Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Nishkam Centre, Soho Rd, Birmingham **Date** 2 April 2015; 1330h – 1630h

Members attending

Mr R Samuda	(RSM)	[Chairman]
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	(RBA)	[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 R Goodby	(RG)	[Director of Workforce & OD]
Mrs C Rickards	(CR)	[Trust Convenor]

Guests

Patient for patient story [Item 6]

Secretariat

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

Time	Item	Title	Reference Number	Lead
1330h	**1**	**Apologies**	**Verbal**	**SG-L**
	2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**SG-L**
	2.1	Register of interests	SWBTB (4/15) 056	SG-L
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 5 March 2015 a true and accurate records of discussions*	**SWBTB (3/15) 054**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (3/15) 054 (a)**	**SG-L**
	4.1	Fit and Proper Persons Test: process for handling concerns	SWBTB (4/15) 057 SWBTB (4/15) 057 (a)	KD
	4.2	Pressure ulcers and falls over winter 2014	Verbal	CO/ OD
	5	**Questions from members of the public**	**Verbal**	**Public**
1345h	**6**	**Patient story**	**Presentation**	**CO**
1405h	**7**	**Chair's opening comments and Chief Executive's report**	**SWBTB (4/15) 058**	**RSM/ TL**
	MATTERS FOR DISCUSSION AND APPROVAL			
1420h	**8**	**To receive Care Quality Commission Report and note the Trust's Improvement Plan – see: www.cqc.org.uk/directory/RXK for all reports**	**SWBTB (4/15) 059 SWBTB (4/15) 059 (a) SWBTB (4/15) 059 (b)**	**KD/TL**

1445h	**9**	**End of year stocktake against recommendations in the Francis Report**	**SWBTB (4/15) 060 SWBTB (4/15) 060 (a)**	**KD**
1500h	**10**	**Trust Risk Register**		
	10.1	Overview and any new considerations	SWBTB (4/15) 061 SWBTB (4/15) 061 (a)	KD
	10.2	Ophthalmology privacy and dignity risk	Verbal	TL
	10.3	Oncology contract with University Hospitals Birmingham	Verbal	RSt
1515h	**11**	**Nurse staffing report**	**SWBTB (4/15) 062 SWBTB (4/15) 062 (a)**	**CO**
1525h	**12**	**Corporate integrated performance dashboard**	**SWBTB (4/15) 063 SWBTB (4/15) 063 (a)**	**TW**
1540h	**13**	**Financial performance – Month 11 and end of year forecast outturn**	**SWBTB (4/15) 064 SWBTB (4/15) 064 (a)**	**TW**
1550h	**14**	**Annual Priorities and Plan 2015/16**	**SWBTB (4/15) 065 SWBTB (4/15) 065 (a)**	**TL**
1600h	**15**	**Financial plan 2015/16**	**SWBTB (4/15) 066 SWBTB (4/15) 066 (a)**	**TW**
	UPDATES FROM THE COMMITTEES			
1615h	**16**	**Update from the meeting of the <u>Quality & Safety Committee</u> held on 27 March 2015 and minutes of the meeting held on 27 February 2015**	**SWBQS (2/15) 030**	**OD/ CO**
1620h	**17**	**Safeguarding update**	**SWBTB (4/15) 072 SWBTB (4/15) 072 (a)**	**CO**
	18	**Any other business**	**Verbal**	**All**
	MATTERS FOR INFORMATION			
	19	**Details of next meeting** *The next public Trust Board will be held on 7 May 2015 at **1330h** in the Anne Gibson Boardroom, City Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REGISTER OF INTERESTS AS AT APRIL 2015

Name	Interests Declared
Chairman	
Richard Samuda	▪ Director – Horton's Estates Ltd. ▪ Director – 'Kissing It Better' ▪ Non Executive Director – Warwick Racecourse
Non Executive Directors	
Olwen Dutton	▪ Partner – Bevan Brittan LLP ▪ Fellow – Royal Society of Arts ▪ Member – Lunar Society ▪ Member – Birmingham Forward ▪ Member – Council of the Birmingham Law Society ▪ Member – Labour Party
Gianjeet Hunjan	▪ College Finance and Administration Team Manager – University of Birmingham ▪ Lay Member – Advisory Committee on Clinical Excellence Awards – West Midlands ▪ Lay Member – NHS Midlands and East Workforce Deanery ▪ Governor – Oldbury Academy ▪ Governor – Ferndale Primary School
Sarindar Singh Sahota OBE	▪ Trustee – Acorns Hospice ▪ Member – Court of University of Birmingham ▪ Trustee – Nishkam Schools Trust ▪ Director – Asian Business Forum ▪ Member – Smethwick Delivery Board ▪ Chair – Birmingham City Council Citizen-Led Quality Board for Assessment and Support Planning
Harjinder Kang	▪ Managing Consultant – PA Consulting Group
Paramjit Gill	▪ Trustee South Asian Health Foundation ▪ Trustee – Healthy Hearts ▪ Clinical Academic at University of Birmingham collaborating with colleagues based at the Trust on a number of research studies ▪ General Practitioner
Voting Executive Directors	
Toby Lewis (Chief Executive)	▪ Board member – Sandwell University Technical College
Rachel Barlow (Chief Operating Officer)	None
Colin Ovington(Chief Nurse)	None

Roger Stedman (Medical Director)	▪ Partner – Excel Anaesthesia (private anaesthesia services)
Tony Waite (Director of Finance & Performance Mgt)	None
Associate Members	
Kam Dhami (Director of Governance)	▪ None
Raffaela Goodby (Director of Workforce & OD)	▪ Board member in PPMA (public sector people manager's association) member's organisation ▪ E4S Practitioner Board member (voluntary national body)
Michael Hoare (Non Executive)	▪ Director, Fujitsu UK
Trust Secretary	
Simon Grainger-Lloyd	▪ Director – Parkfields Management Ltd.

April 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 5 March 2015

Present	In Attendance	Secretariat
Mr Richard Samuda [Chair]	Mr Mike Hoare	Mr Simon Grainger-Lloyd
Ms Olwen Dutton	Miss Kam Dhami	
Dr Sarindar Sahota OBE	Mrs Raffaela Goodby	
Mrs Gianjeet Hunjan	Mrs Chris Rickards	
Mr Harjinder Kang	Mr Wasim Ali [Healthwatch]	
Dr Paramjit Gill	Ms Kayleigh Jepson [Nurse Rising Star]	
Mr Toby Lewis		
Mr Colin Ovington	**Guests**	
Miss Rachel Barlow	Patient	
Dr Roger Stedman	Rev Graham Field	
Mr Tony Waite	Mr Matthew Dodd	
	Ms Jill Barnes	

Minutes	
1 Apologies for absence	**Verbal**
No apologies for absence were received. The Chairman welcomed Mrs Goodby to her first meeting as Director of Organisational Development.	
2 Declaration of Interests	**SWBTB (3/15) 035**
Mr Grainger-Lloyd asked the Board to note Mrs Goodby's declarations of interest.	
3 Minutes of the previous meeting	**SWBTB (2/15) 033**
The minutes of the Trust Board meeting held on 5th February 2015 were presented for consideration and approval. The minutes were approved subject to slight amendment.	

4 Update on Actions arising from Previous Meetings	SWBTB (2/15) 033 (a)
The Board received the updated actions log. It was noted that the actions concerning the presentation of an end of year stocktake against the Francis recommendations and the preparation of a rolling slide deck of organisational change were delayed but would be expedited over coming weeks.	
5 Questions from members of the public	**Verbal**
Mr Cash drew the Board's attention to the Sandwell and West Birmingham CCG's equality awards event on 19 March and welcomed representation at the event. It was noted that the Trust was represented by a number of nominations. Mr Cash asked for information concerning the Trust's mortality rate. Dr Stedman reported that the position for the Trust – as outlined in the public papers - was a ratio of 86 compared to the national expected average of 100. Mr Cash noted that the plans to attract volunteering as outlined at the recent meeting of the Members' Leadership Group were under development and asked what progress had been undertaken since. The Chairman noted that the meeting of the Members Leadership Group had been successful and there was a good turnout and mix of experience represented. The value in sustained momentum for the Group was underlined. Mr Ovington highlighted that there was keenness to engage with volunteers and a firm plan was being developed. It was reported that a stakeholder event had been run recently and that the entire organisation would be engaged with the plans. Mr Ovington reported that the use of traditional media and social media would be used to attract individuals. He underlined the value in attracting people of a diverse age range and ethnic background. Mr Lewis noted that in view of the Saville enquiry, care would be taken to undertake robust security checks as part of the on-boarding plans.	
6 Patient story	**Presentation**
Mrs Andrea Kerr gave an account of her inpatient stay on Critical Care Unit and Ward D26 where she remained. She praised the staff on Ward D26 in particular for their care and highlighted that the new WiFi facility was well received. Aspects of her two year stay which she reported were less pleasing included the restrictive choices at lunchtimes, and the delay with receiving pain relief and other medication when the ward was busy or staffing seemed short. Mr Lewis asked whether there was a forward plan for her care and whether she had been involved in this. The patient advised that this was the case although it was managed on a day to day basis rather than being planned over a longer timeframe. The patient advised that any changes to the care plan were explained as and when there was a need. Mr Kang asked for further clarity on the impact of the long stay on the patient's family. He was advised by the patient that the new open visiting time was positive and there was provision to spend time with her children in the TV room on ward	

D26. Ms Dutton noted that it was good to hear praise for the chaplaincy service. She also asked whether there was adequate support at home from the hospital and social services. The patient stressed her independence, however the support she had received had been adequate and it was arranged in readiness for discharge. The patient advised that when there was a readmission needed, then it was sometimes difficult and laborious to go through the Accident & Emergency unit and the assessment units each time. Dr Gill noted that it was pleasing how the nursing staff had looked after the patient and he asked how the relationship was with the medical staff. The patient advised that she was looked after by several consultants due to the multiple facets of her condition, however sometimes it was difficult to access the most relevant consultant when needed. The Board was advised that the doctors did not appear to talk to each other, have a predictable visiting regime and often appeared to be making decisions independent of each other. Miss Dhami asked if there was one particular change that the patient could suggest to make a difference to the patients' experience. The patient suggested that entertainment and television for elderly patients would be beneficial. Mr Samuda asked for further detail of the delay with administering medication. The patient advised that when staffing was short then there was a need to wait in turn. Dr Stedman asked if there had been an opportunity to self-medicate. The patient advised that this was not the case as drugs were removed when the patients arrived. Mrs Hunjan asked about the experience at night time. The patient advised that there was now additional nurse cover available at night, however this was interrupted when staff were sick. The patient was thanked for her candidness and illuminating story. And the Chairman noted that a discussion of actions and reflections would take place in our private meeting.	
7 Chair's opening comments and Chief Executive's report	**SWBTB (3/15) 036**
The Chairman reported that work was underway to recruit additional Non-Executive Directors, with two terms concluding during 2015. Further to the prior month's decision on Vice Chair appointment, and after consultation with all Board colleagues, he confirmed the appointment of Harjinder Kang as senior independent director for the Board. In addition to the written report, Mr Lewis reported that only one ward was now affected by Norovirus. Mr Lewis highlighted good progress in cutting planned care waiting times in recent months. This included cancer waits. However, the Board's oncology plan needed further work, as despite considerable sum being invested for the next	

year a contract with University Hospitals Birmingham remained outstanding. The Board was advised that in terms of the tariff choice, the Trust had been asked to make a decision and the Enhanced Tariff Option had been chosen. The crucial positives of this option were reported to be certainty and access to CQuIN incentives payments. But as a result of the decision the Trust would be subject to a specialist services marginal rate. This rate would be applied to pass through costs as well as incremental growth. Mr Lewis highlighted the rationing work that would have to commence around specialist care as a result of this approach. He committed to keep the Board appraised of this. Ms Dutton asked what the implications of the mandated 3.5% reduction in admissions were likely to be. Mr Lewis reminded the Board of the CCG's commitment to introduce these changes in partnership, with the major effect expected to fall in 2016-17. Better Care Fund engagement locally was reported to be improving, but the Trust was still not able to have confidence in the admission avoidance work proposed locally, and recent data did not show a downward trend in arrivals or admissions.	
8 Communicating matters of patient safety	**SWBTB (3/15) 044** **SWBTB (3/15) 044 (a)**
Miss Dhami asked the Board to note all methods by which patient safety matters were communicated across the Trust. She highlighted that there were significant means and frequency of communicating, however it was suggested that sharing of good practice could be improved. It was highlighted that brevity was key to successful communication. The Board was advised that according to the staff survey, the communication was being well received. Example means of communication were drawn to the Board's attention, including 'Top Tips', 'Learning Alerts' and screensavers. Mr Kang noted the effort that was given to ensuring that the messages were not wasted and suggested that systematic feedback needed to be undertaken to assess the most successful methods of communicating. Miss Dhami reported that the 'Hot Topics' question this month was designed to make this assessment. She agreed that messages needed to be targeted. Mr Kang suggested that focus groups needed to be organised which would seek views on the value of the communications. Dr Sahota asked whether the messages were available to all staff. Mr Lewis reported that this was not the case and it was noted that there was mixed control of notice boards and that the paper dissemination was not as effective as it could be. It was suggested that effort needed to be directed to ensuring that staff did not communicate the wrong things or deliver too many messages at any one time. It was reported that the forthcoming Quality Improvement half days would assist with the communication and discussions. Ms Dutton noted that there were different learning styles and this should be borne in mind as part of the communication. Ms Dhami reminded the Board of her autumn paper on the learning approach across the organisation, which	

remained the Trust's guide to action in the year ahead.	
9 Nurse staffing levels	**SWBTB (3/15) 043** **SWBTB (3/15) 043 (a)**
Mr Ovington noted that he had offered to source nurse staffing reports from those organisations against which the Trust benchmarked itself which he had circulated earlier in the week. It was noted that the quality and comprehensiveness of the reports varied considerably, but none appeared materially advanced on the Trust's own product. In discussing the issues raised by the report the following material issues were discussed: • It was confirmed that all new ward establishments approved in November, were now rostered and in operation. Gaps arose through vacancies and sickness. • Mr Ovington highlighted work to reinvigorate the posting of staffing levels at the entrance to wards, which was national policy, adopted early at SWBH. • As agreed at the prior Board meeting, it was noted that the opening and closing ward process was to be assessed at the next meeting of the Quality & Safety Committee. Temporary wards were not currently included within this overall safe staffing report. Mr Lewis noted that the Trust was adopting the national model for reporting Safe Staffing. However, he remained concerned that the position reported could overstate the fill rate, because the denominator used did not reflect focused care, but the numerator did. Mr Ovington agreed that this was an issue, locally and nationally, and undertook to seek to separate out 'specials' from the fill rate.	
ACTION: Mr Ovington to revise the nurse staffing report from April to take into account comments made at the meeting	
10 Trust risk register update	
10.1 Overview and any new considerations	**SWBTB (3/15) 041** **SWBTB (3/15) 041 (a)**
The Board was asked to consider adding a risk to the Trust Risk Register around lifts in maternity. It was highlighted that a robust treatment plan was available for the risk and therefore it was likely to be a short term matter. The Board approved the suggestion to add the risk to the Trust Risk Register. The Chairman asked where the impact of disgruntled staff and potential key staff losses were reflected, highlighting recent regional publicity elsewhere. Mr Lewis reported that minimum staffing levels were tracked, particularly in the case of a strike. He agreed that the risk register should consider where the Trust was exposed to key-person risks, either clinically or non-clinically. He undertook to	

examine that further through the Risk Management Committee. Discussion was focused on A&E, where specific triggers for closure are being developed, and interventional radiology, where long-term vacancies further to the 2013 transfer of vascular services to UHB remain an issue for the Trust. Miss Dhami highlighted that at the next Board meeting she expected the major risks cited to be augmented with a detailed assessment of IT resilience and issues of middle management capacity given the vacancy rate in some clinical groups.	
AGREEMENT: The Board approved the addition of a risk around lifts in maternity to the Trust Risk Register	
10.2 Ophthalmology privacy and dignity risk	**Verbal**
Mr Lewis reported that there was optimism that the situation could be resolved in the next few month, based on recent discussions with the Birmingham Community Trust.	
11 Trust response to controls for revised Never Events	**SWBTB (3/15) 042** **SWBTB (3/15) 042 (a)**
Miss Dhami drew the Trust's attention to the controls in place to prevent Never Events yet to occur at the Trust. She summarised these controls as adequate, apart from the Never Event concerning maladministration of insulin. She highlighted that there was a reliance on individual professionals rather than systems and processes which could prevent the occurrence. It was agreed that the situation would be revisited in six months' time at the Board, and be tracked within the Executive in the intervening period. Mr Lewis expressed his lack of assurance on the controls in some cases, highlighting the potential weakness of some measures cited. An example, he raised a concern around the suggested controls in place around access to controlled drugs and epidural medication. Assurance was provided through Dr Stedman that these restrictions on access were real and current. Mr Lewis raised the issue around rail bumpers and asked whether there was confidence that staff had access to rail bumpers. Mr Ovington advised that this was the case although they were not on every ward. He was asked to give further consideration as to the availability of these, notwithstanding the definition constraint cited in the paper. Ms Dutton noted that she had not seen a sign providing warning of very hot water in a range of languages. She was advised that there was no universal sign but that visual cues would be re-examined.	
ACTION: Miss Dhami to present an update on controls to prevent never Events at the September meeting	

12 Corporate integrated performance dashboard	SWBTB (3/15) 039 SWBTB (3/15) 039 (a)
Mr Waite reported that the referral to treatment time performance had improved. It was noted that there had been no cases of *C difficile* for two months and there had also been no mixed sex accommodation. It was reported that there had been a reduction in patient bed moves out of hours. Miss Barlow noted that this was important as this reduced the risk associated with handover out of hours and that to move a patient at night was disturbing. In terms of mortality, the crude mortality in December and January reflected the higher number of frail and elderly patients treated during the period. It was noted that risk adjusted scores were not yet available for December and January. Mr Ovington drew attention to his data quality briefing on falls, circulated to the Quality and Safety Committee. This suggested that Trust performance remained relatively strong compared to peers, but that the absolute falls numbers had been historically inaccurate at the margin. This related to data-catch up within the corporate nursing team. Mr Waite noted that from April all data in the report would be centrally produced and validated. And crucially that data manually adjusted in the nursing and risk teams would be automated. Mr Lewis noted that at this meeting and the prior one, there did not appear to be a singular understanding of whether the falls and pressure sores position related to a true increase, the additional beds opened or whether this was a function of the cited data issues. It was agreed that this would be considered in detail at the next Quality & Safety Committee and would return to the Board as a matter arising for clarity at its next meeting. Mr Kang noted that the Trust was behind trajectory in terms of mortality reviews. Dr Stedman recognised the dip on performance but noted that the latest monthly figure would see the Trust return to 90% in line with performance in Quarter 1 2014/15. Miss Barlow reported that performance against the rapid access chest pain met the standard, and apologised that the data was again omitted. In terms of cancelled operations in Ophthalmology, it was highlighted that this reflected the cancellation of an entire operation list due to decontamination issues. It was reported that frank feedback had been delivered to the decontamination services provider and that as Chief Operating Officer, the lead for this contract now sat with Miss Barlow. Dr Gill noted that medical appraisal and revalidated had deteriorated. Dr Stedman noted that this related to appraisal only and there was an intention to improve this position by year end, in line with the overall Trust commitment to 100%.	
ACTION: **Mr Ovington to present an update on performance against the falls and pressure sores measures at the next meeting of the Quality & Safety Committee, and then at April's full Board**	

meeting	
13 Financial performance – Month 10	**SWBTB (3/15) 040** **SWBTB (3/15) 040 (a)**
Mr Waite reported that progress in month 10 was ahead of plan. The forecast remained to deliver our year-end surplus, albeit with reliance on non-recurrent measures beyond those identified at the start of the financial year. The Board was advised that the capital resource limit was to be undershot and the funds would be carried forward. Cash was reported to be ahead of plan. The risk rating for the year was reported to be as planned at 3. Mr Hoare asked whether the slow capital spend impacted on any cost reduction schemes or risk mitigation. Mr Waite reported that this was not the case and that any delays were monitored for quality and safety impact. It was noted that pay cost appendices were provided, which highlighted particularly the impact of controls for temporary pay costs including a clear shift from agency to bank staffing. Dr Sahota noted that there was a variance in drugs and consumables. It was noted that this reflected the reimbursement of high cost drugs and devices. Mr Waite reiterated his absolute determination that in future his team's report would separate pass through income and cost out. Mr Lewis highlighted that both pay targets and non-pay targets had been bettered in month. He added that £7-£8m of exceptional items underpinned the year end. The Board was asked to note that the 2015/16 financial position was very tight, but income and pay planning was on schedule. Further work on non-pay controls was needed.	
14 2020 plan	**Hard copy**
Mr Lewis asked the Board to note the draft 2020 Plan which he advised would come back together with an implementation plan for finalisation at the next meeting. All were asked to provide any comments on the plan to either Mr Lewis or the Director of Communications. It was highlighted that the focus of the plan was on the future destination of the Trust aside from the new hospital plans. The Chairman asked whether the plans had been risk assessed. Mr Lewis advised that the Plan did not explicitly consider risks. It was noted that in some areas the plan may not be considered as sufficiently ambitious. Mr Kang asked whether the document reflected the Trust's plan solely or whether it aligned to the plans of other local healthcare organisations. It was reported that the version was primarily the Trust's ambition. Mr Kang suggested that the input of other stakeholders needed to be canvassed. It was reported that this work would be undertaken over the summer. Dr Sahota underlined the importance of seeking stakeholder input as the Trust could not operate in isolation. He also suggested that a view to beyond 2020 needed to be considered. Mr Lewis noted that the	

Plan articulated some very specific commitments rather than a general view of ambition to ensure that the plan was real to the public. Dr Gill suggested that research, evaluation and lessons learned needed to feature in the report. Mr Lewis agreed that the plan would be considered in the light of innovation and research. Ms Dutton reported that integration, with a view to prevention needed to be built into the plan. It was agreed that the link to the public health plan would be incorporated. Dr Stedman noted that the plan was aligned to the organisational structure and suggested that it needed to be better focussed on patient pathways. Mr Lewis reported that the strategy needed to be suitable for a number of different fora.	
ACTION: **Mr Lewis to arrange for the amendments based on the feedback received on the 2020 plan to be incorporated where relevant**	
15 Public engagement about Rowley Regis Hospital	**SWBTB (3/15) 046** **SWBTB (3/15) 046 (a)**
Mr Lewis presented the plans for engaging with the public around the future operation for Rowley Regis Hospital and advised that the 'in principle' outcomes would be presented in May. It was noted that by 2015/16 the final model would be set for the hospital in a way similar to the plans for the Sheldon Block. It was noted that GP colleagues were involved with the process and the decisions around community locations would incorporate these plans. Miss Barlow highlighted the partnership with the Social Services and suggested that this could be widened to other locations, given the lack of estate and facilities to discharge patients. It was noted that the plans facilitated treatment and consultation at locations close to patients' homes, although this would be on an 'opt out' basis. Dr Gill noted that Rowley Regis Hospital did not appear to be a convenient location for relatives who wished to visit patients. Mr Lewis reported that this issue was being considered as part of the wider plans.	
16 Workforce change: safe and sound 2014-16	**SWBTB (3/15) 052** **SWBTB (3/15) 052 (a)**
Mr Lewis asked the Board to note the report and that the redundancy considerations would be made in the private session. The report was highlighted to be a position statement of the situation, with considerable numbers of individuals having been redeployed into alternative roles. It was reported that an evaluation of the deployment process was to be undertaken. Some difficulties with engaging managers in the process were highlighted.	

A group of individuals were reported to remain at risk and continued effort was being made to redeploy individuals. It was noted that the lessons from Phase 1 needed to be borne in mind for Phase 2 which would start in April 2015. Mr Kang added that the support of the trade unions was instrumental to the operation of the process. It was noted that going forward limiting the number of redundancies would be challenging. Mrs Rickards suggested that better clarity was needed at a local level, particularly the use of and the legal implications of the use of a trial period. She highlighted that the cadre of individuals left at risk for a long time had been an unacceptable situation. Mr Lewis reported that the process had impacted on some long standing employees, which had been received painfully. Ms Dutton suggested that a public statement of lessons learned needed to be developed. Mr Lewis agreed to circulate such a document. Dr Stedman highlighted that natural wastage had played a part in the process, although the scale of this was not clear. Mr Lewis reported that turnover was c. 10-14% and some 'at risk' people had stepped away from the organisation. It was noted that further individuals had also resigned and that there was a sense that in some cases very valuable staff had been lost. Despite, this, it was proposed that the selection process for Phase 2 remained to be by interview rather than by criteria. Ms Dutton asked whether the mix of individuals in terms of protected characteristics, affected by the process was significant. It was noted that the previous analysis would be rerun once redundancy had concluded. It was reported that the sum for the redundancy was provided for as part of the Trust's financial plan and the Board was asked to delegate individual redundancy arrangements to Mr Lewis up to 30 April 2015. It was noted that the MARS scheme had been approved at the last informal session which would be an option for some individuals. The Board was advised that some clinical individuals may be made redundant and the payback periods were all within two years. Approval was given to this delegated authority to Mr Lewis and Mrs Goodby.	
ACTION: Mr Lewis to circulate a lessons learned document from the Phase 1 of the Safe and Sound work **AGREEMENT: The Board gave approval to the request to delegate the execution of individual redundancy arrangements to Mr Lewis and Mrs Goodby up until 30 April 2015**	
17 Trust response to the Fit and Proper Person Test	**SWBTB (3/15) 038** **SWBTB (3/15) 038 (a)**

Miss Dhami presented an overview of the Trust's response to the Fit and Proper Persons Test which she had introduced at the January meeting of the Trust Board. The standards needing to be met and the sources of assurance were highlighted. It was proposed that Board members made a personal declaration on an annual basis, however the possibility of a retrospective review may be considered. It was suggested that the declarations be extended to the Executive Group and the Trust Board members. The Board was advised that referees would also be asked to make any declarations for new members and that contracts would reflect the requirements. Mr Kang noted that the Trust Development Authority was following this process, a matter which Mr Lewis suggested needed to be picked up externally to ensure a co-ordinated approach was being taken. Mr Lewis suggested that the process needed to pick up in year complaints or issues in connection with the Fit and Proper Persons Test and a process should be articulated. It was agreed that the retrospective declaration would be made for all directors.	
ACTION: Miss Dhami to devise a process for handling in year concerns raised under the Fit and Proper Persons regulations	
18 Service presentation - Year of Outpatients	**SWBTB (3/15) 047** **SWBTB (3/15) 047 (a)**
Miss Barlow asked the Board to welcome Jill Barnes, Service Manager from Cardiology and Matthew Dodd, Deputy COO for Planned Care. It was highlighted that good progress had been made in outpatients through service improvement, evidenced by the number of patients waiting less time for treatment. It was noted that there were a number of Trustwide initiatives that supported the work. Ms Barnes reported that in Cardiology, patients were waiting a significant time for their first appointment, however this had reduced from 12 weeks to 6 weeks. Clinical engagement with the work was highlighted to be a key success. All clinic templates were reported to have been redesigned and clinics were monitored to ensure clinics were filled. Patients were reported to be triaged for diagnostics. GP open access for diagnostics was also reported to have started and GP walk in patients were now treated differently to ensure that they are handled more efficiently. The management structure in the speciality was reported to have been revised which would allow extended working days and additional catheterisation laboratory sessions. Miss Barlow highlighted that the productivity between consultants could be compared. It was noted that this practice was also in place in Respiratory. Mr Dodd presented an overview of the way outpatients were handled in general.	

He advised that the challenge was to bring together a set of initiatives to generate efficiency and create an environment in which people wanted to work and deliver better patient experience. It was reported that to achieve this, flexibility and innovation needed to be introduced. The Board was advised that a tactical implementation board would be established to co-ordinate the work and bring in patient representation into the plans. It was also reported that regulation of utilisation would be undertaken and targets would be set in 2015/16. Miss Barlow reported that it was the intention to bring the patient experience strategy to life as part of the plans. She added that a form of PLACE visits was also planned. The Chairman noted that the plans were aimed to achieve a cost reduction. Miss Barlow reported that some initiatives would change work structures, such as kiosks and improving utilisation which would generate a reduction in costs. In terms of GP input, it was reported that GP representation was in place in the plans and the advice back to the GP was being considered as a pilot. Dr Sahota noted the remarkable reduction in waiting time however noted that six weeks was still a long time and asked whether in the appointment letter a statement around deterioration of condition needed to prompt a revisit to the GP. It was noted that this was not the case and would be considered. Mrs Hunjan asked how plans had changed in BMEC. It was reported that kiosks had been trialled in this area and e-outcomes had also been piloted, which meant that outcomes were better recorded and waiting lists were more accurate. It was noted that further work was needed to improve the area however. Mrs Hunjan noted that in her experience, some patients waiting in BMEC were unhappy with long waits which appeared to be linked to inefficient booking practice. Mr Dodd advised that the wider plans would capture these issues. Miss Barlow reported that the appointment letter had also been redesigned. Dr Gill advised that he had a good experience of the process. Miss Dhami noted that the revised process was good and addressed some of the complaints received during previous months around waiting times and outpatient clinics. Miss Barlow reported that the proposals for volunteering would be built into the plans. Dr Sahota noted that the patient experience response rate (FFT) had dropped, although it was noted that the position remained favourable. The guests were thanked for their presentations.	
19 Update from the meeting of Quality & Safety Committee held on 27 February 2015 and minutes from the meeting held on 30 January 2014	**SWBQS (1/15) 015**
Ms Dutton asked the Board to note the overview of the key discussions from the Quality & Safety Committee meeting held on 27 February 2015.	

20 Update from the meeting the Finance & Investment Committee held on 27 February 2015 and minutes from the meeting held on 30 January 2014	**SWBFI (1/15) 009**
Mr Samuda asked the Board to note the overview of the key discussions from Finance & Investment Committee meeting held on 27 February 2015.	
21 Any Other Business	**Verbal**
There was none.	
Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1330h on 2 April 2015 and would be held at the Nishkam Centre, Soho Road, Birmingham.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 2 April 2015, Nishkam Centre, Soho Rd, Birmingham

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

5 March 2015, Anne Gibson Boardroom, City Hospital

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

In Attendance: Mr M Hoare (MH), Miss K Dhami (KD), Mrs R Goodby (RG), Mrs C Rickards (CR)

Apologies: None

Secretariat: Mr Simon Grainger-Lloyd (SGL)

Last Updated: 30 March 2015

	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.333	Learning plan 2014-17	SWBTB (10/14) 164 SWBTB (10/14) 164 (a)	02-Oct-14	Schedule a discussion about the rolling slide pack showing organisational change for a future Board Informal session	SG-L	12/12/2014 16/01/2015	Scheduled for the December January February April meeting	R
SWBTBACT.330	Francis Report action plan – mid-year review	SWBTB (10/14) 161 SWBTB (10/14) 161 (a)	02-Oct-14	Make an assessment of the adequacy of the proposed end year position against the actions raised in connection with the Francis Report	KD	05/03/2015 02/04/2015	Included on the agenda of the April meeting	A
SWBTBACT.354	Trust risk register update	SWBTB (2/15) 026 SWBTB (2/15) 026 (a)	05-Feb-15	Provide an update on progress with resolving the Ophthalmology privacy and dignity risk at the next meeting	TL	05/03/2015	Included on the agenda of the March April 2015 meeting	A
SWBTBACT.349	Reaudit of consent	SWBTB (2/15) 022 SWBTB (2/15) 022 (a)	05-Feb-15	Undertake the 'April' consent project as suggested by Mr Lewis	KD/RST	30/04/2015	ACTION NOT YET DUE	G
SWBTBACT.339	Trust risk register update	SWBTB (11/14) 190 SWBTB (11/14) 190 (a)	06-Nov-14	Consider the means of better publicising the Trust's maternity services	RW	30/04/2015	ACTION NOT YET DUE	G

SWBTBACT.346	Chair's opening comments and Chief Executive's report	SWBTB (2/15) 021	05-Feb-15	Consider the promotion of Never Events success within public areas of the Trust	RW	30/04/2015	ACTION NOT YET DUE	G
SWBTBACT.352	Corporate integrated dashboard	SWBTB (2/15) 024 SWBTB (2/15) 024 (a)	05-Feb-15	Present an update on falls at the next meeting of the Quality & Safety Committee	CO	27/02/2015	Discussed at the March meeting of the Quality & Safety Committee and verbal update due at the Board meeting scheduled for 2/4/15	G
SWBTBACT.359	Nurse staffing levels	SWBTB (3/15) 043 SWBTB (3/15) 043 (a)	05-Mar-15	Revise the nurse staffing report from April to take into account comments made at the meeting	CO	02/04/2015	Revised as requested and included on the agenda of the April meeting	G
SWBTBACT.360	Trust response to controls for revised Never Events	SWBTB (3/15) 042 SWBTB (3/15) 042 (a)	05-Mar-15	Present an update on controls to prevent Never Events at the September meeting	KD	03/09/2015	ACTION NOT YET DUE	G
SWBTBACT.361	Corporate integrated performance dashboard	SWBTB (3/15) 039 SWBTB (3/15) 039 (a)	05-Mar-15	Present an update on performance against the falls and pressure sores measures at the next meeting of the Quality & Safety Committee, and then at April's full Board meeting	CO	02/04/2015	Discussed at the March meeting of the Quality & Safety Committee and verbal update due at the Board meeting scheduled for 2/4/15	G
SWBTBACT.362	2020 plan	Hard copy	05-Mar-15	Arrange for the amendments based on the feedback received on the 2020 plan to be incorporated where relevant	TL	02/04/2015	Included on the agenda of April meeting	G
SWBTBACT.363	Workforce change: safe and sound 2014-16	SWBTB (3/15) 052 SWBTB (3/15) 052 (a)	05-Mar-15	Circulate a lessons learned document from the Phase 1 of the Safe and Sound work	TL	30/04/2015	ACTION NOT YET DUE	G

SWBTBACT.364	Trust response to the Fit and Proper Person Test	SWBTB (3/15) 038 SWBTB (3/15) 038 (a)	05-Mar-15	Devise a process for handling in year concerns raised under the Fit and Proper Persons regulations	KD	02/04/2015	Include don the agenda of the April meeting	G
SWBTBACT.332	Research and development plan 2014-17	SWBTB (10/14) 162 SWBTB (10/14) 162 (a)	02-Oct-14	Arrange for the citation index for Research & Development to be considered at the next meeting of the Research & Development Committee	RST	31/12/2014	Considered as requested	B
SWBTBACT.347	Chair's opening comments and Chief Executive's report	SWBTB (2/15) 021	05-Feb-15	Present the model for opening and closing beds at the next meeting of the Quality & Safety Committee	RB	27/02/2015	Draft policy for opening and closing beds discussed at the March meeting of the Quality & Safety Committee	B
SWBTBACT.350	Update on Never Events assurance	SWBTB (2/15) 023 SWBTB (2/15) 023 (a)	05-Feb-15	Present a report into 'near miss' Never Events at the March meeting	KD	05/03/2015	Included on the agenda of the March 2015 meeting	B
SWBTBACT.351	Update on Never Events assurance	SWBTB (2/15) 023 SWBTB (2/15) 023 (a)	05-Feb-15	Present an update on measures in place to prevent the occurrence of any Never Events that had not occurred at the Trust at a future meeting of the Quality & Safety Committee	KD	05/03/2015	Included on the agenda of the March 2015 meeting	B
SWBTBACT.344	Never Events controls assurance	SWBTB (12/14) 203 SWBTB (12/14) 203 (a)	04-Dec-14	Consider further measures to communicate matters of patient safety and report back to the Board in March 2015	KD	04/03/2015	Included on the agenda of the March 2015 meeting	B
SWBTBACT.355	Nurse staffing levels	SWBTB (2/15) 027 SWBTB (2/15) 027 (a)	05-Feb-15	Present an update nurse staffing report at the next meeting, clarifying the nurse establishments the Trust was currently using	CO	05/03/2015	Included on the agenda of the March 2015 meeting	B

SWBTBACT.356	Nurse staffing levels	SWBTB (2/15) 027 SWBTB (2/15) 027 (a)	05-Feb-15	Circulate a nurse staffing report from other organisations	CO	05/03/2015	Circulated as requested	B

KEY:

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	The Fit and Proper Person Test
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	2 April 2015

EXECUTIVE SUMMARY:

At its March meeting the Board considered the requirements of the Fit and Proper Person Test (FPPT) for directors. A request was made for additional information on how concerns raised would be handled. A flowchart has been produced that sets out the key stages of the process and is presented to discuss and agree.

REPORT RECOMMENDATION:

The Trust Board is asked to **DISCUSS** and **ACCEPT** the key stages of the process for handling concerns raised under the FPPT requirements for directors.

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:

Requirement to meet statutory regulations.

PREVIOUS CONSIDERATION

The requirements of the FPPT for directors considered by the Trust Board in March 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Handling concerns raised under the Fit and Proper Persons Test (FPPT) Regulations

❶ A concern is received about a Director(s) under the FPPT requirements.

Notes: **a)** Concerns can be received from a number of sources e.g. staff, patients, the public, via the CQC, external. stakeholders etc. **b)** anonymous concerns will be subject to the same approach.

❷ If not directly received by them, the matter must be referred immediately to:

- The **Chairman** if the concern is about:
  - a Non-Executive Director
  - the Chief Executive
  - the Chief Executive and Executive Directors
- The **Chief Executive** if the concern is about an Executive Director
- The **Trust Development Authority** if the concern is about the Chairman

The Chairman / CE / TDA will act as the **Lead Officer** for dealing with this matter.

❸ The Lead Officer will acknowledge receipt of the concern and assure the person raising the matter that this will be looked into.

If not already aware, the CQC, through the Chairman, will be notified that a concern has been raised and is being dealt with.

❹ The Lead Officer will consider the concerns raised about the Director(s) and decide what action is warranted, including the need for a formal investigation.

❺ If the Lead Officer is of the view that no action is required this must be discussed at a higher level (CEO with Chairman, Chairman with the TDA) before the Lead Officer reaches a final decision.

❻ The Lead Officer will notify the person raising the concern how the matter is to be handled.

The person raising the matter will also be assured that appropriate feedback will be provided to them when the matter is concluded.

If the decision is to not take the matter further, an explanation must be provided.

❼ An Investigation Panel (IP), chaired by a NED, will be established by the Lead Officer, to investigate the concerns raised about the Director(s).

Note: The framework set out in the Trust's Investigatory Guidance Notes must be followed.

❽ If there is no evidence to substantiate the concerns raised the IP Chair will recommend to the Lead Officer that the matter be closed. The Lead Officer will inform the person who raised the concern.

If it is found that there is a case to answer the matter will proceed to a formal hearing in accordance with the relevant Trust Policy. The Lead Officer will Chair the hearing.

Notes: Examples of relevant Trust Policies include, Dignity at Work, Counter Fraud, Bribery and Corruption, Capability.

Malicious or vexatious allegations will be handled in line with existing Trust processes.

❾ The Chairman will notify the CQC / TDA of the outcome of the hearing.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE PUBLIC TRUST BOARD

Chief Executive's Report – April 2015

The Board considers for approval today some key documents, which will very much set the tone of the organisation in the next twelve months. We review our Annual Plan 2015/2016. Within that thirty quantified metrics are specified, each designed to drive improvements in community and acute services, as well as in how the organisation works and feels. They span the six strategic objectives which underpin our work, consistent now for several years. In support of that we have our draft Financial Plan for the year. This proposes a very modest surplus and considerable revenue and capital investment in new services. In line with our long term financial model these gains rely on our ability to again make significant efficiencies in how spend pay and non-pay costs. The early part of the financial year will see the flow-through from the first phase of our Safe and Sound workforce changes. We delayed February's second phase, which is now due to commence in late April. Finally, in our private board meeting, we examine the Electronic Patient Record Outline Business Case. If approved, this will proceed to consideration by the Trust Development Authority. This is a vitally important part of coming years within our Trust, as we look to reduce the burden of paperwork on staff, and the risks of process variation, both of which are reflected in the regulator's report.

The Trust published our CQC Improvement Plan on March 26th. The publication of the CQC's report provides an opportunity to discuss once again the overall results, with 50% of services rated as Good, with adult community teams hailed by the inspectors. The report is an important piece of feedback on the state of services more than six months ago, albeit our own data on the views of patients, staff, partners and others is of equal importance. If we reflect on our critical care, end of life care and maternity services, all of which received high ratings, each have focused hard on responding to those local feedback loops, and must avoid a future in which we in any way 'manage to the next inspection'. I discuss below some of the key findings in the report.

1. Our patients

The integrated performance report brings together safety, quality, workforce and finance data. It examines delivery at Trust and Group level. Behind it is data held at directorate level. For national minimum standards, and key local goals, we see a similar picture to many recent reports presented to the Board:

- Delivery on planned care waits, and deviation by agreement with commissioners on 18 weeks. We are meeting cancer and diagnostic waits, as well as the important dignity standard on single sex accommodation. In March we expect to meet the 18 week standard as we typically do, and the Board heard direct last month from frontline teams about the work going on to make that a result of good smooth systems, rather than heroic effort.
- Stable, but not yet compliant, performance on emergency care. It remains the case that we are not having very long waits in our system, and that we perform comparatively well for handover waits from ambulances. However, our aim to bring DTA into the first hour is not yet showing full traction, and our four hour delivery continues to reflect pressures, especially

bed pressures as a direct result of delayed transfers of care for Birmingham City Council residents.

- Continued downward pressure on our cost base, which now shows a sustained improvement in our use of agency staff, and in our overall pay costs. We have more work to do to grip the non-pay expenditure system, and I will be holding weekly meetings through April and May to oversee work in that area across procurement, medicines management, and supplies.
- Continued high sickness rates, and vacancy rates that need improvement, along with good mandatory training performance, and a month's slippage on our appraisal goal. Redeployment from last autumn's workforce process is continuing to deliver our goals, with over sixty colleagues currently undertaking trial periods in new roles. I will update the Board orally on the redundancy position.

The Quality and Safety Committee will report back to the Board on the work undertaken on falls and pressure ulcers. The Trust's numbers compare favourably to other organisations, but we are all determined to continue to bear down on these harms. The success in that work sits alongside our impressive reduction in c-diff rates over the last two years, as well as our work on mortality reduction. It was noticeable that for staff and some media representatives, these firm data points, with national comparison, were important when we considered the observational material from the CQC in recent days.

We know that the Trust remains, encouragingly, a high incident reporting organisation. Anonymised survey data confirms that over 96% of respondents feel confident about the system, and 89% feel that incidents have appropriate salience in our work. Equally, there is room for improvement to make sure that everyone sees the loop closed on incidents that are reported. Reporters can choose either to have feedback or not have feedback. I need to re-affirm for the Board that the grading system and process used by the Trust is the national system, to the letter, and any insinuation in the CQC report that the gradings used reflect in some way senior management preference, is a profound, and rather irritating, failure to reflect a factual accuracy challenge submitted in late January by the Trust's team. This approach is open to inspection at any time.

2. Our colleagues

Since the Board met last, the Trust won awards hosted by the local CCG for our work on equality and diversity. This is a nice symbol of progress made, and is evidently relevant to the CQC responsiveness domain. In the statutory section, all three top places were taken by Trust projects: Live Work from our Learning Works team; our FNP work with teenage parents; and the overall winner, our Vulnerable Families Health Visiting Team. Both of the latter are part of our Community Children's Service. It was also pleasing to note the comments made by the largest Voluntary Sector winner at the ceremony, Age-well, who reflected on their partnership with the Trust.

Through Your Voice we continue to track staff morale and attitude. The latest results reflect continued stable responses. We are making headway with ensuring employees are aware of what changes as a result of their feedback. A clear divergence is emerging within the Trust between teams who consistently perform well on these indicators, and those where the response rate and responses are towards the lower end of our league table. This is important 'soft' data to set alongside the information we see on outcomes or key process indicators. I understand NHS Employers intend to use our Your Voice work as a good practice example of organisational engagement.

The CQC report contains a recommendation from the Chief Inspector that we examine our nursing staffing levels. Clearly, during October and November, as the CQC were made aware in September, we reviewed all of our nursing staffing levels, and implemented changes from January 2015. Accordingly, we consider this recommendation a closed matter. Those changes have been discussed at each subsequent Board meeting. Prior to implementation I asked the CQC to clarify the then draft recommendation that they proposed to make, given the relatively unclear detail contained in the body of their report. The briefing at Annex A is my current state summary of the issues that they asked me to consider, reported in public, so that there can be no future ambiguity.

3. Our partners

Joint work with Sandwell Metropolitan Borough Council continues to show progress around long-stay patients. Encouragingly Birmingham City Council officials now accept that, to make progress in West Birmingham, they need to adopt the approach adopted there. This is useful clarity, which needs to be built in through the SRG process in the weeks ahead. That said, the Trust has not been able to offer assurance to outside bodies about Easter resilience because of concerns about social care cover, as well as primary care gaps.

Changes at Heart of England NHS Foundation Trust, and publicity around Monitor's deferral of the BCHS's Foundation application have been trailed elsewhere. We continue to collaboratively with both organisations, and the involvement of BCHS in recent work on trying to unblock capacity at City Hospital has been helpful. Similarly, we remain engaged with the Vanguard process, not least through the Right Care, Right Here partnership board. The Trust is supporting the appointment of an independent chair and programme director for that important work, the success of which is crucial to the execution of the Midland Metropolitan Hospital in 2018.

More immediately, we are moving ahead with reconfiguration changes in cardiology and acute general surgery. The public listening exercise led by the CCG is now concluded. Plans for both changes are in hand, and we remain open to suggestions about how the projects can be improved from the results of those exercises. The CQC report of course underlines the, in their view, unsustainable workload pattern arising from the current configuration of acute surgery. Board members will have seen publicity internally for other changes within cardiology, with the opening of our new Cardiac MRI service, bringing an important diagnostic tool closer to local residents.

Orally, we will again consider the oncology contract with University Hospitals Birmingham. It remains unsigned. At the same the trauma peer review process has highlighted a range of concerns about our own service, and about the capacity of the Major Trauma Centre. We will approach both UHB and NHS England during April to seek resolution on these issues in the weeks ahead.

4. Our regulators

Issues in relation to the CQC, and the trauma review, are covered above. The Board's papers include a report on bowel screening for information. The financial and contractual position in respect of R&D for 2015-2016 is satisfactory. No educational contract documentation for 2015-16 has yet been forwarded to the Trust from Health Education England. We understand providers will have sight of this in the spring.

5. Ending 2014-2015

Over coming weeks, we will complete the governance and reporting cycle for the year. A summary of 14-15 objectives will be presented at May's Board together with the final report on the 2014/15 BAF. The annual plan for 15-16 reflects some continuation from the year just ending, notably in our determination to deliver on sickness rate improvement, which has not improved markedly in the last twelve months.

I will circulate separately for Board members before we meet the latest state of play with outstanding audit recommendations. I would expect no more than ten to remain open going into the new fiscal year. I would suggest at the ARM in April we need to look critically at outstanding audit reports, and at the proposed internal and clinical audit plans. Considerable resource flows through both and we need to be assured about content and impact, not merely process completion.

A summary of 2014-2015 delivery will be shared with all staff in our usual way, with payslips in April.

Toby Lewis, Chief Executive
29th March 2015

Staffing considerations raised privately by the CQC, which sit behind the inspection report's recommendations:

i. High levels of bank and agency being used in medicine (including CCU) and surgical wards, and in A&E

We all agree that this is a longstanding issue, with the Trust in 2013-14 being among the highest users in the NHS. Agency use has reduced sharply over the last six months, and we have taken steps to encourage our own employees to work on the bank. In planning for 2015-16 we will continue our work to drive down this use, and we will try and distinguish for the Board between a planned long-term use of agency staff (for instance among ED doctors) and unplanned use.

ii. Displacement of staff from planned shifts to cover additional capacity

This was an issue for us, and on occasion continues to be so. It is one of the reasons that we invested from January in additional qualified nursing staff on night shifts, in order to provide greater resilience where difficult choices need to be made. The quality and safety committee is reviewing the protocol for opening and closing capacity put forward by the Chief Operating Officer to ensure that decision making is governed in a way that we all can support. Inevitably risks have to be balanced when these decisions are made.

iii. Opinions expressed to the CQC about the discharge liaison team staffing levels, and Bradbury Day Hospice staffing

I am wholly content with the staffing picture we have around specialist liaison work, which has not changed over the last twelve months. I think that the underlying issue is how we ensure that patients at the end of their life are able to die in a place they have chosen. Our work on identifying admissions during the last year of life will provide an opportunity to reflect on our action plan in this regard. I met face to face with our end of life care team last week and we discussed some ideas that would help accomplish further improvements. The position with the Day Hospice reflects the ongoing CCG-led change process. The service is entirely safe, but when one of two members of staff are away, they are cross covered from the specialist nursing team. The case to immediately change that is not made.

iv. Overnight staffing at Leasowes Intermediate Care Centre

The palliative care team have yet again confirmed that they do not consider there are any safety issues arising from the staffing of the two beds in the unit. That assessment was made before the unit was opened, was tested with commissioners, and remains extant. However, our consultation in October did make the case for two qualified nurses overnight to support the general bed base on the site. That has been implemented, and visits to the unit over recent weeks confirm that it is now in place.

v. Maternity staffing levels at the time of the inspection

Notwithstanding the good outcomes of the unit, and indeed the CQC's inspection outcome, we face national challenges with midwifery recruitment. Our ratios per birth are excellent. Our caseloads less so, and of course we have a complex population. We have invested since January

in additional labour ward midwives and continue to support retire-and-return applications. Discussions are ongoing about a further recruitment campaign in both midwifery and neonates to try and ensure that we have outstanding ratios, albeit at the same time a discussion with commissioners continues about the economics of maternity services generally.

vi. Community caseloads in both district nursing and health visiting

Again reflecting national workforce issues, we have higher caseloads than we would like, albeit not outlying positions by comparison to others, in both of these fields. Community caseloads feature as one of five proposed Quality and Safety Priorities for the Trust in our annual plan. We need both to address recruitment and retention, and to ensure that more of the working week of these teams is spent on face to face client contact. Within district nursing considerable work has gone on during 2014-2015 to address this, including reducing home visiting where a community clinic would be a modern delivery model. In addressing our universal health visiting offer we have work to do in 2015-2016 to drive up coverage at one and two years, and this is one of ten priorities on which it is proposed I report monthly to the Trust Board on progress.

