDD 2 Final Report received from PwC, to be reviewed at Finance & Performance Committee (22/02/13)
- BGAF action plan developed
- LTFM remodelling commenced
- MMH Project structure reactivated

Planned Next Period

- Board development plan to be discussed at March FT Board Development seminar
- Continue programme of raising staff awareness of FT issues.
- OBC financial re-modelling to be continue
- Board Quality Governance self assessment to take place in June
- Timetable for 2015/16 TSP planning to be issued
- Visit by DH to discuss MMH

Issues for Resolution/Risks for Next Period

- Implications of Francis report on FT process to be understood
- Risk that momentum is lost on required Board and wider governance improvement

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit Committee – Version 0.2

Venue Anne Gibson Cttee Room, City Hospital **Date** 6 December 2012

Members Present		In Attendance		Secretariat
Mrs G Hunjan	[Chair]	Mr T Wharram		Mr S Grainger-Payne
Ms C Robinson		Mr I Kendall		
Dr S Sahota		Mr B Stone	(KPMG LLP)	
Mr H Kang		Mr P Capener	(CW Audit)	
		Ms R Proudlove	(CW Audit)	
		Mr D Ferguson	(CW Audit)	
		Mr R Trotman		

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Ms Olwen Dutton, Mr Robert White, Mrs Sarah-Ann Moore, Mr Andy Bostock and Mrs Rubina Chaudary. The Committee welcomed Ms Rachel Proudlove to the meeting who was in attendance as an observer as part of her development programme with CW Audit. Mrs Hunjan thanked Mr Trotman for his time served as a member of the Audit Committee while employed as a Non Executive Director. Mr Phil Gayle, former Non Executive Director was also thanked in retrospect for his time served as a member of the Audit Committee. Ms Clare Robinson and Mr Harjinder Kang, newly appointed Non Executive Directors were welcomed to their first meeting of the Audit Committee.	
2 Minutes of the previous meeting	**SWBAC (9/12) 056**
The minutes of the meetings held on 13 September 2012 were approved as a true and accurate reflection of discussions held.	

Minutes	Paper Reference
AGREEMENT: The minutes of the meetings held on 13 September 2012 were approved as an accurate record	
3 Matters arising	**SWBAC (9/12) 056 (a)**
The Audit Committee received and noted the updated actions log.	
3.1 Salary overpayments	**SWBAC (12/12) 058** **SWBAC (12/12) 058 (a)**
Mr Wharram reminded the Committee that an update on salary overpayments had been presented at the last meeting of the Audit Committee. It was reported that the number and value of the overpayments was small, however it was acknowledged that the issue was important. It was highlighted that the most significant cause of a salary overpayment related to managers not completing the documentation needed to register a staff change and therefore sanctions to be applied in these circumstances were being considered. It was reported that it had been decided that the Director of Finance would intervene in these circumstances. In addition, it had been agreed that improved use of the nominal roll information would be investigated, which the Committee was advised was issued monthly to all budget managers at present. It was suggested that managers would be asked to positively confirm entries in future. Mr Kang asked whether the instance of salary overpayments was rare. Mr Wharram reported that within the past year 169 cases had been reported which totalled £316k, including a single overpayment of £47k which was handled immediately. It was highlighted that the cases represented 0.1% of payroll transactions, however they were not isolated or focussed in one area. Ms Robinson noted that an instance of a salary overpayment had been raised at a recent meeting of the Finance & Performance Management Committee. She asked how the disciplinary process could be used as part of the sanctions being devised and asked what clause was included in the employees' contract concerning the onus to notify the Trust if they received an overpayment of salary. Mr Wharram reported that at present, there was no inclusion within employment contracts. Mrs Hunjan advised that this was the case in contracts used by other organisations. She asked whether finance managers discussed the financial information with budget managers. Mr Wharram advised that given that there were in excess of 500 budget managers, it was unfeasible to meet all on a monthly basis. Mr Capener reported that as part of an internal audit, the overall business processes and controls were being reviewed. Ms Robinson suggested that variations in payroll could be examined to	

