Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 26 September 2013; 1330h

Members

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

In attendance

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

Guests

Ms L Hesk	(LH)	[Matron]
Ms T Weston	(TW)	[Ward Manager – D27]
Mr M Budhoo	(MB)	[Group Director – Surgery A]

Secretariat

Mr S Grainger-Payne (SGP) [Trust Secretary]

Time	Item	Title	Reference Number	Lead
1330h	1	**Apologies**	**Verbal**	**SGP**
	2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**All**
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 29 August 2013 a true and accurate records of discussions*	**SWBTB (8/13) 180**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (8/13) 180 (a)**	**SGP**
	5	**Chair's opening comments and Chief Executive's report**	**SWBTB (9/13) 182**	**Chair/ CEO**
	6	**Questions from members of the public**	**Verbal**	**Public**
1345h	7	**Patient Story**	**Presentation**	**LH/TW**
1400h	8	**'Never Event' – Plastic Surgery**	**Verbal**	**RST**
		MATTERS FOR APPROVAL		
1415h	9	**Maintenance of Digital Mammography Systems – Approval of Waiver of Tendering Process**	**SWBTB (9/13) 183** **SWBTB (9/13) 183 (a)**	**GS**
	10	**Performance Management Regime – monthly submission**	**SWBTB (9/13) 184** **SWBTB (9/13) 184 (a)** **SWBTB (9/13) 184 (b)**	**MS**
	11	**Trust Development Authority submission: Winter Bed Plan**	**To follow**	**RB**

1425h	**12**	**Estates strategy**	**SWBTB (9/13) 186** **SWBTB (9/13) 186 (a)**	**GS**
	MATTERS FOR DISCUSSION			
	13	**Safety, Quality and Governance**		
1445h	13.1	Update from the meeting of the Quality & Safety Committee held on 20 September 2013, minutes from the meeting held on 23 August 2013	SWBQS (8/13) 128	OD
1450h	13.2	Quality report	SWBTB (9/13) 187 SWBTB (9/13) 187 (a)	LP/ RST
	▶	Klebsiella infection briefing	SWBTB (9/13) 188 SWBTB (9/13) 188 (a)	LP
	▶	Readmissions update	SWBTB (9/13) 189 SWBTB (9/13) 189 (a)	RB
1505h	13.3	'Never Event' briefing	SWBTB (9/13) 190 SWBTB (9/13) 190 (a)	KD
	14	**Finance & Performance Management**		
1520h	14.1	Update from the meeting of the Finance & Performance Management Committee held on 20 September 2013, minutes from the meeting held on 23 August 2013	SWBFC (8/13) 081	CRO
1525h	14.2	Monthly finance report – Month 5	SWBTB (9/13) 192 SWBTB (9/13) 192(a)	RW
1530h	14.3	Update on plans to address Medicine Group's financial position	SWBTB (9/13) 193 SWBTB (9/13) 193 (a)	RB
1540h	14.4	Monthly performance monitoring report	SWBTB (9/13) 194 SWBTB (9/13) 194 (a)	RB
1545h	**15**	**Any other business**	**Verbal**	**All**
	MATTERS FOR INFORMATION			
	16	**Update on Trust's planned response to the Francis Inquiry**	**SWBTB (9/13) 191** **SWBTB (9/13) 191 (a)**	
	17	**Midland Metropolitan Hospital project: monitoring report**	**SWBTB (9/13) 195**	
	18	**Foundation Trust application programme: monitoring report**	**SWBTB (9/13) 196** **SWBTB (9/13) 196 (a)**	
	19	**NHS Performance Framework & FT Compliance Framework report**	**SWBTB (9/13) 197** **SWBTB (9/13) 197 (a)**	
	20	**Details of next meeting** *The next public Trust Board will be held on 31 October 2013 at **1330h** in the Boardroom, Sandwell Hospital* ***PLEASE NOTE NEW TIMING***		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 29th August 2013

Present	**In Attendance**
Mr Richard Samuda [Chair]	Miss Kam Dhami
Dr Sarindar Sahota OBE	Mrs Jessamy Kinghorn
Ms Olwen Dutton	Mrs Chris Richards
Ms Clare Robinson	Mr Bill Hodgetts [Healthwatch]
Mr Toby Lewis	Mr Chris Archer [for Mr White]
Miss Rachel Overfield	Dr Deva Situnayake [for Dr Stedman]
Miss Rachel Barlow	

Secretariat

Mrs Lesley Broadway

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Professor Richard Lilford, Mr Harjinder Kang, Mrs Gianjeet Hunjan, Mr Robert White, Dr Roger Stedman and Mr Simon Grainger-Payne.	
2 Declaration of Interests	**Verbal**
There had been no declarations of interest made since the last meeting and no Board member declared an interest with any item on the agenda of the meeting.	
3 Minutes of the previous meeting	**SWBTB (7/13) 162**
The minutes of the Trust Board meeting held on 25th July 2013 were presented for	

consideration and were approved as an accurate record of discussions held.	
AGREEMENT: The minutes of the last meeting were approved.	
4 Update on Actions arising from Previous Meetings	**SWBTB (7/13) 162 (a)**
4.1 Francis Report	
The current position with regard to the Trusts action in respect of the Francis report was discussed. It was noted that the presentation of the baseline assessment against the recommendations within the Francis report to the Quality & Safety Committee and Trust Board had been deferred until September. It was further noted that the recently published Keogh and Berwick reports would also need to be reviewed and action plans drawn up as appropriate. Ms Dutton confirmed that the Keogh report was included on the agenda of the next meeting of the Quality & Safety Committee. Mr Sharon highlighted that it was important to reference the contents of the reports as part of the FT process. Ms Robinson advised that the Francis report headlines were available on the TDA website.	
4.2 Audit Committee	
Mr Lewis drew attention to an assurance from the Director of Finance & Performance Management that all outstanding actions had now been completed.	
ACTION: Mr Grainger-Payne to arrange for consideration of Internal Audit actions at the next meeting of the Audit & Risk Management Committee	
5 Chair's Opening Comments and Chief Executive's report	**SWBTB (8/13) 164**
The Chairman provided a summary of the key activities in which he had been involved since the Board had met in July. It was noted that the recent visit made by Richard Douglas, Finance Director of the Department of Health, to The Learning Works had been successful and he had been impressed with the work being undertaken to the benefit of the local population. The work undertaken by Mr Jim Pollitt in setting up the Learning Works and the Reconfiguration work undertaken by Mrs Jayne Dunn had both been nominated for HSJ Awards. The Chair had also met informally with Black Country chairs, had met with staff from Imaging and Newton 1 and had met with Tom Storrow, Chair of Birmingham Community Trust. Mr Lewis asked the Board to receive and accept his written update. He highlighted that there was now a clear linkage between the disbursement of Trust finances and the risk register process. The Joint Consultation and Negotiating Committee (JCNC) had agreed to focus on four areas of particular mutual concern; namely reduction of substantially long-term sickness rates, ensuring that the Trust offered the right support for flexible working of staff, development of better models for policy implementation and ensuring that the Trust exceeded its	

equality duties as an employer. A rolling-programme of monthly on-line staff surveys in each clinical group and corporate directorates would be introduced in the near future to collate data on how the Trust was performing. This would be reviewed after Christmas. Arrangements were in hand to ensure that any staff that did not have access to electronic communication were not excluded from the surveys. It was aimed to achieve a 20%+ response rate. In answer to a query from Ms Dutton, Mr Lewis advised that, although the North-West Midlands pathology tendering exercise had been formally abandoned by CCGS, discussions would continue with the CCGs and other hospitals within the Black Country to ascertain whether there would be any value in forming a partnership. An update report would be presented to Trust Board on the outcome of these discussions when clarity was gained.	
6 Questions from Members of the Public	**Verbal**
There were no questions from members of the public.	
7 Presentation of Nursing Staff Awards	**Presentation**
Miss Overfield gave a background to the introduction of the Nursing with Pride awards that had commenced in May 2013. The criteria for achieving the badges (bronze, silver and gold) was explained following which a presentation was made by the Chair to Ms Julie Romano (gold award) and to Ms Clare Garbett (silver award). It was noted that two other members of the nursing staff had also achieved the awards but were currently on leave. Miss Overfield reported that a monthly Award Ceremony would be introduced and it was proposed to extend the Nursing with Pride awards to include health visitors, midwives and therapists. It was noted that a QUEST training system had also been launched in May 2013.	
MATTERS FOR APPROVAL	
8 Chair's Action: Application of the Trust Seal to Church Lane Lease	**SWBTB (8/13) 165**
Miss Overfield advised that the lease for the Church Lane industrial estate Unit 3 where the Trust's transport service (general and PTS) was based, would expire on 10th June 2014. It was deemed favourable to negotiate a new lease agreement for the same site. Trust Board approval was sought to affix the Trust's seal to the document.	
AGREEMENT: The Trust Board agreed to the affixation of the Trust Seal on the Church Lane lease	
9 Performance Management Regime – Monthly Submission	**SWBTB (8/13) 167** **SWBTB (8/13) 167 (a)**
Mr Sharon presented the latest version of the Performance Management Regime (PMR) submission for approval. It was noted that there was nothing significant to	

report or changes that had been made since the last meeting.	
AGREEMENT: The Performance Management Regime monthly submission was approved	
11 Safety, Quality & Governance	
11.1 Update from the meeting of the Quality & Safety Committee held on 23rd August 2013 and Minutes from the Meeting held on 19th July 2013	**SWBQS (7/13) 113**
Ms Dutton updated the Board on the key discussion points from the meeting of the Quality & Safety Committee that had been held on 23rd August 2013. It was noted that the Committee had received a detailed update on the Trust's practice in respect of child protection duties. It had been highlighted that at present the new IT system in ED did not have the functionality to be able to flag when a patient presenting had been previously referred to social services and was therefore potentially a safeguarding case (both child and adult). The Quality & Safety Committee would continue to maintain a focus on this. Miss Overfield advised that there was communication with schools regarding children at risk via the Safeguarding Board. However, poor communication and the transfer of information between organisations was the single most difficult issue to resolve. It was noted that Miss Barlow would be presenting a paper regarding readmission rates to the next Quality & Safety Committee meeting which would then be presented to the full Board. The positive report from the CQC following their recent visits had been well received, however it was agreed that there remained a need to resolve issues of consent.	
ACTION: Miss Barlow to present a report regarding readmissions to the next Quality & Safety Committee	
11.2 Quality Report	**SWBTB (8/13) 168** **SWBTB (8/13) 168 (a)**
The Board was asked to consider the Quality Report. It was noted that the Q1 ward reviews had been included in the report (plus Q4 2012/13 for comparison). There remained concern across several wards regarding resource management and this was being addressed via a more robust use of e-rostering and BRAD (acuity tool). Many of the wards struggling with resource management were wards that had been subject to several changes in bed configuration and specialty mix over the past 12 months. Dr Situnayake reported that compliance with the World Health Organisation checklist was 99.8% across all patients which underwent surgery, an improvement on previous months. It was possible that there would be a fluctuation in the VTE risk assessments for the month of August in view of the junior doctor changeover and changes in IT systems. The Trust's 12-month	

cumulative HSMR remained below 100 and was lower than that of the SHA peer.

Ms Robinson highlighted that the patient safety walkabout had taken place and had proved a worthwhile visit with positive feedback. It had been noted during the visit that there were high window blinds and asked what arrangements were in place for cleaning. Miss Overfield advised that the blinds were only cleaned when ward were empty as cleaning them on an occupied ward was problematic.

With regard to complaints, Ms Robinson expressed the view that the information provided within the themes/learning section was difficult to interpret and understand. Mr Lewis advised that changes to the Quality Report style were proposed and agreed that there would need to be some adjustment to complaints reporting and that sample reporting would need to be meaningful. Miss Dhami advised that detailed complaints reports were considered by the Quality & Safety Committee.

The Patient Safety Committee had requested an assurance report and plan from the T&O directorate in respect of the recent outbreak of Klebsiella deep joint infection and an increase in surgical site infections. As this had been linked to infection control and environmental concerns around Sandwell Theatres, an assurance report and robust plan had been drawn up and the theatres had, at the time, been closed by the DIPC for a mandatory sterenis deep clean and declutter. Estates work was also planned for Sandwell Theatres during the Christmas shutdown. There were no concerns in respect of the T&O wards. The Trust had informed the Public Health Department about the Klebsiella outbreak and it was likely that an unannounced visit by Public Health would take place in the foreseeable future. In answer to a question from Mr Lewis, Miss Overfield reported that regular audits were undertaken by the T&O directorate with support from the microbiology team. T&O have been asked to present a report to the Infection Control Committee.

Ms Robinson asked for an update in respect of nurse recruitment. Miss Overfield reported that recruitment should be concluded by November/December 2013. However she highlighted that there would be issues if there was a necessity to open additional intermediate care beds both within and outside of the Trust as this would cause a drain on local nurse availability. She recommended that there would be a need to over recruit staff as per previous winter periods to cover such eventualities.

Mrs Rickards reiterated the concerns that had been raised by Staff Side during 2012 about the proposals which had been put forward regarding the establishment of a virtual ward to cover winter 2012 and hoped that similar proposals were not being considered for the forthcoming winter 2013 period.

Mr Lewis confirmed that the Trust did not intend to issue zero-hour contracts. However, he indicated that we would continue to recruit on a rolling basis, nothwithstanding Staff Side concerns.

12 CQC Reports	**SWBTB (8/13) 170** **SWBTB (8/13) 170 (a)** **SWBTB (8/13) 170 (b)**
The formal reports received from the Care Quality Commission (CQC) following their unannounced inspections at Sandwell and City Hospitals in June 2013 were received.	
12 Finance & Performance Management	
12.1 Update from the meeting of the Finance & Performance Management Committee held on 23rd August 2013 and Minutes of the Meeting held on 19th July 2013	**SWBFC (7/13) 070**
In Mr White's absence, Mr Archer provided a summary of discussions held at the meeting of the Finance & Performance Management Committee held on 23rd August 2013. He advised that the financial performance was reported to be behind plan by £191k with the underlying position for the Medicine & Emergency Care Clinical Group remaining a concern. There was an adverse position with regard to non-pay spend which reflected expenditure associated with high cost drugs, high cost pathology reagents, hotel services in the BTC and postage.	
12.2 Monthly Finance Report – Month 4	**SWBTB (8/13) 171** **SWBTB (8/13) 171 (a)**
Mr Archer reiterated that work was being undertaken to address the financial deficit within the Medicine & Emergency Care Clinical Group which was mainly linked to staffing and the high level of agency use. A new system had been implemented within the Pathology Group to help resolve the adverse position with regard to the non-pay spend on high cost pathology reagents. However there were noted to be 'teething problems' in respect of the charging mechanisms for consumables. Discussions were on-going with the company that had provided the system. It was reported that it had been hoped to reduce the high amount of expenditure on postage through the use of electronic communications but this had not proved as successful as hoped and was deteriorating partly due to the number of letters being sent from the Trust to patients regarding the current data quality matter. It was noted that the majority of post was sent by second class mail. Miss Barlow reported that the TSO team had been asked to work with Health Informatics to achieve a solution to reduce postage and the possibility of outsourcing was also being considered. It was agreed that Miss Barlow should keep the Board updated on this matter. Ms Dutton queried whether it was still a Department of Health regulation that hard copies of letter should be sent. Mr Lewis agreed to progress this query. Mr Hodgetts queried why it was no longer possible for patients to be given their next appointment date when they attended outpatients. Dr Situnayake advised that this procedure had changed due to the introduction of the partial booking system. Patients were now sent an appointment once it was	

certain that clinic would proceed and that follow-ups were not cancelled. Mr Lewis highlighted that the cost of postage was cheaper than the cost of DNAs. Mr Lewis requested that the wider issue of turbulence/stability in non-pay should be considered in detail at the next meeting of the Finance & Investment Committee.	
12.3 Plans to address the Medicine & Emergency Care Group's Financial Position	**SWBTB (8/13) 172** **SWBTB (8/13) 172 (a)**
Miss Barlow presented an update on the financial position of the Medicine & Emergency Care Clinical Group. The recovery plan was designed to tackle both the existing overspend year to date and the projected deficit of £2.7m. Both figures excluded the unidentified TSP of £1.1m, which the Trust level financial plan provides for non-recurrent coverage in 2013-14. Mr Lewis questioned why the forecast position was as large as cited, given that the Month 4 overspend was considerably less than in prior months. Mr Archer noted that that position included exceptional adjustments, and confirmed that he agreed with the forecast presented in Miss Barlow's paper. Mr Lewis asked for confirmation that the income improvement cited was 'real' and would result in the Trust's year end income being above the sum forecast in the Month 4 report. Mr Archer agreed that some further work was needed in this area, but accepted that this would be necessary for the improvement to be as presented. Ms Robinson raised concern that as part of the recovery plan process, the Medicine Group had highlighted two areas where income would increase by the introduction of correct capturing and charging and asked whether this could this be a problem in other areas of the Trust. Mr Lewis confirmed that this would be looked at as part of the LTFM process. Ms Dutton asked whether consideration had been given to the quality and safety impact of the proposals and asked for an assurance that the plans would not have an adverse effect on quality and safety. Miss Barlow noted that the plan as set out was not for approval and was subject to impact assessment in the usual manner. However, she noted that the establishment plans were in line with prior proposals accepted by the Board. The pace of change on outpatient transformation was necessarily more rapid than previously. Ms Dutton asked for wider views on the safety of reducing bank and agency posts. Miss Overfield considered that the issue was a complex one. Though the proposals were not new it was agreed that there was a need to see them in the context of all the changes that had occurred within the Group over the past couple of year. This included changes to bed plans, ward establishment reviews and changes in leadership. As a result compliance with rostering and establishment control, whilst generally good, needed some improvement. She agreed that the Trust needed to identify expenditure on specialling and drew attention to the latest updated acuity reviews.	

Mr Lewis advised that if investment was required for wards in year then it would be necessary to put on hold some of the decisions made at the last Clinical Leadership Executive, at which no leader had identified outstanding unconsidered proposals. He suggested that he would review that position outside the meeting and ensure that, in future, the timing of establishment reviews was, other than in exceptional circumstances, congruent with the revised investment cycle. It was noted that nursing vacancies were actively being recruited to and once the majority were in post (expected November 2013) the use of expensive agency staffing would cease. All use of agency HCA staff was reported to have ceased. Miss Barlow agreed to revisit whether a rolling recruitment programme, to vacancy levels anticipated, given turnover, was taking place. Ms Dutton expressed the hope that the paper would contain a risk assessment report when it returned to the Board for further discussion. Mr Lewis reported that the paper did not describe anything that had been agreed in the Trust's Annual Plan; however this did not mean that Trust could not change its stance. The biggest challenge would be the need to achieve £4.5 million savings in 2014/15 (14-15 TSP target plus unmet 13-14 TSP) as quality, though not safety, may be an issue that required detailed debate. The risk assessment for these changes would be considered further and reported to October's Board meeting.	
12.4 Monthly Performance Monitoring Report	**SWBTB (8/13) 174** **SWBTB (8/13) 174 (a)**
It was noted that the percentage of stroke patients reported as receiving a CT scan within 24 hours of presentation remained at less than 100% and that the proportion of MRI scans reported within 24 hours had reduced during the month of July to 70%. A detailed analysis of delays had been requested. Mr Lewis queried why the Dementia (Find, Assess and Refer) CQUIN target was currently failing. Miss Overfield reported that Mrs Talbot was investigating the reasons for this and was continuing to raise awareness. Mr Sharon advised that he would investigate the variances in the activity figures that had been recorded.	
ACTION: Miss Overfield to arrange for an update on performance against the dementia CQUIN target to be presented at a future meeting of the Quality & Safety Committee	
12.5 Annual Planning Update	**SWBTB (8/13) 174** **SWBTB (8/13) 174 (a)**
The report outlined progress against a list of actions included within the 2013/14 internal annual plan, focusing on those that were currently delayed and the further action required to ensure completion. The Board was asked to consider overall progress against delivery of the actions in the 2013/14 annual plan and	

consider the key risks to delivery and planned actions for the next quarter. It was noted that there were two actions facing significant delay; namely response to complaints and sickness absence. The RAG rating definitions were discussed and clarified. The background to new service models was explained. Miss Robinson felt that the report made it difficult to ascertain clearly the implications for the Trust. She felt that an extra column detailing risk assessment should be included as it was important for the Board to be in receipt of all relevant information. Mr Sharon felt that it might not be appropriate to set up a separate risk management record outside of the Trust's wider risk management process. The Risk Register should be used to ensure that the Trust was kept up-to-date of any failures to hit milestones. Mr Lewis reported that the Annual Planning update for Quarter 2 would be presented to the Board in October and that the format would be revisted in the light of comments received.	
13 Any Other Business	**Verbal**
There was none.	
14 Farewells	
The Chair wished to record the Trust Board's appreciation for the work undertaken by Miss Overfield and Mrs Kinghorn during their time at the Trust and wished them every success in the future careers.	
Matters for Information	
The Board received the following for information: • Midland Metropolitan Hospital Project: Monitoring Report • Foundation Trust Application Programme: Monitoring Report • NHS Performance Framework & FT Compliance Framework Report	
Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1330h on 26th September 2013 and would be held in the Anne Gibson Board Room, City Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 26 September 2013, Anne Gibson Boardroom @ Sandwell Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

29 August 2013, Boardroom @ Sandwell Hospital

Members present: Mr R Samuda (RSM), Ms C Robinson (CR), Dr S Sahota (SS), Mr H Kang (HK), Ms O Dutton (OD), Mr T Lewis (TL), Mr M Sharon (MS), Miss R Overfield (RO), Miss R Barlow (RB)

In Attendance: Miss K Dhami (KD), Mrs J Kinghorn (JK), Mrs c Rickards (CR), Mr b Hodgetts (BH), Mr C Archer (CA), Dr D Situnayake (DS)

Apologies: Prof R Lilford, Mr H Kang, Mrs G Hunjan, Mr R White, Dr R Stedman, Mr s Grainger-Payne

Secretariat: Mrs L Broadway

Last Updated: 20 September 2013

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.245	Trust's initial response to the report of the Mid Staffordshire NHS Foundation Trust public inquiry	SWBTB (2/13) 032 SWBTB (2/13) 032 (a)	28-Feb-13	Present the baseline assessment against the recommendations within the 'Francis' report at the next meeting of the Quality & Safety Committee and Trust Board	KD	~~26/04/2013~~ ~~30/06/2013~~ ~~31/08/2013~~ 30/09/2013	Summary response included on the agenda of Trust Board meeting planned for 26 September 2013, however more detailed update deferred to a further meeting. Request renegotiation of delivery date for action.	R
SWBTBACT.262	Health Informatics Services (HIS) –key decisions and timeline	SWBTB (7/13) 149 SWBTB (7/13) 149 (a)	25-Jul-13	Provide a further update on the procurement of an EPR system in September 2013	FS	26/09/13	Update not available for presentation. Request renegotiation of delivery date of action.	R
SWBTBACT.263	Monthly finance report – Month 3	SWBTB (7/13) 155 SWBTB (7/13) 155 (a)	25-Jul-13	Present the position in terms of compliance with the better payments code at a future meeting of the Finance & Performance Management Committee	RW	20/09/13	Update not presented to Finance & Investment Committee in September. Request renegotiation of delivery date of action.	R
SWBTBACT.260	Update from the Audit Committee held on 9 May 2013, minutes of the meeting held on 14 February 2013 and	SWBAC (2/13) 020 SWBAC (5/13) 036 (a)	30-May-13	Present an update on Internal Audit actions still outstanding at the next Audit Committee meeting	SG-P	~~12/09/2013~~ 25/10/2013	Date change due to revised meeting schedule	G
SWBTBACT.256	Single tender action: maintenance contract for Olympus video and ultrasonic endoscopes	SWBTB (5/13) 085	30-May-13	Arrange for the Trust's standard contract terms to be amended to include a warranty related to best NHS UK price	RW	30/09/13	When single tender actions are made, the proposer is reminded to seek an undertaking from the company that the best price is offered. The formal contract documentation is being reviewed however. ACTION NOT YET DUE.	G

SWBTBACT.261	18 weeks 2013/14 and Data Quality review	SWBTB (6/13) 123 SWBTB (6/13) 123 (a)	27-Jun-13	Schedule a discussion about 18 weeks data quality lessons learned onto the agenda of the October 2013 meeting	SG-P	31/10/13	ACTION NOT YET DUE	G
SWBTBACT.260	Update from the meeting of the Quality & Safety Committee held on 23rd August 2013 and Minutes from the Meeting held on 19th July 2013	SWBQS (7/13) 113	29-Aug-13	Present a report regarding readmissions to the next Quality & Safety Committee	RB	20/09/13	Presented as requested	B
SWBTBACT.261	Monthly Performance Monitoring Report	SWBTB (8/13) 174 SWBTB (8/13) 174 (a)	29-Aug-13	Arrange for an update on performance against the dementia CQUIN target to be presented at a future meeting of the Quality & Safety Committee	RO	20/09/13	Discussed at the meeting of the Quality & Safety Committee on 20 September 2013	B

KEY:

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE PUBLIC TRUST BOARD

Chief Executive's Report – September 2013

1. Our patients

The key issues in our Board papers this month relate to safety and to quality.

Building on discussions that have taken place at Quality and Safety and in the executive domain, we have papers examining respectively:
a. our approach to substantially reducing unplanned readmissions to hospital b. ensuring that our practices support eliminating avoidable infection c. examining the controls pursuant to the last three years of Never events

Regrettably, that discussion takes place against the backdrop of our second Never event, which whilst the error dates from December 2012, was formally identified in August 2013. The Group Director accountable for plastic surgery will attend the Board meeting.

Encouragingly, we continue to see mortality review numbers rise. And our work to tackle MRSA screening rates has seen our best ever results.

August, and so far in September, has also seen big improvements in performance on emergency care. In practice that means keeping ambulance handover rapid, waits in emergency departments below four hours, and making sure patients do not stay in our dedicated (doubled in size since last winter) assessment wards for more than forty eight hours. The critical metric on the latter issue is how many empty staffed beds we have at 21.00. Our modelling and experience is that, broadly, if we have 16 such beds empty, without placed ED patients in them, our night-time plans meet our ambitions and standards. What is encouraging about August and September is that our City site is seeing days, and indeed weeks, of delivery. In June, when we met the standard for the first time in a year, and July when we almost did, we relied very heavily on exceptional performance at Sandwell. None of these results suggest we are a sustainable success as yet: Hence our infection control improvements, and extra beds, which come on line over the next four weeks. We are better placed to succeed than last year.

It is disappointing that August saw us fell short of our local aim (achieved in the last three months) of at least 95% VTE assessment. The commitment of our incoming trainee doctors is not in doubt and we did change the computer arrangements with their arrival. This double-whammy has had some effect. Daily and weekly data in September sees recovery to prior levels in most areas and our determined effort to achieve 100% will continue until it is achieved. Patients will be safer when we do.

During July and August over 60,000 letters have been issued to patients, dating back several years, where we want to be certain that our records of care are accurate. This is a specific issue relating to waiting time status for planned patients. I wish to place on record my own thanks to call-centre staff,

managers and clinicians who have worked tirelessly on this look-back exercise. As expected a small proportion of patients have contacted us to discuss concerns, which range from clinical to communication issues. Each individual case is being handled expeditiously. Despite this work in October we do have several thousand as yet unconcluded look-back cases and in line with the plan of action proposed to the Board in spring 2013 we will record those patients on our waiting list until such time as their status is confirmed. In almost every case we expect that conclusion to be reached during October. Over the coming six months we have considerable work to do in a small minority of specialties to cut waiting times. We need to bring the same focus to elective care as we now see Trust-wide on emergency care.

2. Our colleagues

During September, we have started our monthly staff polling regime. Four clinical groups have received the short survey. We will review with our workforce and organisational development the progress of the programme: Your Voice. This work has active trade union support and has the potential to provide a valuable data set about local team 'health'. The national annual staff survey is also out NHS-wide this month, and in line with prior SWBH practice, we are adopted the sample size nationally commended this year, having undertaken a whole staff survey last year. Results from the sample will be available in early 2014.

In April we initiated work to make sure that our establishment (planned staffing) and vacancy information was fit for purpose, and was routinely in use to manage our workforce, their and our patient's safety. The Board has routinely seen such material for nurses and HCAs through the Quality and Safety report. Initial results of this wider work were presented to the Clinical Leadership Executive this month, with final results due in October. We could be very encouraged that discrepancies between the various data sources were minimal. And that our vacancy level would appear to be not more than 340 posts, from over 7,000, and may be closer to 200, of which most are being actively marketed presently. This data, when linked to electronic rostering for future shifts, should give us much greater local and corporate grip over staffing levels.

3. Our partners

We welcome the NHS mental health director, Louis Appleby, to the Trust on October 1st. This reflects the continued profile and esteem of the RAID service, which supports our City-site wards and ED. Commissioner discussions on the future of this service continue across the conurbation. Meanwhile, our pilot project at Sandwell with the Black Country Partnership Trust commences later in the autumn. Our focus on mental health provision is driven by the underlying health needs of those we look after, and well established data on secondary causes of admission. We need to turn attention now, with partners, to services for children and adolescents with mental health issues.

I am delighted to be able to confirm the commitment of both Birmingham City Council and Sandwell Metropolitan District Council to a seven day pattern of social care delivery for emergency patients. This will commence in October and will comprise, but not be limited to, social work support in each A&E, routine access to social care funded beds regardless of the day of the week, and open access to equipment stores across the conurbation at weekends. These are crucial steps to change care which we have been working to put in place since April of this year. Their availability this winter will make a difference to quality of care.

4. Our regulators

I am pleased that the papers confirm that the completion of the two policy document where we judged their absence was a technical concern, given the new regulatory regime, emergent since April 2013. On our draft returns to the Trust Development Authority this leaves non-compliance in three categories: middle management capacity (to be discussed in October), constitution compliance on elective care (target December 2013 for compliance), and the areas where no national framework of evaluation has been published (which remain numerous).

5. 'Hot Topics' feedback

September's ongoing Hot Topic discussion for our teams focuses on how we will work when our configuration changes in the future. For most staff, not later than 2018, they will be working across multiple locations. The traditional NHS model for this is in-week travel. Given our award winning experience in NHS reconfiguration, we believe that there are better ways to ensure quality of care, continuity of expertise, and the development of strong multi-professional teams. We have asked leaders to identify existing successful practices and to think through the steps needed now to be ready for change over the next five years. This is of course part of a wider effort to think through the "nothing to do with bricks and mortar" elements of the Midland Metropolitan Hospital. What we suspect will come through strongly from the feedback, as it did very strongly at this month's Consultant Staff Conference is the critical importance of IT-connectivity to make our 'Right Care, Right Here' model a success.

Toby Lewis, Chief Executive – 20 September 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Maintenance of Digital Mammography Systems – Approval of Waiver of Tendering Process**
SPONSOR (EXECUTIVE DIRECTOR):	**Graham Seager, Director of Estates & New Hospital Project**
AUTHOR:	**Lawrence Barker, Medical Engineering Manager**
DATE OF MEETING:	**26 September 2013**

EXECUTIVE SUMMARY:

The Trust owns seven digital mammography systems and associated IT equipment. This represented a major investment in new technology between 2010 & 2013 in excess of £3,000,000, equipping three fixed rooms at BTC and four mobiles providing our screening service.

The maintenance contract for the equipment is due for renewal and the sole supplier of comprehensive technical support, including remote diagnostics, software and hardware support, available on NHS Supply Chain framework agreement is the original equipment manufacturer, Hologic.

The maintenance agreement has been pre-tendered via NHS Supply Chain, with costs held at 2012/13 prices.

REPORT RECOMMENDATION:

To seek approval for the waiver of tendering process for the renewal of the Hologic maintenance agreement.

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

Accept	Approve the recommendation	Discuss
	X	

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

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

Comments:

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

Safe, high quality care

PREVIOUS CONSIDERATION:

None

MAINTENANCE OF DIGITAL MAMMOGRAPHY SYSTEMS – APPROVAL OF WAIVER OF TENDERING PROCESS

Briefing paper to Trust Board – 26 September 2013

The Trust currently owns seven digital Mammography systems, three within the Breast Screening Unit at BTC and four on mobiles as part of the national breast screening service. All of the systems and their associated IT workstations are manufactured by Hologic. Over £3 million was invested in digital breast screening technology between 2010 and 2013.

The maintenance contract for the equipment is due for renewal at month end and the sole supplier of comprehensive technical support, including remote diagnostics, software and hardware support, available on NHS Supply Chain framework agreement is the original equipment manufacturer.

The maintenance agreement has been pre-tendered via NHS Supply Chain, with costs held at the 2012/13 price. The total contract agreement is £110,580 + VAT

The Trust Board are asked to approve the waiver of tendering process for the renewal of the maintenance agreement.

26 September 2013

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:	26 September 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 August 2013 are as follows:

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

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 Committee.

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

NHS Trust Over-sight self certification template

Returns to XXX by the last working day of each

NHS Trust Governance Declarations : 2013/14 In-Year Reporting

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

Organisational risk rating

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

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

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

Governance Declarations

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

Supporting detail is required where compliance cannot be confirmed.

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

Governance declaration 1

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

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

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

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:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Board Statements

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August 2013

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

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SOM's Oversight Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	
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.	
	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.	
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.	
	For GOVERNANCE, that:	**Response**
6	The board will ensure that the trust at all times has regard to the NHS Constitution.	
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	
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.	
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.	
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).	
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.	
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	
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.	
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.	
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.	

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO			
Chair			

QUALITY

Information to inform the discussion meeting

Sandwell & West Birmingham Hospitals NHS Trust

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Board Action
1	SHMI - latest data	Score	96.0	96.3	95.3	94.2	95.6	94.9	94.4	94.2	94.3	95.5	95.9	99.2	SHMI data relates to period May 2012 - April 2013 which is the most recent period for which data is available (source HED).
2	Venous Thromboembolism (VTE) Screening	%	91.0	91.5	91.7	90.2	91.5	91.0	86.1	90.8	92.5	95.3	95.9	94.4	
3a	Elective MRSA Screening	%	38.7	104.6	96.2	112.0	130.9	193.6	138.9	196.6	173.2	196.9	249.9	217.1	Data reported is screens not matched with patients. Screens matched to patients for the month is 75.9%.
3b	Non Elective MRSA Screening	%	66.1	66.0	78.6	78.4	80.7	82.3	76.8	79.2	82.2	81.3	84.1	87.1	Data reported is screens not matched with patients. Screens matched to patients for the month is 77.3%.
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	161	114	2	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	2	3	1	2	0	4	2	5	9	8	11	8	This includes any ward closures, grade 3 or 4 pressure sores, serious injuries following fractures and infection control issues. This includes 2 of which were downgraded following review.
6	"Never Events" occurring in month	Number	1	0	0	0	0	0	0	0	0	1	0	1	Wrong site surgery
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	10	8	5	4	3	10	10	5	5	3	6	6	2 overdue open alerts. Spinal / Epidural needles remain a manufacturing problem.
9	RED rated areas on your maternity dashboard?	Number	3	2	4	4	2	2	3	2	3	1	2	2	August - Midwifery Staff Sickness Absence (4.9%) and Neonatal Mortality Rate - 0 to 28 days (3.9 / 1000 babies).
10	Falls resulting in severe injury or death	Number	6	0	2	2	1	2	2	3	2	5	0	0	
11	Grade 3 or 4 pressure ulcers	Number	3	1	1	6	1	2	2	2	1	1	1	2	There were 2 avoidable Grade 3 pressure ulcers and 2 unavoidable Grade 3 pressure ulcers reported during August.
12	100% compliance with WHO surgical checklist	Y/N	No	No	No	No	No	No	No	No	No	No	No	No	Compliance was 99.2% in August (2889 records compliant of 2912 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	56	62	68	38	60	70	57	63	59	50	60	75	
14	Agency as a % of Employee Benefit Expenditure	%	1.8	2.3	2.45	2.91	2.62	4.57	6.41	4.29	4.28	2.6	3.71	3.27	
15	Sickness absence rate	%	4.18	4.51	4.47	4.58	4.86	4.42	4.55	4.36	4.01	3.94	3.99	3.97	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	84	83	87	86	88	81	77	77	78	77	81	81	These figures indicate the percentage of Consultant Appraisals that were completed at that time without reference to completed PDPs which are seen as a more dynamic document.

FINANCIAL RISK RATING

Sandwell & West Birmingham Hospitals NHS Trust

			Risk Ratings					Insert the Score (1-5) Achieved for each Criteria Per Month				
								Reported Position		Normalised Position*		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	3	3	3	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	4	5	4	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	4	4	4	4	
	I&E surplus margin %	20%	3	2	1	-2	<-2	3	3	3	3	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	Includes effect of assumed working capital facility.
Weighted Average		**100%**						**3.3**	**3.4**	**3.3**	**3.4**	
Overriding rules												
Overall rating								**3**	**3**	**3**	**3**	

Overriding Rules :

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

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

FINANCIAL RISK TRIGGERS

Sandwell & West Birmingham Hospitals NHS Trust

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

Refresh Triggers for New Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Dec-12	Qtr to Mar-13	Qtr to Jun-13	Jul 13	Aug-13	Sep-13	Qtr to Sep-13	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	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			
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			Outstanding debtors include overseas patients where the debt continues to be pursued but is fully provided for.
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No			
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No			
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No			
8	Quarter end cash balance <10 days of operating expenses	No	No	No	No	No			
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No			Trust is on track in relation to its internal plan following review of detailed programmes.
10	Yet to identify two years of detailed CIP schemes	Yes	No	No	No	No			

GOVERNANCE RISK RATINGS

Sandwell & West Birmingham Hospitals NHS Trust

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

Refresh GRR for New Quarter

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

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Dec-12	Historic Data: Qtr to Mar-13	Historic Data: Qtr to Jun-13	Current Data: Jul 13	Current Data: Aug-13	Current Data: Sep-13	Current Data: Qtr to Sep-13	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	No	Yes	Yes	Yes	Yes			
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		No	Yes	Yes	Yes	Yes			
			Patients dying at home / care home	50%		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			
	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			
	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			
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes			
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes			July 2013 performance confirmed from National Cancer Waiting Times system report. August 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			July 2013 performance confirmed from National Cancer Waiting Times system report. August 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			July 2013 performance confirmed from National Cancer Waiting Times system report. August 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			July 2013 performance confirmed from National Cancer Waiting Times system report. August 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	No	No	No	No	Yes			
	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			
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes	Yes			There was 1 case of post 48 hour MRSA Bacteraemia (contaminant) reported during April.
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		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			
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	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			
			TOTAL			**2.0**	**1.0**	**1.0**	**1.0**	**0.0**	**0.0**	**0.0**	
						AR	AG	AG	AG	G	G	G	

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	**2.0**	**1.0**	**1.0**	**1.0**	**0.0**	**0.0**	**0.0**	
			AR	AG	AG	AG	G	G	G	

CONTRACTUAL DATA

Information to inform the discussion meeting

Sandwell & West Birmingham Hospitals NHS Trust

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

Refresh Data for new Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Dec-12	Qtr to Mar-13	Qtr to Jun-13	Jul 13	Aug-13	Sep-13	Qtr to Sep-13	
1	Are the prior year contracts* closed?	Yes	Yes	Yes	Yes	Yes			
2	Are all current year contracts* agreed and signed?	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			
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes			
5	Are there any disputes over the terms of the contract?	No	No	No	No	No			
6	Might the dispute require third party intervention or arbitration?	No	No	No	No	No			
7	Are the parties already in arbitration?	No	No	No	No	No			
8	Have any performance notices been issued?	Yes	Yes	Yes	No	No			Notices to date relate to performance during May - RTT Performance in specific specialties and Mixed Sex Accommodation Breaches.
9	Have any penalties been applied?	Yes	Yes	Yes	Yes	Yes			

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

TFA Progress

Sep-13

Sandwell & West Birmingham Hospitals NHS Trust

Select the Performance from the drop-down list

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

Notes

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST DEVELOPMENT AUTHORITY BOARD STATEMENTS & LICENCING CONDITIONS: SEPTEMBER 2013

REF	BOARD STATEMENT	COMPLIANCE AS AT AUGUST 2013	REASONS FOR DECLARING NON-COMPLIANCE
1	*The Board is satisfied that to the best of its knowledge and using its own processes (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints and including any further metrics it chooses to adopt), its NHS 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*	Y	
2	*The Board is satisfied that to the best of its knowledge and using its own processes, plans in place are sufficient to ensure ongoing compliance with the CQCs registration requirements*	Y	
3	*The Board is satisfied that processes and procedures are in place to ensure that all medical practitioners providing care on behalf of the Trust have met the relevant registration and revalidation requirements*	Y	
4	*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*	Y	
5	*The Board will ensure that the Trust remains at all times compliant with the NTDA accountability framework and shows due regard to the NHS Constitution*	N	• *The Trust identified in August 2012 a substantial reporting issue with incomplete compliance. Until the programme of change to remedy that is complete in December 2013 we consider that our duty to promote the constitution cannot be discharged fully – we await feedback on that interpretation since our submission in May 2013.* • *No assessment against TDA accountability framework undertaken as metrics being used to form judgement of compliance are yet to be clarified*
6	*All current key risks to compliance with the NTDA's accountability framework have been identified (raised wither 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*	N	• *No assessment against TDA accountability framework undertaken as metrics being used to form judgement of compliance are yet to be clarified*

REF	BOARD STATEMENT	COMPLIANCE AS AT AUGUST 2013	REASONS FOR DECLARING NON-COMPLIANCE
7	*The Board is aware of likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for the mitigation of these risks to ensure continued compliance*	N	• *No assessment against TDA accountability framework undertaken as metrics being used to form judgement of compliance are yet to be clarified*
8	*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*	N	• *Need to strengthen risk management processes* • *Construction of 2013/14 BAF still to be undertaken – linked in with revised risk management plans*
9	*An Annual Governance Statement (AGS) 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*	Y	
10	*The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all commissioned targets going forward*	N	• *The Trust is rated as performing on the DH framework. We rate as amber red on Monitor's framework. We are not consistently delivering monthly ED compliance and have several specialties non-compliant with 18 weeks.*
11	*The Trust has achieved a minimum Level 2 performance against the Department of Health's Information Governance Toolkit*	Y	
12	*The board will ensure that the Trust at all times will 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*	Y	
13	*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, ensuring management capacity & capability*	Y	
14	*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*	N	• *Trust level mitigations will continue to deliver the annual plan. But capacity issues in middle management need to be addressed by the executive and the development work on leadership capability needs to show traction. The Board will consider in October what success looks like and a final trajectory for compliance.*

REF	LICENCING CONDITION	COMPLIANCE AS AT AUGUST 2013	REASONS FOR DECLARING NON-COMPLIANCE
G4	*Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)*	Y	
G7	*Registration with the Care Quality Commission*	Y	
G8	*Patient eligibility and selection criteria*	Y	
P1	*Recording of information*	Y	
P2	*Provision of information*	Y	
P3	*Assurance report on submissions to Monitor*	Y	
P4	*Compliance with the National Tariff*	Y	
P5	*Constructive engagement concerning local tariff modifications*	Y	
C1	*C1 – The right of patients to make choices*	Y	
C2	*C2 – Competition oversight*	Y	
IC1	*IC1 – Provision of integrated care*	Y	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

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DOCUMENT TITLE:	**Estates Strategy Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Graham Seager, Director of Estates & New Hospital Project**
AUTHOR:	**Graham Seager/Rob Banks**
DATE OF MEETING:	**26 September 2013**

EXECUTIVE SUMMARY:

The attached estates strategy covers the period 2013/14 to 2019/20 as such it builds on previous years estates strategies. The aim of the strategy is to support the Trusts strategic objectives by reviewing the current key estate issues of the Trust, setting out how the clinical services will be supported by a safe, secure and appropriate environment and ensuring that capital investments support service strategies and plans. The strategy document has been set out in line with DH guidance

REPORT RECOMMENDATION:

The Board is asked to approve he attached Estates strategy

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	
Business and market share		Legal & Policy		Patient Experience	X
Clinical	X	Equality and Diversity	X	Workforce	

Comments:

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

21st Century Facilities- New Hospital Project

PREVIOUS CONSIDERATION:

Annual review.

Estates Strategy 2013/14 - 2019/20

ESTATES STRATEGY ANNUAL UPDATE 2013/14 – 2019/20

CONTENTS

1.0 INTRODUCTION

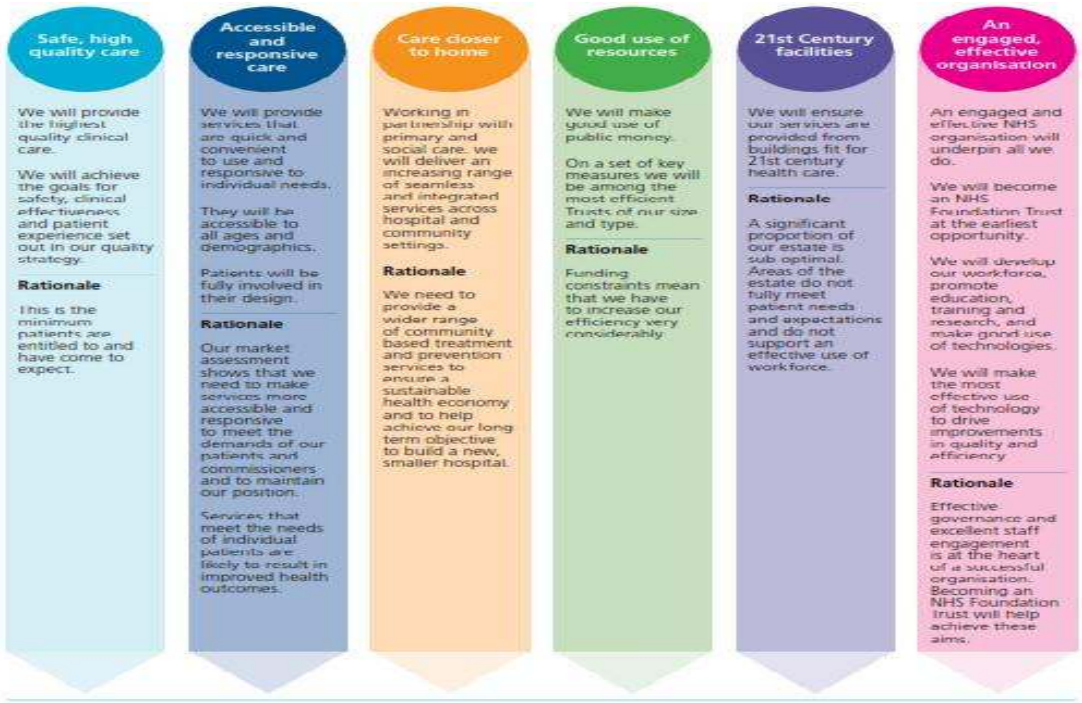
A patient's first impression of healthcare services is formed by the appearance of healthcare buildings and facilities. Services should be delivered in safe and suitable environments. Patients and staff need to feel safe, secure and comfortable. Healthcare buildings should ensure good functionality, meet expectations in terms of privacy and dignity, provide good access to all, reduce infection and minimise accidents.

In line with guidance (Developing an Estate Strategy) this strategy has been developed on a framework asking three fundamental questions across a range of criteria, as follows:

- Where are we now?
- Where do we want to be?
- How do we get there?

2.0 AIMS OF AN ESTATE STRATEGY

The Trust's Strategic Objectives are summarised:-



To support these objectives the Estates Strategy document:-

- Reviews the current key estate issues of the Trust
- Sets out how the clinical services will be supported by a safe, secure and appropriate environment
- Ensures that capital investments support service strategies and plans

3.0 OBJECTIVES

1. To analyse the estate condition and its performance.

2. To identify costs to achieve Estatecode Condition B for key facets of Condition Survey

3. To prioritise capital investment in estate statutory compliance issues.

4. To support compliance with Care Quality Commission registration.

5. To achieve year-on-year improvement on performance in line with the Trust approved Carbon Management Plan.

6. To operate all Estate and Facilities services at a benchmark between the lower and upper quartiles of the Estates Return Information Collection (ERIC) returns of comparable Trusts and demonstrate value for money

7. Maintain Patient Led Assessments of the Care Environment (PLACE) standards year on year to achieve a minimum of 90% compliance level across all criteria for all sites.