In summary there are no unknown issues highlighted by the Care Quality Commission on staffing. The material two tasks are to tackle vacancy rates and to tackle sickness rates. We will continue to focus on both.

Where there is national data for comparison the Trust is not an outlier now, where it was a year ago on agency use.

We have demonstrated our ability to act, not just through investment, but also through practice change. It is worth highlighting that nursing turnover at band 5 in our medicine wards has halved in the last year (it remains too high). And that our work on focused care (so-called specialing) in September 2014 has subsequently seen us reduce the use of ad-hoc staffing by almost 80%. This gives me a measure of confidence in our ability to further improve over coming months.

Toby Lewis, Chief Executive
29th March 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Care Quality Commission's report and the Trust's Improvement Plan
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	2nd April 2015

EXECUTIVE SUMMARY:

Our Improvement Plan was published last week, and will be familiar to Board members, who have seen drafts weekly. The Clinical Leadership Executive have also had oversight of the plan, which will be developed further through Hot Topics in the coming month. The Board are invited to discuss and agree how collective confidence will be obtained on the completion and impact of the 69 actions in the plan, 13 of which fell due, by our choosing at the end of March.

The Care Quality Commission's report following the inspection of the Trust in October 2015 is attached. The report was published on Thursday 26 March and overall provides the Trust with an overall rating of 'Requires Improvement'. The CQC report confirms that we have caring, compassionate staff, delivering effective services, with over half of the CQC ratings for hospital and community services domains found to be "good".

The CQC identified room for improvement in some areas especially in the domain of safety, rated as "inadequate". The quality summit presentation by the CQC confirmed that this rating does NOT mean that the services offered by the Trust are unsafe. Instead it indicates process gaps observed by the inspection team.

Several of our services are singled out for praise by the CQC for being innovative and of exceptional quality, particularly adult community services with an overall rating of "good". As an integrated care organisation this good rating supports our ambition to develop seamless care and more services closer to people's homes. We aim for more of our services to reach that high level and we will be sharing best practice and lessons learned with all staff.

REPORT RECOMMENDATION:

The Trust Board is asked to note the improvement plan to address the Must and Should Do recommendations in the report and confirm the monitoring regime to be applied during Q1 2015-2016

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Alignment to the CQC five key questions and the Trust's performance against these
PREVIOUS CONSIDERATION:
Public report issued on 26 March 2015

Sandwell and West Birmingham Hospitals NHS Trust

Quality report

City Hospital, Dudley Road, Birmingham. B18 7QH

Tel: 0121 554 3801
http://www.swbh.nhs.uk/

Date of inspection visit:
14-17 October 2014

Date of publication:
March 2015

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Overall rating for this trust	**Requires improvement**
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Letter from the Chief Inspector of Hospitals

Sandwell and West Birmingham Hospitals NHS Trust is a provider of both acute hospital and community services for the west of Birmingham and six towns in Sandwell. It serves a population of around half a million people. There are two main acute locations: City Hospital and Sandwell General Hospital; there is also the Birmingham Treatment Centre on the City site. The trust provides community services in the form of inpatients at the Leasowes Intermediate Care Centre and Rowley Regis Hospital, alongside other community services such as district nursing and community palliative care. All community services are offered in the Sandwell area. The Birmingham and Midland Eye Centre based on the City site is a specialist service which will be scheduled for a full inspection separately. Please note we did look at its outpatient department as part of the outpatient core service.

We carried out this comprehensive inspection because the trust is known as an aspirational trust wanting to become a foundation trust. The inspection took place between 14 and 17 October 2014, and unannounced inspection visits took place between 25 and 30 October.

Overall, this trust requires improvement. We rated it good for caring for patients and effective care but it requires improvement in being responsive to patients' needs and being well-led. We rated the safe domain as inadequate.

Our key findings were as follows:

- Staff were caring and compassionate, and treated patients with dignity and respect.
- Shared learning from incident reporting needed to be improved across the organisation.
- Infection control practices were generally good but there were pockets of poor practice that needed to be addressed.
- Medicines management was inconsistent. Pharmacy support was good and staff valued the input of the pharmacists. However, across the trust, the safe storage of medicines was not robust. This was an area in which the trust had failed to meet its targets for 2013/14.
- The trust had consistently failed to meet the national target for treating 95% of patients attending the accident and emergency (A&E) department within 4 hours.
- Generally community services were good, but required improvement for safety.
- We were concerned about wards D26 and D11 at City Hospital, which were not meeting the basic care needs for patients.
- The trust had recognised that end of life care was an area for development for the Bradbury House Day Hospice.
- The mortuary on both sites had long-standing environmental issues that needed to be addressed.

We saw several areas of outstanding practice including:

- The iCares service within the community and the diabetic service. These were outstanding and had received national recognition. Critical care services were good overall, with both staff and patients feeling well supported.
- The compassionate and caring dedication for end of life care with regard to a minor, which was rated as outstanding, especially how the service used the wider healthcare team to meet the needs of the individual. We were confident that this level of support would be repeated in a similar situation.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- review the levels of nursing staff across all wards and departments to ensure that they are safe and meet the requirements of the service;
- ensure that all staff are consistently reporting incidents, and that staff receive feedback on all incidents raised so that service development and learning can take place;
- ensure that all patient-identifiable information is handled and stored securely;
- follow through from findings of safety audit data, and follow up absence of safety audit data;
- address systemic gaps in patient assessment records;
- take steps to improve staff understanding of isolation procedures.

There were also areas of practice where the trust should take action, and these are identified in the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

January 2015

Background to Sandwell and West Birmingham Hospitals NHS Trust

Sandwell and West Birmingham Hospitals NHS Trust serves a population size of 530,000 from across West Birmingham and six towns in Sandwell. The trust employs approximately 7,500 staff who work across acute and community services.

The trust provides care from two main hospital sites: City Hospital in Birmingham and Sandwell General Hospital in West Bromwich. Intermediate care is provided from Rowley Regis Hospital and the Leasowes Intermediate Care Centre, which is where the trust's stand-alone birthing centre is located.

The trust is an integrated care organisation and by self-admission there is more work to be done. The executive team has seen newly appointed members over the past 18 months to include a Chief Executive Officer, Chief Nurse and Director of Finance The trust is considered a likely future applicant for foundation trust status, but this is at an early stage and the trust will use this report as part of their evidence.

The trust provides acute and community care to a diverse population of Sandwell and Birmingham with a high level of deprivation, ranked 12th and 9th, respectively, out of 326 authorities.

Over two years ago the Trust published a long term financial model indicating major pay savings. With the announcement of the proposed new Midland Metropolitan Hospital in July 2014, public attention focused again on these issues. The Trust commenced internal discussions with staff in August 2014 about workforce changes, roughly equivalent to the loss of 1400 jobs over a five year period.

During the week of our inspection an NHS wide strike was planned.

Our inspection team

Our inspection team was led by:

Chair: Karen Proctor, Director of Nursing & Quality, Kent Community Health NHS Trust.
Team Leader: Tim Cooper, Head of Hospital Inspections, Care Quality Commission.

The team included 15 CQC inspectors, 27 specialist advisers including consultants, doctors, matrons, nurses, midwives, a therapist, student nurses and 4 'experts by experience'. Experts by experience have personal experience of using, or caring for someone who uses, the type of service we were inspecting. The inspection team was supported by CQC analysts, planners and recorders.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out announced visits between 14 and 17 October 2014 and unannounced visits on 25, 27 and 30 October 2014. During our visits, we held focus groups and interviews with a range of staff who worked within the service, such as palliative care nurse specialists, district nurses, nurses, healthcare assistants and senior clinicians. We talked with people who used the services. We observed how people were being cared for, talked with carers and/or family members and reviewed care or treatment records of people who used the services. We met with people who used

services, as well as carers, who shared their views and experiences of the core service.

What people who use the trust's services say

A public listening event was held on 25 September at City Hospital and 8 October 2014 at West Bromwich Town Hall. Feedback from people who used acute and community services was mixed including many who were happy with their care. People were happy with overall care from ward staff and out-patient appointments, but dissatisfied with complaints management and care from both accident and emergency (A&E) departments because of staff rushing and not having enough time to provide safe and effective care.

Focus groups were held with three black and minority ethnic community groups to include people who are homeless, blind or visually impaired, Asian females and mothers of young children.

Main themes to emerge were concerns about waiting times and poor staffing levels at both City and Sandwell Hospital A&E departments, and poor management of complaints.

Facts and data about this trust

Sandwell and West Birmingham Hospitals NHS Trust serves a population of over 530,000. It provides acute services from City Hospital in Birmingham and Sandwell General Hospital in West Bromwich. The trust provides community services across the Sandwell area. It has a community hospital at Rowley Regis and an intermediate care service at Leasowes in Oldbury. The trust's community services merged with the acute trust in April 2011.

The trust serves the two main local populations of Sandwell and Birmingham with a population of over 530,000. Sandwell and Birmingham local authorities have a significantly high level of deprivation compared with the England average, ranked 12th and 9th out of 326 authorities. There is a high level of health inequality between the most deprived and least deprived areas in Sandwell and Birmingham (a difference in male life expectancy of more than 10 years, and in female life expectancy of more than 5 years).

The trust has annual revenue of £439 million. Each year the trust spends £430 million of public money, £25 million of which is spent on new equipment and service expansion. In 2018/19, the trust plans to open the Midland Metropolitan Hospital (Midland Met), which will be built close to the boundary between Birmingham and Sandwell.

The trust employs around 7,500 members of staff, including around 760 medical and dental staff and 1,990 qualified nurses.

The trust has 764 acute beds, including 70 maternity beds and 19 critical care beds. It has a further 44 beds in its community services.

In 2013/14, 5,586 women gave birth across the sites and 564,395 people attended outpatient clinics. There were 736,852 community contacts made within the 'same time frame; 176,496 attended both accident and emergency (A&E) departments and the trust's eye casualty centre, called the Birmingham and Midland Eye Centre, which was not inspected during our inspection. The trust conducted 82,295 emergency and elective operations, of which 47,431 were on a day-case basis.

Summary of findings

Are services at this trust safe?	Inadequate

Summary

We judged safety to be inadequate for the trust overall. The safe domain for both acute sites was rated inadequate. On the Sandwell General Hospital site surgery and outpatients department were rated inadequate. Within the City Hospital site the core services of medicine, surgery and outpatients were rated as inadequate.

Within outpatients we found that essential training records were missing for the imaging department they were unable provide proof of staff competency. Within surgery they had been a 'never event' for which the control measures identified were still not being used consistently. Within children and young people's service we found infection control practices, resuscitation equipment and the environment for children and adolescents with mental health issues was required improvement.

Safety concerns we found on D26 at City Hospital was the main reason for the inadequate rating in medicine on that site. The trust had identified issues on this ward, but at the time of the inspection had not taken effective action to address these.

It was clear that the drive to improve safety was potentially at cross purposes with the trust's planned reduction of staff numbers. The Trust were sighted on this. The current situation resulted in some cases of staff not being able to attend training because of staffing constraints, or offer services over extended hours, also due to lack of staff.

Learning from incidents was not well embedded beyond a local level. This presented a risk to the organisation because staff were not always learning from incidents and 'near misses'. We also noted reluctance on the part of some staff to raise concerns because they felt that the feedback process was ineffective. Where serious incidents had occurred the control measures put in place to address them had not been adhered to.

A number of environmental and equipment issues were not dealt with in a timely fashion; although staff told us they had reported them, they remained unaddressed.

Medication storage and security was inconsistent and we found the trust needed to improve this across both acute sites and within the community. This was despite failing to meet its agreed improvement target with commissioners in the last year.

Duty of candour

- Duty of candour is a new part of the regulations that providers have to comply with. This came into force for NHS providers in November 2014. However, although our inspection took place before this, providers needed to be aware and prepare their organisations for this regulation change.
- The trust's senior executive team was aware of its responsibilities with regard to this.
- During the inspection, we saw evidence of the spirit of the regulations to be open with patients when care did not meet best practice. We observed this within the accident and emergency (A&E) department.

Incidents

- The trust reported 5 'never events' (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) in 2013/14. There has been another reported event in 2014/15. These included two wrong site surgeries. We noted that current processes still placed patients at considerable risk of this occurring again. The staff within surgery had recognised the potential risk and had put control measures in place; however, these were not being routinely adhered to.
- The trust had an average number of serious incidents given its size.
- Widespread learning from incidents outside staff's own wards or departments was limited, despite the trust using different communication platforms to share learning with the operational staff. This was acknowledged by representatives of the executive team. Staff felt they required more learning from outside their own wards or departments. Currently no audit of staff attendance of ward or department meetings had been undertaken.

- Previously staff had graded the incidents and if re-grading had occurred, the person reporting the incident was to be informed but this had not always happened. At the time of our inspection incidents were assessed by senior management for grading after 24–48 hours. Management used the review of all incidents and their personal experience to determine the grading.
- The trust had good processes in place for the analysis of incidents. A review of all incidents reported was undertaken daily by trust senior management. Investigations were also undertaken by relevant staff but it was recognised by senior trust staff that those undertaking the investigations would benefit from root cause analysis training.
- New pressure ulcers were reported as incidents; this enabled learning to be shared so that the number of occurrences could be reduced. Though we noted that in some areas of the trust, although staff had identified that preventable pressure ulcers had occurred, there were no management plans in place to prevent future occurrences. However, figures provided by the trust do show the prevalence of pressure ulcers to be falling.

Cleanliness, infection control and hygiene

- The arrangements in place regarding infection control were well planned. There were procedures for audit and reporting. Staff had a good understanding of best practice and were well supported by infection protection control (IPC) staff. Regular audits showed that most staff, wards and departments used good IPC. However, we saw a few staff not using IPC as set out in the trust policy, and in some of these cases local audits had not identified this as an issue. This indicates that this was an ongoing issue and that the trust must continually remind staff of their responsibilities. The practices in place revealed that this was being done, but extra local focus would be constructive.
- Across both community and acute settings, 72% of staff had attended infection control training. The trust understood that it needed to improve the attendance of training, aiming for 95% compliance by March 2015.

Environment and equipment

- Resuscitation equipment checks across both acute sites needed to be improved; we found numerous incidents were checks had not been maintained on a daily basis of this emergency equipment. This was against the trust's own policy. We also saw that some equipment was out of date, missing or faulty, which put people at risk.
- Most areas of the trust environment were fit for purpose, enabling staff to undertake their roles safely. We also found that equipment was readily available and safe to use. However, we noted that, despite the need for some repairs being escalated appropriately, some remained unaddressed for extended lengths of time. Examples were cracks in the flooring in the mortuaries and, in a number of areas, broken chairs not suitable for patients to use. We saw that issues raised within the community remained unaddressed for extended lengths of time, such as a room where medications were stored being too warm. This could compromise the integrity of the medicines stored there. Also, the environment of the Bradbury House Day Hospice adversely affected the activities that patients could undertake.
- Some elderly care wards had areas designed for patients living with dementia; unfortunately these were not used because staff could not see patients using these spaces if they were unsupervised.

Medicines

- We found that the pharmacy team was actively involved in all aspects of an individual's medicine requirements. People's medicines were reviewed and checked for safety by a clinical pharmacist at the point of admission through to discharge. Nursing staff we spoke with also told us that the pharmacy service was essential for medicine safety and that, if they had any medicine queries, they had access to pharmacist advice at all times, including an out-of-hours pharmacy service. We found that the pharmacy team provided an efficient clinical service to ensure that people were safe from harm.
- Although the trust had an online 'incident-reporting' system in place to record and report medicine incidents or errors, we found that learning from these errors did not always take place. There was

an open culture of reporting medicine errors. However, nursing staff were not always informed of the overall outcomes and thereby able to learn and change practice. Learning from such incidents would help to improve patient safety.

- Arrangements for the safe storage of medicines remained an issue for the trust. We found numerous breaches where medications had not been stored either correctly or securely.
- Two wards on the City site were placing carrying cases with handles on top of a metal dressing trolley to take medicines to people during medication rounds. This system had not been risk assessed for safety or security.
- We found chaotic medicine storage in the A&E department, with medications out of their original packaging and stored in a haphazard manner.
- There was no consistent system for safe medicine storage, despite the trust failing to achieve its Commissioning for Quality and Innovation (CQUIN) for the Safe Storage of Medicines 2013-14. We would have expected additional efforts to improve, but we did not see that during the inspection.

Records

- Information governance was an area of concern. During an unannounced visit, we found serious breaches of unsecured patient notes. During an announced visit, we noted in various documents that information vital to delivering good-quality care was missing, such as records within notes with no information to identify the patient concerned. This could lead to confusion because staff would not know if the record applied to the person in whose notes it was found. We alerted appropriate hospital staff in all instances we found.
- When reviewing Do Not Attempt Cardio Pulmonary Resuscitation documents we found incorrect or missing information for patients which put patients at considerable risk of not having their wishes adhered to.
- Data supplied by the trust showed that 76% of staff had undertaken information governance training at the time of our inspection.
- The imaging department was not operating to expected levels in some areas; these included the lack of training records and safety guidelines for staff. This had resulted in the department being judged as in breach of Ionising Radiation (Medical Exposure) Regulations 2000. This meant the trust would be issued with an improvement notice, and would need to make improvements within an agreed timescale. This would improve both the working conditions for staff and outcomes for patients using the service. This seriously compromised the ability of the department to demonstrate staff competency around the equipment they were using.

Safeguarding

- The trust had a good reporting structure and staff knew how to access the appropriate person for support. The chief nurse was the safeguarding lead for the trust.
- The trust had adult and children's policies in place, although we noted the safeguarding children's policy was due for renewal at the end of August 2014 which at the time of the inspection was still the case. We note that the trust took an active decision to work with an out of date policy until the feedback from the CQC safeguarding review was received.
- Safeguarding adults training received by staff was not based on best practice. Not all staff whose position brought them into contact with vulnerable patients had received training to the appropriate level. This was because the trust had taken a decision to only offer level 2 adult training to senior staff (band 7 and above) or to more junior staff if their roles demanded it. However, within the outpatients department, only senior staff had been trained to level 2, despite junior staff being responsible for clinics.
- When we were aware of safeguarding issues during our inspection, we alerted the trust to these so that appropriate actions could be taken.

Mandatory training

- Mandatory training for 2013/14 was reported by the trust in its annual report as completed by 87% of staff.
- Documents supplied to us by the trust showed that across all the staff groups and departments mandatory training (including statutory training) was 77% at the time of our inspection. We did note

that the document was undated, but we assumed that it was the latest version for 2014/15 supplied to us as part of the information requested from the provider before our inspection.

- We noted a considerable difference in compliance between the professions of nursing and midwifery and medical and dental with mandatory training. Nursing and midwifery attendance completion rate was 77% and 54% for medical and dental staff. The trust needed to ensure the same amount of importance was applied to medical and dental staff attendance as to nursing and midwifery staff.

Nursing staff

- We saw that nursing staffing numbers was an issue for some areas of the trust. For example, within the community at the Leasowes Intermediate Care Centre, they had serious issues regarding the number of qualified staff on duty at night. There was one nurse working over two floors totalling 20 patients, which included two palliative care beds. Documents supplied corroborated this. The trust recognised this as a safety issue and had put an interim control measure in place, although a permanent solution had not been addressed. There were similar issues within both the acute and community settings where staff were working over and above their contracted hours to cover vacancies and sickness.
- There was reconfiguration taking place within the trust. Over the next five years, the Trust will be reducing its all professions workforce by 17%. Some estimates suggest that this will be in the face of rising demand, although local commissioners dispute this. During our visit, the Trust was part way through a consultation to change some workforce roles. Although this was to improve access to the service for patients, the extra strain on existing staff to cover the additional hours without more staff was noticeable. We found this resulted in poor morale and staff were concerned for their job security. The process for accessing both bank and agency staff was overly complicated and resulted in staff sometimes not receiving the cover they needed. However, the trust had identified that overspend on both agency and bank staff represented a risk and needed extra controls. It was clear that, although a robust process was required, the current situation was not effective, being lengthy, for staff making requests, and may not have been the best use of time for the chief nurse. At the time of our inspection, there were additional measures pertaining to the one to one process which had been in place a few weeks.

Medical staffing

- The trust had a higher (worse) ratio of middle-grade doctors to consultants than the England average. The trust had 235 whole time equivalent doctors with 33% at consultant level, which was worse than the national average of 38%.
- Doctors we interviewed and who attended focus groups gave mixed views regarding the proposed changes within the trust. It was felt that some decisions made by the trust were arbitrary and they had not had the opportunity to give their opinions. The trust informed the CQC that the trust has an active and well attended medical staffing committee and a regular Local Negotiating and Consultation Committee (LNCC).
- Some doctors expressed frustration at the current level of their workload, particularly across two hospital sites. When we spoke with the trust leadership about this, they thought the reconfiguration of services and new hospital opening would reduce this.
- The Postgraduate Medical Education Training Board (PMET) review findings report summary dated 9 October 2014 from Health Education West Midlands gave a positive review of trainee doctors' education and training at Sandwell and West Birmingham Hospitals NHS Trust.

Are services at this trust effective?

Good

Summary

We judged that this domain to be good. We found that evidence-based treatment was delivered and

patients were mostly pain free. Although audit of all pain relief procedures was not undertaken.

Identified treatment pathways were used across the trust. We noted that identification of deteriorating patients was used to good effect in most instances, but we found some wards were not undertaking observations when due and in some cases staff were not escalating concerns to medics when results demonstrated this was required.

The trust was performing well against their targets for commissioning for quality and innovation. These targets are put in place to improve services for patients.

Care planning within the acute sector was not always personalised. The trust used pre-printed care plans and we found that some patients did not have care planned for all their needs, even when a risk assessment had identified that extra support was required. The trust also needed to improve arrangements about mental capacity because some junior medical staff did not know how to discharge their duties in this area.

Evidence based care and treatment

- The trust used identified treatment pathways to deliver care across all the services we inspected.
- Identification of the deteriorating patient was used to good effect within the trust.
- The trust took part in 31 national audits in 2013/14, which represented 100% of the audits the trust could take part in. However, in some cases where the trust had not performed well, re-audit had not been undertaken to see if improvements had been achieved.
- The hospital had not yet implemented the British Thoracic Society's care bundle for community-acquired pneumonia as recommended by NHS England earlier in 2014 which aims to improve administration of antibiotics within 4 hours of admission to hospital.

Pain relief

- Generally pain relief that patients received was good. They reported that they received analgesia when they needed it.
- Staff used recognised tools to identify pain levels in patients, although within acute children's services a new tool had been introduced for which staff said they lacked training; however, no child was seen or reported to be in pain.
- The use of anticipatory prescribing was well embedded across both acute and community end of life services.
- We did note that, within maternity and surgery, epidurals were used as pain relief. Within surgery, the use of epidurals was not audited for effectiveness against less invasive and less labour-intensive pain relief methods. The trust supported postoperative patients with patient-controlled analgesia or epidural pain relief. Best practice guidelines for epidurals indicated that the decision to continue using epidurals should be guided by regular audits and risk–benefit assessment.

Patient outcomes

- Care plans in use were pre-printed documents that lacked personalisation.
- Some patients did not have care plans in place for known conditions. Also, after risk assessments that identified that extra support was needed, patients did not always have care plans to support the outcomes of the risk assessments. This put patients at considerable risk, because professionals delivering care used these documents as tools to identify care requirements. It also showed that care was not always discussed with patients or their relatives. Finally, having pre-printed care plans deterred staff from personalising them, although with good leadership staff could have been encouraged to personalise the care plans.
- The outreach service was effective in supporting patients appropriately and accessing timely care.
- The Hospital at Night team of doctors and senior nurses were not using the Royal College of Physicians' Toolkit for handovers as recommended in 2011. This toolkit gives clear guidance and structure to ensure effective handovers are completed that address patient's needs and conditions.

- The Trust's Hospital Standardised Mortality Ratio (HSMR) for the most recent 12-month cumulative period is 85.2, which remains below that of peer trusts. The City hospital site HSMR was below the national average with 70.4, and the Sandwell hospital site's HSMR was 99.7, which was within the expected range for the most recent 12-month cumulative period, as reported in the trust's Integrated Quality and Performance report for the second quarter of 2014.
- The Integrated Quality and Performance report for the second quarter of 2014 showed 100% compliance with the 90% target set by the Commissioning for Quality and Innovation (CQUINs) payment framework for July 2014 form dementia screening.
- The trust reported meeting the 62 day cancer standard (from urgent GP referral to treatment) in Quarter 2 2014-15, with overall performance of 88.6%, which was higher than the trust target of 85%.
- The trust was meeting its target for carrying out mortality reviews within 42 days by achieving 89% compliance above the trust target of 86% as of June 2014.
- Use of hand-held devices, as well as other tools, was well embedded to identify a deteriorating patient.

Nutrition and hydration

- Access to food and drink was good. Patients reported they could obtain snacks and drinks when they needed them.
- We noted that, when patients needed encouragement with fluids, their fluid intake and output were monitored. However, this was not done consistently the completion of these records was patchy and no targets had been identified for patients. Local audit of the quality of the completion of these documents was missing.
- There was no specific policy to support staff and children and young people regarding Nil by Mouth (NBM). This resulted in staff relying on past experience to determine when and for how long a child should be NBM for prior to surgery. This meant the practice was inconsistent and contained elevated risk to the child.

Competent staff

- The trust had improved the appraisal rate to 100% of staff receiving appraisals in 2013/14. Staff we spoke with agreed they had received appraisals.
- Induction practices across the trust were good; within each ward or department, new staff were supported to achieve competencies to deliver their new roles.
- Attendance at mandatory training was well supported and encourage. The trust reported 86% for the period 2013/14. Other undated documents shared with us by the trust showed that 77% of staff had completed their mandatory training.
- There was a widespread lack of staff supervision throughout the trust. Staff told us the reason was staff shortages, which prevented them from supporting staff with supervision on a regular basis.
- Bank nurses told us that there was not an effective system for their supervision or their appraisals.
- Medical staff within Emergency medicine, General surgery and Gynae-oncology needed clearly agreed job plans. These would enable them to plan their duties, responsibilities and objectives for the coming year. They also covered all aspects of their professional practice. Without these in place, it was difficult to assess the performance of each individual. Following the inspection the trust informed us that job plans were in place for general surgeons but they were in dispute.

Multidisciplinary working

- Allied healthcare professionals were used to ensure that patients' outcomes were optimised. Across the trust we saw good examples of cross-professional work. The community services appeared to work well within the local healthcare community, and worked hard to overcome obstacles to ensure that patients received the service they needed.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- A letter dated 29 May 2013 had been sent to trust medical staff from the trust medical director identifying the importance of obtaining consent for the provision, withholding or withdrawing of a medical intervention. There had been a previous 'never event' where the investigation had identified consent as a contributory factor.
- Mental capacity issues were not embedded within all the staff groups as well as they should have been. Junior doctors' knowledge and skills needed more support and training to allow them to be more confident. However, we noted that passports were in use for people with learning disabilities and the trust provided specialist support for both staff and patients in this area. Passports are documents produced by the patient and family, which details their likes and dislikes, especially if the patient has difficulty communicating.

Are services at this trust caring?

Good

Summary

We judged the trust to be caring. In all the services we inspected across the whole of the trust we found staff and patient interactions to be good. All levels of staff who had patient contact were polite and treated patients with dignity. We observed interactions across the trust and spoke to patients, most of whom said they were treated well. They were also made aware of their treatment plans and felt well supported throughout the process.

Compassionate care

- Most patients received compassionate care from staff. We witnessed many interactions that showed that staff were respectful and kind to patients.
- We saw on some occasions that patients' dignity had been compromised, but these were in the minority. One particular incident we observed involved staff not removing a person to use the bathroom while meals were being eaten; this resulted in other patients not wanting to finish their meals. It also showed a lack of dignity and respect for the other patients in the vicinity.

Emotional support

- In most instances, staff involved patients in their care and emotional support to patients was forthcoming.
- Patients spoke very highly of the staff, notably in the intensive care unit (ITU; they said the staff were patient and attentive).
- The identification of empathetic staff was part of the recruitment process, which senior staff told us had resulted in good-quality staff being recruited to the trust.

Are services at this trust responsive?

Requires improvement

Summary

We judged responsiveness to patients' needs to require improvement. We saw that the trust provide services to meet the needs of the local people, but these were not always well planned or implemented (for instance, the extending of hours of service in imaging with no related increase in staff, which effectively meant one room could not be staffed). However, the provision of a GP service in the accident and emergency (A&E) department was responsive to patients' needs.

The translation services were not uniform: some areas did not have information readily available in different languages, and some procedures had to be cancelled because of a lack of interpreters to support patients' needs. Whereas other areas did have information available not in English, and age appropriate.

The complaint process had been devolved to local level, with support from the central complaints team.

The trust needed to ensure that it made inroads into the local community to gather the views of the diverse population it served.

Service planning and delivery to meet the needs of local people

- The trust had implemented a number of initiatives to ensure that patients received the care they needed close to home. The community pathfinder diabetes project was a planned and delivered service that had devolved the traditional outpatients appointment into the community, making it easier for patients to access the service.
- We also noted that the trust had reconfigured some services to be delivered across extended days. However, the common theme of concern was the inability to staff the extended hour's services appropriately.
- We saw that GPs were in the A&E department so that patients could access primary care if that was more appropriate than emergency treatment.
- Before the inspection, we spoke with a group that supported homeless people, some of whom had issues with alcohol. They told us they felt able to access the services of the trust and had been well supported in most cases.
- The trust has community services which aim to address the needs of local people. Notably services delivered within schools which was child and family centric. Therapists empowered parents to deliver therapy to their children.

Meeting people's individual needs

- The community that the trust served was culturally diverse but the trust did not have a universal response to this. We saw that in some areas information was accessible in different languages and formats, but in others it was lacking.
- Overall, access to interpreters was good; the trust had invested in interpretation services, although we noted that the service was not universal in its accessibility. Community staff told us they adhered to trust policy regarding not using relatives as interpreters; however, acute staff continued to do so, especially in emergency services. Because it was emergency services, there was some level of mitigation; however, the use of third-party interpreters should always be preferred. We were made aware that on occasion patients' appointments or procedures had been cancelled because of a lack of translators.
- The trust served an ageing population with patients displaying dementia-type illnesses. This put extra strain on the service to deliver safe and responsive care. The trust used to have a lead for dementia services but had taken the decision not to re-recruit to that role. There were dementia champions within the trust. However, we observed, and staff told us of, many instances where they were required to support patients with this kind of condition, but felt unprepared to do so.
- The trust employed a lead for learning disability, whom staff found to be very supportive. However, during our inspection, we saw that the learning disability advice for one patient was disregarded by a medic.

Access and flow

- Delayed discharge had a significant impact on the trust's ability to have beds available for patients. An area where the impact was felt deeply was in end of life care. Patients were given the choice of where they wanted to end their lives and, because of the nature of their condition, this had to be undertaken in a timely fashion. Reorganisation and staffing were sighted as reasons for delayed in transfers.
- In the trust's Integrated Quality and Performance report for the second quarter of 2014, it reported Delayed Transfers of Care increased during the month to 4.3% (from 3.7% in June).
- Patients did not always receive their medicines promptly on discharge. We were told that sometimes people were discharged or transferred without their prescribed medicines, which were then sent on later using hospital transport. Discharges were often delayed because of the need to wait for medicines to come from pharmacy. There were many reasons discussed for the delay.

These included the time taken for a doctor to write up the discharge prescription and changes made to a person's medicines, which resulted in further delays in dispensing new medicines.
- Patients attending outpatients regularly experienced delays and extended waiting times. The department appeared to appreciate this was a problem but at the time of the inspection it had not been resolved. The outpatients department was part way through the "Year of the Outpatients" initiative, with one of the objectives to improve patient flow.

Learning from complaints and concerns

- We spoke to a number of medical and nursing staff in a variety of areas who told us about the changes to the complaints process. The trust told us that their new complaints process was a devolved system. This meant that staff of all grades were involved in investigating and responding to complaints made by patients and their carers about their care and experience while at the trust.
- One of the changes made by staff in response to complaints was sleep packs, which included eye shields and ear plugs to help patients get a good night's sleep.
- Consultants who had been involved in responding to complaints told us they had found it a useful experience and were pleased to be involved in responding to complainants.
- Senior management at the trust told us that they shared patients' stories and complaints at the board meeting so that the whole trust could understand patients' experiences.
- We met with trust representatives who told us that the trust had just started to monitor the numbers and trends of locally resolved complaints. These were complaints that staff dealt with as they arose and resolved for patients immediately.
- Most complaints were received from Caucasian people and those of Caribbean origin. Trust board members we spoke with admitted that they needed to improve the links to other communities that they served, because the voice of those communities was under-represented. The trust had just started some work to become more involved with the local community, but it was too soon for us to judge this during our inspection.
- Complaint resolution time was improving within the trust, averaging 40 days to resolution previously it had been up to 70 days. The trust wanted to improve on this further.

Are services at this trust well-led?

Requires improvement

Summary

We judged leadership to require improvement. Although we saw many arrangements that showed good management, we observed issues that needed further management input. The tools which the board used to be aware of risks within the organisation did not always contain the all risks to the organisation.

Staff knew the chief executive, but did not recognise other members of the trust board. The workforce transformation was presenting major problems because it adversely affected morale within the trust with staff citing lack of communication about their roles as a major contributor.

Innovative practice was taking place, notably iCares (which is a service which supports patients with long term conditions working closely with the acute hospitals to maintain patients within the community) and the community pathfinder diabetes project, a planned and delivered service that had devolved the traditional outpatients' appointment into the community, making it easier for patients to access the service. both of which had received national recognition for good service.

Vision and strategy

- The trust had a vision it was working towards, which was to be known as 'the best integrated care organisation in the NHS' by 2020.
- The medium-term vision and strategy was to have completed and moved into a new hospital, the Midland Metropolitan.
- The trust has to achieve a staffing reduction of 1,400 in the next five years.
- The trust had set six strategic objectives for 2014/15. The first was safe high-quality care and the main initiative for this was 'Ten out of Ten care'. This required staff to always undertake 10 actions, with the aim of reducing harm, for every patient admitted. During our inspection, we found that a considerable number of staff were not aware of this initiative. However, when we spoke with

members of the trust board, it became clear that it was a pilot being trialled on a limited number of wards and departments. We also noted in trust board papers that the '10 out of 10 care' initiative had been launched in September 2014.

- Also as part of safe high-quality care strategic objectives, an extra priority was 'the year of the outpatients', although, when we visited staff in outpatients and asked about this, not all staff were aware of this initiative. Some were aware that systems and processes were being reviewed and updated.
- This showed that, although the trust had many devices available to share information, key messages were still failing to reach operational staff. Also, we were not clear on the ability to achieve this strategic objective for 2014/15, when the pilot phase started 6 months into the delivery year.
- Four-hour A&E department breaches are another indicator of safe high-quality care and identified as another priority for 2014/15. Documents supplied by the trust showed that, since April–July 2014, the A&E department had breached the 4-hour wait times three of the four months. Although this was a strategy identified for the 'front door', it had implications for the whole hospital: if there were insufficient beds available, this could have an impact on the A&E department's ability to transfer patients to a ward and result in a breach occurring. Staff had expressed concern that this issue was seen only as theirs, when it was a wider trust issue.
- The trust board was aware of delayed transfers of care and these were discussed in the quality and safety committee in August 2014. The trust had regular contacts within the community to try and address the need for more social care support to help with the discharge processes.
- Within services such as critical care and focus groups of the wider staff group, staff expressed their dissatisfaction with the instability of middle management. This was also noted in minutes of committee meetings and presented to the board. As middle management was essential to ensuring that operational staff understood the vision and strategy of the organisation, this uncertainty put the organisation at considerable risk.

Governance, risk management and quality measurement

- The trust had to make changes in the workforce that would result in 1,400 whole time equivalent posts being lost. This resulted in staff undergoing consultation for some roles and management reviewing establishment numbers. The trust confirmed the statutory consultation process began in October 2014.
- Trust executives confirmed that the identification of risks and how they were presented on the risk registers needed further work. Staff required extra support and training to present the risks and control measures in a uniform fashion. However, we saw risk registers having future control measures applied to reduce the current risk. This did not appear to be a safe practice because the trust board was looking at residual risk ratings associated with current control measures. Therefore, if a residual risk was lower but the appropriate control measures were not in place; this was falsely reducing the risk. We spoke with a member of the trust board who did not see this as an issue. However, as the trust was already aware that the quality of the risk registers needed to improve, 'it should also consider the control measures that should be applied.
- We found that not all departments had a robust system in place for reviewing risks on a regular basis to monitor if the control measures had reduced the levels of risk. This was notable in the A&E department.
- The process for accessing additional bank or agency staff was time consuming and at times inadequate to meet the needs of the units needing the extra support. It was clear from our conversations with executive staff and from documents supplied by the trust that the additional monitoring of bank and agency staff use was required to ensure spending controls. However, the system in place at the time of the inspection was convoluted and created barriers between staff requests and executive management approval. This meant that sometimes no staff were available even when approval had been granted.
- The trust's 'Safer staffing' document was produced and published every month on NHS choices. This showed the number of expected nursing and healthcare assistant staff compared with actual, by those who had attended in the past month. We spoke with the chief nurse about these figures because they showed the percentages achieved. The overview demonstrated that, for the past 3 months (as presented to the trust board) the staffing was more than that expected in most instances. However, the experience of staff did not reflect these results. The figures presented had

associated explanations; however, the explanations failed to address the largest anomaly within the report. For instance, the report presented to the trust in September 2014, which related to July 2014, showed that on ward D5 the fill rate for healthcare assistants was over 2,000% for night-time. When we asked for an explanation regarding the fill rates which were considerably over 100% we were told it was a data error, which had not been challenged.

- The IT systems in place were presenting issues for staff. These occurred across many different departments both in the acute hospital setting and in the community. Within maternity, we saw two different systems for updating records for a mother and her baby, requiring staff to log out of one system to add information to another. Also within the community, because of the number of different systems in place, information that staff relied on was not readily available to staff, and showed the NHS number and if admitted the hospital identity number which staff found problematic at times. The trust was helping staff with IT support and champions to try and reduce the difficulties, but not all had been resolved. The trust recognised this as a current risk, but it needed sharper focus to resolve it as a matter of urgency.
- We noted in documents supplied by the trust that the procurement process had begun to replace the trust's electronic patient records. The trust informed us the implementation is due October 2017.
- The workforce delivery plan had cost improvement plans (CIPs) and quality impact assessments (QIAs) associated with it. Members of the trust board told us that there were 451 projects and 390 of them needed QIAs, of which 264 had been completed at the time of the inspection. We were sent a selection of QIAs to review, but these lacked detail as to how the impact was assessed.
- The trust's governance arrangements were comprehensive with clear responsibilities. Sub-committees fed into committees, which fed into the clinical leadership executive, which fed into the trust board. The non-executive directors were also responsible for committees such as the quality and safety committee, which fed into the trust board. This arrangement should have meant that the trust board was well aware of the issues affecting the trust.

Leadership of the trust

- The chief executive was very visible around the trust and used many communication platforms to interact with staff. He was well recognised by all staff groups. Some staff described him as dynamic and inspirational. However, the rest of the executive team were less visible. Nursing leadership was cited as less visible by the nursing staff, which led to their believing that the local pressures they faced were not understood at executive level.
- The trust did not have a director of organisational development at the time of our inspection. This would be a strategic role to help with the workforce reconfiguration and also to support the leadership in its development to meet the future needs of the trust. Shortly after our inspection the trust appointed to this post.
- According to the trust's 5-year plan, the trust was investing in leadership across the organisation. Given the amount of transformation, the leadership's ability to lead was paramount to its success. The trust recognised that offering a leadership development programme was required.
- The trust board accepted that middle management was suffering from low morale, and this was attributed, in part, to the workforce changes. Middle management felt they lacked the information needed about the forthcoming changes to support their staff adequately. Some of their roles were under consideration, which meant they could not be part of the planning and so could not effectively support their staff.
- We noted that the trust no longer had a lead for patients with dementia-type illnesses. They had chosen to use dementia champions. However, staff felt they required the support of a person with appropriate extended skills.

Culture within the trust

- Relationships between professionals within the trust were mostly good, but we found that the nurses' influence was not as prominent as it might have been. In both surgery and emergency medicine, we noted nursing staff not being recognised as equal partners in delivering care. This issue is recognised by the executive management team of the trust.
- We found that staff wanted to do the best for their patients, and they showed that they were

prepared to work beyond their contractual obligations to meet the needs of patients. However, this, coupled with the workforce transformation, meant that staff were beginning to feel that this was too much, and could not be sustainable in the longer term.
- The leadership took part in 'First Fridays', which meant that they worked with operational staff on the first Friday of every month. They could then see first-hand how staff worked, and share information about the trust.

Public and staff engagement

- The trust undertook NHS Friends and Family Tests for 2012/13, and identified a target for inpatients of over 60%. For that period, the trust averaged 73%, a few percentage scores below the NHS England average of 76%. The trust had made a target to improve the response rates, notably within maternity services.
- For the period April 2013 to July 2014, the trust's Family and Friends Test score response rate was an average of 26%, below the trust average of 33% and the national average of 30%.
- We noted that, on some wards and departments, patients were helped to give feedback in real time, either using iPads or tokens. This information was collated and reviewed to improve the service.
- Staff were committed to improvements in broad terms but felt undermined by the reconfiguration process the trust was undertaking; this in turn affected their morale and made it harder to engage proactively with further change. Some staff were confident about the review while others felt insecure. The view expressed by most staff was that they had not been adequately consulted about what the changes meant for them. The trust had sent us an overview of the changes and confirmed they had begun consultations with staff early in October 2014. This did not match the views expressed by staff in conversation with us and in focus groups.
- The trust used an online survey tool called 'Your voice', which aimed to get a whole trust response over a 3-month period. The response rate was 21%. The survey tool had a number of open questions, such as "What top two things could we introduce or improve to make you more positive about working in the trust?" This enabled staff to give their feedback regarding working within the trust.
- Feedback had been captured from staff through the staff survey. We saw the results for January, April and July 2014, and observed a reduction in % scores relating to engagement, advocacy, involvement and motivation. For example, 34% of staff felt involved and 41% felt engaged this corroborates the high numbers of staff expressing low morale during our inspection.

Innovation, improvement and sustainability

- The trust had staff who were keen to take part in research and innovation. They have been commended for services such as iCares and the community pathfinder diabetes project, both of which received recognition and awards nationally. Both were good examples of how the trust had provided a service that not only met the needs of patients by making services easily accessible and closer to home, but also demonstrated sustainability. For instance, the community pathfinder diabetes project took place within local GP practices with both a hospital doctor and patient's GP present. This enabled the GP to manage the patient without the need of the hospital input if the patient or others presented at the practice with the same or similar issues.
- The trust took part in 250 clinical research trials for 2013/14, covering areas such as cancer, rheumatology, neurology, dermatology and surgery.

Overview of ratings

Our ratings for Sandwell General Hospital are:

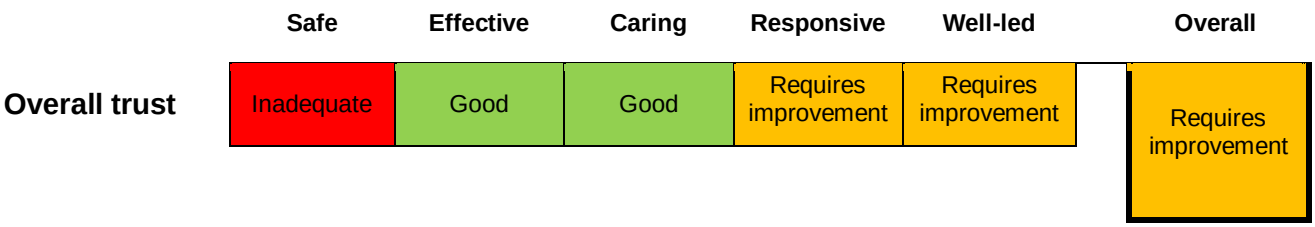
	Safe	Effective	Caring	Responsive	Well-led		Overall
A&E	Requires improvement	Good	Good	Requires improvement	Requires improvement		Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement		Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement		Requires improvement
Critical care	Good	Good	Good	Good	Good		Good
Children & young people	Requires improvement	Good	Good	Requires improvement	Requires improvement		Requires improvement
End of life care	Good	Good	Good	Requires improvement	Good		Good
Outpatients	Inadequate	Inspected but not rated[1]	Good	Inadequate	Inadequate		Inadequate
Overall	Inadequate	Good	Good	Requires improvement	Requires improvement		Requires improvement

Our ratings for City Hospital are:

	Safe	Effective	Caring	Responsive	Well-led		Overall
A&E	Requires improvement	Good	Good	Requires improvement	Requires improvement		Requires improvement
Medical care	Inadequate	Good	Good	Requires improvement	Requires improvement		Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement		Requires improvement
Critical care	Good	Good	Good	Good	Good		Good
Maternity & family planning	Good	Good	Good	Good	Good		Good
Children & young people	Requires improvement	Good	Good	Good	Requires improvement		Requires improvement
End of life care	Requires improvement	Good	Good	Requires improvement	Good		Requires improvement
Outpatients	Inadequate	Inspected but not rated[1]	Good	Inadequate	Inadequate		Inadequate
Overall	Inadequate	Good	Good	Requires improvement	Requires improvement		Requires improvement

Our ratings for Community Services are:

	Safe	Effective	Caring	Responsive	Well-led		Overall
Children and Young people	Inspected but not rated[2]	Inspected but not rated[2]	Inspected but not rated[2]	Inspected but not rated[2]	Inspected but not rated[2]		Inspected but not rated[2]
In patients	Requires improvement	Good	Good	Good	Good		Good
Adults	Requires improvement	Good	Good	Good	Good		Good
End of life care	Requires improvement	Good	Good	Good	Good		Good
Overall	Requires improvement	Good	Good	Good	Good		Good



Notes:

1. We are currently not confident that we are collecting sufficient evidence to rate the effectiveness of Outpatients.
2. We were unable to collect sufficient evidence during this inspection to rate these services fully. They will be subject to a further focused inspection.
   This is not a reflection on the Trust, nor of the service; but of an internal CQC difficulty.

Our Improvement Plan – responding to the Care Quality Commission Report

March 2015

Richard Samuda, Trust Chairman
Toby Lewis, Chief Executive

Version as at March 26 2015 – Not yet approved with CQC

The plan is a live document, and will be adapted based on feedback

Room for improvement

Tackling must and should dos | By October 2015

- **No denial**: We are committed to addressing each CQC requirement and recommendation. Where we believe that the issue goes beyond the domain or service identified by inspectors, we will tackle the issue on a Trust-wide basis. Many of the issues were highlighted to the CQC by Trust leaders.
- **No delay**: There are a small number (13) of requirements which are already completed. The balance will be addressed either by the end of June 2015 (30) or by the end of October 2015 (26) (i) . Routine monitoring of the Improvement Plan will occur at the Board and throughout our structure. Our website will provide public information on delivery. If we fall behind, we will be open about that and explain why.
- **Maximising participation:** We want to involve patients, partners and colleagues employed by the Trust in identifying the solutions to the issues raised, and in continuing to work with us to identify and address concerns about care – especially in the responsiveness, leadership and safety domains.
- **Sustaining improvements:** We have invested in a major three year leadership development programme supported by the Hay Group, which is just less than one year old. During 2015-16 we are prioritising reforming our corporate functions to better support local clinical leaders with the data and time-efficient processes needed to develop stronger middle management cultures on a multi-professional basis.
- **Listening into Action:** We have a longstanding commitment to hearing the views of all involved in providing care and acting on that feedback. We intend to build on that tradition, and become better at spreading the learning from improvement across our organisation's many sites and teams.

(i) Where our improvement plan specifies several actions, the data used is the last one that is cited. So more actions are imminent than this proportion suggests.

