Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 31 January 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]

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 3	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 20 December 2012 as a true and accurate record of discussions*	**SWBTB (12/12) 310**	**Chair**
Pg 16	4	**Update on actions arising from previous meetings**	**SWBTB (12/12) 310 (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**		
	7	**Safety, Quality and Governance**		
	7.1	Update from the meeting of the Quality & Safety Committee held on 25 January 2013	Verbal	GH
Pg 18	7.2	Quality report	SWBTB (1/13) 002 SWBTB (1/13) 002 (a)	RO/ KD/ RST

Pg 51	7.3	Beacon services	SWBTB (1/13) 003 SWBTB (1/13) 003 (a)	RST
1615h	**8**	**Performance Management**		
	8.1	Draft minutes from the meeting of the Finance & Performance Management Committee held on 25 January 2013	Hard copy	CRO
Pg 58	8.2	Monthly finance report	SWBTB (1/13) 004 SWBTB (1/13) 004 (a)	RW
Pg 70	8.3	Monthly performance monitoring report	SWBTB (1/13) 005 SWBTB (1/13) 005 (a)	RW
Pg 77	8.4	NHS Performance Framework & FT Compliance Framework report	SWBTB (1/13) 006 SWBTB (1/13) 006 (a)	RW
Pg 81	8.5	Performance Management Regime – monthly submission	SWBTB (1/13) 007 SWBTB (1/13) 007 (a)	MS
Pg 96	8.6	Annual plan activity report – Quarter 3	SWBTB (1/13) 008 SWBTB (1/13) 008 (a)	MS
Pg 110	8.7	Update on the delivery of the Transformation Plan	SWBTB (1/13) 011 SWBTB (1/13) 011 (a) SWBTB (1/13) 011 (b)	RB
1700h	**9**	**Strategy and Development**		
	9.1	Foundation Trust application programme		
Pg 122	▶	Monitoring report	SWBTB (1/13) 009 SWBTB (1/13) 009 (a)	MS
	10	**Any other business**	**Verbal**	**All**
	11	**Details of next meeting** *The next public Trust Board will be held on 28 February 2013 at 1530h in the Boardroom, Sandwell Hospital* *Non-routine agenda items due to be considered at the meeting are:* • Leasowes Intermediate Care facility business case (DSOD) • Nursing annual report including evaluation of ward leadership model (CN) • National inpatient survey results (HCE) • Radiation protection annual report (COO) • Update on Medical Education (MD) • Patient experience strategy (CN) • Board Assurance Framework update – Quarter 3 (DG) • Health & Wellbeing update (DSOD) • Reconfiguration update (DSOD)		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.3

Venue Boardroom, Sandwell Hospital **Date** 20 December 2012

Present		**In Attendance**
Mr Richard Samuda	(Chairman)	Mr Mike Sharon
Ms Clare Robinson		Miss Kam Dhami
Mr Harjinder Kang		Mr Graham Seager
Mrs Gianjeet Hunjan		Mrs Jessamy Kinghorn
Dr Sarindar Sahota OBE		Mr Roger Trotman
Prof Richard Lilford		Mrs Linda Pascall
Mr John Adler		
Mr Robert White		**Secretariat**
Miss Rachel Barlow		Mr Simon Grainger-Payne
Dr Roger Stedman		

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Ms Olwen Dutton and Miss Rachel Overfield.	
2 Declaration of Interests	**Verbal**
There were no interests declared.	
3 Minutes of the previous meeting	**SWBTB (11/12) 283**
The minutes of the Trust Board meeting held on 29 November 2012 were approved.	

AGREEMENT: The minutes of the last meeting were approved	
4 Update on actions arising from previous meetings	**SWBTB (11/12) 283 (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 the evaluation of the ward leadership model would be presented at the meeting planned for January 2013.	
5 Chair and Chief Executive's opening comments	**Verbal**
Mr Adler and Mr Trotman were presented with gifts from the Trust as a mark of their imminent departure from the Trust. The Chairman thanked both for their time served as Chief Executive and Vice Chair respectively. Mr Trotman thanked the Board for its time, professionalism and courtesy during his ten year time in post. Mr Adler remarked that he was privileged to have worked with such a supportive and unified Board. He advised that he was pleased to have worked under the different Trust Chairs that had served during his time with the Trust. Mr Adler highlighted that the outcome of the 'Francis Review' was expected to be published in January 2013 and asked the Board to note the key highlights outlining the probable findings which had been prepared and issued by the NHS Confederation. The Board was advised that there was an expectation that the Trust would be well placed against the likely recommendations, particularly those relating to nurse staffing. In relation to this presentation, Mr Sharon reported that the Trust was not unique in its poor performance against the Accident and Emergency waiting time target, however it was worse than that of a number of peer Trusts nationally. The Chairman reported that the recent regional Chairs' meeting he had attended had extensively covered the large level of cuts to services, mainly in Social Services budgets which would impact on the range of support that local Government would be able to sustain. He advised that he had spent significant time involved with the selection and interview process to recruit a replacement Chief Executive. The Board was informed that the selection process had involved a number of key senior external assessors and a strong candidate, Mr Toby Lewis, had been chosen and accepted the post with a start date of 2 April 2013. The Chairman commended Mr Adler for his recent work to reinvigorate the new hospital project. Mr Adler advised that he had been occupied during the last month with organising for his departure.	
6 Questions from members of the public	**Verbal**
There were no members of the public present.	

7 Execution of a contract as a Simple Contract: building works for Gamma camera accommodation at City Hospital	**SWBTB (12/12) 285**
Mr Seager advised that construction work was planned to provide suitable accommodation for the Gamma camera at City Hospital and that the Trust was required to execute the contract as a Simple Contract under deed with a value of £280,174.18 including VAT. The Board was asked for and gave its approval to the recommendation that the contract should be executed as a deed.	
AGREEMENT: The Board gave its approval to the recommendation that the contract for building works in respect of Gamma camera accommodation should be executed as a deed	
8 Execution of a contract as a Simple Contract: building works for Endoscopy decontamination suite at Sandwell Hospital	**SWBTB (12/12) 286**
Mr Seager advised that construction work was planned to provide an Endoscopy decontamination suite at Sandwell Hospital and that the Trust was required to execute the contract as a Simple Contract under deed with a value of £398,180.26 including VAT. The Board was asked for and gave its approval to the recommendation that the contract should be executed as a deed.	
AGREEMENT: The Board gave its approval to the recommendation that the contract for building works in respect of the development of an Endoscopy decontamination suite should be executed as a deed	
9 Execution of a contract as a Simple Contract: building works for a Blood Sciences Laboratory at Sandwell Hospital	**SWBTB (12/12) 287**
Mr Seager advised that construction work was planned to develop a Blood Sciences Laboratory at Sandwell Hospital and that the Trust was required to execute the contract as a Simple Contract under deed, and given that the value of the contract was £2,995,000.00, including VAT that the Trust Seal be applied to it. The Board was asked for and gave its approval to the recommendation that the contract should be executed as a deed and that the Trust Seal should be applied to it. The Chairman suggested that to avoid the need for the Trust Board to approve contracts of a low value, the stipulations within the Standing Financial Instructions and Standing Orders should be amended. It was agreed that the proposed amendments would be presented to the Audit Committee for approval at its meeting scheduled for February 2013.	
ACTION: Mr Grainger-Payne to amend the SFIs/SOs to ensure that only contracts of significant value require Trust Board approval	

AGREEMENT: The Board gave its approval to the recommendation that the contract for building works in respect of the development of an Blood Sciences Laboratory should be executed as a deed and the Trust Seal should be applied to it	
10 Health Informatics Services (HIS) strategy – version 2.0	**SWBTB (12/12) 288** **SWBTB (12/12) 288 (a)**
Mr Adler presented the revised Health Informatics Services (HIS) strategy for approval, which he advised had been amended to take into account feedback from the Strategic Health Authority's review. The Board was asked to note that the National Programme for IT (NPfIT) was referenced within the strategy, the future of which was highlighted to remain uncertain. In the absence of any clarity on the future funding available from the NPfIT it was reported that projects agreed to be a priority for the Trust were being progressed. Prof Lilford offered to make contact with the Interim Chief Information Officer, Mrs Fiona Sanders to discuss potential sources of grants and funding from which the Trust might benefit. The Trust Board was asked for and gave its approval to the revised HIS strategy.	
AGREEMENT: The Trust Board gave its approval to the revised HIS strategy	
11 Workforce strategy	**Hard copy paper**
Mr Sharon presented a revised version of the Workforce strategy, which he advised had been updated to incorporate feedback following the Strategic Health Authority's review. The Board was asked to note in particular the inclusion of benchmarked information, showing how the Trust compared to peer organisations against a range of metrics. It was highlighted that the Trust employed a lower proportion of Band 5 staff than a number of other trusts. It was suggested that the Trust should take steps to attract a greater number of apprentices. Dr Sahota asked when information from the latest staff census might be available to include. Mrs Kinghorn advised that the national data had been released already and that the local data would be available in July 2013.	
ACTION: Miss Overfield to provide an update on steps being taken to attract a greater number of apprentices into the Trust **AGREEMENT: The Trust Board gave its approval to the revised workforce strategy**	
12 Assurance and Escalation Framework	**Hard copy paper**
Miss Dhami reminded the Board that the key principles of the Assurance and Escalation Framework had been discussed at the 'Time Out' session held in	

October 2012. The Board was advised that the Framework set out how issues were identified and reported, together with the sources of assurance available internally and externally. The service and financial performance monitoring frameworks were outlined. It was reported that the Board and Committee structure at an Executive level was currently being revised, with a view to simplifying and making more effective the reporting systems up to the Trust Board and its Committees. Mr Sharon advised that work to revise the operation of the current Trust Management Board (TMB) and the Strategic Investment Review Group (SIRG) would be undertaken in the new year. It was suggested that all action plans and trackers needed to be monitored, including recommendations arising from external reports and visits. The Chairman asked what progress was being made to revise the Trust Board walkabouts. Miss Dhami advised that Patient Safety walkabouts would be arranged, which would be led by the Risk Management team. It was reported that these sessions would commence from January or February 2013. Dr Sahota asked how theatre utilisation concerns were being handled. Miss Barlow advised that work to improve the utilisation of the Trust's operating theatres was incorporated within the Transformation plan. The Chairman suggested that the Board Assurance process could be included within the remit of the Audit Committee. Ms Robinson observed that assurance from risk was gained from several disparate sources at present and that it was not clear which held overall responsibility for risk management. Miss Dhami agreed that risk management was an implicit part of the role of a number of the boards and committees. Mrs Hunjan suggested that there was a link between the remit of the Audit Committee and the work of the proposed Compliance & Assurance Committee, including risk management processes. Ms Robinson suggested that the Assurance and Escalation Framework needed to be owned by the Audit Committee. Mr Sharon recommended that the Audit Committee Terms of Reference be broadened to accommodate responsibility for the management of the Assurance and Escalation Framework. The Chairman suggested that approval of the Assurance and Escalation Framework could be given by the Board, however he agreed that the Audit Committee needed to provide input. The Board agreed to approve the Assurance and Escalation Framework in principle, subject to the comments made in relation to ownership and clarity on risk management and the interface with the Audit Committee.	
AGREEMENT: The Trust Board approved the Assurance & Escalation Framework, subject to comments made at the meeting	

13 Long Term Quality Goals	**Hard copy paper**
Miss Dhami advised that an outcome of the assessment against the Quality Governance Framework as part of the readiness for Foundation Trust status review was to define targets to assess the delivery of the Quality & Safety strategy. The Board was asked to approve the long term quality goals that had been developed for this purpose, which Miss Dhami reported had been approved by the Quality & Safety Committee at its last meeting. It was highlighted that the baseline position for some of the goals remained to be set. The Chairman asked whether Patient Related Outcome Measures (PROMs) needed to be included within the list of goals. He was advised that these indicators were measured elsewhere and therefore there was no need to duplicate monitoring of these. Prof Lilford suggested that different targets needed to be reported in different ways using a variety of means. Dr Stedman advised that the Quality Report would be used to report on progress with the Quality Goals in a comprehensive way. The Trust Board approved the long term Quality Goals.	
AGREEMENT: The Trust Board approved the long term Quality Goals	
14 Safety, Quality & Governance	
14.1 Update from the meeting of the Quality & safety Committee held on 14 December 2012	**Verbal**
Mrs Hunjan, in Ms Dutton's absence, provided an outline of discussions that had occurred at the meeting of the Quality & Safety Committee, which she advised had included consideration of the Assurance & Escalation Framework and the Long Term Quality Goals approved by the Trust Board earlier in the agenda.	
14.2 Quality Report	**Hard copy**
Miss Barlow provided an update on the latest impact of the Norovirus outbreak. She advised that at present eight wards were closed due to Infection Control issues and that business continuity plans had been put into place to handle the situation. Mr Sharon reported that the Trust had a higher number of wards closed than other trusts in the region and that the configuration of the Trust's estate made it difficult in some situations to isolate patients if needed. In terms of communications, it was reported that a daily press release was being issued. The Board was advised that consideration was being given to relaxing the current position regarding visiting over the Christmas period. Prof Lilford asked what risk was presented to patients and visitors by this measure. Dr Stedman advised that although infections were contagious, the risk could be mitigated to some degree by limiting the time of exposure and good housekeeping by visitors. Ms Robinson asked whether there was a trend in terms of Norovirus infections. Dr Stedman	

advised that the infection was more prevalent in the winter months, however the pattern varied between years. Mrs Pascall reported that there was a shortfall in nurse staffing due to the paused bed reconfiguration plan, however the position was being mitigated to some extent by the use of non-ward based nurses and the use of bank and agency staff. It was reported that every effort was being directed into ensuring that adequate nurse staffing levels were being maintained. The position against a number of quality and safety metrics was outlined. In connection with the plans outlined by Miss Dhami in respect of the implementation of a revised model for complaints handling, Mr Sharon asked whether the temporary staff currently employed in the department would be retained. Miss Dhami advised that this was the case until February 2013. Ms Robinson asked whether the current caseload of open complaints would be reduced further. Miss Dhami advised that a pilot was being organised to issue complaints responses within 40 working days. Ms Robinson asked whether there was any benchmarked information for complaints handling. Miss Dhami advised that there was no national register which detailed performance by trust. Mr Adler agreed that there was a paucity of data in this area. Ms Robinson noted that no Tabletop Reviews (TTRs) of serious incidents appeared to have been held in November 2012. Miss Dhami agreed to check the reasons why no TTRs had been held.	
ACTION: **Miss Dhami to check the reason why no Tabletop Reviews had been held in November 2012**	
14.3 Emergency Department performance update	**SWBTB (12/12) 291** **SWBTB (12/12) 291 (a) - SWBTB (12/12) 291 (d)**
Miss Barlow reported that a meeting to discuss the Emergency Department performance had been held with the Clinical Commissioning Group (CCG), where it had been agreed that closer monitoring of the position would be required. The Board was advised that incident trends from the Emergency Departments was positive, however performance against the four hour waiting time target remained poor. It was reported that new escalation standards were in place which had been well received by staff in the area. The Board was informed that professional standards and an operational policy were also being developed to supplement the escalation standards. Ms Robinson asked what guidance the operational policy would provide. She was advised that this would set out the standard way that a patient presenting at the Emergency Departments should be handled. Miss Barlow advised that the report from the Department of Health's Intensive Support Team (IST) was due and that programme management support from the Transformation Support Office was now in place.	

In terms of the emergency flow project, it was reported that progress had been good, although this had been difficult in the face of the current Norovirus outbreak. It was highlighted however that number of capacity-related breaches would be likely to reduce through the emergency flow work.

The Chairman noted that leadership of the area was a key issue, particularly at City Hospital and asked what measures were planned to address the position and achieve the required trajectory to achieve an acceptable level of performance. Miss Barlow advised that an outcome of the discussions with the CCG had been the agreement of a trajectory and that it had been accepted that it was unlikely that the Trust would meet the required 95% target by the year end, however every effort would be directed into achieving this level of performance in the final quarter. In terms of the leadership of the area, it was reported that a more permanent solution to the current Clinical Director position was being investigated.

Mr Adler presented a dashboard showing the performance of the Emergency Department across a number of metrics. Ms Robinson suggested that the dashboard needed to be constructed so that the reasons for the poor performance against the ambulance turnaround target were clarified. Mr Sharon advised that more detailed information was available behind the headline performance in the dashboard, however poor patient flow was a key reason for the delay in the ambulance turnaround. Dr Stedman added that there was evidence that the process for handling patients requiring admission to hospital was problematic at present and that the model for medical admissions needed to be reviewed in this respect. Dr Stedman advised that demand on the Emergency Departments was variable, with peak attendances being at around 1300h and 1800h – 1900h. Mr Adler emphasised the need for an improvement on the performance with handling non-admitted patients, which would have a consequential improvement on the performance with handling patients requiring admission.

Prof Lilford suggested that consideration should be given to the use of Physician Assistants and Ms Robinson suggested that junior doctors might need to assist with clerking patients. Mrs Pascall advised that the staffing models in the Emergency Departments had changed recently. Dr Stedman added that it had been identified that the use of medical assessment units needed to be improved. Mr Kang highlighted that the admission of patients was administratively burdensome. Dr Stedman agreed, advising that the admission process handled by a junior doctor took approximately an hour per patient.

Miss Barlow was asked to circulate the report issued by the Intensive Support Team when available.

Ms Robinson asked whether there was any further support that the Board could give to ensuring that performance in the Emergency Departments improved. Miss Barlow suggested that increased visibility by the Board in the area would be received well.

ACTION: **Miss Barlow to share the report prepared by the Intensive Support Team (IST) into Emergency Department performance with the Board when available**	
14.4 Fire Safety annual report	**SWBTB (12/12) 292** **SWBTB (12/12) 292 (a)**
Mr Seager reported that the Trust had a Fire Safety Committee in place which met quarterly. The Board was reminded that it has recently approved the Trustwide Fire Safety policy. It was reported that the response regime by the West Midlands Fire Service had changed during the year. In terms of fire incidents and false alarms, the Board was advised that the number of arson threats was a concern. Mr Sharon suggested that a risk assessment needed to be undertaken in this respect. Mr Seager advised that this had been completed, however it had not been included within the Board papers. It was agreed that this should be presented to the Compliance & Assurance Committee once established. Mr Seager advised that there was no longer a legal obligation for the annual fire statement to be signed by the Chief Executive following approval by the Trust Board.	
15 Performance Management	
15.1 Update from the meeting of the Finance & Performance Management Committee held on 20 December 2013	**Verbal**
Mr Trotman reported that the meeting of the Finance and Performance Management Committee held earlier in the day had included a detailed review of the performance of the Pathology division. Mr White advised that the Committee had been informed that the forecast year end surplus was higher than initially planned and that at present all divisions were meeting or exceeding their required financial targets.	
15.2 Monthly finance report	**SWBTB (12/12) 293** **SWBTB (12/12) 293 (a)**
The Trust Board was asked to receive and note the monthly finance report, which detailed performance as at the end of Month 8.	
15.3 Monthly performance monitoring report	**SWBTB (12/12) 294** **SWBTB (12/12) 294 (a)**
Mr White presented the key exceptions in terms of performance across all major internal and external targets. It was reported that key areas of focus included the need to ensure 95% of staff had undertaken training on Information Governance and that the staff appraisal rate improved.	

Miss Barlow reported that in view of the infection outbreak, all routine surgery had been cancelled during the previous week, although some was being outsourced where possible. It was highlighted that meeting the Dementia CQUIN target was unlikely.	
15.4 NHS Performance Framework report	**SWBTB (12/12) 295** **SWBTB (12/12) 295 (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'.	
15.5 Provider Management Regime monthly return	**SWBTB (12/12) 296** **SWBTB (12/12) 296 (a)**
Mr Sharon presented the proposed Provider Management Regime return for submission to the Strategic Health Authority. It was highlighted that in terms of the Governance Risk Rating, the only area reported as being at red status was Emergency Department performance. On the Financial Risk Rating, two areas at red status were highlighted, those being related to debtor payments and capital spend. Regarding the Board statements, it was reported that compliance with the Information Governance toolkit may be achieved by 31 December 2012, however for the present non-compliance needed to be declared. Non-compliance with the statement around meeting operational targets was highlighted in the light of the poor performance against the Emergency Department target.	
AGREEMENT: The Trust Board gave its approval to the submission of the Provider Management Regime return	
15.6 Update on the delivery of the Transformation Plan	**SWBTB (12/12) 297** **SWBTB (12/12) 297 (a)** **SWBTB (12/12) 297 (b)**
Miss Barlow reported that the Transformation Plan was delivering a positive impact in terms of ensuring that the occupancy of medical assessment units was improved and that the level of discharges was higher, thereby assisting better patient flow. It was highlighted that seven day working needed to be focussed in some areas, the driver being an apparent variation in medical care. Dr Stedman highlighted however that the Trust's mortality position did not differ significantly between weekends and weekdays. Miss Barlow reported that a specific briefing for Non Executive Directors on the Transformation Plan was being organised.	
ACTION: Miss Barlow to organise a specific briefing on the Transformation Plan for Non Executive Directors	
16 Strategy & Development	

16.1 Reconfiguration	
Minutes from the meeting of the Clinical Reconfiguration Board held on 6 December 2012	**SWBTB (12/12) 298** **SWBTB (12/12) 298 (a)**
Mrs Hunjan reported that the Chairmanship of the Clinical Reconfiguration Board would change to Prof Lilford from February 2013. Areas highlighted as being considered or planned for reconfiguration were highlighted to include Haematology, Cardiology and Interventional Radiology. It was reported that any clinical cases for reconfiguration would be presented to the Trust Board prior to work starting.	
16.2 'Right Care, Right Here' programme: progress report, including an update on decommissioning	**SWBTB (12/12) 300** **SWBTB (12/12) 300 (a)**
The Trust Board received and noted the 'Right Care, Right Here' programme progress report. Mr Sharon reported that a number of care pathways were being redesigned. The Board was informed that a new partnership structure had been implemented and joint meetings were being held. It was highlighted that non elective activity was above plan for the year.	
16.3 Communications and Engagement strategy update	**SWBTB (12/12) 301** **SWBTB (12/12) 301 (a)**
Mrs Kinghorn presented the biennial update on the delivery of the Communications and Engagement strategy. She advised that the action plan to deliver the strategy comprised 147 actions, the progress against which the Board was asked to note. In terms of the membership element of the Communications and Engagement strategy, it was reported that there was much work to do to achieve the target membership of 8000. The Chairman asked whether the membership website would be relaunched. Mrs Kinghorn advised that this was the case and this was due by mid January 2013. The Chairman raised an issue concerning a clinician running a media article concerning their speciality and while he emphasised that he welcomed initiative being taken, he was disappointed that this matter had not been handled using central support from the Communications team. Mrs Kinghorn advised that two incidents of this had been experienced, both relating to the same source. Mr Sharon asked whether a policy was in place to govern this practice. He was advised that a policy was under development.	
16.4 Staff engagement update	**SWBTB (12/12) 302** **SWBTB (12/12) 302 (a)**
Mrs Kinghorn advised that the Trust had won an award for staff engagement. It was reported that recruitment of 'Listening into Action' champions was underway, given that a central co-ordinator was no longer in post. Mr Sharon	

highlighted a risk that staff engagement might deteriorate with the departure of Mr Adler who had spearheaded the 'Listening into Action' work. Mrs Kinghorn advised that a birthday party to mark the fifth anniversary of 'Listening into Action' was planned.	
16.5 Foundation Trust application: programme director's report	**SWBTB (12/12) 303** **SWBTB (12/12) 303 (a)**
The Trust Board received and noted the Foundation Trust programme director's report. Mr Sharon reminded the Board that it had approved the case for change for a revised version of the Tripartite Formal Agreement, which set out the timescales for the Trust to gain Foundation Trust status at its private session held earlier in the day.	
17 Update from the Committees	
17.1 Audit Committee – 6 December 2012	**Verbal**
Mrs Hunjan advised that all routine items had been covered by the agenda of the Audit Committee that had taken place on 6 December 2012. It was reported that the Reference Cost position had been reviewed which had showed a stable position despite the amalgamation with Community Services staff in April 2011. It was reported that the specification for future Internal Audit services had been discussed.	
17.2 Charitable Funds Committee – 6 December 2012	**Verbal**
The Board was asked to receive and note the update from the Charitable Funds Committee held on 6 December 2012.	
18 Any other business	**Verbal**
There was none	
19 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 31 January 2013 and would be held in the Anne Gibson Boardroom at City Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 31 January 2012, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

20 December 2012, Boardroom @ Sandwell Hospital

Members present: Mr R Samuda (RS), Ms C Robinson (CR), Mr H Kang (HK), Dr S Sahota (SS),Mrs G Hunjan (GH), Prof R Lilford (RL), Mr J Adler (JA), Mr R White (RW), Dr R Stedman (RST), Miss R Barlow (RB)

In Attendance: Mr M Sharon (MS), Miss K Dhami (KD), Mr G Seager (GS), Mrs J Kinghorn (JK), Mrs L Pascall (LP), Mr R Trotman (RT)

Apologies: Ms O Dutton (OD), Miss R Overfield (RO)

Secretariat: Mr S Grainger-Payne (SGP)

Last Updated: 24 January 2013

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.234	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	Prepare a letter on behalf of the Chairman to recognise the improvement in the performance of the Trauma & Orthopaedics team	RB	20/12/12	Prepared as requested	B
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 2013 meeting	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	To be revised from January 2013	G
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	28/02/13		G
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 to be given at January 2013 meeting	G

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		G
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 currently being organised	G

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:	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:	31 January 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:

Routine monthly update.

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

January 2013

Where EVERYONE Matters

CONTENTS

QUALITY REPORT

1 INTRODUCTION

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

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

2 KEY POINTS TO NOTE

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

PATIENT SAFETY

- Safety Thermometer results in December decreased to 92.4% with increases in pressure damage, falls and new VTE on the day of the audit.
- Falls incidents rose slightly in November 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.
- During December there was an unprecedented number of ward closures due to norovirus/D&V. A total of 15 wards across the Trust were closed in December with 10 confirmed as norovirus.
- Pressure Damage – remains broadly the same as last month.
- Bank/agency (nursing) dropped slightly during December – thought to be due more to supply restrictions than any reduction in demand.

CLINICAL EFFECTIVENESS

- Fractured Neck of Femur operated on within 24 hours of admission during December was 77%, exceeding the local target of 70%.
- Compliance with the use of the World Health Organisation (WHO) checklist is 99.80%. Completion of the Briefing and debriefing has improved. Work continues on assessing the spirit of the adoption of the checklists as a qualitative evaluation is underway. Performance management arrangements established for non-complaint operators.
- Stroke Care- Some performance indicators dipped during December due to pressure on bed availability.
- VTE performance remains above 90% during December for all admitted patients.
- Performance for October was 53% which is below the target of 68%. A plan has been put in place to recover and restore target achievement.
- The 97% target for documenting allergy status on the prescription was achieved in for the first time December, 98.4% compliance was achieved. The Warfarin CQUIN was also achieved with compliance of 100%.

PATIENT EXPERIENCE

- The Net Promoter score in December increased to 65 achieving the SHA 10 point improvement target. The SHA average is currently at 69.
- 44 complaints were received in December and 93 final responses were sent out.

WORKFORCE QUALITY

- The Trust is currently meeting its overall mandatory training target – 86.8% (85%). PDR rates however, are lower than our target rate.
- Sickness absence is 4.58%

3 TARGETED AREAS OF SUPPORT

The areas of the Trust being provided with targeted support this month are:

- EAU Sandwell – is now out of special measures but will continue with monthly ward reviews within the division
- ED, City
- ED, Sandwell

Continues in Special Measures but we have agreed that assuming the remaining key actions are completed this month then Special Measures will be removed next month.

- L3, P4, P5 and L4 wards – all are struggling as a result of paused bed closures and therefore have staffing issues. Active support is being provided and close monitoring of standards.

