Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Carters Green Business Centre, West Bromwich **Date** 2 July 2015; 1330h – 1700h

Members attending

Mr R Samuda	(RSM)	[Chairman]
Ms O Dutton	(OD)	[Vice Chair]
Dr S Sahota OBE	(SS)	[Non-Executive Director]
Mrs G Hunjan	(GH)	[Non-Executive Director]
Mr H Kang	(HK)	[Non-Executive Director]
Dr P Gill	(PG)	[Non-Executive Director]
Mr R Russell	(RR)	[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]
Mr W Zaffar	WZ)	[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 3]
Miss G Downey (GD) [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**
	3	**Patient story (discussion to follow in private Board meeting)**	**Presentation**	**CO**
	4	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 4 June 2015 a true and accurate records of discussions*	**SWBTB (6/15) 097**	**Chair**
	5	**Update on actions arising from previous meetings**	**SWBTB (6/15) 097 (a)**	**SG-L**
	5.1	Consent audit	SWBTB (7/15) 099	KD
	5.2	Surgery A video reflexivity	Verbal	TL
	6	**Never Event – Women & Child Health Group**	**Presentation**	**RSt**
	7	**Questions from members of the public**	**Verbal**	**Public**
	8	**Chair's opening comments**	**Verbal**	**Chair**
	9	**Chief Executive's report**	**SWBTB (7/15) 101**	**TL**
1430h	**10**	**Equality & diversity – escalated from Public Health, Community Development & Equalities Committee**	**SWBTB (7/15) 102** **SWBTB (7/15) 102 (a)**	**TL**
1445h	**11**	**Infection Control – escalated from Quality & Safety Committee**	**SWBTB (7/15) 103** **SWBTB (7/15) 103 (a)**	**CO**

1500h	**12**	**Education Plan – for discussion prior to approval in August**	**SWBTB (7/15) 104 SWBTB (7/15) 104 (a)**	**RG**
1515h	**13**	**'Ten out of Ten' deployment**	**SWBTB (7/15) 105 SWBTB (7/15) 105 (a)**	**CO**
1530h	**14**	**Cardiology & surgery reconfiguration**	**Presentation**	**TL**
1545h	**15**	**CQC Improvement Plan update**	**SWBTB (7/15) 100 SWBTB (7/15) 100 (a)**	**KD**
1600h	**16**	**Trust Risk Register**	**SWBTB (7/15) 106 SWBTB (7/15) 106 (a)**	**KD**
1610h	**17**	**Board Assurance Framework 2015/16 – post mitigation red risks**	**SWBTB (7/15) 107 SWBTB (7/15) 107 (a)**	**KD**
1620h	**18**	**Safe & Sound Phase II update**	**SWBTB (7/15) 117 SWBTB (7/15) 117 (a) SWBTB (7/15) 117 (b)**	**RG**
1625h	**19**	**Financial update**	**SWBTB (7/15) 109 SWBTB (7/15) 109 (a)**	**TW**
1635h	**20**	**Medical staff appraisal and revalidation**	**SWBTB (7/15) 110 SWBTB (7/15) 110 (a) - SWBTB (7/15) 110 (e)**	**RSt**
	21	**MATTERS FOR INFORMATION AND QUESTIONS**		
	21.1	Nurse staffing report	SWBTB (7/15) 108 SWBTB (7/15) 108 (a) - SWBTB (7/15) 108 (l)	CO
	21.2	Corporate integrated performance dashboard	SWBTB (7/15) 112 SWBTB (7/15) 112 (a)	TW
		UPDATES FROM THE COMMITTEES		
1645h	**22**	**Update from the meeting of the <u>Quality & Safety Committee</u> held on 26 June 2015 and minutes of the meeting held on 29 May 2015**	**SWBQS (5/15) 060**	**GH/ CO**
	23	**Update from the meeting of the <u>Configuration Committee</u> held on 26 June 2015 and minutes of the meeting held on 17 April 2015**	**Hard copy summary**	**RS/ TL**
	24	**Update from the meeting of the <u>Workforce & OD Committee</u> held on 29 June 2015 and minutes of the meeting held on 17 April 2015**	**SWBWO (4/15) 005**	**HK/ RG**
	25	**Any other business**	**Verbal**	**All**
		MATTERS FOR INFORMATION		
	26	**Details of next meeting** *The next public Trust Board will be held on 6 August 2015 at **1330h** at Rowley Regis Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.4

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 4 June 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	
Ms Olwen Dutton	Mrs Chris Rickards	
Mrs Gianjeet Hunjan		
Mr Harjinder Kang		
Dr Paramjit Gill		
Mr Toby Lewis	**Guests**	
Mr Colin Ovington	Patient	
Miss Rachel Barlow	Mrs Dawn Hall	
Dr Roger Stedman		
Mr Tony Waite		

Minutes	Matron Marion Long
1 Apologies for absence	**Verbal**
Apologies for absence were received from Mr Robin Russell and Mr Waseem Zaffar. The Chairman advised that although the two new Non Executives could not join the meeting, they had taken up post from 1 June. Mr Russell was noted to be the Chief Financial Officer of Aston Villa Football Club, with significant financial experience gained in other private sector organisations. Mr Zaffar was reported to be a local councillor covering Lozells and East Handsworth.	
2 Declaration of Interests	**Verbal**
Mr Grainger-Lloyd asked the Board to note the declarations of interest provided by Mr Robin Russell and Mr Waseem Zaffar and advised that the register of interests would be updated accordingly.	

3 Patient story	Presentation
Mr Ovington introduced the patient, who was also a member of Trust staff. The patient reported that she had attended the triage area of maternity with breathlessness following an ultrasound scan at antenatal where the sonographer was concerned about her condition. She had a previous history of pulmonary embolism. The patient explained that she was not happy with the way the doctor carried out the cannulation and blood test. From here, she was admitted to a side room on M1 where she was unhappy with the number of times she was monitored. She felt that she was labelled as 'having anxiety' and felt she was not treated properly. She had a long wait for a lung function test and many weeks for the results following discharge from hospital. As a member of staff, the patient reported that it concerned her greatly that patients who have no knowledge of the system could be treated and cared for in the way she was and may think that this is safe practice and the way that the Trust actually works. Dr Gill thanked the patient for her story and asked how the patient diabetes was managed. It was reported that a monitoring arrangement was in place on a two weekly basis as an outpatient. Ms Dutton asked whether the care for the patient was good in terms of maternity services and was advised that this is the case. Dr Stedman asked the patient whether the issues suggested systemic poor working practices or poor working localised to an individual. He was advised that this was the latter and it was suggested that the experience needed to be fed back to the individual. Mr Lewis apologised for the experience. He asked if there was anything that could have been done to make it easier to raise the concerns she had. The patient advised that her primary focus was to progress her care and to ensure that there were no recriminations should a concern be raised in advance of a further episode. The use of the appropriate needles was discussed and Dr Stedman suggested that local anaesthetic should be used for the wider needles. Dr Gill asked whether she had let the consultant know that she was a staff member and the patient confirmed that this was the case, although this had made no difference to the level of care she received. The patient was thanked for her attendance and candidness.	
4 Minutes of the previous meeting	**SWBTB (5/15) 074**
The minutes of the Trust Board meeting held on 7th May 2015 were presented for consideration. They were approved as a true and accurate record. Mr Waite reported that the managed equipment service for the fixed imaging equipment would conclude by March 2016 and a procurement phase would start in late summer. It was noted that a confirmatory business case would brought	

back to the Board in future. Mr Lewis suggested that a timetable to March 2016 needed to be considered by the Finance & Investment Committee at a future meeting and thereafter as a standing item. It was reported that a signed Heads of Agreement had been drawn up in respect of the Acute Oncology service with University Hospital Birmingham NHSFT, in advance of a Service Level Agreement. Mr Lewis reported that in terms of the apheresis service raised at previous meetings, this would remain a commissioned NHS England service, however by August a clearer position would be provided as to how the service might be deployed locally based on discussions with NHS England.	
ACTION: **Mr Waite to organise for a timetable for the MES implementation to March 2016 to be presented to the Finance & Investment Committee at its next meeting**	
5 Update on Actions arising from Previous Meetings	**SWBTB (5/15) 074 (a)**
The Board received the updated actions log. There were no actions outstanding or requiring escalation.	
5.1 Consent audit	**SWBTB (6/15) 096**
Miss Dhami reminded the Board that there had been prior concerns raised over consent being taken on the day of surgery and as such a revised approach to taking consent had been introduced. A stocktake against these intentions was presented, which showed that out of 102 cases, 26 patients did have consent taken on the day of surgery and therefore a review of these individual cases would be undertaken. The revised process was reported to include sanctions should it be identified that consent was taken inappropriately. It was reported that a wider audit of consent was needed based on the findings and lack of assurance evident in some areas. Mr Kang noted that Oral Surgery was a clear outlier. He was advised that this may concern direct access practice however. Dr Stedman highlighted that Urology was of most concern, given that there appeared no clear reason for consent being taken on the day. Mr Lewis noted the longevity of the issue and highlighted that work was needed to encourage staff to report when patients were consented on the day of surgery. It was agreed that this should be a standing item for the forthcoming future.	
ACTION: **Mr Grainger-Lloyd to add a standing item to Board agendas to discuss consent**	
6 Questions from members of the public	**Verbal**

Mr Cash asked for an update on the CQC improvement plan. Mr Lewis reported that CQC would come back to see the Community Children's area very shortly and that the improvement plan was next to be considered by the Board informally. It was agreed that focus on the improvement plan was to consider the evidence available that would indicate that the actions due for completion could be signed off. Mr Bates noted that the Board was making decisions that impacted on wards and patient treatment and asked what process was in place to explain the rationale for the decisions made to Trust staff. Mr Lewis advised that there was further work to do to explain the reasons for decisions in some cases, however it was noted that many of the decisions that the Board was asked to make had been previously discussed and supported by the Clinical Leadership Executive. In terms of cascade of the decisions, the use of monthly Hot Topics briefings, Quality Improvement Half Days and Heartbeat were described. It was highlighted that it was the 'ask' of the middle managers to explain the reasons for decisions rather than reporting that the decisions were imposed. It was also reported that for staff, there were several means of providing feedback, either in an anonymous way or non-anonymised. It was emphasised that there was no cultural intention to create a 'Just Do It' culture. The Chairman added that the Trust measured staff engagement, given the clear benefits of this, and the Trust performed well in this respect. Mr Kang suggested that the messages needed to be more targeted depending on the messages. Ms Dutton agreed that over communication was not helpful and suggested that should people understand the reason for decisions then implementation of consequential actions would be more effective. Mr Cash asked whether the Trust had ceased making people redundant. Mr Lewis reported that redeployment in Phase I of Safe and Sound had been extensive but a handful remained to be redeployed and could potentially be made redundant. It was reported that the second Phase of Safe and Sound, which was currently underway, was the last part of the restructuring programme.	
7 Chair's opening comments	**Verbal**
The Chairman reported that the discussions at the Board to Board with Birmingham and Solihull Mental Health Trust had been productive. It was agreed that the actions within the Mental Health paper should be scheduled into the Board tracker. It was reported that a breakfast meeting had been held with the Midwives recently, which had also raised issues over the recruitment and the processes for onboarding.	
ACTION: Mr Grainger-Lloyd to expand the meeting action tracker to include the activities planned in respect of Mental Health	
8 Chief Executives report	**SWBTB (6/15) 076**

Dr Stedman advised that a further Never Event had been reported. Dr Zoe Huish joined the Board and provided the details, where an anaesthetic block had been administered to the wrong site. It was noted that the 'Stop Before You Block' practice had not been undertaken which could have ensured that this event was prevented. The patient was reported to be unharmed by the event. The tabletop review highlighted that the 'Stop Before You Block' practice was not embedded across the Trust, apart from in the Birmingham and Midland Eye Hospital. Mr Lewis suggested that learning from the experience in BMEC was needed and asked how quickly it could be embedded elsewhere. It was noted that in BMEC staff were more likely to prompt if there was a suspicion that the practice would not be executed, which was agreed to be a pleasing change in culture.

It was noted that in this case, there had been a long period of time before the sign in and the administration of the anaesthetic. Dr Stedman suggested that in this case additional checks were needed prior to commencement of the procedure.

Dr Gill asked whether in view of this incident, the patient had been given adequate pain relief and advised that this was the case.

Mr Lewis asked what assistance was needed to implement the 'Stop Before You Block' practice into general theatres. Dr Huish reported that the QIHD would be used to view a video of the sign in 'Stop Before You Block'. It was noted that cross group practice needed to be addressed, which would be picked up through the Theatre Management Board and as part of induction. It was agreed that the reasonable timescale over which the practice should be implemented needed to be agreed and presented at the next meeting.

Dr Huish was thanked for her attendance.

Mr Lewis advised that over £3m of investments in new staff and innovations covering all areas of the organisation had been agreed based on bids list. The performance gains from these investments needed to be identified which would be worked through in the next month.

It was noted that the next steps in terms of recruitment would be presented at a future meeting, drawing from experience in other organisations.

Mr Lewis reported that it had been identified that the existing circumstances where the beliefs and prejudices of a patient determined the offer to treat the individual needed to be agreed. It was agreed that the position where patients were specific about the individuals handling their care also needed to be agreed. It was reported that this would be presented to the Board in August. Mr Kang asked for the rationale behind this and it was noted that concerns had been raised around the processes used to raise such instances and a couple of table top reviews had also given rise to some concern as to when we refuse treatment based on the patients views and prejudices. It was noted that this went beyond policy statements and the most appropriate communication needed to be agreed. Dr Sahota supported the plans. He suggested that findings from OSCAR needed to be harnessed. Mr Lewis reported that there was a lack of academic information in the field of sickle cell anaemia and therefore a post was being established. Dr

Sahota encouraged that a similar approach be considered in terms of tuberculosis. Planned work with the two Mental Health Trusts was noted.	
ACTION: Mr Lewis to present an update on progress with rolling out video reflexivity at the next meeting **ACTION: Mr Lewis to present the Trust's position on treatment of individuals and patient requirements based on prejudices and beliefs at the August meeting**	
9 Annual Accounts 2014/15	**SWBTB (6/15) 077** **SWBTB (6/15) 077 (a)** **SWBTB (6/15) 077 (b)**
Mr Waite presented the annual accounts for consideration which he highlighted had been discussed by the Audit & Risk Management Committee earlier in the day. The accounts report that all financial targets had been met including delivery in excess of plan. The external auditors provided a clean opinion in respect of VFM and annual accounts. Mrs Hunjan reported that opportunity had been provided through the Audit & Risk Management to challenge and confirm and the Board was recommended to adopt the annual accounts. The Board agreed to adopt the accounts.	
AGREEMENT: The Board resolved to adopt the annual accounts 2014/15	
10 2014/15 audit memorandum	**SWBTB (6/15) 078**
Three unadjusted audit misstatements were reported around the treatment of enabling monies; good received not invoiced; and a credit note provision of £0.8m to capture any debits arising from cancelled or disputed NHS invoices.	
11 2014/15 letter of representation	**SWBTB (6/15) 079**
The Board supported the letter of representation and agreed that it should be duly signed by the Chief Executive and Director of Finance.	
12 2014/15 annual governance statement and report	**SWBTB (6/15) 080** **SWBTB (6/15) 080 (a)** **SWBTB (6/15) 091**
It was reported that the Audit & Risk Management Committee had discussed the AGS. Mr Lewis reported that Miss Barlow would present the Business Continuity Plans	

to the Audit & Risk Management Committee at its next meeting. In terms of the annual report, it was reported that a final version was being developed and comments were invited by Tuesday 9 June. The Board agreed that the tone of the annual report was much improved from previous years. It was noted that the annual report production had been fast tracked by three months.	
ACTION: Miss Barlow to present the Business Continuity arrangements at the next meeting of the Audit & Risk Management Committee **ACTION: All to provide comments on the annual report by Tuesday 9 June** **AGREEMENT: The Board resolved that the Chief Executive should sign the annual governance statement**	
13 MATTERS FOR DISCUSSION – 2015/16	
13.1 Trust Risk Register	**SWBTB (6/15) 081** **SWBTB (6/15) 081 (a)**
Miss Dhami asked the Board to confirm that the risk around open referrals should be added to the Risk Register and that the risk around the maternity lifts to be removed as the equipment had been fixed. Miss Barlow reported that an update on open referrals had been discussed at Quality & Safety Committee. Progress with closing down some of the pathways was discussed and issuing letters to patients was going well, albeit it was paused following a recent incident where some deceased patients had been contacted in error. The Chairman asked how effective the call centre had been in handling the enquiries. He was advised that additional resources had been added to handle the calls. Mr Lewis reported that the Patient Administration Review sought to address some patient administration issues such as this. It was noted that due focus needed to be given to ensuring that the issue did not arise again. It was noted that the revised process and training would be completed by July. Ms Dutton noted that the assurances around data quality in the integrated performance report were lacking in many cases.	
AGREEMENT: The Board resolved that the risk around open referrals should be added to the Trust Risk Register and the entry concerning the maternity lifts be removed	
13.2 Board assurance Framework 2015/16 – post mitigation red risks	**SWBTB (6/15) 082** **SWBTB (6/15) 082 (a)**
The Board noted the extract of the Board Assurance Framework where the risks were pre and post mitigation scores remained red. It was noted that good progress had been made.	

Miss Barlow commented that the process for considering the BAF at Committee level had improved.	
13.3 Nurse staffing report	**SWBTB (6/15) 083** **SWBTB (6/15) 083 (a)**
Mr Ovington reported that where additional beds had been open, some anomalies had been effected on the national data return. Auditing on accuracy of data was reported to be ongoing. It was reported that the data showed that the organisation was safe in terms of nurse staffing levels. The Board was asked to review the ward dashboards. Mr Lewis sought clarity on some particular aspects of the report. The escalation processes were described. Mrs Rickards noted that the dependency of patients fluctuated and asked how this was taken into account. Mr Ovington reported that additional staff would be provided where the acuity of patients increased in some instances. Some national policy updates were discussed.	
13.4 Sickness plan	**SWBTB (6/15) 084** **SWBTB (6/15) 084 (a)**
Mrs Goodby reported that tackling sickness was a key means of reducing temporary staffing. She asked the Board to note the action plan to do this, which was based on best practice internally and externally, in addition to guidance from NHS Employers. It was highlighted that in addition to the control measures for handling sickness absence, it was reported that a set of support measures would be implemented, including return to work interviews. Other measures included strengthening occupational health, training & development, provision of information and face to face engagement. Next steps were reported to include introducing additional monitoring measures. Mr Kang noted that it was pleasing to have a co-ordinated strategy and suggested that it needed to be applied consistently across the organisation. He highlighted that meeting the 3.5% sickness absence level was a key challenge. It was noted that the plans needed to ensure that those genuinely off sick did not feel victimised by the additional measures. Mr Lewis reported that a trajectory of sickness absence needed to be created for the Workforce & OD Committee to be able to assess whether the order and sufficiency of the measures was appropriate and adequate. Dr Sahota reported that return to work interviews were critical. The suggestion of a sickness absence level of 3.5% was near to a NHS norm and	

was also based on NHS guidance. It was reported that work was needed to tackle the hot spots in particular. Mrs Rickards suggested some flexibility in working practice and training would assist with the position. Mr Lewis agreed that there was good scope for these suggestion but noted that there was some instances where inflexibility needed to be instilled, such as mandating that annual leave should be taken to handle child care issues. Ms Dutton emphasised that return to work interviews did not equate to bullying. Mrs Goodby noted that managers needed to take responsibility for managing sickness absence more robustly. She noted that there was a variation in the use of HR Managers to assist with managing the position. Miss Barlow reported that there needed to be confidence to assist with individuals off sick with rejoining work, including maintaining contact with individuals off sick. She added that addressing Monday sickness needed to be addressed more robustly. Dr Stedman advised that recorded sickness absence among medics was low, although there was an anticipation that this was due to under recording, nothwithstanding doctors having lower sickness absence levels generally.	
13.5 Safeguarding scorecard	**SWBTB (6/15) 085** **SWBTB (6/15) 085 (a)**
Mr Ovington presented the revised safeguarding dashboard which included some more ambitious targets, with information collected on a quarterly basis and triangulated. Mr Lewis noted that the list of indicators was helpful and clear, however ambitious goals and targets now needed to be set, with clarity on success added into the dashboard. Ms Dutton added that the outcomes needed to be defined. Miss Barlow encouraged children transitioning into adult care to be considered. Ms Dutton noted that there were particular provisions in the Child and Family Act in this respect. Mr Lewis suggested that it was the Trust's responsibility to take the lead on some of these indicators, even if they would naturally fall within the remit of local or national bodies. Dr Sahota encouraged the Trust to consider the link to work already underway in the community, including domestic violence. Mr Ovington reported that this was the case. Access to information in accident and emergency concerning at risk children within the local population was noted to be difficult. It was agreed that this needed to be picked up as part of this work and that joining up via electronic means was necessary. The use of Multi Agency Service Hubs was discussed, which in Sandwell was working well, but was not working as effectively in Birmingham. The flags in use in Accident and Emergency were to be presented as part of the next update.	
13.6 Urgent Care Challenge	**SWBTB (6/15) 086** **SWBTB (6/15) 086 (a) -**

	SWBTB (6/15) 086 (c)
Miss Barlow presented an overview of the Urgent Care Challenge week, which was reported to have delivered some key achievements. The detail of the week's activities was discussed. It was noted that staff were used as the face of the messages being delivered. An Urgent Care challenge team was reported to be established, with a clear focus on sustainability and moving the rhythm of the day to ensure that as many patients as possible are discharged before lunchtime. Dr Stedman reported that the event had been successful, particularly in making the assessment process more robust. Mr Lewis noted that late evening practice for staff needed to be addressed as a next step. It was noted that there was a link to the Accident & Emergency consultants risk in terms of the impact on retention due to working patterns. In terms of the patients feedback, it was pleasing that people felt the place was clean and that they felt well informed. Mr Ovington reported that some of the non-clinical areas had played a good part in the plans.	
13.7 Quarter 1 financial update	**SWBTB (6/15) 087** **SWBTB (6/15) 087 (a)**
Mr Waite presented the key points of discussion from the Finance & Investment Committee at its meeting on 29 May. It was reported that there was much work to do to deliver the plan and the key risks were discussed. Significant progress was noted to have been made with budget setting, with clear plans to address gaps in areas where a plan remained outstanding. The performance in Period 1 was reported to be as expected, although there had been over performance against emergency work. A spike in agency staff was noted although the actual paybill was in line with plan. Some significant additional usage of agency staff usage during the period was highlighted. The route to addressing this was management of sickness absence and more robust recruitment processes, given that an ongoing high level of agency usage was not sustainable. It was noted that the 2015/16 plan provided for investment. The scale of the risk associated with antenatal pathway changes was discussed, where it was reported there had been a change to the tariff associated with this, meaning that there was a charging mechanism between providers. No SLA governing this relationship was reported to be in place although this was under development. It was noted that the 2014/15 positon would be resolved when a SLA was in place for 2015/16. As a result of the debates, some significant disagreement with other providers was expected. The Board was advised that the underlying economics of maternity services overall was unsustainable and the Trust reserved the position to cease providing these should the positon not be remedied. Local resolution was noted to be being pursued. It was reported that the Trust was disproportionately affected by these arrangements with many	

births being elsewhere despite antenatal cases being handled by the Trust. Mrs Hunjan asked whether there was sufficient capacity to handle more births. She was advised that estates capacity was limited and it was highlighted that the return rate for the FFT survey in maternity was low. Mr Lewis suggested that the Women and Child Health Group should be invited to a Board informal session to discuss these matters.	
ACTION: Mr Grainger-Lloyd to arrange for the Women and Child Health Group to be invited to a future Board Informal session	
14 MATTERS FOR INFORMATION AND QUESTIONS – 2014/15	
14.1 Trust's response to the Lampard Review	**SWBTB (6/15) 088** **SWBTB (6/15) 088 (a)**
The Board received and noted the update.	
14.2 Corporate integrated performance dashboard	**SWBTB (6/15) 089** **SWBTB (6/15) 089 (a)**
Mr Waite reported that there had been a reduction in the number of falls; no breaches in mixed sex accommodation; and there had been a slight improvement in A & E performance. Prospective performance for 62 day cancer waits and thrombolysis rates had dipped. Miss Barlow reported that each of the pathways for these thrombolysis breaches had been reviewed and new practices would be introduced. Mrs Hunjan asked what impact this had on patients. Dr Stedman reported that the standard target was 60 minutes although the window of opportunity for the administration of thrombolysis was three hours. Admission to a stroke unit within four hours was reported to be challenging and escalated by the CCG. In terms of the cancer standards, the forecast was reported to be underperformance in May and June due to a longstanding issue concerning the urology pathway with UHB NHSFT. It was reported that an offer had been accepted by UHB for them to clear patients waiting longer than desired.	
15 Service presentation – Patient Transport Service	**Presentation**
Mrs Dawn Hall joined the meeting and presented an overview of the Patient Transport Service, including key risks and future plans. Mr Ovington reported that reconfiguration of the team was planned to ensure that it supported the flow of the organisation better and to tackle some of the issues outlined by Mrs Hall including the most appropriate use of transport. Mrs Hunjan asked what reasons lay behind cancellation of journeys and was advised that these were various including clinic cancellations and patients dying between bookings made and journey. Dr Sahota asked whether transport was available between City and Sandwell Hospitals and was advised that this was	

dependent on capacity. It was noted that transport offers were based on medical need. The catchment area was significant, particularly for eye patients and nuclear medicine treatment. It was reported that transport was funded as part of the block contract with the CCG. Mr Lewis reported that there was an obligation on the Trust to provide the service. It was noted that the possibility of charging patients for some journeys outside the clinical need threshold would be investigated. Mrs Hunjan supported this proposal. Mrs Hall underlined the need to engage transport services early in the complex discharge process. It was agreed that better linkages with the patient information systems to ensure that the service is fully informed.	
16 Update from the meeting of Quality & Safety Committee held on 29 May 2015 and minutes from the meeting held on 24 April 2015	**SWBQS (4/15) 048**
Ms Dutton presented an overview of the key discussions from the Quality & Safety Committee meeting held on 29 May 2015. It was reported that the presentation by the Coroner was particularly useful. The TDA cleanliness inspection outcome would be reviewed once the revisit had happened.	
17 Update from the meeting of Finance & Investment Committee held on 29 May 2015 and minutes from the meeting held on 2 April 2015	**SWBFI (4/15) 018**
Mr Samuda presented an overview of the key discussions from the Finance & Investment Committee held on 29 May 2015. It was reported that procurement efficiencies would be progressed over the coming period and the position regarding delivery plans for CQUINs was to be discussed by the Executive shortly.	
18 Update from the meeting of Public Health, Community Development and Equalities Committee held on 28 May 2015 and minutes from the meeting held on 27 November 2015	**SWBCC (10/14) 046**
Mr Samuda presented an overview of the key discussions from the meeting of Public Health, Community Development and Equalities Committee held on 28 May 2015. It was reported that further attention was to be given to the process for handling voluntary retail outlets.	
19 Any Other Business	**Verbal**
Mrs Goodby reminded the Committee of the planned staff awards and asked for any ideas for sponsorship. All were asked to consider good practice and nominations for various categories.	
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 July 2015 and would be held at the Carters Green Business Centre, West Bromwich.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 2 July 2015, Carters Green Business Centre, West Bromwich

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

4 June 2015, Churchvale/Hollyoak Rooms, Sandwell Hospital

Members present: Mr R Samuda (RSM), Ms O Dutton (OD), Mrs G Hunjan (GH), Mr H Kang (HK), Dr S Sahota (SS), Dr P Gill (PG), Mr T Lewis (TL) [Part], 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: Mr R Russell (RR), Mr W Zaffar (WZ)

Secretariat: Mr Simon Grainger-Lloyd (SGL)

Last Updated: 26 June 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 22/05/2015	Scheduled for the December January February May June July meeting	R
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.371	Nurse staffing levels	SWBTB (4/15) 062 SWBTB (4/15) 062 (a)	02-Apr-15	Examine by October how we can seek to create a broader Safe Staffing report for the Trust	RG	01/10/2015	ACTION NOT YET DUE	G
SWBTBACT.470	Minutes of the previous meeting	SWBTB (5/15) 074	04-Jun-15	Organise for a timetable for the MES implementation to March 2016 to be presented to the Finance & Investment Committee at its next meeting	TW	31/07/2015	ACTION NOT YET DUE	G
SWBTBACT.472	Chair's opening comments	Chair's opening comments	04-Jun-15	Expand the meeting action tracker to include the activities planned in respect of Mental Health	SGL	31/07/2015	Summary of meeting still to be received	G

SWBTBACT.474	Chief Executives report	SWBTB (6/15) 076	04-Jun-15	Ppresent the Trust's position on treatment of individuals and patient requirements based on prejudices and beliefs at the August meeting	TL	06/08/2015	ACTION NOT YET DUE	G
SWBTBACT.475	2014/15 annual governance statement and report	SWBTB (6/15) 080 SWBTB (6/15) 080 (a) SWBTB (6/15) 091	04-Jun-15	Present the Business Continuity arrangements at the next meeting of the Audit & Risk Management Committee	RB	30/07/2015	ACTION NOT YET DUE	G
SWBTBACT.477	Quarter 1 financial update	SWBTB (6/15) 087 SWBTB (6/15) 087 (a)	04-Jun-15	Arrange for the Women and Child Health Group to be invited to a future Board Informal session	SGL	17/07/2015	ACTION NOT YET DUE	G
SWBTBACT.471	Consent audit	SWBTB (6/15) 096	04-Jun-15	Add a standing item to Board agendas to discuss consent	SGL	02/07/2015	Added as requested	B
SWBTBACT.473	Chief Executives report	SWBTB (6/15) 076	04-Jun-15	Present an update on video reflexivity at the next meeting	RST	02/07/2015	Included within the video reflexivity item under matters arising	B
SWBTBACT.476	2014/15 annual governance statement and report	SWBTB (6/15) 080 SWBTB (6/15) 080 (a) SWBTB (6/15) 091	04-Jun-15	Provide comments on the annual report by Tuesday 9 June	All	09/06/2015	Comments received	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

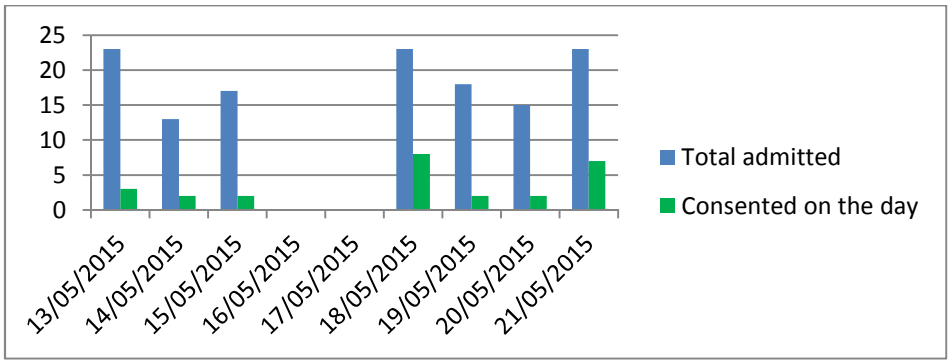
Consent process for elective patients

Report to the Trust Board on the 2 July 2015

1. Introduction

1.1 In June 2015 a paper was presented to the Board detailing a review of consent taking practice on the Adult Surgical Unit within the Birmingham Treatment Centre over a 7 day period.

1.2 The number of patients admitted to the ASU over the 7 days was 121. **26** patients had consent taken on the day of their procedure. This is shown daily in the graph below.



1.3 This report outlines the reason that consent was taken on the day and whether consent could have been taken prior to the procedure taking place.

1.4 The two stage consent process requires that information is provided to the patient, ideally in both written and verbal form. It is the Trust's responsibility to show that this has been completed through documentation in the healthcare records, clinic letter or consent form. Patients may then sign on the day of procedure that they consent to the procedure, having had this information with enough time to consider and weigh up all the options, including doing nothing. The process in this circumstance should be that the clinician has completed their section of the consent form at this time and the patient affirms their consent on the day or at preadmission.

1.5 Procedures which can be deemed as direct access rely on the provision of information to the patient ahead of the day of admission, and crucially documented evidence of this provision, with the consent form then being signed on the day of the procedure.

Specialty	Number of cases	Reason for consent taken on the day	Assessment of practice
Gynaecology	2/24	One case referred from elsewhere. One case wrongly identified as consent taken on the day.	Probable direct access Correct process as information given prior to admission

Specialty	Number of cases	Reason for consent taken on the day	Assessment of practice
Breast	1/16	Wrong consent taken at pre-admission so had to be corrected on the day. Correct procedure discussed at OPD and leaflet given.	Correct process undertaken but incorrect procedure documented
Urology	5/9	Information given in clinic by a different surgeon x2 Two options for treatment discussed with patient ahead of procedure. Consent taken but lost when arrived for surgery so retaken Information provided at clinic but no consent	Correct two stages but required consent signature of doctor. Correct two stages but required consent signature of doctor. Correct process – loos of consent form Correct process as discussion outlined in clinic letter, consent completion would have been ideal
Plastics / Dermatology	1/7	Information provided at clinic but no consent	Correct process as discussion outlined in clinic letter, consent completion would have been ideal
Oral Surgery	11/13	Patients listed from other organisations	Could be a direct access process
Trauma and Orthopaedics	2/30	Letter and information sent to patient after consultation Patch and plan from ED	Correct two stages but required consent signature of doctor. Possibly viewed as direct access
Vascular	1/2	Discussion and leaflet in clinic, letter sent after consultation	Correct two stage but required consent signature of doctor
ENT	1/11	Consent taken but lost when arrived for surgery so retaken	Correct process – loss of consent form
General Surgery	2/9	Urgent procedure Two part procedure – surgery dependent upon another test result	OPD consent would have delayed surgery. Operation could be identified as direct access.

2. Findings

2.1 The majority of cases were from Oral Surgery, where patients are largely seen at other Trusts for their consultation and are admitted to us for their procedure. Whilst the information is provided to the patients this is not obvious in our healthcare records as the

documentation of this lies in another Trust's records. Discussions with the Oral Surgeons are taking place to find a resolution for this.

2.2 There are a number of pathways for patients which are dependent upon a two stage process. One example is in Trauma & Orthopaedics where patients are seen in the Emergency Department and treated (known as 'patch') and then they are placed on a semi elective trauma list (known as 'plan'). These patients are not seen by a surgeon and are booked to attend for surgery, usually within the next 24-48 hours.

2.3 Additionally there are some instances when a procedure may be undertaken dependent upon results from a test. It is reasonable in these instances for a patient not to have to return to clinic but this means that the consent needs to be undertaken on a provisional basis ahead of undertaking the tests.

2.4 Of the 26 cases, 12 are ideally suited to be classed as direct access procedures. Two processes need some discussion about their applicability and the ways ensure appropriate information is given and access to a clinician if advice or further information is required (patch and plan).

2.5 One case required urgent surgery which would have been delayed through an additional step to take consent.

2.6 The remaining 11 cases all had information provided in their clinic appointments as evidenced from the letters dictated and the records, however the clinician completion of the consent form at this stage would have been optimal. The consent forms for two of these cases were lost between being taken and the patient arriving for their procedure so had to be rewritten on the day.

3. Conclusion

3.1 In the majority of cases where consent was thought to be taken on the day of the procedure the review has shown that patients were provided with information and given time to consider their options prior to admission.

3.2 There are many facets to gaining consent from patients which do not easily group themselves into the three categories existing within the Trust's consent policy of elective, emergency and direct access.

4. Next Steps

4.1 As agreed in June, to widen the audit to encompass other elective admission wards and units, but excluding areas where direct access consent has already been agreed, and report the findings and actions to the Trust Board in August.

4.2 The Medical Director to lead a review of the consent processes and policy.

5. Recommendation

5.1 The Board is asked to **NOTE** the report and **APPROVE** the next steps.

Allison Binns
Assistant Director of Governance

26 June 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE PUBLIC TRUST BOARD

Chief Executive's Report – July 2015

An overall view of quarter one performance will be discussed at our start of August meeting. There are clear improvements visible in operational delivery, but we need to take steps to make sure some of our top ten issues are addressed in the planning stage this next month. Financial performance is broadly acceptable, but with some emerging risks that are outlined in the private Board session. The executive remains focused critically on both quality improvement and workforce engagement. The key issues within those discussions are outlined below.

1. Our patients

All Board members will note with concern the third Never Event experienced by a patient in our care in the last 100 days. We discussed this openly this week at our AGM. This follows over 400 days without a Never Event here, whilst 308 occurred across England. We are very confident of site-marking in lithotripsy (our first NE), and the last QIHD was used to again reinforce the Stop Before You Block message for anaesthesia (our second). I will update orally when we meet on the timeframe to deploy our BMEC 'team building' solution across all theatres. Whilst learning the lessons from each event, we clearly need to reinforce our efforts to pre-empt issues and risks. We know we can succeed, because we did when moving from 2013-14 into 2014-15, and it will take vigour, discipline, and commitment to regain the improvement we made.

The infrastructure that we have created around Quality Improvement Half Days will be important in developing our response to a number of organisational learning issues. Whilst in many ways our OK to Ask campaign has made progress on hand-washing, there remain infection risks to be addressed if the Trust is to sustain our longstanding 'low infection' status. In that context the discussion we are having as a Board about Ten Out Ten matters too, because that is a project that is entirely about Always events – getting something to happen every single time. The issues we are discussing around infection or error remain, positively, incidents and isolated ones, but we have to be able to eliminate them, recognising that the evidence suggests that the potential for harm in providing care is innate.

Emergency care performance has improved significantly in June, when compared to work in prior months. This gain reflects the efforts around Urgent Care Challenge, which we discussed when we last met as a Board. A second UCC week kicks off on July 6th focused on discharge practice, and incorporating the work of partner agencies. Moving during quarter two to Expected Dates of Discharge as a fixed marker in our system is a very big change in

how we deliver care, and the relationships between our own staff, as well as those between partners and their supply chain.

At our June Leadership Conference, we devoted the largest part of the time to future plans around safety and quality. This summer will finalise our medium term ambitions, with a focus on core safety standards from 2015, as well as on ambitious outcome improvements by 2019. We sought to make clear that this is the business of the whole organisation, regardless of professional background, and is very much the purpose of clinical directorate and clinical group leadership teams. Clearly the significant investments made in services in recent months will continue to contribute to those efforts.

The Board has discussed previously the improvements being made, and the need to improve further, the responsiveness of our complaints systems. It remains a source of frustration to some complainants that our timeliness could be improved, and we need to do more to make sure that cross organisational learning is achieved. Ourselves and CCG are working to draw out key themes from both complaint sources. Meanwhile, the recent Ombudsman's Annual Report, highlights the work to be done on these issues across the whole service, and includes three historic cases from our Trust, alongside those from other neighbouring organisations.

2. Our colleagues

We discussed tackling sickness rates at our last Board meeting. The workforce and organisational development committee has also reviewed emerging plans to alter how we recruit and induct, both organisation wide and in addressing so-called hot spots. There is no question that both issues feature much more directly on the agenda of local managers, and efforts to make sure that that continues and bears fruit, will be supported not only by Raffaela Goodby, but by the whole executive as we move through the summer. The smart and compassionate management of our workforce is not the 'job of HR'. It is central to the organisation. Tackling issues such as MSK absence, through our £100k investment in new services, and how conduct cases are addressed in a timely manner, are detailed examples of this intent and spirit.

Engagement and morale continue to be tracked through our Your Voice model. Rates of engagement have improved, on the back of local betterment in specific Groups (see IPR), with a jump in some of our historically lowest performers.

Our workforce consultation forms part of the Board's papers at its July meeting. The advice will be to consider the formal consultation process duly concluded. This enables us to move to redeploy individuals this summer. Of course involvement and listening continues. For example, the changes we have long planned to implement around patient administration have to proceed in two parts, this summer with changes in how letters are produced and the volume of work individuals undertake, and next spring with the introduction of new technology. I very much hope that the certainty we are increasingly being able to offer

staff, in an NHS environment of considerable turbulence, will become a distinctive feature in the months ahead.

3. Our partners

I have reported previously that no educational contractual offer had been made to the Trust through Health Education West Midlands. An offer has now been presented to us, and we are considering how best to address the modest shortfall in funding that it proposes. Our long term workforce plans do depend on great collaboration with organisations like HEWM, and we need to consider how that is achieved to reduce surprises and support long term planning. This summer will take the next step in that long term planning, by focusing on our workforce model for 2016-2018. The Education Plan which comes in draft to July's Board forms part of a local response to the issues of needing to make sure that our staff are supported and developed over a career, either solely with us, or in concert with partners across the Black Country, and those in primary care.

With the CCG and Local Authorities, detailed planning is now underway around the longer term urgent care model in Sandwell and West Birmingham. Clearly Midland Met, and the large Urgent Care Centre at Sandwell, are fixed points in that landscape, but they will depend on how services like GP Out of Hours works. We want to try together to co-design, and design with patients, systems that work both clinically and for those needing to use them across a seven day week. Many of the challenges faced by, for instance, our Trust from Monday reflect pressures and issues arising through Saturday and Sunday.

Both local Health and Wellbeing Boards are considered currently how they work. The Birmingham HWB has invited provider organisations to consider representation within their Board, and similar considerations are being explored within Sandwell. Clearly through RCRH, we also need to take an interest in how systems are aligning across boundaries, with Midland Met for example creating a situation where differences in social, community and mental health practice, will become a daily reality for staff co-located from 2018.

4. Our regulators

The Board will be aware of national changes in the organisation of some regulatory organisations. A single chief executive is to be appointed across Monitor and the TDA. Meanwhile, Monitor continues to consult on its latest risk framework, and the Trust is undertaking work to self-assess our performance against the new Well-Led framework. This will feature in Board business as we move through the next three months.

The Trust has received final draft feedback on our Annual Plan. Though broadly positive from the TDA we need to progress in July discussions on some specific local points, as well as one or two emerging national issues now inserted into the planning process. During July we will meet with the TDA twice, once to discussion infection control, and to examine overall performance in quarter 1.

The Care Quality Commission have now had the Trust's submission on the December 2014 Imaging Improvement Notice. We await their feedback. The Trust is being visited too to examine children's community services and conclude the inspection undertaken last October, where issues within the CQC prevented a final judgement being reached. The Board considers the Improvement Plan we published in March, in effect at the half point, towards our target delivery of the end of October. In many areas good improvements are being made but we need to make sure that they are embedded and that we are taking the opportunity to redesign and improve systems to release staff time to care wherever that is feasible.

5. And finally a proposal

In November 2014, Olwen Dutton asked that we examined our wage structure when compared to the Living Wage. We subsequently reported back on our compliance and identified up to 400 roles which were short of the measure, or could be. Although we were able to assure practice in parts of our supply chain, we could not do so consistently. Having largely completed our investment plans for 2015-16 it is now apparent that we have earned the opportunity to become Living Wage compliant for employed staff excluding apprentices. The cost of this has been calculated and remains inside our reserve threshold. The sums are not Board level business, however, I wanted the full Board to consider the Executive's recommendation for two reasons. Firstly it was the Board as a whole who drove this issue. And secondly, we will then need to operate our long term workforce model without using band 1 employees. I believe that that is wholly possible and desirable, because our strategy has never been a low-wage one. But want the full Board to endorse increasing expenditure this year by £35,000 to cover this commitment from 1 October 2015.

Toby Lewis

Chief Executive

26 June 2015

SWVTB (7/15) 101 (a)
ANNEX B - **Our annual plan 2015/16 – top ten**

Objective (listed by improvement quarter order)	End of May update	Improvement quarter	Success quarter	Likelihood of delivery assessment
Work within our agreed capacity plan for the year ahead	Plan in place. Trajectories need signing off, and April planned care delivery <u>below</u> expectations.	Q1	Q1-4	As May As May
Create balanced financial plan…	Anticipate 6 of 8 Groups having CEO agreed plans by June 4. *Surgery A and B are the exceptions.*	Q1	Q1-4	As May As May
Agree EPR OBC and initiate procurement process	Infrastructure case with Board. Output specification needs agreeing for planning to go green.	Q1	Q1 and Q3	Improved As May
Achieve the gains promised in our 10/10 programme	*Delivery plan to be discussed at July Board*	Q2	Q2	Improved As May
Implement our Rowley Regis expansion…	Plan for approval at July Board.	Q2	Q3	As May Improved
Cut sickness absence below 3.5%...	Good mobilisation but data flows need firming up if planning to go green.	Q2	Q3 and Q4	As May As April
Reduce readmissions by 2% at Sandwell	*Delivery plan needs further work within the executive in July*	Q2	Q3-4	Behind plan As May
Deliver our plans for significant improvements in our universal health visiting offer	Plan development advanced within WCH. Review timetable at executive level set. Concern remains scale of improvement needed.	Q2	Q4	As May As May
Tackle caseload management in community teams	Planning arrangements clarified across teams, and budget established. Plan available in early July.	Q3	Q4	As May As May
Reach financial close on the Midland Met	External dependencies operating broadly to timetable and visibly, so assurance reinforced	Q4	Q4	As May As May

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Equality & Diversity – a position statement**
SPONSOR (EXECUTIVE DIRECTOR):	**Toby Lewis, Chief Executive**
AUTHOR:	**Toby Lewis, Chief Executive**
DATE OF MEETING:	**2nd July 2015**

EXECUTIVE SUMMARY:

The attached paper is submitted to the Board on an escalated basis from the Public Health, Community Development and Equality committee. It reflects the view taken by that committee that progress on the equality and diversity agenda agreed by the Board in October 2014 was inadequate and the route forward was insufficiently clear. I agreed to revisit the matter with relevant executive colleagues and present my own summary of findings.

REPORT RECOMMENDATION:

The Trust Board is asked to consider the assessment presented as support the proposed actions to strengthen the Trust's equality & diversity framework.

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

Accept	Approve the recommendation	Discuss
		X

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

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

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

Compliance with equality & diversity legislation

PREVIOUS CONSIDERATION:

Public Health, Community Development and Equalities Committee in May 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

EQUALITY & DIVERSITY – POSITION STATEMENT

REPORT TO THE TRUST BOARD ON 2 JULY 2015

Background

1. This paper is submitted to the Board on an escalated basis from the Public Health, Community Development and Equality committee. It reflects the view taken by that committee that progress on the equality and diversity agenda agreed by the Board in October 2014 was inadequate and the route forward was insufficiently clear. I agreed to revisit the matter with relevant executive colleagues and present my own summary of findings.

2. The limited progress reflects, having reviewed the matter, three things:
    - The very underdeveloped inheritance on these issues that gave rise to the Board's attention in 2014. This remains an enthusiasm, not core business.
    - The extended period taken to complete a relatively basic task, an EDS2 self-assessment, which was scheduled to take three months and has taken twelve
    - The distributed nature of leadership on these issues, with the Chief Nurse leading, to be supported by the director of organisational development and communication. The latter two roles are only now in situ.

Current state

3. The Trust complies with its basic legal duties under the act, in that we do undertake equality impact assessments on key pieces of work, and we are publishing a scrutinised Board level report. Our 2015 review of the latter suggested that there was insufficient coverage of protected characteristic data in patient care areas, and inadequate use of that data to assess service provision. By implication this must change by the time we report in early 2016. Staff data on protected characteristics is comparatively strong on ESR.

4. In spring 2014, we soft-launched discussions across the leadership about diversity issues. This reflected a series of concerns shared across the board about the relative invisibility of diversity issues inside the Trust, as well as some expressed concerns from BME staff about issues of discrimination and development. Many of these issues were focused on nursing and nursing leadership and had developed as concerns over many years. The Trust signed up to cultural ambassadors work with the RCN in summer 2014.

5. In October 2014 we agreed a paper presented by Colin on our future plans. This contained ten commitments for our future and it is those commitments which need to be considered today. And a clear forward timeframe established, which can be tracked through the Board.

The italicised statements are as per the prior plan. The text is an assessment of current state compiled by the author with Colin Ovington and Raffaela Goodby. The bold statements are next steps, which I propose are entered as actions in the Board's business log, and are thereby tracked at the Board each month.

(i) Commitments that we have delivered:

(2) The CLE education committee is overseeing analysis of training requests and training funds vs ESR protected characteristics data. This will be available in draft at the end of January 2014, in time for our annual declaration. This will be compared to our overall by band staff profile.

This was done, and continues to be done. PC data completeness is mixed, with many individuals declining to provide data. Crucially however we can evidence that those requesting training and those being granted into are not distinguished by PC differences. Jim Pollitt is responsible for ensuring it happens, with Raffaela Good by as the accountable director.

*(3) The CLE equality committee and whole Board have received initial **training** in the duties of the Act and in the precepts of the EDS system. We need to consider what further awareness training individual Board members consider has merit.*

This was done, with local training provided to CLE equalities, and Capsticks providing input to the Board through an informal session. **The suggested next step is to ask Board members to undertake a baseline knowledge assessment this summer on equality and diversity, which can then inform a training plan for Q3.** This work will be led by Raffaela Goodby, supported by the Head of Corporate Governance.

(5) We would undertake an EDS2 self-assessment for any single directorate in the Trust. This was due to be completed by the end of May. It is likely to now be completed by the beginning of November. Almost all directorates have submitted to post a draft for review.

This has been diligently pursued by Colin Ovington and team. It is largely complete, and has been reviewed by both the CLE committee and the Local Implementation Group**. I propose now that it is reviewed in full and final form at the next meeting of the Board's PHCD&E committee in September 2015.**

(ii) Commitments we have delivered in part:

(1) Collect, collate and examine protected characteristics data on our workforce and, largely, on our staff: We will undertake towards the end of 14-15 a one off ESR data validation. The use of outpatient kiosks (from Q3) will be our vehicle to improving patient data. Both will be compared through our Board committee against the demographic for SWB as per the ONS.

The intent of this pledge has been delivered. However, we have yet to undertake the one off data validation. This should be planned now for autumn 2015, but we will need to resource data inputting work.

(7) Undertaking monthly characteristics of emphasis (starting from November) in which we host events that raise awareness of protected characteristics (PC)

Perhaps generously assessed, in that we made a start, with LD month in late 2014. However, there is no forward programme, not least as we had wanted to frame the programme in light of (6). **The director of communications needs to plan a year of work, starting from October 2015.**

(8) Add into our portfolio of leadership development activities a series of structured programmes for people with PC

This has been prepared by the L&D team. Again its launch was to be interwoven with the development of (9) below. **Raffaela Goodby will determine how we move ahead by October 2015 with an unambiguous programme which will certainly include a specific BME leadership offer.**

(iii) Commitments where we have not yet made progress:

(4) We proposed and agreed with staff-side that Harjinder Kang, as JCNC independent chair, would review whether our workforce policies and procedures match (if implemented) our ambitions and commitments. This was due to occur in Q2 but will now occur in Q3.