8. To have a formal system of control to ensure a robust Development Control Plan (DCP) to support clinical services.

4.0 TIMESCALE

This is an annual review of the 2012/13 – 2019/20 Estates Strategy. This timescale has been chosen as it encompasses the planned Midland Metropolitan Hospital (MMH) opening date and the timescale for community facilities schemes that cannot be commenced prior to MMH opening. This strategy identifies the areas of land for disposal but does not include the schemes to support disposal as they are planned to be outside of this timescale. The strategy will be reviewed on an annual basis as part of the Trust's business planning process.

5.0 ESTATE PERFORMANCE – ACHIEVING OBJECTIVES 1, 2 & 3

5.1 Where are we?

As can be seen from Table 1 overleaf, (Building Age and Asset Profile) much of the existing estate is of a significant age and does not comply with Department of Health guidelines or aspirations for 40% of the NHS estate to be less than 15 years old by 2010. Currently more than 70% of City site is over 30 years old and over 90% of Sandwell site is over 20 years old.

Compliance with Department of Health requirements is dependent upon the implementation of the Trust's long term strategic plan for the construction of the Midland Metropolitan Hospital as part of the Right Care, Right Here programme.

Table 1 – Building Age and Asset Profile as at 31st March 2013

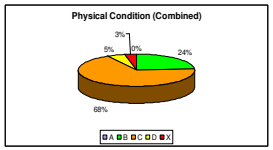
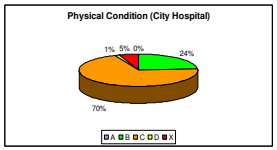
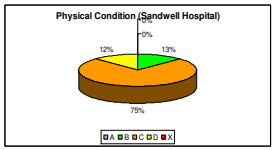
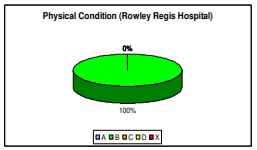
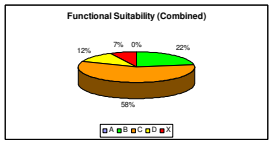
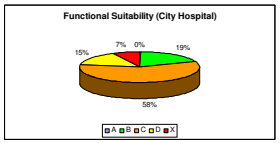
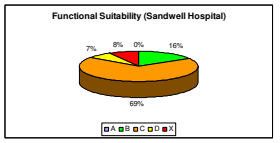
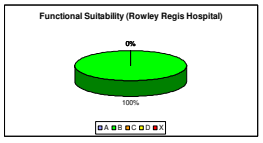
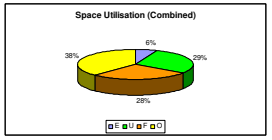
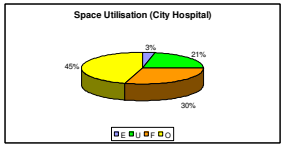
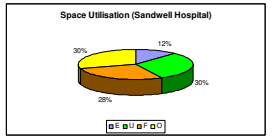
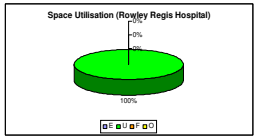
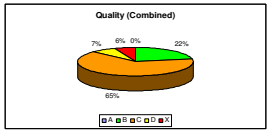
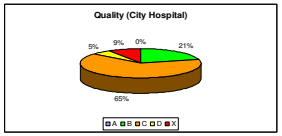
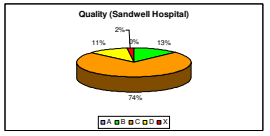
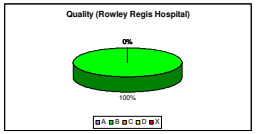
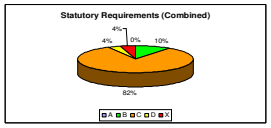
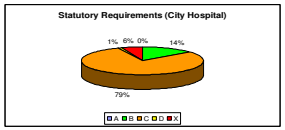
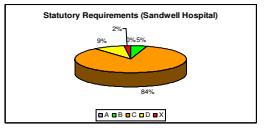
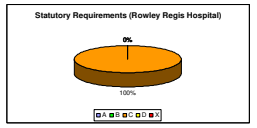
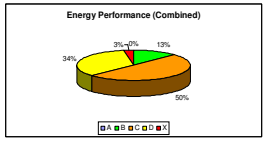
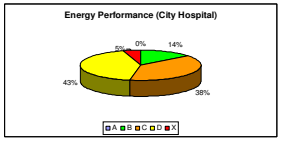
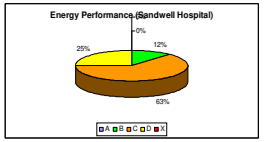
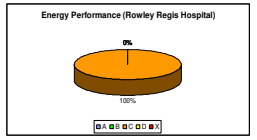
Age & Asset Profile	Unit	Sandhill	City	Redhill	Total %
Age Profile - 2005 to present	%	0	21.29	0	11.11
Age Profile - 1995 to 2004	%	0	9.31	0	4.86
Age Profile - 1985 to 1994	%	0	3.98	100	9.16
Age Profile - 1975 to 1984	%	88.87	5.12	0	38.86
Age Profile - 1965 to 1974	%	4.28	7.27	0	5.54
Age Profile - 1955 to 1964	%	0	3.11	0	1.62
Age Profile - 1948 to 1954	%	0	0.41	0	0.22
Age Profile - pre 1948	%	6.85	49.5	0	28.63
Age Profile - Total (must equal 100)	%	100	100	100	100
Building Asset Value by Age - 2005 to present	£	0	19,823,558	0	0
Building Asset Value by Age - 1995 to 2004	£	0	8,671,351	0	0
Building Asset Value by Age - 1985 to 1994	£	0	3,703,174	12,645,075	0
Building Asset Value by Age - 1975 to 1984	£	64,555,097	4,763,401	0	0
Building Asset Value by Age - 1965 to 1974	£	3.105.862	6,769,133	0	0
Building Asset Value by Age - 1955 to 1964	£	0	2,895,786	0	0
Building Asset Value by Age - 1948 to 1954	£	0	384,821	0	0
Building Asset Value by Age - pre 1948	£	4,977,581	46,085,876	0	0
Total Building Asset Value	£	72,638,540	93,097,100	12,645,075	178,380,715

Condition surveys of the two principle sites were undertaken in December 2002 by French Thorpe Consultancy supported by Malcolm Lamb Associates. The criteria that were used to assess the estate were those defined by Estatecode:

- Physical Condition
- Space Utilisation
- Statutory standards
- Energy performance
- Functional suitability

Desktop surveys were undertaken in August 2007 and the additional facet of Quality was included in June 2012 to identify areas where condition has deteriorated or improved via capital investment. The following pie charts summarise the performance for the categories. Note the 'Part Dangerous and Inoperable' areas are generally disused areas of the estate with the exception of the upper floors of Arden House where the lack of passenger lifts limits operational use of the building for staff.

The findings of the survey are summarised graphically as follows (Ref 31st March 2012):-

	Tis	Cit	Sad ell	Rowley Regis
Physical Condition Key A = As new (built within last 2 years) B = Sound, operationally safe and exhibits only minor deterioration C = Operational but major repair/replacement needed soon, within 3 years for building elements and one year for engineering elements D = Runs serious risk of imminent breakdown X = Supplementary rating added to C or D to indicate that nothing but a total rebuild or relocation will suffice				
Functional Suitability Key A = Very satisfactory no change needed B = Satisfactory minor change needed C = Not satisfactory major change needed D = Unacceptable in its present condition X = Supplementary rating added to C or D to indicate that nothing but a total rebuild or relocation will suffice				
Space Utilisation Key A = Empty or grossly under used at all times (excluding temporary closure) U = Under-used, utilisation could be significantly increased F = Fully used – a satisfactory level of utilisation O = Overstretched, overcrowded, overloaded and facilities generally overstretched				
Quality Key A = A facility of excellent quality B = A facility requiring general maintenance investment only C = A less than acceptable facility requiring capital investment D = A very poor facility requiring significant capital investment or replacement X = Supplementary rating added to C or D to indicate that nothing but a total rebuild or relocation will suffice				
Statutory Requirements Key A = Complies with all statutory requirements and guidance B = Action needed in the current plan to comply with statutory requirements and guidance C = Known contravention of one or more standards which falls short of B D = Dangerously below standard X = Supplementary rating added to C or D to indicate that nothing but a total rebuild or relocation will suffice				
Energy Performance Key A = 35-55 GJ per 100 cubic metres B = 56-65 GJ per 100 cubic metres C = 66-75 GJ per 100 cubic metres D = 76-100 GJ per 100 cubic metres X = Supplementary rating added to C or D to indicate that nothing but a total rebuild or relocation will suffice				

The cost to Condition B for key facets, which is the Trust's Backlog Maintenance Level, has also been estimated:-

• City Hospital	-	87,148m^2	-	£ 57,707,267
• Sandwell Hospital	-	54,614 m^2	-	£34,321,531
• Rowley Regis Hospital	-	8,735 m^2	-	£ 384,602
• Leasowes Intermediate Care Centre	-	921m^2	-	£ 2,500,000
		151,418m^2		**£97,913,400**

The High and Significant Risk elements of this assessment equate to £34.3m which has been funded in the 2013/14 capital programme.

5.2 Where do we want to be?

Backlog of this magnitude has potential safety implications and may influence patient perception. This could also affect business with greater patient choice arrangements.

The issues of poor physical condition need to be addressed to maintain the building fabric and to ensure patient's expectations are met. This is assessed through the Patient Led Assessment of the Care Environment action team initiative (PLACE). A strategic objective for the Trust is to achieve 21st century facilities, achieving condition B for all facets of the survey through strategic capital investment and to achieve good or excellent standards for PLACE Assessments would meet this objective. However, this cannot be achieved without strategic investment; therefore, detailed risk assessments are undertaken in line with the Trust's formal risk assessment process and managed through the governance/risk management structure to ensure a safe facility.

5.3 How do we get there?

Issues associated with statutory compliance have to be managed through the Trust's risk management arrangements. These arrangements consist of the Estates and Facilities Governance Group, which meets on a monthly basis and reports through the Trust's Governance arrangements. The risk management process identifies a number of estates and facilities issues as red risks; these are reported with their control measures through the Trust's risk management arrangements. All risks are updated annually and implications identified through the business planning process. Continued investment into the Estate is required in order to control the backlog position, maintain compliance with statutory standards and minimise risk.

To date specific funding has been made available to address the high and significant backlog issues. Wider condition survey related issues are addressed as part of the briefing process for capital investments.

5.4 2013/14 Capital Programme

The capital programme for the 2013/14 financial year includes £3.43m allocated to statutory standards and estates related improvement schemes. The £3.43m expenditure has been identified through a detailed risk assessment process and covers areas including:

- Fire Safety
- Asbestos Management
- Legionella Precautions
- Electrical Safety

Other capital schemes to support the implementation of the Trust's Transformation Saving Plans (TSPs) will also include elements of environmental improvements and statutory standards compliance works as well as facilitating the functional change required to deliver these TSPs.

However, to achieve condition B for all facets requires strategic investment. Notable capital schemes for 2013/14 are as follows:

- Major Estate Rationalisation
- Endoscopy Reconfiguration at Sandwell
- Pathology Reconfiguration, Blood Sciences laboratory
- Stroke Reconfiguration
- Imaging Reconfiguration
- Replacement Gamma Cameras at City
- Winter will be Better 2013 (range of schemes across all sites)
- Theatre Hygiene Works
- Improving the Environment for Dementia

6.0 RISK MANAGEMENT AND GOVERNANCE - ACHIEVING OBJECTIVE 4

6.1 Where are we now?

The Estates division has a robust system of risk management managed through the division's Governance Group. Chaired by either the Director of Estates or the Head of Estates, this group meets monthly and reports through the Trust's Governance arrangements.

The standing agenda items are:

- Privacy and Dignity
- Disability Discrimination Act
- PLACE
- Compliance with HTMs, HBNs, Best Practice Guides
- Complaints and Litigation
- Statutory Enforcement Bodies
- Risk Management
- Consultation and Patient Involvement
- Staff Management
- Education and Training
- Governance Development
- External Publications
- HEFMA
- Divisional Health & Safety Meetings

All significant Estates related risk assessments are managed through the Trust's risk management processes. To provide Board assurance that the estate is suitable and safe the Estates department have commissioned external consultants to provide Board assurance. This builds on the external assurance provided to Audit Committee during the last financial year.

The 2013/14 external assurance review will be undertaken during autumn 2013 and presented to a subsequent committee.

6.2 Where do we want to be?

The Trust needs to maintain progress on all of the above issues and provide its services in a safe, suitable and secure environment. This needs to be achieved in a transparent way and be responsive to patient perception and views through surveys and complaints. The objective is to maintain compliance with Outcome 10 and 11 for Care Quality Commission registration requirements and maintain the robust approach to Risk Management and Governance.

6.3 How do we get there?

The Risk Management and Governance arrangements of the Trust provide a framework to meet the objective of maintaining a safe and secure environment.

The Risk Register is a statutory requirement and an aid in determining the prioritisation of funding for capital investment and informs ongoing service provision. The division will maintain its Risk Register and ensure the divisional "red risks" and associated control measures are notified to through the Trust's risk management arrangements.

The current risk assessment process is based around the long term strategic objectives to move to the Midland Metropolitan Hospital with the risks managed over a 5 year planning horizon.

Establishing external assurance of Estates will become an annual occurrence.

7.0 ENVIRONMENTAL PERFORMANCE – ACHIEVING OBJECTIVE 5

7.1 Where are we now?

Carbon Management Plan

The Carbon Management Plan is the Trust's route-map to achieving sustainability and carbon related targets. The Carbon Management Plan document includes a series of projects and programmes that will help the Trust achieve rigorous carbon reduction goals over the next five years.

The Trust's baseline carbon emissions footprint for 2012/2013 encompassing energy, business travel, water and waste was 26,956 tCO2. This can be broken down as follows:

	Electricity (kWh)	Fossil fuels (kWh)	Water (m3)	Waste (tonnes)	Transport (km)	Business Travel (km)	Total
Amount	24,740,263	23,056,772	227,945	2,486	549,914	7,373,269	
CO_2 emissions (tonnes)	12,869	12,042	246	132	116	1551	**26956**

Carbon Reduction Projects

The Trust has already engaged in some carbon reduction projects which include a 50KWp Solar Voltaic system installed at the Birmingham Midland Eye Centre. The project was installed and commissioned within 5 weeks and within the first month of operation generated 7713 KWh of electricity. This project aims to save the Trust >£8000 of electricity per year and reduce the carbon footprint by 23 tons.

The Trust has also begun to replace light fittings with energy efficient LED fittings and advanced lighting controls. This has so far been introduced at City, Birmingham Midland Eye Centre, Sheldon Block, Sandwell OPD, Lift lobbies and at Rowley Regis circulation areas. Lighting had been identified as a significant electrical energy consumer so it was an obvious choice to invest in making improvements.

Sustainability Working Group and Sustainability Action Plan

The Trust has an active Sustainability Working Group with membership from key stakeholders such as Procurement, Estates, Facilities, Pharmacy and Information Technology and is chaired by The Director of Estates and New Hospital Project with lead responsibility for sustainability.

The Sustainability Working Group members have identified a range of actions and have developed a Sustainability Action Plan. The action plan is reviewed monthly and progress monitored

Sustainability Champions

The Trust has developed a network of around 100 Sustainability Champions and an additional 100 Sustainability Supporters. The Sustainability Champions and Supporters are vital in driving forward the Trust's sustainability objectives including energy reduction, waste reduction and recycling, water conservation, promoting sustainable travel and transport.

A quarterly Sustainability Champions meeting is held which is open for attendance from any of the current Champions. The meeting is an opportunity to communicate progress with carbon management, future aspirations and an opportunity for the Champions to feedback their experiences within departments.

Sustainability Events and Engagement

Sustainability events are run annually with additional engagement campaigns run throughout the year. Last year a Sustainability Garden Party was held which provided key engagement and recruited numerous extra champions.

The aim of these events is to gain further support and engagement across the organisation and to demonstrate the successes we have achieved to date.

Good Corporate Citizen

The Trust continues to report to the Sustainable Development Unit bi-annually via the Good Corporate Citizen assessment tool. This assessment tool covers a range of sustainable development topics, including:

- Transport
- Procurement
- Facilities management
- Workforce
- Community engagement
- New buildings
- Adaptation
- Models of Care

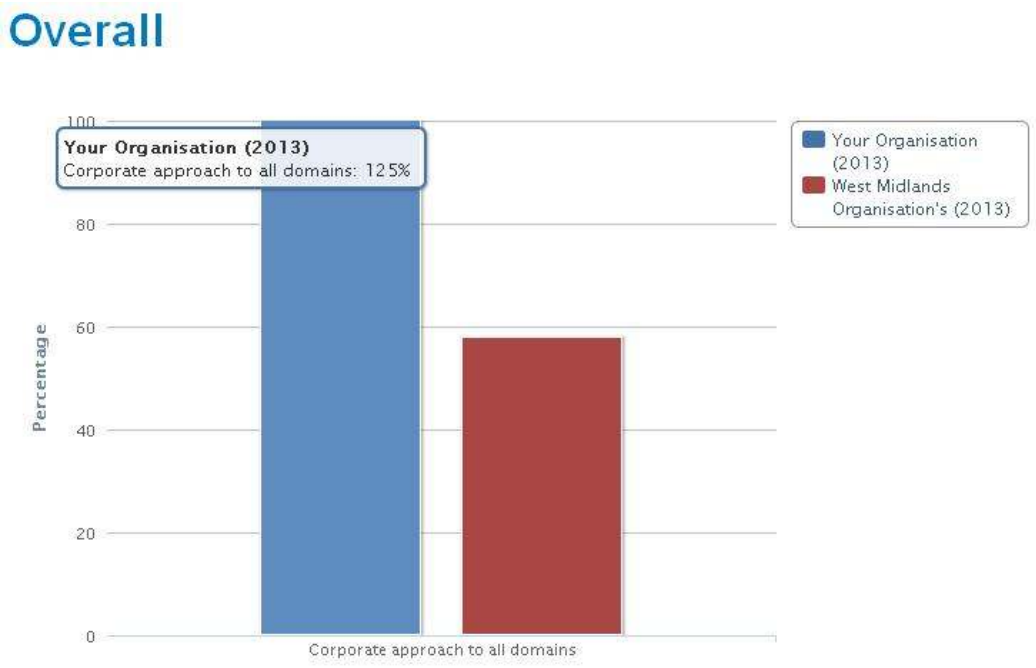
For each of the above areas, the Trust answers a series of questions to gauge what we are doing and to track progress. The last submission was in August 2013 and showed an improvement on the previous submission in February 2013.

- Score in February = 47%
- Score in August = 51%
- Overall score for 2013 = 56%

The scores achieved by this Trust for 2013 show a continuing improvement.

	Feb 2013	Aug 2013
Travel	43%	29%
Procurement	32%	42%
Facilities Management	56%	65%
Workforce	66%	70%
Community Engagement	39%	37%
Buildings	48%	51%
Adaptation	41%	46%
Models of Care	35%	35%

The graph below shows how this Trust compares to all other Acute Trusts that have published their results in 2013



Carbon Reduction Commitment

There is a statutory requirement for the Trust to comply with Carbon Reduction Commitment (CRC). This scheme assesses the gas and electricity consumption of the Trust and calculates carbon emissions based upon consumption. The Trust is then obliged to buy carbon (in tons) from the Environment Agency and surrender the equivalent emissions back to the EA. The Trust has completed the qualification requirements for Phase 2 of the scheme which introduces the next stages of carbon emission prediction in a bid to ensure organisations set targets that should be at least matched or be required to purchase addition carbon allowances at a higher unit rate than offered originally. Work is underway to collect data and evidence for submission in July 2014 (2013/14 data).

The Trust is also a member of the European Union Emission Trading Scheme (EUETS) and is currently part of Phase III which runs from January 2013 to December 2020. The aim of EUETS was to introduce carbon as a commodity that could be allocated and purchased, with organisations having the ability to trade surplus carbon if they had made savings. The Trust has so far been able to emit less carbon than allocated and accumulate a substantial 'bank' of carbon units. Phase III has introduced an annual reduction in organisation allocation of carbon and the Trust has enough carbon 'banked' to top up the reduced allocation until 2016. By this point the Trust will expect to be in deficit.

CRC and EUETS schemes rely upon individual meter points as a measure of energy consumption and carbon emission based upon this. A single meter point can only be part of one of these schemes. Currently the largest Gas consuming meter within the Trust at City is part of EUETS which currently offers a much lower unit rate of carbon than CRC.

Display Energy Certificates

All Trust buildings over 1,000m² (and where there is access to the public) are required to display their energy performance/efficiency rating on a scale of A to G by use of Display Energy Certificates (DECs). The Trust has updated these for 2013/14 and they are on display at the main entrances to buildings included within the scheme. DECs have to be renewed annually

There are seventeen buildings across the Trust that fall into the category of requiring a Display Energy Certificate. Due to the variety and different ages of the buildings the energy performance varies significantly. In summary most buildings fall within the mid-range of C to F. Display Energy Certificates are also accompanied by an Energy Advisory Report that contains recommendations for improvement in energy performance. The recommendations are being considered as part of the Carbon Management Plan identified above.

As can be seen in more detail in the ERIC Returns, generally the Trust is operating environmental related performance indicators below the lower quartile for both cost of energy and the carbon emissions per occupied floor area. The Trust is proactively monitoring its energy usage and implementing measures to reduce consumption.

7.2 Where do we want to be?

The Trust is committed to ongoing improvement in its environmental impact, energy reduction programme and sustainable development, whilst providing a cost efficient service to the public. The Trust will undertake a voluntary BREEAM Assessment for its existing sites and aspire to a 'Good' rating.

The Trust will undertake a mandatory BREEAM Assessment on the Midland Metropolitan Hospital development and aim to achieve an 'Excellent' rating

7.3 How do we get there?

The revised carbon target will be a 15% reduction in carbon by 2016/17 (from the 2011/12 baseline). The Carbon Management Plan will be assessed and accredited by the Carbon Trust over the next few months. Work is underway to progress us towards this ambitious target, including:

- The Estate Rationalisation programme
- Installation of energy efficient lighting and controls
- Installation of air conditioning controls
- Investigating installation of Solar PV at Rowley Regis Hospital
- Installing new boiler plant at City and SGH
- Introduction of recycling at SGH and RRH

8.0 ERIC AND PERFORMANCE INDICATORS – ACHIEVING OBJECTIVE 6

8.1 Where are we now?

Estates Return Information Collection (ERIC) Returns

The Trust has a mandatory requirement to submit information annually to the Department of Health on a whole range of hard and soft FM services. This information is provided in line with the Estates Return Information Collection requirements. Trusts are categorised according to their size and type. Sandwell and West Birmingham Hospitals NHS Trust is in the category of Large Acute Trusts Outside Of London – of which there are 38 such Trusts. Obviously the benchmarking information is more meaningful when provided in this way.

The returns are summarised for each service into quartiles, lower, median and upper. Any service that fall outside the upper and lower quartiles will be identified and further detailed analysis undertaken to understand the reasons why.

8.2 Where do we want to be?

For each element of service delivery the objective remains to keep the cost of provision of those services within the benchmark between lower and upper quartiles and demonstrate value for money

8.3 How do we get there?

To inform the business planning process, the division will utilise the 2012/13 ERIC returns, factor in the current TSP plans and forecast its benchmark position. Areas outside of the benchmark will be reviewed and these are shown below

Where appropriate, proposals will be developed to make changes to operational services to comply with objective.

8.4 Summary of ERIC returns where the Trust lies outside of the Upper or Lower Quartile

Capital Investment for new build per Occupied Floor Area – Upper Quartile

Finance	Unit	SWBH Position	Lower Quartile	Median	Upper Quartile
Capital Investment for new build per Occupied Floor Area	£/m ^{2}	83.66	2.26	15.82	53.23

Almost £ 129 million has been invested in new build during 2012/13 a large amount of which (£16.2m) was utilised to purchase land and property at Grove Lane for the proposed new hospital project. The Trust Value excluding Grove Lane land and property purchases is £ 74.95, just above the upper quartile.

Total Capital Investment – Upper Quartile

Finance	Unit	SWBH Position	Lower Quartile	Median	Upper Quartile
Total Capital Investment	£	17,318,078	5,174,605	7,626,047	13,750,379

Total Capital Investment per Occupied Floor Area – Upper Quartile

Finance	Unit	SWBH Position	Lower Quartile	Median	Upper Quartile
Total Capital Investment per Occupied Floor Area	£/m²	112.97	34.82	50.94	94.80

The capital invested in new build together with the £54 million invested in improving existing buildings and addressing statutory standards has resulted in the total capital investment being above the upper quartile. The Trust value excluding Grove Lane land and property purchases is £108.80 placing the Trust above the Upper Quartile.

Total backlog cost – Upper Quartile

Quality of Buildings	Unit	SWBH Position	Lower Quartile	Median	Upper Quartile
Cost to eradicate Backlog	£	96,659,400	9,298,253	20,919,816	42,488,791

Significant investment has been utilised from Capital Programme to address high and significant backlog and minimise risk to the organisation. It is accepted that the Trust will continue to have a very high backlog maintenance until such time as the Midland Metropolitan Hospital is opened. The emphasis must continue to be to keep high and significant backlog to a minimum.

Percentage of Risk Adjusted Backlog to Total Backlog – Lower Quartile

Quality of Buildings	Unit	SWBH Position	Lower Quartile	Median	Upper Quartile
Percentage of Risk Adjusted Backlog to Total Backlog	%	7.90	16.95	33.05	55.57

Despite reporting a huge figure required to eradicate total backlog maintenance, the Trust has continued to expend Capital investment in addressing Statutory Standards which has resulted in a large reduction of high and significant risks.

Total Energy Cost per Occupied Floor Area – Upper Quartile

Energy	Unit	SWBH Position	Lower Quartile	Median	Upper Quartile
Total Energy Cost Per Occupied Floor Area	£/m²	30.96	24.86	27.02	28.85

The ageing estate contains many buildings with low energy performance resulting in a high energy input to maintain required environmental conditions. As a result of the Estate Rationalisation programme a number of buildings closed during 2012/13. Though the reduced occupied floor area was reported in the submitted data the energy consumed up until closure was included for these buildings. Had the building closures not happened the Trust figure would have been £28.67 which is below the upper quartile.

Contracted Out Services per Occupied Floor Area - Lower Quartile

Contracted Out Services	Unit	SWBH Pilot	Lower Quartile	Median	Upper Quartile
Contracted Out Services per Occupied Floor Area	£/m²	16.28	33.31	66.96	149.86

The majority of Facilities services are in-house inclusive of PTS and Security.

Total Hard FM (Estates) and Soft FM (Hotel Services) costs (Cost of Occupancy) per Occupied Floor Area Upper Quartile

Finance	Unit	SWBH Pilot	Lower Quartile	Median	Upper Quartile
Total Hard FM (Estates) and Soft FM (Hotel Services) costs (Cost of Occupancy) per Occupied Floor Area	£/m²	425.41	237.63	313.51	404.90

The Hard and Soft FM costs for all the buildings during the Estate Rationalisation programme are included within the reported figure. However, the floor area following these closures was reported therefore placing the Trust above the upper quartile. Had the buildings not closed the Trust figure would have been £394.07 which is below the upper quartile.

Gross Cost of Inpatient Services per Main Meals Requested (Cost per Inpatient Meal) – Upper Quartile

Food Services	Unit	SWBH Pilot	Lower Quartile	Median	Upper Quartile
Gross Cost of Inpatient Meal	£/meal	4.35	3.02	3.45	4.18

The reason for this figure being above the upper quartile is being investigated.

Cost of Laundry and Linen Services per Item (Upper Quartile)

Laundry and Linen	Unit	SWBH Pilot	Lower Quartile	Median	Upper Quartile
Cost of Laundry and Linen Services per Item	£/item	0.41	0.27	0.31	0.37

The reason for this figure being above the upper quartile is being investigated.

9.0 PATIENT LED ASSESSMENTS OF THE CARE ENVIRONMENT (PLACE) – ACHIEVING OBJECTIVE 7

9.1 Final PLACE Audits 2013

The audits for 2013 were held later in the year and were undertaken between 2nd April and 29th June 2013. Trusts and other participating organisations no longer determine the date(s) on which to undertake the assessments. The Health and Social Care Information Centre (HSCIC) has given Trusts and other organisations six weeks' notice of the week in which assessments at any particular hospital/unit are to be undertaken. Notification was received in relation to all of the assessment dates for our Trust and they were undertaken as detailed below

- City Hospital – Friday 19th April 2013
- Leasowes PCT – Friday 3rd May 2013
- Rowley – Friday 24th May 2013
- Sandwell – Wednesday 5th June 2013
- BTC – Thursday 13th June 2013

Feedback from the audits are that the overall standards are very good and the majority of the detailed checks have passed, there were a few qualified passes and a couple of failures that are being addressed.

The NHS Information Centre have indicated the results of the PLACE 2013 programme for Cleanliness, Food, Privacy and Dignity and Condition Appearance and Maintenance score for each hospital within the Trust. However, the results need to be verified prior to release, confirmation is expected by 18th September 2013.

Site Name	Cleanliness Score %	Food Score %	Privacy & Dignity Score %	Condition Appearance & Maintenance Score %
SANDWELL GENERAL HOSPITAL	99.32	92.81	97.08	95.96
CITY HOSPITAL	97.32	90.38	96.32	94.96
EYE HOSPITAL	99.79	95.05	95.00	97.14
ROWLEY REGIS HOSPITAL	98.37	94.81	89.73	92.68
LEASOWES	100.00	94.37	95.00	89.81

Percentages TBC.

10.0 SUMMARY DISPOSAL AND PROCEEDS OF SALE – ACHIEVING OBJECTIVE 8

The Trust currently provides its services from an estate that covers over 80 acres and 170,000m^2 of buildings. There are currently a number of building areas that have been vacated and plans are developing to vacate further areas as the Trust improves its performance and implements the interim reconfiguration. The Estates division are developing plans to "right size" its estate by closing peripheral buildings through the Estate Rationalisation Transformation Savings Plan. However, until such time as the Outline Planning Application and Outline Business Case for the Midland Metropolitan Hospital have been approved and there is much more certainty about the future of the remaining estate, site disposal will be put on hold.

An Estates Terrier summary of the three existing sites is shown in Table 2 below

General Information	City Hospital (1)	Sandwell Hospital (2)	Rowley Regis Hospital (3)	Leasehold Intermediate Care
Gross internal site floor area	98,2210 m^2	61,762m^2	8,735m^2	980m^2
Occupied floor area	87,148m^2	54,614m^2	8,735m^2	921m^2
NHS Estate occupied floor area	87%	100%	100%	100%
Site heated volume	202,763m^3	138,442m^3	22,760m^3	2,211m^3
Site building footprint	60,067m^2	27,790m^2	4,868m^2	980m^2
Site land area	19.47 hectares	8.14 hectares	2.76 hectares	0.84 hectares
Leased in land area (2) All Saints Way Car Park Hallam Street Car Park (2.66h) Unit 3, Church Lane, West Bromwich, (no details of land or buildings)	Nil	2.97 hectares	Nil	
Patient occupied floor area	59,940m^2	32,285m^2	5,990m^2	600m^2
Non-patient occupied floor area	27,207m^2	22,329m^2	2,745m^2	321m^2
Unoccupied floor area	11,063m^2	7,148m^2	Nil	59m^2
Main circulation area	7,300m^2	8,012m^2	832m^2	115m^2
Leased in floor area	Nil	Nil	Nil	Nil
Leased out floor area (1)	869m^2			Nil
Artificial Eye BHBN				
Leased out floor area (2)		60m^2		Nil
WRVS MRI 24 and 25 Hallam Close GP Deputising?				Nil
Leased out floor area (3)			Nil	Nil
Temporary buildings and portacabins	540m^2	176m^2	Nil	Nil

11.0 DEVELOPMENT CONTROL PLANS – ACHIEVING OBJECTIVE 8

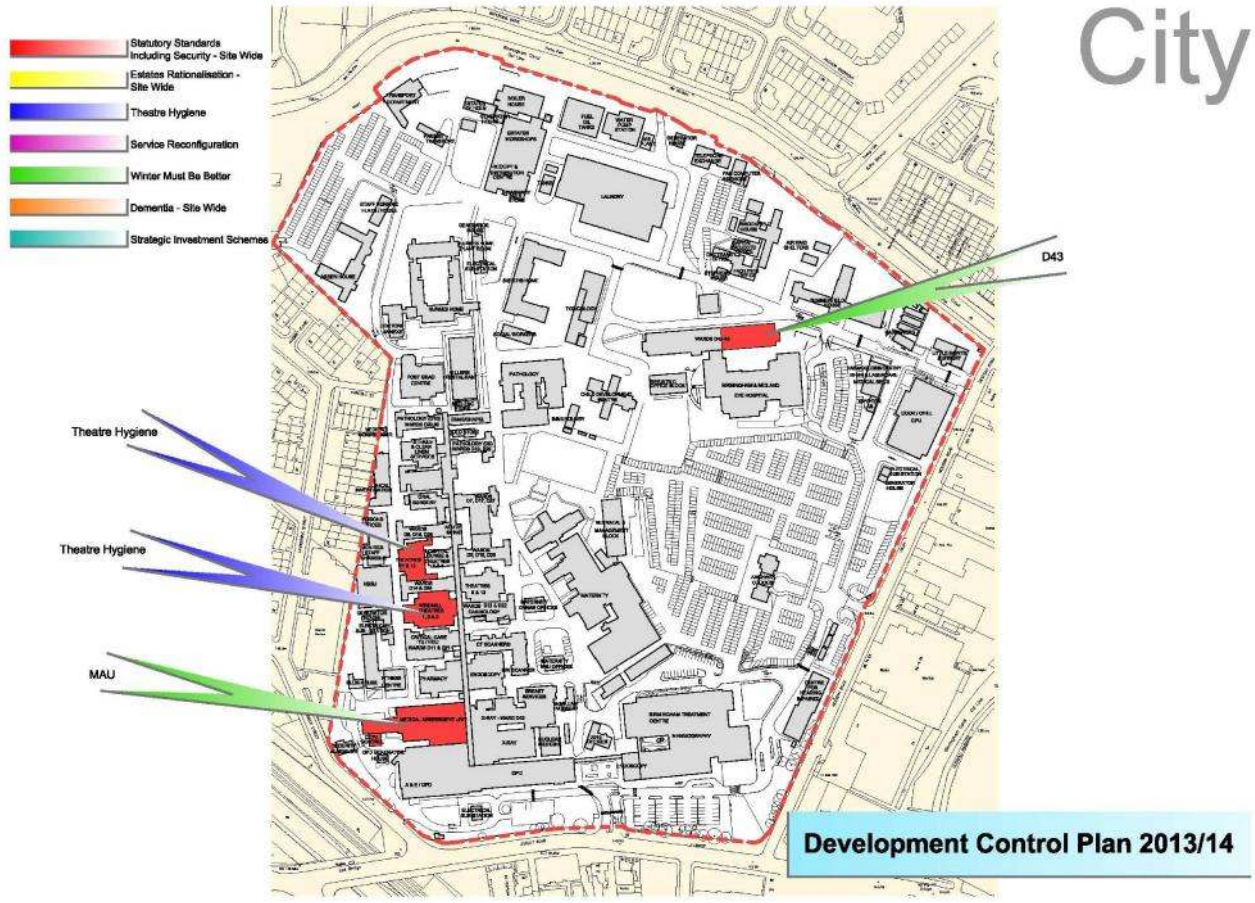
The Trust's Development Control Plan has to take into account clinical service requirements in the form of:-

- Clinical Service Developments
- Clinical Service Reconfigurations
- Clinical Service Transformation Savings Plans
- Long Term Clinical Configuration

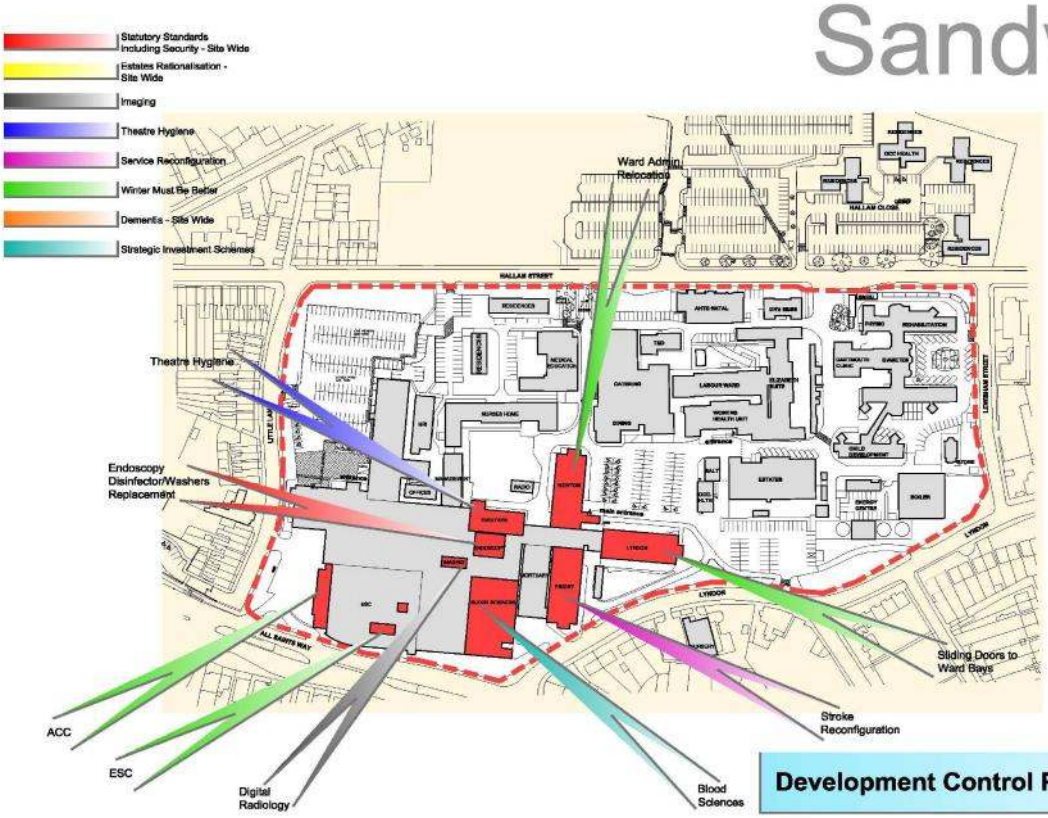
Estates related issues:-

- Condition of the estate
- Statutory Compliance issues
- Transformation Savings Plans - Estates Rationalisation Programme
- Long term estates plans

The following illustrations show the 2013/14 development control plans for each site:

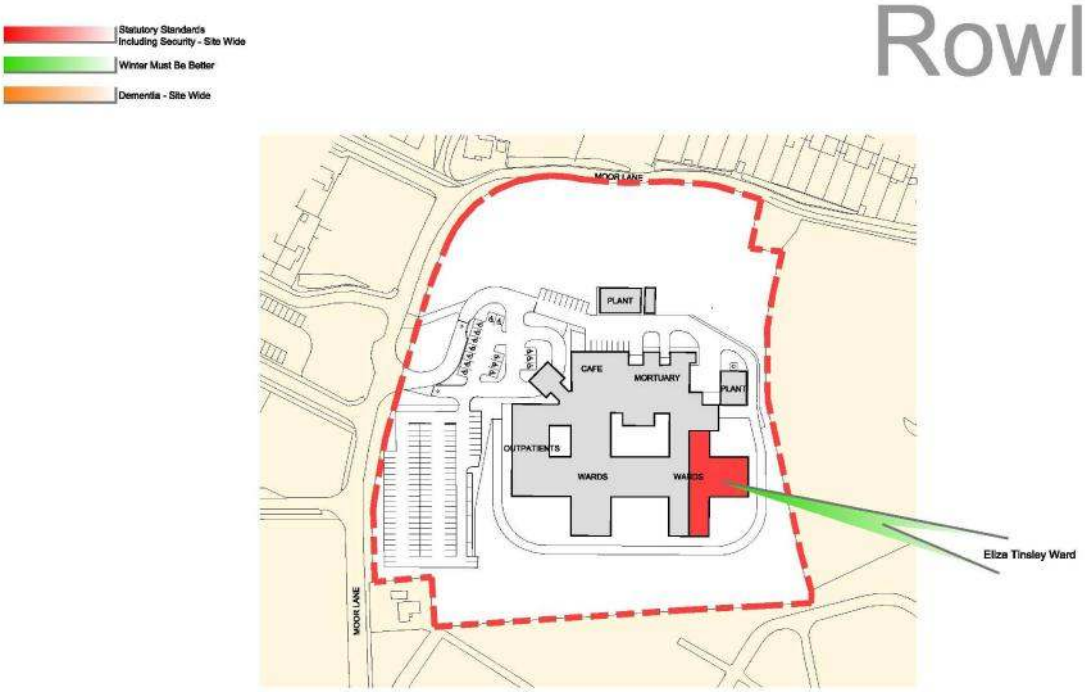


Sandwell



Development Control Plan 2013/14

Rowley



Development Control Plan 2013/14

11.1 Development Clinical Plan for City Hospital 2014/15 to 2017/18

These plans need to be updated following further discussion with the groups and feedback from the Transformation Savings Plans.

	Clinical Service Development	2014/15	2015/16	2016/17	2017/18
1.	Achieving Right care Right Here Activity projections	Over time should release acute capacity (beds & clinics) but requires increase in community capacity Initial increase in acute beds in 13/14 but the intention is for these to be closed again by 15/16.			
2.	Other Possible Reconfigurations: Clinical Haematology (inpatients)	If inpatients integrated onto one site will need increase in beds for the specialty on that site & possible ward refurbishment e.g. hepafiltration to some isolation rooms (areas currently where service delivered are: Newton 5, BTC, D7 & D41- think D41 pts moving to other wards at City as part of winter 13 plans). Any change likely to happen in 14/15 (assuming consultation required).			
3.	Other Possible Reconfigurations: emergency PPCI (Cardiology) Any change unlikely to be before 14/15 unless emergency change	If emergency PPCI or all PCI integrated onto one site may need increase in CCU/Cardiology beds on that site & review of Cardiac Cath Lab capacity & upgrade of C ath Lab (City). Areas currently where service delivered are: City & Sandwell - CCU, Cath Lab, Cardiology ward on each site. Any change likely to happen in 14/15			
4.	Other Possible Reconfigurations: Interventional Radiology (IR). Others may be identified via specialty strategies or TSPs	If IR based on one site may have implications for recovery space in Imaging & upgrade of existing rooms/equipment (especially at Sandwell) likely to stay on both sites until MMH although not finalised yet. Still under review			
5.	Development of Gynae Oncology as supra regional service; may include reconfiguration of	May have implications for equipment, theatre capacity beds			

	Urogynaecology (in partnership with BWH), increase in laparoscopic surgery development of radical & ultra radical surgical skill (including with colorectal surgery. 2014/15 to 2015/16				
6.	Development of specialist/tertiary Ophthalmology Services; includes developing R&D capacity, securing national or regional commissioned status for specialised services in e.g. mucous membrane pemphigoid, posterior Uveitis, scleral contact lenses etc., enhancing training facilities. 14/15-17/18	Will have implications for BMEC capacity in outpatients especially development of teaching facilities e.g. simulation theatre and potential development of private patient facilities.			
7.	Development of Breast Surgery including Oncology plastic work, expansion of breast screening service. 14/15-15/16	Unclear at this stage but will require investment in Imaging technology			
8.	Review of Theatre capacity and activity to determine if closures can be made. 2014/15.	2014/15			
9.	Development of minor ops facility BTC	2014/15			
10.	Imaging – 4th CT scanner	2014/15-15/16			
11.	Imaging 3rd MRI ; site unclear but would make sense to be at City next to BTC in line with long term plans	2014/15-15/16			

11.2 Development Control Plan for Sandwell Hospital 2014/15 to 2017/18

	Clinical Service Development	2014/15	2015/16	2016/17	2017/18
1.	Achieving Right care Right Here Activity projections	Over time should release acute capacity (beds & clinics) but requires increase in community capacity as for City			
2.	Other Possible Reconfigurations: Clinical Haematology (inpatients & chemotherapy units)	If inpatients integrated onto one site will need increase in beds for the specialty on that site & possible ward refurbishment e.g. hepafiltration to some isolation rooms (areas currently where service delivered are: Newton 5, BTC, D7 & D41- think D41 pts moving to other wards at City as part of winter 13 plans). Any change likely to happen in 14/15 (assuming consultation required).			
3.	Other Possible Reconfigurations:	If emergency PPCI or all PCI integrated			

	emergency PPCI (Cardiology)	onto one site may need increase in CCU/Cardiology beds on that site & review of Cardiac Cath Lab capacity & upgrade of Cath Lab (City). Areas currently where service delivered are: City & Sandwell - CCU, Cath Lab, Cardiology ward on each site. Any change likely to happen in 14/15 (assuming consultation not required). Assume any reconfiguration will be to City site & therefore expansion at City in above areas. **All subject to consultation if necessary** Any change likely to happen in 14/15			
4.	Other Possible Reconfigurations: Interventional Radiology (IR). Others may be identified via specialty strategies or TSPs	If IR based on one site may have implications for recovery space in Imaging & upgrade of existing rooms/equipment (especially at Sandwell) As for City			
5.	Medical Day Case Unit	Medical Day Case Unit 14/15-15/16			
6.	Development of part of Lyndon 2 into an SAU	Development of part of Lyndon 2 into an SAU 14/15			

11.3 Development Plan for Russells Hall Hospital 2014/15 to 2017/18

	Clinical Service Development	2014/15	2015/16	2016/17	2017/18
1.	Expansion of market share for Ophthalmology with growth from Dudley residents	Increase in outpatient activity			
2.	Relocation of School Health Nurse office base into one centre RRH	2014/15			
3.	Primary Care Assessment and Treatment bed pilot	Additional beds/reallocation of space			

11.4 Development Clinical Service Plan for City 2014/15 to 2017/18

	Clinical Service Development	2014/15	2015/16	2016/17	2017/18
1.	Increase in Health Visitors (Sandwell Community).	Additional bases required for additional staff; needs discussion with GPs re best locations	Additional bases required for additional staff; needs discussion with GPs re best locations	Additional bases required for additional staff; needs discussion with GPs re best locations	
2	Review of Bradbury Day Hospice	Either closure or development of facility to meet new service model. Likely to start in 13/14/ but go into 14/15.			

12.0 STRATEGIC OPTIONS FOR ESTATE CHANGE

12.1 Where are we now?

Sandwell and the west of Birmingham has some of the highest levels of deprivation in the country. This is a major factor in determining the poor health of the diverse and disadvantaged communities. Local health and social care services face very challenging health needs that are a major cause for concern. For example:

- Men and women live three to four years less than the national average
- Infant mortality rates are high . In some parts they are twice the national average
- One in five people have a long-term illness that affects their daily life
- There is significant variation in health status within the area, and in general Black and Minority Ethnic groups have poorer health than others.

The need for major investment to develop and improve health and social care services to address these needs was formally recognised by the development of a Strategic Outline Case during 2003 and 2004. The Strategic Outline Case sets out a clear direction of travel to deliver a vision of improved physical, mental and social well being for the population of Sandwell and the west of Birmingham and described the need to redesign the whole health and social care system by creating a major step change in service provision.

