Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Boardroom, Sandwell Hospital **Date** 31 October 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]
Mrs C Rickards	(CR)	[Trust Convenor]

Guests

Dr C Wright	(CW)	[Consultant Haematologist]
Ms P Charlotte	(PC)	[Ward Sister]
Ms E Ferguson	(EF)	[Matron]

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 26 September 2013 a true and accurate records of discussions*	**SWBTB (9/13) 203**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (9/13) 203 (a)**	**SGP**
	4.1	Establishments and rolling headcount	Verbal	TL
	4.2	Handling of cancelled operations as part of the Outpatient Efficiency programme	Verbal	RB
	5	**Chair's opening comments and Chief Executive's report**	**SWBTB (10/13) 212** **SWBTB (10/13) 212 (a)**	**Chair/ CEO**
	6	**Questions from members of the public**	**Verbal**	**Public**
1350h	**7**	**Patient Story**	**Presentation**	**CW**
		MATTERS FOR APPROVAL		
1405h	**8**	**Business case for the replacement of a catheter laboratory at City Hospital**	**SWBTB (10/13) 213** **SWBTB (10/13) 213 (a)**	**MS**
1420h	**9**	**Hallam Street properties lease/disposal**	**SWBTB (10/13) 214** **SWBTB (10/13) 214 (a)** **SWBTB (10/13) 214 (b)**	**TL**

	MATTERS FOR DISCUSSION			
	11	**Safety, Quality and Governance**		
1435h	11.1	Update from the meeting of the Quality & Safety Committee held on 25 October 2013, minutes from the meeting held on 20 September 2013	SWBQS (9/13) 139	OD
1440h	11.2	Quality report	SWBTB (10/13) 215 SWBTB (10/13) 215 (a)	LP/ RST
	▶	Thrombolysis performance	Verbal	RST
	▶	Readmissions update	Verbal	RB
1500h	11.3	Forward look of the delivery of the 18 week standard	SWBTB (10/13) 216 SWBTB (10/13) 216 (a)	RB
1510h	11.4	Trust's response to the Francis Inquiry and related national reports	SWBTB (10/13) 217 SWBTB (10/13) 217 (a)	KD
1525h	11.5	Update from the meeting of the Audit Committee held on 25 October 2013, minutes from the meeting held on 9 May and 6 June 2013	SWBAC (5/13) 043 SWBAC (6/13) 044	GH
	12	**Finance & Performance Management**		
1530h	12.1	Monthly finance report – Month 6	SWBTB (10/13) 218 SWBTB (10/13) 218 (a)	RW
1540h	12.3	Monthly performance monitoring report	SWBTB (10/13) 219 SWBTB (10/13) 219 (a)	RW
1550h	12.4	Quarter 2 annual plan update	SWBTB (10/13) 220 SWBTB (10/13) 220 (a)	MS
	13	**Board Committee update**		
1600h	13.1	Update from the Configuration Board held on 15 October 2013	Verbal	RSM
1610h	**14**	**Any other business**	**Verbal**	**All**
	MATTERS FOR INFORMATION			
	15	**Performance Management Regime – monthly submission**	**SWBTB (10/13) 221** **SWBTB (10/13) 221 (a)** **SWBTB (10/13) 221 (b)**	
	16	**Midland Metropolitan Hospital project: monitoring report**	**SWBTB (10/13) 222**	
	17	**Foundation Trust application programme: monitoring report**	**SWBTB (10/13) 223** **SWBTB (10/13) 223 (a)**	

	18	**NHS Performance Framework & FT Compliance Framework report**	**SWBTB (10/13) 224** **SWBTB (10/13) 224 (a)**
	19	**Details of next meeting** *The next public Trust Board will be held on 28 November 2013 at **1330h** in the Anne Gibson Boardroom, City Hospital ***PLEASE NOTE NEW TIMING****</br>	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Anne Gibson Boardroom, City Hospital **Date** 26th September 2013

Present	**In Attendance**	
Mr Richard Samuda [Chair]	Miss Kam Dhami	
Ms Clare Robinson	Mr Mike Sharon	
Dr Sarindar Sahota OBE	Mr Bill Hodgetts	[Healthwatch]
Ms Olwen Dutton		
Mrs Gianjeet Hunjan	**Guests**	
Mr Harjinder Kang	Mr Graham Seager	[Director of Estates & New Hospital Project]
Mr Toby Lewis	Mrs Liz Hesk	[Matron]
Mr Robert White	Ms Tracy Weston	[Ward Manager]
Mrs Linda Pascall	Mr Misra Budhoo	[Group Director – Surgery A]
Miss Rachel Barlow		
Dr Roger Stedman		

Secretariat

Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Prof Richard Lilford.	
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 (8/13) 180**
The minutes of the Trust Board meeting held on 29th August 2013 were presented for consideration and approval. The following amendments were suggested: 11.2 – Ms Robinson advised that the point she had made concerned the nurse recruitment strategy that was in place to ensure that an overestablished position was secured. Mr Lewis advised that within the Medicine & Emergency Care Group, 56 more posts had been filled than had been budgeted for, however a final number would be settled upon in October when establishments were set. 11.1 – Ms Dutton noted that her comments concerning the positive nature of the CQC report that had been received and her wish to publicise these key messages had not been reflected accurately. 11.2 – Ms Dutton noted that her comments regarding the difference between thematic and specific learning points from complaints had not been captured. Ms Robinson suggested that the issue concerning variability of non-pay expenditure needed to be followed up at a forthcoming meeting of the Finance & Investment Committee. Mr Grainger-Payne agreed to make these amendments and present the final version of the minutes to the Chairman for his approval before the next meeting. Subject to these corrections, the Board approved the minutes.	
ACTION: **Mr Grainger-Payne to add an item concerning non-pay expenditure variability to the agenda of the next Finance & Performance Management Committee** **AGREEMENT:** **The minutes of the last meeting were approved subject to amendments suggested**	
4 Update on Actions arising from Previous Meetings	**SWBTB (8/13) 180 (a)**
Ms Robinson noted that a number of actions were marked as being at red status and urged expedient delivery of actions raised. Mr Lewis highlighted that this had been one of the first time that overdue actions had been flagged to the Board and advised that plans were in place to address each before the next meeting. Miss Dhami advised that in connection with the action concerning the Trust's response to the Francis Inquiry, that the Board had received the initial response at its meeting in February 2013. She reported that an integrated report would be presented at the meeting of the Trust Board in October to allow the inclusion of some of the recommendations from the national reports that had been published. In the meantime, it was highlighted that a summary of the plan to respond was attached to Board papers for information.	

In response to the action concerning presentation of the Trust's performance against the Better Payment Practice Code, Mr Grainger-Payne advised that this would be included on the agenda of the meeting of the Finance & Investment Committee in November. Mr White added that the Trust was currently paying 92 – 95% of invoices within the required timescale. In terms of the action concerning the presentation of the EPR options, it was reported that a check on the financial implications needed to be made against the Long Term Financial Model (LTFM) and that a paper discussing the options would be presented at the October meeting of the Trust Board.	
5 Chair's Opening Comments and Chief Executive's report	**SWBTB (9/13) 182**
The Chairman advised that since the last meeting he had met with two local MPs, James Morris and John Spellar. The Board was informed that the Chairman has also attended a 'Right Care, Right Here' facilitated workshop, which had identified the need to reinvigorate some of the work needed to manage work away from an acute setting. It was reported that during the period, the Consultant Conference had been held, which had focussed on integrated care and public health. The Board was advised that Mr Kang had been one of the key speakers at the conference. Mr Lewis asked the Board to receive and accept his written update. He drew the Board's attention to the current operational pressures. Ms Robinson noted that the achievement of the VTE target had appeared to have been impacted by a change in technology and asked what lessons had been learned from this. Mr Lewis was advised that in his opinion, this had been an appropriate measure, given that the change co-incided with the commencement of a new set of staff. He reported that the issues associated with the changeover had been anticipated, however he acknowledged that any lessons learned from a review of the situation would be acted upon where appropriate.	
6 Questions from Members of the Public	**Verbal**
Mr Hodgetts outlined his concerns in respect of a number of delayed and cancelled outpatient appointments he had personally experienced recently. Miss Barlow acknowledged this issue and provided reassurance that the outpatient improvement programme aimed to reduce the number of cancelled operations and reduce waiting times for outpatient appointments. She offered to investigate Mr Hodgetts specific concerns and report back. Ms Robinson asked whether there appeared to be an increased trend of repeated cancellations. Miss Barlow advised that an update should be provided to the Quality & Safety Committee on this position.	
ACTION: Miss Barlow to present an update on cancelled operations performance at a future meeting of the Quality & Safety Committee	
7 Patient story	**Presentation**

Matron Lis Hesk and Ward Manager Tracy Weston joined the meeting to outline the experience of a cancer patient that had been treated on Ward D27. It was highlighted that key issues that had been experienced by the patient concerned the lack of understanding of the need for nurse-led personal care given her young age, which had given rise to abruptness by some members of staff. The Board was advised that these attitude issues had been addressed through the introduction of a competency package for staff. A further issue concerned the lack of wheelchair facilities, which Mrs Hesk advised had been rectified by purchasing a dedicated wheelchair for the ward. The Chairman asked how new staff were inducted. Ms Weston advised that the university provided an overall induction, which was then supplemented by a local induction programme when staff joined the Trust. It was suggested that the local induction should include some additional elements in future such as awareness of personal care requirements and emotional support. Mr Sharon asked what value the team felt should be placed on the participation in the Friends and Family Test. Ms Weston advised that the process was useful to gauge opinion from relatives. Mrs Pascall added that feedback was also canvassed prior to discharge of patients and that suggestion boxes were in place in the Trust. Ms Dutton remarked that patient stories at the Board were valuable and highlighted that as an inpatient, poor staff communication had the potential to make individuals feel vulnerable. She asked for a view as to how the importance of good communication and the impact of poorly delivered comments could be emphasised. Mrs Hesk advised that there was a need to raise the awareness of the impact of poor communication through informal means but also through mandatory training. Mrs Pascall advised that this should take into account the impact on the entire family. Ms Dutton noted that staff attitude was one of the major themes of complaints and she suggested that feedback concerning complaints should be given to staff on regular basis. It was confirmed that feedback was given as part of staff meetings on a regular basis. The nursing team from ward D27 were thanked for their attendance and enlightening presentation.	
8 Never Event	**Verbal**
Mr Misra Budhoo, Group Director for Surgery A joined the meeting for this item. Dr Stedman advised that a 'Never Event' originating in the Plastic Surgery speciality had recently been reported, although the event had occurred some time previously. The Board was advised that the identification of the 'Never Event' had occurred during a follow up appointment after surgery and had been identified as being a result of human error. Mr Budhoo outlined the details of the Never Event which he advised concerned the undertaking of a cubital rather than a carpal tunnel decompression procedure. It was highlighted that the use of consent forms on the day of surgery should be reconsidered and completed instead in a less frenetic setting prior to	

the procedure. Mr Lewis advised that control systems were in place that would have prevented the 'Never Event', however on this occasion they had not been used to best effect. He asked whether the patient had been harmed as a consequence of the 'Never Event'. Mr Budhoo advised that the patient was well and had undergone an investigation. Dr Sahota asked whether failure to use the World Health Organisation checklist had contributed to the issue. Dr Stedman advised however, that the theatre list information had been incorrect, rather than there having been issues with the use of the checklist. Mr Lewis advised that the consent process needed to be split, so that consent was taken prior to the day of surgery, followed by a confirmation of consent on the day of surgery. Mr Budhoo added that at present, the practice by which consent was obtained was variable. Dr Stedman advised that he had written to all consultants about expectations around consent. The Chairman asked whether a process was in place to disseminate lessons learned from incidents. Mr Budhoo advised that following the investigation into the 'Never Event' action plans were created containing measures aimed at preventing a reoccurrence of the incident and that these action plans were shared widely. Mr Kang asked what the root cause of the 'Never Event' was seen to be. Dr Stedman confirmed that the cause had been identified as human error. He acknowledged however, that the situation was unacceptable. Ms Robinson suggested that the existing checks and balances would have been expected to have identified the error and asked whether a further check by a second individual would prevent a reoccurrence. Mr Lewis advised that the existing controls if followed were adequate and were regarded as accepted international practice in surgery. Ms Robinson asked in this respect whether a disciplinary process was to be invoked. Dr Stedman advised that this was a matter included in the action plan arising from the tabletop review of the incident. Ms Robinson asked whether there was certainty that there were no other 'Never Events' that had occurred elsewhere yet remained undetected. Dr Stedman advised that he was not able to confirm this. Mr Budhoo was thanked for his attendance and useful contributions.	
MATTERS FOR APPROVAL	
9 Maintenance of Digital Mammography Systems – Approval of Waiver of Tendering Process	**SWBTB (8/13) 165**
Mr Seager advised that the Trust owned seven digital mammography systems and associated IT equipment.	

He advised that the maintenance contract for the equipment was 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 was the original equipment manufacturer, Hologic. It was reported that the maintenance agreement had been pre-tendered via NHS Supply Chain, with costs held at 2012/13 prices, with the total contract agreement being £110,580 + VAT. Mr Seager was asked whether the costs were in line with those incurred by other trusts. He advised that this was the case. Mr Seager was asked whether a market test had been conducted of the potential suppliers. He advised that this was the case and the only successful supplier had been the original equipment manufacturer, Hologic. The Trust Board approved the proposal to waive the tendering process for the renewal of the maintenance agreement.	
AGREEMENT: The Trust Board approved the proposal to waive the tendering process for the renewal of the maintenance agreement for the digital mammography systems	
10 Performance Management Regime – Monthly Submission	**SWBTB (9/13) 184** **SWBTB (9/13) 184 (a)** **SWBTB (9/13) 184 (b)**
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. The Board was advised that the Trust Development Authority was due to publish an assessment of Trusts against the new accountability framework. It was reported that there was an expectation that the Trust would be classed as a 'Category 2 (emerging concerns)' organisation. Noting the paucity of organisations classed as 'Category 1' organisations, Mr Lewis emphasised that the Trust's assessment was not a negative classification. Ms Dutton noted that there appeared to be a lack of synergy between the various external assessment frameworks against which the organisation was judged. It was agreed that although there was a significant amount of common data in the algorithms used, each appeared to have a different focus. The Board approved the monthly Performance Management Regime submission.	
AGREEMENT: The Performance Management Regime monthly submission was approved	
11 Trust Development Authority submission: Winter Bed Plan	**Hard copy**
The Chairman, noting that the winter bed plan had been circulated shortly before	

the meeting, commented that there had not been much time to review the document. Miss Barlow advised that the submission comprised an assurance template and table for self-assessing the Trust's readiness and plans for winter. She highlighted that the submission was closely aligned to work already in train through the 'Winter 2013 Must Be Better' programme. It was also noted that the work included the recovery plans for achievement of the Emergency Care target. It was highlighted that implementation of the Rapid Access to Treatment Service (RATS) had been limited by the recruitment process, however an action plan was in place to address this issue. The Board was asked to note the areas rated as being at 'amber' status, which were associated with some areas of current practice that required further embedding. It was reported that an Elderly Care assurance model was being developed, which considered early assessment and treatment. The Board was advised that assistance from the Department of Health Intensive Support Team had been invited to support the delivery of the plans and that work was underway with Social Services to deliver seven day working. The outcome of the current recruitment campaign into key areas was reported to be anticipated to be successful. Ms Robinson suggested that some work on complaints was needed to inform the plans. Mr Kang also suggested that the plans should be 'stress tested', by running scenarios and developing clear contingency arrangements. It was agreed that there were many risks that needed to be factored into the plans, such as the possibility of an infection control outbreak. It was agreed that prior to submission, all would provide comments on the plan to Miss Barlow. Subject to any further feedback, the Board approved the TDA winter bed plan submission.	
AGREEMENT: Subject to any comments received prior to submission, the Board approved the winter bed plan	
12 Estates strategy	**SWBTB (9/13) 186** **SWBTB (9/13) 186 (a)**
Mr Seager presented the latest version of the estates strategy which he advised looked ahead until 2020. The Chairman asked whether the issues identified by the Patient Safety walkabouts would be addressed by the strategy. Mr Seager confirmed that this would be the case through the estates assessment process and the ability to fast track some elements where necessary. He highlighted that every effort was being made to ensure that disruption to wards was minimised when work was necessary. The Board was advised that the strategy encompassed plans to actively reduce the amount of travel to and from work, however further measures were needed. Mr Kang noted that three quarters of the Trust's estate was over 30 years old. Mr Seager acknowledged that this was the case and that condition surveys and ERIC	

returns monitored the quality of the assets. Mr Lewis asked, in the event that a decision was taken to make a significant capital investment, how much of the backlog maintenance would be cleared and which parts would be seen as being unaffordable. Mr Seager advised that this was not clear at this present time. Dr Sahota asked whether while the plans for the Midland Metropolitan Hospital were in progress, measures were being taken to ensure that essential repairs impacting on patient and staff safety were completed. Mr Seager advised that risk assessment and management processes influenced the priority of the maintenance and the investment decisions. He also advised that funds were committed through the statutory standards process. The Trust Board approved the estates strategy.	
AGREEMENT: The Board approved the estates strategy	
13 Safety, Quality & Governance	
13.1 Update from the meeting of the Quality & Safety Committee held on 20th September 2013 and minutes from the meeting held on 23rd August 2013	**SWBQS (8/13) 128**
Ms Dutton updated the Board on the key discussion points from the meeting of the Quality & Safety Committee that had been held on 20th September 2013. Mr Lewis advised that the establishments of the 20 Medicine & Emergency Care Group's wards had been reviewed and of these 16 had been identified to be successful, with the remaining four requiring further attention. Mrs Pascall reported that the assessment of acuity would be aligned with the budget cycle in future.	
13.2 Quality Report	**SWBTB (9/13) 187** **SWBTB (9/13) 187 (a)**
The Board was asked to consider the Quality Report. Mrs Pascall reported that there had been deterioration against a number of quality indicators, therefore some detailed investigations into key areas were planned. It was highlighted that the Trust's Hospital Standardised Mortality Ratio (HSMR) position had improved. The Board was advised that wards Lyndon 3 and Newton 4 had been placed in Special Measures and were being given targeted support. Mrs Pascall was asked what indicators were used to conclude that a ward needed special focus. She advised that a combination of deteriorating patient satisfaction scores, together with slippage against a number of quality indicators was used. It was highlighted that a review of the data quality against national indicators would be presented to the Audit and Risk Management Committee on 25 October. Ms Robinson suggested that an estimate of the confidence in the quality	

of the data against each needed to be considered as part of this work.	
Klebsiella briefing	**SWBTB (9/13) 188** **SWBTB (9/13) 188 (a)**
Mrs Pascall reported that there had been a robust attempt to tackle the estates issues that had been identified as being contributory to the Klebsiella infections, however some of the cultural issues remained to be concluded. Mr Lewis remarked that there was a need to determine the behavioural indicators of success in this respect.	
Readmissions update	**SWBTB (9/13) 189** **SWBTB (9/13) 189 (a)**
Dr Stedman delivered a presentation outlining the current position with respect to readmissions. He advised that the Transformation Support Office was engaged with undertaking work to better understand the reasons behind the admission rates and he asked the Board to note that the majority of readmissions were confined to a group of patients within a narrow age band. Given that the readmission rates at City Hospital were highlighted to be lower than those at Sandwell Hospital, Mr Lewis advised that work would begin to identify whether the practice at City Hospital was more beneficial. Dr Stedman advised that this was integral to the diagnostic work that was underway at present. Mr Kang asked whether the predictability of readmissions had been built into the Trust's forecasting of activity. He was advised that this was not currently considered as fully as it would be in future.	
14 'Never Event' briefing	**SWBTB (9/13) 190** **SWBTB (9/13) 190 (a)**
Miss Dhami reminded the Board that at the June meeting of the Trust Board, the list of 'Never Events' reported had been presented. She advised that since then an assessment of the robustness of the controls that had been put in place to prevent a reoccurrence had been made using evidence to make this judgement. It was reported that in some cases, audits used to assess the robustness of controls had not been undertaken, therefore work was underway to ensure that these occurred. Overall, it was noted that there was a mixed picture in terms of the assurances in place. Compliance with the use of the World Health Organisation checklist was reported to be high in some of the areas of concern. Mr Lewis advised that the work to improve the levels of assurance was likely to span 3 – 4 months. Ms Robinson asked whether all the actions needed would be completed by the end of December 2013. Miss Dhami advised that the timings for completion of the actions were still to be verified in some cases, however the assurance plan would be presented to the Quality & Safety Committee at its next	

meeting. Ms Dutton agreed that there was a need to finalise the anticipated timetable for the completion of actions.	
ACTION: Miss Dhami to present the updated 'Never Events' assurance plan to the Quality & Safety Committee on 25 October 2013	
15 Finance & Performance Management	
15.1 Update from the meeting of the Finance & Investment Committee held on 20th September 2013 and minutes of the meeting held on 23rd August 2013	**SWBFC (8/13) 081**
Ms Robinson updated the Board on the key discussion points from the meeting of the Finance & Investment Committee that had been held on 20th September 2013. The Board was advised that there was an urgent need to gain an understanding of the reliability of the data quality in relation to the performance against national indicators. Mr Lewis suggested that the future focus of the Committee should move from being operational to assuring itself that the plans to deliver the Long Term Financial Model were robust. Ms Robinson agreed and advised that there was a need to gain comfort on the assumptions underpinning the Long Term Financial Model.	
15.2 Monthly Finance Report – Month 5	**SWBTB (9/13) 192** **SWBTB (9/13) 192(a)**
Mr White advised that although the July results had reported a deviation from plan, the August results were more positive in that a balanced position had been achieved. It was reported that the position of the Medicine & Emergency Care Group had improved, particularly in terms of staffing costs. The Trust's cash balance was reported to remain strong. It was reported that there were some changes in services provided between commissioners. Mr Lewis advised, that as agreed previously, there was a need to review the fluctuations in the non-pay position.	
15.3 Plans to address the Medicine & Emergency Care Group's Financial Position	**SWBTB (9/13) 193** **SWBTB (9/13) 193 (a)**
Miss Barlow presented an update on the financial position of the Medicine & Emergency Care Group. She advised that matters were positive as the Group was ahead of its monthly forecast due primarily to a reduction in expenditure on agency staffing. The Board was advised that good staffing controls were being put into place and staffing establishments were being finalised. In terms of TSP planning, it was reported that the Group had received support from corporate	

reserves to offset the position. The development of the future financial model for the Group was reported to be being assisted by growing cohesion of staff within the area. Ms Robinson advised that the recruitment position had been discussed in the previous meeting of the Finance & Investment Committee and it had been suggested that the entire staffing picture needed to be reviewed, given that the recruitment of new staff into the organisation was being offset significantly by staff leaving. Mr Lewis asked whether in terms of the financial position for the Group, the forecast was higher than previously anticipated to offset the current shortfall. Miss Barlow advised that a cautious view had been taken in terms of the income associated with Cardiology services, however overall the forecast was higher than previously planned. Mr Lewis asked whether this position was attributable to the effect of pay or non-pay expenditure. Miss Barlow advised that this was associated with a mix of pay and non-pay elements.	
15.4 Monthly Performance Monitoring Report	**SWBTB (9/13) 194** **SWBTB (9/13) 194 (a)**
The Board was asked to receive and accept the monthly performance monitoring report. In particular, the Board was asked to note the improvement in the compliance with undertaking PDRs. The Board was advised that a matter arising to be discussed at the next meeting would concern the Trust's compliance with thrombolysis targets.	
ACTION: Dr Stedman to present an update on compliance with thrombolysis targets at the next meeting	
16 Any Other Business	**Verbal**
There was none.	
Matters for Information	
The Board received the following for information: Update on Trust's planned response to the Francis Inquiry 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 31st October 2013 and would be held in the Boardroom, Sandwell Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 31 October 2013, Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

26 September 2013, Anne Gibson Boardroom @ City Hospital

Members present: Mr R Samuda (RSM), Ms C Robinson (CR), Dr S Sahota (SS), Mr H Kang, Mrs G Hunjan (GH), Mr H Kang (HK), Ms O Dutton (OD), Mr T Lewis (TL), Mr M Sharon (MS), Mrs L Pascall (LP), Miss R Barlow (RB), Mr R White (W), Dr R Stedman (RST)

In Attendance: Miss K Dhami (KD), Mr M Sharon (MS), Mr B Hodgetts (BH), Mr G Seager (GS)

Apologies: Prof R Lilford (RL)

Secretariat: Mr Simon Grainger-Payne (SGP)

Last Updated: 28 October 2013

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
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 ready for presentation - further work needed to reconcile EPR expenditure to the developing LTFM	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	To be included on the agenda of the F & I Committee meeting scheduled for 22 November 2013	R
SWBTBACT.262	Minutes of the previous meeting	SWBTB (8/13) 180	26-Sep-13	Add an item concerning non-pay expenditure variability to the agenda of the next Finance & Investment Committee	SGP	22/11/13	Will be included as requested	G
SWBTBACT.263	Questions from Members of the Public	Verbal	26-Sep-13	Present an update on cancelled operations performance at a future meeting of the Quality & Safety Committee	RB	22/11/13	Included as a verbal update on the agenda of the October 2013 meeting and a further report to be presented at the meeting of the Quality & Safety Committee planned for 22-11-13	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	Verbal update to be given at meeting of the Trust Board planned for 31-10-13	G

SWBTBACT.245	Trust's initial response to the report of the Mid Staffordshire NHS Foundation Trust public inquiry	SWBTB (2/13) 032 SWBTB (2/13) 032 (a)	28-Feb-13	Present the baseline assessment against the recommendations within the 'Francis' report at the next meeting of the Quality & Safety Committee and Trust Board	KD	~~26/04/2013~~ ~~30/06/2013~~ ~~31/08/2013~~ 30/09/2013	Included on the agenda of the Board meeting planned for 31-10-2013	B
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	Internal audit recommendations discussed at the meeting of the Audit Committee held on 25 October 2013	B
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	Included on the agenda of the meeting planned for 31-10-13	B
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
SWBTBACT.264	'Never Event' briefing	SWBTB (9/13) 190 SWBTB (9/13) 190 (a)	26-Sep-13	Present the updated 'Never Events' assurance plan to the Quality & Safety Committee on 25 October 2013	KD	25/10/13	Presented as requested	B
SWBTBACT.265	Monthly Performance Monitoring Report	SWBTB (9/13) 194 SWBTB (9/13) 194 (a)	26-Sep-13	Present an update on compliance with thrombolysis targets at the next meeting	RST	25/10/13	Included as a verbal item on the agenda of the meeting scheduled for 31-10-13	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 – October 2013

Our agenda today again has a very strong focus on safety and quality. We revisit stroke services, six months after reconfiguration to Sandwell, and again discuss our readmission reduction programme. As we agreed to do last spring, after a period of reflection on Robert Francis' recommendations, we aim to agree our plans for successful implementation of the change over the coming fifteen months. I will provide an oral update on progress with our flu vaccination campaign.

1. Our patients:

Emergency care

Understandably public concern remains about the ability of the NHS to manage more than adequately in the coming winter. In Quarter 2, the Trust met its waiting time obligations for the first time in over a year. Unfortunately October has seen a big deterioration in delivery on both of our acute sites. On a minority of days this reflects additional demand pressure (either in A&E or the admissions arising). But typically our challenge remains a supply side one. By the time the Board meets we will have concluded the door-installation programme and as such we will be better placed to tackle infection.

From November 4th substantial volumes of intermediate care and other beds open in Birmingham (70+). This will help to tackle a mounting pattern of delayed transfers of care, especially for City Council residents using both our hospitals. However, during October, we saw bed numbers in Sandwell MBC cut, and sustained difficulties obtaining timely discharge. Our own teams have implemented major changes but we have more work to do to embed those changes, with lower than desired occupancy in our medically fit for discharge wards, as well as some weaknesses in how our enlarged assessment units work with base wards. From November 11th a surgical assessment unit separated from medicine will open at Sandwell.

It is increasingly clear as system pressure arises how important it will be to manage sensitively but firmly nursing home allocation for inpatients, reflecting LA policies on choice, and managing family expectations. November has to see improved delivery across our admitting and discharge practice. The incoming A&E specialty lead, Colin Holburn, and Clinical Director for Emergency Care and Acute Medicine, Shaun Nakash will help to provide added impetus and leadership to our work, supported by seven day social care which starts next month for the first time.

The care environment

We know from our survey work how important it is that we provide a good environment for patients, and one that supports privacy and dignity. What used to be called PEAT inspections, now relabelled PLACE inspections, have just been reported nationally. Our Trust does exceptionally well, especially when we consider the age of our estate, and our thanks are due to many teams across estates and facilities for their work to keep our wards and departments clean, food fresh, and environments well

signposted. There is always more to do but our performance is towards the very top in the West Midlands NHS.

Child protection

It is obvious that the identification last spring of Birmingham and Sandwell as two of twenty Local Authorities with inadequate children's services outcomes is a matter of concern and obligation. Those services are provided by us alongside social care, education and police service staff. In Sandwell from November very new arrangements will be deployed to try and focus social work time on children most in need of child protection interventions. The MASH system is used in many other districts and will be deployed here for the first time. It depends on better information flow between organisations' staff, as well as multi-disciplinary review of casework and case selection. I have agreed to join the overseeing body, which is independently chaired by Professor Ray Jones. We anticipate that the LAs' status will mean that we are inspected for our child protection work by the CQC over coming weeks. Of course we know that there is room for improvement from our own review at our Quality and Safety Committee, as well as the inspection of all agencies last spring. Having met with senior clinicians in the service over recent days, I know that there is determination and continued commitment to work to support services' improvement. We continue to approach colleagues within Birmingham to understand how best to support their improvement efforts.

2. Our colleagues

On Friday October 19th we hosted the biggest ever Annual Awards ceremony for teams in our organisation. In addition to long service awards and beacon status badges, we selected winners in diverse categories such as innovation, excellence in customer care, safety and lifetime achievement. Our Employee of the Year prize was given to Angela Hook, Ward Clerk on D25 at City Hospital. Non-clinical team of the year are our trust-wide Ward Service Officers, while the breast care nursing team carried off the award for Clinical Team of the Year. Feedback from those attending the event, and hearing about it in the organisation over the last week, has been immensely positive. It was an honour to welcome the Mayors of Sandwell and Birmingham to congratulate our staff on behalf of the local residents that we serve. We are thinking through within the Executive, how we develop our 'rewarding success' culture and make our awards process part of monthly activities building to the annual awards next year.

We always acknowledge that one of the critical issues faced by our NHS is recruitment and retention. Reviewing the recent pattern of consultant staff hires, it is encouraging to see a notable upswing in successful appointments. Of 28 vacancies, 15 now have offers made, and we have been able to recruit significantly in Imaging. The Clinical Leadership Executive has approved revised recruitment controls to place more authority in the hands of medical leaders to progress hires at pace and we have also amended with effect from December 1 the AAC process deployed here. This moves us significantly towards the values-based recruitment approach urged by Robert Francis, and reflects our own assessment that the final selection process for senior doctors should demand advanced interpersonal and team-working skills.

Attached to this note for information is the mid-year review document that we have provided to all Trust employees with their October payslips. This inevitably brief synopsis aims to highlight some of our team's successes over the first six months the fiscal year, whilst pointing out the key improvement priorities we have for the rest of this winter. A focus on changing our complaints

process to make it faster and more effective for the 750 people a year who raise concerns is at the heart of the document.

3. Our regulators

On October 24th the CQC made public initial data from which they will choose to form judgements about organisations prior to on-site inspections. This Trust was not selected for an immediate inspection. Our banding was judged to be level four of six. The CQC have yet to determine how that banding translates into a rating, though we know that Foundation Trust applications will require a rating of good or excellent to progress. During November we will conclude our own assessment of the indicators selected by the CQC to support our quality improvement work over coming months. We are due to receive plans to improve our PROMs score in orthopaedics at the upcoming Clinical Effectiveness Committee.

4. Our partners

Liaison work with local schools continues. As part of our agreement with the CCG to enhance vaccination rates in Sandwell, we are putting dedicated resource into Orchard School for children with learning difficulties. That school will also benefit in the spring from on-site ophthalmology expertise to avoid the necessity for families to take children out of school and attend an environment less suited to their wellbeing.

The Trust has now made its final tender submission for school nursing service provision in Sandwell. Our bid to maintain and enhance the service is in partnership with Murray Hall and Sandwell Women's Aid. We have volunteered a pricing structure which incentivises our own excellence. In both respects I think we are operating differently and offering our Local Authority commissioners a significant chance to change outcomes in early years.

Our Board papers today contain an important proposal about future estate use for dilapidated properties on Hallam Street. We see a tremendous opportunity to expand our apprenticeship schemes to include young people at risk of homelessness. We have a range of potential partners and I know that local residents and other stakeholders will be pleased at our commitment to re-occupy and use these buildings adjacent to local houses and church amenities.

5. Feedback from our 'Hot Topics' system

The monthly engagement programme continues. At Rowley Regis the main issues raised by leaders continue to relate to the hospital's future disposition. The opening of Eliza Tinsley is important, and soon we will see a pilot emergency care assessment function on that site too. In November (a month later than we planned) we will finalise proposals for which clinics will relocate from Sandwell to Rowley next spring. We have held useful discussions too with the Sandwell Council of Voluntary Organisations to see how their members might make constructive use of space on the site.

At Sandwell discussions focused on the process to change our complaints system, while the main debate in our City session was our public health agenda. Under that we expect to try and cut out smoking from our sites by around 2017 and to alter our catering and gym facilities to support both

staff and visitor health. The key step in both debates for leaders was how we generate staff time to undertake new obligations or to focus on their own wellbeing. As we refine our Transformation plans, it is worth considering how that concept of released time (time to care) might be thought about and highlighted.

Toby Lewis, Chief Executive – 25 October 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Mid Year Review 2013/14

Dear colleague,

This short document is about you. And it is for you.

It provides an inevitably brief description of our organisation's work since April to improve care. There are over a hundred and fifty days left this fiscal year in which to do more. Make sure you know the part you are being asked to play.

1.5 million times a year we have face to face contact with a patient. We deliver care in more than 150 different locations, in addition to the homes of those we serve. 85% of the people we see tell us that they are very satisfied by what we do. 750 people a year are so dissatisfied that they make a formal complaint. Most of these are about our communication skills and teamwork.

All of us can play our part by taking responsibility for every aspect of the care someone has from us, regardless of the department we work in.

We may not know how to help, but we are usually expert in finding someone who can. Integrating care is not about changing locations of clinics or reorganising which organisations do what, it is about all 7,500 of us 'joining up' to put our patients first: Whether someone is lost in the corridor, misconnected on the phone, did not understand what was said in the consulting room, or needs to know how to get more advice, we can all find the time to find that person the right person to help. That is what our values and promises are all about.

The upcoming winter is a test of all of us and of our NHS too. We think we are better prepared than ever before. Our plans to control infection are strong. At Sandwell we can isolate patients in a way we could not last winter, because of our bay-doors.

Our flu vaccination programme is intended to cut our own sickness rates and make sure teams are staffed with our people, not temporary staff.

Though we have more beds than last winter, the big change is in how we use the resources we have. We have a huge opportunity to make winter 2013 better than last year. But even a model based on professional advice and proper maths, depends on our behaviours. Each of us has a part to play to BE the difference. If we do what we have always done, we should expect more of the same. In this review you can find more details of how we can improve care this winter. But look on Connect, search Winter Must Be Better for all the information you need.

There have been major successes in the last six months. Our infection rates remain low, though we must drive up MRSA screening rates. Our VTE assessment rates are the best we have ever had, but we want them to be the best in the NHS at 100%. Our campaign to cut pressure damage is working, both at home and in our wards: No grade 4 pressure sores and grade 3 rates down.

The Trust's mortality rate has fallen sharply – meaning fewer people die in our care than might be expected. Tackling sepsis quickly is the single biggest thing we could do to change that further.

Thank you for your hard work and your teamwork. We hope you are proud of SWBH – what we do matters and we do it well.

Richard Samuda
Chairman

Toby Lewis
Chief Executive

Where EVERYONE Matters

"MRSA screening is an essential weapon in our armoury in the battle to deliver harm free care."

Linda Pascall
Interim Chief Nurse

Half way through the year – making the difference for patients and staff

Our latest Hospital Standardised Mortality Rate data shows four quarters out of the last five with **substantially below expected mortality rates**. Our programme to review all unexpected deaths within 42 days is gathering pace, with more than 81.7% of reviews completed on time. This matters because we need to learn about how we can improve even further what we do.

We are well advanced with medical revalidation and preparing for educational supervisory validation. We are putting plans in place to have 360-degree appraisal in 2014 for all our leaders. But both are not worthwhile unless we continue the good work to have routine employee **appraisals carried out and acted upon in all departments**. The current data shows 79.6% success and we have 1509 appraisals left to undertake this year. Everyone deserves an meaningful appraisal in our Trust.

Our Health Visiting services continue to transform and **meet the National Call to Action**. Recruitment is on plan to increase staff numbers. We are meeting our plan to improve early years childhood assessments in Sandwell, not just providing a universal service but a targeted 'universal plus' service for vulnerable families. Integrating care for children is part of our public health ambitions.

The CQC re-inspected our two acute sites and our maternity teams in June. We now have **no outstanding concerns registered by our regulator**. This was not true in 2012. We have work to do to keep up our success as the regime for inspection changes. And our focus on informed consent for treatment or to with hold treatment must be maintained and improved.

Six months gone. **We have spent £204m and brought in income of £216m**. We are just £0.02m behind our plan. That success has meant we have made investments in extra staff and services, in equipment and IT. In particular we plan to invest in our PACS system in imaging. And we have spent money to release our Clinical Nurse Practitioner time overnight to care for our sickest patients.

Venous thromboembolism **[VTE] assessment rates since June have been our best ever**. Most wards and most teams now do this for every patient. If we act on the assessment, lives are saved. Our emergency wards and patients admitted at weekends remain the parts of our system where we miss 100%. Congratulations to everyone who is working hard to make this consistently what we do.

In June and in August we cut long waits for emergency treatment below 5% of those coming to A&E. Taking July, August and September together **we met the four hour minimum standard for a 'quarter' for the first time in over twelve months**. Handovers of unwell patients from ambulances happened much more quickly than before. City Hospital was the best in Birmingham and the Black Country. And most specialties deliver our own local goal to undertake all unplanned surgery inside 48 hours.

Half a year left to go – plenty of time to do more to deliver brilliant outcomes

Winter must be better 2013 – the single action that will make the most difference to dark winter evenings is early morning daylight discharges. The night before we know someone may go home. How we organise breakfast, write up their medicines, talk to their relatives, prioritise their transport: Everybody in SWBH has a minute to spare to make an hour's difference to discharge time. That hour means the next admitted patient is on the ward when our multi-disciplinary team are on shift. That hour is truly 'golden'.

We must cut unplanned readmissions to our hospitals. In a handful of specialties we see rates thirty percent above what might be expected. This summer a clinician driven programme has been put in place to understand and tackle this. If we are to be renowned as the best integrated care organisation in the NHS, we must be the very best at supporting patients we have discharged to home or nursing home care.

Never Events are what they say. Things no health service should inflict on a patient. We have had 2 in a year and 14 over four years. Between now and the end of 2013 we will evaluate in every part of our Trust the changes, controls and knowledge of how to prevent repeat events. Everyone matters, we take no chances.

From November, **investigating and responding to complaints** will be locally organised. We want to cut waiting times for replies to below forty days (from seventy +). And we want to make sure that every team learns promptly from what complainants tells us and teach us. Do not be the reason we delay saying sorry.

Both in Sandwell and in Birmingham the Councils' **children's services** have been repeatedly externally assessed as failing core safety and quality standards. Assessments of NHS work have often, but not always, been very positive. Our children and families depend on a whole system to safeguard and to care. We have a big part to play, across almost every part of our Trust, in helping to improve care for vulnerable children and families.