Minutes	Paper Reference
identify some anomalies. Mr Wharram agreed that there were some standard exceptions reports which could be run on payroll for this purpose. Mrs Hunjan asked that as part of the next update on salary overpayments, the recovery rate and trends by division and over time be presented.	
ACTION: **Mr Wharram to provide details of the salary overpayment recovery rate and trends by division and over time as part of the next routine update**	
4 External Audit Matters	
4.1 External Audit progress report	**SWBAC (12/12) 059**
Mr Stone reported that the Charitable Funds audit work had been completed during the period and that the Audit Memorandum (ISA260) had been prepared. Mr Trotman advised that at the Charitable Funds Committee meeting held earlier that day that it had been agreed that within the Charitable Funds Committee annual report, the phrase concerning 'expected return' should be amended to reflect that this related to 'eventual annual return'. Mr Stone agreed to make this amendment. It was reported that the Audit Opinion would be issued shortly, however it was anticipated that this would be 'Unqualified'. Mr Stone advised that during the next quarter, there was an expectation that planning would commence for the 2012/13 audit and that the key financial controls would also be reviewed. In addition, it was reported that the scoping and plan for the Quality Accounts work would also be started. The Committee was asked to note two technical updates, including one prepared by the King's Fund related to Payment by Results. In relation to the update on Gaming to meet Healthcare targets Mrs Hunjan asked, when the clock started for patients being seen in Accident & Emergency departments. Mr Grainger-Payne offered to clarify this information with the Chief Operating Officer. Ms Robinson suggested that the Internal Audit reviewing the Trust's performance against Accident & Emergency clinical indicators needed to be expedited if possible. It was agreed that this should be circulated prior to the next meeting of the Audit Committee if possible.	
ACTION: **Mr Stone to amend the Charitable Funds annual report to amend the reference from 'expected return' to 'eventual annual return'** **ACTION:** **Mr Grainger-Payne to determine when the clock started for patients being seen in Accident & Emergency departments**	

Minutes	Paper Reference
ACTION: Mr Grainger-Payne to arrange for the Internal Audit report concerning performance against the Accident & Emergency clinical indicators to be circulated prior to the next meeting of the Audit Committee	
5 Update on National Schedule of Reference Costs	**SWBAC (12/12) 060** **SWBAC (12/12) 060 (a)**
Mr Kendall presented an update on the final published reference cost index for the Trust. The Committee was advised that reference cost information presented a measure of performance benchmarked against the national average. It was reported that the Trust's average reference cost position was 102, which was highlighted to be a maintained position from the previous year, despite the integration of the provider arm of Sandwell PCT during the period, with the position therefore suggesting an overall degree of improvement. Excess bed days was noted to be overall lower than average, however the position of some individual specialities was highlighted to be higher than the national average. It was reported that the reference costs work was linked into the plans for strengthening a Service Line Reporting approach within the Trust. Mr Kang asked how the data was used, given that it was of limited value without an understanding of the detail behind the information. Mr Kendall provided an example as to how the data was used to determine the Service Line Reporting position. It was noted that the reference cost information would be considered and monitored more closely on a regional basis.	
6 Internal Audit Matters	
6.1 Internal Audit progress report	**SWBAC (9/12) 044** **SWBAC (9/12) 044 (a)** **SWBAC (9/12) 044 (b)**
Mr Capener reminded the Committee that should an assessment provide moderate, limited or no assurance, the report would be presented in full to the Audit Committee. In terms of progress against the Internal Audit plan, the Audit Committee was advised that delivery was ahead of schedule, with the expectation being that the plan would be completed before the year end. The detail of the work completed and planned was discussed. Ms Robinson suggested that the relevant accountable Executive Director should be invited to join the meeting when the internal audit reviews were presented. Mrs Hunjan confirmed that this was the case for any audits providing a level of assurance less than 'significant'. Ms Robinson	