The big themes identified in the report

5 priorities to address | Work has already started

i. We need to be **better at learning across our organisation**, spreading good practice and identifying why some wards, teams and departments are better able to deliver outstanding outcomes for patients – the solution to our issues is already being implemented somewhere in our Trust

ii. We need to ensure that we **consistently deliver the basics of great care**, with disciplined implementation of policies on hand-washing, medicines security, end of life decision making, and personalised care observations – we have to get this right every time

iii. **We need to tackle our sickness and vacancy rates** if we are to reduce gaps in our care, and ensure that all of our staff have time and space to be trained and to develop their skills – being fully staffed matters.

iv. We need to **build on our best practice around local management and leadership**, empowering capable local managers, and reducing hierarchies between executive and departmental leaders – communication can be better here and must be two-way

v. We need to do even more to evidence how our incident, risk management, and safety data inform the decisions that we make and the priorities that we set – **we know where our issues are, and need to address them more quickly when they are identified**

Accident and Emergency [1/3]

What the CQC has told us we need to improve
How we are responding

What the CQC has told us we need to improve	How we are responding
Learning from incidents and errors is not taking place which means they could recur. There was a risk of less 'serious incidents' not being reported by doctors and as a result trends missed	Reporting rates among nursing, medical and admin staff in A&E are high. These incidents are examined at executive, group, directorate and team level. Incident reporting data will be incorporated into medical appraisal during 2015-2016 to help identify any employees who are unaware of, or not engaging with, the reporting system **(October 2015)**. [Director of Governance]
The absence of some safety audit data, such as hand hygiene spot checks and the negative findings from some audits such as storage of medication, were not followed through to improve patient safety	In March 2015 we kicked off our 'OK to ask' campaign to support all staff who do challenge risky behaviours. **(March 2015)** Safety audit data will be reviewed during our Quality Improvement Half Days. **(June 2015)** We will ask patient representatives locally to join us in conducted unannounced inspections every quarter on these issues. **(October 2015)** [Chief Nurse]
Isolation procedures not being effectively followed by staff	Visual prompts, including notices on rooms and cubicles, are being put in place to prompt the behaviours our policies and best practice require **(March 2015)**. The Infection Control team are carrying out unannounced visits to check that procedures are being followed. **(October 2015)** [Chief Nurse]
There was a lack of a system for safe medicine storage	We have begun procurement of sufficient automated dispensaries to cover all our wards and Emergency departments **(June 2015)** In March 2015 we kicked off our 'OK to ask' campaign to support all staff who do challenge risky behaviours. **(March 2015)** [Chief Nurse]

Accident and Emergency [2/3]

What the CQC has told us we need to improve	How we are responding
There were systems in place to assess and respond to patient risk including using nationally accredited systems to identify early any deterioration in a patient's condition. Systematic gaps in some patient records were noted.	The Trust uses a standard system, and gaps should not arise. Our retrospective data on care in ED is among the best in the W/Midlands. Record keeping standards have been reissued to teams and will be audited on a sample basis each month starting from March 2015 **(June 2015)** *Note link to other should do recommendation* [Chief Nurse]
A review of governance arrangements in relation to supporting the A&E department to more consistently achieve the national 4-hour target.	All employees working in A&E will be issued with written explanations of the governance processes, and local induction will include that briefing **(March 2015**) A review of emergency care governance, undertaken with the CCG in November 2014, has been completed – daily huddles now include presence from the executive team with a specific brief to ensure multi-professional learning **(March 2015)** [Chief Operating Officer]
The management of governance arrangements in the A&E department.	We will use the new monthly Quality Improvement Half Days to share learning and improve patient care. Participation and attendance is centrally tracked and we will report ED participation through our weekly Emergency Care scorecard, which is widely disseminated among senior clinical leaders. **(June 2015)** [Director of Governance]
Inter-professional relationships within the A&E department must continue to improve.	A bespoke development programme that began in December 2014, supported by Hay Group and our Learning Work Team, is in place. It will take several months to evaluate the impact of this major initiative. **(October 2015)** [Chief Operating Officer]

Accident and Emergency [3/3]

What the CQC has told us we need to improve
How we are responding

What the CQC has told us we need to improve	How we are responding
There is a need to consider what the systemic gaps in the use of patients' early warning score records are indicating about usage of this tool.	The Trust has committed to tackled sepsis, and will meet the new national CQuin which commences assessment monitoring in ED. **(October 2015)** We are exploring implementing in Q1 15-16 the same VitalPacs system we have in place in our acute wards to track remotely and centrally vital signs monitoring status. **(June 2015)** [Medical Director]
Some analysis of staff practice of relying on patients' relatives for language interpretation, and what impact this has on the accuracy of assessment of a patient's condition should be considered.	We will monitor the scale and use of Language Line for immediate interpretation, and work with staff to see how this, and electronic translation material may help us. The use of relatives will only arise when absolutely necessary. Our training budget will provide some scope to support employees learning relevant local languages to support initial communication with patients. **(June 2015)** [Chief Nurse]
Better promotion of the Trust's complaints policy and procedure in the A&E department.	We now have posters and leaflets available in different languages within our A&E departments that explain how people can make a complaint or raise a concern. **(March 2015)** [Director of Governance]
Multi-disciplinary communications within the A&E Department at City Hospital.	A review of emergency care governance, undertaken with the CCG in November 2014, has been completed – daily huddles now include presence from the executive team with a specific brief to ensure multi-professional learning **(March 2015)** [Chief Operating Officer]

Medical Care [1/2]

What the CQC has told us we need to improve
How we are responding

The Trust should take action to improve the compliance with staff's mandatory training targets.

In 2013-2014 the Trust attained mandatory training coverage that the CQC have advised is more than sufficient.

In 2014-15 we have revised our training models to reduce time away from clinical practice. We expect by October 2015 to be consistently achieving 90%+ in all domains. **(October 2015)**

New arrangements to tackle trainee doctor recording compliance issues are in place within the Trust, which will improve delivery among medical staff. **(June 2015)**

[Director of Organisational Development]

The Trust should ensure all care documentation, including food balance charts, are completed accurately and in a timely fashion.

Fluid balance assessment (sic) is one of our Ten Out Of Ten. We are overtly committed to ensuring that this occurs, and data on nutrition and hydration within the Trust does not suggest a systemic difficulty. Ten Out Of Ten encourages patients and relatives to highlight concerns immediately or escalate them to the Chief Nurse.

Sample auditing of Ten Out Of Ten commences from May 2015, and we will ensure data on this issue is routinely reviewed during the first six months of 2015-2016 by the Nurse Executive, as part of our ward support programme. **(October 2015)**

[Chief Nurse]

The Trust should ensure all patients have person centred care plans that reflect their current needs and provide clear guidance for staff to follow.

We have worked with our Matrons over recent weeks to make sure care documentation is complete, person-centred and up to date. We will hold a staff engagement event in May to explore ways of further individualising and personalising care planning. **(June 2015)**

We will undertake structured reviews of individual case notes to assess both documentation completion and the accuracy of those care plans against delivery – as we did in January 2015 on D26. **(October 2015)**

[Chief Nurse]

The Trust should ensure all patients are aware of and in agreement with their treatment plan.

This is one of our Ten Out Of Ten, and so will audited routinely. Care planning documentation is being changed to provide additional prompts to patient signature and confirmation of planning consent. **(June 2015)**

[Chief Nurse]

Medical Care [2/2]

The Trust should ensure all medicines are stored in accordance with Trust procedures

This is already our policy, and ward pharmacists will be asked to report any discrepancies or innovations that have not been risk assessed **(March 2015)**

We have begun procurement of sufficient automated dispensaries to cover all our wards and Emergency departments **(June 2015)**

[Chief Nurse]

Surgery [1/2]

What the CQC has told us we need to improve	How we are responding
The Trust must take action to ensure that general surgeons have up-to-date job plans.	Retrospective analysis does not suggest material deviation against in place plans. Job plan final offers to in post general surgeons have been issued by the Medical Director and Group Director of Operations. Even if these go to regional appeal they should be in place by the end of Q1. **(June 2015)** A revised configuration for acute surgery has been subject to a CCG-led public listening exercise with a view to reconfiguration of emergency provision from August 2015. The job plan offer above already makes a second-stage proposal on how this would be reflected in future job plans. **(October 2015)** [Medical Director]
The Trust must take action to ensure that hand hygiene is carried out appropriately by all members of staff across the Trust at all times.	In March we launched our 'OK to ask' campaign to support staff in challenging behaviours. **(March 2015)** The numbers of hand hygiene audits has increased and are now undertaken by ward managers and matrons. Results will be displayed at ward and theatre level. **(June 2015)** A more robust escalation process is in place for those not adhering to the hand hygiene requirements. This includes the executive triumvirate. Repeat escalation of individuals will be treated as a conduct issue. **(October 2015)** [Chief Nurse]
The Trust must take action to ensure that a suitable system is in place to ensure that patient records are kept secure at all times.	Our all-areas audit and "speak up amnesty on local storage arrangements" will be complete by the end of April 2015. Remedial changes will be put in place in May and June. **(June 2015)** Additional information governance publicity and training has been distributed organisation wide to encourage awareness of risks **(March 2015)** New lockable trolleys and other storage containers have been procured and will be fully deployed in coming weeks **(June 2015)** [Director of Governance - SIRO]
The Trust must take action to ensure that a suitable system is in place to regularly assess and monitor the quality of postoperative surgical care.	A review of existing data does not suggest that that there is extant risk, bearing in mind that complication data is locally assessed and mortality reviews take place consistently. A post-operative standard care bundle is being developed, for consideration by the Clinical Effectiveness Committee. This will be widely discussed within our Quality Improvement Half Days. **(June 2015)** Implementation of the bundle during Q2 will be part of our autumn audit programme. **(October 2015)** [Medical Director]

Surgery [2/2]

What the CQC has told us we need to improve
How we are responding

The Trust should ensure that a safe system is in place, which all surgical staff have received appropriate training in, to safely book patients into the theatre suite and record same.

- The booking systems for our emergency theatres are via a standardised whiteboard. The Standard Operating Policy for that process will be reissued to all three surgical groups' staff during April. Wait times for emergency surgery are already tracked at senior level within the Trust and published **(June 2015)**
- Booking systems for elective booking, following our October 2013 Never Event, were re-designed and guidance was reissued to staff late in 2014. Error rates and near misses are tracked and a month's data for April will be presented to the Clinical Leadership Executive in May**. (June 2015)**
- Our new operating standard is to 'lock down' elective theatre lists one week prior to session. Compliance with this approach will be tracked and systems re-designed to meet this routinely through Q2**. (October 2015)**

[Medical Director]

The Trust should ensure that the World Health Organisation (WHO) surgical safety checklist and preoperative briefing follow the WHO guidelines. The Trust should ensure that staff know what is expected of them and that the checklists are assessed and monitored for quality.

- There is no ambiguity that the Trust complies with this standard, which is already monitored through three different audit methods.
- We have removed the need for staff to sign the WHO surgery checklist, which goes beyond WHO requirements. The new form goes into place at the start of April. **(June 2015)**
- Observational audit of team behaviours around the checklist will become routine for 2015-2016, with all theatre sessions visited at least once over that period **(October 2015)**
- ur highly successful video reflexivity project to allow teams to discuss their approach to working together will be rolled out from eye theatres, across general adult theatres. **(October 2015)**

[Medical Director]

The Trust should consider improving the environment in the pre-assessment unit at **City Hospital** because it is not patient friendly, has inadequate staff facilities and does not promote patients' dignity.

A risk assessment of this environment has been completed. The results of that assessment and any remedial work will be considered in April against competing priorities within our capital plans. **(June 2015)**

[Director of New Hospital Project]

The Trust should consider reviewing its process for booking bank and agency staff. The current system does not flow as the Trust expects it to, and it obstructs staff in ensuring that shifts are staffed safely.

- Fill rates are tracked using the Safe Staffing tool. This does not substantiate the supposition from the CQC. No central system for approval of bank staff was in place when the CQC visited the Trust, nor before or since.
- We moved approval of agency staffing back from Executive (started July 14) to Clinical Group level in December 2014. The Trust Board is monitoring whether this devolution is consistent with good practice Trustwide and continued control of agency use. **(March 2015)**
- Late requests arise through sickness and rostering practices. Both are subject to extensive change work within the Trust, and central monitoring of e-rostering now provides comprehensive data on ward management of workforce issues. **(June 2015)**

[Chief Executive]

Children and Young People [1/3]

What the CQC has told us we need to improve
How we are responding

What the CQC has told us we need to improve	How we are responding
The Trust must ensure that the nurse staffing skill mix reflects the appropriate national guidance for staffing the specialty reviewed. Staffing skill mix and support on some shifts within the clinical areas were not always meeting national best practice guidance.	Our staffing in paediatrics was reviewed in September 2014. It has been re-examined since. It meets all mandatory national guidance. We will consider whether there is a case to go beyond current staffing as part of examining our future workforce plans for the Trust. **(October 2015)** [Chief Nurse]
The Trust must ensure that at least one nurse per shift in each clinical area (ward or department) will be trained in advanced paediatric life support or undertake a European paediatric life support course depending on service need.	We already have at least one member of the on-call medical team with APLS qualifications at all times. We make sure that there is always a doctor or nurse on duty with APLS qualifications. We will fund additional training time for paediatric nursing staff in this area **(June 2015)** [Chief Nurse]
The Trust must ensure that staff receive appropriate training including mandatory training updates and supervision.	Our training plans and budget are openly displayed Trust-wide. The Board's Workforce and OD committee will review the 2015-2016 plan for paediatrics to ensure that it is satisfied with the sufficiency of proposals coming forward from local leaders**. (June 2015)** [Director of Organisational Development]
The Trust must ensure that all records are kept securely for the purpose of carrying on the regulated activity.	Our all-areas audit and "speak up amnesty on local storage arrangements" will be complete by the end of April 2015. Remedial changes will be put in place in May and June. **(June 2015)** Additional information governance publicity and training has been distributed organisation wide to encourage awareness of risks **(March 2015)** New lockable trolleys and other storage containers have been procured and will be fully deployed in coming weeks **(June 2015)** [Director of Governance]

Children and Young People [2/3]

What the CQC has told us we need to improve
How we are responding

The Trust must ensure that there is an accurate record in respect of each child that includes appropriate information and documents in relation to the care and treatment provided to each child	The Trust should consider retraining staff in infection prevention practices
Paediatric Matrons and the specialty Clinical Director will ensure that this issue is discussed during May's Quality Improvement Half Day to understand any constraints that staff feel exist in achieving this basic standard. **(June 2015**) A specific audit of the accuracy of paediatric record keeping will be included in our Clinical Audit Plan for 2015-2016. **(October 2015).** [Chief Nurse]	Our focus on infection control is Trust-wide and data does not suggest a specific elevated risk in children's services. We will not be undertaking re-training en masse, other than where individual performance is identified as an issue. In March 2015 we kicked off our 'OK to ask' campaign to support all staff who do challenge risky behaviours. **(March 2015)** We will ask patient representatives locally to join us in conducted unannounced inspections every quarter on these issues. **(October 2015)** [Chief Nurse]

Maternity and Gynaecology [1/3]

What the CQC has told us we need to improve
How we are responding

The Trust should display the results of safety checks prominently so that the information is accessible to staff, patients and visitors.	The Trust should take active steps to ensure that all staff consistently follow best practice guidance in relation to hand cleansing and infection control dress code.
We will ensure that our measures boards in both maternity and gynaecology reflect our Trustwide standards **(March 2015)** We will undertake listening and survey activity with families to understand if there is additional data on our performance that they would value being displayed. **(June 2015)** [Chief Nurse]	In March 2015 we kicked off our 'OK to ask' campaign to support all staff who do challenge risky behaviours. **(March 2015)** We will ask patient representatives locally to join us in conducted unannounced inspections every quarter on these issues. **(October 2015)** A more robust escalation process is in place for those not adhering to the hand hygiene requirements. This includes the executive triumvirate. Repeat escalation of individuals will be treated as a conduct issue. **(October 2015)** [Chief Nurse]
The Trust should ensure that resuscitation equipment is checked daily in keeping with best practice guidance provided by Resuscitation Up 2010 in all areas.	**The Trust should ensure that all medication on the maternity unit is securely stored at all times.**
We provided daily check data to the CQC in responding to their report in draft. We will monitor during the first three months of the new year data and report the results to our Patient Safety Committee of the Clinical Leadership **Executive (June 2015)** [Chief Nurse]	We have begun procurement of sufficient automated dispensaries to cover all our wards and Emergency Departments **(June 2015)** [Chief Nurse]

Maternity and Gynaecology [2/3]

What the CQC has told us we need to improve	How we are responding
The Trust should consider placing the record keeping on the Trust risk register to ensure that monitoring occurs at the highest level of the organisation.	We will consider a risk assessment on this issue at April's Risk Management Committee. Review since the visit does not suggest that this would merit a risk entry above 12 which is the trigger for Board escalation. **(June 2015**) [Director of Governance]
The Trust should consider separating out the number of hospital-acquired pressure ulcers into specific wards so that action can be targeted accordingly.	We have been doing this for the past three years (it is required nationally too). The data can be viewed on request as reported to the CQC in our Factual Accuracy response to their draft report. No such data was requested during the inspection visits. The Trust Board will continue to monitor pressure ulcer information at specialty level, adding a further data item to our Board reports for any ward reporting more than one pressure ulcer in a given month. **(June 2015)** [Chief Nurse]
The Trust should investigate further ways of improving communication for women who do not understand English.	We have a full translation service in place presently. In addition we are going to review maternity information for patients to see what gaps can be identified. We will also develop a range of audio-visual support guides. We will identify best practice from other areas and work with different community groups to make sure our information is comprehensive and available in the right formats and languages. **(October 2015)** [Director of Communications]
The Trust should ensure that staff who are expected to translate are provided with the skills required to carry out this function well.	None of our staff are 'expected' to translate. We will monitor the scale and use of Language Line for immediate interpretation, and work with staff to see how this, and electronic translation material may help us. The use of relatives will only arise when absolutely necessary. Our training budget will provide some scope to support employees learning relevant local languages to support initial communication with patients. **(June 2015)** [Chief Nurse]

Maternity and Gynaecology [3/3]

What the CQC has told us we need to improve
How we are responding

The Trust should consider improving how the outcome of an investigation and resulting action are communicated to complainants.

Improving complaint response times, complainant's reported satisfaction with the process and reducing subsequent complaints are priorities at Board level in the Trust – complaints are falling. We are aiming to resolve more complaints through face to face resolution meetings. All complainants receive a detailed written response scrutinised at executive level.

We are introducing new approaches to try and involve complainants in examining whether our actions to tackle the issues they highlighted have been effective. **(October 2015)**

[Director of Governance]

The Trust should consider updating all midwifery staff about the rationale and outcomes for 'high-risk' women who choose to give birth at the midwifery-led units, so that all staff can be confident that the maternity service promotes the best emotional and physical outcomes for women and babies.

The dataset implied by the CQC will be routinely shared within maternity services over the coming year **(October 2015)**

[Chief Operating Officer]

The Trust should consider ensuring that all risks and issues of high concern are included on the corporate risk register to ensure that senior directors are aware of the progress in reducing and managing the risk.

- All group risk registers are reviewed at the Executive-led Risk Management Committee. Risks are escalated as appropriate to our Clinical Leadership Executive and to the Trust Board. Three Executives are members of the Risk Management Committee and have sight of these registers (all our registers are now published on our Trust Intranet).
- A list of all pre-mitigated 'red' rated risks is shared with our Clinical Leadership Executive and the Trust Board.
- We will make this our standard every three months**. (June 2015)**

[Director of Governance]

The Trust should find a way of increasing feedback about working for the Trust from obstetric and midwifery staff.

- We run the largest staff survey programme in the NHS, asking teams their views every three months. We openly encourage staff to share their feedback about working for the Trust. In March we ran a second series of "Time2Talk" open staff sessions with our Chief Executive and Executive Team for employees to raise any issues of concern or hear about the work of the Trust. We share the CQC's concern about low engagement among our midwives.
- We will hold a specific open event for the Women and Child Health group in May 2015. **(June 2015)**
- We will use the Kirkup Review, within our Quality Improvement Half Days, to develop a specific response plan for maternity services at the Trust. **(June 2015)**

[Director of Organisational Development]

End of Life Care

What the CQC has told us we need to improve	How we are responding
The Trust should schedule repairs to the previously reported cracked concrete floor in the mortuary. This presented an infection control risk and did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance	This was resolved in December 2014 (i.e. before the report was received by the Trust) **(March 2015)** [Director of New Hospitals]
The Trust should review the hospital discharge processes. These have an impact on patients' ability to achieve their preferred place for end of life care and fast-track discharges. This is contrary to national best practice guidance including *One chance to get it right*, Department of Health, 2014	We have made significant progress on this issue over the last three years. A Trust-wide piece of work, led directly by the Trust Board, will analyse the last year of life of palliative patients for additional improvements. When we have the outcome of that audit the Board will oversee a focused improvement plan in this area. This is identified as a priority in our Annual Plan for 2015-16**. (October 2015)** [Chief Operating Officer]
Review how the reduced chaplaincy services can continue to provide a caring and responsive service to patients when required. The reduction in these services is contrary to national guidance including the NICE *Quality standards for end of life care*, 2011, updated 2013.	The chaplaincy service was included in the staffing consultation undertaken in October 2014. In November 2014 we took the decision not to proceed with changes outlined in that consultation. There will be denominational changes, but we remain consistent with the guidance cited, and guidance issued last month to the NHS as a whole. **(March 2015)** [Chief Nurse]
The Trust should ensure processes are in place to ensure that doctors consistently complete 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms correctly in line with national guidance published by the General Medical Council.	• Using our extant IT system which centrally records those inpatients with a DNACPR order, we will comprehensively test, ward-by-ward, week-by-week, whether we have accurate information held locally. This analysis will be made available on an ongoing basis to the Chief Executive, and through him to the Board. **(October 2015)** • In March we launched a 'OK to ask' campaign to support staff in challenging behaviours. This asked teams to examine whether at local level they know the DNA CPR status of all their patients. **(March 2015)** [Chief Nurse]

Outpatients and Diagnostic Imaging [1/3]

What the CQC has told us we need to improve
How we are responding

The Trust should ensure that communications to staff about workforce changes are timely, clear and consistent.

The CQC visited the Trust during a consultation period, accordingly proposals were developing and being developed based on feedback.

Having examined the specific outpatient and diagnostic imaging concern it is clear that open team meetings were sparse in some areas. The introduction of Quality Improvement Half Days from April 2015 should resolve this issue in key clinical support departments. We will use Your Voice to test the outcome. **(June 2015)**

[Chief Executive]

The Trust should ensure that the outpatient risk register captures all known risk issues.

The publication of the risk register online from December 2014 will allow all staff in all departments to check the accuracy of entries.

The new Quality Improvement Half Days commencing in April 2015 will provide an opportunity for multi-disciplinary review and learning regarding potential and actual risks. **(June 2015)**

[Chief Operating Officer]

The Trust should ensure that support for people with dementia and learning disabilities is available in the outpatients department.

November 2014 was learning disabilities month Trust-wide. This was an opportunity to promote Reasonable Adjustments in all clinical areas. We have asked Changing Our Lives to examine our practice for LD and advise us on any further changes and improvements required. **(June 2015**)

We are actively exploring how to put memory loss scoring methods into key relevant outpatients departments. Part of that work will be providing additional training and support to outpatient staff. **(October 2015)**

[Chief Nurse]

The Trust should ensure that the planned review to assess the current and future capacity in outpatients is undertaken urgently so that the findings can inform the current change programme

It is not factually accurate to state that the staffing consultation in October 2014 took place without an understanding of future capacity.

Our annual capacity planning exercise, using the Intensive Support Team template, is being finalised. This will be the basis for distinguishing backlog supply from routine capacity. We will monitor volumes against this capacity quarterly **(June 2015).**

[Chief Operating Officer]

Outpatients and Diagnostic Imaging [2/3]

What the CQC has told us we need to improve
How we are responding

The Trust must maintain adequate records regarding the qualifications and training of imaging department staff.	The Trust must ensure guidance be available for imaging staff regarding exposure parameter guidance or information surrounding expected dose values.
We hold full records already on qualifications of imaging staff and have extensive training in place. Full competency assessment records were found to be missing and we have an action plan in place that we submitted to the submitted to the CQC in November 2014 that will ensure we are fully compliant by **March 2015** (three months ahead of the compliance notice sent to us in January 2015 for resolution by July) – March 2015. [Chief Operating Officer]	This was largely in place at the time of the CQC visit and is now fully implemented. **(March 2015)** [Chief Operating Officer]
The Trust should ensure that, when complaints about outpatients are resolved at the time they arise, records are kept so that lessons can be learned from the incidents.	**The Trust should ensure that urgent action is taken to improve the privacy of patients in the eye clinic.**
We will introduce a simple proforma to capture these resolutions and share the results across all Outpatient Departments through our Quality Improvement Half Days **(October 2015).** [Director of Governance]	This features explicitly on the corporate risk register, which was provided to the CQC, along with evidence that this has been resolved at Board level. The delay in implementation is because we need to move a third party occupier, which we are working to resolve. **(October 2015)** [Chief Executive]

Outpatients and Diagnostic Imaging [3/3]

What the CQC has told us we need to improve	How we are responding
The Trust should ensure that urgent action is taken to improve the confidentiality of patient records in outpatients, and that patients' privacy and dignity are maintained at all times.	Our all-areas audit and "speak up amnesty on local storage arrangements" will be complete by the end of April 2015. Remedial changes will be put in place in May and June. **(June 2015)** Additional information governance publicity and training has been distributed organisation wide to encourage awareness of risks **(March 2015)** New lockable trolleys and other storage containers have been procured and will be fully deployed in coming weeks **(June 2015**) [Director of Governance]
The Trust should provide Safeguarding adults level 2 training to all staff who run clinics and are likely to have contact with vulnerable people.	Training is provided on the basis described. However, our mandatory training policy distinguished face to face from cascade training. This has now been revised. **(March 2015)** [Chief Nurse]
The Trust should improve staff understanding and knowledge of responsibilities regarding the Mental Capacity Act 2005.	Mental Capacity Act training and Deprivation of Liberty training is included within Safeguarding Level 2 training. We will update training packages for staff and monitor who has been trained, making sure that people keep up to date with their training and knowledge of this important area. **(June 2015)** [Chief Nurse]

Community Services: Children and Young People

What the CQC has told us we need to improve
How we are responding

The Trust should have an alerting system for missing children, with links to the MAPPA Multi Agency Public Protection Agency (MAPPA) and multi-agency meeting processes in place to discuss missing children.

We already have this in place through the MASH (multi-agency safeguarding hub) The Safeguarding children's policy review and dashboard will be updated with this detail**. (March 2015)**

[Chief Nurse]

Community Services: Inpatients

What the CQC has told us we need to improve	How we are responding
The Trust should ensure sufficient numbers of staff in the early evening and at night.	Staffing levels were examined as part of the establishment review which was taking place when the CQC visited the Trust. That review concluded that additional qualified night staff should be added to the ward roster. This has been implemented, using agency staff where vacancies currently prevent full cover**. (March 2015)** [Chief Nurse]
The Trust should ensure sufficient supply of hoists resulting in people not having to wait to be transferred at busy times (for example, after meal times and at bed times.)	This recommendation was reviewed on receipt. The local 'frontline' staff teams have examined it. They then met with the Chief Executive and recommended no action was taken. That recommendation has been accepted. **(March 2015)** [Chief Operating Officer]

Community Services: Adults

What the CQC has told us we need to improve	How we are responding
All out-of-date stock should be removed from clinical areas. The Trust should put processes in place to identify and remove out-of-date stock.	We already have processes in place to do this and will check the compliance in community locations, reporting this to the Board. **(June 2015).** [Chief Nurse]
The Trust should ensure that medication is stored appropriately.	We have begun procurement of sufficient automated dispensaries to cover all our wards **(June 2015)** [Chief Nurse]
The Trust should ensure that community staff are supplied with appropriate equipment when providing care at low levels.	The intermediate care wards have hoists to transfer patients. We also have other equipment available to support patient's rehabilitation. We will complete an equipment inventory for community teams to make sure the right equipment is available at the right time. **(June 2015)** [Chief Operating Officer]
The Trust should complete recruitment processes to fill vacancies across the organisation in a timely fashion.	We monitor the time it takes to recruit staff and fill vacant positions. Currently this takes on average 18 weeks. Meanwhile our completed staffing review means that we can, from April 2015, reduce the time it takes for pre-authorisation on recruitment. It is worth noting that some vacancies are held in a planned way to provide opportunities to 'at risk' colleagues to ensure equality of opportunity. We are revising band 4-6 notice periods to reduce the risk of gaps, in line with practice elsewhere in West Midlands **(March 2015**). [Director of Organisational Development]

Community Services: End of Life Care

What the CQC has told us we need to improve	How we are responding
The Trust should ensure safe staffing levels, particularly at pick-up and drop-off times and times of absenteeism, such as training, annual leave and sickness	A full review of staffing and rostering models at Bradbury Day Hospice will be complete by May 2015 **(June 2015)** [Chief Nurse]
The Trust should ensure adequate registered nurse staffing levels on night shifts at the Leasowes Intermediate Care Centre.	Staffing levels were examined as part of the establishment review which was taking place when the CQC visited the Trust. That review concluded that additional qualified night staff should be added to the ward roster. This has been implemented, using agency staff where vacancies currently prevent full cover. **(March 2015)** [Chief Nurse]
The Trust should ensure a variety of activities provided on a daily basis.	An audit of activities, and survey work on client's views of them, will be completed by the end of May 2015**. (June 2015**) [Chief Nurse]
The Trust should ensure reliability of ambulance transport.	Ambulance reliability will be monitored and reported to the End of Life Care group (chaired by the Chief Nurse) for six months, so that we can make sure improvements have been made, if that is necessary. **(October 2015)** [Chief Nurse]

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Response to the Francis Report – end of year stocktake**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Kam Dhami, Director of Governance**
DATE OF MEETING:	**2 April 2015**

EXECUTIVE SUMMARY:

In December 2013 the Board 'signed off' the Trust's response to the recommendations made following the Francis Inquiry and associated reviews. The actions arising were themed into eight categories mirroring chapters in the Francis Report, each one having a clear aim and overall achievement measure.

Work to implement actions remains on-going, with progress reported and monitored at various Board and Executive fora.

The attached paper provides an end of year update on all eight themes:

- Effective complaints handling
- Accurate, useful and relevant information
- Medical education and training
- Compassionate, caring and committed nursing
- Getting fundamental standards right
- Caring for the elderly
- Creating the right culture with values that put patients first
- Openness, transparency and candour

REPORT RECOMMENDATION:

The Board is asked to note and discuss the progress made.

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

Accept	Approve the recommendation	Discuss
X		

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

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

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

Supports the Trust's plans to improve quality & safety

PREVIOUS CONSIDERATION:

The Trust Board last discussed the response to the Francis recommendations at its meeting in October 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Our response to the Francis 2 Report

2014-2015

Full Year Report

Where EVERYONE Matters

Effective complaints handling

Aim	Measure	Position as at end of March 2015
All feedback from patients, whether it is concerns voiced on the ward at the time, or complaints made once they are back home, will make a difference. These will be taken seriously and lessons learned.	Linked complaint figures are reduced by 75% or more, and complaints raised with the Trust are responded to within 30 days consistently across our services. Staff report high levels of awareness of learning from complaints through Your Voice	Reopened (linked) complaint numbers are variable month on month. Numbers have not reduced as we encourage meetings following a written response. However, we are seeing less cases due to not answering all issues in the initial response. We are not yet consistently responding to all complaints within the 30 working days but continue to work towards this.

What we said we would do	What we have achieved this year and our future focus
• Introduce a devolved model of complaints investigation and management. • Publish the main issues patients complain about and what we are doing about them. • Publish themes, trends about compliments, concerns and complaints. • Inform individual complainants what we have learned and what we will do differently as a result of their complaint. • Proactively share details of complaints (suitably anonymised) with external stakeholders.	✓ A devolved model of complaints handling was introduced in November 2013 and is now fully operational. ✓ Lessons learned and changes made as a direct result of feedback received from complaints are included within the complaint response or at the complaint resolution meetings held. ✓ A database of 'lessons learned' has been developed so that this can be shared widely. ✓ The quarterly complaints report has been refreshed, with a greater focus on changes arising from complaints and emerging themes trends, and is presented at the public Trust Board. ✓ Changes are mostly made on receipt of the complaint and confirmed in the final response. ✓ Compliments and departmentally resolved complaints are better captured. ✓ Updates are provided to complainants about actions which have a future date. ✓ There has been a consistent reduction of those who return because we have not responded to all of their queries with an average of 2 a month. **Focus in 2015/16** ▶ Except where complex cases require extended investigation, complaints will be consistently responded to within the 30 working day target. ▶ The number of complainants returning because all issues were not addressed will be less than 10% of all reopened cases. ▶ We aim to increase the number of complaints resolved through meetings. ▶ Develop a suite of reports to inform staff and patients about our complaint handing and lessons.

Accurate, useful and relevant information

Aim	Measure	Position as end of March 2015
Ensuring a culture where the quality of data is viewed as important by all staff providing as well as those using data with a known framework and assurance systems in place for delivering accuracy	Using the RAG rating system applied to each KPI within the IQPF report, ensure that the system of assurance and improvement of data quality delivers not less than an annual 25% reduction in red RAG rated	We have a kitemark system adopted by the Board with CCG support in place. We must agree in preparing for our 2015-2016 internal audit plan a prioritised list of areas to be assessed and improved.

What we said we would do	What we have achieved this year and our future focus	
• Replace the current quality performance reports with an integrated report. • Develop a system to provide an assessment of data quality so that the reader can understand whether weaknesses exist in terms of the robustness of the source and consistency. • Undertake rolling systematic audits of data quality, with various factors taken into account when ranking data quality. • Improve systems which provide effective real time information on the performance of each service, consultant, teams in relation to mortality, morbidity, outcome and patient satisfaction. • Make available to stakeholders in as near "real-time" as possible, results and analysis of patient feedback.	✓ An integrated report provides Group and directorate level analysis as well as Trust-wide views. A revised finance report will be integrated into that single document after Baker Tilly report. ✓ Completed our initial DQ audits across national indicators including IM metrics. This has led to data collection changes in diagnostics, 18 weeks, theatres and ED. ✓ Committed to a single organisational taxonomy in which data will be analysable at team, directorate, group and Trust level. We have further work to do now to chase that ambition down and make it real. ✓ The basis for real time feedback on patient views is to be the new Connect. That product has now been delayed for some time. ✓ A single group level report will go to the Board which includes remedial actions where we have deviation.	✓ A single integrated performance report is available at Directorate, Group and Trust level monthly. This includes annual plan, national contract, mandate and local SLA indicators, as well as others identified at the start of the year ✓ This report is widely shared within the organisation, including in support of Quality Improvement Half Days, and the performance cycle **Focus in 2015/16** ▶ All workforce, finance and quality data needs to migrate to electronic availability by working day 8 of the month ▶ Data quality focus will be as directed by the executive group and Audit and Risk Management Committee

Medical education and training

Aim	Measure	Position as at end of March 2015
Hearing the voice of doctors in training at every level of the organisation for improving the learning from complaints and incidents, ensuring they have the knowledge, skills and attitudes that equip them as champions for safety throughout their career.	Junior doctors report high engagement scores at JEST feedback. Involvement of junior doctors in the safety management of patients including – increased reporting of incidents, increased involvement in investigations, table top reviews and trust governance meetings. Engagement with safety processes such as the WHO check list and VTE assessment. Junior Doctors as vocal champions for patient safety – appointment of 'Chief Resident	Trainee recommender index: aggregate score 91.4% - all tiers above 90%+. A baseline score for incident reporting in 2014-2015 will be compiled, with a focus in Q1 and Q2 on increasing reporting rates among trainees. Appointment of Chief Resident will proceed from autumn 2015 subject to affordability considerations.

What we said we would do	What we have achieved this year and our future focus	
• Encourage openness on the part of medical trainees in relation to raising concerns and provide protection from any adverse consequences. • Junior doctors to routinely participate in the Trust's mortality and morbidity reviews. • Develop new ways in which to tap into the latent energy of junior doctors	✓ We hold regular junior doctor's forums – which take place monthly and alternate between the two hospitals. These are led by the clinical tutors and are attended by the Medical Director ✓ We have involved junior doctors in the design and implementation of the 'Last Year of Life' audit. Junior doctors are routinely involved in specialty M&M meetings ✓ We have developed a role description for the 'Chief Resident' and have had approval in principal from Health Education West Midlands for the post to be part time training or OOPE	**Focus in 2015/16** ▶ Ensuring strong trainee attendance at, and voices within, the Quality Improvement Half Days ▶ Working through operational managers to ensure that rota and line management of trainees within directorates is clear and functional ▶ Emphasis on trainee involvement in incident reporting Trust-wide, including feedback from what changes as a result ▶ Making sure that handover arrangements in all disciplines meet best practice expectations set out professionally

Compassionate, caring and committed nursing	Aim	Measure	Position as at end of March 2015
	Patients can be confident of receiving the highest quality, knowledge based care, delivered consistently with compassion by caring and competent nurses.	National inpatient survey reports high levels of patient confidence in our nursing staff – improvements of 10%+ on base - and complaints associated with nursing staff attitude or communication are halved over two years	Fall in number of complaints related to nursing from 7% to 5% (despite overall complaint fall). CQC confirmed all Trust services as caring. But survey methods still show significant issues with 'patients talked about' not with.

What we said we would do	What we have achieved this year and our future focus	
• Patients will know who is caring for them through assignment of a key nurse who will co-ordinate care. • Participate in the 'Care Makers' campaign to embed the 6 Cs in practice. • Further embedding QUEST (an on-line competency framework) and expansion of clinical MOT. • Introduce a process of sharing information with patients and carers on staff on duty, per shift and by grade. • Strengthen the nurse recruitment process to incorporate a more values based assessment. • Develop ways to harness the loyalty and innovation of student nurses, so they become ambassadors for their hospital and for promoting innovative nursing practice. • Ward nursing leaders are visible and accessible to patients and carers out-of-hours. • Ensure nursing care provided consistently meets minimum quality standards.	➢ Every patient is assessed on admission by a registered nurse and this nurse remains as their key worker throughout their stay. ➢ QUEST is now firmly embedded into the competency programme and is a requirement to be achieved before nurses can apply for their hospital badge. The number of Clinical MOT sessions has doubled as a consequence of relocating the clinical team ➢ E-rostering is available throughout the Trust and this allows sight of the staff on duty by the hour. In addition each ward displays the breakdown of staff on duty for all to see ➢ The first value based recruitment event took place in May for THE recruitment of newly qualified staff nurses and was very successful. The second event took place in October. ➢ AA global Trigger tool has been developed and piloted – to provide assurance about care being delivered but also to identify areas that may need careful monitoring for signs of deterioration ➢ We have developed a safety tool checklist, Ten out of Ten	➢ The Focussed Care policy has been reviewed and re-introduced with special attention on the care needs of patients with Dementia and the best way to assess risk and manage it. **Focus in 2015/16** ▶ Embedding fully staffed rotas agreed by the Trust in January 2015, whilst keeping the sufficiency of those staffing levels under review ▶ Implementing our new appraisal policy across HCA and qualified nursing teams, supported by the promises in our forthcoming Education Plan 2015-2018 ▶ Tackling community caseloads in line with our annual plan 2015-2016 ▶ Tracking with Friends and Family our progress in addressing communication issues at local team level

Getting fundamental standards right

Aim	Measure	Position as at end of March 2015
Through an accountability framework ensure fundamental standards are delivered in a standardised way, reducing variability in practice. Through a culture and behaviour which strives for best practice, service development improvement plans will be in place to ensure best practice.	Outcome variation between sites and between in/out of hours is substantially reduced in emergency care and is in the national upper quartile	We have made progress with our 7-day plan. The site mortality gap has narrowed. The re-admission gap has not yet closed, and tackling re-admission at Sandwell remains part of our Annual Plan for 2015-2016 – in our Top Ten. A review of out of hours rotas continues and will be presented to the Executive by the end of Q1 for action.

What we said we would do	What we have achieved this year and our future focus	
• Identify key areas of practice for development of standard operating procedures. • Improve the consistent application of existing standard operating procedures. • Review all relevant Quality Standards and produce a 'gap' analysis and associated development plans in line with commissioning requirements as part of the contracts	✓ Invested in staffing in emergency care and imaging to ensure common wait time standards between our acute sites ✓ Led by Medical Director acted to tackle chemotherapy variations between our units, work which will complete in 2015-2016 ✓ Commenced work on current out of hours rotas, and on Midland Met rotas, to try to create an improvement trajectory from here to there ✓ Begun work to develop three year Safety and Quality plans, which will define our improvement ambitions for the 2015-2018 period	**Focus in 2015/16** ▶ Tackling re-admission at Sandwell and reducing the headline rate by 2% ▶ Tracking our 7-day service checklist and ensuring equity of access across our two acute sites ▶ Completing our baseline audit of, and action plan for, out of hours care – both inputs and outcomes ▶ Tackling postcode variation in community services where practice and resident populations diverge

Caring for the elderly

Aim	Measure	Position as at end of March 2015
A culture where older patients are valued and listened to and are treated with compassion, dignity and respect.	Age sensitised analysis of complaints, satisfaction, incidents shows no material disadvantage to elderly patients.	Dementia friendly environments in place at ward level. But more work to do on day-care provision. Frail-safe project provides basis for improved care, with work to do on surgical experience of older adults beyond orthopaedics. Focus on mental capacity highlighted by the CQC.

What we said we would do	What we have achieved this year and our future focus	
• Develop our frail elderly services in partnership with SWB CCG in order to ensure safe, high quality care, early senior assessment , alternative pathways to admission where clinically appropriate, integrated care and supported discharge • Work with staff and patients / carers to decide on how the money secured (£904k) from the DH '*Enhancing the Acute Environment for Patients with Dementia*' fund is spent. • Implement the dedicated team to progress the dementia agenda to improve the patient and carer experience. • Development of a 'dementia survival guide' for staff (based on a version produced by staff at Worcester University) and an information folder for all wards and departments. • Review and update the 'Managing Challenging Behaviours' policy to reflect best practice**.** Standards of appropriate discharge to be set and effectively communicated and monitored. • Review current arrangements for ensuring consultant led care for every patient so that the patient and their supporters are clear who is in overall charge of a patient's care. • Patients will know who is caring for them and regular monitoring will be achieved	✓ Trust is one of 12 pilot sites for Frail-safe project through British Geriatric Society to identify optimal model for preventing avoidable admissions ✓ Standard care model now in place across older people's wards cross site. Recruitment ongoing for consultant team. ✓ Launch of Edna's Army has provided a first step in galvanising efforts of local third sector. Trust-wide volunteering programme has continued focus on these issues in all care settings. ✓ Focused care project shows powerful impact on 'specialing' practices within the Trust, which now needs to be sustained ✓ Launch of open visiting in January 2015 provides a basis for encouraging family contact through inpatient stay. ✓ August 2014 start of ADAPT pathway supports decision making around long term nursing home provision	**Focus in 2015/16** ▶ Complaints, and other data, continue to show issues in acute admissions pathway, where patients move through several teams. Need to ensure that advocacy in place for patients, including named nurses and consultants. ▶ Reach conclusions about the improvement trajectory for surgical admissions among older adults, to ensure good practice in orthopaedics now spread to other specialties. ▶ Pilot work in audiology and ophthalmology outpatients to improve dementia screening tool use in ambulatory settings ▶ Develop further work to support activities of daily living at early stage of admission, modelled on our stroke breakfast club.

Creating the right culture with values that put patients first

Aim	Measure	Position as at end of March 2015
Our patient promises are consistently delivered across all our services and our staff report that ours is a safe organisation in which they would choose to be treated, within a health and social care system that is integrated	Patient satisfaction with their care is substantially improved with '*Friends and Family'* rates above 80% - as staff morale and engagement improves (and we halve the proportion of disengaged employees)	Incremental but insufficient improvement in Friends and Family coverage and results. Employee engagement not improved during 14-15. Revised focus on these issues needed in 2015-2016.

What we said we would do	What we have achieved this year and our future focus	
• Raise the profile of the Trust values and promises and align more closely to workforce practices and training. • Reinforce the requirement to abide by the NHS values and Constitution in staff recruitment, selection, appointment, training and development. • Strengthen standard statements in job descriptions and contracts of employment requiring an express commitment from staff to abide by both the NHS values and the Constitution. • Incorporate the requirement to abide by the NHS values and Constitution into SLA templates and approaches to procurement. • Finalise the culture programme for the Trust's organisational development. • Introduce 'Your Voice', an employee on-line, survey of 2500 staff each month. • Launch the Patient Experience and Staff Engagement long-term strategy: Patient Knows Best. • Pilot the 'Patient Knows Best' electronic system in selected specialties. • Improve people's experience in outpatients (as this is where most have contact with the Trust) through implementation of eight outpatient standards. • Plans to be developed to reinforce leadership development in the Trust. • Introduce 360^0 degree appraisal for all staff, including Board members. • Expand existing staff reward and recognition schemes, ensuring awards criteria linked to the NHS values and Constitution. • Introduce arrangements to demonstrate to staff, patients and the public changes made as a direct result of staff and patient feedback.	✓ Emphasis on staff feedback has increased with use of Your Voice. This now differentiates teams who have responded from those with limited engagement ✓ Outpatient survey data has been widely used in developing our Year of Outpatients programme, with over 30,000 responses so far ✓ Leadership development work has emphasised patient voice, and how we act rapidly on concerns from patients ✓ Trust promises translated into multiple languages for use in our work, alongside clear leadership emphasis on super-diverse population served by the Trust	**Focus in 2015/16** ▶ Expansion of FFT to cover most Trust services, with inclusion of results in key performance management processes: Putting voice at the heart of our organisation's performance culture ▶ Introduction of new appraisal and leadership 360 work over the course of 2015-2016, alongside new-style Awards ceremony and revitalised Long Service Awards ▶ Publication of our Education Plan will support a clearer 'contract' with all employees which focuses on development and potential ▶ Our community development projects will be brought together, through the Board's Public Health Committee to test whether we have coverage across all relevant local stakeholder groups

	Aim	Measure	Current Position
Openness, transparency and candour	Everyone working in the Trust will be honest, open and truthful in all their dealings with patients and the public. Organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	Patients are given the truth in all cases when mistakes occur, whether serious or not. Performance measures that are meaningful to patients are widely published, including failings and corrective actions being taken	Trust focused on candour and ensuring Being Open applied consistently. Deployment of annual staff declaration will reinforce simple rules behind these principles. We have more work to do to encourage candour across the organisational hierarchy in our Trust.

What we said we would do	What we have achieved so far and our future focus
• Active promotion of Board meetings to encourage members of the public to attend. • Only necessary items to be discussed in the private sessions of Board meetings and for clear guidance on what is considered 'private' to be agreed. • Put in place a robust process to examine the aggregate analysis of incidents, claims and complaints to ensure all of this information is being triangulated effectively. • Introduce a formal framework to support organisational learning from reported incidents, claims and complaints. • Revise and re-launch the Whistleblowing Policy, making it easy and safe for staff to raise concerns. • Check that all serious incidents are disclosed to those affected in a timely manner, appropriately reported and investigated, with findings shared with those involved in accordance with the Being Open Policy. • Ensure all teams and services can demonstrate they share learning and the improvement or changes that have resulted.	✓ Only commercially sensitive or employee confidential items considered in private Trust Board meetings. ✓ When an incident, claim or complaints is reported the database used to record these is checked so that links are made between the three. Themes and trends are reviewed to see if they are consistent. ✓ A Learning Plan has been produced which outlines learning opportunities in place such as monthly learning alerts. ✓ Patient safety initiatives are shared across Clinical Groups / Corporate Directorates at the Patient Safety Committee and patient stories are presented to the Board. ✓ Heartbeat, our bi-monthly staff newsletter, includes a page devoted to 'learning'. ✓ No never events have been reported and we are capturing and investigating never event near misses. ✓ A revised Whistleblowing policy was launched in June 2015 and provides the option for staff to report a concern via an external company ✓ 'Being Open' following serious incidents is monitored and consistently shows over 90% compliance. **Focus in 2015/16** ▶ Introduction of 'protected time' Quality Improvement Half days to share lessons. ▶ Implement the Duty of Candour process to strengthen the quality of discussions after a serious incident. ▶ Develop targeted reports for Clinical Groups and directorates regarding claims, incidents and complaint themes.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Risk Register Update
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Mariola Smallman, Head of Risk Management
DATE OF MEETING:	2 April 2015

EXECUTIVE SUMMARY:

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.

This report provides an overview of high (red) risks which have been previously accepted by the Board for inclusion on the Trust Risk Register and includes lead Executive Director updates.

As at writing there are eight additional risks for Trust Board to review.

REPORT RECOMMENDATION:

- **REVIEW** the Trust Risk Register and updates provided by Executive Directors.
- **REVIEW** and **AGREE** whether the additional risks are included on 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 the risk register on a monthly basis.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Risk Register

Report to the Trust Board on 2 April 2015

1. EXECUTIVE SUMMARY

1.1 This report provides an overview of high (red) risks which have been previously accepted by the Board for inclusion on the Trust Risk Register. The current Trust Risk Register with lead Executive Director updates is at **Appendix A.** As at writing there are nine proposed additional risks for Trust Board to review:

- There is a risk that IT systems failure caused by a not fit for purpose Infrastructure results in operational disruption and potential patient harm.
- There is a risk that a not fit for purpose IT infrastructure will result in a failure to achieve strategic objectives and significantly diminishes the ability to realise benefits from related capital investments. e.g. successful move to paperlite MMH, successful implementation of Trust Wide EPR.
- There is a risk of failure of a trust wide implementation of a new EPR due to insufficient skilled resources in Informatics, significant time constraints (programme should have started earlier) and budgetary constraints (high risk that in adding the full costs of an EPR into the LTFM that there is insufficient capital for related and pre-requisite schemes - e.g. Infrastructure Remediation / MMH Infrastructure preparation / Business Plan schemes).
- There is a risk of a breach of patient or staff confidentiality due to inadequate information security systems and processes which could result in regulatory and statutory non-compliance.
- Not all shifts have an appropriately trained trauma nurse on duty due to a lack of nurses trained in ATNC or equivalent which could compromise the quality of care.
- Failure to provide tranexamic acid due to a lack of training and awareness of the need to provide it as a critical part of the patient pathway may result in death by haemorrhage.
- Delays in performing and reporting CT scans because of aging equipment may lead to delays in adequate treatment for trauma patients.
- Current reduced ability to provide an Interventional Radiology service as a result of difficulties in recruiting Interventional Radiology consultants results in delays for patients and loss of business.
- Clinical Groups are unable to transact basic business processes because of key person gaps resulting in performance delays and failures.

1.2 The RMC reviews and reports on high (red) risks to CLE on a monthly basis, including highlighting new risks or changes to existing risks. The CLE will update the Board on existing risks and escalate 'new' risks.

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

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

	particular activity.

2. PUBLICATION OF RISK REGISTERS ON CONNECT

2.1 Risk Registers (RR) held at Clinical Group and Corporate Directorate levels are published internally on Connect.

3. ELECTRONIC RISK REGISTER

3.1 The Risk Team are currently implementing an additional Safeguard risk register module during quarter 4. The system set-up fields are being populated and a pilot using Governance risk assessments and risk register is scheduled during March.

3.2 The Safeguard risk register module will provide an integrated risk register which will be able to report on risk themes, by different management levels, by risk scores, etc., which be visible to all staff from the Safeguard Incident Reporting Icon on Connect. Scheduled reports and reminders will also be developed.

3.3 Individual risk leads at ward / department, directorate and Group levels will be given access to read /write risk assessment data for their area(s) on the system. All other staff will be given read access to all risk registers. The Risk Team will have a temporary and limited resource to assist with the implementation of the system including provision of training/guidance to clinical group / corporate directorate risk leads.