Our Care Closer to Home agenda is very important to our patients. This year's Right Care, Right Here priorities will see us move **more services to Rowley Regis**, as well as transferring most diabetic clinic care into community settings in both West Birmingham and Sandwell: We will do it by March 2014!

Huge improvements are being made in our Information Technology. Community teams on SystmOne are going paperlight, and our diabetes project is award winning. But by March we want to have Badgernet in place across maternity services. Freeing up staff time and giving us vital data on our public health work with pregnant mums – **Making Every Contact Count.**

"I moved to Rowley after a stay at Sandwell Hospital and am so glad to be here. It is a wonderful environment, close to home, so my family and friends can easily visit me."

Janet Pritchard
Patient
Eliza Tinsley Ward

Our future is in our own hands – where everyone matters

Half a million people depend on our work:

Confidence in the NHS has been dented over recent years. We know that most of the time we get things right. Committed, skilled colleagues provide a great service. We need to make sure that that is consistently true by **expanding the best of what we do already**. Evenings and weekends need to be as safe as the rest of the week. Our community, outpatient and elective services need 52-week a year resilience, which can only be achieved through teamwork.

We know that patients with long-term chronic conditions need care organised around them, by them in most cases. Often at home. Integrating social care, our services, mental health and voluntary agencies. Our Trust has some great examples for children and adults of doing that well. We need to accelerate the pace of change in diabetes, respiratory medicine, for those with arthritis, dementia or depression. **SWBH can be an integrated care beacon to the NHS** if we are prepared to innovate, evaluate and change at pace.

Half of all large Trusts are forecasting a financial deficit:

And we are not one of that group. We are on track to have an eighth successive year of planned surplus, allowing us to reinvest in new roles, equipment, and new services: Expanding imaging into weekends or having more obstetrician cover for maternity are just two of this year's priorities which have been funded.

Though we plan to invest in IT, in training and development, and in buildings over the next five years we will still need to deliver a surplus. That will not come through more income, but will have to come through treating more people less expensively.

In 2014-15 we have lots to do to standardise equipment, medicines, and products used. A single SWBH approach is needed.

Meanwhile, we need to speed up recruitment, making it easier to fill vacant roles and slash bank and agency costs.

Retaining people who already work here because we become known as a great place to work.

All of our success will be about our people:

That is why it matters that we start to change our culture, without losing traditions and strengths that work well. The Trust is a big place and decisions need to be made locally. Successful teams will be able to make investment decisions, recruitment decisions, and change services more easily than at present.

Successful teams work together and have informed and credible leaders.

That is why in 2014-15 we will invest more than ever before in developing leadership at SWBH, so frontline supervisors, specialty leads, Group Directors of Nursing or Board members – all of us – have common core skills in managing people and managing change.

Managing change means mitigating risks. It is not enough to report incidents or concerns, we need to act to prevent recurrence.

Over the next six months every team will be asked to determine how it becomes part of a learning culture that operates Trustwide.

Our reputation for openness, raising concerns and ideas without reproach will be critical.

"I strongly believe that people are the greatest strength of our organisation. We should engage in two-way communication – active listening to capture innovation and then sharing information about the improvement that demands participation."

Dr Ganesh Ganesan
Co-Chair of Medical Staff Comittee

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Cardiac Catherisation Laboratory – Replacement, City Hospital
SPONSOR (EXECUTIVE DIRECTOR):	Rachel Barlow, Chief Operating Officer
AUTHOR:	Amanda Robson, Director of Operations – Medicine & Emergency Care
DATE OF MEETING:	31st October 2013

EXECUTIVE SUMMARY:

This is a business case for the replacement of the Cardiac Catherisation Laboratory at City Hospital. There is an urgent need to replace the catheterisation lab because of the age and unreliability of the equipment and the unsuitability of the environment.

REPORT RECOMMENDATION:

The Board is asked to APPROVE the proposal to replace the City Hospital cardiac catheter lab on the assumption of a managed service provided that procurement responses fall within the Board approved economic envelope, and subject to confirmation that the cost of providing two catheterisation labs at Sandwell is prohibitive

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	**X**	Legal & Policy		Patient Experience	**X**
Clinical	**X**	Equality and Diversity		Workforce	
Comments:					

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

Supports the delivery of Accessible and responsive care and Sage, high quality care

PREVIOUS CONSIDERATION:

The Configuration Committee has previously considered the Long term options for the configuration of cardiac services

BUSINESS CASE

CARDIOLOGY
CAPITAL REPLACEMENT OF CARDIAC CATHERISATION LABORATORY AT CITY HOSPITAL

1. Introduction

This paper sets out the case for replacing the catheterisation laboratory at City hospital.

The issues that need urgently to be addressed are:

The age and unreliability of the equipment
The unsuitability of the environment

2. Background

Interventional and non-interventional cardiology services are provided at SWBH with cardiac catheterisation laboratories on both sites. The current cardiac catheter laboratories carried out 2,002 procedures in a year on the City Hospital site with Sandwell Hospital delivering 1,837 cases (year 2012-13). The cardiac catheterisation laboratory at City Hospital has reached the end of its life and needs to be urgently replaced. It has been affected by many technical faults over the past 10 years leading to expensive repairs, documented clinical incidents, frequent breakdowns and 33 reported faults in the last 12 months. The life of a cardiac catheterization laboratory is approximately 8 years.

3. Age and unreliability of the equipment

The unavailability of the City based laboratory for any period of time results in delays for patients having to wait for cardiac catheter procedures and an increased length of stay in hospital. Previously, in the short term, emergency cases only (primary PCI) have been transferred to Sandwell Hospital but this has meant City inpatients have had to wait longer causing bed pressures on wards, the Medical Assessment Units and elective care. The Cardiac Catheter Laboratory at Sandwell Hospital does not have sufficient capacity to perform the level of procedures required for both Sandwell and City Hospitals for in-patient and elective patients. Due to the number of breakdowns with the current cardiac catheter lab at City, this has put immense pressure on the 18 week patient care pathways, with the specialty not achieving 90% - for each month the specialty breaches 18 weeks, a fine has to be paid to CCG.

4. Unsuitability of the environment

A Control of Infection Report stated that the Cardiac laboratory will need to move to a more appropriate environment in order to meet regulatory standards for:

Health and safety (NHSLA standards)
Control of infection issues (NHSLA standards)
Privacy and dignity (CQC Essential quality and safety standards)
COSHH standards (NHSLA standards)

The current City catheter lab environment is not fit for purpose and does not meet regulatory requirements therefore necessitating replacement.

5. Strategic Context

Cardiology is undertaking a review of PPCI and PCI services which has been considered by the Configuration Committee of the Trust Board.

The Review has formed the view that if nothing is done to change the way interventional cardiology services are delivered there is a high risk of failure to consistently deliver the quality of care that is required within the expected national standards, make further service and patient improvements and be at risk of losing PPCI and PCI Centre status especially if there is a wider review of these services within Birmingham. Retention of PPCI and PCI Centre recognition allows the Trust to continue to provide a local service to the population we serve which has higher than average CHD and related mortality.

The Review process has identified 3 options that are considered clinically/operationally viable and at a high level has excluded some of the options/sub options that do not appear viable from a capital cost and feasibility perspective. In all options a cath lab is required at City Hospital as the option of locating 2 cath labs and an expanded CCU/Cardiology ward at Sandwell has been assumed to be prohibitive in terms of cost, feasibility and disruption to other services (the Estates department is undertaking a high level cost and feasibility exercise to confirm this). Therefore it is assumed that replacing the catheter laboratory facility at City before the final outcome of the Review would not prejudice any conclusions likely to be reached as a result of the Review.

6. Compliance with Trust Priorities

Accessible & Responsive Care:

The new cardiac catheter laboratory will enable Cardiology to deliver a service that is immediately accessible as clinical need dictates, 24 hours a day, seven days a week in a robust, reliable manner. The service will provide the following:

- Diagnostic and interventional procedures for patients presenting with acute coronary syndrome.
- Facilities for insertion of temporary or permanent pacemakers
- Cardiac resynchronization therapy and implantable cardio defibrillators.
- A range of other procedures in the treatment of heart disease, e.g. Reveal implantation, periocardiocentesis, electrophysiological procedures.
- Day case procedures – pre-assessment and handover will take place in the Medical Day Case Unit and patients will be taken directly to the lab.
- In-patients from wards for any of the aforementioned procedures.
- Emergency 24/7 primary PCI procedures, supported by an on-call rota, which requires the national standard of call to balloon time of 150 minutes to be delivered as stated by the British Cardiac Interventional Society, to be reduced to 120 minutes.
- Possibility of direct ambulance access to catheter lab for primary PCi.
- An environment conducive to the rapid recovery of patients with complex needs.
- A back-up lab in the same area to ensure that clinical care and emergency patient flows are not compromised, should there be a breakdown in the new cardiac catheterisation laboratory. This enables flexibility in times of pressure for both labs. The 2nd area will consist of the C-arm back up and a theatre table to perform pacing procedures, thus assisting with patient flow.
- Improved patient flow between ward and cath lab regarding patient interventions.
- Opportunities for multi-professional skills training.

It is necessary to deliver and maintain the 18 weeks referral to treatment target: Currently the existing cardiac catheter lab at City is unreliable with frequent breakdowns and has resulted in patient cancellations both for in-patients and elective patients. The cardiac catheter laboratory at Sandwell is unable to accommodate the number of procedures required to be carried out for both sites. This has resulted in an increase in the waiting time for the booking of procedures within 18 weeks.

It will improve the Patient Experience: Due to equipment failures, patients have had to be cancelled at short notice, causing undue distress, anxiety and inconvenience in the current catheter lab. It is essential to ensure that we have equipment that is "fit for purpose" in an appropriate environment which addresses the privacy and dignity issues that currently exist in D2.

The new catheter lab will enable the specialty to consistently deliver a high quality cath lab services.

7. Planned Outcomes and Benefits

Benefits	Achieved by when	How will it be measured	Review Date and Forum	Lead Manager
Reduce LOS from admission to procedure.	March 2014	BCIS and MINAP audits	Cardiology Directorate Meetings	Dr C Varma
Improve patient flows from MAU/A&E to the cardiac catheter lab. & throughput into the Medical Day Case Unit.	March 2014	Trust LOS data	Cardiology Directorate Meetings	Dr C Varma
Reduction in cancelled sessions	March 2014	Theatre utilization data	Cardiology Directorate Meetings	Dr C Varma
2 labs (2nd lab C-arm & operating table for pacing procedures) will enable cross-site procedures to be standardised	March 2014	Monthly – site specific activity data	Cardiology Directorate Meetings	Dr C Varma
Reduction in postponed sessions due to limited capacity available for in-patients in the cardiac catheter lab.	March 2014	Monthly – site specific activity data	Cardiology Directorate Meetings	Dr C Varma
Meeting the 18 week RTT of 90% and above.	March 2014	Weekly waiting list data	Weekly WL data	Dr C Varma

8 Options

Option	Description
1	Do Nothing
2	Refurbishment of D2
3(a)	Relocate to new location and procurement of new cardiac catheterisation laboratory
3(b)	Relocate to new location and procurement of new cardiac catheterisation laboratory via Managed Services contract.

8.1 Option 1 – Do nothing

The impact of option 1 would be as follows:

I. Existing cardiac catheter lab kit has reached the end of its life and unable to sustain full-time activity, with frequent breakdowns.
II. Control of Infection has raised the existing cardiac catheter lab environment on D2 as a red risk, therefore increasing the risk of infection rates.
III. Long waits for elective patients and in-patients for procedures.
IV. Transferring of patients to Sandwell will increase length of stay on the wards.
V. Increase in frequency of breakdowns with the use of one cardiac catheter lab due to activity well in excess of supplier stipulated volumes.
VI. Breach of 18 week RTT target with subsequent financial penalties.
VII. Breach of 6 week diagnostic target.
VIII. Loss of income to the Trust and inability to deliver contracted activity levels

8.2 Option 2 - Refurbishment of D2

I. Cost of refurbishing the existing space will be costly with limited flexibility in meeting all of the health and safety and control of infection issues identified.
II. No additional space would be available to house a back up lab in the future, as stated by the British Cardiac Society guidelines.
III. Installing a new cardiac catheter laboratory in the existing space would maintain existing service delivery, but the environment would not meet all the regulatory standards.
IV. Due to structural load bearing walls in the existing area, refurbishment to comply with recommendations for infection control is not possible.
V. Additional cost of mobile catheter lab - £9,000 per week whilst works completed.

8.3 Option 3 (a) – Relocation of existing space to new location with the procurement of new cardiac catheter lab (Theatres 9 & 10) & C-arm back up facility.

I. An alternative environment will enable the new cardiac catheter laboratory to be installed effectively and would enable all the health and safety, control of infection and privacy and dignity issues to be addressed without interrupting current workload.
II. The new lab will enable a more sophisticated and integrated practice which is currently standard practice in other units.
III. Accommodation will be available for a C-arm facility, should the core lab break down in the middle of a procedure.

8.4 Option 3 (b) – Managed Services Option

I. Benefits of option 3 (a) above and
II. No requirement for upfront investment.
III. Replacement of equipment as part of contract should it be required.
IV. Offer 24/7 hours service to attend to breakdowns (currently in-hours only).
V. Flexibility to support transfer of equipment to MMH and this will be a condition of the 8 year contract.
VI. Experience in providing managed services to other Trusts nationally for cardiac catheter laboratories.

9. **Non Financial Option Appraisal**

Benefit Description	**Option Scores**			
	Option 1	**Option 2**	**Option 3a**	**Option 3b**
Reduce LOS from admission to procedure	1	2	3	3
Improve patient flows from MAU/A&E to the cardiac catheter lab. & throughput into the Medical Day Case Unit	1	1	3	3
The new lab will enable cross-site procedures to be standardised with C-arm facility	1	1	4	4
Reduction in postponed sessions due to limited capacity available for in-patients in the cardiac catheter lab.	1	1	4	4
Meeting the 18 week RTT of 90%	1	1	3	3
Total Score	**5**	**6**	**17**	**17**

10. **Estimated Capital Cost and Funding**

Expenditure/Funding Item	Option 1 £000s	Option 2 £000s	Option 3a £000s	Option 3b £000s
Expenditure:				
Land	0	0	0	0
Buildings	0	(1,068)	(1,026)	0
Furniture & Equipment	0	(780)	(780)	0
Design Fees	0	(111)	(107)	0
Other (contingency)	0	(120)	(120)	0
VAT Recovery allowance	0	44	40	0
Total Expenditure	**0**	**(2,035)**	**(1,993)**	**0**
Funding:				
External Grants	0	0	0	0
Other Externally Generated Funds	0	0	0	0
Specific Capital Allocation	0	0	0	0
Trust Capital Programme	0	2,035	1,993	0
Charitable Funds	0	0	0	0
Other	0	0	0	0

Option 2 is to upgrade the accommodation in the current location D2. The costs assume the existing structure can accommodate the proposals without the need for any structural upgrades. They assume that the existing Services infrastructure including drainage has sufficient capacity to accommodate the proposals. No allowance is included for any asbestos strip out works that may be required. It is envisaged that any works required will be the subject of separate funding.

Option 3 is to relocate the cath lab to theatres 9 and 10 under differing procurement options.

11. **Estimated Revenue Costs and Income (Full Year Effect)**

The expectation is that activity and income will be maintained therefore this paper concentrates on the expenditure associated with each of the options and associated funding.

Income/Expenditure Item	Option 1 £000s	Option 2 £000s	Option 3a £000s	Option 3b £000s
Costs:				
Premium costs of having agency consultants	(176)	0	0	0
Mobile to support capacity constraints due to inceased breakdowns - 2 per week	(225)	0	0	0
Equipment & capital works amortisation - 8 years	0	0	0	(279)
OneLIFE Management Fee - 6%	0	0	0	(105)
Maintenance Costs - through MSC	0	0	0	(50)
Maintenance Costs - non MSC	(50)	(89)	(89)	(11)
Cost of Breakdowns - EBME	(150)	0	0	0
Depreciation	(13)	(176)	(173)	0
Cost of Financing	(9)	(36)	(35)	0
Consumable spend - through MSC	0	0	0	(1,310)
Consumable spend - non MSC	(2,890)	(2,890)	(2,890)	(1,317)
Non recurrent - mobile cath lab		(234)	0	0
Total Expenditure	**(3,513)**	**(3,425)**	**(3,186)**	**(3,071)**
Savings:				
Estates rationalisation - closure of theatre 9 &10	150	150	0	0
Total Costs Saved	**150**	**150**	**0**	**0**
Net Income/(Cost) of Proposal	**(3,363)**	**(3,275)**	**(3,186)**	**(3,071)**
Recurrent funding available:	**£000s**	**£000s**	**£000s**	**£000s**
Medicine non pay budget	2,930	2,930	2,930	2,930
Medicine TSP related to MSC				(250)
Futher savings made through tender for MSC provisder				250
EBME maintenance budget	50	50	50	50
Capital charges budget	22	22	22	22
TOTAL funding available	**3,002**	**3,002**	**3,002**	**3,002**
Funding Surplus / (shortfall)	**(361)**	**(273)**	**(184)**	**(69)**

As part of the estates rationalisation program there is a TSP for £150,000 linked to use of theatre 9-10 but this is being addressed by reviewing other options.

Consumables costs and maintenance through the MSC are based on indicative figures.

Under option 2 there would be a need to have a mobile lab for 26 weeks at a cost of £9,000 per week

The MSC will deliver savings of c£250k which medicine have identified as part of 14/15 TSPs.

The extra cost of option 2 above funding is the non recurrent costs of the mobile cath lab and the increased capital charges, the current equipment is at the end of its economic life and has been fully depreciated

The extra cost above budget in option 3a is the increased capital charges due to the current assets being fully depreciated.

The extra cost above budget in option 3b is the due to the amortised cost of the equipment that the MSC provider would charge the Trust (equivalent to capital charges if bought out right).

The option at 3b is presented on the basis of it meeting the definition of a managed service including the accounting treatment associated with this. Until supplier responses are received a full assessment cannot be undertaken as the features of the service need to be tested for risks and rewards. This point is highlighted so that board is aware of that option 3b does not envisage a charge to the capital resource limit.

12. **Staffing Numbers (Full Year Effect)**

It is assumed that staffing numbers will not change

13. **Activity**

It is assumed that there may be a temporary increase on current activity levels within cardiology as a result of fewer breakdowns but that underlying activity trends will not be altered as a result of this case

14. **Investment Appraisal (Capital Cases and Mixed Schemes where Capital Investment is over £50,000)**

Measure	Option 1 £000s	Option 2 £000s	Option 3a £000s	Option 3b £000s
Payback*	N/A	N/A	N/A	N/A
Rate of Return	N/A	N/A	N/A	N/A
Total costs @ year 8	(26,797)	(25,184)	(26,102)	(24,566)
Net Present Value (NPV) [Discounted Cash Flow] @ year 8	(23,831)	(21,951)	(22,709)	(21,847)
Equivalent Annual Cost (EAC) based on NPV	(2,979)	(2,744)	(2,839)	(2,731)

Of the 4 options, option 3b has the lowest EAC, it is £248k less than option 1, £13k less than option 2 and £108k less than option 3a on average per annum.

Over 8 years option 3b is £2m less than option 1, £104k less than option 2 and £862k less than option 3a. The savings are generated through reduced consumable costs that run through the MSC.

15. **Risk Assessment and Management**

Risk	Option Scores				Mitigation
	Option 1	Option 2	Option 3a	Option 3b	
Breakdown during procedures – clinical risk	5	5	2	2	C-arm facility to be immediately available to continue with procedure.
Delivery of 18 week RTT	5	4	2	2	
Reduce LOS from admission to procedure	5	4	3	3	
Reduction in postponed sessions due to limited capacity available for in-patients in the cardiac catheter lab.	5	5	2	2	
	20	**18**	**9**	**9**	

16. **Preferred Option**

The preferred option is option 3 as it meets all of the regulatory standards required of the Trust for NHSLA and for meeting CQC Essential Standards of Quality and Safety. It also provides space for 1 cardiac catheterisation laboratory with a C-arm back up facility to be maintained in the same area, as the British Cardiac Intervention Society states any hospital performing emergency PCI must have a back-up C-arm or back up cardiac catheterisation laboratory available. Additional pacing sessions would be performed with the C-arm facility at times of pressure.

Of the 2 procurement methods – traditional v MSC, the MSC option 3b is assumed to be the best value option as it allows consumable savings opportunities and has a much lower NPV than the traditional procurement method 3a.

Following approval of the case a mini competition process would be held to identify the managed service partner. The description 'mini competition' refers to the fact that suppliers will be invited from an already pre-competed central framework agreement. Flexibility will be built into the procurement process to enable consideration of future service configuration.

17. **Cash flow Phasing of Preferred Option**

Option 3b

Cash Flow	15/16	16/17	17/18	18/19	19/20	Subsequent years - YR 6-8	TOTAL
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Capital Expenditure (-)	0	0	0	0	0	0	0
Income (+)	0	0	0	0	0	0	0
Revenue Expenditure (-)	(3,071)	(3,071)	(3,071)	(3,071)	(3,071)	(9,212)	(24,566)
Cost Savings (+)	0	0	0	0	0	0	0
Net Cash Flow (+/-)	**(3,071)**	**(3,071)**	**(3,071)**	**(3,071)**	**(3,071)**	**(9,212)**	**(24,566)**
DCF	**(3,071)**	**(2,967)**	**(2,867)**	**(2,770)**	**(2,676)**	**(7,497)**	**(21,847)**

18. **Proposed Timetable**

Expected Date of Commencement for mini tender process: November 2013

Expected Date of Commencement of work: TBC following tender award

Expected completion dates: TBC following tender award

19. **New Hospital Considerations**

When MMH opens it is expected that the equipment within the Cath Lab will transfer to MMH. This context will be factored into the procurement decision making process.

20. **Procurement route**

The intention would be to conduct a mini-competition utilising the existing London Procurement Programme (LPP) Contract for a Vendor Neutral Managed Services Framework, Ref. T05-12 To facilitate the mini-competition, a specification will be sent to the 3 companies on the framework, against which bids will be received. The outcome will identify the most suitable partner to go forward with. As the suppliers are all vendor neutral, the Trust would not be tied to any particular equipment manufacturer.]

The initial specification will enable the 3 providers to produce a response, ensuring a level playing field with flexibility to vary exact requirements. The process of selecting a partner does not commit the Trust to a managed service.

As reconfiguration is an option being explored for cardiology it is suggested that in gaining approval to initiate this process that costs are also gained at the same time for the potential procurement of a second lab within one year. This will give the reconfiguration team outline costs for several options involved in reconfiguration.

21. **Recommendation**

It is recommended that the Trust approve **Option 3** for a replacement cardiac catheter Lab within theatres 9 and 10 as this will meet all regulatory standards for control of infection and health and safety. It will also meet waiting time issues for in-patients and elective cardiology procedures, maintain emergency out of hours activity and enable at times of bed pressures for additional lists to be planned.

The Board is asked to APPROVE the proposal to replace the City Hospital cardiac catheter lab,on the assumption of a managed service provided that procurement responses fall within the Board approved economic envelope, and subject to confirmation that the cost of providing two catheterisation labs at Sandwell is prohibitive

SIGN OFF

It is important to ensure that any consequences for other Divisions/ supporting departments are included in this case.

FOR ALL NEW CONSULTANT POSTS – N/A

Have OPD Nurse Managers confirmed the availability of clinic sessions?	N/A
Have theatre sessions (if required) been reserved?	N/A
Have costs been included for the impact on clinical support departments (e.g. pathology, imaging)?	N/A
Have costs been included for the impact on non-clinical support departments (e.g. medical records)	N/A

FOR ALL CASES

Other Divisions or supporting Departments consulted: *Please list as appropriate, for example:*	**Have they confirmed all implications are included?**
Imaging	YES
IM&T	YES
Estates e.g. EBME	YES
Facilities e.g. Domestic service	YES
Supplies	YES

DIVISIONAL SIGN- OFF

_____ Print name **DR CHETAN VARMA**
Clinical Director

_____ Print name **AMANDA ROBSON**
Divisional General Manager

_____ Print name **NICOLA REID**
Senior Finance Manager

_____ Print name **DR MATTHEW LEWIS**
Divisional Director

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Outline Business Case – Homeless Prevention Programme
SPONSOR (EXECUTIVE DIRECTOR):	Toby Lewis, Chief Executive
AUTHOR:	James Pollitt, Head of Learning & Development
DATE OF MEETING:	31 October 2013

EXECUTIVE SUMMARY:

The Trust Board is invited to consider the attached business case which has been developed with the primary aim of equipping and supporting young local homeless people via an apprenticeship scheme.

REPORT RECOMMENDATION:

The executive recommendation is that we proceed to advertise the opportunity to participate in the initiative and conclude receipt of bidders submissions during 2013. The successful bid will be assessed against a number of key criteria.

The Board is invited to ask the chair of the Audit Committee to assess bids alongside the Chief Executive, Chairman, and Finance Director.

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		Legal & Policy	**X**	Patient Experience	**X**
Clinical		Equality and Diversity	**X**	Workforce	**X**

Comments:

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

Supports the Trust's key aim to engage more closely with its local community. Other benefits include increasing the value of the Trust's estate, reduced hospital admissions from homeless individuals, financial return on the investment and supports delivery of the Trust's corporate social responsibility.

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Homeless Prevention Programme – Business Case

Report to the Trust Board – 31 October 2013

Overview

1. This project is a continuation of our Learning Works programme on apprenticeships. It targets a specific perceived need among younger people who are likely to fall into homelessness.

2. The project cannot be guaranteed to succeed. But the risks of proceeding with the scheme are modest, in other words, our ability to stand-down the project in years to come is straightforward and apart from reputational awkwardness unfettered.

3. The exam question of the Board is whether we see any reason to reserve these properties for other purposes. The recommendation is based on the view that:

   Our need for residential accommodation is modest
   Where it arises it supports acute care, which is not long term planned for Sandwell
   In so far as it does, we have other better properties still in use

4. Our land disposal strategy for Sandwell cannot be finalised until MMH is accepted or rejected. But no version of our estate plan uses land for NHS purposes on that side of Hallam Street, rather we retrench to the hospital side.

5. Though our LTFM does not include it, it is assumed we would seek land disposal for housing re-development of the current car parks on that site. This is not inhibited by disposing of these properties.

6. A whole series of potential bidders have come forward, who are summarised and locally prioritised in the attached papers from Learning Works. The executive recommendation is that we proceed now to advertise the opportunity and conclude receipt of bidders submissions during 2013. The successful bid would be assessed against the key criteria:

   Best delivers a credible partnership for apprentices
   Creates no financial obligation on Trust resources
   Does not extend beyond a ten year commitment
   Has a reasonable prospect of carrying any change of use permission required by the LA

7. The merit of this recommendation is that it avoids a real or perceived preference by a public body (ourselves) towards established partners.

8. The Board is invited to ask the chair of the Audit Committee to assess bids alongside the Chief Executive, Chairman, and Finance Director.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

OUTLINE BUSINESS CASE

Project Name A partnership project to:-	**Homeless Prevention Programme** – (Working title) This project will be specifically focussed on getting young (16-18 year olds) homeless people employment within the Trust via the apprenticeship scheme.
Project Sponsor	**Sandwell & West Birmingham NHS Trust**
Partner Authorities Involved	A partnership project that will include the following Strategic Partners:– • Local authorities (Sandwell & Birmingham) • Voluntary and charitable sectors • Private sector (Construction) Sign-up by specific key partners already includes: • Directors of Public Health (Sandwell & Birmingham) • CCG (Sandwell & West Birmingham) • Mental Health Commissioner (Sandwell) • Homeless leads for local authorities (Sandwell & Birmingham) Sandwell Housing Association Social Services (Sandwell & Birmingham) Police Job Centre Plus. TBG Training Provider Charities: Trident Reach The Princes Trust St Basils YMCA
Summary of Project Benefits	The Trust, via this project, will offer employment and training opportunities to support the local authorities and charities in addressing the youth homelessness situation within the Trust area of patient responsibility. This unique and ambitious strategy should (over the longer term) see a reduction in homelessness amongst the younger generation due to the provision of employment opportunities and a reduction in hospital admissions from this client group. The local authorities will benefit from the project by seeing a reduction in homelessness care provision and benefits claims from

	this client group due to them achieving employed status. The individual's health and wellbeing will be improved, with a reduced dependency on social care which will hopefully lead to independent living.

Introduction

Statistics from our workforce profile show that in 2011 there were only two employees in post that were aged between 16 -18. The current workforce profile shows this number has increased to fourteen employees as a direct result of the work carried out with apprenticeships.

National statistics identify that the Birmingham and Sandwell regions have some of the highest youth unemployment and homelessness issues within that age group in the country. We are committed to support national and local agendas such as Public Health Prevention Programme, Health & Wellbeing, Right Care Right Here, Health Equality & Integration, and we also have our own Health Promotion Strategy and arguably a duty to address this issue as part of our Corporate Social Responsibility.

Background

There are assertions and supporting evidence throughout current research and literature that all segments of the homeless population - unaccompanied adults, heads of family households, and youth - face significant and multiple barriers to employment. These barriers are personal, programmatic, and systemic.

People who are homeless often lack skills in stress management and social interaction, independent living skills, and skills for vocational engagement (Munoz, Reichenbach, & Hansen, 2005), as well as a place to live and financial resources. Barriers such as lack of transportation and educational credentials are prevalent among homeless people in both urban and rural areas (Taylor, 2001). In addition, homeless young adults and youth experience high levels of trauma and typically have poor educational and vocational preparation (Barber et al., 2005).

According to the 'Young & Homeless' report, a survey of 79 homeless charities and 108 local authority housing services found that, over the past year:

1. Nearly half of homelessness services (44%) and councils (48%) have seen an increase in young people seeking help because they are homeless or are at risk of becoming homeless.
2. The number one cause for homelessness among this age group is relationship breakdowns with family and friends, and cases of this have increased.
3. The majority (62%) of young homeless clients seen by charities were not in education, employment or training and 46% were in financial difficulties.
4. A quarter of young clients (26%) seen by services had experience of sleeping rough.

Lorna Esien, Director of Operations for the homelessness charity St. Basils (a local Midland's charity) said:

"We have seen a definite trend in terms of a significant increase in the numbers of young people presenting as homeless, mainly due to family conflict and overcrowding. For the first 6 months of 2011, we saw 2289 young people which is a significant increase on 2010. Over 30% were aged 16/17 and nearly 80% were Not in Education, Employment or Training (NEET).

It is commonly acknowledged that homeless people are major users of social services, primary care services and acute services. Our hospitals treat the health conditions associated with homelessness; however we are also in a great position to prevent homelessness from occurring in the first place, thereby breaking the cycle that young homeless people find themselves in.

Cost of Homelessness to Communities

It is estimated homeless people use 4 times as many acute health services and 8 times as many inpatient health services as the general population.

This places a huge financial burden on our health services. Research by the Office of the Chief Analyst at the Department of Heath places this cost at £85.6m per year. This breaks down as:

£76.2m of Inpatient services, likely to be a minimum estimate because it is based on inpatient care funded under Payment by Results

£50m A&E costs, not including ambulance services. It is estimated homeless people have A&E attendance rates of 5 times as much as the general population

Hospital usage overall was found to be 4 times that of the general population. For inpatient costs (the bulk of usage for this client group) this rises to 8 times more per person.

The above research clearly shows the disproportionate usage of hospital services by homeless people and highlights the need to explore more cost efficient ways to address these issues before they reach crisis point. This project will support the initiative from a prevention perspective.

Causes of Youth Homelessness

One of the major causes of homelessness for young people is the breakdown of family relationships. This usually happens when the family dynamic changes. Sometimes violence can also be a contributing factor. In these cases, vulnerable young people are left without the support of their family and can feel like they have nowhere left to turn.

While family breakdown is the most common cause of homelessness many other issues such as unemployment, debts and health problems also contribute to the problem.

The graph below illustrates national statistics of the main causes of young people becoming homeless.

Local Context

Homelessness in Birmingham is double that of any other region in the UK excluding the London boroughs.

- In Quarter 1 of 2013, 1469 people applied to Birmingham City Council as homeless.
- Previous research has shown the between 17-25% of that figure will be young people; unfortunately the city does not break down its statistics by age.
- There are large amounts of hidden homelessness within this customer group due to fact young people are much more likely to sofa surf.
- 43% of new young clients had experienced rough sleeping with 35% having been street homeless before the age of 15.

AIM

The primary aim of this project is to equip and support young local homeless people, to build their emotional resilience, confidence and skills to enter or re-enter the labour market, which in turn, will provide opportunities for them to thrive in the workplace and society as a whole.

We acknowledge that we are not the experts in this field, so it is vital to the success of the programme that we work closely with our strategic partners to ensure we have the correct expertise and support where necessary. Being a pivotal part of the community enables us to utilise that influence.

Objectives

Sandwell & West Birmingham NHS Trust has a powerful presence in the heart of the communities it serves. As the largest employer in the area we are in a position to engage local young homeless people in training opportunities and employment within the Trust.

The main objectives of this project are:

1. Reduce the number of homeless young people in the region by providing employment opportunities linked to training and development with supported accommodation.
2. To engage with partner organisations to support the delivery of our Health Promotion Strategy
3. To meet out Trust objectives by providing a cost effective workforce that represents the community it serves
4. To meet our Corporate Social Responsibilities (CSR) as a large employer in the region.
5. To satisfy some of the requirements needed for Foundation Trust status.

This business case will look at a number of options available to us and the extent to which joint work by different departments and agencies will achieve the objectives set out in the project business plan.

Reason Why?

There are many reasons why we, as a Trust should engage in this project. We have the accommodation, we have the workforce to deliver the training, we have the political will and support from senior management and we have the jobs, however one overwhelming reason why we should be doing it is because '**it is the right thing to do'**.

Project Business Plan

The project business plan is divided into 3 Stages:

1. Stage 1 – Development and delivery of a Training Programme
2. Stage 2 – Refurbishment and occupancy of the Accommodation Blocks
3. Health & Wellbeing Support Pathway.

1. Training Programme

A work experience and apprenticeship delivery model will be developed for this client group. Robust recruitment and selection processes need to be adhered too and this will be supported by partner organisations. Once suitable candidates have been identified they will be offered an apprenticeship with supported accommodation and other amenities such as access to the Trusts Health and Wellbeing service and Occupational Health services. The duration of the support will be for the term of the apprenticeship which is normally twelve months. Upon completion of the apprenticeship it is anticipated that the apprentice will be selected to fill the vacancy that has supported the apprenticeship. They will also lose the right to occupy the accommodation.

2. Accommodation

The whole project is based on utilising the disused accommodation block in Hallam Street, opposite Sandwell General Hospital.

There are four blocks; each block has nine apartments over 3 floors. All the blocks are currently in a state of disrepair with an estimated cost for refurbishment at circa £600K per block. The initial concept is to utilise one of the blocks for apprentice accommodation with the other 3 blocks remaining in a state of disrepair. Several partners have shown an interest of supporting the Trust with the refurbishment of one of the block to meet this requirement. However, indications from some of the potential partners would suggest the remaining three blocks could be utilised as leverage for further development or investment.

Once the accommodation block has been refurbished and become occupied the management of the building needs to be established. It is anticipated that a partner charity will fulfil this role.

3. Health & Wellbeing Support Pathway

This part of the project will be provided in partnership with local charities, Local authority social services, trust community services and the Trusts Occupational Health department.

Project Forecasting Benefits

Trust

Increase the profile of the Trust and its image as a caring organisation
Leading the Way - Potential for significant replication of the model at regional or national levels. Kudos.
Workforce succession planning – having a workforce that reflects the community it serves.
In year financial savings by employing an apprentice against a fully salaried vacant position.
Robust recruitment processes 'grow our own' Workforce. Quicker and more efficient.
Increase in the value of the estate due to refurbishment of accommodation block/s.
Reduced hospital admissions from young homeless people.
Financial return on the investment

Locality (Social and Primary care)

Reduction in local authority demand and costs associated with hospital services, discharge and on-going social and residential care.
Reduction in unemployment benefit payments and other welfare support.
Investment into local economy reducing the number of homeless youngsters within Sandwell

and West Birmingham Boroughs.
Reducing avoidable premature deaths/mortality rates
Enhancing the quality of life for residents of Sandwell and West Birmingham by taking them out of poverty or social deprivation.
Reduce unnecessary A & E admissions and readmissions
Regeneration of local areas by providing jobs for local people

Strategic Partners

Increased profile both locally and nationally
Meets their CSR, sustainability or other self- set community based agendas.
Leading the Way - Potential for significant replication of the model at regional or national levels.

Project funding

The project will need significant capital investment to enable the refurbishment of the accommodation block however; the project can still progress without the accommodation by just offering apprenticeships to homeless people.

It is the allocation of the accommodation to support the individual whilst undertaking the apprenticeship that makes this project unique and that is what we believe will make the difference to the individual.

The accommodation is the element of the project that requires the major funding investment; however the table below gives some indication of how the project can be funded and how the accommodation supports the long term sustainability of the project.

Income is based on 27 homeless young people eligible for full apprenticeship funding.

Income Table

	Income	Year 1	Year 2	Year 3	Total
Apprenticeship based on £5k for 16 – 18 year old	£135,000	£135,000	£135,000	£135,000	£405,000
Housing benefit based on a maximum entitlement of £55 per week	£77,220	£77,220	£77,220	£77,220	£231,660
Wage supplement from BCC of £3k per apprentice (based on 5 apprentices being eligible)	£3,000	£15,000	Nil	nil	£15,000
Sub total		£227,220	£212,220	£212,220	£651,660
Additional funding options					
Levy against service in year cost efficiency for apprentice	£2000 per placement	£54,000	£54,000	£54,000	£162,000
Charitable funds	£20,000	£20,000	nil	nil	£20,000
Totals		**£286,220**	**£266,220**	**£266,220**	**£833,660**

Expenditure Table

	Expenditure	Year 1	Year 2	Year 3	Total
Building refurbishment	£600,000	£600,000	nil	nil	£600,000
Capital Charges	Not sure of cost so allocated £50k pa	£50,000	£50,000	£50,000	£150,000
Rates	Not sure if payable so allocated £7.5k pa	£7,500	£7,500	£7,500	£22,500
Council Tax	To be paid by individuals				
Utilities					
Buildings maintenance		Nil	£5000	£10,000	£15,000
Facilities					
Housekeeper					
Security					
Staffing					
Total		**£657,500**	**£62,500**	**£67,500**	**£787,500**

The income/ expenditure tables show a working profit within 3 years based on the maximum funding entitlement and based on setting a levy against service. Indications from partners would suggest the cost of £600k for the refurbishment to be excessive with cost more likely to be in the region of £250 – 300K. There are also indications that some, if not all the capital refurbishment costs could be met by partner organisations. If this is the case the reliance on funding from housing benefit and the service levy could be waivered, which would still leave a operational budget of approximately £200,000 over the 3 years.

Project Options

Option 1

The Trust manages and delivers the whole project on its own with limited support from partner organisations. This is a financially viable option (see tables above) but would bring with it some risks. The Trust is not an expert in this field so would be exposing itself to an environment of uncertainty and one of competition with other providers. *Whilst exciting, this option may prove a step too far from Trust norms.*

Option 2

The Trust works in partnership with a preferred provider and they deliver the project together.

This is also a viable option however the question of capital expenditure required to bring the buildings up to a habitable standard still in needs to be addressed. An estimate of £1.5m capital investment would be required to bring all 4 buildings to habitable standard. Based on a rental income of £170,000 per annum an income of £3,400,000 could be generated of a 20 year lease showing a £1.9m return on investment of the lease period. *This option should be given consideration.*

Option 3

This option is broken down into three separate proposals put forward by SMBC.