4 EMERGING TRENDS/NOTICEABLE PATTERNS

- Norovirus outbreak

5 OF SPECIFIC NOTE

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

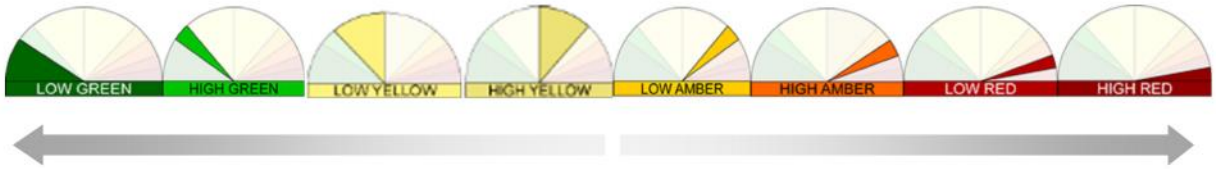
6 KEY CLINICAL RISKS

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

7 CARE QUALITY COMMISSION'S QUALITY AND RISK PROFILE

Care Quality Commission (CQC): Quality and Risk Profile (QRP)

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 for quality and safety for the Trust are:

Risk estimate	Frequency	Outcomes
No Data	-	-
Insufficient data	0	
Low Green	2	21 and 11
High Green	1	14
Low Yellow	11	1, 5, 6, 7, 8, 9, 10, 12, 13, 16, 17
High Yellow	1	2
Low Amber	-	-
High Amber	1	4
Low Red	-	-
High Red	-	-

There are currently no outcome risk estimates Red and one in Amber. This shows the Trust overall as being at a low risk of non-compliance with the CQC's 16 essential standards of quality and safety. Since December 2010, there have been few changes which have not been significant enough to have an effect on the overall RAG status for the Outcomes. It is important to state that low risk estimates in a QRP do not guarantee compliance. On-going monitoring of compliance will take place to ensure that this position is maintained and improved.

8 CQuINs

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST CORPORATE DASHBOARD - DECEMBER 2012

Exec Lead			PATIENT SAFETY				August	September	October	November			December			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	%	87.5 ■	91.0 ■	91.5 ▲	→		91.7 ▼	→		90.0 ▼	90.01*	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	%	99.7 ■	99.8 ■	99.8 ■	→		99.8 ■	→		99.8 ■	99.8	99	100		No variation		Any variation	●
RS	H	9		Safe Surgery - Other Areas		%	99.6 ■	100 ▲	99.8 ▼	→		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	Met Q2 req's	Meeting Q3 req's	→		Meeting Q3 req's	→		Meeting Q3 req's	Met Q3 req's	80	90		No variation		Any variation	●
RS	H	3		Mortality Review	743	%	64.9 ▲	68.9 ▲	53.9 ■	→			→			53.9	68	80	a	No variation		Any variation	●●
RO	H	11	Community CQUIN	Dementia	44	%	Met Q2 req's	Met Q2 req's	Not Meeting Q3 req's	→		Not Meeting Q3 req's	→			Not Meeting Q3 req's	80	90		No variation		Any variation	●
PATIENT EXPERIENCE																							
RO	H	8	Acute CQUIN	Personal Needs	396	%	→	→	→	→		→	→		→	67.9	67.6	71.6		No variation		Any variation	●
RO	H	8		Net Promoter	372	No.	60 ▲	63 ▲	64 ▲	→		65 ▲	→			65	62	65		No variation		Any variation	●
RO	H	8		End of Life Care	372	%	57 ▲	60 ▲	59 ▼	→		65 ▲	→			65	50	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	95.5 ▲	91.5 ▼	96.0 ▲	→		93.0 ▼	→			96.0	90	90		No variation		Any variation	●
RO	H	11		Net Promoter	88	No	71 ■	81 ■	88 ▲	→		86 ▼	→			86	75	75	a	No variation		Any variation	●
RO	H	11		Every Contact Counts	132	%	Base data being captured	Baseline established	Met Monthly requirement	→		Met Monthly requirement	→			Met Monthly requirement	Comply with KPI trajectories			No variation		Any variation	●
RO	H	11		Smoking Cessation	132	%	Base data being captured	Baseline established	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	→	→		→	→			Q2 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●
RS	H	13		Neonatal - Hypothermia Treatment	73	%	→	Q2 Return Submitted	→	→		→	→			Q2 Return Submitted	Derive Base	Derive Base		No variation		Any variation	●
RS	H	13		Neonatal - Discharge Planning / Family Experience and Confidence	122	%	→	Q2 Return Submitted	→	→		→	→			Q2 Return Submitted	Derive Base	Derive Base		Met		Not Met	●
RS	H	12		HIV - Optmum Therapy	147	%	→	Q2 Return Submitted	→	→		→	→			Q2 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●

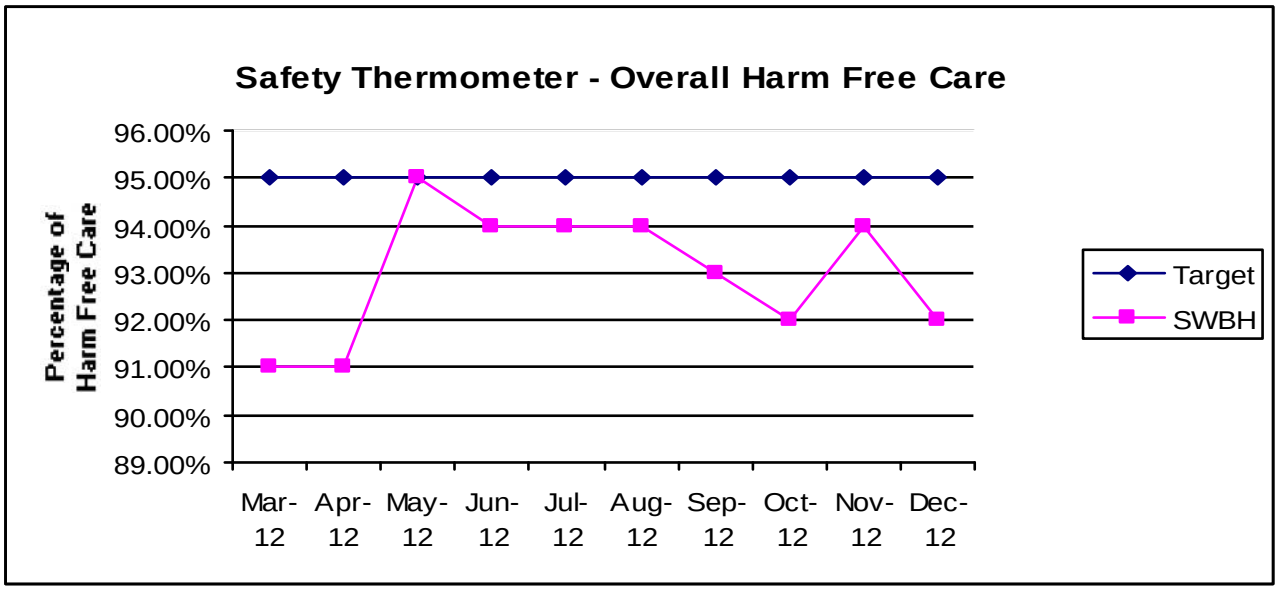
9 PATIENT SAFETY

9.1 Safety Thermometer

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

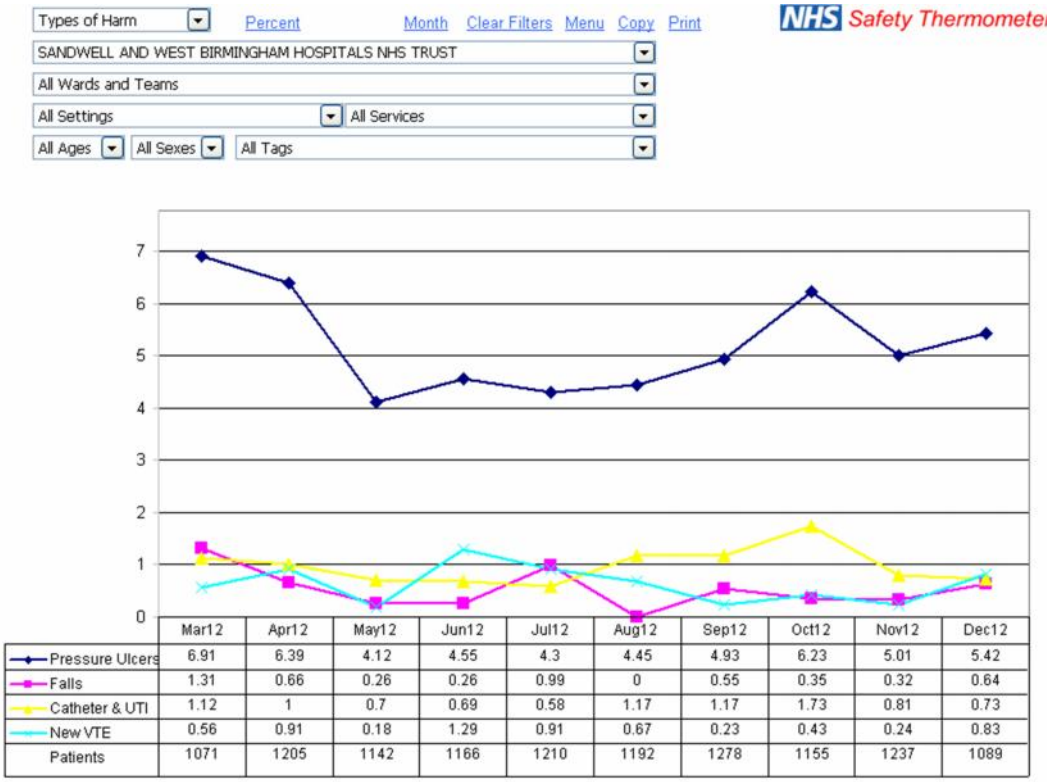
Conducting monthly whole Trust census of patients for 4 harm events (falls, pressure damage, CAUTI and VTE) continues to go well with good engagement of nursing staff. Work has commenced to add other harm measures to the tool, eg avoidable weight loss.

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

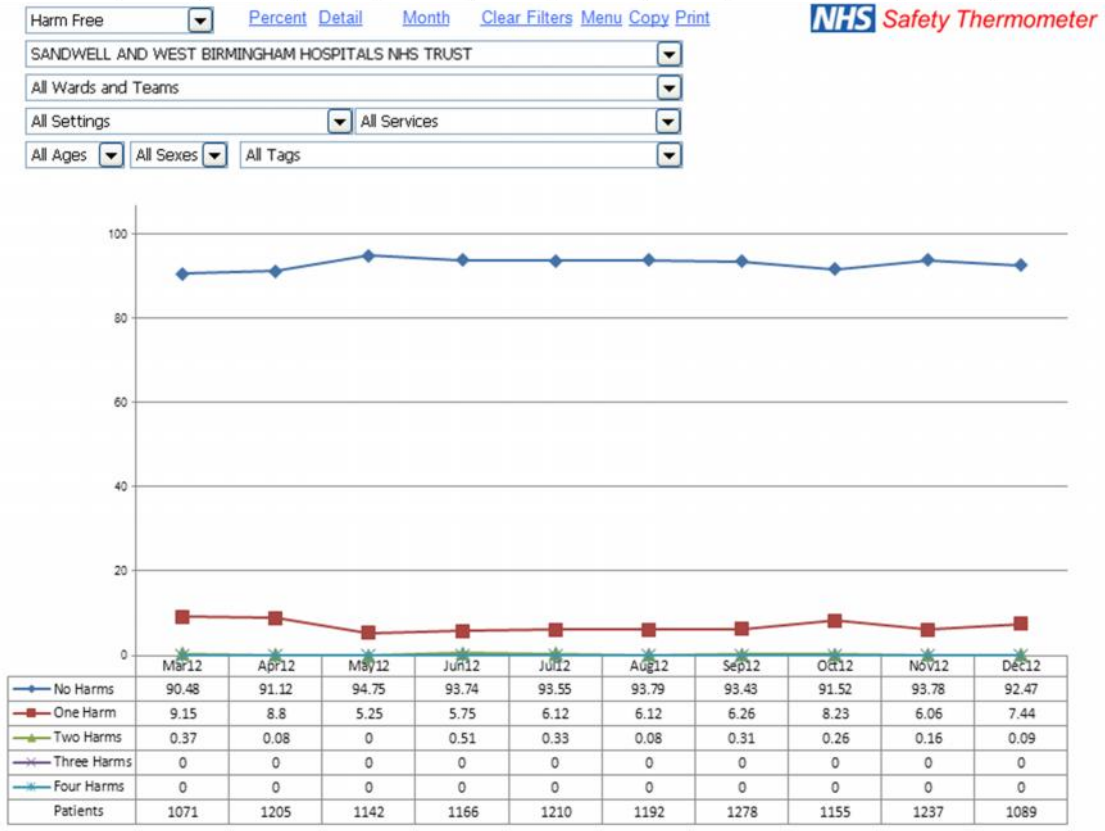


Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-13
90.48%	91.12% ë	94.75% ë	93.74% í	93.55% í	93.79% ë	93.43% í	91.52% í	93.78% ë	92.47% í

Figure 1: *Harm free care trend*



	Mar12	Apr12	May12	Jun12	Jul12	Aug12	Sep12	Oct12	Nov12	Dec12
Pressure Ulcers	6.91	6.39	4.12	4.55	4.3	4.45	4.93	6.23	5.01	5.42
Falls	1.31	0.66	0.26	0.26	0.99	0	0.55	0.35	0.32	0.64
Catheter & UTI	1.12	1	0.7	0.69	0.58	1.17	1.17	1.73	0.81	0.73
New VTE	0.56	0.91	0.18	1.29	0.91	0.67	0.23	0.43	0.24	0.83
Patients	1071	1205	1142	1166	1210	1192	1278	1155	1237	1089



	Mar12	Apr12	May12	Jun12	Jul12	Aug12	Sep12	Oct12	Nov12	Dec12
No Harms	90.48	91.12	94.75	93.74	93.55	93.79	93.43	91.52	93.78	92.47
One Harm	9.15	8.8	5.25	5.75	6.12	6.12	6.26	8.23	6.06	7.44
Two Harms	0.37	0.08	0	0.51	0.33	0.08	0.31	0.26	0.16	0.09
Three Harms	0	0	0	0	0	0	0	0	0	0
Four Harms	0	0	0	0	0	0	0	0	0	0
Patients	1071	1205	1142	1166	1210	1192	1278	1155	1237	1089

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

<u>Acute Divisions</u> 20 patients experienced **1 new harm**. **No** patients experienced **2, 3 or 4 harms**
<u>Community Division</u> **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.

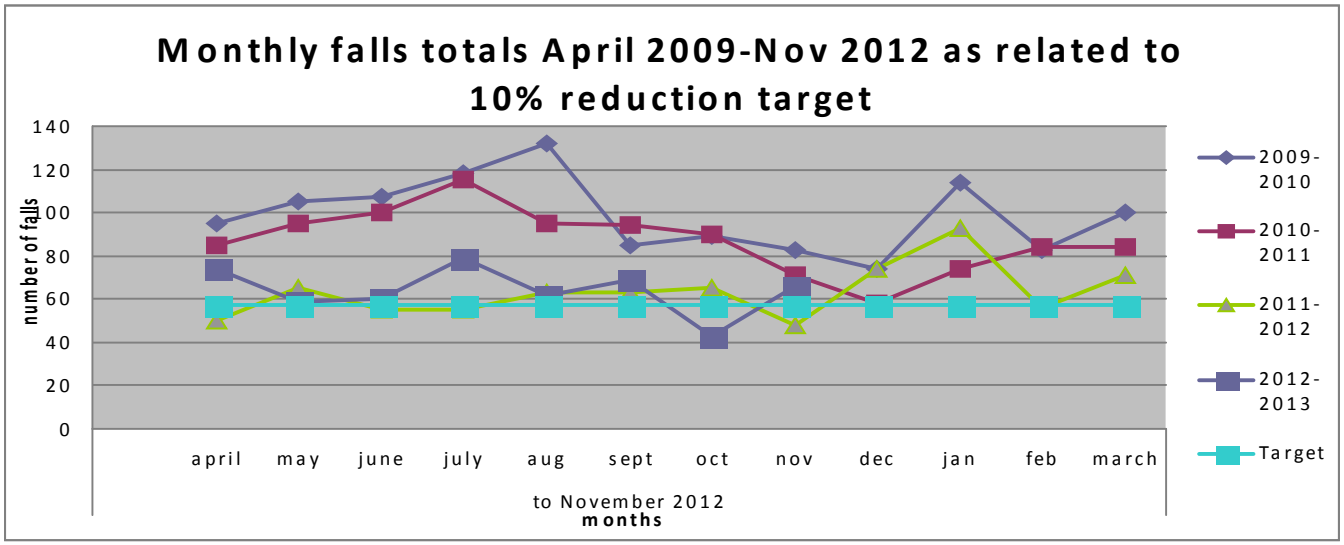


Figure 4: *Trend of falls*

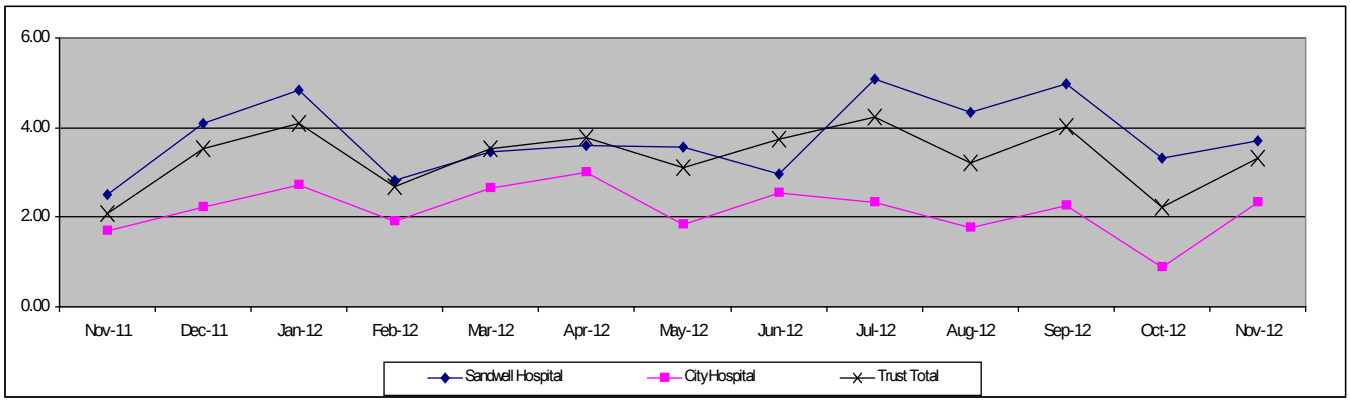


Figure 5: *Incidence of falls per 1000 bed days across Acute Inpatient Divisions*

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.

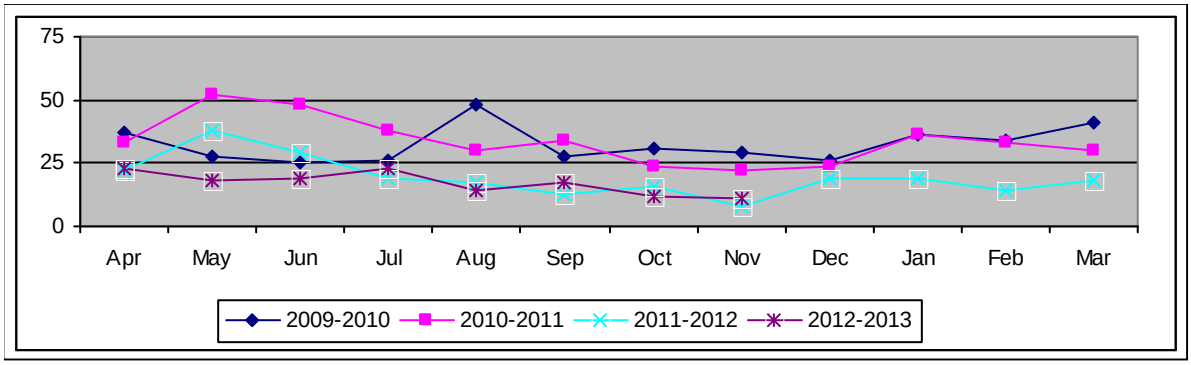


Figure 6: *Number of hospital acquired pressure damage Grade 2, 3 & 4, April 2009 - July 2012*

New pressure ulcers (reported on ST):
November – 5 (4 grade 2, 1 grade 3, 0 grade 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 December was 90.39% 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*

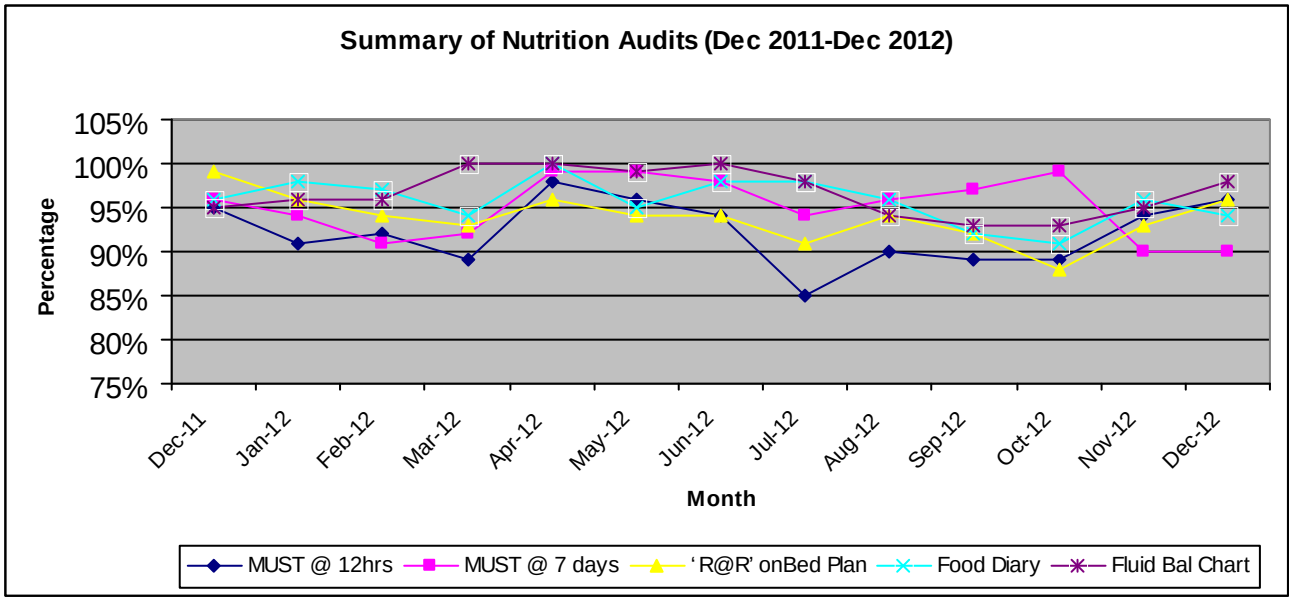


Figure 7: *Nutrition Audit Results*

9.3 Infection Control

Targets 2012/13: *C difficile* – 57 cases (post 48 hours, using SHA testing methodology)

(National Priority Local contract)

MRSA – 2 cases (post 48 hours)
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

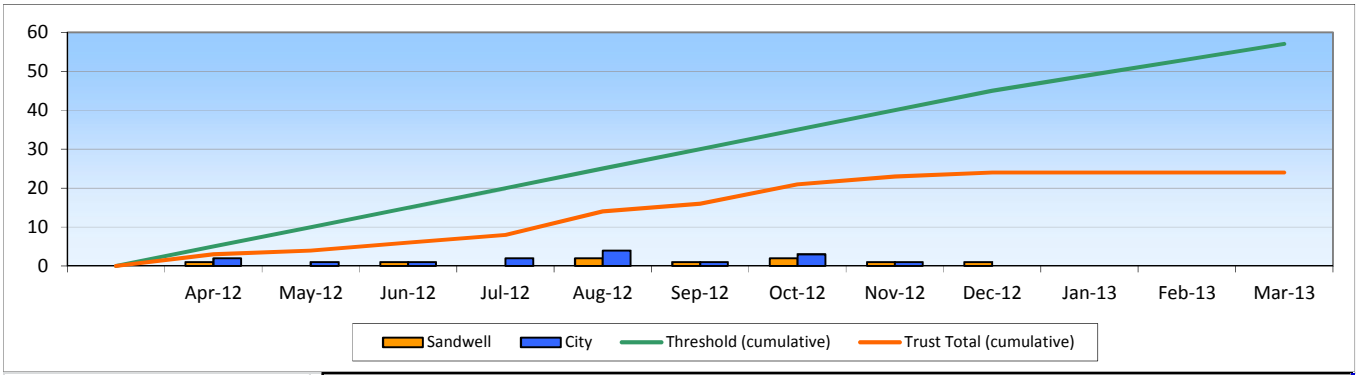
There were no post-48 hour MRSA bacteraemia for December. The total number of MRSA bacteraemias against the Trust target to date is 1.

MRSA Screening

Target: 85% eligible patients by March 2013.