The Strategic Outline Case indicated a required rebalancing of capacity to reflect a substantial transfer of care into a primary care setting alongside a demanding performance improvement in acute hospital services. Substantial reductions in hospital lengths of stay are anticipated, with much of the consequent reduction in acute hospital capacity being re-provided in new services and facilities closer to people's homes. Investment in community health and social care services, as well as investment in acute hospital facilities, is seen as key to making the vision a success. This investment will also enable new models of care to be put in place in advance of any changes to acute hospital facilities.

The development of an Outline Business Case for all of the investment needed across the local health and social care system commenced under the auspices of the Right Care Right Here Partnership.

Milestones of progress;-

- The Strategic Outline Case was approved by the Department of Health in July 2004.

- Department of Health approved the Outline Business Case in August 2009 to enable application for Trust to activate a Compulsory Purchase Order. Caveats were made that HM Treasury would need to approve the Outline Business Case before procurement is initiated.

- Compulsory Purchase Inquiry completed in June 2010 and Secretary of State Health confirmed that the Compulsory Purchase Order can be made in January 2011.
- Right Care, Right Here review to the programme and subsequent scope review process leading to revision of size of the Midland Metropolitan Hospital and change to assumptions (Trust will now retain facilities on the City and Sandwell sites) - winter 2009/10. Driven by more adverse financial environment.
- Full update of the Outline Business Case approved by Trust Board in September 2010 and Strategic Health Authority in October 2010 – this addressed the new requirements to meet International Financial Reporting Standards to model partial indexation and to meet Monitor's Prudential Borrowing Ratios.
- General Vesting Declaration 1 activated in July 2011 – the most complex properties are now owned by the Trust (taking ownership to circa 50% of the total site).
- Detailed Department of Health scrutiny of the Outline Business Case and Long Term Financial Model (LTFM) during 2011 /12, approval not yet granted.
- Procurement documents completed by September 2011.
- General Vesting Declaration activated in June 2012 – secures all remaining areas of the site.
- HM Treasury review of Private Finance Initiative procurement route commenced with collection of evidence in December 2011, report pending.
- Outcome of HMT review announced, PF2 initiative launched, Trust project timescales re-established

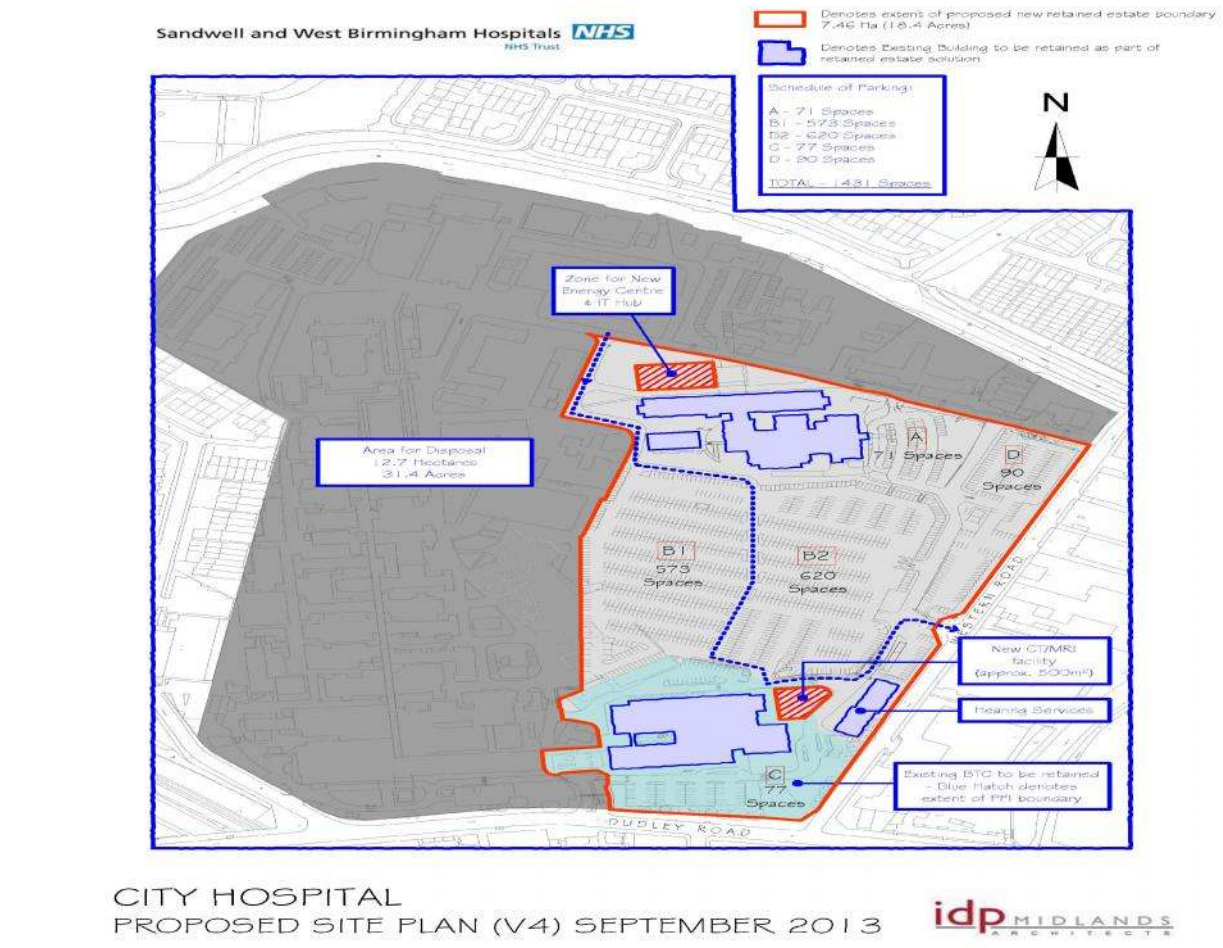
Task	End date
Close Trust Case Proceeding to for the integ	September
Update FT LTFM to with detailed CIP plans for 14/15 and 15/16	November
Fully revised LTFM approved SWBH Board	End November
Trust issues notice to quit to remaining tenants at Grove Lane	September
Architectural Design Refresh	September / October
Update Procurement Documents	November
Agreement of PF2 Update of documentation	December / January
DH/ NHSTDA approve OBC & updated PF2 Documents	December /January
Commence Pre Market Engagement	December
Final SWBH Board approval to issue OJEU	End January 2014
HMT approve OBC & updated PF2 Documents	February 2014
Secretary of State Approval Letter	February 2014
Issue OJEU Notice	March 2014
ITPD issued to 3 Bidders	April 2014
3 Bidders reduced to 2 Bidders	August 2014
Draft ABC to request permission to close dialog issued	End January 2015

Task	End date
Apply Process DH, NHSTDA/Mid and HMT Close Dialogue letter issued	End March 2015
Final ABC and and Preferred Bidder Appointed	June 2015
CBC and and Financial Close	January 2016
Construction	August 2018
Commissioning	October 2018
New Hospital Opens	October 2018

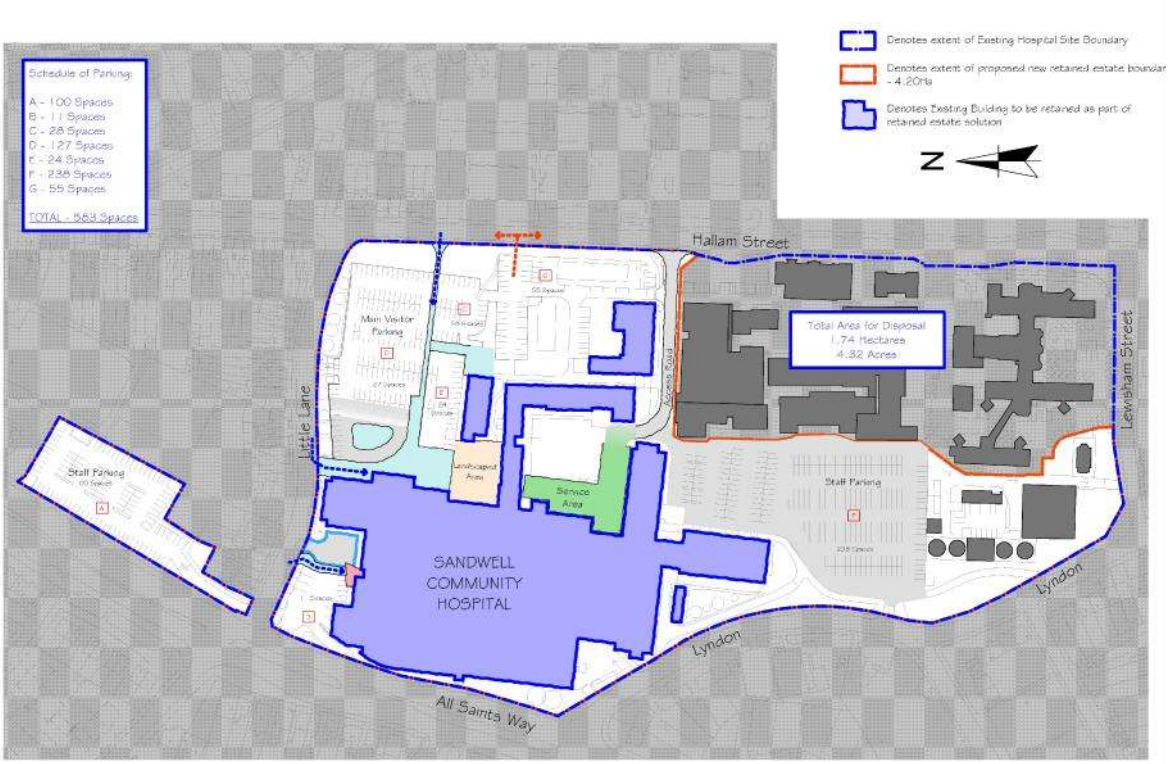
12.2 Right Care Right Here Community Facilities

SWBH will continue to provide healthcare services from its Trust owned estate that comprises City, Sandwell, RRH and Leasowes Intermediate Care. These sites will be reconfigured to support relocation of acute inpatient services to MMH. Work has been undertaken to establish DCPs for each site. These are illustrated below

City Hospital Site



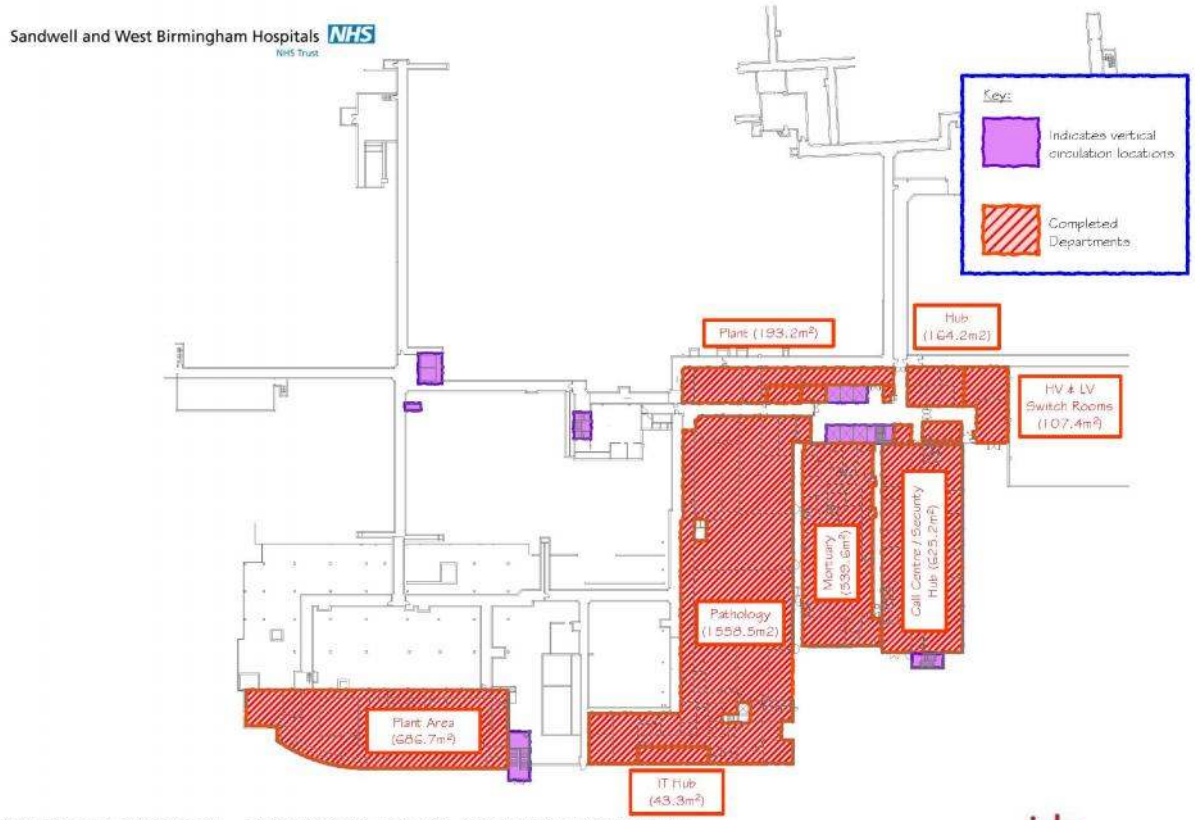
Sandwell Hospital Site



SANDWELL HOSPITAL
PROPOSED SITE PLAN (V4) SEPTEMBER 2013

idp MIDLANDS ARCHITECTS

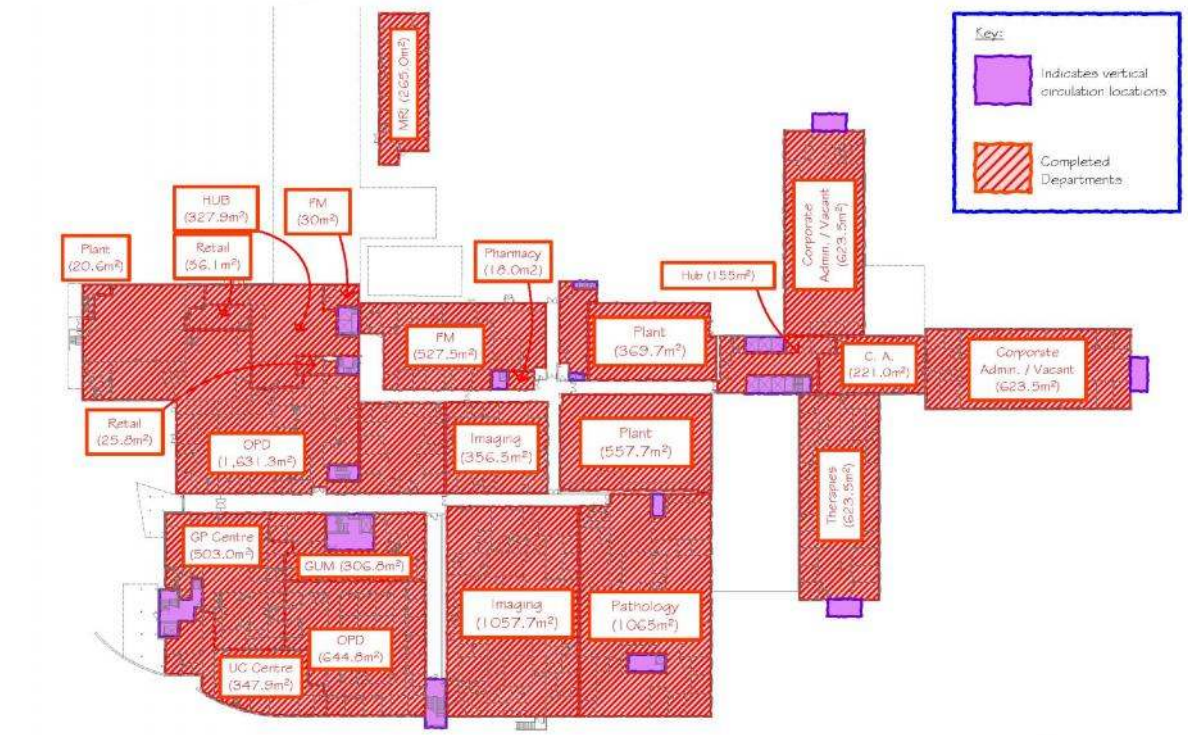
Sandwell and West Birmingham Hospitals NHS
NHS Trust



SANDWELL HOSPITAL - PROPOSED LOWER GROUND FLOOR PLAN
(REVISED 11.09.13)

idp MIDLANDS ARCHITECTS

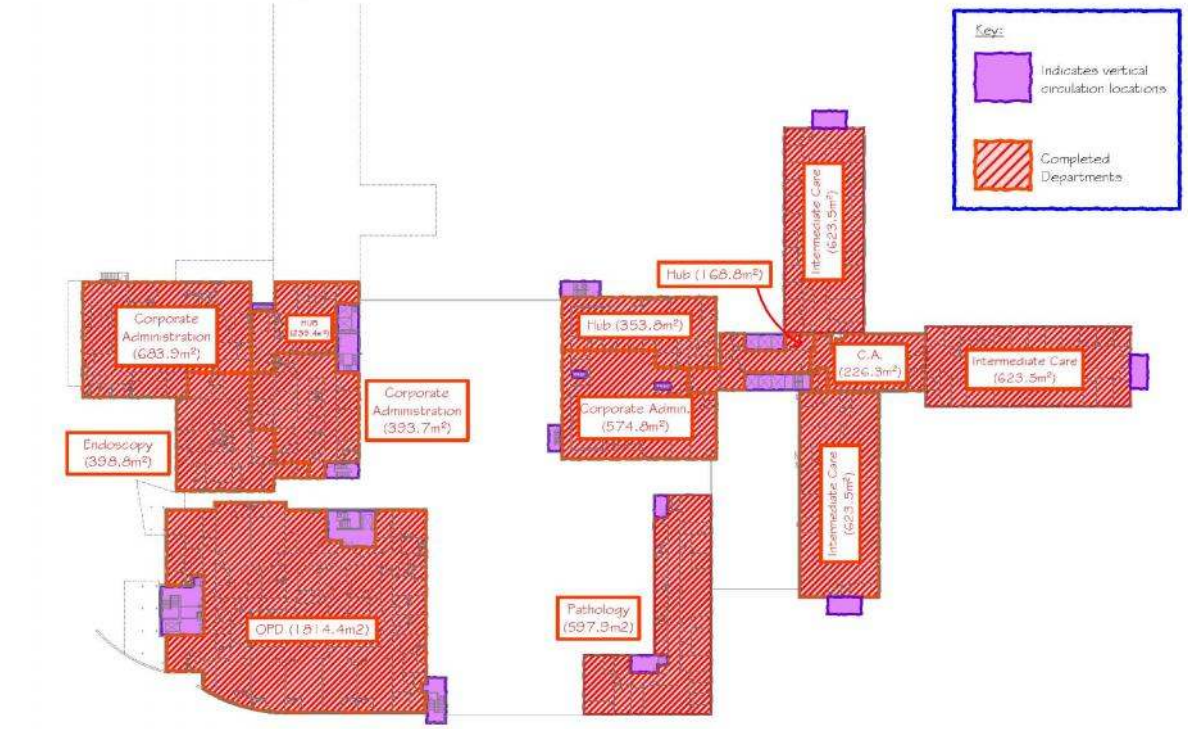
Sandwell and West Birmingham Hospitals NHS
NHS Trust



SANDWELL HOSPITAL - PROPOSED GROUND FLOOR PLAN
(REVISED 11.09.13)

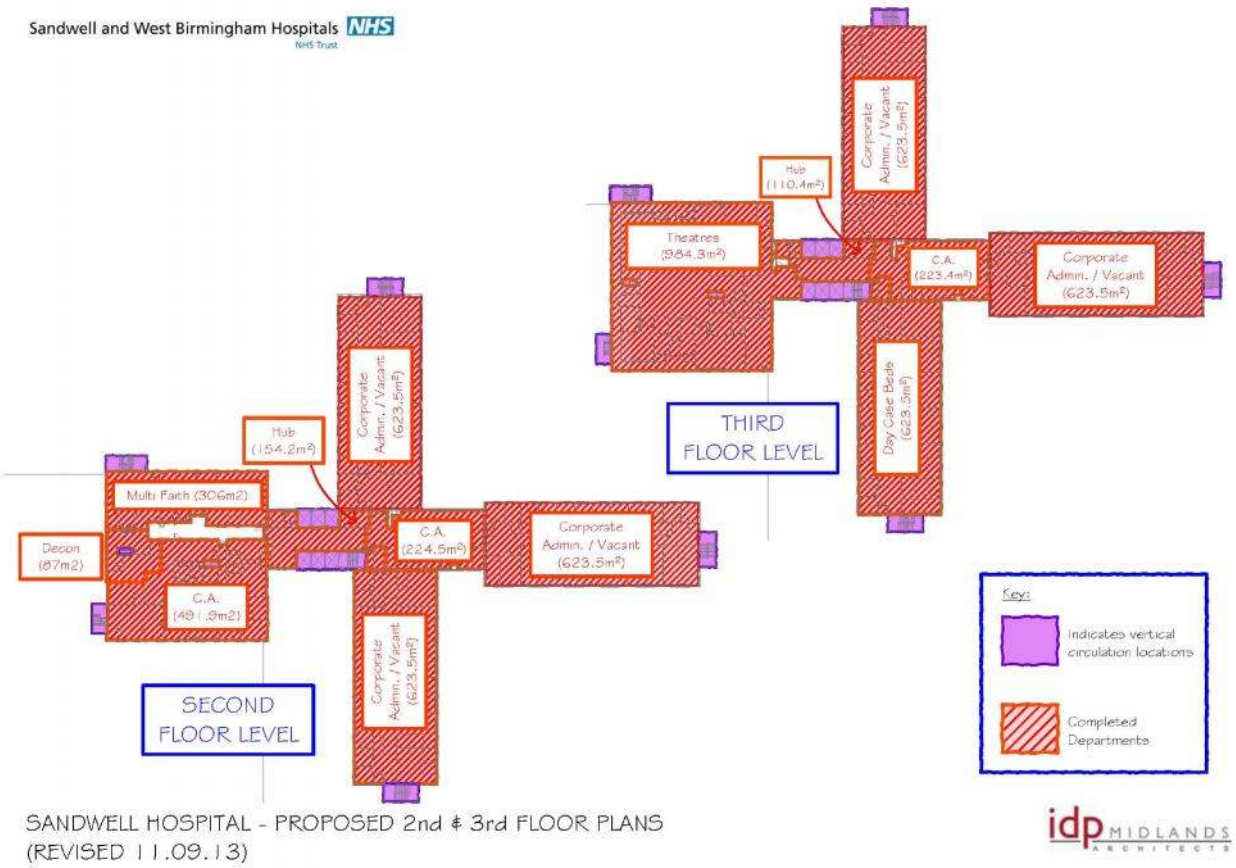
idp MIDLANDS ARCHITECTS

Sandwell and West Birmingham Hospitals NHS
NHS Trust

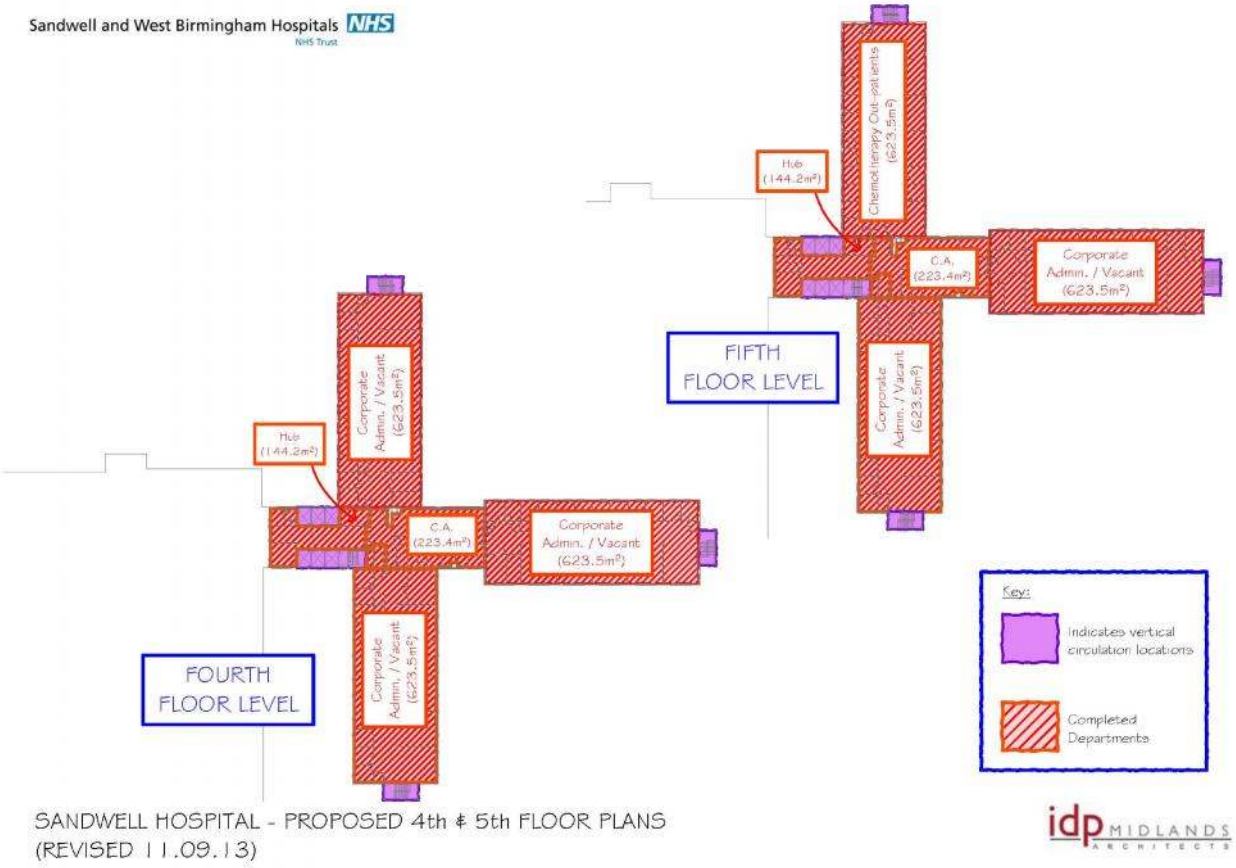


SANDWELL HOSPITAL - PROPOSED FIRST FLOOR PLAN
(REVISED 11.09.13)

idp MIDLANDS ARCHITECTS

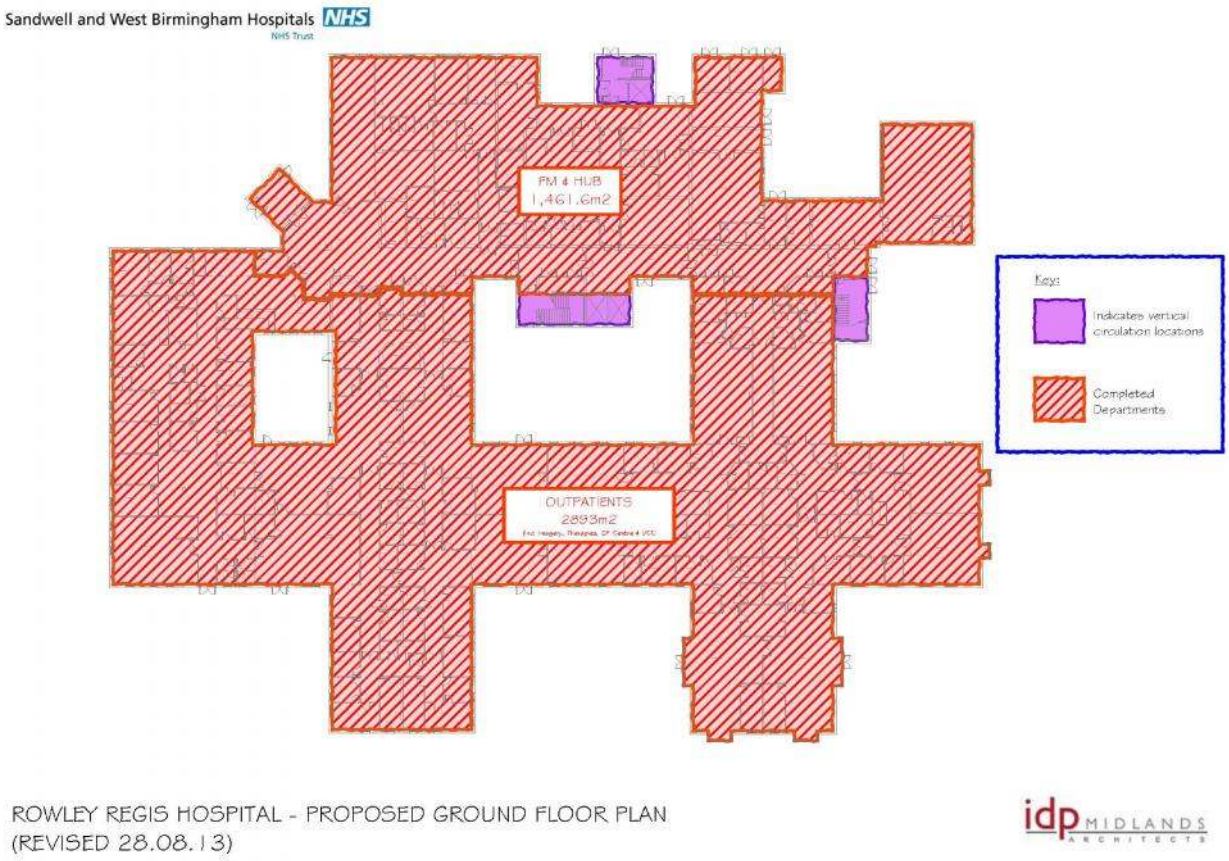


SANDWELL HOSPITAL - PROPOSED 2nd & 3rd FLOOR PLANS
(REVISED 11.09.13)



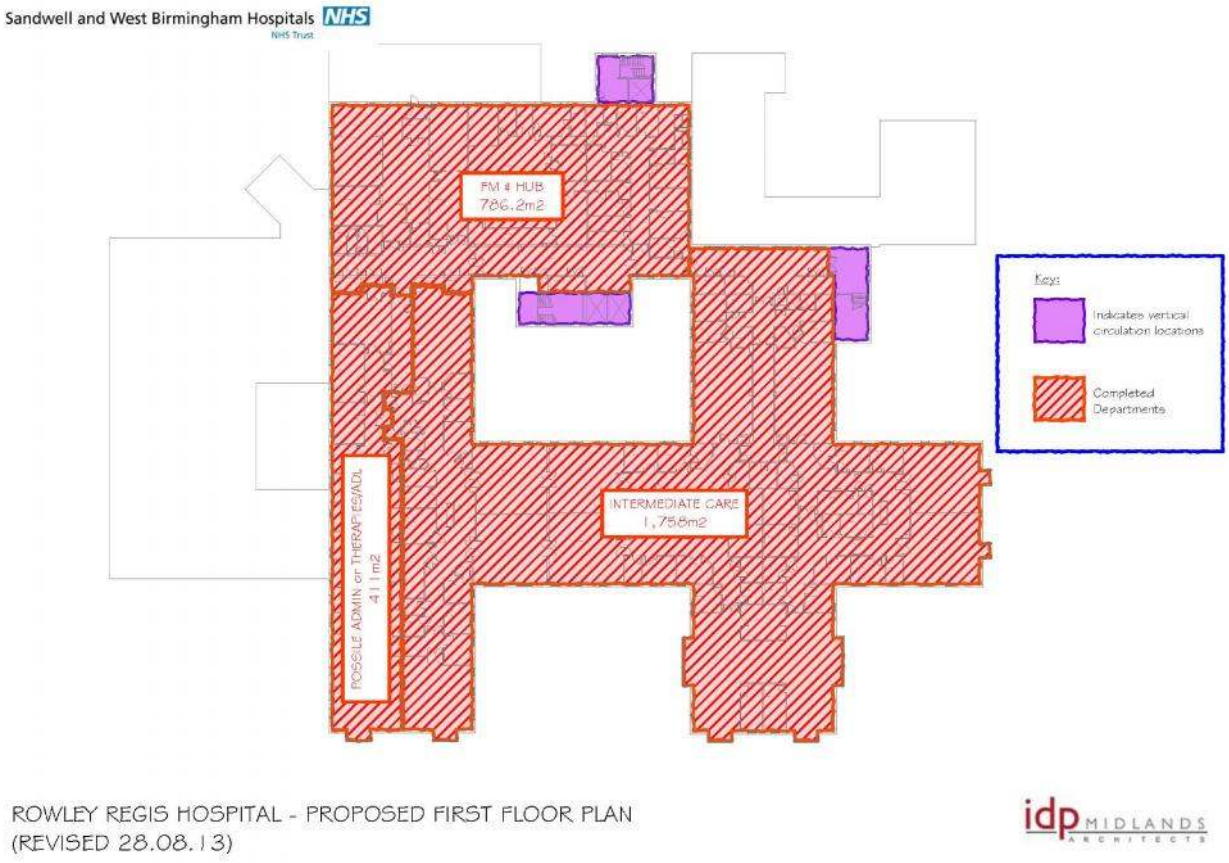
SANDWELL HOSPITAL - PROPOSED 4th & 5th FLOOR PLANS
(REVISED 11.09.13)

RGH Regis Hospital Site



ROWLEY REGIS HOSPITAL - PROPOSED GROUND FLOOR PLAN
(REVISED 28.08.13)

idp MIDLANDS ARCHITECTS



ROWLEY REGIS HOSPITAL - PROPOSED FIRST FLOOR PLAN
(REVISED 28.08.13)

idp MIDLANDS ARCHITECTS

12.3 No -To Cil Est

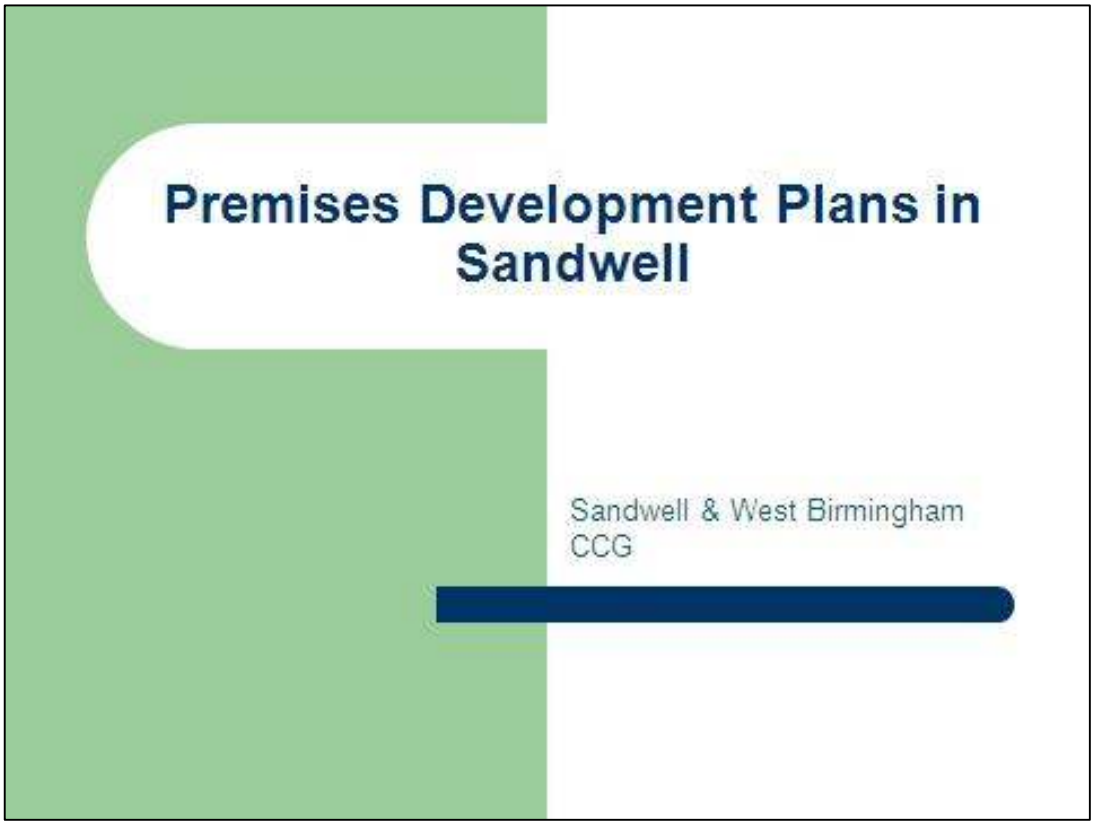
The Trust provides services from non-owned estate. Over the coming 12 months SWBH with its partners need to develop an estates strategy to support clinical services in the community. These partners will include CCGs, Local Authorities, NHS Property Services and Community Health Partnerships who all have an interest in ensuring the estate is optimised for clinical care.

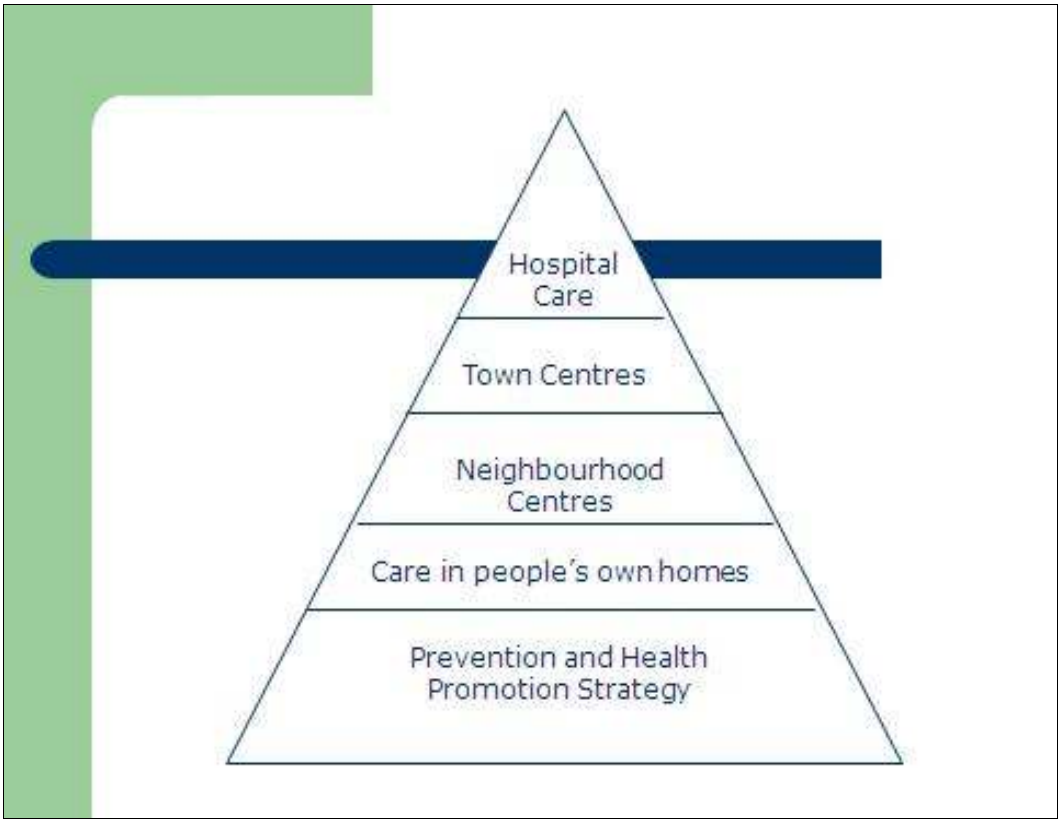
Properties in which community facilities are currently delivered are detailed below. These are currently under review with the CCG.

- Beeches Road Childrens Centre, Beeches Road, West Bromwich, B70 6QE
- Bradbury Day Care Centre, Wolverhampton Road,Oldbury B68 8DG
- Burnt Tree Childrens Centre, 20-25 Tividale Street, Tipton. DY4 7SD
- Cape Hill CC, Cape Hill, Smethwick
- Cape Hill Medical Centre, Raglan Rd, Smethwick B66 3NR
- Central Clinic, Horsley Rd Tipton DY4 7NB
- Cradley Heath Surestart, Valley Road, Cradley Heath, B64 7LR 01384 414747
- Crocketts Lane School
- Dr K Paramanathan, The Surgery, 348 Bearwood Road, Smethwick, B66 4ES
- Edward Street Hospital, Edward Street, West Bromwich. B70 8NL
- Friar Park Clinic, Friar Park Road, Wednesbury WS10 0JS
- Gayton Road Community Centre,
- Glebefields HC, St Marks Rd Tipton DY4 0SN
- Great Barr Group Practice, 912 Walsall Road, Great Barr, Birmingham. B43 7QP
- Great Bridge Children's Centre, Sheepwash Lane, Great Bridge, Tipton, DY4 7JF
- Green Acres Childrens Centre, Brennand Road, Oldbury B68 0ST
- Greets Green Childrens Centre, Wattle Road, West Bromwich, B70 9EZ
- Haden Hill Leisure Centre, Barrs Road, Cradley Heath, B64
- Hallam Street Hospital
- Hateley Heath FETC, Huntingdon Road, Hateley Heath. B71 2RP
- Heath Lane Hospital, Heath Lane, West Bromwich, B71 2BQ
- Hillside Children's Centre, Pennyhill Primary School, Hollyhedge Road, Stone Cross, B71 3BU
- Hill Top Medical Centre, (Dr Hanna/Sonday Surgery), 15 Hill Top Road Oldbury Warley B68 9DU
- Hollybush Medical Centre, 435 Hagley Road West, Quinton B32 2AD
- Holly Lane Clinic: Holly Lane, Smethwick B66 1QN
- Hurst Road Community Centre, Hurst Road, Smethwick, B67 6ND
- Independent Living Centre(Wheelchair Service), Oldbury Road, Smethwick B66 1JA
- Jubilee Health Centre, 1 Upper Russell Street, Wednesbury, WS10 7AR
- Langley Leisure Centre
- Leasowes Intermediate Care Centre, Oldbury Rd, Smethwick B66 1JA
- Lyng Centre, Frank Fisher Way, West Bromwich B70 7AW.
- Mace St Clinic, Mace Street, Cradley Heath. B64 6HP
- Malling Health Great Bridge, Unit 18 Black Country Park, Great Bridge Street, West Bromwich, West Midlands, B70 0EN
- Malling Health Wednesbury, Wednesbury Leisure Centre, High Bullen, Wednesbury, West Midlands, WS10 7HP
- Malling Health, Western Road, Langley, Rood End, Oldbury, West Midlands B69 4LV 0121 612 3630
- Meadows Sports College, Dudley Road East, Oldbury, B69 3BU
- Mesty Croft Clinic, Alma Street, Wednesbury. WS10 0BQ
- Neptune Health Park, Sedgley Rd West, Tipton DY4 8LT
- Oldbury Health Centre, Albert Street, Oldbury, B69 4DE
- Orchard School, Causeway Green Road, Oldbury B68 8LD

- Popes Lane (TDC) Popes Lane, Oldbury, B69 4PJ
- Portway Lifestyle Centre, Newbury Lane, Oldbury, B
- Regis Medical Centre, Darby Street, Rowley Regis, B65 0BA
- Rood End Childrens Centre, Greenwood Avenue, Oldbury, B68 8TE
- Rowley Childrens Centre (Springfield) Dudley Road, Rowley Regis B65 8JY
- Rowley Regis Hospital, Moor Lane, Rowley Regis B65 8DA
- Rowley Learning Centre.(inc St Michaels, Westminster School and PRU)
- Rowley Village Surgery, Rowley Village, Rowley Regis. B65 9AF
- Sai Surgery, Slater Street, Great Bridge, DY4 7EY
- Sandwell General Hospital B71 4HJ
- SGS House, John's Lane, Tividale, B69 3HX
- Sherwood House Surgery, 9 Sandon Road, Edgbaston. B17 8DP
- Smethwick Library, High Street, Smethwick B 66 1AA
- Smethwick Medical Centre, Regent Street, Smethwick. B66 3BQ
- Spires Health Centre, Victoria Street, Wednesbury, WS10 7EH
- Stone Cross Clinic, Jervoise Lane, Stone Cross. B71 3AR
- Stone Cross Medical Centre, 291 Walsall Road, West Bromwich, B71 3LN
- Stoney Lane Day Centre, Summer Street, West Bromwich, B71 4JA
- Surestart Friar Park, Mesty Croft and Woods, Priory Family Centre, Dorsett Road, Wednesbury WS10 0JG
- Surestart Nursery, Capehill and Windmill Lane, Corbett Street, Smethwick B66 3PX
- Swanpool Medical Centre
- Tanhouse Centre, Hamstead Road, Great Barr, B43 5EL
- Tipton Surestart, 24 Ridgeway Road, Tipton, DY4 0TB
- Tipton Swimming Centre. Alexander Road, Tipton, DY4 8TA
- The Brambles, Yew Tree Estate(annexe of Hillside Children's Centre), Bramley Road, Walsall, WS5 4LE
- Thimblemill Leisure Centre,
- Thimblemill Library, Thimblemill Road, Smethwick B67 5RJ
- Tividale Childrens Centre, Ashleigh Road, Tividale, B69 1LL
- Uplands Manor Primary School
- Victoria Health Centre: Suffrage Street, Smethwick B66 3PZ
- Warley Medical Centre, Ambrose House, Kingsway Oldbury B68 0RT
- Wednesbury North Children's Centre, Woden Road North, Wednesbury, WS10 9LX
- Wellman Building, Dudley Road East, Oldbury, B69 3DE 0121 569 7273
- Whiteheath Clinic, Badsey Road, Whiteheath B69 1EJ
- Yew Tree Healthy Living Centre, Redwood Rd., WS5 4LB
- YMCA

12.4 Premises Development Plans and Sale


Premises Development Plans in Sandwell
Sandwell & West Birmingham CCG



Services Closer to Home

- Acute Hospital
  - Complex/rare outpatient appointments
  - Full range of diagnostic tests
  - Inpatient surgery
  - A&E


Services Closer to Home
Community Hospitals
Serving a population of approximately 150k
Most outpatient appointments
Most diagnostic tests
Intermediate care
Urgent care for minor injuries
GP surgery


Services Closer to Home
Town Centres
Serving a population of approximately 100k
Urgent primary care
Minor surgery
Specialist nursing
Diagnostics
Outpatients
GP practices
Dental services
Physiotherapy
Occupational health
Mental health services
Pharmacy
Social care
Voluntary sector

Services Closer to Home

- Neighbourhood Centres
  - Serving a population of 10-15k
  - GP practices
  - Community nursing
  - Mental health
  - Pain management
  - Minor surgery
  - Social care
  - Pharmacy
  - Therapy services
  - Dental services
  - Low level diagnostics

Identifying Local Priorities

Category	Criteria
1	The scheme is essential for the delivery of RCRH
2	There is a high level of commitment a. Too far developed to halt b. The scheme is a joint venture c. Politically sensitive
3	The scheme mitigates obvious gaps in provision across the borough
4	Other

Outcome of Prioritisation

- Community Hospitals
- Town Centres
- Enhanced Neighbourhood Centres
  - Neptune Health Park
  - Great Bridge

Outcomes of Prioritisation (Con't)

- Neighbourhood Centres
  - Glebefields
  - Portway
  - Langley/Rood End
  - Holly Lodge
  - Hamstead (satellite)

Smethwick

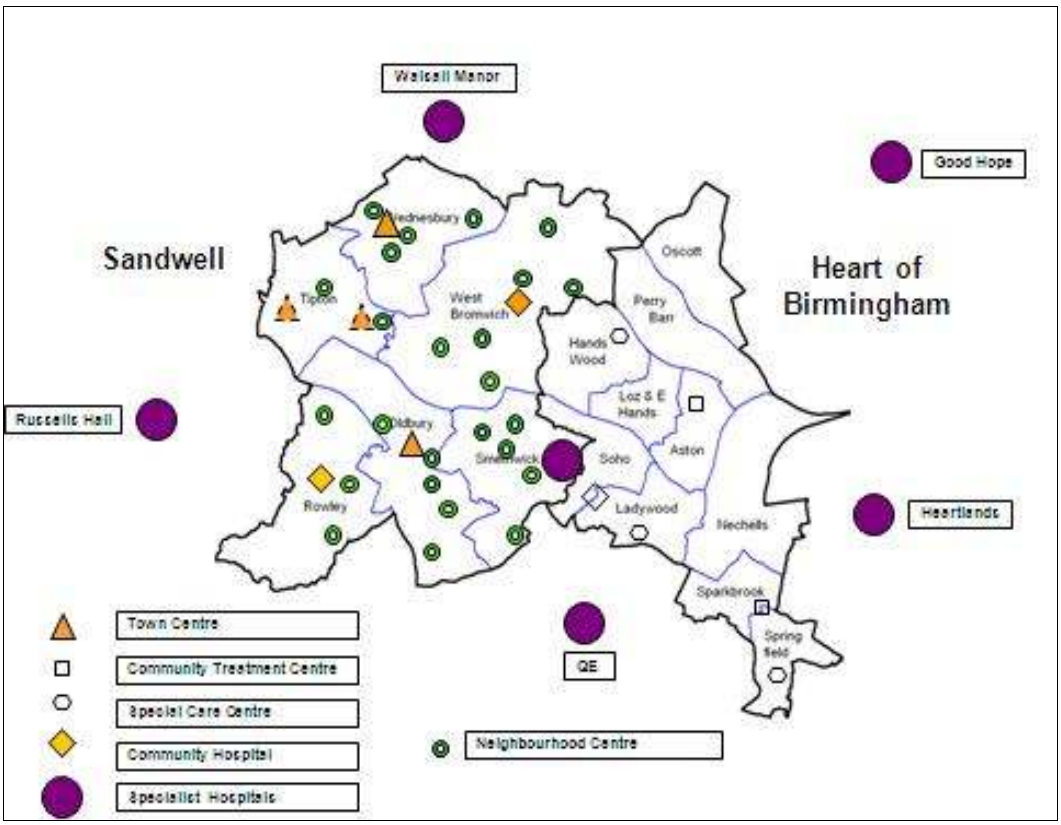
- Birmingham Treatment Centre
- Cape Hill Medical Centre (extension)
- New Acute Hospital
- Victoria Health Centre
- Third Party Development

- No compelling case for a Town Centre in Smethwick

Implications of Prioritisation

- Schemes in delay
  - Dudley Port
  - Great Barr
  - Friar Park
  - Greets Green
  - Cradley Heath
  - Stone Cross (incl satellite)
  - Hill Top (Wednesbury)

12.5 Proposed Healthcare Services across Sandwell & West Birmingham



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 23 August 2013; 1030h – 1330h

Members Present

Ms O Dutton [Chair]
Mr R Samuda
Dr S Sahota OBE
Prof R Lilford
Mr T Lewis
Miss R Overfield
Miss R Barlow
Mrs D Talbot

In Attendance

Ms A Binns
Mr S Parker
Dr H Grindulis [Part]

Secretariat

Mr S Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies for absence from Gianjeet Hunjan, Roger Stedman, Robert White and Kam Dhami.	
2 Minutes of the previous meeting	**SWBQS (7/13) 113**
The minutes of the Quality and Safety Committee meeting held on 19 July 2013 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBQS (7/13) 113 (a)**
The updated actions list was noted by the Committee. It was agreed that Miss Binns should write to the Coroner's office by the end of August to invite them to attend one of the future meetings. It was agreed that it would be appropriate to invite only the Birmingham Coroner at present.	