1. Proposition A – SMBC take full ownership of the buildings/land and in return refurbish the buildings and allow the Trust to use one of the buildings for the homeless apprenticeship accommodation. This option is about purchasing the blocks and land from the Trust based on market value and SMBC work with the Trust to deliver the project using one block. The other blocks will used for temporary lets and family homeless lets. *This option offers little financial risk to the Trust other than in the value of the property/land so needs careful consideration.*
2. Proposition B – SWBHT refurbish the buildings and then sign over 3 of the buildings to SMBC on a 2 year rolling lease with a guaranteed income from the flats (27 x 2 bedrooms). SMBC will be interested in 2 bedroom apartments within dedicated blocks for a 2 year private sector lease. The rent paid is based around the Local Housing Allowance, which is £450 per month per flat. There is no management fee and rent is paid even if the apartments are empty until let. The Trust will have to look after the repairs. At the end of the 2 year lease the properties are handed back to the Trust you with the current occupiers. The scheme is to help homeless families and based around demand and need. *Significant capital investment required to bring the blocks up to standard. Financial risk regarding rental income at the end of year 2. Also, does the Trust want to become a social landlord?*
3. Proposition C – SMBC refurbish the properties and manage them on a 20 year lease from SWBHT, but allow the Trust to use one block for apprentices. Assets return to SWBHT at the end of the lease. *Minimal financial risk to the Trust. Asset could be sold after 20 years. Clarity around on-going maintenance needs to be established.*

Option 4

That the Trust works in partnership with a homeless charity and construction company to refurbish the building and manage the occupancy of the building on a day to day basis. The refurbishment of the building is carried out by the construction company utilising its charitable arm 'Employment Foundation' which is a charity for supporting young people into employment. The labour would be met by using the companies 'give a day of your time' programme which allows skilled people to help on projects of this nature. The companies supply chain providers would also be called upon to support the project.

A charity partner (St Basils) has also offered access to capital (£125,000) for building refurbishment. As part of the package they would also offer to manage the building and occupants on behalf of the Trust. The income from the housing benefit and an additional service charge would be used to support this activity. The package is reliant upon the signing of a 10 year lease on the building.

This option poses little risk to the organisation as there is no capital outlay (met by Construction Company, their supply chain and the Charity) or building management costs (met by homeless charity via housing and other benefits). Income from the delivery of apprenticeship programmes will be maintained and reinvested to support the on-going delivery of the programme.

Option 5

Leave the blocks as they are and carry on as before. *From 1st April 2013 all unoccupied living accommodation will attract a 50% council tax charge for the first 6 months of un-occupancy then 100% charge thereafter thus attracting a council tax charge of approximately £40,000 per annum. It is not an option to do nothing…*

Conclusion

This is an exciting project that if delivered successfully will be life changing for those involved. It will have a direct impact their health and wellbeing and could set them up for the rest of their lives. The project is innovative and unique however, as with all projects there are risks associated with it. There are financial risks which cannot be ignored but can be managed and mitigated with good project management.

One of the biggest risks is the attitudes and behaviours of those on programme and those of Trust staff. Employing people from the homeless community, many of whom have different attitudes, behaviours and values to those we, as employers, have become familiar with will be difficult and risky. That said, with training and development we can change those attitudes and behaviours.

Taking risks in the NHS goes against the grain. This project is a challenge to the 'organisational culture' and the way we do things round here. We also know that culture eats strategy for breakfast so no matter how good the plan, if we don't get buy in or engagement from 'the top down within the organisation and from external stakeholders the project will fail.

However, if life was risk free and unchallenging how boring would it be?? We can change culture, we can change attitudes and we can change the lives of many young homeless people, so let's take the risk and deliver the project.

Recommendations

This project has generated interest from many areas of the community and from politicians on how best to utilise the buildings in question. The initial project was for the development of one block which was to be used as apprentice accommodation and that is what the recommendation below is based upon.

It is recommended (author's opinion) that the Trust opts for **Option 4**.

It is also recommended that the Trust Board decide which route to take regarding the utilisation of the remaining 3 blocks. There are many possibilities/opportunities available to the Trust as to how best develop the blocks, if that is the route the Trust wishes to pursue.

James Pollitt

Head of Learning and Development

Sandwell and West Birmingham Hospitals NHS Trust

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 20 September 2013; 1030h – 1230h

Members Present

Ms O Dutton [Chair]
Mr R Samuda
Mrs G Hunjan
Dr S Sahota OBE
Dr R Stedman
Mrs L Pascall
Miss R Barlow
Mr R White
Miss K Dhami

In Attendance

Ms A Binns
Mr S Parker

Secretariat

Mr S Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies for absence from Prof Richard Lilford, Mr Toby Lewis and Mrs Debbie Talbot.	
2 Minutes of the previous meeting	**SWBQS (8/13) 128**
The minutes of the Quality and Safety Committee meeting held on 23 August 2013 were approved as a true and accurate reflection of discussions held. Mr Samuda suggested that an action needed to be included concerning the need to streamline the use of the e-rostering and acuity tools. The Committee agreed that this was appropriate to include within the next action log.	
ACTION: Mr Grainger-Payne to add an action to the Committee's log for Mrs Pascall to report back on progress with streamlining the use of e-rostering an acuity tools **AGREEMENT: The minutes of the previous meeting were approved**	

3 Matters arising from the previous meeting	**SWBQS (8/13) 128 (a)**
The updated actions list was received and noted by the Committee.	
3.1 Progress with finalising Medicine & Emergency Care Group's TSP	**Verbal**
Dr Stedman advised that the Medicine & Emergency Care Group's individual schemes had all been risk and quality impact assessed. It was highlighted that a small number of schemes had been rejected on the basis of this assessment. The Committee was advised that the majority of schemes related to outpatient efficiency. Mrs Pascall reported that a mitigation plan in terms of the proposed bed reduction had been developed.	
MATTERS FOR DISCUSSION/DEBATE	
4 Update on 'Winter 2013 Must Be Better' programme	**Verbal**
Miss Barlow reported that the overall performance against the Emergency Care target had improved. It was reported that the medically fit for discharge wards had been opened, which would assist with improving patient flow. The model of acute assessment being introduced was reported to have liberated beds in the evenings in readiness for the evening admissions. In terms of staffing in the Emergency Departments, it was reported that further recruitment was needed to replace staff leaving and those withdrawing from the recent appointments exercise. It was also noted that the supply of trainees from the Deanery had been less than required, which it was highlighted was in line with the regional position.	
5 Quality Report	**SWBQS (9/13) 130** **SWBQS (9/13) 130 (a)**
The key highlights within the Quality Report were presented to the Committee. Mrs Pascall highlighted that based on the results of the safety thermometer, further work was needed to understand the reasons for the deterioration. It was reported that in particular, work was underway to identify the reasons for the increase in falls. Ms Dutton noted that there appeared to be an increase in the use of bank and agency staff which was a concern. She asked why establishments were being budgeted for either less or more than the recommended levels. Mrs Pascall advised that budgets had been set on a historical basis. Moving forward, it was reported that a more sophisticated approach would be taken to setting establishments which would address this and would use acuity tools to inform the decisions. Ms Dutton asked how often the budget was reviewed. She was advised that a review was undertaken on a quarterly basis, however the budget was set in September. The Committee was advised that more work was to be done to reconcile the financial and nursing view of the budgeting process. Mrs Hunjan asked how quickly the financial systems aligned to the changes in the ward and speciality configuration. It was suggested that input from internal audit could assist in identifying the position in this respect. Miss Barlow suggested that narrative needed to be added to the information to provide assurance on some of the discrepancies noted. Ms Dutton underlined the need for the information in the	

quality report to be as current as possible, highlighting in particular some of the gaps in the establishment overview. Mr Samuda suggested that there was a need to present a forward view of the likely establishments. Miss Dhami reported that each clinical group had undertaken a reconciliation exercise that had been presented to the Clinical Leadership Executive which would support this request. Ms Dutton asked whether there was any sharing of good practice with areas where good practice was less developed. Mrs Pascall advised that a matron development programme was in place and that a 'buddy' scheme between new and more experienced individuals had been developed.

Mrs Pascall updated the Committee on the work undertaken since the identification of Klebsiella infections in Sandwell operating theatres, including a deep clean and some organisational development with relevant teams.

Mrs Hunjan asked whether the changeover of junior doctors had impacted on the safety thermometer score and incidence of harm. Mrs Pascall advised that there had been no specific review in this respect, however this would be considered. It was agreed that an update would be presented at the next meeting.

It was reported that Newton 3 had been placed in 'special measures'.

Mrs Hunjan highlighted that in terms of infection control, the use of flat keyboards she had observed on a recent Patient Safety Walkabout was pleasing and asked if these were rolled out further. Mrs Pascall offered to determine the plans.

Dr Stedman reported that there had been a dip in performance against the VTE assessment target. Ms Dutton asked to how many patients the shortfall against the 100% target related. Dr Stedman offered to pursue this enquiry. It was reported that the use of a new IT solution was assisting with delivery of the target. Mr Samuda asked what plans were underway to ensure that the induction programme for junior doctors captured the requirements against the national targets. Dr Stedman reported that VTE assessment was included as an item on the agenda of the induction programme, however the use of performance management was necessary in some instances. He advised that there was an expectation that an improvement against the target would be seen within the next month. It was reported that a root cause analysis for venous thromboembolisms was undertaken.

Good performance against the fractured neck of femur target was noted.

The Committee was provided with an update on plans to improve the performance against the mortality review target. It was reported that the percentage of reviews was acceptable, however the timeliness of the reviews required further improvement. The Committee was pleased that the process was attracting national recognition. The Trust's mortality figures were highlighted to be acceptable and had improved over recent months. Ms Dutton expressed her congratulations for this improvement. Mr Parker advised that the regional position was to be rebased shortly which might impact on the Trust's performance to some degree, however this was unlikely to affect the position significantly. Dr Sahota noted that performance against the target concerning the use of the 'Five Steps to Safer Surgery' overall, the position was declining. Dr Stedman advised that further work

was being undertaken to improve the culture of the Trust to improve the position. Mrs Pascall reported that in terms of the Friends and Family Test results, the Trust was not an outlier and much work was underway to improve the position. In terms of complaints, the increase in complaints received was noted, particularly the number of link complaints. The Committee was advised that as a result work was underway to understand the reasons for the returned requests. Ms Binns advised that some of the further queries sought further clarity or were requesting meetings with staff. It was highlighted that a few were returned expressing concerns over the complaints handling process. Ms Dutton asked whether the themes were being analysed and actions delivered. Miss Dhami advised that specific examples would be included in future reports where the themes and learning had been acted upon. Dr Sahota raised a specific instance where there had been miscommunication between a junior doctor and a consultant. Mrs Hunjan noted that a number of incidents remained unassigned to an investigating manager. Ms Binns advised that work was underway to re-engineer the process which would seek to address this position. It was highlighted that another 'Never Event' had been reported which would be presented to the Trust Board at its forthcoming meeting.	
ACTION: **Mrs Pascall to report back on the impact of the changeover of junior doctors on the incidence of harm** **ACTION:** **Mrs Pascall to determine the plans for the roll out of flat keyboards on wards** **ACTION:** **Dr Stedman to determine to how many patients, the shortfall against the VTE assessment target related**	
5.1 Falls	**Verbal**
It was noted that this had been discussed as part of the Quality Report.	
5.2 Readmission rates	**SWBQS (9/13) 131** **SWBQS (9/13) 131 (a)** **SWBQS (9/13) 131 (a)**
Dr Stedman reported that a readmissions task force had been established. It was reported that some 'deep dive' analysis had been undertaken to examine the reasons for some of the readmissions. It was reported that there was a correlation between readmission and mortality, which would be investigated further. In addition, a greater understanding of the link with End of Life Care was reported to also be being sought. Miss Barlow advised that much attention was being directed to the improvement to the pathways that could influence the position. The Committee was asked to note the age ranges for patients being readmitted,	

where 21.4% were over 73 years of age. A significant number of patients were reported to be experiencing co-morbidities. Ms Dutton, based on her personal experience, encouraged all efforts to be directed to ensuring that the experience of patients needing to be readmitted, be made as comfortable as possible. It was agreed that external support for the work should be secured where possible. Ms Dutton highlighted that there were significant differences between readmission rates at City and Sandwell Hospitals. Miss Barlow advised that further work was being taken to better understand the position. It was reported that a specification for an audit that would identify the reasons was being developed at present. The Committee received and noted the readmissions action plan. Mr Samuda suggested that in due course a more detailed update, possibly linked to a patient story, should be presented to the Trust Board. Mrs Hunjan asked whether any other trusts in the region were undertaking similar work. She was advised that a comparison across diagnostic groups could be undertaken. Miss Barlow advised that mechanisms would be put in place to ensure that learning from readmissions was harnessed and acted upon. It was agreed that a further update should be presented in November.	
ACTION: **Miss Barlow to present an update on readmissions at the November meeting of the Quality & Safety Committee**	
6 Trust response to the Keogh review	**SWBQS (9/13) 132** **SWBQS (9/13) 132 (a)**
Dr Stedman reminded the Committee that Sir Bruce Keogh had undertaken a review of eleven trusts with the highest levels of mortality in the country and set out a series of ambitions following the review. The Committee was guided through the Trust position against each ambition. It was noted that an electronic patient observation system would improve the Trust's current processes. Dr Stedman offered to further investigate the requirement for a Chief Quality Officer within the Keogh guidance.	
ACTION: **Dr Stedman to further investigate the requirement for a Chief Quality Officer within the Keogh guidance**	
Never Events	**Tabled paper**
Ms Binns presented an update on the assurance levels against the evidence that controls are in place to prevent the reoccurrence of the 'Never Events' that had	

occurred in the Trust. The report presented the detail of the assurance evidence and actions required to further improve assurance. It was noted that in some cases there was a lack of evidence that sufficient controls were in place to prevent reoccurrence. Miss Barlow noted that despite some 'Never Events' occurring some years ago, there was little assurance and suggested that there was a need to follow through a Group's processes to identify how the governance arrangements in place addressed the controls needed. It was suggested that for all of the areas, further scrutiny was needed in the way of further audits to ensure that the most robust assurance was provided. It was agreed that a timetable for improving the level of assurance against the 'Never Events' be provided at the next meeting. Mrs Hunjan suggested that the auditing needed to take into account the training undertaken.	
ACTION: **Ms Binns to provide a timetable for improving the level of assurance against the 'Never Events' be provided at the next meeting**	
7 Corporate Quality & Performance dashboard	**SWBQS (9/13) 133** **SWBQS (9/13) 133 (a)**
The Committee was asked to receive and note the report. Ms Dutton observed that there had been under reporting of the performance against the 28 day guarantee for cancelled operations. Miss Barlow reported that further work was underway to better inform the reasons for this. It was highlighted that there was underperformance against the target to issue a complaint response within the required timescales. Miss Dhami reported that measures were being put into place to prevent a further non-compliance.	
8 CQUIN performance	**Tabled paper**
The Committee was asked to receive and note the report.	
9 Mortality development plan: update	**SWBQS (9/13) 135** **SWBQS (9/13) 135 (a)**
Dr Stedman reported that the mortality task and finish group continued to meet, and work was underway to determine the reasons for the site differences in mortality. It was highlighted that there had been a failure to recruit to the facilitator position.	
10 Patient story for the Trust Board	**Verbal**
Mrs Pascall provided an overview of the patient story that would be presented at the next Trust Board meeting, which was reported to be that of a complainant.	
11 Complaints development plan: update	**SWBQS (9/13) 136** **SWBQS (9/13) 136 (a)**

Miss Dhami advised that the Clinical Leadership Executive had been updated earlier in the week on progress with the roll out of the devolved model of complaints handling. It was highlighted that Groups were gaining a better understanding of their requirements under the new model and that nominations for investigating officers had been received. It was highlighted that from 4 November, all dates agreed for a response to be issued would be met. Ms Dutton reported that she had asked to be updated on all Level 4 complaints when received. It was agreed that the role of the Complaints Non Executive champion would also be published.	
12 Serious Incident report	**SWBQS (9/13) 137** **SWBQS (9/13) 137 (a)**
The Committee was asked to receive and note the report. Mr Samuda asked for the reasons for the late identification of the recent 'Never Event' being presented at the Trust Board meeting. Dr Stedman reported that the incident had been reported late and had only been recognised during the patient's second follow up appointment. Dr Sahota noted that should the patient have not returned, the incident would not have been identified. He suggested that the detail of the incident be included in the follow up information that was included in the report.	
MATTERS FOR RECEIPT AND ACCEPTANCE	
13 Clinical Audit forward plan: monitoring report	**SWBQS (9/13) 138** **SWBQS (9/13) 138 (a)**
The Committee was asked to receive and note the report. Mrs Hunjan asked where the detail of the action plans for the audits that had been developed would be reported. She was advised that a summary was included within the narrative of the report.	
14 Foundation Trust Quality Governance	**Verbal**
Miss Dhami reported that a conversation would be held at the Board Development session on 27 September in respect of QGAF.	
15 – 17 REPORT BACK FROM THE COMMITTEES	
A brief summary of key points of discussion at the Quality Committees was provided.	
18 Matters of topical or national media interest	**Verbal**
It was agreed that there were no matters to raise.	
19 Any other business	**Verbal**
Miss Barlow reported that a near miss 12 hour breach in had occurred in City Hospital Accident & Emergency Department and that a multi-agency review would	

be undertaken.	
20 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 25 October 2013 at 0800h 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:	31 October 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 Board is invited to accept the report, noting in particular the key points highlighted in Section 2 of the report.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
✓		

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 25 October 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

October 2013

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

September saw an overall reduction in the incidence of pressure ulcers with a particular improvement shown in the community falling from 13 to 8.

There was no post 48hrs MRSA bacteraemia in September. We are achieving 83% in MRSA screening, an improvement on previous months. Screening in the 4 largest clinical groups is 89% (only medicine/elderly care are below 90%).

There have been no reported outbreaks in September.

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 99.63% across all patients who underwent surgery.

VTE risk assessments were carried out on 95.11% of admitted patients against a standard of 95%.

Mortality Reviews of July deaths was 81.5% reviewed within 42 days which exceeds the target of 80%.

Fractured Neck of Femur being operated on within 24 hours of admission during September was 81.8% which is below the target of 85%.

The Trusts 12-month cumulative HSMR (92.2) remains below 100, and is less than the lower statistical confidence limit and continues to remain lower than that of the now disestablished SHA Peer (98.1).

PATIENT EXPERIENCE

IInpatient FFT score 72 with a response rate of 18%

ED FFT score 50 with a response rate of 13%.

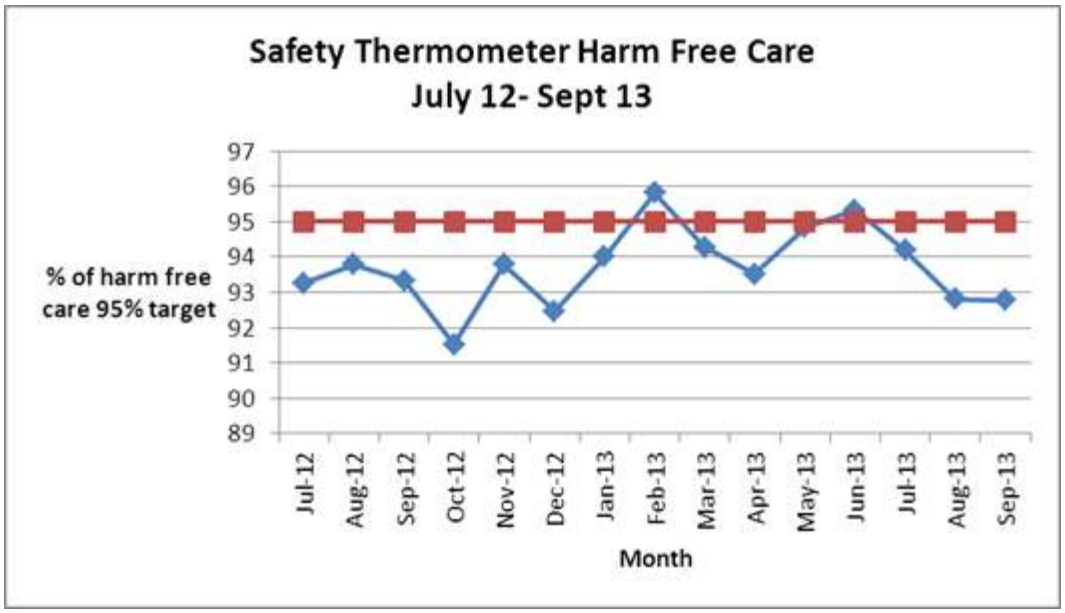
Combined result 60 with a response rate of 13%.

3 TARGETED AREAS OF SUPPORT

T&O – infection control
Theatres – infection control

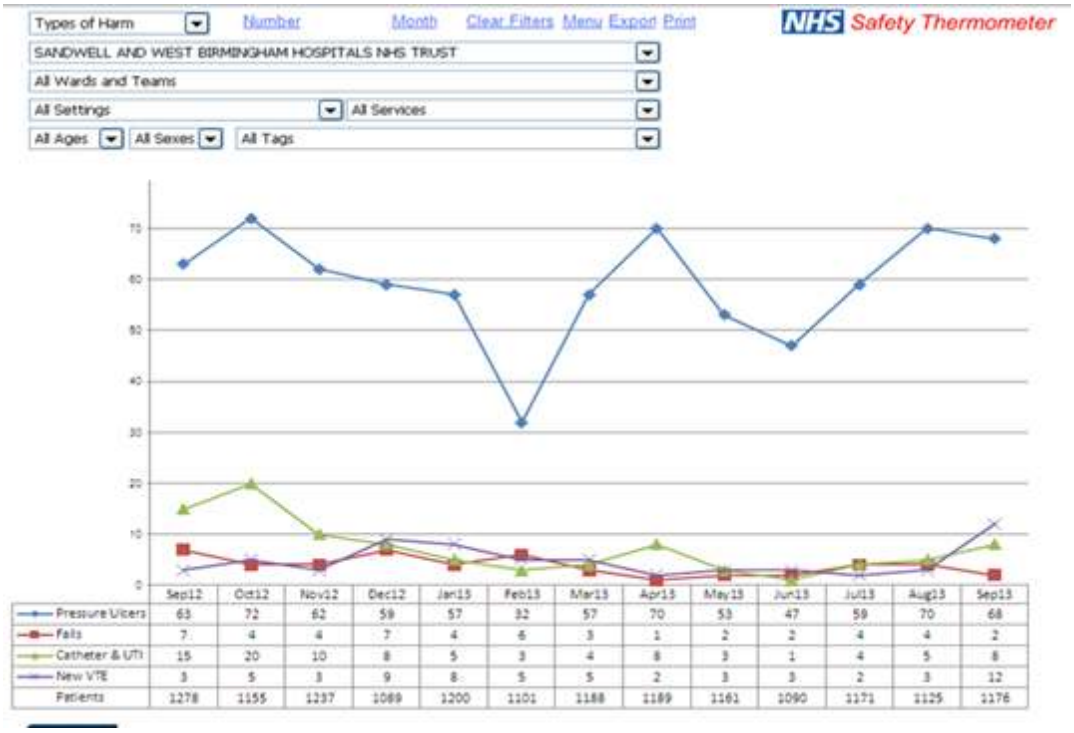
4 PATIENT SAFETY

4.1 Safety Thermometer



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

Figure 1: *Harm free care trend*



	Sep12	Oct12	Nov12	Dec12	Jan13	Feb13	Mar13	Apr13	May13	Jun13	Jul13	Aug13	Sep13
Pressure Ulcers	63	72	62	59	57	32	57	70	53	47	59	70	68
Falls	7	4	4	7	4	6	3	1	2	2	4	4	2
Catheter & UTI	15	20	10	8	5	3	4	8	3	1	4	5	8
New VTE	3	5	3	9	8	5	5	2	3	3	2	3	12
Patients	1278	1155	1237	1089	1200	1101	1188	1189	1161	1090	1171	1125	1176

Figure 2: *Number of patients by type*

Acute Divisions **20** patients experienced **1 new harm**. **2** patients experienced more than one harm.

Community Division **9** patients experienced **1 new harm**. **No** patients experienced more than one harm.

a) Falls

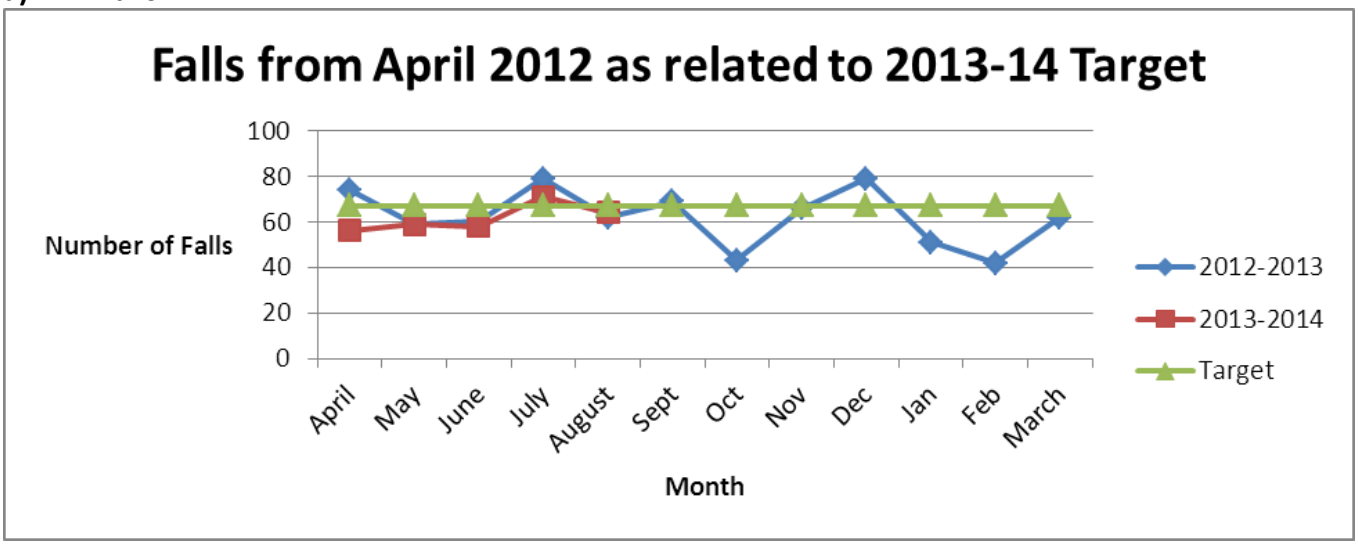


Figure 3: *Trend of falls April 2012 – August 2013*

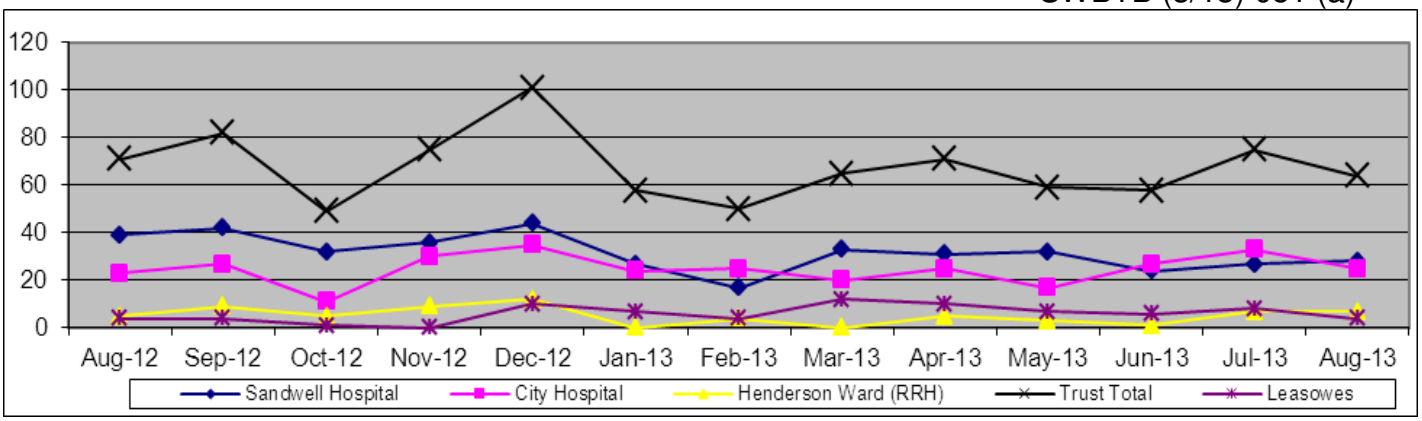


Figure 4: *Incidence of falls per 1000 bed days across Acute Inpatient Divisions*

MONTH	Ward/Area	Grade of Fall	Injury	TTR outcome
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

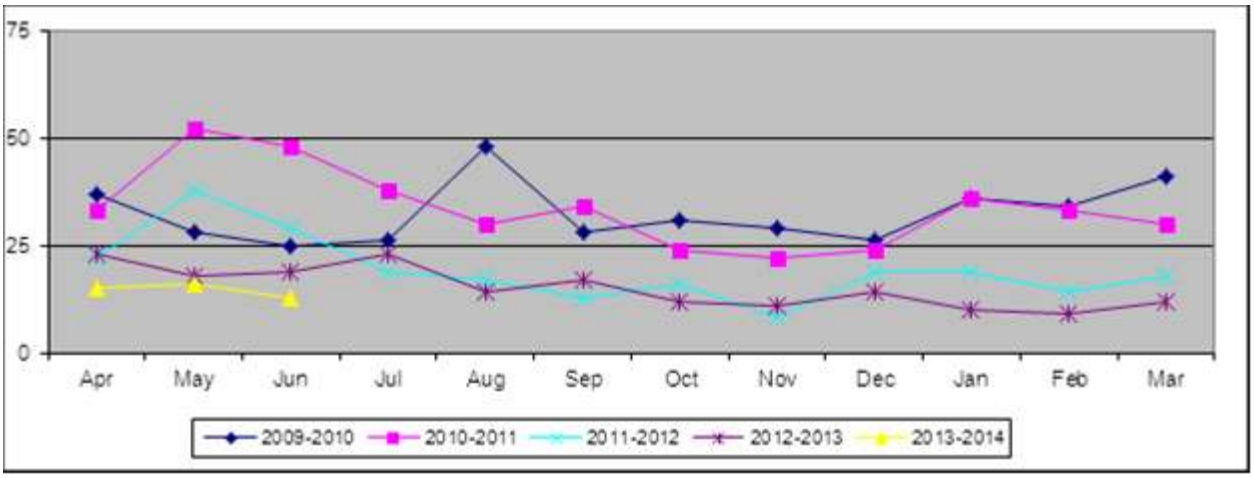


Figure 6: *Number of hospital acquired pressure damage Grade 2, 3 & 4, April 2009 – April 2013*

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. Performance during September was 95.11% which meets the target of 95%.

The particular areas of focus are the assessment units where many patients are admitted as emergencies. The Medical Director's teams are working closely with the clinical leads to ensure that all patients are VTE assessed on admission. *CQUiN*

4.2 Nutrition/Fluids

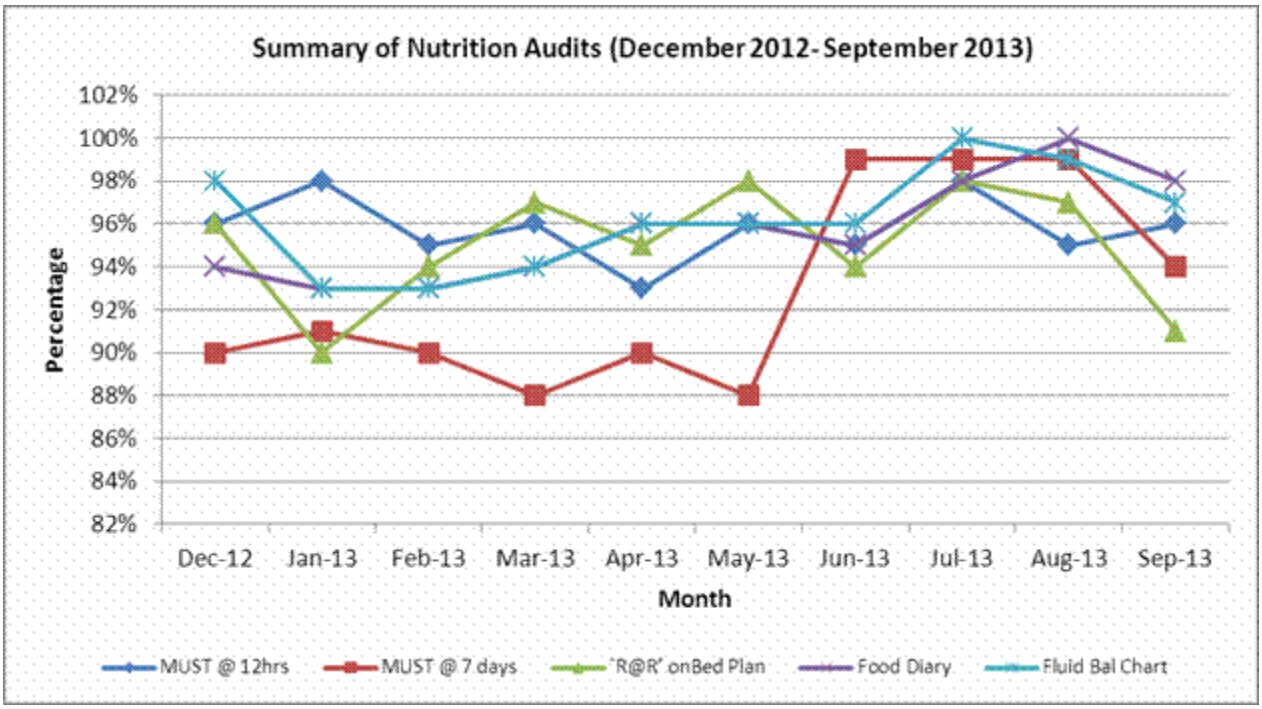


Figure 8: *Nutrition Audit Results*

4.3 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

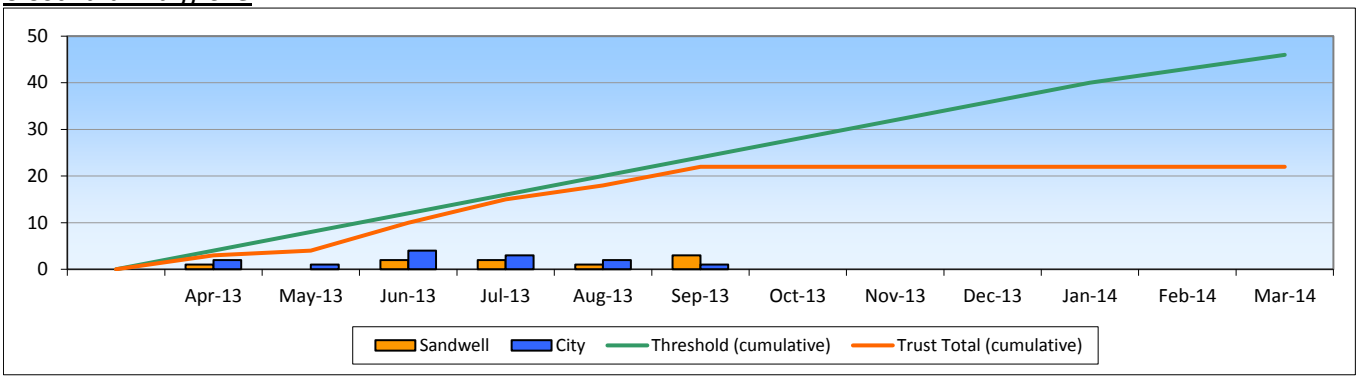
There was one post-48 hour MRSA bacteraemia for September. The total number of MRSA bacteraemia to date is 5.

MRSA Screening

			To Date (*=most recent month)	TARGET	
				YTD	2013/14
MRSA Screening - Elective	Patient Not Matched	%	**253.3***	87	90
	Best Practice - Patient Matched	%	**89.5***	76	80
MRSA Screening - Non Elective	Patient Not Matched	%	**87.9***	87	90
	Best Practice - Patient Matched	%	**90.9***	76	80

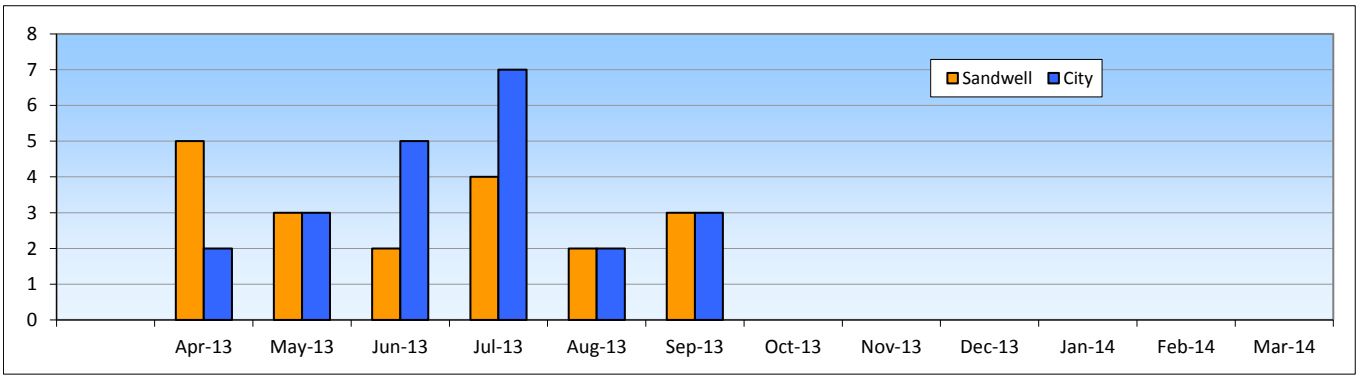
Figure 9: *MRSA screening eligibility*

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	1	3							**9**
City	2	1	4	3	2	1							**13**
Trust	3	1	6	5	3	4	0	0	0	0	0	0	**22**
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	18	22	22	22	22	22	22	22	-
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	2	3							**19**
City	2	3	5	7	2	3							**22**
Trust	7	6	7	11	4	6	0	0	0	0	0	0	**41**
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Trust Total (cumulative)	7	13	20	31	35	41	41	41	41	41	41	41	-

Figure 11: *Trust Best Practice Data*

Blood Contaminants

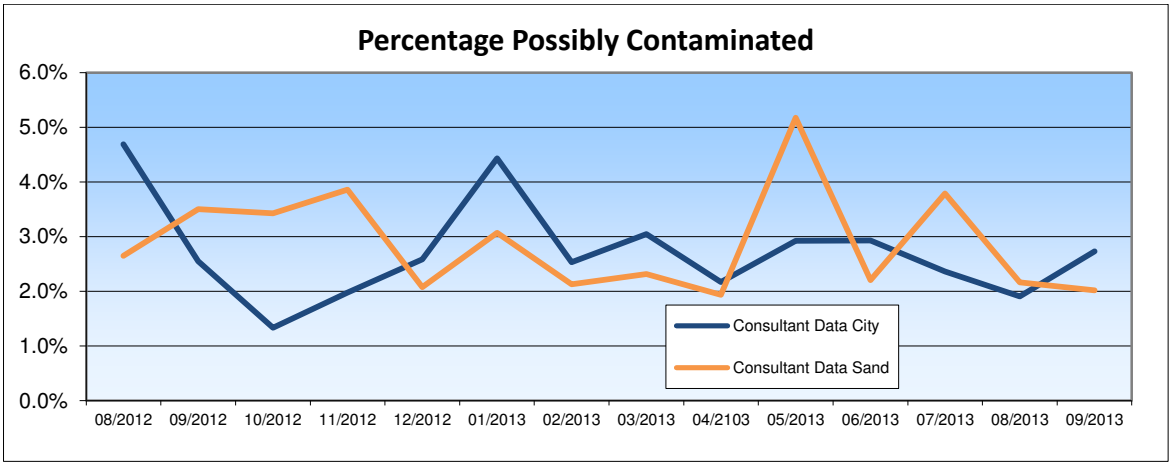


Figure 12: *Blood Contaminants*

E Coli Bacteraemia

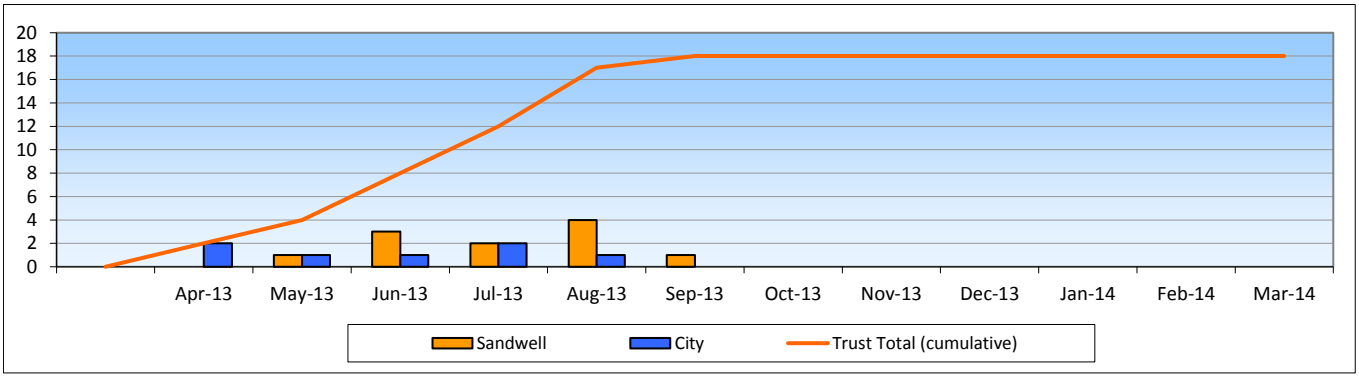


Figure 13: *E Coli Bacteraemia*

MSSA

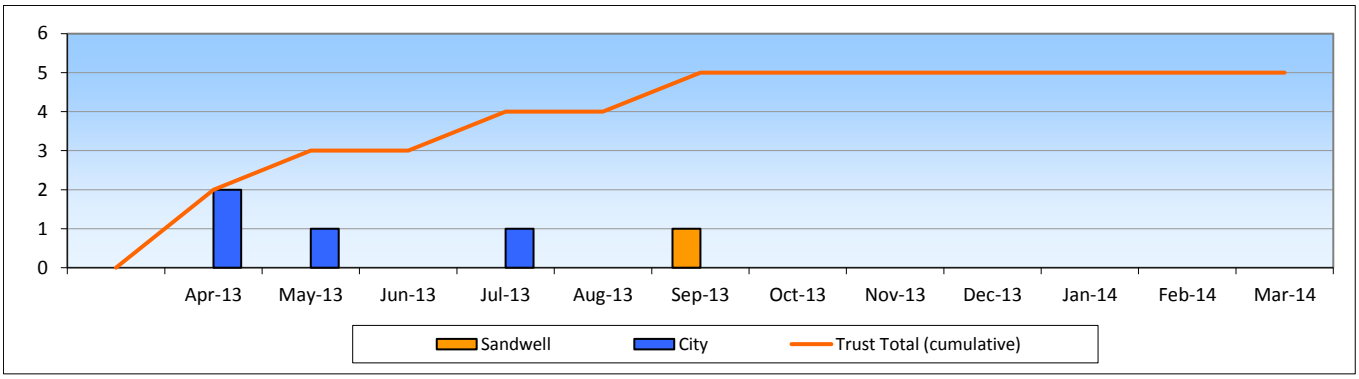


Figure 14: *MSSA*

4.4 Maternity

The Obstetric Dashboard is produced on a monthly basis. The data below is what was reported the previous month (August Quality Report):

*Post-Partum Haemorrhage (PPH)(>2000ml): t*here 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 August was 5.9 which was lower than the trajectory (8) and was lower than the previous month (8.0). 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 August was 25.5%, which is just above the trajectory of 25% over the year and slightly lower than the previous month (25.7%).