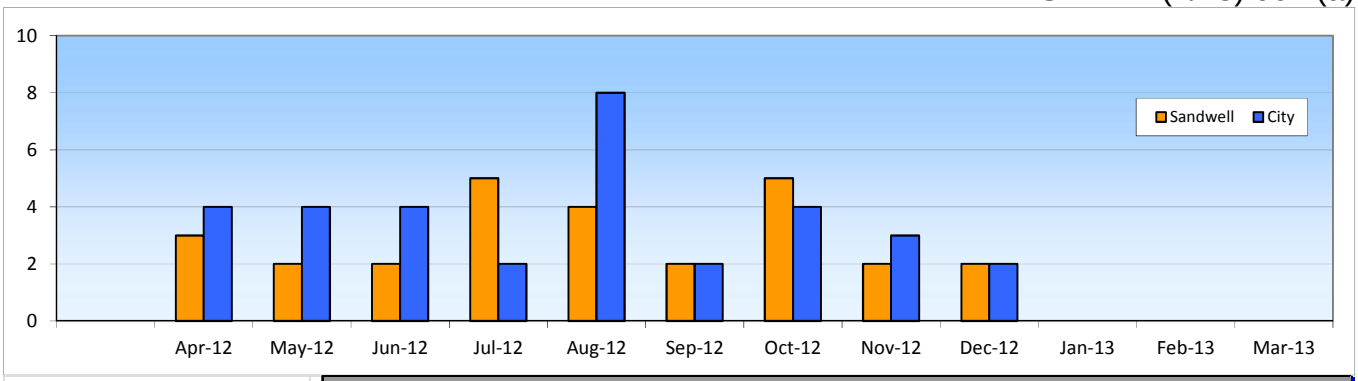
			To Date (*=most recent month)	TARGET	
				YTD	12/13
MRSA Screening - Elective	Patient Not Matched	%	112.0*	70	85
	Best Practice - Patient Matched	%	55.2*	70	85
MRSA Screening - Non Elective	Patient Not Matched	%	78.4*	70	85
	Best Practice - Patient Matched	%	67.0*	70	85

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				**9**
City	2	1	1	2	4	1	3	1	0				**15**
Trust	3	1	2	2	6	2	5	2	1	0	0	0	**24**
Intermediate Care	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	24	24	24	-
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				**27**
City	4	4	4	2	8	2	4	3	2				**33**
Trust	7	6	6	7	12	4	9	5	4	0	0	0	**60**
Intermediate Care	0	0	0	0	0	0	0	0	0				**0**
Trust Total (cumulative)	7	13	19	26	38	42	51	56	60	60	60	60	-

Figure 9: *Trust Best Practice Data*

Blood Contaminants

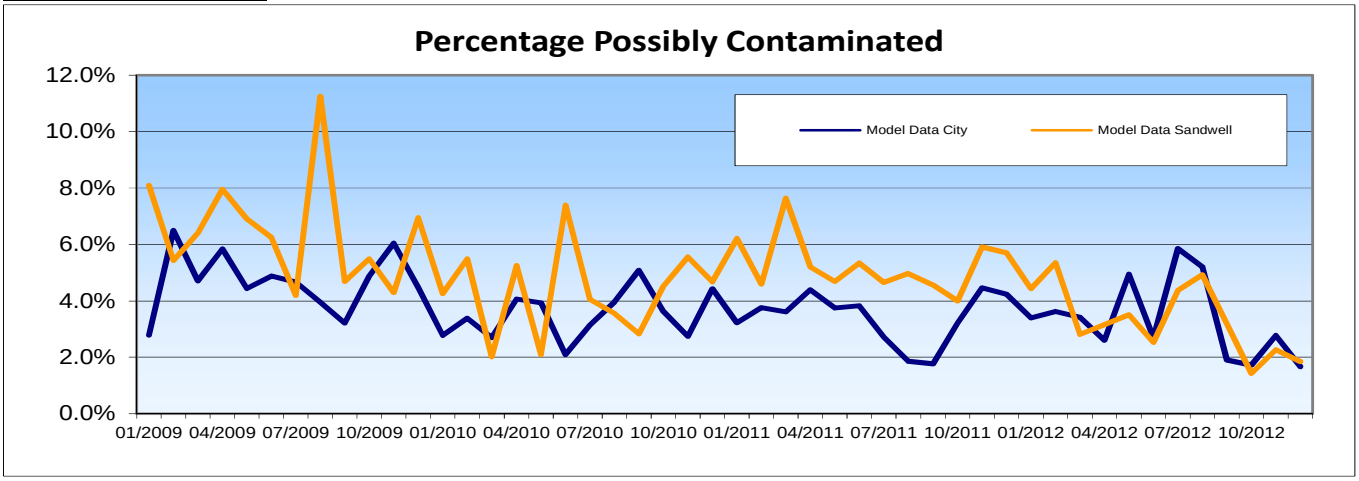


Figure 10: *Blood Contaminants*

E Coli Bacteraemia

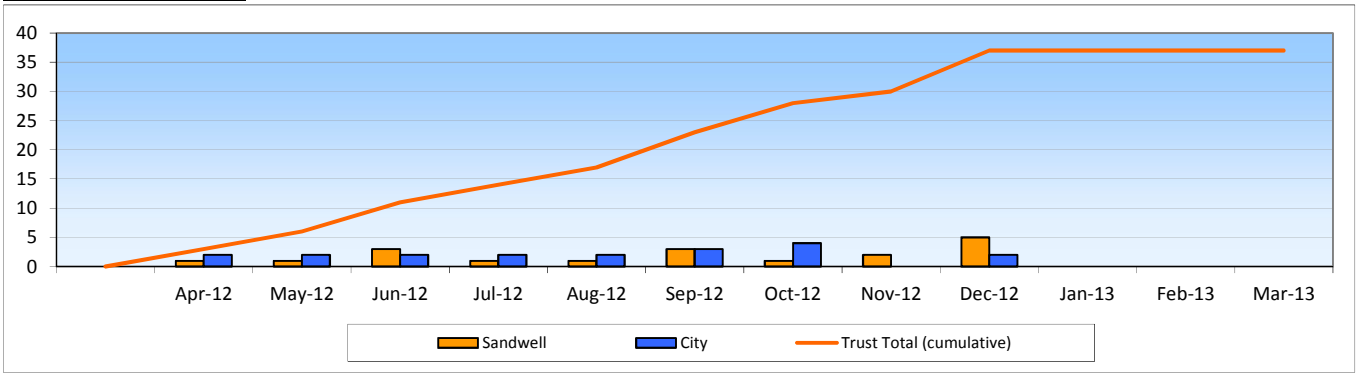


Figure 11: *E Coli Bacteraemia*

MSSA

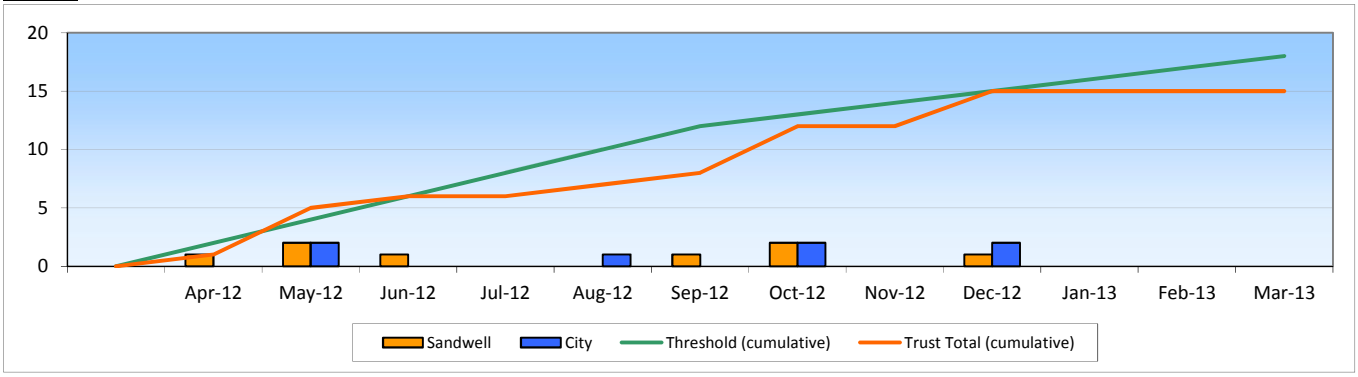


Figure 12: *MSSA*

Outbreak and Other Infection Control Activity

During December there was an unprecedented number of ward closures due to diarrhoea and vomiting, most of which were due to norovirus.

A total of 15 wards across the trust were closed during December; 10 were confirmed to be due to norovirus (one ward also had a case of rotavirus). The cumulative total of days wards were closed for is 154 (several wards closed at any one time).

It must be noted that all staff worked extremely hard to ensure that wards were closed for as short a time as possible and vacated wards were cleaned thoroughly and quickly.

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 November.

Adjusted Perinatal Mortality Rate (per 1000 babies): the adjusted perinatal mortality rate for November was 10.3 which was over the trajectory (8) and was higher 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 November was 26.6%, which is above 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 November was 6% which is below the trajectory (15).

Community Midwife Caseload (bi-monthly): The community midwife caseload in November remained the same as the previous month (138), which is just below the trajectory of 140.

Vacancies: Vacancy rates decreased to 8 in November (from 10.5 in October).

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

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 December 2012.

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: 082 – Waking frames, various models (signed off as no action required and 083 - Laboratory analyser. Mass spectrometers manufactured by Waters Corporation, a US corporation. Specific products (signed off as actions completed)

9.11 Lessons Learned

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

During December there were two incident reviews completed both of which identified that comprehensive documentation and assessment was completed.

The lesson from these two incidents is that documentation can show evidence of notable practice and clearly identifies the care planning for patients.

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.

Existing risks on the Corporate Risk Register have been reviewed and a summary update report will be provided to the Quality & Safety Committee on a monthly basis from February 2013.
No new risks were presented for inclusion in December 2012.

9.13 Patient & Staff Safety Listening into Action: Update

- The Risk Management website has been developed and 'live'. Work is underway to upload key documents e.g. data reports, minutes, newsletters and other information.
- The Risk Management blog is delayed but will be 'live' once the intranet pages are complete.

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

Dec-12																			
Medicine	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)
	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	42.4	78.44%	16.84%	2.49	8.14%	46.4	98	0	1	0	100	88	68
CCU Sandwell	19.22	85.54%	10	1.92	10	1.92	17.39	71.88%	19.38%	1.74	0.19%	18.43	93	0		1	100	88	71
D7 (13base/12 ww)	43.04	49.37%	25	1.72	25	1.72	35.21	48.99%	9.09%	1.41	0.00%	42.81	88	1	3	0	100	95	75
D11	32.14	59.52%	21	1.53	21	1.53	32.54	49.42%	21.33%	1.55	13.37%	27.43	94	0	3	0	100	76	57
D12	17.12	64.95%	10	1.71	10	1.71	16.5	60.01%	16.96%	1.65	0.45%	11.76	85	0	2	0	100	60	100
D15	26.51	58.28%	24	1.10	24	1.10	28.75	53.59%	18.59%	1.20	5.40%	29.9	95	0	1	1	100	91	69
D16	30.85	44.47%	23	1.34	23	1.34	37.08	35.38%	26.86%	1.61	8.62%	18.62	92	1	1	0	100	76	100
D17	30.09	63.48%	26	1.16	26	1.16	33.21	51.19%	20.05%	1.28	2.72%	19.62	70	0	1	0	100	100	100
D18	24.36	44.66%	16	1.52	16	1.52	28.14	37.28%	33.26%	1.76	5.80%	21.07	100	0	1	1	93	92	63
D41	29.58	75.86%	19	1.56	19	1.56	29.13	61.73%	21.13%	1.53	3.44%	29.99	91	0	1	1	100	95	65
D43	31.83	57.21%	28	1.14	24	1.33	28.82	38.31%	25.47%	1.20	0.00%	34.98	93	0	2	2	100	95	100
MAU	65.3	64.89%	28	2.33	28	2.33	70	58.37%	15.53%	2.50	9.23%	NA	NA	1	1	0	80	100	71
PRIORY 3	30.7	52.18%	29	1.06	29	1.06	32.46	43.13%	13.99%	1.12	4.62%	27.83	87	0	5	1	100	100	80
EAU	63.73	47.64%	28	2.28	32	1.99	68.67	39.98%	41.14%	2.15	2.66%	NA	NA	0	3	0	100	71	44
NEWTON 4	30.92	43.31%	22	1.41	24	1.29	38.19	28.62%	40.35%	1.59	10.30%	42.97	100	1	1	0	100	83	73
NEWTON 1	21.15	81.99%	12	1.76	14	1.51	20.61	72.67%	13.75%	1.47	3.44%	19.15	89	1	6	0	100	82	100
PRIORY 4 (base)	19.08	47.75%	14	1.36	14	1.36	20.98	41.62%	29.30%	1.50	*3.22%	40.95	99	0	5	1	97	85	67
LYN4(13 base,20ww	39.94	55.41%	33	1.21	33	1.21	32.1	44.54%	21.88%	0.97	4.09%	NA	NA	0	2	0	87	84	100
NEWTON 5	22.43	69.73%	15	1.50	15	1.50	24.34	68.33%	14.41%	1.62	1.02%	15.37	91	0	1	0	100	100	100
Priory 4 (winter)	22.35	58.26%	20	1.12	20	1.12	19.4	49.07%	13.56%	0.97	*3.22%	40.95		0		0		-	67
D30 (winter)	23.59	61.89%	19	1.24	19	1.24	24.08	44.85%	31.89%	1.27	12.89%				1	2	100	82	100
PRIORY 5	36.59	52.61%	34	1.08	34	1.08	42.1	46.91%	15.29%	1.24	7.00%	68.99	99	0	5	0	89	100	33

Figure 13: *Medicine*

Dec-12																			
Surgery	Budgeted Posts & Funded Beds				Actual Bed Usage		Actual In Post				Sickness	SNCT	Bed Occupancy	Complaint	Falls	Pressure sores	MUST	ST (Target 95%)	FFT (Target 65)
	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
D6 (Pre Assess)	8.15	75.46%	27	0.30	27	0.30	8.15	73.62%	4.29%	0.30	13.59%	NA		0➲	0	0	100➲	na	na
D21(was D30)	28.84	56.80%	23	1.25	23	1.25	30.43	49.03%	12.19%	1.32	8.29%	NA	92	0➲	3↓	0	86↑	93↑	71↓
D25	28.28	60.04%	19	1.49	19	1.49	25.89	51.41%	13.25%	1.36	4.44%	NA	83	1➲	1	0	100➲	100➲	61↑
SAU/D42	22.98	73.89%	14	1.64	14	1.64	21.84	67.68%	8.09%	1.56	13.72%	NA		0➲	1	0	100➲	100➲	84↑
ASU	24.6	72.36%	20	1.23	26	0.95	23.18	67.30%	5.61%	0.89	18.97%	NA		1↓	0	0		-	33↓
NEWTON 2	18.05	62.22%	24	0.75	24	0.75	17.05	60.01%	1.51%	0.71	7.74%	NA	93	0➲	0	0	100➲	93↓	89↑
LYNDON 2	27.93	56.57%	26	1.07	20	1.40	29.74	43.62%	24.34%	1.49	16.14%	NA	93	0↑	2	0	90➲	95↓	37↓
LYNDON 3	39.8	58.27%	33	1.21	33	1.21	39.12	47.98%	7.63%	1.19	2.73%	NA	81	0➲	1	0	100➲	97➲	56↑
PRIORY 2	26.87	61.11%	26	1.03	26	1.03	32.8	44.88%	22.09%	1.26	9.58%	NA	97	1↓	0	0	100↑	95↑	67↓
NEWTON 3	41.27	57.98%	33	1.25	33	1.25	39.63	50.35%	6.65%	1.20	2.08%	NA	93	1➲	3	0	90↑	100↑	75
Please note NEWTON 2 is a 5 day ward.																			

Figure 14*: Surgery A*

Dec-12	Budgeted Posts & Funded Beds				Actual Bed Usage		Actual In Post				Sickness
	Total WTE	% Trained Staff	No. Funded Beds	Budgeted Staff per bed	Average Actual Bed Usage	Budgeted Staff: Actual Bed	Total WTE In Post	% Trained Staff	% Bank & Agency Staff	Actual Staff:Actual Bed Ratio	% (previous Month)
HENDERSON	28.67	49%	22	1.30	20	1.43	21.22	53%	35.70%	1.06	6.19%
LEASOWES	25.58	40%	20	1.28	20	1.28	20.14	38%	11.00%	1.01	10.05%

NB It is acceptable to have a lower ratio of registered:unregistered staff in Community Rehabilitiation facilities

Figure 15: *Community*

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.

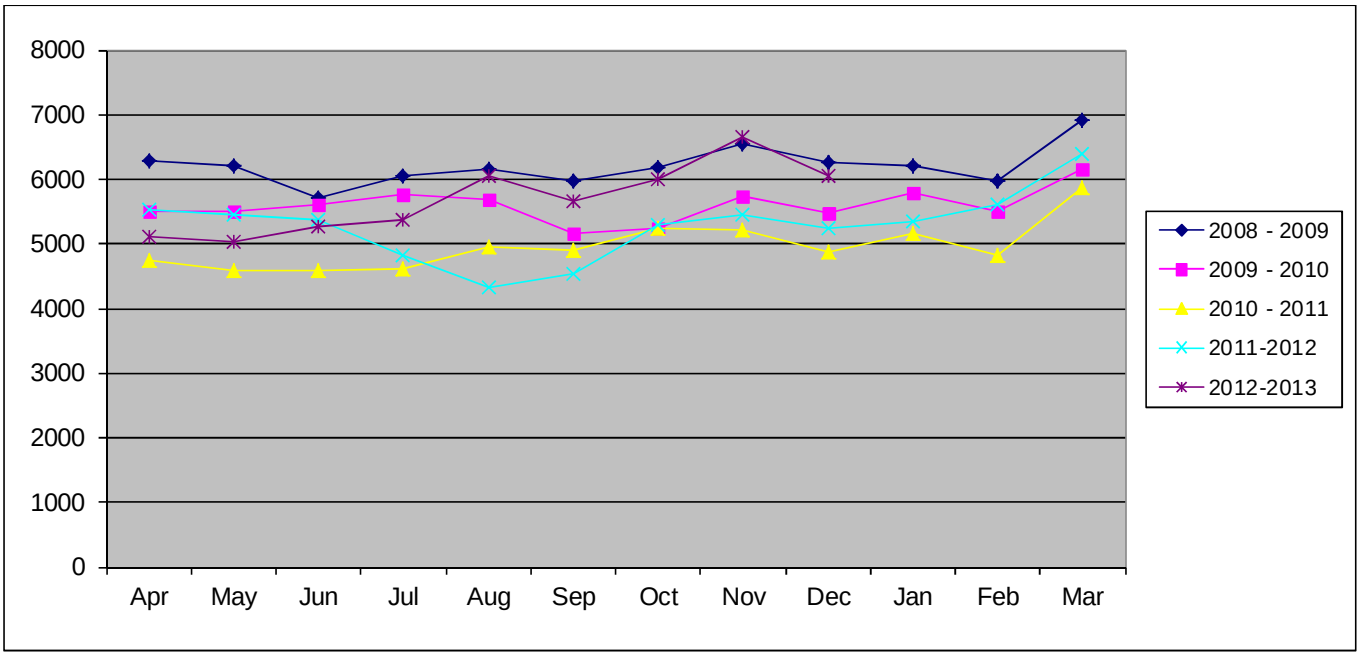


Figure 16: *Total Bank & Agency Use Nursing April 2008 –date.*

10 CLINICAL EFFECTIVENESS

10.1 Mortality

CQUIN Target

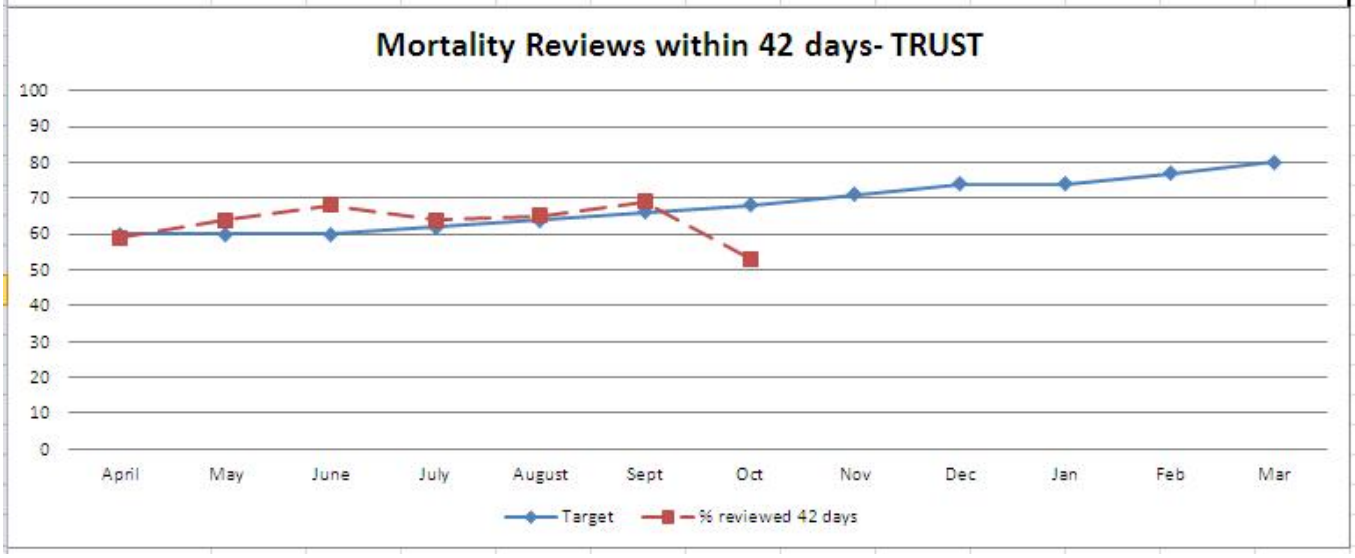
As part of the Trust's annual contract agreement with the commissioners the Trust has agreed a CQUIN scheme with an end year target to review 80% of hospital deaths within 42 working days.

During the most recent month for which complete data is available (October) the Trust reviewed 53% of deaths compared with a target trajectory for the period of 68.0%. The Trust has failed to meet the trajectory for October. 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	68	64	65	69	53					
DEATHS (all trust)	133	146	126	121	132	121	139	108	136			



Data from QMF dashboard, CDA 17/1/12

Figure 17: *Mortality review results*

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 (92.5) remains below 100, and is less than the lower statistical confidence limit and continues to remain lower than that of the SHA Peer (96.7). The in-month (October 12) HSMR for the Trust has increased to 91.1 and this remains within statistical confidence limits (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 23/10/12 for the period April 11 – March 12. For this period the Trust has a SHMI value of 0.97 and was categorised in band 2.

- 10 trusts had a SHMI value categorised as 'higher than expected'
- 16 trusts had a SHMI value categorised as 'lower than expected'
- 116 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 (September 11- August 12) is 94.2

Mortality table 2012/13

	Apr	May	June	July	Aug	Sept	Oct
Internal Data:							
Hospital Deaths		146	126	121	132	121	139
Dr Foster 56 HSMR Groups:							
Deaths		129	111	100	113	101	124
HSMR (Month)		89.2	89.7	85.5	83.9	84.8	91.1
HSMR (12 month cumulative)		88.3	96.4	95.5	94.2	93.1	92.5
HSMR (Peer SHA 12 month cumulative)		93.3	101.3	100.2	98.7	97.8	96.7

Figure ( ) Mortality Statistics

CQC Mortality Alerts received in 2012/13

A new CQC Alert was received by the Trust in December relating to perinatal mortality. An investigation has now been completed and a report has been submitted to the Commission. The findings will be presented to a meeting of the Quality & Safety Committee to be held in January 2013.

Dr Foster generated alerts (RTM)

There were no new diagnoses or procedures alerting with significant variation in terms of mortality when the data period November 2011 – October 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	40484	1503	3.7%	1624.1	4.0%	92.5	87.9	97.3		2
ALL	Acute and unspecified renal failure	308	45	14.6%	62.2	20.2%	72.3	52.7	96.7		1
ALL	Acute bronchitis	1292	26	2.0%	37.9	2.9%	68.6	44.8	100.5		1
ALL	Acute cerebrovascular disease	619	110	17.8%	118.3	19.1%	93.0	76.4	112.1		1
ALL	Aspiration pneumonitis, food/vomitus	156	43	27.6%	54.1	34.7%	79.5	57.5	107.0		1
ALL	Biliary tract disease	1105	18	1.6%	16.2	1.5%	111.3	66.0	176.0	1	
ALL	Cancer of prostate	704	7	1.0%	10.4	1.5%	67.6	27.1	139.2		1
ALL	Congestive heart failure, nonhypertensive	806	77	9.6%	98.6	12.2%	78.1	61.6	97.6		2
ALL	Diabetes mellitus with complications	437	9	2.1%	15.5	3.5%	58.0	26.5	110.2		2
ALL	Other psychoses	176	9	5.1%	5.2	2.9%	173.7	79.3	329.8	1	
ALL	Pulmonary heart disease	269	21	7.8%	12.6	4.7%	167.1	103.4	255.5	1	
ALL	Residual codes, unclassified	662	3	0.5%	6.5	1.0%	46.4	9.3	135.5		1
ALL	Septicemia (except in labour)	103	12	11.7%	21.1	20.5%	56.8	29.3	99.2		1
ALL	Short gestation, low birth weight, and fetal growth retardation	788	9	1.1%	18.4	2.3%	48.9	22.3	92.8		1
Mortality (in-hospital 30 days) - Procedures										**Alert**	
Team	Procedures	Superspells	Deaths	%	Expected	%	Relative Risk	Low	High	-	+
ALL	Puncture of joint	502	1	0.2%	4.2	0.8%	23.7	0.3	131.9		1
ALL	Reduction of fracture of bone (upper/lower limb)	839	1	0.1%	3.8	0.4%	26.6	0.3	148.1		1

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

Figure ( ) Mortality in hospital diagnoses

National Clinical Audit Supplier – Potential Outlier Alerts

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

Patient Related Outcome Measures (PROMs)

Provisional data in the form of experimental statistics was published on 13/11/12 for the 2011/12 financial year and also for the period April 12 to June 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.

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	1
1 - Audit not yet due to start	7
2- Significant delay	2
3- Some delay - expected to be completed as planned	3
4- On track - Audit proceeding as planned	45
5- Data collection complete	15
6- Finding presented and action plan being developed	4
7- Action plan developed	3
A - Abandoned	3
Grand Total	83

The status of the audits that have been included in the plan as at the end of October is shown in the table above. A further audit (2.24, Audit of the uptake of long acting reversible contraceptives) has been indicated as experiencing a 'Significant delay' and will not be completed as originally planned.

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 November 2012 is shown in the table below (data source CDA Dashboard) .

2012/13	July	August	Sept	October	Nov	Dec	YTD performance
WHO Checklist Safer Surgery Audit - 3 Sections (All areas)	99.45% ■	99.65% ▲	99.83% ▲	99.46% ▼	99.82% ▲	99.80% ▼	99.65%
WHO Checklist Safer Surgery Audit - 3 Sections and Brief	92.89% ■	93.90% ▲	93.50% ▼	93.55% ▲	94.17% ▲	96.75% ▲	94.04%
WHO Checklist Safer Surgery Audit - 3 Sections, Brief and Debrief	80.61% ■	80.67% ▲	76.33% ▼	81.71% ▲	81.61% ▼	89.19▲	81.03%

Figure 21: *WHO checklist compliance (data source CDA Dashboard 17/1/13)*

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.

Performance 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 18/01/13	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD
% Spending >= 90% of stay on stroke unit	91.18%▼	93.88%▲	94.12%▲	85.11%▼	85.19%▲	86.96%▲	84.91%▼	86.79%▲	82%▼	87.61%
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%▼	63,21%
CQUIN: % pts receiving brain imaging in 24 hrs of admission	94.74%■	98.11%▲	98.33%▲	95.00%▼	88.37%▼	96.23%▲	100.00% ▲	91.84%▼	92.31▲	93.96%
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%	93.65%
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%	53.39%
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%▼	69.23%
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%	78.46%

Figure 22: *Performance against stroke care targets (data CDA Dashboard 17/1/13)*

Some performance indicators have suffered during December because of pressure on bed capacity.

The Clinical Implementation Group continues to meet twice a month to continue with the agreed action plan. Stroke outreach nurses at both City and Sandwell on all shifts are now becoming more effective at pulling patients into the acute wards from ED following an automated stroke alert.

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 18/12/12) indicates 76.9% of patients with a Fractured Neck of Femur received an operation within 24 hours of admission, resulting in a year to date performance of 67%. Performance has improved significantly throughout the year from 45.83% in April 2012. *Internal Priority*

10.7 Ward Reviews

The ward reviews are not due for reporting this month.

10.8 Quality Audits

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.

