Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Churchvale/Hollyoak Room, Sandwell Hospital **Date** 1 October 2015; 1330h – 1730h

Members attending:

Mr R Samuda	(RSM)	Chairman
Ms O Dutton	(OD)	Vice Chair
Mr M Hoare	(MH)	Non-Executive Director
Mr H Kang	(HK)	Non-Executive Director
Dr P Gill	(PG)	Non-Executive Director
Mr R Russell	(RR)	Non-Executive Director
Cllr W Zafffar	(WZ)	Non-Executive Director
Mr T Lewis	(TL)	Chief Executive
Mr T Waite	(TW)	Director of Finance
Dr R Stedman	(RST)	Medical Director
Mr C Ovington	(CO)	Chief Nurse
Miss R Barlow	(RB)	Chief Operating Officer

In attendance:

Mrs R Goodby	RG	Director of OD
Mrs C Rickards	(CR)	Trust convenor
Mr A Kenny	(AK)	Director of Estates / New Hospital Project
Ms A Binns	(AB)	Asst. Director of Governance

Secretariat

Ms L Fairfield	(LF)	Interim Trust Secretary

Time	Item	Title	Reference Number	Lead
1330h	**1.**	**Apologies – Kam Dhami, Olwen Dutton**	**Verbal**	**LF**
	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**	**Chair**
	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 3 September 2015 as a true and accurate records of discussions*	**SWBTB (9/15) 153**	**Chair**
	5.	**Update on actions arising from previous meetings**	**SWBTB (9/15) 153 (a)**	**LF**
14.00	5.1	**DNACPR: presentation of audit data**	**SWBTB (10/15) 154** **SWBTB (10/15) 154 (a)**	**RST**
	5.2	**Public Health Committee escalated matter: volunteer service**	**Presentation**	**CO**
	6.	**Questions from members of the public**	**Verbal**	**Public**
	7.	**Chair's opening comments**	**Verbal**	**Chair**
	8.	**Chief Executive's report**	**SWBTB (10/15) 156**	**TL**
14.20	**9.**	**Trust Risk Register**	**SWBTB (10/15) 157** **SWBTB (10/15) 157 (a)**	**AB**
14.30	**10.**	**Wider safe staffing report**	SWBTB (10/15) 158	**RG**

Time	Item	Title	Reference Number	Lead
14.40	**11.**	**Safe nurse staffing**	SWBTB (10/15) 159 SWBTB (10/15) 159 (a)	**CO**
15.00	**12.**	**Corporate integrated performance dashboard**	SWBTB (10/15) 160 SWBTB (10/15) 160 (a)	**TW**
15.15	**13.**	**Financial performance - period 5 August 2015**	SWBTB (10/15) 161 SWBTB (10/15) 161 (a)	**TW**
15.30	**14.**	**CQC improvement plan update**	SWBTB (10/15) 162 SWBTB (10/15) 162 (a)	**TL**
15.50	**15.**	**Annual plan priorities**		
	15.1	**Ten out of Ten**	SWBTB (10/15) 163 SWBTB (10/15) 163(a)	**CO**
	15.2	**Reducing readmissions**	SWBTB (10/15) 164 SWBTB (10/15) 164 (a -b)	**RB**
	15.3	**Community caseload: forward development programme**	SWBTB (10/15) 165 SWBTB (10/15) 165a-	**RB**
	15.4	**Sickness – way forward and plan 'B'**	SWBTB (10/15) 166 SWBTB (10/15) 166 a-b	**RG**
16.20	**16.**	**R&D Plan 2015-2018 – likelihood of delivery assessment**	SWBTB (10/15) 167 SWBTB (10/15) 167(a)	**RST**
16.35	**17.**	**Patient, staff and visitor food – current state and future plans**	SWBTB (10/15) 168 SWBTB (10/15) 168(a)	**CO**
16.50	**18.**	**Our 2020 vision: consultation response**	SWBTB (10/15)170 SWBTB (10/15) 170(a)	**RW**
17.05	**19.**	**Revalidation for nurses and midwives**	SWBTB (10/15) 171 SWBTB (10/15) 171(a)	**CO**
	UPDATES FROM THE COMMITTEES			
	20.	**Update from the meeting of the Quality & Safety Committee held on 25 September 2015 and minutes of the meeting held on 28 August 2015**	SWBQS (8/15) 094 **To Follow**	**OD/ CO**
	21.	**Update from the meeting of the Finance and Investment Committee held on 25 September 2015 and minutes of the meeting held on 31 July 2015**	SWBFI (7/15) 028	**RSM/ TW**
	22.	**Update from the meeting of the Workforce and Organisational Development Committee held on28 September 2015 and minutes of the meeting held on 29 June 2015**	SWWO (6/15) 012 **To Follow**	**KK/ RG**
	23.	**Any other business**	Verbal	**All**
	24.	Details of next meeting *The next public Trust Board will be held on 5th November 2015 at 1330h , Anne Gibson Board Room, City Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC

Venue Anne Gibson Board Room, City Hospital **Date** 3rd September 1.30pm – 4.30pm

Members Present		**In Attendance**	
Mr. Samuda	Chair		
Ms. O. Dutton	Vice Chair	**Mrs. R. Goodby**	Director of Organisational Devel.
Mr. H. Kang	Non Executive Director	**Miss K. Dhami**	Director of Governance
Mr. M. Hoare	Non Executive Director	**Mr. N. Rogers**	Group Dir of Ops (Interim) – Surg A
Dr. P. Gill	Non Executive Director	**Mrs. C. Rickards**	Trust Convenor
Cllr. W Zaffar	Non Executive Director		
Mr. R. Russell	Non Executive Director		
Mr. T. Lewis	Chief Executive	**Secretariat**	
Mr. T. Waite	Director of Finance & Perf. Mgt	**Miss R. Fuller**	Executive Assistant
Dr. R. Stedman	Medical Director		
Mr. C. Ovington	Chief Nurse		

Minutes	**Paper Reference**
1 Apologies	
Apologies were received from: Rachel Barlow	
2 Declaration of interests	
No declarations of interests were recorded.	
3 Patient Story (discussion to follow in private board meeting)	
Carol Poole a patient on Ward D16 was accompanied by the Ward Sister Maureen Smith to discuss inpatient food. Ms. Poole has been an inpatient for 5 weeks. She commented that her quality of care was good and the staff she came into contact with are very helpful and kind. Ms Poole informed the Trust Board that the food was not as good as expected. The food could be cold if you were the last person to be served, the food was not as described and if you wanted a condiment they were not always available when requested. It was noted that Ms. Poole has never completed a food feedback form during her stay. Ward staff help with food ordering, however Ms. Poole saw a lot of waste food at lunch time as many people did not want a hot meal. Ms. Poole stated the breakfasts were very good with a choice of cereal and toast. Sr. Smith did confirm that patients who were served last did complain about cold food but this was due to the food being placed on top of the heated trolley while it was been distributed. Hot food at lunch time as well received and wastage was no greater than any other time.	

Ms. Poole also asked if snacks could be available during the day as only biscuits are available when the tea trolley goes round. Mr. Lewis asked if a kitchen was available where you could make your own snacks. Ms. Poole said this would only be available if you had support. Sr. Smith commented that patients making own meals was a good idea as patients relatives and visitors did on occasion bring in the hot food but they are aware that they could not use the trust kitchens to re-heat any food. Mr. Kang queried if relatives were encouraged to bring in food for patients. Mr. Lewis confirmed that the trust has a legal duty to ensure food is tested before consumed and the legal framework around this issue is tricky. Ms Goodby asked if the menu was different in the Summer and Winter. Mr. Ovington confirmed that the menu is changed. Mr Samuda thanked Ms. Poole and Sr. Smith for attending the Trust Board today and expressed he was happy that the care Ms. Poole has received has been of a high standard. The Trust Board would discuss food again in its private meeting later on today and formulate any actions.	
4 Minutes of previous meeting – 6th August 2015	**SWBTB (8/15) 135**
The minutes were agreed as an accurate record.	
5 Update on actions arising from previous meetings	**SWBTB(8/15) 135(a)**
ACTION: Schedule of Organisation Change to be placed on agenda of Board Informal session in November	**K Dhami**
5.1 Approach to near misses	SWBTB (9/15) 137
Mr. Lewis reported there were three never events now called near misses in April and June and page 2 of his report shows what the plan is for the next 6 months. It was discussed that more staff communications needs to be done and for appropriate staff to be aware of actions that come out of a TTR, as it was noted that some actions are not being followed up. Going forward staff will received a letter informing them of the action and they then need to return the slip at the bottom, it was confirmed that this action of returning the slip was not a legal matter just a change in mindset and behaviour. Cllr Zaffar asked where there any comparisons from other Trusts on how actions from near misses were communicated. Mr. Lewis noted this information was not known but he would make contact with partner trusts obtain a view. It was reported that action plans on near misses are charted following the TTR and staff were always eager to take on the learning experience as they do not want it to happen again. Also following a change in the law the patients view is also taken into account. TL also informed the Trust Board that all near misses are emailed to the exec team the following morning. Mr. Hodgetts stated that lessons have not been learnt in ophthalmology over the years ago so improving is going to be hard. Mr. Hodgetts was reassured that ophthalmology had not had a near miss in over 15 months and they were an example on how you go forward, they use video	

reflexology as part of the learning experience with staff. Ms Barlow reminded the Trust Board that she would be discussing with Mr. Tyagi a follow up presentation on video reflexology for the Trust Board in November and also the Theatre Management Board are managing the actions and so far the feedback has been positive. Mr. Samuda thanked Mr. Lewis for his report.	
ACTION: Ms. Barlow to follow up with a presentation on video reflexology to the Nov Trust Board	R. Barlow
5.2 Consent on the day of surgery	SWBTB (9/15) 139
It was reported that over a 5 day period in certain areas at Sandwell Hospital 28 elective patients out of 165 were identified as giving consent on the day of surgery, however these patients were given time and information to consider their answer. The current procedure piloted is during the consultation the consultant completes the Decision to Admit electronic form which includes a section on consent. Once this form is completed the patient is then listed for surgery. Following a brief discussion Dr Stedman confirmed the protocol for consent of patients who lack capacity to make an informed decision about surgery; this is done by a best interest group of people who comprise of the patient, next of kin and a patient advocate. Miss Dhami informed the Board that more work still needed to be done to ensure consent on day is only done in exceptional circumstances; this guidance still needs to be completed. The Trust Board noted the report	
5.3 Safe staffing data quality	SWBTB (9/15) 140
Mr. Ovington informed the Board that over recent months the wrong data has been submitted this has been corrected however a double check is being undertaken to ensure the systems that gather this information to ensure a sustainable and assured submission. Mr. Ovington talked through his paper on how shift requests were covered using staff, bank and agency. The reliance on agency is currently being mitigated by increasing the pay rates of our bank staff to encourage more of our staff to join the Trust Bank. Currently the fill rates are being checked daily which also includes the look ahead. Following a question it was noted that the data used between January and July was incorrect, the July data is correct but some under reporting of fill rates as bank and agency were not included. This should be rectified by the 15th October. The information is recorded in the Unify system which cannot be corrected once inputted; however other Trusts have reported the same problem. Ms Dutton queried the number of shift patterns to complete of 380. Mr. Ovington reported it was complicated and work is being done looking at these. The Board asked Mr. Ovington to keep the Board updated on progress.	
ACTION: An update report to be presented to the Board at each future meeting	C Ovington
6 Questions from members of the public	
Mr. Samuda opened the meeting for questions from the public.	

Mr. Bates queried the Trust was striving to be the best integrated care Trust however for that first class communication was required. How was the Trust going to ensure our community based locations and staff are part of that? Dr Stedman informed the Trust Board that improvements were taking place in the community to address that, i.e. EPR and an improvement in the IT systems. Also it was noted that in week commencing 12th October a focus week looking at readmissions which will involve the community would take place. **Responses back to GP**. The Trust was making a commitment to have responses back to GPs within 5 days. It is envisaged by April 2016 this will be being delivered. Following another query about the new hospital, Mr. Lewis stated this was included in his CEO Report. Mr. Samuda thanked the public for their questions and continued interest in the Trust.	
7 Chair's opening comments	
Mr. Samuda paid tribute to the teams in A&E and the progress they have made over the last few weeks in meeting their targets. The reconfiguration on cardiology was a big change and good effort was also being undertaken by the teams involved.	
8 Chief Executive's Report	**SWBTB (9/15) 141**
The CEO highlighted the following from his report: **Sickness** – only 1 in 20 staff were currently being subject to a formal review, but sustained work is being undertaken in groups to ensure the communication and support is continuing. **Freedom to Speak up** – this will be discussed in more detail at the Board Informal Session and Miss Dhami will be producing a paper. **New Hospital** – the project is on time and budget. The Planning Committee of Sandwell MBC is meeting on the 23rd September to consider the application; current indications are good for the application to be approved. The seal is required for the S106 and work is being looked at on the community garden etc. Over the next few months a number of rooms for the new hospital will be mocked up in the CPU for patient groups to look around and comment. **Surgical Configuration** – this will proceed in November. The issue on head injuries pathway has been signed off by Dr. Stedman. Travel arrangements, medical cover etc. have all been resolved.	
ACTION: Freedom to Speak up – to be agenda at the Board Information meeting on the 18th September	**K Dhami**
9 Trust Risk Register	**SWBTB (9/15) 142**
Miss Dhami reported no new items to be escalated. The Rhapsody risk noted in 9.2 was a new risk to be presented by Dr Stedman. Miss Dhami reminded the Trust that appendix b was a summary of the red pre mitigated risks. These risks are challenged by the triumvirate team and mitigation plans are in place which is monitored by the Risk Management Committee and CLE.	
9.1 Oncology	SWBTB (9/15) 143
It was noted that 3 weeks ago University Hospitals Birmingham served notice on its current SLA	

for oncology services; this is specific to the provision of consultant's time at our Trust for outpatient clinics and MDT attendances. For some time the SLA has been recognised to be unsatisfactory in scale and capacity and working arrangements and renegotiating the SLA was being sought. With this notice this gives the Trust an opportunity to obtain a new service with a view to employing its own oncology consultant. Mr. Kang asked what continuity plans were in place for the current patients. Dr Stedman reported that there will still be continuity of service but it may not be the same consultant, however it is well know that when a Consultant moves, many of their patients tend to follow. Mr. Lewis stated arrangements will be put in place as UHB want to terminate the service by December 2015, therefore if we recruit a consultant and they cannot commence in post due to working notice, UHB may well provide cover as we have been proactive in organising the service. Following discussion and queries Dr Stedman also informed the Trust Board that an approach will be made to the Black Country Alliance to take this service on. In the past it has been hard to recruit in oncology but with a greater area to serve, a consultant which a sub speciality would find the role attractive. The transitional period to get the service right could take up to 2 years. Mr. Lewis confirmed the BCA Board will be meeting at the end of September and oncology is an item on its agenda. Also Dr Stedman will have additional management support to assist on this service.	
9.2 Rhapsody	SWBTB (9/15) 144
Dr. Stedman informed the Trust Board the Rhapsody system was an integration engine for hard and software and it allows IT systems within the trust to connect/speak with each other. One of the two systems has failed and due to the age of the system it cannot be repaired safely. A virtual machine has been created which could take the Rhapsody system data if it failed completed but it would be untested. The long-term plan is to upgrade to a modern system over the next 6 months. Support has been brought in to help with this work. Dr Stedman stated that currently the system is kept in house but the IT plan in place is to look at which aspects of the system can be outsourced as is common practice with other organisations. An infrastructure review has taken place and plans are in place to address any other risks. It was confirmed that if Rhapsody failed the IT Risk plan would be actioned. Mr. Samuda thanked Dr. Stedman for informing the board, and the Trust Board accepted the risk.	
Ms Dutton noted that some of the risks noted in the report could be removed. It was agreed that the housekeeping of risks would be reviewed and those no longer necessary would be removed. Stroke Services – a letter was received from the CCG supporting the service but made some comments about Walsall. The BCA have been asked to come back with a proposal on stroke services for the future.	
ACTION: Ms. Dhami to review the risks and remove those which were obsolete	**K. Dhami**
10 Annual Plan Priorities	
10.1 Community caseload	SWBTB (9/15) 145
Mr. Rogers, Group Director of Operations (Interim) – Surgery A presented this item on behalf of Ms. Barlow. It was reported that the community caseload of each team member would be assessed noting the complexity for the team. The vision is to increase patient contact by 10%	

through better scheduling of visits, looking at current caseloads and a reduction in travel time of staff. £100,000 has been invested for this project. Following a query the 7 day service would be an opportunity for patients to be seen on Saturday and Sunday at home, this would help with the peak number of visits on a Friday and Monday. The Trust will also liaise with the CCG to tackle the areas when a district nurse is used as an alternative for a GP. Through the QHIDs this will be established and communicated with teams. The Trust Board noted the report.	
10.2 Health visitor visiting	SWBTB (9/15) 146
Ms. Amanda Geary, Group Director of Operations – Women & Child Health Clinical Group presented this item. There has been an overview on the responsibilities of the Health Visitors. The service is currently the responsibility of NHS England but in October the service will transfer to local authorities therefore there will be a move from registrant to residential access of the Health Visiting service within the borough. During the last 3 years significant work has been undertaken to improve the service with increasing the number of health visitors even though recruitment and retention is still a challenge. The Trust Board is aware of the improvements but to meet the indicators required further more work is required. One of the key targets is to see all women by 28 weeks in pregnancy, new baby review between 10 - 14 day of birth, and undertake more development assessments of baby/child at difference time periods. The contract with the local authority is due to be signed next week. Mr. Lewis stated the current contract is valued at £5m, therefore it is imperative for the Trust's future business to ensure the indicators are sorted in the next few months, to ensure the contract is kept with us. The board discussed further and Mr. Samuda thanked Ms. Geary for her attendance at the meeting.	
11 Corporate integrated performance dashboard	**SWBTB (9/15) 147**
Mr. Waite presented his usual report on performance noting there has been a focus on discharge and readmission. Mr. Rogers stated the cancer care deteriorated in August but discussions are underway with oncologist to provide support at MDTs, the board were also forewarned about a problem with UHB and radiotherapy, the data will be adverse. The Trust Board discussed, the focus on cancelled operations and an improvement is likely. Data quality especially the friends and family data has improved this will be checked. Managers in some areas of the Trust are achieving 100% in staff sickness, the Trust Board agreed this should be celebrated and any good practices should be shared with other groups. The Trust Board accepted the performance report and Mr. Samuda thanked Mr. Waite for his report.	
12 Financial performance (Period 4 July 2015)	**SWBTB (9/15) 148**
Mr. Waite reported that the finances are off plan and will require an improvement in financial management. The Trust is expected to delivery £2m a month worth of savings to achieve financial balance. Capacity is underperforming and the pay bill on agency rate is still high.	

Remedial actions taken on demand and capacity will be reviewed weekly. CIP is monitored at the biweekly PMO review where Mr. Waite and Ms Barlow will be looking at escalating with groups those who do not have a balance financial plan. The Finance & Investment Committee will be meeting monthly from October and fortnightly telephone conferences have been scheduled with Messrs. Samuda, Lewis, Waite and Russell. The stretch target – for the organisation the original plan is being used, however the Trust will try to meet the stretch targets by using non recurrent measures. Capital will be discussed later on in this agenda and there is some year-end management to do on the External Finance Limit. Agency Spend. Mr. Ovington reported that work on how agency staff are engaged is continuing especially with the national target of reducing agency spend by 5%. The Trust has agreed along with other Trusts in the area to cease using Thornbury Agency due to their high costs from the 1st September, Thornbury were used only a short notice to fill staff in specialist areas of Trust like critical care. More is being done to encourage our own staff to join the bank however no staff member are allowed to work at this Trust via an agency. Following discussion Mr. Waite would continue to keep the Board abreast with developments and Mr. Samuda thanked him his for his report.	
13 Forward capital plan 2015-17	**SWBTB (9/15) 149**
Mr. Waite reported that a two year review of the capital programme for 2015-17 is currently being undertaken and once completed a further review will be presented to the Board. The paper presented focused on this year's commitment and investment in the retained estates approved by the Board within its capital resource limit. In 2016/17 shows the advancement on the retained estate investment programme and the firming up on the IM&T investment. The board discussed the MES contract needing to be in place within 6 weeks valued at £22m but the Finance & Investment Committee is keeping an overview on this. Mr. Waite asked the Board to note the recommendations for the programme for 2015/16 and to support the programme going forward noting any due governance and SFIs as appropriate. The Trust Board approved the recommendations.	
ACTION: A report on the capital programme review to be presented at a future Trust Board	**T Waite**
14 CQC Improvement Plan Update	**SWBTB (9/15) 150**
Ms Dhami presented her report on the delivery actions on the CQC improvement plan. Out of the 67 actions 26 have been completed to date, the project is still on track to complete all actions by October 2015. Ms Dhami highlighted the following: **Practices** – some practices would need to change and a report on progress in test areas will be presented at the October Board **Medicine Storage** – cabinets with lockable systems have been ordered. **Social scheduling** – to be managed by the Theatre Management Board.	

All the actions will continue to be discussed at the weekly executive team meeting. Mr. Lewis informed the Trust Board October 2015 will be a year since the CQC visited the Trust. At the next meeting Mr. Lewis confirmed a paper would be presented to show the successes over the last year which would also be taken to the Quality & Safety meeting.	
ACTION: A paper on the test areas where practices have changed due to the CQC implementation plan for a future Trust Board meeting **A paper on success to be presented to the Quality and Safety Committee and the Trust Board in October**	**K Dhami/R Stedman** **K Dhami/O Dutton**
15 Authority to use Trust seal: Midland met S106	**SWBTB (9/15) 151**
Mr. Kenny reported that the application for Midland Met will be taken to the Planning Committee on the 23rd September for approval. There is be a condition attached to the approval notice which is required to be signed, this shows consent on the Section 106 Agreement valued at approximately £303,000. Mr. Kenny stated the seal request was request early as when the agreement is approved the need to seal to the document is required within a very short period of time. The board agreed for the Seal to be used and to allow a £50k buffer if the agreement was different.	
16 Update from Q&S Committee 28.8.15 & minutes of meeting 31.7.15	**SWBQS (7/15) 082**
Ms Dutton stated to the board that issues discussed at the Q&S Committee on sickness, agency/bank staffing, CQC improvement plan, risks have been discussed at this meeting.	
17 Update from Configuration Committee 28.8.15 & minutes of meeting 26.6.15	**SWBFI (6/15) 060**
Mr. Samuda paid tribute to the team working on MMH. A Board to Board with the TDA is currently being arranged and the date will be forwarded once agreed. Mr. Kenny stated the ABC has been approved.	
18 Update from Public Health, Community Development & Equality Committee 27.8.15 & minutes held on 28.5.15	**SWBCF (5/15) 028**
Mr. Kang reported that there was a debate on Smoking and e-cigarettes. The board will be invited to make a decision on smoking and e-cigarettes in due course, however in the meantime Mr. Ovington and Dr. Stedman were available to discuss outside of this meeting.	
12 Any Other Business	
No other items were discussed	
19 Details of the next meeting : 1st October 2015	**Verbal**
An off-site venue for the next meeting is currently being arranged. This will be communicated in due course.	**K Dhami**

Signed .....

Print .....

Date .....

Next Meeting: 5th November, Anne Gibson Board Room, City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

6th August 2015, Rowley Regis Hospital

Members present: Mr R Samuda (RSM), Ms O Dutton (OD), Mr H Kang (HK), Mr R Russell (RR), Dr P Gill (PG), Mr M Hoare (MH), Mr W Zaffar (WZ), Mr T Lewis (TL), Mr T Waite (TW), Mr C Ovington (CO), Dr R Stedman (RST),

In Attendance: Miss K Dhami (KD), Mrs R Goodby (RW), Mr A Kenny (AK)

Apologies: Miss R Barlow (RB)

Secretariat: Miss R Fuller

Last Updated: 25th September 2015

	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
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	On October Agenda	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	Scheduled for presentation at the October meeting of the Audit Committee	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	Arranged for October Board informal meeting	B
SWBTBACT.484	Ten out of Ten deployment	SWBTB (7/15) 105 SWBTB (7/15) 105 (a) SWBTB (6/15) 091	02-Jul-15	Present an update on Ten out of Ten deployment in October	CO	01/10/2015	On October Agenda	G
SWBTBACT.485	DNACPR Plan	SWBTB (7/15) 121	06-Aug-15	Feedback to the board when 3 month data is available and mid point report to board in October	RSt	01/10/2015	On October Agenda	B
SWBTBACT.486	Consent on the day of surgery	SWBTB (7/15) 122	06-Aug-15	Provide update with analysis of how many people on our waiting list pre-date eDTAs introduction	KB	3/9/15 & 1/10/15	completed	B
SWBTBACT.487	CEO Report	SWBTB (8/15) 123	06-Aug-15	100,000 Genome Project - R&D team to prepare a paper for future board	TL	03/12/2015	Provide report to December board	G
SWBTBACT.488	CEO Report	SWBTB (8/15) 123	06-Aug-15	Mutual Tolerance Report at 6 months	TL	01/03/2016	Provide report to March 2016 board	G
SWBTBACT.489	Annual Plan Delivery Report - Q1 - update	SWBTB (8/15) 130	06-Aug-15	Workforce delivery Board to look at sickness and the way forward. Inform board with a plan B	RG	01/10/2015	Present report to October Board	G

SWBTBACT.491	Board Assurance Framework 2015/16 - Q1	SWBTB (8/15) 129	06-Aug-15	Health Visiting staff position to be updated at September board	RB	03/09/2015	completed	B
SWBTBACT.492	Trust Risk Register	SWBTB (8/15) 128	06-Aug-15	Update position on Ultrasound at September Board	RB	03/09/2015	completed	G
SWBTBACT.493	Matters arising	SWBTB (8/15) 135(a)	03-Sep-15	Schedule of Organisational Change to be included on agenda for Board Informal	KD	18/09/2015	completed	B
SWBTBACT.494	Approach to Near Misses	SWBTB (9/15) 137	03-Sep-15	Obtain data from other Trust on what they report on Near Misses	KD	01/10/2015	Update to October meeting	G
SWBTBACT.495	Approach to Near Misses	SWBTB (9/15) 137	03-Sep-15	Video Reflexology presentation at November Trust Board	RB	05/11/2015	November Trust Board	G
SWBTBACT.496	Staff Staffing Data Quality	SWBTB (9/15) 140	03-Sep-15	Update report to be presented to a future Trust Board	CO	05/11/2015	November Trust Board	G
SWBTBACT.497	Chief Executives report	SWBTB (9/15) 141	03-Sep-15	Freedom to Speak Up to be included on Board Informal agenda	KD	18/09/2015	completed	B
SWBTBACT.498	Trust Risk Register	SWBTB (9/15) 142	03-Sep-15	Risks to be reviewed and any obsolete to be removed	KD	01/10/2015	Update Trust Board	G
SWBTBACT.499	Forward Capital Plan 2015-17	SWBTB (9/15) 149	03-Sep-15	Update the Trust Board on the capital programme review	TW	05/11/2015	Update Trust Board	G
SWBTBACT.500	CQC Improvement Plan Update	SWBTB (9/15) 150	03-Sep-15	Update on areas where practices have improved following CQC inspection	KD	05/11/2015	Update Trust Board	G
SWBTBACT.501	CQC Improvement Plan Update	SWBTB (9/15) 150	03-Sep-15	A paper on successes following the CQC inspection to be presented to the Q&S Committee	KD	03/12/2015	Update Trust Board	G

KEY:

R	Action highly likely to not be completed as planned or not delivered to agreed timescale.
A	Action potentially will not delivered to original timetable or timing for delivery of action has had to be renegotiated more than once.
Y	Slight delay to delivery of action expected or timing for delivery of action has had to be renegotiated once.

G	Action that is scheduled for completion in the future and there is evidence that work is progressing as planned towards the date set
B	Action that has been completed since the last meeting

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	**DNACPR Documentation and eBMS Flag Audit**
SPONSOR (EXECUTIVE DIRECTOR):	**Dr Roger Stedman (Medical Director)**
AUTHOR:	**Dr Roger Stedman**
DATE OF MEETING:	**Thursday 1st October 2015**

EXECUTIVE SUMMARY:

The Trust Board has sought assurance regarding the robustness of control measures in place to ensure that decisions to not perform cardio-pulmonary resuscitation (DNACPR) are carried out in a timely and appropriate way. In particular, following near-miss incidents that resulted from poor hand over practice, that it is clear to all staff on a ward at any particular time which patients have a current valid DNACPR order.

We have identified that there is a mechanism for identifying patients with a DNACPR order on the eBMS system using a flag which has to be manually set by the clinician completing the DNACPR form. We undertook to audit the use of this flag along with the standard DNACPR documentation audit that is carried out monthly. During the months of May and June 2015 the use of DNACPR flag was audited (this is prior to any intervention to improve the use of the DNACPR flag on eBMS).

The results of this audit found the following:

- During the period 145 patients with a DNACPR form were audited
- 25% of these patients also had the eBMS flag set
- The majority of wards relied on manual handover sheets to communicate DNACPR status
- Notable exceptions were – Newton 5, D21 and D25
- Other notable findings from the audit:
- 100% of DNCPR forms had a consultant signature
- 23% of forms had incomplete escalation plans (interventions other than CPR also to be withheld)
- 5.5% of forms gave inadequate reasons for DNACPR

Due sickness in the resuscitation team we were unable to carry out the audit during July and August.

The following interventions have taken place since the last audit:

- Communication to all doctors to remind them of the need to set DNACPR flag
- Training update to FY1&2 doctors
- Launch of the 'Board Round Peer Review Tool' – incorporating DNACPR flag reminder (see attached)

This audit will be repeated for the months of September and October.

Is the report to be considered in the private session of the Trust Board meeting? ***(Indicate 'x' where applicable):***

No	**X**	Yes		If 'yes', please justify reason:

REPORT RECOMMENDATION:

We recommend that this issue is re-visited by the board following intervention and re-audit

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

Accept	Approve the recommendation	Discuss
		X

IMPACT ASSESSMENT AND REPORT LINKAGES

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

Financial		Environmental & estates		Communications & media	
Commercial		Legal and regulation	**X**	Patient Experience	**X**
Clinical	**X**	Policy development	**X**	Workforce	

Comments:

EQUALITY AND DIVERSITY

Does your proposal/report present any equality and diversity consideration?	No	**X**	Yes	

If 'yes', please outline these, including any reasonable adjustments or engagement that may be required to handle these:

RISK MANAGEMENT AND ALIGNMENT TO BOARD ASSURANCE FRAMEWORK:

BAF items:

013-CCH – Ensuring that we support patients to die in a place of their own choosing including their own home

004-SHQC – Meeting the improvement requirements agreed with the CQC

003-SHQC – Achieving the gains promised from our 10/10 programme

ALIGNMENT TO TRUST STRATEGIC OBJECTIVES, ANNUAL PRIORITIES, STANDARDS AND PERFORMANCE METRICS:

Safe High Quality Care
CQC Improvement Plan (SD27)

PREVIOUS CONSIDERATION:

Previously discussed at Trust Board

NEXT STEPS:

Board Round Peer Review - "Go, Look, See" Feedback Sheet

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Ward: Date:

Start time: Finish time: Duration:

Started on time? **Yes** **No** ← Circle as appropriate

Where did the board round take place?			
Is this location appropriate? (patient confidentiality, not obstructing ward work)	**Yes**	**No**	?
Was eBMS set up to be viewed by all participants?	**Yes**	**No**	?
Was it clear to you who was leading the board round?	**Yes**	**No**	?
Was someone nominated to update eBMS as individual patients were discussed?	**Yes**	**No**	?
For each patient was:			
- diagnosis stated	**Yes**	**No**	?
- plan for the day agreed	**Yes**	**No**	?
- actions allocated to MDT members	**Yes**	**No**	?
- EDD (re)confirmed	**Yes**	**No**	?
Were any patients identified who required a senior review by a consultant?	**Yes**	**No**	?
Was the following recorded on eBMS for each patient?			
- diagnosis	**Yes**	**No**	?
- board round notes/actions	**Yes**	**No**	?
- discharge plan	**Yes**	**No**	?
- transport flag	**Yes**	**No**	?
- EDD and time	**Yes**	**No**	?
- MFFD	**Yes**	**No**	?
- Go Home today flag	**Yes**	**No**	?
- Weekend Plan	**Yes**	**No**	?
For patients due for discharge today, were the discharge dependant actions agreed?	**Yes**	**No**	?
Was VTE status recorded for all patients [Green V]?	**Yes**	**No**	?
Was the flag ticked for all patients with DNACPR plan in place [Black Star]?	**Yes**	**No**	?

minimum requirement

as and when required

↑ Circle as appropriate

For each patient was their EDD agreed/confirmed/revised?:	**Yes**	**No**	?
Did the lead conclude with a summary of:			
the number of agreed discharges?	**Yes**	**No**	?
restate patient names and any outstanding actions required?	**Yes**	**No**	?

Any other observations or comments to make:

Any suggested improvements the team could make?

Any ideas that you will take back to your ward?

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE PUBLIC TRUST BOARD

Chief Executive's Report – October 2015

This is our first public Board meeting since the exciting confirmation that Carillion Plc, our preferred bid partner for Midland Met, have received final planning consent for the development. Although this is not the end of the journey to irrevocable confirmation that the development will proceed, it is a hugely significant step, both for local residents and our staff, and in terms of the commercial milestones needed prior to financial close. It was especially positive, for me, to be present at the planning committee and hear experienced councillors, used to receiving applications, complement the Trust and partners on both the excellence of the design solution and the engagement work undertaken to date on issues such as transport. We reiterated our commitment to ensure good two-way neighbourhood communications continue once construction commences.

The Board's papers today are especially full and extensive. This reflects the mid-way point of the financial year. We are reporting back on performance, looking forward to year end delivery, and responding to issues of concern highlighted by Board members. In that guise, we consider a presentation on the volunteering strategy, and our first report-back on the three year R&D Plan 2015-2018. And we have a detailed discussion planned on the food that we serve. As we build towards the end of October, which is a key milestones in our Improvement Plan, we review again not only whether actions promised have been taken but whether they have had the benefit we sought. These are local priorities, to which we do and must give the same salience as national initiatives and policies: Looking out not up.

1. **Our patients**

We continue to make progress with our Never Events response plans. And can demonstrate continued improvements in our work on mortality reviews, sepsis, and re-admissions. Although the Trust is a safe provider of care, with a lower than anticipated mortality rate, we are ambitious to do much better. Over coming months we will finalise our Safety and Quality Plans, which will set forward targets for performance in these vital areas. The Board considers again today progress with Ten Out Of Ten, and that reflects our belief that it is often the consistency of what we usually do well that lies at the heart of poor experiences of care, complaints or poor performance.

In September, emergency care services have performed well under sustained pressure. Regrettably we will not achieve the four hour standard in month or for the quarter, but have repeated the 94%+ success of June and July, where in August we achieved 95%. We have seen some demand spikes during this period, including but not limited to 'level 4' status in neighbouring Trusts. Our big challenge has been discharges, both volume and timing. Although delayed transfers of care remain an issue for us, in this month it has been our own practices which on occasion have left difficulties – exacerbated inevitably by our planned bed closure programme. Looking forward to winter we need to ensure that we address major strategic issues such as social work availability and the sustainability of neighbouring units, but particularly that we need defined progress in October and November with estimated dates of discharge and morning discharge targets. These are both the

national quality standard under ECIST, and our own analysis of what we could best to improve care. Like Ten Out Of Ten, this rests on ward clinical teams, their teamwork and communication.

There is very encouraging progress with improving our scheduling. Whilst there is work to do before we deploy outpatient partial booking, we have made huge strides in theatre scheduling in the last three weeks. The organisational norm of late booking has and is being replaced by a genuine forward look achieved already by the best local hospitals. Whilst the board's attention on this issue in part reflects income under-recovery year to date, as well as a modest backlog increase, the driving force for this work is safety. Better scheduling will allow us to ensure equipment and pre-assessment issues are tackled and will help us to tackle cancellations and DNAs. We should under-estimate the scale or nature of our changes, nor the inevitable new problems to be solved that disrupting long established systems will create.

2. Our workforce

The Clinical Leadership Executive continues to focus not just on these individual patient-benefit projects but on how we implement change in the organisation. Linked to our Improvement Plan, and the national well-led framework, we need to continue to consider whether we are doing the right things and doing enough to implement good change management practices. Part of that is ensuring that we hear discordant voices as we implement change, and the Board's workshop a fortnight ago on doing even more work on whistleblowing is a symbol of that determination. We will work through over coming weeks, involving stakeholders like our JCNC, the proposal to appoint 8 Speak Up guardians in our organisation mapped to our eight service and corporate groups. This will help to ensure that being open is part of the middle management culture, as well as the Board level value base.

When we issue our mid-year Annual Plan Review with payslips in October, we would expect to reiterate the strong position of the Trust on many measures. But the continued weakness we see around sickness rates and vacancies in some areas. Tackling these issues is a key priority for all our Groups, and I can confident that the subject has sufficient salience within the wider leadership of the Trust. Of course these are longstanding issues and issues faced by other Trusts. But that does not deter nor excuse the problems we face which we need to surmount. We have made strides in switching use from agency to bank. We now need to see reduced nursing turnover rates at middle-grades and improved nurse recruitment from our student nurses, who report their educational experiences very positively. Among medical staff we can already see the benefits of the Black Country Alliance vision for recruitment, as well as the ambition signalled by our IT and R&D plans.

Engagement and morale continue to be issues in some deeps. Our Your Voice tracking data gives us a regularity and scale of information not seen in other organisations. It shows the local volatility of opinion as change deploys as well as underlying factors such as pension changes and wider NHS job security. The tracking of trainee medical staff opinion continues to be important to us, with executive colleagues routinely attending the Junior Doctor's Forums on both hospital sites. As BMA/NHS Employer negotiations continue we need to remain vigilant about vacancy rates and cross cover in our organisation.

Mid-October sees our annual SWBH Awards ceremony. It is our biggest yet, and reflects new award categories in areas of priority like equality and diversity and primary care. For the first time we

dedicate an award to children's services. This reflects the priority we have on the one in six of our patients who is under 18, as well as the wider population demographic of our communities. At a time when both Local Authority services for children face continued scrutiny it is right that as an organisation we give even greater priority to this. The CQC inspection report on Community Children and Young People's Services is anticipated in final form in coming weeks.

The Board meeting kicks off our annual flu vaccination campaign. Recruitment of vaccinators has gone well. We must maintain our tradition that this is not a 'nice to have'. It is an obligation for those of us looking after patients. The full focus of the leadership, clinical and non-clinical, is on achieving rapid coverage across our staff base, with a focus on high risk areas. We reserve the right to temporarily move unvaccinated staff into lower risk areas of the Trust if we cannot achieve collective coverage in coming months. In the last two years, this has not proved necessary because of our success.

3. Our partners

The first meeting of the Black Country Alliance board takes place later this month. There is real energy being generated around ideas from clinicians about collaboration. It is far too early to specify defined ideas, but what is clear is:

- There is great practice in all three organisations which can be adapted everywhere
- There are real inequities for patients in the community at the boundary of the boroughs
- Our ideas should not be limited to services we currently provide, this is a growth story

The Right Care, Right Here partnership has held its first Board meeting under the new independent chair. There was a very welcome collective focus on bigger issues than simply Midland Met, reaching into the next decade and addressing need and demand, not just in the NHS but the wider care system. It is to be hoped that not only does RCRH develop into a source of collective strength, but the developing partnership helps to build and maintain public trust around service changes to come.

It is now public knowledge that the Black Country Partnership Foundation Trust are seeking to identify a long term potential merger partner. They have also just been awarded Vanguard status for their joint work with two other mental health Trusts. Longstanding Chief Executive, Karen Dowman has also announced her intention in due course to retire. We share a number of services with BCP and will be exploring with them how our collaboration can continue.

The Trust has been invited to become a formal member of the Sandwell Health and Wellbeing Board. We will be progressing this opportunity. For both adult and children's services the local authority has a full forward agenda, and we want to work in smart collaboration with them. Given the apparent failure of the Better Care Fund to deliver its promised admission reduction benefits, the financial challenge of our system in 2016-17 is increased, and we want to play a full part in identifying and implementing changes which we believe will work. In that regard our focused work on re-admissions is before the Board at this meeting, as part of the work starting October 12th to tackle this anew. The Trust's annual consultant conference focuses heavily on this subject, as well as end of life care, on October 14th. As I indicated in our staff newspaper, Heartbeat, notwithstanding

the economic impact of readmissions on our revenues, we are pressing hard to improve the position, because it is "simply the right thing to do".

4. Our regulators

The Trust is anticipating an invited review by the CQC against our December 2014 improvement notice for imaging training records. This will take place in October. A submission has meanwhile been made to the HSE in respect of a July contravention of electrical working regulations.

I am pleased to report an exceptionally positive review of Core Medical Training by Health Education West Midlands. Through the CLE Education committee, which I chair, we now examine all of these reports on receipt, building on the work of our education specialist leaders. A future restructure of that function will take place ready for 2016-17 to ensure, among other benefits, that our approach to educational excellence operates on a single cross Trust basis. It is very much our aim to ensure that leading education is a Clinical Group function, with expert input from educationalists. This is a widely welcomed move to integrate service, R&D and education. That is already the case in therapies and midwifery, and we will explore the route to that journey for nurse education as well.

We had an invited infection control review with NTDA earlier in September. This was a very positive review in respect of City Hospital, and raised some new and some longstanding issues at Sandwell. The positive is therefore the mirror opposite of July's review. The full executive are working through the issues raised to understand how our internal multi-professional inspection processes can give quicker sight of issues. The Board will recall that a proposed part of our CQC response is to undertake a wave of unannounced inspections across all matters during November. Kam Dhami will be leading that work, and we are very keen to have 'fresh pairs of eyes' on the issues; this will include patient representatives as we have promised.

5. Other matters

I attach my updated schedule against our top ten and our Equality and Diversity plans. I am encouraged by recent catch-up progress in both areas.

At the last Board we considered health visiting performance and saw the detail of significant changes in deliver between April and July 2015. The latest data shows sustained good performance still shy of our Q3 improvement aim. The real focus by the Board on health visiting is, I know, appreciated by our teams. The opportunity to better connect midwifery, health visiting, children's centres and general practice is a chance we must seize as develop collaborations in the months ahead. This is a much more complex issue that relocating staff or attaching them. It is about maximising the value of clinical interventions and ensuring a focus not just on the highest risk families, but on those who may become the highest risk families. MASH success in Sandwell in the last 12 months has seen progress with the former goal, which must now be matched by progress with the larger tier 3 pool.

The Board continues to pay routine attention to issues around imaging and secretarial functions. Weekly data on both service transformations is available. It is clear that there is imaging improvement in acute care, which must now be matched by planned care. And that improvements in clinical administration vary from the significant to a worsening position. In each case we are looking to confirm whether the changes planned have been made and fallen short, or have not, for good or other reasons, yet been implemented. The Board agreed named non-executive directors to

track those projects and I shall chair one to one sessions with each in coming weeks to ensure that in the next six months that oversight of progressed with gusto.

Toby Lewis, Chief Executive - September 25th 2015

ANNEX A - **Our annual plan 2015/16 – top ten**

Objective (listed by improvement quarter order)	End of August update	Improvement quarter	Success quarter	Likelihood of delivery assessment
Work within our agreed capacity plan for the year ahead	Recovery plan in place. Planned care delivery below expectations.	Q1	Q1-4	As before As before
Create balanced financial plan…	Anticipate 5 of 8 Groups having CEO agreed plans by end of September.	Q1	Q1-4	As before As before
Agree EPR OBC and initiate procurement process	Approved and out to advert. Work being done now to resolve the 'grey area' systems that might stay or go.	Q1	Q1 and Q3	As before As before
Achieve the gains promised in our 10/10 programme	Delivery plan was discussed at July Board, outcome update at Board in October.	Q2	Q2	Worsened As before
Implement our Rowley Regis expansion…	Plan approved and tenders let.	Q2	Q3	As before As before
Cut sickness absence below 3.5%...	Good mobilisation but data flows need firming up if planning to go green. Plan now needed for medium term sickness.	Q2	Q3 and Q4	As before As before
Reduce readmissions by 2% at Sandwell	Delivery plan needs further work within the executive, but focus on on UCC3 in w/b Oct 12 to try and tackle this.	Q2	Q3-4	Improved Improved
Deliver our plans for significant improvements in our universal health visiting offer	Plan now before the Board and a clear priority for WCH Group. Some gains through DQ, but changed processes required.	Q2	Q4	As before Improved
Tackle caseload management in community teams	Budget established and a plan to get a plan is before the Board. Need to establish the balance between more staff and changed supply model.	Q3	Q4	As before Improved
Reach financial close on the Midland Met	Reached PB stage, with planning consent due in late September.	Q4	Q4	As before

Annex B – Board Equality and Diversity Plan (October 2014 version – July revisions)

Key deliverable	Commitment at July 15 board	Current state
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 in time for our annual declaration. This will be compared to our overall by band staff profile.	On track
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.	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.	On track
We would undertake an EDS2 self-assessment for any single directorate in the Trust. Almost all directorates have submitted to post a draft for review.	It is to be reviewed in full and final form at the next meeting of the Board's PHCD&E committee in September 2015	Could not be done. Will be completed at November Committee.
Collect, collate and examine protected characteristics data on our workforce and, largely, on our staff: We will undertake 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.	We need to agree within the EG who will do what when to make sure that these changes happen
Undertaking monthly characteristics of emphasis in which we host events that raise awareness of protected characteristics (PC)	The director of communications needs to plan a year of work, starting from October 2015.	Agreed early at September Committee, and starts from December.
Add into our portfolio of leadership development activities a series of structured programmes for people with PC	Raffaela Goodby will determine how we move ahead by October 2015 with an unambiguous programme which will certainly include a specific BME leadership offer.	Proposal in hand and will be available by mid October. Discussed at Board's workforce committee.
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.	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.	Not yet due
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.	Started but in delay

Key deliverable	Commitment at July 15 board	Current state
Work with senior leaders with protected characteristics for them to provide visible support within the organisation to others	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.	Forms part of the leadership programme proposals

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:	1 October 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 September 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 September 2015

FOR DECISION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Risk Register

Report to the Trust Board on 1 October 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. There are no additional risks to be highlighted from the recent CLE meeting. However Women's and Child Health provided an update on the BCG vaccine shortage risk; some stocks will be made available which W&CH will work with partners to ensure these are prioritised based on those at highest risk. There are approximately 1500 babies that are awaiting their BCG vaccination.

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. ELECTRONIC RISK REGISTER (ERR)

2.1 The Trust Risk Register will be uploaded to the ERR over the coming weeks, which will include the opportunity to review and refresh all risks. It is intended that the move to electronic risk registers will facilitate easier review and refresh by Executive Director risk leads as previously there has been some slippage in the frequency of review.

2.2 The Risk Team has arranged for risk registers from W&CH, M&EC, Surgery B and Informatics to be uploaded to the electronic system and roll-out is in progress to enable access for individuals to manage their risks online. 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. MMH project risks associated with scenario testing for derogations from HBNs are also now on the ERR.

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

2.4 Colleagues from remaining Groups / Corporate Directorates have been asked to provide all of their excel based risk registers for review/data cleaning and uploading to the live system. (Surgery A, Estates, Pathology, Community and Therapy, Imaging, Workforce, Corporate Nursing & Facilities, Finance, Corporate Operations, Medical Director Office).

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

3. RECOMMENDATION(S)

3.1 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
1 October 2015

Appendix A - Trust Risk Register (version as at 23 September 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. **Previous update:** A more detailed plan is being developed through CLE workforce committee, led personally by the Chief Executive. Will culminate in review at Board's Workforce and OD committee in September 2014. **Update:** Detailed plans for 14/15 and 15/16 in development due for implementation during Q3 and Q4 of 2014. Key planning assumptions for 2016 onwards in development.	Director of Workforce and OD	Mar-20	Jun-14	bi-monthly	3	5	15	=

Appendix A - Trust Risk Register (version as at 23 September 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
2013HASU01	CCG	Medicine	Stroke/Admitted Care	Operational	Potential loss of the Hyper Acute Stroke Unit which is subject to an external commissioner led review.	4	4	16	Trust representatives on Strategic Review sub groups; SWBH Stroke Action Team continues to monitor stroke activity and performance on a monthly basis and to develop actions plans for service improvement; Implement action plans to improve data capture and accuracy. **Previous updates:** Standard operating procedure agreed and in place for data collection and validation. KPI improving new pathways, e.g., thrombolysis pathways direct from ambulance to CT scanner and strengthened capacity planning to ensure availability of gender specific beds to support timely admission. Feedback received from Stroke Review Advisory panel to be considered to strengthen position as preferred provider. Update 21.11.2014 - outcome of review has been put on hold and no definitive outcome has been received due to data validation issue. No current timeline. Update 12.2.2015 Awaiting final decision from CCG Commissioners and the independent panel that has been set up to review the whole process. CCG have not confirmed a timeline or completion date	Chief Operating Officer	TBC - Commissioner led review	Feb 15	Monthly	4	3	12	=

Appendix A - Trust Risk Register (version as at 23 September 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
TRR1401CCC01	Management review	Corporate Operations		Operational	Lack of assurance of standard process and data quality approach to 18 weeks.	4	4	**16**	Task and Finish Group established to oversee rapid improvement programme; SOP to be agreed and implemented in March for new processes; Elective access team structure to be reviewed; Central booking process to be strengthened to ensure real time data quality management; IST visit will inform work programme content. **Previous update:** New Waiting List Manager recruited and starting in July. Year of Out Patients programme will deliver automation to strengthen real time data. Plans to centralise elective access team in Q2. Data Validation Team still required - funding until end Q2. Perceived knowledge deficit in some services regarding 18 weeks - New Elective Access Manager to assess competency of teams and provide re-training in Q2. **Progress:** Timelines for assessment and training September to December and SOP / policy review in September	Chief Operating Officer	Jul-14	Sep-14	Jul-14	2	4	**8**	=

Appendix A - Trust Risk Register (version as at 23 September 2015)

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TRR1401COO02	Management review	Corporate Operations		Operational	Sustained high Delayed Transfers of Care (DTOC) patients remaining in acute bed capacity.	4	4	16	Joint working through joint discharge teams on both acute sites established; 7 day working pilot; Weekly urgent care call with Chief Executives and Chief accountable officers from LAT, CCG, NTDA, acute Trust and social services includes DTOC review, strategic and operational work; Commissioning plans for 7 day working in 2014 in train. **Previous update:** Additional capacity closed end July although DTOC remains high. Plan will remain in place to re-open additional beds if required and triggers are agreed and activated through Operations Centre and authorised by COO or on call Executive Directors. Resilience System Plan (winter) submissions includes additional beds in community and social care – outcome of funding decision to be agreed in July. This will impact on DTOC reduction. Work to establish a Joint Health Social Care assessment and discharge team continues – now in training phase for go live at Sandwell in August and then at City. **Progress:** DTOC numbers remain high. The System Resilience plan awaits clarification from Birmingham City Council on aspects of plan workforce and the re-ablement bed plan for the locality. New joint team with Sandwell is in implementation phase with good engagement.	Chief Operating Officer	Jun-14	Sep-14	Jul-14	2	4	8	=

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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	Trust Solution fitting in with RCRH required; Compliance with Medical Device and ICOC standards; Service Improvement application to Sandwell OPD; Greater use of Rowley facilities. **Previous update:** Rowley Max has been scoped and will be delivered in Year of Out Patients programme on track for completion Q2. Plans for relocation of oral surgery OP to enable ophthalmology to meet privacy and dignity standards in development with intention to complete in Q3. SGH outpatients privacy and dignity risk treatment plan stalled as dependant on Oral Surgery being relocated, which is still to be resolved Update 24.2.2015 Continuing to seek potential solution through re-location of Oral Surgery either off-site or to another SWBH location.	Chief Operating Officer	31/12/2015	Feb 15	GBM	3	3	9	=

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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**	Bank and agency staff utilised where available. Incidents to be escalated to the Health Forum / SSCB / PAB LA. Monthly report to be developed and reviewed at Paediatric Governance meeting and information provided to risk, Health Forum / SSCB / PAB. Honorary contracts for psychiatrists to be explored. Mental health commissioners report that they are working up enhanced assessment service for children's mental health which intends to reduce numbers of children needing admission. Impact expected in autumn. Confirmed new assessment service and intended benefits will enable review of residual risk. The Trust continues working closely to support this work. Agreed with both adult providers access to mental health bank to support specialist staffing. Guidance on booking process to be agreed in July. Previous Update: Direct access to agency booking approved by Chief Nurse 11.08.14 Update: Continue to monitor any incidents as they arise. Funding identified by the Mental Health Trust to provide both a Crisis Team and a Home Treatment team – both due to be in place January 2015, however funding is currently only available until end on March 2015.	Chief Operating Officer	TBC	Dec-14	Monthly	4	4	**16**	=

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	Oncology Peer Review	Medicine	Scheduled Care	Operational	Oncology Service is currently unable to treat approx. 120 patients a month due to workforce issues.	5	4	20	**Previous update:** SLA with Royal Wolverhampton Hospital NHS FT to provide consultant AOS – 2 sessions to augment the 2 sessions provided by UHB Update: Provision of replacement locum through New Cross Hospital, Wolverhampton to provide Consultant AOS - 2 sessions to augment the 2 sessions provided by UHB. Update 12.2.2015. Locum secured through agency. Clinic modelling re: breast and lung taking place as per actions through Cancer Taskforce Group	Chief Operating Officer	TBC	Feb 15	Monthly	3	4	12	=
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Trust non-compliant with Oncology Standards.	5	4	20	**Previous update:** Workforce and service design issues (hot clinics) to be negotiated through enhanced SLA with oncology provider. Meeting scheduled with QE for September. Intention is to agree model of service and agree workforce model and SLA for Q3. Developing nurse led services to see pre-chemotherapy patients – to mitigate oncology demand issues. Previous Update: Clinic Modelling and AOS proposal completed as a pre-requisite to negotiations with UHBFT re: SLA provision. Pilots to commence re: oral chemotherapy pharmacist role and rescheduling of chemotherapy in BTC. Update12.2.2015: Interviews for x 2 Band 6 AOS nurses taking place. IAP being completed for 7 day service through business planning process.	Chief Operating Officer	TBC	Feb 15	Monthly	1	4	4	=

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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	**Previous update:** Trust has extended discussions with UHB and executive led cancer futures workshop now scheduled for early September. Update: Workshop has taken place and proposal for oncology clinic model has been submitted to UHBFT. Update 12.2.2015: Awaiting reply from UHBFT re: model proposal. Cancer Action Taskforce Group working through actions and proposed model.	Chief Operating Officer	TBC	Feb 15	Monthly	1	5	5	=
201109DEL30	Risk Assessment	Women's and Child Health	Maternity	Clinical	The existing provision of a 2nd theatre team for an obstetric emergency.	2	5	10	Process to request opening of a second theatre in and out of hours for obstetrics is in place. Ongoing monitoring of any second theatre team issues through the incident reporting process. (Risk initially RED, downgraded to AMBER due to reduced frequency). Previous Update: TB has previously reviewed the risk and agreed it is to be tolerated. Update: Continued monitoring	Chief Operating Officer	TBC	Nov 14	Monthly	2	5	10	=

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TBC	Risk assessment	Women and Child Health	Maternity	Financial	Unpredictable birth activity and the impact of cross charging from other providers against the AN / PN tariff is significantly affecting the financial position of the service impacting on the affordability and quality provision of the service.	4	4	16	Previous Update: Maximise tariff income through robust electronic data capture. Review of activity and income data 6 months post BadgerNet roll out. Comprehensive review of maternity pathway payment system underway for presentation to FD. Update: Options appraisal from finance in progress which will be discussed between the Clinical Group Director of Operations and Director of Finance	Chief Operating Officer	Ongoing	Oct-14	Monthly	3	4	12	=

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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	=

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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. The Staff running the resus area particularly do not necessarily have trauma qualifications. The peer review team advised that these staff should have the Advanced Trauma Nurse Course (ATNC) or equivalent. The staff will be scheduled to attend training. In the meantime local trauma teaching will take place as a re-fresher session.	Chief Operating Officer	30.5.15		Monthly	2	3	6	=

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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	Service covered weekdays resulting in potential delays for patients presenting out of hours. Clinically these cases may be appropriate to manage in a scheduled service. If clinically required urgent patients will be transferred to another local centre with 24/7 cover. The intention is to secure alternative and robust 24/7 cover arrangements through recruitment, and partnership arrangements through a network approach with other providing organisations. Current recruitment includes extending the search for locums; also consider recruitment from abroad. Develop collaboration with Dudley - supports service resilience and potentially better chances of joint recruitment. Immediate potential for joint appointment of fellow or specialist doctor. Explore options to develop extended roles for radiographer or nurse to cover some procedures. Revisit previous plans to consolidate services onto one site to make cover easier to manage	Chief Operating Officer	Appointment of fellow / specialist doctor; clear plans agreed for other actions - end Q1 15/16	19/03/2015	Fortnightly	2	3	6	=
CEO1503001		Corporate Operations		Operational	Clinical Groups are unable to transact basic business processes because of key person gaps resulting in performance delays and failures.	4	4	16	Executive Group weekly monitoring of recruitment processes; investing in high quality agency staff to cover gaps; peer support network set up by COO for existing staff to buddy with high quality agency staff. Interview timetable for Director of Operations scheduled for mid may conclusion	Chief Operating Officer	30/06/2015	Mar 15	Weekly	4	3	12	=

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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	01/06/2015	Mar 15	Monthly	2	5	10	=

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		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. Update: Due to the continued attrition of sonographers the Group lacks confidence that the sonography team will be able to maintain attendance at all community gynae clinics given the low priority a one stop outpatient clinic will have compared to urgent / emergency activity. A worsening position is anticipated.	Chief Operating Officer	01/06/2015	Apr 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	01/06/2015	Apr 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	30/06/2015	Apr 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.	Chief Operating Officer	Ongoing	07/05/2015	Monthly	3	5	15	=
		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	1. automated referral closure of selected and risk assessed group of patients, 2. Letter to go to selected group of patients, 3. 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	31.08.15	May 15	monthly	3	3	9	=

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INFORMATICS_0010	Delivery Review	Medical Directors Office	Informatics	Clinical	There is a risk that the Trust's integration engine fails, as 50% of the disks have already failed and are not repairable and the current version is unsupported by the supplier. Resulting in inability to transfer key clinical information between key clinical systems, making these systems unusable (e.g. CDA, eMBS etc).	4	5	20	The Rhapsody V2 system is on old unreliable hardware and V2 software is no longer supported. A disk failure has removed resilience and another disk failure would not be recoverable on the existing hardware. • Put in place business continuity and communications plan for the event of hardware failure • Activities underway to identify how to effectively and safely transition Rhapsody V2 off this server onto a virtual server. Treatment plan is to migrate of Rhapsody V2 to current V5 software. This will require downtime and implementation of business continuity over the migration period.	Medical Director	Nov 15	Aug 15	Weekly	4	5	20	na

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Wider Safe Staffing – taking a wider view**
SPONSOR (EXECUTIVE DIRECTOR):	**Dr Roger Stedman – Medical Director**
AUTHOR:	**Raffaela Goodby – Director of Organisation Development**
DATE OF MEETING:	**1st October 2015**

EXECUTIVE SUMMARY:

At April 2015's meeting, whilst discussing the Nurse Safe Staffing agenda item, the board questioned the Trust's wider understanding of what constitutes 'safe' in relation to a clinical ward team, with a focus on junior doctor staffing.

The attached report updates the board the following mains areas:

1) What is wider safe staffing? What is in scope and out of scope?
2) A piece of work that will be completed over the next 12 weeks to establish an accurate and live data flow to present a picture of ward clinical teams
3) An update on a high profile piece of work being led by Dr Mike Durkin, under the auspices of NHS Improvement, which will seek to develop a methodology that properly assesses and publishes what appropriate levels of staffing should be. This piece of work will inform whether our clinical ward team establishment is 'safe' as outlined in (2)
4) The Dr Durkin research will also establish 'safe' guidelines for mental health and community settings.

.

REPORT RECOMMENDATION:

The report is discussed by the Board.
The national Wider Safe Staffing work led by Dr Mike Durkin is fully understood and supported by the board and SWBH - to enable recommendations to be quickly implemented and responded to.

