Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Archers Ward, Rowley Regis Hospital **Date** 6 August 2015; 1330h – 1630h

Members attending

Mr R Samuda	(RSM)	[Chairman]
Ms O Dutton	(OD)	[Vice Chair]
Mr M Hoare	(MH)	[Non-Executive Director]
Mrs G Hunjan	(GH)	[Non-Executive Director]
Mr H Kang	(HK)	[Non-Executive Director]
Dr P Gill	(PG)	[Non-Executive Director]
Mr R Russell	(RR)	[Non-Executive Director]
Mr T Lewis	(TL)	[Chief Executive]
Miss R Barlow	(RBA)	[Chief Operating Officer]
Mr T Waite	(TW)	[Director of Finance]
Dr R Stedman	(RST)	[Medical Director]

In attendance

Mr W Zaffar	WZ)	[Non-Executive Director]
Miss K Dhami	(KD)	[Director of Governance]
Mrs R Goodby	(RG)	[Director of Workforce & OD]
Mrs C Rickards	(CR)	[Trust Convenor]
Mrs D Talbot	(DT)	[Deputy Chief Nurse]

Secretariat

Mrs A Winwood (AW) [Executive Assistant]

Time	Item	Title	Reference Number	Lead
1330h	**1**	**Apologies – Colin Ovington**	**Verbal**	**SG-L**
	2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**SG-L**
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 2 July 2015 a true and accurate records of discussions*	**SWBTB (7/15) 119**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (7/15) 119 (a)**	**SG-L**
	4.1	DNACPR plan	SWBTB (7/15) 121	RST
	4.2	Consent on the day of surgery	SWBTB (7/15) 122	KD
	5	**Questions from members of the public**	**Verbal**	**Public**
	6	**Chair's opening comments**	**Verbal**	**Chair**
	7	**Chief Executive's report including:** • **update on equality & diversity commitments** • **delivery of 'top ten' annual priorities** • **policy on issues of care and exclusion**	**SWBTB (8/15) 123** **SWBTB (8/15) 123 (a)**	**TL**
	8	**Annual Plan delivery report – Quarter 1 update**	**SWBTB (8/15) 130** **SWBTB (8/15) 130 (a)**	**TW**
	9	**Financial update**	**SWBTB (8/15) 131** **SWBTB (8/15) 131 (a)**	**TW**

	10	**Board Assurance Framework 2015/16 – Quarter 1 update**	**SWBTB (8/15) 129** **SWBTB (8/15) 129 (a)**	**KD**
	10.1	Vacancy positon in Health Visiting	Verbal	DT
	11	**Trust Risk Register**	**SWBTB (8/15) 128** **SWBTB (8/15) 128 (a)**	**KD**
	12	**CQC improvement plan update**	**SWBTB (8/15) 127** **SWBTB (8/15) 127 (a)**	**KD**
	13	**Education Plan – for approval**	**SWBTB (8/15) 126** **SWBTB (8/15) 126 (a)**	**RG**
	14	**Visits by the TDA: infection control**	**SWBTB (8/15) 125** **SWBTB (8/15) 125 (a) -** **SWBTB (8/15) 125 (d)**	**DT**
	15	**MATTERS FOR INFORMATION AND QUESTIONS**		
	15.1	Nurse staffing report	SWBTB (8/15) 132 SWBTB (8/15) 132 (a)	CO
	15.2	Quarterly complaints report	SWBTB (8/15) 133 SWBTB (8/15) 133 (a)	KD
	15.3	Corporate integrated performance dashboard	SWBTB (8/15) 134 SWBTB (8/15) 134 (a)	TW
		UPDATES FROM THE COMMITTEES		
1600h	**16**	**Update from the meeting of the <u>Quality & Safety Committee</u> held on 31 July 2015 and minutes of the meeting held on 26 June 2015**	**SWBQS (6/15) 071**	**OD/ DT**
	17	**Update from the meeting of the <u>Audit & Risk Management Committee</u> held on 30 July 2015 and minutes of the meeting held on 30 April and 4 June 2015**	**SWBAR (4/15) 031** **SWBAR (6/15) 037**	**GH/ KD**
	18	**Update from the meeting of the <u>Finance & Investment Committee</u> held on 31 July 2015 and minutes of the meeting held on 29 May 2015**	**SWBFI (5/15) 022**	**RS/ TW**
	19	**Update from the meeting of the <u>Charitable Funds Committee</u> held on 30 July 2015 and minutes of the meeting held on 7 May 2015**	**SWBCF (5/15) 004**	**WZ/ RW**
	20	**Any other business**	**Verbal**	**All**
		MATTERS FOR INFORMATION		
	21	**Details of next meeting** *The next public Trust Board will be held on 3 September 2015 at **1330h** in Anne Gibson Boardroom, City Hospital.*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.5

Venue Carters Green Business Centre, West Bromwich **Date** 2 July 2015

Present	**In Attendance**	**Secretariat**
Mr Richard Samuda [Chair]	Mr Mike Hoare	Mr Simon Grainger-Lloyd
Ms Olwen Dutton	Mr Waseem Zaffar	
Dr Sarindar Sahota OBE	Miss Kam Dhami	
Ms Olwen Dutton	Mrs Raffaela Goodby	
Mrs Gianjeet Hunjan	Mrs Chris Rickards	
Dr Paramjit Gill		
Mr Robin Russell		
Mr Harjinder Kang		
Mr Toby Lewis	**Guests**	
Mr Colin Ovington	Patient	[Item 3]
Miss Rachel Barlow	Sister J Thomas	[Item 3]
Dr Roger Stedman	Miss G Downey	[Item 6]
Mr Tony Waite		