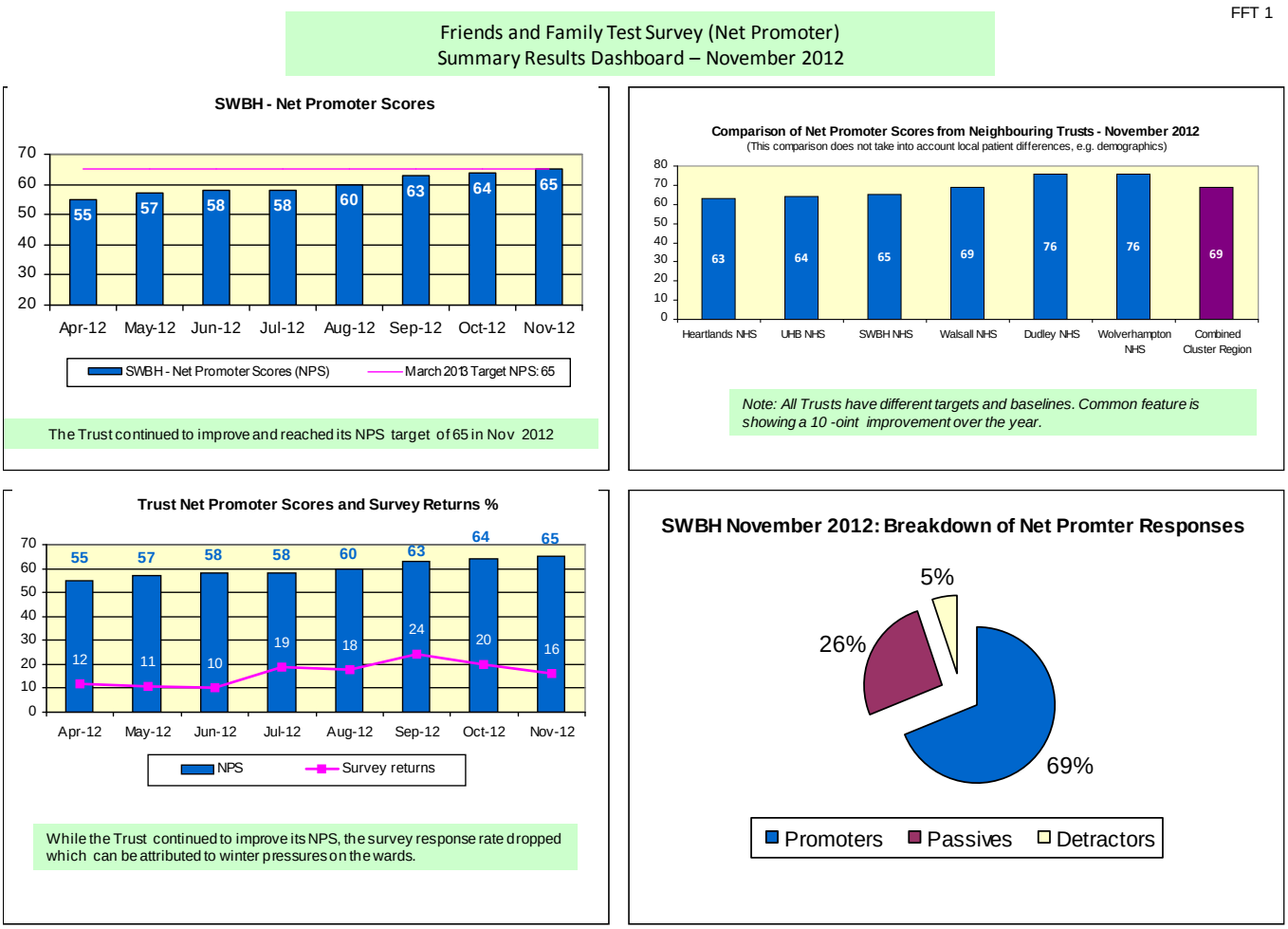


Figure 28: *Net Promoter position*

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.

11.2 Complaints and PALS

a) Complaints and PALS data

i) **Complaints:** Tables A sets out the complaints data for December 2012 with reference to previous months where relevant.

A) Table A: number of complaints received and sent

MONTH	Complaint type: RECEIVED			Complaint type: SENT		
	First contact*	Link*[2]	TOTAL	First contact*	Link*[2]	TOTAL
Aug 2012	77	10	87	58	3	61
Sept 2012	55	5	60	81	11	92
Oct 2012	62	12	74	97	19	116
Nov 2012	68	11	79	113	15	128
Dec 2012	39	5	44	76	17	93

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.*

Complaint responses times

From 1 January 2013 the Complaints team have been will be undertaking a pilot which involves responding to all complaints received after this date as early as possible but within 40 working days. This will mean using the capability of acknowledging complaints by telephone (rather than by letter as is current practice) and at the same time confirming the issues which need to be addressed personally with the person raising the concerns. This will ensure that the response answers the query that the complainant is raising, where it is not obvious from the information provided in their letter. 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 investigation and response drafting to divisions and directorates. A 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 include:

- 2 cases where the complainant is unavailable to provide a date for a meeting
- 2 cases where the complainant is considering next steps

- 1 case where the complainant has requested the Trust wait to respond until after the Coroner's inquest.

b) Complaints and PALS data

ii) PALS

- **Contacts and general enquiries:** In December 2012 PALS recorded 109 PALS enquiry contacts and 159 General enquiry contacts. In comparison to November 2012 169 PALS enquiry contacts and 194 general enquiry contacts. The general informal enquiries are not captured on the PALS database but relate to enquiries taken at the PALS reception desk.

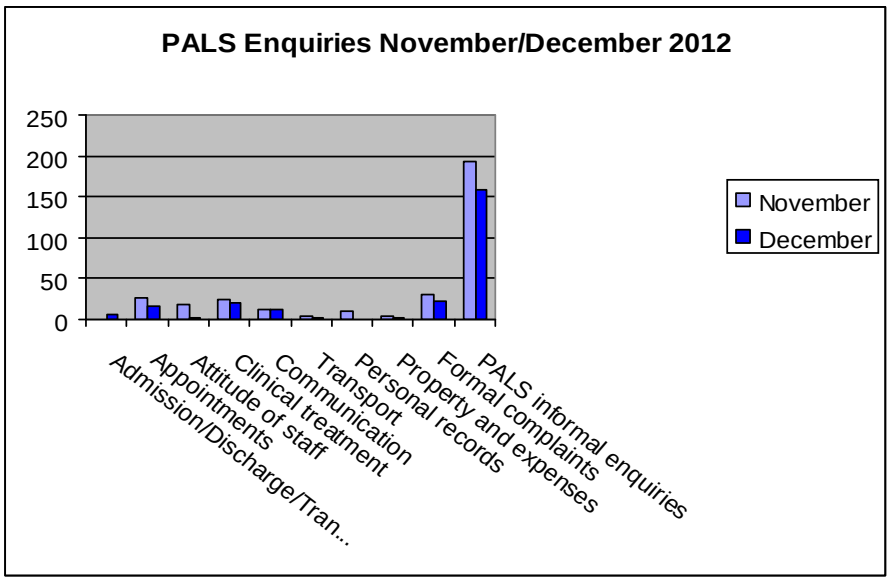
- Chart A provides a breakdown of the themes identified via PALS contacts in December 2012. The main categories reported during the month of December 2012, were issues relating to:

- Clinical Treatment - PALS received 21 this month in comparison to 24 issues reported during November 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 x-ray/scan.

- During December 2012 there was a reduction in the number of appointment enquiries where 16 were reported this month, in comparison to 26 enquiries during November 2012. Appointment enquires relate to appointments cancelled, delay, notification and time.

- There has also been a slight reduction in the number of formal complaint issues which comprise the categories of handling, advice, process, referral and response time from 22 enquiries received this month in comparison to 30 enquiries reported during November 2012.

CHART A – Breakdown of top 10 issues



a) Parliamentary and Health Service Ombudsman (PHSO) cases

õ 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.

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

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%.

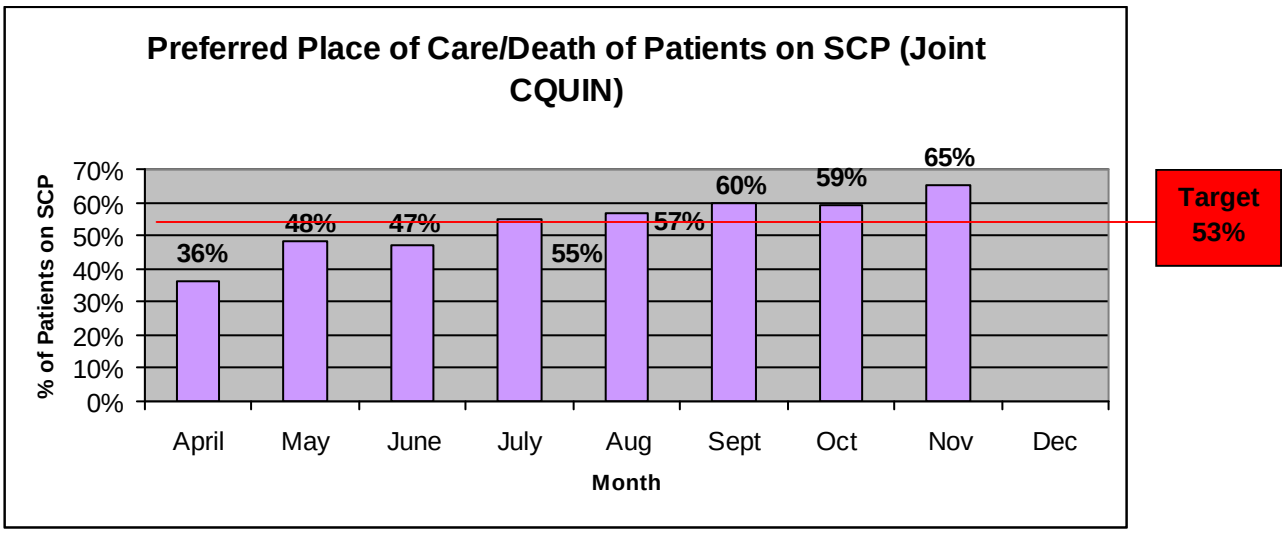


Figure 29: *Preferred place of death/death of patients on SCP*

12 WORKFORCE QUALITY

The Board is asked to note key headlines from the workforce dashboard for December 2012.

	% Trust
Mandatory Training	88.9% (85%)
PDR	71.04% (85%)
Turnover (leavers)	10.15%
Sickness absence	4.58% (3.5%)

13 RECOMMENDATION

The Trust Board is asked to:

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

APPENDIX 1

Glossary of Acronyms

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Proposal to Develop Beacon Services
SPONSORING DIRECTOR:	Dr Roger Stedman, Medical Director
AUTHOR:	R Stedman/ Rosey Monaghan, Business Manager to the MD
DATE OF MEETING:	31 January 2013

SUMMARY OF KEY POINTS:

This paper proposes the establishment of Beacon Services in the Trust, which represent a particularly high standard of clinical quality, management, patient experience, innovation and delivery.

Benefits to the trust and patients are numerous including increasing trust profile, promoting the Trust's reputation, better services for patients, increasing staff morale, attracting additional income by demonstrating striving for excellence to commissioners.

It is proposed that over 3 years, 7 services will be awarded Beacons Service status. They will be provided with resources to promote their service and will be able to apply for non- recurrent capital funding to develop their service.

The process, criteria and financial incentives are described which outlines the 3 year schedule.

Resources to support this initiative would be included in the financial plans from 2013-2016.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)*:

Approval	Receipt and Noting	Discussion
	x	

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

The recommendation is that:

- The Board receives and notes the proposed Beacon Services incentive scheme,
- The Board notes the intention to include the implications within the financial planning for 2013-2016;
- The Board supports this initiative.

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	Safe High Quality ,
Annual priorities	
NHS LA standards	
CQC Essential Standards Quality and Safety	Various
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)*:

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

PREVIOUS CONSIDERATION:

At Executive Team Meeting, Dec 2012.

Beacon Services Initiative Proposal

1.0 Objective:

1.1 One of the key elements of the Trust Clinical Strategy is the development of 'Beacon Services'. This paper outlines the method by which we will identify these services through competition, how we will use the outcome of the process to promote our services and reward our most successful directorates.

2.0 Definition of a Beacon Service:

2.1 The broad definition of a beacon service is one that delivers a significantly higher quality service than its peers, and does so within budget, and at the same time as creating a reputation, influence and reach beyond that which would normally be expected. The criteria defining a Beacon Service covers the following domains:

- **Scope of service** – Do we offer more than our peers?
- **Quality of service** - Do we have better outcomes and are our patients satisfied?
- **Innovation** - Do we do things differently, use technology, and have an innovative service model?
- **Reputation** - Do we attract referrals and patients from beyond our catchment? Have we been recognised elsewhere for our service (e.g. HSJ, Hospital Doctor, Peer Review)?
- **Research and Teaching** - Do others learn from us? Do we present our findings and publish in reputable journals? Do we empower and develop our own staff?
- **Continuous Improvement** - Do we have systems in place that constantly review performance and outcomes? Are these fed back with a demonstrable impact on quality?
- **Collaborative** - Do we work together (inter-site, inter-professional, inter-disciplinary, integrated)?
- **Well managed** - Do we live within our means? Do we have a strategy for growth and improvement? Do we manage things well when they go wrong?

2.2 In the first year awards are made for Clinical Directorates only. Subsequent years are open to competition from clinical and non-clinical directorates/services. Tenure is for 3 years, for which Beacon status will need to be reapplied for after this period. Should the services not meet their KPIs and meet the above criteria to be a Beacon Service; the Trust will reserve the right to remove the Beacon status.

3.0 Benefits of having Beacon Services:

3.1 The benefits to a trust of being able to provide highest quality services are many. The people who benefit most are patients.

3.2 Developing Beacon Services will give us an opportunity to bring attention to the Trust for the right reasons and promote the reputation of the organisation locally, regionally and nationally. This will provide an opportunity for our highest quality and most productive services to consolidate and articulate an effective service strategy.

3.3 Benefits to patients

1. Patients will benefit from having a motivated workforce delivering the best care.
2. By investing in excellence, commissioners will be instilled with confidence that the Trust is ambitious and striving for best care for the people we serve.
3. Beacon services are exactly the right place to exhibit innovation and transformation which will allow creative and dynamic services previously not available in their locality.

3.4 Benefits for staff and the organisation

1. Staff like to work in trusts which have a good reputation and get credit for doing a good job. By highlighting our Beacon Services, we are more likely to attract higher quality more motivated staff.
2. Staff will feel proud of being part of a good thing. This level of motivation instils a pride that comes from within and can spread infectiously and will result in best practice and high quality services for patients.
3. It will promote and raise clinical leadership.
4. It will promote clinical and non-clinical engagement
5. Encourages team building and pride in their work and service.
6. It promotes good management and clinical governance.

3.4 Financial benefits

The challenge is to make a good return on our investment, but that will be seen by careful appraisal of any bid for resources and setting and performance managing the key performance indicators, which must be linked both to qualitative and financial success. Although it is difficult to give specific figures around the financial benefits, some suggestions below indicate how financial benefits will be gained.

1. Attracting patients to our services who might have attended elsewhere and with them will be associated income which might otherwise have been spent elsewhere.
2. It will provide a framework for marketing and growth
3. It will promote a performance culture and desire to succeed.

3.5 Risk Management

There are risks that the services may not deliver the standard which had initially been described for various reasons such as staff changes, the competitive market, changing in the political landscape, operational pressures, commissioner behaviours for example. However, if a rigorous performance management framework is in place then risks can be minimised and remedial actions implemented at early indications of transgression from anticipated trajectories.

4.0 Competitive Process:

4.1 The application to become a Beacon Service will be through a competitive process, which will be designed to keep bureaucracy to the minimum but will provide enough rigour to ensure that it is viable.

4.2 Phase 1: Directorates will be invited to submit a 1000 word report (jointly authored by the directorate triumvirate) that describes their service in terms of the criteria above, with supporting evidence.

4.3 Phase 2: Proposals are shortlisted and the directorates make their 'pitch' as part of a public presentation. Presentations will be open to anyone in Trust, and will be judged by a panel comprised of Patients representatives, Executive & Non-Executive Directors. The audience can express views, but the panel will make the final decision.

4.4 Phase 3: During a dedicated award ceremony, successful directorates will be awarded beacon status, benefits include:

- £10,000 capital for patient facing service / environment improvement
- Opportunity to submit mini-business case against a substantial 'Innovation Fund' via SIRG
- The right to use the 'Beacon' logo on signage / posters / stationary / e-mail
- Staff issued with 'Beacon' badges / tie pins
- Report is professionally converted into promotional material - booklet, website, posters

Note any resources awarded will be capital and non-recurrent.

5.0 Timeline:

It is proposed that the Trust embarks on recruiting interested parties immediately and that the timeline below is applied:

- February 2013 - Call for proposals ;
- End February/March 2013 – Shortlisting and Presentations;
- April 2013 - Services to be agreed and in place .

6.0 Schedule of Awards:

6.1 Year 1: 3 Beacon Services will be authorised and receive £10k allocations (Clinical) plus the right to be allowed to apply to the 'Innovation Fund'

6.2 Year 2: 2 additional Beacon Services will be authorised and receive £10k allocation (Clinical & Non-Clinical) plus the right to be allowed to apply to the 'Innovation Fund'

6.3 Year 3: 2 additional Beacon Services will be authorised and receive£10k allocation (Clinical & Non-Clinical) plus the right to be allowed to apply to the 'Innovation Fund'

7.0 Summary of Costs (capital, non-recurrent)

Year	Annual Basic Cost	Potential resource as a result of successful bid (from Innovation Fund)	Additional Costs- badges, promo materials	Total
Year 1 (a) (3 services)	£30k	Up to £ 150k	£2000	£182,000
Year 2 (b) (2 additional services)	£50k	Up to 250k	£2000	£302,000
Year 3 (c)	£70K	Up to 350k	£2000	£422,000
Total costs over 3 years (a+b+c)	£150k	Up to £750k	£6000	£906,000

•

8.0 Review and Deliverables:

- Beacon Services are expected to deliver a significantly higher quality service than their peers, within budget, and at the same time have a reputation, influence and reach beyond that which would usually be expected.
- KPIs would be performance monitored and managed as part of the Trust Performance Management regime.
- Following the award, Beacon Services will be reviewed annually by the Executive Team to ensure they continue to meet the criteria of a Beacon Service and are achieving their baseline objectives.
- Beacon Service Status can be withdrawn by the Executive Team if the service criteria are not being met.

9.0 Recommendation

The recommendation is that:

1. The Board notes the proposed incentive scheme,
2. The Board notes the intention to include the implications within the financial planning for 2013-2016;
3. The Board supports this initiative.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – December 2012
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White/Tony Wharram
DATE OF MEETING:	31 January 2013

EXECUTIVE SUMMARY:

The report presents the financial performance for the Trust and operational divisions for the period to 31st December 2012.

Measured against the DoH target, the Trust generated an actual surplus of £895,000 during December against a planned surplus of £513,000. For the purposes of its statutory accounts, the in month surplus was slightly higher at £924,000.

REPORT RECOMMENDATION:

The Trust Board is requested to NOTE the contents of the report, ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position and APPROVE the amendment to the capital programme to include £135,000 in respect of the replacement transport control system.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x	x	

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

Financial	**x**	Environmental		Communications & Media	
Business and market share		Legal & Policy	**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 22 January 2013 and Finance & Performance Management Committee on 25 January 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – December 2012

EXECUTIVE SUMMARY

• For the month of December 2012, the Trust delivered a "bottom line" surplus of £895,000 compared to a planned surplus of £513,000 (as measured against the DoH performance target).

• For the year to date, the Trust has produced a surplus of £3,141,000 compared with a planned surplus of £2,353,000 so generating an positive variance from plan of £788,000.

• Both in month and year to date performance are consistent with the revised year end target agreed with the Strategic Health Authority of £5,777,000 or 1.3% of turnover.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 244 below planned levels. After taking account of the impact of agency staff, WTE's were 70 below plan. Total pay expenditure for the month, inclusive of agency costs, is £652,000 below the planned level.

• The month-end cash balance remained approximately £23m 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	382	788	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	370	736	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	652	1,883	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(344)	(3,405)	<= Plan	< 1% above plan	> 1% above plan
WTEs Actual v Plan	70	35	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000	22,696	22,696	>= 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	2,353	3,141
Capital Resource Limit	12,610	6,592
External Financing Limit	---	22,696
Return on Assets Employed	3.50%	3.50%

2011/2012 Summary Income & Expenditure Performance at December 2012	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	383,803	32,164	32,694	530	289,043	291,645	2,602	389,540
Other Income	39,108	3,748	3,280	(468)	29,553	29,209	(344)	38,563
Operating Expenses	(396,292)	(33,499)	(33,191)	308	(299,139)	(300,661)	(1,522)	(399,582)
EBITDA	26,619	2,413	2,783	370	19,457	20,193	736	28,521
Interest Receivable	100	8	18	10	75	109	34	136
Depreciation & Amortisation	(14,738)	(1,228)	(1,231)	(3)	(11,054)	(11,078)	(24)	(14,771)
PDC Dividend	(5,594)	(466)	(466)	0	(4,196)	(4,196)	0	(5,594)
Interest Payable	(2,157)	(185)	(180)	5	(1,664)	(1,622)	42	(2,162)
Net Surplus/(Deficit)	**4,230**	**542**	**924**	**382**	**2,618**	**3,406**	**788**	**6,130**
IFRS/Impairment/Donated Asset Related Adjustments	(353)	(29)	(29)	0	(265)	(265)	0	(353)
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,877**	513	895	382	2,353	3,141	788	5,777

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

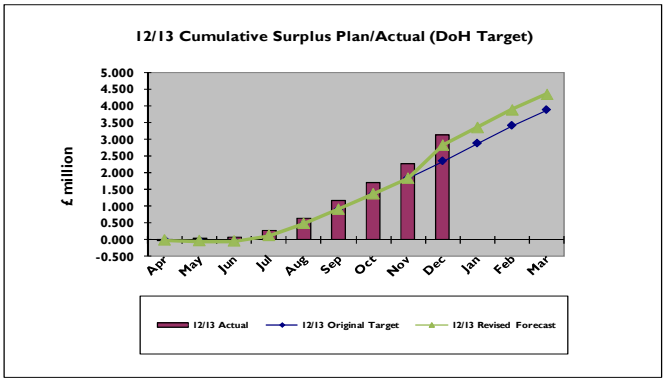
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – December 2012

Overall Performance Against Plan

• The overall performance of the Trust against the DoH planned position is shown in the adjacent graph. Net bottom-line performance delivered an actual surplus of £895,000 in December against a planned surplus of £513,000. The resultant £382,000 positive variance moves the year to date position to £788,000 above targeted levels which is consistent with the revised target agreed with the Strategic Health Authority.



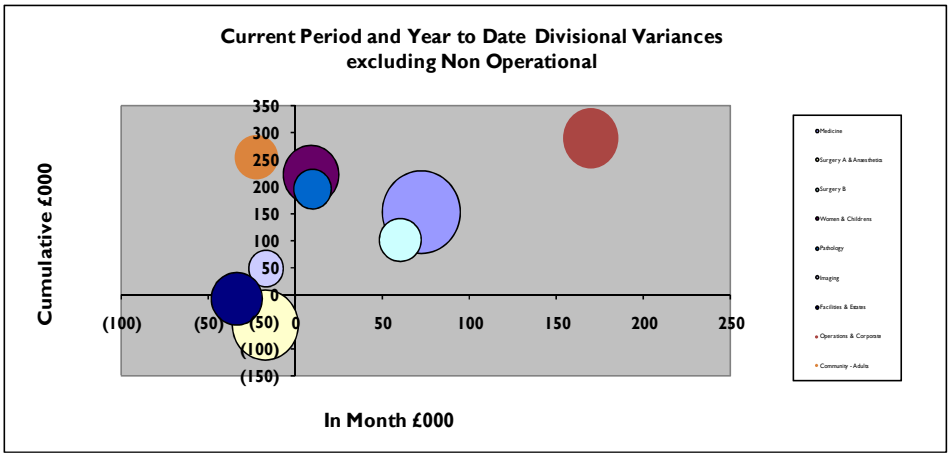
Divisional Performance

• For December, although a number of divisions have posted bottom line in month deficits, none of these are material and they do not affect the overall in month or year to date performance of the Trust as a whole.

• Performance in non operational areas reflects a cautious view of a number of uncertain items, including patient related SLA income where year end projections are subject to final agreement being reached with commissioners.

• SLA performance which is based on fully costed information for November 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 are no material year to date adverse variances from plan although Surgery A and Facilities continue to have relatively small adverse variances.



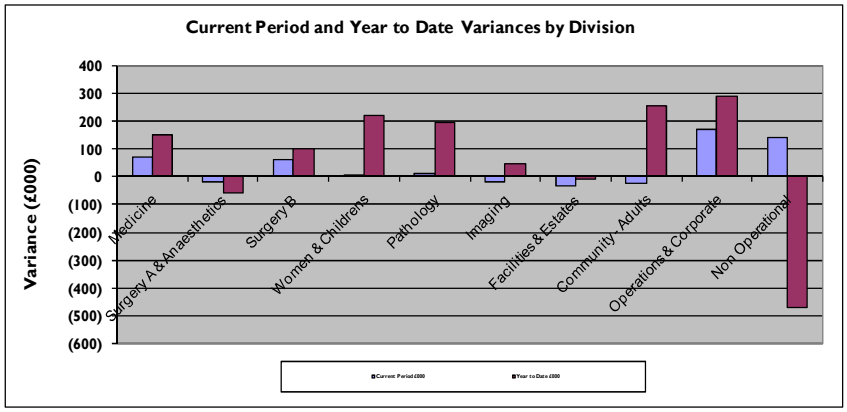
The tables adjacent and below show small adverse year to date variance for Surgery A and Facilities (although the latter is combined with Estates in the adjacent graph and shows a small year to date surplus).

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – December 2012

Divisional Variances from Plan

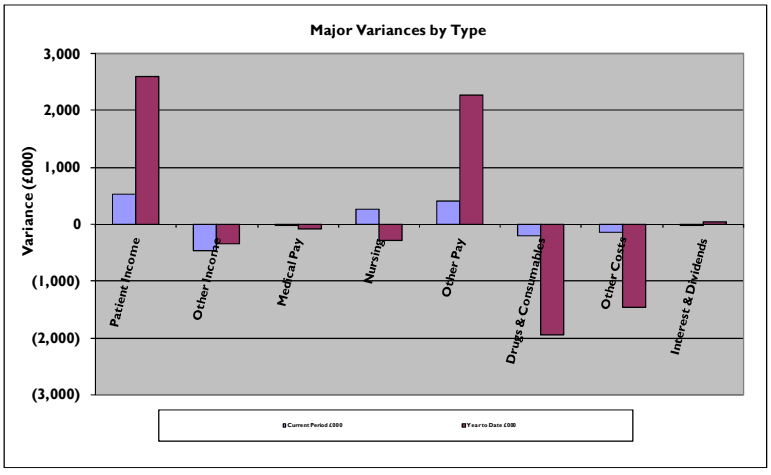
	Current Period £000	Year to Date £000
Medicine	73	154
Surgery A & Anaesthetics	(17)	(56)
Surgery B	60	102
Women & Childrens	9	222
Pathology	10	196
Imaging	(16)	49
Facilities & Estates	(33)	(8)
Community - Adults	(22)	255
Operations & Corporate	170	290
Non Operational	140	(469)



For December, patient related SLA income again shows a positive variation from plan . Injury Cost recover (ICR) charges also remain above plan. The adverse in month performance for Research & Development income is a one off item and reflects the creation of budget (covering both income and expenditure) for schemes which have started since original budgets were set. Overall pay expenditure is below planned levels particularly with the administration & estates, scientific, therapeutic & technical and nursing & midwifery pay groups although the last is primarily the result of Research & Development budget changes and without these changes, performance would have been marginally worse than plan. Overall non pay expenditure is £344,000 higher than plan in month, mainly in respect of patient related consumables and equipment and IT equipment and maintenance (including significant one off expenditure on enhanced systems and hardware within the Community – Adults Division).

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	530	2,602
Other Income	(468)	(344)
Medical Pay	(9)	(91)
Nursing	263	(291)
Other Pay	398	2,265
Drugs & Consumables	(208)	(1,946)
Other Costs	(136)	(1,459)
Interest & Dividends	10	34



Sandwell and West Birmingham Hospitals NHS

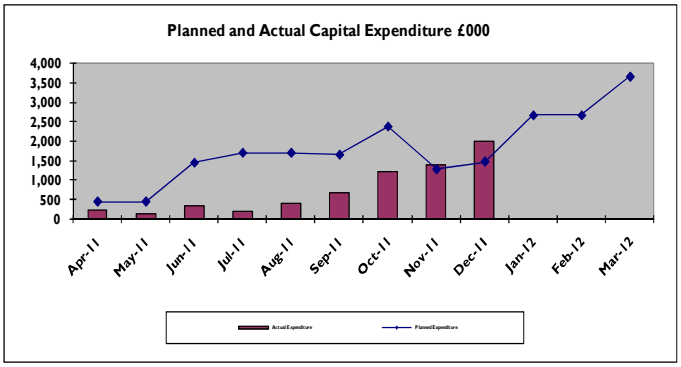
NHS Trust

Financial Performance Report – December 2012

Capital Expenditure

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

• In month expenditure is again significantly higher than that for the earlier part of the year although the year to date actual spend remains significantly lower than planned levels mainly as a result of delays in the acquisition of Grove Lane land. Recent additions to the programme include £350k for replacing conventional equipment with digital imaging, a new analyser (£187k)



Capital Expenditure (cont)

to support external pathology screening contracts and replacement of aged blood gas analysers at £42k.