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	

Comments:

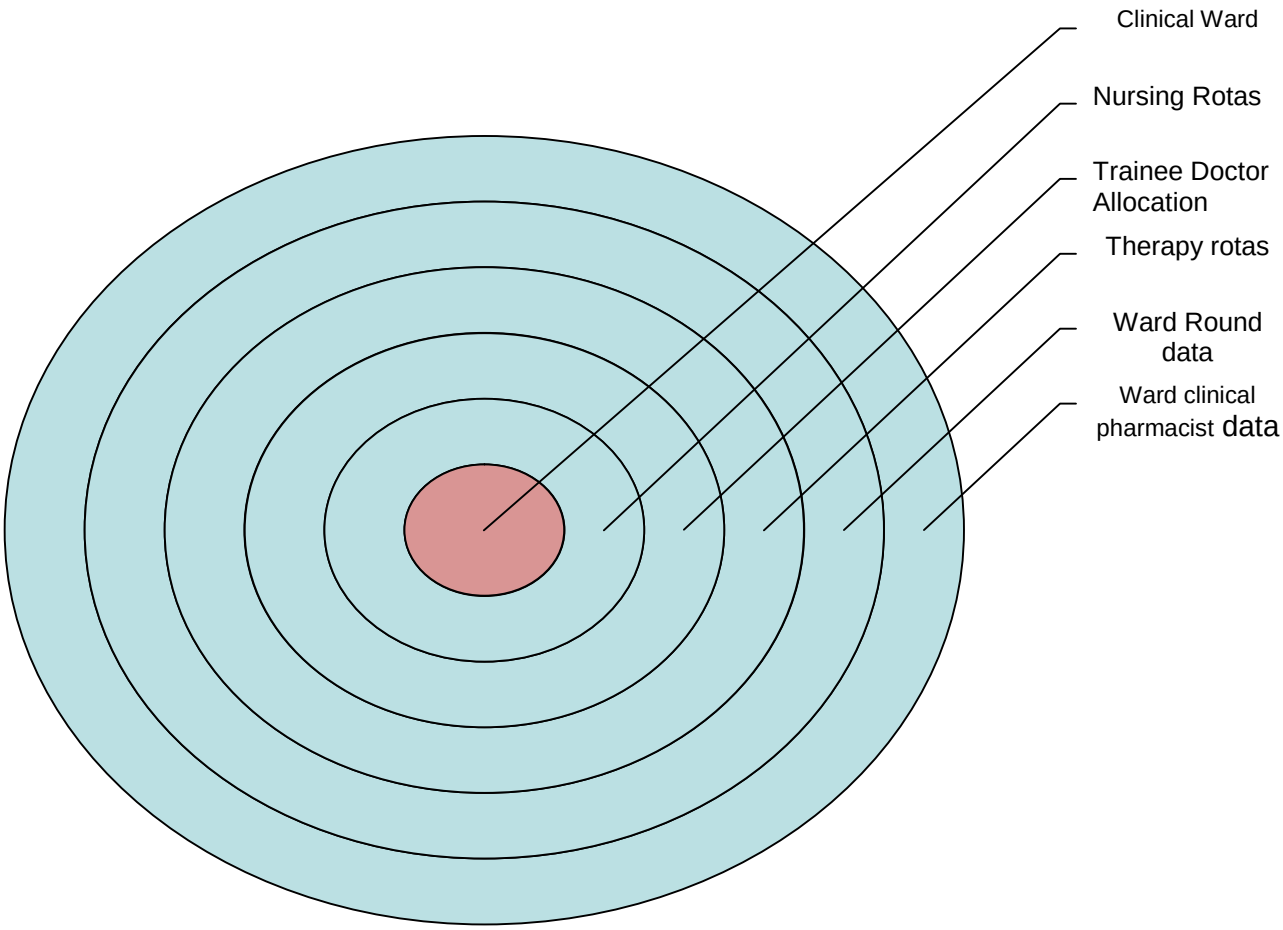
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

PREVIOUS CONSIDERATION:

Safe Staffing Data considered monthly at Trust Board.
CLE Monthly
Quality and Safety Committee.

1) Why Wider Safe Staffing?

At April board there was an extended discussion about safe staffing, and in particular the levels of staffing routinely in place at ward level. This is linked to the work on nursing safe staffing, which is nationally mandated, whereas other staffing levels are not; unless from Royal Colleges in some instances. There are a number of inputs that make up the full complement of expected staffing on a clinical ward. These include:



- Nursing numbers (nationally mandated through NICE)
- Trainee doctor allocations
- Ward round data
- Ward clinical pharmacist data
- Therapy staff rotas (such as occupational therapists, physiotherapists or other services)

These different sets of rotas tend to be managed locally in Groups and by Clinical Directors / Clinical Lead.

2) How to get to "one clear view" of the staffing complement on our clinical wards.

It will take 8-10 weeks to build live data flows for this work. The sources of data to be audited will be:

- Rotawatch
- Job plans
- Therapy and pharmacy rotas
- Existing nursing data flow

Once this clear set of data is established, we can then track how often that expected staffing complement is matched. It will obviously differ throughout the week to cover the rhythm and working practises of the hospital.:

For example:

- Night versus day
- Weekday versus weekend

What we cannot do at the moment is say whether this baseline is considered 'safe', be that guided by mandated standards or available guidance from other sources. However, there is a significant piece of work about to be launched nationally, led by Dr Mike Durkin to establish what is considered 'safe'.

3) Ensuring the NHS is Safely Staffed - National Work

In August 2015 the Chief Nurse of NHS Improvement wrote to all Chief Nurses in Trust's across the UK to inform them of a shared work programme which aims to improve the safety and quality of NHS Staffing.

This body of work aims to:

- Improve experience of care for patients and staff
- Improve the effective and safe clinical outcomes for our patients; and
- Achieve an improved efficiency and productivity in every pathway of care and staffing guidance.

The project therefore will:

- Take a multi professional approach that takes in to account all staff involved, not just nurses
- Takes in to account at here are many care settings that are not in a hospital, and span organisational boundaries
- Remember that this is not just about filling rotas or looking only at numbers or input measures
- Recognise there is not a one size fits all

This will not change the NICE guidance that has already been issued, and it will not contradict the CQC's role to inspect and rate hospitals and providers, and it is not about saving money - but about using the money we have as efficiently and effectively as possible.

There is also a project being led by the Mental Health Taskforce, on establishing what is the right balance of staff in the many settings that treat those with mental illness.

The outcomes of this piece of work will be independently reviewed by NICE, CQC and Sir Robert Francis QC to ensure they meet the high standards of the care the NHS aspires to and of which patients deserve. Staffing guidance will be published by the National Quality Board taking in to account the feedback from an oversight advisory group and independent reviews.

The outcomes of this work will inform points 1 and 2 above – and ascertain whether SWBH's ward clinical teams are considered 'safe' by the new national standards. It is assumed they will also make recommendations for improvements with a monitoring and reporting regime for doing so.

Doing this work now means that the Trust will be in a positive position from which to make changes swiftly and efficiently with minimum impact to patients and to the Trust's reputation.

It is recommended therefore that SWBH keep an oversight of this important piece of national work through the Chief Nurse and Medical Director where appropriate over the coming months and year.

Raffaela Goodby

Director of Organisation Development.

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:	1st October 2015

EXECUTIVE SUMMARY:

1.1 This report is an update on safe nurse staffing August data.
1.2 Board members were alerted to the data accuracy problems in preceding months that have led to an inaccurate understanding of the nurse staffing position across the trust. A programme of work to correct this is part way though with a deadline agreed 15th October, I have given an update of our current position.
1.3 A number of operational changes have been made in an effort to maintain safe nursing establishments; these are detailed in the report.
1.4 Internal audit have been requested to undertake a review of the systems, processes and data accuracy in relation to safe nurse staffing.
1.5 next steps are outlined which include daily, weekly and six weekly review mechanisms of ward staffing

REPORT RECOMMENDATION:

To restate our safe staffing position on our web site
To receive an update at the November 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:

FOR INFORMATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAFE NURSE STAFFING UPDATE

Report to Trust Board on 1st October 2015

1 EXECUTIVE SUMMARY

1.1 This report is an update on safe nurse staffing August data.

1.2 Board members were alerted to the data accuracy problems that have led to an inaccurate understanding of the nurse staffing position across the trust. A programme of work to correct this is part way though with a deadline agreed 15th October.

1.3 A number of operational changes have been made in an effort to maintain safe nursing establishments, these are detailed below.

1.4 Internal audit have been requested to undertake a review of the systems, processes and data accuracy in relation to safe nurse staffing.

2 AUGUST DATA UPDATE

Since the last Board meeting intensive checking activities have been undertaken and will continue throughout the programme of work to mid-October. The August data is feeling closer to reality although the fill rate percentages are lower than the actual staffing checked on a daily basis.

The August data is in table 1. Areas that demonstrate a significant shortfall have been checked to explore whether the gaps in the roster were real or still a data capture problem. For clarity ward staffing is checked on a shift by shift basis on every ward to ensure safety. Group Directors of Nursing have identified that not all temporary staff have been added into the monthly data return, this affects the fill rate percentage. Additional checks of the nurse bank part way through September have also identified additional staff that were on duty but not included in the data submission, the team are now working through how to capture this data closer to the point of use in readiness for the data submission due on 15th October. Table 2 gives the trending data, given for comparison and to help Board members see the differences we are seeing in the data over the last three months.

I have met with our internal auditors to describe the problems we have encountered and specifically requested that they use a subject expert to undertake an audit of our systems and processes, to check on data accuracy and how the information is gathered from different systems to inform the monthly return.

It has been agreed that the Group Directors of Nursing may sign off staff nurse vacancies to help to speed up the placing of adverts for recruitment, it is too early to say whether this has had any impact so far, however recruitment open days and block adverts have continued. The majority of our nursing vacancies are in medicine and emergency care, and mostly at the City Hospital. A recruitment open day was held on 19th September, ten staff nurses have been recruited from this event with on the day interviews and all documents completed. Vacancies on Sandwell medical wards have reduced significantly since we merged Lyndon 4 and Lyndon 5 wards and distributed staff to fill vacancies.

During the week of 7th September we temporarily closed an additional two beds on ward D15 at the City hospital because their vacancy position was becoming critical with 8.31wte vacancies, this is over half of the registered nurse team. The permanent staff have been very dedicated to working additional shifts via the nurse bank and this has enabled the ward to continue as normal. This ward achieves good quality standards and has excellent practices surrounding patient discharge. Staff are leaving this ward to further their careers and not because of any unhappiness or concern about the ward, staff recount the excellent support and development that they have had whilst on the ward.

We increased the normal pay rate via the nurse bank at the start of August to try to attract our own staff and those from agencies to join the bank, anecdotally this has had a small affect. We temporarily increased the bank pay rate further on 1st September as we stopped using Thornbury the most expensive agency on this date. All registered nurses and healthcare assistants were sent a letter to explain this change. There is stronger evidence that staff from some wards have taken this opportunity to join the nurse bank, I will quantify this next month. Matrons report more bank staff than agency on shifts which is encouraging in terms of quality and safety as these staff are inducted into our own ways of working and more able to abide by trust policy and procedures.

The escalation procedure to use temporary staff has been re-written to help ensure that the procedures demonstrate a governance mechanism. Staff have continued to raise incident alerts when staffing has not met with minimum standards. Matrons across the trust are undertaking night shifts on rotation to ensure that there is a senior presence in the trust and to help with patient care when gaps are difficult to fill, this is in addition to moving staff between wards and hospital sites when necessary and the subsequent use of temporary staffing measures when we are able.

Next Steps

1. The Group Directors of Nursing (GDoN) will produce a six week staffing plan at the point the e-roster is signed off.
2. GDoN's will meet with matrons daily to ensure that the plan is being executed effectively and to ensure any new short term gaps are staffed to meet NICE guidance.
3. GDoN's will meet with the Chief Nurse on a weekly basis to review and where necessary challenge their six week and weekly staffing plan.

4. Exploring ways of getting temporary staffing requests directly into the bank IT system (AVA) to cut out request delays and improve data quality
5. Weekly reporting of the vacancy position on ward establishments.
6. Updated the daily public display of staff on duty and ratio's

Table 1.

	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 August 2015	Percentage night time fill rate during August 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during August 2015	Percentage night time fill rate during August 2015
Medicine & Emergency care	D5	City	13	5	5	5	35.68%	27.82%	1	1	0	35.34%	-
	D7	City	19	3	3	3	joint with D5		1	1	0	Joint with D5	
	D11	City	21	3	3	3	81.30%	73.96%	2	2	1	86.92%	87.10%
	D12	City	10	2	2	2	84.57%	41.65%	1	1	1	62.41%	37.03%
	D15	City	24	3.5	3.5	3	77.46%	46.38%	2	2	1	83.66%	89.76%
	D16	City	25	3.5	3.5	3	60.02%	56.10%	2	2	1	98.21%	200.00%
	D26	City	21	3	3	3	91.07%	47.31%	2	2	1	71.60%	
	AMU 1	City	41	10	10	10	67.21%	65.46%	4	4	4	118.71%	68.55%
	AMU 2	City	19	5	5	5	90.94%	60.95%	1	1	1	89.06%	83.87%
	CCU Sandwell	Sandwell	10	3	3	3	24.73%	25.81%	0	0	0	-	-
	PR4	Sandwell	25	7	7	7	103.71%	78.40%	3	3	3	113.07%	54.75%
	PR5	Sandwell	34	5	5	4	84.35%	80.61%	3	3	2	143.31%	154.98%
	NT4	Sandwell	28	4	4	4	71.74%	89.55%	3	3	3	166.08%	158.44%
	LY 4	Sandwell	34	5	5	4	59.78%	50.00%	3	3	2	106.05%	132.05%
	LY5	Sandwell	29	4	4	4	95.86%	62.54%	4	4	2	83.64%	133.27%
	N5	Sandwell	15	5	5	2	75.74%	98.32%	1	1	1	128.75%	83.87%
	AMU A	Sandwell	32	11	11	11	88.27%	68.91%	4	4	3	121.19%	88.17%
	AMU B	Sandwell	20	3.5	3.5	3	88.06%	61.29%	3	3	3	45.07%	35.48%

	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 August 2015	Percentage night time fill rate during August 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during August 2015	Percentage night time fill rate during August 2015
Surgery A	D21	City	23	4	4	2	82.28%	94.04%	2	2	2	91.65%	67.39%
	D25	City	19	4	4	2	87.54%	85.41%	2	2	2	66.90%	65.92%
	SAU	City	14	4	4	3	87.62%	87.05%	1	1	1	163.25%	74.05%
	N2	SGH	24	4	4	2	75.92%	112.50%	2	2	1	98.75%	143.48%
	L2	SGH	20	6	6	4	76.09%	83.87%	3	3	2	109.98%	87.10%
	P2	SGH	20	5	5	3	54.03%	68.02%	4	4	3	95.30%	116.48%
	N3	SGH	33	5	5	3	70.77%	82.80%	4	4	3	93.60%	96.03%
	L3	SGH	33	5	5	3	80.36%	94.53%	4	4	3	80.01%	96.77%
	CCS	City		Staff flexed to the dependency/number of patients in the units			135.48%	94.77%	Staff flexed to the dependency/number of patients in the units			123.14%	-
	CCS	SGH					133.82%	90.33%				104.49%	-

	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 August 2015	Percentage night time fill rate during August 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during August 2015	Percentage night time fill rate during August 2015
Community & Therapies	Henderson	RH	24	3	3	2	64.75%	59.92%	3.5	3.5	2.5	73.19%	89.99%
	Elisa Tinsley	RRH	24	3	3	2	95.28%	80.86%	3.5	3.5	2.5	78.29%	73.60%
	D43	City	24	6	6	4	63.30%	64.39%	5	5	2	90.46%	111.15%
	Leasowes	RH	20	3	3	2	67.32%	82.19%	3	3	2	113.88%	97.12%

	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 August 2015	Percentage night time fill rate during August 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during August 2015	Percentage night time fill rate during August 2015
Surgery B	Eye ward	City	10	2	2	2	86.67%	90.45%	1	1	0	79.73%	-

	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 August 2015	Percentage night time fill rate during August 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during August 2015	Percentage night time fill rate during August 2015
Womens & Children's	L G	SGH	14	3	3	2	72.11%	94.35%	1	1	1	37.38%	35.28%
	L1	SGH	26	5	5	4	87.00%	121.48%	3	3	2	136.72%	90.60%
	D19	City	8	3	3	2	86.77%	91.50%	1	1	0	34.18%	-
	D27	City	18	4	3	2	59.53%	90.11%	2	2	1	81.87%	84.86%
	Maternity	City	42	6	5	4	97.22%	94.32%	4	4	2	59.57%	87.10%

Table 2

	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 (%)
			63336	64995	36356	37070	37961	40562	17674	21264	102.6%	102.0%	106.9%	120.3%
Jun-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2276.25	2172.167	419	426	555	527.25	166.5	184.75	95.4%	101.7%	95.0%	111.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
	RXK02	CITY HOSPITAL	28309.5	29468.17	15410.18	14755.27	18281	19637.77	6748.5	7504.317	104.1%	95.8%	107.4%	111.2%
	RXK10	ROWLEY REGIS HOSPITAL	2442	2374.75	3676.5	3263	1302.5	1494	1587	1916.5	97.2%	88.8%	114.7%	120.8%
	RXK01	SANDWELL GENERAL HOSPITAL	26826	28578.08	15516.5	17366.28	15139.5	17222.75	8432.5	10183	106.5%	111.9%	113.8%	120.8%
			59854	62593	35022	35811	35278	38882	16935	19789	104.6%	102.3%	110.2%	116.9%
Jul-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	930	1951.583	465	512.75	589	555	0	166.5	209.8%	110.3%	94.2%	0.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
	RXK02	CITY HOSPITAL	32069.5	27187.57	13190.5	13134.5	27450.5	19260.02	8199.5	7613.267	84.8%	99.6%	70.2%	92.9%
	RXK10	ROWLEY REGIS HOSPITAL	3208	2495	3565	2970.667	2139	1486.75	2495.5	1923	77.8%	83.3%	69.5%	77.1%
	RXK01	SANDWELL GENERAL HOSPITAL	30178.5	26279.73	15686	15236.02	23885.5	17973.25	11764.5	11337.25	87.1%	97.1%	75.2%	96.4%
			66386	57914	32907	31854	54064	39275	22460	21040	87.2%	96.8%	72.6%	93.7%
Aug-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	930	806	465	370.75	573	518.25	0	171	86.7%	79.7%	90.4%	0.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
	RXK02	CITY HOSPITAL	31861.5	24502	13158.25	11459.75	27419.5	18006.17	7843	7162.517	76.9%	87.1%	65.7%	91.3%
	RXK10	ROWLEY REGIS HOSPITAL	3208.5	2431.5	3565	3108.117	2139	1589.75	2495.5	2150.5	75.8%	87.2%	74.3%	86.2%
	RXK01	SANDWELL GENERAL HOSPITAL	29192	24223	14735.5	15146	22765.5	17481.07	11251	11176.75	83.0%	102.8%	76.8%	99.3%
			65192	51963	31924	30085	52897	37595	21590	20661	79.7%	94.2%	71.1%	95.7%
3-month Avges	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1378.75	1643.25	449.6667	436.5	572.3333	533.5	55.5	174.0833	119.2%	97.1%	93.2%	313.7%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
	RXK02	CITY HOSPITAL	30746.83	27052.58	13919.64	13116.51	24383.67	18967.98	7597	7426.7	88.0%	94.2%	77.8%	97.8%
	RXK10	ROWLEY REGIS HOSPITAL	2952.833	2433.75	3602.167	3113.928	1860.167	1523.5	2192.667	1996.667	82.4%	86.4%	81.9%	91.1%
	RXK01	SANDWELL GENERAL HOSPITAL	28732.17	26360.27	15312.67	15916.1	20596.83	17559.02	10482.67	10899	91.7%	103.9%	85.3%	104.0%
	Total	*Latest 3 month average====>*	63811	57490	33284	32583	47413	38584	20328	20496	90.1%	97.9%	81.4%	100.8%

3 RECOMMENDATION(S)

3.1 The Board are requested to receive this update and agree to publishing it on our public website.

Colin Ovington

Chief Nurse

23rd September 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Performance Report
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance
AUTHOR:	Yasmina Gainer, Head Performance Management & Costing
DATE OF MEETING:	1 October 2015

EXECUTIVE SUMMARY:

The report is presented to inform the Trust Board of the summary performance for the Trust for the period April 2014 to August 2015.

In addition to that information presented in the IPR on cancer performance by specialty below is performance for the latest month presented by tumour site. The national standard is 85%. This information shall be incorporated into the IPR going forwards.

Tumour Site Analysis :	Accountable Total treated	Accountable Total over target	% meeting standard
Breast	22	0	100
Gynaecology	13	2	84.6
Haematology	4	0	100
Head & Neck	2.5	0	100
Lower GI	9.5	2.5	73.7
Skin	12	0	100
Upper GI	4	1	75
Urology	17	6	64.7
Total	84	11.5	86.3

July 2015: 62 Day Cancer compliance split out by tumour site:

REPORT RECOMMENDATION:

The Trust Board is asked to consider the content of this report. Its attention id drawn to the 'At a glance' summary page.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

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

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

Sandwell and West Birmingham Hospitals NHS Trust

Integrated Quality & Performance Report

Month Reported: August 2015

Reported as at: 25/09/2015

Contents

At Glance - August 2015

Infection Control

There were 3 cases of C. Diff reported during the month of August (3 Medicine). The number of cases year to date is at 13 against a year to date target of 13.

No cases of MRSA Bacteraemia reported within the month of August.

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

Both MRSA elective and non-elective screening remain above the 80% target overall; however Medicine elective screening is below the target for the month of August at 63% (worsening in medicine to July which was at 76%).

Harm Free Care

Overall Harm Free Care as assessed through the NHS Safety Thermometer indicates a level of Harm Free Care of 93.9% for August, beneath the 95.0% operational threshold and a deterioration on last month.

There were 76 falls reported in August (49 Acute; 27 Community), a decrease from previous trends. No reported serious injuries from the falls in August.

Pressure ulcers data for August not reported at this stage. Patient Safety Thermometer - Catheters & UTIs reporting increase in the month - being investigated.

There was 1 serious incident reported in the month; no medication errors reported in August. Venous Thromboembolism (VTE) Assessments are above target in August - a recovery from July's performance.

There were 11 Open CAS Alerts reported at the end of August, of which 1 was overdue at the end of the reporting period.

Obstetrics

The overall Caesarean Section rate for August is 26.2%, 25.1% on a cumulative year to date basis and which are above the target of 25.0%. Elective and Non-Elective rates for the month were 8.8% and 17.4% respectively (an improvement from last month across both pathways).

Adjusted perinatal mortality rate (per 1000 births) increased during the month of August to 10.0, above the target of 8.0 or less.

Early Booking Assessment (<12 + 6 weeks) - SWBH Specific target of 90% has not been met and delivery stands at 76.71% in August.

Breastfeeding initiation is at 74.3% on a cumulative basis, below the target of 77% (met in June quarter).

Mortality & Readmissions

The Trust RAMI for most recent 12-mth cumulative period is 91. City RAMI at 78, Sandwell at 99.

Latest data available data indicates weekday and weekend mortality rates are within statistical confidence limits.

During the most recent month of June the mortality review rate is 93% which implies that the overall Trust performance for review of deaths within 42 days improved. The trajectory currently is 100%, but the target is under review again (Medical Director).

Readmissions rate for August is 9.1% - a significant increase from last month (8.5%); cumulative rate at 8.4%. CHKS 12-months cumulative reports the Trust at 8.5% for Emergency Readmissions (within 30 days) with biggest volumes reported against Medicine and Surgery A. The CHKS peer group reports at a 6% rate. The Trust has lined up a 'readmissions focus week' beginning of October to support improvement of the readmissions rate.

Stroke Care & Cardiology

Stroke data for August indicates Patients spending >90% of their time on a stroke ward was 93.2% compared with a the 90% operational threshold (year to date 90.9%). Admittance to an acute stroke unit within 4 hours remains relatively stable at 80.4% (falling short on 90% local target, but meeting 80% national target). The August percentage of patients receiving thrombolysis within 60 minutes of admission was at 100% compared with a target of 85% - a significant improvement from last month delivery of 80%. August patients receiving a CT scan within 1 hour and 24 hours of presentation was at 82.1% (target 50%) and 100% respectively (target 100%).

For August the Primary Angioplasty Door to balloon time (<90 minutes) was 95.2% against an 80% target and Call to balloon time (<150 minutes) was 95.5% for the same period, also against an 80% target - both targets are delivering year to date. RACP performance for August at 100% (improving from last month), with a year to date performance is at 98.9% (target 98%).

Cancer Care

The Trust met the 62-day urgent GP referral to treatment target of 85% during July, with performance of 86.3%. Other high level targets were also met in July (2WW and 31day). August projections are that the Trust will not achieve the 62 Day target (forecast for August at 75%).
Groups that failed the 62 day target : Surgery A - 82.5% Women's 84.6%
Other high level targets were also met in July (2WW and 31day).
2ww none achievement by : Surgery B & Women's is due to patient choice.

The projection is that all targets other than the 62 day will be met in August, all of them will be met in Sept and Oct.

New indicators have been put in place to measure patient waiting times - those are:

11.5 patients are waiting over 62 days and 4.5 patients are waiting 104 days.

The longest waiting patient is at 180 days (Urology). Action plan being put in place for Urology.

Patient Experience - MSA & Complaints

There was 1 mixed sex accommodation breach reported during the month of August within Critical Care.

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 (within 3 days) further improved to 7.1% in August (from 22%).

Inpatient FFT response rate and score are tracking close to the target or above, however the Emergency FFT rate is below target of 20% at 9.6% in August (consistently below target since March).

The oldest complaint currently in the system is in Medicine at 208 days

Patient Experience - Cancelled Operations

The number of Last Minute Cancelled Operations (elective) increased again in August to 1.0% (June 0.6%, 0.9% in July) against a 0.8% target. The cancellations are in Surgery A (1.41%) followed by Surgery B (1.29%) and WCH (1.59%).

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

The trust has reviewed its reporting of the 'urgent operations cancelled on the day' to ensure it is not mis-reporting. Consequently a new KPI has been added 'Urgent Cancellations' which report 7 cases in August - all in Surgery A. The KPI trend has been shown from April onwards.

Patients experiencing multiple cancellations are at 10.5% (highest in Surgery A).

Theatre utilisation is below the target of 85% at a Trust average of 72.7% as at August.

Emergency Care

The Trust's performance against the 4-hour ED wait target of 95.0% during the Month (August) was 95.84%. July performance was at 94.18%. Performance for the first Quarter is 92.99%.

WMAS fineable 30 - 60 minute and greater than 60 minute handover delays have shown consistent improvement (reduction) over the most recent 3 month period, at 58 delayed handovers in August. Over 60 minutes was at 2 delayed handovers. As a %age of the overall conveyances the over 60 min delays are at 0.05% (target at 0.02%)

Fractured Neck of Femur who received an operation within 24 hours of admission remains static at 67% in August against a target of 85% .

DTOC at 2.7% for the month of August against a target of 3.5%.

Referral To Treatment

RTT overall is meeting targets against all pathways. The forecast is that RTT will be met over the next 3 months across all pathways.

At the end of August 5 patients were waiting more than 52 weeks for commencement of treatment.

9 (last month 6) Treatment Functions failed the respective RTT pathway performance thresholds for the month. The split of those is as follows: Completed Pathway – Admitted (T&O 68%); Completed Pathway – Non Admitted (Plastic – 94%, Dermatology – 88%, Respiratory - 93%, Urology - 89%);
Incomplete Pathway (T&O – 91%, Cardiology – 91%, Oral – 87%, Respiratory - 88%)

Diagnostic waits (August) beyond 6 weeks were 0.38%, remaining well beneath the operational threshold of 1.00% and improving on July.

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. AE and OP parameters remain above target, but IP data with valid entries has fallen to just below the required threshold.

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 August reported as 95.8%. 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 August of 39.1%.

Open Referrals are at 203,025 as at the end of August being 30,000 higher than at April 2015.

Staff

PDR overall compliance as at the end of August at 88.6%. The Medical Appraisal / Revalidation rate as at August is 89.7% measuring only validated appraisals not carried out.

Mandatory Training at the end of August at 87.7% overall against target of 95%. Health & Safety mandatory training at 97.87%

Sickness Absence at 4.91% for August which represents a 12-month rolling period, a 0.01% improvement on last month. The Return to Work interview rate following Sickness Absence is at 63.16% for the 12-month cumulative period concluding August - below target.

Overall Trust vacancies at 823 WTE (actual WTE vs plan WTE). Qualified nurse vacancies as at August reported as 320.9WTE. The Trust turnover rate is at 13.56% as at August.

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

Nurse Bank & Agency shifts still high although some improvement in group usage.

CQUIN

In preparation for Q2 submission a full review of the schemes has been carried out with a number of schemes being rated as amber or red at August month. From October onwards monthly meetings will be put in place to monitor the delivery.

Ext Assessment Frameworks & Data Quality

Current Observation & Escalation assessment of the trust is at 'level 3 - Intervention'. The August position is unlikely to influence / change this rating.

Data Quality - the Performance Committee has agreed to re-visit all data quality kitemark assessments as part of an ongoing improvement cycle. The initiative completes at the end of December 2015 when all data reported in the IQ&PR will have a completed kitemark.

Summary Scorecard - August month

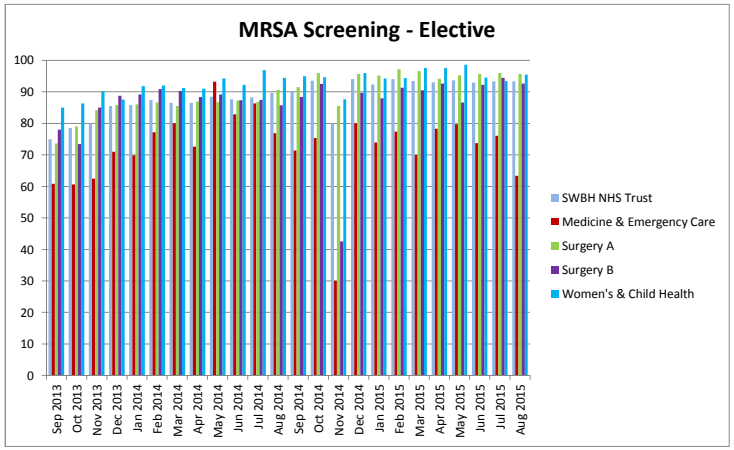
Section	Red Rated	Amber Rated	Green Rated	None	Total
Infection Control	0	0	6	0	6
Harm Free Care	5	0	7	2	14
Obstetrics	1	2	4	6	13
Mortality and Readmissions	1	0	0	11	12
Stroke and Cardiology	1	0	10	0	11
Cancer	0	0	8	4	12
FFT, MSA, Complaints	4	0	4	6	14
Cancellations	4	1	3	1	9
Emergency Care & Patient Flow	6	0	6	4	16
RTT	2	0	4	0	6
Data Completeness	3	0	7	1	11
Staff	9	0	1	11	21
Total Trust-Level	**36**	**3**	**60**	**46**	**145**

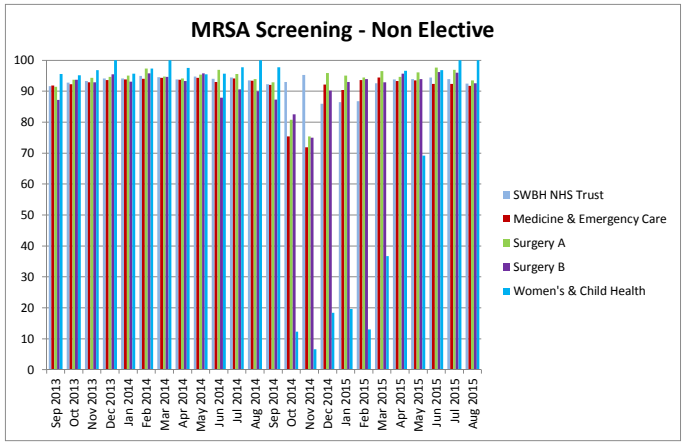
36 exceptions (red rated) reported at August. Focus will be in place to address these and progress will be reported at the performance committee.

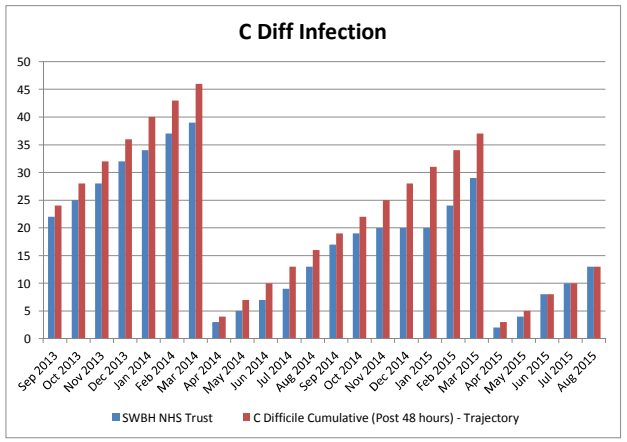
Note: Items in red are outstanding at the time of reporting.

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Mar 2014) M A M J J A S O N D J F M A M J J A	Data Period	Group M	Group A	Group B	Group W	Group P	Group I	Group C	Group CO	Month	Year To Date	Trend	Next Month	3 Months
4			C. Difficile	<= No	30	3		Aug 2015	3	0	0	0					3	13			
4			MRSA Bacteraemia	<= No	0	0		Aug 2015	0	0	0	0					0	1			
4			MRSA Bacteraemia (rate per 100,000 bed days)	<= Rate2	9.42	9.42		Aug 2015									0.0	0.6			
4			E Coli Bacteraemia (rate per 100,000 bed days)	<= Rate2	94.9	94.9		Aug 2015									0.0	19.7			
3			MRSA Screening - Elective	=> %	80	80		Aug 2015	63.4	95.7	92.7	95.5					93.4				
3			MRSA Screening - Non Elective	=> %	80	80		Aug 2015	91.8	93.5	92.6	100					92.5				

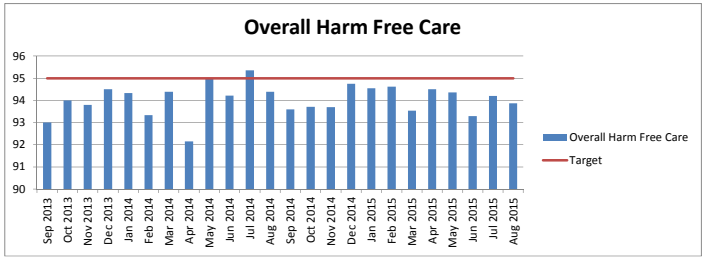


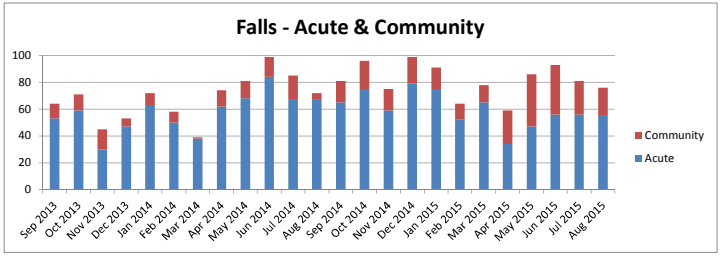


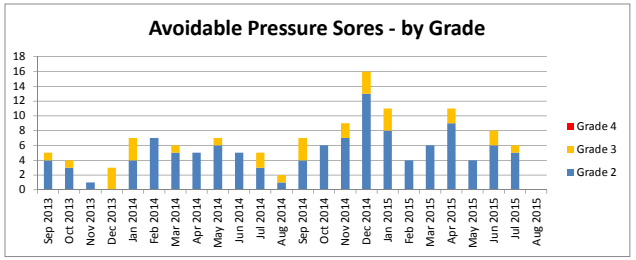


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Mar 2014) M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		d	Patient Safety Thermometer - Overall Harm Free Care	=> %	95	95																			Aug 2015									93.9				
8		d	Patient Safety Thermometer - Catheters & UTIs	%			0.43	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	4.00	2.00	1.00	9.00	Aug 2015									0.76				
8			Falls	<= No	804	67	39	74	81	99	85	72	81	96	75	99	91	64	78	80	106	90	70	76	Aug 2015	41	2	0	1	2	1	27		76	422			
9			Falls with a serious injury	<= No	0	0	2	1	5	4	1	5	1	1	2	1	1	0	1	1	1	1	5	0	Aug 2015	0	0	0	0		-	0		0	8			
8			Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	7	5	7	5	5	2	7	6	9	16	11	4	6	11	4	8	6	-	Jul 2015	2	1	0	0			3		6	29			
3		d	Venous Thromboembolism (VTE) Assessments	=> %	95	95																			Aug 2015	94.9	97.3	98.7	89					95.2				
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	=> %	98	98																			Aug 2015	100.0	100.0	100.0	99.8		0.0			100.0				
3			WHO Safer Surgery - brief (% lists where complete)	=> %	95	95																			Aug 2015	100	100	100	100		100			100				
3			WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	85	85																			Aug 2015	100	100	100	100		100			99.7				
9		d	Never Events	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	Aug 2015	0	0	0	0	0	0	0		0	3			
9		d	Medication Errors causing serious harm	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0		Aug 2015	0	0	0	0	-	0	0		0	1			
9		d	Serious Incidents	<= No	0	0	1	3	2	2	2	2	1	1	2	3	4	4	6	4	3	4	1	1	Aug 2015	0	0	0	1	0	0	0	0	1	13			
9			Open Central Alert System (CAS) Alerts	<= No			11	9	5	7	5	6	5	5	15	17	10	9	4	8	5	4	8	11	Aug 2015									11				
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	2	0	1	Aug 2015									1				

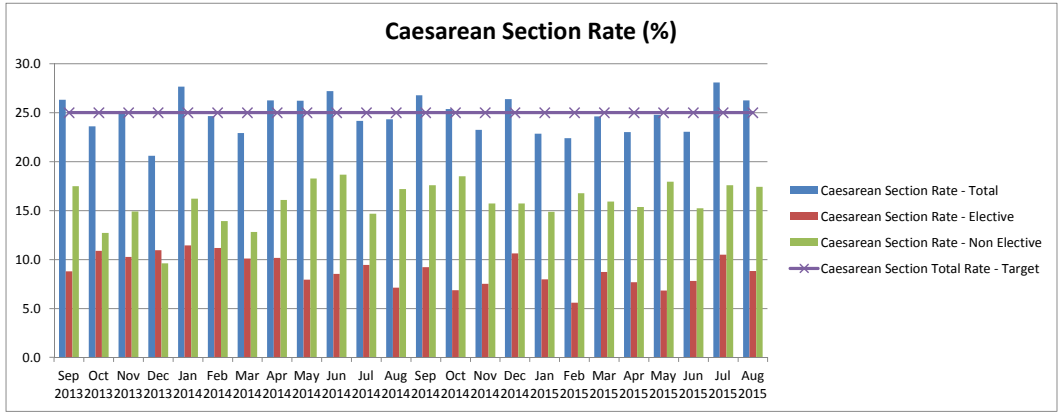


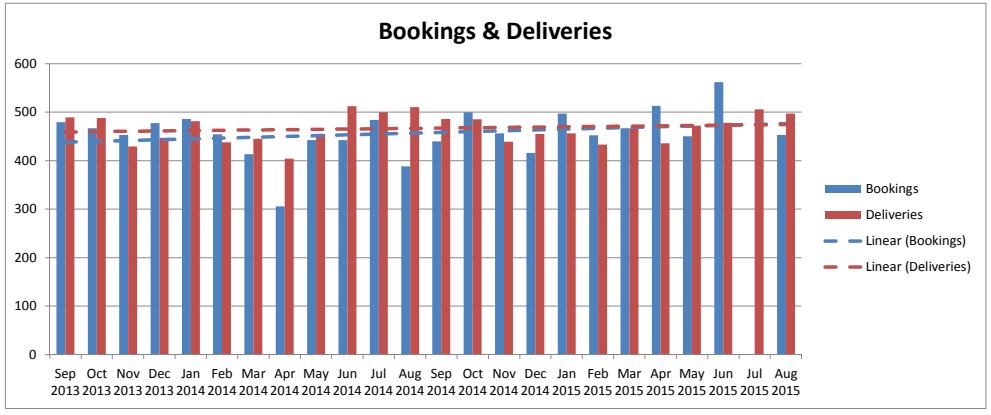




Patient Safety - Obstetrics

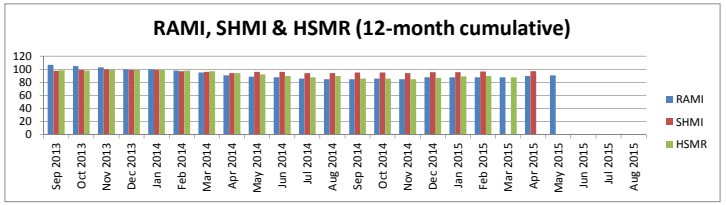
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Mar 2014) M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Caesarean Section Rate - Total	<= %	25.0	25.0																			Aug 2015	26.2	25.1			
3		•	Caesarean Section Rate - Elective	<= %			10	10	8	9	9	7	9	7	8	11	8	6	9	8	7	8	11	9	Aug 2015	8.8	8.4			
3		•	Caesarean Section Rate - Non Elective	<= %			13	16	18	19	15	17	18	19	16	16	15	17	16	15	18	15	18	17	Aug 2015	17.4	16.7			
2		•d	Maternal Deaths	<= No	0	0																			Aug 2015	0	0			
3			Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Aug 2015	3	10			
3			Admissions to Neonatal Intensive Care (Level 3)	<= %	10.0	10.0																	-		Aug 2015	2.82	2.80			
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Aug 2015	10.00				
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	90.0	90.0																			Aug 2015	76.71				
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	=> %	90.0	90.0																	-	-	Jun 2015	154.2				
2			Breast Feeding Initiation (Quarterly)	=> %	77.0	77.0	-->	-->	-->		-->	-->		-->	-->		-->	-->		-->	-->		-->	-->	Aug 2015	-	74.29			
2		•	Puerperal Sepsis and other puerperal infections (variation 1) (%)	<= %			0.7	2.3	1.8	2.6	1.8	0.9	0.9	0.7	1.5	1.2	1.3	0.5	2.1	2.1	2.1	1.3	1.6	1.6	Aug 2015	1.61	1.74			
2		•	Puerperal Sepsis and other puerperal infections (variation 2) (%)	<= %			0.5	1.5	1.8	1.6	1.6	0.7	0.3	0.7	1.3	0.8	0.3	0.5	1.5	1.6	1.0	1.3	1.0	1.1	Aug 2015	1.15	1.22			
2		•	Puerperal Sepsis and other puerperal infections (variation 3) (%)	<= %			0.0	0.8	0.7	0.4	0.4	0.2	0.0	0.0	1.0	0.4	0.0	0.0	1.2	0.7	0.8	0.9	0.2	0.5	Aug 2015	0.46	0.61			

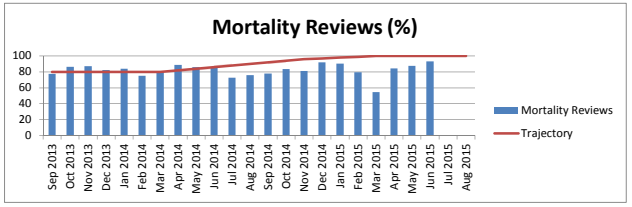


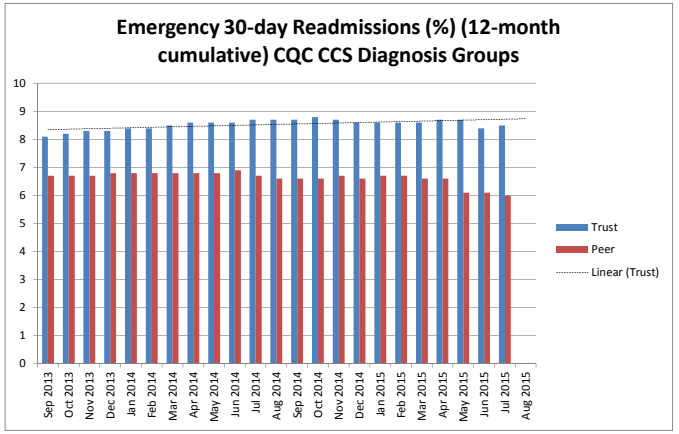


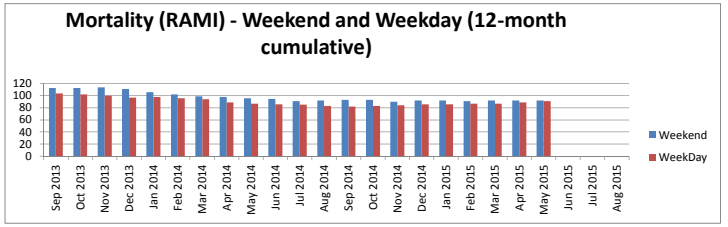
Clinical Effectiveness - Mortality & Readmissions

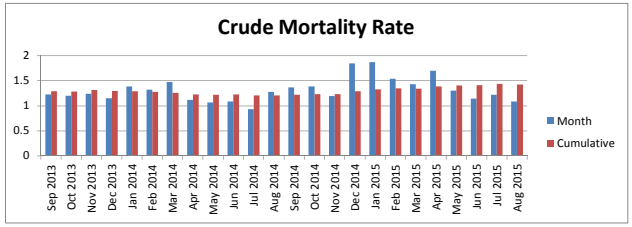
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Mar 2014) M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
5			Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	95	91	89	88	86	85	85	86	85	88	88	88	88	90	91	-	-	-	May 2015										181	●		
5			Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	94	89	87	86	85	83	82	83	84	86	86	87	87	89	91	-	-	-	May 2015										180	●		
5			Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	99	98	96	95	91	92	93	93	90	92	92	91	92	92	92	-	-	-	May 2015										184	●		
6			Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	96	94	96	96	94	94	95	95	94	96	96	97	-	97	-	-	-	-	Apr 2015										97	●		
5			Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			97	94	92	90	88	90	86	86	85	87	89	90	88	-	-	-	-	-	Mar 2015										1065.0	●		
5			Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	106	66	75	47	51	71	89	80	76	111	105	94	93	75	84	-	-	-	May 2015									84		●		
3			Mortality Reviews within 42 working days	=> %	100	99	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	-	-	Jun 2015	96	63	0	100					93		●		
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			1.5	1.1	1.1	1.1	0.9	1.3	1.4	1.4	1.2	1.8	1.9	1.5	1.4	1.7	1.3	1.1	1.2	1.1	Aug 2015									1.09				
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.3	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.3	1.3	1.3	1.3	1.4	1.4	1.4	1.4	1.4	Aug 2015										1.41			
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			7.5	8.5	8.6	7.8	8.1	8.3	7.8	8.2	7.5	8.0	8.5	8.3	8.4	9.4	8.7	8.5	9.1	-	Jul 2015									9.09				
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			-	8.1	8.2	7.9	7.8	7.8	7.7	7.7	7.7	7.7	8.1	8.1	8.2	8.2	8.2	8.3	8.4	-	Jul 2015										8.28			
5			Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative)	%			8.5	8.6	8.6	8.6	8.7	8.7	8.7	8.8	8.7	8.6	8.6	8.6	8.6	8.7	8.7	8.4	8.5	-	Jul 2015	-	-	-	-						8.57			





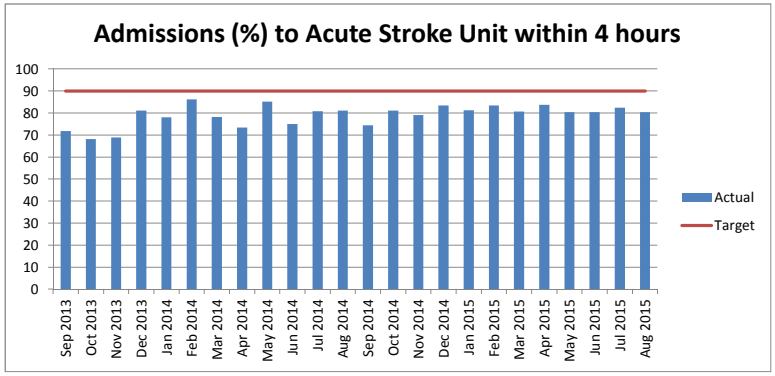


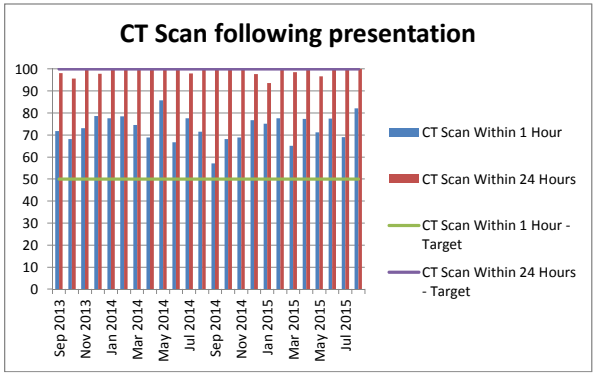


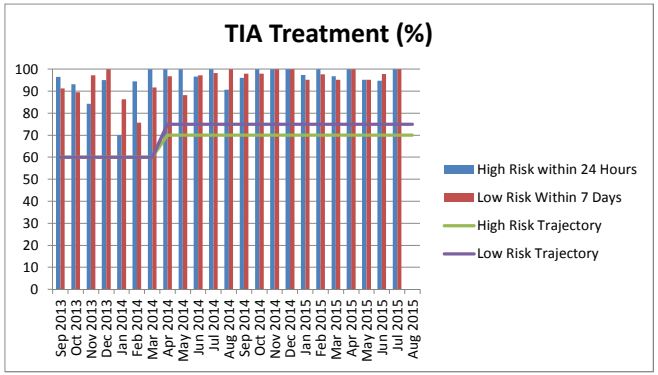


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (Since Mar 2014) M A M J J A S O N D J F M A M J J A	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Pts spending >90% stay on Acute Stroke Unit	=> %	90.0	90.0		Aug 2015	93.2	90.9			
3			Pts admitted to Acute Stroke Unit within 4 hrs	=> %	90.0	90.0		Aug 2015	80.4	81.3			
3			Pts receiving CT Scan within 1 hr of presentation	=> %	50.0	50.0		Aug 2015	82.1	75.3			
3			Pts receiving CT Scan within 24 hrs of presentation	=> %	100.0	100.0		Aug 2015	100.0	99.3			
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0		Aug 2015	100.0	80.0			
3			Stroke Admissions - Swallowing assessments (<24h)	=> %	98.0	98.0		Aug 2015	100.0	100.0			
3			TIA (High Risk) Treatment <24 Hours from receipt of referral	=> %	70.0	70.0		Aug 2015	100.0	97.3			
3			TIA (Low Risk) Treatment <7 days from receipt of referral	=> %	75.0	75.0		Aug 2015	100.0	98.2			
9			Primary Angioplasty (Door To Balloon Time 90 mins)	=> %	80.0	80.0		Aug 2015	95.2	93.8			
9			Primary Angioplasty (Call To Balloon Time 150 mins)	=> %	80.0	80.0		Aug 2015	95.5	94.3			
9			Rapid Access Chest Pain - seen within 14 days	=> %	98.0	98.0		Aug 2015	100.0	98.8			

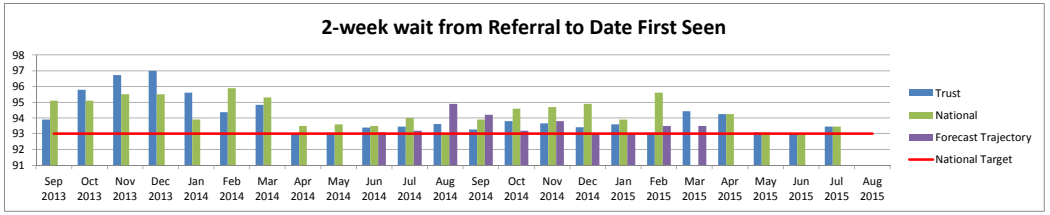


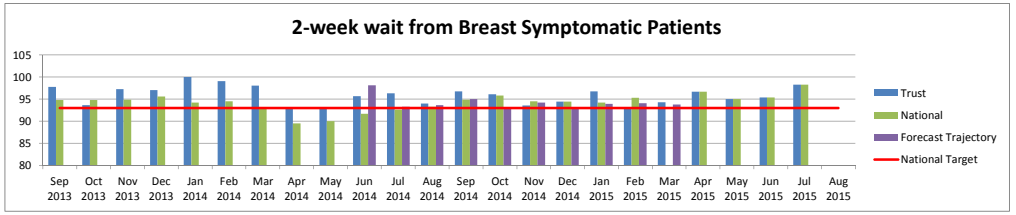


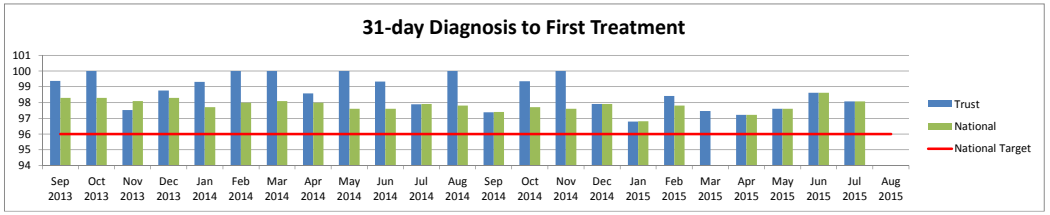


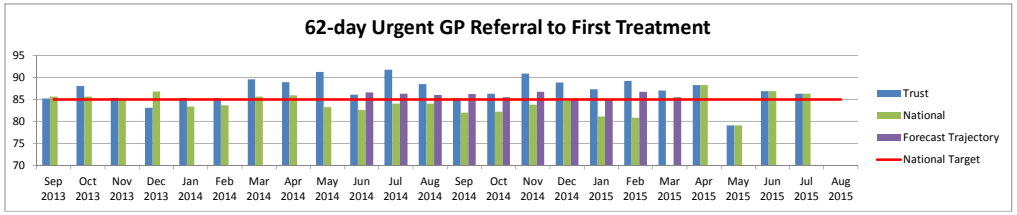
Clinical Effectiveness - Cancer Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Mar 2014) M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
1			2 weeks	=> %	93.0	93.0																		-	Jul 2015	94.9	93.7	90.1	90.6					93.5	93.4			
1			2 weeks (Breast Symptomatic)	=> %	93.0	93.0																		-	Jul 2015		-							98.3	96.5			
1			31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Jul 2015	100.0	98.8	100.0	94.1					98.1	97.9			
1			31 Day (second/subsequent treatment - surgery)	=> %	94.0	94.0																		-	Jul 2015									100.0	98.4			
1			31 Day (second/subsequent treatment - drug)	=> %	98.0	98.0																		-	Jul 2015									100.0	98.0			
1			31 Day (second/subsequent treat - radiotherapy)	=> %	94.0	94.0																		-	Jul 2015										0.0			
1			62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Jul 2015	95.0	82.5	100.0	84.6					86.3	85.7			
1			62 Day (referral to treat from screening)	=> %	90.0	90.0																		-	Jul 2015	100.0	0.0	0.0	80.0					98.0	96.2			
1			62 Day (referral to treat from hosp specialist)	=> %	90.0	90.0																		-	Jul 2015	77.8	100.0	100.0	87.5					90.6	88.7			
1			Cancer - Patients Waiting over 62 days	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	11.5	-		Jul 2015	0.0	0.0	0.0	0.0					0.0	0.0			
1			Cancer - Patients Waiting over 104 days	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4.5	-		Jul 2015	0.0	3.5	0.0	1.0					4.5	4.5			
1			Cancer - Longest Waiter in days	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	180	-		Jul 2015	62	180	62	123					180				



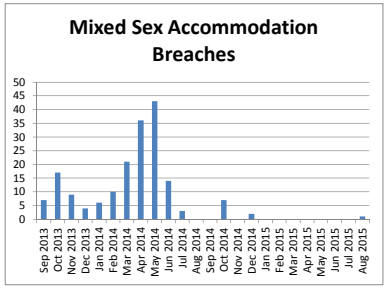


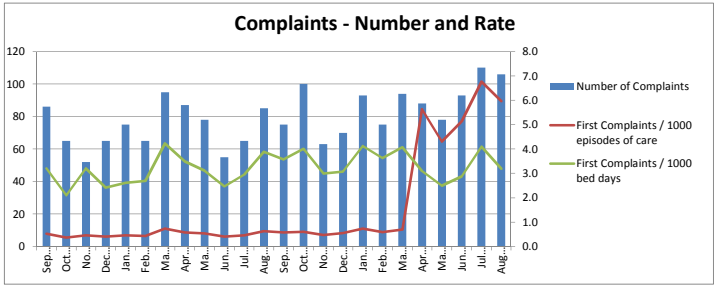


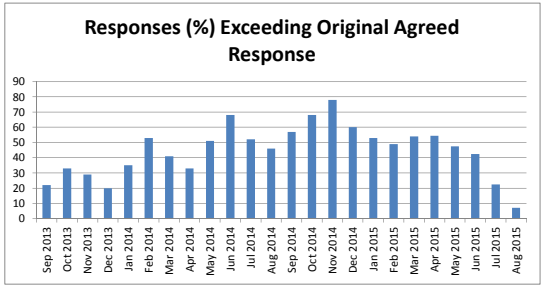


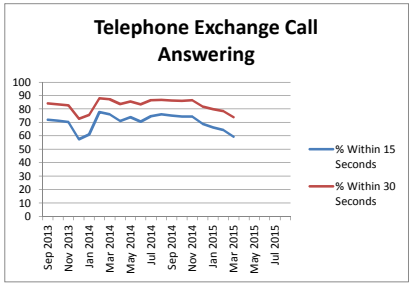
Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Mar 2014) M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		b	FFT Response Rate - Inpatients	=> %	30.0	30.0	36	36	44	45	41	32	31	28	31	28	33	43	43	29	31	31	28	25	Aug 2015									25				
8		a	FFT Score - Inpatients	=> No	60.0	60.0	73	74	74	70	73	76	74	73	73	69	70	68	72	95	95	95	96	95	Aug 2015									95				
8		b	FFT Response Rate Emergency Department (Type 1 Only)	=> %	20.0	20.0	15	15	16	16	16	17	17	17	18	17	18	21	22	9.9	8.4	7.2	9.4	9.6	Aug 2015	9.57								9.6				
8		a	FFT Score - Emergency Department (Type 1 Only)	=> No	46.0	46.0	48	47	49	48	47	49	47	48	49	49	50	44	52	79	79	79	84	88	Aug 2015	88.3								88				
13		a	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	21	36	43	14	3	0	0	7	0	2	0	0	0	0	0	0	0	1	Aug 2015	0	1	0	0		0	0		1	1			
9			No. of Complaints Received (formal and link)	No			95	87	78	55	65	85	75	100	63	70	93	75	94	88	78	93	110	106	Aug 2015	36	15	15	12	2	8	3	15	106	475			
9			No. of Active Complaints in the System (formal and link)	No			210	194	245	270	219	258	282	324	359	219	249	266	265	278	225	186	170	174	Aug 2015	74	26	22	17	3	11	5	16	174				
9		a	No. of First Formal Complaints received / 1000 bed days	Rate1			4.2	3.5	3.1	2.5	2.9	3.9	3.6	4.0	3.0	3.1	4.1	3.6	4.1	3.1	2.5	2.9	4.1	3.2	Aug 2015	2.41	3.05	23.7	2.8					3.19	3.14			
9			No. of First Formal Complaints received / 1000 episodes of care	Rate1			0.7	0.6	0.5	0.4	0.5	0.6	0.6	0.6	0.5	0.6	0.7	0.6	0.7	5.6	4.3	5.1	6.8	6.0	Aug 2015	4.82	6.94	10.7	5.35			0		5.96	5.56			
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	=> %	100	100	99	100	100	100	99	99	100	99	100	100	99	98	100	99	100	100	100	100	Aug 2015	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	41	33	51	68	52	46	57	68	78	60	53	49	54	54	47	42	22	7.1	Aug 2015	8.11	11.5	9.09	0	0	9.09	20	0	7				
9			No. of responses sent out	No			67	117	30	4	138	66	42	35	26	198	59	52	84	56	115	102	129	77	Aug 2015	38	9	6	10	1	4	2	7	77				
9			Oldest' complaint currently in system	No			127	104	124	145	127	133	131	174	161	182	192	213	234	254	188	210	186	208	Aug 2015	208	122	148	57	18	43	140	24	208				
14		e	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes																	-	-	Jun 2015	-	-	-	-	-	-	-	-	Yes				