ACTION: Miss Binns to extend an invitation to the Birmingham Coroner's Office to attend a future meeting of the Quality & Safety Committee	
3.1 Progress in finalising Medicine & Emergency Care Group CSP	**Verbal**
Miss Barlow reported that Medicine & Emergency Care Group had identified a set of savings schemes to address the majority of the previously reported shortfall and that the Quality & Safety Committee would receive this detail with the quality impact assessments at the next meeting. Mr Lewis encouraged the acceleration of the quality impact assessment work. Miss Barlow advised that this would be prioritised.	
ACTION: Miss Barlow to prioritise the quality impact assessment of the Medicine & Emergency Care Group CSPs	
MATTERS FOR APPROVAL	
4 Terms of Reference	**SWBQS (8/13) 115** **SWBQS (8/13) 115 (a)**
Mr Grainger-Payne presented the revised terms of reference for the Committee, highlighting that these had been prepared using the generic template which had also been used to prepare the terms of reference for the other Board subcommittees. It was highlighted that the terms of reference had been reframed to focus more closely on the Committee's assurance role and reflected the points suggested at the last meeting. Mr Lewis highlighted that the purpose included the focus on long term quality goals. Ms Dutton raised a number of points in connection with the terms of reference. It was highlighted that the focus on performance needed to be clarified more explicitly within the purpose and duties in the terms of reference. Prof Lilford highlighted that there were various sources of performance which could be harnessed. Mr Lewis agreed that performance needed to be more explicitly captured in areas in addition to section 9.1. He advised that a data set would be made available to the Committees in October to ensure that all elements of performance were reviewed between all bodies. It was suggested that themes and trends on complaints needed to be included as a separate duty and that the 80% attendance needed to be clarified that this was over a year.	
ACTION: Mr Grainger-Payne to amend the terms of reference for the Quality & Safety Committee to take into account the suggestions made at the meeting	

MATTERS FOR DISCUSSION/DEBATE	
5 Update on Winter 2013 Must Be Better programme	**Hard copy**
Miss Barlow reported that the action plan to implement the revised bed model was on track, including the recruitment plans into key positions with the Accident & Emergency departments. It was reported that the team was ahead of trajectory for the implementation of the bed model and that the Medically Fit for Discharge wards would be opened shortly. The Committee was advised that the addition of doors to the Sandwell ward bays was underway. It was reported that a new Clinical Director for Emergency Care was now in post. In terms of performance against the Emergency care target, it was reported that the August position was above 95% but for the quarter performance was behind trajectory. Ms Dutton asked whether the number of attendances had reduced. Miss Barlow confirmed that this was not the case, therefore the improved performance was clearly associated with changes in the area, rather than a downturn in patients attending. The difference in performance between the two sites was highlighted, which Miss Barlow advised would be closely monitored on a performance dashboard. Miss Overfield advised that there was a high level of newly qualified staff in Medicine & Emergency Care Group. Mr Lewis remarked that there was a balance of risk in terms of having substantive individuals that were newly qualified as opposed to more experienced temporary staff. To mitigate this position, it was reported that robust supervisory arrangements were in place. The need to induct staff comprehensively was underlined. Ms Dutton asked whether the relationship with the Social Services was effective. Miss Barlow advised that this was largely the case, particularly with the Sandwell Social Services. Mr Lewis advised that the need for seven day working was a key priority that needed to be delivered from Social Services. Miss Barlow advised that the Trust's joint discharge team which included Social Services was working well.	
6 Quality Report	**SWBQS (8/13) 116** **SWBQS (8/13) 116 (a)**
The key highlights within the Quality Report were presented to the Committee. Miss Overfield reported that the investment in dementia care would assist with further improving the current falls performance. On pressure damage, it was reported that additional focus would be directed to Grade 2 ulcers with a view to eradication. MRSA screening performance was reported to be improving gradually, however agreement needed to be reached on the cohort of patients needing to be screened. It was reported that *C difficile* rates had increased slightly, however the Trust remained within trajectory. In terms of Trauma & Orthopaedics speciality, it was reported that a case of Klebsiella had been reported in the area and therefore mitigations were being put into place to address this and prevent further infections. It was reported however,	

that housekeeping practice by staff in the area remained to be improved. Wards Newton 3 and Lyndon 3 were reported to be alerting against the quality standards, which the Committee was advised was being investigated. It was reported that the theatres capital plan would be delivered over the Christmas closedown. Miss Overfield reported that elective and emergency case separation in Trauma & Orthopaedics was not a distinct as desired. On nurse staffing, the use of bank and agency staff was reported to be falling, although usage remained high in the Medicine & Emergency Care Group. Ms Dutton asked how many nurses were leaving. It was reported that this was c. 10 per month in Medicine. It was reported that the time to hire process needed to be improved. It was agreed that an update on this needed to be presented at the next meeting. The Committee received and noted the Quarter 1 ward reviews. It was reported that e-rostering and the acuity tool ('Safer Nursing Care') needed to be used more robustly within the Trust. The Committee was asked to note that based on the outputs of the acuity tool it was highlighted that there was a variance in actual and suggested nurse staffing requirements on a number of wards. It was reported that the ward review process had expanded to include theatres. The Committee was advised that further investment into Patient Experience had been agreed. Dr Cobb reported that performance against the VTE assessment CQUIN target was pleasing, with c. 95% being achieved. The impact of the arrival of the new junior doctor cohort was reported to be being seen at present, however. Completion of nutrition audits was reported to be pleasing. It was noted that there had been an increase in incident reporting and was highlighted that there was a significant focus on sepsis at present. Ms Dutton asked in connection with mortality, what evidence was available to suggest that the new review process was working well. Dr Cobb advised that the numbers of cases reviewed was higher and that the spread of cases being handled was more evenly distributed across consultants. It was agreed that further work was needed to harness the learning from the deaths reviewed and that a 'task and finish' group was in place to examine the difference in mortality rates across the Trust. It was reported that there had been no further mortality outlier alerts received since the last meeting. Dr Sahota asked whether the sepsis bundle had been fully implemented. Dr Cobb advised that this was a complex process that involved many areas and Mrs Talbot advised that a process of audit and data collection was in place.	
ACTION: Miss Overfield to arrange for an update on plan to improve the time to hire metric to be presented at the next meeting	
6.1 Readmission rates	**Verbal**

Miss Barlow reported that a four point plan had been developed around readmission around the main services, including respiratory and cardiology specialities. In terms of the high level principles, the risk assessment post-discharge work would be developed within the next few weeks. The introduction of the ambulatory care pathway was reported to also contribute to the improvement of readmission rates.	
7 Child Protection Update	**SWBQS (8/13) 117** **SWBQS (8/13) 117 (a)** **SWBQS (8/13) 117 (b)**
Dr Grindulis joined the meeting. Mrs Talbot provided an overview of Childrens' Safeguarding matters. The Committee received a summary of some of the key child protection reviews. Mrs Talbot highlighted the need for an ongoing training programme, facilitated by the local Safeguarding Board. It was reported that referrals to the Safeguarding team were being monitored. In terms of the structure for the Safeguarding team, it was reported that recruitment was being undertaken into some key positions, including some arising within the community. It was highlighted that there was further work to do to refine the most appropriate structure to support the work, including domestic abuse handling. Ms Dutton noted that domestic abuse impacted on the Trust in terms of repeat attendances. Mr Lewis asked when all key posts would be filled. He was advised that this would be the case by the end of the calendar year. Dr Grindulis advised that there was a cross over between Child and Adult Safeguarding regulations that impacted 16-18 year old patients. Miss Overfield advised that the majority of staff were trained to be aware of matters, such as child grooming and were aware of the process as to where a referral needed to be made to a specialist resource. The pattern of internal referrals to the named nurse for safeguarding was reviewed. The Committee also noted the maternity 'cases for concern', which were highlighted to be significant in number. Dr Grindulis noted that a referral was reflected in patient notes and that a conference with social services would be held for the most concerning cases. It was reported that the medical teams also received a number of referrals. Ms Dutton asked whether current IT systems detected the same patient presenting at both City and Sandwell Hospitals. She was advised that patients who were frequent attendees were identified. In January to June 2013 it was reported that there had been 71 safeguarding incidents. Ms Dutton asked whether all possible measures to avoid a breakdown in communication between the various agencies were in place. Dr Grindulis advised that although every effort was taken to eliminate communication breakdown, this remained an issue. Mr Lewis suggested that a central point was needed to review incidents reported to identify whether there was safeguarding implications whether the incident had been reported as a Safeguarding matter explicitly or not.	

Prof Lilford suggested that safeguarding could be included within the remit of the new Public Health, Community Development & Equality Committee. He also drew the link to mental health services. Dr Cobb also suggested that there may need to be a link with patients presenting with alcohol abuse.

Miss Overfield advised that the governance arrangements in the NHS in respect of child protection were significantly more robust than in other agencies. She highlighted that the cost efficiencies in Local Authorities were a contributory factor to this position.

The Committee reviewed a number of current cases in overview.

It was reported that a flag was in place in the Trust's IT systems, with the exception of the new Emergency Department system, that highlights where a patient has a previous attendance at Social Services. It was noted that a formal risk assessment of the Emergency Department system in this respect was being undertaken and work was underway as a matter of priority to address the position. Ms Dutton highlighted the need to track referrals made by the Trust robustly.

A key challenge for the team was a lack of resource for data collection. Mrs Talbot reported that there were a number of patient referrals that were not being allocated expeditiously or actioned in a timely way by external agencies and that this was a keen focus of the local Safeguarding Board.

The linkage of the work with Health Visitor agenda was highlighted. Miss Overfield reported that the recruitment plans were progressing well.

Miss Overfield advised that provision of Level 3 Safeguarding training had been challenging given that it relied on access from external organisations.

Dr Sahota asked whether CRB checking was a challenge for the Trust. Miss Overfield advised that only individuals employed after a certain date were required to undergo CRB checking. She reminded the Committee that it had been agreed by the Trust Board previously that staff in priority areas who had been recruited before the requirement had been introduced would undergo CRB checking. She added that the community services staff undertook a rolling programme of CRB checking. It was reported that further work was needed to support staff against which a safeguarding allegation had been made.

Mrs Talbot reported that the 'Prevent' agenda was likely to extend to child protection.

It was agreed that a further update on child protection should be received in six months' time. Mr Grainger-Payne offered to schedule this update. Miss Overfield suggested that the update needed to include Adult Safeguarding.

It was agreed that the structures and processes internally were robust, however the Board should be made are of the issues of concern or needing improvement that were outside of the Trust's control and in particular within social services.

ACTION: Mrs Talbot to present an update on child protection at the meeting

of the Quality & Safety Committee scheduled for February 2014	
8 Ward team challenge feedback	**SWBQS (8/13) 118** **SWBQS (8/13) 118 (a)**
Miss Overfield presented the outputs of the recent ward team challenge for receipt and noting. In terms of themes, it was highlighted that there was good performance against drug calculations; knowledge of mental health; end of life care; infection control; and management of workforce. Poor performance identified was highlighted to relate to sepsis identification and management; naso-gastric tube management; clinical supervision; e-rostering familiarisation; and action plans to improve patient experience scores. It was highlighted however, that there was already clear focus on most of these areas of shortfall. Dr Cobb suggested that assurance was needed in terms of the actions around naso-gastric tube management given that this related to 'Never Events'. Ms Dutton asked whether the team challenge could be replicated in other areas. It was reported that an event had been held for theatres and for student nurses. It was highlighted that there was a desire to make the events more multidisciplinary focussed.	
9 End of Life Care update	**SWBQS (8/13) 127** **SWBQS (8/13) 127 (a)**
Mrs Talbot presented an update on End of Life Care management in the Trust. She advised that the Trust used a Supportive Care Pathway. The differences to the Liverpool Care Pathway were highlighted. The Committee was advised that as a result of the recent national review of the Liverpool Care Pathway, the Trust had taken the opportunity to review its own practice and that a number of changes were planned. Dr Sahota asked how this linked into DNACPR decisions. Mrs Talbot advised that there were triggers in the tool used to prompt consideration of this. It was highlighted that the practice engaged family and relatives with the application of an Order when required.	
10 Corporate Quality & Performance dashboard	**SWBQS (8/13) 119** **SWBQS (8/13) 119 (a)**
The Committee was asked to receive and note the report.	
11 Mortality development plan: update	**SWBQS (8/13) 120** **SWBQS (8/13) 120 (a)**
Mr Parker reported that the mortality development plan was progressing largely on track and that there was a good focus on the learning from deaths reviewed. The progress with the actions was outlined. Interviews for staff to assist with the mortality review process were reported to be planned shortly.	
12 Patient story for the Trust Board	**Verbal**
It was reported that there was not a patient story planned for the Trust Board on	

29 August, however a stocktake of the value of the presentations to date was planned.	
13 Complaints development plan: update	**SWBQS (8/13) 121** **SWBQS (8/13) 121 (a)** **SWBQS (8/13) 121 (a)**
Ms Binns advised that the recruitment of complaints support managers was underway. The Committee was advised that the Standard Operating Procedures had been developed and would be launched shortly. Progress overall was reported to be pleasing. In terms of performance against the complaints handling targets, it was reported that every effort was being made to issue complaints as swiftly as possible. Ms Dutton asked how many complaints were currently within the system. She was advised that c. 300 complaints were in progress at present. It was reported that matters were being escalated where necessary. Dr Sahota asked whether the employment tribunal for the member of staff previously working in complaints had impacted significantly. Ms Binns reported that the process had been resource intensive.	
14 Serious Incident report	**SWBQS (8/13) 122** **SWBQS (8/13) 122 (a)**
It was reported that there had been a lower number of incidents reported during the last month.	
15 Serious graded complaints report	**SWBQS (8/13) 123** **SWBQS (8/13) 123 (a)**
Miss Binns asked the Committee to receive and note the update, highlighting that a number related to the Emergency Departments.	
16 Reports from the CQC visits	**SWBQS (8/13) 125** **SWBQS (8/13) 125 (a)** **SWBQS (8/13) 125 (b)**
Miss Overfield presented a summary of the formal reports received from the Care Quality Commission following the unannounced inspections in June 2013. It was highlighted that the outcome was positive overall, while recognising that there was further work to do to embed processes around DNACPR and complaints handling.	
MATTERS FOR RECEIPT AND ACCEPTANCE	
17 Clinical Audit forward plan: monitoring report	**SWBQS (8/13) 124** **SWBQS (8/13) 124 (a)**
The Committee was asked to receive and note the report.	
18 Foundation Trust Quality Governance	**Verbal**

Mr Grainger-Payne reported that a self-assessment against Monitor's Quality Governance Framework would be presented to the Trust Board in September 2013.	
19 – 22 REPORT BACK FROM THE COMMITTEES	
A brief summary of key points of discussion at the Quality Committees was provided.	
MINUTES FOR NOTING	
23 Minutes from the Clinical Quality Review Group	
23.1 Minutes from the meeting held on 1 July 2013	**SWBQS (8/13) 126**
The Quality and Safety Committee received and noted the minutes from the Clinical Quality Review Group meeting held on 1 July 2013.	
24 Matters of topical or national media interest	**Verbal**
It was agreed that there were no matters to raise.	
25 Any other business	**Verbal**
There was none.	
26 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 20 September 2013 at 1030h in the D29 (Corporate Suite) Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Quality Report
SPONSOR (EXECUTIVE DIRECTOR):	Linda Pascall (Interim Chief Nurse), Dr Roger Stedman (Medical Director) and Kam Dhami (Director of Governance)
AUTHOR:	Various
DATE OF MEETING:	26 September 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 Group.

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

REPORT RECOMMENDATION:

The Committee is recommended to ACCEPT the contents of the report.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
✓		

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

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

Comments:

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

- Improve and heighten awareness of the need to report and learn from incidents.
- NHSLA Acute and Community risk management standards – 'Learning from experience'
- Includes performance against a number of CQuIN targets and national & local targets and priorities
- Aligned to the priorities set out within the Quality Account

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 20 September 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY REPORT

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

September 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 showed a decrease again from 94.2% to 93%
- The incidence of falls has increased.
- Nutrition audits are fairly static with the notable exception of a fall in the number of MUST assessments @ 12 hours.
- The Safety Committee has received an assurance report and plan regarding the Klebsiella joint infection. An environmental action plan has been implemented in SGH Theatres arising from issues of concern relating to maintaining good infection control practice. This work is being led by the Surgical Clinical Management Team.
- Medical Clinical Group report – they are fully recruited to nursing vacancies at the time of writing the report.

CLINICAL EFFECTIVENESS

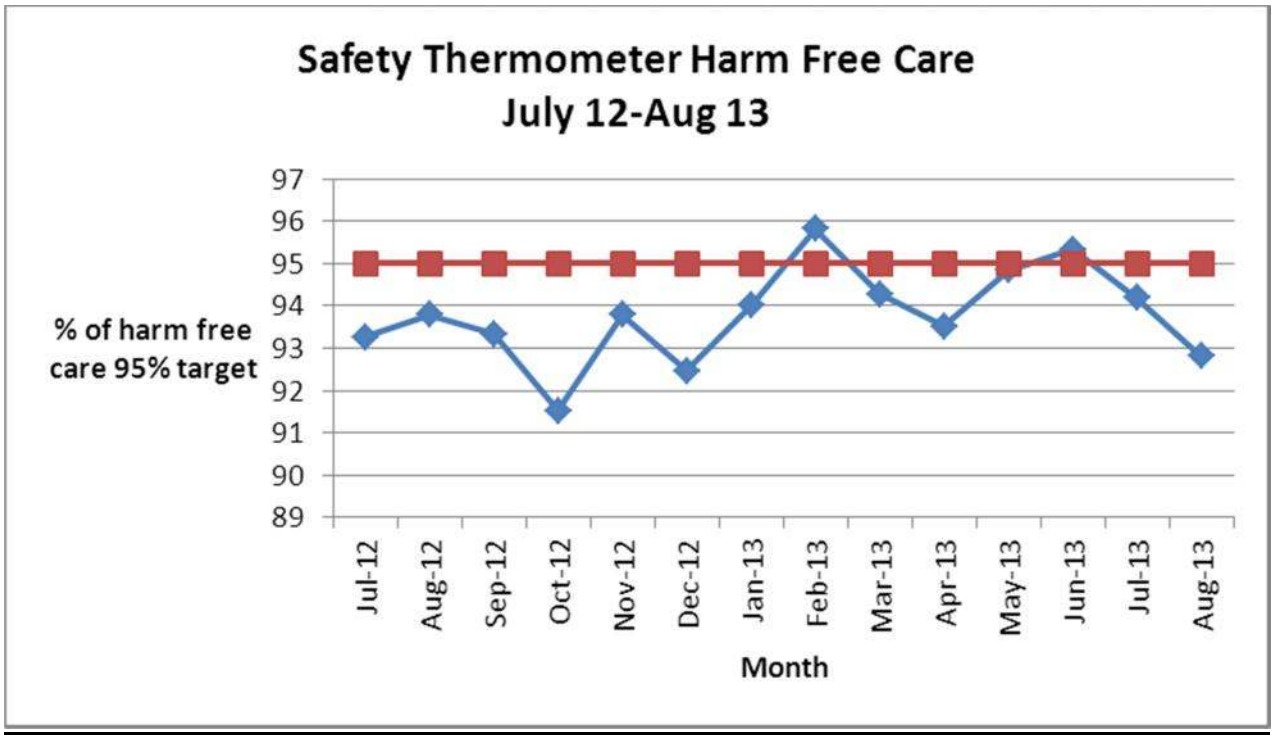
- There are no ward review reports due to be completed for this quarter.
- The ward dashboard is included but there are still IT issues to be resolved which means this data may be inaccurate.
- Compliance with the use of the World Health Organisation (WHO) checklist was 99.21% across all patients who underwent surgery.
- VTE risk assessments were carried out on 94.4% of admitted patients against a standard of 95%.
- Mortality Reviews of June deaths was 72% reviewed within 42 days.
- Fractured Neck of Femur being operated on within 24 hours of admission during August was 85.7% which is above the standard of 70% and represents the performance this year.
- The Trusts 12-month cumulative HSMR (88.4) remains below 100, and is less than the lower statistical confidence limit and continues to remain lower than that of the SHA Peer (97.5).

PATIENT EXPERIENCE

- The combined Trust FFT score was 61 for August and the Trust response rate was 12%. The Inpatient FFT score in August was 67 and the response rate was 32%. The ED FFT score was 49, and the response rate was 5%.

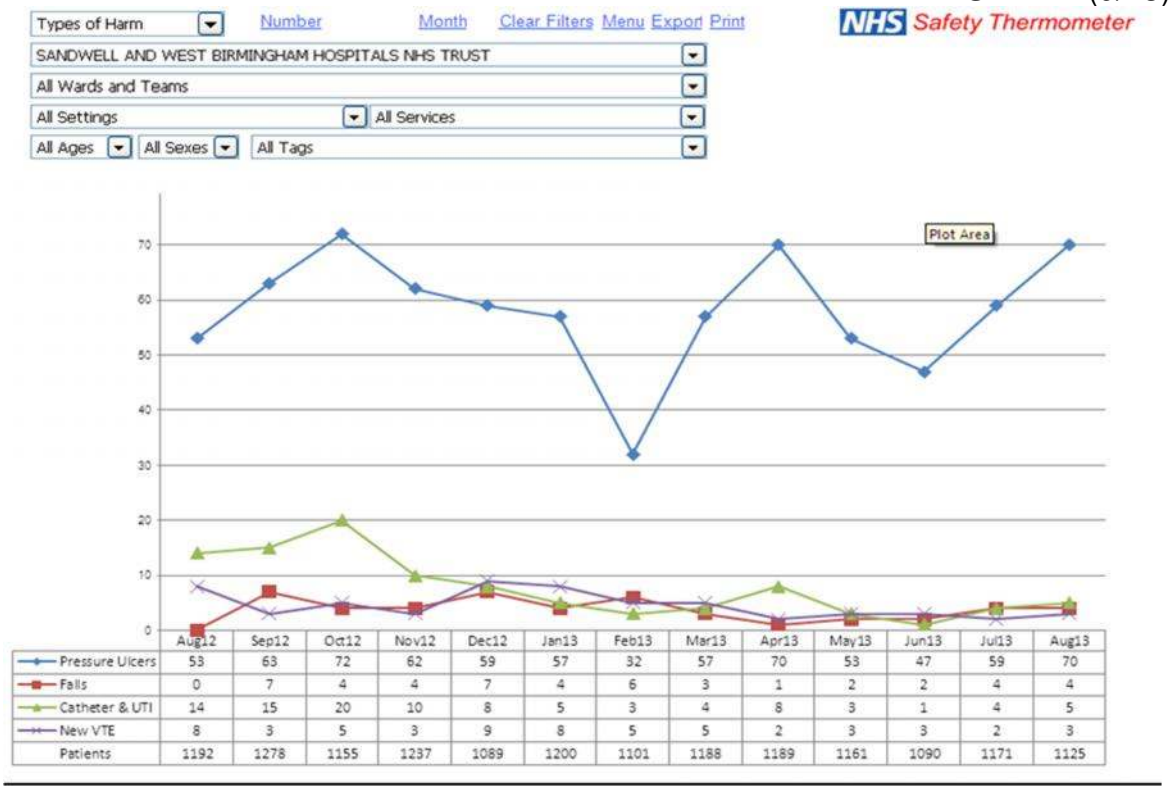
3 PATIENT SAFETY

3.1 Safety Thermometer



Mar -13	Apr-13	May -13	Jun-13	Jul-13	Aug-13
95% ↓	93.5 % ↓	94.8 % ↑	95.3 %↑	94.2 % ↓	93% ↓

Figure 1: *Harm Free*



	Aug12	Sep12	Oct12	Nov12	Dec12	Jan13	Feb13	Mar13	Apr13	May13	Jun13	Jul13	Aug13
Pressure Ulcers	53	63	72	62	59	57	32	57	70	53	47	59	70
Falls	0	7	4	4	7	4	6	3	1	2	2	4	4
Catheter & UTI	14	15	20	10	8	5	3	4	8	3	1	4	5
New VTE	8	3	5	3	9	8	5	5	2	3	3	2	3
Patients	1192	1278	1155	1237	1089	1200	1101	1188	1189	1161	1090	1171	1125

Figure 2: *Number of patients by type*

Acute Divisions **13** patients experienced **1 new harm**. **No** patients experienced more than one harm.

Community Division **16** patients experienced **1 new harm**. **No** patients experienced more than one harm.

a) Falls

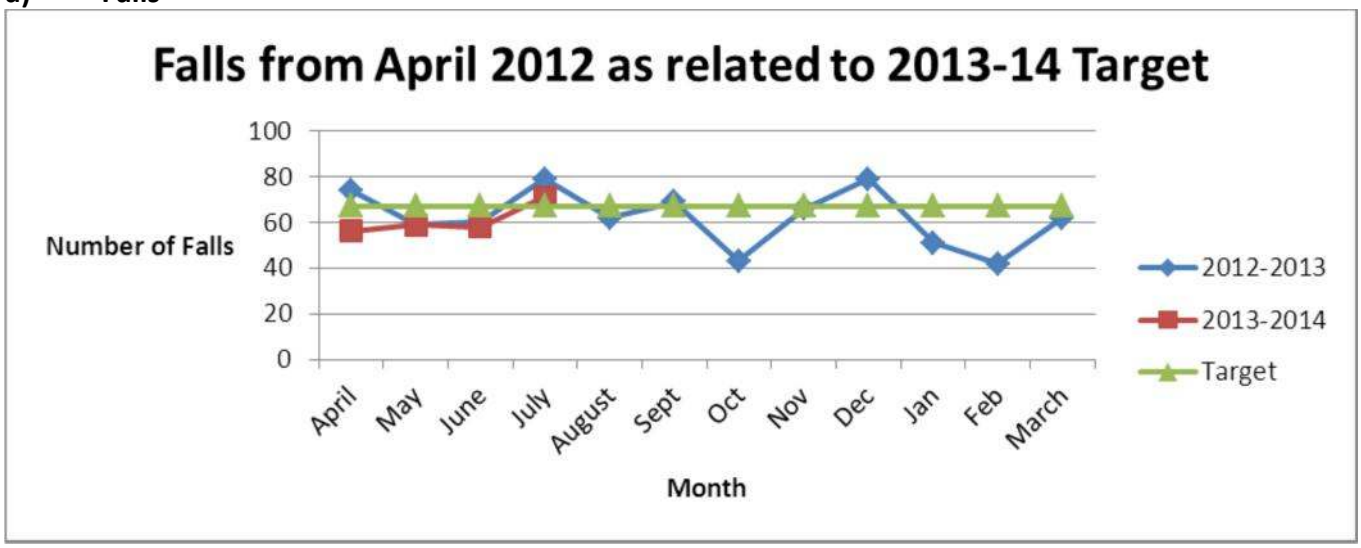


Figure 3: *Trend of falls April 2012 – July 2013*

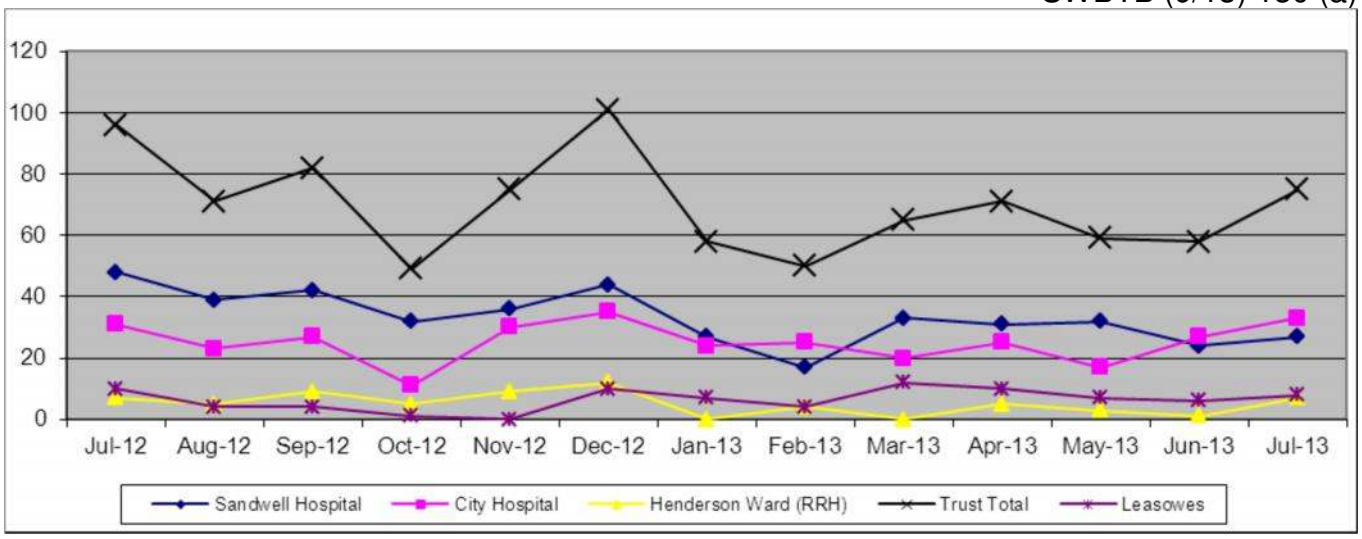


Figure 4: *Incidence of falls per 1000 bed days across Acute Inpatient Divisions*

MONTH	Ward/Area	Grade of Fall	Injury	TTR Action
April	N4	RED	# Ankle	Preventable
April	N2	RED	# Wrist and clavicle	Preventable
April	D21	RED	# Facial bones	Non-Preventable
May	Eye In patients	RED	#Humerus	Non-Preventable
May	MAU	RED	# NOF	Preventable
May	P3	RED	Peri prosthetic #	Preventable
June	P3	RED	#Humerus	Preventable
June	MAU	RED	#Gt Trochanter	Awaiting TTR
June	L5	RED	#Sub/Ex dural haemorrhage (RIP)	Preventable
June	P4	RED	#Rt NOF	Non-Preventable

Figure 5: *Falls resulting in serious injury from April 2013-June 2013 (City and Sandwell Hospital)*

b) Pressure Damage

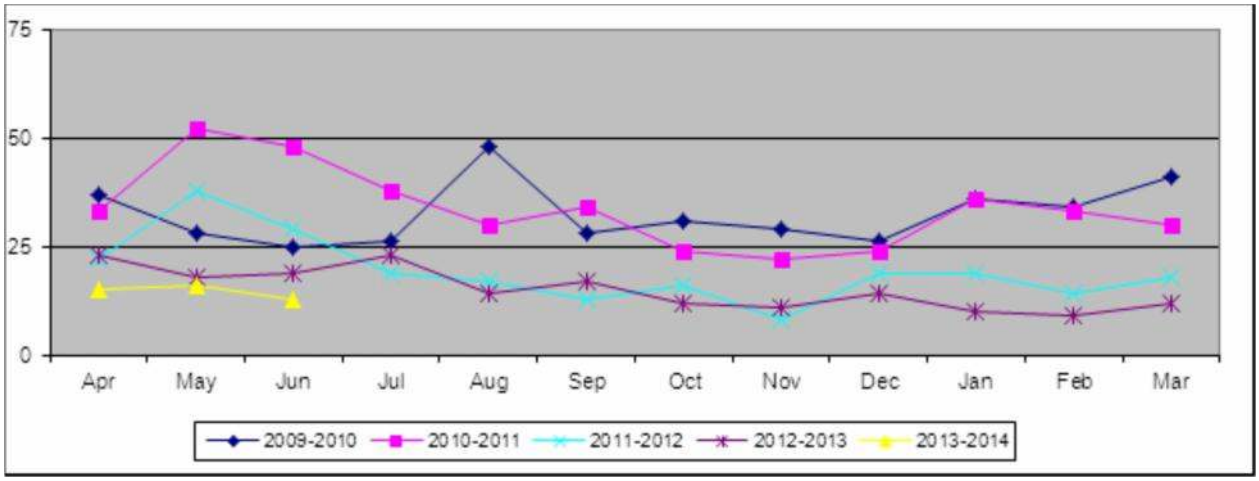


Figure 6: *Number of hospital acquired pressure damage Grade 2, 3 & 4, April 2009 – April 2013*

Grade of Sore	2012-2013													2013-2014				
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	12/13 Total	Apr-13	May-13	Jun-13	Jul-13	13/14 Total
Grade 2	21	16	17	21	11	14	11	11	11	7	9	9	158	13	15	12		40
Grade 3	2	2	2	2	3	3	1	0	3	3	0	3	24	2	1	1		4
Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Trust Total	**23**	**18**	**19**	**23**	**14**	**17**	**12**	**11**	**14**	**10**	**9**	**12**	**182**	**15**	**16**	**13**		**44**

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

c) VTE Risk Assessment

The VTE Risk Assessment CQUIN target is 95%. Intensive work has continued to improve the VTE assessment position. However, performance during August was 94.4% which is slightly below target of 95%. There are various reasons that this may have happened which includes newly graduated doctors staffing the wards, annual leave, and less elective and daycase activity because of the August bank holiday.

VTE assessment was stressed in new doctor induction and the MDs team have attended junior doctors forums, monitored VTE assessment of emergency admissions and made daily visits to the units to prompt junior doctor conformance. Consultants are also reminded to ensure that junior carry out the assessments. The new EBMS calculator has been implemented and is working well, taking less time to complete than the iCM tool. . *CQUiN*

3.2 Nutrition/Fluids

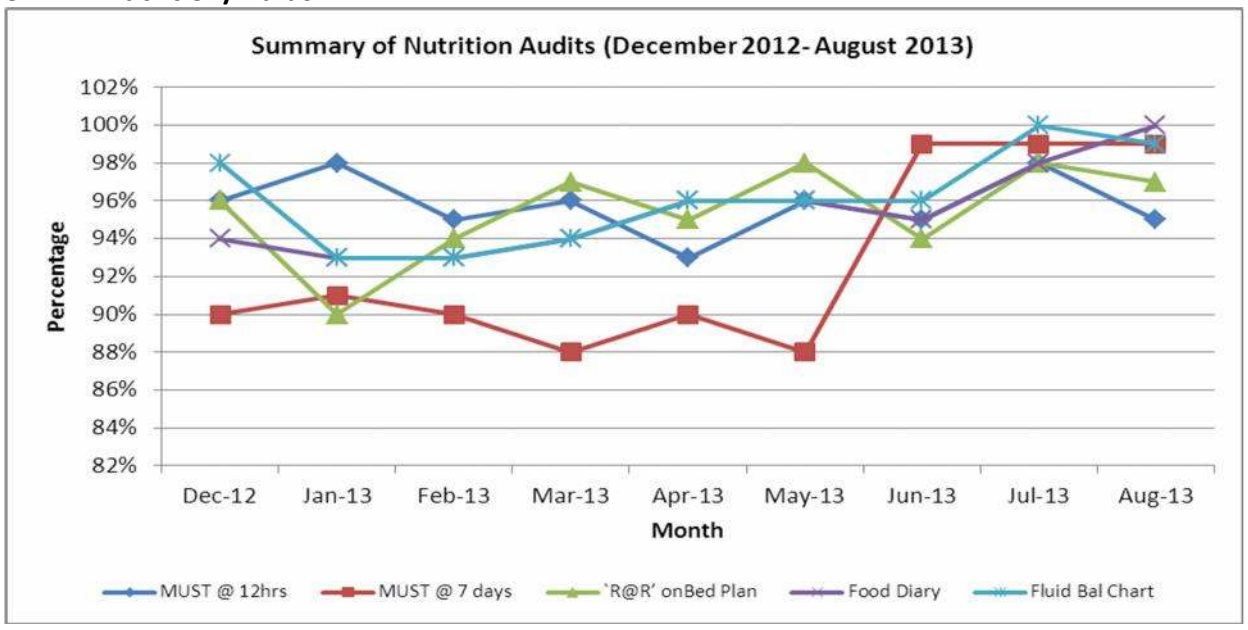


Figure 8: *Nutrition Audit Results*

3.3 Infection Control

The infection control information was not available at the time of writing the report, so the previous data has been left in the report.

MRSA

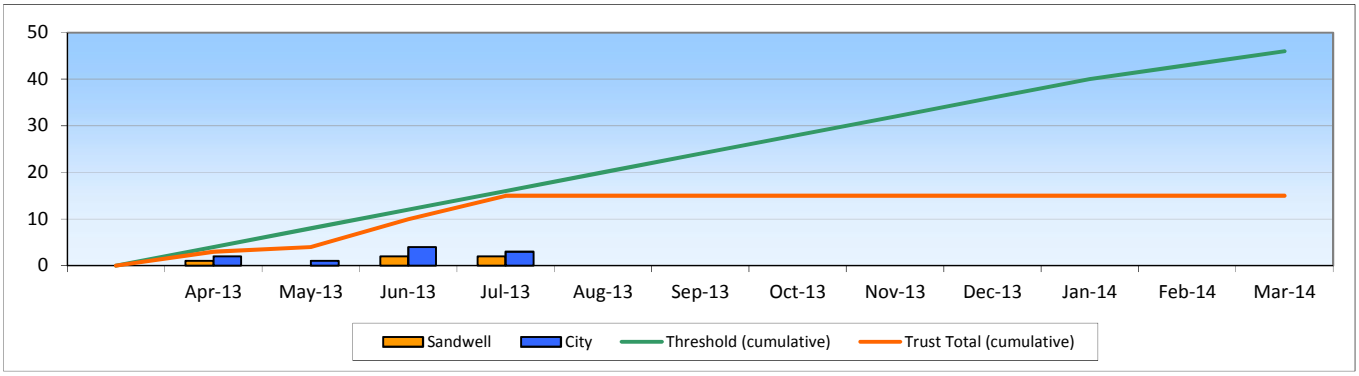
There were no post-48 hour MRSA bacteraemia for August. The total number of MRSA bacteraemia to date is 1.

MRSA Screening

			To Date (*=most recent month)	TARGET	
				YTD	13/14
MRSA Screening - Elective	Patient Not Matched	%	217.1*	86	90
	Best Practice - Patient Matched	%	75.9*	74	80
MRSA Screening - Non Elective	Patient Not Matched	%	87.1*	86	90
	Best Practice - Patient Matched	%	77.3*	74	80

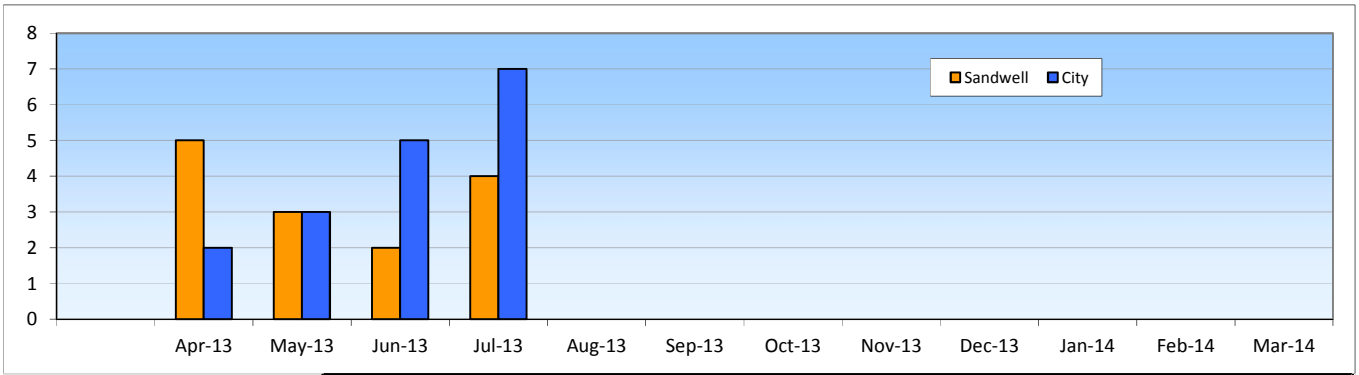
Figure 9: *MRSA screening eligibility*

Clostridium difficile



	2013-2014												
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Sandwell	1	0	2	2									**5**
City	2	1	4	3									**10**
Trust	3	1	6	5	0	0	0	0	0	0	0	0	**15**
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0	**0**
DoH Trajectory	4	4	4	4	4	4	4	4	4	4	3	3	**46**
Trust Total (cumulative)	3	4	10	15	15	15	15	15	15	15	15	15	-
Threshold (cumulative)	4	8	12	16	20	24	28	32	36	40	43	46	-

Figure 10: *SHA Reportable CDI*



	2013-2014												
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Sandwell	5	3	2	4									**14**
City	2	3	5	7									**17**
Trust	7	6	7	11	0	0	0	0	0	0	0	0	**31**
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Trust Total (cumulative)	7	13	20	31	31	31	31	31	31	31	31	31	-

Figure 11: *Trust Best Practice Data*

Blood Contaminants

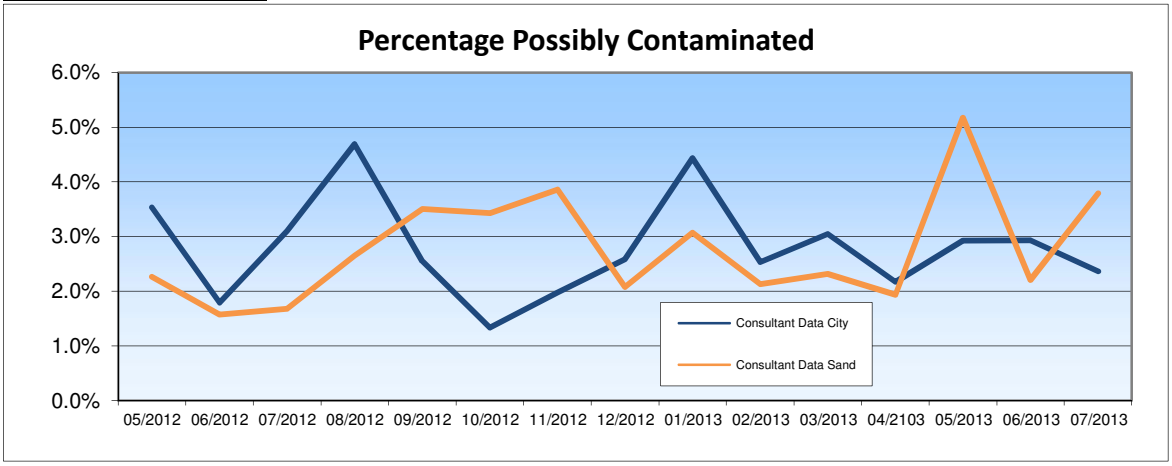


Figure 12 : *Blood Contaminants*

E Coli Bacteraemia

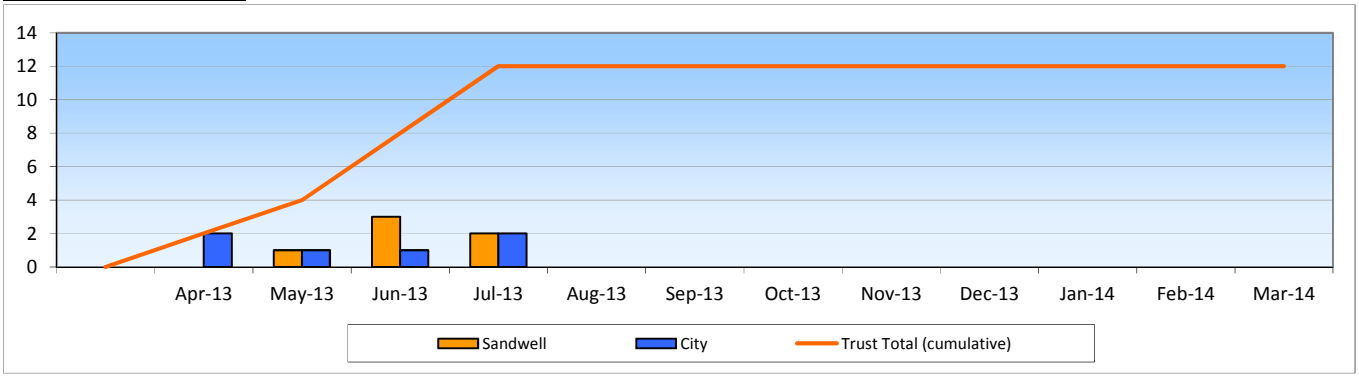


Figure 13: *E Coli Bacteraemia*

MSSA

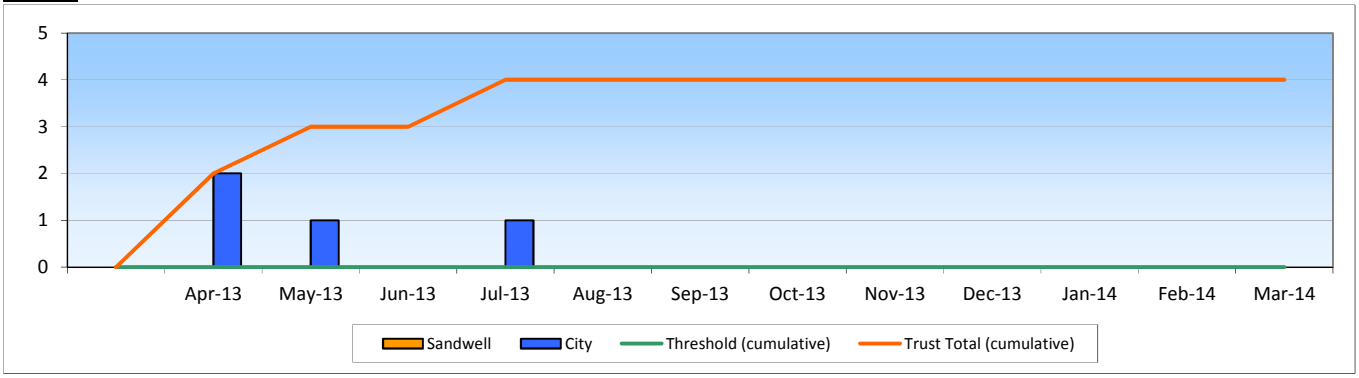


Figure 14: *MSSA*

3.4 Maternity

The Obstetric Dashboard is produced on a monthly basis. The data for August was not available at the time of writing the report. The data below is what was reported the previous month (August Quality Report):

Post-Partum Haemorrhage (PPH)(>2000ml): there were 0 patients recorded to have had a PPH of >2000ml in July.