•For the year to date, actual expenditure is approximately £6.7m primarily related to statutory standards , estates rationalisation , pathology reconfiguration and medical equipment.

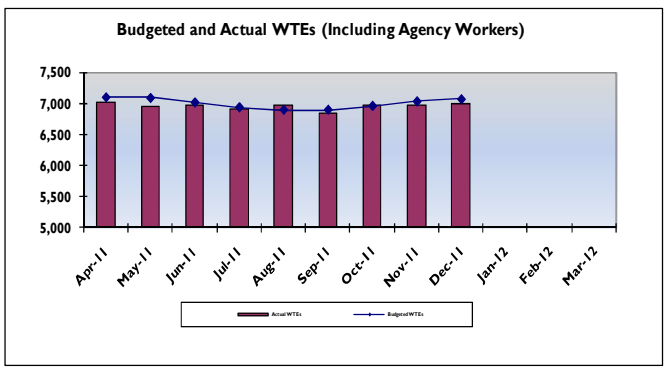
• Provision has been made for a proposed scheme to replace the transport control system (£135,000) and agreement to vary the allocation of capital in 12/13 is requested in this report.

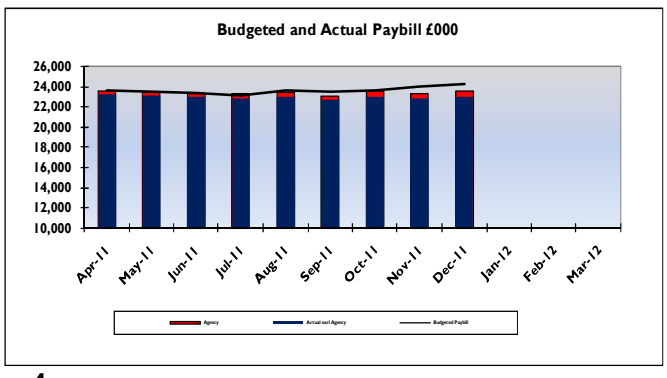
Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are approximately 70 below plan compared with 63 below plan for November. Excluding the impact of agency staff, whole time equivalent (wte) numbers are around 244 below plan. Actual wte's have risen by 28 compared with November although this is wholly the result of movements in bank and agency staff numbers (primarily in medical and nursing staff groups) increasing by 17 and 18 wte's respectively in month. Actual substantive wte's have fallen by 6 in month and 256 since the start of the year.

• Total pay costs (including agency workers) are £652,000 lower than budgeted levels for the month , particularly within the administration & estates, scientific, therapeutic & technical and nursing pay groups although the last of these is largely the result of changes to Research & Development budgets.

• Expenditure for agency staff in December was £688,000 compared with £573,000 in November, an average of £526,000 for 2011/12 and a December 2011 spend of £361,000. The biggest single group accounting for agency expenditure remains medical staffing.





Sandwell and West Birmingham Hospitals NHS

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Financial Performance Report – December 2012

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 December					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	56,438	54,141		2,388	56,529	(91)
Management	11,502	10,803		0	10,803	699
Administration & Estates	23,625	21,606	1,038	414	23,058	567
Healthcare Assistants & Support Staff	23,494	21,338	2,179	14	23,531	(37)
Nursing and Midwifery	64,749	61,132	2,819	1,089	65,040	(291)
Scientific, Therapeutic & Technical	32,692	31,223		456	31,679	1,013
Other Pay	39	16			16	23
Total Pay Costs	212,539	200,259	6,036	4,361	210,656	1,883

NOTE: Minor variations may occur as a result of roundings

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 December are approximately £46.5m which is around £12m higher than at 31st March and marginally lower than in November.

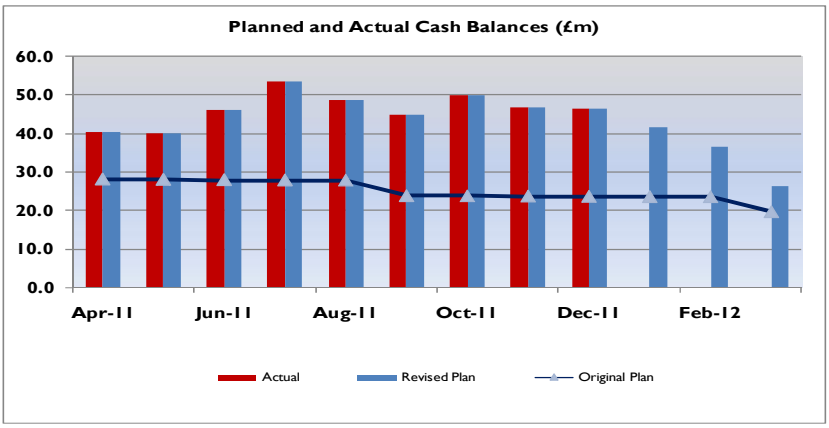
Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION 2012/2013

		Opening Balance as at 1st April 2012 £000	Balance as at end December 2012 £000	Forecast at 31st March 2013 £000
Non Current Assets	Intangible Assets	1,075	1,048	1,025
	Tangible Assets	227,072	222,711	229,349
	Investments	0	0	0
	Receivables	865	865	950
Current Assets	Inventories	4,065	3,959	4,050
	Receivables and Accrued Income	14,446	14,320	13,500
	Investments	0	0	0
	Cash	34,465	46,459	26,310
Current Liabilities	Payables and Accrued Expenditure	(33,751)	(42,729)	(35,469)
	Loans	(2,000)	(2,000)	(2,000)
	Borrowings	(1,166)	(977)	(914)
	Provisions	(15,649)	(12,382)	(9,489)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	0
	Loans	(5,000)	(4,000)	(3,000)
	Borrowings	(29,995)	(29,443)	(29,262)
	Provisions	(2,532)	(2,530)	(2,500)
		191,895	195,301	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)	(14,241)	(12,492)
		191,895	195,301	192,550

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – December 2012



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 December 2012

ACTUAL/FORECAST	Dec-12 £000s	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
Receipts													
SLAs: Black Country Cluster	**17,630**	17,165	17,165	17,165	16,993	16,993	16,993	16,993	16,993	16,993	16,993	16,993	16,993
Birmingham & Solihull Cluster	**11,590**	11,341	11,341	11,341	11,228	11,228	11,228	11,228	11,228	11,228	11,228	11,228	11,228
Other Clusters	**634**	575	575	575	569	569	569	569	569	569	569	569	569
Pan Birmingham LSCG	**1,944**	1,944	1,944	1,944	1,925	1,925	1,925	1,925	1,925	1,925	1,925	1,925	1,925
Education & Training		4,347			4,300	0	0	4,300	0	0	4,300	0	0
Loans													
Other Receipts	**3,986**	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	**35,784**	38,272	33,925	33,925	37,915	33,615	33,615	37,915	33,615	33,615	37,915	33,615	33,615
Payments													
Payroll	**13,460**	13,700	13,700	13,700	13,068	13,068	13,068	13,068	13,068	13,068	13,068	13,068	13,068
Tax, NI and Pensions	**9,145**	14,950	9,150	9,150	9,455	9,455	9,455	9,455	9,455	9,455	9,455	9,455	9,455
Non Pay - NHS	**3,294**	2,650	2,650	2,650	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Non Pay - Trade	**7,909**	8,995	8,314	9,041	8,000	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500
Non Pay - Capital	**1,738**	1,975	4,665	4,970	1,750	1,750	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
BTC Unitary Charge	**416**	416	416	832	430	430	430	430	430	430	430	430	430
Other Payments	**324**	175	175	175	175	175	175	175	175	175	175	175	175
Total Payments	**36,286**	42,861	39,070	44,340	35,378	34,878	33,628	33,628	33,628	37,348	33,648	33,648	33,648
Cash Brought Forward	**46,961**	46,459	41,870	36,725	26,310	28,847	27,585	27,572	31,859	31,846	28,114	32,381	32,348
Net Receipts/(Payments)	**(502)**	(4,589)	(5,145)	(10,415)	2,537	(1,263)	(13)	4,287	(13)	(3,733)	4,267	(33)	(33)
Cash Carried Forward	**46,459**	41,870	36,725	26,310	28,847	27,585	27,572	31,859	31,846	28,114	32,381	32,348	32,315

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – December 2012

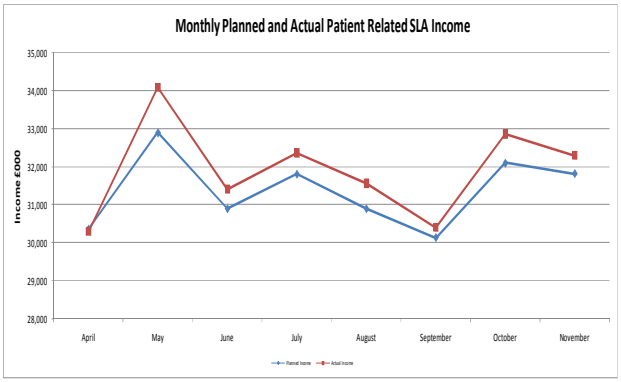
Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	6.7%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	103.8%	5
Net Return After Financing	Surplus after dividends over average assets employed	2.6%	4
I&E Surplus Margin	I&E Surplus as % of total income	1.1%	3
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	24.3	3
Overall Rating			**3.4**

Risk Ratings

•The adjacent table shows the Monitor risk rating score for the Trust based on performance at December.
• 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 has now risen to a 3 which reflects the profiling of surpluses growing towards the year end (and year to date now being greater than the 1% threshold required to achieve a score of 3).
• Formal reporting of overall performance would be rounded to a score of 3.

Performance Against Service Level Agreement Target

•The adjacent graph and table shows 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 – November. 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.
•The adjacent graph and table show the extent of the overall over performance against the planned financial position.



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
Total	**250,895**	**255,275**	**4,380**

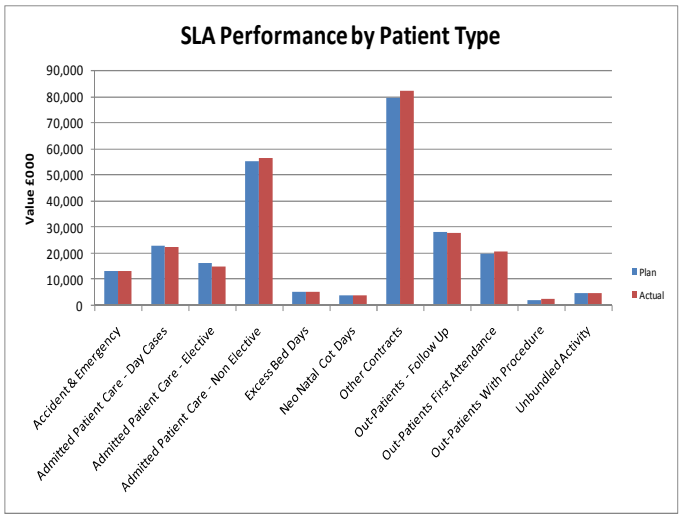
Sandwell and West Birmingham Hospitals NHS

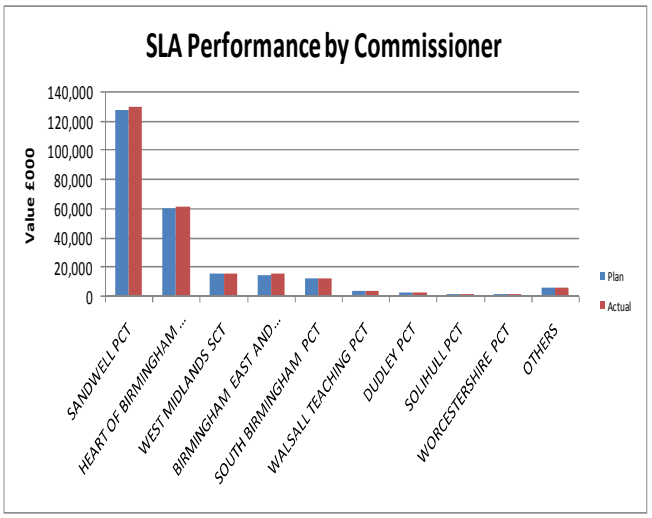
NHS Trust

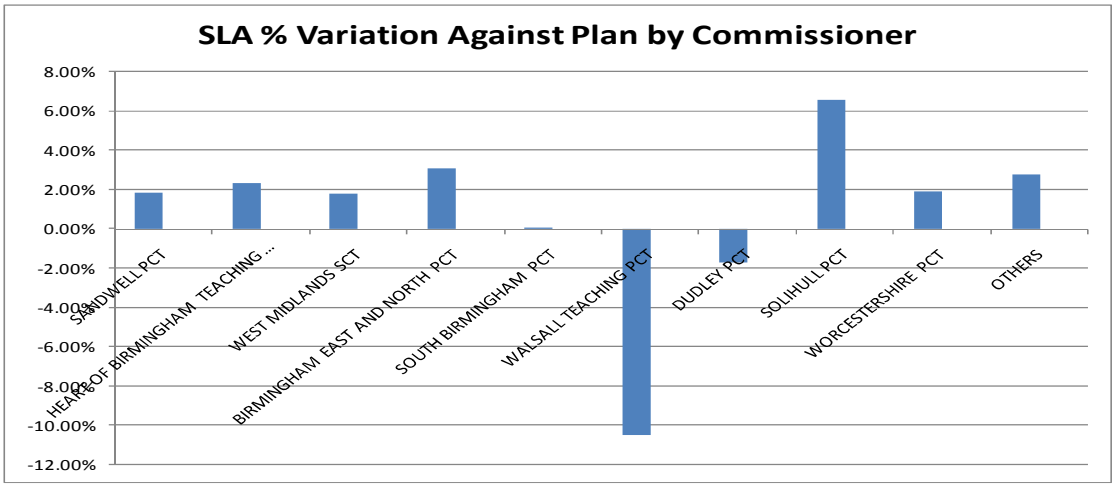
Financial Performance Report – December 2012

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.

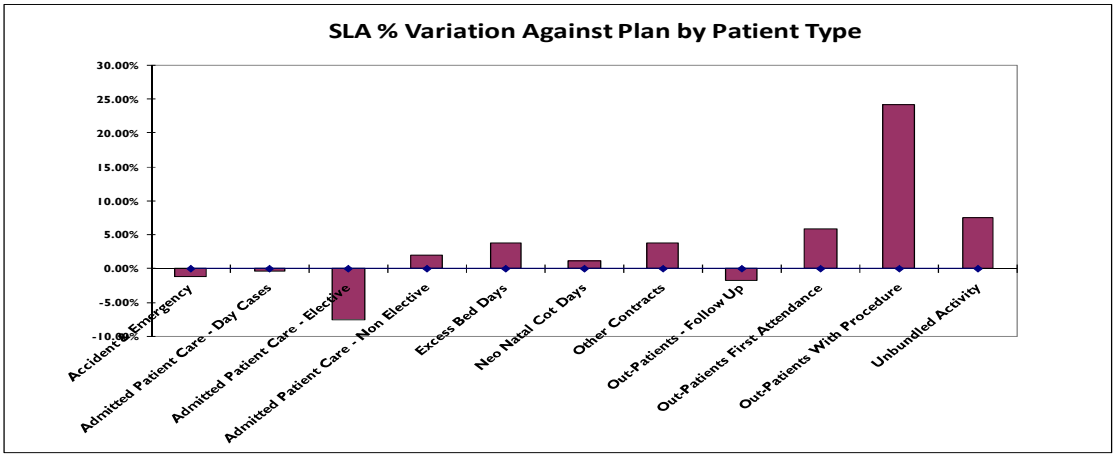






Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – December 2012

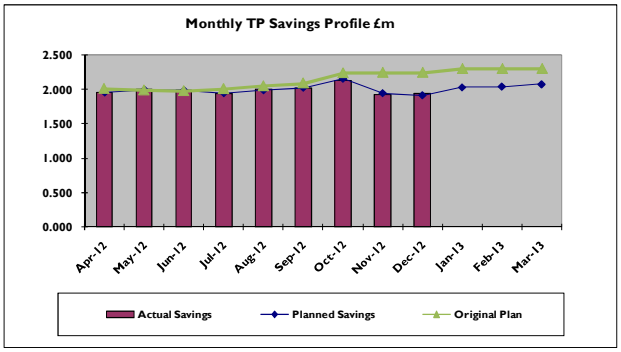


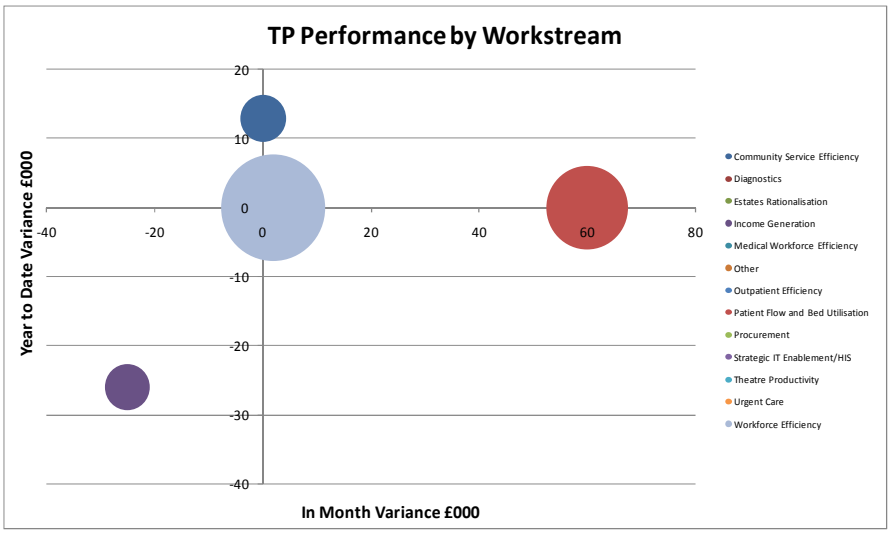
Transformation Programme

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

• At 31st December and against the revised target, actual savings were £17,000 or 0.1% lower than planned levels although 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.





Transformation Programme

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

• At December, the Income Generation workstream had an adverse variance against plan . This is related to a shortfall in direct access income growth in Imaging.

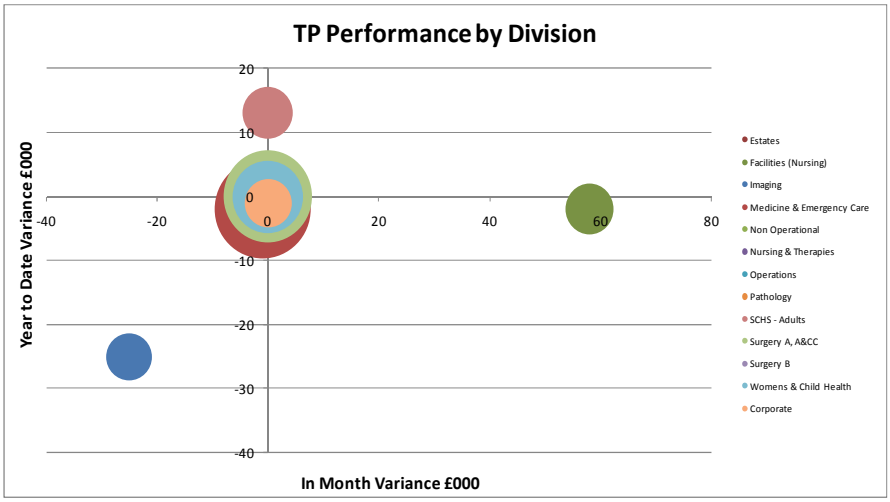
Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – December 2012

Transformation Programme

•At the end of December, only the Imaging Division is reporting a deficit against 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



External Focus

• Planning guidance for 2013/14 issued recently by the NHS Commissioning Board gives an overall uplift of 2.3% to NHS Clinical Commissioning Groups. The Commissioning Board also announced an 'urgent, fundamental' review of the funding distribution formula as it is concerned that current arrangements disproportionately reward areas with the best health outcomes, which is inconsistent with objectives to reduce health inequalities. The review will be completed in time for the 2014/15 allocations.

• The special administrator appointed to run South London Healthcare has recommended that the Trust is broken up with other organisations taking over the running and management of services. The report is currently being considered by the Secretary of State who has until 1st February to review the report's findings.

• More widely, the Bank of England Monetary Policy Committee left interest rates unchanged at 0.5% and the quantitative easing stimulus at £375 bn. The European Central Bank also voted to leave interest rates unchanged.

Conclusions

• Measured against the DoH target, the Trust generated an actual surplus of £895,000 during December against a planned surplus of £513,000. For the purposes of its statutory accounts, the in month surplus was slightly higher at £924,000. 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 £895,000 surplus in December is £382,000 better than originally planned for the month.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – December 2012

Conclusions (cont)

•For the year to date, the Trust has generated a surplus (as measured against the DoH target) of £3,141,000 which is £788,000 better than the originally planned position.

• In month capital expenditure is £2.1m which represents a continuing increase on earlier months but the year to date position remains significantly lower than plan. The main reason for the variance from plan is the later than planned acquisition of land in Grove Lane and the incorporation of this assumption into the profiling of the Trust's Capital Resource Limit (CRL).

•At 31st December, cash balances are approximately £22.7m higher than the cash plan and around £12m greater than the balance held at 31st March.

• Although there has been some adverse bottom line in month performance 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 performance 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. NOTE 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.

iii. APPROVE the variation to the capital programme outlined in the capital section of this report.

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Corporate Performance Monitoring Report
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Planning & Performance Management
DATE OF MEETING:	31 January 2013

EXECUTIVE SUMMARY:

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

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 - DECEMBER 2012

EXECUTIVE SUMMARY AND KEY EXCEPTIONS

KEY EXCEPTIONS

a

Stroke Care - the percentage of Stroke patients who spend more than 90% of their time in hospital in an acute stroke unit reduced to 80.8% during December. This continues to meet the national performance threshold of 80%, but is marginally short of the local 83% threshold. The percentage of patients admitted to an acute stroke unit within 4 hours also reduced to 51.3%. Almost 93% of patients received a CT Scan within 24 hours of arrival, with 61.5% receiving a scan within 1 hour of arrival. High Risk TIA performance reduced to 57.9% across the Trust, although remains in excess of the 60% threshold for the year to date.
Stroke Care performance for admitted patients was adversely affected during the month by the number of ward closures as a consequence of Norovirus, and the consequential significant demand for medical beds.

c

Workforce - **PDR** (12-month rolling) compliance improved further during December to 71.0%, with 5282 staff reported as having received a PDR within the last 12 months. Overall **Mandatory training** compliance now stands at 88.1%. Sickness Absence increased slightly during the month to 4.58% (range by Division 0.00 - 5.91%). **Sickness absence** for Quarter 3 is 4.52%, against a current trajectory for the quarter of less than 3.15%.

More recent (18 January) data indicates 94.11% compliance against the 4 modules which comprise the Information Governance Toolkit (target 95%).

d

Emergency Department - performance against the **A&E 4-hour maximum wait** target reduced to 88.9% during December, and 93.25% for the year to date. Inclusion of the Sandwell site non-chargeable GP Triage data improves performance for the month and year to date to 89.6% and 93.38% 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, both of which are also being met for the year to date. Reporting Times of **Imaging Requests** from the Emergency Department show further improvement, such that trajectories by modality for December were all met.

A number of Ward Closures due to infection, which continued into the early part of January, considerably reduced the number of available Medical Beds, adversely affecting patient flow, including admissions from the ED. Much of this pressure has now been alleviated with wards re-opened, with performance incrementally improving week on week (88.2%, 92.4% and 96.0%) for the month of January to date. A trajectory to deliver 95% 4-hour wait performance during Quarter 4 has been submitted to, and agreed with commissioners, and is currently being met. A number of measures designed to improve patient flow through the Emergency Department have been implemented, complemented by the Emergency Flow Action Plan within the rest of the hospitals. Daily management of performance continues, internally and externally with commissioners.

e

Ambulance Turnaround - the indicators within the report reflect those contained in the Quality section of the Trust's 2012 / 2013 contract with its commissioners. The percentage of Clinical Handovers completed within 15 minutes improved overall to 63.7% (target 85%) during the month, with site specific performance of 47.1% and 75.9% for Sandwell and City respectively (West Midlands average = 70.5%). The average turnaround time worsened to 38 minutes, compared with a target of 30 minutes or less. There were a total of 323 instances reported where ambulance turnaround was in excess of 60 minutes, 128 at Sandwell and 195 at City (target 0).

The Trust is set to pilot the introduction of an ambulance assessment bay at City Hospital. It is intended that this will expedite the requests for any required diagnostic investigations, which will in turn enhance clinical decision making. Such a facility should also reduce the average clinical handover time from ambulance service to hospital. Work in conjunction with the ambulance service is on-going to ensure the accuracy of WMAS data capture and turnaround data recording.

g

Referral to Treatment Time & Diagnostic Waits - each high level, Admitted, Non-Admitted and Incomplete Pathway RTT target was met during the month. There were 2 specialities which failed to meet the operational threshold of 90% for Admitted Care, Trauma & Orthopaedics (81.3%) and Plastic Surgery (86.6%), although in both instances performance had improved from that reported for the previous month, 78.1% and 81.1% respectively. Trauma & Orthopaedics also failed to meet the RTT Incomplete Pathway threshold of 92%, with performance for the month of 84.3%, the same as the previous month. Diagnostic Waits in excess of 6-weeks at the end of December were 1.85% (100 patients in total, 97 waiting for an Endoscopy procedure).

The specialties of Trauma & Orthopaedics remain on improvement trajectories to meet the relevant RTT operational thresholds by end March 2013. Diagnostic Waits performance is not meeting an improvement trajectory, which for December was 1.5%. A number of systems related issues need to be resolved, weekly updates on their resolution are being provided at the request of the Chief Operating Officer. It is expected that performance will meet the required 1.0% maximum performance threshold at the end of February.

CQUIN PERFORMANCE

b

	Patient Safety			Effectiveness of Care			Patient Experience			ALL		
	R	A	G	R	A	G	R	A	G	R	A	G
Acute			9	1		1	1		4	2		14
Community			3	1					4	1		7
Specialised									4			4

CQUIN - the proportion of Mortality Reviews which were undertaken within 42 days of death reduced to 53.9% during the month of October. The Dementia Community CQUIN target has not been met for the months of October and November. Results from an audit of compliance conducted during November against 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. It is anticipated that the Adult Community Division will meet the Dementia target both for the month of December and Quarter 3. A number of actions have been identified to raise awareness of the importance of this CQUIN and improve data collection.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.

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	4603	4127	476	11.5	46806	43461	3345	7.7	47649	46806	-843	-1.8
IP Non-Elective	4858	5128	-270	-5.3	43121	42212	909	2.2	40838	43121	2283	5.6
OP New	12523	9696	2827	29.2	128371	107838	20533	19.0	117814	128371	10557	9.0
OP Review	27199	31193	-3994	-12.8	289205	323781	-34576	-10.7	313831	289205	-24626	-7.8
OP Review:New	2.17	3.22	-1.05	-32.5	2.25	3.00	-0.75	-25.0	2.66	2.26	-0.40	-15.2
AE Type I	13597	13921	-324	-2.3	132514	132171	343	0.3	132684	132514	-170	-0.1
AE Type II	1847	2564	-717	-28.0	20792	24345	-3553	-14.6	27949	20792	-7157	-25.6
Adult Community	42495	43346	-851	-2.0	370647	333107	37540	11.3	326267	370647	44380	13.6
Child Community	12700	15073	-2373	-15.7	102368	105892	-3524	-3.3	95572	102368	6796	7.1

f

Overall Elective activity for the month and year to date remains in excess of the plan by 11.5% and 7.7% for the periods respectively. Non Elective activity was 5.3% less than plan for the month, but continues to exceed the plan for the year to date by 2.2%. Month and year to date New and Review Outpatient performance is such that the Follow Up : New Outpatient Ratio for the year to date further improved (reduced) to 2.25 which compares favourably with a ratio derived from plan of 3.00. A&E Type I activity (+0.3%) is essentially on plan for the year to date although Type II (BMEC) activity (-14.6%) remains well below plan. Adult Community activity is currently 11.3% above plan for the year to date. Child Community activity is 3.3% below plan.

