

# AGENDA

## Trust Board – Public Session

**Venue** Anne Gibson Boardroom, City Hospital

**Date** 4 September 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]  
 Dr R Stedman (RST) [Medical Director]

### In attendance

Mr M Hoare (MH) [Non-Executive Director]  
 Miss K Dhami (KD) [Director of Governance]  
 Mrs C Rickards (CR) [Trust Convenor]

### Guests

Patients for patient story  
 Rev A Stevenson

### Secretariat

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

Time	Item	Title	Reference Number	Lead
1330h	1	<b>Apologies</b>	Verbal	SG-L
	2	<b>Declaration of interests</b> <i>To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting</i>	Verbal	SG-L
	3	<b>Minutes of the previous meeting</b> <i>To approve the minutes of the meeting held on 7 August 2014 a true and accurate records of discussions</i>	SWBTB (8/14) 136	Chair
	4	<b>Update on actions arising from previous meetings</b>	SWBTB (8/14) 136 (a)	SG-L
	4.1	Theatres capital works update	Verbal	RB
	5	<b>Questions from members of the public</b>	Verbal	Public
1345h	6	<b>Patient story</b>	Presentation	CO
1405h	7	<b>Chair's opening comments and Chief Executive's report, including NHS mutual briefing</b>	SWBTB (9/14) 139 SWBTB (9/14) 139 (a)	RSM/ TL
<b>MATTERS FOR DISCUSSION AND APPROVAL</b>				
1415h	8	<b>Ratification of Chairman's action to approve capital works on D47</b>	SWBTB (9/14) 140	TW
1420h	9	<b>Progress with strengthening consent process</b>	SWBTB (9/14) 141 SWBTB (9/14) 141 (a)	RST
1430h	10	<b>Year of Outpatients overview</b>	SWBTB (9/14) 142 SWBTB (9/14) 142 (a)	RB

1445h	11	Corporate integrated performance dashboard	SWBTB (9/14) 143 SWBTB (9/14) 143 (a)	TW
1455h	12	System Resilience Plan	SWBTB (9/14) 144 SWBTB (9/14) 144 (a) SWBTB (9/14) 144 (b)	RB
1505h	13	Financial performance – Month 4	SWBTB (9/14) 145 SWBTB (9/14) 145 (a)	TW
1515h	14	Trust Risk Register update		
	14.1	Update on actions agreed at previous meetings	SWBTB (9/14) 146 SWBTB (9/14) 146 (a)	KD
	14.2	New considerations		
1525h	13	Complaints update – Quarter 1	SWBTB (9/14) 147 SWBTB (9/14) 147 (a)	KD
PRESENTATION				
1535h	14	Chaplaincy services	Presentation	CO
UPDATES FROM THE COMMITTEES				
1550h	17	Update from the meeting of the <u>Finance &amp; Investment Committee</u> on 29 August 2014 and minutes of the meeting held on 25 July 2014	SWBFI (7/14) 042	RSM/ TW
	18	Update from the meeting of the <u>Quality &amp; Safety Committee</u> held on 29 August 2014 and minutes of the meeting held on 25 July 2014	SWBQS (7/14) 045	OD/ CO
	19	Update from the meeting of the <u>Configuration Committee</u> held on 3 September 2014 and minutes of the meeting held on 31 July 2014	SWBCC (6/14) 028	RSM/ TL
	20	Any other business	Verbal	All
MATTERS FOR INFORMATION				
1600h	21	Midland Metropolitan Hospital project: monitoring report	SWBTB (9/14) 148	
	22	Foundation Trust application programme: monitoring report	SWBTB (9/14) 149	
	23	Chief Inspector of Hospitals visit – preparation plan	SWBTB (9/14) 150	
	24	Nurse staffing levels	SWBTB (9/14) 151 SWBTB (9/14) 151 (a) SWBTB (9/14) 151 (b)	
	25	Details of next meeting <i>The next public Trust Board will be held on 2 October 2014 at 1330h in the Churchvale/Hollyoak Rooms, Sandwell Hospital</i>		

# MINUTES

## Trust Board (Public Session) – Version 0.1

**Venue** Archer Ward, Rowley Regis Hospital

**Date** 7 August 2014

### Present

Mr Richard Samuda [Chair]  
Ms Clare Robinson  
Dr Sarindar Sahota OBE  
Mrs Gianjeet Hunjan  
Mr Harjinder Kang  
Dr Paramjit Gill  
Ms Olwen Dutton  
Mr Toby Lewis  
Mr Tony Waite  
Mr Colin Ovington  
Miss Rachel Barlow

### In Attendance

Mr Mike Hoare  
Miss Kam Dhami  
Dr Nigel Trudgill  
Mr Bill Hodgetts [Healthwatch]

### Secretariat

Mr Simon Grainger-Lloyd

### Guests

Patient  
Ms Ruth Williams

Minutes	Paper Reference
<b>1 Apologies for absence</b>	<b>Verbal</b>
Apologies for absence were received from Chris Rickards and Dr Stedman. Dr Trudgill was welcomed to the meeting in his absence.	
<b>2 Declaration of Interests</b>	
There were no further interests declared since the last meeting or in connection with any agenda item.	
<b>3 Minutes of the previous meeting</b>	<b>SWBTB (7/14) 116</b>
The minutes of the Trust Board meeting held on 3 <sup>rd</sup> July 2014 were presented for consideration and approval.	

<b>4</b>	<b>Update on Actions arising from Previous Meetings</b>	<b>SWBTB (7/14) 116 (a)</b>
<p>The Board received the updated actions log.</p> <p>It was noted that there were no actions outstanding or requiring escalation to the Board for resolution. It was noted that some actions would need to be deferred until the next Board informal session.</p>		
<b>4.1</b>	<b>Children's mental health services</b>	<b>Verbal</b>
<p>Miss Barlow reported that a significant number of children were seen in A &amp; E with mental health issues and adolescent patients could often experience long waiting times and therefore there was close working with mental health trusts to improve the efficiency of the service. It was reported that as part of the winter initiative, additional funding had been provided for children's' health assessment facilities. It was highlighted however there is a national shortage of beds for these patients.</p> <p>Ms Dutton commented that although this was clear progress, she was disappointed around the national shortage of beds and resources. Mr Lewis advised that there was a risk-based investment into these services, however the timescales around a developmental solution were not clear at present. It was noted that work was underway to ensure that mental health providers were fully focussed on the position. Additionally, it was reported that there was pressure on the parents of these patients.</p> <p>Dr Gill asked whether those waiting for a long time were awaiting assessment or whether there were signs that these patients needed to be definitely treated. He was advised that many of the individuals were known to mental health services.</p> <p>Dr Sahota noted that a national group had been set up to handle mental health issues. It was noted that there was some lack of clarity as to how services for patients aged 16 – 18 were provided.</p>		
<b>5</b>	<b>Questions from members of the public</b>	<b>Verbal</b>
<p>Mr Hodgetts reported that the Healthwatch report would be issued shortly. Additionally he asked what the position was in terms of transporting escorts with patients using hospital transport. Mr Lewis advised that it was Trust practice not to allow escorts to travel with patients, noting that a degree of common sense needed to be applied to this policy.</p> <p>Mr Hodgetts reported that there had not been involvement with the Cardiology reconfiguration to date. Mr Lewis advised that although he accepted that the public consultation had not yet commenced, the prime face clinical case for reconfiguration of interventional Cardiology case had been accepted, with public consultation being planned as part of the next phase, following discussions with commissioners.</p>		



6 Patient story and iCares presentation story	Presentation
<p>The Board heard the story of a patient that had been cared for through the iCares service. The patient expressed her contentment at the service she had received overall, especially the welcome and staff attitude. In terms of learning, she advised that the lighting could be improved in some of the clinical rooms and she could have been better prepared for the after effects of the treatment. The Chairman asked if she felt that the treatment had been joined up and handled effectively. The patient agreed that this was the case and the communications between the team had been effective.</p> <p>Dr Gill asked how long the patient had spent in the care of the Trust. He was advised that IV treatment had been administered over six sessions of day care. The patient was pleased with the patient transport arrangements. Dr Gill asked when the patient had seen her GP after the episode of care. The patient advised that she liaised regularly with the GP by phone. The relay of information back to the patients' GP was noted to be around 80% using SystemOne, an electronic patient record. Mr Lewis advised that there would always need an interface with GPs and that this would be discussed at the September meeting of the Board as part of the discussion of the Trust's Electronic Patient Record. Mr Ovington advised that without iCares, it was likely that the patient would have needed to visit the Emergency Department and be admitted for several days for intravenous treatment. Mrs Hunjan asked in terms of continuing care, whether the patient was receiving any ongoing support from iCares. She was advised that this was not the case.</p> <p>Ms Williams provided an overview of the iCares service. Ms Dutton thanked Ms Williams for the presentation and asked how the serviced was funded. She was advised that finding was from the CCG but partnerships with community charitable and self-help groups were key to the ongoing success of the service. It was suggested that it was the intention to expand the model to a number of other areas in West Birmingham. Mr Lewis commented that as part of the Kings Fund, the funding was loosely arranged and that the team was successful as a result of good leadership and attention to detail for the team. Ms Williams advised that much attention was taken to addressing culture and valuing staff and giving them permission to act with a degree of autonomy. Mr Hodgetts suggested that in the case of 'Jane' some additional work could have been done prior to discharge. Ms Williams agreed that a slightly more proactive approach would have assisted.</p> <p>Ms Robinson asked who manned the iCares telephone service. Ms Williams advised that staff manning the landline had come from a community contact centre and a clear programme of operation was in place for using mobile phones. Dr Sahota asked whether the time of the call had impacted and was advised that although a response at some times of the day may be difficult, the team was committed to delivering a robust service whenever possible, even if that extended to outside of usual working hours.</p>	
<p><b>ACTION:</b> Dr Stedman to include the arrangements for interfacing with GPs as part of the EPR discussions at the Board meeting in September</p>	

<b>7 Chair's opening comments and Chief Executive's report</b>	<b>SWBTB (8/14) 118</b>
<p>Mr Samuda reported that since the last meeting, communication of the support for the Midland Met project had been received, which had been delivered by the Chancellor of the Exchequer. He thanked all those directly involved but also commissioners and stakeholders that had supported the plans to approval and those in post at the Trust during past years.</p> <p>The Chairman reported that he had met with the Chair of Heart of England FT, who was very keen to engage with the Trust on joint working and a number of non-clinical services.</p> <p>The mutual status for healthcare trusts was reported to have headlined in recent news. It was agreed that this would be presented to the Board at the next meeting.</p> <p>Mr Lewis reported that the new 'Right Care, Right Here' partnership body would meet shortly and a partnership board would be created under Bob Alexander's chairmanship. He thanked colleagues for the contributions to the NHS66 celebrations, in addition to the support of the recent commissioner/Trust cricket match.</p> <p>It was reported that the City Council had supported the Trust's involvement with the Better Care Fund plans.</p> <p>In terms of Never Events, it was reported that a briefing note on the arrangements for consent would be issued mid-August. It was noted that the way in which consent currently operated was not entirely in line with how it should be operate. Failure to comply with the revised robust arrangements was noted to result in punitive action.</p> <p>Mr Ovington reported that the CQC would visit to review Safeguarding arrangements on Monday 11 August.</p>	
<p><b>ACTION: Mr Lewis to present an overview of the proposals for 'mutual status' for NHS trusts at the September Board meeting</b></p> <p><b>ACTION: Mr Lewis to circulate a briefing note concerning the strengthened arrangements for consent prior to the next Board meeting</b></p>	
<b>8 Corporate integrated dashboard</b>	<b>SWBTB (8/14) 120</b> <b>SWBTB (8/14) 120 (a)</b>
<p>Mr Waite reported that there had been an increase in the number of falls during the month. In terms of stoke care, performance against the targets concerning admission within 4 hours of a stroke unit and thrombolysis was reported to have fallen short of expectations. Performance against the fractured neck of femur target was noted to have fallen short of the required standard. Mr Waite added that cancer care data showed all high level targets had been met and there had been no mixed sex accommodation breaches. Performance against the</p>	

<p>emergency care target was reported to have fallen short of the 95% target.</p> <p>The additional information in the report was noted to provide an insight into contractual standards and operational performance.</p> <p>Dr Trudgill reported that an initiative would start shortly which targeted falls prevention, known as 'Frailsafe'.</p> <p>Ms Robinson suggested that the 'At a Glance' page needed to summarise the indicators where there was underperformance, together with a trajectory for achieving improvement.</p> <p>Mr Lewis suggested that the agreement of targets was needed, and that the dashboard should be fully populated in future.</p> <p>Miss Barlow reported that the Trust was not performing well on diagnostic waits and that although a recovery trajectory had been set, it was expected that the position would not be rectified until September. Mr Ovington reported that in terms of dementia, the targets had been met earlier in the year but not at present and much work was being undertaken to assess the reasons for and areas responsible for missing the targets. Ms Dutton asked whether iCares could be rolled out to cover patients with dementia. It was agreed that this was possible, however screening by ward on performance was needed to ensure that there was sufficient rigour.</p> <p>It was agreed that a note needed to be circulated on mortality figures given that the latest data reflected the February position.</p> <p>The position regarding the cancer two week GP referral was reported to be being met overall, although other work was being done to better improve the position. It was noted that this was reflective in some part, of patient choice.</p> <p>Data quality on ambulance turnarounds was reported to be being reviewed and a meeting was being convened with the ambulance trusts to agree the protocols and interventions that currently presented a challenge. Mrs Hunjan reported that the unannounced walkabout in A &amp; E had also highlighted the position.</p> <p>Mr Lewis noted an erroneous unplanned reattendance rate and suggested that this needed to be investigated outside of the meeting.</p>	
<p><b>ACTION: Mr Waite to circulate a note providing an updated position on mortality (SHMI)</b></p> <p><b>ACTION: Miss Barlow to investigate and update Mr Lewis concerning unplanned reattendance rates</b></p>	
<p><b>9 System resilience: elective and non-elective care planning and performance update</b></p>	<p><b>SWBTB (8/14) 121</b> <b>SWBTB (8/14) 121 (a)</b></p>
<p>Miss Barlow provided an overview of the new Systems Resilience Group which was now to be focussed on elective care. It was reported that the plan would be presented at the next meeting which would include recovery of performance</p>	

<p>against the 18 weeks referral to treatment time target.</p> <p>In terms of performance against the emergency care target it was noted that this was much improved despite the large number of delayed transfers of care. In terms of the additional 20 intermediate care beds for which the Trust had made a bid, it was noted that there was hope of a successful outcome in terms of temporary funding.</p> <p>Ms Robinson asked whether delayed transfers of care were occurring across Birmingham. It was reported that there was a difficulty with handling patients with a complex package of care and that other trusts were also experiencing an issue. In terms of fining, it was suggested that this be invoked where necessary should it be felt to be of benefit.</p> <p>Ms Robinson suggested that effort should be directed to ensuring that the monitoring work be undertaken as part of business as usual. It was reported that a new head of access would be appointed who would be charged with overseeing this work. The situation with the two 52 week breaches was discussed in detail. It was noted that controls be put into place to prevent the situation occurring.</p>	
<p><b>ACTION: Miss Barlow to present the System Resilience Plan at the next meeting</b></p>	
<p><b>10 Publication of patient safety on NHS Choices</b></p>	<p><b>SWBTB (8/14) 122</b> <b>SWBTB (8/14) 122 (a)</b></p>
<p>Miss Dhami reported that on NHS Choices, safety and staffing indicators were displayed which were available for public review. It was suggested that this might drive better standards. The various standards were discussed and data for the Trust was reviewed. It was noted that in terms of cleanliness and infection control, Rowley Regis was pleasing. It was noted that there 60% of staff strongly recommended the organisation, with the remaining views relating mainly to corporate and back office functions. Dr Sahota suggested that this information needed to be fed back to staff and asked how practice was being addressed in relation to patient safety alerts. Miss Dhami reported that there were some alerts which had not been signed off at the time of the report's production. Dr Gill asked what the response rate had been. He was advised that at 40-50% this was in line with other organisations. Dr Gill asked for a check to be made in relation to neighbouring trusts. Mrs Hunjan noted that the response rate had increased. Ms Robinson supported the comparison with other organisations.</p>	
<p><b>ACTION: Miss Dhami to circulate a comparative analysis of NHS choices patient safety information</b></p>	
<p><b>11 CQC Intelligent Monitoring</b></p>	<p><b>SWBTB (8/14) 123</b> <b>SWBTB (8/14) 123 (a)</b></p>
<p>Miss Dhami reported presented the outcome of a recent intelligent monitoring output and that the Trust's position had improved to a Band 6 (out of 6). The areas of concern flagged were discussed.</p> <p>It was noted that it was important that any concerns in the intelligent monitoring</p>	

<p>information be challenged if needed.</p> <p>In terms of PROMS, it was noted that an action plan to improve the position had been developed. It was agreed that the Quality &amp; Safety Committee consider the position at the next meeting.</p>	
<p><b>ACTION: Dr Stedman (deputy in his absence) to present an update on PROMs at next meeting of the Quality &amp; Safety Committee</b></p>	
<p><b>12 Annual plan 2014/15 monitoring report</b></p>	<p><b>SWBTB (8/14) 125</b>  <b>SWBTB (8/14) 125 (a)</b></p>
<p>Mr Waite reported that two items were marked as red in respect of complaints and use of temporary staffing. The Board was asked to confirm that the actions to address the annual priorities were necessary and sufficient. It was reported that a review of the reason for the increased number of complaints was planned. Mrs Hunjan noted that the Quality &amp; Safety Committee had noted the increase in complaints and that an update was due in August. Ms Robinson noted that repeat complaints were of concern particularly and that when looking at single tender actions at the recent meeting of the Audit &amp; Risk Management Committee, a number related to complaints staffing. It was noted that an annual report on complaints needed to be produced. Miss Dhami reported that in terms of single tender actions this related to the previous year and that a stable workforce was now in place with no agency staff being in post. Mr Lewis reported that the process improvement that needed to be achieved, was being delayed at present although an improvement had been seen. Ms Dutton suggested that the increase in complaints was not necessarily a negative issue, however acting on and gathering the learning from complaints was of paramount importance. She added that continuing support for the devolved model was necessary. It was agreed that shortly the actions arising from complaints needed to be understood. The length of time to embed the complaints process was noted to be overly lengthy although it was reported that the devolved model together with the new leadership in the department was yielding results. The Chairman asked Dr Trudgill asked whether the learning was permeating into groups. He advised that the message was reaching the groups, however more rigour needed to be put into place to ensure that clinicians responded more promptly.</p> <p>Mr Lewis advised that the scoring against the indicators needed to be reviewed for consistency, particularly where the timings had been reset, such as 18 weeks RTT.</p> <p>It was agreed that readmission position needed to be reviewed by the Quality &amp; Safety Committee.</p> <p>The Chairman suggested that the green rating on outpatients and letters to GPs might need to be challenged, based on anecdotal information. It was noted that this was reflective of the planned year end position.</p> <p>Dr Sahota noted that agency spend was increasing however he was advised that that this was to be discussed later in the agenda.</p>	

<b>ACTION: Miss Barlow to present an update on readmissions at the next meeting of the Quality &amp; Safety Committee</b>		
<b>13</b>	<b>Financial performance – Month 3</b>	<b>SWBTB (8/14) 126</b> <b>SWBTB (8/14) 126 (a)</b>
<p>Mr Waite highlighted that the financial results had been disappointing to date, with costs running over budget and under delivery of the Transformation Savings Plan. It was noted that the action to get back on track required significant and urgent attention.</p> <p>Capital expenditure was noted to be slow at present and the programme was to be reviewed consistent with some opportunities outlined in the Trust's plan.</p> <p>Mr Lewis asked for an explanation of the costs associated with emergency care, where it was noted that there had been a failure to deliver the plan to reduce costs in the area. Miss Barlow reported that the majority related to staffing but this was coming to an end when new staff had been recruited. It was noted that this was a matter of significance.</p> <p>Ms Robinson asked what controls were in place to review the consultants Programmed Activities (PAs) and ensure that they were delivered. Dr Trudgill reported that this was picked up through the job planning process and tight review of contracts. Ms Robinson asked whether annualisation of contracts had produced a pressure. She was advised that the situation benefitted the Trust to some degree. The controls were outlined. It was agreed that the controls around delivery of private practice needed to be confirmed however. Mr Kang asked whether there was potential difficulties with arranging cover when it was needed. Mr Lewis advised that team based working practice and annualisation of contracts assisted in this respect. In terms of seven day working, it was reported that this was being built into the job planning work. Miss Barlow agreed to bring a benchmarked position in terms of seven day working to the October meeting of the Board. It was noted that there would be a change to working practice in the Midland Met to stream elective and acute working practice. Mrs Hunjan noted that revalidation work was being considered by Internal Audit in December which would pick up some of the work.</p> <p>In terms of the Midland Met advisory fees, it was noted that this was to be picked up as part of the review of the capital programme.</p>		
<b>ACTION: Miss Barlow to present a benchmarked position concerning seven day working at the October meeting of the Board</b>		
<b>14</b>	<b>Trust risk register update</b>	<b>SWBTB (8/14) 127</b> <b>SWBTB (8/14) 127 (a)</b>
<b>14.1</b>	<b>Update on actions agreed at the last meeting</b>	

<p>An update on the actions to address the risks raised at the June meeting was provided. Mr Lewis reported that a level of investment would be directed to resolving the Ophthalmology outpatient privacy and dignity issues.</p> <p>Mr Ovington reported that in terms of the Paediatrics HDU resources, continued implementation of monitoring processes for balancing beds and resources was planned. It was agreed that the position should be reviewed again in future when the new model was embedded.</p> <p>In terms of acute Oncology, it was reported that a meeting with UHB was planned to discuss and resolve non-compliance with standards in Oncology, chaired by Mr Lewis. It was noted that uniform agreement with partners was unlikely. It was agreed that at the October Board meeting, the future of acute Oncology would be presented by Mr Lewis.</p> <p>It was noted that cancer service relationships overall, needed further discussions were needed.</p>	
<p><b>ACTION: Mr Lewis to present an update on the future of acute Oncology at the October meeting of the Board</b></p>	
<p><b>14.2 New considerations</b></p>	
<p>Miss Dhami reported that no new risks had been requested for addition. It was noted that the risks score ratings need to be altered. In terms of the gynaecology risks raised at the last meeting, it was reported that these would be managed locally (at Group level). Mr Lewis asked for a further update at the next meeting.</p>	
<p><b>ACTION: Miss Dhami to present an update on the work to address the maternity risks at the next meeting</b></p>	
<p><b>15 Equalities plan</b></p>	<p><b>Presentation</b></p>
<p>Mr Lewis provided an overview of the proposed equalities plan. It was noted that the successful outcomes needed to be defined and getting the basics right was necessary. It was noted that the review of the workforce policies needed to be reviewed in respect of equality &amp; diversity and that the EDS2 self-assessment had commenced. As a next step it was noted that the switch to promoting diversity would be given attention. The new Director of Communications was noted to be being actively engaged in the work.</p> <p>The implementation of cultural ambassadors was reported to be underway, with a set of 10-20 individuals currently being recruited.</p> <p>The proposed results of the work were suggested to be as follows:</p> <ul style="list-style-type: none"> <li>(a) The proportion of band 8 and above senior leaders in the Trust with a protected characteristic rises (i) to the workforce profile and (ii) to local demography over a three year period</li> <li>(b) The Trust can demonstrate progress on EDS2 scoring over a two year period, with role-model teams reaching the highest ratings over time and</li> </ul>	



<p>no red rating being judged in 2016-17</p> <p>(c) The Trust achieves staff survey results for BME employees and patient survey results for all protected characteristics that display congruence</p> <p>(d) Our complaints, incidents and other indicators demonstrate no material discrepancy based on protected characteristics vs. the overall treated population</p> <p>(e) The Trust has active membership groups in key PC (more than half of statutory list)</p> <p>(f) The Trust successful bids for accreditation in this field from relevant bodies (NHS Employers, Stonewall etc)</p> <p>All were asked to provide comments on the plans by 22 August 2014.</p> <p>Ms Dutton suggested that work with external contractors needed to be incorporated within plans.</p>	
<p><b>16 Infection control annual report</b></p>	<p><b>SWBTB (8/14) 128</b> <b>SWBTB (8/14) 128 (a)</b></p>
<p>The Board was asked to receive and note the annual report.</p> <p>It was noted that the position was positive and that in the forthcoming year SSA infections, in addition to MRSA would be given attention.</p> <p>The Chairman asked whether training was a rigorous. He was advised that training would be part of routine business rather than separate. In terms of operating theatres, further work was needed, which reflected to some degree access and maintenance would be addressed between September to December. It was agreed that this should be a matter arising at the next meeting.</p> <p>Dr Sahota noted that ward D17 had been closed for 10 days in April 2013 and asked for the reason behind this. He was advised that the ward would have been closed pending confirmation of Norovirus and that as the ward was a gastroenterology ward, it was expected that there was more screening. It was noted that the closure could extend for several days pending confirmation of the infection.</p>	
<p><b>ACTION: Miss Barlow to provide an update on the work to improve the theatres environment at the next meeting</b></p>	
<p><b>17 Update from the meeting of Finance &amp; Investment Committee held on 25 July 2014 and minutes from the meeting held on 26 June 2014</b></p>	<p><b>SWBFI (6/14) 034</b></p>
<p>Ms Robinson presented an overview of the key discussions from the Finance &amp; Investment Committee held on 25 July 2014.</p> <p>It was reported that trajectories for 2014/14 were being considered and that actions needed to be taken to control spend to prevent an adverse year end</p>	



position.	
<b>18 Update from the meeting of the Quality &amp; Safety Committee held on 25 July 2014 and minutes from the meeting held on 30 May 2014</b>	<b>SWBQS (5/14) 044</b>
Mrs Hunjan presented an overview of the key discussions from the Quality & Safety Committee held on 25 July 2014. She reported that an update on Cardiology would be considered at the next meeting.	
<b>ACTION: Miss Barlow to present an update on the Cardiology recovery plan at the next meeting of the Quality &amp; Safety Committee</b>	
<b>19 Update from the meeting of the Audit &amp; Risk Management Committee held on 31 July 2014 and minutes from the meeting held on 24 April 2014</b>	<b>SWBAR (4/14) 030 SWBAR (6/14) 037</b>
Mrs Hunjan presented an overview of the key discussions from the Audit & Risk Management Committee held on 31 July 2014. She reported that there had been concern at the waived tender position and that the Board Assurance Framework had been considered which had generated a number of comments for improvement.	
<b>20 Any Other Business</b>	<b>Verbal</b>
There was none.	
<b>Matters for Information</b>	
<p>The Board received the following for information:</p> <ul style="list-style-type: none"> <li>• Midland Metropolitan Hospital Project: Monitoring Report</li> <li>• Foundation Trust Application Programme: Monitoring Report</li> <li>• Chief Inspector's visit – preparation plan</li> <li>• Nurse staffing levels</li> </ul>	<b>SWBTB (8/14) 130</b> <b>SWBTB (8/14) 131</b> <b>SWBTB (8/14) 124</b> <b>SWBTB (8/14) 124 (a)</b> <b>SWBTB (8/14) 132</b> <b>SWBTB (8/14) 132 (a)</b>
<b>Details of the next meeting</b>	<b>Verbal</b>
The next public session of the Trust Board meeting was noted to be scheduled to start at 1330h on 4 <sup>th</sup> September 2014 and would be held in the Anne Gibson Boardroom, City Hospital.	

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Signed: .....

Name: .....

Date: .....

Next Meeting: 4 September 2014, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

7 August 2014, Archer Ward @ Rowley Regis 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), Mr C Ovington (CO)





**In Attendance:** Miss K Dhami (KD), Mr M Hoare (MH), Dr N Trudgill (NT)

**Apologies:** Dr R Stedman and Mrs C Rickards

**Secretariat:** Mr Simon Grainger-Lloyd (SGL)






Last Updated: 29 August 2014

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
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	Deferred to the October meeting	
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	
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	
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 - update due at the October meeting	
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 September 14 meeting	
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	
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	Included as an update on the agenda of the September 14 meeting	
SWBTBACT.308	Patient story and iCares presentation story	Presentation	07-Aug-14	Include the arrangements for interfacing with GPs as part of the EPR discussions at the Board meeting in September	RST	04/09/2014	Included as part of discussions in the private session of the Trust Board in September	

SWBTBACT.309	Chair's opening comments and Chief Executive's report	SWBTB (8/14) 118	07-Aug-14	Present an overview of the proposals for 'mutual status' for NHS trusts at the September Board meeting	TL	04/09/2014	Provided as an annexe to the CEO report in September 2014	
SWBTBACT.310	Chair's opening comments and Chief Executive's report	SWBTB (8/14) 118	07-Aug-14	Circulate a briefing note concerning the strengthened arrangements for consent prior to the next Board meeting	TL	04/09/2014	Included as an update on the agenda of the September 14 meeting	
SWBTBACT.312	Corporate integrated dashboard	SWBTB (8/14) 120 SWBTB (8/14) 120 (a)	07-Aug-14	Investigate and update Mr Lewis concerning unplanned reattendance rates	RB	04/09/2014	Verbal update to be provided as part of consideration of the integrated performance report	
SWBTBACT.313	System resilience: elective and non-elective care planning and performance update	SWBTB (8/14) 121 SWBTB (8/14) 121 (a)	07-Aug-14	Present the System Resilience Plan at the next meeting	RB	04/09/2014	Included as an update on the agenda of the September 14 meeting	
SWBTBACT.317	Financial performance – Month 3	SWBTB (8/14) 126 SWBTB (8/14) 126 (a)	07-Aug-14	Present a benchmarked position concerning seven day working at the October meeting of the Board	RB	02/10/2014	ACTION NOT YET DUE	
SWBTBACT.318	Trust risk register update	SWBTB (8/14) 127 SWBTB (8/14) 127 (a)	07-Aug-14	Present an update on the future of acute Oncology at the October meeting of the Board	TL	02/10/2014	ACTION NOT YET DUE	
SWBTBACT.319	Trust risk register update	SWBTB (8/14) 127 SWBTB (8/14) 127 (a)	07-Aug-14	Present an update on the work to address the maternity risks at the next meeting	KD	04/09/2014	Included within the risk register update considered by the Board in September 2014	
SWBTBACT.320	Infection control annual report	SWBTB (8/14) 128 SWBTB (8/14) 128 (a)	07-Aug-14	Provide an update on the work to improve the theatres environment at the next meeting	RB	04/09/2014	Included as a matter arising on the agenda of the September Board meeting	
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 letters : '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) . Implementation commenced in August.	
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	Update received at the Quality & Safety Committee and also include on the agenda of the Trust board on 7 August 2014	
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 discussion of the Trust Risk Register at the August meeting	

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 discussion of the Trust Risk Register at the August meeting	
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	
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	
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	
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	
SWBTBACT.311	Corporate integrated dashboard	SWBTB (8/14) 120 SWBTB (8/14) 120 (a)	07-Aug-14	Circulate a note providing an updated position on mortality (SHMI)	TW	04/09/2014	Presented to Quality & Safety Committee on 29 August 2014. The report showed differences in mortality rates between the two main sites, however there was no suggestion that this reflected a variation in the quality of care	
SWBTBACT.314	Publication of patient safety on NHS Choices	SWBTB (8/14) 121 SWBTB (8/14) 121 (a)	07-Aug-14	Circulate a comparative analysis of NHS choices patient safety information	KD	04/09/2014	Circulated separately to Board papers in September 2014	
SWBTBACT.315	CQC Intelligent Monitoring	SWBTB (8/14) 123 SWBTB (8/14) 123 (a)	07-Aug-14	Present an update on PROMs at next meeting of the Quality & Safety Committee	RST	29/08/2014	Presented as requested - the report showed a mixed picture with further work to do to understand the position around knee replacements	
SWBTBACT.316	Annual plan 2014/15 monitoring report	SWBTB (8/14) 125 SWBTB (8/14) 125 (a)	07-Aug-14	Present an update on readmissions at the next meeting of the Quality & Safety Committee	RB	29/08/2014	Presented as requested - the report showed that further work was needed to address the readmission position, with attention needing to be focussed on a small number of specialties	
SWBTBACT.321	Update from the meeting of the Quality & Safety Committee	SWBQS (5/14) 044	07-Aug-14	Present an update on the Cardiology recovery plan at the next meeting of the Quality & Safety Committee	RB	29/08/2014	Presented as requested. Report showed although there was still much work to do to improve the performance of the speciality, good progress had been made with the recovery plan	

KEY:

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

## CHIEF EXECUTIVE'S REPORT

### Report to the Public Trust Board – September 2014

It has been a very busy month, and I apologise accordingly the longer than normal length of this briefing note.

Today's Board papers continue to focus on the basics of delivery. There remains a mixed picture of performance that illustrates both effort and improvement in our work to improve quality. But it also illustrates variation, with pockets of weaker performance, and a lack of resilience in which week in week, day by day, results vary. It will be next month's Board before we try and crystallise where we will focus additional attention in the second half of the year, as we publish our mid-year review. The debate around relative priorities from the performance scorecard today is therefore a key discussion. This is an opportunity to very clearly link our current work on productivity to the benefit both of our patients and the underlying finances of the local NHS.

The Board discusses in our private session today, for reasons for commercial confidentiality, the Electronic Patient Record procurement. An inclusive process has been run over the last four months to produce a specification for that important work. We have committed to implementation not less than twelve months before the Midland Metropolitan Hospital – which means that execution needs to complete in 2017. If we can secure change sooner we will do so, both because of the need to improve our IT, and because discretionary improvements in IT risk being delayed whilst the base position is improved. We are on track to complete our hardware resilience improvement to reduce risks of catastrophic IT breakdown during this financial year as planned. What is most interesting within the proposed EPR specification is our intention to maximise the patient portal opportunity to give patients access to their data. With our existing Patient Knows Best work we have some experience of the opportunities and pitfalls of this work.

Our Annual General Meeting takes place on September 25<sup>th</sup> (this year at City Hospital). This will feature a presentation from both patients and staff about existing innovative work we are doing to use technology in clinical practice.

#### **1. Our patients**

Considerable attention has been focused over recent weeks on ensuring that we have clear and appropriate measures in place should patients with suspected Ebola virus use our services. Colin Ovington is leading that work and I am satisfied that we have the relevant supplies and protective equipment in place. We are also clear what measure of isolation of two acute sites can support.

The papers today make clear the latest waiting time positions for the organisations which show either improvement or stability, but not deterioration. As promised we are meeting the diagnostic waiting time standard once again consistently and will now press ahead to try and reduce below six weeks the diagnostic wait. This intention is driven by recognition that this wait is a period of

uncertainty for patients and also that reducing this portion of delay will improve our overall 18 week pathway. Although we continue to meet the Trust level 18 week standards, our specialty position remains inconsistent. The revised commitment issued in submissions to commissioners earlier this summer was to meet the standards in Q4 at specialty level. Of course this depends on demand stability and supply availability over winter months. We will not undertake premium rate activity and employ agency staff to meet the standard unless there is a manifest clinical risk in delay. We are determined to create a sustainable system of planned care provision at sub-specialty level.

The outpatient change programme is gathering pace. Though satisfaction levels among the 22,000 patients who have responded to our feedback tracking, is broadly high, there remains dissatisfaction with our booking processes, and missed opportunities to reduce visits to hospital. The first months of this year have been spent planning the various IT and process changes due to be implemented in Q3 and Q4. We are very conscious that change in outpatients has been pledged in the Trust over many, many years and demonstrating credible transformation from good to great is now required. Of course the shift to greater use of IT may be daunting for some staff and patients, although trials within BMEC have been very positive. We can see at UHB or in local GP practices that it is wholly possible to work in this way. With some of the released staff time, and potentially in time with greater use of volunteers, we want our outpatient departments to be able to help and support patients with confusion or questions and spend less time on basic repetitive processes.

The Board focused time last month of cancer services. A full report, in my name, will come to the Board next month outlining the changes we now intend to make. It is very clear in preparing for stakeholder events during September that there is variation in clinical pathways between our sites, as well as a lack of clarity about accountability structures where we partner with other organisations or buy in care. Cancer care is inevitably a multi-clinician, multi-partner aspect of healthcare and it is therefore very important that roles are clear and understood. No options for change at this stage can be ruled out, other than adjustments which reduce access for patients. This Trust has some outstanding cancer services, including the specialist centre with the lowest mortality rate in the UK for gynae-oncology, and research rich medicine in breast care and colorectal surgery. Our tradition of patient involvement and inclusion is strong and our annual cancer celebration event takes place this year in early October.

At Rowley Regis we operate a primary care assessment and treatment centre, in partnership with local GPs. The latest commissioning review of that service is a positive one and we are hopeful that CCG funding will be confirmed through to April 2015. The Board heard at its last meeting about this and related services, and we are optimistic that as the unit beds into local provision it cannot become part of how WMAS respond to local urgent care need between Dudley and Sandwell.

Finally, our 10/10 programme starts in earnest in coming days. This is a small change and a very big one in our approach to safety. A small change in that the commitments in our checklist are all things that we currently do. A big change in that we are committing that they will be done within the first 24 hours on a ward and committing to be very visible at ward level about their completeness. We are also inviting our patients and relatives to speak up if they have concerns that they have not been completed and acted upon. This programme is directly derived from analysis of our complaints and incidents, in which it is clear that the best of what we do, could more consistently delivered.



## 2. Our colleagues

Everyone within the organisation is aware of the work that has been going on from some time but not intensifies to make sure that our workforce is aligned to the needs of our patients, the volume of care we need to provide, and the cost-base that the NHS can afford. The recent focus on our long-term position helps us to make sure that where we have retraining and redeployment opportunities those are put in place sooner rather than later. The short term focus remains on eliminating, or dramatically reducing, our use of agency staff, and moving away from a reliance on unplanned premium working and overtime. The commitment to colleagues and their managers is that we work swiftly and safely this autumn to provide clarity about roles for 2015 and 2016. In some cases we know that changes we are committed to alter our workforce needs – so use of IT in clinic for instance reduces administrative requirements, in other cases we will need to make choices about the productivity changes that can be made to reduce the scale of our paybill. The overall focus remains on spending more of each pound on patient care and reducing overheads and layers of supervision where we can. Whilst that is the principle there is no one size fits all solution, just as there is no single descriptor of either morale or staffing levels in a large organisation. Though unrelated it is worth drawing attention once again to the investment we made a few weeks ago in additional counselling support services to try and tackle the proportion of our sickness rate that relates to stress and mental ill health.

Over 400 nominations have been received for our Staff Awards, the most ever. The shortlist has now been published, after a judging panel led by Richard Samuda. Healthwatch has assisted us in shortlisting for the excellence in care award, which is based on patient and community nominations. As last year, three awards will be subject to staff vote from the shortlist, and that detail will be issued with September payslips. I very much hope that the ceremony on October 17<sup>th</sup> provides a chance to celebrate and showcase the dedication and talent that we have across the organisation. During August we held the first of our new Long Service award ceremonies. Invitees who had 20-40 years NHS service effective in Q1 this year were invited and over half found time to come to hear from Richard and to receive medals and certificates. This will be a quarterly celebration of the service and of course the flexibility of many people who have built a whole career with us.

That flexibility will be important as move through the upcoming workforce change process. Equally it will be important that that process does not unwittingly drive out innovation may removing roles that are unique or that are pilots for role re-design. We are alert to that risk in respect of physician's assistant and the apprenticeship programme that we have in place. I am delighted to confirm that we have secured match funding from the University to support the Trust's first Consultant Physiotherapy appointment. That post will drive both service change and research, especially within MSK services in the years ahead. I very much hope that creating a clear career structure right to the most senior level for therapists at the Trust maintains our apparent distinctive recruitment pitch for these staff. Of course, the role is also an opportunity to reinforce the idea that clinical seniority does not require a move into management or less face to face time spent with patients.

There is considerable national publicity presently in relation to both hospital food for patients and for staff. Rowley Regis sees the most positive patient reviews for food. Though the food is the same, other sites have a more mixed position. Our food offer changes in the months ahead in various ways, including the move to a single main meal daily at dinner time. There is some evidence that satisfaction with the food reflects less the innate quality and more whether people get what they have ordered. Clearly in our more acute sites throughput is such that the evening occupant may not be the person who placed the daytime order. Our shift to iPad-based ordering should help us to

shorten the order lead time and reduce that issue, as well as allowing us to make it more difficult for food near misses to occur around puree restriction and other dietary rules. That goes into place in the next two months. In October we, subject to confirmation at the CLE committee on September 12<sup>th</sup>, will implement the Board's agreed Public Health strategy in relation to canteen food. That introduces greater subsidy of, information about, and prominence for more healthy options, and, controversially, it makes more expensive (high street prices) less healthy options. Ruth Wilkin will oversee in her first few weeks the communications effort on this work which has huge potential benefits, but clearly will occasion some disquiet from some staff at a time of nationally determined low wage rises.

### **3. Our partners**

During the autumn we will contribute to the recruitment work for children 14-18 to enrol in the new University Technical College in Sandwell, for which the University of Wolverhampton is the academic sponsor. This has a focus on health and social care, and alongside the Ambulance Trust, we are a key partner (note my declaration of interest). Our Learning Works team have played a key role in helping to support curriculum development, and the new building for the UTC opens next year on West Bromwich High Street. Our involvement reflects the Board's commitment to the next generation of NHS staff, and to the idea that work within our service is a career, not simply a job. Many of our staff are keen to play a role in developing local young people into health service careers and we are discussing with the UTC how that faculty opportunity might best fit with day to day work.

With the announcement of the business case approval for the Midland Met, we have participated in a renewal discussion around the governance of Right Care, Right Here. This encouraging discussion focused not on the building, but on out of hospital care transformation in the next four years. We also agreed that RCRH would be the vehicle through which we sought to implement system wide public health work targeting SWB 2030 and ensuring that our long term health need locally was reduced. Healthwatch is engaged with RCRH and discussion continue about how best to ensure public oversight and involvement in the changes that were agreed in 2007 and we continue to implement them, most evidently with the closure of two A&E departments in 2018.

The issue of the Midland Met Pre-Qualification Questionnaire (PQQ) has been completed to time and the recommendations for next stage shortlisting come to the Board in private. Likewise the invitation to participate in dialogue has now been issued in final form, having been issued in draft in July. Again this is running to timescale. The Trust is continuing to receive insightful assistance from IUK on behalf of Treasury, and the first TDA-Trust-Department of Health-Treasury Partnership Board takes place at the end of September: This quarterly review will ensure that the procurement timetable and the remaining approval stages proceed to plan.

### **4. Our regulators**

The CQC undertook an unannounced review of child safeguarding services in Sandwell (all NHS) during August. The visits were geographically focused in that they did not consider services at City Hospital to Sandwell children, other than visiting the maternity unit which is based there. The feedback in writing is awaited and oral feedback accorded with our own insights into strengths and weaknesses. Both Local Authorities are in the process of revising their governance arrangements, as well as service models for safeguarding, and in November, we will schedule a discussion at the full Board on our place within that wider system. By then we expect to have the outcome of the CQC visit.

It has recently become clear that commissioning bodies locally undertake a quarterly assessment of provider's status. This review was not something to which providers had access or insight in the past. Correspondence with the Local Area Team has now confirmed new arrangements for ensuring that we are aware of formal judgements made about the care we provide and the basis for those judgements. The Trust is one of many locally to be judged to need enhanced surveillance. This does vary from the current TDA position, although that reflects differing calibration of the same data, as well as some divergent frames of analysis. We have requested the opportunity to outline our response to the quarterly assessment in September and are in particular keen to ensure a common view between regulators on our serious incident position. The Trust Board has reiterated previously that a high reporting rate of incidents is, in principle, a strength in our system, and we want to agree with other parties what additional indicators of relative concern are considered in this domain.

## **5. Feedback from Hot Topics**

During August and September, both Hot Topics have been and will be focused on our CQC work. In addition from September 3<sup>rd</sup> we have a series of open staff forums with me on all sites both in and 'out of' hours to talk about the inspection, the implication of Midland Met, and other matters of concern for colleagues. Specific medical secretary forums have also taken place over recent weeks to ensure collaboration in the design of future roles. These have been really well attended and provide an excellent basis for work together in the future. A further series of forums will be scheduled for November.

**Toby Lewis**  
**Chief Executive**  
**29 August 2014**

## REPORT TO THE PUBLIC TRUST BOARD

### NHS Mutuals – briefing note

1. Professor Chris Ham recently published a review of work on staff engagement and devolved decision making. This contains a conclusion that a mutual model might be of interest to health services in driving up engagement. It also notes that the acute sector has less diversity of ownership models than other sectors of care, although it does not, in my view, present compelling evidence that this leads to lower engagement.
2. As we discussed at the Board's August meeting, on July 28<sup>th</sup> Ministers requested expressions of interest in becoming one of ten pilot sites to consider the opportunities, barriers and practicalities of extended a mutual model into the NHS on a larger scale. These pilots will each receive £100,000 to work on this over the next six months, as well as benefitting from peer collaboration on this work with the other pilots. EOI are due by Thursday September 4<sup>th</sup>, as the first stage in a two stage bid process.
3. The invitation to bid suggests that the 'outcomes from this work will feed into the Government's broader programme of work in 2015-16 to enable a range of new options for providers of NHS care, alongside recommendations resulting from the review being led by Sir David Dalton'.
4. After discussions with relevant executive colleagues, including incoming members, and with our Chairman, I make the following suggestions to the Board:
  - Our interest in and commitment to employee engagement is not at question. We have a history of such work, which continues, and our Your Voice model gives us good and extensive data on how that engagement deploys variously across our Trust.
  - We have an interest in organisational form, which we are exploring in our FT pipeline work, and through our community engagement work which builds to the start of our 'shadow governor' roles in late 2014.
  - The time period of the pilots is an immensely busy one for us, with the CQC visit and resultant action plan, preparing for the Better Care Fund, confirming our preferred PF2 bidder, and securing EPR approval. It is not obvious that we have the headroom to devote to this successfully.
  - As the circular makes clear this work is an entrée to further guidance and policy after a General Election. Though I would suggest that we continue to explore the scope for changed forms in examining our FT intent, I do not believe that we should put forward for this programme at this time.
5. Chris Ham's Review can be accessed at <http://www.kingsfund.org.uk/sites/files/kf/field/field-publication/file/improving-nhs-care-by-engaging-staff-and-devolving-decision-making-jul14.pdf>

**Toby Lewis**  
**Chief Executive**  
**August 28th 2014**

**TRUST BOARD**

<b>DOCUMENT TITLE:</b>	Chair's action for negotiated tender for D46 conversion works				
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Graham Seager, Director of Estates				
<b>AUTHOR:</b>	Graham Seager, Director of Estates				
<b>DATE OF MEETING:</b>	4 September 2014				
<b>EXECUTIVE SUMMARY:</b>					
<p>1.1 The Trust has responded to an invitation to tender from Clinical Commissioning Group Service Resilience Group which required the provision of 20 flexible, level 2 beds (intermediate care/interim care) for 6 month pilot</p> <p>1.2 Timescales of the service tender precludes works tendering and required the use of Chairs action.</p> <p>1.3 This report is to report the use of Chairs action in Public Session</p>					
<b>REPORT RECOMMENDATION:</b>					
The Board is asked note the use of Chair's action to single source the supply works					
<b>ACTION REQUIRED</b> <i>(Indicate with 'x' the purpose that applies):</i>					
The receiving body is asked to receive, consider and:					
<b>Accept</b>		<b>Approve the recommendation</b>		<b>Discuss</b>	
X					
<b>KEY AREAS OF IMPACT</b> <i>(Indicate with 'x' all those that apply):</i>					
Financial	X	Environmental		Communications & Media	
Business and market share		Legal & Policy	X	Patient Experience	
Clinical		Equality and Diversity		Workforce	
Comments:					
<b>ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:</b>					
21 <sup>st</sup> Century Facilities					
<b>PREVIOUS CONSIDERATION:</b>					
Not previously considered					

**TRUST BOARD**

<b>DOCUMENT TITLE:</b>	<b>Changes to the Consent Process</b>
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	<b>Toby Lewis, Chief Executive</b>
<b>AUTHOR:</b>	<b>Allison Binns / Dr Roger Stedman</b>
<b>DATE OF MEETING:</b>	<b>4 September 2014</b>

**EXECUTIVE SUMMARY:**

Following two never events in which failure to properly obtain consent was identified as either a direct or contributory causal factor - the newly set up 'never events assurance committee' has been tasked with implementing a change to the consent process.

Failure to obtain informed consent presents safety risks to the patient, risks of litigation to the Trust and risks to the professional registration of the clinician

This paper outlines the proposed change to the consent process for all elective procedures that are booked following an outpatient attendance. It also outlines the consequences of the failure to follow the process. Also presented is a draft of the proposed letter to all clinicians.

Further work is required to identify all procedures that are carried out on a direct access basis (i.e. procedures carried out at the same time as the decision to treat, e.g. outpatient procedures). A different process will be developed for these procedures.