Minutes	Paper Reference
questioned how 'significant' assurance had been provided by the audit into risk management given that it identified that staff were not always trained appropriately or aware of the policy. Mrs Hunjan offered to discuss the findings of the internal audit with Miss Dhami as the relevant Executive Lead. Mr Capener added that at a corporate level, the application of the policy was acceptable. Mrs Hunjan asked what triggers were used to apply the various assurance levels. Mr Capener was advised that criteria were in place, however a degree of professional judgement was used. He agreed to circulate the definitions of assurance to the Committee and present them formally for discussion at the next meeting. In term of the staff expenses audit, it was reported that 14 of the 17 actions had been completed. Mrs Hunjan noted that it appeared there had been a delay with issuing the report and asked for the reasons behind this. Mr Capener offered to determine the reasons. Mr Trotman questioned the number of days provisionally allocated to the review of the Transformation Plan, particularly given that the Plan was already subject to much scrutiny. Mr Capener advised that the scope of the audit had not yet been agreed. Ms Robinson highlighted that the Historical Due Diligence audit would also incorporate a review of Transformation Savings Plans, therefore there was little need for additional external scrutiny. Mr Capener agreed to discuss the position with Mr White. Ms Robinson suggested that consideration needed to be given on an ongoing basis as to whether there were any other matters to which additional internal audit resource needed to be directed. Ms Robinson suggested that progress with the outstanding 16 recommendations needed to be presented at the next meeting, including an indication of the impact of the actions remaining outstanding and the reasons why they remained open. It was agreed that Executive Directors needed to be invited to the Committee to discuss any issues that needed to be resolved in order to close the actions. Ms Robinson noted that a process was in place to track the delivery of the recommendations however she observed that there was no composite system in place to review recommendations from all national reports, enquiries, visits and audits. Mr Grainger-Payne reported that the closest system in place was the Integrated Development Plan, however this did not encompass recommendations from external national clinical reports or Internal Audit recommendations. He agreed to raise this issue with the relevant Executive Directors.	
ACTION: **Mrs Hunjan to discuss the outstanding recommendations from the risk management internal audit with Miss Dhami** **ACTION:** **Mr Capener to circulate the explanations behind the levels**	

Minutes	Paper Reference
of assurance provided by internal Audit reviews **ACTION: Mr Grainger-Payne to add an item to the agenda of the February 2013 meeting concerning Internal Audit assurance levels** **ACTION: Mr Capener to determine the reasons behind the delay with issuing the staff expenses audit** **ACTION: Mr Capener to discuss the suggested allocation of time to the audit of the Transformation Plan** **ACTION: Mr Capener to present the list of outstanding audit recommendations at the next meeting, including an indication of the impact of the actions remaining open and the barriers to closing them** **ACTION: Mr Grainger-Payne to raise the issue concerning the lack of a composite action plan to monitor delivery of Trustwide actions and recommendations**	
6.2 Internal Audit report – 18 week referral to treatment	**SWBAC (12/12) 062** **SWBAC (12/12) 062 (a)**
Mr Capener reported that the audit had been commissioned as a result of issues with the reporting of and adherence to the 18 week referral to treatment time target. The Committee was advised that the review had considered the overarching policy for recording waiting times. It was highlighted that the data quality issues that had been identified in connection with the reporting of 18 week referral to treatment targets had been investigated by separate external consultants, which had also been asked to provide a view of any solutions for improvement. The Committee was advised that the review had identified a number of issues concerning the policies and protocols in this area. It was reported that the changes made as a result of the work undertaken following the external review would need to be audited again in future. It was suggested that the Chief Operating Officer should be invited to join the meeting of the Audit Committee in February 2013 to present the outcomes of the audits undertaken.	
ACTION: Mr Grainger-Payne to invite the Chief Operating Officer to the meeting of the Audit Committee scheduled for February 2013	
6.3 Counterfraud progress update, including update on open cases	**SWBAC (12/12) 063** **SWBAC (12/12) 063 (a)**

Minutes	Paper Reference
Mr Ferguson reported that presentations on Counter Fraud continued to be delivered as part of staff induction. He advised that a Counter Fraud newsletter had also been issued and offered to share this with the members of the Audit Committee when published. Mr Ferguson was asked whether a log of all the issues and pieces of advice was maintained. He advised that a significant number of requests for advice related to overseas visitors, however he agreed to provide an analysis of the themes of the work in future. The detail of the open cases was presented. A discussion was held concerning the means by which detection of fraud could be built into recruitment checks. Mr Kang asked whether there were processes in place to identify patients who were illegally claiming treatment. It was agreed that further work was required to raise awareness of the processes and checks needed to prevent this occurring. Mrs Hunjan suggested that this could be added to the presentations delivered as part of staff induction.. Mr Kendall advised that a greater number of cases were being received by the Medicolegal Department in this respect, suggesting that staff were more aware of the processes to follow.	
ACTION: **Mr Wharram to present an update on measures taken to raise the profile of the treatment of overseas visitors policy at a future meeting**	
6.4 Internal Audit service specification	**SWBAC (12/12) 063** **SWBAC (12/12) 063 (a)**
Mr Capener observed that the notice period for the Internal Audit service extended to September 2013. He advised that a comprehensive plan would be devised for the full financial year, however he asked that the plan should not be made available within the public domain and in particular to competitor organisations who may be bidding as part of the tender for services. Mr Capener asked that the timetable for the tendering process be shared with him as soon as possible. Mr Capener, Mr Ferguson and Ms Proudlove left the meeting. Mrs Hunjan presented a draft specification for the future provision of Internal Audit services, which it was highlighted had taken a view of practice in a number of peer organisations. Mr Kang asked whether there was a preferred NHS supplier for the provision of internal audit services. He was advised that this was not the case. Mrs Hunjan highlighted that the plans presented some implications in	