3.4 Reporting of the Trust Risk Register to the Board will continue throughout the implementation of the electronic risk register system.

4. RECOMMENDATION(S)

4.1 The Board is recommended to:

- **REVIEW** the Trust Risk Register and updates provided by Executive Directors;
- **REVIEW and take a DECISION** whether the additional risks are included on the Trust Risk Register.

Kam Dhami, Director of Governance
2 April 2015

414MARWK03		Chief Executive	Workforce Strategy	Organisational (Strategic)	Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment reduction of 1400 wtes, 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. Previous update: A more detailed plan is being developed through CLE workforce committee, led personally by the Chief Executive. Will culminate in review at Board's Workforce and OD committee in September 2014. Update: Detailed plans for 14/15 and 15/16 in development due for implementation during Q3 and Q4 of 2014. Key planning assumptions for 2016 onwards in development.	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. Previous updates: 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. Update 21.11.2014 - outcome of review has been put on hold and no definitive outcome has been received due to data validation issue. No current timeline. Update 12.2.2015 Awaiting final decision from CCG Commissioners and the independent panel that has been set up to review the whole process. CCG have not confirmed a timeline or completion date.	Chief Operating Officer	TBC - Commissioner led review	Feb 15	Monthly	4	3	12
TRR1401COO01	Management review	Corporate Operations		Operational	Lack of assurance of standard process and data quality approach to 18 weeks.	4	4	16	Task and Finish Group established to oversee rapid improvement programme; SOP to be agreed and implemented in March for new processes; Elective access team structure to be reviewed; Central booking process to be strengthened to ensure real time data quality management; IST visit will inform work programme content. Previous update: New Waiting List Manager recruited and starting in July. Year of Out Patients programme will deliver automation to strengthen real time data. Plans to centralise elective access team in Q2. Data Validation Team still required - funding until end Q2. Perceived knowledge deficit in some services regarding 18 weeks - New Elective Access Manager to assess competency of teams and provide re-training in Q2. Progress: Timelines for assessment and training September to December and SOP / policy review in September	Chief Operating Officer	Jul-14	Sep-14	Jul-14	2	4	8

TRR1401COO02	Management review	Corporate Operations		Operational	Sustained high Delayed Transfers of Care (DTOC) patients remaining in acute bed capacity.	4	4	16	Joint working through joint discharge teams on both acute sites established; 7 day working pilot; Weekly urgent care call with Chief Executives and Chief accountable officers from LAT, CCG, NTDA, acute Trust and social services includes DTOC review, strategic and operational work; Commissioning plans for 7 day working in 2014 in train. Previous update: Additional capacity closed end July although DTOC remains high. Plan will remain in place to re-open additional beds if required and triggers are agreed and activated through Operations Centre and authorised by COO or on call Executive Directors. Resilience System Plan (winter) submissions includes additional beds in community and social care – outcome of funding decision to be agreed in July. This will impact on DTOC reduction. Work to establish a Joint Health Social Care assessment and discharge team continues – now in training phase for go live at Sandwell in August and then at City. Progress: DTOC numbers remain high. The System Resilience plan awaits clarification from Birmingham City Council on aspects of plan workforce and the re-ablement bed plan for the locality. New joint team with Sandwell is in implementation phase with good engagement.	Chief Operating Officer	Jun-14	Sep-14	Jul-14	2	4	8
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. Previous update: Rowley Max has been scoped and will be delivered in Year of Out Patients programme on track for completion Q2. Plans for relocation of oral surgery OP to enable ophthalmology to meet privacy and dignity standards in development with intention to complete in Q3. SGH outpatients privacy and dignity risk treatment plan stalled as dependant on Oral Surgery being relocated, which is still to be resolved Update 24.2.2015 Continuing to seek potential solution through re-location of Oral Surgery either off-site or to another SWBH location.	Chief Operating Officer	31/12/2015	Feb 15	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. Previous updates: 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. Current review of budgets and redeployment of resources. Monthly activity and staffing review of HDU care to be carried out and reported to paediatric clinical governance. Update: Monitoring in place; monthly reports to Clinical Directorate Governance Group and activity monitored through monthly directorate meeting	Chief Operating Officer	TBC	Dec-14	Monthly	3	4	12
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. 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. Previous Update: Direct access to agency booking approved by Chief Nurse 11.08.14 Update: Continue to monitor any incidents as they arise. Funding identified by the Mental Health Trust to provide both a Crisis Team and a Home Treatment team – both due to be in place January 2015, however funding is currently only available until end on March 2015.	Chief Operating Officer	TBC	Dec-14	Monthly	4	4	16

	Oncology Peer Review	Medicine	Scheduled Care	Operational	Oncology Service is currently unable to treat approx. 120 patients a month due to workforce issues.	5	4	20	Previous update: SLA with Royal Wolverhampton Hospital NHS FT to provide consultant AOS – 2 sessions to augment the 2 sessions provided by UHB Update: Provision of replacement locum through New Cross Hospital, Wolverhampton to provide Consultant AOS - 2 sessions to augment the 2 sessions provided by UHB. Update 12.2.2015. Locum secured through agency. Clinic modelling re: breast and lung taking place as per actions through Cancer Taskforce Group.	Chief Operating Officer	TBC	Feb 15	Monthly	3	4	12
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Trust non-compliant with Oncology Standards.	5	4	20	Previous update: Workforce and service design issues (hot clinics) to be negotiated through enhanced SLA with oncology provider. Meeting scheduled with QE for September. Intention is to agree model of service and agree workforce model and SLA for Q3. Developing nurse led services to see pre-chemotherapy patients – to mitigate oncology demand issues. Previous Update: Clinic Modelling and AOS proposal completed as a pre-requisite to negotiations with UHBFT re: SLA provision. Pilots to commence re: oral chemotherapy pharmacist role and rescheduling of chemotherapy in BTC. Update12.2.2015: Interviews for x 2 Band 6 AOS nurses taking place. IAP being completed for 7 day service through business planning process.	Chief Operating Officer	TBC	Feb 15	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	Previous update: Trust has extended discussions with UHB and executive led cancer futures workshop now scheduled for early September. Update: Workshop has taken place and proposal for oncology clinic model has been submitted to UHBFT. Update 12.2.2015: Awaiting reply from UHBFT re: model proposal. Cancer Action Taskforce Group working through actions and proposed model.	Chief Operating Officer	TBC	Feb 15	Monthly	1	5	5
201109DEL30	Risk Assessment	Womens and Child Health	Maternity	Clinical	The existing provision of a 2nd theatre team for an obstetric emergency.	2	5	10	Process to request opening of a second theatre in and out of hours for obstetrics is in place. Ongoing monitoring of any second theatre team issues through the incident reporting process. (Risk initially RED, downgraded to AMBER due to reduced frequency). Previous Update: TB has previously reviewed the risk and agreed it is to be tolerated. Update: Continued monitoring	COO	TBC	Nov 14	Monthly	2	5	10

TBC	Risk assessment	Women and Child Health	Maternity	Financial	Unpredictable birth activity and the impact of cross charging from other providers against the AN / PN tariff is significantly affecting the financial position of the service impacting on the affordability and quality provision of the service.	4	4	16	Previous Update: Maximise tariff income through robust electronic data capture. Review of activity and income data 6 months post BadgerNet roll out. Comprehensive review of maternity pathway payment system underway for presentation to FD. Update: Options appraisal from finance in progress which will be discussed between the Clinical Group Director of Operations and Director of Finance	Chief Operating Officer	Ongoing	Oct-14	Monthly	3	4	12
201501NYOBS02	Incidents	Women and Child Health	Maternity	Clinical	Breakdown of lifts risk delay in transfer in an emergency situation which could result in a catastrophic event for either a pregnant woman / unborn baby.	4	5	20	• A& E type stretcher in Delivery suite & ward available at all times. • When both lifts out try to utilise M1 as opposed to M2. • Notice displayed clearly when lift out of use. • Ensure frequent maintenance of each lift. • Ensure incident reporting to indicate frequency of lifts out of action. Update: Lift 11 repair completed; Lift 20 upgrade works will commence 7 April.	Chief Operating Officer	Ongoing	Mar 15	Monthly	2	3	6
PROPOSED ADDITIONAL RISKS																	

INFORMATICS002	Departmental Review	Medical Director's Office	Informatics Service	Organisational (Strategic)	There is a risk that a not fit for purpose IT infrastructure will result in a failure to achieve strategic objectives and significantly diminishes the ability to realise benefits from related capital investments. e.g. successful move to paperlite MMH, successful implementation of Trust Wide EPR.	5	4	20	Cause: (as per Informatics001) Risk Control: Infrastructure Stabilisation Programme Appropriate benefits realisation on the programme Clear identification of dependency linkage between key programmes / business objectives and underlying IT enablement	MD	Apr-16	Jan-15	Monthly	5	4	20	na

INFORMATICS003	Departmental Review	Medical Director's Office	Informatics Service	Organisational (Strategic)	There is a risk of failure of a trust wide implementation of a new EPR due to insufficient skilled resources in Informatics, significant time constraints (programme should have started earlier) and budgetary constraints (high risk that in adding the full costs of an EPR into the LTFM that there is insufficient capital for related and pre-requisite schemes - e.g. Infrastructure Remediation / MMH Infrastructure preparation / Business Plan schemes)	4	4	16	Cause - Significant time pressure to carry out a full EPR procurement and implementation in given time period prior to MMH opening - Significant dependency on underlying Infrastructure - Significant dependency on Informatics resource - Significant dependency on LTFM budget and capital allocation between EPR costs and other required capital schemes Risk Control - Hiring of a suitably skilled programme manager / external resource for EPR programme - As risk Informatics001 – a review of LTFM – to ensure appropriate funding - Completion of the formal procurement process – SOC / OBC / OBS at speed in attempt to claw back time required for implementation - Managerial and Board support for programme ensuring investment in infrastructure dependencies and required resource is given priority. - Management time will be given for programme elements (benefit realisation / change processes etc.) - Setup of appropriately manned programme board with strict governance and TORs - Development of a 'Plan B' to ensure that if there is any slippage (for example a TDA query / Legal challenge) there is an alternative and fully considered option.	MD	Nov-18	Jan-15	Monthly	4	4	16	na

INFORMATICS004	Departmental Review	Medical Director's Office	Informatics Service	Organisational (Strategic)	There is a risk of a breach of patient or staff confidentiality due to inadequate information security systems and processes which could result in regulatory and statutory non-compliance.	4	4	16	Cause: - Not fit for purpose Security Infrastructure which has been poorly managed and maintained - Poor skill sets within Informatics regarding Security / Information Security - No dedicated security manager within Informatics - Lack of time and resource spent on IGTK compliance within Informatics Risk Control - Increased investment required across security infrastructure – determinant on LTFM review. - Security manager required to bring immediate focus to upgrades, improvements and IGTK and best practice activities. - Review all NHS National mandates for Informatics and clinical systems and ensure compliance - Deep discovery activities required to bring out any 'under the cover' issues - End of XP and Windows 2003 support to be given higher priority to ensure issue is mitigated (windows 7 migration). This could involve the use of external consultancy companies to speed up the process.	MD	Oct-15	Jan-15	Monthly	2	4	8	na
COO1503001	Trauma peer review	Medicine and Emergency Care	ED	Clinical	Not all shifts have an appropriately trained trauma nurse on duty due to a lack of nurses trained in ATNC or equivalent which could compromise the quality of care.	5	3	15	All shift coordinators have ATLS qualifications. The Staff running the resus area particularly do not necessarily have trauma qualifications. The peer review team advised that these staff should have the Advanced Trauma Nurse Course (ATNC) or equivalent. The staff will be scheduled to attend training. In the meantime local trauma teaching will take place as a re-fresher session.	COO	30.5.15		monthly	2	3	6	na
COO1503002	Trauma peer review	Medicine and Emergency Care	ED	Clinical	Failure to provide tranexamic acid due to a lack of training and awareness of the need to provide it as a critical part of the patient pathway may result in death by haemorrhage.	3	4	12	Work programme in place to update trauma team procedures. Education activities underway. Data recording amendments facilitate interrogation of notes by data entry staff.	COO	30/05/2015			2	4	8	na

COO1503003	Trauma peer review	Imaging	Radiology	Clinical	Delays in performing and reporting CT scans because of aging equipment may lead to delays in adequate treatment for trauma patients.	3	4	12	Plan to replace CT scanner at City. Of all ED patients who require a CT scan, 98% are scanned within 1 hour. Trauma performance audit to be carried out to gain more certainty regarding performance as currently a lack of a specific flag for major trauma patients means the dataset is likely to be showing performance to be worse than it actually is. Develop appropriate mechanism for identifying trauma patients to aid both prioritisation and data analysis.	COO	Audit / patient flag - end April 15 New scanner - Q4 15/16	19/03/2015	Monthly	2	4	8	na
COO1503004	Clinical and operational	Imaging	Interventional radiology	Operational	Reduced ability to provide an Interventional Radiology service as a result of difficulties in recruiting Interventional Radiology consultants results in delays for patients and loss of business.	4	3	12	Extend search for locums; also consider recruitment from abroad. Develop collaboration with Dudley - supports service resilience and potentially better chances of joint recruitment. Immediate potential for joint appointment of fellow or specialist doctor. Explore options to develop extended roles for radiographer or nurse to cover some procedures. Revisit previous plans to consolidate services onto one site to make cover easier to manage.	COO	Appointment of fellow / specialist doctor; clear plans agreed for other actions - end Q1 15/16	19/03/2015	Fortnightly	2	3	6	na
CEO1503001		Corporate Operations		Operational	Clinical Groups are unable to transact basic business processes because of key person gaps resulting in performance delays and failures.	4	4	16	Executive Group weekly monitoring of recruitment processes; investing in high quality agency staff to cover gaps; peer support network set up by COO for exiting staff to buddy with high quality agency staff.	COO	30/06/2015	Mar 15	Weekly	4	3	12	na

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Safe Nurse Staffing
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Colin Ovington – Chief Nurse
DATE OF MEETING:	2nd April 2015

EXECUTIVE SUMMARY:

This report is an update using the data collected during February 2015.

The data from the national reporting system has been applied to our own expected staffing data to help understand our nurse staffing position.

Quality indicators have been presented alongside Medicine and Emergency care, and Surgery A to observe any connection between data about staffing and the impact of their care of patients. No real trends can be observed at this point in time but continued work on this will monitor any trending in the longer term. Additional quality indicators will be applied alongside the other clinical groups in the coming month

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Relates to our safety objectives and BAF

PREVIOUS CONSIDERATION:

Monthly report

FOR INFORMATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAFE NURSE STAFFING

Report to Trust Board on 2nd April 2015

1 EXECUTIVE SUMMARY

1.1 This report is an update using the data collected during February 2015.

1.2 The data this month has also had a number of quality indicators applied to the Medicine and Emergency Care group, and Surgery A.

1.3 The data from the national reporting system has been applied to our own expected staffing data to help understand our nurse staffing position.

1.4 Three wards were randomly selected by the information team to re test the staffing data for accuracy.

2 FEBRUARY 2015 POSITION

2.1 Table 1. is the output data from the national data collection for February 2015 which demonstrates that we achieve higher fill rates against our rota's in most areas. This month I have colour coded the average fill rates which are +/- 10%, in the first instance this is to bring to the attention of the senior nursing team where variances are and to help with forward planning. This may also help with the fuller understanding of where additional bank or agency staff are being routinely used. Higher levels of additional staff are consistently being used at night.

Table 1.

	Safe Staffing data return - Summary (Feb15)		Day				Night				Day		Night	
			Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff					
	Site Code	Site Name	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Nov-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2082.5	2122.167	569.75	590.9167	490.25	499.75	0	55.75	101.9%	103.7%	101.9%	0.0%
	RXK02	CITY HOSPITAL	26188.75	26959.63	15119	15017.5	14937	16194.5	6939	8142	102.9%	99.3%	108.4%	117.3%
	RXK10	ROWLEY REGIS HOSPITAL	3040.5	2955.25	3894	3722.75	1306.5	1463	1511.5	1800	97.2%	95.6%	112.0%	119.1%
	RXK01	SANDWELL GENERAL HOSPITAL	29371	30796.57	18168.5	19839.58	15566	17377.82	7733	11116.5	104.9%	109.2%	111.6%	143.8%
	Total		60683	62834	37751	39171	32300	35535	16184	21114	103.5%	103.8%	110.0%	130.5%
Dec-14	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1963.75	1844.167	554	471.5	518	465.5	0	139.25	93.9%	85.1%	89.9%	0.0%
	RXK02	CITY HOSPITAL	26367.75	26839.52	15860.5	15872.08	15638.5	16717.67	7044	7930	101.8%	100.1%	106.9%	112.6%
	RXK10	ROWLEY REGIS HOSPITAL	3280	3003	3634.5	3553.5	1262.5	1255.5	1501.5	1622.5	91.6%	97.8%	99.4%	108.1%
	RXK01	SANDWELL GENERAL HOSPITAL	30676	30848.75	17822	19391.08	16710.5	17467	8177.017	10390.08	100.6%	108.8%	104.5%	127.1%
	Total		62288	62535	37871	39288	34130	35906	16723	20082	100.4%	103.7%	105.2%	120.1%
Jan-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2123.25	2227.333	505.5	492.25	582.75	555	129.5	157.5	104.9%	97.4%	95.2%	121.6%
	RXK02	CITY HOSPITAL	30328.5	30574.63	15962.5	15937.82	18989.5	20653.42	7731	8767.25	100.8%	99.8%	108.8%	113.4%
	RXK10	ROWLEY REGIS HOSPITAL	2919	3183.5	3472.5	3411.5	1333	1558.5	1429	1542.25	109.1%	98.2%	116.9%	107.9%
	RXK01	SANDWELL GENERAL HOSPITAL	29286.5	30702.12	17609.5	19883.43	16561.5	18341	8455	11660.25	104.8%	112.9%	110.7%	137.9%
			64657	66688	37550	39725	37467	41108	17745	22127	103.1%	105.8%	109.7%	124.7%
Feb-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1867.25	2053.5	464.5	462	490.25	518	129.5	101.75	110.0%	99.5%	105.7%	78.6%
	RXK02	CITY HOSPITAL	27390.25	27677.75	14544.5	14620.48	17409.5	18193.92	6915.5	7414.25	101.0%	100.5%	104.5%	107.2%
	RXK10	ROWLEY REGIS HOSPITAL	2542	2743.25	3000.5	3185.5	1194.5	1192	1457.5	1407	107.9%	106.2%	99.8%	96.5%
	RXK01	SANDWELL GENERAL HOSPITAL	25298.5	27136.1	14521.5	16240.82	14720	16798	7292	9867.25	107.3%	111.8%	114.1%	135.3%
			57098	59611	32531	34509	33814	36702	15795	18790	104.4%	106.1%	108.5%	119.0%
3-month Avges	*RXK03*	*BIRMINGHAM MIDLAND EYE CENTRE (BMEC)*	*1984.75*	*2064.556*	*543.0833*	*518.2222*	*530.3333*	*506.75*	*43.16667*	*117.5*	100.2%	95.4%	95.7%	40.5%
	RXK02	*CITY HOSPITAL*	*28028.83*	*28124.59*	*15647.33*	*15609.13*	*16521.67*	*17855.19*	*7238*	*8279.75*	101.8%	99.7%	108.0%	114.4%
	RXK10	*ROWLEY REGIS HOSPITAL*	*2913.667*	*3047.25*	*3667*	*3562.583*	*1300.667*	*1425.667*	*1480.667*	*1654.917*	99.3%	97.2%	109.4%	111.7%
	RXK01	*SANDWELL GENERAL HOSPITAL*	*28420.33*	*30782.48*	*17866.67*	*19704.7*	*16279.33*	*17728.61*	*8121.672*	*11055.61*	103.4%	110.3%	109.0%	136.2%
	Total	*Latest 3 month average====>*	61348	62945	35984	37841	35137	37905	16754	20333	102.6%	105.2%	107.8%	121.3%

Table 2. demonstrates the expected numbers of registered Nurses and Health Care Support staff we plan to be on our rosters over the 24 hour day using the newly agreed nursing establishments for medicine and emergency care wards, and the surgery A wards. Quality indicators have been applied alongside the staffing data in order to explore any connections between staffing and the impact of their care for patients. This is the first time this has been done against the safer staffing data and does require further attention to get consistency in data collection, and observing for trends over time. It is difficult to make any real conclusions from the exercise for this month, with this data set. Lyndon 4 has the highest level of additional fill rate on their staffing roster and equally has the highest level of vacancy and one of the highest sickness records. The wards with NR (No Record) applied to indicators are being addressed by the Group Directors of Nursing

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 February 2015	Percentage night time fill rate during February 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during February 2015	Percentage night time fill rate during February 2015	Vacancy WTE	Sickness%	PDR	mandatory training	falls risk assessment	Number of falls	waterlow %	Avoidable pressure sores graded 2 - 4	Nutrition Audit	Fluid balance audit	pain audit	10\10 completion	safety thermometer	Incidents	Compliments	Complaints	FFT	hand hygiene	Clostridium difficile	MRSA BSI
Medicine & Emergency care	D5	City	13	5	5	5	see	D7	1	1	0	see	D7	SEE D7				83	0	72.2	0	100	100	NR	100	100	10	2	0	100	NR	0	0
	D7	City	19	3	3	3	96.1	89.9	1	1	0	90.1	88.9	9.48	5.36	100	90.7	73	1	83.3	0	100	100	NR	100	100	6	0	0	92	87	0	0
	D11	City	21	3	3	3	108.6	118.5	2	2	1	102.7	85.4	4.64	NR	84.38	90.4	100	7	100	0	100	84	NR	100	100	3	0	0	74	97	0	0
	D12	City	10	2	2	2	93.9	90.7	1	1	1	81.6	81.7	1.8	14.39	33.3	87.6	80	2	60	0	80	90	NR	100	100	0	5	1	100	99	0	0
	D15	City	24	3.5	3.5	3	109.1	106.8	2	2	1	129.7	108.7	4.31	9.41	15	80.2	NR	0	NR	0	NR	NR	NR	100	100	0	5	1	97.6	0	0	0
	D17	City	25	3.5	3.5	3	98.4	111.2	2	2	1	95.9	98	6.1	8.71	25	83.6	63	2	68	0	63.1	89.4	NR	94	100	13	4	0	87.5	100	0	0
	D26	City	21	3	3	3	96	92.6	2	2	1	94	71.2	3.81	NR	90	79.46	80	4	100	0	93	54	NR	100	95.2	11	0	0	46	100	0	0
	AMU 1	City	41	10	10	10	95.5	122.2	4	4	4	93.2	102.6	0	NR	81.19	82.85	100	NR	100	NR	80	100	NR	100	NR	NR	NR	NR	NR	NR	0	0
	AMU 2	City	19	5	5	5	96	97.6	1	1	1	101.5	145	NR	NR	NR	NR	100	NR	100	NR	100	100	NR	100	NR	NR	NR	NR	NR	NR	0	0
	CCU Sandwell	Sandwell	10	3	3	3	92.8	110.6	0	0	0	100	0	0.5	6.89	100	93.77	100	0	100	0	100	100	NR	100	100	12	5	0	100	100	0	0
	PR4	Sandwell	25	7	7	7	97.3	98.4	3	3	3	100.1	136.7	NR	7.03	98	84.83	100	3	100	1	100	100	100	100	100	18	25	0	88	100	0	0
	PR5	Sandwell	34	5	5	4	99.2	94.5	3	3	2	88.4	106.4	2	4.97	95	79	98	2	98	2	97	100	99	94	100	2	12	1	93	97	0	0
	NT4	Sandwell	28	4	4	4	157.4	174.1	3	3	3	190.3	140.3	3.65	5.03	96	88	100	4	100	0	100	100	100	100	100	8	39	0	100	100	0	0
	LY 4	Sandwell	34	5	5	4	158.7	148.4	3	3	2	111	166.1	11.43	9.5	94	79	80	2	70	0	90	90	100	100	100	24	7	0	93.39	98	0	0
	LY5	Sandwell	29	4	4	4	92.2	87.8	4	4	2	98.6	142.8	2.12	9.89	92.5	77.54	80	3	75	0	90	85	100	87	100	32	10	1	33	96	0	0
	N5	Sandwell	15	5	5	2	101.2	100.1	1	1	1	95.7	0	4	5.09	100	92.1	100	2	100	0	100	100	100	100	100	7	14	1	NR	100	0	0
	AMU A	Sandwell	32	11	11	11	108	116.8	4	4	3	111.2	159.3	5	4.82	73	79	88	0	99	0	60	78.5	70	80	78.9	39	8	2	67	100	0	0
	AMU B	Sandwell	20	3.5	3.5	3	98.2	123.6	3	3	3	127.4	107.1	4	3.53	60.8	79.44	94	0	86.9	0	93	0	50	100	86.6	26	6	0	90	NR	0	0

	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 February 2015	Percentage night time fill rate during February 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during February 2015	Percentage night time fill rate during February 2015	Vacancy WTE	Sickness%	PDR	mandatory training	falls risk assessment	Number of falls	waterlow %	Avoidable pressure sores graded 2 - 4	Nutrition Audit	Fluid balance audit	pain audit	10\10 completion	safety thermometer	Incidents	Compliments	Complaints	FFT	hand hygiene	Clostridium difficile	MRSA BSI
Surgery A	D21	City	23	4	4	2	106.4	112.4	2	2	2	103.8	108.7	2.3	11.65	100	99.23	100	0	75	0	92	78	100	100	100	11	10	1	79	98	0	0
	D25	City	19	4	4	2	89.2	117	2	2	2	140	117.4	3	15.05	79.31	90.07	100	1	80	0	89	97	100	94	100	9	14	0		73	0	0
	SAU	City	14	4	4	3	110.5	112.1	1	1	1	114.2	118.6	2.45	6.54	100	93.81	100	0	80	0	100	81	100	100	100	NR	5	0	56	99	0	0
	N2	SGH	24	4	3	2	105.1	98.1	2	2	1	92.1	89.5	1	12.84	45.95	54.55	100	0	100	0	100	100	92	92	100	4	16	0	56	NR	0	0
	L2	SGH	20	6	6	4	86.8	115.2	3	3	2	90.4	103.7	2.1	6.37	92.86	91.61	50	0	66	0	82	80	100	100	100	9	21	0	53	95	0	0
	P2	SGH	20	4	4	2	97.9	116.1	3	3	2	113.5	136.8	4.4	12.84	93.1	84.05	88	0	85	0	100	95	100	100	100	NR	28	0	69	58	1	0
	N3	SGH	33	6	6	3	115.8	116.2	4	4	3	114.4	157.3	1.92	4.81	63.64	86.06	70	1	79	0	85	76	100	100	92	24	13	1	76	99.5	1	0
	L3	SGH	33	6	6	3	112.8	118.5	4	4	3	121.4	106.5	0	9.03	82.61	84.93	100	1	100	0	100	89	100	100	100	11	13	0	72	0	0	0
	CCS	City		Staff flexed to the dependency/number of patients in the units			104.9	98.5	Staff flexed to the dependency/number of patients in the units			100.3	0		6.68	83.61	93.2								NR			11	0	92	100	2	0
	CCS	SGH					101.8	105.6				94.7	0		9.38	87.72	91.72			0	0				NR			12	0	97	98	0	0

NR – No Record

Table 3 - The remaining groups have not as yet had quality data applied to the staffing data and this is work in progress over the coming month.

Table 3

Community & Therapies													
	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 February 2015	Percentage night time fill rate during February 2015	Morning HCSW expected	Afternoon/Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during February 2015	Percentage night time fill rate during February 2015
	Henderson	RH	24	3	3	2	130.1	96.3	3.5	3.5	2.5	132.5	88.1
	Elisa Tinsley	RRH	24	3	3	2	89.3	89.5	3.5	3.5	2.5	96.9	89.8
	D43	City	24	6	6	4	123.6	264	5	5	2	96.5	112.4
	Leasowes	RH	20	3	3	2	112.1	121.5	3	3	2	99.6	110.8

Surgery B													
	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 November 2014	Percentage night time fill rate during November 2014	Morning HCSW expected	Afternoon/Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during November 2014	Percentage night time fill rate during November 2014
	Eye ward	City	10	2	2	2	110	105.7	1	1	0	99.5	0

Women's and Children's													
	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 February 2015	Percentage night time fill rate during February 2015	Morning HCSW expected	Afternoon/Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during February 2015	Percentage night time fill rate during February 2015
	L G	SGH	14	3	3	2	150.6	142.8	1	1	1	318	0
	L1	SGH	26	5	5	4	109.2	150.6	3	3	2	135.3	119.1
	D19	City	8	3	3	2	110.4	98	1	1	0	107.1	0
	D27	City	18	4	3	2	100.4	103.8	2	2	1	105	138.5
	Maternity	City	42	6	5	4	101.9	102.9	4	4	2	93.3	100

3 RECOMMENDATION(S)

3.1 To continue to develop the application of quality indicators alongside the staffing data, and over time identify trends

3.2 To publish patient to RN ratio's on our public web site and on NHS Choices on a monthly basis as per national requirement.

3.2 To receive an update at the May Trust Board meeting

Colin Ovington

Chief Nurse

27th March 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Quality, Performance and Finance Report
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Mgt
AUTHOR:	Gary Smith, Head of Performance Management (acting)
DATE OF MEETING:	2 April 2015 (Report prepared 26 March 2015)

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period November 2013 – February 2015.

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
		x

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

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

February 2015

Contents

At A Glance

Infection Control

There were 4 cases of C. Diff reported during the month of February, 3 in Medicine and 1 in Surgery A. The number of cases for the month exceeded the trajectory, but the numbers for the year to date remain within the trajectory.

There were no cases of post-48 hour MRSA Bacteraemia reported during the month of February.

The incidence of MSSA Bacteraemia (expressed per 100,000 bed days) for the month of February remained around the same level. The incidence for the month and year to date remains well within the operational threshold.

Both MRSA elective and non-elective screening remain above the 80% target at 97.9% and 93.8% respectively for February.

Harm Free Care

Overall Harm Free Care as assessed through the NHS Safety Thermometer indicates a level of Harm Free Care of 94.6% for February, beneath the 95.0% operational threshold.

There were 64 falls reported in February, a decrease from the previous month (91) Of these 42 were in Medicine, 4 in Surgery A and 16 in Community.

The total number of hospital acquired, avoidable, pressure ulcers decreased to 12 (9 Grade 2, 3 grade 3) during the month of January.

There were 9 Open CAS Alerts reported at the end of February, non were overdue at the end of the reporting period.

Obstetrics

The overall Caesarean Section rate for February decreased to 22.4%, with Elective and Non-Elective rates of 5.6% and 16.8% respectively. The overall rate for year to date is 25.0% compared with an operational threshold of 25.0%.

Adjusted perinatal mortality rate (per 1000 births) increased during the month of February to 13.7, in excess of the target of 8.0 or less.

Quarterly breast feeding initiation was at 75.5% for Q3. Year to date is 75.3 just short of the 77% target

Mortality & Readmissions

Mortality Data is now extracted from the CHKS system which reports the Risk Adjusted Mortality Index (RAMI) as the principal measure of an organisations mortality. HSMR data is also available from CHKS, but currently only available at Trust level. SHMI data derived from HED, continues to be reported.

The Trust's RAMI for the most recent 12-month cumulative period is 85, which remains beneath that of the National Peer. City and Sandwell site RAMIs are 65 and 102 respectively.

Mortality rates for weekday and weekend and low risk diagnoses remain within statistical confidence limits. RAMI values for all CQC diagnosis groups are also within or beneath statistical confidence limits, other than 'Paediatrics and Congenital Disorders', which has an in-month RAMI of 4869, in excess of upper confidence limits.

During the most recent month for which complete data is available (December) the overall Trust performance for review of deaths within 42 days improved to 92.0%, compared with the trajectory for the period of 97.0%.

The Crude Mortality Rate for February is 1.6%.

Stroke Care & Cardiology

Stroke data for the month of February indicates Patients spending >90% of their time on a stroke ward remains above the 90% operational threshold at 97.9% for the month, Admittance to a stroke unit within 4 hours remains relatively stable at 83.3% (90% target) and all (100%) eligible patients received thrombolysis within 60 minutes of admission (target85%). Patients receiving a CT scan within 24 hours of presentation was 100% against a 100% target, with 77.6% patients receiving a CT Scan within 1hour of presentation.

Primary Angioplasty (Door to balloon time <90 minutes %) was 90.9%. for February against an 80% target. Primary Angioplasty (Call to balloon time <150 minutes %) was 100% for February against an 80% target. RACP percentage for February was 98.9% above the 98% target. 97.9% for the year.

Cancer Care

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

1 Group, Medicine, failed to meet 93.0% operational threshold for the 2-week maximum cancer wait with performance for the month of 91.2%

Women's and Children's missed the 31 day diagnosis to treatment target of 96% with performance during January of 86.4% (19 of 22 patients).

Surgery A, B and Women & Child Health Groups failed to meet the 62 day urgent GP referral to treatment target (85%) at 83.6% (28 of 33.5 patients), 66.7% (1.0 of 1.5 patients) and 77.3% (8.5 of 11 patients) respectively. Women&Child Health also failed to meet the 62 day referral to treatment from a hospital specialist at 75% (1.5 patient out of 2) against a 90% target.

Patient Experience - MSA & Complaints

There were no mixed sex accommodation breaches reported during the month of February.

In February the FFT Response Rate within ED has improved to 21% exceeding the operational threshold of 20.0% for the first time this year. The score in ED fell below the 46% target at 44% the first time this year.

The percentage of complaints exceeding the response date has fallen (improved) again to 49% in February. Further work is being undertaken to ascertain specifically where in the system delays are occurring.

The oldest complaint currently in the system is in Surgery A at 213 days

Patient Experience - Cancelled Operations

Cancelled Operations fell (improvement) to 0.7% during the month of February, against a 0.8% target. There were a total of 29 SitRep declared late cancellations reported, a fall from 36 during the previous month. Of the 29 cancellations, 13 were in Surgery A, 11 Surgery B and 5 in Women&Children's

There was one second or subsequent urgent operation cancellations in February in Women and Children's Group in the Gynae Directorate.

There were no 28 day breaches of the late cancelled operation guarantee reported during the month of February.

Emergency Care

The Trust did not meet the 4-hour ED wait target during February with performance of 91.02% for the month and 92.5% YTD (at February end). Current performance for March is 91.77% making 95% for March unattainable. Quarter 4 is 92.21% and Year to Date is 92.58% (all as of 24th March 2015).

Delayed Transfers of Care increased to 4.2% for the month (City 5.7%, Sandwell 3.1%).

The proportion of patients admitted with a Fractured Neck of Femur who received an operation within 24 hours of admission during February was 61.54% (8 of 13 patients), and 69.66% for year to date.

Referral To Treatment

Trust level Admitted and Non-Admitted RTT Pathway targets were not met for the month of February. The Incomplete RTT Pathway target was met.

2 patients waited more than 52 weeks for commencement of treatment on the RTT Non Admitted Pathway (1 x Ophthalmology and 1 x Neurology) and 1 patient was waiting for commencement of treatment on the RTT Incomplete Pathway in Urology.

23 Treatment Functions failed the respective RTT pathway performance thresholds for the month of February.

Diagnostic waits (February) beyond 6 weeks were 0.22%, compared with an upper operational threshold of 1.00%. Of the 20 patients waiting in excess of 6 weeks, 16 are in Imaging, 3 Surgery A and 1 Surgery B.

Data Completeness

The Healthcare and Social Care Information Centre (HSCIC) assess the percentage of Trust submitted records for A&E, Inpatients and Outpatients to the Secondary Uses Service (SUS) for completeness of valid entries in mandatory fields. All three parameters are above target. (latest data provided January)

The Trust's internal assessment of the completion of valid NHS Number Field within inpatient data sets remains below the 99.0% operational threshold, with actual performance (completeness) during February reported as 96.9%.

The Trust's internal assessment of the percentage of invalid fields completed in the SUS submission for Maternity records remains in excess of the operational threshold of =<15.0%, with a value for February of 38.79%.

Staff

PDR overall compliance as at the end of February improved to 84.3%. The range by Group is 76 - 93%. The Medical Appraisal and Revalidation Rate improved slightly to 89.1%.

Mandatory Training at the end of February stayed around the same level at 87.1% overall. The range by Group is 84 - 92%.

An update to your voice shows a decline in score from 3.57 to 3.55 (Lowest Finance 2.77 to highest Immunology and Maternity at 3.98). Response rate stayed the same at 12.7% (Lowest Maternity 3% to highest Governance 52%)

Sickness Absence still remains high at 5.27% for February, and 4.65% for the 12-month rolling period. (Range by Clinical Group during February is 3.46% to 6.9% and by Corporate Directorate 1.75% to 6.67%).

CQUIN

In summary, 20 schemes are classified as performing, with the remaining 2 underperforming.

Underperforming schemes are 1) Medication and falls 2) Community Dietetics. Further detail is contained within the CQUIN section of this report.

To date three confirm and challenge meetings have been held with scheme leads. Community Dietetics has been subject to detailed discussion with CCG leads, with a revised implementation plan and payment profile having now been agreed. Confirmation has been received from Specialised Commissioners that all 4 schemes have been fully achieved for Q3, and payment criteria satisfied.

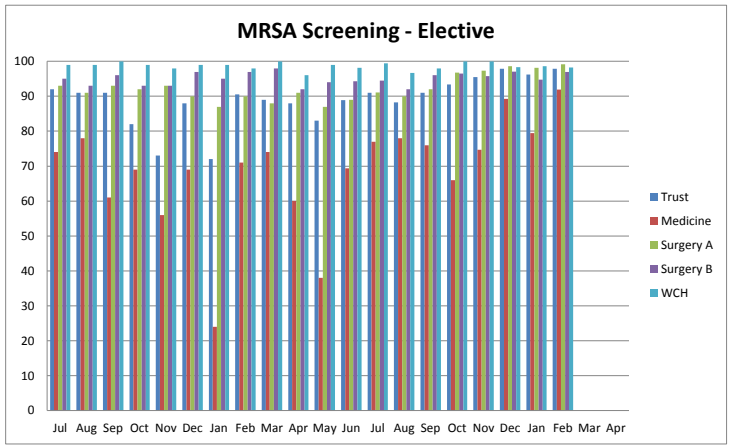
External Assessment Frameworks

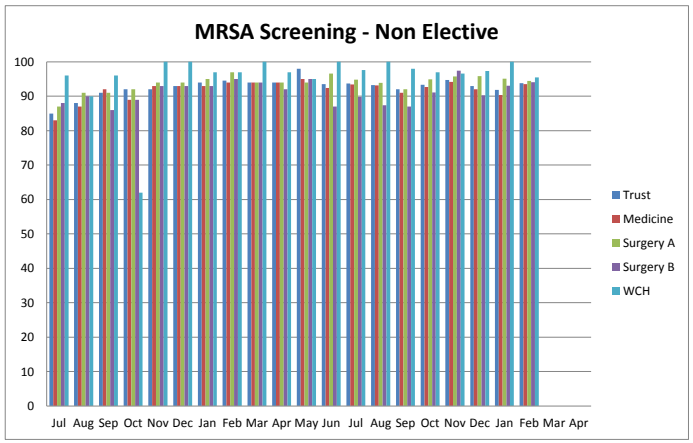
TDA Accountability Framework - Quality Scores for each of the 5 domains which comprise the framework are indicated in the main body of this report, with the areas of 'adverse' performance against each domain identified. The sum of the domain scores are used to derive the overall quality score which for the most recent period is 2 (1 is highest risk rating and 5 is lowest risk rating). The overall score is also influenced by the application of any override rules which may be applied, which during February related to ED 4-hour performance of 91.02%.

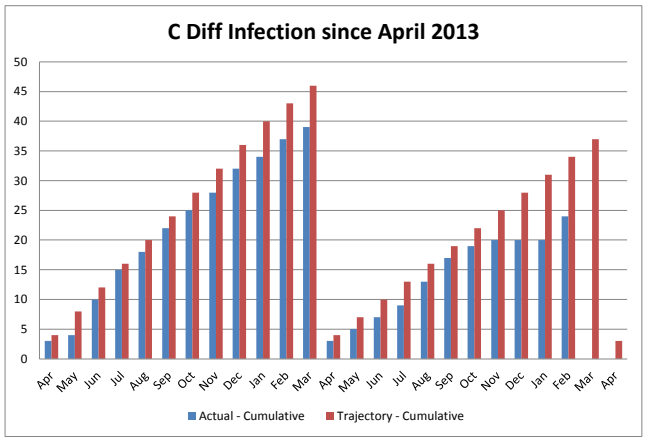
Monitor Risk Assessment Framework - compliance against this framework is also indicated. For the month of February performance (actual and projected) attracts a Governance Rating of 1.0 (Amber / Green), influenced adversely by ED 4-hour wait performance.

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
4			C. Difficile	No.	37	3	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	3	1	0	0					4	24	●	●	●
4			MRSA Bacteraemia	No.	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0					0	3	●	●	●
4			MSSA Bacteraemia (rate per 100,000 bed days)	Rate	<9.42	<9.42	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15									4.8	5.4	●	●	●
4			E Coli Bacteraemia (rate per 100,000 bed days)	Rate	<94.9	<94.9	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15									9.5	18.0	●	●	●
3			MRSA Screening - Elective	%	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	92	99	97	98					97.9		●	●	●
3			MRSA Screening - Non Elective	%	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	94	94	94	95					93.8		●	●	●

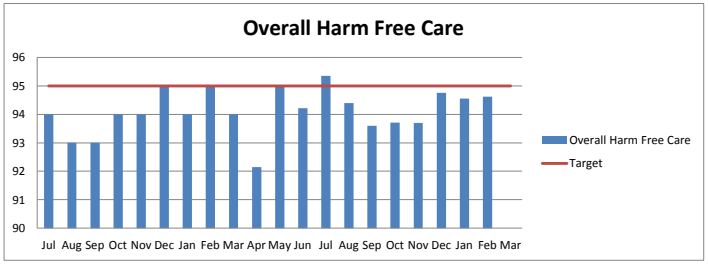


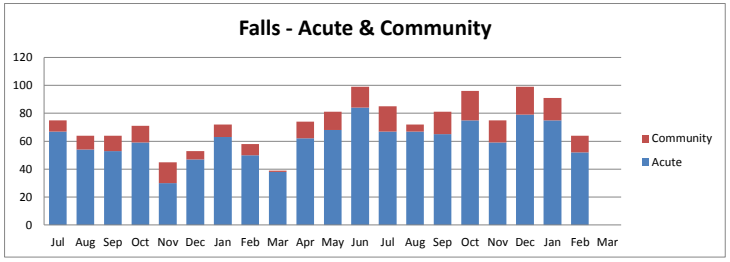


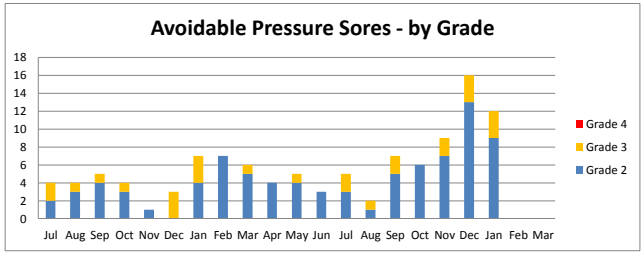


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		d	Patient Safety Thermometer - Overall Harm Free Care	%	=>95	=>95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15									94.6		●		
8		d	Patient Safety Thermometer - Catheters & UTIs	%			0.72	0.52	0.69	0.43	0.43	0.53	0.48	0.51	0.49	0.42	0.41	0.40	0.25	0.31	0.41	0.40			Feb-15									0.40				
8			Falls	No.	804	67	45	53	72	58	39	74	81	99	85	72	81	96	75	99	91	64			Feb-15	42	4	0	0	0	0	16		64	917	●		
9			Falls with a serious injury	No.	0	0	2	6	2	1	2	1	5	4	1	5	1	1	2	1	1	0			Feb-15	0	0	0	0		0	0		0	22	●		
8			Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	No.	0	0	1	2	7	8	7	5	6	5	5	2	8	6	9	16	12				Jan-15	10	0	0	0			2		12	74	●		
3		d	Venous Thromboembolism (VTE) Assessments	%	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	99.7	98.1	98	90.1					97.8		●		
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	%	98	98	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	99.8	99.8	100.0	99..1		100			99.84		●		
3			WHO Safer Surgery - 3 sections and brief (% lists where complete)	%	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	100.0	100	100		96.6			99.4		●		
3			WHO Safer Surgery - Audit - 3 sections, brief and debrief (% lists where complete)	%	85	85	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	99.1	99	100		96.6			99.4		●		
9		d	Never Events	No.	0	0	2	●	2	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	0	0		0	0	●		
9		d	Medication Errors causing serious harm	No.	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	0	0		0	0	●		
9		d	Serious Incidents	No.	0	0	4	0	2	0	1	3	2	2	2	2	1	1	2	3	4	4			Feb-15	2	0	0	1	1	0	0		4	26	●		
9			Open Central Alert System (CAS) Alerts	No.			6	9	9	8	11	9	5	7	5	6	5	5	15	17	10	9			Feb-15									9		●		
9		d	Open Central Alert System (CAS) Alerts beyond deadline date	No.	0	0							1	1	1	0	0	0	4	0	1	0			Feb-15									0		●		

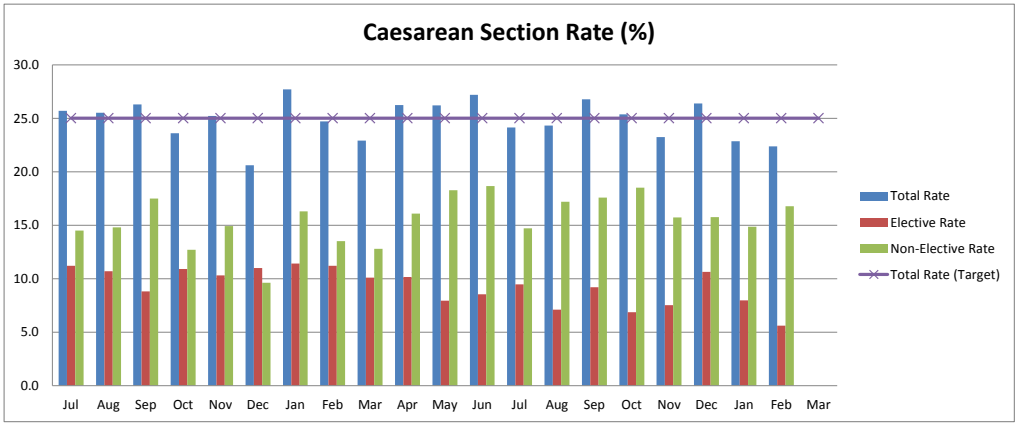


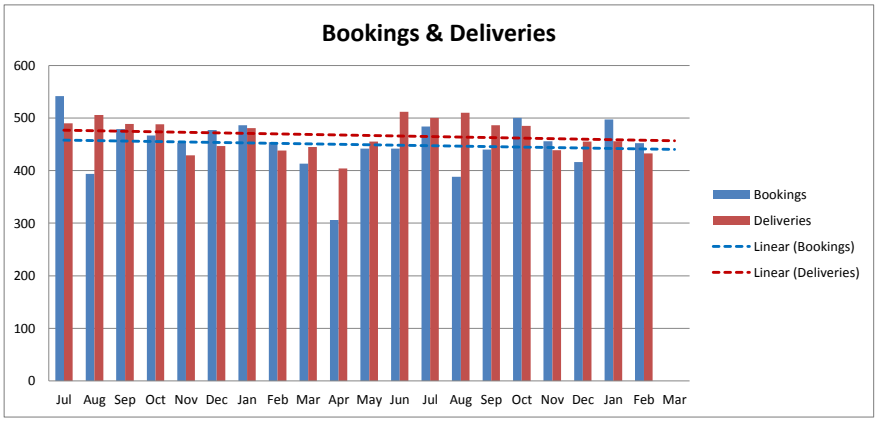




Patient Safety - Obstetrics

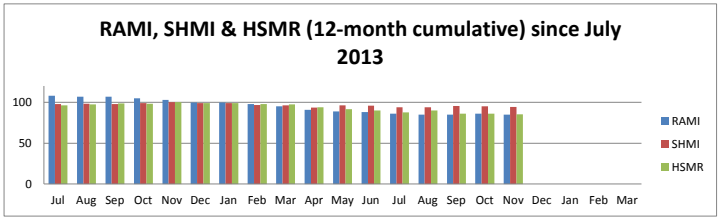
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Caesarean Section Rate - Total	%	=<25.0	=<25.0																			Feb-15	22.4	25.0			
3			Caesarean Section Rate - Elective	%			10	11	12	11	10	10	8	9	9	7	9	7	8	11	8	6			Feb-15	5.6	8.3			
3			Caesarean Section Rate - Non Elective	%			15	10	16	14	13	16	18	19	15	17	18	19	16	16	15	17			Feb-15	16.8	16.8			
2			Maternal Deaths	No.	0	0														1					Feb-15	0	1			
3			Post Partum Haemorrhage (>2000ml)	No.	48	4																			Feb-15	0	6			
3			Admissions to Neonatal Intensive Care	%	=<10.0	=<10.0																			Feb-15	2.31	2.32			
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	Rate	<8.0	<8.0																			Feb-15	13.7				
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	%	=>90.0	=>90.0																			Feb-15	76				
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	%	=>90.0	=>90.0																			Feb-15	190				
2			Breast Feeding Initiation (Quarterly)	%	=>77.0	=>77.0																			Dec-14	75.5	75.33			
2			Puerperal Sepsis and other puerperal infections (variation 1) (%)	%			1.9	3.4	1.3	2.3	0.7	2.3	1.8	2.6	1.8	0.9	0.9	0.7	1.5	1.2	1.4	0.5			Feb-15	0.5	1.6			
2			Puerperal Sepsis and other puerperal infections (variation 2) (%)	%			0.5	1.4	0.2	1.6	0.5	1.5	1.8	1.6	1.6	0.7	0.3	0.7	1.3	0.8	0.3	0.5			Feb-15	0.5	1.2			
2			Puerperal Sepsis and other puerperal infections (variation 3) (%)	%			0.2	0.5	0.2	0.2	0.0	0.8	0.7	0.4	0.4	0.2	0.0	0.0	1.0	0.4	0.0	0.0			Feb-15	0.0	0.4			