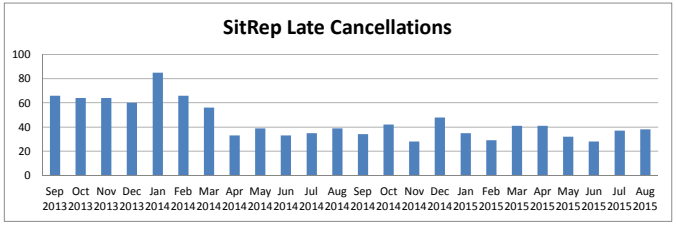


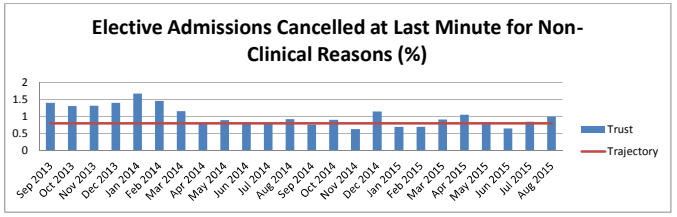


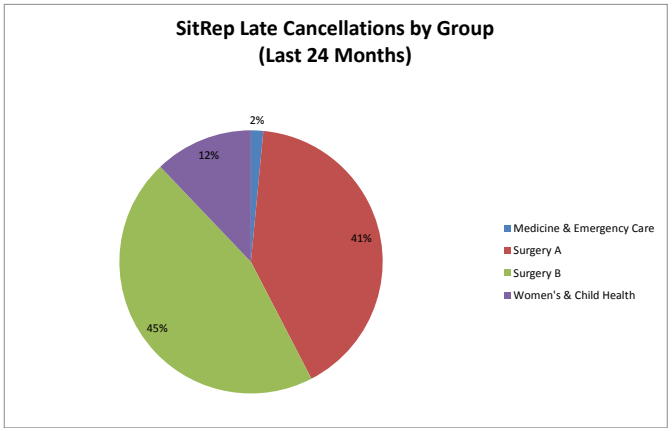


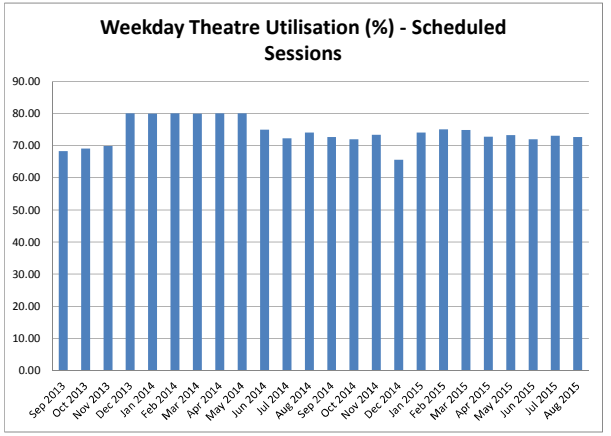
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Mar 2014) M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2			Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Aug 2015	0.45	1.41	1.29	1.59					1.0	0.9			
2			Number of 28 day breaches	<= No	0	0	1	1	1	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	Aug 2015	0	0	0	0					0	0			
2			No. of second or subsequent urgent operations cancelled	<= No	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	1	0	0	0	Aug 2015	0	0	0	0					0	1			
2			No. of Sitrep Declared Late Cancellations	<= No	320	27	56	38	43	33	36	39	34	42	28	48	36	29	41	41	32	28	37	38	Aug 2015	7	13	14	4					38	176			
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	<= No	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	4	1	0	0	Aug 2015	0	0	0	0					0	5			
3			Multiple Cancellations experienced by same patient (all cancellations)	<= %	0.0	0.0	11	12	7	10	12	11	13	11	14	10	11	13	12	11	13	13	13	10	Aug 2015	2.0	15.5	8.1	9.8					10.5				
3			All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	<= %	3.1	3.1	6	5	6	5	5	6	7	6	6	8	6	7	5	5	5	5	5	6	Aug 2015	1.7	8.3	6.6	14.7					5.51				
3			Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0																			Aug 2015	44.5	78.2	70.5	76.2					72.7				
2			Urgent Cancellations	No			-	-	-	-	-	-	-	-	-	-	-	-	-	11	5	6	0	7	Aug 2015	0.0	7.0	0.0	0.0					7.0	29			



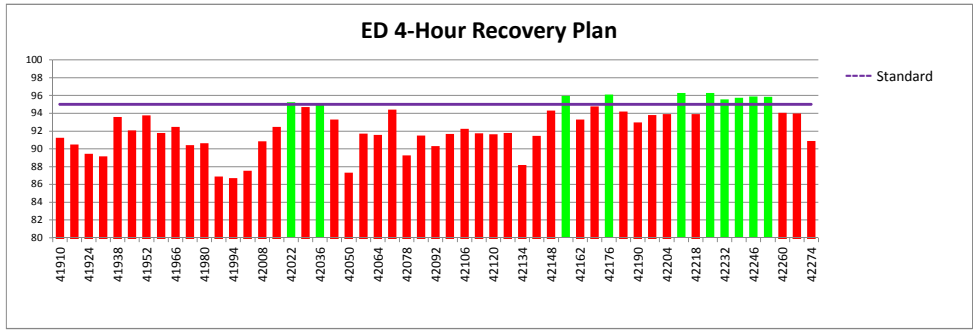


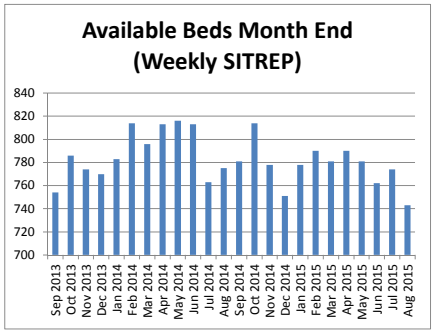


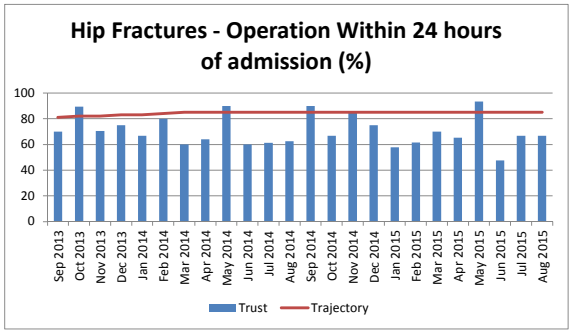


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From) M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend	Next Month	3 Months
2		e	Emergency Care 4-hour waits	=> %	95.00	95.00																			Aug 2015	96.6	94.5	99.0	95.84	93.77			
2			Emergency Care 4-hour breach (numbers)	No			1076	741	1210	1277	1122	876	1460	1636	1440	2234	1054	1481	1695	1527	1406	1037	1086	741	Aug 2015	245	475	21	741	5797			
2		e	Emergency Care Trolley Waits >12 hours	<= No	0.00	0.00																			Aug 2015	0	0		0	0			
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.00	15.00																			Aug 2015	14	18	14	16	17			
3			Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			Aug 2015	42	59	16	43	51			
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			Aug 2015	8.93	8.60	3.56	8.07	7.73			
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Aug 2015	3.63	5.45	1.37	4.18	4.47			
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	171	119	136	125	145	51	136	219	159	282	185	149	164	43	116	90	72	58	Aug 2015	12	46		58	379			
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	9	13	8	8	8	1	13	21	14	31	7	6	8	9	8	3	3	2	Aug 2015	0	2		2	25			
11		•	WMAS - Handover Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Aug 2015	0.00	0.08		0.05	0.15			
11			WMAS - Emergency Conveyances (total)	No			4271	4044	4227	4093	4278	3994	4067	4193	4168	4470	4001	3829	4182	3981	4214	114	4256	4241	Aug 2015	1734	2507		4241	16806			
2			Delayed Transfers of Care (Acute) (%)	<= %	3.5	3.5																			Aug 2015	1.3	4.6		2.7	2			
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	<10 per site	<10 per site	-																		Aug 2015	3.2	9.2		12				
2			Patient Bed Moves (10pm - 8am) (No.) -ALL	No			835	668	751	722	751	694	681	720	646	806	651	683	743	675	737	612	682	646	Aug 2015				646	3352			
2			Patient Bed Moves (10pm - 8am) (No.) - exc. Assessment Units	No			369	312	331	330	329	339	276	353	293	323	250	302	293	267	333	270	284	272	Aug 2015				272	1426			
3			Hip Fractures - Operation < 24 hours of admission (%)	=> %	85.0	85.0																			Aug 2015				67	66.3			

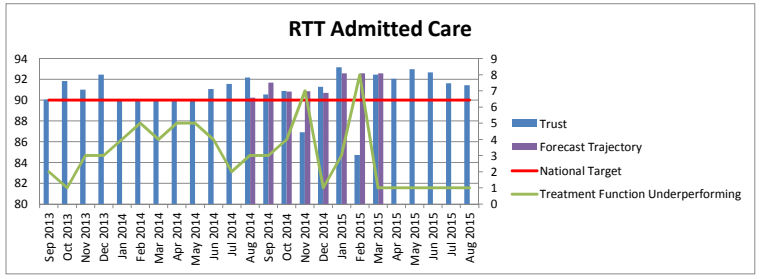


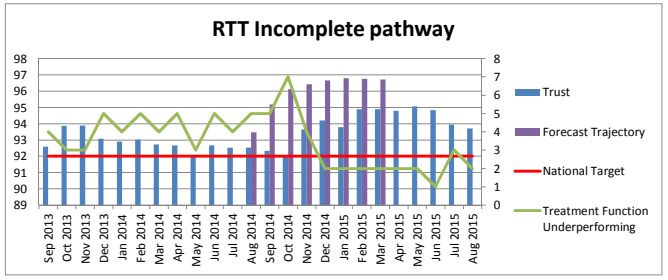


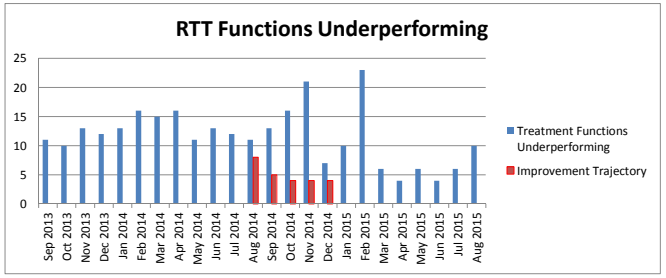


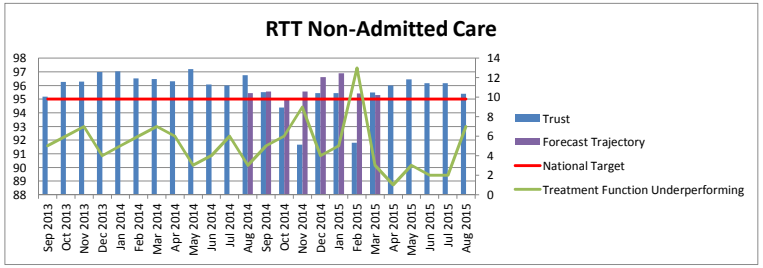
Referral To Treatment

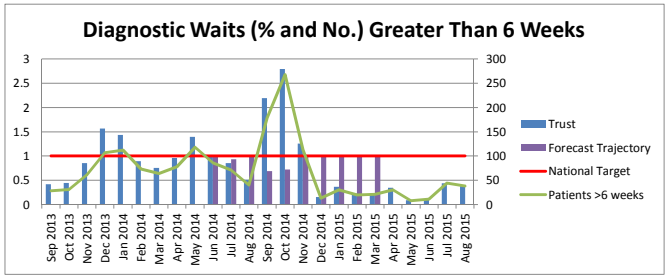
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Mar 2014) M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2			RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Aug 2015	95.1	85.0	91.0	92.5					91.44				
2			RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Aug 2015	93.8	95.4	96.2	98.6					95.39				
2			RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Aug 2015	93.6	92.7	93.6	98.1					93.71				
2			Patients Waiting >52 weeks	<= No	0	0	1	1	2	2	3	4	4	3	3	0	4	3	4	1	2	1	3	5	Aug 2015	1	2	2	0.0					5				
2			Treatment Functions Underperforming	<= No	0	0	15	16	12	13	12	11	13	16	19	8	10	23	6	4	6	4	6	9	Aug 2015	4	4	1	0.0					9				
2			Acute Diagnostic Waits in Excess of 6-weeks	<= %	1.0	1.0	0.76	0.96	1.4	0.98	0.86	0.51	2.19	3.16	1.09	0.16	0.37	0.22	0.23	0.35	0.09	0.11	0.44	0.38	Aug 2015	0.0	0.3	0.0	0.0		0.5			0.38				

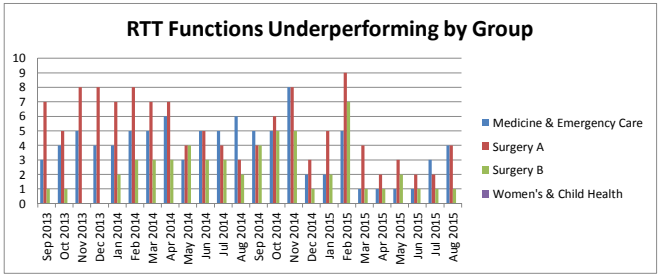










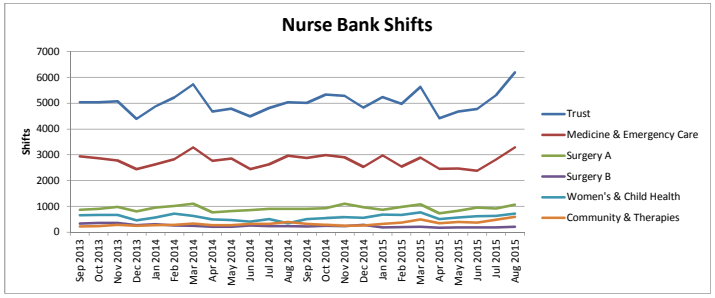


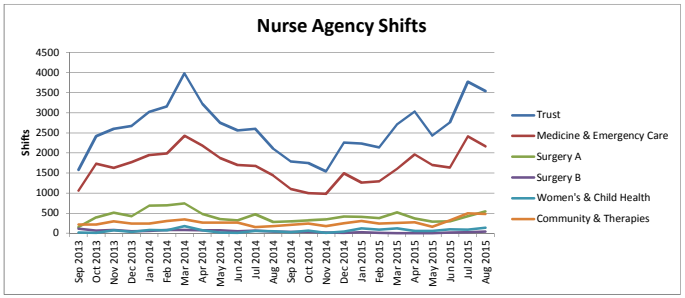
Data Completeness

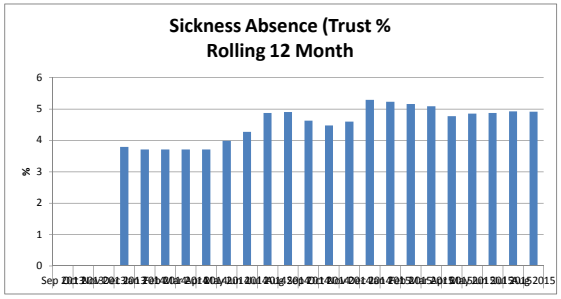
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Mar 2014) M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Data Completeness Community Services	=> %	50.0	50.0																			Aug 2015								61.2	61.19				
2			Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Jul 2015									99.4				
2			Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Jul 2015									98.57				
2			Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Jul 2015									99.17				
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=> %	99.0	99.0	98.7	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	96.6	96.3	96.5	95.8	Aug 2015									95.8	96.4			
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	99.5	99.4	99.4	99.5	99.5	99.5	99.6	99.6	99.6	99.6	99.6	99.6	99.5	99.4	Aug 2015									99.4	99.6			
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=> %	95.0	95.0	95.9	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	96.9	96.9	96.3	96.0	Aug 2015									96.0	96.6			
2			Ethnicity Coding - percentage of inpatients with recorded response	=> %	90.0	90.0																			Aug 2015									90.59	91.44			
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	95.0	95.5	98.7	Indicator discontinued for 2015/16										Dec 2014									98.7				
2			Maternity - Percentage of invalid fields completed in SUS submission	<= %	15.0	15.0																			Aug 2015									39.06	38.9			
2			Open Referrals	No			-	-	-	-	-	-	-	-	-	-	-	-	-	173,131	180,758	183,245	191,411	203,025	Aug 2015	70,965	39,612	65,129	25,152	1,957	178	42		203,025				

Staff

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Mar 2014) M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
7		b	WTE - Actual versus Plan (FTE)	No			567	531	558	580	584	626	608	628	674	685	701	732	689	888	831	733	763	823	Aug 2015	261.5	120	49.7	111	33.7	55.9	87.7	103	823				
3		b	PDRs - 12 month rolling	=> %	95.0	95.0																			Aug 2015	85.88	85.3	83.6	87.8	92.3	77.9	86.8	85.3		88.63			
7		b	Medical Appraisal and Revalidation	=> %	95.0	95.0														-					Aug 2015	80.23	81.7	90.3	82.6	83.3	112	0	100		89.73			
3		b	Sickness Absence (Rolling 12 Months)	<= %	3.15	3.15																			Aug 2015	4.91	5.18	3.25	5.6	4.36	4.61	5.36	4.73	4.91	4.86			
3			Return to Work Interviews following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-	-		-	-				Aug 2015	57.7	61.7	51.9	55.7	79.0	42.6	78.7	70.8	63.16	63.57			
3			Mandatory Training	=> %	95.0	95.0																			Aug 2015	82.2	88.3	85.8	82.7	95.5	86.3	89.0	89.7		87.73			
3			Mandatory Training - Health & Safety (% staff)	=> %	95.0	95.0																			Aug 2015	97.26	98.4	95.4	96.5	99.7	98.5	99	98.9		97.87			
7		b	Staff Turnover (rolling 12 months)	<= %	10.0	10.0																			Aug 2015									13.56	13.3			
7			New Investigations in Month	No			5	1	4	6	5	2	15	3	1	0	3	4	5	8	11	5	8	4	Aug 2015	1	1	0	1	0	0	0	1	4				
7			Vacancy Time to Fill	Weeks			19	19	20	19	18	19	19	20	21	20	20	23	22	23	24	26	25	27	Aug 2015									27				
7			Professional Registration Lapses	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Aug 2015	0	0	0	0	0	0	0	0	0	0			
7			Qualified Nursing Variance (FIMS) (FTE)	No			162	161	169	173	177	201	200	188	200	228	238	247	263	221	247	288	303	321	Aug 2015									320.9				
10			Nurse Bank Fill Rate	=> %	100.0	100.0	76	76	82	82	80	77	78	78	82	73	78	78	78	75	81	81	79	80	Aug 2015	75.48	76.4	96.9	91	0	94.9	89.7	100	80.12	79.3			
10			Nurse Bank Shifts Not Filled	<= No	0	0	1627	1723	969	919	1087	1802	1370	1036	1440	1727	1716	1432	1487	1532	1378	1073	1622	1423	Aug 2015	977	303	7	68	0	6	62	0	1423	7028			
10			Nurse Bank Use (shifts)	<= No	46980	3915																			Aug 2015	3284	1065	217	718	0	109	597	193	6183	25350			
10			Nurse Agency Use (shifts)	<= No	0	0																			Aug 2015	2160	548	46	135	0	159	482	14	3544	15541			
10			Admin & Clerical Bank Use (shifts)	<= No	0	0	-	-																	Aug 2015	1118	172	176	65	540	192	302	2999	5564	27060			
10			Admin & Clerical Agency Use (shifts)	<= No	0	0	-	-																	Aug 2015	41	45	21	20	0	0	0	99	226	932			
			Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-	-	-			
15			Your Voice - Response Rate	No			-->	-->	19.8	-->	-->	18.2	-->	-->	17.4	-->	12.6	12.7	-->	-->	-->	13.9	-->	-->	Jun 2015	6	10	12	13	21	19	26	16	13.9				
15			Your Voice - Overall Score	No			-->	-->	3.63	-->	-->	3.68	-->	-->	3.65	-->	3.57	3.55	-->	-->	-->	3.59	-->	-->	Jun 2015	3.49	3.56	3.59	3.66	3.69	3.41	3.77	3.5	3.59				







CQUIN (I)

	Data Quality	CQUIN	Values (£000)	Indicator	Trajectory / Notes	Q1	Q2	Q3	Q4	Monthly Trend A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Year To Date	Trend	Next Month	3 Months
1		National	£795	Acute Kidney Injury	Improvement from previous Quarter	Derive Base Data	Improvement to last Qtr - GP Letter Pilot Oct	Improvement to last Qtr	Improvement to last Qtr	Q1 Met	●	-	-	-	-	-	-	-	Jul-15	●	●	●	●
2		National	£396	Sepsis Screening	Improvement from base to agreed target	Derive Base Data	Target set at 32.5%	Improvement to Target	Improvement to Target	Q1 Met	●	●	-	-	-	-	-	-	Aug-15	●	●	●	●
3		National	£400	Sepsis Antibiotic Administration	90% by Q4	Establish Audit Mech.	CCG aware - small samples	Work towards 90%	90% Achieved	Q1 Met	●	●	-	-	-	-	-	-	Aug-15	●	●		
4		National	£455	Dementia - Find, Assess, Investigate, Refer & Inform	90% (each of 3 elements) in Q4	Carry fwd from last year	Query with CCG - inform?	Work towards 90%	90% Achieved	Q1 Met	Qtrly measure - on target	-	-	-	-	-	-	Aug-15	●	●	●	●
5		National	£170	Dementia - Staff Training	Target tba - Qly reports to Board	Carry fwd from last year	Work towards 90%	Work towards 90%	90% Achieved	Q1 Met	Qtrly measure - on target	-	-	-	-	-	-	Aug-15	●	●	●	●
6		National	£170	Dementia - Supporting Carers	Bi-annual reports to Board	Carry fwd from last year	Work towards 90%	Work towards 90%	90% Achieved	Q1 Met	Qtrly measure - on target	-	-	-	-	-	-	Aug-15	●	●	●	●
7		National	£1,591	Improvement in diagnosis recording in HES Data Set of Mental Health presentations	85% in one month	Qly Data Collection	Achieve 85% in one month to complete CQUIN - already achieved in July & August at 99%			Q1 Met	●	●	●	●	●	●	●	●	Aug-15	●	●	●	●
8		Local	£406	Community Therapies - Dietetics Community Communication with GPs	Deliver outstanding actions from 14 / 15	One data submission at end of Q2				Met									Aug-15	●	●	●	●
9		Local	£989	Reduce Number of Ward Transfers experienced by patients with Dementia	Agree improvement trajectory from base	Derive Base Data	Improvement Required	Improvement Required	Improvement Required	Q1 Met	●	●	-	-	-	-	-	-	Aug-15	●	●	●	●
10		Local	£989	Reduce Number of Out Of Hours Patient Transfers	Agree improvement trajectory from base	Derive Base Data	Improvement Required	Improvement Required	Improvement Required	Q1 Met	●	●	-	-	-	-	-	-	Aug-15	●	●	●	●
11		Local	£1,591	Safeguarding	Carry Forward from last year	Report to Board (Pat Story)	Report to Board (Pat Story)			Q1 Met	●	●							Aug-15	●	●	●	●
12		Spec.	£118	Reduce Number of Consultant-Led Follow Up OP Attendances	Implement plans to & monitor FUN ratio	Formulate Plans	Sign Off of Plans	Monitor & Improve	Monitor & Improve	Q1 Met	●	●	-	-	-	-	-	-	Aug-15	●	●	●	●
13		Spec.	£118	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	Qly Data Collection	Q1 Met	●	●	-	-	-	-	-	-	Aug-15	●	●	●	●
14		Spec.	£118	Haemoglobinopathy Networks - develop partnership working, define pathways and protocol	Publish agreed care p'ways and protocols	Set Up initial network meet				Q1 Met	●	●	-	-	-	-	-	-	Aug-15	●	●	●	●
15		Spec.	£118	Breast Cancer - help patients make more informed choices regarding treatment	Provion of anon. pt. Datasets	Derive Base Data	Qly Data Collection	Qly Data Collection	Qly Data Collection	Q1 Met	●	●	-	-	-	-	-	-	Aug-15	●	●	●	●
16		Spec.	£118	Bechet's Disease (Highly Specialised Service) - set up clinical outcome collaborative workshop	Submit Quarterly return	Qly Data Collection	Qly Data Collection	Qly Data Collection	Qly Data Collection	Q1 Met	●	●	-	-	-	-	-	-	Aug-15	●	●	●	●

CQUIN (II) and summary

	Data Quality	CQUIN	£ Values	Indicator	Note	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					
17		Public Health	£94	Breast Screening - improvement in uptake	Annual Report			Q1 Met			●	●	-	-	-	-	-	-	-	Aug-15										●	●	●	●
18		Public Health	£42	Bowel Screening - improvement in uptake	Annual Report			Q1 Met			●	●	-	-	-	-	-	-	-	Aug-15										●	●	●	●
19		Public Health	£154	Maternity and Health Visiting Services - Integrated working	Implement Shared Assessment Framework			Q1 Met			●	●	-	-	-	-	-	-	-	Aug-15										●	●	●	●
20		Local	£0	Falls Medication	Still pending base-lining			Not active Q1			-	-	-	-	-	-	-	-	-	Aug-15									-	-	-			

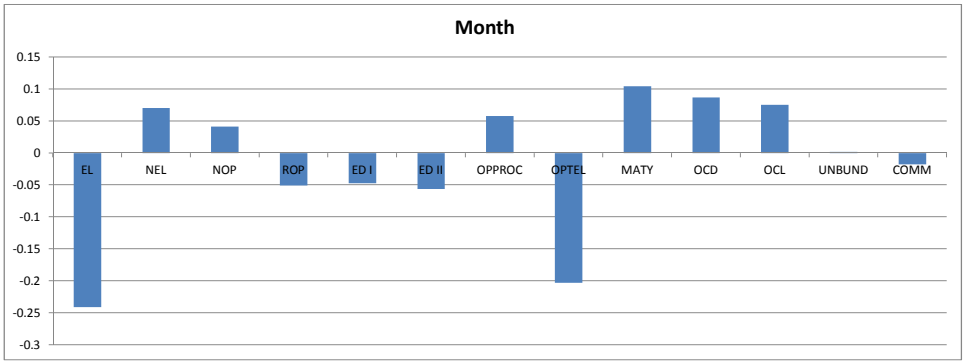
The Trust is contracted to deliver a total of **20 CQUIN** schemes during 2015 / 2016. 7 schemes are nationally mandated, a further 4 have been agreed locally, 5 identified by the West Midlands Specialised Commissioners and 3 by Public Health. The collective financial value of the schemes is **c.£8.8m.**

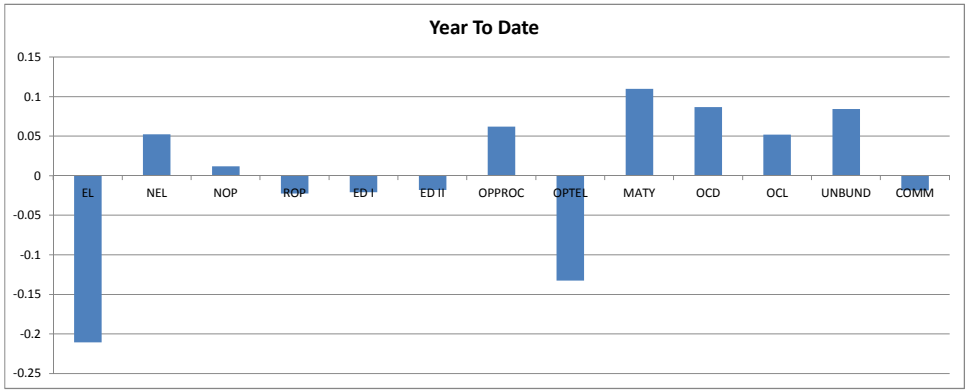
As at **August month** reporting, it appears that some schemes are off target without appropriate, previous exception reporting or notification taken place. This has surfaced in the last week and senior involvement is in place to recover the position (Sepsis A) . It has been escalated to the Executive. Monthly meetings have now been put in place to monitor CQUIN performance with relevant group leads and senior group leadership. This takes place from October onwards. The CQUIN summaries here present a reasonable assessment on current status based on information received from the leads or lack of receipt of appropriate information where re-assurance was not given at this stage. The rating in amber and red represent risk to financial income as well as patient outcomes at this stage.

It has been recognised that monthly performance meetings are necessary to monitor regular performance. Quarterly confirm and challenge meetings with lead executive will also take place before submission to commissioners. Formal submission of CQUIN performance to commissioners will be required each quarter. The next submission is at the end of September/early October.

Activity Summary

View shown as per August reporting





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.

Adverse variances to plan in elective and outpatient care are being addressed through the demand and capacity work being led by the Chief Operating Officer. The plan formulated proposes to recover Q1 underperformance across most specialties whilst maintaining underlying plan performance during Q2, Q3 and Q4. It also builds into plan the effect of delivering 6 week waits for first outpatient attendance in most specialties by the end of October and in all specialties by the end of the year. Repatriation opportunities are also being explored to deliver that planned activity during Q3 and Q4.

There has been some movement in point of activity delivery since plans were set with activity in plans as daycase procedures now recorded in the outpatient setting.

Adverse variances in A&E are across all departments with the exception of GP activity which is performing to plan in August.

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 O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	RAG	Data Period	Group M	A	W	B	C	P	I	CO	Month	Year To Date	Trend	Next Month	3 Months
																										100	200	300	400	500	600	700	800					
18		f	Bottom Line Income & Expenditure position - Forecast compared to plan £m	£0.0		●	●	●	●	●	●	●	●	●	●	●								GREEN	Aug-15									£1.200				
18		f	Bottom Line Income & Expenditure position - Year to Date Actual compared to plan £m	£0.0	£0.0	●	●	●	●	●	●	●	●	●	●	●								RED	Aug-15	-2.2	-1.7	-1.3	-1.2	-0.1	-0.1	-0.9	-0.6		-£1.448			
18		f	Actual efficiency recurring / non-recurring compared to plan - Year to Date actual compared to plan	£0.0	£0.0	●	●	●	●	●	●		●	●	●	●								GREEN	Aug-15	0.0	-0.8	0.3	-0.2	0.1	0.2	0.3	-0.2		£0.453			
18		f	Actual efficiency recurring / non-recurring compared to plan - Forecast compared to plan	£0.0		●	●	●	●	●	●		●	●	●	●								GREEN	Aug-15	-1.2	-3.0	0.1	-0.2	-0.8	0.0	-0.1	-2.6		£0.000			
18		f	Forecast underlying surplus / deficit compared to plan	£0.0		●	●	●	●	●	●	●	●	●	●	●								GREEN	Aug-15										£0.000			
18		f	Forecast year end charge to capital resource limit	£22.8		●	●	●	●	●	●	●	●	●	●	●								GREEN	Aug-15									£20.153				
18		f	Is the Trust forecasting permanent PDC for liquidity purposes?	No		●	●	●	●	●	●	●	●	●	●	●								GREEN	Aug-15									£0.000				
18		b	Temporary costs and overtime as % total paybill	2.6%	2.6%	●	●	●	●	●	●	●		●	●	●								RED	Aug-15	12.0%	4.8%	1.5%	1.3%	10.9%	0.0%	7.0%	2.6%	6.2%	6.1%			
18			Continuity of Service Risk Rating - Year to Date	2.5		●	●	●	●	●	●	●		●	●	●	●							GREEN	Aug-15										3.0			

MONTHLY: PASTE IN TDA KEY METRICS PAGE TO THIS FILE

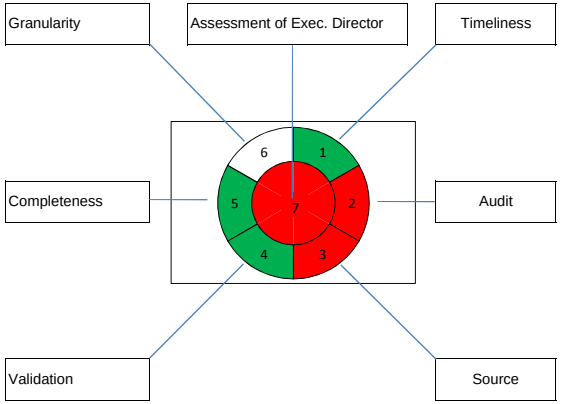
Legend

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	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		EC	AC	SC					
C. Difficile	<= No	30	3																			Aug 2015	0	3	0	3	12			
MRSA Bacteraemia	<= No	0	0																			Aug 2015	0	0	0	0	1			
MRSA Screening - Elective (%)	=> %	80	80																			Aug 2015	71	63	55	63.4				
MRSA Screening - Non Elective (%)	=> %	80	80																			Aug 2015	92	94	76	91.8				
Falls	<= No	0	0	29	33	40	61	42	44	41	67	50	66	63	42	52	43	47	42	39	41	Aug 2015	13	22	6	41	212			
Falls with a serious injury	<= No	0	0	1	1	3	3	1	4	1	1	2	0	1	0	1	1	0	1	5	0	Aug 2015	0	0	0	0	7			
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	3	2	3	3	3	0	5	3	6	7	10	1	1	8	3	6	2	-	Jul 2015	0	2	0	2	19			
Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Aug 2015	94.3	79.9	98.5	94.9				
WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0	98.0																			Aug 2015	100.0	100.0	100.0	100.0				
WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0	95.0																			Aug 2015	100	0	0	99.6				
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0	85.0																			Aug 2015	100	0	0	99.6				
Never Events	<= No	0	0																			Aug 2015	0	0	0	0	0			
Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	Aug 2015	0	0	0	0	1			
Serious Incidents	<= No	0	0																			Aug 2015	0	0	0	0	7			
Mortality Reviews within 42 working days	=> %	100	98																	-	-	Jun 2015	95	95	97	96				

Indicator		Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		EC	AC	SC					
Pts spending >90% stay on Acute Stroke Unit (%)	=> %	90.0	90.0																			Aug 2015		93.2		93.2	90.9			
Pts admitted to Acute Stroke Unit within 4 hrs (%)	=> %	90.0	90.0																			Aug 2015		80.4		80.4	81.3			
Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			Aug 2015		82.1		82.1	75.3			
Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.0																			Aug 2015		100.0		100.0	99.3			
Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																			Aug 2015		100.0		100.0	80.0			
Stroke Admissions - Swallowing assessments (<24h) (%)	=> %	98.0	98.0																			Aug 2015		100.0		100.0	100.0			
TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=> %	70.0	70.0																		-	Jul 2015		100.0		100.0	97.3			
TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=> %	75.0	75.0																		-	Jul 2015		100.0		100.0	98.2			
Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=> %	80.0	80.0																			Aug 2015		95.2		95.2	93.8			
Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=> %	80.0	80.0																			Aug 2015		95.5		95.5	94.3			
Rapid Access Chest Pain - seen within 14 days (%)	=> %	98.0	98.0																			Aug 2015		100.0		100.0	98.8			
2 weeks	=> %	93.0	93.0																		-	Jul 2015			94.9	94.9				
31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Jul 2015			100.0	100.0				
62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Jul 2015			95.0	95.0				
Mixed Sex Accommodation Breaches	<= No	0.0	0.0	21	36	43	14	0	0	0	7	0	0	0	0	0	0	0	0	0	0	Aug 2015	0	0	0	0	0			
No. of Complaints Received (formal and link)	No			-	-	38	28	28	32	36	48	18	31	30	36	38	41	35	41	53	36	Aug 2015	14	9	13	36	206			
No. of Active Complaints in the System (formal and link)	No			-	-	117	129	106	130	131	156	149	93	106	126	117	112	104	87	90	74	Aug 2015	28	25	21	74				
Oldest' complaint currently in system (days)	No			-	-	124	145	127	133	131	174	161	182	188	209	230	250	188	210	186	208	Aug 2015	137	208	51	208				

Indicator	Measure	Trajectory		Previous Months Trend																			Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		EC	AC	SC					
Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Aug 2015	-	5.68	0.14	0.45				
28 day breaches	<= No	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Aug 2015	0.0	0.0	0.0	0	0			
Sitrep Declared Late Cancellations	<= No	0	0	4	10	2	7	7	3	2	5	4	1	0	0	9	8	1	2	4	7		Aug 2015	0.0	5.0	2.0	7	22			
Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	45	43	43	60	50	61	54	57	60	62	61	49	48	54	60	46	47	45		Aug 2015	68.1	21.6	60.7	44.5				
Emergency Care 4-hour waits (%)	=> %	95.0	95.0																				Aug 2015	96.6	94.5	Site S/C	95.4	93.0			
Emergency Care 4-hour breach (numbers)	No			871	570	1003	1016	907	736	1201	1390	1181	1913	940	1242	1412	'	'	'	'	'		Mar 2015	1361	4	47	1412	13511			
Emergency Care Trolley Waits >12 hours	<= No	0	0																				Aug 2015	0.0	0.0	Site S/C	0	0			
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.0	15.0																				Aug 2015	14.0	18.0	Site S/C	16	17			
Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60.0	60.0																				Aug 2015	42.0	59.0	Site S/C	51	58			
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																				Aug 2015	8.9	8.6	Site S/C	8.8	8.4			
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																				Aug 2015	3.6	5.5	Site S/C	4.6	4.9			
WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	171	119	136	125	145	51	136	219	159	282	185	149	164	43	116	90	72	58		Aug 2015	12	46		58	379			
WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	9	13	8	8	8	1	13	21	14	31	7	6	8	9	8	3	3	2		Aug 2015	0	2		2	25			
WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																				Aug 2015	0.00	0.08		0.05	0.15			
WMAS - Emergency Conveyances (total)	No			4271	4044	4227	4093	4278	3994	4067	4193	4168	4470	4001	3829	4182	3981	4214	114	4256	4241		Aug 2015	1734	2507		4241	16806			

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		EC	AC	SC					
RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																			Aug 2015	0.0	91.2	96.3	95.1				
RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																			Aug 2015	0.0	95.2	93.1	93.8				
RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																			Aug 2015	0.0	94.4	93.1	93.6				
Patients Waiting >52 weeks	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	Aug 2015	0	0	1	1				
Treatment Functions Underperforming	<= No	0	0	5	6	3	5	5	6	5	5	7	2	2	6	1	1	1	1	3	4	Aug 2015	0	1	3	4				
Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Aug 2015	0	0	0	0.00				
WTE - Actual versus Plan	No			163	171	161	157	151	166	160	166	197	232	242	244	176	200	200	219	236	262	Aug 2015	117.6	80.76	59.2	262				
PDRs - 12 month rolling (%)	=> %	95.0	95.0																			Aug 2015	90.3	83.67	83.66		87.1			
Medical Appraisal and Revalidation	=> %	95.0	95.0														-					Aug 2015	76.19	86.67	77.14		84.7			
Sickness Absence (%)	<= %	3.15	3.15																			Aug 2015	4.79	5.32	4.33	4.91	4.81			
Return to Work Interviews (%) following Sickness Absence	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	-		-	-				Aug 2015	54.1	67.8	35.7		59.38			
Mandatory Training (%)	=> %	95.0	95.0																			Aug 2015	82.98	81.38	82.53		83.4			
New Investigations in Month	No			1	1	1	1	2	1	2	1	0	0	1	2	2	2	1	1	2	1	Aug 2015	1	0	0	1				
Nurse Bank Fill Rate %	=> %	100	100	'	'	'	'	'	'	'	'	'	'	'	'	72	2528	3008	2311	3287	3019	Aug 2015				75				
Nurse Bank Shifts Not Filled (number)	<= No	0	0	'	'	'	'	'	'	'	'	'	'	'	'	1031	1136	1055	771	1146	977	Aug 2015				977				
Nurse Bank Use	<= No	34560	2880																			Aug 2015				3284	13403			
Nurse Agency Use	<= No	0.00	0.00																			Aug 2015				2160	9865			
Admin & Clerical Bank Use (shifts)	<= No	0.00	0.00	-	-																	Aug 2015				1118	4848			
Admin & Clerical Agency Use (shifts)	<= No	0.00	0.00	-	-																	Aug 2015				41	249			
Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-			
Your Voice - Response Rate (%)	No			-->	-->	8	-->	-->	9	-->	-->	9	-->	-->	6	-->	-->	-->	6	-->	-->	Jun 2015	5.0	5.0	11.0	6.0				
Your Voice - Overall Score	No			-->	-->	3.68	-->	-->	3.76	-->	-->	3.76	-->	-->	3.57	-->	-->	-->	3.49	-->	-->	Jun 2015	3.54	3.49	3.44	3.49				

Surgery A Group

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		A	B	C	D					
C. Difficile	<= No	7	1																			Aug 2015	0	0	0	0	0	1			
MRSA Bacteraemia	<= No	0	0																			Aug 2015	0	0	0	0	0	0			
MRSA Screening - Elective	=> %	80	80																			Aug 2015	93.85	100	95.9	0	95.7				
MRSA Screening - Non Elective	=> %	80	80																			Aug 2015	94.75	91.18	94.03	100	93.5				
Falls	<= No	0	0	7	9	7	4	8	3	9	9	6	6	0	4	4	5	9	5	4	2	Aug 2015	0	2	0	0	2	25			
Falls with a serious injury	<= No	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	Aug 2015	0	0	0	0	0	0			
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	1	0	0	0	1	1	0	0	4	0	0	2	0	0	1	1	-	Jul 2015	0	0	0	1	1	2			
Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Aug 2015	97.88	95.31	97.27	99.45	97.3				
WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0	98.0																			Aug 2015	100	100	100	100	100.0				
WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0	95.0																			Aug 2015	100	100	100	0	100.0				
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0	85.0																			Aug 2015	100	100	100	0	100.0				
Never Events	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	Aug 2015	0	0	0	0	0	2			
Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Aug 2015	0	0	0	0	0	0			
Serious Incidents	<= No	0	0																			Aug 2015	0	0	0	0	0	2			
Mortality Reviews within 42 working days	=> %	100	98.0																	-	-	Jun 2015	40	100	0	100	62.5				

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		A	B	C	D					
2 weeks	=> %	93.0	93.0																		-	Jul 2015	96.2		86.8		93.74				
2 weeks (Breast Symptomatic)	=> %	93.0	93.0																		-	Jul 2015	98.3				98.31				
31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Jul 2015	98.3		100.0		98.75				
62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Jul 2015	92.1		64.7		82.47				
Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	3	0	0	0	0	2	0	0	0	0	0	0	0	1	Aug 2015	1	0	0	0	1	1			
No. of Complaints Received (formal and link)	No			-	-	12	11	8	19	15	13	13	7	15	9	16	16	8	16	16	15	Aug 2015	3	5	5	2	15	71			
No. of Active Complaints in the System (formal and link)	No			-	-	50	50	34	39	49	57	78	53	45	40	45	46	27	32	23	26	Aug 2015	8	8	6	4	26				
Oldest' complaint currently in system (days)	No			-	-	124	131	118	99	109	133	143	171	192	213	234	254	97	157	108	122	Aug 2015	90	106	122	26	122				
Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Aug 2015	0.91	2.42	2.36	-	1.41				
28 day breaches	<= No	0	0	1	1	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	Aug 2015	0	0	0	0	0	0			
Sitrep Declared Late Cancellations	<= No	0	0	18	13	16	5	6	16	10	18	6	33	11	13	17	12	10	8	21	13	Aug 2015	3	5	5	0	13	64			
Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	74.1	78	75.3	80.2	76.8	76.1	78	75	76.8	70.8	77.6	78.7	75.1	78.5	77.78	78.7	80.2	78.2	Aug 2015	79.8	75.7	75.8	85.4	78.18				
Emergency Care 4-hour breach (numbers)	No			99	81	100	100	119	52	103	118	94	121	43	108	127	-	-	-	-	-	Mar 2015	66	53	8	0	127	1166			
Hip Fractures - Operation < 24 hours of admission (%)	=> %	85	85																			Aug 2015		66.7			66.7	66.3			

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		A	B	C	D					
RTT - Admittted Care (18-weeks) (%)	=> %	90.0	90.0																			Aug 2015	90.1	68.5	94.9	0.0	85.0				
RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																			Aug 2015	97.9	95.0	88.9	0.0	95.4				
RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																			Aug 2015	94.7	91.0	92.2	0.0	92.7				
Patients Waiting >52 weeks	<= No	0	0	0	1	1	0	2	4	2	1	2	0	3	1	2	1	0	0	0	2	Aug 2015	0	0	2	0	2				
Treatment Functions Underperforming	<= No	0	0	7	7	5	5	4	3	4	6	7	4	5	8	4	2	3	2	2	4	Aug 2015	1	2	1	0	4				
Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Aug 2015	0.3	0.0	0.4	0.0	0.32				
WTE - Actual versus Plan	No			76	64	71	77	78	71	71	71	76	66	62	70	70.1	88.3	97.11	103	110	120	Aug 2015	32.6	13.44	37.36	35.02	120.41				
PDRs - 12 month rolling	=> %	95.0	95.0																			Aug 2015	83.7	72.7	90.1	88.1		88.8			
Medical Appraisal and Revalidation	=> %	95.0	95.0														-					Aug 2015	63.16	84.62	100	85.71		87.7			
Sickness Absence	<= %	3.15	3.15																			Aug 2015	5.5	4.1	6.0	4.4	5.2	5.2			
Return to Work Interviews (%) following Sickness Absence	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	-		-	-				Aug 2015	50.0	34.6	73.0	72.1	61.7	61.5			
Mandatory Training	=> %	95.0	95.0																			Aug 2015	85.1	82.9	92.8	87.7		89.6			
New Investigations in Month	No			1	0	0	0	0	0	2	0	1	0	1	1	2	3	3	1	2	1	Aug 2015	0	1	0	0	1				
Nurse Bank Fill Rate	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-	-	76	71	79.97	82.2	75.6	76.4	Aug 2015					76.44	77			
Nurse Bank Shifts Not Filled	<= No	0	0	'	'	'	'	'	'	'	'	'	'	'	'	335	313	247	197	347	303	Aug 2015					303	1407			
Nurse Bank Use	<= No	9908	826																			Aug 2015					1065	4504			
Nurse Agency Use	<= No	0	0																			Aug 2015					548	1933			
Admin & Clerical Bank Use (shifts)	<= No	0	0	-	-																	Aug 2015					172	883			
Admin & Clerical Agency Use (shifts)	<= No	0	0	-	-																	Aug 2015					45	103			
Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00					-	-			
Your Voice - Response Rate	No			-->	-->	13	-->	-->	11	-->	-->	11	-->	-->	9	-->	-->	-->	10	-->	-->	Jun 2015	11	5	9	10	10				
Cancer = Patients Waiting Over 62 days for treatment	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	-	Jul 2015	-	-	-	-	0	0			

Surgery B Group

Indicator	Measure	Trajectory		Previous Months Trend																			Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		O	E					
C. Difficile	<= No	0	0																				Aug 2015	0	0	0	0			
MRSA Bacteraemia	<= No	0	0																				Aug 2015	0	0	0	0			
MRSA Screening - Elective	=> %	80	80																				Aug 2015	90	93.3	92.7				
MRSA Screening - Non Elective	=> %	80	80																				Aug 2015	97	90.2	92.6				
Falls	<= No	0	0	0	1	0	0	2	0	0	0	0	1	1	0	0	0	0	2	1	0		Aug 2015	0	0	0	3			
Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Aug 2015	0	0	0	0			
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-		Jul 2015	0	0	0	0			
Venous Thromboembolism (VTE) Assessments	=> %	95	95																				Aug 2015	98.1	99.8	98.7				
WHO Safer Surgery Checklist - Audit 3 sections	=> %	98	98																				Aug 2015	100	100	100				
WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95	95																				Aug 2015	100	100	100				
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85	85																				Aug 2015	99.4	100	99.59				
Never Events	<= No	0	0																				Aug 2015	0	0	0	0			
Medication Errors	<= No	0	0																				Aug 2015	0	0	0	0			
Serious Incidents	<= No	0	0																				Aug 2015	0	0	0	0			
Mortality Reviews within 42 working days	=> %	100	97				-	-	-		-	-	-	-	-	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	-	-		Jun 2015	0	0	0				

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		O	E					
2 weeks	=> %	93	93																		-	Jul 2015		90.1	90.1				
31 Day (diagnosis to treatment)	=> %	96	96										-								-	Jul 2015		100	100				
62 Day (urgent GP referral to treatment)	=> %	85	85		-					-											-	Jul 2015		100	100.0				
Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Aug 2015	0	0	0	0			
No. of Complaints Received (formal and link)	No			-	-	9	3	10	11	8	12	11	14	14	12	16	14	9	6	15	15	Aug 2015	13	2	15	59			
No. of Active Complaints in the System (formal and link)	No			-	-	31	40	34	37	36	37	47	33	35	35	36	39	35	17	17	22	Aug 2015	20	2	22				
Oldest' complaint currently in system (days)	No			-	-	117	100	103	129	98	63	138	109	102	123	144	164	135	102	126	148	Aug 2015	148	18	148				
Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Aug 2015	0.72	2.28	1.29				
28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Aug 2015	0	0	0	0			
Sitrep Declared Late Cancellations	<= No	0	0	22	3	22	17	16	14	16	12	11	7	24	11	8	15	17	16	10	14	Aug 2015	5	9	14	72			
Weekday Theatre Utilisation (as % of scheduled)	=> %	85	85	74.2	74	74.4	72.5	74.5	72	73.6	72	73	68	74.1	72	75.2	73.3	71.4	73.1	73.9	70.5	Aug 2015	73.2	65.1	70.51				
Emergency Care 4-hour waits (%)	=> %	95	95																			Aug 2015	99		99.0	99.4			
Emergency Care 4-hour breach (numbers)	No			9	10	15	80	13	26	29	10	27	25	8	8	39	-	-	-	-	-	Mar 2015	29	10	39	290			
Emergency Care Trolley Waits >12 hours	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-							Aug 2015	0		0	0			
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15	15																			Aug 2015	14		14	14			
Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			Aug 2015	16		22	21			
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5	5																			Aug 2015	3.56		3.56	3.51			
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5	5																			Aug 2015	1.37		1.37	1.89			

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		O	E					
RTT - Admittted Care (18-weeks) (%)	=> %	90	90																			Aug 2015	91.0	90.9	91.0				
RTT - Non Admittted Care (18-weeks) (%)	=> %	95	95																			Aug 2015	96.9	94.5	96.2				
RTT - Incomplete Pathway (18-weeks) (%)	=> %	92	92																			Aug 2015	93.2	94.3	93.6				
Patients Waiting >52 weeks	<= No	0	0	1	0	1	1	0	0	2	2	1	0	0	1	1	0	1	0	3	2	Aug 2015	2	0	2				
Treatment Functions Underperforming	<= No	0	0	3	3	4	3	3	2	4	5	5	1	2	7	1	1	2	1	1	1	Aug 2015	0	1	1				
Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1	1																			Aug 2015	0	0	0.00				
WTE - Actual versus Plan	No			37	28	34	38	33	32	28	30	27	30	32	29	28.5	35.3	35.1	47	43.1	49.7	Aug 2015			49.7				
PDRs - 12 month rolling	=> %	95	95																			Aug 2015	80.9	90		91.7			
Medical Appraisal and Revalidation	=> %	95	95														-					Aug 2015	88.5	100	83.6	96.06			
Sickness Absence	<= %	3.15	3.15																			Aug 2015	3.7	2.08	3.25	3.23			
Return to Work Interviews (%) following Sickness Absence	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	-		-	-				Aug 2015	42.3	79.7	51.93	51.11			
Mandatory Training	=> %	95	95																			Aug 2015	83.9	91.4		87.2			
New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	Aug 2015			0				
Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	-	100	99	99.6	98.4	98.2	96.9	Aug 2015			96.94	98.45			
Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	1	2	1	3	4	7	Aug 2015			7	17			
Nurse Bank Use	<= No	2796	233																			Aug 2015			217	964			
Nurse Agency Use	<= No	0	0																			Aug 2015			46	94			
Admin & Clerical Bank Use (shifts)	<= No	0	0	-	-																	Aug 2015			176	640			
Admin & Clerical Agency Use (shifts)	<= No	0	0	-	-																	Aug 2015			21	85			
Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-			
Your Voice - Response Rate	No			-->	-->	18	-->	-->	17	-->	-->	17	-->	-->	14	-->	-->	-->	12	-->	-->	Jun 2015	6	27	12				
Your Voice - Overall Score	No			-->	-->	3.72	-->	-->	3.52	-->	-->	3.52	-->	-->	3.54	-->	-->	-->	3.59	-->	-->	Jun 2015	3.38	3.75	3.59				

Women & Child Health Group

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		G	M	P	C					
C. Difficile	<= No	0	0																			Aug 2015	0	0	0	0	0	0			
MRSA Bacteraemia	<= No	0	0																			Aug 2015	0	0	0	0	0	0			
MRSA Screening - Elective	=> %	80.00	80.00																			Aug 2015	95.5				95.5				
MRSA Screening - Non Elective	=> %	80.00	80.00																			Aug 2015	0	100			100.0				
Falls	<= No	0	0	2	0	0	2	0	1	0	0	0	0	0	0	0	1	2	1	0	1	Aug 2015	1	0	0	0	1	5			
Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Aug 2015	0	0	0	0	0	0			
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	0	0	0	0	0	0	2	0	0	0	2	0	0	0	0	0	-	Jul 2015	0	0	0	0	0	0			
Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Aug 2015	99.5	81.3			89.0				
WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0	98.0																			Aug 2015	100	99.4			99.8				
WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0	95.0																			Aug 2015	100	100			100.0				
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0	85.00																			Aug 2015	100	100			100.0				
Never Events	<= No	0	0																			Aug 2015	0	0	0	0	0	1			
Medication Errors	<= No	0	0																			Aug 2015	0	0	0	0	0	0			
Serious Incidents	<= No	0	0																			Aug 2015	0	1	0	0	1	3			

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		G	M	P	C					
Caesarean Section Rate - Total	<= %	25.0	25.0																			Aug 2015		26.2			26.2	25.1			
Caesarean Section Rate - Elective	%			10	10	8	9	9	7	9	7	8	11	8	6	9	8	7	8	11	9	Aug 2015		8.81			8.8	8.4			
Caesarean Section Rate - Non Elective	%			13	16	18	19	15	17	18	19	16	16	15	17	16	15	18	15	18	17	Aug 2015		17.4			17.4	16.7			
Maternal Deaths	<= No	0	0																			Aug 2015		0			0	0			
Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Aug 2015		3			3	10			
Admissions to Neonatal Intensive Care	<= %	10.0	10.0																	-		Aug 2015		2.82			2.8	2.8			
Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Aug 2015		10			10.0				
Early Booking Assessment (<12 + 6 weeks) (>=%) - SWBH Specific	=> %	90.0	90.0																			Aug 2015		76.7			76.7				
Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=> %	90.0	90.0																	-	-	Jun 2015		154			154.2				
Mortality Reviews within 42 working days	=> %	100.0	97.0					-						-				#DIV/0!		-	-	Jun 2015	100	0	0		100.0				
2 weeks	=> %	93.0	93.0																		-	Jul 2015	90.3		100		90.6				
31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Jul 2015	94.1				94.1				
62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Jul 2015	84.6				84.6				
Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Aug 2015	0				0	0			
No. of Complaints Received (formal and link)	No			-	-	4	6	11	8	8	8	12	7	11	9	11	7	9	14	14	12	Aug 2015	4	4	4	0	12	56			
No. of Active Complaints in the System (formal and link)	No			-	-	15	21	21	24	29	29	33	12	21	27	32	28	28	20	18	17	Aug 2015	0	0	0	0	17				
Oldest' complaint currently in system (days)	No			-	-	61	82	52	66	87	104	123	151	52	73	94	113	128	96	50	57	Aug 2015	26	57	24	0	57				

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		G	M	P	C					
Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Aug 2015	2.13		-		1.6				
28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Aug 2015	0				0	0			
Sitrep Declared Late Cancellations	<= No	0	0	12	12	3	4	7	6	6	7	7	7	1	5	7	6	4	2	2	4	Aug 2015	4				4	18			
Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	77	83	83	81	83	78	76	77	77	80	77	78	79	76	78	74	75	76	Aug 2015	76.2	-			76.2				
Emergency Care 4-hour breach (numbers)	No			19	18	14	14	18	14	30	23	36	82	5	30	16	-	-	-	-	-	Mar 2015	8	0	8	0	16	300			
RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Aug 2015	92.5				92.5				
RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Aug 2015	98.6				98.6				
RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Aug 2015	98.1				98.1				
Patients Waiting >52 weeks	<= No	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	Aug 2015	0				0				
Treatment Functions Underperforming	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Aug 2015	0				0				
Acute Diagnostic Waits in Excess of 6-weeks	<= %	0.1	0.1																			Aug 2015	0				0.0				

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		G	M	P	C					
WTE - Actual versus Plan	No			34	48	58	60	67	81	61	60	59	66	67	68.6	66.9	67.9	70.77	87.2	95.8	111	Aug 2015	24.1	38.2	24	25.8	111.0				
PDRs - 12 month rolling	=> %	95.0	95.0																			Aug 2015	83.5	90.3	88.2	83.2		89.1			
Medical Appraisal and Revalidation	=> %	95.0	95.0														-					Aug 2015	89.5	100	91.7	0		93.2			
Sickness Absence	<= %	3.15	3.15																			Aug 2015	4.89	5.91	4.44	6.8	5.6	5.5			
Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-	-		-	-				Aug 2015	58.1	53.4	59.3	82.4	55.73	56.14			
Mandatory Training	=> %	95.0	95.0																			Aug 2015	88.9	77.4	86.8	89		85.0			
New Investigations in Month	No			0	0	0	0	2	0	0	0	0	0	0	1	1	1	3	2	2	1	Aug 2015	1	0	0	0	1				
Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	-	90	93.6	95.39	91.9	93.9	90.9	Aug 2015					91.0	93.2			
Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	81	37	35	53	50	68	Aug 2015					68	93			
Nurse Bank Use	<= No	6852	571																			Aug 2015					718	3051			
Nurse Agency Use	<= No	0	0																			Aug 2015					135	442			
Admin & Clerical Bank Use (shifts)	<= No	0	0	-	-																	Aug 2015					65	337			
Admin & Clerical Agency Use (shifts)	<= No	0	0	-	-																	Aug 2015					20	87			
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																													
Your Voice - Response Rate	No			-->	-->	11	-->	-->	12	-->	-->	12	-->	-->	9	-->	-->	-->	13	-->	-->	Jun 2015	18	8	18	14	13				
Your Voice - Overall Score	No			-->	-->	3.79	-->	-->	3.65	-->	-->	3.65	-->	-->	3.53	-->	-->	-->	3.66	-->	-->	Jun 2015	3.79	3.68	3.57	3.58	3.7				

Pathology Group

Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	Data Period	Directorate HA	HI	B	M	I	Month	Year To Date	Trend	Next Month	3 Months
Never Events	<= No	0	0																			Aug 2015	0	0	0	0	0	0	0			
No. of Complaints Received (formal and link)	No			-	0	0	1	0	1	1	3	0	2	3	1	5	0	2	3	0	2	Aug 2015	1	0	0	0	1	2	7			
No. of Active Complaints in the System (formal and link)	No			-	-	1	2	1	2	3	6	5	5	8	7	6	4	6	5	2	3	Aug 2015	2	0	0	0	1	3				
Oldest' complaint currently in system (days)	No			-	-	91	112	27	46	68	92	111	90	96	117	138	73	92	27	23	18	Aug 2015	0	0	0	0	18	18				
WTE - Actual versus Plan	No			33	30	32	31	32	29	27	25	27	27	24	16	16	20.4	22.8	32.5	34	33.7	Aug 2015	2.3	3.2	13.5	3.71	2.82	34				
PDRs - 12 month rolling	=> %	95.0	95.0																			Aug 2015	82.3	95	90.3	98.3	93.3		93.15			
Medical Appraisal and Revalidation	=> %	95.0	95.0														-					Aug 2015	80	85.7	100	75	100		89.74			
Sickness Absence	<= %	3.15	3.15																			Aug 2015	5.65	1.32	4.25	3.7	5.1	4.36	4.3			
Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-	-		-	-				Aug 2015	80.8	90	85.7	91.6	100	79.0	78.8			
Mandatory Training	=> %	95.0	95.0																			Aug 2015	92	97.1	95.8	95.1	98		95.8			
New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Aug 2015	0	0	0	0	0	0				
Admin & Clerical Bank Use (shifts)	<= No	0	0	-	-																	Aug 2015						540	2607			
Admin & Clerical Agency Use (shifts)	<= No	0	0	-	-																	Aug 2015						0	0			
Your Voice - Response Rate	No			-->	-->	30	-->	-->	31	-->	-->	31	-->	-->	12	-->	-->	-->	21	-->	-->	Jun 2015	24	26	12	28	69	21				
Your Voice - Overall Score	No			-->	-->	3.43	-->	-->	3.74	-->	-->	3.74	-->	-->	3.76	-->	-->	-->	3.69	-->	-->	Jun 2015	3.37	3.49	3.58	3.71	4.15	3.69				