Minutes	
1 Apologies for absence	**Verbal**
No apologies for absence were received. The Chairman welcomed Waseem Zaffar and Robin Russell to their first meeting.	
2 Declaration of Interests	**Verbal**
There were no declarations that had been made since the last meeting.	
3 Patient story	**Presentation**
The Board heard the story of a patient who had spent a number of weeks under the care of the Trust recovering from a stroke on ward Priory 4 and Newton 4 in	

November 2014. Mrs Hunjan asked whether the patient had been admitted through the accident & emergency department. The patient advised that he had been admitted after falling down in the house on the advice of 111, however initial tests had not diagnosed a stroke. Once diagnosed, the patient was taken onto the acute stroke ward, although it had taken 4-5 hours. Sister Thomas advised that the patient had not been eligible for thrombolysis as he was outside of the four hour window when he presented to the Trust. Dr Gill noted that the patient's experience with the Trust had been positive and asked what appeared to be the experience of other patients on the ward. The patient advised that in the majority, others had received a good experience. It was noted that there had not been a television available for the length of the stay although effort was made to share a set at times. Mr Lewis asked the patient's wife what support had been provided to her in preparation for the patient coming home. The carer advised that the experience had been good and communication & support had been provided well. Sister Thomas advised that quality listening time had been introduced to meet with patients relatives in a structured way to explain discharge plans and other goals. It was noted that there had been no formal complaints on ward Newton 4 within 11 months. Ms Dutton asked how the handover experience had been when the patient had arrived home. She was advised that this had been good and efficient assessments & modifications had been undertaken. It was pleasing to hear that family members had been involved in his rehabilitation. Mr Hoare asked how important the social aspects of the rehabilitation had been and was advised that this had been critical and there was a good sharing of experiences. The patient was thanked for his illuminating story and he was wished well.	
4 Minutes of the previous meeting	**SWBTB (6/15) 097**
The minutes of the Trust Board meeting held on 4th June 2015 were presented for consideration and approval. They were agreed as a true and accurate record.	
5 Update on Actions arising from Previous Meetings	**SWBTB (6/15) 097 (a)**
The Board received the updated actions log. It was noted that thought would be directed to the most appropriate time and means of telling the organisational story. Mr Lewis noted that there was an intention to widen the nurse staffing report in due course to incorporate wider staffing indicators.	

5.1 Consent audit	**SWBTB (6/15) 099**
Miss Dhami reminded the Board that a seven day audit of consent had been presented at the last meeting which had identified that of 121 cases admitted, 26 had been consented on the day of surgery. These had since been reviewed to establish whether it was appropriate to have taken consent in this way, which had found that 11 of the Oral Surgery cases were direct access and therefore consent on the day of surgery had been unavoidable. The Board was assured that in other areas, in the majority of cases, consent was taking place in the proper way but it was not being documented robustly. Mr Lewis asked whether the EDTA initiative was assisting with the situation. Miss Barlow advised that this was the case and the process would be rolled out over the summer. She offered to report back on progress at the next meeting. An update on the patch and plan process was provided by Dr Stedman. He advised that these fell into the category of emergency patients and therefore consent could not be taken in advance. Dr Gill suggested that consent could be incorporated within GP letters so consent could be taken prior to arrival at the Trust. He was advised that this was the intention. Within the guidance, it was noted that the initial completion of the consent was cited as being 'optimal', which it was agreed suggested that this optional and therefore this wording needed to be revised. It was reported that further update would be presented at the next meeting, which would discuss practice in other areas across the organisation.	
ACTION: Miss Barlow to present an update on the roll out of the EDTA initiative at the next meeting **ACTION: Miss Dhami to present an update on the consent audit at the next meeting**	
5.2 Surgery A video reflexivity	**Verbal**
Mr Lewis reminded the Board that video reflexivity had been rolled out in the eye hospital and would be extended to other theatres over the next four months, a process which would be tracked through the Theatre Management Board. The purpose of the practice was to reflect on the experience in a multi-disciplinary way.	
6 Never Event – Women & Child Health Group	**Hard copy briefing**
Miss Downey, Group Director for Women & Child Health Group, joined the	

meeting in support of this item.

Dr Stedman reported that the investigation into the recent Never Event had concluded. It was reported that weaknesses in the swab counting process had been identified, particularly in relation to major surgery. Procedures where swabs were counted at the end were noted to be counted twice, whereas procedures where swabs were bagged in an ongoing way during surgery were only counted once. As such, a system of bagging that allowed visible counting would be introduced. The Board was provided with a demonstration of some tools available for this purpose. It was reported that three near misses had been identified that were associated with swab counting. The root cause of the Never Event was failure to implement the policy change introduced some time earlier.

The Chairman expressed his deep concern that this was a third Never Event in short order and asked how lessons were being learned from these incidents were across all areas.

Dr Gill noted that some members of the team had not challenged during the procedure and asked who was to facilitate the video reflexivity. Mr Lewis advised that in the Eye Centre the use of external individuals and junior members of staff would do this and the process would be rolled out in the same way across other theatres.