Adjusted Perinatal Mortality Rate (per 1000 babies): the adjusted perinatal mortality rate for July was 8.0 which was equal to the trajectory (8) but was higher than the previous month (6.0). 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 July was 25.7%, which is just above the trajectory of 25% over the year and slightly higher than the previous month (25.1%).

Delivery Decision Interval (Grade I, CS) >30 mins: the delivery decision interval rate for July was 8% which is below the trajectory (15) and lower than the previous month (11%).

Community Midwife Caseload (bi-monthly): The community midwife caseload in July was 138, which is just below the trajectory of 140 but is higher than the previous month (130).

3.5 Medicine Management (Last updated 25th July)

The 2013/14 CQUINs include safe storage of medicines; the aim is to improve safe storage of medicines in ward areas.

The threshold for improvement is to be agreed following review of the Q1 baseline audit results.
Drug storage audits are being undertaken quarterly across inpatient areas in 2013/14 using a revised audit tool. Nursing and Pharmacy colleagues have developed the audit plan and a process for reviewing audit results. Following review of audit results action plans are being developed to deliver improvements. An improvement trajectory is to be agreed following review of the Q1 audit results.

The Q1 audits have been carried out and data quality checks are being done. The findings of the audits will be available for the next Quality Report and will be presented to the August meeting of the Medicines Safety Group.

3.6 Incidents

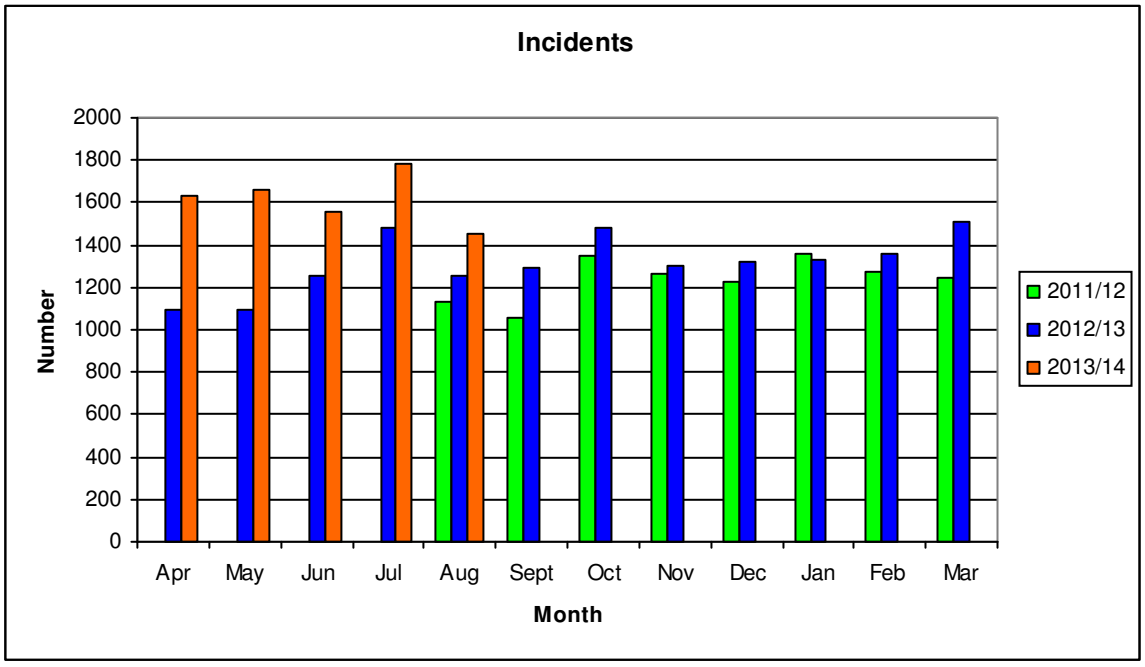


Figure 15: *Incidents*

Incidents in August 2013

Total Number of Incidents reported	**1453**

Of the total: *(* incidents still under investigation)*

Near miss	204
No Harm	812
Low (minimal harm)	366
Moderate	61
Severe (permanent or long term harm)	8
*Death (related to the patient safety incident)	2

"Top 5" Reporters (Acute)

1	Emergency Departments (both)	284
2	Labour ward	47
3	Medical Assessment unit	45
4	Emergency Assessment Unit	37
5	Lyndon 2	33

"Top 3" Reporters (Community)

1	Community Nurses Mesty	20
2	Community Nurses Cross	14
3	Community Nurses Out of hours	13

"Top 5" Type**

1	Verbal abuse (patient on staff)	100
2	Non SWBH pressure sore	53
3	SWBH Pressure sore (comm acquired)	46
4	Communication failure with patient/team	34
5	Lack of suitably trained staff	34

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

3.7 Serious Incidents (SIs)

In **August 2013** there were 5 new SIs reported to CCG. Two were later downgraded (both infections)

1 2013/24551 - Gastroenterology
Anticoagulation drug error

2 2013/24685 – Plastic Surgery
Wrong site surgery – NEVER EVENT

3 2013/25315 – Stroke Services
Incorrect actions taken following Imaging.

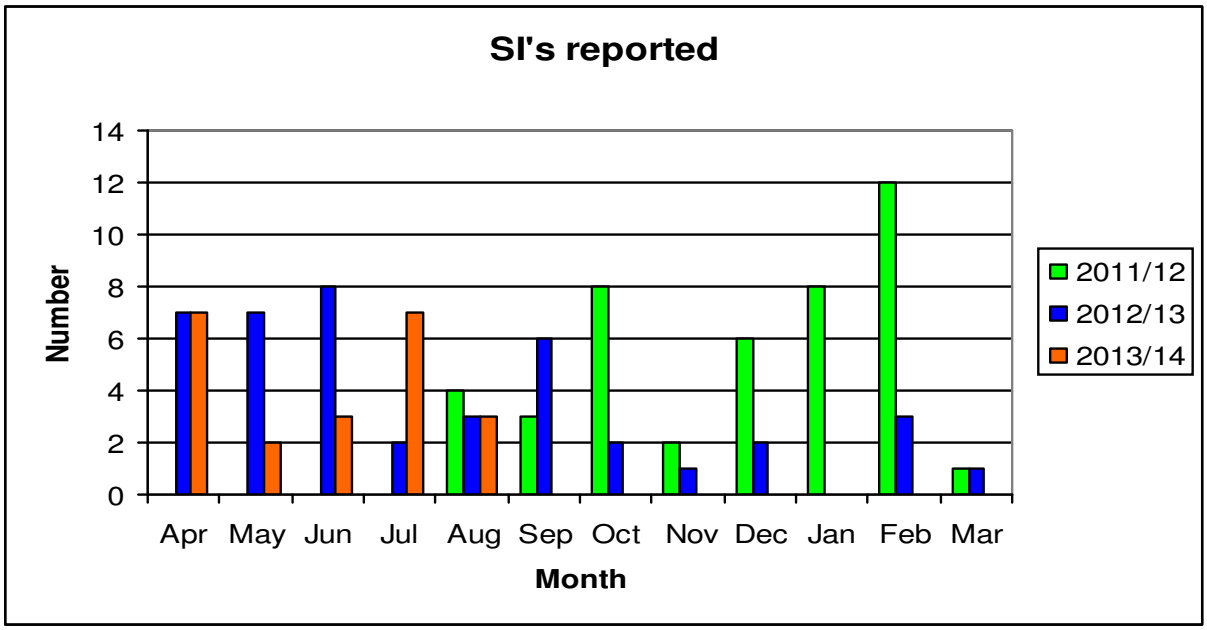


Figure 6: *Serious Incidents*

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

Issue/Risk	Action to take/taken	Who by	When by
Delay in being able to provide themes and trends due to Managers having to input the cause.	Plans being looked at to move the cause of the incident to the "reporters" screen.	Head of Risk	Jan 14

3.8 Patient Safety Walkabouts

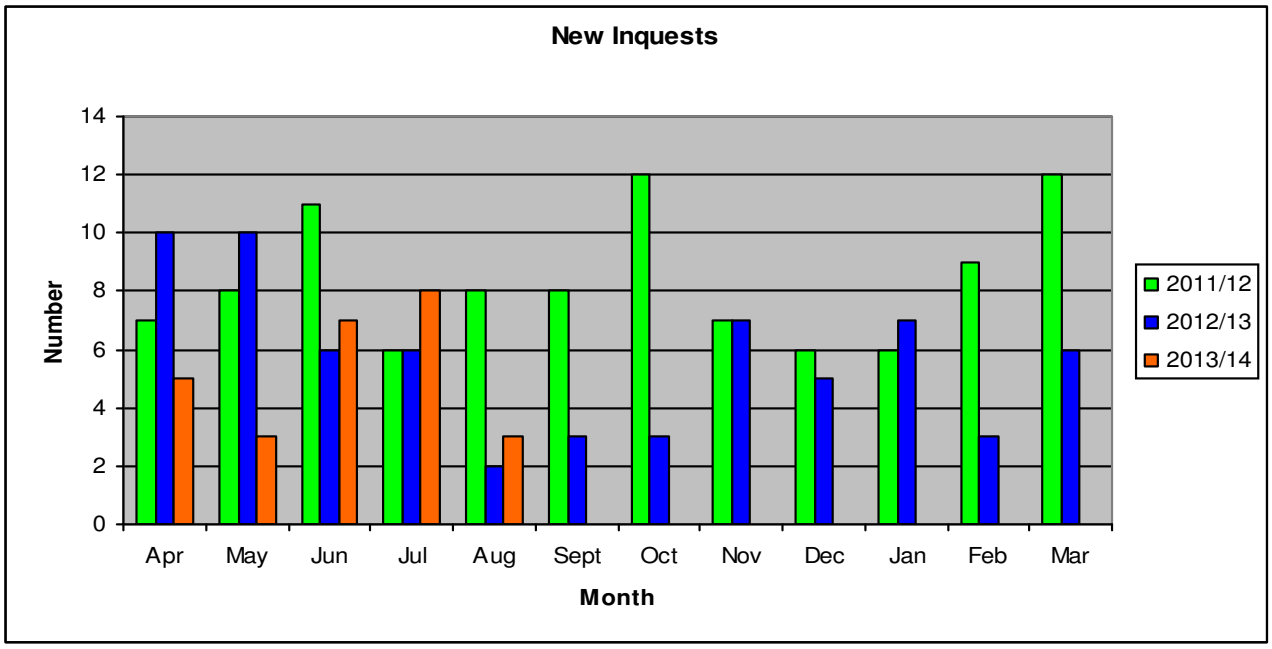
The Patient Safety Walkabouts continue to take place. In August the walkabout to Newton 1 occurred, with the visit to the Imaging area needing to be postponed. Again the visit proved extremely useful experiences for both staff and patients and highlighted some areas of good practice and some which require some action.

Varied points came up from the visit to Newton 1, including the possibility of creating additional storage space for the ward, creation of a discharge lounge, and creation of additional patient information concerning the ward environment.

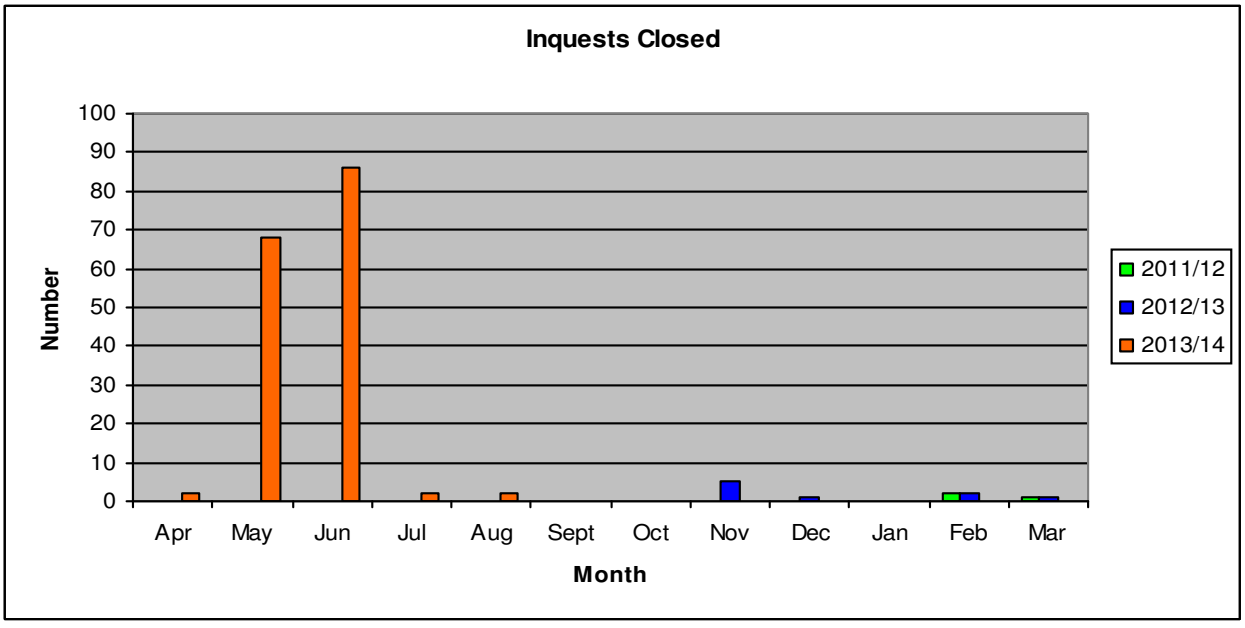
In September two further walkabouts are planned to the Eye Ward and to Maternity. The outcome from these visits will be included in next month's report.

3.9 Inquests

During August 2013 3 new Inquest cases were notified to the Trust.
2 cases were closed during this period following a final Inquest hearing.



During August 2013 **2** cases were closed.

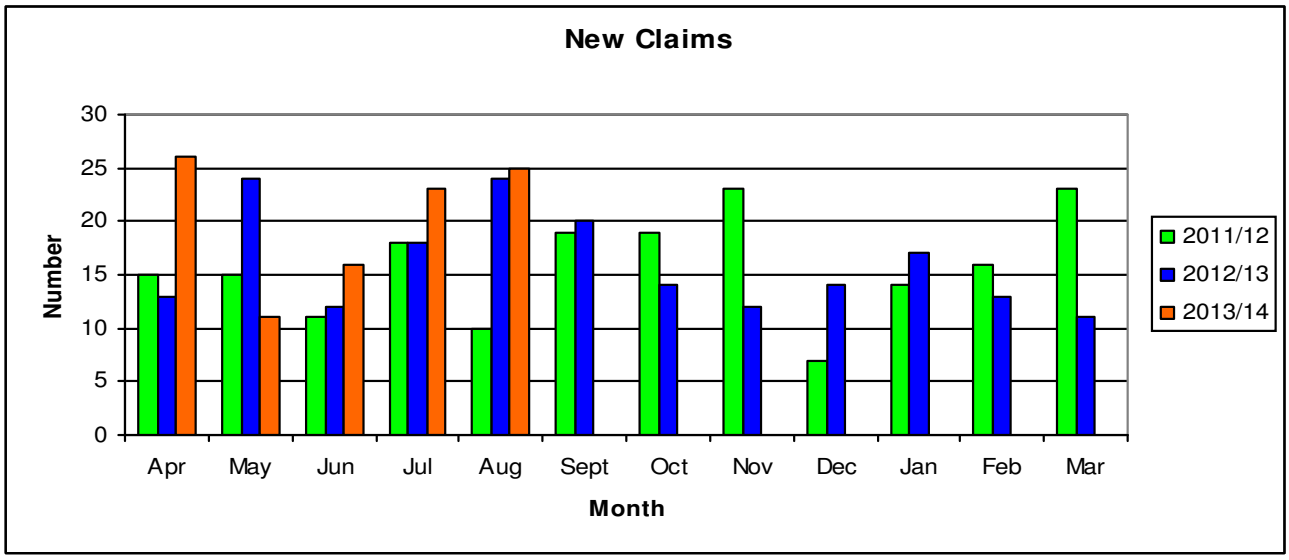


3.10 Claims

There were 25 new claims opened in August 2013.

The claims opened in August consist of 5 employer liability and 20 clinical negligence cases.

4 clinical negligence claims were closed during August 2013.



3.11 Nurse Staffing Levels

Bank & Agency

The Trust's nurse bank/agency rates are detailed 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.

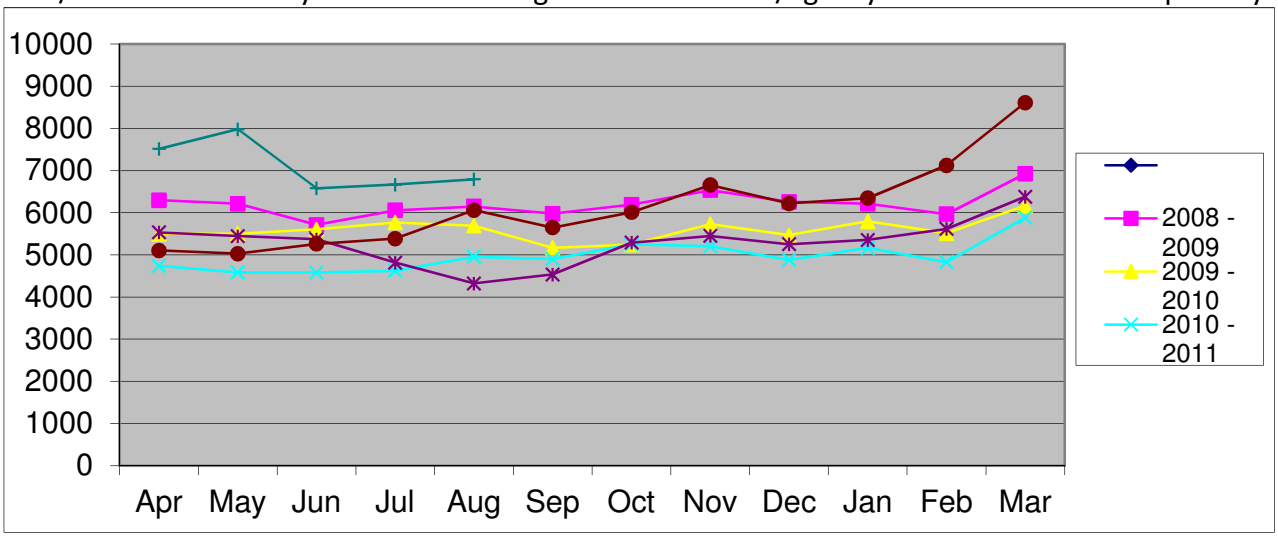


Figure 17: *Total Bank & Agency Use Nursing April 2008 –date.*

4 CLINICAL EFFECTIVENESS

4.1 Mortality

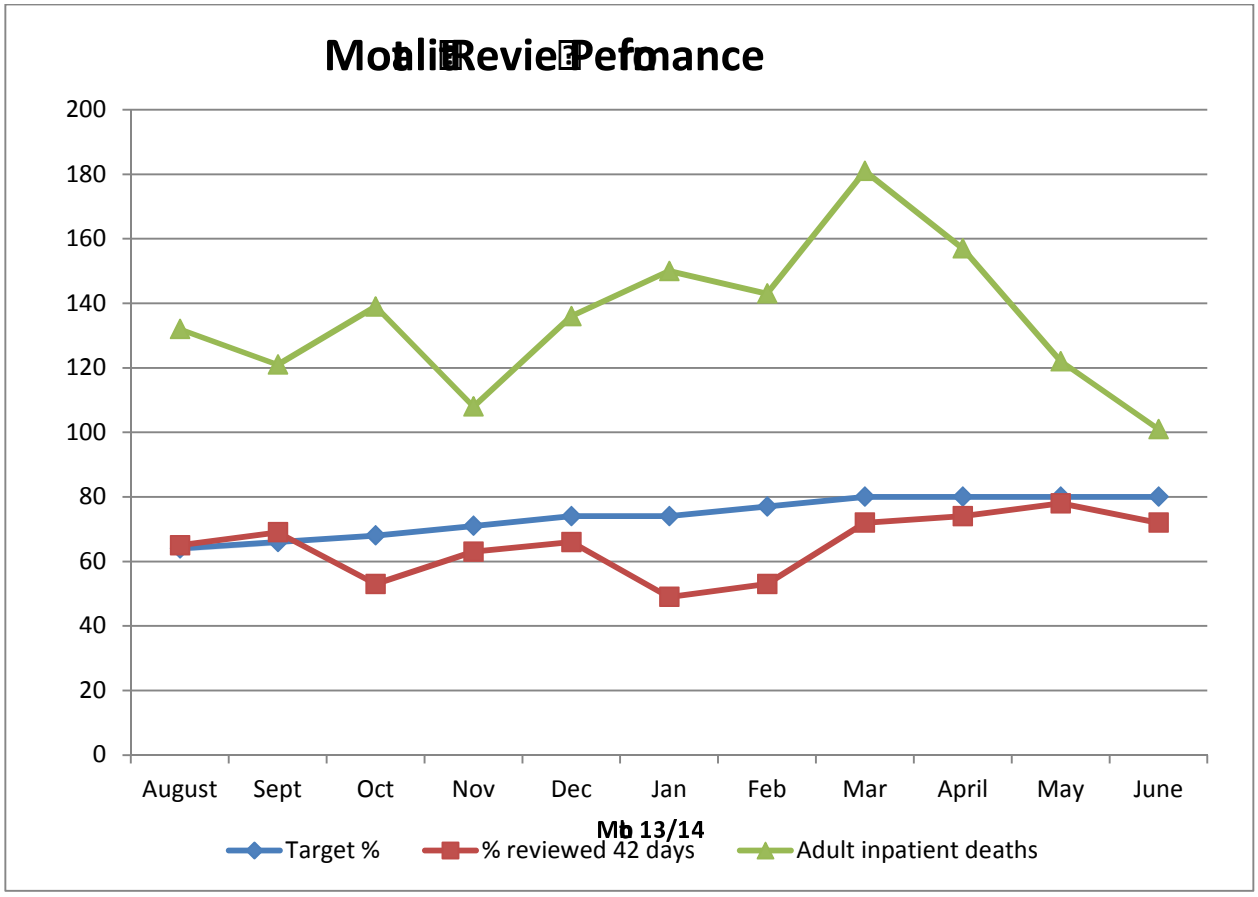
CQUIN Target

As part of the Trust's annual contract agreement with the commissioners the Trust has agreed a CQUIN scheme which requires the Trust to review 80% of adult inpatient deaths within 42 working days. 42 days have to elapse after the end of the reported month so that all deaths which occurred within the month can be included.

During June 2013, which is the most recent month for which complete data is available, the Trust reviewed 72% of deaths compared with a target trajectory for the month of 80%.

Micro management of reviews due has identified several consultants who are not reviewing their allocated patients. This information is being passed to the Group Director to take corrective action.

The Medical Director's Team is producing weekly prompt messages to remind consultants to carry out allocated reviews.



2013/14	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Target	64	66	68	71	74	74	77	80	80	80	80
% reviewed 42 days	65	69	53	63	66	49	53	72	74	78	72
Adult inpatient deaths	132	121	139	108	136	150	143	181	157	122	102

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 (88.4) remains below 100, and is less than the lower statistical confidence limit and continues to remain lower than that of the SHA Peer (97.5). The in-month (May 13) HSMR for the Trust has decreased to 93.9, but remains within statistical confidence limits.

12 month cumulative site specific HSMR's are 77.3 and 100.1 for City and Sandwell respectively, neither of which are currently in excess of upper statistical confidence limits. In month site specific HSMR's are 66.4 and 98.4 for City and Sandwell respectively.

Summary Hospital – Level Mortality Indicator (SHMI)

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

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

The last SHMI data was published on 24/07/13 for the period January 12 – December 12. For this period the Trust has a SHMI value of 0.95 and was categorised in band 2.

- 11 trusts had a SHMI value categorised as 'higher than expected'
- 15 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 for which data is available is 99.2, having gradually risen during the course of the last few months.

Mortality

All Specialties		2012/13						2013/14	
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Trust Data:									
Hospital Deaths	Trust	144	106	140	157	148	179	158	123
	City	54	51	51	64	69	75	64	44
	Sandwell	90	55	89	92	79	104	94	79
Dr Foster 56 HSMR Groups:									
HSMR (Month)	Trust	92.6	65.0	83.2	81.4	102.5	103.7	93.9	82.9
	City	71.8	66.1	62.9	73.9	89.1	85.1	75.1	66.4
	Sandwell	112.6	63.6	103.8	88.3	121.4	124.9	112.0	98.4
HSMR (12 month cumulative)	Trust	92.7	90.5	89.1	87.8	88.1	88.9	89.1	88.4
	City	81.7	79.7	76.6	78.2	77.2	78.1	77.5	77.3
	Sandwell	104.1	101.7	101.9	99.7	99.3	100.2	101.2	100.1
HSMR (Peer SHA 12 month cumulative)		96.7	96.4	97.0	96.7	97	98.0	97.5	97.6
Healthcare Evaluation Data (HED) SHMI (12 month cumulative)		94.9	94.4	94.2	94.3	95.5	95.9	99.2	

CQC Mortality Alerts received in 2013/14

No new mortality outlier alerts have been received.

Dr Foster generated alerts (Quality Investigator Tool)

In the data period July 2012 – June 2013 there were no new diagnoses groups alerting with a significant variation from the benchmark.

National Clinical Audit Supplier – Potential Outlier Alerts

No new potential outlier alerts have been notified.

4.2 Clinical Audit

Clinical Audit Forward Plan 2013/14

The Clinical Audit Forward Plan for 2013/14 contains 79 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 July 2013	Total
0 – Further Information requested	6
1 - Audit not yet due to start	14
2- Significant delay	0
3- Some delay - expected to be completed as planned	13
4- On track - Audit proceeding as planned	37
5- Data collection complete	0
6- Finding presented and action plan being developed	3
7- Action plan developed	5
D- Discontinued	1
Grand Total	79

The status of the audits that have been included in the plan as at the end of August 13 is shown in the table above. No audits have been indicated as experiencing a 'Significant delay'.

4.3 Compliance with the Five Steps to Safer Surgery

Close monitoring of compliance with the WHOCL continues. Performance for June was 99.21% across all areas.

4.4 Stroke care

Performance against the principal stroke care targets was as outlined in the table below at the end of August, this is subject to change following final validation.

Month 2013/14	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
% Spending >= 90% of stay on stroke unit	88.3	96.23	90	95	89.1							
% Admitted to stroke unit within 4 hrs of arrival at hospital	69.35	83	93	91.53	82							
% pts receiving brain imaging in 24 hrs of admission	93.18	90	87	86.5	91.9							
% Pts scanned within 1 hr of arrival at hospital	61.54	68.57	33.3	Not yet available	Not yet available							
% high risk TIA treated within 24 hours	66.67	63.16	83.3	83.3	72							
% low risk TIA treated within 7 days	74.07	88.37	88.24	91.2	92.5							

Figure 22 : *Performance against stroke care targets (data CDA QMF dashboard 10/9/13)*

4.5 Treatment of Fractured Neck of Femur within 24 hours

The Trust has an internal Clinical Quality target whereby 70% of patients with a Fracture Neck of Femur receive an operation within 24 hours of admission. Data for August (Source CDA –QMF Dashboard 10/9/13) indicates 85.7% of patients with a Fractured Neck of Femur received an operation within 24 hours of admission. This is a significant improvement and demonstrates the best performance this financial year. *Internal Priority*

4.6 Ward Reviews

The Ward Review results are not due for reporting this month.

4.7 Quality Audits

The Quality Audits are not due for reporting this month.

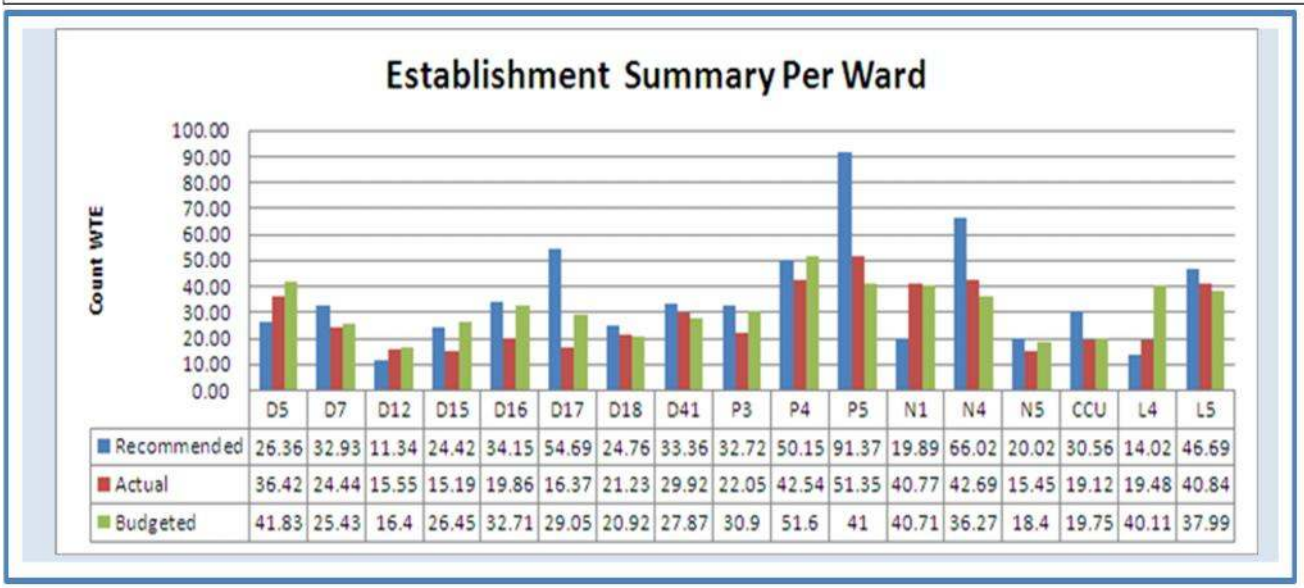
4.8 Ward Clinical Dashboard

	MRSA bacteraemias (post 48 hours) - No	C.Difficile Cases (post 48 hours) - No	MRSA Screening - Elective %	MRSA Screening - Non Elective - %	Hand Hygiene - %	Red Incidents - No	Amber Incidents - No	Falls - Total (Acute) hosp acquired avoidable - No	MUST - within 12 hours of admission - %	MUST - Avoidable Weight Loss - No	Pressure Ulcers - hosp acquired avoidable grade 3 & 4 - No	Safety Thermometer - Harm Free - %	Safety Thermometer - Catheters & UTIs - %	Safety Thermometer - New Harms - %	Complaints - No	Pt Exp - Friends and family recommendation - %	Mandatory Training Rate - %	Sickness Absence - %	PDR Completion Rate - %	Trained Nursing Staff - %
BTC - Adult Surgical Unit	0	0	97		0	0	0	0							0	56	85	7	50	72
CCS - Critical Care Services - City	0	0		100	96	0	0	0				75	0	100	1	97	94	5	81	
Coronary Care Unit - City	0	0	100	90	0	0	0	0							0	72	90	0	69	92
Coronary Care Unit - Sandwell	0	0		96	0	0	0	0				100	0	100	0	84	87	1	81	88
Critical Care - Sandwell	0	0		100	98	0	3	0				100	0	100	1	100	94	5	76	
D12 - Isolation	0	0		50	0	0	0	0	100	0		100	0	100	0	68	90	1	20	67
D15 - Medical	0	1	100	60	0	0	0	1	100	0		100	0	100	0	49	85	2	47	58
D16 - Medical	0	0			96	0	0	5	86	1		95	0	100	0	75	79	7	79	49
D17 - Medical	0	0	100	40	0	0	1	1	100	1		100	0	100	0	0	78	3	85	65
D18 - Medical	0	0		0	98	0	4	3	100	0		100	0	100	0	82	93	0	76	54
D21 - Male Surgery ENT/Urology	0	0	100	96	75	0	1	3	100	0		100	0	100	0	82	95	11	82	56
D25 - Surgical (Female)	0	0	100	55	0	0	4	1	100			100	0	100	0	70	95	1	51	60
D27 - Oncology	0	0	100	100	96	0	0	0	100	0		93	0	93	0	53	88	7	66	69
D30 - Winter pressures	0	0		100	0	0	0	0	100	0		78	0	94	0		0	0	0	
D41 - Medical Short Stay Unit	0	0	77	51	99	0	1	0	100			100	0	100	0	72	94	1	90	81
D7 - Medical	0	0			100	2	1	1	95	0		87	0	95	1	41	80	10	33	45
Day Treatment Unit - Sandwell	0	0	90		0	0	0	0							0	0	83	6	57	
EAU - Sandwell	0	0	100	73	0	0	1	2	0			100	0	100	2	56	82	9	49	72
Henderson	0	0			0	0	0	0	94	0		90	0	90	0	0	0	0	0	
Leasowes	0	0			0	0	0	0							0	0	0	0	0	
Lyndon 2	0	0	83	77	97	0	1	0	85	2		100	0	100	0	58	80	15	63	56
Lyndon 3	0	0	93	100	97	0	2	2	85	0		100	0	100	0	73	87	6	48	57
Lyndon 4	0	0			0	0	0	1	100	0		94	0	100	1	50	86	1	72	54
Lyndon 5	0	0		0	97	0	0	6	73	0		88	0	100	0		87	6	56	49
MAU - Mau Transfer - City	0	0	100	70	0	0	1	2	80			100	0	100	2	33	90	4	77	64
Neonatal Unit - City	0	0			0	0	0	0				100	0	100	0		93	4	81	
Newton 1 Short stay unit	0	0		100	100	0	0	1	100			100	0	100	0		0	0	100	
Newton 2	0	0	96	72	0	0	0	0	100			100	0	100	0	73	87	1	61	62
Newton 3	0	0	75	86	100	0	0	2	95	0		100	0	100	1	61	83	4	26	57
Newton 4 - Stroke rehab	0	0		100	100	0	0	3	100	0		100	0	100	1	100	87	8	92	59
Newton 5	0	0		100	99	0	0	2	100	0		80	0	100	0		89	6	82	74
Ophthalmology Main Ward - City	0	0	94	76	0	0	0	1	100	0		83	0	83	0	86	76	1	25	76
Planned Admissions Unit (D6)	0	0	98		0	0	0	0	100						0	0	96	2	88	75
Post Coronary Care - City	0	0			0	0	0	0	92	0		100	0	100	0	0	0	0	0	
Priory 2	0	0	95	59	98	0	3	1	100	0		85	10	90	0	80	91	0	93	61
Priory 3	0	0			87	0	1	5	100	4		100	0	100	0	100	80	8	33	50
Priory 4 - acute stroke unit	0	0		94	99	0	1	3	100	0		96	0	96	1	65	90	6	78	80
Priory 5	0	0	66	33	97	0	13	3	100	0		90	0	100	0	46	80	2	85	51
Surgical Assesment Unit (D42) - City	0	0		93	0	0	1	0	100						0	69	96	4	90	73

NB – Data feeds remain problematic to this dashboard, eg FFT results not showing this month. We are working with IT to resolve.

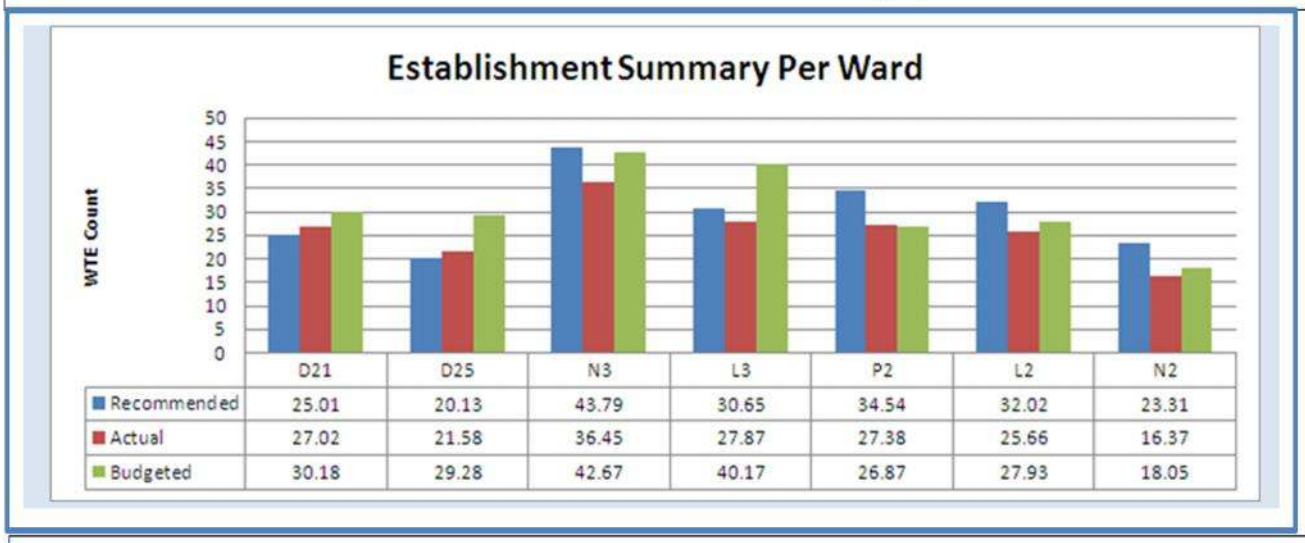
4.9 BRAD/SNCT (acute) Staff

Medicine



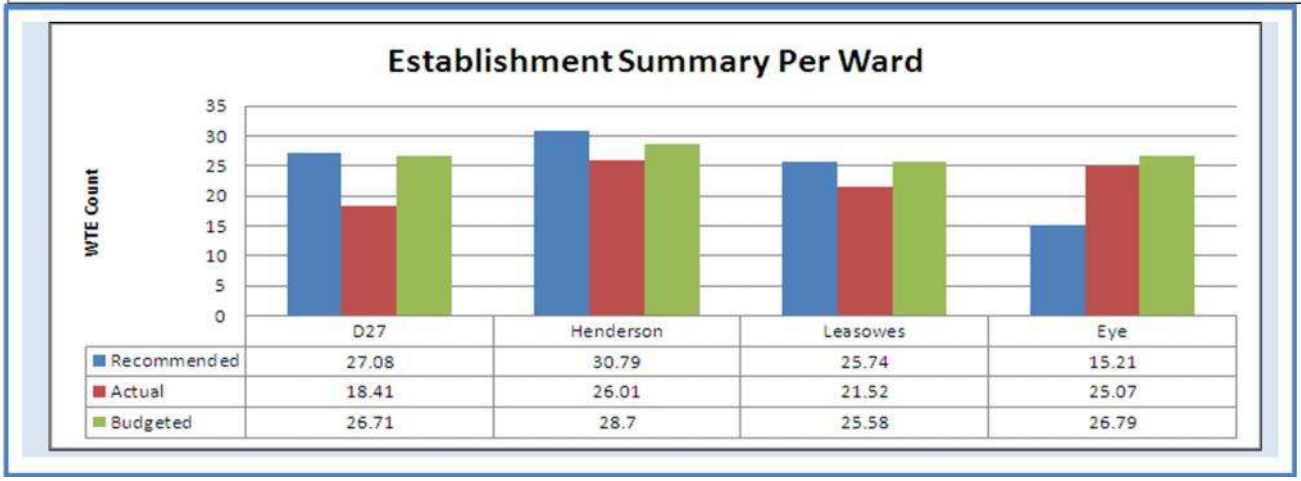
	D5	D7	D12	D15	D16	D17	D18	D41	P3	P4	P5	N1	N4	N5	CCU	L4	L5
Recommended	26.36	32.93	11.34	24.42	34.15	54.69	24.76	33.36	32.72	50.15	91.37	19.89	66.02	20.02	30.56	14.02	46.69
Actual	36.42	24.44	15.55	15.19	19.86	16.37	21.23	29.92	22.05	42.54	51.35	40.77	42.69	15.45	19.12	19.48	40.84
Budgeted	41.83	25.43	16.4	26.45	32.71	29.05	20.92	27.87	30.9	51.6	41	40.71	36.27	18.4	19.75	40.11	37.99

Surgery



	D21	D25	N3	L3	P2	L2	N2
Recommended	25.01	20.13	43.79	30.65	34.54	32.02	23.31
Actual	27.02	21.58	36.45	27.87	27.38	25.66	16.37
Budgeted	30.18	29.28	42.67	40.17	26.87	27.93	18.05

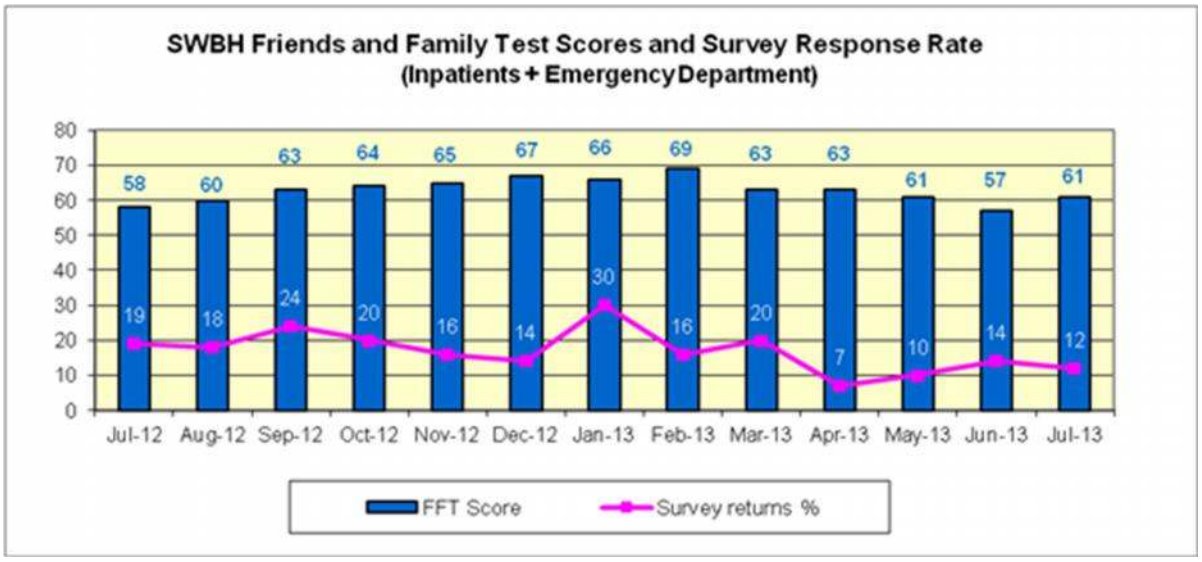
Misc

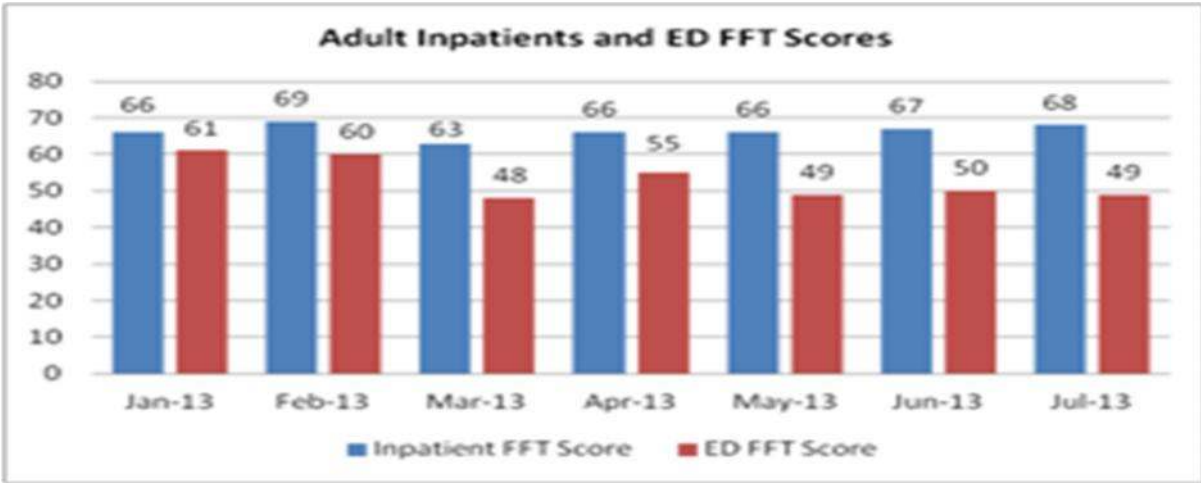


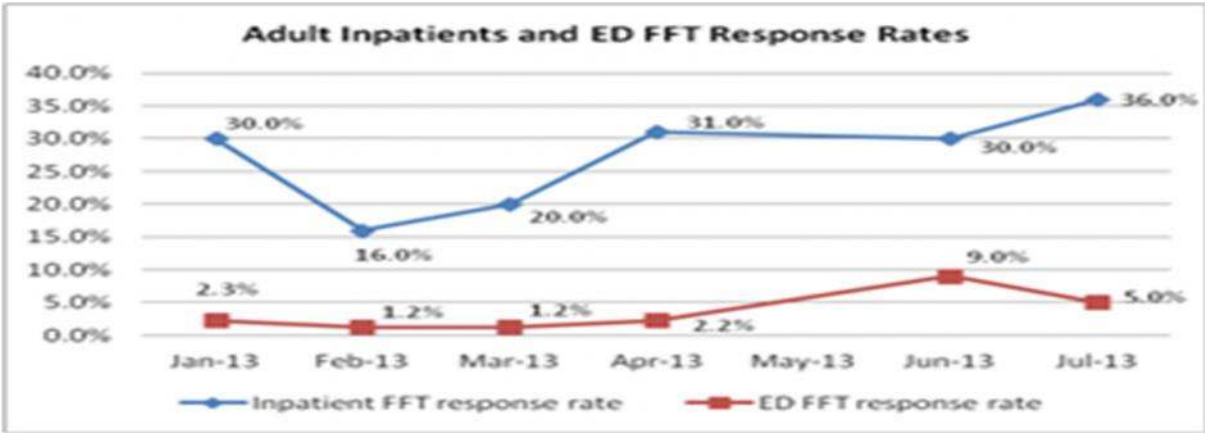
	D27	Henderson	Leasowes	Eye
Recommended	27.08	30.79	25.74	15.21
Actual	18.41	26.01	21.52	25.07
Budgeted	26.71	28.7	25.58	26.79

5 PATIENT EXPERIENCE

5.1 Net Promoter



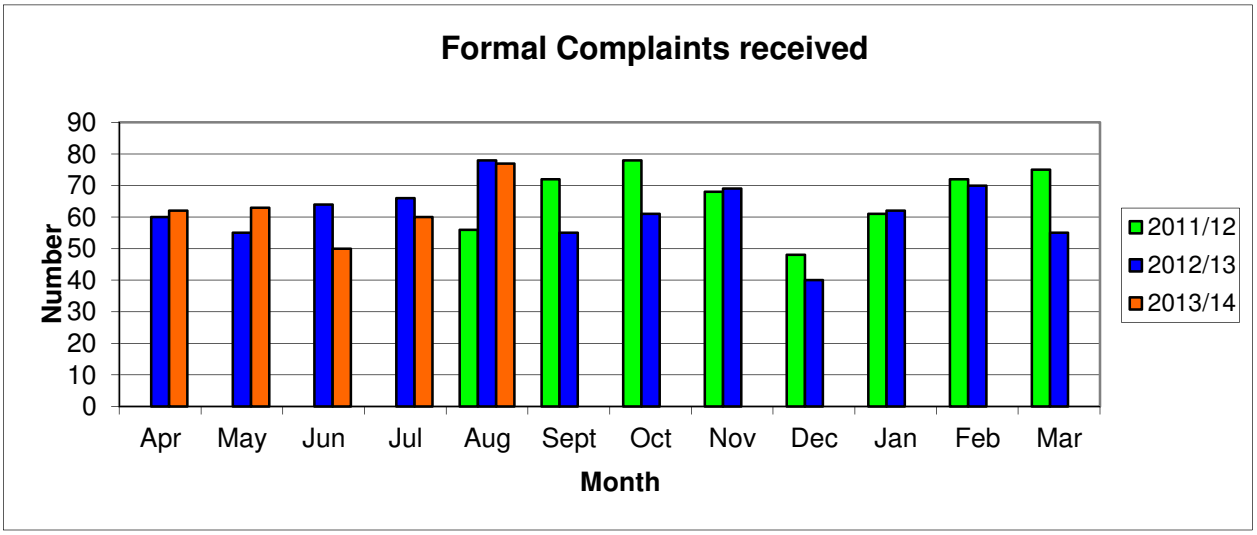


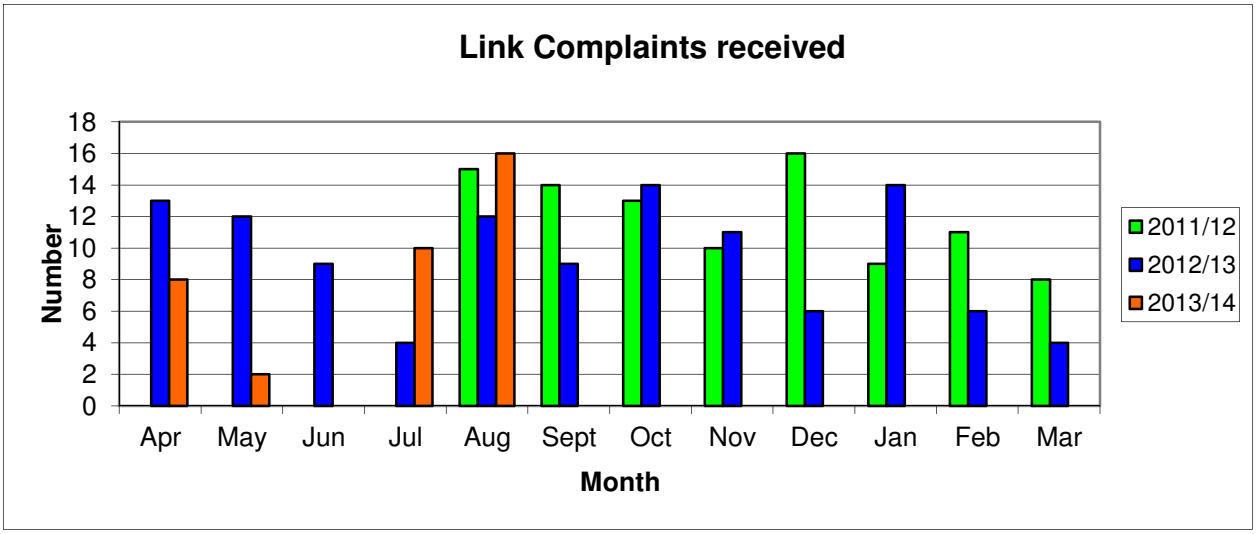


Groups	FFT Score	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know	Score Movement
Medicine and EC	61	600	388	168	22	6	4	12	↓
Surgery and CC	75	534	415	97	10	6	2	4	↑
Surg B	87	38	33	5	0	0	0	0	↓
W & CH	54	13	9	2	2	0	0	0	↓

Figure 23: *Net Promoter position & Friends and Family Test*

5.2 Complaints





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

Complaints data

Context

The total formal and link complaints received requiring a response in August 2013 (n =93) has risen significantly when compared with July 2013 (n = 70).