This feel by the wayside after the false start with our prior director of OD. **It now needs to be progressed, to conclude by December 2015. Critically we are looking to determine not simply whether our policies avoid overt discrimination, but whether they actively take steps to promote diversity.**

(6) With partners to ensure a peer group in each protecting characteristic is active [we have BMSOG and there is an emerging LGBT group]

This will require some further discussions across the leadership, to prioritise how we create interest groups with integrity. We will work with TU colleagues and others to think through how this is best developed in time for the PHCD&E committee in September.

(9) Work with senior leaders with protected characteristics for them to provide visible support within the organisation to others

The interdependence with (6) it noted above. We will start by producing a pictoral representation, and data graph, of who our leaders are. We will also use the next stage of the leadership development programme to explore how issues of diversity can become a more explicit part of our leadership programmes.

(10)Identify the key priority arising from the EDS2 work outlined above.

This will be proposed to the PHCD&E committee in September.

Resourcing and responsibility

6. In spring 2013, the Trust disestablished its distinct E&D team and blended the roles into the wider corporate nursing function. This was controversial at the time. It has not led to a clear set of individuals able to take forward issues relating to E&D. However, the drive that led to that move, which predated by time as CEO, seems to me to remain sound. E&D needs to be the work of everyone, not a distinct department. But to make a reality of that we do need to identify an 'advance guard' of individuals committing time and attention to this work. I will work with Colin and Raffaela to produce at least ten senior names of individuals who will play a role in taking forward this agenda in the coming months. We will also ensure that their annual objectives reflect that responsibility in writing.

7. We have in place a chaired monthly executive committee, covering matters of public health and equality. Relevant executive directors form part of that committee. To date we have been insufficiently structured about this work, and have very much diverted into EDS2. This will change with immediate effect, with the ten point plan being reviewed monthly. The commitments in the plan will form part of CEO/director 1:1s from July.

Conclusion

8. In addition, I would draw to the attention of the Board:

    - That the Trust has a series of contractual obligations under the 2015-2016 Race Equality Standard, which forms an addendum to the national contract. Initial review confirms our compliance with this standard. We will undertake work at the end of Q2 to confirm contractual compliance for the year in preparation for our 2015 annual equality report issued in January 2016, and will seek an internal audit opinion prior to doing so.
    - That next month, our new policy of issues of care and exclusion, in relation to discrimination and choice, discussed in my CEO report in June, will come forward for approval. This has been drafted and considered by our ethics committee. It requires Board agreement in my view given that it could result in the Trust declining under certain circumstances to provide care.

I would suggest that the overall picture presented in this report is disappointing. But that the position is wholly recoverable over a six month period. The enhanced governance role for the Board highlighted above will contribute to ensuring that this happens.

Toby Lewis

Chief Executive

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Environmental hygiene update
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Colin Ovington – Chief nurse
DATE OF MEETING:	2nd July 2015

EXECUTIVE SUMMARY:

The Trust Development Agency have now made three visits to the City and Sandwell Hospitals to inspect ward environmental hygiene standards. The inspections have found lapses in environmental cleaning and standards of cleanliness which are of concern. Immediate actions were put in place to ensure that patients remain safe. And a detailed action plan has been worked on to ensure sustainability of standards.

Actions following the last visit included:

1. Hotel services supervisors and the matrons to undertake daily inspections until problems are resolved
2. Reinforced the OK to ask campaign with the expectation that everyone will be compliant with hand hygiene practices with no exceptions and an escalation route to senior leaders in the trust if challenges are not met with compliant actions. We have been clear with everyone that any breach in this policy will be managed robustly using our disciplinary policy where necessary.
3. Use the opportunity to discuss feedback from the TDA at quality Improvement half day to make as many staff aware of the problem and to gain their commitment to improving fundamental quality.

The TDA has called a summit to discuss progress on the 7th July and will re-inspect the trust premises on 20th July

This action plan will be discussed at the Quality and Safety Committee on 26th June and verbal update on matters arising from this discussion will be given at the Board meeting.

REPORT RECOMMENDATION:

Board members are requested to discuss the concerns and subsequent action plan. Board members are also requested to be observant of the environmental cleanliness and to help by reporting any concerns seen so that these can be actioned appropriately.

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

Accept	Approve the recommendation	Discuss
X		X

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

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

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Hygiene Code Criterion 2.Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections Criterion 9.3.b. Clinical procedures should be carried out in a manner that maintains and promotes the principles of asepsis.
PREVIOUS CONSIDERATION:
Considered by the infection control team Quality and Safety Committee

Action plan – Following External Inspection by the Trust Development Authority (Version 2)

City Hospital wards D26 /D12	Infection, Prevention and Control Advisory Committee
Reason for action plan:	Poor standards
Date of action plan	17.04.2015
Operational Lead:	S Clarke /J Clarke
Expected completion of action plan:	Physical application to begin immediately
Version	2 – 18.0515

The following action plan outlines issues identified by the Trust Development Authority [TDA], following recent visits to SWBH. The initial inspection took place on City site - 16.04.15 with a follow up inspection the 18.05.15. Sandwell Hospital was inspected on the 27.04.15. Whilst the audit highlighted issues on specific wards and departments it is recognised that these issues may not be to specific wards and therefore any action implemented has been cascaded across the organisation to ensure a standard approach to practices. For the purpose of the action plan issues identified by the TDA has been divided into specific wards and departments and corporate issues.

The action plan is a live document and will be updated as issues identified have be rectified.

The inspection highlighted several issues relating to cleanliness of the environment, equipment, compliance with BBE and poor completion of documentation. Outlined below are the key issues and action taken to rectify issues.

Table 1 – Specific issues identified by ward and department

	Issues identified and Action Required	Person Responsible	Action Required	Completed
D26	Visit 16.04.15			
	• Domestic Trolley requires deep cleaning	K.Godwin-Facilities	• Schedules/procedure/ audit/ staff on the spot training all areas	Complete
	• Sink edges in kitchen need resealing	K.Godwin-Facilities	• Remedial work carried out by Estates	Complete
	• Toilet brushes need changing	K.Godwin-Facilities	• Schedules/procedure /audit /Check toilet brush/holder frequency of change	Complete
	• Sharps boxes aperture not temporarily closed	Joy Walker- Ward Manager	Ward Managers responsible for monitoring cleanliness of equipment. IPSC have undertaken the following Action. • Communications message to reinforce consistent operation of sharps boxes against policy sent to ward managers and matrons • Verbal Feedback given to Ward Managers at time of audit. All audits followed up with a copy of the audit with pictorial evidence to Ward Managers • Copies of the audit sent to Director of Nursing for Clinical Groups, Risk Management and Chief Nurse • Verbal Feedback was given to members of the IPCAC 20.0515	Complete

	Issues identified and Action Required	Person Responsible	Action Required	Completed
	• BP machines, no Clinell wipes attached. No evidence machines are being cleaned between use	Joy Walker- Ward Manager	Ward Managers responsible for monitoring cleanliness of equipment. IPSC have undertaken the following Action. • Replaced signage on the portable machines to indicate the requirement of Clinell wipes and their use • Verbal Feedback given to Ward Managers at time of audit. All audits followed up with a copy of the audit with pictorial evidence to Ward Managers. • Copies of the audit sent to Director of Nursing for Clinical Groups, Risk Management and Chief Nurse • Notices reapplied to all machines, ward staff instructed not to remove notices. • Emails have been sent to all Ward Managers and Matrons. • Verbal Feedback was given to members of the IPCAC 20.0515	Complete
	• High dusting on ward needs cleaning	K.Godwin-Facilities	• Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Medical equipment generally requires cleaning	Group Directors of Nursing	• Communication from the Chief Nurse and reinforcing consistent behaviours by the Group Directors of Nursing and Matrons	17/04/2015
	• Hoist needs cleaning – blood and tape evident on frame	Joy Walker – Ward Manager	Ward Managers responsible for monitoring cleanliness of equipment. IPSC have undertaken the following Action. • Replaced signage on the portable machines to indicate the requirement of Clinell wipes and their use • Verbal Feedback given to Ward Managers at time of audit. All audits followed up with a copy of the audit with pictorial evidence to ward managers. • Copies of the audit sent to Director of Nursing for Clinical Groups, Risk Management and Chief Nurse • Verbal Feedback was given to members of the IPCAC 20.0515	Complete
	• Computer key boards dusty – need replacing with washable keyboards	Chief Informatics Officer	• Replace key boards as soon as can be achieved	Complete
	• Fan blades ingrained dirt need cleaning or replacing	R Banks	• Immediate action on the wards affected and check on the rest of the trust	Complete
	• VIP scores not consistent	Joy Walker – Ward Manager	• Communicate with Group Directors of Nursing and Matrons about reinforcing practice and test out behaviours in ward audits	Complete
	• Inconsistent compliance with PPE. Breaches in uniform policy –excessive jewellery untidy uniforms	K.Godwin-Facilities	• Schedules/procedure /audit/ staff on the spot training all areas	
	Visit 18.05.14			
	• High dust on curtain rails	K.Godwin	• Need to review cleaning process and monitoring	Complete
	• Raised toilet seat visibly contaminated and cracked	Joy Walker – Ward Manager/K.Godwin	• Need to review cleaning process and reinforce to staff to check seats prior to use	Complete

	Issues identified and Action Required	Person Responsible	Action Required	Completed
	• Commodes rusty and visibly contaminated	Joy Walker – Ward Manager	• Need to reinforce cleaning process	Complete
	• Shower curtain contaminated	K.Godwin/ Joy Walker – Ward Manager	• Needs replacing	Completed
	• Cups stained and washed in sink in ward kitchen	K.Godwin	• Need to review cleaning process with a view to stained cups being replaced and cups being decontaminated in the central spine dishwashers	Complete
	• Wipes not available on all BP machines	Joy Walker – Ward Manager	• Need to ensure wipes are available and used on all machines	Clinell wipes with the new laminated clinell information cards attached
	• HWB seal damaged	Joy Walker – Ward Manager	• Needs repair	Escalated to estates for repair
	• Keyboards dirty	Joy Walker – Ward Manager	• Needs replacing with washable key boards	now part of the routine ward clean
	• Incorrect documentation on cannula care	Joy Walker – Ward Manager	• Need to ensure all documentation in up to date	Vip chart was not completed correctly, bur addressed with the individuals involved.
	• Staff discharging bath water down HWB	Joy Walker – Ward Manager	• Should be disposed of in sluice	This has been a routine practice which I was unaware was not good practice. therefore nursing staff would have to walk the length of the ward with a basin of contaminated water which posed a health and safety risk.
	• Wrong colour lid on sharps boxes	Joy Walker – Ward Manager	• Need to ensure correct lids on sharps boxes	Sharps bin signage clearly

	Issues identified and Action Required	Person Responsible	Action Required	Completed
				displayed
D11	16.04.15 visit		•	
	Safety cross not completed for the 16.04.15	Ann Robinson – Ward Manager	• Ensure that the safety cross is kept up to date	Complete
	Kitchen			
	• Microwave dirty	K.Godwin-Facilities/J Briant	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Plates and bowls ingrained food – replaced at time of audit	J Owen/J Briant	Replace crockery /review dish washing procedures and Audits	Complete
	• Seal on HWB needs replacing	R Banks		Complete
	• Kitchen needs deep clean	K.Godwin-Facilities/J Briant	Schedules/procedure/ audit/ staff on the spot training all areas	
	• Skirting damaged needs repair – difficult to clean	R Banks	Replace/repair skirting board	
	• Water dispenser needs cleaning	K.Godwin-Facilities	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	Activity room			
	• – mattress on floor ? clean	Ann Robinson – Ward Manager	Ward Managers responsible for monitoring cleanliness of equipment. IPSC have undertaken the following Action • Verbal Feedback given to Ward Managers at time of audit. All audits followed up with a copy of the audit with pictorial evidence to ward managers. • Copies of the audit sent to Director of Nursing for Clinical Groups, Risk Management and Chief Nurse	Complete
	• Underneath of chair not clean	K.Godwin-Facilities	Schedules/procedure /audit/ staff on the spot training all areas	
	• Walking aids ? clean	Ann Robinson – Ward Manager	Ward Managers responsible for monitoring cleanliness of equipment. IPSC have undertaken the following Action • Replaced signage on the portable machines to indicate the requirement of Clinell wipes and their use • Verbal Feedback given to Ward Managers at time of audit. All audits followed up with a copy of the audit with pictorial evidence to ward managers. • Copies of the audit sent to Director of Nursing for Clinical Groups, Risk Management and Chief Nurse	Complete
	• Linen Room			
	• Pressure aids in linen room -? Clean visibly looked stained	Nursing	Schedules/procedure/ audit/ staff on the spot training all areas	
	• NHS slippers [appeared clean] stored in ASDA bag but no evidence they were clean and unused	matron	Remove to appropriate storage	Complete
	• Cleaning schedules in linen room intermittent	K.Godwin-Facilities	Review schedules	Complete

	Issues identified and Action Required	Person Responsible	Action Required	Completed
	• Pumps stored in sluice	matron	Remove and ensure that no medical equipment is stored in the dirty utility room	Complete
	• Domestic trolley needs cleaning (all trolleys to be reviewed)	K.Godwin-Facilities	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Staff member observed not wearing aprons and gloves carrying urine to sluice	Ann Robinson – Ward Manager	Ward Managers responsible for monitoring cleanliness of equipment. IPSC have undertaken the following Action • Communication from Chief nurse • Reinforce trust policy on the use of PPE • Verbal Feedback given to Ward Managers at time of audit. All audits followed up with a copy of the audit with pictorial evidence to ward managers • Copies of the audit sent to Director of Nursing for Clinical Groups, Risk Management and Chief Nurse	Complete
	Visit 18.05.15			
	• Staff observed not changing PPE	Ann Robinson – Ward Manager	• Challenged at time of audit. Ward Manager to reinforce practices to all staff.	No feedback
	• No urinary catheter documentation for one patient with long term catheter	Ann Robinson – Ward Manager	• Need to ensure process is in place to check all documentation	No feedback
	• VIP scores not recorded	Ann Robinson – Ward Manager	• Need to ensure process is in place to check all documentation	No feedback
	• High dust	K.Godwin-Facilities	• Need to review cleaning processes	Complete
	• Toilet seats contaminated	K.Godwin-Facilities	• Need to review cleaning processes	Complete
	• Seals on sinks.	K.Godwin-Facilities	• Need to review cleaning processes	Complete
	• Ward food trays dirty	K.Godwin-Facilities	• Need to review cleaning processes	Complete
D27, D25, D5	• Crockery stained and contained ingrained food. • Evidence process of cleaning crockery needs reviewing to include ensure a robust programme of auditing cleanliness is in place • Cup stained – need to review process for washing as washed at ward level • Food regen trolleys City site need deep cleaning	J Owen/J Briant	• Review of all crockery • Stained Crockery removed • Purchase of Replacement Crockery • Review of decontamination process for crockery undertaken by Facilities • Facilities to review process for washing cups at ward level • Process in place to deep clean all food regeneration trolleys • Review of all kitchen taken place	Complete
A&E	Visit 16.04.15			
	• Domestic not Bare below the elbow	K.Godwin-Facilities	Schedules/procedure/ audit/ staff on the spot training all areas	Complete
	• Domestic trolley needs cleaning	K.Godwin-Facilities	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Domestic room cluttered needs cleaning	K.Godwin-Facilities	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Items of personal clothing in domestic room	K.Godwin-Facilities	Schedules/procedure /audit/ staff on the spot training all areas	Complete

	Issues identified and Action Required	Person Responsible	Action Required	Completed
	• Batteries on shelf next to paper warm	K.Godwin-Facilities	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Bins in reception need replacing	K.Godwin-Facilities	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Sharps boxes not closed or signed	Ian Gillespie – Unit Manager	• Communications message to reinforce consistent operation of sharps boxes against policy sent to ward managers and matrons • Verbal Feedback given to Ward Managers at time of audit. All audits followed up with a copy of the audit with pictorial evidence to Ward Managers • Copies of the audit sent to Director of Nursing for Clinical Groups, Risk Management and Chief Nurse • Verbal Feedback was given to members of the IPCAC 20.0515	Complete
	• Equipment trolleys need cleaning	Ian Gillespie – Unit Manager	Ward Managers responsible for monitoring cleanliness of equipment. IPSC have undertaken the following Action • Replaced signage on the portable machines to indicate the requirement of Clinell wipes and their use • Verbal Feedback given to Ward Managers at time of audit. All audits followed up with a copy of the audit with pictorial evidence to Ward Managers. • Copies of the audit sent to Director of Nursing for Clinical Groups, Risk Management and Chief Nurse • Notices reapplied to all machines, ward staff instructed not to remove notices. • Emails have been sent to all Ward Managers and Matrons. Verbal Feedback was given to members of the IPCAC 20.0515	Complete
	• No clinell wipes on trolleys or machines	Ian Gillespie – Unit Manager	As Above	Complete
	• High dusting	K.Godwin-Facilities	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	Visit 18.05.15			
	• High Dust on curtain rails	K. Godwin	• Review of Cleaning process and technique in place	Complete
	• Resuscitation Trolley dusty	Ian Gillespie – Unit Manager	• Needs to be reinforced at all team handovers for all staff working in A&E	Complete
	• Cleaner not BBE	K.Godwin	• Practices reinforced to all staff.	Complete
	• Floor taped and in a state of disrepair	Ian Gillespie – Unit Manager	• There is an action plan in place to complete floor repairs but due to capacity issues it awaits sanctioning by Director of Operations.	Plans to replace
	• Not all sharps boxes closed when not in use	Ian Gillespie – Unit Manager	• Needs to be reinforced at all team handovers for all staff working in A&E	Complete
	• Not all machines PAT tested	Ian Gillespie – Unit Manager	• Need to ensure machines are identified to medical Engineers for PAT testing.	Complete
	• Splash back needed in cleaners cupboard	K. Godwin		Complete
D27	Visit 16.04.15			
	• Regen trolley needs cleaning [prepped for serve dinners!]	K.Godwin-Facilities/ J Owen/J Briant	Review cleaning procedure and frequency of deep clean	Complete

	Issues identified and Action Required	Person Responsible	Action Required	Completed
	• Cleaning cloths under U bend	K.Godwin-Facilities	Rectification of poor housekeeping practices	Complete
	• Bread bin , no lid and requires cleaning	K.Godwin-Facilities/J Briant	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Beverage machine requires cleaning	K.Godwin-Facilities/J Briant	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Condiment holders need cleaning	K.Godwin-Facilities/J Briant	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Domestic hat on top of regen trolley(hat soiled)	K.Godwin-Facilities/J Briant	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Plate stand needs cleaning	K.Godwin-Facilities/J Briant	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	Visit 18.04.15			
	• High Dust observed	K.Godwin-Facilities/J Briant	• Need to review cleaning tools and practices	Complete
	• Bed pans visibly contaminated	Tracy Weston- Ward Manager	• Need to reinforce to staff need to clean between each patient use	Daily checklist now in place for cleaning
	• Commodes Contaminated	Tracy Weston – Ward Manager	• Need to reinforce to staff need to clean between each patient use	Daily checklist now in place for cleaning
	• Microwave dirty	K. Godwin	• Need to review monitoring process	Complete
	• Workmen observed putting dirty tools on top of drinks machines	R.Evans	• Challenged at time of audit. • Email to Kevin Reynolds to reinforce to workmen and contractors staff practices.	Completed
	• Wipes not available on all BP machines	Tracy Weston – Ward Manager	• Need to ensure wipes are readily available	Additional wipes ordered to ensure one for each Bp machine
	• Toilet Seat Contaminated	K.Godwin	• Needs review as part of cleaning process	Complete
	• Crash Trolley dusty	Tracy Weston – Ward Manager	• Need to review monitoring process for cleaning	On part of daily check list for cleaning
	• Shower curtain stained	K.Godwin-Facilities/J Briant	• Needs replacing	Complete
	• Multi – use skin cleansers – should be single patient use	Tracy Weston – Ward Manager	• Challenged at time of audit.	Completed
	• Chairs ripped	Tracy Weston – Ward Manager	• Need repair or replacement	Chairs discarded
	• No lid on chlor clean bottles	Tracy Weston – Ward Manager	• Need to ensure staff adhere to H&S and COSHH guidelines	Completed

	Issues identified and Action Required	Person Responsible	Action Required	Completed
D25	Visit 18.05.15			
	• Kitchen surface damaged	Jo Mansell – Ward Manager	• Need to report to estates	Reported on 15/5/15 and
	• High dust observed	K. Godwin	• Review cleaning process	Completed
	• Dust under beds	K. Godwin	• Review cleaning process	Completed
	• Crash trolley dusty	Jo Mansell – Ward Manager	• Review cleaning process	Implementation of a cleanliness champion to carry out inspection on each shift. Checklist has to be signed Due to start this week.
	• Commodes dirty	Jo Mansell – Ward Manager	• Review cleaning process	The commodes were stained (rust marks and inodene marks on the back rest). Escalated during challenge week and 3 new commodes ordered, awaiting delivery.
	• No aprons in sluice	Jo Mansell – Ward Manager	• Review cleaning process	Actioned and re-stocked.
	• Defib trolley dusty	Jo Mansell – Ward Manager	• Review cleaning process	As crash trolley
	• Sharps box on crash trolley not signed for	Jo Mansell – Ward Manager	• Need to reinforce protocol to staff	Protocol will be reinforced at ward meeting. Senior team on ward will

	Issues identified and Action Required	Person Responsible	Action Required	Completed
				continue to spot check.
D19	Visit 18.05.15			
	• Display cupboard at entrance need replacing with washable covers	Paul Deflot – Ward Manager	• Update display ensuring it is wipeable	Complete
	• Hand audit displayed on door out of date March 15	Paul Deflot – Ward Manager	• Need to ensure information is up todate	complete
	• High dust	K. Godwin	• Cleaning tools to be reviewed	Completed
	• Relative z beds need repair/replacing	Paul Deflot – Ward Manager	• Need to be replaced or repaired	Condemned, to be replaced
	• Microwave dirty	Paul Deflot/K. Godwin	• Cleaning schedules to be reviewed and practices to clean up spillages to staff reinforced	Microwave was replaced due to rusty interior
	• Crash trolley dusty		• Cleaning schedules need to be reviewed	Schedule in place to clean trolley along with daily equipment trolley check
	• Functionality of sluice multi purpose	Paul Deflot – Ward Manager	• Need to review functionality of area to ensure a segregated clean to dirty flow is maintained	Removal of toilet requested ID 4496. Clean and dirty now segregated
	• Sharps boxes in sluice left in sun,	Paul Deflot – Ward Manager	• Need to find appropriate storage area and any boxes that have perished must not be used as it could damage the integrity of the surfaces	Damaged sharps bins replaced and stored in appropriate area
	• Excess toys, no cleaning schedule	Paul Deflot – Ward Manager	• Need to review number of toys, use and cleaning schedules.	Excess toys remove now more storage available. Cleaning schedule implemented

Table 2 – Corporate Actions

	Action taken by Facilities.	By whom	Date Completed
	Review and monitor staffs adherence to working procedures.	K.Godwin-Facilities/Departmental Managers	24th April
	Raise awareness to working schedules for wards and departments.	K.Godwin-Facilities/Departmental Managers	Complete
	Re-issue of pocket schedules for all wards.	K.Godwin-Facilities/Departmental Managers	24th April
	Re-introduction of random departmental and senior manages audits of the audit process.	K.Godwin-Facilities/Departmental Managers/Monitory officer	24th April
	Reinforcement of daily positive/productive communication/hand over of service information.	K.Godwin-Facilities/Departmental Managers/Supervisors	24th April
	Strengthening of audit process, audit/rectification officers to be trained by infection control to ensure an aligned approach to the audit process.	K.Godwin-Facilities/Infection control/Departmental Managers/Supervisors	28th/2nd June
	Proactive back to the floor daily tours of inspection by departmental managers.	Departmental Managers	24th April
	Re-introduction of senior manager's weekly inspections.	Deputy director of Facilities/Head of Facilities/Infection Control/Estates/Catering Manager/Departmental Managers	24th April
	Reinforcement of the use of documented rectification process for poor standards.	K.Godwin-Facilities/Infection control/Departmental Managers/Supervisors	24th April
	Staff on D11/D26 booked on domestic retraining program.	Departmental Managers/Training Supervisor.	8th May
	Re-introduction of deep cleaning program of Burlodge trolleys	K.Godwin-Facilities/Catering Manager/ Departmental Managers	29th April
	Deep clean of ward/departments radiators	K.Godwin-Facilities/Estates Manager/ Departmental Managers/Supervisors	27TH April
			17th April
	Sharps container on wards with wrong colour lids - requires Facilities to review sharps container and training at ward level	Dawn Hall	
	Facilities Action plan following revisit by TDA on the 18th of May.	By whom	Date Completed
	Equipment audit /purchase of replacement and additional tools where requirement identified.	K.Godwin-Facilities/Departmental Managers	Completed
	Revises local ordering of cleaning materials/stock control.	K.Godwin-Facilities/Departmental Managers	Completed
	Additional adjustments of work schedules on City wards to ensure clarity for allotted time for cleaning of sanitary areas.	K.Godwin-Facilities/Departmental Managers	Complete 31/05/2015
	Retraining of Supervisors in the poor audit rectification process.		Completed
	Introduction of Schedules for the audit process.	K.Godwin-Facilities/Departmental Managers/Supervisors	Completed
	Introduction of weekly formal handover/feedback audit meetings with Departmental managers and Supervisors.	K.Godwin-Facilities/Departmental Managers/Monitory officer	Completed
	Reinforcement/clarity of escalation procedure for poor standards. .	K.Godwin-Facilities/Departmental Managers	20th May
	Increases re-training on cleaning techniques to 6 monthly for staff that are under performing were identified through the audit process or complaints from Ward/Departmental managers.	K.Godwin-Facilities/Estates Manager/ Departmental Managers/departmental trainer.	Completed
	Reintroduction on the job assessment of staff against cleaning procedures.	K.Godwin-Facilities/Estates Manager/ Departmental Managers/departmental trainer.	Completed
	Action by IPCS and Risk Management following TDA visit	By whom	Completed

	All wards were audited by IPC and Risk Management week commencing 11.05.15 findings were disseminated as outlined below.	IPCS/ Risk Management	Completed
	• Verbal Feedback was given to all ward Managers at the time of the audit.	IPCS/ Risk Management	Completed
	• Where cleaning labels had been removed these have been replaced with instruction not to remove labels as they are all wipeable	IPCS/ Risk Management	Completed
	• Audits were followed up with a copy of the audit to ward managers with pictorial evidence where appropriate	IPCS/ Risk Management	Completed
	• Copies of the audit findings with pictorial evidence was given Director of Nursing for relevant Clinical Groups and Chief Nurse.	IPCS/ Risk Management	Completed
	Chief Nurse has sent out correspondence to all Ward/Departmental Managers and Director of Nursing outlining findings of audit and TDA response with instruction to action issues.	Chief Nurse	Completed
	Summary of issues also sent to out as an email to all ward managers, matrons, Director of Nursing. IPC identifying issue and feeding back to wards as part on day to day clinical	IPCS	Completed
	Findings have been fed back to members of the IPCAC	Rebecca Evans	Completed
	Chief Nurse has audited kitchens on all wards City site and fed back findings at time of audit.	Rebecca Evans	Completed

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Education, Learning & Development Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Raffaela Goodby – Director of Organisation Development**
AUTHOR:	**Raffaela Goodby – Director of Organisation Development**
DATE OF MEETING:	**2nd July 2015**

EXECUTIVE SUMMARY:

The Trust has invested significantly in learning, education and development for all staff and this has reached £1 million for the first time in 2015 – 2106. The attached paper is a draft 3 year plan, that sets out an ambitious set of aims and objectives to be achieved reflecting the Trust's commitment to a skilled, passionate workforce delivering great care to our patients, both now, and to meet the changing needs of the future.

The plan was launched at the Leadership Conference on 23rd June 2015 to the Trust's top 150 managers in a group specific workshop. Each group has given feedback on how they will use the plan to effectively workforce plan, how they will communicate, and contributed to the importance of learning within the Trust. This feedback will be used to shape a final plan for August Trust Board consideration and approval. The feedback has also been considered alongside recruitment and vacancies – to strategically plan our workforce.

REPORT RECOMMENDATION:

The Trust Board is asked to :

- consider the attached Education, Learning & Development Plan and offer suggestions, feedback and thoughts
- the Trust Board is asked to agree to consider the finalised plan at the August 2015 Board for final approval

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

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

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

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

Delivery of Trust's long term workforce strategy and plan

PREVIOUS CONSIDERATION:

Education, Learning & Development Committee

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Education, Learning & Development Plan 2015-2018

SWBH Trust firmly believes that effective education, learning and development makes a major contribution to the provision of a committed, professional and competent workforce enabling the delivery of safe and effective patient care. The Trust takes learning seriously, clearly demonstrated by the increasing investment in the development of our colleagues, reaching £1 million at the time this plan was produced. The leaders of this Trust understand that by investing in a high quality workforce that are competent and clear on our values and behaviours, we will enable high quality care to be delivered to our patients and positively affect health outcomes in our communities.

We encourage all our colleagues to develop their skills & competence, to ensure that service users, families and carers have a positive, effective and safe experience in all their encounters with us.

This document sets out the strategic direction for the Trust's Education, Learning & Development (EL&D) over the next three years ensuring that our finances, energy and efforts are demonstrably focused on outcomes and seeing a real difference in the skills & competence of all of the 7200 colleagues in the SWBH family. We will continue to use the core dimensions of the nationally acknowledged Knowledge and Skills Framework (KSF) to measure individual development, use our own Leadership Competency Framework and our 9 Trust promises, focussing on the 'how' we do things, as well as the things that we do.

***'How' we do things is as important as what we do. We will focus on our Trust promises to help develop a culture that enables all of our colleagues to thrive*.**

We are investing in bringing the significant resources we invest in education, learning and development together and by doing so we will enable staff to have essential knowledge and skills to help service users today, but are prepared and skilled enough to meet the challenges we will face in the future.

This plan sets out an ambitious 'offer' for colleagues at all levels, whether you are joining the Trust and in your first few years in an NHS career, whether you wish to develop your skills and competence to develop your career, or whether you are an experienced colleague taking the step to senior leadership or technical excellence. SWBH can offer a vibrant, interesting and varied career for all, and our education, learning and development plan aims to be a significant vehicle to enable and support our talented colleagues to enjoy a long, challenging and varied career, delivering fantastic care to the patients of Sandwell and West Birmingham.

We want to be the employer of choice for people living in the region, attracting local talent to work with us and for us, whilst becoming renowned for ensuring all our staff are educated, developed and trained in order to achieve the highest standards of leadership and patient care.

A skilled, passionate workforce is the greatest asset of any organisation. This 3 year education, learning and development plan is designed to put excellence at the heart of all learning in our Trust and to equip us all to deal competently and confidently, with the challenges of the future.

Toby Lewis – Chief Executive

Your learning journey at SWBH

This plan outlines learning and development opportunities at every stage of your career with Sandwell & West Birmingham Hospitals Trust. It sets out clear objectives at every stage in order to deliver on our ambitious 3 year plan to develop a competent, confident workforce who can safely meet the future workforce challenges and deliver our 2020 Vision.

This plan puts your career aspirations at the heart of your learning journey

1. Attracting Talented People

We aim to open more doors to training and employment in the Trust and wider NHS, attracting people with the right values and ability to do an excellent job and gaining the benefits of a diverse workforce. The Trust offers opportunities ranging from work experience placements, traineeships, apprentices and an extensive student nurse programme to a medical undergraduate programme where we have up to 180 students on placement at any one time, plus more than 200 doctors-in-training where FY1 and FY2 doctors are fully supported to achieve the Foundation Curriculum and portfolio. We will broaden the ways into training and employment by enhancing our existing work with schools, colleges and universities.

In order to achieve this we will:	By 2018 we aim:
To become the employer of choice for young people by increasing the number of work experience placements, apprenticeships, and traineeships.	
Extend the range of placement opportunities across the Trust for work experience and traineeships	To have at least 150 work experience placements per year

Extend the number of frameworks, as well as the level, available for apprentices. *For example*: healthcare support worker roles which would include healthcare portering.	To have at least 100 apprenticeships per year To have at least 30 traineeships per year
To become the employer of choice for medical students & retain talent from our local communities and universities.	
Develop our undergraduate and postgraduate programmes further to meet 'tomorrow's doctors' requirements	To have all named medical education and clinical supervisors accredited as trainers
Maintain & enhance existing links with universities, and forge closer links with Aston University	To have developed alternative teaching programmes & methods to support traditional methods and new models of care
Develop medical education and clinical supervisors further	All trainees receive human factors training
To attract talented clinical staff into posts within the Trust	
Work with local universities to develop academic programmes and placements for students from non-medical, create clinical courses where they do not already exist	To have 80% of students on placement with the Trust who would choose to build their career with SWBH
Further develop pathways into these careers	To have development frameworks available for non-medical, clinical courses where they do not already exist

'Doing this apprenticeship has given me the skills and confidence to kick start my career. It has also taught me how to be independent and to always challenge myself'. Rene Mahon just finishing her apprenticeship in the MEC at Sandwell and has gained a job at The Children's Hospital.

CASE ST

Development Issue

The Trust employs approximately 400 Healthcare Scientists working within disciplines sitting within a number of different Clinical Groups. The Healthcare Science workforce is made up of Assistants, Practitioners, Scientists and Higher Specialist Scientists or Healthcare Science Consultants. In some departments, recruitment of Practitioner-level staff, which should form the largest staff group in many areas, is difficult as nationally the number of trainee Practitioners has fallen. The level of workforce planning within different departments is variable, but initial assessment of the workforce demographics indicate succession planning for senior / Consultant level posts is required.

Development Solution

As part of our plans to address this, we aim to further develop and consolidate career pathways in Healthcare Science to become renowned as a centre of excellence for placement provision, as well as working with local schools and colleges to interest more people in choosing Healthcare science careers.

2. Induction & first year in post

A key part of our approach to education, learning and development focusses on the initial 'onboarding' new members of staff experience when they first join our Trust. The experience is the first year is a critical component to retaining our new recruits, and a great opportunity to set a high standard and expectation of what they can expect to develop in this Trust. This ranges from the corporate induction available to all new starters, support offered to our newly qualified nurses through the preceptorship programme, fundamental skills training for healthcare assistants, new clinicians sharing good practise and understanding standards, as well as orienting all our staff on the behaviours and standards we expect from all our colleagues.

To provide a welcoming 'onboarding' to new recruits	
To provide a welcome to the Trust that clearly demonstrates 'what is expected' as well as 'what you can expect'	100% of new recruits have attended a refreshed corporate induction programme Enable 'e learning' of standard parts of induction Corporate induction to include developing a personal development plan as part of your appraisal Clear and consistent standards on equality & diversity set out during induction
Enable a positive and engaging 'first year experience' to newly qualified staff	Consistent offer to 100% of newly qualified staff to enable them to develop practical skills in first year in post Coaching & mentoring available to all staff who are new in post Peer support networks set up for newly qualified staff

3. Developing and retaining skilled colleagues

This part of the plan is about valuing our colleagues, and ensuring that we offer opportunities for formal recognition (through nationally consistent standards) that enable our colleagues to build their careers with SWBH. Our plan is to ensure our colleagues have the opportunity to access development and are supported to have enough time and energy to devote to learning. We need to invest in all our staff to keep pace with technology and new working practices, and we will ensure that everyone in the SWBH family feels confident and supported to be the best that they can be for their colleagues and our patients.

We will implement a programme for all colleagues that are "over and above" the provision in annual appraisals and mandatory training courses. We will use the tried and tested principles from the Knowledge and Skills Framework. The KSF has been piloted successfully in a number of areas of the organisation, and we plan to simplify the KSF and use it as a solid foundation to ensure consistency and quality.

Ensure that performance in managed and colleagues have an annual conversation about their performance and a 3 year personal development plan

In order to achieve this we will:	By 2018 we aim:
Ensure all staff will have an annual appraisal and a personal development plan which identifies their development needs for the next 3 years	Achieve 100% attendance of all mandatory training requirements
Ensure all staff will meet the core requirements of their current role with development for stretch and working to best practise.	All staff will demonstrably meet the clinical or professional competencies for their role measured through their annual appraisal
Promote the retention of key skill & motivation by offering flexible moves inside the organisation	Staff are supported by their managers to undertake flexible development opportunities including job shadowing, short term secondments, mentoring & 'job tasters'
Use the 6 core dimensions of the KSF to ensure consistent standards, developing skills that are transferable to all levels across the Trust.	
We will identify and embed transferable skills, based on the six KSF Core Dimensions, in our development offer. Communication Personal and People Development Health, Safety & Security Service improvement Quality Equality & Diversity	Bands 1-3 should have achieved level 1 in all dimensions and Bands 4-5 should meet level 2. Bands 6 & 7 should meet level 3; this includes middle grade doctors. Band 8 and above, including consultants, should achieve level 4 in all The Trust will have adequate provision to sustain this level of development

WITHIN AN ACUTE HOSPITAL SETTING AND AS INDIVIDUALS MOVE FROM LEARNER TO PRACTITIONER; THE SEPARATION BETWEEN UNDERGRADUATE AND POSTGRADUATE MEDICAL EDUCATION BECOMES ARTIFICIAL. OUR GOAL FOR BOTH UNDERGRADUATE AND POSTGRADUATE MEDICAL AND NURSING TRAINING MUST BE, TO EQUIP INDIVIDUALS WITH THE NECESSARY SKILLS AND HABITS TO PARTICIPATE IN THE DELIVERY OF HIGH QUALITY AND RELIABLE HEALTHCARE IN THE FUTURE. Dr Roger Stedman. Medical Director

KSF EXAMPLES

Using the Knowledge and Skills Framework as a development tool

The KSF is a tool that sets out competence in four levels, under six core dimensions. These are observable skills that can developed as you progress throughout your career, and measured through your annual appraisal or performance conversations, in one to ones, in development conversations, or when you are planning with a mentor or assessor for the year ahead.

CORE DIMENSION OF QUALITY - Four levels of competence

Quality is one of the core dimensions of the KSF, it encourages staff at all levels to question poor practise and behaviour, to feel able to make suggestions to improve their work and to adapt to change and consistently improve the care and service SWBH provides.

e.g. A ward officer at band 2 will be expected to display level 1 in all six core dimensions by 2018. For quality, this means that the staff member would understand the policies and procedures in his or her ward, for example the visitor policy and what to do in an emergency. They would raise any concerns or issues to relevant people in the ward and be expected to use Trust resources effectively, not being wasteful of products and following the correct infection control procedures.

4. Develop & retain senior leaders & specialists

The Trust has an ambition to enable our people to further develop and learn, to access promotions and to build their leadership careers within the SWBH family. This may be a clinical specialist role or general leadership role. It may include research and development, clinical trials or a complete career change from one focus to another. Preparation for academic study to support those making the transition from vocational training to a higher level education should also be encouraged and supported.

The Trust is acutely aware that not all practitioners want to lead and manage people or services and may want to stay as highly specialised clinical practitioners. We aim to support everyone in their career ambitions and recognise the need to retain a breadth of skilled people in our Trust.

Develop and retain confident & competent senior leaders and clinical specialists within the Trust	
For those who wish to develop as leaders the Trust will provide a structured framework with tailored coaching & support to embed practise across leadership cadre	New and aspiring leaders will be offered a Band 2-5 programme Develop a tailored programme for bands 6/7/8 Top leaders programme for all senior leaders All leaders will undertake a 360 degree appraisal every 3 years Coaching & mentoring to develop advanced leadership skills
We will make more opportunities available for clinical development to attract and retain talented clinical staff	We will create and fund research posts to attract and retain talented clinical staff Offer advanced levels of clinical qualifications through our links to local universities and national institutes We will enable opportunities for shadowing and

	secondments to share learning
Education & continuous learning will become a key component in the Trust's executive structure	Medical education will be fully integrated in to the delivery and future requirements of each service Full use of interventions such as quality improvement half days to share and learn right across the Trust Develop holistic approach to learning from mistakes and successes that is Trust wide

CASE STUDY

Health Visiting and Midwifery

At Sandwell and West Birmingham Hospitals we pride ourselves on striving to give the best service and patient experience possible to those in our care. We know that to do this we need to ensure all staff knows what is expected of them, that they are engaged and that they are supported to enable them to give their best. This includes being able to undertake the appropriate education and training to be skilled and equipped to play their part effectively and with compassion.

We want to become the best integrated care organisation in the country and this is taken into consideration when considering the educational needs of our staff so they are able to deliver their care in whatever setting they find themselves. Our Midwifery and Health Visiting Education plan is designed to meet the professional training needs of all Midwives, Health Visitors and Non-registered Healthcare support staff.

Programmes are delivered with due regard to the requirements of the NMC code of conduct and requirements of safe practice, ensuring we deliver a high quality Midwifery and Health Visiting service in an ever changing health economy and in preparation for the move to the Midland Metropolitan Hospital in 2018. These opportunities will be enhanced by using up to date media, learning environments and practical training rooms, by utilising modern simulation training techniques and developing the use of e-learning products.

How will this plan be used?

Within the broad guidelines given above each department will produce a three-year development plan for the department as a whole and, through annual appraisal and planning, a development plan for the roles and colleagues who work for that service. This will feed into the Directorate and Group level three-year development plans. This will also inform the annual training needs analysis and future commissioning to meet the Trust vision and priorities.

There are already a wide range of learning and development opportunities available to colleague in the SWBH family. A summary is attached with more detail is available in the Trust training prospectus on Connect, your relevant professional development pages and university higher education brochures.

CONTACT DETAILS

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"My 360 feedback made me change some of the things I was doing that demotivated my team."

Team manager in Surgery

"I have found meeting with my mentor the most useful part of my first year, it really helps to share how it's going with someone who is more experienced" Nurse in Medicine

"Thank you for offering me an enlightening work experience placement, that gave me a flavour of what medicine is really like, and how doctors and nurses work together to produce high quality care. This placement will be instrumental in firmly grounding my decision to *hopefully* apply for medicine." Work experience student.

Quick Reference. Education, Learning & Development Summary

Choose Your Band

Then find your pages ì

- **Executives**
- **Band 8/ Doctors**
- **Band 7/ Doctors**
- **Band 6**
- **Band 5**
- **Band 4**
- **Band 3**
- **Band 2**
- **Trainees**

Opportunities for All Staff

Refer to Green Page

Post Registration
Professional Development

Refer to Blue Page

Undergraduate Programmes
Refer to Red Page

Support Post Programmes

Refer to Orange Page

Widening Participation
Refer to Black Page

Leadership Development

Refer to Purple Page

Leadership Development

Refer to Yellow Page

Opportunities for All Staff

- Corporate & Local Induction
- Mandatory Training
  - Fire
  - Infection Control
  - Health & Safety
  - Moving & Handling
  - Safeguarding
  - Conflict Resolution
  - Information Governance
  - Medical Devices
  - Medicines Management
  - Blood Transfusion
  - Resuscitation
  - Safeguarding (Higher)
  - Breakaway
  - Consent
- Team Development
  - MBTI
  - Bespoke Training Provision
  - Action Centred Leadership - Team Level
  - Short Workshops e.g. Customer Service

See Trust Training Prospectus on Connect for more details and relevant Professional Development Pages

Post Registration Professional Development

- University Post-Registration courses (Degrees, Masters)
- Doctors In Training
- Clinical Updates e.g. MOT for qualified nurses, acupuncture
- Short Workshops (In Service Training) e.g. Five presentations of shock, CONI
- eLearning on OLM or specialist sites e.g. QUEST
- Mentorship

See Trust Training Prospectus on Connect for more details and relevant Professional Development Pages

Undergraduate Programmes

- University Undergraduate Programmes
- Clinical Placements
- Undergraduate Academy Medical Programmes
- Mentorship and Clinical Supervision

See Trust Training Prospectus on Connect for more details and relevant Professional Development Pages

Support Post Programmes

- Apprenticeships
- HCA MOT Assessment Days
- Short Courses e.g. Vital Signs, NVQ
- Care Certificate
- eLearning on OLM or specialist sites eg QUEST

See Trust Training Prospectus on Connect for more details and relevant Professional Development Pages

Widening Participation Initiatives

- Work Experience
- Traineeship Programmes
- Learning Works
- Live and Work Project

See Trust Training Prospectus on Connect for more details and relevant Professional Development Pages

Leadership Development

1. Action Centred Leadership – Operational Level
2. Top Leaders Programme
3. New Consultants Programme
4. Coaching
5. Masterclasses
6. NHS Leadership Academy programmes & coaching

See Trust Training Prospectus on Connect for more details and relevant Professional Development Pages

Leadership Development

- Band 2-5 Leadership Programme
- Action Centred Leadership

See Trust Training Prospectus on Connect for more details and relevant Professional Development Pages

Summary descriptions of 6 KSF core dimensions

These descriptions summarise the 6 KSF core dimensions, as part of the simplified KSF, which can be tailored locally. These are observable measurable behaviours and competences that apply to all learners in SWBH.

Communication – definition This dimension relates to effectively communicating the needs and requirements of patients, carers, staff and others to provide excellent care and service. Effective communication is a two way process. It involves identifying what others are communicating and the development of effective relationships as well as one's own communication skills.		**Why it is important**: Communication underpins all else we do. Effective communication is a two way process which develops and cements relationships, keeps people informed and reduces the likelihood of errors and mistakes.	
Level 1 Communicate with a limited range of people on day-to-day matters. For example: ■ actively listens and asks questions to understand needs ■ shares and disseminates information ensuring confidentiality where required ■ checks information for accuracy ■ presents a positive image of self and the service ■ keeps relevant people informed of progress ■ keeps relevant and up to date records of communication	**level 2 Communicate with a range of people on a range of matters** ■ uses a range of communication channels to build relationships ■ manages people's expectations ■ manages barriers to effective communication ■ improves communication through communication skills	**level 3 Develop and maintain communication with people about difficult matters and/or in difficult situations** ■ identifies the impact of contextual factors on communication ■ adapts communication to take account of others' culture, background and preferred way of communicating ■ provides feedback to others on their communication where appropriate ■ shares and engages thinking with others ■ maintains the highest standards of integrity when communicating with patients and the wider public	**level 4 Develop and maintain communication with people on complex matters, issues and ideas and/or incomplex situations** ■ encourages effective communication between all involved ■ develops partnerships and actively maintains them ■ anticipates barriers to communication and takes action to improve communication ■ articulates a vision for trust focus which generates enthusiasm and commitment from both employees and patients/wider public ■ is proactive in seeking out different styles and methods of communication to assist longer terms needs and aims ■ is persuasive in putting forward own view and that of the organisation ■ communicates effectively and calmly in difficult situations and with difficult people
Think about what behaviours and actions are positive indications the that the knowledge and skills of this dimension are present and those that warn that they are absent			
Positive indications: ■ positive patient/public/partner and colleague relationships ■ positive patient/public/partner feedback ■ timely and accurate performance ■ accurate information given ■ appropriate information given ■ people feel communication in the trust is effective and different parts of the trust communicate with each other ■ people feel patient confidentiality is respected		Warning signs: ■ patient/public/partner complaints about communication and unmet needs ■ others not treated nor considered with respect ■ over-reliance on email ■ information given inaccurate ■ information given inappropriate ■ recipient not understood information given ■ people do not feel patient confidentiality is respected	

Personal and People Development – definition This dimension is about developing oneself using a variety of means and contributing to the development of others during ongoing work activities. This might be through structured approaches (egg appraisal and development review, mentoring, professional/clinical supervision) and/or informal and ad hoc methods (such as enabling people to solve arising problems and appropriate delegation)		**Why it is important** Everyone needs to develop themselves in order for services to continue to meet the needs of patients, clients and the public.	
Level 1 Contribute to own personal development. For example: ■ identifies whether own skills and knowledge are in place to do own job ■ prepares for and takes part in own appraisal ■ identifies (with support if necessary) what development gaps exist and how they may be filled ■ produces a personal development plan with appraiser ■ takes an active part in learning/development activities and keeps a record of them	**Level 2 Develop own skills and knowledge and provide information to others to help their development** ■ seeks feedback from others about work to help identify own development needs ■ evaluates effectiveness of own learning/development opportunities and relates this to others ■ identifies development needs for own emerging work demands and future career aspiration ■ offers help and guidance to others to support their development or to help them complete their work requirements effectively ■ offers feedback promptly	**Level 3 Develop oneself and contribute to the development of others** ■ Assesses how well met last year's objectives and helps set this year's. Assesses self against KSF outline ■ takes responsibility for meeting own development needs ■ identifies development needs for others emerging work demands and future career aspiration ■ enables opportunities for others to apply their developing knowledge and skills ■ actively provides learning and development opportunities to others ■ actively contributes to the evaluation of the effectiveness of others' learning/development opportunities and relates this to others ■ ensures all employees managed have annual appraisals and personal development plans in place and comply with mandatory training	**Level 4 Develop oneself and others in areas of practice** ■ contributes to development in the workplace as a learning environment ■ actively creates opportunities to enable everyone to learn from each other and from external good practice ■ uses a coaching approach to encourage others to develop
Think about what behaviours and actions are positive indications the that the knowledge and skills of this dimension are present and those that warn that they are absent			
Positive indications: ■ identified development needs and feedback accepted positively ■ people feel they have the knowledge and skills to do their jobs ■ people feel there is strong support for learning and development in their area ■ time and provision are made for on the job and informal development ■ everyone has a PDP that they understand ■ people feel responsible for developing their own expertise ■ people feel they have opportunities to progress		Warning signs: ■ staff defensive about development needs ■ staff do not feel they have the knowledge and skills to do their jobs ■ development frequently cancelled or senior staff too busy to offer informal development to others ■ people do not feel there is strong support for learning and development in their area ■ PDPs not completed or incomplete ■ people feel development is done to them and it is not their responsibility ■ development needs and training/development opportunities available do not match	

Health Safety and Security– definition This dimension focuses on maintaining and promoting the health, safety and security of everyone in the organisation or anyone who comes into contact with it either directly or through the actions of the organisation. It includes tasks that are undertaken as a routine part of one's work such as moving and handling		**Why it is important** Everyone needs to promote the health, safety and security of patients and clients, the public, colleagues and themselves	
Level 1 Assist in maintaining own and others' health, safety and security. For example: ■ follows trust policies, procedures and risk assessments to keep self and others safe at work ■ helps keep a healthy, safe and secure workplace for everyone ■ work in a way that reduces risks to health, safety and security ■ knows what to do in an emergency at work, knows how to get help and acts immediately to get help ■ reports any issues at work that may put self or others at a health, safety or security risk	**Level 2 Monitor and maintain health, safety and security of self and others** ■ looks for potential risks to self and others in work activities and processes ■ manages identified risk in the best way possible ■ works in a way that complies with legislation and trust policies and procedures on health, safety and risk management ■ takes action to manage an emergency, calling for help immediately when appropriate ■ reports actual or potential problems that may put health, safety or security at risk and suggests solutions ■ supports and challenges others in maintaining health, safety and security at work	**Level 3 Promote, monitor and maintain best practice in health, safety and security** ■ identifies and manages risk at work and helps others to do the same ■ makes sure others work in a way that complies with legislation and trust policies and procedures on health, safety and risk management ■ Carries out, or makes sure others carry out risk assessments in own area. Checks work area to make sure it is free from risks and conforms to legislation and trust policies and procedures on health, safety and risk management ■ takes the right action when risk is identified ■ finds ways of improving health, safety and security in own area	**Level 4 Maintain and develop an environment and culture that improves health, safety and security** ■ evaluates the extent to which legislation and trust policies and procedures on health, safety and risk management have been implemented across the trust, in own sphere of activity ■ evaluates the impact of policies, procedures and legislation across the trust in own sphere of activity ■ identifies the processes and systems that will promote health, safety and security in the trust ■ regularly assesses risks and uses the results to make improvements and promote best practice ■ takes appropriate action when there are issues with health, safety and security ■ investigates any actual or potential health, safety or security incidents and takes the required action
Think about what behaviours and actions are positive indications the that the knowledge and skills of this dimension are present and those that warn that they are absent			
Positive indications: ■ Trust procedures are followed including for hand hygiene ■ confidential information is kept safe and secure ■ work areas are clean and tidy ■ health, safety or security risks or incidents are reported, at all levels ■ behaviour is monitored and action taken when necessary ■ incidents are handled appropriately and acted up immediately at all levels ■ health, safety and security incidents are declining		Warning signs: ■ legislation, policies and processes around health, safety and security are not followed ■ confidentiality is breached ■ incidents are not reported or not reported by staff at all levels ■ there is not monitoring of compliance or monitoring exists but action is not taken when required ■ people do not know what to do if an incident occurs ■ health, safety and security incidents are increasing (which is not due to increased reporting)	

Service Improvement– definition This dimension is about improving services in the interests of the users of those services and the public as a whole. The services might be services for the public (patients, clients and carers) or services that support the smooth running of the organisation (such as finance, estates).The services might be single or multi-agency and uni or multi-professional. Improvements may be small scale, relating to specific aspects of a service or programme, or may be on a larger scale, affecting the whole of an organisation or service.		**Why it is important** Everybody has a role in implementing policies and strategies and improving services for users and the public	
Level 1 Make changes in own practice and offer suggestions for improving services. For example: ■ discusses with line manager changes that might need making to own work practice and why ■ adapts own work and takes on new tasks as agreed and asks for help if needed ■ helps evaluate the service when asked to do so ■ passes on any good ideas to improve services to line manager or appropriate person ■ alerts manager if new ways of working, polices or strategies are having a negative impact on the service given to users or the public.	**Level 2 Contribute to the improvement of services** ■ discusses with team the likely impact of changing policies, strategies and procedures on practice. Also about changes the team can make and how to make them effective ■ takes on new work and make changes to own work when agreed, requesting relevant help if needed ■ supports colleagues in understanding and making agreed changes to their work ■ evaluates own and others' work when needed ■ make suggestions to improve the service ■ constructively identifies where new ways of working, polices or strategies are having a negative impact on the service given to users or the public.	**Level 3 Appraise, interpret and apply suggestions, recommendations and directives to improve services** ■ identifies and evaluates potential improvements to the service ■ discusses improvement ideas with appropriate people and agrees a prioritised plan of implementation to take forward agreed improvements ■ presents a positive role model in times of service improvement ■ supports and works with others to help them understand the need for change and to adapt to it ■ enables and encourages others to suggest change, challenge tradition and share good practice with other areas of the trust ■ evaluates the changes made and suggests further improvements where needed ■ evaluates draft policies and strategies and feeds back thoughts on impacts on users and the public.	**Level 4 Work in partnership with others to develop, take forward and evaluate direction, policies and strategies** ■ involves and engages users of the service and others in discussions about service direction, improvements and the values on which they are based ■ works with others to make sure there is a clear direction for values, strategies and policies and leads the way when interests are in conflict ■ continually reviews the values, strategic plans and directions of the service to take account of changing circumstances ■ works with others to develop strategic plans and business objectives for the service. These need to be consistent with values, realistic, detailed and take account of constraints ■ communicates values, strategic plans and service direction to help all colleagues understand how they are affected. Also creates opportunities for people to contribute their views and ideas ■ works with people affected by service improvements to evaluate the impact of the changes on the service. Feeds this information into ongoing improvements.

