Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Committee Room, Rowley Regis Hospital **Date** 7 August 2014; 1330h

Members attending

Mr R Samuda	(RSM)	[Chairman]
Ms C Robinson	(CRO)	[Vice Chair]
Dr S Sahota OBE	(SS)	[Non-Executive Director]
Mrs G Hunjan	(GH)	[Non-Executive Director]
Ms O Dutton	(OD)	[Non-Executive Director]
Mr H Kang	(HK)	[Non-Executive Director]
Dr P Gill	(PG)	[Non-Executive Director]
Mr T Lewis	(TL)	[Chief Executive]
Mr C Ovington	(CO)	[Chief Nurse]
Miss R Barlow	(RB)	[Chief Operating Officer]
Mr T Waite	(TW)	[Director of Finance]

In attendance

Mr M Hoare	(MH)	[Non-Executive Director]
Miss K Dhami	(KD)	[Director of Governance]
Mrs C Rickards	(CR)	[Trust Convenor]
Mr N Trudgill	(NT)	[Associate Medical Director for Dr Stedman]

Guests

Patients for patient story & service presentation
Mrs R Williams

Secretariat

Mr S Grainger-Lloyd (SGL) [Trust Secretary]

Time	Item	Title	Reference Number	Lead
1330h	**1**	**Apologies**	**Verbal**	**SG-L**
	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**	**SG-L**
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 3 July 2014 a true and accurate records of discussions*	**SWBTB (7/14) 116**	**Chair**
	3.1	Children's mental health services	Verbal	RB
	4	**Update on actions arising from previous meetings**	**SWBTB (7/14) 116 (a)**	**SG-L**
	5	**Questions from members of the public**	**Verbal**	**Public**
1340h	**6**	**Patient story and iCares presentation**	**Presentation**	**CO**
1410h	**7**	**Chair's opening comments and Chief Executive's report**	**SWBTB (8/14) 118**	**RSM/ TL**
	MATTERS FOR DISCUSSION AND APPROVAL			
1420h	**8**	**Corporate integrated performance dashboard**	**SWBTB (8/14) 120** **SWBTB (8/14) 120 (a)**	**TW**
1430h	**9**	**System Resilience: elective and non-elective care planning an d performance update**	**SWBTB (8/14) 121** **SWBTB (8/14) 121 (a)**	**RB**
1445h	**10**	**Publication of safety measures on NHS Choices**	**SWBTB (8/14) 122** **SWBTB (8/14) 122 (a)**	**KD**

1450h	**11**	**CQC intelligent monitoring**	**SWBTB (8/14) 123** **SWBTB (8/14) 123 (a)**	**KD**
1455h	**12**	**Annual Plan 2014/15 monitoring report (Quarter 1)**	**SWBTB (8/14) 125** **SWBTB (8/14) 125 (a)**	**TW**
1500h	**13**	**Financial performance – Month 3**	**SWBTB (8/14) 126** **SWBTB (8/14) 126 (a)**	**TW**
1510h	**14**	**Trust Risk Register update**		
	14.1	Update on actions agreed at previous meetings	SWBTB (8/14) 127 SWBTB (8/14) 127 (a)	KD
	14.2	New considerations		
1520h	**15**	**Equalities plan**	**Presentation**	**TL**
1535h	**16**	**Infection control annual report**	**SWBTB (8/14) 128** **SWBTB (8/14) 128 (a)**	**CO**
		UPDATES FROM THE COMMITTEES		
1545h	**17**	**Update from the meeting of the Finance & Investment Committee on 25 July 2014 and minutes of the meeting held on 26 June 2014**	**SWBFI (6/14) 034**	**CR/ TW**
	18	**Update from the meeting of the Quality & Safety Committee held on 25 July 2014 and minutes of the meeting held on 30 May 2014**	**SWBQS (5/14) 044**	**GH/ CO**
	19	**Update from the meeting of the Audit & Risk Management Committee held on 31 July 2014 and minutes of the meeting held on 24 April 2014**	**SWBAR (4/14) 030** **SWBAR (6/14) 037**	**GH/ KD**
	20	**Any other business**	**Verbal**	**All**
		MATTERS FOR INFORMATION		
1600h	**21**	**Midland Metropolitan Hospital project: monitoring report**	**SWBTB (8/14) 130**	
	22	**Foundation Trust application programme: monitoring report**	**SWBTB (8/14) 131**	
	23	**Chief Inspector of Hospitals visit – preparation plan**	**SWBTB (8/14) 124** **SWBTB (8/14) 124 (a)**	
	24	**Nurse staffing levels**	**SWBTB (8/14) 132** **SWBTB (8/14) 132 (a)**	
	25	**Details of next meeting** *The next public Trust Board will be held on 4 September 2014 at **1330h** in the Anne Gibson Boardroom, City Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 3 July 2014

Present	In Attendance	Secretariat
Mr Richard Samuda [Chair]	Mr Mike Hoare	Mr Simon Grainger-Lloyd
Ms Clare Robinson	Miss Kam Dhami	
Dr Sarindar Sahota OBE	Mrs Chris Rickards	
Mrs Gianjeet Hunjan		
Mr Harjinder Kang	**Guests**	
Dr Paramjit Gill	Patient	
Ms Olwen Dutton	Ms R Wyatt	
Mr Toby Lewis	Mr K Singh	
Mr Tony Waite	Mrs J Malpass	
Mr Colin Ovington	Ms R Clarke	
Miss Rachel Barlow	Dr M Lewis	
Dr Roger Stedman	2 x members of the public	

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
No apologies were received.	
2 Declaration of Interests	
There were no further interests declared since the last meeting or in connection with any agenda item.	
3 Minutes of the previous meeting	**SWBTB (6/14) 096**
The minutes of the Trust Board meeting held on 5th June 2014 were presented for consideration and approval.	

4 Update on Actions arising from Previous Meetings	SWBTB (6/14) 096 (a)
The Board received the updated actions log. It was noted that there were no actions outstanding or requiring escalation to the Board for resolution.	
5 Questions from members of the public	**Verbal**
There were no questions.	
6 Patient story	**Presentation**
The Board listened to the experience of a patient of the Trust who had been treated on wards Newton 3 and Lyndon 3. He advised that he was particularly impressed with the care to improve his bowel function. The Board was also made aware that the staff who treated the patient had been very professional and compassionate. It was highlighted that a wet room on the wards could have improved his experience. Mr Ovington advised that this facility had now been installed. Miss Barlow asked what contributed to the positive atmosphere that the patient experienced. She was advised that the atmosphere was very inclusive and welcoming. It was agreed that the learning from these points should be taken back to the staff. Mr Lewis asked whether the patient found the access across the site was adequate given that he used a wheelchair. The patient advised that there was adequate access. Mr Ovington noted that access into the Anne Gibson Boardrooms had not been as good as expected however. The patient reported that although the reputation of Sandwell Hospital was not good in his experience, his personal episode of care had been pleasing. Miss Dhami asked what else could have improved the experience. The patient suggested that maintaining the professionalism of the staff was necessary. Sister Wyatt advised that the staff who had treated the patient were pleased that the patient was presenting the experience to the Board. The patient suggested that the opportunity should be taken where possible to visit the work of the FINCH team.	
7 Chair's opening comments and Chief Executive's report	**SWBTB (7/14) 098**
It was reported that a meeting had been held with the two chairs of the Mental Health Trusts with a view to engendering a productive relationship between the trusts. Mr Lewis advised that the Trust had been given access to the bank of staff held by the Mental Health trusts. It was also reported that these individuals would work in close proximity with the Accident & Emergency department. Thirdly, it was reported that the bed base for mental health patients would be arranged to ensure it was more appropriate. Miss Barlow advised that discussions with	

commissioners had been held to invest in mental health capacity for assessing patients. It was noted that there are very different arrangements in Sandwell to Birmingham and much work was being done to look at children's services. It was agreed that a further briefing would be provided at a later date when there was further work to report. It was noted that a meeting had been held with the Ambulance Trust, which had been constructive. The Chairman reported that he had attended a good session with vulnerable families and that in due course a follow up to this session would be organised. Mr Lewis reported that the homeless plans were now at contract stage and that the refurbishment of the greenhouses at the entrance to City Hospital was planned which would be central to a community project. It was reported that the discussions to address the delayed transfers of care had been positive. The Board was advised that the Hospaedia contract was due to terminate shortly and a separate WiFi network was being established which patients would be able to access in Autumn. Mr Lewis highlighted that performance against a number of key targets was poor at present during the first quarter and work was needed over the remaining months to address the position. The Chairman asked whether the Healthwatch visit report had been received. Mr Ovington was asked to establish the timeline for the provision of this report.	
ACTION: **Miss Barlow to provide an update on discussions regarding Children's mental health services at a forthcoming Board meeting** **ACTION:** **Mr Ovington to check on the timing for the receipt of the Healthwatch visit report**	
8 Never Event in Medicine & Emergency Care	**Presentation**
Dr Stedman referring to the recent Never Event, advised that a note had been circulated providing greater detail on the incident. He advised that the root cause was failure to follow the governance arrangements for the use of a new device, meaning that there was a failure to clarify the responsibilities in this respect at the time. Dr Lewis was welcomed to the meeting. He advised that the lines involved in the Never Event had been withdrawn formally and that access to these would be limited to those who had been adequately trained. Enhanced tracking procedures were reported to be being introduced, including the use of a checklist. It was highlighted that there were other procedures that had been carried out that would be assessed for the risk of a further incident. Dr Stedman advised that there were a number of areas where the checking process was robust but this was	

not the case in the current Never Event. Mr Kang asked whether the matter was device-related or a training issue. He was advised that the incident was primarily related to training and did not appear to be reflective of a failure in the device itself, however the MHRA had been notified of the case. Ms Robinson asked what measures were taken to ensure that there were no further patients who would present with the same issue. Dr Stedman advised that the patient records of those having the similar procedure were being reviewed. It was noted that the service was relatively new and the number of patients who may have had a line inserted through this was small. Dr Gill asked whether the procedure was elective or an emergency. Dr Stedman advised that the line had been inserted to facilitate early discharge, however the individual was being treated for an emergency situation. It was reported that there should be no need to insert these lines out of hours. The Chairman noted that there appeared to be a lack of process to roll out a new procedure into another part of the organisation. Dr Stedman advised that there was a process which was ultimately signed off by the Clinical Effectiveness Committee, however this had not been followed in this instance. It was noted that the matter highlighted a risk associated with inpatient bedside procedures which would need to be closely considered. Mr Kang asked why the technology that had been superseded had been used. Dr Stedman advised that it was a judgement call as to when equipment should be upgraded. Dr Lewis reported that the broader review of the bedside interventions would commence with establishing the scope of the procedures that may carry a risk. He added that the processes being put into place to address this incident could be translated to other procedures. Ms Robinson asked whether there was a national database which captured all Never Events that had occurred. Dr Stedman advised that at a recent event hosted by the Trust Development Authority, plans to establish the database were discussed. Miss Dhami advised that the information was captured centrally by the NRLSA, which would generate a patient safety alert to which the Trust would need to respond should there be a pattern of incidents, including Never Events. Dr Lewis was thanked for his attendance.	
ACTION: **Dr Stedman to oversee a review of the risks associated with bedside procedures, with specific reference to the possibility of a Never Event occurring** **ACTION:** **Dr Stedman to develop an approach to ensuring consent procedures are robust, including consequences that would be implemented in the case of non-compliance**	

ACTION: **Miss Dhami to establish a task and finish group to identify additional controls and sources of assurance around Never Event prevention** **ACTION:** **Miss Dhami to provide a further update on Never Event controls assurance at the next meeting**	
9 Never Event controls assurance	**SWBTB (7/14) 099** **SWBTB (7/14) 099 (a)**
Miss Dhami reminded the Board that the outcome of the first round of Never Events audits was received in September 2013, which provided a degree of assurance that the Never Events would not be repeated due to the controls in place. The Board was asked to note the updated summary of work needed to address any gaps in assurance that the controls were in place at a directorate level. It was noted that there were some gaps of significance at this level, which would be picked by the Patient Safety Committee. In terms of provision of information leaflets, where an assurance level of 1 was recorded, it was suggested that leaflets may be being disseminated, however this was not being documented on the consent form. Mr Lewis suggested that a three month timeframe should be set for a group to identify the outline the additional controls and assurances that would be put into place. Furthermore a six week timescale should be set to develop an approach to ensuring consent would be made robust, including the consequences that would be implemented should non-compliance be identified. He underlined that a zero tolerance approach would be taken to this matter. Dr Gill supported this approach based on his experience of seeing patients at his surgery. It was agreed that a further update on these plans would be presented to the Trust Board at its next meeting. Ms Dutton asked whether there were any other areas where there might be gaps in the processes in outpatient procedures similar to those identified for the Never Event. Dr Stedman advised that a contributory factor was failure to share information with the patient and the consent issue was specific and may relate to failure to document, however he agreed that the position was unacceptable. He highlighted all medical staff had been written to in respect of consent. Dr Sahota noted that there should be a stringent approach taken to completion of checklists where used. Mr Lewis agreed that there was a concern that there had been a failure to learn from Never Events across the Trust. Miss Dhami noted that work was starting in this respect, in that a number of specialities had volunteered for the audits following a Never Event in another area. Ms Robinson suggested that a risk register should have picked up the matter. It was agreed that the matter should be discussed further outside of the meeting.	
10 Corporate integrated dashboard	**SWBTB (7/14) 100** **SWBTB (7/14) 100 (a)**

Mr Waite reported that the performance against key targets in Quarter 1 was not acceptable overall. He highlighted that the RTT target was met at a Trustwide level, although this was not the case at a speciality level. The diagnostic waits target was reported to have been missed and the Emergency Care target was 93.2% for the month against a target of 95%. The position against the Single Sex Accommodation targets was reported to have improved.

In terms of performance against Cardiology targets, it was reported that there had been an improvement.

The CQUIN target for dementia was reported to have been missed and had therefore incurred a financial penalty of £65k.

The Chairman asked in terms of dementia, why the assessment performance was poor. Mr Ovington advised that this did not reflect any skills and training issues and that it was anticipated that this target would be met in subsequent quarters.

The bed moves after 10pm was noted to be linked to the bed moves during the day, which was reported to be challenging at present, with delayed transfers of care. The Board was advised that much work would be undertaken to reduce the number of moves overall.

Mr Kang noted that in terms of the data quality score, the four hour waiting time performance appeared to have a low level of confidence. Mr Waite reported that the GP deflect numbers associated with the Malling Healthcare provision had been included in the position previously, however the data had now been excluded and therefore a reassessment of the degree of confidence of the information was needed. It was noted that the thresholds in the report were to be reviewed by the Executive to ensure that these were aligned to the Trust's ambitions, such as turnover.

Mrs Hunjan asked whether many patients required 'specialling'. It was agreed that this matter would be covered later on the agenda as part of a discussion around temporary staffing.

Ms Robinson noted that sickness absence was deteriorating and asked whether a trajectory for improvement would be set. Mr Lewis advised that the long term sickness position had improved, however there was a spike for less lengthy sickness absence. He added that short term sickness was associated with 50 areas predominantly and a trajectory for reaching an acceptable level would be set in readiness for review at the next meeting of the Workforce & OD Committee. Ms Robinson asked what the difference would be with previous plans to improve performance and was advised that the current focus moved from long term sickness to shorter term sickness. Mr Lewis advised that there were Executive committees that provided a focus on this and that the new television screen displays would publish the poorest areas. Mr Kang underlined the need to focus closely on the small cohort of areas where sickness absence was poorest. A clear focus was reported to be being directed to reviewing sickness absence on a Monday. It was highlighted that there was a link between poor sickness absence and troubling leadership. Mr Lewis highlighted the link to the bank and agency

controls, where the restrictions to covering sickness absences were anticipated to be addressed.	
10.1 Plan for remedying constitutional deviations	**Verbal**
Miss Barlow advised that a zero tolerance approach was being taken to single sex accommodation breaches and spot audits were being undertaken to confirm compliance. In terms of diagnostic waiting time target, it was highlighted that this reflected issues with cardiac echo which would be cleared, however the main areas of concern were highlighted to be endoscopy suites, where this was partly due to revised capacity but also to a change in pathways such as cancer. The Board was advised that practice would change to address this position and gain a tighter grip. Mr Hoare left the meeting.	
10.2 18 weeks RTT position and plans to improve	**SWBTB (7/14) 101** **SWBTB (7/14) 101 (a)**
Miss Barlow reported that the performance against the 18 weeks RTT position was improving although the performance at a speciality continued to remain unacceptable. It was highlighted that the long waiting time cases had been validated and it had been established that there had been no harm caused. The Board was advised that a national mandate had been received which required the elimination of backlogs over the summer holiday period and therefore the Trust's original plan would be accelerated. An increase in referrals was noted to be influencing the position in some cases. It was noted that flow was being addressed for all elective care, which included diagnostic interventions. The Chairman asked how the funding aligned to this. Miss Barlow advised that an allocation was to be received for backlog clearance and some winter monies were also expected. Ms Robinson suggested that the funds should be ringfenced and that effort should be directed to applying the funds appropriately. Mr Lewis advised that there would be no specific of allocation of funding on a consultant basis. Dr Gill noted that there was a possibility of patients going elsewhere should they have to wait excessively for diagnostic procedures.	
10.3 Emergency Care recovery plan	**SWBTB (7/14) 102** **SWBTB (7/14) 102 (a)**
Miss Barlow highlighted that a recovery plan to meet the Emergency Care target had been prepared. It was reported that a performance of 94.16% had been achieved during the last quarter which was behind the desired position. The various measures to generate an improvement were outlined and the priority supporting areas such as mental health and social care assistance for delayed transfers of care had been reviewed. It was noted that much progress had been	

made in the recent weeks in this respect, led by the Community and Therapies Group. Ms Robinson asked how the intermediate care beds outside of the control of the Trust were being handled and influencing the movement on from these as expeditiously as possible. Miss Barlow advised that occupation of all intermediate care beds were reviewed and the review process was at several points over the day. The intermediate care pathway was reported to be being given good focus with partners. It was also reported that the opportunities to open social care funded beds were being investigated. Dr Sahota asked what the overall volume of admissions was at present particularly out of hours. Miss Barlow advised that patients should call '111' to get a GP appointment and work was underway with GPs to ensure that they were booked in appropriately.	
10.4 CQC Intelligent Monitoring	**Verbal**
It was agreed that this matter would be deferred to the next meeting to allow more time for discussion of subsequent items.	
10.5 Publication of patient safety on NHS Choices	**SWBTB (7/14) 103** **SWBTB (7/14) 103 (a)**
It was agreed that this matter would be deferred to the next meeting to allow more time for discussion of subsequent items.	
11 Financial performance – Month 2	**SWBTB (7/14) 104** **SWBTB (7/14) 104 (a)**
Mr Waite reported that the Trust was behind the financial plan at present, mainly due to pay costs being above plan and a shortfall against the delivery of the Transformation Savings Plan. Capital expenditure was reported to be below plan, however a monthly process for managing and monitoring capital spend was noted to be in place. The cash position was noted to have recovered as anticipated. Ms Dutton left the meeting. Ms Robinson noted that the report had been reviewed at the recent meeting of the Finance & Investment Committee and there had been a concern around payments associated with bank and agency spend, the trajectory for reducing this being considered at the next meeting. It was also reported that work would be undertaken to review spending on 'specialling' and to understand the year end position should the current influences continue to be brought to bear. The Board was advised that there needed to be a clear focus on transformation and delivery of the cost savings work.	

11.1 Two year financial view	Presentation
Mr Waite delivered a presentation on the current financial challenge and the progress being made to address the position. It was noted that the financial position was recoverable. It was noted that the route for delivering a solution to the current financial position was threefold: finalising delivery of the £13m savings plan and resolving the £7m part year effect gap; financial control to avoid overspending; and creating a firm route to achieving the £46m savings plan over two years. It was noted at present that the actual savings plan was short of that set out in the budget. The additional measures to increasing the £13m of plans to £16m were discussed, a number of which it was noted had originated from the Executive. The austerity controls for waiting list initiatives and agency & bank staff usage were outlined. Stationery rationalisation was reported to have introduced. Reserves and contingencies were reviewed, in addition to the resilience funding and the impact of an incentive scheme. The Chairman asked for an update on the use of external resources. Miss Barlow advised that much work continued to establish local PMOs alongside the Change Team. It was noted that training of staff by the external consultants had been undertaken and some handover work had started. Mr Kang noted the importance of the engagement of staff. Mr Waite advised that the Clinical Leadership Executive had been closely engaged with the work and the use of some of the tools available were being used to good effect. Mr Lewis advised that there was a difference in the view of middle management vs. front line staff on the financial position, however there was a need to provide the route to the solution to make it clear that the task was possible. He added that the austerity measures were challenging to 'sell' to the organisation. Ms Robinson expressed her concern over the level of activity being undertaken by the Executive and encouraged additional resources be engaged to maintain the momentum if needed. Mr Lewis advised that external resources were being retained selectively and additional resources were being targeted at improving performance. It was noted that the non-recurrent reserve was available to fund additional resources should this be needed.	
12 Trust risk register update	
12.1 Update on actions agreed at the last meeting	**SWBTB (7/14) 105** **SWBTB (7/14) 105 (a)**
It was agreed that the timeline for the resolution of the risks discussed at the last meeting needed to be presented at the next meeting.	

12.2 New considerations	
Miss Dhami presented the updated version of the Trust Risk Register, highlighting that the acute oncology risk had been separated into three distinct risks. It was reported that there had been a request from the Women and Child Health Group to add in a risk around the lack of a second onsite obstetrics team out of hours. It was reported that there was further consideration of the risk scores and that further work was needed at the Risk Management Committee to understand the risk and that as an initial view, it appeared that the Trust was not an outlier by having only one maternity theatre team.	
13 Five year plan	**SWBTB (7/14) 106** **SWBTB (7/14) 106 (a)**
It was agreed that the five year plan summary would be considered in private.	
14 Nurse staffing levels	**SWBTB (7/14) 107** **SWBTB (7/14) 107 (a)**
Mr Ovington presented an overview of nurse staffing, including the use of 'specialling' and agency usage. The benchmarked information for other trusts was reviewed, which showed that the fill rate for shifts was higher than peers, with some fill rates being in excess of 100%. It was reported that this would be presented and published on a monthly basis. Ward by ward information was reviewed. It was noted that the neonatal unit showed the widest deficit on the data collection, however the position was reported to be being closely monitored and efforts directed into filling any vacancies. The Board was advised that controls had been put into place to ensure that all agency staff requests needed to be risk assessed and approved by the Chief Nurse. It was noted that the use of Thornbury nurses had reduced from 8% to 3%. Mr Lewis noted that there would be a lag between the reduction in the number of shifts and the cost reduction. Mr Ovington also reported that work was also being undertaken to mandate claims for shifts being submitted in a timely way. Mrs Hunjan noted that during a recent Patient Safety Walkabout staff had expressed concerns about poor cover for 'specialling' on the nightshift. Ms Robinson noted that forward requests for cover might impact on the position as the costs for these would not be realised immediately. Mr Ovington explained that there was a degree of flexibility in nurse establishments which should cope with annual leave commitments, however bank staff might be used in this case which incurred a lower cost. It was agreed that at a future informal session, the various data sources for nurse staffing needed to be presented.	
ACTION: Mr Ovington to present the various data sources for nurse staffing at a future meeting	

15 Annual report on the implementation of medical appraisal	**SWBTB (7/14) 108** **SWBTB (7/14) 108 (a) - SWBTB (7/14) 108 (e)**
Dr Stedman reported that the update on medical revalidation had been presented to the Workforce & OD Committee. The Board approved the signing of the statement of compliance for the annual revalidation. It was suggested that thanks be expressed to the medical staffing team for the work on behalf of the chairman.	
ACTION: Mr Grainger-Lloyd to arrange for a letter of thanks to be issued to the medical staffing team for their work on revalidation	
16 Service update – Anticoagulation	**Presentation**
Ms Malpass and Ms Clarke joined the meeting to present an overview of the anticoagulation service. Dr Gill noted that new NICE guidelines might generate an additional expense as a result of the more expensive medication. He was advised that warfarin would be prescribed firstly and the new drugs be offered when appropriate. It was highlighted that the use of SMS messaging was productive in the operation of the area. Dr Stedman asked whether there had been a cost effectiveness assessment of the use of the new drugs and was advised that they were cost effective for some patients. Mr Kang noted the tension provided by the costs argument in the Pharmaceutical industry. He asked how it was decided as to who was entitled to a home visit by the anticoalgulation team. Ms Malpass advised that there was clear guidance as to who was entitled to a home visit in the same way that patient transport was awarded. The work to link in with other specialities and exploit new technology was discussed. Ms Malpass and Ms Clarke were thanked for their presentation.	
17 Update from the meeting of Configuration Committee held on 27 June 2014 and minutes from the meeting held on 25 April 2014	**SWBCC (4/14) 019**
The Chairman presented an overview of the key discussions from the Configuration Committee held on 27 June 2014.	
18 Update from the meeting of the Finance & Investment Committee held on 26 June 2014 and minutes from the meeting held on 30 May 2014	**SWBFI (5/14) 031**

Ms Robinson presented an overview of the key discussions from the Finance & Investment Committee held on 26 June 2014.	
19 Update from the meeting of the Workforce & Organisational Development Committee held on 27 June 2014 and minutes from the meeting held on 28 March 2014	**SWBWO (3/14) 044**
Mr Kang presented an overview of the key discussions from the Workforce & Organisational Committee held on 27 June 2014. It was highlighted that CRB checking and the revisions to mandatory training had been major considerations for the Committee.	
20 Any Other Business	**Verbal**
Dr Sahota reported that a meeting of the Charitable Funds Committee had occurred earlier that day and summarised that there had been a recommendation that the risk profile of the portfolio be changed from low/medium to moderate risk. A major item was reported to have been the consideration of a new bidding process which would be launched in the autumn.	
Matters for Information	
The Board received the following for information: • Midland Metropolitan Hospital Project: Monitoring Report • Foundation Trust Application Programme: Monitoring Report • Annual Plan 2014/15 monitoring template	**SWBTB (7/14) 109** **SWBTB (7/14) 110** **SWBTB (7/14) 111**
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 7th August 2014 and would be held in the Committee Room, Rowley Regis Hospital.	

Signed: …….

Name: ……………………………………………………………….

Date: ………………………………………………………………

Next Meeting: 7 August 2014, Committee Room @ Rowley Regis Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

3 July 2014, Anne Gibson Boardroom @ City Hospital

Members present: Mr R Samuda (RSM), Ms C Robinson (CR), Dr S Sahota (SS), Mrs G Hunjan (GH), Mr H Kang (HK), Dr Paramjit Gill (PG), Ms O Dutton (OD), Mr T Lewis (TL), Miss R Barlow (RB), Mr T Waite (TW), Dr R Stedman (RST), Mr C Ovington (CO)

In Attendance: Miss K Dhami (KD)

Apologies: None

Secretariat: Mr Simon Grainger-Lloyd (SGL)

Last Updated: 4 July 2014

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.288	Questions from members of the public	Verbal	05-Jun-14	Introduce a contact point into patient letters that may be accessed should there be a need to raise any inaccuracies	RB	31/07/14	Contact point agreed to be direct to consultant or lead health care professional with a standard Trust narrative to be included in leters : 'If any information in this letter is unclear or incorrect, please feel free to contact me on the above number ' (add secretaries / departmental contact number to all letters) . This will be completed in August.	Y
SWBTBACT.278	Complaints handling KPIs	SWBTB (4/14) 049 SWBTB (4/14) 049 (a)	03-Apr-14	Provide an update on performance against the Complaints handling KPIs at a future meeting	KD	31/08/14	ACTION NOT YET DUE Update to Quality & Safety Committee arranged for August 2014	G
SWBTBACT.289	Chair's opening comments and Chief Executive's report	SWBTB (6/14) 075	05-Jun-14	Arrange for the Board to be appraised of the Trust's capacity to handle patients with learning difficulties at a future meeting	SGL	04/09/14	ACTION NOT YET DUE	G
SWBTBACT.290	Chair's opening comments and Chief Executive's report	SWBTB (6/14) 075	05-Jun-14	Present the revised research & development strategy to the Board in October	RST	02/10/14	ACTION NOT YET DUE	G
SWBTBACT.296	Trust risk register update	SWBTB (6/14) 085 SWBTB (6/14) 085 (a) - SWBTB (6/14) 085 ©	05-Jun-14	Investigate what financial solution was available to addressing the Paediatrics HDU risk in August	CO	03/07/14	Included as part of the discusion of the Trust Risk Register at the August meeting	G
SWBTBACT.297	Trust risk register update	SWBTB (6/14) 085 SWBTB (6/14) 085 (a) - SWBTB (6/14) 085 ©	05-Jun-14	Investigate and report back on the solutions available to addressing the acute oncology risks	RB	03/07/14	Included as part of the discusion of the Trust Risk Register at the August meeting	G

SWBTBACT.298	Chair's opening comments and CEO update	SWBTB (7/14) 098	03-Jul-14	Provide an update on discussions regarding Children's mental health services at a forthcoming Board meeting	RB	07/08/14	Included as a verbal update on the agenda of the August 14 meeting	G
SWBTBACT.300	Chair's opening comments and CEO update	SWBTB (7/14) 098	03-Jul-14	Check on the timing for the receipt of the Healthwatch visit report	CO	11/07/14	Still in production	G
SWBTBACT.301	Never Event in Medicine & Emergency Care	Presentation	03-Jul-14	Oversee a review of the risks associated with bedside procedures, with specific reference to the possibility of a Never Event	RST	30/09/14	ACTION NOT YET DUE	G
SWBTBACT.302	Never Events controls assurance	SWBTB (7/14) 099 SWBTB (7/14) 099 (a)	03-Jul-14	Develop an approach to ensuring consent procedures are robust, including consequences that would be implemented in the case of non-compliance	RST	15/08/14	Included as an update on the agenda of the August 14 meeting	G
SWBTBACT.303	Never Events controls assurance	SWBTB (7/14) 099 SWBTB (7/14) 099 (a)	03-Jul-14	Establish a task and finish group to identify additional controls and sources of assurance around Never Event prevention	KD	01/10/14	ACTION NOT YET DUE	G
SWBTBACT.304	Never Events controls assurance	SWBTB (7/14) 099 SWBTB (7/14) 099 (a)	03-Jul-14	Present a further update on Never Event controls assurance at the next meeting	KD	07/08/14	Included as an update on the agenda of the August 14 meeting	G
SWBTBACT.305	CQC Intelligent monitoring	Verbal	03-Jul-14	Present a further update on the recent outcome of the CQC intelligent monitoring at the next meeting	KD	07/08/14	Included as an update on the agenda of the August 14 meeting	G
SWBTBACT.306	Publication of patient safety on NHS Choices	SWBTB (7/14) 103 SWBTB (7/14) 103 (a)	03-Jul-14	Present the patient safety on NHS Choices information at the next meeting	KD	07/08/14	Included as an update on the agenda of the August 14 meeting	G
SWBTBACT.307	Nurse staffing levels	SWBTB (7/14) 107 SWBTB (7/14) 107 (a)	03-Jul-14	Present the various data sources for nurse staffing at a future Board informal session	CO	15/08/2014	Scheduled for the August informal session	G
SWBTBACT.277	Complaints handling KPIs	SWBTB (4/14) 049 SWBTB (4/14) 049 (a)	03-Apr-14	Provide an update on the measures to address the issues highlighted in the patient story at a future meeting	CO	13/06/14	Included on the agenda of the private session on 3 July 2014	B
SWBTBACT.308	Annual report on the implementation of medical appraisal	SWBTB (7/14) 108 SWBTB (7/14) 108 (a) - SWBTB (7/14) 108 (e)	03-Jul-14	Write to the Medical Staffing team to thank them for the work on revalidation	RSM	11/07/2014	Letters written to P Andrew, L Randall and S Kannan	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

CHIEF EXECUTIVE'S REPORT

Report to the Public Trust Board – August 2014

A third of the way through the public service year, our agenda as a Board is now a repetitive one. Inevitably therefore the papers for the public meeting that we are holding at Rowley Regis for the first time have an air of similarity to prior sessions. The need to 'grind out' improvements in waiting times (now called System Resilience), to ensure an improvement – safely - in expenditure reduction, and to make sure that our Never Event controls have the traction we would expect. In that circumstance of implementation emphasis and re-emphasis it becomes even more important that we look at a very local level at progress and at a local level at patterns of difficulty. A Trust level figure or position will not convey the mixture of reality that we need to face. That local emphasis also allows us to see the relatively narrow parts of the Trust's work covered by these three features, and ensure that our focus does not obscure the wider issues that might impact on parts of the Trust less visible through these measures.

Of course, this is our first meeting since the Chancellor visited Rowley Regis to convey the long waited news about the Midland Met. It is also our first meeting since we achieved the top rating from the CQC in their latest Intelligent Monitoring report, together with confirmation that we will be inspected across community and acute services in October 2014 – using their revised model, which is, as we have discussed, an explicitly local one.

I am delighted that in August we launch our Ten Out of Ten campaign to ensure that we improve basic care standards consistently across our inpatient services. As promised to our members at our Quality Events earlier in the year, we will report back on that work at the AGM in late September. In September, we begin a new channel for communication internally, with our open staff meetings across our sites. With such much going on these are, as much as anything, a way of trying to 'join up' initiatives and agendas. We know, from informal feedback, but also first Friday and Your Voice, that sometimes the delivery of our annual plan can appear a disparate set of tasks, where we know we can get synergy if we succeed in simultaneously implementing different projects for improvement.

1. Our patients

We met last month in light of the Never Event that took place in late 2013/14. Some progress has been made since in creating the architecture for tracking change that we agreed. I established a deadline of mid-August for us to have a less discretionary approach to before-the-day consent initiation. It is clear we will need to take until mid-month to be sure how we embed these changes, albeit it is understood within our clinical teams that a change in practice is now overdue and will be required. Completion of work to audit the care of others under the OPAT pathway who may have received guide-wire insertion is ongoing.

Last month also saw significant debate on emergency care delivery. After all-site achievement in April for the first time in two years, May and June saw poor performance. Last week we broke the cycle of eleven weeks of below 95% performance. At the time of writing we are above standard for

the week to date. There is some lessoning of external pressure in our system both at the front and back door, and renewed attention to detail in managing our flow – with better fill rates for A&E medical staffing being a key factor in improvement at City. Having missed the standard in Q1 and being below plan in Q2, we need to continue both that focus and improvement, and the signed off recovery plan requires further improvement this winter, just as necessarily have to stand down beds in our system to meet our financial obligations.

Positive discussions continue with partners on two important pieces of work, reflected in the COO's papers to today's Board:

- The launch of the new arrangement for integrated working with social care. These start in August, albeit preparation is a work in progress over the coming three months. Of particular note is the apparent resolution of very longstanding (four years +) IT issues between the Trust and Local Authority, which now appear resolved. This opens up considerable smoothing of joint working to which we are all committed.

- The disposition of the so-called 'winter' funds across the SWB system which will be focused in four areas – bed stock, A&E staffing, mental health and re-ablement. These are of course non-recurrent revenue funds, and as such we need to ensure that they are used to pump prime ideas or to fund functions that reflect winter pressure, or we become reliant upon them for core service.

2. Our staff

The announcement about the Midland Met is a crucial one for everyone working within the Trust. Naturally, for many people it was inevitable that the case would prevail. Nonetheless, the approval is the very first time that we have had had this endorsement, complete with taxpayer investment. The scheme has proceeded to advert at PQQ stage and a draft ITPD has been issued to the market. During the next six months the specifics of the design will be finalised and within that any remaining contention about the clinical flow of the Trust's estate will need to be resolved. Consistent with discussions within our Board, we are progressing interim discussions regarding cardiology and surgery in advance of 2018. The CCG have asked us for confirmation about any other site change proposals that might be under consideration beyond that and we will govern through our CLE-MMH committee whether any other cases have overwhelming merit given the fixed nature of the 2018 timeline to which we are all now working. Although there will doubtless be a longer list of proposed reconfigurations, we will set a very high bar indeed for the change case, consistent with no or very limited capital expenditure in redundant estate.

The key construction associated with the Midland Met is the team-building work that we will need to do to make the programme a success. This has been emphasised in internal discussion since the announcement on July 14th. The existing Leadership Programme and other changes will facilitate the skills required to develop those single teams, as will our work on workforce re-design and on technology. With Raj Bhamber starting as our director of organisational development in September, she will take the lead in ensuring not that we have activity in this regard, but that it is sufficient to drive success in four years. The Board's Workforce Committee will oversee that effort as part of the 1400 wte re-sizing of our workforce that is the long term plan for the Trust and from which the team development work cannot be divorced.

We have determined to retain training investment, even at these difficult times in NHS finance. Indeed we added 50% to the budget for 2014-15. I am pleased to confirm sign off of the plans for those investments. This will be overseen through the Education Committee of CLE.

3. Our partners

Discussions continue about the local Better Care Fund arrangements. Nationally, deadlines continue to see some adjustment. However, the Trust remains actively involved in the proposals and in particular in ensuring no double-counting of assumptions across provider and commissioner plans. The longstanding Right Care, Right Here partnership creates a mechanism through which this can be achieved perhaps more straightforwardly than in other geographies and the SWBCCG continue to maintain a clear view that a separate section 75 agreement will be required from West Birmingham distinct from other parts of the city. This will assist all involved in ensuring that the specific needs of the local population are supported, albeit where appropriate within a wider framework of consistent service provision.

The Trust remains very active in both Local Authority geographies in respect of child protection. It remains the case that there is considerable further work to do to join up and focus services on the most vulnerable, whilst ensuring early help is available to less high risk cases. Our concern remains that budgetary constraints on LA budgets drive an expectation of NHS funding over lower risk cases. The budgetary disciplines of personal budgets whilst helpful in many respects may have the unintended consequence of unpicking historic risk sharing arrangements for joint service provision. We need to ensure that those risks are understood and managed locally, perhaps especially in Sandwell where our Trust has a more extensive role in community delivery.

4. Our regulators

We continue to have productive discussions with the TDA about the Trust's performance. It is encouraging that we will be able to (re) comply from August with the diagnostic standard and that we have, broadly, reached agreement about the 18 week trajectory for the local health system. We will work through with our regulators:

- How best to govern the conditions associated with Midland Met, including but not limited to the IT case which we need to pass to the TDA in January to maintain timeline. The leadership transition from Fiona Sanders to Alison Dailly will need to be carefully managed, as it occurs at a key stage in Q3. Meanwhile, the financial appraisal merits review with our FIC early in Q3.
- How to ensure that collective financial obligations and forward financial risk are managed and considered in proportion to the costs of programme delay. The approval conditions on Midland Met financially are broadly pass/fail and are consistent with our LTFM, as well as the CCG's five year plan. We will explore the governance of that at the future RCRH Partnership Board, which restarts its work in mid-August.

Toby Lewis
Chief Executive
1 August 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Integrated Performance Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite, Director of Finance and Performance Management**
AUTHOR:	**Gary Smith, Acting Head of Performance Management**
DATE OF MEETING:	**7 August 2014**

EXECUTIVE SUMMARY:

This report is to inform the Board of the summary performance of the Trust for the period June 2014.

REPORT RECOMMENDATION:

The Board members are asked to consider the content of this 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 good value for money.

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals
NHS Trust

Integrated Quality and Performance Report

June 2014

Contents

At A Glance

Infection Control

The number of cases of C Diff reported during the month was 2, one in D15 and one in Priory 2. Both monthly and year to date cases remain within the trajectories for the respective periods. There were no cases of MRSA Bacteraemia reported during the month. The incidence of MSSA and E. Coli, both expressed per 100,000 bed days are within TDA identified operational thresholds.

MRSA Screening for Elective and Non-Elective patients is reported as 89% and 93% respectively for the month.

Harm Free Care

All Groups met each of the 3 components reported for the WHO Surgical Checklist, with Trust performance for all elements continuing to exceed operational thresholds.

There were 7 Open CAS Alerts reported, 1 of which was overdue at the end of the reporting period (June).

VTE Assessment performance continues to exceed the 95.0% operational threshold, with many Clinical Directorates near to 100%.

Obstetrics

The overall Caesarean Section rate for June is 27.98% remaing above 25.0% for the year to date. The Elective rate for the month is 8.55% and the Non-Elective rate is 18.29%. *Agenda item at imminent Group Review meeting.*

Admissions to Neonatal Intensive Care further reduced to 2.34% for the month of June, and 4.23% for the year to date.

Data for Puerperal Sepsis and other puerperal infections is included in the report, aligned to CQC definitions.

Mortality & Readmissions

The Trust's HSMR for the most recent 12-month cumulative period is 86.9, which remains beneath that of the SHA Peer. The City site HSMR remains beneath lower statistical confidence limits (73.2), with the Sandwell site HSMR (100.4), within statistical confidence limits for the most recent 12-month cumulative period.

As of 31.07.14 Dr Foster has not got the re-admission data for March

Mortality rates for weekday and weekend, low risk diagnoses and CQC diagnosis groups are within or beneath statistical confidence limits.

During the most recent month for which complete data is available (April) the overall Trust performance for review of deaths within 42 days further improved to 89%.

Stroke Care & Cardiology

Stroke Care - performance against the range of stroke care related indicators is contained within the main body of this report. The main features to highlight are the continued improvement in the proportion of patients spending 90% or more of their stay on an Acute Stroke Unit (91.2%). There is a decline in the proportion of patients admitted to an Acute Stroke Unit within 4 hours (from 89.1%May to 76.0% June). Other reported Stroke Care metrics all met the identified operational thresholds with the exception of stroke admission to thrombolysis time which is below target at 66.7% against a 85% target.

Cancer Care

The Trust continues to meet, for month (May) and year to date all high level Cancer Treatment targets, and compares well against national data, other than for 2-week waits for first outpatient appointment following GP referral.

3 Groups narrowly failed to meet 93.0% operational threshold for the 2-week maximum cancer wait; Medicine (91.8%), Surgery B (91.0%) and Women & Child Health (92.1%). Surgery B (0.0% (0.0 / 0.5 patients)) and Women & Child Health (84.2% (8.0 / 9.5 patients)) also both failed to meet the 85.0% operational threshold for 62-day urgent GP referral to treatment.

Patient Experience - MSA & Complaints

A total of 14 Mixed Sex Accommodation breaches were reported during the month of June, a significant reduction (improvement) compared with recent months. The 14 breaches comprised; Coronary Care Sandwell (12) and AMU A Sandwell (2). Fines levied by commissioner (£250 / occupied bed day) are c.£33K for the year to date. Discussions / outcomes of recent Table Top Review meetings of breaches have further informed policies / escalation procedures in place, which have been further tightened, designed to eliminate breaches.

Patient Experience - Cancelled Operations

Cancelled Operatons remain at 0.9% during the month of June, with a total of 33 SitRep declared late cancellations during the period, a reduction from previous months. Of the 33 cancellations the greatest number (17) were in Surgery B, which also had the highest percentage (1.54%). A working group within Surgery B has identified specific areas to focus attention on reducing cancellations as effective pre-operative assessment procedures and theatre scheduling.

There were no breaches of the 28-day late cancelled operation guarantee during the month and no patients were subject to a second or subsequent operation being cancelled.

Emergency Care

The Trust did not meet the 4-hour ED wait target during June and for Q1, with performance of 93.22% and 94.16% respectively. The report includes a copy of the TDA Recovery Plan trajectory with weekly performance aligned to this. The Trust is currently required to submit a weekly Emergency Care Standard Exception report to the TDA. (94.1% as of 30.07.14)

Delayed Transfers of Care increased during the month to 3.7% (3.3% in May). Trust is working with S'well Social Services to increase the availability of placements for discharge.

The proportion of patients admitted with a Fractured Neck of Femur who received an operation within 24 hours of admission during June reduced to 60.0% (9 of 15 patients). Year to date performance is 70.8%. Actions to improve are built upon use of trigger tools to predict overall demand and therefore capacity and its flexibility.

Referral To Treatment

Data for June is showing 2 patients that have breached 52 weeks, one in ENT and one in Gynaeoncology

13 specialties are 'off trajectory' in terms of improving RTT performance for June. An improvement trajectory has been agreed from August and included in the graph.

Acute diagnostic waits in excess of 6 weeks has improved below the <1% threshold at 0.98%. An improvement plan was submitted to the NDTA, on time, and the new trajectory has been added to the graph.

Staff

PDR overall compliance as at the end of June was 88.29%, a reduction from May (91.45%) and April (94.61%). The range by Group is 84 - 94% and by Directorate 76 - 100%. Delivery plans to improve performance and achieve a more even distribution across the year (25% / Quarter) are to be picked up as part of forthcoming Group Review meetings.

Mandatory Training compliance has remained relatively stable during recent months, with 87.15% compliance at the end of June. The range by Group is 82 - 95% and by Directorate 81 - 98%.

Sickness Absence during June is reported as 4.25% (range 3.6 - 5.1%), and 4.30% for the 12-month cumulative period.

CQUIN

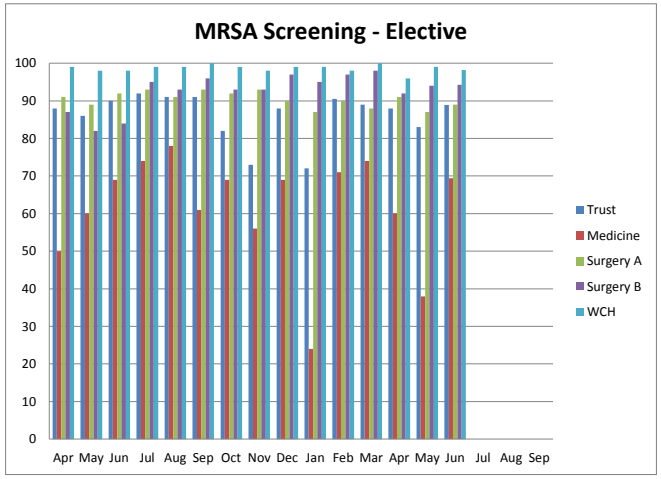
Of the 22 CQUIN schemes the Trust is contracted to deliver during 2014 / 2015, 12 are currently classified as Performing, Baseline data has been demonstrated to be collected in a further 8 areas, with one scheme for which data is not currently available.(Maternity-low risk births)

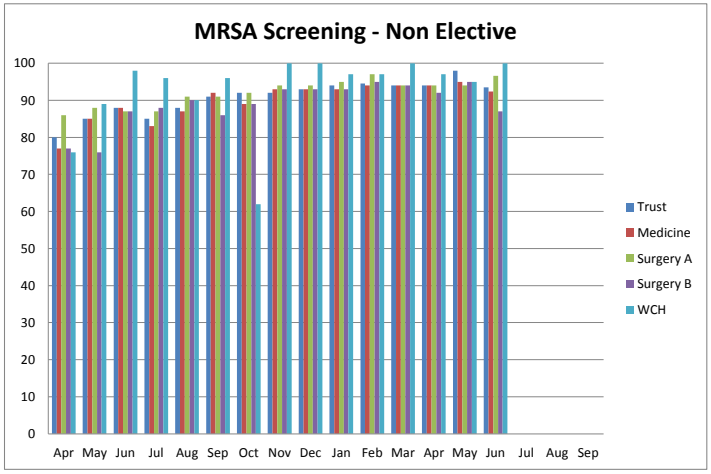
The scheme 'Find, Assess and Refer' Dementia screening, failed to meet all 3 components during the month of April. Although performance improved during the month of May, the scheme requirements were such that thresholds for each parameter needed to be met for each month during the quarter to attract the £63K attributed for the period. Again in June only 2 of 3 components were met

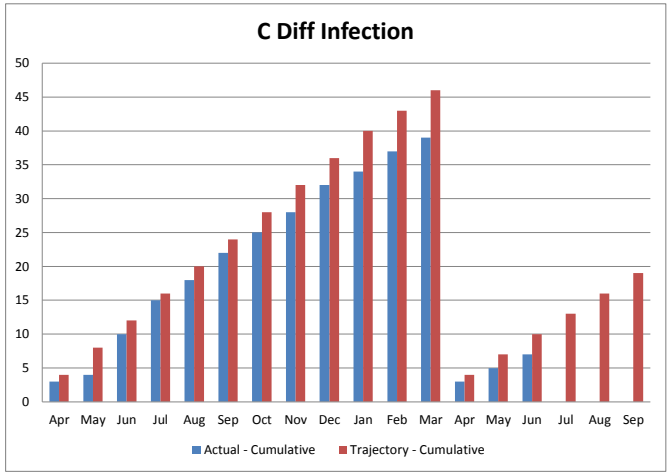
It is planned to convene a Confirm and Challenge meeting with scheme leads following success of a similar meeting last year.