Imaging Group

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		DR	IR	NM	BS					
Never Events	<= No	0	0																			Aug 2015	0	0	0	0	0	0			
Medication Errors	<= No	0	0																			Aug 2015	0	0	0	0	0	0			
Unreported Tests / Scans	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-										
Outsourced Reporting	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-										
IRMA Instances	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-										
Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			Aug 2015			82.1		82.14	75.27			
Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.00																			Aug 2015			100		100	99.28			
Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Aug 2015	0	0	0	0	0	0			
No. of Complaints Received (formal and link)	No			-	-	4	2	3	3	0	4	2	2	3	2	1	0	4	3	5	8	Aug 2015	6	2	0	0	8	20			
No. of Active Complaints in the System (formal and link)	No			-	-	5	7	8	5	5	8	10	8	9	7	5	0	5	5	7	11	Aug 2015	8	3	0	0	11				
Oldest' complaint currently in system (days)	No			-	-	19	40	59	30	52	76	72	75	83	75	96	123	102	27	24	43	Aug 2015	43	27	0	0	0				
Emergency Care 4-hour breach (numbers)	No			37	30	39	41	32	34	49	50	52	45	41	49	51	-	-	-	-	-	Mar 2015	51	0	0	0	51	513			
Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Aug 2015	0.5				0.5				
WTE - Actual versus Plan	No			28	15	13	11	13	22.1	14	16	15	21	21	33	33.6	41.4	46.3	57.9	58.9	55.9	Aug 2015	34.3	1.75	3.05	7.21	55.9				
PDRs - 12 month rolling	=> %	95.0	95.0																			Aug 2015	82	90.9	96.6	67.3		84.6			
Medical Appraisal and Revalidation	=> %	95.0	95.0														-					Aug 2015	114	0	100	100		98.3			
Sickness Absence	<= %	3.15	3.15																			Aug 2015	3.2	7.8	2.8	5.1	4.61	4.72			
Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-	-		-	-				Aug 2015	43	95	69.4	17	42.6	43.6			
Mandatory Training	=> %	95.0	95.0																			Aug 2015	83.9	82.2	89.6	92.2		88.1			
New Investigations in Month	No			0	0	2	2	0	0	6	0	0	0	0	0	0	0	0	0	0	0	Aug 2015					0				
Nurse Bank Use	<= No	288	24																			Aug 2015					109	214			
Nurse Agency Use	<= No	0	0																			Aug 2015					159	1208			
Admin & Clerical Bank Use (shifts)	<= No	0	0	-	-																	Aug 2015					192	976			
Admin & Clerical Agency Use (shifts)	<= No	0	0	-	-																	Aug 2015					0	0			
Your Voice - Response Rate	No			-->	-->	19	-->	-->	33	-->	-->	33	-->	-->	18	-->	-->	-->	19	-->	-->	Jun 2015	15	30	35	22	19				
Your Voice - Overall Score	No			-->	-->	3.72	-->	-->	3.73	-->	-->	3.73	-->	-->	3.28	-->	-->	-->	3.41	-->	-->	Jun 2015	3.21	0	3.55	3.63	3.41				

Community & Therapies Group

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		AT	IB	IC					
MRSA Screening - Elective	=> %	80.0	80.0														-	-	-	-	-	Aug 2015	-	-	-	-				
Falls	<= No	0	0	1	8	9	11	13	4	14	20	17	21	22	16	13	30	47	37	25	27	Aug 2015	0	25	2	27	166			
Falls with a serious injury	<= No	0	0	0	0	2	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	Aug 2015	0	0	0	0	1			
Grade 3 or 4 Pressure Ulcers (avoidable)	<= No	0	0	2	2	4	2	2	1	1	1	3	5	2	1	3	3	1	1	3	-	Jul 2015	0	3	0	3	8			
Never Events	<= No	0	0																			Aug 2015	0	0	0	0	0			
Medication Errors	<= No	0	0																			Aug 2015	0	0	0	0	0			
Serious Incidents	<= No	0	0																			Aug 2015	0	0	0	0	0			
FFT Response Rate - Wards (Community)	=> %	25.0	25.0	-	39	67.9	42.9	60	59.5	56.7	47	37.5	32.6	33	41.3	101	27.73	40.36	28.16	30.68	33.19	Aug 2015	-	-	-	33.19				
FFT Score - Wards (Community)	=> No	68.0	68.0	82	81	95	87	83	91	82	88	73	87	100	95	92	98.59	96.66	91.37	91.3	91	Aug 2015	-	-	-	91				
Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Aug 2015	0	0	0	0	0			
No. of Complaints Received (formal and link)	No			-	-	3	0	0	5	2	5	1	1	2	1	1	0	1	2	1	3	Aug 2015	1	1	1	3	7			
No. of Active Complaints in the System (formal and link)	No			-	-	10	8	3	8	8	10	12	3	4	3	6	0	7	6	4	5	Aug 2015	1	1	3	5				
Oldest complaint currently in system (days)	No			-	-	94	115	75	38	60	64	81	75	61	82	103	158	0	99	118	140	Aug 2015	11	12	140	140				
WTE - Actual versus Plan	No			34	27	36	45	45	61.8	65	67	71	75	76	72.2	77.4	174.3	92.79	77.27	85.27	87.72	Aug 2015	9.03	32.4	46.3	87.72				
PDRs - 12 month rolling	=> %	95.0	95.0																			Aug 2015	85.6	84.1	89.6		89.7			
Sickness Absence	<= %	3.15	3.15																			Aug 2015	3.88	5.68	5.6	5.36	5.21			
Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-	-		-	-				Aug 2015	95.1	79.1	72.8	78.68	79.52			

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		AT	IB	IC					
Mandatory Training	=> %	95.0	95.0																			Aug 2015	90.2	87.2	90		89.5			
New Investigations in Month	No			1	0	0	0	0	0	0	0	0	0	0	0	0	1	3	0	0	0	Aug 2015				0				
Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	-	93	89.51	94.17	89.15	88.96	89.67	Aug 2015	-	-	-	89.67	90.3			
Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	36	41	31	46	72	62	Aug 2015	-	-	-	62	252			
Nurse Bank Use	<= No	5408	451																			Aug 2015				597	2198			
Nurse Agency Use	<= No	0	0																			Aug 2015				482	1741			
Admin & Clerical Bank Use (shifts)	<= No	0	0	-	-																	Aug 2015				302	1190			
Admin & Clerical Agency Use (shifts)	<= No	0	0	-	-																	Aug 2015				0	0			
Your Voice - Response Rate	No			-->	-->	18	-->	-->	32	-->	-->	32	-->	-->	28	-->	-->	-->	26	-->	-->	Jun 2015	42	22	23	26				
Your Voice - Overall Score	No			-->	-->	3.75	-->	-->	3.88	-->	-->	3.88	-->	-->	3.76	-->	-->	-->	3.77	-->	-->	Jun 2015	3.68	3.76	3.87	3.77				
DVT numbers	=> No	730	61	53	53	62	87	39	33	70	35	42	47	54	53	55	56	53	67	64	-	Jul 2015				64	240			
Therapy DNA rate OP services	<= %	9	9	12	12	16	11	10.6	10.5	11.3	12	13.6	12	12.3	13.9	12.9	13.35	11.97	14.49	10.65	9.849	Aug 2015				9.9	12.0			
FEES assessment	<= No	100	8	1	7	10	3	4	4	5	5	3	2	14	1	2	0	2	0	0	-	Jul 2015				0	2			
ESD Response time	<= Hr	48	48													-	-	-	-	-	-	Feb 2015				0	0			
STEIS	<= No	0	0	1	0	2	1	0	1	0	0	0	1	0	0	-	-	-	0	0	0	Aug 2015				0	0			
Rapid response to AMU, RRTS	<= mins	60	60	75	75	71	72	73	68	81	79	82	86	79	98	-	-	-	-	-	-	Feb 2015				98	864			
Avoidable weight loss	<= %	20.0	20.0	-	18	0	8	0	0	0	0	0	9	0	0	8	0	25	20	0	-	Jul 2015				0.0	11.8			
Green Stream Community Rehab response time for treatment (days)	<= No	11.0	11.0	11	12	7.9	11.2	16.1	15.6	17.1	14.3	12.3	13.1	9.5	12.1	13.7	16	14	11	15	-	Jul 2015				15	56			

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		AT	IB	IC					
DNA/No Access Visits	%			-	-	-	-	-	3	1	1	1	1	1	1	-	-	-	-	6	1	Aug 2015				0.65				
Falls Assessments - DN service only	%			-	-	-	-	-	72	58	49	45	45	62	54	65	47	55	50	46	44	Aug 2015				44.2				
Pressure Ulcer Assessment - DN service only	%			-	-	-	-	-	73	61	50	48	46	63	57	65	51	55	51	48	44	Aug 2015				43.91				
Healthy Lifestyle Assessments - DN Service only	%			-	-	-	-	-	61	54	48	39	43	58	54	36	47	57	45	37	37	Aug 2015				37.3				
At risk of Social Isolation Referrals to 3rd sector DN service only	%			-	-	-	-	-	46	75	67	57	65	95	77	-	-	-	-	50	75	Aug 2015				75				
MUST Assessments - DN Service only	%			-	-	-	-	-	9	11	10	11	10	19	18	-	22	22	24	21	23	Aug 2015				22.91				
Incident Rates - per 1000 charge	Rate1			-	-	-	-	-	4	5	5	4	4	5	4	-	#####	#####	#####	#####	#####	Aug 2015				0				
Dementia Assessments - DN Service only	%			-	-	-	-	-	72	62	55	52	51	61	62	-	46	56	40	48	45	Aug 2015				44.96				
48 hour inputting rate	%			-	-	-	-	-	91	83	81	85	86	89	83	-	87	89	92	91	94	Aug 2015				93.72				

Corporate Group

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate							Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A		CEO	F	W	M	E	N	O					
No. of Complaints Received (formal and link)	No			-	-	8	4	5	6	5	7	6	6	15	5	6	5	7	8	6	15	Aug 2015	4	0	0	3	1	2	5	15	41			
No. of Active Complaints in the System (formal and link)	No			-	-	16	13	12	13	21	21	25	12	21	16	18	14	12	14	9	16	Aug 2015	4	0	0	3	1	2	6	16				
Oldest' complaint currently in system (days)	No			-	-	69	90	77	99	121	106	104	104	123	145	138	158	99	121	53	24	Aug 2015	-	-	-	-	-	-	-	24				
WTE - Actual versus Plan	No			164	149	154	162	176	162	183	194	203	168	175	200	220	260	267	110	99.6	103	Aug 2015	11.3	3.62	-11.9	24.1	0.09	33.9	41.8	102.97				
PDRs - 12 month rolling	=> %	95.0	95.0																			Aug 2015	94	85	81	89	86	89	75		88.3			
Medical Appraisal and Revalidation	=> %	95.0	95.0																			Aug 2015			95						100			
Sickness Absence	<= %	3.15	3.15																			Aug 2015	2.37	2.08	3.44	3.00	2.55	5.86	5.33	4.73	4.69			
Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-	-		-	-				Aug 2015	69.5	68.1	35.9	83.1	42.9	78.2	70.4	70.8	70.7			
Mandatory Training	=> %	95.0	95.0																			Aug 2015	94	92	92	89	92	88	90		90			
New Investigations in Month	No			2	0	1	3	1	0	5	0	0	0	1	0	0	1	0	1	2	1	Aug 2015	0	0	0	0	0	1	0	1				
Nurse Bank Use	<= No	1088	91																			Aug 2015								193	997			
Nurse Agency Use	<= No	0	0																			Aug 2015								14	258			
Admin & Clerical Bank Use (shifts)	<= No	0	0	-	-																	Aug 2015	-	-	-	-	-	-	-	2999	15579			
Admin & Clerical Agency Use (shifts)	<= No	0	0	-	-																	Aug 2015	-	-	-	-	-	-	-	99	408			
Your Voice - Response Rate	No			-->	-->	26	-->	-->	24	-->	-->	21	-->	-->	15	-->	-->	-->	16	-->	-->	Jun 2015	76	24	38	24	16	9	11	16				
Your Voice - Overall Score	No			-->	-->	3.76	-->	-->	3.60	-->	-->	3.49	-->	-->	3.48	-->	-->	-->	3.50	-->	-->	Jun 2015	3.71	3.34	3.72	3.39	3.24	3.46	3.32	3.5				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Financial performance – P05 August 2015**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Finance Director**
AUTHOR:	**Tim Reardon – Associate Director of Finance**
DATE OF MEETING:	**1 October 2015**

EXECUTIVE SUMMARY:

Key messages:

- Off plan year to date and requiring a step improvement in financial performance of minimum £2m per month from P06 September.
- TDA proposed stretch surplus of £6m being £2.2m above plan. Any contribution to this stretch to be delivered on a non-recurrent basis. Focus of organisation firmly on remedy to deliver original plan.
- To secure exit run-rate consistent with 2016.17 plan requires remedy to current year performance, delivery of CIP to full year effect value and progression of workforce change plan for 2016-18.
- Capital programme reviewed and re-profiled to be consistent with emergent firm requirements of retained estate and IM&T strategies consistent with effective delivery of MMH models of care.

Key actions:

- Confirm and deliver revised demand and capacity plans consistent with remedy of year to date under-performance on planned care. Delivery to be contained within original plan costs.
- Reduce pay bill run-rate in the first instance through reduction in premium rate agency spend to a level consistent with that achieved in Q3 / Q4 of 2014.15.
- Resolve dispute in respect of ante-natal secondary provider charges and establish fit for purpose SLA
- Discipline in delivery of CIP schemes to realise plan value on a full year effect basis.
- Confirm actions to manage resources within approved External Finance & Capital Resource Limits having regard to any reliance on non-cash contingencies and revised capital programme.

Key numbers:

- Month deficit £(418)k being £(564)k adverse to budget; YTD deficit £(981)k being £(1,448)k adverse.
- Forecast surplus £3.8m in line with financial plan. Any stretch to be delivered on N/R basis.
- Agency spend £1.5m in month; £7.5m YTD. Rate of spend double that achieved during 2014.15.
- CIP delivery to date £5.7m being £1.4 favourable to TDA plan. Step up in CIP in Q3 / Q4 required.
- Capex YTD £3.9m being £2.5m below plan. Revised profile proposed in line with updated programme.
- Cash at 31 August £38.7m being £7.2m above plan due to timing differences
- CoSRR 3 to date being below plan of 4 due to adverse EBITDA performance; forecast 3 as plan
- Capital Resource Limit (CRL) charge forecast at £20.2m being as plan
- External Finance Limit (EFL) charge forecast at £(0.7)m being consistent with approved EFL.

REPORT RECOMMENDATION:

The Board is recommended to RECEIVE the report and REQUIRE & SUPPORT those actions necessary to secure key financial targets consistent with the delivery of safe, high quality care.

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

Comments:

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

Good use of resources

PREVIOUS CONSIDERATION:

Finance & Investment Committee

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2015 (P05)

EXECUTIVE SUMMARY

- **For the period to the end of August 2015 the Trust is reporting :**
  - **I&E deficit of £981k being £1,448k behind plan**
  - **Capital spend of £3.9m, £2.5m below plan**
  - **Cash held at the end of August is £38.7m being £7.2m more than plan.**
- **Key issues remain an under-recovery of SLA income driven by below plan delivery of planned care activity and excess pay costs driven by volume and unit cost of temporary staffing. These issues have been moderated in the period to date by the significant use of contingencies and balance sheet flexibility.**
- **The current forecast is that the trust will deliver all key financial targets. This is dependent on the delivery of remedial actions to increase activity to improve income recovery, consistent discipline in workforce management & controls to reduce agency costs, to deliver in full CIP plans and to progress workforce change consistent with an exit run rate expenditure in line with medium term plan obligations.**
- **The Trust has responded to the TDA request to increase its planned surplus to £6.0m by indicating that £5.0m may be deliverable on a non-recurrent basis if certain risks are managed and CCG support is received.**

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	(564)	(1,448)	>= Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	(343)	(1,183)	>= Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	(275)	(2,126)	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	1,692	4,117	<= Plan	<= Plan	>1% above plan
WTEs Actual v Plan	307	166	<= Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000		7,158	>= Plan	>=95% of plan	<95% of plan

Note: positive variances are favourable, negative variances unfavourable

- **Cash balance at 31 August £38.7m is £7.2m ahead of cash plan**. Plan in place to meet EFL having regard to any reliance on non-cash contingencies
- Year to date capital expenditure of £3.9m is £2.5m behind plan.
- Revised capital programme agreed and expected to be delivered within approved CRL

2015/16 Summary Income & Expenditure Performance at August 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	399,693	33,363	31,540	(1,824)	166,479	163,648	(2,832)
Other Income	40,002	3,363	3,426	63	16,797	16,454	(343)
Pay Expenses	(286,659)	(23,745)	(24,020)	(275)	(119,704)	(121,830)	(2,126)
Non-Pay Expenses	(126,684)	(10,957)	(9,266)	1,692	(53,701)	(49,584)	4,117
EBITDA	**26,352**	**2,024**	**1,680**	**(343)**	**9,871**	**8,688**	**(1,183)**
Depreciation & Impairment	(14,881)	(1,240)	(1,240)	0	(6,200)	(6,200)	0
PDC Dividend	(6,000)	(500)	(500)	0	(2,500)	(2,500)	0
Net Interest Receivable / Payable	(2,039)	(169)	(161)	8	(858)	(853)	6
Other Finance Costs / P&L on sale of assets	0	0	0	0	0	0	0
Net Surplus/(Deficit)	**3,432**	**115**	**(220)**	**(335)**	**312**	**(866)**	**(1,178)**
IFRIC12/Impairment/Donated Asset Related Adjustments	372	31	(198)	(229)	155	(115)	(270)
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,804**	**146**	**(418)**	**(564)**	**467**	**(981)**	**(1,448)**

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2015 (period 5)

I&E Performance against DoH Plan

The Trust is reporting a year to date deficit of £981k which is £1,448k behind plan.

Performance of Clinical Groups

- Key risks for **Medicine** continue to be use of medical and nursing agency and delivery of savings plans. Expedient success with nurse recruitment and progress with medical recruitment is required. Quality of coding is a necessary focus of attention.
- **Surgery A** is key to the capacity and demand work to remedy delivered activity and income to contracted levels. Granular plans are in delivery. September delivery remains a cause for concern. Savings plans are being reviewed to identify remaining gaps and to ensure delivery of schemes.
- **Women & Child Health** key variance (£1.1m YTD) is ante natal maternity pathway payments, including impact of settlement of 2014/15 invoices which are subject to significant challenge by SWBH.
- **Surgery B** is required to contribute to activity & income recovery. A plan to achieve contracted Lucentis pathways is at risk of delay in delivery. Savings delivery is the other key risk.
- **Community & Therapies**' position includes significant reliance on vacancy control to deliver savings targets. This is the subject of scrutiny to assure safety. Agency spend driven by additional bed capacity.
- **Imaging** is underachieving on income and overspending on pay (lack of savings delivery) and non-pay (consumables and maintenance).
- **Pathology** underlying position in balance

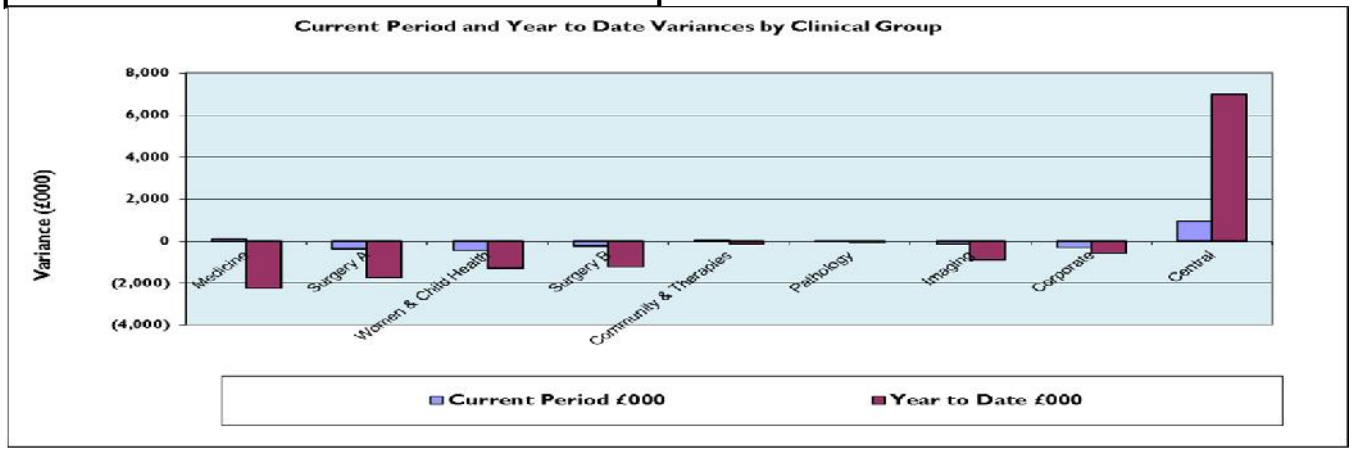
Corporate Areas

- Pay underspends on management and administration of £0.7m are offset by SLA underperformance, savings under-delivery of £0.5m and non-pay overspending.

Central

- Year to date use of £3.3m flexibility and reserves expenditure being £3.7m below plan.

Group Variances from Plan (Operating income and expenditure)	Current Period £000	Year to Date £000
Medicine	101	(2,246)
Surgery A	(368)	(1,728)
Women & Child Health	(430)	(1,276)
Surgery B	(222)	(1,221)
Community & Therapies	61	(143)
Pathology	(23)	(79)
Imaging	(148)	(890)
Corporate	(287)	(594)
Central	973	6,992

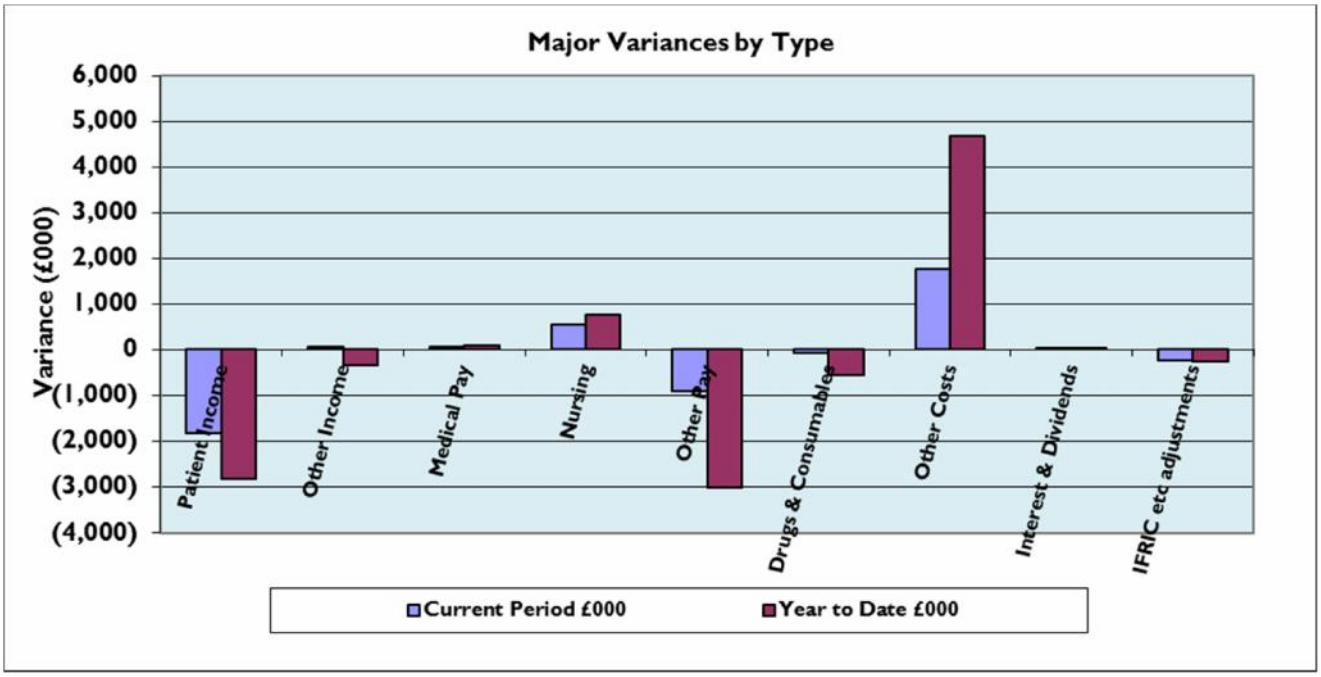


Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2015 (period 5)

- **Patient income** £4.4m under-performance YTD on elective inpatients and day cases and A&E under-performance £0.5m; £0.8m over-performance on emergency and £0.8m on pass through and cancer drugs fund.
- **Other income** is down primarily (£0.4m) due to underperformance on LDA. Undergraduate medical student weeks and non-medical particularly.
- **Medical staffing** YTD overspend in Medicine £0.5m mitigated by underspends in W&CH to give a small underspend.
- **Nursing** (includes agency) overspends on bank and agency totalling £5.8m are offset by £6.6m underspend on substantive staff.
- **Other pay** includes savings targets not yet allocated to specific budgets. This is a risk for delivery of the financial plan.
- £0.8m of the **drugs/consumables** variance is pass through. Overspending on medicine £0.5m and imaging of £0.2m are the largest adverse variances.
- **Other costs** favourable variance reflects use of balance sheet flexibility and that reserves actual costs are below plan; £1.2m over-spend on maternity pathway charges. It also includes overspending on other imaging non-pay and corporate postage.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	(1,824)	(2,832)
Other Income	63	(343)
Medical Pay	68	93
Nursing	551	776
Other Pay	(894)	(2,995)
Drugs & Consumables	(64)	(561)
Other Costs	1,756	4,678
Interest & Dividends	8	6
IFRIC etc adjustments	(229)	(270)
Total	(564)	(1,448)

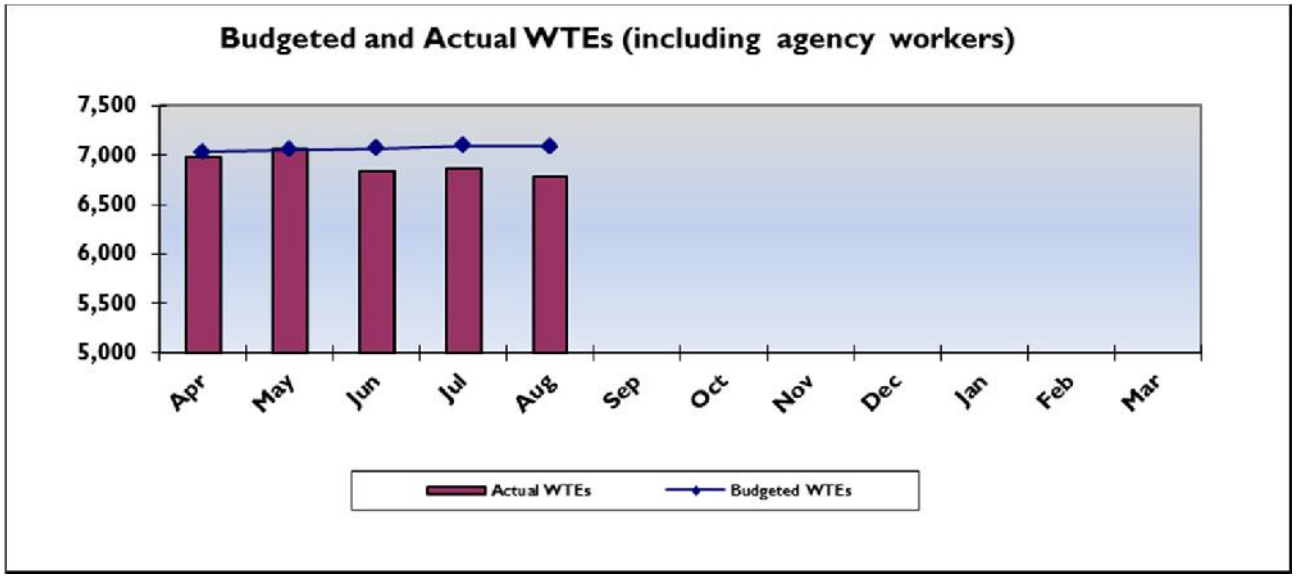


Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2015 (period 5)

Paybill & Workforce

- Total workforce of 6,786 WTE [being 307 WTE below plan] including 225 WTE of agency staff.
- Total pay costs (including agency workers) were £24.0m in July being £0.3m over plan.
- **Agency staff cost in month was £1,490k and £7.5m for the year to date. This rate of spend is significantly in excess of plan and not consistent with delivery of key financial targets. Appropriate actions are being progressed to address this and to reduce the forward pay bill to sustainable levels.**
- The trust has given notice as regards the discontinued use of off-framework agency. Appropriate risk assessment has been undertaken and necessary mitigation is being progressed. Granular and prospective agency usage information is routinely provided to senior managers within the Trust to assist with managing this issue.



Total Pay Costs by Staff Group

	Year to Date to August 2015					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	33,615	31,850	0	1,672	33,522	93
Management	5,793	5,072	0	0	5,072	721
Administration & Estates	12,738	11,009	970	719	12,698	40
Healthcare Assistants & Support Staff	12,998	11,661	1,715	540	13,917	(919)
Nursing and Midwifery	39,785	32,701	2,719	3,589	39,009	776
Scientific, Therapeutic & Technical	19,205	16,367	0	960	17,328	1,877
Other Pay / Technical Adjustment	(4,430)	285	0	0	285	(4,715)
Total Pay Costs	119,704	108,945	5,404	7,480	121,830	(2,126)

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – August 2015 (period 5)

Balance Sheet

Cash at 31 August was £38.7m being £7.2m higher than plan. This reflects lower than planned capital expenditure to date of £2.5m and higher than planned payables which continue to reflect disputed payments to NHS suppliers, including those for maternity pathway attendances at other Trusts.

Surplus cash is now routinely invested in National Loans Fund, robust weekly cash flow forecasts underpin this and this process is one of those being enhanced by the finance team.

Sandwell & West Birmingham Hospitals NHS Trust

STATEMENT OF FINANCIAL POSITION 2015/16

	Balance as at 31st March 2015		Balance as at 31st August 2015	TDA Planned Balance as at 31st August 2015	Variance to plan as at 31st August 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		231,047	234,175	(3,128)		246,555	246,555
Intangible Assets	677		576	577	(1)		437	437
Trade and Other Receivables	890		815	830	(15)		1,011	1,011
Current Assets								
Inventories	3,467		3,636	3,165	471		2,972	2,972
Trade and Other Receivables	16,318		13,185	16,421	(3,236)		15,966	15,966
Cash and Cash Equivalents	28,382		38,663	31,505	7,158		27,082	27,082
Current Liabilities								
Trade and Other Payables	(45,951)		(53,707)	(48,597)	(5,110)		(53,620)	(53,620)
Provisions	(4,502)		(2,926)	(3,883)	957		(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)		(2,969)	(2,363)	(606)		(4,133)	(4,133)
Borrowings	(26,898)		(26,479)	(26,473)	(6)		(25,881)	(25,881)
DH Capital Loan			0	0	0		0	0
	200,689		**199,824**	**203,340**	**(3,516)**		**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)		(14,623)	(11,107)	(3,516)		(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		**199,824**	**203,340**	**(3,516)**		**206,017**	**206,017**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2015 (period 5)

Cash

The favourable cash position at the end of August is reported above.

To the extent that delivery of the trust's financial plan is necessarily reliant on the use of balance sheet flexibilities this will represent a drain on the trust's cash balances. This does not represent a near term risk but may be relevant to the trust's medium term plans.

There is significant scope for near term working capital management, including a stretch on payables, to manage year end EFL target delivery.

CASH FLOW 2015/16

PLAN, ACTUAL AND YEAR END FORECAST AT 30 JULY 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 Balance (Sept15)	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 Actual £000s	July Actual £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	21,573	21,841	21,454	21,568	21,568	21,568	21,568	21,568	21,568	21,568
Associates	6,800	6,632	6,727	6,548	6,328	6,380	6,380	6,380	6,380	6,380	6,380	6,380
Other NHS	1,957	1,877	1,368	845	854	1,500	1,500	1,500	1,500	1,500	1,500	2,800
Specialised Services	3,042	5,448	4,272	4,863	3,718	3,292	3,292	3,292	3,292	3,292	3,292	3,287
Over Performance	2,758	598		0	0	0	0	0	0	0	0	0
Education & Training	463	0	4,666	0	4,146	4,666	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	1,626	2,479	1,631	1,000	1,004	2,000	2,000	2,200	2,200	2,800
Total Receipts	38,527	37,189	40,233	36,575	38,131	38,406	38,410	34,740	34,740	39,606	34,940	36,835
Payments												
Payroll	13,364	13,207	13,374	13,387	13,193	13,600	13,600	13,600	13,600	13,600	13,600	13,600
Tax, NI and Pensions	3,638	9,224	9,111	9,177	9,028	9,250	9,250	9,250	9,250	9,250	9,250	9,250
Non Pay - NHS	3,099	1,659	1,564	2,422	1,849	6,600	1,800	1,500	1,550	1,500	1,550	1,550
Non Pay - Trade	10,987	8,519	9,184	9,998	9,541	14,940	10,811	7,932	7,844	12,067	7,610	6,263
Non Pay - Capital	459	1,070	4,544	1,658	840	1,151	1,866	1,375	1,413	1,566	1,943	2,322
PDC Dividend	0	0	0	0	0	3,105	0	0	0	0	0	2,400
Repayment of Loans & Interest	0	0	0	0	0	1,004	0	0	0	0	0	0
BTC Unitary Charge	0	429	444	438	443	440	440	440	440	440	440	880
NHS Litigation Authority	685	685	685	685	685	685	685	685	685	686	0	0
Other Payments	68	375	134	408	113	100	100	100	100	100	100	100
Total Payments	32,300	35,168	39,040	38,173	35,693	50,875	38,552	34,882	34,882	39,209	34,493	36,365
Cash Brought Forward	28,382	34,609	36,630	37,823	36,225	38,663	26,194	26,052	25,910	25,768	26,165	26,612
Net Receipts/(Payments)	6,227	2,021	1,193	(1,598)	2,438	(12,469)	(142)	(142)	(142)	397	447	470
Cash Carried Forward	34,609	36,630	37,823	36,225	38,663	26,194	26,052	25,910	25,768	26,165	26,612	27,082
Plan v Actual Carry Forward	6,500	7,716	8,104	5,613	7,158	(0)	(0)	(0)	(0)	(0)	(0)	(0)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2015 (period 5)

Capital Expenditure & Capital Resource Limit

- Capital expenditure to date £3.9m against a year to date plan of £6.4m. A further £2.5m of firm commitments have been made to date.
- A revised programme has been proposed with an updated profile of expenditure over the remainder of the financial year. The revised programme will be managed within the Trust's notified capital resource limit.
- The Capital Resource Limit (CRL) charge forecast is £20.229m which is in line with plan. A retiming of capital spend has been identified which may increase 2015/16 spend on certain projects. This will be managed through a mix of planned slippage.
- The Trust has sufficient cash to support the full capital programme and is not anticipating the use of external borrowing to fund the programme.

Continuity of Service Risk Rating

- Rating of 3 year to date compared with planned rating of 4 due to lower EBITDA than plan
- Rating of 3 forecast being consistent with plan. The liquidity rating component reflects an appropriate recognition of the potential use of balance sheet flexibility and working capital stretch.

	Continuity of Services Risk Rating	Historic Year to 31-Mar-15	Current Month Metrics			Forecast Outturn Metrics		
			Plan	Actual / Forecast	Variance	Plan	Actual / Forecast	Variance
		(mc 01) £000s	(mc 02) £000s	(mc 03) £000s	(mc 04) £000s	(mc 05) £000s	(mc 06) £000s	(mc 07) £000s
Liquidity Ratio (days)	WORKING CAPITAL BALANCE	-7,770	-6,571	-6,802	-231	-14,944	-10,380	4,564
	ANNUAL OPERATING EXPENSES	421,427	172,168	171,416	-752	409,971	409,321	-650
	Liquidity Ratio Days: (Working Capital Balance / Annual Operating Expenses)	-7	-6	-6	0	-13	-9	4
	Liquidity Ratio Metric	3	3	3	0	2	2	0
Capital Servicing Capacity (times)	REVENUE AVAILABLE FOR DEBT SERVICE	25,180	9,902	8,491	-1,411	26,450	27,050	600
	ANNUAL DEBT SERVICE	10,610	3,835	3,829	-6	10,201	9,601	-600
	Capital Servicing Capacity (times) (Revenue available for Debt Service / Annual Debt Service)	2	3	2	0	3	3	0
	Capital Servicing Capacity metric	3	4	3	-1	4	4	0
CoSRR	Continuity of Services Risk Rating for Trust	3	4	3	-1	3	3	0

Score metrics	4	3	2	1
Liquidity ratio (days)	0	-7	-14	<-14
Capital servicing capacity	3	2	1	<1.25

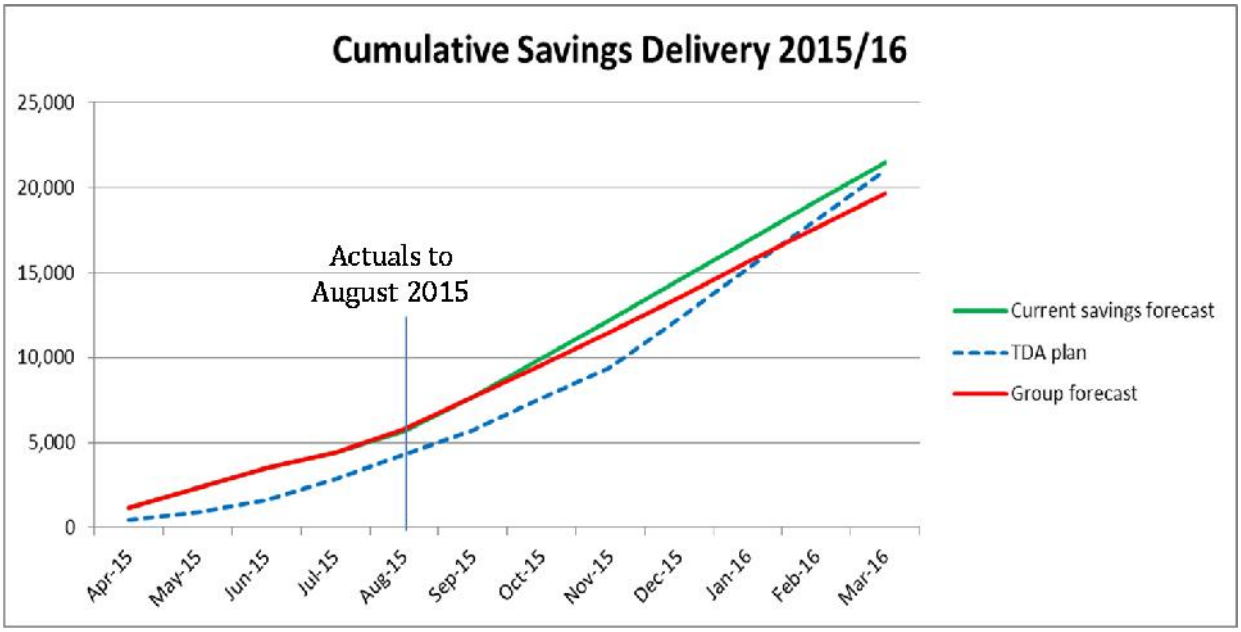
Service Level Agreements

- NHS Commissioner activity and income data year to date shows a shortfall of £3.3m. This reflects £4.4m shortfall on elective and day case activity and a £544k shortfall on A&E, offset by £1.3m over-performance on emergency inpatients. Outpatients as a whole is broadly on line with more procedures and fewer follow up attendances than plan.
- Pass through drugs and devices, cancer drugs fund and Lucentis are all over-performing resulting in overspending on the related non-pay areas.
- The year to date smoothing adjustment reflecting the differential phasing of activity over the year against the broadly flat profile of spending is £1.1m.
- The position assumes 100% delivery of CQUIN income and fines consistent with the fines cap of £2.0m for the year.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – August 2015 (period 5)

- **Savings Programme**
- Delivery to date is reported as £5.7m which is £1.4m favourable compared to phased plans.
- Schemes in delivery are forecast to realise £15.7m during 2015/16 and with full year effect of £23.6m in 2016/17 against plan target of £21.0m. Further schemes totalling £1.9m in year [£3.6m full year] have been proposed and are subject to confirmation and implementation.
- A programme of work to identify and progress further pay and workforce change consistent with the delivery of necessary cost reduction for 2016 -18 is on-going. This work is underpinned by robust arrangements to assess and assure the impact of any proposals on safety & quality.
- Work is on-going through the PMO to further enhance the governance and assurance of savings delivery.
- The forecast profile of savings delivery is shown below together with the original plan against which the TDA continues to monitor the Trust. This analysis comprises both elements of the Trust's savings plan; those schemes classed as savings targets and those classed as delivering run rate reductions.



Risks

Identification and delivery of savings at necessary scale and pace; the current forecast for savings indicates delivery of £21.5m in year of which £16.3m will allow budgets to be reduced. This compares with the £21.0m required. The full year effect of schemes is £27.2m of which £19.5m allow budget reductions.

Income repatriation. The 2015/16 plan 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. Q1 has been secured on this basis. Enhanced scrutiny and oversight arrangements have been put in place to secure delivery Q2 through Q4.

Ante-natal pathway charges. Secondary provider charges continue to run at a rate significantly above plan. The trust has disputed a significant element of charges for 2014.15 and which remains to be resolved. The trust's objective of securing a fit for purpose SLA in 2015.16 consistent with a reduction in the level of charges received has not yet been realised.

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

Elective capacity management. Confirm and deliver revised demand and capacity plans consistent with remedy of year to date under-performance on planned care. Delivery to be contained within original plan costs.

Over spending on pay costs, particularly premium rate staffing. Spending on interim staffing has spiked in the new financial year. At an average spend of £1.5m per month in July and August spending continues to run £0.7m per month more than the average of £875k per month used between November 2014 and February 2015.

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

There is, as yet, no one view of vacancies and so the key enabler of a coordinated recruitment plan is lacking.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – July 2015 (period 4)

Recommendations

The Finance & Performance Management Committee 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:	CQC Improvement Plan – Progress against actions
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	1st October 2015

EXECUTIVE SUMMARY:

Attached is an update on progress with the delivery of the actions within the CQC Improvement Plan, which reports that as at the end of September of the 67 actions 26 have been completed and with confidence of delivery of the remainder by the end of October 2015. The paper includes:

- A reminder of the big themes identified in the CQC report and the interventions and data points available to the Board for assurance purposes (Appendix 1). A view on the sufficiency of these is sought from members.
- Delivery of the Improvement Plan at a glance (Appendix 2). The rating at this point relates to having taken the planned action not whether this has been successful. A list of completed actions is also provided.
- A weekly timeline for the remaining actions to be achieved by the end of October is provided in Appendix 3

Throughout November a range of approaches will be used to check if the changes / improvements made have had the desired outcome. This will include unannounced visits, interviews, evidence submission, snap shot audits etc. Based on the results the Executive Group will make a decision on the successful delivery of the improvement action.

REPORT RECOMMENDATION:

Trust Board are requested to receive note the update and provide ongoing support to the delivery of the improvement plan.

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	X
Clinical	X	Equality and Diversity		Workforce	

Comments:

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

Safe high quality care

PREVIOUS CONSIDERATION:

Monthly update to CLE

Sandwell and West Birmingham Hospitals NHS Trust

Appendix 1

The big themes identified in the CQC report

5 priorities to address	Are these interventions and data points sufficient?
1. We need to be **better at learning across our organisation**, spreading good practice and identifying why some wards, teams and departments are better able to deliver outstanding outcomes for patients – the solution to our issues is already being implemented somewhere in our Trust.	• Quality Improvement Half-Days, including shared-learning themes. • Video reflexivity • Newsletters e.g. Death Matters • Learning alerts, patient safety notices, learning alerts videos • Reflective practice, eg. Schwartz rounds • Mortality reviews
2. We need to ensure that we **consistently deliver the basics of great care**, with disciplined implementation of policies on hand-washing, medicines security, end of life decision making, and personalised care observations – we have to get this right every time.	• Ten out of Ten patient safety standards • WHO checklist • Intergrated Performance Review (IPR) KPIs • IT programme to provide decision-making and support care e.g. eBMS • VitalPac and escalation process • 'Ok to Ask' • Board rounds
3. **We need to tackle our sickness and vacancy rates** if we are to reduce gaps in our care, and ensure that all of our staff have time and space to be trained and to develop their skills – being fully staffed matters.	• 3-year Education Plan • Sickness rates • Vacancy process / time to hire statistics • Staff appraisal / PDRs • Return to work interviews • Use of sickness policy triggers • E-rostering / forward planning • Exit interviews
4. We need to **build on our best practice around local management and leadership**, empowering capable local managers, and reducing hierarchies between executive and departmental leaders – communication can be better here and must be two-way.	• Your Voice feedback loop • Leadership competencies • Leadership Management programme • Collection of events e.g. Leadership Conference, Consultant Conference
5. We need to do even more to evidence how our incident, risk management, and safety data inform the decisions that we make and the priorities that we set – **we know where our issues are, and need to address them more quickly when they are identified.**	• 'Ok to Ask' • Risk Registers • Incident reporting and action plans • Safety Plan: 2016 – 2019 • IPR KPIs • Audit processes • Multi-level themed reports, e.g. top 5 incidents

Appendix 2

CQC Improvement Plan: Delivery at at a glance

- **67** Areas for improvement, **25 'must dos'** (MD) and **42 'should dos'** (SD)
- **26** actions completed (x8 MDs, x18 SDs). Of the remainder the majority are on-track to be completed by the end of October, the original timeframe set for delivery of the Plan.

Accident and Emergency

MD1	2		
MD2	1	2	2
MD3	2		
MD4	1	2	
MD5	2	1	
MD6	1	1	
MD7	1		
MD8	2		
SD1	2	2	
SD2	2		
SD3	1		
SD4	1		

Medicine and Emergency Care

MD9	2	
MD10	2	
SD5	2	2
SD6	2	2
SD7	3	

Patients should be aware of and in agreement with their treatment plan. *(Trust-wide action)*

Surgery

MD11	1	2	
MD12	1	2	2
MD13	2	1	1
MD14	2	2	
SD8	2	1	2
SD9	1	2	2
SD10	1		
SD11	2	3	

Bank and agency staff: forward planning to avoid late requests through tightening grip on sickness and rostering processes. *(Trust-wide action)*

Children and Young People

MD15	2		
MD16	2		
MD17	1		
MD18	2	1	1
MD19	2	2	2

Maternity

SD12	2	2	
SD13	1	2	2
SD14	1		
SD15	2		
SD16	1		
SD17	1		
SD18	2		
SD19	2		
SD20	1		
SD21	2		
SD22	2		
SD23	2	2	

End of Life Care

SD24	1	
SD25	2	
SD26	1	
SD27	2	1

Outpatients and Diagnostic Imaging

MD20	1	
MD21	1	
SD28	2	
SD29	1	
SD30	3	2
SD31	1	
SD32	2	
SD33	2	
SD34	2	1	1
SD35	2	
SD36	1	

Support in outpatients for people with dementia and LD

Community: Inpatients

SD37	1
SD38	1

Community: Adults

SD39	1
SD40	2
SD41	1
SD42	1

Community: End of Life Care

MD22	1
MD23	1
MD24	2
MD25	1

Key: Action completed | 1 Segment completed | 2 On-track | 3 Off-track

Some examples of what has been achieved so far. More to do by the end of October.

a) **'OK to ask' – and act - campaign** established to support all staff who challenge risky behaviours.
b) **Monthly Quality Improvement Half-Days** introduced Trust-wide
c) Improvements to **storage, dispensing and governance of medicines** are being satisfied by purchasing two solutions – fully automated cabinets for high risk/volume areas and electromechanical locks, with access audit trail, for all residual areas.
d) **VitalPAC roll out** to paediatrics and ED to make late observations visible in eBMS.
e) A more **robust escalation process is in place for those not adhering to the hand hygiene requirements**. This includes the Executive triumvirate. Repeat escalation of individuals treated as a conduct issue.
f) New **lockable trolleys** and other storage containers **to keep patient records secure** purchased and in use.
g) Group DoNs undertaking **random checks to monitor compliance to medicines storage standards**. Reported via ward dashboards. Most areas achieving 100% on the audit,
h) The need for staff to sign the **WHO surgery checklist** removed, which goes beyond WHO requirements. Compliance audit shows 99.9% performance
i) **Resuscitation trolley checks** in place and carried out by matrons and Group DoNs
j) Surgical scheduling: An **8-6-4-2 planning cycle started**, first operating lists that have been through the process will happen on 19 October. This is being implemented across all specialties.
k) **Video reflexivity** taking place in the BMEC and being introduced in all theatres over coming months.
l) 98% of operators (123 people) all have the required **IR(ME)R competency records completed and available** (radiologists, radiographers, nuclear medicine technologists, physics staff, cardiologists, staff in ophthalmology and oral surgery and agency workers).
m) **Daily debrief expanded** to include capacity team, all groups represented and the COO.
n) **Patient First Electronic Sepsis tool** being implemented during September 2015
o) Written explanations of the governance processes provided to staff in the EDs, and local induction includes that briefing.
p) **Complaints 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.
q) All **consultant surgeons have an agreed job plan** for the current service configuration.
r) A new **3-year education, learning & development plan** signed-off by the Board.
s) **Palliative care services** moved to the Community and Therapy Clinical Group, aligning the palliative care team with the District Nurse Team who are linked to GP locations. A dedicated operational manager will support the integrated service.

Appendix 3

CQC Improvement Plan: Timeline for completion of remaining actions by 31 October 2015

Ref:	Action	Exec	21/9	28/9	5/10	12/10	19/10	26/10
Accident and Emergency								
MD1	Introduce a quarterly report showing changes made as a consequence of staff incident reporting.	KD					●	
MD2	Safety metrics specific to Groups to be designed.	CO						●
MD2	Patient representatives to join in conducted unannounced inspections every quarter in response to safety audit data	CO						●
MD3	Record keeping standards to be audited on a sample basis each month starting March 2015.	CO						●
MD4	The Infection Control team carrying out unannounced visits to check that isolation procedures are being followed.	CO			●			
MD5	Procurement of vending machines and locking system for medicines storage.	CO						●
MD8	Evaluate impact of bespoke development programme in place in the A&E departments.	RB						●
SD1	Meet the new national Sepsis CQUIN. Q1 submit baseline data, Qs 2-4 month on month improvement on Q1	RST						●
SD1	Implementing the VitalPacs system in A&E to track remotely and centrally vital signs monitoring status.	RST		●				
SD2	Raise awareness re: application of guidance on use of staff / family, based on a risk assessment, for language interpretation. • Increase bank interpreters for the top 10 languages. • Address functional problems in accessing Language Line.	CO				●		

Ref:	Action	Exec	21/9	28/9	5/10	12/10	19/10	26/10
Medicine								
MD9	Achieve 100% compliance with medicines storage standards, reported via ward dashboards. Audit proforma for medication storage in theatres in development.	CO						●
MD10	Care documentation: Revised methods being used in Surgery A which include individualised checklists in patients notes and sign off in the medical notes to demonstrate that they have been completed to ensure that the mechanisms to embed 'Ten out Ten' are more robust than over the last year. Success of these methods will be rolled out across the Trust during 2015. • Review of fluid management module of VitalPacs	CO						●
SD5	To be consistently achieving 90%+ in all mandatory training modules.	RG						●
SD5	Increase mandatory training compliance rates of junior doctors with this taking place in first few weeks of placement. New in-take joins 3/8/15	RG						●
SD6	Ensure care documentation is complete, person-centred and up-to-date. Introduce ways of further individualising and personalising care planning.	CO						●
SD6	Results of the sample audit of Care Rounds.	CO			●			
SD7	As part of care planning format review patients / carers will sign up to each plan of care. • Auditing patients are aware of and in agreement with their treatment plan.	CO						●
Surgery								
MD11	Outstanding questions regarding the post reconfiguration service model and how this relates to job plans.	RST		●				
MD12	Hand hygiene: some staff visitors to wards still not compliant all of the time.	CO				●		
MD12	Hand hygiene: repeat escalation of	CO			●			

Ref:	Action	Exec	21/9	28/9	5/10	12/10	19/10	26/10
	individuals to be treated as a conduct issue.							
MD13	Response to notes amnesty to be considered and areas for action identified addressed.	KD					●	
MD14	Develop a post-operative standard care bundle.	RST					●	
MD14	Implementation of the care bundle will be part of the Autumn audit programme.	RST						●
SD8	Electronic booking system for emergency theatres.	RST						●
SD8	Surgical scheduling – 'lock down' of elective theatre lists. 8-6-4-2 to be implemented across all specialties	RST					●	
SD9	Observational audit of WHO checklist routine and reported to TMB. All theatre sessions to be visited at least once in 2015/16.	RST		●				
SD9	Video reflexivity programme to be delivered over August, September and November.	RST					●	
SD11	Agency staff - grip being retightened. Deep dive review of locum pod model in September.	TL					●	
SD11	Rostering practices – all wards using rostering and have clear 6/8 week forward look rotas in place.	TL						●
Children and Young People								
MD15	Consider if whether there is a case to go beyond current staffing as part of examining future workforce plans.	CO	●					
MD16	Improve % of qualified nurses with PiLS. All ward managers to attend EPLS.	CO						●
MD17	W&OD Committee to review the 2015/16 training plan and budget for paediatrics to check adequacy.	RG		●				

Ref:	Action	Exec	21/9	28/9	5/10	12/10	19/10	26/10
MD18	Response to notes amnesty to be considered and areas for action identified addressed.	KD					●	
MD19	Accurate record in respect of each child – joint documentation reviewed and amended, ward managers reviewing nursing process with emphasis on planning and evaluation of nursing care. Work on-going. VitalPacs launch in Paediatrics delayed until 2015 due to technical updates being applied. Paediatric Safety Thermometer under review.	CO						●
MD19	Patient representatives to join in conducted unannounced inspections every quarter in response to these issues.	CO						
Maternity								
SD12	Measures boards in maternity and gynaecology to reflect Trust-wide standards.	CO				●		
SD12	Undertake listening and survey activity with families to understand if there is additional data on our performance that they would value being displayed.	CO				●		
SD13	Patient representatives to join in conducted unannounced inspections every quarter on hand hygiene and infection control dress code.	CO						●
SD13	Hand hygiene: repeat escalation of individuals to be treated as a conduct issue.	CO			●			
SD15	Procurement of vending machines and locking system for medicines storage.	CO						●
SD18	The dataset implied by the CQC will be routinely shared within maternity services over the coming year. Existing communication channels to be used to discuss, review and act on the data.	CO			●			
SD19	7 patient leaflets are being revised with new content and 2 new leaflets are being produced. The key patient	RW			●			

Ref:	Action	Exec	21/9	28/9	5/10	12/10	19/10	26/10
	leaflets are being translated into our top languages. Community groups to be engaged in updates to the patient information literature as well as development of films about the maternity service.							
SD21	Developing a systematic process to share the outcome of an investigation and resulting action with complainants.	KD				●		
SD23	Find a way to of increasing feedback about working for the Trust from obstetric and midwifery staff. Need to capture a plan that captures outputs of all interventions to date.	RG				●		
SD23	We will use the Kirkup Review, within our QIHDs, to develop a specific plan for maternity services at the Trust.	RG		●				
End of Life Care								
SD25	Review hospital discharge processes / preferred place for EOLC. Aligning the palliative care team with the District Nurse team who are linked to GP locations. A dedicated operational manager to support the integrated service.	RB						●
SD27	Audit data from August / September to check the eBMS DNACPR flag status.	RST			●			
Outpatients and Diagnostic Imaging								
SD28	Timely, clear and consistent communications to staff about workforce changes – SS2 post-project feedback. 2016/17 workshops. Organisational learning exercise, including industry examples of long term large scale restructuring.	TL				●		
SD30	Support for dementia and LD patients in Ops – audit arrangements for LD patients. Bid to CCG for additional senior nursing post to support LD.	CO						●
SD30	Memory loss scoring methods - plans being developed to implement screening in ophthalmology and audiology departments.	CO						●

Ref:	Action	Exec	21/9	28/9	5/10	12/10	19/10	26/10
SD32	Introduce a simple proforma to capture complaints resolutions and share the results across all OPs through QIHDs.	KD					●	
SD33	Improve privacy of patients in eye clinic – dental theatre remains to be located. May slip towards December for completion.	TL					●	
SD34	Response to notes amnesty to be considered and areas for action identified addressed.	KD					●	
SD35	Safeguard Level 2 training for all staff who run OP clinics – All trained staff booked on or completed L2 training by October. • Review of training matrix planned.	CO						●
Community Services: Adults								
SD40	Procurement of vending machines and locking system for medicines storage.	CO						●
Community Services: End of Life Care								
MD24	Ensure a variety of activities provided on a daily basis – the day hospice model is currently under review as part of the procurement of activity with the CCG.	CO						●

24 September 2015

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:	22nd September 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 the last 3 months

REPORT RECOMMENDATION:

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	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 14
TB June 15

FOR INFORMATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TEN OUT OF TEN SAFETY STANDARDS

Progress Report September 2015

Progress against 15/16 plan submitted in previous report June 2015 (section 3.2)

1.0 Organisational Strategy

Ten out of Ten included in Annual Plan, BAF and Quality Accounts at strategic level

2.0 Communication Strategy

- Provision of banners in top 5 languages has now been placed in public areas to raise awareness with our ethnically diverse communities.

- Screen saver which promotes person centred care includes Ten out of Ten were put in place during September.

CARE PLANS ARE BEING REVIEWED TO FURTHER PROMOTE PATIENT CENTRED CARE AND SUPPORT DELIVERY OF OUR TEN OUT OF TEN PATIENT SAFETY STANDARDS

The developments will support our ward teams to make Care Plans more personalised for every patient by setting objectives in response to needs and risks identified during the assessment process (e.g. fluid management, discharge needs, referrals). These risks should be discussed and escalated as part of multi-disciplinary review, board rounds and ward rounds.

If you need to know more about the plans and what is expected, please talk to your Matron, Ward Manager or Debbie Talbot - Deputy Chief Nurse.

Visit the
Nursing & Facilities Connect Page
to access Care Plans, Checklists and Updated Patient Bedside Folder Content

- Connect page launched under Corporate Nursing to promote revised documentation and Ten out of Ten included in care plan library

3.0 Patient Safety

- Initial discussions have taken place with specialist areas to develop Ten out of Ten safety standards checklist for eyes, paediatrics, community, CCU etc.

- In response to work undertaken in surgery individual patient safety standard checklists have been designed in the same format as the Single Assessment and Care Rounds Documents. The design and format is in line with the revised Care Plans to provide an aide memoire to staff and can be held as a record of events in the patient's health care records.

- Patient bedside folder under review to up-date generic information such as nursing roles etc.

4.0 Patient Experience

Patient Satisfaction Surveys:

Question: Do you feel that Patient Safety Standards are given a high priority at our hospital? Please give reasons to help us make improvement.

This question was part of the larger Patient Experience Survey carried out over a period of **Apr– Jun 2015**. A total of **1280 patients** responded to this question with the following responses:

- Yes: 1091 (85%)
- Yes, sometimes: 175 (14%)
- No: 14 (1%)

Period of **01 Jul– 15 Sept 2015**. A total of **526 patients** responded (about 50% less respondents to this question compared to last quarter) with the following responses:

- Yes: 478 (91%)
- Yes, sometimes: 44 (8%)
- No: 4 (1%)

Comments

"I just felt safe".

"Staff always clarify my name with my wrist band before administering medication and carrying out observations so that no mistakes are made".

"I don't know what the safety standards are so the question is vague. However, the staff members always made sure that I was safe as an individual."

4.0 Clinical Effectiveness

- At operational level the clinical groups have included ten out of ten in ward performance dashboards.
- Prevalence audits undertaken monthly.
- IPR reflects that indicators are not meeting 100% standard.