In addition consent in the emergency setting and in the setting where patient's lack capacity to make their own decisions require additional work.

We will report to the Board in December progress on these issues.

**REPORT RECOMMENDATION:**

The Board is requested to consider the actions being taken. In particular consider the risk to patients of cancellation on the day of surgery as a consequence of implementing this policy change.

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

The receiving body is asked to receive, consider and:

<b>Accept</b>	<b>Approve the recommendation</b>	<b>Discuss</b>
X		X

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

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

Comments:

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

Safe High Quality care

Never Events and Never Events Assurance

**PREVIOUS CONSIDERATION:**

Discussed as part of the Never Events controls assurance report considered by the Board in July 2014

## **CONSENT PROCESS FOR ELECTIVE PATIENTS (NON-DIRECT ACCESS)**

### **REVISED ARRANGEMENTS**

#### **REPORT TO THE TRUST BOARD – 4 SEPTEMBER 2014**

##### **1. Introduction**

The Consent process for elective, direct access and emergency patients requires revision because repeated audits have shown that in a significant minority of cases it is not being carried out with sufficient rigour. This has implications both for patient safety and is also a prima facie breach of the law. Poor consent practice has also contributed directly to one never event and indirectly to at least one other.

The most recent audit results showed that in only 74% of eligible cases was there evidence to show that consent was taken before the day of the procedure. In 39% of cases where consent was taken on the day, it could have occurred prior to the admission and this cannot be confirmed. Equally we could only evidence that patients were provided with supporting written information in only 28% of cases. We know operationally that not all specialties are consistently undertaking pre-operative consent at listing.

Equally, following a visit in the autumn 2013, the CQC were concerned about taking of consent, admittedly regarding consent on a broader scale than just that taken during interventions or procedures. In 2012 the Trust was subject to a 'Rule 43' notice from the coroner requiring us to improve the process of informing patients and families and obtaining consent for DNACPR orders.

##### **2. The new approach**

This is an issue of poor process. Accordingly we are implementing new processes from October 1<sup>st</sup>. Those processes for planned care and for direct access are clear. An audit of current practice for emergency care will be undertaken in October as clearly the issues involved are different.

For planned care patients:

- Patients will have part one consent undertaken when they are added to the waiting list
- From October the electronic waiting list addition form will not be accepted unless the clinician confirms that part one consent has been taken and documented. Incomplete forms will be escalated immediately to the directorate general manager.

For direct access patients:



- At the time of appointment booking written material will be issued to the patient together with detail of who to contact prior to the day of the procedure should they wish to discuss that information in more detail

This approach should ensure prospectively that we comply with our own expectations.

Arrangements are being put in place to assess how we tackle patients listed for surgery who have not yet had written consent. We will orally update on that matter at October's Board meeting.

Where a patient attends and has not had part one consent obtained in advance, the patient will be given the option to book another date or to proceed. Where they wish to book another date, this will be arranged within 28 days.

The revised process for elective procedures can be found at appendix 1.

All healthcare professionals must take consent ahead of admission for the procedure, usually in clinic. The consent form will be completed at this time by someone capable of performing the procedure or with the approved delegation and will include:

- Patient details
- Proposed procedure
- Risks and Benefits
- Additional procedures
- Information leaflets/media
- Type of anaesthesia
- Signature of clinician giving information and date given

***NB: All sections (as detailed above) on the consent form must be completed even if it is to confirm that the section is not relevant or no information was given.***

**The name of all patient information leaflets/DVDs given must be clearly documented.**

**The clinician taking consent will circle that the patient has received the white copy of the consent form and this copy must be handed to the patient, together with all appropriate patient information discussed with the patient.**

#### At Pre-Op Assessment

If the patient attends pre-op assessment, staff carrying out the assessment will check that the gold copy of the consent form is present in the notes and ask the patient if they have received sufficient information regarding their procedure.

If the form is missing or the patient requests further information then the pre-op assessment staff will contact the clinician to come and complete the consent process. In this instance the non-compliance procedure will be invoked but the patient will not be cancelled.

On admission

On admission, clinical staff receiving the patient will check whether the gold copy of the consent form is within the records and completed with the information above. If it is not present or fully completed they will:

- Immediately contact the person carrying out the procedure who will be required to:
  - personally discuss the situation with the patient, provide an apology and give the patient an explanation;
  - arrange for them to have consent taken at a time suitable to the patient; and
  - rebook the patient that day for the procedure at the earliest opportunity but within 28 days
  - In circumstances where it is particularly problematic for the patient to be re-scheduled (e.g. where they have care commitments or difficult domestic arrangements or they have previously been cancelled) – and the patient is willing to give consent on the day and wishes to proceed on that basis then dispensation may be sought to do so.
- Complete an incident form detailing the cancellation of the patient, that day, stating the name of the person who listed the patient for the procedure.

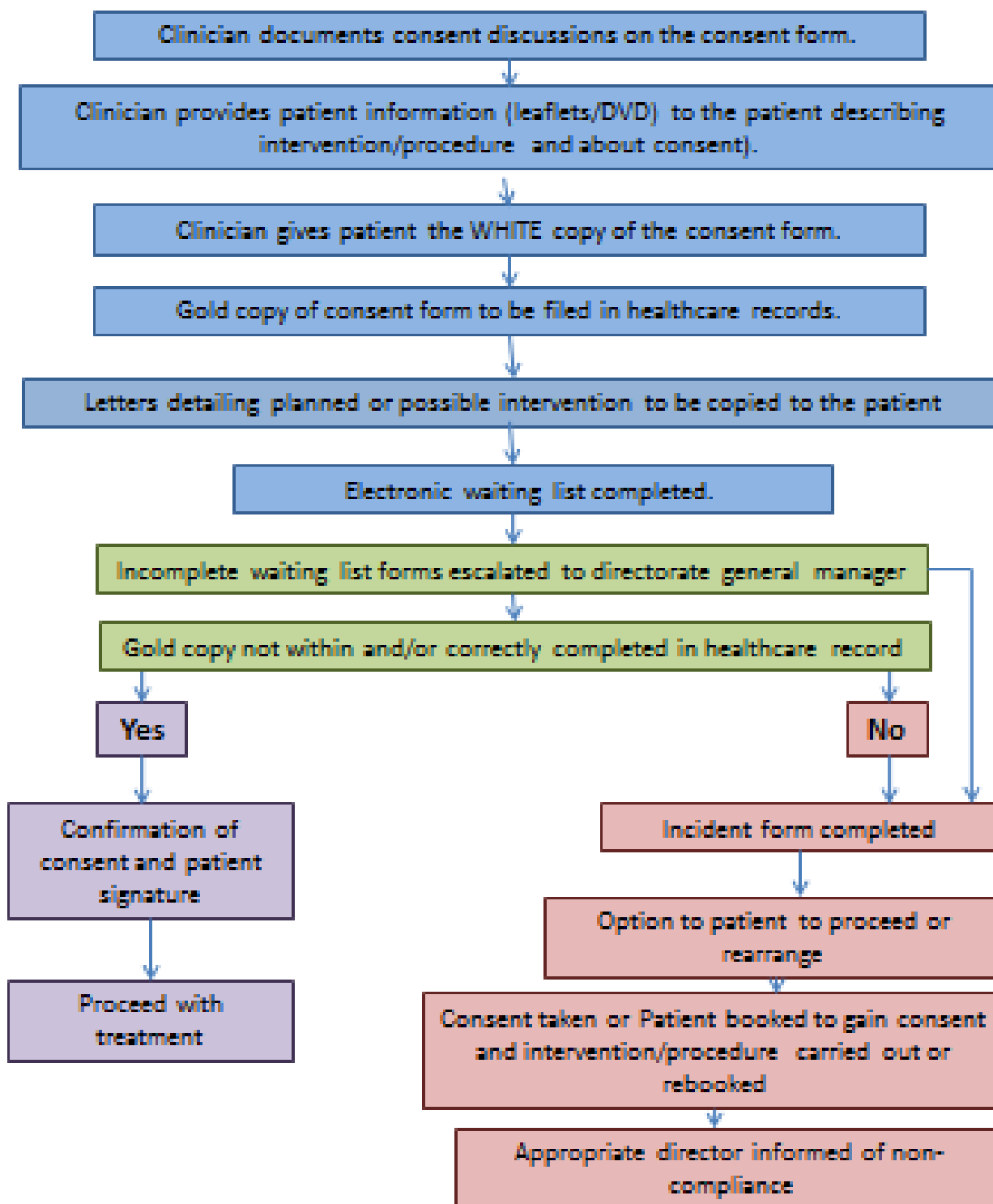
3. Implementation monitoring

We will write to all clinicians on September 5<sup>th</sup> outlining again this expectation. With effect from December 1<sup>st</sup> the following action will be taken for cases of non-compliance added to the waiting after October 1<sup>st</sup>.

- **1<sup>st</sup> non-compliance:** Within 2 working days of the incident being reported to them, the CD will meet with the clinician. Supportive discussion will centre on the individual/team practice regarding taking correct informed consent, any changes required to ensure that correct practice is followed and agreement of a plan for correction and monitoring, including the timescale. This meeting will be documented and retained within the clinician's personal file.
- **2<sup>nd</sup> non-compliance:** Within 1 working day of the incident being escalated to the MD or CN, a meeting will be convened with the named clinician and the CD. This will form a final discussion about the matter and will determine whether the individual continues to operate or needs a period of practice supervision.

- **3<sup>rd</sup> non-compliance:** Within 2 working days of the incident a meeting will be convened with the individual, medical director and Chief Executive. Written confirmation from the individual of their intent to follow the Trust procedure will be required. Failure to provide that confirmation will lead to action under the Trust's performance regime as defined in all employees contract of employment. The basis for proceeding will be a failure to follow a reasonable management instruction.

## Consent process for Elective Patients (non Direct Access)



**TRUST BOARD**

<b>DOCUMENT TITLE:</b>	<b>Year of Outpatients update</b>
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	<b>Rachel Barlow, Chief Operating Officer</b>
<b>AUTHOR:</b>	<b>Matthew Dodd, Deputy COO and Suki Heer, Project Manager</b>
<b>DATE OF MEETING:</b>	<b>4 September 2014</b>

**EXECUTIVE SUMMARY:**

The attached slide pack provides an update of the YOOP programme.

The programme is comprehensive and is making progress. The large number of electronic projects dominated the initial part of the year as specifications were worked up. A comprehensive workforce plan is in development for delivery over the remainder of the year. Demand and capacity planning in parallel with the 18 week recovery plan is in train to reduce waiting times.

**Patient experience**

The programme ambition is that 98% of patients rate our services as outstanding; 2 surveys have identified a majority of patients rate experience in Outpatients as very good. This is a positive benchmark from which we can further improve to meet our ambitious outpatient standards.

**OP standards**

Progress is being made against OP standards with improvements in DNA and cancellation rates however there is still more work to do. 36% of patients are currently waiting over 6 weeks to be seen in OP. Our aim is to reduce waits to less than 6 weeks for most specialities. All specialties have signed up to an 18 week delivery plan, reducing the backlog of long waiting times to treatment. The next stage is to agree trajectories for OP at 6 weeks and 4 week diagnostic waiting times. This will require different ways of working to release capacity. Specialties are working up delivery plans and local trajectories for confirmation in September.

**Improving what we do through technology**

Implementation of a number of E projects over Q3 and 4 will have impact on the standards:

- Electronic referral management: benefits in real time tracking and data quality
- Self check in kiosks: benefits in data quality
- E outcome and decision to admit: benefits in full cashing up of clinics and real time data management,
- Partial booking: benefits include elimination of cancellations and reduce DNA rates
- Voice recognition: benefits include standardised letter formats and communications to patients in 2 days

**Workforce changes**

The above innovations will have workforce implications; a wider workforce review is in train to review nursing and administration roles in OP to support elective care. The intention is to have roles that are patient focussed to track our more complex patient pathways efficiently and effectively. Voice recognition will result in less need for typing. The new workforce plan is being developed with engagement of key staff groups over August and September.

**Communications**

Over Q3 the review Directory of Services will be completed and standardised letters will be implemented. Both initiatives include primary care partners.

The complexity of the programme has been challenging to manage; the programme management has been reviewed and strengthened going forward with oversight from the Head of the Change Team.

**REPORT RECOMMENDATION:**

To note and discuss programme focus and progress

**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, previous Trust Board discussions

**PREVIOUS CONSIDERATION:**

The Trust Board has been appraised of the Year of Outpatients initiative on several occasions

# Year of Outpatients

**Aspiring for 98% of patients to rate our care as outstanding**

## **During 2014- 15 we are redesigning through:**

### **Implementation of E projects:**

- Electronic referral management
- Self check in kiosks
- E outcome and decision to admit,
- Partial booking
- Voice recognition

### **Implementing a workforce review**

- Administration review
- Nursing workforce review

### **Improving access and time to treatment**

- Demand and capacity planning – getting waits to below 6 weeks for OP
- Pathways - increasing discharge rate, follow up in different ways such as virtual clinic, primary care, Map of Medicine, diagnostics before OP where appropriate

### **Communications**

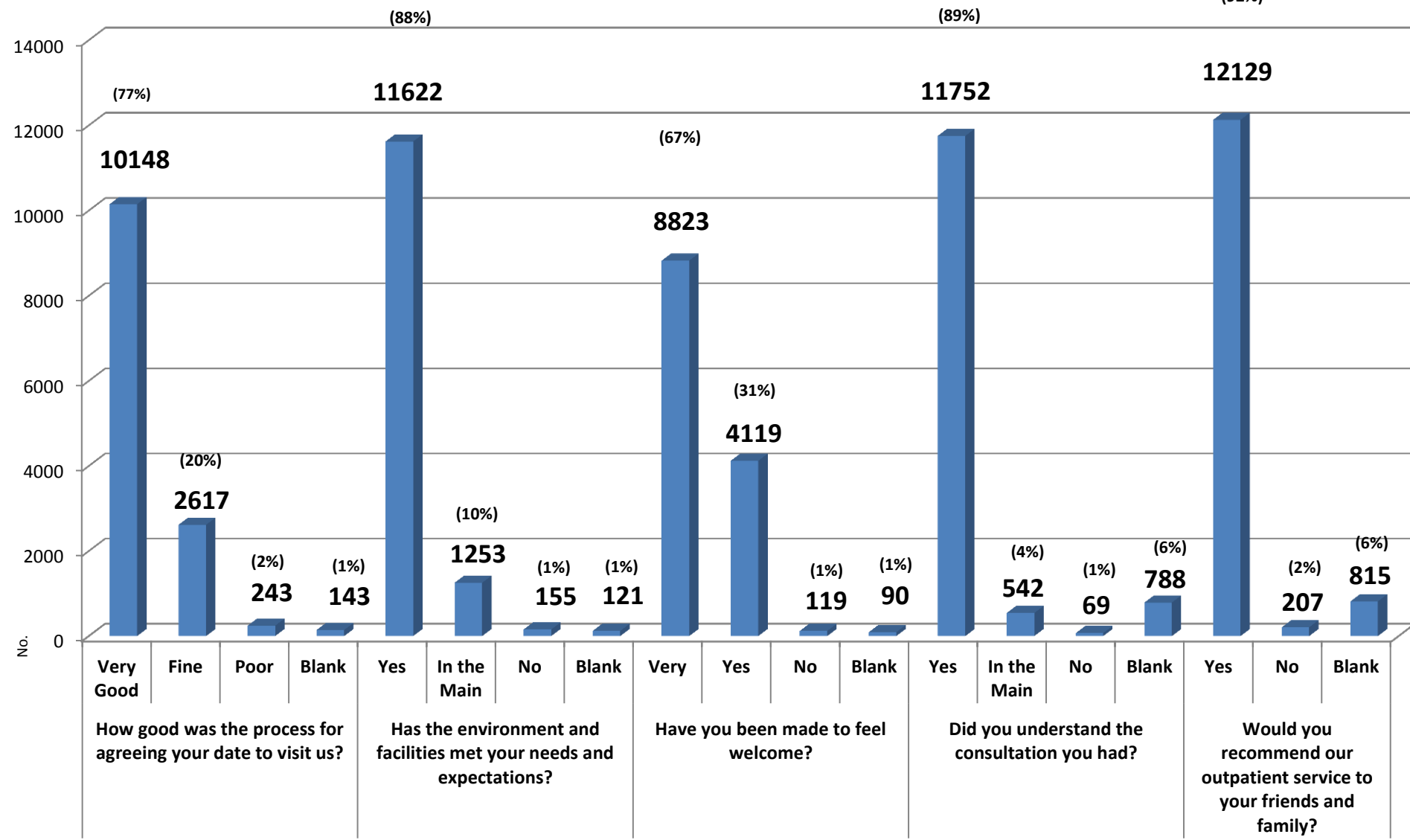
- Review Directory of Services
- Choose and book
- Letter content standards



# What are our patients are telling us? In April and July we surveyed all patients attending out patients; we got over 18,000 responses across the 2 months

## April - Outpatient Care – ‘How did we do today?’

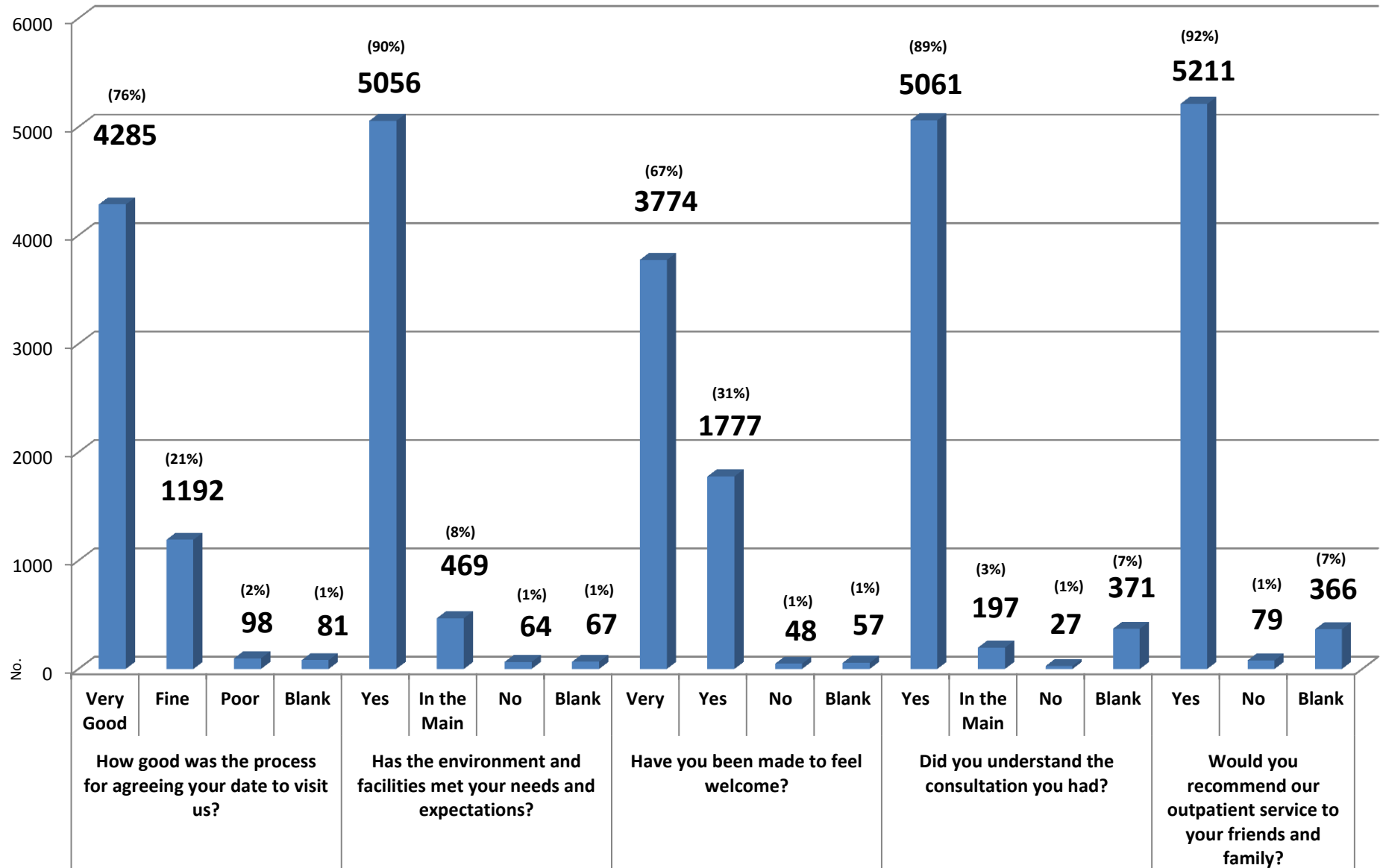
n = 13,151  
(23% Response Rate)  
(92%)



# The results showed a majority of our patients rated their experience as very good

## July Outpatient Care – ‘How did we do today?’

n = 5,656  
(9% Response Rate)



## **We aspire through the change programme to meet the 8 Outpatient Quality Standards**

- 1. All patients will be seen within 6 weeks of the hospital receiving their referral. All referral letters will be scanned into CDA within 24hrs of receipt**
- 2. The patient's first visit will always be to the correct clinic**
- 3. No patient will wait more than 20 minutes later than their appointment time to be seen**
- 4. By March 2014, no patient will have their clinic appointment cancelled by the hospital**
- 5. All patients will have their first appointment for diagnostics within locally agreed targets**
- 6. All patients will be investigate and treated according to the Directorate's agreed clinical pathways**
- 7. A documented outcome of an outpatient visit will be available to the GP electronically within 2 working days. All communications will be easily accessible within the Electronic Patient Record. All patients will receive a copy letter within 5 working days**
- 8. All patients will be given an opportunity to comment on the outpatient service that they have received**

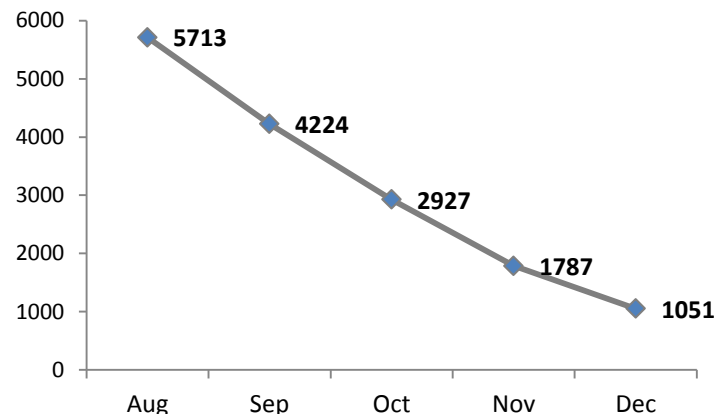
# Meeting the new OP within 6 week standard: we need to see more patients within the 6 week standard. Specialities will set their trajectories in September in line with the 18 week recovery plan

A. 22% of the current waiting list are 6+ weeks New Appointments (below)

August 2014	Waiting List	6+ weeks (New Appt)	%
100-GENERAL SURGERY	1467	229	16%
101-UROLOGY	1087	267	25%
110-TRAUMA AND ORTHOPAEDICS	2262	142	6%
120-ENT	1661	196	12%
130-OPHTHALMOLOGY	4717	923	20%
140-ORAL SURGERY	455	25	5%
160-PLASTIC SURGERY	261	30	12%
300-GENERAL MEDICINE	17	5	28%
301-GASTROENTEROLOGY	997	370	37%
320-CARDIOLOGY	1445	317	22%
330-DERMATOLOGY	1538	579	38%
340-Respiratory Medicine	988	470	48%
400-NEUROLOGY - ACUTE	840	251	30%
502-GYNAECOLOGY	1282	149	12%
X01-Other Specialties	6608	1759	27%
TRUST	25625	5713	22%

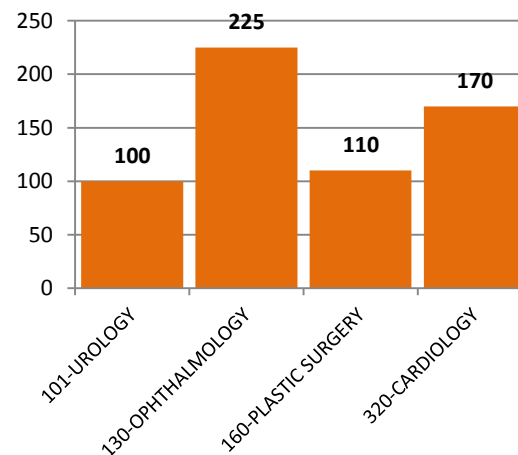
B. The New Appointment backlog will need reducing from 5071 to 1051 to achieve 90% of patients seen within 6 weeks (right)

Non Admit 6+ week backlog (new patients) to achieve 6+ week backlog (new|follow up) of 10% by End of December 2014



C. Certain specialties will need to undertake more work to achieve this (right)

Non Admit Patient Pathway clock stop extra numbers (Sept-Dec 2014)



## Actions to Achieve This

Standardise Clinic Templates

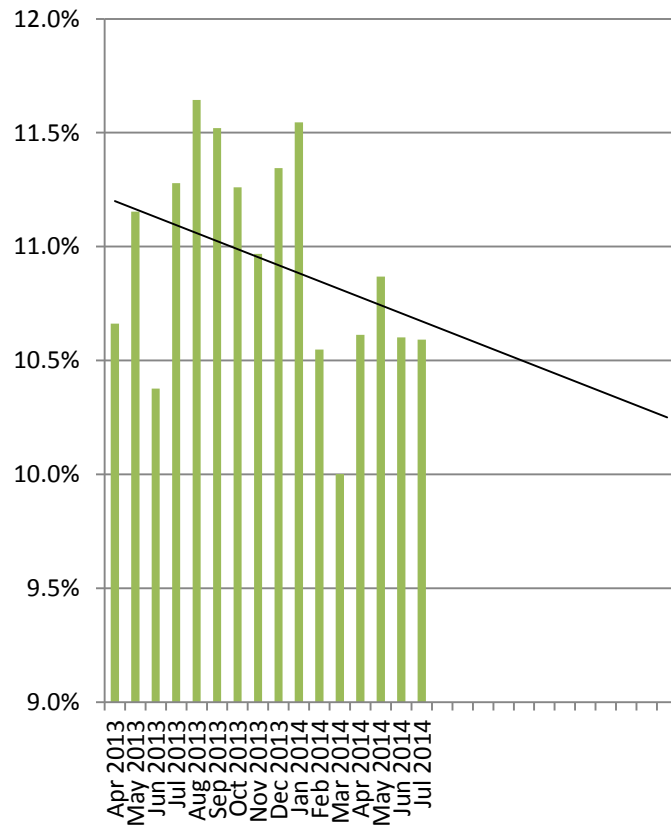
Realign New and Follow up appointment slots

Increased discharge rates

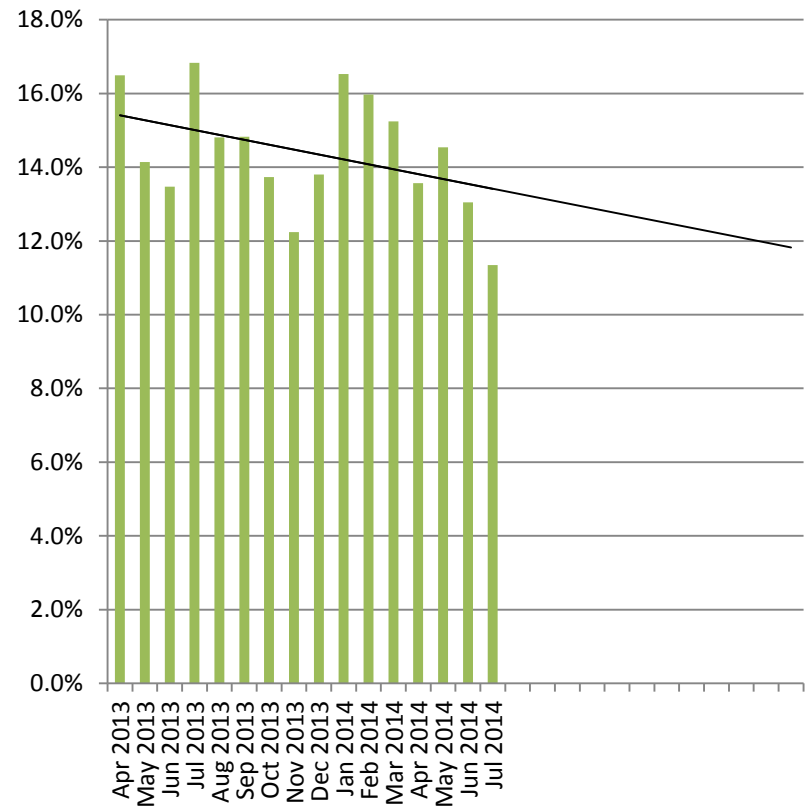
Pathway redesign to include Clinical Nurse Specialists , virtual clinics and diagnostics being carried out prior to initial appointment, therefore reducing the need for follow up appointments, which can be converted to new appointment.

Measuring what we do: DNA rates and hospital cancellations are too high, but are on a downward trajectory ; partial booking will mitigate the need for cancellations and reduce DNA by providing choice nearer to the time of appointment starting in Q3

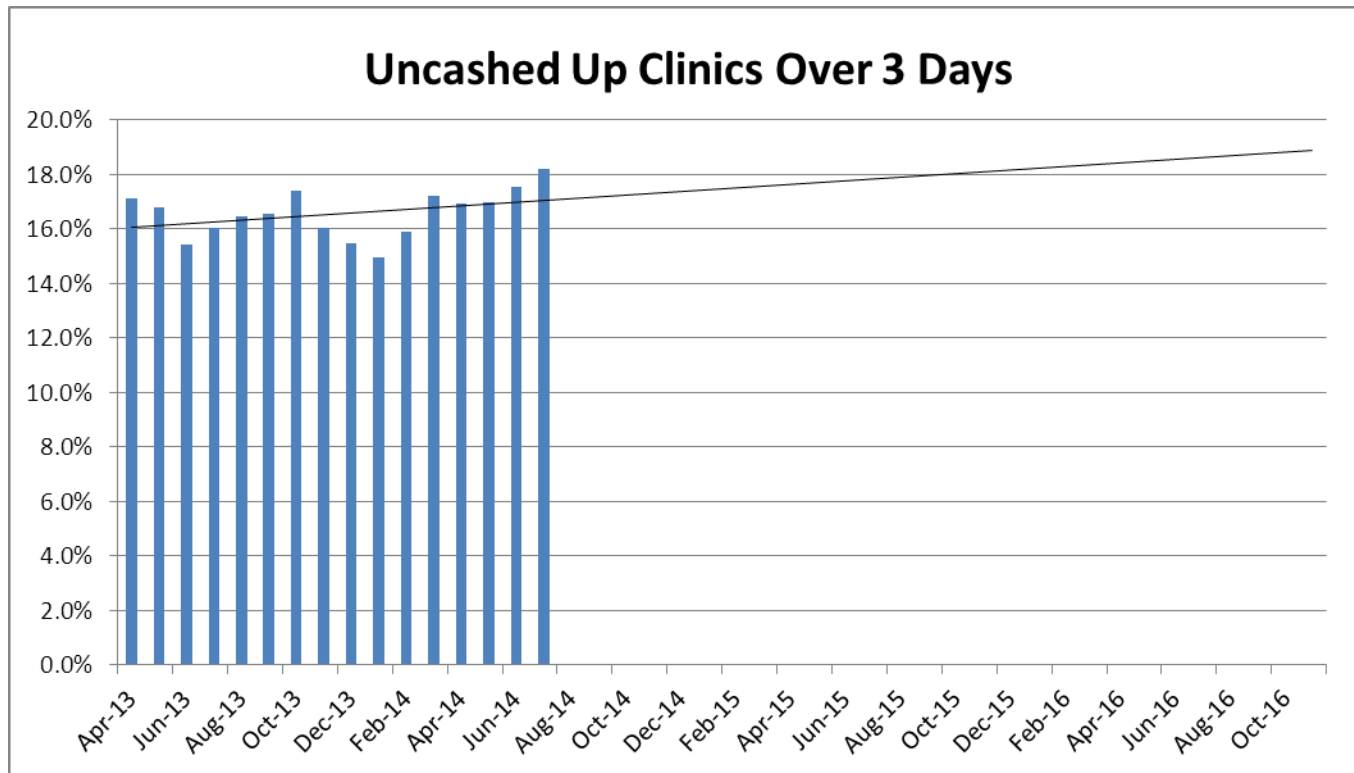
**DNA Rate**



**Outpatient Hospital Cancellations  
(as % of Appointments in the Month)**



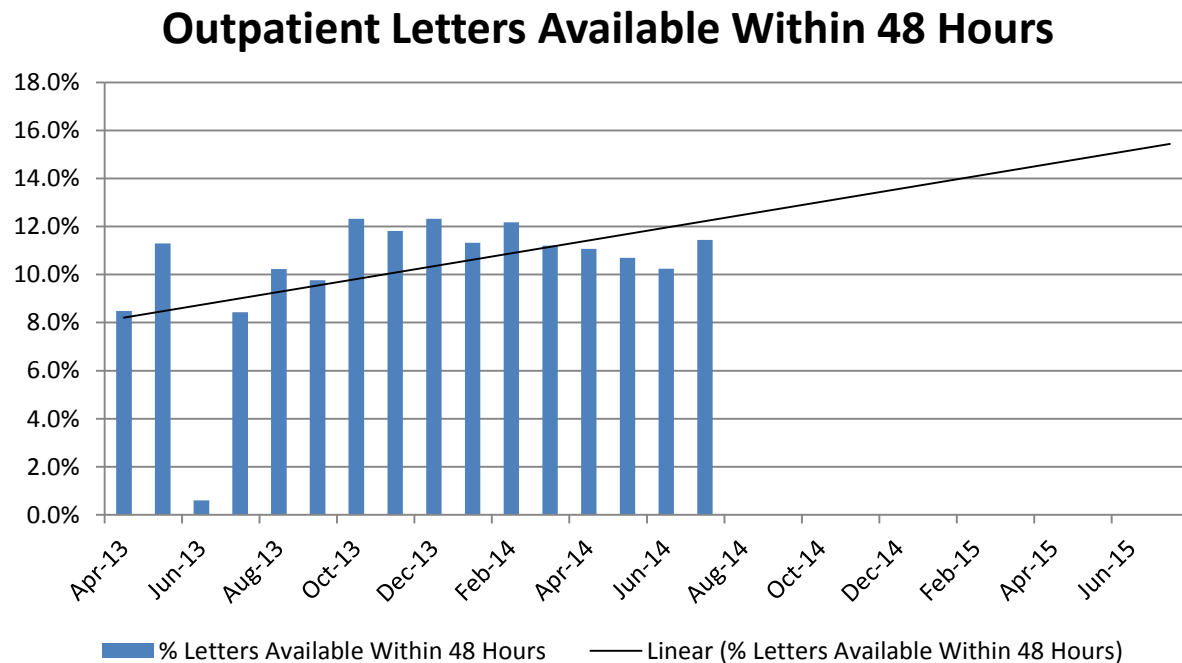
**Measuring what we do: our over all cashed up OP clinics in month have improved this year, but the real time cashing up remains a challenge. Performance will be improved through the introduction of electronic outcome forms that clinicians will complete in the clinics after seeing each patient**



**Measuring what we do: Discharge rates from OP clinics are in the 20% range with a 2% increase in Q1. Rates need to be improved to ensure that we are in line with the LTFM projections for MMH. Capacity & demand reviews of OP specialties will seek to identify ways of improving discharge rates through the use of virtual clinics and better tracking of patients awaiting results from diagnostic tests . This will enable capacity to meet the 6 week standards**

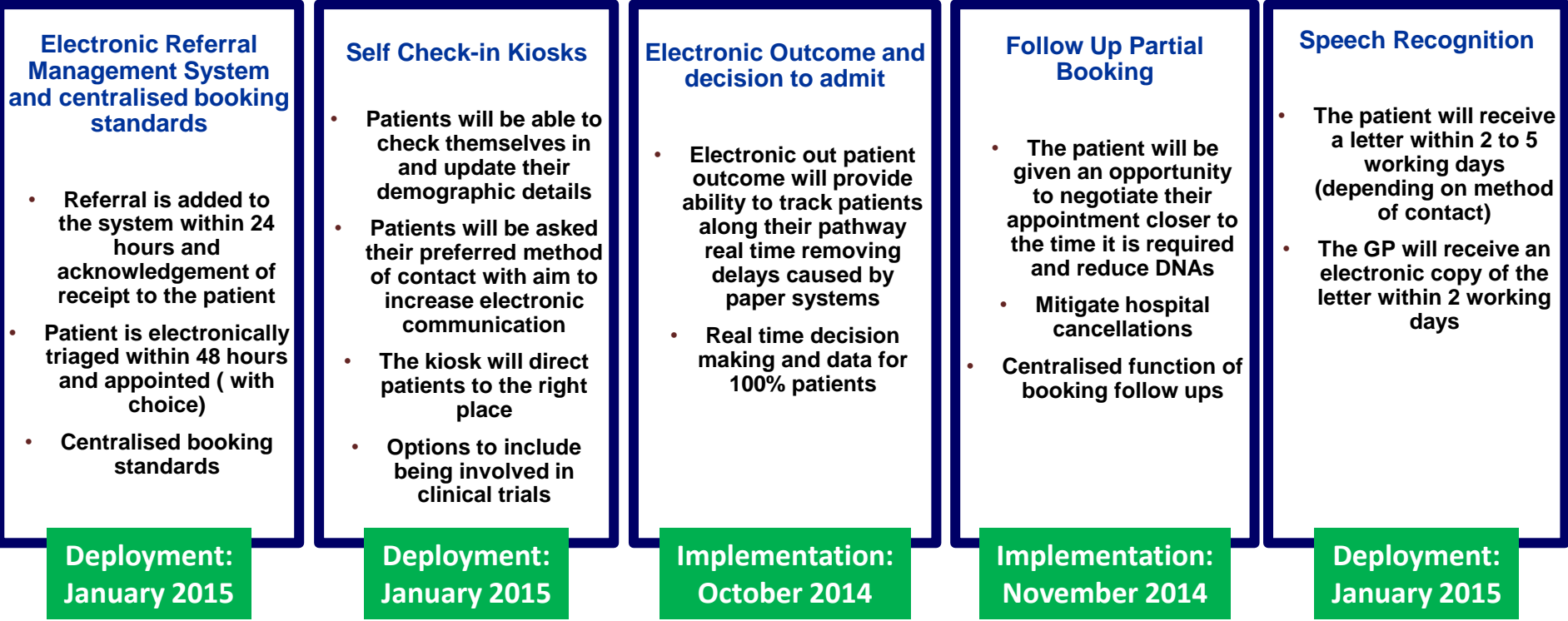
CMonth	Discharge d	Attended	% Discharge Rate (Outpatient ts)
Apr-14	12461	56290	22.1%
May-14	12091	56241	21.5%
Jun-14	11536	54840	21.0%
Jul-14	13365	60437	22.1%
Aug-14	11115	52035	21.4%
Sep-14	11802	54996	21.5%
Oct-14	13608	60967	22.3%
Nov-14	12505	57440	21.8%
Dec-14	10685	49747	21.5%
Jan-15	13014	59674	21.8%
Feb-15	11591	54246	21.4%
Mar-15	12719	58982	21.6%
Apr-15	11785	54510	21.6%
May-15	12034	55334	21.7%
Jun-15	13020	57680	22.6%
Jul-15	13733	59628	23.0%

**Measuring what we do: currently 10.9% of letters are available within 48 hours; with the introduction of voice recognition the turnaround times for letters to be dictated, typed and checked to meet this standard. This will involve significant change to the role of the Medical Secretary and the way clinicians work in Q4**





**Improving what we do using technology ; by investing in real time technologies, work force redesign, optimal centralisation and adoption of best practice we will put patients at the centre of a quality driven outpatient services that ensures the right care at the right time by the right person to improve clinical outcomes and patient experience**



**Elective Pathway – treat in appropriate order, complex pathways to be tracked**

Improving what we do through workforce redesign; as administration processes are automated and standardised there will be less need for the traditional roles of receptions and medical secretaries; the value of new roles in tracking patient pathways, retaining and empowering local team administration which is patient centred will require workforce change over the autumn

Centralised booking: Deployment: January 2015	Self Check in kiosks Deployment: January 2015	E- outcome and DTA Implementation: October 2014	FU partial booking Implementation: November 2014	Speech recognition Deployment: January 2015
<p>Staff working to centralised booking standards</p> <p>Currently 60% of our scheduling is centralised. Standards are variable.</p> <p><u>Through training and supervising staff in centralised standards but retaining local 'team' focus and relations we will be able to :</u></p> <ul style="list-style-type: none"><li>• Treat patients in clinical and chronological order</li><li>• Improve utilisation of resources be it OP or theatres</li></ul>	<p>Working differently to welcome patients and help them navigate our OP areas</p> <p>With check in kiosks there will be no need for reception desks</p> <p><u>Volunteers and patient assistants will circulate and welcome patients to our OP facilities; they will also assist with the check in kiosks for those that need help</u></p>	<p>Tracking patients through their RTT pathways</p> <p>Real time data will give us the ability to navigate and better coordinate assessment and care for patients on complex pathways ; eg scheduling tests and appointments in the right order, organising and dating treatment with the clinician and patients.</p> <p><u>Patient tracker roles will be developed over the autumn</u></p>	<p>Agreeing with the patient the follow up appointment</p> <p><u>A centralised and expanded function of booking follow up appointments</u></p> <p>Will decrease the need for multiple enquires and administration transactions in booking team and via secretaries</p> <p>Reduce letter output associated with cancelled or rescheduled appointments</p>	<p>Speech Recognition will decrease the need for typing and electronic communication the reliance on post</p> <p>Current Med sec roles across the Trust have variable role content. <u>The need to coordinate groups of clinicians and act as a advocate for patients remains and will be considered in the over all workforce redesign.</u></p>

**Engaging with staff; The OP workforce model is being developed over the course of September; the first round of engagement events have been completed with over 100 medical secretaries and a series of engagement events will follow with clinical and operational teams**

Reflections of the medical secretary engagement events :

- Good turn out and contributions
- Discussed what works well – and what doesn't
- Roles vary across departments as does medical secretary to consultant ratio
- Communication structures variable
- Issues with CDA identified
- Important relationships with patients – but not always empowered to enact solutions, so often relies on other departments to enable solution
- Medical secretary forum established to help shape Speech Recognition
- Considering a professional lead for secretarial and administrative standards for the Trust
- WTE impact of innovations being scoped
- Workforce design to take place over September – involving med secretary reps

## Risks to programme delivery

Risk	RAG	Mitigation
Programme management		Initial focus became narrowed to e projects; Additional support from Head of Change Team to programme manage and clear HR leadership identified for workforce change
HIS delivery		Specifications agreed; procurement timelines to be set at next YOOP Board; operational processes to be defined to support HIS products as part of implementation
Staff resistance to change		Early and open engagement processes
Finance		Money identified in capital plan

**TRUST BOARD**

<b>DOCUMENT TITLE:</b>	Integrated Quality, Performance and Finance Report
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Tony Waite, Director of Finance and Performance Mgt
<b>AUTHOR:</b>	Gary Smith, Head of Performance Management (acting)/ Mike Harding.
<b>DATE OF MEETING:</b>	4 September 2014 (Report prepared 28 August 2014)

**EXECUTIVE SUMMARY:**

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – July 2014.

**REPORT RECOMMENDATION:**

The Trust Board is 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
		<b>x</b>

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

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

Comments:

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

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

**PREVIOUS CONSIDERATION:**

Operational Management Committee, Performance Management Committee, Clinical Leadership Executive and Quality & Safety Committee.

Sandwell and West Birmingham Hospitals

NHS Trust



## **Integrated Quality and Performance Report**

**July 2014**

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# At A Glance

## Infection Control

The number of cases of C Diff reported during the month was 2, both at Sandwell. 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.

Both Elective and Non-Elective MRSA Screening performance continues to meet operational thresholds, although variation remains at Group and Clinical Directorate level.

## Harm Free Care

Overall Harm Free Care as assessed through the NHS Safety Thermometer continues to indicate a level of Harm Free Care (95.4%) exceeding operational performance threshold.

The number of Falls reported during the month of July were 65, a reduction from 75 the previous month. Included within this number are falls with a serious injury, which also fell from 4 during June to 1 during July.

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 5 Open CAS Alerts reported, 1 of which was overdue at the end of the reporting period (July), which has subsequently been actioned.

## Obstetrics

The overall Caesarean Section rate for July reduced to 24.2%, comprising 9.5% Elective and 14.7% Non Elective.

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 85.2, which remains beneath that of the SHA Peer. The City site HSMR remains beneath lower statistical confidence limits (70.4), with the Sandwell site HSMR (99.7), within statistical confidence limits for the most recent 12-month cumulative period.

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 (May) the overall Trust performance for review of deaths within 42 days was 85%, remaining above the improvement trajectory.

## 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 a significant increase (improvement) in the proportion of patients receiving thrombolysis within 60 minutes of admission to 88.9% and a decline from 100% to 93.8% in the proportion of patients receiving swallowing assessments within 24 hours (1 of 16 patients). The proportion of patients admitted to an Acute Stroke Unit within 4 hours remains reasonably stable at 75.0%, although less than the operational threshold of 90.0% and a reduction from 100% to 98.1% in those patients receiving a CT Scan within 24 hours of presentation.

## Cancer Care

The Trust continues to meet, for month (June) and year to date all high level Cancer Treatment targets, and continues to compare well against national data.

2 Groups narrowly failed to meet 93.0% operational threshold for the 2-week maximum cancer wait; Medicine (92.7%) and Women & Child Health (92.2%).

Surgery A (84.0% (34.0 / 40.5 patients)) and Surgery B (42.9% (1.5 / 3.5 patients)) also both failed to meet the 85.0% operational threshold for 62-day urgent GP referral to treatment. In Surgery B, in all cases breaches were where patient care had been shared with another provider.

## Patient Experience - MSA & Complaints

A total of 3 Mixed Sex Accommodation breaches were reported during the month of July, a further reduction (improvement) compared with recent months. The 3 breaches were all attributed to Critical Care. A report identifying the circumstances which led to the breaches has been produced and a reminder issued with immediate effect to staff of the escalation process which must be followed in the event of any potential breaches. Further actions are to be considered following an urgent meeting with the CNP / Capacity Team.

## Patient Experience - Cancelled Operations

Cancelled Operations remain at 0.9% during the month of July with a total of 36 SitRep declared late cancellations during the period. Of the 36 cancellations the greatest number (16) were in Surgery B.

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 July with performance of 94.11% (94.23% year to date (April - Aug 26th)). The report includes a copy of the TDA Recovery Plan trajectory with weekly performance aligned to this.

Delayed Transfers of Care further increased during the month to 4.3% (3.7% in June).

The proportion of patients admitted with a Fractured Neck of Femur who received an operation within 24 hours of admission during July was 61.5% (8 of 13 patients). Year to date performance is 65.2%.

## Referral To Treatment

All high level RTT thresholds were met during the month of July. Variable performance by Group is indicated in the body of this report.

Data for July is showing 3 patients that have breached 52 weeks, 1 in Gynaecology on an Admitted Care Pathway, 1 in General Surgery and 1 in Trauma & Orthopaedics, both on an Incomplete Pathway.

12 treatment functions failed the respective RTT pathway performance thresholds for the month of July.

Acute diagnostic waits in excess of 6 weeks remain below the maximum 1% threshold at 0.86%.

## Staff

PDR overall compliance as at the end of July was 85.3%, having reduced month on month from April (94.61%). The range by Group is 84 - 91% and by Directorate 71 - 98%.

Mandatory Training compliance remains relatively stable at 87%. The range by Group is 82 - 95% and by Directorate 81 - 99%.

Sickness Absence during July is reported as 4.75% (range 3.8 - 5.7%), an increase from 4.25% during June. Absence for the for the 12-month cumulative period is 4.35%.

## CQUIN

**A confirm and challenge meeting was held with a number of scheme leads on 13 August 2014. A further meeting with those unable to attend, and with some of those who did, was held on 27 August 2014.**

In summary, no schemes are currently classified as failing, 17 are performing and baseline data is awaited for the remaining 5.

Of note is that national definitions / requirements have been amended for 2 schemes; the FFT scheme to reduce Negative Responses has been replaced by the requirement to deliver an Inpatient FFT response rate of 40% during March 2015, which the Trust is currently delivering and the second scheme, Dementia - Find, Assess and Refer, no longer requires the 90% threshold for each parameter to be met for each month in the quarter, performance will now be assessed as an aggregate across the quarter. During July, 100% compliance was achieved for each parameter of the scheme.