Delivery Decision Interval (Grade I, CS) >30 mins: the delivery decision interval rate for August was 6% which is below the trajectory (15) and lower than the previous month (8%).

Community Midwife Caseload (bi-monthly): The community midwife caseload in July was 128, which is below the trajectory of 140 and is lower than the previous month (138).

4.5 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.

4.6 Incidents

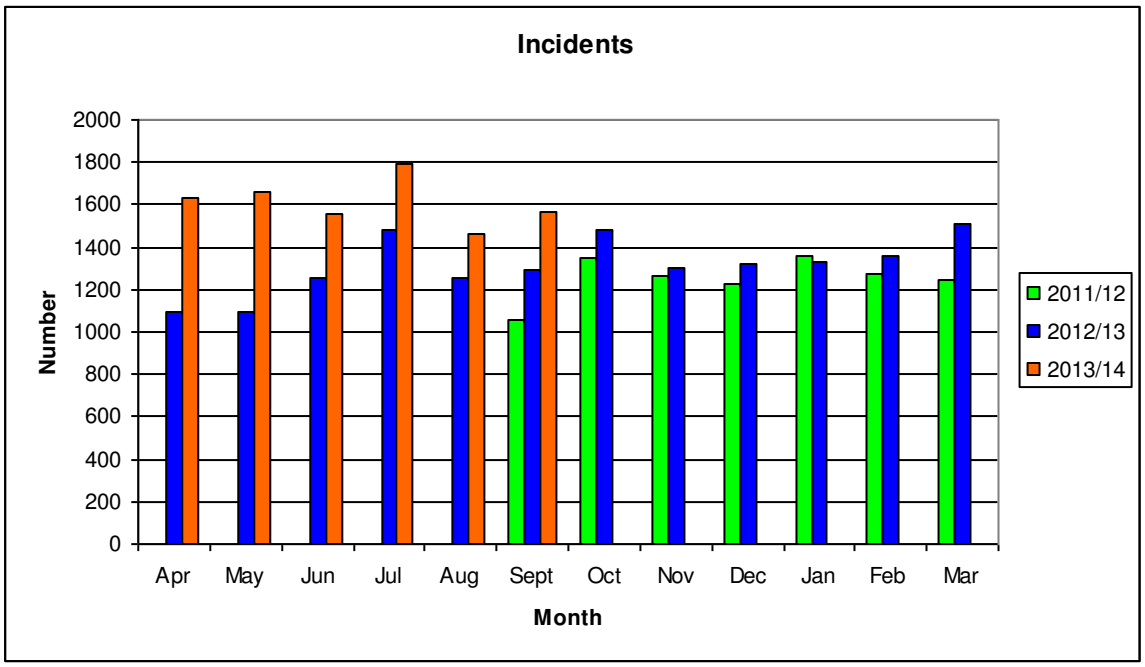


Figure 15: *Incidents 2011/12 – 2013/14*

Incidents in September 2013

Total Number of Incidents reported		**1567**
Of the total: *(* incidents still under investigation)*		
Near miss		221
No Harm		841
Low (minimal harm)		389
Moderate		102
Severe (permanent or long term harm)		11
*Death (related to the patient safety incident)		3
"Top 5" Reporters (Acute)		
1	Emergency Departments (both)	273
2	Labour ward	61
3	Medical Assessment unit	51
4	Emergency Assessment Unit	43
5	Neonatal Unit	42
"Top 3" Reporters (Community)		
1	Community Nurses Out of Hours	18
2	Community Nurses Mesty	17
3	Community Nurses Oldbury	16
"Top 5" Type**		
1	Verbal abuse (patient on staff)	83
2	Non SWBH pressure sore	71
3	Communication failure with patient/team	48
4	SWBH Community acquired pressure sore	37
5	Organisational issues	32

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

4.7 Serious Incidents (SIs)

In **September 2013** there were 4 new SI's reported to CCG.

1 2013/26928 – Acute Medicine
Unsafe discharge following GI bleed.

2 2013/27726 – Maternity
Unexpected Neonatal death.

3 2013/27743 – Critical Care Services

VRE outbreak.

4 2013/27786 – Surgery A

Food Contamination.

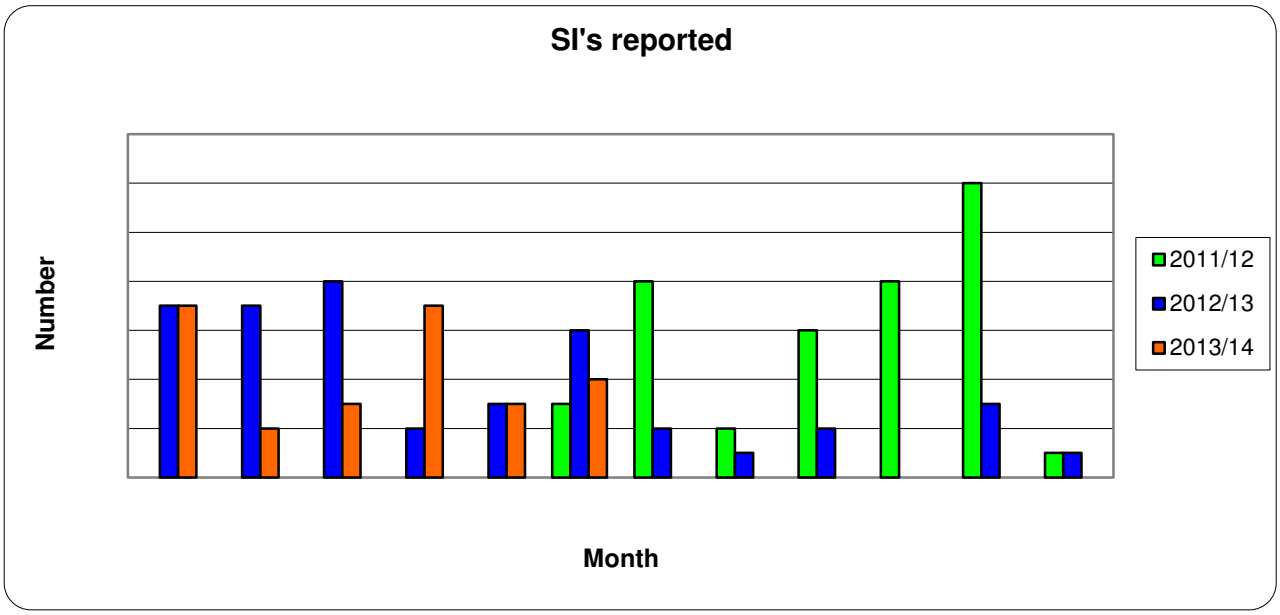


Figure 16: *Serious Incidents 2011/12 – 2013/14*

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

Issue/Risk	Action to take/taken	Who by	When by
High level of incidents awaiting action to progress to allow for meaningful data.	Meeting with senior staff in each clinical group and review of processes within their areas.	Head of Risk	December 13

4.8 Patient Safety Walkabouts

The Patient Safety Walkabouts continue to take place. In September the Serenity unit and Eye wards had a visit. Again the visits 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 the Eye ward, including the need for better patient information material for visually impaired patients. There were also one or two estates issues, including temperature control and better television & vending machine access.

The walkabouts continue with two more planned for October.

4.9 Inquests

During September 2013 4 new Inquest cases were notified to the Trust.
2 cases were closed during this period following a final Inquest hearing.

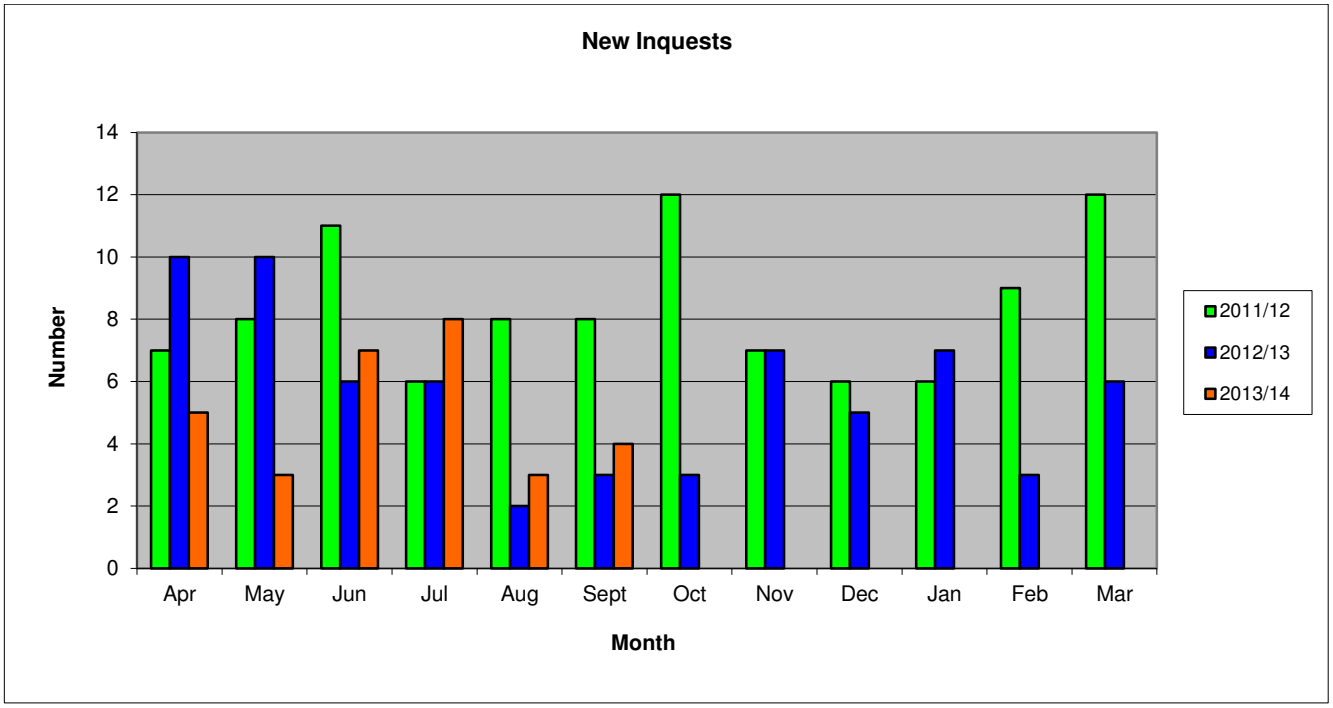


Figure 17: *New Inquests 2011/12 – 2013/14*

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

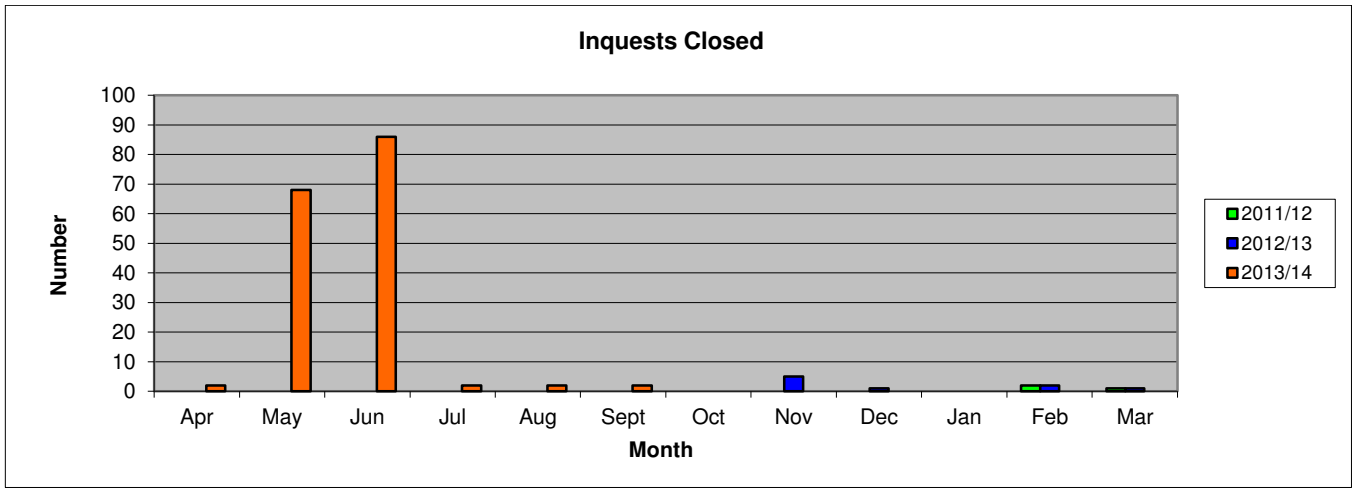


Figure 18: *Closed Inquests 2011/12 – 2013/14*

Issue / Risk	Action to take / taken	Who by	When by
Change in process as directed by the coroner will mean inquests will be held within 3-6 months of the death.	Use of checklists to meet requirements of coroner Use of a robust 'bring forward system' Early escalation processes when statements not received on time. Early notification to Coroner's office of any delay. Scanning records so that they can be available to a number of staff at one time so reports can be completed by each witness at the same time. Audit of this process	Head of Legal Services	August 2013 – achieved.

4.10 Claims

There were 11 new claims opened in September 2013. All 11 claims were clinical negligence cases.

No clinical negligence claims were closed during September 2013.

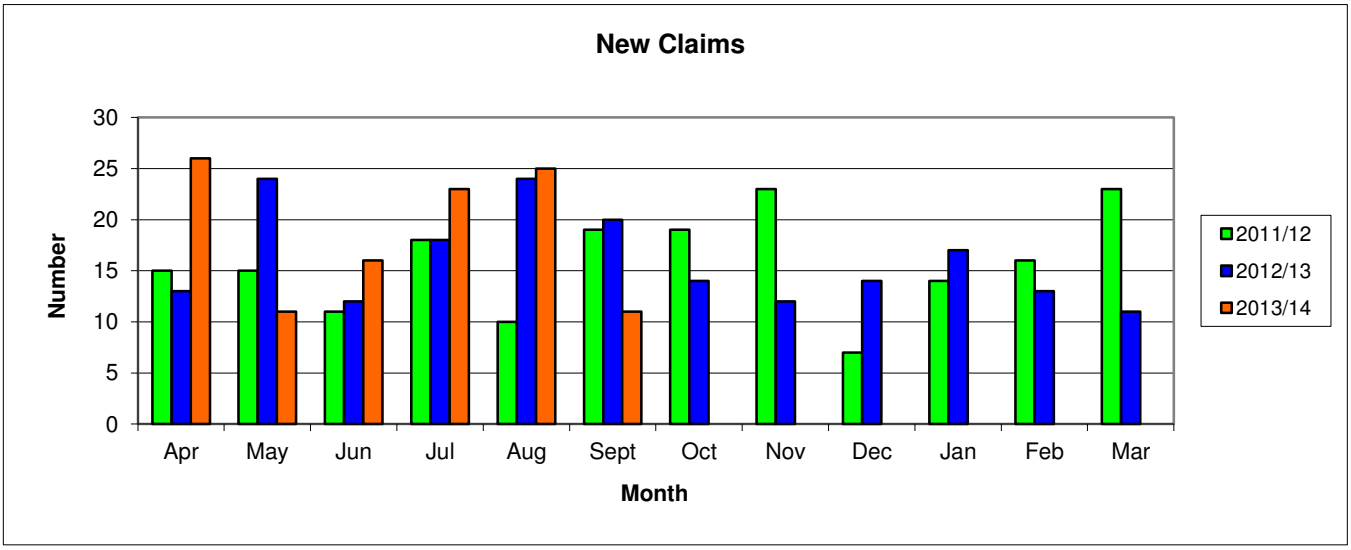


Figure 19: *New Claims 2011/12 – 2013/14*

Issue / Risk	Action to take / taken	Who by	When by
The deadlines for decisions on liability for employer and public	A checklist has been devised and introduced. Shorter timescales are now given to	Head of Legal Services	June 13 – achieved.

liability claims have reduced significantly.	staff to comply A central diary is used to bring forward all reminders for paperwork Escalation processes have proven effective.		

4.11 Nurse Staffing Levels

Bank & Agency

The Trust's nurse bank/agency rates are detailed below and show year on year comparison. *Notably we are now using more nurse bank/agency than we have for the past 4 years.*

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011 - 2012	5533	5445	5369	4816	4323	4535	5292	5449	5251	5356	5617	6380
2012 - 2013	5105	5030	5259	5384	6059	5649	6011	6656	6220	6346	7122	8611
2013 - 2014	7516	7902	6312	6682	6922	6669						
2014 - 2015												

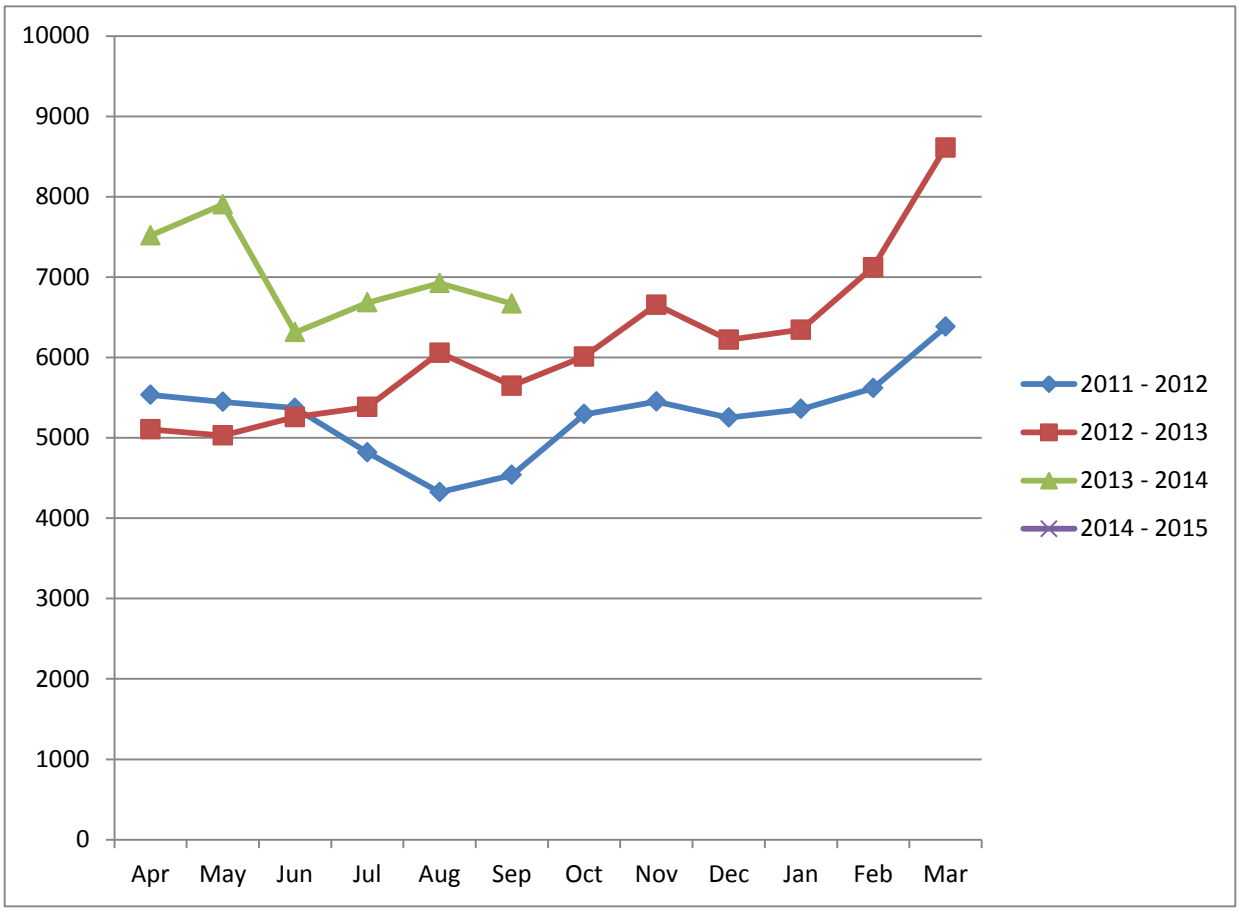


Figure 20: *Total Bank & Agency Use Nursing*

5 CLINICAL EFFECTIVENESS

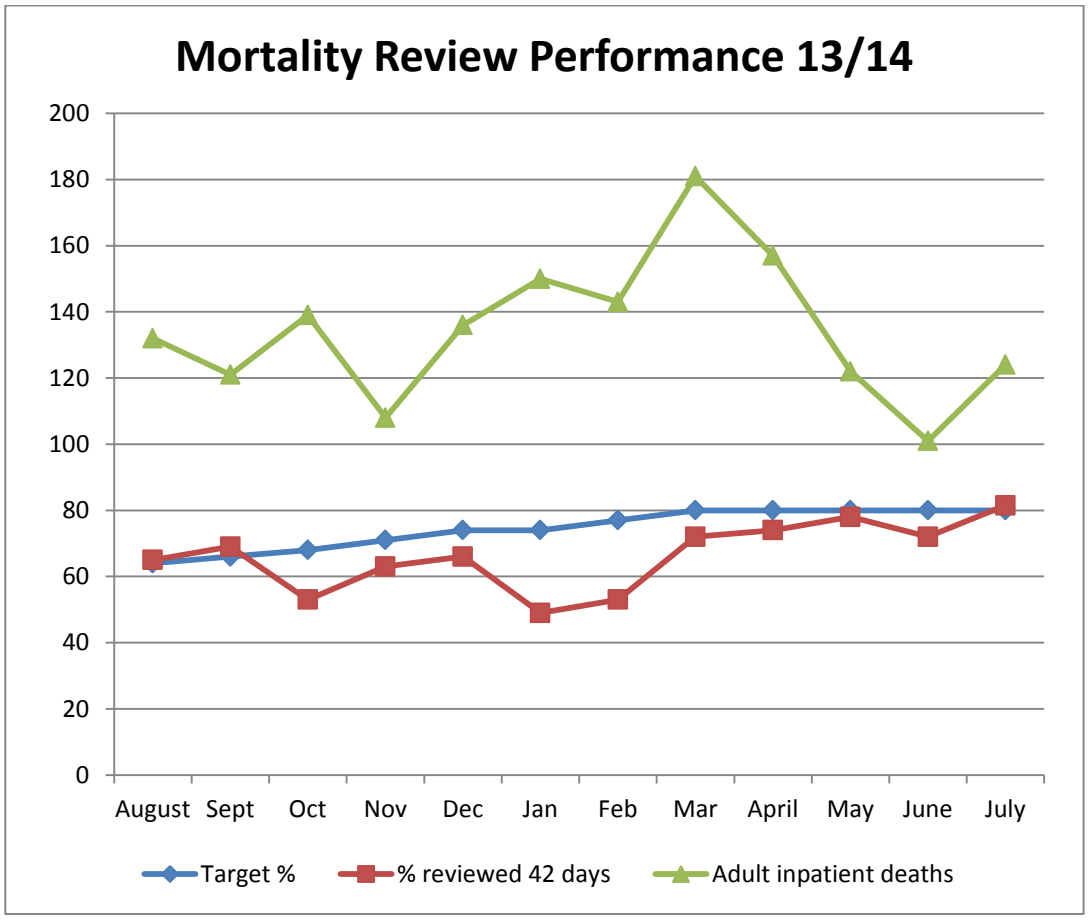
5.1 Mortality

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.

By the end of September the mortality reviews for deaths during the month of July were completed. This is the most recent month for which complete data is available. The Trust reviewed 81.5% of deaths compared with a target trajectory for the month of 80%.

This is the first month that the Trust has exceeded the target of 80%. This is because of an increased focus on directed performance management interventions. The Medical Director's Team is also producing personalised weekly prompt messages to remind consultants to carry out their allocated reviews.



2013/14	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Target %	64	66	68	71	74	74	77	80	80	80	80	80
% reviewed within 42 days	65	69	53	63	66	49	53	72	74	78	72	81.5
Adult inpatient deaths	132	121	139	108	136	150	143	181	157	122	101	124

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.

Dr Foster has undertaken its annual rebasing exercise, which impacts upon its calculation of the relative risk of mortality. The Trust's HSMR for the most recent 12-month cumulative period has increased from 88.4 to 92.2, with site specific HSMRs also increasing to 80.6 (City) and 104.2 (Sandwell). The HSMR of the SHA and National Peer values also increased by a similar proportion to 101.9 and 98.1 respectively for the same period

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 is currently 98.1 for the most recent period for which data is available, a slight reduction from the previous period of assessment.

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Mortality table

All Specialties		2012/13						2013/14		
		Oct	Nov	Dec	Jan	Feb	Mar	April	May	June
Internal Data:										
Hospital Deaths	Trust	144	106	140	157	148	179	158	123	103
	City	54	51	51	64	69	75	64	44	43
	Sandwell	90	55	89	92	79	104	94	79	60
Dr Foster 56 HSMR Groups:										
HSMR (Month)	Trust	92.6	65.0	83.2	81.4	102.5	103.7	93.9	82.9	87.8
	City	71.8	66.1	62.9	73.9	89.1	85.1	75.1	66.4	77.9
	Sandwell	112.6	63.6	103.8	88.3	121.4	124.9	112.0	98.4	98.7
HSMR (12 month cumulative)	Trust	92.7	90.5	89.1	87.8	88.1	88.9	89.1	88.4	92.2
	City	81.7	79.7	76.6	78.2	77.2	78.1	77.5	77.3	80.6
	Sandwell	104.1	101.7	101.9	99.7	99.3	100.2	101.2	100.1	104.2
HSMR (Peer SHA 12 month cumulative)		96.7	96.4	97.0	96.7	97	98.0	97.5	97.6	101.9
Healthcare Evaluation Data (HED) SHMI (12 month cumulative)		94.9	94.4	94.2	94.3	95.5	95.9	99.2	98.1	

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 August 2012 – July 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.

5.2 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	3
1 - Audit not yet due to start	8
2- Significant delay	1
3- Some delay - expected to be completed as planned	12
4- On track - Audit proceeding as planned	36
5- Data collection complete	9
6- Finding presented and action plan being developed	2
7- Action plan developed	7
D- Discontinued	1
Grand Total	79

The status of the audits that have been included in the plan as at the end of September 13 is shown in the table above. One audit has been indicated as experiencing a 'Significant delay'

National Heart Failure Audit

From April 2013 there has been a requirement to submit a record to the audit for all patients in hospital with a discharge diagnosis of heart failure. Currently approximately 30% of eligible admissions are entered into the audit. The Clinical Effectiveness Committee has requested an action plan from the audit lead to address this shortfall.

5.3 Compliance with the 'Five Steps for Safer Surgery'

Close monitoring of compliance with the WHOCL continues. Performance for September was 99.63% across all areas.

5.4 Stroke care

Performance against the principal stroke care targets was as outlined in the table below at the end of September.

Month 2013/14	target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
% Spending >= 90% of stay on stroke unit	83%	88.3	96.23	91.5	95	91.5	94.6						
% Admitted to stroke unit within 4 hrs of arrival at hospital	90%	69.35	84.1	92.3	92.1	76.3	72.1						
% pts receiving brain imaging in 24 hrs of presentation	100%	93.18	86.1	85.2	85	95.7	97.7						

% Pts scanned within 1 hr of presentation	50%	61.54	63.2	67.3	64.1	71.4	67.5						
% high risk TIA treated within 24 hours	60%	66.6	63.2	81.3	83.3	72	75.9						
% low risk TIA treated within 7 days	60%	74.07	88.4	88.2	91.2	92.5	87.9						

Figure 21: *Performance against stroke care targets (data Trust Performance Report16/10/13)*

5.5 Treatment of Fractured Neck of Femur within 24 hours

The Trust has an internal Clinical Quality target whereby 85% of patients with a Fracture Neck of Femur receive an operation within 24 hours of admission. Data for September (Source- *Trust Performance Report16/10/13*) indicates 81.8% of patients with a Fractured Neck of Femur received an operation within 24 hours of admission. *Internal Priority*

5.6 Ward Reviews

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

5.7 Quality Audits

The Quality Audits are not due for reporting this month.

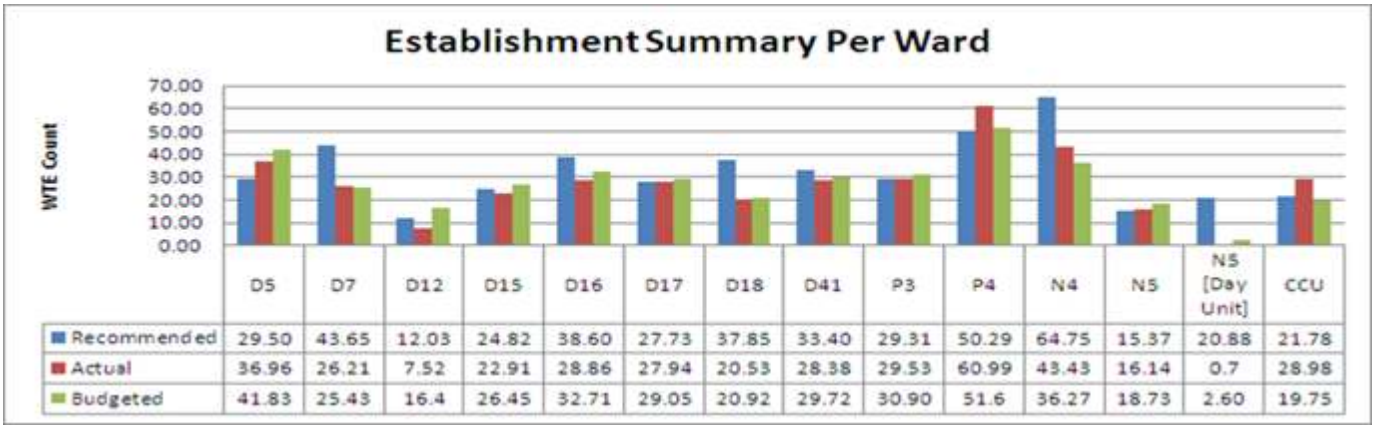
5.8 Ward Clinical Dashboard

	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■	95▼	100▼	0■	0■			■	■		■	■	■	0■	0▼	85▼	7■		72■
CCS - Critical Care Services - City	0■	0■	■	94▼	98▲	0■			■	■		83▼	0■	83▼	1■	0▼	93▼	5■		■
Coronary Care Unit - City	0■	0■	■	69▼	0■	0■			■	■		■	■	■	0■	0▼	91▼	0■		92■
Coronary Care Unit - Sandwell	0■	0■	87▼	96▼	0■	0■			■	■		100■	0■	100■	0■	0▼	86▼	1■		88■
Critical Care - Sandwell	0■	1▼	■	100■	100▲	0■			■	■		57▼	0■	71▲	1■	0▼	95▼	5■		■
D12 - Isolation	0■	0■	100▼	100▲	0■	0■			100■	0■		100■	0■	100■	0■	0▼	90▼	1■		67■
D15 - Medical	0■	2▼	33▼	100▲	0■	0■			100■	0■		100■	0■	100■	0■	0▼	86■	2■		58■
D16 - Medical	0■	0■	■	■	98▲	0■			86■	1■		90▼	4▼	90▼	0■	0▼	79▼	7■		49■
D17 - Medical	0■	0■	■	50▲	100▼	0■			100■	1■		100▲	0■	100■	0■	0▼	78▼	3■		65■
D18 - Medical	0■	0■	■	100▲	98▼	0■			100■	0■		87▲	0■	93▲	0■	0▼	94▼	0■		54■
D21 - Male Surgery ENT/Urology	0■	0■	100■	72▼	91▲	0■			100■	0■		100▲	0▲	100■	0■	0▼	94▼	11■		56■
D25 - Surgical (Female)	0■	0■	100■	60▲	0■	0■			100■	■		100▲	0■	100▲	0■	0▼	93▼	1■		60■
D27 - Oncology	0■	0■	100■	100■	94▼	0■			100■	0■		100■	0■	100■	0■	0▼	84▼	7■		69■
D30 - Winter pressures	0■	0■	■	100■	0■	0■			100■	0■		100■	0■	100■	0■	0▼	0■	0■		■
D41 - Medical Short Stay Unit	0■	0■	100▲	60▲	97▼	0■			100■	■		100■	0■	100■	0■	0▼	94▼	1■		81■
D7 - Medical	0■	1▼	■	100▼	100■	0■			95■	0■		96▼	0■	96▼	1■	0▼	77▼	10■		45■
Day Treatment Unit - Sandwell	0■	0■	85▼	■	0■	0■			■	■		■	■	■	0■	0■	84▼	6■		■
EAU - Sandwell	0■	0■	■	93▲	0■	0■			0■	■		100▲	0■	100■	2■	0▼	79▼	9■		72■
Henderson	0■	0■	■	■	0■	0■			94■	0■		90■	0■	100■	0■	0■	0■	0■		■
Leasowes	0■	0■	■	■	0■	0■			■	■		■	■	■	0■	0■	0■	0■		■
Lyndon 2	0■	0■	■	88▲	95▼	0■			85■	2■		100■	0■	100■	0■	0▼	79▼	15■		56■
Lyndon 3	0■	0■	93■	■	98▲	0■			85■	0■		95▼	0■	95▼	0■	0▼	87▼	6■		57■
Lyndon 4	0■	0■	■	100▼	96▼	0■			100■	0■		81▼	9▼	100■	1■	0▼	81▼	1■		54■
Lyndon 5	0■	0■	■	50▲	98▲	0■			73■	0■		73▼	0▲	96▼	0■	0▼	87■	6■		49■
MAU - Mau Transfer - City	0■	0■	100■	82▲	0■	0■			80■	■		100■	0■	100■	2■	0▼	86▼	4■		64■
Neonatal Unit - City	0■	0■	■	■	0■	0■			■	■		100■	0■	100■	0■	0▼	85▼	4■		■
Newton 1 Short stay unit	0■	0■	■	0▼	0▼	0■			100■	■		93▼	0■	100▲	0■	0▼	0■	0■		■
Newton 2	0■	0■	100▲	87▲	98▼	0■			100■	■		100■	0■	100■	0■	0▼	86▼	1■		62■
Newton 3	0■	0■	100▲	88▲	0▼	0■			95■	0■		100■	0■	100■	1■	0▼	82▼	4■		57■
Newton 4 - Stroke rehab	0■	0■	■	100■	0▼	0■			100■	0■		96▼	0■	96▼	1■	0▼	89▼	8■		59■
Newton 5	0■	0■	■	50▼	99▼	0■			100■	0■		100■	0■	100■	0■	0▼	91■	6■		74■
Ophthalmology Main Ward - City	0■	0■	87▼	88▲	0■	0■			100■	0■		100■	0■	100■	0■	0▼	75▼	1■		76■
Planned Admissions Unit (D6)	0■	0■	100▲	■	0■	0■			100■	■		■	■	■	0■	0■	96■	2■		75■
Post Coronary Care - City	0■	0■	■	■	97▼	0■			92■	0■		93▼	0■	100■	0■	0■	0■	0■		■
Priory 2	0■	0■	97▲	52▼	98▼	0■			100■	0■		94▼	5▼	94▼	0■	0▼	90▼	0■		61■
Priory 3	0■	0■	■	■	98▲	0■			100■	4■		86▼	0■	93▼	0■	0▼	79▼	8■		50■
Priory 4 - acute stroke unit	0■	0■	100▼	92▼	99▲	0■			100■	0■		100▲	0■	100▲	1■	0▼	89▼	6■		80■
Priory 5	0■	0■	88▲	100▲	94▼	0■			100■	0■		79▼	4▼	100■	0■	0▼	81▼	2■		51■
Surgical Assesment Unit (D42) - City	0■	0■	■	93▼	0■	0■			100■	■		■	■	■	0■	0▼	94▼	4■		73■