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A M J J A S O N D J F M A M J J A S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
4			C. Difficile	37	4		Jun-14	1	1	0	0					2	7			
4			MRSA Bacteraemia	0	0		Jun-14	0	0	0	0					0	0			
4			MSSA Bacteraemia (rate per 100,000 bed days)	<9.42	<9.42		Jun-14									9.0	6.0			
4			E Coli Bacteraemia (rate per 100,000 bed days)	<94.9	<94.9		Jun-14									22.58	14.3			
3			MRSA Screening - Elective	80	80		Jun-14	69.4	89	93.8	98					88.9				
3			MRSA Screening - Non Elective	80	80		Jun-14	92.3	97	87	100					93.53				

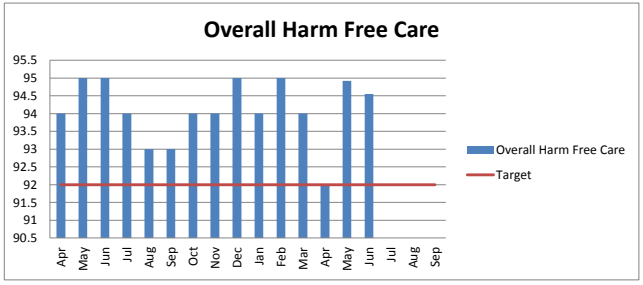


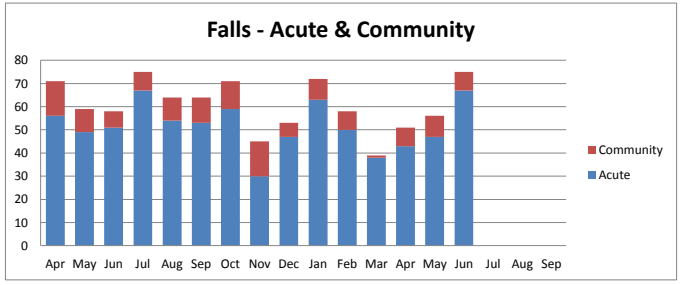


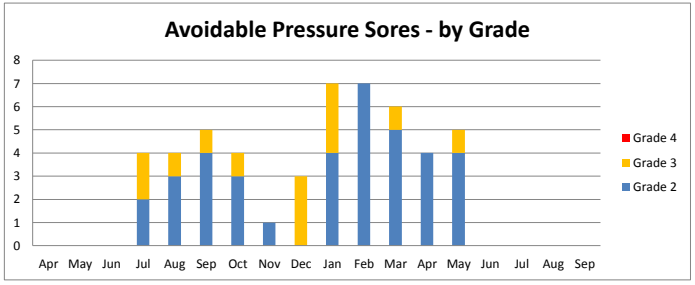


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		d	Patient Safety Thermometer - Overall Harm Free Care (%)	=>92	=>92	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14									94.6		●		
8			Falls	804	67	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	61	4	0	2	0	0	8		75	182	●		
9			Falls with a serious injury	0	0	3	3	4	●	●	1	6	2	6	2	1	2	1	4	4				Jun-14	3	0	0	0		0	1		4	9	●		
8			Grade 2,3 or 4 Pressure Ulcers (avoidable)	0	0	14	16	13	4	4	5	4	1	2	7	8	7	4	5					May-14	3	0	0	0			2		5	9	●		
3		d	Venous Thromboembolism (VTE) Assessments	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	99	98	98	89					97.51		●		
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	98	98	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	100	100	100	100					100		●		
3			WHO Safer Surgery - 3 sections and brief (% lists where complete)	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	99.6	100	100	100					99.5		●		
3			WHO Safer Surgery - Audit - 3 sections, brief and debrief (% lists where complete)	85	85	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	99.6	100	99.5	100					99.3		●		
9		d	Never Events	0	0	●	●	1	●	1	●	●	2	●	2	●	●	●	●	●				Jun-14	0	0	0	0	0	0	0		0	0	●		
9		d	Medication Errors causing serious harm	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	0	0		0	0	●		
9		d	Serious Incidents	0	0	0	5	3	10	7	5	1	4	0	2	0	1	3	2	2				Jun-14	0	0	2	0	0	0	0		2	7	●		
9			Open Central Alert System (CAS) Alerts			5	5	3	6	6	8	7	6	9	9	8	11	9	5	7				Jun-14									7		●		
9		d	Open Central Alert System (CAS) Alerts beyond deadline date	0	0														1	1				Jun-14									1		●		

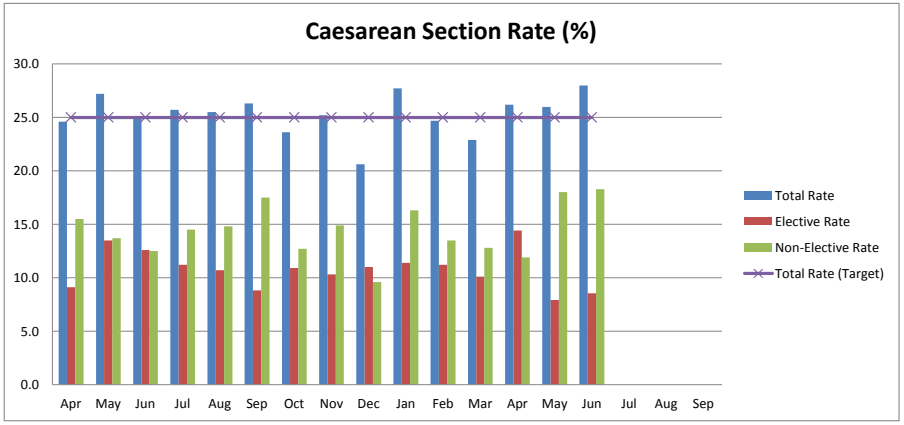


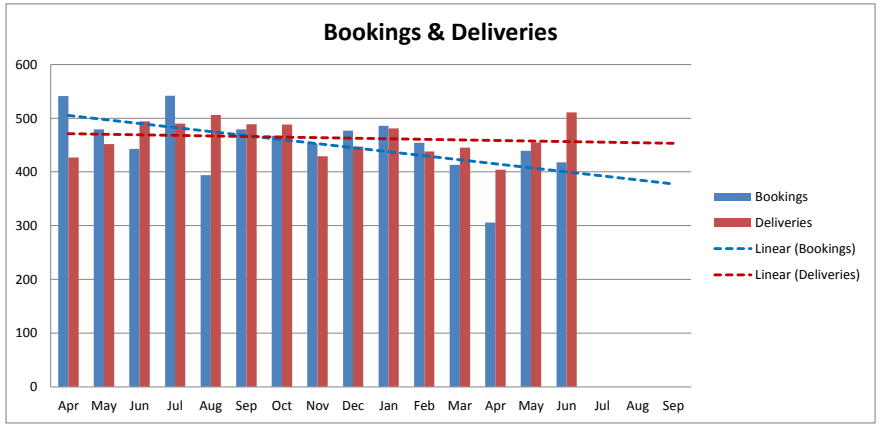




Patient Safety - Obstetrics

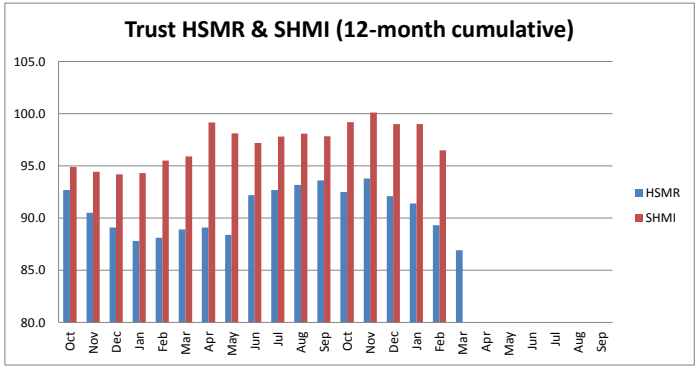
Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Caesarean Section Rate - Total (%)	=<25.0	=<25.0																			Jun-14	27.98	26.9			
3			Caesarean Section Rate - Elective (%)			9	14	13	11	11	13	11	10	11	12	11	10	10	8	9				Jun-14	8.55	8.8			
3			Caesarean Section Rate - Non Elective (%)			16	14	13	15	15	16	13	15	10	16	14	13	16	18	18				Jun-14	18.29	17.6			
2			Maternal Deaths	0	0																			Jun-14	0	0			
3			Post Partum Haemorrhage (>2000ml)	48	4																			Jun-14	0	0			
3			Admissions to Neonatal Intensive Care (%)	=<10.0	=<10.0																			Jun-14	2.34	4.23			
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<8.0	<8.0																			Mar-14	11.3				
12			Early Booking Assessment (<12 + 6 weeks) (%) - SWBH Specific	=>90.0	=>90.0																			Jun-14	72.49				
12			Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=>90.0	=>90.0																			Mar-14	134				
2			Breast Feeding Initiation (Quarterly) (%)	=>77.0	=>77.0																			Jun-14	76.12	76.12			
2			Puerperal Sepsis and other puerperal infections (variation 1) (%)			4.2	7.0	2.3	5.1	4.3	2.4	1.9	1.9	3.4	1.3	2.3	0.7	2.3	1.8	2.0				Jun-14	2.0	2.0			
2			Puerperal Sepsis and other puerperal infections (variation 2) (%)			1.5	1.9	0.6	1.7	1.4	1.3	1.0	0.5	1.4	0.2	1.6	0.5	1.5	1.8	0.3				Jun-14	0.25	1.2			
2			Puerperal Sepsis and other puerperal infections (variation 3) (%)			0.5	0.9	0.0	0.9	0.6	0.9	0.2	0.2	0.5	0.2	0.2	0.0	0.8	0.7	0.0				Jun-14	0	0.5			

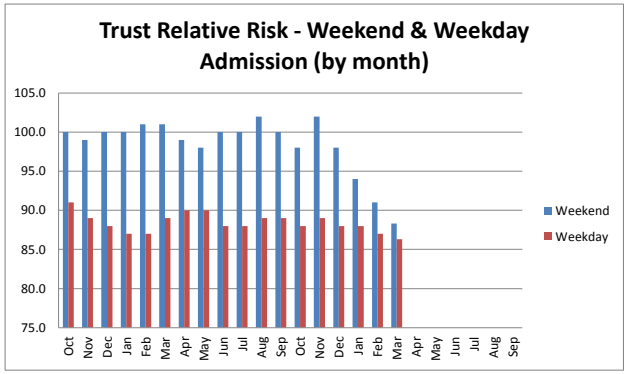


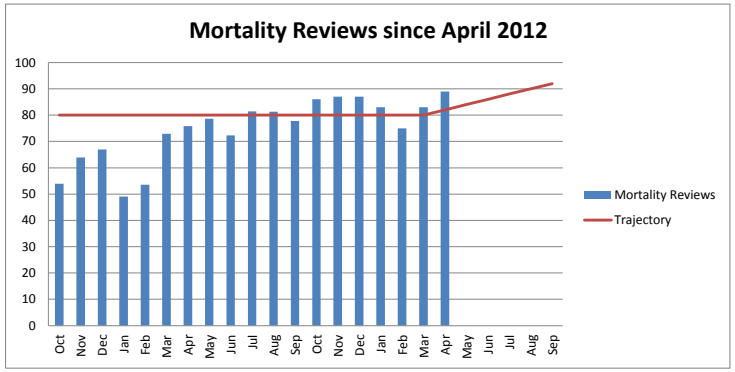


Clinical Effectiveness - Mortality & Readmissions

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
5		C	Hospital Standardised Mortality Rate - Overall (12-month cumulative)	Below Upper CI	Below Upper CI	89	88	92	93	93	94	93	94	92	91	89	87							Mar-14										86.91	●		
5		C	Hospital Standardised Mortality Rate - Weekday (12-month cumulative)	Below Upper CI	Below Upper CI	90	90	88	88	89	89	88	89	88	88	87	86							Mar-14										86.3	●		
5		C	Hospital Standardised Mortality Rate - Weekend (12-month cumulative)	Below Upper CI	Below Upper CI	99	98	100	100	102	100	98	102	98	94	91	88							Mar-14										88.3	●		
6		C	Summary Hospital-level Mortality Index (12-month cumulative)	Below Upper CI	Below Upper CI	99	98	97	98	98	98	99	100	99	99	97								Feb-14										96.5	●		
5		C	Deaths in Low Risk Diagnosis Groups	Below Upper CI	Below Upper CI	●	●	●	●	●	●	●	●	●	●	●	●							Mar-14									89.82		●		
3			Mortality Reviews within 42 working days	100	=>82.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-14	89	95	100	0					89		●		
5		C	Emergency Readmissions (within 30 days) - Overall (%) (12-month cumulative)			9.1			8.9			8.9												Jan - Dec 13									8.9				
5			Emergency Readmissions (within 30 days) - Following Initial Elective Admission (%) (12-month cumulative)			4.1			4.2			4.1												Jan - Dec 13									4.1				
5			Emergency Readmissions (within 30 days) - Following Initial Non Elective Admission (%) (12-month cumul.)	=<10.9	=<10.9	13.7			13.3			13.4												Jan - Dec 13									13.4		●		

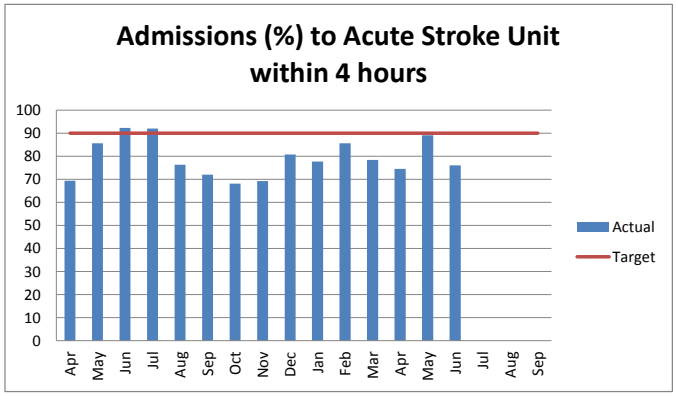


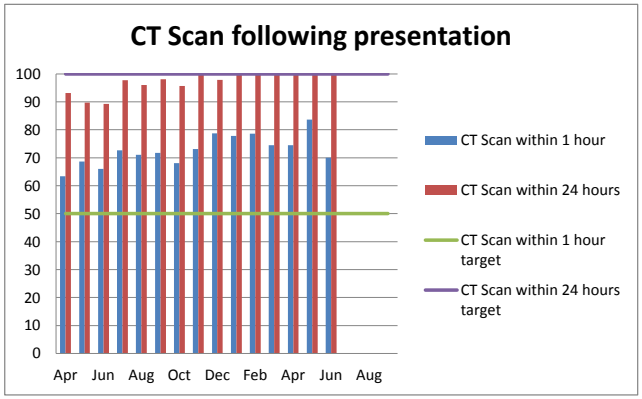


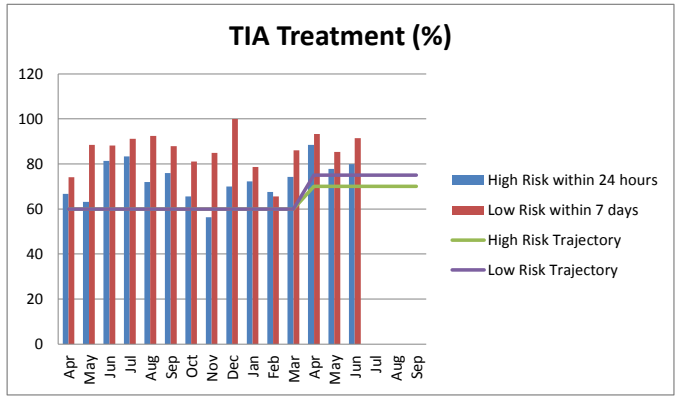


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Pts spending >90% stay on Acute Stroke Unit (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	91.2	87.4	●		
3			Pts admitted to Acute Stroke Unit within 4 hrs (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	76.0	79.2	●		
3		●	Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	70.0	75.8	●		
3			Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	100.0	100.0	●		
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	66.7	77.3	●		
3			Stroke Admissions - Swallowing assessments (<24h) (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	100.0	100.0	●		
3			TIA (High Risk) Treatment <24 Hours from initial presentation (%)	=>70.0	=>70.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	80.0	81.5	●		
3			TIA (Low Risk) Treatment <7 days from initial presentation (%)	=>75.0	=>75.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	91.4	90.0	●		
9			Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	100 (C) & 100 S)	90.3	●		
9			Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	100 (C) & 100(S)	95.2	●		
9			Rapid Access Chest Pain - seen within 14 days (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	100.0	98.5	●		

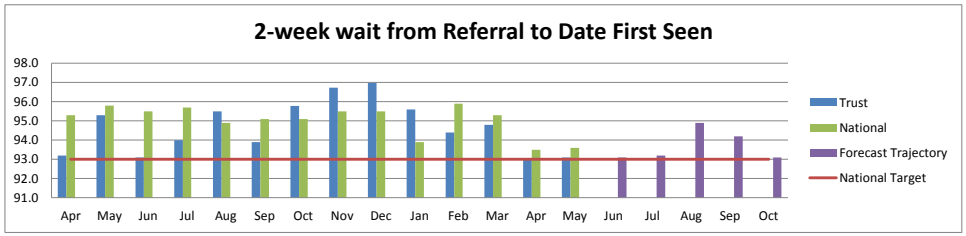


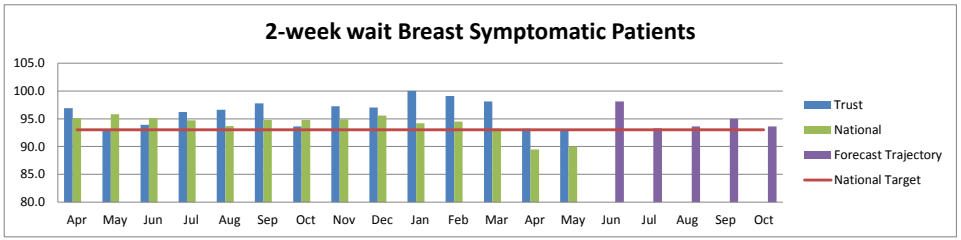


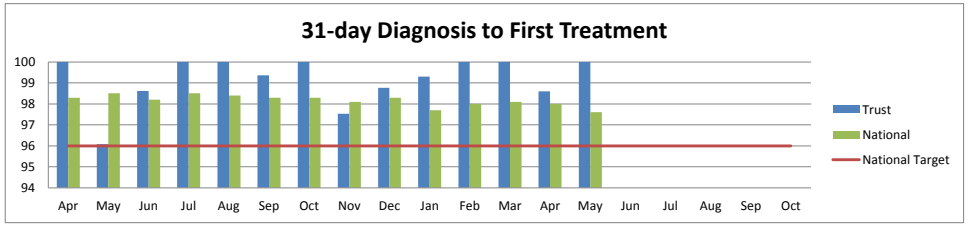


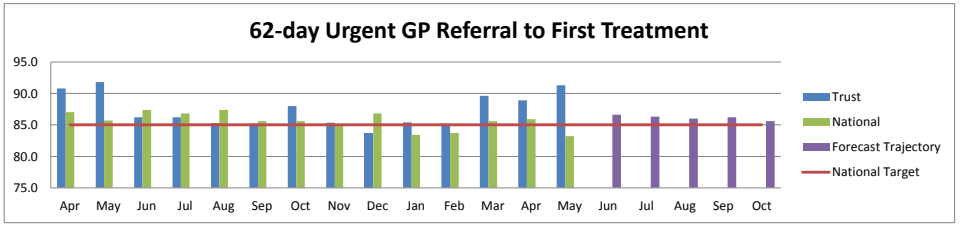
Clinical Effectiveness - Cancer Care

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
1			2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	91.8	94.4	91.0	92.1					93.1	93.0	●		
1			2 weeks (Breast Symptomatic)	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14		93.1							93.1	93.1	●		
1			31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	100	100	100	100					100.0	99.3	●		
1			31 Day (second/subsequent treatment - surgery)	=>94.0	=>94.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14									100.0	98.9	●		
1			31 Day (second/subsequent treatment - drug)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14									100	100	●		
1			31 Day (second/subsequent treat - radiotherapy)	=>94.0	=>94.0	n/a	n/a	n/a	n/a	n/a	n/a	n/a	●	n/a	n/a	n/a	●	n/a	n/a					May-14											●		
1			62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	88.2	95.5	0.0	84.2					91.3	90.1	●		
1			62 Day (referral to treat from screening)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14		100							100	100.0	●		
1			62 Day (referral to treat from hosp specialist)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-14	88.9	100	100	100					95.0	97.4	●		



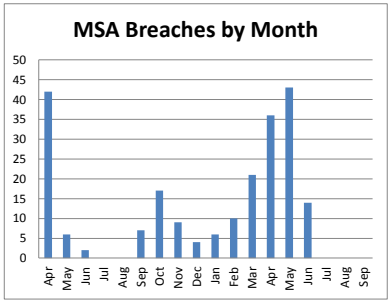


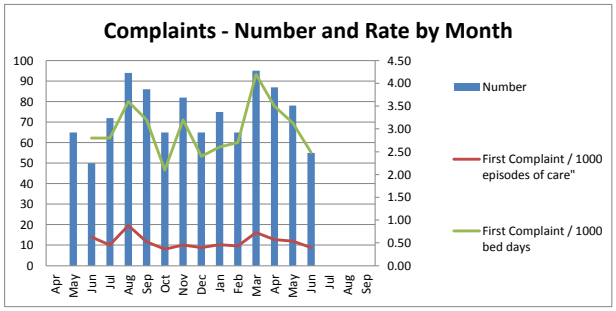


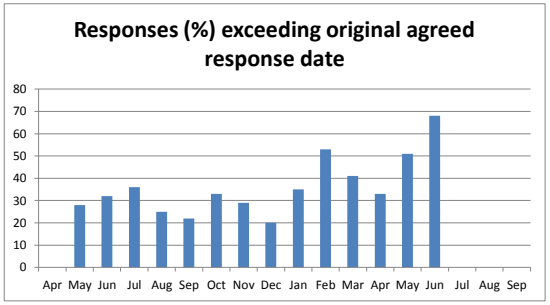


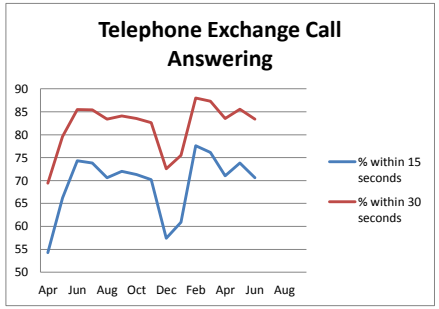
Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		•b•	FFT Response Rate - Inpatients	=>30.0	=>30.0	31	40	30	35	31	19	29	31	29	31	34	36	36	44	45				Jun-14								45.0		●		
8		•a•	FFT Score - Inpatients	=>60.0	=>60.0	66	66	67	68	37	72	71	70	73	71	75	73	74	74	70				Jun-14								70.0		●		
8		•b•	FFT Response Rate Emergency Department	=>20.0	=>20.0	2.2	3.7	9.6	5	5.3	12	21	17	15	15	16	15	15	16	16				Jun-14	16								16.0		●		
8		•a•	FFT Score - Emergency Department	=>46.0	=>46.0	55	49	50	49	50	51	46	47	44	47	48	48	47	49	48				Jun-14	48								48.0		●		
13		•a	Mixed Sex Accommodation Breaches	0	0	42	6	2	0.5	0.4	7	17	9	4	6	10	21	36	43	14				Jun-14	14	0	0	0		0	0		14	93	●		
9		•	No. of Complaints Received (formal and link)			63	65	50	72	94	56	65	52	65	75	65	95	87	78	55				Jun-14	28	11	3	6	1	2	0	4	55	220			
9			No. of Active Complaints in the System (formal and link)				302	336	272	254	238	201	201	190	188	188	210	194	245	270				Jun-14	129	50	40	21	2	7	8	13	270				
9		•a	No. of First Formal Complaints received / 1000 bed days					2.8	2.8	3.6	3.2	2.1	3.2	2.4	2.6	2.7	4.2	3.5	3.1	2.5				Jun-14									2.48	3.00			
9			No. of First Formal Complaints received / 1000 episodes of care					0.6	0.5	0.9	0.5	0.4	0.5	0.4	0.5	0.4	0.7	0.6	0.5	0.4				Jun-14									0.40	0.51			
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	100	100		97	78	94	97	75	97	99	98	97	95	99	100	100	100				Jun-14	100	100	100	100	100	100	100	100	100		●		
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	0	0		28	32	36	25	22	33	29	20	35	53	41	33	51	68				Jun-14	65	62	70	67	50	71	100	69	68		●		
9			No. of responses sent out				17	5	128	73	78	109	59	79	81	58	67	117	30	4				Jun-14	0	2	1	1	0	0	0	0	4				
9			Oldest' complaint currently in system (days)				197	155	165	147	150	107	174	91	112	118	127	104	124	145				Jun-14	145	131	100	82	112	40	115	90	145				
14		•e•	Access to healthcare for people with Learning Disability (full compliance)	Yes	Yes	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	Y	Y	Y	Y	Y	Y	Y	Y	Yes		●		



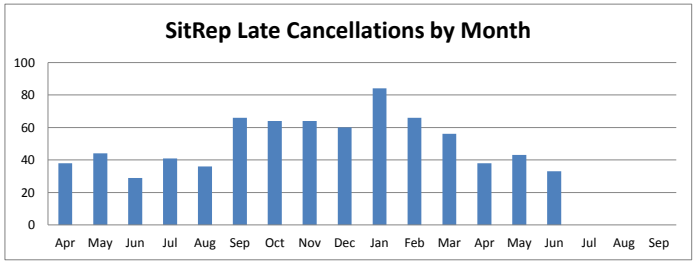


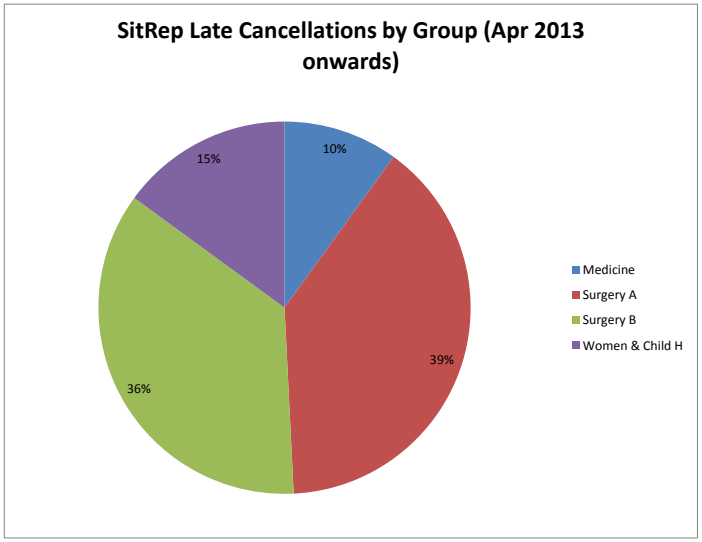


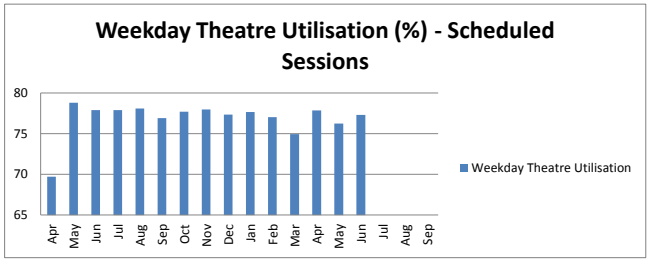


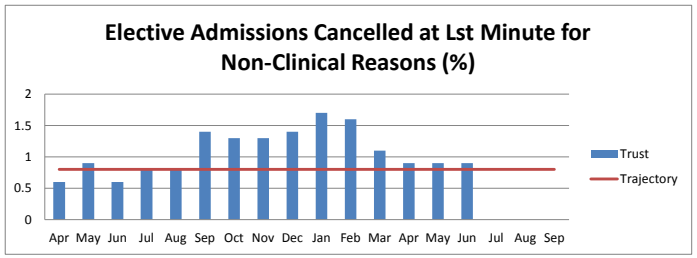
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2		●	Elective Admissions Cancelled at last minute for non-clinical reasons (%)	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	0.37	0.33	1.54	1.22					0.9	0.9	●		
2		●e●	28 day breaches	0	0	4	1	5	1	0	0	0	0	0	0	0	1	1	1	0				Jun-14	0	0	0	0					0	2	●		
2		●e	No. of second or subsequent urgent operations cancelled	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0					0	0	●		
2			Sitrep Declared Late Cancellations	320	27	38	44	29	41	36	66	64	64	60	84	66	56	38	43	33				Jun-14	7	5	17	4					33	114	●		
3			Sitrep Declared Late Cancellations (Pts. >1 occasion)	0	0	5	6	6	2	9	10	7	5	7	13	13	0	0	1	0				Jun-14	0	0	0	0					0	1	●		
3			Multiple Cancellations experienced by same patient (all cancellations) (%)	0	0	18	13	17	12	19	14	12	13	13	13	13	11	12	7	10				Jun-14	4.6	11.2	9.5	14.6					9.71		●		
3			All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	3.1	3.1	7	6	6	6	5	6	6	6	5	8	6	6	5	6	5				Jun-14	2.0	6.6	7.6	6.4					5.1		●		
3			Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14									77		●		



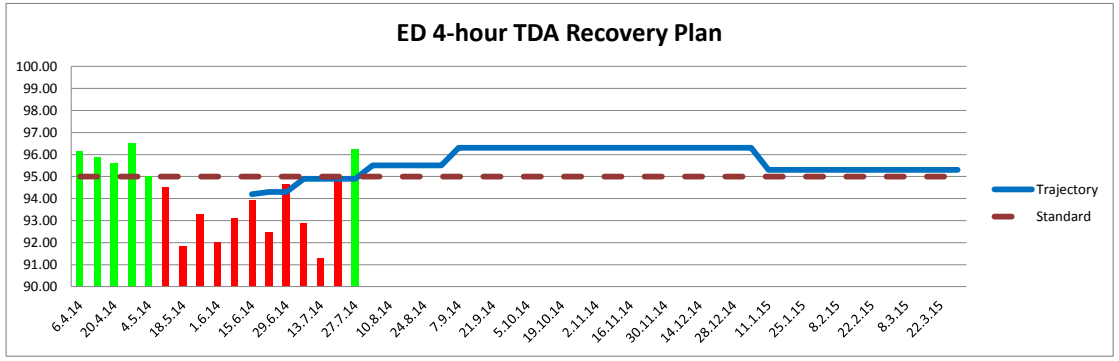


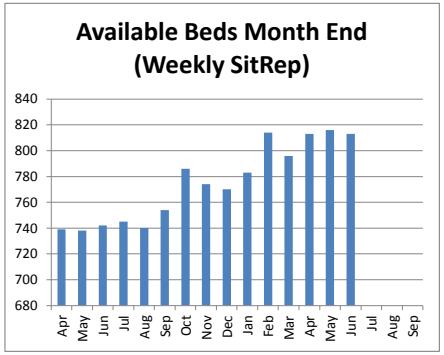


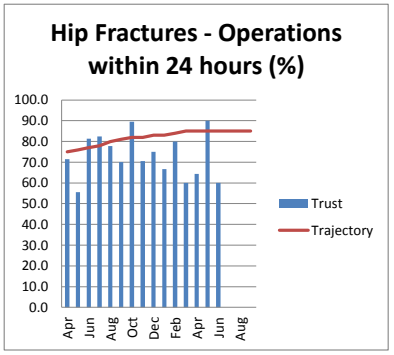


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Unit S	C	B	Month	Year To Date	Trend	Next Month	3 Months
2			Emergency Care 4-hour waits (%)	=>95.0	=>95.0																			Jun-14	94.3	91.5	96.6	93.22	94.16			
2			Emergency Care Trolley Waits >12 hours	0	0	1																		Jun-14	0	0	0	0	0			
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins																			Jun-14	13	18	13	16	18			
3			Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins																			Jun-14	53	69	22	54	51			
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0																			Jun-14	7.98	6.94	3.61	6.94	6.31			
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0																			Jun-14	3.48	5.61	2.51	4.34	4.07			
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	0	0																			Jun-14	68	57		125	377			
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	0	0																			Jun-14	2	6		8	31			
11			WMAS - Turnaround Delays > 60 mins (% all journeys)	=<0.02	=<0.02																			Jun-14	0.1	0.3		0.2				
2			Delayed Transfers of Care (Acute) (%)	=<3.5	=<3.5																			Jun-14				3.7	3.4			
2			Delayed Transfers of Care (Acute) (Av./Week)	<10 per site	<10 per site																			Jun-14	7	6		13				
2			Patient Bed Moves (10pm - 8am) (No.) -ALL															668	751	722				Jun-14				722	2141			
2			Patient Bed Moves (10pm - 8am) (No.) - exc. Assessment Units															312	331	329				Jun-14				329	972			
3			Hip Fractures - Operation < 24 hours of admission (%)	=>85.0	=>85.0																			Jun-14				60.0	70.8			

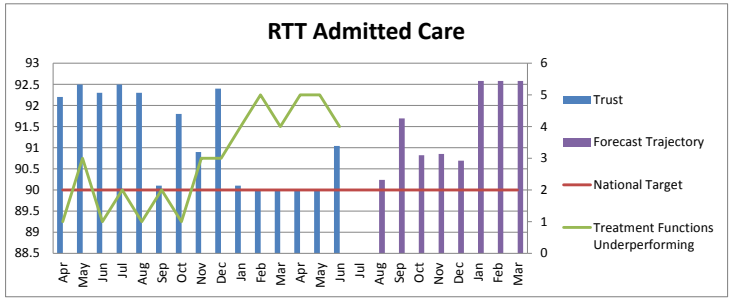


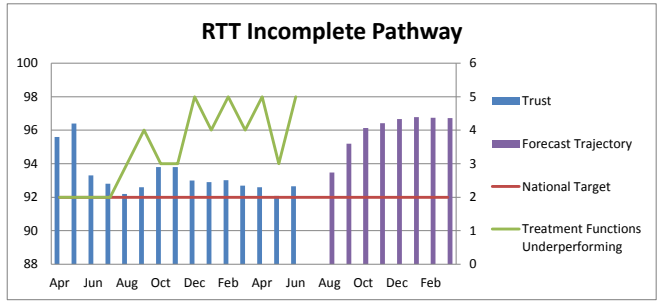


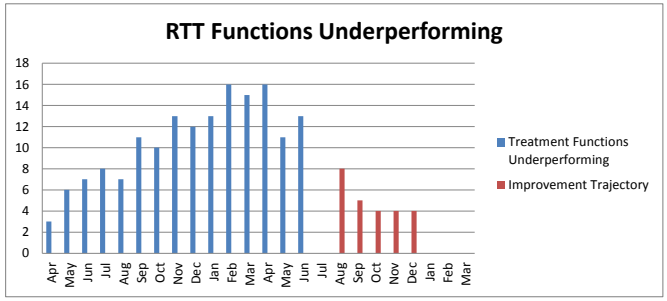


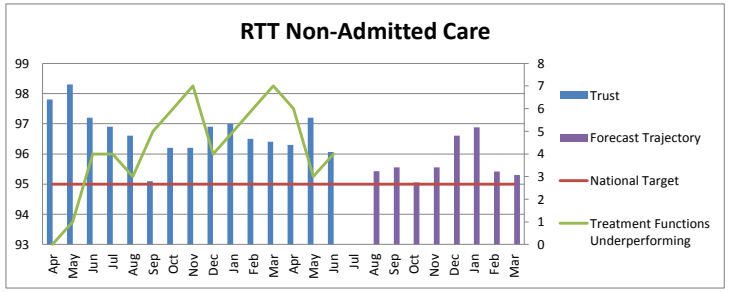
Referral To Treatment

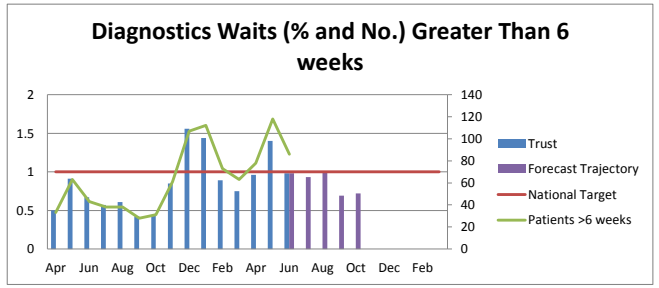
Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2			RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0																			Jun-14	98.6	83.4	90.1	94.3					91.04				
2			RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0																			Jun-14	92.6	93.9	97.6	97.8					96.06				
2			RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0																			Jun-14	92.9	89.1	93.9	98.9					92.66				
2			Patients Waiting >52 weeks	0	0	8	28	50	57	29	20	66	36	12	3	1	1	1	2	2				Jun-14	0	0	1	1					2				
2			Treatment Functions Underperforming	0	0	3	6	7	8	7	11	10	13	12	13	16	15	16	11	13				Jun-14	5	5	3	0					13				
2			Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0																			Jun-14	1.90	11.2	0.00	0.00		0.20			0.98				

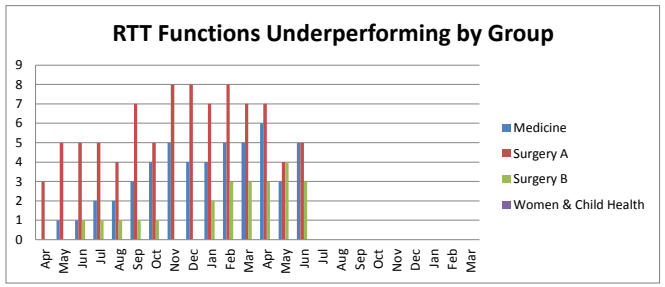










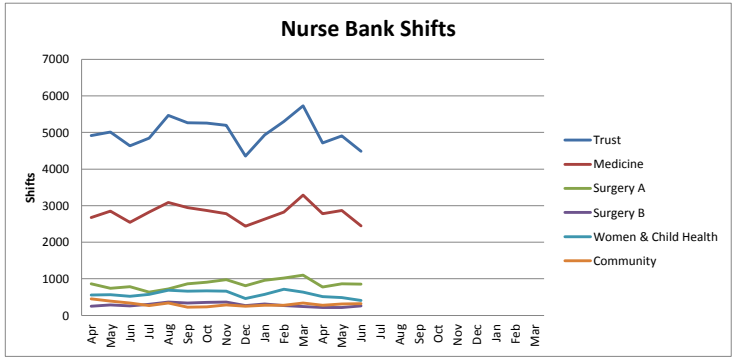


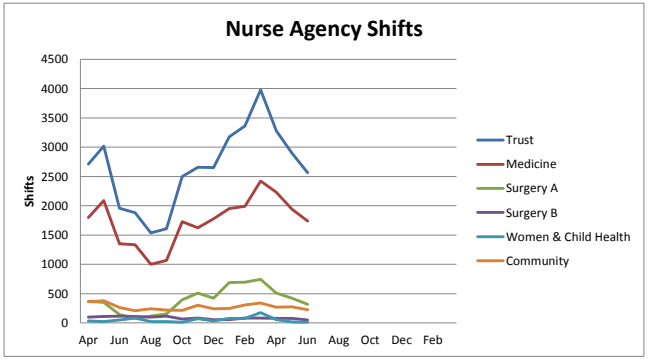
Data Completeness

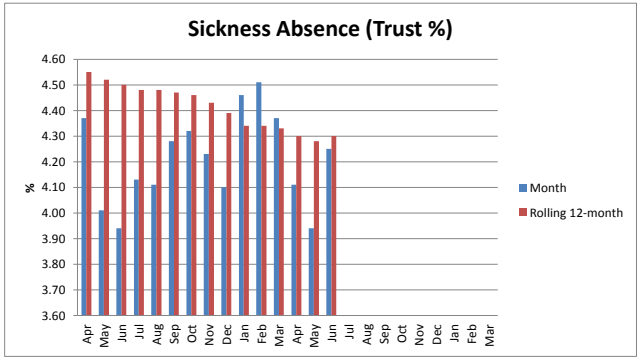
Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Data Completeness Community Services	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14								>50	>50		●		
2		●	Percentage SUS Records for AE with valid entries in mandatory fields	=>99.0	=>99.0																																
2		●	Percentage SUS Records for IP care with valid entries in mandatory fields	=>99.0	=>99.0																																
2		●	Percentage SUS Records for OP care with valid entries in mandatory fields	=>99.0	=>99.0																																
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=>99.0	=>99.0	99.3	99.3	99.2	99.2	99.1	99.1	99.1	98.9	99.2	98.9	98.9	98.7	98.7	96.8	95.3				Jun-14								95.3	97.0	●		
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	=>99.0	=>99.0	99.7	99.8	99.7	99.7	99.7	99.7	99.7	99.7	99.7	99.7	99.6	99.5	99.5	99.5	99.5				Jun-14								99.5	99.5	●		
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=>95.0	=>95.0	97.8	97.3	97.4	97.2	97.4	97.3	97.5	97.2	97.1	97.6	96.8	95.9	96.3	95.8	96.2				Jun-14								96.2	96.1	●		
2			Ethnicity Coding - percentage of inpatients with recorded response	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14								91.95	92.58	●		
2		●b●	Data Quality of Trust Returns to the HSCIC																																		
2			Maternity - Percentage of invalid fields completed in SUS submission	=<15.0	=<15.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14								39.61	24.51	●		

Staff

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
7		b	WTE - Actual versus Plan			312	456	465	458	511	610	643	626	572	541	567								Feb-14	163	76	37	34	33	28	34	162	567	567			
3		b	PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	88	86	85	86	94	92	87	91		88.29	●		
7		b	Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	93	91	94	90	100	97	100	100		93.3	●		
3		b	Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	4.1	5.1	3.6	4.1	4.4	5.1	4.1	4.2	4.25	4.30	●		
3			Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	82	87	87	85	95	91	90	91		87.15	●		
3		●	Mandatory Training - Health & Safety (% staff)	=>75.0	=>75.0											●	●	●	●	●				Jun-14	97	98	97	97	100	98	99	99		98.36	●		
7		b ●	Staff Turnover (rolling 12 months) (%)	=<10.0	=<10.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14									11.99	11.83	●		
7			New Investigations in Month			4	5	8	9	1	4	3	1	4	2	4	5	1	4	6				Jun-14	1	0	0	0	0	2	0	3	6				
7			Vacancy Time to Fill (weeks)			15	19	18	18	18	18	18	17	18	20	18	19	18	20	19				Jun-14									19				
7		●	Professional Registration Lapses	0	0	3	0	0	1	0	4	7	0	0	0	0	0	0	0	0				Jun-14	0	0	0	0	0	0	0	0	0	0	●		
7			Qualified Nursing Variance (FIMS) (FTE)			26	108	138	143	181	236	177	199	210	163	162								Feb-14									162	162			
10			Nurse Bank Fill Rate			72	77	75	77	78	76	75	76	71	73	75	76	76	82	82				Jun-14									81.9	79.5			
10			Nurse Bank Use (shifts)	46980	3915	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	2449	851	258	409	0	12	319	188	4488	14025	●		
10			Nurse Agency Use (shifts)	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	1699	320	49	13	0	202	268	13	2565	8681	●		
15			Your Voice - Response Rate														19.8							May-14	7	12	19	14	30	27	33	29					
15			Your Voice - Overall Score														3.63							May-14	3.6	3.5	3.7	3.7	3.4	3.8	3.8	3.6					





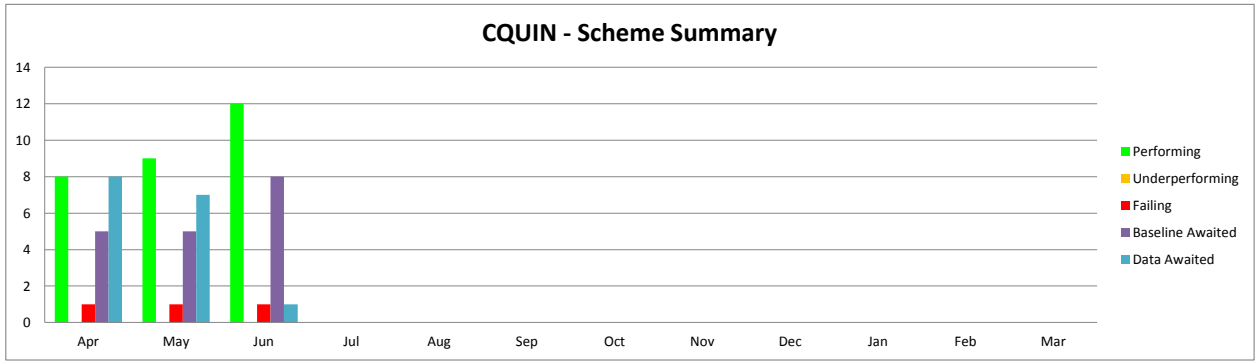


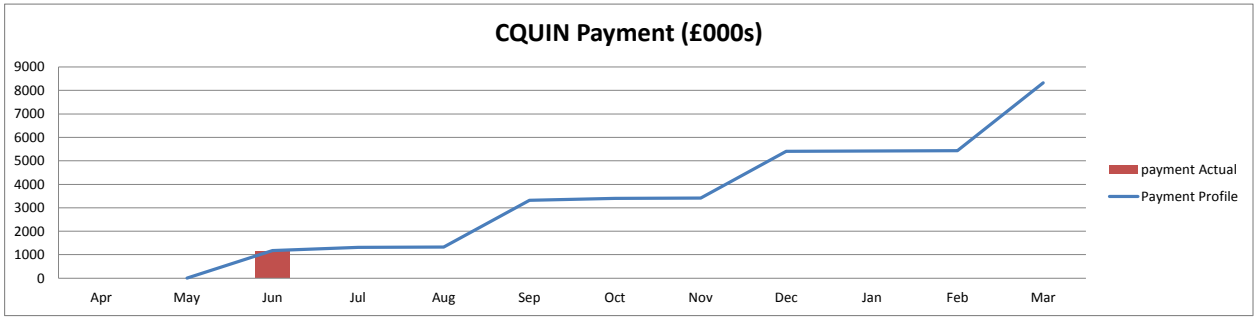
CQUIN (I)

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8			FFT - Implementation of Staff FFT	Implement by end July		●	●	●										Jun-14									On Track	On Track	●		
8			FFT - Early Implementation of Patient FFT in OP / DC Departments	Implement by end Oct		●	●	●										Jun-14									On Track	On Track	●		
8			FFT - Increase and / or Maintain Response Rate in ED areas	>Q1 rate		15	16	16										Jun-14									On Track		●		
8			FFT - Increase and / or Maintain Response Rate in IP areas	>Q1 rate		36	44	45										Jun-14									On Track		●		
8			FFT - Reduce Negative Responses (ED, IP and Mat'y) (%)	0		Derive base data												Jun-14									On Track	On Track	●		
8			NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	50% reduction		Derive base data												Jun-14									On Track	On Track	●		
8			Dementia - Find, Assess and Refer	=>90	=>90	●	●	●										Jun-14									2 of 3 met	2 of 3 met	●		
8			Dementia - Clinical Leadership and Staff Training			Confirm training req's												Jun-14									Clinician in place	Clinician in place	●		
8			Dementia - Supporting Carers of People with Dementia	Monthly Audit	Monthly Audit	●	●	●										Jun-14									On Track	On Track	●		
9			Learning From Safeguarding Concerns	Quarterly report to Board			●											Jun-14									On Track	On Track	●		
2			Quality of Outpatient and Discharge Letters	Trust/CCG to agree assess. criteria		Derive base data												Jun-14									On Track	On Track	●		
4			Sepsis - Use of Sepsis Care Bundles	Informed by base data		Derive base data												Jun-14									On Track	On Track	●		
8			Pain Relief - Use of Pain Care Bundles	Informed by base data		●	●	●										Jun-14									On Track	On Track	●		
9			Medication and Falls	Informed by base data		Derive base data																					On Track	On Track	●		
9			Serious Untoward Incidents	Informed by base data		Derive base data												Jun-14									On Track	On Track	●		
14			Community Therapies - Effective Referral Management	Informed by base data		Derive base data												Jun-14									On Track	On Track	●		

CQUIN (II) and summary

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Community Therapies - Community Dietetics	Informed by base data		Derive base data												Jun-14									On Track	On Track			
12			Maternity - Low Risk Births	Quarterly audit / action plan		Base data																									
16			Bechet's Disease	Submit Quarterly return		Met (Q1)												Jun-14									met (Q1)	met (Q1)			
17			HIV Home Delivery Medicines (% patients receiving)	70		Met (Q1)												Jun-14									met (Q1)	met (Q1)			
17			Retinopathy of Prematurity Screening (%)	95		Met (Q1)												Jun-14									met (Q1)	met (Q1)			
17			Timely Administration of TPN for preterm infants	95		Met (Q1)												Jun-14									met (Q1)	met (Q1)			





The Trust is contracted to deliver a total of 22 CQUIN schemes during 2014 / 2015. 9 schemes are nationally mandated, a further 9 have been agreed locally, with the remaining 4 identified by the West Midlands Specialised Commissioners. The collective financial value of the schemes is c.£8.3m.

12 schemes are currently classified as performing, including the 'Implementation of Staff FFT' and the 'Early Implementation of Patient FFT Iin OP / DC Departments', which are both on track for the respective dates.

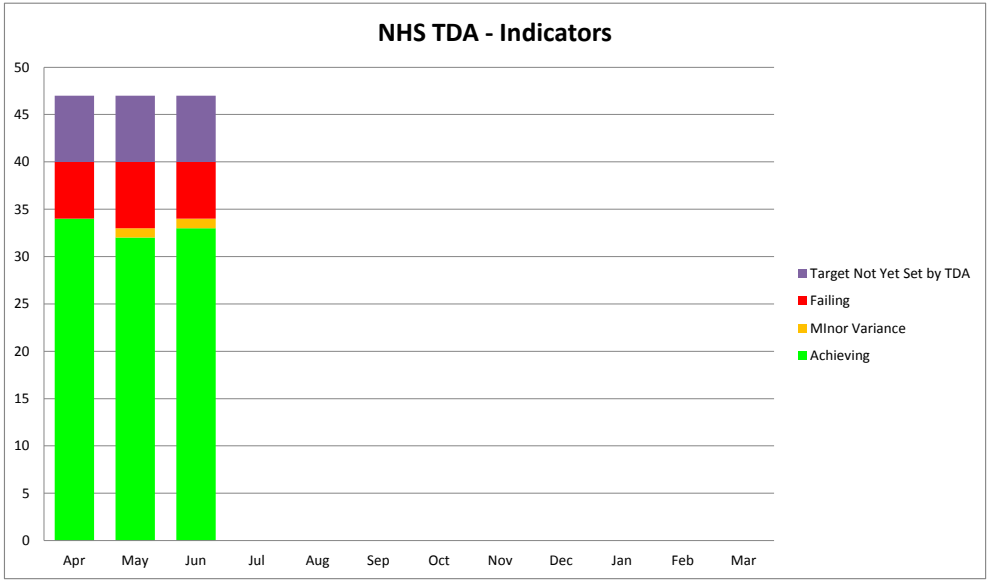
Baseline data has been demonstrated to be collected in 8 areas which will inform and determine the trajectories and targets for the remainder of the year.

There is 1 schemes for which data is currently not available; Maternity (Low Risk Births).

The scheme 'Find, Assess and Refer' Dementia screening, failed to meet all 3 components during the month of April. Although performance improved during the month of May, the scheme requirements were such that thresholds for each parameter needed to be met for each month during the quarter to attract the £63K attributed for the period. Again in June only 2 of 3 components were met

It is planned to convene a Confirm and Challenge meeting with scheme leads following success of a similar meeting last year.

External Assessment Frameworks



NHS TDA Accountability Framework

NHS TDA Accountability Framework for 2014 / 2015 comprises 3 principal elements; Quality Score, Finance RAG Assessment and Sustainability Score, each of which contribute to the derivation of an Overall Escalation Score. The Quality Score comprises 5 component scores; Caring, Effective, Response, Safe and Well-led, each of which comprise a variable number of metrics. It is intended that individual organisations will be able to score their own performance, although how to do this, and the thresholds for a number of individual metrics have not yet been published.

Metrics within the framework which are currently identified as outside of operational thresholds are:

- There were 1 CAS Alert at the end of June beyond the deadline date

- There were 2 Serious Incidents reported during June

- There were 2 waits in excess of 52 weeks at the end of June

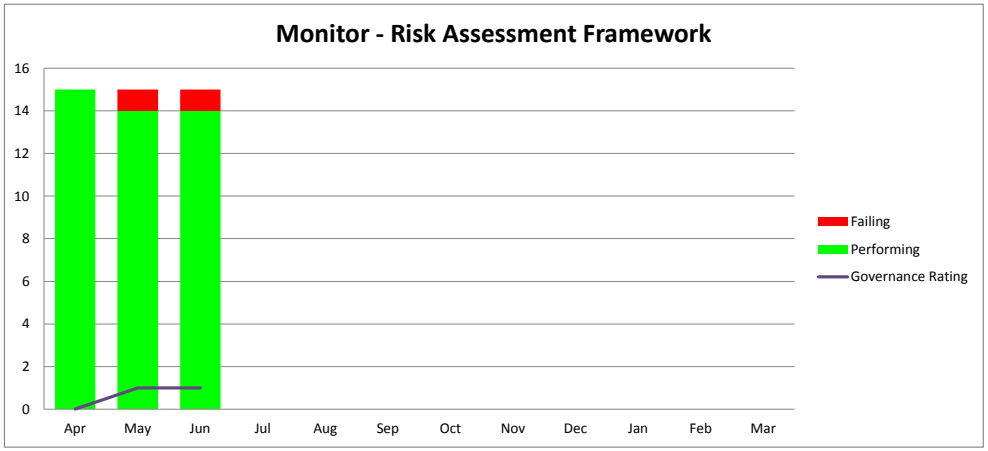
- The Trust's FFT Response Rate in ED is 16%

- A total of 14 Mixed Sex Accommodation Breaches were reported during the month

- An increase in Delayed Transfers of Care to 3.7% during the month of June

- ED 4-hour performance of 93.22%

High Level Cancer and RTT Thresholds are projected to be met



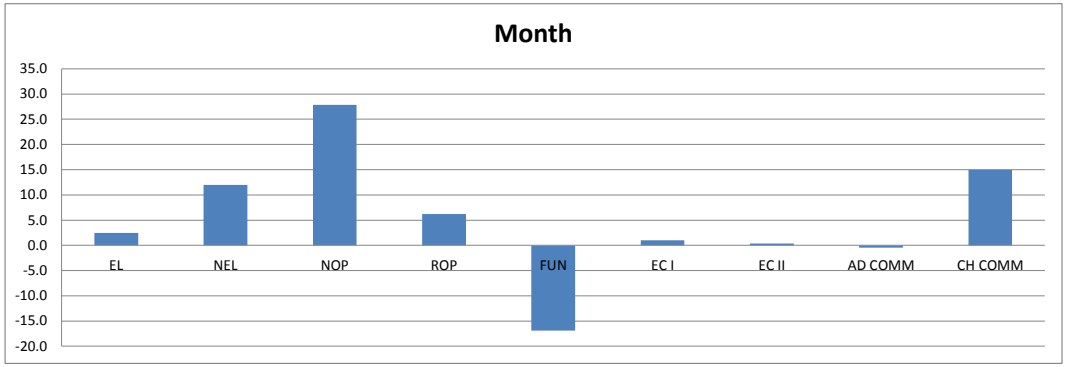
Monitor Risk Assessment Framework

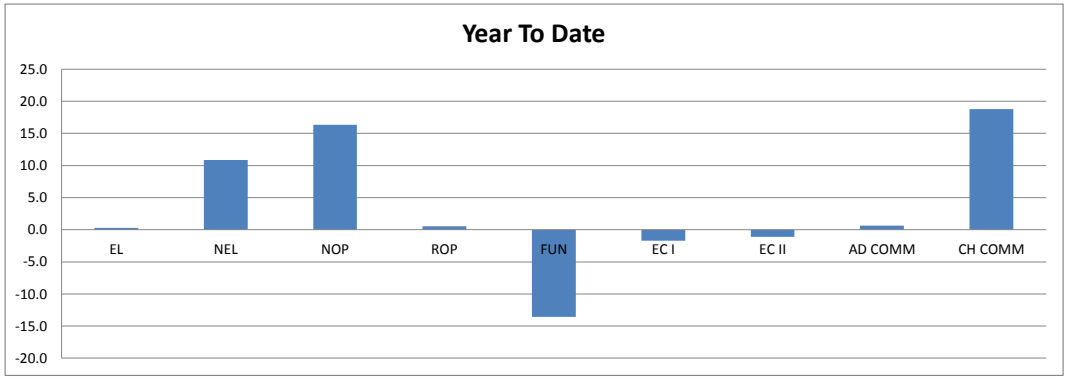
Monitor introduced its ***Risk Assessment Framework*** for NHS Foundation Trusts with effect from 1 October 2013, which replaced its previous Compliance Framework. The range of indicators utilised by Monitor within this framework is less extensive than those used by the NHS TDA. The Access and Outcome metrics used by Monitor have thresholds identified and weightings attributed.