Miss Downey reported that nationally, the Trust was not an outlier in terms of Never Events in Obstetrics. She advised that the training in the area was different to other surgeons and she highlighted that the pressures in a labour ward contributed to the higher number of Never Events in this environment nationally. The Board was advised that the Group management team would meet to identify shared responsibility for behaviours and the use of Quality Improvement Half Days would assist with discussing lessons learned. An external facilitation process would also be used to support the behavioural aspects of the work. She expressed her support for the value in the use of video reflexivity.

Miss Dhami asked if the near miss investigations had generated similar recommendations to that of the Never Event. Dr Stedman reported that none of the near misses involved swab bagging issues. Having said this, should the recommendations of the near misses have been properly embedded, there was a possibility that the situation could have been avoided. He noted that culture and systems needed to be addressed.

Mr Lewis noted that the Trust had moved culturally on the issue of Never Events over the last few years, however the learning of lessons from other areas was not yet in place and learning from near misses as opposed to a Never Event was not clear.

Miss Barlow reported that a Theatre Management Board had been established at which all clinical groups were represented which would look at quality improvements in the wider sense. Mr Kang suggested that the culture needed to be focussed on continual improvement.

The Chairman asked if there was a link to appraisal. He was advised that as part of medics' appraisals, evidence was being sought that individuals were employing reflective practice. Miss Downey added that the appraisal process incorporated reflection on whether individuals had been involved in serious incidents and accountable managers also received incident reports. Mr Ovington noted that the issue was not restricted to medics but concerned the wider team. Miss Downey noted that there was reluctance in some cases of more junior members to challenge. Mr Lewis summarised the actions which were: • Introduction of new bagging arrangements in August • Miss Downey to pursue a leadership challenge with those in the Women & Child Health clinical group • Measures will be introduced to ensure that previous cavity swab arrangements are enforced in theatres • Consideration would be given to determine how policy travelled from learning from near misses • Implement video reflexivity across all our theatres by November	
7 Questions from members of the public	**Verbal**
Mr Hodgetts, Healthwatch, expressed a concern over the patient story heard earlier, where there appeared to have been a delay in diagnosis of the stroke. Mr Lewis disagreed that the patient had arrived and been ambulance triaged as a stroke case, but noted that we would examine how the clerking had operated in this case. Mr Hodgetts also expressed a concern over the number of patients arriving without being registered with a GP. Mr Lewis noted that we had divert practices for ED, and did our best to connect patients to registration systems operated by the CCG and NHS England	
8 Chair's opening comments	**Verbal**
Mr Samuda reported that he had attended a discussion on the devolution of healthcare process to assess what the impact was for the Birmingham area. He offered to share some feedback when available. Ms Dutton noted that Leeds was planning to take a different approach to Manchester. It was reported that agency spend had been raised as a concern by the Secretary of State for health, in addition to consultancy costs and VSM terms. The Board was advised that a breakfast meeting had been held with the Patient Transport services team and the reliance on team working with the ward to	

deliver maximum efficiency from the service was underlined. Miss Barlow reported that the Patient Transport team had been involved in the Urgent Care Challenge and specifically the discharge work, which would address this point.	
9 Chief Executives report	**SWBTB (7/15) 101**
Mr Lewis reported that emergency care performance had improved significantly. Urgent Care Challenge week 2 would take place shortly and improvement would be expected on Delayed Transfers of Care rates and other associated mattes. Moving to expected dates of discharge within 48 hours of admission was reported to be a significant change for the organisation. Mr Lewis provided an example of this change in medical practice and advised that this was the custom in a number of other organisations. Dr Sahota noted that patients needed to involved in dates of discharge. Miss Barlow noted that this was within the considerations as part of the Urgent Challenge week and discharge checklists would be standardised. Expected dates of discharge would be added into patient header boards. Mr Ovington added that patients more widely needed to be involved in their care plan. Ms Dutton suggested that this information sharing needed to include domestic issues such as when patients could expect a bath. An Urgent Care seminar was reported to have been held with the CCG at which the future plans concerning the Sandwell Treatment Centre had been resolved. Mr Waite presented a proposal to address the salaries of individuals who were not earning the living wage (219 staff). It was noted that this action was modest in scale but was affordable to the organisation. Ms Dutton expressed her support for this proposal and encouraged that this requirement should be built into contracts in future. The Chairman asked whether there was a plan to address this. Mr Lewis advised that suppliers to suppliers needed to be thought through in detail in this respect. Mr Zaffar added his support to this proposal and suggested that partners working with the Trust should be encouraged to do the same. He advised that this was a step to address health inequalities. It was noted that the plan would be communicated carefully. Mrs Rickards expressed her support for the elimination of Band 1 payments. The proposal was approved by the Board. The Chairman asked what plans were followed after the visit to the Mental Health Trust. It was agreed that the matters needed to be built into the Board action tracker.	
ACTION: Mr Grainger-Lloyd to add in the mental health plan actions into the Board action tracker	
10 Equality & diversity	**SWBTB (7/15) 102** **SWBTB (7/15) 102 (a)**
Mr Lewis provided an assessment of the state of the Trust's equality and diversity plan, agreed in October 2014, and advised that the actions would be tracked by the Board as part of its routine business. This had been escalated to the Board from the relevant Board committee. The suggested actions were agreed by the	