August 2013 shows a similar number of formal complaints received when compared with the same month last year (n = 78). There was a slight increase in link cases.

Categorisation

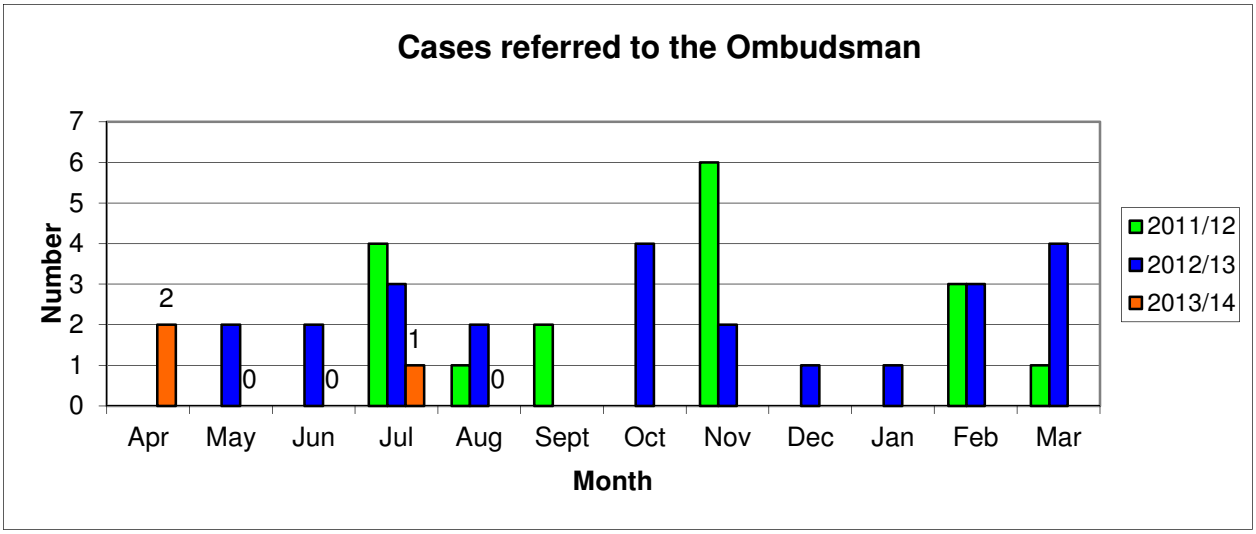
The 77 formal complaints received in August 2013 were graded as follows:

Red	0	Amber	8	Yellow	40	Green	29

Themes
The top 5 themes are: • Attitude of staff (n = 17) • Dissatisfied with Medical treatment (n = 15) • Dissatisfied with Nursing care (n = 8) • Long wait for treatment or medication (n=8) • Other treatment issues (n = 8)

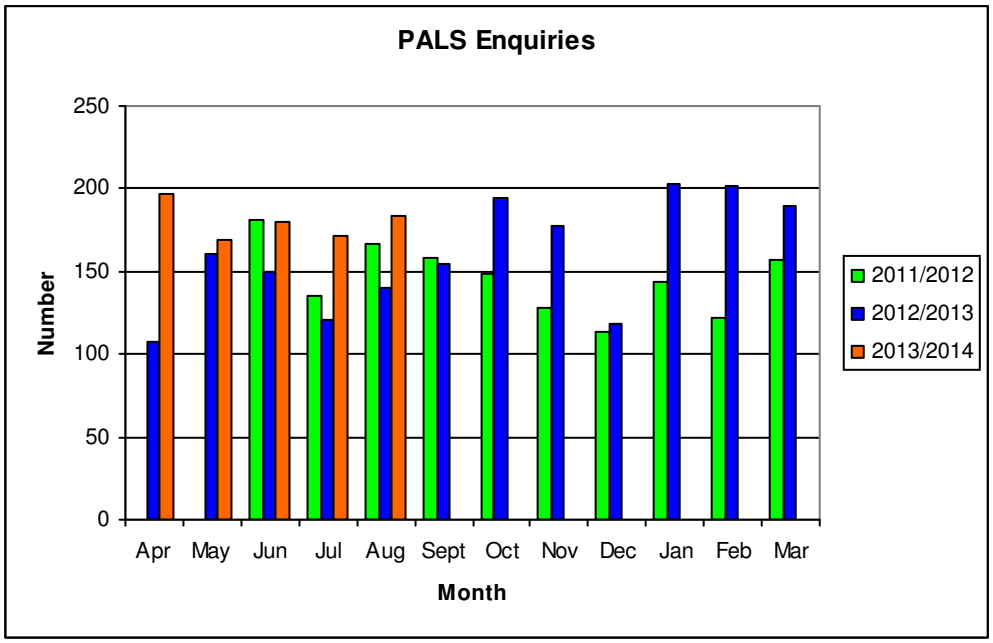
Learning
The complaints received in August are in the process of being investigated. Three complaints received in August, were closed within the month. Learning from complaints closed in July/August include: • Staff members have been provided with further training in relation to customer care focussed approached, and have reflected on how attitudes can be perceived. • The Emergency Department team are providing additional training to ensure staff members are aware of the care pathway for missed fractures, and the procedures for ensuring that patients, carers and GPs are informed quickly. • Birmingham Treatment Centre has removed trays from the reception desks which collected appointment letters, to assist in ensuring patient's confidentiality and privacy is maintained.

5.3 Parliamentary and Health Service Ombudsman (PHSO)



The Trust currently has 4 active cases with the PHSO

5.4 PALS



PALS comparative data

Chart

Total PALS enquiries received in August 2013 (n=183) have increased when compared to July 2013 (n=172) There were 6 PALS cases related to the community.

August 2013 shows a significant increase compared with the same month last year (n = 140). However, the Patient Support Centre also deals with general enquiries and these were significantly increased (2012/13 n = 246 compared with 2013/14 n = 343).

Themes
The top 5 themes are: ▪ Issues relating to clinical treatment ▪ Cancellation of appointments, mainly relating to cancellation, delays and notification of appointments. ▪ Issues relating to the request for formal complaints advice. ▪ Lack of communication, mainly with relatives. ▪ General enquiry issues, mainly relating to general advice and information.

Learning
In August 2013, PALS have investigated concerns and have assisted with a number of initiatives to improve the patient experience including: ▪ Patient contacted chiropody department as she had not received a follow-up appointment having received new insoles. On contact with the department she was informed that she had been discharged. The patient was not satisfied with this as she had not been informed. On investigation into the issue, the patients concerns were raised with the Head of service and PALS were informed that there had been a misunderstanding, and that a review appointment would be allocated to the patient. ▪ Patients relative contacted PALS regarding concerns regarding his father having 3 falls in 3 weeks. He felt that his father was not being given enough care and attention. On contact with Henderson Ward, Matron requested that the Ward Manager contacted the patient the same day the relative had raised concerns and provided the option of meeting face to face. Feedback provided and explained to the patient's relative the measures that had been put in place to reduce the risk of the patient falling, including a chair sensor. As patient suffers with Parkinsons Dementia he has very little ability to balance and can fall very quickly. Other special measures had been taken to reduce the patient falling.

5.5 End of Life

End of Life Report

The number of patients achieving their preferred place of care/death irrespective if they were on the SCP for July was **66%.**

6 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:	**Klebsiella Outbreak – Briefing Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Linda Pascall, Interim Chief Nurse**
AUTHOR:	**Linda Pascall, Interim Chief Nurse**
DATE OF MEETING:	**26th September 2013**

EXECUTIVE SUMMARY:

This report has been compiled as a briefing for the Trust Board with regard to the increased detection of ESBL Klebsiella pneumonia (KP) organism in wards and Operating theatre at Sandwell Hospital (SGH).

REPORT RECOMMENDATION:

The Trust Board is asked to note the report.

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

Accept	Approve the recommendation	Discuss
		x

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

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

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

Safe, effective care

PREVIOUS CONSIDERATION:

None.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	*Klebsiella Outbreak – Briefing Update*
Meeting	*Trust Board*
Author	*Linda Pascall, Interim Chief Nurse*
Date	*26th September 2013*

1) Introduction

This report has been compiled as a briefing for the Trust Board with regard to the increased detection of ESBL Klebsiella pneumonia (KP) organism in wards and Operating theatres at Sandwell Hospital (SGH).

2) Background

ESBL Klebsiella pneumonia [KP] is a multi-resistant organism. This is not an organism that patients are routinely screened for however as part of routine surveillance of clinical specimens and surgical site surveillance it was noted by the Trust Microbiologists that there had been an increase in infections following both total hip and total knee joint replacements. Review of these cases revealed that following revision of the joint for infections due to a different organism (mainly *staphylococcus aureus*), infection due to KP was subsequently diagnosed in these patients. It must be noted that this organism was not found to be a deep infection in the majority of patients, but isolated from urine samples taken for diagnosis of urinary tract infection. Typing of all isolates revealed then to be the same strain, unique to the Trust. To date, a total of 7 Orthopaedic patients have been found to carry the same strain of KP.

A timeline has been produced and commonalities looked for.

Although Theatres staff were initially thought to be a commonality due to the limited staff available for this type of surgery, this has not proven to be the case. Six of the 7 patients had been to Theatre prior to isolation of the KP.

All 7 patients had been on Newton 3 for most or part of their hospital stay, raising concerns that environment could be a contributing factor.

The concern of the Microbiologists was escalated to the Director of Infection Prevention Control (DIPC) and an investigation was undertaken of the wards and theatre by the Infection Prevention & Control Service team. This involved a detailed examination of the cases concerned using a root course analysis approach, a thorough scoping of the environment and a review of clinical practice.

3) Investigations and Actions

The immediate action of temporary closure of Theatres for the deep clean also allowed the completion of some minor estates work.

Meetings continue to be held with Public Health England and the CCG and the following contributory factors have been considered:

i) Theatres - one case had never been to theatres and cases have continued to be detected following a deep clean and use of HPV hydrogen peroxide vapour). This has largely been discounted as a source of infection. However, there are still several environmental issues identified in the Theatres which are of significant concern, compounded by significant poor practice in relation to compliance with very basic infection prevention and control.

   The Clinical Group Management team took ownership of the immediate action which involved:

   - Complete review of all theatre storage - Funding secured to improve this
   - De-clutter male and female changing rooms and remove store items.
   - Daily cleaning schedule introduced to all areas of theatres
   - Reintroduction of the red line for infection prevention and control practice; at that point a large poster with a must do list, i.e. bare below elbow, carry out hand hygiene, removed jewellery, wear PPE (personal protective equipment), etc was put up in theatres.

ii) Environment as a whole - it remains a concern that the fabric of Sandwell Hospital may predispose to harbouring organisms despite rigorous cleaning and use of HPV. Theatres, Newton 3 and Lyndon 3 have all been deep cleaned and HPV used. Environmental issues are being addressed by the Director of Estates in collaboration with the Clinical Group.

iii) Community - it is possible that this KP is a community strain that some patients are colonised with; however it is evident that cross transmission has occurred within the hospital setting.

iv) Hydration - many of these patients were catheterised and infection prevention and control are working with the anaesthetic and orthopaedic teams to look at catheter care and hydration.

v) Most of these patients had more than two moves to different wards whilst in hospital. The external agencies felt that reducing these multiple moves may help to reduce the transmission of infection.

Actions to date (an action plan is available for all actions)

- Regular teaching sessions on the wards by infection prevention and control
- An unannounced visit to theatres by the Lead Infection Control Nurse and Group Director of Nursing; this showed that both practice and environment had improved but there were still improvements to be made
- Observational audits are being undertaken by the orthopaedic team to look at practice both in theatres and on the wards.
- Discussion has been held regarding the use of "yellow" and "red" cards for all trust staff not complying with Trust infection prevention and control policy with escalation to the Chief Nurse, Group Director of Surgery Anaesthetics and Critical Care and Medical Director when a red card is issued as appropriate.

- Clinical group ownership of infection prevention and control practices and surgical site surveillance. This has improved significantly but there remains the need for further work on this, with the support of the infection prevention and control team.

4) Summary

Thorough investigations have not revealed one specific root cause, with this outbreak considered to be multi-factorial. However, both environment and practices throughout Theatres and T&O remain major contributory factors; these are under constant review and on-going monitoring is in place.

Funding has been secured to undertake the key environmental work required which requires closing the department for two weeks and this is currently being negotiated to ensure minimum disruption to activity.

The review of Theatre practice identified some very fundamental cultural issues - not simply related to poor infection prevention and control practice but poor team working and a lack of mutual respect between the different groups of staff working in the area. The clinical group recognise this is a vital issue to be addressed and have undertaken some action towards improving the way in which the team work. They have strengthened local clinical leadership and the Group Director of Nursing is directly supporting the Theatre Matron and Group Clinical lead in the turnaround work. Funding has also been secured for facilitated support to work through the cultural issue with the team.

The action plan in place has been supported and monitored by key members of the Executive Group: Interim Chief Nurse, Medical Director, Director of Estates and Chief Operating Officer.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Update on a review of Readmission rates**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Rachel Barlow – Chief Operating Officer**
DATE OF MEETING:	**26 September 2013**

EXECUTIVE SUMMARY:

The Trust Readmission Taskforce has been established to review the high readmission rate and determine work to reduce readmissions.

The attached paper reports progress on:

- Continuation of the diagnostic work
- Developing alert and risk predictor tool for readmissions
- Developing speciality level pathways and discharge bundles

This work is complex and challenging. There are various methods of calculating readmissions rates. The taskforce has established a data set following CQC definitions. The themes identified include:

- Elective readmissions - same both sites and on a par with national
- Emergency readmissions - high but particularly high at Sandwell for some diagnosis codes.
- Top specialties Cardiac, Respiratory, Elderly Care and Acute Medicine.
- Analysis shows there appears to be close correlation between mortality and readmission rates, for these particular specialties, typically the rate of readmission increasing towards the end of life.

Initiatives to reduce readmission rates include:

- Ambulatory care pathways
- Enabling earlier specials input for high risk readmissions through an alert system
- Implementing innovations to predict of risk of readmission
- Discharge bundles including case management with community support for discharge
- Better provision of community based outpatient antibiotic and diuretic services
- Clinical pathway redesign

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

Readmission rates are reported within the Trust's corporate performance dashboard

PREVIOUS CONSIDERATION:

Quality and Safety Committee on 20 September 2013

BRIEFING PAPER ON THE REVIEW OF RE-ADMISSION RATES FOR SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to Trust Board – 26 September 2013

1. Key themes

The Trust Readmission Taskforce has been established to review the high readmission rate and determine work to reduce readmissions.

The themes below reflect analysis of readmission rates within 30 days of discharge in 2012 for a 12 month period:

- Elective readmissions - same both sites and on a par with national
- Emergency readmissions - are high but particularly high at Sandwell for some diagnosis codes. Over all Trust readmission rate within 30 days of discharge is 11.27%, City 9.31 % and Sandwell 14.66 %.
- Top specialties Cardiac, Respiratory, Elderly Care and Acute Medicine.
- Analysis shows that there appears to be close correlation between activity and readmission rates, for these particular specialties, typically the rate of readmission increasing towards the end of life.
- Readmissions to hospital are higher Monday – Friday
- Source of readmissions is from home place of residence and closer variance in residents to nursing homes.
- Readmission following a elective admission for the top 30 Conditions for Patients over the age of 65 years show that 50% of patients readmitted are above 80 years old and 25 % specifically between 81 -85 years old.

The Readmission Taskforce has work has related those specialties and diagnosis codes with the highest rates of readmission cardiology, respiratory, elderly care and acute medicine.

The work of the taskforce has been centred on the following areas:

- Continuation of the diagnostic work
- Develop alert and risk predictor for readmission
- Develop specialty level pathways and discharge bundles

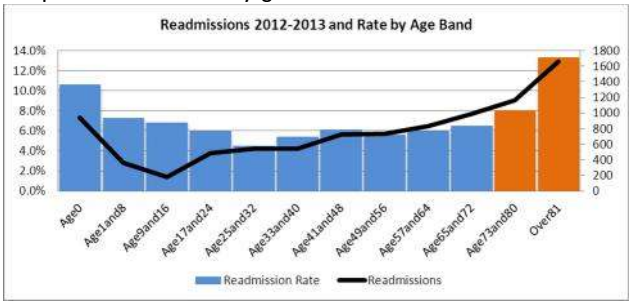
2. Reducing readmissions

a) Continuation of the diagnostic work on the data.

The work is complex and integration of the data, initially raises more areas of analysis to reason the background of the readmission rates, rather than evidence single cause answers.

Patient Age

Graph 2.1 shows readmissions by age band for 2012-2013.



Graph 1.1

The size of the bar represents the proportion of readmissions against the number of admissions in this age band.

21.4% of readmissions are for the over 73 year olds.

A disproportionate amount are in the group over 81 and 0 ages

Number of Previous A&E Attendances

Graph 2.2 shows number of previous A&E attendances within 6 months of all readmissions.

Graph 1.2

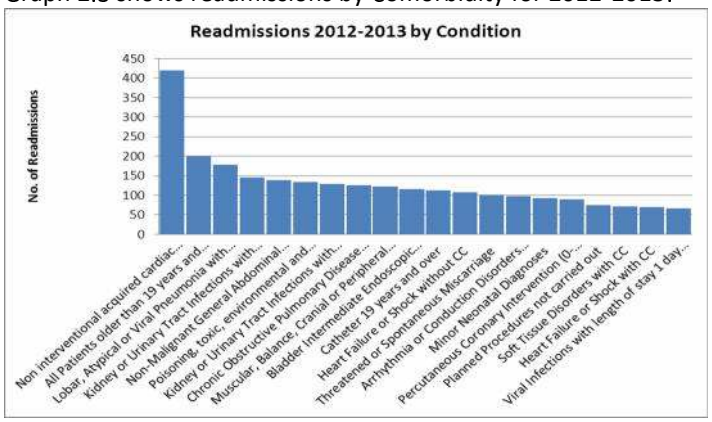
The size of the bar represents the proportion of readmissions against the number of A&E visits that patient has had within 6 months prior to their initial spell.

Over 1/2 (59%) of readmissions have 2 or more A&E attendances within 6 months prior to their spell.

The line indicates number of A&E patients with (x) number of visits and should be viewed against RHS axis.

Co-morbidit

Graph 2.3 shows readmissions by Comorbidity for 2012-2013.

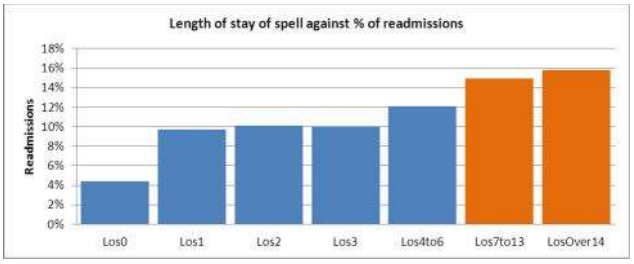


Graph 1.3

Certain conditions occur frequently across all readmissions.

Length of Sta

Graph 2.4 shows readmissions by length of Stay for 2012-2013.



Graph 1.4

The size of the bar represents the proportion of readmissions against number of admissions at this Length of Stay.

It can be seen that as the length of stay increases for a spell so does its potential for readmissions against the number of admissions at that spell length.

The cumulative analysis of the above suggests that a patient with a number of recent A&E attendances, High Length of stay of certain ages and/or presenting with certain conditions have a high potential to readmit. The LACE Tool, Krielkamp et al, Ontario uses these type of conditions L (length of stay) A (acuity of admission) C (Comorbidity) E (number of previous emergency attendances) to predict a patients likelihood of readmission by scoring their Spell (previous and current). This informs a key development of an electronic predictor tool to reduce readmissions (see section 2b).

At specialty level, the initial work has been on the highest readmission diagnostic codes with the highest patient volume; COPD, bronchiectasis, non-specific chest pain and heart failure. Interestingly these do not necessarily demonstrate significant variance in readmission rates between sites. The initiates to reduce these specialty and diagnostic specific readmissions are summarised in section 2.c.

Further detailed analysis is required at specialty level to determine the underlying cause of site variances for other diagnostic codes; a specification for this audit will be signed off by the Taskforce by end September. Over the next 2 months analysis continues of the highest and most frequent readmissions groups retrospectively, as well as the diagnostic groups with the significant variances between sites but with a lesser volume of patients.

In the moderate term during Quarter 3, a Readmission Quality Assurance Committee will be established along the same lines as the Trust Mortality Quality Assurance Committee (MQAC) , to review all readmissions with a predicted high risk of readmission*. Criteria of discharge planning for high risk groups for readmission will be established and evaluated. (*see section 2b re development of risk predictor tool).

b) Developing alert systems and risk predictor tool for readmissions

During Quarter 3, two electronic initiatives will be implemented; i) an electronic alert system to alert consultant teams of readmitted patients and ii) an electronic risk predictor tool

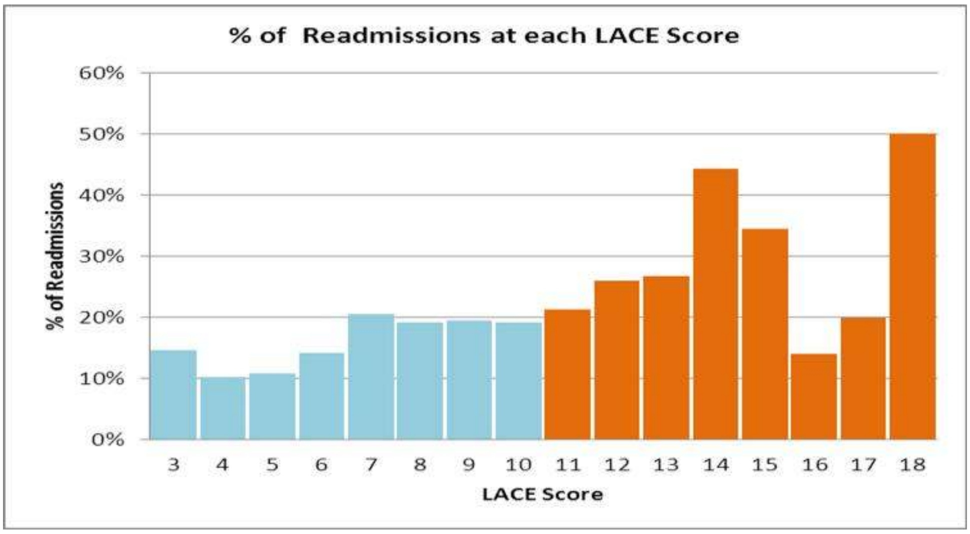
i) An electronic alert system to alert consultant teams of readmitted patients

Building on the successes of electronic admission alert systems in cancer, the taskforce is developing an electronic email alert system to consultant teams to alert them of readmissions following discharge from their care. This does not directly reduce the need for readmission, but does facilitate earlier specialist senior led review and assessment of those re-admitted for non-elective hospital care.

Initial roll out will include respiratory and cardiology.

ii) Electronic risk predictor tool

Using a weighted scoring system, the components of LACE predict the likelihood of readmission. The higher the score the higher the chances of readmission:



Graph 2.5 shows readmissions as a % of all emergency admissions at a specific LACE score. So in the case of score 18, out of 42 admissions, 21 resulted in readmissions 50%.

The impact of using the predictive tool is difficult to assess. Eliminating LACE scores above 11 would reduce readmissions by 1%.

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c) Developing specialit level pathas a nd discharge budles
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- Develop pathways and case to expand for CT angiography (to prevent admission for invasive diagnostics)
- Out patient diuretic service has commenced in September

Care of Elderly:
A review of the clinical service model for elderly care is in train. External visit from Elderly Care specialists within the DH Emergency Care Intensive Support Team on 20th September will validate and further advice on the clinical model as part of the redesign under the Winter 2013 programme.

Acute Medicine:
Current focus is on implementation of ambulatory pathways, the first phase of implementation in September relates to the high readmission diagnostic codes.

Modelling of the 49 ambulatory pathways with full implementation suggests an impact of 1% reduction in readmission.

3. Conclusion and next steps

The review of readmission is a complex and challenging area for work. There are many ways in which readmissions are measured, covering periods of time. A comprehensive data set has been established. Initial analysis has demanded more questions than perhaps providing the definitive answers, but has established some key themes for work.

The key themes have informed development of an electronic alert system and risk predictive tool, which will be implemented in Quarter 3. The clinical response process established these alerts and predictive tools, will sit locally at specialty level, will be supported by the TSO for rapid implementation.

At specialty level, the Clinical Directors are accountable for work plans to deliver initiatives to reduce readmissions. Some of these are rapid implementation e.g. IV diuretic services already established, weekend consultant review of discharges. Other initiatives will require more significant service planning and will take longer. The delivery of local specialty plans will be monitored through Clinical Group governance and the Readmission Task force.

A follow up report will be submitted to Quality and Safety in November 2013.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Never Event review
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Allison Binns, Assistant Director of Governance
DATE OF MEETING:	26 September 2013

EXECUTIVE SUMMARY:

This report sets out details of the never events which have occurred at the Trust since 2009, the key controls put in place and the mechanisms by which these can be monitored.

An assurance check on these controls was undertaken and an overview of the level of assurance provided from the results.

The assurance levels are variable across specialties and further work is required to strengthen and sustain mechanisms already put in place and review whether additional controls are required.

Greater emphasis will be placed on sharing learning from never events across other clinical specialties.

REPORT RECOMMENDATION:

The Committee is recommended to DISCUSS and NOTE the contents of the report.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
✓		

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

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

Comments:

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

Improve and heighten awareness of the need to report and learn from incidents.
NHSLA Acute and Community risk management standards – 'Learning from experience'

PREVIOUS CONSIDERATION:

Individual notifications to Executive Team and CG management teams.

Quality & Safety Committee on 20 September 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

'"Never Events" Review

Since the inception of the national "Never Events" policy **14** such events have occurred in the Trust; each one is summarised below by date. The key controls put in place to minimise the occurrence of a similar incident have been reviewed in order to gain assurance that they are operational and effective. The findings are set out below together with the planned action to address the gaps identified.

	Date of Incident	Clinical Group	Specialty	Type of Never Event	Current level of Assurance
1.	17/06/2009	W&CH	Gynaecology	Wrong site surgery	3
2.	27/07/2009	Surgery A	Colorectal	Retained foreign object post operation	4
3.	20/10/2010	Medicine	Stroke	Wrong route administration of oral / enteral treatment	1
4.	01/04/2011	Surgery A	Breast	Retained foreign object post operation	2
5.	21/06/2011	W&CH	Maternity	Retained foreign object post operation	2
6.	22/06/2011	W&CH	Gynaecology/Surgery	Retained foreign object post operation	4
7.	25/11/2011	Surgery B	Ophthalmology	Retained foreign object post operation	4
8.	23/01/2012	Surgery A + A&CC	Critical Care	Wrong route administration of oral / enteral treatment	2
9.	01/02/2012	W&CH	Gynaecology	Retained foreign object post operation	4
10	16/03/2012	Surgery B	Ophthalmology	Wrong implant / prosthesis	4
11	13/07/2012	Surgery A + A&CC	Critical Care	Retained foreign object post operation	3
12	11/09/2012	Surgery B	Oral Surgery	Wrong site surgery	1
13	17/06/2013	Surgery B	Ophthalmology	Wrong implant / prosthesis	4
14	15/12/2012	Surgery A	Plastic Surgery	Wrong site surgery	-

Grade	1	Low assurance, audit results poor	2	Medium, audit results need improving	3	Medium/high, reasonable compliance and audit results	4	High level of assurance and compliance

Assurance Evidence

- The WHO checklist is used universally throughout theatres and for some interventional procedures. Between April and August 2013, 15667 cases were included in the audit, of which 49 cases did not have all three sections completed (99.68% compliance). Of the 49 cases the majority did not adhere to the sign out section. The majority of these occurred in emergency lists in General Surgery Ophthalmology was 99.87% compliant and Breast Surgery and Gynaecology 100% compliant

- Consent for every intervention is a directorate responsibility and should be carried out monthly . Within this audit documentary evidence of information provided is asked. In an audit period April – August 13 only 22% of cases documented on the consent form that information leaflets were provided. Information is provided following an outpatient appointment and is therefore not documented purely on the consent form but to evidence show that this is documented in the healthcare records .

- An audit of practice in 2012 for nasogastric insertion showed a good level of understanding and compliance. However at the recent Ward Team Challenge the results of the scenario posed was universally poor . Only one team scored higher than 5/10 with 6 teams scoring 0 or 1.

- An audit in May 2013 of the operation notes of patients undergoing Breast surgery showed 75% compliance of the removal of the guide wire being documented. A further audit is planned for October 2013 following reinforcement of the need for this to be documented.

- Oral surgery was to implement universal use of the pre-printed teeth notation chart for all surgeon teeth. An audit in July of 60 notes showed that 45 cases required use of the notation chart. In 40 cases a hand drawn chart was used showing only 11% compliance.

- Ophthalmology have introduced and reinforced their Lens protocol. An audit of compliance was undertaken in September 2013 and showed 100% compliance across 8 patients They have also introduced a policy for visitors to theatres which has yet to be audited for compliance.

- Critical Care introduced an adapted WHO checklist for some of their interventional procedures Following this implementation, a never event occurred. Following reinforcement actions and audit was undertaken on each site 's CCS. This audit covered 5 months (September 2012 – January 2013) and revealed 88% compliance with areas for improvement in sign-out and the response to whether the person doing the procedure was supervised.

Actions required for improving assurance

- Screensavers for NG and DNACPR
- Continue the idea of using the 'mystery shopper' in theatres
- Action audits on surgical site marking and instrument and swab counts
- Reissue never event list
- Focused action audits on specific issues in specific clinical specialties (see table 1 below).
- Nasogastric audit – commencing in September 2013 (all wards)
- Adoption of Theatre visitor policy across all theatres

Table 1 - Targeted audits

	Plastic surgery	Breast surgery	Colorectal surgery	General surgery	Gynaecology	Maternity	Oral surgery	ENT	Ophthalmology	T&O	Urology / Vascular surgery	Critical care	Theatres
Theatre visitor policy													X
Surgical site marking	X	X	X	X	X		X	X	X	X	X		
Swab / instrument count	X	X	X	X	X	X	X	X	X	X	X		
Guide wire count		X											
Use of Information leaflets	X	X	X	X	X	X	X	X	X	X	X		
Consent audit	X				X	X		X	X	X			
Amended interventional WHO checklist audit												X	

Conclusion

Assurance has been gained, however further evidence is to be sought of a more targeted nature to gain confidence. Learning from never event investigations needs to be improved with evidence from Clinical Groups that issues have been considered and appropriate and timely actions taken..

Allison Binns
Assistant Director of Governance

September 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance & Performance Management Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 23 August 2013; 0800 – 1000h

Present	**In attendance**	**Secretariat**
Mr Richard Samuda	Mr Chris Archer	Mr Simon Grainger-Payne
Mr Harjinder Kang		
Mr Toby Lewis		

Minutes	**Paper Reference**
1 Apologies for Absence	**Verbal**
Apologies for absence were received from Clare Robinson, Robert White, Rachel Barlow and Mike Harding.	
2 Minutes from the previous meeting	**SWBFC (7/13) 070**
The minutes of the meeting held on 19 July 2013 were accepted as a true and accurate record of discussions held.	
AGREEMENT: The minutes of the previous meeting were accepted as a true and accurate reflection of the discussions held	
3 Matters arising from previous meeting	**SWBFC (7/13) 070 (a)**
The Committee was asked to receive and note the action tracker It was agreed that Mr Lewis would agree the way in which the financial implications of the seven day working should be reported to the Finance Committee with Mr White. Mr Lewis asked what progress had been made with broadening the business development register to include details of contracts for consultancy services Mr Archer advised that work was in progress, however Groups and Directorates needed to be approached to gather further details. Mr Kang advised that it was important to be able to capture the details of the contacts to ensure there was adequate visibility It was highlighted that a number contracts were of a small value, however they presented a financial risk nonetheless and should be captured.	

3.1 Monitoring social services response times	**Verbal**
Mr Lewis advised that a monitoring system was in place to track social services response times, however further detail would be provided at the next meeting as to how this operated.	
ACTION: Miss Barlow to provide further detail of process by which social services response times are being monitored	
3.2 Controls for the use of bank and agency staff	**Verbal**
It was agreed that Miss Barlow would circulate a note outlining the controls in place for the use of bank and agency staff.	
ACTION: Miss Barlow to circulate a note outlining the controls in place for the use of bank and agency staff	
3.3 Memorandum response to question on LTFM	**SWBFC (8/13) 080** **SWBFC (8/13) 080 (a)**
As requested at the May meeting of the TSB Board, the Committee received and noted a report explaining the element of the Long Term Financial Model identified as 'Other Cost Base Changes' with a value of £1.8m. The key components of this were reported to include the inflationary benefit from CIP values and the net impact of savings in former interest-related revenue costs which had been increased to reflect the annual inflationary assumptions in the LTFM. Mr Lewis advised that where the Trust was making savings as a result of workforce changes, then there was a need to show value of savings in a manner consistent with other entries in the LTFM.	
4 Trust financial management	
4.1 2013/14 Month 4 financial position	**SWBFC (8/13) 073** **SWBFC (8/13) 073 (a)** **SWBFC (8/13) 073 (b)**
Mr Archer reported that a surplus had been generated during the month, although this was below the planned level, meaning that the financial position was £191k behind plan. It was highlighted that there remained a high usage of bank and agency staff by the Medicine & Emergency Care Group. It was reported that a high level forecast out had been prepared which indicated that the Trust would be able to reach its end of year financial targets non-recurrently. Mr Lewis suggested that work needed to be undertaken to ensure that the financial position for 2014/15 was not compromised by the current year's position. Mr Lewis advised that there was no assumption that additional costs needed to be incurred in respect of commissioning external support for Trauma & Orthopaedics work during the year, particularly given the plan to open an additional number of beds in the Trust over the next few months.	

Mr Kang asked whether the financial cap on fines negotiated as part of the current contract was likely to be maintained. He was advised that particularly in light of the improved performance against ambulance turnaround time targets, there was no reason to believe that this would change.

Mr Archer was asked to present an update on the possible financial risk associated with the delivery of CQUIN targets at the next meeting.

It was suggested that the forward income position needed to be presented at the next meeting. Mr Archer highlighted that where there was any additional income benefit, this was reflected in the Group's financial positions.

Mr Lewis asked for further clarification on non-pay expenditure, given that this was showing an adverse variance of £712k against plan associated with one particular month at present. Mr Archer advised that non-pay spend included expenditure on drugs and therefore if overspend was incurred then this was passed on to the Commissioners for reimbursement. Mr Lewis suggested that this needed to be clarified in terms of the presentation in future reports. Mr Archer advised that in terms of spend on high cost Pathology reagents to deliver direct access or external Pathology tests, there was a corresponding receipt of income. Mr Lewis suggested that a review of the accruals process in this respect was needed. Mr Archer advised that a new development in Pathology that was in place as a result of a change in supplier was double running at present and was a significant contributory factor to the non-pay position. Mr Lewis suggested that the point at which this needed to be escalated to Executive, with the intention of challenging the position with the supplier needed to be agreed. It was agreed that an update should be presented at the next meeting. Mr Samuda encouraged a revisitation of the post-investment appraisal be conducted. Mr Archer drew the Committee's attention to the expenditure associated with hotel services in the Birmingham Treatment Centre, however he reported that this variance might be addressed through a planned difference in the handling of the Unitary Payment is handled as planned. Furthermore it was reported that costs associated with energy consumption were being reviewed at present. Mr Lewis advised that this continued to represent a risk for the Trust. However Mr Archer reported that postage was a further contributor to the non-pay position and in particular the price and volume change associated with franking. Mr Lewis advised that the planned use of electronic means of contacting patients would assist with the position. It was highlighted that the letters being sent to patients affected by the 18 week RTT validation exercise might contribute to the position.

In terms of the capital programme, the Committee was advised that this reflected the recent investments agreed by the Investment Advisory panel, with the exception of a Medical Illustration initiative. Mr Lewis advised that a business case for the Cath Lab needed to be presented to the Trust Board in September.

Mr Lewis asked in terms of the rolling forecast, whether providing expenditure and income did not deteriorate significantly, it suggested that there was likely to be a degree of financial headroom at the year end. Mr Archer advised that the forward look was based on annual budget rather than the actual position, however he broadly agreed with the observation. Mr Kang asked whether there was a degree of seasonality that needed to be taken into account. Mr Archer

agreed that this was the case however cashflow was likely to be relatively stable in line with the contract agreed, subject to the recognised contractual risks. Mr Lewis asked for clarity to be provided on the likely year end position ready for reporting to the Trust Board on 29 August 2013. It was noted that the Trust paid its tax and NI liability in March, thereby explaining the usually low position in April.	
ACTION: Mr Archer to present an update on the possible financial risk associated with the delivery of CQUIN targets at the next meeting **ACTION:** Mr Archer to present a view of the forward income position for 2013/14 at the next meeting **ACTION:** Mr Archer to ensure that the element of non-pay spend which related to higher than expected expenditure on drugs & Pathology reagents be represented separately within future versions of the financial performance report **ACTION:** Miss Barlow to present an update on the double running of the Pathology process at the next meeting **ACTION:** Miss Barlow to present the Cath Lab business case to the Trust Board in September **ACTION:** Mr Archer to confirm the likely year-end financial position to Mr Lewis prior to the meeting of the Trust Board on 29 August 2013	
4.2 Financing and cash guidance from Trust Development Authority	**SWBFC (8/13) 074** **SWBFC (8/13) 074 (a)**
Mr Archer reported that there had been little change to current practice as a result of the new guidance from the Trust Development Authority, apart from the treatment of dividend capital which would benefit the Trust on initiatives such as Dementia. It was highlighted that payments would need to be made in terms of Public Dividend Capital on this additional cash however Mr Lewis suggested that the depreciation impact of the Trust configuration plans needed to be borne in mind.	
4.3 Financial risks to the organisation	**Vebal**
It was agreed that the financial risks featuring in the Trust risk register needed to be discussed within this item in future.	
5 Transformation Plan	
5.1 TSP delivery report 2013/14	**SWBFC (8/13) 075** **SWBFC (8/13) 075 (a)** **SWBFC (8/13) 075 (b)**
Mr Archer presented an update on the delivery of the Transformation Savings Plan from a financial perspective.	

It was reported that after the application of Internal Transitional Funding, the position was £426k behind plan, with a forecast that by the year end, a £500k shortfall would be incurred by the year end. It was reported that the assumption had been made that the Medicine & Emergency Care Group delivered its mitigation plans fully. Mr Lewis highlighted that the position suggested that the delivery of savings needed to be considered more fully as part of the planning process for 2014/15 in the light of the stable, rather than decreasing expenditure position. Mr Samuda highlighted that Monitor would expect demonstration of sustainability of the Transformation Savings Plans. Mr Kang asked what the position was likely to be should the Medicine & Emergency Care Group's mitigating actions be delivered. Mr Lewis advised that this would deliver a £600k financial liability that would be unlikely to compromise the overall end of year financial position. Mr Samuda asked whether there was clear sight of possible savings as a result of procurement practice. He was advised that this was the case and was captured within one of the Transformation Plan workstreams. It was reported that there would be further detail provided at the October meeting.	
6.2 Progress update	**Verbal**
It was reported that there was no further matters to report in connection with the Transformation Plan at present.	
6 Trust performance monitoring	
6.1 Performance Monitoring Report	**SWBFC (8/13) 076** **SWBFC (8/13) 076 (a)**
Mr Lewis reported that the Trust continued to achieve a 'performing rating' against the NHS Performance Framework. It was highlighted however, that the Trust was rated as 'amber red' against the FT Compliance Framework due to underperformance against the Emergency Care target. It was reported that it was a continuing challenge to deliver the required performance against the Emergency Care target going forward. It was reported that 18 week RTT targets were not being met in a number of specialities at present. Mr Lewis suggested that further consideration needed to be given to the *C difficile* infection rates and the delivery of the dementia CQUIN target and that this detail needed to be available in readiness for the TB Board meeting on 29 August 2013. Mr Kang asked for further clarity on the improvements needed in terms of MRSA screening. Mr Lewis advised that the denominator had been set correctly now which would lead to better data improvement, together with improved processes to screen patients at the 'front door'. Mr Lewis suggested that the falls position should be considered by the Quality & Safety Committee. Mr Samuda highlighted that a balance approach was needed in terms of	

maintaining quality while achieving an acceptable financial position, including the appropriate use of resources ('special' patients Mr Archer asked whether the reason for individual requests to apply bank and agency staff was recorded. He was advised that this could be collected, however was not routinely completed when requests were made at present. Mr Lewis suggested that a view needed to be taken as to the impact of bank and agency on the flow through to the financial and activity positions during the previous and forthcoming months. Mr Samuda asked whether there was a review of the use of bank and agency staff in the context of leaves. He was advised that this would be considered as part of the work of the Workforce & OD Committee. Mr Lewis advised that a more significant piece of work was to understand the establishment position in terms of budgeted and actuals across the Trust and to agree the appropriate use of agency and bank staff in the context of effective rostering for instance. It was noted that rostering would assist in this respect.	
ACTION: **Miss Overfield (Mrs Pascall) to present the position in terms of falls at the next meeting of the Quality & Safety Committee** **ACTION:** **Miss Barlow to present an assessment of the operational impact of the use of bank and agency staff both in retrospect and as a forward view at the next meeting**	
6.2 NHS Performance Framework	**SWBFC (8/13) 077** **SWBFC (8/13) 077 (a)**
It was noted that this was covered as part of previous discussions.	
6.3 FT Compliance Framework	**SWBFC (8/13) 078** **SWBFC (7/13) 078 (a)**
The Committee was asked to receive and accept the FT Compliance Framework update. It was reported that the performance was classed as being 'amber/green'.	
7 Terms of reference for the Finance & Investment Committee	**SWBFC (8/13) 079** **SWBFC (8/13) 079 (a)**
Mr Grainger-Payne presented the revised terms of reference for the Committee, highlighting that these had been prepared using the generic template which had also been used to prepare the terms of reference for the other Board subcommittees. It was highlighted that the terms of reference had been reframed to focus more closely on the Committee's assurance role and reflected the points raised at the last meeting. It was agreed that the Committee should receive the notes of the Performance Management Committee to assist with its duty to assure the Board the financial plan was being delivered. It was also suggested that the Board members should also continue to be provided with the monthly financial results.	