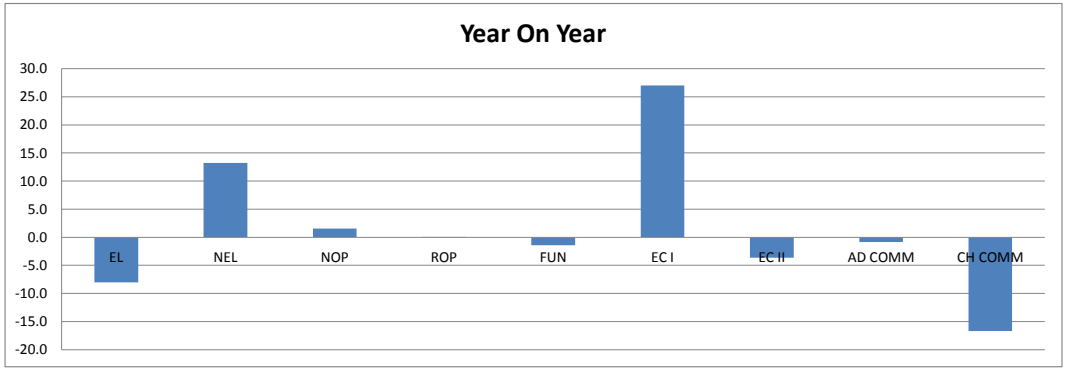
During the month of June the Trust met, or is projected (Cancer and RTT targets) to meet the required thresholds for each of the Access and Outcomes indicators, other than the ED 4-hour target, with performance during the month of June reported as 93.22%. This continues to attract an overall weighted score for the month of 1.0 with an AMBER / GREEN Governance Rating.

Governance Rating	Green (0.0)	Amber / Green (1.0 - 1.9)
	Amber / Red (2.0 - 3.9)	Amber / Red (>3.9)

Activity Summary







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 opposite. Additionally, there is a year on year comparison of current year with previous year for the corresponding period of time.

High level Elective activity is ahead of plan for the month by 2.4% and remains essentially on plan for the year to date. Non-Elective activity during the month is 12.0% greater than plan, is 10.9% higher for the year to date, and 13.2% higher than the corresponding period last year. New outpatient attendance numbers are ahead of plan by 16.4% for the year to date. With OP Review attendances 13.6% below plan for the year to date, the Follow-Up to New OP Ratio for the period to date has further reduced to 2.23, compared with a plan derived from contracted activity of 2.58. Type I Emergency Care activity for the month is slightly (1.0%) ahead of plan, but remains less than plan for the year to date (-1.7%), although considerably higher than the corresponding period last year, due to the inclusion within plan of GP Triage Activity. Type II activity is essentially on plan for the month and 1.1% less than plan for the year to date. Adult Community and Child Community activity exceeds plans for the year to date by 0.6% and 18.8% respectively, although both are less than the corresponding period last year, -0.9% and -16.7% respectively.

Finance Summary

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (data from July 13) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
18		f	Bottom Line Income & Expenditure position - Forecast compared to plan £m	£0.0		●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	£0.0		●	●	●
18		f	Bottom Line Income & Expenditure position - Year to Date Actual compared to plan £m	£0.0	£0.0									●	●	●	●				Jun-14	-1.1	-0.2	-0.4	-0.3	0.1	-0.3	-0.1	-0.1		-£1.0	●	●	●
18		f	Actual efficiency recurring / non-recurring compared to plan - Year to Date actual compared to plan	£0.0	£0.0									●	●	●	●				Jun-14	-0.2	0.0	0.0	-0.1	-0.1	-0.2	-0.2	0.1		-£0.6	●	●	●
18		f	Actual efficiency recurring / non-recurring compared to plan - Forecast compared to plan	£0.0										●	●	●	●				Jun-14	-1.5	-1.0	-1.2	-1.1	-1.0	-0.6	-0.4	-1.0		-£7.9	●	●	●
18		f	Forecast underlying surplus / deficit compared to plan	£0.0										●	●	●	●				Jun-14	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	£0.0	-£0.1	●	●	●
18		f	Forecast year end charge to capital resource limit	£21.3										●	●	●	●				Jun-14									£19.1		●	●	●
18		f	Is the Trust forecasting permanent PDC for liquidity purposes?	No		●	●	●	●	●	●	●	●	●	●	●	●				Jun-14									No		●	●	●
18		b	Temporary costs and overtime as % total paybill	2.6%	2.6%	●	●	●	●	●	●	●	●	●	●	●	●				Jun-14	11%	4%	2%	1%	0%	2%	3%	1%	4.5%	4.1%	●	●	●
18			Continuity of Service Risk Rating - Year to Date	2.5										●	●	●	●				Jun-14										3.0	●	●	●

Contractual Requirements - Operational Standards (OS) / National Quality Requirements (NQR)

Data Source	Data Quality	OS / NQR	Indicator	Threshold	APRIL (£000s)									MAY (£000s)									JUNE (£000s)									YEAR TO DATE (£000s)								
					M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		OS	RTT Admitted Care (£400 per breach by specialty)	=>90.0%	0.0	39.6	2.0	0.0					41.6	0.0	28.0	7.6	0.0					35.6	0.0	27.2	0.8	0.0					28.0	0.0	94.8	10.4	0.0					105.2
2		OS	RTT Non-Admitted Care (£100 per breach by specialty)	=>95.0%	4.6	2.3	0.0	0.0					6.9	2.9	0.4	0.0	0.0					3.3	5.4	3.7	0.0	0.0					9.1	12.9	6.4	0.0	0.0					19.3
2		OS	RTT Incomplete Pathway (£100 per breach by specialty)	=>92.0%	14.1	23.7	5.9	0.0					43.7	12.0	27.7	7.4	0.0					47.1	12.4	25.0	8.7	0.0					46.1	38.5	76.4	22.0	0.0					136.9
2		OS	Diagnostic Waits (£200 per breach)	=>99.0%	0.0	0.0	0.0	0.0		0.0			0.0	0.0	5.4	0.0	0.0		1.4			6.8	0.0	0.0	0.0	0.0		0.0			0.0	0.0	5.4	0.0	0.0		1.4			6.8
2		OS	ED Waits >4 hours (£200 per breach between 92.0% and 95.0%)	=>95.0%	0.0		0.0						0.0	56.0		0.0						56.0	67.2		0.0						67.2	123.2		0.0						123.2
1		OS	Cancer Waits (2 weeks, 31 days and 62 days - £200, £1000 and £1000 per breach respectively)	Various	Assessed Quarterly									Assessed Quarterly																	0.0	0.0	0.0	0.0					0.0
13		OS	Mixed Sex Accommodation Breaches (£250 per day per Service Uder affected)	0	16.5	0.0	0.0	0.0					16.5	12.8	0.0	0.0	0.0					12.8	3.5	0.0	0.0	0.0					3.5	32.8	0.0	0.0	0.0					32.8
2		OS	Cancelled Operations 28-day (non-payment of rescheduled episode of care)	0	0.0	1.3	0.0	0.0					1.3	1.8	0.0	0.0	0.0					1.8	0.0	0.0	0.0	0.0					0.0	1.8	1.3	0.0	0.0					3.1
4		NQR	MRSA Bacteraemia (£10,000 per incidence)	0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0
4		NQR	C Diff (differential impact if annual target exceeded)	37	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0
2		NQR	RTT Waits >52 weeks Incomplete Pathway (£5,000 per breach)	0	0.0	5.0	0.0	0.0					5.0	0.0	0.0	5.0	0.0					5.0	0.0	0.0	0.0	5.0					5.0	0.0	5.0	5.0	5.0					15.0
11		NQR	WMAS Handovers to ED (£200 per breach 30 - 60 minutes)	0	23.2								23.2	27.2								27.2	25.0								25.0	75.4								75.4
11		NQR	WMAS Handovers to ED (£1000 per breach >60 minutes)	0	15.0								15.0	8.0								8.0	8.0								8.0	31.0								31.0
2		NQR	ED Trolley Waits >12 hours (£1,000 per breach)	0	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0
2		NQR	Cancelled Operations - no urgent operation cancelled for second time (£5,000 per breach)	0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
3		NQR	VTE Risk Assessment (£200 per breach)	=>95.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
13		NQR	Publication Of Formulary (withholding of 1% of actual monthly contract value for non publication)	0								0.0	0.0								0.0	0.0								0.0	0.0								0.0	0.0
9		NQR	Duty Of Candour (Non-payment for cost of care or £10,000 if cost of care unknown / indeterminate)	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
2		NQR	Completion of valid NHS Number in Acute Commissioning Data Set (£10 per breach)	=>99.0%									0.0									0.0									0.0	0.0	0.0	0.0						0.0
2		NQR	Completion of valid NHS Number in A&E Commissioning Data Set (£10 per breach)	=>95.0%	0.0		0.0						0.0	0.0		0.0						0.0	0.0		0.0						0.0	0.0		0.0						0.0
			ALL		73.4	71.9	7.9	0.0	0.0	0.0	0.0	0.0	153.2	120.7	61.5	20.0	0.0	0.0	1.4	0.0	0.0	203.6	121.5	55.9	9.5	5.0	0.0	0.0	0.0	0.0	191.9	315.6	189.3	37.4	5.0	0.0	1.4	0.0	0.0	548.7

Contractual Requirements - Local Quality Requirements

Data Source	Data Quality	Req	Indicator	Threshold	APRIL (£000s)									MAY (£000s)									JUNE (£000s)									YEAR TO DATE (£000s)								
					M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
3		LQR	Maternity - various (8)	Various									0.0									0.0									0.0				0.0					0.0
3		LQR	Stroke - thrombolysis (non payment for any >30 hours if 3 consecutive months of failure)	=>50.0%	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0
3		LQR	Stroke - >90% stay on ASU (non payment for breach if 3 consecutive months of failure)	=>90.0%	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0
3		LQR	Stroke - CT Scan <1 hr presentation (non payment for any >2 hours if 3 consec. months failure)	=>50.0%	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0
3		LQR	Stroke - CT Scan <24 hr presentation (non pay't for any >30 hours if 3 consec. months failure)	100%	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0
3		LQR	ED - Time to Initial Assessment <15 mins (£50 per breach between 92.0% and 95.0%)	=>95.0%									0.0									0.0									0.0	0.0			0.0					0.0
3		LQR	ED - Unplanned Reattendance within 30 days (£50 per breach between 5.00% and 8.00%)	=<5.00%	4.2		0.0						4.2	10.2		0.0						10.2	15.2		0.0						15.2	29.5		0.0						29.5
3		LQR	ED - Left Without Being Seen (lower £23 pay't per pt., & £15 per breach between 5.00% and 8.00%)	=<5.00%	0.0		0.0						0.0	0.0		0.0						0.0	0.0		0.0						0.0	0.0		0.0						0.0
2		LQR	DTOC - Less than 10 (provider responsible) per site (non pay't XS bed days)	<10 per site	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2		LQR	Letters for Evictions from Wards (non pay't XS bed days)	100%									0.0									0.0									0.0	0.0	0.0	0.0						0.0
2		LQR	Morning Discharges (< m'day) (no conseq. breach, traj. Q1(23%),Q2(27%),Q3(31%),Q4(35%))	Q1 (23%) - Q4 (35%)									0.0									0.0									0.0									0.0
2		LQR	DTA (delay in unplanned admiss. to clinically appro. bed) (8 hr(£250),10hr(£500),12hr(£1000)	0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
19		LQR	Pt's with small-cell lung cancer have t'ment initiated =<2w path. diagnosis (non pay't for breach)	=>80.0%	0.0								0.0	4.2								4.2									0.0	4.2								4.2
2		LQR	Paeds. have OP F/U app't <6 w discharge post meningoccal septicaemia (non pay't OP app't >6w)	100%				0.0					0.0				0.1					0.1				0.1					0.1				0.2					0.2
19		LQR	Pts. Admit. with MI presc. antiplatelet,statin or b. blocker(non pay for breach if 3 consec. m'ths fail.)	=>98.0%	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0
8		LQR	EOL Care (pt's (on SCP) achieving pref. place of death) (Consec. Fail triggers contract clause)	=>75.0%	0.0	0.0		0.0					0.0									0.0									0.0	0.0			0.0					0.0
3		LQR	WHO Safer Surgery Checlkist Compliance (3 components) (Consec. Breaches £1000 / month)	98%, 95% and 85%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
3		LQR	MRSA Screening (EL and NEL) (£1000 per month after 4 months consecutive breaches)	=>80.0% matched	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
4		LQR	Appro. Antimicrobial Stewardship (Q'ly Reporting (cc. CCG) (£1000 / Q'ter after 2 Q'ters breaches)	Submit Report	Assessed Quarterly									Assessed Quarterly													0.0				0.0					0.0					0.0
19		LQR	HbA1c (pt's achieved target <6 m after being set) (non pay't for breach after 3 m'ths fail)	=>75.0%	Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly								
19		LQR	HbA1c (pt's receiving written care plan with agreed targets) (£50 per breach)	=>90.0%	Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly								
2		LQR	Ethnicity Coding (£1000 per month after 2 months failure)	=>90.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
			ALL		4.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.2	14.4	0.0	0.0	0.1	0.0	0.0	0.0	0.0	14.5	15.2	0.0	0.0	0.1	0.0	0.0	0.0	0.0	15.3	33.7	0.0	0.0	0.2	0.0	0.0	0.0	0.0	33.9

Contractual Requirements - CQUIN (CQ)

Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	APRIL (£000s)									MAY (£000s)										JUNE (£000s)										YEAR TO DATE (£000s)									
						M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
8		CQ	FFT - Implementation of Staff FFT	125	Implement by end July	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8		CQ	FFT - Early Implementation of Patient FFT in OP / DC Departments	67	Implement by end Oct	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
8		CQ	FFT - Increase and / or Maintain Response Rate in ED areas	33.5	>Q1 rate	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0
8		CQ	FFT - Increase and / or Maintain Response Rate in IP areas	33.5	>Q1 rate	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0	0.0			0.0	0.0	0.0	0.0	0.0	0.0			0.0	0.0	0.0	0.0	0.0	0.0			0.0	0.0
8		CQ	FFT - Reduce Negative Responses (ED, IP and Mat'y) (%)	167	0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0	0.0			0.0	0.0	0.0	0.0	0.0	0.0			0.0	0.0	0.0	0.0	0.0	0.0			0.0	0.0
8		CQ	NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	42	50% reduction	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0	0.0			0.0	0.0	0.0	0.0	0.0	0.0			0.0	0.0	0.0	0.0	0.0	0.0			0.0	0.0
8		CQ	Dementia - Find, Assess and Refer	250	=>90.0%	47.3	15.8	0.0	0.0					63.0	0.0	0.0	0.0	0.0					0.0										0.0	47.3	15.8	0.0	0.0					63.0
8		CQ	Dementia - Clinical Leadership and Staff Training	42	In Place	0.0	0.0	0.0	0.0				0.0	0.0	0.0	0.0	0.0	0.0				0.0	0.0										0.0	0.0	0.0	0.0	0.0				0.0	0.0
8		CQ	Dementia - Supporting Carers of People with Dementia	133	Monthly Audit								0.0	0.0								0.0	0.0								0.0	0.0								0.0	0.0
9		CQ	Learning From Safeguarding Concerns	1332	Q'ly Report to Board	Assessed Quarterly									Assessed Quarterly																	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
2		CQ	Quality of Outpatient and Discharge Letters	489	Derived from base	Q1 Establish Assessment Criteria									Q1 Establish Assessment Criteria																	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
4		CQ	Sepsis - Use of Sepsis Care Bundles	1237	Derived from base									0.0								0.0									0.0	0.0	0.0	0.0	0.0					0.0
8		CQ	Pain Relief - Use of Pain Care Bundles	77	Derived from base	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0	0.0					0.0									0.0	0.0	0.0	0.0	0.0					0.0
9		CQ	Medication and Falls	1237	Derived from base	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0	0.0			0.0	0.0	0.0	0.0	0.0	0.0			0.0	0.0	0.0	0.0	0.0	0.0			0.0	0.0
9		CQ	Serious Untoward Incidents	1237	Derived from base	Assessed Quarterly									Assessed Quarterly																	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
14		CQ	Community Therapies - Effective Referral Management	83	Derived from base							0.0		0.0								0.0									0.0								0.0		0.0							0.0
14		CQ	Community Therapies - Community Dietetics	1237	Derived from base							0.0		0.0								0.0									0.0								0.0		0.0							0.0
12		CQ	Maternity - Low Risk Births	70	Q'ly Audit / Action Plan									0.0								0.0									0.0				0.0					0.0							0.0
16		CQ	Bechet's Disease	109	Quarterly Return	Assessed Quarterly									Assessed Quarterly											0.0						0.0			0.0					0.0							0.0
17		CQ	HIV Home Delivery Medicines (% patients receiving)	109	Derived from base	Assessed Quarterly									Assessed Quarterly												0.0					0.0			0.0					0.0							0.0
17		CQ	Retinopathy of Prematurity Screening (%)	109	Derived from base	Assessed Quarterly									Assessed Quarterly												0.0					0.0			0.0					0.0							0.0
17		CQ	Timely Administration of TPN for preterm infants	109	Derived from base	Assessed Quarterly									Assessed Quarterly												0.0					0.0			0.0					0.0							0.0
			ALL	8328		47.3	15.8	0.0	0.0	0.0	0.0	0.0	0.0	63.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	47.3	15.8	0.0	0.0	0.0	0.0	0.0	0.0	63.0

Contractual Requirements - Outcome Thermometer (OT) Incentive Scheme

Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	QUARTER 1 (£000s)									QUARTER 2 (£000s)									QUARTER 3 (£000s)									QUARTER 4 (£000s)									YEAR TO DATE (£000s)								
						M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		OT	ED Waits >4 hours (=>95.0% each Quarter)	400	=>95.0%	100.0		0.0						100.0									0.0									0.0									0.0	100.0		0.0						100.0
2		OT	RTT Admitted Care (0 failing specialties after Q1)	200	0	na	na	na	na					0.0	22.2	22.2	22.2	0.0					66.6	22.2	22.2	22.2	0.0					66.6									0.0	44.4	44.4	44.4	0.0					133.2
2		OT	RTT Non-Admitted Care (0 failing specialties after Q1)	200	0	na	na	na	na					0.0	66.7								66.7	66.7								66.7									0.0	133.4	0.0	0.0	0.0					133.4
1		OT	Cancer Waits (2 weeks)	400	=>93.0%									0.0									0.0									0.0									0.0	0.0								0.0
19		OT	Urgent & Emergency Care - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0									0.0	0.0								0.0
19		OT	Lipid Management in OP Clinics - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0									0.0	0.0								0.0
2		OT	Community Nursing (Quality & Info Requirements) - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0									0.0	0.0								0.0
14		OT	Dev'ment of Advice & Guidance Service and Map of Medicine - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0									0.0	0.0								0.0
2		OT	Cardiology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.61									0.0									0.0									0.0									0.0	0.0								0.0
2		OT	Paediatrics - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.64									0.0									0.0									0.0									0.0	0.0								0.0
2		OT	Dermatology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<2.48									0.0									0.0									0.0									0.0	0.0								0.0
2		OT	Geriatric Medicine - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.76									0.0									0.0									0.0									0.0	0.0								0.0
2		OT	Rheumatology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<4.99									0.0									0.0									0.0									0.0	0.0								0.0
2		OT	Gastroenterology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.45									0.0									0.0									0.0									0.0	0.0								0.0
2		OT	General Medicine - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<2.38									0.0									0.0									0.0									0.0	0.0								0.0
9		OT	Never Events (reduced incentive available (1 = 85% available, 2 (65), 3 (40), 4 (10), 5 (0)	-2000	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0									0.0									0.0									0.0	0.0								0.0
			ALL			100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	88.9	22.2	22.2	0.0	0.0	0.0	0.0	0.0	133.3	88.9	22.2	22.2	0.0	0.0	0.0	0.0	0.0	133.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	277.8	44.4	44.4	0.0	0.0	0.0	0.0	0.0	366.6

Contractual Requirements - Price Activity Matrix (PAM)

Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	APRIL (£000s)									MAY (£000s)									JUNE (£000s)									YEAR TO DATE (£000s)								
						M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		PAM	Elective (IP and DC)	52721	Contract Plan	31	62	-33	-6	-1	-1			52	-39	-39	-74	-25	1	2			-174										-8	23	-107	-31	0	1			-122
2		PAM	Non-Elective	82299	Contract Plan	38	-20	6	-24					0	104	1	-36	-24					45										142	-19	-30	-48					45
2		PAM	Excess Bed Days	20352	Contract Plan	14	10	-9	-19					-4	50	17	-7	-19					41										64	27	-16	-38					37
2		PAM	Accident & Emergency	20352	Contract Plan	-23		-23						-46	8		-33						-25										-15		-56	0					-71
2		PAM	Outpatient New	26337	Contract Plan	0	5	-1	-13	-1	0	0		-10	-9	-7	-32	-19	-1	0	0		-68										-9	-2	-33	-32	-2	0	0		-78
2		PAM	Outpatient Review	33208	Contract Plan	14	-15	14	-9	0	0	1		5	-1	-16	-25	-14	-1	0	0		-57										13	-31	-11	-23	-1	0	1		-52
2		PAM	Outpatient with Procedure	7336	Contract Plan	-11	23	-35	4					-19	-8	2	-56	-2					-64										-19	25	-91	2					-83
2		PAM	Outpatient Telephone Conversation	196	Contract Plan	1	0							1	1	0							1										2	0							2
2		PAM	Maternity	14219	Contract Plan				24					24				-10					-10													14					14
2		PAM	Occupied Cot Days	6000	Contract Plan				5					5				-3					-3													2					2
2		PAM	Unbundled Activity	9520	Contract Plan	-6	8	-4	1	0	0			-1	-38	-6	-4	2	0	0			-46										-44	2	-8	3	0	0			-47
2		PAM	Other Contract Lines	89552	Contract Plan	210	-10	108	15	-6	-27	0		290	-120	-2	173	9	-7	-41	0		12										90	-12	281	24	-13	-68	0		302
2		PAM	Community	36003	Contract Plan	0	0		-4		0	0		-4				-2		0	-2		-4										0	0		-6		0	-2		-8
			ALL			268	63	23	-26	-8	-28	1	0	293	-52	-50	-94	-107	-8	-39	-2	0	-352										216	13	-71	-133	-16	-67	-1	0	-59

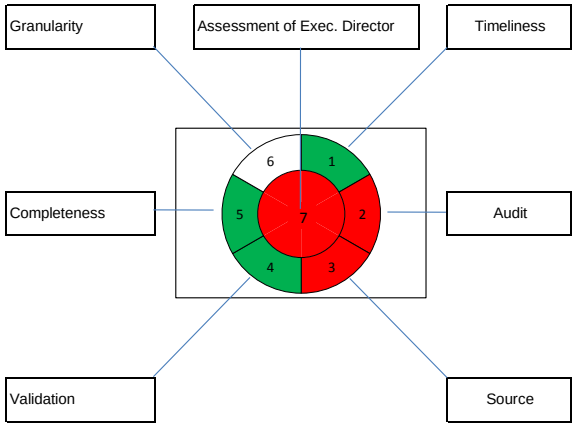
Legend

Data Sources	
1	Cancer Services
2	Information Department
3	Clinical Data Archive
4	Microbiology Informatics
5	Dr Foster
6	Healthcare Evaluation Data (HED) Tool
7	Workforce Directorate
8	Nursing and Facilities Directorate
9	Governance Directorate
10	Nurse Bank
11	West Midlands Ambulance Service
12	Obstetric Department
13	Operations Directorate
14	Community and Therapies Group
15	Strategy Directorate
16	Surgery B
17	Women & Child Health
18	Finance Directorate
19	Medicine & Emergency Care Group

Indicators which comprise the External Performance Assessment Frameworks		
●		NHS TDA Accountability Framework
	a	Caring
	b	Well-led
	c	Effective
	d	Safe
	e	Responsive
	f	Finance
●		Monitor Risk Assessment Framework
●		CQC Intelligent Monitoring

Groups	
M	Medicine & Emergency Care
A	Surgery A
B	Surgery B
W	Women & Child Health
P	Pathology
I	Imaging
C	Community & Therapies
CO	Corporate

Data Quality - Kitemark



Each outer segment of indicator is colour coded on kitemark to signify strength of indicator relative to the dimension, with following key:

Red	Insufficient
Green	Sufficient
White	Not Yet Assessed

The centre of the indicator is colour coded as follows:

Red / Green	As assessed by Executive Director
White	Awaiting assessment by Executive Director

If segment 2 of the Kitemark is Blank this indicates that a formal audit of this indicator has not yet taken place

Medicine Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
C. Difficile	30	3	●	●	●	●	●	●	●	●	●				Jun-14	0	0	1	1	4	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	●		
MRSA Screening - Elective (%)	80	80	●	●	●	●	●	●	●	●	●				Jun-14	75	86	44	69.4		●		
MRSA Screening - Non Elective (%)	80	80	●	●	●	●	●	●	●	●	●				Jun-14	92	95	88	92.41		●		
Falls	0	0							33	40	61				Jun-14	11	44	6	61	134	●		
Falls with a serious injury	0	0	5	2	5	1	1	1	1	2	3				Jun-14	2	0	1	3	6	●		
Grade 3 or 4 Pressure Ulcers (avoidable)	0	0	3	0	0	2	3	3	2	3					May-14				3	5	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	99.4	99.5	99.5	99.4		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●				Jun-14	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●				Jun-14	100	100	100	100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	●		
Serious Incidents	0	0					●	●	●	●	●				Jun-14	0	0	0	0	3	●		
Mortality Reviews within 42 working days	100	=>82.0	●	●	●	●	●	●	●						Apr-14	77	94	91	89		●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S	EC	AC	SC					
Pts spending >90% stay on Acute Stroke Unit (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●					91.2		91.2	87.4	●		
Pts admitted to Acute Stroke Unit within 4 hrs (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●					76.0		76.0	79.2	●		
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●					70.0		70.0	75.8	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●					100		100.0	100.0	●		
Stroke Admission to Thrombolysis Time (% within 60 mins)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●					50		50.0	73.9	●		
Stroke Admissions - Swallowing assessments (<24h) (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●					100		100.0	100.0	●		
TIA (High Risk) Treatment <24 Hours from initial presentation (%)	=>70.0	=>70.0	●	●	●	●	●	●	●	●	●					80.0		80.0	81.5	●		
TIA (Low Risk) Treatment <7 days from initial presentation (%)	=>75.0	=>75.0	●	●	●	●	●	●	●	●	●					91.4		91.4	90.0	●		
Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●					####		100.0	90.3	●		
Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●					####		100.0	95.2	●		
Rapid Access Chest Pain - seen within 14 days (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●					####		100.0	98.5	●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●							91.8	91.8		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●							100	100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●							88.2	88.2		●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
FFT Response Rate																						
FFT Score																						
Mixed Sex Accommodation Breaches	0	0	5	4	2	3	7	21	36	43	2				Jun-14	2	0	12	14	93	●		
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●				Jun-14	2.22	0.00	0.36	0.37		●		
28 day breaches	0	0	●	●	●	●	●	●	●	1	●				Jun-14	0	0	0	0	1	●		
Sitrep Declared Late Cancellations	0	0	13	2	2	7	7	4	10	2	7				Jun-14	1	0	6	7	19	●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	94.3 (s)	91.5 (c)		93.2	94.2	●		
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0 (s)	0 (c)		0	0	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●	●				Jun-14	13 (s)	18 (c)		16	18	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●	●				Jun-14	53 (s)	69 (c)		54	51	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●				Jun-14	7.98 (s)	6.94 (c)		6.94	6.31	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●				Jun-14	3.48 (s)	5.61 (c)		4.34	4.07	●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	0	0	●	●	●	●	●	●	●	●	●				Jun-14	68 (s)	57 (c)		125	377	●		
WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	0	0	●	●	●	●	●	●	●	●	●				Jun-14	2 (s)	6 (c)		8	31	●		
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●				Jun-14	####	99.2	98.4	98.6		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	####	90.8	93.9	92.6		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●				Jun-14	95.8	88.8	95.5	92.9		●		
Patients Waiting >52 weeks	0	0	17	6	4	0	0	0	0	0	0				Jun-14	0	0	0	0		●		
Treatment Functions Underperforming	0	0	4	5	4	4	5	5	6	3	5				Jun-14	0	2	3	5		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●				Jun-14	0.00	1.26	3.79	1.90		●		
WTE - Actual versus Plan			176	158	165	135	163								Feb-14				163				
PDRs - 12 month rolling (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	88	88	87		88	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	95	92	93		93	●		
Sickness Absence (%)	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●				Jun-14	3.84	4.69	3.08	4.06	4.15	●		
Mandatory Training (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	82	83	83		82	●		
New Investigations in Month			2	0	0	0	0	1	1	1	1				Jun-14				1				
Nurse Bank Use	34560	2880	●	●	●	●	●	●	●	●	●				Jun-14				2449	8069	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●				Jun-14				1699	5750	●		
Your Voice - Response Rate (%)			11		8		7								May-14	7	6	10	7				
Your Voice - Overall Score			3.73		3.68		3.58								May-14	3.53	3.68	3.59	3.58				

Surgery A Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
C. Difficile	7	1	●	●	●	●	●	●	●	●	●				Jun-14	1	0	0	0	1	3	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●				Jun-14	94	99	73	0	89.02		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●				Jun-14	97	95	99	93	96.57		●		
Falls	0	0							9	7	4				Jun-14	2	0	2	0	4	20	●		
Falls with a serious injury	0	0	1	0	1	1	0	1	0	0	0				Jun-14	0	0	0	0	0	0	●		
Grade 3 or 4 Pressure Ulcers (avoidable)	0	0	1	0	2	0	1	0	1	0					May-14					0	1	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●					Jun-14	98	99	97	99	98.1		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●				Jun-14	100	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	100	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●				Jun-14	100	100	100	100	100		●		
Never Events	0	0	●	1	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	0	●		
Serious Incidents	0	0				●	●	●	●	●	●				Jun-14	0	0	0	0	0	1	●		
Mortality Reviews within 42 working days	100	=>82.0	●	●	●	●	●	●	●						Apr-14	100	100	100	91	95.0		●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●					May-14	96		91		94.4		●		
2 weeks (Breast Symptomatic)	=>93.0	=>93.0	●	●	●	●	●	●	●	●					May-14	93.1				93.1		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●					May-14	100		100		100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●					May-14	100		90.5		95.5		●		
FFT Response Rate																								
FFT Score																								
Mixed Sex Accommodation Breaches	0	0	12	5	2	3	3	●	●	●	●				Jun-14	0	0	0	0	0	0	●		
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●				Jun-14	0.3	0.4	0.6	0.0	0.33		●		
28 day breaches	0	0	0	0	0	0	0	1	1	0	0				Jun-14	0	0	0	0	0	1	●		
Sitrep Declared Late Cancellations	0	0	28	35	25	28	37	18	13	16	5				Jun-14	2	1	2	0	5	34	●		
Hip Fractures - Operation < 24 hours of admission (%)	85	85	●	●	●	●	●	●	●	●	●				Jun-14		60.0			60.0	70.8	●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●				Jun-14	89.7	60.4	91.7		83.4		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	96.3	89.5	97.3		93.9		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●				Jun-14	93.4	84.8	90.6		89.1		●		
Patients Waiting >52 weeks	0	0	28	13	3	3	0	0	1	1	0				Jun-14	0	0	0	0	0		●		
Treatment Functions Underperforming	0	0	5	8	8	7	8	7	7	5	5				Jun-14	1	3	1	0	5		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●				Jun-14	4.45	0.00	26.4	0.00	11.23		●		
WTE - Actual versus Plan			70	71	72	88	76								Feb-14					76				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	90	76	89	84		86	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	95	86	100	88		91	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●				Jun-14	4.96	5.48	5.01	4.56	5.14	5.33	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	81	82	90	89		87	●		
New Investigations in Month			0	0	2	1	1	1	0	0	0				Jun-14					0				
Nurse Bank Use	9908	826	●	●	●	●	●	●	●	●	●				Jun-14					851	2443	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●				Jun-14					320	1155	●		
Your Voice - Response Rate			16		13			12							May-14	15	5	6	13	12				
Your Voice - Overall Score			3.03		3.55			3.53							May-14	3.5	3.4	3.6	3.6	3.53				

Surgery B Group

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		O	E					
C. Difficile	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●				Jun-14	93.75	95	94.39		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●				Jun-14	88	86	86.96		●		
Falls	0	0							1	0	0				Jun-14	0	0	0	1	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0				Jun-14	0	0	0	0	●		
Grade 3 or 4 Pressure Ulcers (avoidable)	0	0	0	0	0	0	0	0	0	0					May-14	0	0	0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●						Jun-14	98.5	97.2	98.1		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●				Jun-14	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●				Jun-14	99.4	100	99.53		●		
Never Events	0	0	●	1	●	1	●	●	●	●					Jun-14	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	●		
Serious Incidents	0	0				●	●	●	●	●	●				Jun-14	2	0	2	2	●		
Mortality Reviews within 42 working days	=>82.0	=>82.0	●	●	●	●	●	●	●						Apr-14		0	0		●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		O	E					
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●					May-14		91.0	**91.0**		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●			●	●	●	●					May-14		100	**100.0**		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0		●	●	●	●	●		●					May-14		0.0	**0.0**		●		
FFT Response Rate																						
FFT Score																						
Mixed Sex Accommodation Breaches	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	**0**	**0**	●		
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●				Jun-14	1.22	2.18	**1.54**		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0				Jun-14	0	0	**0**	**0**	●		
Sitrep Declared Late Cancellations	0	0	**19**	**14**	**19**	**36**	**15**	**22**	**3**	**22**	**17**				Jun-14	9	8	**17**	**42**	●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	96.56		**96.6**	**98.5**	●		
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0		**0**	**0**	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●	●				Jun-14	13		**13**	**13**	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●	●				Jun-14	22		**22**	**20**	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●				Jun-14	3.61		**3.61**	**3.18**	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●				Jun-14	2.51		**2.51**	**1.68**	●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		O	E					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●				Jun-14	90.3	89.8	90.1		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	98.0	96.5	97.6		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●				Jun-14	95.8	90.0	93.9		●		
Patients Waiting >52 weeks	0	0	9	9	2	0	1	1	0	1	1				Jun-14	0	1	1		●		
Treatment Functions Underperforming	0	0	1	0	0	2	3	3	3	4	3				Jun-14	0	3	3		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●					Jun-14	0.00	0.00	0.0		●		
WTE - Actual versus Plan			31	24	23	27	37								Feb-14			37				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	82	89		85	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	92	100		94.0	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●				Jun-14	3.38	3.33	3.57	3.04	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	85	93		87	●		
New Investigations in Month			0	0	0	1	0	0	0	0	0				Jun-14			0				
Nurse Bank Use	2796	233	●	●	●	●	●	●	●	●	●				Jun-14			258	702	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●				Jun-14			49	198	●		
Your Voice - Response Rate			17			18			19						May-14	13	31	19				
Your Voice - Overall Score			3.66			3.72			3.73						May-14	3.75	3.69	3.73				

Women & Child Health Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
C. Difficile	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●				Jun-14	99				98.16		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●				Jun-14		100			100		●		
Falls	0	0							0	0	2				Jun-14	0	2	0	0	2	2	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0				Jun-14	0	0	0	0	0	0	●		
Grade 3 or 4 Pressure Ulcers (avoidable)	0	0	0	0	0	0	0	0	0	0					May-14	0	0	0	0	0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●					Jun-14	97	82			88.6		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●				Jun-14	100	100			100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	100	100			100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●				Jun-14	100	100			100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	0	●		
Serious Incidents	0	0				●	●	●	●	●	●				Jun-14	0	0	0	0	0	2	●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
Caesarean Section Rate - Total (%)	=<25.0	=<25.0	●	●	●	●	●	●	●	●	●				Jun-14		28			27.98	26.9	●		
Caesarean Section Rate - Elective (%)			11	10	11	12	11	10	14	8	9				Jun-14		8.6			8.55	8.8			
Caesarean Section Rate - Non Elective (%)			13	15	10	16	14	13	12	18	18				Jun-14		18			18.29	17.6			
Maternal Deaths	0	0	●	●	●	●	●	●	●	●	●				Jun-14		0			0	0	●		
Post Partum Haemorrhage (>2000ml)	48	4	●	●	●	●	●	●	●	●	●				Jun-14		0			0	0	●		
Admissions to Neonatal Intensive Care (%)	=<10.0	=<10.0	●	●	●	●	●	●	●	●	●				Jun-14		2.4			2.35	4.26	●		
Adjusted Perinatal Mortality Rate (per 1000 babies)	<8.0	<8.0	●	●	●	●	●	●							Mar-14		11			11.3		●		
Early Booking Assessment (<12 + 6 weeks) (%) - SWBH Specific	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●				Jun-14		72			72.49		●		
Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=>90.0	=>90.0	●	●	●	●	●	●							Jun-14		134			134		●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
Mortality Reviews within 42 working days	=>80.0	=>80.0	●	●	●	●	●	●	●						Apr-14	100				100		●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●					May-14	92		100		92.1		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●					May-14	100				100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●					May-14	84				84.2		●		
FFT Response Rate																								
FFT Score																								
Mixed Sex Accommodation Breaches	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0				0	0	●		
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●				Jun-14	1.2				1.22		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0				Jun-14	0				0	0	●		
Sitrep Declared Late Cancellations	0	0	4	13	14	13	7	12	12	3	4				Jun-14	4				4	19	●		
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●				Jun-14	94.3				94.3		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	97.9				97.9		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●				Jun-14	98.9				98.9		●		
Patients Waiting >52 weeks	0	0	4	4	2	0	0	0	0	0	1				Jun-14	1				1		●		
Treatment Functions Underperforming	0	0	0	0	0	0	0	0	0	0	0				Jun-14	0				0		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●				Jun-14	0.0				0.0		●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
WTE - Actual versus Plan			64	39	42	41	34								Feb-14					34				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	87	85	88	89		86	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	100	73	100			90	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●				Jun-14	3.87	4.18	3.81	4.91	4.12	4.41	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	88	84	85	88		85	●		
New Investigations in Month			1	0	0	0	0	0	0	0	0				Jun-14					0				
Nurse Bank Use	6852	571	●	●	●	●	●	●	●	●	●				Jun-14					409	1483	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●				Jun-14					13	107	●		
Your Voice - Response Rate			17		11			14							May-14	21	7	22	20	14				
Your Voice - Overall Score			3.74		3.79			3.74							May-14	3.9	3.9	3.6	3.6	3.74				

Pathology Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate					Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		HA	HI	B	M	I					
Never Events	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	0	0	●		
WTE - Actual versus Plan			31	32	30	37	33								Feb-14						33				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	95	93	89	100	88		94	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	100	100	100	100	100		100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●				Jun-14	6.45	0.34	3.13	3.19	0.37	4.39	4.12	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	94	96	95	94	98		95	●		
New Investigations in Month			0	0	0	0	0	0	0	0	0				Jun-14						0				
Your Voice - Response Rate			17		36			30							May-14	38	34	20	32	56	30				
Your Voice - Overall Score			3.31		3.6			3.43							May-14	3	3.4	3.9	3.4	3.79	3.43				

Imaging Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		DR	IR	NM	BS					
Never Events	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	0	●		
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●				Jun-14			70.0		70.0	75.8	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●				Jun-14			100		100.0	100.0	●		
Mixed Sex Accommodation Breaches	0	0	●	●	●	●	●	●	●	●	●				Jun-14	0	0	0	0	0	0	●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●			Jun-14	0.2				0.20		●		
WTE - Actual versus Plan			26	20	21	18	28								Feb-14					28				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	88	100	100	95		92	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	96		100			97.0	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●				Jun-14	4	7.4	0.19	6.9	5.11	4.45	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	89	92	92	94		91	●		
New Investigations in Month			0	0	1	0	0	0	0	2	2				Jun-14					2				
Nurse Bank Use	288	24	●	●	●	●	●	●	●	●	●				Jun-14					12	40	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●				Jun-14					202	491	●		
Your Voice - Response Rate			30		19		27								May-14	25	18	43	27	27				
Your Voice - Overall Score			3.73		3.72		3.79								May-14	3.6	4.6	4.2	3.8	3.79				

Community & Therapies Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		AMB	IB	IC					
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●				Jun-14				100		●		
Patient Safety Thermometer - Overall Harm Free Care	=>92	=>92	91	90	92	94	93	92	90	94	93				Jun-14				92.58		●		
Falls	=<0.4	=<0.4	0.4	0.2	0.0	0.0	0.2	0.0	0.6	0.0	0.0				Jun-14				0.0	0.2	●		
Pressure Ulcers	=<7.0	=<7.0	8.9	9.5	7.5	5.6	6.9	8.7	9.5	5.7	7.4				Jun-14				7.42	7.5	●		
Never Events	0	0	●	●	●	●	●	●	●	●	●				Jun-14				0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●				Jun-14				0	0	●		
FFT Response Rate - Wards	=>28.0	=>28.0	19	13	15	13	6	22	16	19	15				Jun-14				15	50	●		
FFT Score - Wards	=>68.0	=>68.0	94	100	93	85	83	82	81	95	87				Jun-14				87	87	●		
Mixed Sex Accommodation Breaches	0	0	●	●	●	●	●	●	●	●	●				Jun-14				0	0	●		
WTE - Actual versus Plan			55	70	32	34	34								Feb-14				34				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14					87.5	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14					100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●				Jun-14	3.24	3.8	4.51	4.07	3.95	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14					90	●		
New Investigations in Month			0	0	1	0	1	1	0	0	0				Jun-14				0				
Nurse Bank Use	5408	451	●	●	●	●	●	●	●	●	●				Jun-14				319	868	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●				Jun-14				268	804	●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		AMB	IB	IC					
Your Voice - Response Rate			28		18			33							May-14				33				
Your Voice - Overall Score			3.71		3.75			3.78							May-14				3.78				
DVT numbers	730	>61			30	40	57	53	53	62	87				Jun-14				87	202	●		
Therapy DNA rate OP services (%)	=<9	=<9					11	12	12	16	11				Jun-14				11	13	●		
FEES assessment	>100	>8.3						1	7	10	3				Jun-14				3	6.7	●		
ESD Response time	<48 hrs	<48 hrs				●	●	●	●	●	●				Jun-14						●		
STEIS	0	0			2	0	0	1	0	2	1				Jun-14				1	3	●		
Rapid response to AMU, RRTS	<60 mins	<60 mins			77	75	75	75	75	71					May-14				71	73	●		
Avoidable weight loss	<20%	<20%		●	●	●	●	●	●	●	●				Jun-14				8	8.6	●		
Green Stream Community Rehab response time for treatment (days)	=<11	=<11					15	11	12	7.9	11				Jun-14				11.2	10.36	●		

Corporate Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate							Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		CEO	F	W	M	E	N	O					
WTE - Actual versus Plan			191	215	187	161	164								Feb-14								164				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	83	77	85	91	96	95	84		91	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14			100						100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●				Jun-14	2.31	1.55	2.57	2.94	1.68	5.62	3.93	4.17	4.16	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jun-14	95	93	96	89	99	89	92		91	●		
Nurse Bank Use	1088	91	●	●	●	●	●	●	●	●	●				Jun-14								188	452	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●				Jun-14								13	32	●		
New Investigations in Month			0	1	0	0	2	2	0	1	3				Jun-14								1				
Your Voice - Response Rate					26			29							May-14	63	45	38	30	21	28	19	29				
Your Voice - Overall Score					3.56			3.57							May-14	3.70	3.65	3.65	3.52	3.34	3.51	3.66	3.57				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**System Resilience : elective and non-elective care planning an d performance update**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow Chief Operating Officer**
AUTHOR:	**Rachel Barlow Chief Operating Officer**
DATE OF MEETING:	**7 August 2014**

EXECUTIVE SUMMARY:

NHS England are introducing 'System Resilience Groups' (SRG's) , which are local groups that build on the existing Urgent Care Network Boards, their next evolvement being elective care.
This paper outlines the purpose of these groups and a briefing on the principles of system wide planning for elective and non-elective care. The final (resilience) plan will be presented to the September Trust Board and other partner governing bodies for approval.

18 weeks:
In June the delivery against plan from the original trajectory was to achieve Trust level compliance with underperformance planned in 6 treatment functions. Trust compliance was achieved; but with 12 points of specialties failing ENT, General Surgery, Urology, Respiratory, Gastroenterology and Dermatology being the outliers.

There were two 52 week breaches reported in month, the initial root causes are complete and no adverse clinical outcomes have been identified as a result of these long waits.

The Trust is setting up an elective project office, led full time by Matthew Dodd Deputy COO to tackle diagnostic and elective care waits, with new expertise joining the delivery team.

The Trust has submitted a plan that holds Trust compliance on a monthly basis and recovers T&O, Oral Surgery and Cardiology to specialty performance in January, maintaining Trust Compliance throughout. This is dependent on finalising staffing an independent sector capacity and funding from resilience monies in August.

Emergency Care:
The Trust have underperformed against the improvement plan in the first 5 weeks; main breach causes:

- Delays in time to assessment in ED
- Mental health delays – are long with high impact on ED capacity.
- Delayed transfers of care remain consistently high affecting bed flow; these pressures compounded further on the Sandwell site by high unforecast activity and acuity

It is anticipated that in late July and August onwards the performance standards are met.

REPORT RECOMMENDATION:

The Trust Board is asked to consider the briefing and discuss the findings

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

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

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Risk register and previous board discussion and presentations related to 18 week performance, ED
PREVIOUS CONSIDERATION:
Trust Board and Quality & Safety Committee

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Operational Resilience planning and performance update for 18 Week Referral to Treatment and Emergency Care

REPORT TO THE TRUST BOARD – 7 AUGUST 2014

1. Introduction

Further to the Trust Boards last update on 18 weeks, following national announcement by the Secretary of State to reduce backlogs above 16 weeks waits, NHS England are introducing 'System Resilience Groups' (SRG's) , which are local groups that build on the existing Urgent Care Network Boards, their next evolvement being elective care.

This paper outlines the purpose of these groups and provides an update to the resilience planning for both elective and emergency care as well as a performance update.

2. System Resilience Groups (SRG)

SRG's will be chaired by a senior CCG member, in our case the Chief Officer of SWBCCG. The forum will include managerial and clinical membership from health and social care system. The remit is to come together to plan for the capacity to ensure delivery, oversee coordination and integration of services to support the delivery of high quality accessible services which are good value for tax payers. The remit to the work is both elective and urgent (non-elective) care, across the entire year – not just 'winter'.

The principles of good practice within the published guidance for operational resilience and capacity planning are as follows;

Non elective care

- Planning – accurate demand and capacity modelling system wide
- Primary care- increase provision as part of a local integration strategy to support out of hospital care; focus on disease prevention e.g.; flu
- 7 day working – improve services to provide a more responsive and patient centred delivery across the 7 day week including social services at weekends; SRG's should service to link to the Better Care Fund principles
- Patient experience – expand and adapt services to meet the needs of the highest intensity patients within emergency care; consultant led rapid assessment and treatment systems must be in place, medicines optimisation across 7 days, processes in place to minimise delayed discharges and reduce admissions of older people
- Measurement – real time data system wide

Elective care

- Planning – standard policies and SOPs to include cancer, urgent planned and elective patients; training programme for all staff involved in RTT, demand and capacity analysis
- Building on existing work – build upon capacity mapping currently underway
- Pathway redesign – common pathways from referral (including demand management) to treatment, ensure patient choice, right size waiting lists
- Measurement – review local application of rules, pay attention to data quality, put in place clear performance management standards
- Governance – assurance at Board level

Whilst decisions on any aspect of funding will be made by the relevant statutory body or shared governance arrangements, the SRG has a key role in building consensus across members and stakeholders and advising on the use of non-recurrent funds and marginal tariff.

Governance of this group reports to then LAT and through membership back to host organisations. Membership of the local SRG will be confirmed in the next month and will include Executive level membership. A Chief Executive, Chief Officer Forum is likely to sit alongside the SRG and the delivery arm supported by a number of focused sub groups (e.g.; urgent care, planned care, mental health).

The SRG will coordinate an initial system wide plan to be submitted to NHS England end of July. This includes bids for non-recurrent funding for both emergency and elective care. The plan will be further developed over August and be presented to the respective governing bodies and Boards at the end August / start September. The Trust Board will receive the System wide Resilience Plan for approval in September.

3. 18 week Referral to treatment

June's performance:

In June the delivery against plan from the original trajectory was to achieve Trust level compliance with underperformance planned in 6 treatment functions. Trust compliance was achieved; but with 12 points of specialties failing ENT, General Surgery, Urology, Respiratory, Gastroenterology and Dermatology being the outliers. Whilst there is some unanticipated demand side growth and capacity issues with unplanned absence in ENT, a small impact from emergency surgery demand, underperformance has been attributed to failure to operationally deliver the plan for medical specialties.

There were two 52 week breaches reported in month, the initial root causes point to; incorrectly adding a patient to the planned waiting list instead of the elective waiting list and clock stopping a patient at a diagnostic admission. Audits of both groups will be completed by end August seek assurance if an isolated error.

Both patients have been risk assessed and whilst the long wait is unacceptable, there were no adverse clinical outcomes.

In line with national resilience planning the Trust has been asked by the CCG to re-profile its trajectories to achieve compliance with the 18 week Referral to Treatment targets (for Admitted, Non-admitted and Incomplete pathways) and to ensure that backlogs of patients waiting greater than 18 weeks would be reduced. Initially this was with a view to achieving 16 weeks RTT, but it has now been agreed that the trajectories will focus on compliance with the 18 weeks standards at speciality level and reduction in overall waiting list backlog.