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

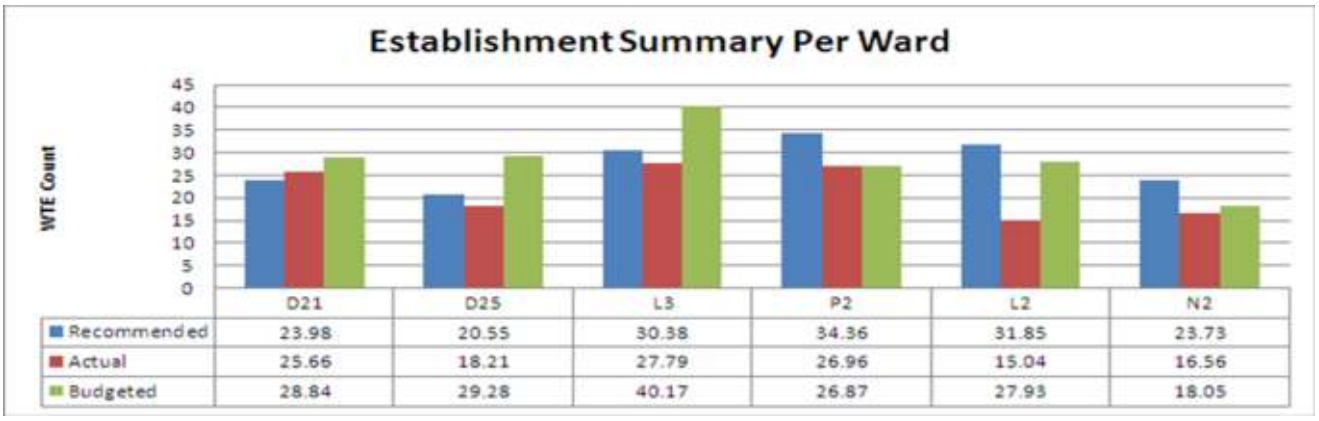
5.9 BRAD/SNCT (acuity tool) Summary

Medicine



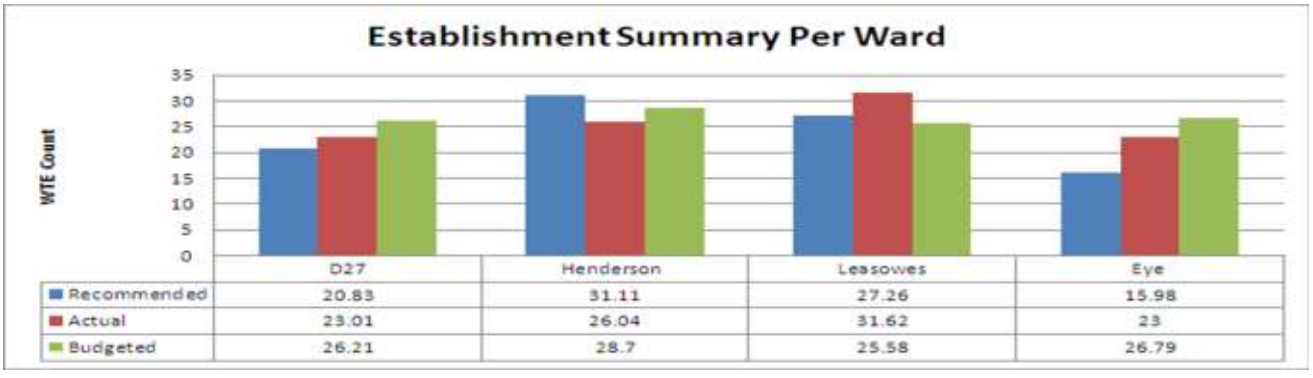
	D5	D7	D12	D15	D16	D17	D18	D41	P3	P4	N4	N5	N5 [Day Unit]	CCU
Recommended	29.50	43.65	12.03	24.82	38.60	27.73	37.85	33.40	29.31	50.29	64.75	15.37	20.88	21.78
Actual	36.96	26.21	7.52	22.91	28.86	27.94	20.53	28.38	29.53	60.99	43.43	16.14	0.7	28.98
Budgeted	41.83	25.43	16.4	26.45	32.71	29.05	20.92	29.72	30.90	51.6	36.27	18.73	2.60	19.75

Surgery



	D21	D25	L3	P2	L2	N2
Recommended	23.98	20.55	30.38	34.36	31.85	23.73
Actual	25.66	18.21	27.79	26.96	15.04	16.56
Budgeted	28.84	29.28	40.17	26.87	27.93	18.05

Miscellaneous



	D27	Henderson	Leasowes	Eye
Recommended	20.83	31.11	27.26	15.98
Actual	23.01	26.04	31.62	23
Budgeted	26.21	28.7	25.58	26.79

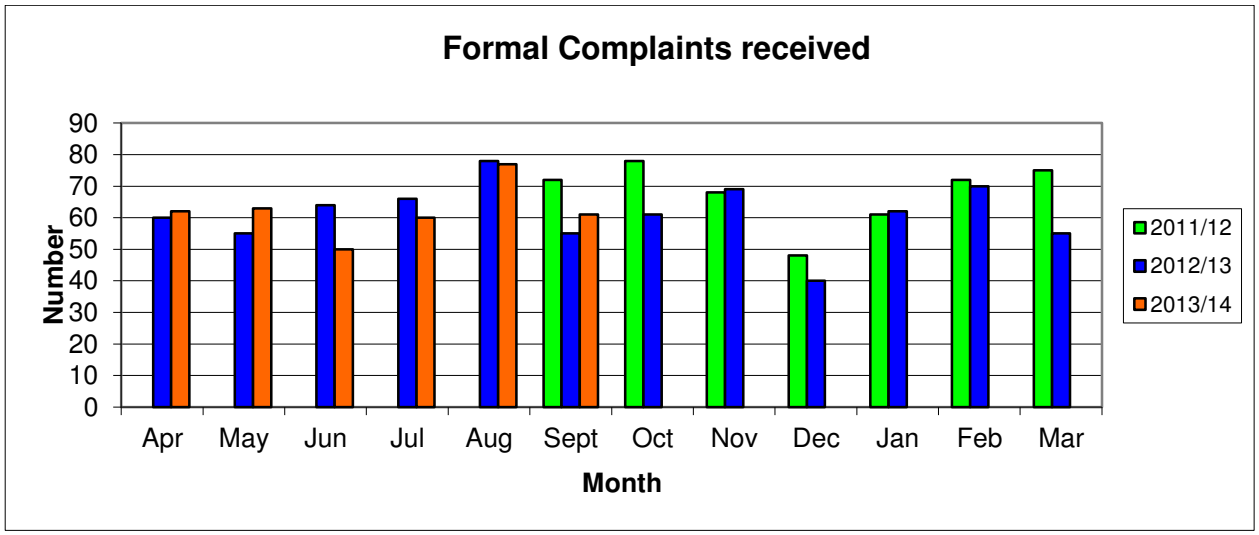
6 PATIENT EXPERIENCE

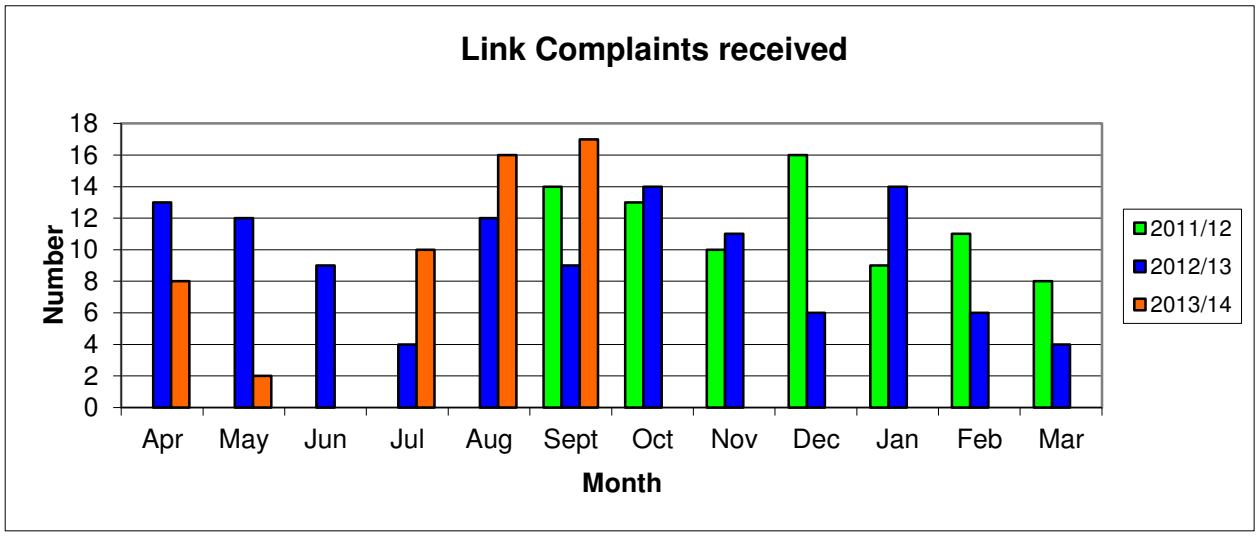
6.1 Net Promoter

Comparison of Inpatient and ED FFT scores and response rates:

Figure 22: *Net Promoter position & Friends and Family Test*

6.2 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 comparative data

Context

The total formal and link complaints received requiring a response in September 2013 (n =78) has reduced compared with August 2013 (n = 70).

September 2013 shows a slight increase in formal complaints received when compared with the same month last year (n = 55). There is an increase in link cases.

Categorisation

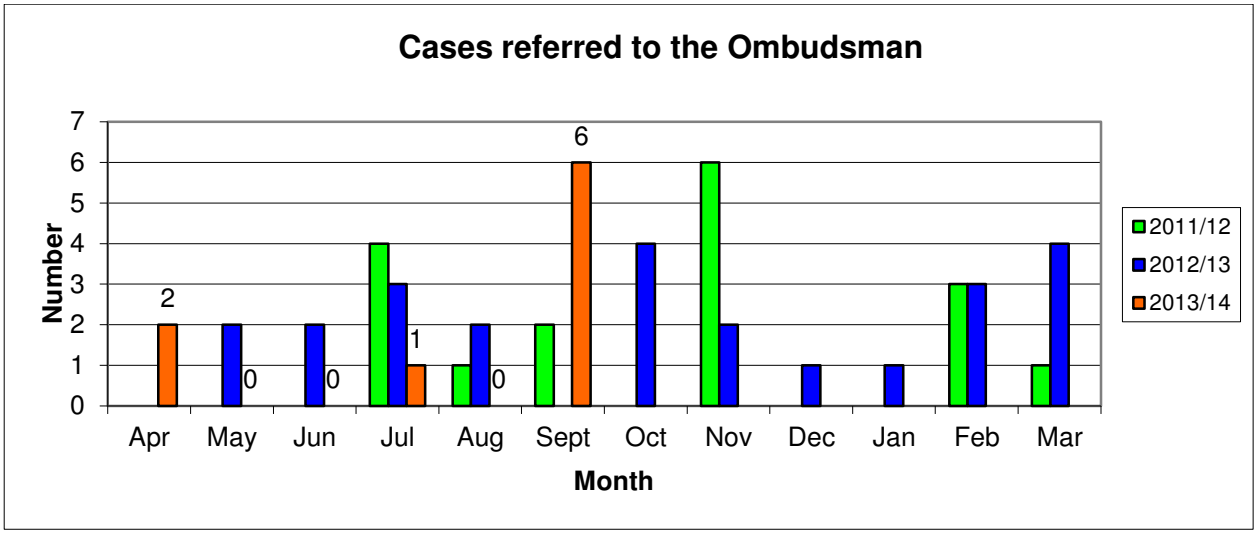
The 61 formal complaints received in September 2013 were graded as follows:

Red	**2**	**Amber**	**6**	**Yellow**	**37**	**Green**	**16**

Themes
The top 5 themes are: Dissatisfied with Medical treatment (n = 15) Dissatisfied with Nursing care (n = 11) Attitude of staff (n = 7) Breakdown in Communication (n=4) Failure/Delay in Diagnosis (n = 3)

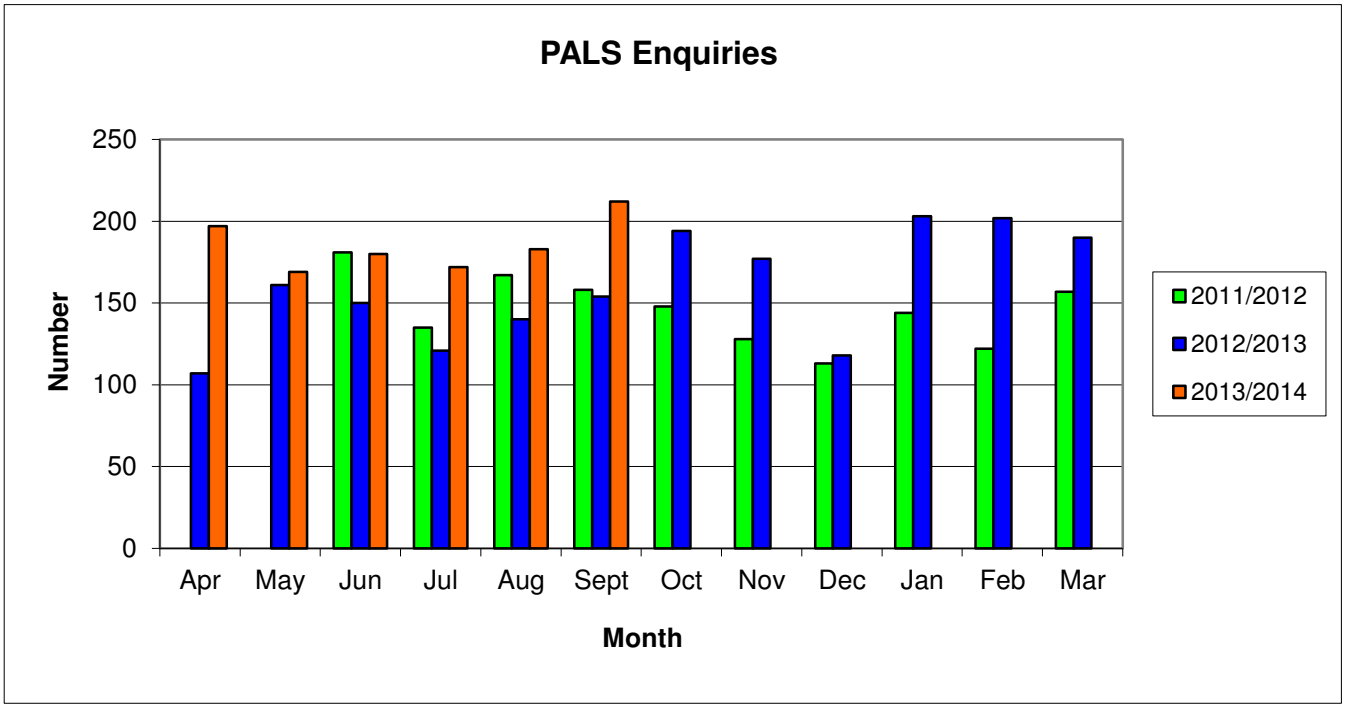
Learning
The complaints received in September are in the process of being investigated. Learning from complaints August include: The policy procedure for bleeding patients has had to be reiterated to all phlebotomy staff. Midwifery staff members have been reminded of the importance of ensuring that all women are offered something to eat and drink at appropriate intervals. Midwifery staff members reminded it is appropriate that escorts should be provided to patients during transfer between hospitals.

6.3 Parliamentary and Health Service Ombudsman (PHSO)



The Trust currently has 6 active cases with the PHSO

6.4 PALS



PALS comparative data

Context

Total PALS enquiries received in September 2013 (n=212) have increased significantly when compared to August 2013 (n=183). There were 3 PALS cases related to the community.

September 2013 also shows a significant increase compared with the same month last year (n =154). However, the Patient Support Centre also deals with general enquiries and these were significantly increased (2012/13 n = 192 compared with 2013/14 n = 276).

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 September 2013, PALS have investigated concerns and have assisted with a number of initiatives to improve the patient experience including:

Patient attended breast screening in a mobile unit. Patient expressed concern regarding the process itself and confidentiality. Patient advised that the member of staff within the mobile unit also lived within the vicinity of where the patient lived, and felt that staff should not be placed to work near to where they live. Breast Screening programme Manager contacted patient directly to assure her that confidentiality was completely safe and not under any question. Staff often choose to work in a unit near their home. Patient's concerns regarding the process of undertaking a mammogram also discussed, images obtained following this, and Manager was able to confirm the reason why the patient may have been in pain, however, also reassured the patient that she would speak to the Radiographer concerned and ensure that extra training was provided to improve her technique and make her aware of the concerns raised particularly where the patient has a skin fold.

Patient received a text message stating details of his appointment, however, message did not state location of appointment. Assuming the appointment was for T&O as this is where the patient normally attends, patient arrived and no appointment had been made. Further enquiries by PALS resulted in patient being informed that he needed to attend for a physio appointment, and that a further appointment needed to be arranged. The Head of Service agreed for the patient to be seen the day after, as he was in a lot of pain. Also advised that patients do normally receive a letter confirming details of the appointment, however, it appeared the patient had not received this, and therefore relied upon the details of the text message. It was agreed that the text messaging facility would include address and location of appointment.

6.5 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 **76%.**

11 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:	**18 week referral to treatment data quality**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Rachel Barlow – Chief Operating Officer**
DATE OF MEETING:	**28 October 2013**

EXECUTIVE SUMMARY:

The Trust has previously identified an ongoing concern relating to the electronic data records held on the iPM PAS (Patient Administration System) concerning 18 week Referral to Treatment (RTT) patient pathways. Some pathways appeared to be incomplete on the PAS and had not been updated to reflect treatment that has been given; mostly on an outpatient basis.

This paper reports on the validation exercise conducted between June and October. A majority of records have been validated and closed, with patients previously being treated but the administration event not closed. Under 1% of patients have been invited into be reviewed in outpatients to date.

During the validation period a number of long waits over 52 weeks have been reported; 195 reported in the period April - September. 86% of cases breached on a non-admitted pathway. All patients have been risk assessed and no adverse impact has been determined, despite the unacceptable long wait for treatment in a small number of cases.

At a Trust level, 18 week standards are being met. However, a number of specialities are underperforming on 18 weeks. The improvement trajectory is summarised in the paper and full specialty compliance is anticipated in Quarter 1 2014.

REPORT RECOMMENDATION:

The Trust Board is asked to note the approach to validation and closure of open pathways.

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:

Risk register, BAF, 18 week performance, data quality

PREVIOUS CONSIDERATION:

The Trust Board has been kept appraised of the 18 weeks data quality work at several points over the year. Audit committee October 2013.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

18 week Referral to Treatment Data Quality

REPORT TO TRUST BOARD – October 2013

1.0 BACKGROUND

1.1 The Trust has previously identified an ongoing concern relating to the electronic data records held on the iPM PAS (Patient Administration System) concerning 18 week Referral to Treatment (RTT) patient pathways for non-urgent, elective referrals. Some pathways had appeared to be incomplete on the PAS and had not been updated to reflect treatment that has been given; mostly on an outpatient basis.

In June the Trust Board received a report outlining the approach to completing validation. This report summarises progress and outlines the recovery trajectory at specialty level to meet 18 week standards.

2.0 VALIDATION APPROACH

1. Referrals from 1.4.2012 – 31.12.2012: There were 9045 open pathways in this group. Manual validation of these open pathways was conducted.

2. Referrals predating 1.4.2012: there were 92,650 open pathways on the system dating back to 2007. It was likely the majority of these will have received treatment but their record has not been closed. Patients were written to and asked to respond if they had not received treatment. A call centre was set up for this validation and individual cases triaged quickly by clinicians. Some patients were invited to attend outpatients.

Any patients identified who are still to receive treatment during this process , were contacted and their case reviewed by a senior clinician. Patients who require treatment will be scheduled quickly.

In October all open incomplete pathways were added to the Patient Tracking List (PTL) .

2.1 Outcome of validation:

Phase 1. Referrals pre-1st April 2012	95,562
Phase 2. Referrals 1st April – 31st December 2012	9,045
Current Incomplete Pathways	36,432
Total	141,039

Outcome of Phase1. Patients Pre-1st April 2012 (95,652 pathways)

Description	Patient Pathways
Phase 1.a. Pathways where no letter sent as excluded from 18 weeks or had active pathway:	**19,526**
Phase 1.b. Pathways where letters were sent:	
Records still to be closed once 22 days post letter & no response	18
Pathways closed after validation letter sent out & no response	69,281
Still being reviewed by Clinical Groups	289
To be booked appointments	70
Appointment booked	49
Discharged after review by Clinical Group	6,418
Total	**95,652**

Responses to letter validation:

NB*some patients had multiple pathways but only received one letter listing all the pathways.

Status	Number	%
Total No letters to be sent*	76,125	
Total Letters sent	76,125	100%
Of the 76,125 letters sent		
Responses to date	6,826	9%
Of the 6,826 responses		
Patient feels does not require appt	3,161	46.30%
Query about the letter itself	11	0.20%
Require review/action by Speciality	3,654	53.50%
Of the 3,654 requiring speciality review		
Discharged	3,246	88.80%
Outstanding	289	7.90%
Appointment required	119	3.30%

Outcome of Phase 2 Referrals 1st April – 31st December 2012.

Nb; the numbers of pathways increased due to referrals restarting clock within the period.

Validated clock stop	Validation clock still ticking	Validation with clinical groups	Validation with Data validation team	Validation by letter	Total
8656	550	313	271	138	9928

The remaining outcomes will be determined for Octobers monthly 18 week return.

2.2 Long Waits

During the validation period a number of long waits over 52 weeks have been reported; 195 reported in the period April - September. 86% of cases breached on a non-admitted pathway.

All patients have been risk assessed and no adverse impact has been determined, despite the unacceptable long wait for treatment in a small number of cases.

3. RECOVERY TRAJECTORY

At a Trust level, 18 week standards are being met. However, a number of specialities are underperforming on 18 weeks. The recovery trajectory is summarised below.

4. RECOMMENDATION

The Trust Board is asked to note the progress on validation and the trajectory for delivering full 18 week compliance at speciality level.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Response to the Francis Inquiry and associated reports**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Kam Dhami, Director of Governance**
DATE OF MEETING:	**31 October 2013**

EXECUTIVE SUMMARY:

The attached paper provides an update on the reports that have been published in direct response to the Francis Inquiry.

It brings together all their recommendations to assist the Trust in determining its priority areas for focus to further improve quality and safety.

REPORT RECOMMENDATION:

The Board is asked to REAFFIRM approval of the priority areas for improvement previously agreed and acceptance of the additions (risk management and data quality / analysis).

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

Accept	Approve the recommendation	Discuss
	x	

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

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

Comments:

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

Supports the Trust's plans to improve quality & safety

PREVIOUS CONSIDERATION:

The Trust Board has discussed the outcome of the Francis Inquiry on a number of occasions, including at the formal Board meetings in February 2013 and September 2013.

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Response to the Francis Inquiry and associated reports

1. Introduction

1.1 This paper provides an update on the reports that have been published in direct response to the Francis Inquiry. It brings together all their recommendations to assist the Trust in determining its priority areas for focus to further improve quality and safety.

2. Background

2.1 The report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Robert Francis QC) was published on 6 February 2013. The Trust Board has discussed the report on a number of occasions, and received formal papers on 28 February and 26 September.

2.2 The Keogh Reviews were published on 16 July 2013 and examined quality issues at fourteen Trusts that have had consistently high mortality rates (HSMR or SHMI). They set eight ambitions for the NHS. Several of these ambitions mirror declared SWBH priorities following the publication of the Francis report. Notable additions are the focus on the quality of data and the analysis of those data and ambition 7 of the report which highlights the potential of junior doctors as leaders for quality.

2.3 Central to the Keogh reviews is the introduction of a new process for assessing quality in NHS trusts. The process is data-driven, multi-disciplinary, and transparent and has a great deal of patient involvement both in providing feedback, but also as members of the review teams.

2.4 The quality findings were:

Poor engagement of patients and staff;
Poor implementation of early warning scoring, particularly with reference to hospital acquired pneumonia;
Weak workforce data that did not reflect the reality of the situation in clinical areas with over reliance on temporary staff;
Lack of clear approaches to quality improvement;
A disconnect between the leadership view of the clinical risks and the frontline reality.

2.5 Ambition 4 of the Keogh review is for improvement in Care Quality Commission (CQC) inspections drawing on the experience of the Keogh review process. The report also suggests that Trusts might use the methodology of the reviews to assess and improve their own clinical quality.

2.6 The Berwick Report, itself, a government response to Francis 2, was published on 6 August 2013. If focuses on creating an effective safety culture within the NHS. The risk management culture that Berwick advocates is one of transparency, learning and improvement. Like Keogh he emphasises the importance of defining safe staffing levels for all clinical areas based on the clinical burden and the real-time monitoring of actual staffing against this standard.

2.7 Berwick's report centres on patient safety. He argues that quality and safety cannot be separated. Safety can never be absolute, but it is the first requirement for clinical quality. He identifies three necessary elements for effective quality management:

Quality control
Quality improvement
Quality planning

2.8 A summary of the recommendations from the reports mentioned above is provided in **Appendix 1**.

3. Work within the Trust relevant to Francis, Keogh and Berwick

3.1 Several relevant pieces of work have been underway within the Trust pre-dating the publication of the Francis Report, including the mortality review process, and the introduction of a devolved model of complaints handling.

3.2 At its meeting in February 2013 the Trust Board agreed that the priority areas for improvement in response to the Francis report were:

Culture	The Trust should consider whether the work underway is sufficient.
Mortality	They systematic review of patient deaths already underway should be strengthened, and the differences in mortality rates between the two hospitals investigated.
Care of the frail elderly	The action plan for improvements in dementia care needs to be implemented, including securing funding to improve the environments to make the ward settings elderly care / dementia friendly.
Complaints	The plan to achieve an improved response to patient concerns and to learn from complaints needs to be implemented.
Patient experience	The Strategy to improve the patient experience by engaging patients, collecting and measuring feedback and taking action to make improvements needs to be put in place.
Nurse staffing	Review the established systems for reviewing and monitoring nurse staffing arrangements

3.3 In addition, creating a culture where effective **risk management** is an integral, and natural part of the way most people work was agreed as a priority aim for the Trust by the Board in July 2013.

3.4 What we are already doing in these areas and the work planned for 2013/14 is summarised in **Appendix 2** against the themes from the recommendations in the Francis report.

3.5 Encouragingly, these priorities have been supported in the reports published in response to the Francis Inquiry. An additional issue that was not specifically identified in the Trust's priorities earlier this year, but did emerge from the Keogh report was the need for much **improved data quality and data analysis** on clinical quality. This has since been identified by the Trust as an area requiring attention following data quality issues with regard to 18 week referral to treatment and open pathways.

3.6 A more fundamental issue is a radical change in the approach to the assessment and assurance of quality signalled by the Keogh report and now adopted by the CQC. Regulatory hospital inspections up till now have been heavily reliant upon the self-reporting of evidence of compliance tested by a relatively generic physical inspection process, often itself focusing on documentation rather than practice.

3.7 The Keogh approach is on of multi-disciplinary, expert peer review with emphasis on taking evidence from staff and patients rather than trust managerial reports. More time is spent in clinical areas and more clinical areas are visited.

4. Next steps

4.1 Review the detailed action plan against the recommendations in the Francis report and associated publications at the Clinical Leadership Executive in November and take stock of progress achieved.

4.2 In line with the requirement for all NHS hospitals to set out publicly how they intend to respond to the Inquiry's conclusions, for the members to consider and approve the detailed action plan at the November Board meeting.

5. Recommendation

5.1 The Board is asked to REAFFIRM approval of the priority areas for improvement previously agreed and acceptance of the additions (risk management and data quality / analysis).

Kam Dhami
Director of Governance

October 2013

Appendix 1

The Government response to the Francis Inquiry

The Government subsequently published its initial response to the Public Inquiry on 28th March. The response takes its title from a phrase used by Francis *"Patients First and Foremost".* The Government's response does not try to respond to all of Francis' recommendations. It focuses on the themes it identifies from the report. The actions proposed are presented under five headings.

Preventing Problems

The culture of the NHS will be addressed to increase transparency, enhance leadership and strengthen accountability.
Paperwork, box ticking, duplicity of regulation and information burdens will be reduced by at least one third.
The Chief Inspector of Hospitals will create a balanced scorecard presenting a single version of the truth.
There will be a single national portal, the Health and Social Care Information Centre, for collecting information.
The review led by Don Berwick will promote a culture focused on safety with zero tolerance for avoidable harm.
The NHS constitution will be amended to reflect the new culture.

Detecting problems quickly

Expert led inspections will take place of all hospitals. Each hospital will have a single balanced assessment that will reflect what is important to patients.
Hospitals will be rated as outstanding, good, requiring improvement or poor.
Clinical outcomes will be published for an increasing number of specialities.
There will be sanctions, possibly criminal, against organisations that misreport data.
There will be a statutory duty of candour.
There will be a review of best practice in the management of complaints

Taking action promptly

A new set of fundamental standards will be drawn up by the CQC.
The CQC will no longer take action against hospitals where poor quality is identified; this responsibility will rest with the board of the hospital and Monitor or the NHS Trust Development Authority.
If this does not resolve the issues, the Chief Inspector of Hospitals will be able to initiate a failure regime, eventually leading to the hospital being put into administration.

Ensuring robust accountability

Criminally negligent practice will become the responsibility of the Health and Safety Executive.
There will be a review of the legislation governing the role of the General Medical Council and the Nursing and Midwifery Council.
There will be national barring list of unfit managers and unsuitable healthcare assistants.

Ensuring staff are trained and motivated

Nursing students will be required to undertake a year as a healthcare assistant.
A national scheme of revalidation will be introduced for nurses.
There will be enhancements to the role of the NHS Leadership Academy.
Every Department of Health civil servant will have "real and extensive" frontline experience of caring for

patients

Review into the quality of care and treatment provided by 14 hospital trusts in England

Professor Sir Bruce **Keogh** published his report into 14 hospitals with consistently high mortality rates on 16 July 2013. The review was not simply focussed on confirming the presence of problems, these were already known. The drive was to add value by providing an accurate diagnosis, and identify what help and support the 14 hospitals needed to assist their recovery and accelerate improvement.

The Keogh Review methodology utilised 4 underlying Principles, Patient and Public Participation, listening to the views of staff, openness and transparency, co-operation between organisations. This approach involved a 3 stage process of **information gathering**, **rapid response review** and a **risk summit and action plan**. Eight ambitions for the NHS were set. These are set out below together with the improvement actions recommended at local level.

Ambition 1

We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.

Action: Rapidly embed the use of an early warning system, have clinically appropriate escalation procedures for deteriorating high risk patients, in particular at weekends and out of hours.

Ambition 2

The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level.

Action: Boards must take collective responsibility for quality within their organisation and across each and every service line they provide. People with specific expertise to know what data to look at, and how to scrutinise it and then use it to drive tangible improvements.

Ambition 3

Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others

Action: ● Real time patient feedback and comment must become a normal part of the Trust's customer service and reach well beyond FFT ● Forge strong links with Healthwatch ● Patients and the public should have their

Ambition 4

Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in inspections.

Action: Boards to consider how they could apply aspects of the Keogh review methodology in their quest for improved quality.

complaints welcomed ● Transparent reporting of issues, lessons and actions arising from complaints.

Ambition 5

No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past

Action: Providers should actively release staff to support improvement across the wider NHS, including future hospital inspections, peer review and education and training activities, including those of the Royal Colleges.

Ambition 6

Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards.

Action: Directors of Nursing should use evidence based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis. ● Boards should sign-off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience.

Ambition 7

Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors

Action: MDs to consider how they might tap into the latent energy of junior doctors, who move between organisations and are potentially the most powerful agents for change ● DNs to think about how they can harness the loyalty and innovation of student nurses, who move from ward to ward, so they become ambassadors for their hospital and for promoting innovative nursing practice ● Junior doctors must routinely participate in trusts' mortality and morbidity review meetings.

Ambition 8

All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy

Action: Think about innovative ways of engaging staff.

A promise to learn – a commitment to act: Improving the Safety of Patients in England

The **Berwick Report** was published on 6 August 2013. It focuses on creating an effective safety culture within the NHS. The risk management culture Berwick advocates is one of transparency, learning and improvement. Berwick's report centres on patient safety. He argues that quality and safety cannot be separated. Safety can never be absolute, but it is the first requirement for clinical quality. He identifies three necessary elements for effective quality management – quality **control**, quality **improvement** and quality **planning**.

The 10 Berwick Recommendations

The overarching goal

1. The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.

Leadership

2. All leaders concerned with NHS Healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support

Action: All staff have a duty to identify and help to reduce risks to the safety of patients and to acquire the skills necessary to do so in relation to their own job, team and adjacent teams ● **Leaders (including clinical) and managers have a duty to provide the environment, resources and time to enable staff to acquire these skills**. ● All leaders and managers should actively address poor teamwork and poor practices of individuals, using approaches founded on learning, support, listening and continual improvement, as well as effective appraisals, retraining and, where, appropriate revalidation.

Patient and public involvement

3. Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts

Action: Patients and carers should be helped to establish effective relationships with their clinicians at every stage of their care, from GP surgery to hospital ward. ● **Patients and their carers should always be given the opportunity to share their health concerns, histories, family situations, needs, preferences and hopes in order to help staff build effective partnerships during every stage of their care** ● Patients (and if the patient wishes) their carers should be invited to and be involved in ward rounds, multi-disciplinary meetings, Care Programme-Approach meetings, discharge planning meetings and other significant clinical meetings ● **Patients and their carers should always have access to and be given on request a clear, understandable and relevant summary of their health needs and preferences, which states how these needs will be met.** This should include information about risks and alternatives and should allow them greater control of their healthcare ● **It should always be clear who is responsible for patient safety concerns, and someone should be accessible to patients at every stage of treatment and 24 hours a day. When things do go wrong, incidents should be investigated appropriately and transparently, with the full involvement of the patient and their carers who should be kept informed at every step of the way.** ● Patient feedback is instrumental to the measurement, maintenance and monitoring of safety; feedback should be collected as far as possible in real time and be responded to as quickly as possible ● **Complaints provide vital information about the quality and safety of care and should be gathered and responded to in a timely way. The leaders of healthcare organisations should continually improve their local complaint systems.** ● Patients and carers should be represented throughout the governance structures, for example by sitting on and actively participating in safety and quality committees. Patients and carers should be given appropriate support and training to take a full part in these structures, to understand safety science, and to

contribute meaningfully.

Staff

4. Government, Health Education England and NHS England should assure that sufficient staff is available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.

Action: Staffing levels should be consistent with the scientific evidence on safe staffing, adjusted to patient acuity and the local context. Boards and leaders of organisations should utilise evidence based acuity tools and scientific principles to determine the staffing they require in order to safely meet their patients' needs. They should make their conclusions public and easily accessible to patients and carers and accountable regulators ● **The leaders of all NHS-funded organisations should foster good teamwork in care. They should ask teams to set challenging and measurable team objectives; facilitate better communication and coordination within and among teams; and encourage teams to regularly take time out to review their performance and how it can be improved** ● Leaders and managers should actively support staff by excellent human resource practices, promoting staff health and well-being, cultivating a positive organisational climate, involving staff in decision-making and innovation, providing staff with helpful feedback and recognising good performance, addressing systems problems, and making sure staff feel safe, supported, respected and valued at work ● **NHS organisations, working with professional regulators, should create systems for supportively assessing the performance of all clinical staff, building on the introduction of medical revalidation** ● Each organisation should be expected to listen to the voice of staff, such as through department and ward level cultural and teamwork safety surveys, to help monitor the safety and quality of care and variation among units. (However, surveys of culture have not been scientifically validated as a performance metric and should not be used for this purpose.) Staff should all be free to state openly their concerns about patient safety without reprisal. There is no place for compromise agreements ("gagging clauses") in such cases.

Training and capacity building

5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives

6. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS

Action: NHS-funded health care providers should invest in building capability within their organisations to enable staff to contribute to improvement of the quality and safety of services to patients. A properly resourced capability programme must be in place within 12 months ● **Every NHS organisation should participate in one or more collaborative improvement networks as the norm.**

Measurement and transparency

7. Transparency should be complete, timely and unequivocal. All data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public

8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care

Action: Healthcare organisations should shift away from their reliance on external agencies as the guarantors of safety and quality and toward proactive assessment and accountability on their own part. ● **Providers should make use of peer review outside of formal systems – for example by partnering with other organisations – to facilitate learning** ● Unless and until a better metric is developed, the NHS should use mortality rate indicators like the Hospital Standardised Mortality Rate or suitable alternatives as one of its ways to detect potentially severe performance defects worth investigating further. Mortality measurement should be used as a 'smoke

detector' in a spirit of supportive and genuine inquiry, not used to generate league tables or similar comparisons ● **Organisations should routinely collect, analyse and respond to local measures that serve as early warning signals of quality and safety problems such as the voice of the patients and the staff, staffing levels, the reliability of critical processes and other quality metrics. These can be 'smoke detectors' as much as mortality rates are, and they can signal problems earlier than mortality rates do** ● In addition to reporting aggregated data for the whole organisation, data on fundamental standards and other reportable measures, as required by CQC, should be reported by each ward, clinical department (and health care professional, where appropriate) within the Trust's Annual Quality Account. Leaders must understand the variation in their organisation, not just among organisations, in order to improve.

Structures

9. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction

Enforcement

10. We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment

Action: Employers need to improve their support of staff around implementing guidance on reporting of serious incidents and professional regulators should take appropriate action when required. Organisations should demonstrate that they have in place fully functional reporting systems for serious incidents, that staff know how to use them, that the systems are used, and that appropriate action is taken in response to incidents, including provision of appropriate support to the affected patients and their carers

The Berwick Report goes onto focus on 7 key '**problems'** that face the whole of NHS and this provides the framework for the 8 key **'solutions'** in response. This approach is well expressed and succinct and offers a much better template for front line teams.

The problems

1. Patient safety problems exist throughout the NHS: the whole NHS should strengthen patient safety now and into the future.
2. NHS staff are not to blame: the vast majority of staff wish to do a good job, to reduce suffering and to be proud of their work.
3. Incorrect priorities do damage: the prime directive, "the needs of the patient come first".
4. Warning signals abounded and were not heeded. Loud and urgent signals were muffled and explained away.
5. Responsibility is diffused and therefore not clearly owned: When so many are in charge, no one is.
6. Improvement requires a system of support: The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.

7. Fear is toxic to both safety and improvement: “Better not to know” became the order of the day.

The solutions

1. Recognise with clarity and courage the need for wide systemic change.
2. Abandon blame as a tool.
3. Reassert the primacy of working with patients and carers to set and achieve health care goals.
4. Use quantitative targets with caution.
5. Recognise that transparency is essential and expect and insist on it at all levels and with regard to all types of information.
6. Ensure that responsibility for functions related to safety and improvement are vested clearly and simply.
7. Give the people of the NHS – top to bottom – career-long help to learn, master and apply modern methods for quality control, quality improvement and quality planning.
8. Make sure pride and joy in work, not fear, infuse the NHS.

The report highlights the need for the NHS to fully commit to an open, transparent culture with a continual drive for zero harm with continual improvement being the key.

There is an expectation that NHS leaders and Boards will also commit to 7 core principles

1. Listen to and involve patients and carers in every organisational process and at every step in their care
2. Monitor the quality and safety of care constantly, including variation within the organisation.
3. Respond directly, openly, faithfully, and rapidly to safety alerts, early warning systems, and complaints from patients and staff. Welcome all of these.
4. Embrace complete transparency
5. Train and support all staff all the time to improve the processes of care
6. Join multi-organisational collaboratives – networks – in which teams can learn from and teach each other
7. Use evidence-based tools to ensure adequate staffing levels

In moving forward Don Berwick places great importance for the NHS to be a learning organisation which is fully committed to:

Placing the quality of patient care, especially patient safety, above all other aims	Engaging, empowering and hearing patients and carers throughout the entire system and at all times	Fostering whole-heartedly the growth and development of all staff, including their ability and support to	Embracing transparency unequivocally and everywhere, in the service of accountability, trust and

		improve the processes in which they work	the growth of knowledge

An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings

Camilla Cavendish, the Associate Editor of the Sunday Times was asked by the Prime Minister to undertake a review of the key issues of how healthcare assistants and social care assistants are valued and supported. This 'Cavendish Review' was launched in May 2013 with a report published in July 2013.