NATIONAL PERFORMANCE FRAMEWORKS

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

MONITOR COMPLIANCE FRAMEWORK - Summary					
	August	September	October	November	December
Performing	14	14	13	15	15
Failing	1	1	2	1	1
No Data	1	1	1	0	0
Governance Rating	**2.0**	**2.0**	**3.0**	**1.0**	**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 - DECEMBER 2012

Exec Lead	PATIENT SAFETY						August	September	October	November		December		To Date (*=most recent month)	TARGET		Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
							Trust	Trust	Trust	S'well	City	S'well	City		YTD	12/13							
RS	H	3	Stroke Care	Pts spending >90% stay on Acute Stroke Unit		%	88.9 ▲ ■	87.2 ▼ ■	88.7 ▲ ■	→		→		87.4	83	83	a	No Variation	0 - 2% Variation	>2% Variation	●	72.8	85.9
	K			Pts admitted to Acute Stroke Unit within 4 hrs		%	68.7 ▲ ■	65.1 ▼ ■	51.1 ▼ ■	→		→		64.5	90	90		No Variation	0 - 2% Variation	>2% Variation	● ●		68.7
	K			Pts receiving CT Scan within 24 hrs of arrival		%	93.8 ▼ ■	100 ■ ■	93.3 ■ ■	→		→		93.7	100	100		No Variation	0 - 2% Variation	>2% Variation	●		100
	K			Pts receiving CT Scan within 1 hr of arrival		%	53.1 ▲ ■	61.5 ▲ ■	42.9 ■ ■	→		→		53.9	50	50		No Variation	0 - 2% Variation	>2% Variation	●		37.5
	H			TIA (High Risk) Treatment <24 h from initial presentation		%	80.0 ■ ■	60.0 ▼ ■	84.6 ▲ ■	62.5 ▼ ■	88.9 ▼ ■	55.6 ■ ■	60.0 ▼ ■	69.2	60	60		No Variation	0 - 2% Variation	>2% Variation	●	46.15	53.2
	K			TIA (Low Risk) Treatment <7 days from initial presentation		%	82.5 ■ ■	83.9 ▲ ■	86.5 ▲ ■	100.0 ▲ ■	95.0 ▲ ■	88.9 ▼ ■	85.7 ▼ ■	78.4	60	60		No Variation	0 - 2% Variation	>2% Variation	●		30.4
R0	A	4	Infection Control	C. Difficile (DH Reportable)		No.	6 ■ ■	2 ■ ■	5 ▼ ■	1 ▲ ■	1 ▲ ■	1 ■ ■	0 ▲ ■	24	45	57		No variation		Any variation	●	120	95
	K			C. Difficile (Best Practice Numbers)		No.	12 ■ ■	4 ■ ■	9 ▼ ■	2 ▲ ■	3 ▲ ■	2 ■ ■	2 ▲ ■	54	72	95					●	120	95
	A			MRSA Bacteraemia		No.	0 ■ ■	0 ■ ■	0 ■ ■	0 ■ ■	0 ■ ■	0 ■ ■	0 ■ ■	1	2	2		No variation		Any variation	●	5	2
				MSSA Bacteraemia		No.	1	1	0	0	0	0	0	13	No. Only	No. Only						22	12
				E Coli Bacteraemia		No.	3	6	5	2	0	5	2	37	No. Only	No. Only						73	50
	F	3		MRSA Screening - Elective	Patient Not Matched	%	110.6 ▼ ■	115.0 ▲ ■	104.6 ▼ ■	Numerator = 2794	Denominator = 2905	Numerator = 2251	Denominator = 2009	112.0*	70	85		No variation		Any variation	●	40.3	40.6
	F				Best Practice - Patient Matched	%	39.5 ▼ ■	38.7 ▼ ■	53.7 ▲ ■	Numerator = 1640	Denominator = 2905	Numerator = 1109	Denominator = 2009	55.2*	70	85		No variation		Any variation	● ●	40.3	40.6
	F			MRSA Screening - Non Elective	Patient Not Matched	%	69.2 ▲ ■	66.4 ▼ ■	66.0 ▼ ■	Numerator = 2322	Denominator = 2956	Numerator = 2250	Denominator = 2869	78.4*	70	85		No variation		Any variation	●	18.9	26.0
	F				Best Practice - Patient Matched	%	69.1 ▲ ■	66.1 ▼ ■	66.3 ▲ ■	Numerator = 2458	Denominator = 3706	Numerator = 2392	Denominator = 3571	67.0*	70	85		No variation		Any variation	●	18.9	26.0
RS	A	3	Acute CQUIN	VTE Risk Assessment (Adult IP)	396	%	87.5 ■ ■	91.0 ■ ■	91.5 ▲ ■	→		→		90.01*	90	90	b	=>90		<90	●	92.3	92.4
RB	K	20		Appropriate Use of Warfarin	372		→	Compliant	→	→		→		Compliant	Comply with audit			No variation		Any variation	●		
RO	H	8		Safety Thermometer	396	%	Data Submitted	Data Submitted	Data Submitted	→		→		Data Submitted	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	Comply with audit			No variation		Any variation	●		
RO	H	8		Nutrition and Weight Management	743		Compliant	Compliant	Compliant	→		→		Compliant	Comply with audit			No variation		Any variation	●		
RS	H	9		Safe Surgery - Operating Theatres	743	%	99.7 ■ ■	99.8 ■ ■	99.8 ■ ■	→		→		99.8	99	100		No variation		Any variation	●		
RS	H	9		Safe Surgery - Other Areas		%	99.6 ■ ■	100 ▲ ■	99.8 ▼ ■	→		→		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	Monthly data collection			No variation		Any variation	●		
RO	D			Reducing Avoidable Pressure Ulcers	176		Compliant	Compliant	Compliant	→		→		Compliant	Comply with audit			No variation		Any variation	●		
RO	H			Nutrition and Weight Management	176		Compliant	Compliant	Compliant	→		→		Compliant	Comply with audit			No variation		Any variation	●		
KD	F	14	Never Events - in month			No.	0 ■ ■	1 ■ ■	0 ■ ■	→		→		0*	0	0		No variation		Any variation	●		
	F		Open Serious Incidents Requiring Investigation (SIRI)			No.	4	2	3	→		→		2*	No. Only	No. Only							
	F		Open Central Alert System (CAS) Alerts			No.	9	10	8	→		→		4*	No. Only	No. Only							
RO	D		Falls Resukting In Severe Injury or Death			No	2 ▼ ■	6 ▼ ■	0 ■ ■	→		→		2*	0	0		No variation		Any variation	●		
RO		8	High Impact Nursing Actions	Inpatient Falls reduction		%	62 ▲ ■	69 ▼ ■	43 ■ ■	→		→		446	456	684		=<57/m		>57/m	●	1024	763
				Nutritional Assessment (MUST)		%	90 ■ ■	91 ▲ ■	89 ■ ■	→		→		96*	90	90		=>90		<90	●		89.0
				Fluid Balance Chart Completion		%	94	93	93	→		→		98*									100

Exec Lead						August	September	October	November		December		To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
			PATIENT SAFETY (Continued)			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	12/13						
RS		3	Obstetrics	Post Partum Haemorrhage (>2000 ml)	No.	1 ▼	3 ▼	3 ■	→		0 ▲	→		0 ■	10	36	48		=<2	3 - 4	>4	●	9	7
				Admissions to Neonatal ICU	%	8.7 ■	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	7.1 ▲	7.9 ▼	3.8 ▲	→		10.3 ■	→			10.3*	<8.0	<8.0		<8	8.1 - 10.0	>10	●	6.5	11.9*
				Caesarean Section Rate	%	27.1 ■	21.4 ■	22.6 ▼	→		26.6 ■	→		24.7 ■	23.4	<25.0	<25.0		=<25.0	25-28	>28.0	●	23.6	22.2
	H			Early Booking (Completed Assessment <12+6 weeks)	%	84 ■	80 ▼	80 ■	→		81 ▲	→			81*	=>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. (%)	4836 (65.4) ▲	4904 (65.6) ▲	5087 (68.2) ▲	→		5178 (69.3) ▲	→		5282 (71.0) ▲	5282 (71.0)	7389 (100)	7389 (100)	c	0-15% variation	15 - 25% variation	>25% variation	● ●	4635	5348
RS				Medical Appraisal and Revalidation	%	79	84	83	→		87	→		86	86	No. Only	No. Only							
RO	K	3		Mandatory Training Compliance	%	80.8 ■	83.3 ■	85.1 ■	→		87.4 ▲	→		88.1 ▲	88.1	100	100		=>90	85 - 89	<85	●	86.8	71.9
			EFFECTIVENESS OF CARE																				
RO	H	8	Acute CQUIN	Dementia	396	%	Met Q2 req's	Met Q2 req's	Meeting Q3 req's	→		Meeting Q3 req's	→		Meeting Q3 req's	Met Q3 req's	80	90	b	No variation		Any variation	●		
RS	H	3		Mortality Review	743	%	64.9 ▲	68.9 ▲	53.9 ■	→			→			53.9	68	80		No variation		Any variation	● ●		66.9
RO	H	11	Community CQUIN	Dementia	44	%	Met Q2 req's	Met Q2 req's	Not Meeting Q3 req's	→		Not Meeting Q3 req's	→			Not Meeting Q3 req's	80	90		No variation		Any variation	●		
RS		6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate		HSMR	88.3 Jun'11 to May'12	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	93.1								
				Peer (SHA) HSMR		HSMR	93.3	101.3	100.2	→		98.7	→		97.8	97.8								
				Peer (National) HSMR - Quarterly		HSMR	→	97.0	→	→		→	→		95.4	95.4								
	D	19		SHMI		SHMI	96.0 Jun'11-May'12	96.3 Jul'11-Jun'12	95.3 Aug'11-Jul'12	→		94.2 Sep'11-Aug'12	→		95.6 Oct'11-Sep'12	95.6								
RB		3	Readmission Rates (to any specialty) within 30 days of discharge - Operating Framework Definition effective April 2011	Following initial Elective Admission		No.	141 ▼	138 ▲	124 ■	→		146 ■	→		106 ■	1215	1097	1463		No Variation	0 - 5% Variation	>5% Variation	●		1463
				Following initial Elective Admission		%	1.34 ▼	1.36 ▼	1.10 ■	→		1.32 ■	→		1.04 ■	1.30	1.15	1.15		No Variation	0 - 5% Variation	>5% Variation	●		1.15
				Following initial Non-Elective Admission		No.	648 ▲	613 ▲	620 ▼	→		591 ■	→		582 ▲	5696	5131	6842		No Variation	0 - 5% Variation	>5% Variation	●		6842
				Following initial Non-Elective Admission		%	6.17 ▲	6.04 ▲	5.48 ■	→		5.33 ■	→		5.73 ■	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		%	76.2 ▼	80.0 ▲	90.0 ▲	→		92.9 ▲	→		70.6 ▼	75.0	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 ■	95 ■	→		94 ▼	→		94 ■	95	90	90		>/=90	89.0-89.9	<89	●	94.5	95
		3		Maternity HES		%	6.3 ▲	6.2 ▲	6.4 ▼	→		6.9 ▼	→		6.7 ▲	6.4	<15	<15		=<15	16-30	>30	●	5.4	6.0
	G	11		Data Completeness Community Services		%	No Data	No Data	>50	→		>50	→		>50	>50	=>50	=>50		=>50		<50	●		
			PATIENT EXPERIENCE																				
RB	A	2	A&E 4-hour waits	4-hour waits		%	93.4 ▼	93.9 ▲	91.5 ▼	92.6 ▲	90.8 ▼	91.5 ■	86.5 ▼	90.2 ▼	88.9 ▼	93.25	=>95	=>95	d	=>95		<95	XXX	96.99	95.38
		2		4-hour waits (inc. Sandwell on-site GP Triage activity)		%	93.4 ▼	93.9 ▲	92.0 ▼	93.8 ▲	90.8 ▼	92.0 ■	89.0 ▼	90.2 ▼	89.6 ▼	93.38	=>95	=>95		=>95		<95	● ● ●		
	D	3	A&E Timeliness	Total Time in Department (95th centile)		h : m	4 : 37 ▼	4 : 58 ▼	5 : 38 ▼	→		5 : 21 ▲	→		6 : 14 ▼	4 : 59	=<4hrs	=<4hrs		=<4hrs		=<4hrs	● ●		3 : 59
	D			Time to Initial Assessment (=<15 mins)(95th centile)		mins	18 ▼	18 ■	19 ▼	→		17 ▲	→		21 ▼	18	<15	<15		<15		<15	● ●		21
	D			Time to treatment in department (median)		mins	60 ■	53 ▲	54 ▼	→		52 ▲	→		54 ▼	59	=<60	=<60		=<60		>60	●		59
	D		A&E Patient Impact	Unplanned re-attendance rate		%	8.25 ▲	7.88 ▲	7.59 ▲	→		7.79 ▼	→		7.46 ▲	7.90	=<5.0	=<5.0		=<5.0		>5.0	● ● ●		8.66
	D			Left Department without being seen rate		%	4.91 ■	4.23 ▲	4.77 ▼	→		4.06 ▲	→		4.60 ▼	4.81	=<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		%	14	46	63 ■	→		75 ▲	→		98 ■	98*	90	90		No variation		Any variation	●		
				Ultrasound		%	100	100	98 ■	→		100 ▲	→		99 ▼	99*	90	90		No variation		Any variation	●		
				MRI		%	60	60	76 ■	→		91 ▲	→		100 ▲	100*	90	90		No variation		Any variation	●		
				CT		%	98	99	99 ■	→		99 ■	→		99 ■	99*	90	90		No variation		Any variation	●		

Exec Lead							August	September	October	November		December			To Date (*=most recent month)	TARGET		Exec Summary Note	THRESHOLDS			12/13 Forward Projection	10/11 Outturn	11/12 Outturn
			PATIENT EXPERIENCE (Continued)				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		%	79.4 ■	77.6 ▼	70.3 ▼	24.5 ▼	78.5 ▼	55.0 ▼	47.1 ▲	75.9 ▼	63.7 ▲	63.7*	=>85	=>85	e	=>85		<85	● ● ●		
RB	H	18	Ambulance Turnaround	Average Turnaround Time		m : s	32:37 ▲	33.07 ▼	35:56 ▼	34:36 ▲	34:42 ▲	34:40 ▲	38:41 ▼	37:29 ▼	38:00 ▼	33:33	=<30:00	=<30:00		=<30:00		>30:00	●		29:23
RB	H	18	Ambulance Turnaround	In Excess of 60 minutes		No.	149 ▲	163 ▼	232 ▼	67 ▲	134 ■	201 ▲	128 ▼	195 ▼	323 ▼	1593	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.	79	56	62	→		68	→		38	537	No. Only	No. Only							834
RO	H	8	Acute CQUIN	Personal Needs	396	%	→	→	→	→		→	→		→	67.9	67.6	71.6	b	No variation		Any variation	●		
RO	H	8	Acute CQUIN	Net Promoter	372	No.	60 ▲	63 ▲	64 ▲	→		65 ▲	→			65	62	65		No variation		Any variation	●		
RO	H	8	Acute CQUIN	End of Life Care	372	%	57 ▲	60 ▲	59 ▼	→		65 ▲	→			65	50	53		No variation		Any variation	●		
RS	H	10	Acute CQUIN	Every Contact Counts - Alcohol	372	%	→	57 ■	→	→		61 ▲	→		→	61	66	80		No variation		Any variation	●		
RO	H	12	Acute CQUIN	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	95.5 ▲	91.5 ▼	96.0 ▲	→		93.0 ▼	→			96.0	90	90		No variation		Any variation	●		
RO	H	11	Community CQUIN	Net Promoter	88	No	71 ■	81 ■	88 ▲	→		86 ▼	→			86	75	75		No variation		Any variation	●		
RO	H	11	Community CQUIN	Every Contact Counts	132	%	Base data being captured	Baseline established	Met Monthly requirement	→		Met Monthly requirement	→			Met Monthly requirement	Comply with KPI trajectories			No variation		Any variation	●		
RO	H	11	Community CQUIN	Smoking Cessation	132	%	Base data being captured	Baseline established	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	→	→		→	→			Q2 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●		
RS	H	13	Specialised Commissioners	Neonatal - Hypothermia Treatment	73	%	→	Q2 Return Submitted	→	→		→	→			Q2 Return Submitted	Derive Base	Derive Base		No variation		Any variation	●		
RS	H	13	Specialised Commissioners	Neonatal - Discharge Planning / Family Experience and Confidence	122	%	→	Q2 Return Submitted	→	→		→	→			Q2 Return Submitted	Derive Base	Derive Base		Met		Not Met	●		
RS	H	12	Specialised Commissioners	HIV - Optmum Therapy	147	%	→	Q2 Return Submitted	→	→		→	→			Q2 Return Submitted	Submit Data	Submit Data		No variation		Any variation	●		
RB		15	Elective Access Contact Centre	Number of Calls Received		No.	12090	11492	13408	→		12725	→		9812	107215	No. Only	No. Only						137824	111793
RB		15	Elective Access Contact Centre	Average Length of Queue		mins	0.29 ▲	0.39 ▼	0.37 ▲	→		0.39 ▼	→		0.27 ▲	0.27*	<1.0	<1.0		<1.0	1.0-2.0	>2.0	●	0	0.21
RB		15	Elective Access Contact Centre	Maximum Length of Queue		mins	9.1 ▲	13.2 ▼	33.2 ▼	→		10.1 ■	→		8.5 ▲	8.5*	<6.0	<6.0		<6.0	6.0-12.0	>12.0	●	6.3	10
RB		15	Telephone Exchange	Number of Calls Received		No.	75331	70935	83144	→		78030	→		75409	673576	No. Only	No. Only						909301	849502
RB		15	Telephone Exchange	Calls Answered		%	89.8	90.7	89.4	→		91.5	→		88.1	90.8	No. Only	No. Only						90.5	90.2
RB		15	Telephone Exchange	Answered within 15 seconds		%	54.6	64.4	54.3	→		60.6	→		54.4	56.8	No. Only	No. Only						52.4	52.5
RB		15	Telephone Exchange	Answered within 30 seconds		%	70.1	77.1	69.5	→		75.3	→		69.6	72.0	No. Only	No. Only						68.4	68.1
RB		15	Telephone Exchange	Average Ring Time		Secs	25.3	19.5	25.8	→		20.5	→		24.3	24.3*	No. Only	No. Only						21.2	25
RB		15	Telephone Exchange	Longest Ring Time		Secs	1173	734	782	→		615	→		977	977*	No. Only	No. Only						731	718
			TRANSFORMATION PLAN																						
RB		2	Spells	Elective IP		No.	1034 ▼	672 ■	721 ▼	→		836 ▲	→		643 ▼	7479	8234	10981	f	No Variation	0 - 2% Variation	>2% Variation		11748	10610
RB		2	Spells	Elective DC		No.	4017 ▼	4213 ▲	4893 ▼	→		4801 ▲	→		3960 ▲	39327	35228	46983		No Variation	0 - 2% Variation	>2% Variation		53959	53685
RB		2	Spells	Total Elective		No.	5051 ▼	4885 ▲	5614 ▼	→		5637 ▲	→		4603 ▲	46806	43461	57964		No Variation	0 - 2% Variation	>2% Variation	●	65707	64295
RB		2	Spells	Total Non-Elective		No.	4732 ▲	4618 ▼	5016 ▲	→		4841 ▼	→		4858 ■	43121	42212	57105		No Variation	0 - 2% Variation	>2% Variation	●	59000	55675
RB		2	Outpatient Attendances	New		No.	13634 ▼	13605 ▲	15781 ▲	→		15435 ▼	→		12523 ▲	128371	107838	144072		No Variation	0 - 2% Variation	>2% Variation	●	163493	159051
RB		2	Outpatient Attendances	Review		No.	31369 ▼	30151 ▲	34608 ▼	→		32451 ▼	→		27199 ▲	289205	323781	430846		No Variation	0 - 2% Variation	>2% Variation	●	440812	421494
RB		2	A/E Attendances	Type I (Sandwell & City Main Units)		No.	14293 ▼	13076 ■	13884 ▲	5814 ▲	7795 ■	13609 ▲	5647 ▼	7950 ■	13597 ■	132514	132171	175107		No Variation	0 - 2% Variation	>2% Variation	●	181494	177201
RB		2	A/E Attendances	Type II (BMEC)		No.	2143 ▼	1973 ▼	2158 ▲	→	2055 ▲	2055 ▲	→	1847 ▼	1847 ▼	20792	24345	32254		No Variation	0 - 2% Variation	>2% Variation	● ● ●	36756	36362
RB		16	Community	Adult - Aggregation of 18 Individual Service Lines		No.	47984 ▼	45297 ▼	51293 ▲	→		42495 ■	→			370647	333107	492472		No Variation	0 - 2% Variation	>2% Variation	●	461797	493163
RB		16	Community	Children - Aggregation of 4 Individual Service Lines		No.	10284 ▼	12435 ▲	15076 ■	→		12700 ■	→			102368	105892	158876		No Variation	0 - 2% Variation	>2% Variation	●	102773	143400
RB		2	Outpatient Efficiency	New : Review Rate		Ratio	2.30 ■	2.22 ▲	2.19 ▲	2.46 ▲	1.95 ▲	2.10 ▲	2.58 ▼	2.00 ▼	2.17 ▼	2.25	2.30	2.30		No Variation	0 - 5% Variation	>5% Variation	●	2.70	2.65
RB		2	Outpatient Efficiency	DNA Rate - New Referrals		%	12.6 ▼	11.9 ▲	12.0 ▼	→		12.8 ▼	→		12.1 ▲	11.3	10.0	10.0		No variation		Any variation	● ●	13.1	11.8
RB		2	Outpatient Efficiency	DNA Rate - Reviews		%	10.9 ▲	11.0 ▼	11.1 ▼	→		11.1 ■	→		11.1 ■	10.1	10.0	10.0		No variation		Any variation	●	11.9	10.5

Exec Lead			TRANSFORMATION PLAN (Continued)			August	September	October	November		December		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	%	93.4 ▼	93.9 ▲	91.5 ▼	92.6 ▲	90.8 ▼	91.5 ■	86.5 ▼	90.2 ▼	88.9 ▼	93.25	=>95	=>95		=>95		<95	XXX	96.99	95.38
	C			Acute Delayed Transfers of Care	%	2.5 ▲	3.6 ■	2.5 ■	2.0 ▲	4.8 ■	3.4 ▼	1.6 ▲	1.8 ■	1.7 ▲	2.3	<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	%	0.4 ▲	0.7 ▼	0.5 ▲	0.7 ▼	0.9 ■	0.8 ■	0.4 ▲	0.5 ■	0.4 ■	0.6	<0.8	<0.8		<0.8	0.8 - 1.0	>1.0	●	0.8	0.6
				Average Length of Stay	Days	3.5 ▼	3.6 ▼	3.6 ■	3.6 ▲	3.2 ▲	3.4 ▲				3.7	4.3	4.3		No Variation	0 - 5% Variation	>5% Variation	●	4.3	4.2
				Day of Surgery (IP Elective Surgery)	%	91.6 ▼	86.5 ▼	92.6 ▲	93.6 ▲	95.0 ▲	94.4 ▲	92.9 ▼	95.2 ▲	94.2 ▼	91.8	82.0	82.0		No Variation	0 - 5% Variation	>5% Variation	●	88.7	89.5
				Daycase Rate - All Procedures	%	78.4 ▲	85.0 ■	86.0 ▲	84.5 ▼	83.8 ▼	84.1 ▼	85.7 ▲	84.5 ▲	85.0 ▲	83.3	80.0	80.0		No Variation	0 - 5% Variation	>5% Variation	●	81.5	82.7
RO		7	Sickness Absence	Long Term (> 28 days)	%	3.34 ▼	3.28 ▲	3.43 ▼	→		3.29 ▲	→		3.45 ▼	3.39 (Q3)	<2.15	<2.15	c	<2.15	2.15-2.50	>2.50		3.12	2.95
				Short Term (<28 days)	%	0.76 ▲	0.91 ▼	1.08 ■	→		1.18 ▼	→		1.13 ▲	1.13 (Q3)	<1.00	<1.00		<1.00	1.00-1.25	>1.25		1.05	0.95
	D			Total	%	4.10 ▲	4.19 ▼	4.51 ▼	→		4.47 ▲	→		4.58 ▼	4.52 (Q3)	<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	%	86.9	87.0	83.2	→		83.8	→		77.9	85.5	No. Only	No. Only						86.2	87.2
				Nurse Bank Shifts covered	No.	5389 ▼	5007 ▲	4904 ▲	→		5433 ▼	→		4779 ▲	44015	35235	46980		0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	●●●	54952	56396
				Nurse Agency Shifts covered	No.	703 ▼	642 ▲	1101 ▼	→		1208 ▼	→		1268 ▼	7220	2872	3830		0 - 5% Variation	5 - 10% Variation	>10% Variation	●●●	4550	6948
KEY ACCESS TARGETS																								
RB	A	1	Cancer	2 weeks	%	94.4 ▼	93.0 ▼	95.2 ▲	→		94.8 ▼	→			94.6	=>93	=>93		No variation		Any variation	●	94.5	94.8
	A			2 weeks (Breast Symptomatic)	%	98.0 ▼	93.3 ▼	97.9 ▲	→		93.7 ▼	→			96.6	=>93	=>93		No variation		Any variation	●	94.7	95.8
	A			31 Day (diagnosis to treatment)	%	98.8 ▼	98.7 ▼	99.4 ▲	→		100 ▲	→			99.5	=>96	=>96		No variation		Any variation	●	99.7	99.5
	A			31 Day (second/subsequent treatment - surgery)	%	97.8 ▼	97.6 ▼	99.0 ▲	→		100 ▲	→			99.2	=>94	=>94		No variation		Any variation	●	99.5	100.0
	A			31 Day (second/subsequent treatment - drug)	%	100 ■	100 ■	100 ■	→		100 ■	→			100	=>98	=>98		No variation		Any variation	●	100	99.2
	A			31 Day (second/subsequent treat - radiotherapy)	%	100 ■	100 ■	n/a	→		n/a	→			100	=>94	=>94		No variation		Any variation	●	100	100
	A			62 Day (urgent GP referral to treatment)	%	93.7 ▲	80.2 ■	85.4 ■	→		90.7 ▲	→			86.9	=>85	=>85		No variation		Any variation	●	88.0	86.9
	A			62 Day (referral to treat from screening)	%	92.9 ▲	96.0 ▲	93.5 ▼	→		100 ▲	→			97.5	=>90	=>90		No variation		Any variation	●	99.2	98.5
	H			62 Day (referral to treat from hosp specialist)	%	97.9 ■	96.0 ▼	94.7 ▼	→		91.3 ▼	→			93.4	=>85	=>85		No variation		Any variation	●	95.6	91.6
RB	A	2	RTT 18-Weeks	Admitted Care (RTT <18 weeks)	%	95.3 ▲	93.3 ▼	93.5 ▲	→		93.1 ▼	→		94.9 ▲	93.1*	=>90.0	=>90.0	g	=>90.0	85-90	<85.0	●	92.7	93.2
	A			Non-Admitted Care (RTT <18 weeks)	%	98.5 ▼	96.5 ▼	98.4 ▲	→		98.8 ▲	→		98.5 ▼	98.8*	=>95.0	=>95.0		=>95.0	90 - 95	=<90.0	●	96.7	97.5
	A			Incomplete Pathway (RTT <18 weeks)	%	97.7 ▲	97.0 ▼	97.1 ▲	→		96.9 ▼	→		96.4 ▼	96.9*	=>92.0	=>92.0		=>95.0	87 - 92	=<87.0	●		97.2
	E			Treatment Functions Underperforming	No.	3 ▲	4 ▼	6 ▼	→		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	%	0.97 ▼	1.47 ■	1.98 ▼	→		1.68 ▲	→		1.85 ▼	1.85*	<1.0	<1.0		<1.0	1.0 - 5.0	>5.0	●		0.99
RB	C	2	Delayed Transfers of Care	Acute	%	2.5 ▲	3.6 ■	2.5 ■	2.0 ▲	4.8 ■	3.4 ▼	1.6 ▲	1.8 ■	1.7 ▲	2.3	<3.5	<3.5		<3.5	3.5 - 5.0	>5.0	●	4.6	5.2
				Pt's Social Care Delay	No.	11 ▼	11 ■	9 ▲	7 ▼	6 ▼	13 ▼	0 ▲	2 ▲	2 ▲	2*	<18	<18		No Variation	0 - 10% Variation	>10% Variation		23	13
				Pt.'s NHS & NHS plus S.C. Delay	No.	8 ▼	10 ■	7 ■	3 ▼	3 ▲	6 ▲	2 ▲	4 ▼	6 ■	6*	<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	%	0.4 ▲	0.7 ▼	0.5 ▲	0.7 ▼	0.9 ■	0.8 ■	0.4 ▲	0.5 ■	0.4 ■	0.6	<0.8	<0.8		<0.8	0.8 - 1.0	>1.0	●	0.8	0.6
	H			28 day breaches	No.	0 ■	1 ■	0 ■	→		0 ■	→		0 ■	1	1	3		3 or less	4 - 6	>6	●	1	1
				Sitrep Declared Late Cancellations by Speciality	No.	17 ■	34 ■	28 ■	17 ■	36 ▼	53 ■	7 ■	12 ■	19 ■	251	240	320		0-5% variation	5 - 15% variation	>15% variation	●	500	363
RB		10	Cardiology	Primary Angioplasty (<150 mins)	%	92.3 ▼	76.9 ■	84.2 ■	100 ■	77.8 ▲	88.2 ▲				90.2	=>80	=>80		=>80	75-79	<75	●	90.7	88.4
				Rapid Access Chest Pain	%	96.0 ▲	97.7 ■	97.0 ▲	100 ■	97.2 ▲	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:	31 January 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 (December and Quarter 3):
There were 3 areas of underperformance during the month of December and Quarter; A&E 4-hour waits, Diagnostic Waits in excess of 6 weeks and RTT Delivery in all specialties.