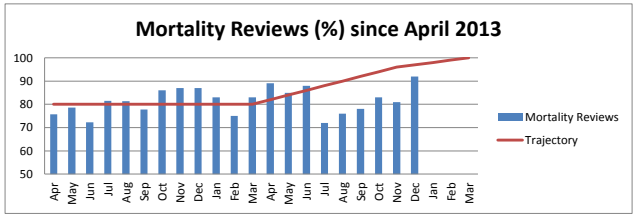


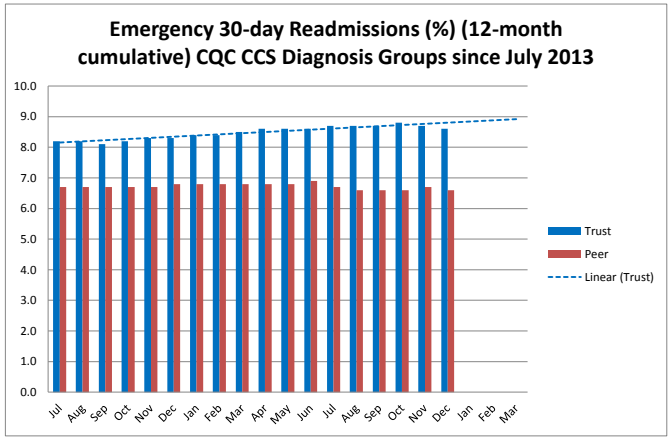


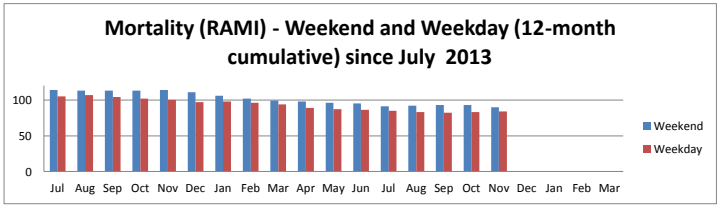
Clinical Effectiveness - Mortality & Readmissions

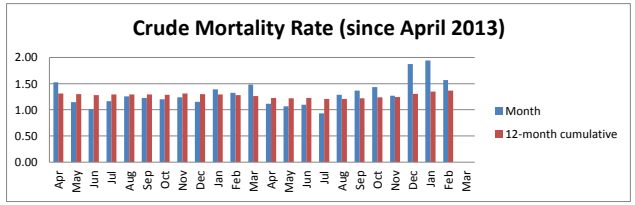
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	103	100	100	98	95	91	89	88	86	85	85	86	85						Nov-14										85			
5		C	Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	100	97	98	96	94	89	87	86	85	83	82	83	84						Nov-14										84			
5		C	Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	114	111	106	102	99	98	96	95	91	92	93	93	90						Nov-14										90			
6		C	Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	100	99	99	97	96	94	96	96	94	94	95	95	94						Nov-14										94.2			
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			100	99	99	98	97	94	92	90	88	90	86	86	85						Nov-14										85.3			
5			Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	67	104	78	73	106	66	75	47	51	71	89	80	76						Nov-14									76				
3			Mortality Reviews within 42 working days	%	100	=>97	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Dec-14	93	94		86					92				
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			1.2	1.2	1.4	1.3	1.5	1.1	1.1	1.1	0.9	1.3	1.4	1.4	1.3	1.9	1.9	1.6			Feb-15									1.57				
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.3	1.3	1.3	1.3	1.3	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.3	1.4	1.4			Feb-15										1.25			
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			7.3	7.7	7.3	7.4	7.5	8.1	8.2	7.3	7.6	7.9	7.4	7.8	7.1	7.9					Dec-14									7.86				
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%								8.1	8.2	7.9	7.8	7.8	7.7	7.7	7.7	7.7				Dec-14										7.69			
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative)	%			8.3	8.3	8.4	8.4	8.5	8.6	8.6	8.6	8.7	8.7	8.7	8.8	8.7	8.6					Dec-14										8.6			





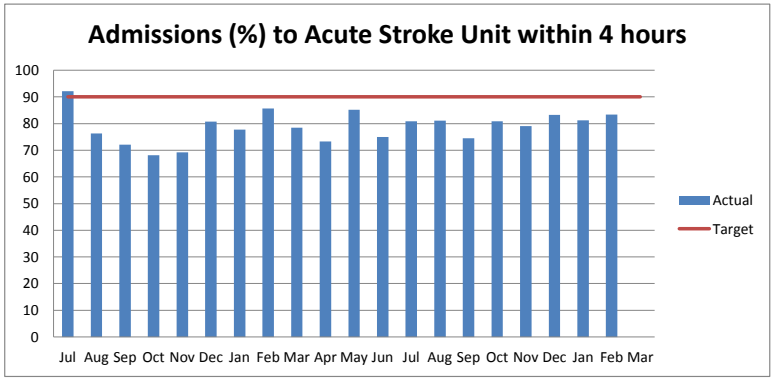


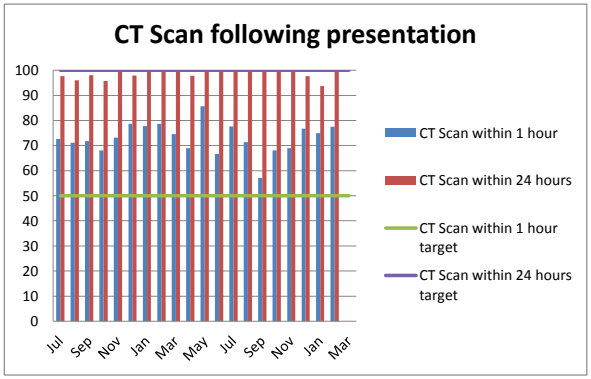


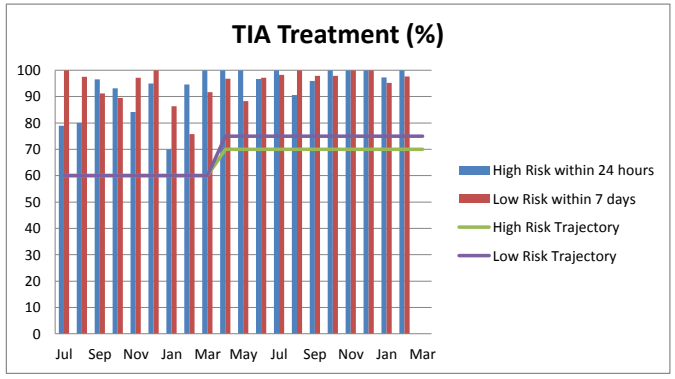


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N D J F M A M J J A S O N D J F M A	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Pts spending >90% stay on Acute Stroke Unit	%	=>90.0	=>90.0		Feb-15	97.9	91.6			
3			Pts admitted to Acute Stroke Unit within 4 hrs	%	=>90.0	=>90.0		Feb-15	83.3	79.5			
3			Pts receiving CT Scan within 1 hr of presentation	%	=>50.0	=>50.0		Feb-15	77.6	72.0			
3			Pts receiving CT Scan within 24 hrs of presentation	%	100	100		Feb-15	100.0	98.9			
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	%	=>85.0	=>85.0		Feb-15	100.0	79.7			
3			Stroke Admissions - Swallowing assessments (<24h)	%	=>98.0	=>98.0		Feb-15	100.0	100.0			
3			TIA (High Risk) Treatment <24 Hours from receipt of referral	%	=>70.0	=>70.0		Feb-15	100.0	98.2			
3			TIA (Low Risk) Treatment <7 days from receipt of referral	%	=>75.0	=>75.0		Feb-15	97.6	97.3			
9			Primary Angioplasty (Door To Balloon Time 90 mins)	%	=>80.0	=>80.0		Feb-15	90.9	88.5			
9			Primary Angioplasty (Call To Balloon Time 150 mins)	%	=>80.0	=>80.0		Feb-15	100.0	90.5			
9			Rapid Access Chest Pain - seen within 14 days	%	=>98.0	=>98.0		Feb-15	98.9	97.9			

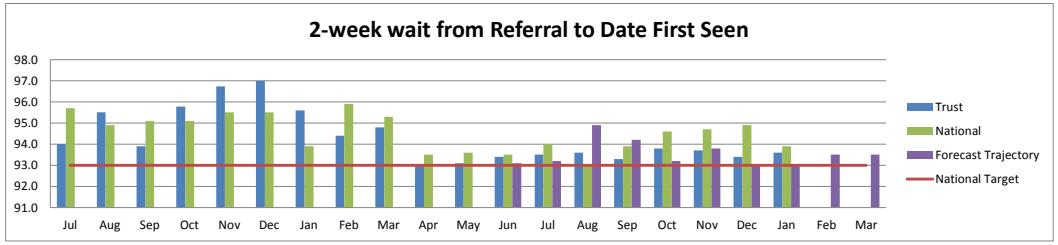


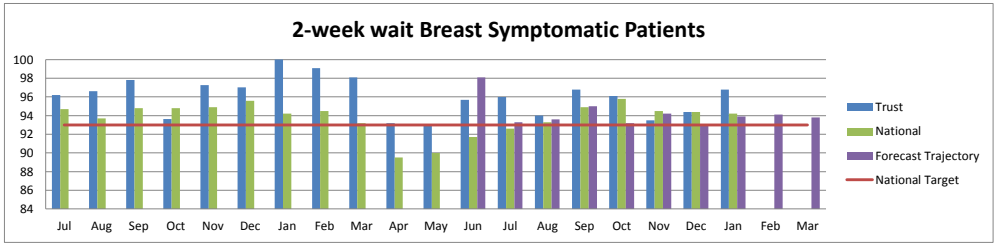


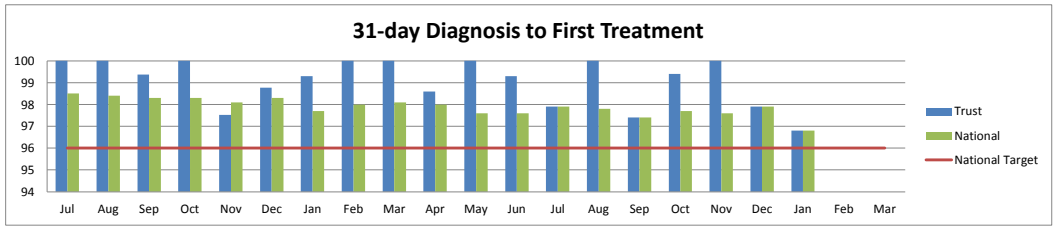


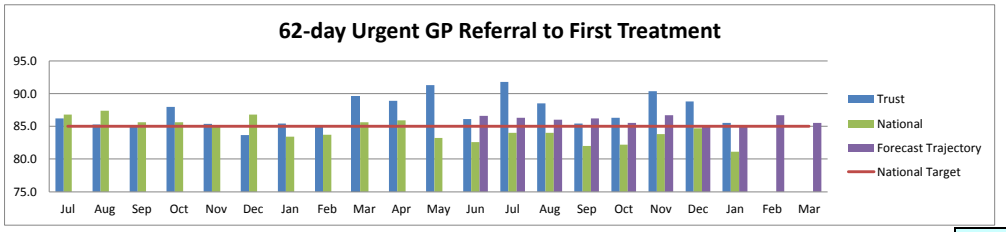
Clinical Effectiveness - Cancer Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
1			2 weeks	%	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15	91.2	94.2	94.4	95.9					93.6	93.4	●		
1			2 weeks (Breast Symptomatic)	%	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15		96.8							96.8	95.0	●		
1			31 Day (diagnosis to treatment)	%	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15	100	98.8	100	86.4					96.8	98.7	●		
1			31 Day (second/subsequent treatment - surgery)	%	=>94.0	=>94.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15									94.8	97.9	●		
1			31 Day (second/subsequent treatment - drug)	%	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15									100	100	●		
1			31 Day (second/subsequent treat - radiotherapy)	%	=>94.0	=>94.0	●	n/a	n/a	n/a	●	n/a	n/a	n/a	n/a	n/a	n/a	●	n/a	n/a	n/a				Jan-15									n/a	100	●		
1			62 Day (urgent GP referral to treatment)	%	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15	90.6	83.6	66.7	77.3					85.5	88.3	●		
1			62 Day (referral to treat from screening)	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15		96.0		100					96.2	97.4	●		
1			62 Day (referral to treat from hosp specialist)	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15	100	100	100	75.0					96.8	94.3	●		



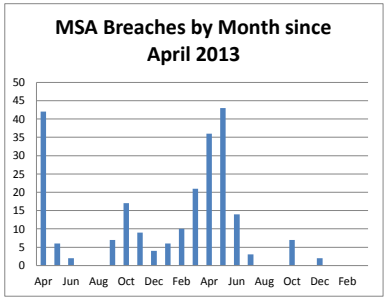


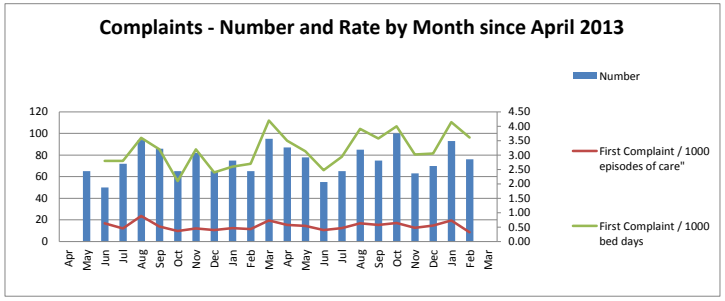


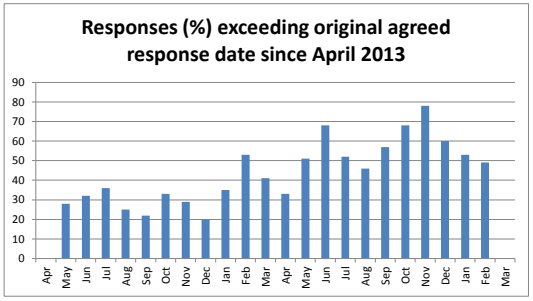


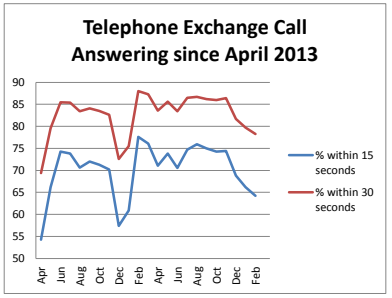
Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		b	FFT Response Rate - Inpatients	%	=>30.0	=>30.0	31	29	31	34	36	36	44	45	41	32	31	28	31	28	33	43			Feb-15									42.5				
8		a	FFT Score - Inpatients	No.	=>60.0	=>60.0	70	73	71	75	73	74	74	70	73	76	74	73	73	69	70	68			Feb-15									68.0				
8		b	FFT Response Rate Emergency Department	%	=>20.0	=>20.0	17	15	15	16	15	15	16	16	16	17	17	17	18	17	18	21			Feb-15	21								21.0				
8		a	FFT Score - Emergency Department	No.	=>46.0	=>46.0	47	44	47	48	48	47	49	48	47	49	47	48	49	50	50	44			Feb-15	44								44.0				
13		a	Mixed Sex Accommodation Breaches	No.	0	0	9	4	6	10	21	36	43	14	3	0	0	7	0	2	0	0			Feb-15	0	0	0	0		0	0		0	107			
9			No. of Complaints Received (formal and link)	No.			52	65	75	65	95	87	78	55	65	85	75	100	63	70	93	76			Feb-15	36	9	12	9	1	2	1	5	76	771			
9			No. of Active Complaints in the System (formal and link)	No.			201	190	188	188	210	194	245	270	219	258	282	324	359	219	249	266			Feb-15	126	40	35	27	7	7	3	16	266				
9		a	No. of First Formal Complaints received / 1000 bed days	Rate			3.2	2.4	2.6	2.7	4.2	3.5	3.1	2.5	2.9	3.9	3.6	4.0	3.0	3.1	4.1	3.6			Feb-15	3.2	1.7	21.9	2.4					3.61	3.54			
9			No. of First Formal Complaints received / 1000 episodes of care	Rate			0.5	0.4	0.5	0.4	0.7	0.6	0.5	0.4	0.5	0.6	0.6	0.6	0.5	0.6	0.7	0.3			Feb-15	1	1	0.8	0.4			0		0.32	0.60			
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	%	100	100	99	98	97	95	99	100	100	100	99	99	100	99	100	99	99	98			Feb-15	97	100	100	86	100	100	50	20	98				
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	%	0	0	29	20	35	53	41	33	51	68	52	46	57	68	78	60	53	49			Feb-15	48	62	46	37	57	57	50	67	49				
9			No. of responses sent out	No.			59	79	81	58	67	117	30	4	138	66	42	35	26	198	59	52			Feb-15	13	14	14	2	1	3	3	2	52				
9			Oldest' complaint currently in system	Days			174	91	112	118	127	104	124	145	127	133	131	174	161	182	192	213			Feb-15	209	213	123	73	117	75	82	145	213				
14		e	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	Y	Y	Y	Y	Y	Y	Y	Y	Yes				



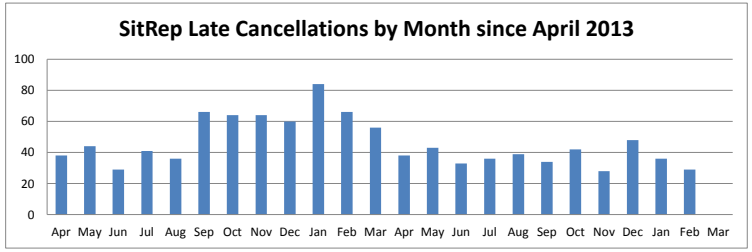


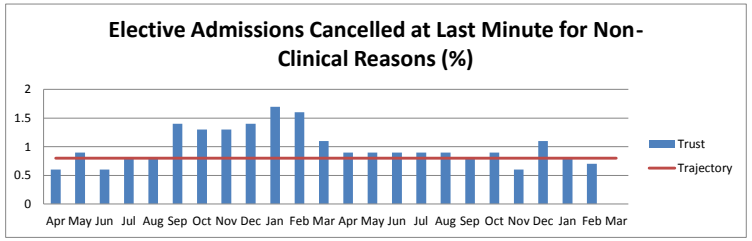


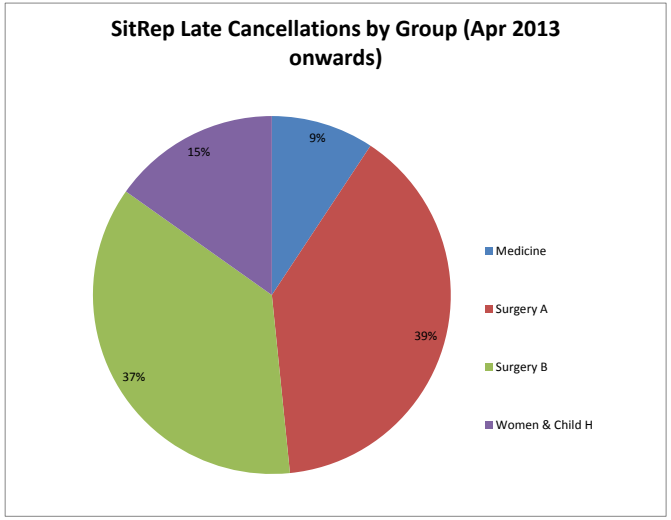


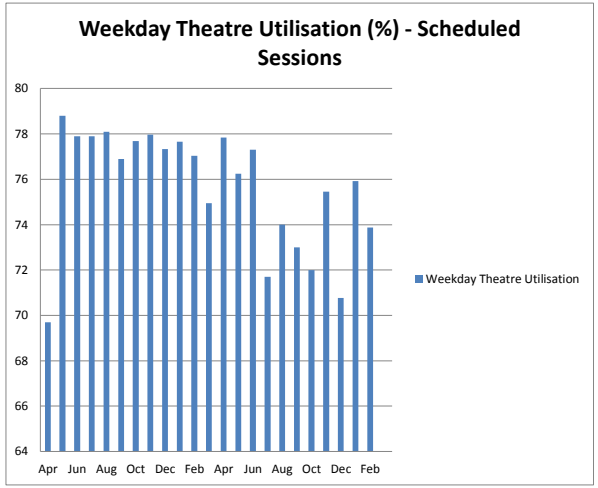
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2		●	Elective Admissions Cancelled at last minute for non-clinical reasons	%	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0.00	1.24	1.05	1.61					0.7	0.8	●		
2		●e●	Number of 28 day breaches	No.	0	0	0	0	0	1	1	1	0	0	0	1	0	0	1	0	0				Feb-15	0	0	0	0					0	4	●		
2		●e	No. of second or subsequent urgent operations cancelled	No.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1				Feb-15	0	0	0	1					1	2	●		
2			No. of Sitrep Declared Late Cancellations	No.	320	27	64	60	84	66	56	38	43	33	36	39	34	42	28	48	36	29				Feb-15	0	13	11	5					29	406	●		
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	No.	0	0	5	7	13	13	0	0	1	0	0	0	0	0	0	0	0	0				Feb-15	0	0	0	0					0	1	●		
3			Multiple Cancellations experienced by same patient (all cancellations)	%	0	0	13	13	13	13	11	12	7	10	12	11	13	11	14	10	11	13				Feb-15	7.0	11.7	18.1	12.5					12.91		●		
3			All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	%	3.1	3.1	6	5	8	6	6	5	6	5	5	6	7	6	6	8	6	7				Feb-15	2.3	9.5	8.0	10					6.5		●		
3			Weekday Theatre Utilisation (as % of scheduled)	%	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Feb-15	49	79	72.4	78					74		●		



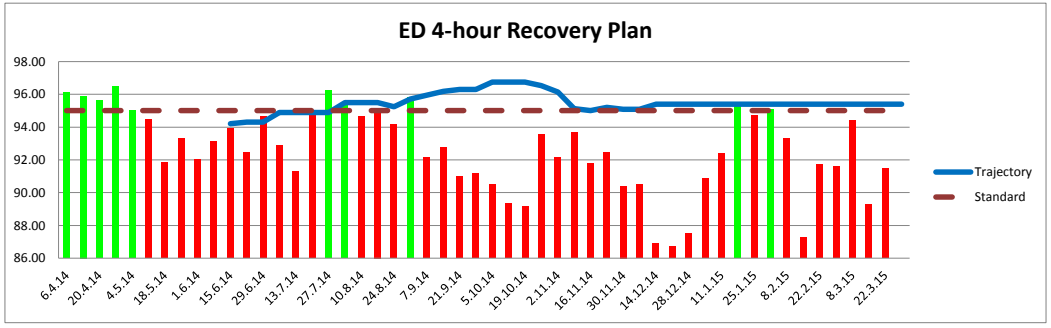


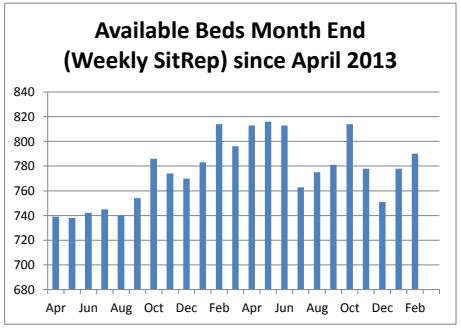


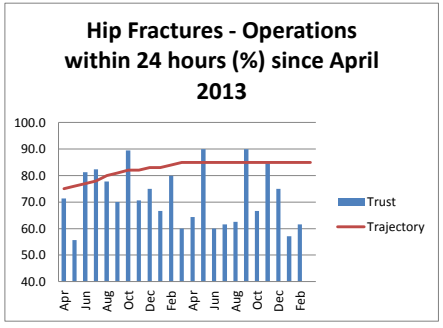


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend	Next Month	3 Months
2		e	Emergency Care 4-hour waits	%	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	92.1	88.3	99.8	91.02	92.65	●		
2			Emergency Care 4-hour breach (numbers)	No.								741	1210	1277	1122	876	1460	1636	1440	2234	1054	1479			Feb-15	532	943	4	1479	14529			
2		e	Emergency Care Trolley Waits >12 hours	No.	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	●		
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	mins	=<15	=<15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	16	21	14	19	18	●		
3			Emergency Care Timeliness - Time to Treatment in Department (median)	mins	=<60	=<60	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	52	70	13	52	51	●		
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	%	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	8.16	8.10	3.00	7.51	6.85	●		
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	%	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	2.86	5.26	1.36	3.82	4.1	●		
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	No.	0	0	●	●	●	●	●	119	136	125	145	51	136	219	159	282	185	149			Feb-15	110	39		149	1706	●		
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	No.	0	0	●	●	●	●	●	13	8	8	8	1	13	21	14	31	7	6			Feb-15	6	0		6	130	●		
11		●	WMAS - Handover Delays > 60 mins (% all emergency conveyances)	%	=<0.02	=<0.02	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0.28	0		0.16	0.29	●		
11			WMAS - Emergency Conveyances (total)	No.			3927	4122	4009	3826	4271	4044	4227	4093	4278	3994	4067	4193	4168	4470	4001	3829			Feb-15	2124	1705		3829	45364			
2			Delayed Transfers of Care (Acute) (%)	%	=<3.5	=<3.5	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	3.1	5.7		4.2	3.7	●		
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	No.	<10 per site	<10 per site						●	●	●	●	●	●	●	●	●	●	●			Feb-15	6	8		14		●		
2			Patient Bed Moves (10pm - 8am) (No.) -ALL	No.								668	751	722	753	697	680	709	650	807	650	672			Feb-15				672	7764			
2			Patient Bed Moves (10pm - 8am) (No.) - exc. Assessment Units	No.								312	331	330	329	337	270	337	294	313	242	286			Feb-15				286	3422			
3			Hip Fractures - Operation < 24 hours of admission (%)	%	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15				61.5	69.7	●		

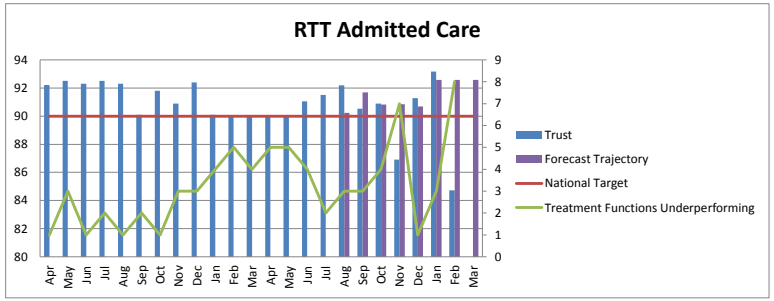


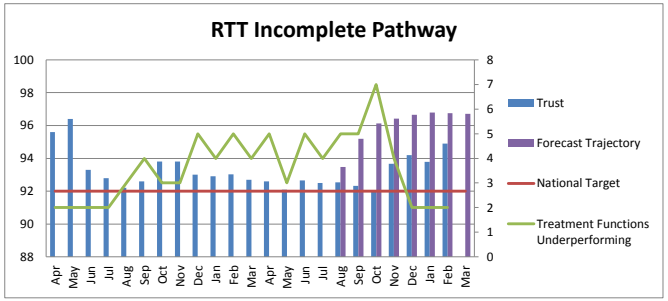


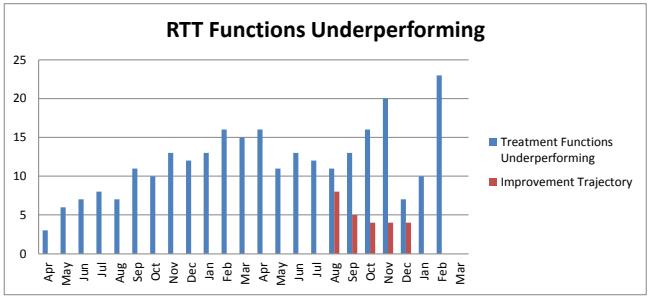


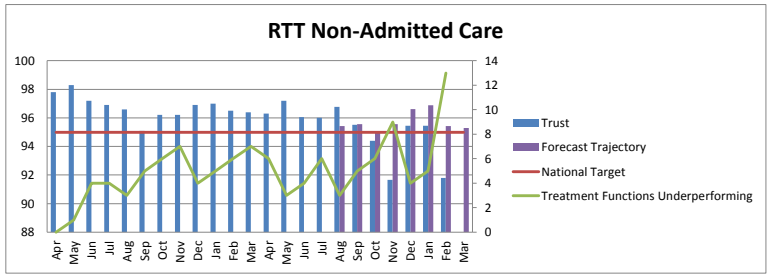
Referral To Treatment

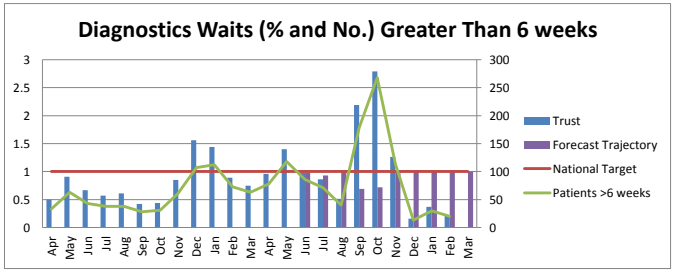
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2			RTT - Admittted Care (18-weeks)	%	=>90.0	=>90.0																			Feb-15	91.9	80.7	81.2	92.5					84.73				
2			RTT - Non Admittted Care (18-weeks)	%	=>95.0	=>95.0																			Feb-15	89.7	92.1	91.9	97.7					91.80				
2			RTT - Incomplete Pathway (18-weeks)	%	=>92.0	=>92.0																			Feb-15	96.6	92.5	94.0	98.4					94.89				
2			Patients Waiting >52 weeks	No.	0	0	36	12	3	1	1	1	2	2	3	4	4	3	3	0	4	3			Feb-15	1	1	1	0					3				
2			Treatment Functions Underperforming	No.	0	0	13	12	13	16	15	16	11	13	12	11	13	17	20	7	10	23			Feb-15	6	8	7	0					23				
2			Acute Diagnostic Waits in Excess of 6-weeks	%	=<1.0	=<1.0																			Feb-15	0.0	0.6	0.2	0.0		0.2			0.22				

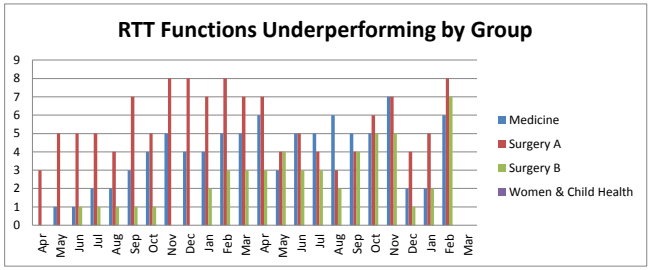










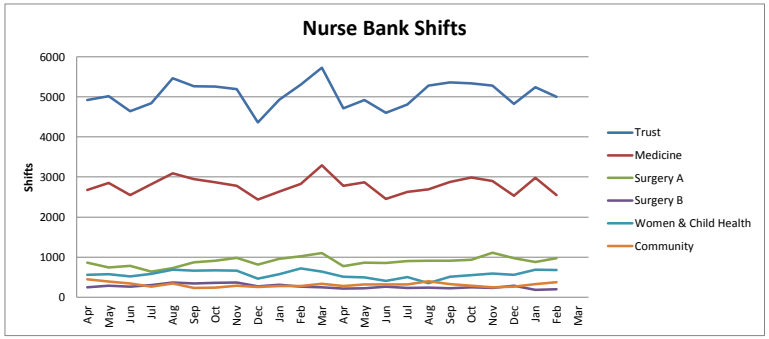


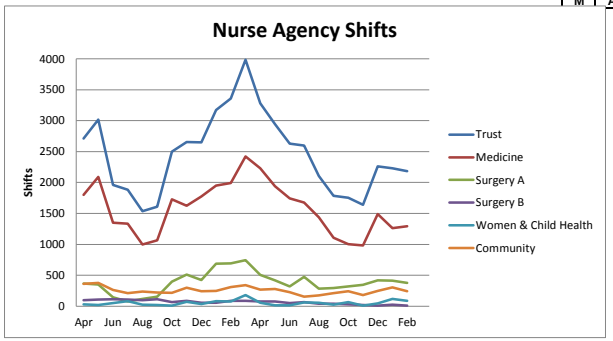
Data Completeness

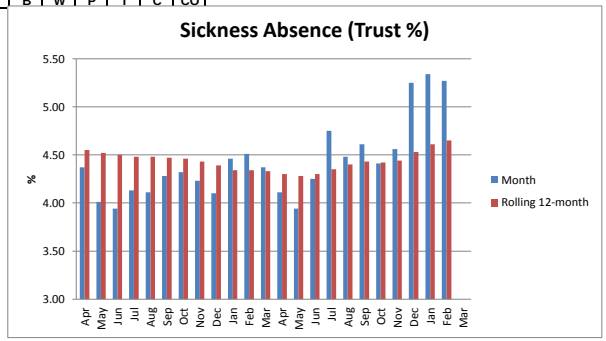
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Data Completeness Community Services	%	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15								>50	>50		●		
2		●	Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	%	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15									99.49		●		
2		●	Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	%	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15									99.56		●		
2		●	Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	%	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15									99.45		●		
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	%	=>99.0	=>99.0	98.9	99.2	98.9	98.9	98.7	98.7	97.0	95.6	95.4	95.2	95.7	95.3	95.7	96.0	96.5	96.9			Feb-15									96.9	96.5	●		
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	%	=>99.0	=>99.0	99.7	99.7	99.7	99.6	99.5	99.5	99.5	99.5	99.5	99.4	99.4	99.5	99.5	99.5	99.6	99.6			Feb-15									99.6	99.5	●		
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	%	=>95.0	=>95.0	97.2	97.1	97.6	96.8	95.9	96.3	95.8	96.3	96.1	96.1	96.2	96.4	96.6	96.2	97.0	96.7			Feb-15									96.7	96.6	●		
2			Ethnicity Coding - percentage of inpatients with recorded response	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15									91.9	92.13	●		
2		●	Data Quality of Trust Returns to the HSCIC (provided by TDA)	%	=>96.0	=>96.0			94.9	94.9	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.5					Nov-14									95.5		●		
2			Maternity - Percentage of invalid fields completed in SUS submission	%	=<15.0	=<15.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15									38.79	35.52	●		

Staff

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since November 2013) N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
7		b	WTE - Actual versus Plan (FTE)	No.			626	572	541	567	567	531	558	580	584	626	608	628	674	685	701	732			Feb-15	244	70	29	69	16	33	72	200	732.26				
3		b	PDRs - 12 month rolling	%	=>95.0	=>95.0																			Feb-15	76	85	88	87	86	77	93	86		84.34			
7		b	Medical Appraisal and Revalidation	%	=>95.0	=>95.0																			Feb-15	95	85	94	83	86	97		100		89.1			
3		b	Sickness Absence	%	=<3.15	=<3.15																			Feb-15	4.9	5.4	3.5	5.7	5.0	6.9	6.0	5.2	5.27	4.65			
3			Mandatory Training	%	=>95.0	=>95.0																			Feb-15	84	89	86	85	92	89	92	89		87.1			
3			Mandatory Training - Health & Safety (% staff)	%	=>95.0	=>95.0																			Feb-15	96	97	93	96	99	100	99	99		97.3			
7		b	Staff Turnover (rolling 12 months)	%	=<10.0	=<10.0																			Feb-15									12.46	12.18			
7			New Investigations in Month	No.			1	4	2	4	5	1	4	6	5	2	15	3	1	0	3	4			Feb-15	2	1	0	0	0	0	1	0	4				
7			Vacancy Time to Fill	weeks			17	18	20	18	19	19	20	19	18	19	19	20	21	20	20	23			Feb-15									23				
7			Professional Registration Lapses	No.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			Feb-15	0	0	0	0	0	0	0	0	0	0			
7			Qualified Nursing Variance (FIMS) (FTE)	No.			199	210	163	162	162	161	169	173	177	201	200	188	200	228	238	247			Feb-15									247.4	199.9			
10			Nurse Bank Fill Rate	%			76	71	73	75	76	76	82	82	80	77	78	78	82	73	78	72			Feb-15									72	78.5			
10			Nurse Bank Use (shifts)	No.	46980	3915																			Feb-15	2546	976	196	676	0	18	370	189	5001	52687			
10			Nurse Agency Use (shifts)	No.	0	0																			Feb-15	1295	378	8	90	0	114	243	56	2184	21862			
10			Admin & Clerical Bank Use (shifts)	No.	0	0																			Feb-15	524	204	190	54	499	128	226	3205	5030	60794			
10			Admin & Clerical Agency Use (shifts)	No.	0	0																			Feb-15	50	20	20	20	0	0	0	1	111	1359			
15			Your Voice - Response Rate	%							19.8			18.2			17.4			12.6	12.7				Feb-15	6	9	14	9	12	18	28	15					
15			Your Voice - Overall Score	No.							3.63			3.68			3.65			3.57	3.55				Feb-15	3.6	3.4	3.5	3.5	3.8	3.3	3.8	3.5					
																										M	A	B	W	P	I	C	CO					





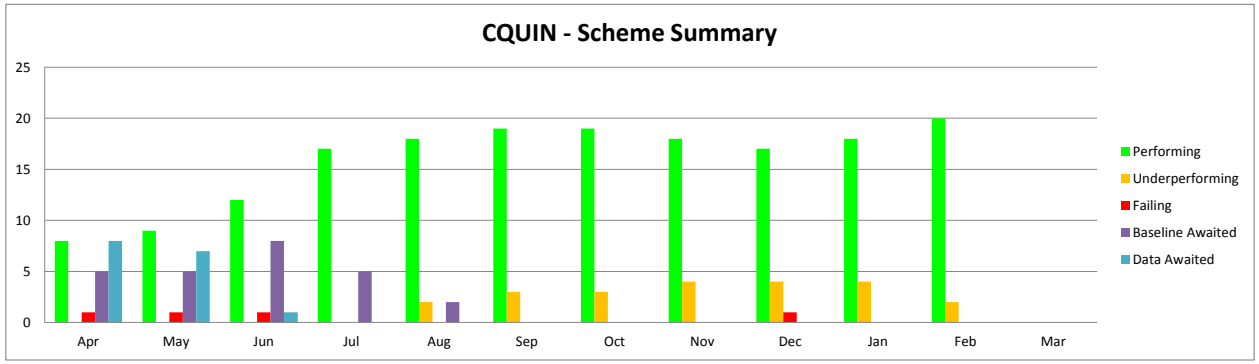


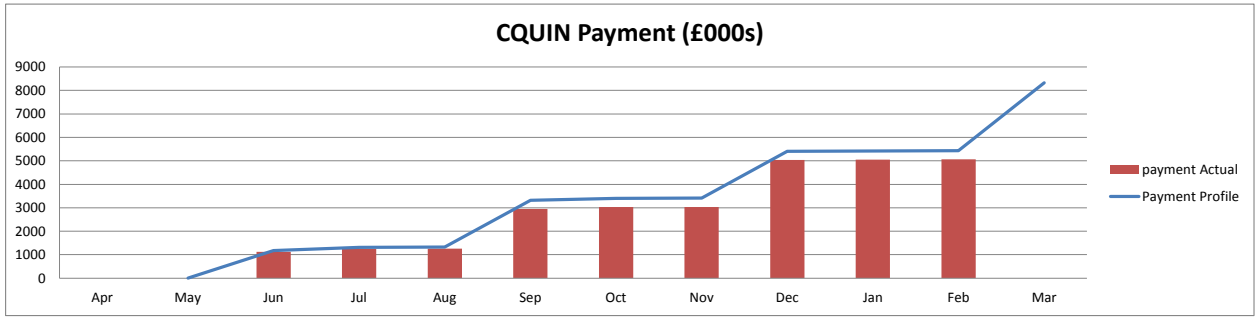
CQUIN (I)

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8			FFT - Implementation of Staff FFT	Implement by end July		●	●	●	●	●	●	●	●	●	●	●		Feb-15									In Place	In Place	●	●	●
8			FFT - Early Implementation of Patient FFT in OP / DC Departments	Implement by end Oct		●	●	●	●	●	●	●	●	●	●	●		Feb-15									In Place	In Place	●	●	●
8			FFT - Increase and / or Maintain Response Rate in ED areas	>Q1 rate		15	16	16	16	17	17	17	18	17	18	21		Feb-15									On Track	On Track	●	●	●
8			FFT - Increase and / or Maintain Response Rate in IP areas	>Q1 rate		36	44	45	41	32	31	28	31	28	33	43		Feb-15									On Track	On Track	●	●	●
8			FFT - IP Response Rate (March 2015 target 40%) - replaces Reduce Negative Responses	40		●	●	●	●	32	31	28	31	28	33	43		Feb-15									On Track	On Track	●	●	●
8			NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers (community avoidable)	10% reduction		●	●	●	●	●	●	●	●	●	●	●		Feb-15									On Track	On Track	●	●	●
8			Dementia - Find, Assess and Refer	=>90	=>90	●	●	●	●	●	●	●	●	●	●	●		Feb-15									3 of 3 met	3 of 3 met	●	●	●
8			Dementia - Clinical Leadership and Staff Training			●	●	●	●	●	●	●	●	●	●	●		Feb-15									On Track	On Track	●	●	●
8			Dementia - Supporting Carers of People with Dementia	Monthly Audit	Monthly Audit	●	●	●	●	●	●	●	●	●	●	●		Feb-15									On Track	On Track	●	●	●
9			Learning From Safeguarding Concerns	Quarterly report to Board			●			●			●					Dec-14									On Track	On Track	●	●	●
2			Quality of Outpatient and Discharge Letters	Trust/CCG to agree assess. criteria			●		●	●	●	●	●	●	●	●		Feb-15									On Track	On Track	●	●	●
4			Sepsis - Use of Sepsis Care Bundles	Informed by base data target 65%			●		●	●	●	●	●	●	●	●		Feb-15									On Track	On Track	●	●	●
8			Pain Relief - Use of Pain Care Bundles	Informed by base data			●		●	●	●	●	●	●	●	●		Feb-15									On Track	On Track	●	●	●
9			Medication and Falls	Informed by base data			●		●	●	●	●	●	●	●	●		Feb-15									actions in place	actions in place	●	●	●
9			Serious Untoward Incidents (Never Events)	Informed by base data			●			●			●		●	●		Feb-15									On Track	On Track	●	●	●
14			Community Therapies - Effective Referral Management	Informed by base data			●			●		●	●	●	●	●		Feb-15									On Track	On Track	●	●	●

CQUIN (II) and summary

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Community Therapies - Community Dietetics	Informed by base data				●		●	●	●	●	●	●	●		Feb-15									actions in place	actions in place	●	●	●
12			Maternity - Low Risk Births	Quarterly audit / action plan			●		●			●	●	●	●	●		Feb-15									On Track	On Track	●	●	●
16			Bechet's Disease	Submit Quarterly return			Met (Q1)			Met (Q2)			Met (Q3)					Dec-14									On Track	Met (Q3)	●	●	●
17			HIV Home Delivery Medicines (% patients receiving)	70	Quarterly		Met (Q1)			Met (Q2)			Met (Q3)					Dec-14									On Track	Met (Q3)	●	●	●
17			Retinopathy of Prematurity Screening (%)	95	Quarterly		Met (Q1)			Met (Q2)			Met (Q3)					Dec-14									On Track	Met (Q3)	●	●	●
17			Timely Administration of TPN for preterm infants	95	Quarterly		Met (Q1)			Met (Q2)			Met (Q3)					Dec-14									On Track	Met (Q3)	●	●	●





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, 18 schemes are classified as performing, with the remaining 4 underperforming. No schemes are currently failing.

Underperforming schemes are; 1) A current FFT response rate of less than the Q1 base in inpatient areas; 2) Related to this is the requirement to deliver a response rate of 40% or more in inpatient areas during March 2015; 3) Medication and Falls - an e-BMS development is signed off, with a scheduled implementation during February, which will provide continuous audit data on the number of admissions at high risk of falling, should improve compliance. CCG agreement to a contract variation to reflect this has been obtained: 4) The Community Dietetics scheme is now back on track to an agreed revised implementation plan. Subject to delivery during Q4, the Trust will receive 75% of the original scheme value. Initial data (as at 17 February) for January indicates significant improvement against the Sepsis Care CQUIN, with 95% patients receiving the Sepsis Care Bundle within 1 hour, compared with a Q4 trajectory of 65%.

To date three confirm and challenge meetings have been held with scheme leads. Formal submission of CQUIN performance to commissioners has been made for the first 2 Quarters. Initial feed back from Commissioning (29th Dec) showed concern for 3 areas; FFT inpatients, Community Dietetics and Maternity. Maternity and FFT inpatients have subsequently been cleared for payment. Community Dietetics has been subject to more detailed discussion, with a revised implementation plan and payment profile having now been agreed. Confirmation has been received from Specialised Commissioners that all 4 schemes have been fully achieved for Q3, and payment criteria satisfied.

External Assessment Frameworks

TRUST DEVELOPMENT AUTHORITY (TDA) ACCOUNTABILITY FRAMEWORK - SUMMARY

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
QUALITY SCORE		5	3	3	3	3	2	2	2	2	3	2	
Domain													
Responsiveness	Initial Score	5	4	4	4	4	4	4	3	5	5	3	
	Override Rules Applied	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	Revised Score	5	3	3	3	3	2	2	2	2	3	2	
	Indicators Not Achieving TDA Standard	RTT >52weeks 28 day canc. Ops	RTT >52weeks 28 day canc. Ops Diagnostic Waits ED 4-hours	RTT >52weeks ED 4-hours DTOC	RTT >52weeks ED 4-hours DTOC	RTT >52weeks ED 4-hours DTOC	28-day canc. Op. ED 4-hours Diagnostic Waits	ED 4-hours DTOC Diagnostic Waits RTT >52weeks Non-Ad RTT	ED 4-hours DTOC Diagnostic Waits RTT >52weeks Admitted RTT Non-Ad RTT	ED 4-hours 28 day canc. Ops Urgent Op - canc x2	ED 4-hours DTOC	ED 4-hours DTOC Urgent Op - canc x2 RTT >52weeks Admitted RTT Non-Ad RTT	
Effectiveness	Initial Score	5	5	5	5	5	5	5	5	5	5	5	
	Override Rules Applied	No	No	No	No	No	No	No	No	No	No	No	
	Revised Score	5	5	5	5	5	5	5	5	5	5	5	
	Indicators Not Achieving TDA Standard												
Safe	Initial Score	4	5	4	5	5	4	5	5	5	5	5	
	Override Rules Applied	No	No	No	No	No	No	No	No	No	No	No	
	Revised Score	4	5	4	5	5	4	5	5	5	5	5	
	Indicators Not Achieving TDA Standard	Pt. Safety Incidents Open CAS Alerts Harm Free Care	Pt. Safety Incidents Open CAS Alerts	Pt. Safety Incidents Open CAS Alerts Harm Free Care	Pt. Safety Incidents Open CAS Alerts	Pt. Safety Incidents Harm Free Care	Harm Free Care MRSA Bact.	Harm Free Care	Harm Free Care Open CAS Alerts	Harm Free Care Maternal Death	Harm Free Care Open CAS Alerts	Harm Free Care	
Caring	Initial Score	5	5	5	5	5	5	5	5	5	5	3	
	Override Rules Applied	No	No	No	No	No	No	No	No	No	No	No	
	Revised Score	5	5	5	5	5	5	5	5	5	5	3	
	Indicators Not Achieving TDA Standard	MSA Breaches	MSA Breaches	MSA Breaches	MSA Breaches			MSA Breaches		MSA Breaches		ED FFT Score	
Well Led	Initial Score	3	3	3	3	3	3	2	2	2	3	4	
	Override Rules Applied	No	No	No	No	No	No	No	No	No	No	No	
	Revised Score	3	3	3	3	3	3	2	2	2	3	4	
	Indicators Not Achieving TDA Standard	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	IP FFT Resp. Rate ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	IP FFT Resp. Rate ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	DQ Returns to HSCIC Temp. Staff Costs	
FINANCE SCORE		AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	

Override Rules

Metric	Override Rule	Domain	Domain Score Affected	Max Domain Score Achievable	Quality Score Affected	Max Quality Score Achievable
RTT - Admitted	Below 90%	Responsiveness	Yes	3	Yes	3
Accident & Emergency	Between 92% and 95%	Responsiveness	Yes	3	Yes	3
Accident & Emergency	Below 92%	Responsiveness	Yes	2	Yes	2
Cancer 62-day Standard	Below 85%	Responsiveness	Yes	3	Yes	3
HSMR or SHMI	High Outlier for 1 Quarter	Effectiveness	Yes	3	No	n/a
HSMR or SHMI	High Outlier for 1 Quarter	Effectiveness	Yes	2	No	n/a
HSMR or SHMI	High Outlier for 2 Quarters or more	Effectiveness	Yes	2	Yes	3
HSMR or SHMI	High Outlier for 1 Year or more	Effectiveness	Yes	2	Yes	2
HSMR and / or SHMI	High Outlier for 2 Years	Effectiveness	Yes	1	Yes	1

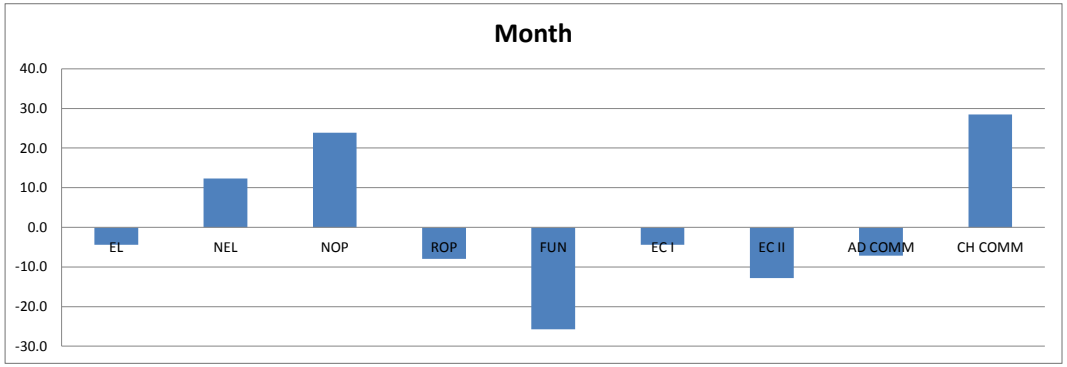
MONITOR RISK ASSESSMENT FRAMEWORK - SUMMARY

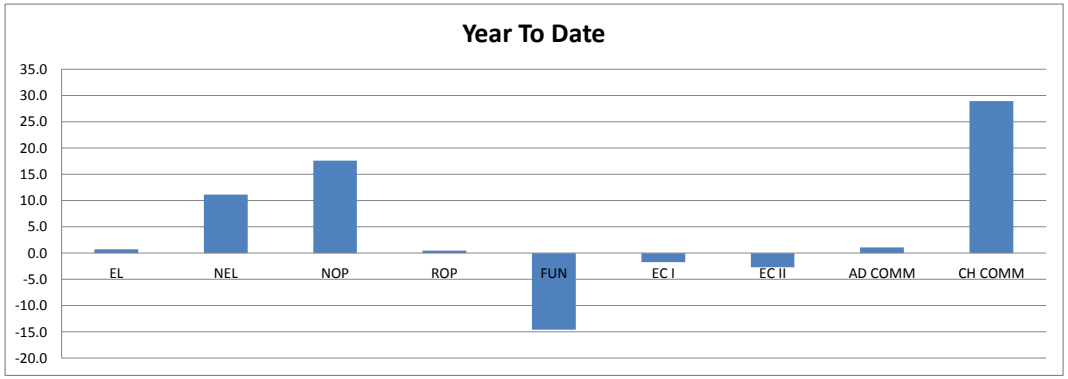
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Indicators Achieving Monitor Standard	15	14	14	14	14	14	13	12	14	14	14	
Indicators Not Achieving Monitor Standard	0	1	1	1	1	1	2	3	1	1	1	
		ED 4-hours	ED 4-hours	ED 4-hours	ED 4-hours	ED 4-hours	ED 4-hours RTT Non-Admitted	ED 4-hours RTT Admitted RTT Non-Admitted	ED 4-hours	ED 4-hours	ED 4-hours	
GOVERNANCE RATING	0.0	1.0	1.0	1.0	1.0	1.0	2.0	3.0	1.0	1.0	1.0	

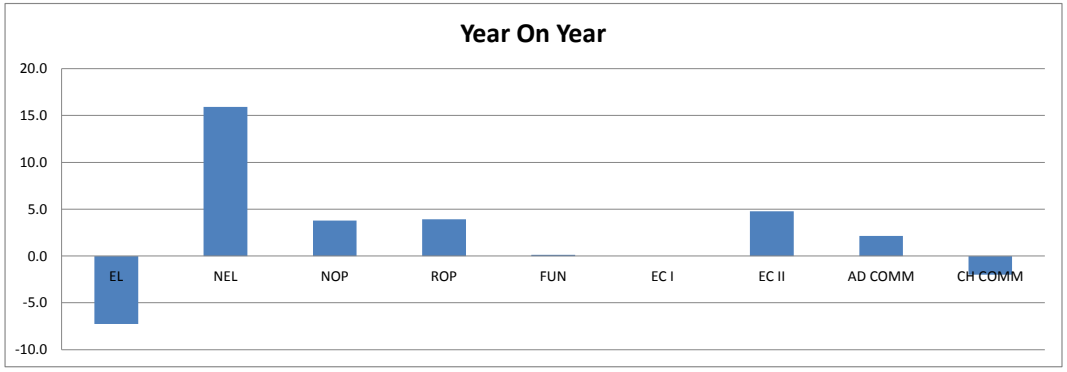
PLEASE NOTE:

For both Frameworks - Performance is projected where data is not available for the period of assessment (e.g. RTT and Cancer)

Activity Summary







Activity - Variance expressed as a percentage between actual activity and planned (contracted) activity is reflected for the month and year to date in the graphs opposite. Additionally, there is a year on year comparison of current year with previous year for the corresponding period of time.