TEN OUT OF TEN TARGET for 2015/16
Ward results as at 19th August 2015

Ward	No. of patients audited (Numerator)	Total Number of Patients that met 10/10 Standards (Denominator)	TOTAL Percentage
D5	17	17	**100%**
D7	17	17	**100%**
D11	21	21	**100%**
D12	5	5	**100%**
D15	22	22	**100%**
D21	18	18	**100%**
D25	11	11	**100%**
D26	21	21	**100%**
D27	15	15	**100%**
D43	21	21	**100%**
D47	18	18	**100%**
Eye Ward	3	3	**100%**
N2	12	11	**92%**
P2	20	20	**100%**
L2	15	15	**100%**
N3	21	21	**100%**
N4	28	28	**100%**
L4	20	20	**100%**
P4	19	19	**100%**
N5	13	13	**100%**
L5	25	24	**96%**
P5	34	33	**97%**
AMU A	28	23	**82%**
AMU B	17	17	**100%**
AMU 1	1	1	**100%**
Henderson	23	19	**83%**
Leasowes	18	18	**100%**
ET	17	13	**76%**
SAU	0	0	
SSAU	0	0	
AMU 2	8	7	**88%**
L3	27	27	**100%**

M1	15	14	**93%**
M2	13	13	**100%**
D17	14	10	**71%**

- N2, L5, P5, AMU 2 & M1, failed to complete all ten standards for 1 patient.
- Henderson, D17 & ET failed to complete all ten standards for 4 patients.
- AMU A failed to complete all ten standards for 5 patients.
- CCS both Sandwell & City failed to submit the audit every month**.**

5.0 Next steps

- For inclusion in Patient Safety Plan as key priority.
- Continue promoting in all MDT meetings and discuss at part of assessment and care planning activity on Board and Ward Rounds. Escalate as indicated.
- Promote deep diving within the clinical groups where wards are not improving key quality indicators which form part of Ten out of Ten.
- Supportive teaching material being developed to aide deep diving and coaching activities.
- Review local and operational dashboard to indicate which standards are not met.
- Review of ward boards /checklist – redesign, consider electronic answer.

6.0 Recommendations

- Accept the report.
- Promote Ten out of Ten during Executive walkabouts.

Colin Ovington,
Chief Nurse
22nd September 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Reducing readmissions**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Neil Roger Deputy Chief Operating Officer**
DATE OF MEETING:	**1st October 2015**

EXECUTIVE SUMMARY:

Readmissions are defined as the percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after an admission. We compare with other Trusts for readmissions following an initial elective admission, but our rate of readmission following an initial emergency admission is high. Our current rate of readmission is 8.4% cumulative for the previous 12 months.

Our objective is to reduce the readmission rate by 2%. There has been a project team working on readmission for some time now, that has designed ways of working and approaches to developing clinical and discharge pathways that support a reduction in readmissions, but to date there is no evidence of a sustained nor consistent approach to improvement.

Learning from the success of implementing change through focused improvement initiatives such as the recent Urgent Care Challenges, the approach to readmissions will be tackled through a focus week in October.

The refreshed project delivery will be followed by some moderate term development over the remainder of the year with partners input.

REPORT RECOMMENDATION:

The Trust Board are asked to discuss the improvement plan and approach to reduce readmissions.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

BAF

PREVIOUS CONSIDERATION:
Quality and Safety Committee

Annual priority update: Reducing Readmissions

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

1. Introduction

Within the domain of Safe High Quality Care is an annual objective to tackle and reduce readmissions.

Readmissions are defined as the percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after an admission. We compare with other Trusts for readmissions following an initial elective admission, but our rate of readmission following an initial emergency admission is high. Our current rate of readmission is 8.4% cumulative for the previous 12 months.

2. Current position

The appendices show the top 6 specialties for readmissions following an initial emergency admission which are:

Speciality	Readmission rate (April to July 2015), source CHKS
Acute medicine	15.6% (Peer is 11.8%)
Gastroenterology	14.5% (Peer is 6.4%)
Elderly care	18.3% (Peer is 15%)
Cardiology	12.6% (Peer is 7.9%)
Respiratory medicine	18.5% (Peer is 12.3%)
General surgery	11.2% (Peer is 5.3%)

The speciality slides show condition based readmissions and the reduction required per week to deliver the overall 2% reduction.

3. Work to date

LACE tool

To predict the likelihood that a patient would be readmitted there are a number of quantifiable factors that can contribute. A review of a group of patients readmitted determined the patients age, comorbidity, recent hospital activity and length of stay are indices that can form the basis of a tool

to predict those patients with a 'high potential' to readmit. Our local work is based on the LACE Tool, developed by a Canadian team Krielkamp et al, in Ontari.

Our local work also has observed patients living alone are more vulnerable to readmission in some speciality groups.

LACE is an automatically generated symbol on the Trust's electronic bed management system (eBMS) and gathers information on patients and scores them against the following criteria:

- Length of stay
- Acuity of admission
- Case mix of the patient
- Number of ED attendances within the past 6 months

Scores are weighted and only patients with a high score currently generate a symbol. When the symbol is generated on the eBMS system by clicking onto the symbol  a discharge checklist is generated which then needs to form the basis of a conversation with the patient and carer, including advice to try and prevent further admission. Once the discharge checklist is printed the symbol turns green.
This information should be used to review the discharge plans for these patient, ensuring discharge plans with relevant primary, community and social care partners are made to prevent readmission.

Readmissions work in AMU

It is logical to come point and demonstrated elsewhere that follow up of patients soon after discharge by a health practitioner can reduce readmission. A recent piece of work on 2 of our medical wards, 90 patients who were first line triaged at high risk of readmission, were called by a member of the ICARES Admin Team to review with a 'script' how patient were getting on at home. 76 patients were subsequently contacted by a Community Matron. Of this 76 following an initial telephone conversation with the patient/carer resulted in:

- 8 patients requiring an urgent visit (same day) to avoid re-admission
- 11 were triaged as high priority and a visit arranged with the most appropriate speciality team (within 72 hours)
- 35 after discussion were given a routine appointment (visit within 15 days of contact) and issued with advice and PCAT telephone number should the need arise to arrange a visit for admission avoidance

This follow up process successfully avoided readmissions through personalising the level and response of community care should be more widely rolled out.

Specialty level design of improvements

Speciality focus has been on condition based readmission profiles. The top conditions that result in readmission are shown in the appendices for the top 6 specialties. Specialties leads have been engaged in redesign of care pathways but we are yet to see impact on the actual readmission rates.

In essence, the work to date enables clinical teams to easily identify the patients at risk of readmission. There has been conceptual work in terms of redesign of pathways but the

implementation of consistent processes, discharge pathways and MDT review of our most frequently admitted patients has not made sufficient progress.

4. Developing an improvement plan

A change of tact is necessary to now make the progress in achieving the reduction in readmissions we aspire to of 2%. The next phase must be about haw we successfully deliver and implement change.

Learning from the Urgent Care Challenge Weeks, a focus week starting on the 12th October aims to embed practice already designed for reducing readmissions through the following approaches:

- The focus week incorporates the Trust Consultant Conference, where readmissions will be a focus of that agenda.
- On the same day we will utilise the scheduled Quality Improvement half day to facilitate MDT reviews for the top 6 specialties with the most frequent readmissions. The outcome will identify patient level clinical plans for safe treatment and admission avoidance in the community as well as the identification of themes to avoid further readmissions across our patient population. This review will include partners from social services, community services, mental health and primary care.
- The focus week will have a Project Management Office (based in the capacity office) which will track 4 hourly the readmission activity, LACE assessment and discharge planning. A number of underpinning impact key performance indicators will be tracked.
- A multi-professional daily learning opportunity at 12.30 will follow 2 patients at risk of readmission through their discharge process
- Issues logs and a determination to empower and implement solutions at source , supported by a robust communication campaign will be part of the focus week.
- Implementation of the ICARES “pull” model from the assessment units and case management in the community following a pilot will see patients assessed for rapid community contact and follow up post discharges.
- Development of electronic alerts to community teams when target patients present at ED will be part of the moderate term work that will progress that week.
- Feedback to commissioners on nursing and residential homes with a high rate of readmission.
- Implement a structured process for medication reconciliation for all admissions 7 days a week.
- Targeted use of supportive clinician peer review where there is variation between consultant performance on readmissions within speciality.
- Expedite roll out of electronic discharge summary and identification of “likely to readmit” patients.

In addition the following areas will deliver over Q3 a contribution towards reducing readmissions:

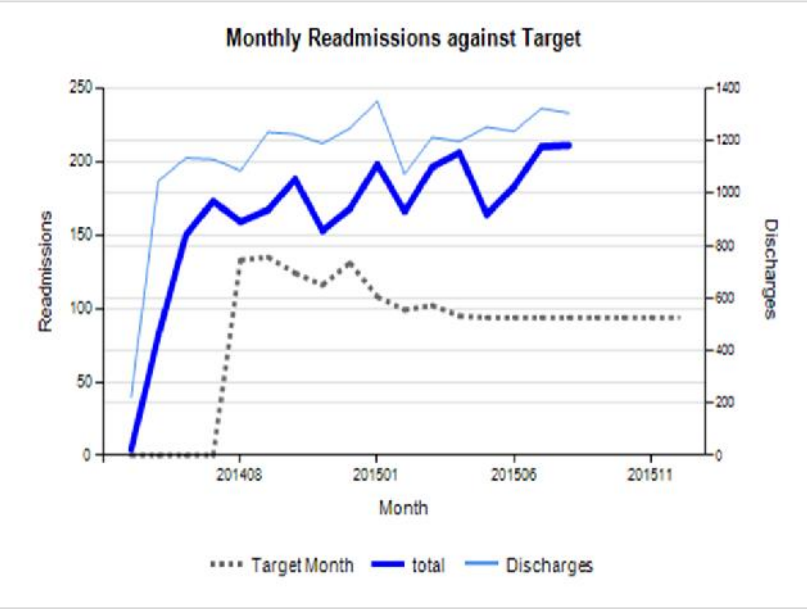
- Accountability of commissioners to ensure that effective chronic disease management is in place in primary care.
- Review of Directory of Services to publicise all alternatives to hospital attendance and active engagement / feedback with 111 provider.

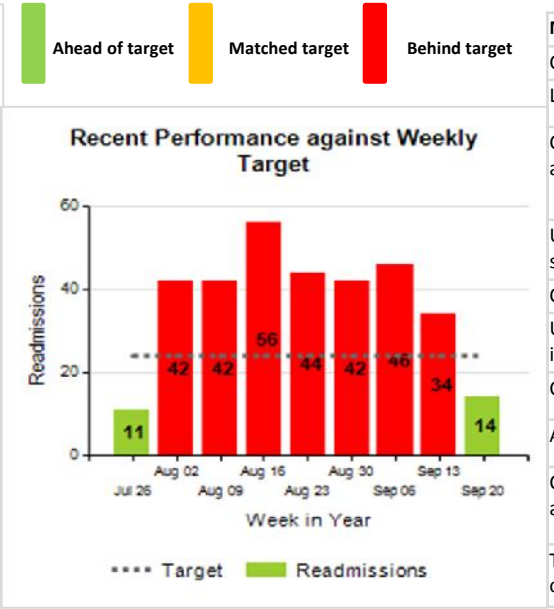
- Work with the 111 and WMAS services, to pilot patient level triggers for patients at risk of readmission and clear alternative and appropriate pathways for admission avoidance
- Review and potential expansion of scope of “FrailSafe” model for elderly patients.
- Thorough understanding of rapid rebounds, given the high volume of readmissions within 1-3 days of discharge, and agreement of strategies to manage this (eg hot clinics, nurse hotline, online support or virtual phone follow up.)

4. Conclusion

The work to date has not made impact on readmission rate. A new approach is being taken to implementation of consistent risk assessment, discharge planning and delivery of condition level pathways. Wok with partners is essential to the success of this objective. The intention is to brief the board on the output of the focus week in December. The Board is asked to discuss and support the improvement approach to reducing readmissions.

Specialty Readmission Trajectories





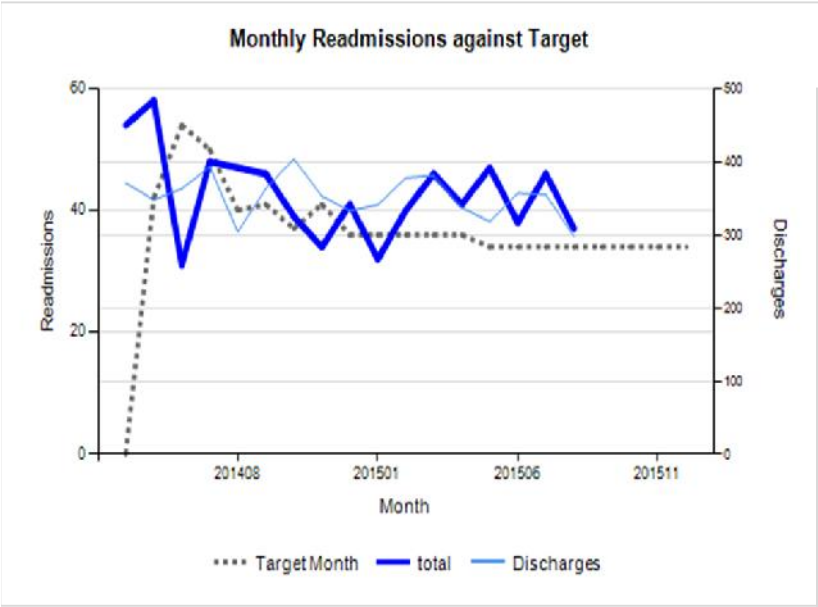
Top 10 Initial Diagnosis resulting in Readmission

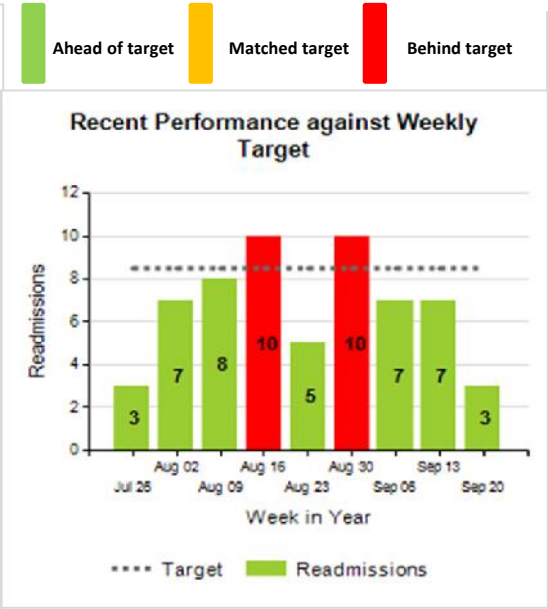
Main Diagnosis	Year	Month	Week
Chest pain, unspecified	164	13.7	3.4
Lobar pneumonia, unspecified	82	6.8	1.7
Chronic obstruct pulmonary dis with acute lower resp infec	78	6.5	1.6
Urinary tract infection, site not specified	68	5.7	1.4
Other chest pain	64	5.3	1.3
Unspecified acute lower respiratory infection	58	4.8	1.2
Cellulitis of other parts of limb	52	4.3	1.1
Atrial fibrillation and flutter	46	3.8	1.0
Chron obstruct pulmonary dis wth acute exacerbation, unspec	46	3.8	1.0
Tendency to fall, not elsewhere classified	46	3.8	1.0

ACUTE MEDICINE

April 15 – July 15
Readmission Rate 15.6%

Readmission Target is calculated from comparing SWBH against Upper Qtile of Peer Trusts by case mix volume, source: Dr Foster Readmission data from SWBH data sources using 30 day Readmissions





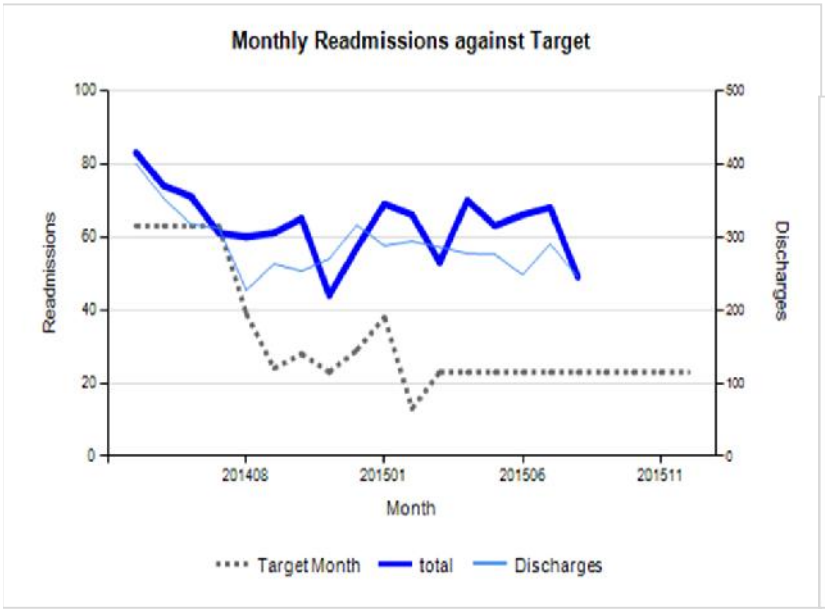
Top 10 Initial Diagnosis resulting in Readmission

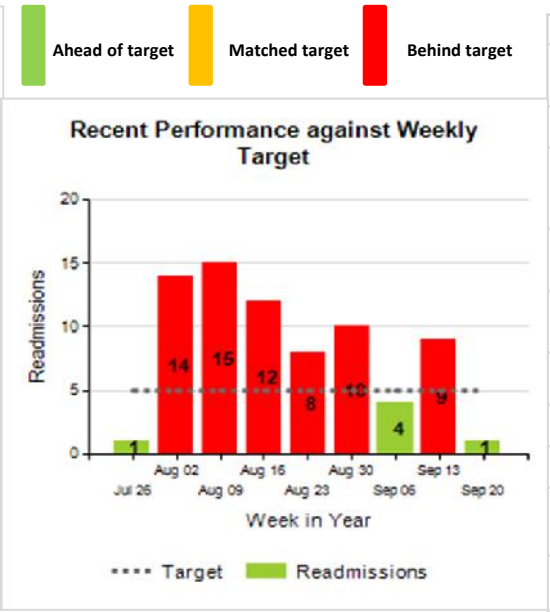
Main Diagnosis	Year	Month	Week
Atherosclerotic heart disease	62	5.2	1.3
Acute subendocardial myocardial infarction	46	3.8	1.0
Chest pain, unspecified	36	3.0	0.8
Congestive heart failure	34	2.8	0.7
Atrial fibrillation and flutter	30	2.5	0.6
Acute transmural myocardial infarction of inferior wall	28	2.3	0.6
Acute transmural myocardial infarction of anterior wall	22	1.8	0.5
Syncope and collapse	20	1.7	0.4
Acute myocardial infarction, unspecified	10	0.8	0.2
Unstable angina	10	0.8	0.2

Cardiology

April 15 – July 15
Readmission Rate 12.6%

Readmission Target is calculated from comparing SWBH against Upper Qtile of Peer Trusts by case mix volume, source: Dr Foster Readmission data from SWBH data sources using 30 day Readmissions





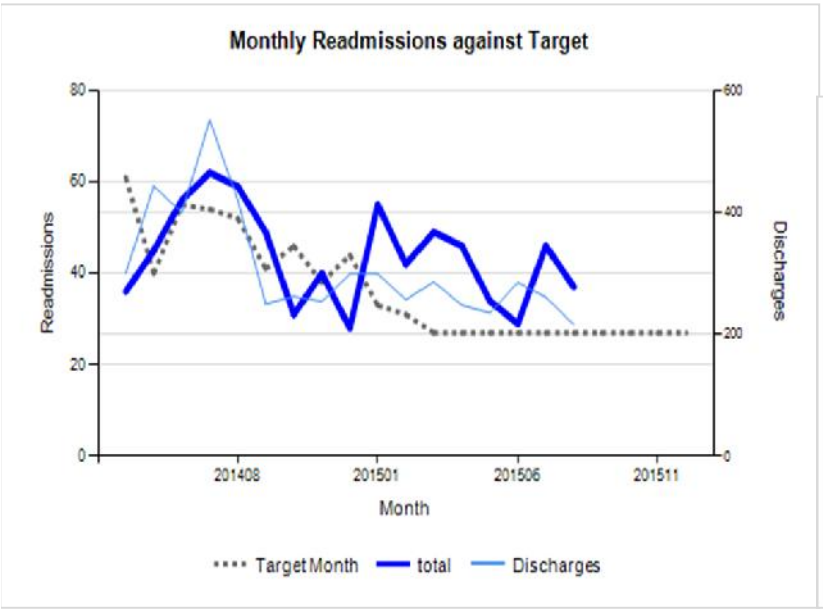
Top 10 Initial Diagnosis resulting in Readmission

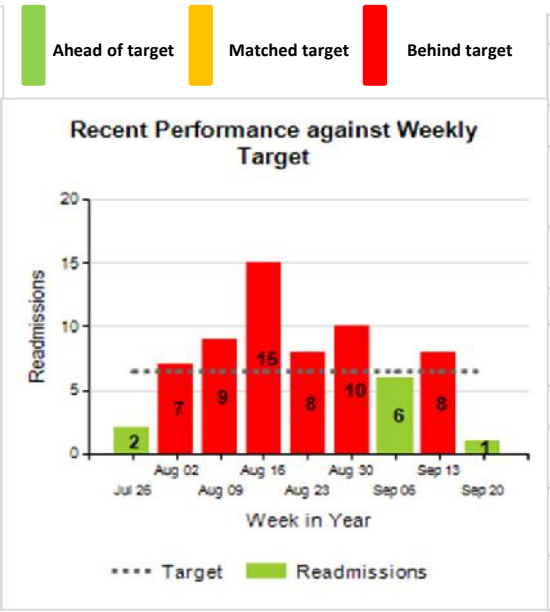
Main Diagnosis	Year	Month	Week
Urinary tract infection, site not specified	44	3.7	0.9
Lobar pneumonia, unspecified	36	3.0	0.8
Chronic obstruct pulmonary dis with acute lower resp infec	36	3.0	0.8
Unspecified acute lower respiratory infection	26	2.2	0.5
Tendency to fall, not elsewhere classified	22	1.8	0.5
Pneumonia, unspecified	20	1.7	0.4
Cellulitis of other parts of limb	20	1.7	0.4
Acute renal failure, unspecified	18	1.5	0.4
Congestive heart failure	16	1.3	0.3
Pneumonitis due to food and vomit	12	1.0	0.3

Elderly Care

April 15 – July 15
Readmission Rate 18.3%

Readmission Target is calculated from comparing SWBH against Upper Qtile of Peer Trusts by case mix volume, source: Dr Foster Readmission data from SWBH data sources using 30 day Readmissions





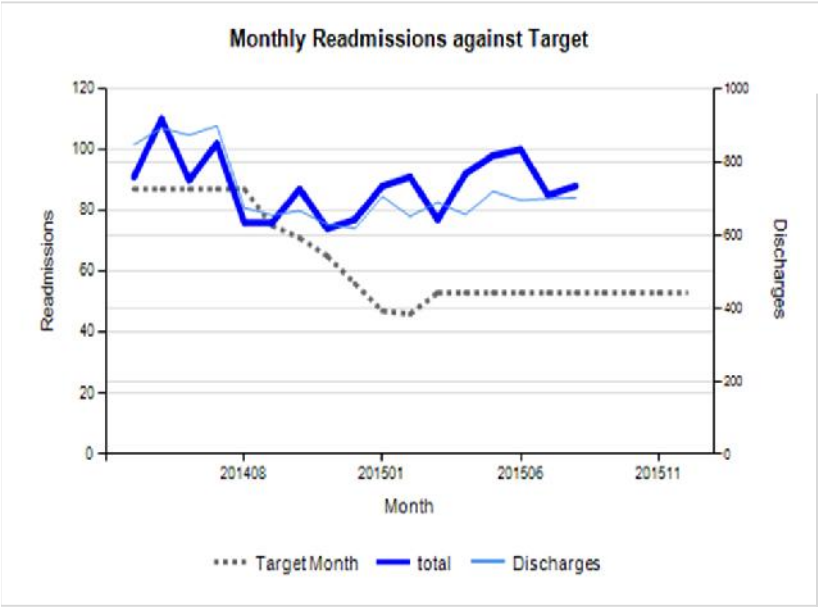
Top 10 Initial Diagnosis resulting in Readmission

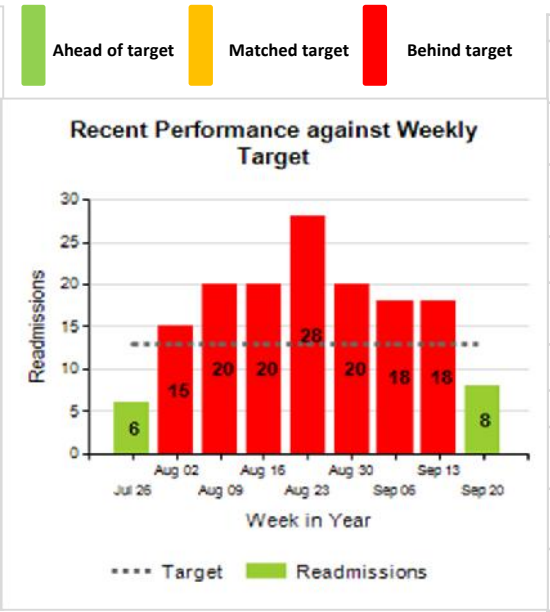
Main Diagnosis	Year	Month	Week
Gastroenteritis and colitis of unspecified origin	26	2.2	0.5
Lobar pneumonia, unspecified	22	1.8	0.5
Urinary tract infection, site not specified	16	1.3	0.3
Gastrointestinal haemorrhage, unspecified	14	1.2	0.3
Ascites	14	1.2	0.3
Chronic obstruct pulmonary dis with acute lower resp infec	10	0.8	0.2
Unspecified jaundice	10	0.8	0.2
Tendency to fall, not elsewhere classified	10	0.8	0.2
Unspecified acute lower respiratory infection	8	0.7	0.2
Pneumonitis due to food and vomit	8	0.7	0.2

Gastroenterology

April 15 – July 15
Readmission Rate 14.5%

Readmission Target is calculated from comparing SWBH against Upper Qtile of Peer Trusts by case mix volume, source: Dr Foster Readmission data from SWBH data sources using 30 day Readmissions





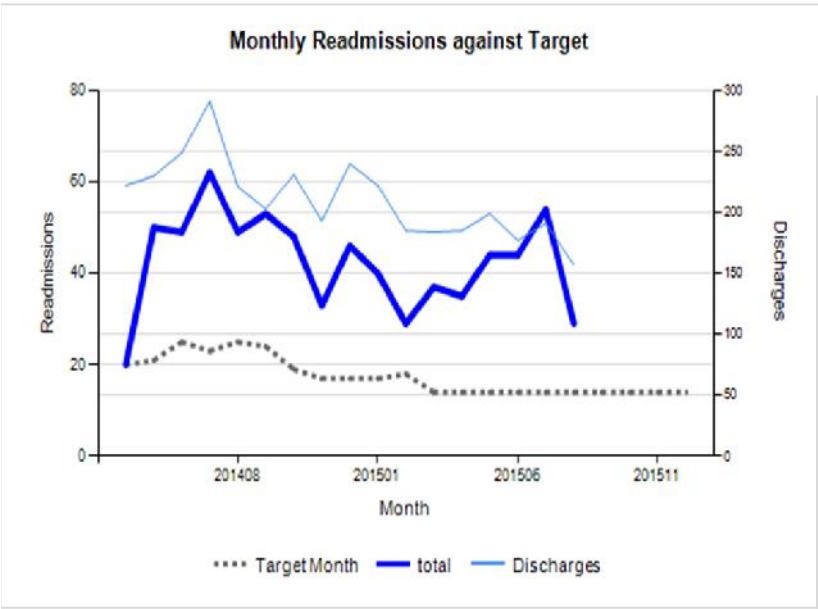
Top 10 Initial Diagnosis resulting in Readmission

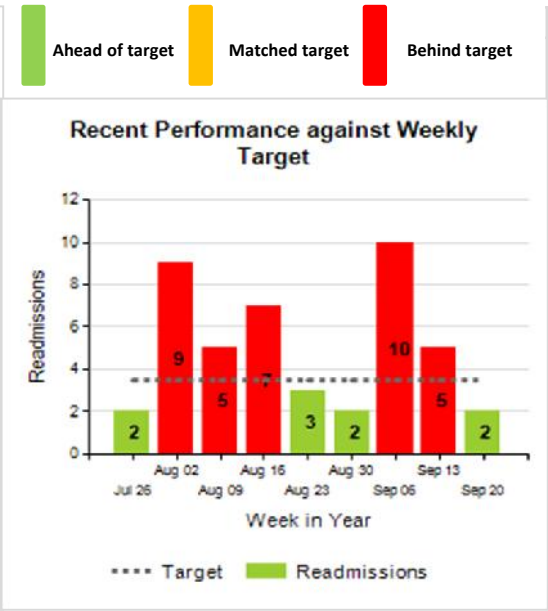
Main Diagnosis	Year	Month	Week
Other and unspecified abdominal pain	106	8.8	2.2
Pain localized to other parts of lower abdomen	50	4.2	1.0
Pain localized to upper abdomen	46	3.8	1.0
Constipation	42	3.5	0.9
Cutaneous abscess, furuncle and carbuncle of trunk	40	3.3	0.8
Pilonidal cyst with abscess	40	3.3	0.8
Anal abscess	38	3.2	0.8
Cutaneous abscess, furuncle and carbuncle of limb	22	1.8	0.5
Volvulus	20	1.7	0.4
Calculus of gallbladder without cholecystitis	18	1.5	0.4

General Surgery

April 15 – July 15
Readmission Rate 11.2%

Readmission Target is calculated from comparing SWBH against Upper Qtile of Peer Trusts by case mix volume, source: Dr Foster Readmission data from SWBH data sources using 30 day Readmissions





Top 10 Initial Diagnosis resulting in Readmission

Main Diagnosis	Year	Month	Week
Chronic obstruct pulmonary dis with acute lower resp infec	60	5.0	1.3
Lobar pneumonia, unspecified	46	3.8	1.0
Chron obstruct pulmonary dis with acute exacerbation, unspec	24	2.0	0.5
Pleural effusion, not elsewhere classified	22	1.8	0.5
Unspecified acute lower respiratory infection	20	1.7	0.4
Congestive heart failure	10	0.8	0.2
Status asthmaticus	10	0.8	0.2
Urinary tract infection, site not specified	10	0.8	0.2
Atrial fibrillation and flutter	8	0.7	0.2
Bronchiectasis	8	0.7	0.2

Respiratory

April 15 – July 15
Readmission Rate 18.5%

Readmission Target is calculated from comparing SWBH against Upper Qtile of Peer Trusts by case mix volume, source: Dr Foster Readmission data from SWBH data sources using 30 day Readmissions

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Community caseload: forward development programme**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow - Chief Operating Officer**
AUTHOR:	**Amanda Geary Director of Operations for Women and Children** **Fiona Shorney – Group Director for Community and Therapies**
DATE OF MEETING:	**1st October 2015**

EXECUTIVE SUMMARY:

Following a Quality Improvement Half Day focus event, hosted by 2 of our clinical groups that have community facing services, this paper provides an introduction to those services and a forward view on the joint development plan between Adult Community services and our community services aligned to maternity, health visiting and children's services.

Over the next 6 months:

- Fully implement GEL solutions acuity and caseload planning tool
- Develop KPI to monitor patient contact time
- Single point of access and triage pathways will be reviewed
- Smart scheduling systems will be embedded
- A review of 7 day services to 'smooth ' activity profiles and caseload over the week that is resourced
- Reduce unnecessary multi-practitioner input though better scheduling of treatment plans and skilling up of staff for non-complex clinical care across a multi-professional team
- Improve mobile IT infrastructure for staff

REPORT RECOMMENDATION:

Consider the forward plan to achieve improved caseload management in the community .

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

Comments:

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

BAF

PREVIOUS CONSIDERATION:

Annual priority update: Tackling Community caseloads

Priority for 2015-16	How were we performing at the start of 2015/16?	Where do we need to get to?
Tackling caseload management in community teams	• **Successful implementation of new IT tools to make caseload management more visible and part of our management of performance**	• **All nursing caseloads (at team level) reduced to median in Black Country** • **Patient contact time increased by 10% among district nurses, health visitors and midwives**

1. Introduction

Within the domain of Safe High Quality Care is an annual objective to tackle the management of community case loads.

For the purpose of this report the community teams included are from Community and Therapies Clinical Group (C&T CG) and Women and Child Health Clinical Group (WCH CG), namely:

- District Nurses (DN) C&T CG
- Community Midwifery (CMW) WCH CG
- Health Visiting WCH CG
- Children's Therapies WCH CG – which includes Speech and Language therapists, physiotherapists and occupational therapists
- Community Children's Nurses WCH CG – which includes acute / chronic children's nurses, special education nurse team (SENT), complex care team and palliative care team

2. Current position

2.1 Caseloads and venues

The five community services within the groups have been reviewed for total caseload numbers, wte numbers of staff, average practitioner caseloads and work bases; the findings are detailed below.

Service	Total caseload	WTE	Practitioner caseload (average)	Work bases
District Nurses	2558	151.78	17	Home and clinics
Community Midwifery	10,000	91.3	115 funded 144 actual	Home, GP practices, Children's centres
Health Visiting	27,000	85.6	320	Home, GP practices, Children's centres, nurseries
Children's therapists	4,647	41.07	113	Schools, home and clinics
Children's Nurses	590	27.6	Varies	Schools, nurseries, home and clinics

District Nurses work through 7 teams and 23 GP practices and workload includes red (urgent, unplanned) pathways and green (more routine, planned) pathways.

Community Midwifery caseloads are driven by the number of pregnant women in Sandwell and West Birmingham areas (ideal caseloads for the population demographics is 95 women per 1.0 wte) and the contact with women is prescribed and delivered in line with NICE guidance and college standards.

Health Visiting caseloads are driven by the number of 0-5s in the Sandwell borough with 5 key visits mandated. For this population, a caseload of 250 is the ideal.

Children's Therapy Services (Physiotherapy, Occupational Therapy, Speech & Language Therapy) - Children's therapists' caseloads are dictated by demand (some children are duplicated as they sit with more than one specialty)

Children's Community Nurses – the total caseload is 590 and is delivered by the four teams as detailed in the table below.

Acute/Chronic post discharge	100
Special Education Team (Special and mainstream)	450
Complex Care (Continuing Healthcare Needs)	8
Palliative Care	32

2.2 Activity and monitoring

Also reviewed were activity monitoring tools, acuity monitoring tools and single point of access (SPA) availability. The findings are detailed below.

Service	Activity monitoring tool	Use of acuity tool	Single Point of access
District Nurses	Systm1	GEL plus Systm1	Yes
Community Midwifery	BadgerNet	None – although high risk and low risk numbers are available on BadgerNet.	Yes – Midwifery hub
Health Visiting	Systm1	Systm1	Yes – Health Visiting Admin hub
Children's therapists	Systm1	Caseload weighting dependency tool	Yes – FASTA (Faster access to Sandwell therapy assessment)
Children's Nurses	Systm1	Due to review use of GEL	No – due to implement FASTA

Over Quarter 1, a caseload management tool has been procured in adult community services to provide real time capacity information by combining staff availability with patient dependency to provide visualisation of current and future workload projections across the teams. There is currently no national capacity management tool but on-going partnership working with BCHC colleagues facilitated discussions with GEL Data Solutions following their successful pilot.

The tool will capture the known daily need for each patient and their future care plan and visit schedule. Specifically the tool will provide information regarding dependency gaps, team caseload (number of active patients, number of palliative patients, discharges and deaths), analysis by referring GP and team caseload comparisons.

Unfortunately full implementation of the caseload capacity tool has been delayed because TPP, the provider of Systm1, the EPR used by community services made sudden, unannounced changes to the system making the interface with Gel Solutions tools and data extraction from Systm 1 extremely difficult. The issue has been logged with IT via Sarah Cooke as access to these data files will save staff time due to the frequency with which patients care plans have to be updated to address their changing needs.

In the meantime we continue the preparatory work to develop the electronic roster system that needs to be in place and the development of specific work units and time allocations to inform our baseline caseload activity and dependency at practitioner level. Work to date is currently being analysed in detail.

Appendix 1 shows a screen shot example for some of the District Nurse Teams for weeks commencing 14th and 21st September.

In the absence of anything that is nationally recognised Community Therapies are currently using a caseload weighting tool/effectiveness rating in conjunction with a locality caseload supervision session held termly. However this is not deemed appropriate for nursing caseload management.

Children's nursing teams are reviewing the use of the GEL tool.

2.3 7 day working

In addition – a review of 7 day working in the services was undertaken – results as below:

Service	Required	Available
District Nurses	Yes	Yes
Community Midwifery	Yes	Yes
Health Visiting	No	n/a
Children's therapists	No	n/a
Children's Nurses	Yes	Yes (acute team 6 days only)

3 Developing an improvement plan

A number of themes had been scoped to be included in a programme of work to achieve the objective which aims to increase patient contact time by 10%. A joint QIHD was held with the 5 services and was the first time these community services had come together but served as a springboard to generate new ideas and develop potential harmonisation of working practice.

- **Review the Single Point of Access and triage model**

  Within Children's Nursing there is currently no formal SPA but there are some good examples of 'hub' working for complex / safeguarding patient pathways. The Clinical Lead is

looking at the feasibility of rolling out FASTA across the nursing service. Best practice will be reviewed and a recommendation made for the future operating service models.

All other services have a SPA.

- **Smart scheduling**

  Scheduling is largely done at practitioner level through both paper and electronic means which is appropriate provided there is accessibility to appropriately interfaced scheduling tools via mobile devices. There is opportunity to standardise scheduling to optimise time available for time for clinical care and reduce administration and travel through improved scheduling.

  Community Adults and Children's Therapies and Paediatric teams utilise scheduling and EPR on SystemOne and Children's Nursing are now using it for EPR and will be extending to utilise scheduling.

  The District Nursing caseload includes red (urgent) and green (planned) work. During the working day new, urgent work (eg blocked catheter) will be referred. Invariably this means that the planned schedule for the day is disrupted and the nurse becomes distracted and anxious regarding the impact this will have on her patients. To resolve this, the plan is for each team to have a dedicated 'red' worker roster. We are also reviewing the benefit of District Nurse input in to the contact centre at the point of triage.

  Within Adult and Children's nursing services work to become paperlite by eliminating dual capture of records on paper and via Systm1 is on-going but slow. To facilitate further progression IT has provided a dedicated member of staff to work with us on this.

  All services are working with GP practices, children's centres etc to rationalise clinics and increase clinic capacity to minimise home visits where possible and appropriate – improving productivity.

- **7 day services**
  Community midwives provide a 24/7 service.
  Adult services operate 08:00 – 20:00 over 7 days. Children's Therapies operate 08:00 – 17:00 Monday to Friday. There are no plans or requirement in the immediate future to extend to 7 days. There is a 6 day service for the acute children's team and 24/7 for the continuing care service services.
  With children's services a considerable amount of their work is within schools so there is no requirement to work 7 days.
  Both services have peak activities on Mondays and Friday despite different operating models. The intention is to use the capacity tools to 'smooth' the unnecessary variation in patient activity over 7 days impacting on caseload by day of week.

- **Multiple practitioner input**
  Benchmarking multiple practitioner input to patients in the community and developing competency based skills for non- complex interventions, could impact on caseload by reducing duplicate visits and improve patient experience.

  In iCares the plan is to pilot the co-location of services to include PCAT Admission Avoidance, Heart Failure, Respiratory and IV clinics working to a joint rota across 7 days reducing handovers to maximise efficiency and efficiency.

We also intend to maximise the assistance of services such as Age Concern and the voluntary sector. They are keen to work with us and referrals to these services at the point of triage will ensure professional staff can direct their time appropriately

- **Improving technology**
  All community staff need access to mobile, lightweight devices to facilitate EPR and electronic scheduling. In addition – the availability of mobile devices in patient homes should be considered to support tele medicine consultations.

  The services would benefit from dedicated IT support to scope requirements, support roll out and provide on-going IT support to the teams.

Key milestones:

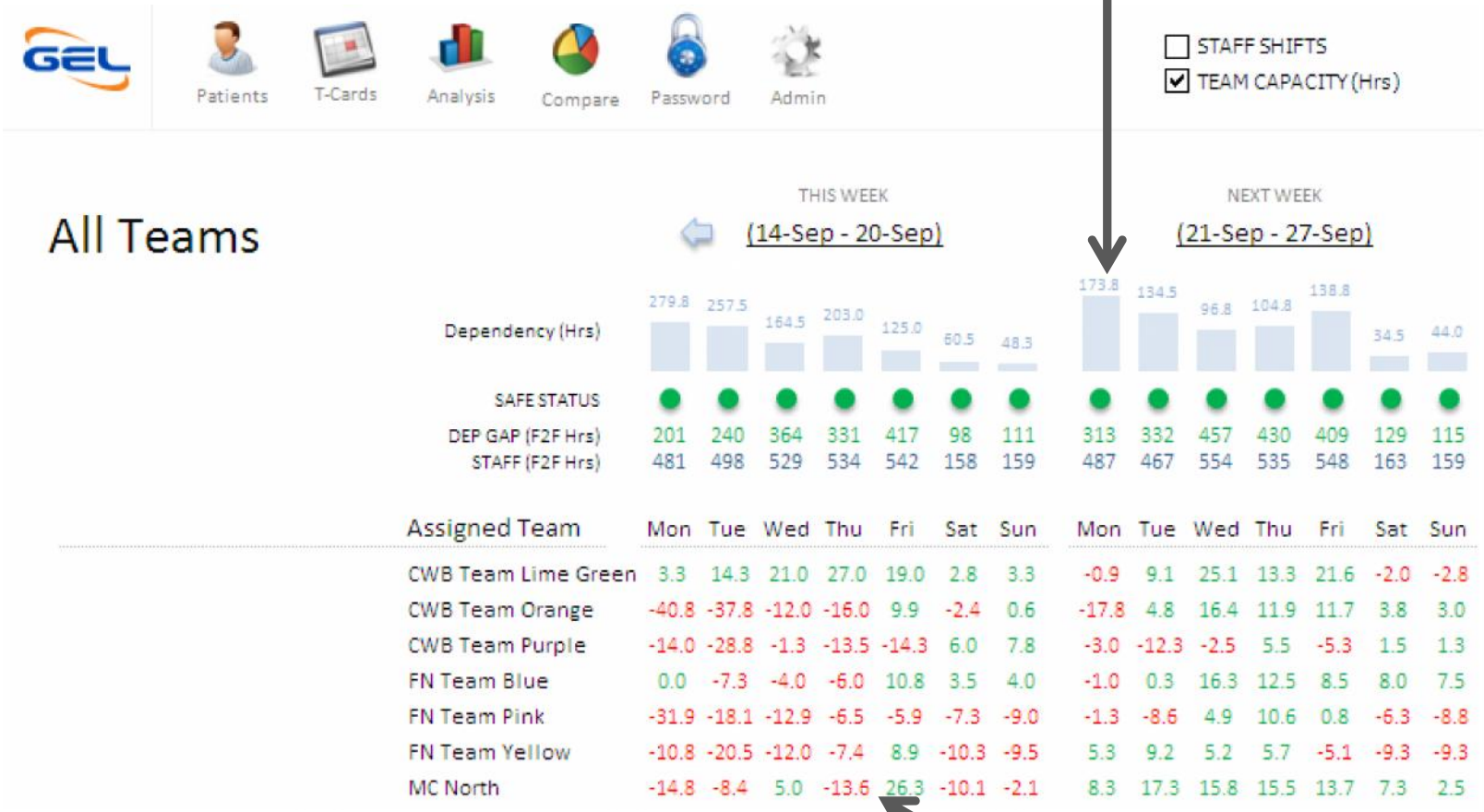
- Resolve data extraction issues with Systm1 (end of Oct 2015)
- Operational demonstration of GEL solution to the paediatric team (end of Oct 2015)
- Pilot red / green rostering in adult service (end of Nov 2015)
- Analysis of GEL outputs (end of Dec 2015)
- Implement FASTA in community paediatrics (end of Dec 2015)
- Review progression to paper light in adult and children nursing (end of Dec 2015)
- Co-locate adult community services with joint rotas (end of Dec 2015)
- Review scoping exercise for IT improvements / developments (end of Jan 2016)
- Review use of GEL in paediatrics (end of Jan 16)

4. Conclusion

The initial work between Community & Therapies and Women and Children has been encouraging and beneficial. Both services acknowledge that maximising patient contact time is a key priority and service leads have agreed to meet on a bi-monthly basis and update the Trust Board in February 2016 on the outcome of developments.

APPENDIX 1

Shows the total clinical hours required for the day



Assigned Team	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
CWB Team Lime Green	3.3	14.3	21.0	27.0	19.0	2.8	3.3	-0.9	9.1	25.1	13.3	21.6	-2.0	-2.8
CWB Team Orange	-40.8	-37.8	-12.0	-16.0	9.9	-2.4	0.6	-17.8	4.8	16.4	11.9	11.7	3.8	3.0
CWB Team Purple	-14.0	-28.8	-1.3	-13.5	-14.3	6.0	7.8	-3.0	-12.3	-2.5	5.5	-5.3	1.5	1.3
FN Team Blue	0.0	-7.3	-4.0	-6.0	10.8	3.5	4.0	-1.0	0.3	16.3	12.5	8.5	8.0	7.5
FN Team Pink	-31.9	-18.1	-12.9	-6.5	-5.9	-7.3	-9.0	-1.3	-8.6	4.9	10.6	0.8	-6.3	-8.8
FN Team Yellow	-10.8	-20.5	-12.0	-7.4	8.9	-10.3	-9.5	5.3	9.2	5.2	5.7	-5.1	-9.3	-9.3
MC North	-14.8	-8.4	5.0	-13.6	26.3	-10.1	-2.1	8.3	17.3	15.8	15.5	13.7	7.3	2.5

Numbers in red identify days where the clinical need outweighs the about of resource available

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Tackling Sickness Absence**
SPONSOR (EXECUTIVE DIRECTOR):	**Raffaela Goodby, Director of Organisational Development**
AUTHOR:	**Raffaela Goodby – Director of Organisation Development** **Lesley Barnett, Head of Workforce (Deputy Director)**
DATE OF MEETING:	**1st October 2015**

EXECUTIVE SUMMARY:

The Trust's sickness absence rates remain a serious concern and remains flagged as red on the Trust Risk Register. The 12 month rolling sickness absence level as at August 2015 is at 4.91% - a tiny improvement from July which was 4.92% (0.01%). This small decrease still represents a saving of £200k on the annual cost of absence. This absence rate remains above the NHS national average of 4.44%.

There was a marginal improvement for the "in month" figure for August at 4.70% although the improvement is very marginal and the level of absence is very high particularly for the time of the year. Surgery B remains the best performing clinical group and is below target of 3.5%. Both Community & Therapies and Imaging have improved their performance significantly – and these are represented in the August figures. Well done to the managers and teams concerned for their concerted effort and interventions which are making an impact.

The attached report sets out an escalation of governance activities that are working well in areas of the Trust, to spread those to **all** areas of the Trust. Medicine & Emergency Care is showing a deteriorating performance with the In-Month rate in August of 5.64% above the YTD Trust rate of 4.91%.

There are a number of escalating interventions described in the attached report that set out the range of group and corporate actions being undertaken to support an improvement in sickness absence. It is detailed in to short term (STS) and long term sickness (LTS) interventions. This will require an active focus by all Group managers if the current adverse trend is to be actively addressed before the challenges of the winter period hit.

The winter activities will be complimented by an active and robust Flu Jab Campaign - which was successful last year and given extra focus in our communications with clinicians and front line staff groups. Both Dr Roger Stedman and Chief Nurse Colin Ovington are signed up as vaccinators. This along with the full range of health and well-being activities are detailed in appendix 3. This newsletter goes out regularly to staff across the Trust, and is backed up my relevant posters, brochures, leaflets, social media coverage and targeted communications.

REPORT RECOMMENDATION:

- Introduce centralised system of reporting of sickness absence to Group Director of Nursing or equivalent to improve short term sickness
- Commit to improve completion of return to work interviews
  Commit to promote staff health and well-being interventions with your staff
- Note the sickness panels that are being set up in your group to support sickness
- Note and support Health and Well Being offer as detailed in appendix 3

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		Equality and Diversity		Workforce	x

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

Reduction in sickness absence to 3.5% by March 2016.
Red rating on Board Trust Risk Register
Board Assurance Framework Objective 2015-2016

PREVIOUS CONSIDERATION:

Being Fully Staffed – Tackling Sickness Absence June 2015
Monthly review at Clinical Leadership Executive

INTRODUCTION

The Trust's sickness absence rates remain a concern with the YTD rate of 4.91% - costing the Trust in excess of £9m per year in lost days. The In-Month rate in was August 4.70%, this is an improvement for many areas. Surgery B remains the best performing clinical group and is below target. Community & Therapies and Imaging are all showing improved performance as at August 2015.

Medicine & Emergency Care is showing a deteriorating sickness rate with the In-Month rate in August being 5.64%, above the YTD rate of 4.91%.

A breakdown of sickness across all Groups as at August 2015 set out in the table below.

Group	Short-Term – In Month Aug 15	Short-Term 12 Months Rolling	Long Term – In Month Aug 15	Long Term 12 Months Rolling	Total In Month Aug 15	Total 12 Month Rolling
Community & Therapies	0.87%	1.71%	2.84%	3.65%	3.71%	5.36%
Corporate	1.12%	1.73%	3.19%	3.00%	4.31%	4.73%
Imaging	1.00%	1.79%	2.83%	2.82%	3.83%	4.61%
Medicine & Emergency Care	2.00%	2.00%	3.64%	2.91%	5.64%	4.91%
Pathology	1.63%	1.65%	2.38%	2.71%	4.02%	4.36%
Surgery A	1.76%	2.18%	3.13%	3.00%	4.88%	5.18%
Surgery B	0.99%	1.36%	2.37%	1.89%	3.37%	3.25%
Women & Child Health	1.43%	1.88%	4.09%	3.72%	5.52%	5.60%
SWBH	**1.43%**	**1.85%**	**3.27%**	**3.06%**	**4.70%**	**4.91%**

This paper set out the support available to group directors and leaders from the Workforce team and outlines the multiple actions and progress being taken in relation to "Being Fully Staffed – Tackling Sickness Absence..

1. Support available to Managers from the OD Directorate

- Group sickness reports are available on the workforce pages on Connect to enable managers to view how their cost centre and group are doing on managing absence on a monthly basis.
- Password protected reports are available on the workforce pages on Connect with details of the employees hitting Trust Triggers or about to hit the triggers
- Manager's toolkit on Managing Sickness on Connect
- HR advice line for queries on individual cases that are not covered by the toolkit or FAQs
- Access to BDMA Counselling Services
- Access to a range of leadership development programmes including coaching and 360 feedback
- Workshops on how to manage sickness delivered by HR Specialists in groups, with case studies and practical examples
- Coaching for managers with difficult sickness cases
- Advice on case management in respect of all cases 3+ months from monthly OH/ HR case conference
- Access to specialist advice from OH to inform case management of employees

- Popular and well communicated health and well-being programme designed to promote healthy lifestyles including walking, exercise, stopping smoking, managing stress, sleeping, weight management etc
- Training to support employee suffering with stress delivered by BDMA (detailed in appendix 3 – health and wellbeing newsletter)

In addition all managers with responsibility for sickness have been sent a personal letter from the Director of Organisational Development setting out their responsibilities for sickness absence management and signposting them to the support available. A copy of the letter issued is attached as Appendix 3.

Controls and governance – data enables local action.

2. Group Governance Arrangements for Sickness Absence

The new governance arrangements for sickness absence include 1)Sickness Clinics 2) Directorate Confirm and Challenge Meeting 3) Group Sickness Assurance Meetings are now in place within the following areas:

- Facilities
- Surgery B
- Women and Child Health
- Community and Therapies

Other areas are in the process of setting up Sickness Clinics and the above meeting structure.

Sickness absence clinics

Under this structure managers can discuss case management of complex cases at the newly formed sickness clinics. For example, actively dealing with employees who are off sick with stress or who have multiple issues presenting.

Directorate confirm and challenge meetings

The purpose of directorate Confirm and Challenge meetings is to provide directorate leads with assurance that sickness is being managed in accordance with the Sickness Policy and to identify swift corrective action as required. Managers will be required to attend to discuss how they

create a working environment which fosters team working and promotes health and well-being. This meeting will also confirm the actions being taken (or not) in respect of employees who have hit trust triggers (3 in six months).

The Workforce team is developing a directorate score-card to capture the key facts for discussion including:

- RTW compliance
- Names of employees meeting sickness triggers (3+ Months and 28+ Days)
- Sickness reasons
- Sickness trends

Group sickness assurance meetings
These are expected to be convened when the directorate are above Trust target (practically all groups as at August 2015) and are unable to provide assurance that sickness absence is appropriate managed in the group. The outcomes are:

- Review performance in relation to sickness trajectories levels and effectiveness of action plans
- Hold the directorate leads / heads of service to account for not being compliant and carrying out timely action in their management roles.
- Set out and closely monitor remedial plans as appropriate.

3. Reduce rates of short term sickness

In order to achieve the Trust target of 3.5% it is clear that short term sickness needs to be at, or below 1.00%. Currently only Community & Therapies and Surgery B have reduced their "in-month" rate to below 1%. Short term sickness across other groups is significantly above 1% with Medicine & Emergency Care having the highest short-term sickness rate of 2.00% in August 2015.

To immediately address this adverse trend the following actions are recommended:

Introduce a centralised system of reporting of sickness absence to Group Director of Nursing or designated equivalent i.e. 'one reporting line'.

A centralised system of reporting sickness absence within wards in Medicine and Emergency Care was in operation in 2013. The system required an employee reporting sick to speak directly to the Group Director of Nursing or nominated deputy in order to explain why they are not fit to attend for duty. As part of the conversation the employee was given advice about self-care and where appropriate agreement reached for them to attend for duty later on in the day, i.e 'Take some paracetamol and call me in a few hours". When this 'one reporting line' was in operation short term sickness across Medicine and Emergency Care was consistently below 1%. A similar approach has been successfully implemented within Community and Therapies and Surgery B. It is recommended that a similar reporting system be rolled out across the Trust to tackle short term sickness. It is recognised that this will be a significant investment of someone's time, but the benefits will be significant. The directorates who are operating this approach (C&T and Imaging) have already seen a reduction in their sickness, and are sharing their 'scripts with other groups for consistency and learning.'

Improve compliance with return to work interviews

Overall compliance rates with return to work interviews has improved slightly over the past quarter from 34% to 64.05% but is still significantly below the Trust target. RTW compliance will be monitored at the directorate confirm and challenge meetings and group sickness assurance meetings. There is already executive challenge through the group reviews.

The Committee should note that the following departments which have all had 15+ episodes of absence within the last 12 months achieved 100% compliance for Return to Work Interviews. Congratulations and thank you to everyone involved in these areas.

NSCHI - Foot Health
NSMUS - Musculo-skeletal
COSPT - Speech Therapy
NSPOT - Physiotherapists & Occupational Therapists
NSDME - District Nursing Mesty Croft & Hateley Heath
NHMEA - Clinical Effectiveness
RFRSS - Catering Department
NGPAY - Payroll Services
NGSUP - Procurement & Supplies
CURSN - Research Nurses
NJVID - Data Quality
CMD11 - D11 Acute Elderly (Male)
NWSAC - Urology & Vascular Medical Secretaries
CXHS7 - New Born Hearing Screening
CYGCW - Gynae Cancer Ward
NYANL - Ante Natal Clinic

Weekly sickness absence recording
To improve access to sickness absence data, it is recommended that managers be asked to update ESR self-service with absence data on a weekly basis. This will enable them to use timely and accurate data to support effective management and enable effective reporting and timely actions to be taken.

Reducing long term sickness

1 to 3 months
An analysis of employees' absence for between 1-3 months in June 2015 evidenced that the main reasons for sickness absence related to MSK and anxiety with action required as follows:

MSK
Increase compliance for manual handling training to target of 95%
Promote MSK service to managers and employees
Increase referrals to OH for MSK
Target hot spot areas

Promotion of the MSK service and the importance of departmental risk assessments has been discussed with Dally Masaun, Health and Safety lead. Discussions on how the health and safety department can help to support improvements in MSK related absences took place at the Health and Safety Committee in September 2015. It has been agreed that the health and safety department will work in conjunction with HR to support improvements in MSK absences in 'hot spot' areas.

Anxiety
Increase use of staff engagement and improve 'staff experience'.
Improve return to work interviews compliance to pick up problems earlier
Promote requirement for stress risk assessment
Target hot spot areas
Increase referrals to OH for MSK
Promote staff counselling service to employees and managers
Re-launch management training on sickness absence with a focus on soft skills
Review whether long shifts are a contributory factor (anecdotal feedback suggests it is a factor, OH are now monitoring)

3+ months

Monthly OH/ HR case conferences are in place to review of all cases of 3+ months duration. Following these meetings feedback is provided to the relevant group director of operations or equivalent. Although the majority of managers comply with recommendations from case conferences there are instances where corrective action has not taken place resulting in significant delays with the case-management.

To address this, notes from case conferences have been issued to directorate leads to facilitate discussions at monthly directorate confirm and challenge meetings and escalation to the group sickness absence assurance meetings / Chief Operating Officer/Chief Executive as appropriate.

The key themes from the September case conferences include the following:

- Failure to hold timely review meetings
- Failure to address delays with case management within the Group

Things happening in the background…

- HR is undertaking a feasibility study of purchasing a technical solution that will offer managers notifications via email or text on their employees' sickness and triggers. There are software companies that advertise they can 'sit on top of' ESR and work with our existing data effectively to make things easier for managers. Cheshire and Wirral have used this approach successfully and a site visit will shortly be undertaken. This would take a financial investment, but offer a return in reduced absence for groups and the Trust.
- In addition we are researching and taking advice on the feasibility and risk of adjusting terms and conditions. This would involve a legal process of dismissing and re-engaging every member of staff, and prove challenging in a local and national context. However, the board are considering every single option available to reduce absence in the Trust, and not discounting any intervention at this stage.

Conclusions:

The above actions **must be** taken within groups to effectively manage absence and drive down sickness rates if we are to effective tackle our staffing position. HR can support you with the data, but there is no substitute for groups taking this seriously at a local level, and creating a culture of positive attendance, where sickness is the exception rather than the norm. If there are no improvements during September and October the Trust Board will consider further punitive measures both for managers and employees – including consideration of a change to terms and conditions on sickness payments.

APPENDIX 2

Dear

I am writing to you because you have the important role of line managing employees within SWBH Trust. As a line manager your role is vital to the motivation, health and well-being of your colleagues, and has a direct impact on our culture through the way you manage your department/directorate.
As you will know, the Trust is committed to reducing sickness absence to 3.5% by March 2016. It currently stands at just under 5%, costing the Trust over £9m per year. We can only get to a fully staffed position, reducing absence, reducing agency spend and increasing our colleagues' well-being if we all work together and undertake our individual responsibilities.
Your role as a manager is proven **as the most important** in driving down sickness absence across the Trust, and so I would like to remind you of what you are required to do, and where you can get development and support if you need it.
Key responsibilities for you as a manager must include:

- Hold a return to work meeting following every episode of sickness with your team member.
- Know the Trust policy! If you've not read it recently – here it is: Sickness Absence Management Policy.
- Review case management of all sickness cases regularly and apply the proper processes when they are triggered, including holding dismissal hearings when necessary.
- Ensure your team ring you personally to let you know they are sick, no texts or messages through a colleague.
- Ask your team when they plan to return on the first day of absence, and keep in regular touch whilst they are off.
- If your team member is off sick with stress, the absence policy still applies.
- Ensure you accurately record absence on ESR – including when the person returns to work.
- Seek advice from HR and Occupational Health where appropriate whilst retaining ownership of each case (it's your job to manage absence, not HR's) There is accelerated access to physiotherapy for musculoskeletal issues, you can refer on first day of absence or whilst still in work.
- Actively trying to create a working environment that fosters team work e.g. communicate well, provide clarity, and manage performance.
- Maintain an environment which supports the health and wellbeing of all staff – encourage your team to look after themselves.
- Promote the Trust's well-being offer to your team, including BDMA Counselling Services, the employee gym, free flu jabs, eating green, health advice and much more. Visit the Occupational Health Home Page on Connect.
- Use information from ESR to inform your actions on individual case management and sickness absence trends within your area of responsibility.

We recognise that you may need support at different stages of your line management career and there is a lot of development and advice on offer so you can carry out your role effectively.