Board. Compliance with EDS2 was reported to be acceptable however little progress had been made to promote equality and diversity within the organisation. A policy for diversity and exclusion is to be presented at the next meeting. Dr Sahota suggested that softer issues needed to be borne in mind, such as food. Mr Zaffar noted that equality and diversity champions needed to have time allocated to taking forward these roles.	
ACTION: Mr Lewis to present the policy for diversity and care exclusion at the next meeting	
11 Infection Control	**SWBTB (7/15) 103** **SWBTB (7/15) 103 (a)**
Mr Ovington advised that the Trust had received visits from the TDA to inspect the environmental hygiene and although progress had been made with recommendations, each time further issues had been raised. It was reported that the cultural issues needed to be addressed. The Board was advised that an urgent meeting had been held between the Chief Nurse and relevant staff following the last visit to stress accountability and the importance of the corrective actions. A new process had been introduced, which would include daily inspections, where a sign off process for achievements on the shift would be introduced. A key concern of the facilities team was the misalignment of the cleaning regime to the operation of the ward environment. The cleaning schedules were also being reviewed for suitability, as was the disbandment of the deep cleaning team in favour of requiring nurses to undertake the cleaning of medical equipment. It was reported that colleagues from the TDA would visit shortly to work with the organisation prior to the inspection on 20 July. Non Executives were asked to contribute to work where possible. Dr Stedman suggested that there was a further challenge in terms of staff not covering theatre scrubs. Dr Sahota asked how actions for specific wards would be implemented more widely to other areas. Mr Ovington reported that action was being taken to implement and addressing specific issues more widely across the organisation. Mrs Hunjan advised that she had visited an outpatient department recently and asked how the most appropriate standard could be judged. It was agreed that a note would be prepared. In terms of impact on nursing colleagues, the discipline needed to ensure that there was cleaning of equipment prior to handling a patient. It was agreed that the matter would be tracked through the Quality & Safety Committee.	

ACTION: **Mr Ovington to prepare a note outlining the cleaning standards expected**	
12 Education Plan 2015-2018	**SWBTB (7/15) 104** **SWBTB (7/15) 104 (a)**
Mrs Goodby presented the education plan in draft form for comment prior to approval in August. The plan was reported to reflect the ambitious learning aims of the Trust and highlighted that it recognised what investment into learning was already in place. It was reported that the plan had been presented at the recent Leadership Conference and feedback from this would be built into the next iteration. The plan was noted to be aligned to the Trust's recruitment plan in terms of the offering to individuals working within the organisation. Mr Lewis suggested that the implementation of the plan was a significant change for the organisation and that although there had already been an increase in training spend, the plan would ensure that the learning and development of people would be made the job of directorates and groups, rather than centrally. Additionally, the plan aimed to focus on development of the individuals in the organisation throughout the Trust rather than just those at the start of their career or those in a senior post. Mr Kang suggested that the plan needed to be strategic and it would be made clear to individuals that the offering to potential recruits was attractive and as such he endorsed the plan. Dr Gill expressed his support for the plan and noted that it aimed to transform the organisation into a learning organisation. He selected some specific areas which needed additional detail, including a challenge as to why Aston University had been highlighted specifically. He added that the pursuit of research as opposed to education needed to be offered to some individuals. Dr Sahota noted that the opportunity to use external organisations needed to be a key aim. Ms Dutton suggested that the plan needed to address the requirement for immediate managers to develop their direct reports. It was noted that non-clinical mentoring arrangements were not in place. Dr Stedman reported that the induction into the organisation for doctors needed to be better planned. Mr Zaffar noted that the retention of graduates in the local area was an matter of current focus and suggested that the plan needed to generate an aspiration to work for the organisation. Mr Lewis highlighted that care needed to be taken to ensure that the 'ask' of staff and managers was clear and as such the communications plan needed to be robust. The process for identifying training needs was discussed and the need to consider learning and development above and beyond attendance at courses. Mrs Goodby asked the Board to note the alignment of the plan to safe staffing and	

recruitment plans. Mr Ovington suggested that the temporary workforce used by the organisation needed to be built into the plan. Ms Dutton agreed and noted that this had been discussed at the Quality & Safety Committee. The Board was advised that the final plan would be presented to the Board at its next meeting.	
ACTION: **Mrs Goodby to present the education plan for approval at the next meeting**	
13 Ten out of Ten deployment	**SWBTB (7/15) 105** **SWBTB (7/15) 105 (a)** **SWBTB (6/15) 091**
Mr Ovington presented an overview of the Ten out of Ten initiative. It was reported that in some cases the Trust was not fully compliant with some of the individual elements which suggested that Ten out of Ten was not fully embedded. It was reported that some examples and photographs were available which highlighted that some areas, particularly in the surgical areas, were embracing Ten out of Ten well. The Board was advised that there was a possibility of a week being organised in a way analogous to the Urgent Care Challenge, which could pick up the deployment of the Ten out of Ten initiative, and focus on specific safety improvements. Miss Dhami asked whether there was any evidence that patients and their relatives were aware of and challenged when they were aware that they had not received their ten interventions. She was advised that patients were asked to raise this to the Chief Nurse or ward staff if they were concerned that their care did not include Ten out of Ten. Mr Russell asked whether Ten out of Ten was a permanent fixture and asked whether it would feed into EPR. He was advised that as it formed part of the routine nursing documentation it would fit into EPR. Mr Kang asked how, without using an electronic system, there was confidence that the interventions were occurring. Mr Ovington reported that a ward board was being used for this recording. It was highlighted that the individual indicators were recorded in a number of systems. The Chairman noted that the tracking of the individual actions was disparate and therefore consideration needed to be given to building it into existing processes and IT systems. Dr Stedman cautioned that the introduction of additional tracking would be unhelpful. Mr Lewis noted that it should be simple to know if the checks had been done. It was agreed that an update would be presented to the Board again in due course.	