Think about what behaviours and actions are positive indications the that the knowledge and skills of this dimension are present and those that warn that they are absent	
Positive indications: ■ staff at all levels question poor practice, process and behaviour ■ staff at all levels feel they are involved in deciding on service improvements that affect them ■ staff feel able to make suggestions that improve their work or their area ■ staff feel they deliver a service to a standard that they are personally pleased with ■ staff adapt to change ■ consistently improving care and service are provided	Warning signs: ■ staff do things the way they've always been done, without question ■ staff feel that service improvement is "nothing to do with them" ■ staff feel that they are not involved in decision making ■ staff do not feel they deliver a service to a standard that they are personally pleased with ■ staff struggle to adapt to change or openly resist it ■ services are considered to be static or declining rather than improving

Quality– definition This dimension relates to maintaining high quality in all areas of work and practice, including the important aspect of effective team working. Quality can be supported using a range of different approaches including codes of conduct and practice, evidence-based practice, guidelines, legislation, protocols, procedures, policies, standards and systems. This dimension supports the governance function in organisations – clinical, corporate, financial, information, staff etc.		**Why it is important** Quality is a key aspect of all jobs as everybody is responsible for the quality of their own work. It underpins all the other dimensions in the NHS KSF.	
Level 1 Maintain the quality of own work. For example: ■ works as required by relevant trust and professional policies and procedures ■ works within the limits of own competence and area of responsibility and refers any issues that arise beyond these limits to the relevant people ■ works closely with own team and asks for help if necessary ■ uses trust resources efficiently and effectively thinking of cost and environmental issues ■ reports any problems, issues or errors made with work immediately to line manager and helps to solve or rectify the situation.	**Level 2 Maintain quality in own work and encourage others to do so** ■ follows trust and professional policies and procedures and other quality approaches as required. Encourages others to do the same. Maintains professional registration if has one ■ works within the limits of own competence and area of responsibility and accountability. Gets help and advice where needed ■ works to support the team. Can be counted on when people ask for help or support ■ prioritises own workload and manages own time to ensure priorities are met and quality is not compromised ■ uses trust resources and effectively and encourages others to do the same ■ monitors the quality of work in own area and alerts others to quality issues, reporting any errors or issues to the appropriate person.	**Level 3 Contribute to improving quality** ■ promotes quality approaches making others aware of the impact of quality ■ understands own role, its scope and how this may change and develop over time in developing a high quality organisation ■ reviews effectiveness of own team and helps and enables others to work as a team ■ prioritises own workload and manages own time in a manner that maintains and promotes high quality ■ evaluates the quality of own and others' work in own area and raises quality issues and related risks with the appropriate people ■ supports changes in own area that improves the quality of systems and processes ■ takes appropriate action when there is a persistent problem with quality.	**Level 4 Develop a culture that improves quality** ■ initiates, implements, supports and monitors quality and governance systems and processes ■ alerts others to the need to improve quality. Ensures others maintain professional registration ■ is an effective member of the organisation. Works with others to develop and maintain high quality services ■ role models quality delivery ■ enables others to understand, identify and deal with risks to quality ■ actively promotes quality in all areas of work ■ responsible for continually monitoring quality and takes effective action to address quality issues.

Think about what behaviours and actions are positive indications the that the knowledge and skills of this dimension are present and those that warn that they are absent	
Positive indications: ■ people are confident in asking for support where necessary and feel well supported ■ people respond positively when colleagues ask for help and support ■ people feel encouraged to report errors and near misses ■ when errors and quality issues occur the focus is on resolving the issue and learning from it ■ there is a no-blame culture ■ resources are used effectively ■ people adapt to changing priorities and changing quality systems ■ high quality care and services are delivered and improving	Warning signs: ■ people do not feel they can ask for help or support and do not feel well supported ■ people do not make time to help and support others when asked ■ when errors and quality issues occur the focus is on blaming someone else ■ resources are wasted ■ people struggle to cope with or moan about changing quality systems or processes ■ care and services are not considered to be high quality or are declining in quality.

Equality and diversity – definition It is the responsibility of every person to act in ways that support equality and diversity. Equality and diversity is related to the actions and responsibilities of everyone – users of services including patients, clients and carers; work colleagues; employees, people in other organisations; the public in general		**Why it is important** This is a key aspect of all jobs and of everything that everyone does. It underpins all dimensions in the NHS KSF. Successful organisations are the ones that reflect the richness of diversity that exists in society and will include people of different: abilities; ages, bodily appearances; classes; castes, creeds; cultures; genders; geographical localities; health, relationship, mental health, social and economic statuses; places of origin; political beliefs; race; religion; sexual orientation; and those with or without responsibilities for dependants. Where diversity and equality are not integral to the organisation, discrimination may occur.	
Level 1 Act in ways that support equality and value diversity. For example: ■ acts in accordance with legislation, policies, procedures and good practice ■ treats everyone with dignity and respect ■ allows others to express their views even when different from one's own ■ does not discriminate or offer a poor service because of others' differences or different viewpoints.	**Level 2 Support equality and value diversity** ■ challenges bias, prejudice and intolerance if appropriate or brings it to the attention of a manager ■ uses plain language when carrying out duties ■ aware of the impact of own behaviour on others.	**Level 3 Promote equality and value diversity** ■ interprets equality, diversity and rights in accordance with legislation, policies, procedures and good practice ■ actively acts as a role model in own behaviour and fosters a non-discriminatory culture ■ promotes equality and diversity in own area and ensures policies are adhered to ■ manages people and applies internal processes in a fair and equal way.	**Level 4 Develop a culture that promotes equality and values diversity** ■ actively promotes equality and diversity ■ monitors and evaluates the extent to which legislation and policies are applied ■ monitors and act on complaints around equality and diversity ■ actively challenges unacceptable behaviour and discrimination ■ supports people who need assistance in exercising their rights.
Think about what behaviours and actions are positive indications the that the knowledge and skills of this dimension are present and those that warn that they are absent			
Positive indications: ■ patients/public/partners, colleagues and staff feel fairly treated ■ people feel confident in speaking up if they feel there is bias in a system or process of if they feel they have witnessed bias, prejudice or intolerance ■ staff understand what diversity is and why it is important.		Warning signs: ■ high level of staff and patient or wider public complaints about unfair treatment, bias or discrimination ■ policies and procedures only exist in writing with little application in day to day activity ■ bias in the application of processes affecting equality of outcome.	

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Ten out of Ten Safety Standards
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Debbie Talbot – Deputy Chief Nurse
DATE OF MEETING:	2nd July 2015

EXECUTIVE SUMMARY:

Ten out of Ten is one of our key safety improvement strategies with a focus on patient empowerment. Enclosed is a summary of progress with Ten out of Ten in 14/15 and plans for 15/16 which will include learning from areas who have developed the concept to meet the needs of their patient base and integrated Ten out of Ten in the ward safety culture .

REPORT RECOMMENDATION:

To implement a plan which embeds the 10 out of 10 culturally across the trust.

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

Accept	Approve the recommendation	Discuss
X		X

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

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

Comments:

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

- Annual Plan
- Quality Accounts
- Patient Safety Plan

PREVIOUS CONSIDERATION:

PSC and Q&S May 15

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TEN OUT OF TEN SAFETY STANDARDS

Report to Trust Board on 2nd July 2015

1 EXECUTIVE SUMMARY

1.1 Introduction

Patient Safety Is at the heart of the NHS, reflected in many national and local standards monitored on behalf of service users by Clinical Commissioning Groups and the Care Quality Commission.

Some processes encourage us to review incidences retrospectively but fail to influence in real time. Checklists have been used effectively to influence real time performance (such as theatre checklists).

1.2 Vision

Our vision is that 'Ten Out Of Ten' (10/10) (patient standards check list, see below) becomes our number one quality initiative. Responding to local complaints and incidences which often highlight delays, falling below the 100% expectation and overlooking /missing key actions. Ten out of ten is part of our Patient Safety Plan 2015

2 METHODOLOGY

2.1 Checklist

'Ten out of Ten' (10/10) commenced in late 2013 and aims to support the improvement of safety culture and reduce harm to patients. This idea has been illustrated by ten must do patient safety standards aimed at all patient areas. These expectations have been collated onto a checklist whereby the ward sister/matron facilitates members of the Multi-disciplinary team to complete this list of interventions in a timely manner and records this completion on a board.

These standards need to be completed within 24hrs of admission although recognising some of standards will be repeated throughout the patient stay. Copies of the standards are in the folder at each patient bedside and should be discussed as part of the admission process with each patient and their carer's. Patients are encouraged to question staff regarding any standards not met. We want patients to feel safe.

The aim is to use the checklist as an aide memoire to ensure no omissions and to prompt effective intervention to reduce any potential risk of harm to our patients in 100% of cases. Omissions or risks would be escalated promptly and to the most appropriate person. This will be a Senior Nurse in the organisation.

2.2 Culture Change

We aim to educate and empower patients and relatives to be involved in this major change regarding the balance of power and enable patients to manage many parts of their healthcare journey.

2.3 Quality metrics

Other data, already available to the organisation will provide information regarding how these cultural and behavioural changes affect patient safety indicators such as falls, blood clots etc.

3 THE JOURNEY

3.1 Achievements 14/15

- Multi-disciplinary project group including Chief Nurse and Medical Director
- Ten safety standards checklist development (Appendix 1)
- Roadshows including scenario review
- Workshops
- Communication – leaflets/ banners/leaflets/ logo on vehicles/ public meetings/conferences/video
- Staff Guidance leaflet
- Prevalence monitoring monthly on wards introduced
- Ward checklist on display
- Making Every Contact Count introduction- health education challenge
- Introduction of question into Patient Satisfaction Surveys Q3; *Question : Do You Feel the Patient Safety Standards are given high priority in our hospital?*
  Results Q4 :
  Respondents 1486
  Yes 1254 (84%)
  Sometimes 196 (13%)
  No 36 (3%)
- Positive staff feedback

3.2 Plan 15/16

- Annual Plan /Quality Accounts to reflect importance of safety and patient empowerment
- Patient Safety Plan to reflect key priority standards

- Provision of banners in top 5 languages to be placed in public areas to raise awareness with our ethnically diverse communities
- Integration in hearts and minds- coaching teams encompassing corporate and clinical group facilitators, mock visits to facilitate deep diving beyond checklist -are risk assessments accurate , have strategies to reduce risk been implemented, do patients understand about ten out of ten – are they asking questions , observation of staff : patient interactions
- Need clinical group sign in , multi-disciplinary approach
- Learn from wards where they have captured the ten out of ten philosophy and amended the delivery style to suit their patient group – for example , some areas use ten out of ten transfer lists, some areas have individualised the concept to individual patient checklist at each bedside (Appendix 2) and this has increased exposure /understanding/ discussion and completion. Some wards have promoted health promotion and ten out of ten (Appendix 3),
- high profile communication strategy, QIHD, OMC
- provision of supportive patient information on all ten standards in ward racking system to allow easy access
- work with specialist areas to facilitate appropriate development of 'ten out of ten ' safety standards – neonates, community , CCS etc
- Review of ward boards /checklist – redesign , consider electronic solution
- Improvement in quality metrics March prevalence data illustrated 7 wards (from 36) reported less than 100% compliance – health promotion being the main challenge, not always reflected in incidence data for each metric ie they are not 100% !
- Focus on Making Every Contact Count (MECC) – provision of patient information and staff training to support initiative

4 RECOMMENDATION(S)

5.1 Accept the report

5.2 Promote Ten out of Ten during Executive walkabouts

Colin Ovington,

Chief Nurse

25th June 2015

APPENDICES:

Appendix 1 – Ten out of Ten Safety Standards Information Leaflet

If you are worried that you or your relative are not 10/10 please:

- Ask any member of the ward team, either nurse, therapist or doctor
- Ask to speak to the ward manager or matron
- Overnight please ask to speak to the clinical site practitioner
- Or contact the Chief Nurse through our daytime switchboard

We want your help. We want to keep our promise

Additional Information:

For additional information or advice the following contacts below may be of assistance:

Debbie Talbot - Deputy Chief Nurse

Where EVERYONE Matters

A leading Trust of The University of Birmingham
Incorporating City, Sandwell and Rowley Regis Hospitals

ML4736
Issue Date: August 2010
Review Date: August 2016

Sandwell and West Birmingham Hospitals NHS

'Ten out of Ten' patient safety standards checklist

Ten out of Ten

Where EVERYONE Matters

Introduction

'Ten out of Ten' is the Sandwell and West Birmingham NHS Trust's patient safety checklist. It is our commitment that each and every patient admitted on to our wards will be taken through these standards within 24 hours of arriving. Every patient will be told when their check list is complete and they will also have a copy of the 'Ten out of Ten' standards in their bedside folders. Ward staff should be challenged by any patient (or carer) who believes the checklist has not been completed within 24 hours of admission.

The Safety Standards

We will ask your name, address, date of birth and match these details to your wristband

We will ensure you (and with your permission, your carer) have all the information you need to make decisions about your care and treatment options.

On admission, a registered nurse will observe and record your temperature, blood pressure, pulse, height, weight and breathing, and will take any appropriate action.

We will check and record your current medication and any allergies.

We will assess your levels of pain and offer you appropriate pain relief.

We will test you for MRSA, as well as other hospital bugs, and give you appropriate treatment.

We will assess your risk of developing a pressure ulcer (bed sore) or falling, and take all relevant action.

We will assess your risk of developing a blood clot (venous thrombo-embolism or VTE) and prescribe any appropriate treatment.

We will assess your fluid levels and identify and record any special dietary requirements.

We will review your lifestyle choices (healthy eating, smoking, alcohol, drug/solvent abuse) and offer appropriate support and advice.

Appendix 2 - Lyndon 2

Appendix 3 – Lyndon 4

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Our Improvement Plan – responding to the Care Quality Commission Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Kam Dhami, Director of Governance**
DATE OF MEETING:	**2nd July 2015**

EXECUTIVE SUMMARY:

Following the Board informal session held on 19 June, the attached paper presents an assessment of the current positon concerning the delivery of the actions within the improvement plan.

REPORT RECOMMENDATION:

The Board is invited to confirm agreement with the Executive assessment of the delivered improvements.

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

CQC registration

PREVIOUS CONSIDERATION:

Board informal session on 19 June 2015

FOR APPROVAL

SWBTB (7/15) 100 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Our Improvement Plan – responding to the Care Quality Commission Report

Report to the Trust Board on the 2 July 2015

1. On the 19 June 2015 Board members reviewed the current position against the areas for improvement included in the Care Quality Commission's (CQC) inspection report published in March 2015. The aim of the discussion was to reach a shared understanding of the achievements to date and to be clear about what remained to be done.

2. Board members worked through the actions planned to address the **67 areas for improvement**, with the lead Executive Director providing a progress update and their self-assessment of the state of play. The evidence to be relied upon to demonstrate achievement was presented along with the outcome criteria to be used to provide the required assurance of success. Any deadline slippage was explained and a revised date given.

3. The discussion was an opportunity for Board members to raise questions and constructively challenge the position presented.

4. It was agreed that the Chief Executive would provide verbal updates at the July Board on:
    a. **Mandatory training for doctors** – improving and sustaining current compliance levels
    b. **Job planning in general surgery –** ensuring that the Trust position on the combined now and long term offer made to the general surgeons is understood by all.
    c. **Rostering** – whether the current system can be made to work.
    d. **Medicine storage** – the option to procure automated dispensaries

5. The discussion highlighted three areas of October delivery concern:
    a. **Theatre booking** - including the relationship between change projects around theatres
    b. **DNACPR** – knowing on any given day in the Trust which patients have such an order placed on them.
    c. **Ward level documentation** - is it fit for purpose?

6. The position reached at the end of June is that of the 67 actions **46 are on track** and **21 off track** but with **confidence of delivery**. Appendix A sets out the areas for improvement that the Executive consider to be delivered.

Recommendation

7. The Board is invited to confirm agreement with the Executive assessment of the delivered improvements shown in Appendix A.

Kam Dhami
Director of Governance

26 June 2015

Appendix A

Areas for improvement that the Executive consider to be delivered

Ref:	Issue identified	Our response
Accident and Emergency		
MD4	The trust must take steps to improve staff understanding of isolation procedures.	Visual prompts provided through new signage. Training programmes in place to raise staff awareness.
MD6	The trust must review its governance arrangements in relation in relation to supporting the A&E department to more consistently achieve the national 4-hour target.	Written explanations of the governance processes provided to staff, and local induction includes that briefing. Additions to the governance structure include (a) QIHDs implemented from April 2015 and (b) Urgent Care Challenge Delivery Group established to include all key specialties in the delivery of Urgent Care.
MD7	The trust must improve its management of governance arrangements in the A&E department.	Active participation in the first three QIHDs from the Emergency Care Directorate to facilitate shared learning and improved patient care. Participation and attendance is centrally tracked and will be reported through the weekly Emergency Care scorecard, which is widely disseminated among senior clinical leaders.
SD3	The trust should consider how to better promote its complaint policy and procedure in the A&E departments.	Posters in the top 5 languages now on display in the EDs. 'Your Views Matter' leaflets in the open waiting areas providing information on how to make a complaint. The leaflets translated into the top 5 languages.
SD4	The Trust should consider ways of improving multi-disciplinary communication within the A&E Department at City Hospital.	Daily huddles continue at Directorate level. Daily debrief expanded to include capacity team, all clinical groups are represented and the COO. Executive input through Urgent Care Challenge Delivery Group fortnightly.
Surgery		
SD10	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.	The environment in the BTC pre-assessment unit has been reviewed with staff. The following works have been undertaken: - the Nurse Call system has been repaired. - the Unit's Reception area has been reconfigured. - options to improve staff facilities on the unit and through the wider use of facilities have developed with staff
Children and Young People		
MD17	The trust must ensure that staff receive appropriate training including mandatory training updates and supervision.	Training plans and budget are openly displayed Trust-wide. A new 3-year education, learning & development plan launched at the Leadership Conference on 23rd June.

Ref:	Issue identified	Our response
Maternity and Gynaecology		
SD16	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.	Review since the Inspection visit does not suggest that this would merit a risk entry above 12 which is the trigger for Board escalation.
SD17	The trust should consider separating out the number of hospital-acquired pressure ulcers into specific wards so that action can be targeted accordingly.	Incident reports are presented at corporate, group and ward level monthly to IPR, CN Business Meeting and up-loaded onto the shared drive for access by senior nurses to review and action. Wards with increased need are targeted for support by the Tissue Viability Service with use of concepts from the national Eradicate rapid improvement change model. Prevalence via safety thermometer accessed via same shared drive.
End of Life Care		
SD24	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).
SD26	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 the decision was taken to <u>not</u> proceed with changes outlined in that consultation. There will be denominational changes, but the Trust remains consistent with the guidance cited, and guidance issued to the NHS as a whole. Recruitment to a Roman Catholic post is to be undertaken but covered by on-call arrangements until this is complete.
Outpatients and Diagnostic Imaging		
MD20	The trust must maintain adequate records regarding the qualifications and training of imaging department staff.	98% of operators (123 people) all have the required competency records completed and available (radiologists, radiographers, nuclear medicine technologists, physics staff, cardiologists, staff in ophthalmology and oral surgery and agency workers). The outstanding records relate to two operators who have been absent from work due to long-term absence. A letter confirming the Trust's compliance against the Improvement Notice was sent to the CQC on 18/6/2015.
MD21	The trust must ensure guidance be available for imaging staff regarding exposure parameter	Lists of local Diagnostic Reference Levels have been posted on the walls in all radiography,

Ref:	Issue identified	Our response
	guidance or information surrounding expected dose values.	fluoroscopy and CT rooms at City Hospital and Sandwell Hospital. Nuclear Medicine DRLs are posted in the injection room.
SD29	The trust should ensure that the outpatient risk register captures all known risk issues.	The new Quality Improvement Half Days introduced in April 2015 provide an opportunity for multi-disciplinary review and learning regarding potential and actual risks. The local risk register is reviewed and updated at this monthly meeting.
Community Services: Inpatients		
SD38	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.
Community Services: Adults		
SD39	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.	Processes were already in place to do this and have been checked, including compliance in community locations.
Community Services: End of Life Care		
MD23	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. Establishment budgets are in place and recruitment to vacancies under way. Temporary staff are filling gaps on rosters.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

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

EXECUTIVE SUMMARY:

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

The Trust Risk Register was reported to the Board at its June meeting and Executive Director updates are highlighted where these were provided for the meeting.

REPORT RECOMMENDATION:

- **RECEIVE** monthly updates on progress with treatment plans from risk owners for high (red) risks 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:

Clinical Leadership Executive 26 May 2015

FOR REVIEW

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Risk Register

Report to the Trust Board on 2 July 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.**

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 updateS the Board on existing risks and escalates '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 module is now populated with Clinical Group and Corporate Directorate level risk register data. Risk module maintenance table fields (e.g. data in drop down boxes) have been populated and the Risk team has received system maintenance training. Web based screens which will be accessed by staff are being configured. A phased roll-out commenced during April, starting with Chief Executive Directorate risks. The electronic risk register roll-out is proposed as follows:

- Chief Executive, Women and Child Health
- Medicine and Emergency Care, Surgery B
- Surgery A, Estates, Pathology, Community and Therapy,
- Imaging, Workforce, Corporate Nursing & Facilities
- Finance, Corporate Operations, Medical Director Office

3.2 The Risk Team has contacted colleagues in WCH, MED and Surgery B to request all excel format risk register. The Risk Team will merge, data clean and format the risk registers and will then arrange for them to be imported into the electronic risk register. This will pre-populate the vast majority of data fields, which will save time.

3.3 Members of the risk team will contact RMC members to confirm local risk leads for each directorate to support roll-out. Once roll-out is complete at directorate level the local risk leads will be responsible for further roll-out to wards and departments. The risk team will provide ongoing support and advice.

3.4 Specific risk module training for end users is not planned as the "look and feel" of the risk module is the same as the incident reporting and complaints modules, which staff are familiar with. The risk assessment / risk register methodology and terminology is also the same. There will, however, be a "Risk Fact Sheet" to support local risk leads.

3.5 The risk team is working on standard reports which will be available to all staff.

3.6 Reporting of the Trust Risk Register to RMC, CLE and the Board will continue throughout the implementation of the electronic risk register system.

4. RECOMMENDATION(S)

4.1 The Board is recommended to:

RECEIVE monthly updates on progress with treatment plans from risk owners for high (red) risks on the Trust Risk Register

Kam Dhami, Director of Governance
2 July 2015

Appendix A - Trust Risk Register (version as at 26 June 2015)

Reference No.	Source of risk	Clinical Group / Corporate Directorate	Speciality / Ward / Team	Risk category	Risk Statement	Likelihood	Severity	Risk Rating	Summary of Risk Controls and Treatment Plan	Executive Lead	Expected date of completion	Date of latest review	Review frequency	Likelihood	Severity	Residual risk rating	Change since last month
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. Key planning assumptions for 2016 onwards developed and reported to CLE, WDC. Focus in Q3 - creation of a series of TSP schemes designed to achieve required WTE and pay cost reductions in 2016/17 and 2017/1	Director of Workforce and OD	Mar-20	Jun-15	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	Awaiting final decision form CCG Commissioners on decision.	Chief Operating Officer	TBC - Commissioner led review	Jun 15	Monthly	4	3	12	=

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TRR1401COO01	Management review	Corporate Operations		Operational	Lack of assurance of standard process and data quality approach to 18 weeks.	4	4	16	• E-outcome automation roll-out due for completion in Quarter1. • Comprehensive data validation exercise completed in March on 'backlog' patients. • A new training programme to be launched in July (linked to open referrals risk) to ensure robust referral management; this will include a RTT training module. • Regular RTT audit in place led by the BIU. • Internal audit due for reporting in Quarter 2. • Risk assessment to be reviewed end September 2015.	Chief Operating Officer	Jul-14	Jun 15	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 health and social care team in post (the ADAPT Team). Birmingham City Council staff are temporary staff and the council have been asked to review their workforce plan to move to substantive and regular workforce model. • Pathway agreed by all partners but slow implementation; an Urgent Care Challenge week in July will focus on ADAAT pathway implementation with the aim to progress and fully embed by Quarter 2 • EBMS development to be implemented in July which will enable us to track delivery of discharge pathways from admission. • Social care pilot ward commenced in March at Rowley and needs evaluating in Quarter2.	Chief Operating Officer	Jun-14	Jun 15	Jul-14	2	4	8	=

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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	Continuing to seek potential solution through re-location of Oral Surgery.	Chief Operating Officer	31/12/2015	Jun 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	Escalation process in place locally to flex beds and staffing according to demand. Safe staffing levels and HDU demand reviewed though Directorate governance meetings. Risk is currently tolerated.	Chief Operating Officer	TBC	Jun 15	Monthly	3	4	12	=

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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	Specialist bank and agency staff used where necessary to care for these children. Monthly report through local governance structure. Risk raised by Trust as on-going issue with specialist commissioners. CAHMs commissioning confirmed through BCH for 15-16.	Chief Operating Officer	TBC	Jun 15	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	Cancer taskforce led by Medical Director. New SLA in draft with Heads of Terms of Agreement signed in June 2015.Need to translate SLA to service improvement in terms of trajectory for reducing backlog and improving access to oncologists via clinics and MDTs.	Medical Director	TBC	Jun 15	Monthly	3	4	12	=
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Trust non-compliant with Oncology Standards.	5	4	20	Cancer taskforce led by Medical Director. New SLA in draft with Heads of Terms of Agreement signed in June 2015.Need to translate SLA to service improvement in terms of trajectory for reducing backlog and improving access to oncologists via clinics and MDTs. Peer review of AOS in June 2015.	Medical Director	TBC	Jun 15	Monthly	1	4	4	=

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	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	Cancer taskforce led by Medical Director. New SLA in draft with Heads of Terms of Agreement signed in June 2015.Need to translate SLA to service improvement in terms of trajectory for reducing backlog and improving access to oncologists via clinics and MDTs.	Medical Director	TBC	Jun 15	Monthly	1	5	5	=
201109DEL30	Risk Assessment	Women's and Child Health	Maternity	Clinical	The existing provision of a 2nd theatre team for an obstetric emergency.	2	5	10	Process in place to open 2nd theatre with business continuity emergency staffing levels. Trust Board agreed previously to tolerate this risk which is monitored locally.	Chief Operating Officer	TBC	Jun 15	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	Maximum tariff income through robust monitoring. Option appraisal and review of the maternity pathway payment system complete and work in train via Finance Director with other organisations to ensure fair payment model.	Chief Operating Officer	Ongoing	Jun 15	Monthly	3	4	12	=

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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	• Approved Business Case for Infrastructure Stabilisation Programme achieved June 2015. • Specialist technical resources engaged (direct and via supplier model) to facilitate key activities. • Appropriate governance model and controls underway. • Phase 1 Deep Dive - commenced to identify detailed IT infrastructure issues – network element completed by end May 2015. • Phase 2: Infrastructure Improvements - addresses need to upgrade to 21st Century IT infrastructure. Procurement Strategy under development; key Workstreams identified; high-level delivery schedule subject to Procurement outcome, in draft, but overall delivery scheduled to complete by end April 2016. • Appropriate benefits realisation plan to be incorporated within programme plan. • Clear identification of dependency linkage between other key programmes e.g. EPR, and wider strategic objectives.	Medical Director	Apr-16	Jun-15	Monthly	5	4	20	=

Appendix A - Trust Risk Register (version as at 26 June 2015)

Reference No.	Source of risk	Clinical Group / Corporate Directorate	Speciality / Ward / Team	Risk category	Risk Statement	Likelihood	Severity	Risk Rating	Summary of Risk Controls and Treatment Plan	Executive Lead	Expected date of completion	Date of latest review	Review frequency	Likelihood	Severity	Residual risk rating	Change since last month
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	• Recruitment of suitably skilled specialist resource for the EPR Programme and associated Infrastructure Programme. • Informatics LTFM will be prioritised to ensure appropriate funding is allocated to EPR and necessary dependencies. • 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 contingency plans in relation to clinical IT systems will be established to ensure that if there is any slippage (for example a TDA query / Legal challenge) there is an alternative and fully considered option.	Medical Director	Nov-18	Jun-15	Monthly	4	4	16	=

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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	• Prioritised and protected investment required across security infrastructure. • Specialist Security Manager recruited; bringing 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 initiated to flush 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.	Medical Director	Oct-15	Jun-15	Monthly	2	4	8	=
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. Local training completed and Advanced Trauma Nurse Course standards to be met by end Quarter 2.	Chief Operating Officer	Sep 15	Jun 15	Monthly	2	3	6	=
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	On-going recruitment challenges in this field, despite national recruitment efforts on-going. Next option is to explore a Black Country Alliance solution with Dudley and Walsall. For emergencies transfer to QE available if on site OOH cover not available.	Chief Operating Officer	Sep 15	Jun 15	Fortnightly	2	3	6	=

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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	Director of Operations recruitment plan successful for Pathology, Surgery A and Surgery B. Medicine covered by high quality interim appointment and out to substantive recruitment over the summer. New starter will be in post by Sep 15.	Chief Operating Officer	Sep 15	June 15	Weekly	4	3	12	=
201503NYOBS01		Women's and Child Health	Maternity	Operational	Current capacity is restricted resulting in a number of women having dating USS performed > 12/40 and some being outwith the screening window and therefore not receiving screening as per National NSC guidelines which results in the potential for an inequitable service for those women choosing to book at SWBH.	3	5	15	Existing Controls: • Implemented alternative ways of providing services to minimise impact. ✓ Bank / Agency Sonographers / scanning midwives ✓ Additional Clinics • Task group established to monitor and manage. • HR/Recruiting policies designed to support managers to recruit where there are difficulties to recruit. • Ongoing review of referrals to ensure inappropriate scans are not being undertaken and requests are in line with best practice guidance. Additional Controls: • Link action to workforce planning methodologies. Support Groups to link in with Recruitment to support "Open Days" and other innovative methods to recruit	Chief Operating Officer	Jun 15	Jun 15	Monthly	2	5	10	=

Appendix A - Trust Risk Register (version as at 26 June 2015)

Reference No.	Source of risk	Clinical Group / Corporate Directorate	Speciality / Ward / Team	Risk category	Risk Statement	Likelihood	Severity	Risk Rating	Summary of Risk Controls and Treatment Plan	Executive Lead	Expected date of completion	Date of latest review	Review frequency	Likelihood	Severity	Residual risk rating	Change since last month
		Women's and Child Health	Gynaecology	Clinical	Provision of ultra sound support for Gynaecology services is at risk due to difficulties in recruitment and retention of ultra-sonographers which results in the potential for delayed diagnoses, failure to achieve 31day cancer investigation targets plus impacts on the one-stop community service contract.	3	4	12	Existing Controls: • Ultra sound services currently actively recruiting externally. • Training provided to support the development of sonographers in house. • Developing pathways for other multi professional to take up elements of sonographers role. (i.e midwives completing dating scan service.) • Prioritising work and concentrating on high risk areas i.e. EPAU and Emergency Gynaecology, PMB. • Use of agency staff to cover gaps in the current service. Additional Controls: • Radiology directorate considering more 'creative' advertising, offering incentives. Consider consolidating CGS to 2 venues at City and Sandwell where scan provision can be utilised more appropriately.	Chief Operating Officer	Jun 15	Jun 15	Monthly	3	4	12	=

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201409NYOBS02		Women's and Child Health	Community Midwifery	Operational	BadgerNet connectivity problems associated with the use of I Pads is affecting Community Midwives' (CMW) ability to access/ update patient live records.	4	4	16	Existing controls: • Connectivity issues reported to EPR team via the IT Service Desk for investigation. • A proforma has been developed to enable CMW to send critical information to the IT service desk. • Utilisation of local super users and dedicated midwife for day- to- day support. Additional controls: IT Service Desk exploring solutions, e.g. enable access onto GP computers, establish uninterrupted WIFI 4G connection	Chief Operating Officer	Jun 15	Jun 15	Monthly	3	4	12	=

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	Operational issue	Women's and Child Health	Maternity and neonatal	Clinical	National shortage of intradermal BCG vaccination leading to a potential increase in babies affected with TB.	5	4	20	Existing Controls: • Pooling all available vaccines from other areas in the Trust including the Paediatric Clinic BTC and Occupational Health. • Getting the maximum number of doses out of each vial when opened to prevent unnecessary wastage. • A vial is not opened unless there are a sufficient number of infants to vaccinate. • All the community midwives informed that infants will be discharged without being vaccinated. Additional Controls: • Record all infants who are discharged from Maternity and Neonates who qualify but don't receive the vaccine. • Pharmacy locating other areas in the Trust that they distribute BCG vaccine to and sending them to Maternity. • To inform all parents of eligible infants of the shortage of the vaccine and how to raise any concerns with relevant agencies. • Clinics to be set up from May 2015 onwards to enable infants to return and be vaccinated when the BCG vaccine is available. • Advise community midwives and parents to be extra vigilant in observing and referring infants where necessary. • Inform Paediatrics and the HV of potential admissions.	Chief Operating Officer	Jun 15	Jun 15	Monthly	4	4	16	=

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	Medicine & Emergency Care	Medicine & Emergency Care	Emergency Department	Operational	There is a risk that further reduction or failure to recruit senior medical staff in ED leads to an inability to provide a viable rota at consultant level which may impact on delays in assessment, treatment and patient safety.	4	5	20	Recruitment campaign through local networks, national adverts, head-hunters and international recruitment expertise. Agree a recruitment and retention premium. Marketing of new hospital plans pending approval of full business case. Leadership development and mentorship Programme to support staff development. Continued communication and engagement of the Urgent Care Strategy. Clinical Director appointed in June 2015	Chief Operating Officer	Ongoing	Jun 15	Monthly	3	5	15	na
		Operations	Operations	Operational/Business	There is a risk that within a large group of open referrals that there are potentially patients whose clinical or administrative pathway is not fully completed as a result of historical and inadequate referral management which may lead to delayed treatment.	5	3	15	• automated referral closure of selected and risk assessed group of patients, • Letter to go to selected group of patients, • Review data quality score card KPI set, • 4. Formulate new or revised set of SOPs , training schedule and compliance assurance measures for new smart and accurate referral management	Chief Operating Officer	Aug 15	Jun 15	monthly	3	3	9	na

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Board Assurance Framework 2015/16: post mitigation red risks
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Rachel Barlow, Chief Operating Officer and Tony Waite, Director of Finance
DATE OF MEETING:	2 July 2015

EXECUTIVE SUMMARY:

Following consideration and approval of the Board Assurance Framework at the May meeting of the Board, it was agreed that those five risks remaining at red status should be monitored on a monthly basis.

The focus of the review is specifically on progress with ensuring that the additional controls and assurances to achieve a lower post mitigation risk score (tolerable risk score) is achieved.

The updates are as per those provided at the June meeting, which indicate that good progress is being made to put in place additional controls and secure sources of further assurance, with there being no anticipated slippage in the timescales for the finalisation of these at this point.

REPORT RECOMMENDATION:

The Trust Board is recommended to review and accept the update and challenge & confirm that the measures for risk 017b-GUR have been delivered as planned.

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

The Board Assurance Framework is aligned to all Trust's annual priorities.

PREVIOUS CONSIDERATION:

Trust Board on 4 June 2015.

Sandwell and West Birmingham Hospitals NHS Trust
BOARD ASSURANCE FRAMEWORK 2015/16

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
COO	007-AR	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	There is a significant risk that the volume of patient discharges from hospital beds each morning is insufficient as a result of poor understanding of expected date of discharge, poor discharge planning or the coordination of activities to effect a safe discharge leading to not enough beds available to admit patients with an emergency or urgent requirement for hospital care and financial penalties	Q&SC	4	4	16	1. An Urgent Care Board has been established and standard operating procedures for 7 day safe discharge across all Clinical Groups have been developed 2. Full realisation of benefits of ADAPT pathway. 3. Arrangements for delivery and monitoring of associated KPI daily / weekly are in place 4. Monitoring through Capacity meeting.	Internal: CLE discussions, Q&S reports up to Trust Board Peer: CCG contract review meeting, System Resilience Group and TDA performance review	4	4	16		On going training and reinforcement of good discharge practices Focused project on Expected Date of Discharge May update : Urgent Care Challenge Week held week of the 18.5.15 with focus on discharge dates and times. Improvement seen by 2-3 hours across the day but still not meeting home before lunch standards. Urgent Care challenge delivery group are following up theme of 'rhythm of the day' to reorgnasie the clinical day on the wards to support earlier discharge. This work will be completed by end of July.	Jul-15	2	4	8
DOF	017b-GUR	Create financial balanced plans for all directorates and deliver Group-level I & E balance on a full year basis [2015.16 financial year] **MF**	There is a risk that the scale & pace of financial improvement delivered is insufficient. This is caused by a lack of necessary capacity and capability. This could result in a failure to generate those financial surpluses necessary to underpin the approval & delivery of key strategic investments.	FIC	4	5	20	Expedited recruitment to fit for purpose senior management structures and follow through on senior leadership development programme. Utilisation of expert support as necessary and appropriate. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective financial performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning, budgetary control, CIP delivery and data quality. External audit review of arrangements for securing VFM. Regulator scrutiny of safe, effective, financially viable services.	3	5	15		Completion of necessary recruitment and leadership development programme. Embedding PMO arrangements in Group management teams & alignment of Change Team resources to support critical improvement projects. Review & amendment of SOPS for TPRS such that it is effective tool for monitoring and managing change programmes. Progression and conclusion of Safe & Sound 2 programme consistent with necessary scale of workforce and paybill change. Confirm downside contingency plan to deliver trust level I&E balance on a full year basis. May update: route to balance established for all corporate directorates and 4/7 clinical groups. Plausible contingency plan for trust level balance considered at FIC.	Jun-15	2	5	10

Sandwell and West Birmingham Hospitals NHS Trust
BOARD ASSURANCE FRAMEWORK 2015/16

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOF	017d-GUR	Create financial balanced plans for all directorates and deliver Group-level I & E balance on a full year basis [2016.17 financial year] **MF**	There is a risk that the identified opportunity for financial improvement is insufficient to deliver balanced financial plans across each and all directorates. There is a risk that the scale & pace of financial improvement delivered is insufficient. This is caused by a lack of necessary capacity and capability and risk of compromise to the safety and quality of services provided. This could result in a failure to generate those financial surpluses necessary to underpin the approval & delivery of key strategic investments.	FIC	4	5	20	Effective use of comparative information including peer benchmarking, best practice review and expert scrutiny. Expedited recruitment to fit for purpose senior management structures and follow through on senior leadership development programme. Effective QIA / EIA process. Transparent & explicit process for plan sign off. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective financial performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning, budgetary control, CIP delivery and data quality. External audit review of arrangements for securing VFM. Regulator scrutiny of safe, effective, financially viable services.	3	5	15		Completion of necessary recruitment and leadership development programme. Focussed executive support to directorates to develop plans. Utilisation of expert support as necessary and appropriate. May update: accelerated solution programme in progress with Surgery B; facilitated plan development programme in progress with Surgery A; expert support re theatres commissioned Surgery A; facilitated plan development programme concluded with Medicine	Sep-15	2	5	10
DOF	018b-GUR	Develop our capital plan and execute in line with that plan on a quarter by quarter basis [2016.17 financial year]	There is a risk that the capital plan is constrained by the requirement to secure key financial metrics and which compromises the timely progression of key estate development and necessary equipment replacement without compromise to key statutory standards. There is a risk that the scale and pace of capital programme delivery is delayed as a result of lack of necessary capacity and capability and which compromises the timely progression of key estate development and necessary equipment replacement.	FIC	4	5	20	Detailed review of absolute and sequenced capital requirements in particular for imaging, medical equipment replacement and retained estate development. IM&T programme confirmed. Routine consideration of full range of financing options to optimise flexibility within financial plan. Appropriate focus and development of senior leadership. Transparent & explicit process for plan sign off. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective capital plan performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning & budgetary control. External audit review of arrangements for securing VFM. Regulator scrutiny of arrangements for compliance with statutory standards.	3	5	15		Conclusion of MES contract during 2015.16 for delivery of key fixed equipment from 2016.17. Confirm retained estate investment programme. Establish and confirm necessary & sufficient management resources to deliver critical elements of the programme. Confirm financial plan for 2016.17 consistent with delivery delivery of necessary surplus to underpin capital programme investment [see risk 017d above]. May update: indicative retained estate development sequencing established	Dec-15	2	5	10

Sandwell and West Birmingham Hospitals NHS Trust
BOARD ASSURANCE FRAMEWORK 2015/16

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOF	022-21CF	Reach financial close on the Midland Met Hospital **MF**	There is a risk that approving bodies [TDA, DH, HMT] delay or fail to approve the business case. This may be as a result of lack of confidence in the business case or trust ability to deliver, political or policy change, absence of a compliant bid, withdrawal of commissioner support or other significant reason. This would give rise to delay or absence of financial close an with potential requirement for expedient service change to secure safe, effective & financially viable services. There is a risk that the senior debt funding competition fails to secure sufficient funds as a result of lack of market appetite and which may cause the case to fail.	CC	4	5	20	Delivery of coherent appointment business case consistent with OBC evidenced with sufficient cost improvement and workforce plans. Ongoing delivery against approval conditions. Confirmation of compliant bid through conclusion of evaluation process. Effective engagement with EIB to secure their commitment to [part-] funding of the development. Routine oversight and management through Stakeholder Board and trust Reconfiguration Committee.	Management Assurance. Routine oversight and assurance through trust Configuration Committee. Independent assurance. Due diligence using external advisors of bid and key elements of business case.	3	5	15		Further development of cost reduction and workforce plans and commissioner confirmation of downside plans. May update: TDA deep dive CIP & workforce change assurance work satisfactory; improvement in CIP schemes recorded on TPRS and signed off; Commissioner support verbally re-confirmed & to be assured in letters of support June.	Dec-15	2	5	10

KEY

Safe high quality care	Q&SC - Quality & Safety Committee
Accessible and Responsive	FIC - Finance & Investment Committee
Care closer to home	CC - Configuration Committee
Good use of resources	W&ODC - Workforce & OD Committee
21st Century facilities	TB - Trust Board
Engaged and effective organisation	**MF** - Annual priorities which will be given monthly focus

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Safe & Sound 2 – Approval to close workforce consultation**
SPONSOR (EXECUTIVE DIRECTOR):	**Raffaela Goodby – Director or Organisation Development**
AUTHOR:	**Raffaela Goodby – Director of Organisation Development**
DATE OF MEETING:	**2nd July 2015**

EXECUTIVE SUMMARY:

The attached paper sets out the workforce change process, Safe and Sound 2, that was undertaken between 29th April 2015 – 13th June 2015. The committee is asked to note and validate that a genuine consultation has taken place, demonstrated by approx. 25% of the schemes changing during the consultation

Approval to implement the detail of the schemes was given at the Workforce and Organisation Development Committee on Monday 29th June.

The report seeks board approval to formally close the consultation process, and to note the approvals and quality assurances sought during the board approval processes in June 2015.

REPORT RECOMMENDATION:

The Trust Board is asked to approve the closing of the formal consultation process with regards to Safe and Sound, phase 2.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

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

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

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

Delivery of Trust's long term workforce strategy and plan

PREVIOUS CONSIDERATION:

Quality & Safety Board Committee 26th June 2015
Workforce & Organisation Development Board Committee 29th June 2015
Workforce Delivery Committee 19th June 2015
Weekly Workforce Change Meetings with Group Directors of Operations.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

WORKFORCE CHANGE: SAFE AND SOUND 2014 – 16

REPORT TO THE TRUST BOARD 2nd JULY 2015

Purpose

This paper reports on progress with the consultation on the Trust's workforce change: Safe and Sound 2014 – 2016, Phase 2 – and seeks Board approval to formally close the workforce consultation.

Introduction

Phase 2 of the workforce change programme was (as previously forecasted) considerably smaller than the number of wte posts affected by Phase 1. The profile of posts affected by the organisational change proposals is also different as it affects more senior bands and impacts on those from a nursing and therapies background.

The commitment to minimise the risk of redundancy through effective redeployment remains in place. To support the delivery of this objective, vacancy controls were put in place at the beginning of the process, with the aim of undertaking a robust redeployment exercise in July 2015.

This paper demonstrates to the Trust Board that a robust and genuine consultation process was followed and to seek approval to formally close the consultation.

Workforce Change, process followed

The process outlined below is broadly in line with that followed during Phase 1, however it should be noted that a number of steps have been modified in view of feedback from the implementation of Phase 1.

a). **Development of Phase 2 –** Groups were required to submit phase 2 scheme proposals by the end of March 2015. A number of late submissions were subsequently received resulting in 61 schemes being submitted for formal consultation with a net WTE reduction of 128.

The schemes consulted on are detailed in appendix A

All Groups submitting scheme proposals were required to:

- ensure schemes had been developed with involvement of the staff groups concerned and engagement with key stakeholders, as a pre-consultation process.
- ensure schemes were quality impact and equality impact assessed.

Prior to submission for formal consultation, scheme proposals and associated quality impact assessments were considered by the Quality and Safety Committee. A small number of late submissions were given Executive approval to proceed.

b). **Formal Collective Redundancy Consultation:** Given the potential number of employees affected by the proposals was greater than 100, we have undertaken a formal 45 day consultation process with our trade unions, individuals at risk and relevant stakeholders. The formal consultation period commenced on 29th April and concluded on 13th June 2015. Consultation took place via the Trust's PPAC committee, chaired by Lesley Barnett, Head of

Workforce (Deputy Director). All the scheme leads attended the committee to consult on their proposals with the trade union representatives on the scheme proposals and pooling requirements, with some managers returning to further update the committee in view of feedback from trade union representatives.

During the consultation 15 schemes were amended or withdrawn – with an audit trail maintained through the issues logs kept within each group and with PPAC.

A number of changes took place during consultation, resulting in nearly 25% of schemes changing, in response to listening and feedback.