- We provide a range of leadership development programmes including coaching and 360 feedback. Please contact Associate Director of Education, James Pollitt. james.pollitt@nhs.net
- There is sickness absence training available through your group. If you have never managed absence before, or need a refresher, please contact your group HR lead.
- A toolkit for managing sickness is available on Connect.
- The HR advice line can be contacted for queries on individual cases that are not covered by the toolkit or FAQs on 0121 507 6680.
- As a manager you may need emotional support when dealing with difficult cases or employees. The BDMA Service is available from 7am-11pm and has a 24 hour answering service. This is available for all members of staff. The Counselling Care Line number is 0800 919 765.
- Your group reports on sickness absence by cost centre and directorate are available on the workforce pages on Connect - see how you and your group are doing on managing absence.
- Keep an eye on the daily bulletin for courses or programmes that may help you in your leadership and line management role and look at the Learning and Development pages on Connect.
- If you're unsure and not confident in managing difficult cases, please ask! It's better that you ask for support than someone remains off sick unmanaged.

Your management effectiveness in managing sickness will form part of your management appraisal so please ensure that you fully understand the expectations of you and the support you require to achieve carry out this important aspect of your job.

Thank you for taking this seriously and please get in touch if you have ideas or good practise you wish to share. I know there are many managers who do all of the above all of the time, and I would really like to hear from you to capture your learning and skills.
Yours sincerely

Raffaela Goodby
Director of Organisation Development

	Groups		Target	Baseline (14/15)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Rank	Current Mth v *Target*	Current Mth v *Baseline*
Rolling 12 month sickness	Community & Therapies		3.50	4.93	5.03	5.19	5.20	5.29	5.36								7		
	Corporate		3.50	4.46	4.57	4.64	4.75	4.78	4.73								4		
	Imaging		3.50	4.63	4.74	4.71	4.78	4.78	4.61								3		
	Medicine & Emergency Care		3.50	4.57	4.67	4.83	4.75	4.87	4.91								5		
	Pathology		3.50	4.17	4.20	4.27	4.34	4.34	4.36								2		
	Surgery A		3.50	5.36	5.39	5.32	5.21	5.23	5.18								6		
	Surgery B		3.50	3.24	3.19	3.28	3.24	3.18	3.25								1		
	Women's & Child Health		3.50	5.21	5.32	5.48	5.56	5.64	5.60								8		
	Trust		**3.50**	**4.69**	**4.77**	**4.86**	**4.87**	**4.92**	**4.91**										

	Directorates	Directorate HC	Target	Baseline (14/15)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Rank	Current Mth v *Target*	Current Mth v *Baseline*
Community & Therapies	Ambulatory Therapies	142	3.50	4.25	4.13	4.06	4.03	4.02	3.88								15		
	iBeds	255	3.50	3.82	4.92	5.19	5.11	5.42	5.68								30		
	iCares	303	3.50	5.70	5.47	5.61	5.72	5.64	5.60								28		
Corporate	Chief Executive & Governance	65	3.50	4.46	2.86	2.76	2.47	2.48	2.37								6		
	Corporate Nursing & Facilities	943	3.50	5.68	5.83	5.89	5.98	6.00	5.86								31		
	Estates & New Hospital Project	96	3.50	2.35	2.42	2.61	2.67	2.56	2.55								7		
	Finance	84	3.50	2.12	2.15	2.09	2.04	2.15	2.08								4		
	Medical Director	163	3.50	2.67	2.87	2.99	2.94	2.94	3.00								10		
	Operations	374	3.50	4.66	4.78	4.95	5.21	5.20	5.33								26		
	Workforce & Organisational Development	164	3.50	2.77	2.70	2.67	2.97	3.34	3.44								12		
Imaging	Breast Screening	58	3.50	5.51	5.72	5.53	5.09	4.84	5.11								24		
	Diagnostic Radiology	144	3.50	3.25	3.38	3.44	3.47	3.73	3.20								11		
	Group Management - Imaging	47	3.50	8.97	9.08	9.04	10.02	9.26	9.14								38		
	Interventional Radiology	13	3.50	5.90	5.98	5.85	5.64	6.66	7.76								36		
	Nuclear Medicine	29	3.50	2.66	2.61	2.54	2.62	2.64	2.79								8		
Medicine & Emergency Care	Admitted Care	637	3.50	4.98	5.07	5.22	5.08	5.22	5.32								25		
	Emergency Care	497	3.50	4.60	4.70	4.81	4.69	4.84	4.79								21		
	Group Management - Medicine	5	3.50	0.34	0.43	0.40	0.95	1.15	1.18								1		
	Scheduled Care	307	3.50	3.80	3.90	4.16	4.28	4.29	4.33								18		
Pathology	Biochemistry	106	3.50	3.53	3.57	3.91	3.86	3.98	4.25								17		
	Group Management - Pathology	46	3.50	6.38	6.79	6.92	6.80	6.76	6.67								34		
	Haematology	62	3.50	5.83	5.67	5.49	5.71	5.74	5.65								29		
	Histopathology	40	3.50	1.73	1.72	1.64	1.78	1.47	1.32								3		
	Immunology	15	3.50	2.84	3.90	4.33	4.99	5.10	5.10								23		
	Microbiology	58	3.50	4.28	4.07	3.87	3.89	3.84	3.70								13		
Surgery A	Cancer Services	17	3.50	1.64	1.67	1.92	1.53	1.33	1.31								2		
	Directorate A	195	3.50	5.30	5.50	5.47	5.45	5.75	5.53								27		
	Directorate B	151	3.50	4.84	4.71	4.47	4.02	4.08	4.13								16		
	Directorate C	364	3.50	6.26	6.31	6.30	6.26	6.04	6.00								33		
	Directorate D	244	3.50	4.39	4.25	4.09	4.14	4.33	4.36								19		
	Group Management - Surgery A	18	3.50	7.35	8.46	9.65	8.56	8.41	7.83								37		
Surgery B	ENT, Oral Surgery & Audiology	110	3.50	2.49	2.43	2.45	2.28	2.07	2.08								5		
	Group Management - Surgery B	9	3.50	1.80	1.67	1.68	1.71	2.04	2.83								9		
	Ophthalmology	283	3.50	3.56	3.53	3.64	3.65	3.63	3.70								14		
Women's & Child Health	Community Children's	143	3.50	5.99	6.08	6.12	7.39	7.17	6.80								35		
	Group Management - W&CH	4	3.50	1.71	1.76	1.69	1.53	10.29	10.28								39		
	Gynaecology, Gynae-Oncology & GUM	138	3.50	3.73	3.67	4.07	4.24	4.50	4.89								22		
	Maternity & Perinatal Medicine	452	3.50	5.74	6.04	6.31	6.38	5.93	5.91								32		
	Paediatrics	248	3.50	5.16	5.01	4.95	4.41	4.54	4.44								20		

September 2015

Health & Wellbeing

SWBH Staff Health & Wellbeing – helping you live a healthier life

FREE 12 weeks (NRT) Nicotine Replacement Therapy for Staff

From 1 October 2015 it will be illegal to smoke in a car (or other vehicles) with anyone under 18 present. The law is changing to protect children and young people from the dangers of second hand smoke.

FREE NHS HEALTH CHECKS

All attendees must be aged between 40-70 years and live or have a general practitioner within Sandwell. You must not have had a previous health check for heart disease within the past 5 years.

The seasonal flu programme starts 5th October 2015 – see staff bulle flu webpage for more details

Inside this month's issue:

- **Smoking Cessation**
- **NHS Health Checks**
- **Flu campaign**
- **FREE Debt Advice for Trust Employees**
- **New Health & Wellbeing activities**
- **Check out our recipe of the month**

ARE YOU READY TO QUIT!

To register contact; Jati on extension 3854 or e-mail jatinder.sekhon@nhs.net

FREE (NRT) for Staff Nicotine Replacement Therapy - 12 weeks

Free, professional one to one advice and support to help you quit.

FREE Quit smoking sessions are available now :

Sandwell Hospital Occupational Health Department

Monday & Tuesday 11-12.30pm Contact Nicola Groves 07890 638616

City Hospital Occupational Health Department

Tuesday 10-1pm Contact Julia Weekes on 07572518148.

Takes Steps now to STOP smoking

Nicotine replacement therapy (NRT) is a way of getting nicotine into the bloodstream without smoking. There are nicotine gums, patches, inhalers, tablets, lozenges, and sprays.

How effective is nicotine replacement therapy?

Nicotine replacement therapy (NRT) does increase the chance of quitting smoking. Various studies have looked at this issue. The studies compared NRT to a similar dummy (placebo) product in people who were keen to stop smoking. The results from the studies showed that, on average, about 17 in 100 people who took NRT stopped smoking successfully. This compared with about 10 in 100 who took the dummy (placebo) product rather than NRT. In other words, it increased the rate of success by about 70%. A combination of NRT with support or counselling may give the best chance of success.

How do I use nicotine replacement therapy?

Take advice from a Stop Smoking Clinic.

Decide on which type of nicotine replacement therapy (NRT) will suit you best. Set a date to start. Some people prefer to stop smoking at the end of one day, and start NRT when they wake the following day. You should use NRT regularly at first, and not 'now and then'.

Use an adequate dose of NRT. The higher doses are used if you smoked more than 18-20 per day.

Use NRT for at least 8-12 weeks for the best chance of stopping smoking in the long term.

The dose of NRT is typically reduced in the later part of the course, and then stopped.

You should not combine NRT with other medicines that help you stop smoking, such as bupropion or varenicline.

You are more likely to stop smoking if you receive counselling or support whilst taking NRT. Also, the manufacturers of NRT often offer support such as telephone counselling, tapes, internet sites, personalised written programmes, etc. The details come on the packets of the various NRT products. It is strongly advised that you take up any offer of support whilst going through the difficult time of giving up smoking.

How effective is nicotine replacement therapy?

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Self help Tips to help you stop smoking

Get some support. If friends or family want to give up too, suggest to them that you give up together.

Think Positive. You may have given up before, but tell yourself you’re really going to do it this time.

Make a plan to give up. Set a date and stick to it.

Identify your problem times. A craving can last five minutes. Before you give up make a list of five minute strategies.

Get moving, exercise cuts cravings and may help your brain to produce ant- craving chemicals.

When your at a party stick with the non-smokers.

Make a list. Keep reminding yourself why you gave up.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

FIGHT FLU THIS WINTER

Free flu vaccination for staff

Simerjit Rai
2014 Top Flu Vaccinator

Did you know that seasonal flu is a serious illness that kills about 500 people and causes 10,000 hospital admissions every year in the UK.

As healthcare staff, you are likely to come in to contact with the flu virus through contact with patients and the public. One in four healthcare staff will get the virus in an outbreak which is nine times higher than the rest of the population.

Vaccination is not just about keeping yourself safe, it's about protecting your patients and your family. You can carry and pass the virus on to others without having any symptoms yourself, so even if you consider yourself healthy, you might be risking the lives of others around you.

If you were vaccinated last year you joined the global fight against flu and took an extra step towards protecting yourself, your patients and your family.

THREE STEPS TO FIGHTING FLU

1 Get your vaccine

Having your flu jab protects you and the people around you, including your patients and your family.

2 Wash your hands

As well as getting the jab, remembering to wash your hands will reduce the spread of the flu virus.

3 Stay Away

If you have the flu, stay away from work until you are better. The virus is highly infection and spread extremely easily.

@SWBHnhs @FluFighterSWBH and swbh.nhs.

If you have not had your Flu Vaccination on the Trust premises, please complete and return this slip to Occupational Health.

You will still be entered into the prize draw and included in the Trust vaccination statistics.

Name: ..... **Department:** .....

Date of Birth: ..... **Contact Number:** .....

Please tick as appropriate:

☐ I have had my flu vaccination from another healthcare provider this season

☐ I do not want to have my flu vaccination

Reason: .....

WHEN AND WHERE CAN I GET VACCINATED?

	MONDAYS	THURSDAYS	FRIDAYS
5TH OCTOBER – 16TH OCTOBER	7:30am - 12:00pm Main Reception, Sandwell Hospital	7:30am - 12:00pm Occupational Health, Courtyard Gardens, Sandwell Hospital	1:00pm – 4:00pm Occupational Health, Courtyard Gardens, Sandwell Hospital
	7:30am - 12:00pm Quiet Room, Main Spine, City Hospital	7:30am - 12:00pm Quiet Room, Main Spine, City Hospital	1:00pm – 4:00pm Occupational Health, Sheldon Block, City Hospital
19TH OCTOBER – 13TH NOVEMBER	8:30am - 12:00pm Main Reception, Sandwell Hospital	8:30am - 12:00pm Occupational Health, Courtyard Gardens, Sandwell Hospital	1:00pm – 4:00pm Occupational Health, Courtyard Gardens, Sandwell Hospital
	8:30am - 12:00pm Quiet Room, Main Spine, City Hospital	8:30am - 12:00pm Quiet Room, Main Spine, City Hospital	Friday 1:00pm – 4:00pm Occupational Health, Sheldon Block, City Hospital
16TH NOVEMBER – 24TH DECEMBER	10:30am - 12:00pm Occupational Health, Courtyard Gardens, Sandwell Hospital		2:00pm – 4:00pm Occupational Health, Courtyard Gardens, Sandwell Hospital
	10:30am - 12:00pm Occupational Health, Sheldon Block, City Hospital		2:00pm – 4:00pm Occupational Health, Sheldon Block, City Hospital

COMMUNITY VACCINATIONS

Our FluMobile Flu Fighting Ambulance will be available during the flu season providing vaccinations in the community. Find out where it will be by checking the Flu Calendar on the intranet or calling **Occupational Health on 0121 507 3306.**

FEAR OF NEEDLES STOPPING YOU FROM HAVING YOUR FLU JAB?

Come to one of our Needlephobic Clinics

WEDNESDAY 4TH NOVEMBER
10.30am - 12pm Occupational Health Department, Courtyard Gardens, Sandwell Hospital

WEDNESDAY 11TH NOVEMBER
10.30am – 12pm Occupational Health Department, Sheldon Block, City Hospital Hospital

Be a Flu Fighter, protect yourself, your colleagues, your patients and your family from Flu

Flu Vaccination
Occupational Health & Wellbeing Service
Courtyard Gardens
Sandwell Hospital, Lyndon
West Bromwich, B71 4HJ

The 32inch Television will be given away as a prize to someone chosen at random who has their vaccination in October.

FREE NHS HEALTH CHECKS.

Do you want to know your risk of heart disease?

The Occupational Health and Wellbeing services in conjunction with 'My Time Health' are offering free health checks including cholesterol, glucose, blood pressure measurements and lifestyle risk assessments. The health check aims to help you prevent heart disease, stroke, diabetes, kidney disease and dementia.

Date: Wednesday, 1st October 2015
Venue: Breast Feeding Room, City Hospital
Time: 9.30 – 4.00pm

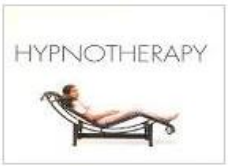
Date: Thursday, 8th October 2015
Venue: Old Nurses Training Room, Sandwell Hospital
Time: 9.30- 4.00pm

Time: appointments are between 9.30 and 4.00pm. Appointments will last 30 minutes and must be booked.

For booking appointments please contact Jatinder Sekhon on 3854

***Please Note**
All attendees must be aged between 40-70 years and live or have a general practitioner within Sandwell. You must not have had a previous health check for heart disease within the past 5 years.

New Service Hypnotherapy



Do you feel stressed? Need to lose weight? Desire to quit smoking? Hypnosis may be the answer…
Hypnosis is completely safe and has been used successfully to treat a range of issues including
Anxiety, Stress Reduction, Smoking Cessation, Fears and Phobias, Weight Control, Confidence and Self esteem…

Lawrence Pagett fully registered and qualified Hypnotherapist (with over ten years professional experience) invites you to experience the gentle effective power of Hypnosis to assist you making those all-important changes and help improve your life.

Simply call: **01562 755979 or 07790476811** for your initial inquiry and to book your hypnotherapy sessions…

Running/Jogging Club

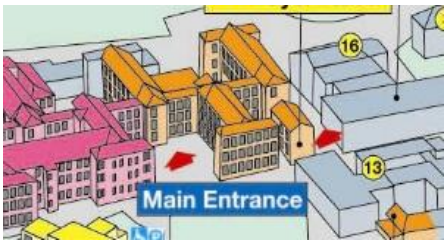
Beginners running/ jogging group based at Sandwell.

An introduction to canoeing
Nordic walking at Sandwell valley

For further information please email: Gary Woodhouse; [woodhousegary@hotmail.co.uk]

FREE Bike Assessments for Staff – More dates for the diary

Cycling is one of the best ways to reduce your environmental impact (and get fit and save money!) is to get on a bike. BikeRight!, the UK's largest cycle training organisation, are on site at City shortly to offer staff FREE cycle maintenance training:



Thursday, 24th September, 12 – 2pm
Outside Hallam Restaurant, SGH
Thursday, 22nd October, 12-2pm
Main spine entrance, City Hospital
Thursday, 19th November 12-2pm
Outside Hallam Restaurant, SGH

Netball Club

If you are interested in joining the netball club or forming a team for the Trust please contact Jenny Wright via email jenny.wright9@nhs.net or Ext 3848

Halfords cycle

The next order window for the cycle to work scheme will be in November until 21st December 2015. For further details contact Gally on Ext 2856

Lunchtime Walks

Starts Friday 18th September from 12.30 – 1pm from Western Gate, City Hospital. FREE pedometers. Just turn up and wear sensible shoes. For more information contact Gally Ext 2856

Prescription4exercise

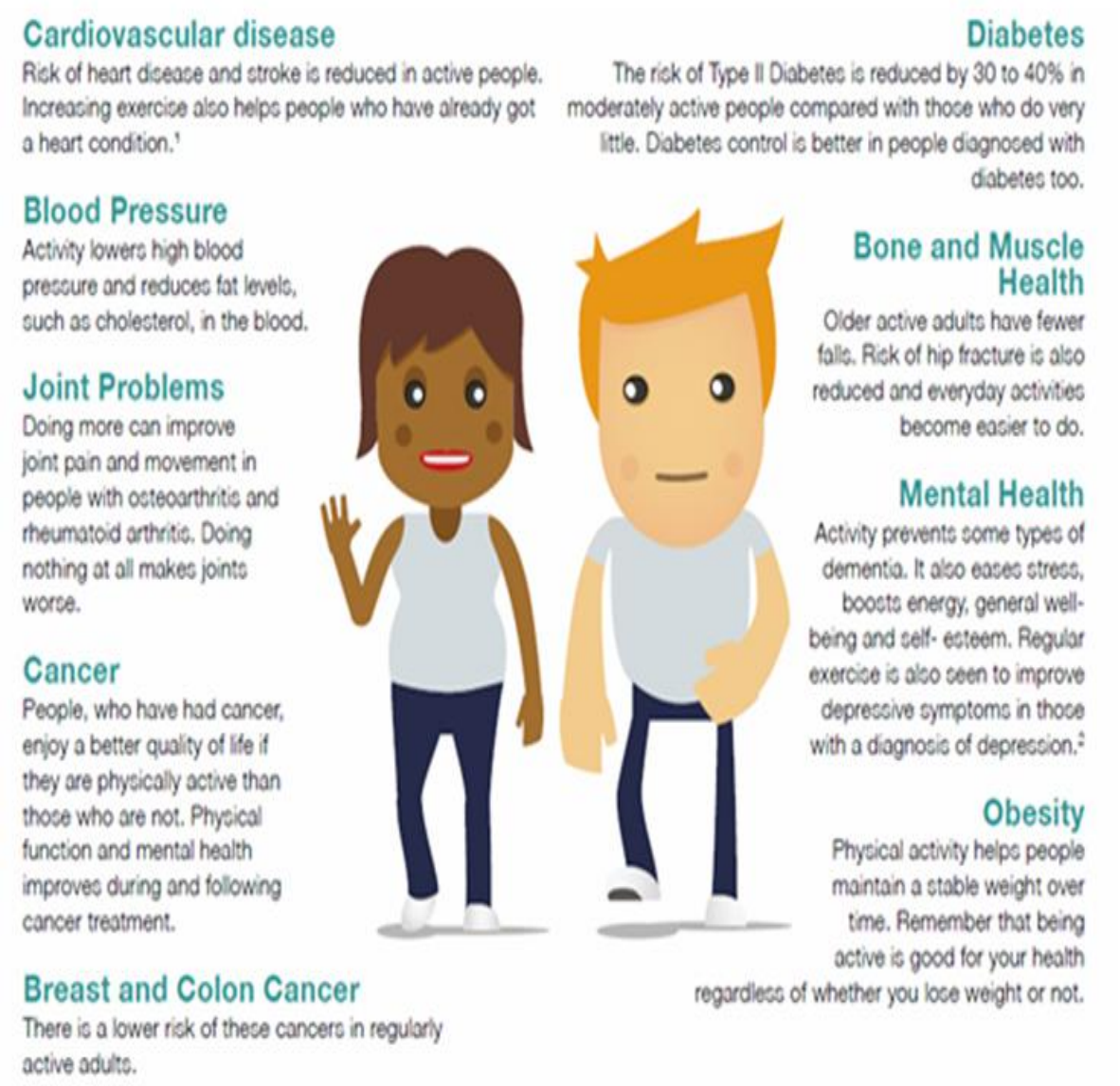
Physical Inactivity is described as the biggest health threat of the 21st Century.

Please click link to the P4E website for more information;

www.prescription4exercise.com

Being active is just as important as having good control of blood pressure, cholesterol, weight and giving up smoking. In fact, if physical activity was a drug, then taking regular doses of it would bring you wider health benefits than any known medication.

Stay active and live a longer, healthier life.



Did you Know

1 in 4 women experience Domestic Abuse

Domestic abuse comes in many forms

physical...sexual...verbal abuse...threatening or controlling behaviour

Call 0121 552 6448
email IDVA@sandwellwomensaid.co.uk

INVESTORS IN PEOPLE | Bronze

WEST MIDLANDS POLICE

Community Legal Service

Sandwell Independent Domestic Abuse Services
we listen, we support, we care

Sandwell Women's Ai
we listen, we support, we care

Managing Change Effectively

Change is one of life's hazards, we are born, and we grow up, get married, go to work and make friends; but then we fall out, get divorced, have new managers, loose our jobs and source of income; all actions that by their nature humans hate.
The Managing Change workshop is devised and presented by Dr Kevin Buchanan-Dunne whom many of you will know as the leader of the BDMA counselling service and Stress Management workshops we have used for almost 10 years.
Kevin brings his knowledge of human emotions and psychology, coupled with practical commons sense to help you get through this time of change.

Agenda

What is change and why can it hurt?
What are the different stages of change?
What are the personal aspects of change?
What are the workplace aspects of change?
How to deal with change.
Activities that help you build resistance to the negative influences.

- Preparing for changes
- Getting mentally and physically fit
- Taking control of your way forward
- What are the options and opportunities?
- Do you want a new job or career?

During this workshop you will be introduced to methods of relaxation, building positivity and understanding your value as a person.

Tuesday 29th September from 9.30 – 16.30
Monday 12th October 9.30 – 16.30
Monday 26th October 9.30 – 16.30
Venue: Old Nurses Training Room, SGH

Monday 2nd November 2015 9.30 – 16.30
Venue Sandwell Meeting Room 2, Old Social Club, SGH

Places must be booked and are they are limited to 15 places. Please contact extension 3306 to book your place

Pool Bike Hire Scheme

SWBH NHS offers a free cycle hire service for use by staff. The bikes are intended for staff to use to cycle between City and Sandwell Hospital but there may be flexibility if staff want to cycle to/from work and use the bike recreationally. There are 3 cycles available for hire, alongside a helmet and lock if required. The bikes can be hired for up to 4 weeks at a time.

The pool bikes are intended to aid staff in travelling between sites to reduce the use of vehicles. This reduces our impact on the environment and also improves the health and wellbeing of staff.

How the scheme works:

- You will need to be a member of staff
- Contact the Travel Plan Co-ordinators (Jenny Wright or Fran Silcocks) who will send over the terms and conditions (contact details below)
- Read, agree and sign the terms and conditions
- Collect the pool bike from City or Sandwell Hospital with your own padlock to safely secure the bike in the Trust cycle pods
- Return the bike and any equipment within 4 weeks of hire to:
    - Occupational Health Department (Courtyard Gardens) at Sandwell (Jenny Wright), or
    - Estates Department at City (Fran Silcocks)

If you are interested in free cycle proficiency training to improve your cycling confidence, please contact Jenny or Fran.

The security of the bike is your responsibility. It is advisable that you do not leave the bike in areas where theft is possible. If the bike is used aside from travelling between Trust sites, the user must take out adequate insurance to cover you (the user), the bike and other equipment.

For more information, contact Jenny Wright (jenny.wright9@nhs.net / ext. 3848) or Fran Silcocks (francesca.silcocks@nhs.net / ext. 4065).

Pool bikes now available for staff to hire

Are you thinking about getting a bike but want to trial one out first? We now have three new pool bikes available for staff to hire, alongside a helmet and lock. The bikes are intended for staff to use to cycle between City and Sandwell Hospital but there may be flexibility if staff want to cycle to/from work and use the bike recreationally.

For more information, please contact Jenny Wright (jenny.wright9@nhs.net / ext. 3848) or Fran Silcocks (francesca.silcocks@nhs.net / ext. 4065).

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Pool Bike Hire Scheme

Terms and Conditions

Eligibility and Criteria for Use:

- Cycles may only used by staff who are employed by Sandwell and West Birmingham Hospitals NHS Trust
- Any cycle issued to a member of staff can only be used by that particular member of staff
- Loans of cycles are free to staff and will be for a **maximum loan period of 4 weeks** at any one time

Essential Information:

Staff wishing to use a loan cycle must:

- Ensure that you are able to ride a bike – if you cannot ride a bike then FREE cycling proficiency training can be arranged by contacting Fran Silcocks (francesca.silcocks@nhs.net) or Jenny Wright (jenny.wright9@nhs.net
- Return the cycle (and any other equipment loaned) in the same condition as originally borrowed at the end of the loan period to:
    - Occupational Health Department (Courtyard Gardens) at Sandwell, or
    - Estates Department at City (Fran Silcocks)
- Always wear protective headgear and preferably luminous clothing when cycling
- Always secure the bike using a solid padlock before leaving it

The bikes are stored and will need to be collected from and returned to:

- City Hospital: Fran Silcocks in Estates
- Sandwell Hospital: Occupational Health Department, Courtyard Gardens (reception)

The security of the bike is your responsibility – a lock is provided to minimise the risk of theft. It is advisable that you do not leave the bike in areas where theft is possible. If the bike is used aside from travelling between Trust sites, the user must take out adequate insurance to cover you (the user), the bike and other equipment.

Maintenance:

Users must not under any circumstance take a bike out in the knowledge that a fault is present. You (the user) must check the brakes, lights, tyres and free movement of wheels and pedals before commencing use. All faults must be reported **immediately** by the user to Fran Silcocks (francesca.silcocks@nhs.net / 0121 507 4065) or Jenny Wright (jenny.wright9@nhs.net / 0121 5073848) either upon initial inspection by the user or at any time subsequently as soon as the user becomes aware of a fault.

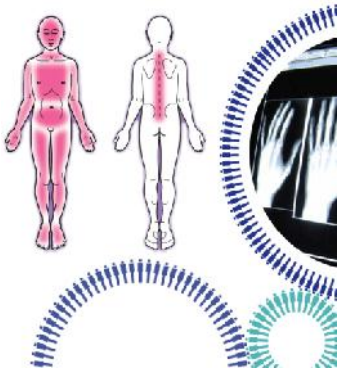
Disclaimer:

- Users of the pool cycles shall abide by the Highway Code at all times. **Sandwell and West Birmingham Hospitals NHS Trust shall not be liable for any injury or loss whatsoever in relation to use or loan of a cycle.** Users have a duty to report any damage or faults relating to the cycles immediately, so that they can be maintained in a roadworthy condition
- If any damage is sustained to a cycle or other loaned equipment while in the possession of a user (beyond reasonable wear and tear) then the user will reimburse Sandwell and West Birmingham Hospitals NHS Trust on demand the cost of any repair required and shall be invoiced accordingly by the Trust (see costs to replace section)
- If you have any health concerns about riding a bike, speak to your GP or an OH advisor

Staff Physiotherapy Service

Did you know that you can refer yourself in for a specialist physiotherapy assessment for any musculoskeletal problem? If it is affecting your work we could assess you within hours of you contacting us.

TO SELF REFER TO PHYSIOTHERAPY RING 0121 507 2664 OPT 3. Please state you are a staff member when self referring **and let us know if you are not at work or at risk of going off work with your problem. Even if your work isn't affected you can still access the service on the same number.**



Services available;
- Assessment and treatment of musculoskeletal problems.
- Mobilisation techniques
- Acupuncture
- Hydrotherapy Sessions
- Pain Management sessions

Choice of venue available at;
- Sandwell and City
- Referrals are accepted from GP, Consultant, Self referral, Community Orthopaedic Service

Appointments are usually within one week and appointments last 30 minutes

Tai Chi

Tai Chi is a gentle exercise which is suitable for everyone. It originates from China. The particular benefits of Tai Chi lie in its accessibility to those unable to do other exercises due to age, illness or disability.

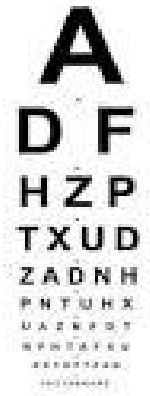
Tai Chi is excellent for conditions such as arthritis.

Beginners and wheelchair users welcome.

Date: 1st 2nd and 4th Tuesday of each month
Venue: Sandwell Physiotherapy Outpatients Gym
Time: 6-7pm
Cost: £2.50

For more information, contact Margaret Haines, West Bromwich Arthritis Care on 0121 556 5786/email: margaretgrahamhaines@talktalk.net

Free Eyesight Test



If you regularly use visual display units (Display Screen Equipment) you are entitled to a free eye test.

To qualify for the test please complete part A of form Eye 1 ensuring your manager has completed part B of the form and then collect your VDU eye care voucher from the Occupational Health Department.

You can then arrange for a test at Specsavers Practice of your choice. This voucher will also entitle you to receive a pair of £45 single vision CR39 glasses, solely for VDU use only.

Forms can be found on connect intranet using search word 'eye test' or by contacting the Occupational Health Department on Ext: 3306

BDMA Counselling Service

Worried, anxious, or problems, contact your BDMA Counsellor free of charge to all of our SWBH NHS Trust Employees. **Call 0800 919 765**

BDMA Counselling Service

Worried, anxious, or problems, contact your BDMA Counsellor free of charge to all of our SWBH NHS Trust Employees. **Call 0800 919 765**

In the counsellor's chair
Questions often asked of the BDMA counselling service

Q. Is the service confidential?
A. The counselling offered by BDMA is independent of the Trust and works to the Ethical framework (Code of Ethics and Practice of the BACP) and is therefore confidential. No report is made to any manager of the clients attending, nor the subjects discussed. However, if a client tells a counsellor they are going to break the law and hurt themselves or someone else, then there is no confidentiality. This rule applies to doctors, nurses, social services, etc., as well.

Q. Where will I be seen?
A. The counselling service has its own room within Occupational Health at both Sandwell and City hospitals.

Q. What issues can I discuss in the counselling? Is it just for workplace problems?
A. The counsellors are trained to deal with a wide range of issues/problems and the majority (some 65%) are nothing to do with the workplace.

Q. How many sessions will I have and how often will I be seen?
A. BDMA counsellors are brief therapists and work to a 6 session model, but the average number of appointments clients take is an average 3.8. Because we work in a very cognitive behavioural way we space the sessions out to every 4 to 5 weeks, this enables you to complete the tasks the counsellor sets and provides you with support over a longer period of time.

Q. What happens if I have had 4 sessions and I experience a personal tragedy, such as bereavement?
A. Your counsellor would discuss this with one of the directors of BDMA and in most cases extra sessions are awarded.

Q. What happens if I need to talk to a counsellor today?
A. The BDMA counselling help-line is available 365 days a year and is open from 7am to 11pm every day, including Christmas day and New Years day.
Help-line number is **0800 919 765.**

If you have any questions about the counselling service you would like answered or to be featured in future editions of "In the counsellor's chair" please contact Dr Kevin Buchanan-Dunne, Director, BDMA Ltd on 01948 665 129 or email info@bdma-oc.co.uk

Books on Prescription – all available from the library

Coping with memory problems
by Baxendale, Sallie.

Material type: Book; Format: print ; Literary form: not fiction

Publisher: London : Sheldon Press, 2014

Online Access: DWMH Athens users click here

Availability: **Items available for loan:** Birmingham Heartlands Hospital [WM 221] (1), Good Hope Hospital [WM 221] (1), Solihull Hospital Library [WM 221] (1), Uffculme Library [WM 224] (1). **Items available for reference:** Dorothy Pattison Hospital Library [WM 224] (1).

Reserve

Understanding Alzheimer's disease and other dementias
by Draper, Brian.

Material type: Book; Format: print bibliography ; Literary form: not fiction

Publisher: London : Jessica Kingsley Publishers, 2013

Online Access: DWMH Athens users click here

Availability: **Items available for loan:** Dorothy Pattison Hospital Library [WM 222] (1), Tariq Saraf Library [WM 222] (1). **Items available for reference:** Dorothy Pattison Hospital Library [WM 222] (1).
Checked out (1).

Reserve

Can I tell you about Dementia? : a guide for family, friends and carers
by Welton, Jude.

Material type: Book; Format: print bibliography ; Literary form: not fiction

Publisher: London : Jessica Kingsley, 2013

Availability: **Items available for loan:** Birmingham Heartlands Hospital [WM 221] (1), Dorothy Pattison Hospital Library [WM 221] (1), Good Hope Hospital [WM 221] (1), Solihull Hospital Library [WM 221] (1), Tariq Saraf Library [WM 221] (1), Uffculme Library [WM 221] (1).

Reserve

Dementia : support for family and friends
by Pulsford, Dave; Thompson, Rachel.

Material type: Book; Format: print bibliography ; Literary form: not fiction

Publisher: London : Jessica Kingsley, 2013

Availability: **Items available for loan:** Birmingham Heartlands Hospital [WM 221] (1), Dorothy Pattison Hospital Library [WM 221] (1), Good Hope Hospital [WM 221] (1), Solihull Hospital Library [WM221] (1), Tariq Saraf Library [WM 221] (1). Checked out (1).

Reserve

The Complete Guide to Overcoming Eating Disorders, Perfectionism and Low Self-Esteem (ebook bundle) [electronic resource]
by Freeman, Christopher.

Material type: Book; Format: electronic available online

Publisher: New York : Constable & Robinson, 2013

Online Access: BSMHFT Athens users click here

Availability: No items available

Overcoming Depression [electronic resource] : A Books on Prescription Title
by Gilbert, Paul.

Material type: Book; Format: electronic available online

Publisher: New York : Constable & Robinson, 2009

Online Access: BSMHFT Athens users click here

Availability: **Items available for reference:** Electronic Library [WM 171] (1).

Overcoming Obsessive-Compulsive Disorder [electronic resource] : A Books on Prescription Title
by Veale, David; Willson, Rob.

Material type: Book; Format: electronic available online

Publisher: New York : Constable & Robinson, 2009

Online Access: BSMHFT Athens users click here

Availability: **Items available for reference:** Electronic Library [WM 172] (1).

Overcoming Anxiety [electronic resource] : A Books on Prescription Title
by Kennerley, Helen.

Material type: Book; Format: electronic available online

Publisher: New York : Constable & Robinson, 2009

Online Access: BSMHFT Athens users click here

Availability: **Items available for reference:** Electronic Library [WM 172] (1).

Losing Clive to younger onset dementia : one family's story
by Beaumont, Helen.

Material type: Book; Format: print ; Nature of contents: ; Literary form: not fiction

Publisher: London : Jessica Kingsley, 2009

Online Access: Table of contents only

Availability: **Items available for loan:** Birmingham Heartlands Hospital [WM 221] (1), Good Hope Hospital [WM 221] (1), Solihull Hospital Library [WM 221] (1), Uffculme Library [WM 40] (1).

Reserve

Class Hydrotherapy Exercise

Starting 11th October then sessions every other week.

Saturday, 3.30-4.30pm

£3.00 per session

Portway Centre, Newbury Lane, Oldbury B69 1HE

Hosted by West Bromwich Arthritis Care.

For more information, contact Margaret Haines, West Bromwich Arthritis Care on 0121 556 5786/email: margaretgrahamhaines@talktalk.net

Staff Rehabilitation & Physical Exercise Programme

What is the staff rehabilitation and physical exercise programme?
This is a referral service, in partnership with Active Health Club, (the staff gym based at City Hospital), we are able to offer you 4 **week free membership** to Active Health Club.

Why have I been referred for?
It has been shown that physical activity is beneficial for your health.
Specifically physical activity helps prevent and manage certain conditions. These include: Diabetes, Cardiovascular disease, Stress, anxiety and depression, Weight management, Musculoskeletal problems and Post operative recovery.

What happens now?
The nurse, doctor or physiotherapist who has assessed you will complete a referral on your behalf. Please ring Occupational Health, Ext 3306 to arrange for a referral to be sent .

BOSTIN BIKES

Black Country residents can purchase a Raleigh bike for just £50 when they complete cycle training levels one and two.

HOW TO BENEFIT

1. Complete and pass the Level One - Novice Cycle Training Course.
   Book at bikeright.co.uk/ westmidlands

2. Commit to the Level Two - Improvers Cycle Training Course on the day and pay a £50 deposit

3. You will then be able to borrow the bike for **free** to practice with until your next course date

4. Return to the training centre to complete your Level Two - Improvers Cycle Training Course

5. Complete and pass the Level Two - Improvers Cycle Training Course

6. You will then be able to purchase the bike and the accessories using your £50 deposit or if you do not wish to purchase the bike, the deposit will be returned to you

You will also need to read and agree to the terms and conditions, available at: mynetwork.org.uk/bostinbikes.

Planning for Your Retirement Seminar

Are you thinking about retiring? This seminar guides you through the financial complexities of retirement in a clear and jargon free presentation. Whether you are planning to retire in the not too distant future or thinking about the best financial options for retirement at a later date this seminar covers: state pensions, NHS pensions, saving and investing, taxation, credit history, mortgage/remortgages, wills and inheritance tax, and how to get the best advice. This seminar is available for all staff and there will be opportunity for questions and answers after the seminar.

Date: Wednesday, 4th November 2015
Venue: Hayward Lecture, Postgraduate Centre, City Hospital
Time 9.30-1.00pm

Date: Wednesday, 11th November 2015
Venue: Hennessy Lecture Theatre, Medical Education Centre, Sandwell
Time 9.15-1.00 pm

A Representative from the National Health Service Retirement Fellowship will also be giving a short presentation after the seminar.

For bookings please contact Jatinder Sekhon on ext. 2856

SANDWELL AND WEST BIRMINGHAM NHS RETIREMENT FELLOWSHIP

Would you like to maintain contact with friends and colleagues?
Then why not join the branch of the NHS Retirement Fellowship which was formed in 2005.
The branch is open to everyone who has ever worked, and is now retired or semi-retired from the National Health Service - our members, male and female, worked in all areas of the NHS.

Monthly meetings are held on 2nd Monday of the month between 2and 4 p.m., at Hallam Street Methodist Church Hall, Lewisham Street, West Bromwich.
There is a varied programme of speakers/quizzes and social events.

If you are interested then please contact - Ann Harrison - 0121 525 1123
email - annken26@btinternet.com

Further information can be found at www.nhsrf.org.uk"

SANDWELL AND WEST BIRMINGHAM
NHS RETIREMENT FELLOWSHIP PROGRAMME
FOR 2015/16

Meetings are held 2nd Monday in the month between 2 and 4 p.m., at Hallam Street Church Hall (entrance in Lewisham Street) West Bromwich.

2015		
April 13	*Medical Detection Dogs*	*Hannah Malloy*
May 11th	*Annual General Meeting*	
June 8th	*Welsh Love Spoons*	*Keith LLewelyn*
July 13th	*Solomon Islands*	*Carol Gibbs*
August	*NO MEETING*	
September 14th	*DVD/CD Sale*	
October 12th	*Sandwell Sargeant at Arms*	*George Murray*
November b9th	*History on the Wall* *Blue Badges*	*Keith Hodgkins*
December 14th	*Christmas Tea*	
2016		
January 12th	*Mexico*	*Janet Linney*
February 8th		*Hilary Shotton*
14th March	*Bring and Buy Sale*	

Walks and meals out to be arranged during the year.
Annual subscription - £7 + £2 per month (towards refreshments and incidental) expenses Monthly raffle
Apologies to Secretary please - Ann Harrison (0121-525-1123) answerphone for messages

Circuit Training with Marina

Every Tuesdays
Time 5.45-6.30pm

Fitness Classes available for members and non-members Personal Programmes to help improve your own fitness goals Spacious Changing rooms and showers

£3.50 for members and £5.00 for non members

For more information please Contact Sarah On - s.clifford1@nhs.net/ sjclifford@live.com 07966282049 or 0121 507 5008

Gym is situated at Ellis House behind the Pharmacy Department

WALKING CHALLENGE

Birmingham Walking Challenge

Take to your feet with the Birmingham Walking Challenge and feel the benefits. Walking is a sociable, free and easy and it's a great way to keep in shape. You can also save money on travel costs, spend quality time with friends and family and make new discoveries in your local area.

All you need to do is:

Sign up for your free account

Log you walks on the challenge website and this can be walks connected with work, e.g. walks to meetings.

Track distance walked and calories burned and CO2 saved.

Compete with family and friends

Challenge yourself to increase walking month by month

There will be a prize for the most amount of miles walked.

GET STARTED AT www.livingstreetschallenge.org.uk/birmingham

Mandi Slater
Sustainable Promotions Officer
Smarter Choices
Tel: 0121 303 1873

Activ Health Club

Open Day Active Health Club Gym - City Hospital
Ellis house. Behind the Pharmacy department.

Monday 14th of September. 10.30am - 5.00pm
Free BMI and BODY FAT testing and get the chance to sign up for our Special offer for September:

SEPTEMBER SPECIAL -
Join up on a monthly membership in September and pay £0 till October - You get the rest of September for FREE!

To find out about other membership options
pl***ease contact Sarah: 07966282049/ext 5008 or s.clifford1@nhs.net***

TRACEY'S HOLISTIC AND BEAUTY THERAPY

Activ Health Gym, Ellis House, **City Hospital** – *(Sandwell appointments available from October 2015*) Mobile No: 07716 811038 Email : tracey.moore7@btinternet.com

NOW AVAILABLE
GEL NAIL POLISH £20.00 (inc. dry manicure)
Gentle on the natural nail and the polish stays intact on the nail for at least a couple of weeks with high shine and no cracking, peeling or chipping.

SPRAY TANNING £15.00
I have pleasure in introducing IBIZA BRONZE, as the latest spray tan on the market using ECOCERT certified DHA that will ensure a fantastic NATURAL, streak free tan for up to 7 days as long as you look after it properly.




SPECIAL OFFERS
AROMATHERAPY MASSAGE
Shoulder & Neck Massage £10.00. A great lunch time treat.
Back Massage Normally £20.00 (£15.00 for September 2015 only)
Full Body £30.00
GIFT VOUCHERS ARE AVAILABLE (For any treatment or any amount)

REFLEXOLOGY Normally £30.00 (£25.00 for September 2015 only)
On attendance of these days; take advantage and book an Aromatherapy Back Massage or Mini Manicure for £10.00.

Macmillan Coffee Morning - Friday 25th September 2015. 11.30 - 14.00 pm
Take a break and pop along for a treat and relax with a hand and arm massage. Donations appreciated for such a worthy charity. Everyone welcome.

Free Debt Advice for Trust Employees

NHS Health Check

R D R V W P E W L B P D R J J

E O T E Y E P I M C U A K W N

Q I T Z Z J F I S H I R K L P

E R U S S E R P Q O B L O O D

M T O J S F E L E L C Q K W V

Z Q R T P C F U Y E H H I Z M

R E Y O U U R C S S T K E F S

J L I D P D E H X T L E O C I

E F E G M P E K U E A T O M K

E R V G V M U U X R E P M H C

A H U C T F G S O O H C F K U

O W K B K M H N Q L D K A A R

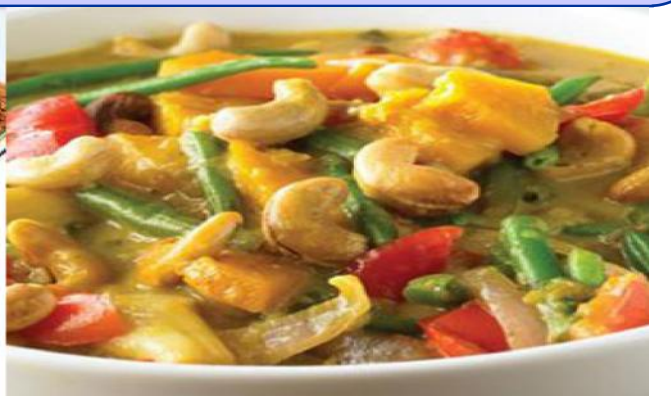
G J M D J Q X D V E V A K F T

L T H J K A Q H Z M W Y Z R A

T I P N K Y H A O W M S U N U

BLOOD
BMI
CHECK
CHOLESTEROL
FREE
HEALTH
LIFESTYLE
MOT
PRESSURE
REDUCE
SUPPORT

Vegetable Curry



Ingredients

1 packets of green beans
1 large onion, peeled
4 carrots, peeled
1 large courgette
1 medium sized Aubergine
1 large red pepper
2-3 sweet potatoes, peeled
1 bag spinach
1 tablespoon of oil
1tsp garam masala
1tsp curry powder

1 can of reduced fat coconut milk (400ml)- this ingredient is optional
2tbsp balti curry paste

Method

1. Wash the vegetables and then cut them into small chunks or strips

2. Fry the vegetables in the oil until softened, add a little water if the vegetables start to stick.

3. Add the chilli, spices and curry paste and fry for 1 minute

4. Add the chopped tomatoes, turn the heat down and simmer for 10 minutes

5. Add the coconut milk and sprinkle the spinach over the top, simmer for another 5 minutes until the spinach has wilted then serve.

For further information on anything featured in this newsletter please contact, Jenny Wright, Health and Wellbeing Facilitator ext. 3848 or email: jenny.wright9@nhs.net

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**R&D Report for the Trust Board October 2015**
SPONSOR (EXECUTIVE DIRECTOR):	**Dr Roger Stedman**
AUTHOR:	**Prof Karim Raza (R&D Director) & Dr Jocelyn Bell (Head of R&D)**
DATE OF MEETING:	**1st October 2015**

EXECUTIVE SUMMARY:

The Trust's R&D Plan 2014-17 defines the following nine objectives:

1. **To increase the *number of patients* recruited to clinical studies**
2. **To increase the *internationally recognised excellence* of our research portfolio**
3. **To increase the *breadth* of our clinical research portfolio**
4. **To increase the *range of health care professionals* contributing to our clinical research portfolio**
5. **To translate research into *better and safer clinical care***
6. **To align R&D with the Trust's vision of being renowned as the best integrated care organisation in the NHS**
7. **To align R&D with the strategic aims of our academic partner organisations**
8. **To make patients aware of R&D and empower them to influence it**
9. **To ensuring rigorous governance processes and necessary infrastructure**

Significant progress is being made towards each of these as described in the attached report (see Page 5-11 column 3 "Now: 2015").

Notable successes have been achieved in relation to a number of our objectives, in particular 2, 3, 4, 8 and 9.

Regarding objective 1, 2014-15 saw us recruit our *largest ever number* of patients to NIHR portfolio adopted studies (n=2,085). In 2015-16 we predict that we will *exceed this* and recruit circa 2,500 patients to NIHR portfolio adopted studies. These achievements will have been realised in the context of challenging circumstances, in particular (i) reduced R&D staff capacity and (ii) additional external regulatory demands (as described in the attached report (see Page 12 "Contextualisation"). Nevertheless this increased activity falls short of the targets set in our R&D Plan. Via the two workforce reviews in 2014-15, the R&D department has been restructured in a way that we anticipate will significantly improve efficiency. Approaches to facilitate increased patient recruitment and increased departmental efficiency are described in the attached report (see Page 12 "Contextualisation").

REPORT RECOMMENDATION:

To review progress against Objectives 1-9 in the context of the recent restructuring of the R&D department. Performance against these will be monitored via the 2 monthly R&D committee chaired by Dr Roger Stedman.

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

Accept	Approve the recommendation	Discuss
		x

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

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

Comments:

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

PREVIOUS CONSIDERATION:

R&D Report for the Sandwell and West Birmingham Hospitals NHS Trust Board meeting: October 2015

The Trust's 2014-17 Plan R&D Plan focuses on nine key objectives (below).

This report provides an update on **progress towards those objectives** with relevant **contextualisation** and a **summary of key threats and opportunities**.

OBJECTIVE 1: To increase the *number of patients* recruited to clinical studies adopted onto the National Institute for Health Research (NIHR) portfolio from ca 2,000 patients per year to 6,000 patients per year by April 2017.

OBJECTIVE 2: To increase the *internationally recognised excellence* of our research portfolio. Specifically we will develop an additional two areas of research excellence.

OBJECTIVE 3: To increase the *breadth* of our clinical research portfolio. Specifically we will develop a **new research portfolio** in at least **five disease areas** where research activity was absent / modest between 2011 -2014.

OBJECTIVE 4: To increase the *range of health care professionals* contributing to our clinical research portfolio. Specifically we will promote the involvement of Nurses and Allied Health Professionals (AHPs) in research, ensuring that at least three NIHR portfolio adopted studies are led at SWBH by Nurses / AHPs.

OBJECTIVE 5: To translate research into *better and safer clinical care*. Specifically we will develop innovative ways of implementing evidence based health care in at least new three domains.

OBJECTIVE 6: To align R&D with the Trust's vision of being renowned as the best integrated care organisation in the NHS. Specifically we will develop a new forum with representation from primary and secondary care within which we can develop a strategy for research at the primary / secondary care interface.

OBJECTIVE 7: To align R&D with the strategic aims of our academic partner organisations. Specifically we will develop our links with our partner Universities to develop at least **two** new joint positions to support Objective 2 (Promoting internationally recognised excellence in clinical research).

OBJECTIVE 8: To make patients aware of R&D and empower them to influence it. Specifically we will: (i) Develop a consistent approach to the branding of the Trust's R&D activities. (ii) Develop the R&D website and the effective use of social media. (iii) Expose patients to R&D from the time of their initial contact with the organisation with a focus on electronic check in desks with 70% of all outpatients being asked if they would be interested in taking part in research. (iv) Ensure patient representation in decision making processes via patient representation on the R&D committee.

OBJECTIVE 9: To ensuring rigorous governance processes and necessary infrastructure. Specifically (i) The Research Management team will ensure that all research studies are reviewed and set up in accordance with national time lines and delivery of studies is performance managed to ensure adherence to national recommendations. (ii) We will have increased annual income generated from commercial research and though IP management from £400,000 to £1,000,000 by 2017.

Why Research and Development matters at Sandwell and West Birmingham Hospitals NHS Trust

Research is integral to our ambition to continually improve the safety and quality of the care we provide to our patients.

A strong culture of research at Sandwell and West Birmingham Hospitals matters to us because:

- It matters to our patients. Extensive research has shown that patients believe it is important for the NHS to carry out clinical research with the vast majority wanting to be treated in a hospital where research takes place.
- It allows us develop and deliver more effective ways of looking after our patients.
- It matters to our staff. Encouraging and facilitating our clinical staff to ask questions, to develop research strategies to address them and to contribute to local, regional, national and international research studies will allow our healthcare workforce to develop to its full potential. A culture of research in any NHS organisation empowers its staff to think critically and facilitates innovation.
- It allows for income generation through innovation to support the development of research capability and the translation of research findings into improvements in patient care.
- It matters to the NHS. The Government is committed to the promotion and conduct of research as a core NHS role, recognising that this is an integral component of its strategy to "*improve the health and wealth of the nation*".

In becoming an organisation recognised as delivering the highest quality health research, and in developing our unique R&D portfolio, we will:

- Meet our patients' expectations that they are cared for in an environment where research is at the centre of improving the safety and quality of their healthcare.
- Attract patients who want to be looked after in such an environment.
- Attract the highest calibre of staff to work in our organisation.
- Attract investment from commercial and non-commercial organisations to underpin growth and development.

How the Trust's 2014-17 R&D Plan fits with our strategic objectives:

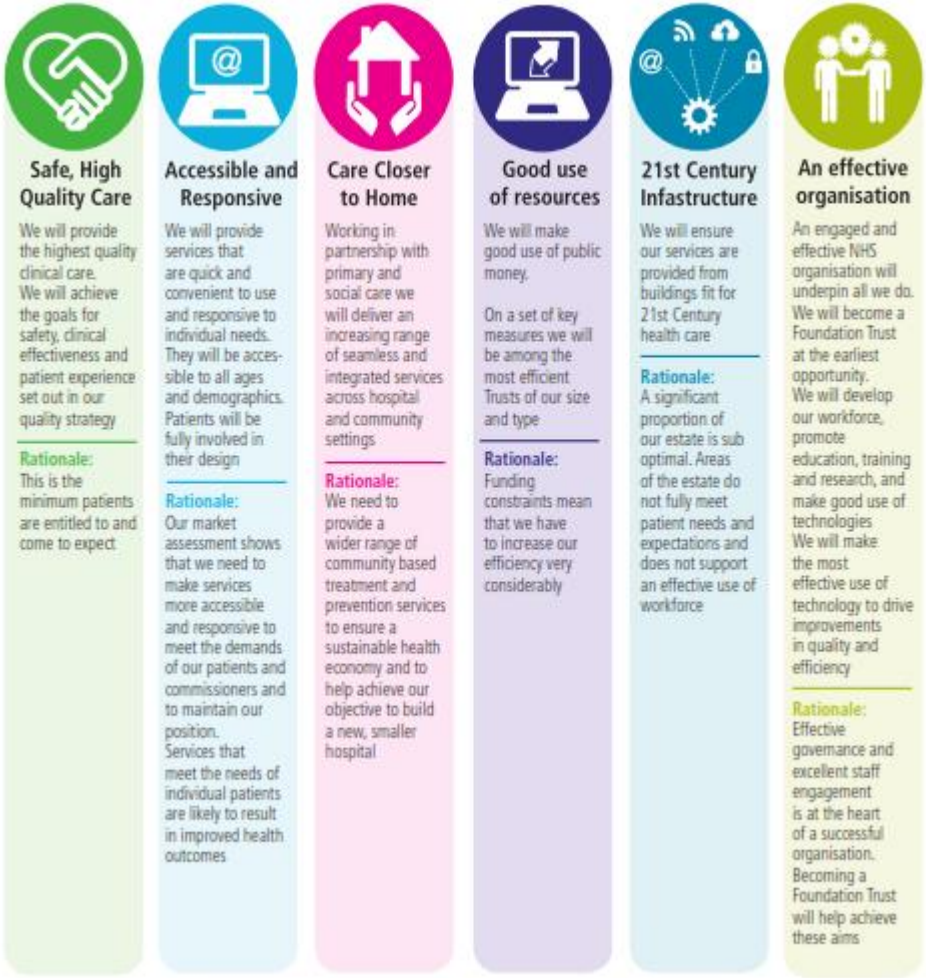
Delivering safe high quality care is at the centre of everything we do. Making care safer and of higher quality is the critical objective of the research we undertake and is why the R&D plan is so important.

There some areas in which research at SWBH is already of the highest standard and where our work has influenced approaches to disease management at both national and international levels. We want to grow those areas. But we also want to increase the breadth of our research, empowering the full spectrum of health care staff to deliver research and to give all our patients the opportunity to take part in research. In doing, so we will make ourselves truly responsive to our patients' needs.

The Trust serves a large and ethnically mixed population and has excellent links into the community, where the care of many patients with chronic longer term condition is increasing focussed. This population and these links put us in a privileged position to develop a diverse and innovative research programme.

High quality research requires considerable resource. We already have the two most important elements of that resource– committed and enthusiastic staff and patients who are keen to work with us. We will continue to develop our resource recognising that the success of R&D plan will be facilitated by the success of all the Trust's plan, for example the IT plan. To deliver to our full potential we will, however, need to engage more actively and strategically with our partner organisations. The Universities in the West Midlands are some of the best in the country and our local enterprise are some of the most innovative. We will develop our links with them, ensuring that our plan complements that of important local and regional initiatives such as the Institute for Translational Medicine, under the direction of Birmingham Health Partners, and the West Midlands Academic Health Sciences Network.

We begin from a strong position. Three years is not long but it is long enough to position ourselves as an organisation with a unique focus which delivers outstanding clinical research and contributes as a critical stakeholder to translational biomedical research in the West Midlands.



Current excellence in Clinical Research at Sandwell and West Birmingham Hospitals NHS Trust

The Trust has a long and proud track record of excellence in clinical research. The following examples give a flavour of our ability to attract significant research grant funding, and to develop new products and approaches to clinical management that have improved the quality of life of many of our patients.

Our **Cardiologists** have developed risk scores for stroke (CHA2DS2-VASc) and bleeding (HAS-BLED) specifically for use in atrial fibrillation, providing clinicians with simple tools to assess stroke and bleeding risk and allowing them to identify and counsel patients, thereby improving clinical practice and patient safety. This, amongst other achievements, led to the 'BMJ Group Cardiovascular Team of the Year' award in 2013. These 2 risk scores are recommended within the 2014 NICE guidelines for atrial fibrillation.

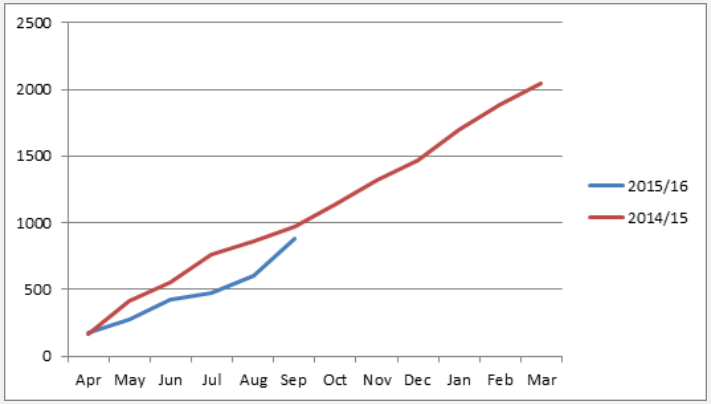
Our **Rheumatologists** have been awarded the Arthritis Research UK Centre of Excellence in the Pathogenesis of Rheumatoid Arthritis (RA), and lead a European Union consortium funded at €5.7M to develop strategies to predict and prevent the development of RA in those at risk. They have identified that the earliest phase of joint inflammation in those destined to develop RA is characterized by a distinct pattern of inflammation, a finding which has significant implications for the approaches to the treatment of early disease.

Our **Neurologists** have recently published, in *The Lancet,* the largest drug study in Parkinson's disease ever conducted. It shows that levodopa therapy leads to better patient-rated quality of life than dopamine agonists and MAOB inhibitors and will lead to changes in clinical practice at an international level.

Our **Ophthalmologists** have been developing a synthetic flowable dressing to prevent scarring of the cornea, currently a leading cause of worldwide blindness, and a tool to measure conjunctival scarring. In addition they have made important discoveries regarding the roles that cell of the immune system play in conditions causing inflammation at the front and the back of the eye. Excellence in these areas was central to SWBH being awarded the status of National Centre of Excellence for Beçhet's Disease.

Our **Gynaecological Oncologists** have developed new approaches to diagnostic testing in patients with gynaecological cancer and have been commissioned by the National Institute for Health and Care Excellence to develop and deliver a study to investigate approaches to the treatment of ovarian cancer.