Minutes	Paper Reference
terms of TUPE. Mr Trotman suggested that consideration should be given to absorbing these without undue challenge should there be an agreement to change provider. It was highlighted that the exercise provided an opportunity to strengthen Board Assurance and place greater emphasis of the role of risk management within the responsibility of the internal audit function. It was agreed that the Committee's self-evaluation work should be picked up more effectively as part of any new arrangements. It was also suggested that provision for an extension to the contract should be built into the specification and that the provider should be able to demonstrate best practice for scoring reports. Further suggestions for refining the specification included the incorporation of clinical audit responsibilities and an interface with the development of the annual plan needed to be built into the specification.	
ACTION: Mr White to amend the Internal Audit specification in line with feedback received from Committee members	
7 Governance matters	
7.1 Self assessment of Audit Committee effectiveness	**SWBAC (12/12) 065** **SWBAC (12/12) 065 (a)**
Mr Capener presented the proposed template to be used to self-assess the Audit Committee's effectiveness, which he highlighted had been developed being based on the requirements set out in the Audit Committee Handbook. Ms Robinson observed that the self-assessment document was process orientated. She suggested that the self-assessment be broadened out to include an additional set of questions, aimed at encouraging improvement. It was agreed that this would be considered and discussed again at the next meeting of the Audit Committee.	
ACTION: Ms Robinson to send Mr Capener examples of Audit Committee self assessment proformas	
8 Minutes and notes from the Trust Board Committees	
8.1 Finance & Performance Management Committee	**SWBFC (9/12) 087** **SWBFC (10/12) 096** **SWBFC (11/12) 107**
The Committee noted the minutes of the Finance and Performance Management Committee meeting held on the 20 September 2012, 19 October 2012 and the draft version from the meeting held on 23	

Minutes	Paper Reference
November 2012.	
8.2 Charitable Funds Committee	**SWBCF (9/12) 014**
The Committee noted the minutes of the Charitable Funds Committee meeting held on 13 September 2012.	
8.3 Quality and Safety Committee	**SWBQS (9/12) 074** **SWBQS (10/12) 082** **SWBAC (12/12) 066**
The Committee noted the minutes of the Quality and Safety Committee meetings held on 20 September 2012, 19 October 2012 and the briefing given of the meeting held on 22 November 2012.	
9 Schedule of meeting dates - 2013	**SWBAC (12/12) 067**
The Committee received and noted the schedule of meeting dates for 2013.	
10 Any Other Business	**Verbal**
Mrs Hunjan thanked those present for their input and attendance.	
11 Date and time of next meeting	**Verbal**
The date and time of the next meeting will be 14 February 2013 at 1100h in the Anne Gibson Committee Room, City Hospital.	

Signed:……..

Name:……

Date:……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Charitable Funds Committee – Version 0.1

Venue G19 Hilda Lloyd House, City Hospital **Date** 6 December 2012 at 0930h

Trustees Present		In attendance	Guest
Dr S Sahota	[Chair]	Mr P Smith	Mr M Burgess (Barclays Wealth)
Ms C Robinson		Mrs J Kinghorn	
Mr J Adler		Mrs C Jones	**Secretariat**
		Mr R Trotman	Mr S Grainger-Payne

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Mr Richard Samuda and Mr Robert White.	
2 Minutes of the previous meetings	**SWBCF (9/12) 014**
The minutes of the meeting held on 13 September 2012 were approved.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meeting	**SWBCF (9/12) 014 (a)**
3.1 Maternity fund payment	**Verbal**
Mr Grainger-Payne reported that payment of the funds from the PCT had been made into the Charitable Funds account rather than the exchequer account given that they were in respect of a one off payment for development-related training needs for community midwives.	
3.2 Target income stream for the investment portfolio	**Verbal**
Mr Grainger-Payne advised that the target income stream was included within the Charitable Funds annual report and was highlighted to be £175k. It was noted that the income received was someway short of this at present. Mr Burgess suggested that a better target might be a percentage of income. Ms Robinson agreed with this approach and it was proposed that Mr Burgess should	