- 4 pools within schemes withdrawn due to natural wastage
- 9 schemes were amended. 7 of these related to the medical secretary schemes, where numbers and allocations have resulted in changes to the scheme.
- The remaining two amended schemes are OP413w Community Bed Hub (amended due to a vacancy arising and consultation feedback) and OP413w Contact Centre Scheme (amended following consultation which involved band 5 staff no longer being put at risk).
- 1 scheme has been withdrawn, a Palliative Care proposal affecting two bands within nursing and facilities, agreed by Chief Nurse during consultation.
- The Chief Nurse has quality assessed the amended schemes and is assured that there is no adverse quality impact, as the amended schemes have lessened the number of staff at risk and potential service impact.
- 6 schemes are still under review based on feedback during consultation.
- The band 4 medical secretaries are undergoing an extended 'listening phase' to enable allocations of roles to be considered.

Quality Impact Assessments Update

- As of 25th June there were 31 QIA's to be logged as completed on TPRS.
- The Quality and Safety Board Committee considered the safety and quality implications of implementation on 26th June 2015.
- In many cases the QIA's have been verbally completed with the Chief Nurse and Chief Medical Director and not yet logged
- All outstanding quality impact assessments will be completed and logged on TPRS by Weds 1st July

Following the close of the consultation on 13th, the triumvirate raised a small number of safety impact concerns about the following schemes and asked for additional investigations and assurances before implementation.

- SB 515 – Audiometric maintenance and calibration. At the time of writing the Chief Nurse is following up with relevant clinician to check with EBME that they are comfortable to provide additional support if required.

- SA610 – Theatre and Sterile Services – theatre band 2's to double up as porters for weekend elective lists, as plan is to reduce the number of lists at the weekend. It is the one scheme that has caused quite a bit of discussion with the staff side and a number of concerns expressed about the risks/practicalities. Following further investigation, the medical director feels assured that this scheme is sound and will not cause adverse safety impact.

c). **Selection Process:** Selection of displaced employees was undertaken by an interview process. In view of feedback from Phase 1, the process was modified to ensure the inclusion of appropriate selection tests, and a more robust selection interview. The process was supported by a robust toolkit developed by Human Resources and interview selection training provided by Learning and Development.

d). **Pooling Appeals:** At Risk employees have been offered the opportunity of a 'pooling appeal'. This was designed to give them the opportunity to challenge their inclusion within a selection pool or selection on the basis that they are 'unique' post holders. In total 26 appeals were received. Of these, 1 was subsequently withdrawn, and three were rejected on the grounds that their appeal was on matters not related to pooling. Of the 22 appeals that were heard 8 were upheld and 14 not upheld.

e). **Individual Consultation:** In addition to all of the above and on-going dialogue, scheme managers have been required to meet with selected employees to hold a formal consultation meeting at which the employee has formal rights of representation.

f). **Issues Logs:** Scheme leads have been asked to maintain a working issues log for each of their scheme. This document is designed to record all concerns raised by the individuals affected and stakeholders together with the response. Final documents will be made available week commencing 29th June on Connect as a means of ensuring full transparency.

g). **Final Appeals:** The Trust's Organisational Change process allows for employees to submit an appeal regarding the application of the organisational change process. In total 8 appeals have currently been received. These are scheduled to be heard week commencing 29th June 2015. The appeal panels will be chaired by an Executive Director supported by a HR Manager.

h). **Redeployment:** At risk employees have been assigned a lead manager responsible for supporting the individual with redeployment search and pastoral support. Employees were also provided with a named HR contact to support the co-ordination of the redeployment process. There will be 74 staff requiring redeployment. This means 38 colleagues requiring support to find suitable alternative employment across the Trust or in the wider NHS and 36 colleagues to be offered SAE as part of a restructure, should all schemes receive final approval. It is anticipated that the majority of these employees will be offered suitable alternative employment (SAE) during mid to late July 2015.

i). **Job Search:** At risk employees are being registered on the NHS Jobs, recruitment website as 'restricted applicant's' to ensure they were afforded special consideration by other local NHS employers.

This process will be co-ordinated by the HR and Recruitment Departments through the provision of a series of 1:1 meetings. These will have largely been completed by 26th June 2015 and will enable their named HR contact to develop a comprehensive understanding of their job search needs. The Recruitment Department are also providing one to one support to assist employees with registering and using the NHS Jobs2 system.

In addition to the above, the Learning and Development Department have provided:

- A programme of interview skills workshops throughout the consultation period and beyond. Feedback from the programme has been positive and sessions were well attended.

We anticipate that there will be a small number of employees for whom internal redeployment opportunities will be limited due to the specialist nature of their role. The managers of these employees (in the main employees from the allied health professions staff group) have been

asked to support the external redeployment search by contacting their counterparts with NHS employers across the West Midlands to develop a comprehensive understanding of future as well as current vacancies that may prove to be opportunities for suitable alternative employment.

j). **Natural Wastage:** Throughout the process the HR Department has continued to monitor continued natural wastage (staff leaving the Trust, creating a vacancy) to reduce the number of employees remaining as 'at risk'.

k). **Suitable Alternative Employment:** As with Phase 1, managers have been advised that in order to deliver a successful redeployment programme, they are expected to be flexible about the minimum skill set required of an employee prior to appointment. This will enable a broader spectrum of vacancies to be considered for at risk employees, limited to the provision that any assessed training gap be reasonably addressed within a twelve month period.

l). **Trial Periods:** Employees successful in securing a job offer will be offered the new post with the provision of a four week trial period.

m). **Pay Protection:** Employees that are subsequently redeployed to a post with a lower band will be entitled to receipt of pay protection in accordance with the Trust's Organisational Change Policy.

n). **Evaluation and Key Performance Indicators:** Clinical leads are being asked to produce and subsequently monitor key performance indicators in order to monitor the effective implementation of each scheme. An evaluation of phase one was completed after implementation and it is envisaged that phase 2 will have an ongoing evaluation as implementation progresses. The Quality & Safety Committee will have oversight of the KPI's to ensure all stakeholders (including the CCG represented on this committee) have an eye to the schemes being implemented safely.

Outcome of Consultation:
Band 4 Medical Secretaries: In view of feedback from relevant stakeholders, it has been agreed that the Groups should implement an extended listening period, to allow the opportunity for further discussion and clarification of outstanding matters. This process is due to conclude on 1st July. By 3rd July 2015, the medical secretary establishments for each speciality will be finalised.

This paper illustrates that the consultation process outlined above has been undertaken with a genuine intent to listen and adapt proposals in view of feedback.

Raffaela Goodby
Director of Organisation Development

Lesley Barnett
Head of Workforce (Deputy Director)

Group	DIRECTORATE	Scheme Description	TPRS Ref	Net WTE reduction
Corporate	Estates	Restructuring of Project Administrators in MMH Project Office	ES528W	1.00
Corporate	Medical Directors	Restructure of Informatics Department	IT511(W)	3.00
Corporate	Medical Directors	Restructure of Telephonist Rotas in Informatics Department	IT512W	0.00
Corporate	Medical Directors	Restructure of Reseach and Development	MD TBC1	2.50
Corporate	Medical Directors	Admin review of WMQRS	MD511W	0.53
Corporate	Corproate Nursing and Facilites	Remodelleing of Internal and external waste and soiled linin collection at City Hospital	FA504W	0.00
Corporate	Corproate Nursing and Facilites	Review of staffing establishment in palliative care team	FA TBC 1	0.80
Corporate	Corproate Nursing and Facilites	Tissue Viability Service - Change in matress service provision	FA510	1.00
Corporate	Corproate Nursing and Facilites	Implementation of the patient electronic meal ordering system (Ipads)	FA 516W	1.25
Corporate	Operations	Restructuring of the Contact Centre	OP 413w	2.00
Corporate	Operations	Pharmacy Aseptic Structure Change	OP 408W	3.61
Corporate	Workforce	Occupational Health Nursing	WO506w	1.00
Corporate	Workforce	Restructure of Human Resources Department	WO513w	0.00
Community & Therapies	iBeds	Redesign of Therapy Service within T & O	CT 424 (W)	1.00
Community & Therapies	iCares	Restructure and redesign within Directorate of nursing and therapy roles and responsibilities	CT 434 (W)	23.78
Community & Therapies	iBeds	Integration of strokes services across acute and community	CT 437 (W)	3.40
Community & Therapies	Ambulatory Therapies	Redesign of Foot Health	CT 438 (W)	1.78
Community & Therapies	Ambulatory Therapies	Redesign of Message Taking (Community Contact Centre)	CT 440	6.21
Community & Therapies	iBeds & ambulatory therapies	Redesign of Speech and Language Therapy Service	CT 443 (W)	3.51
Community & Therapies	Ambulatory Therapies	Workforce Redesign of MSK	CT 444 (W)	1.50
Community & Therapies	iBeds and icares	Redesign of Dietetic Services	CT 445 (W)	4.94
Community & Therapies	Ambulatory Therapies	Rationalisation of 8a posts within Foot Health Services	CT 448(W)	1.00
Community & Therapies	iBeds	Rationalisation of 8a posts within Speech & Language Therapy & Dietetic Services	CT 449(W)	1.00
Community & Therapies	iBeds	Integration of Community Bed Hub & Community Bed Therapy Team	CT 450(W)	4.80
Community & Therapies	iBeds, iCares & Ambulatory Therapies	Workforce and pay related scheme	CT 451W	3.91
Community & Therapies		Integration and Redesign of Musculoskeletal Services to Optimise Skill Mixing and Ensure Efficiency, Productivity, and Clinical Effectiveness.	CT453W	2.24
Community & Therapies	iBeds, iCares and Ambulatory Therapies	Redesign of Operational Management Support	CT454	1.80
Imaging		Removal of band 2 as a result of self check in desks	IM328	2.00
Imaging	Cross Directorate	Medical secretary review project	IM413W	0.00
Imaging	Breast	Undertake an in-depth review of the Breast Screening Administration function in balance with the national changes proposed	IM410	0.75
Imaging		Physics & Nuclear Medicine/Radiopharmacy Reconfiguration	IM414W	1.00
Medicine and Emergency Care	Scheduled Care Directorate	Endoscopy Administration Team: reorganisation and reduction	ME493W	1.89
Medicine and Emergency Care	Cross Directorate	Medical Secretaries Review	ME502W	17.62
Medicine and Emergency Care	Admitted Care	Workforce Reduction on Bed Closure	ME604	24
Medicine and Emergency Care	Admitted Care	Workforce Reduction on Bed Closure	ME604w	24

Group	DIRECTORATE	Scheme Description	TPRS Ref	Net WTE reduction
Medicine and Emergency Care	Cross Directorate	Review Of Specialist Nursing Roles within Medicine and Emergency Care	ME614	4.00
Medicine and Emergency Care	Cross Directorate	Review Of Specialist Nursing Roles within Medicine and Emergency Care	ME489	4.00
Medicine and Emergency Care	Emergency Care	Emergency Medicine Workforce Strategy	ME TBC 3	0.00
Medicine and Emergency Care	Emergency Care	Reduction in Band 5 nursing establishment (5.5wte)	ME TBC1	0.00
Medicine and Emergency Care	Emergency Care	Emergency Medicine Workforce Strategy	ME TBC 1	0.00
Pathology	Haematology	Reduction of MLA vacancies in Haematology	PA974	2.70
Pathology	Clinical Biochemistry	Disestablish 1.0 wte Band 7 Clinical Scientist vacancy	PA973	1.00
Pathology	Microbiology	Disestablish Vacant Band 2 MLA in Microbiology	PA 978W	1.00
Surgery A	Cross Directorate	Medical secretary review project - Central	SA522	7.35
Surgery A	Directorate C	Theatre Efficiency Plan following Meridian Review	SA607	7
Surgery A	Directorate C	Scope closure of D6 admissions ward	SA608	
Surgery A	Directorate D	Retirement of Associate specialist – Directorate D	SA609W	0.80
Surgery A	Directorate C	Theatre and Sterile Services – Integration of Band 2 roles	SA610W	2.00
Surgery A	Directorate C	Proposal to integrate the Pre-Assessment Unit and Day Unit Nursing Workforce	SA611	0.00
Surgery A	Cross Directorate	Group A Surgery - Bed reduction review project - Central	SA 635	5.20
Surgery A	T & O	Removal of Band 2 Plaster Technician	SA614	1.00
Surgery A	Directorate A - plastics	Plastic Nurse led dressing service review - Central	SA613W	0.60
Surgery A		Bed capacity realignment.	SA635	
Surgery B	Ophthalmology	Surgery B – Admin – 18 Week Capacity Co-ordinator (Proposed Role Change)	SB519W	0.00
Surgery B	Ophthalmology, ENT, Oral Services and Audiology	Administration Workforce Scheme - Band 5-7	SB520W	1.00
Surgery B	ENT, Oral Surgery & Audiology	Review of audiometric maintenance and calibration	SB 515W	1.00
Surgery B	Surgery B	Administration Workforce Scheme – Surgery B Band 3	SB517W	0.89
Surgery B	Oral Surgery	Surgery B - Admin Workforce Scheme – Oral Surgery Band 3 disestablishment	SB 527W	0.40
Surgery B	Ophthalmology, ENT, Oral Services and Audiology	Administration Workforce Scheme Band 4 – Medical Secretarial Scheme	SB518W	5.00
Surgery B	Ophthalmology	Developing a Nurse Intravitreal Injection Service for Ophthalmology	SB526W	1
Surgery B	Ophthalmology and Imaging	Ophthalmology - Medical Retina Service (Imaging and Consultant Establishment Proposal)	SB523	1.00
Women and Child Health	Gynaecology/ Gynae-Oncology/ GUM & CaSH	Development of generic Health Care Support Worker / Admin roles in GUM / CASH integrated services	WC TBC2	0
Women and Child Health	Maternity and Perinatal Medicine	Loss of funding for B6 Implementation Officer for Baby Friendly Service	WC TBC1	1.00
Women and Child Health	Gynaecology, Gynae Oncology & GUM/CaSH	Reduction of Medical Staffing Establishment in GUM services	WC502W	0.60
Women and Child Health	Gynaecology, Gynaecology-Oncology & GUM Paediatrics Maternity	Reduction of WCH Medical Secretaries wte as a result of full implementation of a voice recognition system	WC506W	4.00
Women and Child Health	Gynaecology, Gynaecology-Oncology & GUM	Redesign of the supervision and management of CASH and GUM administration	WC522W	1.10

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Update – Month 2
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance & Performance Management
AUTHOR:	Tony Waite, Director of Finance & Performance Management & Tim Reardon, Associate Director of Finance
DATE OF MEETING:	2nd July 2015

EXECUTIVE SUMMARY:

- For the period to the end of May 2015 the Trust is reporting :
  - I&E surplus consistent with plan
  - Capital spend below plan
  - Cash held at the end of May exceeds plan
- The I&E surplus includes £432k of balance sheet flexibility. SLA income includes an accrual consistent with plan.
- Key risks remain as previously reported and urgent action is required to address agency expenditure which is at a level that is not sustainable or consistent with delivery of financial targets.
- A detailed evaluation of CQUIN performance and prospective delivery and recently the notified Learning & Development Agreement is ongoing. This work will assess downside risk and determine meaningful mitigations.
- Work continues to resolve those clinical groups which have yet to determine balanced financial plans.
- The current forecast is to deliver plan financial targets. A detailed assessment will be made based on Q1 numbers.

REPORT RECOMMENDATION:

The Board is asked to receive and accept the update.

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

- Financial plan 2015/16

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – May 2015 (month 2)

EXECUTIVE SUMMARY

- **For the period to the end of May 2015 the Trust is reporting :**
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  - **Capital spend below plan**
  - **Cash held at the end of May exceeds plan**
- **The I&E surplus includes £432k of balance sheet flexibility. SLA income includes an accrual consistent with plan.**
- **Key risks remain as previously reported and urgent action is required to address agency expenditure which is at a level that is not sustainable or consistent with delivery of financial targets.**
- **A detailed evaluation of CQUIN performance and prospective delivery and recently the notified Learning & Development Agreement is ongoing. This work will assess downside risk and determine meaningful mitigations.**
- **Work continues to resolve those clinical groups which have yet to determine balanced financial plans.**
- **The current forecast is to deliver plan financial targets. A detailed assessment will be made based on Q1 numbers.**

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	4	3	>=Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	28	24	>=Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	(657)	(1,628)	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	676	1,704	<=Plan	<=Plan	>1% above plan
WTEs Actual v Plan	(8)	(0)	<=Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000		7,716	>=Plan	>=95% of plan	<95% of plan

Note: positive variances are favourable, negative variances unfavourable

- **Cash balance at 31 May £36.6m is £7.7m ahead of cash plan**. Plan in place to meet EFL without material undershoot
- Year to date capital expenditure of £0.5m is £1.9m behind plan.
- **No risk of undershoot has been identified in respect of the Capital Resource Limit**

2015/16 Summary Income & Expenditure Performance at May 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
Income from Activities	397,672	33,147	33,423	276	66,288	66,632	345
Other Income	41,239	3,460	3,193	(268)	6,888	6,491	(397)
Pay Expenses	(284,588)	(24,224)	(24,881)	(657)	(47,529)	(49,157)	(1,628)
Non-Pay Expenses	(127,926)	(10,443)	(9,766)	676	(21,765)	(20,061)	1,704
EBITDA	**26,397**	**1,940**	**1,968**	**28**	**3,881**	**3,905**	**24**
Depreciation & Impairment	(14,881)	(1,240)	(1,239)	1	(2,480)	(2,480)	0
PDC Dividend	(6,000)	(500)	(500)	0	(1,000)	(1,000)	0
Net Interest Receivable / Payable	(2,084)	(174)	(185)	(11)	(347)	(355)	(7)
Other Finance Costs / P&L on sale of assets	0	0	0	0	0	0	0
Net Surplus/(Deficit)	**3,432**	**27**	**44**	**17**	**54**	**70**	**16**
IFRIC12/Impairment/Donated Asset Related Adjustments	372	31	18	(13)	62	49	(13)
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,804**	**58**	**62**	**4**	**116**	**119**	**3**
Surplus / (Deficit) against TDA plan	0	0	0	0	0	0	0

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – May 2015 (month 2)

Overall Performance against DoH Plan

The Trust is reporting a year to date surplus of £119k being in line with plan. Key issues agency pay spend and elective income recovery.

Performance of Clinical Groups

- Medicine income is favourable due to additional emergency inpatient activity. However, this benefit is offset by spending on Nursing and medical interim staffing.
- Surgery A income is down due to lower planned admissions and outpatient activity. This is compounded by the unallocated savings.
- Women & Child income is supporting the overall Women and Child group position. There is an adverse variance on pay due to savings not yet allocated, also non-pay is adverse due to maternity pathway payments to other providers.
- Surgery B is under-performing on elective activity, despite this pay is adverse due to unallocated savings schemes.
- Community & Therapies is adverse due to £0.3m on nursing overspend.
- Imaging is adverse due to unallocated savings schemes which are to be adjusted in month 3.

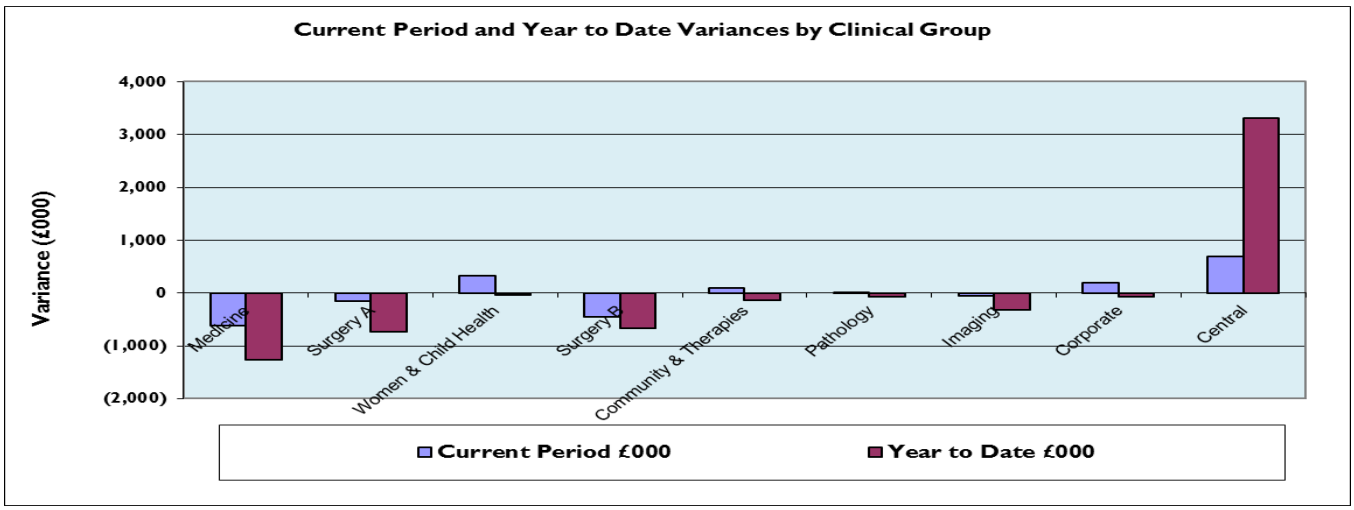
Corporate Areas

- A shortfall on training income together with adverse variances on non-pay offset any benefit of pay underspends.

Central

- Release of CCG RTT funding and central reserves account for the saving in central .

Group Variances from Plan (Operating income and expenditure)	Current Period £000	Year to Date £000
Medicine	(618)	(1,267)
Surgery A	(160)	(727)
Women & Child Health	324	(44)
Surgery B	(445)	(668)
Community & Therapies	94	(132)
Pathology	6	(66)
Imaging	(58)	(313)
Corporate	190	(71)
Central	693	3,313

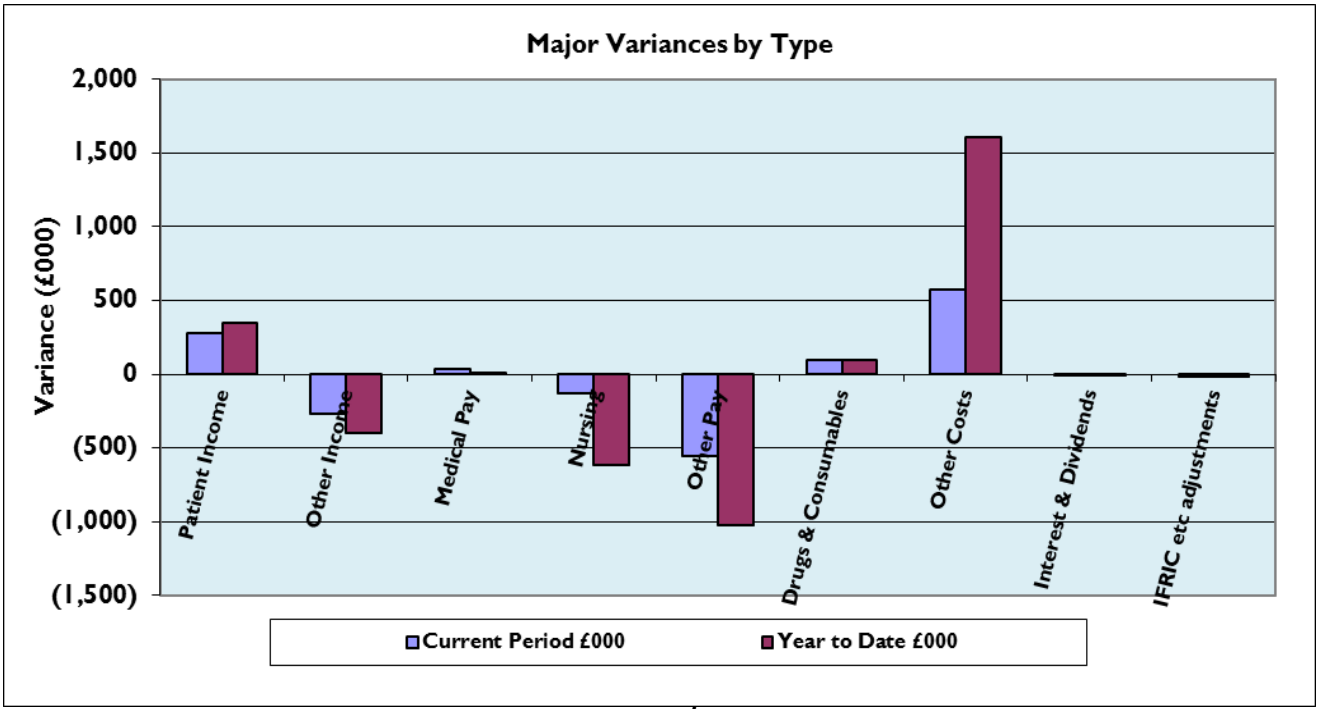


Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – May 2015 (month 2)

- Patient income over performing due to SLA income, additional in year income £0.3m favourable driven by emergency activity. Provision has been made for fines of £2m, in line with full year value.
- Medical staff pay is in line with budget to date though there is overspending in Medicine £0.3m which includes premium rate working.
- Nursing overspends £0.6m to date in driven by premium usage in medicine.
- Savings targets that are yet to be allocated have been held within the Other Pay line of the I&E. These have the effect of reducing the budget and so result in an adverse variance. During period 3 an exercise will be undertaken to allocate out savings targets to specific areas. This will include re-phasing and some movement between pay and non-pay lines.
- Drugs/consumables variance to date relates to surgery B drugs saving offset by medicine consumable overspend.
- Other costs includes maternity pathway payments overspend £0.5m to date and proportion of unallocated reserves of £2.2m.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	276	345
Other Income	(268)	(397)
Medical Pay	34	8
Nursing	(131)	(616)
Other Pay	(560)	(1,020)
Drugs & Consumables	100	98
Other Costs	576	1,606
Interest & Dividends	(10)	(7)
IFRIC etc adjustments	(13)	(13)



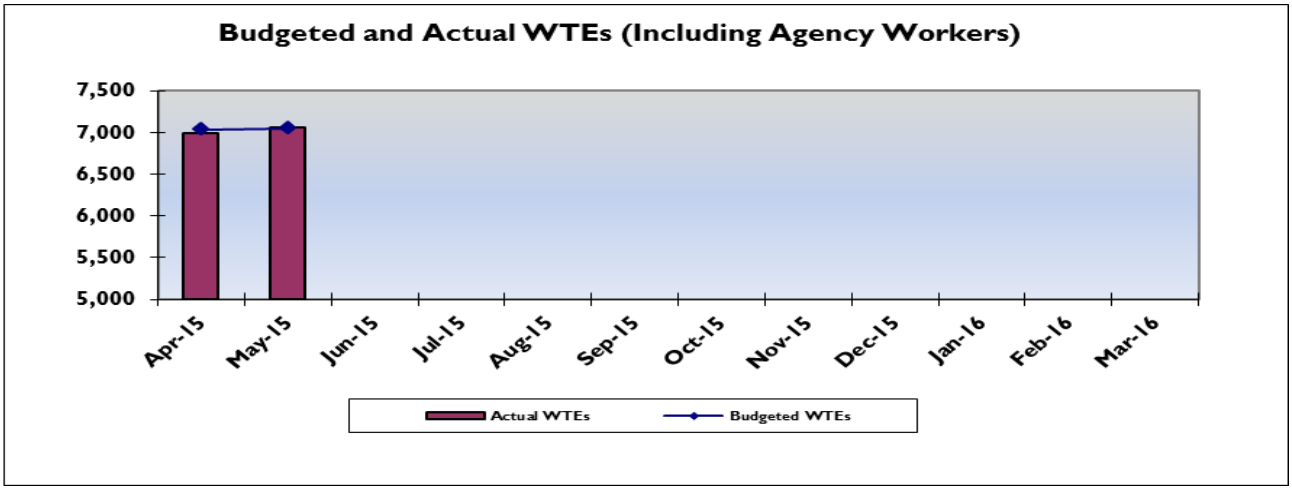
Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – May 2015 (month 2)

Paybill & Workforce

- There were 6,599 WTE in post in May plus an estimated 454 WTE of agency staffing across the month. In total this is 8 WTE above planned establishments.
- Total pay costs (including agency workers) were £24.9m in May being £0.7m higher than plan.
- This inconsistency between the variances for WTE and expenditure is counter intuitive but can be explained by two factors:
  - The use of the pay budgets to hold unallocated savings targets
  - The premium paid for agency staff
- **Agency staff cost in month was £1,720k in month, this £962k above the level reported for September 2014 and £1,135k above the plan level submitted to the TDA. This rate of spend is not sustainable or consistent with delivery of key financial targets.**
- Principal overspending is for nursing staff premium rate working and for healthcare assistants providing enhanced care support to vulnerable patients. The Trust is currently running with a social care ward supported by agency staff which was budgeted for permanent staff. Spend on scientific and therapeutic staff and on management and admin is below plan.



Total Pay Costs by Staff Group

	Year to Date to May 2015					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	13,450	12,825	0	616	13,441	8
Management	2,326	2,051	0	0	2,051	274
Administration & Estates	5,183	4,468	362	220	5,050	133
Healthcare Assistants & Support Staff	5,184	4,693	646	5	5,344	(160)
Nursing and Midwifery	15,723	13,317	992	2,030	16,339	(616)
Scientific, Therapeutic & Technical	7,671	6,604	0	213	6,817	854
Other Pay / Technical Adjustment	(2,007)	114	0	0	114	(2,121)
Total Pay Costs	47,529	44,072	2,000	3,085	49,157	(1,628)

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – May 2015 (month 2)

Balance Sheet

Cash at the end of May was £36.6m being £7.7m higher than plan. This reflects the higher than plan cash balance held at the end of the previous month and is primarily due to a better debtors and creditors position than planned. Disputed payments to NHS suppliers have been held and these are not expected to be resolved until the end of quarter 1. This accounts for £6m of the difference.

Capital payments are also behind the planned phasing (£1.9m), it is not expected that this will be corrected by the end of Q1 and so there is likely to be a favourable cash variance throughout Q1 and Q2.

Surplus cash is now routinely invested in National Loans Fund underpinned by weekly cash flow forecasts.

STATEMENT OF FINANCIAL POSITION 2015/16

	Balance as at 31st March 2015	Balance as at 31st May 2015	TDA Planned Balance as at 31st May 2015	Variance to plan as at 31st May 2015	TDA Plan at 31st March 2016	Forecast 31st March 2016
	£000	£000	£000	£000	£000	£000
Non Current Assets						
Property, Plant and Equipment	233,309	231,357	233,775	(2,418)	246,555	246,555
Intangible Assets	677	678	637	41	437	437
Trade and Other Receivables	890	927	752	175	1,011	1,011
Current Assets						
Inventories	3,467	3,585	3,246	339	2,972	2,972
Trade and Other Receivables	16,318	21,467	16,616	4,851	15,966	15,966
Cash and Cash Equivalents	28,382	36,630	28,914	7,716	27,082	27,082
Current Liabilities						
Trade and Other Payables	(45,951)	(57,976)	(46,555)	(11,421)	(53,620)	(53,620)
Provisions	(4,502)	(4,175)	(3,883)	(292)	(3,355)	(3,355)
Borrowings	(1,017)	(1,017)	(1,017)	0	(1,017)	(1,017)
DH Capital Loan	(1,000)	(1,000)	(1,000)	0	0	0
Non Current Liabilities						
Provisions	(2,986)	(2,985)	(2,363)	(622)	(4,133)	(4,133)
Borrowings	(26,898)	(26,730)	(26,728)	(2)	(25,881)	(25,881)
DH Capital Loan			0	0	0	0
	200,689	**200,761**	**202,394**	**(1,633)**	**206,017**	**206,017**
Financed By						
Taxpayers Equity						
Public Dividend Capital	162,210	162,210	162,210	0	162,210	162,210
Retained Earnings reserve	(13,758)	(13,686)	(12,053)	(1,633)	(8,430)	(8,430)
Revaluation Reserve	43,179	43,179	43,179	0	43,179	43,179
Other Reserves	9,058	9,058	9,058	0	9,058	9,058
	200,689	**200,761**	**202,394**	**(1,633)**	**206,017**	**206,017**

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – May 2015 (month 2)

CASH FLOW 2015/16

PLAN, ACTUAL AND YEAR END FORECAST AT 31st May 2015

	April £000s	May £000s	June £000s	July £000s	August £000s	September £000s	October £000s	November £000s	December £000s	January £000s	February £000s	March £000s
Planned cash balances:												
TDA plan	**28,109**	**28,914**	**29,719**	**30,612**	**31,505**	**26,194**	**26,052**	**25,910**	**25,768**	**26,165**	**26,612**	**27,082**

ACTUAL/FORECAST	April Actual £000s	May Actual £000s	June Forecast £000s	July Forecast £000s	August Forecast £000s	September Forecast £000s	October Forecast £000s	November Forecast £000s	December Forecast £000s	January Forecast £000s	February Forecast £000s	March Forecast £000s
Receipts												
SLAs: SWB CCG	**21,084**	**21,716**	21,568	21,568	21,568	21,568	21,568	21,568	21,568	21,568	21,568	21,568
Associates	**6,800**	**6,632**	6,380	6,380	6,380	6,380	6,380	6,380	6,380	6,380	6,380	6,380
Other NHS income	**1,957**	**1,877**	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	2,800
Specialised Service (LAT)	**3,042**	**5,448**	3,292	3,292	3,292	3,292	3,292	3,292	3,292	3,292	3,292	3,287
Over/(Under) Performance Payments	**2,758**	**598**	0	0	0	0	0	0	0	0	0	0
Education & Training	**463**	**0**	4,666	4,666	0	0	4,666	0	0	4,666	0	0
Public Dividend Capital	**0**	**0**	0	0	0	0	0	0	0	0	0	0
Loans	**0**	**0**	0	0	0	0	0	0	0	0	0	0
Other Receipts	**2,423**	**918**	1,000	2,000	2,000	2,000	2,000	2,000	2,000	2,200	2,200	2,800
Total Receipts	**38,527**	**37,189**	38,406	39,406	34,740	34,740	39,406	34,740	34,740	39,606	34,940	36,835
Payments												
Payroll	**13,364**	**13,207**	13,600	13,600	13,600	13,600	13,600	13,600	13,600	13,600	13,600	13,600
Tax, NI and Pensions	**3,638**	**9,224**	9,250	9,250	9,250	9,250	9,250	9,250	9,250	9,250	9,250	9,250
Non Pay - NHS	**3,099**	**1,659**	5,800	1,500	500	750	1,200	700	750	1,250	750	650
Non Pay - Trade	**10,987**	**8,519**	13,986	11,483	8,121	9,965	12,259	8,144	8,144	11,817	7,910	5,819
Non Pay - Capital	**459**	**1,070**	1,456	1,455	1,151	1,151	2,014	1,963	1,913	2,066	2,443	3,066
PDC Dividend	**0**	**0**	0	0	0	3,105	0	0	0	0	0	3,000
Repayment of Loans & Interest	**0**	**0**	0	0	0	1,004	0	0	0	0	0	0
BTC Unitary Charge	**0**	**429**	440	440	440	440	440	440	440	440	440	880
NHS Litigation Authority	**685**	**685**	685	685	685	685	685	685	685	685	0	0
Other Payments	**68**	**375**	100	100	100	100	100	100	100	100	100	100
Total Payments	**32,300**	**35,168**	45,317	38,513	33,847	40,050	39,548	34,882	34,882	39,208	34,493	36,365
Cash Brought Forward	**28,382**	**34,609**	36,630	29,719	30,612	31,505	26,194	26,052	25,910	25,768	26,165	26,612
Net Receipts/(Payments)	**6,227**	**2,021**	(6,911)	893	893	(5,310)	(142)	(142)	(142)	398	447	470
Cash Carried Forward	**34,609**	**36,630**	29,719	30,612	31,505	26,194	26,052	25,910	25,768	26,165	26,612	27,082
Plan v Actual Carry Forward	**6,500**	**7,716**	0	(0)	(1)	0	0	(0)	(1)	0	0	0

Financial Performance Report – May 2015 (month 2)

Capital Expenditure & Capital Resource Limit

- Year to date capital expenditure is £527k which is £1,934k below plan. Expenditure is at variance to initial plan phasing in respect of the following schemes:
- £700k relating to the MMH project for preparing the land for building.
    - £400k relating to the schemes deferred from 2014/15, most notably the Catheterisation laboratory.
    - £250k relating to the project of improvement work for the CQC plan
    - £230k of under spending on the medical equipment investment scheme

There is no significant delay in respect of these schemes and confirmation of final programme phasing is ongoing.

- The remaining underspend is spread over a number of projects including IM&T and EPR
- The Capital Resource Limit (CRL) charge forecast is £20.229m which is in line with plan. There is risk of pressure to the capital programme and which may require management across financial years. Consequent requirement for CRL amendment is not considered to be a risk and will be progressed with the TDA.
- The Trust has sufficient cash to support the full capital programme and is not anticipating the use of external cash to fund the programme.

Continuity of Service Risk Rating

- Year to date rating 3.5, forecast 3 both of which are in line with the Trust plan.

Memorandum Continuity of Services Risk Ratings	Sub Code	SIGN	Current Month Metrics			Forecast Outturn Metrics		
			Plan (mc 01) £000s	Actual / Forecast (mc 02) £000s	Variance (mc 03) £000s	Plan (mc 04) £000s	Actual / Forecast (mc 05) £000s	Variance (mc 06) £000s
Liquidity Ratio (days)								
Working Capital Balance	780	+/-	(6,925)	(6,071)	854	(14,944)	(14,944)	0
Annual Operating Expenses	790	+/-	68,938	69,235	297	409,971	409,971	0
Liquidity Ratio Days	800	+/-	(6)	(5)	1	(13)	(13)	0
Liquidity Ratio Metric	810	+/-	**3.00**	**3.00**	**0.00**	**2.00**	**2.00**	**0.00**
Capital Servicing Capacity (times)								
Revenue Available for Debt Service	820	+/-	3,890	3,899	9	26,450	26,450	0
Annual Debt Service	830	+/-	1,534	1,515	(19)	10,201	10,201	0
Capital Servicing Capacity (times)	840	+/-	2.5	2.6	0.0	2.6	2.6	0.0
Capital Servicing Capacity metric	850	+/-	**4.00**	**4.00**	**0.00**	**4.00**	**4.00**	**0.00**
Continuity of Services Rating for Trust	860	+/-	**3.50**	**3.50**	**0.00**	**3.00**	**3.00**	**0.00**

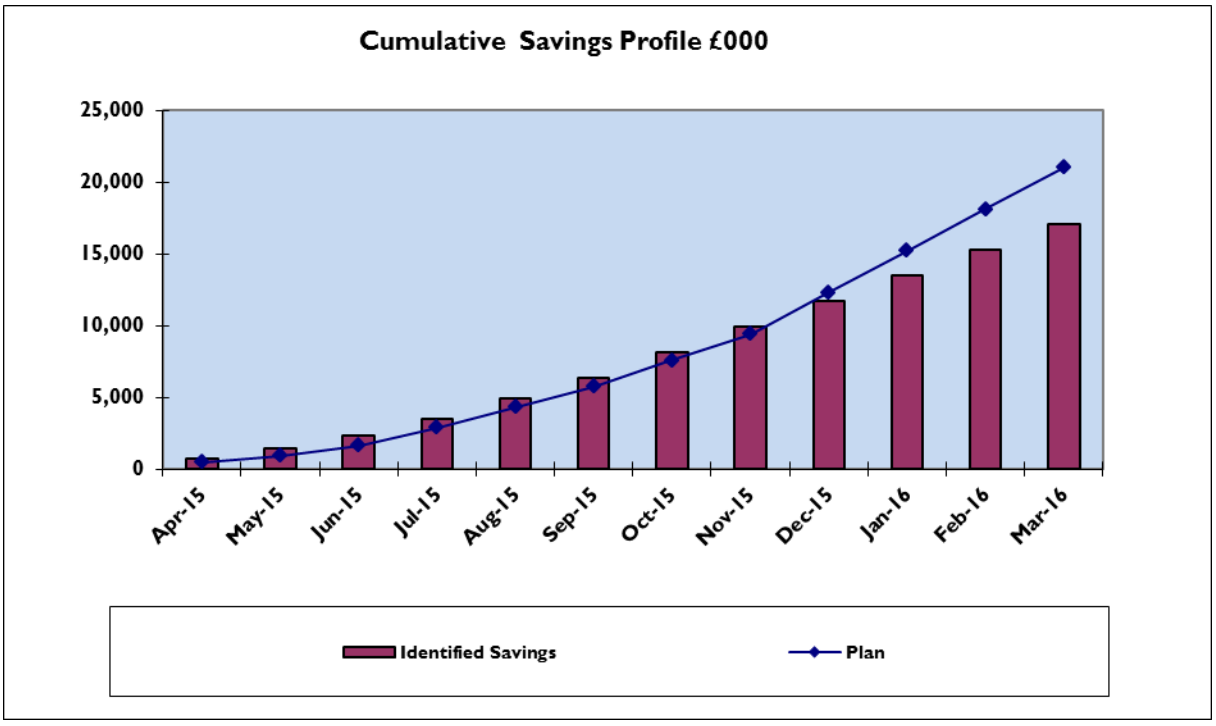
Service Level Agreements

- NHS Commissioner activity and income data for the first two months of the year indicates an activity based over-performance of £345k this includes £2m in additional emergency activity offset by £1.7m shortfall on elective.
- SLA income includes an income accrual which is in line with plan and provides for a smoothing of reported I&E performance across the financial year. This approach is consistent with that adopted in previous years.
- Within the total the contract with NHS England for specialised services is under-performing by £0.1m to date although there is an emergency increase which represents a potential risk to MRET payments.
- There is also a risk the Trust may not secure all of the CQUIN funding allocated in the contract and which was budgeted for. This is the subjected of discussion with the commissioner and constructive proposals have been tabled.

Financial Performance Report – May 2015 (month 2)

Savings Programme

- **Delivery to date is £1,431k which is £0.5m favourable compared to initial phased plans**. The ledger will be updated during period three to reflect the latest position.
- Schemes in delivery are forecast to realise £17.1m during 2015/16 and with full year effect of £21.3m in 2016/17 against plan target of £21.0m.
- 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 drawing to a close. This work is underpinned by robust arrangements to assess and assure the impact of any proposals on safety & quality.
- The forecast profile of savings delivery is shown below together with the original plan against which the TDA continues to monitor the Trust



Risks

Identification and delivery of savings at necessary scale and pace; the current forecast for savings indicates delivery of £17.1m in year compared with £21.0m required. The full year effect of these schemes is £21.3m giving a carry forward benefit in 2016.17.

Income repatriation. The 2015/16 depends on repatriation of activity bringing a financial benefit of £3.0m. Approximately £1m of this income is expected as a consequence of a change in policy at UHB . A detailed assessment of the opportunity in respect of the balance of £2m has been completed, however a robust plan to realise that opportunity remains to be established and secured.

CQUIN. CQUIN has been assumed at 100% in the Trust's plan for 2015/16. The initial risk to this is the national target for mental health assessments in A&E requires 90% achievement and while the Trust is currently achieving 77% this represents a threat to full achievement of CQUIN. Confirm and challenge session discussions are at an early stage but discussions are underway to adjust the interpretation of this target to reflect work already undertaken by the Trust.

Readmissions and MRET. Trust readmission rates are currently running at approximately 125% of peer average and while this does not carry a financial consequence in the current financial year it is too high and likely to result in 2016/17 consequences if unchecked. MRET will not be reached in the 2015/16 year despite additional emergency activity. However the specialty MRET does pose a potential risk this financial year. This is currently being assessed.

Elective capacity management. Throughout April and May the Trust has reported RTT breaches yet recorded activity levels for elective below plan and below prior year levels. Reasons given for cancellations do not suggest that non-elective activity is crowding out elective activity and so raises concerns that current capacity is not able to service current demand. If this is the case then there is a risk to the Trust's ability to service repatriated activity.

Ante-natal pathway charges. The Trust is currently withholding NHS payments of £3m and accruing income of £2m for inter-provider charges relating to this pathway. Although apparently a net creditor this does represent uncertainty to the Trust's financial position and therefore represents a level of risk.

Training income. The allocation recently notified by Health Education West Midlands appears to be below the level anticipated in the Trust's planning assumptions for 2015/16. This is for part year and current placements only but represents a potential risk to the Trust. Detailed evaluation ongoing.

Issues – failure to act will result in failure to achieve key financial plan targets

Over spending on pay costs, particularly premium rate staffing. Spending on interim staffing has spiked in the new financial year. Agency spend stands at £1m higher than in the month of September 2014. There are no indications of a change in this and this is a significant threat to the achievement of the required pay cost reductions for 2015/16. The new social care ward that is staffed using agency poses a risk to the Trust's position as this has been included within the budgeted pay costs at permanent rates not agency.

Mitigating action is required to address this issue:

- Director led task and finish group to tackle agency
- Improved roster and sickness management
- Improve Recruitment of key staff groups

Financial Performance Report – May 2015 (month 2)

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:	**Annual Report on the Implementation of Medical Appraisal**
SPONSOR (EXECUTIVE DIRECTOR):	**Dr Roger Stedman, Medical Director**
AUTHOR:	**Philip Andrew, Head of Medical Staffing**
DATE OF MEETING:	**2 July 2015**

EXECUTIVE SUMMARY:

Medical Revalidation has been in place since December 2012 and is well established within the Trust. Approximately 260 doctors have now been through the revalidation process. The Medical Director acting as the Responsible Officer (RO) has a statutory duty to ensure that the requirements of revalidation are met. To be revalidated a doctor has to demonstrate that they have been participating in annual appraisal (assessed against the requirements of the GMC's Good Medical Practice) and have undertaken at least one patient and colleague multisource feedback exercise prior to their revalidation date.

This report provides a summary of the medical appraisal and revalidation activity within the Trust in the period 1st April 2014 to 31 March 2015. It includes information on the number of doctors that the RO is responsible for (404), the number of appraisals undertaken (319) and the number of revalidation recommendations made (182).

The report sets out the governance arrangements around revalidation, provides details on how the performance of doctors is monitored and how concerns with doctors are responded to.

The report seeks to assure the Board that the Trust is compliant with the requirements of medical revalidation.

REPORT RECOMMENDATION:

To accept this report and to note that it will be shared (along with the annual audit) with the higher level RO.

To approve the `statement of compliance' confirming that the Trust, as a designated body, is in compliance with the regulations (see Appendix 4).

To agree that a report on medical revalidation be presented to the Trust on an annual basis

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	
Clinical	**X**	Equality and Diversity		Workforce	X
Comments:					

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

Engaged & effective organisation

PREVIOUS CONSIDERATION:

Considered annually by the Board

FOR DECISION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Annual Report on the Implementation of Medical Appraisal

Report to Trust Board on 2nd July 2015

1 EXECUTIVE SUMMARY

1.1 Medical Revalidation has been in place since December 2012 and is well established within the Trust. Approximately 260 doctors have now been through the revalidation process. The Medical Director acting as the Responsible Officer (RO) has a statutory duty to ensure that the requirements of revalidation are met. To be revalidated a doctor has to demonstrate that they have been participating in annual appraisal (assessed against the requirements of the GMC's Good Medical Practice) and have undertaken at least one patient and colleague multisource feedback exercise prior to their revalidation date.

1.2 This report provides a summary of the medical appraisal and revalidation activity within the Trust in the period 1st April 2014 to 31 March 2015. It includes information on the number of doctors that the RO is responsible for (404), the number of appraisals undertaken (319) and the number of revalidation recommendations made (182).

1.3 The report sets out the governance arrangements around revalidation, provides details on how the performance of doctors is monitored and how concerns with doctors are responded to.

1.4 The report seeks to assure the Board that the Trust is compliant with the requirements of medical revalidation.

2 BACKGROUND

2.1Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Previous Board Reports on Medical Revalidation were presented to the Trust Board in May 2012 November 2012 and July 2014.

Trusts have a statutory duty to support their Responsible Officers (RO) in discharging their duties under the Responsible Officer Regulations(`The Medical Profession (Responsible Officers) Regulations 2010 as amended in 2013' and `The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012') and it is expected that Trust Boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their

organisations;

- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

3 GOVERNANCE ARRANGEMENTS

3.1 A Medical Revalidation Implementation Group (MRIG), chaired by the RO, was established in 2012 and was the main forum for ensuring the various components of medical appraisal and revalidation were being adhered to and that the Trust kept up to date with new requirements and developments. MRIG is no longer meeting as revalidation has been fully implemented. The main group is now the Appraiser Forum.

3.2 The medical appraisal and revalidation process is clearly set out in the Trust Appraisal Policy for Career Grade Medical Staff which was implemented in 2012 and further revised in October 2013.

3.3 An IT system, PReP, was acquired in 2012 that fully documents the appraisal process. The Consultant or SAS Doctor completes their appraisal input form on PReP with the necessary supporting information uploaded for each domain under the GMC's Good Medical Practice document. The appraiser then has access to the input form on PReP and can reject the form in advance of the appraisal meeting if it is felt that that the input form does not meet the necessary requirements. The PDP and Output form is completed as part of and after the appraisal meeting and signed off on PReP by both appraiser and appraisee. The PReP system provides the RO with access to all the appraisal input and output information for all the doctors he has responsibility for. There is also an RO dashboard and a suite of reports available on the system.

3.4 The operational management of the PReP system and the revalidation process is now undertaken by Business Manager to the Medical Director who has weekly meetings with the Head of Medical Staffing to report progress and/or concerns.

3.5 The process for ensuring the Trust maintains an accurate of list of prescribed connections is undertaken by the Business Manager to the Medical Director and Head of Medical Staffing. New Consultants and SAS Doctors are trained on the PReP system and we obtain confirmation of their current appraisal and revalidation status when they commence.

3.6 The ROs have established a regional network to share concerns about doctors who work in their Trust. The SWBH RO has also set up meetings with the main private healthcare providers to ensure that any concerns that might have been flagged in private practice are fedback to the Trust.

3.7 The RO has to provide regular self assessments for the Revalidation Support Team of NHS England. This has been in the form of quarterly Organisational Readiness Self Assessments (ORSAs) which have now been replaced by Annual Organisational Audits (AOAs).

4 MEDICAL APPRAISAL

4.1 Appraisal and Revalidation Performance data

As at 31st March 2015 the Trust had a prescribed connection with 404 doctors (286 Consultants, 63 SAS Doctors, 54Temporary or short term contract holders and 1other doctor with a prescribed connection to this designated body)

In the period 1 April 2014 to 31st March 2015 the number of completed appraisals was 319(251Consultants, 40 SAS Doctors and 28 Temporary or short term contract holders). A summary of the reasons for missed or incomplete appraisals is contained in Appendix 1 (`Other doctor reasons' account for the majority of missed appraisals and the vast majority of those would best be described as `underestimation of preparation and workload involved in appraisal process leading to delay in appraisal').