ACTION: Mr Ovington to present an update on Ten out of Ten deployment in October	
14 Cardiology & surgery reconfiguration	**Presentation**
Mr Lewis reported that there had been a consultation process on the plans for Interventional cardiology and general surgery reconfiguration, and support had been given to the planned changes by the CCG. He provided an overview of the timeline for the work. The cardiology changes will deploy in August, and reflect prior Board discussions. The surgical changes are more complex and Mr Lewis presented the results of the stocktake chaired by Olwen Dutton on the Board's behalf. Key considerations were reported to include head injuries, SAU and general surgery input. It was reported that there was an aim to move in October. Of importance, it was noted that the infrastructure downtime would impact on Sandwell, which needed to be considered. It was noted that the *status quo* for surgery in the organisation was not acceptable. Mr Lewis would return to the Board in August with a timing recommendation around surgical change. Mr Russell raised financial consierations, and it was confirmed that the revenue investments for the plans would be committed in the current year. There were no new financial implications however. Mr Hodgetts noted that transport had been a concern by the Health & Scrutiny Committee as part of the plans. This was noted.	
15 CQC improvement plan update	**SWBTB (7/15) 100** **SWBTB (7/15) 100 (a)**
Miss Dhami presented a summary of discussions following the Board informal session in terms of the delivery of the Improvement Plan. The Board was invited to sign off the elements where there was confidence that they had been delivered. It was reported that plans were being put in place to ensure that assessment of embededness was made. All were asked to direct any points of clarity to Miss Dhami outside of the meeting. Mr Lewis provided an oral update on four specific areas. In terms of job planning for general surgery, it was reported that a position had been agreed with general surgeons, however steps were being taken to make the agreement unambiguous and diary carding would be introduced. Regarding medicines storage, there were two options including the use of electronic keys or introducing new drugs trolleys. The financial implications were covered. Further work was needed to discuss rostering and a decision was needed as to	

whether the current product would be replaced or amendments made to e-rostering. Work was reported to be being implemented to address mandatory training for doctors to ensure full compliance with training requirements. It was noted that there were certain portfolios which needed to have been completed prior to discharge from the Trust. In terms of ward level documentation, it was reported that effort should be directed to enforcing the use of the assessment documentation. The care planning documentation was suggested to need improvement and in particular they should be used to identify a personal care plan. It was agreed that this work should be taken to the Quality & Safety Committee.	
ACTION: Mr Ovington to present the plans to improve the care planning documentation at a future meeting of the Quality & Safety Committee	
16 Trust Risk Register	**SWBTB (7/15) 106** **SWBTB (7/15) 106 (a)**
Miss Dhami presented the Trust Risk Register. It was noted that there were no red risks proposed for addition. It was reported that further detail on the timelines for addressing the actions to mitigate the risk would be presented at the next meeting. Good progress was reported to have been made to recruitment into senior clinical group leadership teams. An update on open referrals was provided. Miss Barlow reported that to date a significant number of the open referrals had been closed and all letters had been issued. 8% patients were phoning in on receipt of their letter and there was a 5% review rate. It was highlighted that no clinical risk had been identified to date. In terms of the oral surgery risk, it was noted that a location for the transfer of the team had not been found. The risk around oncology services was discussed, where it was noted that University Hospital Birmingham NHS Foundation Trust (UHBNHSFT) was yet to provide a final response to the Heads of Agreement that had been issued. It was noted more widely that there were a number of issues arising from the Trust's relationship with UHBNHSFT. The national shortage in tuberculosis vaccinations was noted to be a concern.	
17 Board Assurance Framework 2015/16 – post red mitigated risks	**SWBTB (7/15) 107** **SWBTB (7/15) 107 (a)**
Miss Dhami presented the post mitigation red risks from the Board Assurance Framework. In terms of discharges, it was reported that the rate of discharges before lunch	