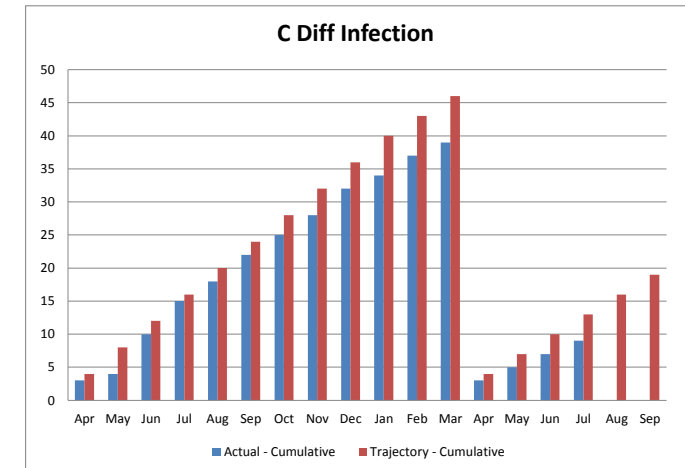
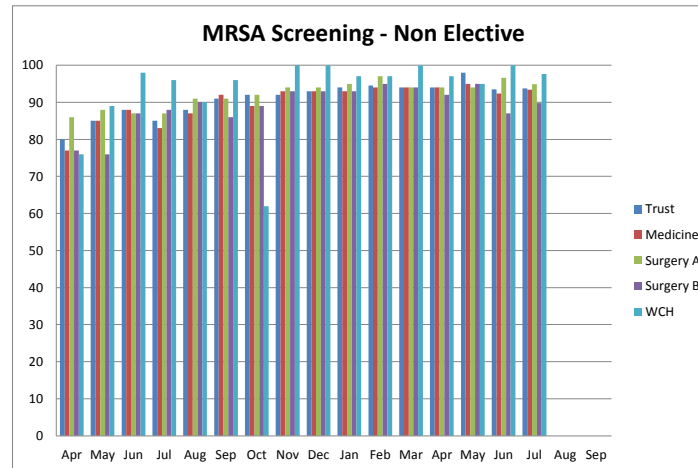
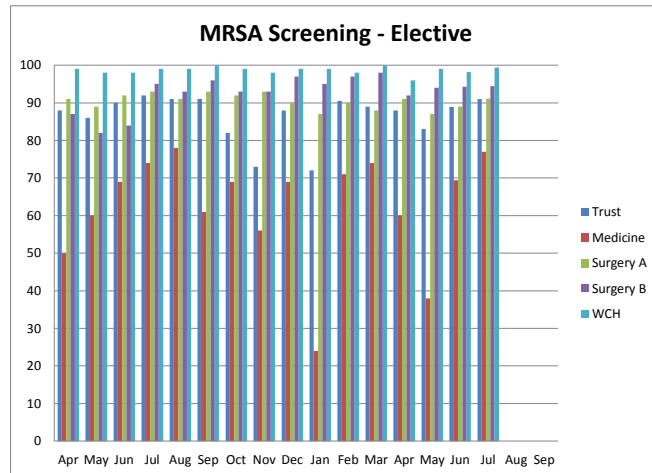


# Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Trajectory	
				Year	Month
4			C. Difficile	37	4
4			MRSA Bacteraemia	0	0
4			MSSA Bacteraemia (rate per 100,000 bed days)	<9.42	<9.42
4			E Coli Bacteraemia (rate per 100,000 bed days)	<94.9	<94.9
3			MRSA Screening - Elective	80	80
3			MRSA Screening - Non Elective	80	80

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								Month	Year To Date	Trend	Next Month	3 Months
	M	A	B	W	P	I	C	CO					
Jul-14	2	0	0	0					2	9			
Jul-14	0	0	0	0					0	0			
Jul-14									0.0	4.6			
Jul-14									18.1	17.1			
Jul-14	77	91	94	99					91.0				
Jul-14	93	95	95	98					93.7				



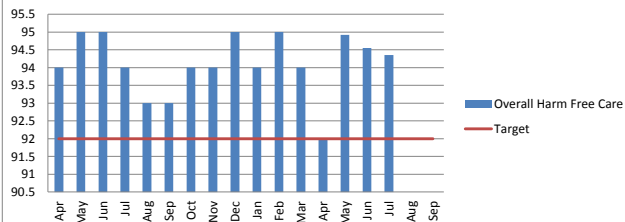
# Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Trajectory	
				Year	Month
8		•d	Patient Safety Thermometer - Overall Harm Free Care (%)	=>92	=>92
8			Falls	804	67
9			Falls with a serious injury	0	0
8			Grade 2,3 or 4 Pressure Ulcers (avoidable)	0	0
3		•d•	Venous Thromboembolism (VTE) Assessments	95	95
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	98	98
3			WHO Safer Surgery - 3 sections and brief (% lists where complete)	95	95
3			WHO Safer Surgery - Audit - 3 sections, brief and debrief (% lists where complete)	85	85
9		•d•	Never Events	0	0
9		•d	Medication Errors causing serious harm	0	0
9		•d•	Serious Incidents	0	0
9			Open Central Alert System (CAS) Alerts		
9		•d	Open Central Alert System (CAS) Alerts beyond deadline date	0	0

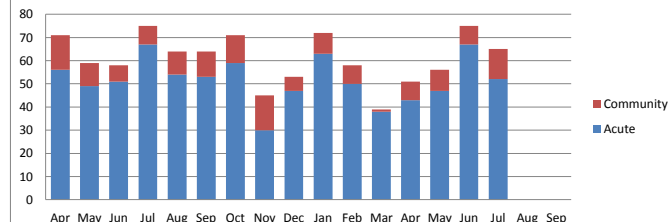
Previous Months Trend (since April 2013)																	
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Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
	M	A	B	W	P	I	C	CO					
Jul-14									95.4		•		
Jul-14	42	8	2	0	0	0	13		65	247	•		
Jul-14	1	0	0	0		0	0		1	10	•		
Jun-14									3	12	•		
Jul-14	99	98	98	90					97.74		•		
Jul-14	99.9	100	100	100					99.9		•		
Jul-14	99.6	100	100	100					99.4		•		
Jul-14	99.6	98.1	98.7	100					96.8		•		
Jul-14	0	0	0	0	0	0	0		0	0	•		
Jul-14	0	0	0	0	0	0	0		0	0	•		
Jul-14	2	0	0	0	0	0	0		2	9	•		
Jul-14									5		•		
Jul-14									1		•		

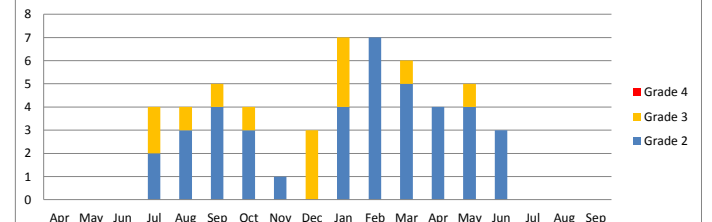
Overall Harm Free Care



Falls - Acute & Community



Avoidable Pressure Sores - by Grade



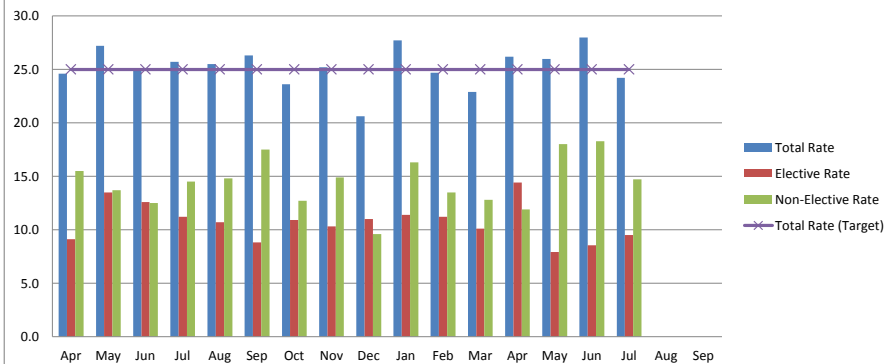
# Patient Safety - Obstetrics

Data Source	Data Quality	PAF	Indicator	Trajectory	
				Year	Month
3			Caesarean Section Rate - Total (%)	=<25.0	=<25.0
3			Caesarean Section Rate - Elective (%)		
3			Caesarean Section Rate - Non Elective (%)		
2			Maternal Deaths	0	0
3			Post Partum Haemorrhage (>2000ml)	48	4
3			Admissions to Neonatal Intensive Care (%)	=<10.0	=<10.0
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<8.0	<8.0
12			Early Booking Assessment (<12 + 6 weeks) (%) - SWBH Specific	=>90.0	=>90.0
12			Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=>90.0	=>90.0
2			Breast Feeding Initiation (Quarterly) (%)	=>77.0	=>77.0
2			Puerperal Sepsis and other puerperal infections (variation 1) (%)		
2			Puerperal Sepsis and other puerperal infections (variation 2) (%)		
2			Puerperal Sepsis and other puerperal infections (variation 3) (%)		

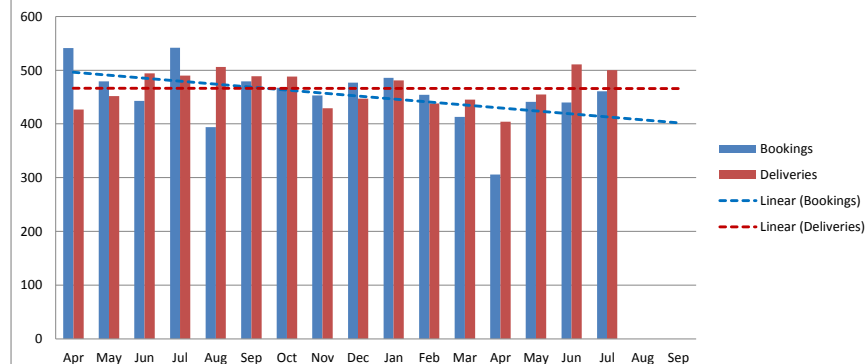
Previous Months Trend (since April 2013)																		
A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	
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Data Period	Month	Year To Date	Trend	Next Month	3 Months
Jul-14	24.2	26.1			
Jul-14	9.5	9.0			
Jul-14	14.7	16.8			
Jul-14	0	0			
Jul-14	1	2			
Jul-14	2.00	3.63			
Jun-14	3.9				
Jul-14	75.17				
Jul-14	128				
Jun-14	76.12	76.12			
Jul-14	1.1	2.0			
Jul-14	1.1	1.5			
Jul-14	0.3	0.5			

Caesarean Section Rate (%)



























Bookings & Deliveries

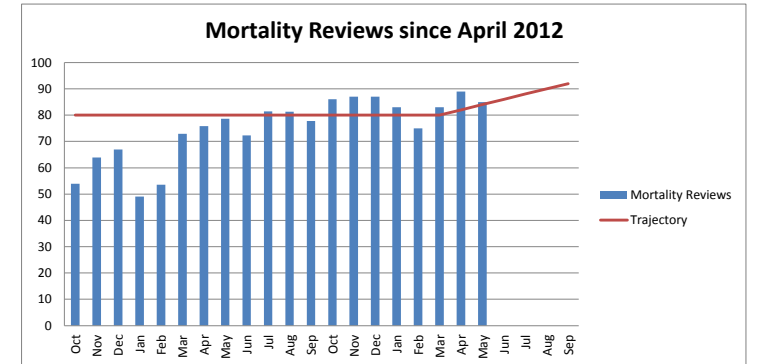
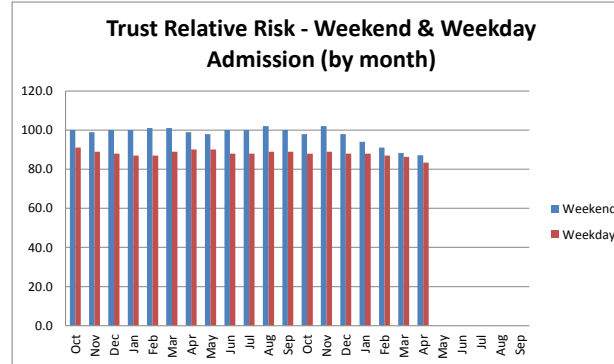
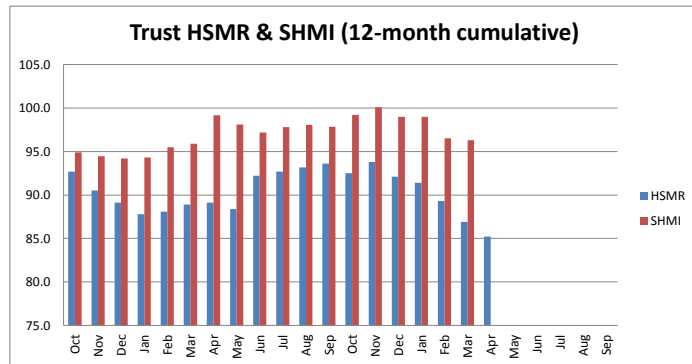


# Clinical Effectiveness - Mortality & Readmissions

Data Source	Data Quality	PAF	Indicator	Trajectory	
				Year	Month
5			Hospital Standardised Mortality Rate - Overall (12-month cumulative)	Below Upper CI	Below Upper CI
5			Hospital Standardised Mortality Rate - Weekday (12-month cumulative)	Below Upper CI	Below Upper CI
5			Hospital Standardised Mortality Rate - Weekend (12-month cumulative)	Below Upper CI	Below Upper CI
6			Summary Hospital-level Mortality Index (12-month cumulative)	Below Upper CI	Below Upper CI
5			Deaths in Low Risk Diagnosis Groups	Below Upper CI	Below Upper CI
3			Mortality Reviews within 42 working days	100	=>84.0
5			Emergency Readmissions (within 30 days) - Overall (%) (12-month cumulative)		
5			Emergency Readmissions (within 30 days) - Following Initial Elective Admission (%) (12-month cumulative)		
5			Emergency Readmissions (within 30 days) - Following Initial Non Elective Admission (%) (12-month cumul.)	=<10.9	=<10.9

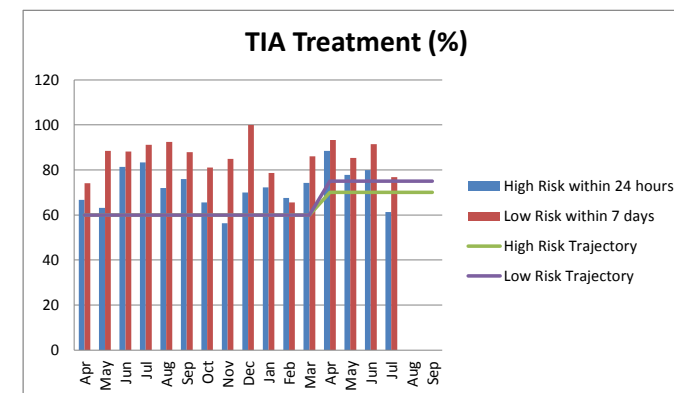
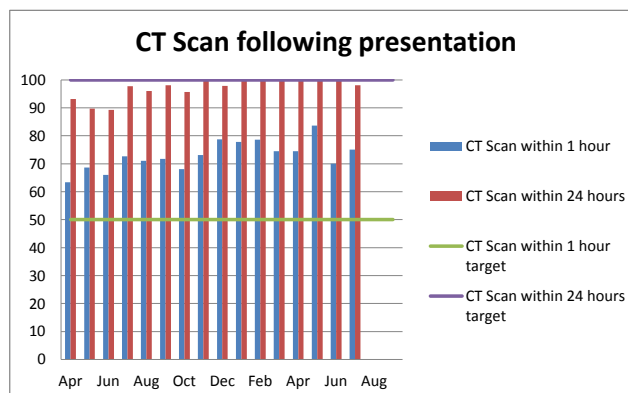
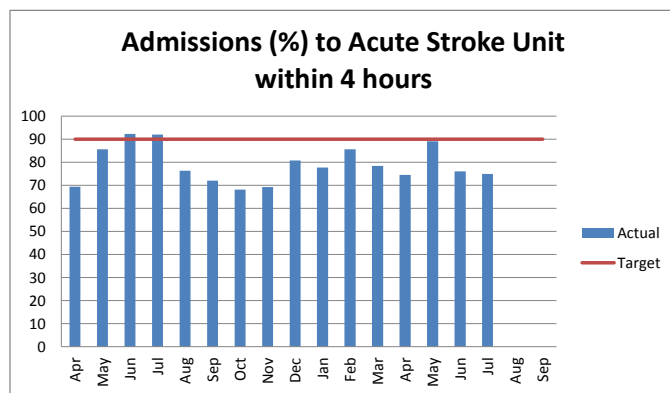
Previous Months Trend (since April 2013)																
A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A
89	88	92	93	93	94	93	94	92	91	89	87	85				
90	90	88	88	89	89	88	89	88	88	87	86	83				
99	98	100	100	102	100	98	102	98	94	91	88	87				
99	98	97	98	98	98	99	100	99	99	97	96					
																
																
9.1				8.9			8.9			9.1						
4.1				4.2			4.1			4.1						
13.7				13.3			13.4			13.6						

Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
	M	A	B	W	P	I	C	CO					
Apr-14										85.2			
Apr-14										83.3			
Apr-14										87.1			
Mar-14										96.3			
Apr-14									129.7				
May-14	84	88	0	100					85				
Apr13 - Mar14										9.1			
Apr13 - Mar14										4.1			
Apr13 - Mar14										13.6			



# Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Trajectory		Previous Months Trend (since April 2013)																			Data Period	Month	Year To Date	Trend	Next Month	3 Months
				Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S							
3			Pts spending >90% stay on Acute Stroke Unit (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	95.0	89.3	●			
3			Pts admitted to Acute Stroke Unit within 4 hrs (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	75.0	76.5	●			
3		●	Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	75.0	75.0	●			
3			Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	98.1	99.0	●			
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	88.9	83.3	●			
3			Stroke Admissions - Swallowing assessments (<24h) (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	93.8	97.6	●			
3			TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=>70.0	=>70.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	100.0	99.2	●			
3			TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=>75.0	=>75.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	98.2	95.5	●			
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	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	100.0	98.5	●			



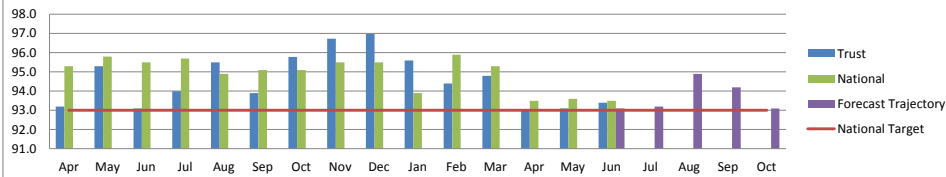
# Clinical Effectiveness - Cancer Care

Data Source	Data Quality	PAF	Indicator	Trajectory	
				Year	Month
1		•e•	2 weeks	=>93.0	=>93.0
1		•e•	2 weeks (Breast Symptomatic)	=>93.0	=>93.0
1		•e••	31 Day (diagnosis to treatment)	=>96.0	=>96.0
1		•e•	31 Day (second/subsequent treatment - surgery)	=>94.0	=>94.0
1		•e•	31 Day (second/subsequent treatment - drug)	=>98.0	=>98.0
1		•e•	31 Day (second/subsequent treat - radiotherapy)	=>94.0	=>94.0
1		•e••	62 Day (urgent GP referral to treatment)	=>85.0	=>85.0
1		•e••	62 Day (referral to treat from screening)	=>90.0	=>90.0
1			62 Day (referral to treat from hosp specialist)	=>90.0	=>90.0

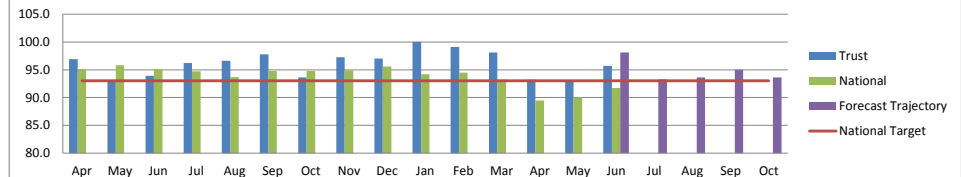
Previous Months Trend (since April 2013)																		
A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	
•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			
•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			
•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			
•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			
n/a	n/a	n/a	n/a	n/a	n/a	n/a	•	n/a	n/a	n/a	•	n/a	n/a	n/a	n/a			
•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			
•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			
•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•			

Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
	M	A	B	W	P	I	C	CO					
Jun-14	92.7	93.4	97.2	92.2					93.4	93.2	●		
Jun-14		95.7							95.7	94.0	●		
Jun-14	100	100	100	97					99.3	99.3	●		
Jun-14									99.0	98.9	●		
Jun-14									100	100	●		
Jun-14											●		
Jun-14	96.9	84.0	42.9	88.9					86.1	88.6	●		
Jun-14		100		100					100	100.0	●		
Jun-14	100	100		100					100	98.4	●		

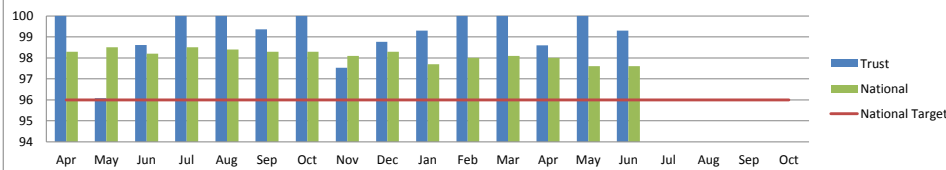
2-week wait from Referral to Date First Seen



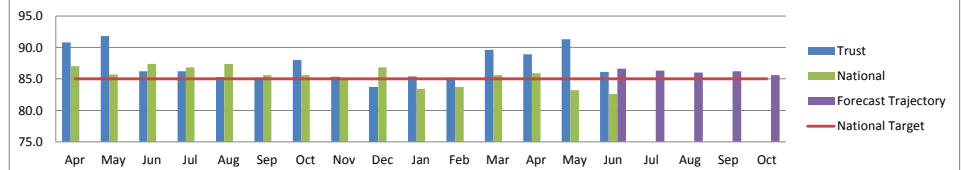
2-week wait Breast Symptomatic Patients



31-day Diagnosis to First Treatment

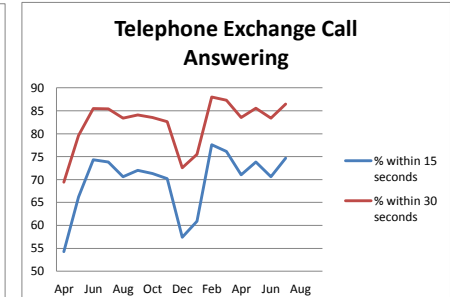
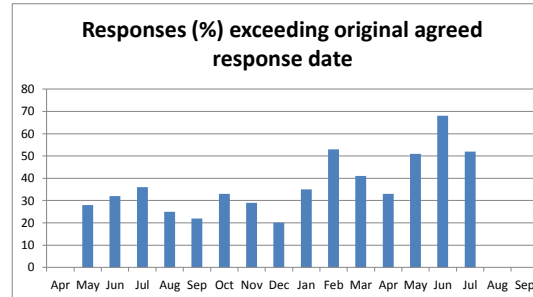
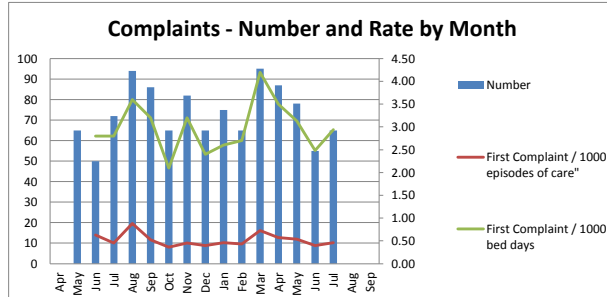
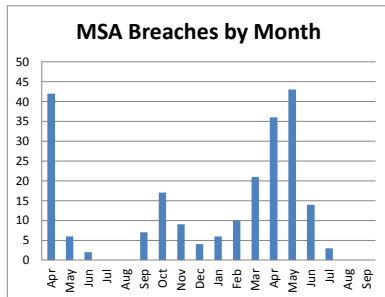


62-day Urgent GP Referral to First Treatment



# Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Trajectory		Previous Months Trend (since April 2013)																			Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
				Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	M		A	B	W	P	I	C	CO						
8			FFT Response Rate - Inpatients	=>30.0	=>30.0	31	40	30	35	31	19	29	31	29	31	34	36	36	44	45	41			Jul-14										41.0				
8			FFT Score - Inpatients	=>60.0	=>60.0	66	66	67	68	37	72	71	70	73	71	75	73	74	74	70	73			Jul-14										73.0				
8			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	16			Jul-14	16									16.0				
8			FFT Score - Emergency Department	=>46.0	=>46.0	55	49	50	49	50	51	46	47	44	47	48	48	47	49	48	47			Jul-14	47									47.0				
13			Mixed Sex Accommodation Breaches	0	0	42	6	2	0	0	7	17	9	4	6	10	21	36	43	14	3			Jul-14	0	3	0	0		0	0		3	96				
9			No. of Complaints Received (formal and link)			63	65	50	72	94	56	65	52	65	75	65	95	87	78	55	65			Jul-14	28	8	10	11	0	3	0	5	65	285				
9			No. of Active Complaints in the System (formal and link)				302	336	272	254	238	201	201	190	188	210	194	245	270	219			Jul-14	106	34	34	21	1	8	3	12	219						
9			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	2.9			Jul-14									2.94	3.04				
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	0.5			Jul-14									0.46	0.50				
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	98.5			Jul-14	96	100	100	100		100		100	98.5					
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	52			Jul-14	56	59	56	28	0	62	67	33	52					
9			No. of responses sent out				17	5	128	73	78	109	59	79	81	58	67	117	30	4	138			Jul-14	57	29	20	14	1	2	7	8	138					
9			Oldest' complaint currently in system (days)				197	155	165	147	150	107	174	91	112	118	127	104	124	145	127			Jul-14	127	118	103	52	27	59	75	77	127					
14			Access to healthcare for people with Learning Disability (full compliance)	Yes	Yes																			Jul-14	Y	Y	Y	Y	Y	Y	Y	Y	Y	Yes				

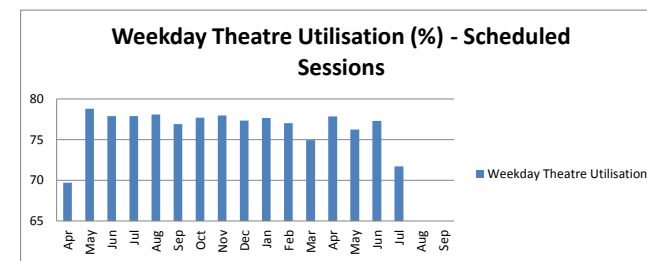
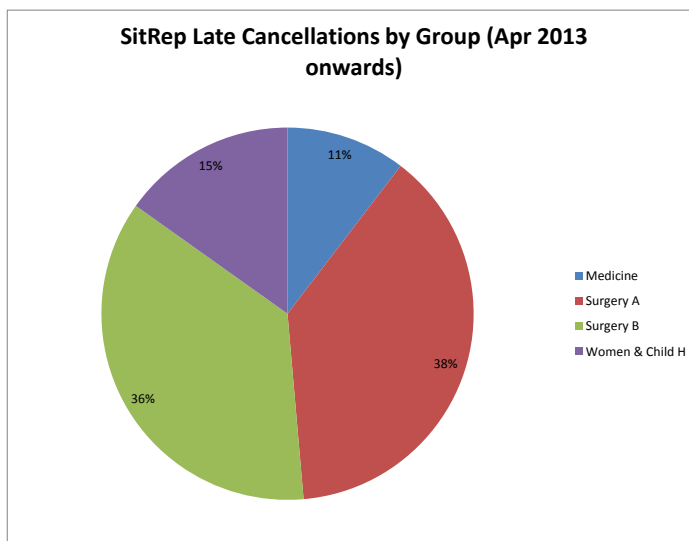
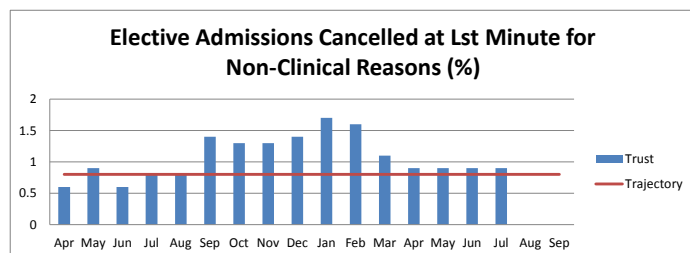
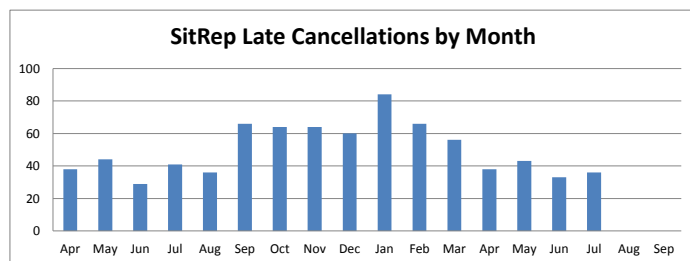


# Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Trajectory	
				Year	Month
2			Elective Admissions Cancelled at last minute for non-clinical reasons (%)	=<0.8	=<0.8
2			28 day breaches	0	0
2			No. of second or subsequent urgent operations cancelled	0	0
2			Sitrep Declared Late Cancellations	320	27
3			Sitrep Declared Late Cancellations (Pts. >1 occasion)	0	0
3			Multiple Cancellations experienced by same patient (all cancellations) (%)	0	0
3			All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	3.1	3.1
3			Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0

Previous Months Trend (since April 2013)																		
A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	
4	1	5	1	0	0	0	0	0	0	0	1	1	1	0	0			
38	44	29	41	36	66	64	64	60	84	66	56	38	43	33	36			
5	6	6	2	9	10	7	5	7	13	13	0	0	1	0	0			
18	13	17	12	19	14	12	13	13	13	13	11	12	7	10	12			
7	6	6	6	5	6	6	6	5	8	6	6	5	6	5	5			

Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
	M	A	B	W	P	I	C	CO					
Jul-14	0.32	0.41	1.29	2.27					0.9	0.8			
Jul-14	0	0	0	0					0	2			
Jul-14	0	0	0	0					0	0			
Jul-14	7	6	16	7					36	150			
Jul-14	0	0	0	0					0	1			
Jul-14	8.6	16.1	11.2	7.5					12.4				
Jul-14	1.9	7.9	7.9	7.1					5.5				
Jul-14	49	77	73	83					72				

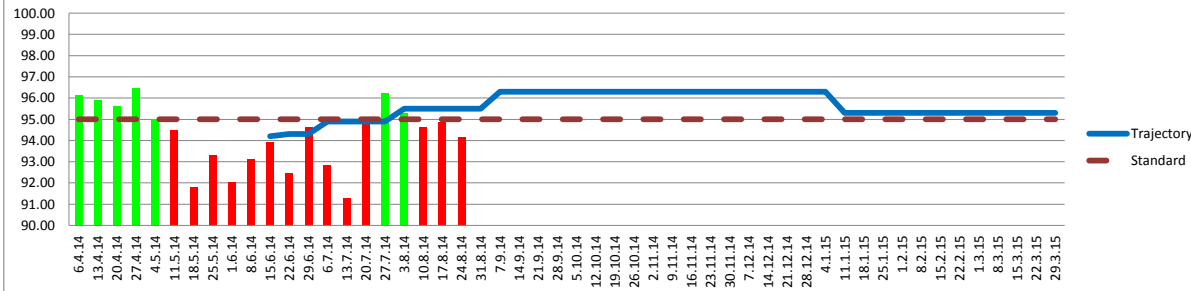




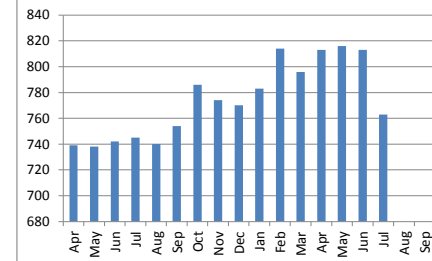
# Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Trajectory		Previous Months Trend (since April 2013)																			Data Period	Unit			Month	Year To Date	Trend	Next Month	3 Months
				Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	S		C	B						
2			Emergency Care 4-hour waits (%)	=>95.0	=>95.0																			Jul-14	94.3	92.6	99.7	94.11	94.15				
2			Emergency Care Trolley Waits >12 hours	0	0	1																		Jul-14	0	0	0	0	0				
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins																			Jul-14	15	19	14	17	18				
3			Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins																			Jul-14	51	59	24	49	51				
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0																			Jul-14	8.93	6.97	3.55	7.35	6.59				
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0																			Jul-14	4.09	4.99	1.38	4.16	4.09				
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	0	0																			Jul-14	60	85		145	522				
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	0	0																			Jul-14	7	1		8	39				
11			WMAS - Turnaround Delays > 60 mins (% all journeys)	=<0.02	=<0.02																			Jul-14	0.30	0.04		0.17					
2			Delayed Transfers of Care (Acute) (%)	=<3.5	=<3.5																			Jul-14				4.3	3.6				
2			Delayed Transfers of Care (Acute) (Av./Week)	<10 per site	<10 per site																		Jul-14	9	7		16						
2			Patient Bed Moves (10pm - 8am) (No.) -ALL															668	751	722	753		Jul-14				753	2894					
2			Patient Bed Moves (10pm - 8am) (No.) - exc. Assessment Units															312	331	330	329		Jul-14				329	1302					
3			Hip Fractures - Operation < 24 hours of admission (%)	=>85.0	=>85.0																			Jul-14				61.5	65.22				

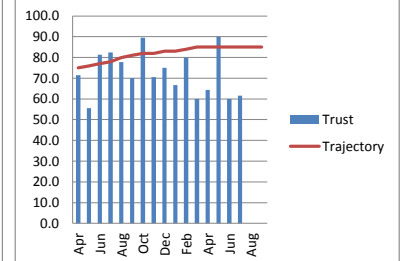
ED 4-hour TDA Recovery Plan



Available Beds Month End (Weekly SitRep)



Hip Fractures - Operations within 24 hours (%)

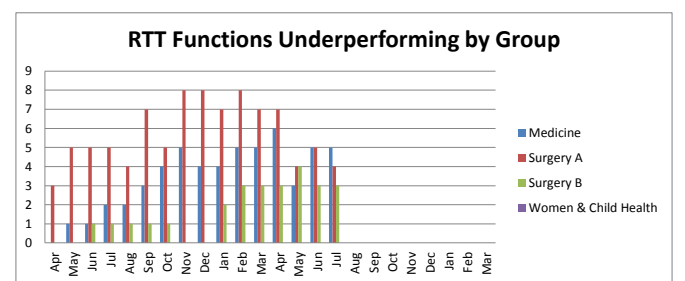
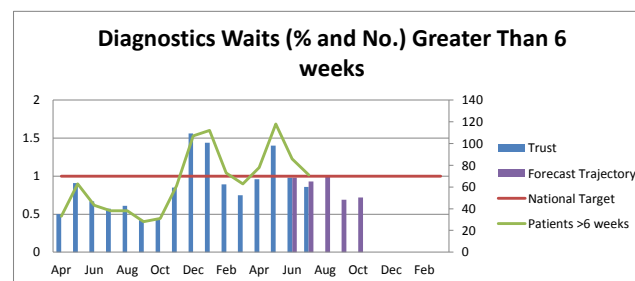
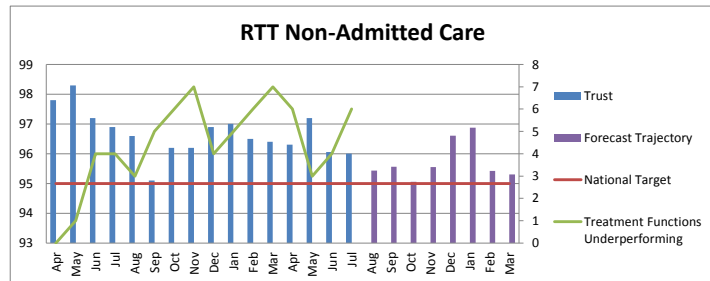
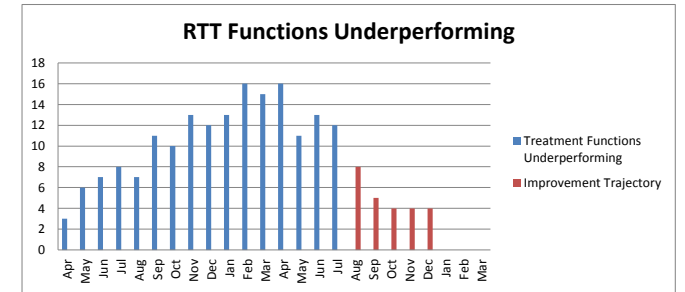
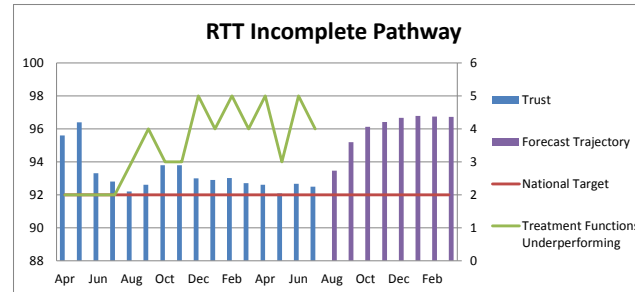
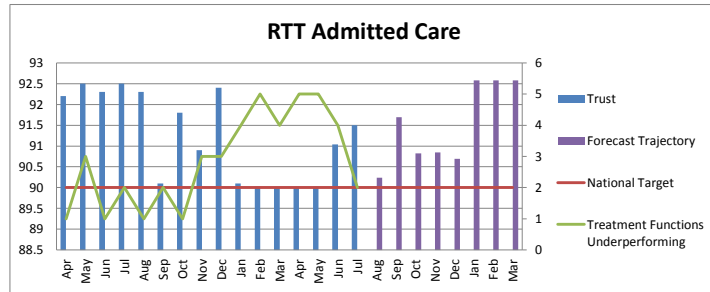


# Referral To Treatment

Data Source	Data Quality	PAF	Indicator	Trajectory	
				Year	Month
2			RTT - Admitted Care (18-weeks) (%)	=>90.0	=>90.0
2			RTT - Non Admitted Care (18-weeks) (%)	=>95.0	=>95.0
2			RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0
2			Patients Waiting >52 weeks	0	0
2			Treatment Functions Underperforming	0	0
2			Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0

Previous Months Trend (since April 2013)																	
A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S
●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
8	28	50	57	29	20	66	36	12	3	1	1	1	2	2	3		
3	6	7	8	7	11	10	13	12	13	16	15	16	11	13	12		
●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
	M	A	B	W	P	I	C	CO					
Jul-14	94.6	85.6	90.6	94.5					91.54		●		
Jul-14	92.7	95.2	96.9	97.7					96.01		●		
Jul-14	91.6	90.2	93.6	97.9					92.53		●		
Jul-14	0	2	0	1					3		●		
Jul-14	5	4	3	0					12		●		
Jul-14	1.9	12.1	0.3	0.0		0.1			0.86		●		



# Data Completeness

Data Source	Data Quality	PAF	Indicator	Trajectory		Previous Months Trend (since April 2013)																	Data Period	Group									Month	Year To Date	Trend	Next Month	3 Months
				Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		S	M	A	B	W	P	I	C	CO					
14			Data Completeness Community Services	=>50.0	=>50.0																							>50	>50								
2			Percentage SUS Records for AE with valid entries in mandatory fields	=>99.0	=>99.0																							99.32	99.32								
2			Percentage SUS Records for IP care with valid entries in mandatory fields	=>99.0	=>99.0																							99.44	99.43								
2			Percentage SUS Records for OP care with valid entries in mandatory fields	=>99.0	=>99.0																							99.53	99.53								
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	97.0	95.6	95.2							95.2	96.6								
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	99.6	99.5	99.5	99.5	99.5	99.5	99.5							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	96.3	96.1							96.1	96.1								
2			Ethnicity Coding - percentage of inpatients with recorded response	=>90.0	=>90.0																							92.11	92.49								
2			Data Quality of Trust Returns to the HSCIC																																		
2			Maternity - Percentage of invalid fields completed in SUS submission	=<15.0	=<15.0																							39.79	29.13								

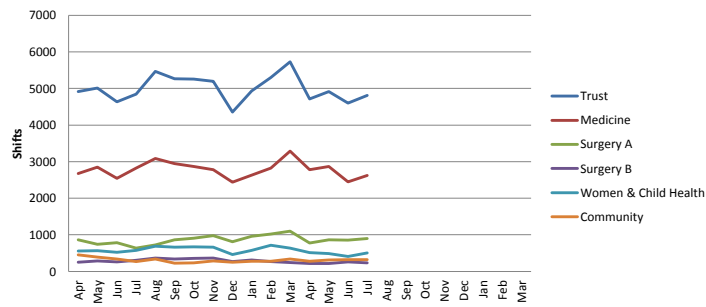
# Staff

Data Source	Data Quality	PAF	Indicator	Trajectory	
				Year	Month
7			WTE - Actual versus Plan (FTE)		
3			PDRs - 12 month rolling	=>95.0	=>95.0
7			Medical Appraisal and Revalidation	=>95.0	=>95.0
3			Sickness Absence	=<3.15	=<3.15
3			Mandatory Training	=>95.0	=>95.0
3			Mandatory Training - Health & Safety (% staff)	=>75.0	=>75.0
7			Staff Turnover (rolling 12 months) (%)	=<10.0	=<10.0
7			New Investigations in Month		
7			Vacancy Time to Fill (weeks)		
7			Professional Registration Lapses	0	0
7			Qualified Nursing Variance (FIMS) (FTE)		
10			Nurse Bank Fill Rate		
10			Nurse Bank Use (shifts)	46980	3915
10			Nurse Agency Use (shifts)	0	0
15			Your Voice - Response Rate		
15			Your Voice - Overall Score		

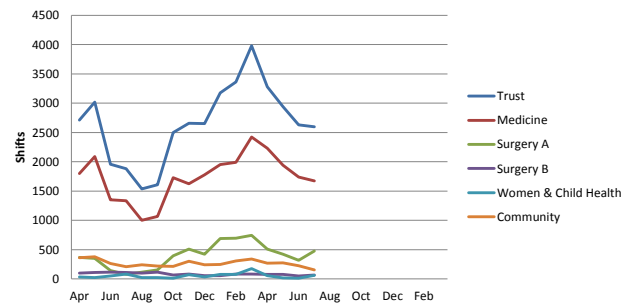
Previous Months Trend (since April 2013)																											
A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S										
312	456	465	458	511	610	643	626	572	541	567	567	531	558	580	593												
4	5	8	9	1	4	3	1	4	2	4	5	1	4	6	5												
15	19	18	18	18	18	18	17	18	20	18	19	19	20	19	18												
26	108	138	143	181	236	177	199	210	163	162	162	161	169	173	178												
72	77	75	77	78	76	75	76	71	73	75	76	76	82	82	80												

Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
	M	A	B	W	P	I	C	CO					
Jul-14	151	78	33	67	32	12	45	176	593	593			
Jul-14	84	84	88	91	87	87	87	83		85.3			
Jul-14	90	85	90	83	100	100		100		88.0			
Jul-14	4.5	5.6	4.4	5.7	4.1	4.4	3.8	4.5	4.75	4.35			
Jul-14	82	86	87	85	95	91	90	92		87.0			
Jul-14	97	98	96	97	100	99	99	99		98.2			
Jul-14									11.88	11.96			
Jul-14	2	0	0	2	0	0	0	1	5				
Jul-14									18				
Jul-14	0	0	0	0	0	0	0	0	0	0			
Jul-14									178	178			
Jul-14									80.1	79.6			
Jul-14	2626	903	231	505	0	15	319	211	4810	19047			
Jul-14	1674	477	65	62	0	152	157	13	2600	11456			
May-14	7	12	19	14	30	27	33	29					
May-14	3.6	3.5	3.7	3.7	3.4	3.8	3.8	3.6					

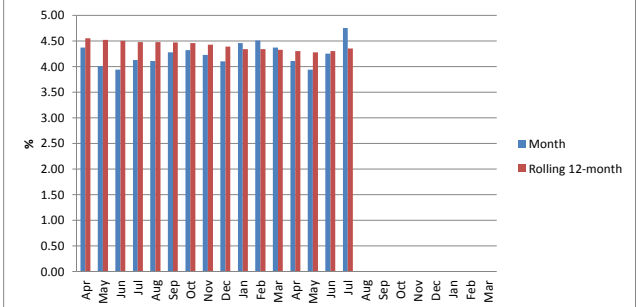
## Nurse Bank Shifts



## Nurse Agency Shifts



## Sickness Absence (Trust %)



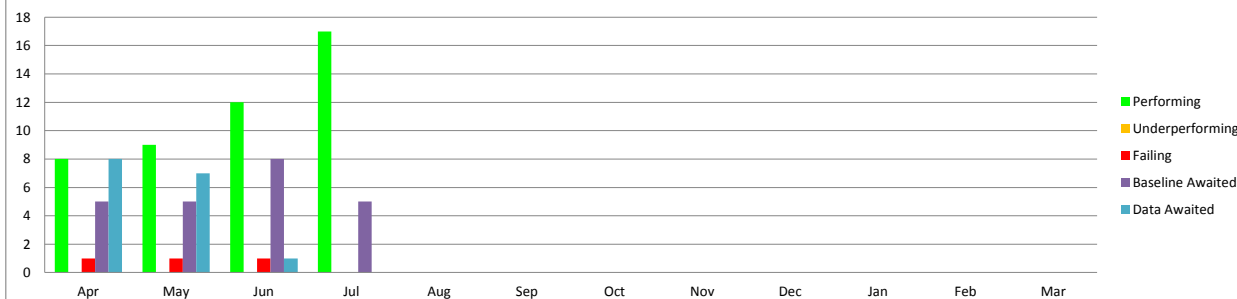
# CQUIN (I)

Data Source	Data Quality	PAF	Indicator	Trajectory		Previous Months Trend													Data Period	Group									Month	Year To Date	Trend	Next Month	3 Months
				Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	M		A	B	W	P	I	C	CO							
8			FFT - Implementation of Staff FFT	Implement by end July		<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>									Jul-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>		
8			FFT - Early Implementation of Patient FFT in OP / DC Departments	Implement by end Oct		<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>									Jul-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>			
8			FFT - Increase and / or Maintain Response Rate in ED areas	>Q1 rate		15	16	16	16									Jul-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>			
8			FFT - Increase and / or Maintain Response Rate in IP areas	>Q1 rate		36	44	45	41									Jul-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>			
8			FFT - IP Response Rate (March 2015 target 40%) - replaces Reduce Negative Responses	40		<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>									Jul-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>			
8			NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	50% reduction		<div><div></div></div>												Jun-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>				
8			Dementia - Find, Assess and Refer	=>90	=>90	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>									Jul-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	3 of 3 met	3 of 3 met	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>			
8			Dementia - Clinical Leadership and Staff Training			<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>									Jul-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>			
8			Dementia - Supporting Carers of People with Dementia	Monthly Audit	Monthly Audit	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>									Jul-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>			
9			Learning From Safeguarding Concerns	Quarterly report to Board		<div><div></div></div>												Jun-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>				
2			Quality of Outpatient and Discharge Letters	Trust/CCG to agree assess. criteria		<div><div></div></div>												Jun-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>				
4			Sepsis - Use of Sepsis Care Bundles	Informed by base data		<div><div></div></div>												Jun-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>				
8			Pain Relief - Use of Pain Care Bundles	Informed by base data		<div><div></div></div>												Jun-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>				
9			Medication and Falls	Informed by base data		<div><div></div></div>														<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>				
9			Serious Untoward Incidents (Never Events)	Informed by base data		<div><div></div></div>												Jun-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>				
14			Community Therapies - Effective Referral Management	Informed by base data		<div><div></div></div>												Jun-14	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>	On Track	On Track	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>				

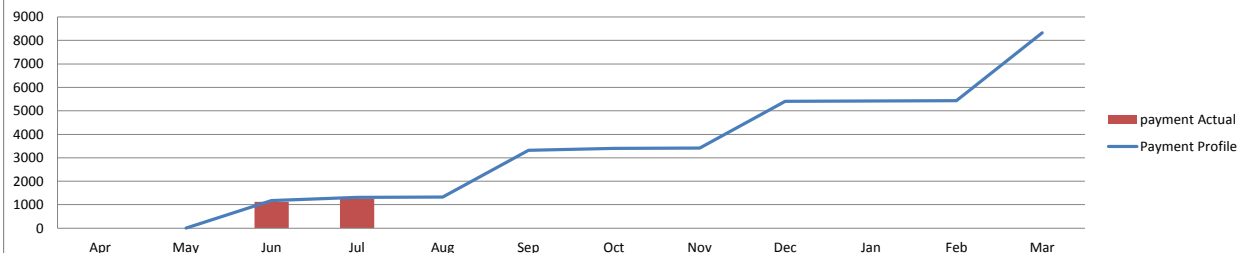
# CQUIN (II) and summary

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

**CQUIN - Scheme Summary**



**CQUIN Payment (£000s)**



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.