In the period 1 April 2014 to 31st March 2015 there were 6 doctors in remediation and/or disciplinary processes. In addition there were 7 GMC referrals that the Trust was involved with three complaints were made by patients; two were complaints from another NHS Body and two referrals made by the Trust. The Trust referrals were conduct concerns raised about an agency locum and an ex-employee).

As part of the appraisal and revalidation process all doctors that have a prescribed connection to the Trust will undertake a colleague and patient multisource feedback (360 degree feedback) every three years. The doctor is required to evidence reflection on the results of this feedback with their appraiser in advance of their revalidation date.

4.2 Appraisers

As at 31st March 2015 there are 152 medical appraisers within the Trust, all of whom have undertaken Strengthened Appraisal Training. In the period 1st April 2014 to 31st March 2015 122 of those trained appraisers undertook at least one appraisal. This training is a one day training session that the Trust has commissioned (the objectives of the training include: Be familiar with SWBH appraisal policy for medical staff; Understand the purpose of the medical appraisal and how it relates to other management and regulatory processes; Be aware of the General Medical Council (GMC), British Medical Association (BMA) and Department of Health's guidance on appraisals in line with Good Medical Practice; Understand the role of the appraisal in the revalidation process, based on the most current information from the Revalidation Support Team (RST) and the Trust; Understand what preparatory work needs to be done by the appraiser and appraisee before the appraisal interview and the timescales; Have examined the appraisal process and what supporting information should be included under each section in terms of evidence; Have explored the

role of the appraiser and the skills required to conduct an effective appraisal interview; Know how to complete the summary of appraisal form and PDP sections with the appraisee, using SMART objectives; Be able to handle difficult appraisals which may include: performance or capability issues; inadequate evidence; reluctance to agree the need for further development; health and probity issues and who to communicate concerns to within the Trust; Have practised the skills required to carry out appraisals by appraising a colleague(s) during the workshop.)

An Appraiser Forum has been established which meets quarterly and his chaired by Dr Santhana Kannan (Medical Appraisal Lead). Items that have been discussed include the following: improvements required on PReP system (both from an appraiser and appraisee perspective), reflection, discussions re appraiser feedback, PDP and SMART Objectives)

We would like to improve attendance at the Appraiser Forum by having a development programme that is valued by the group. There are issues of discussion that should make attendance of at least a proportion of the forum meetings mandatory.

A regional appraiser network has been established in parallel to the Responsible Officers network so that good practice and experience can be shared.

4.3 **Quality Assurance**

The Quality Assurance Process has three strands to it – the appraisal portfolio, the individual appraiser and the organisation.

For the appraisal portfolio an audit of 39 anonymised input forms and output forms has been undertaken by the RO (Medical Director), Associate Medical Directors and Medical Appraisal Lead. This audit reviewed electronic appraisal folders to provide assurance that the appraisal inputs (pre- appraisal declarations and supporting information) provided is available and appropriate; that the appraisal outputs (Personal Development Plan (PDP), summary and signoffs) are complete and to an appropriate standard and any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs.

The summary of the audit is contained in Appendix 2.

Each individual medical appraiser will be required to provide an annual record of their reflections as an appraiser on appropriate continuing professional developments and an annual record of their participation in appraisal calibration events such as reflection on Appraisal Forum meetings.

The Medical Appraisal process is all captured on the PReP IT system and before the appraisee is able to countersign the output form on PReP they have to complete the feedback questionnaire which includes ratings on how the appraisal was undertaken and the skills of the appraiser. It has been agreed that this feedback will be shared at the Appraisers Forum but will only be done so once there have been a sufficient number of appraisals undertaken to provide robust data and to minimise issues of confidentiality.

4.4 **Access, security and confidentiality**

The PReP system limits access of appraisal information to only those who need such access. The appraisee has access to their own appraisal inputs and outputs; an appraiser has access to their appraisees appraisal inputs and outputs. The RO has access to all the doctors appraisal input and outputs. The only others with access are the administrators of the PReP system (Head of Medical Staffing and Business Manager to the Medical Director). The system is web based and has a high level of data security. All users of PReP have to sign an undertaking that the information is used and stored in accordance with Data Protection legislation and must not contain any patient identifiable data.

4.5 **Clinical Governance**

There is an expectation that individual Consultants and SAS Doctors should already be aware of the complaints and Serious Untoward Incidents (SUIs) that they have been involved in and that reflection on these should not be left until appraisal. It is recognised however that complaints and incident information is not always available to every Consultant and SAS Doctor so every quarter the Business Manager to the Medical Director provides the Risk Department with a list of doctors whose appraisal is due in the quarter so an individual summary containing the complaint and SUI information can be sent to those people being appraised (the appraiser is copied into this report too).

There have been occasions where the RO has chaired a Table Top Review (TTR) and as part of the outcomes of the TTR process a doctor has been required to ensure that their learning and reflections on the event have been captured on PReP. There is a specific section on PReP which asks the individual doctor to confirm whether or not they have been required by the RO to ensure that information is discussed at appraisal. This has to be completed and a failure to complete correctly would be seen as a potential disciplinary issue.

5 REVALIDATION RECOMMENDATIONS

5.1 During the period 1st April 2014 to 31st March 2015 there were 182 revalidation recommendations made to the GMC by the Trust. All of the recommendations were made on time. There were 182 positive recommendations, 7 deferral requests and 0 non engagement notifications.

5.2 The revalidation recommendations are usually made no later the third week of the preceding month and there is a robust process managed by the Business Manager to the Medical Director to ensure timescales are always kept to. The Head of Medical Staffing and the Business Manager to the Medical Director work together to action the recommendations jointly on behalf of the Medical Director. The Head of Medical Staffing and/or the Business Manager to the Medical Director escalate any concerns to the Medical Director.

6 RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

6.1 All staff employed by SWBH undergo the necessary pre-employment checks in accordance with NHS Employers and Trust policy.

6.2 All locums engaged via locum agencies are procured via either the Health Trust Europe (HTE) or Crown framework agreements which have a stringent requirement on pre-employment checks and are independently audited to ensure compliance. Every locum booked via an agency would have been first screened by a Consultant in the specialty to ensure that the qualifications and experience are suitable for the post. Agency locum recruitment is now managed by the Trust Bank

7 MONITORING PERFORMANCE

7.1 The RO and Head of Medical Staffing meet regularly and as part of that meeting issues relating to doctors performance are routinely discussed. There is also a monthly Decision Making Group which is attended by the RO, Associate Medical Directors, Deputy Director of Workforce, Deputy Director of Governance, Head of Medical Staffing and Business Manager to the Medical Director where a summary of current concerns is presented. There is a detailed discussion of the approach being taken in each case and challenge is encouraged to ensure the RO is managing the issues appropriately. New concerns or issues are also raised at this meeting. The Deputy Director of Governance has the opportunity to bring to the group's attention any issues with complaints data, SUI data, trends etc that might indicate poor practice or learning and development needs of individual doctors and/or teams.

7.2 The RO and Head of Medical Staffing meet the GMC Employer Liaison Adviser every quarter and the current GMC issues with our doctors are discussed. This meeting also provides the RO with the opportunity to discuss any other matters that have not yet been notified to the GMC or are low level concerns.

7.3 The RO regularly discusses clinical outcome data with Group Directors and Clinical Directors and areas of concern or further investigation are identified.

8 RESPONDING TO CONCERNS AND REMEDIATION

8.1 Where there are concerns raised then the Trust Disciplinary Policy for Medical Staff is used (this incorporates the national framework Maintaining Higher Professional Standards in the NHS (MHPS) document). The policy covers the process for dealing with issues relating to doctors conduct, capability and health. This policy also outlines the process for exclusion of a doctor.

8.2 An important component of responding to concerns is effective investigation. A need has been identified for more people to be trained in case investigation within the Trust. The aim is for all the Associate Medical Directors and Group Directors to be trained along with a number of HR Managers. A number have now been trained and Case Investigators will now have more specialised support from the Case Investigation Unit.

8.3 The processes within the disciplinary policy are well established however more work is required to develop remediation, re-skilling and rehabilitation options within the Trust.

8.4 The RO and Head of Medical Staffing have established good links with the National Clinical Assessment Service (NCAS), GMC (via the aforementioned Employers Liaison service) and Capsticks the Trust's solicitors to obtain specialist advice when concerns are raised.

9 DEVELOPMENTS REQUIRED/ NEXT STEPS

9.1 The medical appraisal and revalidation systems within the Trust have worked effectively since revalidation was introduced in 2012. The main areas to be developed now are:

- Further Appraiser development and improvement: through ongoing training, reflection, feedback and performance review. The Appraisal Forum needs to be integral to this improvement process and attendance at the forum must become a mandatory requirement for ongoing status as a medical appraiser.
- Develop processes for remediation, re-skilling and rehabilitation of doctors within the Trust;
- Explore the possibility of greater patient involvement in the medical appraisal process over and above the patient feedback exercises.
- Raise awareness amongst SAS Doctors and other non-consultant grades regarding appraisal and revalidation

10 RECOMMENDATIONS

10.1 To accept this report and to note that it will be shared (along with the annual audit) with the higher level RO.

10.2 To approve the `statement of compliance' confirming that the Trust, as a designated body, is in compliance with the regulations (see Appendix 4).

10.3 To agree that a report on medical revalidation be presented to the Trust on an annual basis

Dr Roger Stedman
Medical Director
25 June 2015

APPENDICES:

Appendix 1 – Summary of Missed or Incomplete appraisals 2014-15

Appendix 2 – Quality assurance audit of appraisal inputs and outputs 2014-15

Appendix 3 – Audit of revalidation recommendations 2014-15

Appendix 4 – Statement of Compliance

Appendix 1 Summary of missed or incomplete appraisals 2014-15

Audit of all missed or incomplete appraisal in period 1 April 2014 -31 March 2015

Doctor factors [total]	**Number**
Maternity leave during the majority of the 'appraisal due window'	0
Sickness absence during the majority of the 'appraisal due window'	0
Prolonged leave during the majority of the 'appraisal due window'	0
Suspension during the majority of the 'appraisal due window'	0
New starter within the 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio/insufficient supporting information	7
Appraisal outputs not signed off by the doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors	78
Appraiser factors	
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors [describe]	0
[describe]	0
Organisational factors	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors [describe]	0
Total	**85**

Quality assurance audit of appraisals inputs and outputs 2014-15

Total number of appraisals completed		Number
	Number of appraisal portfolios sampled [to demonstrate adequate sample size]	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs	39	
Scope of work: has a full scope of practice been described.		39
Continuing Professional Development [CPD]: Is CPD compliant with GMC requirement?		38
Quality improvement activity: Is quality improvement activity compliant with GMC requirement?		37
Patient feedback exercise: Has a patient feedback exercise been completed?		39
Colleague feedback exercise: Has a colleague feedback exercise been completed?		39
Review of complaints: Have all complaints been included?		39
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?		39
Is there sufficient supporting information from all the doctor's role and places of work?		39
Has any patient identifiable evidence been submitted		0
Is the portfolio sufficiently completed for the stage of the revalidation cycle year [year 1 to year 4]		39
Appraisal Outputs	39	
Appraisal summary present		34
Appraisal statements present		30
PDP (3- 6 targets set)		34
PDP containing SMART objectives		28

Audit of revalidation recommendations

Revalidation recommendation between 1 April 2014 to 31 March 2015	**Number**
Recommendations completed on time [within the GMC recommendation window].	182
Late recommendations [completed, but after the GMC recommendation window closed]	0
Missed recommendations [not completed]	0
TOTAL	182
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified.	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resource or support for the responsible officer role	0
Other	0
Describe other	
TOTAL [sum of [late] + [missed]	0

SWBTB (7/15) 110 (e)

Appendix 4 – Statement of Compliance

Designated Body Statement of Compliance

The board/executive management team –[delete as applicable] of [Insert official name of designated body] has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments:

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments:

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments:

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments:

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments:

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments:

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

[1]Doctors with a prescribed connection to the designated body on the date of reporting.

Comments:

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments:

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Comments:

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments:

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

[2]Doctors with a prescribed connection to the designated body on the date of reporting.

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 July 2015

EXECUTIVE SUMMARY:

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

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

Data accuracy continues to be a concern with three wards having vastly high reported fill rates which are not the reality of staffing on those wards. The TDA will be helping the trust to explore these variances during July, and I expect to be able to report on any findings at the August Board meeting. Overall we are slightly closer to 100% across the trust, although almost all wards have a slightly higher fill rate from their planned nurse staffing rosters

Quality indicators are presented in the appendices in the same manner as last month's Board meeting for consistency and to demonstrate how we use these data in the governance processes at Group level.

REPORT RECOMMENDATION:

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

FOR INFORMATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAFE NURSE STAFFING

Report to Trust Board on 2nd July 2015

1 EXECUTIVE SUMMARY

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

1.2 Data accuracy continues to be checked by the information team and the Group Directors of Nursing but we are failing to identify the root cause of the high fill rates the system is reporting.

1.3 Last month I reported that I had brought to the attention of the TDA nuances about how data came out of the safer staffing system. Currently we are inputting data correctly from the information we have tested with them. The TDA have offered to come to the trust to check and test this out with us, this I have welcomed and initial work with them is scheduled for 8th July.

1.3 Ward based quality data is supplied in the same manner as the previous month for consistency.

2 MAY 2015 POSITION

Table 1. is the output data from the national data collection for May 2015 which demonstrates that we achieve higher fill rates against our rota's in most areas although slightly closer to 100%.

Table 2 gives the individual ward data. The ward quality indicators are presented in appendices 1 to 3. There is a nuance in the data for D5, Newton 5 and Lyndon ground wards where the Healthcare Assistant night shift fill rate is vastly over 100% and is not fully explainable by exploring the e-rostering system where the base data is derived. These percentages don't fit with our understanding of how these wards have been staffed during May 2015.

Last month I reported a positive variation in the staffing of the Eye ward, this has been brought into control.

Table 1.

	Safe Staffing data return - Summary (May 15)		Day				Night							
			Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Day		Night	
	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 (%)
	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%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Jan-15	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%
	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%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Feb-15	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%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2353.25	2352.417	501.5	447	573.5	565.25	148	139.5	100.0%	89.1%	98.6%	94.3%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Mar-15	RXK02	CITY HOSPITAL	29823.73	30744.15	16727.5	15515.32	18670	21136.23	7507.5	7752	103.1%	92.8%	113.2%	103.3%
	RXK10	ROWLEY REGIS HOSPITAL	2702.5	3084.9	3546.75	3896.583	1211.5	1717.75	1670.5	2067	114.1%	109.9%	141.8%	123.7%
	RXK01	SANDWELL GENERAL HOSPITAL	28133.5	30365.28	15989.5	17373.25	15995	20147.07	7760.517	10975.02	107.9%	108.7%	126.0%	141.4%
			63013	66547	36765	37232	36450	43566	17087	20934	105.6%	101.3%	119.5%	122.5%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1502	1941	305.5	396.25	444	536.5	92.5	101.75	129.2%	129.7%	120.8%	110.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Apr-15	RXK02	CITY HOSPITAL	30171.5	31776.33	16684	15468.25	18810.5	20221.75	7285.5	8325	105.3%	92.7%	107.5%	114.3%
	RXK10	ROWLEY REGIS HOSPITAL	2614	2568.5	3772	3448.067	1116.5	1351.5	1763	1778	98.3%	91.4%	121.0%	100.9%
	RXK01	SANDWELL GENERAL HOSPITAL	27100	29153.3	15850.25	17460.35	16443.5	18445.28	7508	10431.5	107.6%	110.2%	112.2%	138.9%
			61388	65439	36612	36773	36815	40555	16649	20636	106.6%	100.4%	110.2%	123.9%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2034.5	1941	434	402.25	573.5	527.25	138.75	138.75	95.4%	92.7%	91.9%	100.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
May-15	RXK02	CITY HOSPITAL	32094.5	32675.33	16822.25	16256	19465	21176.25	7493	8437	101.8%	96.6%	108.8%	112.6%
	RXK10	ROWLEY REGIS HOSPITAL	2645.5	2576.067	3508.5	3169.083	1083.5	1475.067	1842.5	2033	97.4%	90.3%	136.1%	110.3%
	RXK01	SANDWELL GENERAL HOSPITAL	26561	27802.15	15591.5	17242.17	16839	17383.17	8199.5	10655	104.7%	110.6%	103.2%	129.9%
			63336	64995	36356	37070	37961	40562	17674	21264	102.6%	102.0%	106.9%	120.3%
	RXK03	*BIRMINGHAM MIDLAND EYE CENTRE (BMEC)*	*1963.25*	*2078.139*	*413.6667*	*415.1667*	*530.3333*	*543*	*126.4167*	*126.6667*	108.2%	103.8%	103.8%	101.4%
3-month	*RXKTC*	*BIRMINGHAM TREATMENT CENTRE*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0.0%	0.0%	0.0%	0.0%
Avges	*RXK02*	*CITY HOSPITAL*	*30696.58*	*31731.94*	*16744.58*	*15746.52*	*18981.83*	*20844.74*	*7428.667*	*8171.333*	103.4%	94.0%	109.8%	110.0%
	RXK10	*ROWLEY REGIS HOSPITAL*	*2654*	*2743.156*	*3609.083*	*3504.578*	*1137.167*	*1514.772*	*1758.667*	*1959.333*	103.3%	97.2%	133.0%	111.6%
	RXK01	*SANDWELL GENERAL HOSPITAL*	*27264.83*	*29106.91*	*15810.42*	*17358.59*	*16425.83*	*18658.51*	*7822.672*	*10687.17*	106.7%	109.8%	113.8%	136.8%
	Total	*Latest 3 month average====>*	62579	65660	36578	37025	37075	41561	17136	20945	104.9%	101.2%	112.2%	122.3%

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 May 2015	Percentage night time fill rate during May 2015		Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during May 2015	Percentage night time fill rate during May 2015
Medicine & Emergency care	D5	City	13	5	5	5	101.3	127.1		1	1	0	94.6	745.7
	D7	City	19	3	3	3	joint with	D5		1	1	0	Joint with	D5
	D11	City	21	3	3	3	107.7	119.4		2	2	1	98.4	104
	D12	City	10	2	2	2	98.4	75		1	1	1	76.7	88
	D15	City	24	3.5	3.5	3	120	119.6		2	2	1	108.4	162.6
	D17	City	25	3.5	3.5	3	111.4	87		2	2	1	98	123.5
	D26	City	21	3	3	3	94.6	84.7		2	2	1	76.3	107.7
	AMU 1	City	41	10	10	10	96.4	125.8		4	4	4	93.4	98.9
	AMU 2	City	19	5	5	5	105	130		1	1	1	91.2	103.2
	CCU Sandwell	Sandwell	10	3	3	3	108.8	95.1		0	0	0	-	-
	PR4	Sandwell	25	7	7	7	97.9	88.4		3	3	3	116.2	140.8
	PR5	Sandwell	34	5	5	4	105.7	98.8		3	3	2	96.6	134.6
	NT4	Sandwell	28	4	4	4	139.2	139.7		3	3	3	190	273.3
	LY 4	Sandwell	34	5	5	4	134	118.8		3	3	2	111.9	139.6
	LY5	Sandwell	29	4	4	4	87.8	84.3		4	4	2	82.7	86.3
	N5	Sandwell	15	5	5	2	103.1	98.4		1	1	1	66.9	520
	AMU A	Sandwell	32	11	11	11	108.5	104.4		4	4	3	109.1	107.5
	AMU B	Sandwell	20	3.5	3.5	3	108.2	108.2		3	3	3	112.5	121.4

	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 May 2015	Percentage night time fill rate during May 2015		Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during May 2015	Percentage night time fill rate during May 2015
Surgery A	D21	City	23	4	4	2	103.9	107.4		2	2	2	76.4	90.1
	D25	City	19	4	4	2	80.1	100		2	2	2	98.7	113.9
	SAU	City	14	4	4	3	98.7	117.9		1	1	1	119.5	130.4
	N2	SGH	24	4	4	2	110.5	110.7		2	2	1	92.7	153.8
	L2	SGH	20	6	6	4	96.6	92.5		3	3	2	105.2	100
	P2	SGH	20	5	5	3	99.3	106.3		4	4	3	115	158.5
	N3	SGH	33	5	5	3	113.1	146.6		4	4	3	126.2	120.3
	L3	SGH	33	5	5	3	95.1	94.5		4	4	3	96.4	91.4
	CCS	City		Staff flexed to the dependency/number of patients in the units			99.7	101.3		Staff flexed to the dependency/number of patients in the units			97.7	-
	CCS	SGH					98.4	98.6					108.5	-

	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 May 2015	Percentage night time fill rate during May 2015		Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during May 2015	Percentage night time fill rate during May 2015
Community & Therapies	Henderson	RH	24	3	3	2	101.3	168.5		3.5	3.5	2.5	86	101.2
	Elisa Tinsley	RRH	24	3	3	2	90.6	110		3.5	3.5	2.5	88	127.9
	D43	City	24	6	6	4	113.4	164.4		5	5	2	103.9	111.2
	Leasowes	RH	20	3	3	2	102.7	147.1		3	3	2	98	106.7

	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 May 2015	Percentage night time fill rate during May 2015		Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during May 2015	Percentage night time fill rate during May 2015
Surgery B	Eye ward	City	10	2	2	2	95.4	91.9		1	1	0	92.7	100

	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 May 2015	Percentage night time fill rate during May 2015		Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during May 2015	Percentage night time fill rate during May 2015
Womens & Children's	L G	SGH	14	3	3	2	111.7	87		1	1	1	132.4	400
	L1	SGH	26	5	5	4	106.4	143.1		3	3	2	131.5	127.9
	D19	City	8	3	3	2	104.3	102		1	1	0	123.1	-
	D27	City	18	4	3	2	91.5	92.4		2	2	1	105.9	186.1
	Maternity	City	42	6	5	4	99.8	96.9		4	4	2	102.2	93.3

3 RECOMMENDATION(S)

3.1 To publish patient to RN ratios 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 August Trust Board meeting

Colin Ovington

Chief Nurse

25th June 2015

Appendix 1 – Community & Therapy ward quality indicators

Overview of June findings:

Ward	Positive results	Areas for improvement	Key actions
Leasowes	• Safety audits – 100% compliance • Compliments av. 17.5 per month; No complaints. • FFT 100% recommended • Hygiene – ^100% hand hygiene and 100% ward cleanliness • Mandatory training 95%; PDR's 96%	• Avoidable PU's 3 in last 12 months *, none since March. • Staff sickness remains high @15.34% (12.7% STS) • Use of temp staffing to cover vacancies (5.37) and sickness	• Continue to reduce staff sickness • Recruit to outstanding vacancies – some post awaiting commencement now.
D43	• No complaints • Avoidable PU's- 0 for 4 months • FFT results 89% recommended • Low number of falls related incidents	• Safety audits two result below 100%; missed dose 90%, obs chart 98%. • March ward cleanliness remains at 85% • Staff sickness –ᵛ 5.71 total, 11.0% LTS^ • Use of temporary staffing – having to cover D47 and vacancies • Mandatory training data not available • PDR's ^75% (68%)	• Work continues with estates & facilities to improve ward cleanliness compliance. Kitchen has been refurbished. • Recruit to vacancies • Reduce sickness rates • Discussions continue with CCG re future for D47 and care model • To increase PDR's and mandatory training rates
D47	• Safety audits 100% compliance but missed dose audit result missing • No complaints • FFT 100% recommended	• Use of temporary staffing	• Improve systems for monitoring and reporting compliance with the required standards
ET	• Improved drugs storage compliance to 100% • Avoidable PU's- 0 for 6 months • MRSA screening 100% • Use of focussed care -	• Safety audits 4 not achieving 100% compliance o Fluid balance 75% o Pain 70% o Missed dose	• Improve consistency of compliance with safety requirements as increase in number not achieving 100% • Recruit to vacancies • Discussions continue to agree future model of care

	0	medicines 80% o Observations charts 80% • Staff sickness no data this month • Mandatory training ˅ 75% • PDR 58%	for McCarthy /ET with CCG so ongoing use of temporary staffing • Review of re-admissions underway
Henderson	• FFT 100% recommended • Drug storage ^100% (60%) • IPC audit - 100% • No avoidable pressure damage	• Safety audits compliance – three areas for improvement o Missed dose medications 80% o Fluid balance 90% o Pain 90% • Staff sickness results not available • Mandatory training 84% • PDR's 60% • Complaints – 1	• Address compliance with patient safety documentation compliance • Increase compliance with mandatory training and PDR's with the completion of recruitment to vacancies.
Community - The icares Directorate are currently developing the community nursing dashboard; this will be an electronic version that will be accessible on desk tops. Once available this will be reported, it is expected by end of Q2 2015. It may be possible in future to roll out the electronic version to our in-patient areas.			

*Data prior to completion of avoidability template and decision made by TVS based on incident reported detail

2.0 Ward Reviews

No results to report at time of submission as awaiting reported on reviews completed in June.

Ward reviews are now on quarterly programme to be phased throughout 15-16 unless concerns are identified:

Ward	**Due date**	**Reported**	**Due date**	**Reported**	**Due date**	**Reported**	**Due date**	**Reported**
D43	June		Sept		Nov		Jan	
D47	June		Sept		Nov		Jan	
ET	July		Oct		Dec		Feb	
Henderson	July		Oct		Dec		Feb	
Leasowes	July		Oct		Dec		Feb	

3.0 Other

The general risks for the group are:

- The current levels of vacancy continue across both in-patient areas and community teams, but with some appointments awaiting commencement. Despite continued recruitment efforts not all posts have been filled and repeat advertisements are pursued with Band 5 nurses being the most difficult to fill. This has been exacerbated by maternity leave with no backfill agreement for community posts. The high level of vacancy has negatively impacted upon other parameters of workforce indicators - staff sickness, PDR's and Mandatory training, especially for those areas where there is not ease of access to temporary staff cover.

- Time from offer of post to complete the recruitment process.

- Access to some mandatory training e.g. safeguarding training.

- Safer staffing community nursing – May and June are test months across all District Nursing Teams supporting full role out of dependency tool following pilot in two teams. This will identify patient dependency and required staffing to deliver safe care.

- Time taken to complete required audits and dashboards as not automated from the various data sources.

Appendix 2 – Medicine and Emergency Care

Appendix 3 – Surgery A

Appendix 2 - Medicine & Emergency care dashboard

Ward Clinical Teams - Quality, Safety and Patient Experience Dashboard

Leading the Culture of Compassionate Care

	Area	Unit	CITY								Sandwell								
			D11	D12	D15	D17	D26	AMU1	AMU2	D5	D7	L4	P4	N4	L5	N5	P5	CCU	AMU A	AMU B
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	95	100	100	100	77.5	100	100	100	100	90	100	100	100	100	100	100	100	100
	Nutrition Audit (MUST)	Score %	100	100	80	70	91	70	100	100	100	100	100	100	100	100	98	100	80	93.3
	Fluid Balance Audit	Score %	60	100	100	100	70	100	100	100	100	70	100	100	90	100	100	90	90	84.62
	Pain Audit (CQUIN)	Score %	100	100	100	100	100	100	100	100	100	80	100	100	100	100	100	100	100	76.79
	Safe storage of drugs audit	Score %	No data	100	no data	77.7	No Data	Not done	100	89	89	pass	82	100	100	No data	86	No data	93	94.74
	Compliance against drug safety cross	Score %	70.96	100	81	42	83.87	100	100	74	68	90	90.3	98	94	86	100	100	90	94.74
	Observation Chart Audit	Score %	98	99	100	100	99	Vitalpac	Vitalpac	99	99	81	96	100	100	100	100	100	90	76.79
	Falls Risk Assessment Audit	Score %	93.3	100	100	85	70	100	100	100	100	78.3	100	100	100	100	100	100	100	100
	Safety/Privacy & Dignity	Score %	100	100	100	93	100	100	100	100	100	90	100	100	93	100	100	100	80	0
	Pressure Ulcers Avoidable (none hospital acquired)	Score %	5	0	1	0	2	0	0	0	1	6	1	0	2	0	0	1	0	5
	Pressure Ulcers Avoidable (hospital acquired)	Score %	0	1	0	0	1	1	5	0	0	0	0	2	0	0	7	0	8	0
	Falls (target <) no harm	Score %	5	0	1	0	3	0	0	1	2	5	3	1	6	0	4	1	2	0
	Falls (target <) resulting in harm	Score %	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
	Dementia screening audit	Score %	100	100	N/A	25	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	Safety Thermometer (No new harm)	Score %	95.24	87.5	91.3	100	100	100	100	100	100	0	100	100	100	100	100	100	100	100
	Incidents Total (inc Falls)	No of	22	11	23	26	10	27	50	19	8	1	37	5	24	3	24	44	58	25
	Incidents (red)	No of	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Incidents (amber)	No. of	0	0	0	2	0	1	3	0	4	3	0	0	4	0	0	3	7	3
	PALS Queries	No of	0	0	0	1	1	0	0	1	0	0	1	0	0	1	0	0	0	0
	Compliments	No. of	5	7		4	6	0	0	5	3	4	22	24	6	15	24	1	5	8
	Complaints	No. of	1	0	3	0	1	0	0	0	0	0	1	0	0	1	1	0	1	2
	Likely to/Extremely Likely to Recommend our Hospital	Score (%)	96.97	100	100	50	97.5	94.29	95.24	96	100	90	91	100	30/34	89	85	88.46	79	93
	Mixed Sex Breaches	No. of	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	10/10 Standard	Score (%)	100	100	0	0	100	100	100	100	100	Compliant	100	100	93	100	100	100	100	100
Infection Prevention and Control	MRSA	Total Eligible Screened within 28 days (%)	0	0	0	0	1	0	0	95	100	0	0	0	0	0	72	97.22	93	94.7
	C Diff	No. of	0	0	0	0	0	0	0	0	0	2	0	0	0	1	0	0	0	0
	E-Coli	No. of Bloodstream	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		No. of Bloodstream YTD	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Hand Hygiene	Score (%)	97	97	98		100	Variable, done daily	94	Not done	Not done	100	100	100	98	100	91	82	100	90
	ESBL	Score (%)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	VRE	No of	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
	Ward Cleanliness	Score (%)	100	100	91	39	100	No issues. Daily inspections since TDA report	No issues. Daily inspections since TDA report	52	45	pass	100	100	100	100	100	No data	100	100
	Compliance against environmental standards	Score (%)	100	87.45	no data	76	100	100	100	58	68	pass	83	98	100	100	92	No data	100	No data
	Outbreaks	No. of	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
	Post infection reviews	No. of	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	N/A	0	0
	Cannulas (VIP), (CAUTI's)	Score (%)	96	100	47	70	100	70	93.4	100	100	59.62	100	100	96	100	90	100	84	85.71
Patient Flow	No of days daily discharge goals achieved No of days where 16 beds are available at 9pm (AMUs)	No. of	10	20	18	10	4	Data not collected until June 2015	Data not collected until June 2015	15	42%	no data	0	5	No data	13	14	17	No data	No data
	No of days where patient discharged before lunch	No. of	8	2	20	20	4	Data not collected until June 2015	Data not collected until June 2015	13	6	no data	3	3	No data	7	5	15	No data	No data
Staffing	Vacancies Band 7	No. of	0	0	0	1	0	0	0	1	1	0	0	0	0	0	0	0	0	0
	Vacancies Band 6	No. of	0	0	0	1	0	0	0	3.02	3.02	0	1	1	0	0	0	0.5	0	0
	Vacancies Band 5	No. of	4.73	1.58	5.31	6.88	4.81	0	5.61	2.6	2.6	10.5	0	0	4.35	0	4	0	5	5
	Vacancies Band 2	No. of	3.83	0.2	0	0	3.14	0	0	0	0	0	4	2	0	0.4	0	0.24	0	-0.92
	Sickness long term	%	2.75	8.33	4.26	0	4.52	2.25	2.39	0	0	4.2	0	0	5.56	3.05	5.21	6.2	4.21	0
	Sickness short term	%	2.57	4.81	2.77	3.5	3.47	1.27	2.13	6.5	6.5	13.53	2.11	3.2	3.6	0.56	6.82	2	1.87	34.6
	Sickness total	%	5.32	17.07	8.25	3.71	7.98	3.51	4.52	6.5	6.5	17.73	4.57	3.2	9.16	3.61	9.46	8.2	6.08	34.6
	No of specials used	No. of	2.32	0	0	49	1.2	0	0	0	3	78	163	160 hrs	0	0	13.8	0	0	0
	Is the ward compliant with Erostering rules?	Y/N?	Y	Y	Y	Y	Y	Y	Y	Y	Y	y	Y	Y	Y	Y	Y	Y	Y	Y
	Brad Score		40.54	a/w data	a/w data	No data	39.31	N/A	N/A	Not complete	Incomplete	No data	51.6	35.6	No data	No data	91.86	100	n/a	n/a
	PDR %	%	100	85.71	68	59.26	93.1	91.26	91.26	No data	No data	100	100	100	80	92	95	100	87.36	100
	Mandatory Training %	%	92	85.71	81.62	81.45	79.82	83.54	89.53	93	93	79	80.51	88.2	80	95.07	79	92.41	68.53	82.2
Finance	Is the ward in budget? (Record overall position)	Y/N	No data	no data	no data	no data	No data	N	N	N (-£19,712)	N (-£19,712)	N	Awaiting report	Awaiting 2015/16 report	N	Y	Awaiting new report 2015/16	N (-£16,322)	Y	Y
	Did monthly finance meeting take place?	Y/N	N	N	N	N	N	N due to recommence in June 2015	N due to recommence in June 2015	N	N	N	N	N	N	N	N	N	N	Y

WARD ASU

Leading the Culture of Compassionate Care

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%										100%
	Nutrition Audit (MUST)	Score %	100%	96%	100%										99%
	Documentation Audit	Score %	95%	99%	96%										97%
	Fluid Balance Audit	Score %	100%	100%	100%										100%
	Pain Audit (CQUIN)	Score %	100%	100%	100%										100%
															#DIV/0!
	Missed Dose Audit	Score %	100%	100%	100%										100%
	Medications Audit	Score %	100%	100%	100%										100%
	Drugs Storage	Score %	100%	80%	90%										90%
	CD Audit	Score %	100%	100%	90%										97%
	Falls Risk Assessment Audit	Score %	100%	100%	100%										100%
	Safety/Privacy & Dignity	Score %	100%	100%	100%										100%
	Pressure Ulcers Avoidable	No. of	0	0	0										0
	Pressure Ulcers Unavoidable	No.of	0	0	0										0
	Falls (target =0)	No. of	0	0	0										0
															#DIV/0!
															#DIV/0!
															#DIV/0!
	10 Out of 10	Score %	90%	90%	90%										90%
	Incidents Total (inc Falls)	No of	7	2											9
	Incidents (red)	No of	1	0	0										1
	Incidents (amber)	No. of	0	0	0										0
Patient Experience	PALS Queries	No of	0	0	0										0
	Compliments	No. of	4	6											10
	Complaints	No. of	0	0											0
	Patient Experience	Score (%)													#DIV/0!
	FFT Overall Results	Score (%)	100%	94.93%											97.47%
	FFT Reponse Rate	Score (%)	119%	100.00%											109.50%
	Mixed Sex Breaches	No. of	0	0	0										0
Infection Prevention and Control	MRSA	Screening % Emergency	95.20%	98.67%											96.94%
		No. of Bloodstream	0	0											0
		No. of Clinicals	0	0	0										0
	C Diff	No. of	0	0	0										0
	MSSA	No. of Bloodstream	0	0	0										0
	E-Coli	No. of Bloodstream	0	0	0										0
	Hand Hygiene	Score (%)	100%	100.00%	100.00%										100.00%
	Ward Cleanliness	Score (%)	99%	98.00%											98.50%
	Outbreaks	No. of	0	0	0										0
	Cannulas (VIP)	Score (%)	95%	100.00%	100.00%										98.33%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	1.6WTE	1.0WTE	1.0WTE	0WTE									
	Sickness in Month with Trajectory of management	ST/LT Added Together %	12.99%	16.04%											14.52%
	Sickness long term	%	10.14%	11.44%											10.79%
	Sickness short term	%	2.84%	4.60%											3.72%
	Did monthly HR meeting take place?	Y/N	no	NO	no										
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	83	225											154
		No. of HCA's in Hrs	8	8											8
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	yes	YES	YES										
	PDR %	%	100.00%	92.00%											96.00%
	Mandatory Training % by Month	%	96.65%	95.65%											96.15%
	Uniform Audit	%	75.00%	100.00%	100.00%										91.67%
Finance	Is the ward in budget? This month, last month, projection	Y/N	yes	YES	YES										
	Did monthly finance meeting take place?	Y/N	no	NO	NO										

WARD D21

Leading the Culture of Compassionate Care

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	96%	98%	94%										96%
	Nutrition Audit (MUST)	Score %	100%	100%	100%										100%
	Documentation Audit	Score %	95%	94%	96%										95%
	Fluid Balance Audit	Score %	83%	93%	88%										88%
	Pain Audit (CQUIN)	Score %	100%	100%	100%										100%
	Protected Meal Time Audit	Score %	100%	100%	100%										100%
	Missed Dose Audit	Score %	100%	100%	100%										100%
	Medications Audit	Score %	100%	100%	100%										100%
	Drugs Storage	Score %	100%	100%	100%										100%
	CD Audit	Score %	90%	100%	100%										97%
	Falls Risk Assessment Audit	Score %	96%	94%	100%										97%
	Safety/Privacy & Dignity	Score %	100%	100%	100%										100%
	Pressure Ulcers Avoidable	No. of	0	0											0
	Pressure Ulcers Unavoidable	No.of	0	0											0
	Falls (target =0)	No. of	1	1											2
	Dementia screening audit results	Score %	100%	100%	100%										100%
	Safety Thermometer (No new harm)	Score %	100%	100%											100%
		No. of Harms	0	0											0
	10 Out of 10	Score %	100%	100%											1
	Incidents Total (inc Falls)	No of	14	10											24
	Incidents (red)	No of	0	0											0
	Incidents (amber)	No. of	0	0											0
Patient Experience	PALS Queries	No of	1	0											1
	Compliments	No. of	11	14											13
	Complaints	No. of	1	0											1
	Patient Experience	Score (%)	93%	96%											94%
	FFT Overall Results	Score (%)	93%	96%											95%
	FFT Reponse Rate	Score (%)	26%	31%											29%
	Mixed Sex Breaches	No. of	0	0											0
Infection Prevention and Control	MRSA	Screening % Emergency	100%	100%											100%
		Screening % Elective	100%	100%											100%
		No. of Bloodstream	0	0											0
		No. of Clinicals	0	0											0
	C Diff	No. of	0	0											0
	MSSA	No. of Bloodstream	0	0											0
	E-Coli	No. of Bloodstream	0	0											0
	Hand Hygiene	Score (%)	78%	100%											89%
	Ward Cleanliness	Score (%)	68%	99%											83.50%
	Outbreaks	No. of	0	0											0
	Cannulas (VIP)	Score (%)	96%	97%											97%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	1	1											
	Sickness in Month with Trajectory of management	ST/LT Added Together %	4.76%	3.21%											3.99%
	Sickness long term	%	4.07%	0.00%											2.04%
	Sickness short term	%	0.69%	3.21%											1.95%
	Did monthly HR meeting take place?	Y/N	y	N	y										
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	0	0											0
		No. of HCA's in Hrs	0	0											0
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	y	y	y										
	Brad Score	Reccommended	29.64	29.75											
		Actual	24.79	23.57											
		Budgeted	25.64	25.64											
	PDR %	%	100%	96.00%											98%
	Mandatory Training % by Month	%	99.74%	100%											99.87%
	Uniform Audit	%	100%	100%											100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	y	Y											
	Did monthly finance meeting take place?	Y/N	n	n											

Leading the Culture of Compassionate Care

WARD D25

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%										100%
	Nutrition Audit (MUST)	Score %	100%	100%	100%										100%
	Documentation Audit	Score %	100%	90%	99%										96%
	Fluid Balance Audit	Score %	97%	88%	100%										95%
	Pain Audit (CQUIN)	Score %	100%	100%	100%										100%
	Protected Meal Time Audit	Score %	100%	97%	100%										99%
	Missed Dose Audit	Score %	100%	100%	100%										100%
	Medications Audit	Score %	100%	100%	100%										100%
	Drugs Storage	Score %	100%	100%	100%										100%
	CD Audit	Score %	100%	95%	100%										98%
	Falls Risk Assessment Audit	Score %	100%	100%	100%										100%
	Safety/Privacy & Dignity	Score %	100%	100%	100%										100%
	Pressure Ulcers Avoidable	No. of	0	0	0										0
	Pressure Ulcers Unavoidable	No.of	0	0	0										0
	Falls (target =0)	No. of	0	1	0										1
	Dementia screening audit results	Score %	100%	100%	100%										100%
	Safety Thermometer (No new harm)	Score %	100%	100%	100%										100%
		No. of Harms	0	0	0										0
	10 Out of 10	Score %	100%	78%	100%										93%
	Incidents Total (inc Falls)	No of	0	0											0
	Incidents (red)	No of	0	0	0										0
	Incidents (amber)	No. of	0	0	0										0
Patient Experience	PALS Queries	No of	0	0	0										0
	Compliments	No. of	9	14											23
	Complaints	No. of	0	0	0										0
	Patient Experience	Score (%)	100%	100%											100.00%
	FFT Overall Results	Score (%)	96%	94%											95%
	FFT Reponse Rate	Score (%)	61%	60%											61%
	Mixed Sex Breaches	No. of	0	0	0										0
	MRSA	Screening % Elective	100%	100%	100%										100%
		No. of Bloodstream	0	0	0										0
		No. of Clinicals	0	1	1										2
	C Diff	No. of	0	0	0										0
	MSSA	No. of Bloodstream	0	0	0										0
	E-Coli	No. of Bloodstream	0	0	0										0
	Hand Hygiene	Score (%)	91%	97%	100.00%										96%
	Ward Cleanliness	Score (%)	99%	88%											93.50%
	Outbreaks	No. of	0	0	0										0
	Cannulas (VIP)	Score (%)	100%	100%	100.00%										100%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	1	1	2										
	Sickness in Month with Trajectory of management	ST/LT Added Together %	10.55%	13.35%											11.95%
	Sickness long term	%	9.82%	11.90%											10.86%
	Sickness short term	%	0.73%	1.46%											1.10%
	Did monthly HR meeting take place?	Y/N	Y	N	y										
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	209.1												209
		No. of HCA's in Hrs	22.8												23
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y	Y										
	Brad Score	Reccommended	29.29	26.70											
		Actual	27.54	25.76											
		Budgeted	29.41	29.41											
	PDR %	%	96.55%	96.55%	96.55%										96.55%
	Mandatory Training % by Month	%	90.21%	91.42%											90.82%
	Uniform Audit	%	100%	100%	100.00%										100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	Y	Y	N										
	Did monthly finance meeting take place?	Y/N	N	N											

WARD Lyndon 2

Leading the Culture of Compassionate Care

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%										100%
	Nutrition Audit (MUST)	Score %	100%	100%	100%										100%
	Documentation Audit	Score %	79%	99%	89%										89%
	Fluid Balance Audit	Score %	93%	77%	100%										90%
	Pain Audit (CQUIN)	Score %	100%	100%	100%										100%
	Protected Meal Time Audit	Score %	100%	97%	100%										99%
	Missed Dose Audit	Score %	100%	88%	95%										94%
	Medications Audit	Score %	97%	95%	96%										96%
	Drugs Storage	Score %	80%	100%	100%										93%
	CD Audit	Score %	85%	90%	85%										87%
	Falls Risk Assessment Audit	Score %	100%	100%	100%										100%
	Safety/Privacy & Dignity	Score %	90%	97%	98%										95%
	Pressure Ulcers Avoidable	No. of	0	0	0										0
	Pressure Ulcers Unavoidable	No.of	2	0	0										2
	Falls (target =0)	No. of	2	0	1										3
	Dementia screening audit results	Score %	100%	100%	100%										100%
	Safety Thermometer (No new harm)	Score %	100%	100%	100%										100%
		No. of Harms	0	0	0										0
	10 Out of 10	Score %	87%	100%	100%										96%
	Incidents Total (inc Falls)	No of	25	8											33
	Incidents (red)	No of	0	0											0
	Incidents (amber)	No. of	1	0											1
Patient Experience	PALS Queries	No of	0	0											0
	Compliments	No. of	28	29											57
	Complaints	No. of	1	0											1
	Patient Experience	Score (%)	98%	100.00%											99%
	FFT Overall Results	Score (%)	55%	63%											59%
	FFT Reponse Rate	Score (%)	68%	58%											63.00%
	Mixed Sex Breaches	No. of	0	0											0
Infection Prevention and Control	MRSA	Screening % Emergency	91%	85.71%											88%
		No. of Bloodstream	0	0											0
		No. of Clinicals	0	0											0
	C Diff	No. of	1	0											1
	MSSA	No. of Bloodstream	0	0											0
	E-Coli	No. of Bloodstream	0	0											0
	Hand Hygiene	Score (%)	62%	78.00%											70%
	Ward Cleanliness	Score (%)	95%	95.00%											95.00%
	Outbreaks	No. of	0	0											0
	Cannulas (VIP)	Score (%)	83%	90.00%	100.00%										91%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	3.01.	3.01.	3.01.										#DIV/0!
	Sickness in Month with Trajectory of management	ST/LT Added Together %	11.56%	7.31%											9.44%
	Sickness long term	%	6.06%	5.60%											5.83%
	Sickness short term	%	5.50%	1.70%											3.60%
	Did monthly HR meeting take place?	Y/N	Y	Y											
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	82.8	62.5											73
		No. of HCA's in Hrs	260.8	47.8											154
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y											
	Brad Score	Reccommended	33.63.	32.65.											
		Actual	25.76.	24.08.											
		Budgeted	26.01.	26.01.											
	PDR %	%	88.89%	88.46%	92.31%										89.89%
	Mandatory Training % by Month	%	92.38%	92.33%	95.07%										93.26%
	Uniform Audit	%	100%	100.00%	100.00%										100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	N/A	N	N										
	Did monthly finance meeting take place?	Y/N	N	N											

Leading the Culture of Compassionate Care

WARD Lyndon 3

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	74%	92%											83%
	Nutrition Audit (MUST)	Score %	98%	100%											99%
	Documentation Audit	Score %	68%	80%											74%
	Fluid Balance Audit	Score %	89%	89%											89%
	Pain Audit (CQUIN)	Score %	100%	100%											100%
	Protected Meal Time Audit	Score %	93%	99%											96%
	Missed Dose Audit	Score %	98%	96%											97%
	Medications Audit	Score %	99%	100%											100%
	Drugs Storage	Score %	80%	80%											80%
	CD Audit	Score %	N/A	N/A											#DIV/0!
	Falls Risk Assessment Audit	Score %	95%	95%											95%
	Safety/Privacy & Dignity	Score %	97%	98%											98%
	Pressure Ulcers Avoidable	No. of	0	0											0
	Pressure Ulcers Unavoidable	No.of	0	0											0
	Falls (target =0)	No. of	0	0											0
	Dementia screening audit results	Score %	100%	100%											100%
	Safety Thermometer (No new harm)	Score %	100%	100%											100%
		No. of Harms	0	0											0
	10 Out of 10	Score %	100%	100%											1
	Incidents Total (inc Falls)	No of	0	3											3
	Incidents (red)	No of	0	0											0
	Incidents (amber)	No. of	0	0											0
Patient Experience	PALS Queries	No of	1	0											1
	Compliments	No. of	20	18											38
	Complaints	No. of	0	0											0
	Patient Experience	Score (%)	100%												100%
	FFT Overall Results	Score (%)	81%	98%											90%
	FFT Reponse Rate	Score (%)	60%	50%											55.00%
	Mixed Sex Breaches	No. of	0	0											0
	MRSA	Screening % Elective	100%	100%											100%
		No. of Bloodstream	0	0											0
		No. of Clinicals	0	0											0
	C Diff	No. of	0	0											0
	MSSA	No. of Bloodstream	0	0											0
	E-Coli	No. of Bloodstream	0	0											0
	Hand Hygiene	Score (%)	100%	67.50%											84%
	Ward Cleanliness	Score (%)	n/a	n/a											#DIV/0!
	Outbreaks	No. of	0	0											0
	Cannulas (VIP)	Score (%)	90%	93%											92%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	3	3											
	Sickness in Month with Trajectory of management	ST/LT Added Together %	5.67%	2.47%											4.07%
	Sickness long term	%	2.12%	0.00%											1.06%
	Sickness short term	%	3.55%	2.47%											3.01%
	Did monthly HR meeting take place?	Y/N	yes	yes											
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	0	0											0
		No. of HCA's in Hrs	0	0											0
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	y	y											
	Brad Score	Reccommended	41.11	40.06											
		Actual	34.56	33.36											
		Budgeted	38.98	38.98											
	PDR %	%	88.10%	81.40%											84.75%
	Mandatory Training % by Month	%	83.20%	83.20%											83.20%
	Uniform Audit	%	100%	100.00%											100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	y	y											
	Did monthly finance meeting take place?	Y/N	y	y											