The latest round of activity modelling has been undertaken with a view to reducing backlogs faster than originally planned and has afforded an opportunity to review the capacity that specialties are intending to provide. The plan is deliverable in terms of activity and capacity through a mix of in house and/or private sector work. Final delivery through these routes is being determined as we confirm independent sector capacity and appoint locums. The estimated cost at this stage is £2.4m

The Trust has submitted a plan that holds Trust compliance on a monthly basis and recovers T&O, Oral Surgery and Cardiology to specialty performance in January, maintaining Trust Compliance throughout.

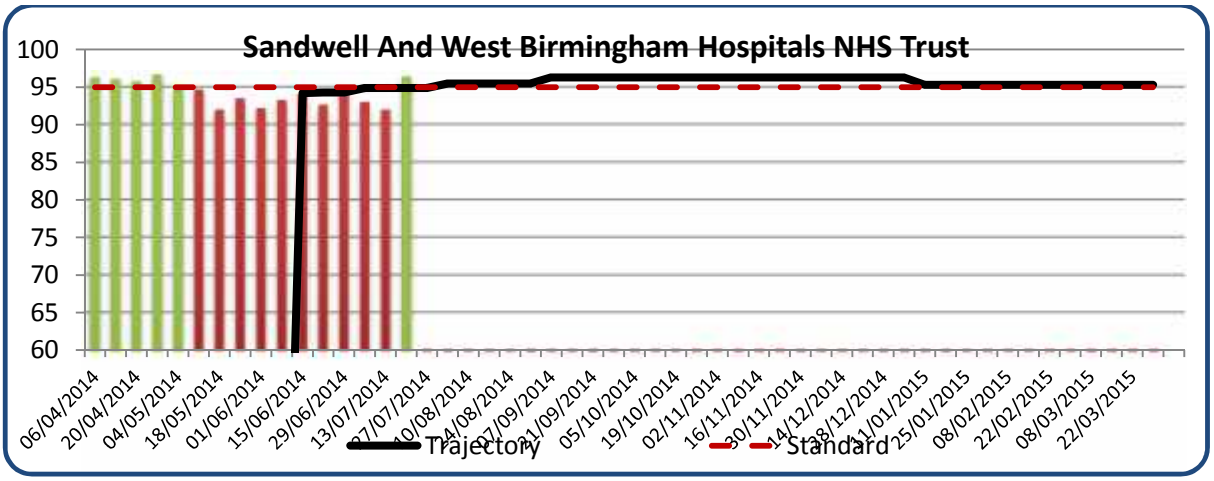
Area	Specialty	Breach until:	Aug	Sept	Oct	Nov	Dec	Jan
Admitted								
	T&O	End of 12/ 014	60	76.23	75	75	75	90
	Oral Surgery	End of 12/2014	85	85	87	87	87	90
	Cardiology	End of 12/2014	87.85	87.5	85.12	85.96	79.17	91.54
	Trust		90.3	91.7	91	90.0	90.6	92.6
Non-Admitted								
	Cardiology	End of 12/2014	71.57	77.10	76.74	85.72	85	95
	Trust		95.4	95.6	95.1	95.6	96.6	96.9
Incomplete								
	T&O	End of 08/2014	88.67					
	Oral Surgery	End of 09/2014	87.42	91.80				
	Cardiology	End of 09/ 2014	86.91	90.99				
	Trust		93.5	95.2	96.2	96.4	96.6	96.6

In terms of affordability the recovery plan is dependent on non-recurrent funding from the CCG. The final delivery plan and funding will be confirmed over the coming weeks with the CCG. Final resilience delivery plans will be submitted to Trust Board September.

The Trust is setting up an elective project office, led full time by Matthew Dodd Deputy COO to tackle diagnostic and elective care waits. He is supported by a new post of project manager for 18 weeks, Nicola Cooper, who has undertaken that role elsewhere and brings new expertise to the Trust. Alison Davies from the IST has joined the Trust to run the dominant elective care group – surgery A. These changes were effective July 1st. A PMO expert in the trust (KMT) is also commissioned to support the rapid set-up of this office.

4. Emergency Care

The Trust submitted a recovery trajectory for emergency performance but has under delivered for the first 5 weeks. It is anticipated that standards are met in late July and August onwards.



The key breach reasons throughout the period of underperformance remain related to the key focus of the recovery plan:

- Delays in time to assessment in ED – recruitment results are positive, City ED can now consistently staff the additional day time consultant shift over the peak period. Situational shift leadership at City remains a consistent area of attention. Shaun Nakash (CD) is concentrating clinical time on this site, with increased Executive oversight with the Group and Directorate Triumvirate working with the Executive on the local development plan.
- Mental health delays – are long with high impact on ED capacity. Work in train to establish additional assessment capacity with good engagement from both partners.
- Delayed transfers of care remain consistently high affecting bed flow - mitigated by opening additional beds – up to 20. Preparatory work in train to launch new joint health and social care assessment team in August.

The Sandwell site had a period of particularly pressure in June / early July with unforecast high activity and acuity, this coupled with high levels of DTOC on site impacted directly on performance. The Ambulance service remained on their highest escalation alert REAP level 4 with the Black Country area being a particular area of pressure.

Resilience bids are expected to fund schemes aligned to the recovery plan across winter to further increase senior decision makers capacity in ED, increase bed stock in intermediate and acute care and support the mental health initiatives.

5.0 Conclusion

The Trust Board is recommended to note the mandated introduction of the System Resilience Group and discuss the performance trajectories for elective and non-elective care. The Trust Board will receive a full system resilience plan for approval in September.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Patient safety data on NHS Choices
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	7 August 2014

EXECUTIVE SUMMARY:

New data was published for the first time at the end of June to allow the public the opportunity to compare key safety measures across NHS trusts in England.

The patient safety information on NHS Choices allows you to compare hospitals and find out how they are doing in terms of cleanliness and infections such as MRSA, preventing blood clots, or reporting incidents. It also shows if a hospital has enough nursing and midwifery staff to provide safe care to patients.

No data can provide certainty about how safe the care of an individual patient was, is or will be, or determine whether hospitals are safe or not. But it is an important tool that allows patients, the public and the NHS to ask questions and encourage continuous improvement.

The patient safety data published on NHS Choices for our locations has been extracted and is provided in **Appendix A**. **In all areas published a good position is shown for the Trust**. This is not the case for some organisations where indicators are described as "*amongst the worst*" or "*some standards not met*". Maintenance and improvement of our performance against the indicators will continue through our established monitoring and assurance arrangements.

To assist the public, a glossary is available on the website which provides a description of the each indicator and explains the data sources that inform the ratings. This can be found at **Appendix B**.

REPORT RECOMMENDATION:

1. **Board members are asked to DISCUSS** the Trust's position against the patient safety indicators published on NHS Choices.

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:

To provide Safe, High Quality Care

PREVIOUS CONSIDERATION:

None

Appendix A

Patient Safety Data on NHS Choices for Sandwell and West Birmingham Hospitals NHS Trust

Hospital	Infection control and cleanliness	Care Quality Commission national standards	Recommended by staff	Safe Staffing	Patients assessed for blood clots	NHS England patient safety notices	Open and honest reporting
Sandwell General Hospital	As expected	All standards met	Within expected range with a value of 59.02%	121% of planned level	98.30% of patients assessed	Good - All alerts signed off where deadline has passed	As expected
City Hospital	As expected	All standards met	Within expected range with a value of 59.02%	114% of planned level	98.30% of patients assessed	Good - All alerts signed off where deadline has passed	As expected
Rowley Regis Hospital	Among the best	All standards met	Within expected range with a value of 59.02%	121% of planned level	98.30% of patients assessed	Good - All alerts signed off where deadline has passed	As expected
Bradbury Day Care Centre	n/a Data not available	All standards met	Within expected range with a value of 59.02%	n/a Data not available	98.30% of patients assessed	Good - All alerts signed off where deadline has passed	As expected
Birmingham Treatment Centre	n/a Data not available	n/a Data not available	Within expected range with a value of 59.02%	n/a Data not available	98.30% of patients assessed	Good - All alerts signed off where deadline has passed	As expected

Appendix B

Glossary of patient safety indicators

Care Quality Commission: national standard

The Care Quality Commission (CQC) is the independent regulator for health and adult social care in England. CQC checks whether services meet national standards of quality and safety. The indicator on NHS Choices shows you whether a hospital is meeting safety standards as expected.

Hospitals are rated as either meeting the required standards or not. This is the most authoritative view of the safety of a hospital and is the most meaningful source of data on patient safety available.

Safe staffing: nursing hours filled as planned hide

Find out how well a hospital's nursing and midwifery staffing requirements are being met.

Nurses, midwives and care staff are part of a wider team of healthcare professionals providing patient care. Often working alongside therapists, specialist nurses and psychologists, they play an important role in providing high quality and safe care to patients.

Safety of care relates to a number of factors, including the skills and experience of staff and the different needs of patients in their care. Each ward manager works closely with the director of nursing to make decisions about staff requirements for each shift, and ensure patient needs can be met. The number of staff required at any time is called the planned staffing number.

The data is presented in two ways on NHS Choices:

1. You can see if a hospital's nursing and midwifery staffing requirements are being met overall.
2. For each hospital, you can also see as a percentage of hours in a day or night whether the actual number of nurses on duty met what was planned in a hospital or ward. We will present a result for both registered and unregistered nurses.

Sometimes the actual staffing number is below the planned number. This may be the result of staff sickness, or because there is a lower number of patients on the ward than usual, so staff have been moved to work in another area.

Sometimes the actual staffing number will be higher than the planned number. This may be because there are a lot of patients on the ward who need extra care because of their physical or mental health condition.

Some hospitals will be unable to meet their staffing needs with permanent staff all of the time on every shift.

Information about staffing levels alone cannot tell you whether a hospital is safe or unsafe, but a regular lower percentage of the planned staff being in place is a cause for concern.

What is the difference between an unregistered and a registered nurse?

A registered nurse is a member of the registered nursing or midwifery staff on the duty rota dedicated to the inpatient wards. This includes supervisory ward managers, sisters, charge nurses, midwives and staff nurses.

An unregistered nurse is a member of staff on the duty rota dedicated to the inpatient wards whose work is supervised by a registered nurse.

Infection control and cleanliness

Find out how well an organisation performs in terms of infection control and cleanliness.

The indicator you can see on this website is constructed from the existing data displayed about the number of Clostridium difficile (C. difficile) and MRSA infections, and patients' views on the cleanliness of wards.

The patient safety indicator combines this information with additional data to provide an overall rating for preventing infection and cleanliness.

The results are displayed with different coloured icons:

- green = good
- blue = OK
- red = poor

The rating does not describe whether a hospital is safe, but it does give an indication of how it is performing in terms of cleanliness and infections.

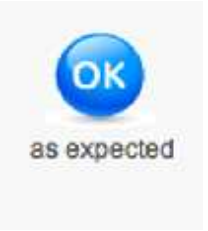
Open and honest reporting

You can now find out how well your hospital performs in open and honest reporting of patient safety incidents. This indicator gives an overall picture of whether the hospital has a good patient safety incident reporting culture.

A good reporting culture means that the hospital reports incidents frequently – serious incidents as well as those with low or no harm to patients. Reporting even these less serious incidents shows that an organisation understands that these are opportunities to learn and improve.

A good reporting culture is also indicated when members of staff can say their organisation has a fair and effective incident reporting procedure.

The ratings for this indicator are displayed with different coloured icons:



- green = good
- blue = OK
- red = poor

This does not describe whether a hospital is safe, but it does give an indication of how well developed the hospital's patient safety incident reporting culture is.

Patients assessed for risk of blood clots hide

Deep vein thrombosis (DVT) and pulmonary embolism are collectively known as venous thromboembolism (VTE), a condition where blood clots form in the veins. Anyone can develop VTE, but people are more at risk when they are less mobile and unwell. This means that the risk of VTE increases with acute medical illness, long-term health problems, and some surgical operations.

Hospitals are expected to assess the patients they admit for the risk of VTE. All hospitals should risk-assess at least 95% of inpatients when they are admitted. A value above 95% is good and fewer than this is poor.

NHS England patient safety reporting

Patient safety alerts are sent out by NHS England to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death.

Alerts are key in helping hospitals to improve the quality of care they provide. They also demonstrate a hospital's accountability for the safety of their patients. All hospitals should respond to patient safety alerts in the timeframe given to them by NHS England. Any delay in taking the relevant actions required is a cause for concern.

The performance of your hospital is shown on NHS Choices in two ways:

- poor = the hospital has not completed one or more safety alerts for which the deadline has passed
- good = the hospital has dealt with all patient safety alerts within the given timeframe

Recommended by staff

This indicator shows the percentage of staff (as measured by the NHS Staff Survey) happy to recommend the hospital if a friend or relative needed treatment. It is based on the standard of care the hospital provides.

The indicator is displayed on three ways on this site. It shows if the hospital is performing:

- as expected
- worse than average
- better than average

The rating does not describe whether a hospital is safe, but staff opinion of the quality of care provided by an organisation is an important indicator about the safety of care and the quality of care in general.

NHS Safety Thermometer data on pressure ulcers and falls with harm

% of patients who have been hurt in a fall in the last 3 days	0.30%
% of patients being treated for a bed sore (pressure ulcer)	4.42

The NHS Safety Thermometer is a point of care survey instrument. It is used in hospitals and other organisations to check how many patients in their care have suffered one or more of a defined list of "harms" associated with patient safety. It allows teams to measure harm and the proportion of patients that are "harm free" during their working day.

For more detailed information, visit either the NHS Safety Thermometer or the Health and Social Care Information Centre(HSCIC) website.

On NHS Choices we display two "harms" measured by the NHS Safety Thermometer on each hospital's overview page profile. You can see:

- the number of patients being cared for who have a pressure ulcer (bed sore)
- the number of patients being cared for who have been hurt by a fall in the last three days

You'll also be able to see the percentage of patients surveyed each month.

Note: NHS Safety Thermometer data should not be used to compare hospitals or make judgments about which hospitals are safer than others.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	CQC Intelligent Monitoring
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	7 August 2014

EXECUTIVE SUMMARY:

The Care Quality Commission (CQC) has this month published the third set of Intelligent Monitoring (IM) reports for acute and specialist trusts in England.

The CQC looks at more than 150 different pieces of data (indicators), including information from staff and patient surveys, mortality information and hospital performance information such as waiting times and infection rates. Together with local information from partners and the public, this monitoring helps the CQC decide when, where and what to inspect.

The CQC has taken the results of their Intelligent Monitoring analysis and grouped the 160 acute and specialist NHS trusts into six priority bands for inspection which are based on the possibility that people may not be receiving safe, effective and high quality care. The trusts which have already been inspected and are categorised as "recently inspected" are not included. Trusts in band 1 are the CQC's highest priority for inspection and those in band 6 are the lowest. The CQC uses the indicators to raise questions about the quality of care. They do not use them on their own to make final judgments. This will only happen once CQC has carried out an inspection.

The 'headline' is that the Trust has been placed in Band 6, meaning we have the lowest risk of breaching the Essential Standards. Our Intelligent Monitoring report is attached.

Of positive note is that since their launch three IM reports have been issued and each time our rating against the quality indicators has improved (October 2013 - Band 4, March 2014 - Band 5, July 2014 - Band 6). We are now in the most favourable category. This together with our aspirant FT status is likely to have played a part in the CQC deciding to carry out their Chief Inspector of Hospitals visit at the beginning 13 October 2014.

REPORT RECOMMENDATION:

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

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	✓	

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

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

Comments:

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

High quality care

PREVIOUS CONSIDERATION:

Results verbally reported to the Quality and Safety Committee on 25 July 2014.

SWBTB (8/14) 123 (a)

Intelligent Monitoring Report

Report on

Sandwell and West Birmingham Hospitals NHS Trust

July 2014

CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. These indicators relate to the five key questions we will ask of all services – are they safe, effective, caring, responsive and well-led? The indicators will be used to raise questions about the quality of care. They will not be used on their own to make judgements. Our judgements will always be based on the result of an inspection, which will take into account our Intelligent Monitoring analysis alongside local information from the public, the trust and other organisations.

What does this report contain?

This report presents CQC's analysis of the key indicators (which we call 'tier one indicators') for Sandwell and West Birmingham Hospitals NHS Trust. We have analysed each indicator to identify two possible levels of risk.

We have used a number of tests to determine where the thresholds of "risk" and "elevated risk" sit for each indicator, based on our judgement of which statistical tests are most appropriate. These tests include CUSUM and z-scoring techniques. Where an indicator has 'no evidence of risk' this refers to where our statistical analysis has not deemed there to be a "risk" or "elevated risk". For some data sources these thresholds are determined by a rules-based approach - for example concerns raised by staff to CQC (and validated by CQC) are always flagged in the model.

NHS Trusts that have had an inspection at the time of producing this update of Intelligent Monitoring have not been assigned a banding; all other indicator analysis results are shown in their report. "Recently inspected" is stated for these trusts. This is to reflect the fact that CQC's new comprehensive inspections will provide its definitive judgements for each organisation.

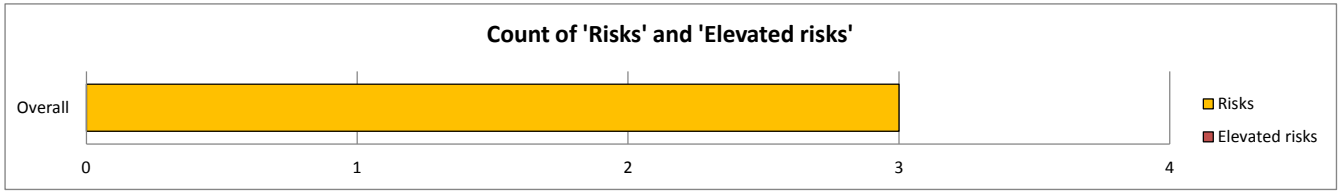
Further details of the analysis applied are explained in the accompanying guidance document.

What guidance is available?

We have published a document setting out the definition and full methodology for each indicator. If you have any queries or need more information, please email enquiries@cqc.org.uk or use the contact details at www.cqc.org.uk/contact-us

Sandwell and West Birmingham Hospitals NHS Trust

Trust Summary



Priority banding for inspection	6
Number of 'Risks'	3
Number of 'Elevated risks'	0
Overall Risk Score	3
Number of Applicable Indicators	95
Percentage Score	1.58%
Maximum Possible Risk Score	190

Risk	Composite of Central Alerting System (CAS) safety alerts indicators (01-Apr-04 to 30-Apr-14)
Risk	Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality
Risk	Maternity outlier alert: Neonatal readmissions (01-Apr-12 to 11-Jul-14)

Tier One Indicators

Section	ID	Indicators	Observed	Expected	Risk?
Never Events	STEISNE	Never Event incidence (01-May-13 to 30-Apr-14)	4	-	No evidence of risk
Avoidable infections	CDIFF	Incidence of Clostridium difficile (C.difficile) (01-Apr-13 to 31-Mar-14)	39	35.91	No evidence of risk
	MRSA	Incidence of Meticillin-resistant Staphylococcus aureus (MRSA) (01-Apr-13 to 31-Mar-14)	3	2.9	No evidence of risk
Deaths in low risk diagnosis groups	MORTLOWR	Dr Foster Intelligence: Mortality rates for conditions normally associated with a very low rate of mortality (01-Oct-12 to 30-Sep-13)	Within expected range	-	No evidence of risk
Patient safety incidents	NRLSL03	Proportion of reported patient safety incidents that are harmful (01-Feb-13 to 31-Jan-14)	0.35	0.29	No evidence of risk
	NRLSL04	Potential under-reporting of patient safety incidents resulting in death or severe harm (01-Feb-13 to 31-Jan-14)	37	45.6	No evidence of risk
	NRLSL05	Potential under-reporting of patient safety incidents (01-Feb-13 to 31-Jan-14)	13012	7657.57	No evidence of risk
Central Alerting System	COM_CASIM	Composite of Central Alerting System (CAS) safety alerts indicators (01-Apr-04 to 30-Apr-14)	-	-	Risk
	CASIM01A01	*The number of alerts which CAS stipulated should have been closed by trusts during the preceding 12 months, but which were still open on the date CQC extracted data from the CAS system (01-May-13 to 30-Apr-14)*	*1-4 alerts still open*	-	*Risk*
	CASIM01B01	*The number of alerts which CAS stipulated should have been closed by trusts more than 12 months before, but which were still open on the date CQC extracted data from the CAS system (01-Apr-04 to 30-Apr-13)*	*0 alerts still open*	-	*No evidence of risk*
	CASIM01C01	*Percentage of CAS alerts with closing dates during the preceding 12 months which the trust has closed late (01-May-13 to 30-Apr-14)*	*< 25% of alerts closed late*	-	*No evidence of risk*
Venous Thromboembolism	VTERA03	Proportion of patients risk assessed for Venous Thromboembolism (VTE) (01-Oct-13 to 31-Dec-13)	0.95	0.95	No evidence of risk
Mortality: Trust Level	SHMI01	Summary Hospital-level Mortality Indicator (01-Oct-12 to 30-Sep-13)	Trust's mortality rate is 'As Expected'	-	No evidence of risk
	COM_HSMR	Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ratio indicators (01-Oct-12 to 30-Sep-13)	-	-	No evidence of risk
	HSMR	*Dr Foster Intelligence: Hospital Standardised Mortality Ratio (01-Oct-12 to 30-Sep-13)*	*Within expected range*	-	*No evidence of risk*
	HSMRWKDAY	*Dr Foster Intelligence: Hospital Standardised Mortality Ratio (Weekday) (01-Oct-12 to 30-Sep-13)*	*Within expected range*	-	*No evidence of risk*
	HSMRWKEND	*Dr Foster Intelligence: Hospital Standardised Mortality Ratio (Weekend) (01-Oct-12 to 30-Sep-13)*	*Within expected range*	-	*No evidence of risk*

Indicators displaying * represent a suppressed value between 1 and 5

Section	ID	Indicators	Observed	Expected	Risk?
	COM_CARDI	Composite indicator: In-hospital mortality - Cardiological conditions and procedures	-	-	No evidence of risk
	HESMORT24CU	*In-hospital mortality: Cardiological conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTAMI	*Mortality outlier alert: Acute myocardial infarction (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTARRES	*Mortality outlier alert: Cardiac arrest and ventricular fibrillation (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTCABGI	*Mortality outlier alert: CABG (isolated first time) (01-Apr-12 to 14-Jul-14)*	*Not included*	*Not included*	*Not included*
	MORTCABGO	*Mortality outlier alert: CABG (other) (01-Apr-12 to 14-Jul-14)*	*Not included*	*Not included*	*Not included*
	MORTCASUR	*Mortality outlier alert: Adult cardiac surgery (01-Apr-12 to 14-Jul-14)*	*Not included*	*Not included*	*Not included*
	MORTCATH	*Mortality outlier alert: Coronary atherosclerosis and other heart disease (01-Apr-12 to 14-Jul-*	-	-	*No evidence of risk*
	MORTCHF	*Mortality outlier alert: Congestive heart failure; nonhypertensive (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTDYSRH	*Mortality outlier alert: Cardiac dysrhythmias (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTHVD	*Mortality outlier alert: Heart valve disorders (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTPHD	*Mortality outlier alert: Pulmonary heart disease (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_CEREB	Composite indicator: In-hospital mortality - Cerebrovascular conditions	-	-	No evidence of risk
	HESMORT21CU	*In-hospital mortality: Cerebrovascular conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTACD	*Mortality outlier alert: Acute cerebrovascular disease (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_DERMA	Composite indicator: In-hospital mortality - Dermatological conditions	-	-	No evidence of risk
	HESMORT35CU	*In-hospital mortality: Dermatological conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTSKINF	*Mortality outlier alert: Skin and subcutaneous tissue infections (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTSKULC	*Mortality outlier alert: Chronic ulcer of skin (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_ENDOC	Composite indicator: In-hospital mortality - Endocrinological conditions	-	-	No evidence of risk
	HESMORT29CU	*In-hospital mortality: Endocrinological conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTDIABWC	*Mortality outlier alert: Diabetes mellitus with complications (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTDIABWOC	*Mortality outlier alert: Diabetes mellitus without complications (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTFLUID	*Mortality outlier alert: Fluid and electrolyte disorders (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_GASTR	Composite indicator: In-hospital mortality - Gastroenterological and hepatological conditions and procedures	-	-	No evidence of risk
	HESMORT27CU	*In-hospital mortality: Gastroenterological and hepatological conditions (01-Dec-12 to 30-Nov-*	-	-	*No evidence of risk*
	MORTALCLIV	*Mortality outlier alert: Liver disease, alcohol-related (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTBILIA	*Mortality outlier alert: Biliary tract disease (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTGASHAE	*Mortality outlier alert: Gastrointestinal haemorrhage (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTGASN	*Mortality outlier alert: Noninfectious gastroenteritis (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTINTOBS	*Mortality outlier alert: Intestinal obstruction without hernia (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTOGAS	*Mortality outlier alert: Other gastrointestinal disorders (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTOLIV	*Mortality outlier alert: Other liver diseases (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTOPJEJ	*Mortality outlier alert: Operations on jejunum (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTPERI	*Mortality outlier alert: Peritonitis and intestinal abscess (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTTEPBI	*Mortality outlier alert: Therapeutic endoscopic procedures on biliary tract (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTTEPLGI	*Mortality outlier alert: Therapeutic endoscopic procedures on lower GI tract (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTTEPUGI	*Mortality outlier alert: Therapeutic endoscopic procedures on upper GI tract (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTTOJI	*Mortality outlier alert: Therapeutic operations on jejunum and ileum (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*

Section	ID	Indicators	Observed	Expected	Risk?
Mortality	COM_GENIT	Composite indicator: In-hospital mortality - Genito-urinary conditions	-	-	No evidence of risk
	HESMORT31CU	*In-hospital mortality: Genito-urinary conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTUTI	*Mortality outlier alert: Urinary tract infections (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_HAEMA	Composite indicator: In-hospital mortality - Haematological conditions	-	-	No evidence of risk
	HESMORT28CU	*In-hospital mortality: Haematological conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTDEFI	*Mortality outlier alert: Deficiency and other anaemia (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_INFEC	Composite indicator: In-hospital mortality - Infectious diseases	-	-	No evidence of risk
	HESMORT26CU	*In-hospital mortality: Infectious diseases (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTSEPT	*Mortality outlier alert: Septicaemia (except in labour) (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_MENTA	Composite indicator: In-hospital mortality - Conditions associated with Mental health	-	-	No evidence of risk
	HESMORT33CU	*In-hospital mortality: Conditions associated with Mental health (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTSENI	*Mortality outlier alert: Senility and organic mental disorders (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_MUSCU	Composite indicator: In-hospital mortality - Musculoskeletal conditions	-	-	No evidence of risk
	HESMORT36CU	*In-hospital mortality: Musculoskeletal conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTPATH	*Mortality outlier alert: Pathological fracture (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_NEPHR	Composite indicator: In-hospital mortality - Nephrological conditions	-	-	No evidence of risk
	HESMORT30CU	*In-hospital mortality: Nephrological conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTRENA	*Mortality outlier alert: Acute and unspecified renal failure (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTRENC	*Mortality outlier alert: Chronic renal failure (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_NEURO	Composite indicator: In-hospital mortality - Neurological conditions	-	-	No evidence of risk
	HESMORT34CU	*In-hospital mortality: Neurological conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTEPIL	*Mortality outlier alert: Epilepsy, convulsions (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_PAEDI	Composite indicator: In-hospital mortality - Paediatric and congenital disorders and perinatal mortality	-	-	Risk
	HESMORT32CU	*In-hospital mortality: Paediatric and congenital disorders (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MATPERIMOR	*Maternity outlier alert: Perinatal mortality (01-Apr-12 to 14-Jul-14)*	-	-	*Risk*
	COM_RESPI	Composite indicator: In-hospital mortality - Respiratory conditions	-	-	No evidence of risk
	HESMORT25CU	*In-hospital mortality: Respiratory conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTASTHM	*Mortality outlier alert: Asthma (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTBRONC	*Mortality outlier alert: Acute bronchitis (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTCOPD	*Mortality outlier alert: Chronic obstructive pulmonary disease and bronchiectasis (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTPLEU	*Mortality outlier alert: Pleurisy, pneumothorax, pulmonary collapse (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTPNEU	*Mortality outlier alert: Pneumonia (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*

Indicators displaying * represent a suppressed value between 1 and 5

Section	ID	Indicators	Observed	Expected	Risk?
	COM_TRAUM	Composite indicator: In-hospital mortality - Trauma and orthopaedic conditions and procedures	-	-	No evidence of risk
	HESMORT37CU	*In-hospital mortality: Trauma and orthopaedic conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTCRAN	*Mortality outlier alert: Craniotomy for trauma (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTFNOF	*Mortality outlier alert: Fracture of neck of femur (hip) (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTHFREP	*Mortality outlier alert: Head of femur replacement (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTHIPREP	*Mortality outlier alert: Hip replacement (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTINTINJ	*Mortality outlier alert: Intracranial injury (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTOFRA	*Mortality outlier alert: Other fractures (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTREDFB	*Mortality outlier alert: Reduction of fracture of bone (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTREDFBL	*Mortality outlier alert: Reduction of fracture of bone (upper/lower limb) (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTREDFNOF	*Mortality outlier alert: Reduction of fracture of neck of femur (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTSHUN	*Mortality outlier alert: Shunting for hydrocephalus (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	COM_VASCU	Composite indicator: In-hospital mortality - Vascular conditions and procedures	-	-	No evidence of risk
	HESMORT23CU	*In-hospital mortality: Vascular conditions (01-Dec-12 to 30-Nov-13)*	-	-	*No evidence of risk*
	MORTAMPUT	*Mortality outlier alert: Amputation of leg (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTANEUR	*Mortality outlier alert: Aortic, peripheral, and visceral artery aneurysms (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTCLIP	*Mortality outlier alert: Clip and coil aneurysms (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTOFB	*Mortality outlier alert: Other femoral bypass (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTPVA	*Mortality outlier alert: Peripheral and visceral atherosclerosis (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTREPAAA	*Mortality outlier alert: Repair of abdominal aortic aneurysm (AAA) (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
	MORTTOFA	*Mortality outlier alert: Transluminal operations on the femoral artery (01-Apr-12 to 14-Jul-14)*	-	-	*No evidence of risk*
Maternity and women's health	MATELECCS	Maternity outlier alert: Elective Caesarean section (01-Apr-12 to 11-Jul-14)	-	-	No evidence of risk
	MATEMERCS	Maternity outlier alert: Emergency Caesarean section (01-Apr-12 to 11-Jul-14)	-	-	No evidence of risk
	MATSEPSIS	Maternity outlier alert: Puerperal sepsis and other puerperal infections (01-Apr-12 to 11-Jul-14)	-	-	No evidence of risk
Re-admissions	MATMATRE	Maternity outlier alert: Maternal readmissions (01-Apr-12 to 11-Jul-14)	-	-	No evidence of risk
	MATNEORE	Maternity outlier alert: Neonatal readmissions (01-Apr-12 to 11-Jul-14)	-	-	Risk
	COM_ELRE_ON	Composite indicator: Emergency readmissions with an overnight stay following an elective admission (01-Nov-12 to 31-Oct-13)	-	-	No evidence of risk
	HESELRE_ON	*Emergency readmissions with an overnight stay following an elective admission (Cross sectional) (01-Nov-12 to 31-Oct-13)*	*663*	*638.34*	*No evidence of risk*
	HESELRECU_ON	*Emergency readmissions with an overnight stay following an elective admission (CUSUM) (01-Jul-13 to 31-Oct-13)*	-	-	*No evidence of risk*
	COM_EMRE_ON	Composite indicator: Emergency readmissions with an overnight stay following an emergency admission (01-Nov-12 to 31-Oct-13)	-	-	No evidence of risk
	HESEMRE_ON	*Emergency readmissions with an overnight stay following an emergency admission (Cross sectional) (01-Nov-12 to 31-Oct-13)*	*4237*	*4165.55*	*No evidence of risk*
	HESEMRECU_ON	*Emergency readmissions with an overnight stay following an emergency admission (CUSUM) (01-Jul-13 to 31-Oct-13)*	-	-	*No evidence of risk*

Section	ID	Indicators	Observed	Expected	Risk?
PROMs	PROMS52	PROMs EQ-5D score: Groin Hernia Surgery (01-Apr-13 to 31-Dec-13)	Nil significance	-	No evidence of risk
	PROMS_HIP	Composite of hip related PROMS indicators (01-Apr-13 to 31-Dec-13)	-	-	No evidence of risk
	PROMS53	*PROMs EQ-5D score: Hip Replacement (PRIMARY) (01-Apr-13 to 31-Dec-13)*	*Nil significance*	*-*	*No evidence of risk*
	PROMS54	*PROMs Oxford score: Hip Replacement (PRIMARY) (01-Apr-13 to 31-Dec-13)*	*Nil significance*	*-*	*No evidence of risk*
	PROMS_KNEE	Composite of knee related PROMS indicators (01-Apr-13 to 31-Dec-13)	-	-	No evidence of risk
	PROMS55	*PROMs EQ-5D score: Knee Replacement (PRIMARY) (01-Apr-13 to 31-Dec-13)*	*Nil significance*	*-*	*No evidence of risk*
	PROMS56	*PROMs Oxford score: Knee Replacement (PRIMARY) (01-Apr-13 to 31-Dec-13)*	*Nil significance*	*-*	*No evidence of risk*
Audit	MINAP22	Proportion of patients who received all the secondary prevention medications for which they were eligible (01-Apr-12 to 31-Mar-13)	1.00	0.90	No evidence of risk
	NHFD01	The proportion of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database. (01-Apr-12 to 31-Mar-13)	0.62	0.6	No evidence of risk
	SSNAPD02	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01-Oct-13 to 31-Dec-13)	Level C	-	No evidence of risk
Compassionate care	IPSURTALKWOR	Inpatient Survey Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	5.12	-	No evidence of risk
	IPSURSUPEMOT	Inpatient Survey Q35 "Do you feel you got enough emotional support from hospital staff during your stay?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	6.99	-	No evidence of risk
Meeting physical needs	IPSURHELPEAT	Inpatient Survey Q23 "Did you get enough help from staff to eat your meals?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	6.5	-	No evidence of risk
	IPSURINVDECI	Inpatient Survey Q32 "Were you involved as much as you wanted to be in decisions about your care and treatment?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	7.24	-	No evidence of risk
	IPSURCNTPAIN	Inpatient Survey Q39 "Do you think the hospital staff did everything they could to help control your pain?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	8.08	-	No evidence of risk
Overall experience	IPSUROVERALL	Inpatient Survey Q68 "Overall…" (I had a very poor/good experience) (Score out of 10) (01-Jun-13 to 31-Aug-13)	8.06	-	No evidence of risk
	FFTNHSESCORE	NHS England inpatients score from Friends and Family Test (Score out of 100) (01-Apr-13 to 31-Mar-14)	69.84	-	No evidence of risk
Treatment with dignity and respect	IPSURRSPDIGN	Inpatient Survey Q67 "Overall, did you feel you were treated with respect and dignity while you were in the hospital?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	8.74	-	No evidence of risk
Trusting relationships	IPSURCONFDOC	Inpatient Survey Q25 "Did you have confidence and trust in the doctors treating you?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	8.92	-	No evidence of risk
	IPSURCONFNUR	Inpatient Survey Q28 "Did you have confidence and trust in the nurses treating you?" (Score out of 10) (01-Jun-13 to 31-Aug-13)	8.47	-	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Maternity Survey	MATSVBIRADV	Maternity Survey C1 "At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	8.42	-	No evidence of risk
	MATSVBIRCOM	Maternity Survey C2 "During your labour, were you able to move around and choose the position that made you most comfortable?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	7.78	-	No evidence of risk
	MATSVCARBAT	Maternity Survey D6 "Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	7.78	-	No evidence of risk
	MATSVCARINF	Maternity Survey D3 "Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	7.56	-	No evidence of risk
	MATSVSFINT	Maternity Survey C12 "Did the staff treating and examining you introduce themselves?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	8.58	-	No evidence of risk
	MATSVSTAFCON	Maternity Survey C14 "If you raised a concern during labour and birth, did you feel that it was taken seriously?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	7.79	-	No evidence of risk
	MATSVSTFDIG	Maternity Survey C18 "Thinking about your care during labour and birth, were you treated with respect and dignity?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	8.77	-	No evidence of risk
	MATSVSTFWOR	Maternity Survey C13 "Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?" (Score out of 10) (01-Feb-13 to 28-Feb-13)	6.87	-	No evidence of risk
Access measures	COM_AD_A&E	Composite indicator: A&E waiting times more than 4 hours (05-Jan-14 to 30-Mar-14)	-	-	No evidence of risk
	AD_A&E13	*Proportion of patients spending more than 4 hours in Type 1 only A&E departments from arrival to discharge, transfer or admission (05-Jan-14 to 30-Mar-14)*	*0.09*	*0.05*	*No evidence of risk*
	AD_A&E14	*Proportion of patients spending more than 4 hours in Type 2 only A&E departments from arrival to discharge, transfer or admission (05-Jan-14 to 30-Mar-14)*	*0.01*	*0.05*	*No evidence of risk*
	AD_A&E15	*Proportion of patients spending more than 4 hours in Type 3 only A&E departments from arrival to discharge, transfer or admission (05-Jan-14 to 30-Mar-14)*	*0*	*0.05*	*No evidence of risk*
	COM_RTT	Composite indicator: Referral to treatment (01-Mar-14 to 31-Mar-14)	-	-	No evidence of risk
	RTT_01	*Monthly Referral to Treatment (RTT) waiting times for completed admitted pathways (on an adjusted basis): percentage within 18 weeks (01-Mar-14 to 31-Mar-14)*	*90.1%*	*90.0%*	*No evidence of risk*
	RTT_02	*Monthly Referral to Treatment (RTT) waiting times for completed non-admitted pathways: percentage within 18 weeks (01-Mar-14 to 31-Mar-14)*	*96.5%*	*95.0%*	*No evidence of risk*
	RTT_03	*Monthly Referral to Treatment (RTT) waiting times for incomplete pathways: percentage within 18 weeks (01-Mar-14 to 31-Mar-14)*	*92.7%*	*92.0%*	*No evidence of risk*
	DIAG6WK01	Diagnostics waiting times: patients waiting over 6 weeks for a diagnostic test (01-Mar-14 to 31-Mar-14)	0.008	0.016	No evidence of risk
	WT_CAN26	All cancers: 62 day wait for first treatment from urgent GP referral (01-Jan-14 to 31-Mar-14)	0.87	0.85	No evidence of risk
	WT_CAN27	All cancers: 62 day wait for first treatment from NHS cancer screening referral (01-Jan-14 to 31-Mar-14)	0.98	0.9	No evidence of risk
	WT_CAN22	All cancers: 31 day wait from diagnosis (01-Jan-14 to 31-Mar-14)	1	0.96	No evidence of risk
	CND_OPS02	The proportion of patients whose operation was cancelled (01-Jan-14 to 31-Mar-14)	0.015	0.009	No evidence of risk
	CND_OPS01	The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason (01-Jan-14 to 31-Mar-14)	0.005	0.047	No evidence of risk
	AMBTURN06	Proportion of ambulance journeys where the ambulance vehicle remained at hospital for more than 60 minutes (01-Apr-14 to 30-Apr-14)	0.006	0.024	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Discharge and Integration	DTC40	Ratio of the total number of days delay in transfer from hospital to the total number of occupied beds (01-Jan-14 to 31-Mar-14)	0.013	0.023	No evidence of risk
Patient-led assessments of the care environment	COM_PLACE	Composite of PLACE indicators (01-Apr-13 to 30-Jun-13)	-	-	No evidence of risk
	PLACE01	*PLACE score for cleanliness of environment (01-Apr-13 to 30-Jun-13)*	*0.99*	*0.96*	*No evidence of risk*
	PLACE02	*PLACE score for food (01-Apr-13 to 30-Jun-13)*	*0.93*	*0.84*	*No evidence of risk*
	PLACE03	*PLACE score for privacy, dignity and well being (01-Apr-13 to 30-Jun-13)*	*0.96*	*0.88*	*No evidence of risk*
	PLACE04	*PLACE score for facilities (01-Apr-13 to 30-Jun-13)*	*0.95*	*0.89*	*No evidence of risk*
Reporting culture	NRLS14	Consistency of reporting to the National Reporting and Learning System (NRLS) (01-Apr-13 to 30-Sep-13)	6 months of reporting	-	No evidence of risk
	COM_SUSDQ	Data quality of trust returns to the HSCIC (01-Apr-13 to 28-Feb-14)	-	-	No evidence of risk
	SUSA&E02	*Percentage of Secondary Uses Service (SUS) records for Accident and Emergency care with valid entries in mandatory fields. (01-Apr-13 to 28-Feb-14)*	*99.2%*	*96.6%*	*No evidence of risk*
	SUSAPC02	*Percentage of Secondary Uses Service (SUS) records for inpatient care with correct entries in mandatory fields. (01-Apr-13 to 28-Feb-14)*	*99.1%*	*97.3%*	*No evidence of risk*
	SUSOP02	*Percentage of Secondary Uses Service (SUS) records for outpatient care with valid entries in mandatory fields. (01-Apr-13 to 28-Feb-14)*	*99.6%*	*97.6%*	*No evidence of risk*
	FFTRESP02	Inpatients response percentage rate from NHS England Friends and Family Test (01-Apr-13 to 31-Mar-14)	31.5%	29.1%	No evidence of risk
Partners	MONITOR01	Monitor - Governance risk rating (27-May-14 to 27-May-14)	Not included	Not included	Not included
	MONITOR02	Monitor - Continuity of service rating (27-May-14 to 27-May-14)	Not included	Not included	Not included
	TDA01	TDA - Escalation score (01-Mar-14 to 31-Mar-14)	1. No identified concerns	-	No evidence of risk
	NTS12	GMC National Training Survey – trainee's overall satisfaction (26-Mar-14 to 08-May-14)	Within the middle quartile (Q2/IQR)	-	No evidence of risk
Staff survey	STASURBG01	NHS Staff Survey - The proportion of staff who would recommend the trust as a place to work or receive treatment (01-Sep-13 to 31-Dec-13)	0.68	0.65	No evidence of risk
	NHSSTAFF04	NHS Staff Survey - KF7. The proportion of staff who were appraised in last 12 months (01-Sep-13 to 31-Dec-13)	0.85	0.83	No evidence of risk
	NHSSTAFF06	NHS Staff Survey - KF9. The proportion of staff reported receiving support from immediate managers (01-Sep-13 to 31-Dec-13)	0.67	0.65	No evidence of risk
	NHSSTAFF07	NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months (01-Sep-13 to 31-Dec-13)	0.81	0.75	No evidence of risk
	NHSSTAFF11	NHS Staff Survey - KF15. The proportion of staff who stated that the incident reporting procedure was fair and effective (01-Sep-13 to 31-Dec-13)	0.63	0.62	No evidence of risk
	NHSSTAFF16	NHS Staff Survey - KF21. The proportion of staff reporting good communication between senior management and staff (01-Sep-13 to 31-Dec-13)	0.38	0.29	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Staffing	ESRSIC	Composite risk rating of ESR items relating to staff sickness rates (01-Apr-13 to 31-Mar-14)	-	-	No evidence of risk
	ESRSIC01	*Proportion of days sick due to back problems in the last 12 months (01-Apr-13 to 31-Mar-14)*	*0.003*	*0.002*	*No evidence of risk*
	ESRSIC02	*Proportion of days sick due to stress in the last 12 months (01-Apr-13 to 31-Mar-14)*	*0.008*	*0.007*	*No evidence of risk*
	ESRSIC03	*Proportion of days sick in the last 12 months for Medical and Dental staff (01-Apr-13 to 31-Mar-14)*	*0.009*	*0.035*	*No evidence of risk*
	ESRSIC04	*Proportion of days sick in the last 12 months for Nursing and Midwifery staff (01-Apr-13 to 31-Mar-14)*	*0.052*	*0.042*	*No evidence of risk*
	ESRSIC05	*Proportion of days sick in the last 12 months for other clinical staff (01-Apr-13 to 31-Mar-14)*	*0.049*	*0.045*	*No evidence of risk*
	ESRSIC06	*Proportion of days sick in the last 12 months for non-clinical staff (01-Apr-13 to 31-Mar-14)*	*0.043*	*0.039*	*No evidence of risk*
	ESRReg	Composite risk rating of ESR items relating to staff registration (31-Mar-14 to 31-Mar-14)	-	-	No evidence of risk
	ESRREG01	*Proportion of Medical and Dental staff that hold an active professional registration (31-Mar-14 to 31-Mar-14)*	*1*	*0.99*	*No evidence of risk*
	ESRREG02	*Proportion of Nursing and Midwifery staff that hold an active professional registration (31-Mar-14 to 31-Mar-14)*	*0.99*	*0.99*	*No evidence of risk*
	ESRTO	Composite risk rating of ESR items relating to staff turnover (01-Apr-13 to 31-Mar-14)	-	-	No evidence of risk
	ESRTUR01	*Turnover rate (leavers) for Medical and Dental staff (01-Apr-13 to 31-Mar-14)*	*0.09*	*0.1*	*No evidence of risk*
	ESRTUR02	*Turnover rate (leavers) for Nursing and Midwifery staff (01-Apr-13 to 31-Mar-14)*	*0.16*	*0.11*	*No evidence of risk*
	ESRTUR03	*Turnover rate (leavers) for other clinical staff (01-Apr-13 to 31-Mar-14)*	*0.13*	*0.12*	*No evidence of risk*
	ESRTUR04	*Turnover rate (leavers) for all other staff (01-Apr-13 to 31-Mar-14)*	*0.11*	*0.11*	*No evidence of risk*
	ESRSTAB	Composite risk rating of ESR items relating to staff stability (01-Apr-13 to 31-Mar-14)	-	-	No evidence of risk
	ESRSTA01	*Stability Index for Medical and Dental staff (01-Apr-13 to 31-Mar-14)*	*0.95*	*0.94*	*No evidence of risk*
	ESRSTA02	*Stability Index for Nursing and Midwifery staff (01-Apr-13 to 31-Mar-14)*	*0.88*	*0.91*	*No evidence of risk*
	ESRSTA03	*Stability Index for other clinical staff (01-Apr-13 to 31-Mar-14)*	*0.89*	*0.9*	*No evidence of risk*
	ESRSTA04	*Stability Index for non clinical staff (01-Apr-13 to 31-Mar-14)*	*0.91*	*0.91*	*No evidence of risk*
	ESRSUP	Composite risk rating of ESR items relating to staff support/ supervision (31-Mar-14 to 31-Mar-14)	-	-	No evidence of risk
	ESRSUP01	*Ratio of Band 6 Nurses to Band 5 Nurses (31-Mar-14 to 31-Mar-14)*	*0.44*	*0.4*	*No evidence of risk*
	ESRSUP02	*Ratio of Charge Nurse/ Ward Sister (Band 7) to Band 5/6 Nurses (31-Mar-14 to 31-Mar-14)*	*0.18*	*0.18*	*No evidence of risk*
	ESRSUP03	*Proportion of all ward staff who are registered nurses (31-Mar-14 to 31-Mar-14)*	*0.65*	*0.68*	*No evidence of risk*
	ESRSUP04	*Ratio of consultant doctors to non-consultant doctors (31-Mar-14 to 31-Mar-14)*	*0.53*	*0.67*	*No evidence of risk*
	ESRSUP05	*Ratio of band 7 Midwives to band 5/6 Midwives (31-Mar-14 to 31-Mar-14)*	*0.3*	*0.25*	*No evidence of risk*
	ESRSTAFF	Composite risk rating of ESR items relating to ratio: Staff vs bed occupancy (31-Mar-14 to 31-Mar-14)	-	-	No evidence of risk
	ESRRAT01	*Ratio of all medical and dental staff to occupied beds (31-Mar-14 to 31-Mar-14)*	*3.99*	*4.53*	*No evidence of risk*
	ESRRAT02	*Ratio of all nursing staff to occupied beds (31-Mar-14 to 31-Mar-14)*	*2.23*	*2.18*	*No evidence of risk*
	ESRRAT03	*Ratio of all other clinical staff to occupied beds (31-Mar-14 to 31-Mar-14)*	*1.71*	*2.02*	*No evidence of risk*
	ESRRAT04	*Ratio of all midwifery staff to births (31-Mar-14 to 31-Mar-14)*	*25.39*	*28.56*	*No evidence of risk*
	FLUVAC01	Healthcare Worker Flu vaccination uptake (01-Sep-13 to 31-Dec-13)	0.77	0.58	No evidence of risk

Section	ID	Indicators	Observed	Expected	Risk?
Qualitative intelligence	WHISTLEBLOW	Whistleblowing alerts (22-Mar-13 to 02-Jun-14)	0	-	No evidence of risk
	GMC	GMC - Enhanced monitoring (01-Mar-09 to 21-Apr-14)	-	-	No evidence of risk
	SAFEGUARDING	Safeguarding concerns (23-May-13 to 22-May-14)	-	-	No evidence of risk
	SYE	CQC Share Your Experience - the number of negative comments is high relative to positive comments (01-Feb-13 to 31-Jan-14)	7	6.4	No evidence of risk
	NHSCHOICES	NHS Choices - the number of negative comments is high relative to positive comments (31-Jan-13 to 30-Jan-14)	15	8.34	No evidence of risk
	P_OPINION	Patient Opinion - the number of negative comments is high relative to positive comments (22-Feb-13 to 21-Feb-14)	1	3.78	No evidence of risk
	CQC_COM	CQC complaints (23-May-13 to 22-May-14)	31	32.82	No evidence of risk
	PROV_COM	Provider complaints (01-Apr-12 to 31-Mar-13)	668	902.87	No evidence of risk

Indicators displaying * represent a suppressed value between 1 and 5

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Plan Delivery Report 2014/15 – Q1 Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Director of Finance & Performance Management**
AUTHOR:	**Neetu Sharma – Head of Strategic Planning**
DATE OF MEETING:	**7 August 2014**

EXECUTIVE SUMMARY:

The document provides an update on progress of delivery for the key activities and objectives included in the Trust Annual Plan for Q1. Each action is reported via a Trust Board or Executive Committee on a monthly/bi-monthly basis and this provides more regular monitoring of the various projects/schemes that sit beneath each objective.

REPORT RECOMMENDATION:

To discuss progress against achievement of the key objectives outlined in the Trust Annual Plan for Q1.

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

Accept	Approve the recommendation	Discuss
		x

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

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

Comments:

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

Relates to all annual priorities

PREVIOUS CONSIDERATION:

April 2014 (2013-14 Annual Plan – final monitoring update)

Annual Plan Monitoring 2014-15 (Q1)

RAG Code:	
5	Action complete
4	Progressing as planned
3	Some delay but expect to be completed as planned
2	Significant delay - unlikely to be completed as planned
1	Action not yet due to start

Ref	Strategic Objective	Priority	Exec Lead	Currently reported	RAG	Current status	Key actions to progress & expected date of completion
S1	Safe, High Quality Care	Reducing preventable deaths, in particular by focusing on the Sepsis Six Care Bundle	RS	Mortality & Quality Alerts Committee	4	The Trust's HSMR for the most recent 12-month cumulative period is 86.9, which remains beneath that of the SHA Peer. The City site HSMR remains beneath lower statistical confidence limits (73.2), with the Sandwell site HSMR (100.4), within statistical confidence limits for the most recent 12-month cumulative period. During the most recent month for which complete data is available (April) the overall Trust performance for review of deaths within 42 days further improved to 89%. VitalPacs will be completely rolled-out by end of July.	• Predicted to meet quarterly target for mortality reviews. • Currently exceeding target for VTE assessments (98.2%). • On track for VitalPAC nurse observations monitoring rollout (October 2014). • Awaiting sepsis six data – to follow at earliest opportunity.
S2	Safe, High Quality Care	Reducing readmissions by 1%, through integrating care and better managing risk	RB	Mortality & Quality Alerts Committee Quality & Safety Committee	3	Readmission rate: 8.9% (Jan-Dec 2013)	Coding project to commence in Q3. Speciality focus plans in respiratory, older people and cardiology to be delivered in Q3. These focus on pathway redesign and enhances supported discharge to community teams.
S3	Safe, High Quality Care	Meeting the emergency care waiting time standard, as we did in April 2014	RB	Urgent Care Board Trust Board	3	The Trust did not meet the 4-hour ED wait target during June and for Q1, with performance of 93.22% and 94.16% respectively. The report includes a copy of the TDA Recovery Plan trajectory with weekly performance aligned to this.	ED staffing: recruitment plan on track; DTOC reduction: working with social services to embed a joint health social care assessment team at AMU and processes that will reduce LOS and DTOC ; reducing mental health delays through establishing assessment beds facility and piloting 24/7 enhanced model for winter; increasing intermediate care through additional capacity (winter plan with CCG) and decreasing LOS in current beds; recovery plan submitted; Trust behind plan in July, anticipated to be on track in August.