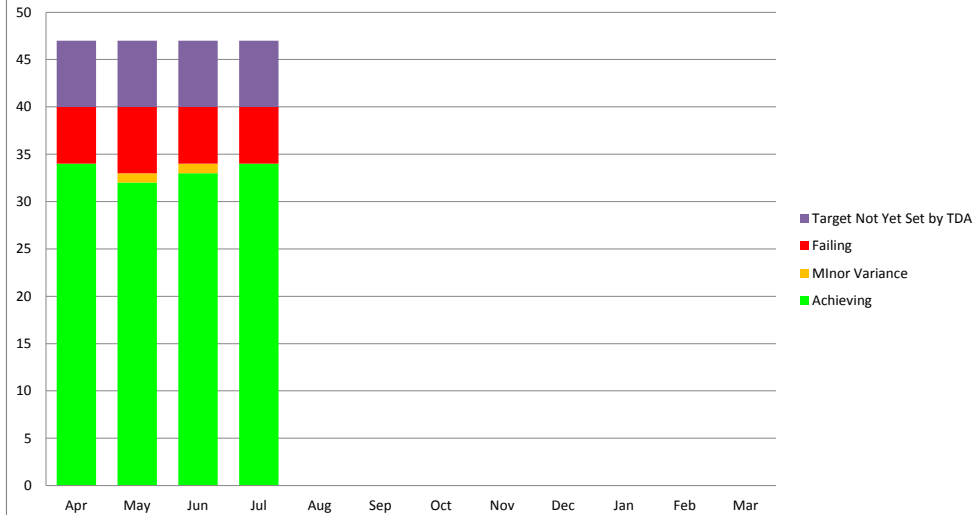
In summary, no schemes are currently classified as failing, 17 are performing and baseline data is awaited for the remaining 5.

Of note is that national definitions / requirements have been amended for 2 schemes; the FFT scheme to reduce Negative Responses has been replaced by the requirement to deliver an Inpatient FFT response rate of 40% during March 2015, which the Trust is currently delivering and the second scheme, Dementia - Find, Assess and Refer, no longer requires the 90% threshold for each parameter to be met for each month in the quarter, performance will now be assessed as an aggregate across the quarter. During July, 100% compliance was achieved for each parameter of the scheme.

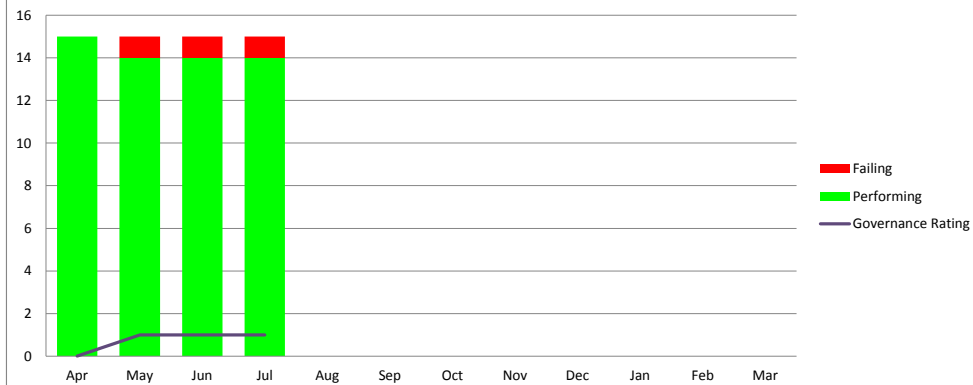
A confirm and challenge meeting was held with a number of scheme leads on 13 August 2014. A further meeting with those unable to attend, and with some of those who did, for a further update is to be convened.

# External Assessment Frameworks

NHS TDA - Indicators



Monitor - Risk Assessment Framework



## 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 July beyond the deadline date (subsequently closed early August)
- There were 2 Serious Incidents reported during July
- The Trust's FFT Response Rate in ED remains 16%
- A total of 3 Mixed Sex Accommodation Breaches were reported during the month
- An increase in Delayed Transfers of Care to 4.3% during the month of July
- ED 4-hour performance of 94.11%

High Level Cancer and RTT Thresholds are met or projected to be met

## Monitor Risk Assessment Framework

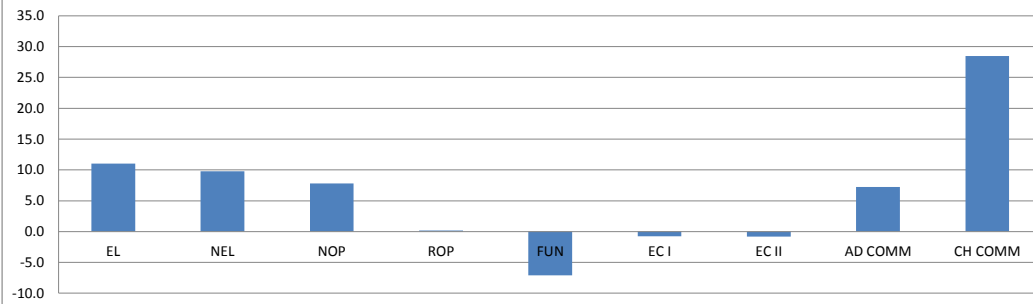
Monitor introduced its **Risk Assessment Framework** for NHS Foundation Trusts with effect from 1 October 2013, which replaced its previous Compliance Framework. The range of indicators utilised by Monitor within this framework is less extensive than those used by the NHS TDA. The Access and Outcome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

During the month of July 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 94.11%. This continues to attract an overall weighted score for the month of 1.0 with an AMBER / GREEN Governance Rating.

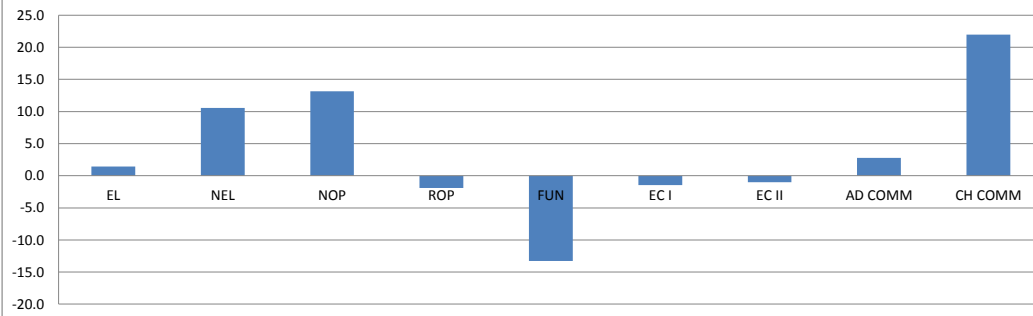
Governance Rating	Green (0.0)		Amber / Green (1.0 - 1.9)	
	Amber / Red (2.0 - 3.9)		Amber / Red (>3.9)	

# Activity Summary

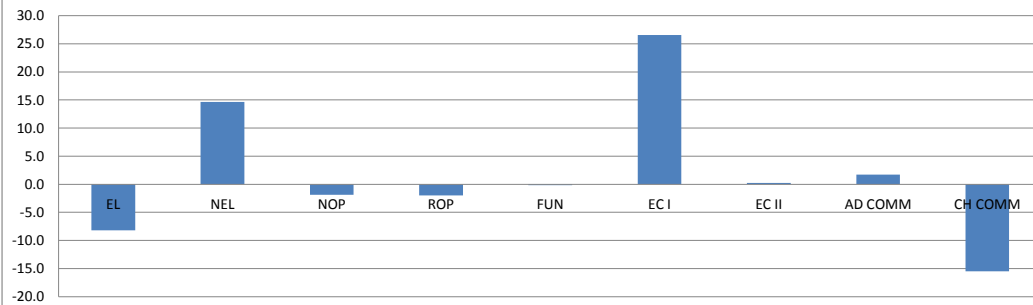
Month



Year To Date



Year On Year



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 11.0% and 1.5% for the year to date. Non-Elective activity during the month is 9.8% greater than plan, is 10.6% higher for the year to date, and 14.6% higher than the corresponding period last year. New outpatient attendance numbers are ahead of plan by 13.1% for the year to date. With OP Review attendances 1.9% below plan for the year to date, the Follow-Up to New OP Ratio for the period to date is 2.20, compared with a plan derived from contracted activity of 2.53. Type I Emergency Care activity for the month is slightly (-0.7%) down on plan, and is 1.5% less than plan for the year to date, although remains well in excess of activity delivered for the corresponding period last year, by 26.6%, due to the inclusion within plan of GP Triage Activity. Type II activity is essentially on plan for the month and year to date. Adult Community and Child Community activity exceeds plans for the year to date by 2.8% and 22.0% respectively, although the latter is 15.5% less than the corresponding period last year, due to the transfer of School Health Nursing to another provider.



# Finance Summary

Data Source	Data Quality	PAF	Indicator	Trajectory		Previous Months Trend (data from July 13)													Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
				Year	Month	J	A	S	O	N	D	J	F	M	A	M	J	J		A	S	M	A	B	W	P	I					
18			Bottom Line Income & Expenditure position - Forecast compared to plan £m	£0.0																								£0.0				
18			Bottom Line Income & Expenditure position - Year to Date Actual compared to plan £m	£0.0	£0.0																								-£0.7			
18			Actual efficiency recurring / non-recurring compared to plan - Year to Date actual compared to plan	£0.0	£0.0																								£1.4			
18			Actual efficiency recurring / non-recurring compared to plan - Forecast compared to plan	£0.0																									-£7.1			
18			Forecast underlying surplus / deficit compared to plan	£0.0																									£0.1			
18			Forecast year end charge to capital resource limit	£21.3																									£19.1			
18			Is the Trust forecasting permanent PDC for liquidity purposes?	No																								No				
18			Temporary costs and overtime as % total paybill	2.6%	2.6%																							4.4%	4.5%			
18			Continuity of Service Risk Rating - Year to Date	2.5																								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)										JULY (£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		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	23.2	2.4	0.0					25.6	0.0	118.0	12.8	0.0					130.8				
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	5.5	1.4	0.8	0.0					7.7	18.4	7.8	0.8	0.0				27.0					
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	17.4	23.7	9.7	0.0					50.8	55.9	100.1	31.7	0.0					187.7				
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	0.0	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	33.8		0.0						33.8	157.0		0.0					157.0					
1		OS	Cancer Waits (2 weeks, 31 days and 62 days - £200, £1000 and £1000 per breach respectively)	Various	Assessed Quarterly										Assessed Quarterly										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 User 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	0.0	1.3	0.0	0.0					1.3	32.8	1.3	0.0	0.0					34.0				
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	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	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	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	0.0	0.0						10.0	0.0	0.0						25.0					
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	29.0								29.0	104.4							104.4					
11		NQR	WMAS Handovers to ED (£1000 per breach >60 minutes)	0	15.0								15.0	8.0									8.0	8.0								8.0	8.0							8.0	39.0							39.0						
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	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	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	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							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				
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					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					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	0.0	203.6	121.5	55.9	9.5	5.0	0.0	0.0	0.0	0.0	191.9	93.7	59.6	12.9	0.0	0.0	0.0	0.0	166.2	409.3	248.9	50.3	5.0	0.0	1.4	0.0	0.0	714.8					

[illegible][illegible]

Contractual Requirements - CQUIN (CQ)	
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[illegible]

Contractual Requirements - Outcome Thermometer (OT) Incentive Scheme	
1	Contractual Requirements - Outcome Thermometer (OT) Incentive Scheme

[illegible]

## Contractual Requirements - Price Activity Matrix (PAM)

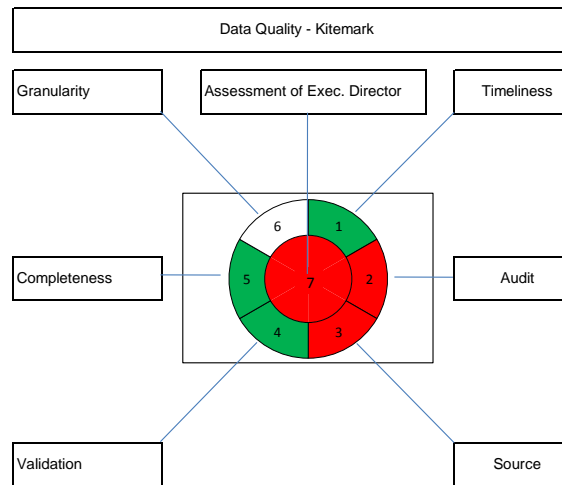
Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	APRIL (£000s)										MAY (£000s)										JUNE (£000s)										YEAR TO DATE (£000s)									
						M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL				
2		PAM	Elective (IP and DC)	52721	Contract Plan	31	62	-33	-6	-1	-1			52	-39	-39	-74	-25	1	2			-174	57	53	45	5	0	-1			161	49	76	-62	-26	0	1			39				
2		PAM	Non-Elective	82299	Contract Plan	38	-20	6	-24					0	104	1	-36	-24					45	10	-2	-15	46				40	152	-21	-45	-2					85					
2		PAM	Excess Bed Days	20352	Contract Plan	14	10	-9	-19					-4	50	17	-7	-19					41	10	-2	-5	-22				-19	74	25	-21	-60					18					
2		PAM	Accident & Emergency	20352	Contract Plan	-23		-23						-46	8		-33						-25	4		-30					-26	-11		-86	0					-97					
2		PAM	Outpatient New	26337	Contract Plan	0	5	-1	-13	-1	0	0		-10	-9	-7	-32	-19	-1	0	0		-68	31	7	13	-4	0	0	0		47	22	5	-20	-36	-2	0	0		-31				
2		PAM	Outpatient Review	33208	Contract Plan	14	-15	14	-9	0	0	1		5	-1	-16	-25	-14	-1	0	0		-57	45	-3	1	-4	1	0	-1		39	58	-34	-10	-27	-1	0	0		-13				
2		PAM	Outpatient with Procedure	7336	Contract Plan	-11	23	-35	4					-19	-8	2	-56	-2					-64	-3	19	-47	10				-21	-22	44	-138	12					-104					
2		PAM	Outpatient Telephone Conversation	196	Contract Plan	1	0							1	1	0						1	1	0							1	3	0						3						
2		PAM	Maternity	14219	Contract Plan				24					24				-10					-10				58.1				58.1				72					72					
2		PAM	Occupied Cot Days	6000	Contract Plan				5					5				-3					-3				15.8				15.8				18					18					
2		PAM	Unbundled Activity	9520	Contract Plan	-6	8	-4	1	0	0			-1	-38	-6	-4	2	0	0			-46	72	0	0	3	0	0		75	28	2	-8	6	0	0			28					
2		PAM	Other Contract Lines	89552	Contract Plan	210	-10	108	15	-6	-27	0		290	-120	-2	173	9	-7	-41	0		12	29	-2	50	-13	4	-10	0	59	119	-14	331	11	-9	-78	0		361					
2		PAM	Community	36003	Contract Plan	0	0		-4		0	0		-4	0	0		-2		0	-2		-4	0	0		3		0	-3		0	0	0		-3		0	-5		-8				
			ALL			268	63	23	-26	-8	-28	1	0	293	-52	-50	-94	-107	-8	-39	-2	0	-352	256	71	12	100	5	-11	-4	0	429	472	84	-59	-33	-11	-78	-5	0	370				

# 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



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	●	●	●	●	●	●	●	●	●	●			Jul-14	0	1	1	2	6	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14	0	0	0	0	0	●		
MRSA Screening - Elective (%)	80	80	●	●	●	●	●	●	●	●	●	●			Jul-14	100	90	53	76.98		●		
MRSA Screening - Non Elective (%)	80	80	●	●	●	●	●	●	●	●	●	●			Jul-14	94	94	87	93.41		●		
Falls	0	0							33	40	61	42			Jul-14	9	24	9	42	176	●		
Falls with a serious injury	0	0	5	2	5	1	1	1	1	2	3	1			Jul-14	0	1	0	1	7	●		
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	●	●	●	●	●	●	●	●	●	●			Jul-14	99.9	99.0	99.2	99.5		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●			Jul-14	100	99.0	100	99.9		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●			Jul-14	100	97.0	99.6	99.6		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●			Jul-14	100	97.0	99.6	99.6		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14	0	0	0	0	0	●		
Serious Incidents	0	0				●	●	●	●	●	●	●			Jul-14	2	0	0	2	5	●		
Mortality Reviews within 42 working days	100	=>84.0	●	●	●	●	●	●	●	●					May-14	71	86	92	84		●		



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	●	●	●	●	●	●	●	●	●	●			Jul-14		95.0		95.0	89.3	●		
Pts admitted to Acute Stroke Unit within 4 hrs (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●			Jul-14		75.0		75.0	76.5	●		
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●			Jul-14		75.0		75.0	75.0	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●		Jul-14		98		98.1	99.0	●		
Stroke Admission to Thrombolysis Time (% within 60 mins)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●			Jul-14		89		88.9	73.3	●		
Stroke Admissions - Swallowing assessments (<24h) (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●			Jun-14		100		100.0	100.0	●		
TIA (High Risk) Treatment <24 Hours from initial presentation (%)	=>70.0	=>70.0	●	●	●	●	●	●	●	●	●	●	●		Jul-14		61.3		61.3	76.4	●		
TIA (Low Risk) Treatment <7 days from initial presentation (%)	=>75.0	=>75.0	●	●	●	●	●	●	●	●	●	●			Jul-14		76.8		76.8	85.3	●		
Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●			Jun-14		####		100.0	90.3	●		
Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●			Jun-14		####		100.0	95.2	●		
Rapid Access Chest Pain - seen within 14 days (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●			Jul-14		####		100.0	98.5	●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●			Jun-14			92.7	92.7		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●			Jun-14			100	100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●			Jun-14			96.9	96.9		●		

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					
Mixed Sex Accommodation Breaches	0	0	5	4	2	3	7	21	36	43	14	0			Jul-14	0	0	0	0	93			
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8													Jul-14	0.00	2.02	0.15	0.32				
28 day breaches	0	0								1					Jul-14	0	0	0	0	1			
Sitrep Declared Late Cancellations	0	0	13	2	2	7	7	4	10	2	7	7			Jul-14	0	4	3	7	26			
Emergency Care 4-hour waits (%)	=>95.0	=>95.0													Jul-14	94.3 (s)	92.6 (c)		94.1	94.2			
Emergency Care Trolley Waits >12 hours	0	0													Jul-14	0 (s)	0 (c)		0	0			
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins													Jul-14	15 (s)	19 (c)		17	18			
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins													Jul-14	51 (s)	59 (c)		49	51			
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0													Jul-14	8.93 (s)	6.97 (c)		7.35	6.59			
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0													Jul-14	4.09 (s)	4.99 (c)		4.16	4.09			

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	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Jul-14	<div>60 (s)</div>	<div>85 (c)</div>	<div></div>	145	522	<div></div>	<div></div>	<div></div>
WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	0	0	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Jul-14	<div>7 (s)</div>	<div>1 (c)</div>	<div></div>	8	31	<div></div>	<div></div>	<div></div>
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Jul-14	<div>####</div>	90.8	96.3	<div>94.6</div>		<div></div>	<div></div>	<div></div>
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Jul-14	<div>####</div>	89.3	94.4	<div>92.7</div>		<div></div>	<div></div>	<div></div>
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Jul-14	95.0	<div>87.3</div>	94.1	<div>91.6</div>		<div></div>	<div></div>	<div></div>
Patients Waiting >52 weeks	0	0	<div>17</div>	<div>6</div>	<div>4</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	Jul-14	0	0	0	<div>0</div>		<div></div>	<div></div>	<div></div>	
Treatment Functions Underperforming	0	0	<div>4</div>	<div>5</div>	<div>4</div>	<div>4</div>	<div>5</div>	<div>5</div>	<div>6</div>	<div>3</div>	<div>5</div>	<div>5</div>	<div></div>	Jul-14	0	<div>3</div>	<div>2</div>	<div>5</div>		<div></div>	<div></div>	<div></div>	
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Jul-14	0.0	0.4	<div>2.9</div>	<div>1.9</div>		<div></div>	<div></div>	<div></div>	
WTE - Actual versus Plan			176	158	165	135	163	163	171	161	157	151		Jul-14				151					
PDRs - 12 month rolling (%)	=>95.0	=>95.0	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Jul-14	<div>84</div>	<div>82</div>	<div>87</div>		84.1	<div></div>	<div></div>	<div></div>	
Medical Appraisal and Revalidation	=>95.0	=>95.0	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Jul-14	<div>90</div>	<div>85</div>	<div>91</div>	<div>90</div>		<div></div>	<div></div>	<div></div>	
Sickness Absence (%)	=<3.15	=<3.15	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Jul-14	<div>4.58</div>	<div>5.00</div>	<div>3.11</div>	<div>4.49</div>	<div>4.20</div>	<div></div>	<div></div>	<div></div>	
Mandatory Training (%)	=>95.0	=>95.0	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Jul-14	<div>81</div>	<div>82</div>	<div>83</div>	<div>81.9</div>		<div></div>	<div></div>	<div></div>	
New Investigations in Month			2	0	0	0	0	1	1	1	1	2		Jul-14				2					
Nurse Bank Use	34560	2880	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Jul-14				<div>2626</div>	<div>10742</div>	<div></div>	<div></div>	<div></div>	
Nurse Agency Use	0	0	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	Jul-14				<div>1674</div>	<div>7646</div>	<div></div>	<div></div>	<div></div>	
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	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	0	0	0	0	0	3	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	97	99	77	25	91.1		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	95	94	96	94	94.9		●		
Falls	0	0							9	7	4	8			Jul-14	3	1	4	0	8	28	●		
Falls with a serious injury	0	0	1	0	1	1	0	1	0	0	0	0			Jul-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	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	97	98	99	99	98.1		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	100	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	100	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	94.4	100	100	100	98.1		●		
Never Events	0	0	●	1	●	●	●	●	●	●	●	●	●	●	Jul-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	0	0	0	0	0	0	●		
Serious Incidents	0	0				●	●	●	●	●	●	●	●	●	Jul-14	0	0	0	0	0	1	●		
Mortality Reviews within 42 working days	100	=>84.0	●	●	●	●	●	●	●	●					M,ay 14	100	100		85	88.0		●		

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	●	●	●	●	●	●	●	●	●				Jun-14	97.3		78.3		93.4		●		
2 weeks (Breast Symptomatic)	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●				Jun-14	95.7				95.7		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●				Jun-14	100		100		100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●				Jun-14	98.2		53.8		84.0		●		
Mixed Sex Accommodation Breaches	0	0	12	5	2	3	3	0	0	0	0	3			Jul-14	0	0	0	3	3	3	●		
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●				Jul-14	0.3	0.0	1.1	0.0	0.41		●		
28 day breaches	0	0	0	0	0	0	0	1	1	0	0	0			Jul-14	0	0	0	0	0	1	●		
Sitrep Declared Late Cancellations	0	0	28	35	25	28	37	18	13	16	5	6			Jul-14	2	0	4	0	6	40	●		
Hip Fractures - Operation < 24 hours of admission (%)	85	85	●	●	●	●	●	●	●	●	●				Jul-14		61.5			61.5	65.2	●		

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		A	B	C	D					
RTT - Admitted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●			Jul-14	92.6	67.7	92.1		85.6		●		
RTT - Non Admitted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●			Jul-14	97.7	94.4	89.6		95.2		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●			Jul-14	95.2	84.8	92.5		90.2		●		
Patients Waiting >52 weeks	0	0	28	13	3	3	0	0	1	1	0	2			Jul-14	1	1	0	0	2		●		
Treatment Functions Underperforming	0	0	5	8	8	7	8	7	7	5	5	4			Jul-14	0	3	1	0	4		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●			Jul-14	4.3	0.0	27.3	0.0	12.1		●		
WTE - Actual versus Plan			70	71	72	88	76	76	64	71	77	78			Jul-14					78				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●			Jul-14	87	84	82	87		84.3	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●			Jul-14	84	79	100	83		85	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●			Jul-14	5.33	4.25	6.63	4.47	5.61	5.41	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●			Jul-14	81	82	88	89		86.1	●		
New Investigations in Month			0	0	2	1	1	1	0	0	0	0			Jul-14					0				
Nurse Bank Use	9908	826	●	●	●	●	●	●	●	●	●	●			Jul-14					903	3423	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14					477	1760	●		
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	●	●	●	●	●	●	●	●	●	●			Jul-14	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●			Jul-14	95	94	94.4		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●			Jul-14	87	92	89.8		●		
Falls	0	0						1	0	0	2				Jul-14	2	0	2	3	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0	0			Jul-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	●	●	●	●	●	●	●	●	●	●			Jul-14	98.16	96.74	97.7		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●			Jul-14	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●			Jul-14	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●			Jul-14	98.5	100	98.7		●		
Never Events	0	0	●	1	●	1	●	●	●	●	●	●			Jul-14	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14	0	0	0	0	●		
Serious Incidents	0	0			●	●	●	●	●	●	●	●			Jul-14	0	0	0	2	●		
Mortality Reviews within 42 working days	=>82.0	=>82.0	●	●	●	●	●	●	●	●	●	●			May-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	●	●	●	●	●	●	●	●	●				Jun-14		97.2	97.2		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●			●	●	●	●	●				Jun-14		100	100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0		●	●	●	●	●		●	●				Jun-14		42.9	42.9		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0				Jul-14	0	0	0	0	●		
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●			Jul-14	1.57	0.74	1.3		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0				Jul-14	0	0	0	0	●		
Sitrep Declared Late Cancellations	0	0	19	14	19	36	15	22	3	22	17	16			Jul-14	13	3	16	58	●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●			Jul-14	99.7		99.7	98.8	●		
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14	0		0	0	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●	●	●			Jul-14	13		14	13	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●	●	●			Jul-14	22		24	21	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●			Jul-14	3.61		3.55	3.28	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●			Jul-14	2.51		1.38	1.61	●		



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 - Admitted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	91.6	88.6	90.6		●		
RTT - Non Admitted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	97.9	94.8	96.9		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	95.1	90.2	93.6		●		
Patients Waiting >52 weeks	0	0	9	9	2	0	1	1	0	1	1	0			Jul-14	0	0	0		●		
Treatment Functions Underperforming	0	0	1	0	0	2	3	3	3	4	3	3			Jul-14	0	3	3		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●			Jul-14	0.0	0.3	0.3		●		
WTE - Actual versus Plan			31	24	23	27	37	37	28	34	38	33			Jul-14			33				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	86.17	93.69		87.8	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	92	80		90.3	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	4.23	4.91	4.41	3.16	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	85	91		86.8	●		
New Investigations in Month			0	0	0	1	0	0	0	0	0	0			Jul-14			0				
Nurse Bank Use	2796	233	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14			231	931	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14			65	267	●		
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	●	●	●	●	●	●	●	●	●	●			Jul-14	0	0	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●			Jul-14	99				99.4		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●			Jul-14		98			97.6		●		
Falls	0	0							0	0	2	0			Jul-14	0	0	0	0	0	2	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0	0			Jul-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	●	●	●	●	●	●	●	●	●	●			Jul-14	98	84			89.9		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●			Jul-14	100	100			100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●			Jul-14	100	100			100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●			Jul-14	100	100			100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14	0	0	0	0	0	0	●		
Serious Incidents	0	0				●	●	●	●	●	●	●			Jul-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	●	●	●	●	●	●	●	●	●				Jul-14		24.2			24.2	26.1	●		
Caesarean Section Rate - Elective (%)			11	10	11	12	11	10	14	8	9	10			Jul-14		9.5			9.5	9.0			
Caesarean Section Rate - Non Elective (%)			13	15	10	16	14	13	12	18	18	15			Jul-14		14.7			14.7	16.8			
Maternal Deaths	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14		0			0	0	●		
Post Partum Haemorrhage (>2000ml)	48	4	●	●	●	●	●	●	●	●	●	●			Jul-14		1			1	2	●		
Admissions to Neonatal Intensive Care (%)	=<10.0	=<10.0	●	●	●	●	●	●	●	●	●	●			Jul-14		2.0			2.00	3.63	●		
Adjusted Perinatal Mortality Rate (per 1000 babies)	<8.0	<8.0	●	●	●	●	●	●	●	●	●				Jun-14		11			11.3		●		
Early Booking Assessment (<12 + 6 weeks) (%) - SWBH Specific	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●				Jul-14		75			75.17		●		
Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●				Jul-14		128			128		●		

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	●	●	●	●	●	●	●	●					May-14	100			100		●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●				Jun-14	92.2			92.2		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●				Jun-14	96.7			96.7		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●				Jun-14	88.9			88.9		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0				Jul-14	0			0	0	●		
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●				Jul-14	3.0			3.0		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0				Jul-14	0			0	0	●		
Sitrep Declared Late Cancellations	0	0	4	13	14	13	7	12	12	3	4	7			Jul-14	7			7	26	●		
RTT - Admitted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●				Jul-14	94.5			94.5		●		
RTT - Non Admitted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●				Jul-14	97.7			97.7		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●				Jul-14	97.9			97.9		●		
Patients Waiting >52 weeks	0	0	4	4	2	0	0	0	0	0	1	1			Jul-14	1			1		●		
Treatment Functions Underperforming	0	0	0	0	0	0	0	0	0	0	0				Jul-14	0			0		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●				Jul-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	34	48	58	60	67			Jul-14					34				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	90	90	96	90		90.6	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	80	74	100			82.9	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	5.01	6.73	4.36	6.48	5.72	4.58	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14	88	84	85	89		84.8	●		
New Investigations in Month			1	0	0	0	0	0	0	0	0	2			Jul-14					2				
Nurse Bank Use	6852	571	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14					505	1948	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Jul-14					62	154	●		
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	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>			Jul-14	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div></div>		
WTE - Actual versus Plan			<div>31</div>	<div>32</div>	<div>30</div>	<div>37</div>	<div>33</div>	<div>33</div>	<div>30</div>	<div>32</div>	<div>31</div>	<div>32</div>			Jul-14	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div>32</div>		<div></div>		
PDRs - 12 month rolling	=>95.0	=>95.0	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>		Jul-14	<div>93</div>	<div>95</div>	<div>71</div>	<div>98</div>	<div>82.4</div>		<div>87.0</div>	<div></div>		
Medical Appraisal and Revalidation	=>95.0	=>95.0	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>			Jul-14	<div>100</div>	<div>100</div>	<div>100</div>	<div>100</div>	<div>100</div>	<div>100</div>	<div>100</div>	<div></div>		
Sickness Absence	=<3.15	=<3.15	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>		Jul-14	<div>8.96</div>	<div>4.08</div>	<div>1.78</div>	<div>3.52</div>	<div>0.91</div>	<div>4.07</div>	<div>4.05</div>	<div></div>		
Mandatory Training	=>95.0	=>95.0	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>			Jul-14	<div>94</div>	<div>98</div>	<div>95</div>	<div>95</div>	<div>99</div>	<div>95.4</div>	<div></div>			
New Investigations in Month			<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>	<div>0</div>			Jul-14	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div>0</div>	<div></div>			
Your Voice - Response Rate			<div>17</div>			<div>36</div>			<div>30</div>					May-14	<div>38</div>	<div>34</div>	<div>20</div>	<div>32</div>	<div>56</div>	<div>30</div>	<div></div>	<div></div>			
Your Voice - Overall Score			<div>3.31</div>			<div>3.6</div>			<div>3.43</div>					May-14	<div>3</div>	<div>3.4</div>	<div>3.9</div>	<div>3.4</div>	<div>3.79</div>	<div>3.43</div>	<div></div>	<div></div>			

# 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	●	●	●	●	●	●	●	●	●	●			0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●			0	0	0	0	0	0	●		
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●					75.0		75.0	75.0	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●					98		98.1	99.0	●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0			0	0	0	0	0	0	●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●			0.1				0.1		●		
WTE - Actual versus Plan			26	20	21	18	28	28	15	13	11	13							13				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●			86	83	91	89		86.8	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●			100		100			100.0	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●			3.3	0.8	0.20	5.4	4.43	4.45	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●			89	91	94	95		90.9	●		
New Investigations in Month			0	0	1	0	0	0	0	2	2	0							0				
Nurse Bank Use	288	24	●	●	●	●	●	●	●	●	●	●							15	63	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●							152	644	●		
Your Voice - Response Rate			30		19			27							25	18	43	27	27				
Your Voice - Overall Score			3.73		3.72			3.79							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		AT	IB	IC					
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●				Jul-14				100		●		
Patient Safety Thermometer - Overall Harm Free Care	=>92	=>92	91	90	92	94	93	92	90	94	93	93			Jul-14				93.43		●		
Falls	0	0							8	9	11	13			Jul-14		13		13	41	●		
Falls with a serious injury	0	0						0	2	0	0				Jul-14	0	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	6.4			Jul-14				6.39	7.3	●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14				0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14				0	0	●		
FFT Response Rate - Wards	>25%	>25%						39	68	43	60				Jul-14				60	52	●		
FFT Score - Wards	=>68.0	=>68.0	94	100	93	85	83	82	81	95	87	83			Jul-14				83	86.5	●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0			Jul-14				0	0	●		
WTE - Actual versus Plan			55	70	32	34	34	34	27	36	45	45			Jul-14				45				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●			Jul-14	97	91	80		86.5	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●			Jul-14	3.47	2.71	4.58	3.80	3.81	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●			Jul-14	93	92	88		90.4	●		
New Investigations in Month			0	0	1	0	1	1	0	0	0	0			Jul-14				0				
Nurse Bank Use	5408	451	●	●	●	●	●	●	●	●	●	●			Jul-14				319	1272	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●			Jul-14				157	940	●		



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		AT	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	39			Jul-14				39	241	●		
Therapy DNA rate OP services (%)	=<9	=<9					11	12	12	16	11	11			Jul-14				11	12.4	●		
FEES assessment	>100	>8.3						1	7	10	3	4			Jul-14				4	6	●		
ESD Response time	<48 hrs	<48 hrs				●	●	●	●	●	●	●			Jul-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	72	73			Jul-14				73	73	●		
Avoidable weight loss	<20%	<20%		●	●	●	●	●	18	0	8	0			Jul-14				0	6.5	●		
Green Stream Community Rehab response time for treatment (days)	=<11	=<11					15	11	12	7.9	11	16			Jul-14				16.1	11.8	●		

# 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	164	149	154	162	176		Jul-14									176				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●		Jul-14	75	89	84	93	91	84	75		82.8	●			
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●		Jul-14			100						100	●			
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●		Jul-14	3.30	2.80	2.94	2.98	3.30	5.38	4.02		4.54	4.21	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●		Jul-14	94	95	96	89	99	90	93		91.5	●			
Nurse Bank Use	1088	91	●	●	●	●	●	●	●	●	●	●		Jul-14									211	668	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●		Jul-14									13	45	●		
New Investigations in Month			0	1	0	0	2	2	0	1	3	1		Jul-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				

**TRUST BOARD**

<b>DOCUMENT TITLE:</b>	<b>System Resilience</b>
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	<b>Rachel Barlow, Chief Operating Officer</b>
<b>AUTHOR:</b>	<b>Rachel Barlow, Chief Operating Officer</b>
<b>DATE OF MEETING:</b>	<b>4 September 2014</b>

**EXECUTIVE SUMMARY:**

Following on from last month's Trust Board, the attached documents:

- a) Operational resilience and capacity planning and Management 2014/2015  
Sandwell and West Birmingham Health Economy summary
- b) The final System Resilience plan for elective and non-elective care

The Trust has engaged fully in the process of creating the plan and in the consideration of resilience funding allocation.

However, we have now been asked to confirm the sufficiency of the plan to meet future challenges and have declined to do so pending further confirmation of the implementation plans of Birmingham City Council.

**Urgent Care****SRG plan**

The SRG have prioritised spending towards ED staffing, mental health and beds in line with the recovery plan. Both social services have money allocations for beds and staffing, although the Birmingham plan for this locality is not yet clear. On that basis, the CEO has not been able to fully sign up to the plan although it is hoped this matter can be resolved shortly.

**Performance**

The Trust continues to underperform in respect of the ED target with August to date = 94.62% and Quarter to date 94.33% (reference performance / plan in IPR). The main issues remain ED waits and the impact of the increasing DTOC on bed capacity. Over the past month, DTOC are an increasing issue for Birmingham City Council and little assurance of a plan to mitigate these has been provided. Additional capacity has been put in place to maintain safe flow but does not replace the 40 - 50 beds plan Trust often required for DTOC patients. A Chief Executive level meeting will take place in late August with Birmingham City Council.

A refreshed improvement ED trajectory aims to recover the year to date position in November with a breach tolerance of 30 breaches a day throughout the winter period to achieve year end compliance. The quarter performance is becoming more challenging with a tolerance of 22 breaches per day for the remainder of the quarter.

**Elective Care**

The delivery plans for RTT are supported have been supported by the CCG as part of the resilience plan. An activity and development plan is in place to recover the performance for oral surgery, T&O and cardiology by December. The plan is on track assuming successful recruitment and outsourcing of additional work to support plans. There is a current risk to the respiratory plan with failure to appoint a locum this month; the delivery plan is being revised to include new staff starting in October.

Diagnostic performance is forecast to meet all points of delivery in August.

There continue to be a small but unacceptable number of 52 week breaches each month. A number of development areas to be completed in the next 2 months as part of our RTT improvement plan include reviewing standard operating procedures, competence and training which will ensure best practice against long wait prevention. Each individual breach has been reviewed to a root cause. A comparative review of all breaches is underway to identify themes and will be reported to the next Quality and Safety Committee.

#### REPORT RECOMMENDATION:

To note and discuss exceptions

#### 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, previous Trust Board discussions

#### PREVIOUS CONSIDERATION:

Discussed at the August meeting of the Trust Board



# Operational resilience and capacity planning and Management 2014/2015 Sandwell and West Birmingham Health Economy

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## 1. Sandwell and West Birmingham Local Context

- 1.1 Delivering sustainable change in our local health care system is an on-going commitment from all key partners and we recognise that this is under pinned by innovation and transformation. This plan sets out how our health economy plans to deliver that, along with describing some of the changes that are already in place. Our plans will be consistent with a much wider long-term strategy.
- 1.2 Locally, we have Right Care, Right Here - a ten year long partnership for change, to which all the organisations in this plan subscribe. We have now had Ministerial agreement to close two A&E Departments and to create a single acute site that serves half a million residents opening in 2018. Sandwell and West Birmingham Hospital Trust have encountered successive difficult winters due to reduced staffing capacity and bed flow issues. Multiple external reviews have been undertaken and as a result a major programme of transformation has been initiated across the whole urgent care system, and performance managed through the Urgent Care Network Board.
- 1.3 Sandwell and West Birmingham has a well-established Urgent Care Network and robust partnerships across the Health Economy. The local health and social care system has worked closely together to develop services and build close links between organisations to assist in improving and sustaining Urgent Care services across Sandwell and West Birmingham. This Board, with additional partners, on the advice from NHS England will transform into the System Resilience Group, who will performance manage this plan as from August 2014.
- 1.4 The plan to develop and support out of hospital services, to enable the planned reduction in acute beds is well underway. The short term vision over the next two years in Sandwell and West Birmingham will see seven-day working across all services embedded and fully operational by the end of the 2015/16 financial year. This will be supplemented by improved access to community bed provision through nursing and residential homes, facilitated by more flexible access criteria, improved communication and collaborative working. During winter 2013/14, we commissioned extensions to seven-day services such as social care, rapid home visiting services, acute on-site mental health psychiatric liaison services and primary care services.
- 1.5 Evaluation of the winter plan 2013/14 showed areas where investment had made an impact on the urgent care system and others where resources were not as effective as anticipated. (A full evaluation of all winter schemes from 2013/14 has been prepared and is available upon request to the Area Team). Therefore, the operational resilience plan for 2014/15 is focussing on replicating the successful schemes, learning from past experience and addressing the current issues across the system. Evaluation of the winter plan 2013/14 showed that seven-day working, particularly in mental health and social care has been highly successful in avoiding admissions and speedier discharges. The CCG is continuing to commission these services for 2014/15

and will be strengthening the length of out of hours services for children and young adults with mental health issues.

- 1.6 The System Resilience funding has therefore been prioritised into six key areas to support the forthcoming winter. Taking into consideration past learning and current issues we are facing such as high numbers of Delayed Transfers of Care and reduced capacity in Emergency Departments we believe these are the areas in which to prioritise funding.
- 1.7 Prioritisation is focussed on A&E capacity, Winter Beds, Mental Health (determining place of safety at both EDs) and Enhanced Assessment Beds and Intermediate Care beds. In addition, schemes that supported the introduction of the new discharge pathway across Sandwell and West Birmingham Hospitals aimed at reducing Delayed Transfers of Care were also prioritised as high. The CCG then received confirmation that local SR plans must also reflect investment in WMAS bringing the number of priority areas to 6 in total.
- 1.8 In summary, we are proposing to commit the £3.278,190 million System Resilience funding as follows:

Priority Heading	Planned investment
A&E capacity	£276,248
Winter Beds	£546,124
Mental Health	£484,300
EAB and Intermediate Care Beds	£1,076,310
WMAS	£93,633
Facilitation of the new DTOC pathway	£801,575
	<b>£3,278,190</b>

- 1.9 During the same period of time, the bulk of the Better Care Fund will have been deployed in support of a continued downward trajectory of acute beds and an upward trajectory of outpatient services transferred to primary care and community service providers

- 1.10 Analytical Review of 2013/14 – as required by the published guidance, the CCG has asked the regional capacity management team to undertake an independent analysis of the patterns and trends seen across our local health economy last year. This is attached to the accompanying email, Titled Analytical Review of 2013/14.

## 2. Investment underpinning System Resilience

- 2.1 The plan for the Sandwell and West Birmingham is essentially straight forward. On top of our recurrent contracts, there are four major investment areas designed to deliver system resilience. These are:
- 2.2 **Demand management:** £6.7m invested by the CCG to support QIPP and primary care development. This comprises £2.5m for the QIPP projects delegated to LCGs and £4.2m for primary care development. The £6.7 million has been identified to support the development and implementation of demand management systems at a local level and the creation of a LIS for the prevention of unplanned admissions in our 75 years and over population. Furthermore, this money will also fund development of commissioning plans through push sites as part of the Better Care Fund and additional support and development of primary care through our work with the Primary Care Foundation in relation to access to services. As part of this programme of work there are projects which focus on the prevention agenda such as vaccination and immunisations, readmissions and long term conditions.
- 2.3 **Urgent Care Capacity:** £3.2m additional funding from NHS England to improve capacity during the winter. This will be committed to increase staffing to ensure seven day working, extra physical capacity in hospital and community care, mental health services to support A&E and increased intermediate care and re-ablement to maintain through put in the secondary care system. The SRG Plan has committed £93,633 as part of the required allocation to West Midlands Ambulance Service.
- 2.4 **Elective Capacity:** £2.5m from NHS England to deliver RTT. This will be invested in support of a plan agreed with SWBH Trust to maintain 18 week access overall and to ensure compliance for every specialty by the end of January 2015. There will be a focus on looking at elective demand management, in particular Trauma and Orthopaedics and Long Term Conditions.
- 2.5 **Better Care Fund:** £34m of funds transferred from the CCG to Sandwell Metropolitan Borough Council and Birmingham City Council to support adult



social care by 2015/16. This money will be invested by joint agreement between the CCG and both Councils through section 75 agreements and should ensure that there is adequate social care provision to support the local health and social care system.

- 2.6 In total this represents £12.4m of additional non recurrent funding this year and £34m of recurrent funding for 2015/16 through the BCF. It is a massive investment in the future of the health and social care system in Sandwell and West Birmingham and underpins the future for system resilience planning.
- 2.7 Whilst a marginal rate of 30% of the relevant published tariff it should be noted that the Emergency Threshold Marginal Tariff for 2014/15 is anticipated to be £0. This is due to the reduction in emergency admissions that SWBH has experienced since the benchmark was set in 2008/9, meaning that the threshold has not been breached since.

### **3. Governance Arrangements**

#### **System Resilience Group**

- 3.1 Sandwell and West Birmingham CCG has previously hosted the Urgent Care Network Board which provided a forum for all key partners and stakeholders to come together and review performance across the urgent care system and discuss developments and improvements. This forum already contains many of the stakeholders required to participate in the system resilience process and has demonstrated strong partnership working and ownership of performance issues.
- 3.2 At the July meeting of the Urgent Care Network board, members agreed that this group would morph into the System Resilience Group from August 2014. A revised Terms of Reference has been drafted (Appendix 1) and the membership is being refreshed to ensure appropriate seniority and scope. A number of new organisations have been invited to join the group, such as voluntary and community sector representatives, to ensure full compliance with the guidance.
- 3.3 The group will continue to be chaired by Andy Williams, Accountable Officer for Sandwell and West Birmingham CCG and a sub structure of specialised meetings around Urgent Care, Elective Care and Children's Services is being considered.
- 3.4 Given the accountability placed upon CCGs by the system resilience process a robust Governance process has been developed to ensure delivery against the agreed plans and the desired impacts are observed across the system.
- 3.5 The final list of schemes will be deliberated upon by senior officers from key partners and recommendations will be taken to a System Resilience Funding panel for ratification in August 2014. This panel will comprise clinical leaders, finance, performance, commissioners and the CCG Accountable Officer and

will continue to meet on a monthly basis (as a minimum) to review in detail commitment of funds, implementation progress of schemes and performance and activity. This panel may make recommendations to the System Resilience Group regarding the continuation of schemes and will formally report performance and activity to the System Resilience Group each month. Where schemes are dis-continued, investment will be reallocated to other schemes already submitted for consideration (this will be done on the basis of impact, ability to implement and available resource).

- 3.6 The monthly review of activity and performance will monitor each scheme against the key performance indicators and activity levels agreed at the outset. The CCG will request weekly reporting from providers to ensure real time decisions can be made and funding re-directed as appropriate. The CCG will oversee reporting upwards to the System Resilience Group and where appropriate the Area Team on plan performance.
- 3.7 In identifying the cohort of final schemes the CCG and partners will seek to guarantee that providers possess the necessary capacity and capability. Where the CCG is aware of provider issues with performance where there are issues with safety or quality, extra steps will be taken to safeguard patients, if the scheme is considered as a high priority and is needed to ensure system resilience.

#### **4. Conclusion**

- 4.1 This plan has been prepared by Sandwell and West Birmingham CCG with input from partners across the system. Principles for selection of the schemes to be included in this plan were ratified on 17/07/2014 at the Urgent Care Network Board with all partners present. Further work to prioritise and allocate funds to the six areas has been undertaken using previous learning and intelligence and targeting where are current issues in the system are. This is the final version of this System Resilience plan, with cross party sign off across the Health Economy.

**Appendix 1 – Draft Terms of Reference Sandwell and West Birmingham System Resilience Group**

**SANDWELL & WEST BIRMINGHAM CLINICAL COMMISSIONING  
GROUP**

**SYSTEM RESILIENCE GROUP**

**TERMS OF REFERENCE**

**1 PURPOSE OF THE GROUP**

Sandwell and West Birmingham System Resilience has been established in order to support the development and delivery of urgent and emergency care services and Planned Care Services in Sandwell and the West of Birmingham.

The System Resilience Group (SRG) will:-

1. Plan the capacity required to oversee the coordination and integration of services to support the delivery of effective, high quality, good value, and accessible services.
2. Be responsible for rigorous and on-going analytical review of the drivers of system pressures and the development of solutions through effective collaboration between partners.
3. Have a key responsibility in building consensus across members and stakeholders and advising especially on the use of non-recurrent funds and marginal tariff.
4. Hold members to account for actions resulting from internal review and shall share intelligence and pool resources to improve system delivery against agreed key performance indicators.
5. Give due regard to the targets, standards, plans and progress of other relevant work streams in the local health and social care economy.

The SRG have a specific focus upon:-

1. Year round resilience including allocation and performance management of system resilience funding and non elective and elective care pathways.
2. As part of planning for both elective and non elective care SRGs will ensure that there is a linkup between the principles incorporated within the wider planning agenda such as the Care Act 2014, Social Action Fund and the Better Care Fund.

- a). The Care Act consolidates the 2003 Delayed Discharges Act, SRGs must be aware of new regulations and take steps to ensure they are considered within the overall strategic approach to avoid hospital admissions and ensuring speedy discharge from hospital
  - b.) As part of operational resilience and capacity planning for non-elective care SRGs should serve to link BCF principles in the wider planning agenda – this will support integrated seven day working across health and social care organizations.
3. Determine service needs on a geographical footprint
4. Initiate the local changes needed and address issues that have previously hindered whole system improvements.
5. Each local system is expected to undertake a rigorous independent analytical review of the drivers of pressure to inform their planning for 2014/14 and thereafter.
6. Producing resilience and capacity plans that are risk assessed based on past performance, financial position, local intelligence and previous ability to successfully implement plans.

### **3. MEMBERSHIP OF THE GROUP**

The SRG will be Chaired by the Accountable Officer for the CCG, the Vice Chair will be the Chief Operating Officer for the CCG.