The 2014-17 Plan: Main deliverables – then and now

	Then: 2014	Now: 2015
OBJECTIVE 1: **Increasing clinical research activity** The central objective of the R&D plan is to bring about an increase in recruitment achieving 6,000 patients recruited to NIHR (National Institute for Health Research) portfolio adopted studies by April 2017. The increase will be incremental as follows: 2,500 patients in year 2014-15, 4,000 patients in year 2015-16 and 6,000 patients per year by April 2017.	In 2013-14, 2,042 patients were recruited from SWBH into clinical studies on the NIHR research portfolio. This itself was our best ever year in the context of the numbers of patients recruited.	**2014-15 saw us recruit our *largest ever number* of patients to NIHR portfolio adopted studies (n=2,085).** **Current recruitment in 2015-16 is shown below** (data for 2015/16 will be **up to 12 weeks behind real time** due to delays in national uploading of recruitment information):  **Despite a slow start we predict that we will exceed the number of patients recruited in 2014-15 and anticipate recruiting circa 2,500 patients this year. This enhanced rate of recruitment will be facilitated by:** 1. **Vacant R&D posts being filled in October / November 2015 giving us access to more delivery staff.**

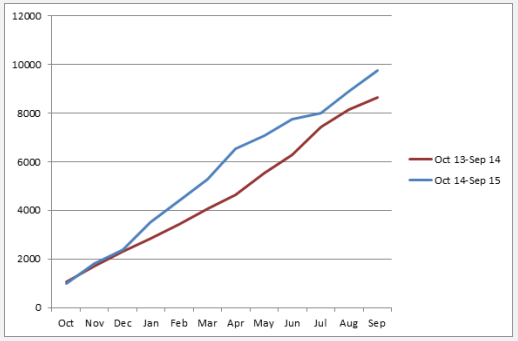
		2. Likely high recruiting clinical studies becoming active in October / November 2015-16. **This increase activity in 2014-15 and 2015-16 has been achieved in the face of reduced staff resource. The reasons for failing to meet the original target within the R&D plan are described on p12 (Contextualisation).**
OBJECTIVE 2: **Promoting national and international excellence and leadership in clinical research** We will continue to support and develop our areas of research excellence. We will expand our portfolio of research by developing at least two disease areas in which we are national / international leaders.	Researchers at SWBH lead internationally recognised research programmes in several disease areas including: • Atrial fibrillation • Gynaecological malignancies • Inflammatory eye disease • Parkinson's disease • Rheumatoid arthritis • Systemic lupus erythematosus Research carried out at SWBH has: • Led to significant advances in our understanding of disease mechanisms. Enhanced our ability to predict, prevent and treat common diseases associated with major health burdens. • Informed national and international guidelines on disease management.	**Over the last year we have achieved considerable success in developing research by securing major national grants in a range of areas including:** • **Behçet's disease:** MRC funding secured for a clinical trial investigating 'Optimal utilisation of biologic drugs in Behçet's Disease: a randomised controlled trial of infliximab vs alpha interferon, with genotyping and metabolomic profiling, towards a stratified medicines approach to treatment'. • **Systemic lupus erythematosus:** MRC funding secured for 'Maximizing SLE therapeutic potential by Application of Novel and Stratified approaches (MASTERPLANS)'. • **Rheumatoid arthritis:** MRC funding secured for **'**Maximising Therapeutic Utility for Rheumatoid Arthritis using genetic and genomic tissue responses to stratify medicines (MATURA)'. • **Gyane-oncology:** NIHR funding secured for 'ROCkeTS - Refining Ovarian Cancer Test Accuracy Scores' and 'SOCQER-2: Surgery in Ovarian Cancer – Quality of Life Evaluation Research' has been commissioned by NICE. • **Cardiology:** NIHR funding secured for 'CBT-AF: Cognitive Behavioural Therapy to reduce anxiety and depression in

		patients with atrial fibrillation'. • **Neurology:** Funding secured for 'PD COMM: Lee Silverman Voice Treatment versus standard NHS Speech and Language Therapy in Parkinson's Disease' study'. **Working with Jessica Barlow, Library Services Manager, we have collated data on all research publications from SWBH staff in 2014-15. This exercise will be repeated annually. Moving forward we will capture the extent to which these publications have been cited as a surrogate measure of their impact. This will serve as one of a number of objective measures in relation to Objectives 2 and 3 in our R&D Plan.**
OBJECTIVE 3: **Increasing the breadth of our clinical research portfolio** It is our vision that all patients looked after at the Trust are given the opportunity to take part in clinical research.	Our research portfolio has breadth as well as depth. In addition to disease areas where we are recognised as leaders in the field, we actively contribute to nationally and internationally recognised research across all clinical directorates with active research programmes in areas including: • Dermatology • Diabetes • Gastroenterology • Haematology • Metabolic medicine • Oncology	**We have raised the profile of research amongst Trust staff using a number of strategies including:** • **Promotion of R&D activity in Trust publications including Heartbeat and Innovation and via social media including Twitter.** • **The institution of a regular forum for current and potential Investigators to meet and discuss best practice and the potential for collaborative opportunities.** **We have worked with clinical groups to develop research in areas of historically limited activity. Specifically we have developed new research portfolios in the following specialities:** • **Respiratory medicine** • **Renal medicine** • **Clinical Immunology** • **Anaesthesia & Critical Care**

	• Paediatrics • Reproductive health • Stroke	
OBJECTIVE 4: **Increasing the *range of health care professionals* contributing to our clinical research portfolio** We will have promoted the research leadership by Nurses and Allied Health Professionals (AHPs), ensuring that at least three NIHR portfolio adopted studies are led at SWBH by Nurses / AHPs.	Our research portfolio is led predominantly by doctors. There are however several examples of Nurses and Allied Health Professionals (AHPs) conducting research as part of educational projects e.g. MSc projects and PhD training Fellowships.	**We have achieved notable success in promoting research amongst AHPs for example:** • **Mohammed Tallouzi, a Surgical Care Practitioner working in BMEC, has been successful in gaining an NIHR/HEE Clinical Doctoral Research Fellowship.** • **Roanna Burgess, a Consultant Physiotherapist, has been successful in obtaining funding to pursue a Doctoral Research programme between SWBH and the Arthritis Research UK Centre of Excellence in Primary Care at the University of Keele.** • **Neil Smith, a Physiotherapist, has been funded to study for an MRes at Coventry University.**
OBJECTIVE 5: **Translating research into better and safer clinical care** In addition to our current approaches, we will continue to work with the CLAHRC-WM to institute changes in clinical practice at the Trust in at least 3 clinical domains. This will improve the quality and safety of the care that we provide to our patients	The National Institute for Health and Clinical Excellence works to facilitate the implementation of evidence based healthcare throughout the NHS and Governance systems at the Trust ensure that guidelines are integrated into clinical care. We have worked with CLAHRC-WM (Collaborations for Leadership in Applied Health Research – West Midlands) to improve the quality of care we provide in relation to	**We have contributed to the 'Preventable Incidents, Survival and Mortality Study 2 (PRISM2)' and though this are involved with the development of a national system for mortality reviews.** **We are an active participant in 'Enhanced Peri-Operative Care for High-risk patients (EPOCH) Trial: A stepped wedge cluster randomised trial of a quality improvement intervention for patients undergoing emergency laparotomy'.** **Via the CLAHRC, researchers from Warwick Business School have worked with clinicians at SWBH in relation to '*Implementing a 'Patients Know Best', Personal Health Records pilot'.***

	our Readmissions project and our 10 out of 10 safety in healthcare project	
OBJECTIVE 6: **Aligning with the Trust's strategy** The Trust's vision is to be renowned as the best integrated care organisation in the NHS provides an ideal environment within which to strengthen a research programme operating at the interface between secondary care and, for example, primary care and social care. Research themes operating at these interfaces will be supported through close engagement between researchers at the Trust and local partner groupings and organisations. We will have developed a new forum with representation from primary and secondary care within we can develop strategy for research at the primary / secondary care interface. We will host research programmes to: • Understand the earliest phases of disease and to facilitate appropriate referral to secondary care. • Develop strategies for integrated care for patients with long term conditions including diabetes, heart failure and arthritis.	Several of our current research themes align with the Trust's objective of delivering 'care closer to home' through an integrated service across hospital, intermediate care and community settings.	**A number of examples have developed over the last year which demonstrate innovate ways of working at the primary care / secondary care interface:** • The **Community Rheumatology clinic**, operating within the Vitality Partnership, now recruits patients from primary care directly into research studies operating in secondary care. • The **Cardiology** IMPRESS-AF study now identifies patients directly from primary care to participate in a secondary care based interventional trial.

OBJECTIVE 7: **Aligning with the strategic aims of our academic partner organisations** We will develop our longstanding and highly successful academic links with the University of Birmingham and Aston University.	Many researchers at SWBH have very close links with local academic organisations, in particular the University of Birmingham and Aston University. These links have enabled the development of outstanding translational research programmes capitalising on the clinical strengths of SWBH and the scientific strength of its associated universities.	**Dr Depak Kotecha has been appointed to a joint UoB / SWBH position in academic Cardiology.** **Prof Paulus Kirchhof has been successful in securing a British Heart Foundation Senior Clinical Research Fellowship.** **Links with the University of Birmingham have facilitated free access to the Health Research Bus, currently based at Sandwell Hospital but that will facilitate research across the Black Country Alliance.**
OBJECTIVE 8: **Making patients aware of R&D and empowering them to influence it** We will increase the visibility of R&D and the research opportunities within it so patients are aware of studies they may be able to participate in.	We carry out our research to benefit our patients and can only do our research with our patients' support. Many of our research groups actively involve patients in the development, delivery and dissemination of research and individual examples of excellence in Patient and Public Involvement have been recognised at a national level.	**We have developed a strategy to expose patients to R&D from the time of their initial contact with the organisation with a focus on electronic check-in desks. Through this we will develop a database of patients interested in taking part in research studies.** **We have involved a patient representative in decision making processes, allowing the patient voice to help shape the direction of R&D and approaches to its delivery. Mr Brin Heliwell now acts as Patient Representative on the Trust's R&D Committee. Mr Heliwell is a passionate advocate for clinical research (http://www.theguardian.com/healthcare-network/nihr-crn-partner-zone/2015/jun/05/my-research-journey-video), is a PPI representative on several national research studies and has direct experience of working in the state sector having held senior teaching and management roles in secondary education.** **We have actively promoted research to members of the public through, for example, the Stroke Research Awareness Day 2015 and International Clinical Trials Day 2014.**

OBJECTIVE 9: **Ensuring rigorous governance processes and necessary infrastructure** We continue to ensure that our research is carried out to conform to the requirements of the Research Governance Framework and the highest standards of Good Clinical Practice and that we meet the delivery requirements of the National Institute for Health Research. The development of our R&D portfolio will be supported by an expansion in core members of the Research Management and Governance team and the Research Delivery team. This will be facilitated by income generated through: • Increased NIHR portfolio research • Increased commercial research • The effective management of intellectual property generated by researchers at the Trust Specifically we will increase the annual income which supports R&D, and that is generated from research grants, commercial research and IP management, from £400,000 to £1,000,000.	R&D activities at the Trust are supported by a Research Management and Governance team, and dedicated Research Nurses, Clinical Trials Practitioners and Data Coordinators. These teams work to ensure that approvals for clinical studies take place in a timely fashion and that the research process follows appropriate governance standards.	**We have submitted successful bids for strategic funding from the Clinical Research Network:** • **Prior to 2014 we had not been awarded strategic funding.** • **In 2014-15 we bid for, and were awarded, £10,000.** • **In 2015-16 we bid for £295,921 and were awarded £218,489.** **Importantly, the number of Activity Based Funding (ABF) Units that our recruitment of patients to NIHR portfolio adopted studies has attracted this year is greater than last year** (data for 2015/16 will be **up to 12 weeks behind real time** due to delays in national uploading of recruitment information):  **The ABF Unit cycle runs from October-September (as opposed to the cycle of number of patients recruited to studies which runs from April-March (see graph on p5)). The increased ABF Units this year is a result of (i) an increased number of patients recruited (ii) an increased proportion of patients recruited to complex studies.** **In relation to income from commercial research, we achieved just under £600,000 in 2014/15 and are on track to reach £700,000 in 2015/16.**

Contextualisation:

2014-15 and 2015-16 have been challenging for R&D for the following principal reasons:

- **Reduced R&D staff capacity**. During the course of the workforce reviews, three R&D posts were disestablished (a data coordinator post, a finance post and the Sandwell Medical Research Unit manager post). In addition, a number of members of staff have left to take up post at a range of organisations including University Hospitals Birmingham, Birmingham Children's Hospital, the Clinical Research Network and in the private sector. A feeling of lack of security at SWBH played a role in a number of these departures. Considerable Trust procedural delays in appointing to vacant posts have meant that we have been operating at below capacity for at least a year. **For example we currently have 10 posts unfilled out of a workforce of 40**.
- **New Governance systems** introduced by the Health Research Authority (HRA) have created significant additional work for the Research Management and Governance staff.

Although we are currently doing more with less (for example we recruited more patients to research studies in 2014-15 with a smaller number of staff in post compared with the previous year and are likely to do the same again in 2015-16), **we recognise that to meet our key objectives we need to improve efficiency further**. A number of approaches have been / are being taken in relation to this:

- The **Research Nurse team has been restructured**. We have disestablished the Band 8 Lead Research Nurse post and have replaced it with three Band 7 posts with each Band 7 research nurse managing a smaller pool of R&D delivery staff. The expectation is that this will allow each team to operate in a more efficient way with members of the teams providing more effective cover for studies across the team's portfolio.
- A new forum has been established within which all members of the R&D team meet 2 monthly to review progress towards the Objectives within the R&D plan.
- We have engaged with Dr Hilary Brown (Senior Fellow and Co-Director of Policy, Health Services Management Centre, University of Birmingham) who is conducting a study with R&D staff and local stakeholders exploring the role of the Clinical research nurse and addressing issues of 'productivity', identifying limiting factors and examining the structures/mechanisms that support research nurses effectively. Data will be made available once the second round of interviews is complete.
- Time sheet data have been collected from R&D staff and are currently being analysed by Lakbir Virk. This will help us to identify examples of excellence in productivity from which we can learn and also areas of weakness that we need to address.

Relevant R&D developments in Birmingham that will impact on SWBH:

- The multi-million pound **Institute of Translational Medicine (ITM)** http://www.birmingham.ac.uk/university/colleges/mds/about/institute-translational-medicine.aspx has recently opened at the University Hospitals Birmingham NHS Foundation Trust site. The ITM is a joint initiative between University Hospitals Birmingham NHS Foundation Trust, the University of Birmingham and Birmingham Children's Hospital as part of Birmingham Health Partners (BHP). It is likely that the ITM will attract resource from its partner organisation and will attract staff for neighbouring organisations.
- Plans for a Medical School at **Aston University** raise the possibility of joint clinical academic appointments with Aston. In particular the appointment of Mrs Shagaf Bakour as Director of Medical Education at Aston University creates the opportunity to appoint a joint academic post in Obstetrics with Aston.
- Discussions are underway as to how the **Black Country Alliance** can facilities research across its partner organisations. Shared resources, for example statistical support for researchers, and shared Governance reviews represent examples of potential benefit.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Patient, Staff & Visitor Food
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Steve Clarke – Deputy Director - Facilities
DATE OF MEETING:	Thursday 1st October 2015

EXECUTIVE SUMMARY:

The purpose of the paper is to inform the Trust Board of the current position of the Patient, Staff & Visitor food service and give a brief update as to any developments.

The report is to update on a number of questions that were raised following the food tasting and comment from the patient representative at the September Board Meeting.

REPORT RECOMMENDATION:

To receive an update at the October 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	X	Communications & Media	X
Business and market share	X	Legal & Policy		Patient Experience	X
Clinical		Equality and Diversity		Workforce	X

Comments:

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

PREVIOUS CONSIDERATION:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

PATIENT, STAFF & VISITOR FOOD

REPORT TO THE TRUST BOARD ON 1ST OCTOBER 2015

Patient Food

The patient meal service was reduced from two hot meals per day to one hot meal per day in October 2014. Prior to the introduction the views from both the patients and staff were that the preferred option was for the hot meal service to be served on the evening.

Following the change the feedback has been very positive; the evening meal service is a choice from the A La Carte menu. The lunch time service consists of soup and sandwiches or jacket potatoes. Any patient requiring a special meal still has the option of a puree or soft-mash meal at both the lunch and supper service.

All patient meals are developed in conjunction with the dieticians to ensure that the calorific and nutritional content meets the necessary requirement. There is no added seasoning in any of the food; seasoning can be added at the point of service in consultation with the ward staff. Some of the patient meals are cooked in a bouillon stock, this gives the dish additional taste and flavour and has been approved for use by our dieticians, the sauce has a very low salt content.

The Catering Department are now preparing all vegetarian curries in-house. The halal meals are all purchased externally from a validated specialist supplier, however the options are being explored as to a specialist chef or purchasing the service from within the Black Country Alliance (BCA).

A new patient meal ordering system has been introduced utilising I-Pads; this has improved the communication between the wards and catering. The system allows the patient to order a meal of their choice closer to the point of service. The development has also helped reduce the food waste from 11% to 9%, as the system does not allow for bulk ordering, each meal is designated to the individual patient thus reducing over-ordering and plate waste as the patient is receiving the meal of their choice. The national average for patient food waste is 10%.

The cost of the patient food meal provisions per day is currently £3.43 (not inclusive of snacks/water), the national Estates Return Information Collection (ERIC) indicates that the median range for acute Trusts in the West Midlands is £3.42 with the upper range £4.18.

To ensure all patients receive a quality meal service it is crucial for the ward and facilities staff to communicate and work together. This requirement will ensure the patient receives the meal of their choice, well presented, hot and in a timely manner.

Healthy Eating

In 2014 the Trust introduced a healthy eating campaign in our restaurants and cafes so that staff, visitors and patients who are purchasing food and drink on our premises have the choice of cheaper, healthier food. The menu consists of at least two healthy meals per day; the healthy meals are sold at a discounted price.

Catering has developed a number of new dishes to make healthy eating more attractive. The new dishes will be launched in tandem with the revised marketing strategy and signage for the cafés, timescales to be agreed.

Staff & Visitor Food

All of the catering outlets are providing a positive return on income as can be evidenced from the cafés individual trading accounts.

The majority of the outlets are busy with Arches being exceptionally busy as it is the preferred outlet for staff and visitors at City due to its location, hence there can be lengthy queues at the outlet at peak periods. The café in the Post Graduate Centre offers a similar service, although the service is profitable its capacity is not fully utilised mainly due to location

Future Plans

All of the patient meals are prepared at Rowley Regis Hospital in the Central Food Production Unit. It is planned to review this facility to ensure that it is still delivering value for money following the decision to change the lunch time service.

A re-launch of the healthy eating campaign is required. The intention is to improve the information and signage at all of the cafés and to promote the benefits of eating healthy, a prominent display of the dishes available, plus the nutritional information and the cost need to be in view and easy for all to see.

The Royal Voluntary Service (RVS) will be terminating their contract with the Trust from January 2016. The Catering Department will be incorporating the outlets and patient trolley rounds into their service. The RVS outlet at City Hospital will become an additional Costa/sandwich bar service which will subsequently ease the pressure on the Arches outlet in the main reception.

It is planned to install vending facilities for an out-of-hours hot meal service for staff at both City and Sandwell. The areas will be secure with access to staff only, locations have been identified, but awaiting confirmation re change of use.

Steve Clarke
Deputy Director - Facilities

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Our 2020 Vision**
SPONSOR (EXECUTIVE DIRECTOR):	**Toby Lewis, Chief Executive**
AUTHOR:	**Ruth Wilkin, Director of Communications**
DATE OF MEETING:	**1st October 2015**

EXECUTIVE SUMMARY:

In July we launched our 2020 vision and sought feedback from local residents, staff and stakeholders over its content. The resulting document has been amended in light of that feedback. Our clinical groups are continuing to develop the 2020 vision for their areas and will come back with updates to their chapters for discussion at the next informal board meeting.

We had feedback that the vision was clear and compelling and set out a strong commitment to seeing seamless integrated care for the residents of Sandwell and West Birmingham. We have updated the 2020 vision with increased reference to palliative and end of life care, health and social care commissioning and the role of the 3rd sector in delivering integrated care for patients.

In November we will launch our completed 2020 vision so that the public, patients, partner organisations, stakeholders and staff understand our plans for how care will develop over the next five years. We very much want people to continue to engage with us as we build our plans for the ambitious changes that we want to deliver.

REPORT RECOMMENDATION:

To note the revised 2020 vision document.

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

PREVIOUS CONSIDERATION:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Our 2020 Vision

Where EVERYONE Matters

Welcome to our 2020 vision

We want everyone to have the chance to learn about our vision for care in 2020.

This is for everyone involved with local care. Patients, carers, professionals, other organisations, members of staff, public members, volunteers, funders, suppliers, and students. Depending on your area of interest or expertise you are likely to spend more time understanding our vision for certain areas but there is always a common thread which is what our 2020 vision sets out.

This 2020 vision, described with patient stories and case studies, summarises what services will be like in five years' time, what will be different, and what will stay the same. The strategy shows you the highlights, not every detail, but it makes firm commitments to improvement.

Our goal is to become renowned as the best integrated care organisation in the NHS. That is a big ambition and we already have a strong track record and reputation for placing integrated care at the heart of what we do. We are not starting from scratch. Whether it is in our work to help patients and staff make healthy lifestyle choices, or in offering more locally accessible outpatient clinics in community centres and GP practices. The focus is now on this becoming the way we do things across every part of the Trust not just in some specialist areas.

This comes at a time when many care organisations are making a similar claim or stating a similar commitment. We know that in Sandwell and West Birmingham, patients experience integrated care on a daily basis. Our single measures of success will be the opinion of those we care for: Our patients.

We cannot achieve these plans alone. We have important partnerships in place with the voluntary sector, with our commissioners, with social care services, local schools, with GPs, dentists, optometrists, and pharmacies. We work with other hospitals, and expect to do that much more actively, especially across the Black Country, in coming years. We are deeply involved in educational excellence locally, and have high ambitions to develop research further at the Trust. We believe our plans fit well with those of other partners, especially those providing mental health care on which our work always depends. The 2020 Vision gives our partners clarity about our aims and ambitions.

Contents

1. Developing our vision for care in 2020

We have been working on our 2020 vision throughout 2014 with teams and services, clinicians and managers, having time to consider and develop their ambitions and plans for transforming the care they provide. Starting with our leadership conference in 2014, workshops, surveys and other tools have allowed us to test and refine the ideas of our staff, and to engage patients in developing ideas.

In July 2015 we launched our draft vision for care in 2020 and engaged with staff, patients, stakeholders and third sector organisations to gain their views. Our 2020 vision now reflects that feedback.

Our eight clinical groups have worked through how they can support each other's plans.
This work has led us not just to choices about priorities but also to a descriptive series of patient stories showing how care models will change.
In many cases most care will be delivered in the same way, and certainly to high quality standards but in all sorts of ways we expect to change the coordination of care - joining up more effectively with patients and their relatives, with GPs and other care partners, and across our own organisation, between sites and specialties. This coordination is a seven day a week ambition.

Our detailed plans will evolve as time moves on but the direction of travel is clear and consistent, in line with this 2020 vision. We want to take a lead role in disease prevention. We aim to provide care for long-term conditions in different ways and in partnership with GPs. Acute hospital care will be specialised and centralised for excellence and long-term rehabilitation and social care will be part of what we do, working alongside others to meet the changing needs of our population.

2. What do we mean by integrated care?

Sandwell and West Birmingham Hospitals NHS Trust provides care to over half a million local residents. One and a half million times each year someone has contact with one of our 7,000 staff. We are not, however, the biggest provider of care locally, nor the biggest provider of NHS care. We work in partnership with professionals in primary care, and with families and voluntary groups who support people in their own homes. Their roles will be enhanced by what we do.

Integrated care can mean different things to different people. It is for this reason, at the outset of developing our 2020 vision, that we felt it important to adopt one definition which clearly describes what integrated care means and which forms the basis of how we see care developing over the coming months and years. Central to this is making sure that we always put our patients at the centre with our services coordinating care on their behalf.

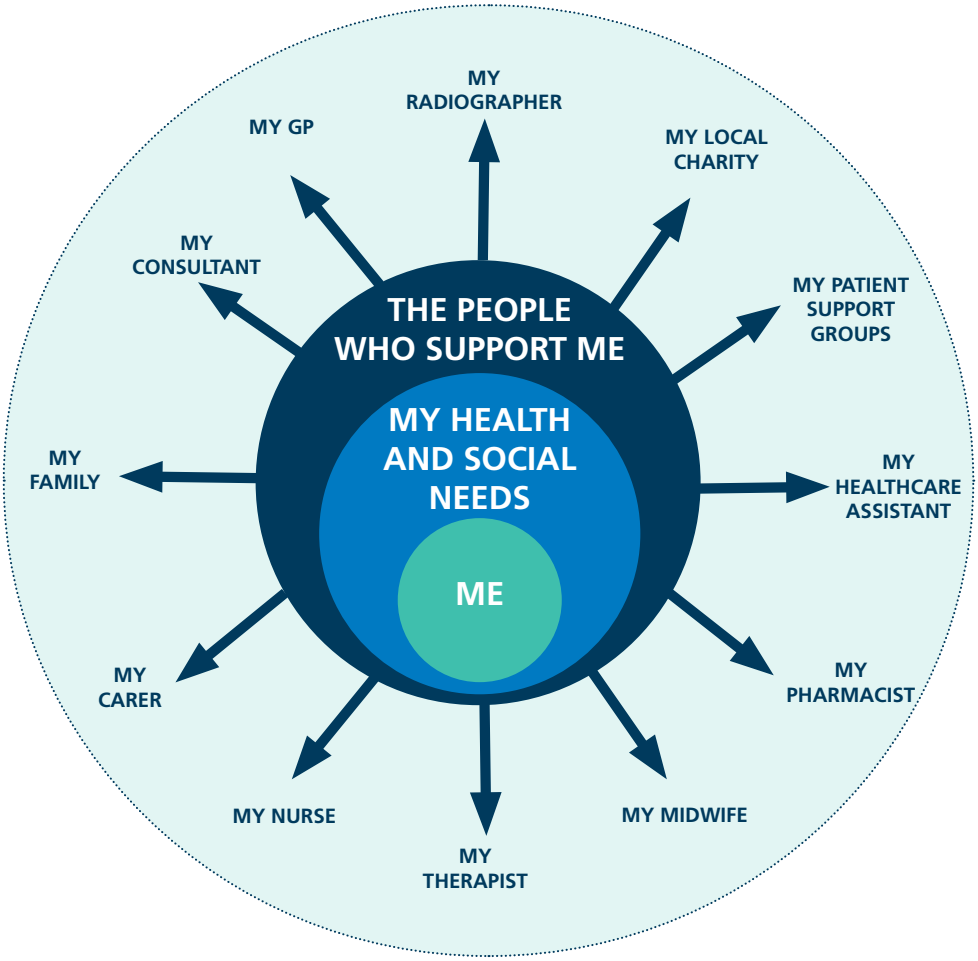
National Voices, a national coalition of health and social care charities in England, were tasked with developing a definition for person-centred coordinated care in 2013. This definition has been developed to take away the jargon of integration, and describe what this really means, feels and looks like from a patient's point of view. It is this definition we adopted in 2014 to set the direction for our organisation. This definition clearly puts patients, their families and carers in the driving seat when it comes to their care.

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"

Importantly, this definition makes it clear that location alone is not enough. Simply moving services "out of hospitals" does not deliver integrated working and it does not necessarily orientate services around the patient's needs. Location can be very important, especially where repeated consultation is needed. That is why the Right Care, Right Here focus is on local services for people with long term conditions. In the chapter on location we describe how patients who need follow-up outpatient appointments over a sustained period of time can expect to have these appointments or treatment at the most suitable place that is closest to them. We will for instance be supporting care provision In GP practices as we do now for diabetes, on a scale not seen elsewhere in the NHS.

Co-ordinated care does depend on connections made through technology. We are investing over £50million in technology in coming years. We want to be able to work across geographical and organisational boundaries. We strongly support Your Care Connected, which provides access to a summary care record for GPs and hospital staff. We are also working to improve patient access to the information we hold about you and your care.

Skilled, motivated people provide the best care. Teamwork is always at the heart of what we do, and good integrated care relies on inter-disciplinary working. Traditionally, NHS staff choose a career discipline, a job location, and a 'sector' to work in. We are working with our staff and our students to understand how to work best when we organise what we do differently, and how to prepare and prosper professionally when integrated models of care becomes our norm. These changes are exciting, but also daunting. We need to involve people, be clear with them, and support them in making the changes that we know need to be made. This is a Trust "where everyone matters".



INTEGRATED CARE PIONEER

New clinic helps patients manage their breathlessness

Patients who suffer with fatigue, anxiety and breathlessness are being helped by a new six week pilot clinic (F.A.B.) which has been established to help them manage their symptoms. The pilot clinic is a collaborative venture between the Specialist Palliative Care Team, Respiratory and iCares team. The team recognised that some patients were suffering more because of their anxiety about their symptoms, which in turn leads to increased attendance at A&E departments and even admittance to hospital. The clinic is specifically being piloted for those people who need to have help to manage their symptoms and use relaxation techniques, pacing and other self management skills to lessen their symptoms and empower them to feel in control of their breathing. It is a holistic approach where we address symptoms not conditions.

3. Does our 2020 vision fit the changing landscape around us?

The NHS has to meet changing needs in years to come, and has to do so more efficiently as demand will rise faster than funding. Our vision to integrate care is consistent with national policy and evidence. We will play our part through the Right Care, Right Here partnership in delivering care without boundaries in the years ahead.

In the next five years we expect the local population to:

- continue to be among the most ethnically diverse in England, including additional immigration from Eastern Europe and Sub-Saharan Africa;
- see rising and changing patterns of need, with diabetes and dementia increasing among local people; and
- increase significantly with many more living past 85 years of age.

At the same time, the care that the NHS can provide will change. Genetic medicine will make a big difference to how we personalise care. Treatments for a host of diseases, including cancer, are changing and we need to be able to provide the most modern interventions for local people. More of our patients live with a number of long term conditions such as arthritis and respiratory disease. These mean they have much more frequent contact with healthcare services over extended periods of time, but also that they themselves become an expert in managing their own care. It is right that healthcare services become more tailored to their requirements and to those who care for and support them. And of course, changes in technology and treatments allow much more healthcare to be self-managed or delivered in people's homes.

The NHS Five Year Forward view, published in October 2014, summarised a vision for the future of the NHS. In order to respond to changes in health needs, address the widening health gap and respond to the development of new technologies, there is a need to fundamentally consider how the NHS is structured to deliver the best care to patients to meet their future needs.

We believe that the NHS in West Birmingham and in Sandwell is well placed to meet the challenges of the Forward View. We work closely with our main commissioning organisations, the Clinical Commissioning Groups, to co-design health outcomes and services so that patients are offered good quality care in the right place at the right time. We have a tradition of innovation and partnership. This ranges from new care models, like our work with GPs on diabetes, through to supporting local people with employment opportunities. We have over 100 apprentices in the Trust, and work with partners like St Basils to target employment opportunities for traditionally vulnerable groups. Our plans for the Midland Met Hospital in 2018, and longer term work as part of the Right Care Right Here programme, will help to ensure we are at the fore-front of this transformation. The single most critical step to change is the traditional outpatient visit model, retaining it in acute hospital settings only where

it is the right approach for a specific patient, and replacing it in other cases with consultation through technology, via local GPs, and in group consultations where long term therapy can be delivered to large number of patients.

It is important that we sustain our outstanding partnerships with primary care. We must also ensure that specialist acute services are improved and that we develop sub-specialisation locally. It is in that context that we are strengthening our existing ties with Walsall Healthcare NHS Trust and Dudley Group of Hospitals NHS Foundation Trust. These important acute centres, each of which also offers community based care, are both essential to the Midland Met Hospital as emergency models of care change,

Right Care, Right Here

A multi-agency collaboration to reshape how local services are delivered, Right Care Right Here has been in place for over ten years. The Trust remains a key part of this partnership which is focused on Sandwell and West Birmingham, and works with the 110 GP practices in that boundary to improve consistency and accessibility of care. Our 2020 Vision is consistent with our Right Care Right Here heritage and future plans.

Where does the Black Country Alliance fit in?

The Black Country Alliance is a partnership between The Dudley Group NHS Foundation Trust, Sandwell and West Birmingham Hospitals NHS Trust and Walsall Healthcare NHS Trust. Our aims are to improve health outcomes, improve people's experience of healthcare and maximise the resources available so that together we can do even more for the people of the Black Country with what we have.

For the first time the BCA brings together health providers across a local population of over 1 million people, with a combined budget of a billion pounds. We want to use that scale to provide specialist and sub-specialist care, to integrate research and education, and to ensure that expertise stays local. We will not do everything together but where we choose to work across the Alliance we will be able to achieve outcomes that we cannot deliver alone.

INTEGRATED CARE PIONEER

Wrapping care around patients: our iCares team

Seen as a model of national as well as local best practice, our Integrated Care Service or iCares places coordinating care at the heart of what they do. Through care jointly provided by nurses and therapists, iCares help people avoid a hospital stay or get home from hospital more quickly and safely.

This service is not about working in a set way with rigid pathways, or expecting our patients to fit into the way we deliver care. It is about wrapping our community services and others who can provide support around each and every patient we care for so that they have what they need to be safe, well and happy with life.

The team are made up of community specialists delivering care in people's homes and out in the community. The team work on behalf of patients to help them navigate moving between different boundaries and organisations for their care, so that from a patient's point of view their care is joined up and they have one point of contact.

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

4. Our diverse population

The NHS aims to offer a defined standard of service as set out in the NHS Constitution. But the people we serve locally have diverse, as well as common, needs so we have to respond differently to achieve the same outcomes.

Our population is dominated by high levels of deprivation and poor health when compared with the rest of England, with Sandwell ranked as the 12th most deprived local authority in England and Birmingham ranked 9th.

Whilst comparatively, we serve a relatively young population, we estimate the number of people of pensionable age in Sandwell is expected to increase by 33% between 2008 and 2033 (more than double that of other age groups). This is coupled with an expectation that late onset dementia is expected to rise by 50% between 2006 to 2030.

We are also an ethnically diverse population, including those from an Indian, Pakistani and Black and Caribbean background. As migration patterns change we anticipate an even greater ethnic mix in the population we serve. Such diversity is associated with certain specific health needs, and therefore future care services need to ensure they meet the needs of these population groups and remain culturally sensitive.

The lifestyle factors and choices that people make have a major bearing on their health needs. The number of smokers, obese adults and people admitted to hospital as a result of alcohol in Sandwell and West Birmingham is well above the average for England. Housing status and employment both impact on people's health, wellbeing and use of NHS services.

This means three principles for our future:

1. We have to play our part in tackling poverty and exclusion in the communities we serve. We can do that through how we spend NHS resources and by the partnerships we develop and support.
2. We have to address health behaviours, starting with the wellbeing of our staff, but also helping those we care for make lifestyle changes that can be sustained. Every service we provide needs to make every contact count.
3. We have to offer services suitable to need, delivering diversity not uniformity that addresses cultural differences to make sure that our services are clinically effective.

In 2014 we published our three year Public Health Plan for the Trust setting out specific commitments for improvement by 2017. A further three year plan will follow, taking us towards 2020. However, unless we work with partners to address the three principles by 2020 services locally by 2030 will face severe difficulties as underlying needs will rise beyond our funding, workforce and service plans - and beyond what is foreseeably achievable. Success is entirely possible, but we must act now.

In 2020…Mary's story

Mary is an 81 year old lady who lives alone. She was previously independent with mobility and all activities of daily living, including shopping. She had a fall at home while preparing a meal in the kitchen and, after pressing her STAY Telecare alarm button, was taken to hospital by ambulance.

Doctors found that Mary had not broken anything, but was bruised and sore. She was assessed by the Rapid Response Therapy Team in A&E. They found that Mary's confidence was low and she was very unsteady on her feet. As Mary lives alone with minimal support, it was decided in discussion with Mary and her family that a short period of rehabilitation was required before returning home.

She was transferred from A&E to an Intermediate Care Bed where she received a short period of rehabilitation. At this point, Mary was still lacking confidence when getting out of bed and walking around, and she required some support when getting something to eat and drink. It was decided with Mary and her family, that Mary could return home with an increased level of support and ongoing rehabilitation to assist in her return to complete independence. Mary was therefore referred to the Own Bed Instead (OBI) Service for a period of rehabilitation and support in her own home. After a short period of support from the OBI service, Mary regained her independence and confidence and was able to continue living in her home, to Mary and her family's delight.

What do we mean by Long Term Conditions?

Long term conditions is a term used to describe health problems that cannot be cured but can be managed by medication or other therapies. It is estimated that more than 15 million people in England have a long term condition. Examples include high blood pressure and coronary heart disease, depression, dementia and arthritis. Many of us call these diseases "chronic conditions".

It is estimated that the number of people with a long term condition will increase significantly over the next ten years, particularly the prevalence of people with 3 or more conditions at once. Long term conditions can affect many parts of a person's life, from their ability to work and have relationships, to housing and education opportunities.

Care of people with long term conditions accounts for 70% of the money that is spent on health and social care across the whole of England.

We do excellent work in some parts of our Trust that "wrap" services around our patients. In simple terms to focus on the person not on the diseases. We need this approach to become routine if we are to meet the rising demand in our population, and to meet our integrated care ambition.

We will need to provide more of our care in multi-specialty clinics and for more care to be coordinated through general practices. In turn this requires major changes in how primary care functions at a time when that system is faced with major workforce issues. We can and will play an important role in helping to address those issues - making the experience of providing primary care locally a simpler, easier, more rewarding one.

Palliative and End of Life Care

Palliative care is the active treatment of symptoms for patients whose illness or disease cannot be cured. It involves holistic management including pain control and support with spiritual, psychological and social issues for patients and their families and carers. Palliative care is closely linked to End of Life care where we aim to allow patients to die with dignity whilst receiving individualised care based on their own wishes.

Our trust has made excellent advances in improving care in this area with patients and their carers at the heart of our work. We have a specialist palliative care team which includes specialist nurses, End of Life Care facilitators and palliative care consultants working across hospital and community services. The team provide direct care to patients with complex palliative needs such as difficult to treat physical symptoms and unresolved psychological or spiritual needs. The team work closely with the Macmillan Occupational Therapy team to support patients who can be discharged home.

We recognise that palliative and end of life care is the responsibility of all staff and so training is undertaken with nurses, doctors and other health professionals empowering them to recognise dying patients, assess their wishes and to treat and alleviate symptoms. We now have more patients dying in their preferred place.

Our vision for the future is for greater coordination of palliative and end of life services so patients and their carers can receive prompt care, tailored to their wishes and delivered by the right service at the right time without duplication. This will involve teams in the trust such as district nurses, specialist teams and therapists working in collaboration with local GPs, ambulance services, hospices, voluntary services, care homes and social services.

We will aim for all services to communicate effectively and share information so that patients and carers can be confident that in times of crisis there will be no delays or confusion and their needs will be met in conjunction with their individual wishes.

5. How do we keep everything that's good in Sandwell and West Birmingham?

The vast majority of people who use services offered by the Trust rate them highly. Our health outcomes are good when compared to other similar Trusts. So it is important that in adapting to meet the challenges of the future we do not lose sight of those strengths.

Our Workforce

In many parts of our Trust engagement and morale are high, sickness and turnover are low, and there is a very strong commitment to the local NHS. Almost half of our staff have worked for the Trust for over ten years, and 92% of staff report in anonymised surveys that their role makes a positive difference to care. Staff routinely have appraisals and mandatory, compulsory training is undertaken consistently.

We want to maintain that strength but we want to make it consistently true across our organisation, in every team, developing a clear plan for the potential of every employee, as roles change and as individuals want to develop.

In support of that ambition we believe that we must:

- Achieve morale and employee engagement scores that are among the best in the NHS, rather than results which are better than average. We will do this by developing local leaders and managers who have the skills to work with their teams to achieve quality improvements;
- Reduce sickness rates, fill vacancies and reduce staff turnover - especially among employees who have been with us for less than two years. We will do this by offering clear career pathways and supporting training and development;
- Create clear job roles for individuals to work across community and hospital practice, whilst retaining the job satisfaction of working in a defined team, and the work/life balance that comes with a base and a routine.

Our Primary Care Colleagues

Our annual GP survey suggests that some current services are especially valued, including our breast service, the regional eye hospital, and diabetes and pain management. Other strengths include our gastroenterology advice and guidance service which allows GPs to request email advice from hospital consultants. Similar services are being introduced Trust-wide during 2015. GPs tell us that they want better communication and integration with hospital teams.

Work with local optometrists, pharmacists, dentists and other contractors is very important to the Trust. By 2020 we want to have clear networked partnerships in place with both independent and commercial local organisations, whose care is a vital part of local High Street NHS provision.

Our Partners

Research undertaken on our behalf independently highlights the strong tradition the Trust has of partnership working. Statutory partnerships with local authority and other NHS bodies, are reinforced by specific joint working initiatives with the third sector and a collaborative openness with Healthwatch. We have private sector partnerships in a number of clinical fields, as well as through our Birmingham Treatment Centre contract.

Our 2020 vision expects the scale, breadth and depth of those partnerships to grow. We will maintain links with existing educational partners at Birmingham, Birmingham City and Wolverhampton Universities. We work collaboratively with both Birmingham Community Healthcare and the city's regional Children's Hospital. As services become more specialised in any number of clinical fields, we need to find the right balance of local provision, and rationalisation of services into larger specialist centres.

Our Commissioners

We have strong relationships with our commissioners and work in partnership with them to meet agreed health outcomes for patients, deliver the right amount and standards of care in the right locations, and support them in delivering the health plans for the people that we serve. We work in collaboration to co-design how health services should and could look in the future. The local clinical commissioning groups lead on consultation and engagement activity with patients and the public.

Our Patients

96% of those who are admitted to our Trust rate their care as good or outstanding. Over 30,000 local residents have fed back their views on outpatient services, and more than 19 out of 20 are very satisfied with the way that they were cared for. Individual services offered by the Trust consistently undertake patient feedback surveys, focus groups and other methods to gather opinions and ideas.

This feedback matters. During 2015 for example we have completely changed the arrangements across our sites for visitors to come and see friends and family in our wards, by moving to what we call 'open visiting'. This reflects patient feedback, but also our commitment to making sure that we don't isolate people when they are in our care.

We have clear feedback on what people want us to change, and we are acting on that:

- Ensuring that patients are always involved in conversations about their care and are not talked about;
- Giving more notice for appointments and cancelling fewer operations at the last minute;
- More consistent care for patients who are cared for by several teams, during their hospital stay or over several visits to our services;

6. Our 2020 Vision: Clinical and corporate services

Services cut across all of our teams. A patient may have contact with multiple services, many times, across several sites. The teams within our Trust are organised into care groups, and we have organised the ideas put forward about our future on that basis. But for many patients, it will be helpful to summarise what you can expect on a pathway basis - from home onwards.

Our Vision expects that general practice remains the fundamental unit of care within our NHS. We will ensure that our community based teams are organised to fit alongside and within the extended primary healthcare team. That integration may be geographical, as in the case of district nursing, or may reflect local authority teams for services where that is most appropriate.

Where a GP refers a patient to our care, we will provide expert advice. More commonly than at present that advice will not require a patient to come to a hospital clinic. Where it makes sense to do so, we will undertake diagnostic tests before a clinic visit or on the same day. The scale of same day services will be larger than it is today. More planned care services will be open in the evening and at weekends.

Planned care services will be offered through our two Treatment Centres, on Dudley Road and in West Bromwich: Birmingham and Sandwell. In some cases we will be able to provide outpatient procedures even more locally than that. Follow up care will take place, if it is long term, closer to home.

Emergency care will be focused on the Midland Metropolitan Hospital, but only where being admitted to a bed is the next step for care. We will work to prevent admission wherever we can do so, by both providing and supporting alternatives to admission that sustain home or nursing home care.

These alternatives, as well as step down facilities from acute provision, form the basis for our intermediate and rehabilitative care model, which will be delivered from at least four locations - Leasowes, Dudley Road, Sandwell and Rowley Regis.

The Trust is committed to providing care on a long term basis to local residents. Over the next five years we would expect to become much more involved in delivering extended social care services. This reflects the changing needs of our population.

Finally, and crucially, our preventative care services are being expanded, and developed alongside traditional NHS provision. We expect this part of what we do to grow, because we know that by 2030 we have to tackle the underlying determinants of ill-health in our local communities.

Community and Therapy care in 2020

Did you know?
Telecare personal alarms are available across our communities to let a friend or family member know you need help, and motion sensors to turn light on and reduce your risk of falls

What services do we offer and why might you use them?

iCares is a Sandwell service that helps organise healthcare for adults with long term conditions no matter what is wrong with them, where they live or how old they are. It includes a whole range of staff including nurses, therapists and support workers providing specialist community interventions to support patients to remain out of hospital, coordinate their care and receive the appropriate rehabilitation.

The long term conditions we support patients with include; respiratory problems, heart failure, incontinence, those needing help with dietary advice and tube feeding, progressive neurological diseases (Parkinson's disease, motor neurone disease, multiple sclerosis and Huntington's disease), stroke, and the elderly who are frail and need help to regain independence including following falls and osteoporosis. We also provide the therapy input into palliative care (support for people at the end of life) and STAR (Short Term Assessment and Reablement) service.

Our District Nurses support patients in their own homes for whom attending a healthcare centre is difficult due to their health. Depending on our patients' needs, we make referrals to other agencies for additional treatment where required or appropriate.

IBEDS are intermediate care beds and specialist therapy services for patients in Midland Metropolitan Hospital, Rowley Regis Hospital, Sandwell Hospital, City Hospital and Leasowes helping patients recover as soon as possible.

Ambulatory Care refers to all of our therapy services that provide specialist interventions in an outpatient setting. This could be in a hospital clinic or a community health centre. We support both Consultants and GPs to restore function or enable management of chronic long term conditions.

Examples of our specialist pathways are, chronic back pain, frozen shoulder, rehabilitation following hand surgery, knee replacement, management of a foot ulcer, voice therapy following surgery and after surgery care for an ingrown toe nail.

As we are a single team and work together we will make sure you receive the full range of services in a coordinated way to ensure that you do not have to make lots of visits to your GP to get new referrals for our services. These clinic based services enable GPs to refer patients that require specialist therapy in facilities that are closer to your home without the need to attend a hospital setting. The specialist staff will also ensure that if an additional Consultant opinion is required all the diagnostic tests will be completed and ready for the Consultant appointment. We provide hospital and home based end of life care across Sandwell and Birmingham. Our integrated team operates seven days a week, supporting primary care, and supported by the third sector.

Where can you access services now and in 2020?

The Community & Therapies group comprises a large range of services in community settings and patient homes, as well as supporting inpatients across our acute and intermediate care facilities. Our services work closely together and in partnership with external agencies to provide an integrated package of care for patients.

Our service will discuss with you where you are best seen. We see patients in a range of locations, including: home, work, health centre, leisure centres. You can refer yourself to the service or get your friend, local GP, social services to refer you; even the Ambulance Service can make a referral.

What will be the same in 2020?

- We will provide intermediate care across Sandwell, Ladywood and Perry Barr.
- We will aim to maintain 7 day a week 8am - 8pm services.
- We will offer research-led therapy care across our Trust.
- A specialist palliative care team will be available to directly see patients with complex palliative needs 7 days a week and provide telephone advice out of hours

What will be different in 2020?

- All referrals will come through a single point of access, no matter who is making the referral.
- Our collaboration with local GPs will be strengthened, and we will roll out our Early Support Discharge model (having piloted in stroke).
- Much greater use of technology will allow us to help support for your self-care, plan for needs after hospital discharge, and keep track of your care progress.
- We will further improve our ability to help support people's choice of where they die and how they supported.
- Greater collaboration with our partners to deliver coordinated palliative and End of Life Care, ensuring patients' needs are met by the right team at the right team

What are we aiming to be renowned for in 2020?

- A national pioneer in hospitals admission avoidance work through iCares, supporting those at home and in care homes.
- A beacon of excellence in Long Term Conditions, Stroke and Rapid Response therapy care.
- Our integrated Musculoskeletal service, and a seamless foot health offer to those in need.
- Fully integrated and coordinated holistic services in palliative care with the ability to respond urgently to patients in crisis, meeting their needs appropriately.

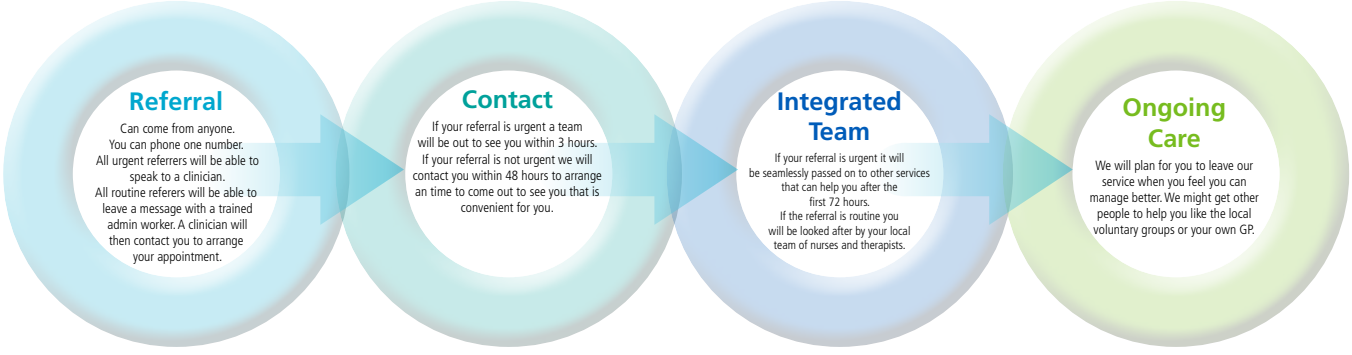
In 2020... Mohamed's story

Mohammed is a 52 year old self employed accountant. Whilst visiting a client Mohammed began to suddenly feel unwell, his speech became slurred and difficult to understand. When he attempted to stand up his leg gave way and he collapsed to the floor. His colleagues rang the emergency services. The attending paramedics recognised Mohammed was "FAST" positive, diagnosing a potential stroke. With time being critical to Mohammed's recovery he was taken immediately to Sandwell General Hospital. Once there, he was seen immediately by the Stroke Alert Nurses and Stroke Consultant and sent for a scan of his brain, which confirmed the suspicion of stroke. Mohammed was given a clot busting drug and admitted to the Hyper Acute Stroke Unit.

After 24 hours, Mohammed was assessed by the rest of the stroke team (including therapists), and, together with Mohammed, they agreed rehabilitation goals and treatment plans. Mohammed progressed from the hyper acute unit to the rehabilitation unit. He began to regain his mobility and independence by practising daily tasks such as dressing and making a cup of tea. As Mohammed progressed, the Stroke Early Supported Discharge Team (ESD) came to review him to discuss discharge home.

After 3 weeks in hospital, Mohammed went home with a carer visiting him daily. For the next 6 weeks the ESD Team supported Mohammed within his own home, continuing rehabilitation with regaining life skills, returning to everyday tasks such as outdoor mobility, shopping, planning and cooking meals and lifestyle advice. Mohammed wanted to return to work but recognised he would require ongoing support. The ESD team liaised closely with the community therapy team and, after a joint hand over session, Mohammed continued with rehabilitation. After 6 months hard work, Mohammed no longer required a daily carer, was independent and safe at home.

Your patient experience



Imaging services in 2020

Did you know?
In 2014 we did 133000 X Rays, 32000 CT scans and 22000 MRI scans. We expect that to expand in the years ahead.

What services do we offer and why might you use them?

Diagnostic Radiography – X Ray:
X Rays can be used to tell whether or not a patient has a broken or fractured bone. They are also commonly used for assessing joint problems. Chest x-rays are commonly used to look at the heart and lungs. The team undertakes work for all outpatient clinics, GP practices, emergency medicine and inpatients.

Interventional Radiology:
These are a wide range of procedures usually done under local anaesthetic, that can be used as a less invasive alternative to surgery.

CT and MRI scans:
These machines produce 3D images of the body, with MRI scans being particularly effective for viewing the brain, spinal cord and joints. CT is particularly useful for looking at the lungs in more detail than is possible with chest x-rays. Cardiac CT and MRI enable assessment of the blood supply to the heart via the coronary arteries and assessing the function of the heart muscle. Both CT and MRI are used for viewing the internal organs of the abdomen and pelvis.

Dexa scans are used to measure bone density, looking for osteoporosis.

Ultrasound scans are used during pregnancy but are also very useful for assessing small joints, looking for blood clots in the veins, checking for gall stones and as an initial test for viewing the abdominal and pelvic organs.

Nuclear Medicine:
These tests usually involve injection of a radioactive substance followed by a scan to detect the substance in the body. Common tests include bone scans, kidney scans and heart scans. Some radioactive substances can also be used as treatments.

Breast screening:
We run one of the largest breast screening programmes in the country, providing imaging services for the NHS Screening Programme and symptomatic services.

Where can you access services now and in 2020?

We have CT and MRI scanners at Sandwell and on Dudley Road, plus Neptune and Victoria Health Centre. Midland Met comes on line in 2018. We expect to offer some services on a mobile as we do breast screening now.

What will be the same in 2020?

- We will be providing breast screening services in support of our symptomatic service.
- We will be offering tests and treatments like joint injections across our sites and primary care.

What will be different in 2020?

- You will have a say in where and when your scan is.
- We will contact you tell you your test results are ready.
- More of our services will be open at weekends and in the evening.
- With more scanners, wait times will be even shorter.

What are we aiming to be renowned for in 2020?

- Our diagnostic scanning for musculo-skeletal services, such as orthopaedics.
- Our cardiac imaging services, improving diagnosis and care.
- Our leading nuclear medicine department, pioneering new techniques and research.

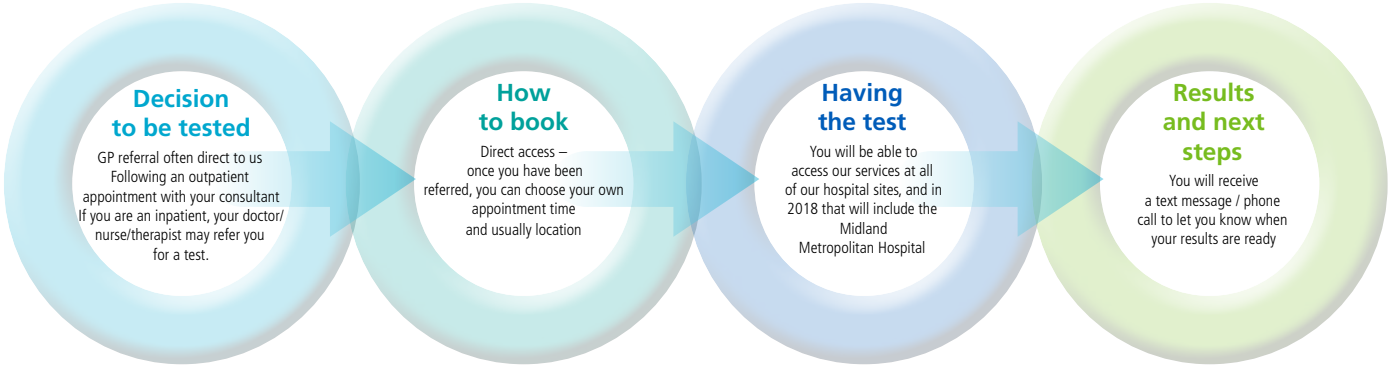
In 2020... Alice's story

Alice is a 51 year old teacher who has three children, aged 21, 18 and 15. It has been a particularly stressful time as all of her children are working towards exams at school and university. Whilst rushing around she tripped and hurt her ankle. Alice went to see her GP who sent her for an X Ray. She was able to ring up and book an appointment for the next day, and as this was a Saturday, she was particularly pleased not to have to take any time off work. The X-ray was reported by an Advanced Practitioner while she waited and she was referred straight to the Emergency Department.

In 2020... Bob's story

Bob had been experiencing some tingling down his right arm, so went to see his GP who referred him for an MRI scan. Having booked his appointment online, he arrives at the MRI department and checks in at the self-check in kiosk. Mohammed makes sure that all of his patient details are up to date before he goes in for his scan. Once he has had the scan, the team let him know that they will be in touch when his results are ready. They also put him in touch with the Neurology team as he mentioned to his radiographer that he had been struggling with migraines and wasn't sure how to access any support.

Your patient experience



Medicine and emergency care services in 2020

Did you know?
In 2018 our Emergency Department will be based at the Midland Met Hospital and for all non-life threatening injuries a new Urgent Care Centre at Sandwell Hospital will be available.

What services do we offer and why might you use them?

Admitted Care: After an assessment on the Acute Medical Units or Emergency Department it may be necessary to offer some patients admission on one of the hospital wards, in either single or 4 bedded accommodation. Where this is required patients will be moved, as soon as possible, with a plan for on-going investigation and treatment. This will be under the direction of appropriate specialist medical, nursing, pharmacy and therapy teams. For example, usually, asthmatics would be looked after by the respiratory team, older people with several illnesses by the elderly care team, those with multiple sclerosis by the neurological team and people with liver problems by the gastroenterology team. Other specialty teams include cardiology and stroke who will often admit patients directly to their specialist units from the Emergency Department.

Scheduled Care/Long Term Conditions: Patients with chronic long-term diseases will be empowered to manage their condition and will feel confident in knowing they can access healthcare when they need it. They will feel familiar with the team of doctors, nurses and therapists that are ready to support them and who understand their individual condition; confident that they are available and accessible. They will know how to manage a change in symptoms. They know they may utilise day-case therapy or drop-in clinics and so will not expect to need hospital admissions or A+E.

Emergency and Acute Medicine: Patients who attend the Emergency Department having had an accident or in an emergency situation will be seen by our Emergency Medicine team and if a specialist opinion is required that will be received within 60 minutes. Most of these patients will be discharged home or with follow-up care from their GP. Some patients will need to be admitted to one of our Assessment Units for additional tests and investigations and will either be discharged home later that day or will need to stay in hospital.

If a GP sees a patient, in their own home or at the surgery, and believes the patient needs an urgent specialist opinion at the hospital, he can contact a single point of access and will be advised which department to send the patient to. This means patients do not need to go to the Emergency Department but straight to the specialist team on one of our Assessment Units. A member of staff with the right skills and experience will carry out tests and investigations on the patient as an outpatient in an ambulatory area or as an admission to the Unit. The patient will either be discharged home later that day or will need to stay in hospital.

There are some patients who attend the Emergency Department who have not had an accident or in an emergency situation. These patients are either seen by a co-located GP or advised that they can seek advice in a more appropriate setting for example from their own GP or a pharmacist.

Where can you access services now and in 2020?

Physicians who work in these teams will help to diagnose what is wrong with you, and will work with you to deal with your condition using medication. Some patients may only access our medical specialties once, whereas others with long-term conditions (such as diabetes or heart disease) are likely to require ongoing support. Our Medical teams work in many locations in our hospitals and GP Practices. Most initial appointments for care will be by 2018 in either our Birmingham or Sandwell Treatment Centre. But long term follow up will be as close to home as possible.

What will be the same in 2020?

- We will continue to provide care in partnership with GPs, by continuing to offer Advice and Guidance to Primary Care clinicians thus reducing unnecessary hospital visits for patients.
- Patients will continue to be able to have their outpatient appointment at a location nearer to their home. In many cases this means that they will not need to come to the hospital to get specialised care and treatment.
- Patients, and their families, will have access to information about their condition and will be actively involved in plans for both treatment and discharge from hospital.
- We will plan discharge at the earliest opportunity with support from the social work team when necessary.

What will be different in 2020?

- We will provide outpatient care in community locations across our catchment area, providing patients with care closer to there homes.
- We will provide more services 7 days a week such as Cardiology.
- We will conduct research across our specialities thus attracting a high calibre of staff.
- We will be in the top quartile for waiting times to see our speciality teams.

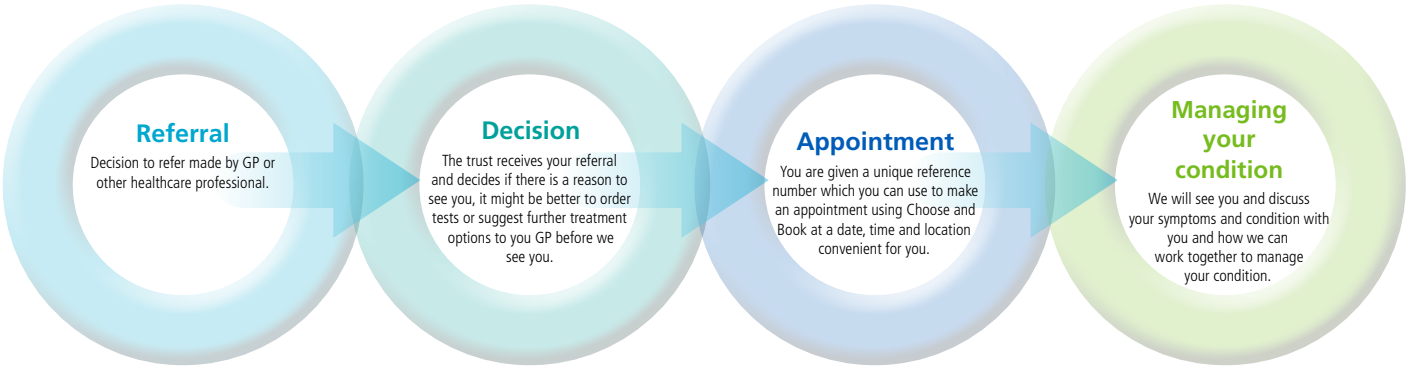
What are we aiming to be renowned for in 2020?