had been improved and was the focus of Urgent Care challenge. Mr Waite talked the Board through the financial risks in the BAF where overall good progress was noted to have been made with the delivery of additional controls and assurances, with confidence that they would be completed in line with the original action timescales.	
18 Safe & Sound II update	**SWBTB (7/15) 117** **SWBTB (7/15) 117 (a)** **SWBTB (7/15) 117 (b)**
Mrs Goodby reported that Safe & Sound Phase II consultation had concluded and 25% of the schemes had changed as a result of feedback from this process. It was noted that the Workforce & OD Committee had approved the implementation of the schemes and the Quality & Safety Committee had been appraised of the quality & safety implications. At present 74 staff would need to be redeployed, 38 of which would require assistance to find a suitable alternative employment from mid-late July. The Board was asked to approve the formal closure of the consultation. Mr Kang provided an update on the discussions on this item from the Workforce & OD Committee. Consistency of the process was noted to be a key concern, including the adoption of the concerns log. Mrs Rickards noted that the paperwork to support the changed schemes needed to be provided in a timely way in future. It was noted that matching individuals to suitably graded opportunities needed to be picked up. Mr Lewis advised that the new directives on the process for approving redundancies by the TDA had been a challenge, particularly ensuring that there was no undue delay for approving schemes. He then drew the Board's attention for a further representation from the medical staff committee asking for the schemes to be paused or abandoned. Review of their concerns did not give rise to new information unconsidered at the prior Board committees. Their concerns were Voice Recognition, the process of staff change, risks of letters being slowed in issue, and how medical staff had been involved in the selection processes. The Board approved the closure of the workforce redesign.	
19 Financial update	**SWBTB (7/15) 109** **SWBTB (7/15) 109 (a)**
Mr Waite reported that the Trust was in line with the financial plan. Overperformance on elective activity was highlighted and it was reported that the financial plan included a significant repatriation component. Adverse variance on pay was noted, with this positon being higher than April, driven by temporary staffing levels. In terms of hours used in June, the increased levels of usage looked like being maintained.	

Spend at a rate below that set in the capital plan was highlighted and further work was needed to address the phasing. No key schemes were behind schedule including land remediation. The cash positon was reported to remain on line with target. Dr Gill asked for details of the impact on the Health Education West Midlands funding plans. Mr Waite reported that a detailed piece of evaluation work was to be undertaken on nurse training. Some amendments to the agreement were noted to have been seen during 2014/15. Mr Russell asked for the detail on the non-recurrent effect. He was advised that some flexibility had been used to support the position and that this was in line with plan. Mr Lewis drew attention to the inconsistency with the non-pay spend on a month on month basis. He was advised that this was noted to be less volatile than previously. In terms of agency staff spend, it was reported that there had been success in reducing the use of agency staff in the previous financial year, however in March, April and May there had been a notable increase. There was clear evidence that more expensive use of agencies contributed to the position. It was noted that the control issues would be considered and were being debated. Mr Ovington reported that the controls in place during the previous year had required him to sign off all requests, however the controls currently rested with the Group Directors of Nursing. He suggested that there were a number of reasons for the use of agency staff escalating. It was noted that there was a drift from bank staff to agency staff. The process for engaging agency staff was discussed including the last resort measures where off framework agencies were used. Mr Kang asked whether additional specialist nurses needed to be engaged and was advised that this was not the case. Dr Sahota asked whether the new residency rules around international nurses would impact. He was advised that the Trust as yet did not actively seek individuals from international sources It was reported that agency spend also reflected usage in Radiography and corporate functions. To address the nurse agency nursing issues, it was reported that the controls in Groups were being made more stringent and additional monitoring would be implemented. The link between e-rostering and bank usage would be tested to create a forward look. Mr Lewis highlighted that bank rates would be changed to equalise rates and over time over the cluster the Trust would opt out of nursing agency. Staff would also need to be moved around to ensure that some wards would not be operated on a primarily agency staff basis. The Executive would also look at the positon on a week on week basis. It was noted that urgency and effort needed to be focussed on reducing spend over coming months. Radiography and finance agency would be addressed shortly. Critical care nursing needed to be given focussed attention. Mr Waite reported that the situation with temporary staff usage had been the preoccupation at a national level and frameworks would be enforced. National	

work would be undertaken on capping rates and imposing ceilings of expenditure. The Chairman asked for a regular briefing in between meetings.	
20 Medical staff appraisal and revalidation	**SWBTB (7/15) 110** **SWBTB (7/15) 110 (a)** **SWBTB (7/15) 110 (b)**
The Board was asked to note the summary of the position concerning revalidation process. It was reported that the seven deferrals cited were for genuine reasons. The Board approved the statement of compliance with the revalidation requirements.	
21 MATTERS FOR INFORMATION AND QUESTIONS	
21.1 Nurse staffing report	**SWBTB (7/15) 108** **SWBTB (7/15) 108 (a) -** **SWBTB (7/15) 108 (l)**
The Board received and noted the report.	
21.2 Corporate integrated performance dashboard	**SWBTB (7/15) 112** **SWBTB (7/15) 112 (a)**
The Board received and noted the report.	
22 Update from the meeting of Quality & Safety Committee held on 26 June 2015 and minutes from the meeting held on 29 May 2015	**SWBQS (5/15) 060**
Mrs Hunjan, on behalf of Ms Dutton, presented an overview of the key discussions from the Quality & Safety Committee meeting held on 26 June 2015. It was noted that the majority of items had been discussed by the Board through its agenda. It was noted that the approach to patient stories would be discussed at the August meeting.	
23 Update from the meeting of Configuration Committee held on 26 June 2015	**Hard copy summary**
The Chairman presented an overview of the key discussions from the Configuration Committee held on 26 June 2015. It was reported that the taper relief issue in respect of the Midland Met scheme had been resolved. The programme was reported to be in delay at present awaiting the letter of approval from the Department of Health.	
24 Update from the meeting of Workforce & OD Committee held on 29 June 2015 and minutes from the meeting held on 17 April 2015	**SWBWO (4/15) 005**
Mr Kang presented an overview of the key discussions from the Workforce & OD Committee held on 29 June 2015. It was noted that the recruitment revolution was about to start. There had been discussion on sickness absence, particularly	

the plan to address the sickness absence between 28 days and 3 months. The aspiration of 3.5% for the year as a whole was unlikely to be met.	
25 Any Other Business	**Verbal**
Dr Sahota was thanked for his service during his tenure as Non Executive Director. Mr Grainger-Lloyd was also thanked for his service to the Board during his time as Trust Secretary.	
Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1330h on 6 August 2015 and would be held at Rowley Regis Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 6 August 2015, Rowley Regis Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