#### **Core members**

- Sandwell and West Birmingham CCG Officers including Clinical Leads
- Sandwell and West Birmingham Hospitals Trust including Clinical Leads and Community Services representation
- West Midlands Ambulance Service
- Sandwell MBC (Public Health, Social Services and Children's Services))
- Birmingham City Council (Public Health, Social Services and Children's Services)
- Black Country Partnership
- Birmingham and Solihull Mental Health Trust
- NHSE Area Team
- Crisis and Rapid Response Teams
- Birmingham Community Health Care
- Patient/Carer representative

#### **Ad hoc members**

- Primary Care representatives
  - Pharmacy

- Dental
- Minor Injuries/Walk In Centre providers
- Out of Hours providers
- Local Education Authority representative

#### **4. MEETING ARRANGEMENTS, ADMINISTRATION AND FREQUENCY**

The SRG shall meet on a monthly basis.

The Accountable Officer will be responsible for managing and co-ordination of the SRG.

- The PA to the Accountable Officer will be responsible for:-
- Preparation of the agenda in conjunction with the Chair/ Vice Chair
- Minuting the proceedings and resolutions of all meetings of the Group including recording the names of those present and in attendance. Minutes shall be circulated promptly to all members of the Group and any Sub-Committees;
- Keeping a record of matters arising and issues to be carried forward;
- Meeting papers must be sent out 7 days (5 working days) in advance of the meeting

#### **5 QUORUM**

Quoracy of the group will require at least 5 representatives from each partner organization to be present from the core list above.

#### **6 CONFLICTS OF INTEREST**

To ensure transparent governance arrangements, all members are requested to declare any conflict of interest at the start of each meeting, this is to be recorded by the minute taker.

Any member of the committee who has declared a conflict of interest should not take part in the discussion and any voting for that part of the meeting. It will be at the discretion of the Chair to permit the relevant member/s to remain in the room during discussions or ask them to step out of the meeting.

In the event that the Chair or the Chair and Deputy Chair have a conflict of interest, another voting member of the Committee will chair that part of the meeting.

Wherever a conflict of interest may be perceived, the matter must always be resolved in favour of the public interest rather than the individual member.

## **7      ASSURANCE AND RISK**

The Committee is responsible for reviewing the risks relating to the objectives in its work plan and; escalating key concerns to the Board of any updates or actions, or actions outstanding, so that the Board Assurance Framework/Corporate Risk register can be updated.

## **8      CONFIDENTIALITY AND FREEDOM OF INFORMATION**

All Committee minutes and papers could be disclosable under the Freedom of Information Act 2000. There are limited exemptions but copies may still need to be produced in a more limited format (e.g. where patient information is included).

The committee must set out a statement of what information falls within exemptions, if any, and ensure that papers and minutes are prepared appropriately and with this borne in mind.

It is the responsibility of the SWBCCG to ensure that there are appropriate secretariat arrangements in place in respect of the production, storage and archiving of Committee minutes.

All Board level committee minutes and agendas must be on the SWBCCG website with an archive of the last twelve months' minutes and agendas and up to date terms of reference.

Date of Agreement ...../...../.....

Date of Review ...../...../.....

## **Appendix 1**

### **THE NOLAN SEVEN PRINCIPLES OF PUBLIC LIFE**

#### **SELFLESSNESS**

Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

#### **INTEGRITY**

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

#### **OBJECTIVITY**

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

#### **ACCOUNTABILITY**

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

#### **OPENNESS**

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

#### **HONESTY**

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

#### **LEADERSHIP**

Holders of public office should promote and support these principles by leadership and example.

Operational resilience planning template for non-elective care 2014/15

Lead CCG:	Sandwell and west Birmingham CCG
Lead acute trust:	Sandwell and West Birmingham NHS Trust

Central Resilience Funding	£3,278,190
Marginal Tariff savings to reinvest	£0
Other funding available locally	£6,700,000
Total non-elective care support funding for 2014/15	£9,978,190

Section 1: Narrative on local system configuration, key strengths and key challenges

Delivering sustainable change in our emergency care system is an on-going commitment from all key partners and we recognise that this is under pinned by innovation and transformation. This plan sets out how partners plan to deliver that. Some of the changes are already in place. Our plans will be consistent with a long-term strategy. Locally, we have Right Care, Right Here - a ten year long partnership for change to which all the organisations in this plan subscribe. We have now had the agreement to close two A&Es and to create a single acute site that serves half a million residents opening in 2018. Sandwell and West Birmingham Hospitals encountered successive difficult winters due to reduced staffing capacity and bed flow issues. Multiple external reviews have been undertaken and as a result a major programme of transformation has been initiated across the whole urgent care system, performance managed through the urgent care network board.

Sandwell and West Birmingham has a well-established Urgent care Network and robust partnerships across the Health Economy. The local health and social care system has worked closely together to develop services and build close links between organisations to assist in improving and sustaining urgent care services across Sandwell and West Birmingham.

SWBCCG is also investing significant funds into areas of the wider urgent care system. £6.7 million has been identified to support the development and implementation of demand management systems at a local level and the creation of a LIS for the prevention of unplanned admissions in our 75 and over population. Furthermore, this money will also fund development of commissioning plans through push sites as part of the Better Care Fund and additional support and development of primary through our work with the Primary Care Foundation in relation to access to services. As part of this programme of work there are projects which focus on the prevention agenda such as vaccination and immunisations, readmissions and long term conditions.

Evaluation of the winter plan 2013/14 showed areas where investment had made an impact on the urgent care system and others where resources were not as effective as anticipated. Therefore, the operational resilience plan for 2014/15 is focussing on replicating the successful schemes, learning from past experience and addressing the current issues across the system.

The focus in 2014 to date has been on the reduction of delayed transfers of care (DTOCs). Levels of DTOCs are currently unprecedented. A recent bed audit has shown system flow pressures and our resources are directed at resolving these inefficiencies across the whole system.

This plan has been prepared by Sandwell and West Birmingham CCG and principles for selection of the schemes to be included in this plan was ratified on 17/07/2014 at the Urgent Care Network Board with all partners present. Further work to prioritise and allocate funds to the six areas has been undertaken using previous learning and intelligence and targeting where are current issues in the system are. This is the final version of this System Resilience plan, with cross party sign off across the Health Economy.

Section 2: Minimum plan requirements. Please note that development of a sufficient plan to deliver all of these elements is a pre-requisite to qualify for any central resilience funding in 2014/15. More detail on these plan requirements can be found on page 8 of the operational resilience and capacity planning document.

Ref	Minimum Plan Requirements	Summary of plan to achieve requirement	KPIs	Target Outcomes	Timeframe for Completion	Lead Accountable Officer	Estimated Costs in 2014/15
1	Enabling better and more accurate capacity modelling and scenario planning across the system	<b>Additional Acute medical beds</b> to accommodate DTOC and winter pressures, based on average of 12 beds; inclusive of medical and nursing cover.	Minimal medical outliers. 21.00hrs (7/7) 16 AMU medical beds available to enable out of hours flow and minimise 4 hr Access breaches	Available beds form AMU to core wards 24/7 to enable deliveru of the 4hr Access target. Additional DLN: Provides enhanced support for social workers and in-patient wad teams at weekends	Lead in time August - Oct - Beds identified. Workforce; recruitment programme in place	Name: Andy Williams Email: andywilliams5@nhs.net Job Title: Accountable Officer Organisation: SWBCCG	£546,124
2	Working with NHS 111 providers to identify the service that is best able to meet patients' urgent care needs	The CCG actively commissions this service and has already invested funds into meeting this requirement. Please see below for details (section 3.2)				Name: Andy Williams Email: andywilliams5@nhs.net Job Title: Accountable Officer Organisation: SWBCCG	
3	Additional capacity for primary care	Additional GP support to cover Hall Green in order to provide health support to the unit 7 days a week.	Regular (as agreed) proactive visiting schedule, OOH response within agreed timesclaes, patient satisfaction,	reduced admissions for patients on the unit, robut care planning, holistic assessment of needs, faster flow through bed stock	cover In place September - March, dependent upon release of funds	Name: Andy Williams Email: andywilliams5@nhs.net Job Title: Accountable Officer Organisation: SWBCCG	£26,124
		Utilisation of newly emerging ECP capacity within WMAS to provide a primary care urgent care response during times of peak demand (likely to be OOHs periods)	number of incidents, outcomes, number of patients referred to A&E or OOH GP Cover, patient experience	Increased number of patients dealt with in a community setting, reduced referrals to A&E or Out of Hours services, pilot service of new skill set within WMAS	service operational October - March		£93,633
		Mental Health Street Triage - pilot service in colloboration with West Mids Police.	Number of pt contacts, pt outcomes, patient experience, response time	Rapid identification of patients in MH crisis, correct resource available first time, early intervention and agreement of next stage of care	October - March		£50,987
		Occupational Therapy/ wrap around therapy support in EAB setting	number of patient contacts, patient experience, number of readmissions, number of 999 calls from home	improved health outcomes for patients, quicker flow through bed system , reduced readmissions, reduced falls	Support in place Sep - Mar		£25,124
4	Improve services to provide more responsive and patient-centred delivery seven days a week	Additional transport capacity will be required to respond to the extra beds and patient transfers over the winter period. The scheme includes the expansion of the service over a 7 day operational week.	number of additional journeys undertaken (above baseline). Number of failed discharges due to transport, response time	Removal of barrier to discharge to ensure patients have a good discharge experience, flow is created in bed system and capacity is available for new patients	additional transport capacity in place Sep - Mar	Name: Toby Lewis Email: tobylewis@nhs.net Job Title: Chief Executive Organisation: SWBH	£96,124
5	SRGs should serve to link Better Care Fund (BCF) principles in with the wider planning agenda					Name: Email: Job Title: Organisation:	
6	Seven day working arrangements for social care	Establish a joint health and social care team in the assessment units 7 days a week. Plan discharge from admission with single trusted assessment protocols.	DTOC in single figures. Initial EDD to be accurate for 70% of patients.	DTOC below 10 per acute site	Q3	Name: Andy Williams Email: andywilliams5@nhs.net Job Title: Accountable Officer Organisation: SWBCCG	£151,624
		Recruitment of additional CHC assessors to cover 7 days a week and minimise delays in assessment and discharge	number of assessments completed within agreed response time, number of assessments completed on weekends/bank holidays/ pt/carers satisfaction	to reduce delays in discharge associated with waiting for continuing healthcare assessments, facilitate flow within bed system and to provide excellent patient experience	1st October - 31st March		£70,213
7	Expand, adapt and improve established pathways for highest intensity users within emergency departments. Organisations will want to review the pathways for the group(s) most relevant to them (e.g. frail/elderly pathways, minors pathways, and mental health crisis presentations) and there must be evidence of sign-up to local Mental Health Crisis Care Concordat arrangements.	<b>Mental health:</b> Further increase in quality of care for patients with acute mental needs including late evening and night by establishing a place of safety and 24/7 mental health service on both acute sites. Additional support measures to ensure Places of Safety are fully effective (i.e. secure transport, AHMP capacity, home crisis HTT)	No 12 hr trolley breaches. Improved patient experience with reduced time spent in busy ED department.	Patient experience improved. Shorter trolley waits	Meeting scheduled with mental health Trust 27th July to established a model. Interim model of a designated cubicle on AMU's identified to transfer mental health patients into. Mental health Trust to estblish a 'flexible' RMN workforce to match daily demands	Name: Toby Lewis Email: tobylewis@nhs.net Job Title: Chief Executive Organisation: SWBH	£332,083
		Mental Health Early Response and Crisis Support arrangement for under 18s to be provided by Birmingham Childrens Hospital	Number of patients treated, response time, outcome, patient experience	Improve model of care offered to children and young people with faster response times and appropriate care settings. Redcution in number of DTA breaches linked to Mental Health	1st October - 31st March	Name: Andy Williams Email: andywilliams5@nhs.net Job Title: Accountable Officer Organisation: SWBCCG	£101,230



		Social Worker based in A+E at Sandwell sites. Will assist in social issues in order to decrease admissions of those admitted based on social needs	number of patient contacts, number of avoided admissions, number of referrals into care providers, hours of coverage	Early identification of those patients who may be admitted due to social care needs. Referrals into care and support organisations to enable patient to return to normal place of residence	1st October - 31st March	Name: David Stevens Email: david_stevens@sandwell-gov.uk Job Title: Director of Adult Social Care Organisation: Sandwell Metropolitan Borough Council	£96,124
8	Have consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand	<b>ED 7 day working / extended hours of senior decision makers</b> 1. Additional consultant cover at the weekends – 16:00-00:00 (Sat & Sun) 2. Additional ENP cover – Friday and Saturday night – 21:00-05:00 3. Additional fast-track cover (middle grade or Our GP) on Mondays 16:00-20:00  Oct-Mar :£90,062  <b>Nursing Initiatives</b> 1. Transfer Nurse (with existing porter) 7 days per week (16:00-22:00) 2. RMN nurse cover (ad-hoc 8hr bank shifts) circa 3-4 times per site per week Oct-Mar :£90,062	Zero tolerance to Non Admitted breaches. 8 D/C or transfers off the AMU's by 12 noon	4 hour Access target achieved cumulatively above 95%	Recruitment programme in place. Middle grade appointments scheduled to start August, Sept October and with ENP's appointments	Name: Toby Lewis Email: tobylewis@nhs.net Job Title: Chief Executive Organisation: SWBH	£180,124
9	All parts of the system should work towards ensuring patients' medicines are optimised prior to discharge	Additional investment has already been made in this area by SWBH, please see section 3.9 for more detail.				Name: Toby Lewis Email: tobylewis@nhs.net Job Title: Chief Executive Organisation: SWBH	
10	Processes to minimise delayed discharge and good practice on discharge	Additional Continuing Health care bed capacity to accommodate patients with particular needs (End of Life, Challenging Behaviour) to minimise delays in discharges	bed occupancy, LoS, patient satisfaction, number of DTOCs due to CHC placement	Rapid placement of patients with bespoke care needs to give better patient experience and reduce blockages in system. Ability to allow patients choice over place of death	5 beds 26 weeks and 2 beds 22 weeks. To be commissioned as soon as funding released	Name: Toby Lewis Email: tobylewis@nhs.net Job Title: Chief Executive Organisation: SWBH	£110,524
		Assessors will complete all assessments for care home providers to avoid delays in discharges. They will be sent with the referral paperwork. 2 x assessor roles to be created	number of assessments completed, number of pts accepted by care homes, response time for admission, number of DTOCs due to placements	reduction in discharges delays in system due to patients requiring placements, improved pt experience of discharge pathway	Septemeber - March		£20,000
		Providers will receive an incentive to complete assessments within 12 hours of receiving the referral and to also ensure providers work with the authority through a process of ensuring throughput of '10 in, 10 out'	Number of assessments completed within agreed response time, outcome of assessment, home occupancy rates, number of DTOCs due to placements	reduction in discharges delays in system due to patients requiring placements, improved pt experience of discharge pathway	Septemeber - March		£1,124
		20 flexible use community beds will be commissioned to ease discharge processes and ensure patients get the onward care, support and therapy that they require	LoS (against pt health and social care need), patient satisfaction, health outcomes, readmission rates, holistic care plans, Discharge destination,	Reduced LoS, better flow in system, more people returning to normal place of residence, holistic identification of needs and care planning	1st November - mid April		£596,124
		ICARES: model expansion / increase in-reach capacity in intermediate care settings to cover both Sandwell and west Birmingham across 7 days). It was piloted last year and could be implemented this winter & extended to Birmingham / City site	No increase in harm indicators, clinical incidents or complaints. Reduced LOS. More admission avoidance effective signposting, right bed right time	Safe discharges to Community beds. No adverse increase in harm indicators/complaints	Risk stratification model in place for Winter 2014/15.		£244,124
11	Plans should aim to deliver a considerable reduction in permanent admissions of older people to residential and nursing care homes	We intend to commission a number of enhanced assessment beds to allow assessments for ongoing care needs to occur in a non-acute setting which will lead to a reduction in the number of patients requiring permanent admissions to care homes	bed occupancy, LoS, patient satisfaction, number of DTOCs due to placement, number of patients who return home to normal place of residence	ensure that as many patients as possible are able and are supported to return to normal place of residence, prevent readmissions by putting support packages in place	Septemeber - March	Name: David Stevens Email: david_stevens@sandwell-gov.uk Job Title: Director of Adult Social Care Organisation: Sandwell Metropolitan Borough Council Name: Alan Lotinga Email: alan.lotinga@birmingham.gov.uk Job Title: Director of Adult Social care Organisation: Birmingham City Council	£288,414
		Additional 5 flats in the borough dispersed at different locations for patients who do not require an intermediate care bed. The model will be based on existing reablement model in Sandwell focussing on domestic reablement supporting with money management, confidence, washing, cleaning, cooking etc	bed occupancy, LoS, patient satisfaction, number of DTOCs due to placement, number of patients who return home to normal place of residence	ensure that as many patients as possible are able and are supported to return to normal place of residence, prevent readmissions by putting support packages in place	Septemeber - March		£56,124
12	Cross system patient risk stratification systems are in place, and being used effectively	Those individual that have been discharged from hospital or iEAB following rehabilitation will also need to be prevented from needing further support. Early use of technology whilst receiving reablement / rehabilitation will allow packages to be shaped / tested / tailored to meet the individual's needs during and after the intervention. This will help to withdraw services at the earliest opportunity, increasing capacity whilst safeguarding service users from any identified future risks. Full training of all reablement / rehabilitation staff and embedding the technology in the first contact assessment process will increase the speed of delivery and appropriateness of the technological solution. Adjustments to the technology can be identified by front line care staff on a day to day basis and relayed to STAY / MAPP engineers.	Number of people who avoid an admission to an intermediate care bed  30% reduction in admissions to Intermediate Care  Reduction in length of stay in IC units due to wrapping services around the patient's own home. (measure to be determined during September 2014)	Admission Avoidance to an Intermediate care bed by keeping patients in their own home with extra support  Number of patients whose rehabilitation goals that are met within 6 weeks at home  Enhanced flow within Intermediate care beds with reduced length of stay	Work of plans have commenced, modelling over August and Early September for model to commence 1st November 2014	Name: David Stevens Email: david_stevens@sandwell-gov.uk Job Title: Director of Adult Social Care Organisation: Sandwell Metropolitan Borough Council	£192,242
13	The use of real time system-wide data	The CSU has developed a dash board to give an overview of the urgent care system. The CCG is working with the CSU to understand roll out timescales. In addition daily data is available from a number of providers e.g. WMAS, 111, A&E. The SRG will be monitoring performance of all data as part of its terms of reference	Maintenance and performance of 95%, Reduction in number of DTAs and DTOCs, Management of Turn around times and handover times.	Performance review of all data concerning all providers across the Sesyem Resilience Group	Ongoing as part of the SRG	Name: Toby Lewis Email: tobylewis@nhs.net Job Title: Chief Executive Organisation: SWBH	Within existing resources

Total costs of all minimum requirement schemes:

Sum of cells above

£3,278,190

Section 3: Local Plans for Innovation. Plans over and above the minimum requirements to meet local patient needs. If there is any funding gap between the total emergency care support funding and the total costs of the minimum plan requirements, SRGs must present plans to close such gaps such that the minimum requirements are deliverable

Ref	Local Requirements	Summary of plan to achieve requirement	KPIs	Target Outcomes	Lead Accountable Officer	Estimated Costs in 2014/15
3.1	Enabling better and more accurate capacity modelling and scenario planning across the system	Escalation triggers developed and managed by Regional Capacity Management Team (RCMT) , economy wide surge planning linked to recognised triggers. The Trust and social care have established an joint operational hub. Development of a patient level electronic system in 2014 will further assist with flow through community and social care beds.	LOS, minimum bed availability, discharge goals daily	Understanding of whole system capacity and blockages within the system. Improved ability of organisation to match demand for beds throughout the day.This is the first time we are able to piece all these areas together to see the whole picture	Name: Andy Williams Email: andywilliams5@nhs.net Job Title: Accountable Officer Organisation: SWBCCG	RCMT service recurrently commissioned as part of the service level agreement with the CSU £54,000
		Increase the Capacity Management team at each acute site to support weekend working on 12 hour basis for the next 7 months (1.5 x Band 6).	Use of existing KPIs from Urgent Care scorecard relating to performance against 95% standard and availability of beds throughout the day	Improved ability of organisation to match demand for beds throughout the day	Name: Toby Lewis Email: tobylewis@nhs.net Job Title: Chief Executive Organisation: SWBH	£35,000

3.2	Working with NHS 111 providers to identify the service that is best able to meet patients' urgent care needs	SWBCCG hosts regional commissioning for NHS 111. Robust DOS in place which is regularly reviewed and updated. Reports of caller disposition received monthly and gaps or pressures across services are identified. The West Midlands DoS is agreed and validated by DoS leads and is monitored and reviewed on a regular basis. The service details are jointly ratified with Clinicians from Providers and by the Commissioners of the service. The usage of 111 is regularly monitored and reviewed. A reporting process is in place for call centre staff to highlight any DoS/Service issue encountered. Further training and support is being provided to call centre staff outside of pathways training to increase usage of alternative services. Integration with 111 and OOH is a key component of the service direct bookings access and GP streaming on key operational days	KPI's are consistently achieved (i.e. call answered in 60 seconds and abandonment rate ) Now 111 is stable and delivering high quality care work is underway to improve integration 111 with the broader Urgent Care System.	Understanding and use of all alternative pathways to enable patients to receive the right service, at the right time by the right professional and giving patients a choice whilst, avoiding unnecessary hospital attendances	Name: Andy Williams Email: andywilliams5@nhs.net Job Title: Accountable Officer Organisation: Sandwell and West Birmingham CCG (on behalf of CCG's in West Midlands)	The CCG commissions WMAS to update and maintain an accurate Directory of Services to ensure that patients contacting NHS 111 are directed to the most appropriate service - £32,126 recurrently
		SWBH is one of 8 pilots working with national team to reduce inappropriate attendances at City and Sandwell ED departments. SWBH looking to align outcomes of the behavioural audit with 111 initiative	Patients deflected by 111 to alternative providers	Reduced numbers of in appropriate attendances at City and Sandwell ED depts	Name: Toby Lewis Email: tobylewis@nhs.net Job Title: Chief Executive Organisation: SWBH	Costs are met through NHS 111 Central funding
3.3	Additional capacity for primary care	The CCG commissions a GP front end on both ED's 9am – midnight, this service will continue. Extension of Walk in Centre Hours at both parsonage street and Summerfield can be put in place over winter as pressures dictate. There is currently a Primary Care Assessment and Treatment Centre at Rowley Regis Hospital which is Primary Care led. An evaluation is currently taking place so may be extended over this winter period once a robust evaluation has taken place. The CCG invested heavily in primary care last winter with many practices opening 7 days per week. The winter evaluation did not shine favourably on these services as many appointments were not utilised and ED demand did not decrease. Better Care Fund commissioning plans will look to increase capacity in this area. £2.5 Million investments available for the over 75 LIS. There are 4 components: follow up of patients from 10 - 30 days discharge, Care planning training for practices, medicines anagements reviews, participation in Primary Care Foundation word regarding access.	100% of practices completed the PCF tool. 100% of practices signed up to deliver the over 75s LIS. Number of patients seen within 4 hours through the primary care front end service.	Improved access to primary care access as a result of better management of demand. Better flow through ED due to removal of minors. Improved experience for patient - getting the right care in the right place	Name: Andy Williams Email: andywilliams5@nhs.net Job Title: Accountable Officer Organisation: Sandwell and West Birmingham CCG	£2,500,000 is available via the LIS plus a further £2, 017,088 has been invested in the primary care A&E front end this year
3.4	Improve services to provide more responsive and patient-centred delivery seven days a week / Seven day working arrangements	Workshop held for all key partner organisations in May. Monthly project implementation (multi agency) group, is clinically led, chaired by CCG clinical lead for urgent care.this group will oversee the development of a work plan to support implementation of the 10 clinical standards	Acheivement of 10 clinical standards	better patient experineice, consistent admission/discharge rates across the week, reduced LOS, reduced mortality rates, reduced readmission rates	Name: Andy Williams Email: andywilliams5@nhs.net Job Title: Accountable Officer Organisation: Sandwell and West Birmingham CCG	Costs of implementation of 7 day working and achievement of 10 clinical standards still to be determined
3.5	SRGs should serve to link Better Care Fund (BCF) principles in with the wider planning agenda	investment in community development. Push site commissioning sites will seek to address areas of high non elective activity which will create headroom to invest resources in community based services, reducing pressure on Urgent Care. The principles put forward by the BCF around integration are key to the resilience of the urgent care system. Health and Social Care colleagues have developed strong working relationships over the past 2 years and the results of this can be seen in how the wider system is managed as a whole.	reduction in non elective admissions, reduced DTOCs, Reduced re-admissions (within 90 days) reduced admissions to care homes	Greater integration between health and social care, more efficient investment of resources across the system, greater range of preventative community services	Name: Andy Williams Email: andywilliams5@nhs.net Job Title: Accountable Officer Organisation: Sandwell and West Birmingham CCG	Over £2,000,000 has been earmarked for investment in the better care fund this year across Sandwell and West Birmingham
3.6	7 Day Working Arrangements for Social Care	Sandwell MBC and Birmingham City Councils have been delivering 7 day assessments and discharges 7 days per week since last winter. Funding to continue these services continues.	Increased number of assessments/discharges over weekends, better patient experience	reduced DTOCs, reduced LOS,		
		Establish a joint health and social care team in the assessment units 7 days a week. Plan discharge from admission with single trusted assessment protocols.	DTOC in single figures. Initial EDD to be accurate for 70% of patients.	DTOC below 10 per acute site		
3.7	Expand, adapt and improve established pathways for highest intensity users within emergency departments. Organisations will want to review the pathways for the group(s) most relevant to them (e.g. frail/elderly pathways, minors pathways, and mental health crisis presentations) and there must be evidence of sign-up to local Mental Health Crisis Care Concordat arrangements.	Alert system in place so that key clinicians are notified when high risk/frequent service users arrive in the ED. Pathways are then enacted to return patients to community services, where possible, as an alternative to acute admission. Considerable work is also ongoing around preventing these vulnerable groups from requiring an admission. A number of local organisations provide support to care homes and their patients who fall in to these target groups. Flags on SWBH IT systems so Icares are alerted when patients known the them attend the ED. Mental health crisis beds are in place and extra capacity is being commissioned, along with a rapid response ED service over the winter months. Frequent ED attenders who fall into the minors stream are picked up through the primary care front end, as described above. The CCG continues to commission a Care Home Lis to ensure medical coverage for these patients. Capacity has been added to the minors stream via the primary care front end (see 13.4) Through the UC board all key stakeholders are signed up to the MH Crisis Care Condorat and support these proposals	number of avoided admissions, number of patients on case load, reduced number of DTAs, reduction in number of patients breaching the 4 hour 95% standard	Improved patient experience, better flow through the ED, better integration of acute/community health services with social care, improved community offer to facilitate patients staying at home. Provision of the Right Care in the Right Place at the Right Time	Q3 Name: Toby Lewis Email: tobylewis@nhs.net Job Title: Chief Executive Organisation: SWBH	The cost of the nursing home LIS for 14/15 is £92,000. Cost of Implementating new pathway to be met from each responsible organisation and system resilience funds where appropriate.
3.8	Have consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand	RATS in place in peak periods in ED. This can be extended with 7 day staffing proposal.	Time to assessment , direct referral to AMU from ED	Reduction in time to assessment and increase in direct referral to AMU from ED	Name: Toby Lewis Email: tobylewis@nhs.net Job Title: Chief Executive Organisation: SWBH	TBC
3.9	All parts of the system should work towards ensuring patients' medicines are optimised prior to discharge	Pharmacists already review patient medication on the in-patient ward. Proposal: An enhanced model of provision to take account of greater interaction on the assessment units on a 7/7 basis; Reources: 2 x Band 7 for weekend and extended out of hours cover	Medication assessments undertaken out of hours	Avoidance of error and use of optimal medication	Name: Toby Lewis Email: tobylewis@nhs.net Job Title: Chief Executive Organisation: SWBH	Additional Pharmacist cover August - March: £30,000
3.10	Processes to minimise delayed discharge and good practice on discharge	Daily Cross organisational teleconfereces are in place to discuss blackages at an individual patient level and weekly multi agency meetings are held to review performance and remove blockages at a strategic level. Significant work has been undertaken at a CEO level to drive the development of a transformational pathway for assessment and discharge to remove delays from the system.	Reduced DTOC number, reduced section 5 issued (as action taken before issued)	Improved patient experience, agreed estimated dates of discharge, mult agency planning, reduction in DTOCs and LOS	Name: Toby Lewis Email: tobylewis@nhs.net Job Title: Chief Executive Organisation: SWBH	Implementation of new pathway - costs to be met from each responsible organisation and system resilience funds where appropriate.
		Additional DLN capacity to support 7 day working and fast track CHC assessment capacity throughout the full week	Assessments undertaken over the weekend; discharges over the weekend; waiting time for CHCAs	Reduced waiting times for assessments leading to earlier discharges / reduced length of stay	1st September: Recruitment to commence as soon as funding confirmed - use of bank & agency as interim measure	Additional DLN: £16,000 (August - Mar)

3.11	Plans should aim to deliver a considerable reduction in permanent admissions of older people to residential and nursing care homes	The response to point 10 (above) should also be considered here. The new pathway around DTOCs aims to ensure that assessments regarding care needs are not undertaken in an acute environment. Increased enhanced assessment bed provision is being sourced to ensure robust assessments can be undertaken with meaningful outcomes. This will result in fewer people requiring a permanent care home placement.	Number of permanent care home placements required (to reduce); number of assessments undertaken in an EAB; Number of assessments undertaken in an acute setting; patient experience	More patients get to return home- improved patient experience. Better management of available bed market. Integrated community services to support patient at home	Name: Andy Williams Email: andywilliams5@nhs.net Job Title: Accountable Officer Organisation: Sandwell and West Birmingham CCG	Implementation of new pathway - costs to be met from each responsible organisation and system resilience funds where appropriate.
3.12	Cross system patient risk stratification systems are in place, and being used effectively	The work undertaken by the primary care foundation/BCF will support practices to identify those patients who are at risk of becoming high intensity users without preventative input. CCG is currently investigating IT solutions for risk stratification and will be rolling a service out to member practices	reduced non-elective admissions, number of robust care plans in place,	better co-ordination/planning for at risk patients, better health outcomes. Robust commissioning plans	Name: Andy Williams Email: andywilliams5@nhs.net Job Title: Accountable Officer Organisation: Sandwell and West Birmingham CCG	Risk Stratification costs to be confirmed. Primary Care Foundation - £125000 non-recurrently
3.13	The use of real time system-wide data	Real time information regarding acute and community beds and pressures is circulated multiple times per day. This allows capacity and flow issues to be identified immediately and resolved before further escalation	Data items being automatically populated on screen	Quicker access to data that identifies areas for intervention	Name: Toby Lewis Email: tobylewis@nhs.net Job Title: Chief Executive Organisation: SWBH	£20,000

\*please add rows as appropriate

Section 4: Local Stakeholder Engagement. Please describe how you have considered each of the elements listed below and how you have included them in your resilience plans (as appropriate)

A	Independent Sector non-acute bed capacity (intermediate care, nursing homes, etc.)	Work has been undertaken throughout the year with care home providers to review current service available to patients and commissioners and to raise awareness of wider system pressures. Engagement with the West Midlands Care Home Association has also been undertaken around the 7 day working agenda and the role that care homes have to play in developing the system to meet these requirements. Considerable support and training is already in place for service providers to ensure that high quality care is available to patients
B	Other Independent Sector capacity (e.g. healthcare at home etc.)	Independent providers were engaged through last years "winter wash up" and they have been continuously engaged through the planning process for the own bed instead strategy to ensure the market is ready to respond to this initiative
C	Voluntary Sector capacity and expertise	The Voluntary and Community sector work in close partnership with the wider system and several engagement events have been held this year to talk organisations through the current pressures within the system and to seek actions as to how this sector can support service users to stay well and prevent crisis. Engagement at the Urgent Care Network Board has previously been via a nominated patient representative and through the Senior Commissioning Manager for Engagement. Going forward, the VCS umbrella organisations across Sandwell and West Birmingham have been invited to attend the SRG.
D	Flu vaccination of healthcare workers	Proposals are being developed to ensure that care workers across the system are vaccinated and there is a target in the main acute contract to ensure a vaccination rate of 75% amongst front line staff.
E	7-day a week commencement of new care packages (including over holiday periods)	The Sandwell and West Birmingham SR plan incorporates additional social worker resource to ensure that assessments and referrals can continue to be completed 7 days a week. Local Authority colleagues continue to develop strategies and plans to ensure discharges can be enacted 7 days a week and are working with providers to ensure they can be responsive.
F	Improvement in access to psychiatric liaison service teams in A&E	The local health and social care economy have prioritised Mental Health services as part of resilience planning. Whilst rapid response services are already operational across both acute sites improvements are required to avoid delays in care, to improve patient experience and enhance quality of care. Both local Mental Health trusts are key partners at system wide forums and are key in developing these services further.
G	Collaboration with and development of Children's services	With particular regard to Mental Health services there has been much focus at both a regional and unit of planning level. The CCG has been actively involved in working with providers of services for children and young people to develop a responsive service to those patients in need of mental health care. SWBH has developed a proposal for a Paediatric HDU to ensure that patients presenting at one of their hospital sites can access the highest level of care.
H	Engagement with patient representative groups	Umbrella voluntary and community sector organisations are operational across both Sandwell and Birmingham. These groups liaise across all VCSs and hold the ring for communication and engagement. Both organisations have been invited to join the SRG to ensure that the valuable insight and knowledge the VCS possess can be shared and that system wide resources can be activated as necessary.

Section 5: Key Partner Organisation Sign-Off. By signing this document you are stating both that you have been fully involved in developing this plan and that you will commit to attending all SRG meetings (or sending an appropriate deputy when unavailable).

Representative of:*	Name	Email	Job Title	Electronic Signature
SRG (Chair)	Andy Williams	<a href="mailto:andy.williams5@nhs.net">andy.williams5@nhs.net</a>	Accountable Officer SWBCCG	
Lead Acute Trust	Toby Lewis	<a href="mailto:Tobylewis@nhs.net">Tobylewis@nhs.net</a>	Chief Executive SWBH	
Lead Community Care Provider Icares	Fiona Shorney	<a href="mailto:fiona.shorney@nhs.net">fiona.shorney@nhs.net</a>	Clinical Group Director Community & Therapies	
Lead Community Care Provider BCHC	Tracy Taylor	<a href="mailto:tracy.taylor@bhamcommunity.nhs.uk">tracy.taylor@bhamcommunity.nhs.uk</a>	Chief Executive BCHC	
Local Authority SMBC	David Stevens	<a href="mailto:david_stevens@sandwell.gov.uk">david_stevens@sandwell.gov.uk</a>	Director of Adult Services SMBC	
Local Authority BCC	Alan Lotinga	<a href="mailto:alan.lotinga@birmingham.gov.uk">alan.lotinga@birmingham.gov.uk</a>	Director of Adult Services BCC	
Lead Mental Health Provider BCMHP	Karen Dowman	<a href="mailto:karen.dowman@bcpft.nhs.uk">karen.dowman@bcpft.nhs.uk</a>	Chief Executive	
Lead Mental Health Provider BSMHFT	John Short	<a href="mailto:John.short@bsmhft.nhs.uk">John.short@bsmhft.nhs.uk</a>	Chief Executive	
Ambulance Service	Jill Harvey	<a href="mailto:sue.green@wmas.nhs.uk">sue.green@wmas.nhs.uk</a>	Director of Nursing & Quality (Interim)	

\*please add rows as appropriate

Section 6: CCGs and Trust Finance Directors sign off that the plans are affordable, and will delivered whilst maintaining or improving their financial position

Representative of:*	Name	Email	Job Title	Electronic Signature
CCG representative	James Green	<a href="mailto:jmgreen@nhs.net">jmgreen@nhs.net</a>	Chief Officer Finance SWBCCG	
Lead Acute Trust	Tony Waite	<a href="mailto:tonywaite@nhs.net">tonywaite@nhs.net</a>		
Lead Community Care Provider Icares	Tony Waite	<a href="mailto:tonywaite@nhs.net">tonywaite@nhs.net</a>		
Lead Community Care Provider BCHC	Peter Axon			
Local Authority SMBC				
Local Authority BCC				
Lead Mental Health Provider BCMHP	Paul Stefanoski			
Lead Mental Health Provider BSMHFT				

Non-elective care costings template 2014/15

Section 1: Minimum Plan Requirements

Minimum Plan Requirements	Itemised Net Costings	WTE Nurse increases	WTE Doctor increases	WTE other staff increases	Increases in bed capacity	comments
Enabling better and more accurate capacity modelling and scenario planning across the system	£546,124 - Forecast requirement for additional beds. Costs inclusive of medical and nursing cover. £85K Q1 spent on additional beds.					
					12	Costs also include medical and nursing cover
Working with NHS 111 providers to identify the service that is best able to meet patients' urgent care needs						
Additional capacity for primary care	£26,124 to provide additional cover for patients in Hall Green		0.5			Dificult to specifiy required capacity as dependent upon bed occupancy and ad hoc call outs.
	£25,124 to provide wrap around services to these community beds			0.5		Costs to be split across required services, equating to around 0.5WTE in total additional capacity
	Street triage - £50,987 to cover 2 x band 6 CPNs	2				part year effect
	Utilisation of newly emerging ECP capacity within WMAS . £93,633 all costs to be spent on staffing and transportation costs required for service provision.			1		Service requirements still being developed, WTE may change due to final hours of operation agreed
Improve services to provide more responsive and patient-centred delivery seven days a week	£96,124 to meet the increased demand for patient transportation during winter and also in recognition of the additional beds being put into the system					
SRGs should serve to link Better Care Fund (BCF) principles in with the wider planning agenda						
Seven day working arrangements	Additional S/W capacity to facilitate new MDT meetings £151,624 . Staffing and on costs			3.5		3 Social Workers and 0.5 WTE admin support
	Additional CHC assessors - £70,213. Band 7 posts. Staffing and on costs	3				
Expand, adapt and improve established pathways for highest intensity users within emergency departments. Organisations will want to review the pathways for the group(s) most relevant to them (e.g. frail/elderly pathways, minors pathways, and mental health crisis presentations) and there must be evidence of sign-up to local Mental Health Crisis Care Concordat arrangements.	Mental health - ED place of safety and support services. Sandwell - £104,846 to cover 4.7 WTE increase in resource. City - £171,461 to cover 6.4 WTE increase in resource. Additional support measures to ensure Places of Safety are fully effective £ 55,776	11		2.6		
	Mental Health Early Response and Crisis Support arrangement for under 18s to be provided by Birmingham Childrens Hospital -£101,230	3		0.5		3 nurses + 0.5WTE Psychologist
	A&E based Social Worker 7 days a week - £96,124 staffing and on costs			1.4		
Have consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand	<b>ED 7 day working / extended hours of senior decision makers</b> 1. Additional consultant cover at the weekends – 16:00-00:00 (Sat & Sun) 2. Additional ENP cover – Friday and Saturday night – 21:00-05:00 3. Additional fast-track cover (middle grade or Our GP) on Mondays 16:00-20:00  Oct-Mar :£90,062  <b>Nursing initiatives</b> 1. Transfer Nurse (with existing porter) 7 days per week (16:00-22:00) 2. RMN nurse cover (ad-hoc 8hr bank shifts) circa 3-4 times per site per week Oct-Mar :£90,062	2	0.21			
All parts of the system should work towards ensuring patients' medicines are optimised prior to discharge						
Processes to minimise delayed discharge and good practice on discharge	£110,524 - Additional Continuing Health care bed capacity - 1 Ehnanced Bed, 1 complex needs bed and 5 palliative care bed				7	
	£20,000 will be invested in a trusted assessor model whereby an assessor will undertake assessments on behlaf of care homes. Additionally, we may incentivise homes who responsd within 24 hours (£1124)			1		
	20 flexible beds to include GP cover £580,000 plus additional funding (£16,124) for Wrap around support services					Amount of additional wrap around resource still to be determined
	Icares - £244,124 to cover recruitment of additional staff (Therapists/Nurses/RSWs)	1		7		20 therefore unable to specifiy additional WTE staff resource curenently

Plans should aim to deliver a considerable reduction in permanent admissions of older people to residential and nursing care homes	£288,414 (£116,124 Sandwell, £172,290 Birmingham) will be invested in 18 Beds (5 EAB and 3 Nursing Home Birmingham, 10 EAB Sandwell ) across both localities				1	18	1 staff member = Occupational Therapist
	5 reablement flats will be commissioned across Sandwell for patients who do not require an intermediate care bed - £56,124					5	
Cross system patient risk stratification systems are in place, and being used effectively	Own Bed instead Strategy implementation - £192,242					48	please note that these are bed equivalents as patients will be in their own homes.
The use of real time system-wide data							
Sub Totals		22	0.71	18.5	110		

Section 2: Local Plans for Innovation

Minimum Plan Requirements	Itemised Net Costings	WTE Nurse increases	WTE Doctor increases	WTE other staff increases	Increases in bed capacity	Comments
Enabling better and more accurate capacity modelling and scenario planning across the system	£35,000 to support increased staffing in capacity management team at SWBH. £54,000 SLA value covering agreement between CCG and CSU for regional capacity management			2.5		1.5 WTE Capacity Manager, approx 1 WTE support from RCMT
Working with NHS 111 providers to identify the service that is best able to meet patients' urgent care needs	CCG commissions a role to maintain and regularly update the Dos - £32,126			0.25		
Additional capacity for primary care	£2, 017,088 has been invested in the primary care A&E front end this year	2.5	2.5	2.5		
Improve services to provide more responsive and patient-centred delivery seven days a week / Seven day working arrangements	To be Determined					Costs of implementation of 7 day working and achievement of 10 clinical standards still to be determined therefore WTE increases currently unknown
SRGs should serve to link Better Care Fund (BCF) principles in with the wider planning agenda	Money is already being invested to support the commissioning of services through BCF principles, please see lines 23 & 27 for detail					
7 Day Working Arrangements for Social Care	Sandwell MBC and Birmingham City Councils have been delivering 7 day assessments and discharges 7 days per week since last winter. Funding to continue these services continues. Bham £89k			8.9		Birmingham - 0.8 - 1.6 WTE social worker dependent upon demand. 0.25 wte manager and 0.25WTE home care planner. Sandwell - Joint Equipment Store: 0.4 Manager, 0.4 x ARO, 0.4x Warehouse Op, 0.8 x Technicians. Sundays as per but 0.2 technician Hospital team: 0.8 x LP, 1.6 x AP, 0.8 x CCO all working 8-4, STAR 3.6
	Establish a joint health and social care team in the assessment units 7 days a week. Plan discharge from admission with single trusted assessment protocols.			TBC		This is a new element of the service and action/implementation plans are still being developed. Some costs are to be met through the SR funding and any other costs will be met from exsiting resources across the partner agencies
Expand, adapt and improve established pathways for highest intensity users within emergency departments. Organisations will want to review the pathways for the group(s) most relevant to them (e.g. frail/elderly pathways, minors pathways, and mental health crisis presentations) and there must be evidence of sign-up to local Mental Health Crisis Care Concordat arrangements.	£92,000 is invested by the CCG into additional medical cover for nursing homes					The CCG anticipates 1791 visits to care home residents to be undertaken this year by primary care staff (GPs, PNs, HCAs etc)
Have consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand	RATS in place in peak periods in ED. This can be extended with 7 day staffing proposal.	2.4	0.75			
All parts of the system should work towards ensuring patients' medicines are optimised prior to discharge	Additional Pharmacist cover August - March: £30,000			1		part year effect only
Processes to minimise delayed discharge and good practice on discharge	Additional DLN: £16,000 (August - Mar)	1				part year effect only
Cross system patient risk stratification systems are in place, and being used effectively	Risk Stratification costs to be confirmed. Primary Care Foundation - £125000 non-recurrently					The Primary Care Foundation work is aimed at helping practices manage their workload more effectively/efficiently and work smarter. This work will not increase overall staffing resource across the CCG but it should create space for existing teams
* add more rows as required						
Sub Totals		5.9	3.25	15.15	0	

Total Capacity Increases*		27.9	3.96	33.65	110		
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\* needs to link to capacity plan

Operational resilience planning template for elective care 2014/15

Lead CCG:	Sandwell and West Birmingham CCG
Lead acute trust:	SWBH NHST

Central Resilience Funding	
Other funding available locally	£2,470,000
Total elective care support funding for 2014/15	

Section 1: Narrative on local system configuration, key strengths and key challenges

The plan for 2014-15 was to achieve specialty level compliance by October 2014. Unfortunately the Trust is behind its plan for three reasons:

- Failures of supply provision, including prioritising emergency surgical work
- Problems of supply provision, leading to unacceptable high costs to meet delivery
- Demand side growth above expectations

The plan for 2014-15 is to maintain compliance during the recovery period with delivery by specialty in January 2015

The Trust has delivered the 18 week standard for several years every month. In 2013-14 the organisation remedied a very long-term misreporting issued, primarily associated with non-admitted patients. The IST have reviewed the scripts now operating in the Trust and considers them acceptable.

Section 2: Minimum plan requirements. Please note that development of a sufficient plan to deliver all of these elements is a pre-requisite to qualify for any central resilience funding in 2014/15. More detail on these plan requirements can be found on page 10 of the operational resilience and capacity planning document.