High level Elective activity is below plan for the month by 4.4% but remains ahead of plan for the year to date by 0.7%. Non-Elective activity during the month is 12.3% greater than plan, is 11.1% higher than plan for the year to date, and 15.9% higher than the corresponding period last year. New outpatient attendance numbers are ahead of plan by 23.9% for the year to date. With OP Review attendances just above plan (0.4%) for the year to date, the Follow-Up to New OP Ratio for the period to date is 1.96, compared with a plan derived from contracted activity of 2.53. Type I Emergency Care activity for the month is 4.4% behind plan, and is 1.7% less than plan for the year to date. this is below the activity delivered for the corresponding period last year. Type II activity is 12.8% above plan for the month, and 2.7% above plan for the year to date. Adult Community and Child Community activity exceeds plans for the year to date by 1.1% and 28.9% respectively, although the latter is 2.0% 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 Year	Trajectory Month	Previous Months Trend O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
18		•f	Bottom Line Income & Expenditure position - Forecast compared to plan £m	£0.0		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Feb-15									£1,279		●	●	●
18		•f	Bottom Line Income & Expenditure position - Year to Date Actual compared to plan £m	£0.0	£0.0						●	●	●	●	●	●	●	●	●	●	●	●		Feb-15	-2.7	-2.9	-2.7	-1.4	0.1	-1.3	1.3	0.3		£1,036	●	●	●
18		•f	Actual efficiency recurring / non-recurring compared to plan - Year to Date actual compared to plan	£0.0	£0.0						●	●	●	●	●	●	●	●	●	●	●	●		Feb-15	-0.9	-1.0	-1.0	-0.9	-0.8	-0.6	-0.5	-1.0		-£6.7	●	●	●
18		•f	Actual efficiency recurring / non-recurring compared to plan - Forecast compared to plan	£0.0							●	●	●	●	●	●	●	●	●	●	●	●		Jan-15	-0.9	-1.3	-1.2	-1.1	-1.1	-0.7	-0.7	-1.3		-£8.2	●	●	●
18		•f	Forecast underlying surplus / deficit compared to plan	£0.0							●	●	●	●	●	●	●	●	●	●	●	●		Feb-15										-£128.1	●	●	●
18		•f	Forecast year end charge to capital resource limit	£22.8							●	●	●	●	●	●	●	●	●	●	●	●		Feb-15									£5,185		●	●	●
18		•f	Is the Trust forecasting permanent PDC for liquidity purposes?	No		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Feb-15									No		●	●	●
18		•b	Temporary costs and overtime as % total paybill	2.6%	2.6%	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Feb-15	8.8%	4.0%	1.5%	1.5%	0.0%	1.7%	2.6%	0.0%	3.7%	3.9%	●	●	●
18			Continuity of Service Risk Rating - Year to Date	2.5							●	●	●	●	●	●	●	●	●	●	●	●		Feb-15										3.0	●	●	●

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

Data Source	Data Quality	OS / NQR	Indicator	Threshold	QUARTER 1 (£000s)									QUARTER 2 (£000s)									QUARTER 3 (£000s)									JANUARY (£000s)									FEBRUARY (£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	M	A	B	W	P	I	C	CO	ALL
2		OS	RTT Admitted Care (£400 per breach by specialty)	<=90.0%	0.0	94.8	10.4	0.0					105.2	1.6	72.4	9.2	0.0						83.2	0.0	98.4	13.2	0.0					111.6	0.0	9.2	0.4	0.0					9.6	0.0	28.4	32.8	0.0					61.2	1.6	303.2	66.0	0.0					370.8
2		OS	RTT Non-Admitted Care (£100 per breach by specialty)	<=95.0%	12.9	6.4	0.0	0.0					19.3	19.8	2.0	0.9	0.0						22.7	30.4	15.9	5.2	0.0					51.5	3.0	0.5	0.0	0.0					3.5	10.8	6.3	7.9	0.0					25.0	76.9	31.1	14.0	0.0					122.0
2		OS	RTT Incomplete Pathway (£100 per breach by specialty)	<=92.0%	38.5	76.4	22.0	0.0					136.9	53.0	75.1	25.5	0.0						153.6	19.4	35.5	7.4	0.0					69.7	0.0	7.9	4.7	0.0					12.6	0.0	8.8	2.4	0.0					11.2	110.9	203.7	62.0	0.0					373.3
2		OS	Diagnostic Waits (£200 per breach)	<=99.0%	0.0	5.4	0.0	0.0		1.4			6.8	16.8	2.6	0.0	0.0		0.0				19.4	37.8	1.2	0.0	0.0		18.0			57.0	0.0	0.0	0.0	0.0		0.0			0.0	0.0	0.0	0.0	0.0		0.0			0.0	54.6	9.2	0.0	0.0		19.4			83.2
2		OS	ED Waits >4 hours (£200 per breach between 92.0% and 95.0%)	<=95.0%	123.2		0.0						123.2	145.8		0.0							145.8	330.2		0.0						330.2	41.6		0.0						41.6	98.8		0.0						98.8	739.6		0.0						739.6
1		OS	Cancer Waits (2 weeks, 31 days and 62 days - £200, £1000 and £1000 per breach respectively)	Various	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0	Assessed Quarterly									Assessed Quarterly									0.0	0.0	0.0	0.0					0.0
13		OS	Mixed Sex Accommodation Breaches (£250 per day per Service Uder affected)	0	32.8	0.0	0.0	0.0					32.8	0.0	1.3	0.0	0.0						1.3	2.3	0.5	0.0	0.0					2.8	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	35.1	1.8	0.0	0.0					36.9
2		OS	Cancelled Operations 28-day (non-payment of rescheduled episode of care)	0	1.8	1.3	0.0	0.0					3.1	0.0	1.3	0.0	0.0						1.3	0.0	1.3	0.0	0.0					1.3	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	1.8	3.9	0.0	0.0					5.7
4		NQR	MRSA Bacteraemia (£10,000 per incidence)	0	20.0	0.0	0.0	0.0			0.0		20.0	10.0	0.0	0.0	0.0			0.0			10.0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0		0.0			0.0	0.0	0.0	0.0	0.0			0.0		0.0	30.0	0.0	0.0	0.0			0.0		30.0
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	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	5.0	5.0					15.0	0.0	20.0	0.0	0.0						20.0	0.0	10.0	10.0	0.0					20.0	0.0	5.0	0.0	0.0					5.0	0.0	5.0	0.0	0.0					5.0	0.0	45.0	15.0	5.0					65.0
11		NQR	WMAS Handovers to ED (£200 per breach 30 - 60 minutes)	0	76.0								76.0	66.4									66.4	132.0								132.0	37.0								37.0	29.8								29.8	341.2								341.2
11		NQR	WMAS Handovers to ED (£1000 per breach >60 minutes)	0	29.0								29.0	22.0									22.0	66.0								66.0	7.0								7.0	6.0								6.0	130.0								130.0
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	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	5.0					5.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	5.0					5.0	0.0	0.0	0.0	10.0					10.0
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					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	0.0								0.0	0.0
9		NQR	Duty Of Candour (Non-payment for cost of care or £10,000 if cost of care unknown / indeterminate)	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	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						0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	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 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						0.0	0.0		0.0						0.0
			ALL		334.2	189.3	37.4	5.0	0.0	1.4	0.0	0.0	567.3	335.4	174.7	35.6	0.0	0.0	0.0	0.0	0.0	545.7	618.1	162.0	35.0	5.0	0.0	18.0	0.0	0.0	847.1	88.6	22.6	5.1	0.0	0.0	0.0	0.0	0.0	116.3	145.4	48.5	43.1	5.0	0.0	0.0	0.0	0.0	242.0	1544.3	597.5	157.0	15.0	0.0	19.4	0.0	0.0	2318.4

Contractual Requirements - Local Quality Requirements

Data Source	Data Quality	Req	Indicator	Threshold	QUARTER 1 (£000s)									QUARTER 2 (£000s)									QUARTER 3 (£000s)									JANUARY (£000s)									FEBRUARY (£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	M	A	B	W	P	I	C	CO	ALL
3		LQR	Maternity - various (8)	Various									0.0									0.0									0.0																										
3		LQR	Stroke - thrombolysis (non payment for any >30 hours if 3 consecutive months of failure)	=>50.0%	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0
3		LQR	Stroke - >90% stay on ASU (non payment for breach if 3 consecutive months of failure)	=>90.0%	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0
3		LQR	Stroke - CT Scan <1 hr presentation (non payment for any >2 hours if 3 consec. months failure)	=>50.0%	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0
3		LQR	Stroke - CT Scan <24 hr presentation (non pay't for any >30 hours if 3 consec. months failure)	100%	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0
3		LQR	ED - Time to Initial Assessment <15 mins (£50 per breach between 92.0% and 95.0%)	=>95.0%	44.0		0.0						44.0	34.9		0.0						34.9	47.5		0.0						47.5	14.7		0.0						14.7	14.8		0.0						14.8	155.9		0.0						155.9
3		LQR	ED - Unplanned Reattendance within 30 days (£50 per breach between 5.00% and 8.00%)	=<5.00%	29.5		0.0						29.5	49.9		0.0						49.9	41.0		0.0						41.0	13.9		0.0						13.9	17.1		0.0						17.1	151.3		0.0						151.3
3		LQR	ED - Left Without Being Seen (lower £23 pay't per pt., & £15 per breach between 5.00% and 8.00%)	=<5.00%	0.0		0.0						0.0	0.0		0.0						0.0	0.3		0.0						0.3	0.0		0.0						0.0	0.0		0.0						0.0	0.3		0.0						0.3
2		LQR	DTOC - Less than 10 (provider responsible) per site (non pay't XS bed days)	<10 per site	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2		LQR	Letters for Evictions from Wards (non pay't XS bed days)	100%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2		LQR	Morning Discharges (< m'day) (no conseq. breach. traj Q1(23%),Q2(27%),Q3(31%),Q4(35%))	Q1 (23%) - Q4 (35%)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2		LQR	DTA (delay in unplanned admiss. to clinically appro. bed) (8 hr(£250),10hr(£500),12hr(£1000)	0	0.0	0.0	0.0	0.0					0.0	0.3	0.0	0.0	0.0					0.3	0.5	0.0	0.0	0.0					0.5	0.8	0.0	0.0	0.0					0.8	0.5	0.0	0.0	0.0					0.5	2.0	0.0	0.0	0.0					2.0
19		LQR	Pt's with small-cell lung cancer have t'ment initiated =<2w path. diagnosis (non pay't for breach)	=>80.0%	6.3								6.3	2.1								2.1	8.4								8.4	0.0								0.0										16.8								16.8
2		LQR	Paeds. have OP F/U appt <6 w discharge post meningoccal septicaemia (non pay't OP appt >6w)	100%				0.1					0.1				0.1					0.1				0.0					0.0				0.0					0.0				0.0					0.0	0.0			0.2					0.2
19		LQR	Pts. Admit. with MI presc. antiplatelet,statin or b. blocker(non pay for breach if 3 consec. m'ths fail.)	=>98.0%	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0
8		LQR	EOL Care (pt's (on SCP) achieving pref. place of death) (Consec. Fail triggers contract clause)	=>75.0%	0.0	0.0		0.0					0.0	0.0	0.0		0.0					0.0	0.0	0.0		0.0					0.0																	0.0	0.0		0.0						0.0
3		LQR	WHO Safer Surgery Checklist Compliance (3 components) (Consec. Breaches £1000 / month)	98%, 95% and 85%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
3		LQR	MRSA Screening (EL and NEL) (£1000 per month after 4 months consecutive breaches)	=>80.0% matched	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
4		LQR	Appro. Antimicrobial Stewardship (Q'ly Reporting (cc. CCG) (£1000 / Q'ter after 2 Q'ters breaches)	Submit Report					0.0				0.0					0.0				0.0					0.0				0.0	Assessed Quarterly									Assessed Quarterly													0.0					0.0
19		LQR	HbA1c (pt's achieved target <6 m after being set) (non pay't for breach after 3 m'ths fail)	=>75.0%	Assessed 6-monthly								0.0									0.0	Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly									0.0								0.0
19		LQR	HbA1c (pt's receiving written care plan with agreed targets) (£50 per breach)	=>90.0%	Assessed 6-monthly								0.0									0.0	Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly									0.0								0.0
2		LQR	Ethnicity Coding (£1000 per month after 2 months failure)	=>90.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
			ALL		79.8	0.0	0.0	0.1	0.0	0.0	0.0	0.0	79.9	87.2	0.0	0.0	0.1	0.0	0.0	0.0	0.0	87.3	97.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	97.7	29.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	29.3	32.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	32.4	326.3	0.0	0.0	0.2	0.0	0.0	0.0	0.0	326.6

Contractual Requirements - CQUIN (CQ)

Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	Q1 M	Q1 A	Q1 B	Q1 W	Q1 P	Q1 I	Q1 C	Q1 CO	Q1 ALL
8		CQ	FFT - Implementation of Staff FFT	125	Implement by end July	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8		CQ	FFT - Early Implementation of Patient FFT in OP / DC Departments	67	Implement by end Oct	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
8		CQ	FFT - Increase and / or Maintain Response Rate in ED areas	33.5	>Q1 rate	0.0								0.0
8		CQ	FFT - Increase and / or Maintain Response Rate in IP areas	33.5	>Q1 rate	0.0	0.0	0.0	0.0			0.0		0.0
8		CQ	FFT - IP Response Rate (March 2015 target 40%) - replaces Reduce Negative Responses	167	0	0.0	0.0	0.0	0.0			0.0		0.0
8		CQ	NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	42	50% reduction	0.0	0.0	0.0	0.0			0.0		0.0
8		CQ	Dementia - Find, Assess and Refer	250	=>90.0%	47.3	15.8	0.0	0.0					63.0
8		CQ	Dementia - Clinical Leadership and Staff Training	42	In Place	0.0	0.0	0.0	0.0				0.0	0.0
8		CQ	Dementia - Supporting Carers of People with Dementia	133	Monthly Audit								0.0	0.0
9		CQ	Learning From Safeguarding Concerns	1332	Q'ly Report to Board								0.0	0.0
2		CQ	Quality of Outpatient and Discharge Letters	489	Derived from base	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
4		CQ	Sepsis - Use of Sepsis Care Bundles	1237	Derived from base	0.0	0.0	0.0	0.0					0.0
8		CQ	Pain Relief - Use of Pain Care Bundles	77	Derived from base	0.0	0.0	0.0	0.0					0.0
9		CQ	Medication and Falls	1237	Derived from base	0.0	0.0	0.0	0.0			0.0		0.0
9		CQ	Serious Untoward Incidents (Never Events)	1237	Derived from base								0.0	0.0
14		CQ	Community Therapies - Effective Referral Management	83	Derived from base							0.0		0.0
14		CQ	Community Therapies - Community Dietetics	1237	Derived from base							0.0		0.0
12		CQ	Maternity - Low Risk Births	70	Q'ly Audit / Action Plan				0.0					0.0
16		CQ	Bechet's Disease	109	Quarterly Return			0.0						0.0
17		CQ	HIV Home Delivery Medicines (% patients receiving)	109	Derived from base				0.0					0.0
17		CQ	Retinopathy of Prematurity Screening (%)	109	Derived from base				0.0					0.0
17		CQ	Timely Administration of TPN for preterm infants	109	Derived from base				0.0					0.0
			ALL	8328		47	16	0	0	0	0	0	0	63

Indicator	Q2 M	Q2 A	Q2 B	Q2 W	Q2 P	Q2 I	Q2 C	Q2 CO	Q2 ALL	Q3 M	Q3 A	Q3 B	Q3 W	Q3 P	Q3 I	Q3 C	Q3 CO	Q3 ALL
FFT - Implementation of Staff FFT	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
FFT - Early Implementation of Patient FFT in OP / DC Departments	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
FFT - Increase and / or Maintain Response Rate in ED areas	0.0								0.0	0.0								0.0
FFT - Increase and / or Maintain Response Rate in IP areas	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0
FFT - IP Response Rate (March 2015 target 40%) - replaces Reduce Negative Responses	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0
NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0
Dementia - Find, Assess and Refer	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
Dementia - Clinical Leadership and Staff Training	0.0	0.0	0.0	0.0				0.0	0.0	0.0	0.0	0.0	0.0				0.0	0.0
Dementia - Supporting Carers of People with Dementia								0.0	0.0								0.0	0.0
Learning From Safeguarding Concerns								0.0	0.0								0.0	0.0
Quality of Outpatient and Discharge Letters	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
Sepsis - Use of Sepsis Care Bundles	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
Pain Relief - Use of Pain Care Bundles	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
Medication and Falls	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0
Serious Untoward Incidents (Never Events)								0.0	0.0								0.0	0.0
Community Therapies - Effective Referral Management							0.0		0.0							0.0		0.0
Community Therapies - Community Dietetics							309		309							0.0		0.0
Maternity - Low Risk Births				0.0					0.0				0.0					0.0
Bechet's Disease			0.0						0.0			0.0						0.0
HIV Home Delivery Medicines (% patients receiving)				0.0					0.0				0.0					0.0
Retinopathy of Prematurity Screening (%)				0.0					0.0				0.0					0.0
Timely Administration of TPN for preterm infants				0.0					0.0				0.0					0.0
ALL	0	0	0	0	0	0	309	0	309	0	0	0	0	0	0	0	0	0

Indicator	Jan M	Jan A	Jan B	Jan W	Jan P	Jan I	Jan C	Jan CO	Jan ALL	Feb M	Feb A	Feb B	Feb W	Feb P	Feb I	Feb C	Feb CO	Feb ALL
FFT - Implementation of Staff FFT	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
FFT - Early Implementation of Patient FFT in OP / DC Departments	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
FFT - Increase and / or Maintain Response Rate in ED areas	0.0								0.0	0.0								0.0
FFT - Increase and / or Maintain Response Rate in IP areas	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0
FFT - IP Response Rate (March 2015 target 40%) - replaces Reduce Negative Responses	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0
NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0
Dementia - Find, Assess and Refer	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
Dementia - Clinical Leadership and Staff Training	0.0	0.0	0.0	0.0				0.0	0.0	0.0	0.0	0.0	0.0				0.0	0.0
Dementia - Supporting Carers of People with Dementia								0.0	0.0								0.0	0.0
Learning From Safeguarding Concerns	Assessed Quarterly									Assessed Quarterly								
Quality of Outpatient and Discharge Letters	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
Sepsis - Use of Sepsis Care Bundles	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
Pain Relief - Use of Pain Care Bundles	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
Medication and Falls	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0
Serious Untoward Incidents (Never Events)	Assessed Quarterly									Assessed Quarterly								
Community Therapies - Effective Referral Management							0.0		0.0							0.0		0.0
Community Therapies - Community Dietetics							0.0		0.0							0.0		0.0
Maternity - Low Risk Births				0.0					0.0				0.0					0.0
Bechet's Disease	Assessed Quarterly									Assessed Quarterly								
HIV Home Delivery Medicines (% patients receiving)	Assessed Quarterly									Assessed Quarterly								
Retinopathy of Prematurity Screening (%)	Assessed Quarterly									Assessed Quarterly								
Timely Administration of TPN for preterm infants	Assessed Quarterly									Assessed Quarterly								
ALL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Indicator	YTD M	YTD A	YTD B	YTD W	YTD P	YTD I	YTD C	YTD CO	YTD ALL
FFT - Implementation of Staff FFT	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
FFT - Early Implementation of Patient FFT in OP / DC Departments	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
FFT - Increase and / or Maintain Response Rate in ED areas	0.0								0.0
FFT - Increase and / or Maintain Response Rate in IP areas	0.0	0.0	0.0	0.0			0.0		0.0
FFT - IP Response Rate (March 2015 target 40%) - replaces Reduce Negative Responses	0.0	0.0	0.0	0.0			0.0		0.0
NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	0.0	0.0	0.0	0.0			0.0		0.0
Dementia - Find, Assess and Refer	47.3	15.8	0.0	0.0			0.0		63.0
Dementia - Clinical Leadership and Staff Training	0.0	0.0	0.0	0.0			0.0		0.0
Dementia - Supporting Carers of People with Dementia								0.0	0.0
Learning From Safeguarding Concerns	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Quality of Outpatient and Discharge Letters	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
Sepsis - Use of Sepsis Care Bundles	0.0	0.0	0.0	0.0					0.0
Pain Relief - Use of Pain Care Bundles	0.0	0.0	0.0	0.0					0.0
Medication and Falls	0.0	0.0	0.0	0.0			0.0		0.0
Serious Untoward Incidents (Never Events)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Community Therapies - Effective Referral Management							0.0		0.0
Community Therapies - Community Dietetics							309		309
Maternity - Low Risk Births				0.0					0.0
Bechet's Disease			0.0						0.0
HIV Home Delivery Medicines (% patients receiving)				0.0					0.0
Retinopathy of Prematurity Screening (%)				0.0					0.0
Timely Administration of TPN for preterm infants				0.0					0.0
ALL	47	16	0	0	0	0	309	0	372

Contractual Requirements - Outcome Thermometer (OT) Incentive Scheme

Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	QUARTER 1 (£000s)									QUARTER 2 (£000s)									QUARTER 3 (£000s)									QUARTER 4 (£000s)									YEAR TO DATE (£000s)								
						M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		OT	ED Waits >4 hours (=>95.0% each Quarter)	400	=>95.0%	100.0		0.0						100.0	100.0		0.0								100.0	100.0		0.0								0.0	300.0		0.0						300.0
2		OT	RTT Admitted Care (0 failing specialties after Q1)	200	0	na	na	na	na					0.0	8.3	25.0	33.3	0.0					66.6	0.0	33.3	33.3	0.0					66.6								0.0	8.3	58.3	66.6	0.0					133.2
2		OT	RTT Non-Admitted Care (0 failing specialties after Q1)	200	0	na	na	na	na					0.0	42.9	14.3	9.5	0.0					66.7	22.2	22.2	22.2	0.0					66.6								0.0	65.1	36.5	31.7	0.0					133.3
1		OT	Cancer Waits (2 weeks)	400	=>93.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0									0.0								0.0	0.0								0.0
19		OT	Urgent & Emergency Care - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0								0.0	0.0								0.0
19		OT	Lipid Management in OP Clinics - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0								0.0	0.0								0.0
2		OT	Community Nursing (Quality & Info Requirements) - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0								0.0	0.0								0.0
14		OT	Dev'ment of Advice & Guidance Service and Map of Medicine - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0								0.0	0.0								0.0
2		OT	Cardiology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.61	0.0								0.0	0.0								0.0	14.3								14.3								0.0	14.3								14.3
2		OT	Paediatrics - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.64				0.0					0.0				14.3					14.3				14.3					14.3								0.0	0.0			28.6					28.6
2		OT	Dermatology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<2.48	14.3								14.3	14.3								14.3	14.3								14.3								0.0	42.9								42.9
2		OT	Geriatric Medicine - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.76	0.0								0.0	14.3								14.3	14.3								14.3								0.0	28.6								28.6
2		OT	Rheumatology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<4.99	14.3								14.3	14.3								14.3	0.0								0.0								0.0	28.6								28.6
2		OT	Gastroenterology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.45	14.3								14.3	0.0								0.0	0.0								0.0								0.0	14.3								14.3
2		OT	General Medicine - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<2.38	0.0								0.0	0.0								0.0	0.0								0.0								0.0	0.0								0.0
9		OT	Never Events (reduced incentive available (1 = 85% available, 2 (65), 3 (40), 4 (10), 5 (0)	-2000	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	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			142.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	142.8	194.1	39.3	42.8	14.3	0.0	0.0	0.0	0.0	290.5	165.1	55.5	55.5	14.3	0.0	0.0	0.0	0.0	290.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	502.0	94.8	98.3	28.6	0.0	0.0	0.0	0.0	723.7

Contractual Requirements - Price Activity Matrix (PAM)

Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	QUARTER 1 (£000s)									QUARTER 2 (£000s)								
						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	48	75	-62	-26	2	0			37	116	6	91	-83	10	-2			138
2		PAM	Non-Elective	82299	Contract Plan	167	-17	-45	3					108	184	121	-46	21					280
2		PAM	Excess Bed Days	20352	Contract Plan	74	25	-21	-60					18	112	-12	-18	-44					38
2		PAM	Accident & Emergency	20352	Contract Plan	-11		-86						-97	37		-68						-31
2		PAM	Outpatient New	26337	Contract Plan	23	5	-20	-36	-3	0	0		-31	16	6	8	-38	-1	0	0		-9
2		PAM	Outpatient Review	33208	Contract Plan	59	-34	-10	-27	-1	0	-1		-14	30	-25	102	-29	4	0	-2		80
2		PAM	Outpatient with Procedure	7336	Contract Plan	-22	44	-138	12					-104	24	53	-155	22					-56
2		PAM	Outpatient Telephone Conversation	196	Contract Plan	3	0							3	3	0							3
2		PAM	Maternity	14219	Contract Plan				72					72				300					300
2		PAM	Occupied Cot Days	6000	Contract Plan				18					18				-117					-117
2		PAM	Unbundled Activity	9520	Contract Plan	28	1	-8	6	0	0			27	185	-13	4	3	0	0			179
2		PAM	Other Contract Lines	89552	Contract Plan	119	-6	331	11	-8	-78	0		369	419	7	172	-40	-13	-81	0		464
2		PAM	Community	36003	Contract Plan	0	0		-8		0	0		-8	0	0		-12		0	4		-8
			ALL			488	93	-59	-35	-10	-78	-1	0	398	1126	143	90	-17	0	-83	2	0	1261

Data Source	Data Quality	Req	Indicator	QUARTER 3 (£000s)									JANUARY (£000s)								
				M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		PAM	Elective (IP and DC)	74	-85	-89	-37	16	10			-111	29	-74	-22	-29	3	2			-91
2		PAM	Non-Elective	218	-68	-66	-30					54	196	-42	-24	-22					108
2		PAM	Excess Bed Days	-30	-6	-30	-45					-111	16	10	-7	-11					8
2		PAM	Accident & Emergency	64		-85						-21	-13		-38						-51
2		PAM	Outpatient New	66	14	-82	-57	-3	0	0		-62	14	-5	-30	-16	-1	0	0		-38
2		PAM	Outpatient Review	-24	-40	47	-26	2	0	0		-41	5	-14	15	-17	1	0	1		-9
2		PAM	Outpatient with Procedure	6	38	-111	20					-47	1	10	-27	1					-15
2		PAM	Outpatient Telephone Conversation	2	0							2	0	0							0
2		PAM	Maternity				391					391				128					128
2		PAM	Occupied Cot Days				27					27				-7					-7
2		PAM	Unbundled Activity	130	-35	-1	3	0	0			97	59	-6	-1	0					52
2		PAM	Other Contract Lines	762	7	6	-45	-39	-59	0		632	284	4	-21	24	-12	-23			256
2		PAM	Community	1	0		-7		0	1		-5	0	0		2		0	0		2
			ALL	1269	-175	-411	194	-24	-49	1	0	805	591	-117	-155	53	-9	-21	1	0	343

Data Source	Data Quality	Req	Indicator	FEBRUARY (£000s)									YEAR TO DATE (£000s)								
				M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		PAM	Elective (IP and DC)									0	267	-78	-82	-175	31	10			-27
2		PAM	Non-Elective									0	765	-6	-181	-28					550
2		PAM	Excess Bed Days									0	172	17	-78	-160					-47
2		PAM	Accident & Emergency									0	77		-277	0					-200
2		PAM	Outpatient New									0	119	20	-124	-147	-8	0	0		-140
2		PAM	Outpatient Review									0	70	-113	154	-99	6	0	-2		16
2		PAM	Outpatient with Procedure									0	9	145	-431	55					-222
2		PAM	Outpatient Telephone Conversation									0	8	0							8
2		PAM	Maternity									0				891					891
2		PAM	Occupied Cot Days									0				-79					-79
2		PAM	Unbundled Activity									0	402	-53	-6	12	0	0			355
2		PAM	Other Contract Lines									0	1584	12	488	-50	-72	-241	0		1721
2		PAM	Community									0	1	0		-25		0	5		-19
			ALL	0	0	0	0	0	0	0	0	0	3474	-56	-535	195	-43	-231	3	0	2807

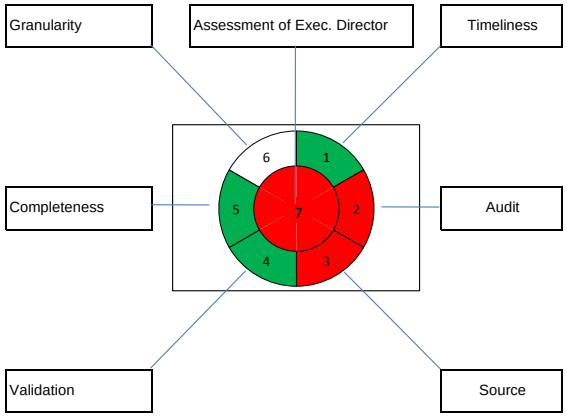
Legend

Data Sources	
1	Cancer Services
2	Information Department
3	Clinical Data Archive
4	Microbiology Informatics
5	CHKS
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
20	Change Team (Information)

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

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

Data Quality - Kitemark



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

Red	Insufficient
Green	Sufficient
White	Not Yet Assessed

The centre of the indicator is colour coded as follows:

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

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

Medicine Group

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		EC	AC	SC					
C. Difficile	30	3	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	3	0	3	16	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	1	●		
MRSA Screening - Elective (%)	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	94	96	67	91.9		●		
MRSA Screening - Non Elective (%)	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	94	95	87	93.55		●		
Falls	0	0						33	40	61	42	44	41	67	50	66	63	42			Feb-15	8	27	7	42	549	●		
Falls with a serious injury	0	0	2	5	1	1	1	1	3	3	1	4	1	1	2	0	1	0			Feb-15	0	0	0	0	17	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	0	0	2	3	3	2	3	3	3	0	6	4	6	7	10				Jan-15	10	0	0	10	44	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	99.5	100	99.7		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	99.2	100	99.8		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	100	100	100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	●		
Serious Incidents	0	0				●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	1	1	2	15	●		
Mortality Reviews within 42 working days	100	=>97	●	●	●	●	●	●	●	●	●	●	●	●	●	●					Dec-14	90	98	90	93		●		

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		EC	AC	SC					
Pts spending >90% stay on Acute Stroke Unit (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		97.9		97.9	91.6	●		
Pts admitted to Acute Stroke Unit within 4 hrs (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		83.3		83.3	79.5	●		
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		77.6		77.6	72.0	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		###		100.0	98.9	●		
Stroke Admission to Thrombolysis Time (% within 60 mins)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		100		100.0	79.7	●		
Stroke Admissions - Swallowing assessments (<24h) (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		100		100.0	100.0	●		
TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=>70.0	=>70.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		###		100.0	98.2	●		
TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=>75.0	=>75.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		97.6		97.6	97.3	●		
Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		91		90.9	88.5	●		
Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		100		100.0	90.2	●		
Rapid Access Chest Pain - seen within 14 days (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		99		98.9	97.9	●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15			91	91.2		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15			100	100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15			90.6	90.6		●		
Mixed Sex Accommodation Breaches	0	0	4	2	3	7	21	36	43	14	0	0	0	7	0	0	0	0			Feb-15	0	0	0	0	100	●		
No. of Complaints Received (formal and link)									38	28	28	32	36	48	18	31	30	36			Feb-15				36	325			
No. of Active Complaints in the System (formal and link)									##	##	##	##	##	##	##	93	##	##			Feb-15				126				
Oldest' complaint currently in system (days)									##	##	##	##	##	##	##	##	##	##			Feb-15				209				

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		EC	AC	SC					
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0.00	0.00	0.00	0.00		●		
28 day breaches	0	0	●	●	●	●	●	●	1	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	**0**	**1**	●		
Sitrep Declared Late Cancellations	0	0	2	2	7	7	4	10	2	7	7	3	2	5	4	1	0	0			Feb-15	0	0	0	0	**41**	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0										61	54	57	60	62	61	49			Feb-15			48.7	**48.73**		●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	92.1 (s)	88.3 (C)		**90.0**	**91.9**	●		
Emergency Care 4-hour breach (numbers)								570	1003	1016	907	736	1201	1390	1181	1913	940	1242			Feb-15	###	1	23	**1242**	**12099**			
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0 (s)	0 (c)		**0**	**0**	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	16 (s)	21 (c)		**19**	**18**	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	52 (s)	70 (c)		**61**	**58**	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	8.16 (s)	8.10 (c)		8.13	7.39	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	2.86 (s)	5.26 (c)		4.06	4.36	●		
WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	0	0	●	●	●	●	●	119	136	125	145	51	136	219	159	282	185	149			Feb-15	110	39		149	1706	●		
WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	0	0	●	●	●	●	●	13	8	8	8	1	13	21	14	31	7	6			Feb-15	6	0		6	130	●		
WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	=<0.02	=<0.02	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0.28	0		0.16	0.29	●		
WMAS - Emergency Conveyances (total)			3927	4122	4009	3826	4271	4044	4227	4093	4278	3994	4067	4193	4168	4470	4001	3829			Feb-15	2124	1705		3829	45364			

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		EC	AC	SC					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		91.0	92.6	91.9		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		91.8	88.7	89.7		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		95.4	97.2	96.6		●		
Patients Waiting >52 weeks	0	0	6	4	0	0	0	0	0	0	0	0	0	0	0	0	0	1			Feb-15	0	1	0	1		●		
Treatment Functions Underperforming	0	0	5	4	4	5	5	6	3	5	5	6	5	5	7	2	2	6			Feb-15	0	2	4	6		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0.0	0.0	0.0	0.00		●		
WTE - Actual versus Plan			158	165	135	163	163	171	161	157	151	166	160	166	197	232	242	244			Feb-15				244				
PDRs - 12 month rolling (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	72	76	85		76.5	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15					94.7	●		
Sickness Absence (%)	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	4.43	5.80	3.83	4.88	4.51	●		
Mandatory Training (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	84	84	85		83.9	●		
New Investigations in Month			0	0	0	0	1	1	1	1	2	1	2	1	0	0	1	2			Feb-15				2				
Nurse Bank Use	34560	2880	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15				2546	29289	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15				1295	13835	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15				524	7141	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15				50	423	●		
Your Voice - Response Rate (%)				8		7		9		9		6									Feb-15	5	4	12	6				
Your Voice - Overall Score				3.68		3.58		3.76		3.76		3.57									Feb-15	3.6	3.7	3.5	3.57				

Surgery A Group

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		A	B	C	D					
C. Difficile	7	1	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	1	0	0	1	7	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	100	98	0	99.2		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	95	95	94	78	94.5		●		
Falls	0	0						9	7	4	8	3	9	9	6	6	0	4			Feb-15	0	3	1	0	4	65	●		
Falls with a serious injury	0	0	0	1	1	0	1	0	0	0	0	0	0	0	0	1	0	0			Feb-15	0	0	0	0	0	1	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	0	2	0	1	0	1	0	0	0	1	1	0	0	4	0				Jan-15	0	0	0	0	0	7	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	98.2	99.3	94.8	99.5	98.06		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	100	100	100	99.1		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	98	100	100	99	97.5		●		
Never Events	0	0	1	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	0	●		
Serious Incidents	0	0			●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	3	●		
Mortality Reviews within 42 working days	100	=>97	●	●	●	●	●	●	●	●	●	●	●	●	●	●					Dec-14	90	100		95	94		●		

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		A	B	C	D					
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15	95.1		91.0		94.2		●		
2 weeks (Breast Symptomatic)	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15	96.8				96.8		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15	98.0		100		98.8		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15	75		86.3		83.6		●		
Mixed Sex Accommodation Breaches	0	0	5	2	3	3	0	0	0	0	3	0	0	0	0	2	0	0			Feb-15	0	0	0	0	0	5	●		
No. of Complaints Received (formal and link)									12	11	8	19	15	13	13	7	15	9			Feb-15					9	122			
No. of Active Complaints in the System (formal and link)									50	50	34	39	49	57	78	53	45	40			Feb-15					40				
Oldest' complaint currently in system (days)									124	131	118	99	109	133	143	171	192	213			Feb-15					213				
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	1.8	0.4	2.3	0.0	1.24		●		
28 day breaches	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	1	0	0			Feb-15	0	0	0	0	0	3	●		
Sitrep Declared Late Cancellations	0	0	35	25	28	37	18	13	16	5	6	16	10	18	6	33	11	13			Feb-15	7	1	5	0	13	147	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0										76	78	75	77	71	78	79			Feb-15	78.2	77.7	73.7		78.6		●		
Emergency Care 4-hour breach (numbers)								81	100	100	119	52	103	118	94	121	43	108			Feb-15	67	31	10	4	108	1039			
Hip Fractures - Operation < 24 hours of admission (%)	85	85	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		61.5			61.5	69.7	●		

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		A	B	C	D					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	82.9	72.5	88.4		80.7		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	96.1	89.9	86.2		92.1		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	96.5	88.5	92.8		92.5		●		
Patients Waiting >52 weeks	0	0	13	3	3	0	0	1	1	0	2	4	2	1	2	0	3	1			Feb-15	0	0	1	0	1		●		
Treatment Functions Underperforming	0	0	8	8	7	8	7	7	5	5	4	3	4	6	7	4	5	8			Feb-15	3	3	2	0	8		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	1.2		0		0.64		●		
WTE - Actual versus Plan			71	72	88	76	76	64	71	77	78	71	71	71	76	66	62	70			Feb-15					70.16				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	85.7	79.6	89.7	85.4		85.3	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15						85.4	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	5.65	4.62	6.50	4.39	5.44	5.37	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	84	81	94	90		89.0	●		
New Investigations in Month			0	2	1	1	1	0	0	0	0	0	2	0	1	0	1	1			Feb-15					1				
Nurse Bank Use	9908	826	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15					976	9737	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15					378	3795	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15					204	2667	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15					20	83	●		
Your Voice - Response Rate				13			12			11			11			9					Feb-15	13	5	7	7	9				
Your Voice - Overall Score				3.55			3.53			3.57			3.57			3.41					Feb-15	3.35	3.42	3.45	3.43	3.41				

Surgery B Group

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		O	E					
C. Difficile	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	96	97.0		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	96	93	94.1		●		
Falls	0	0						1	0	0	2	0	0	0	0	1	1	0			Feb-15	0	0	0	5	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			Feb-15	0	0	0	0	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				Jan-15	0	0	0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	99.4	95.4	98		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	98.8	100	99.1		●		
Never Events	0	0	1	●	1	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	●		
Serious Incidents	0	0			●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	2	●		
Mortality Reviews within 42 working days	100	=>97	●	●	●	●	●	●	●				●								Dec-14					●		

Indicator	Trajectory		Previous Months Trend																	Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		O	E					
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15		94.4	**94.4**		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●			●	●	●	●	●	●	●	●	●	●		●				Jan-15			**100**		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●		●	●	●	●		●	●	●	●				Jan-15		66.7	**66.7**		●		
Mixed Sex Accommodation Breaches	0	0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**			Feb-15	0	0	**0**	**0**	●		
No. of Complaints Received (formal and link)									9	3	10	11	8	12	11	14	14	12			Feb-15			**12**	**104**			
No. of Active Complaints in the System (formal and link)									31	40	34	37	36	37	47	33	35	35			Feb-15			**35**				
Oldest' complaint currently in system (days)									117	100	103	129	98	63	138	109	102	123			Feb-15			**123**				
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	1.0	1.07	**1.05**		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			Feb-15	0	0	**0**	**0**	●		
Sitrep Declared Late Cancellations	0	0	**14**	**19**	**36**	**15**	**22**	**3**	**22**	**17**	**16**	**14**	**16**	**12**	**11**	**7**	**24**	**11**			Feb-15	7	4	**11**	**153**	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0										**72**	**74**	**72**	**73**	**68**	**74**	**72**			Feb-15	72.25	72.65	**72.4**		●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	99.76		**99.8**	**99.02**	●		
Emergency Care 4-hour breach (numbers)								7	14	72	6	25	29	5	25	21	8	8			Feb-15	4	4	**8**	**220**			
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0		**0**	**0**	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	14		**14**	**14**	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	13		**13**	**20**	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	2.97		**2.97**	**3.27**	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	1.36		**1.36**	**1.7**	●		

Indicator	Trajectory		Previous Months Trend																	Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		O	E					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	79.5	84.3	81.2		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	92.6	90.0	91.9		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	94.8	92.4	94.0		●		
Patients Waiting >52 weeks	0	0	9	2	0	1	1	0	1	1	0	0	2	2	1	0	0	1			Feb-15	1	0	1		●		
Treatment Functions Underperforming	0	0	0	0	2	3	3	3	4	3	3	2	4	5	5	1	2	7			Feb-15	2	5	7		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0.0	0.2	0.16		●		
WTE - Actual versus Plan			24	23	27	37	37	28	34	38	33	32	28	30	27	30	32	29			Feb-15			28.8				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	85.66	98.2		88.4	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15				94.1	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	3.07	4.87	3.46	3.44	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	84	91		86.0	●		
New Investigations in Month			0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0			Feb-15			0				
Nurse Bank Use	2796	233	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15			196	2387	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15			8	453	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15			190	2089	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15			20	324	●		
Your Voice - Response Rate				18			19			17			17			14					Feb-15	7	29	14				
Your Voice - Overall Score				3.72			3.73			3.52			3.52			3.54					Feb-15	3.65	3.49	3.54				

Women & Child Health Group

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		G	M	P	C					
C. Difficile	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	1	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	97			98.3		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		95.5			95.5		●		
Falls	0	0						0	0	2	0	1	0	0	0	0	0	0			Feb-15	0	0	0	0	0	3	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			Feb-15	0	0	0	0	0	0	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0				Jan-15	0	0	0	0	0	2	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	98.6	82.6	0		90.1		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	99.0	99.4			99.1		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	100	100		100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	100	100	100		100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	0	●		
Serious Incidents	0	0			●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	4	●		

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		G	M	P	C					
Caesarean Section Rate - Total (%)	=<25.0	=<25.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		22.4			22.4	25.0	●		
Caesarean Section Rate - Elective (%)			10	11	12	11	10	10	8	9	9	7	9	7	8	11	8	6			Feb-15		5.6			5.6	8.3			
Caesarean Section Rate - Non Elective (%)			15	10	16	14	13	16	18	19	15	17	18	19	16	16	15	17			Feb-15		16.8			16.8				
Maternal Deaths	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		0			**0**	1	●		
Post Partum Haemorrhage (>2000ml)	48	4	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		0			**0**	**6**	●		
Admissions to Neonatal Intensive Care (%)	=<10.0	=<10.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		2.3			**2.31**	**2.32**	●		
Adjusted Perinatal Mortality Rate (per 1000 babies)	<8.0	<8.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		13.7			**13.7**		●		
Early Booking Assessment (<12 + 6 weeks) (%) - SWBH Specific	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		74			74		●		
Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15		190			**190**		●		
Mortality Reviews within 42 working days	100	=>97	●	●		●	●	●	●	●		●	●	●	●	●					Dec-14	86				**86**		●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15	95.9		100		95.9		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15	86.4				**86.4**		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jan-15	77.3				**77.3**		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			Feb-15	0				**0**	**0**	●		
No. of Complaints Received (formal and link)									4	6	11	8	8	8	12	7	11	9			Feb-15					**9**	**84**			
No. of Active Complaints in the System (formal and link)									15	21	21	24	29	29	33	12	21	27			Feb-15					**27**				
Oldest' complaint currently in system (days)									61	82	52	66	87	104	123	151	52	73			Feb-15					**73**				

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		G	M	P	C					
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	2.0		0.0		1.61		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			Feb-15	0				0	0	●		
Sitrep Declared Late Cancellations	0	0	13	14	13	7	12	12	3	4	7	6	6	7	7	7	1	5			Feb-15	5				5	65	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0										78	76	77	77	80	77	78			Feb-15	77.9	83.6			78.0		●		
Emergency Care 4-hour breach (numbers)								18	14	14	18	14	30	23	36	82	5	30			Feb-15	9	0	21	0	30	284			
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Feb-15	92.5				92.5		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Feb-15	97.7				97.7		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Feb-15	98.4				98.4		●		
Patients Waiting >52 weeks	0	0	4	2	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0		Feb-15	0				0		●		
Treatment Functions Underperforming	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Feb-15	0				0		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		Feb-15	0.0				0.0		●		

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		G	M	P	C					
WTE - Actual versus Plan			39	42	41	34	34	48	58	60	67	81	61	60	59	66	67	69			Feb-15					68.62				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	93.9	81.6	91	86.6		86.6	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15						83.3	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	4.13	6.16	4.13	7.20	5.69	5.07	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	92	84	87	85		85.0	●		
New Investigations in Month			0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	1			Feb-15					1				
Nurse Bank Use	6852	571	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15					676	5700	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15					90	410	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15					54	814	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15					20	46	●		
Your Voice - Response Rate				11			14		12			12			9						Feb-15	17	3	15	12	9				
Your Voice - Overall Score				3.79			3.74		3.65			3.65			3.53						Feb-15	3.44	3.98	3.2	3.78	3.53				

Pathology Group

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate					Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		HA	HI	B	M	I					
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	**0**	**0**	●		
No. of Complaints Received (formal and link)									0	1	0	1	1	3	0	2	3	1			Feb-15						**1**	**12**			
No. of Active Complaints in the System (formal and link)									1	2	1	2	3	6	5	5	8	7			Feb-15						**7**				
Oldest' complaint currently in system (days)									91	112	27	46	68	92	111	90	96	117			Feb-15						**117**				
WTE - Actual versus Plan			32	30	37	33	33	30	32	31	32	29	27	25	27	27	24	16			Feb-15						**16.02**				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	60.3	100	83.2	96.8	100		**85.7**	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15							**85.71**	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	4.69	1.51	5.57	3.60	4.24	**5.04**	**3.94**	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	89	92	94	97	94		**92.5**	●		
New Investigations in Month			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			Feb-15						**0**				
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15						**499**	**5769**	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15						**0**	**0**	●		
Your Voice - Response Rate				36			30			31			31			12					Feb-15	18	24	15	27	36	**12**				
Your Voice - Overall Score				3.6			3.43			3.74			3.74			3.76					Feb-15	3.29	3.77	3.74	3.85	3.98	**3.76**				