The recommendations included:

- Common training standards across health and social care, along with a new 'Certificate of Fundamental Care', written in language that is meaningful to patients and the public. For the first time, this would link healthcare assistant training to nurse training.
- The opportunity for talented care workers to progress into nursing and social care through the creation of a 'Higher Certificate of Fundamental Care'. This will ensure they have a route to progress in their careers and an opportunity to use their vocational experience of working as healthcare assistant to enter the nursing profession.
- Health Education England along with Skills for Health and Skills for Care, should develop proposals for a rigorous system of quality assurance for training and qualifications, which links to funding outcomes, so that money is not wasted on ineffective courses.
- Healthcare assistants should be allowed to use the title 'Nursing Assistant' on completion of the Certificate of Fundamental Care to improve clarity and communication between staff and patients, enhance the status of support workers and reduce the number of job titles - which currently stands at more than 60.
- The Nursing and Midwifery Council should make caring experience a prerequisite to starting a nursing degree and review the contribution of vocational experience towards degrees.
- Trusts should empower Directors of Nursing to take full responsibility for the recruitment, training and management of Healthcare Assistants. Employers should also be supported to test the values, attitudes and aptitude of future staff for caring at the recruitment stage.
- The legal processes for challenging poor performance should be reviewed so that employers can be more effective in identifying and removing any unsatisfactory staff

It is anticipated that the government will publish a full response to the 4 extremely high profile national reports (Francis, Cavendish, Keogh and Berwick) in November 2013.

The Clwyd Report focussing on the NHS complaints system and the Review of Bureaucratic Burdens (which were both due for publication in September 2014) will also feature heavily in the overall government response

Sandwell and West Birmingham Hospitals NHS
NHS Trust

High level response to the Francis Inquiry and associated publications

Themes from the recommendations	What we are already do in this area	Work planned for 2013/2014	Where we know we need to improve
Putting the patient first			
Patients must be the first priority in all the NHS does by ensuring that, within available resources, they receive effective care from caring, compassionate and committed staff, working within a common culture, and protected from avoidable harm and any deprivation of their basic rights. The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first. All NHS staff should be required to enter into an express commitment to abide by the NHS values.	We have a set of values to underpin everything we do as an organisation which reflect the things that are most important to our patients, their relatives and carers, along with our staff and partners. Our values are given practical expression through our customer care promises which set out the behaviours that patients can expect from our staff, and are widely available and visible in the Trust. Our values and customer care promises form part of staff induction and are prominently displayed around across our premises. Our Trust website allows patients and users to vote on whether our customer care promises are delivered.	Finalise the culture programme for the Trust's organisational development. Develop mechanisms to measure adherence to standards, promises and values. Introduce 'Your Voice', an employee on-line survey of 2500 staff each month. *Launched in September, following a pilot*. The launch of our Patient Experience and Staff Engagement long-term strategy which will link satisfaction with departmental funding for the first time. 'Patient knows best' is an IT system that we are piloting in some specialities. Review our approach to Equality	Expand how we get feedback from patients and from staff about what they think about us. Ensure a wide range of ways of engaging patients in all of our services and evidence that patient views are listened to. Demonstrate how we have made changes as a direct result of what staff and patients tell us. Deploy reliable and transparent measures of the cultural health of the Trust using a robust methodology, such as the "care cultural barometer", when available Invite patients to be part of our formal structures.

Themes from the recommendations	What we are already do in this area	Work planned for 2013/2014	Where we know we need to improve
	We have introduced the Friends and Family test as one of our routine indicators. Standard statements about values are incorporated into job descriptions and contracts of employment (but need strengthening) We ask patients and service users what they think about the care and treatment we provide through experience survey, patient forums and engagement events. We consult and listen to staff and patients / users when we plan to make changes to services. Recognising and celebrating good practice and success – Staff Awards, Beacon Services. A programme of patient stories has been devised to take to the Trust Board every month. Hospital volunteers help and assist with various patient experience activities.	and Diversity. Use the patient stories presented to the Board for staff training and awareness raising events. Introduce Patient Safety Walkabouts by NEDs. *Commenced in May 2013* Build up a team of reliable hospital volunteers to help and assist patients in activities such as completion of surveys, directing through the hospitals and dementia buddies Improve people's experience in outpatients as this is where most have contact with the Trust through implementation of 8 outpatient standards. Review and reinforce the requirement to abide by the NHS and Trust values in the staff recruitments, selection and appointment processes. Introduce 360 degree appraisal for all staff, including Board members.	

Themes from the recommendations	What we are already do in this area	Work planned for 2013/2014	Where we know we need to improve
Fundamental standards of behaviour			
Health professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Need to not only encourage but insist upon the reporting of incidents of concern relevant to patient safety and compliance with fundamental standards Staff to receive feedback in relation to any report they make, including information on any action taken or reasons for not acting.	The established Ward Review process is designed to ensure all wards can identify their standard of care in order to ensure it is safe, effective and of high quality, mindful of the patient experience. The quality of services is monitored through CQC mock inspections. Competency frameworks are in place in nursing, therapies and midwifery. Various forums exist for professionals to contribute to standard procedures. Clinical guidelines exist and a rolling programme of audit checks compliance against the set standards. Standard operating procedures exist in some areas. In some services we have clear service specifications and policies based on NICE guidance.	Be clearer about standards we expect – both behaviour and quality of care. Identify key areas of practice for development of standard operating procedures, and improve the consistent application of existing standard operating procedures. Improve how we learn from what's gone well and how we share good practice and improve how we learn from things that have gone wrong to reduce the chance they could happen again. Introduce a formal framework to support shared learning.	Ensure all staff can access to standard procedures. Review competency frameworks and training is fit for purpose. Learn from other organisations.

Themes from the recommendations	What we are already do in this area	Work planned for 2013/2014	Where we know we need to improve
Responsibility for, and effectiveness of, healthcare standards			
Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them. This should be made available via each trust's website. Reports should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information	Our annual Quality account is audited by External Auditors and published on our website.	The format of the Quality Account will be reviewed in line with national guidance, as required.	
Complaints handling			
Recommendations from Patients Association's peer review into complaints at the Mid Staffs should be reviewed and implemented. Making a complaint should be easy and any concern made by a patient should be treated as a complaint unless the patient's permission is refused.	Patients are able to raise concerns through our complaints process which allows them to contact us in a variety of ways including email, telephone and letter and to receive a response within a timescale agreed with them. In recent times performance in this area has required improvement. Our Patient Advice and Liaison team	Introduction of a devolved model of complaints investigation and response drafting, with responsibility transferring from the corporate Complaints team to Clinical Groups and directorates. Our formal response to complaints is not always within the timescales we agree with patients; this will be improved.	Making our complaints process more accessible particularly to vulnerable people such as people with mental health and learning disability problems. Routinely notifying complainants about how we have learnt from their complaint. Sharing details of complaints

Themes from the recommendations	What we are already do in this area	Work planned for 2013/2014	Where we know we need to improve
A senior clinician and nurse should be obliged to be involved in responding to complaints to facilitate a speedy resolution, wherever possible. Complaints relating to possible breaches of basic standards and serious complaints should be accessible to the CQC, relevant commissioners, health scrutiny committees, Communities and Local HealthWatch. Learning from complaints must be effectively identified, disseminated and made known to the complainant and the public, subject to suitable anonymisation.	help patients get help and advice about dealing with concerns and can provide support to patients through the complaints process. Our Quality and Safety Committee and commissioners receive basic information about the serious complaints received each month.	Introduce a system to capture action taken by clinical services following a complaint and to make this information available and share learning. Publishing the main issues our patients complain about and what we are doing about them. Publishing themes and trends about compliments, concerns, complaints. Devise a system to inform individual complainants what we have learned and what we will do differently as a result of their complaint. Reviewing the Patient Association peer review of complaints into Mid Staffs.	proactively with CQC, health scrutiny committees etc.
Medical education and training			
Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.	We encourage trainees to give informal feedback through forums for foundation, core and advanced trainees We encourage trainees to give	Seek further engagement with trainees on this issue, through trainee representatives and the Deanery.	

Themes from the recommendations	What we are already do in this area	Work planned for 2013/2014	Where we know we need to improve
	feedback through the GMC annual survey and we make formal responses to issues raised.		
Openness, transparency and candour			
Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered. **Transparency**: allowing true information about performance and outcomes to be shared with staff, patients and the public. **Candour**: ensuring patients harmed are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it. "Gagging clauses" or non-disparagement clauses should be prohibited in the policies and contracts insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	'Being Open Policy' in place and KPIs audited. Whistle blowing policy in place. Good levels of incident reporting Our contracts of employment do not include any inappropriate 'gagging clauses'. Also, compromise agreements do not include any inappropriate confidentiality clauses.	Improve how we learn from what's gone well and how we share good practice and improve how we learn from things that have gone wrong to reduce the chance they could happen again. Introduce a formal framework to support shared learning. Revising and re-launching our whistleblowing policy, making it easy and safe for staff to raise concerns. Close the loop so that staff are informed of the outcomes of investigations into reported incidents and more widely across the organisation and with patients.	Ensure all teams and services can demonstrate they share learning and the improvements or changes that have resulted.

Themes from the recommendations	What we are already do in this area	Work planned for 2013/2014	Where we know we need to improve
Nursing			
Focus on a culture of compassion and caring in nurse recruitment, training and education. Ward nurse managers should work in a supervisory capacity and are not office bound. They should be involved and aware of the plans and care for their patients. There should be a responsible officer for nursing in each trust, and they should be accountable to the NMC	Investment made into a new model of ward leadership in May 2012 (£700k) to provide much closer and consistent leadership at ward level to improve clinical and professional standards, patient experience, relative / carer support and patient flow. Implemented **B**ed **R**atios, **A**cuity and **D**ependency based on the Safer Nursing Care Tool. Established e-roster which complements BRAD Having sufficient supervisory nursing leadership has enabled the following processes to be embedded on the majority of wards: - Board rounds every day on every ward - Senior ward nurse on ward rounds - Senior clinical nurse presence, including OOHs An action plan in place following the CNO's 'Compassion in Practice'	Nursing competences and expectations to be explicit in job descriptions. Further embedding QUEST (an on-line competency framework) and expansion of clinical MOT. Working on a process of sharing information on staff on duty, per shift, per grade with patients and carers. "Nursing with Pride" badges have been introduced to recognise and reward the hard work and success of our nurses. Badges have been designed at three different levels; Bronze, Silver and Gold, each of the three badges symbolising a different level of achievement. Signed up to participate in the 'Care Makers' campaign to embed the 6 Cs in practice.	Strengthen the nurse recruitment process to include specific assessment of values.

Themes from the recommendations	What we are already do in this area	Work planned for 2013/2014	Where we know we need to improve
	launch. Implemented value led recruitment The annual Ward Team challenge event reinforces values. Intentional care rounding established. Locally agreed and established regulatory process for non-registered nurses. Privacy and dignity action plan. The established Ward Review process required evidence of care delivery.		
Leadership			
The common culture and values of the NHS must be applied at all levels of the organisation, particularly to leaders. A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and should be consistent with the common culture (Fit and Proper Persons Test).	The Trust has a leadership development framework that focuses on the leader's ability to achieve the task, maintain the team and develop the individuals. Focus on patient safety and effective service delivery is the main theme running through the	Plans to be developed to reinforce leadership development in the Trust. A Board Development and support programme to be put in place.	

Themes from the recommendations	What we are already do in this area	Work planned for 2013/2014	Where we know we need to improve
The principles appearing in those ethics and standards should apply to all staff, and it is the responsibility of employers to ensure that they are honoured.	framework. The action centred leadership programme that forms part of the foundations of all leadership development within the Trust focuses on: - the generic qualities of the leader and the functions of leadership - using those qualities and applying the functions of leadership ensures leadership competence. Trust leadership behaviours developed by the Trust Board and finalised following staff engagement through the Trust's Hot-Topics two way briefing system.		
Caring for the elderly			
Consider identifying a senior clinician who is in charge of each patient's care. Effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient. Regular interaction and engagement between nurses and patients and those close to them should be systematised	Dementia Strategy and action plan Intentional rounding introduced and working well on audit. Matrons/senior sister clinics / open door policy Day rooms are available in some areas.	Develop our frail elderly services in partnership with SWB CCG in order to ensure safe, high quality care, early senior assessment , alternative pathways to admission where clinically appropriate, integrated care and supported discharge. Work with staff and patients / carers to decide on how the money	

Themes from the recommendations	What we are already do in this area	Work planned for 2013/2014	Where we know we need to improve
through regular ward rounds. It should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provided continued care to the patient. All staff and visitors to be reminded to comply with hygiene requirements. The arrangements and best practice for the provision of food and drink to elderly patients need to be constantly reviewed, monitored and implemented. In the absence of automatic checking and prompting, medicines administration to be overseen by the nurse in charge or nominated delegate, with frequent checks that patients have received what they have been prescribed. Recording of routine observations as they are taken and available to all staff electronically.	Hand hygiene audits consistently score well Regular PEAT inspections are carried out. Reviewed and implemented new meal choices, snacks and OOH availability Food diaries and fluid balance chart in place. Protected mealtimes Discharge lounges available.	secured (£904k) from the DH '*Enhancing the Acute Environment for Patients with Dementia*' fund is spent. Implement the dedicated team to progress the dementia agenda to improve the patient and carer experience. *Funding has been secured through the IAP process*. Development of a 'dementia survival guide' for staff (based on a version produced by staff at Worcester University) and an information folder for all wards and departments. *In place* Review and update of the 'Managing Challenging Behaviours' policy to reflect best practice.	

Themes from the recommendations	What we are already do in this area	Work planned for 2013/2014	Where we know we need to improve
Information			
A need for all to accept common information practices and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: - patients to be granted access to their records and ability to enter comments - System must be designed in partnership with patient groups A Board-level member with responsibility for information. Independent auditing of Quality Accounts Vigilant auditing at local level of data put into the system. Patient feedback to be made available to all stakeholders in near "real time". Systems for real-time information on performance of services and consultants / teams.	Our Quality Account meets Department of Health content specification and contains data comparable with other organisations and details of compliance with regulatory requirements. Our commissioners and overview and scrutiny committees provide comments on our Quality Account which we include in the report. The Chief Operating Officer is the Board-level director with responsibility for information.	The current Quality Report to be replaced with and Integrated Quality, Performance and Finance report. A system is being developed to provide a colour coded assessment of data quality so that the reader can understand whether weaknesses exist in terms of the robustness of the source and consistency. Resources are being put in place to undertake rolling systematic audits of data quality with various factors taken into account when ranking data quality. Our Autonomy and Accountability framework will embed staff views, alongside patient views in how directorates are managed from April 2014. How individuals lead and how teams respond will form part of the performance system of the Trust.	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit Committee – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 9 May 2013

Members Present		In Attendance	Guests
Mrs G Hunjan	[Chair]	Mrs S-A Moore	Miss R Barlow
Ms C Robinson		Mr P Capener	Mrs T Trueman [Solutions in eHealth]
Dr S Sahota		Mr D Ferguson	Dr R Stedman
Mr H Kang		Mr R White	Mrs J Kinghorn
		Mr T Wharram	

Secretariat

Mr S Grainger-Payne

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Ms Olwen Dutton, Mr Andy Bostock and Mrs Rubina Chaudary.	
2 Minutes of the previous meeting	**SWBAC (2/13) 020**
The minutes of the meetings held on 14 & 28 February 2013 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the meetings held on 14 & 28 February 2013 were approved as an accurate record	
3 Matters arising	**SWBAC (2/13) 020 (a)**
The Audit Committee received and noted the updated actions log.	
3.1 Progress with actions from the Outpatient Utilisation Internal Audit review	**Verbal**
Miss Barlow advised that a key action arising from the Internal Audit	

Minutes	Paper Reference
review of Outpatient Utilisation was to review job planning in the area. She advised that disappointingly, this had not yet been undertaken, however the new Clinical Director had been briefed and a was arranging a job planning clinic, with a view to completing the process by July 2013.	
3.2 'Clock starts' for attendances at Accident & Emergency departments	**Verbal**
Miss Barlow advised that there was a number of routes by which patients arrived at the Trust's Accident & Emergency departments and to ensure that the 'clock starts' were as prompt as possible administration staff had been located as close to the points of arrival, thereby ensuring that patient waiting times were as accurately monitored as possible. It was reported that a new IT solution had been implemented into the area and that all Emergency Department staff would be trained in its use, which included recording arrival times.	
3.3 Payment into Charitable Funds for maternity training	**Verbal**
Mr White reported that there had been an error in processing the payment from Sandwell PCT in respect of maternity training, in that it had been erroneously marked as being for Charitable Funds, rather than exchequer. The Committee advised that the matter had been rectified and that all other payments had been processed accurately.	
3.4 Measures being taken to raise the profile of the overseas visitors policy	**Verbal**
Mr Wharram reported that there had been increased communication of the rules for treating overseas visitors through staff communication and through more informal means. It was reported that the medico-legal team that handled the invoicing of overseas visitors had transferred to the Governance Directorate to ensure that a proper focus was directed to the handling of the process going forward.	
4 Data Quality matters	
4.1 18 weeks – open pathway update	**Presentation**
Miss Barlow gave an overview of the 18 weeks open pathway validation work, advising that to date, no issues of safety or poor health outcomes had been identified. It was reported that the number of pathways subject to sampling was 26,005 and that it had been identified that the most significant number of breaches to the 18 weeks referral to treatment time (RTT) target originated	

Minutes	Paper Reference
in the Trauma & Orthopaedics, ENT and Cardiology specialities. The Committee was advised that a new monitoring system had been developed which could review cases across all specialities. It was reported that an improvement plan had also been developed which would ensure that the achievement of the 18 week RTT was met more robustly. In terms of any linkage between the 18 week RTT breaches and mortality rates, Miss Barlow advised that this had been difficult to ascertain, given that the data validation work had excluded records from deceased patients. It was reported however, that during the period under review, there had not been any unexpected change in either mortality rates or the level of complaints received. The Committee was advised that a separate mortality review process was in place, under the remit of the Medical Director, which would identify any trends of concern. Ms Robinson asked whether it had been possible to identify the patients that had been on an open pathway and had died. Miss Barlow confirmed that this was the case and advised that these patients were mainly those being treated for cancer. She emphasised that the data quality issue related especially to those patients being treated with elective care. Mrs Hunjan asked whether it was possible to identify those individuals that had originally been patients of the Trust, however they had not been seen within the required time and instead had died in an alternative hospital. Miss Barlow advised that this was a complex analysis and that the records would need to be considered and followed up individually to identify these cases. The Committee was advised that some patients may have more than one open pathway. Mr Capener asked whether, in this instance, all pathways would close should the patient die. He was advised that this was the case. Ms Robinson suggested that it might be likely that in the event of the delays with treating patients, there would have been a degree of patient dissatisfaction and urged that a cross check against complaints received during the period be undertaken. Mrs Trueman advised that a review had been undertaken and that there had been no apparent fluctuation, peaks or trends in complaints. Dr Sahota suggested that some of the patients being affected by the delay may have returned to their referring GP to register their concern. Ms Robinson asked what work had been undertaken to communicate with the patients that had been affected by the delays. Miss Barlow advised that in the most serious cases, the patients had been telephoned and a risk assessment had been undertaken to determine the impact of the delay. She reiterated however, that to date there had been no evidence of safety issues or poor health outcomes as a result of the delays. Miss Barlow was asked if the patients affected had received an apology. She advised that this was the case. Mr Kang asked whether patients were aware of the targets for referral to treatment time. Miss Barlow advised that this was	

Minutes	Paper Reference
not clear. Dr Stedman suggested that there was a spectrum of understanding, from patients who were unaware of the targets to patients who were fully aware of the obligations under the NHS Constitution. Ms Robinson asked how the Audit Committee would be assured that measures were in place to prevent a reoccurrence of the situation. Miss Barlow advised that the key performance standards would be included within the integrated dashboard which was available to the Board and its Committees. She advised that an audit programme would also be put into place. It was agreed that the Internal Audit programme would incorporate this requirement. Mr Capener suggested that the scope of the audit should include a review of the validation techniques. Mrs Trueman advised that a separate audit system was being used to track this. Mrs Hunjan congratulated Miss Barlow and team for their ongoing efforts and asked for a further update at the next meeting.	
ACTION: **Mr Capener to include an audit of 18 week RTT compliance within the scope of the Internal Audit plan for 2013/14** **ACTION:** **Miss Barlow to present an update on the 18 weeks RTT data validation work at the next meeting**	
5 External Audit Matters	
5.1 External Audit progress report **5.2 External Audit fees letter**	**SWBAC (5/13) 022** **SWBAC (5/13) 023**
Mrs Moore advised that the onsite audit of the annual accounts was due to commence and that national guidance had been received, which included a requirement to test against two indicators as part of the audit: patient safety incidents for harm/death and readmissions within 28 days. The Committee was advised that the readmissions data was analysed differently within the Trust as 30 day readmissions were reported, rather than 28 day, however this had been resolved with the team locally. Mrs Hunjan noted that NHS internal audit standards had been published. Mr Capener advised that the implications of this would mean that there would be a need for the organisation to sign a charter or a terms of reference in due course. Mrs Moore advised that the planned fee for the provision of external audit services was £111,107 for 2013/14, a level set in line with the national tendering process. It was reported that the scale of fee was identical to that of 2012/13.	
5.3 Review of draft accounts 2012/13	**SWBAC (5/13) 024** **SWBAC (5/13) 024 (a)** **SWBAC (5/13) 024 (b)**

Minutes	Paper Reference
Mrs Hunjan thanked Mr Wharram for the useful covering report that had been prepared to accompany the annual accounts. Mr Wharram advised that the accounts had been prepared in line with the standard format issued by the Department of Health. He advised that they had been submitted on 19 April, with the audit commencing on 13 May. The Committee was advised that the Trust had met all of its statutory financial duties. It was reported that the Trust had been required to achieve a surplus of £5,777,000 and that against this, an actual surplus of £6,523,000 had been reported. The Committee was asked to note however, that for the purposes of the statutory accounts, a position of £3,441,000 deficit had been reported, a situation generated primarily as a result of the asset impairments charged within the year. Mr Wharram reported that the Trust had 'undershot' its External Financing Limit by £16,222,000, which was reflective of an underspend of circa £4m against the capital programme target, a decrease in receivables of £32.8m and an increase in payables and accrued expenditure of £9.3m, including a significant element associated with capital expenditure. The Committee was advised that there had been an underspend against the Capital Resource Limit (CRL), the most significant influence being the delay in the purchase of the Grove Lane land. Mr Kang asked whether an accrual was made for capital funding not spent. Mr Wharram advised that this was not the case. Mr Kang asked for further detail on the NHS Ligation Authority charges and in particular, how the costs were calculated. He was advised that all organisations were required to submit a return which included a number of metrics and details of the number of births being handled by the Trust, the information being used to calculate the premiums due. Mr White added that to some degree the premium was dependent on the number of staff employed by the Trust. Ms Robinson noted that the spend on consultancy for the Transformation Plan that had been approved by the Board did not accord with the entries in the annual accounts. Mr Wharram advised that the discrepancy reflected that the use of 'in house' was incorporated into one figure, but not the other. Ms Robinson asked whether the termination benefits of £7m included all provisions signed off by the Trust Board. She was advised that this was the case. Mrs Hunjan noted that a number of staff mentioned in the annual accounts were classified as 'other' and asked whether these were temporary or fixed term staff. She was advised that these were bank, agency and locum staff. Mrs Hunjan asked whether these individuals would be automatically	

Minutes	Paper Reference
converted into permanent employees after two years in post. She was advised that this was unlikely. Mrs Hunjan suggested that there was a need to ensure that the accounts incorporated the impact of autoenrolment into an employee pension scheme. She was advised that this was taken into account. Mr Wharram was asked what the loan costs classified as 'other' and valued at £30m reflected. He advised that this was the liability associated with the Trust's PFI. Mrs Hunjan thanked Mr Wharram for submitting the accounts for audit promptly and before the deadline required.	
5.4 Annual Governance Statement	**SWBAC (5/13) 025** **SWBAC (5/13) 025 (a)**
Mr White presented the Annual Governance Statement (AGS), which he advised had been prepared according to the required format. The Committee was asked to note that the AGS described the risk and internal control framework and the significant control issues were highlighted. It was suggested that an overview of each Board Committee should be included in the AGS and that Committee and Board attendance be reflected within this section. Mr Kang noted that the planned changes to the Committee structure were not included in the report. Mrs Moore advised that the structure and content of the AGS needed to be kept as succinct as possible and that this level of detail could be reflected in the annual report instead. Ms Robinson recommended that the recent IT outage be included within the section discussing significant control issues. Mr Wharram advised however, that the outage had not disrupted the Trust's financial systems. Mr Capener asked that the concerns highlighted within the Head of Internal Audit's Opinion (HOIA) be reflected within the AGS. He also suggested that an indication of the number of Serious Untoward Incidents be incorporated. Dr Sahota noted that the number of voting Board members stated was incorrect and that this needed to be amended in the final version.	
ACTION: Mr Grainger-Payne to incorporate comments on the Annual Governance Statement where relevant	
6 Draft annual report 2012/13	**SWBAC (5/13) 026** **SWBAC (5/13) 026 (a)**
Mrs Jessamy Kinghorn joined the meeting to present the first draft of the Annual Report 2012/13. She advised that there was a requirement for the report to contain a number of statutory elements, including a section concerning sustainability. The Committee was asked to note that a number	

Minutes	Paper Reference
of case studies were included within the report. Mrs Moore advised that in terms of the involvement of External Audit, a check was made against the national guidance and a comparison was made with the annual accounts audit. Mr Kang asked whether the annual report format would vary when the Trust was authorised as a Foundation Trust. Mr White advised that the annual report of a Foundation Trust adhered to a format in line with requirements set out in the Companies Act. Mr Kang asked who the principal audience for the annual report was likely to be. He was advised that the report would be presented to the public at the Annual General Meeting (AGM) in September. Ms Robinson commented that the contents and format of the report appeared to be inconsistent and cluttered and that she had made a comparison between the Trust's annual report and those of other organisations and on this basis, she suggested that the Trust adopted a more concise business style. It was highlighted that other organisations used appendices to good effect. Mr White reminded the Committee that the Trust had received a number of awards previously for its annual report, however he acknowledged that the future format needed to be considered. It was agreed that the annual report should feature tables showing attendance of the Board members at meetings of the Trust Board and its Committees. Mrs Moore advised that the guidance for the annual report was prescribed, however it was common for organisations to prepare two documents; one for public consumption and one for internal use. Dr Sahota noted that the report did not include any mention of charitable funds activity. He was advised that this had not been included pending approval of the charitable funds strategy and branding. Mrs Moore advised that a separate set of annual accounts needed to be prepared for the Trust's charitable funds to a timescale that was different to that for the exchequer accounts. Mrs Hunjan asked that key metrics concerning equality & diversity and workforce be included in the report. Mr Capener suggested that the report should reflect the recommendations from the outcome of the Robert Francis QC report where possible. Mrs Kinghorn highlighted that this was included within the section of the report dealing with the external environment. Ms Robinson suggested that the narrative around the new hospital scheme needed to be more factual. It was agreed that the next version of the annual report should be considered at the June meeting of the Committee.	
ACTION: **Mrs Kinghorn to present an updated iteration of the Annual Report at the meeting of the Audit Committee in June 2013**	
7 Quality Account 2012/13	**Hard copy**

Minutes	Paper Reference
Dr Stedman presented the draft Quality Account 2012/13, advising that key stakeholders had been invited to comment on the report. The Committee was advised that the process for developing the Quality Account had followed guidelines set by the Department of Health and that the final version would be submitted in June. Ms Robinson noted that no executive summary of the report had been produced and she encouraged consideration to be given to the balance between the main body of the report and the appendix. Dr Stedman advised however that the content, format and level of detail provided was prescribed the Department of Health. Mrs Moore added that the guidance on content was inflexible. Mrs Hunjan advised that the Quality Account would be audited as part of the work of External Audit. She noted that it was disappointing however, that the report had been issued to external parties without typographical errors and inconsistencies **being** corrected. Dr Stedman advised that in some areas, information was not available to include within the Quality Account until the end of the year. Mrs Hunjan highlighted the plan for the national roll out of the Friends & Family Test reporting system and asked to what services this would be applicable. Dr Stedman advised that it was not clear at this stage. It was agreed that a report back on the 'Kissing it Better' organisation should be considered as part of the Committee's annual cycle of business. The Committee discussed the possibility of validating the information that was submitted to the national audits, where the burden of so doing within the available timescale was highlighted as a major constraint. Mr Capener noted that none of the priorities in the Quality Account reflected the need to deliver an improvement against the 95% Emergency Care target. He also asked whether the Trust was comfortable with signing the statement confirming the robustness of the quality of the data in the light of the 18 weeks referral to treatment time target that had been discussed earlier in the meeting. Dr Stedman highlighted however, that this statement related solely to the information disclosed within the Quality Account. Ms Robinson highlighted the inconsistency within the report and a lack of 'house style' narrative. Dr Stedman advised that this would be addressed by the review planned by the Communications department. He emphasised that the document presented was a first draft and that the timescale for submission of papers to the Committee had not permitted the creation of a more refined version. Dr Sahota noted that in some instances, it appeared that the Trust had not submitted the required information to the national audits. Dr Stedman	

Minutes	Paper Reference
advised that in terms of the TARN audit, the issue had been complicated by a coding issue, however the Trust had not been penalised for not submitting the information and was putting plans in place to rectify the position. Mrs Hunjan noted that from the initial Quality Account that had been prepared, the position concerning compliance had improved considerably. In terms of finalising CQUIN targets for the coming year, Mrs Hunjan urged that this be handled with some expediency. Mr White advised that the matter was being addressed with the Trust's commissioners. All were asked to provide any further comments and questions on the Quality Account to Dr Stedman outside of the meeting if needed. Dr Stedman was thanked for his attendance.	
ACTION: Mr Grainger-Payne to schedule an update from the 'Kissing It Better' charity at a future meeting	
8 Internal Audit Matters	
8.1 Draft Internal Audit annual report, including the Head of Internal Audit Opinion and the assessment of the Assurance Framework 2012/13	**SWBAC (5/13) 028** **SWBAC (5/13) 028 (a)** **SWBAC (5/13) 028 (b)**
Mr Capener presented the draft Head of Internal Audit Opinion, which he advised overall provided a significant level of assurance. The areas providing moderate and limited assurance were highlighted to include 18 weeks referral to treatment time target compliance; data quality of the performance reported against the Accident & Emergency indicators; and theatre utilisation. The Committee was advised that it was anticipated that a level 'A' for the Board Assurance Framework was to be given, however Mr Capener highlighted that a number of recommendations had been made in respect of improvements which could be made.	
8.2 Internal Audit progress report	**SWBAC (5/13) 028 (c)**
Mr Capener presented an overview of the progress made to date with the delivery of the Internal Audit programme. In terms of the review of the Key Skills Framework (KSF), Mrs Hunjan suggested that the Workforce & Organisational Development Committee should consider the recommendations. Ms Robinson suggested that Mr Lewis, the newly commenced Chief Executive should review the internal audit recommendations as a whole. Mr White offered to ensure that the internal audit recommendations were reviewed. It was noted that no response had	

Minutes	Paper Reference
been received in respect of some recommendations which was agreed to be an unacceptable position. Mr White agreed to raise the outstanding recommendations with the relevant Executive Leads and work with Internal Audit to chase the delivery of the recommendations. It was highlighted that although it was disappointing that a number of recommendations remained unsatisfied, the process for the delivery of the actions to address any recommendations raised had been strengthened over recent months.	
ACTION: Mr White to appraise Mr Lewis of the outstanding internal recommendations and chase delivery with relevant Executive Leads	
8.3 Counter Fraud annual report 2012/13	**SWBAC (5/13) 030** **SWBAC (5/13) 030 (a)**
Mr Ferguson reported that a revised Counter Fraud policy had been developed. It was noted that work had been undertaken with the UK Borders Agency during the year. Mr Kang asked whether there had been any implication for the work as a result of the Queen's Speech about fraud in the healthcare community. Mr Ferguson advised that this was not the case at present although there were plans to make the eligibility criteria for healthcare treatment clearer. It was reported that at present patients' eligibility was tested against reciprocal arrangements.	
8.4 Counter Fraud annual plan 2013/14	**SWBAC (5/13) 031** **SWBAC (5/13) 031 (a)**
Mr Ferguson presented an overview of the 2013/14 Counter Fraud plan, which he highlighted covered routine elements and the new NHS standard contract requirements.	
8.5 Counter Fraud progress report	**Verbal**
Mr Ferguson advised that there were no additional matters to bring to the Committee's attention.	
9 Governance matters	
9.1 Audit Committee's effectiveness self-assessment	**SWBAC (5/13) 032** **SWBAC (5/13) 032 (a)**
Mrs Hunjan reported that a task and finish group had been set up to oversee the self-assessment process and that the Committee was invited to comment on the outcome presented. It was agreed that there was a need to reflect some of the actions raised in the self-assessment into the Audit Committee annual report.	

Minutes	Paper Reference
9.2 Losses and special payments	**SWBAC (5/13) 032** **SWBAC (5/13) 032 (a)**
The Committee was invited to receive and accept the losses and special payments update.	
9.3 Breaches of SOs/SFIs	**SWBAC (5/13) 033** **SWBAC (5/13) 033 (a)**
The Committee was invited to receive and accept the schedule of breaches of Standing Orders and Standing Financial Instructions. Ms Robinson asked what disciplinary action was being taken when a breach occurred and asked whether compliance with the Standing Orders and Standing Financial Instructions was a contractual obligation. Mr White advised that non-adherence was handled in the same manner as that for any other Trust policy and that for SFI breaches, the relevant departments were appraised, particularly when high levels were noted in a particular area. The Committee was advised that the schedule included all breaches, including both avoidable and those that were by and large unavoidable.	
9.4 Proposed changes to the Standing Orders/Standing Financial Instructions and Scheme of Delegation	**SWBAC (5/13) 035** **SWBAC (5/13) 035 (a)**
The proposed changes to the Standing Orders/Standing Financial Instructions and Scheme of Delegation, which were highlighted to mainly concern the revised remits of the Trust Board Committees and the changed EU Procurement limit, were approved by the Committee.	
AGREEMENT: The Audit Committee approved the proposed revisions to the Standing Orders/Standing Financial Instructions and Scheme of Delegation	
9.5 Audit Committee Chair's annual report	**SWBAC (5/13) 035** **SWBAC (5/13) 035 (a)**
The Audit Committee received and accepted the Audit Committee Chair's annual report. Ms Robinson drew attention to the apparent issue concerning inconsistent attendance of members at the Committee meetings. It was suggested that the improvements to the Board Assurance Framework highlighted by Internal Audit needed to be reflected in the report prior to presentation to the Trust Board.	
ACTION: Mr Grainger-Payne to amend the Audit Committee Chair's annual report to include suggestions made	
10 Minutes and notes from the Trust Board Committees	

Minutes	Paper Reference
10.1 Finance & Performance Management Committee	**SWBFC (2/13) 024** **SWBFC (3/13) 035** **SWBFC (4/13) 040**
The Committee noted the minutes of the Finance and Performance Management Committee meeting held on the 22 February 2013, 22 March 2013 and the draft version from the meeting held on 19 April 2013.	
10.2 Quality and Safety Committee	**SWBQS (1/13) 012** **SWBQS (2/13) 031** **SWBQS (3/13) 052** **SWBAC (5/13) 037**
The Committee noted the minutes of the Quality and Safety Committee meetings held on 25 January 2013, 21 February 2013, 21 March 2013 and the briefing given of the meeting held on 19 April 2013.	
10.3 Charitable Funds Committee	**SWBCF (2/13) 010**
The Committee noted the minutes of the Charitable Funds Committee meeting held on 14 February 2013.	
11 Any Other Business	**Verbal**
Mrs Hunjan thanked those present for their input and attendance.	
12 Date and time of next meeting	**Verbal**
It was noted that the date and time of the next meeting would be 6 June 2013 at 1100h in the Anne Gibson Boardroom, City Hospital and would be used to consider the audited version of the annual accounts prior to consideration by the Trust Board.	

Signed:……..

Name:……

Date:……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit Committee – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 6 June 2013

Members Present		In Attendance	Secretariat
Mrs G Hunjan	[Chair]	Mrs S-A Moore	Mr S Grainger-Payne
Ms C Robinson		Mr A Bostock	
Dr S Sahota		Ms Janet Dean	
Ms O Dutton		Mr R White	
		Mr T Wharram	

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Mr Harjinder Kang.	
2 2012/13 annual accounts	**SWBAC (6/13) 038** **SWBAC (6/13) 038 (a)** **SWBAC (6/13) 038 (b)**
Mr Wharram presented the annual accounts for 2012/13 for consideration, advising that they had been subjected to review by External Audit. It was highlighted that a number of presentational changes had been made as a result and that there had been small changes made to the cash flow position and the statement of financial position. It was reported that a number of key issues and recommendations had been made in the ISA260 (audit memorandum) report, although management responses had been developed to these. The Committee was asked and agreed to recommend the adoption of the annual accounts to the Trust Board.	
AGREEMENT: The Committee agreed to recommend the adoption of the annual accounts to the Trust Board	

Minutes	Paper Reference
3 External Audit memorandum	**SWBAC (6/13) 039**
Mr Bostock reminded the Committee that External Audit had been invited to make an assessment of the Trust's Use of Resources, which focussed on the financial resilience of the organisation, in addition to a view on the annual accounts. He advised that it was the intention to issue a clean (unqualified) opinion on both aspects. It was reported that across the NHS there was a pressure concerning financial resilience more widely. From an accounts perspective, Mr Bostock advised that two significant unadjusted statements had been highlighted, concerning the treatment of deferred income and provisions. It was noted however, that a comprehensive management response had been received in relation to these. The Committee was asked to note that this had been a long standing, but not material issue, however Mr Bostock explained that there was a potential for this to form a more substantive issue in future. Ms Robinson suggested that in terms of the deferred income position, the treatment adopted by the Trust appeared to be a prudent measure. Mr Bostock acknowledged that this was the case, however he highlighted the External Auditors' view of the treatment. There followed a discussion concerning the treatment of the deferred income. Performance in terms of meeting statutory targets was reported to have been reviewed. Mr White advised that the Trust was ahead of trajectory in terms of meeting the 4 hour Emergency Care target. The Committee was advised that the consideration of the Quality Account would not form part of the present meeting, however this would be presented for approval at a forthcoming meeting of the Trust Board. Mrs Hunjan asked whether the auditors had reviewed the annual report. Mrs Moore advised that the remuneration section of the annual report had been reviewed as part of the audit of the annual accounts, however a review of the annual report in totality would be undertaken when a final version had been prepared. Mr Bostock thanked Mr Wharram for his assistance with the audit and for his team's responsiveness to the requests from the auditors. Mrs Hunjan added her thanks to the finance team for delivering the financial targets and assisting with the preparation of a high quality report.	
4 Revised Annual Governance Statement 2012/13	**SWBAC (6/13) 040**
Mr White advised that the updated Annual Governance Statement included additional information concerning the Committee attendance and the inclusion of the IT outage as a serious control issue. Mrs Hunjan asked whether attendance at the Board should be included. Mrs Moore advised that there was no specific requirement for this to be included. Mr Grainger-	

Minutes	Paper Reference
Payne advised that the annual report would include this information. It was agreed that the signing of the Annual Governance Statement by the Chief Executive should be recommended to the Trust Board.	
AGREEMENT: The Audit Committee agreed that the signing of the Annual Governance Statement (AGS) by the Chief Executive should be recommended to the Trust Board	
5 Letter of Representation	**SWBAC (6/12) 041**
The Board considered the letter of representation, which Mr White highlighted acknowledged the issue concerning provisions balances relating to monies received from Commissioners in prior periods for the 'Right Care, Right Here' and transformation programme and a further provision in relation to high cost treatment where income had been received yet full treatment had not been provided. It was agreed that the signing of the Letter of Representation by the Chief Executive and Director of Finance & Performance Management should be recommended to the Trust Board.	
AGREEMENT: The Audit Committee agreed that the signing of the Letter of Representation by the Chief Executive and Director of Finance & Performance Management should be recommended to the Trust Board	
6 Review of waived tenders	**SWBAC (6/12) 042** **SWBAC (6/12) 042 (a)** **SWBAC (6/12) 042 (b)**
It was agreed that the schedule of waived tenders should be deferred for discussion by a future meeting of the Finance & Performance Management Committee.	
ACTION: Mr Grainger-Payne to schedule consideration of the list of waived tenders to a future meeting of the Finance & Performance Management Committee	
7 Any Other Business	**Verbal**
There was none.	
8 Date and time of next meeting	**Verbal**
It was noted that the date and time of the next meeting would be 12 September 2013 at 1100h in the D29 Meeting Room, City Hospital	

Signed:……..