2 July 2015, Carters Green Business Centre, West Bromwich

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

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

Apologies: None

Secretariat: Mr Simon Grainger-Lloyd (SGL)

Last Updated: 31 July 2015

	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.333	Learning plan 2014-17	SWBTB (10/14) 164 SWBTB (10/14) 164 (a)	02-Oct-14	Schedule a discussion about the rolling slide pack showing organisational change for a future Board Informal session	SG-L	12/12/2014 16/01/2015 22/05/2015	Remaining to be scheduled	R
SWBTBACT.360	Trust response to controls for revised Never Events	SWBTB (3/15) 042 SWBTB (3/15) 042 (a)	05-Mar-15	Present an update on controls to prevent Never Events at the September meeting	KD	03/09/2015	ACTION NOT YET DUE	G
SWBTBACT.371	Nurse staffing levels	SWBTB (4/15) 062 SWBTB (4/15) 062 (a)	02-Apr-15	Examine by October how we can seek to create a broader Safe Staffing report for the Trust	RG	01/10/2015	ACTION NOT YET DUE	G
SWBTBACT.470	Minutes of the previous meeting	SWBTB (5/15) 074	04-Jun-15	Organise for a timetable for the MES implementation to March 2016 to be presented to the Finance & Investment Committee at its next meeting	TW	31/07/2015	Included on the agenda of the private Board session	G
SWBTBACT.472	Chair's opening comments	Chair's opening comments	04-Jun-15	Expand the meeting action tracker to include the activities planned in respect of Mental Health	SGL	31/07/2015	Updated as requested (attached to this tracker)	G

SWBTBACT.474	Chief Executives report	SWBTB (6/15) 076	04-Jun-15	Present the Trust's position on treatment of individuals and patient requirements based on prejudices and beliefs at the August meeting	TL	06/08/2015	Annex to CEO report in August	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 September Board informal meeting	G
SWBTBACT.478	Consent audit	SWBTB (6/15) 099	02-Jul-15	Present an update on the roll out of the EDTA initiative at the next meeting	RB	06/08/2015	Verbal update under matter arising	G
SWBTBACT.479	Consent audit	SWBTB (6/15) 099	02-Jul-15	Present an update on the consent audit at the next meeting	KD	06/08/2015	Included on the agenda of the August meeting	G
SWBTBACT.480	Chief Executives report	SWBTB (7/15) 101	02-Jul-15	Add in the mental health plan actions into the Board action tracker	SGL	06/08/2015	Updated as requested (attached to this tracker)	G
SWBTBACT.481	Equality & diversity	SWBTB (7/15) 102 SWBTB (7/15) 102 (a)	02-Jul-15	Present the policy for diversity and care exclusion at the next meeting	TL	06/08/2015	Attached to CEO rpeort in July	G

SWBTBACT.483	Education Plan 2015-2018	SWBTB (7/15) 104 SWBTB (7/15) 104 (a)	02-Jul-15	Present the education plan for approval at the next meeting	RG	06/08/2015	Included on the agenda of the August meeting	G
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	ACTION NOT YET DUE	G
SWBTBACT.485	CQC improvement plan update	SWBTB (7/15) 100 SWBTB (7/15) 100 (a)	02-Jul-15	present the plans to improve the care planning documentation to a future meeting of the Quality & Safety Committee	CO	25/08/2015	Scheduled for the August meeting of the Q & S Committee	G
SWBTBACT.482	Infection Control	SWBTB (7/15) 103 SWBTB (7/15) 103 (a)	02-Jul-15	Prepare a note outlining the cleaning standards expected	CO	06/08/2015	Prepared and circulated as requested	B

KEY:

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**DNACPR update**
SPONSOR (EXECUTIVE DIRECTOR):	**Dr Roger Stedman, Medical Director**
AUTHOR:	**Dr Roger Stedman, Medical Director**
DATE OF MEETING:	**6th August 2015**

EXECUTIVE SUMMARY:

The Board has sought assurance that we are able to identify all patients currently occupying in-patient beds that have a DNACPR order in place. The mechanism for achieving his is through the eBMS system where a flag is set once a DNACPR order is in place. This is a manual process which needs to be fulfilled by the doctor when they have completed the DNACPR form. The need for this to be done is communicated to all doctors through:

- Mandatory Training
- Staff induction
- ILS updates

Currently the DNACPR process is audited on a monthly basis as part of the safety thermometer audit process – every patient has their DNACPR status noted and whether a mental capacity assessment has taken place and an appropriate discussion had with the family.

The resuscitation team are introducing a quarterly in-depth audit of DNACPR documentation including the appropriateness of the conversation had with the patient and/or carers and also whether commitments with respect to the mental capacity act have been fulfilled.

From August the monthly audit will include a check of the eBMS DNACPR flag status as part of the routine check of process compliance. This will be followed up with a communication to all doctors of the importance of this and a trajectory for improved compliance over the following 3 months.