Imaging Group

Indicator	Trajectory Year	Trajectory Month	Previous Months Trend N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	Data Period	Directorate DR	IR	NM	BS	Month	Year To Date	Trend	Next Month	3 Months
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	0	●		
Unreported Tests / Scans																														
Outsourced Reporting																														
IRMA Instances																														
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15			77.6		77.6	72.0	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15			100		100.0	98.9	●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			Feb-15	0	0	0	0	0	0	●		
No. of Complaints Received (formal and link)									4	2	3	3	0	4	2	2	3	2			Feb-15					2	25			
No. of Active Complaints in the System (formal and link)									5	7	8	5	5	8	10	8	9	7			Feb-15					7				
Oldest' complaint currently in system (days)									19	40	59	30	52	76	72	75	83	75			Feb-15					75				
Emergency Care 4-hour breach (numbers)								30	39	41	32	34	49	50	52	45	41	49			Feb-15	49				49	462			
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0.2				0.24		●		
WTE - Actual versus Plan			20	21	18	28	28	15	13	11	13	22	14	16	15	21	21	33			Feb-15					32.75				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	74	91	81	91		77.3	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15						96.9	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	5.4	3.4	3.83	8.3	6.88	4.77	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	88	86	90	90		88.8	●		
New Investigations in Month			0	1	0	0	0	0	2	2	0	0	6	0	0	0	0	0			Feb-15					0				
Nurse Bank Use	288	24	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15					18	168	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15					114	1025	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15					128	1262	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15					0	0	●		
Your Voice - Response Rate				19		30		33		33		18									Feb-15	16		31	16	18				
Your Voice - Overall Score				3.72		3.73		3.73		3.73		3.28									Feb-15	3.1		3.3	3.9	3.28				

Community & Therapies Group

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		AT	IB	IC					
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15				100		●		
Falls	0	0						8	9	11	13	4	14	20	17	21	22	16			Feb-15	0	16	0	16	155	●		
Falls with a serious injury	0	0						0	2	0	0	1	0	0	0	0	0	0			Feb-15	0	0	0	0	3	●		
Grade 2,3 or 4 Pressure Ulcers (avoidable)	0	0						2	4	2	2	1	1	1	3	5	2				Jan-15		2		2	23	●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	●		
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	0	0	0	0	0	●		
FFT Response Rate - Wards	>25%	>25%						39	68	43	60	59	57	47	38	33	33	41			Feb-15				41.3		●		
FFT Score - Wards	=>68.0	=>68.0	100	93	85	83	82	81	95	87	83	91	82	88	73	87	100	95			Feb-15				95		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			Feb-15	0	0	0	0	0	●		
No. of Complaints Received (formal and link)									3	0	0	5	2	5	1	1	2	1			Feb-15				1	20			
No. of Active Complaints in the System (formal and link)									10	8	3	8	8	10	12	3	4	3			Feb-15				3				
Oldest' complaint currently in system (days)									94	##	75	38	60	64	81	75	61	82			Feb-15				82				
WTE - Actual versus Plan			70	32	34	34	34	27	36	45	45	62	65	67	71	75	76	72			Feb-15				72.21				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	95	94	92		93.3	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	4.8	4.2	7.2	5.95	4.92	●		

Indicator	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		AT	IB	IC					
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	94	93	90		91.7	●		
New Investigations in Month			0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0			Feb-15				0				
Nurse Bank Use	5408	451	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15				370	3374	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15				243	2231	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15				226	2658	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15				0	0	●		
Your Voice - Response Rate				18			33		32			32			28						Feb-15	21	36	26	28				
Your Voice - Overall Score				3.75			3.78		3.88			3.88			3.76						Feb-15	3.7	3.7	3.8	3.76				
DVT numbers	730	>61		30	40	57	53	53	62	87	39	33	70	35	42	47	54	53			Feb-15				53	575	●		
Therapy DNA rate OP services (%)	=<9	=<9				11	12	12	16	11	11	11	11	12	14	12	12	13			Feb-15				12.8	12.2	●		
FEES assessment	>100	>8.3					1	7	10	3	4	4	5	5	3	2	14	1			Feb-15				1	58	●		
ESD Response time	<48 hrs	<48 hrs			●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15						●		
STEIS	0	0		2	0	0	1	0	2	1	0	1	0	0	0	1	0	0			Feb-15				0	5	●		
Rapid response to AMU, RRTS	<60 mins	<60 mins		77	75	75	75	75	71	72	73	68	81	79	82	86	79	98			Feb-15				98	78.5	●		
Avoidable weight loss	<20%	<20%	●	●	●	●	●	18	0	8	0	0	0	0	0	9	0	0			Feb-15				9	3.8	●		
Green Stream Community Rehab response time for treatment (days)	=<11	=<11				15	11	12	7.9	11	16	16	17	14	12	13	9.5	12			Feb-15				12.1	12.8	●		

Indicator	Trajectory		Previous Months Trend																	Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		AT	IB	IC					
DNA/No Access Visits		%										3.3	0.9	0.7	0.9	0.9	0.9	0.8			Feb-15				0.75				
Falls Assessments - DN service only		%										72	58	49	45	45	62	54			Feb-15				54.4				
Pressure Ulcer Assessment - DN service only		%										73	61	50	48	46	63	57			Feb-15				56.5				
Healthy Lifestyle Assessments - DN Service only		%										61	54	48	39	43	58	54			Feb-15				54.4				
At risk of Social Isolation Referrals to 3rd sector DN service only		%										46	75	67	57	65	95	77			Feb-15				76.6				
MUST Assessments - DN Service only		%										9.4	11	9.9	11	9.8	19	18			Feb-15				17.6				
Incident Rates		per 1000 charge										3.6	4.8	4.9	3.5	3.5	5.1	4.1			Feb-15				4.1				
Dementia Assessments - DN Service only		%										72	62	55	52	51	61	62			Feb-15				62				
48 hour inputting rate		%										91	83	81	85	86	89	83			Feb-15				83.4				

Corporate Group

Indicator	Trajectory		Previous Months Trend																Data Period	Directorate							Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A		CEO	F	W	M	E	N	O					
No. of Complaints Received (formal and link)									8	4	5	6	5	7	6	6	15	5			Feb-15	0	0	0	3	0	2	0	5	67			
No. of Active Complaints in the System (formal and link)									16	13	12	13	21	21	25	12	21	16			Feb-15	1	0	0	6	0	9	0	16				
Oldest' complaint currently in system (days)									69	90	77	99	121	106	104	104	123	145			Feb-15	145	0	0	26	0	117	0	145				
WTE - Actual versus Plan			215	187	161	164	164	149	154	162	176	162	183	194	203	168	175	200			Feb-15								199.79				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	87	63	84	72	85	92	84		86.4	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15			100						100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	3.50	2.46	2.46	2.40	1.75	6.37	6.67	5.19	4.41	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15	90	94	92	90	95	88	89		89.4	●		
New Investigations in Month			1	0	0	2	2	0	1	3	1	0	5	0	0	0	1	0			Feb-15								0				
Nurse Bank Use	1088	91	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15								189	1921	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Feb-15								56	111	●		
Admin & Clerical Bank Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15	100	87	81	136	0	2368	433	3205	35066	●		
Admin & Clerical Agency Use (shifts)	0	0							●	●	●	●	●	●	●	●	●	●			Feb-15	0	1	0	0	0	0	0	1	462	●		
Your Voice - Response Rate				26			29			24			21			15					Feb-15	52	28	28	20	12	10	11	15				
Your Voice - Overall Score				3.56			3.57			3.6			3.49			3.48					Feb-15	3.81	2.77	3.85	3.49	3.24	3.52	3.37	3.48				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – P11 February 2015
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Management
AUTHOR:	Chris Archer, Associate Director of Finance - Corporate
DATE OF MEETING:	2 April 2015

EXECUTIVE SUMMARY:

Key messages:

- Forecast delivery of £4.6m plan surplus being better than LTFM commitment – reliant on significant non-recurrent measures and use of uncommitted reserves as contingency. Also requires mitigation of identified key risks. SLA income position with NHS England is now resolved and with SWBCCG agreed.
- In month headline performance £1.0m surplus including benefit of non-recurrent measures. Underlying operational surplus for month £833k. Year to date £4.0m surplus.
- Pay bill in month £23.6m being 3% lower on like for like basis than same period last year. Agency flat.
- CIP delivery continues below plan – Phase 1 workforce review concluded with Phase 2 in planning with a view to addressing 2015/16 pay bill reduction requirements.
- Capex spend remains significantly below plan with £1.1m undershoot forecast against amended CRL. No significant safety or quality issues arising from capital slippage. Resources c/fwd to 2015.16.
- Cash £13.6m above plan due to timing differences.

Key actions:

- Secure residual non-recurrent & expedient measures
- Secure expenditure run rate reductions and in particular in premium rate temporary pay costs. Consistent with run-rate requirements for 2015.16
- Secure service delivery to operational and CQUIN standards to minimise avoidable income losses

Key numbers:

- Month £970k surplus being £1,154k adverse to budget; YTD surplus £4,014k being £1,279k adverse.
- CIP delivery to date £10,8m being £7.5m adverse to revised plan and £4.9m adverse to TDA plan
- Forecast surplus £4.6m being £1.2m better than financial plan.
- Capex YTD £9,622k being £7,674k below plan.
- Cash at 28 February £45.5m being £13.6m above plan due to capex & working capital timing differences.
- CoSRR 3 to date as plan; forecast 3 as plan.
- Capital Resource Limit (CRL) charge forecast at £16.2m being £1.1m undershoot of revised CRL. Resources & capex c/fwd to 2015.16.
- External Finance Limit (EFL) charge forecast at £11.1m being consistent with approved EFL.

REPORT RECOMMENDATION:

The Trust Board 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 Finance & Investment Committee

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – February 2014 (month 11)

EXECUTIVE SUMMARY

- For the **month** of February 2015 against the DoH target, the Trust delivered a **"bottom line" surplus of £970k** being £1,154 adverse to flex budget. The **underlying operational surplus for the month is £833k,** materially better than the underlying break even anticipated in the forecast outturn.
- The **year to date surplus is £4,014k** being £1,279k adverse to flex budget to the end of February.
- A **year end forecast of £4,653k**, £1,279k better than its planned forecast. This forecast reflects delivery of significant non-recurrent benefits and management of key risk factors. The underlying position is break even.
- Actual **savings delivery year to date is assessed at £10,819k being £7,511k adverse to trust phased plan** [£4.9m adverse vs TDA plan]. The full year effect of schemes in delivery is £18.9m compared to plan of £20.6m. Further schemes with a potential full year value of £8.7m are in development.
- At month end there were 6,802 whole time equivalent (WTE) staff in post (excluding use of agency), 253 below the currently planned level. After 248 WTE agency staff, total **WTE's were 5 below plan**.
- Total **pay expenditure for the month is £23.6m** being in line with forecast and **being 3% lower than same period 12 months previous.** Agency spend is unchanged at £862k in February**.**

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	(1,154)	(1,279)	>= Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	(1,236)	(1,943)	>= Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	318	(6,073)	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	(2,460)	(2,939)	<= Plan	<= Plan	>1% above plan
WTEs Actual v Plan	5	(98)	<= Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000		13,622	>= Plan	>=95% of plan	<95% of plan

Note: positive variances are favourable, negative variances unfavourable

- **Cash balance at 28 February £45.5m being £13.6m ahead of cash plan**. Plan in place to meet EFL without material undershoot
- Year to date capex £9.6m. TDA has been advised of a year end forecast of £16.2m with a £1.1m undershoot on adjusted CRL . Resource will be carried forward to 2015/16.

2014/15 Summary Income & Expenditure Performance at February 2015	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	396,176	35,659	35,368	(291)	362,729	366,279	3,550	395,163
Other Income	40,178	3,379	4,576	1,197	36,810	40,329	3,519	46,067
Pay Expenses	(285,494)	(23,924)	(23,607)	318	(261,843)	(267,916)	(6,073)	(292,174)
Non-Pay Expenses	(126,460)	(11,237)	(13,697)	(2,460)	(113,129)	(116,069)	(2,939)	(123,670)
EBITDA	**24,400**	**3,876**	**2,640**	**(1,236)**	**24,567**	**22,624**	**(1,943)**	**25,386**
Depreciation & Impairment	(13,734)	(1,145)	(1,108)	37	(12,589)	(12,179)	411	(18,733)
PDC Dividend	(5,220)	(435)	(435)	0	(4,785)	(4,785)	0	(5,288)
Net Interest Receivable / Payable	(2,150)	(179)	(143)	36	(1,971)	(1,897)	74	(2,100)
Other Finance Costs / P&L on sale of assets	(150)	(13)	0	13	(138)	(77)	61	84
Net Surplus/(Deficit)	**3,146**	**2,105**	**954**	**(1,151)**	**5,084**	**3,687**	**(1,397)**	**(651)**
IFRIC12/Impairment/Donated Asset Related Adjustments	228	19	16	(3)	209	327	118	5,304
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,374**	**2,124**	**970**	**(1,154)**	**5,293**	**4,014**	**(1,279)**	**4,653**
Surplus / (Deficit) against TDA plan	3,374	395	970	575	2,978	4,014	1,036	4,643

In year Trust phasing of budgets reflects updated local plans

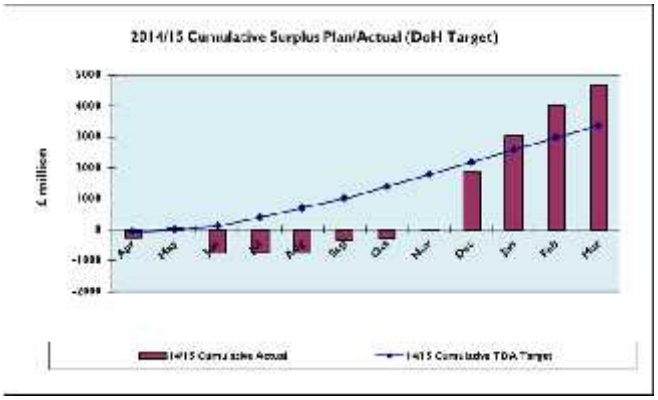
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – February 2014

Overall Performance against DoH Plan

The Trust delivered an actual surplus of £970,000 against a planned surplus of £2,124,000 in February. It is anticipated that this will be further improved in order to deliver a year end surplus target of £4.653m surplus.



Performance of Clinical Groups

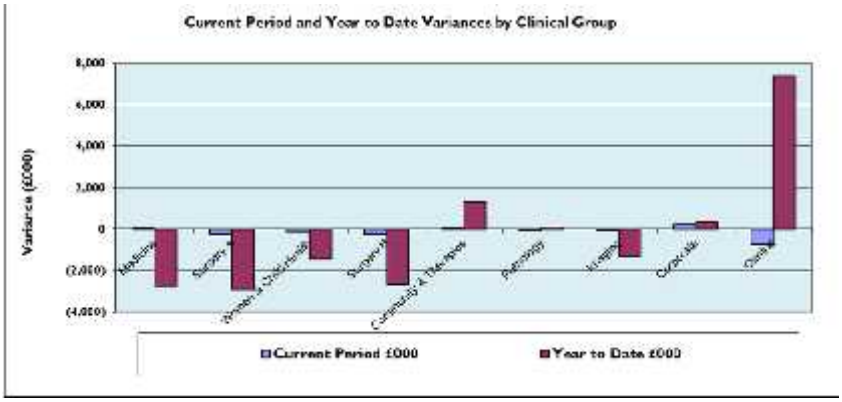
- The Group positions reflect the transfer of responsibility for the medically fit for discharge ward (MFFD) from Medicine to Community & Therapies and the transfer of Haematology from Pathology to Medicine.
- Medicine pay overspend of £2.7m includes £1.3m on HCAs and £1.1m on medical staff. Part of the £1.9m drugs and cardiology non-pay over spends are offset by additional income.
- Surgery A overspend includes £0.9m medics including waiting list initiatives and £0.9m shortfall on savings target delivery.
- Women & Child overspend includes £1.4m 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 £0.7m to date. continues.
- Community & Therapies is underspending by £0.8m on pay after savings shortfall and £0.3m on non-pay.

Group Variances from Plan (Operating income and expenditure)	**Current Period £000**	**Year to Date £000**
Medicine	19	(2,741)
Surgery A	(287)	(2,936)
Women & Child Health	(99)	(1,422)
Surgery B	(266)	(2,657)
Community & Therapies	30	1,316
Pathology	(52)	91
Imaging	(63)	(1,300)
Corporate	206	308
Central	(723)	7,398

- Imaging £0.9m savings shortfall. MRI over-performance.

Corporate Areas

- Corporate reflects net pay underspends offsetting savings shortfall.
- Central includes year to date benefit of VAT and depreciation review as well as release of reserves and provisions .

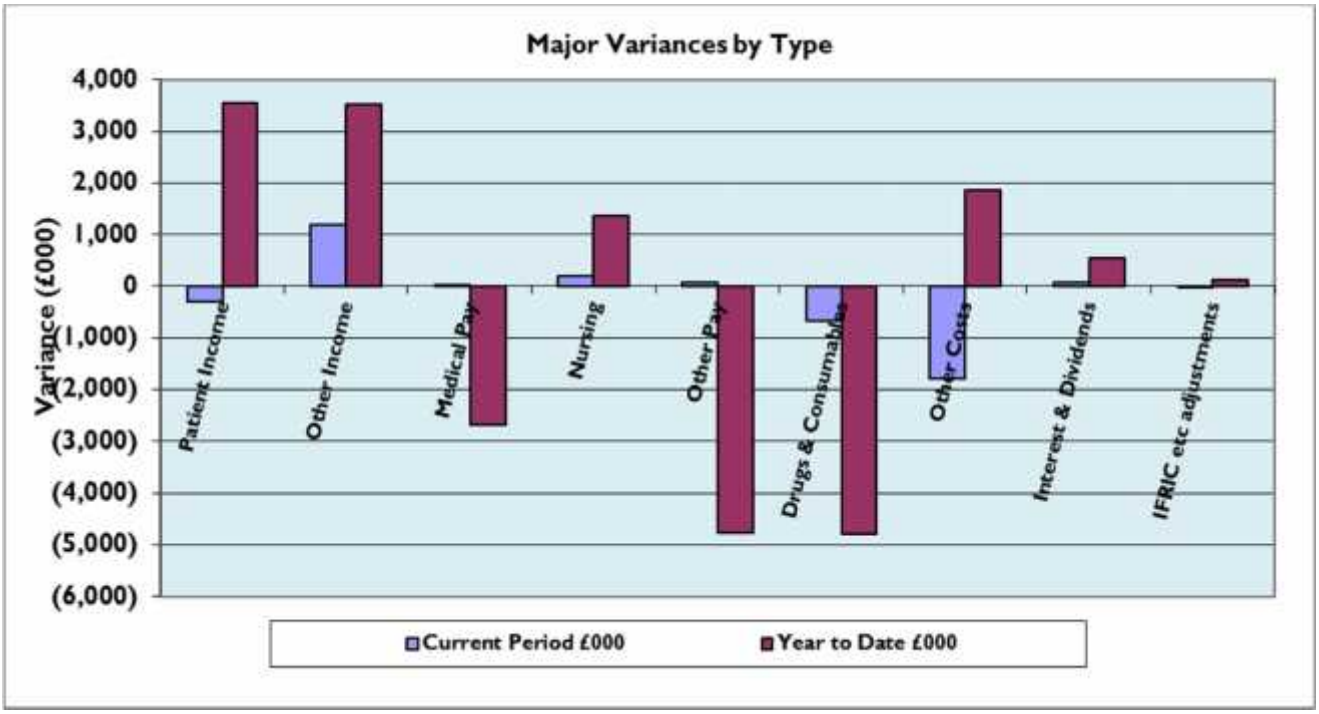


Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – February 2014

- Overall headline adverse variance to plan £1,154k in February, adverse £1,279k year to date. The variance position reflects the intended holding of investment reserves as contingency against failure to delivery savings plans.
- Patient income over performing due to pass through drugs and devices £1.7m, additional in year income £0.8m and emergency activity.
- Medical staff pay overspend in Medicine £1.1m includes A&E agency , Surgery A £0.9m and Surgery B £0.7m includes premium rate working.
- Nursing underspends £0.8m to date in W&CH.
- £1.7m of drugs / consumables overspend to date is pass through recovered through income.
- Other costs includes maternity pathway payments overspend £1.4m to date and release of unallocated reserves of £6.8m.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	(291)	3,550
Other Income	1,197	3,519
Medical Pay	34	(2,674)
Nursing	199	1,354
Other Pay	85	(4,753)
Drugs & Consumables	(678)	(4,799)
Other Costs	(1,782)	1,860
Interest & Dividends	86	546
IFRIC etc adjustments	(3)	118

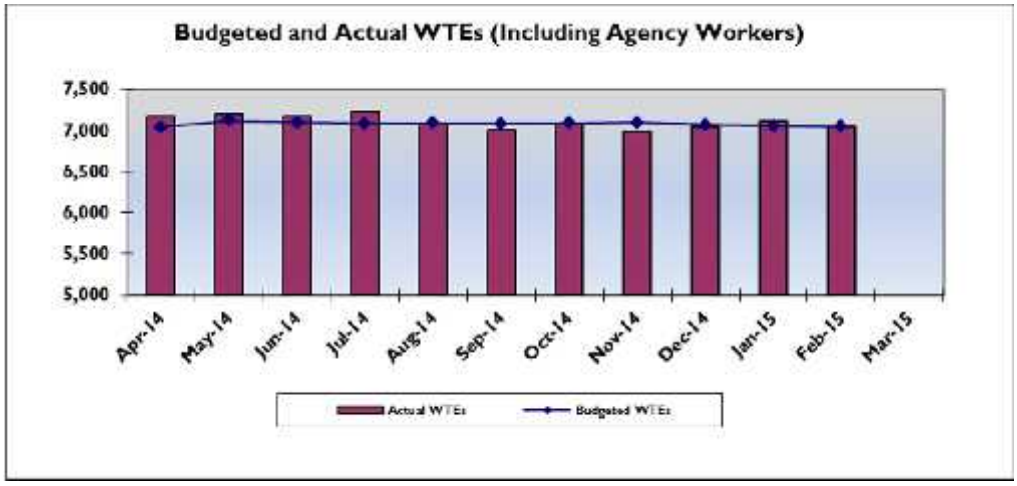


Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – February 2014

Paybill & Workforce

- There were 6,802 WTE in post in February plus an estimated 248 WTE of agency staffing across the month. In total this is 5 **WTE below planned establishments.**
- Total pay costs (including agency workers) were £23.6m in February. Pay spend is in line with the level anticipated in the Q3 forecast outturn. **Year on year pay is 3% lower on a like for like basis**.
- In month pay spend is £318k lower than budgeted. The year to date variance for pay is £6.1m adverse to plan.
- 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. Spending on scientific and therapeutic staff and on management and admin is below plan.
- Within the overall pay spend above, **agency staff in month was £862k in month, in line with February and marginally lower than November and December.**



Total Pay Costs by Staff Group

	Year to Date to February 2015					
		Actual				
	Budget	Substantive	Bank	Agency	Total	Variance
	£000	£000	£000	£000	£000	£000
Medical Staffing	72,241	71,110	0	3,805	74,915	(2,674)
Management	13,398	12,041	0	0	12,041	1,357
Administration & Estates	28,621	25,389	2,064	802	28,254	367
Healthcare Assistants & Support Staff	29,473	26,503	3,686	831	31,020	(1,547)
Nursing and Midwifery	84,687	74,289	4,727	4,317	83,333	1,354
Scientific, Therapeutic & Technical	41,092	37,533	0	703	38,236	2,857
Other Pay / Technical Adjustment	(7,670)	117	0	0	117	(7,787)
Total Pay Costs	261,843	246,982	10,476	10,457	267,916	(6,073)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – February 2014

Balance Sheet

Cash at the end of February was £45.5m, £8.2m higher than at the end of January and £13.6m higher than plan. This includes capital cash outflows being £11.8m lower than plan and reflecting higher cash receipts than planned, including some £4m from last year's activity over-performance settlements.

Payables is higher than plan at the end of February in part due to timing and prompt payment performance. Receivables are £7.2m above plan reflecting cash for contract over-performance not yet being received.

The forecast taxpayers' equity PDC reflects the receipt of capital funding from DH for Safer Hospitals Technology Fund; movement on retained earnings reflects the forecast surplus of £4.6m and impairments. The revaluation reserve has been updated following a valuation report on the Trust's assets.

STATEMENT OF FINANCIAL POSITION 2014/15

	Balance at 31st March 2014	Balance as at 28th February 2015	TDA Planned Balance as at 28th February 2015	Variance to plan as at 28th February 2015	TDA Plan at 31st March 2015	Forecast 31st March 2015
	£000	£000	£000	£000	£000	£000
Non Current Assets						
Property, Plant and Equipment	226,403	224,015	227,220	(3,205)	228,768	235,201
Intangible Assets	886	671	588	83	562	649
Trade and Other Receivables	1,011	1,295	700	595	700	700
Current Assets						
Inventories	3,272	3,223	3,600	(377)	3,600	3,600
Trade and Other Receivables	17,448	17,482	10,286	7,196	11,746	14,045
Cash and Cash Equivalents	41,808	45,531	31,909	13,622	24,252	28,300
Current Liabilities						
Trade and Other Payables	(55,138)	(58,134)	(43,427)	(14,707)	(43,546)	(43,679)
Provisions	(8,036)	(4,280)	(7,654)	3,374	(3,724)	(3,883)
Borrowings	(1,064)	(1,021)	(1,029)	8	(1,029)	(1,017)
DH Capital Loan	(2,000)	(2,000)	(2,000)	0	(1,000)	(1,000)
Non Current Liabilities						
Provisions	(2,562)	(2,985)	(3,262)	277	(2,522)	(2,363)
Borrowings	(27,915)	(26,998)	(27,884)	886	(27,884)	(26,897)
DH Capital Loan	(1,000)		0	0	0	0
	193,113	**196,799**	**189,047**	**7,752**	**189,923**	**203,656**
Financed By						
Taxpayers Equity						
Public Dividend Capital	161,640	161,640	161,712	(72)	162,211	162,210
Retained Earnings reserve	(19,484)	(15,798)	(10,632)	(5,166)	(10,255)	(12,366)
Revaluation Reserve	41,899	41,899	28,909	12,990	28,909	44,754
Other Reserves	9,058	9,058	9,058	0	9,058	9,058
	193,113	**196,799**	**189,047**	**7,752**	**189,923**	**203,656**

Financial Performance Report – February 2014

CASH FLOW

12 MONTH ROLLING FORECAST AT February 2015

ACTUAL/FORECAST	Jan-15 £000s	Feb-15 £000s	Mar-15 £000s	Apr-15 £000s	May-15 £000s	Jun-15 £000s	Jul-15 £000s	Aug-15 £000s	Sep-15 £000s	Oct-15 £000s	Nov-15 £000s	Dec-15 £000s
Receipts												
SLAs: SWB CCG	21,089	22,866	22,036	21,168	21,168	21,168	21,168	21,168	21,168	21,168	21,168	21,168
Associates	6,458	9,538	6,543	4,689	4,689	4,689	4,689	4,689	4,689	4,689	4,689	4,689
Other NHS income	598	670	1,085	2,371	2,371	2,371	2,371	2,371	2,371	2,371	2,371	2,371
Specialised Service (LAT)	4,280	8,649	4,150	4,338	4,338	4,338	4,338	4,338	4,338	4,338	4,338	4,338
Over/(Under) Performance Payments												
Education & Training	266			5,041			5,041			5,041		
Public Dividend Capital			570									
Loans												
Other Receipts	1,592	2,146	1,755	1,795	1,795	1,795	1,795	1,795	1,795	1,795	1,795	1,795
Total Receipts	34,284	43,869	36,139	39,402	34,362	34,362	39,402	34,362	34,362	39,402	34,362	34,362
Payments												
Payroll	13,574	13,431	13,360	13,323	13,323	13,323	13,323	13,323	13,323	13,323	13,323	13,323
Tax, NI and Pensions	8,634	9,378	14,448	8,882	8,882	8,882	8,882	8,882	8,882	8,882	8,882	8,882
Non Pay - NHS	2,173	2,389	3,875	1,397	1,397	1,397	1,397	1,397	1,397	1,397	1,397	1,397
Non Pay - Trade	12,473	6,770	15,300	9,350	9,350	9,350	9,350	9,350	9,350	9,350	9,350	9,350
Non Pay - Capital	1,171	2,968	1,591	1,781	990	990	990	990	990	990	990	990
PDC Dividend			2,610						3,267			
Repayment of Loans			1,000						1,009			
Interest			8	183	183	183	183	183	183	183	183	183
BTC Unitary Charge	421	415	878	278	278	278	278	278	278	278	278	278
NHS Litigation Authority	705	0	0	559	559	559	559	559	559	559	559	559
Other Payments	300	300	300									
Total Payments	39,451	35,651	53,370	35,753	34,961	34,961	34,961	34,961	39,237	34,961	34,961	34,961
Cash Brought Forward	42,480	37,313	45,531	28,300	31,949	31,350	30,750	35,191	34,592	29,716	34,157	33,558
Net Receipts/(Payments)	(5,167)	8,218	(17,231)	3,649	(600)	(600)	4,441	(600)	(4,875)	4,441	(600)	(600)
Cash Carried Forward	37,313	45,531	28,300	31,949	31,350	30,750	35,191	34,592	29,716	34,157	33,558	32,958

Sandwell and West Birmingham Hospitals NHS Trust

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Capital Expenditure & Capital Resource Limit

- Year to date capital expenditure is £9,6226k being £7,674k below plan.
- Forecast capex £16.2m being £1.1m undershoot against a revised CRL of £17.3m.
- No significant matters of safety or quality being impaired by capex undershoot. Cash resources carried forward to underpin 2015/16 capital programme.

Continuity of Service Risk Rating

- Year to date rating 3, forecast 3.0 which is an improvement against the planned rating of 2.5.

Memorandum		SIGN	Current Month Metrics			Forecast Outturn Metrics		
Continuity of Services Risk Ratings	Sub Code		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
Liquidity Ratio (days)								
Working Capital Balance	780	+/-	(11,915)	(2,422)	9,493	(13,301)	(6,493)	6,808
Annual Operating Expenses	790	+/-	371,401	383,985	12,584	405,044	415,689	10,645
Liquidity Ratio Days	800	+/-	(11)	(2)	9	(12)	(6)	6
Liquidity Ratio Metric	810	+/-	**2.00**	**3.00**	**1.00**	**2.00**	**3.00**	**1.00**
Capital Servicing Capacity (times)								
Revenue Available for Debt Service	820	+/-	22,657	22,693	36	24,842	25,418	576
Annual Debt Service	830	+/-	8,821	8,739	(82)	10,532	10,416	(116)
Capital Servicing Capacity (times)	840	+/-	2.6	2.6	0.0	2.4	2.4	0.1
Capital Servicing Capacity metric	850	+/-	**4.00**	**4.00**	**0.00**	**3.00**	**3.00**	**0.00**
Continuity of Services Rating for Trust	860	+/-	**3.00**	**3.50**	**0.50**	**2.50**	**3.00**	**0.50**

Service Level Agreements

- NHS Commissioner activity and income data for the first eight months of the year indicates an activity based over-performance of £2,783k including pass through drugs and devices over-performance of £1.7m. The block arrangement with Sandwell CCG worsens the position by £0.5m year to date.
- Within the total the contract with NHS England for specialised services is over-performing by £3.6m.
- Dialogue with commissioners has largely secured the outturn position with Sandwell CCG and Specialised Services which serve to reduce the risk to the forecast outturn position of the Trust as a whole.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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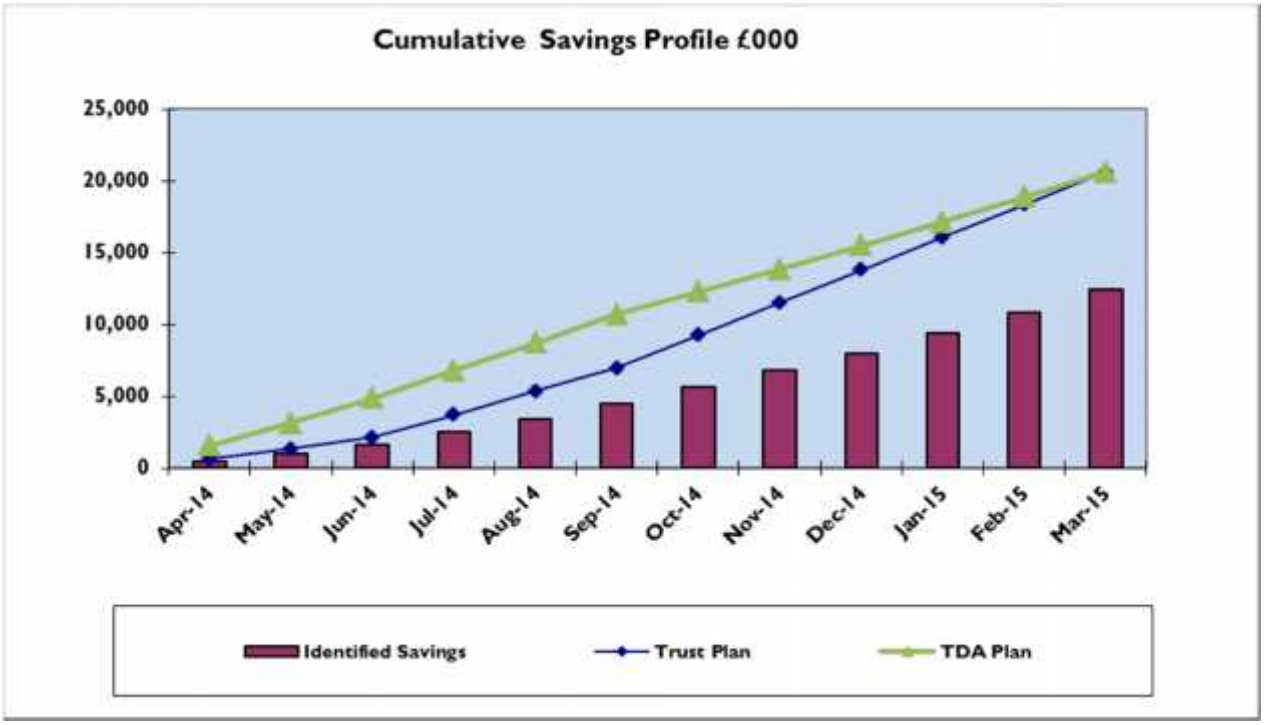
Savings Programme

- **Delivery to date is £10,819k which is £7.5m adverse to trust phased plan** [£4.9m adverse vs TDA plan].
- Schemes in delivery are forecast to realise £12.4m during 2014/15 and with full year effect of £18.9m in 2015/16 against plan target of £20.6m. Further schemes with full year value of £8.7m are in development.
- A programme of work to identify and progress further pay and workforce change consistent with the delivery in full of necessary cost reduction for 2014-16 is underway. This work is underpinned by arrangements to assess and assure the impact of any proposals on safety and quality.
- The forecast profile of savings delivery is shown below together with the original plan against which the TDA continues to monitor the Trust



Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – February 2014

Key issues informing the forecast position

- An overview has been taken of the Trust's likely position at 31st March which resulted in the Trust declaring a forecast surplus for the year of £4,653k to the TDA. This is £1,279k better than the planned surplus of £3,374k. The underlying forecast is break even.
- The year end position will reflect final agreement with commissioners on the year end position. Progress on those agreements has informed the declared position, particularly in relation to Specialised Services and Sandwell CCG's position on contract penalties.
- The position reflects the likely under-achievement of the savings programme. Savings with a full year effect of £18.9m have been identified, a shortfall of £1.7m which becomes the first call on reductions identified for 2015/16. These have been remedied by the delivery of substantial non recurrent measures.
- The forecast reflects overspending on Group pay positions in relation to premium rate staffing. Implementation of the first tranche of workforce review schemes is now underway. There remains a significant shortfall in the required pay cost reductions in order to meet the Trust's plan in 2015/16.
- The review of balance sheet flexibility and pressures includes the impact of staff restructuring.
- Significant progress has been made in determining the approach to maternity pathway payments to other providers and the year end position reflects the anticipated settlement position.

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Trust Annual Plan – 2015-16**
SPONSOR (EXECUTIVE DIRECTOR):	**Toby Lewis – Chief Executive**
AUTHOR:	**Toby Lewis – Chief Executive**
DATE OF MEETING:	**2 April 2015**

EXECUTIVE SUMMARY:

Our draft annual plan for 2015-16 sets out the Trust's 30 priority metrics for the year ahead. Of these, 10 priorities (emboldened in our plan) will be sponsored personally by our Chief Executive and Chairman, and reported monthly to the Trust Board. Our annual plan is reported publicly on a quarterly basis. The 30 priority metrics span our long-term objectives, which have underpinned our annual plans for several years. The goals reflect ambitions set out in Group and Directorate business plans submitted between January and March 2015.

These priority metrics are set out in the context of our Trust's overall vision, as well as the following:

- Key successes and shared learning in 2014-15
- Our 2020 ambitions
- Responding to the CQC report
- Supporting our workforce
- Preparing for changes in our technology in the next two years
- Preparing for Midland Met in 2018

REPORT RECOMMENDATION:

The Board is asked to approve the Trust's Annual Plan for 2015/16.

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

Accept	Approve the recommendation	Discuss
x		x

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

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

Comments:

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

Aligned to Trust strategic objectives

PREVIOUS CONSIDERATION:

None.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Our Annual Plan 2015/16

Board draft

April 2015

Contents

1. Introduction and purpose

Our long-term ambition to become renowned as the best integrated care organisation in the NHS: Everything in our plans, for services, education and research, reflects that goal.

The annual plan sets out what we are promising to do in *the coming twelve months*. There should be few surprises in the plan, which reflects work already underway within our Trust. Increasingly we are able to look forward with confidence to our long term 2020 vision. And we try within this document to briefly explain how the short term fits with that five year forward look.

The vast majority of the goals that we are setting out in this plan take us *beyond and above the standard* mandated by the NHS. They reflect feedback from patients, members, local residents, partners and 7,000 employees. On occasion, the priorities reflect instructions from government or our regulators. But good performance in 2014/2015 continues to give us a platform from which to control our own choices about what is most important.

Again and again within the plan, you will see that we are working to take good practice within the Trust, and make it Trust-wide. We have award winning community (iCares) and specialist (gynae-oncology) services in our midst. Five of our services have now achieved our prestigious Beacon service standard. But we know that those standards are not met consistently everywhere, and that spreading good practice and learning need work. So from April 2015, once a month, our whole organisation will devote itself to *organisational learning*. This commitment to becoming one organisation, spanning sites, hospital and community services, adult and childrens' teams, is a foundation for the work we have to do with partners beyond the organisation.

2015/2016 is a year in which the wider NHS will be under pressure as never before. Financial challenges are around us, and we face them too, and need is rising. National and regional policies are actively encouraging the transformation of services and organisations, and that means both risk and opportunity. With local community workers, statutory and third sector partners, GP colleagues, and with other Trusts, we need to work to align ambitions and get the best from our collective efforts. We would want, at the end of this coming year, to have in *particular improved further both trust and working relationships* with:

- Excluded communities in the super-diverse population that we serve
- Continuity and consistency of care with primary care and mental health providers
- Sub-specialist joint working with Walsall Healthcare and Dudley Groups of Hospitals

Although the focus of our plan is on patient care, the next twelve months must see us create and sustain the organisational form in which our staff can thrive – moving from the

organisation that we were, to the one we need to become to meet our future challenges. That means that we have work to do to recruit and retain key workers, even as we take further steps to reduce our pay costs – and we must cut our rates of sickness absence. It means that we will publish and begin to implement our three year Education Plan, in support of a clearer relationship to training and developing people. Training costs were in 2014-15 were ring-fenced, and we expect to continue that promise in the year ahead. It also means that we will invest in technology to help us to work smarter across the Trust. Reforming how our non-clinical services work will be important in *supporting leaders who run clinical teams*. Those leaders remain the heart of our development work, so that they are equipped to lead the Trust, not just for a year, but for many years ahead.

2. 2014/15– A Year in review

2014/15 saw us achieve clarity on our long-term plans for the Midland Metropolitan Hospital, a significant milestone in how we deliver care for the people of Sandwell and West Birmingham. We also began a long term process of workforce transformation, with the successful redeployment of over 150 staff in our midst. At the same time, we recognise that there is more to do to make the organisation a fulfilling place to work, and a place in which local teams can see their part in our long term future. Finally, our year ended with publication of the Care Quality Commission report. This highlighted the overwhelmingly caring nature of the Trust, whilst also confirming that we had significant areas of weakness, where basics we do well usually, were not consistently delivered. More than half our services were rated as Good, including all of our adult community teams. But the Trust as a whole has Room for Improvement.

As our plans for 2015-2016 reflect on that improvement, but also on consistent change over the recent past, it is worth highlighting some significant achievements over the last twelve months. Our plans lead to real action and genuine improvement, such as:

April: Full implementation of our **GP-based diabetes service, DiCE across SWB**: This provides specialist nursing and consultant physician support to practices, with a risk stratified focus on the population within that practice. Trust expert clinicians act to coach GPs and others in the latest developments in the field. The project won national recognition later in the year.

May: After an initial pilot in March 2015, **deployment of VitalPacs** reached more than half our target wards, and completed rollout over the summer. This system ensures observations are electronically recorded and alerts staff to patients at risk of deterioration. It is a key part of our safety culture.

June: We launched our revised **Whistleblowing Policy**, with information in everyone's payslips. The new approach, backed by staff-side and endorsed by the Trust Board,

provides a range of routes through which to raise concerns, including an independent external helpline.

July: Confirmation by the Chancellor of Exchequer that Treasury and the Department of Health are supporting the **Midland Metropolitan Hospital** development, now scheduled to open in 2018. £100m of taxpayer's money will be spent alongside the Private Finance 2 basis for this long awaited project, which brings acute care excellence onto a single site capable of offering 24/7 care to a high and consistent standard.

August: **Start of the pilot phase of Ten Out Of Ten**, a key safety project aimed at standardising care basics across our wards.

September: Our nurse leaders launched revised guidance and support tools to ensure that we have the right support in place for complex inpatient care, especially patients with dementia who need additional support. **The Focused Care toolkit** has helped us to reduce the use of agency staff and improve the quality of our service for some of the most vulnerable people.

October: We won the prestigious **Nursing Times Award for Integrated Care**. Our iCares team of nurses and therapists beat off national competition to scoop this inaugural award. The prize reflects wider praise for the service, both from the King's Fund and the Care Quality Commision.

November: **Conclusion of consultation on our workforce changes** – which signalled a major investment in overnight qualified nursing, as well as midwifery care. Almost a quarter of the proposals put forward for consultation were withdrawn or adapted based on feedback from staff and managers. The redeployment process began immediately and continues.

December: Opening of **our latest Intermediate Care unit** - D47 in Sheldon Block. This reflects our continued efforts to best meet the needs of residents across our districts for ongoing care and rehabilitation. This facility is delivered in partnership with Midland Heart. In February, a further pilot project with Seva-Care opened on behalf of Sandwell Metropolitan Borough Council.

January: The end of January saw us celebrate **1 full year without a Never Event.** BMEC had worked especially diligently to tackle a persistent issue with errors. But the whole Trust is engaged in ensuring that mistakes around consent, patient identification, and equipment do not re-occur.

February: Launch of our **new Cardiac MRI service based at City** Hospital. When combined with our outstanding Cardiac CT provision at Sandwell this provides an excellent basis for local expert care. Cardio-vascular diseases remain extremely prevalent in our local community. The Trust has strong service, educational and research presence in this field.

March: Launch of **our Live/Work scheme**. This project provides apprentice opportunities to young people from across Birmingham and Sandwell, many at risk of being without education or employment. The project is delivered for us by St Basils, and offers benefits free opportunities to over 25 apprentices. The Trust as a whole now has over 100 apprentices, and won two major awards for this work the Health Education West Midlands 2014 ceremony.

There are many more achievements of note, and these will be showcased in our 2014-2015 Annual Report, launched at our Annual General Meeting in June 2015.

3. Our 2015/16 Priorities: Safety and improvement through …

Taken together, we have 30 priority metrics for the year ahead. Of these 10 (emboldened in our plan) will be sponsored personally by our Chief Executive and Chairman, and reported monthly to the Trust Board. Our annual plan is reported publicly on a quarterly basis.

The 30 priority metrics span our long-term objectives, which have underpinned our annual plans for several years. The goals reflect ambitions set out in Group and Directorate business plans submitted between January and March 2015.

We will focus on aims and goals beyond this top 30, or the 10 with monthly focus. But the annual plan sets out a hierarchy of aims to which the Trust is committed.

Safe High Quality Care

We all contribute to the delivery of safe, high quality services to our patients. In 2014-15, we have made considerable progress in a number of key areas where our performance had not been as it should be. Through shared learning and focused improvement plans, the Trust has been 'Never Event' free for over 12 months. This is a huge achievement, and one which must be sustained throughout the coming year. Our CQC inspection has highlighted further areas of improvement for 2015-16. First and foremost we are an organisation that provides care for a diverse patient population: we must continue to aspire to the highest quality & safety performance standards as we move towards 2020.

Priority for 2015-16	How are we performing currently?	Where do we need to get to?
1. Reducing readmissions	• **Readmission rates seen marked improvement since we started actively implementing specialty based targets with clinical groups and other aspects of the readmission improvement project in April 2014**	• **2% fall in re-admission rates at Sandwell**

2. Improving outpatients by implementing phase 2 of our Year of Outpatients programme	• 2014-15 was our Year of Outpatients and we are about to implement Self Check In Kiosks, Partial Booking and other developments	• Maximum wait of 6 weeks • Elimination of clinic rescheduling • Reduction of 2% in DNA rate • 98% patient satisfaction rate
3. Achieving the gains promised within our 10/10 programme	• **10/10 launched in September 2014 and rolled out across number of wards**	• **Trust wide implementation of 10/10** • **Investment in ward managers to support**
4. Meeting the improvement requirements agreed with the Care Quality Commission	• Our Improvement Plan outlines in detail the specific areas of improvement across the Trust that must be achieved by October 2015.	We have five themes to our Improvement Plan: i. Better at learning across our organisation & spreading good practice ii. Consistently delivering the basics of great care iii. A visible reduction in sickness and vacancy rates iv. Best practice evident around local management & leadership v. Further evidence of incident reporting & risk management
5. Tackling caseload management in community teams	• **Successful implementation of new IT tools to make caseload management more visible and part of our management of performance**	• **All nursing caseloads (at team level) reduced to median in Black Country** • **Patient contact time increased by 10% among district nurses, health visitors and midwives**

Accessible & Responsive

Our Integrated Performance Report is produced on a month by month basis and captures all of our performance targets across the organisation. More locally, clinical and corporate directorate business plans for 2015-16 set out specific measures for improvement across their services. We all need to make sure that our patients are able to access our services as quickly, and safely as possible. GPs and primary care colleagues will be provided with an updated Directory of Services in summer 2015, which will allow patients to book an appointment into the most appropriate service at a time and date to suit them.

Priority for 2015-16	How are we performing currently?	Where do we need to get to?
6. Meet national wait time standards, and deliver from October a guaranteed maximum	• Consistent Trust level delivery of Referral to Treatment pathway targets, and Cancer Waiting Time targets	• Six week wait first OPD consistently met • 18 week RTT standard consistently met

six week outpatient wait	however underperformance by a number of specialties	
7. Double the number of safe discharges each morning, and reduce by at least a half the number of delayed transfers of care in Trust beds	• Project to have more patients 'home for lunch' in place in 2014-15 in medicine • DTOC projects at Sandwell reducing volume. No progress in Birmingham.	• Fewer than 15 DTOCs in Trust bed base • 40% of discharges take place before 12 midday
8. Implement Advice and guidance support for GPs in all specialties, and expand use of video technology to consult with patients	• From April 1st 2015, all Trust specialties will use Advice and Guidance, accessed through Choose and Book.	• All referrals triaged within 72 hours • 200% increase in AG use among GPs • Skype used for 500 consultations per month
9. Deliver our plans for significant improvements in our universal Health Visiting offer, so 0-5 age group residents receive high standards of professional support at home	• **Trust largely meets 14 day standard within Universal offer** • **Trust achieves less than half standard required for one and two year developmental checks** • **2015-16 sees switch to population based service model**	• **Trust meets by end of Q3 all standards set out in the contract** • **Trust agrees re-procurement plan with the new commissioning body**
10. Work within our agreed capacity plan for the year ahead, thereby cutting Do Not Attend rates, cancelled clinic and operation numbers, largely eliminate use of premium rate expenditure, and accommodating patients declined NHS care elsewhere	• **Demand & Capacity plans modelled at specialty level and detailed plans developed** • **Expectation of WLI below £1m for the full year in 2015-2016** • **Transfer of patients from UHB to SWBH**	• **DNA rates fall by 2% vs. outturn** • **All specialties by October 2015 achieve recurrent demand-supply balance** • **Weeks worked calculation delivered across all specialties**

Care Closer to Home

Our ambitions in our 2020 plan see us needing to grow more rapidly our local offering to patients and our communities. In 2014-15, we moved over 20 clinics to Rowley Regis and began a consultation process with our local patient population to ask for their input as to which other services they would like to see provided from Rowley. We also opened an intermediate care ward in Sheldon (D47) and the McCarthy ward at Rowley Regis.

The Trust's 2020 plan is centred on our ambition to be renowned as the best integrated care organisation in the NHS. This means that we need to continue to strengthen our partnerships with the third sector, general practice, and Local Authority supply chains so that patients are guaranteed coordinated care. We will strive to provide a greater number of our services in community settings, and seek to support all patients (particularly those with long term conditions) to self-manage their own health care needs.