S4	Safe, High Quality Care	Improving our Friends and Family results, towards being the best in the region	CO	Patient Experience Committee	3	IP FFT score: 72 (Q1- 2014): +6 points from Q1 2013. ED FFT score: 48 (Q1- 2014): -3 points from Q1 2013. IP FFT response rate: 42% (Q1- 2014): +9% from Q1 2013 ED FFT response rate: 16% (Q1- 2014): +11% from Q1 2013	Phased expansion of FFT programme to include Maternity, Paediatrics, Outpatients and Day cases – To be completed by April 2015 'Patient Knows Best' – Staff and Patient Engagement Strategy implementation - on going. Real time results for front line teams and further support to understand their results – on going 'You said We did' actions from Clinical groups and teams which are key drivers of improvement – On going Increase access to FFT for all groups of patients to reflect the broad and diverse population we serve (comply with new DoH guidelines) - To be completed by April 2015
S5	Safe, High Quality Care	Implementing year one of our Public Health plan, making every contact count	TL	Public Health, Community Development & Equality Committee	4	Trajectory for MECC training: 80% staff trained by October 2015. This has been included as a local quality requirement as part of CCG contract variation.	Waiting on e-learning software from PH dept at Local Authority. Due to receive in January 2015. Plan is to test software in Feb 2015. March 2015 - Oct 2015 - training launched across the Trust. Leaflet/DVD attached to January 2015 payslip - additional method of training alongside e-learning.
S6	Safe, High Quality Care	Reducing the number of complaints, especially repeat complaints	KD	Trust Board Quality & Safety Committee	2	Number of complaints in Q1 2014: 232 an increase of 48 on same period in 2013 Number of repeat complaints in Q1 2014: 34 double that of the same period in 2013	Continued support for the devolved model of complaints handling with more emphasis on learning lessons and making appropriate service changes. With the launch of the new intranet we will monitor the locally resolved complaints and hope to see that these are rising too. Date to be confirmed.
S7	Safe, High Quality Care	Delivering our Year of Outpatient programme, to reach 98% patient satisfaction	RB	YOOP Programme Board	4	Patient experience survey undertaken across all sites in April 2014 was very positive. Over 13,000 patients gave us their view: • 98% were made to feel very welcome by our teams • 92% would recommend our service to family and friends • 89% understood the consultation (5% did not and 6% left this blank) • 88% felt that the environment was suitable to their needs • 77% found the process for choosing their clinic date was satisfactory Through the YOOP programme we will build on current strength and provide a service that exceeds expectations	• Acknowledgement of a referral to a patient (has been built into the protocol for the electronic referral management service which will be fully operational by March 2015) • A choice of appointment times – moving to a partially booked clinic service from October 2014 • Self check-in kiosks will come into use across the Trust before 2015 • Clinician will electronically outcome patient in clinic – Trialling in Ophthalmology at the end of August and will be rolled out following trial evaluation • Letter from the clinician sent to the patient, copied to the GP • From April 2015 every GP practice in England is obliged to have a secure email account – phase out posted letters to practices • Medical Secretary Forums are being organised for August/September 2014 to help shape the discussion and plans on speech recognition • Specialities putting plans together to create different relationships with GPs (especially in long term conditions) to help sustain and improve the satisfaction rates

AR1	Accessible & Responsive Care	No mixed sex breaches of our privacy and dignity standard, now reported from eBMS	RB	Quality & Safety Committee	3	Mixed sex breaches: 93 reported in Q1 A total of 14 Mixed Sex Accommodation breaches were reported during the month of June, a significant reduction (improvement) compared with recent months. The 14 breaches comprised; Coronary Care Sandwell (12) and AMU A Sandwell (2). Fines levied by commissioner (£250 / occupied bed day) are c.£33K for the year to date.	Electronic tracking solution implemented; identified issues in stroke unit and CCU. These with focussed work and continued spot audits are now well managed, forecast 0 MSA breaches from July.
AR2	Accessible & Responsive Care	By October 2014, specialty delivery of 18 week wait standards, and introducing these standards into therapy services	RB	Quality & Safety Committee	3	18 week wait: treatment functions underperforming in Q1 by month April (15), May (16), June (11)	Revised plan made through Resilience planning system to clear all specialty level non compliance for Q4. (Oral surgery, Cardiology, T&O being the specialities recovering in Q3)
AR3	Accessible & Responsive Care	Cutting cancelled operations numbers, and eliminating repeat cancellations	RB	Quality & Safety Committee	3	Cancelled ops: 38, 43 and 33 for first 3 months of this year. Performance improving from Q4 2013/14 but still above monthly trajectory. Compliance expected August 2014. Cancelled Operations remain at 0.9% during the month of June, with a total of 33 SitRep declared late cancellations during the period, a reduction from previous months. Of the 33 cancellations the greatest number (17) were in Surgery B, which also had the highest percentage (1.54%).	Cancelled operation policy in place. Focussed work in preassessment and rapid improvement trajectory agreed with Surgery B as main outlying Clinical Group.Compliance expected August 2014.
AR4	Accessible & Responsive Care	Delivering national cancer wait times, even where other Trusts deliver part of the care	RB	Quality & Safety Committee	4	Achievement of all national cancer waiting times targets by the Trust from April 2014. 62 day performance: April – 88.9% May – 91.3% June – being validated 3 Groups narrowly failed to meet 93.0% operational threshold for the 2-week maximum cancer wait; Medicine (91.8%), Surgery B (91.0%) and Women & Child Health (92.1%). Surgery B (0.0% (0.0 / 0.5 patients)) and Women & Child Health (84.2% (8.0 / 9.5 patients)) also both failed to meet the 85.0% operational threshold for 62-day urgent GP referral to treatment.	Review of Escalation policy internally Review of pathways with Clinical Groups to identify blocks in the pathway which could be improved Work with Imaging to maintain the 2 week wait staging target Meeting with Tertiary providers with COO to discuss pathway issues i.e. HEFT – gynaeoncology late referrals UHBFT – Urology capacity & radiotherapy capacity MDT Leads to review each breach and carry out a root cause analysis to be discussed at Local Cancer Action Team (LCAT) Meeting with Clinical Groups to discuss PTL and raise concerns or issues that need resolving per patient Continue peer review and demand and capacity planning. Work with QE on interhospital referral pathways which have long waits associated to some specialties treatment. Remedy plan to be completed by September.
AR5	Accessible & Responsive Care	Achieving the emergency care standard, and meeting our own ambitions around mental health care in an acute setting	RB	Urgent Care Board Trust Board	3	Mental Health: the trend of mental health breaches increased in Q1 and the length of time spent in ED also increasing.	Working with both providers to establish Place of safety / assessment space out side of ED; pathway mapping to be complete to set new standard operating procedures and shared care protocols to decrease waits within pathways. New processes to be in place end September pending winter funding agreement.
AR6	Accessible & Responsive Care	Complying with both the letter and the spirit of the Safe Staffing promise made after the Francis Inquiry	CO	Trust Board	4	Monthly review of nurse staffing numbers, daily public presentation of ratio of patients to RN's on every ward. Use of temporary staffing to remedy gaps in staffing rotas.	Daily requesting for temporary staff is controlled by group Director of Nursing and any requirement for external agency usage is controlled by the Chief Nurse. Waiting for further NICE guidance for other areas of the trust which may not be available until 2015

C1	Care Closer to Home	Develop further our model of intermediate care at Leasowes, Rowley Regis and in Sheldon	RB	Configuration Committee	4	Operations hub for community established with expected outcome to decrease LOS in line with peers. Plan in train to respond to expand IC facilities within the Trust pending tender process. Business case TBA.	Anticipated plan expansion of IC in Q3, pending business case proving commercially viable.
C2	Care Closer to Home	Complete the transfer of 27 clinics into Rowley Regis, as agreed by the Clinical Leadership Executive	RB	Year Of Outpatients Board	4	Programme moves are part of YOOP; Women's and children's move complete.	Medicine in Q2; Surgery A in Q2.
C3	Care Closer to Home	Reform another long term conditions specialty into general practice, year two of what we have achieved with Diabetes	RB	Configuration Committee	1	New Diabetes model now being delivered. Respiratory speciality focus; working with CCG through readmissions work to design Long Term Condition Pathway to general practice	Undertake initial evaluation and identify lessons learnt: end of September. Confirm the next long term condition to reform: end of September. Delivery plan agreed: end of Nov. Implement Q4.
C4	Care Closer to Home	Implement our pacesetting project to change the shape of district nursing delivery, making our services part of the primary health care team	RB	C&T Directorate meetings Group performance review	4	Service model implemented in Q1.	To embed and evaluate in Q3.
C5	Care Closer to Home	Resolve the long term configuration of midwifery services for 2015-16, with our CCG partners, local families and the Local Authorities	RB	W&CH Directorate meetings Group performance review	1	There is a stakeholder event planned on the 8th August to agree a way forward with regard to community midwifery services.	TBC based on output from stakeholder event.
C6	Care Closer to Home	Ensure that our plans for winter 2014 are supported by consistent models of our of hospital care in nursing homes and the other settings of risk	RB	Urgent Care Board Operational Management Committee	4	Older peoples strategy includes support to nursing homes and intermediate care. New consultants recruited and team job plans to be reviewed for winter delivery.	Job plans TBA for Q3.
G1	Good Use of Resources	Cut our reliance on agency, overtime and bank staffing, on which last year we spent over £25m	RB	Workforce & Organisational Development Committee	2	Agency spend: Q1 2014-15 = £3.3m (Q1 2013-14 = £2.7m / total outturn for 13/14 was £11.3m) Bank staffing spend: Q1 2014-15 = £2.7m (Q1 2013-14 = £2.4m / total outturn for 13/14 was £11.1m) Overtime spend: Excluding Employers on costs, we paid out £1,272,513 in overtime last year, and in the first 3 months of this year £312,237. If this carried on we would spend £1,248,948 (almost the same).	Austerity controls put in place at exec level to authorise agency, locums and WLI. Review of overtime and extra payments in train in August 2014.
G2	Good Use of Resources	Standardise our consumables & equipment, especially in theatres to reduce the costs and safety risks of variation	TW	Clinical Leadership executive	4	Extant Product Rationalisation Group [PRG].	Invigorate PRG to include senior clinical leadership and focussed work plan to provide sharper route to standardisation for safety and cost efficiency improvement. To include revised arrangements for working with groups/directorates & decision assurance; identification of clinical champions including evaluation of peer models of clinical expertise embedded within procurement function. Re-launch September 2014.
G3	Good Use of Resources	Make sure that the way we work is productive and efficient, across the week and in every month of the year, making smarter use of technology	RB	Finance & Investment Committee	4	Extant projects include Year of Outpatients, 7/7 working, EPR. TSP programme includes schemes to improve productivity through more effective production planning, workforce re-design and improved discipline in leave & sickness management.	Follow through on extant projects. Embed capability to assess, plan & manage demand & capacity across the year consistent with sustained delivery of key operational standards and cost effective working. Create fit for purpose contracting / business development function to better align corporate and devolved activity & capacity plans. Establish fit for purpose business intelligence function. December 2014.

G4	Good Use of Resources	Reduce overheads in our system, so that more of every pound is spent on patient care	TW	Finance & Investment Committee	1	MMH retained estate plans in development. Capital programme provides for progression in line with future model. Middle & back office functions cost effectiveness improvement being transacted through TSP programme.	Estate strategy update due September 2014. Target to identify & remove 18000m2 of occupied space by March 2016. Establish specific middle & back office improvement programme with expert support as necessary. Project scoping & way forward confirmation October 2014.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – P03 June 2014
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Management
AUTHOR:	Chris Archer, Associate Director of Finance - Corporate
DATE OF MEETING:	7 August 2014

EXECUTIVE SUMMARY:

Key messages:

- Significant in month deficit – income recovery & reduced benefit of reserves compound on-going over spending with flat pay costs and lumpy advisor fees re Midland Met approval
- Forecast remains delivery of £3.4m plan surplus in line with LTFM commitment – at risk and requires expedient measures to accelerate CIP delivery and reduce run rate of cost; likely requires significant reliance on reserves & contingencies
- CIP delivery below plan and route to full delivery in year remains to be identified
- Reported position moderated by benefit of £743k reserves – intended for development
- Capex modest and requires confirmation of plan & expedited delivery – emergent in year schemes consistent with retained estate strategy following Midland Met approval
- Cash below plan due to timing differences & CCG deferral of payment re performance exceptions

Key actions:

- Secure net expenditure within budget including as necessary continuation of expedient measures to contain and control expenditure with emphasis on reduction of premium rate agency and medical staff premium rate working.
- Secure extant CIP scheme delivery & confirm route to resolution of residual balance.
- Secure service delivery to operational & CQUIN standards to minimise avoidable income losses
- Complete work to confirm detailed capital programmes for IM&T, Estates and medical equipment.

Key numbers:

- Month deficit £889kk being £791k adverse to budget; YTD deficit £841kk being £1,114k adverse.
- CIP delivery to date £1,496k being £622k adverse to revised plan & £1.8m adverse to TDA plan
- Forecast surplus £3.4m in line with financial plan.
- Capex YTD £592k being £910k below plan.
- Cash at 30 June £31.6m being £7.1m below plan due to timing difference on receipt of E&T income
- CoSRR 3 to date as plan; forecast 3 as plan
- Capital Resource Limit (CRL) charge forecast at £19.1m being within approved CRL of £21.3m
- External Finance Limit (EFL) charge forecast at £15.1m being consistent with approved EFL.

REPORT RECOMMENDATION:

The Board is requested to RECEIVE the contents of the report and REQUIRE & ENDORSE those actions necessary to secure key financial targets.

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

PREVIOUS CONSIDERATION:

Finance & Investment Committee and Performance Management Committee.

SWBTB (8/14) 126 (a)

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – P03 June 2014

EXECUTIVE SUMMARY

- For the **month** of June 2014, the Trust delivered a **"bottom line" deficit of £889k being £791k adverse** to a flex budget deficit of £98k. The **year to date deficit of £841k is £1,114k adverse** to flex budget to the end of June.
- The month deterioration in actual run rate reflects reduced SLA income recovery £350k, reduced support from central reserves £280k together with advisor fees in respect of Midland Met.
- The year to date adverse variance consists of £622k shortfall against savings targets, up to £743k benefit of release of central reserves (some of which June be offsetting Group overspends on particular initiatives) leaving a **net underlying overspend of £1,235k** after the benefit of pass through costs funding additional to budget of £170k.
- Forecast anticipates that the position will be recovered and the annual surplus target of £3.146m will be met through CIP development and delivery with uncommitted reserves as contingency.
- Actual **savings delivery year to date is assessed at £1,496k being £622k adverse to trust phased plan** [£1.75m adverse vs TDA plan].
- At 30 June there were 6,895 whole time equivalent (WTE) staff in post (excluding use of agency) & 281wte agency staff. Total **WTE's were 80 above plan**. Total **pay expenditure for the month flat** at £24.9m being **£301k above plan. Agency spend remains flat at £1.15m.**
- Key risks include management of costs pressures and income recovery compromised by shortfalls in delivery of operational standards. Additional resources have been announced nationally to address system resilience issues in emergency care and in achieving referral to treatment time standards.

Financial Performance Indicators - Variances					
Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	(791)	(1,114)	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	(789)	(1,113)	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	(301)	(1,115)	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(362)	(334)	<= Plan	<= Plan	> 1% above plan
WTEs Actual v Plan	(80)	(98)	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000		(7,054)	>= Plan	> = 95% of plan	< 95% of plan
Note: positive variances are favourable, negative variances unfavourable					

- **30 June cash balance £31.6m being £7.1m lower than revised cash plan**. This reflects £4.6m Q1 E&T funding received in July, £1.4m deferred SLA payments in respect of performance exceptions received in July & £1.1m timing differences.
- Year to date spend on capital is £592k being £910k below plan; forecast phasing of spend under review.

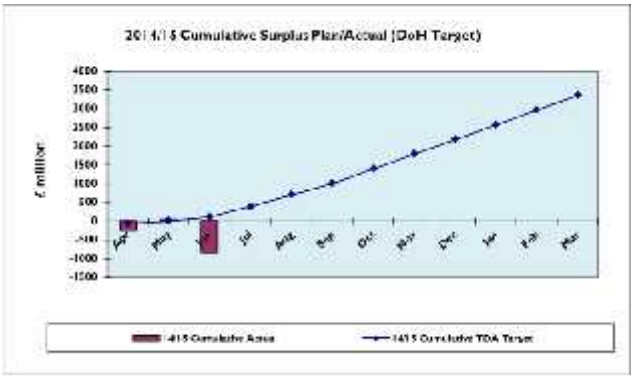
Summary Income & Expenditure Month: June 2014	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from activities	390,074	32,531	32,383	(149)	97,542	97,940	398	390,074
Other income	42,678	3,640	3,663	23	10,537	10,474	(62)	42,678
Pay costs	(282,863)	(24,615)	(24,917)	(301)	(73,242)	(74,357)	(1,115)	(282,863)
Non-pay costs	(125,489)	(9,940)	(10,301)	(362)	(29,307)	(29,641)	(334)	(125,489)
EBITDA	**24,400**	**1,616**	**828**	**(789)**	**5,530**	**4,417**	**(1,113)**	**24,400**
Depreciation	(13,734)	(1,107)	(1,107)	0	(3,433)	(3,433)	0	(13,734)
PDC Dividend	(5,220)	(435)	(435)	0	(1,305)	(1,305)	0	(5,220)
Net Interest Payable	(2,150)	(179)	(181)	(2)	(537)	(538)	(1)	(2,150)
Other Finance Costs / P&L on asset disposal	(150)	(13)	(13)	0	(38)	(38)	0	(150)
Headline surplus / (deficit)	**3,146**	**(117)**	**(908)**	**(791)**	**216**	**(898)**	**(1,114)**	**3,146**
IFRIC12 / Impairment / Donated Asset Adjustments	228	19	19	0	57	57	0	228
Surplus / (deficit) for performance reporting	**3,374**	**(98)**	**(889)**	**(791)**	**273**	**(841)**	**(1,114)**	**3,374**
MEMO: Position reported to TDA against TDA plan	3,374	112	(889)	(1,001)	118	(841)	(959)	3,374

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – June 2014

Overall Performance against Plan

The Trust delivered an actual deficit of £889,000 against a planned deficit of £98,000 in June. It is currently anticipated that this will be recovered in order to achieve the year end surplus target of £3.374m surplus.

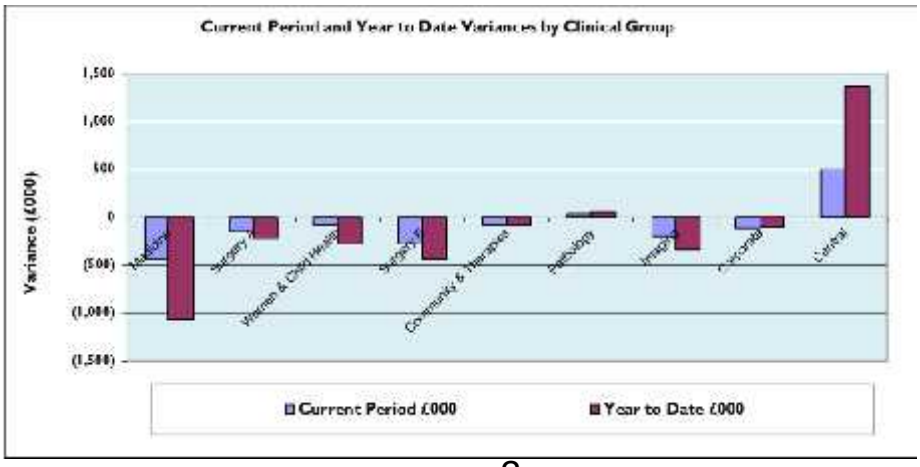


Performance of Clinical Groups / Corporate Areas

- Medicine pay overspend includes £154k on HCAs and £165k on medical staff. Drugs and cardiology non-pay over spends offset by additional income.
- Surgery A overspend includes waiting list initiatives and private sector work.
- Women & Child overspend is mainly anticipated costs of antenatal pathways at other providers.
- Surgery B income under-recovered in ophthalmology with overspent medical staff premium rate working. Additional income received to cover some costs of Lucentis, though SWB contract is capped.
- Imaging premium rate working and under-recovery of income.
- Corporate overspend palliative care nursing and transport staffing.

Group Variances from Plan (Operating income and expenditure)	Current Period £000	Year to Date £000
Medicine	(435)	(1,070)
Surgery A	(144)	(221)
Women & Child Health	(81)	(275)
Surgery B	(276)	(443)
Community & Therapies	(82)	(87)
Pathology	35	53
Imaging	(199)	(337)
Corporate	(110)	(105)
Central	504	1,372

- Underlying Group year to date position is £622k CIP not delivered and some £1,236k of underlying other overspends having taken account of £170k additional income to cover pass through drugs. This is supported by release of unallocated central reserves of £743k.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – June 2014

Overall headline adverse variance to plan £791k in June (£1,114k year to date).

Patient income under performed in month on outpatient attendances; this is partly offset by pass through drugs arrangements and cardiology activity.

Medical pay in month overspend mainly in Medicine £165k mainly agency use and premium rate working.

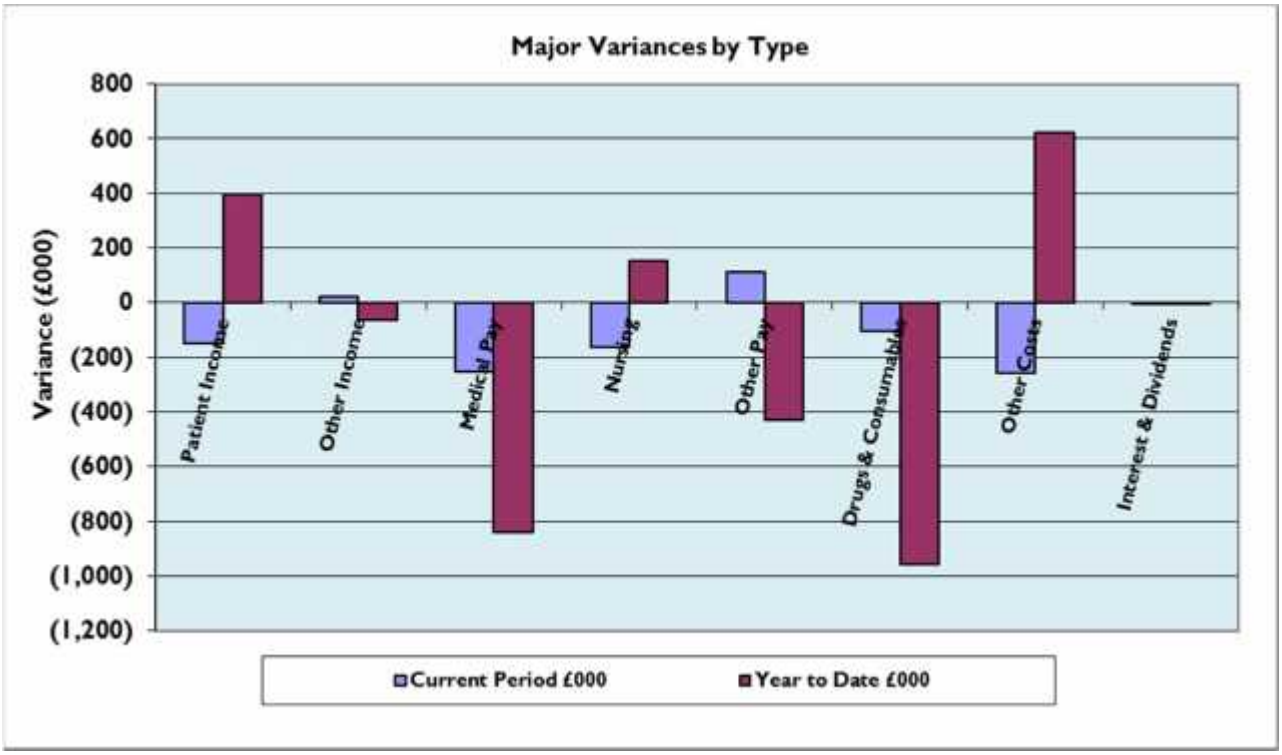
Nursing overspend in month includes Community & Therapies £105k.

Most drugs overspend is pass through recovered through income.

Other costs in month overspend includes maternity pathway payments £80k, £303k to date. Year to date position includes release of investment reserves and balance sheet flexibility.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	(149)	398
Other Income	23	(62)
Medical Pay	(254)	(840)
Nursing	(161)	152
Other Pay	113	(428)
Drugs & Consumables	(104)	(956)
Other Costs	(258)	622
Interest & Dividends	(2)	(1)

- Pass through drugs & consumable costs variance £24k month / £170k YTD. Costs covered by additional SLA income.



Sandwell and West Birmingham Hospitals NHS
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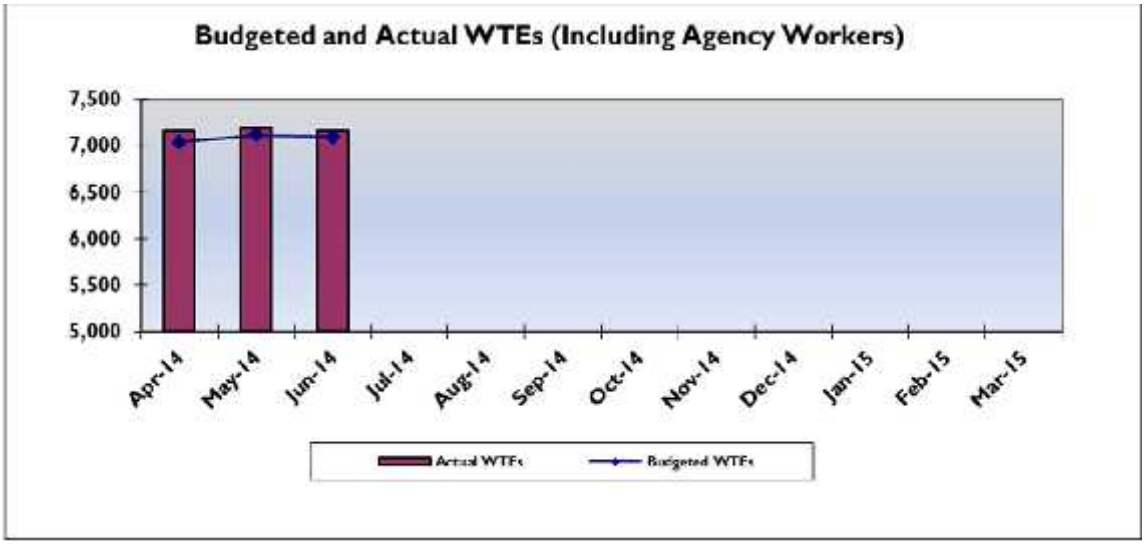
Financial Performance Report – June 2014

Paybill & Workforce

- There were 6,895 WTE in post in June plus 281 WTE of agency staffing across the month. In total this is **80 WTE above planned establishments**, though these are subject to change as savings and investment plans are finalised.
- Total pay costs (including agency workers) **flat in month at £24.9m being £301k adverse to budget**; year to date £1,115k adverse to budget.
- Principal overspending is for medical staff premium rate working and for healthcare assistants providing enhanced care support to vulnerable patients.
- Gross expenditure for **agency staff in month was flat at £1,159k**.



Analysis of Total Pay Costs by Staff Group

	Year to Date to June 2014					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	19,635	19,080	0	1,394	20,474	(840)
Management	3,794	3,536	0	0	3,536	257
Administration & Estates	7,918	7,134	555	208	7,896	22
Healthcare Assistants & Support Staff	8,206	7,425	1,065	239	8,729	(523)
Nursing and Midwifery	22,970	20,562	1,058	1,198	22,818	152
Scientific, Therapeutic & Technical	11,079	10,350	0	279	10,629	450
Other Pay / Technical Adjustment	(360)	274	0	0	274	(634)
Total Pay Costs	73,242	68,362	2,677	3,318	74,357	(1,115)

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – June 2014

Balance Sheet & External Finance Limit

- Cash at 30 June £31.6m; decrease of £4.8m over the month and £7.1m lower than plan.
- Variance reflects £4.6m Q1 E&T funding received in July, £1.4m deferred SLA payments in respect of performance exceptions received in July & £1.1m timing diffs.
- External Finance Limit (EFL) charge forecast at £15.1m being consistent with approved EFL.

Sandwell & West Birmingham Hospitals NHS Trust
STATEMENT OF FINANCIAL POSITION 2014/15

	Balance at 31st March 2014 £000	Balance as at 30th June 2014 £000	TDA Planned Balance as at 30th June 2014 £000	Forecast at 31st March 2015 £000
Non Current Assets				
Property, Plant and Equipment	226,403	223,561	221,122	232,148
Intangible Assets	886	886	796	562
Trade and Other Receivables	1,011	1,296	700	700
Current Assets				
Inventories	3,272	3,346	3,600	3,600
Trade and Other Receivables	16,177	27,229	8,436	11,746
Cash and Cash Equivalents	41,808	31,553	38,607	24,252
Current Liabilities				
Trade and Other Payables	(53,867)	(56,053)	(44,093)	(40,019)
Provisions	(8,036)	(5,251)	(7,654)	(3,936)
Borrowings	(1,064)	(1,059)	(1,029)	(1,029)
DH Capital Loan	(2,000)	(2,000)	(2,000)	(1,000)
Non Current Liabilities				
Provisions	(2,562)	(2,562)	(3,262)	(2,310)
Borrowings	(27,915)	(27,675)	(27,884)	(27,884)
DH Capital Loan	(1,000)	(1,000)	(1,000)	
	193,113	**192,271**	**186,339**	**196,830**
Financed By				
Taxpayers Equity				
Public Dividend Capital	161,640	161,640	161,712	162,211
Retained Earnings reserve	(19,484)	(20,326)	(13,340)	(16,338)
Revaluation Reserve	41,899	41,899	28,909	41,899
Other Reserves	9,058	9,058	9,058	9,058
	193,113	**192,271**	**186,339**	**196,830**

Financial Performance Report – June 2014

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT June 2014

ACTUAL/FORECAST	Jun-14 £000s	Jul-14 £000s	Aug-14 £000s	Sep-14 £000s	Oct-14 £000s	Nov-14 £000s	Dec-14 £000s	Jan-15 £000s	Feb-15 £000s	Mar-15 £000s	Apr-15 £000s	May-15 £000s
Receipts												
SLAs: SWB CCG	20,275	20,275	23,155	21,165	21,165	21,165	21,165	21,165	21,165	21,165	21,165	21,165
Associates	5,647	5,647	7,187	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417
Other NHS income	213	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461	1,461
Specialised Service (LAT)	4,251	3,260	3,260	3,260	3,260	3,260	3,260	3,260	3,260	3,260	3,260	3,260
Over/(Under) Performance Payments												
Education & Training		9,216			4,608			4,608			4,608	
Public Dividend Capital										571		
Loans												
Other Receipts	2,482	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755
Total Receipts	32,868	41,614	36,818	34,058	38,666	34,058	34,058	38,666	34,058	34,629	38,666	34,058
Payments												
Payroll	13,620	14,281	14,263	14,263	13,865	13,865	13,865	13,863	13,863	13,863	13,863	13,613
Tax, NI and Pensions	9,514	9,521	9,509	9,509	9,243	9,243	9,243	9,242	9,242	9,242	9,242	9,076
Non Pay - NHS	1,471	1,923	2,403	1,923	2,163	2,163	1,682	2,403	2,163	2,164	2,164	2,148
Non Pay - Trade	12,207	7,355	9,193	7,355	8,274	8,274	6,435	9,193	8,274	8,274	8,274	8,282
Non Pay - Capital	253	957	1,207	1,315	1,463	1,463	1,086	2,525	2,156	2,660	2,775	2,775
PDC Dividend				2,610						2,610		
Repayment of Loans				1,000						1,000		
Interest				13						8	178	178
BTC Unitary Charge	421	439	439	439	439	439	439	439	439	439	375	375
Other Payments	154	700	700	700	700	700	700	700	700	700		
Total Payments	37,640	35,176	37,714	39,127	36,148	36,148	33,451	38,364	36,836	40,959	36,870	36,446
Cash Brought Forward	36,325	31,553	37,990	37,094	32,025	34,543	32,453	33,060	33,361	30,583	24,252	26,048
Net Receipts/(Payments)	(4,772)	6,437	(896)	(5,069)	2,518	(2,090)	607	301	(2,779)	(6,331)	1,795	(2,389)
Cash Carried Forward	31,553	37,990	37,094	32,025	34,543	32,453	33,060	33,361	30,583	24,252	26,048	23,659

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – June 2014

Capital Expenditure & Capital Resource Limit

- Year to date capital expenditure is £592k being £910k below plan.
- A revised profiled plan is being prepared based upon programme manager's detailed spending intentions.
- Capital Resource Limit (CRL) charge forecast at £19.1m being within approved CRL of £21.3m

Continuity of Service Risk Rating

- Year to rate rating 3 being in line with plan

Memorandum		SIGN	Current Month Metrics			Forecast Outturn Metrics		
Continuity of Services Risk Ratings	Sub Code		Plan (mc 01) £000s	Actual / Forecast (mc 02) £000s	Variance (mc 03) £000s	Plan (mc 04) £000s	Actual / Forecast (mc 05) £000s	Variance (mc 06) £000s
Liquidity Ratio (days)								
Working Capital Balance	780	+/-	(7,733)	(5,581)	2,152	(13,301)	(7,405)	5,896
Annual Operating Expenses	790	+/-	101,957	103,941	1,984	405,044	408,052	3,008
Liquidity Ratio Days	800	+/-	(7)	(5)	2	(12)	(7)	5
Liquidity Ratio Metric	810	+/-	**3.00**	**3.00**	**0.00**	**2.00**	**3.00**	**1.00**
Capital Servicing Capacity (times)								
Revenue Available for Debt Service	820	+/-	5,485	4,500	(985)	24,842	24,416	(426)
Annual Debt Service	830	+/-	2,133	2,119	(14)	10,532	10,466	(66)
Capital Servicing Capacity (times)	840	+/-	2.6	2.1	(0.4)	2.4	2.3	(0.0)
Capital Servicing Capacity metric	850	+/-	**4.00**	**3.00**	**(1.00)**	**3.00**	**3.00**	**0.00**
Continuity of Services Rating for Trust	860	+/-	**3.50**	**3.00**	**(0.50)**	**2.50**	**3.00**	**0.50**

Service Level Agreements

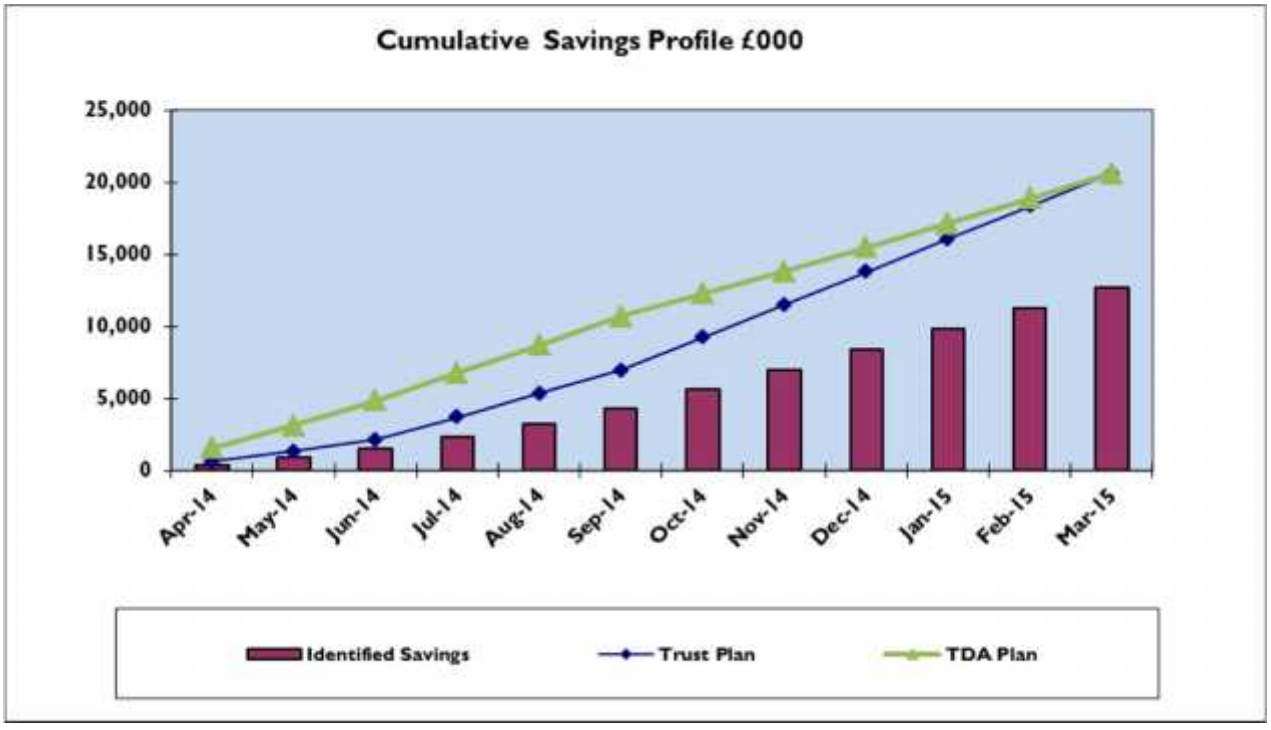
- NHS Commissioner activity and income data for April and May indicates an minor underperformance before fines and penalties of £56k. This includes over performance on pass through drugs of £147k for those two months & which is estimated to rise to £170k in June.
- Fines notices have been received for April and May and do not materially exceed fines cap levels. The CCGs have with-held £1.4m of the monthly payment pending receipt of remedial action plans to deliver RTT & MSA targets. The cash flow statement assumes that that income is restored during the year.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – June 2014

Savings Programme

- Following a detailed review of schemes the Trust has identified £12.7m of savings against the annual target of £20.6m. These have a full year effect of £17.0m.
- **Delivery to date is £1,496k being £622k adverse to trust phased plan** [£1.75m adverse vs TDA plan].
- The forecast profile of savings delivery is shown below together with the original plan against which the TDA continues to monitor the Trust
- Detailed work continues with Groups and Corporate Directorates to identify the balance of the programme using benchmark information where appropriate, to ensure savings do not adversely impact quality or safety and to deliver the savings plans identified.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – June 2014

Key risks

- **Identification and delivery of savings at necessary scale & pace**; The required level of savings delivery increases significantly in July from £0.7m per month to £1.6m per month whereas current plans show savings rising from £0.6m in June to £0.8m in July.
- **Over spending on pay costs & in particular premium rate staffing**. Pay bill & within that agency costs remain flat rather than reducing as required. Escalated controls on agency staffing from 1 July. Waiting list initiative work being reviewed as part of RTT improvement plan with view to minimising requirement through improved productivity.
- **Demand risk in respect of SWB CCG contract**. Trust carries demand risk & which is giving rise to some cost pressures in areas of additional activity; limited opportunity to release costs beyond marginal costs in under-performing areas of service.
- **Operational standards not met & give rise to penalties & fines** beyond £2m in plan. Current run rate consistent with plan but pressures on CQUIN delivery and incentive scheme elements.
- **Cost pressures which cannot be absorbed without risk to safety & quality**. Includes estimated maternity payments to other providers (pending receipt of invoices) continues to be anticipated as giving rise to a financial pressure which may reach £1.0m for the year.

External Focus

- **National funding for system resilience** has been announced by NHS England to address emergency care and waiting list performance. More details and local arrangements are yet to be agreed. Such funding will help to mitigate operational and financial risks at least in year.
- Monitor has announced an investigation into Dudley Group NHS Foundation Trust after it was found to have consistently failed to meet the national A&E waiting target. The regulator said it had not met the target in four of the last five quarters. It would also look into the trust finances as it had concerns about the deterioration in financial performance.
- Analysis by the Nuffield Trust showed that in 2012/13 one pound in every five spent by commissioners was in the independent sector – an increase of 34% in one year alone. Together with spending in voluntary and other community providers, nearly a third of the £9.75bn community budget is now spent in non-NHS providers. However, spending in non-NHS hospitals had slowed.
- Most finance directors expect the quality of care to be maintained (53%) or even improved (39%), according to the HFMA's first 'NHS financial temperature check'. The directors are optimistic despite an increase in the number of organisations overspending or reporting a deficit since 2012/13. A fifth of provider trust finance directors and 21% of their CCG peers were not confident they would reach their financial targets in 2014/15 financial year. Finance directors wanted the pace of transformation to pick up and called for an honest debate with the public and politicians about the need for change.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – June 2014

Recommendations

The Board is asked to:

i. RECEIVE the contents of the report; and

ii. REQUIRE & ENDORSE those actions necessary to ensure that the Trust achieves key financial targets.

Tony Waite
Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Risk Register Update
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Mariola Smallman, Head of Risk Management
DATE OF MEETING:	7 August 2014

EXECUTIVE SUMMARY:

The Trust Risk Register compromises high (red) risks that have been through the validation processes at directorate / group and Executive Committee levels. The Clinical Leadership Executive is responsible for reviewing and approving high (red) risks validated by Risk Management Committee, which are proposed for inclusion on the Trust Risk Register reported to Trust Board.

The Trust Risk Register is reported to the Board to ensure oversight of the high red risks managed by the Clinical Groups, Corporate Directorates and Corporate Project Teams under the direction of Executive Leads.

The Trust Risk Register was reported to the Board at its July meeting. There is one amendment to report since the last Trust Board meeting relating to the MMH risk: "Increase in cost of Midland Metropolitan Hospital if approval delayed, then restarts approval cycle". The decision was announced and the MMH Project Team will review the risk register and confirm changes to the overarching MMH risk. The Trust Risk Register is at Appendix A.

High (red) risks that have been reviewed by the Risk Management Committee and continue to be managed at Clinical Group, Corporate Directorate or Project levels but are not proposed for inclusion on the Trust Risk Register have previously been reported to the Board. This high (red) risk summary log is available on request; however there have not been any notable changes to report since the last update to the Board.

REPORT RECOMMENDATION:

1. **REVIEW** the Executive Director updates to the Trust Risk Register

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:

Aligned to BAF, quality and safety agenda and requirement for risk register process as part of external accreditation programmes.

PREVIOUS CONSIDERATION:

The Board receives regular risk register updates.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Risk Register

Report to the Trust Board on 7 August 2014

1. EXECUTIVE SUMMARY

1.1 The Trust Risk Register compromises high (red) risks that have been through the validation processes at directorate / group and Executive Committee levels.

1.2 The Risk Management Committee (RMC) is responsible for overseeing the development of risk registers across the Trust utilising a consistent methodology and standardised format. Review of high (red) risks by RMC provides a trust-wide validation stage to ensure consistency, identify duplicates and interdependencies.

1.3 The Clinical Leadership Executive is responsible for reviewing and approving high (red) risks validated by Risk Management Committee, which are proposed for inclusion on the Trust Risk Register reported to Trust Board.

1.4 The Trust Risk Register is reported to the Board to ensure oversight of the high red risks managed by the Clinical Groups, Corporate Directorates, and Corporate Project Teams under the direction of Executive Leads.

1.5 Management of individual risks continues at each level of risk register they feature; escalation of risks through management reporting structures does not transfer all ownership of the risk.

1.6 As a reminder, the options available for handling risks are:

Terminate	Cease doing the activity likely to generate the risk
Treat	Reduce the probability or severity of the risk by putting appropriate controls in place
Tolerate	Accept the risk or tolerate the residual risk once treatments have been applied
Transfer	Redefine the responsibility for managing the risk e.g. by contracting out a particular activity.

2. Trust Risk Register Update

2.1 There is one amendment to report since the last Trust Board meeting relating to the MMH risk: "*Increase in cost of Midland Metropolitan Hospital if approval delayed, then restarts approval cycle*". The decision was announced and the MMH Project Team will review the risk register and confirm changes to the overarching MMH risk.

2.2 As at writing there are no proposed additional risks for Trust Board to review.

2.3 The Trust Risk Register with lead Executive Director updates is at **Appendix A.**

2.4 High (red) risks that have been reviewed by the Risk Management Committee and continue to be managed at Clinical Group, Corporate Directorate or Project levels but are not proposed for inclusion on the Trust Risk Register have previously been reported to the Board. This high (red) risk summary log is available on request; however there have not been any notable changes to report since the last update to the Board.

2.5 The RMC will review and report High (red) risks to CLE on a monthly basis and highlight new risks or changes to existing risks. The CLE will update the Board on existing risks and escalate 'new' risks.

3. RECOMMENDATION(S)

The Board is recommended to:

3.1 **REVIEW** the Trust Risk Register and updates provided by Executive Directors.

Kam Dhami
Director of Governance
31 July 2014

Reference Number	Source of Risk	Clin Grp / Corp Dir / Corp project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
1414MARWK03		Chief Executive	Workforce Strategy	Organisational (Strategic)	Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment reduction of 1300 wte's, leading to excess pay costs.	4	5	20	Review of existing policy levers to ensure options are maximised and are executed sufficiently early. Strong governance oversight by the Trust Board. Update: A more detailed plan is being developed through CLE workforce committee, led personally by the Chief Executive. Will culminate in review at Board's Workforce and OD committee in September 2014.	Chief Executive pending appointment of Director of OD.	Mar-20	Jun-14	bi-monthly	3	5	15
2013HASU01	CCG	Medicine	Stroke/Admitted Care	Operational	Potential loss of the Hyper Acute Stroke Unit which is subject to an external commissioner led review.	4	4	16	Trust representatives on Strategic Review sub groups; SWBH Stroke Action Team continues to monitor stroke activity and performance on a monthly basis and to develop actions plans for service improvement; Implement action plans to improve data capture and accuracy. Update: Standard operating procedure agreed and in place for data collection and validation. KPI improving new pathways, e.g., thrombolysis pathways direct from ambulance to CT scanner and strengthened capacity planning to ensure availability of gender specific beds to support timely admission. Update: feedback received from Stroke Review Advisory panel to be considered to strengthen position as preferred provider.	Chief Operating Officer	TBC - Commissioner led review	Jun-14	Monthly	4	3	12

Reference Number	Source of Risk	Clin Grp / Corp Dir / Corp project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
TRR1401COO01	Management review	Corporate Operations		Operational	Lack of assurance of standard process and data quality approach to 18 weeks.	4	4	16	Task and Finish Group established to oversee rapid improvement programme; SOP to be agreed and implemented in March for new processes; Elective access team structure to be reviewed; Central booking process to be strengthened to ensure real time data quality management; IST visit will inform work programme content. Update: New Waiting List Manager recruited and starting in July. Year of Out Patients programme will deliver automation to strengthen real time data. Plans to centralise elective access team in Q2. Data Validation Team still required - funding until end Q2. Perceived knowledge deficit in some services regarding 18 weeks - New Elective Access Manager to assess competency of teams and provide re-training in Q2.	Chief Operating Officer	Jul-14	Jun-14	Jul-14	2	4	8
TRR1401COO02	Management review	Corporate Operations		Operational	Sustained high Delayed Transfers of Care (DTOC) patients remaining in acute bed capacity.	4	4	16	Joint working through joint discharge teams on both acute sites established; 7 day working pilot; Weekly urgent care call with Chief Executives and Chief accountable officers from LAT, CCG, NTDA, acute Trust and social services includes DTOC review, strategic and operational work; Commissioning plans for 7 day working in 2014 in train. Update: Additional capacity closed end July although DTOC remains high. Plan will remain in place to re-open additional beds if required and triggers are agreed and activated through Operations Centre and authorised by COO or on call Executive Directors. Resilience System Plan (winter) submissions includes additional beds in community and social care – outcome of funding decision to be agreed in July. This will impact on DTOC reduction. Work to establish a Joint Health Social Care assessment and discharge team continues – now in training phase for go live at Sandwell in August and then at City.	Chief Operating Officer	Jun-14	Jun-14	Jul-14	2	4	8

Reference Number	Source of Risk	Clin Grp / Corp Dir / Corp project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
0907SOP15	Inspections: H&S and PEAT	Surgery B	Ophthalmology	Clinical	Risk of Breach of Privacy and Dignity Standard, Information Governance Risk and Infection Control Risk at Sandwell Outpatient Department Risk that either a patient's health, or privacy/dignity will be compromised as a consequence of poor building design in Sandwell Ophthalmology OPD. Clean/dirty utility failings cannot be addressed without re-development of the area.	5	4	20	Trust Solution fitting in with RCRH required; Compliance with Medical Device and ICOC standards; Service Improvement application to Sandwell OPD; Greater use of Rowley facilities. Update: Rowley Max has been scoped and will be delivered in Year of Out Patients programme on track for completion Q2. Plans for relocation of oral surgery OP to enable ophthalmology to meet privacy and dignity standards in development with intention to complete in Q3.	Chief Operating Officer	31/12/2015	Jun-14	GBM	3	3	9
1103PAE02	Risk Assessment	Womens and Child Health	Paediatrics	Clinical	Children that require but may not receive HDU 1:1 care - due to unpredictable demand, inadequate funding, poor staffing levels. Quality of care compromised for these and non HDU children due to inadequate staffing levels.	4	4	16	IAP submitted for HDU funds secured 12-13 to staff areas. Additional IAP submitted 13-14 for Paediatric Outreach team. Awaiting outcome from November IAP submission. Update: Local escalation process is in place to ensure care is provided to HDU patients and tailoring the remaining services to accommodate the demand and maintain safety.Tracking occurrences to further quantify risk to those non-HDU patients.	Chief Operating Officer	TBC	Jun-14	Monthly	4	4	16

Reference Number	Source of Risk	Clin Grp / Corp Dir / Corp project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
1103PAN01	Risk Assessment	Womens and Child Health	Paediatrics	Clinical	Lack of Tier 4 beds for C&YP with Mental Health problems means that they are admitted to the paediatric ward. There is no specialist medical or nursing mental health team to care for their needs with limited access to in / out of hours CAMHS support. Care for these children is compromised and impacts also on other children and parents.	4	4	16	Bank and agency staff utilised where available. Incidents to be escalated to the Health Forum / SSCB / PAB LA. Monthly report to be developed and reviewed at Paediatric Governance meeting and information provided to risk, Health Forum / SSCB / PAB. Honorary contracts for psychiatrists to be explored. Update: Mental health commissioners report that they are working up enhanced assessment service for children's mental health which intends to reduce numbers of children needing admission. Impact expected in autumn. Confirmed new assessment service and intended benefits will enable review of residual risk. The Trust continues working closely to support this work. Agreed with both adult providers access to mental health bank to support specialist staffing. Guidance on booking process to be agreed in July.	Chief Operating Officer	TBC	Jun-14	Monthly	4	4	16
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Acute Oncology Service is currently unable to treat approx. 120 patients a month due to workforce issues.	5	4	20	Update: SLA with Royal Wolverhampton Hospital NHS FT to provide consultant AOS – 2 sessions to augment the 2 sessions provided by UHB	Chief Operating Officer	TBC	Jun-14	Monthly	5	4	20

Reference Number	Source of Risk	Clin Grp / Corp Dir / Corp project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Trust non-compliant with Acute Oncology Standards.	5	4	20	Update: Workforce and service design issues (hot clinics) to be negotiated through enhanced SLA with oncology provider. Meeting scheduled with QE for September. Intention is to agree model of service and agree workforce model and SLA for Q3. Developing nurse led services to see pre-chemotherapy patients – to mitigate oncology demand issues.	Chief Operating Officer	TBC	Jun-14	Monthly	5	4	20
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Trust has inconsistent cancer pathways between its sites and mixed visiting oncology MDT attendance patterns.	5	4	20	Update: Trust is extended discussions with UHB and executive led cancer futures workshop now scheduled for early September.	Chief Operating Officer	TBC	Jun-14	Monthly	5	4	20
The decision was announced and the MMH Project Team will review the risk register and confirm changes to the overarching MMH risk.																
1401MMH001	Project Risk Assessment	MMH Project Board		Organisational (Strategic)	Increase in cost of Midland Metropolitan Hospital if approval delayed, then restarts approval cycle.	4	5	20	Involvement of Chair and Chief Executive with Department of Health and HM Treasury officials.	Director of Estates and New Hospital Project	Oct-18	Jun-14	Quarterly	3	5	15

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Infection Prevention and Control Annual Report (April 2013 - March 2014)
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse, Director of Infection Prevention and Control
AUTHOR:	Rebecca Evans – Head of Infection Prevention and Control Nursing Services & Richard Anderson – Informatics Officer
DATE OF MEETING:	7 August 2014

EXECUTIVE SUMMARY:

•Organisational structures continue to work well both within our own organisation and across the wider healthcare economy.
•The Trust annual target for C. difficile was met (39 against a trajectory of 46). In relation to MRSA bacteraemia's there were 4 (1 post 48hr and 3 pre 48hrs) against a target of 0. As the pre 48 hour bacteraemia's were deemed to be contaminants these also count against the Trust's trajectory. The target set for 2014/2015 for both C. difficile (37 cases) and MRSA bloodstream infections (BSI) is zero tolerance.
• During the period April 2013 - March 2014 there were a total of 11 ward closures that were attributed to D&V. Closures by site equated to 8 at City, 3 at Sandwell and none in Intermediate Care. The outbreaks involved a total of 105 patients and 21 staff over a period of 58 days with a range of between 1 and 13 days dependent upon severity of the outbreak
•The Infection Prevention and Control Services (IPCS) continues to adopt a proactive approach to the prevention and control of HCAIs through:- surveillance of target organisms; monitoring compliance against infection prevention and control practices to include:- root cause analysis of specific cases, investigation of outbreaks and increased incidence of infection, audit of both clinical and non-clinical practice, antibiotic stewardship and education and training.
•Key to maintaining standards is continued commitment and compliance with infection prevention and control policies by Clinical and non-Clinical Groups and healthcare personnel. Audit and training continues to be prioritised as a means of monitoring and delivering continuous improvements.