Ward Newton 2

Leading the Culture of Compassionate Care

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%										100%
	Nutrition Audit (MUST)	Score %	100%	100%	98%										99%
	Documentation Audit	Score %	79%	94%	94%										89%
	Fluid Balance Audit	Score %	88%	93%	98%										93%
	Pain Audit (CQUIN)	Score %	100%	100%	100%										100%
	Protected Meal Time Audit	Score %	97%	100%	93%										97%
	Missed Dose Audit	Score %	94%	88%	90%										91%
	Medications Audit	Score %	100%	98%	99%										99%
	Drugs Storage	Score %	100%	100%	100%										100%
	CD Audit	Score %	95%	85%	95%										92%
	Falls Risk Assessment Audit	Score %	100%	98%	100%										99%
	Safety/Privacy & Dignity	Score %	100%	90%	96%										95%
	Pressure Ulcers Avoidable	No. of	0	0	0										0
	Pressure Ulcers Unavoidable	No.of	0	0	0										0
	Falls (target =0)	No. of	0	0	0										0
	Dementia screening audit results	Score %	100%	94%	100%										98%
	Safety Thermometer (No new harm)	Score %	100%	100%	100%										100%
		No. of Harms	0	0	0										0
	10 Out of 10	Score %	91%	94%	94%										1
	Incidents Total (inc Falls)	No of	0	0											0
	Incidents (red)	No of	0	0	0										0
	Incidents (amber)	No. of	0	0	0										0
Patient Experience	**PALS Queries**	No of	2	0											2
	Compliments	No. of	18	15											33
	Complaints	No. of	1	1	2										4
	Patient Experience	Score (%)													#DIV/0!
	FFT Overall Results	Score (%)	69%	98%											84%
	FFT Reponse Rate	Score (%)	14%	30%											22%
	Mixed Sex Breaches	No. of	0	0	0										0
	MRSA	Screening % Elective	93.14%	94.78%											94%
		No. of Bloodstream	0	0											0
		No. of Clinicals	0	0											0
	C Diff	No. of	0	0											0
	MSSA	No. of Bloodstream	0	0											0
	E-Coli	No. of Bloodstream	0	0											0
	Hand Hygiene	Score (%)	84%	61.00%											73%
	Ward Cleanliness	Score (%)	95%	79%											87%
	Outbreaks	No. of	0	0											0
	Cannulas (VIP)	Score (%)	89%	95.00%											92%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	2	2	2										
	Sickness in Month with Trajectory of management	ST/LT Added Together %	7.43%	9.15%											8.29%
	Sickness long term	%	6.40%	6.29%											6.35%
	Sickness short term	%	1.03%	2.86%											1.95%
	Did monthly HR meeting take place?	Y/N	y	N	N										
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	241	186											213
		No. of HCA's in Hrs	142	191											166
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	y	y	y										
	Brad Score	Reccommended	22.32	23.02											
		Actual	11.96	9.11											
		Budgeted	17.54	17.54											
	PDR %	%	63.64%	61.90%											62.77%
	Mandatory Training % by Month	%	82.81%	88.66%											85.74%
	Uniform Audit	%	100%	100.00%	100.00%										100.00%
Finance	Is the ward in budget? This month, last month, projection	Y/N	N	N	N										
	Did monthly finance meeting take place?	Y/N	N	Y	Y										

Leading the Culture of Compassionate Care

WARD Newton 3

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	98%	98%											98%
	Nutrition Audit (MUST)	Score %	96%	100%											98%
	Documentation Audit	Score %	94%	89%											92%
	Fluid Balance Audit	Score %	84%	75%											80%
	Pain Audit (CQUIN)	Score %	100%	100%											100%
	Protected Meal Time Audit	Score %	100%	100%											100%
	Missed Dose Audit	Score %	100%	100%											100%
	Medications Audit	Score %	100%	100%											100%
	Drugs Storage	Score %	100%	100%											100%
	CD Audit	Score %	100%	100%											100%
	Falls Risk Assessment Audit	Score %	90%	78%											84%
	Safety/Privacy & Dignity	Score %	83%	83%											83%
	Pressure Ulcers Avoidable	No. of	0	0											0
	Pressure Ulcers Unavoidable	No.of	0	0											0
	Falls (target =0)	No. of	0	0											0
	Dementia screening audit results	Score %	100%	100%											100%
	Safety Thermometer (No new harm)	Score %	96%	88%											92%
		No. of Harms	1												1
	10 Out of 10	Score %	100%	100%											1
	Incidents Total (inc Falls)	No of													0
	Incidents (red)	No of	0	0											0
	Incidents (amber)	No. of	0	0											0
Patient Experience	PALS Queries	No of	2	2											4
	Compliments	No. of	13	10											
	Complaints	No. of	0	0											0
	Patient Experience	Score (%)	100%	100%											100.00%
	FFT Overall Results	Score (%)	71%	98%											85%
	FFT Reponse Rate	Score (%)	30%	96%											63.00%
	Mixed Sex Breaches	No. of	0	0											0
Infection Prevention and Control	MRSA	Screening % Emergency	96%												96.00%
		Screening % Elective	100%	%											100.00%
		No. of Bloodstream	0	0											0
		No. of Clinicals	0	0											0
	C Diff	No. of	0	0											0
	MSSA	No. of Bloodstream	0	0											0
	E-Coli	No. of Bloodstream	0	0											0
	Hand Hygiene	Score (%)	82%	80%											81%
	Ward Cleanliness	Score (%)	95%	96%											95.50%
	Outbreaks	No. of	0	0											0
	Cannulas (VIP)	Score (%)	100%	100%											100.00%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	3												
	Sickness in Month with Trajectory of management	ST/LT Added Together %	7.61%	4.12%											5.87%
	Sickness long term	%	4.66%	3.60%											4.13%
	Sickness short term	%	2.95%	0.60%											1.78%
	Did monthly HR meeting take place?	Y/N	y	y											
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs													#DIV/0!
		No. of HCA's in Hrs													#DIV/0!
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	y	y											
	Brad Score	Reccommended	57.00	57.11											
		Actual	18.00	35.38											
		Budgeted	20.00	39.98											
	PDR %	%	86.96%	90.91%											88.94%
	Mandatory Training % by Month	%	83.53%	85.53%											84.53%
	Uniform Audit	%	100%	100%											100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	y	y											
	Did monthly finance meeting take place?	Y/N	N	n											

Leading the Culture of Compassionate Care

WARD Priory 2

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	90%	100%											95%
	Nutrition Audit (MUST)	Score %	100%	100%											100%
	Documentation Audit	Score %	90%	100%											95%
	Fluid Balance Audit	Score %	90%	100%											95%
	Pain Audit (CQUIN)	Score %	100%	100%											100%
	Protected Meal Time Audit	Score %	100%	100%											100%
	Missed Dose Audit	Score %	100%	100%											100%
	Medications Audit	Score %	100%	100%											100%
	Drugs Storage	Score %	100%	100%											100%
	CD Audit	Score %	95%	100%											98%
	Falls Risk Assessment Audit	Score %	100%	100%											100%
	Safety/Privacy & Dignity	Score %	100%	100%											100%
	Pressure Ulcers Avoidable	No. of	0	0											0
	Pressure Ulcers Unavoidable	No.of	0	0											0
	Falls (target =0)	No. of	0	2											2
	Dementia screening audit results	Score %	100%	100%											100%
	Safety Thermometer (No new harm)	Score %	100%	100%											100%
		No. of Harms	0	0											0
	10 Out of 10	Score %	100%	100%											1
	Incidents Total (inc Falls)	No of	16	12											28
	Incidents (red)	No of	0	0											
	Incidents (amber)	No. of	0	0											
Patient Experience	PALS Queries	No of	1	0											
	Compliments	No. of	52	55											
	Complaints	No. of	0	0											
	Patient Experience	Score (%)	100%	100%								.			100%
	FFT Overall Results	Score (%)	97%	100%											99%
	FFT Reponse Rate	Score (%)	59%	70%											65%
	Mixed Sex Breaches	No. of	0	0											0
	MRSA	Screening % Elective	87.50%												87.50%
		No. of Bloodstream	0	0											0
		No. of Clinicals	0	0											0
	C Diff	No. of	0	0											0
	MSSA	No. of Bloodstream	0	0											0
	E-Coli	No. of Bloodstream	0	0											0
	Hand Hygiene	Score (%)	65%	89%											77%
	Ward Cleanliness	Score (%)	79%	89%											84%
	Outbreaks	No. of	0	0											0
	Cannulas (VIP)	Score (%)	79%	100%											89.50%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	3.8	5											
	Sickness in Month with Trajectory of management	ST/LT Added Together %	10.29%	14.40%											12.35%
	Sickness long term	%	8.76%	10.22%											9.49%
	Sickness short term	%	1.53%	4.88%											3.21%
	Did monthly HR meeting take place?	Y/N	Y	Y											
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	145												145
		No. of HCA's in Hrs	398												398
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y											
	Brad Score	Reccommended	40.98	38											
		Actual	29.91	31											
		Budgeted	29.60	30											
	PDR %	%	100%	100%											100%
	Mandatory Training % by Month	%	87.02%	86.00%											86.51%
	Uniform Audit	%	100%	100%											100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	N	N											
	Did monthly finance meeting take place?	Y/N	N	N											

WARD SAU

Leading the Culture of Compassionate Care

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%											100%
	Nutrition Audit (MUST)	Score %	100%	100%											100%
	Documentation Audit	Score %	100%	93%											97%
	Fluid Balance Audit	Score %	100%	100%											100%
	Pain Audit (CQUIN)	Score %	100%	100%											100%
	Protected Meal Time Audit	Score %	100%	96%											98%
	Missed Dose Audit	Score %	100%	100%											100%
	Medications Audit	Score %	100%	100%											100%
	Drugs Storage	Score %	100%	100%											100%
	CD Audit	Score %	100%	100%											100%
	Falls Risk Assessment Audit	Score %	100%	100%											100%
	Safety/Privacy & Dignity	Score %	100%	100%											100%
	Pressure Ulcers Avoidable	No. of	0	0											0
	Pressure Ulcers Unavoidable	No.of	0	0											0
	Falls (target =0)	No. of	0	1											
	Dementia screening audit results	Score %	100%	100%											100%
	Safety Thermometer (No new harm)	Score %	100%	100%											100%
		No. of Harms	0	0											0
	10 Out of 10	Score %	100%	100%											100%
	Incidents Total (inc Falls)	No of	10	12											
	Incidents (red)	No of	0	0											0
	Incidents (amber)	No. of	0	0											0
Patient Experience	PALS Queries	No of	0	0											0
	Compliments	No. of	14	18											32
	Complaints	No. of	1	1											2
	Patient Experience	Score (%)	100%	100%											100%
	FFT Overall Results	Score (%)	97%	96%											97%
	FFT Reponse Rate	Score (%)	40%	27%											33.50%
	Mixed Sex Breaches	No. of	0	0											0
Infection Prevention and Control	MRSA	Screening % Emergency	96.70%	93.22%											94.96%
		No. of Bloodstream	0	0											0
		No. of Clinicals	0	0											0
	C Diff	No. of	0	0											0
	MSSA	No. of Bloodstream	0	0											0
	E-Coli	No. of Bloodstream	0	0											0
	Hand Hygiene	Score (%)	70%	77.00%											74%
	Ward Cleanliness	Score (%)	ND	ND											#DIV/0!
	Outbreaks	No. of	0	0											0
	Cannulas (VIP)	Score (%)	81%	100.00%											91%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	1. 45	1. 45											
	Sickness in Month with Trajectory of management	ST/LT Added Together %	1.71%	5.42%											3.57%
	Sickness long term	%	0.00%	4.47%											2.24%
	Sickness short term	%	1.71%	0.95%											1.33%
	Did monthly HR meeting take place?	Y/N	Yes	Yes											
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs													#DIV/0!
		No. of HCA's in Hrs													#DIV/0!
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Yes	Yes											
	PDR %	%	96%	88.46%											92.23%
	Mandatory Training % by Month	%	98.34%	96.41%											97.38%
	Uniform Audit	%	100%	100.00%											100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	Yes	Yes											
	Did monthly finance meeting take place?	Y/N	NO	No											

WARD SSAU

Leading the Culture of Compassionate Care

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	93%	100%											97%
	Nutrition Audit (MUST)	Score %	100%	100%											100%
	Documentation Audit	Score %	88%	92%											90%
	Fluid Balance Audit	Score %	96%	100%											98%
	Pain Audit (CQUIN)	Score %	100%	100%											100%
	Protected Meal Time Audit	Score %	100%	97%											99%
	Missed Dose Audit	Score %	100%	100%											100%
	Medications Audit	Score %	100%	93%											97%
	Drugs Storage	Score %	100%	100%											100%
	CD Audit	Score %	85%	90%											88%
	Falls Risk Assessment Audit	Score %	92%	100%											96%
	Safety/Privacy & Dignity	Score %	100%	100%											100%
	Pressure Ulcers Avoidable	No. of	0	0											0
	Pressure Ulcers Unavoidable	No.of	0	0											0
	Falls (target =0)	No. of	0	0											0
	Dementia screening audit results	Score %	100%	100%											100%
	Safety Thermometer (No new harm)	Score %	100%	100%											100%
		No. of Harms	0	0											0
	10 Out of 10	Score %	88%	92%											1
	Incidents Total (inc Falls)	No of	5	4											9
	Incidents (red)	No of	0	0											0
	Incidents (amber)	No. of	0	0											0
Patient Experience	PALS Queries	No of	1	1											2
	Compliments	No. of	11	15											26
	Complaints	No. of	0	0											0
	Patient Experience	Score (%)	100%	100%											100%
	FFT Overall Results	Score (%)	100%	92%											96%
	FFT Reponse Rate	Score (%)	15%	22%											18.50%
	Mixed Sex Breaches	No. of	0	0											0
Infection Prevention and Control	MRSA	Screening % Emergency	93.15%	96.47%											94.81%
		No. of Bloodstream	0	0											0
		No. of Clinicals	0	0											0
	C Diff	No. of	0	0											0
	MSSA	No. of Bloodstream	0	0											0
	E-Coli	No. of Bloodstream	0	0											0
	Hand Hygiene	Score (%)	79%	65%											72%
	Ward Cleanliness	Score (%)	95%	95%											95.00%
	Outbreaks	No. of	0	0											0
	Cannulas (VIP)	Score (%)	67%	100%											84%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	2. 08	2. 08											
	Sickness in Month with Trajectory of management	ST/LT Added Together %	4.91%	1.51%											3.21%
	Sickness long term	%	0.00%	0.00%											0.00%
	Sickness short term	%	4.91%	1.51%											3.21%
	Did monthly HR meeting take place?	Y/N	Yes	Yes											
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	129.2	64.5											97
		No. of HCA's in Hrs	111.2	75.2											93
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Yes	Yes											
	PDR %	%	100%	88.89%											94%
	Mandatory Training % by Month	%	89.54%	95.41%											92.48%
	Uniform Audit	%	100%	100.00%											100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	Yes	Yes											
	Did monthly finance meeting take place?	Y/N	No	No											

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:	Mike Harding, Performance Management
DATE OF MEETING:	2 July 2015 (Report finalised 25 June 2015)

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

The Trust Board is asked to consider the content of this report and its associated commentary.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		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 and Quality & Safety Committee.

Sandwell and West Birmingham Hospitals
NHS Trust

Integrated Quality and Performance Report

May 2015

Contents

At A Glance

Infection Control

There were 2 cases of C. Diff reported during the month of May, both in Medicine. The number of cases for the month and year to date are within the respected trajectories for the periods.

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

The incidence of MSSA Bacteraemia and E. Coli (both expressed per 100,000 bed days) for the month of May remain with the operational threshold.

Both MRSA elective and non-elective screening remain above the 80% target at 97.7% and 94.5% respectively for May.

Harm Free Care

Overall Harm Free Care as assessed through the NHS Safety Thermometer indicates a level of Harm Free Care of 94.4% for May, beneath the 95.0% operational threshold.

There were 86 falls reported in May, an increase from the previous month (59). None of the falls reported sustained serious injury.

The total number of hospital acquired, avoidable pressure ulcers increased to 11 during April, from 6 reported during March. Of the 11 reported, 9 were Grade 2 and 2 were Grade 3.

There was 1 never event in May in T&O - Fascia Iliac Block on wrong side.

There were 5 Open CAS Alerts reported at the end of May, 3 of which were overdue at the end of the reporting period.

Obstetrics

The overall Caesarean Section rate for May of 24.8% remained beneath the target of 25.0%. Elective and Non-Elective rates for the month were 6.8% and 18.0% respectively.

Adjusted perinatal mortality rate (per 1000 births) increased during the month of April to 9.1 (6.4 in march), above the target of 8.0 or less.

Mortality & Readmissions

The Trust's RAMI for the most recent 12-month cumulative period is 88, identical to that of the National HES Peer. City and Sandwell site RAMIs are 73 and 100 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.

During the most recent month for which complete data is available (March) the overall Trust performance for review of deaths within 42 days was 81%, a reduction from the previous month's performance of 86%. The trajectory is now 100%.

The Crude Mortality Rate for May is 1.31%. 12 month figure is 1.44%

Stroke Care & Cardiology

Stroke data for the month of May indicates Patients spending >90% of their time on a stroke ward improved to 95.4% compared with a the 90% operational threshold. Admittance to an acute stroke unit within 4 hours remains relatively stable at 80.7% (90% target). The percentage of patients receiving thrombolysis within 60 minutes of admission improved to 75.0% (target 85%). Patients receiving a CT scan within 1 hour and 24 hours of presentation was 73.3% and 96.7% respectively.

Primary Angioplasty Door to balloon time (<90 minutes) was 95.0% for April against an 80% target and Call to balloon time (<150 minutes) was 94.4% for April against an 80% target. RACP performance for April was 100% (98% target).

Cancer Care

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

Medicine Group did not meet the 93.0% operational threshold for the 2-week maximum cancer wait with performance for the month of 91.9%.

Surgery A Group narrowly failed the 31 day diagnosis to treatment target of 96% during April, with performance of 95.5%.

All 62-day targets were met with the exception of the 62-day referral to treatment from hospital specialist target of 90% which was not met in Women & Child Health (Gynaecological Cancer), where performance was 66.7% (1.0 of 1.5 patients).

Patient Experience - MSA & Complaints

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

The FFT national definitions have been revised, with performance thresholds yet to be established. Performance (with effect from April 2015) is now reported as an FFT rating of recommendation and a response rate, derived from an extended patient base. As such values are not comparable to 2014 / 2015 measures.

100% of complaints received during the month were acknowledged within 3 days of receipt.

The percentage of complaints exceeding the original agreed response date has improved to 50% in May.

The oldest complaint currently in the system is in Medicine at 188 days

Patient Experience - Cancelled Operations

The number of Last Minute Cancelled Operations reduced during May to 33, equivalent to 0.9%, against a 0.8% target. The majority of cancellations (18) were seen in Surgery B, with the highest number by specialty in Ophthalmology (10).

There was a second or subsequent urgent operation cancellation during May in Gynae-oncology.

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

Emergency Care

The Trust's performance against the 4-hour ED wait target of 95.0% during the Month (May) was 92.66%. Performance for June (as at 25 June) is 94.69%.

Delayed Transfers of Care for the month of May further improved to 2.3% overall, although the rate for City remains high at 4.1% (Sandwell is 1.0%).

The proportion of patients admitted with a Fractured Neck of Femur who received an operation within 24 hours of admission during May was 100% (12 of 12 patients).

Referral To Treatment

Trust level Admitted, Non-Admitted and incomplete RTT Pathway targets were all met for the month of May.

2 patients were waiting more than 52 weeks for commencement of treatment on the RTT Incomplete Pathway at the end of May (1 in Ophthalmology and 1 in Paediatric Ophthalmology).

6 Treatment Functions failed the respective RTT pathway performance thresholds for the month.

Diagnostic waits (May) beyond 6 weeks were 0.09%, a further fall (improvement) from last month. This compares with an upper operational threshold of 1.00%. There were a total of 8 patients waiting in excess of 6 weeks for a diagnostic test / investigation.

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 March)

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 May reported as 96.3%. Outpatient and A&E data sets continue to exceed their respective thresholds.

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 May of 38.72%.

Staff

PDR overall compliance as at the end of May is 89.9%. The Medical Appraisal / Revalidation Rate for the month is 92.8%.

Mandatory Training at the end of May fell slightly to 87.2% overall.

The most recent 'Your Voice' data, response rate and score is included in the report.

Sickness Absence remains high at 4.99% for May, and 4.86% for the 12-month rolling period. (Range by Clinical Group during May is 3.46% to 6.06% and by Corporate Directorate 0.63% to 5.89%.

The Return to Work interview rate following Sickness Absence is 61.93% for the 12-month cumulative period concluding May (range by Group 44.5% - 78.6%).

Data on the number of Unfilled Bank shifts is now included in the report.

CQUIN

The Trust is contracted to deliver a total of 19 CQUIN schemes during 2015 / 2016. 7 schemes are nationally mandated, a further 4 have been agreed locally, 5 identified by the West Midlands Specialised Commissioners and 3 by Public Health. The collective financial value of the schemes is c.£8.8m.

In summary 12 schemes are classified as performing, a total of 6 schemes require baseline data to be gathered before improvement trajectories and targets are finalised, with 1 scheme currently underperforming. The scheme underperforming is 'Improvement in diagnosis recording in HES Data Set of Mental Health presentations in A&E'. Performance currently is 77% data recording, against a requirement of 90% or more in order to attract full funding. Current performance would attract 50% of the CQUIN value of this nationally mandated scheme. The Trust is seeking an amendment to this CQUIN with commissioners, to work to an agreed improvement trajectory from the current base position.

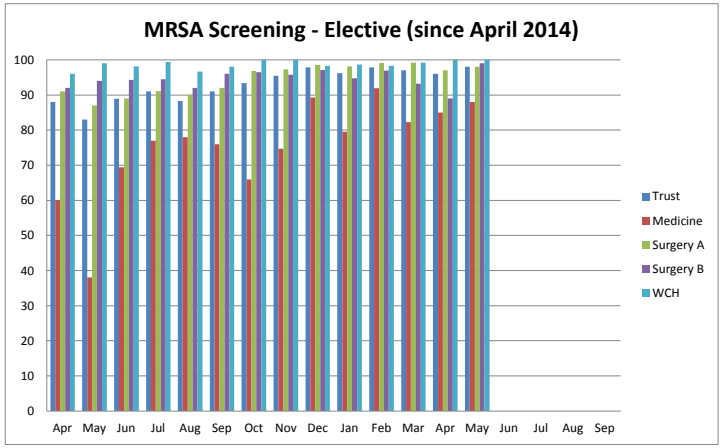
External Assessment Frameworks

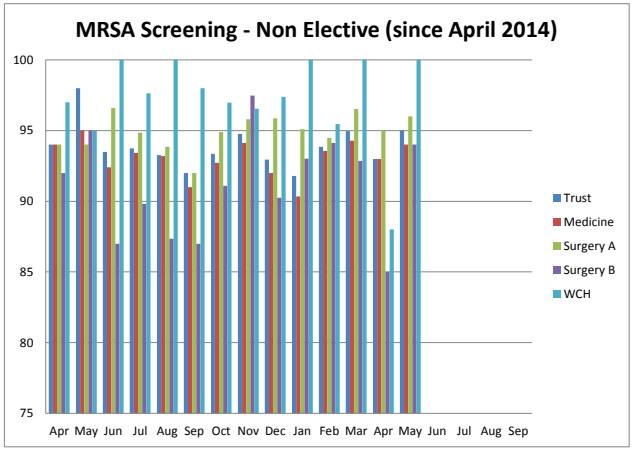
TDA Accountability Framework - Quality Scores for each of the 5 domains which comprise the framework are indicated in the main body of this report, with the areas of 'adverse' performance against each domain identified. The sum of the domain scores are used to derive the overall quality score which for the most recent period is 3 (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 May related to ED 4-hour performance of 92.66% and projected underperformance against the 62-day Cancer Urgent GP Referral to Treatment target.

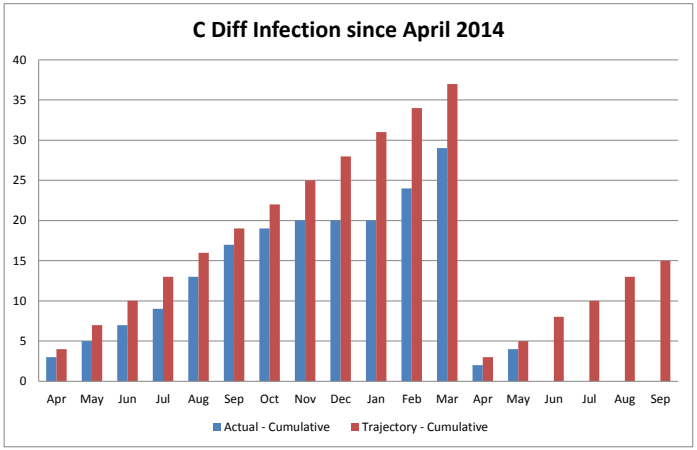
Monitor Risk Assessment Framework - compliance against this framework is also indicated. For the month of May performance (actual and projected) attracts a Governance Rating of 2.0 (Amber / Red), influenced adversely by ED 4-hour wait performance during the month, and projected failure of the Cancer-62 day target.

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
4			C. Difficile	No.	30	2	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	2	0	0	0					2	4	●	●	●
4			MRSA Bacteraemia	No.	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0					0	0	●	●	●
4			MSSA Bacteraemia (rate per 100,000 bed days)	Rate	<9.42	<9.42	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15									0.0	0.0	●	●	●
4			E Coli Bacteraemia (rate per 100,000 bed days)	Rate	<94.9	<94.9	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15									13.6	20.6	●	●	●
3			MRSA Screening - Elective	%	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	88	98	99	100					97.7		●	●	●
3			MRSA Screening - Non Elective	%	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	94	96	94	100					94.5		●	●	●

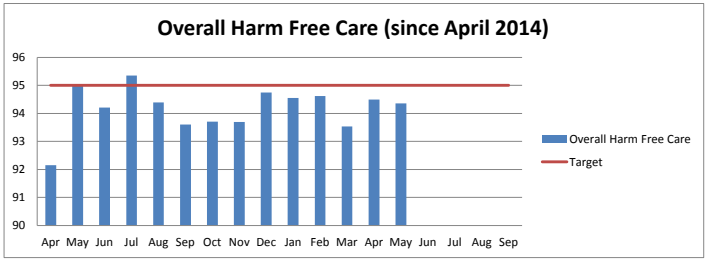


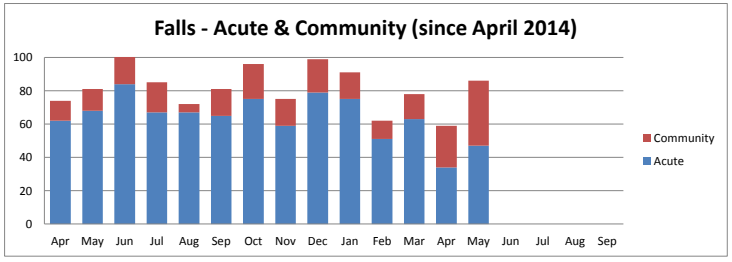


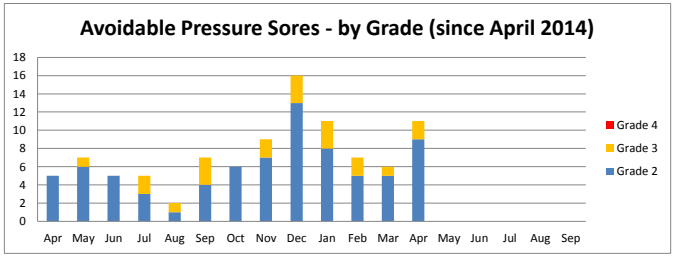


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		d	Patient Safety Thermometer - Overall Harm Free Care	%	=>95	=>95	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15									94.4		●		
8		d	Patient Safety Thermometer - Catheters & UTIs	%			0.53	0.48	0.51	0.49	0.42	0.41	0.40	0.25	0.31	0.41	0.40	0.64	0.25	0.33					May-15									0.33				
8			Falls	No.	804	67	74	81	102	85	72	81	96	75	99	91	62	78	59	86					May-15	37	7	0	0	0	0	39		86	145	●		
9			Falls with a serious injury	No.	0	0	1	5	4	1	5	1	1	2	1	1	0	1	2	0					May-15	0	0	0	0		0	0		0	2	●		
8			Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	No.	0	0	5	7	5	5	2	7	4	9	16	11	4	6	11						Apr-15	10	0	0	0			1		11	11	●		
3		d	Venous Thromboembolism (VTE) Assessments	%	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	99.0	97.9	98.2	95.9					98.1		●		
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	%	98	98	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	99.7	99.7	99.9	100.0		100			99.8		●		
3			WHO Safer Surgery - 3 sections and brief (% lists where complete)	%	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	100	100	100		100			100.0		●		
3			WHO Safer Surgery - Audit - 3 sections, brief and debrief (% lists where complete)	%	85	85	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	98.1	100	100		100			99.6		●		
9		d	Never Events	No.	0	0	●	●	●	●	●	●	●	●	●	●	●	●	1	1					May-15	0	1	0	0	0	0	0		1	2	●		
9		d	Medication Errors causing serious harm	No.	0	0	●	●	●	●	●	●	●	●	●	●	●	1	●	●					May-15	0	0	0	0	0	0	0		0	0	●		
9		d	Serious Incidents	No.	0	0	3	2	2	2	2	1	1	2	3	4	4	6	4	3					May-15	2	1	0	0	0	0	0	0	3	7	●		
9			Open Central Alert System (CAS) Alerts	No.			9	5	7	5	6	5	5	15	17	10	9	4	8	5					May-15									8		●		
9		d	Open Central Alert System (CAS) Alerts beyond deadline date	No.	0	0		1	1	1	0	0	0	4	0	1	0	1	0	3					May-15									3		●		

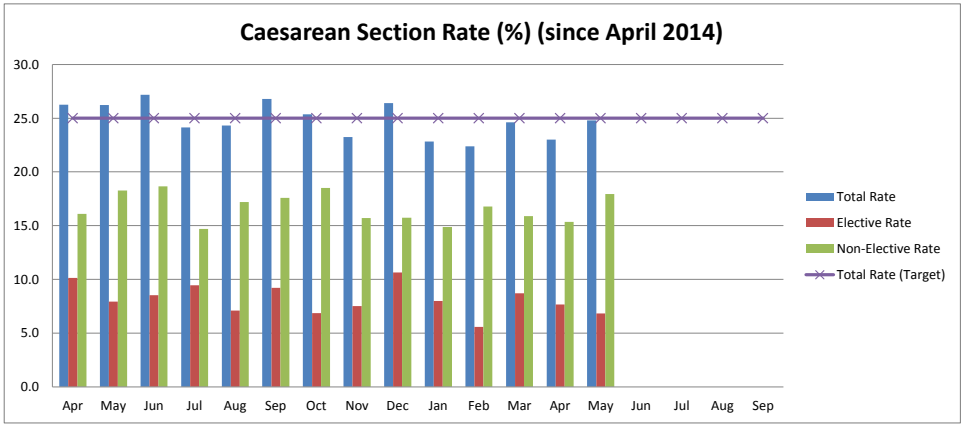


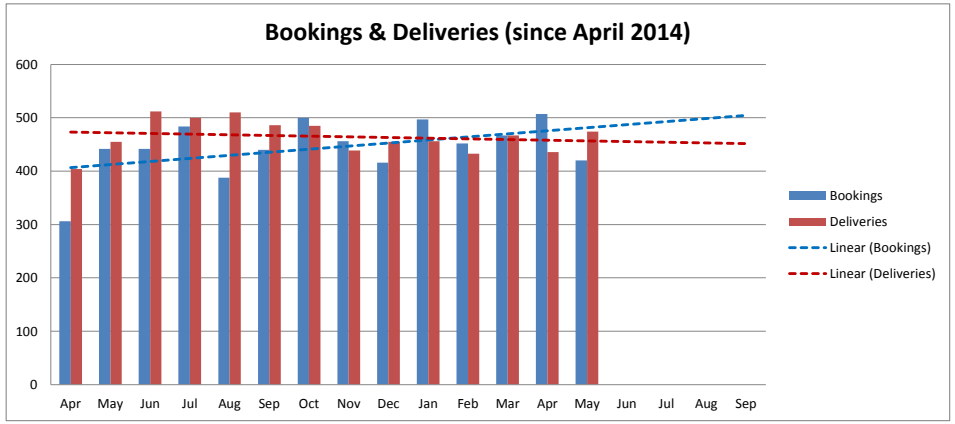




Patient Safety - Obstetrics

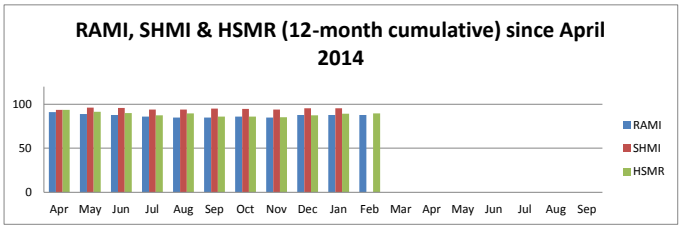
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Caesarean Section Rate - Total	%	=<25.0	=<25.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	24.8	23.9	●		
3		●	Caesarean Section Rate - Elective	%			10	8	9	9	7	9	7	8	11	8	6	9	8	7					May-15	6.8	7.2			
3		●	Caesarean Section Rate - Non Elective	%			16	18	19	15	17	18	19	16	16	15	17	16	15	18					May-15	18.0	16.7			
2		●d	Maternal Deaths	No.	0	0	●	●	●	●	●	●	●	●	1	●	●	●	●	●					May-15	0	0	●		
3			Post Partum Haemorrhage (>2000ml)	No.	48	4	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	●		
3			Admissions to Neonatal Intensive Care	%	=<10.0	=<10.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	1.27	1.32	●		
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	Rate	<8.0	<8.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					Apr-15	9.1		●		
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	71.67		●		
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					Apr-15	164		●		
2			Breast Feeding Initiation (Quarterly)	%	=>77.0	=>77.0		●		●			●			●									Mar-15	77.52	75.86	●		
2		●	Puerperal Sepsis and other puerperal infections (variation 1) (%)	%			2.3	1.8	2.6	1.8	0.9	0.9	0.7	1.5	1.2	1.4	0.5	2.1	1.9	1.3					May-15	1.29	1.63			
2		●	Puerperal Sepsis and other puerperal infections (variation 2) (%)	%			1.5	1.8	1.6	1.6	0.7	0.3	0.7	1.3	0.8	0.3	0.5	1.5	1.4	1.0					May-15	0.97	1.22			
2		●	Puerperal Sepsis and other puerperal infections (variation 3) (%)	%			0.8	0.7	0.4	0.4	0.2	0.0	0.0	1.0	0.4	0.0	0.0	1.2	0.5	0.7					May-15	0.65	0.54			

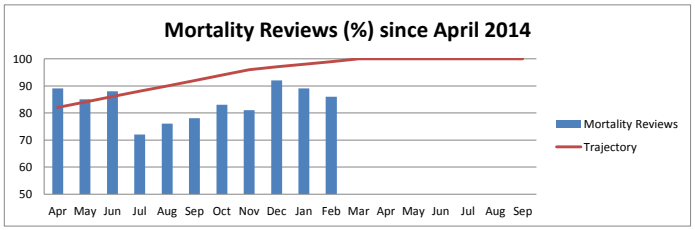


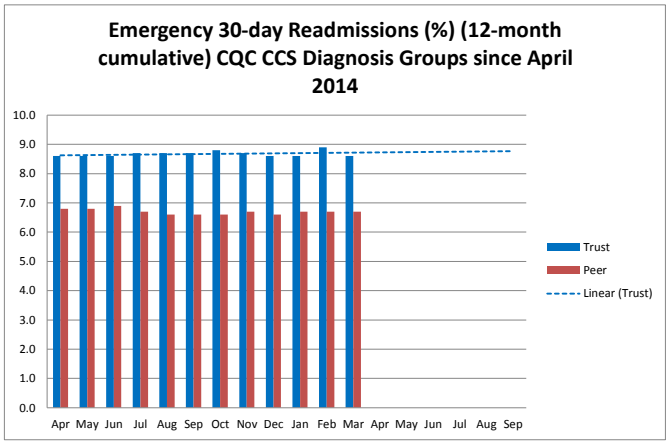


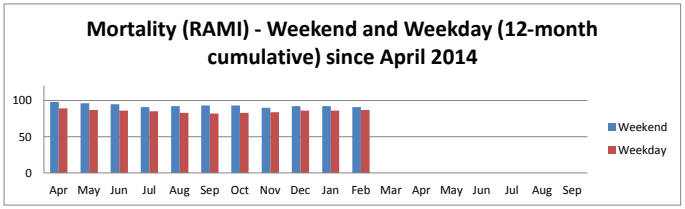
Clinical Effectiveness - Mortality & Readmissions

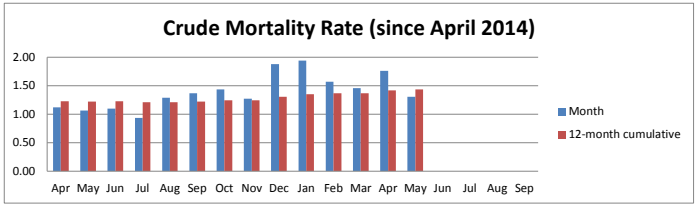
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	91	89	88	86	85	85	86	85	88	88	88									Feb-15										88	●		
5		C	Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	89	87	86	85	83	82	83	84	86	86	87									Feb-15										87	●		
5		C	Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	98	96	95	91	92	93	93	90	92	92	91									Feb-15										91	●		
6		C	Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	94	96	96	94	94	95	95	94	96	96										Jan-15										95.7	●		
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			94	92	90	88	90	86	86	85	87	89	90									Feb-15										89.8	●		
5		C	Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	66	75	47	51	71	89	80	76	111	105	94									Feb-15									94		●		
3			Mortality Reviews within 42 working days	%	100	=>99	●	●	●	●	●	●	●	●	●	●	●									Mar-15	82	91		100					81		●		
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			1.1	1.1	1.1	0.9	1.3	1.4	1.4	1.3	1.9	1.9	1.6	1.5	1.8	1.3						May-15									1.31				
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.3	1.4	1.4	1.4	1.4	1.4						May-15										1.44			
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month - internal data	%			8.1	8.2	7.3	7.6	7.9	7.4	7.8	7.6	8.2	8.7	8.4	8.5	9.5							Apr-15									9.54				
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative - internal data	%			8.1	8.2	7.9	7.8	7.8	7.7	7.7	7.7	7.7	7.9	8.0	8.2	8.4							Apr-15										8.38			
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative) - CHKS data	%			8.6	8.6	8.6	8.7	8.7	8.7	8.8	8.7	8.6	8.6	8.9	8.6								Mar-15	12.8	8.1	2.2	7.7						8.9			





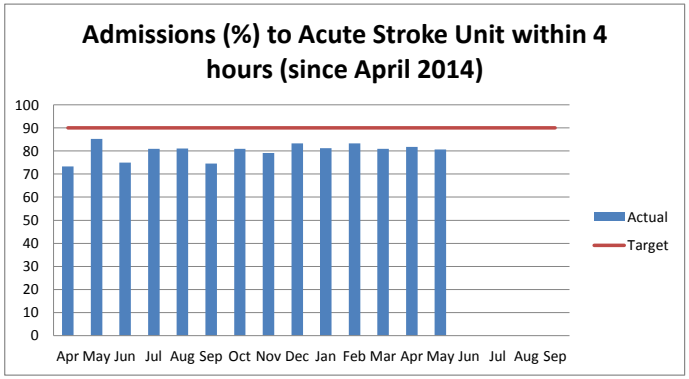


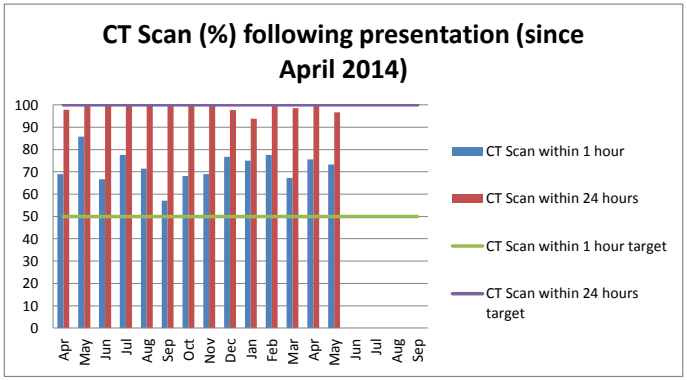


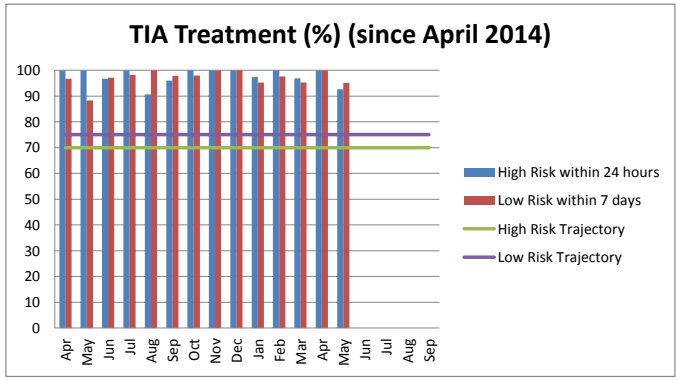


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A M J J A S O N D J F M A M J J A S	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Pts spending >90% stay on Acute Stroke Unit	%	=>90.0	=>90.0		May-15	95.4	92.4			
3			Pts admitted to Acute Stroke Unit within 4 hrs	%	=>90.0	=>90.0		May-15	80.7	82.0			
3			Pts receiving CT Scan within 1 hr of presentation	%	=>50.0	=>50.0		May-15	73.3	75.0			
3			Pts receiving CT Scan within 24 hrs of presentation	%	100	100		May-15	96.7	98.1			
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	%	=>85.0	=>85.0		May-15	75.0	63.6			
3			Stroke Admissions - Swallowing assessments (<24h)	%	=>98.0	=>98.0		May-15	100.0	100.0			
3			TIA (High Risk) Treatment <24 Hours from receipt of referral	%	=>70.0	=>70.0		May-15	92.7	96.0			
3			TIA (Low Risk) Treatment <7 days from receipt of referral	%	=>75.0	=>75.0		May-15	95.1	97.4			
9			Primary Angioplasty (Door To Balloon Time 90 mins)	%	=>80.0	=>80.0		Apr-15	95.0	95.0			
9			Primary Angioplasty (Call To Balloon Time 150 mins)	%	=>80.0	=>80.0		Apr-15	94.4	94.4			
9			Rapid Access Chest Pain - seen within 14 days	%	=>98.0	=>98.0		Apr-15	100.0	100.0			

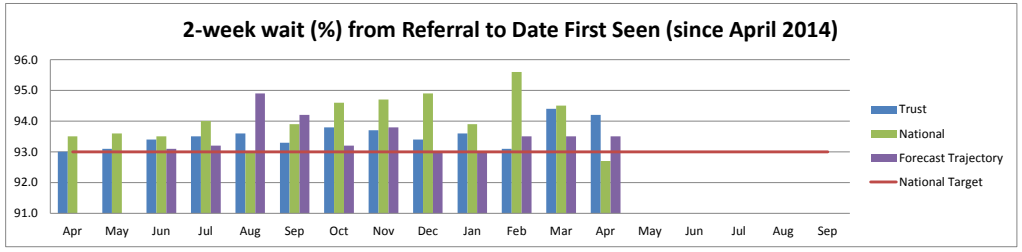


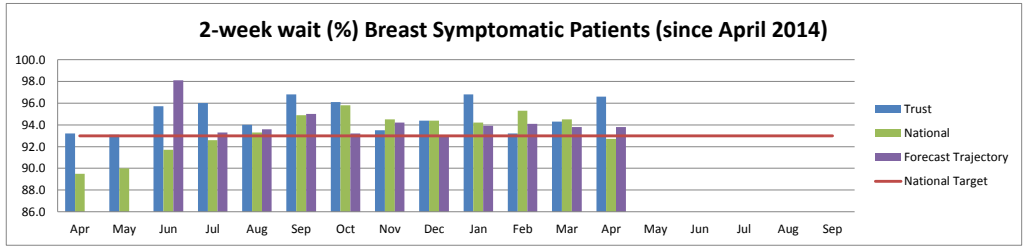


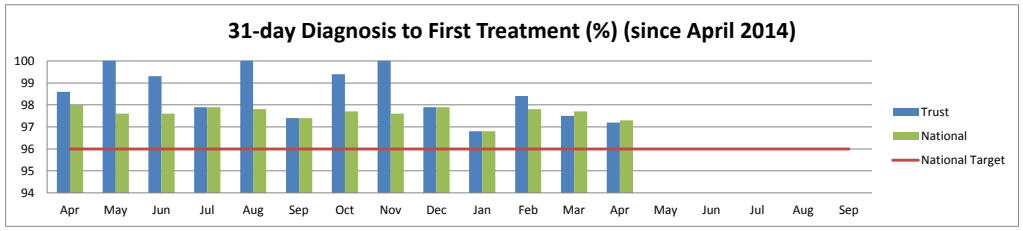


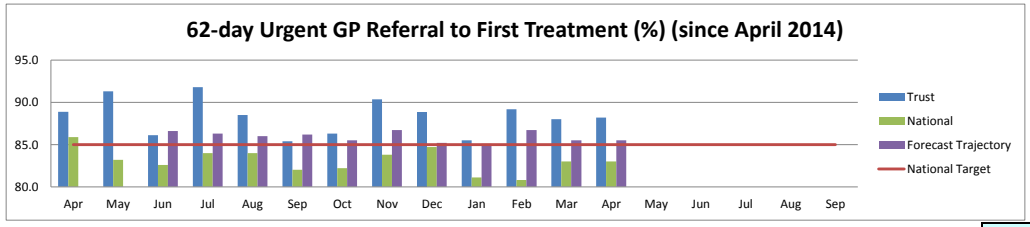
Clinical Effectiveness - Cancer Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
1			2 weeks	%	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	91.9	94.6	97.2	97.6					94.2	94.2	●		
1			2 weeks (Breast Symptomatic)	%	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15		96.6							96.6	96.6	●		
1			31 Day (diagnosis to treatment)	%	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	97.9	95.5	100	100					97.2	97.2	●		
1			31 Day (second/subsequent treatment - surgery)	%	=>94.0	=>94.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15									100	100	●		
1			31 Day (second/subsequent treatment - drug)	%	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-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	●						Apr-15									100	100	●		
1			62 Day (urgent GP referral to treatment)	%	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	91.3	85.5	100	85.7					88.2	88.2	●		
1			62 Day (referral to treat from screening)	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15		100		100					100	100	●		
1			62 Day (referral to treat from hosp specialist)	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	100	100		66.7					95.5	95.5	●		



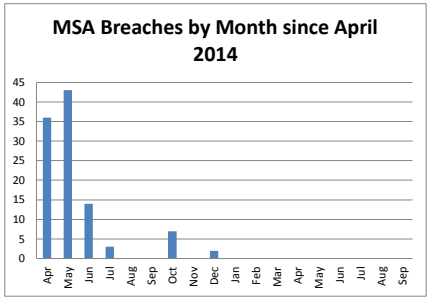


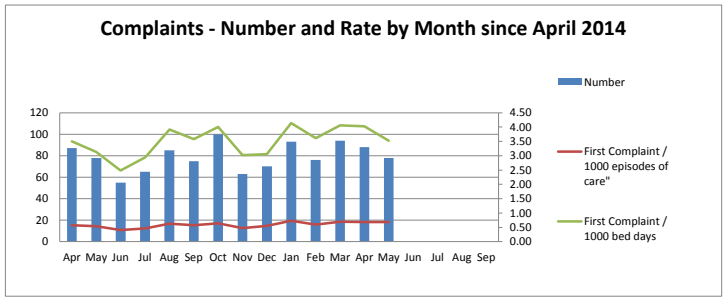


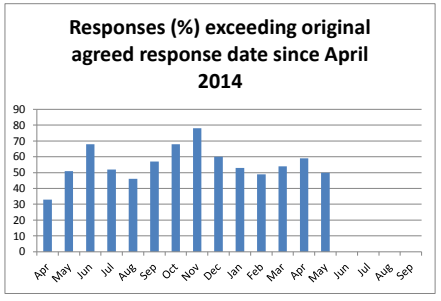


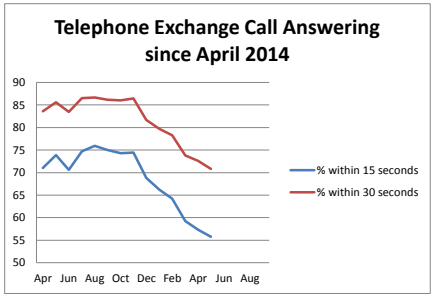
Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		b	FFT Response Rate - Inpatients - definition revised April 2015	%	Above lowest national decile		36	44	45	41	32	31	28	31	28	33	43	43	21	21					May-15									21				
8		a	FFT Score - Inpatients - definition revised April 2015 - now measured as would recommend rating	No.	Above lowest national decile		74	74	70	73	76	74	73	73	69	70	68	72	95	95					May-15									95				
8		b	FFT Response Rate Emergency Department - definition revised April 2015	%	Above lowest national decile		15	16	16	16	17	17	17	18	17	18	21	22	10	8					May-15									10				
8		a	FFT Score - Em. Department - definition revised April 2015 - now measured as would recommend rating	No.	Above lowest national decile		47	49	48	47	49	47	48	49	50	50	44	52	79	79					May-15									79				
13		a	Mixed Sex Accommodation Breaches	No.	0	0	36	43	14	3	0	0	7	0	2	0	0	0	0	0					May-15	0	0	0	0		0	0		0	0	●		
9			No. of Complaints Received (formal and link)	No.			87	78	55	65	85	75	100	63	70	93	76	94	88	78					May-15	35	8	9	9	2	4	1	7	78	166			
9			No. of Active Complaints in the System (formal and link)	No.			194	245	270	219	258	282	324	359	219	249	266	265	278	225					May-15	104	27	35	28	7	5	7	12	225				
9		a	No. of First Formal Complaints received / 1000 bed days	Rate			3.5	3.1	2.5	2.9	3.9	3.6	4.0	3.0	3.1	4.1	3.6	4.1	4.0	3.5					May-15	2.9	1.5	15.1	2.3					3.52	3.79			
9			No. of First Formal Complaints received / 1000 episodes of care	Rate			0.6	0.5	0.4	0.5	0.6	0.6	0.6	0.5	0.6	0.7	0.6	0.7	0.7	0.7					May-15	1.0	1.0	0.6	0.7			0.0		0.69	0.72			
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	%	100	100	100	100	100	99	99	100	99	100	99	99	98	100	99	100					May-15	100	100	100	100	100	100	100	100	100		●		
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	%	0	0	33	51	68	52	46	57	68	78	60	53	49	54	59	50					May-15	45	42	50	36	60	17	50	29	50		●		
9			No. of responses sent out	No.			117	30	4	138	66	42	35	26	198	59	52	84	56	115					May-15	41	27	18	11	5	3	4	6	115				
9			Oldest' complaint currently in system	Days			104	124	145	127	133	131	174	161	182	192	213	234	254	188					May-15	188	97	135	128		92	102	99	188				
14		e	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	Y	Y	Y	Y	Y	Y	Y	Y	Yes		●		