recommend a target percentage income to the Trustees at a future meeting. Ms Robinson asked for details of the fees charged for the management of the portfolio. Mr Burgess advised that these were included within the Charitable Funds annual report and were set at 0.3%. He added that any commission received was offset against the fees. It was agreed that the details of the brokerage fees would be provided at the next meeting.	
ACTION: Mr Burgess to recommend a target level of income from the portfolio **ACTION: Mr Burgess to provide details of the investment brokerage fees for the next meeting**	
4 Investment update – Barclays Wealth	
4.1 Investment review and valuation from Barclays Wealth for the three month period 1 July 2012 to 30 September 2012	**SWBCF (12/12) 016**
Mr Burgess provided an overview of the international and UK investment market positions. Dr Sahota asked what likely effect the Chancellor's Autumn statement would have on the UK investment market. Mr Burgess advised that this impact was anticipated to be broadly neutral. It was highlighted that the statement would deliver a cut in corporation tax, a reduction in the tax payable on pension contributions, payment of a higher level of personal tax contributions overall and measures to incentivise the business sector. Dr Sahota asked whether in view of the market conditions, the same asset allocation within the investment portfolio was appropriate. Mr Burgess highlighted that the portfolio was currently being managed on a medium to low risk basis. It was suggested that a higher exposure to equities should be considered. Mr Trotman observed that the current positions regarding sterling and the fixed interest element, were currently outside the proposed portfolio allocations. It was suggested that the investment in cash should be up to 8%. Mr Burgess advised that investment in equities looked positive in the long term and advocated a move to a moderate level of risk. Ms Robinson suggested that measures to improve the income stream from the portfolio should be implemented, including rebalancing the asset allocation. She also suggested that the chargeable fees needed to be clarified. Dr Sahota noted that the return on fixed assets was low in some cases, however the current allocation into the fixed interest element was relatively high. Mr Burgess advised that the outlook for some corporate bonds was positive. Mr Trotman suggested that the movement in the asset allocation needed to be effected over a period of time. It was agreed that the proposed changes should be discussed between Mr Burgess and Mr White. Mr Smith advised that should the investment policy alter, then this should be reflected in the next annual report.	

It was agreed that the targets and asset allocation should be clarified at the next meeting.	
ACTION: **Mr White to confirm the proposed revised targets and portfolio asset allocation at the next meeting**	
5 Quarterly finance report	**SWBCF (12/12) 017** **SWBCF (12/12) 017 (a) - SWBCF (12/12) 017 (d)**
Mr Smith presented the finance report for the Charitable Funds which it was noted covered the period between 1 August 2012 – 31 October 2012. He reported that the cash position stood at £681k overall, however a credit to the exchequer account to the value of £382k was required, leaving a c. £300k balance. The Trustees were asked to note that a legacy of £77k had been received and that the total income for the period was £450,256. It was highlighted that donations of £1000 or greater amounted to 66.8% of the total receipts. Expenditure was reported to have been £137,559, with individual expenditure entries of £1000 representing 81.4% of the total. The revaluation reserve was reported to be valued at £301k. Ms Robinson asked what interest rate was available on the Nat West reserve account. Mr Smith advised that this was not significantly high. It was suggested that consideration should be given to securing a higher rate in future. Ms Robinson noted that some funds had been set aside for a contingency for Biochemistry and a Christmas meal for the Pathology division. She questioned whether this was an appropriate use of funds. Mr Adler confirmed that according to the Charitable Funds policy, this was acceptable. Mr Smith added that the Biochemistry contingency fund was populated from outside commercial organisations rather than from public donations. Mr Adler advised that in terms of the Christmas meal, the expenditure did not make provision for the purchase of alcohol.	
ACTION: **Mr Smith to consider the means by which a higher rate of interest may be secured for the reserve account**	
6 Audited accounts and Trustees Annual Report for the year ending 31 March 2012	**SWBCF (12/12) 018** **SWBCF (12/12) 018 (a)** **SWBCF (12/12) 018 (b)**
Mr Smith presented the Charitable Funds annual accounts, which he reminded the Committee had been received in draft version at the previous meeting. The Committee was advised that the audit had concluded and the Trustees were asked to adopt the accounts. It was reported that the accounts needed to be submitted to the Charities Commission by 31 January 2013. The Committee was advised that the auditors had not identified any material	