Text in blue italics is provided as examples only and should be overtyped

Ref	Minimum Plan Requirements	Summary of plan to achieve requirement	Timeframes for completion	Assurance Mechanisms	Lead Accountable Officer	Estimated Costs in 2014/15
1	Review and revise the Trusts' patient access policy, and supporting operating procedures. The policy should include reference to cancer and other urgent patients, and should be made accessible to patients and the public. A revised policy should be publicly available by September 2014	The Elective Access Policy has been revised and SOPs have been developed. The policy is not currently available on the internet however this will be corrected	By 31 August 2014	Trust RTT Lead to review against national guidelines	Name: Matthew Dodd Email: matthew.dodd@nhs.net Job Title: Deputy COO Organisation: SWBHT	<i>Backfill for Trust Elective Care lead full-time (2 months): £10,000</i>
2	Develop and implement a RTT training programme for all appropriate staff, focussing on rules application, and local procedures, ensuring all staff have been trained during 2014/15	Look into whether there is an 18 week training package already developed and whether it meets the Trust needs. If so work with the company to roll out the training to all appropriate staff. If not then work with the Trust RTT Lead to develop an in house training.	Mar-15	Staff to pass a test to confirm knowledge	Name: Nicola Cooper Email: nicolacooper2@nhs.net Job Title: Interim Head of Elective Access Organisation: SWBHT	Developer & facilitation time: £25,000; Product licencing and implementation costs: £10,000; backfill costs for staff: £15,000
3	Carry out an annual analysis of capacity and demand for elective services at sub specialty level, and keep under regular review and update when necessary. This should be done as part of resilience and capacity plans and then updated in operating plans for 2015/16	After completing the modelling exercise for the remedial action plan the trust and commissioners have agreed to using activity and capacity modelling to form part of the ongoing delivery of 18 weeks	Complete	Confirm& challenge with SWBHT of local plans	Name: Matthew Dodd Email: matthew.dodd@nhs.net Job Title: Deputy COO Organisation: SWBHT	
4	Build upon any capacity mapping that is currently already underway, and use the outputs from mapping exercises as an annex to resilience and capacity plans. This will avoid duplication and integrate capacity mapping into 'business as usual' arrangements	Existing capacity modelling has been carried out by the trust and has been used to develop a model for the delivery of the national remedial action plan for RTT	Complete	Confirm& challenge with SWBHT of local plans	Name: Matthew Dodd Email: matthew.dodd@nhs.net Job Title: Deputy COO Organisation: SWBHT	
5	Ensure that all specialties understand the elective pathways for common referral reason/treatment plans, and have an expected RTT 'timeline' for each (e.g. DTA by week x). This should be in place by September in order to ensure that activity is maintained at a level where waiting lists are stable	This information is known within the specialities but is not always documented.	Sep-14	Documented evidence of common pathways per specialty	Name: Nicola Cooper Email: nicolacooper2@nhs.net Job Title: Interim Head of Elective Access Organisation: SWBHT	Additional waiting list management support to Clinical Groups for the rest of the year (2 x Band 6): £30,000
6	'Right size' outpatient, diagnostic and admitted waiting lists, in line with demand profile, and pathway timelines (see IMAS Capacity and demand tools)	Use activity and capacity modelling tools to scope out capacity in the short term but to also future proof the sustained delivery of 18 weeks going forward. <b>Resources:</b> Additional IT support with profiling: 1 x Bd 6	Oct-14	Waiting lists have been reviewed and profile understood	Name: Nicola Cooper Email: nicolacooper2@nhs.net Job Title: Interim Head of Elective Access Organisation: SWBHT	Additional IT support with profiling: 1 x Bd 6 (August - Oct) £6,000
7	With immediate effect, review local application of RTT rules against the national guidance, paying particular attention to new clock starts and patient pauses	Review all local SOP's to ensure that they are line with RTT Rules	Dec-14	Rules within each specialty have been reviewed	Name: Nicola Cooper Email: nicolacooper2@nhs.net Job Title: Interim Head of Elective Access Organisation: SWBHT	
8	Pay attention to RTT data quality. Carry out an urgent 'one off' validation if necessary if not done in that last 12 months, and instigate a programme of regular data audits	SWBH carried out a data validation exercise in 2013 and has had its scripts agreed with the IST. The trust also has 'kite marked' data quality assurance processes in place. <b>Resources:</b> Additional Data Validation team funding to expand the number of records that can be reviewed (4 x Band 3)	Ongoing	Real time' validation of waiting lists	Name: Matthew Dodd Email: matthew.dodd@nhs.net Job Title: Deputy COO Organisation: SWBHT	Additional DV team August - Mar: £48,000
9	Put in place clear and robust performance management arrangements, founded on use of an accurate RTT PTL, and use this in discussion across the local system	The trust PTL is reviewed by commissioners on a weekly basis and queries raised as to the actions needed to remove long waits from the system. T	Complete	Weekly information sent to CCG	Name: Nicola Cooper Email: nicolacooper2@nhs.net Job Title: Interim Head of Elective Access Organisation: SWBHT	
10	Ensure that supporting KPIs are well established (size of waiting list, clearance time, weekly activity to meet demand, RoTT rate, etc) and are actively monitored	The trust currently looks at these KPIs as a regular part of 18 weeks monitoring the suggestion is that these will form part of the commissioners review of 18 weeks performance	Complete	Dashboard	Name: Nicola Cooper Email: nicolacooper2@nhs.net Job Title: Interim Head of Elective Access Organisation: SWBHT	
11	Demonstrate how good practice in referral management is being followed	There are few referral management schemes being followed in primary care. There needs to be greater focus on use of the Map of Medicine arrangements which detail the pre-referral and referral pathways.	Ongoing	More pathways actively managed ia the Map of Medicine	Name: Nicola Cooper Email: nicolacooper2@nhs.net Job Title: Interim Head of Elective Access Organisation: SWBHT	
12	Demonstrate that patients receiving NHS funded elective care are made aware of and are supported to exercise choice of provider	The Trust has policies which support this. A robust communication plan from the CCG is required to reiterate patients rights under the NHS constitution and the role of GPs in offering choice.	Ongoing		Name: Matthew Dodd Email: matthew.dodd@nhs.net Job Title: Deputy COO Organisation: SWBHT	
13	Provide assurance during Q2 2014/15 at Board level on implementation of the above	Resilience plan to go to governign bodies August / September			Name: Rachel Barlow Email: rachel.barlow2@nhs.net Job Title: COO Organisation: SWBHT	Project maanger cost to establish support PMO £50K
Total costs of all minimum requirement schemes: <i>Sum of cells above</i>						

Section 3: Local Plans for Innovation. Plans over and above the minimum requirements to meet local patient needs. If there is any funding gap between the total elective care support funding and the total costs of the minimum plan requirements, SRGs must present plans to close such gaps such that the minimum requirements are deliverable

Ref	Local Requirements	Summary of plan to achieve requirement	KPIs	Target Outcomes	Lead Accountable Officer	Estimated Costs in 2014/15
13	Implement plans to reduce waiting list backlogs and ensure that as many patients as possible are treated within 18 weeks	Implementation of additional working to support accelerated reduction of waiting lists	% of non-admitted patients treated within 18 weeks; % of admitted patients treated within 18 weeks; % of incomplete pathways where patients have been waiting under 18 weeks	95% of non-admitted patients treated within 18 weeks; 90% of admitted patients treated within 18 weeks; 62% of incomplete pathways where patients have been waiting under 18 weeks	Name: Rachel Barlow Email: rachel.barlow2@nhs.net Job Title: COO Organisation: SWBHT	£2,480,000

\*please add rows as appropriate

Section 4: Local Stakeholder Engagement. Please describe how you have considered each of the elements listed below and how you have included them in your resilience plans (as appropriate)

A	Independent Sector non-acute bed capacity (intermediate care, nursing homes, etc.)	
B	Other Independent Sector capacity (e.g. healthcare at home etc.)	IS theatre and bed capacity is to be used to support the Trust trajectory recovery plan
C	Voluntary Sector capacity and expertise	
D	Flu vaccination of healthcare workers	
E	7-day a week commencement of new care packages (including over holiday periods)	
F	Collaboration with and development of Children's services	
G	Engagement with patient representative groups	

Section 5: Key Partner Organisation Sign-Off. By signing this document you are stating both that you have been fully involved in developing this plan and are committed to its delivery

Representative of:* CCG representative	Name	Email	Job Title	Electronic Signature
Acute Trust Representative				
Lead Community Care Provider				
Local Authority				
Lead Mental Health Provider				
Ambulance Service				

\*please add/delete rows as appropriate

Section 6: CCGs and Trust Finance Directors sign off that the plans are affordable, and will delivered whilst maintaining or improving their financial position

Representative of:*	Name	Email	Job Title	Electronic Signature
CCG representative				
Acute Trust Representative				
Lead Community Care Provider				
Local Authority				
Lead Mental Health Provider				
Ambulance Service				

\*please add rows as appropriate

Elective care costings template 2014/15

Section 1: Minimum Plan Requirements

Ref	Minimum Plan Requirements	Itemised Net Costings	WTE Nurse increases	WTE Doctor increases	WTE other staff increases	Additional Outpatient Appointments	Additional Inpatient/Daycase procedures	Add more columns as required
1	Review and revise the Trusts' patient access policy, and supporting operating procedures. The policy should include reference to cancer and other urgent patients, and should be made accessible to patients and the public. A revised policy should be publicly available by September 2014	1 x band 7 manager - £10,000	N/A	N/A	1 wte manager (2 months)	N/A	N/A	
2	Develop and implement a RTT training programme for all appropriate staff, focussing on rules application, and local procedures, ensuring all staff have been trained during 2014/15	Developer & facilitation time: £25,000; Product licencing and implementation costs: £10,000; backfill costs for staff: £15,000			1			
3	Carry out an annual analysis of capacity and demand for elective services at sub specialty level, and keep under regular review and update when necessary. This should be done as part of resilience and capacity plans and then updated in operating plans for 2015/16							
4	Build upon any capacity mapping that is currently already underway, and use the outputs from mapping exercises as an annex to resilience and capacity plans. This will avoid duplication and integrate capacity mapping into 'business as usual' arrangements							
5	Ensure that all specialties understand the elective pathways for common referral reason/treatment plans, and have an expected RTT 'timeline' for each (e.g. DTA by week x). This should be in place by September in order to ensure that activity is maintained at a level where waiting lists are stable	Additional waiting list management support to Clinical Groups for the rest of the year (2 x Band 6): £30,000			2			
6	'Right size' outpatient, diagnostic and admitted waiting lists, in line with demand profile, and pathway timelines (see IMAS Capacity and demand tools)	Additional IT support with profiling: 1 x Bd 6 (August - Oct) £6,000			1			
7	With immediate effect, eview local application of RTT rules against the national guidance, paying particular attention to new clock starts and patient pauses							
8	Pay attention to RTT data quality. Carry out an urgent 'one off' validation if necessary if not done in that last 12 months, and instigate a programme of regular data audits	Additional DV team August - Mar: £48,000			4			
9	Put in place clear and robust performance management arrangements, founded on use of an accurate RTT PTL, and use this in discussion across the local system							
10	Ensure that supporting KPIs are well established (size of waiting list, clearance time, weekly activity to meet demand, RoTT rate, etc) and are actively monitored							
11	Demonstrate how good practice in referral management is being followed							
12	Demonstrate that patients receiving NHS funded elective care are made aware of and are supported to exercise choice of provider							
13	Provide assurance during Q2 2014/15 at Board level on implementation of the above	Project manager costs to supprot PMO establishment £50K			1			
Sub Totals								

Section 2: Local Plans for Innovation

Local plans for innovation	Itemised Net Costings	WTE Nurse increases	WTE Doctor increases	WTE other staff increases	Additional Outpatient Appointments	Additional Inpatient/Daycase procedures	Add more columns as required
12The CCG are currently looking at a centralised decision and clinical support tool. The system has the functionality of pathway and referral management but includes the ability to capture centralised information such as monitoring of pathway usage and referrals. The pathway element has the option to have trigger points in the pathways so for example GPs won't be able to proceed to referral if the referral criteria as indicated in the pathway has not been met.	Purchase of the tool and implementation costs - £80K						
* Add more rows as required							
Sub Totals							
Total Capacity Increases*							

\* needs to link to capacity plan



## Wider Planning Considerations for SRGs 2014/15

### Section 1: Planning

Wider Planning Considerations for SRGs	Summary of plan to achieve requirement
<b>Discharge Planning.</b> SRGs can support improved discharge by ensuring members of the SRGs have effective systems in place, and work towards avoiding inappropriate delays	Delayed Transfers of Care (DTOCS) have been an issue for the SWB Health economy during 2014. Projected DTOCS should be less than 10 at each acute site. Currently and throughout the past 7 months DTOCS have risen in their 20's on each site. The CCG has played a pivotal role in getting all partners together to understand the issues and establish a way forward for change. All partners have agreed to deliver a different discharge pathway commencing October 2014. This will have a wider effect on the whole discharge system and how patients flow through the system. DTOCs in particular will be reduced by having all assessments undertaken in community EAB beds, rather than taking up an acute bed when the patient is medically fit for discharge.
<b>Working with ambulance services</b> to ensure they have access to live data from emergency departments to help distribute the workload and regulate the flow between hospitals	There are a number of ways in which West Midlands Ambulance Service are aware of the live situation in hospitals. There is the Escalation Management System managed by the Regional Capacity Management Team that gives regular updates on the situation across the health economies in the West Midlands. WMAS will be notified when acute trusts escalate to a new level of pressure. There is also the SOC (Strategic Operation Centre part of WMAS) that monitors activity of ambulances in real time across the West Midlands and helps to manage the flow of ambulances where pressure points arise. Particular issues are dealt with by the SOC or escalated to Gold Command. There is also the Hospital Ambulance Liaison Officers (WMAS staff) that have been commissioned by SWBCCG and by many CCG's in the West Midlands to work directly between hospitals and WMAS to manage the flow of patients at A&E Departments. All of this is on top of a range of WMAS operational staff who manage issues as required in their areas of responsibility.
<b>Unscheduled care.</b> Focus on the cause of the rise of unscheduled care and act to avoid unnecessary episodes.	As a system we recognise the rise in attendances and admissions that our local urgent care system has seen over the last 18 months and are working hard to reverse this trend and manage presenting demand efficiently. A more detailed breakdown of the particular issues we have seen is included in the accompanying word document "Operational Resilience and Capacity Planning and Management 2014/15". Collectively partners across the local Health Economy have been working hard to develop the long term out of hospital strategy that includes unscheduled care along with step down and step up services. Much attention has been on developing the strategy for "own bed instead". An audit of all Intermediate care facilities, both health and social care commissioned, has been undertaken during 2013/2014 along with bed and service modelling for the future. The current lengths of stay in all IC facilities are well above the national average of 26.9 days so we are working with our providers to reduce lengths of stay along with incorporating 7 day discharges and 7 day services. We have recently been given the go ahead to move from two acute sites to build the brand new hospital with one single ED. A whole system of change programmes are being undertaken to build the capacity in primary and community care to enable the bed reduction requirements. Much work is being undertaken on developing primary care and radically changing access.
<b>Flu Planning.</b> SRGs should submit plans that include robust and flexible preparations for the unpredictability of flu and should meet all vaccinations requirements.	To mitigate the risk of high ambulance call-outs, hospital admissions and re-admissions from vulnerable patients residing in nursing homes, ICOF LCG has developed a plan to actively offer vaccinations to all high risk patients in the 32 nursing homes across the Sandwell and West Birmingham CCG footprint during September and October. This will contribute to reduction in ambulance call-outs, hospital admissions and re-admissions and other vaccine preventable illnesses. The CCG will also actively run an Influenza awareness campaign supported by Communications team, CSU to raise awareness of the benefits and risks associated with flu. All member practices are encouraged to offer the Influenza DES and to maximise uptake rates ensuring the majority of our most vulnerable patients are protected.
<b>Publication</b> - SRGs are expected to publish resilience and capacity plans including a breakdown of how allocated monies will be spent.	Following agreement and sign off of the plan through the system resilience group, the plan will then be taken through internal CCG Governance processes in recognition of the accountability placed on it by the plan. After this process, the plan will be published on the CCG website, accessible by anyone and awareness will be raised by our communications and engagement teams through the usual channels (twitter, patient forums, VCS networks, newsletters etc).

### Section 2: Patient Experience

Wider Planning Considerations for SRGs	Summary of plan to achieve requirement
<b>Right care, right time, right place.</b> SRGs should eliminate unnecessary gatekeeping and work to enable ambulances to take patients to urgent care centres and access social care and mental health teams	DoS updated with all appropriate services, WICs on patch accept ambulances and meet turnaround times. Encourage use of 111 so that patients get the care they need in the most appropriate setting and timeframe

<p><b>Children's services.</b> Children and their parents or guardians should be able to access appropriate emergency care as close to home as possible, and should be consulted whenever possible on service changes taking place.</p>	<p>The CCG is keen to ensure that parents of small children and young adults are able to make informed choices regarding how/when to access care and that those services are responsive to their needs. A guide on common childhood illnesses has been produced and circulated to offer advice and practical support on managing symptoms at home and when to seek further help. Currently there are multiple access points for urgent care services across the CCG area such as GP practices, Pharmacies, WICs, EDs, OOH clinics, and NHS 111 ensuring there are accessible and convient services available at all times. In determining future strategy and plans around urgent care services the CCG will be keen to hear the views of this target population who make up a significant proportion of contacts. Early work has already been undertaken with focs groups comprised of young parents to establish their understanding of urgent care services and behaviours in accessing services.</p>
<p><b>Mental health services.</b> SRGs need to ensure that mental health trusts are represented on networks and must identify individuals in mental health trusts and emergency departments who are responsible for liaison between the organisations.</p>	<p>The Sandwell and West Birmingham health and social care system spans across the catchment area of 2 local Mental Health provider trusts. The Urgent Care Network Board, which has been running for almost a year, has included representatives from both the Black Country Partnership NHS Trust and Birmingham and Solihull Mental Health Foundation Trust as core members .Given the close relationship between ED and Mental health services relationships between SWBH and both Mental Health trusts are well developed. Liaison between organisations happens across multiple layers with both front line staff and managers in regular contact.</p>

### Section 3: Chronic Conditions and Home Care

Wider Planning Considerations for SRGs	Summary of plan to achieve requirement
<p><b>Caring for patients with chronic conditions.</b> SRGs should promote better self-care support for patients and consider auditing common re-admissions.</p>	<p>SWB CCG are focussing on four common readmissions – Heart failure, Respiratory/COPD, Gastro, UTI’s. Collaborative work is taking place with SWB NHS Trust clinical workforce group to consolidate both readmission work programmes. Ambulatory care pathways are being developed between acute/primary care (eg more immunisation uptake, telehealth). SWB CCG are also taking part in a research trial programme with University of Birmingham to offer home based cardiac rehabilitation for 100 heart failure patients to self-manage their condition at home. Programme will include home visits by a nurse and topics to be covered eg knowledge about heart failure, meds management and adherence, managing anxiety and low mood, exercise, appropriate help seeking, sleep, diet and weight management, smoking. The programme also has an intervention for carers who may suffer from anxiety and depression. SWB CCG have invested in Simple Teleheath/Flo for self-management of COPD/Respiratory/Asthma/Diabetes via mobile phone texting between patients and clinicians. This includes patients to self-manage their blood pressure monitoring, weight management, and medicine management. SWB CCG commission a structured education for all type 1 and type 2 diabetes patients.</p>
<p><b>Planning for care home residents.</b> SRGs should think about regular health surveillance to decrease the risk of hospital admission. Whole system escalations plans which are predictable and not reactive should be worked towards.</p>	<p>Cross organisational support is available to care homes across Sandwell and West Birmingham in order to ensure the highest level of care and experience is offered to residents. SWBCCG’s care home team monitor quality of care provision and provide professional advice to providers, including advice on nursing care and medicines management, to support providers to deliver care compliant with legislation, national guidance and standards. The team complete quality review visits, share relevant information with providers by email, investigate concerns and incidents where they arise, and respond to safeguarding alerts raised by other agencies. The team also work closely with local authority colleagues and other agencies (including CQC) to address quality and performance issues in local homes through the Senior Strategy process and professional meetings. Community Nursing Teams treat all residents in residential or nursing homes as though it were their own home and so they are entitled to the full range of services ie - admission avoidance, care management and community rehabilitation, in addition there are also specific care home teams that offer a range of interventions. WMAS Units attend 999 calls as required and If the home is a frequent user then we will go in and offer advice and support to enable the appropriate care/services to be provided to their patients/residence. WMAS also offer AED and Basic Life Support training to homes to support their patients. Finally, local Authority colleagues provide a range of training and support packages to staff members.</p>

### Section 4: Engagement with the Independent and Voluntary Sectors

Engagement with the independany and voluntary sectors	Summary of plan to achieve requirement
<p><b>Capacity Planning.</b> All resilience plans should describe how systems have identified and engaged with independent and voluntary providers of elective care and step up and step down care.</p>	<p>Much work has been undertaken with independent providers of elective, step up and step down services. A workshop held in April 2014 gathered all providers together to discuss and evaluate the previous winter and establish learning. Work has been on-going with this sector in engaging them in the strategy for the future. Crucial to success has been ensuring providers are able to accept 7 day admissions and 7 day discharges to ensure flow . Meetings have been held with independent providers to explain the commissioning intentions of partners to develop enablement in care homes and a system that assesses people for long term care outside a hospital bed. The councils are seeking to commission a bridging service with home care providers to enable patients to be discharged quicker. Training has been provided for care home staff in enablement. Much Engagement has also been undertaken through the development of the bette care fund proposals and clarification of the community offer.</p>
<p><b>Pricing.</b> In the absence of a national tariff for step up / step down care it will be necessary for price negotiations to be undertaken locally.</p>	<p>A tariff has been developed for enablement bedded units dependent upon the service specification to achieve equality, this has been discussed openly with providers</p>

<p><b>Governance.</b> Plans should set out how systems will involve local independent and voluntary sector providers in their governance arrangements.</p>	<p>Involvement in decision making groups forums work streams. Consultation participatory groups and statutory framework for consultation Umbrella VCS organisations have been invited to join the SRG and will participate in decision making alongside other key stakeholders. Individual organisations will also have the opportunity to be involved in the development and delivery of local commissioning plans through the better care fund.</p>
<p><b>The Social Action Fund</b> is a joint fund between the tripartite and the Cabinet Office. This is to develop the potential of services that use social action to help older people manage their conditions or recover from illness or injury, and thereby reduce growing pressure on hospitals</p>	<p>Adult care services are promoting independence through the own bed instead strategy and encouraging service users to consider care at home. Prevention models are also in development to increase hospital avoidance rates.</p>
<p><b>The Care Act 2014.</b> SRGs will need to ensure they are aware of the main components of the Care Act 2014. This is essential as the Act fundamentally changes the way social care providers and their partners support vulnerable people and their carers in the Community. SRGs will also need to be aware of the new criteria to assess carers, the introduction of preventative regulations and the introduction of a cap on care costs and an extension to means tested support.</p>	<p>Through the BCF we are working with partners to understand the implications of the care bill and develop plans for implementation. This work is in its infancy and will be developed over the autumn period and will be managed by the SRG.</p>
<p><b>The Better Care Fund.</b> The BCF provides an opportunity to transform local services so that people are provided with better integrated care and support. It puts the patients at the centre of their own care, giving them control and in doing so provides people with the right care, in the right place, at the right time.</p>	<p>There are 2 BCFs for the CCG, one in Birmingham and one in Sandwell. Within both plans there is a component of building community resilience to mobilise the voluntary sector and volunteers within the community to support vulnerable groups. There are pilot sites for the development of healthy communities with a focus on sharing intelligence, reducing admissions, care and response in a crisis, preventative services.</p>

**TRUST BOARD**

<b>DOCUMENT TITLE:</b>	Financial Performance Report – P04 July 2014
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Tony Waite, Director of Finance and Performance Management
<b>AUTHOR:</b>	Chris Archer, Associate Director of Finance - Corporate
<b>DATE OF MEETING:</b>	4 September 2014

**EXECUTIVE SUMMARY:****Key messages:**

- In month headline break-even – improvement on prior month deficit but adverse to plan surplus; costs remain stubborn
- CIP delivery below plan and rate of saving did not step up in line with plan requirement – not sustainable
- Reported position moderated by benefit of £1,358k reserves – intended for development
- Forecast remains delivery of £3.4m plan surplus in line with LTFM commitment – requires expedient measures to accelerate CIP delivery & likely requires significant reliance on reserves & contingencies
- Capex modest and requires confirmation of plan & expedited delivery – emergent in year schemes consistent with retained estate strategy following Midland Met approval
- Cash in line with plan
- Key risks scale & pace of savings delivery, management of cost pressures and income recovery compromise by shortfall in delivery of operational standards

**Key actions:**

- Programme of work to identify and progress further pay & workforce change consistent with the delivery in full of necessary cost reduction for 2014-16 has commenced. This work is underpinned by robust arrangements to assess and assure the impact of any proposals on safety & quality.
- 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 capital programme having regard to emergent priorities consistent with strategic business opportunity and retained estate development.

**Key numbers:**

- Month break-even £38k being £433k adverse to budget; YTD deficit £746kk being £1,547k adverse.
- CIP delivery to date £2,295k being £1.4m adverse to revised plan & £2.4m adverse to TDA plan
- Forecast surplus £3.4m in line with financial plan.
- Capex YTD £1,452k being £728k below plan.
- Cash at 31 July £40.8m being £3.3m above plan due to timing differences on E&T income and working capital
- 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 Committee is requested to RECEIVE the contents of the report and to require that the Trust takes those actions necessary and safe to achieve 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:**

Considered by CLE and Finance & Investment Committee

## Financial Performance Report – July 2014 (month 4)

### EXECUTIVE SUMMARY

- For the **month** of July 2014, the Trust delivered a **“bottom line” surplus of £38k being £433k adverse** to a flex budget surplus of £471k. The **year to date deficit of £746k is £1,547k adverse** to flex budget to the end of July.
- The year to date adverse variance consists of £1,416k shortfall against savings targets, up to £1,358k benefit of release of central reserves leaving a **net underlying overspend of £1,489k** after the benefit of pass through costs funding additional to budget of £946k.
- Forecast anticipates that the position will be recovered and the annual surplus target of £3.374m will be met through CIP development and delivery with uncommitted reserves as contingency.
- Actual **savings delivery year to date is assessed at £2,295k being £1,416k adverse to trust phased plan** [£2.4m adverse vs TDA plan].
- At month end there were 6,949 whole time equivalent (WTE) staff in post (excluding use of agency), 138 below the currently planned level (which may not reflect final savings or investment plans). After 275WTE agency staff, total **WTE's were 137 above plan**. Total **pay expenditure for the month is £348k lower than June** at £24.6m being **£530k above plan**. **Agency spend remains flat at £1.1m in the month**.
- Key risks include scale & pace of savings delivery, management of cost pressures and income recovery compromise by shortfall 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	(433)	(1,547)	>= Plan	>= 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	(438)	(1,550)	>= Plan	>= 99% of plan	< 99% of plan
Pay Actual v Plan £000	(530)	(1,645)	<= Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	(623)	(957)	<= Plan	<= Plan	> 1% above plan
WTEs Actual v Plan	(137)	(108)	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000		3,344	>= Plan	>= 95% of plan	< 95% of plan

Note: positive variances are favourable, negative variances unfavourable

- 31st July cash balance £40.8m is £3.3m ahead of revised cash plan.**
- This reflects timing of receipt of education & training funding and timing on working capital receipts & payments.
- Year to date spend on capital is £1,452k being £728k below plan.
- On-going review of capex priorities.

2014/15 Summary Income & Expenditure Performance at July 2014	Annual Plan	CP Plan	CP Actual	CP Variance	YTD Plan	YTD Actual	YTD Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Income from Activities	390,115	32,523	33,204	681	130,065	131,144	1,079
Other Income	42,798	3,698	3,733	35	14,235	14,207	(28)
Pay Expenses	(284,342)	(24,038)	(24,569)	(530)	(97,280)	(98,925)	(1,645)
Non-Pay Expenses	(124,171)	(9,960)	(10,582)	(623)	(39,210)	(40,166)	(957)
<b>EBITDA</b>	<b>24,400</b>	<b>2,223</b>	<b>1,785</b>	<b>(438)</b>	<b>7,809</b>	<b>6,259</b>	<b>(1,550)</b>
Depreciation	(13,734)	(1,145)	(1,145)	0	(4,578)	(4,578)	0
PDC Dividend	(5,220)	(435)	(435)	0	(1,740)	(1,740)	0
Net Interest Receivable / Payable	(2,150)	(179)	(174)	5	(717)	(713)	4
Other Finance Costs / P&L on sale of assets	(150)	(13)	(13)	0	(50)	(50)	0
<b>Net Surplus/(Deficit)</b>	<b>3,146</b>	<b>452</b>	<b>19</b>	<b>(433)</b>	<b>725</b>	<b>(822)</b>	<b>(1,547)</b>
IFRIC12/Impairment/Donated Asset Related Adjustments	228	19	19	0	76	76	0
<b>SURPLUS/(DEFICIT) FOR DOH TARGET</b>	<b>3,374</b>	<b>471</b>	<b>38</b>	<b>(433)</b>	<b>801</b>	<b>(746)</b>	<b>(1,547)</b>
Surplus / (Deficit) against TDA plan	3,374	279	38	(241)	397	(746)	(1,143)

## Financial Performance Report – July 2014

### Overall Performance against Plan

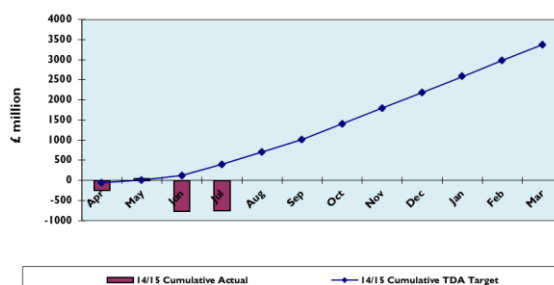
The Trust delivered an actual surplus of £38,000 against a planned surplus of £471,000 in July. It is anticipated that this will be recovered in order to achieve the year end surplus target of £3.374m surplus.

### Performance of Clinical Groups / Corporate Areas

- Medicine pay overspend includes £584k on HCAs and £416k on medical staff. Part of the drugs and cardiology non-pay over spends are offset by additional income.
- Surgery A overspend includes waiting list initiatives and shortfall on savings target delivery.
- Women & Child overspend includes £406k to date on costs of antenatal pathways at other providers.
- Surgery B is over-performing on ophthalmology Lucentis although the capped SWB CCG contract results in a net pressure of £110k to date. Premium rate working continues.
- Imaging premium rate working and saving shortfall.
- Corporate over spending reflects timing in respect of advisor fees for new hospital development.

- Underlying Group year to date position is £1,416k CIP not delivered and some £1,489k of underlying other overspends having taken account of £946k additional income to cover pass through drugs. This is supported by release of unallocated central reserves of £1,358k.

2014/15 Cumulative Surplus Plan/Actual (DoH Target)



### Group Variances from Plan

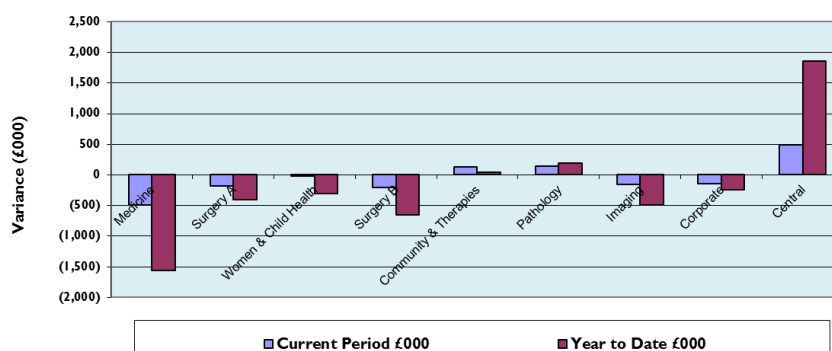
(Operating income and expenditure)

Current Period £000

Year to Date £000

Group Variances from Plan (Operating income and expenditure)	Current Period £000	Year to Date £000
Medicine	(487)	(1,557)
Surgery A	(180)	(401)
Women & Child Health	(25)	(300)
Surgery B	(210)	(653)
Community & Therapies	129	42
Pathology	139	192
Imaging	(158)	(495)
Corporate	(138)	(243)
Central	493	1,865

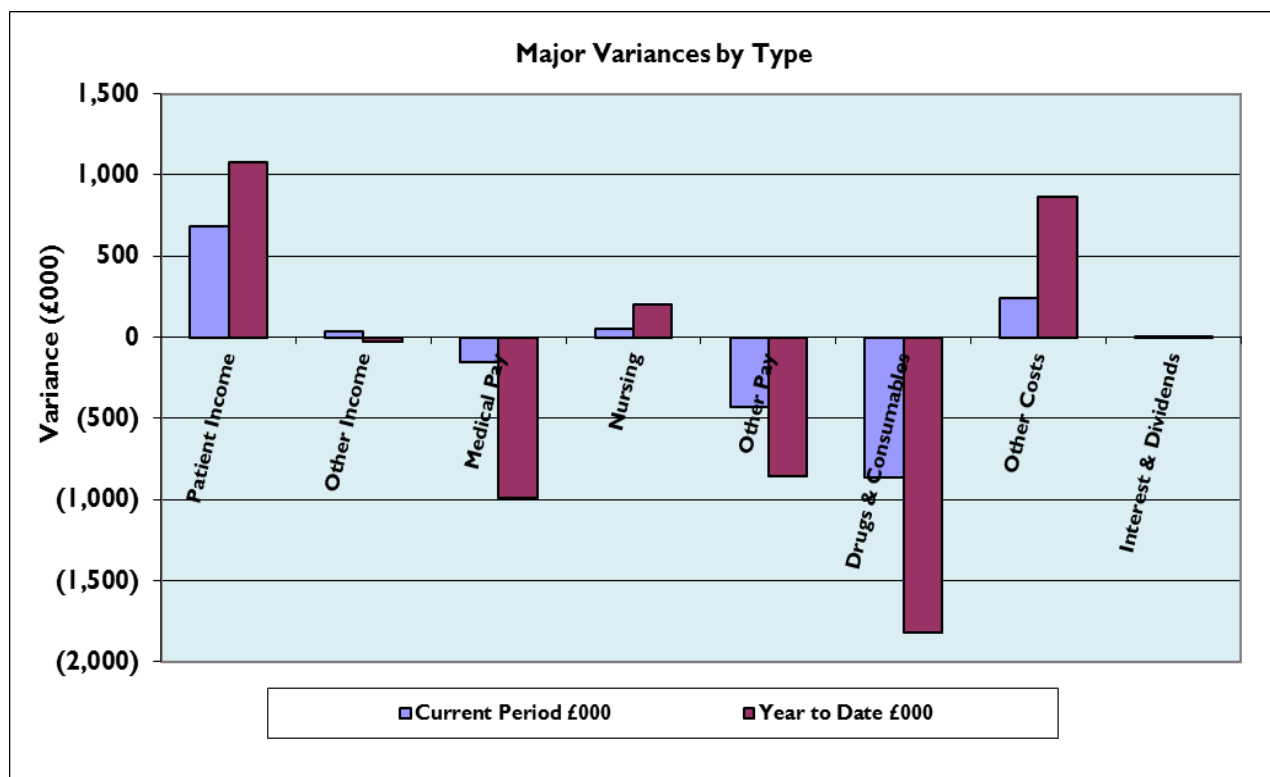
Current Period and Year to Date Variances by Clinical Group



## Financial Performance Report – July 2014

- Overall headline adverse variance to plan £433k in July (£1,547k year to date).
- Patient income over performed in month due to pass through drugs and devices.
- Medical pay in month overspend mainly in Surgery A and Surgery B premium rate working.
- Nursing underspends £247k to date in W&CH.
- £650k of drugs overspend to date is pass through recovered through income.
- Other costs includes maternity pathway payments overspend £406k to date and release of reserves £1,358k.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	681	1,079
Other Income	35	(28)
Medical Pay	(152)	(992)
Nursing	53	206
Other Pay	(431)	(859)
Drugs & Consumables	(866)	(1,822)
Other Costs	243	866
Interest & Dividends	5	4



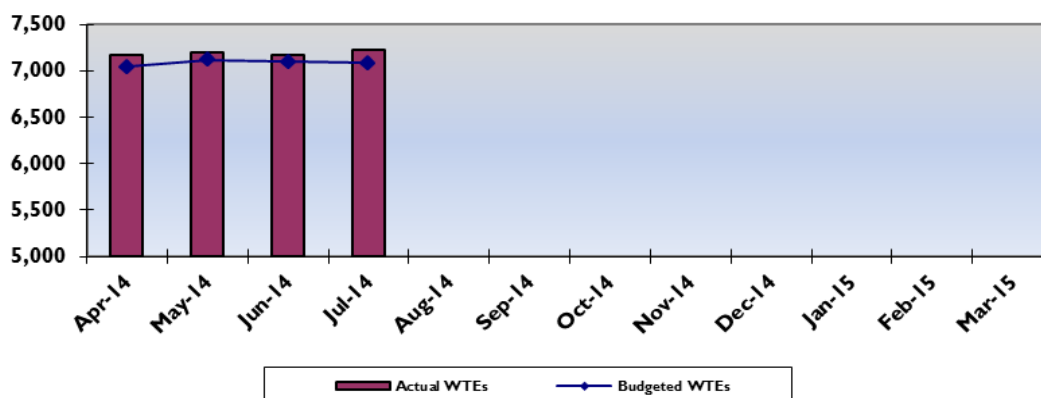


## Financial Performance Report – July 2014

### Paybill & Workforce

- There were 6,949 WTE in post in July plus an estimated 275 WTE of agency staffing across the month. In total this is **137 WTE above planned establishments**, though these are subject to change as savings and investment plans are finalised.
- Total pay costs (including agency workers) **£348k lower than June in month at £24.6m being £530k adverse to budget**; year to date £1,645k adverse to budget.
- Principal overspending is for medical staff premium rate working and for healthcare assistants providing enhanced care support to vulnerable patients, as well as savings targets on pay not being met.
- Gross expenditure for **agency staff in month was flat at £1,086k**.

**Budgeted and Actual WTEs (Including Agency Workers)**



### Analysis of Total Pay Costs by Staff Group

	Year to Date to July 2014					
	Budget £000	Actual				Variance £000
		Substantive £000	Bank £000	Agency £000	Total £000	
Medical Staffing	26,239	25,431	0	1,800	27,231	(992)
Management	5,155	4,712	0	0	4,712	444
Administration & Estates	10,561	9,439	800	305	10,544	17
Healthcare Assistants & Support Staff	10,868	9,869	1,378	311	11,558	(690)
Nursing and Midwifery	30,605	27,329	1,459	1,612	30,399	206
Scientific, Therapeutic & Technical	14,928	13,771	0	375	14,146	782
Other Pay / Technical Adjustment	(1,076)	335	0	0	335	(1,412)
<b>Total Pay Costs</b>	<b>97,280</b>	<b>90,886</b>	<b>3,636</b>	<b>4,404</b>	<b>98,925</b>	<b>(1,645)</b>

## Financial Performance Report – July 2014

### Balance Sheet & External Finance Limit

- Cash at 31<sup>st</sup> July £40.8m; increase of £9.2m over the month and £3.3m higher than plan.
- Movement reflects timing of receipt of education & training funding and timing on working capital receipts & payments
- External Finance Limit (EFL) charge forecast at £15.1m being consistent with approved EFL.

### STATEMENT OF FINANCIAL POSITION 2014/15

	Balance at 31st March 2014 £000	Balance as at 31st July 2014 £000	TDA Planned Balance as at 31st July 2014 £000	Variance to plan 31 July 2014 £000	TDA Plan at 31st March 2015 £000
<b>Non Current Assets</b>					
Property, Plant and Equipment	226,403	223,277	221,802	1,475	228,768
Intangible Assets	886	886	770	116	562
Trade and Other Receivables	1,011	1,296	700	596	700
<b>Current Assets</b>					
Inventories	3,272	2,957	3,600	(643)	3,600
Trade and Other Receivables	16,177	15,236	8,436	6,800	11,746
Cash and Cash Equivalents	41,808	40,801	37,457	3,344	24,252
<b>Current Liabilities</b>					
Trade and Other Payables	(53,867)	(53,754)	(43,337)	(10,417)	(43,546)
Provisions	(8,036)	(4,254)	(7,654)	3,400	(3,724)
Borrowings	(1,064)	(1,059)	(1,029)	(30)	(1,029)
DH Capital Loan	(2,000)	(2,000)	(2,000)	0	(1,000)
<b>Non Current Liabilities</b>					
Provisions	(2,562)	(2,503)	(3,262)	759	(2,522)
Borrowings	(27,915)	(27,593)	(27,884)	291	(27,884)
DH Capital Loan	(1,000)	(1,000)	(1,000)	0	
	<b>193,113</b>	<b>192,290</b>	<b>186,599</b>	<b>5,691</b>	<b>189,923</b>
<b>Financed By</b>					
<b>Taxpayers Equity</b>					
Public Dividend Capital	161,640	161,640	161,712	(72)	162,211
Retained Earnings reserve	(19,484)	(20,307)	(13,080)	(7,227)	(10,255)
Revaluation Reserve	41,899	41,899	28,909	12,990	28,909
Other Reserves	9,058	9,058	9,058	0	9,058
	<b>193,113</b>	<b>192,290</b>	<b>186,599</b>	<b>5,691</b>	<b>189,923</b>

## Financial Performance Report – July 2014

CASHFLOW													
12 MONTH ROLLING FORECAST AT July 2014													
ACTUAL/FORECAST	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	Jun-15 £000s	Jul-15 £000s
<b>Receipts</b>													
SIAs: SWB CCG	21,084	21,927	21,084	21,084	21,084	21,084	21,084	21,084	21,084	21,165	21,165	21,165	21,165
Associates	7,181	6,846	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417
Other NHS Income	777	850	850	850	850	850	850	850	850	1,461	1,461	1,461	1,461
Specialised Service (LAT)	4,152	4,150	4,150	4,150	4,150	4,150	4,150	4,150	4,150	3,260	3,260	3,260	3,260
Over/(Under) Performance Payments	9,281			4,608			4,608			4,608			4,608
Education & Training									571				
Public Dividend Capital													
Loans													
Other Receipts	1,219	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755
<b>Total Receipts</b>	43,694	35,528	34,256	38,864	34,256	34,256	38,864	34,256	34,827	38,666	34,058	34,058	38,666
<b>Payments</b>													
Payroll	13,750	13,740	13,740	13,360	13,360	13,360	13,360	13,360	13,360	13,360	13,613	13,613	13,613
Tax, NI and Pensions	9,411	9,487	9,480	9,480	9,218	9,218	9,218	9,218	9,218	9,218	9,076	9,076	9,076
Non Pay - NHS	1,074	1,138	910	977	1,071	910	977	1,071	910	910	2,148	2,148	2,148
Non Pay - Trade	8,220	10,894	9,403	10,491	10,665	9,403	10,491	10,665	9,403	9,403	8,282	8,282	8,282
Non Pay - Capital	935	1,107	1,115	1,263	1,363	1,086	2,180	1,956	2,431	2,775	2,775	2,775	2,775
PDC Dividend			2,610						2,610				
Repayment of Loans			1,000						1,000				
Interest			13						8				
BTC Unitary Charge	0	875	439	439	439	439	439	439	439	375	375	375	375
NHS Litigation Authority	668	668	668	668	668	668	668	0	0				
Other Payments	388	300	300	300	300	300	300	300	300				
<b>Total Payments</b>	34,446	38,209	39,678	36,978	37,084	35,384	37,633	37,009	39,679	36,219	36,446	36,446	36,446
<b>Cash Brought Forward</b>	31,553	40,801	38,120	32,698	34,584	31,755	30,627	31,858	29,105	24,252	26,699	24,311	21,922
<b>Net Receipts/(Payments)</b>	9,248	(2,681)	(5,422)	1,886	(2,828)	(1,128)	1,231	(2,753)	(4,852)	2,447	(2,389)	(2,389)	2,220
<b>Cash Carried Forward</b>	40,801	38,120	32,698	34,584	31,755	30,627	31,858	29,105	24,252	26,699	24,311	21,922	24,142

## Financial Performance Report – July 2014

### Capital Expenditure & Capital Resource Limit

- Year to date capital expenditure is £1,452k being £728k below plan.
- Capital commitments through orders placed £1.5m.
- 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	Sub Code	SIGN	Current Month Metrics			Forecast Outturn Metrics		
			Plan	Actual / Forecast	Variance	Plan	Actual / Forecast	Variance
			(mc 01)	(mc 02)	(mc 03)	(mc 04)	(mc 05)	(mc 06)
			£000s	£000s	£000s	£000s	£000s	£000s
<b>Liquidity Ratio (days)</b>								
Working Capital Balance	780	+/-	(8,127)	(5,030)	3,097	(13,301)	(9,986)	3,315
Annual Operating Expenses	790	+/-	135,716	139,091	3,375	405,044	408,214	3,170
Liquidity Ratio Days	800	+/-	(7)	(4)	3	(12)	(9)	3
<b>Liquidity Ratio Metric</b>	810	+/-	2.00	3.00	1.00	2.00	2.00	0.00
<b>Capital Servicing Capacity (times)</b>								
Revenue Available for Debt Service	820	+/-	7,553	6,267	(1,286)	24,842	24,416	(426)
Annual Debt Service	830	+/-	2,844	2,810	(34)	10,532	10,466	(66)
Capital Servicing Capacity (times)	840	+/-	2.7	2.2	(0.4)	2.4	2.3	(0.0)
<b>Capital Servicing Capacity metric</b>	850	+/-	4.00	3.00	(1.00)	3.00	3.00	0.00
<b>Continuity of Services Rating for Trust</b>	860	+/-	3.00	3.00	0.00	2.50	2.50	0.00

### Service Level Agreements

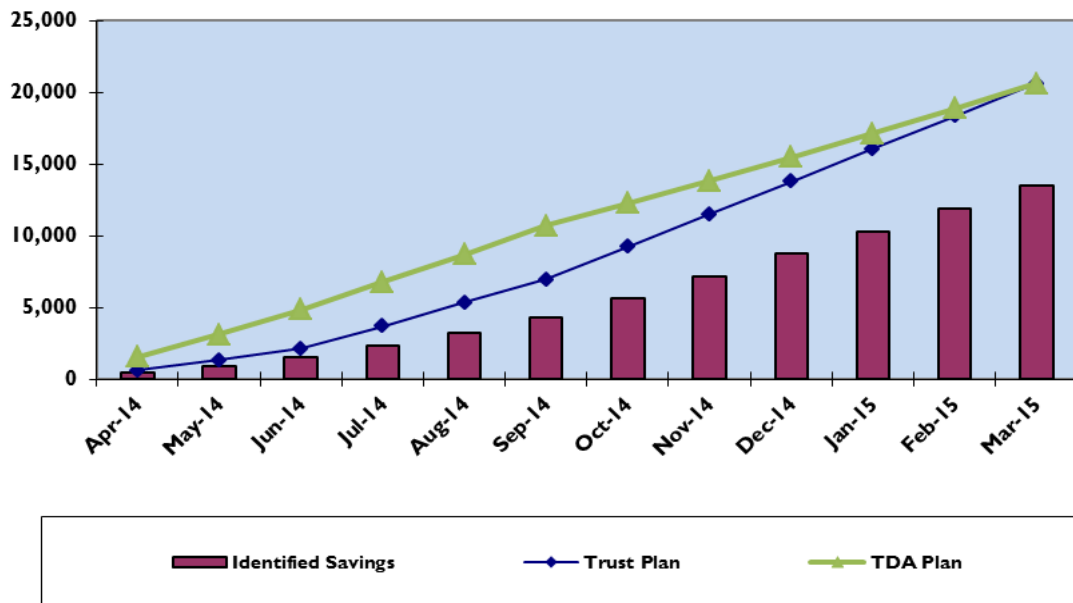
- NHS Commissioner activity and income data for Q1 indicates an activity based over-performance of £370k including pass through drugs and devices; the block arrangement with Sandwell CCG benefits the position by £167k for the first quarter. Pass through items of £946k are in the position to July.
- Fines notices have been received for April and May and do not materially exceed fines cap levels. The £1.4m of income held back by commissioners in June in respect of delay in remedy to operational standards action plans has been recovered.

## Financial Performance Report – July 2014

### Savings Programme

- **Delivery to date is £2,295k which is £1.4m adverse to trust phased plan** [£2.4m adverse vs TDA plan].
- £13.5m of in-year savings have now been identified against the annual target of £20.6m. These have a full year effect of £19.0m.
- A programme of work to identify and progress further pay & workforce change consistent with the delivery in full of necessary cost reduction for 2014-16 has commenced. This work is underpinned by robust arrangements to assess and assure the impact of any proposals on safety & quality.
- The forecast profile of savings delivery is shown below together with the original plan against which the TDA continues to monitor the Trust

**Cumulative Savings Profile £000**



## Financial Performance Report – July 2014

### Key risks

- **Identification and delivery of savings at necessary scale & pace;** The plan required level of savings increased significantly in July from £0.7m per month to £1.6m per month whereas actual savings have risen from £0.6m in June to £0.8m in July.
- **Over spending on pay costs & in particular premium rate staffing.** There has been a reduction of £0.3m in pay bill in July although agency use remains flat. A detailed programme of work to identify and progress further pay & workforce change consistent with the delivery in full of necessary cost reduction for 2014-16 has commenced. This may give rise to restructuring costs which exceed extant sums provided and available.
- **Demand risk in respect of SWB CCG contract.** The Trust carries demand risk which is giving rise to some cost pressures in areas of additional activity such as Lucentis; there remains limited opportunity to release costs beyond marginal costs in under-performing areas of service.
- **Operational standards not met giving rise to contract penalties and 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 stands at £0.4m for the first four months of the year.

### External Focus

- Monitor and NHS England have published supplementary guidance on the **maternity pathway payment** system. In particular it clarifies whether particular services are included or excluded from the pathway payment and provides guidance on establishing data flows and contracting and invoicing arrangements.
- The Department of Health has published proposals for the detailed design of the NHS Pension Scheme for England and Wales, together with transitional arrangements for existing members. The document sets out differences with the current scheme, as well as arrangements for current scheme members who are close to retirement and current scheme members who will transfer to the new scheme. 'The NHS pension scheme for England and Wales 2015' also sets out member contribution rates from April 2015 and looks at the later normal pension age in the new scheme. A consultation on the legal framework for the reformed pension scheme will take place in the autumn.
- Health secretary Jeremy Hunt has called for a renewed focus on patients who have waited longer than 18 weeks for treatment. Mr Hunt said waiting times had come down, but the 18-week target had produced some unintended consequences, including 500 patients who had waited more than a year. He said that by the end of this calendar year no-one should have to wait more than a year for treatment, except in exceptional circumstances, while 90% of patients should be treated within 18 weeks. This amounted to a managed breach of the 18-week target over a short period while the focus was on long waiters. NHS England has commissioned additional activity over the summer, including 40,000 inpatient admissions, he added.

## Financial Performance Report – July 2014

### Recommendations

The Trust 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

## TRUST BOARD

<b>DOCUMENT TITLE:</b>	Risk Register Update
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Kam Dhami, Director of Governance
<b>AUTHOR:</b>	Mariola Smallman, Head of Risk Management
<b>DATE OF MEETING:</b>	4 September 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 August meeting. There are no amendments to report since the last Trust Board. 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:

- 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.