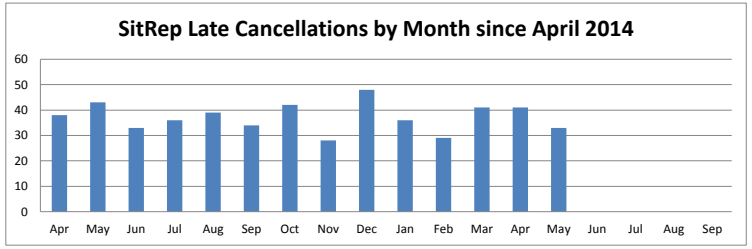


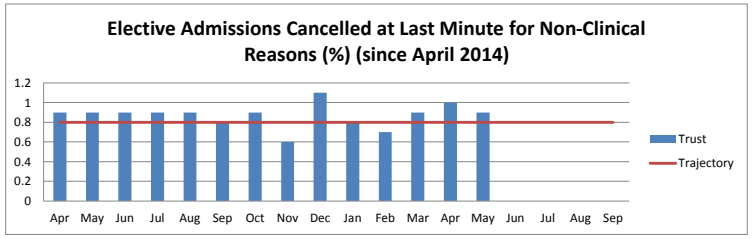


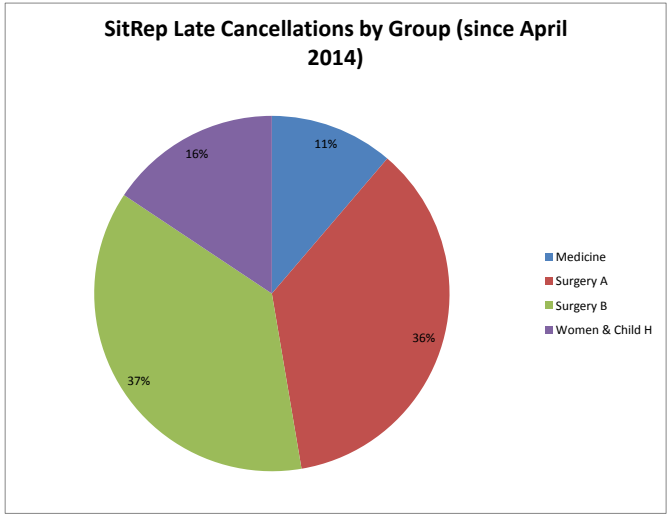


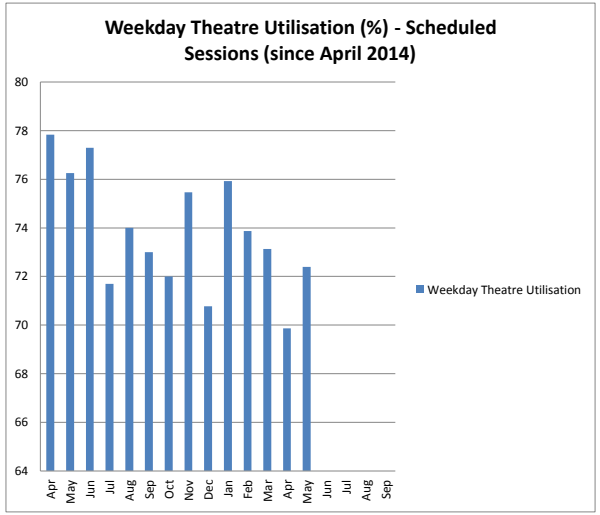
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2		●	Elective Admissions Cancelled at last minute for non-clinical reasons	%	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●						May-15	0.06	1.05	1.88	1.50					0.9	1.0	●		
2		●e●	Number of 28 day breaches	No.	0	0	1	1	0	0	0	1	0	0	1	0	0	0	0	0						May-15	0	0	0	0					0	0	●		
2		●e	No. of second or subsequent urgent operations cancelled	No.	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	1						May-15	0	0	0	1					1	1	●		
2			No. of Sitrep Declared Late Cancellations	No.	320	27	38	43	33	36	39	34	42	28	48	36	29	41	41	33						May-15	1	10	18	4					33	74	●		
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	No.	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0						May-15	0	0	0	0					0	0	●		
3			Multiple Cancellations experienced by same patient (all cancellations)	%	0	0	12	7	10	12	11	13	11	14	10	11	13	12	11	14						May-15	5.0	17.7	18.1	3.6					14.05		●		
3			All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	%	3.1	3.1	5	6	5	5	6	7	6	6	8	6	7	5	6	5						May-15	2.9	6.1	8.3	7.5					5.4		●		
3			Weekday Theatre Utilisation (as % of scheduled)	%	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●						May-15	46.2	77.0	71.5	77.9					72.4		●		



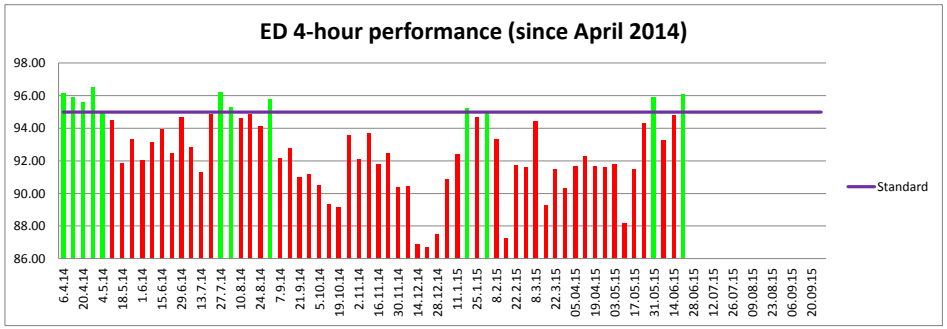


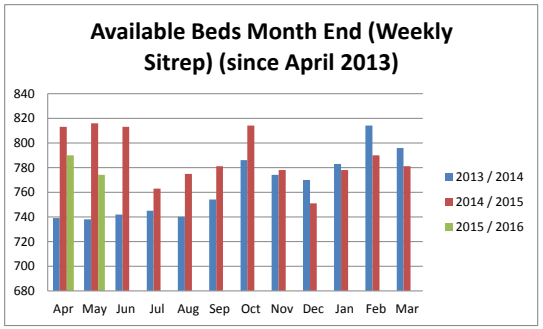


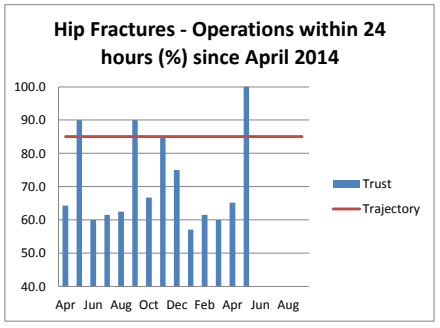


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Unit S	C	B	Month	Year To Date	Trend	Next Month	3 Months
2			Emergency Care 4-hour waits	%	=>95.0	=>95.0																			May-15	93.5	90.3	99.3	92.66	92.22			
2			Emergency Care 4-hour breach (numbers)	No.			741	1210	1277	1122	876	1460	1636	1440	2234	1054	1481	1695	1527	1406					May-15	501	889	16	1406	2933			
2			Emergency Care Trolley Waits >12 hours	No.	0	0																			May-15	0	0	0	0	0			
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	mins	=<15	=<15																			May-15	16	18	34	17	17			
3			Emergency Care Timeliness - Time to Treatment in Department (median)	mins	=<60	=<60																			May-15	56	68	26	56	54			
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	%	=<5.0	=<5.0																			May-15	8.59	8.17	3.31	7.68	7.62			
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	%	=<5.0	=<5.0																			May-15	3.23	6.13	2.07	4.43	4.58			
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	No.	0	0	119	136	125	145	51	136	219	159	282	185	149	164	144	136					May-15	54	82		136	280			
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	No.	0	0	13	8	8	8	1	13	21	14	31	7	6	8	8	8					May-15	3	5		8	16			
11			WMAS - Handover Delays > 60 mins (% all emergency conveyances)	%	=<0.02	=<0.02																			May-15	0.16	0.20		0.18	0.19			
11			WMAS - Emergency Conveyances (total)	No.			4044	4227	4093	4278	3994	4067	4193	4168	4470	4001	3829	4182	3981	4214					May-15	1789	2425		4214	8195			
2			Delayed Transfers of Care (Acute) (%)	%	=<3.5	=<3.5																			May-15	1.0	4.1		2.3	2.4			
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	No.	<10 per site	<10 per site																			May-15	1	3		4				
2			Patient Bed Moves (10pm - 8am) (No.) -ALL	No.			668	751	722	751	694	681	720	646	806	651	683	743	675	736					May-15				736	1411			
2			Patient Bed Moves (10pm - 8am) (No.) - exc. Assessment Units	No.			312	331	330	329	339	276	353	293	323	250	302	293	267	328					May-15				328	595			
3			Hip Fractures - Operation < 24 hours of admission (%)	%	=>85.0	=>85.0																			May-15				100.0	77.1			

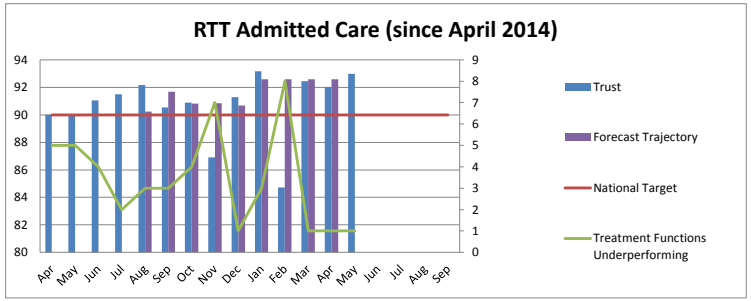


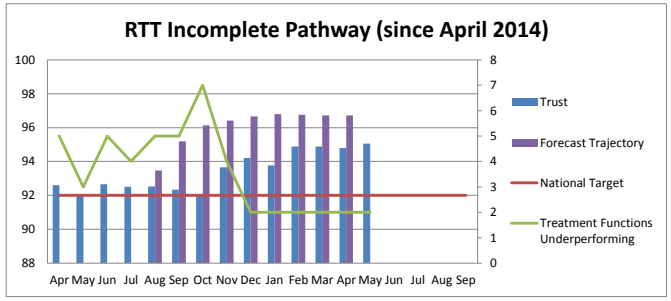


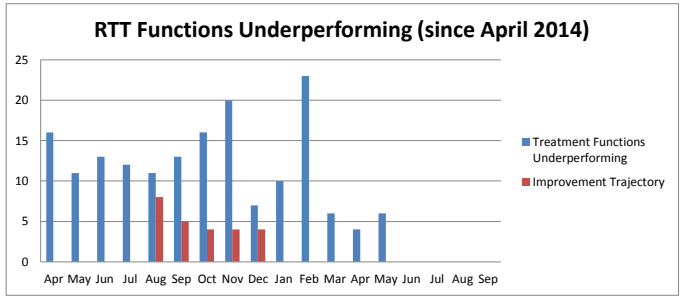


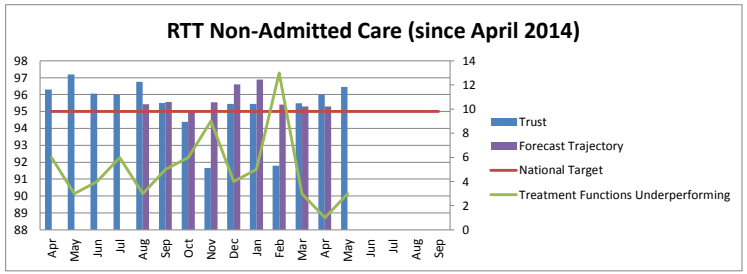
Referral To Treatment

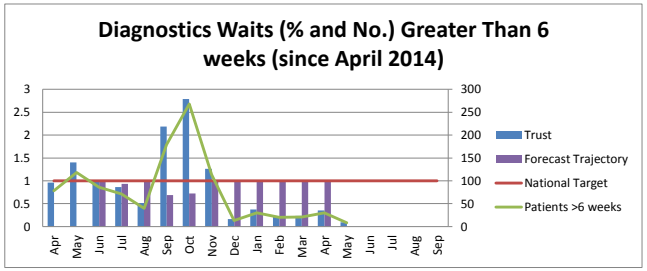
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2		e	RTT - Admittted Care (18-weeks)	%	=>90.0	=>90.0																				May-15	95.1	88.7	91.5	91.2					92.98				
2		e	RTT - Non Admittted Care (18-weeks)	%	=>95.0	=>95.0																				May-15	97.0	95.6	96.2	97.4					96.45				
2		e	RTT - Incomplete Pathway (18-weeks)	%	=>92.0	=>92.0																				May-15	95.5	93.7	94.3	98.6					95.06				
2		e	Patients Waiting >52 weeks	No.	0	0	1	2	2	3	4	4	3	3	0	4	3	4	1	2						May-15	0	0	2	0					2				
2			Treatment Functions Underperforming	No.	0	0	16	11	13	12	11	13	17	20	7	10	23	6	4	6						May-15	1	3	2	0					6				
2		e	Acute Diagnostic Waits in Excess of 6-weeks	%	=<1.0	=<1.0																				May-15	0.4	0.7	0.0	0.0		0.0			0.09				

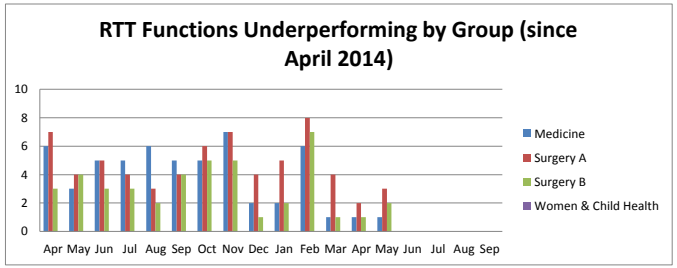










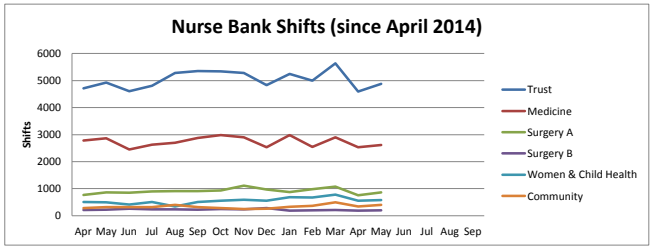


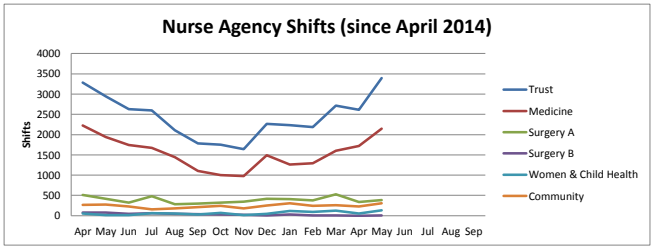
Data Completeness

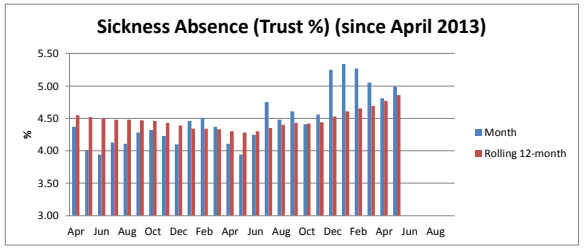
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Data Completeness Community Services	%	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15								>50	>50		●		
2		●	Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	%	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●								Mar-15									99.44		●		
2		●	Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	%	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●								Mar-15									99.60		●		
2		●	Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	%	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●								Mar-15									99.36		●		
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	%	=>99.0	=>99.0	98.7	97.0	95.6	95.4	95.2	95.7	95.3	95.7	96.0	96.5	96.9	96.6	96.9	96.3					May-15									96.3	96.6	●		
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	%	=>99.0	=>99.0	99.5	99.5	99.5	99.5	99.4	99.4	99.5	99.5	99.5	99.6	99.6	99.6	99.6	99.6					May-15									99.6	99.6	●		
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	%	=>95.0	=>95.0	96.3	95.8	96.3	96.1	96.1	96.2	96.4	96.6	96.2	97.0	96.7	96.8	96.8	96.8					May-15									96.7	96.8	●		
2			Ethnicity Coding - percentage of inpatients with recorded response	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15									91.02	92.03	●		
2		●	Data Quality of Trust Returns to the HSCIC (provided by TDA)	%	=>96.0	=>96.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.5	98.7										Dec-14									98.7		●		
2			Maternity - Percentage of invalid fields completed in SUS submission	%	=<15.0	=<15.0	●	●	●	●	●	●	●	●	●	●	●	●							May-15									38.72	38.74	●		

Staff

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
7		b	WTE - Actual versus Plan (FTE)	No.			531	558	580	584	626	608	628	674	685	701	732	807	777	849						May-15	207	102	35	73	26	51	86	271	849				
3		b	PDRs - 12 month rolling	%	=>95.0	=>95.0																				May-15	88	91	96	90	94	87	90	89		89.9			
7		b	Medical Appraisal and Revalidation	%	=>95.0	=>95.0																				May-15	86	93	97	100	100	100		100		92.8			
3		b	Sickness Absence	%	=<3.15	=<3.15																				May-15	5.4	4.9	3.5	5.4	3.9	4.7	6.1	4.7	4.99	4.86			
3			Return to Work Interviews following Sickness Absence	%	100	100																				May-15	57.2	58.5	48.1	55.4	75.4	44.5	78.6	69.7		61.93			
3			Mandatory Training	%	=>95.0	=>95.0																				May-15	82.8	89.7	87.5	83.8	95.5	87.1	89.6	89.6		87.2			
3			Mandatory Training - Health & Safety (% staff)	%	=>95.0	=>95.0																				May-15	96.0	98.5	95.9	96.6	99.1	99.3	98.9	99.2		97.9			
7		b	Staff Turnover (rolling 12 months)	%	=<10.0	=<10.0																				May-15									13.14	12.98			
7			New Investigations in Month	No.			1	4	6	5	2	15	3	1	0	3	4	5	8	11						May-15	1	3	1	3	0	0	3	0	11				
7			Vacancy Time to Fill	weeks			19	20	19	18	19	19	20	21	20	20	23	22	23	24						May-15									24				
7			Professional Registration Lapses	No.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						May-15	0	0	0	0	0	0	0	0	0	0			
7			Qualified Nursing Variance (FIMS) (FTE)	No.			161	169	173	177	201	200	188	200	228	238	247	263	221	247						May-15									247.1				
10			Nurse Bank Fill Rate	%	100	100	76	82	82	80	77	78	78	82	73	78	78	78	75	80						May-15	73.1	78.8	99.5	95.7	100	87.5	92.9	97.6	79.7	77.1			
10			Nurse Bank Shifts Not Filled	No.	0	0	1723	969	919	1087	1802	1370	1036	1440	1727	1716	1432	1487	1857	1165						May-15	889	214	1	25	0	2	29	5	1165	3022			
10			Nurse Bank Use (shifts)	No.	60912	5076																				May-15	2618	858	199	573	1	13	403	212	4877	9228			
10			Nurse Agency Use (shifts)	No.	0	0																				May-15	2144	385	4	133	0	349	310	69	3394	5650			
10			Admin & Clerical Bank Use (shifts)	No.	0	0																				May-15	854	160	110	75	479	182	172	2914	4946	10109			
10			Admin & Clerical Agency Use (shifts)	No.	0	0																				May-15	48	0	21	15	0	0	0	42	126	261			
			Medical Staffing - Number of instances when junior rotas not fully filled	No.	0	0																																	
15			Your Voice - Response Rate	%			19.8			18.2			17.4			12.6	12.7	13.5								Mar-15	7	9	14	9	27	18	30	14	13.5				
15			Your Voice - Overall Score	No.			3.63			3.68			3.65			3.57	3.55	3.57								Mar-15	3.5	3.4	3.5	3.5	3.7	3.3	3.8	3.5	3.57				





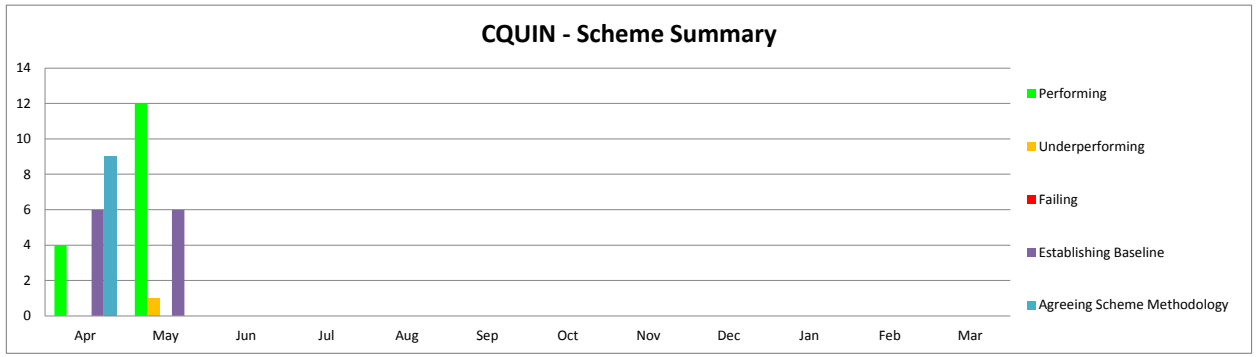


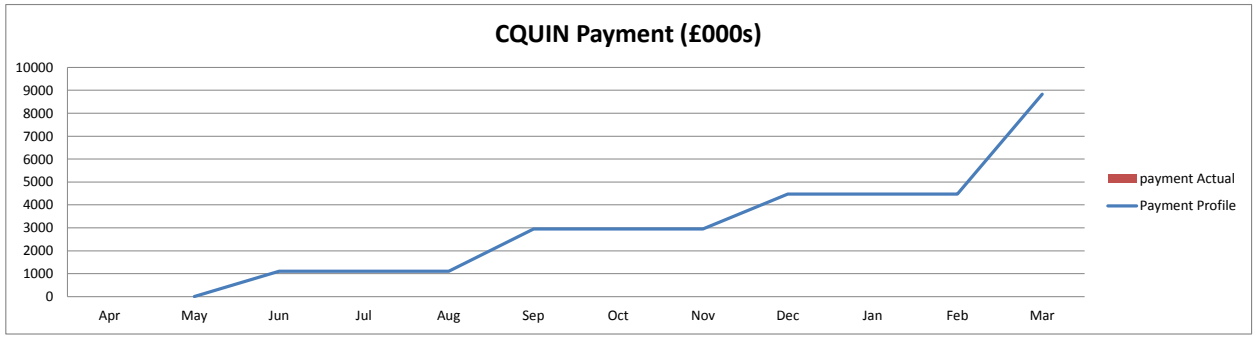
CQUIN (I)

Data Source	Data Quality	CQUIN	Indicator	Trajectory		Previous Months Trend												Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
				Year	Month	A	M	J	J	A	S	O	N	D	J	F	M		M	A	B	W	P	I	C	CO					
		National	Acute Kidney Injury	Improvement from previous Quarter		Derive Base Data												May-15									Manual Audit	On Track	●		
4		National	Sepsis Screening	Improvement from base to agreed target		Derive Base Data												May-15									On Track	On Track	●		
4		National	Sepsis Antibiotic Administration	90% by Q4		Establish Audit Mech.			Derive Base Data									May-15									On Track	On Track	●		
8		National	Dementia - Find, Assess, Investigate, Refer & Inform	90% (each of 3 elements) in Q4		●	●											May-15									3 of 3 Met	3 of 3 Met	●		
8		National	Dementia - Staff Training	Target tba - Qly reports to Board		Agree programme												May-15									On Track	On Track	●		
8		National	Dementia - Suporting Carers	Bi-annual reports to Board		Agree survey & process			Report to Board									May-15									On Track	On Track	●		
2		National	Improvement in diagnosis recording in HES Data Set of Mental Health presentations in A&E	90% by Q4		Qly Data Collection												May-15									77	77	●		
14		Local	Community Therapies - Dietetics Community Communication with GPs	Deliver outstanding actions from 14 / 15		One data submission at end of Q2												May-15									Met	Met	●		
8		Local	Safeguarding - continue to embed into practice, implement lessons learnt, reflect on practice.	Submit completed proforma to CCG		Q. Proforma Submission												May-15									On Track	On Track	●		
		Local	Reduce Number of Ward Transfers experienced by patients with Dementia	Agree improvement trajectory from base		Derive Base Data												May-15									On Track	On Track	●		
2		Local	Reduce Number of Out Of Hours Patient Transfers	Agree improvement trajectory from base		Derive Base Data												May-15									On Track	On Track	●		
		Spec.	Reduce Number of Consultant-Led Follow Up OP Attendances	Implement plans to & monitor FUN ratio		Formulate Plans			Sign Off of Plans									May-15									On Track	On Track	●		
17		Spec.	HIV - Reducing Unnecessary CD4 Monitoring	90% pts have no more than 1 CD4 count in 9m		Qly Data Collection			Qly Data Collection			Qly Data Collection						May-15									On Track	On Track	●		
		Spec.	Haemoglobinopathy Networks - develop partnership working, define pathways and protocol	Publish agreed care p'ways and protocols		Set Up initial network meet												May-15									On Track	On Track	●		
		Spec.	Breast Cancer - help patients make more informed choices regarding treatment	Provision of anon. pt. Datasets		Derive Base Data												May-15									On Track	On Track	●		
16		Spec.	Bechet's Disease (Highly Specialised Service) - set up clinical outcome collaborative workshop	Submit Quarterly return		●												May-15									On Track	On Track	●	●	●

CQUIN (II) and summary

Data Source	Data Quality	CQUIN	Indicator	Trajectory		Previous Months Trend												Data Period	Group								Month	Year To Date	Trend	Next Month	3 Months
				Year	Month	A	M	J	J	A	S	O	N	D	J	F	M		M	A	B	W	P	I	C	CO					
		Public Health	Breast Screening - improvement in uptake	Annual Report		Agree Strategy			Demonstrate Improvement			Demonstrate Improvement			Demonstrate Improvement			May-15									Work in Progress On Plan	On Track	●		
		Public Health	Bowel Screening - improvement in uptake	Annual Report		Agree Strategy			Demonstrate Improvement			Demonstrate Improvement			Demonstrate Improvement			May-15									Work in Progress On Plan	On Track	●		
		Public Health	Maternity and Health Visiting Services - Integrated working	Implement Shared Assessment Framework		Baseline of existing			Develop Integrated Framework			Action plan & mobilisation			Implement			May-15									On Track	On Track	●		





The Trust is contracted to deliver a total of 19 CQUIN schemes during 2015 / 2016. 7 schemes are nationally mandated, a further 4 have been agreed locally, 5 identified by the West Midlands Specialised Commissioners and 3 by Public Health. The collective financial value of the schemes is c.£8.8m.

In summary 12 schemes are classified as performing, a total of 6 schemes require baseline data to be gathered before improvement trajectories and targets are finalised, with 1 scheme currently underperforming. The scheme underperforming is 'Improvement in diagnosis recording in HES Data Set of Mental Health presentations in A&E'. Performance currently is 77% data recording, against a requirement of 90% or more in order to attract full funding. Current performance would attract 50% of the CQUIN value of this nationally mandated scheme. The Trust is seeking an amendment to this CQUIN with commissioners, to work to an agreed improvement trajectory from the current base position.

A confirm and challenge meeting was held with scheme leads on 22 June 2015, with the intention that similar regular meetings are held at various stages during the year. Discussions at this initial meeting identified that 17 of the schemes are on plan to satisfy Quarter 1 requirements, although a number of schemes will need to make progress with certain requirements of the schemes and deliver to various plans, trajectories and strategies as the year progresses. The scheme 'Community Therapies - Dietetics Community Communication with GPs', a carry over scheme from last year, has fully met the requirements of the scheme for this year, prior to its Quarter 2 deadline. Formal submission of CQUIN performance to commissioners will also be required each quarter.

External Assessment Frameworks

TRUST DEVELOPMENT AUTHORITY (TDA) ACCOUNTABILITY FRAMEWORK - SUMMARY

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
QUALITY SCORE		2	3										
Domain													
Responsiveness	Initial Score	5	4										
	Override Rules Applied	Yes	Yes										
	Revised Score	2	3										
	Indicators Not Achieving TDA Standard	ED 4-hours	ED 4-hours Urgent Op - canc x2 Cancer 62-day RTT 52w Waits										
Effectiveness	Initial Score	5	5										
	Override Rules Applied	No	No										
	Revised Score	5	5										
	Indicators Not Achieving TDA Standard												
Safe	Initial Score	5	4										
	Override Rules Applied	No	No										
	Revised Score	5	4										
	Indicators Not Achieving TDA Standard	Harm Free Care Never Event	Harm Free Care Never Event Open CAS Alerts										
Caring	Initial Score	5	5										
	Override Rules Applied	No	No										
	Revised Score	5	5										
	Indicators Not Achieving TDA Standard												
Well Led	Initial Score	4	4										
	Override Rules Applied	No	No										
	Revised Score	4	4										
	Indicators Not Achieving TDA Standard	Temp. Staff Costs	Temp. Staff Costs										
FINANCE SCORE			GREEN										

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

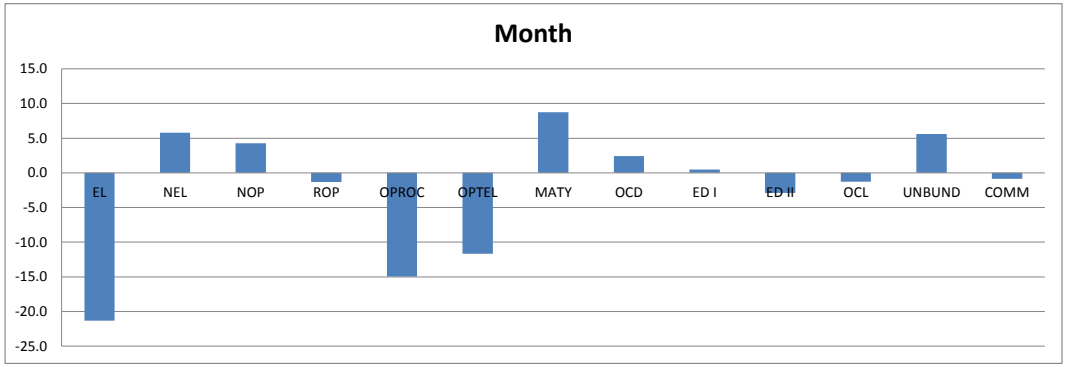
MONITOR RISK ASSESSMENT FRAMEWORK - SUMMARY

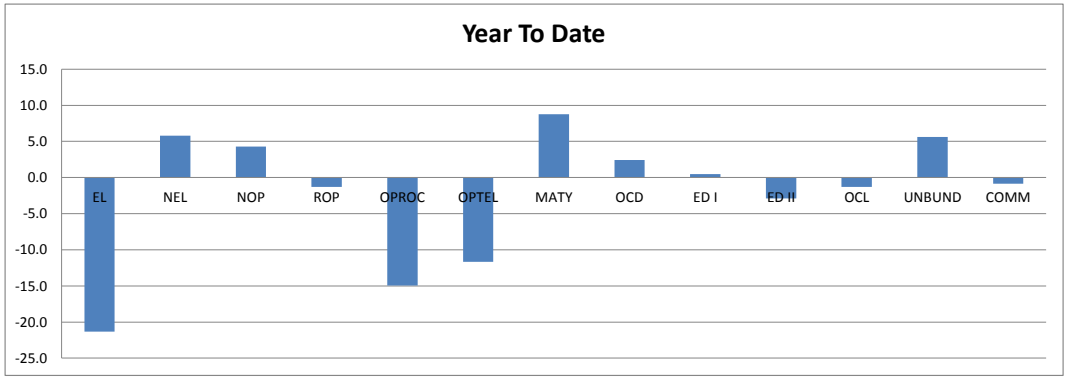
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Indicators Achieving Monitor Standard	14	13										
Indicators Not Achieving Monitor Standard	1	1										
	ED 4-hours	ED 4-hours Cancer 62-day										
GOVERNANCE RATING	1.0	2.0										

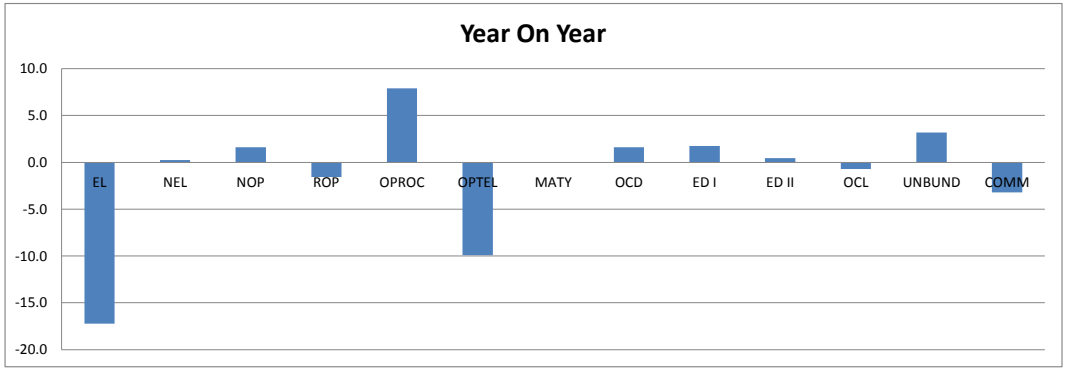
PLEASE NOTE:

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.

The volume of overall Elective activity for the month of April is significantly less than plan for the period and for the corresponding period last year. A total of 692 fewer elective spells, spread across a number of specialties, were delivered during April 2015, compared with April 2014. Overall Non Elective activity is 5.8% lower than plan for the month of April, although a similar level to April 2014. Outpatient New activity is ahead of plan by 4.3% (257 attendances) and Review activity is 1.3% below plan (451 attendances). Maternity pathway activity is reported as 8.7% above plan for the month. Comparison with 2014 / 2015 is not included as there were recording issues during the initial period of the Badgernet Information System implementation. ED Type I activity is slightly ahead of plan for the month (0.5%) and higher (1.7%) than the corresponding month last year. ED Type II activity is below plan (2.9%), although similar numerically to April 2014.

KEY

EL	IP and DC Elective	OPTEL	Outpatient Telephone Conversation	OCL	Other Contract Lines
NEL	IP Non Elective	MATY	Maternity Pathways	UNBUND	Unbundled Activity
NOP	New Outpatient	OCD	Occupied Cot Days	COMM	Adult and Child Community
ROP	Review Outpatient	ED I	ED City & Sandwell Acute and Malling		
OPPROC	Outpatient Procedures	ED II	ED BMEC		

Finance Summary

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
18		•f	Bottom Line Income & Expenditure position - Forecast compared to plan £m	£0.0		●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15									£0.000				
18		•f	Bottom Line Income & Expenditure position - Year to Date Actual compared to plan £m	£0.0	£0.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	-1.3	-0.7	-0.7	0.0	-0.1	-0.3	-0.1	-0.1		£0.005			
18		•f	Actual efficiency recurring / non-recurring compared to plan - Year to Date actual compared to plan	£0.0	£0.0	●	●	●	●	●	●	●	●	●	●	●	●		●					May-15	-0.2	-0.2	0.0	0.4	0.1	0.0	0.0	0.1		-£0.008			
18		•f	Actual efficiency recurring / non-recurring compared to plan - Forecast compared to plan	£0.0		●	●	●	●	●	●	●	●	●	●	●	●		●					May-15	-1.2	-3.0	-0.2	0.1	0.0	-0.1	-0.8	-2.6		£0.000			
18		•f	Forecast underlying surplus / deficit compared to plan	£0.0		●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15										£0.000			
18		•f	Forecast year end charge to capital resource limit	£22.8		●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15									£20,153				
18		•f	Is the Trust forecasting permanent PDC for liquidity purposes?	No		●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15									£0.000				
18		•b	Temporary costs and overtime as % total paybill	2.6%	2.6%	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	12.7	4.6	0.8	1.6	0.0	6.3	12.9	1.7	6.9	6.3			
18			Continuity of Service Risk Rating - Year to Date	2.5		●	●	●	●	●	●	●	●	●	●	●	●		●					May-15										3.5			

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

Data Source	Data Quality	OS / NQR	Indicator	Threshold	APRIL (£000s)									MAY (£000s)									JUNE (£000s)									YEAR TO DATE (£000s)								
					M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		OS	RTT Admitted Care (£400 per breach by specialty)	=>90.0%	0.0	4.8	0.0	0.0					4.8	0.0	6.0	0.0	0.0						6.0									0.0	0.0	10.8	0.0	0.0					10.8
2		OS	RTT Non-Admitted Care (£100 per breach by specialty)	=>95.0%	0.1	0.0	0.0	0.0					0.1	0.7	3.7	0.2	0.0						4.6									0.0	0.8	3.7	0.2	0.0					4.7
2		OS	RTT Incomplete Pathway (£150 per breach by specialty)	=>92.0%	0.0	14.1	1.8	0.0					15.9	0.0	5.7	5.3	0.0						11.0									0.0	0.0	19.8	7.1	0.0					26.9
2		OS	Diagnostic Waits (£200 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
2		OS	ED Waits >4 hours (£120 per breach between 85.0% and 95.0%)	=>95.0%	72.1		0.0						72.1	53.8		0.0						53.8									0.0	125.8		0.0						125.8
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
13		OS	Mixed Sex Accommodation Breaches (£250 per day per Service User affected)	0	0.0	0.0	0.0	0.0					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		OS	Cancelled Operations 28-day (non-payment of rescheduled episode of care)	0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0									0.0	0.0	0.0	0.0	0.0					0.0
4		NQR	MRSA Bacteraemia (£10,000 per incidence)	0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0			0.0									0.0	0.0	0.0	0.0	0.0			0.0		0.0
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
2		NQR	RTT Waits >52 weeks Incomplete Pathway (£5,000 per breach)	0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	10.0	0.0						10.0									0.0	0.0	0.0	10.0	0.0					10.0
11		NQR	WMAS Handovers to ED (£200 per breach 30 - 60 minutes)	0	28.8								28.8	27.2									27.2									0.0	56.0								56.0
11		NQR	WMAS Handovers to ED (£1000 per breach >60 minutes)	0	8.0								8.0	8.0									8.0									0.0	16.0								16.0
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
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	5.0						5.0									0.0	0.0	0.0	0.0	5.0					5.0
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
9		NQR	Never Events (cost of original procedure plus any rectification)	0	0.0	0.4	0.0	0.0	0.0	0.0	0.0		0.4	0.0	8.4	0.0	0.0	0.0	0.0	0.0			8.4									0.0	0.0	8.8	0.0	0.0	0.0	0.0	0.0			8.8
13		NQR	Publication Of Formulary (withholding of 1% of actual monthly contract value for non publication)	0								0.0	0.0								0.0	0.0									0.0	0.0							0.0	0.0
9		NQR	Duty Of Candour (Non-payment for cost of care or £10,000 if cost of care unknown / indeterminate)	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.0									0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0			0.0
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
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
			ALL		109.0	18.9	1.8	0.0	0.0	0.0	0.0	0.0	129.7	89.7	23.8	15.5	5.0	0.0	0.0	0.0	0.0	133.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	198.6	43.1	17.3	5.0	0.0	0.0	0.0	0.0	264.0

Contractual Requirements - Local Quality Requirements (Acute Services)

Data Source	Data Quality	Req	Indicator	Threshold	APRIL (£000s)									MAY (£000s)									JUNE (£000s)									YEAR TO DATE (£000s)								
					M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
3		LQR	Mat'y health and social risk assessment (£1000 / month if 4 consecutive months of failure)	=>90.0%				0.0					0.0				0.0					0.0									0.0				0.0					0.0
3		LQR	Mat'y - % of babies at risk of TB vaccinated (non payment if 3 consecutive months failure)	=>98.0%									0.0									0.0									0.0				0.0					0.0
3		LQR	Mat'y - % mothers who have initiated breasfeeding within 48 hours. (£50 each breach)	=>77.0%	Assessed Quarterly									Assessed Quarterly																	0.0				0.0					0.0
3		LQR	Mat'y - BMI recorded by 12+6 weeks pregnancy (£1000/month if 4 consecutive months of failure)	=>90.0%				0.0					0.0				0.0					0.0									0.0				0.0					0.0
3		LQR	Mat'y - % with BMI >35 referred to weight m'ment (£1000/month if 4 consecutive months of failure)	=>90.0%				0.0					0.0				0.0					0.0									0.0				0.0					0.0
3		LQR	Mat'y - % with BMI =<18 referred to weight m'ment (£1000/month if 4 consecutive months of failure)	=>90.0%				0.0					0.0				0.0					0.0									0.0				0.0					0.0
3		LQR	Mat'y - CO recorded & documented by 12+6 weeks. (£1000/month if 4 consecutive months of failure)	=>90.0%				0.0					0.0				0.0					0.0									0.0				0.0					0.0
3		LQR	Mat'y - report on no.'s ceased smoking / referred (£1000/month if 4 consecutive months of failure)	=>90.0%				0.0					0.0				0.0					0.0									0.0				0.0					0.0
3		LQR	Mat'y - AN detection of IUGR (£1000/month if 4 consecutive months of failure)	100%									0.0									0.0									0.0				0.0					0.0
3		LQR	Stroke - thrombolysis (non payment for any >30 hours if 3 consecutive months of failure)	=>50.0%	0.0								0.0	0.0								0.0									0.0	0.0								0.0
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
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
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
3		LQR	ED - Time to Initial Assessment <15 mins (£25 per breach between 92.0% and 95.0%)	=>95.0%	6.1		0.0						6.2	7.0		0.1						7.1									0.0	13.1		0.1						13.2
3		LQR	ED - Unplanned Reattendance within 30 days (£50 per breach between 5.00% and 8.00%)	=<5.00%	19.4		0.0						19.4	21.6		0.0						21.6									0.0	41.0		0.0						41.0
3		LQR	ED - Left Without Being Seen (lower £23 pay't per pt., & £15 per breach between 5.00% and 8.00%)	=<5.00%	0.0		0.0						0.0	0.0		0.0						0.0									0.0	0.0		0.0						0.0
2		LQR	Morning Discharges (< m'day) (£50 per 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
11		LQR	WMAS CAD Compliance Minimum Standard (penalty dependent upon magnitude of breach)	=>80%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0									0.0	0.0	0.0	0.0	0.0					0.0
		LQR	WMAS Patient Level MDS - inclusion of CAD number (method of measurement tba)	=>80%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0									0.0	0.0	0.0	0.0	0.0					0.0
		LQR	WMAS - Reduce non-ED Clinical Hanover Delays >1 hour (method of measurement tba)	=<20%									0.0									0.0									0.0	0.0	0.0	0.0	0.0					0.0
		LQR	WMAS - Reduce non-ED Clinical Hanover Delays >30 mins(method of measurement tba)	=<25%									0.0									0.0									0.0	0.0	0.0	0.0	0.0					0.0
2		LQR	Paeds. have OP F/U app't <6 w discharge post meningoccal septicaemia (non pay't OP app't >6w)	100%				0.0					0.0				0.0					0.0									0.0	0.0			0.0					0.0
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
3		LQR	WHO Safer Surgery Checlkist Compliance (3 components) (Consec. Breaches £1000 / month)	98%, 95% and 85%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0									0.0	0.0	0.0	0.0	0.0					0.0
19		LQR	HbA1c (pt's achieved target <6 m after being set) (non pay't for breach after 3 m'ths fail)	=>75.0%	Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly								
19		LQR	HbA1c (pt's receiving written care plan with agreed targets) (£50 per breach)	=>90.0%	Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly								
2		LQR	Ethnicity Coding (£1000 per month after 2 months failure)	=>90.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0									0.0	0.0	0.0	0.0	0.0					0.0
		LQR	High Cost Drug Prior Appoval (non payment by CCG)	=>95%									0.0									0.0									0.0	0.0	0.0	0.0	0.0					0.0
1		LQR	Cancer - Inter-provider tertiary referrals for 62-day cancer, referrals <42days. (£500 per breach)	100%									0.0									0.0									0.0	0.0	0.0	0.0	0.0					0.0
2		LQR	ED - Coding should include diagnosis (£1000/month after 3 consequetive breaches)	=>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
		LQR	MASH - Compliance with MASH Protocol (£25,000 per quarter for breach)	100%	Assessed Quarterly									Assessed Quarterly																	0.0	0.0	0.0	0.0	0.0					0.0
			ALL		25.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	25.6	28.6	0.0	0.1	0.0	0.0	0.0	0.0	0.0	28.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	54.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	54.2

Contractual Requirements - Local Quality Requirements (Community Services)

Data Source	Data Quality	Req	Indicator	Threshold	APRIL (£000s)									MAY (£000s)									JUNE (£000s)									YEAR TO DATE (£000s)								
					M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
14		LQR	Corporate - Ethnicity Coding - (£1000/month if 4 consecutive months of failure)	=>90%							0.0		0.0								0.0		0.0								0.0								0.0
14		LQR	Community Nursing - Flu vaccinations (£25 per patient breach)	100% (who have agreed)							0.0		0.0								0.0		0.0								0.0								0.0
14		LQR	Community Nursing - Pts. on caseload with a care plan (£1000 / Qtr if 2 consecutive q'ly breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
14		LQR	Community Nursing - Dementia Screening (£1000 / Qtr if 2 consecutive q'ly breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
14		LQR	Community Nursing - EOL patients on SCP (£1000 / Qtr if 2 consecutive q'ly breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
14		LQR	Community Nursing - Compliance with wound m'ment formulary (Non compliant = no payment)	=>90%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
14		LQR	Community Nursing - Falls Risk Assessment (£1000 / Qtr if 2 consecutive q'ly breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
14		LQR	Community Nursing - Staff S'guarding/COI Training (£1000 / Qtr if 2 consecutive q'ly breaches)	=>95%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
17		LQR	Community Gynaecology - Referral to first OP appointment <4 weeks (no penalty)	100%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
17		LQR	Community Gynaecology - One Stop Service (£1000 / Qtr if 2 consecutive q'ly breaches)	=>90%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
17		LQR	Community Gynaecology - FUN Ratio (no penalty)	<1.2	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
17		LQR	Community Gynaecology - Onward Referral Rate <10% (£1000 / Qtr if 2 consecutive q'ly breaches)	100% <10%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
17		LQR	Community Gynaecology - Reports to referring GP <1 working week of appointment (no penalty)	100%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
17		LQR	Community Gynaecology - Patient Experience Satisfaction Rate (no penalty)	=>95%	Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly								
17		LQR	Community Gynaecology - No. clinics / sessions cancelled (no penalty)	100%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
17		LQR	Community Gynaecology - Same day ultrasound available within clinic (no penalty)	=>95%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
17		LQR	Community Gynaecology - Adherance to Formulary & Wound M'ment Formulary (no penalty)	Annual Report	Assessed Annually									Assessed Annually									Assessed Annually									Assessed Annually								
14		LQR	Community MSK-Pts ref. for Card. Rehab who complete course(£1000/Q if 2 consec.Q breaches)	tba									0.0										0.0								0.0								0.0
14		LQR	Community MSK-Pts ref. for Hydrotherapy who complete course(£1000/Q if 2 consec.Q breaches)	tba									0.0										0.0								0.0								0.0
14		LQR	Community MSK-Pts ref. for Group Gym who complete course(£1000/Q if 2 consec.Q breaches)	tba									0.0										0.0								0.0								0.0
14		LQR	Community MSK-Pts ref. for Pain M'ment who complete course(£1000/Q if 2 consec.Q breaches)	tba									0.0										0.0								0.0								0.0
14		LQR	Community Resp. - Urgent referrals seen <48hrs (£1000/Qtr if 2 consecutive quarterly breaches)	=>90%									0.0										0.0								0.0								0.0
14		LQR	Community Resp. - COPD referrals to Pulmonary Rehab. (no penalty)	100%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
14		LQR	Community Continence - Referrals to assessment <2 weeks (no penalty)	=>95%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
14		LQR	Community Home O2-Av. wait for LTOT assessment <48 hrs(£1000/Q if 2 consec.Q breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
14		LQR	Community Home O2-Pts. Who have a F/U home visit <4weeks (£250/Q if 2 consec.Q breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
14		LQR	Community Home O2-Pts. Who have a F/U home visit <3 months (£250/Q if 2 consec.Q breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
14		LQR	Community Home O2-Pts. Who have a F/U home visit <6 months (£250/Q if 2 consec.Q breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
14		LQR	Community Home O2-Pts. Who have a F/U home visit <12 months (£250/Q if 2 consec.Q breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
14		LQR	Community Home O2-Pts. With CO2 retention given O2 alert cards (£1000/Q if 2 consec.Q breaches)	tba	Assessed Quarterly									Assessed Quarterly																	0.0								0.0
			ALL		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Contractual Requirements - CQUIN (CQ)

Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	APRIL (£000s)									MAY (£000s)										JUNE (£000s)										YEAR TO DATE (£000s)									
						M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
		CQ	Acute Kidney Injury	795	Improvement from previous Quarter	0.0								0.0	0.0								0.0									0.0									0.0
4		CQ	Sepsis Screening	398	Improvement from base to agreed target	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		CQ	Sepsis Antibiotic Administration	398	90% by Q4	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0									0.0									0.0
8		CQ	Dementia - Find, Assess, Investigate, Refer & Inform	455	90% (each of 3 elements) in Q4	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0									0.0									0.0
8		CQ	Dementia - Suporting Carers	170	Target tba - Qly reports to Board	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0									0.0									0.0
8		CQ	Dementia - Suporting Carers	170	Bi-annual reports to Board	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		CQ	Improvement in diagnosis recording in HES Data Set of Mental Health presentations	1591	90% by Q4	0.0								0.0	0.0								0.0									0.0									0.0
14		CQ	Community Therapies - Dietetics Community Communication with GPs	406	Deliver outstanding actions from 14 / 15							0.0		0.0							0.0		0.0									0.0									0.0
8		CQ	Safeguarding - continue to embed into practice, implement lessons learnt, reflect on practice.	1591	Submit completed proforma to CCG								0.0	0.0								0.0	0.0									0.0									0.0
		CQ	Reduce Number of Ward Transfers experienced by patients with Dementia	991	Agree improvement trajectory from base	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0									0.0									0.0
2		CQ	Reduce Number of Out Of Hours Patient Transfers	989	Agree improvement trajectory from base	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0									0.0									0.0
		CQ	Reduce Number of Consultant-Led Follow Up OP Attendances	118	Implement plans to & monitor FUN ratio	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0									0.0									0.0
17		CQ	HIV - Reducing Unnecessary CD4 Monitoring	118	90% pts have no more than 1 CD4 count in 9m				0.0					0.0				0.0					0.0									0.0									0.0
		CQ	Haemoglobinopathy Networks - develop partnership working, define pathways and protocol	118	Publish agreed care p'ways and protocols	0.0								0.0	0.0								0.0									0.0									0.0
		CQ	Breast Cancer - help patients make more informed choices regarding treatment	118	Provion of anon. pt. Datasets		0.0							0.0		0.0							0.0									0.0									0.0
16		CQ	Bechet's Disease (Highly Specialised Service) - set up clinical outcome collaborative workshop	118	Submit Quarterly return			0.0						0.0			0.0						0.0									0.0									0.0
		CQ	Breast Screening - improvement in uptake	94	Annual Report		0.0							0.0		0.0							0									0.0									0.0
		CQ	Bowel Screening - improvement in uptake	42	Annual Report	0.0								0.0	0.0								0.0									0.0									0.0
		CQ	Maternity and Health Visiting Services - Integrated working	154	Quarterly Reports				0.0					0.0				0.0					0.0									0.0									0.0
			ALL	8834		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Contractual Requirements - Price Activity Matrix (PAM)