REPORT RECOMMENDATION:

The Board is required to accept the annual report of infection control for 2013/14

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Compliance with Health Code and National Targets for MRSA and C.difficile and

- Ensure systems are in place for the prevention and control of healthcare associated infections.
- Meticillin Resistant Staphylococcus aureus (MRSA) targets
- Clostridium difficile targets
- To meet the statutory requirements as set out in 'The Health and Social Care Act 2008' – Code of practice for health and adult social care on the prevention and control of infections and related guidance'

- NHS LA Risk Assessment - 2.2.8 – Infection Control

PREVIOUS CONSIDERATION:

The report has been scrutinised and supported at the Infection Prevention & Control Committee

Contents

Appendices

1. Executive Summary

Organisational structures continue to work well both within our own organisation and across the wider healthcare economy.

The Trust annual target for C. difficile was met (39 against a trajectory of 46). In relation to MRSA bacteraemias there were 4 (1 post 48hr and 3 pre 48hrs) against a target of 0. As the pre 48 hour bacteraemias were deemed to be contaminants these also count against the Trust's trajectory. The target set for 2014/2015 for both C. difficile (37 cases) and MRSA bloodstream infections (BSI) (zero tolerance) will prove a major challenge.

During the period 2012-2013 the IPCS, along with other healthcare organisations experienced an unprecedented amount of outbreaks attributed to symptoms of diarrhoea and or vomiting as a result of Norovirus. During the current reporting period the number of outbreaks has significantly reduced. During the period April 2013 - March 2014 there were a total of 11 ward closures that were attributed to D&V. Closures by site equated to 8 at City, 3 at Sandwell and none in Intermediate Care. The outbreaks involved a total of 105 patients and 21 staff. Wards were closed for a total period of 58 days with a range of between 1 and 13 days dependent upon severity of the outbreak (see appendix 4).

The Infection Prevention and Control Service continues to adopt a proactive approach to the prevention and control of Healthcare Associate Infections (HCAIs) through:- surveillance of target organisms; monitoring compliance against infection prevention and control practices to include:- post infection review of target organisms, investigation of outbreaks and periods of increased incidence of infection, audit of both clinical and non-clinical practice, antibiotic stewardship, education and training and appropriate decontamination of the environment and equipment.

Key to maintaining standards is continued commitment and compliance with infection prevention and control policies by Clinical and non-Clinical Groups and healthcare personnel. Audit and training continues to be prioritised as a means of monitoring and delivering continuous improvements.

2. Management and Organisation

The Infection Prevention and Control Service (IPCS) is a fully integrated service incorporating the Acute and Community arms of the Organisation.

During 2013-2014 Infection Prevention and Control continue to work closely with clinical and non – clinical departments, focusing on key areas of practice to help facilitate the prevention and control of HCAIs. The overall organisation of infection prevention and control within the Trust continues to works well. The IPCS reports to the Patient Safety Committee via the Infection Prevention and Control Advisory Committee (IPCAC) which monitors compliance against infection prevention and control standards to include:- compliance against the Health Act 2008 – (amended 2012), ratification of policies and guidelines and monitor compliance against infection prevention and control practices

Partnership working with the Clinical Commissioning Groups (CCG), Trust Development Agency and Health Protection Unit and Public Health England through the Health Economy Groups for Infection Prevention and Control continues to thrive.

Within the Trust the IPCS continues to adopt a proactive approach to the prevention and control of HCAIs, liaising with all designations of staff to monitor and improve practices and activity that have a positive impact on patient care. This includes: - improving clinical practice, reviewing practices relating to decontamination of equipment the environments, policy development, audit and education and training to all healthcare workers both internal to the organisation and external to the organisation e.g. teaching of pre and post registration medical and nursing staff.

3 Surveillance

Microbiological surveillance is undertaken by the IPCS identified from clinical specimens received in the hospital laboratory and focuses on organisms which are known to have the ability to cross-infect, or are multiple antibiotic-

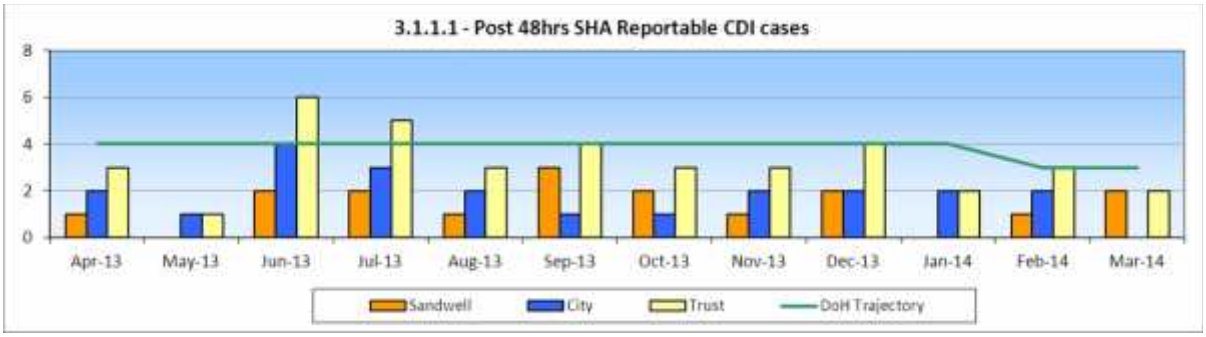
resistant and not normally present in high numbers in the patient population – Target organisms. An increase in numbers of these 'target organisms' isolated in a particular ward/department, or in similar clinical sites may indicate a problem in either the short or long term, requiring investigation and action. The IPCS circulate monthly reports to clinical staff and relevant managers and Executive Directors outlining progress against target organism surveillance and key actions required.

In addition to this the IPCS focus on specific target organisms that are monitored against national targets i.e. MRSA, C.difficile, and MRSA screening compliance. Outlined below is progress against key target organisms for the period 2013- 2014

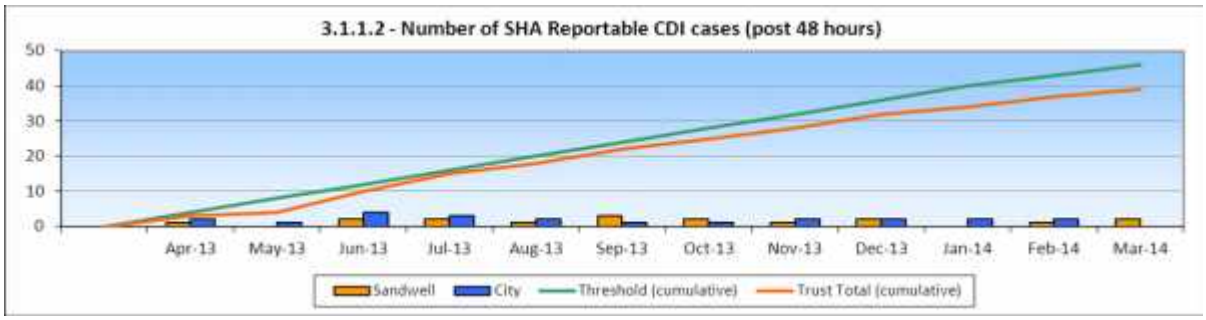
3.1 Clostridium difficile infections

3.1.1 SHA Reportable Clostridium difficile

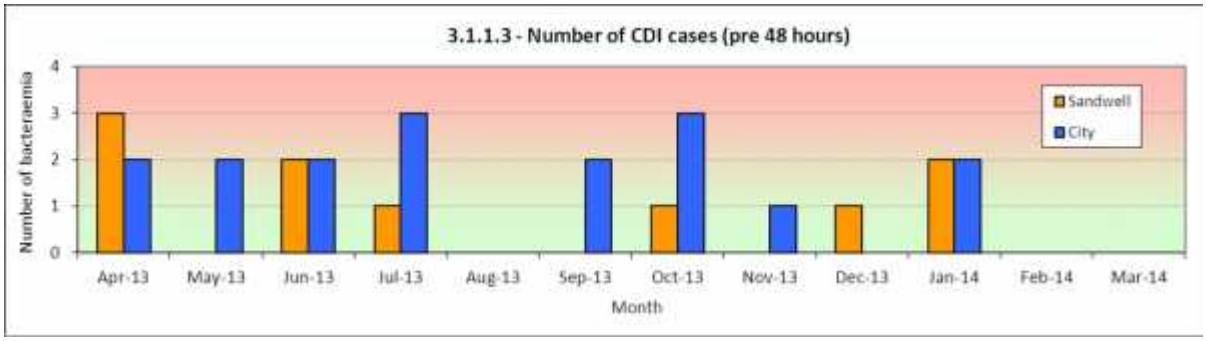
3.1.1.1 Number of Post 48hrs Clostridium difficile infections (CDI) for the period April 2013- March 2014



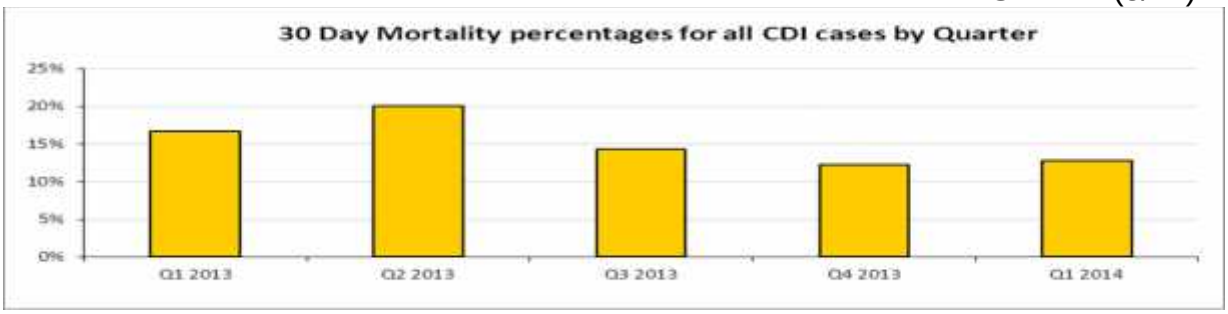
3.1.1.2 Cumulative number of Post 48hrs Clostridium difficile infections (CDI) against trajectory



3.1.1.3 Number of Pre 48hrs Clostridium difficile infections (CDI) for the period April 2013- March 2014



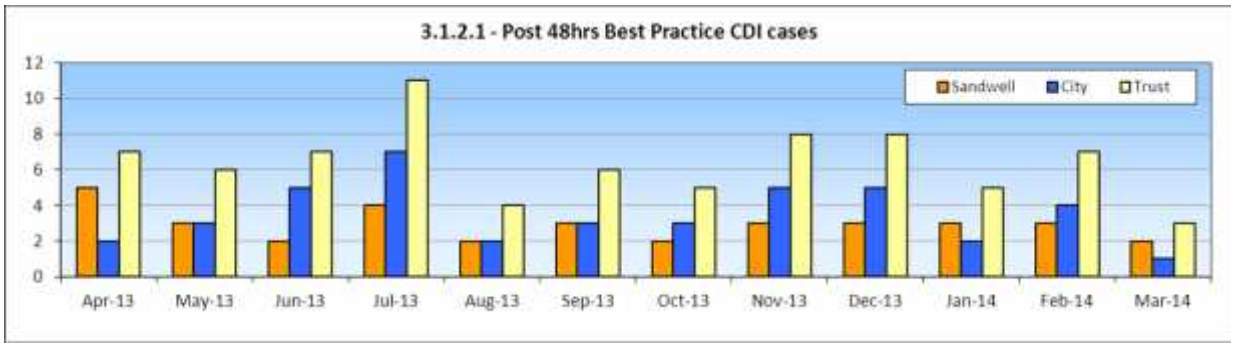
3.1.1.4 Clostridium difficile 30 day Mortality



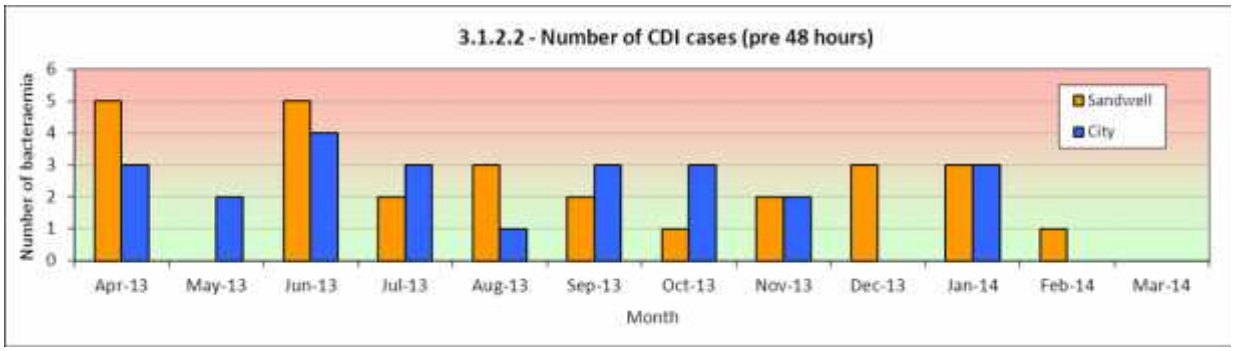
3.1.2 Best Practice CDI Data

As part of the IPCS monitoring of Clostridium difficile infections (CDI) the Trust monitors against both DH definitions and targets and our own internal best practice numbers. The SWBH best practice numbers are determined by a combination of clinical assessment and a recognised testing algorithm. By using this reporting mechanism we can ensure that all patients with clinical signs of CDI are identified and managed appropriately (full breakdown see appendix 1).

3.1.2.1 Number of Post 48hrs Best Practice Clostridium difficile for the period April 2013- March 2014

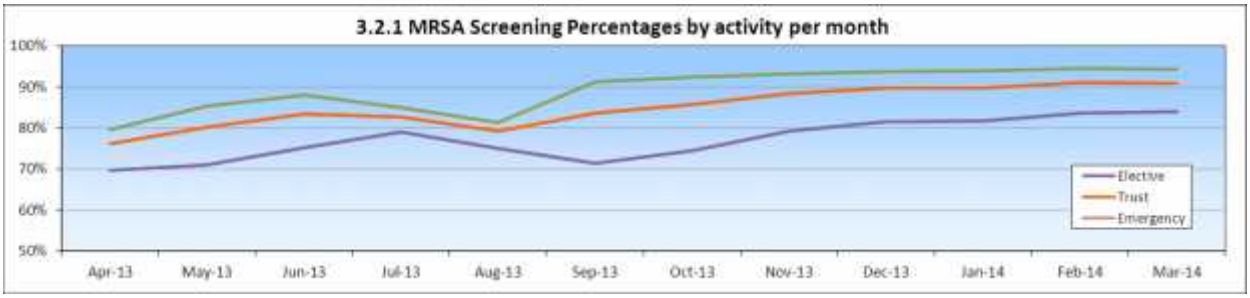


3.1.2.2 Number of Pre 48hrs Best Practice Clostridium difficile for the period April 2013- March 2014

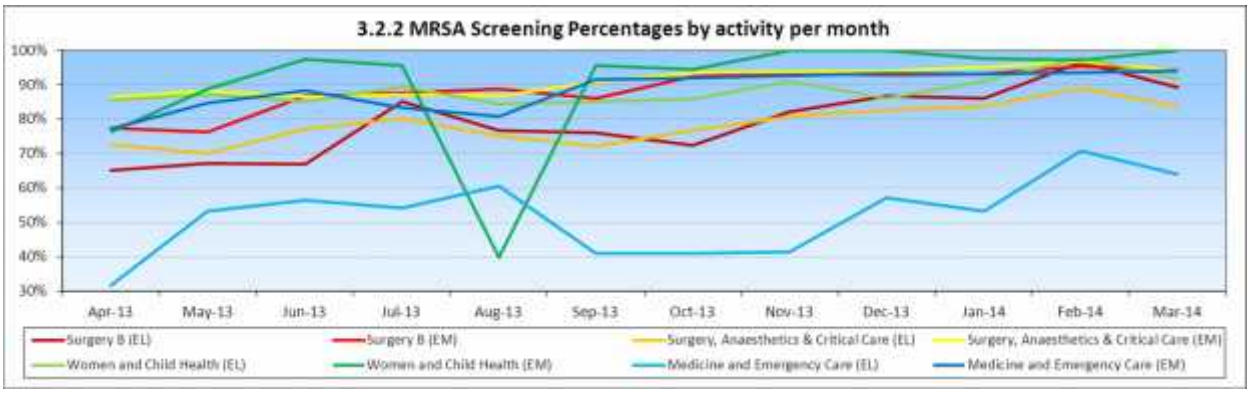


3.2 Meticillin Resistant Staphylococcus aureus (MRSA)

3.2.1 MRSA Screening undertaken by month for the period April 2013- March 2014

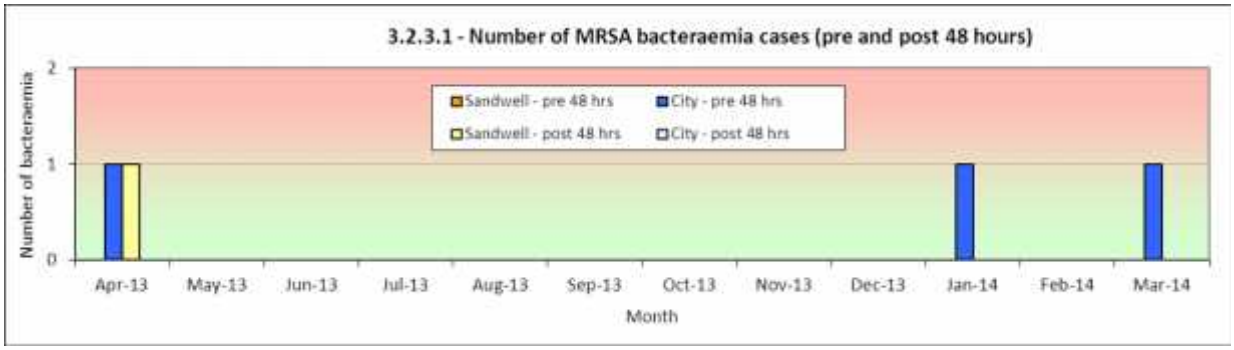


3.2.2 Preadmission MRSA screens by Division and month for the period April 2013- March 2014

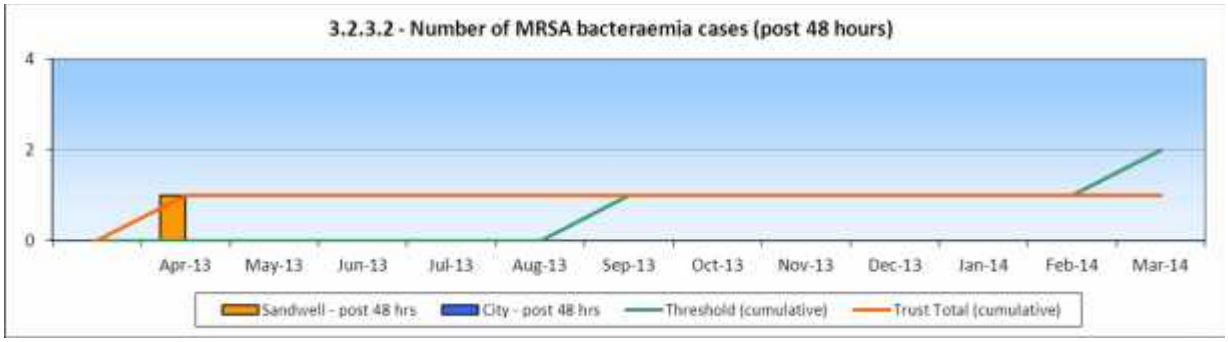


3.2.3 Number of MRSA Bacteraemias for the period April 2013 - March 2014

3.2.3.1 Mandatory Reporting of MRSA bloodstream infections (pre-48hrs)

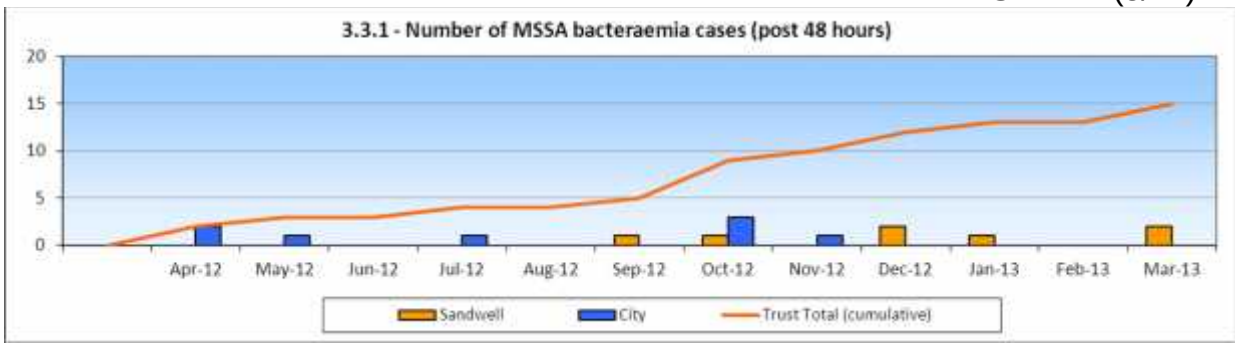


3.2.3.2 Mandatory reporting and cumulative number of Post 48hrs MRSA Bacteraemia against trajectory

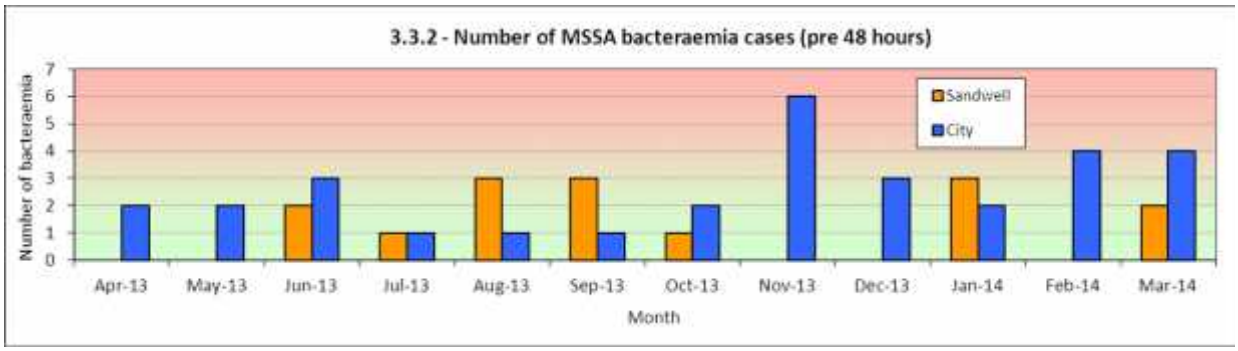


3.3 Number of Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemias by month for the period April 2013- March 2014

3.3.1 Post 48 Hours MSSA

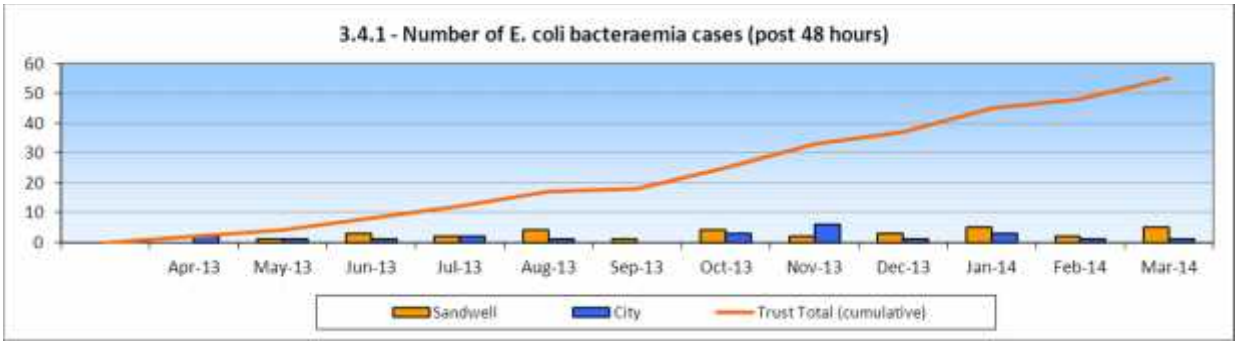


3.3.2 Pre 48 Hours MSSA

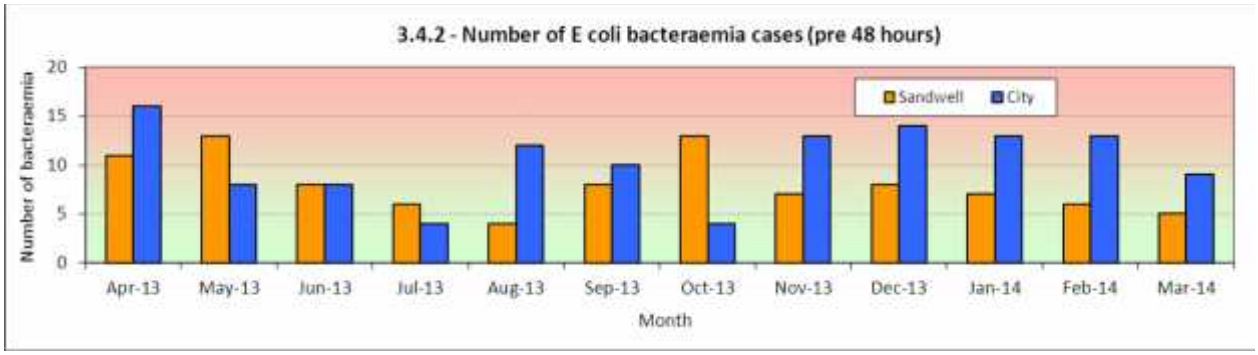


3.4 Escherichia coli (E. Coli) bacteraemia by month for the period April 2012- March 2013

3.4.1 Post 48 Hours E. coli Bacteraemias

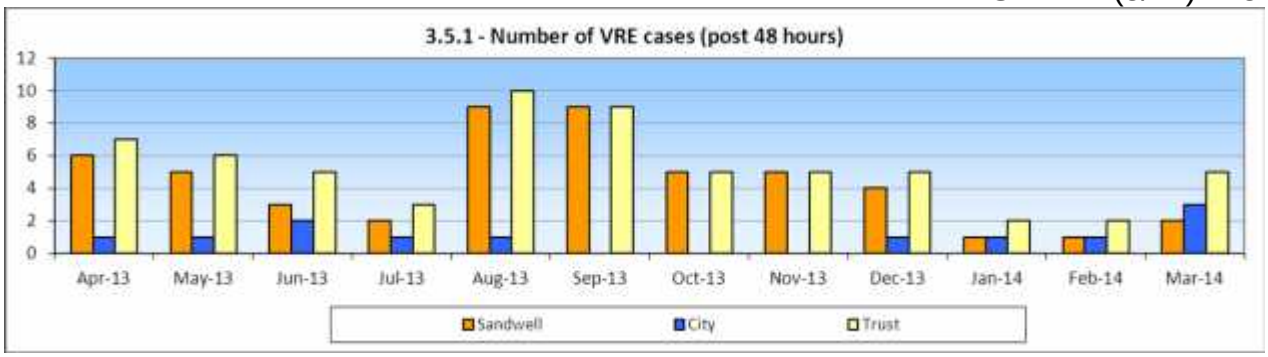


3.4.2 Pre 48 Hours E. coli Bacteraemias.

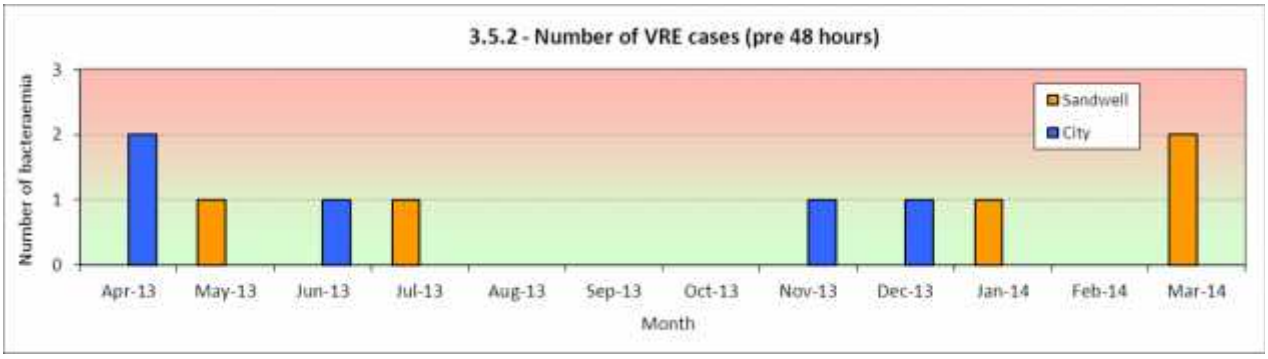


3.5 Vancomycin resistant enterococcus (VRE)

3.5.1 Number of post 48hrs VRE isolates



3.5.2 Vancomycin resistant enterococcus isolates – Pre 48 hrs



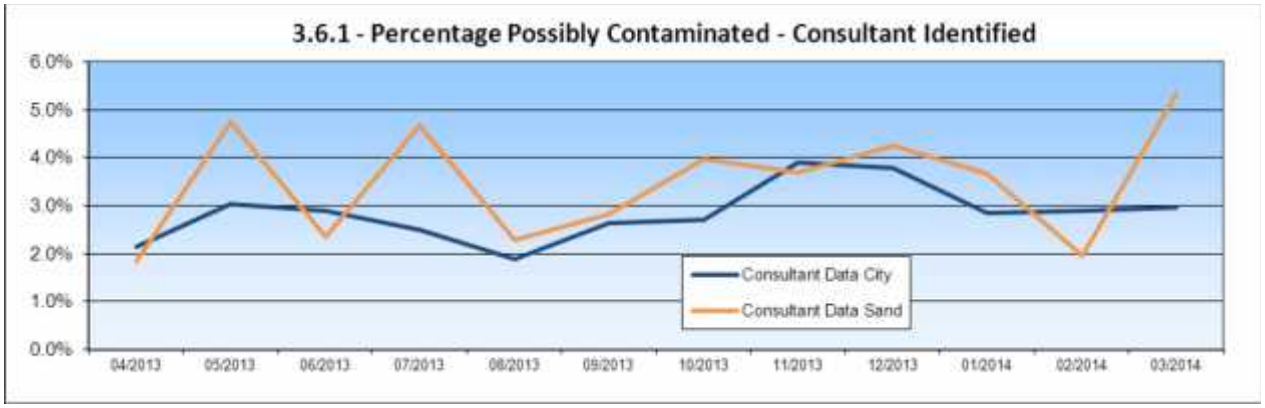
(See appendix 2 for breakdown of VRE isolates by location)

3.6 Percentage of possibly contaminated blood cultures.

The percentage of potentially contaminated blood cultures is monitored closely by the IPCS as a marker of compliance against the good practice when taking blood cultures. Contamination rates are fed back to Clinical Groups on a monthly basis in the form of the Director of Infection Prevention and Control report. Clinical Groups with wards/departments who have contamination rates above the 3% threshold are required to provide an action plan to the Infection Prevention and Control Advisory Committee.

During the latter end of the December and this quarter the IPCS and IV Team have introduced blood culture packs. The packs contain Trust approved products (except blood culture bottles) to facilitate an effective aseptic technique when taking blood cultures, reducing the risk of contamination. All blood cultures received in the laboratory are monitored. Any specimens identified as a contaminant are highlighted to the clinical team and contamination rates monitored (see appendix 3 for full breakdown of contamination rates by location).

3.6.1 Percentage of all positive blood cultures that are possible contaminates by month for the period July 2013 – March 2014



3.8 Surgical Site Surveillance

As part of a programme of monitoring surgical site infections, the IPCS work in collaboration with the Women and Child Health Clinical Group to monitor caesarean section wound infections. Data are collected from proformas completed by midwifery staff post discharge and from target organisms identified from wound specimens received in the laboratory.

In addition to the monitoring of caesarean section infection rates the Trust monitors orthopaedic joint infections as part of the Public Health England (PHE), Surgical Site Infection Surveillance (hip and knee). Orthopaedic infections are monitored by the Surgical Clinical Group. It needs to be recognised that data is collected within parameters set by the PHE and includes any joint infections identified that have occurred up to 12 month post initial surgery i.e. a patient identified with an infection in January may have had surgery within the preceding 12 months.

The tables below outline the number of surgical site infections for the period Apr 13 – Mar 2014.

3.8.1 Table to identify the number of caesarean section wound infections for the period April 2013 - March 2014

For the period April 2013 to March 2014 there were a total of 1410 Caesarean sections performed at SWBH. Of the 1410 caesarean sections a total of 737 proformas were returned to the IPCS. Of those 737, 71 patients were identified as having a Surgical Site Infection (SSI). The table below represents the number of SSI identified against the number of completed proformas returned to the IPCS.

Operative Procedure	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Marc 14	Total
Emergency Caesarean Section	81	78	87	82	87	93	80	81	52	93	66	72	952
Elective Caesarean Section	22	44	42	46	41	46	40	31	35	46	39	26	458
TOTAL	103	122	129	128	128	139	120	112	87	139	105	98	1410
% of SSI against number of proformas returned *(number of SSI's)	14.5% (8)	5% (3)	11% (8)	5% (3)	8% (5)	7% (5)	7% (5)	6% (4)	9% (5)	16% (11)	13% (8)	15% (6)	10% (71)
Number of proformas returned	**55**	**56**	**70**	**61**	**65**	**71**	**68**	**69**	**53**	**70**	**59**	**40**	**737**

NB: - % is based on the number of proformas returned and the accuracy is dependent on timely returns to IPCS

3.8.2 Table to identify the number of orthopaedic joint infections for the period April 2013 – March 2014

Operative Procedure	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Marc 14	Total
Total Knee Replacement	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Hip Replacement	1	0	0	0	0	0	0	0	0	0	0	0	1
TOTAL	1	0	0	0	0	0	0	0	0	0	0	0	1

3.9 Tuberculosis

The West Midlands has the 2nd highest incidence of Tuberculosis (TB) in the United Kingdom. SWBH is responsible for the care and management of a large proportion of those patients known to or suspected of having Tuberculosis (TB). In addition to drug sensitive TB, SWBH also sees a proportion of patients identified as Multi drug resistant tuberculosis (MDR-TB). This year two patients were diagnosed with extended drug resistant TB (XDR-TB) and treated at the Trust. The Trust also cares for an increasing number of complex patients with multiple co-morbidities, socio-economic issues and complicated TB infection.

Patients with TB are identified to the IPCS from either clinical specimens received in the laboratory, by clinical diagnosis at ward/departmental level (i.e. imaging) or via the community chest clinics/GP's. All patients with TB are nursed in line with respiratory and infection prevention and control guidance. All patients suspected or known to have open TB should be nursed in isolation with airborne precautions. The Trust has in place a risk assessment tool to enable staff to determine the risk and isolate appropriately. In some cases patients may not have been nursed in a side room due clinical condition or TB was not considered as a diagnosis. In this event contact tracing is undertaken of any other susceptible patients if the index is confirmed positive for TB. Contact tracing involves notification of patients, Consultant and GP via letter informing of the potential exposure and action required if they have any concerns to ensure monitoring of any potential contacts.

For the period 2013/2014 178 patients were identified as positive for tuberculosis from confirmed laboratory isolates. Of those, 7 patients were not initially nursed in a side room and this required contact tracing to be undertaken. As a result 113 patients and their GP's and Consultants were informed by letter that they may have potentially come into contact with a person with tuberculosis.

3.10 Introduction of rapid testing of enteric pathogens

Microbiology have recently introduced 'EntericBio®' into their mainstream investigation repertoire; only the third laboratory in the UK, and the first in the Midlands, to do so. This major innovation uses a method of testing which exploits the latest gene-probe molecular technology. A panel of common infective bacteria, including Salmonella, Shigella, Campylobacter and Toxigenic E.coli are tested by Polymerase Chain Reaction (PCR). This identifies a gene sequence specific to a target bacteria and, if it is present, amplifies it many thousands of times until a measurable reaction is obtained. By this means a preliminary positive or a negative result can be obtained the same day, as opposed to using traditional bacterial culture techniques which can take up to 48 hours. Although positive findings are still confirmed by culture, negatives and presumptive positives can be reported immediately; thus considerably speeding-up the diagnostic process. This should mean that many patients can move out of side rooms much more quickly than is currently the case, freeing-up isolation beds for other patients who need them.The Microbiology Department intends to expand the EntericBio® repertoire in the very near future to look for other enteric pathogens including Giardia, Cryptosporidium and Clostridium difficile. Over 300 trial tests were conducted during which EntericBio® results were compared with those of conventional culture. EntericBio® was seen to deliver highly accurate results with a much enhanced turn around time.

3.11 Introduction of in house laboratory testing for carbapenem resistant organisms

The SWBH microbiology laboratory now offers screening for carbapenem resistant organisms (CROs) in-house from rectal screening swabs or stool samples. This is in support of the targeted screening of patients with risk factors for carriage or infection with CROs in line with Public Health England guidance published last year. We are piloting a molecular screening assay for the detection of CRO carriage which we hope will decrease turnaround times and reduce the amount of time patients spend isolated waiting for results thus freeing up side rooms.

4. Antimicrobial Stewardship

Antimicrobial stewardship contributes to slowing the development of resistant organisms and is an essential component of reduction of healthcare associated infections. The Department of Health has issued clear guidance of best practice (Start Smart then Focus). We are aiming to make this part of routine practice across the trust to improve medical practice and assist in reducing HCAIs. Part of this drive includes a focus on antimicrobial prescribing, which includes;

1) a self-assessment toolkit, aiming to continuously improve our score

2) 2-monthly point-prevalence ward surveys on antimicrobial prescribing documentation with internal trust targets
3) annual audit on surgical prophylaxis in Trauma & Orthopaedics and General Surgery to demonstrate sustained improvement

Progress to date;

1) SAT score 97 at end March 2014, up from baseline of 80.
2) Planned redesign of drug chart underway to facilitate improvement in prescribing documentation
3) Q4 results show improvement both in General Surgery and Trauma & Orthopaedics in all areas.

The antibiotic pharmacists continue to conduct regular ward rounds to review antibiotic prescribing and provide advice. They review antibiotic use on admissions wards on a daily basis Monday to Friday. The use of restricted antibiotics is closely monitored to ensure prescribing is appropriate and is reported to the Drugs and Therapeutics Committee on a monthly basis. In addition, daily antibiotic ward rounds led by a consultant microbiologist are performed to review patients with complicated infections, prolonged courses of antibiotics, broad spectrum agents or otherwise in need of review.

The Management of Antimicrobial Therapy policy has been updated to reflect the recommendations of 'Start Smart then Focus', as well as clearly outlining the responsibilities of all clinical staff with respect to antimicrobial prescribing. Guidelines for respiratory tract infections, skin and soft tissue infections, diabetic foot infections and gastrointestinal infections have all been revised this year. We have introduced an App for mobile devices in order to improve access to antibiotic guidelines within the trust. This has proved successful with positive feedback from junior doctors.

5. Summary of Outbreaks/Investigations/Periods of Increased Incidence (PII) and Increased incidence of infection.

The management of outbreaks and PIIs is an intrinsic feature in the practice of the Infection Prevention and Control Service. The severity of an outbreak is generally dependent on the type of infective organism and its virulence. Small outbreaks occur reasonably frequently requiring immediate investigation and control measures. Large or protracted outbreaks can be extremely expensive.

5.1 - Diarrhoea and or Vomiting

During the period 2012-2013, along with other healthcare organisations there was an unprecedented amount of outbreaks attributed to symptoms of diarrhoea and or vomiting as a result of Norovirus. During the current reporting period the number of outbreaks has significantly reduced. All outbreaks present an increased cost to healthcare settings and thus require quick action and a structured management approach to control their impact. Communication with the wider health economy (e.g. HPU, CCG) is intrinsic to the management of outbreaks.

In order to prevent the spread of enteric infections it is policy to isolate any patient admitted with, or developing symptoms of diarrhoea and/or vomiting into a single side room, implementing enteric precautions. Outbreaks of diarrhoea and/or vomiting are monitored by IPCS on an on-going basis in line with national and local guidelines. The measures taken to control outbreaks are based on the severity of the outbreak and the ability for organisms to cross infect.

During the period April 2013 - March 2014 there were a total of 11 ward closures that were attributed to D&V. Closures by site equated to 8 at City, 3 at Sandwell and none in Intermediate Care. The outbreaks involved a total of 105 patients and 21 staff. Wards were closed for a total period of 58 days with a range of between 1 and 13 days dependent upon severity of the outbreak (see appendix 4).

Table 1 - Number of outbreaks of diarrhoea and or vomiting annually for the period April 07 – March 14

Period	Total Number of Ward Closed	City	Sandwell	Rowley	Intermediate care	Total no. of Patients affected	Total number of Staff affected	No. of days ward closed (inclusive)
Apr 07 - Mar 08	22	6	15	2	n/a	301	82	154

Period	Total Number of Ward Closed	City	Sandwell	Rowley	Intermediate care	Total no. of Patients affected	Total number of Staff affected	No. of days ward closed (inclusive)
Apr 08– Mar 09	28	10	20	3	n/a	385	95	231
Apr 09– Mar 10	22	15	8	0	n/a	290	53	172
Apr 10– Mar 11	13	8	4	1	n/a	108	33	51
Apr 11– Mar 12	25	14	12	n/a	1	273	77	204
Apr 12 – Mar 13	59	24	31	n/a	4	624	162	483
Apr 13 – Mar 14	11	8	3	0	0	105	21	64

5.2 – Summary of other outbreaks and incidences for the period April 2013 – March 2014

In addition to outbreaks of diarrhoea and or vomiting the IPCS investigate other outbreaks/incidences relating to any other significant target organisms that have the ability to cross infect patients, staff, visitors and the environment. This can result in additional patient morbidity and an increase length of stay in hospital for patients. In some instances these infections can increase the risk of patient mortality. All outbreaks and incidents are investigated by the IPCS to ascertain a root cause and lessons learnt. Incidents and outbreaks are reported to external agencies as required via STEIS. As part of the investigation and management of outbreaks meetings are held with clinical and non-clinical colleagues and external agencies e.g. PHE, CCG's, as appropriate. Summary of outbreaks -see appendix 5.

6 Audit

Audits are seen as a central approach to maintaining clinical effectiveness and as such plays an integral part of Infection Prevention and Control in the prevention, control and management of infections. Audits undertaken comply with current guidelines and legislation (Essence of Care, the NHS Plan and the National Standards of Cleanliness in the NHS). Audits undertaken cover all areas of clinical and non-clinical practices in relation to infection prevention and control. Monitoring of compliance with laid down infection prevention and control practices, policies and standards in clinical settings have been established as an effective method of identifying examples of good practice and areas where improvements in practice are required. This helps to improve the quality of care delivered to patients and decreases the risk of cross infection to and from patients and staff. In addition to the audit programme the IPCS will undertake specific audits as part of investigations of outbreaks and increased incidence of infection. (See appendix 6 for summary of audits undertaken and completed)

7 Decontamination.

Decontamination is a key function in reducing healthcare care associated infection. Issues relating to decontamination have been identified through various methods to include:- observation of practices, audit using both the Department of Health/ Infection Prevention Society audit tool and bespoke audits dependent upon the type of practice or equipment involved. All audits are aimed at ensuring practices applied by the trust comply with National recommendations to include - Health Technical Memorandum, Choice Framework local Policies and Procedures (CFPP),NICE Guidance and Legislation.

Each year the decontamination strategy and decontamination program is reviewed to ensure that they take account of relevant legislation and best practice guidance of the CFPP and that they support the organisations vision. Objectives are used to structure the decontamination programme the progress of which is monitored via the infection prevention control advisory committee and the medical device committee meetings.

Please see appendix 7 for the update of the status of the 2013-2014 Decontamination program. Objectives that are not completed will be carried over as part of the next annual decontamination program. The decontamination manager advises the executive decontamination lead on issues relating to decontamination and the necessary actions required.

8 Education and Training

Education and training is seen as an integral part of improving and maintaining both good clinical and non-clinical practice across the organisation and facilitating the prevention and reduction of HCAIs. During 2013-2014 the Infection Prevention and Control Service (IPCS) have continued to promote best practice through formal and informal

teaching onwards, departments, community facilities and external bodies. The IPCS support Birmingham City University on their infection prevention and control modules for foundation, degree and specialist courses.

The IPCS use a variety of literature, teaching and visual aids to promote infection prevention and control practices to all staff across the organisation. In addition to the education of staff the IPCS use promotional aids to inform visitors and patients of best practice and initiatives adopted by the organisation.

8.1 Infection Prevention and Control Champions

To improve compliance, the IPCS have continued to develop the role of the 'Infection Control Champions' with bi-monthly workshops. These workshops are aimed at both updating the champions on key infection prevention and control issues and empowering champions to promote good infection prevention and control practices in the workplace. The role of the Infection Prevention and Control Champions is important to ensuring key people are present in both clinical and non-clinical areas to facilitate infection prevention and control initiatives.

8.2 Hand hygiene

Across the Trust the Infection Prevention and Control Service recognises the importance of good hand decontamination in the prevention of cross infection. Compliance with hand washing and the use of an effective hand washing decontamination technique is viewed as an integral part of infection prevention and control education and training. Training is delivered to all employees of the Trust both clinical and non-clinical staff as part of the Induction and Mandatory training programme. The IPCS with Learning and Development provide the educational opportunities for all employees to understand the importance of correct and effective hand hygiene. Additionally, where clinical concerns are raised, individuals or ward/departmental teams are facilitated focused formal and informal sessions.

8.3 Visual aids for promoting of infection prevention and control practices

As part of hand hygiene education ultra-violet hand machines continue to be available for use across the Trust. The use of these machines is recognised nationally as a tool to demonstrate hand washing techniques by highlighting the areas that are most often missed during hand decontamination. The machines are also loaned to wards and departments for staff teaching. In this instance IPCS give training to staff with an interest in infection prevention and control, they then cascade the training to staff in their departments.

IPCS have used the ultra-violet hand machine at various lectures and seminars delivered throughout the Trust. Additionally, there are machines permanently available at the Education Centres at both City and Sandwell hospitals, for use by staff as appropriate.

In addition to the use of ultraviolet hand machines the IPCS has purchased other visual aids such as:- posters, wound simulator, paediatric cannulation simulator and adult teaching arms to promote best practices in venepuncture and cannulation. The use of the arms are a vital tool to enable staff to understand the practical application of key clinical tasks to improve both their theoretical and practical knowledge base and skills.

8.4 Induction and mandatory training

The IPCS continues to support the mandatory training and induction programme. The mandatory training package was reviewed and introduced mid-2012 and has undergone regular updates. This has enabled a more convenient delivery to staff via an interactive presentation and integral questions to check learning. This also enables mandatory training compliance to be monitored (see table below). The Service specifically undertakes focused training for medical staff on both mini inductions and the annual induction, in conjunction with the IV Team. All new doctors to the organisation are trained in hand hygiene and the taking of blood cultures to determine level of competency with an aim of obtaining blood cultures that are clinically significant and reducing the number of blood culture contaminants.

Table outlining Mandatory Training 2013/14 - % Compliance by Clinical Group (source: L&D on CDA)

	Community Therapies	Corporate Group	Imaging	Medicine and Emergency Care	Pathology	Surgery A	Surgery B	Child & Women Health
Infection Control	87.24	90.93	89.94	81.38	91.72	87.25	84.64	85.58

In addition to the Mandatory training programme the IPCS have undertaken extensive formal and informal teaching sessions throughout the organisation to highlight and re-enforce infection prevention and control practices in addition to the mandatory and induction training. During 2013/14 the IPCS have undertaken an additional 66 formal teaching sessions, covering 1004 members of staff.

8.5 Clinical teaching sessions

In addition to teaching sessions being undertaken in support of the induction and mandatory training, the IPCS continue to undertake teaching sessions in clinical/non-clinical areas. This also involves implementing teaching sessions for nursing and medical students as part of their curriculum of study. Similarly, the IPCS participate in regular teaching sessions as part of the Trust's induction for Consultants, Specialist Registrars and junior doctors.

As well as supporting medical staff, the IPCS have a commitment to training student nurses both internally to the organisation, with teaching undertaken in the classroom and as part of their time spent on the isolation ward they are allocated time with the IPCT and external to the organisation, supporting Birmingham City University.