Name:……

Date:……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – September 2013
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White / Chris Archer
DATE OF MEETING:	31 October 2013

EXECUTIVE SUMMARY:

The report presents the financial performance for the Trust, clinical groups and corporate directorates for the period to 30th September 2013.

The Trust's Monitor continuity of service risk rating for the year to September is 4 which is satisfactory ("no evident concerns").

Measured against the DH target, the Trust generated an actual surplus of £24,000 during September against a planned surplus of £4,000. 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 £41.3m is £1.5m higher than plan as at 30th September.

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:

Monthly at Clinical Leadership Executive.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2013

EXECUTIVE SUMMARY

• For the month of September 2013, the Trust delivered a "bottom line" surplus of £24,000 compared to a planned surplus of £4,000 (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 £2,179,000 compared with a planned surplus of £2,369,000 so generating an adverse variance from plan of £190,000, below the Trust's year to date target.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 261 below planned levels. After taking account of the impact of agency staff, WTE's were 21 below plan. Total pay expenditure for the month, inclusive of agency costs, is £12,000 below the planned level.

• The month-end cash balance was £41.3m. Year to date spend on capital is £3.7m 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	20	(190)	>=Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	37	(276)	>=Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	12	(219)	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	(308)	(1,106)	<=Plan	<=Plan	>1% above plan
WTEs Actual v Plan	21	(106)	<=Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000	1,535	1,535	>=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	2,369	2,179
Capital Resource Limit	10,203	10,203
External Financing Limit	---	1,535
Return on Assets Employed	3.50%	3.50%

2013/14 Summary Income & Expenditure Performance at September 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	392,227	32,902	33,203	301	196,085	196,673	588	392,227
Other Income	37,533	3,245	3,277	32	19,187	19,648	461	37,533
Operating Expenses	(404,039)	(34,382)	(34,678)	(296)	(202,342)	(203,667)	(1,325)	(404,039)
EBITDA	25,721	1,765	1,802	37	12,930	12,654	(276)	25,721
Interest Receivable	100	8	11	3	50	68	18	100
Depreciation, Amortisation & Profit/(Loss) on Disposal	(13,962)	(1,164)	(1,164)	0	(6,981)	(6,981)	0	(13,962)
PDC Dividend	(5,027)	(419)	(444)	(25)	(2,514)	(2,466)	48	(5,027)
Interest Payable	(2,232)	(186)	(181)	5	(1,116)	(1,096)	20	(2,232)
Net Surplus/(Deficit)	**4,600**	**4**	**24**	**20**	**2,369**	**2,179**	**(190)**	**4,600**
IFRIC12/Impairment/Donated Asset Related Adjustments	0	0	0	0	0	0	0	0
SURPLUS/(DEFICIT) FOR DOH TARGET	**4,600**	**4**	**24**	**20**	**2,369**	**2,179**	**(190)**	**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 – September 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 £24,000 in September against a planned surplus of £4,000. The resultant £20,000 favourable variance provides a 1.1% return.

Performance of Clinical Groups and Directorates

- Group reporting reflects the new structures in Community & Therapies and Corporate.
- Group performance now includes contract income performance for April to August.
- Medicine Group overspends on HCA staffing remains the largest single financial pressure.

Group Variances from Plan

	Current Period £000	Year to Date £000	Budget
Medicine	(65)	(807)	102,197
Surgery A	(23)	21	61,979
Women & Child Health	10	(131)	50,124
Surgery B	(54)	47	25,850
Community & Therapies	3	(68)	27,686
Pathology	6	(10)	19,901
Imaging	88	208	17,911
Corporate	69	107	86,115
Trust Wide	3	357	16,875

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Emergency medicine is above plan though A&E is down; births are below plan; ophthalmology and imaging are above plan.

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

Medical staffing is overspending in Surgery A, Surgery B, Women & Child Health and Medicine . Nursing is underspent mainly in W&CH.

Elements of drugs and consumables overspends are met by additional income.

Variance From Plan by Expenditure Type

	Current Period £000	Year to Date £000
Patient Income	301	588
Other Income	32	461
Medical Pay	(228)	(691)
Nursing	(4)	510
Other Pay	244	(38)
Drugs & Consumables	(133)	(554)
Other Costs	(175)	(552)
Interest & Dividends	(22)	66

Capital Expenditure

• Year to date capital expenditure is £3.7m, mainly on Blood Sciences, statutory standards and estates rationalisation. Detailed programmes have now been approved for medical equipment, estates , including the "Winter Must Be Better" and "Dementia Friendly Environment" programmes of work and HIS.

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Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are 21 below plan . Excluding the impact of agency staff, whole time equivalent (WTE) numbers are 261 below plan.

• Total pay costs (including agency workers) are £12,000 below budgeted levels for the month with overspends on medical and health care assistant staff being offset by underspends on management and scientific, technical and therapy staff. Nursing is on plan for the month across the Trust (including bank and agency).

•Expenditure for agency staff in September was £928,000, slightly higher than the average in the previous five months.

Analysis of Total Pay Costs by Staff Group

	Year to Date to September					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	38,432	37,113	0	2,010	39,123	(691)
Management	7,670	7,127	0	0	7,127	543
Administration & Estates	15,746	14,395	1,104	545	16,044	(298)
Healthcare Assistants & Support Staff	15,738	14,229	2,023	542	16,794	(1,056)
Nursing and Midwifery	45,508	40,952	2,033	2,013	44,998	510
Scientific, Therapeutic & Technical	21,787	20,879	0	220	21,099	688
Other Pay	96	11	0	0	11	85
Total Pay Costs	144,977	134,706	5,160	5,330	145,196	(219)

NOTE: Minor variations may occur as a result of roundings

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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 30th September stood at £41.3m, above the plan of £39.7m.

Sandwell & West Birmingham Hospitals NHS Trust

STATEMENT OF FINANCIAL POSITION 2013/14

		Opening Balance as at 1st April 2013	Balance as at end September 2013	Forecast at 31st March 2014
		£000	£000	£000
Non Current Assets	Intangible Assets	924	506	1,421
	Tangible Assets	216,669	213,548	227,997
	Investments	0		
	Receivables	1,048	966	1,048
Current Assets	Inventories	3,604	3,608	3,604
	Receivables and Accrued Income	10,432	17,289	10,432
	Investments	0	0	
	Cash	42,448	41,257	38,335
Current Liabilities	Payables and Accrued Expenditure	(43,040)	(44,935)	(43,039)
	Loans	(2,000)	(2,000)	(2,000)
	Borrowings	(914)	(1,145)	(914)
	Provisions	(10,355)	(10,535)	(10,049)
Non Current Liabilities	Payables and Accrued Expenditure	0		
	Loans	(3,000)	(2,000)	(1,000)
	Borrowings	(29,263)	(28,426)	(28,706)
	Provisions	(3,168)	(2,570)	(2,474)
		183,385	185,564	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)	(18,080)	(13,754)
		183,385	185,564	194,655

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT September 2013

ACTUAL/FORECAST	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	Aug-14 £000s	Sep-14 £000s
Receipts													
SLAs: SWB CCG	**20,712**	20,684	20,684	20,684	20,684	20,684	20,684	20,978	20,978	20,978	20,978	20,978	20,978
Associates	**6,669**	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900
Other NHS income	**1,584**	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Specialised Service (LAT)	**3,379**	3,372	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			4,700	0	0	4,700	0	0
Loans													
Other Receipts	**3,074**	2,100	2,100	2,100	2,100	2,100	2,100	1,800	1,800	1,800	1,800	1,800	1,800
Total Receipts	**35,418**	38,684	34,256	34,256	38,684	34,256	34,256	38,950	34,250	34,250	38,950	34,250	34,250
Payments													
Payroll	**13,625**	13,400	13,400	13,400	13,400	13,400	13,400	14,100	14,100	14,100	14,100	14,100	14,100
Tax, NI and Pensions	**9,368**	9,500	9,500	9,500	9,500	9,500	9,500	9,650	9,650	9,650	9,650	9,650	9,650
Non Pay - NHS	**2,139**	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200
Non Pay - Trade	**8,810**	8,480	7,540	6,600	7,540	7,540	9,826	7,625	7,625	7,625	7,625	7,625	7,625
Non Pay - Capital	**683**	1,157	1,115	1,257	2,063	2,271	3,064	1,308	1,308	1,308	1,308	1,308	1,308
PDC Dividend	**2,074**						2,577						2,750
Repayment of Loans	**1,000**						1,000						1,500
Interest	**21**						15	0	0	15	0	0	15
BTC Unitary Charge	**792**	428	428	428	428	428	428	225	225	225	225	225	225
Other Payments	**1,133**	350	350	350	350	350	350	92	92	92	92	92	92
Total Payments	**39,645**	35,515	34,533	33,735	35,481	35,689	42,360	35,200	35,200	35,215	35,200	35,200	39,465
Cash Brought Forward	**45,484**	41,257	44,426	44,149	44,670	47,873	46,440	38,336	42,086	41,136	40,171	43,921	42,971
Net Receipts/(Payments)	**(4,227)**	3,169	(277)	521	3,203	(1,433)	(8,104)	3,750	(950)	(965)	3,750	(950)	(5,215)
Cash Carried Forward	**41,257**	44,426	44,149	44,670	47,873	46,440	38,336	42,086	41,136	40,171	43,921	42,971	37,756

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2013

Cash Forecast

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

Continuity of Service Risk Rating

•The previous Monitor Financial Risk Rating has now been retired and has been replaced by the new 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	2.16	3	2.63	4	2.63	4
Liquidity	Cash for liquidity purposes * 360/annual operating expenses	-0.06	3	-0.06	3	-6.45	3
Overall Rating			**3**		**4**		**4**

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.

Sandwell and West Birmingham Hospitals NHS

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Performance Against Service Level Agreement Target

- Performance for April to August is ahead of plan on line overall with emergency medicine above plan though A&E is down; births are below plan; ophthalmology and imaging are above plan.
- The Trust is in discussion with commissioners about the allocation of high cost drugs to the appropriate contract.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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Key risks

• School nursing services are out to tender and the outcome of this is relevant to ongoing discussions regarding this year's contract.

•Births are below plan and invoices are starting to flow between providers in line with the maternity pathway tariffs in place this year, though not sufficiently settled to judge the level of risk.

•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

•The '2014/15 national tariff payment system: a consultation notice' has been published by Monitor and NHS England. This is the first national tariff since they took over responsibility for price setting from the Department of Health. The document, which was published on 3 October, sets out national prices and currencies, as well as rules for the payment of healthcare outside of primary care services.

•The marginal rate for emergency admissions will be retained in 2014/15 and there will be price stability in 2014/15 with only minor currency changes. Prices will be based on 2013/14 prices, rather than updated reference costs, and these would be adjusted for changes to provider input costs and the efficiency requirement, which will be set at 4%. The consultation on the document is open until 31 October.

•NHS England has set out its commissioning intentions for specialised services for 2014/15 and 2015/16.

•The Department of Health has submitted evidence to the NHS pay review body that the 1% the government has made available for pay rises in the NHS in 2014/15 would be best used to support the reform of pay frameworks and that annual pay progression under agenda for change added 2% to the pay bill each year even during the recent pay freeze.

•Monitor has updated its guide for trusts applying for foundation status to take account of the introduction of its new risk assessment framework. The framework, which applies to all providers of NHS-funded services, replaces the 'Compliance framework'.

Recommendations

The Trust Board is asked to:

i. RECEIVE the contents of the report; and

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

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Corporate Performance Monitoring Report
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Performance Management
DATE OF MEETING:	31 October 2013 (Report prepared 24 October 2013)

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – September 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:

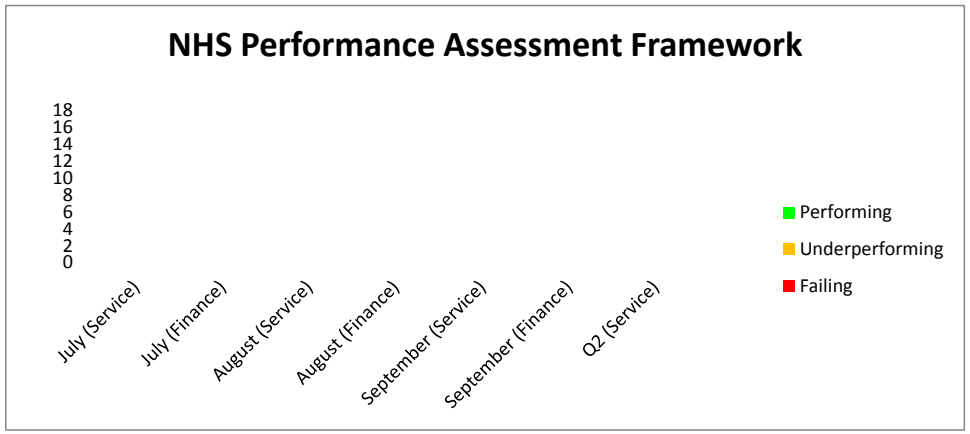
Accessible and Responsive Care, High Quality Care and Good Use of Resources. National targets and Infection Control. Internal Control and Value for Money

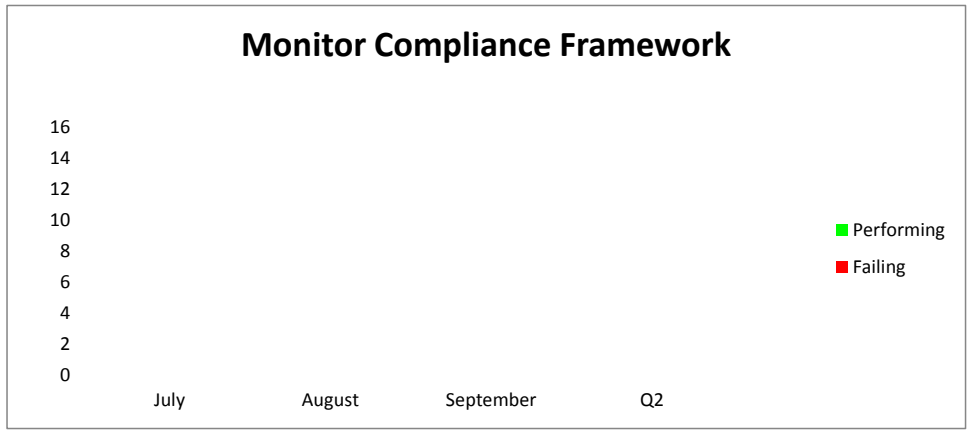
PREVIOUS CONSIDERATION:

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

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

EXECUTIVE SUMMARY

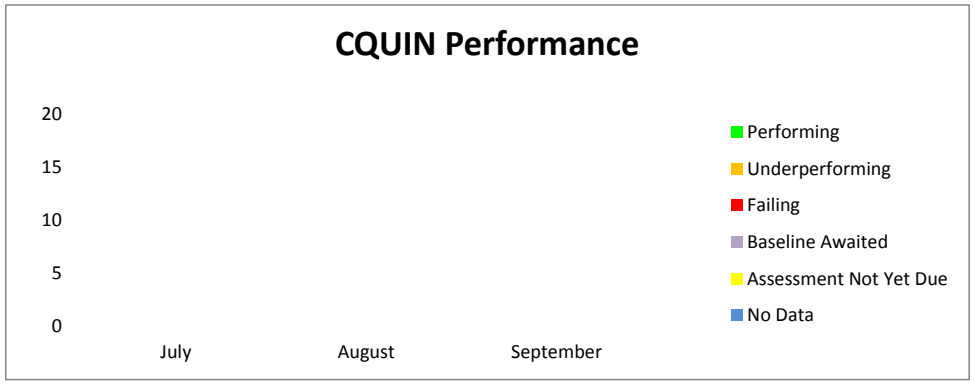




Service Performance - during the month (September) there were 3 areas of underperformance; Emergency Care 4-hour waits (94.74%), Delayed Transfers of Care (3.90%) and Mixed Sex Accommodation Breaches (5 in total, equivalent to 0.04% of all completed FCEs within the month) and 1 area 'failing'; RTT Delivery in All Specialies (11 treatment functions during the month). The Trust is projected to attract an overall weighted score of 2.56 and as such a **PERFORMING CLASSIFICATION** for the month. The Trust is projected to meet performance thresholds for high level Cancer Targets. During Quarter 2 there was 1 area underperformance; Mixed Sex Accommodation Breaches and 1 area 'failing'; RTT Delivery in All Specialities (26 treatment functions during the quarter). The overall weighted score for the quarter is 2.70 (PERFORMING).

Financial Performance (September) 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 September, the Trust underperformed against the Emergency Care 4-hour wait target, but met the required thresholds for each of the other 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 1.0, which attracts an AMBER / GREEN Governance Rating. The Trust is projected to meet performance thresholds for all high level RTT and Cancer targets for the month. During the Quarter the Trust met the operational threshold for each indicator within the framework. The overall governance score was 0.0, with a GREEN Governance Rating.



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 or progress on track regarding staffing, equipment, training etc. One scheme is currently failing; Dementia (Find, Assess & Refer) and one scheme is not yet due for assessment (Annual Staff Survey). A Confirm and Challenge meeting with scheme leads is set up for 5 November 2013.

Clinical Quality & Outcomes

Stroke Care - improvement is noticeable with the timeliness of CT Scans (within 1 hour and within 24 hours) and the proportion of patients receiving thrombolysis within 60 minutes, although further improvement is required is this area. Previously reported data quality issues are being resolved, with a tightly defined action plan supporting migration from one database to another. A reduction in the proportion of patients admitted to an acute stroke unit within 4 hours is considered to be a data issue, in the process of resolution, rather than related to bed pressures delaying admission.

MRSA Screening - the proportion of MRSA screens matched with actual patients requiring screens for both Elective and Non-Elective admissions has improved within month to 89.5% and 90.9% respectively. Much work has been done at specialty level to increase the proportion of patients screened as well as continue to resolve any potential data discrepancies, such as ensuring patient treatment locations are correctly identified and recorded on information systems. A Summary table by Group is adjacent.

	Elective	Non-Elective
Surgery B	95.6%	86.1%
Medicine	58.9%*	91.1%
Surgery A	91.0%	90.8%
Women / CH	100%	95.5%

* 129 eligible patients total

Readmissions - Emergency Readmission Rates within 30 days of discharge are reported by Quarter. Data for the most recent period available (January - March 2013) indicates a rate of 9.05% overall, comprising 3.59% following an initial elective admission and 13.12% following an initial non-elective admission. The calculations are consistent with recommendations published by the CQC earlier in the year which identifies c.220 diagnoses within 23 diagnostic groupings. A readmissions tasforce is meeting regularly to identify specific areas of focus and identify appropriate clinical actions to reduce current rates. A flag on EBMS to inform the admitting clinician of previous admission history, is being developed. It is expected that this will assist in reducing avoidable admissions, with further work on-going with primary care colleagues.

Emergency Care - 4-hour wait performance during September reduced to 94.7% (95.5% during August), and outturned at 95.00% for the Quarter, and 94.5% for the first 6 months of the year. Required performance across the remaining 6 months of the year is 98.18%, to meet the overall target for the year of 96.2%. Performance during the first 2 complete weeks of September averaged 94.1%. Further consideration of winter bed modelling and patient flow through Emergency Care is underway.

WMAS - the number of ambulances subject to turnaround delays in excess of 30 minutes is not reducing, with 1300 plus instances recorded within the month. Work to provide a dedicated ambulance assessment area at Sandwell, similar to the one in place at City, is expected to be completed during November. Data reported is provided by the West Midlands Ambulance Service, a local audit of ambulance turnaround times has been undertaken, with the findings, identifying fewer delays, subject to discussion with the ambulance service.

Patient Experience

Cancelled Operations - Elective Admissions cancelled at the last minute for non-clinical reasons increased to 1.4% during September, affecting 66 patients (10 on more than 1 occasion). Of the 66 cancellations by Clinical Group, 30 related to Surgery B, 27 Surgery A, 8 Women / Child Health and 1 Medicine. Actions within Surgery A are to identify specific reasons for cancellation and measures required to avoid a repeat cancellation.

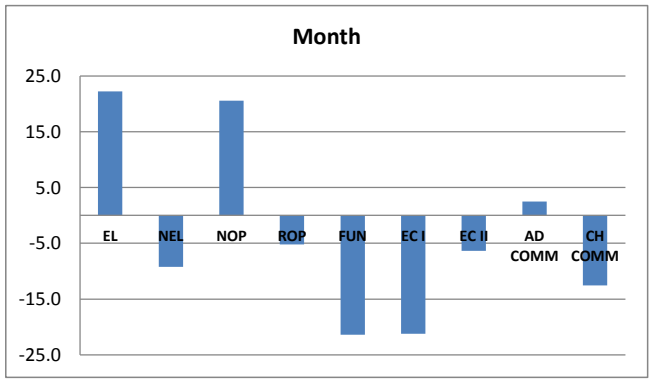
Cancelled Operation 28-day standard - no breaches of this standard occured during the month of September. Following previous underreporting of breaches a daily report on potential breaches is circulated, with actions required to eliminate such breaches identified at weekly Waiting List meetings.

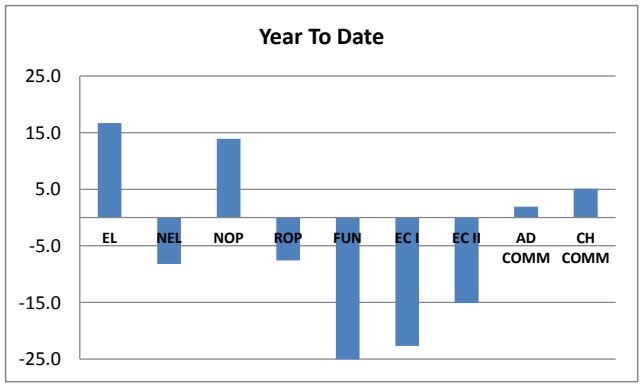
Staff Experience

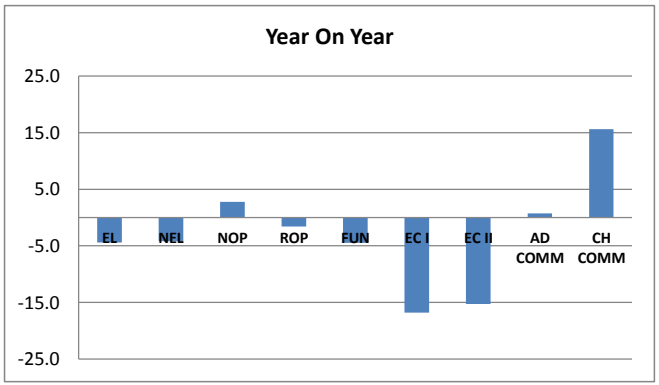
PDR - overall compliance for the most recent 12-month cumulative period further improved to 79.6%. Performance across Clinical Groups is 78.2% and across Corporate Directorates is 83.3%. **Mandatory Training** compliance is not showing sign of improvement, with performance at the end of September 86.1%.

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 (4.4%) less than that delivered during the corresponding period last year. Non-Elective activity is currently 8.2% less than the plan for the year to date, and 4.2% 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 2.20 for the year to date, significantly less than the ratio derived from plan (2.76), 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			May	June	July	August			September			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.	1 ▲	6 ■	5 ▲	1 ▲	2 ■	3 ■	3 ■	1 ▲	4 ▼	22	24	46	No variation		Any variation	●	95	37
	A			MRSA Bacteraemia	No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	1	0	0	No variation		Any variation	●	2	1
RB	A	1	Cancer	2 weeks	%	95.3 ▲	93.1 ▼	94.0 ▲	→		95.5 ▲	→			94.2	=>93	=>93	No variation		Any variation	●	94.8	94.7
	A			2 weeks (Breast Symptomatic)	%	93.1 ▼	93.9 ▲	96.2 ▲	→		96.6 ▲	→			95.3	=>93	=>93	No variation		Any variation	●	95.8	95.9
	A			31 Day (diagnosis to treatment)	%	96.1 ▼	98.6 ▲	100 ▲	→		100 ■	→			99	=>96	=>96	No variation		Any variation	●	99.5	99.5
	A			31 Day (second/subsequent treatment - surgery)	%	94.2 ▼	97.6 ▲	100 ▲	→		100 ■	→			98.4	=>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)	%	91.8 ▲	86.2 ▼	86.2 ■	→		85.3 ▼	→			88.4	=>85	=>85	No variation		Any variation	●	86.9	87.1
	A			62 Day (referral to treat from screening)	%	100 ▲	100 ■	96.0 ▼	→		100 ▲	→			99.2	=>90	=>90	No variation		Any variation	●	98.5	96.9
	H			62 Day (referral to treat from hosp specialist)	%	93.3 ▲	89.3 ▼	83.3 ■	→		94.1 ■	→			87.8	=>85	=>85	No variation		Any variation	●	91.6	93.2
	A	2	Emergency Care 4-hour waits		%	94.4 ▲	95.5 ■	94.7 ■	97.3 ▲	94.3 ▲	95.5 ■	94.9 ■	94.6 ▲	94.7 ■	94.55	=>95	=>95	=>95		<95	●	95.38	92.54
RB	A	2	Referral To Treatment	Admitted Care (RTT <18 weeks)	%	92.5 ▲	92.3 ▼	92.5 ▲	→		92.3 ▼	→		90.1 ▼	90.1*	=>90.0	=>90.0	=>90.0	85-90	<85.0	●	93.2	93.7
	A			Non-Admitted Care (RTT <18 weeks)	%	98.3 ▲	97.2 ▼	96.9 ▼	→		96.6 ▼	→		95.1 ▼	95.1*	=>95.0	=>95.0	=>95.0	90 - 95	=<90.0	●	97.5	98.6
	A			Incomplete Pathway (RTT <18 weeks)	%	96.4 ▲	93.3 ▼	92.8 ▼	→		92.2 ▼	→		92.6 ▲	92.6*	=>92.0	=>92.0	=>95.0	87 - 92	=<87.0	●	97.2	95.3
	E			Treatment Functions Underperforming	No.	6 ▼	7 ■	8 ▼	→		7 ▲	→		11 ▼	11*	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	%	0.91 ▼	0.67 ▲	0.57 ▲	→		0.61 ▼	→		0.42 ▲	0.42*	<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		%	3.2 ▼	2.7 ▲	2.7 ■	3.9 ■	3.5 ■	3.7 ■	3.5 ▲	4.3 ▼	3.9 ▼	3.3	<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	%	0.89 ▲	0.02 ■	0.00 ■	→		0.00 ■	→		0.04 ■	0.04*	0.0	0.0	0.00	0.00 - 0.50	>0.50	●	0.07	
				Numerical	No.	114 ▲	2 ▲	0 ■	→		0 ■	→		5 ■	5*	0.0	0.0	0		>0	●		
RS	A	3	VTE Risk Assessment		%	94.7 ▲	95.3 ■	95.9 ▲	→		94.4 ■	→		95.1 ■	95.1*	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		%	0.57 ▼	0.00 ▼	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	%	0.01 ▼	0.01 ■	-0.04 ▲	→		-8.90 ▲	→		-8.00 ▼	-8.00	0-3.0	0-3.0	0-3.0		=>2.0			
				YTD EBITDA	%	6.69 ▼	5.44 ▼	5.95 ▲	→		6.00 ▲	→		5.80 ▼	5.80	=>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	%	6.46 ▼	6.32 ▼	6.00 ▼	→		6.00 ■	→		6.00 ■	6.00	=>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	%	1.07 ▼	0.92 ▼	1.07 ▲	→		1.10 ▲	→		1.10 ■	1.10	=>0.0	=>0.0	=>0.0		>-2.0			
				EBITDA Margin	%	6.46 ▼	6.32 ▼	6.00 ▼	→		6.00 ■	→		6.00 ■	6.00	=>5.0	=>5.0	=>5.0		<1.0			
			Financial Processe	Better Payment Practice Code Value	%	92.60 ▲	93.84 ▲	87.00 ▼	→		92.10 ▲	→		94.40 ▲	94.40	=>95	=>95	=>95		<60			
				Better Payment Practice Code Volume	%	94.40 ▼	92.76 ▼	87.00 ▼	→		92.70 ▲	→		93.10 ▲	93.10	=>95	=>95	=>95		<60			
				Current Ratio	ratio	1.02 ▼	1.05 ▲	1.06 ▲	→		1.07 ▲	→		1.10 ▲	1.10	=>1.0	=>1.0	=>1.0		<0.5			
				Debtor Days	Days	12.97 ▼	13.29 ▼	13.54 ▼	→		11.71 ▲	→		12.00 ▼	12.00	<=30	<=30	<=30		>60			
				Creditor Days	Days	44.79 ▼	39.03 ▲	39.03 ■	→		13.22 ■	→		13.00 ▼	13.00	<=30	<=30	<=30		>60			

SEPTEMBER 2013	CQUINs

Exec Lead	KPI Source	Data Source	Indicator					May	June	July	August			September			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	%	94.7 ▲	95.3 ■	95.9 ▲	→		94.4 ■	→		95.1 ■	95.1*	95	95	=>90		<90	●	92.4	90.8
RS	H			Root Cause Analysis		224	%	→	100 Base	→	Quarterly Monitoring			→			100 (Base)	100	100				●		
RO	H	8	NHS Safety Thermometer	Reduction in Prevalence of Pressure Ulcers	ACUTE	224	%	8 ▼	11 ■	5 ■	→			→			48	10% reduction on aggregate 6-month base (Oct 2012 - March 2013) of 81 (68 Acute + 13 Comm)					●		
RO	H	8			COMMUNITY	224	%	1 ▼	0 ■	0 ■	→			→			1						●		
RO	H	8	Dementia	Find, Investigate and Refer		269	%	2 of 3 met	2 of 3 met	1 of 3 met	→		0 of 3 met	→		2 of 3 met	2 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	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	→	→		→	→		11.8 ▲	11.8						●		
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			→			Base identified	Compliance against Standard 2		No variation		Any variation	●		
RO	H	8	Dementia Patient Stmulation			1138		→	On Track	→	Quarterly Monitoring			→		On Track	On Track			No variation		Any variation	●		
RS	H		Use of Pain Care Bundles			1138	%	→	On Track	→	Baseline August - October		On Track	Baseline August - October		On Track	On Track	To be agreed		No variation		Any variation	●		
RS	H		Use of Sepsis Care Bundles			1105	%	→	→	→	Baseline Sept. - November		On Track	Baseline Sept. - November		On Track	On Track	To be agreed		No variation		Any variation	●		
RO	H	11	Community Risk Assessment & Advice			1105	%	→	→	→	Baseline Assessment during Q2			→			On Track	To be agreed		No variation		Any variation	●		
RS	H		Recording DNAR Decisions			1105	%	→	→	→	Bi-Annual Ward Audit / Improvement			→			On Track			No variation		Any variation	●		
RS	H		Specialised Commissioners	Clinical Quality Dashboards		60		→	Compliant	→	→			→		Compliant	Compliant			No variation		Any variation	●		
RS	H	22		Behcets Highly Specialised Service		60		→	On Track	→	Annual Workshop & Report			→		On Track	On Track			No variation		Any variation	●		
RS	H	12		HIV - Communication with GPs		180		→	Compliant	→	→			→		Compliant	Compliant			No variation		Any variation	●		
RS	H	12		Neonatal - Retinopathy Of Prematurity (Screening)		180		→	Compliant	→	→			→		Compliant	Compliant			No variation		Any variation	●		

Exec Lead	KPI Source	Data Source	Indicator				May	June	July	August			September			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		%	96.2 ▲	91.5 ▼	95.0 ▲	→		91.5 ▼	→		94.6 ▲	92.0	83	83	No Variation	0 - 2% Variation	>2% Variation	●	85.9	85.6
	H			Pts admitted to Acute Stroke Unit within 4 hrs		%	84.1 ▲	92.3 ■	92.1 ▼	→		76.3 ■	→		72.1 ▼	74.7	90	90	No Variation	0 - 2% Variation	>2% Variation	●	68.7	59.1
	H			Pts receiving CT Scan within 24 hrs of presentation		%	86.1 ▼	85.2 ▼	85.0 ▼	→		95.7 ▲	→		97.7 ▲	92.8	100	100	No Variation	0 - 2% Variation	>2% Variation	●	100	92
	H			Pts receiving CT Scan within 1 hr of presentation		%	63.2 ▲	67.3 ▲	64.1 ▼	→		71.4 ▲	→		67.5 ▼	67.4	50	50	No Variation	0 - 2% Variation	>2% Variation	●	37.5	52.0
	H			Admission to Thrombolysis Time (% within 60 mins)		%	17.0 ■	0.0 ▼	33.0 ▲	→		67.0 ▲	→			23.5	85	85	=>85		<85	● ● ●		
				Admission to Thrombolysis Time (% over 90 mins)		%	50.0 ■	67.0 ▼	33.0 ▲	→		0.0 ■	→			41.2	0	0	0		>0	● ●		
	H			Stroke Admissions - Swallowing assessments (<24h)		%	100.0 ■	92.9 ■	100.0 ■	→		100.0 ■	→		100.0 ■	97.5	100	100	=>98		<98	●		
	H			TIA (High Risk) Treatment <24 h from initial presentation		%	63.2 ▼	81.3 ▲	83.3 ▲	→		72.0 ▼	→		75.9 ▲	74.1	60	60	No Variation	0 - 2% Variation	>2% Variation	●	53.2	69.8
	K			TIA (Low Risk) Treatment <7 days from initial presentation		%	88.4 ▲	88.2 ▼	91.2 ▲	→		92.5 ▲	→		87.9 ▲	86.5	60	60	No Variation	0 - 2% Variation	>2% Variation	●	30.4	75.9
RO		4	Infection Control	MSSA Bacteraemia		No.	1	0	1	0	0	0	1	0	1	5	No. Only	No. Only					12	15
				E Coli Bacteraemia		No.	2	4	4	4	1	5	1	0	1	18	No. Only	No. Only					50	48
	F	3		MRSA Screening - Elective	Patient Not Matched	%	173.2 ▼	196.9 ▲	249.9 ▲	Numerator = 2979	Denominator = 1372	217.1 ▼	Numerator = 3212	Denominator = 1268	253.3 ▲	253.3*	87	90	No variation		Any variation	●		138.9
	F				Best Practice - Patient Matched	%	59.9 ▼	67.2 ▲	80.7 ■	Numerator = 1042	Denominator = 1372	75.9 ▼	Numerator = 1135	Denominator = 1268	89.5 ▲	89.5*	76	80	No variation		Any variation	●		59.5
	F			MRSA Screening - Non Elective	Patient Not Matched	%	82.2 ▲	81.3 ▼	84.1 ▲	Numerator = 2664	Denominator = 3058	87.1 ■	Numerator = 1872	Denominator = 2130	87.9 ▲	87.9*	87	90	No variation		Any variation	●		76.8
	F				Best Practice - Patient Matched	%	72.6 ■	74.5 ▲	72.6 ▼	Numerator = 2664	Denominator = 3447	77.3 ▲	Numerator = 1872	Denominator = 2060	90.9 ▲	90.9*	76	80	No variation		Any variation	●		64.9
RS	H	3	WHO Safer Surgery Checklist	Audit - 3 sections		%	99.9 ■	99.6 ▼	99.8 ▲	→		99.2 ▼	→		99.6 ▲	99.6*	100	100	=>98		<98	●		
	H	3		Audit - 3 sections and brief		%	93.9 ▼	90.4 ▼	92.6 ▲	→		89.5 ▼	→		91.6 ▲	91.6*	100	100	=>95		<95	●		
	H	3		Audit - 3 sections, brief and debrief		%	80.5 ▲	75.3 ▼	76.0 ▲	→		76.3 ▲	→		78.4 ▲	78.4*	100	100	=>85		<85	● ●		
KD	F	14	Never Events - in month			No.	0 ■	1 ■	0 ■	→		1 ■	→		0 ■	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.	9	8	11	→		8	→		6	6*	No. Only	No. Only						2
	F		Open Central Alert System (CAS) Alerts			No.	5	3	6	→		6	→		8	8*	No. Only	No. Only						10
RO	D		Falls Resukting In Severe Injury or Death			No	2 ▲	5 ▼	0 ■	→		0 ■	→		0 ■	10	0	0	No variation		Any variation	●		22
RO	D	8	Grade 3 or 4 pressure ulcers - avoidable			No	1	1	1	→		1	→		0	6								
RO	H	8	High Impact Nursing Actions	Inpatient Falls reduction	Acute	No	49 ■	51 ▼	67 ■	→		54 ■	→			277	275	660	=<55/m		>55/m	●		737
	H				Community	No	10 ■	7 ▲	8 ▼	→		10 ▼	→			50	60	144	=<12/m		>12/m	●		
RS		3	Obstetrics	Post Partum Haemorrhage (>2000 ml)		No.	1 ■	0 ▲	0 ■	→		0 ■	→		0 ■	2	24	48	=<2	3 - 4	>4	●	7	10
				Admissions to Neonatal ICU		%	10.0 ■	8.1	9.2 ▼	→		9.5 ▼	→			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	6.6 ■	6.0 ▲	8.0 ■	→		5.9 ■	→			5.9*	<8.0	<8.0	<8	8.0 - 10.0	>10	●	11.9*	4.5
				Caesarean Section Rate	Elective and Non-Elective	%	27.2 ■	25.1 ▲	25.7 ▼	→		25.5 ▲	→		29.0 ■	26.2	<25.0	<25.0	=<25.0	25-28	>28.0	●	22.2	23.6
	H				Elective	%	13.5	12.6	11.2	→		10.7	→		13.1	11.7								
	H				Non-Elective	%	13.7	12.6	14.5	→		14.8	→		16.0	14.5								
	H			Early Booking (Completed Assessment <12+6 weeks)	National Definition	%	146.0 ■	122.0 ▼	152.0 ▲	→		110.0 ▼	→			110.0*	=>90	=>90	=>90	75-89	<75	●	76.0	78.0
	H				SWBH Early Booking (Bookings > Births)	%	80.0 ▲	79.0 ▼	79.0 ■	→		78.0 ▼	→			78.0*	=>90	=>90	=>90	75-89	<75	● ●	76.0	78.0
RO		2	Infant Health & Inequalities	Maternal Smoking Rates		%	→	9.4 ▼	→	→		→	→		7.83 ▲	8.6	<11.5	<11.5	<11.5	11.5 - 12.5	>12.5	●	9.8	9.9
				Breast Feeding Initiation Rates		%	→	77.0 ▲	→	→		→	→		76.7 ▼	76.9	>63.0	>63.0	>63.0	61-63	<61.0	●	73.0	72.6