Data Source	Data Quality	Req	Indicator	Threshold	APRIL (£000s)									MAY (£000s)									JUNE (£000s)									YEAR TO DATE (£000s)								
					M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		PAM	Elective (IP and DC)	Contract Plan	-136	-533	-136	-89	-2	1			-895	-43	-297	-166	-24	1	4			-525									0	-179	-830	-302	-113	-1	5			####
2		PAM	Non-Elective	Contract Plan	207	199	-36	-39					331	148	272	-24	85					481									0	355	471	-60	46					812
2		PAM	Excess Bed Days	Contract Plan	-67	-22	-4	-48					-141	-47	-27	2	44					-28									0	-114	-49	-2	-4					-169
2		PAM	Accident & Emergency	Contract Plan	-29		-19						-48	-8		-3						-11									0	-37		-22						-59
2		PAM	Outpatient New	Contract Plan	93	-18	21	-14	-3	0	8		87	56	-38	-12	5	-1	0	6		16									0	149	-56	9	-9	-4	0	14		103
2		PAM	Outpatient Review	Contract Plan	-26	-35	19	-33	-1	0	11		-65	-26	-22	18	-16	-3	0	10		-39									0	-52	-57	37	-49	-4	0	21		-104
2		PAM	Outpatient with Procedure	Contract Plan	-29	-39	1	4					-63	-31	-48	-2	19					-62									0	-60	-87	-1	23					-125
2		PAM	Outpatient Telephone Conversation	Contract Plan	-1	0							-1	-1	0							-1									0	-2	0							-2
2		PAM	Maternity	Contract Plan				158					158				113					113									0				271					271
2		PAM	Occupied Cot Days	Contract Plan				-25					-25				-1					-1									0				-26					-26
2		PAM	Unbundled Activity	Contract Plan	30	-14	0	-1	0	0			15	84	-10	6	-3	0	0			77									0	114	-24	6	-4	0	0			92
2		PAM	Other Contract Lines	Contract Plan	115	-2	-129	-84	-14	-34	0		-148	-60	-2	-235	-30	-14	-26	0		-367									0	55	-4	-364	-114	-28	-60	0		-515
2		PAM	Community	Contract Plan	-2	0		0		0	-4		-6	-1	0		-7		0	-13		-21									0	-3	0		-7		0	-17		-27
			ALL		155	-464	-283	-171	-20	-33	15	0	-801	71	-172	-416	185	-17	-22	3	0	-368	0	0	0	0	0	0	0	0	0	226	-636	-699	14	-37	-55	18	0	####

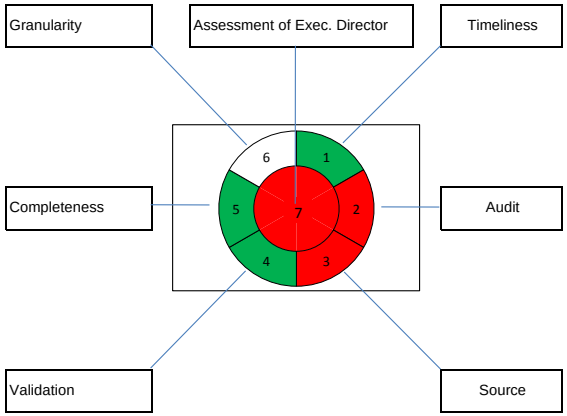
Legend

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 (since April 2014)																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
C. Difficile	30	3	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	1	1	0	2	3	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	0	●		
MRSA Screening - Elective (%)	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	88	98	63	87.7		●		
MRSA Screening - Non Elective (%)	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	94	93	79	93.57		●		
Falls	0	0	33	40	61	42	44	41	67	50	66	63	42	52	28	37					May-15	8	24	5	37	65	●		
Falls with a serious injury	0	0	1	3	3	1	4	1	1	2	0	1	0	1	1	0					May-15	0	0	0	0	1	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	2	3	3	3	0	5	1	6	7	10	1	1	10						Apr-15				10	10	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	99	99.1	99	99.0		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	100	99	99.7		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	100	100	100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	1	●	●					May-15	0	0	0	0	0	●		
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	1	1	0	2	3	●		
Mortality Reviews within 42 working days	100	=>98	●	●	●	●	●	●	●	●	●	●	●	●							Mar-15	100	80	78	82		●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
Pts spending >90% stay on Acute Stroke Unit (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		95.4		95.4	92.4	●		
Pts admitted to Acute Stroke Unit within 4 hrs (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		80.7		80.7	82.0	●		
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		73.3		73.3	75.0	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		96.7		96.7	98.1	●		
Stroke Admission to Thrombolysis Time (% within 60 mins)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		75.0		75.0	63.6	●		
Stroke Admissions - Swallowing assessments (<24h) (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		100		100.0	100.0	●		
TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=>70.0	=>70.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		92.7		92.7	96.0	●		
TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=>75.0	=>75.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		95.1		95.1	97.4	●		
Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15		95.0		95.0	95.0	●		
Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15		94.4		94.4	94.4	●		
Rapid Access Chest Pain - seen within 14 days (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15		100		100.0	100.0	●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15			92	91.9		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15			98	97.9		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15			91.3	91.3		●		
Mixed Sex Accommodation Breaches	0	0	36	43	14	0	0	0	7	0	0	0	0	0	0	0					May-15	0	0	0	0	0	●		
No. of Complaints Received (formal and link)				38	28	28	32	36	48	18	31	30	36	38	41	35					May-15	13	11	11	35	76			
No. of Active Complaints in the System (formal and link)				##	##	##	##	##	##	##	93	##	##	##	##	##					May-15	41	47	16	104				
Oldest' complaint currently in system (days)				##	##	##	##	##	##	##	##	##	##	##	##	##					May-15				188				

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0.00	0.59	0.00	0.06		●		
28 day breaches	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0					May-15	0	0	0	0	0	●		
Sitrep Declared Late Cancellations	0	0	10	2	7	7	3	2	5	4	1	0	0	9	8	1					May-15	0	1	0	1	9	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0					61	54	57	60	62	61	49	48	56	46					May-15			46.2	46.19		●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	93.5 (s)	90.3 (C)		91.8	91.3	●		
Emergency Care 4-hour breach (numbers)			570	1003	1016	907	736	1201	1390	1181	1913	940	1242	1412	1310	1106					May-15	###	1	27	1106	2416			
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0 (s)	0 (c)		0	0	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	16 (s)	18 (c)		17	17	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	56 (s)	68 (c)		62	61	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	8.59 (s)	8.17 (c)		8.36	8.29	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	3.23 (s)	6.13 (c)		4.79	4.98	●		
WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	0	0	119	136	125	145	51	136	219	159	282	185	149	164	144	136					May-15	54	82		136	280	●		
WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	0	0	13	8	8	8	1	13	21	14	31	7	6	8	9	8					May-15	3	5		8	16	●		
WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	=<0.02	=<0.02	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0.16	0.20		0.18	0.19	●		
WMAS - Emergency Conveyances (total)			4044	4227	4093	4278	3994	4067	4193	4168	4470	4001	3829	4182	3981	4214					May-15	1789	2425		4214	8195			

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		94.9	95.3	95.1		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		95.4	97.9	97.0		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		94.7	95.9	95.5		●		
Patients Waiting >52 weeks	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0					May-15	0	0	0	0		●		
Treatment Functions Underperforming	0	0	6	3	5	5	6	5	5	7	2	2	6	1	1	1					May-15	0	1	0	1		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0.0	0.5	0.0	0.37		●		
WTE - Actual versus Plan			171	161	157	151	166	160	166	197	232	242	244	328	195	207					May-15	95	65	47	207				
PDRs - 12 month rolling (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	89	87	90		88.1	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	77	97	84		86.4	●		
Sickness Absence (%)	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	4.64	5.69	6.39	5.44	4.83	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●					May-15	52.7	67.1	38.3		57.2	●		
Mandatory Training (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	83.3	82.6	82.6		82.8	●		
New Investigations in Month			1	1	1	2	1	2	1	0	0	1	2	2	2	1					May-15	1	0	0	1				
Nurse Bank Fill Rate %	100	100												72	69	73					May-15				73.1		●		
Nurse Bank Shifts Not Filled (number)	0	0												1031	1392	889					May-15				889	2281	●		
Nurse Bank Use	34560	2880	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15				2618	5036	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15				2144	3683	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15				854	1698	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15				48	101	●		
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																											
Your Voice - Response Rate (%)			8		9		9		6				7								Mar-15	5	5	15	6				
Your Voice - Overall Score			3.68		3.76		3.76		3.57				3.5								Mar-15	3.4	3.6	3.6	3.54				

Surgery A Group

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
C. Difficile	7	1	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	0	1	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	99	99	99	0	98.3		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	96	95	99	100	96.3		●		
Falls	0	0	9	7	4	8	3	9	9	6	6	0	4	4	3	7					May-15	5	2	0	0	7	10	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0					May-15	0	0	0	0	0	0	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	1	0	0	0	1	1	0	0	4	0	0	2	0						Apr-15					0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	97.7	99.0	96.3	98.8	97.9		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	99.6	99.8	99.6	100	99.7		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	88.9	100	100	98.1		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	1	1					May-15	0	1	0	0	1	2	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	0	0	●		
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	1	0	0	1	3	●		
Mortality Reviews within 42 working days	100	=>98	●	●	●	●	●	●	●	●	●	●	●	●							Mar-15	83			94	91		●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	95.8		90.9		94.6		●		
2 weeks (Breast Symptomatic)	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	96.6				96.6		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	97.9		89.5		95.5		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	95.9		60.0		85.5		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	3	0	0	0	0	2	0	0	0	0	0					May-15	0	0	0	0	0	0	●		
No. of Complaints Received (formal and link)				12	11	8	19	15	13	13	7	15	9	16	18	8					May-15	2	2	3	1	8	26			
No. of Active Complaints in the System (formal and link)				50	50	34	39	49	57	78	53	45	40	45	47	27					May-15	10	10	5	2	27				
Oldest' complaint currently in system (days)				124	131	118	99	109	133	143	171	192	213	234	254	97					May-15					97				
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0.9	1.6	1.5	0.0	1.05		●		
28 day breaches	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	0					May-15	0	0	0	0	0	0	●		
Sitrep Declared Late Cancellations	0	0	13	16	5	6	16	10	18	6	33	11	13	17	12	10					May-15	3	4	3	0	10	22	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0					76	78	75	77	71	78	79	75	77	77					May-15	75.8	79.9	74.6		77.0		●		
Emergency Care 4-hour breach (numbers)			81	100	100	119	52	103	118	94	121	43	108	127	59	67					May-15	50	10	3	4	67	126			
Hip Fractures - Operation < 24 hours of admission (%)	85	85	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		100			100.0	77.1	●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																	Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D				
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	91.2	83.8	91.6		88.7		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	98.2	95.1	89.6		95.6		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	96.3	90.7	95.4		93.7		●		
Patients Waiting >52 weeks	0	0	1	1	0	2	4	2	1	2	0	3	1	2	1	0					May-15	0	0	0	0	0		●		
Treatment Functions Underperforming	0	0	7	5	5	4	3	4	6	7	4	5	8	4	2	3					May-15	0	2	1	0	3		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	1.1	0.0	0.0	0.0	0.68		●		
WTE - Actual versus Plan			64	71	77	78	71	71	71	76	66	62	70	71	77	102					May-15	32	13	34	23	102				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	86.9	84	96.5	89.7		91.0	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	94	92	88	93		92.6	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	5.47	3.17	5.61	3.96	4.92	5.32	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●					May-15	46.7	35.4	69.2	67.5		58.5	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	87.9	82.7	93.7	89.6		89.7	●		
New Investigations in Month			0	0	0	0	0	2	0	1	0	1	1	2	3	3					May-15	0	1	2	0	3				
Nurse Bank Fill Rate	100	100												76	71	79					May-15					78.8		●		
Nurse Bank Shifts Not Filled	0	0												335	369	214					May-15					214	583	●		
Nurse Bank Use	9908	826	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15					858	1590	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15					385	656	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15					160	321	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15					0	0	●		
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																												
Your Voice - Response Rate			13		11		11		9												Mar-15	13	5	7	7	9				
Your Voice - Overall Score			3.55		3.57		3.57		3.41												Mar-15	3.35	3.42	3.45	3.43	3.41				

Surgery B Group

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		O	E					
C. Difficile	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	99	99.0		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	94	94	94.0		●		
Falls	0	0	1	0	0	2	0	0	0	0	1	1	0	0	0	0					May-15	0	0	0	0	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					May-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						Apr-15	0	0	0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	97.87	98.7	98.2		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	99.8	99.9		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	100	100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	●		
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	●		
Mortality Reviews within 42 working days	100	=>97	●	●				●													Mar-15					●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																	Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		O	E				
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15		97.2	**97.2**		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●		●	●	●	●						Apr-15		100	**100**		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0		●	●	●	●		●	●	●	●	●	●	●						Apr-15		100	**100**		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						May-15	0	0	**0**	**0**	●		
No. of Complaints Received (formal and link)				9	3	10	11	8	12	11	14	14	12	16	14	9					May-15	7	2	**9**	**23**			
No. of Active Complaints in the System (formal and link)				31	40	34	37	36	37	47	33	35	35	36	44	35					May-15	28	7	**35**				
Oldest' complaint currently in system (days)				117	100	103	129	98	63	138	109	102	123	144	164	80					May-15			**80**				
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	1.7	2.1	**1.88**		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					May-15	0	0	**0**	**0**	●		
Sitrep Declared Late Cancellations	0	0	**3**	**22**	**17**	**16**	**14**	**16**	**12**	**11**	**7**	**24**	**11**	**8**	**15**	**18**					May-15	10	8	**18**	**33**	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0					**72**	**74**	**72**	**73**	**68**	**74**	**72**	**75**	**71**	**72**					May-15	72	69	**71.5**		●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	99.3		**99.3**	**99.5**	●		
Emergency Care 4-hour breach (numbers)			7	14	72	6	25	29	5	25	21	8	8	39	10	20					May-15	16	4	**20**	**30**			
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0		**0**	**0**	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	34		**34**	**34**	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	26		**26**	**24**	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	3.31		**3.31**	**3.18**	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	2.07		**2.07**	**1.95**	●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																	Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		O	E					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	90.9	92.6	91.5		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	96.6	94.8	96.2		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	94.5	94.0	94.3		●		
Patients Waiting >52 weeks	0	0	0	1	1	0	0	2	2	1	0	0	1	1	0	2					May-15	2	0	2		●		
Treatment Functions Underperforming	0	0	3	4	3	3	2	4	5	5	1	2	7	1	1	2					May-15	0	2	2		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0.0	0.0	0.00		●		
WTE - Actual versus Plan			28	34	38	33	32	28	30	27	30	32	29	32	33	35					May-15	25	10	35				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	96.13	94.74		95.6	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	96	100		97.0	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	4.10	2.12	3.46	3.28	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●					May-15	38.6	76.8		48.1	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	85.8	92.4		87.5	●		
New Investigations in Month			0	0	0	0	0	0	0	0	0	0	0	0	0	1					May-15	1	0	1				
Nurse Bank Fill Rate	100	100												100	99.6	100					May-15			99.5		●		
Nurse Bank Shifts Not Filled	0	0												1	1	1					May-15			1	2	●		
Nurse Bank Use	2796	233	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15			199	369	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15			4	4	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15			110	220	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15			21	43	●		
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																										
Your Voice - Response Rate			18			17			17			14									Mar-15	7	29	14				
Your Voice - Overall Score			3.72			3.52			3.52			3.54									Mar-15	3.65	3.49	3.54				

Women & Child Health Group

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
C. Difficile	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100				100		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		100			100		●		
Falls	0	0	0	0	2	0	1	0	0	0	0	0	0	0	0	0					May-15	0	0	0	0	0	0	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					May-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	2	0	0	0	2	0	0						Apr-15	0	0	0	0	0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	99.1	93.4			95.9		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	100			100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	100			100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	100			100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	0	0	●		
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	0	1	●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
Caesarean Section Rate - Total (%)	=<25.0	=<25.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		24.8			24.8	23.9	●		
Caesarean Section Rate - Elective (%)			10	8	9	9	7	9	7	8	11	8	6	9	8	7					May-15		6.84			6.8	7.2			
Caesarean Section Rate - Non Elective (%)			16	18	19	15	17	18	19	16	16	15	17	16	15	18					May-15		18.0			18.0	16.7			
Maternal Deaths	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		0			**0**	**0**	●		
Post Partum Haemorrhage (>2000ml)	48	4	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		0			**0**	**0**	●		
Admissions to Neonatal Intensive Care (%)	=<10.0	=<10.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		1.4			**1.27**	**1.32**	●		
Adjusted Perinatal Mortality Rate (per 1000 babies)	<8.0	<8.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15		9.1			**9.1**		●		
Early Booking Assessment (<12 + 6 weeks) (%) - SWBH Specific	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		71.7			71.67		●		
Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15		164			**164**		●		
Mortality Reviews within 42 working days	100	=>97	●	●	●		●	●	●	●	●			●							Mar-15	100				**100**		●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	97.6		100		**97.6**		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	100				**100**		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	85.7				**85.7**		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					May-15	0				**0**	**0**	●		
No. of Complaints Received (formal and link)				4	6	11	8	8	8	12	7	11	9	11	7	9					May-15	4	5			**9**	**16**			
No. of Active Complaints in the System (formal and link)				15	21	21	24	29	29	33	12	21	27	32	28	28					May-15	15	11	2		**28**				
Oldest' complaint currently in system (days)				61	82	52	66	87	104	123	151	52	73	94	113	128					May-15					**128**				

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	1.9		0.0		1.50		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					May-15	0				0	0	●		
Sitrep Declared Late Cancellations	0	0	12	3	4	7	6	6	7	7	7	1	5	7	6	4					May-15	4				4	10	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0					78	76	77	77	80	77	78	79	73	78					May-15	78.1	74.6			77.9		●		
Emergency Care 4-hour breach (numbers)			18	14	14	18	14	30	23	36	82	5	30	16	11	13					May-15	10	0	3	0	13	24			
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	91.2				91.2		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	97.4				97.4		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	98.6				98.6		●		
Patients Waiting >52 weeks	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0					May-15	0				0		●		
Treatment Functions Underperforming	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					May-15	0				0		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0.0				0.0		●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																	Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
WTE - Actual versus Plan			48	58	60	67	81	61	60	59	66	67	69	70	69	73					May-15	24	60	21	0	73				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	88.2	88.9	93.2	88.9		90.0	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	100	100			100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	6.42	6.88	3.39	4.32	5.36	5.48	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●					May-15	52.1	54.8	55.6	64.2		55.4	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	90.6	78.9	87.9	89.4		83.8	●		
New Investigations in Month			0	0	0	2	0	0	0	0	0	0	1	1	1	3					May-15	0	2	0	1	3				
Nurse Bank Fill Rate	100	100												90	94	96					May-15					95.7		●		
Nurse Bank Shifts Not Filled	0	0												81	45	25					May-15					25	70	●		
Nurse Bank Use	6852	571	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15					573	1076	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15					133	157	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15					75	151	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15					15	31	●		
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																												
Your Voice - Response Rate			11		12			12			9										Mar-15	17	3	15	12	9				
Your Voice - Overall Score			3.79		3.65			3.65			3.53										Mar-15	3.44	4.0	3.2	3.78	3.53				

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
HV (C1) - No. of mothers who receive a face to face AN contact with a HV at =>28 weeks of pregancy	No threshold														20	26					May-15					**26**				
HV (C2) - % of births that receive a face to face new birth visit by a HV =<14 days	=>95.0	=>95.0													81	82					May-15					**81.8**				
HV (C3) - % of births that receive a face to face new birth visit by a HV >days	No threshold														13	12					May-15					**12.0**				
HV (C4) - % of children who received a 12 months review by 12 months	=>95.0	=>95.0													54	54					May-15					**53.7**				
HV (C5) - % of children who received a 12 months review by the time they were 15 months	No threshold																													
HV (C6i) - % of children who received a 2 - 2.5 year review	=>95.0	=>95.0													56	64					May-15					**64.4**				
HV (C6ii) - % of children who receive a 2 - 2.5 year review using ASQ 3	No threshold																													
HV (C7) - No. of Sure Start Advisory Boards / Children's Centre Boards witha HV presence	100	100													100	100					May-15					**100**				
HV (C8) - % of children who receive a 6 - 8 week review	=>95.0	=>95.0													56	70					May-15					**70.4**				
HV - % of infants for whom breast feeding status is recorded at 6 - 8 week check	100	100													67	66					May-15					**65.8**				
HV - % of infants being breastfed at 6 - 8 weeks	Min. 5% increase on base														22	20					May-15					**20.3**				
HV - % HV staff who have completed mandatory training at L1,2 or 3 in child protection in last 3 years	=>95.0	=>95.0													90	86					May-15					**86.1**				
HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 10 - 14 day developmental check																357					May-15					**357**				
HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 10 - 14 day developmental check	100	100													76	89					May-15					**89.3**				
HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 6 - 8 week developmental check															323						Apr-15					**323**				
HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 6 - 8 week developmental check	100	100													87						Apr-15					**86.8**				
HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 9 - 12 months developmental check															386	369					May-15					**369**				
HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 9 - 12 months developmental check	100	100													85	85					May-15					**85.4**				
HV - movers into provider <1 year of age to be checked =<14 d following notification to HV service																														
HV - all untested babies <1 year of age will be offered NBBS screening & results to HV.																														

Pathology Group

Indicator	Trajectory		Previous Months Trend (since April 2014)																Data Period	Directorate					Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		HA	HI	B	M	I					
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-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	5	0	2					May-15	1	1				**2**	**2**			
No. of Active Complaints in the System (formal and link)				1	2	1	2	3	6	5	5	8	7	6	7	7					May-15	4	2				**7**				
Oldest' complaint currently in system (days)				91	112	27	46	68	92	111	90	96	117	138	158						May-15										
WTE - Actual versus Plan			30	32	31	32	29	27	25	27	27	24	16	18	20	26					May-15	2	4	9	5	2	**26**				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	90.8	94.7	90.2	98.3	100		**93.6**	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	100	100	100	100		**100**	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	2.52	1.22	6.28	1.82	4.94	**3.85**	**4.27**	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●					May-15	87.1	91.7	75.0	93.6	100		**75.4**	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	92.6	98.6	95.9	97.5	95.4		**95.5**	●		
New Investigations in Month			0	0	0	0	0	0	0	0	0	0	0	0	0	0					May-15	0	0	0	0	0	**0**				
Admin & Clerical Bank Use (shifts)	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15						**479**	**994**	●		
Admin & Clerical Agency Use (shifts)	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15						**0**	**0**	●		
Your Voice - Response Rate			30		31			31			12			27							Mar-15	43	33	19	32	47	**27**				
Your Voice - Overall Score			3.43		3.74			3.74			3.76			3.7							Mar-15	3.5	3.7	3.8	3.6	4.1	**3.73**				

Imaging Group

Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Directorate DR	IR	NM	BS	Month	Year To Date	Trend	Next Month	3 Months
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-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	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15			73.3		73.3	75.0	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15			96.7		96.7	98.1	●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					May-15	0	0	0	0	0	0	●		
No. of Complaints Received (formal and link)				4	2	3	3	0	4	2	2	3	2	1	2	4					May-15	3	1			4	6			
No. of Active Complaints in the System (formal and link)				5	7	8	5	5	8	10	8	9	7	5	5	5					May-15	4	1			5				
Oldest' complaint currently in system (days)				19	40	59	30	52	76	72	75	83	75	96	73	92					May-15					92				
Emergency Care 4-hour breach (numbers)			30	39	41	32	34	49	50	52	45	41	49	51	46	35					May-15	35				35	81			
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					Apr-15	0.4				0.00		●		
WTE - Actual versus Plan			15	13	11	13	22	14	16	15	21	21	33	40	43	51					May-15	31	3	3	4	51				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	84	100	100	98		87.5	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100		100			100.0	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	4.30	0.63	0.81	5.87	4.66	4.71	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●					May-15	47.3	82.1	77.4	21.0		44.5	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	85.5	87.7	89.4	88.8		87.1	●		
New Investigations in Month			0	2	2	0	0	6	0	0	0	0	0	0	0	0					May-15	0	0	0	0	0				
Nurse Bank Use	288	24	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15					13	25	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15					349	491	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15					182	385	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15					0	0	●		
Your Voice - Response Rate			19		33		33		18												Mar-15	16		31	16	18				
Your Voice - Overall Score			3.72		3.73		3.73		3.28												Mar-15	3.1		3.3	3.9	3.28				

Community & Therapies Group

Indicator	Trajectory		Previous Months Trend (since April 2014)																	Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		AT	IB	IC					
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15				100		●		
Falls	0	0	8	9	11	13	4	14	20	17	21	22	16	13	25	39					May-15	0	39	0	39	64	●		
Falls with a serious injury	0	0	0	2	0	0	1	0	0	0	0	0	0	0	1	0					May-15	0	0	0	0	1	●		
Grade 2,3 or 4 Pressure Ulcers (avoidable)	0	0	2	4	2	2	1	1	1	3	5	2	1	3	1						Mar-15		1		1	1	●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	0	0	0	0	●		
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	1	●	●						May-15	0	0	0	0	0	●		
FFT Response Rate - Wards	>25%	>25%	39	68	43	60	59	57	47	38	33	33	41	59	38						Apr-15				38.0		●		
FFT Score - Wards	=>68.0	=>68.0	81	95	87	83	91	82	88	73	87	100	95	90	94						Apr-15				94		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					May-15	0	0	0	0	0	●		
No. of Complaints Received (formal and link)				3	0	0	5	2	5	1	1	2	1	1	1	1					May-15		1		1	2			
No. of Active Complaints in the System (formal and link)				10	8	3	8	8	10	12	3	4	3	6	2	7					May-15	4	2	1	7				
Oldest' complaint currently in system (days)				94	##	75	38	60	64	81	75	61	82	103	123	##					May-15				102				
WTE - Actual versus Plan			27	36	45	45	62	65	67	71	75	76	72	15	80	86					May-15	7	43	36	86				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	93	86	94		90.3	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	3.20	7.87	5.48	6.06	5.19	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●					May-15	94.6	78.4	73.8		78.6	●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		AT	IB	IC					
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	93.9	87.5	89.8		89.6	●		
New Investigations in Month			0	0	0	0	0	0	0	0	0	0	0	0	1	3					May-15	0	3	0	3				
Nurse Bank Fill Rate	100	100												93	90	93					May-15				92.9		●		
Nurse Bank Shifts Not Filled	0	0												36	47	29					May-15				29	76	●		
Nurse Bank Use	5408	451	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15				403	741	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15				310	518	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15				172	378	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15				0	0	●		
Your Voice - Response Rate			18		32		32			28				30							Feb-15	36	25	31	30				
Your Voice - Overall Score			3.75		3.88		3.88			3.76				3.8							Feb-15	3.8	3.7	3.8	3.80				
DVT numbers	730	>61	53	62	87	39	33	70	35	42	47	54	53	55	70						Apr-15				70	70	●		
Therapy DNA rate OP services (%)	=<9	=<9	12	16	11	11	11	11	12	14	12	12	14	13							Mar-15				12.9	12.3	●		
FEES assessment	>100	>8.3	7	10	3	4	4	5	5	3	2	14	1	3	0						Apr-15				0	0	●		
ESD Response time	<48 hrs	<48 hrs	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15						●		
STEIS	0	0	0	2	1	0	1	0	0	0	1	0	0	1	1	0					May-15				0	1	●		
Rapid response to AMU, RRTS	<60 mins	<60 mins	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	8.1	0	25					May-15				25		●		
Green Stream Community Rehab response time for treatment (days)	=<11	=<11	12	7.9	11	16	16	17	14	12	13	9.5	12	14	16						Apr-15				15.8	15.8	●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		AT	IB	IC					
DNA/No Access Visits (%)							3.3	0.9	0.7	0.9	0.9	0.9	0.8	0.9	0.8	0.6					May-15				0.64				
Falls Assessments - DN service only (%)							72	58	49	45	45	62	54	65	47	55					May-15				54.5				
Pressure Ulcer Assessment - DN service only (%)							73	61	50	48	46	63	57	65	51	55					May-15				55.1				
Healthy Lifestyle Assessments - DN Service only (%)							61	54	48	39	43	58	54	56	47	57					May-15				56.6				
At risk of Social Isolation Referrals to 3rd sector DN service only (%)							46	75	67	57	65	95	77	53	100	33					May-15				33.3				
MUST Assessments - DN Service only (%)							9.4	11	9.9	11	9.8	19	18	36	22	22					May-15				21.7				
Incident Rates (per 1000 charge)							3.6	4.8	4.9	3.5	3.5	5.1	4.1	4.9	3.9	5.1					May-15				5.1				
Dementia Assessments - DN Service only (%)							72	62	55	52	51	61	62	62	46						Apr-15				46.2				
48 hour inputting rate (%)							91	83	81	85	86	89	83	88	87	89					May-15				88.5				

Corporate Group

Indicator	Trajectory		Previous Months Trend (since April 2014)																Data Period	Directorate							Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		CEO	F	W	M	E	N	O					
No. of Complaints Received (formal and link)				8	4	5	6	5	7	6	6	15	5	6	5	7					May-15	1					1	5	7	12			
No. of Active Complaints in the System (formal and link)				16	13	12	13	21	21	25	12	21	16	18	14	12					May-15						6	6	12				
Oldest' complaint currently in system (days)				69	90	77	99	121	106	104	104	123	145	138	158	99					May-15						99	84	99				
WTE - Actual versus Plan			149	154	162	176	162	183	194	203	168	175	200	234	259	271					May-15	3	28	14	17	18	136	55	271				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	80	89	89	92	93	91	86		89.1	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15			100						100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	2.63	0.63	2.33	2.43	3.13	5.79	5.89	4.66	4.64	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●					May-15	45.1	71.2	42.7	83.5	48.0	75.3	69.7		69.7	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	90.8	94.6	94.0	92.6	94.2	88.2	88.6		89.6	●		
New Investigations in Month			0	1	3	1	0	5	0	0	0	1	0	0	1	0					May-15	0	0	0	0	0	0	0	0				
Nurse Bank Use	1088	91	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15								212	376	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15								69	141	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	21	110	40	32	0	2189	522	2914	5962	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0	22	0	0	0	0	0	42	86	●		
Your Voice - Response Rate			26		24		21			15				14							Mar-15	67	18	34	28	11	6	12	14				
Your Voice - Overall Score			3.76		3.6		3.49			3.48				3.5							Mar-15	3.63	3.03	3.73	3.48	3.45	3.49	3.38	3.51				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue Anne Gibson Committee Room, City Hospital **Date** 29 May 2015; 1030h – 1230h

Present

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

In Attendance

Ms A Binns
Mr G Smith
Mrs D Talbot
Mr Z Siddique [Item 4]
Mrs R Evans [Item 5]
Mr S Clarke [Item 5]

Secretariat

Mr S Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies for absence were received from Mr Colin Ovington and Ms Claire Parker.	
2 Minutes of the previous meeting	**SWBQS (4/15) 048**
The minutes of the Quality and Safety Committee meeting held on 24 April 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 (4/15) 048 (a)**
The updated actions list was received and noted by the Committee.	
3.1 CCG/SWBH joint learning from complaints	**Verbal**
It was reported that a discussion was planned for 8 June.	
3.2 Perinatal mortality update	**SWBQS (5/15) 050** **SWBQS (5/15) 050 (a)**
Dr Stedman reminded the Committee that it had been noted that there had been	

some spikes in perinatal mortality; the CCG likewise had also noticed the increase. It was highlighted that of all reviews of perinatal deaths, only in one case was it deemed to have been avoidable. It was noted that a robust process was in place for the review of these deaths and that the Committee was advised that there was not an undue cause for concern. Deaths were reported to relate to late presentation and issues that related antenatal care for the local demographic. Within the West Midlands region, the Trust to reported to be within average range. It was reported that a significant proportion of the local population were not registered with a GP. Dr Sahota noted the linked issues across all minority communities, including smoking cessation, prior to the delivery of the babies. He added that communication was key to resolving these issues, including the use of the Trust's translation services. Dr Stedman reported that improvements in this respect were needed. Mrs Talbot reported that bank staff and language line were used for this purpose. Dr Sahota asked whether relatives could be used and Mrs Talbot reported that only in a minority number of cases, this was permitted. It was agreed that this matter needed to be discussed by the Public Health, Community Development and Equalities Committee as part of its next meeting.	
ACTION: **Dr Stedman to present an update on perinatal mortality at the next meeting of the Public Health, Community Development and Equalities Committee**	
3.3 Down's Syndrome screening report	**SWBQS (5/15) 058** **SWBQS (5/15) 058 (a)**
Dr Sahota emphasised that this matter needed to be considered on a wider focus. It was noted that the issues were mainly related to referral processes and missing the opportunities to put forward screening. It was agreed that the position vs. other organisations was needed.	
ACTION: **Dr Stedman to present the Down's Syndrome screening position relative to other organisations at the next meeting**	
MATTERS FOR DISCUSSION/DEBATE	
4 Update from HM Coroner	**Presentation**
Ms Dutton welcomed Mr Zaffar Siddiqui, the Coroner for the Black Country. He provided an overview of his role and context of the work. The quality of completion of cause of death on medical certificates was noted to be an issue from his perspective, alongside the handling of end of life care deaths. Hip fractures relating to elderly patients was noted to be of interest and was increasing, where patients admitted to hospital did not make good progress in some cases, passing away fairly rapidly thereafter with hospital acquired pneumonia. Dr Stedman noted that this was a common end of life episode. Mr Siddiqui suggested that the link between the cause of death to the fall needed to be clearer however he made a judgement as to	

which needed further investigation on a case by case basis with guidance being a death within 48 hours of operation. He suggested that should an individual have slipped and incurred a fracture, then in most cases these need to be referred to the coroner, albeit dependent on the nature of the circumstances. In terms of falls in hospital, the coroner was asked whether the information of the root cause analysis was useful in making a judgement. He advised that managers were asked to share key findings after 6-8 weeks if appropriate and he would delay the hearing if the information in the root cause analysis was relevant to the judgement. More cases with deprivation of liberty implications were noted to be raised, although very few are reported to the Coroner. It was noted that there was a discrepancy between the Birmingham and Black Country positions. Mr Siddiqui reported that there had been an increase in the number of suicides and industrial disease deaths (12-13% of all deaths). Digital autopsies were reported to be possible across the community. It was reported that a digital inquest file would be set up and video links could be used which was useful in managing time commitments of staff required to present evidence. It was reported that timeliness of handling cases had improved and it was the intention to streamline the requests for medical notes, using electronic media where possible. Ms Dutton asked if witnesses provided by the Trust were properly prepared. Mr Siddiqui noted that witnessed relied on statement, although some of these lacked structure and were not sufficiently tailored to the case. He added that their presentations needed to be aimed at the families present and effort should be made to eliminate the jargon where possible. It was reported that staff needed to be prepared in terms of the general ethos, including the non-confrontational nature of the discussions and court environment. Miss Barlow suggested that the points made would benefit from being videoed and used within Quality Improvement Half Day sessions. It was noted that some key learning points, issues and trends would be useful from the coroner. Dr Stedman asked what progress had been made with the medical examiner role. He was advised that it was hoped that this would be implemented in Spring 2016 at the earliest, however the matter was the subject to national requirements and funding. Mr Samuda asked if there were any informal cultural issues that needed to be highlighted. He was advised that communication was the most significant issue. Dr Sahota noted that there are a number of cultural sensitivities, such as rapid release and asked what measures could be taken to ensure that the paperwork was as accurate as possible. Mr Siddiqui reported that cause of death on the balance of probability needed to be adequately completed and patients' history was also needed, including GP history. Mr Siddiqi was thanked for his attendance and useful presentation.	
5 TDA ward environment hygiene inspection	**SWBQS (5/15) 051** **SWBQS (5/15) 051 (a)**

	SWBQS (5/15) 051 (b)
Mr Clarke and Mrs Evans joined the meeting to present the TDA ward environment hygiene inspection. Mrs Evans provided an overview of the visits that had occurred. It was reported that the TDA had identified some concerning issues around cleanliness and hygiene when they visited. The second round of visits showed that some of the issues in kitchens had been resolved but some ward issues, including hand hygiene and high dusting remained. The action plan to address the issues was considered which addressed the position on an organisational basis. Mr Clarke reported that some of the matters concerned hotel services and training. Communication regarding equipment cleaning and ownership of the standards on the areas needed to be resolved. Mr Samuda asked whether the areas had been previously self-inspected and it was confirmed that this was the case, which had identified issues. Each of the internal inspections highlighted the issues and took pictures, feeding the outcomes back to the ward managers which had not been addressed prior to the TDA audits. Mrs Hunjan noted the link to reward, accountability and performance management of staff. Mrs Talbot reported that infection control indicators were included within the ward dashboards. It was agreed that ownership at a ward level was critical to delivery of the plans and that some of the issues identified reflected the culture among some groups of staff. Dr Sahota noted that despite the action plan, some of the actions were not being delivered. Mrs Evans reported that this reflected that some of the cleaning had been done but not to the high standards needed. Dr Sahota suggested that the cleanliness regime needed to extend to public areas. Dr Stedman suggested that the silo inspection regime and cleaning schedules prevented ownership and actions. Escalation was noted to be poor. Mrs Evans reported that staff had been open with the TDA as part of their visits. She highlighted that PEAT inspections were funded to assist with the resolving the issues identified. She added that there appeared to be issues with funding more widely which had resulted in compromised cleaning and hygiene. Mr Clarke advised that the bed cleaning time had been withdrawn and equipment cleaning was no longer the responsibility of the facilities staff as this had been delegated back to nurse staffing. Miss Dhami suggested that deep cleaning needed to be built into the programme and was advised that this was the case. Mrs Talbot suggested that communications and prioritisation of matters needing to be addressed was key. Ms Dutton asked whether other wards were in a good place and was advised that this was not likely to be the case. It was reported that a revisit by the TDA would occur on 15 June and that much work would be undertaken in preparation. It was agreed that the matter should be considered at the next meeting.	

Mr Waite left the meeting.	
ACTION: Mr Ovington to present an update on TDA cleanliness inspections at the next meeting	
6 CQC Improvement Plan update	**Verbal**
Miss Dhami reported that the CQC Improvement Plan was being developed into a smarter format which was evidence based. Work was reported to be progressing at pace and the 'OK to Ask' initiative had been relaunched. The next version of the plan would be available, alongside the evidence confirming the delivery of the actions.	
7 Ward concerns update	**Verbal**
Mrs Talbot reported that work was still underway with the D17 ward to improve the position. The assessment role for patients was reported to be a specific area of focus. Staffing and skill mix of some of the uniquely configured wards was reported to be being considered.	
8 Trust's response to the Kate Lampard report on Jimmy Savile	**SWBQS (5/15) 053** **SWBQS (5/15) 053 (a)**
Miss Dhami provided an overview of the overarching Savile review and advised that volunteers were a key focus as part of the plans. It was noted that a policy needed to be put in place in relation to the management of celebrities and VIPs. It was highlighted that advice was needed as to a rolling programme of DBS given that the Secretary of State had not accepted this recommendation. Further advice was also to be taken in respect of the recommendation concerning the use of social media.	
9 Open referrals update	**Verbal**
Miss Barlow reported that 6000 records were being closed down on a daily basis. It was reported that 15,000 letters had been sent out and 169 calls had been received by the call centre to date. Call centre capacity had been increased to handle calls. SOPs were currently being revised and staff training would be undertaken and a data quality dashboard would be developed.	
10 Patient story	**Verbal**
It was reported that the patient joining the Board in June was a maternity services patients.	
11 Board Assurance Framework 2015/16 updates	

11.1 National waiting times performance	**SWBQS (5/15) 055** **SWBQS (5/15) 055 (a)**
Miss Barlow reported that demand and capacity meetings were in place and was progressing well. At a speciality level input and output KPIs were being developed, which would have associated trajectories which would be tracked. Surgery B have not completed job planning work and an accelerated support week had been completed recently which sought to address this. Further work to review the demand and capacity plans and the job plans would be undertaken.	
11.2 Improving discharges and reducing Delayed Transfers of Care	**SWBQS (5/15) 055** **SWBQS (5/15) 055 (a)**
Miss Barlow reported that safe discharges were a key focus of the Urgent Care week and work was to be undertaken to change the rhythm of the day and working differently to ensure that patients could be discharges before lunchtime. Mrs Hunjan asked how staff were being supported to deliver these additional requirements. Miss Barlow noted that there was no additional 'ask' and the Urgent Care week had been delivered as part of a usual operational environment. Much of the redesign had come from the staff themselves.	
MATTERS FOR RECEIPT AND ACCEPTANCE	
12 Integrated performance report	**SWBQS (5/15) 056** **SWBQS (5/15) 056 (a)**
Ms Dutton thanked Mr Smith for his support to the Committee during his tenure. It was reported that during the month falls and pressure sores had reduced and mortality reviews had reduced. The month also saw the Never Event in lithotripsy. Ms Dutton noted that return to work interviews was poor. It was reported that there was significant variability and there was a significant focus on these as part of the sickness absence plan. It was noted that complaints handling there were no breaches in the issuing of complaints responses to time. Cancelled operations were higher than planned. Miss Barlow reported that after Easter capacity tightness meant that there had been some instances where surgery had been cancelled on the day of surgery. She added that work to address avoidable cancellations was planned. It was agreed that this would be presented at the next meeting. Ms Dutton noted that the introduction of the Quality Improvement Half Days had not resulted in adverse performance against any of the key targets. Miss Dhami reported that outpatient clinics were being rebooked. Ms Dutton highlighted the need to complete the data quality kite mark information. Miss Barlow reported that the Business Intelligence Unit would take responsibility for this in future and a sign off process was being introduced.	

ACTION: **Miss Barlow to present an update on cancelled operations at the next meeting**	
13 Serious Incident report	**SWBQS (5/15) 057** **SWBQS (5/15) 057 (a) -** **SWBQS (5/15) 057 (b)**
The Committee received and noted the report.	
14 Forward plan for the Committee	**SWBQS (5/15) 059** **SWBQS (5/15) 059 (a)**
The Committee received and noted the report.	
OTHER MATTERS	
15 Matters of topical or national media interest	**Verbal**
It was noted that there were several matters that needed to be raised to the Board.	
16 Meeting effectiveness	**Verbal**
It was noted to have been an effective meeting.	
17 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.	
18 Any other business	**Verbal**
There was none.	
19 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 26 June 2015 at 1030h in the Anne Gibson Committee Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Workforce & Organisational Development Committee – Version 0.1

Venue Anne Gibson Committee Room, City Hospital **Date** 17 April 2014 at 1400h

Members Present		**In attendance**
Mr H Kang	[Chair]	Mrs L Barnett
Mr R Samuda		Mrs G Deakin
Dr P Gill		Mr J Pollitt
Mr T Lewis		
Miss R Barlow		
Mr C Ovington		**Secretariat**
Mrs R Goodby		Mr S Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies	**Verbal**
No apologies for absence were received.	
2 Minutes of the previous meetings	**SWBWO (12/14) 066**
The minutes of the meeting held on 19 December 2014 were approved subject to minor amendment.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meeting	**SWBWO (12/14) 066 (a)**
The Committee received and noted the updated actions log. It was noted that discussions would be held between Mrs Goodby and Mr Grainger-Lloyd to agree how agendas would be set for the Workforce Delivery Committee and Workforce & OD Committee to ensure minimal duplication. It was also reported that there was some slippage with launching the staff declarations process. Mr Lewis suggested that timing of the launch of the process was needed, particularly to avoid the summer period when it would be difficult to gather returns from staff amid peak holiday time.	

3.1 Junior doctors' conflict resolution training	**Verbal**
Mr Pollitt reported that conflict resolution training would not be delivered to all doctors and a plan had been developed with the Medical Education system to capture all doctors as part of their rotation. It was noted that the Trust's conflict resolution training was to be used as best practice with other organisations. It was reported that monitoring was in place to ensure that the high risk areas compliance was as high as possible. Mr Lewis asked that a review be undertaken to assess in which other areas training update by medics was low.	
3.2 Time to hire position	**Verbal**
It was reported that there had been a slight deterioration in the time to hire position, however it was noted that this included posts held for redeployment and the main delays were into nursing positions. It was noted that DBS was not a significant contributor to delays, although taking up references presented a greater delay. It was suggested that more attractive methods of recruiting and incentivising them needed to be considered. Mrs Goodby reported that overseas recruitment might needed to be considered in future. Mr Lewis reported that all conditional offers needed to be made within 48 hours and that an escalation process was necessary in the event that this deadline was breached. It was agreed that a specific approach to nurse recruitment needed to be adopted, led by Mrs Goodby and Mr Ovington. Mr Kang suggested that a rolling programme of recruitment was needed. Dr Gill also suggested that engagement with the local universities was necessary. Mr Pollitt reported that some of the forthcoming clarity on investment in education would assist with retention of staff. Miss Barlow reported that effort was being undertaken to personalise the recruitment process and the onboarding process. Mr Lewis suggested that the strategic recruitment plan needed to be prepared by the end of June.	
3.3 Notice periods	**Verbal**
Mrs Barnett reported that an increase of notice period from four weeks to eight weeks for bands 4 – 6 would be implemented for new starters from July 2015.	
3.4 Appraisal policy roll-out	**Verbal**
Mrs Deakin reported that the roll-out of the new appraisal process was going to plan, meaning that the Governance department would be ready to launch at the end of April. Discussions would also occur at the Quality Improvement Half Day	

sessions for some areas. It was reported that the progress with the work would be directed through the Workforce Delivery Committee and that the approach was being well received. Peer review of appraisals was reported to be planned and a 360 appraisal would be held on a three year basis.	
4 Sickness absence hot spots – trajectories for reduction	**Hard copy**
Mrs Barnett presented an overview of the sickness absence, highlighting that 50% of the top 50 areas having high sickness absence remained with poor performance. It was reported that the application of the sickness absence policy was inconsistent, with very few formal hearings having been held for those where they should have been. In terms of return to work interviews, it was noted that there was inconsistent practice from very poor to very good. Mrs Barnett reported that there appeared to be a tendency to under report sickness absence in medical staffing. Mr Lewis reported that the management arrangements of trainee doctors were changing to provide better oversight. Dr Gill highlighted the gravity of lack of oversight of medical staff. Mrs Goodby reported that much work was already in train to address sickness absence and that this was to be brought together to balance the punitive policy measures with the sources of assistance and management. It was reported that conducting return to work interviews would be central to the future sickness absence management. Mr Kang asked whether there had been any impact on sickness as a result of the outcome of the CQC review. Mrs Goodby reported that the recommendations in the report in terms of staffing and sickness management were being considered. Mr Kang asked what KPIs were to be set. Mr Lewis emphasised the need for return to work interviews to be conducted needed to be fully implemented in May and June to ensure that the 3.5% target by the end of 2015/16 was met. Mr Ovington suggested that targeted work needed to be undertaken with hot spot areas. Miss Barlow highlighted that there was a need to take into account the management of sickness in those being performance managed. It was agreed that a further update would be provided at the June meeting.	
ACTION: Mrs Goodby to present an update on sickness absence plan at the next meeting	

5 JCNC feedback	**Verbal**
Mrs Goodby reported that the organisational change policy had been discussed, including pay for 'acting up' and protection for those being downgraded. It was reported that the communications around the CQC report had been well received overall. An update on Phase 1 was discussed. Other discussions were reported to have included retire and return, notice periods, long term bank workers, finance report and long service policies.	
6 Appointment business case workforce plan	**Hard copy**
Mrs Deakin provided an overview of the key changes in workforce numbers within the long terms workforce model. Planning for workforce changes in 2016/17 was discussed. It was reported that there were three key drivers which would be used to make these changes. 145 new roles will be created over the period and will play into the workforce development agenda. The numbers were based on the affordability position and the modelling of this was reported to be underway. A set of strategic change themes was reported to be identified, which would drive the delivery of the workforce alterations. Mr Lewis noted that further consideration needed to be given as to how the numbers linked to the planned activity levels and the future developments. It was agreed that this needed to be resolved by June and July. Mr Kang asked for details on the plan to work up the numbers at a granular level. Mrs Deakin reported that conversations needed to be held to discuss priorities for the change team and clinical teams. Mr Pollitt observed that the income needed to be attracted for junior doctors and that this needed to be borne in mind as part of the plans. Mrs Deakin reported that these considerations would be considered and that the number of doctors would not be reduced although the cost per employee would reduce. In terms of next steps it was reported that the change themes would be further refined and the plans to work with clinical groups would be worked up. MMH transition was also being developed. It was agreed that a note would be prepared for the Board in May to discuss the next steps and how the numbers would be pinned down.	
ACTION: Mrs Deakin to prepare a note for the Trust Board in May outlining the key steps to the long term workforce transition	

7 Update on Safe and Sound	**Hard copy**
Mrs Goodby advised that the second phase of the Safe and Sound programme would be launched at the end of April and the timeline had been shared with Group Directors. It was reported that over 60 schemes had been identified to date, which had been reviewed by the Executive triumvirate. Numbers overall were reported to be 305 affected individuals, with an at risk group of 41. Once the schemes had been reviewed, it was reported that these would be published on the intranet. The plans for medical secretaries was discussed, including the introduction of voice recognition in the longer term. The Chairman asked whether the learning from Phase 1 had been harnessed. He was advised that the HR team were undertaking coaching for managers who needed to manage the process.	
8 Integrated performance report	**SWBWO (4/15) 004** **SWBWO (4/15) 004 (a)**
It was agreed that the item would be discussed at the next meeting.	
9 Matters to raise to the Board and Audit & Risk Management Committee	**Verbal**
Sickness absence and a note to the Board on the workforce plan.	
10 Meeting effectiveness	**Verbal**
This item was not discussed.	
11 Any Other Business	**Verbal**
There was none.	
12 Details of the next meeting	**Verbal**
The next meeting is to be held on 29 June 2015 at 1530h in Meeting Room 1, the Old Management Block at City Hospital.	

Signed ……..

Print ……..

Date ……..