Mr Lewis reported that at the November meeting, there would be a focus on the delivery of the Long Term Financial Plan. It was agreed that the Board sub committee structure needed to be presented in overview at the next Board meeting and also within the context of the Executive Committee structure. Mr Kang suggested that there needed to be clarity as to the delegated limits available to the Committee. Mr Lewis advised that this would be agreed as part of the review of the Scheme of Delegation which was planned for later in the year. The Board supported the revised terms of reference.	
8 Matters to highlight to the Board	**Verbal**
It was agreed that the Board needed to be made aware of the position concerning agency spend and the wider Medicine & Emergency Care Group's current financial position and plans to recover this. The Board would also be made aware of the reasons behind the non-pay position. Mr Kang suggested that change to the way in which the balance between the strategic and operational focus of the Committee would be handled needed to be communicated to the Board.	
9 Meeting effectiveness feedback	**Verbal**
It was agreed that the meeting had included a number of productive discussions.	
10 Minutes for Noting	
10.1 Minutes from Performance Management Board – 16 July 2013	**SWBPM (7/13) 068**
The Finance and Performance Management Committee received and noted the minutes of the PMB meeting of the 16 July 2013.	
11 Any Other Business	**Verbal**
There was none.	
12 Details of the next meeting	
The next meeting of the Finance and Performance Management Committee was noted to be scheduled for 20 September 2013 at 0800h in the D29 (Corporate Suite) meeting room at City Hospital.	

Signed: ▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯

Name: ▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯

Date: ▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯▯

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – August 2013
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White / Chris Archer
DATE OF MEETING:	26 September 2013

EXECUTIVE SUMMARY:

The report presents the financial performance for the Trust, clinical groups and corporate directorates for the period to 31st August 2013.

The Trust's Monitor financial risk rating for the year to August is 3 which is satisfactory.

Measured against the DH target, the Trust generated an actual surplus of £629,000 during August against a planned surplus of £646,000. Although there is a small overall adverse variance in month, this performance remains consistent with the annual planned surplus of £4,600,000 agreed with the Local Area Team of NHS England.

The cash balance of £45.5m is £1.3m higher than plan as at 31st August.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

Performance Management Committee and Clinical Leadership Executive on 17 September 2013 and Finance & Investment Committee on 20 September 2013

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2013

EXECUTIVE SUMMARY

• For the month of August 2013, the Trust delivered a "bottom line" surplus of £629,000 compared to a planned surplus of £646,000 (as measured against the DoH performance target). Actual in month performance is consistent with the year end target of 1.1% of turnover.

• For the year to date, the Trust has produced a surplus of £2,155,000 compared with a planned surplus of £2,365,000 so generating an adverse variance from plan of £210,000, below the Trust's year to date target.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 102 below planned levels. After taking account of the impact of agency staff, WTE's were 81 above plan. Total pay expenditure for the month, inclusive of agency costs, is £33,000 above the planned level.

• The month-end cash balance was £45.5m. Year to date spend on capital is £2.4m against a £21.4m annual programme.

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	(17)	(210)	>=Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	(107)	(313)	>=Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	(33)	(229)	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	(91)	(801)	<=Plan	<=Plan	>1% above plan
WTEs Actual v Plan	(81)	(131)	<=Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000	1,348	1,348	>=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	2,365	2,155
Capital Resource Limit	8,503	8,503
External Financing Limit	---	1,348
Return on Assets Employed	3.50%	3.50%

2013/14 Summary Income & Expenditure Performance at August 2013	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	391,687	32,759	32,675	(84)	163,182	163,470	288	391,687
Other Income	37,362	3,270	3,371	101	15,943	16,372	429	37,362
Operating Expenses	(403,328)	(33,622)	(33,746)	(124)	(167,959)	(168,989)	(1,030)	(403,328)
EBITDA	25,721	2,407	2,300	(107)	11,166	10,853	(313)	25,721
Interest Receivable	100	8	9	1	42	57	15	100
Depreciation, Amortisation & Profit/(Loss) on Disposal	(13,962)	(1,164)	(1,164)	0	(5,818)	(5,818)	0	(13,962)
PDC Dividend	(5,027)	(419)	(346)	73	(2,095)	(2,022)	73	(5,027)
Interest Payable	(2,232)	(186)	(170)	16	(930)	(915)	15	(2,232)
Net Surplus/(Deficit)	**4,600**	**646**	**629**	**(17)**	**2,365**	**2,155**	**(210)**	**4,600**
IFRIC12/Impairment/Donated Asset Related Adjustments	0	0	0	0	0	0	0	0
SURPLUS/(DEFICIT) FOR DOH TARGET	**4,600**	**646**	**629**	**(17)**	**2,365**	**2,155**	**(210)**	**4,600**

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

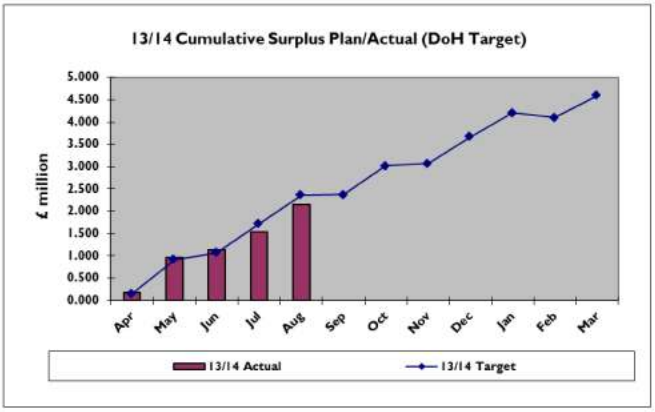
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2013

Overall Performance against Plan

- The overall performance of the Trust against the DoH planned position is shown in the graph. Net bottom-line performance delivered an actual surplus of £629,000 in August against a planned surplus of £646,000. The resultant £17,000 adverse variance provides a 1.1% return.

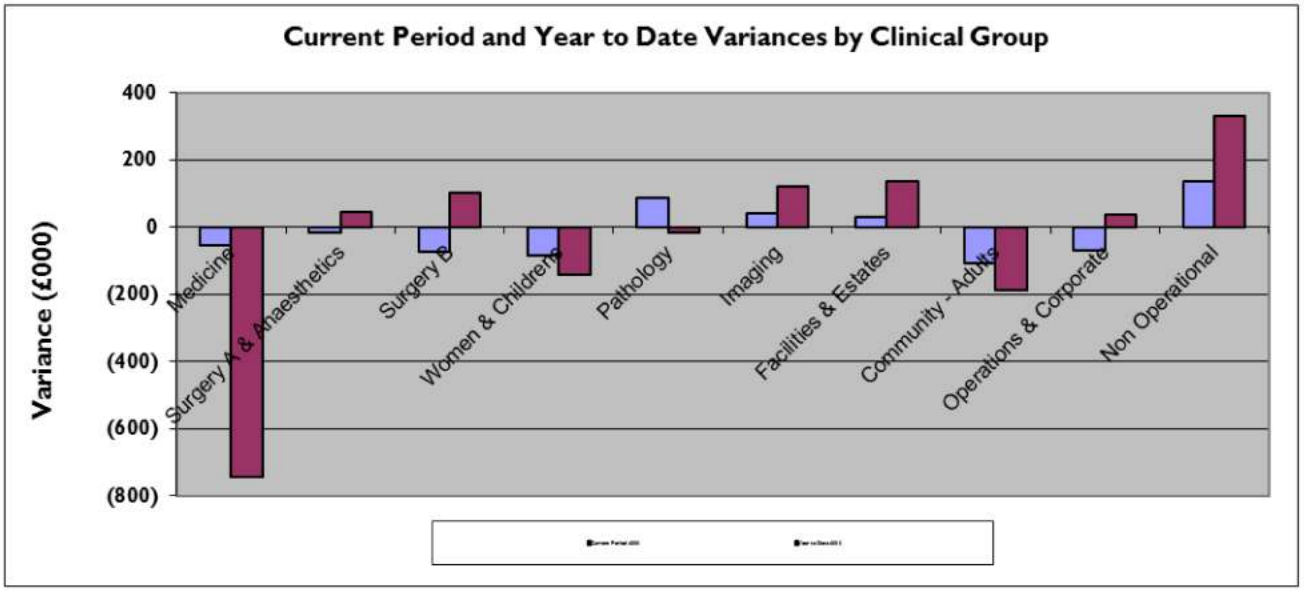


Performance of Clinical Groups and Directorates

- Group performance now includes contract income performance for April to July.
- Medicine Group overspends on HCA staffing remains the largest single financial risk.

Group Variances from Plan

	Current Period £000	Year to Date £000	Budget
Medicine	(56)	(742)	87,295
Surgery A & Anaesthetics	(17)	45	62,434
Surgery B	(71)	102	24,310
Women & Childrens	(86)	(142)	43,866
Pathology	86	(16)	20,163
Imaging	42	121	16,962
Facilities & Estates	31	139	36,168
Community - Adults	(105)	(186)	26,192
Operations & Corporate	(68)	38	44,587
Non Operational	137	330	28,329



Sandwell and West Birmingham Hospitals NHS

NHS Trust

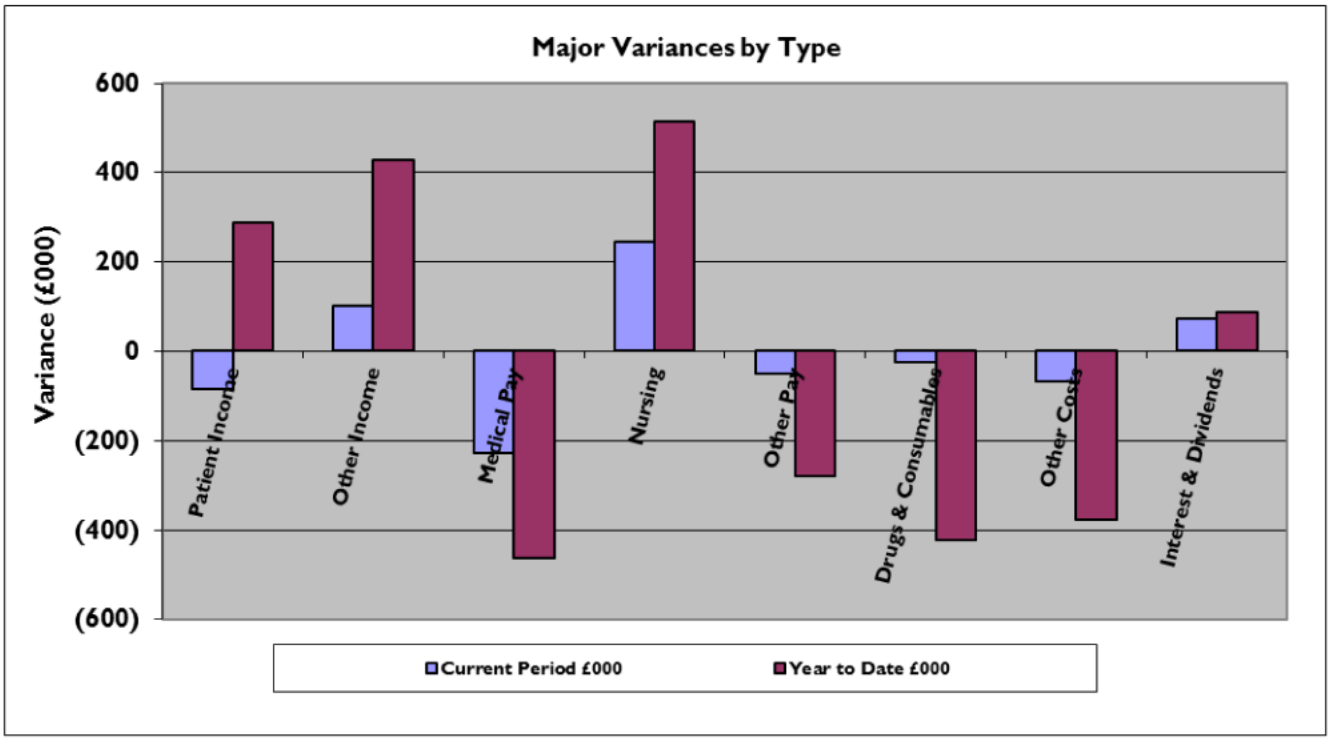
Financial Performance Report – August 2013

Patient income is above plan for planned work (elective inpatients and outpatient attendances) and below plan for emergency work (acute A&E attendances, emergency admissions and maternity). Primary care front end to A&E is diverting attendances from acute A&E. This position is being kept under review as part of winter preparations and use of dedicated and contingency funds.

Other income includes R&D income over-recovery which is matched by pay overspends in that Directorate.

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	(84)	288
Other Income	101	429
Medical Pay	(228)	(462)
Nursing	246	513
Other Pay	(51)	(280)
Drugs & Consumables	(23)	(423)
Other Costs	(68)	(378)
Interest & Dividends	74	88



Capital Expenditure

• Year to date capital expenditure is £2.4m, mainly on Blood Sciences, statutory standards and estates rationalisation. Detailed programmes have now been approved for medical equipment, estates and HIS.

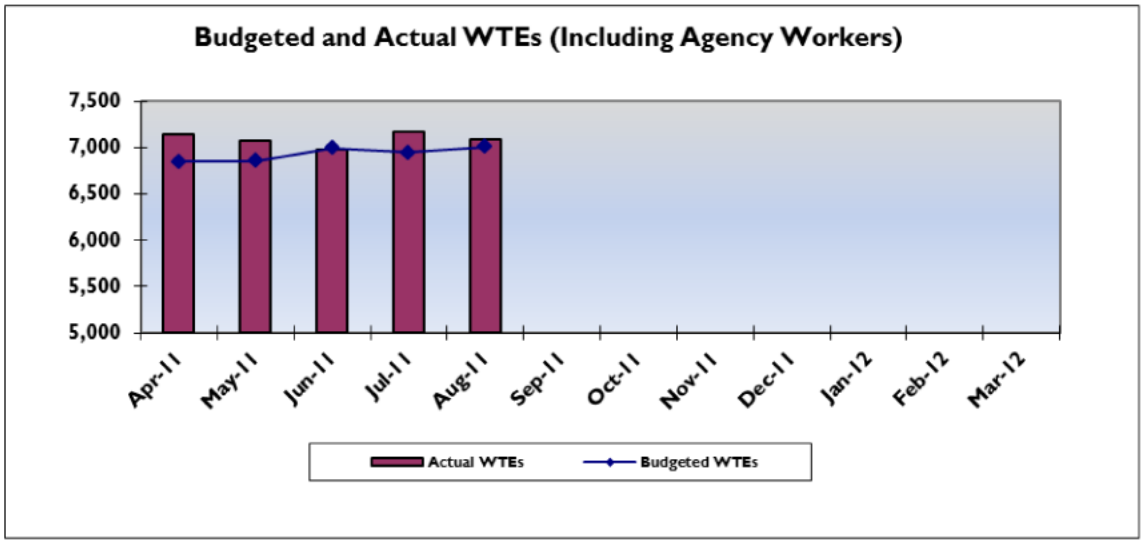
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2013

Paybill & Workforce

- Workforce numbers, including the impact of agency workers, are 81 above plan . Excluding the impact of agency staff, whole time equivalent (WTE) numbers are 102 below plan.
- Total pay costs (including agency workers) are £33,000 above budgeted levels for the month, reflecting premium rates of agency staffing. Nursing shows an overspend in month of £246,000 (including agency).
- Expenditure for agency staff in May was £788,000 , £100,000 lower than the average in the previous four months.



Analysis of Total Pay Costs by Staff Group

	Year to Date to August					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	32,069	30,905		1,626	32,531	(462)
Management	6,371	5,975		0	5,975	396
Administration & Estates	13,087	12,006	916	398	13,320	(233)
Healthcare Assistants & Support Staff	13,019	11,854	1,674	470	13,999	(980)
Nursing and Midwifery	38,136	34,200	1,688	1,735	37,623	513
Scientific, Therapeutic & Technical	18,130	17,433	0	173	17,606	524
Other Pay	22	9			9	13
Total Pay Costs	120,834	112,382	4,278	4,402	121,063	(229)

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2013

Balance Sheet

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

• Cash balances at 31st August stood at £45.5m, slightly above plan.

Sandwell & West Birmingham Hospitals NHS Trust

STATEMENT OF FINANCIAL POSITION 2013/14

		Opening Balance as at 1st April 2013	Balance as at end August 2013	Forecast at 31st March 2014
		£000	£000	£000
Non Current Assets	Intangible Assets	924	823	1,421
	Tangible Assets	216,669	213,348	227,997
	Investments	0	0	
	Receivables	1,048	966	1,048
Current Assets	Inventories	3,604	3,724	3,604
	Receivables and Accrued Income	10,432	18,813	10,432
	Investments	0	0	
	Cash	42,448	45,484	38,335
Current Liabilities	Payables and Accrued Expenditure	(43,040)	(45,152)	(43,039)
	Loans	(2,000)	(2,000)	(2,000)
	Borrowings	(914)	(983)	(914)
	Provisions	(10,355)	(15,265)	(10,049)
Non Current Liabilities	Payables and Accrued Expenditure	0	0	
	Loans	(3,000)	(3,000)	(1,000)
	Borrowings	(29,263)	(28,689)	(28,706)
	Provisions	(3,168)	(2,530)	(2,474)
		183,385	185,539	194,655
Financed By				
Taxpayers Equity	Public Dividend Capital	160,231	160,231	160,231
	Revaluation Reserve	34,356	34,355	39,120
	Other Reserves	9,058	9,058	9,058
	Income and Expenditure Reserve	(20,260)	(18,105)	(13,754)
		183,385	185,539	194,655

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – August 2013

CASH FLOW

12 MONTH ROLLING FORECAST AT August 2013

ACTUAL/FORECAST	Aug-13 £000s	Sep-13 £000s	Oct-13 £000s	Nov-13 £000s	Dec-13 £000s	Jan-14 £000s	Feb-14 £000s	Mar-14 £000s	Apr-14 £000s	May-14 £000s	Jun-14 £000s	Jul-14 £000s
Receipts												
SLAs: SWB CCG	**20,787**	20,684	20,684	20,684	20,684	20,684	20,684	20,684	20,684	20,684	20,684	20,684
Associates	**6,887**	7,884	7,884	7,884	7,884	7,884	7,884	7,884	7,884	7,884	7,884	7,884
Other NHS income	**946**	655	655	655	655	655	655	655	655	655	655	655
Specialised Service (LAT)	**3,762**	3,372	3,372	3,372	3,372	3,372	3,372	3,372	3,372	3,372	3,372	3,372
Education & Training			4,429			4,429			4,429			4,429
Loans												
Other Receipts	**1,588**	1,620	1,620	1,620	1,620	1,620	1,620	1,620	1,620	1,620	1,620	1,620
Total Receipts	**33,970**	34,214	38,643	34,214	34,214	38,643	34,214	34,214	38,643	34,214	34,214	38,643
Payments												
Payroll	**13,701**	13,100	13,100	13,100	13,100	13,100	13,100	13,100	13,100	13,100	13,100	13,100
Tax, NI and Pensions	**9,382**	9,500	9,500	9,500	9,500	9,500	9,500	9,500	9,500	9,500	9,500	9,500
Non Pay - NHS	**1,163**	2,400	2,400	2,400	2,400	2,400	2,400	3,400	3,400	3,400	3,400	3,400
Non Pay - Trade	**8,437**	8,480	8,480	7,540	6,600	7,540	7,540	9,826	9,826	9,826	9,826	9,826
Non Pay - Capital	**726**	2,128	2,157	2,115	2,257	1,663	1,271	421	421	421	421	421
PDC Dividend		2,137						2,577			2,577	
Repayment of Loans		1,000						1,000			1,000	
Interest		20						15			15	
BTC Unitary Charge	**0**	856	428	428	428	428	428	428	428	428	428	428
Other Payments	**868**	188	188	188	188	188	188	188	893	893	893	893
Total Payments	**34,277**	39,809	36,253	35,271	34,473	34,819	34,427	40,455	37,568	37,568	41,160	37,568
Cash Brought Forward	**45,791**	45,484	39,889	42,279	41,223	40,964	44,788	44,576	38,335	39,410	36,056	29,111
Net Receipts/(Payments)	**(307)**	(5,595)	2,390	(1,057)	(259)	3,824	(213)	(6,241)	1,075	(3,354)	(6,946)	1,075
Cash Carried Forward	**45,484**	39,889	42,279	41,223	40,964	44,788	44,576	38,335	39,410	36,056	29,111	30,186

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2013

Cash Forecast

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

Risk Ratings			
Measure	**Description**	**Value**	**Score**
EBITDA Margin	Excess of income over operational costs	6.0%	3
EBITDA % Achieved	Extent to which budgeted EBITDA is achieved/exceeded	97.2%	4
Net Return After Financing	Surplus after dividends over average assets employed	2.1%	4
I&E Surplus Margin	I&E Surplus as % of total income	1.2%	3
Liquid Ratio	Number of days expenditure covered by current assets less current liabilities	23.4	3
Overall Rating			**3.3**

Financial Risk Rating

•The table shows the Monitor risk rating score (out of 5) for the Trust based on performance at August. The liquidity score includes an assumed working capital facility. From September this rating will be retired following Monitor publication of the Risk Assessment Framework.

Continuity of Service Risk Rating

•The new financial risk rating position is shown below (out of 4). Revised threshold for liquidity have been published by Monitor which are now reflected in the rating below.

Continuity of Services Risk Rating

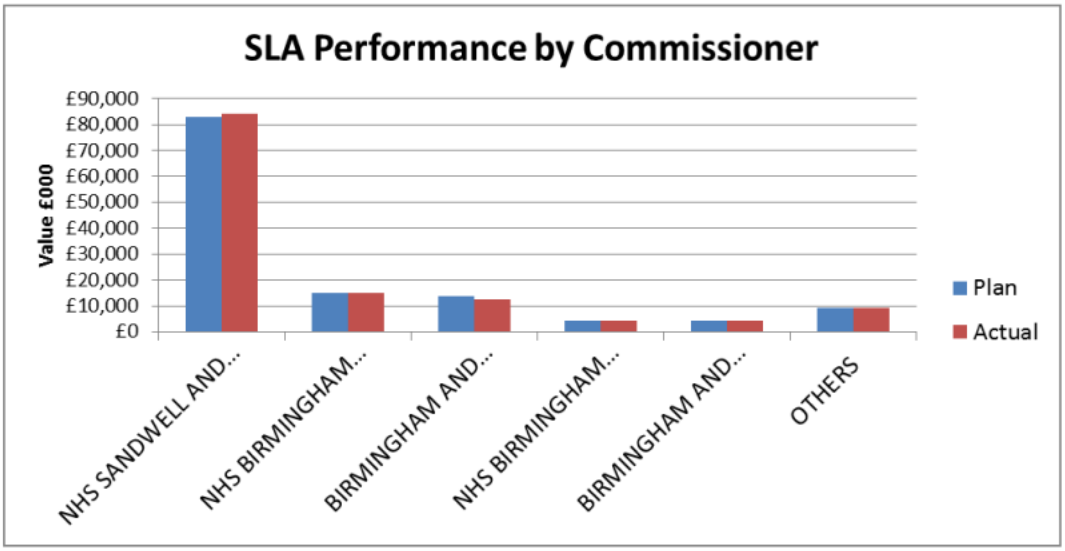
Risk Ratings		Current Month		Year to Date		Forecast Outturn	
Measure	**Description**	**Value**	**Score**	**Value**	**Score**	**Value**	**Score**
Capital Service Capacity	Revenue available for debt service/capital servicing costs	3.17	4	2.73	4	2.63	4
Liquidity	Cash for liquidity purposes * 360/annual operating expenses	0.80	4	4.00	4	-6.46	3
Overall Rating			**4**		**4**		**3**

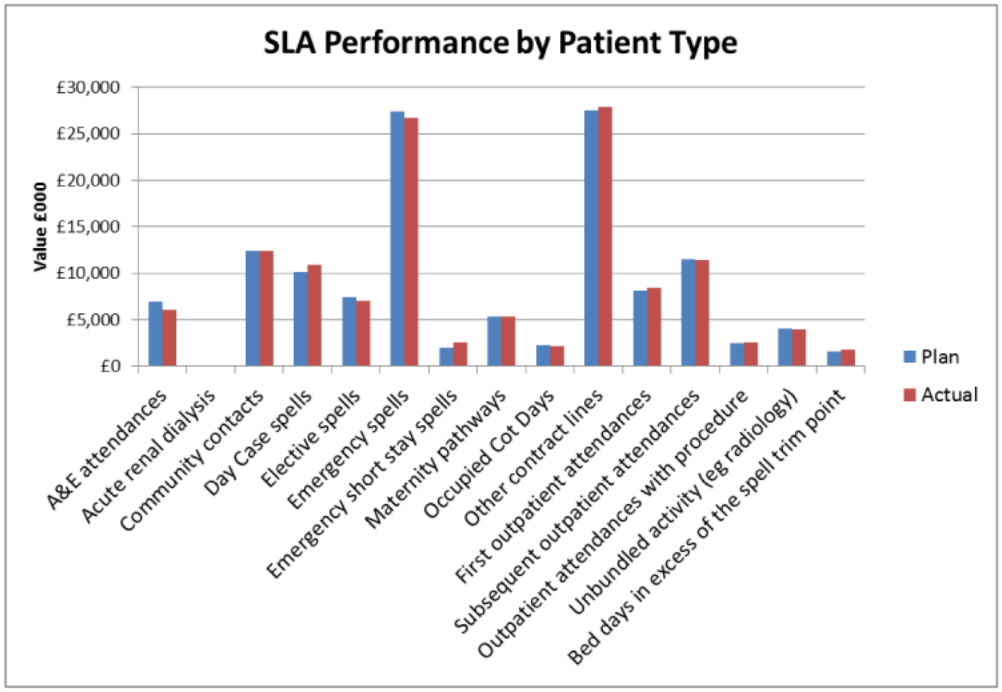
Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2013

Performance Against Service Level Agreement Target

•Performance for April to July is broadly on line overall with A&E and emergency admissions below plan and planned activity including day cases and outpatient attendances above plan.





Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2013

Transformation Programme

•An update on TSP progress is provided separately. The plan for delivering savings in 2014/15 is receiving focus as is setting the programme for 2015/16.

Key risks

• School nursing remains an outstanding issue with public health services run by local authorities. It remains too early to assess the impact of the new maternity pathway tariffs, although births are below plan. An update on CQUIN risk will be provided separately.

•The capacity plan has now been approved and plans are being put in place for Winter 2013. Current capacity is being run at a premium cost which remains a cause of concern and is the focal point for a number of targeted measures within Medicine.

External Focus

•Monitor has now issued its updated Risk Assessment Framework following consultation earlier in the year. This will replace the Compliance Framework for Foundation Trusts from September 2013. The RAF includes revised metrics for the Continuity of Service Risk Rating which are reflected in this report.

•Winter funding for Trusts is to be contingent on uptake of flu vaccinations for staff, the Health Minister has announced.

Recommendations

The Trust Board is asked to:

i. RECEIVE the contents of the report; and

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

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Update on Medicine Group Financial Recovery Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Nicky Reid – Senior Finance Manager Medicine**
DATE OF MEETING:	**20 September 2013**

REPORT RECOMMENDATION:

This brief paper summarises the financial position of the Medicine Group as reported to the Finance & Performance Management Committee on Friday 20th September 2013.

At the end of Month 5 the Group has posted a deficit of £740k inclusive of an adverse movement in August of £54k.

Stabilisation of the position for the Group is a priority and the range of weekly enhanced authorisation measures and intensive support are in place and taking effect.

The bed plan is being implemented in September / October providing further stability to the ward establishments. Recruitment remains on track. As previously reported this will be reviewed in December.

TSP Quality Impact Assessments for 2013/14 are singed off by the Medical Director and interim Chief Nurse. Close monitoring of the delivery programme is in place.

Potential risks are been mitigated through recruitment plans and service development, both under close watch and scrutiny.

The forecast and underpinning plans presented to the Finance & Performance Management Committee have merit and promise.

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

Performance standards

PREVIOUS CONSIDERATION:

Finance & Performance Management Committee on 19 July 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

UPDATE ON MEDICINE GROUP FINANCIAL RECOVERY PLAN M5

1.0 Introduction

This paper gives an update to the financial position and recovery plan of the Medicine Group

2.0 Current Position

At the end of Month 5 the Group has posted a deficit of £740k inclusive of an adverse movement in August of £54k. The variances are summarised in the table below.

Expense type	In Month Variance £000	YTD Variance £000
Income	135	378
Pay	(85)	(744)
Non pay	(104)	(374)
Grand Total	**(54)**	**(740)**

Income

M4 activity generated £12.6M compared to the previous YTD average of £12.0M. Planned activity income for M4 was £12.4M (previous monthly average of £12.1M). The increased activity resulted in an overperformance of £200k of which Medicine received £162K. Overperformance has been seen in a number of specialities, with the main improvements seen in Cardiology PCIs, NICE high cost drugs and Oncology drugs.

ED continues to underperform but the underperformance in M4 was considerably lower than previous months. Income generated was £1.5M compared to the previous monthly average of £1.4M, activity count was 13,497 attendances compared to the average of 12,841 (5% higher). The monthly plan on average is 16,441 attendances.

Pay

The pay overspend in month continues to be around nursing expenditure. There are signs that the pay controls are starting to take effect. Agency spend reduced by £149k compared to the monthly average, band 2 agency used to support specialling has reduced from £100k per month to £39k in month 5 and qualified agency reduced from £240k per month to £145k. Bank spend increased slightly from £321k on average to £425k. Established nurse expenditure reduced by £106k from an average of £2.24M to £2.14M in month M5.

The overall pay spend was £5.83M, £493k less than the previous monthly average of £6.32M.

Non pay

Non pay had the biggest adverse movement in month. The overspend in M5 was £104k, YTD is now £378k. The increase was predominantly on drugs in particular oncology (£68k over) and gastro (£34k over). Drugs expenditure in M5 was £1.75m an increase of £100k on the monthly average.

3.0 Year end forecast

The medicine forecast produced at the end of Month 4 was for a year end deficit of £878k.

Review of the month 5 actuals compared to the forecast spend

The table below shows the predicted month 5 income and expenditure based on the forecast undertaken in month 4 compared to actual expenditure:

August Expenditure type	Forecast M5 £000	Actual M5 £000	Difference M5 £000
Income	**-12,583**	**-12,717**	**134**
Pa	**6,270**	**5,918**	**352**
Nonpay	**2,334**	**2,434**	**-100**
Grand Total	**-3,980**	**-4,365**	**385**

Income

Income was predominately based on a straight-line forecast with the exception being an increase in Cardiology (diagnostics) and Chemotherapy data capture and charging. Month 5 actually saw an increase in activity above plan and forecast in a number of specialities, particularly Cardiology PCIs and NICE / Oncology High cost drugs.

Pay

Pay expenditure is better than forecast at M5 and is broken down further in the table below:

Super Group Description	Forecast M5 £000	Actual M5 £000	Difference M5 £000
Administration and Estates	380	264	116
Agency Staff	522	424	98
Bank Staff	306	425	- 119
Healthcare Assistants and Support Staff	523	534	- 11
Management	49	45	4
Medical Staffing	2,032	1,883	149
Qualified Nursing and Midwifery	2,245	2,139	106
Scientific, Therapeutic and Technical	211	203	8
TOTAL	**6,270**	**5,918**	**352**

The medical staffing reduction is mainly due to reduced consultant costs, a credit note of £80k was received in month relating to the oncology SLA overcharge in 12/13 (supporting the 13/14 TSP).

Nursing expenditure in month was lower than previous months. Agency spend was lower than predicted with the spend on band 2 significantly reduced. Bank spend however was higher than forecast; in part this was to do with higher levels of annual leave being taken in August due to honouring annual leave granted to staff prior to transferring to alternative wards in the new bed model and is not forecast to as a continued expenditure.

Nonpay

Non pay spend was based on a straight-line projection with some adjustments for TSP delivery and MFFD expenditure.

In month 5 non pay increased above that predicted. The main increase in expenditure was on drugs which was £100k higher than the previous YTD average. The increases were in Gastro and Oncology. As activity is monitored a month in arrears the expectation is that there should be an increase in pass through drugs income to support the increased non pay costs.

Forecast based on M5 position

The forecast is still to deliver a deficit of £838k.

The month 4 forecast included income recovery for diagnostic cardiology of c£386k which was based on being able to capture and charge commissioners for diagnostics. Activity through unbundled outpatient activity, will not contribute to the income assumption as it is within a block contract. However, if the attendance is a direct GP referral the activity could be charged for and income incurred. The Trust doesn't currently offer a full direct access service for cardiology diagnostics and it is something that commissioners have recently requested and the Group is committed to set up. It is still the expectation of the Group that the direct access can be used and activity captured and charged for this financial year. The forecast income for diagnostics has been revised downwards to c£250k so that there is time to set up the pathways. The unbundled diagnostic element of the activity still needs to be pursued so that it can be included in the 14/15 contracts.

The table on the next page shows the movement between categories of the forecast variance.

Expense Type	Forecast Variance @ M5 £000	Forecast Variance @ M4 £000	Movement £000
Income	837	692	145
Pay	-1,038	-1,215	177
Non pay	-678	-355	-323
TOTAL	**-878**	**-878**	**0**

The income change is in part due to the impact that the July activity has had on the year end forecast as income with the exception of cardiology and chemotherapy drugs is based on a straight-line projection.

The pay change is mainly due to a further £250k of TSP stretch funding being received, to take the stretch to £1.15M as agreed.

The non pay change is predominantly due to drugs expenditure which saw a rise in August on high cost drugs (oncology / gastro) and higher consumable spend in a number of specialities that has seen an increase in activity.

TSPs 13-14

The division have a recurrent target of £3.48m in year this is being supported by TSP stretch of £1.15m. The full year effect of schemes has been reviewed and totals £2.93m, leaving a shortfall of £552k. All QIAs have been signed off by the Chief Nurse and Medical Director.

Key risks and actions

- Risk - Delayed benefits realisation to the BCBV outpatient TSP. Project management and mapping of schemes at clinic level. Good clinical leadership engagement and workshop held in September.
- Risk - ED medical recruitment for consultants and middle grades not aligned to EDAT projections. Gaps in training doctors placements will be mitigated by ongoing recruitment but potential financial risk associated with interim increase locum expenditure is being assessed.
- Risk - Recurrent delivery of 13/14 TSP target of £3.48m, FYE of schemes identified £2.93m – shortfall of £552k. The Clinical Group TSP planning continues to close this gap.
- Patient pathway under review to introduce GP direct access for cardiology diagnostics. Meeting arranged to discuss with CCG commissioners.

4. Conclusion

The Executive and Clinical Group remain focussed on this as a key priority. Intensive support and heightened authorisation is making impact and will continue to be in place. Recruitment plans remain on track for nursing.

TSP Quality Impact Assessments are complete and the delivery and impact of these is an essential area of monitoring over the coming period.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Corporate Performance Monitoring Report
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Performance Management
DATE OF MEETING:	26 September 2013 (Report prepared 19 September 2013)

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

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

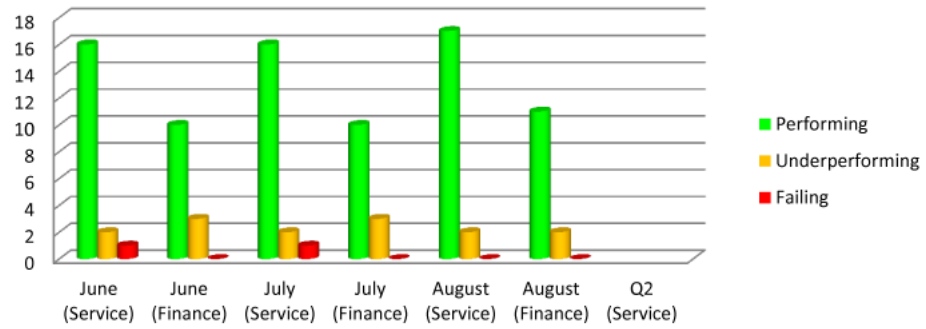
PREVIOUS CONSIDERATION:

Performance Management Committee, Clinical Leadership Executive and Finance & Investment Committee

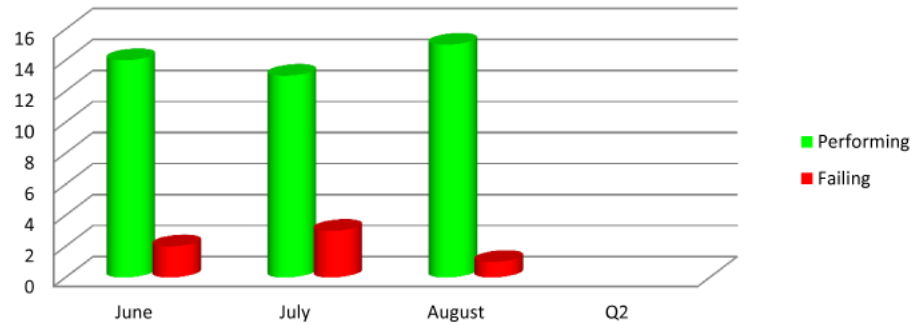
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST INTEGRATED PERFORMANCE CORPORATE DASHBOARD - AUGUST 2013

EXECUTIVE SUMMARY

NHS Performance Assessment Framework



Monitor Compliance Framework

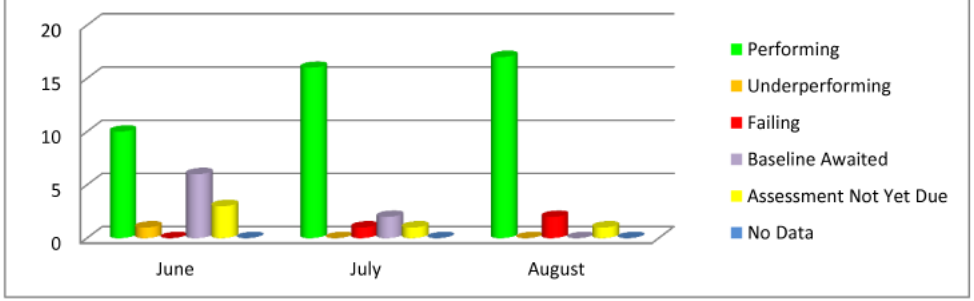


Service Performance - during the month (August) there were 2 areas of underperformance; Delayed Transfers of Care (3.70%) and RTT Delivery in All Specialities (projected). The Trust is projected to attract an overall weighted score of 2.86 and as such a **PERFORMING CLASSIFICATION** for the month. The Trust is projected to meet performance thresholds for high level RTT and Cancer Targets.

Financial Performance (August) the weighted overall score is 2.95 with underperformance reported in 2 areas; Better Payment Practice Code (Value) and Better Payment Practice Code (Volume). The classification for the month remains **PERFORMING.**

Monitor Compliance Framework - within the Service Performance element of the Risk Rating for the month of August, the Trust met the required thresholds for each of the indicators which comprise the framework. Monitor's annual de minimis limit for cases of MRSA Bacteraemia reflecting a governance concern is set at 6, and as such the MRSA Bacteraemia reported (during April) for the year to date does not contribute to the overall score. The overall governance score for the month is 0.0, which attracts a GREEN Governance Rating. The Trust is projected to meet performance thresholds for all high level RTT and Cancer targets for the month.

CQUIN Performance



CQUIN - A summary of the current performance against the various acute, community and specialised CQUIN schemes is reflected in the table opposite. Of the 20 summary schemes, 18 are performing, with either year to date targets being met, progress on track regarding implementation (staffing, equipment procurement, training etc.) or baseline assessments having been completed, with improvement trajectories agreed with commissioners. Within these, proposals to extend the baseline period for 2 schemes; 'Sepsis Care' and 'Community Risk Assessment and Advice' are also agreed with commissioners, to ensure data is sufficiently robust to inform future improvement trajectories. Two nationally mandated schemes are currently failing, VTE performance for the month of August (as at 12 September 2013) is 94.4% and Dementia (Find, Assess and Refer), which requires all 3 components of the scheme to be met.

Clinical Quality & Outcomes

Stroke Care - Corporate Performance reporting systems indicate that the proportion of patients admitted to an acute Stroke Unit within 4 hours and those receiving a CT Scan within 24 hours are less than the quality standards set by the Trust, although local (specialty) data systems suggest that compliance is better. A timed and named action plan has been requested to ensure that any performance issues and any reporting issues are resolved as a matter of urgency. Thrombolysis performance is now also included within the report. Data currently shows that no patients (10) requiring thrombolysis have received this within 60 minutes, with 50% receiving thrombolysis beyond 90 minutes. A rectification plan has been requested as part of the above overall action plan.

MRSA Screening - the proportion of MRSA screens matched with actual patients requiring screens for both Elective and Non-Elective admissions is at 76% and 77% respectively. Recent Corporate messages are to increase the proportion of patients screened, whilst in parallel resolving any potential data discrepancies, such as ensuring patient treatment locations are correctly identified and recorded on information systems. A policy introduced within Surgery A is that each patient admitted to an acute surgical ward must have an MRSA screen beforehand.

Emergency Care - 4-hour wait performance improved during August to 95.5%. The improvement trajectory for the year has been updated to reflect actual attendance numbers for the period since end July. Cumulative performance for the year to 8 September 2013 is 94.6%, compared with the original trajectory of 94.9%. Performance for Quarter 2 (as at 10 September 2013) is 95.1%. Performance against each of the 5 Clinical Quality Indicators improved during August, although only 2 of the 5 continue to be met during the month and year to date.

WMAS - the proportion of clinical handovers within 15 minutes and average ambulance turnaround times both continue to meet operational standards. However, the absolute number of ambulances subject to turnaround delays in excess of 30 minutes is not showing any sign of reducing. An action previously identified (effective end October) is to increase the number of cubicles within the Emergency Care Department at Sandwell to faciltate speedier handover.

Patient Experience

Cancelled Operations - Elective Admissions cancelled at the last minute for non-clinical reasons remain relatively stable and are 0.7% for the year to date. The number of patients experiencing more than 1 late cancellation increased on both sites to 9 during the month. Additionally the overall proportion of patients experiencing multiple cancellations increased to 18.6% during the month.

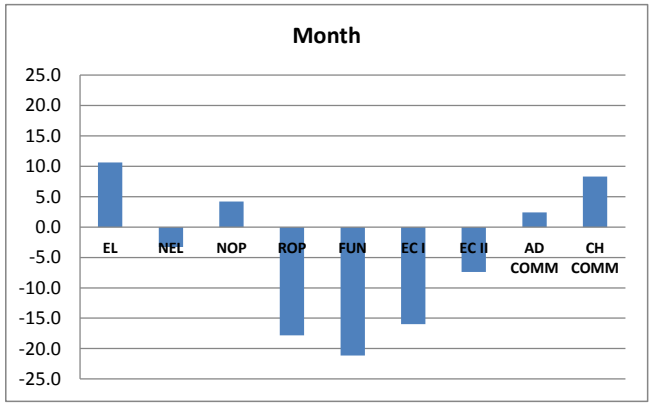
Cancelled Operation 28-day standard - a data validation excercise has identified an underreporting of the number of breaches of this standard, whereby any patient whose operation is cancelled at the 'last minute' for non-clinical reasons is offered a new date for the operation within 28-days of the date that the operation was originally booked for. Since April a total of 12 breaches have actually occured, with 0 having been previously reported.

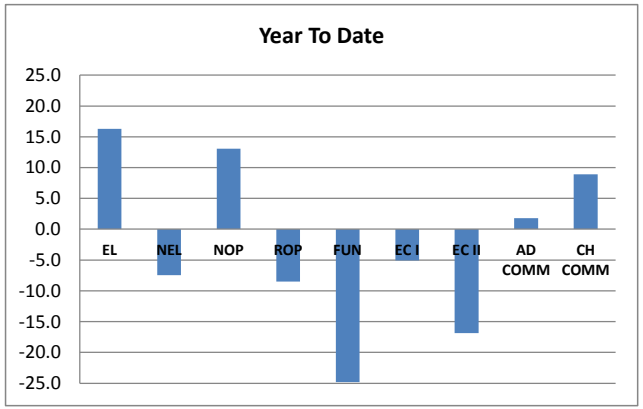
Staff Experience

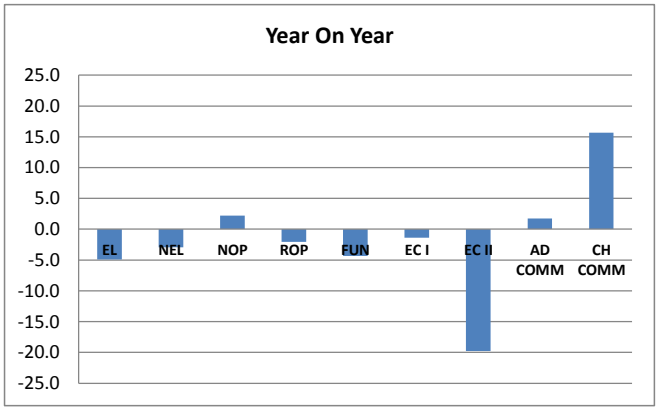
PDR - overall compliance for the most recent 12-month cumulative period improved to 78.75% (range by Group / Directorate 47% - 91%). A total of 923 staff received a PDR during August, increasing the overall number of staff within the most recent 3 months to 2421, representing 42% of the total for the year. **Mandatory Training** - compliance as at the end of August is 86.4% (range by Group / Directorate 80 - 98%). Significant improvement could be achieved by increasing compliance against a targetted number of modules, such as: Conflict Resolution, Fire Safety awareness, Harrassment & Bullying (level 2) and Medical Devices training.

Activity & Contractual

Activity - Variance expressed as a percentage between actual activity and planned (contracted) activity is reflected for the month and year to date in the graphs below. Additionally, there is a year on year comparison of current year with previous year for the corresponding period of time. High level Elective activity continues to exceed the plan for the month and year to date, although remains (4.9%) less than that delivered during the corresponding period last year. Non-Elective activity is currently 7.5% less than the plan for the year to date, and 2.9% less than the corresponding period last year. Overperformance against the New Outpatient activity plan and an underperformance against the Review OP activity plan, gives a Follow Up:New OP Ratio of 2.22 for the year to date, significantly less than the ratio derived from plan, and that for the same period last year. Type I and Type II Emergency Care activity to date remains less than plan and for the corresponding period in 2012 / 2013. Adult Community and Child Community activity is currently exceeding plan for month, year to date and 2012 / 2013.