## Trust Risk Register

## Report to the Trust Board on 4 September 2014

**1. EXECUTIVE SUMMARY**

- 1.1 The Trust Risk Register comprises 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:

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

**2. Trust Risk Register Update**

- 2.1 As at writing there are no proposed additional or downgraded risks for Trust Board to review.
- 2.2 The Trust Risk Register with lead Executive Director updates is at **Appendix A.**
- 2.3 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.
- 2.4 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  
27 August 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. <b>Previous update:</b> 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. <b>Previous updates:</b> 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. 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	<p>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.</p> <p><b>Previous update:</b> 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.</p> <p><b>Progress:</b> Timelines for assessment and training September to December and SOP / policy review in September</p>	Chief Operating Officer	Jul-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
TRR1401CO002	Management review	Corporate Operations		Operational	Sustained high Delayed Transfers of Care (DTC) patients remaining in acute bed capacity.	4	4	16	<p>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 DTC review, strategic and operational work; Commissioning plans for 7 day working in 2014 in train.</p> <p><b>Previous update:</b> Additional capacity closed end July although DTC 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 DTC 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.</p> <p><b>Progress:</b> DTC numbers remain high. The System Resilience plan awaits clarification from Birmingham City Council on aspects of plan workforce and the reablement bed plan for the locality. New joint team with Sandwell is in implementation phase with good engagement.</p>	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 SGH Outpatient Department as a consequence of poor building design in SGH 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. <b>Previous update:</b> 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	Women's 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. <b>Previous update:</b> Local escalation process is in place to ensure care is provided to HDU patients. 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	Women's 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. <b>Previous update:</b> 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. <b>Progress: Resilience monies identified to support mental health improvements. Place for assessment to be identified on each site.</b>	Chief Operating Officer	TBC	Jun-14	Monthly	3	4	12
	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	<b>Previous update:</b> 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	3	4	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
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Trust non-compliant with Acute Oncology Standards.	5	4	20	<b>Previous update:</b> 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	1	4	4
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Trust has inconsistent cancer pathways between its sites and mixed visiting oncology MDT attendance patterns.	3	5	15	<b>Previous update:</b> Trust is extended discussions with UHB and executive led cancer futures workshop now scheduled for early September.	Chief Operating Officer	TBC	Jun-14	Monthly	1	5	5



**TRUST BOARD**

<b>DOCUMENT TITLE:</b>	Q1 14/15 Complaints and PALS report
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Kam Dhami, Director of Governance
<b>AUTHOR:</b>	Karen Beechey, Head of PALS & Complaints
<b>DATE OF MEETING:</b>	4 September 2014

**EXECUTIVE SUMMARY:**

This report sets out details of PALS enquiries and Complaints received between April and June 2014 (Quarter 1) and some comparisons with the same period in the previous year.

References are made throughout the report to the recently published report from HSCIC which shows that we are generally in line with national trends.

In Quarter 1, 2014/15

- 209 complaints were received a 26% increase
- Time to respond to complainants has improved however, the 30 day target is not being met in the majority of cases
- Ethnicity of patients who are the subject of the complaint (where known) are mostly white British, followed by black Caribbean. There are no themes or trends identified.
- The main subjects complained about remain unchanged from previous years and are in line with national data
- The professions identified within complaints (doctors and nurses) equally remain unchanged and in line with national data
- For those complaints closed within the period, approximately a quarter were not upheld, showing that the Trust does not take a defensive attitude to feedback received from our service users
- 37 were cases which were reopened, the majority because issues have not been addressed adequately in the initial response
- Since introducing the devolved model (Nov 13) there is an improving picture of service changes as a direct result of feedback from complaints
- 480 enquiries to PALS were made; a decrease on the same period in 2013

**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:**

Improve and heighten awareness of the need to report and learn from complaints.

**PREVIOUS CONSIDERATION:**

Quality & Safety Committee.

# **Complaints and PALS Report**

## **2014/15: Quarter 1**

# COMPLAINTS AND PALS

## INTRODUCTION

Concerns and complaints raised by patients and visitors must be viewed positively as an unsolicited form of feedback. These are opportunities to improve our services and the care we provide based on user experience.

Complaints are best managed by those who have the ability to change the way we provide care and the introduction of a changed model of complaints handling in November 2013 was central to this.

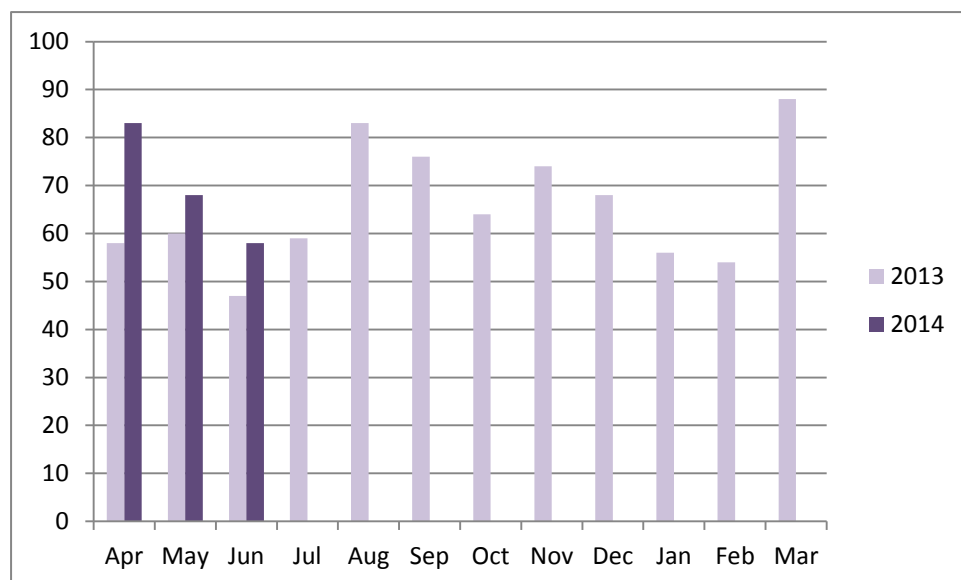
## COMPLAINTS

### 1. Complaints Management

#### 1.1 Total received

The Trust received 209 complaints in the first quarter (April – June 2014) which compares to 165 for the same period last year, an increase of 26%. This is in line with a national increasing trend in complaints based on HSCIC <sup>1</sup>. It is apparent that there is a decreasing trend across the three months reported for this quarter in both years. The continued media coverage regarding NHS failings and our own drive to encourage patients to raise concerns and complaints (improved website, posters and leaflets) may have contributed to this rise.

##### a) Number of complaints received per month

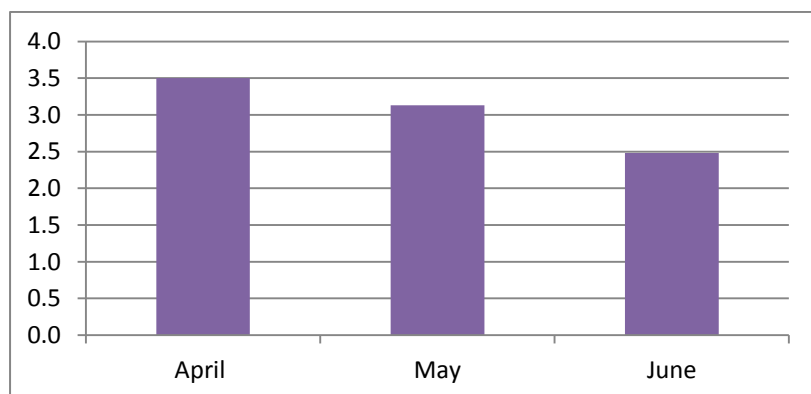


<sup>1</sup> HSCIC – Health & Social Care Information Centre – Data on written complaints in the NHS 2013-14

## 1.2 Complaints received per episodes of care

It is important to look at the number of complaints received in context. Viewing this over time can assist in identifying whether there are peaks which would give rise to concern that care standards may be falling or whether this would be due to a lower number of episodes.

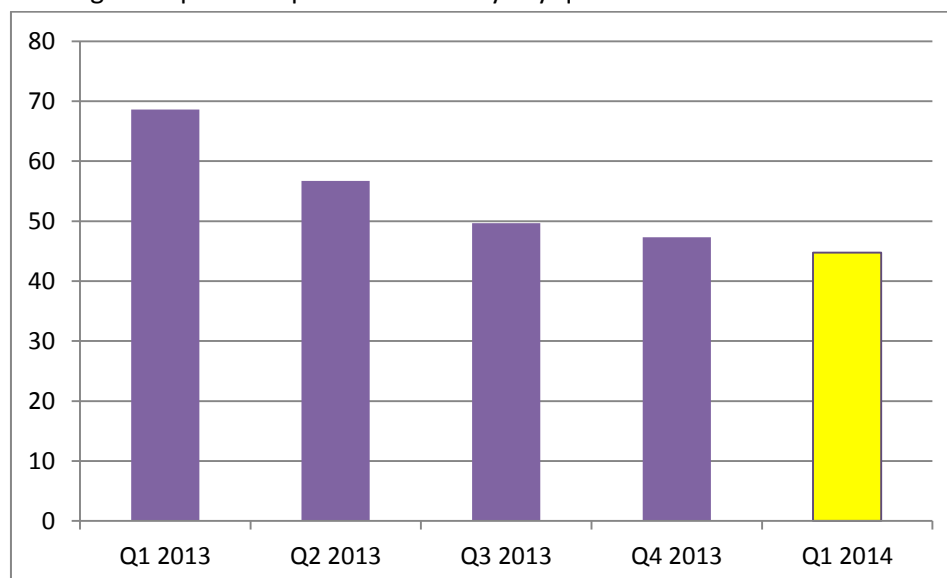
b) Complaints per 1000 bed days Q1 2014



## 1.3 Timeliness of Responses

Following a period of adjustment the Trust is now committed to a devolved model, introduced in November 2013, in the management of complaints. A target response date of 30 working days was introduced at this time. In recent months the time taken to respond to complainants has improved however, we are still not responding within our target deadline in the majority of cases.

c) Average Complaint response time in days by quarter.



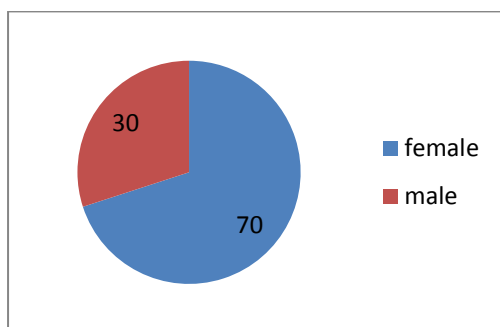
## 2. Complaints in detail

### 2.1 Profile of subject of the complaint

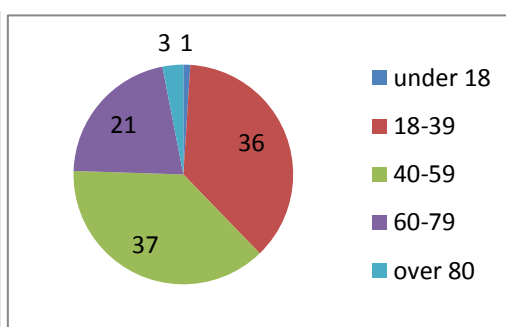
Making an NHS complaint is every patient's right and particular attention should be paid to the profile of complaints in order to ensure that minority groups are not disadvantaged. Historical data can help identify anomalies. Of the 209 complaints logged for this quarter, 52 were recorded as from minority groups.

The profiles detailed below are for the person who is the subject of the complaint. This is important as some complaints are raised by a representative. The patient data within our complaints database is drawn directly from the Patient Administration System (PAS).

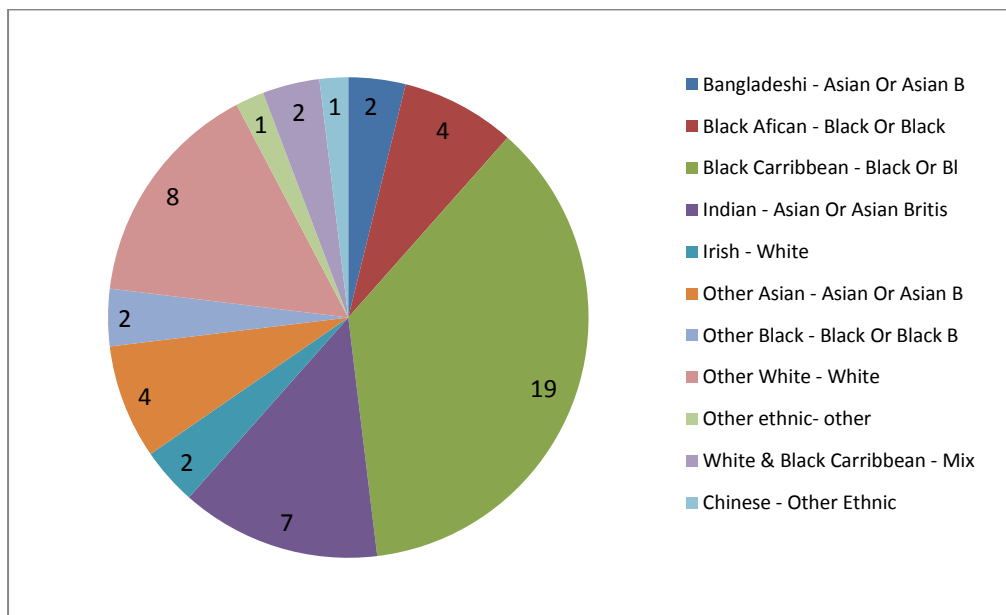
Gender of subject of complaint (%)



Age of subject of complaint (number)



Ethnicity of subject of complaint (number)



Ethnicity is shown by group, taking out White British and not known/ not stated. 76 patients were from a white British background. Two thirds of the complaints were made about inpatient and outpatient services and 60% of the complaints related to the clinical care they received.

The second largest group of complainants are from a Black Caribbean background. The complaints were mainly related to outpatient or emergency department attendances (11/19) and 15 were related directly to the clinical care they received.

A satisfaction questionnaire is sent with each complaint response. Historically returns of these have not been good prompting a review of the form.

Where actions have been identified to improve a service or pathway, a pilot is underway to return to the complainant within six months to advise that these have been completed.

**Planned action:** Future reports will incorporate complaint satisfaction feedback by Group initially and as returns improve, by directorate.

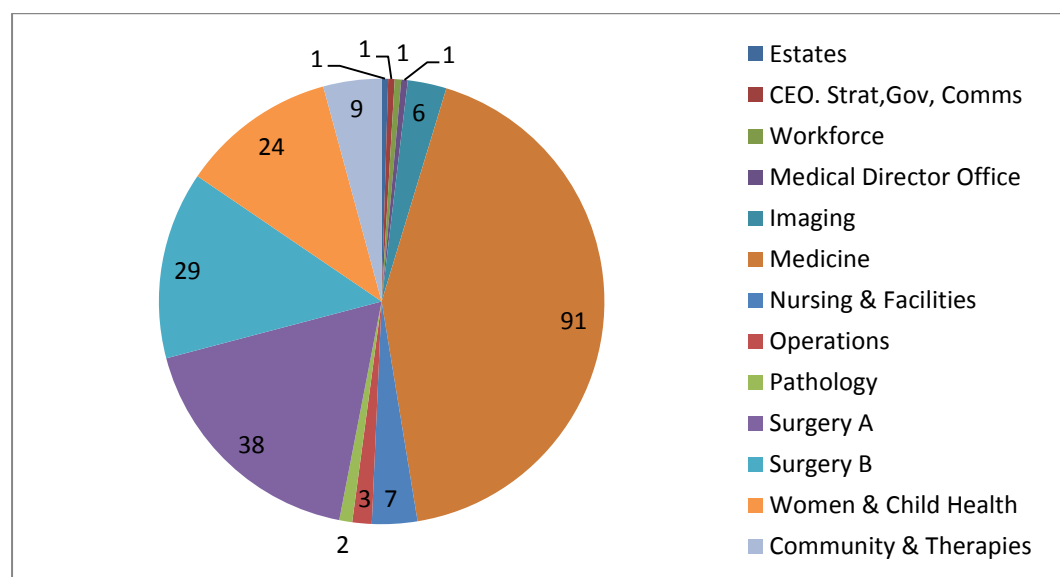
## 2.2 Formal complaints by Clinical Group/Corporate Directorate.

Complaints are managed by their respective clinical group or corporate directorate and can be broken down further by department or speciality. Work is in progress to ensure that data is provided at clinical directorate level for future reports.

The complaints are most prevalent in Medicine, given the volume of patients that they care for. What is not known is whether their rate of complaints per episodes or bed days is adversely high when compared to the other clinical groups.

**Planned action:** Future reports will incorporate the prevalence of complaints at Clinical Group level by either bed days or episodes of care to provide further context.

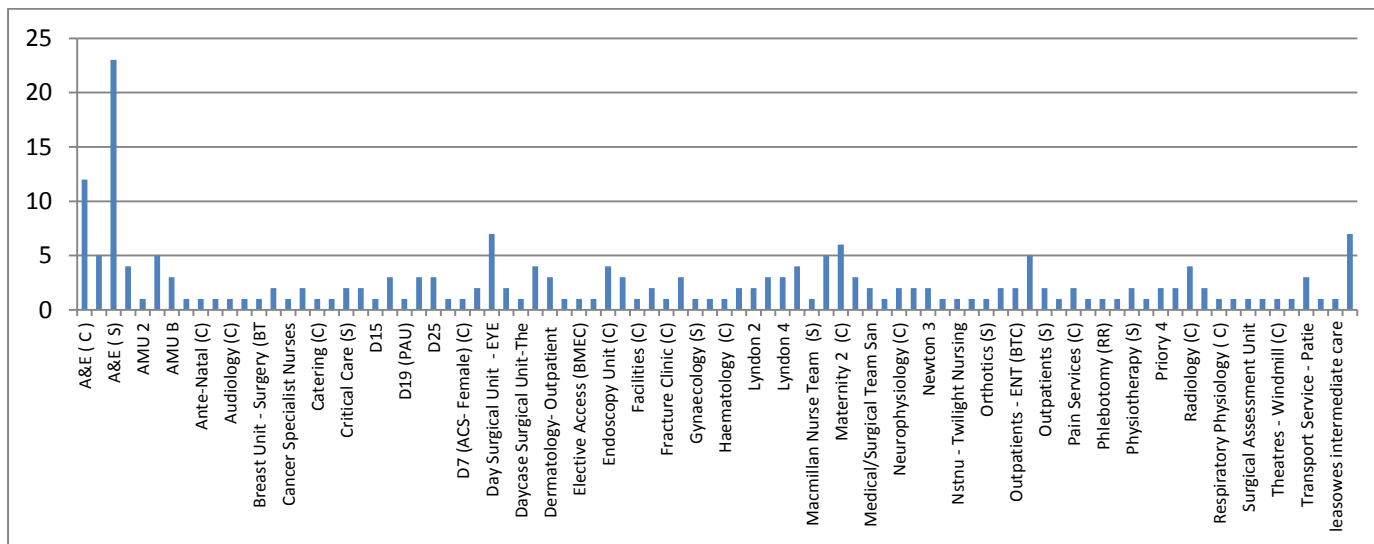
d) Formal complaints by Clinical Group and Corporate Directorate Q1 (14/15)



The data shows that the Clinical Groups with the most activity continue to receive the majority of complaints. This has not changed over time and is not expected to change in the future. What may change is the departments within those groups or the reasons people complain.

**Planned action:** Future reports will show trends of complaints received by group and directorate highlighting any areas which show persistent high numbers of complaints. For the groups, trends in themes will also be highlighted.

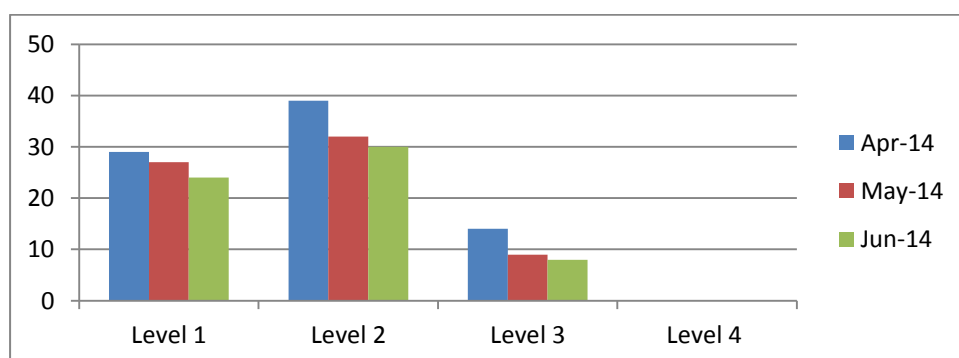
- e) Number of complaints per department Q1 2014 (only departments that have had complaints logged against them will appear in the graph below.)



## 2.3 Formal complaints by severity

In analysing the severity of the complaint, for this quarter there were no Level 4 complaints, the majority (broken down per month) are Level 2. Generally a Level 1 complaint relates to customer service or nonclinical related service failures (including staff attitude.) An area worth considering for future management of concerns and complaints will be to assess whether Level 1 complaints could have been managed in the locality where the concern began. Level 2 complaints will indicate that there are customer service failings during the episode (s) of care, and that there were some poor clinical outcomes, albeit minor. Level 3 complaints will have a worse clinical outcome, or perhaps a longer lasting injury. Level 4 complaints will show a substantial service failure and/or effect on clinical outcome including end of life.

- f) Severity levels by month



The majority of complaints fall into either Level 1 or 2 categories for severity, and whilst not insignificant in themselves, will often have very local lessons learnt and/ or minor remedies if any.

Below are some examples of the types of Level 3 complaints and their conclusion.

### **Medicine**

**Complaint-** *Lodged by the patient's daughter, who expressed concern that investigations into her mother's malignant melanoma were mis- managed in 2012/ 2013. She also expressed concern that her mother was allocated a specialist skin nurse, but then when she left the Trust her mother did not get a new one. Following surgery a follow up appointment should have been offered three months later but she did not get one until five months later. This patient has since passed away.*

**Conclusion-** *the complaint was upheld. Opportunities were missed to engage with the patients GP. Practice has changed to ensure that important follow up appointment slots are kept for just that, and not used to accommodate new patients.*

### **Surgery A**

**Complaint-** *Lodged by the patient's daughter, we were asked to explain why her mother had not been returned to a high dependency ward, or CCU following her readmission to us from another hospital (Queen Elizabeth Hospital) where she had been receiving other treatment. The sequences of events are as follows-*

*Patient admitted to hospital for laparoscopic cholecystectomy, hysterectomy and bilateral salpingo-oophorectomy for endometrial cancer. She had a number of comorbidities and was admitted to critical care post operatively for observation. She then went off site for dialysis and was admitted to a gynaecology ward on return. She then unfortunately suffered cardiac arrest in the early hours of the following morning and died.*

**Conclusion-** *The care and treatment afforded to the patient was appropriate including transfers to other units for specialist treatment. This complaint was not upheld but the family have been invited to a meeting to discuss their complaint and our findings further.*

### **Women and Child Health**

**Complaint** –*The patient questioned why we did not operate on her new born baby, why her baby was left to die in her arms, and why they were not transferred to the Children's Hospital. The patient also queries why she did not get an ECG when she suffered chest pains, and asked for an explanation on all aspects of their care.*

**Conclusion-** *Communication throughout pregnancy was given on this very distressing and complex issue. The investigation showed that care and treatment were appropriate throughout, however it is recognised that this was a very emotive time. This complaint was not upheld and an opportunity to meet and discuss the care provided has been offered to the patient and her family.*

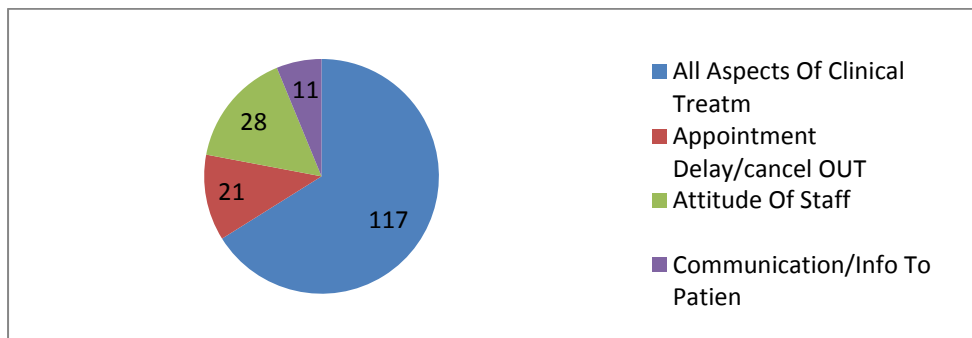


## 2.3 Formal Complaints by Subject

In order to use complaints data to help improve service provision and target poor practice, a breakdown of complaints by trend is required. The two most significant trends (Attitude of Staff and Aspects of Clinical Care) are further broken down by Group.

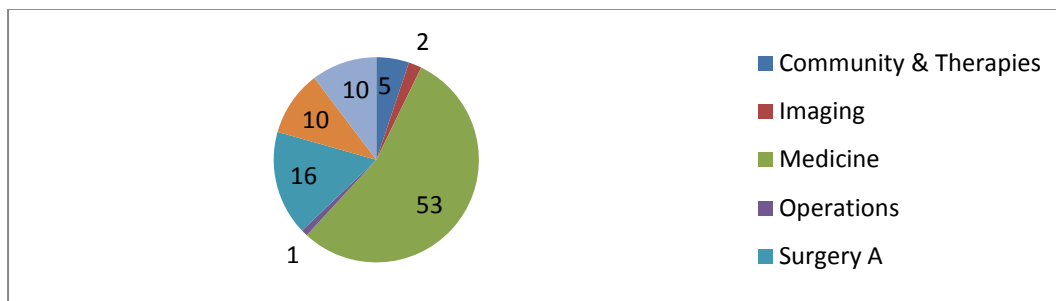
**Planned action:** Further work is taking place to understand the themes which sit behind these subjects, in order to ensure that any changes implemented are effective.

g) Top subject of complaints Q1 2014.

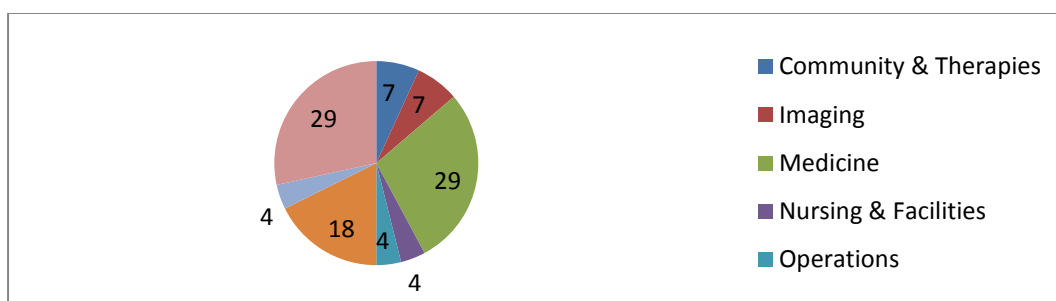


These four subject areas are in line with the HSCIC data for 2013/14, with the exception of attitude and communication which are reversed in order.

h) All aspects of Clinical Treatment by Group (%).

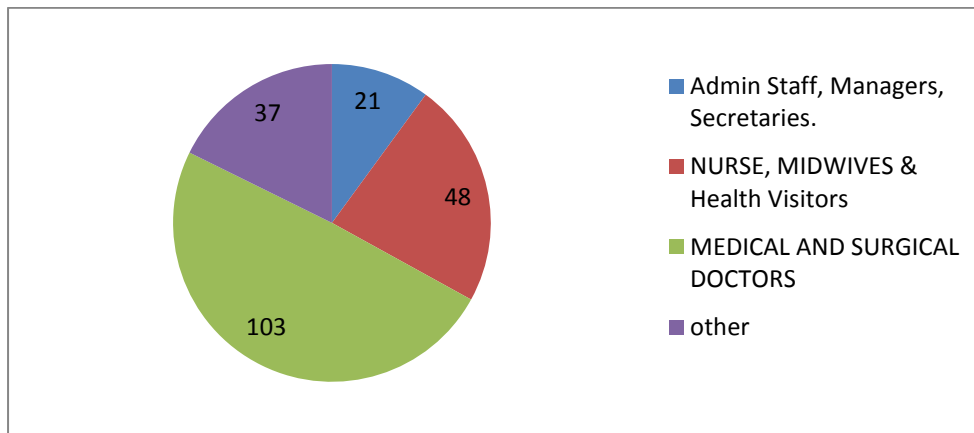


i) Attitude of staff by Group (%)



## 2.4 Formal complaints by profession

### j) Breakdown of complaints by profession



The HSCIC data for 2013/14 identifies the same breakdown by professional group.

The main cause of complaint relates to medical care and by association, medical staff (85). This includes such things as delays in diagnosis, missed diagnosis and treatment preferences.

The services these complaints arise in are the emergency department (34), inpatient episodes (41) and outpatients (28). Whilst medical staff have been identified in the largest proportion of complaints; there have been no particular themes or trends relating to specific doctors identified.

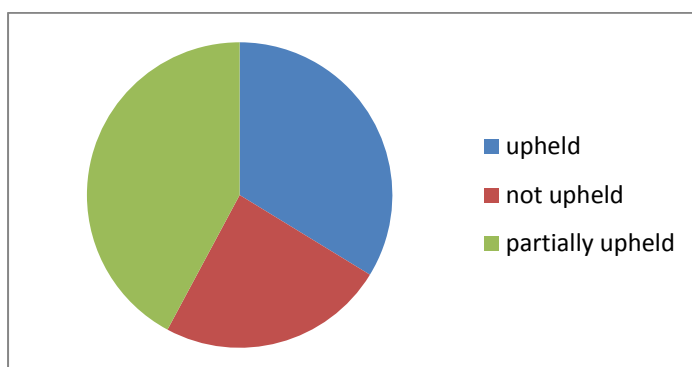
**Planned action:** Further work is taking place to understand the themes which sit behind the identified staff groups at clinical group and directorate level.

## 3. Formal complaints outcomes

### 3.0 Formal complaints upheld

Every complaint has the potential for improvement and learning which is evidenced by the fact that two thirds of the closed complaints were partially or completely upheld. It should be noted that the breakdown of figures is based only on those complaints closed in this quarter.

### k) Breakdown of complaints by outcome Q1 2014



### 3.1 Learning from Complaints

Complaints can provide a learning opportunity for individuals as well as changes in practices or procedures which wouldn't have been evident without the patient or their representative raising the issue. Below are some improvements made as a direct result of this feedback.

Complaint (as described by the complainant)	Investigation Findings	Any significant actions?
The complainant expressed concern that when arriving for a Breast Screen, there were no gowns provided. We had not made ourselves clear enough in our invitation letter that wearing a dress may be inappropriate and our patient felt that her dignity had not been considered, as she had to walk across the room and stand in underwear alone for the lack of a gown.	It is true that the screening clinics do not have the resources to provide gowns to all women accessing this service. The invitation letter did make references to women may wanting to prefer to wear separates but it doesn't say why.	We have agreed to ensure that the invitation letter is clearer and that a small supply of gowns will be made available per clinic 'just in case'.
Our patient unfortunately suffered a still birth and catastrophic bleeding, leading to an emergency hysterectomy. During her time in our care she was not happy about her nursing care, and the way her diabetes was managed by the midwives on her ward.	During our investigation, individual nurses who had been named in the complaint were shown the complaint. Whilst both were extremely upset that their care had caused such distress they acknowledged that they were committed to improving their care to patients.	The nurses on this ward have attended an update Diabetes course, and the customer care course.
Having been scheduled to come in at a weekend to attend for minor day surgery, our patient found there to be no bed available meaning that the procedure could not go ahead. The complaint covered many areas of their experience, and also advised that elements of the complaints leaflet they had received were misleading about the potential to claim compensation from the NHS complaints process.	The various elements of this complaint were investigated and indeed the opening of a ward on a Saturday was in hindsight deemed not to be the best way forward. The leaflet was reviewed for ambiguous wording and it was agreed that a review was needed.	This ward will not be used again for minor day surgery following this trial and a revised version of the complaints leaflet was sent with the complaints response as evidence of the changes suggested.
Our patient underwent a Tonsillectomy and when the tissues were analysed for potential lymphoma it was reported initially as normal when in fact the patient had lymphoma. This was later diagnosed at another hospital.	Upon receipt of the complaint, a thorough review of the case, medical notes and patient care was undertaken, resulting in a TTR. A serious incident was logged and the complainant has had a copy of this along with a full explanation and apology.	A new system of double reporting has been introduced in Histology in order to minimise the risk of reoccurrence.
A patient wrote to the Trust about their experience of the self-serve check in process at the Midland and Birmingham Eye Centre. They were offended that they could not access the check in system in their own language Hindi.	This was investigated and indeed found that when the system (currently a pilot) was put in place the top 40 languages were made available. Not including Hindi was a mistake.	The company who supplied the self-serve machines have added Hindi to their system and once fully tested, will update them to include this language.

### 3.2 Reopened cases

An effective measure of a complaint well managed is that the complainant will be satisfied with our response. That said, there are four main reasons why a complainant may challenge their response.

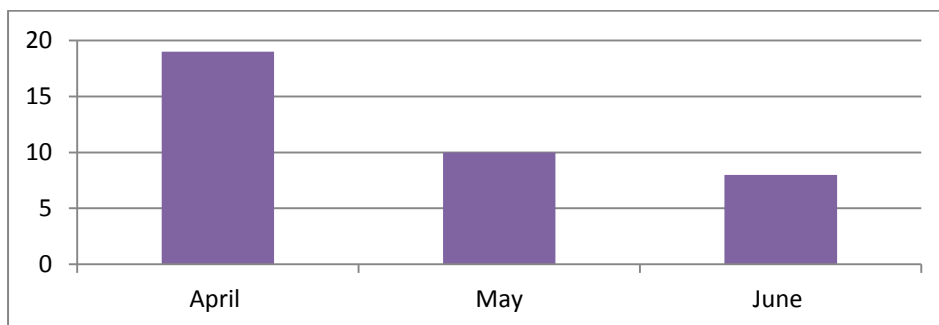
- I. That not all the issues were addressed.
- II. The response needing perhaps a meeting or the support of an advocate.
- III. That it has triggered new questions about this episode of care (or occasionally different episodes of care- when a new complaint would be logged instead.)
- IV. They disagree with the findings and want the complaint reinvestigated.

How these cases are managed

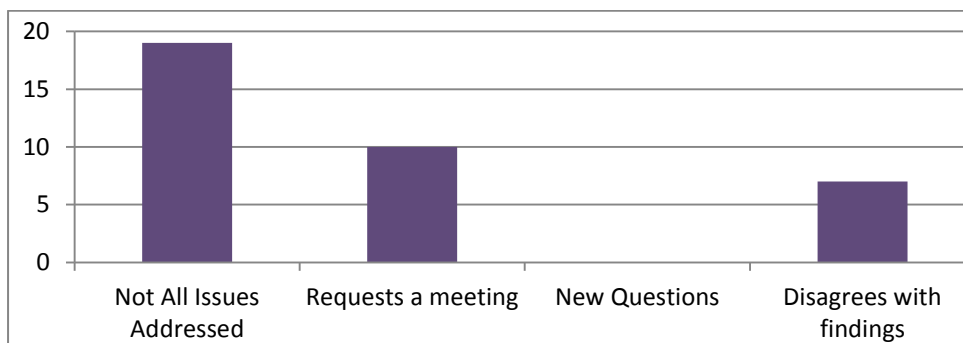
- I. This complaint would go back to the original investigation lead for response.
- II. A meeting is convened which is recorded and the patient sent a copy along with a summary of any salient points to the complainant.
- III. A decision will be taken as to whether this is a new complaint, and if so, will be managed accordingly. If not, as per point one this would go back to the original investigator.
- IV. These reopened complaints would need to be reviewed by someone other than the original investigator. This can be someone with similar expertise/ level of responsibility within the same group, or the original investigators line manager.

There were 37 complaints reopened in this period which represents 17% of the overall enquiries (209) for this period. These are broken down by month and reason below.

#### l) Breakdown of reopened cases by month for Q1 2014



#### m) Reason complaint reopened



Not all complainants articulate the exact issues they wish to be addressed. It is important that we strengthen the management of complaints to ensure that this aspect is clarified on every occasion so that complainants are not having to return dissatisfied with our response. This will lead, in time, to a reduction in returns because of unanswered issues.

### **3.3 Parliamentary and Health Services Ombudsman enquiries.**

Ultimately, if complainants do not feel that their issues are resolved at a local level, the PHSO will investigate independently our handling of the complaint and outcomes therein. There were 9 PHSO enquiries in this period representing 4% of our overall enquiries. Not all of these enquiries will be considered in need of investigation, and those that are investigated will not always be upheld. In this quarter, 3 PHSO investigations were also closed, one did not make it to investigation stage and one was partially upheld in the complainants favour. The third case was not upheld but the PHSO identified an action that had not been completed, following a review of the meeting transcript. The following is a summary of the lessons that were learnt following these two cases.

**Case 1 Partially Upheld-** *It was identified that the complaint had not been managed within acceptable timeframes and a penalty of £50 was awarded to the complainant. It was also identified that the way our patient's care was managed when waiting in ED was unacceptable and we are asked to write an acknowledgement of the service failings identified and highlighting what we have done to prevent this failing occurring again.*

**Learning-** *Since this patients admission significant work has been done by ED to ensure we have more robust pathways for Gynaecology patients, ensuring a more streamlined transfer to the ward where needed. This includes the opening of the Emergency Gynaecology and Early Pregnancy Assessment Unit (EGAU) and the implementation of an Operational Policy for EGAU, detailing patient pathway flows for a range of patients, including those who present with post-operative complications (as in your case.)*

*In response to the poor record keeping highlighted in the PHSO report, forms have been amended to ensure that there is adequate provision for both medical and nursing staff to document their interventions with a patient. A cannulation form should also have been completed, and this was an omission that has been addressed by the management team of ED. All nurses have received written directives from the Matron of ED clearly laying out the importance of accurate patient records. This is also reinforced in the cannulation skills training of new nurses and junior Doctors, also delivered by the Matron of ED.*

*In relation the to the issue around the cleanliness of the side room that the patient waited in, a new audit tool is now in place to ensure that even when busy, this important aspect of patient care is still adhered to. In the most recent audit (covering April 2014) a score of 91% was recorded, with a newly revised cleaning schedule in place and weekly audits being reported both locally and nationally.*

**Case 2 Not upheld- outstanding action-** *This complaint was lodged by the patients son who was very concerned about the care his mother had received. She was elderly with a level of dementia and was also taking medication known to cause hallucinations in some patients. Many of the concerns were adequately addressed in our report to the son, but one of the complaints was that his mother awoke one night to find someone standing over her taking her photograph. Whilst we could find no evidence of this event taking place, a meeting was held with the family to reassure them that this probably didn't occur. During this meeting, we offered to clarify in writing whether there was more*

*than one entrance to the ward. The family asked the PHSO to investigate our handling of the complaint and the conclusions we arrived at.*

**Outcome-** *They were satisfied with our management of the complaint and all outcomes and made the decision not to pursue this case to investigation. They did however pick up that our promise to clarify the ward entrances had not been actioned. The patient's son received a written clarification of the security on both doors on the ward, and reiteration of our apology that his mother had been so distressed whilst in our care.*

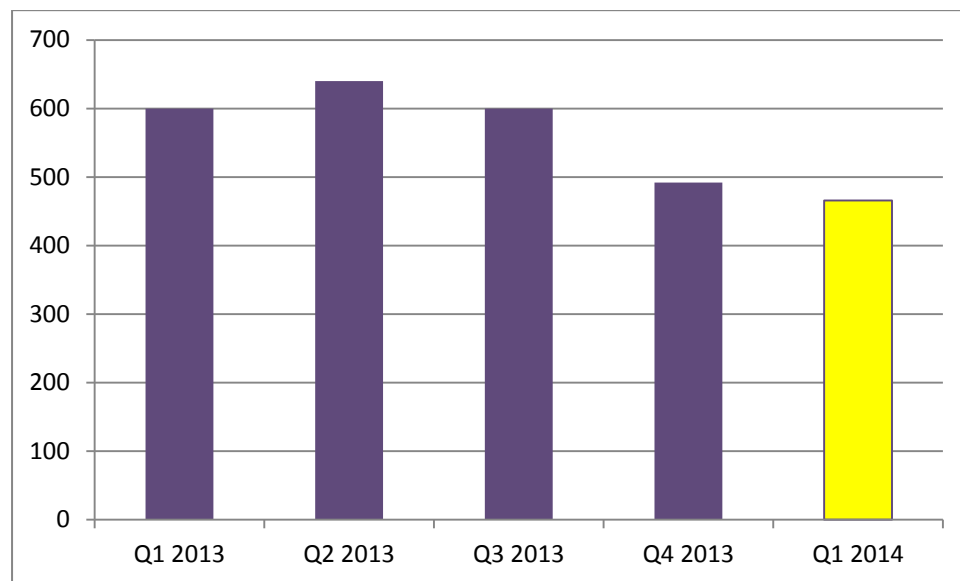
**Planned action:** Future reports will show the local stages for each PHSO case which they investigated.

## PALS

PALS continues to play a vital role in providing patients with a local advocate who can take on a concern from patients or their representatives and investigate this for a speedy resolution.

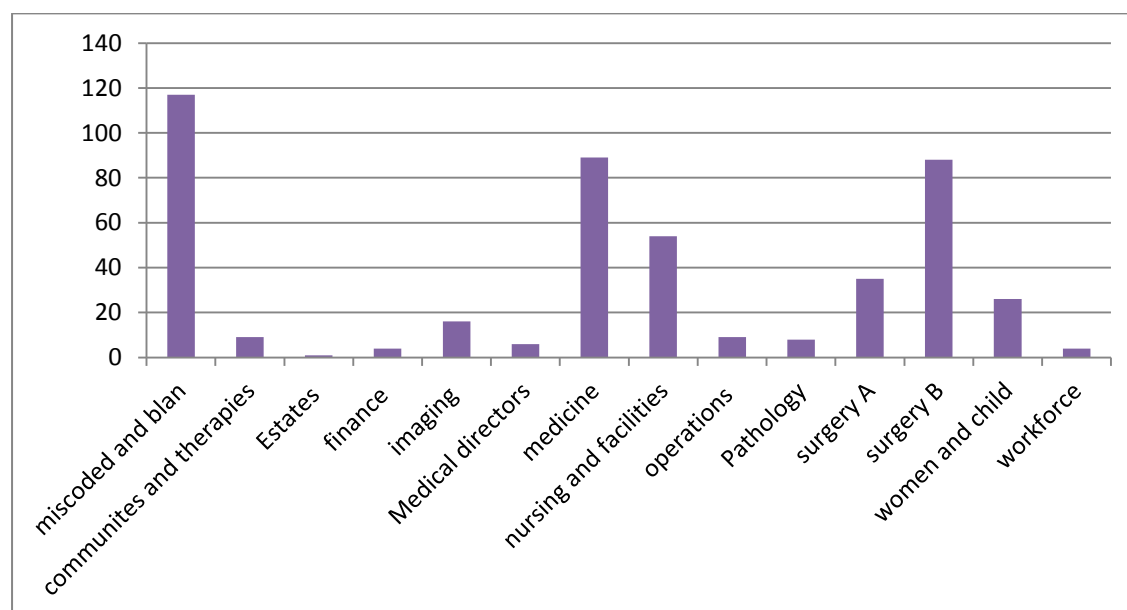
Their enquiry numbers remain steady this year but there has been a marked decrease in the numbers compared to the same quarter last year.

n) comparison between the total number of enquiries

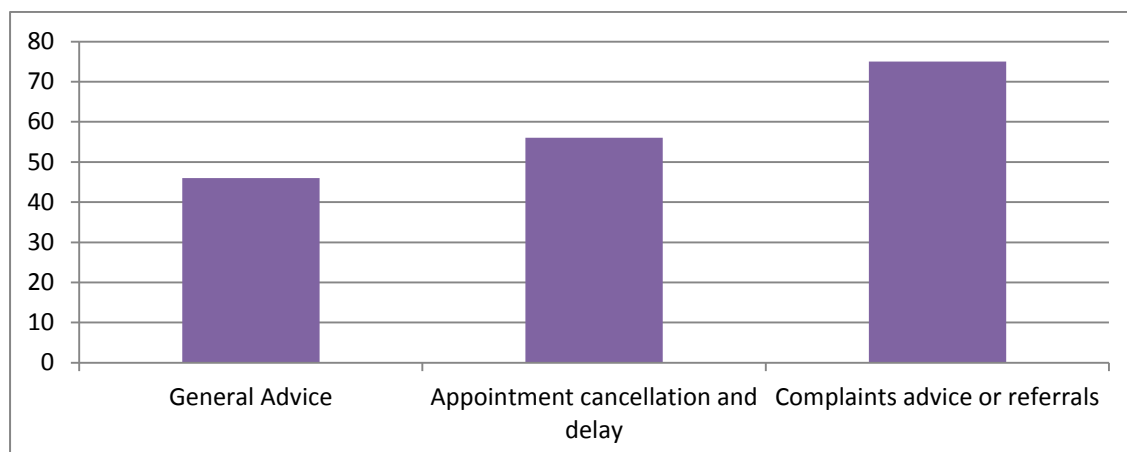


The decrease in enquiries may be attributed to the focus of local, ward or department resolutions from Matrons, and the promotion of devolved complaints management.

o) PALS enquiries by Group for Q1 2014



p) Top 3 categories of enquiries, for Q1 2014.



PALS remain a key referral point for those patients wanting to make complaints this being the single biggest reason why someone may contact PALS with an enquiry. Whilst these enquiries are often about less critical issues without significant learning, the following two stories still demonstrate that at ward and team levels we are still using patient feedback to improve patient care.

**Story 1-** *a patient's stay on one of our wards was not positive, and he wanted to discuss this with one of the ward managers. He wanted to discuss the attitude of the staff, the lack of supervision, what happened on the ward at night, and his perceived lack of focus on the simple needs of patients like drinks and toileting. This was most upsetting for the patient who observed that this was an excellent hospital and the care is normally of a really high standard. He was contacted by the Matron who reassured him that staffing levels had improved and now there were band 6 and 7s on the ward. Matron was now based on this ward to monitor the care and provide supervision. Communication had been improved and a new hand over was being implemented where by staff update their own patients and this handover is recorded on a shared drive so everyone can access it. Documentation improvements implemented include a night shift check list, and audits on ward cleanliness and infection control. 'Intentional rounding' has also been implemented so that patients are visited once per hour to identify drinks and toileting needs. The patient was happy with this feedback, commenting that we clearly 'had our feet on the ground' and were 'committed to making improvements to care'.*

**Story 2-** *When visited by a community nurse, the patient noted that the information the nurse held stated that she was a smoker. As she wasn't, this concerned her as she felt that it might affect her Life Insurance. The community nurse confirmed that she couldn't amend these records; it had to be done via the hospital. The patient contacted PALS and they arranged for these records to be changed. The patient has been sent a revised copy of her booking summary for reassurance.*



## **SUMMARY**

The first quarter's data shows an increase in the number of complaints received as compared to the previous year. This has not identified any particular departments or causes which are of particular concern. Equally the profile of the complainants has not changed.

Medical and Nursing staff make up the largest part of our workforce and are in most contact with patients and their relatives. Therefore being the subject of the majority of complaints is understandable. The devolved model provides opportunity for clinicians to be more actively involved in resolving complaints, often meeting with complainants, having more opportunity to reflect on the issues raised and apologising personally. Local ownership of the complaint and any remedial actions, provide those managing services the ability to work with staff to improve on services, pathways and any attitude issues.

Now that the devolved model of complaints management is settling, improvements are happening sooner due to the local ownership. However, to ensure that changes continue to be made across all services, lessons are shared, data will be streamlined to provide groups and directorates with information on trends and themes in a more systematic way, particularly for lower graded complaints.

As groups and directorates continue to address complaints, lessons and changes will be better captured to further inform this report. Future reports will outline high level information at Trust and group level but also provide more focussed information at clinical directorate level. This will include contextual information relating to care episodes and more targeted themes and trends to further inform changes to service or pathways and gives triggers for failings in performance or a service.

The planned changes to improve the quality of this report are captured throughout this paper in the blue text boxes and some will feature in the next report (Quarter2).

Work continues to embed and improve the process we have for managing complaints which will be evidenced by responding by the agreed date, addressing all of the key points raised by the complainant to their satisfaction and leading to service or pathway improvements.