errors in the annual accounts and that an Unqualified opinion was anticipated. Mrs Jones asked whether the reserves policy needed to include provision for redundancy payments for staff associated with fundraising. It was agreed that this needed to be considered. Mrs Kinghorn noted that an expected income for fundraising was reported to be £1.5m, however she advised that this was unlikely to occur in the first year of the establishment of the fundraising function. It was agreed that the entry would be amended to stipulate that this related to the eventual annual return. Subject to this amendment, the Trustees agreed to adopt the annual accounts and approve the annual report.	
ACTION: **Mr Smith to consider the inclusion of redundancy provisions for fundraising staff within the reserves policy** **AGREEMENT:** **Subject to amendment of the entry concerning the annual return from fundraising to reflect that this referred to eventual annual return, the Trustees agreed to adopt the annual accounts and approve the annual report**	
7 Fundraising strategy	**SWBCF (12/12) 024** **SWBCF (12/12) 024 (a)**
Mrs Jones presented the proposed fundraising strategy, which she advised closely linked to the Board-approved Communications and Engagement strategy. The vision for fundraising was discussed and Trustees were asked for their views on the proposed future approach. Mr Adler advised that raising funds for specific projects or causes was a proven method of securing a pleasing level of donations. Ms Robinson asked what benchmarks for success had been undertaken. Mrs Jones advised that local trusts had been approached and researched to determine practice that was seen to be effective. It was suggested that a brand identity be created which was individual yet was aligned to the Trust's current branding. Ms Robinson suggested that the strategy should promote strong linkages with the local community. Mrs Jones highlighted that the local population suffered high levels of deprivation and therefore suggested that there needed to be a balance between community sources of fundraising with supplementary sources. In terms of options for the fundraising approaches, the Trustees agreed that Option 2, 75% campaign fundraising and 25% unrestricted fundraising was the most practical and attractive approach. It was highlighted that the campaign element would include fundraising for the new hospital.	
AGREEMENT: **It was agreed that fundraising Option 2, 75% campaign fundraising and 25% unrestricted fundraising should be pursued**	
8 Fundraising progress report	**SWBCF (12/12) 019** **SWBCF (12/12) 019 (a)**

The Trustees were asked to receive and accept the fundraising progress report.	
9 Draft Charitable Funds policy	**SWBCF (12/12) 020** **SWBCF (12/12) 020 (a)**
It was agreed that the policy would be discussed in a separate meeting of the Charitable Funds Committee.	
10 Review of the regulation and governance of charities consultation	**SWBCF (12/12) 021** **SWBCF (12/12) 021 (a)**
The details of the regulation and governance of charities consultation were reviewed and it was agreed that the Trust should submit a response to the consultation.	
11 UK Giving 2012 report summary	**SWBCF (12/12) 022** **SWBCF (12/12) 022 (a)**
The Trustees received and accepted the UK Giving 2012 report summary.	
12 Revised Terms of Reference	**SWBCF (12/12) 025** **SWBCF (12/12) 025 (a)**
Mr Grainger-Payne presented the revised terms of reference for the Charitable Funds Committee, which he highlighted had been refreshed to bring them into line with those of the other Board committees. It was agreed that the membership should be bolstered by the addition of one further Executive Director, taking the membership to six of the Trustees. It was agreed that the term 'members' should replace 'trustees' in section 10.1 to reflect that not all Trustees were required to attend the meetings.	
ACTION: Mr Grainger-Payne to agree the most appropriate Executive Director to join the Charitable Funds Committee with Mr Adler	
13 Details of the next meeting	**Verbal**
The next meeting is to be held on 14 February 2013 at 0930h in the D29 (Corporate Suite) Meeting Room, at City Hospital.	

Signed ……..

Print ……..

Date ………………………………………………………………………………………………………..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Revised Terms of Reference for the Charitable Funds Committee**
SPONSOR (EXECUTIVE DIRECTOR):	**Sarindar Sahota, Chair of Charitable Funds Committee**
AUTHOR:	**Simon Grainger-Payne, Trust Secretary**
DATE OF MEETING:	**28 February 2013**

EXECUTIVE SUMMARY:

A key recommendation from both the Historical Due Diligence review and the Deloitte Board Development Plan was to ensure that an annual refresh of the Terms of Reference of all Board Committees was undertaken.