Exec Lead	KPI Source	Data Source	Indicator			April	May	June	July		August			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
R0	A	4	Infection Control	C. Difficile (DH Reportable)	No.	3 ▼	1 ▲	6 ■	2 ■	3 ▲	5 ▲	1 ▲	2 ■	3 ■	18	20	46	No variation		Any variation	●	95	37
	A			MRSA Bacteraemia	No.	1 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	1	0	0	No variation		Any variation	●	2	1
RB	A	1	Cancer	2 weeks	%	93.2 ▼	95.3 ▲	93.1 ▼	→		94.0 ▲	→			93.9	=>93	=>93	No variation		Any variation	●	94.8	94.7
	A			2 weeks (Breast Symptomatic)	%	96.9 ▲	93.1 ▼	93.9 ▲	→		96.2 ▲	→			95.1	=>93	=>93	No variation		Any variation	●	95.8	95.9
	A			31 Day (diagnosis to treatment)	%	100 ▲	96.1 ▼	98.6 ▲	→		100 ▲	→			98.7	=>96	=>96	No variation		Any variation	●	99.5	99.5
	A			31 Day (second/subsequent treatment - surgery)	%	100 ▲	94.2 ▼	97.6 ▲	→		100 ▲	→			97.9	=>94	=>94	No variation		Any variation	●	100.0	99.2
	A			31 Day (second/subsequent treatment - drug)	%	100 ■	100 ■	100 ■	→		100 ■	→			100	=>98	=>98	No variation		Any variation	●	99.2	99.8
	A			31 Day (second/subsequent treat - radiotherapy)	%	n/a	n/a	n/a	→		n/a	→			n/a	=>94	=>94	No variation		Any variation	●	100	100
	A			62 Day (urgent GP referral to treatment)	%	90.8 ▼	91.8 ▲	86.2 ▼	→		86.2 ■	→			89.0	=>85	=>85	No variation		Any variation	●	86.9	87.1
	A			62 Day (referral to treat from screening)	%	100 ▲	100 ▲	100 ■	→		96.0 ▼	→			98.9	=>90	=>90	No variation		Any variation	●	98.5	96.9
	H			62 Day (referral to treat from hosp specialist)	%	85.2 ▼	93.3 ▲	89.3 ▼	→		83.3 ■	→			86.9	=>85	=>85	No variation		Any variation	●	91.6	93.2
	A	2	Emergency Care 4-hour waits		%	92.4 ▲	94.4 ▲	95.5 ■	97.0 ▲	93.1 ▼	94.7 ■	97.2 ▲	94.3 ▲	95.5 ■	94.50	=>95	=>95	=>95		<95	●	95.38	92.54
RB	A	2	Referral To Treatment	Admitted Care (RTT <18 weeks)	%	92.2 ▼	92.5 ▲	92.3 ▼	→		92.5 ▲	→			92.5*	=>90.0	=>90.0	=>90.0	85-90	<85.0	●	93.2	93.7
	A			Non-Admitted Care (RTT <18 weeks)	%	97.8 ▼	98.3 ▲	97.2 ▼	→		96.9 ▼	→			96.9*	=>95.0	=>95.0	=>95.0	90 - 95	=<90.0	●	97.5	98.6
	A			Incomplete Pathway (RTT <18 weeks)	%	95.6 ▲	96.4 ▲	93.3 ▼	→		92.8 ▼	→			92.8*	=>92.0	=>92.0	=>95.0	87 - 92	=<87.0	●	97.2	95.3
	E			Treatment Functions Underperforming	No.	5 ▼	6 ▼	7 ■	→		8 ▼	→			8*	0	0	0 / month	1 - 6 / month	>6 / month	●	10 (Q4)	11 (Q4)
RB	E	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks	%	0.50 ▲	0.91 ▼	0.67 ▲	→		0.57 ▲	→			0.57*	<1.0	<1.0	<1.0	1.0 - 5.0	>5.0	●	0.99	0.88
	G	11	Data Quality	Data Completeness Community Services	%	>50	>50	>50	→		>50	→		>50	>50	=>50	=>50	=>50		<50	●		>50
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	Y
RB	C	2	Delayed Transfers of Care		%	3.1 ▼	3.2 ▼	2.7 ▲	2.7 ▼	2.7 ▲	2.7 ■	3.9 ■	3.5 ■	3.7 ■	3.2	<3.5	<3.5	<3.5	3.5 - 5.0	>5.0	●	5.2	2.9
RB	B	2	Mixed Sex Accommodation Breaches	As percentage of completed FCEs	%	1.30 ■	0.89 ▲	0.02 ■	→		0.00 ■	→		0.00 ■	0.00*	0.0	0.0	0.00	0.00 - 0.50	>0.50	●	0.07	
				Numerical	No.	161 ■	114 ▲	2 ▲	→		0 ■	→		0 ■	0*	0.0	0.0	0		>0	●		
RS	A	3	VTE Risk Assessment		%	92.9 ▲	94.7 ▲	95.3 ■	→		95.9 ▲	→		94.4 ■	94.4*	95	95	=>90		<90	●	92.4	90.8

Financial Metrics - NHS Performance Assessment Framework

RW	E	16	Initial Planning - Planned Outurn as a proportion of turnover		%	0.05 ▲	0.57 ▼	0.00 ▼	→		0.00 ■	→		0.00 ■	0.00	0-3.0	0-3.0	0-3.0		=>-2.0			
			Year To Date	YTD Operating Performance	%	0.00 ▲	0.01 ▼	0.01 ■	→		-0.04 ▲	→		-8.90 ▲	-0.09	0-3.0	0-3.0	0-3.0		=>2.0			
				YTD EBITDA	%	11.29 ▲	6.69 ▼	5.44 ▼	→		5.95 ▲	→		6.00 ▲	0.06	=>5.0	=>5.0	=>5.0		<1.0			
			Forecast Outturn	Forecast Operating Performance	No.	0.00 ▲	0.00 ■	0.00 ■	→		0.00 ■	→		0.00 ■	0.00	0-3.0	0-3.0	0-3.0		=>-2.0			
				Forecast EBITDA	%	6.88 ▲	6.46 ▼	6.32 ▼	→		6.00 ▼	→		6.00 ■	0.06	=>5.0	=>5.0	=>5.0		<1.0			
				Rate of Change in Forecast Surplus of Deficit	%	0.00 ■	0.00 ■	0.00 ■	→		0.00 ■	→		0.00 ■	0.00	=<3.0	=<3.0	=<3.0		>2.0			
			Undrelying Financi	Underlying Position	%	1.46 ▼	1.07 ▼	0.92 ▼	→		1.07 ▲	→		1.10 ▲	0.01	=>0.0	=>0.0	=>0.0		>-2.0			
				EBITDA Margin	%	6.88 ▲	6.46 ▼	6.32 ▼	→		6.00 ▼	→		6.00 ■	0.06	=>5.0	=>5.0	=>5.0		<1.0			
			Financial Processe	Better Payment Practice Code Value	%	90.60 ▼	92.60 ▲	93.84 ▲	→		87.00 ▼	→		92.10 ▲	92.00	=>95	=>95	=>95		<60			
				Better Payment Practice Code Volume	%	94.90 ■	94.40 ▼	92.76 ▼	→		87.00 ▼	→		92.70 ▲	93.00	=>95	=>95	=>95		<60			
				Current Ratio	ratio	1.09 ▲	1.02 ▼	1.05 ▲	→		1.06 ▲	→		1.07 ▲	1.07	=>1.0	=>1.0	=>1.0		<0.5			
				Debtor Days	Days	12.31 ▼	12.97 ▼	13.29 ▼	→		13.54 ▼	→		11.71 ▲	11.71	<=30	<=30	<=30		>60			
				Creditor Days	Days	40.44 ▼	44.79 ▼	39.03 ▲	→		39.03 ■	→		13.22 ■	13.22	<=30	<=30	<=30		>60			

Exec Lead	KPI Source	Data Source	Indicator					April	May	June	July			August			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
								Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RS	A	3	VTE	Risk Assessment		224	%	92.9 ▲	94.7 ▲	95.3 ■	→		95.9 ▲	→		94.4 ■	94.4*	95	95	=>90		<90	●	92.4	90.8
RS	H			Root Cause Analysis		224	%	→	→	100 Base	Quarterly Monitoring			Quarterly Monitoring			100 (Base)	100	100				●		
RO	H	8	NHS Safety Thermometer	Reduction in Prevalence of Pressure Ulcers	ACUTE	224	%	5 ■	8 ▼	11 ■	→		5 ■	→		19 ■	48	10% reduction on aggregate 6-month base (Oct 2012 - March 2013) of 81 (68 Acute + 13 Comm)					●		
RO	H	8			COMMUNITY	224	%	0 ■	1 ▼	0 ■	→		0 ■	→			1						●		
RO	H	8	Dementia	Find, Investigate and Refer		269	%	2 of 3 met	2 of 3 met	2 of 3 met	→		1 of 3 met	→		0 of 3 met	0 of 3 met	90% (F, I and R) for 3 consec. months		No variation		Any variation	● ●		
RO	H			Clinical Leadership		45		→	→	→	→			→			Identified	In Place	In Place	No variation		Any variation	●		
RO	H	8		Supporting Carers of People with Dementia		135		→	→	On Track	→		On Track	→		Audit Undertaken	Audit Undertaken	Monthly Audit		No variation		Any variation	●		
RO	H	8	Friends & Family Test	Phased Data Collection Expansion - Maternity		137	%	→	→	→	By October with 30% response rate			By October with 30% response rate			On Track	30	60				●		
RO	H	8		Increased Response Rate (Emergency Care plus All Wards)		175	%	→	→	10.61 Base	→			→			10.61 (Base)						●		
				Increased Response Rate - All Wards only			%	→	→	33.70 Base	→			→											
				Increased Response Rate - Emergency Care only			%	→	→	5.10 Base	→			→											
RO	H	8		Improve Performance on Staff FFT		137	Score	→	→	→	Autumn Annual Staff Survey			Autumn Annual Staff Survey											
RB	H	20	Safe Storage of Medicines			1105	%	→	→	Base identified	Quarterly Monitoring			Quarterly Monitoring			Base identified	Compliance against Standard 2		No variation		Any variation	●		
RO	H	8	Dementia Patient Stmulation			1138		→	→	On Track	Quarterly Monitoring			Quarterly Monitoring			On Track			No variation		Any variation	●		
RS	H		Use of Pain Care Bundles			1138	%	→	→	Base identified	Quarterly Monitoring			Quarterly Monitoring			Base identified	To be agreed		No variation		Any variation	●		
RS	H		Use of Sepsis Care Bundles			1105	%	→	→	→	Baseline Assessment September - November			Baseline Assessment September - November			On Track			No variation		Any variation	●		
RO	H	11	Community Risk Assessment & Advice			1105	%	→	→	→	Baseline Assessment during Q2			Baseline Assessment during Q2			On Track			No variation		Any variation	●		
RS	H		Recording DNAR Decisions			1105	%	→	→	→	Bi-Annual Ward Audit / Improvement			Bi-Annual Ward Audit / Improvement			On Track			No variation		Any variation	●		
RS	H		Specialised Commissioners	Clinical Quality Dashboards		60		→	→	→	→			→			Compliant			No variation		Any variation	●		
RS	H	22		Behcets Highly Specialised Service		60		→	→	→	Annual Workshop & Report			Annual Workshop & Report			On Track			No variation		Any variation	●		
RS	H	12		HIV - Communication with GPs		180		→	→	→	→			→			Compliant			No variation		Any variation	●		
RS	H	12		Neonatal - Retinopathy Of Prematurity (Screening)		180		→	→	→	→			→			Compliant			No variation		Any variation	●		

AUGUST 2013 | **CLINICAL QUALITY & OUTCOMES**

Exec Lead	KPI Source	Data Source	Indicator				April	May	June	July			August			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RS	H	3	Stroke Care	Pts spending >90% stay on Acute Stroke Unit		%	83.3 ■	96.2 ▲	91.5 ▼	→		95.0 ▲	→		89.1 ▼	90.9	83	83	No Variation	0 - 2% Variation	>2% Variation	●	85.9	85.6
	H			Pts admitted to Acute Stroke Unit within 4 hrs		%	69.2 ▲	84.1 ▲	92.3 ■	→		92.1 ▼	→		83.0 ■	84.5	90	90	No Variation	0 - 2% Variation	>2% Variation	●	68.7	59.1
	H			Pts receiving CT Scan within 24 hrs of presentation		%	87.5 ▲	86.1 ▼	85.2 ▼	→		85.0 ▼	→		91.9 ▲	86.9	100	100	No Variation	0 - 2% Variation	>2% Variation	●	100	92
	H			Pts receiving CT Scan within 1 hr of presentation		%	60.5 ▲	63.2 ▲	67.3 ▲	→		64.1 ▼	→		64.9 ▲	64.1	50	50	No Variation	0 - 2% Variation	>2% Variation	●	37.5	52.0
	H			Admission to Thrombolysis Time (% within 60 mins)		%	0.0 ■	0.0 ■	0.0 ■	→		0.0 ■	→			0.0	85	85	=>85		<85	● ● ●		
				Admission to Thrombolysis Time (% over 90 mins)		%	50.0 ■	50.0 ■	66.7 ▼	→		0.0 ■	→			50.0	0	0	0		>0	● ● ●		
	H			Stroke Admissions - Swallowing assessments (<24h)		%	91.7 ■	100.0 ■	92.9 ■	→		100.0 ■	→		100.0 ■	96.8	100	100	=>98		<98	●		
	H			TIA (High Risk) Treatment <24 h from initial presentation		%	66.7 ▼	63.2 ▼	81.3 ▲	→		83.3 ▲	→		72.0 ▼	73.6	60	60	No Variation	0 - 2% Variation	>2% Variation	●	53.2	69.8
	K			TIA (Low Risk) Treatment <7 days from initial presentation		%	74.1 ▲	88.4 ▲	88.2 ▼	→		91.2 ▲	→		92.5 ▲	86.3	60	60	No Variation	0 - 2% Variation	>2% Variation	●	30.4	75.9
RO		4	Infection Control	MSSA Bacteraemia		No.	2	1	0	0	1	1	0	0	0	4	No. Only	No. Only					12	15
				E Coli Bacteraemia		No.	2	2	4	2	2	4	4	1	5	17	No. Only	No. Only					50	48
	F	3		MRSA Screening - Elective	Patient Not Matched	%	196.6 ▲	173.2 ▼	196.9 ▲	Numerator = 3646	Denominator = 1459	249.9 ▲	Numerator = 2979	Denominator = 1372	217.1 ▼	217.1*	86	90	No variation		Any variation	●		138.9
	F				Best Practice - Patient Matched	%	67.9 ▲	59.9 ▼	67.2 ▲	Numerator = 1178	Denominator = 1459	80.7 ■	Numerator = 1042	Denominator = 1372	75.9 ▼	75.9*	74	80	No variation		Any variation	●		59.5
	F			MRSA Screening Non Elective	Patient Not Matched	%	79.2 ▲	82.2 ▲	81.3 ▼	Numerator = 2555	Denominator = 3039	84.1 ▲	Numerator = 2664	Denominator = 3058	87.1 ■	87.1*	86	90	No variation		Any variation	●		76.8
	F				Best Practice - Patient Matched	%	67.4 ▲	72.6 ■	74.5 ▲	Numerator = 2555	Denominator = 3519	72.6 ▼	Numerator = 2664	Denominator = 3447	77.3 ▲	77.3*	74	80	No variation		Any variation	●		64.9
RS	H	3	WHO Safer Surgery Checklist	Audit - 3 sections		%	99.9 ▲	99.9 ■	99.6 ▼	→		99.8 ▲	→		99.2 ▼	99.2*	100	100	=>98		<98	●		
	H	3		Audit - 3 sections and brief		%	94.1 ■	93.9 ▼	90.4 ▼	→		92.6 ▲	→		89.5 ▼	89.5*	100	100	=>95		<95	●		
	H	3		Audit - 3 sections, brief and debrief		%	79.6 ▼	80.5 ▲	75.3 ▼	→		76.0 ▲	→		76.3 ▲	76.3*	100	100	=>85		<85	● ●		
KD	F	14	Never Events - in month			No.	0 ■	0 ■	1 ■	→		0 ■	→		1 ■	2	0	0	No variation		Any variation	●		2
			Medication Errors causing serious harm			No.	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited										
	F		Open Serious Incidents Requiring Investigation (SIRI)			No.	5	9	8	→		11	→		8	8*	No. Only	No. Only					2
	F		Open Central Alert System (CAS) Alerts			No.	5	5	3	→		6	→		6	6*	No. Only	No. Only					10
RO	D		Falls Resukting In Severe Injury or Death			No	3 ▼	2 ▲	5 ▼	→		0 ■	→		0 ■	10	0	0	No variation		Any variation	●		22
RO	D	8	Grade 3 or 4 pressure ulcers - avoidable			No	2	1	1	→		1	→			5								
RO	H	8	High Impact Nursing Actions	Inpatient Falls reduction	Acute	No	56 ▼	49 ■	51 ▼	→		67 ■	→			223	220	660	=<55/m		>55/m	●		737
	H				Community	No	15 ■	10 ■	7 ▲	→		8 ▼	→			40	48	144	=<12/m		>12/m	●		
RS		3	Obstetrics	Post Partum Haemorrhage (>2000 ml)		No.	1 ■	1 ■	0 ▲	→		0 ■	→		0 ■	2	20	48	=<2	3 - 4	>4	●	7	10
				Admissions to Neonatal ICU		%	10.5 ■	10.0 ■	8.1	→		9.2 ▼	→			9.4	=<10	=<10	=<10	10.0-12.0	>12.0	●	10.7	10.2
				Admissions of full term babies to Neonatal Care		No.	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited										
				Adjusted Perinatal Mortality Rate (per 1000 babies)		/1000	11.7 ■	6.6 ■	6.0 ▲	→		8.0 ■	→			8.0*	<8.0	<8.0	<8	8.0 - 10.0	>10	●	11.9*	4.5
				Caesarean Section Rate	Elective and Non-Elective	%	24.6 ■	27.2 ■	25.1 ▲	→		25.7 ▼	→		25.5 ▲	25.6	<25.0	<25.0	=<25.0	25-28	>28.0	●	22.2	23.6
	H				Elective	%	9.1	13.5	12.6	→		11.2	→		10.7	11.4								
	H				Non-Elective	%	15.5	13.7	12.6	→		14.5	→		14.8	14.2								
	H			Early Booking (Completed Assessment <12+6 weeks)		%	78.0 ■	80.0 ▲	79.0 ▼	→		79.0 ■	→			79.0*	=>90	=>90	=>90	75-89	<75	● ●	76.0	78.0
RO		2	Infant Health & Inequalities	Maternal Smoking Rates		%	→	→	9.4 ▼	→		→	→		→	9.4	<11.5	<11.5	<11.5	11.5 - 12.5	>12.5	●	9.8	9.9
				Breast Feeding Initiation Rates		%	→	→	77.0 ▲	→		→	→		→	77.0	>63.0	>63.0	>63.0	61-63	<61.0	●	73.0	72.6

Exec Lead	KPI Source	Data Source	Indicator				April	May	June	July			July			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RS	H	3	Mortality Reviews within 42 working days			%	74 ▲	78 ▲	72 ▼	→			→			72*	80	80	No variation		Any variation	●	66.9	
RS		6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate		HSMR	87.8 Feb'12 to Jan'13	88.1 Mar'12 to Feb'13	88.9 Apr'12 to Mar'13	→		89.1 May'12 to Apr'13	→		88.4 Jun'12 to May'13	88.4							
				Peer (SHA) HSMR		HSMR	96.7	97.0	98.0	→		97.5	→		97.5	97.5							
				Peer (National) HSMR - Quarterly		HSMR	→	→	94.0	→		→	→		→	94.0							
	D	19		SHMI		SHMI	94.3 Feb'12-Jan'13	95.5 Mar'12-Feb'13	95.9 Apr'12-Mar'13	→		99.2 May'12 - Apr'13	→			99.2							
			Maternal Deaths			No.	0	0	0	→		0	→		0	0							
RB		3	Readmission Rates (to any specialty) within 30 days of discharge - Operating Framework Definition effective April 2011	Following initial Elective Admission		No.	112 ■	148 ■	99 ■	→		131 ■	→		121 ■	618	610	1463	No Variation	0 - 5% Variation	>5% Variation	●	1463	1587
				Following initial Elective Admission		%	1.08 ■	1.38 ■	0.97 ■	→		1.21 ■	→		1.24 ▼	1.19	1.15	1.15	No Variation	0 - 5% Variation	>5% Variation	●	1.15	1.25
				Following initial Non-Elective Admission		No.	609 ■	667 ▼	586 ■	→		612 ■	→		562 ■	3080	2851	6842	No Variation	0 - 5% Variation	>5% Variation	● ●	6842	7528
				Following initial Non-Elective Admission		%	5.88 ■	6.23 ▼	5.76 ▲	→		5.66 ■	→		5.77 ▼	5.94	5.38	5.38	No Variation	0 - 5% Variation	>5% Variation	● ●	5.38	5.91
RB	K	3	Hip Fractures	Operation <24 hours of admission		%	66.7 ■	51.4 ▼	72.0 ■	→		63.0 ■	→		85.7 ■	85.7*	80.0	85.0	No Variation	0 - 2% Variation	>2% Variation	●	66.4	76.7
RB		3	Data Quality	Valid Coding for Ethnic Category (FCEs)		%	93 ■	93 ▼	93 ■	→		93 ■	→		92 ▼	93	90	90	>/=90	89.0-89.9	<89	●	95	93
		3		Maternity HES		%	6.4 ▼	6.9 ▼	6.6 ▲	→		6.8 ▼	→		6.7 ▲	6.7	<15	<15	=<15	16-30	>30	●	6.0	6.6
	D	3	Emergency Care Timeliness	Total Time in Department (95th centile)		h : m	6:02 ▲	5:07 ▲	4:39 ▲	→		4:56 ▼	→		4:34 ▲	5:03	=<4hrs	=<4hrs	=<4hrs		=<4hrs	● ●	3 : 59	5 : 15
	D			Time to Initial Assessment (=<15 mins)(95th centile)		mins	15 ■	18 ■	18 ■	→		18 ■	→		16 ▲	17	=<15	=<15	<15		<15	●	21	17
	D			Time to treatment in department (median)		mins	50 ▲	53 ▼	50 ▲	→		51 ▼	→		42 ▲	49	=<60	=<60	=<60		>60	●	59	58
	D		Emergency Care Patient Impact	Unplanned re-attendance rate		%	7.89 ▼	8.23 ▼	8.38 ▼	→		8.31 ▲	→		5.75 ▲	7.08	=<5.0	=<5.0	=<5.0		>5.0	● ●	8.66	7.81
	D			Left Department without being seen rate		%	3.82 ▲	4.02 ▲	4.03 ▼	→		4.73 ▼	→		3.35 ▲	3.94	=<5.0	=<5.0	=<5.0		>5.0	●	4.83	4.67
			Emergency Care Trolley Waits >12 hours			No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0	0	0	0		>0	●		
RB	H	18	Ambulance Turnaround	Clinical Handovers completed within 15 minutes		%	81.4 ▲	84.89 ▲	83.9 ▼	82.1 ▲	87.8 ■	85.4 ■	82.1 ■	87.2 ▲	85.1 ▲	85.1*	=>85	=>85	=>85		<85	●		71.3
	H			Average Turnaround Time		m : s	29:44 ■	29:06 ▲	27:30 ▲	27:59 ▼	27:47 ▼	27:52 ▼	28:31 ▼	27:30 ▲	27:57 ▼	27:57*	=<30:00	=<30:00	=<30:00		>30:00	●	29:23	34:24
	H			30 - 60 minutes	All Journeys	No.	1459 ▲	1404 ▲	1237 ▲	634 ▼	742 ▼	1376 ▼	591 ▲	742 ■	1333 ▲	6809	0	0	0		0	● ● ●		22089
	H				Hospital Fines (WMAS report)	No.	451 ■	424 ▲	238 ▲	164 ▼	130 ▼	294 ▼	150 ▲	102 ▲	252 ▲	1659	0	0	0		0	● ● ●		
	H			In Excess of 60 minutes	All Journeys	No.	90 ▲	56 ▲	23 ▲	9 ▲	15 ▼	24 ▼	18 ▼	14 ▲	32 ▼	225	0	0	0		0	● ● ●	1256	2354
	H				Hospital Fines (WMAS report)	No.	57 ■	28 ▲	13 ▲	4 ▲	8 ■	12 ▲	11 ▼	10 ▼	21 ▼	131	0	0	0		0	● ● ●		

AUGUST 2013	PATIENT EXPERIENCE

Exec Lead	KPI Source	Data Source	Indicator			April	May	June	July		August		To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	S'well	City	Trust	YTD	13/14						
RB	K	21	Reporting Times of Imaging Requests from Emergency Care - % **reported within 24 hours / next day**	Plain Radiography	%	99 ■	100 ▲	99 ▼	→		→		99 ■	99*	90	90	No variation		Any variation	●		99
	K			Ultrasound	%	100 ■	100 ■	95 ▼	→		→		100 ▲	100*	90	90	No variation		Any variation	●		100
	K			MRI	%	79 ▼	88 ▲	90 ■	→		→		70 ■	84 ▲	84*	90	90	No variation		Any variation	●		84
	K			CT	%	99 ■	99 ■	97 ▼	→		→		99 ▲	99 ■	99*	90	90	No variation		Any variation	●		99
KD	F	14	Complaints	No. of Complaints Received formal and link)	No.	63	65	50	→		→		72	94	344	No. Only	No. Only					834	724
	K			No. of Active Complaints in the System (formal and link)	No.		302	336	→		→		272	254	254*	No. Only	No. Only						
	K			No. of First Formal Complaints received / 1000 episodes of care	No.			0.625	→		→		0.45	0.88	0.88*	No. Only	No. Only						
	K			No. of Days to acknowledge a formal or link complaint (% within 3 working days)	%		97 ■	78 ▼	→		→		94 ▲	97 ▲	97*	100	100	100		<100	●		
	K			No. of responses which have exceeded their original agreed response date (% of total active complaints)	%		28 ■	32 ▼	→		→		36 ▼	25 ▲	25*	0	0	0		>0	● ●		
	K			No. of responses sent out	No.		17	5	→		→		128	73	73*	No. Only	No. Only						
	K			Oldest' complaint currently in system	Days		197	155	→		→		165	147	147*	No. Only	No. Only						
RB		15	Elective Access Contact Centre	Number of Calls Received	No.	12925	12188	11687	→		→		13089	11250	61139	No. Only	No. Only					111793	150454
				Average Length of Queue	mins	0.23 ▲	0.23 ■	0.22 ▲	→		→		0.25 ▼	0.22 ▲	0.22*	<1.0	<1.0	<1.0	1.0-2.0	>2.0	●	0.21	0.25
				Maximum Length of Queue	mins	6.4 ■	6.2 ▲	11.2 ▼	→		→		15.5 ■	17.2 ▼	17.2*	<6.0	<6.0	<6.0	6.0-12.0	>12.0	●	10.1	14.2
			Telephone Exchange	Number of Calls Received	No.	76726	73866	65266	→		→		71422		222014	No. Only	No. Only					849502	901987
				Calls Answered	%	88.1	92.1	92.0	→		→		92.2		91.1	No. Only	No. Only					90.2	90.7
				Answered within 15 seconds	%	54.3	66.2	74.3	→		→		73.8		66.9	No. Only	No. Only					52.5	58.2
				Answered within 30 seconds	%	69.4	79.6	85.5	→		→		85.4		79.8	No. Only	No. Only					68.1	73.0
				Average Ring Time	Secs	24.3	17.1	12.3	→		→		12.3		12.3*	No. Only	No. Only					25	18
				Longest Ring Time	Secs	601	397	366	→		→		411		411*	No. Only	No. Only					718	349
RB		2	Patient Flow	Average Length of Stay	Days	3.6 ▲	3.8 ▼	3.4 ▲	4.1 ▼	3.0 ▼			3.5 ▼		3.6	4.3	4.3	No Variation	0 - 5% Variation	>5% Variation	●	4.2	3.8
				Day of Surgery (IP Elective Surgery)	%	92.1 ▼	94.0 ▲	94.7 ▲	96.2 ▲	96.9 ▲	87.4 ▼	95.4 ▼	96.6 ▲	92.7 ▼	94.1	82.0	82.0	No Variation	0 - 5% Variation	>5% Variation	●	89.5	92.0
				Daycase Rate - All Procedures	%	84.6 ▼	82.4 ▼	82.5 ▲	82.8 ▲	82.3 ▼	84.4 ▲	83.6 ▲	82.5 ■	83.9 ▲	84.6	80.0	80.0	No Variation	0 - 5% Variation	>5% Variation	●	82.7	83.9
				Available Beds at Month End	No.	739	738	742	→		→		745	740	740*								
RB	H	2	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.6 ■	0.9 ■	0.6 ■	1.1 ■	0.5 ▲	0.6 ■	0.9 ■	0.8 ■	0.8 ■	0.7	<0.8	<0.8	<0.8	0.8 - 1.0	>1.0	●	0.6	0.7
	H			28 day breaches	No.	4 ■	1 ▲	5 ▼	→		→		2 ▲		12	0	0	3 or less	4 - 6	>6	● ● ●	1	2
				No. of second or susequent urgent operations cancelled	No.	0 ■	0 ■	0 ■	→		→		0 ■	0 ■	0	0	0	<0		>0	●		0
				Sitrep Declared Late Cancellations	No.	38 ■	44 ▼	29 ▲	24 ■	17 ▲	9 ■	27 ▼	41 ▼	36 ▲	188	133	320	0-5% variation	5 - 15% variation	>15% variation	● ●	363	425
				Sitrep Declared Late Cancellations (Pts. >1 occasion)	No.	5 ▲	6 ▼	6 ■	1 ▲	1 ▲	3 ▼	6 ▼	2 ▲	9 ▼	9*	0	0	No variation		Any variation	●		60
				Multiple Cancellations experienced by same patient (all cancellations)	%	17.7 ▼	12.5 ▲	17.3 ▼	→		→		12.1 ▲	18.6 ▼	18.6*	7.0	0.0	No variation		Any variation	● ●		13.6
				All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	%	6.8 ▲	5.8 ▲	6.0 ▼	→		→		5.8 ▲	5.3 ▲	5.3*	4.5	3.1	No variation		Any variation	●		6.2
RB		10	Cardiology	Primary Angioplasty – Door To Balloon Time (90 mins)	%	85.0 ▼	90.9 ▲	85.7 ▼	75.0 ■	75.0 ■			75.0 ■		83.1	=>80	=>80	=>80	75-79	<75	●	80.1	85.4
				Primary Angioplasty – Call To Balloon Time (150 mins)	%	81.3 ▼	100.0 ▲	92.3 ▼	85.7 ▲	90.9 ▼			88.9 ▼		89.1	=>80	=>80	=>80	75-79	<75	●	88.4	91.2
				Rapid Access Chest Pain	%	96.5 ▼	98.0 ■								97.2	100	100	=>98	96 - 97.9	<96	●	99.1	95.7
RB	H	12	GU Medicine	Patients offered app't within 48 hrs	%	100 ■	100 ■	100 ■	→		→		100 ■	100 ■	100	=>98	=>98	=>98	95-98	<95	●	100	100

AUGUST 2013	STAFF EXPERIENCE

Exec Lead	KPI Source	Data Source	Indicator			April	May	June	July			August			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
MS		7	Staff in Post	Establishment	wte	6851	7010	6994	→			→			6994*								
				Staff In Post (contracted)	wte	6542	6549	6529	→		6491	→			6491*								
				Staff In Post (headcount)	no.	7543	7545	7521	→		7479	→			7479*								
				Staff In Post - FTE / Headcount ratio	Ratio	1.15	1.15	1.15	→		1.15	→			1.15*								
				Potential Vacancies (All)	wte	309	461	464	→			→			464*								
				Potential Vacancies (Qualified Nursing)	wte	26	108	138	→			→			138*								
				Posts Advertised in Month (NHS Jobs)	wte	103	167	154	→		258	→			258*								
				Proportion Temporary Staff - Clinical	%	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
				Proportion Temporary Staff - Non Clinical	%	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
			Nursing Staff	Registered Nurses as percentage of Nurses	%	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
				Nurse : Bed Ratio	Ratio	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
			Staff Turnover	Leavers	wte	65	51	61	→		69	→		281	527	No. Only	No. Only						1064
				Starters	wte	70	39	48	→		44	→		267	468	No. Only	No. Only						862
				Induction	%	94.5 ■	93.0 ■	93.5 ▲	→			→			93.5	100	100	=>85		<85			91.3
RB	K	7	Learning & Development	PDRs (12-month rolling)	No. (%)	5191 (70.0) ▲	5211 (70.3) ▲	5293 (71.5) ▲	→		5374 (72.9) ▲	→		5779 (78.8) ■	5779 (78.8)	7389 (100)	7389 (100)	0-15% variation	15 - 25% variation	>25% variation	● ●	5348	5127
RS	F	14		Medical Appraisal and Revalidation	%	77	78	77	→		81	→		81	81*	No. Only	No. Only						77
MS	K	3		Mandatory Training Compliance	%	87.7 ▲	88.2 ▲	88.6 ▲	→		87.9 ▼	→		86.4 ▼	86.4	100	100	=>95	90 - 95	<90	● ●	71.9	86.4
RB		7	Sickness Absence	Long Term (> 28 days)	%	3.34 ▲	3.24 ▲	3.13 ▲	→		3.20 ▼	→		3.26 ▲	3.23	<2.15	<2.15	<2.15	2.15-2.50	>2.50		2.95	3.39
				Short Term (<28 days)	%	1.03 ■	0.77 ■	0.82 ▼	→		0.79 ▲	→		0.71 ▲	0.82	<1.00	<1.00	<1.00	1.00-1.25	>1.25		0.95	0.99
	D			Total	%	4.37 ▲	4.01 ▲	3.94 ▲	→		3.99 ▼	→		3.97 ▲	4.05	<3.15	<3.15	<3.15	3.15-3.75	>3.75	● ● ●	3.90	4.38
RB		17	Bank & Agency Use	Nurse Bank Fill Rate	%	72.1	76.8	74.7	→		76.8	→		78.0	75.8	No. Only	No. Only					87.2	82.9
				Nurse Bank Shifts covered	No.	4915 ▲	5011 ▼	4630 ▲	→		4745 ▼	→			19301	15660	46980	0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	● ● ●	56396	60463
				Nurse Agency Shifts covered	No.	2706 ▼	2970 ▼	1914 ▲	→		1720 ▲	→			9310	1277	3830	0 - 5% Variation	5 - 10% Variation	>10% Variation	● ● ●	6948	12874
				Agency Spend as % Employee Benefit Expenditure	%	4.29	4.28	2.60	→		3.70	→		3.27	3.27*								

AUGUST 2013	ACTIVITY & CONTRACTUAL

Exec Lead	KPI Source	Data Source	Indicator			April	May	June	July			August			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RB		2	Spells	Elective IP	No.	722 ▲	791 ▼	748 ■	→		786 ■	→		640 ▼	3589	4179	10141	No Variation	0 - 2% Variation	>2% Variation		10610	9596
				Elective DC	No.	4255 ▲	4246 ▼	4088 ▲	→		4495 ▼	→		3804 ▼	21196	16566	40198	No Variation	0 - 2% Variation	>2% Variation		53685	52875
				Total Elective	No.	4977 ▲	5037 ▼	4836 ▲	→		5281 ▼	→		4444 ▼	24785	20745	50339	No Variation	0 - 2% Variation	>2% Variation	●	64295	62471
				Total Non-Elective	No.	4609 ▼	4773 ▲	4567 ▼	→		4687 ▲	→		4537 ▲	22971	24683	60931	No Variation	0 - 2% Variation	>2% Variation	●	55675	56982
			Outpatient Attendances	New	No.	13588 ▲	14346 ▲	13784 ▲	→		16158 ▲	→		12948 ▼	71711	62328	152466	No Variation	0 - 2% Variation	>2% Variation	●	159051	171540
				Review	No.	32513 ■	30945 ▼	30650 ▲	→		32671 ▼	→		29244 ▼	159281	172781	410406	No Variation	0 - 2% Variation	>2% Variation	●	421494	382248
			Emergency Care Attendances	Type I (Sandwell & City Main Units)	No.	12527 ▼	13305 ▼	12823 ▲	6183 ▲	7327 ▲	13510 ▲	5496 ▼	6684 ▼	12180 ▼	74641	78424	184483	No Variation	0 - 2% Variation	>2% Variation	● ●	177201	171701
				Type II (BMEC)	No.	2158 ▲	2224 ▼	2067 ▼	→	1786 ▼	1786 ▼	→	2061 ▲	2061 ▲	10296	12032	28304	No Variation	0 - 2% Variation	>2% Variation	● ●	36362	26649
				All - Contracted plus Non-Contracted	No.	20081 ▲	20945 ▲	17392 ▲	8923 ▲	12478 ▲	21401 ▲	8115 ▲	11768 ▲	19883 ▲	102850	86303	207128						207128
		16	Community	Adult - Aggregation of 18 Individual Service Lines	No.	45560 ■	47015 ■	44725 ■	→		49577 ▼	→			186878	183562	540982	No Variation	0 - 2% Variation	>2% Variation	●	493163	538147
				Children - Aggregation of 4 Individual Service Lines	No.	14617 ■	15496 ▼	15290 ■	→		16106 ▼	→			61492	56012	165757	No Variation	0 - 2% Variation	>2% Variation	●	143400	155412
		16	Contract	Improvement Notices	No.	0 ■	0 ■	2 ■	→		0 ■	→		0 ■	0*	0	0				●		
RB	C	2	Delayed Transfers of Care	Acute	%	3.1 ▼	3.2 ▼	2.7 ▲	2.7 ▼	2.7 ▲	2.7 ■	3.9 ■	3.5 ■	3.7 ■	3.2	<3.5	<3.5	<3.5	3.5 - 5.0	>5.0	●	5.2	2.9
				Pt's Social Care Delay	No.	13 ▼	15 ▼	9 ▲	2 ▲	3 ▲	5 ▲	6 ▼	3 ■	9 ▼	9*	<18	<18	No Variation	0 - 10% Variation	>10% Variation		13	7
				Pt.'s NHS & NHS plus S.C. Delay	No.	10 ■	9 ■	7 ▲	9 ■	4 ▼	13 ■	7 ■	4 ■	11 ■	11*	<10	<10	No Variation	0 - 10% Variation	>10% Variation		20	8
RB		2	Outpatient Efficiency	New : Review Rate	Ratio	2.39 ■	2.16 ■	2.22 ▼	2.30 ■	1.91 ▲	2.02 ▲	2.52 ■	2.16 ▼	2.26 ▼	2.22	2.30	2.30	No Variation	0 - 5% Variation	>5% Variation	●	2.65	2.23
				DNA Rate - New Referrals	%	11.6 ▲	13.6 ▼	11.7 ▲	→		12.9 ▼	→		13.9 ▼	11.8	10.0	10.0	No variation		Any variation	● ●	11.8	11.3
				DNA Rate - Reviews	%	10.8 ▲	12.5 ▼	10.8 ▲	→		12.3 ▼	→		11.9 ▲	10.4	10.0	10.0	No variation		Any variation	●	11.9	10.3

LEGEND

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
22	Surgery B 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:	**Update on the Trust's planned response to the Francis Inquiry**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Kam Dhami, Director of Governance**
DATE OF MEETING:	**26 September 2013**

EXECUTIVE SUMMARY:

The Board will recall that a response to the Francis Inquiry published in February 2013, was scheduled for presentation at the meeting of the Trust Board in September.

Given the timing of the publication of the external reviews following the Inquiry, however, this has been deferred until the October meeting to allow a considered and integrated response to be put forward.

REPORT RECOMMENDATION:

The Board is asked to receive and note the update.

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

The Trust's response to the Francis Inquiry aligns with a number of objectives.

PREVIOUS CONSIDERATION:

The initial response was considered by the Board at its meeting in February 2013.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Francis Report: Update on the Planned Trust Response
(Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013)

Following an extensive public inquiry into the failings at Mid Staffordshire NHS Foundation Trust Robert Francis QC published his final report on 6 February 2013. The Trust's initial response to this report was considered by the Board in the same month and a plan was agreed to take forward the recommendations that applied to provider organisations.

Many of the 290 recommendations within the Francis report relate to bodies other than the Trusts and some of those relating to NHS Trusts are likely to be the subject of national guidance as part of the government's response to the report.

Given this it was decided to revise the original timeline to enable the Board to consider the findings and recommendations from the external work that was expected to be commissioned by the Secretary of State for Health. This would allow a comprehensive and integrated approach to be adopted by the Trust that covered the Francis Report, the government's response and all associated actions.

It had been intended for the Trust's response to be discussed in the public Board meeting in September but due to the timing of the publication of the external review this has been deferred until the October meeting.

For information, the external publications issued to date are:

- **Patients First and Foremost:** The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry
- **After Francis: making a difference -** House of Commons Health Committee
- **Mortality Outlier Review:** A review of the care and treatment provided by 14 hospital trusts in England
- **A promise to learn –** a commitment to act improving the safety of patients in England
- **Valuing and supporting healthcare assistants**

The following reports are expected to be published soon:

- **Reducing the bureaucratic and regulatory burden on the NHS**
- **Review of the NHS Complaints System**

Kam Dhami
Director of Governance

September 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Midland Metropolitan Hospital Monitoring and Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**New Hospital Project Director**
AUTHOR:	**Graham Seager Director of Estates/New Hospital Project Director**
DATE OF MEETING:	**26 September 2013**

EXECUTIVE SUMMARY:

Sandwell and West Birmingham Hospitals NHS

Midland Metropolitan Hospital Status Report September 2013

Activities Last Period

- Ongoing work on work force challenge
- Continue development of new LTFM
- Planning for PSC refresh in Autumn
- Further engagement with DH /NHSTDA
- Community Facilities estate requirements to be consulted upon

Planned Next Period

- Achieve vacant possession of Grove Lane
- Progress Grove Lane site clearance plan
- Planned Assurance work to be completed
- Develop detailed plan for procurement phase
- Agree PF2 commercial documentation with HMT
- Develop plans for pre market engagement
- Agree final approval process

Issues for Resolution/Risks for Next Period

Shortfall in immediate capacity for assurance work and preparing for market

REPORT RECOMMENDATION:

Discuss and Accept status report

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		x

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

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

Comments:

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

21st Century Facilities

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Foundation Trust Programme Monitoring and Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Mike Sharon, Director of Strategy and Organisational Development**
DATE OF MEETING:	**26 September 2013**

EXECUTIVE SUMMARY:

The report gives an update on:

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

REPORT RECOMMENDATION:

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

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

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:

Routine monthly update

FT Programme Monitoring Status Report

Amber

Activities Last Month

- Revised FT timeline to allow for Chief Inspector of Hospitals (CIH) visit in April 2014 – 3 month extension to timeline with final approval moved to July 2014
- Risk & Downside workshop held to determine downside mitigations and financial quantification
- Estates strategy & Workforce redesign strategy presented at CLE & Trust Board for approval
- First cut detailed CIPs for 2014/15 & 2015/16 submitted
- BGAF & QGAF Board self-assessment (September Trust Board)
- AGM & Annual Priorities event (26.09.13)

Planned Next Month

- LTFM developed to include downside and presented to Trust Board for approval
- Final cut detailed CIPs for 2014/15 & 2015/6 including evidence of QIAs
- ED targets being achieved currently
- Trust Board approves decision to go ahead with MMH on basis of internal assurance processes
- External consultant to begin review of Groups' governance procedures

Issues for Resolution/Risks for Next Month

- Agreement from TDA on revised FT timeline
- Continue to make progress on A&E target in line with rectification plan to NTDA
- Plan agreed to address 18 weeks performance

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The NHS Pefomance Famework 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 Chris Archer, Associate Director of Finance
DATE OF MEETING:	26 September 2013

EXECUTIVE SUMMARY:

NHS Performance Framework:

Service Performance (August): - during the month there were 2 areas of underperformance; Delayed Transfers of Care (3.70%) and RTT Delivery in All Specialities (projected). The Trust is projected to attract an overall weighted score of 2.86 and as such a PERFORMING CLASSIFICATION for the month.

Financial Performance (August):
-The weighted overall score is 2.95 with underperformance reported in 2 areas; Better Payment Practice Code (Value) and Better Payment Practice Code (Volume). The classification for the month remains **PERFORMING.**

Foundation Trust Compliance Summary Report (August):

Within the Service Performance element of the Risk Rating for the month of August, the Trust met the required thresholds for each of the indicators which comprise the framework.

Monitor's annual de minimis limit for cases of MRSA reflecting a governance concern is set at 6, and as such the MRSA Bacteraemia reported for the year to date (April) does not contribute to the overall score.

The overall governance score for the month is 0.0, which attracts a **GREEN** Governance Rating.

(Performance in areas where no data are currently available are expected to meet operational standards)

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
		x

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

Performance Management Committee and Finance & Performance Management Committee

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2013/14

QUALITY OF SERVICE

Integrated Performance Measures

Indicator	Weight	Performance Thresholds: Performing (Score 3)	Score 2	Underperforming (Score 0)	Quarter 1 2013/14	Score	Weight x Score	July 2013/14	Score	Weight x Score	August 2013/14	Score	Weight x Score
Emergency Care Waits less than 4-hours	1.00	95.00%	94.00 - 95.00%	94.00%	94.10%	2	2.00	94.70%	2	2.00	95.50%	3	3.00
MRSA Bacteraemia	1.00	0		>1.0SD	1	0	0.00	0	3	3.00	0	3	3.00
Clostridium Difficile	1.00	0		>1.0SD	10	3	3.00	5	0	0.00	3	3	3.00
18-weeks RTT 90% Admitted	1.00	=>90.0%	85.00 - 90.00%	85.0%	92.6%	3	3.00	92.5%	3	3.00	>90.0%*	3	3.00
18-weeks RTT 95% Non -Admitted	1.00	=>95.0%	90.00 - 95.00%	90.0%	97.7%	3	3.00	96.9%	3	3.00	>95.0%*	3	3.00
18-weeks RTT 92% Incomplete	1.00	=>92.0%	87.00 - 92.00%	87.0%	94.9%	3	3.00	92.8%	3	3.00	>92.0%*	3	3.00
18-weeks RTT Delivery in all Specialities (number of treatment functions)	1.00	0	1 - 20	>20	18	2	2.00	8	2	2.00	1-6*	2	2.00
Diagnostic Test Waiting Times (percentage 6 weeks or more)	1.00	<1%	1.00 - 5.00%	5%	0.69%	3	3.00	0.57%	3	3.00	<1.0%*	3	3.00
Cancer - 2 week GP Referral to 1st OP Appointment	0.50	93.0%	88.00 - 93.00%	88.0%	93.9%	3	1.50	94.0%	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%	94.8%	3	1.50	96.2%	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers	0.25	96.0%	91.00 - 96.00%	91.0%	98.3%	3	0.75	100.0%	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%	97.3%	3	0.75	100.0%	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)	0.25	98.0%	93.00 - 98.00%	93.0%	100.0%	3	0.75	100.0%	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)	0.25	94.0%	89.00 - 94.00%	89.0%	100.0%	3	0.75	100.0%	3	0.75	>94.0%*	3	0.75
Cancer - 62 day urgent referral to treatment for all cancers	0.50	85.0%	80.00 - 85.00%	80.0%	89.7%	3	1.50	86.2%	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	96.0%	3	1.50	>90.0%*	3	1.50
Delayed Transfers of Care	1.00	<3.5%	3.5 - 5.00%	>5.0%	3.00%	3	3.00	2.70%	3	3.00	3.70%	2	2.00
Mixed Sex Accommodation Breaches (as percentage of completed FCEs)	1.00	0.0%	0.0 - 0.5%	0.5%	0.74%	0	0.00	0.00%	3	3.00	0.00%	3	3.00
VTE Risk Assessment	1.00	90.0%	80.00 - 90.00%	80.0%	94.29%	3	3.00	95.90%	3	3.00	94.40%	3	3.00
Sum (all weightings)	**14.00**												
Average Score (Integrated Performance Measures)							**2.43**			**2.64**	* projected		**2.86**

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**

Overall Quality of Service Rating

							Performing			**Performing**			**Performing**

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

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - NHS PERFORMANCE FRAMEWORK MONITORING REPORT - 2013/14

Financial Indicators				SCORING			2013 / 2014			2013 / 2014			2013 / 2014			2013 / 2014			2013 / 2014		
Criteria	Metric	Weight (%)		3	2	1	April	Score	Weight x Score	May	Score	Weight x Score	June	Score	Weight x Score	July	Score	Weight x Score	August	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	0.05%	3	0.15	0.57%	3	0.15	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	0.00%	3	0.6	0.01%	3	0.6	0.01%	3	0.6	-0.04%	3	0.6	-8.90%	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.	11.29%	3	0.15	6.69%	3	0.15	5.44%	3	0.15	5.95%	3	0.15	6.00%	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	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.	6.88%	3	0.15	6.46%	3	0.15	6.32%	3	0.15	6.00%	3	0.15	6.00%	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	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	1.46%	3	0.15	1.07%	3	0.15	0.92%	3	0.15	1.07%	3	0.15	1.10%	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	6.88%	3	0.15	6.46%	3	0.15	6.32%	3	0.15	6.00%	3	0.15	6.00%	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	90.60%	2	0.05	92.60%	2	0.05	93.84%	2	0.05	87.00%	2	0.05	92.10%	2	0.05
	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	94.90%	2	0.05	94.40%	2	0.05	92.76%	2	0.05	87.00%	2	0.05	92.70%	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	1.09	3	0.15	1.02	3	0.15	1.05	3	0.15	1.06	3	0.15	1.10	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	12.31	3	0.15	12.97	3	0.15	13.29	3	0.15	13.54	3	0.15	11.71	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	40.44	2	0.1	44.79	2	0.1	39.03	2	0.1	39.03	2	0.1	13.22	3	0.15
						Weighted Overall Score			2.90			2.90			2.90			2.90			2.95

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

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