Exec Lead	KPI Source	Data Source	Indicator				May	June	July	August		September			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			%	78 ▲	72 ▼	82 ■	→			→			81.5*	80	80	No variation		Any variation	●	66.9	
RS		6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate		HSMR	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	→		92.2 Jul'12 to Jun'13	92.2							
				Peer (SHA) HSMR		HSMR	97.0	98.0	97.5	→		97.5	→		101.9	101.9							
				Peer (National) HSMR - Quarterly		HSMR	→	94.0	→	→		→	→		98.1	98.1							
	D	19		SHMI		SHMI	95.5 Mar'12-Feb'13	95.9 Apr'12-Mar'13	99.2 May'12 - Apr'13	→		98.1 Jun'12 - May'13	→			98.1							
			Maternal Deaths			No.	0	0	0	→		0	→		0	0							
RB			Emergency Readmissions (CCS Diagnostic Groups) within 30 days - CQC definition - QUARTERLY	Following an initial Elective or Non-Elective Admission		%	→	8.92	→	→		→	→		9.05	9.05*							
				Following an initial Elective Admission		%	→	3.60 Oct'12 - Dec'12	→	→		→	→		3.59 Jan'13 - Mar'13	3.59*							
				Following an initial Non-Elective Admission		%	→	12.71	→	→		→	→		13.12	13.12*							
RB	K	3	Hip Fractures	Operation <24 hours of admission		%	51.4 ▼	72.0 ■	63.0 ■	→		85.7 ■	→		81.8 ▼	81.8*	81.0	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 ■	→		92 ▼	→		93 ■	93	90	90	>/=90	89.0-89.9	<89	●	95	93
		3		Maternity HES		%	6.9 ▼	6.6 ▲	6.8 ▼	→		6.7 ▲	→		7.1 ▼	6.8	<15	<15	=<15	16-30	>30	●	6.0	6.6
	D	3	Emergency Care Timeliness	Total Time in Department (95th centile)		h : m	5:07 ▲	4:39 ▲	4:56 ▼	→		4:34 ▲	→		5:05 ▼	5:02	=<4hrs	=<4hrs	=<4hrs		=<4hrs	● ●	3 : 59	5 : 15
	D			Time to Initial Assessment (=<15 mins)(95th centile)		mins	18 ■	18 ■	18 ■	→		16 ▲	→		16 ■	17	=<15	=<15	<15		<15	●	21	17
	D			Time to treatment in department (median)		mins	53 ▼	50 ▲	51 ▼	→		42 ▲	→		9 ▲	36	=<60	=<60	=<60		>60	●	59	58
	D		Emergency Care Patient Impact	Unplanned re-attendance rate		%	8.23 ▼	8.38 ▼	8.31 ▲	→		5.75 ▲	→		5.44 ▲	6.75	=<5.0	=<5.0	=<5.0		>5.0	● ●	8.66	7.81
	D			Left Department without being seen rate		%	4.02 ▲	4.03 ▼	4.73 ▼	→		3.35 ▲	→		3.44 ▼	3.66	=<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 ■	1	0	0	0		>0	●		
RB	H	18	Ambulance Turnaround	Clinical Handovers completed within 15 minutes		%	84.89 ▲	83.9 ▼	85.4 ■	82.1 ■	87.2 ▲	85.1 ▲	78.5 ▼	89.6 ▲	84.9 ■	84.9*	=>85	=>85	=>85		<85	●		71.3
	H			Average Turnaround Time		m : s	29:06 ▲	27:30 ▲	27:52 ▼	28:31 ▼	27:30 ▲	27:57 ▼	29:03 ▼	28:08 ▼	28:46 ▼	28:46*	=<30:00	=<30:00	=<30:00		>30:00	●	29:23	34:24
	H			30 - 60 minutes	All Journeys	No.	1404 ▲	1237 ▲	1376 ▼	591 ▲	742 ■	1333 ▲	579 ▲	722 ▲	1301 ▲	8110	0	0	0		0	● ● ●		22089
	H				Hospital Fines (WMAS report)	No.	424 ▲	238 ▲	294 ▼	150 ▲	102 ▲	252 ▲	88 ▲	35 ▲	123 ▲	1782	0	0	0		0	● ● ●		
	H			In Excess of 60 minutes	All Journeys	No.	56 ▲	23 ▲	24 ▼	18 ▼	14 ▲	32 ▼	27 ▼	23 ▼	50 ▼	275	0	0	0		0	● ● ●	1256	2354
	H				Hospital Fines (WMAS report)	No.	28 ▲	13 ▲	12 ▲	11 ▼	10 ▼	21 ▼	13 ▼	3 ▲	16 ▲	147	0	0	0		0	● ● ●		

SEPTEMBER 2013	PATIENT EXPERIENCE

Exec Lead	KPI Source	Data Source	Indicator			May	June	July	August			September			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	K	21	Reporting Times of Imaging Requests from Emergency Care - % **reported within 24 hours / next day**	Plain Radiography	%	100 ▲	99 ▼	99 ■	→		99 ■	→		98 ▼	98*	90	90	No variation		Any variation	●		99
	K			Ultrasound	%	100 ■	95 ▼	100 ▲	→		100 ■	→		100 ■	100*	90	90	No variation		Any variation	●		100
	K			MRI	%	88 ▲	90 ■	70 ■	→		84 ▲	→		65 ▼	65*	90	90	No variation		Any variation	● ●		84
	K			CT	%	99 ■	97 ▼	99 ▲	→		99 ■	→		99 ■	99*	90	90	No variation		Any variation	●		99
KD	F	14	Complaints	No. of Complaints Received formal and link)	No.	65	50	72	→		94	→		86	430	No. Only	No. Only					834	724
	K			No. of Active Complaints in the System (formal and link)	No.	302	336	272	→		254	→		238	238*	No. Only	No. Only						
	K			No. of First Formal Complaints received / 1000 episodes of care	No.		0.625	0.45	→		0.88	→		0.52	0.52*	No. Only	No. Only						
	K			No. of Days to acknowledge a formal or link complaint (% within 3 working days)	%	97 ■	78 ▼	94 ▲	→		97 ▲	→		76 ▼	76*	100	100	100		<100	●		
	K			No. of responses which have exceeded their original agreed response date (% of total active complaints)	%	28 ■	32 ▼	36 ▼	→		25 ▲	→		22 ▼	22*	0	0	0		>0	● ●		
	K			No. of responses sent out	No.	17	5	128	→		73	→		78	78*	No. Only	No. Only						
	K			Oldest' complaint currently in system	Days	197	155	165	→		147	→		150	150*	No. Only	No. Only						
RB		15	Elective Access Contact Centre	Number of Calls Received	No.	12188	11687	13089	→		11250	→		13181	74320	No. Only	No. Only					111793	150454
				Average Length of Queue	mins	0.23 ■	0.22 ▲	0.25 ▼	→		0.22 ▲	→		0.39	0.39*	<1.0	<1.0	<1.0	1.0-2.0	>2.0	●	0.21	0.25
				Maximum Length of Queue	mins	6.2 ▲	11.2 ▼	15.5 ■	→		17.2 ▼	→		17.3	17.3*	<6.0	<6.0	<6.0	6.0-12.0	>12.0	●	10.1	14.2
			Telephone Exchange	Number of Calls Received	No.	73866	65266	71422	→		67671	→		70460	360145	No. Only	No. Only					849502	901987
				Calls Answered	%	92.1	92.0	92.2	→		91.2	→		91.0	91.1	No. Only	No. Only					90.2	90.7
				Answered within 15 seconds	%	66.2	74.3	73.8	→		70.6	→		72.0	68.5	No. Only	No. Only					52.5	58.2
				Answered within 30 seconds	%	79.6	85.5	85.4	→		83.4	→		84.1	81.2	No. Only	No. Only					68.1	73.0
				Average Ring Time	Secs	17.1	12.3	12.3	→		13.8	→		12.9	12.9*	No. Only	No. Only					25	18
				Longest Ring Time	Secs	397	366	411	→		280	→		433	433*	No. Only	No. Only					718	349
RB		2	Patient Flow	Average Length of Stay	Days	3.8 ▼	3.4 ▲	3.5 ▼	4.3 ▼	2.9 ▲	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)	%	94.0 ▲	94.7 ▲	96.6 ▲	87.4 ▼	95.4 ▼	92.7 ▼	96.9 ▲	93.7 ▼	94.9 ▲	94.1	82.0	82.0	No Variation	0 - 5% Variation	>5% Variation	●	89.5	92.0
				Daycase Rate - All Procedures	%	82.4 ▼	82.5 ▲	82.5 ■	84.4 ▲	83.6 ▲	83.9 ▲	82.3 ▼	84.6 ▲	83.7 ▼	84.6	80.0	80.0	No Variation	0 - 5% Variation	>5% Variation	●	82.7	83.9
				Available Beds at Month End	No.	738	742	745	→		740	→		754	754*								
RB	H	2	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%	0.9 ■	0.6 ■	0.8 ■	0.6 ■	0.9 ■	0.8 ■	1.2 ■	1.5 ■	1.4 ■	0.8	<0.8	<0.8	<0.8	0.8 - 1.0	>1.0	●	0.6	0.7
	H			28 day breaches	No.	1 ▲	5 ▼	2 ▲	→		1 ▲	→		0 ■	13	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.	44 ▼	29 ▲	41 ▼	9 ■	27 ▼	36 ▲	21 ■	45 ▼	66 ▼	254	160	320	0-5% variation	5 - 15% variation	>15% variation	● ●	363	425
				Sitrep Declared Late Cancellations (Pts. >1 occasion)	No.	6 ▼	6 ■	2 ▲	3 ▼	6 ▼	9 ▼	3 ■	7 ▼	10 ▼	10*	0	0	No variation		Any variation	●		60
				Multiple Cancellations experienced by same patient (all cancellations)	%	12.5 ▲	17.3 ▼	12.1 ▲	→		18.6 ▼	→		13.6 ▲	13.6*	6.0	0.0	No variation		Any variation	● ●		13.6
				All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	%	5.8 ▲	6.0 ▼	5.8 ▲	→		5.3 ▲	→		5.6 ▼	5.6*	4.3	3.1	No variation		Any variation	●		6.2
RB		10	Cardiology	Primary Angioplasty – Door To Balloon Time (90 mins)	%	90.9 ▲	85.7 ▼	75.0 ■							83.1	=>80	=>80	=>80	75-79	<75	●	80.1	85.4
				Primary Angioplasty – Call To Balloon Time (150 mins)	%	100.0 ▲	92.3 ▼	88.9 ▼							89.1	=>80	=>80	=>80	75-79	<75	●	88.4	91.2
				Rapid Access Chest Pain	%	98.0 ■	100 ▲	98.4 ▼							98.3	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

Exec Lead	KPI Source	Data Source	Indicator			May	June	July	August			September			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	7010	6994	6948	→			→			6948*								
				Staff In Post (contracted)	wte	6549	6529	6491	→		6497	→			6497*								
				Staff In Post (headcount)	no.	7545	7521	7479	→		7485	→			7485*								
				Staff In Post - FTE / Headcount ratio	Ratio	1.15	1.15	1.15	→		1.15	→			1.15*								
				Potential Vacancies (All)	wte	461	464	457	→			→			457*								
				Potential Vacancies (Qualified Nursing)	wte	108	138	143	→			→			143*								
				Posts Advertised in Month (NHS Jobs)	wte	167	154	258	→		178	→			178*								
				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	51	61	69	→		281	→			527	No. Only	No. Only						1064
				Starters	wte	39	48	44	→		267	→			468	No. Only	No. Only						862
				Induction	%	100.0 ▲	95.45 ▼	76.0 ■	→			→			76.0*	100	100	=>85		<85			91.3
RB	K	7	Learning & Development	PDRs (12-month rolling)	No. (%)	5211 (70.3) ▲	5293 (71.5) ▲	5374 (72.9) ▲	→		5779 (78.8) ■	→		5887 (79.6) ▲	5887 (79.6)	7389 (100)	7389 (100)	0-15% variation	15 - 25% variation	>25% variation	● ●	5348	5127
RS	F	14		Medical Appraisal and Revalidation	%	78	77	81	→		81	→		81	81*	No. Only	No. Only						77
MS	K	3		Mandatory Training Compliance	%	88.2 ▲	88.6 ▲	87.9 ▼	→		86.4 ▼	→		86.1 ▼	86.1	100	100	=>95	90 - 95	<90	● ●	71.9	86.4
RB		7	Sickness Absence	Long Term (> 28 days)	%	2.79 ▼	2.60 ▲	2.62 ▼	→		2.75 ▼	→		2.75 ■	2.71	<2.15	<2.15	<2.15	2.15-2.50	>2.50		2.95	3.39
				Short Term (<28 days)	%	1.48 ▲	1.43 ▲	1.48 ▼	→		1.31 ▲	→		1.23 ▲	1.44	<1.00	<1.00	<1.00	1.00-1.25	>1.25		0.95	0.99
	D			Total	%	4.26 ▲	4.03 ▲	4.10 ▼	→		4.05 ▲	→		3.98 ▲	4.15	<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	%	76.8	74.7	76.8	→		78.0	→		75.9	75.8	No. Only	No. Only					87.2	82.9
				Nurse Bank Shifts covered	No.	5014 ▼	4642 ▲	4840 ▼	→		5432 ▼	→		5175 ▲	30020	23490	46980	0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	● ● ●	56396	60463
				Nurse Agency Shifts covered	No.	3009 ▼	1944 ▲	1842 ▲	→		1490 ▲	→		1479 ▲	12474	1915	3830	0 - 5% Variation	5 - 10% Variation	>10% Variation	● ● ●	6948	12874
				Agency Spend as % Employee Benefit Expenditure	%	4.28	2.60	3.70	→		3.27	→		3.84	3.84*								

SEPTEMBER 2013	ACTIVITY & CONTRACTUAL

Exec Lead	KPI Source	Data Source	Indicator			May	June	July	August			September			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.	791 ▼	748 ■	786 ■	→		640 ▼	→		726 ▲	4317	4968	10141	No Variation	0 - 2% Variation	>2% Variation		10610	9596
				Elective DC	No.	4246 ▼	4088 ▲	4495 ▼	→		3804 ▼	→		4062 ▲	25289	19693	40198	No Variation	0 - 2% Variation	>2% Variation		53685	52875
				Total Elective	No.	5037 ▼	4836 ▲	5281 ▼	→		4444 ▼	→		4788 ▲	29606	24661	50339	No Variation	0 - 2% Variation	>2% Variation	●	64295	62471
				Total Non-Elective	No.	4773 ▲	4567 ▼	4687 ▲	→		4537 ▲	→		4402 ▼	27296	29533	60931	No Variation	0 - 2% Variation	>2% Variation	●	55675	56982
			Outpatient Attendances	New	No.	14346 ▲	13784 ▲	16158 ▲	→		12948 ▼	→		14415 ▲	86311	74281	152466	No Variation	0 - 2% Variation	>2% Variation	●	159051	171540
				Review	No.	30945 ▼	30650 ▲	32671 ▼	→		29244 ▼	→		30313 ▲	190285	204752	410406	No Variation	0 - 2% Variation	>2% Variation	●	421494	382248
			Emergency Care Attendances	Type I (Sandwell & City Main Units)	No.	13305 ▼	12823 ▲	13510 ▲	5496 ▼	6684 ▼	12180 ▼	5443 ▼	6563 ▼	12006 ▼	76356	93662	184483	No Variation	0 - 2% Variation	>2% Variation	● ●	177201	171701
				Type II (BMEC)	No.	2224 ▼	2067 ▼	1786 ▼	→	2061 ▲	2061 ▲	→	2189 ▲	2189 ▲	12482	14370	28304	No Variation	0 - 2% Variation	>2% Variation	● ●	36362	26649
				All - Contracted plus Non-Contracted	No.	20945 ▲	17392 ▲	21401 ▲	8115 ▲	11768 ▲	19883 ▲	8161 ▲	11865 ▲	20026 ▲	122878	105120	207128						207128
		16	Community	Adult - Aggregation of 18 Individual Service Lines	No.	47015 ■	44725 ■	49577 ▼	→		46370 ▲	→			233248	228810	540982	No Variation	0 - 2% Variation	>2% Variation	●	493163	538147
				Children - Aggregation of 4 Individual Service Lines	No.	15496 ▼	15290 ■	16106 ▼	→		12147 ■	→			73640	69905	165757	No Variation	0 - 2% Variation	>2% Variation	●	143400	155412
		16	Contract	Improvement Notices	No.	0 ■	2 ■	0 ■	→		0 ■	→		0 ■	0*	0	0				●		
RB	C	2	Delayed Transfers of Care	Acute	%	3.2 ▼	2.7 ▲	2.7 ■	3.9 ■	3.5 ■	3.7 ■	3.5 ▲	4.3 ▼	3.9 ▼	3.3	<3.5	<3.5	<3.5	3.5 - 5.0	>5.0	●	5.2	2.9
				Pt's Social Care Delay	No.	15 ▼	9 ▲	5 ▲	6 ▼	3 ■	9 ▼	3 ▲	11 ■	14 ▼	14*	<18	<18	No Variation	0 - 10% Variation	>10% Variation		13	7
				Pt.'s NHS & NHS plus S.C. Delay	No.	9 ■	7 ▲	13 ■	7 ■	4 ■	11 ■	3 ■	4 ■	7 ■	7*	<10	<10	No Variation	0 - 10% Variation	>10% Variation		20	8
RB		2	Outpatient Efficiency	New : Review Rate	Ratio	2.16 ■	2.22 ▼	2.02 ▲	2.52 ■	2.16 ▼	2.26 ▼	2.24 ■	2.03 ▲	2.10 ▲	2.20	2.30	2.30	No Variation	0 - 5% Variation	>5% Variation	●	2.65	2.23
				DNA Rate - New Referrals	%	13.6 ▼	11.7 ▲	12.9 ▼	→		13.9 ▼	→		12.4 ▲	11.7	10.0	10.0	No variation		Any variation	● ●	11.8	11.3
				DNA Rate - Reviews	%	12.5 ▼	10.8 ▲	12.3 ▼	→		11.9 ▲	→		12.4 ▼	10.6	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:	**Q2 Annual Plan Monitoring update**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Mike Sharon, Director of Strategy and Organisational Development**
DATE OF MEETING:	**31 October 2013**

EXECUTIVE SUMMARY:

This report outlines progress against a list of actions included within the 13/14 annual plan, focusing on those that are currently delayed and the further action required to ensure completion. Q1 status has been included for comparison and to show progress/delay. Those actions that have been completed during Q2 and those that are 'on track' have not been included in the report in detail.

REPORT RECOMMENDATION:

Consider and discuss overall progress against delivery of the actions in the 2013/14 annual plan. Discuss key risks to delivery and planned actions for the next quarter.

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:

All annual plan actions are aligned to the Trust's strategic objectives.

PREVIOUS CONSIDERATION:

Routine quarterly update.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Annual Plan Monitoring 2013/14 – Q2 Report (October 2013)

1.0 Introduction

The Trust's internal Annual Plan (2013/14) was structured around the Trust's strategic objectives and informed by the NTDA annual planning process. Five key areas of focus emerged which underpin all developments and priorities for 2013/14.

This report outlines progress against a list of actions included within the 13/14 annual plan, focusing on those that are currently delayed and the further action required to ensure completion.

2.0 Overall progress

A number of actions have been completed in Q2 and there are currently 83 actions that have been rated as "progressing as planned" (RAG rating: 4). A large proportion of these actions fall under the annual priority: 'delivery of long term quality goals'.

3.0 Delayed actions

The table below groups together a number of actions that are currently facing delay. It shows the status of the action in Q1 compared with Q2. Some actions have now moved to 'progressing as planned', some have had no change, and one action has moved from 'some delay' to 'significant delay'. Each action is listed under a key theme and includes the reason for delay as well as necessary action required to meet the agreed deadline. There are currently 25 actions facing 'some delay' (RAG rating: 3) and 3 actions facing 'significant delay' (RAG rating: 2).

Total actions: 121

RAG	Description	Q1	Q2
5	**Action complete - no update required**	**9**	**9**
4	**Progressing as planned - no update required**	**79**	**83**
3	**Some delay but expect to be completed as planned - please complete columns H & I**	**30**	**25**
2	**Significant delay - unlikely to be completed as planned - please complete columns H & I**	**2**	**3**

[Type text]

1	**Action not yet due to start - no update required**	**1**	**1**

QUARTER 1 UPDATE (AUGUST 2013)				Q2 UPDATE (OCTOBER 2013)	
RAG	**Key theme**	**Reason for delay**	**Key actions required/deadline**	**RAG**	**Update**
4	**Safety Thermometer**			3	Clinical groups to operationalize best practice supported by speciality leads
3	**ED targets**	1. Clinical leadership and scale of change challenging on city site, particularly in ED and elderly care. 2. Recruitment progress. 3. No commitment from social services for 7 day working. Internally a 7 day capacity team, rapid response therapies and increased medical cover have been achieved.	1. Trajectory revised in August. Programme focussed to deliver in Q2/3. EIST assisting in elder people model. 2. Recruitment progressing including overseas recruitment. New CD will positively contribute to building a new team. 3. Escalation via CCG, LAT and social services executive.	3	1. Achieved 95% for Q2. However, performance has dipped in October. Review trajectory in Q3. Recruitment progressing. Programme focussed to deliver in Q2/3. EIST assisting in elder people model. Focus on achieving flow early in day and reducing delays in discharge. 3. Social service 7 day model due end October with additional interim assessment beds. Delay in commitment from social services - now determined to start in October 2013
3	**ED projects to facilitate improvement**	1. Ambulance assessment model pilot awaiting estates work at Sandwell to be completed in October.	1. Plan agreed and scheme approved for completion in October.	4	1. Await estates work at Sandwell to be completed in October.
3		2. Delay in establishing see & treat model at City due to lack of clinical buy in to implement and staffing.	2. New leadership appointed. Recruitment on track. To review change programme in Q2/3 for implementation.	3	2. Focus for Q3 with new Directorate leadership team.
3		3. Diagnostic symptom based bundles implemented. Initial audit showed areas for process improvement in the	3. Re-audit impact of improvements in September.	4	3. Re-audit monthly.

		labs and the ED.			
3		4. Innovative wireless communication systems for emergency MDT not prioritised in winter 2013 improvement plan. Work on handover and board rounds to improve communication on the shop floor in train.	4. Initiative to be reviewed with incoming Directorate leadership team.		4. Scheme not prioritised in winter 2013 improvement plan. Work on handover and board rounds to improve communication on the shop floor in train. Initiative to be reviewed with incoming Directorate leadership team.
3	**Readmission / re-attendance rates**	1. Readmission: delay in establishing a single detailed data set. MQUAC initially hosting work. 2. ED Re-attendance: Audit in Q1. Mental health project and evaluation of EPAU pathways identified as priority for review.	1. Task and Finish group now established with Clinical Directorates. Risk prediction tool in development. Ambulatory pathway programme in implementation phase. 2. Projects in train on both aspects. Re-audit in Q2.	3	1. Complex piece of work. Now has robust governance structure and work programme. Risk prediction tool in development. Ambulatory pathway programme in implementation phase. TSO project support identified. 2. Mental health pilot at Sandwell in Q3. Re-audit in October 2013.
3	**Waiting times**	Waiting times in at least 90% of specialities to be as good as neighbours: completion of 18 week validation will inform demand for this year for OP.	Benchmark to be completed in Q2.	3	No change
3	**MRSA screening targets**	Difficulty identifying denominator in some areas	Groups to either agree to screen all patients or to finalise denominator. Complete by end of August 2013.	4	Sustained improvement over several months is still required to meet the definitive target of 100% and maintain at this level.
3	**Community Risk Assessment (falls & pressure**	Delay in determining data collection & baseline.	Anticipate successful completion as agreed Q4.	3	No change

	ulcers)				
3	**Dementia strategy**	There has been a delay in finalising funding decisions which has impacted on delivery of year 1 of the Dementia Strategy and associated long term quality goals.	Recruiting team & establishing training resource. Expect to be on track to achieve standards & CQUIN.	3	Screening tool attached to admission documentation. Clinical groups /wards informed of performance target
3	**HIS upgrades/ replacements**	1. Upgrade to Data Centre: A location on the retained estate has been identified and planning is underway to develop a combined technical operations centres which will provide facilities for telecommunications and the computer room. 2. Digital dictation pilot has been delayed due to procurement. 3. Replacement of maternity system has been delayed due to supplier delay. 4. Procurement of Business Intelligence system has been delayed due to funding	1. Remedial work on the City computer room scheduled. Planning underway to relocate telecoms and the computer room to be developed under estate rationalisation. 2. Business case to be resubmitted for approval. Supplier identified. 3. The Trust has contingency within the plan and has re-scoped the initial pilot re-ordered the phasing of the plan optimise resource utilisation and mitigate the delay to the plan. 4. Funding has been identified by finance for the recruitment of a project management and technical resource.	3	No change
3	**Developing clinical strategies**	Original objective was to develop 10 further clinical strategies. This has changed to 5. PSC work is a higher priority.	Review of team priorities by September 2013.	2	Deferred due to MMH team commitments.
3	**Implementing redesigned**	Some delay in CCG evaluation of pilots, decisions on forward	Clinicians from CCG & SWBH to agree implementation process for Procedures of	3	No change

	care pathways & other QIPP schemes	commissioning approach and confirming approved list of Procedures of Limited Clinical Value (now approved & list circulated to Clinical Groups). Some delay in Clinical Groups identifying specific schemes to reduce outpatient follow up ratios.	Limited Clinical Value and present to JCCG on 12th Sept for approval – aim to implement from October. CCG have set up implementation groups for a number of redesigned pathways with SWBH representation – implementation dates agreed for some and to be confirmed for others in Sept. CCG PMO now established and will provide more detailed monitoring of implementation plans from Sept. Contract activity profile to be amended from Sept. to include QIPP reductions (in line with specific schemes where identified but reductions to be made pro-rata for remaining QIPP target).		
3	**New service models**	1. Digital First: delay in start of project. 2. Frail Elderly: project started. Good engagement by AHP, operational management and nursing staff. Poor engagement by medical staff. Screening tool developed and current service benchmarked.	1. Baseline will be determined by October. 2. Escalated to EIST who are supporting project in September.	3	No change
3	**Delivery of TSP**	Financial delivery behind forecast at month 4.	Replacement schemes will be determined to close gap.	4	
3	**SLM**	Development of the AAF (Accountability and Autonomy framework) proposes to subsume the SLM workstream. Part of workstream includes assessment of frontend dashboard suppliers and identification of technical solutions to populate this.	To be aligned to consultation phase of AAF which is to be published in late autumn with go-live from April 2014.	3	No change

		Technical and Finance group to concentrate on evaluation of same so that timelines brought back.			
3	**Reduction & revision of complaints**	1. Reduction in linked complaints: this is variable and complainant centred. 2. Review & revision of complaints handling: overdue complaints.	1. Part of the devolution plan is to offer more meetings in the first place which will have the effect of reducing link complaints. Devolution plan to go out to Corporate Directorates on 2nd September for consultation and Clinical Groups on 4th November. 2. This is all part of the devolution and these processes will shortly be out for consultation. This will be measured against the baseline at the end of the year.	3	1. Devolution plan distributed. 2. This is all part of the devolution and these processes have been mapped and are currently being shared with staff through training and then to the wider staff groups through a communications plan.
3	**Improve the recording of sickness/ absence**	Work to determine a single establishment count will be completed in August.	Publish results in September and manage data quality and returns through Clinical Groups.	3	Work to determine a single establishment count making progress and to be completed in October. Publish results in November and manage data quality and returns through Clinical Groups.
2	**Responding to complaints**	Improve the proportion of complaints responded to within set time limits: processes inefficient and some resource issues.	Employment of additional resources and devolution plan will aim to ensure time limits are met.	2	No change
2	**Sickness/ absence**	Objective to attain 10% better than national mean for sickness/absence rates for nurses & midwives has been affected by overall rise in sickness/absence in the Trust	Detailed action plan in place, monitored via the Workforce Operational Committee and Group performance reviews. Now starting to see a steady improvement in overall sickness levels and reductions in long term absence.	2	Detailed action plan in place, monitored via the Workforce Operational Committee and Group performance reviews.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Provider Management Regime Return
SPONSOR (EXECUTIVE DIRECTOR):	Mike Sharon, Director of Strategy & Organisational Development & Kam Dhami, Director of Governance
AUTHOR:	Mike Harding, Head of Performance Management & Simon Grainger-Payne, Trust Secretary
DATE OF MEETING:	31 October 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 September 2013 are as follows:

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

The Amber / Green (1.0) Governance Risk Rating for September is influenced by the Emergency Care 4-hour wait performance during the month of 94.74%.

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:

Routine monthly update

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

Organisational risk rating

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

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

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

Governance Declarations

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

Supporting detail is required where compliance cannot be confirmed.

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

Governance declaration 1

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

Signed by:		Print Name:	
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 :	TO BE ADDED	Print Name :	Toby Lewis
on behalf of the Trust Board	Acting in capacity as:		
Signed by :	TO BE ADDED	Print Name :	Richard Samuda
on behalf of the Trust Board	Acting in capacity as:		

If Declaration 2 has been signed:

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

Target/Standard:	
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

dwell & West Birmingham Hospitals NHS T

September 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	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Board Action
1	SHMI - latest data	Score	96.3	95.3	94.2	95.6	94.9	94.4	94.2	94.3	95.5	95.9	99.2	98.1	SHMI data relates to period June 2012 - May 2013 which is the most recent period for which data is available (source HED).
2	Venous Thromboembolism (VTE) Screening	%	91.5	91.7	90.2	91.5	91.0	86.1	90.8	92.5	95.3	95.9	94.4	95.1	
3a	Elective MRSA Screening	%	104.6	96.2	112.0	130.9	193.6	138.9	196.6	173.2	196.9	249.9	217.1	253.3	Data reported is screens not matched with patients. Screens matched to patients for the month is 89.5%.
3b	Non Elective MRSA Screening	%	66.0	78.6	78.4	80.7	82.3	76.8	79.2	82.2	81.3	84.1	87.1	87.9	Data reported is screens not matched with patients. Screens matched to patients for the month is 90.9%.
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	161	114	2	0	0	5	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	3	1	2	0	4	2	5	9	8	11	8	6	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	0	0	0	0	0	0	0	0	1	0	1	0	
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number	8	5	4	3	10	10	5	5	3	6	6	8	4 overdue open alerts. Spinal / Epidural needles remain a manufacturing problem. 1 MDA alert was closed on Oct 1.
9	RED rated areas on your maternity dashboard?	Number	2	4	4	2	2	3	2	3	1	2	2	2	September - Midwifery Staff Sickness Absence (5.1%) and Caesarean Delivery Rate (29.0%).
10	Falls resulting in severe injury or death	Number	0	2	2	1	2	2	3	2	5	0	0	1	
11	Grade 3 or 4 pressure ulcers	Number	1	1	6	1	2	2	2	1	1	1	1	0	There was 1 unavoidable Grade 3 pressure ulcer reported during September.
12	100% compliance with WHO surgical checklist	Y/N	No	No	No	No	No	No	No	No	No	No	No	No	Compliance was 99.6% in September (2968 records compliant of 2980 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	62	68	38	60	70	57	63	59	50	60	75	66	
14	Agency as a % of Employee Benefit Expenditure	%	2.3	2.45	2.91	2.62	4.57	6.41	4.29	4.28	2.6	3.71	3.27	3.84	
15	Sickness absence rate	%	4.51	4.47	4.58	4.86	4.42	4.55	4.36	4.01	3.94	3.99	3.97	3.98	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	83	87	86	88	81	77	77	78	77	81	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	No	No	
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	No	No	No	No	No	
3	Working capital facility (WCF) agreement includes default clause	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes	Yes	Yes	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	No	No	
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	No	No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	No	No	
8	Quarter end cash balance <10 days of operating expenses	No	No	No	No	No	No	No	
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	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	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	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	Yes	Yes	
			Patients dying at home / care home	50%		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	August 2013 performance confirmed from National Cancer Waiting Times system report. September performance projected.
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	August 2013 performance confirmed from National Cancer Waiting Times system report. September performance projected.
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	August 2013 performance confirmed from National Cancer Waiting Times system report. September performance projected.
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	August 2013 performance confirmed from National Cancer Waiting Times system report. September 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	No	Yes	Performance during September was 94.74%. Quarter 2 = 95.00%.
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3j	Category A call –emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0								
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	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	Yes	Yes	
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No	No	No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No	No	No	
			TOTAL			**2.0**	**1.0**	**1.0**	**1.0**	**0.0**	**1.0**	**0.0**	
						AR	AG	AG	AG	G	AG	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**	**1.0**	**0.0**	
			AR	AG	AG	AG	G	AG	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	Yes	Yes	
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	No	No	No	No	No	No	No	
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
5	Are there any disputes over the terms of the contract?	No	No	No	No	No	No	No	
6	Might the dispute require third party intervention or arbitration?	No	No	No	No	No	No	No	
7	Are the parties already in arbitration?	No	No	No	No	No	No	No	
8	Have any performance notices been issued?	Yes	Yes	Yes	No	No	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	Yes	Yes	

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

TFA Progress

Oct-13

Sandwell & West Birmingham Hospitals NHS Trust

Select the Performance from the drop-down list

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

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	

REF	LICENCING CONDITION	COMPLIANCE AS AT AUGUST 2013	REASONS FOR DECLARING NON-COMPLIANCE
IC1	*IC1 – Provision of integrated care*	Y	

Midland Metropolitan Hospital Status Report October 2013

Activities Last Period

- Ongoing work on work force challenge
- Continue development of new LTFM
- Design Refresh commenced
  - whole hospital layouts restacked
  - departmental bootcamps commenced
- Further engagement with DH /NHSTDA

Planned Next Period

- Achieve vacant possession of Grove Lane
- Progress Grove Lane site clearance plan
- Develop detailed plan for procurement phase
- Agree PF2 commercial documentation with HMT
- Develop plans for pre market engagement
- Agree final approval process
- Commence redraft of OBC refresh

Issues for Resolution/Risks for Next Period

Finalising revised design , revise procurement documents and feed revised capital costs into models

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:	**31 October 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

- LTFM further developed to include downside
- Board development plan confirmed, including programme of one-to-one coaching, Board observations and 360 appraisal of all voting Directors and advisory attendees
- Long term workforce plan developed
- BGAF and QGAF action plans refreshed

Planned Next Month

- Final cut detailed CIPs for 2014/15 & 2015/6 including evidence of QIAs
- External consultant to begin review of Groups' governance procedures
- Outcome of strategic communications review
- Commence redevelopment of IBP
- Commence refresh of Membership, Workforce and Clinical strategies

Issues for Resolution/Risks for Next Month

- 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 Performance Framework Monitoring Report and summary NHS FT Governance Risk Rating (FT Compliance Report)
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Mike Harding, Head of Performance Management and Chris Archer, Associate Director of Finance
DATE OF MEETING:	31 October 2013

EXECUTIVE SUMMARY:

NHS Performance Framework:

- Service Performance (September): - during the month there were 3 areas of underperformance; Emergency Care 4-hour waits (94.74%), Delayed Transfers of Care (3.90%) and Mixed Sex Accommodation Breaches (5 in total (0.04% of all FCEs within month)) and 1 area 'failing'; RTT Delivery in All Specialties (11 Treatment Functions in the month. The Trust is projected to attract an overall weighted score of 2.56 and as such a PERFORMING CLASSIFICATION for the month.

During Quarter 2 there was 1 area of underperformance; Mixed Sex Accommodation Breaches (0.01%) and 1 area 'failing': RTT Delivery in All Specialities (26 Treatment Functions). The Trust is projected to attract an overall weighted score of 2.70 – PERFORMING CLASSIFICATION.

- Financial Performance (September):

-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 remains **PERFORMING.**

Foundation Trust Compliance Summary Report (September):

Within the Service Performance element of the Risk Rating for the month of September, the Trust underperformed against the Emergency Care 4-hour wait target, but met the required thresholds for each of the other indicators which comprise the framework. The overall governance score for the month is 1.0, which attracts an **AMBER / GREEN** Governance Rating.

During the Quarter the Trust met the operational threshold for each indicator within the framework. The overall governance score was 0.0, with a **GREEN** Governance Rating.

(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. Performance in areas where no data are currently available is 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:

None

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	September 2013/14	Score	Weight x Score	Quarter 2 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	94.74%	2	2.00	95.00%	3	3.00
MRSA Bacteraemia	1.00	0		>1.0SD	1	0	0.00	0	3	3.00	0	3	3.00	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	4	3	3.00	12	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	92.3%	3	3.00	90.07%	3	3.00	91.6%	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	96.6%	3	3.00	95.13%	3	3.00	96.2%	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	92.2%	3	3.00	92.58%	3	3.00	92.5%	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	7	2	2.00	11	0	0.00	26	0	0.00
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	0.61%	3	3.00	0.42%	3	3.00	0.53%	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	95.5%	3	1.50	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 2 week GP Referral to 1st OP Appointment - breast symptoms	0.50	93.0%	88.00 - 93.00%	88.0%	94.8%	3	1.50	96.2%	3	1.50	96.6%	3	1.50	>93.0%*	3	1.50	>93.0%*	3	1.50
Cancer - 31 day diagnosis to treatment for all cancers	0.25	96.0%	91.00 - 96.00%	91.0%	98.3%	3	0.75	100.0%	3	0.75	100.0%	3	0.75	>96.0%*	3	0.75	>96.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (surgery)	0.25	94.0%	89.00 - 94.00%	89.0%	97.3%	3	0.75	100.0%	3	0.75	100.0%	3	0.75	>94.0%*	3	0.75	>94.0%*	3	0.75
Cancer - 31 day second or subsequent treatment (drug)	0.25	98.0%	93.00 - 98.00%	93.0%	100.0%	3	0.75	100.0%	3	0.75	100.0%	3	0.75	>98.0%*	3	0.75	>98.0%*	3	0.75
Cancer - 31 Day second/subsequent treat (radiotherapy)	0.25	94.0%	89.00 - 94.00%	89.0%	n/a		n/a	n/a		n/a	n/a		n/a	n/a		n/a	n/a		n/a
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	85.3%	3	1.50	>85.0%*	3	1.50	>85.0%*	3	1.50
Cancer - 62 day referral to treatment from screening	0.50	90.0%	85.00 - 90.00%	85.0%	100.0%	3	1.50	96.0%	3	1.50	100.0%	3	1.50	>90.0%*	3	1.50	>90.0%*	3	1.50
Delayed Transfers of Care	1.00	<3.5%	3.5 - 5.00%	>5.0%	3.00%	3	3.00	2.70%	3	3.00	3.70%	2	2.00	3.90%	2	2.00	3.41%	3	3.00
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	0.04%	2	2.00	0.01%	2	2.00
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	95.11%	3	3.00	95.40%	3	3.00
Sum (all weightings)	14.00																		
Average Score (Integrated Performance Measures)							2.42			2.64			2.85	* projected		2.56	* projected		2.70

CQC Registration Status

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

							Performing			Performing			Performing			Performing			Performing

Overall Quality of Service Rating

							Performing			Performing			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		
Criteria	**Metric**	**Weight (%)**		**3**	**2**	**1**	**July**	**Score**	**Weight x Score**	**August**	**Score**	**Weight x Score**	**September**	**Score**	**Weight x Score**
Initial Planning	Planned Outturn as a proportion of turnover	5	5	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	**0.00%**	**3**	**0.15**	**0.00%**	**3**	**0.15**	**0.00%**	**3**	**0.15**
Year to Date	YTD Operating Performance	25	20	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	**-0.04%**	**3**	**0.6**	**-8.90%**	**3**	**0.6**	**-8.00%**	**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.	**5.95%**	**3**	**0.15**	**6.00%**	**3**	**0.15**	**5.80%**	**3**	**0.15**
Forecast Outturn	Forecast Operating Performance	40	20	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	**0.00%**	**3**	**0.6**	**0.00%**	**3**	**0.6**	**0.00%**	**3**	**0.6**
	Forecast EBITDA		5	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	**6.00%**	**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**
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	**1.07%**	**3**	**0.15**	**1.10%**	**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	**6.00%**	**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	**87.00%**	**2**	**0.05**	**92.10%**	**2**	**0.05**	**94.40%**	**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	**87.00%**	**2**	**0.05**	**92.70%**	**2**	**0.05**	**93.10%**	**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	**1.06**	**3**	**0.15**	**1.10**	**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	**13.54**	**3**	**0.15**	**11.71**	**3**	**0.15**	**12.00**	**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	**39.03**	**2**	**0.1**	**13.22**	**3**	**0.15**	**13.00**	**3**	**0.15**
						Weighted Overall Score			**2.90**			**2.95**			**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