In response to last season's increased incidence of diarrhoea and vomiting, and ward closures, the IPCS have undertaken extra ward based training sessions in the care of patients with diarrhoea and vomiting and 'outbreak management – winter must be better'. The Service has produced an 'outbreak' folder for clinical areas. This provides posters and forms for use during the outbreak and specimen posters and forms to be copied to maintain stock levels. This initiative will empower wards and clinical groups to manage and report outbreak information accurately, in a timely manner to enable appropriate outbreak management decisions to be made.

8.6 IPCS road shows

To ensure key information is delivered to staff, patients and visitors. IPCS have developed a rolling programme of road shows. The road shows were delivered on all sites periodically. During each road show, IPCS team members are available to answer questions and provide information. Visual aids are used throughout to include: display boards; posters; equipment (i.e. ultra-violet gel machine) and examples of suitable products (i.e. PPE).

8.7 Targeted Education and Training

In response to outbreak and periods of increased incidents the IPCS has undertaken targeted training in the following areas.

8.7.1 Orthopaedics

Educational sessions were arranged for the orthopaedic services and topics covered were:

- õ Hand hygiene
- õ Personal Protective Equipment (PPE)

8.7.2 Ward Newton 4 and dieticians

Educational sessions were arranged for the orthopaedic services and topics covered were:

- õ Hand hygiene
- õ Personal Protective Equipment (PPE)
- õ Enteral feeding and infection prevention
- õ Source isolation precautions

8.8 IV therapy training

IPCS continues to work with the IV Team, to deliver infection prevention education for the 'Intravenous Therapy Training Course'. Topics covered were:

- Hand hygiene
- Personal Protective Equipment (PPE)
- Signs and symptoms of peripheral and central line infections
- What factors contribute to line infections
- Importance of identifying and monitoring phlebitis
- Correct skin decontamination prior to peripheral and CVC insertion
- What action should be taken if an infection is suspected or identified
- What role line dressings have in infection prevention
- Importance of accurate record keeping & documentation

9 Informatics

Microbiology Informatics has continued to provide a wide range of support to and for Infection Prevention and Control through a combination of standing, bespoke and innovation outputs.

Standing information is centred on a number of daily, monthly, quarterly and annual data outputs which provide on-going knowledge of trends in infectious disease, monitoring, prevention and quality and input of mandatory surveillance data to the HPA e.g. numbers of MRSA bacteraemias and C. difficile cases

Principle amongst these outputs is the Informatics contribution to the Monthly Infection Prevention and Control Report which provides accumulative surveillance in a number of key areas. These include monitoring MRSA and MSSA rates in situations including bacteraemia, general infection and screening, blood culture specimen contamination rates, E.coli bacteraemias, C.difficile and other alert organism monitoring. In particular Informatics maintains a highly developed in-house database of C.difficile reports which enables on-going monitoring of mortality and survival rates.

Microbiology Informatics continues to ensure the timely delivery of infectious disease related information by email directly from the laboratory Information System. Recipients, besides SWBH's internal Infection Prevention and Control Services, include client administrative authorities such as Birmingham Community Services, Sandwell CCG, HMP Winston Green and Birmingham and Solihull Mental Health Trust. During 2013 the serology work previously undertaken within the Microbiology Department has been transferred to a new automated Blood Sciences Laboratory and new systems of e-mail report delivery to Ante-Natal services have been devised and implemented. This new system offers the possibility of enhanced Blood Borne Virus reporting in general using email, as well as extending to other important microbiology results. This will continue to be explored during 2014-15.

10 Infection, Prevention & Control Service Objectives 2014-15

Inorder to achieve the following aims, a collective approach between Clinical Groups and Directorates is required, with Infection Prevention and Control facilitating the development of local ownership of healthcare associated infections at Clinical Group level.

It needs to be recognised Infection, Prevention and Control objectives are fluid and maybe updated/revised and amended in line with latest DH guidance/innovations.

As part of the infection prevention and control programme for 2014-2015 the organisation will focus on the following objectives:-

1. Monitor compliance against:-
    a. Nationally agreed standards e.g. Meticillin resistant Staphylococcus aureus (MRSA), Clostridium difficile infection (CDI). To include Post Infection reviews (PIR) for all MRSA bacteraemia and C.difficile related deaths
    b. Escherichia Coli (E.Coli) bacteraemias – urinary catheter related.
    c. Extended Spectrum ßeta lactamaseproducing organisms
    d. Meticillin Sensitive Staphylococcus aureus (MSSA)

2. Review systems and processes for the prevention and reduction of MRSA/MSSA bacteraemias in line with National guidance.
3. Review systems and ensure processes are in place for the identification, monitoring and reduction of CDI
4. Review systems and processes are in place for the identification, monitoring and reporting of SSI s to include post discharge surveillance.
5. Review systems and processes are in place for the identification, monitoring and reporting of CAUTI
6. To review the process for the monitoring and reduction of blood culture contaminants
7. Review processes in place for the early diagnosis and management of latent and active Pulmonary Tuberculosis especially in high risk groups across the wider healthcare economy.
8. To review systems and processes are in place for the identification, prevention and control of patients with multi resistant Carbapenemase resistant enterobacter to include the implementation of Carbapenemase screening algorithm in accordance with DH guidance across all clinical groups.
9. Review innovations, systems and processes in place for the identification of enteric pathogens
10. Continue to undertake 'target organisms' surveillance.
11. Continue to review Infection, Prevention and Control Policies and relevant patient/staff information inline with National Guidance and recommendations.
12. Work collaboratively with Trust Surviving Sepsis Committee to ensure a cohesive approach to the early diagnosis and appropriate management of sepsis across the wider healthcare economy.
13. Ensure effective systems for communicating information to internal/external patients/staff and visitors are in place and are in user friendly formats.
14. Review/update Infection, Prevention and Control Education and Training Programme.
15. Develop infection prevention and control 'Quick reference guides' for clinical areas to support the management and control of patients with communicable infection
16. To review all aspects of hand hygiene to ensure effective monitoring and compliance
17. Ensure systems and processes are in place to monitor antimicrobial prescribing and ensure that antimicrobial prescribing is appropriate, justified and cost-effective to reduce the risk of antimicrobial resistance and incidence of HAIs.
18. Review and update surgical site surveillance programme with particular attention:-
    a. To Caesarean sections wound infections.
    b. Collaboration with Surgical Division to monitor orthopaedic infections.
19. Continue to review, monitor and standardise effective decontamination across the organisation to ensure systems of monitoring are in place where appropriate in accordance with local and national guidance.
20. Undertake product evaluations that have the potential to benefit decontamination and Infection Prevention in order to ensure that the organisation are obtaining value for money and that the quality and safety of patient care is not being compromised.
21. To work collaboratively with the water safety group and to facilitate the sampling and remedial action required for the water in augmented care against DOH guidance to ensure patient safety is maintained
22. To contribute and report to the Medical Device Committee with particular attention to progress made against the Decontamination Sub-group annual objectives.
23. Continue to provide the Medical Engineering and Learning and development departments with decontamination instructions for medical device competency training.
24. Support the organisations transitional plan to assist divisions to deliver efficient services.
25. Collaborative working with community colleagues to standardise infection control practices across the Health Economy.
26. Collaborative working with Clinical Groups to incorporate infection prevention and control as part of Care Pathways
27. Infection, Prevention and Control Service continue to be actively involved in building/upgrade works to include the development of Midlands Metropolitan Hospital to ensure compliance with national standards to include Infection Control in the Built Environment and Choice Framework local Policies and Procedures (CFPP).
28. Continue to work with Facilities and Patient Public Involvement (PPI) groups to undertaken Patient-Led Assessments of the Care Environment (PLACE) audits in line with national guidance

Appendix 1

April 2013 – March 2014 - Best practice C diff positives by ward

(excluding those diagnosed within 48 hours of admission)

Areas with no positives in this time period are not included on the grid

Ward	Site	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
BSMH Newbridge House (IP)	MH	0	0	0	0	0	0	1	0	0	0	0	0	1
CCS - Critical Care Services	C	0	1	1	1	0	0	1	1	0	0	2	0	7
CCU - Coronary Care Unit	C	0	0	0	0	0	0	0	0	0	0	0	1	1
CCDU - D11 - Male Adult Medicine	C	0	0	0	0	0	0	0	1	0	0	0	0	1
CRITC - Critical Care Ward	S	0	0	0	0	2	1	0	0	0	1	0	0	4
D12 - Isolation Ward	C	0	0	0	0	0	0	0	0	1	1	0	0	2
D15 - Medical	C	0	0	1	1	2	0	0	1	0	1	0	0	6
D16 - Medical	C	0	0	0	0	0	1	0	0	1	0	1	0	3
D17 - Medical	C	0	0	0	1	0	0	0	0	0	0	0	1	2
D18 - Medical MRSA	C	0	0	1	1	0	0	0	0	0	0	0	0	2
D20 - Medical	C	0	0	0	1	0	0	0	0	1	0	0	0	2
D21 - Vascular and ENT	C	0	2	2	0	0	0	0	0	0	0	0	0	4
D25 - Female surgery	C	0	0	0	0	0	0	0	0	1	0	0	0	1
D27 - Gynae Oncology	C	0	0	0	1	0	0	0	0	0	0	0	0	1
D30 - Urology	C	0	0	0	1	0	0	0	0	0	0	0	0	1
D41 - Sort Stay Medicine	C	1	0	0	0	0	0	0	0	1	0	0	0	2
D43 - Neurology	C	0	0	0	0	0	1	0	0	0	0	0	0	1
D5 - Post Coronary Care	C	1	0	0	0	0	0	1	0	0	0	1	0	3
D7 - Cardiology/Medicine	C	0	0	0	0	0	1	1	3	0	0	0	0	5
LY1 - Lyndon 1	S	0	0	0	2	0	0	0	0	0	0	0	0	2
LY2 - Lyndon 2 Surgery	S	0	1	0	0	0	0	0	0	0	1	0	0	2
LY4 - Lyndon 4	S	0	1	0	0	0	0	0	0	0	0	0	0	1
LY5 - Lyndon 5	S	2	0	0	0	0	1	0	0	0	0	0	0	3
NT1 - Newton 1	S	0	0	0	2	0	0	0	0	0	0	0	0	2
NT4 - Newton 4	S	1	0	0	0	0	0	0	0	0	0	0	0	1
NT5 - Newton 5	S	0	0	1	0	0	0	0	0	0	0	0	0	1
PR2 - Priory 2 - Surgery	S	0	0	0	0	0	1	1	2	2	1	1	0	8
PR3 - Priory 3 (Stroke Unit)	S	0	0	0	0	0	0	0	0	0	0	1	0	1
PR4 - Priory 4	S	1	0	0	0	0	0	0	0	1	0	0	0	2
PR5 - Priory 5	S	1	1	1	0	0	0	0	0	0	0	1	1	5
		7	6	7	11	4	6	5	8	8	5	7	3	77

Appendix 2

Trust VRE isolates by location for the period April 2013- March 2014

Areas with no positives in this time period are not included on the grid

Ward	Site	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
A&E	C	1	0	0	0	0	0	0	1	0	0	0	1	3
A&E	S	0	0	0	0	0	0	0	0	0	1	0	0	1
CCS - Critical Care Services	C	0	1	1	0	1	0	0	0	1	0	0	1	5
CRITC - Critical Care Ward	S	4	5	1	0	6	3	1	3	3	1	2	2	31
D12 - Isolation Ward	C	0	0	1	0	0	0	0	0	1	0	0	0	2
D17 - Medical	C	0	0	0	1	0	0	0	0	0	0	0	1	2
D21 - Vascular and ENT	C	2	0	0	0	0	0	0	0	0	0	0	0	2
D25 - Female surgery	C	0	0	1	0	0	0	0	0	0	0	0	0	1
D5 - Post Coronary Care	C	0	0	0	0	0	0	0	0	0	1	0	0	1
LY2 - Lyndon 2 Surgery	S	0	0	0	0	0	1	1	0	0	0	0	0	2
LY3 - Lyndon 3 - Trauma ward	S	1	0	0	1	0	0	0	0	0	0	0	0	2
LY4 - Lyndon 4	S	0	0	0	0	0	0	1	0	0	0	0	0	1
LY5 - Lyndon 5	S	0	0	0	0	0	0	0	0	0	0	0	1	1
NT3 - Newton 3 Trauma Ward	S	0	0	1	0	1	0	0	0	1	0	0	0	3
NT5 - Newton 5	S	1	1	0	1	0	0	2	0	0	0	0	0	5
PR2 - Priory 2 - Surgery	S	0	0	0	0	2	2	0	2	0	0	0	0	6
PR3 - Priory 3 (Stroke Unit)	S	0	0	0	0	0	1	0	0	0	0	0	1	2
PR4 - Priory 4	S	0	0	0	0	0	1	0	0	0	0	0	0	1
PR5 - Priory 5	S	0	0	1	1	0	1	0	0	0	0	0	0	3
Community/GP	G	0	0	0	0	0	0	1	0	0	0	0	0	1
		9	7	6	4	10	9	6	6	6	3	2	7	149

Appendix 3

Blood Culture Contaminants (CNST, MSF, DIPT, CORY) Monthly by Location

Key:

Specific Local Target Agreed	Under 5 samples taken	3 to 6 %
	Under 3%	Over 6%

Location	Total Pos	Total Neg	Total Cont	01 2012	02 2012	03 2012	04 2012	05 2012	06 2012	07 2012	08 2012	09 2012	10 2012	11 2012	12 2012	01 2013	02 2013	03 2013	Total
A&E City	281	2163	95	10/143 (7%)	11/144 (7.6%)	5/102 (4.9%)	2/140 (1.4%)	10/161 (6.2%)	8/175 (4.6%)	15/151 (9.9%)	12/164 (7.3%)	3/139 (2.2%)	2/165 (1.2%)	4/138 (2.9%)	4/210 (1.9%)	1/234 (0.4%)		8/255 (3.1%)	95/2539 (3.7%)
A&E Sandwell	34	207	9	2/20 (10%)						1/17 (5.9%)	1/20 (5%)				2/32 (6.3%)	1/17 (5.9%)		2/16 (12.5%)	9/250 (3.6%)
Critical Care - City	13	366	10		1/46 (2.2%)	1/38 (2.6%)		3/20 (15%)		3/40 (7.5%)	1/26 (3.8%)		1/20 (5%)						10/389 (2.6%)
Critical Care - Sandwell	30	311	9	1/19 (5.3%)			1/25 (4%)	1/30 (3.3%)		1/13 (7.7%)		2/34 (5.9%)		2/29 (6.9%)				1/11 (9.1%)	9/350 (2.6%)
D11 - Stroke Assessment Unit	2	72	2			1/11 (9.1%)					1/6 (16.7%)								2/76 (2.6%)
D16 - Medical	7	41	3	1/5 (20%)		1/5 (20%)				1/6 (16.7%)									3/51 (5.9%)
D17 - Surgical	3	60	4			1/10 (10%)				2/8 (25%)	1/7 (14.3%)								4/67 (6%)
D19 - Paediatric Medicine	14	201	4		1/18 (5.6%)	2/22 (9.1%)			1/13 (7.7%)										4/219 (1.8%)
D42 - Surgical Admissions	16	112	2					2/3 (66.7%)											2/130 (1.5%)
D47 - Geriatric Medical	2	10	2	2/5 (40%)															2/14 (14.3%)
EAU - Sandwell	112	821	38	7/131 (5.3%)	4/116 (3.4%)	4/103 (3.9%)	4/74 (5.4%)	3/65 (4.6%)	2/55 (3.6%)	7/89 (7.9%)	2/36 (5.6%)	2/55 (3.6%)	1/56 (1.8%)		1/68 (1.5%)			1/30 (3.3%)	38/971 (3.9%)
Lyndon 1	7	139	5	1/12 (8.3%)	1/20 (5%)	1/16 (6.3%)			1/9 (11.1%)						1/17 (5.9%)				5/151 (3.3%)
Lyndon 2	19	143	3			1/12 (8.3%)				1/22 (4.5%)		1/11 (9.1%)							3/165 (1.8%)
Lyndon 5	3	52	2	1/10 (10%)								1/2 (50%)							2/57 (3.5%)
Lyndon Ground	8	226	5		1/12 (8.3%)	1/26 (3.8%)	1/24 (4.2%)		1/13 (7.7%)		1/11 (9.1%)								5/239 (2.1%)

Location	Total Pos	Total Neg	Total Cont	01 2012	02 2012	03 2012	04 2012	05 2012	06 2012	07 2012	08 2012	09 2012	10 2012	11 2012	12 2012	01 2013	02 2013	03 2013	Total
MAU - Mau Transfer - City	59	554	25		2/70 (2.9%)	4/70 (5.7%)	7/52 (13.5%)		1/25 (4%)	6/68 (8.8%)	1/38 (2.6%)	3/58 (5.2%)	1/43 (2.3%)						25/638 (3.9%)
Maternity Healthy Baby	2	225	4					1/13 (7.7%)	1/13 (7.7%)	1/21 (4.8%)	1/15 (6.7%)								4/231 (1.7%)
Neonatal Unit - City	13	430	12		3/31 (9.7%)	1/35 (2.9%)	1/32 (3.1%)	3/33 (9.1%)	1/23 (4.3%)		1/30 (3.3%)					1/26 (3.8%)		1/23 (4.3%)	12/455 (2.6%)
Newton 4	3	40	2				1/7 (14.3%)				1/2 (50%)								2/45 (4.4%)
Newton 5	93	536	17	•	5/39 (12.8%)	1/47 (2.1%)		1/67 (1.5%)		2/30 (6.7%)	3/55 (5.5%)			1/24 (4.2%)	2/85 (2.4%)		1/51 (2%)	1/28 (3.6%)	17/646 (2.6%)
Not Stated - City	206	2435	62	2/41 (4.9%)			4/158 (2.5%)	10/227 (4.4%)	4/245 (1.6%)	5/112 (4.5%)	8/193 (4.1%)	1/86 (1.2%)	5/162 (3.1%)	9/215 (4.2%)	4/121 (3.3%)	3/269 (1.1%)	5/379 (1.3%)	2/403 (0.5%)	62/2703 (2.3%)
Not Stated - Sandwell	163	1290	37	2/22 (9.1%)	1/5 (20%)		2/112 (1.8%)	8/158 (5.1%)	2/110 (1.8%)	1/43 (2.3%)	4/90 (4.4%)	3/84 (3.6%)	3/119 (2.5%)	4/124 (3.2%)	2/155 (1.3%)	3/214 (1.4%)		2/92 (2.2%)	37/1490 (2.5%)
OPD - Sandwell	16	79	10	1/14 (7.1%)	3/20 (15%)	2/11 (18.2%)			2/11 (18.2%)		1/3 (33.3%)				1/6 (16.7%)				10/105 (9.5%)
Priory 2	20	116	2	1/10 (10%)			1/15 (6.7%)												2/138 (1.4%)
Priory 3	6	40	2	1/3 (33.3%)	1/5 (20%)														2/48 (4.2%)
Priory 4	8	59	1		1/18 (5.6%)														1/68 (1.5%)
Priory 5	14	97	5		1/12 (8.3%)		1/3 (33.3%)			1/13 (7.7%)	1/11 (9.1%)	1/14 (7.1%)							5/116 (4.3%)
Tipton Renal Dialysis Cnt	8	52	6			2/8 (25%)	1/3 (33.3%)	2/7 (28.6%)			1/8 (12.5%)								6/66 (9.1%)
Total	1162	10877	378	37/983 (3.8%)	40/989 (4%)	31/914 (3.4%)	27/940 (2.9%)	44/1010 (4.4%)	24/924 (2.6%)	50/950 (5.3%)	46/898 (5.1%)	19/837 (2.3%)	14/945 (1.5%)	22/855 (2.6%)	19/1099 (1.7%)	10/1090 (0.9%)	6/930 (0.6%)	19/1003 (1.9%)	408/ 14437 (2.8%)
Areas with 2 or less contaminates	138	1852	30																

Appendix 4

Table - summary of ward closures due to symptoms of diarrhoea and or vomiting, for the period April 2013 - March 2014

Number	Month	Ward	Hospital	Number of patients involved				Number of staff involved				Did the ward close?	№ of days ward closed (inclusive)	Causative organism identified
				D	V	D&V	TOTAL	D	V	D&V	TOTAL			
1	Apr-13	D17	City	9	2	1	**12**	0	0	1	**1**	YES	6	Norovirus
2	Apr-13	Lyndon 2	Sandwell	12	3	3	**18**	0	5	3	**8**	YES	13	Norovirus
3	Apr-13	D17	City	7	1	3	**11**	0	0	0	**0**	YES	10	None identified
4	Apr-13	MAU	City	3	0	0	**3**	0	0	0	**0**	YES	1	None identified
5	Apr-13	D25	City	0	5	1	**6**	0	0	0	**0**	YES	1	None identified
6	May-13	Priory 3	Sandwell	3	0	1	**4**	0	0	0	**0**	YES	1	None identified
7	Nov-13	D16	City	0	0	3	**3**	0	0	0	**0**	YES	2	None identified
8	Jan-14	Lyndon 3	Sandwell	5	6	2	**13**	8	0	0	**8**	YES	8	Norovirus
9	Jan-14	D43	City	7	1	1	**9**	3	0	0	**3**	YES	1	Norovirus
10	Feb-14	D43	City	14	0	0	**14**	1	0	0	**1**	YES	12	Norovirus
11	Apr-14	D11	City	8	0	4	**12**	0	0	0	**0**	YES	9	Norovirus
TOTAL				**68**	**18**	**19**	**105**	**12**	**5**	**4**	**21**		64	

Appendix 5

Table - summarising Outbreaks, PII, case investigations (CI) & contact tracing (CT) (excluding Diarrhoea and or vomiting) for the period April 2013 to March 2014

Month	Causative organism	Site	Ward/Dept	OB	PII	CI	CT	Status
April 2013	PVL post 48 hrs	City	D17				✓	Closed
	Mumps	City	Oncology BTC				✓	Closed
June 2013	TB	City	D41				✓	Closed
	TB	City	Rheumatology				✓	Closed
	Pertussis	SGH	CCS				✓	Closed
	TB	City	D12				✓	Closed
July 2013	Klebsiella pneumoniae	SGH	Orthopaedics	✓				Closed
	C.diff (Same ribotype)	City	D18	✓				Closed
August 2013	TB	City	CCS				✓	Closed
	TB	City	SAU				✓	Closed
	MSSA (PEG site)	SGH	Newton 4	✓				Closed
	KPC Klebsiella pneumoniae	SGH	Orthopaedics	✓			✓	Closed
	Scabies	City	D17				✓	Closed
	VRE	SGH	CCS	✓				Closed

Month	Causative organism	Site	Ward/Dept	OB	PII	CI	CT	Status
	C.diff	SGH	CCS		✓			Closed
	IGAS	City	D15				✓	Closed
	GAS (post 48 hrs)	City	Maternity				✓	Closed
September 2013	iGAS (associated with HEFT)	City	AMU1 D15				✓	Closed
	GAS (2 cases)	City	Maternity	✓			✓	Closed
	SSI	City	Gynaecology			✓		Closed
October 2013	PVL	City	AMU1				✓	Closed
November 2013	PVL (from Homerton university hospital London)	City	Maternity			✓	✓	Closed
	iGAS	City	BTC				✓	Closed
	S.Tyyphimurium	City	N3			✓		Closed
December 2013	TB	SGH	P5				✓	Closed
	C.diff	SGH	P2	✓				On-going - further possibly associated cases April 2014
	iGAS	SGH	P2				✓	Closed
January 2014	Scabies	Rowley Regis Hospital	Henderson Unit	✓				Closed
	iGAS	Lyng PCC	Family planning				✓	Closed
February 2014	C.diff	City	CCS	✓				Closed
	Influenza A	SGH	AMUB				✓	Closed
	Influenza A	City	D17	✓			✓	Closed
March 2014	Influenza A (False positive)	SGH	N5				✓	Closed

Month	Causative organism	Site	Ward/Dept	OB	PII	CI	CT	Status
	C.diff (different typing)	SGH	Priory 5		✓	✓		
	Influenza A	City	D17	✓			✓	Closed
	VZV	City	Antenatal clinic				✓	Closed
	CRO	City	D5 D16	✓			✓	On-going
	MDR pseudomonas	SGH	Newton 3				✓	Closed
	TB	City	D12				✓	Closed
	TB	City	D5				✓	Closed

Appendix 6

Summary of audits undertaken by Infection Prevention and Control Service 2013/14

	Category	Name of Audit	Status
IP&C - INFECTION CONTROL	Clinical Practice Audits	Hand Hygiene	Completed
		Isolation Precautions/risk proforma	Completed
		Standard Precautions	Completed
		Enteral Feeding	Partial completion
		Peripheral lines	Partial completion
		Short term non-tunnelled CVCs	Partial completion
		Short term urethral catheters	Partial completion
	General	Handling and Disposal of Linen	Completed
		Documentation	Completed
		Transportation of Specimens	Completed
		IP&C Mgt – General Management	Completed
		IP&C Mgt – Staff Health	Completed
		IP&C Mgt – Staff Training	Completed
		IP&C Mgt – Policies, Procedures & Guidelines	Completed
	Food Hygiene	In & Out patient Areas / Departments	Completed
		Oral Surgery – Audit against HTM -01-05	Completed
	Decontamination	Endoscopy Audit - JAG Audit tool (Sandwell, City & BTC)	Completed
		Decontamination of beds, specialist beds and bariatric equipment	Completed
		Review of laundry facilities	Completed
		Review of patient transport	Completed
		Review of Ophthalmology AE & OPD	Completed
		Review of Hydrotherapy	Completed
		Review of Hotel Services monitoring of cleaning standards in relation to using ATP monitors	Completed
		Review of Community Dental Services	Completed
		In & Out patient Areas / Departments	Completed
		Oral Surgery – Audit against HTM -01-05	Completed
ANTIBIOTICS	Surveillance	Monthly point prevalence surveys of antimicrobial consumption	Completed
		Surveillance of restricted antibiotic consumption and monthly report to Drugs & Therapeutics Committee	Completed

Appendix 7

Decontamination Program 2013/2014

OBJECTIVE	STATUS	COMMENTS
Review and update the Policy for the Decontamination of Scopes (Rigid and Flexible)		• Approved at the Infection Control Operational Committee September 2013.
To act as a resource for the Sandwell endoscopy unit project group.		• Developed operational policy • Developed monitoring sheets for equipment • Facilitated and co-ordinated staff training liaising with the external company and the endoscopy manager • Decontamination unit opened May 2013.
Develop Patient information leaflet for relatives or carers relating to washing clothes at home		• Leaflet (ML4311) approved until January 2016
Review decontamination of Transrectal Ultrasound probes to ensure that they are decontaminated in line with manufacturer's instructions and CFPP-01-06 guidance		• Local decontamination will be removed from 6th May 2014, decontamination will be undertaken by Endoscopy to achieve compliance with Best Practice of the DOH CFlPP 01-06
Identify root cause of increase in ward/department Macerator breakdowns and advise		• Based on numbers of user error Chief Nurse authorised change to Maceratable wipes August 2013.
Contribute to the development of a standard specification for Trust furniture		• In conjunction with other specialist, areas (Health & Safety Ergonomic Advisor and Tissue Viability) developed a specification for Chairs' and beds to assist procurement department.
Assist Skin hospital in the development of local Decontamination protocols for inclusion into operational policies		• Advised Skin Laser, PUVA (Psoralen Ultra violet light) and Skin theatres
To contribute to 'this winter must be better' campaign		• Infection Prevention and Control designed outbreak packs incorporating Chlor clean makeup, essential ward ordering codes and decontamination certificate.
Review the processes in place for decontamination of Bladder Scanners that are shared between areas.		• Areas were decontaminating using approved trust products Decontamination instructions have been placed on the Medical Engineers Intranet web page.
Assist BTC Endoscopy department project group in developing a business case to meet CFlPP01-06.		• Decontamination area should have separate dirty, clean and storage areas to create a one-way flow for equipment and separate entry and exit points

Audit Sandwell Theatres		• Issues identified relate to, fabric of the area, clear demarcation flow, storage and decontamination of equipment. Action plan sent to Clinical group and Theatre Matron
Review decontamination of Transvaginal Ultrasound probes to ensure that they are decontaminated in line with manufacturer's instructions and CFPP-01-06 guidance		• Decontamination is currently conducted using an intermediate disinfectant as opposed to high level disinfectant. There is no documented traceability of the process. • Options to achieve best practice of the CFPP-01-06 guidance under review.
Re-audit Birmingham Midland Eye and compile one dossier including an action plan		• Number of issues identified e.g. poor maintenance of areas, signage, organisation of storage, lack of linen cupboard, practices e.g. laying up trays in advance multi use of solutions. Comprehensive report with photographic evidence issued to the Clinical group for action. • Progress against report monitored at Infection Prevention and Control Advisory committee
Audits as part of Infection Prevention and Control Audit Program		
Audit wards and departments using the Infection Prevent Society audit tool 'In and Out Patient areas'		Following the Audit a verbal report is given to the person in charge or one of the available nursing staff. Reports can be viewed on the Clinical Data Archive (CDA) system. Recommendations for improvement remain unchanged from 2011/12 audits • The use of the "Cleaning & Decontamination certificate" at ward/department level prior to sending medical devices for repair, maintenance or storage. • Racks to be available to store bedpans/bedpan holders • Continuous assessment of fittings and furnishings (including bathrooms/ wash areas) required so that essential repairs can be undertaken and equipment requiring replacement can be identified in each area. • Portable electric fans and extractor vents should be included in regular planned cleaning & maintenance to prevent contamination of patient environments due to build up of excessive dust/debris. • Storage of equipment generally is a problem and this should be considered during any planned upgrades or future new builds. • Hotel service staff should not be storing inappropriate items in the domestic store cupboard. • Continue to upgrade the dirty utility areas to improve the environment and reduce risk of infection. Domestic Rooms • Hand Wash Basin to be identified. • Paper towels and soap should not be stored adjacent to where vacuum filters and scrub pads are cleaned and dried. The process needs to be reviewed. • The following Domestic Rooms need upgrading. - Sandwell OPD ground floor - City ground floor contact centre - City 2nd Floor link by D41

Oral Surgery – Audit against HTM - 01-05		Audited conducted 17th July 2013 the department is compliant against the audit tool. Some environmental actions required as follows • evidence of soiling from patients footwear. Require specialist cleaners to remove the soiling to this Safety Flooring. • work top needs attention • small hole in wall Replace small section of welding to Vinyl flooring in Clinical room.
Audit in house Laundry facilities		• Re audit of area against operational policy following release of the DOH Choice frame Work Local Policies and Procedures 01-04 Decontamination for Linen in health and socia care.
Audit Patient transport Vehicles		Recommend • Eye protection for all vehicles Cleaning Facilities • The designated area at City needs to be improved and systems put in place for changing mops etc. City Hospital Site Chlor-clean needs to be made up daily and records kept.
To audit the service provided for specialist beds and bariatric equipment		• Currently equipment is being decontaminated in temporary accommodation (TH 9&10) which does not have adequate washing facilities or maintenance area.
Review Community Dental Services at Rowley Regis		• Local decontamination needs to be removed from the area. This can be achieved by upgrading adjacent area space permitting alternatively procuring a decontamination service from BBruan Ltd or procurement of Sterile Single use instruments.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance & Investment Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 26 June 2014; 1200 – 1400h

Present	**In attendance**	**Secretariat**
Ms Clare Robinson	Mr Chris Archer	Mr Simon Grainger-Lloyd
Mr Richard Samuda	Mrs Jayne Dunn	
Mr Harjinder Kang (via telecon)		
Mr Tony Waite		
Miss Rachel Barlow		

Minutes	**Paper Reference**
1 Apologies for Absence	**Verbal**
Apologies were received from Mr Toby Lewis.	
2 Minutes from the previous meeting	**SWBFI (5/14) 031**
The minutes of the meeting held on 30 May 2014 were accepted as a true and accurate record of discussions held. It was reported that bank and agency staffing levels would be accrued as part of the budget, however Ms Robinson pointed out that submission of retrospective staffing costs may disturb the accruals process, particularly if made several months after the shifts had been worked. She asked whether there was a view of staffing on a weekly basis. Miss Barlow advised that this was currently possible with nurse staffing but was less robust for the medical bank staffing. Ms Robinson underlined the need for this close scrutiny and management. Mr Waite advised that there was a need to understand the drivers for ongoing usage of temporary staffing, such as the requirements emanating from the Francis report or 'specialling patients'. Mr Samuda asked what management information was provided to the Executive in this respect. Miss Barlow advised that the information was not collated into a single report. Mr Kang suggested that attention needed to be given to the timing of the recording of staffing use, in addition to the 'run rate'. Mr Waite advised that existing controls had been strengthened for temporary pay spend, with additional measures being taken to make the controls more effective, including the approval of medical agency and locum staff by the Medical Director. Agency nursing requests were reported to be	

being signed off by the Chief Nurse. Mr Waite added that there was a great effort being directed into cleansing the temporary staffing information. Ms Robinson asked how General Managers monitored the use of temporary staffing. Miss Barlow advised that a week by week plan and review of prior week was undertaken and reported back to the Chief Nurse and herself. It was reported that the 'specialling' policy was currently being reviewed which should assist with the position. Mr Samuda suggested that the use of volunteers could be considered as an alternative to the use of nurse staffing where appropriate, however it was noted that care needed to be taken to ensure that the use of volunteers was not taken as a substitute for substantive staff. It was suggested that the need for 'specialling' individual patients needed to be verified for appropriateness to ensure that only those patients needing this supervision were supplied with additional staffing. Mr Samuda suggested that there was an overriding need to understand what management information was used by the Executives to manage the position. Mr Kang suggested that the new Director of Organisational Development needed to lead the work from a workforce planning point of view. Ms Robinson suggested that there was a need prior to this, to address the position however to ensure that the current overspend was addressed. She suggested that the requests for temporary staffing needed to be correlated against the patients being admitted. Miss Barlow advised that there was work underway to challenge the requests for staffing to support 'specialling' and that the supernumerary staff needed to be counted within the staffing ratios. Mr Kang suggested that criteria needed to be set against which the requests needed to be assessed. Ms Robinson added that best practice also needed to be reviewed. Locum doctors in the Emergency Department and the nurse staffing for 'specialling' in the Medicine Group were noted to be the most significant issue and therefore it was agreed that this needed to be reported back through to the Committee. Ms Robinson advised that she had reviewed the shifts information against the costs where she had noted that the number of shifts in Medicine & Emergency Care had reduced although the overall costs had increased. It was noted that this matter needed to be discussed at the next meeting. Returning to the minutes, it was highlighted that the level of fines and underperformance against CQUIN were reported to have been adequately covered by the provision made.	
ACTION: **Miss Barlow to present an update on temporary staffing usage at the next meeting** **AGREEMENT: The minutes of the previous meeting were accepted as a true and accurate reflection of the discussions held**	
3 2014/15 Month 2 financial update	**SWBFI (6/14) 033** **SWBFI (6/14) 033 (a)** **SWBFI (6/14) 033 (b)**
Mr Waite outlined the key issues from a financial perspective. It was reported that the position presented was consistent with the TDA plan, but off track against the flexed plan, principally due to failure to deliver the transformation savings and some overspending, albeit that the latter was currently masked by	

the use of reserves. It was reported that the forecast for the year and trends on income recovery and loss would be picked up. Mr Kang asked whether the Leadership Cadre was being informed of this situation. He was assured that this was the case through the Clinical Leadership Executive. Pay was reported to be higher than budget, although there was an expectation that the position would be remedied by the next month. Mr Archer added that the position was £323k behind plan at present. Mr Kang observed that the savings plan appeared to get more challenging as the year progressed. Ms Robinson suggested that the year end view needed to be considered in the light of the current financial performance, as a result of pay, failure to deliver savings and the fining regime. It was noted that the dementia CQUIN target had not been met for the quarter which had incurred a £65k loss of income. It was highlighted that there had been more Lucentis procedures that the contract provided for, however there was no possibility of recovering the additional income for this given that the contract clause was capped. Mrs Dunn advised that there was a TSP opportunity that had been identified which switched to a cheaper drug, which would assist this position. Ms Robinson suggested that the year end consequences should the current financial performance continue unadjusted be appended to the future versions of the finance report. The potential additional national funding recently publicised were discussed. The maternity funding position was discussed, where it was highlighted that the income was received for the antenatal pathway started at the 12 week position, however should the mother attend elsewhere as part of the pathway, then the provider could bill the Trust for part of the income which could exceed the overall income received by the Trust dependent on the number of times and nature of attendances.	
ACTION: **Mr Waite to present the year end financial scenarios at the next meeting**	
4 Transformation Savings Plan	
4.1 Update on TSP 2014/15 plan and delivery	**Hard copy**
The Committee received a presentation from Mr Waite concerning the progress with delivery of the Transformation Savings Plan. It was reported that not all of the schemes commenced on 1 April, with many starting part way through the year meaning that the part year effect was c. £13m. On a full year effect basis, the value of the schemes was reported to be £17.47. It was reported that the remaining £7.3m target remained needing to be identified. The profile of the savings plan was reviewed and it was reported that a forward view of the delivery of the plan was being developed. Mrs Dunn reported that for schemes that were delayed or could not be delivered, a substitute scheme needed to be proposed by the Groups. Miss Barlow reported that local PMOs were being established in the Clinical and Corporate Groups. Ms Robinson suggested that the psychology of change could be communicated to those with responsibility for delivering some	

of the TSP schemes. Miss Barlow advised that care was taken to include those with responsibility for enabling functions in discussions. The detail of some of the schemes was discussed and it was highlighted that the need to update Transformation Plan Reporting System (TPRS) with the progress was critical to accurate assessment of the delivery. It was noted that the red schemes reflected the level of confidence in the delivery against the milestones. The plan to replace experienced administrators with apprentices in the Medicine Group was discussed. Ms Robinson encouraged the impact on productivity to be considered as part of this. Miss Barlow advised that a productivity standard was built into the administration review. Ms Robinson asked for an update on the delivery of the July TSP schemes at the next meeting. It was reported that 368 projects were logged on the TPRS, of which 290 had a completed Quality Impact Assessments; 109 were signed off. It was reported that quarterly reviews of QIAs were scheduled throughout the year. There were noted to be 286 projects which had been equality impact assessed, of which 102 had been signed off. Mrs Dunn advised that there was a consideration of equality training as part of the work. It was noted that the schemes were being prioritised according to the significance of the scheme. In terms of the gap against the target, Mr Waite reported that work was underway for the Executive to identify the means of addressing the gap. It was highlighted that the plan would be discussed at the private session of the forthcoming Trust Board. Ms Robinson underlined the need to take advantage of the expertise that was needed to deliver the work. Mr Samuda asked that resources were in place to progress chase the delivery of the projects. Mrs Dunn advised that best practice was being assessed elsewhere across the NHS and in private sector to establish how the PMO model could be devolved. It was suggested that some of the remaining target may come from benchmarking information which needed to be translated into activity and capacity performance. Mr Samuda suggested that the peer process to share good practice needed to be understood. Mrs Dunn advised that this was achieved through the directorates to the central PMO and outwards subsequently. Mr Kang left the call. It was noted that the implementation of a learning model would assist with sharing good practice. It was agreed that should the plan not get traction, there needed to be additional pre-emptive measures lined up to implement, including use of external resources if needed. It was agreed that the Year of Outpatients summary needed to be presented to the Board at a future meeting.	
ACTION: **Mr Grainger-Lloyd to schedule an update on Year of Outpatients onto the agenda of a forthcoming Board meeting**	
5 Matters to highlight to the Board	**Verbal**
It was agreed that the Board should be made aware that the financial position was not as expected, however there was much work and a significant number of	

measures underway to address the position. It should be reported that much positive work on progress to close the TSP gap however the gap still remained and thought was being given to the additional measures needed to address this. It was agreed that by the end of Quarter 3, there needed to be a view as to the position in 2015/16.	
6 Meeting effectiveness feedback	**Verbal**
It was agreed that there had been some productive discussions and there was sufficient space given to reviewing the TSP progress.	
7 Any Other Business	**Verbal**
There was none.	
8 Details of the next meeting	
The next meeting of the Finance and Investment Committee was noted to be scheduled for 25 July 2014 at 0800h at City Hospital.	

Signed: …….

Name: …….

Date: ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue Anne Gibson Committee Room, City Hospital **Date** 30 May 2014; 1030h – 1230h

Present

Ms O Dutton
Mrs G Hunjan
Mr R Samuda
Dr S Sahota OBE
Dr R Stedman
Mr T Waite
Miss K Dhami
Miss R Barlow

In Attendance

Mrs L Pascall
Mrs D Talbot
Mr M Harding
Ms A Binns

Secretariat

Mr S Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies for absence were received from Mr Ovington and Dr Paramjit Gill.	
2 Minutes of the previous meeting	**SWBQS (4/14) 036**
The minutes of the Quality and Safety Committee meeting held on 25 April 2014 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBQS (4/14) 036 (a)**
The updated actions list was received and noted by the Committee.	
3.1 CAS alerts update	**SWBQS (5/14) 038** **SWBQS (5/14) 038 (a)**
Ms Binns provided an overview of the CAS alerts and reported that a number of the NPSA alerts had been removed, given that a plan had been put into place to address them. The detail of the alerts was presented. The spinal and epidural needles alert was noted to have been of previous concern, although an action plan was reported to have been developed. It was noted that the integrated report	

suggested that CAS alerts were overdue when they were not. It was agreed that the presentation of this information in the dashboard should be addressed. Mrs Hunjan asked what timescales were applied to the closure of the actions. She was advised that it was different according to the alert. The action plans were reported to be being considered by the Patient Safety Committee and signed off internally.	
LONG TERM FOCUS	
4 Future workplan of the Quality & Safety Committee	**Verbal**
It was suggested that the future business of the Quality & Safety Committee needed to be considered to better focus the agendas of the meetings. Mr Samuda suggested that the performance of the Trust's key services needed to be considered, in terms of Beacon services for instance. Mrs Hunjan supported this suggestion and added that the vision and obstacles for the areas needed to be presented. Dr Stedman suggested that a comparison of performance to other organisations needed to be considered as part of this but there also needed to be a focus on services where improvement was needed. Ms Dutton suggested that a level below which standards should not fall should be set, including compassionate care and duties for delivering care to patients on a consistent basis. It was agreed that there needed to be a reactive duty of the Committee to look at areas of shortfall, however the long term focus needed to take into account the trajectory towards the long term objectives. Dr Sahota suggested that assurance was needed that quality was maintained when the Trust's services were delivered in the community. Mrs Talbot suggested that the patient pathway work needed to be considered and measures needed to ensure that the Trust was delivering a minimum standard. Dr Stedman suggested that the short term focus of the Committee needed to be directed to areas that were off track or performance shortfalls, as opposed to integration and aspirational ambitions of the Trust. It was suggested that the metrics that would allow the Trust to evaluate its progress with integration needed to be considered. Miss Barlow suggested that the relationship with the Trust's stakeholders needed to be considered in relation to the Trust's ambitions. Mrs Talbot advised that the monitoring needed to focus on over and above the 'no harm' status. Mrs Pascall suggested that the ambitions needed to be realistic and needed to incorporate learning from other organisations. It was suggested that a series of ambitions needed to be set for the Committee against which a series of indicators or measures needed to be developed and monitored. Mr Waite suggested that there needed to be a structure to the workplan in terms of 2020 ambition; the transforming transformation strategies and the operational plan. It was noted that the matters needed to focus on quality and safety. It was agreed that a robust communication plan was needed to ensure that staff feel part of the Trust's work and understand the common language in readiness for the CQC. It was noted that the Quality Plan reflected the one year workplan.	

It was agreed that a final workplan was needed for consideration at the next meeting, which should focus on placing the patient at the centre of everything. Miss Dhami suggested that next time the Committee needed to see the relevant strategies within the transforming transformation initiative. Miss Barlow suggested that the themes from patient stories needed to connect with the patient experience plan. Miss Dhami reported that the feedback on the recent patient stories would be presented to the Board shortly. It was noted that the lessons learned from these needed to be delivered. Dr Sahota noted that there needed to be assurance that the lessons learned were implemented at the lowest levels where it makes a difference. Mrs Hunjan asked whether the patient stories were disseminated. She was advised that Mr Lewis provided the detail in some cases within his Friday message. Dr Stedman reported that although the challenge was fair, there was a need to recognise that the work to drive standards and address the issues was ongoing. In terms of culture change, it was suggested that this related to pride in work however the improvements were difficult to articulate. Mrs Pascall reported that the recent value-based recruitment was intended to employ staff capable of delivering kindness and compassion. It was agreed that a draft of the workplan needed to be prepared for consideration at the next meeting.	
ACTION: **Mr Ovington to lead on developing a final workplan for the Quality & Safety Committee**	
MEDIUM TERM FOCUS	
5 Quality Account 2013/14	**SWBQS (5/14) 040** **SWBQS (5/14) 040 (a)** **SWBQS (5/14) 040 (b)**
Dr Stedman presented the latest version of the Quality Account, which he highlighted included the ambitions for 2014/15 and also set out performance against the 2013/13 priorities. It was highlighted in the coming year, the 'Year of Outpatients' initiative was included, as was Public Health and the 'Ten out of Ten' campaign. Ms Dutton underlined the need for the document to be searchable. Dr Stedman reported that the format of the document was non-negotiable however the document would be uploaded in a searchable format on the internet. Mr Samuda asked whether the auditors highlighted best practice. He was advised that this was the case. Mrs Hunjan observed that the current presentation was pleasing and useful. Mr Samuda questioned whether a 1% reduction in readmissions was sufficiently ambitions. He was advised however, that this represented a challenging target. Mr Samuda asked whether there was merit in considering a more ambitious target in issuing letters to GPs within 5 days. It was agreed that every effort would be directed to issuing letters more expeditiously, however the target should remain as	

stated for the current year. The Committee agreed that the Quality Account could be presented to the Trust Board and recommended for approval.	
ACTION: Mr Grainger-Lloyd to arrange for the Trust Board to consider the Quality Account 2014/15	
6 Ten out of ten	**Hard copy paper**
Mrs Talbot provided an overview of the 'Ten out of Ten' initiative. It was reported that a set of ten indicators would be measured for each patient which would be monitored through a visible scorecard. Indicators were reported to include: positive patient identification; assessment for risk of pressure ulcers; risk of VTE. It was reported that a project team would be created to implement the 'Ten out of Ten' process. Dr Sahota asked what work was planned around diabetes as part of the work. Mrs Talbot advised that blood sugar level was not a routine indictor that was monitored and therefore would not be included. It was noted that the standards would apply to adult inpatients and that the actual timing of the checks remained to be agreed at present.	
7 Cardiology recovery plan	**Hard copy paper**
Miss Barlow reported that a Board-level discussion was planned on Cardiology at the meeting scheduled for 3 July. She advised that the speciality had been placed in a 'turnaround' status six months ago. It was reported that rapid access chest pain performance was not being delivered and waiting times remained excessive. It was noted that the Cathode lab at City Hospital was currently not functional and in terms of readmissions, the rates were high, with mortality rates being average. It was highlighted that a number of single sex accommodation improvements had been reported. A number of new staff were reported to have been recruited into the team, however sickness levels were currently high. The Committee noted that Executive-level oversight was being directed to recovery with an external review proposed. Dr Stedman reported that a validation process had been requested of the longest waiting times to determine whether any harm had been caused as a result. Miss Dhami advised that the CQC would seek assurance that the Board was aware of the position and that an action plan was in place. It was noted that the change required was not being delivered as expeditiously as desired.	
8 Complaints handling update	**Hard copy paper**

Ms Binns provided an overview of the complaints received in terms of numbers and grade of seriousness. It was noted that the most significant numbers of complaints were received in the Accident and Emergency departments. The reasons for complaints were reviewed, with the top being dissatisfaction with medical care provided, which it was highlighted concerned expectations of patients in the majority. It was noted that the correlation to the patient survey had not yet been undertaken. It was suggested that an inpatient contact as opposed to an outpatient view could be useful. The Committee was advised that around 50% of the complaints were upheld which concerned failure to communicate. It was suggested that the detail of the partially held complaints should be analysed at a lower level of granularity to analyse the trends. It was reported that a second complaint was made in some cases. Mr Samuda asked whether some of the complaints were revisited to advise what action had been taken some time after the complaint had been responded to. He was advised that it was the intention to contact complainants six months after the complaint had been received. The Committee noted that a further update on performance against the complaints handling KPIs was due to be considered at its meeting in August.	
SHORT TERM FOCUS	
9 Integrated quality, performance and finance dashboard	**SWBQS (5/14) 039** **SWBQS (5/14) 039 (a)**
Mr Harding presented the integrated quality, performance and finance dashboard, which he highlighted now included a kite mark around data quality against the indicators. The number of bed movements was reported to be included as a placeholder in the dashboard, which Miss Barlow advised could be populated using the Urgent Care Scorecard. It was noted that performance against the cancer services targets was pleasing when compared to the national position. In terms of CQUIN targets, it was noted that the Dementia target had not been met. It was noted that there had been deterioration against the stroke care targets. The Committee was advised that there had been a further breach against the 28 day cancelled operations guarantee. Emergency Care performance was reported to have been met in April, although this was not likely in May. Performance against the fractured neck of femur target was reported to not be improving. The performance against the overall 18 weeks target was reported to be satisfactory, however the targets were not being met at a speciality level. The Committee was asked to note the Group performance scorecards.	
9.1 Breach to the 28 day cancelled operations guarantee	**Verbal**
Miss Barlow reported that there had been two 28 day cancelled operations breaches recently, with themes associated with the events being similar. It was noted that the breaches were reflective of administrative errors due to an inaccurate reporting mechanism.	

9.2 Underperformance against the sepsis care bundle target	**Verbal**
Dr Stedman advised that the target had been met.	
10 June Board meeting patient story	**SWBQS (5/14) 043**
Mrs Pascall provided the detail of the patient story due to be considered at the Trust Board meeting in June, which related to a patient stay on the Henderson Reablement Unit.	
11 2014/15 TSP Quality Impact Assessment update	**Verbal**
Dr Stedman advised that a series of confirm and challenge event had been held with some of the Groups, which suggested a number of adjustments to the schemes. Mr Waite reported that 340 schemes were in place with 75% of them having quality impact assessments. It was agreed that the ongoing process for tracking the quality impact assessment of the schemes needed to be presented at the next meeting. It was noted that further work was underway to address any equality impact assessments that had not been completed.	
ACTION: Miss Barlow to present the process for tracking the quality impact assessment of TSP schemes at the next meeting	
FOR INFORMATION	
12 CQuINs 2014/15	**SWBQS (5/14) 041** **SWBQS (5/14) 041 (a)**
The Committee was asked to receive and note the update.	
13 Serious incident report	**SWBQS (5/14) 042** **SWBQS (5/14) 042 (a)**
The Committee was asked to receive and note the update.	
OTHER MATTERS	
14 Matters of topical or national media interest	**Verbal**
Miss Binns advised that an inquest had been held during the week, which may generate some adverse publicity.	
15 Matters to raise to the Board	**Verbal**
It was noted that there were several matters to raise to the Board. It was agreed that the mixed sex breaches needed to be highlighted to the Board, specifically in relation to stroke services.	
16 Any other business	**Verbal**
There was none.	

17 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 27 June 014 at 1030h at City Hospital. *[NOTE – this meeting was subsequently cancelled]*	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit and Risk Management Committee – Version 0.3

Venue Anne Gibson Boardroom, City Hospital **Date** 24 April 2014

Members Present		**In Attendance**
Mrs G Hunjan	[Chair]	Mr R Chidlow
Ms C Robinson		Mrs R Chaudary
Dr S Sahota		Mrs S Mallinson
Mr H Kang		Mr G Ball
		Miss K Dhami
		Mr T Waite
		Mr C Ovington
Secretariat		Mr T Wharram
Mr S Grainger-Lloyd		

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies were received from Ms Olwen Dutton, Mr Palethorpe, Mr Bostock and Mr Paul Capener.	
2 Minutes of the previous meeting	**SWBAR (1/14) 011**
The minutes of the meeting held on 30 January 2014 were considered and approved as a true and accurate reflection of discussions held subject to some minor amendments.	
3 Matters arising	**SWBAR (1/14) 011 (a)**
The Audit and Risk Management Committee received and noted the updated actions log. It was noted that there were no matters outstanding or requiring escalating to the Committee.	