**Karen Beechey**  
**Head of PALS & Complaints**

## Finance & Investment Committee – Version 0.1

**Venue** D29 Meeting Room, City Hospital

**Date** 25 July 2014; 0800 – 1000h

**Present**

Ms Clare Robinson  
Mr Richard Samuda  
Mr Harjinder Kang  
Mr Tony Waite

**In attendance**

Mr Chris Archer  
Mr Matthew Dodd  
Mrs Jayne Dunn  
Mr Colin Ovington

**Secretariat**

Mr Simon Grainger-Lloyd

Minutes	Paper Reference
<b>1 Apologies for Absence</b>	<b>Verbal</b>
Apologies were received from Miss Barlow.	
<b>2 Minutes from the previous meeting</b>	<b>SWBFI (6/14) 034</b>
The minutes of the meeting held on 26 June 2014 were accepted as a true and accurate record of discussions held.	
<b>AGREEMENT: The minutes of the previous meeting were accepted as a true and accurate reflection of the discussions held</b>	
<b>3 Matters arising from the previous meetings</b>	<b>SWBFI (6/14) 034 (a)</b>
<p>The Committee received and noted the updated action log.</p> <p>Mrs Dunn provided an update on the use of the external consultants to develop and deliver the transformation programme. She advised that some limited resource was being retained at present to roll out the Programme Office Management approach across the business. Mrs Dunn agreed to check on progress with arranging a meeting to 'sign off' the work of the consultants, which she noted would be arranged either in August or September. It was suggested that an overall view of the use of external support across the year was necessary. Mr Kang asked whether there was sufficient expertise across the Trust and he was advised that there were a number of individuals working within the Trust who were accredited project management professionals.</p>	

<b>ACTION:</b> Miss Barlow to provide feedback from advisers with regard to their assessment of the Trust's strengths and weaknesses in CIP and change delivery and their views as to priority areas for attention with regard to the delivery of service & financial sustainability in 2014/16	
<b>3.1 Temporary staffing position</b>	SWBFI (7/14) 036 SWBFI (7/14) 036 (a)
<p>Mr Ovington provided an overview of the temporary staffing usage position. Ms Robinson asked how volunteers could contribute to alleviating the position. She was advised that these individuals could not undertake the duties of paid employees.</p> <p>It was noted that there was a downward trend in the use of bank and agency staff, however the costs remained static. Mr Waite advised that this reflected to some degree, the timeliness of claims for shifts worked and that there may be increased hours in specialist areas where more costly staff were used. Mr Ovington reported that in Critical Care, agency staff costs were particularly expensive and therefore work was being done to encourage staff to sign up through the Trust's internal bank. Mr Samuda highlighted that there was potentially inefficiency in the sign off of images taken by sonographers and radiographers and it was agreed that change and empowerment was needed at this level. Mrs Dunn suggested that these type of issues needed to be picked up by the change leaders embedded in the areas. The Committee discussed the courage and empowerment needed to make the changes. Mr Ovington advised that a risk assessment was underway to inform the practices around 'specialising' patients. It was reported that practice was being assessed in other organisations and work was also underway to apply some control measures and rules that would ensure that a normalised level of agency staff was used in the Trust. It was noted that changing the pay rates and incentivisation schemes for staff might assist, as would a reduction in turnover of nurses.</p> <p>On a separate matter, Mr Samuda highlighted that there was a potential opportunity to deliver efficiencies in the Ophthalmology speciality as identified by the recent CHKS benchmarking work. It was agreed that the plans to address this should be shared at the September meeting of the Committee.</p> <p>Mr Ovington was asked to present the potential impact of the work to address agency staff usage on the Trust's financial position at the next meeting of the Finance &amp; Investment Committee. It was agreed that link to over recruitment was needed.</p>	
<p><b>ACTION:</b> Miss Barlow to provide an overview of the efficiency improvements planned in the Ophthalmology area (as a result of the CHKS benchmarking work) at the next meeting</p> <p><b>ACTION:</b> Mr Ovington to join the Committee at its next meeting to present a trajectory for the reduction in agency usage and costs related to the impact of key interventions to reduce the reliance on temporary staffing</p>	

<b>4</b> <b>2014/15 Month 3 financial update</b>	<b>SWBFI (7/14) 037</b> <b>SWBFI (7/14) 037 (a)</b> <b>SWBFI (7/14) 037 (b)</b>
<p>Mr Waite reported that the change in the financial position reflected under recovery of income in period 3 and that the use of reserves had been less than in periods 2 and 3. It was also highlighted that capital spend had been modest. The issues concerning cash were reported to have been resolved, including the recovery of monies associated with same sex accommodation and education.</p> <p>The capital programme was reported to be tight given the Midland Met programme plans, which could impact on the liquidity position.</p> <p>Mr Waite reported that robust arrangements for reporting activity were in place, meaning that there was a good understanding of the position against the contract, however a prospective view was not yet fully possible, particularly in terms of capacity. Mr Kang asked how often the Trust met with commissioners to discuss demand and capacity. He was advised that a monthly meeting was in place.</p> <p>Ms Robinson asked how realistic the report's forecast outturn was. She was advised that this reflected the delivery of the annual plan. It was noted that there was a big shift in other income and asked for an explanation. Mr Archer agreed to provide this view at the next meeting [for clarification, this was the difference between the budget book and plan].</p> <p>It was agreed that a discussion should be held at the next meeting to look at the presentation and reporting of the financial position as part of the monthly financial performance report.</p> <p>Mr Waite reported that the view of the year end forecast would be presented monthly and that at present there was confidence that the original financial plan would be delivered. Ms Robinson noted that the Board needed to be given assurances that the controls needed to deliver the financial plan were in place. It was agreed that the contingency measures identified needed to achieve the plan also needed to be articulated.</p>	
<p><b>ACTION:</b>      <b>Mr Archer to circulate the detail behind the 'other income' movements</b></p> <p><b>ACTION:</b>      <b>Committee members to provide Mr Waite with feedback as to their views of the robustness, clarity and coherence of the reporting of financial performance. Mr Waite to report back at the next meeting</b></p> <p><b>ACTION:</b>      <b>Mr Waite to report on proposals to achieve the financial plan at the Board meeting planned for 7 August</b></p>	
<b>5</b> <b>Income 2014/15</b>	<b>SWBFI (7/14) 038</b> <b>SWBFI (7/14) 038 (a)</b>
<p>Mr Waite presented the latest position in terms of patient activity-related income. It was noted that there was a level of granularity available in terms of the</p>	

income associated with operational standards and national quality requirements. It was also highlighted that real time reporting of activity and money was in place.	
<b>6 Update on TSP 2014-16 and delivery</b>	<b>SWBFI (7/14) 039</b> <b>SWBFI (7/14) 039 (a)</b> <b>SWBFI (7/14) 039 (b)</b>
<p>Ms Robinson noted that the challenge with identifying the shortfall against the TSP target was the key focus for the Executive Group over the next to 6-8 weeks. It was noted that organisational capacity and availability of resource was largely responsible for a shortfall in some areas against the Monitor checklist. It was noted that the staff engagement and communication plan had been delayed. Mrs Dunn advised that communications were being delivered however the key messages around the TSP needed to be finalised and agreed, including the approach to 2015/16. It was suggested that some exemplars showing how a key change and cost saving had been delivered needed to be issued.</p> <p>It was reported that a list of schemes had been worked up by the Executive Group which had the potential to address an element of shortfall in the 2014/15 TSP.</p> <p>It was noted that the resilience plan was designed to ensure that the beds planned for closure could remain closed.</p>	
<b>ACTION: Miss Barlow to propose how actions identified from the CIP best practice self-assessment may be delivered to time/accelerated [with regard to capacity &amp; capability in the organisation]</b>	
<b>7 Forecast and outlook scenarios 2014/15</b>	<b>Presentation</b>
<p>Mr Waite delivered a presentation concerning the current financial position and the forward look and planned remedial measures. The various scenarios were outlined, assuming firstly performance to date continued at the same pace, secondly delivery of the full savings identified to date continued and thirdly a view was provided of the outlook according to the Groups expectations. It was highlighted that the Groups' view was that spending would accelerate, resulting in a potential overspend by the year end. The overspending was noted to reflect identified additional staffing needs, in areas such as Neonatology.</p> <p>In respect of the Groups' view, it was noted that there needed to be a clear and robust communications plan, which set out the expectation of the senior leadership in respect of achievement of a balanced financial position. Mr Ovington reported that meetings would be held with the Groups again to provide feedback on the recent round of performance reviews and to set out priorities. Ms Robinson noted that although the expectations to Groups were clear, it appeared that this was not being translated into changed behaviours and therefore an action plan was needed. Mr Waite offered that the forthcoming round of meetings with Groups presented an opportunity to set out requirements. It was highlighted that the culture of the organisation was task-orientated at present which was not conducive to pursuing the work robustly. Mr Dodd added that the work was overlaid with targeted initiatives such as action plans to achieve the Referral to Treatment (RTT) time targets which was creating a further layer of tension. It was reported that a manager had been recruited with</p>	

<p>the specific brief to manage the 18 weeks RTT target and Mrs Dunn added that there was further support from the transformation resource available and weekly meetings with the Executive Group were held to review progress with the 18 weeks RTT actions.</p> <p>It was agreed that the Trust Board should be engaged in the discussions around the financial position. Mr Samuda asked that the controls in place needed to be clear to the Board and the actions having been taken to date to manage the operational impact. It was also suggested that the view of the external advisers on the plan also needed to be relayed. Ms Robinson asked that the contingency for the work was also needed, including an outline of the indicators of success should the plan be delivered.</p> <p>Ms Robinson asked whether there was sufficient level of expertise and resources to deliver the plan. It was agreed that the risk assessment may cover these considerations and the view of the external advisers as to where there was sufficient traction needed to be canvassed.</p>	
<b>8 Integrated performance report</b>	<b>SWBFI (7/14) 040</b> <b>SWBFI (7/14) 040 (a)</b> <b>SWBFI (7/14) 040 (b)</b>
The report was received and noted.	
<b>9 Resilience plan 2014/15</b>	<b>SWBFI (7/14) 041</b> <b>SWBFI (7/14) 041 (a)</b>
Mr Dodd outlined the new way of managing year-long pressures, which included a focus on elective care. It was reported that some funding was being made available to support the plan and 24/7 facilities for the management of mental health patients was a key focus. It was noted that the additional funding would be used to support improving the performance against the 18 weeks RTT position.	
<b>10 Financial risks</b>	<b>Verbal</b>
Mr Samuda noted that the implication of tendering for community services needed be considered jointly with the CCG.	
<b>11 Matters to highlight to the Board</b>	<b>Verbal</b>
It was agreed the context of the challenges and the changes to the organisation and challenges with the delivery of TSPs needed to be highlighted, in addition to the difficulties with delivering reducing agency spend. It was agreed that it should be made clear that the Executive plan was a work in progress and more granularity of the next 6-8 weeks was needed, including the contingency measures and indicators to be used to judge performance.	
<b>12 Meeting effectiveness feedback</b>	<b>Verbal</b>
It was noted that the forward view of performance and challenges had been a major focus of the meeting.	

<b>13 Any Other Business</b>	<b>Verbal</b>
There was none.	
<b>14 Details of the next meeting</b>	
The next meeting of the Finance and Investment Committee was noted to be scheduled for 29 August 2014 at 1300h at City Hospital.	

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Signed: .....

Name: .....

Date: .....

## Sandwell and West Birmingham Hospitals



NHS Trust

**Quality and Safety Committee – Version 0.1****Venue** D29 Meeting Room, City Hospital**Date** 25 July 2014; 1030h – 1230h**Present**

Ms G Hunjan

Mr R Samuda

Dr S Sahota OBE

Mr C Ovington

Miss K Dhami

Dr Stedman

Mr T Waite [Part]

**In Attendance**

Mrs D Talbot

Mr G Smith

Mr M Dodd

**Secretariat**

Mr S Grainger-Lloyd

Minutes	Paper Reference
<b>1 Apologies for absence</b>	<b>Verbal</b>
Apologies for absence were received from Ms Dutton, Miss Barlow and Ms Binns.	
<b>2 Minutes of the previous meeting</b>	<b>SWBQS (5/14) 044</b>
The minutes of the Quality and Safety Committee meeting held on 30 May 2014 were approved as a true and accurate reflection of discussions held.	
<b>AGREEMENT: The minutes of the previous meeting were approved</b>	
<b>3 Matters arising from the previous meeting</b>	<b>SWBQS (5/14) 044 (a)</b>
The updated actions list was received and noted by the Committee.	
<b>MATTERS FOR DISCUSSION/DEBATE</b>	
<b>4 Integrated quality, finance and performance dashboard</b>	<b>SWBQS (7/14) 046 SWBQS (7/14) 046 (a) SWBQS (7/14) 046 (b)</b>
Mr Waite drew the Committee's attention to the current performance against the emergency care target, which had not been reached recently, although a recovery trajectory had been identified. Regarding the performance against the 18 weeks	



<p>RTT target, it was noted that a recovery plan had also been developed, although the target could not be achieved until Quarter 3. Mixed sex accommodation breaches were highlighted to have reduced. It was noted that additional tracking mechanisms were in place to monitor performance against the national quality and operational targets.</p> <p>Mrs Hunjan noted that the timescale covered by the information included in the report varied. Mr Waite advised that there was a plan to harmonise the timing of the information, however mortality and cancer performance was not likely to be available any sooner.</p> <p>It was highlighted the performance against the fracture neck of femur target was not as good as required. Dr Stedman advised that there was a conflict between the fractured neck of femur target and 18 weeks RTT work, given that the same clinicians were involved. It was agreed that the performance should be highlighted at the next Board meeting.</p> <p>It was agreed that the contents of the report should be discussed by exception.</p> <p>Mrs Hunjan noted that the number of complaints exceeding their original response date had increased. Miss Dhami reported that the Group with the largest number of complaints was the Medicine &amp; Emergency Care and there were a number of breached, pending the embedding the devolution process. It was agreed that the position would be picked up as part of the Quarter 1 complaints report due at the next meeting.</p> <p>Delayed Transfers of Care were noted to have reduced, which Mr Dodd advised reflected some good joint working with Social Services. Dr Sahota noted that there were upcoming issues in the community which may impact at a later date.</p> <p>A more comprehensive view of the performance and forecast against key CQuIN was reported to be being developed, including the financial implications of performance.</p>	
<p><b>ACTION: Miss Barlow to provide an update on performance against fractured neck of femur target at the next Board meeting</b></p>	
<p><b>5 Cardiology performance and recovery plan</b></p>	<p><b>SWBQS (7/14) 047</b> <b>SWBQS (7/14) 047 (a)</b></p>
<p>Mr Dodd reported that there remained issues with performance against patient access targets and that direct access options were being taken up as an alternative, although this had not yet achieved an improvement in performance overall. Cardiology facilities were reported to be being underutilised, such as the cathode laboratories and some of the same sex accommodation breaches continued to be reported on the Coronary Care Unit. It was reported that a number of remedial actions had been delivered, including reporting back on results and an external review. Dr Stedman reported that the team had moved significantly, however there was still significant work to do to deliver improvements, such as to the 18 weeks access target. In terms of the cathode lab, it was reported that the current configuration was unhelpful, meaning that the elective work was often interrupted</p>	

<p>by emergency procedures. It was noted that the laboratory equipment was also in need of replacement. Mrs Hunjan expressed concerns over the current level of service and asked what changes had caused this. She was advised that the service had been underperforming for some time. The inpatient waiting times for procedures were noted to be poor. It was noted that in terms of the investment into the Cathode lab, the capital plan had been approved including the enabling works, with a procurement plan to use a managed equipment approach.</p> <p>Dr Sahota asked how team working and staff morale was within the speciality. Dr Stedman advised that there had been a committed effort to recruit to vacancies, which had been successful. Morale was reported to be improving although there was some way to go.</p> <p>Mr Dodd reported that a robust approach was being taken to ensure that same sex accommodation beaches were avoided in the Coronary Care Unit, including comprehensive monitoring and management of patients.</p> <p>Miss Dhami advised that the report on clinical audits would be considered at the forthcoming meeting of the Audit &amp; Risk Management Committee, which highlighted concerns that were reported nationally on PCI performance, although an action plan was in place to address the position.</p> <p>Mrs Hunjan asked that a further written report be presented at the next meeting.</p>	
<p><b>ACTION: Miss Barlow to provide a written update on Cardiology at the next meeting</b></p>	
<p><b>6 Dementia</b></p>	<p><b>SWBQS (7/14) 047</b> <b>SWBQS (7/14) 047 (a)</b></p>
<p>Mrs Talbot highlighted that dementia would be more prevalent in future and therefore plans needed to be put in place to handle patients with this condition. It was reported that funding had been received to support the dementia work being undertaken in the Trust.</p> <p>It was noted that although the Trust was not meeting the dementia CQuIN at present, performance had improved significantly including raising awareness and measurement. It was noted that by not meeting the targets fines were incurred.</p> <p>Dr Sahota asked how patients with dementia who did not speak English as a foreign language were handled. Mrs Talbot advised that various resources, including visual aids were available to help, in addition to the interpreting policy.</p>	
<p><b>7 Theatre action plan update</b></p>	<p><b>Hard copy</b></p>
<p>Dr Stedman reported that Mr John Clift had been appointed as new Clinical Director for theatres who was taking a view of the current position on theatres. It was noted that much work was underway to develop better team working in the area and make use of the protected governance time to deliver improvements. Dr Sahota asked how better theatre utilisation would be pursued. Dr Stedman provided an over view of the administrative process behind creating an operating list. It was noted that a baseline view of theatre utilisation was needed to make a</p>	

<p>judgement as to the improvements achieved. Dr Sahota offered to provide a contact at Aston University to assist.</p> <p>Miss Dhami drew the Committee's attention to the entries in the integrated dashboard which showed weekday theatre utilisation to be currently 77% against a target of 85%. It was agreed that additional key performance indicators would be added into the integrated dashboard. Mrs Talbot suggested that the action plan needed to be dated in future. It was agreed that the financial implications of the work and alignment to the Transformation Savings Plan should be presented at a future meeting.</p>	
<p><b>ACTION: Dr Stedman to provide an update on the financial implications of the theatre action plan at a future meeting</b></p>	
<p><b>8 Patient story</b></p>	<p><b>Verbal</b></p>
<p>Mr Ovington reported that the patient story in August related to the experience in Accident &amp; Emergency department.</p> <p>Mr Samuda asked if patients reporting a poor experience were engaged in improvement plans. Mr Ovington agreed to consider how this may be taken forward as part of the wider learning work.</p>	
<p><b>ACTION: Mr Ovington to consider how feedback from patient stories might link into the learning model</b></p>	
<p><b>9 2014/15 TSP – quality impact assessment</b></p>	<p><b>Verbal</b></p>
<p>Mr Ovington reported that 361 TSP schemes had been identified, of which 87% had completed QAIs, half of which have been signed off by the Chief Nurse and Medical Director. It was noted that Equality Impact Assessments were also being undertaken. Miss Dhami advised that a monitoring process was needed to ensure that the quality measures on TPRS were not showing adverse trends.</p> <p>Mr Ovington advised that some schemes would have an impact on quality and safety and particular scrutiny was needed to ensure that there was not a significant deterioration as a result of implementing these.</p>	
<p><b>10 CQC intelligent monitoring</b></p>	<p><b>Verbal</b></p>
<p>Miss Dhami reported that the CQC had issued its intelligent monitoring report and reminded the Committee that the Trust had been classed as a Band 4 (out of 6) in October 2013, which had improved to Band 5 in March 2014. Pleasingly, the Trust was reported to be a Band 6 in the recent publication. It was highlighted that the sign off of the CAS alerts had assisted the position.</p> <p>It was reported that the CQC's Chief Inspector visit was planned for week commencing 13 October.</p>	
<p><b>11 Serious Incident report</b></p>	<p><b>SWBQS (7/14) 052</b> <b>SWBQS (7/14) 052 (a)</b></p>
<p>The Committee received and accepted the report.</p>	

<b>12</b>	<b>Clinical audit forward plan: monitoring report</b>	<b>SWBQS (7/14) 053</b> <b>SWBQS (7/14) 053 (a)</b>
The Committee received and accepted the report.		
<b>OTHER MATTERS</b>		
<b>13</b>	<b>Matters of topical or national media interest</b>	<b>Verbal</b>
<p>Mr Samuda asked how the clinical groups were sighted on the recommendations of national reports, such as those from NICE. Dr Stedman reported that there was a robust process managed through the Clinical Effectiveness Committee. It was noted that the process included the management of disputatious practices, where a judgement call was made by the Trust's Medical Director.</p> <p>It was suggested that an annual report should be presented to summarise how the Trust was complying with national guidance.</p> <p>Mr Ovington advised that a report had been presented around safe staffing against which a self-assessment and baseline was needed.</p>		
<b>ACTION: Dr Stedman to provide an annual report on compliance against national guidance at a future meeting</b>		
<b>14</b>	<b>Meeting effectiveness</b>	<b>Verbal</b>
It was noted that the meeting including some good constructive challenge.		
<b>15</b>	<b>Matters to raise to the Board</b>	<b>Verbal</b>
It was noted that there were several matters to raise to the Board.		
<b>16</b>	<b>Any other business</b>	<b>Verbal</b>
There was none.		
<b>17</b>	<b>Details of the next meeting</b>	<b>Verbal</b>
The date of the next meeting of the Quality and Safety Committee was reported to be 29 August 2014 at 1030h in the Anne Gibson Boardroom, City Hospital.		

**Signed** .....

**Print** .....

**Date** .....

## Configuration Committee – Version 0.1

**Venue** D29 Meeting Room, City Hospital

**Date** 27 June 2014 at 0800h

### Members present

Mr R Samuda [Chair]  
Ms C Robinson  
Mr T Waite  
Dr R Stedman

### In attendance

Mr G Seager  
Mrs J Dunn  
Ms D Lewsley

### Secretariat

Mr S Grainger-Lloyd

Minutes	Paper Reference
<b>1 Apologies</b>	<b>Verbal</b>
Apologies for absence were received from Mr Lewis, Dr Gill and Mrs Hunjan.	
<b>2 Minutes of the previous meetings</b>	<b>SWBCC (4/14) 019</b>
The minutes of the meeting of the Configuration Committee held on 25 April 2014 were approved.	
<b>AGREEMENT: The minutes of the previous meetings were approved</b>	
<b>3 Matters arising from the previous meeting</b>	<b>SWBCC (4/14) 019 (a)</b>
The Committee received and noted the updated actions log.	
<b>4 MMH Project status update</b>	<b>SWBCC (6/14) 021</b>
<p>Mr Seager reported that numerous requests for information had been received from HM Treasury and the Department of Health in support of the consideration of the Midland Met outline business case, all of which had been answered. It was noted that there appeared to be a preoccupation in terms of the Value for Money of the scheme.</p> <p>It was highlighted that the main attention was to secure the approvals of the scheme and preparation for the procurement phase. Ms Lewsley advised that a review of some of the key documentation was still awaited, however it was anticipated that there would not be any impediment to the procurement when this stage could formally commence. It was noted that work had commenced with key clinical group representatives internally who would be key to the progression of</p>	

<p>the programme. It was reported that clinical engagement had been largely good.</p> <p>In terms of the City Hospital site, it was reported that discussions had commenced regarding demolition and the retained estate.</p> <p>It was reported that some work being undertaken by CHKS was being fed into the development of the clinical services.</p>	
<p><b>5 Gateway review</b></p>	<p><b>SWBCC (6/14) 022</b>  <b>SWBCC (6/14) 022 (a)</b>  <b>SWBCC (6/14) 022 (b)</b></p>
<p>Mr Seager reported that an action plan had been developed in response to the recent Gateway Review. It was noted that the action plan included some challenging timescales. Ms Lewsley advised that the communications plan was currently being developed and an external resource had been acquired for this purpose. The risk registers were reported to be being considered on a routine basis.</p>	
<p><b>6 Procurement readiness</b></p>	<p><b>SWBCC (6/14) 023</b>  <b>SWBCC (6/14) 023 (a)</b>  <b>SWBCC (6/14) 023 (b)</b></p>
<p>It was reported that a plan of action had been developed which was based on a proposed decision by 11 July. It was reported that the planned opening date of October 2018 remained feasible, although the timeline was very challenging. It was noted that a key consideration was the construction element of the project and the financial close to April 2016. Ms Robinson noted that there was little flexibility in the timetable and that the General Election had the potential to impact on the achievement of project to the set timescales, including the financial close. She urged consideration of the risks and the contingency. Mr Seager advised that the various scenarios were being modelled however there were inherent risks in the achievement of the construction phase. It was noted that there were some financial safeguards in the case of delay, however there was a financial risk associated with double running which could crystallise. It was noted that the commissioning phase would occur before the opening of the new hospital. The downside risks were reported to have been explored. Ms Robinson noted the scale of the challenge with meeting the current planned opening date and suggested that the expected timeline needed to build in contingency for slippage due to third parties. Mr Seager suggested that there was a need to retain the intention of meeting the financial close date of April 2016. Ms Robinson agreed, however emphasised the need to be realistic and should there be delays then the risks of this needed to be clearly visible and early engagement with the third parties should be pursued.</p> <p>It was agreed in the private Board the risks associated with meeting the timescales needed to be discussed.</p> <p>Ms Lewsley provided the Committee with copies of the Midland Met procurement</p>	

documentation which had been used for the Pre Qualification Questionnaire. A launch event was reported to be planned in the Cap Centre in Smethwick. It was noted that the documentation had been reviewed by the Trust's legal advisers and the key documents would be uploaded after the bidders launch date. The 'boot camps' were reported to be scheduled shortly and recruitment into a service redesign post was underway.	
<b>7 MMH assurance plan</b>	<b>SWBCC (6/14) 024</b> <b>SWBCC (6/14) 024 (a)</b> <b>SWBCC (6/14) 024 (b)</b>
The Committee considered the MMH assurance plan, which had been agreed by the Board in autumn 2013. The final actions commissioned by the Board were reviewed. Ms Robinson suggested that secondments should be considered where appropriate. Mr Waite supported this approach.	
<b>8 Midland Met risk report</b>	<b>SWBCC (6/14) 025</b> <b>SWBCC (6/14) 025 (a)</b>
The Committee considered the risk register for the MMH project. It was noted that there was interplay with the FT application. Ms Robinson encouraged early engagement with Monitor as part of the work. It was noted that the FT timetable would be debated at the Trust Board on 3 July which would pick up this risk. It was highlighted that the risk register was open to public scrutiny as part of the OBC.	
<b>9 Clinical reconfiguration summary update</b>	<b>SWBCC (6/14) 026</b> <b>SWBCC (6/14) 026 (a)</b>
<p>Mrs Dunn reported that in terms of Cardiology, discussions had started with commissioners and it was highlighted that subsequent public consultation for reconfiguration would be necessary. This work would be led by NHS England. Mr Samuda asked how this work interacted with the work on Cardiology currently underway to improve the performance of the area. Dr Stedman advised that the two pieces of work were being kept separate at present. He reported that reconfiguration of Cardiology was a first step for other reconfigurations, such as surgery.</p> <p>In terms of stroke reconfiguration, the CCG was expected to designate five Hyper Acute Stroke Units (HASUs). It was highlighted however, that clarity was yet to be received around the process by which the sites were selected, although a competitive process was possible.</p> <p>Diabetes reconfiguration was reported to be progressing well.</p>	
<b>10 'Right Care, Right Here' activity and capacity assumptions monitoring report</b>	<b>SWBCC (6/14) 027</b> <b>SWBCC (6/14) 027 (a)</b>
<p>The report was presented for information.</p> <p>It was highlighted that highlighted that outpatient attendance was higher than</p>	



<p>plan, however the work on the Year of Outpatients was anticipated to have a beneficial impact.</p> <p>Mr Samuda reported that during a recent meeting with representatives with UHBFT discussions had taken place around emergency care admissions.</p> <p>It was noted that the average length of stay had increased in 2013/14, however there were 4% fewer adult admissions and 3% fewer acute adult bed days than in 2012/13. It was noted that the Board needed to be made aware of the implications of this as part of the reports in future. It was noted that the information flows informing the view of performance against the trajectories were working well.</p>	
<b>11 Matters to raise to the Board</b>	<b>Verbal</b>
<p>It was agreed that the state of procurement readiness and the risks to the timeline needed to be raised. It was also suggested that the proposals around the designation of HASUs needed to be raised, in addition to the good data flows that informed the performance against the trajectories.</p>	
<b>12 Any other business</b>	<b>Verbal</b>
There was none.	
<b>13 Details of the next meeting</b>	<b>Verbal</b>
<p>The next meeting is to be held on 29 August 2014 at 0800h in the D29 (Corporate Suite) Meeting Room, at City Hospital. <i>Subsequently rearranged to 3 September 2014.</i></p>	

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Signed .....

Print .....

Date .....

# Midland Metropolitan Hospital Status Report

## September 2014

### Activities Last Period

- OBC published
- ITPD documents completed
- Potential bidders shortlisted
- Dialogue training session commenced

### Planned Next Period

- Continue site demolitions
- Continue detailed site investigations
- Commence Dialogue process

### Issues for Resolution/Risks for Next Period

ED&AMU review needs to be concluded

# FT Programme Monitoring Status Report

## Activities This Month

- Detailed FT project plan developed, aligned to CIH inspection and external assessment processes
- QGAF action plan to be presented at September Trust Board
- FT Development Committee – proposed new structure presented to Exec Group 2/9/14
- Feedback from TDA on IBP & LTFM (submitted June 2014) anticipated end of August 2014 – not yet received

## Planned Next Month

- Good practice from ward/department CIH self-assessments shared widely
- Rolling programme of staff briefings ahead of CIH
- Announced mock inspection visits to 8 core services
- Key supporting strategies developed and presented to relevant CLE committee for comment (e.g. workforce, estates, HIS)
- Discussion with accountancy firms regarding Independent Financial Review (IFR) process requirements & options for procurement of reviewer

## Issues for Resolution/Risks for This Month

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

# Chief Inspector's Visit

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

## Preparing for Inspection

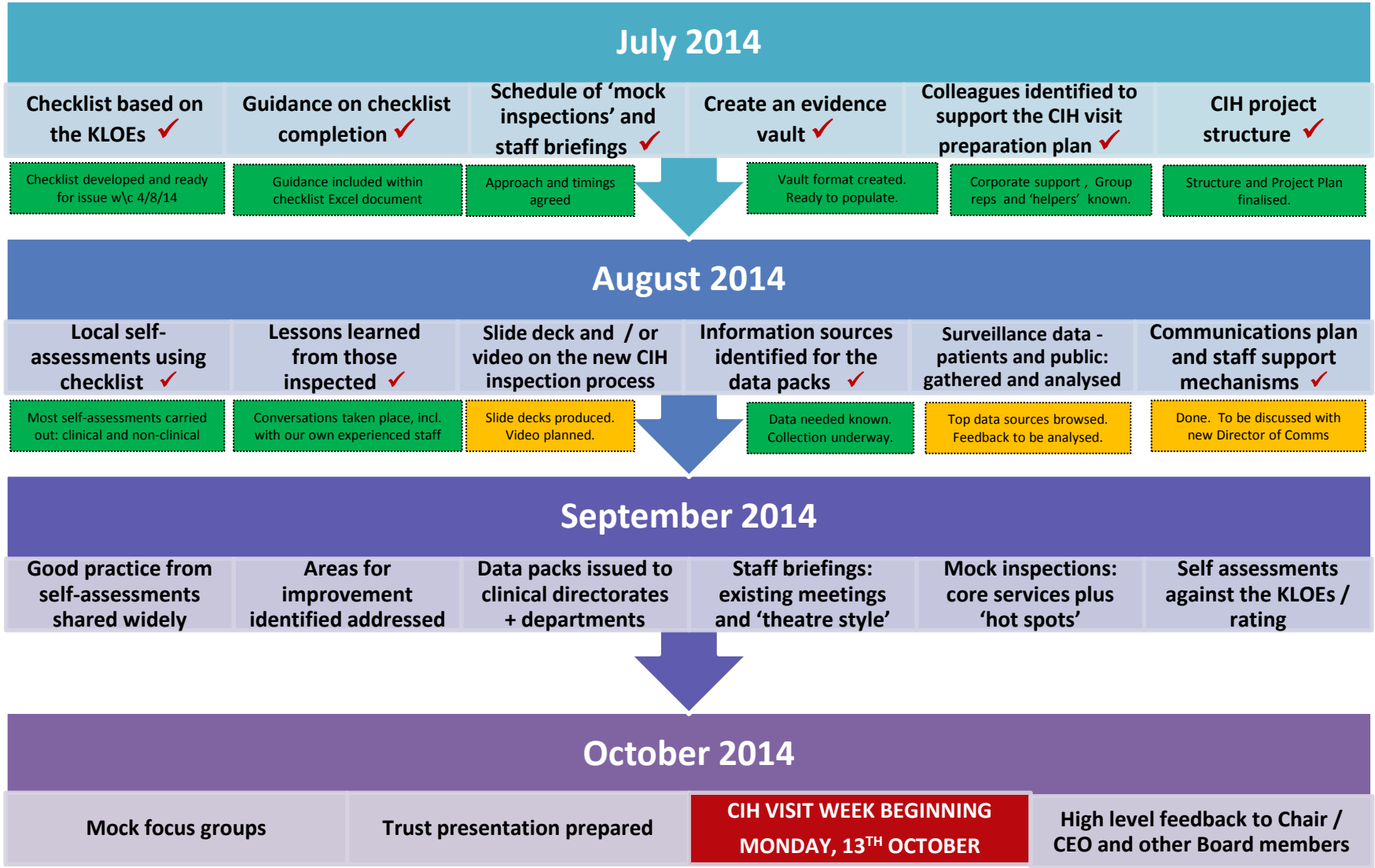
Trust Board: 4 September 2014

Kam Dhami, Director of Governance



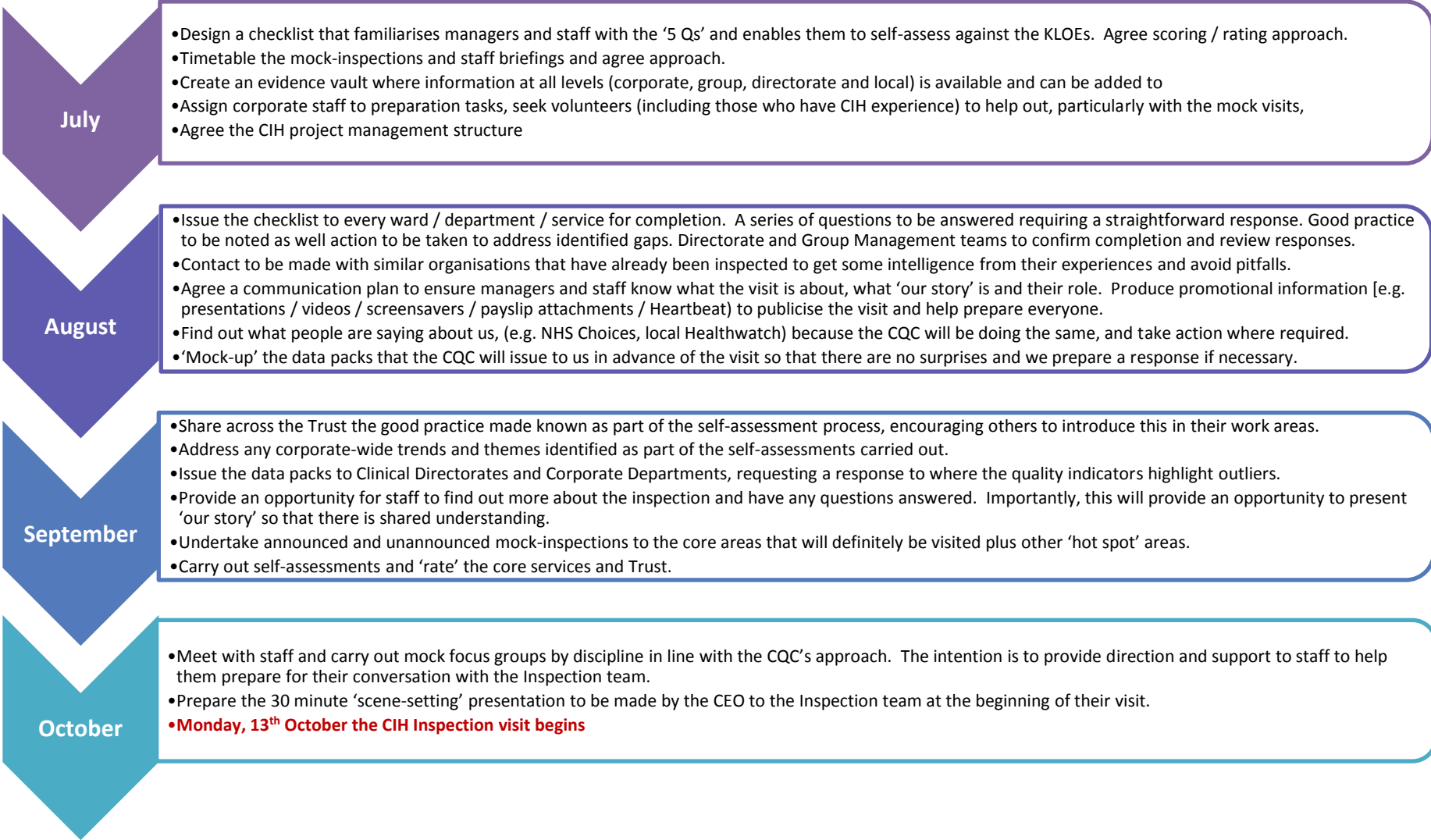
Preparations are underway for the Chief Inspector’s visit and progress against the project plan is mainly on track. Achievements to date are summarised below.

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



A meeting with the Head of Hospital Inspections took place on 7<sup>th</sup> August to work through the logistics and scheduling of the visit. Details on what will happened during the visit and who needs to be involved was confirmed. The inspection will be carried out by a mixture of inspectors, clinicians and ‘experts by experience’. Specialists will be sent to the core services to be inspected; community and acute. A team of 50 is expected. Listening to people’s experiences of care and staff providing services is what the team will spend most of their time doing.

## The outline Inspection schedule

Day 1: 13 October	Inspection team arrive in the area and plan their visit.
Day 2: 14 October <i>Briefing and planning day</i>	<p>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 to the inspection team highlighting the strengths and areas of improvement that the Trust is working on.</p> <p><u>Trust staff involved:</u> CEO, Chairman, NED (Quality &amp; Safety), Medical Director, Chief Nurse and Chief Operating Officer</p> <p>The Inspection team will hold two public listening events in the evening. These are intended for members of the public / carers who have experience of the service. No Trust staff will be present.</p>
Days 3–4: 15 - 16 October <i>Announced site visits</i>	<div><div><ul style="list-style-type: none"><li>▪ Gathering the views of staff and service users / carers</li><li>▪ Hold core focus groups with staff</li><li>▪ Pathway tracking patients through care</li></ul></div><div><ul style="list-style-type: none"><li>▪ Reviewing records</li><li>▪ Reviewing policies and documents</li><li>▪ Consider the financial robustness – how the management of finances impacts on quality</li></ul></div></div>
Day 5: 17 October <i>Closing the visit</i>	Inspection Chair will hold a feedback meeting with the nominated individual (CEO) and Chair to give a high level initial feedback only. <u>Trust staff involved:</u> CEO, Chairman, Chief Nurse and Director of Governance.
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.
Reporting <i>Draft report written by CQC</i>	Draft report written with service level and trust level ratings: outstanding, good, requires improvement or inadequate. The report will be submitted for peer review, to check for quality and consistency. A national panel, chaired by CQC’s Chief Inspector of Hospitals will then review the report. Once approved by the panel, the report will be sent to the CEO for a factual accuracy check. Likely to be December.
Quality Summit following receipt of the final report	<p>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.</p> <p>The Quality Summit will consider:</p> <p>Soon after the Quality Summit the CQC will publish the inspection reports, ratings and data pack on their website. We will publish the same and our action plan on our website.</p>

**TRUST BOARD**

<b>DOCUMENT TITLE:</b>	Safe Nurse Staffing				
<b>SPONSOR (EXECUTIVE DIRECTOR):</b>	Colin Ovington – Chief Nurse				
<b>AUTHOR:</b>	Colin Ovington – Chief Nurse				
<b>DATE OF MEETING:</b>	4 <sup>th</sup> September 2014				
<b>EXECUTIVE SUMMARY:</b>					
<p>This report is an update using the data collected during July 2014.</p> <p>The data from the national reporting system has been applied to our own expected staffing data to help understand our nurse staffing position.</p> <p>An appendix to describe how we calculate a nursing establishment is given for information</p>					
<b>REPORT RECOMMENDATION:</b>					
<p>To publish patient to RN ratios on our public web site and on NHS Choices on a monthly basis as per national requirement.</p> <p>To receive an update at the October Trust Board meeting.</p>					
<b>ACTION REQUIRED</b> <i>(Indicate with 'x' the purpose that applies):</i>					
The receiving body is asked to receive, consider and:					
<b>Accept</b>		<b>Approve the recommendation</b>		<b>Discuss</b>	
X				X	
<b>KEY AREAS OF IMPACT</b> <i>(Indicate with 'x' all those that apply):</i>					
Financial		Environmental		Communications & Media	X
Business and market share		Legal & Policy		Patient Experience	X
Clinical	X	Equality and Diversity		Workforce	X
Comments:					
<b>ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:</b>					
Relates to our safety objectives and BAF					
<b>PREVIOUS CONSIDERATION:</b>					
Routine monthly update.					



# Sandwell and West Birmingham Hospitals

NHS Trust

## SAFE NURSE STAFFING

### Report to Trust Board on 4<sup>th</sup> September 2014

#### 1 EXECUTIVE SUMMARY

- 1.1 This report is an update using the data collected during July 2014.
- 1.2 The data from the national reporting system has been applied to our own expected staffing data to help understand our nurse staffing position.

#### 2 JULY POSITION

- 2.1 Table one is the output data from the national data collection for July 2014 which demonstrates that we achieve higher fill rates against our rotas than planned in most areas although the average fill percentage has reduced slightly from the previous month.

Table 1.

		Day		Night	
		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Site Name				
Jul-14	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	109.0%	100.2%	120.8%	0.0%
	CITY HOSPITAL	105.3%	109.5%	123.3%	123.1%
	ROWLEY REGIS HOSPITAL	115.5%	103.2%	159.7%	116.6%
	SANDWELL GENERAL HOSPITAL	106.9%	115.1%	119.1%	150.1%

The table two demonstrates the expected numbers of registered Nurses and Health Care Support staff we plan to be on our rosters over the 24 hour day. Where there are shortfalls in meeting this requirement or when individual patients require closer attention (specialling) additional staff will be booked on a temporary basis either via our nurse bank or via external agencies if there is no staff available. The fill rate percentage informs us that most of our wards continue to use additional capacity.

Table 2

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during July 2014	Percentage night time fill rate during July 2014		Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during July 2014	Percentage night time fill rate during July 2014
Medicine & Emergency care	D7	City	13	4	4	3	105.6	107		1	1	1	94.6	106.2
	D5	City	19	6	6	5	114.8	136		1	1	0	160.2	2069.6
	D11	City	21	3	3	2	108.9	96.8		3	3	2	98.9	95.6
	D12	City	10	2	2	2	96.6	160.3		1	1	1	92.8	113
	D15	City	24	4	4	3	98.6	167.1		3	3	2	103	227.6
	D17	City	25	4	4	3	117	138.5		3	3	2	173.8	178.5
	D26	City	21	3	3	2	105.6	107		3	3	2	94.6	106.2
	AMU 1	City	41	10	10	9	103.1	119.5		4	4	3	92.4	99
	AMU 2	City	19	5	5	4	101.3	145.1		1	1	1	120.8	110.7
	D43	City	24	4	4	3	103.3	166.8		3	3	2	127.7	117.5
	CCU Sandwell	Sandwell	10	3	3	2	123.6	112.8		0	0	1	232.5	200
	PR3	Sandwell	29	5	4	3	114.4	122.5		4	3	2	135.5	157.4
	PR4	Sandwell	25	8	8	5	114.1	117.2		2	2	1	116.8	191.1
	PR5	Sandwell	34	6	5	3	99.6	112.3		4	4	3	109.9	130.3
	NT4	Sandwell	28	5	4	3	103.6	125.2		3	3	3	134.5	188.6
	LY 4	Sandwell	34	6	4	3	99.7	104.6		4	4	3	105	103
	N5	Sandwell	15	3	3	2	96.7	101.6		1	0	1	119.8	617.4
	AMU A	Sandwell	32	8	8	8	112.3	136.1		4	4	3	117.2	199.7
	AMU B	Sandwell	20	4	3	2	101.9	120.6		4	3	2	144.3	169.7
	Elisa Tinsley	RRH	24	4	3	2	110.6	234.9		3	3	3	94.8	99.9
Surgery A														
	D21	City	23	4	4	2	100.8	186.7		2	2	2	120.8	150.8
	D25	City	19	4	4	2	112.7	121.1		2	2	2	85.7	107.4
	SAU D42	City	14	4	4	2	93.6	130.8		1	1	1	164.4	127.5
	SDU	City	12	4.5	2	0	92.8	103		1	1	0	111.7	96.2
	N2	SGH	24	4	3	2	116.1	151.5		2	2	1	131.4	194.4
	L2	SGH	20	4	3	2	121.7	107.1		3	2	2	98.4	101.3
	P2	SGH	20	4	3	2	102.6	109.8		3	2	2	109.8	139.5
	N3	SGH	33	6	6	3	104.8	126.5		4	4	3	101.8	161
	L3	SGH	33	6	6	3	94.5	122.9		4	4	3	103.6	109.6
Community & Therapies														
	Henderson	RH	24	2	2	2	118.5	123		2	2	2	136.3	173.7
	Leasowes	RH	20	2	2	1	120	129.2		4	3	2	85.7	106.6
Surgery B														
	Eye ward	City	10	2	2	2	109	120.8		1	1	0	100.2	

### **3 CURRENT ISSUES**

- 3.1 Additional controls were introduced from the beginning of August as the previous controls introduced at the beginning of July were not demonstrating any significant reduction although the national data is showing average fill rates which are coming down slowly. Our integrated performance dashboard is also demonstrating good reduction in agency shifts booked, bank shifts are relatively static. A specific piece of work to tighten our risk assessment of patients deemed to require additional nursing time has commenced and I am expecting this to be tested out during September. The Clinical Groups have been challenged to reduce the temporary staffing requirements by 50%, the final decision on agency staff continues to rest with the Chief Nurse.

### **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 October Trust Board meeting

### **5 APPENDIX**

#### **1. Calculating Nurse Staffing**

Colin Ovington

Chief Nurse

28<sup>th</sup> August 2014

# Calculating Nurse Staffing

Colin Ovington

Chief Nurse

- There is no nationally recognised tool for calculating nurse staffing – and there has been no appetite to recommend one until the NICE guidance was issued which is now giving some parameters and the likelihood that only tools ratified by NICE will be acceptable.
- Most organisations use the AUKUH (SNCT) tool for acute care, we use BRAD which is a local interpretation of AUKUH methodology
- Ward nurse staffing is examined every month to check on sickness and absence, vacancy position and an acuity review is undertaken monthly using the BRAD tool
- Historically the normal balance between registered nurses and non-registered HCA's should be 60 to 70% registered and 30 to 40% non-registered, this is however only a guiding principle when calculating a ward establishment of staff.
- A ward should have one ward sister (band 7) supported by two deputy ward sisters (Band 6) – this will vary on specialised units like CCU

- No acute ward should have any less than two registered nurses – this includes small wards which have a minimum staffing requirement despite the number of patients e.g. ophthalmic ward requires two registered nurses at all times even with only two patients
- There should be a registered nurse to co-ordinate shift activities and indirect care activities, the planned duty roster should accommodate this above the level required for direct patient care provision
- Small hospital wards lose an economy of scale – in the majority of hospitals wards would average approximately 24 – 32 beds
- RCN Guidance would suggest that patient care is never compromised when RN's have five patients in their care and where nurses had 6.8 patients in their care nurses reported that their workload was not too heavy. Beyond these figures care began to be compromised and mortality statistics deteriorate. (26% higher in hospitals with the highest patient to nurse ratio's)
- A registered nurse should have no more than eight patients in their care as a maximum although it is accepted that during the night time period many patients care intensity reduces (professional view)
- On national benchmarking data (2012) from all trusts we sit in a slightly better than mid position in terms of registered nurses to bed ratio with 0.38 beds per RN (range = best 0.21 to 0.58 worst)

# Setting an establishment

- Establishments are generally calculated on average statistics and in hours of care
- Should be based on patient need (acuity and dependency)
- Turnover of patients should also be considered as this impacts on the intensity of work (e.g. AMU will have a higher turnover of patients than general wards)
- Layout and size of the ward are factors that affect the ability to observe patients
- The particular care requirements may require specific skills in the staff e.g. intravenous drugs.
- It is recommended that the average nursing hours required per patient is calculated twice a year and be specific to the time of day
- An additional allowance is made for annual leave, sickness and other absences, study leave (21 to 23%)
- As a rule of thumb 5.5 wte nurses will allow for one to be on duty on a three shift rota and allow for routine absences

# Example calculation

- (Average number of hours of care per patient x number of patients) x 23%
- Worked example 20 bedded medical ward where the average number of nursing care required by each patient is one hour and many of the staff are long serving and on maximum annual leave entitlement (23% uplift)

$(20 \times 1) \times 23\% = 24.6$  results in

70% - 17.22 WTE Registered Nurses – this allows for a minimum of three RN's on duty and a ratio of 6.6 patients per nurse

30% - 7.38 WTE Healthcare Assistants – this allows for one HCA to be on duty

This basic calculation requires fine tuning to the sensitivity of the ward and specialty and the activity which is where the acuity and dependency tool add specific context. E.g. if this is a surgical ward then transporting patients to and from theatre needs to be considered and this can be very specific to the day of the week and the time of day.