- Educational and research excellence, in existing strengths like cardiology and important disciplines like sickle cell and thalassemia.
- First class emergency care that is provided 'by the whole hospital' but also connected with general practice and with local pharmacies.
- The quality and compassion of care provided to older people across our services, involving carers from the start of our work.

In 2020... Mario's story

Mario is a 57 year old gentleman who has smoked for many years. Recently he has been getting out of breath more often and his ankles are slightly swollen. Mario's GP referred him for a series for tests including an Angiogram. Mario is admitted for the day to have the procedure carried out by a consultant cardiologist the test shows some of the vessels providing Mario's heart with blood are becoming blocked and so the consultant suggests that Mario has a procedure call an angioplasty preformed. Mario is pleased his appointment is on a Saturday since he works part time this means he does not have to unnecessary time off work before the procedure and as he has been advised to take some time off to recover. Mario is also pleased that the Trust has promised not to cancel his appointment on the day.

Your patient experience



Pathology services in 2020

Did you know?
We tested over 1.5 million samples last year, for things like anaemia, vitamin or hormone deficiency, cancer and diabetes. 70% of hospital visits result in a sample being taken.

What services do we offer and why might you use them?

Pathology uses different areas of science to help study human disease. When you are required to provide a test sample, these come to our laboratories for specialist testing so that we can either diagnose, treat or monitor your condition. SWBH Pathology Department offers a full range of relevant services to our hospitals, local GPs, and a range of specialist services to hospitals across the UK.

Clinical Biochemistry measures a wide range of substances in bodily fluids such as urine, blood and saliva.

Haematology deals with diseases of the blood and blood-forming organs. The Blood Bank provides analysis to ensure that blood products given are properly cross-matched and used in a range of acute medical situations. Our anti-coagulant services offer patient centred care using integrated treatment pathways.

Phlebotomy this is the service you will use when you have a blood test. We provide thirty-two sites across our hospitals and community where you can attend to have your pathology samples taken.

Immunology studies the immune processes in the body and their role in fighting disease. Immunology specialists also look at allergies and how to manage the body's reaction to allergies and intolerances.

Histopathology deals with the fundamental aspects of disease, especially changes in body tissues and organs that cause or are caused by disease and helps in diagnosis and treatment.

Microbiology studies microorganisms such as common bacteria that can cause amongst other things chest and urinary tract infections, as well as viruses e.g. influenza, and fungal infections. We can also look for TB and also more rare organisms, which might have been picked up whilst travelling overseas.

Where can you access services now and in 2020?

We provide phlebotomy from 32 locations, as run pathology tests at the bedside. Our anticoagulation service happens locally and on hospital sites. Our main lab will be in one place by 2018. Our central forensic mortuary will be at Sandwell.

What will be the same in 2020?

- We will continue to offer relevant tests on a near patient testing basis, producing results immediately for speedy diagnosis.
- We will work closely with local GP practices and reduce repeat samples and sample error.
- We will offer short and reducing turnaround times.

What will be different in 2020?

- Pathology will have a single main base, taking samples for analysis seven days a week.
- We will offer a booked phlebotomy service as well as drop in.
- All service users will request tests electronically not on paper.
- We will text results and make some results available securely but remotely.

What are we aiming to be renowned for in 2020?

- We will offer more self requested tests from our lab, alongside traditional NHS services.
- We will continue to be a national specialist centre, harnessing the latest advances in clinical science to improve patient care.
- We will be at the forefront of testing in areas such as bacterial gastroenteritis.

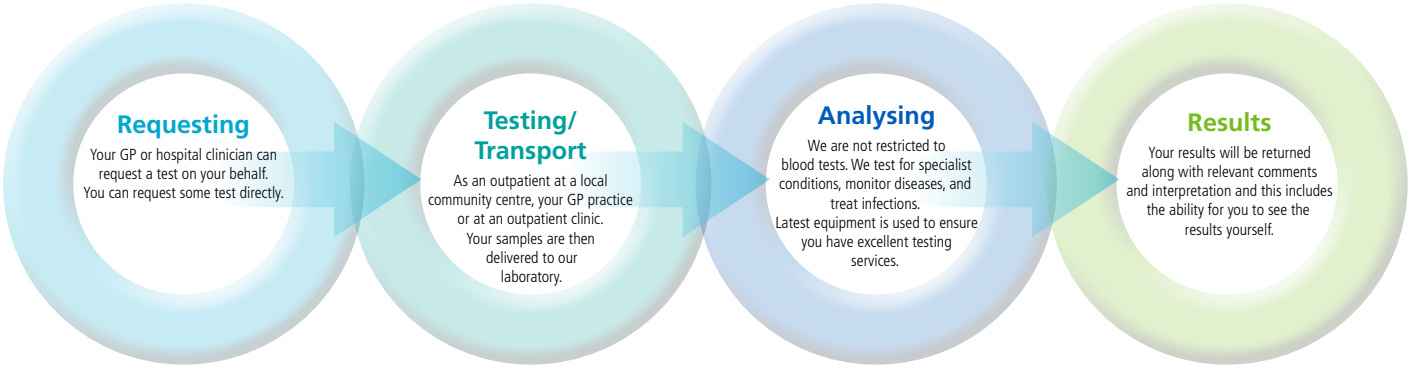
In 2020... Ali's Story

Ali has had diabetes for 15 years and has to have his blood taken and checked regularly, as it has been difficult for Ali to get his condition under control. Ali is really pleased with the changes that the blood taking service has made over the past few years. He finds he can now have his blood taken at a health centre near his home or one nearer where he works. Once his blood is taken the sample is given a barcode, this means that Ali is able register and track his sample on line and can see when his result is available. He can then book an appointment at his GP practice to see the diabetes team to discuss changes that can be made to improve the control of his blood sugar levels.

In 2020... Jay's Story

Jay works full time as an office manager. He has been feeling tired and unwell for some time. He makes an appointment with his GP as he has noticed blood in his urine. Jay receives a text reminder the day before his appointment which was very helpful, as he had accidently double booked himself. Once at the GP surgery, Jay's GP suggests the first thing they should do is check his urine to see if there any clues to what is going on. Jay submits the urine sample at the doctor's surgery, and the doctor tells him that sample will be collected along with the other samples from the practice as they have a regular daily collection. Jay is happy to find that he can register for a patient service which means he can see when his results are available online, which Jay does. He then makes an appointment back with his GP once he sees all his results are back to discuss them.

Your patient experience



Specialist eye, ENT and dental care in 2020

Did you know?
Our hearing services see as many people each year as one of our A&E departments

What services do we offer and why might you use them?

Emergency Eye Care: We offer a rapid access to Ophthalmologists through our A&E in the Birmingham and Midland Eye Centre (BMEC) if you have a problem with your eyes that needs a specialist's attention.

Ophthalmology: We are one of the largest specialist ophthalmic care providers in Europe providing both a full range of general Ophthalmology services alongside our specialist activities.

Ear, Nose and Throat: We offer rapid access through A&E and a full range of routine treatments for example you might need to see the team if you have problems with swallowing or Menière's Disease

Audiology Service: We offer hearing checks and the fitting of hearing aids including some highly specialised hearing aids. We also provide a renowned new born hearing screening service.

Oral Surgery: We work in partnership with other hospitals to provide general oral surgery along with cancer services

Where can you access services now and in 2020?

- Emergency Eye Care is at BMEC on our City site.
- Ophthalmology services are at all 3 of our hospital sites and at a number of community settings.
- Ear, Nose and Throat services are at Sandwell and City sites.
- Audiology Service services are City, Sandwell and a number of locations across Birmingham and Sandwell.
- Oral Surgery is at City Hospital.
- Many services stay where they are with Midland Met but complex ENT and oral surgery will move in 2018.

What will be the same in 2020?

- We continue to be a centre of expertise in eye diseases, providing regional leadership and specialist care in BMEC.
- We offer comprehensive hearing services from neonates through to older residents with high levels of client satisfaction.

What will be different in 2020?

- ENT services will operate in partnership with other centres to maintain specialist services locally.
- Waits will be shorter and many more visits will be on a one stop basis.
- Our links to primary care practitioners will be transformed, offering seamless integrated care.

What are we aiming to be renowned for in 2020?

- Our Eye Centre will be producing exceptional research and innovating with new techniques.
- The Behcets service will be at the forefront of three national centres across England offering joined up care across the ophthalmology and rheumatology teams.
- Hearing services will provide outstanding educations opportunities for the best scientists trained regionally.

In 2020... Martha's story

Martha is a 63 year old lady who has cataracts. She has seen the ophthalmologist and they have agreed she needs an operation. On the day of her surgery she arrived at the department and was pleased to be greeted by someone who welcomed her and her husband who was accompanying her and pointed them in the right direction of the ward. On arrival the nurse checked her details; the nurse also noted that Martha's pre-operative assessment had been completed.

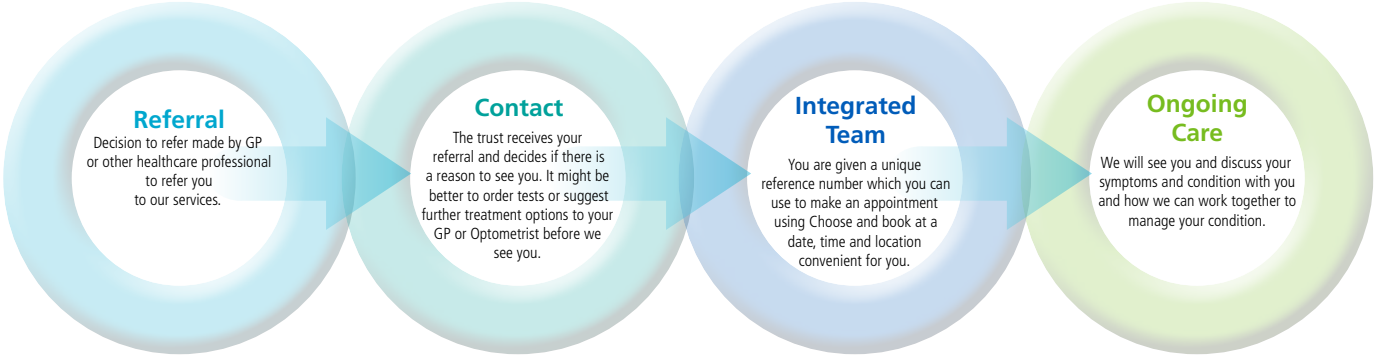
Martha had an armband put on with her details and the nurse mentioned she would be asked for her details several times during the day but Martha did not mind as the nurse explained it was for safety reasons to ensure they operated on her correct eye. Martha was discharged the day of her operation. It was explained that she would have an appointment to check her vision and that was made before she left.

In 2020... Grace's Story

Grace is a six year old girl with a history of problems with her hearing. This has been due to a build-up of fluid in her ears, so she needs an operation to try to prevent the fluid from building up again. Grace was a bit scared about going into hospital but felt reassured by her consultant who has known her since she was a baby. She went to the health centre near to her house to have some tests done before her operation, and remembered some of the nurses there from when she'd been there for check-ups before.

On the day of her operation, Grace got to the hospital and was able to work out where she needed to go with her mum, as there were lots of signs everywhere. She was told what would happen during the operation and how she might feel afterwards. She was particularly happy to find out that she would be able to go home later the same day. Following the operation, Grace has been able to hear much better, and has become more confident both at home and at school.

Your patient experience



Surgical and critical care in 2020

Did you know?
Over 92% of our breast surgery patients were able to return home on the same day as their surgery in 2014

What services do we offer and why might you use them?

The surgical specialties provide high quality care to patients requiring diagnosis and treatment of an injury or disease, typically requiring an operative procedure. Often, patients can return home on the same day as their operation took place. Our surgical specialties deal with different parts of the body, and different conditions/diseases:

Breast surgery: The Breast Unit is a multi-disciplinary team comprising of general / breast surgeons, breast care nurses, radiologists, pathologists, oncologists and plastic surgeons. Within the unit, we provide rapid access clinics for both routine and urgent assessment of all breast symptoms. Additional clinics include follow-up and results clinics and also family history clinics. The Breast Unit also provides the breast screening service for north, east and west Birmingham.

Critical Care provides care to patients who are critically ill following a medical emergency.

The General Surgery department deals with conditions of the stomach, liver, intestines and other vital organs in the abdomen (belly). Many of the procedures carried out by the team are Day Surgery cases. Adults and children with abdominal problems are dealt with either through routine outpatient appointments, or if necessary by emergency procedure. The department offers a comprehensive service from initial assessment through to surgery, medication or counselling.

Pain Management: The team works both in hospital and in the community, helping you to manage pain associated with acute and chronic conditions and patients with cancer.

Plastic surgery has two main parts: reconstructive plastic surgery, which relates to the restoration of appearance and function to the body following illness or accident, and aesthetic and cosmetic plastic surgery which is done to change the appearance following clinical indication. We provide reconstructive plastic surgery in a wide variety of subspecialties covering all aspects of wound healing and reconstruction following birth defects, disease and injuries and breast reconstruction following cancer.

Urology is the medical term focusing on the urinary tracts of men and women, and on the reproductive system of men. We would also treat you for problems with your kidneys, such as kidney stones.

Trauma & Orthopaedics: Orthopaedics is the branch of medical science concerned with disorders or deformities of bones. You would be treated by a member of our team if you were having a joint replacement or surgery to repair a broken bone.

The Vascular surgery service refers to procedures carried out to repair the vascular system (blood vessels and lymphatics), arteries and veins. The general surgery team treats many abdominal conditions, and offers several clinics. The team also carries out endoscopy services (using a tiny video camera on a thin, flexible tube to see inside the body).

Where can you access services now and in 2020?

There are surgical services on both acute sites now. From 2018, complex surgery will occur there, with less complex surgery in the Sandwell and Birmingham Treatment Centres.

What will be the same in 2020?

- Our nationally recognised breast service will go from strength to strength.
- We will continue to meet national wait time guarantees for elective services, but with a six week maximum wait to be seen when first referred.

What will be different in 2020?

- You will have direct access to scanning so that you can book your appointments at a time and location to suit you, meaning more convenience and quicker results.
- We will have standardised our surgical pathways and protocols so that you will experience the same efficient, high quality care in all of our specialties.
- You will only be booked in for a follow up appointment after your surgery if you choose to, rather than it being booked automatically.
- Any screening will take place at your outpatient appointment so that, unless you require general anaesthetic or have complex health needs, you will not be required to attend hospital for a separate pre-operative assessment.

What are we aiming to be renowned for in 2020?

- Our critical care services will be outstanding, supported care across our sites through education and outreach.
- Cancer services will exceed national standards for both waits and quality.
- Operating waiting times will be among the best in the West Midlands.

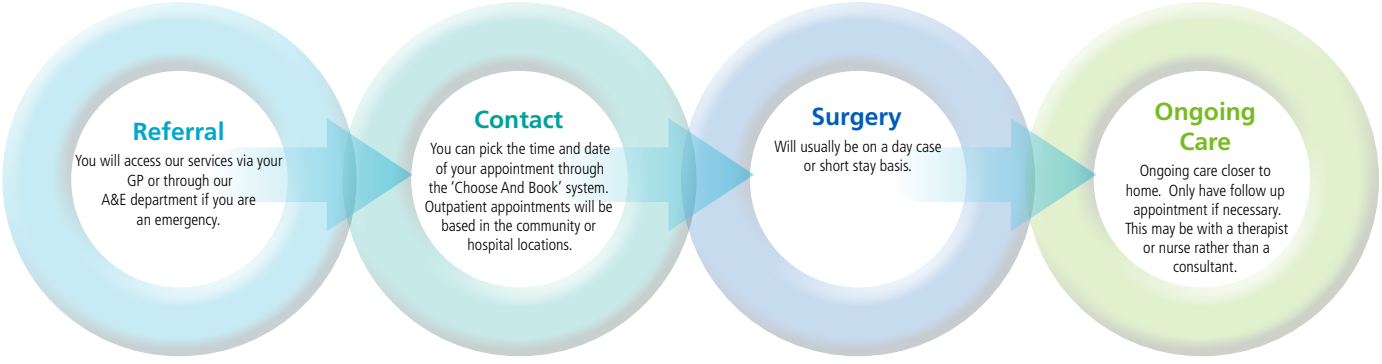
In 2020... Sheila's story

Sheila is a 70 year old lady who was referred to the hospital after she had found a lump in her breast. Her GP referred her using Choose and Book (and online system that allowed her to pick her own appointment time) and she was seen within a week. Sheila's friend had recommended that she choose SWBH as she herself had been under the care of the Breast Team five years earlier and had been seen within two weeks.

Sheila had her initial consultation in a clinic where the breast surgeon worked alongside the radiographer. She knew what to expect as the hospital had sent her a leaflet explaining the procedure in the post with her appointment letter. The next day, she received a phone call to let her know that her test results were available, and she returned to clinic to be told by the surgeon she would need to have an operation to remove the lump as it had been confirmed as breast cancer.
One of the breast care nurses, Emma, contacted Sheila to let her know which checks she would need to have before her operation and where she could go to have this done. Sheila chose to go to the local community health centre and she was familiar with it and felt comfortable. During her appointment, Sheila met Emma, and they discussed what would happen once Sheila was discharged from hospital.

Sheila came in for her operation at 12.30pm and was home by 8pm the same day and was glad she could recover at home with her family. She knew that she would have a visit from one of the District Nurses later that week to dress her wound, and was told about a local Breast Cancer support group that she was pleased to join.

Your patient experience



Women and child health in 2020

Did you know?
One and five year survival rates for gynaecological cancer in our unit are the best in England

What services do we offer and why might you use them?

Gynaecology deals with diseases of the female pelvic organs of the body such as the womb, neck of womb, tubes, ovaries vulva and vagina.

Gynae-Oncology: This is a specialty that looks after cancers of the female pelvic organs.

Genito Urinary Medicine (GUM) and HIV services: These relate to the diagnosis and treatment of sexually transmitted diseases.

Contraception and Sexual Health (CASH): This service offers family planning clinics, sexual health, contraceptive advice and pregnancy testing.

Maternity: Women are supported during their pregnancy (antenatal), during birth (intrapartum) and after birth (postnatal) by our midwives, community midwives and consultant obstetricians. This includes antenatal classes, screening and blood tests.

Neonates: The neonatal unit cares for pre- term (babies born early) and term babies who need additional help.

Paediatrics: Paediatric services are for children and young people up to the age of 16. The teams are based both in the hospital and community. The patient may see our teams just once but some teams care for complex or chronic conditions and thus meet more often. We also provide support for "end of life" care. We provide home-based and specialist school nursing support for children aged up to 16 and their families. This team includes consultants, paediatric nurses, physiotherapists, speech and language therapists together with nursery nurses and occupational therapists.

Health Visiting: Health Visitors support the under '5' Sandwell children through the national Healthy Child programme and includes the Family Nurse Partnership programme of intensive support, advice and information offered to young, first-time mothers living in Sandwell. The teams work in close partnership with GPs, dieticians, social workers, children's centres and other professionals and voluntary groups.

Where can you access services now and in 2020?

- Gynaecology outpatient services are delivered from our 3 hospital sites and community locations within health centres. The Pan-Birmingham Gynaecological Cancer Centre is the hub of the Pan-Birmingham Gynaecological Cancer Network which provides highly specialised care for four cancer units across Birmingham and the Black Country.
- GUM, HIV and CASH services are available at Sandwell and Rowley Hospitals along with a number of community locations.
- Women can access antenatal and post natal care in their homes and many community venues including GP practices, Health Centres and Children Centres. Women preparing to give birth can choose to give birth at one of the two midwifery-led units, one based in our Maternity Unit and one based in the community, in the delivery suite or at home.
- The neonatal unit is based at the City site for inpatient care with outpatient clinics available at both City and Sandwell. This moves to Midland Met in 2018.
- Paediatric assessment, day case and outpatient activity is delivered City and Sandwell sites with inpatient activity at the Sandwell site. This moves to Midland Met in 2018. Health Visiting services are delivered in parent's homes, Children's Centres, Health Centres and nurseries.

What will be the same in 2020?

- Our seven day service model will continue.
- We will continue to strive to promote healthy outcomes both for children and for pregnant mothers.
- We will maintain our excellent risk management systems for care, ensuring we comply with standards of practice.

What will be different in 2020?

- Reduced hospital attendance and readmission to hospital among children, through improved community provision.
- Our GUM and CASH services will be integrated and each service will make sure that all a patient's needs are met.
- Patient and pregnant mothers will be able to access more services through convenient locations, often enabled by technology.

What are we aiming to be renowned for in 2020?

- Consistent successful promotion of breast feeding and low rates of smoking.
- High normal delivery rates, but reduced teenage and unplanned pregnancy rates in our communities.
- Outstanding outcomes from gynaecological cancer care.
- Our One Stop Community Gynaecology Services.

In 2020... Nisha's story

Nisha is a 26 year old who works as an accountant in Smethwick. Nisha went to see her GP as she had been experiencing heavy menstrual bleeding for nearly 12 months. Nisha's GP referred her to the Community Gynaecology specialist service and asked Nisha which of the 6 locations across Sandwell and West Birmingham she would like to go to. Nisha is happy to find one of the locations is near where she works and she chooses that one. Before her appointment Nisha has her scan, full assessment, bloods taken at one of the many locations offered at her first appointment.

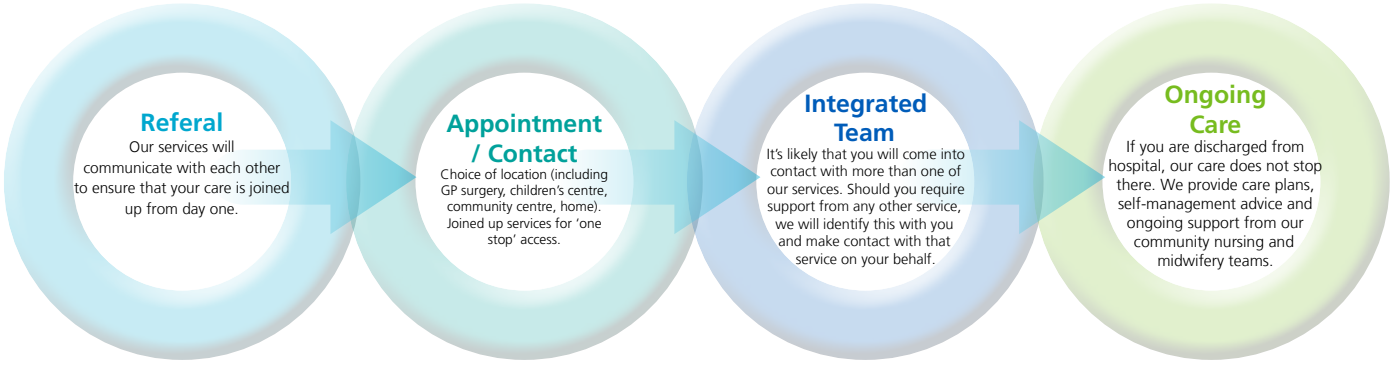
Nisha is notified of her appointment by email and has a text reminder; she arrives at her appointment and is seen on time. Firstly she sees the sonographer for her ultrasound and then she sees the doctor who has her scan results along with her blood results so he can help her choose the best way to treat her. They decide together she needs an operation, and a week later she has her pre-operative appointment at the same clinic. This means that she doesn't have to worry about where she is going as she is familiar with this clinic, and was informed that all of her pre-operative checks would take place at once, which saves her from having to take time off work.

In 2020... Jenny's Story

Jenny is a 38 year old mother of two and is currently expecting her third child. She is considered to be a high risk mum due to her age. Jenny was worried that she would have to go to hospital for all of her appointments. Instead, after her initial booking appointment she has been able to attend the local community centre where she can have her blood tests, growth scans and ante natal support all in one place. She finds this so much easier as she doesn't drive.

Jenny's daughter, Emma, has just given birth to a baby girl, Mia. Emma has been supported by the Family Nurse Partnership as a first time mum under the age of 20. She gave birth to Mia in the Serenity Suite and was really happy with her first birthing experience. Now that Mia is a couple of months old, Emma has been encouraged to think about her future and with the help of the FNP, is looking to attend college 2 days a week. Emma takes Mia to the local Children's Centre on Mondays and Fridays, which gives her a chance to meet other mums, and access benefit support in order to find a new home. Both mum and daughter have been visited by a CASH nurse to discuss ongoing contraception.

Your patient experience



Our Corporate Services

What do we do in 2015?

We have in-house teams which provide human resource, finance and IT expertise in supporting all our employees. We have a facilities staff, who provide vital patient facing services, such as cleaning and portering. Our estates team manage our BTC PFI contract and run services on other sites. And we have a series of expert functions that support teams with risk management, research and development, educational governance and communications.

What do we do well?

- We have a very dedicated team that is well integrated with clinical teams, and that is well integrated across functions.
- Our PLACE scores for facilities services are the best in the NHS region. Patients tell us they value the support of our facilities staff greatly.
- Given the age and dilapidation of our estate, it is kept safe and presentable with great effort and estates energy.
- And our educational capability, particular our medical educational capability is widely regarded by peers and students alike.

What will be different in 2020?

Where there is a chance to automate a process and standardise it safely, we will look to do that consistently. For example, much of our reporting infrastructure, and processes to approve expenditure or decisions, can be supported by technology. That will release members of our workforce to focus on providing more expert support to difficult issues, either in IT, HR or finance.

We will look to explore how we sell or share our expertise with other organisations, in the NHS, or wider local landscape. In doing that, we may make choices to use the services of others instead of providing every service in house. We will approach those issues mindful of our local employment obligations and the values of our Public Health plan.

The relationship between corporate functions and clinical teams will begin to change. Increasingly our directorates will ask for, or commission, what they need from corporate help. This cultural shift is a common issue across public services as we strive to ensure innovation and autonomy is developed for professional teams.

Our corporate services are changed by the 2020 Vision that we have. In 2015-2016 the Board's annual plan has prioritised developing and changing corporate support functions, so they are fit for the future, as well as able to meet the needs of today.

We know that our fixed plans do reshape some key corporate functions. For example:

- Where we provide services changes, and in Midland Met some estates staff will leave us to join the provider organisation, who operate that building.
- Our IT ambitions, set out in this vision, mean that the shape and scale of those services will be very different by the end of the decade.

We have already published specific plans which signal changes in delivery within corporate services:

- Our Research and Development plans mean that our ability to undertake research governance as partners require, and our ability to support multiple trials has to be enhanced.
- We continue to work with multiple education providers, and need to become expert at operating that diversity in one main hospital where currently different is spread by site.

Our long term plan generates new roles and focus for corporate teams:

- Our financial plans see major changes in how we achieve a surplus to reinvest in care, and the scale of surplus we need. Broadly , that surplus has to double by 2020 in order to ensure financial stability having met our obligations from investing in work, IT and estates. This changes the focus of the finance team, although safe delivery of those changes is the job of all Trust employees.
- Our workforce plans focus not just on efficiency, but on how work is organised and the development offer to people who work here. This refocuses the human resource function from processes to the development of our people.

Most significantly of all we want to make sure that the corporate support around safety, risk management, patient experience, quality improvement and change management is outstanding.

These are critical functions to both patient and staff in changing how we work, making sure that what we do is of the best possible quality, and helping the organisation to improve consistently across our teams.These are critical functions to both patient and staff in changing how we work, making sure that what we do is of the best possible quality, and helping the organisation to improve consistently across our teams.

7. Care transformation locally: Innovation and research

Research is integral to our ambition to continually improve the safety and quality of the care we provide to our patients and forms part of our 2020 vision. We are a major centre for research that contributes to the development of vital new ways to prevent, manage, and treat health conditions. Our work has influenced approaches to disease management at both national and international levels. We want to grow those areas. But we also want to increase the breadth of our research, empowering the full spectrum of health care staff to deliver research and to give all our patients the opportunity to take part in research. In doing, so we will make ourselves truly responsive to our patients' needs.

Increasing clinical research activity and the breadth of our clinical research portfolio

We want to significantly increase the numbers of patients recruited to take part in research studies by 2020. It is our vision that all patients looked after at the Trust are given the opportunity to take part in clinical research.

Promoting national and international excellence and leadership in clinical research

We will continue to support and develop our areas of research excellence and we will expand our portfolio of research by developing at least two disease areas in which we are national / international leaders.

Increasing the range of health care professionals contributing to our clinical research

We will make sure that key studies taking place at our Trust are led by nurses and allied health professionals.

Translating research into better and safer clinical care

As a leading integrated care organisation we are an ideal environment within which to strengthen research operating at the interface between secondary care, primary care and social care. We will agree a strategy with representatives from these sectors to lead research into understanding the earliest phases of disease and integrated management of people with long term conditions.

Making patients aware of research and development and empowering them to influence it

We will increase the visibility of research opportunities so patients are aware of studies they may be able to participate in. We will involve patient representatives in decision making processes, allowing the patient voice to help shape the direction of research and development.

The trust is undertaking a major investment in information technology between now and 2020. This will not only provide our staff with the tools to deliver better and more reliable care with access to better and more up to date information about you. It will also transform the way you access your care from us and enable you to better care for yourself with our support.

Safer and more reliable

Technologies such as VitalPacs and Electronic Prescribing will mean that the care that we provide will be safer than ever. Our systems will know when your condition changes whilst in hospital and enable clinical teams to respond more rapidly. Doctors and nurses will be able to ensure you are taking the right medicines, that you always get them on time and that they are the most appropriate medicines for you. Our systems will be able to ensure that you have always had the right tests and are always ready for your appointment or operation.

Information always available everywhere

Mobile technology and the Electronic Patient Record means that your health record will, with your permission, be available to any doctor or nurse caring for you wherever you are - whether it is your GP in their surgery, a community nurse visiting you at home or an A&E doctor when you come to hospital. Your Care Connected enables hospitals, community services and GPs to share the information they have. This will reduce unnecessary repeat tests, repeat appointments and vital information about you will not be lost or forgotten.

Keeping you informed, showing you the way

You will be able to monitor your own progress as you pass through our systems - make and see your appointments online. See your own test results and even ask questions of your clinical team. Our self check in kiosks will welcome you when you arrive at hospital, they will help you find your way to your appointment on time, make sure the information we keep about you is up to date and will even let you know if there is an opportunity for you to take part in one of the many research studies we carry out.

Empowering you through technology to care for yourself

We are pioneering the use of smartphone and tablet technology that provide apps to help you take control of your condition. Patients Know Best is an app that helps you set goals, track your condition, communicate with your clinical team and learn more about your condition - so that you become your own expert. Other devices such as home blood pressure monitoring, heart rate monitors, blood sugar measurement and much more will mean that you can track your own condition and share it with your doctor. You will have access to your own healthcare record and you will be able to take it with you wherever you go. You can even communicate with other patients just like you.

Telling you how we are doing

Technology will make information available to you about the quality of care we provide. We will be able to tell you how safe and clean our wards are, how our services compare to other hospitals and what others think about the services we provide. Information is power and we will use our technology to give you the power to manage your own care and make your own choices to receive the best care possible.

INTEGRATED CARE PIONEER

Delivering more care locally: our DiCE Service

The Diabetes Community Care Extension (DiCE) teams truly are an example of how integrated care really can make a difference. Sandwell & West Birmingham Hospitals NHS Trust has provided every General Practice with its own Diabetes Community Care Extension (DiCE) team, comprising a diabetes specialist, a diabetes specialist nurse and their administrative support.

As part of the transformation, diabetes has had a chance to look into more technological ways of improving patient care. Methods such as using Skype and FaceTime for virtual consultations to free up outpatient capacity and also the use of a simple and effective text messaging system to help patients by managing blood pressure, weight management and medication reminders

The use of this messaging system shows that patient experience is at the heart of everything that the diabetes team does. They have also used proven methods from over the years to improve their care, like the use of volunteers in the diabetes centre to provide refreshments. They have also worked with SWCCG's Esteem team to provide emotional support for patients with diabetes-related foot disease and the families and carers of those effected.

The central theme of the diabetes service transformation story is about identifying resources already available and using these to the absolute maximum to improve the patient experience.

We do not work alone – partnerships matter

right care right here

The most important partnerships we have are with a patient and their loved ones, and through local teams and clinicians. But organisational joint working is important to ensure that systems and processes work in alignment to make collaboration happen. For many years, the Trust has been just one part of the Right Care, Right Here partnership. Initially called Towards 2010, this commitment to tackle issues as a care system – the voluntary sector healthcare commissioners, Sandwell and Birmingham's Local Authorities, primary, mental health, community and hospital partners work alongside each other to deliver major change.

Over the last decade this partnership has helped to:

- Open major facilities for primary care, and extended care services, across Ladywood, Perry Barr, and the five towns within Sandwell – for example the Sparkbrook Community and Health Centre and the Portway Lifestyle Centre in Oldbury;
- Reduce the number of acute beds in our system by over 300, and introduce ideas like "own bed instead" into the way we provide care;
- Support close liaison between mental and physical health provision, but for functional and organic conditions, especially dementia care;
- Reduce the boundary between the statutory and third sector in delivering services in innovative community based ways, such as the Community Offer in Sandwell; and
- Involve local representatives, including patient representative, right from the very start of change ideas.

In the next five years, we want to maintain and develop the Right Care Right Here partnership further, and particularly recognise and support the role of the third sector further. It will be tested by the complex and significant implementation burden of change which every partner has to deliver. But we know that none of those partners can deliver alone. In 2015 a new independent chair of the partnership was appointed, and a programme team created. As a Trust our 2020 Vision is one that we can look forward to with confidence, because of the foundation level of trust and joint working

8. Care transformation locally: Locations

The Trust provides care from 150 locations in 2015. We expect the number of locations to remain similar, but the scale of services provided at home, in general practice, in leisure centres and elsewhere within our communities to grow. Meanwhile, we are investing in all of our four hospital sites, and in 2018 will add a fifth site: The Midland Metropolitan Hospital in Smethwick, on Grove Lane.

Rowley Regis Hospital

The site is vital to local people and services have expanded over the last two years. In March 2015 we undertook a consultation exercise on the final state of the site and further expansion. During 2015 and 2016 we are committed to implementing changes to:

- Ensure intermediate and day hospital care is sufficient, and can support discharges from our hospitals and Russell's Hall, where many local people get their emergency care
- Transfer more outpatient services onto the site, to support long term conditions care close to home, in partnership with GPs and the multi-disciplinary primary healthcare team
- Make sure that our changes do not impose a burden on local residents, for example through car park overspill - while trying to create local amenities on the site.

Leasowes in Oldbury

We provide intermediate care through this centre, as well as offering some end of life and our current midwife led birth centre in the adjacent Halcyon facility. Our strategy remains to support intermediate care beds both on our sites and, where appropriate elsewhere as well. Over the next five years we plan to maintain the centre and to support its use for rehabilitation and out of hospital long term care. The future of the Bradbury Day Hospice will be driven by commissioner decision about the long term strategy for end of life care in our area.

City Hospital on Dudley Road

In 2018, the A&E at City Hospital, and the majority of bed based services will close and transfer to the Midland Metropolitan Hospital. The Birmingham and Midland Eye Centre (BMEC) will remain use at City, alongside the Birmingham Treatment Centre (BTC). Current plans retain hearing services on the site, but this is subject to ongoing review. In addition, we are developing the Sheldon Block as our intermediate care base for Ladywood and Perry Barr. That transformation began in 2014 and will continue progressively over the next five years.

Midland Metropolitan Hospital

This new hospital brings together specialist acute services for adults and children. It allows us to offer seven day a week excellence and team based care. With more diagnostic and interventional facilities this major new hospital for the next century is an essential part of the local health landscape. It is a major change in how care is delivered, as well as where care is delivered. It requires a separation between planned and emergency work, and between community-based care, including outpatients, and admitted care.

Developing the Sandwell Treatment Centre

The future of our site in West Bromwich - Sandwell General - is secure. But the site sees considerable change from 2017 to 2020. These changes are in line with the prior public consultation but seek to provide more services on the site than previously envisaged. Of course over the next five years the position is a changing one, and commissioner intent may require adjustment to our plans.

- Outpatient services will be the heart of the new Sandwell Treatment Centre model. Both new and follow up care in most adult and childrens' specialties will be provided through the site. We expect to invest in improving the outpatient environment, and this forms part of the approved long term financial model for the Trust, which underpins the agreed Midland Metropolitan Hospital business case. Only emergency outpatients and antenatal care will take place inside Midland Met. There may be a small number of specialties where it does not make sense to duplicate clinics on multiple sites. This restriction would be more likely to apply to complex multi-disciplinary care.

- Day surgery and investigative procedures such as planned endoscopy care will be maintained at Sandwell, exactly as we currently do within the Birmingham Treatment Centre. This will allow local provision to be maintained. This was always the intention of Right Care, Right Here. If some surgical procedures are transferred by commissioners into primary care, then we will need to maintain an assessment of the viability of services.

- 35,000 patients are expected to be able to use the new Urgent Care Centre which will replace the existing A&E department. The CCG have begun an engagement exercise on the future shape of emergency care, and subject to that work maintaining the agreed system wide strategy, the Trust will offer with partners this vital service from 2018. The exact clinical exclusions from attending an Urgent Care Centre, as against an A&E department, are well understood nationally. Most ambulance transferred patients will by-pass the Urgent Care Centre and be looked after within an A&E department.

- Intermediate and long term care will be offered at Sandwell. This is the type of care we presently provide in Leasowes and Rowley Regis. We know that local delivery of such a service helps to integrate our care with the support of friends and family.

- Over the course of the next five years, we expect to transfer to majority of our corporate services onto the Sandwell site. Trust Headquarters relocated there in April 2014. Key support departments, which help us to run safe, and develop higher quality services, will locate there. This will include important aspects of our Research and our Education portfolios. These investments both confirm the central role that the site will continue to play in the life of the Trust, but also ensure local employment opportunities, as more than 15% of our workforce are within corporate teams.

We do expect to make some land sales. This is in line with our long term published plans, and we continue to explore with partners such as the Local Authority how these intentions can best meet both local need and economic obligations on the Trust. Taking the re-used property and the excess property we remain able to develop some of our estate with local partner organisations, including the third sector. We are exploring the creation, for example, of a general practice service on the site.

9. Care transformation locally: Our workforce

Everything in our 2020 vision depends on the skills, talents and teamwork of our workforce. That is why we are committed to educating the next generation of NHS staff. And why we are investing heavily in research and development, to ensure that the most innovative care Is delivered by the Trust, and those with a passion for excellence are recruited to local service.

In the future we will employ over 6,000 people. We want to sustain that workforce as a high-skill, high-wage, multi-site, flexible group, able to meet the health challenges faced by local people, supporting them to lead healthy lives. Every employee will have not only an appraisal and training plan, but a clear indication of their potential career trajectory. Whether in full time or part time work with us, our workforce will be supported to become ambassadors for the local NHS - implementing their own ideas to improve care within our organisation and with partners beyond it.

A great place to work

Working for the NHS is a privilege. But the dedication of staff must be rewarded with opportunity, consistency of leadership, and unwavering support to do difficult and challenging jobs. Our investment plans ringfence training expenditure, and provide for support to make major shifts in care. To work in teams requires that we support work-life balance. And that we act to cut sickness and reduce turnover. The Board, and wider leadership, understand that without success in those basics, the Vision outlined in this and other documents, cannot be achieved.

The next generation of employees

We know that part of our contribution to health lies in the jobs that we create and nurture for local people, be they school leavers through our association with the Sandwell UTC; apprentices through our ground-breaking work enrolling young people from our communities; or the skills training we provide to older adults re-entering employment.

Preparing our teams for change

Our care model requires different skills. More reliance on technology. The capability to work across different teams and various sites. These are big changes. 60% of our employees who have worked for us for more than five years. Around 10% of our staff change each year. For both longstanding and newly enrolled staff the future is different to the present and we need to prepare carefully for that, with time, investment and collaboration.

Our multi-year education, learning and development plan

In 2015 we launch our education plan that sets out how we are going to support our workforce to develop the skills and competence that they will need to deliver our ambitions for 2020 and the years in between. Our activity within the education plan aims to attract talented people to come and join our team, give all new starters a welcoming environment and positive joining experience, and ensure we retain our skilled colleagues.

Improvement and leadership skills

In 2015 we launched a major Improvement Plan for care. At the same time we created ring-fenced dedicated time across our services for one half day each month, to be reserved for development, support and quality improvement. That time to talk is crucial to our 2020 Vision. Individual teams need the chance to identify opportunities for change, and to reflect on organisation wide learning. At the same time, the skills to improve services, to bring about and evaluate change are critical, and we will develop a model of routine implementation methodology during 2016. This supports the three year investment in leadership that we made in 2014. Across our directorates and Groups we are working to core leadership competencies, which we need to consistently apply throughout the Trust.

Name: Dean
Department: Medical Director's Office, City Hospital.
Framework: Business Administration, Intermediate Level.

Dean joined the Medical Director's Team in January 2015 and had shown a keen interest in wanting to work in a business environment. He settled in quickly and is already responsible for a variety of tasks which see him working closely with Consultants and Ward staff to gather the information he needs to report on a daily basis.

Dean said: "The work is very varied and at a higher level than I had expected but I am really enjoying the responsibility. I get to go out and visit the Wards to check and gather information I need from the medical staff. One of my main tasks at the moment is to chase VTE Risk Assessments from Consultants who have not yet submitted them. I then enter these into compliance graphs for the Medical Director. I am also responsible for data entry of mortality reviews and checking the Bed Management System."

Dean goes on to explain: "I am enjoying my QCF training from Learning & Development and I have just taken my first exam. I am well supported by my manager, team and assessor and know there are people on hand if I have any difficulties at work. It has been really great joining the NHS and I can see it is going to give me many skills to help in my future career."

Investing in our people

In 2014, and again, in 2015 the Trust has increased significantly the money spent on training and development for our staff. Annual expenditure is now above £1million for the first time. We would expect to continue to grow our training funds in coming years as we strive to both improve the skills of individuals and develop our teams. The Trust works actively with Health Education West Midlands to access national and regional funding, and to understand good practice from elsewhere in the area.

Increasingly, clinical groups will develop multi year training plans, so that staff are clear what is available some time in advance. Part of that work is ensuring that support is available at every step and stage of someone's career, not just when they first start with us, or when they are stepping into very senior roles. Our future plans see many of our staff working in different ways, through technology, or different places, as care moves into the community. Honing new skills through training and development lies at the heart of preparing for our future.

10. Judging our level of integration – you decide in 2020

Successful integration is not easy to measure. As part of our plans, and those of the wider Right Care, Right Here partnership, there are agreed metrics which set expected levels of service change. But the real test is the opinion of each patient about their experience of our care. Have we changed who controls care outcomes? Because that is our aim.

Getting your feedback on care co-ordination

During 2015-2016 we will be changing how we gather feedback in our surveys and focus groups. We will make sure that the co-ordination of care across settings and services is a dominant feature of local data capture. Over the next five years that dataset will build a picture of where we are succeeding and where we are falling short of our vision. In 2020 we will undertake a much larger scale study of patient opinion in order to both assess the delivery of our plans and frame our strategy to 2030.

Making this 2020 Vision happen day to day

We will be establishing a series of patient panels to help us evaluate the plans put forward by our clinical groups, and test with you whether they deliver the level of coordination and joined up care you want to see from our services.

The delivery of this vision matters. It is for this reason that this will be governed through our Trust Board, with progress reported to our Clinical Leadership Executive, which has representation from each of our clinical Groups, as well as the full Trust Executive. Our membership, and the member's leadership group will also be appraised and involved in overseeing our work.

We will report within our annual plan and at our Annual General Meeting on our progress. In particular we will provide commentary on the future state models outlined by each of our Groups, and provide a straightforward assessment of the progress of our Integrated Care Pioneers: These services which will embody the change in how we provide care in 2020 and the decade that follows.

Taking the lead - our Integrated Care Pioneers

During 2016 we will be selecting 20 services that form our Pioneers programme. These are the services that we believe have to be at the forefront, in vanguard of change, in order to accomplish both our 2020 Vision, and the wider Right Care, Right Here programme.

We would expect our pioneers to include services providing integrated models of care, such as diabetes, as well as those where we recognise that the care model needs to change, such as respiratory services. The pioneers are not only current Trust services, but services where we know we need to develop improved provision both to support care at home and to ensure that the Midland Metropolitan Hospital is supported by consistent models and standards of care regardless of the postcode of the person using its services.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Our vision for care in **2020**

Where **EVERYONE** Matters

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Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Registered Nurse and Midwife Revalidation
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Cath Greenway – Lead Nurse, Nurse Education Team
DATE OF MEETING:	1st October 2015

EXECUTIVE SUMMARY:

The attached report outlines the plans to support the Trust's Registered Nursing and Midwifery workforce in meeting NMC revalidation requirements to be introduced in April 2016.

REPORT RECOMMENDATION:

The Trust Board is asked to formally receive the plans outlined

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:

Supports professional requirements of Registered Nursing and Midwifery workforce

PREVIOUS CONSIDERATION:

Nursing and Midwifery Revalidation

Report to Trust Board October 2015

From April 2016 the NMC is introducing a process of revalidation which all nurses and midwives will be required to undertake every 3 years at the point of re-registration in order to remain on the NMC register. The aim of revalidation is to provide reassurance to the public that the nursing workforce is fit to practice.

A nurse or midwife will be required to provide evidence that, over the previous 3 years they have:

- undertaken 450 practice hours (900 hours for dual registered nurse and midwife – 450 nursing, 450 midwifery)
- completed 40 hours of continuing professional development (CPD)
- appropriate professional indemnity arrangement in place
- made a health and character declaration
- obtained at least 5 pieces of practice-related feedback
- recorded at least 5 reflective accounts based on CPD, feedback and the Code
- obtained confirmation from a third party, usually their line manager, on their continuing fitness to practice based on the requirements of the NMC code.

Nurses and midwives will be accountable for their own revalidation process.

Ready to Revalidate (R2R) – The SWBH approach

It is essential that Trust nursing staff become familiar with revalidation requirements and begin to collect evidence that they being met before revalidation is introduced by the NMC in April 2016.

From May 2015 the Nurse Education Team began promoting Ready to Revalidate (R2R) through a combination of awareness-raising during clinical education sessions; cross-site roadshow events from June 2015; Heartbeat articles and awareness leaflets. Templates facilitating reflection on CPD or feedback on performance were introduced into clinical skills training and portfolios in May 2015 to support staff to achieve this aspect of revalidation (Appendix 1).

A Draft policy for Revalidation has been developed which links review of revalidation evidence into the annual appraisal cycle for all NMC registrants. A registrant's portfolio of evidence for revalidation will be reviewed during annual appraisal and any outstanding requirements built into the personal development plan. The Trust policy will be confirmed once the NMC has announced finalised revalidation requirements in Sept/October 2015.

Arrangements to enable the Trust and line managers to identify staff revalidation dates through weekly ESR reports are already in place and staff due to revalidate in the first wave (April-June 2016) will be targeted for initial support by the Nurse Education team from July 2015 onwards to ensure they are ready for the process.

Training for line managers who will act as Confirmers that registrants have met NMC revalidation requirements will commence in September 2015 once NMC requirements have been confirmed.

Work is ongoing with the Trust Bank Service to identify bank staff without a substantive post who may require Trust support to meet revalidation requirements. Current numbers appear to be relatively low (<50) and they can be supported through access to Trust clinical training and a Trust confirmer from the Trust Bank.

Key Risks

As yet is it is unclear if additional resources will be required to support the potential additional education element of revalidation. Guidance is awaited when the NMC finally publish in October2015.

Staff unable to meet NMC revalidation requirements will not be able to re-register, therefore potentially reducing the available nursing workforce. R2R aims to mitigate this risk by ensuring all staff are aware of revalidation requirements and are supported to ensure they are met. (See Revalidation Project plan)

Concern has been raised both regionally and nationally that the work involved in collecting evidence for revalidation may prompt some staff nearing retirement to decide to retire early rather than go through the revalidation process. The R2R roadshows aim to demonstrate how revalidation evidence can be collected quickly and easily using Trust/NMC templates and it is hoped that this will go some way to mitigating this risk.

It is unclear how some nursing/midwifery registrants currently working in non-nursing roles such as management or project roles, who wish to retain their professional registration, will accumulate the practice hours required for revalidation. This is a risk which has been identified at regional level and work is ongoing to identify how such job roles may be mapped to professional requirements in order to ensure consistency across organisations.

Appendix 1: Reflective Template for CPD/Feedback on Practice

Description: Describe the key points of the learning experience or feedback
Feelings: What were you thinking and feeling during the experience?
Evaluation/Analysis: What was good or bad and why? What did you learn, how did the experience relate to your knowledge & theory? What evidence, protocols or guidelines can you find that are relevant?
Action Plan: How will this learning experience/feedback affect your future practice? What have you learned about yourself, what will you change?
The Code: How does this learning experience/feedback and its' impact on your future practice reflect the requirements of the NMC Code? Select a theme – Prioritise people – Practice effectively – Preserve safety – Promote professionalism and Trust

Appendix 2: NURSING & MIDWIFERY REVALIDATION

Project Plan

Date: August 2015

Compiled By: Debbie Talbot/ Cath Greenway

5	Complete
4	On track
3	Expect to be completed as planned
2	Significant delay/unlikely to be completed as planned/will have explanation attached
1	Not yet commenced
0	Objective revised

CG	Cath Greenway	Nursing Education Team
GD	Gayna Deakin	Assistant Director Workforce Planning
AH	Andy Harding	Human Resources Manager
GF	Glynis Fenner	Bank (temporary staffing) Manager
CO	Colin Ovington	Chief Nurse
LP	Linda Pascall	Deputy Chief Nurse

Ref	Action	By Whom	Timeframe	Progress	Status
A	ORGANISATION				
1	State of readiness paper to Trust Board	CG	Oct 2015	Paper completed – awaiting final NMC guidance	3
2	Nursing & Midwifery Revalidation Policy	CG	October 2015	Draft 1 completed – awaiting final NMC guidance	3
3	Revised Appraisal Process and documentation	GD	Oct 2015 tbc		
B	WORKFORCE				
4	Confirmation of number of RN/RM currently employed and holding a registration	AH	Complete	Information available at and up-dated weekly	5

5	Vacancy numbers for RN/RM	AH	Ongoing	Reported monthly	3
6	Confirmation of names of staff needing to revalidate in the first quarter of 2016	AH	Complete	Available	5
7	Identification of confirmers and their role	CG	July 2015	Policy identifies line manager to act as confirmer	5
7	Raising awareness sessions for staff at all sites: City, Sandwell, RRH. Leasowes, Lyng	CG	Ongoing	Roadshows commenced June – 7 sessions delivered, to continue into Sept (Approx 100 attendees) 2 x RCN local learning events on Revalidation (60 attendees) held on City site. Revalidation included in Band 5 conference – 70 attendees (June) Revalidation included in QIHD July.	4
8	Staff information literature	CG	July 2015	Article in Heartbeat published May 15. Information and guidance leaflet printed and distributed at Roadshow events.	5
9	Staff workshops for staff due to revalidate in early 2016 Reflection E portfolio	CG	December 2015	Workshops on reflection and evidence collection to commence September 15	3
10	Training sessions for confirmers regarding role , appraisal process and reflection models	CG	Oct 15	Workshops to commence following NMC final guidance – October 15	3
11	Review and confirmation of confirmer for non – substantive bank staff	CO	Complete	GF confirmed numbers approx. 30 tbc	5
12	Access to training and raising awareness for non – substantive bank staff confirmed	GF	June 2015		3
13	Inclusion of revalidation standards in contract with external nursing agencies	GF	July 2015		1
C	COST				

14	**Identification of pay and non-pay costs to introduce and maintain revalidation standards** **Training activity** **Training material /packs** **Publicity material**	**CG**	**June 2015**	**Pay – 3hrs per week B7 for 6 months tbc (training workshops etc)**	**3**
D	**RISK**				**3**
15	**Identification and mitigation of key risks and escalated to Trust Board**	**DT**	**June 2015**	**Included in Trust Board paper needs formal risk assessment for Risk Management Committee**	**3**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance & Investment Committee - Minutes

Venue Anne Gibson Board Room, City Hospital **Date** 31st July 8am – 10am

Members Present	**In attendance**
Mr. Richard Samuda (Chair)	Ms. D. Lewsley – Commercial Manager, MMH
Mr. Mike Hoare (Non Exec Director)	Mr. R. Knight – Senior Accountant, MMH
Mr. Harjinder Kang (Non Exec Director)	Mr. T. Sturmey (HSBC)
Mr. Tony Waite(Finance Director)	Mr. A. Price (Deloitte)
	Mr. W. Gregg (Carillion)
Secretariat	
Miss Rosie Fuller	

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Toby Lewis and Rachel Barlow	
2 Minutes of the previous meetings – 29th May 2015	**SWBFI (5/15) 022**
The minutes were agreed as a true record.	
2.1 Matters arising from the previous meeting	**SWBFI (5/15) 022(a)**
• **Contract database where SWBH commissioner** – on Procurement Forward Plan but not an immediate priority; being populated as relevant during routine business • **Contract database where SWBH provider** – to be progressed on conclusion of arrangements for end to end contract and business development function. • **Market testing by commissioners** - currently these are managed on a case by case basis; sustainable arrangements to be confirmed as part of functions referred above. • **Change Team** – The transitional changes will be discussed at a future private Trust Board meeting.	
3 Month 3 – finance report	**SWBFI (7/15) 023**
Mr. Waite noted some changes in style; this has been consulted with Robin Russell [non exec director] who has agreed to attend occasional meetings of the Finance & Investment Committee. This new style is intended to show key issues, give foresight and confirm and challenge. Mr. Waite asked for feedback. The Q1 position is reported as off plan. Mr Waite drew the Committee's attention to key matters of SLA income under recovery on planned care and excess pay costs. He also emphasised the level of support included in the reported financial position and consequent underlying deficit run rate. This was not sustainable and would require to be remedied. Mr	

Waite confirmed that the TDA was alert to this position. Agency Spend. The pay bill has improved but it is still above plan, due to a spike in agency spend. The executive team are routinely reviewing this spend at its weekly meetings. A report has been prepared for the CLE Committee which the Finance & Investment asked for sight off. The Committee discussed briefly and asked for the Agency Spend report paper to show hot spots and the processes in place to manage it. Also a forward look with be shown. Mr. Waite reported on the dispute with the Antenatal SLA but confirmed other monies to these Trusts are still being paid. There is approximately £2m across 3 Trusts that is being held back. A report would be provided to the September Trust Board. CIP Delivery. Five of seven clinical groups were noted as not having balanced finance plans. There is a plan to bring Surgery A & B back into balance in the next financial year 2016/17. There is a major efficiency plan underway in Theatres which will optimise efficiency, planning and patient flow. Meetings are progressing with the other groups to help achieve balance. Mr Waite recommended that the Committee move to meet monthly to keep abreast of the issues on contracts, agency and MMH, and to continue with the fortnightly tele conferences. The Committee agreed and asked if Robin Russell could be invited to take part in the tele conference calls.	
ACTION: The CLE paper on agency spend to be circulated to Committee members. **Ante-natal briefing note to September Board.** **Committee to meet monthly from September and fortnightly tele-conference calls to continue extending an invitation to Robin Russell**	**T Waite** **T Waite** **T Waite**
4 MES delivery plan	**Verbal**
The contract needs to be in place by March 2016 to ensure the deliverables for Midland Met are met. The Committee challenged and was advised that necessary capacity and expertise was being put in place to meet that timetable. Mr Alan Kenny and Mr. Waite will bring a statement to the Private Trust Board for recommendation. The Finance & Investment Committee noted the paper.	
ACTION: MES paper to August Trust Board	**A Kenny**
5 Midland Met	
5.2 Debt funding	**SWBFI (7/15)025(a-d)**
Mr. Sturmey confirmed the c£220m debt was required and a working assumption that approximately 50% would come from the European Investment Bank. The approval will be presented to the EIB board in September and Carillion are confident it will be agreed. This process is currently on track. Mr. Samuda asked about any risks in the process. Mr. Sturmey informed the Committee that EIB have approved many healthcare monies for the UK in the past and this was no different. It was also noted that it would be unlikely for the EIB to ask for a return of their investment if the UK left the EU and that the EIB have provided funds for non EU countries in the past. If no backing was provided by the EIB they were confident as to ability to obtain the funds from other sources i.e. the banks and financial institutions. However obtaining the money from the EIB would likely be cheaper. All other sources have been asked if they could provide more	

money if required. The Committee discussed the banking and institutional investors and the cost of early payment, pre-payment fees and the variable/fixed rate charges. The Committee noted that the financial model included a buffer over any funding offers to cover market interest rate increase prior to financial close and which was a trust retained risk. Consequent to financial close interest rates would be fixed for the term of the contract. Mr. Sturmey tabled a booklet to the Committee showing the 18 banks and institutions that were involved in the evaluation process for any comment. Mr. Sturmey informed the Committee that HSBC were included but even though they are linked with Carillion it was unlikely that they would bid. Mr. Waite confirmed that during the evaluation process the Trust has access to analysis and right to become involved to ensure we are getting the best deal and it is value for money. It was noted that a formal governance process has been established by Carillion, PFU and IUK in regard to the debt funding process. This was consistent with conclusion of the debt funding competition by end September to inform the CBC and process to financial close. Mr Waite challenged & the Committee confirmed its contentment with the proposed process and evaluation criteria; recommendation to board on that basis.	
ACTION: The Finance & Investment Committee confirmed a buffer to be retained in CBC to cover market exposure between September and December on the debt funding.	**D Lewsley**
5.1 Equity funding	**SWBFI (7/15) 025**
Mr Sturmey informed the Committee the equity funding was the new element of PF2 and SWBH is a pilot for PF2. A third party equity provider is sought and any benefits associated with the provider are passed onto the Trust. It was stated that a competition had taken place lead by Carillion and with input from IUK and the PFU. Mr Gregg confirmed that Carillion have engaged HSBC to help with the debt and equity funding. The costs of that will be met by Carillion. The winning bidder Richardson's proposed a funding rate of c 9%; the base case was 12% so the difference will be the benefit the Trust receives through the Unitary Payment. Mr Samuda queried he understood Richardson's are known by Carillion but they are not experienced in healthcare only the retail sector. Mr. Sturmey reassured the Committee that as a 3rd party they are brought into sign off the equity documentation, the risk is still with Carillion who provide the knowledge and were involved in the competition to find a supplier. The Committee challenged as to the basis of Richardson's competitive bid. The bid came in low due to Richardson's having a higher cash balance, where the other bidders did not have as large cash holding. However if any of the bid from Richardson's was not correct, then there is still the option to go with the 2nd place bidder. Mr. Waite confirmed that if Richardson's were to pull out the cost of the 2nd place bidder would be very modest given the closeness of the competition results. Mr Price confirmed that Richardson's passed the financial standing and robustness tests. The Committee challenged as to the ethical investor tests that had been applied and the compliance or otherwise of the proposed funder Richardson's. It was agreed that this would be reported to the Trust Board.	

Mr Waite asked the Committee to confirm support of the equity funding outcome and for the Trust Board to be asked to support that recommendation. Mr Waite informed the Committee IUK and PFU have supported the outcome of the competition. The Finance & Investment confirmed it support, subject to assurance on the ethical investor tests, and for the Trust board to be informed of that recommendation.	
ACTION: Mr Waite to draft a paper on the key points on the funding competitions for the Trust Board	**T Waite**
6 Procurement update – for information	**SWBFI (7/15) 027**
This paper was presented for information. The October meeting would be provided with a paper on the delivery plan to secure significant non-pay savings from procurement.	
7 Matters to highlight to the Board and Audit & Risk Management Committee	**Verbal**
• **Agency Spend**. Board to have sight of CLE report showing the remedial plan to reduce agency spend and show forward plan and hotspots. • **MES (Managed Equipment Service)** – paper to be presented to Trust Board; purpose to provide assurance of delivery of fit for purpose MES by 31 March 2016. • **MMH – Equity Funding Competition** – challenged & confirmed proposed equity partner; recommendation to board on that basis [separate note refers on detail]. • **MMH – Debt Funding Competition** – challenged & confirmed proposed process and evaluation criteria; recommendation to board on that basis [separate note refers on detail].	
8 Meeting effectiveness feedback	**Verbal**
No items to report	
9 Any Other Business	**Verbal**
No items to report	
10 Details of the next meeting	**Verbal**
The next meeting is to take place on 25th September 2015, 8am – 10am, Anne Gibson Board Room at City Hospital.	

Signed ……..

Print ……..

Date ……..