Minutes	Paper Reference
4 Data Quality update	**SWBAR (4/14) 013** **SWBAR (4/14) 013 (a)**
Mr Waite reported that substantial work had been completed in respect of data quality processes and that the approach to data quality was now robust and coherent. Mrs Hunjan reported that an Executive-led task and finish group had been established on which two Non Executive Directors were represented, which included within its remit the work to apply a kite marking approach. Ms Robinson reported that the work would include roll out of a communications plan and raising awareness of the data quality processes. It was suggested that a report into the outstanding work and expected completion of these actions was needed at the next meeting of the Committee. It was highlighted that the development of the integrated performance dashboard had been delayed to some degree as part of this work. Mr Waite added that in terms of the work to be completed, the plan to work through the indicators in turn would span the next financial year. It was suggested that from Quarter 1 some routine reports should be prepared and shared as part of business as usual. It was suggested that in terms of the gaps identified as part of the work of the task and finish group, these had been addressed. Ms Robinson suggested that deadlines and timescales needed to be more clearly articulated in a future report. It was agreed that significant progress had been made on the development of the data quality improvement programme.	
ACTION: Mr Waite to present a further update on the development of Data Quality processes at the October meeting, including the actions remaining to complete the work	
5 Update on risk management development	**SWBAR (4/14) 014** **SWBAR (4/14) 014 (a)**
Miss Dhami assured the Committee that the risk management development work had progressed well since the last meeting. It was highlighted that the Board had considered the Trust Risk Register at its last meeting, on which there had been significant productive debate. The next steps were reported to focus on embedding risk management within the culture of the Trust. It was noted that the scheduling of the Risk Management Committee would be altered to better synchronise with the information feeds into the Clinical Leadership Executive and Trust Board. It was noted that the development of the Board Assurance Framework was also underway. Mr Kang asked what proportion of risks, particularly those associated with investment decisions, were adequately mitigated. Miss Dhami advised that although most were adequately mitigated, the articulation of these needed to be clearer. The Committee was advised	

Minutes	Paper Reference
however that the risk management culture varied according to the area of the Trust, most notably in terms of documentation. Miss Dhami reported that pre-mitigated amber risks were also considered in detail, in addition to pre-mitigated red risks. It was reported that there was also a focus on interdependencies between risks in the different areas. Ms Robinson suggested that it would be helpful to understand the final aim of the work and the key milestones towards this end point. She suggested that it would be useful to invite a group into the Committee to gain an understanding of the approach to risk management in a key part of the business. Miss Dhami agreed to provide a milestone statement and a summary of the position by a directorate by directorate basis. Mr Kang supported the suggestion that a view of risk management within the Trust was needed. Mrs Hunjan suggested that better consideration needed to be given to the most appropriate forum the discussion of the risk management approach in directorates. Mr Chidlow advised that it was usual for external audit to join the risk management committee to understand how the approach worked in the Trust. Mrs Mallinson advised that there was an element of the internal audit plan to focussed specifically on risk management. Mr Kang suggested exception reporting on risk management would be useful for the Committee to receive.	
ACTION: **Miss Dhami to provide an update on the progress with the development of risk management in the Trust, particularly at a directorate level, at the October meeting of the Committee**	
6 External Audit matters	
6.1 External Audit progress report	**SWBAR (4/14) 015**
Mr Chidlow reported that the interim external audit work had been completed, which had revealed a limited number of issues. In terms of control, it was highlighted that the bank reconciliation process had needed addressing, although he advised that this matter had been handled and would not impact on the year end accounting position. Ms Robinson highlighted the seriousness of this issue, should it not be resolved. Mr Waite advised that all bank reconciliations had been completed. The background to the issue was discussed which it was reported needed to be further addressed by the finance function including a view of the responsibilities and duties within the team. The Committee reported that the work on the Quality Account was pleasing. The Committee was asked to note a number of technical updates and in particular the impact of the proposed VAT changes, which may be	

Minutes	Paper Reference
significant if adopted by HMRC.	
6.2 External Audit fees letter	**SWBAR (4/14) 016**
Mr Chidlow presented the annual fees letter. He reported that 2014/15 was the last year that the Audit Commission would exist, the body setting the fee for the audit work. It was highlighted that there was no significant change from the prior year. Mr Waite highlighted that the Trust's income was decreasing year on year and therefore a conversation was required to establish how the fee could be adjusted to reflect further efficiency.	
6.3 Review of draft accounts 2013/14	**Hard copy**
Mr Waite reported that the deadline for the submission of the accounts had been Tuesday 22 April and highlighted that the Trust had met all its financial duties. The key matters of judgement were considered. In terms of charitable funds, it was reported that these would not be considered on the grounds of materialism. It was agreed that this was appropriate. Regarding provisions, an approach consistent with previous years was reported to have been taken, although the 'Right Care, Right Here' transitional financial funding was reported to have been released in year. Mr Chidlow flagged that the balances needed to be minimised in this respect where possible. In terms of the Grove Lane acquisition, it was reported that the valuer had been asked to value it as a whole site, which had given rise to a significant impairment. It was agreed that this was appropriate. The Committee was asked for any comments on the draft accounts. Mrs Hunjan noted that despite the transformation savings plan, the year end WTE position was higher than that of the previous year. It was also highlighted that there had been a heavy reliance on temporary staff during the year. Mr Waite noted that there was an expectation that the WTE position would reduce in the coming year. Mrs Hunjan asked for clarity on a number of specific points. In terms of the rise in the benefit associated with the Board, it was noted that the detail would be made transparent within the remuneration report of the annual report, however this was associated with some major changes to Board personnel during the year and some members receiving 'acting up' responsibility payments. The team were thanked for the efforts made to submit the accounts to time.	
6.4 Annual Governance Statement	**SWBAR (4/14) 018** **SWBAR (4/14) 018 (a)**

Minutes	Paper Reference
Miss Dhami presented the draft annual governance statement. It was reported that further changes were needed to the AGS at the request of the Chief Executive. Miss Dhami highlighted that the level of assurance received by the Information Commissioner's audit, had been 'limited' and therefore this had been cited in the matters of control weakness. The other areas of control weakness highlighted were reported to concern Never Events, compliance with the 18 week RTT target and non-pay spend. Mr Chidlow asked whether the Board Assurance Framework would be presented on a routine basis to the Audit & Risk Management Committee. He was advised that the process would be strengthened and that this was a work in progress to finalise the process. A number of amendments to the Annual Governance Statement were suggested and it suggested that consideration be given to whether there was a need to reflect the control in respect of the bank reconciliation.	
ACTION: Miss Dhami to organise for the amendments to the AGS to be made	
7 Draft Quality Account 2013/14	**Hard copy**
The Board considered the draft Quality Accounts, which Mr Ovington highlighted included more work around benchmarking and was consistent with the matters considered by the Board. It was reported that the Quality Account would be issued for public comment shortly. All were asked to provide any additional comments to Dr Stedman as soon as possible.	
8 Internal Audit matters	
8.1 Draft Internal Audit annual report, including Head of Internal Audit Opinion and assessment of the Board Assurance Framework 2013/14	**SWBAR (4/14) 021** **SWBAR (4/14) 021 (a)**
Mrs Chaudary presented the Internal Audit annual report, which provided 'significant' assurance overall, although there were three areas where moderate assurance had been provided: data quality arrangements; theatre utilisation; and use of e-rostering system to administer payments.	
8.2 Internal Audit reviews	**SWBAR (4/14) 022 (b) - SWBAR (4/14) 022 (f)**
Mrs Chaudary guided the Committee through a number of internal audit reports. It was reported that moderate assurance had been provided on	

Minutes	Paper Reference
the e-rostering and non-capitalised IT/mobile equipment reports. Specific questions were raised in connection with the other internal audit reviews. Mr Waite updated the Committee on the progress with reconciling the budget setting process with ward establishments. Ms Robinson asked whether payments for services for staff could be deducted from staff salaries. She was advised that there were some instances when this was the case however the garage service specifically were accessed ad hoc in some cases.	
8.3 Internal audit strategy 2014/15 – 2016/17	**SWBAR (4/14) 023** **SWBAR (4/14) 023 (a)**
Mrs Mallison presented the internal audit strategy for 2014/15 and 2016/17 for comment. It was reported that the plan comprised 375 days and the Committee was asked to note the key elements of the plan. It was noted that the plan remained subject to the Chief Executive's comments. Mrs Hunjan suggested that Medicines Management should feature in the audit plan. Ms Robinson suggested that the lessons learned from complaints needed to be included in the plan and Mr Kang suggested that workforce cost control should also be included. The inclusion of non-pay expense control was also suggested. It was agreed that the plan should be reviewed on an ongoing basis.	
8.4 Clinical Audit plan 2014/15	**SWBAR (4/14) 024** **SWBAR (4/14) 024 (a)**
Miss Dhami advised that the Clinical Audit forward plan for 2014/15 had been discussed by the Clinical Leadership Executive and comprised national 'must dos', internal priorities and some directorate priorities. The Committee reviewed the audit position by directorate. It was reported that the Committee would be presented with the plan on a routine basis and matters would be reported by exception. Ms Robinson asked whether there were any overlaps between the clinical audit work and the internal audit plan. It was suggested that the value for money from the investment in clinical audit needed to be clarified. Ms Robinson suggested that there may be a need to phase the completion of the audits. Miss Dhami agreed to consider this. It was agreed that the Audit & Risk Management Committee should consider any cases where the clinical audits showed the Trust to be an outlier and that the outturn report should be presented.	

Minutes	Paper Reference
8.5 Draft Counter Fraud work plan 2014/15	**SWBAR (4/14) 025** **SWBAR (4/14) 025 (a)**
Mr Ball presented the proposed annual counter fraud plan for 2014/15. It was reported that the plan consisted of 75 days plus 15 days contingency. The Committee was advised that the plan was risk-based and the key elements of the plan were discussed. It was suggested that all KPIs needed to be set at 100%, with the acknowledgement that there would be departures in some exceptions. The Committee concurred that the plan was a proportionate and adequate response to the risk around fraud impacting the Trust.	
8.6 Counter Fraud progress report	**SWBAR (4/14) 026** **SWBAR (4/14) 026 (a)**
The Committee received and noted the progress report. The highlights of the report were considered. Mr Kang asked how the role of the Local Counter Fraud Specialist was perceived in the Trust. He was advised that the role was predominately seen as being assistance & advisory rather than a policing function.	
9 Governance matters	
9.1 Losses and special payments	**SWBAC (4/14) 027** **SWBAC (4/14) 027 (a)** **SWBAC (4/14) 027 (b)**
The Committee received and noted the losses and compensation payments update. 'Personal injury with advice' was reported to form the largest proportion of payments made. Ms Robinson noted that there appeared to be an opportunity to return some of the stock to pharmaceutical companies. Dr Sahota advised that it had been previous practice to hold unnecessary stock on wards.	
9.2 Breaches of SOs/SFIs	**SWBAC (4/14) 029** **SWBAC (4/14) 029 (a)**
The Committee received and noted the breaches of SOs/SFIs. It was noted that the number of instances had reduced, although the value of these was significant. Ms Robinson suggested that these breaches needed to be linked into the disciplinary policy. Mr Waite agreed to review the process in this respect and to report back to the Committee at the next meeting.	
ACTION: Mr Waite to present an update on the breaches of SOs/SFIs approach and its link to the disciplinary process at the next	

Minutes	Paper Reference
meeting	
9.3 Audit and Risk Management Committee observations by Deloitte	**SWBAC (4/14) 028**
Mrs Hunjan asked the Committee to receive and note the outcome of the observation by Deloitte at the October meeting. Mrs Hunjan noted that the meeting observed was unusual.	
9.4 Audit and Risk Management Committee priorities 2014/15	**Verbal**
Miss Dhami advised that the cycle of business for the Committee would be discussed further, following the recent meeting of the Board when an initial view had been devised.	
10 Updates from the Chairs of the Trust Board Committees	**Verbal**
Ms Robinson reported that an interim meeting would be held to review the progress with the remedial plan to comprise the 2014/15 TSP. Dr Sahota outlined the process for bidding for Charitable Funds would change. Mr Kang reported that the Workforce & OD Committee had focussed on the long term workforce plan, in addition to recruitment time issues.	
11 Any Other Business	**Verbal**
Mrs Hunjan thanked CW Audit for their support during recent years. It was suggested that the title of the Committee should be changed to Audit and Risk Committee.	
12 Date and time of next meeting	**Verbal**
It was noted that the date and time of the next meeting would be 5 June 2014 at 1230h in the Anne Gibson Boardroom, City Hospital	

Signed:……..

Name:……

Date:……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit and Risk Management Committee – Version 0.1

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 5 June 2014

Members Present		**In Attendance**
Mrs G Hunjan	[Chair]	Mr R Chidlow
Ms C Robinson		Mr A Bostock
Dr S Sahota		Mr I Kennedy
Mr H Kang		Miss K Dhami
		Mr T Waite
Secretariat		Mr C Ovington
Mr S Grainger-Lloyd		Mr T Wharram
		Mr M Hoare
		Mr R Samuda

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Mr Gavin Ball.	
2 Annual Accounts – Year ended 31 March 2014	**SWBTB (6/14) 076** **SWBTB (6/14) 076 (a)** **SWBTB (6/14) 076 (b)**
Mr Waite presented the draft set of annual accounts for 2013/14. He advised that the accounts had prepared according to the required timescales and he thanked the team for their efforts in preparation. The Trust was reported to have met all of the key duties for the year and a clean opinion was expected.	
3 2013/14 audit memorandum	**SWBTB (6/14) 077**
Mr Bostock thanked the team for their co-operation with the accounts process. A clean opinion on the accounts and the use of resources was reported to be expected to be issued. A key consideration was reported to	

Minutes	Paper Reference
concern financial resilience, which was noted to be pleasing in the current NHS climate. The issues raised in the ISA260 were noted to concern the treatment of provisions which the auditors believed related the deferred income associated with 'Right Care, Right Here' programme. The key recommendations were outlined which concerned the resilience and capacity of the finance team, where it was recognised that a restructuring process was being undertaken, meaning that there was more of a significant burden on one individual compared with that in other organisations. A further recommendation concerned the treatment of the annual accounts and report, which it was noted meant that an earlier deadline might be needed to ensure that all documents could be signed off at the same time. With the significant changes to the NHS sector it was noted that in respect to the accounting standards, the reconciliations had been corrected retrospectively with the finance team taking this on. A low level recommendation on reporting CIP was noted. Ms Robinson referred segmental analysis and asked for clarification of the position in relation to this. Mr Wharram agreed that this could be corrected in readiness for Board consideration. Ms Robinson asked whether the issues in the ISA260 needed to be reflected in the Annual Governance Statement, including the issue in relation to bank account reconciliation and the structure of the finance team. It was agreed that a check on the progress with the actions should be scheduled into the forward cycle of business. Ms Robinson suggested that an explanatory note needed to be included to accompany the remuneration report. Mr Waite advised that this was a statement of fact, however it was agreed that a note needed to be included. Mr Childlow suggested that it might be sensible to refer to the Remuneration report in the Annual Report, which it was agreed should contain this explanatory note. It was agreed that the accounts subject to the amendments suggested could be approved by the Board at its next meeting.	
ACTION: Mr Grainger-Lloyd to schedule a check on actions from the ISA 260 into a future agenda	
4 Letter of representation	**SWBTB (6/14) 078**
Mr Waite presented the letter of representation and asked the Committee to assess whether the representations were fair and it could be recommended to the Board. It was agreed that this was the case.	
5 2013/14 Annual Governance Statement	**SWBTB (6/14) 079** **SWBTB (6/14) 079 (a)**
Mr Waite presented the Annual Governance Statement and asked whether	

Minutes	Paper Reference
the disclosures were satisfactory for recommendation to the Trust Board. Mr Ovington advised that there was some inconsistency in terms of the number of times that the Committees had met and therefore noted that a note was needed to explain that this was as a result of the changes to the meeting cycle. The Committee agreed to recommend the Annual Governance Statement to the Board.	
6 Annual Report 2013/14	**Hard copy**
The Committee received the Annual Report 2013/14 as a working draft for comment. Mr Chidlow reported that the requirements needing the scrutiny of external auditors were sufficient. All were asked to channel any further comments through Mr Grainger-Lloyd. It was noted that the Annual Report would be presented again at the July meeting of the Committee. Mrs Hunjan thanked the finance team for their work to sign off the annual accounts and the external audit team.	
ACTION: Mr Grainger-Lloyd to arrange for the Annual Report 2013/14 to be presented at the July meeting of the Audit & Risk Management Committee	
7 Quality Account 2013/14	**SWBTB (6/14) 035** **SWBTB (6/14) 035 (a) - SWBTB (6/14) 035 (c)**
Mr Ovington presented the summary of the Quality Account. He guided the Committee through the approvals and scrutiny process. Mr Bostock advised that the auditors' review was positive and that it met the requirements set out by external audit. It was noted that the format and content of the document were preprescribed. It was noted that the presentation of the document to external stakeholder had not been met and therefore further work to gain a view of the report was planned prior to sign off. The Committee's attention was drawn to consistency with the Annual Governance Statement and Statement of Director's responsibilities which needed to be borne in mind in future years. Ms Robinson suggested that the deadline for the consideration of the complaints report needed to be revised. Ms Dutton noted that the system	

Minutes	Paper Reference
had been changed in November 2013 and therefore the timing of the consideration of the report would be timed appropriately. The Committee agreed to recommend the Quality Account to the Board.	
8 Counterfraud annual report	**SWBTB (6/14) 036**
Mr Kennedy presented the Counter Fraud annual report to the Board. Some minor amendments were noted. A breakdown of the workplan was presented, including the interim work undertaken by Baker-Tilly. Ms Robinson noted that an issue concerned patients claiming taxi expenses and suggested that the policy in this respect needed to be reconsidered to ensure that the work of Counter Fraud could be directed more appropriately. Mr Waite reported that the work to look at overseas visitors was a key focus. He noted however that counterfraud would review policies as part of the usual review and renew processes. It was noted that there was a significant risk of loss of funds as a result of some of the staff members leaving the Trust and therefore there needed to be a point of principle to follow this up after the individual had left. Mr Waite reported that there needed to be a plan to recover all losses however there needed to be a view as to the cost effectiveness of pursuing some cases. Mrs Hunjan suggested that the newsletter be used to communicate this purpose which she asked be issued to Non Executive Directors. It was agreed that this should be circulated when available.	
ACTION: Mr Grainger-Lloyd to circulate the counterfraud newsletter when available	
9 Any Other Business	**Verbal**
There was none.	
10 Date and time of next meeting	**Verbal**
It was noted that the date and time of the next meeting would be 31 July 2014 at 1400h in the Anne Gibson Boardroom, City Hospital	

Signed:……..

Name:……

Date:……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Midland Metropolitan Hospital Status Report July 2014

Activities Last Period

- OBC approved
- OJEU issued 14th July
- Bidders Launch event 21st July
- ITPD issued as draft 22nd July

Planned Next Period

- PQQs received 15th August
- Evaluate PQQs
- Agree a communications plan with the executive
- Finalise plans for dialogue
- Commence training new clinical procurement team
- Progress MES business case and procurements
- Progress the City site “separation for disposal” plan

Issues for Resolution/Risks for Next Period

- Ensure project resourcing is in place to October 2018

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FT Programme Monitoring Status Report

Activities This Month

- CIH visit confirmed – week commencing 13th October 2014. CIH visit preparation plan presented to Trust Board & CLE.
- Evidence vault developed for key information required for CIH and broader FT requirements. Review of lessons learned from those Trusts who have undergone CIH visit.
- Self-assessment checklist developed based on KLOEs – to be completed at ward/department level.

Planned Next Month

- Good practice from ward/department self-assessments shared widely
- Rolling programme of staff briefings ahead of CIH
- Announced mock inspection visits to 8 core services
- Feedback from TDA on IBP & LTFM (submitted June 2014) expected end of August 2014
- BGAF & QGAF action plans will be presented at August Trust Board (BGAF) and September Trust Board (QGAF)
- Discussion with accountancy firms regarding Independent Financial Review (IFR) process requirements & options for procurement of reviewer

Issues for Resolution/Risks for Next Month

- Confirmation of plan FT timeline with TDA – aligned to MMH timeline (in response to Monitor queries)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Chief Inspector's visit
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	7 August 2014

EXECUTIVE SUMMARY:

The CQC has this month announced the next batch of acute, community healthcare and mental health providers to be inspected between October and December 2014 as part of their new approach. The inspections, which are carried out by a mixture of inspectors, clinicians, and experts by experience, will assess whether the service overall is: safe, effective, caring, responsive to people's needs and well-led.

Following the inspection, each provider will receive an overall rating of either: outstanding, good, requires improvement or inadequate. Additionally, each of the core services such as, maternity, accident and emergency and community services for adults will also be rated in the same way to provide performance information at a service, hospital and trust level.

Providers are being inspected for different reasons. These include trusts that are hoping to secure foundation status, hospitals that are priorities for inspection and those that are low risk, following CQC's analysis of information, following up on concerns raised regionally, a commitment to inspect different types of trusts in different parts of the country and following up on concerns raised by other regulators.

Formal notification that the Trust has been selected for a routine CQC inspection of our services week beginning 13 October 2014 has been received. Being an aspirant foundation trust, that is low risk and a combined acute community organisation will have played a part in the Trust's selection in the next wave of inspections.

Plans have been developed to ensure a successful inspection visit. These are captured on the attached slides together with an update on progress. A reminder of the inspection process is also provided, for information.

REPORT RECOMMENDATION:

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

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	✓	

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

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

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

High quality care

PREVIOUS CONSIDERATION:

Results verbally reported to the Quality and Safety Committee on 25 July 2014. Preparation plan presented and discussed at CLE on 29 July 2014.

SWBTB (8/14) 124 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Chief Inspector's Visit

Are services safe, effective, caring, responsive and well-led?

Preparing for Inspection

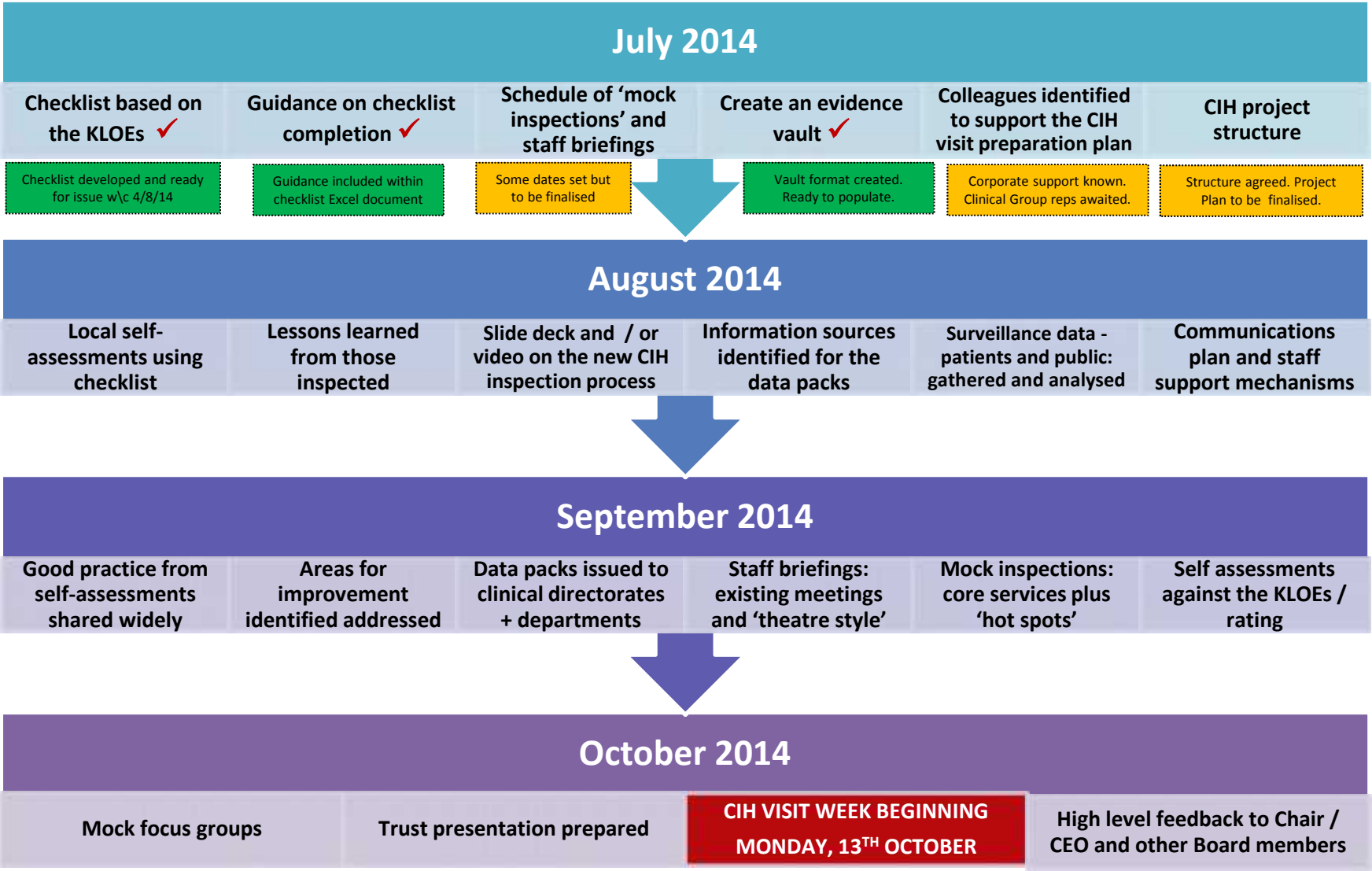
Trust Board: 7 August 2014

Kam Dhami, Director of Governance

Where EVERYONE Matters

Formal notification was received on 25 July that our Trust has been selected for a routine CQC inspection of our services week beginning 13th October 2014. The plan developed in anticipation of a visit in Q3 has been amended to reflect the earlier inspection date. The key aims of the plan are to ensure we are informed and prepared. That we take appropriate and balanced decisions about additional actions in advance of the visit. That we recognise and use the range of work already working to deliver improvements.

Inspection visit preparation: key deliverables



The size of our organisation and spread of locations where services are provided makes the scale of the task to prepare for the CHI visit in the time available significant. The key to success will be ensuring clear and consistent messages are communicated to staff, managers and leaders regarding our approach to the visit and communicating our assessment of how we are doing and the plans in place to make progress

The key deliverables in more detail

July

- Design a checklist that familiarises managers and staff with the '5 Qs' and enables them to self-assess against the KLOEs. Agree scoring / rating approach.
- Timetable the mock-inspections and staff briefings and decide on patient / public involvement
- Create an evidence vault where information at all levels (corporate, group, directorate and local) is available and can be added to
- Assign corporate staff to preparation tasks, seek volunteers (including those who have CIH experience) to help out, particularly with the mock visits,
- Agree the CIH project management structure

August

- Issue the checklist to every ward / department / service for completion. A series of questions to be answered requiring a straightforward response. Good practice to be noted as well action to be taken to address identified gaps. Directorate and Group Management teams to confirm completion and review responses.
- Contact to be made with similar organisations that have already been inspected to get some intelligence from their experiences and avoid pitfalls.
- Agree a communication plan to ensure managers and staff know what the visit is about, what 'our story' is and their role. Produce promotional information [e.g. presentations / videos / screensavers / payslip attachments / Heartbeat) to publicise the visit and help prepare everyone.
- Find out what people are saying about us, (e.g. NHS Choices, local Healthwatch) because the CQC will be doing the same, and take action where required.
- 'Mock-up' the data packs that the CQC will issue to us in advance of the visit so that there are no surprises and we prepare a response if necessary.

September

- Share across the Trust the good practice made known as part of the self-assessment process, encouraging others to introduce this in their work areas.
- Address any corporate-wide trends and themes identified as part of the self-assessments carried out.
- Issue the data packs to Clinical Directorates and Corporate Departments, requesting a response to where the quality indicators highlight outliers.
- Provide an opportunity for staff to find out more about the inspection and have any questions answered. Importantly, this will provide an opportunity to present 'our story' so that there is shared understanding.
- Undertake announced and unannounced mock-inspections to the core areas that will definitely be visited plus other 'hot spot' areas.
- Carry out self-assessments and 'rate' the core services and Trust.

October

- Meet with staff and carry out mock focus groups by discipline in line with the CQC's approach. The intention is to provide direction and support to staff to help them prepare for their conversation with the Inspection team.
- Prepare the 30 minute 'scene-setting' presentation to be made by the CEO to the Inspection team at the beginning of their visit.
- **Monday, 13th October the CIH Inspection visit begins**

A meeting with the Head of Hospital Inspections is to take place on 7th August to work through the logistics and scheduling of the visit, following which details on what will take place and who needs to be involved will become available.

What the CQC inspection is likely to look like?

Day 1 of the inspection: Briefing and planning day	Introductory session explaining: the scope and purpose of the inspection, who will be involved, how the inspection will be carried out, including the CQC's relevant powers and how they will communicate their findings. This session will also include a presentation by the CEO highlighting the strengths and areas of improvement that the Trust is working on.
Day 2 – 4 of the inspection: Announced site visits	- Gathering the views of staff - Gathering the views of service users / carers - Holding listening events-inviting members of the public / carers who have experience of the service - Work in partnership with local organisations such as Healthwatch, community groups to provide opportunities for members of the public to meet with the inspection team via public meetings. - Hold core focus groups with staff - Pathway tracking patients through care - Reviewing records - Reviewing policies and documents - Consider the financial robustness – how the management of finances impacts on quality
Day 5 of the inspection: Closing the visit	Inspection Chair will hold a feedback meeting with the nominated individual (CEO) and Chair to give a high level initial feedback only
Unannounced inspection visits	Usually about 10 days after the main inspection, smaller teams inspecting with a more focused approach to test findings in key areas.
Within 4 weeks of inspection: Draft report written by CQC	Draft report written with service level and trust level ratings: outstanding, good, requires improvement or inadequate. The draft report will be shared with the NTDA
Quality Summit following receipt of the final report	Meeting with partners in the local health and social care system. Purpose of the summit is to develop a plan of action (high level action plan) and recommendations based on the Inspection team's findings as set out in the report. The Quality Summit will consider: (a) whether planned action by the Trust to improve quality is adequate, or whether additional steps need to be taken, and (b) whether support should be made available to the Trust from other stakeholders such as commissioners to help improvement. Within a month of the Quality Summit: Submission of the Trust action plan

Chief Inspector of Hospitals Visit

Are services safe, effective, caring, responsive and well-led?

The CQC's inspection model

To make the most of the time that the CQC are on site for an inspection, they make sure they have the right information to help focus on what matters most to people. This will influence what they look at, who they will talk to and how they will configure their team. The information gathered during this time is also used as evidence when they make their ratings judgements.

Planning the inspection - CQC

Gathering and analysing information

To prepare for the inspection the CQC will analyse data from a range of sources including:

- National datasets
- CQC records
- People who use services
- Other stakeholders
- The provider.

They will collate their analysis in a 'data pack' for each hospital and send it to us in advance of the start of the site visit. We will have an opportunity to review the data pack for accuracy and raise queries on the data.

Gathering information from <u>people who use services</u>

The CQC will gather and analyse information from patients and the public in advance of the site visit, including through:

- Comments/feedback sent to CQC from individual patients and those close to them
- Nationally collated feedback from patients and carers (for example, acute NHS hospital patient survey data, Health Ombudsman's evidence of complaints, acute NHS hospitals choices, quality accounts, the NHS Friends and Family test)
- Local Healthwatch
- Local voluntary groups including equality groups
- The NHS Complaints Advocacy Service
- Patient and carer groups
- Maternity Services Liaison Committee
- PLACE (patient-led assessment of the care environment)
- Community outreach focus groups.

Gathering information from <u>stakeholders</u>

The CQC will contact and gather information from a range of stakeholders. These stakeholders hold information about people's experiences and service performance and the CQC want to make the best use of their evidence. The stakeholders include:

- CCG
- NTDA
- NHS England
- Local authorities
- Overview and scrutiny committees
- Quality surveillance groups
- Local NHS Complaints Advocacy Service
- Professional regulators, including the GMC, NMC and Health and Care Professionals
- Royal Colleges
- Parliamentary and Health Service Ombudsman
- Health and wellbeing boards.

To make the most of the time that the CQC are on site for an inspection, they make sure they have the right information to help focus on what matters most to people. This will influence what they look at, who they will talk to and how they will configure their team. The information gathered during this time is also used as evidence when they make their ratings judgements.

Planning the inspection - CQC

Gathering information from <u>the provider</u>

Eight to 12 weeks before the start of the site visit the CQC will ask us for information about:

- Management and governance structures.
- Numbers and locations of services and teams.
- Safety and quality governance arrangements.
- Commissioning arrangements
- Key performance indicators, issues, risks and concerns.

They also ask to see information on how the Board monitors and takes action on, for example relating to:

- Safety
- Clinical effectiveness
- Patient experience, including complaints
- Staff experience.

- Going forward, the CQC will be asking providers to include their own view of their performance. They want providers to be open and share their views with them in advance about where they are providing good care, and what they are doing to improve in those areas they know are not so good. **Although not in place yet, the timing of our visit means that we may be asked to do this**.

- The CQC will judge providers more harshly on 'well-led' if they find that providers have not been open with them about issues they already know about, and this will affect ratings.

- We will have 10 working days to respond to the CQC's request. They will provide a single point of contact for this liaison and ask providers to do the same. **For SWBH the first point of contact with the CQC will be Kam Dhami, Director of Governance**.

- Providers are asked to only send the information requested by the CQC and to discuss with them any difficulties in sending the information or where they believe they have extra information that they think may be useful to the inspection team

Throughout the year, and particularly in the weeks leading up to an inspection, the CQC may gather additional information about specific quality issues or themes to help target what they look at on inspection. They are considering and testing different options and approaches through to September 2014. Given that our inspection visit is in October 2014 some of the approaches being tested may be used on us and should therefore form part of our preparations.

Other information-gathering activity CQC

Concerns from people who use services and staff
Information about complaints and concerns raised by patients and staff will help the CQC to understand how well a provider listens, investigates and learns, and to highlight potential areas of concern. They will track how patient and staff concerns and complaints are handled to see how effective the provider's systems are. As part of this work they will offer to talk to current and former whistleblowers.

Quality governance
The CQC may gather and use information on quality governance to see what systems and processes we have in place and how effective they are at ensuring provider-wide learning, so that improvements are embedded where necessary. They will also look at how well information is used at providing assurance about the quality of care being delivered

Safety alerts and serious untoward incidents
An organisation with a positive safety culture is one that learns from things that have gone wrong, both from within their own services and from lessons learned from elsewhere. The CQC will be testing this in two aspects of safety management.

The first would explore how well we report, investigate and learn from serious untoward incidents (including never events) and implement the improvements needed to prevent such incidents happening again. The second would test how we disseminate and act on the requirements and supporting information published in selected safety alerts.

Board effectiveness
The CQC may look at how effectively the Board works by observing one or more Board and sub-committee meetings. They will also review and assess reports to the Board (for example on performance, patient experience and staff engagement) and strategic documents such as the board assurance framework.

Site visits are a key part of the CQC inspection process, giving them an opportunity to talk to people using services, staff and other professionals to find out their experiences. They allow the inspection team to observe care being provided and to review people's records to see how their needs are managed both within and between services.

Site Visits

Site visit timetable

The site visit will generally include the following stages:

- Briefing and planning day for inspection team
- Presentation from the Trust
- Announced site visits (three to four days)
- Unannounced visits
- Closing the inspection visit
- Additional site visits (if required)

Trust presentation

At the start of the site visit the Head of Hospital Inspection and the Inspection Chair will hold an introductory session with the trust's contact person, Chair, CEO, MD and CN to explain:

- The scope and purpose of the inspection
- Who will be involved
- How the inspection will be carried out, including our relevant powers
- How we will communicate our findings.
- The trust will also make a 30-minute presentation to the inspection team
- This presentation should set out:
    - Background to the organisation
    - Its approach to ensuring good quality care
    - What is working well or is outstanding
    - The areas of concern or risk.

Gathering the views of people who use services

A key principle of the approach to inspecting hospitals and community health services is to seek out and listen to the experiences of the public, patients and those close to them. This includes the views of people who are in vulnerable circumstances or who are less likely to be listened to by statutory bodies.

The CQC will gather the views of patients and those close to them by:

- Speaking individually with people who use services.
- Holding focus groups with people who use services and their carers.
- Holding drop-in sessions for patients.
- Using comment cards placed in reception areas and other busy areas to gather feedback from people who use services, their families and carers. In many cases we will be asked to distribute these before the site visit. Comment cards will also be available at listening events and focus groups.
- Using posters to advertise the inspection and give an opportunity to speak to the inspection team. These need to be put in areas where patients and other people will see them.
- Using the information gathered from looking at patient complaints and concerns.
- Information gathered by the 'Experts by Experience' whose main role is to talk to people who use services and tell the inspectors what they heard.

Listening activities

The inspection team will hold a public listening event before the start of their site visit or on the evening of the first day. Additional listening events may be planned depending on the size, geographical spread and demographic profile of the trust. These events are intended for members of the public, so the trust's management and press are discouraged from attending.

They will be promoted through all appropriate public communications channels, for example, through local media and local community group newsletters.

The Trust is registered with the CQC to provide hospital services that covers all our hospital and community services Each type of service has its own inspection methods, frameworks, standards and Inspection teams. The CQC has confirmed so far that our visit will be a combined inspection that relates to both Hospital Services and Community Services. A typical inspection team size will have between 30 – 50 members, depending on the size and services of the provider.

Site Visits continued

Gathering the views of staff

The inspection team will interview individual directors and staff at all levels. As a minimum they will interview the following people:

- Chair
- CEO, MD, CN, COO, DOF
- Non-executive director responsible for quality/safety
- Board director responsible for end of life care
- Service leads for each of the core services [CD, DN, GM]
- The complaints lead.
- Senior lead for human resources.

The team will hold focus groups with separate groups of staff. These will be peer to peer focus groups, involving the clinical experts on the inspection team. Normally focus groups will be held with:

- Consultants and other medical staff, junior doctors, registered nurses and midwives / sisters and matrons, students nurses and HCAs, AHPs, admin and support staff
- District nurses, Health visitors, Specialist nurses

Other inspection methods / gathering information

Other ways of gathering evidence will include:

- Observing care including using the SOFI 2 (Short Observational Framework for Inspection) tool.
- Pathway tracking patients through their care.
- Reviewing records
- Reviewing policies and documents.

Financial robustness

- As part of the review of 'well-led' the CQC will consider how the management of finances impacts on quality as part of a judgement on whether the quality of services is sustainable. The findings will be used inform the judgement.
- At core service level this will include the inspection team looking at the potential impact of cost improvement or efficiency plans on safety and quality, and how well understood this is within the service. the assessment at Trust level will include interviews with the DOF, MD and others. Key documents such as Board meeting minutes and the annual audit letter will be reviewed.

Continual evaluation

- Throughout the inspection the Inspection Chair and inspection team leader will continually review the emerging findings with the inspection team. This keeps the team up to date with all issues and enables the focus of the inspection to be shifted if new areas of concern or outstanding practice are identified. It also enables the team to identify what further evidence might be needed in relation to a line of enquiry and which relevant facts might still be needed to corroborate a judgement or, where appropriate, a rating.
- Continual evaluation is also an opportunity to make connections across different areas of inspection where there may be common themes, such as lack of audits, and which might raise questions about governance structures overall.

At the end of the announced inspection visit, the inspection chair and inspection team leader will hold a feedback meeting with the Chief Executive, the Chair and other Board members. This is to give high level feedback only, illustrated with some examples. The CQC will not provide indicative ratings at this stage.

Closing the visit

Other inspection methods / gathering information
The inspection team will carry out one or more unannounced visits.

These visits may be during the day or out of hours. They will involve the inspection methods described above. The team may go back to areas already visited.

At the start of these visits, the team will meet with the 'senior operations lead' on duty at the time, and will feed back if there are any immediate safety concerns.

The closing meeting will cover:

- Thanking the provider's staff for their support and contribution
- Explaining their findings to date, but noting that further analysis of the evidence will be needed before final judgements can be reached on all of the issues.
- Any issues that were escalated during the visit.
- Any plans for follow-up or additional visits (unless they are unannounced)
- Reminding us that they may carry out unannounced visits
- Explaining that further analysis is required before they can award ratings
- Explaining how they will make judgements against the existing regulations.
- Explaining the next steps, including challenging factual accuracy in the report and final report sign-off, quality summits and publication.
- Answering any questions we may have.

For each location inspected, the CQC will rate performance at four levels (see below). For the trust, the CQC will rate performance at two levels. Level 5 - each of the key questions. This will be informed by the findings at Level 3 for each location in the trust, and information on the five key questions that is only available at trust level. Level 6: The Trust as a whole.

Ratings: NHS acute hospitals

NB: Example for illustrative purposes

Level 1
Core services: Community

- Services for children, young people and families
- Services for adults
- In-patient services
- End of life care

Level 1: Every key question for every core service provided

	Safe	Effective	Caring	Responsive	Well-led
A&E	Good	Good	Good	Requires improvement	Good
Medical care (including older people's care)	Good	Requires improvement	Good	Good	Good
Surgery	Good	Good	Good	Good	Good
Intensive/critical care	Good	Good	Good	Good	Good
Maternity & family planning	Good	Good	Good	Requires improvement	Requires improvement
Services for children & young people	Good	Good	Outstanding	Good	Good
End of life care	Good	Good	Outstanding	Outstanding	Good
Outpatients	Requires improvement	Good	Good	Requires improvement	Inadequate

Level 2: Aggregated rating for every core service provided

Overall
*
*
*
*
*
*
*
*

Level 3: Aggregated rating for every key question

Overall					
	*	*	*	*	*

Level 4: Overall rating for the location

Overall location
*

* These will be aggregated ratings (outstanding, good, requires improvement or inadequate), which will be determined using the ratings principles

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Safe Nurse Staffing
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Colin Ovington – Chief Nurse
DATE OF MEETING:	7 August 2014

EXECUTIVE SUMMARY:

This report is an update using the data collected during June 2014.
During July 2014 the final NICE guideline 'Safe staffing for nursing in adult inpatient wards in acute hospitals' was issued. The parameters in this guideline are used to report our position.

REPORT RECOMMENDATION:

To publish patient to RN ratios on our public web site and on NHS Choices on a monthly basis as per national requirement.
To receive an update at the September Trust Board meeting

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

Accept	Approve the recommendation	Discuss
X		X

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

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

Comments:

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

Relates to our safety objectives and BAF

PREVIOUS CONSIDERATION:

Monthly by Trust Board

FOR INFORMATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAFE NURSE STAFFING

Report to Trust Board on 7th August 2014

1 EXECUTIVE SUMMARY

1.1 This report is an update using the data collected during June 2014.

1.2 During July 2014 the final NICE guideline 'Safe staffing for nursing in adult inpatient wards in acute hospitals' was issued. The parameters in this guideline are used to report our position.

2 NICE GUIDELINE SUMMARY

2.1 There is no single nurse staffing to patient ratio than can be applied in every ward in every hospital to safely address the needs of the patients in those environments. The guideline therefore recommends factors that are required to be taken into account and which should be systematically assessed at ward level to determine the nurse staffing establishment. They further recommend 'on the day' assessments to ensure that staff requirements to ensure the individual needs of patients are met throughout a 24 hour period.

2.2 The guideline requires us to make an holistic assessment of each patients nursing needs, specific requirements and disabilities as well as other factors that may increase the requirement for additional nursing staff such as:

- difficulties with cognition or confusion (such as those associated with learning difficulties, mental health problems or dementia)
- end of life care
- increased risk of clinical deterioration
- need for the continuous presence of a member of the nursing team)often referred to as specialing care)

2.3 Whilst there is no single recommended nurse to patient ratio, the evidence if increased risk of harm is associated with a registered nurse caring for more than eight patients during the day shift, this should not include the nurse in charge. There should be close monitoring of 'red flags' and actions taken to ensure that staffing is adequate to meet patients' needs.

2.4 Table one demonstrates the number of Registered Nurses (RN) we plan to be on duty against what we achieve on the rosters with the resultant ratio of patients to RNs in the final three columns. This is prior to the addition of temporary staff.

Medicine & Emergency care

Ward	site	No. Beds	budget establishment includes 22% uplift	RN WTE	HCSW WTE	Percentage RN's on the funded establishment	Morning shift RN's funded	Afternoon /Evening shift RN's funded	Night shift RN's funded	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Ratio of patients per RNs early shift	Ratio of patients per RN's afternoon/ evening	Ratio of patients per RN's night shift
D11 (moved from D18)	City	21	26.18	15.87	10.30	60.6	4	3	2	3	3	2	7	7	10.5
D12	City	10	16.53	11.38	5.15	68.8	2	2	2	2	2	1	5	5	10
D15	City	24	26.88	16.58	10.30	61.7	3	3	2	2.6	2.7	1.3	9.2	8.9	18.5
D17	City	25	29.56	18.47	11.09	62.5	5	4	2	3	3	2	8.3	8.3	12.5
D26 (moved from D7)	City	21	26.18	15.87	10.30	60.6	4	3	2	3.3	3.2	1.8	6.4	6.6	11.7
AMU 1	City	41	73.71	52.95	20.76	71.8	11	11	10	9.2	8.7	8.4	4.5	4.7	4.9
AMU 2 (D41)	City	19	29.69	24.38	5.31	82.1	6	6	4	5	4.7	2.8	3.8	4.0	6.8
D43 (MFFD)	City	24	29.64	15.08	14.56	50.9	4	3	2	3.3	3	2	7.3	8	12
CCU Sandwell	Sandwell	10	18.33	15.76	2.58	86.0	3	3	2	3	3	2	3.3	3.3	5
P3 (ARU)	Sandwell	29	30.45	18.47	11.98	60.6	5	4	2	5.3	4	2.6	5.5	7.3	11.2
PR4	Sandwell	25	48.68	40.17	8.51	82.5	8	8	5	9	7.6	4.4	2.8	3.3	5.7
PR5	Sandwell	34	32.25	18.92	13.33	58.7	4	4	3	5	3.7	2.4	6.8	9.2	14.2
NT4	Sandwell	28	35.15	21.49	13.66	61.1	5	4	3	3.9	3.8	2.1	7.2	7.4	13.3
LY5	Sandwell	34	37.31	21.07	16.24	56.5	5	4	3	4.5	3.5	1.2	7.6	9.7	28.3
N5 (inc day unit)	Sandwell	15	21.03	16.78	4.26	79.8	4	4	2	4.6	2.8	2	3.3	5.4	7.5
AMU A	Sandwell	40	71.61	50.56	21.05	70.6	10	10	8	9.2	8.7	8.4	4.3	4.6	4.8
AMU B (NT1)	Sandwell	20	30.36	19.78	10.58	65.2	5	4	2	3.7	3.6	1.7	5.4	5.6	11.8
Rowley (MFFO)	RRH	24	29.64	15.08	14.56	50.9	4	3	2	2.5	2.2	1.3	9.6	10.9	18.5
TOTAL		**444**	**613.18**	**408.64**	**204.5355**	**66.6**	**92**	**83**	**58**	**82.1**	**73.2**	**49.4**	**5.4**	**6.1**	**9.0**

Surgery A

Ward	site	No. Beds	budget establishment includes 22% uplift	RN WTE	HCSW WTE	Percentage RN's on the funded establishment	Morning shift RN's funded	Afternoon /Evening shift RN's funded	Night shift RN's funded	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Ratio of patients per RNs early shift	Ratio of patients per RN's afternoon/ evening	Ratio of patients per RN's night shift
D21		23	28.49	16.38	12.11	57.5	4	4	2	4.5	4.2	1.1	5.1	5.5	20.9
D25		19	28.28	16.98	11.30	60.0	4	4	2	3.3	2.9	1.7	5.8	6.6	11.2
SAU D42		14	22.98	16.98	6.00	73.9	3	3	0	3.2	3.1	2	4.4	4.5	7
SDU		12	0.00			#DIV/0!	4.5	2	0	4.17	3	0	2.9	4	
N2		24	17.73	11.23	6.50	63.3	4	3	2	2.7	1.9	1	8.9	12.6	24
L2		20	30.73	17.20	13.53	56.0	3	3	2	2.6	2.1	1.6	7.7	9.5	12.5
P2		20	26.87	16.42	10.45	61.1	4	3	2	3.4	2.6	1.4	5.9	7.7	14.3
N3		33	40.65	23.93	16.72	58.9	6	6	3	4.6	4.3	1.9	7.2	7.7	17.4
L3		33	39.17	23.19	15.98	59.2	6	6	3	4.7	4	2.5	7.0	8.25	13.2
TOTAL		**198**	**234.90**	**142.31**	**92.59**	**60.6**	**38.5**	**34**	**16**	**33.17**	**28.1**	**13.2**	**6.0**	**7.0**	**15.0**

Rowley Regis Hospital

Ward	site	No. Beds	budget establishment includes 0% uplift	RN WTE	HCSW WTE	Percentage RN's on the funded establishment	Morning shift RN's funded	Afternoon /Evening shift RN's funded	Night shift RN's funded	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Ratio of patients per RNs early shift	Ratio of patients per RN's afternoon/ evening	Ratio of patients per RN's night shift
Henderson	RH	24	26.83	11.90	14.93	44.4	2	2	2	1.1	1.1	1.2	21.8	21.8	20
Leasowes	RH	20	23.03	8.03	15.00	34.9	2	2	1	1.8	1.7	1	11.1	11.8	20.0
Total		**44**	**49.86**	**19.93**	**29.93**	**79.22**	**4.00**	**4.00**	**3.00**	**2.9**	**2.8**	**2.2**	**15.2**	**15.7**	**20.0**

Surgery B

Ward	site	No. Beds	budget establishment includes 0% uplift	RN WTE	HCSW WTE	Percentage RN's on the funded establishment	Morning shift RN's funded	Afternoon /Evening shift RN's funded	Night shift RN's funded	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Ratio of patients per RNs early shift	Ratio of patients per RN's afternoon/ evening	Ratio of patients per RN's night shift
Eye ward	City	10	14.22	10.86	3.36	76.4	2	2	2	3.8	1.8	1.2	2.6	5.6	8.3

2.5 Table two is the output data from the national data collection for June 2014 which demonstrates that we achieve higher fill rates against our rota's than planned in most areas although the average fill percentage has reduced from the previous month. This is the impact of using temporary staffing to fill gaps on the roster and provide additional care.

	Day		Night	
Site Name	**Average fill rate - registered nurses/ midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	97.1%	112.7%	145.7%	0.0%
CITY HOSPITAL	109.1%	107.4%	121.3%	124.9%
ROWLEY REGIS HOSPITAL	97.9%	109.0%	141.5%	126.4%
SANDWELL GENERAL HOSPITAL	104.9%	113.9%	113.8%	149.9%

3 CURRENT ISSUES

3.1 A great deal of effort to reduce the temporary nursing spend is on-going with final decision on agency staff resting with the Chief Nurse. This commenced on 1st July and the first month's data will be reported in next month's board report. Early indicators are demonstrating fewer hours of agency nurses are being booked but this is not as yet being demonstrated in the spending pattern. Additional initiatives to reduce the most expensive agency usage particularly in critical care are being implemented from the beginning of August 2014.

4 RECOMMENDATION(S)

4.1 To publish patient to RN ratios on our public web site and on NHS Choices on a monthly basis as per national requirement.

4.2 To receive an update at the September Trust Board meeting

Colin Ovington

Chief Nurse

31st July 2014