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

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

Foundation Trust Compliance Summary report (December):

Within the Service Performance element of the Risk Rating for the month of December and Quarter 3 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 Management Board and Trust Management Board on 22 January 2013 and Finance & Performance Management Committee on 25 January 2013

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	October 2012/13	Score	Weight x Score	November 2012/13	Score	Weight x Score	December 2012/13	Score	Weight x Score	Quarter 3 2012/13	Score	Weight x Score
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	91.50%	0	0.00	91.50%	0	0.00	88.90%	0	0.00	90.60%	0	0.00
MRSA Bacteraemia	1.00	0		>1.0SD	1	3	3.00	1	3	3.00	1	3	3.00	1	3	3.00	1	3	3.00	1	3	3.00
Clostridium Difficile	1.00	0		>1.0SD	6	3	3.00	10	3	3.00	5	3	3.00	2	3	3.00	1	3	3.00	8	3	3.00
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	93.3%	3	3.00	93.1%	3	3.00	94.9%	3	3.00	93.6%	3	3.00
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	96.3%	3	3.00	98.8%	3	3.00	98.5%	3	3.00	98.5%	3	3.00
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	96.9%	3	3.00	96.4%	3	3.00	96.8%	3	3.00
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	6	2	2.00	3	2	2.00	3	2	2.00	12	2	2.00
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	1.98%	2	2.00	1.68%	2	2.00	1.85%	2	2.00	1.84%	2	2.00
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	95.2%	3	1.50	94.8%	3	1.50	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms	0.50	93.0%	88.00 - 93.00%	88.0%	96.2%	3	1.50	98.1%	3	1.50	97.9%	3	1.50	93.7%	3	1.50	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers	0.25	96.0%	91.00 - 96.00%	91.0%	99.8%	3	0.75	98.1%	3	0.75	98.4%	3	0.75	100.0%	3	0.75	>96.0%*	3	0.75	>96.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (surgery)	0.25	94.0%	89.00 - 94.00%	89.0%	99.7%	3	0.75	98.5%	3	0.75	99.0%	3	0.75	100.0%	3	0.75	>94.0%*	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)	0.25	98.0%	93.00 - 98.00%	93.0%	100.0%	3	0.75	100.0%	3	0.75	100.0%	3	0.75	100.0%	3	0.75	>98.0%*	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)	0.25	94.0%	89.00 - 94.00%	89.0%	100.0%	3	0.75	100.0%	3	0.75	n/a	3	0.75	n/a	3	0.75	>94.0%*	3	0.75	>94.0%*	3	0.75
Cancer - 62 day urgent referral to treatment for all cancers	0.50	85.0%	80.00 - 85.00%	80.0%	86.4%	3	1.50	86.7%	3	1.50	85.4%	3	1.50	90.7%	3	1.50	>85.0%*	3	1.50	>85.0%*	3	1.50
Cancer - 62 day referral to treatment from screening	0.50	90.0%	85.00 - 90.00%	85.0%	100.0%	3	1.50	93.2%	3	1.50	93.5%	3	1.50	100.0%	3	1.50	>90.0%*	3	1.50	>90.0%*	3	1.50
Delayed Transfers of Care	1.00	<3.5%	3.5 - 5.00%	>5.0%	3.50%	2	2.00	<3.50%	3	3.00	2.50%	3	3.00	3.40%	3	3.00	1.70%	3	3.00	<3.50%	3	3.00
Mixed Sex Accommodation Breaches (as percentage of completed FCEs)	1.00	0.0%	0.0 - 0.5%	0.5%	0.00%	3	3.00	0.00%	3	3.00	0.00%	3	3.00	0.00%	3	3.00	0.00%	3	3.00	0.00%	3	3.00
VTE Risk Assessment	1.00	90.0%	80.00 - 90.00%	80.0%	92.13%	3	3.00	89.96%	2	2.00	91.47%	3	3.00	91.65%	3	3.00	90.01%	3	3.00	91.08%	3	3.00
Sum (all weightings)	14.00																					
Average Score (Integrated Performance Measures)							2.86			2.64			2.64			2.64	* projected		2.64	* projected		2.64

CQC Registration Status

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

							Performing			Performing			Performing			Performing			Performing			Performing

Overall Quality of Service Rating

							Performing			Performing												

Assessment Thresholds for Integrated Performance Measures Average Score	
Underperforming if less than	2.0
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		
Criteria	**Metric**	**Weight (%)**		**3**	**2**	**1**	**October**	**Score**	**Weight x Score**	**November**	**Score**	**Weight x Score**	**December**	**Score**	**Weight x 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**
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**
	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**
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**
	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**
	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**
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**
	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**
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**
	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**
	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**
	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**
	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**

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

Weighted Overall Score	**2.93**	**2.93**	**2.93**

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:	31 January 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 December 2012 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 December are:

- TFA Progress
  – SHA Approval Review – Fully Achieved but late – agreed with SHA pending further discussion on TFA milestones.
  - Board able to certify compliance with IG toolkit – Not Fully Achieved
- Governance – A&E performance for the month of December is 88.9% (operational threshold 95.0%).

Contractual – A number of areas remain subject to performance improvement notices received during November. 2 relating to local quality requirements; Maternity Early Booking and Ambulance 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 on 22 January 2013

SELF-CERTIFICATION RETURNS
Organisation Name:
Sandwell & West Birmingham Hospitals NHS Trust
Monitoring Period:
December 2012

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:	December 2012

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:	Mike Sharon
on behalf of the Trust Board	Acting in capacity as:	Acting Chief Executive	
Signed by:	TO BE ADDED	Print Name:	Richard Samuda
on behalf of the Trust Board	Acting in capacity as:	Chairman	

Governance declaration 2

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

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

If Declaration 2 has been signed:

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

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

Target/Standard:	**12. Achieved a minimum of Level 2 of the IG Toolkit.**
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Board Statements

Iwell & West Birmingham Hospitals NHS T

December 2012

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.	No
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**	**Mike Sharon**	**31/01/2013**
Chair	**TO BE ADDED**	**Richard Samuda**	**31/01/2013**

QUALITY

Information to inform the discussion meeting

Sandwell & West Birmingham Hospitals NHS Trust

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Board Action
1	SHMI - latest data	Score	98.4	97.5	96.8	96.2	96.0	96.3	95.3	94.2	94.2	94.2	94.2	95.6	SHMI data relates to period October 2011 - September 2012 which is the most recent period for which data is available (source HED).
2	Venous Thromboembolism (VTE) Screening	%	92.9	92.4	92.6	92.4	92.9	91.0	91.4	87.5	91.0	91.5	91.7	90.0	
3a	Elective MRSA Screening	%	40.2	39.4	40.8	38.1	39.9	40.7	42.0	39.5	38.7	104.6	96.2	112.0	Data reported is screens not matched with patients. Screens matched to patients for the month is 55.2%.
3b	Non Elective MRSA Screening	%	50.5	58.7	61.7	70.3	64.1	66.3	68.0	69.1	66.1	66.0	78.6	78.4	Data reported is screens not matched with patients. Screens matched to patients for the month is 67.0%.
4	Single Sex Accommodation Breaches	Number	0	8	0	0	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	8	8	2	8	7	9	10	4	2	3	1	2	None of the December incidents were in excess of 45 days at month end
6	"Never Events" occurring in month	Number	1	1	1	0	0	0	1	0	1	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	14	19	23	20	19	17	14	9	10	8	5	4	2 alerts overdue at the end of the month
9	RED rated areas on your maternity dashboard?	Number	4	4	4	2	1	2	4	3	3	2	4	4	November - Midwifery Staff Vacancies (8.0%), Midwifery Staff Sickness Absence (5.3%), Corrected Stillbirth Rate (10.3 / 1000 babies) andAdjusted Perinatal Mortality Rate (10.3 / 1000 babies).
10	Falls resulting in severe injury or death	Number	2	6	2	3	0	1	1	2	6	0	2	2	
11	Grade 3 or 4 pressure ulcers	Number	14	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 99.77% in December (3027 records compliant of 3034 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	59	69	72	60	51	61	62	79	56	62	68	38	
14	Agency as a % of Employee Benefit Expenditure	%	1.7	1.8	2.5	1.7	1.4	1.9	1.9	2.2	1.8	2.3	2.45	2.91	
15	Sickness absence rate	%	4.34	4.39	4.13	4.06	4.51	4.23	4.16	4.10	4.18	4.51	4.47	4.58	
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	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				
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5				
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	4				
	I&E surplus margin %	20%	3	2	1	-2	<-2	3				Reflects in year profiling of surplus
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	4				Includes effect of assumed working capital facility
Weighted Average		**100%**						**3.7**	**0.0**	**0.0**	**0.0**	
Overriding rules												
Overall rating								**4**	**0**	**0**	**0**	

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

GOVERNANCE RISK RATINGS

Sandwell & West Birmingham Hospitals NHS Trust

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

Refresh GRR for New Quarter

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

Area	Ref	Indicator	Sub Sections	Threshold	Weighting	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Current Data: Oct-12	Current Data: Nov-12	Current Data: Dec-12	Current Data: Qtr to Dec-12	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	No	No	No	Yes	Yes	Yes	Yes	Status Changed October 2012
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		No	No	No	Yes	Yes	Yes	Yes	Status Changed October 2012
			Patients dying at home / care home	50%		No	Yes	Yes	Yes	Yes	Yes	Yes	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	No	Yes	Yes	Yes	Yes	Yes	Yes	Status changed June 2012
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	November 2012 performance confirmed from National Cancer Waiting Times system report. December and Quarter performance projected.
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	November 2012 performance confirmed from National Cancer Waiting Times system report. December and Quarter performance projected.
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	November 2012 performance confirmed from National Cancer Waiting Times system report. December and Quarter performance projected.
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	November 2012 performance confirmed from National Cancer Waiting Times system report. December and Quarter 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	Yes	No	No	No	No	No	Performance in December was 88.9% and 90.6% for the Quarter. Departments are in Trust's special measures regime in order to resolve issues. External reviews by SHA and independent expert completed. Action plan being further refined.
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3j	Category A call –emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0								
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No	No	No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No	No	No	

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			
TOTAL	**1.5**	**1.0**	**2.0**	**1.0**	**1.0**	**1.0**	**1.0**
	AG	AG	AR	AG	AG	AG	AG

RAG RATING :

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	**1.5**	**1.0**	**2.0**	**1.0**	**1.0**	**1.0**	**1.0**	
			AG	AG	AR	AG	AG	AG	AG	

CONTRACTUAL DATA

Information to inform the discussion meeting

Sandwell & West Birmingham Hospitals NHS Trust

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

Refresh Data for new Quarter

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

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

TFA Progress

Jan-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			
18	Final submission of all key outstanding documentation to SHA	Jan-13			
19	Final SHA Board to Board	Feb-13			
20	Submission of FT application to DH	Mar-13			
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Notes

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

Notes

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Plan Delivery Report 2012/13 – Q3 Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jayne Dunn – Redesign Director, RCRH/ Acting Director of Strategy and Organisational Development**
AUTHOR:	**Neetu Sharma – Head of Strategic Planning**
DATE OF MEETING:	**31 January 2013**

EXECUTIVE SUMMARY:

The document provides an update on progress of delivery for the key activities and objectives included in the Trust Annual Plan for Q3.

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

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

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

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

- **Progress towards becoming a Foundation Trust** – the timelines in the Tripartite Formal Agreement (TFA) will require further negotiation in light of the PF2 announcement.
- **Right Care Right Here** - QIPP saving activity reductions only identified at a high level and to the value of £6.3million against the LDP agreement of £10 million. Activity to date for 2012/13 is above plan.

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

- **Workforce plans** - sickness absence continues to be off trajectory; E-rostering has been delayed in roll out due to ward closure/opening issues and there are issues around the detail of TSP's to enable identification of potential WTE effect.
- **Achieving key access targets** - ED Performance remains a risk at the end of Q3; impact of bed closures due to infection control issues on delivery of 18 weeks to be determined.

REPORT RECOMMENDATION:

To discuss progress against achievement of the key activities outlined in the Trust Annual Plan for Q3.

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

Accept	Approve the recommendation	Discuss
		x

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

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

Comments:

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

Relates to all annual priorities

PREVIOUS CONSIDERATION:

October 2012 Public Trust Board (Q2 update)

Trust Board – 31st January 2013

Annual Plan – Quarter 3 Update

1.0 Introduction

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

2.0 Delivery against Priorities

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

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

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

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

3.0 Recommendations

The Board is asked to:

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

Update Against Key Priorities – Q3	
Key Priority Area	**Delivering quality priorities set out in our quality account and annual plan.**
Executive Lead	Chief Nurse/Director of Governance/Medical Director
Summary of position	Details of our current position are set out in the Quality Report which is reported to Q&S Committee and Trust Board every month. In summary: • Stroke performance whilst still variable is showing an improvement trend. Stroke reconfiguration is progressing well. • Safer Surgery compliance remains consistently high although elements of the tool still require further embedding. • CQuINs are all on target for end of year achievement. • Infection Control targets are being achieved. • Safety Thermometer is currently registering 93.8% harmfree care (target 95%). • ED action plan (special measures) is progressing well and we anticipate removing 'special measures' (clinical risk issues) by the end of February 2013. • T&O action team is in place and is progressing with work plan • Pressure damage rates are continuing to reduce • Patient experience continues to be measured predominantly by the Friends and Family Test and is currently showing a score of 65 (on target). • A Patient Experience Strategy and action plan is coming to the Trust Board January 2013.
Key issues to flag to the attention of the Board	The considerable capacity pressures in recent weeks have put a strain on maintaining quality standards in some areas. This has been compounded by an extensive and prolonged norovirus outbreak.
Current Reporting Process	All of the quality priorities are included in the Trust monthly Quality report which currently goes to Governance Board/Quality & Safety Committee and Trust Board.
RAG rating – Q3	**4**

Update Against Key Priorities – Q3	
Key Priority Area	**Workforce Plans**
Executive Lead	Chief Nurse
Summary of position	• Workforce Efficiency Programme is currently delivering according to plan and includes: -WTE reduction (TSP) - Sickness absence reduction action plan - Roll out e-rostering and acuity tools - Management review - Bank/agency monitoring/controls - Best use of APC framework • HR dashboard continues to be reported. • The new Workforce Assurance Tool is currently in process of being adopted. • Currently on track with NHSLA standards. • A new HR Department structure has been developed and is now being consulted upon. • A proposed Trust Workforce Assurance structure has been developed and is ready for TB approval.
Key issues to flag to the attention of the Board	• Sickness absence continues to be off trajectory. The action plan has been revised with some new initiatives included. • E-rostering delayed in roll out due to ward closure/opening issues. • Management review is complete but will not produce the anticipated savings. • Issues around detail of TSP's to enable identification of potential WTE effect. • National renegotiation of some AFC terms and conditions.
Current Reporting Process	• The workforce and medical efficiency programmes are reported via the Transformation Programme structures. • HR dashboard is reported at F&PC • Some key workforce measures are in the Quality Report and Performance report. • Various reports go to TMB.
RAG rating – Q3	**3**

Update Against Key Priorities – Q3	
Key Priority Area	**Progressing towards becoming a Foundation Trust**
Executive Lead	Director of Strategy and Organisational Development
Summary of position	In the last quarter the Trust has completed the following stages of the FT application: • Independent assessment of the Board Governance Memorandum self-assessment by Finnamore. • Completion of Historical Due Diligence (HDD) stage 2 by PWC • Updated IBP and LTFM prepared following SHA feedback on previous submission • Submission of updated Health Informatics Strategy to the SHA • Submission of updated workforce strategy to SHA The announcement with regards to the development of PF2 will have implications for the Trust's FT timetable and Tripartite Formal Agreement (TFA). A revised TFA is in development and negotiation with the Trust Development Authority (TDA).
Key issues to flag to the attention of the Board	The timelines included in the TFA will require further negotiation in light of the announcement of PF2 in connection with the New Hospital project. Subject to agreement, this is likely to result in a 6-9 month delay to the Trust's FT timetable. In spite of this delay, the Trust has a number of activities related to the FT application that will require delivery and improvement over the coming months. The Integrated Development Plan sets a number of challenging timescales for the Trust.
Current Reporting Process	FT Programme Director's Report to the Trust Board.
RAG rating – Q3	**2**

Update Against Key Priorities – Q3	
Key Priority Area	**Achieving key access targets**
Executive Lead	Chief Operating Officer
Summary of position	• Overall good performance with the exception of ED performance and 18 weeks at specialty level (Plastics and Orthopaedics): o ED 93.2% YTD; o December performance 18 weeks: orthopaedics admitted: 81.31 % and Plastics 86.67%. • Sustained improvements in Delayed Transfers of Care (2.3%YTD) and continued delivery of Cancer targets. • Stroke: Variable performance in Stroke and TIA services although an improving trend. Reconfiguration business case approved and on track for implementation in Q4.
Key issues to flag to the attention of the Board	**Emergency Department Performance:** Both main ED's were placed into special measures in Q3 but making progress against initial project plan. Sustained reduction in trend of serious incidents over this period. Performance continued to deteriorate in Q3 particularly on the City site. Special measures plan in place and overseen by EDAT chaired by CEO. Primary focus has been quality and safety due to incident trend, which was the primary trigger for special measures. External visit completed by the Department of Health Intensive Support Team to the City site. Key Issues include clinical leadership, effective team working/ communication, a comprehensive approach to local governance and a lack of systems and processes. Despite some progress against the above issues the above remain of concern and ED Performance remains a risk at the end of Q3. A key leadership appointment (part time) Clinical Director was made in October and increased to a full time secondment in January. A new Assistant Head of Nursing post has been introduced. To work alongside the Clinical Director. Escalation operating standards and professional standards have been introduced. This was overseen by site executive, operational and Directorate leadership. A new operational policy is in draft with a number of systems being piloted e.g. ambulance assessment in December / January.

	ED Workforce business case agreed at Trust Board. Sandwell GP service implemented in Q3. 18 weeks**:** Trajectory for improvement for T&O and plastics on track. Impact of bed closures due to infection control issues to be determined and recovered in Q4. Diagnostics: diagnostic waits underperforming in endoscopy. System issues identified in merger of 2 separate units. Recovery plan to be completed in February.
Current Reporting Process	Performance reporting is via PMB to Trust Board. The Trust Board receives a monthly update on performance. Exceptional reporting on areas of risk are via individual agenda items e.g. ED updates and Stroke Reconfiguration Business Case.
RAG rating – Q3	**3**

Update Against Key Priorities – Q3	
Key Priority Area	**Right Care Right Here**
Executive Lead	Director of Strategy and Organisational Development
Summary of position	**RCRH Programme:** The new Programme meeting structure has been established and initial meetings held. **Implementation of Redesigned Care Pathways:** Recent CCG prioritisation events have confirmed implementation of the approved RCRH redesigned care pathways as a priority for the CCG. A stock take of the current position with implementation of each pathway has been undertaken and a project lead, key actions and timescales identified for each. Progress has been made with implementation of the Musculo-Skeletal Pathways for elective joint replacement surgery. The CCG are evaluating a number of new community service models that have been implemented and that link to the pathways with many of these due to be reported on towards the end of 2013/13. It is expected that for many of the pathways full implementation will take place in 2013/14. **QIPP Savings:** Of the £10million income reduction related to QIPP Savings and agreed as part of the LDP, high level plans have been identified with activity reductions equating to circa £6.3million. Monthly activity and income monitoring continues and is showing overall activity is above plan particularly for non-elective (emergency) admissions and so the expected QIPP activity reductions have not been realised. Some of the QIPP savings are expected to come from implementation of the approved RCRH redesigned care pathways (these mostly impact on outpatient activity).
Key issues to flag to the attention of the Board	Whilst progress has been made in quarter 3 with implementing the RCRH redesigned care pathways, full implementation is now expected to take place during 2013/14. QIPP saving activity reductions only identified at a high level and to the value of £6.3million against the LDP agreement of £10 million. This creates a potential gap for the 2013/14 LDP.
Current Reporting Process	Monthly RCRH Implementation Board meeting with monthly progress report to Trust Board
RAG rating – Q3	**2**

Update Against Key Priorities – Q3	
Key Priority Area	**Service Developments (other than RCRH)**
Executive Lead	Director of Strategy and Organisational Development
Summary of position	Clinical Service Reconfigurations: • **Vascular Surgery** – transfer of inpatient service to UHBFT completed 10/9/12 • **Stroke and Transient Ischaemic Attack (TIA) Services** – implementation plan in progress & on track to implement March 2013. Returns submitted to Network as part of SHA Strategic Review of Stroke Services. • **Orthopaedic Inpatient Services** – transfer to Sandwell Hospital completed 24/8/12 • **Development of an Emergency Assessment Unit (EAU) at City Hospital** – As reported last quarter the development of an EAU at City is no longer a service development for 2012/13. Emergency surgical pathways are being reviewed and streamlined and as a result the trolleys on SAU have now been reduced from 19 to 14. No further reductions are planned for 2012/13. • **Pathology** - The Blood Sciences Laboratory phase 1 work remains on track for completion by end of January 2013 and within budget. The LTS study of our and Dudley Group of Hospitals Pathology Laboratories is ongoing with a final report now due early February 2013. The SHA tendering of GP direct access work continues with publication of the tender expected at the end of January 2013. We are currently working on how we will respond and continue to have discussions with potential partners. Following the Black Country tender for Cytology services we are working with partner Trusts in the Black Country on the change management required to see a successful implementation of centralising cytology services to Wolverhampton. A similar service change is expected in Birmingham. Major Capital Redevelopments: • **Endoscopy Unit Upgrade** – This project is on track. Phase 1, (Endoscopy washers and decontamination) will be operational by the end of March 2013. Phase 2, (the Endoscopy unit works) will commence on 1st April 2013 (in line with the Capital Programme). Expansion of Specialist Services: • **National Behçet's Syndrome Centre** – The Centre was established in July with clinics starting slightly ahead of plan. Most of the staff have been recruited including the Lead Nurse who started in post in November. Recruitment for the Consultant Ophthalmologist post is ongoing. The clinics have been transferred to a dedicated area within the Clinical Research Facility (adjacent to BMEC). A number of patients have been transferred from other specialities and new referrals should

	increase in the next quarter. Nurse led telephone clinics are being established. • **Gynae-Oncology Service** - work is ongoing within the speciality to develop pathways with referring units, rollout the Survivorship Programme to include cancer unit patients, identify any further opportunities to convert open surgery to minimal access surgery, develop an outpatient ascitic drainage service and explore an 'at home service'. An External Peer Review visit took place on 29th October 2012 with excellent feedback received. The specialty has developed a 5 year Clinical Strategy which will be presented to the Executive team in February 2013. <u>Expansion of our Community Services:</u> • **Health Visiting Service** - Additional 15wte training posts. We are on track to increase Heath Visitor numbers by 15 wte additional posts in 2012/13. We have extensively re-shaped the way we train Health Visitors and there are 16 due to qualify 2013. In addition a recent care plan audit showed improvements in all of our Health Visiting teams; a Health Visitor Service Rapid Appraisal was undertaken by the SHA in August. An Integrated Development Plan has been produced along with an action plan and monthly progress report.
Key issues to flag to the attention of the Board	**Clinical Service Reconfigurations:** • SHA Strategic Review of Stroke Services ongoing. The aim is to have a preferred configuration of Stroke Services across the SHA by end of March 2013. The Birmingham, Black Country and Solihull CCGs are working together to identify a preferred option locally.
Current Reporting Process	**Clinical Service Reconfigurations:** Reported Quarterly to Clinical Services Reconfiguration Programme Board, quarterly progress report to Trust Board and specific project updates/Business Cases to Trust Board at key milestones. **Major Capital Redevelopments:** Progress reported to Strategic Investment and Review Group (SIRG). **Expansion of Specialist Services:** Divisional Performance Reviews (by exception). **Expansion of our Community Services:** Directorate Meetings & Divisional Performance Reviews (by exception).
RAG rating – Q3	**Clinical Service Reconfigurations: 4** **Major Capital Redevelopments: 4** **Expansion of Specialist Services: 4** **Expansion of our Community Services: 4**

Update Against Key Priorities – Q3	
Key Priority Area	**Sustainability**
Executive Lead	Director of Estates/New Hospital Project Director
Summary of position	**Carbon emissions reduction in line with the Carbon Trust Carbon Management Plan (CMP)** • The CMP document and baseline have been revised to account for organisational changes and to take into account the proposed timeframes for the new hospital. This document has been externally verified by the Carbon Trust and the Trust Board will be updated at the next meeting. • The revised document states that the Trust will reduce carbon emissions 15% by 2016/17 (from the 20011/12 baseline). It lists a number of projects that will help progress the Trust towards achieving this target. • Current and planned projects in the pipeline include energy efficient lighting and controls (main reception of the Sheldon Block completed, with the libraries at City and Sandwell Hospital in the planning stage), air conditioning controls, steam trap repair work, insulation jackets, and on-going staff engagement work. Solar PV for the Birmingham Midland Eye Centre (BMEC) is being investigated as a renewable source of energy for the Trust. **Target reduction of 5% for total site energy consumed per 100m3 heated volume (i.e. reduction to 925kWh per 100m3)** • New steam boiler planned for March 2013 with an economiser at Sandwell Hospital that is estimated to save 5% on gas consumption during the summer months (i.e. April-Sept). • Site rationalisation work is also in progress to reduce energy consumption from buildings (see below). **Site rationalisation / agile work implementation as part of Estates TSP** • Rationalisation work is progressing • The rationalisation / agile working environment will greatly reduce the Trust's energy consumption and help us towards our carbon management target of 15% reduction in carbon emissions by 20156/17 (from 2011/12 levels).
Key issues to flag to the attention of the Board	To note that the energy (and carbon) savings from the site rationalisation / agile working programme will be heavily impacted by any changes to the planned areas for closure and also the timeframes.
Current Reporting Process	Sustainability progress is reported to the Trust Board on a quarterly basis with regards to recently implemented and planned/future projects.
RAG rating – Q3	**4**

Update Against Key Priorities – Q3	
Key Priority Area	**Delivering the Transformation Plan**
Executive Lead	Chief Operating Officer
Summary of position	**Developing an expert level Transformation Support Office (TSO) function within the Trust to improve capacity and capability to deliver large-scale change.** • KMT continue advising and supporting development of TSO as part of commissioned work. • KMT contracted until end of financial year. TSO team development programme in progress. • Development of TSO team well underway with a balance of formal training and continuous "on-the-job" coaching. • TPRS now providing a complete view of projects for the current year as well as FY13/14 & FY14/15. The system provides management of all project timings, QIAs, EIAs as well as workforce elements. The next phase is to standardise the use of the system across the organisation. **Recruitment to key posts: Associate Director Transformation, Chief Informatics Officer, Medical Director** • Transformation Associate Director post appointed. • Additional support for the information function of TSO under review. Focus areas would be TPRS standardisation and supporting delivery teams with real time data analysis and KPIs. **Delivery of workforce plan related to all transformation projects.** • Workforce elements of all transformation projects are now managed centrally through TPRS. Workforce team manage HR functions within TPRS with have a direct link to individual projects. **Impact on other organisations (e.g. primary and community care) to enable change to be identified and delivered, e.g. decommissioning and commissioning of pathway changes to reduce acute hospital activity.** • Q3 work initiated with Birmingham Social services to establish a joint discharge team and joint protocols • Decommissioning plans at service level are light for outpatients and are a potential block to progress in this an area of decommissioning. This is an area of focus for the Out Patients work stream. • Working with GPs on urgent care provision on acute sites eg Sandwell ED **IT strategy and plan to identify key enablers to projects.** • eBMS (electronic bed management system) development has been key to the progress in the patient flow project.