The revisions to the Terms of Reference for the Charitable Funds Committee is attached and are based on the models of best practice sourced from the Foundation Trust Network and more clearly articulate the role, purpose and functions of the Committee.

The Committee is asked to note that the revised Terms of Reference highlight that the Trustee body is to be represented by six voting members of the Trust Board.

REPORT RECOMMENDATION:

The Board is asked to APPROVE its revised Terms of Reference.

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	x
Clinical		Equality and Diversity		Workforce	

Comments:

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

Satisfies the following actions in the Integrated Development Plan: 29, 97 and 133.

PREVIOUS CONSIDERATION:

Discussed and approved by the Charitable Funds Committee on 6 December 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

CHARITABLE FUNDS COMMITTEE

Terms of Reference

1 CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Charitable Funds Committee (the Committee).

2 AUTHORITY

2.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee may act with such authority delegated to it by the Trust Board from time to time.

3 PURPOSE

3.1 The Committee shall provide the Board with a means of independent and objective review of the Trust's management of assets donated or bequeathed to the Trust's Charitable Funds, including in particular the arrangement made to invest the assets.

4 MEMBERSHIP

4.1 The Committee will comprise of six voting members of the Trust Board (the Trustees), who shall take responsibility for discharging the duties of the Trustees.

4.2 The quorum will be 3 members, of which there must be at least one Non-Executive Director and one Executive Director.

4.3 The Chairman of the Committee will be a Non-Executive Director and will be appointed by the Chairman of the Trust.

5 ATTENDANCE

5.1 The Head of Communications & Engagement and the Head of Fundraising will attend the meetings.

5.2 Trust staff or advisers from outside the Trust will be required to attend relevant sections of meetings as appropriate.

5.3 The Trust Secretary shall be secretary to the Committee and will provide administrative support and advice. The duties of the Trust Secretary in this regard are:

- Agreement of the agenda with the Chair of the Committee and attendees with the collation of connected papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee as appropriate

6 FREQUENCY OF MEETINGS

6.1 Meetings will be four times a year.

7 DUTIES

7.1 On behalf of all Members of the Trust Board (being the Trustees in law under the terms of the Charities Acts) the Committee will:

7.1.1 Monitor the safeguarding of those assets donated or bequeathed, in cash or other form, to the Trust's Charitable Funds.

7.1.2 Ensure, as far as is practicable, that the expressed or intended wishes of donors or benefactors are met in the deployment of funds.

7.1.3 Monitor and review the banking, accounting and audit arrangements made in respect of charitable funds.

7.1.4 Advise on the appointment of Investment Brokers to provide professional advice on the investment of charitable funds.

7.1.5 Together with such Brokers, recommend the investment strategy for such funds.

7.1.6 To receive and consider regular reports on income to and expenditure from the Trust's Charitable Funds, prior to submission and to review the regular investment reports supplied by the Trust's brokers.

7.1.7 Monitor Standing Orders, Standing Financial Instructions and operating procedures in so far as these cover the use of charitable funds within the Trust and, as far as practicable, ensure compliance.

7.1.8 Ensure, as far as practicable, that the Trust complies with relevant legislation and formal Department of Health guidance on charitable funds

7.1.9 To consider charitable fundraising for the new hospital

7.1.10 In accordance with the Scheme of Delegated Authority and authorisation limits, (see Standing Orders and Standing Financial Instructions) to consider all business cases involving the use of Charitable Funds prior to any required consideration by the Trust Board.

8 REPORTING

8.1 The minutes of all meetings of the Committee shall be recorded and submitted, together with recommendations where appropriate, to the Board. The submission shall include details of any matters in respect of which actions or improvements are needed. To the extent that such matters arise, the Chair of the Committee shall present details to a meeting of the Board, in addition to submission of the minutes.

8.2 Following each Committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. The draft minutes will then be presented at the next Committee meeting where the person presiding at it will sign them. The approved minutes will be presented to the next immediate public Trust Board meeting for information.

8.3 The Committee will report annually to the Board in respect of the fulfilment of its functions in connection with these terms of reference.

8.4 The Trust's Annual Report shall include a section describing the work of the Committee in discharging its responsibilities.

9 REVIEW

9.1 The terms of reference of the Committee shall be reviewed by the Board annually.

10 REQUIRED FREQUENCY OF ATTENDANCE BY MEMBERS

10.1 Members must attend at least two meetings each financial year, but should aim to attend all scheduled meetings.