Priority for 2015-16	How are we performing currently?	Where do we need to get to?
11. Expand our iCares and heart failure services to provide improved provision in West Birmingham, by agreement with local practices	• Well regarded services offered in Sandwell only • Clear demand for change in West Birmingham to tackle hospital delays	• Functioning services in place across selected GP practices in Birmingham
12. Implement our Rowley Regis expansion plans (Rowley Max), so that by March 2016 we have in place our RCRH model on the site	• **Consultation on potential uses of space concluded during 2014-2015** • **Implementation in year of significant ward and clinic expansion**	• **Plan approved during spring 2015-16** • **Fully implemented and services in situ by April 2016**
13. Ensure that we improve the ability of patients to die in a location of their choosing, including their own home	• Our End of Life service was rated as 'Good' by the CQC • Completed Board commissioned audit on last year of life	• Increase in proportion of patients identified for planned pathway >72 hours before passing • Increase in proportion of patients able to die in place of their choosing vs. audit baseline
14. Support agreed projects with selected GP partners through the CCGs 'push sites' initiative, designed to fit care models to local populations	• Push site picture very mixed, with good engagement with some projects and little with others • Focus on ICOF and YHP projects as a priority	• Push sites projects concluded evaluation, and some demonstrate meaningful impact of admission and outpatient volumes
15. Respiratory medicine service sees material transfer into community setting, in support of GPs	• Community respiratory service in place across Sandwell (now part of iCares) • Too much DCC time committed to routine clinic work	• The respiratory medicine equivalent of the DiCE project is in place • Unplanned readmissions for respiratory patients have been reduced at Sandwell

Good Use of Resources

Our Long Term Financial Model sets out the savings and efficiencies we need to make over the next ten years. The funding we receive continues to be reduced, and our challenge is to continue to provide high quality, reputable services within these means. We need to ensure that our Cost Improvement Programme and associated cost saving schemes are confirmed by X. In 2015-16 there will be a Trust wide review of Corporate Services which will allow us to make sure that clinical groups are supported to deliver their services through both transactional and advisory support functions.

Priority for 2015-16	How are we performing currently?	Where do we need to get to?
16. Implement successfully and safely the new tariff regime (Enhanced Tariff Offer) as the Trust moves to a PBR system with all commissioners by 2017	• Actively repatriate activity from local providers to SWBH • Continue to improve capture of activity and appropriate clinical coding to ensure Trust is remunerated appropriately for activity undertaken	• More SWB £ being purchased through SWBH than in 2014-2015 • Coding depth achieving benchmark levels seen among peers
17. Create balanced financial plans for all directorates, and deliver Group level I&E balance on a full year basis	• **Current focus is on delivering targeted support including use of clinical benchmarks to identify opportunities for improvement** • **£5-10m issue to be closed for 2015-2016**	• **Group level FYE I&E balance**
18. Develop our capital plan, and execute spend in line with that plan on a quarter by quarter basis	• Capital plan for IM&T developed in principle • Now needs to be matched by equipment and estate detail	• Both scale and phasing of spend achieved in line with Board approved plan for 15-16 • Land disposal feasible during 16-17 as stand-alone assets
19. Reform how corporate services support frontline care, ensuring information is readily available to teams from ward to Board	• Transfer of key reporting tool to BIU from April 2015 • Project team in place to create standard cycle of directorate, Group and Trustwide reports	• Reporting tool in place at frontline service level • Standard reports visible monthly to support performance improvement cycle
20. Reform how corporate services operate to create efficient transactional services by April 2016 that benchmark well against peers within the Black Country Alliance	• Project established to develop transactional services, with external support	• KPIs for each corporate service being met • Benchmarking work across partnership concluded and reported to the Programme Board, with rationalisation plan developed

21st Century Infrastructure

2015-16 will see the Trust submitting an Outline Business Case for a new EPR (Electronic Patient Records) system. This will enable us to do X. We will also invest £X in IT?

Our plans to open Midland Met in 2018/19 are progressing well. We will submit an Appointment Business Case to the Department of Health by June 2015, which will outline our preferred bidder and will lead us towards financial close by X.

Our urgent Cardiology services will be reconfigured onto one site (City) to give our acutely unwell patients quicker access to the treatment they need. Additionally, the Surgical Assessment Unit which is currently based at City will be moved to Sandwell to form an integrated assessment unit for emergency surgery and trauma assessment. This will mean that patients will be able to access the services they need in one place: a key foundation of our 2020 plan.

Priority for 2015-16	How are we performing currently?	Where do we need to get to?
21. Agree EPR Outline Business Case, and initiate procurement process, whilst completing infrastructure investment programme	• **The Outline Business Case (OBC) will be presented to Trust Board on 2nd April 2015**	• **Final bids returned in a form and to a value that can be approved by year end** • **Implementation capability in place for 2016-2017 deployment**
22. Reach financial close on the Midland Metropolitan Hospital	• **Appointment Business Case to be submitted in June 2015**	• **Financial close reached in year** • **Start on site commenced**
23. Complete consultation on, implement and evaluate the reconfiguration of interventional cardiology and acute surgery between our acute sites	• Extensive engagement with local population to inform reconfiguration plans • Investment identified to support changes, and projects in place to support new workforce models	• Successful transfer completed and benefits tracked • All SGH surgical specialties meeting 48 hour maximum wait for surgery • Capacity at Sandwell aligned to winter 2015 plans
24. Develop, agree and publicise our final location plans for services in the Sandwell Treatment Centre	• Trust estate strategy and MMH OBC sets out footprint and capital sums • Commitment to conclude planning and discussion by the end of the calendar year 2015	• Architect designed completed plan available for STC 2019 • Departments relocating from City site know their future location at Sandwell • Investment trajectory agreed as part of 2016-2019 capital plan

25. Finalise and begin to implement our RCRH plan for the current Sheldon block, as an intermediate care and rehabilitation centre for Ladywood and Perry Barr	• Successful establishment of 20 additional intermediate care beds in Sheldon in 2014-15 • Layout plan for the new unit beginning to take shape	• Successfully procured as the W/Birmingham Intermediate care facility (under the BCF)

An Engaged and Effective Organisation

The Trust committed to achieving increased levels of patient and staff engagement. The national Friends & Family Test has been rolled out to further departments within the Trust, and we continue to implement improvement schemes to increase response rates and levels of patient satisfaction.

Staff sickness will remain a key priority, with a particular focus on short-term sickness levels. We will be working with teams to ensure that they develop local solutions and trajectories for improvement, grounded in what we know works already in many parts of our organisation.

Priority for 2015-16	How are we performing currently?	Where do we need to get to?
26. Cut sickness absence below 3.5% with a focus on reducing days lost to short term sickness	• **Sickness Absence is reported as 5.34% for January 2015, and 4.61% for the 12-month rolling period.** • **Sickness absence plan being developed based on February Hot Topics feedback, grounded in tackling departmental hit spots**	• **A clear reduction starting from Q2 in sickness rate within the Trust** • **Delivery of trajectories for input measures that we know work, specifically return to work interviews, and referral to formal procedures for majority of staff who appear to breach thresholds in our policy** • **Individual target dates for return to work in place for all individuals off work for 6 months+**
27. Finalise our long term workforce plan, explaining how we will safely remove the paybill equivalent of 1000 posts between 2016 and 2019	• 'Safe and Sound' workforce programme to commence in April 2015 • Plan to meet LTWM in place with project workstreams identified for 16-18 • Group level development days for long term plan being scheduled for June	• 16-17 pay/wte start point and proposed change plans reflects Long Term Workforce model at Trust level
28. Create time to talk within our Trust, so that engagement is	• Quality Improvement Half Days scheduled from April	• Improvement on employee engagement score by 5%+

improved. This will include implementing Quality Improvement Half Days, revamping Your Voice, Connect and Hot Topics, and committing more energy to First Fridays	23rd 2015 (on monthly basis) • Internal communication study undertaken through Hot Topics • Your Voice well established across Trust, with three Groups showing high reporting rates (C&T, path, corporate)	• Your Voice response rate at 25%+, and action recognition rate above 50% • Hot Topics attendance routinely above 100 senior leaders • Survey data on senior leader visibility shows high rates of recognition • Survey data shows improvement in views of organisation communication
29. Agree and begin to implement our three year Education Plan	• Final draft due with Trust Board at June meeting • Education contracting landscape understood and documented	• Individual portfolios established for band 5 and above • Rollout of new appraisal system (performance/potential) on track
30. Complete the second year of our leadership development programme, providing clinical leaders with the skills and expertise to lead the organisation forward	• Several cohorts of the first top leader programme have commenced - 150+ leaders on programme. • 360 degree appraisal to be rolled out for all leaders on a 3 year cycle	• Leadership evaluation shows improvement in organisational climate vs. 2014 baseline data (above 50%+)

4. How this fits with our longer term plans – our 2020 Vision

This annual plan deliberately focuses on the year ahead and what we need to achieve in the coming months. We have, over the course of the last year spent considerable time working with our clinical teams in setting out our vision for the longer term.

As stated, our ambition is to be renowned as the best integrated care organisation in the NHS. Our 2020 Vision describes the path we will take to work towards achieving this, what integrated care will look and feel like for our staff and patients, and what local people can expect to experience and expect from us in 2020.

The objectives in this plan form the building blocks needed to help achieve this ambition. This ranges from the work we are doing to expand our services at Rowley Regis over the next two years as well as our plans to expand our intermediate care services in the current Sheldon Block at City Hospital.

Replicating the success of our DiCE service, we intend to transform the models of care for certain services we offer where we feel these would be better joined up and delivered in

conjunction with our primary care partners in local premises. In the year ahead our focus will be on respiratory medicine.

We will measure our progress on a quarterly basis, and this will be governed through our Board, with progress reported to our Clinical Leadership Executive, which has representation from each of our clinical Groups, as well as the full Trust Executive.

In June and July 2015, we expect to publish our 2020 Vision, so that we can be explicit with local residents, as both patients and taxpayers, how we will secure the future of local NHS excellence, while we transition even more care into homes and community locations.

5. Responding to our 2014 CQC report: Where we need to improve

In March 2015, we published our Improvement Plan. This responded to the CQC inspection published at the same time, from visits undertaken in October 2014. Delivery of that improvement plan forms one of five quality and safety priorities outlined above for the coming year. In its current draft we expect to deliver the full Improvement Plan not later than the end of October 2015. This is the part of the change programme that responds to the must and should do recommendations made by the Chief Inspector.

We identify in our Improvement Plan 5 thematic changes that we want to develop over the course of the coming year. They very much maintain projects and initiatives developed in the prior year, and as such reflect the kind of organisation we are becoming.

We want to:

- Be better at learning across our organisation, spreading good practice and identifying why some wards, teams and departments are better able to deliver outstanding outcomes for patients – the solution to our issues is already being implemented somewhere in our Trust
- Ensure that we consistently deliver the basics of great care, with disciplined implementation of policies on hand-washing, medicines security, end of life decision making, and personalised care observations – we have to get this right every time
- Tackle our sickness and vacancy rates if we are to reduce gaps in our care, and ensure that all of our staff have time and space to be trained and to develop their skills – being fully staffed matters.
- Build on our best practice around local management and leadership, empowering capable local managers, and reducing hierarchies between executive and departmental leaders – communication can be better here and must be two-way

- Do even more to evidence how our incident, risk management, and safety data inform the decisions that we make and the priorities that we set – we know where our issues are, and need to address them more quickly when they are identified

6. Where everyone matters 2015: Supporting our workforce to care

The publication of our education and learning plan in the first few months of 2015-2016, as well as the recent recruitment of the Trust's first Board level workforce director for over five years, are both important milestones in a renewed focus on the people who are our organisation. It is well known that we expect to operate with fewer employees in the future than at present, a position true across the NHS as the Chief Executive of NHS England recently reiterated. Our openness about that future is designed to promote a mature discussion about future workforce needs and shape.

It is imperative that the teams we have are able to function effectively, have time to learn, and are supported to develop the key skills needed to provide outstanding care. 2015-2016 will see us tackle some very basic must-dos. We have to cut our sickness rates, reduce our vacancy rates, and improve morale and engagement. Those aims cannot be instead of reforming services or tackling our finances, but they are part of both of those goals.

We invested in 2014-2015 in leadership. That investment continues as we seek to deepen and broaden the calibre of talent able to take services forward in the future. We ring-fenced and grew our training budget in 2014-2015 and plan to do so again in the years ahead. Importantly we need to commit that spend to employees' future roles with us, as well as their current jobs. The deployment of our new appraisal model over the coming 18 months makes explicit a dual focus on performance and potential for everyone who works with us.

7. Getting ready for our technology revolution 2016/2017

We will make a major decision during 2015-2016 about our IT future. The electronic patient record business case will move through outline to final stage, with approval at both Trust and regulatory level. That is the largest single investment in a wider platform of changes funded within our long term financial model, approved in December 2013.

That investment programme is underpinned by changes we need to make to ensure the resilience of our systems. That investment will be significant in 2015-2016 to bring key infrastructure up to date, improve speed and capacity within our networks, and ensure resilience and security is further enhanced.

But our IT changes are, in reality, changes in how our employees use technology, as well as introducing front-end technology into the patient's experience of care – either through our

outpatient self-check in kiosks, which go Trust-wide in 2015-2016, or our expansion of Skype consultation intended for the year ahead.

The importance we attach to this enabler cannot be under-estimated. Whilst in staff engagement and in planning Midland Met, we are building on long-term traditions within the Trust, our technology changes are described as a revolution, because they do not have precedent in our culture to this point. Whilst 2014-2015 saw significant deployments with both VitalPacs and Badgernet, the changes ahead are whole organisational ones, intended to make work simpler, more standardised, and less paper based.

8. Getting ready for the Midland Met in 2018: Changing acute care

The year ahead will be the one in which the development of the new hospital becomes irrevocable. The scheme needs to achieve final planning consent on its Grove Lane site. Over the last few months, we have completed site demolition, and are now undertaking remediation. Some early works are expected to take shape before the end of 2015, and during this financial year, covered by this plan, we will sign a 30 year+ contract with our preferred provider.

Whilst the new hospital is a crucial part of care transformation locally, and an important regeneration activity on the Windmill Estate and for Smethwick as a whole, it is only one part of the jigsaw of change needed locally. In addition to GP developments in SWB, our own investment programme sees us conclude work in Rowley Regis and on the City site at Sheldon, before we begin a major sequenced redevelopment of the Sandwell/West Bromwich site to create the Sandwell Treatment Centre, and to locate corporate services for the Trust as a whole onto the site.

By 2018 the Trust's services will be delivered on a consistent Sandwell and West Birmingham basis, with variations reflecting local or practice population differences. The scale of change needed to offer all our services on a distributed basis, quite unusual if not unique within the NHS, is not underestimated. The next two years are pivotal in the likelihood of success for the vision, as well as for the wider Right Care, Right Here Partnership.

Comments on, and questions about, our Annual Plan for 2015-2016 are welcome.

Please contact our Communications Team via XXXXXXXXXXXXXXXXXXXXXXX

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Plan 2015/16
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Management
AUTHOR:	Chris Archer, Associate Director of Finance - Corporate
DATE OF MEETING:	2 April 2015

EXECUTIVE SUMMARY:

Introduction

This paper proposes an initial financial plan for 2015/16.
Its focus is on the income and expenditure plan for the year.
A full plan including capital, cash, balance sheet and risk rating shall be represented in an LTFM underpinning the Appointments Business Case for the Midland Met Hospital and which shall be considered by the Board at its next meeting.

Key points

The proposed income & expenditure plan for 2015/16 necessarily contains significant risks. This reflects both the generic financial pressures placed on providers by the NHS financial regime and the trust specific commitment to generate resources to enable investment for necessary change and improvement. Be in no doubt 2015/16 represents a financially very tough and challenging year.

To address these significant risks will require greater consistency in the delivery of operational standards to optimise income recovery and to underpin market share growth through repatriation. Importantly, it will also require the trust to press ahead with further workforce change and to accelerate those transformational changes necessary to maintaining sound finances consistent with safe, high quality services in the period before Midland Met opening. For example middle & back office.

The trust is forecasting to deliver a headline surplus of £4.6m for 2014.15. The underlying position is one of break even and the difference is indicative of the scale of non-recurrent measures necessary to deliver its financial plan for that year. Importantly, it also emphasises a need to improve the scale and pace at which productivity improvement and cost reduction can be safely achieved.

This plan proposes a headline surplus of £3.4m [0.8%] for 2015/16 being consistent with the Trust's agreed LTFM. That requires a c£19m reduction in costs.

SLA income is planned at £392m of which £259m from SWBCCG & including £3m of repatriated activity. As at the time of writing key contracts with CCGs and NHSE remain to be concluded.

There are key risks in respect of contract value [notably the SWBCCG sum exceeds that in the OBC] and terms of trade [notably Lucentis].

The plan assumes contract penalties do not exceed £2m [capped to that value in 2014.15 but prohibited in the proposed standard NHS contract & which places increasingly onerous penalties for ED & RTT non-compliance] and 100% delivery of CQUIN standards to secure £9m.

Under the Enhanced Tariff Option the trust also faces a 70% marginal rate on NHSE specialised services above a yet to be agreed baseline. This shall require appropriate management of those services to

mitigate any adverse financial impact.

The plan makes £9.5m provision for inflation and which reflects agreed pay awards and a realistic assessment of forward non-pay inflation.

Activity growth from local demography and repatriation is assumed to be deliverable at a marginal cost of 60%. This requires to be confirmed by the operational work on demand & capacity planning.

Investment reserves total £4.5m [1%] including £3.0m noted as RCRH consistent with the OBC for MMH. There is a £3m [0.7%] contingency.
Taken together the accountable officer judges these sufficient to meet our known safety and quality obligations in the year ahead.

At the time of writing there remains a gap to secure financially balanced plans from each and all clinical groups & corporate directorates. This further emphasises a need to improve the scale and pace at which productivity improvement and cost reduction can be identified and safely achieved. This gap is weighted into the latter months of the financial year.

This will be remedied through the development & execution of CIP & workforce change plans. There should also be benefit from strategic transformation programmes such as transactional excellence & YoOP and potential acceleration of 2016/17 schemes. The timing of that remedy will necessarily create an end-loaded CIP and consequent risk of Q1 / Q2 deficit coincident with key MMH decision points.

It is intended that finalisation of the 2014/15 accounts enables the retention of some balance sheet flexibility into 2015/16. It is proposed that up to £5m of that flexibility be used across P01 through P06 to appropriately 'smooth' the P&L profile across the year.

Importantly, that groups & directorates are required to live within their approved control total / budget for the year such that that flexibility is 'made good' and there is full & proper delivery of cost reduction consistent with maintenance of the LTFM risk rating profile.

Summary

- 2015/16 represents a financially very tough and challenging year.
- The proposed income & expenditure plan for 2015/16 necessarily contains significant risks.
- To address these significant risks will require greater consistency in the delivery of operational standards and, importantly, it will also require the trust to press ahead with further workforce change and to accelerate those transformational changes necessary to maintaining sound finances consistent with safe, high quality services.
- This plan proposes a headline surplus of £3.4m [0.8%] for 2015/16 being consistent with the LTFM for the business case for new hospital investment. That requires a c£19m reduction in costs.
- Contracts for SLA income remain to be concluded. There are risks to contract value and terms of trade. The ETO tariff option presents challenges to avoid financial risk from marginal rate funding.
- The plan proposes £4.5m [1%] resources for investment in change & improvement and £3m [0.7%] contingency.
- The plan proposes an appropriate use of balance sheet flexibility whilst requiring the full & proper delivery of cost reduction consistent with maintenance of the LTFM risk rating profile.

REPORT RECOMMENDATION:

The Trust Board is requested to CHALLENGE & CONFIRM this initial financial plan for 2015/16 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	x
Business and market share	x	Legal & Policy	x	Patient Experience	
Clinical		Equality and Diversity	x	Workforce	x
Comments:					

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

Good use of Resources

PREVIOUS CONSIDERATION:

Considered by Finance & Investment Committee

FINANCIAL PLAN 2015.16

Summary Income & Expenditure Profile

Financial Plan 2015.16 Profile I&E	Annual Budget	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Plan 2015/16
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
SLA Income	394,125	32,844	32,844	32,844	32,844	32,844	32,844	32,844	32,844	32,844	32,844	32,844	32,844	394,125
SLA income - fines	-2,000	-167	-167	-167	-167	-167	-167	-167	-167	-167	-167	-167	-167	-2,000
SLA Income - resilience	2,397	479	479	479	479	479	0	0	0	0	0	0	0	2,397
Other Income	42,660	3,555	3,555	3,555	3,555	3,555	3,555	3,555	3,555	3,555	3,555	3,555	3,555	42,660
Sub-Total Income	437,182	36,711	36,711	36,711	36,711	36,711	36,232	36,232	36,232	36,232	36,232	36,232	36,232	437,182
Pay	-283,475	-23,623	-23,623	-23,623	-23,623	-23,623	-23,623	-23,623	-23,623	-23,623	-23,623	-23,623	-23,623	-283,475
Pay savings	14,764	492	492	492	984	984	984	1,476	1,476	1,476	1,969	1,969	1,969	14,764
Non-Pay	-117,925	-9,827	-9,827	-9,827	-9,827	-9,827	-9,827	-9,827	-9,827	-9,827	-9,827	-9,827	-9,827	-117,925
Non-Pay savings	4,397	147	147	147	293	293	293	440	440	440	586	586	586	4,397
Reserves - resilience	-2,192	-438	-438	-438	-438	-438	0	0	0	0	0	0	0	-2,192
Reserves - investments	-4,500	0	0	0	-500	-500	-500	-500	-500	-500	-500	-500	-500	-4,500
Other reserves	-21,313	-1,776	-1,776	-1,776	-1,776	-1,776	-1,776	-1,776	-1,776	-1,776	-1,776	-1,776	-1,776	-21,313
Non-recurrent flexibility - use	5,000	300	300	300	250	250	300	0	0	0	0	0	0	1,700
Non-recurrent flexibility - return	-5,000	0	0	0	0	0	0	-250	-250	-250	-350	-300	-300	-1,700
Sub-Total Expenditure	-410,245	-34,726	-34,726	-34,726	-34,637	-34,637	-34,149	-34,060	-34,060	-34,060	-33,521	-33,471	-33,471	-410,245
EBITDA	26,937	1,986	1,986	1,986	2,074	2,074	2,083	2,172	2,172	2,172	2,711	2,761	2,761	26,937
Financing Costs	-23,506	-1,959	-1,959	-1,959	-1,959	-1,959	-1,959	-1,959	-1,959	-1,959	-1,959	-1,959	-1,959	-23,506
Surplus (statutory accounts)	3,431	27	27	27	115	115	124	213	213	213	752	802	802	3,431
Adjustments	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Surplus (DH target)	3,431	27	27	27	115	115	124	213	213	213	752	802	802	3,431

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 27 February 2015; 1030h – 1230h

Present

Ms O Dutton [Chair]
Mr R Samuda
Mrs G Hunjan
Dr S Sahota OBE
Dr R Stedman
Miss R Barlow
Mr C Ovington
Miss K Dhami
Ms C Parker

In Attendance

Ms A Binns
Mr G Smith
Mrs D Talbot
Ms S Amin

Secretariat

Mr S Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
No apologies for absence were received.	
2 Minutes of the previous meeting	**SWBQS (1/14) 015**
The minutes of the Quality and Safety Committee meeting held on 30 January 2015 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBQS (1/15) 015 (a)**
The updated actions list was received and noted by the Committee.	
MATTERS FOR DISCUSSION/DEBATE	
4 Care Quality Commission update – Must and Should Dos	**SWBQS (2/15) 017** **SWBQS (2/15) 017 (a)**
Miss Dhami noted that most Board members had seen the action plan to address	

the Must and Should Do recommendations within the draft report from the Care Quality Commission following the inspection in October. It was noted that the plan was evolving and the plan had been shared with the Clinical Leadership Executive which would provide further input. A further action plan was reported to have been developed which was tailored to staff and public.

Miss Dhami reported that some of the recommendations proposed were identical for both City and Sandwell Hospitals.

The themes arising from the report were discussed. Mr Ovington reported that these included medicines safety, such as unlocked medicine cabinets. It was noted that a further theme included nursing documentation and care planning. Referring to the action plan, Ms Dutton asked whether this recommendation had been fully addressed. She was advised that the documents were robust but they were not always completed which was a serious concern. Other themes included interpreters and nurse staffing.

Miss Barlow added that further themes included ED development and the lack of governance around the area. Imaging was also noted to be of concern, as was outpatients and in particular training, such as mental capacity. It was noted that training arrangements were being revised. Mr Ovington noted that this issue also needed take into account medical staff and other staff groups. Ms Dutton asked if there were any risks that the Committee needed to be particularly aware of. She was advised that the work was challenging but there was confidence that it would be delivered.

Dr Stedman reported that some key medical themes related to surgery and complications arising after surgery. As a result, the post-operative monitoring processes would be reviewed and revised care packages would be introduced. The findings against the WHO checklist practice were noted to be disputed, although the auditing of the completion of these forms and the process for observing the use of the checklists would be given direct attention. Mrs Hunjan noted that the rating for completeness of the checklists had not been provided, although it was noted that this was on track.

Miss Dhami reported that the learning from incidents and complaints was an issue raised by the CQC and further work would be undertaken to strengthen this. It was noted that there was a suggestion that less serious complaints were not being considered robustly meaning that some key themes might be missed. Information governance concerns were also raised around the security of records, which would be addressed.

Mrs Hunjan asked for further information on the position concerning end of life care. Dr Stedman reported that at the forthcoming CD/DD away day, a session was to be facilitated by the Trust's solicitors in terms of doctors' responsibilities in respect of consent and the mental health act requirements.

In terms of the link between the report and the risk register, it was reported that risk assessments would be considered to ensure that robust plans were in plans.

Mr Samuda noted that the outreach service business case had been approved some time ago but had not been acted upon. Dr Stedman reported that this needed to be reviewed in the context of the Hospital at Night team to determine if the team could be rationalised. It was highlighted that following the partial completion of the review, recruitment into critical care outreach had commenced although impact on ITU was being monitored. Miss Dhami noted that plans were in place to support staff referenced in the report. Ms Parker reported that from the CCG perspective, some communications would be developed around the quality work and improvements that had been secured. She highlighted that there were no issues raised in the report that the CCG had not been appraised of previously.	
5 Ward concerns	**SWBQS (2/15) 018** **SWBQS (2/15) 018 (a) - SWBQS (2/15) 018 (e)**
Mr Ovington presented a report highlighting wards of current concern. It was reported that ward D17 was of particular concern. It was reported that there was a high vacancy rate on the ward and there were further concerns around leadership and standards of care. The Committee was advised that steps had been made to improve the leadership of the ward and a condition report had been initiated which had prompted the commencement of an investigation. Mr Ovington reported that there was a tangible improvement in the area that had been seen since the measures had been implemented. It was reported that robust monitoring arrangements were in place on the ward and meetings had been arranged with the current ward team to agree the indicators that would be monitored. Dr Sahota suggested that these concerns needed to be picked up before the matter escalated to unacceptable practice, directed by incidents for example. He suggested that it was unacceptable that the ward needed to borrow equipment from other wards. Mr Ovington acknowledged that this was the case for routine equipment but stressed that the use of an equipment library was an effective solution to equipment not used on a regular basis, such as hoists. Dr Stedman highlighted that the doctors' role in the improvement journey was valuable and that a message was to be delivered to ensure that medics were appreciative of their part in the provision of safe, high quality care on the wards. Ms Parker suggested that the intelligence available from the CCG could inform the work more formally. Mr Ovington welcomed this offer and it was agreed that information from the CCG on particular wards should be provided regularly. Mr Samuda asked whether the ward review process needed to be altered. Mr Ovington advised that the process was being amended to modernise the approach and more robustly identify indictors that could be used to best effect to trigger early warning. It was noted that the use of agency staff was a particular concern and there was clear links between harm and the use of these nurses. A red flag process was reported to be being developed.	

Mrs Hunjan returned to equipment available and asked whether each ward knew where the equipment was placed. Mr Ovington reported that a mechanism of approaching other wards was effective or accessing equipment from specialist areas could be considered. Ms Asim confirmed that this was the case. It was noted that there was no universal list of equipment available centrally for staff, however the benefits of this were agreed.

Mrs Hunjan noted that patient care had been escalated by the doctors and she asked for further details of the mechanism by which this was undertaken. Mr Ovington reported that he had been approached directly in one case. Mrs Hunjan suggested that all the concerns needed to be captured and concerns needed to directed to the most appropriate person to resolve the issue. It was noted that it was the responsibility of all to manage concerns. Ms Asim highlighted the value of the ward coordinators, particularly in supporting the 'Ten out of Ten' work.

Dr Sahota noted that the support for dementia patients would benefit from the backing of a cadre of volunteers.

Ms Dutton suggested that it would be useful to consider an overview of worry wards on a monthly basis, supplemented by the checks in place to ensure transparency of the indicators. She asked what plans were in place to support the other wards cited as a concern. Mr Ovington advised that he was working with the Group Director of Nursing to support the improvement work and was monitoring the wards actively. He added that the red flag mechanism was anticipated to be a good support for the plans. Ward leadership, levels of temporary staffing as well as clinical indicators would be monitored. It was agreed that a report back would be considered on a monthly basis.

It was agreed that the team for Ward D17 should be invited to join the meeting in April to present their findings.

It was noted that the process should focus on learning as a priority as opposed to punitive action. Dr Stedman agreed that the data needed to be multi-disciplinary and the improvement needed to include staff of all disciplines where necessary and an element of peer comparison would be useful. It was agreed that some wards should be set up as exemplars.

Ms Dutton noted that there was further work to do to involve medics in Patient Safety Walkabouts. It was agreed that this needed to be built into the processes.

Mr Waite asked if a ward dashboard heat map was in place. Mr Ovington reported that this was currently being redeveloped. Dr Sahota suggested that the matters monitored needed to be wider than incidents.

ACTION:	**Mr Ovington to present a monthly report into wards of concern to the Quality & Safety Committee**
ACTION:	**Mr Grainger-Lloyd to invite the Ward D17 staff to join the April meeting of the Quality & Safety Committee**

6 Model for closing and opening capacity	**Verbal**
Miss Barlow reported that there were various reasons for opening beds, including planned opening, winter pressures and infections. It was reported that the Trust worked on daily forecasts and responded to these risks by opening wards, supported by the Chief Nurse and Medical Director's input. A checklist of minimum equipment was reported to be referenced when a ward was to be opened. It was suggested that the processes for opening wards was clear, however further attention needed to be directed to the plans for closing wards. It was noted that every effort was being given to preventing the opening of a ward at a weekend. It was agreed that the checklists governing the arrangements for opening and closing beds would reviewed at the next meeting.	
ACTION: Miss Barlow to present the checklists used for closing and opening capacity at the next meeting	
7 Band 5 nursing vacancy position	**SWBQS (2/15) 020** **SWBQS (2/15) 020 (a)**
Mr Ovington reported that a national return was made for safe nurse staffing on a monthly basis, however the Committee was invited to review the current position in terms of Band 5 nurse staff vacancies and recruitment according to the electronic staff record system. Most of the vacancies were reported to be in the medical and emergency care areas, where turnover was high. It was reported that there was currently a 70.1 WTE vacancy rate (10%) in Medicine, which was higher than desired. The need to recruit the most appropriate staff was underlined. It was noted that the Trust did not use international recruitment at present and recruited from local areas primarily. Mr Samuda suggested that further work could be undertaken to better promote and attract staff to join the organisation. The importance of literacy and numeracy skills in selecting staff was noted. Mrs Hunjan noted that some individuals observed as part of Patient Safety Walkabouts, had been observed checking with Pharmacy that their calculations were correct. Ms Parker noted that there had been a reduction in the number of medical calculation errors that had been reported. It was reported that internationally, the most significant risk related to medicine errors. Miss Barlow suggested that the recruitment position could be reviewed on a group basis and Ms Dutton highlighted that there was benefit in a co-ordinated approach.	
8 Safeguarding scorecard and Deprivation of Liberty requirements	**Hard copy**
Mr Ovington presented an overview of Safeguarding children and adults. It was noted that there was good progress with safeguarding work and the plans continued to be developed. The employment of a safeguarding nurse lead was reported to have delivered a good improvement and strengthened the arrangements. Ms Dutton offered to provide input as to the implications for trafficking on an informal basis. Ms Parker asked that the CCG be involved with these discussions. Dr Sahota reported that	

different departments within the local authority needed to work together on these plans.	
9 Controls to prevent Never Events	**SWBQS (2/15) 022** **SWBQS (2/15) 022 (a)**
Miss Dhami presented an overview of the measures in place to prevent Never Events and the revised list of NHS England Never Events. Miss Binns reported that policies were in place to safeguard against the Never Events occurring and monitoring arrangements were in place which in summation should prevent the occurrence. It was reported that the practical controls provide sufficient assurance that a Never Event would not occur was only 'partial' for insulin maladministration, as due to the change in definition there had been a near miss. It was noted that there was little else that could be put in place to prevent the human errors that would cause the Never Event. It was suggested that close monitoring would be put in place through the Patient Safety Committee, however it was anticipated that it was several months before the assurance would be classed as full. Ms Parker noted that the current situation was a significant risk for the Trust.	
10 Integrated performance report	**SWBQS (2/15) 023** **SWBQS (2/15) 023 (a)**
Mr Waite highlighted that the particular issues related to falls and pressure ulcers which were raised and crude mortality had increased. Mr Ovington reported that the positon reflected the winter pressures where many more elderly patients had been admitted and a look back on the data had been reviewed which showed a big reduction in pressure ulcers overall. Pressure sores were reported to be graded as mainly '2'. It was noted that despite the increase in falls, the position remained better than the national average, however the rise might be related to the treatment of more elderly patients and the method of raising & reviewing falls incidents was being reconsidered as the data reported was not a complete picture. It was noted that an action plan was being developed to address the falls position. Ms Dutton asked whether these measures were considered as part of the evaluation of ward performance. She was advised that this was the case. Dr Sahota asked whether the previous incentives and initiatives aimed at ward level to eliminate pressure sores were continuing. He was advised that this was the case and patients were assessed for risk of pressure sores according to the Waterlow Score matrix. Dr Stedman advised that in terms of mortality, the review position remained unacceptable and a further update would be given at the next meeting. Dr Sahota noted that crude mortality remained high. It was noted that the positon reflected to some degree a spike in influenza over the winter and that there was an expectation that there could be relationship between falls, mortality, readmissions and mortality.	

The admissions position was discussed, with there being three different methodologies being used for counting these. In terms of the maternal death, it was reported that the incident had been referred to the Coroner. It was noted that the accuracy of recording the events had been pleasing. Miss Barlow asked the committee to note the improvement in thrombolysis. It was noted that the previous poor performance reflected difficulties in the medical staffing positon at the time. Other contributory factors were discussed and every effort was reported to be being directed to sustaining an improvement. In terms of cancer care waiting times, performance was noted to be poor, however this related to small numbers of patients. Discussions had been held with Surgery B with a view to improving the position further. Miss Barlow reported that in terms of RTT target, there was a current underperformance, however the national target was being reset on a monthly basis, making it difficult. It was reported that the Trust was being asked to reduce the number of patients waiting beyond 18 weeks to 1586. The Trust position was noted to be higher than this at present.	
11 Quality & safety aspects of the Board Assurance Framework	**SWBQS (2/15) 029** **SWBQS (2/15) 029 (a)**
The Committee received and note the Quality & safety aspects of the Board Assurance Framework. In terms of performance against CQUIN targets, it was noted that where there was underperformance, in month the position had improved further. Ms Dutton asked whether there was a reduction in the use of bank and agency staff. Mr Samuda advised that this was not the case. Mr Ovington reported that this had escalated in line with the opening of additional capacity. Controls for temporary staffing were noted to rest with the Chief Nurse and the position was monitored on a weekly basis in terms of hours of agency staff worked. Mr Waite noted that bank staff were being used as a preference to agency staff. Dr Stedman also highlighted the benefit of the medical staff bank which was pleasing. Miss Barlow advised that notwithstanding some medical staff shifts were not being filled. Dr Sahota noted that despite the high sickness absence rate the temporary staffing usage did not appear to have increased.	
12 Patient story	**Verbal**
Mr Ovington gave an overview of the patient story for the Trust Board on 5 March. It was noted that the patient was currently an inpatient.	
MATTERS FOR RECEIPT AND ACCEPTANCE	

13 Safety alerts update	**SWBQS (2/15) 028** **SWBQS (2/15) 028 (a)**
The Board received and noted the update.	
14 Serious Incident report	**SWBQS (2/15) 025** **SWBQS (2/15) 025 (a) -** **SWBQS (2/15) 025 (c)**
The Board received and noted the update.	
15 Clinical audit forward plan: monitoring report	**SWBQS (2/15) 026** **SWBQS (2/15) 026 (a)**
The Board received and noted the update.	
16 Forward plan for the Committee	**SWBQS (2/15) 027** **SWBQS (2/15) 027 (a)**
The Board received and noted the update.	
OTHER MATTERS	
17 Matters of topical or national media interest	**Verbal**
There were none.	
18 Meeting effectiveness	**Verbal**
It was noted that the meeting had been productive.	
19 Matters to raise to the Board and Audit & Risk Management Committee	**Verbal**
It was noted that there were several matters to raise to the Board.	
20 Any other business	**Verbal**
Ms Dutton asked whether any measures were in place to safeguard against the Saville issues. Miss Dhami noted that assurances were in place and had been discussed previously, however it was agreed that this would be refreshed and presented at the next meeting. The plans for volunteering was discussed, where it was noted that usual security checks would be undertaken.	
ACTION: Miss Dhami to present the controls in place to prevent a 'Saville' issue at the next meeting	
21 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 27 March 2015 at 1030h in the D29 (Corporate Suite) Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Safeguarding Dashboard
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Jayne Clarke – Safeguarding Children Lead Nurse & Diane Rhoden Safeguarding Adult Lead Nurse
DATE OF MEETING:	2nd April 2015

EXECUTIVE SUMMARY:

This report is to demonstrate the dashboard of indicators explored on a quarterly basis to ensure that the Trust is undertaking we are obliged to in support of vulnerable children, young people and adults. The dashboard is reviewed and monitored via our internal Safeguarding Steering Group.

Children's Safeguarding– there continues to be significant progress in the last 6 months due to the implementation of senior nursing structure and recruitment of operational staff. There have been 2 CQC visits which have identified areas for improvement such as; supervision of HV, midwives and emergency care staff, Level 3 safeguarding children mandatory training compliance, communication, escalation and record keeping. The CSE and DA agenda continues in raising the profile across the organisation and externally with multi-agency partners. The DA Lead nurse has been successful in a joint bid with Sandwell Women's Aid to obtain charitable monies to support victims of domestic abuse in the emergency care departments.

Adult Safeguarding- following the Supreme Court Ruling regarding application of DOLs in March 2014, authorisation of DoLs has seen an increase. The Care Act 2014 that will come into force April 2015 has seen new categories of abuse within safeguarding adults agenda of Domestic Violence, Modern slavery and Self neglect. The act has also sets the requirement of each organisation to have a Designated Adult Safeguarding Manager which will have responsibility for Persons in Position of Trust allegations. Both Birmingham and Sandwell Boards are working towards the implementation of the act and as a Trust policies and procedures are currently under review to ensure compliance with the Act.

The refinement of our data collection, collation and reporting systems are key to measuring performance in both teams and to populate relevant dashboards.

REPORT RECOMMENDATION:

The Board are requested to review the indicators

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

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

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Relates to our safety objectives and BAF
PREVIOUS CONSIDERATION:
Safeguarding Steering Group

FEBRUARY 2015 SAFEGUARDING UPDATE
REPORT TO THE TRSUT BOARD ON 2 APRIL 2015
Jayne Clarke – Safeguarding Children Lead Nurse & Diane Rhoden Safeguarding Adult Lead Nurse

Enclosed is a 6 month up-date in response to actions/ risks and concerns identified as outstanding as at November 2014

CHILDREN'S SAFEGUARDING
As defined in Section 11 (Children Act 2004), and monitored by Sandwell and Birmingham Safeguarding Children's Boards and internally reported via the Safeguarding Steering Group (SSG) chaired by the Chief Nurse

Organisational:
• Team structure – Sandwell and West Birmingham CCG transferred monies to appoint to an additional Band 7 Domestic Abuse Lead Nurse (previously the CCG had seconded into this post). Nurse commences 2nd March 2015. Safeguarding Specialist Midwife on 6 month adoption leave; successfully seconded a midwife into this post commencing March 2nd.
• Domestic abuse lead nurse and Sandwell Women's Aid successful in charitable bid monies to support specialised domestic abuse workers to support the Emergency Departments (ED) Sandwell and City in the notification and support of victims subject to domestic abuse. At initial stage of project plan and discussion with ED Lead..
• Demand for representation at external meetings of Safeguarding Boards, sub-groups and other safeguarding linked groups (CSE, DASP) continue. Team have reviewed their work streams and associated attendance at the various groups.
• MASH established in Sandwell and Birmingham – remains a positive change in partnership working and risk assessment for safeguarding children. Ongoing work with frontline staff to improve the quality of referrals and identification of risk to children.
• Work continues to identify and promote the Lead Professional role within universal services. This includes providing data to the local authority on numbers of staff undertaking this role in terms single of agency LP role. Workshop planned for March to map and evidence this with other health partners and the LA.
• Dashboard reporting in place, further work need to evidence lessons learnt from the number of serious case reviews being undertaken and CQUIN's completed.
• Permanent administrator in post since February, this will enable more accurate collation of team activity data which has proved challenging to date.

Governance:
• Annual audit programme 15/16- programme to be defined further given recommendations from CQC visits and SCR findings (Indicators of Neglect, Child's Voice, DNA policy adherence, recognition of risk factors associated with adult presentation (toxic trio) escalation and Lead Professional role). Progress for each audit to be monitored via Children's Operational Group.
• Risk Register has now been populated and identifies risks related to :
DA services , A&C support for DA services and CP medicals, team accommodation, supervision of HV and midwives, mandatory training figures for level 2 and 3 (72% and 68% - Q3)
• Training Strategy has been revised following intercollegiate document 2014, recommendations present challenge for the organisation and following consultation a

matrix of attendance has been developed which needs further refinement and agreement.
• Policies reviewed and revised:
Children's Safeguarding Policy ratified 7th Nov
Position of Trust Policy – further amendments made following HR comment- due ratification early Q4
Missing Child/DNA Policy- final version to be ratified February
Child Protection Supervision Policy due to be ratified Q4 following scoping needs of organisation (and recommendation from CQC Reviews)
• Supervision of HV /midwives with a Child Protection case is a local KPI, however denominator figure difficult to determine (in real time) due to the variables given unborn/children being placed on Child Protection Plans. For Q3 a slight improvement seen in numbers supervised but we continue to fail to meet the 90% target of 3 monthly supervision. Trajectory set for team to achieve on a monthly basis.
• CQUIN – 5 case notes reviewed per quarter and patient story /case study 6 monthly – completed for Q3- action planned and progressed. Emerging themes included in safeguarding children training
• Currently 6 SCR/IMR/SILPS/TTR in progress and recommendations included in overarching SCR sub-group Action Plan and template in development for governance reporting against recommendations.
• Work has commenced to update Safeguarding Children Intranet page (CONNECT)- CSE/Child death priorites.
CQC:
• 2 CQC Children's Safeguarding visits in Q2 at both sites and CIH visit in October. Final CQC reports produced- publicised on CQC website. Action Plans developed against recommendations– monitored internally via Safeguarding Children's Operational and Safeguarding Steering Group (and externally via Sandwell and Birmingham CCG's).

Key issues identified:
• IT systems and flagging of CP concerns
• Supervision model/numbers
• Training percentages and level 3 training model (Level 3 now full day)
• Emergency department risk assessment for safeguarding children when adult presenting issue
• Communication between Midwives and Health Visitors – role of record keeping/IT
• Child's voice

Next Steps- March 2015-September 2015
• Recruitment to vacant administrator posts
• Targeted work in ED regarding Domestic Abuse /CSE /Toxic Trio
• Continued participation in CSE sub –group (Safeguarding Lead & Sandwell Designated Nurse leading on health's response to CSE)
• Progress project with ED following successful bid re charitable monies to support victims of DA in ED
• Review options for flagging children with CP status (City) and SWBHT involvement with national CP-IS project
• Disseminate , raise awareness of new /revised policies
• Disseminate outcomes of audits and implement change in practice as indicated.
• Expand user involvement /Child's Voice
• Improve supervision compliance

• Up-date information on Connect

ADULTS SAFEGUARDING

Vulnerable Adult Protection: 184 referrals for advice/support to team in Q3 (Neglect, Capacity and DoLs are the top 3 categories)

• CQUIN – 5 case note reviews per quarter and patient story /case study 6 monthly – completed for Q1, Q2and Q3 - action planned and progressed.
• Targeted Level 2 training 77.6%
• SILP x 1 currently with recommendations

MCA /DOLS:

• Application of MCA continues to be an ongoing challenge particularly in relation to DNACPR /consent as identified by the CI visit
• Continue to await further case law with regards to DoLs authorisations. Birmingham still has a backlog which means that urgent authorisations have expired before standard authorisations are granted. Identified as a risk for the organisation and Birmingham has identified the risk with the Department of Health.
• Further training required for all staff groups (an overview is included in level 2 training)

Dementia:

• Purchase of activity equipment for inpatient wards for distribution
• Meetings with dementia Champions to identify projects to take forward to improve the patient experience
• Corporate nursing reviewing nursing assessment tool with a view to including pertinent parts of the 'All about me' document to ensure person centred care planning

Falls:

• Focussed care report presented to Chief Executive and Chief Nurse identifying majority of risk assessments before requesting extra staff for supervision to be accurate.
• Data cleansing in progress to clearly identify falls from inpatient areas 2013/14 in comparison from 2014/15

Pressure Ulcers: (Tissue Viability Team)

• CQUIN – reduction of avoidable , new pressure ulcers on DN caseload reflected in 10% reduction rate in trajectory– Q1 Q2 and Q3 CQUIN met

Learning Disabilities:

• Commitment at People's Parliament by CE regarding:
Flagging
Reasonable adjustment
Audit of above by Changing our Lives
Explore patient record app
Active employment
• LD month November 2014. Patient story to Trust Board and a number of information stands across community and the inpatient bed units
• Communication app developed by Keele University to be launched across the trust

• Risk of inequity of service if B'ham withdraw HCF team – Chief Nurse to discuss with CCG

Mental Health:
• Confusion regarding when and how to complete section 5 (2) by medical staff. Incorrect completion may result in unlawful detention of patients within the organisation.

Prevent:
• 1 referrals in Q2 and 1 in Q3
• Only 194 staff trained to date this has been escalated to SSG resulting in the following actions: to review original workforce development plan and evaluate how many of the key staff groups have taken up training (HR staff, HV, Learning works etc) and re-target. Some re- profiling of Prevent required .

Quality Assurance:
Ten out of ten (falls/pressure ulcers)
Case note review of VAP /MC cases / dashboard to CCG
DNACPR (MC) audit
Safety Thermometer (falls, pressure ulcers)
EBMS flagging (safeguarding alert)
Safeguarding within Complaints

Safeguarding Vulnerable Children, Young People and Adults Scorecard Quarter three 2014/15

CCG Ref	National and Local Quality Metrics	Definitions of Metrics	Data Source & Type	Target	QUARTER 3
1a	Safeguarding supervision for appropriate frontline staff	% compliance with provider protocol for clinical supervision (for frontline staff who work with children).	Provider	90.00%	39%
1b	% compliance with CCG protocol for clinical supervision for named nurse for safeguarding	Clinical supervision for Named Professionals for Safeguarding from Designated Professionals.	Provider	90.00%	100%
2a	Safeguarding training for children (level 1)	% compliance with staff safeguarding training strategy at level 1.	Provider	90.00%	99.13% (Dec)
2b	Safeguarding training for children (level 2)	% compliance with staff safeguarding training strategy at level 2.	Provider	85.00%	72.45% (Dec)
2c	Safeguarding training for children (level 3)	% compliance with staff safeguarding training strategy at level 3.	Provider	85.00%	67.39% (Dec)
3	Patient experience	Quarterly report on progress on delivering patient experience strategy.	Provider	RAG	Q3 case studies completed
4	Complaints involving services for children	Number of complaints as determined by the contract.	Provider	RAG	2
6	CQC outcome 7/ section 11 reporting	% of compliance with outcome 7 and section 11.	Provider	RAG	Sandwell and Birmingham S11 being updated to reflect recent scutiny panel meeting (Bham)
8	Total Number of Referrals to Social Care involving children	Number of referrals to Social Services. (Figure 1 = red and Amber referrals, Figure 2 = single assessments started/ referrals to social care)	Provider		Figure 1 = 489 individuals Figure 2 = 387 individuals
9	Domestic violence referrals	Number of domestic violence referrals as agreed with the provider. (Figure 1 =m Adult DA referrals, Figure 2 = Child DA referrals)	Provider	N/A	Figure 1 = 114 Families, Figure 2 = 942 Families
10	Drug & Alcohol referrals	Number of referrals to social care that relate to parents experiencing drug and alcohol misuse as agreed with provider.	Provider	N/A	18
11	Mental Health referrals	Number of referrals to social care that relate to parents experiencing mental illness as agreed with provider.	Provider	N/A	11
14	Percentage of children's appointments not attended	DNA rate as agreed with provider.	Provider	10.00%	11.86%
15	Sickness absence	Total sickness absence for the month.	Provider	3.39%	5.77
16	Staff turnover	Number of staff who leave the organisation within the quarter.	Provider	<14.20%	18.80
17	Staff vacancy	Overall vacancy rate for staff.	Provider		-3.19
20	Person in a position of trust allegations	Numbers of employed/ contracted staff referred for persons in a position of trust.	Provider		1 case referral advised to Trust on 22nd December 2014 awaiting Position of Trust meeting date to be confirmed