Key issues to flag to the attention of the Board	• As a relatively new way of working in a 5 year approach to Transformation, the capacity and capability of teams to apply and deliver transformational thinking to future planning. This will be addressed through organisational development plan encompassing transformation. This work is currently in a planning phase and linked with the overall organisational development agenda. • Clinical engagement – the development of the clinical sponsor roles has been successful and a significant area of progress from previous approaches to leading change programmes. A new associate medical director post linked to transformation and innovation will be recruited to in Q4. • Impacts of external commissioning structure changes: Uncertainty still remains particularly at a specialty level on how to work with commissioners, as appointments externally are still being made into new CCG structure. The Trust is working with key CCG leaders through the RCRH Programme Board and local forums to establish infrastructure to support transformation plan.
Current Reporting Process	Transformation Plan Programme update: via TPSG to Trust Board monthly Transformation Plan financial update: via F&PC to Trust Board monthly.
RAG rating – Q3	**4**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

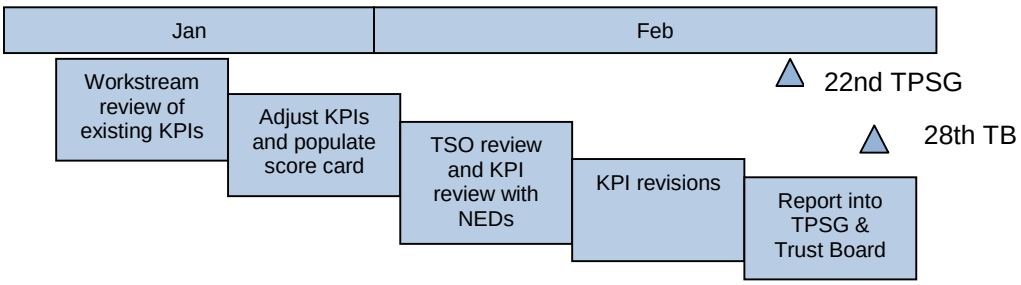
TRUST BOARD

DOCUMENT TITLE:	**Transformation Plan Status Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow, Chief Operating Office**
AUTHOR:	**Mike Banbury / Paul Crabtree, Associate Director of Transformation**
DATE OF MEETING:	**31 January 2013**

EXECUTIVE SUMMARY:

Reporting process review:

- Review process underway to uplift the reporting structure from TSO to Board.
- Key priorities are:
  1. Clear KPI status against Transformation targets
  2. Data driven reporting workstream ➡TPSG➡Trust Board
  3. Involvement of Board in report design to capture requirements
- Process to develop revised report:



Theatres:

- Pre-op 1-Stop-Shop pilot started in T&O, using new eDTA process
- Centralised Booking pilot started in T&). Report under development to establish KPIs. Business case to SIRG on 11th March for report out and future proposal.
- Capacity/Demand model developed and used for 2013 capacity planning for T&O
- Analysis of all T&O consultant procedure times has been analysed to establish more accurate scheduling of lists.
- Daily performance board has now been used on 3rd floor theatres since 10th Dec. Report due on 25th Jan for analysis of delayed start times.
- Theatre step Down project now analysing data for Main Spine day-case unit to support case for Minor Ops unit.

Community:

- Preparation on plan to introduce eBMS to Henderson & Leasows.
- Phase 1 of Rehab process complete at Leasowes (some delays due to Norovirus). Phase 2 planned for early Feb.
- Audit underway for STAR referrals to support Integrated Teams workstream.
- Sexual Health review now fed back to consultant. Action plans being prepared for project delivery.
- Meetings being held with Sandwell Housing and Sandwell Council to establish links with planned projects (internal & external).

Urgent Care

- Practical Problem Solving activity started with 60+ concerns identified.
- Priority projects started:
  - Ambulance Assessment Unit – Target for pilot trial on 19th-21st Jan
  - Visualisation and performance review format within ED
- Standardised Clinical Pathways project started with steering group being identified.
- PO raised for West Mercier standard Pathways data.
- Priority pathways identified as:
  - Phase 1 – Presenting complaint / Symptom Specific (2 specialities, one symptom each)
  - Phase 2 – Diagnosis specific (2 specialities, one diagnosis each)

Outpatients:

- Workstream review carried out to review priorities and direction of workstream.
- 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.
- Partial booking pilot on schedule to start by end of Jan. Priority is to ensure resource in place for pilot start.

Patient Flow:

- Focus now targeting Emergency Flow to support current ED performance priorities. Progress is covered in a separate paper: ED performance update.
- Focus targeted between decision in Assessment Unit, through to patient discharge (including community social care)

TPRS focus:

- TPRS now populated for future years TSP 13/14 & 14/15 (including QIAs & EIAs)
- Following push for divisions to populate future years TSPs, focus now back to current year TPRS accuracy to represent true status. Being followed weekly through COO meeting.
- TSO currently reviewing all future year TSP submissions to identify true Transformation projects to ensure alignment of TSO workstream support.

REPORT RECOMMENDATION:

The Board is asked to note the update

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

Financial	**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:

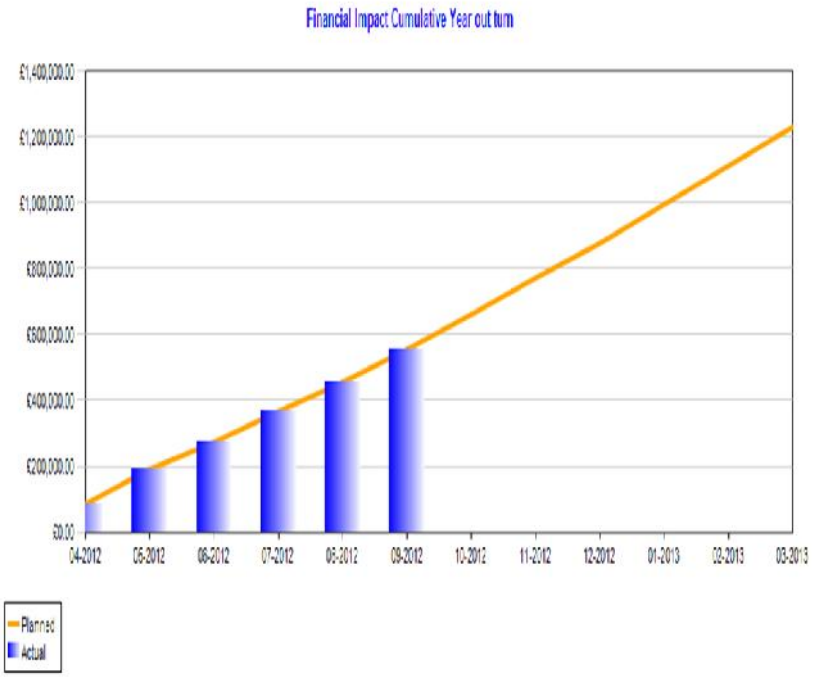
Delivery of the Transformation Plan

PREVIOUS CONSIDERATION:

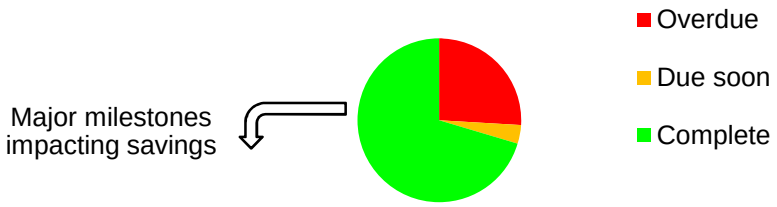
Routine monthly update.

Workstream: Theatres

Financial status



Milestone status



RAG	Milestone(s)		Actions
		SA055 Establishment Reduction – theatres SB017 Theatres Efficiencies - review team requirements	

Next steps

See following slides

Risks / Issues / Escalation

1. Appropriate Capacity to meet demand in theatres
2. Team flexibility to support changing theatre sessions to maximise efficiency
3. Centralised booking timescales/resource practicalities
4. Location of centralised booking team
5. Clinical Engagement

Work-stream Objectives

Clinical/Management Leads:
Zoe Huish
Bethan Downing

Transformation:
Leann Coughlan
Paul Woodhead

T&O Clinical/Management Leads:
Yvette Moore
Mr Roy

BOOKING RULES

-**Lead** Louise Pickering
-Creating a crib sheet which contains accurate procedure times for each consultant, this will also contain median procedure times for consultants based on their relevant triage pools. Develop a clear system of monitoring planned procedure times.
-Updating booking rules within the theatre utilisation policy and ensuring that current systems and structures are in place to promote compliance and escalation.
-Explore the current pooling system
-Ensure that structured

THEATRE WARD FLOW

Lead: Mike Evans
-Determine the line and process of communication between ward & theatre
-Theatre planning board will support this process
-Clarify teams roles and responsibilities
-Use Ormis to clarify the order of the days list
-Review the footfall to promote a seamless theatre session.

PERFORMANCE MANAGEMENT

Lead: Derek Norman
-The use of performance management board in theatres
-Use of new theatre dashboard in current systems & structures
-Clear process in place for reporting and escalating performance
-Theatre Planning board
-The use of Exec Reinforcement?

STEP DOWN

Lead: Lesley Hodgkinson
-Utilise BTC ASU 23 hour stay
-Extended hours in SDU – to remain open until 10.00p.m.
-Minor Ops at SGH
-Community/GP services – procedures currently done as an outpatient being performed in health centres either by our staff or by specialist trained GP's/nurses.

Theatre Utilisation Work-stream: Delivery status

Transformation Plan

NHS Trust

BOOKING RULES

Lead: Louise Pickering
Cons Rep: Mr Prakash

What we have done:

- First draft theatre booking policy has completed. This will be reviewed by cons rep and team.
- Ormis procedure times have been analysed and a first draft crib-sheet been created by joint and consultant
- Procedure times have been validated by the consultant lead

Next Steps:

- CD/DMT to validate crib sheet
- Obtain feedback of the crib sheet from CB team.
- Complete review of current booking policy and begin to rewrite where necessary.
- Create standard agenda for the scheduling meeting including roles and responsibilities
- Create roll out plan to trial the use of the crib sheets (28th Jan)

THEATRE UTILISATION

Lead: Mike Evans

What we have done:

- Project plan developed
- Analysis of data has begun
- Mike & Bethan has begun to edit the theatre utilisation policy

Next Steps:

- Phase 1 to review utilisation policy (all specialties)
- Phase 2 review theatre to ward flow and identify bottlenecks within session

PERFORMANCE MANAGEMENT

Lead: Derek Norman

What we have done:

- Trial of the performance board has been running on 3rd Floor theatres since 10th December
- First analysis of causes of delay to start times will be produced on 21st Jan.
- First draft theatre dashboard has been developed.
- Reviewed WHO & Darzi documentation

Next Steps

- After two weeks trial of the board the data will be analysed to determine area to focus improvement efforts on.
- Begin to build framework for the master performance board
- Make necessary changes to the performance board as a result of feedback from staff.

STEP DOWN

Lead: Lesley Hodgkinson
Cons Rep: Mr Prakash

What we have done:

- Working group organised fortnightly
- Initial analysis has been completed for the step down of day case to minor ops
- Minor ops identified as priority

Next Steps:

- Data Analysis of main to day case. Create business case to justify minor ops unit
- Reviewing patient pathways
- Review area in Sandwell & City for minor ops facility

Delivery status

Pre-Op 'One Stop Shop'

Lead: Pauline Mohan

What we have done:

- One stop shop pilot commenced 07/01
- Nursing documentation being used
- Briefing paper for room move submitted to theatre divisional manager
- eDTA has commenced in parallel with one stop shop.
- The IT team are supporting the eDTA process daily.

Next Steps:

- Consultants to do initial trial eDTA starting 7th Jan
- Aim to have all T&O consultants piloting eDTA by 14th Jan
- Determine key performance indicators and monitor on a weekly basis.
- Determine next speciality to roll out process

Centralised Booking

Lead: Heather Fleming

What we have done:

- 90% of SOPs have been signed off by Elective access manager. Iterations need to be made on risk assessment and KPI's
- Centralised booking has commenced for T&O (In patients).
- Patient experience questionnaires have been developed and are now being sent out with the TCI's
- KPI report has been requested from IT

Next Steps:

- Final 10% SOPs need to be updated
- Training for SOP's
- Next specialty agreed for roll out and to explore the recruitment of staff for rollout

Capacity Strategy

Lead: Leann Coughlan

- Demand capacity model has been validated and has been used to advise T&O for their capacity strategy 2013
- Next speciality to be determined to replicate model

Patient Flow Workstream:

Change of Focus

Patient Flow → Emergency Flow

Consolidate & accelerate existing programme plus additional areas identified through 'back to the floor' exercise

In scope: Decision in Assessment Unit to admit to inpatient bed to patient discharged (inc. community social care)

Out of scope: ED and Assessment Unit (going home/admission avoidance) – part of review of Urgent Care

Revised Governance Arrangements

Emergency Flow Executive Taskforce

↑ Fortnightly – Exec team plus DD & HoN Medicine, Therapies Lead, TSO support

Emergency Flow Delivery Team

Weekly Operational Group –COO, Deputy COO, Head of Capacity, Assistant HoN, Therapies Lead, Assessment Unit Matron & Doctors, TSO support

End of January Deliverables

In place:

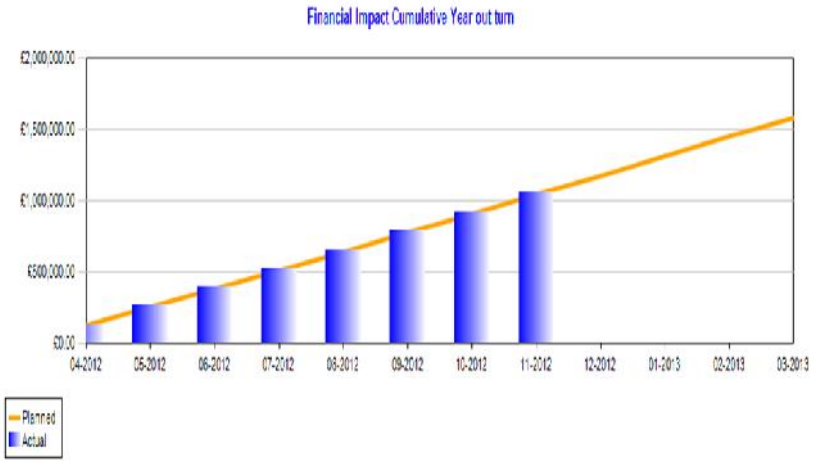
- Professional Standards (measuring 3, plan for others)
- Ward Clinical Teams
- Board Rounds & Peer Review process
- Daily Discharge Reviews to agreed standard

Standards (time bound) for:

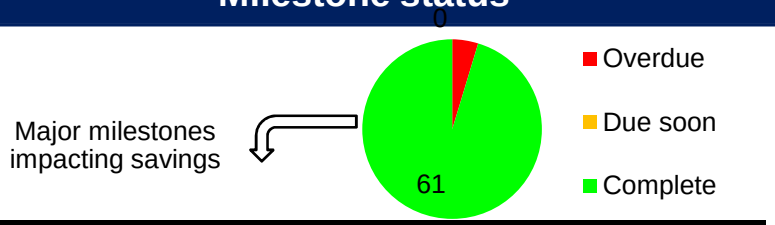
- Declaring beds
- Bed cleaning
- Patient handover & transfer
- Ward dashboard in use
- Flow KPIs consolidated with automated reporting
- Medicine Division review established with a plan for directorate reviews agreed
- Use of existing eBMS functionality embedded as daily practice
- eBMS development & supported roll-out as per implementation plan
- Escalation Standards & Triggers defined and in place
- Joint Partnership Policy/Protocol developed and joint team meetings established
- Operations Centre Model defined
- Weekend discharges and clinical criteria for discharge developed in eBMS
- Patient Contract – proposed approach agreed
- Improved use of discharge lounge
- Live predictor – Demand and capacity in place
- Transport Standard in place
- Near-patient Pharmacy Model roll-out as per plan

Workstream: COMMUNITY

Financial status



Milestone status



RAG	Milestone(s)	Impact	Actions
	Not cross cutting – Division are aware and working to correct		
	CROSS CUTTI NG		

Next steps

- Develop an action plan from review of work at Leasowes
- Complete action plan for eBMS development for Units
- Complete review of single referral forms into IC beds and complete development of form for ICARES - roll-out
- Support Housing Discharge Pilot to get up and running
- Work with Sandwell Council to get telephone support service up and running
- Attend Virtual Patient Visit demonstration

Risks / Issues / Escalation

- Pace of demand for change from other work programmes – community workstream is a key enabler to savings from UC, Beds and OPD in acute
- Complexities around introduction of SPA
- Vascular Repatriation – Receiving a few queries relating to community beds and delayed discharges
- Unmet need for complex stroke care
- ESD target remains a problem discussion with Commissioners planned

Workstream: Community

Delivery status

Rehab Workstream

- Phase 1 of review of processes at Leasowes complete – work held up due to closure of Unit with Norovirus. Phase 2 to be completed early part of Feb but plan to pull together actions to start some work prior to completion of Phase 2
- Work started to prepare for development of eBMS at Henderson & Leasowes
- Meeting to discuss amputee pathway held – action plan produced Task and Finish Group meeting on fortnightly basis to drive work forward

Integrated Teams

- SPARTIC processes documented including a new process around a "virtual" waiting list
- Work ongoing to enable access to eBMS and develop visibility of referrals into STAR
- Audit of numbers and timings of referrals to STAR underway
- ICARES developing actions plans for this year with plan to introduce "virtual ward" model around April time

PCS

- "Deep Dive" into DN services has commenced working with a second team
- Report re findings from sexual health service review fed back to Consultant – action plan being developed due 10th January

Community/Acute Interface

- Review of Single Referral Form for community beds underway plus a referral form for referral into other ICARES services other than a bed
- Group looking at "revolving door patients" – and working differently

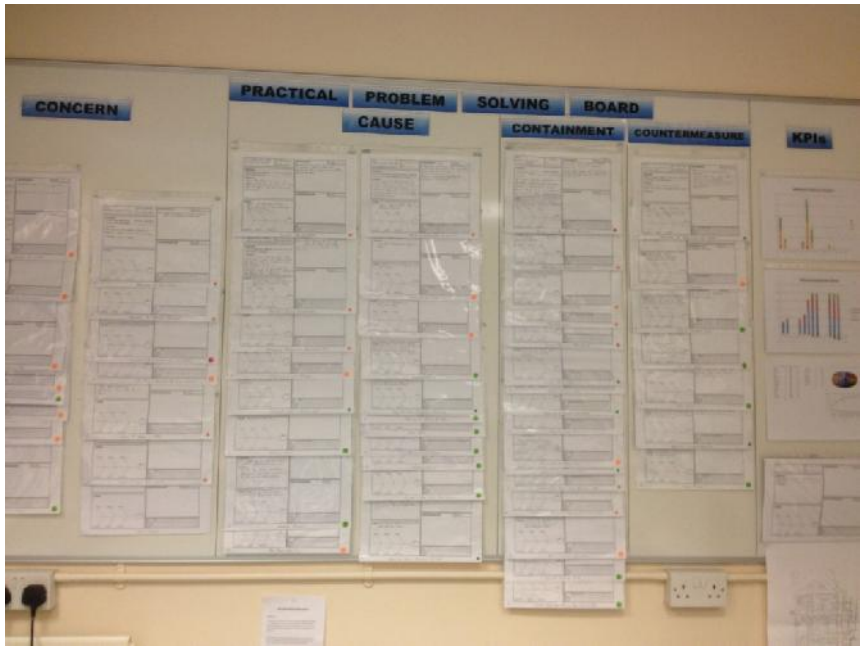
Other

- Working with Sandwell Housing re a Housing Discharge Service Pilot Project
- Attended meeting with Sandwell Council re new telephone support service they are setting up to help support patients post discharge

Urgent Care Workstream

Emergency Department Practical Problem Solving

- Capture of real-time problems from staff
- Main priority areas were:
  - Ambulance assessment
  - Separate area for monitored patients
  - Physical Separation between Majors and Minors
- Most issues related to process, estates and IT
- Quick wins have been partially/fully completed
- Remaining categorised in larger projects that require further analysis and detailed work



Next Steps

- Scope of the projects needs to established
- Projects will need clinical sign off

Urgent Care Workstream

Standardised Clinical Pathways

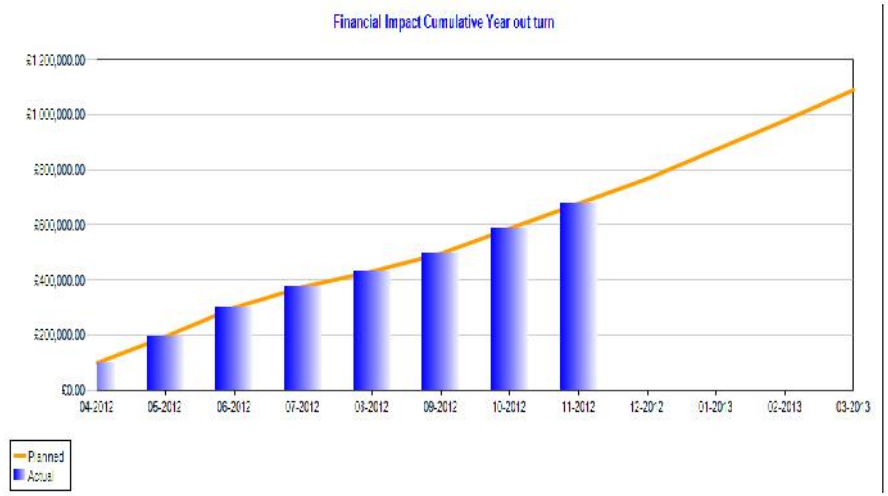
- West Mercia Guidelines have been agreed to be used. Purchase order in process
- Steering group for Standardised Clinical Pathways has been established
  - Exec Sponsor– Roger Stedman
  - Core Group – Roger Stedman, Carol Cobb, Mark Poulson and Lisa Carroll (ad-hoc invitees dependant on pathway)
- Scope : Patient attendance to emergency care → Disposal from emergency care
- Priorities for the pathways have been discussed and awaiting exec. sign off
  - Phase 1 – Presenting complaint / Symptom Specific (2 specialities, one symptom each)
  - Phase 2 – Diagnosis specific (2 specialities, one diagnosis each)

Next Steps

- Engage with specialities
- Establish project groups
- Sign off of outputs expected for phase 1

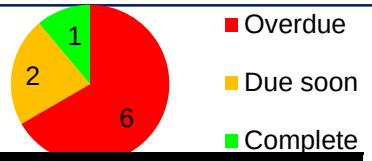
Work stream: Outpatients

Financial status



Milestone status

Major milestones impacting savings



RAG	Milestone(s)	Impact	Actions
	Divisional delays in translating PA reduction to job plans	Projected savings will not be met.	Manage through Divisional leads at COO

Next steps

- Clinical pathway redesign- initial meetings with some directorates held, but limited progress. Cataract , stable prostate cancer and bronchiectasis pathway redesign on-going.
- Deep Dive +: Rheumatology analysis on-going, feedback end of Jan.
- Focus on LiA identified quick wins through the Outpatients Operational Group- action plan devised .
- Plan in progress to roll out partial booking for follow ups from end of January 2013. Business case for workforce investment- x3 band 2 staff for contact centre approved at SIRG 8th Jan.
- Implement 'Blue Prism' in OP early in 2013 - will achieve savings in medical records and anti-coag initially and improve % of clinics cashed up.
- OP self check-in desks will be piloted in BMEC, currently being purchased.
- Develop and roll out Trust wide OP quality standards.

Risks / Issues / Escalation

- Slow/limited progress on engagement with directorates in pathway redesign.
- Clinic decommissioning has not taken place at the required rate.
- Lack of clarity on how much outpatient activity the CCGs and Trust will agree to provide in primary care
- Workforce gaps within divisions are resulting in delays in projects. Escalated locally to DGMs.
- Possible slip in partial booking pending outcome of recruitment .
- Operational transformation of OP at risk due to lack of overarching management structure. This is under review.
- Anti-coag RAID system not compatible with Blue Prism, needs supplier solution- possible slip and/or risk to implementation in anti coag.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Foundation Trust Programme Monitoring and Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Acting Chief Executive**
AUTHOR:	**Mike Sharon, Acting Chief Executive**
DATE OF MEETING:	**31 January 2013**

EXECUTIVE SUMMARY:

The report gives an update on:

- Milestone status
- 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 31 January 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FT Programme Monitoring Status Report

Red

Activities Last Period

- 8th draft IBP/LTFM completed.
- Revised workforce & Health Informatics Strategy submitted to SHA.
- HDD 2 draft report received
- Meeting with PwC to agree final HDD2 report – 23/01/13
- SHA Quality and Safety visit (scheduled for 15.1.13) postponed in light of PF2 announcement/FT delay.
- Final SHA B2B (scheduled for 7.2.13) postponed in light of PF2 announcement/FT delay.

Planned Next Period

- Board development plan to be agreed
- Board seminar on OBC to be held
- Independent assessment of progress against quality governance action plan to be undertaken by Deloitte in late February/early March.
- Continue programme of raising staff awareness of FT issues.
- OBC financial re-modelling

Issues for Resolution/Risks for Next Period

- The timelines included in the TFA will require further negotiation in light of the announcement of PF2 in connection with the New Hospital project. Subject to agreement, this is likely to result in a 6-9 month delay to the Trust's FT timetable.
- A revised TFA is in negotiation with the Trust Development Authority (TDA).
- Risk that momentum is lost on required Board and wider governance improvement