REPORT RECOMMENDATION:

The Board is recommended to note the future plans for DNACPR assurance

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	

Comments:

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

Quality and Safety
CQC improvement plan

PREVIOUS CONSIDERATION:

Included in the CQC Improvement plan

Sandwell and West Birmingham Hospitals NHS
NHS Trust

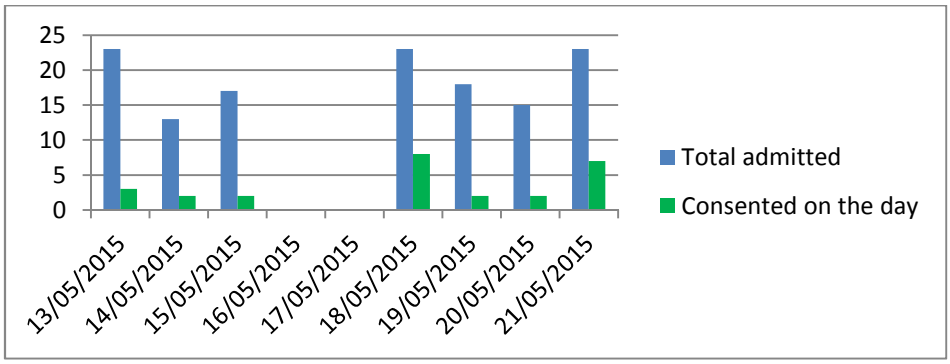
Consent process for elective patients

Report to the Trust Board on the 2 July 2015

1. Introduction

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

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



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

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

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

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

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

2. Findings

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

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

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

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

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

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

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

3. Conclusion

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

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

4. Next Steps

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

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

5. Recommendation

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

Allison Binns
Assistant Director of Governance

26 June 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE PUBLIC TRUST BOARD

Chief Executive's Report – August 2015

The Board's agenda considers primarily how we have done in **the first quarter of 2015-2016**. A year where the NHS as a whole faces unprecedented financial pressures (a national budget settlement is not yet agreed), and where our relative stability compared to other organisations allows us to continue to deliver the majority of national standards. Our challenge is to make sure the last six months of this year, including winter 2015, see a step-up in delivery.

In the few days after the Board meets, interventional cardiology services will transfer onto a single City site, as the new Cath Labs that we funded come on line. Important in themselves , they are also I would venture symbolic both of our commitment to improving quality and of our ability to make local investments decisions to that end. Before the Board meets I will have undertaken a second surgical reconfiguration stocktake to try and address the timing issues. I will provide an oral update on this autumn transfer.

I cover as previously discussed the top ten, albeit the subject is best approached via the Q1 annual plan update and BAF this month. Further to last month's equality and diversity paper, I also update on the inevitably modest progress in the last 32 days, as I suggested I would do monthly. We examine important papers on our long-term education and learning plans, as well as considering the preferred bidder appointment associated with the Midland Met development. Since the Board last met, the OJEU advertisement for our major investment in an electronic patient record has been duly placed. Our long term focus remains resolute and distinctive.

1. <u>Our patient care</u>

We discussed our three **Never Events** in 100 days at the Board four weeks ago. Since that time briefing information has also been shared with the CQC, TDA and HSC. In terms of the actions associated with the retained swab incident we made immediate counting changes as well as completing a trial on the containment options we will adopt from mid-August Trust-wide. Considerable discussions and reflection has taken place within Obstetrics, and Trust-wide communication on our policies and good practice has been shared in written and video formats. As Kam Dhami outlined at the Quality and Safety Committee, we have instituted some changes in how govern the implementation of change following Never Events, including my own personal involvement in action plan approval and sign off, and forthcoming amendments to our approach to near misses. But the single most important Never Event remedy remains our team-dynamics work, and Ajai Tyagi's commitment to ensure it is deployed across all theatres by the end of November – the new theatres management will oversee that work.

The latest infection control data continues to show our organisation as being a low-infection provider. However, as we stress within Ten Out Of Ten we do not yet have 100% MRSA screening compliance, and our hand-washing campaigns continue. Incoming trainee doctors have had both expert briefings from infection control staff, and clear personal guidance from Trust leaders focused

on this subject. Our recent safety walkabouts suggest good clinician compliance, with work to do on ancillary visitors, as well as some visitors to patients. The latest work the TDA to test **our cleanliness** compliance was encouraging, and we have asked for a further visit in late September. As part of that work for assurance purposes we compared our cleaning staffing to that in other West Midlands Trusts. After the reductions we made last autumn, we still have higher numbers of cleaning hours that peers. This is an issue of focus, teamwork and determination, not staffing.

It is encouraging that July has seen us maintain June's improvement in **emergency care** waiting times. Taking Q1 as a whole, we have the lowest very long wait position since mid-2013-14. Ambulance waits have improved again. However, in ED we do have staffing pressures, which the Board is well sighted on. And we need to make sure that we retain site-wide focus on emergency care, including rapid access to imaging. That is crucial to our surgery reconfiguration plans. Of course, we want to push ahead and consistently deliver short wait emergency care. It is clear that our efforts to improve movement to inpatient beds quickly after arrival are bearing some success, but there remains further to go to make sure that our majors areas is for patients who may or may not need admission, but need expert consultant-led care. During August we are completing the difficult work of resolving the flooring issues within City ED. That determination to do this is great credit to staff, including our COO, as we seek to balance patient and staff safety, with the demands of an emergency service 24-7.

2. <u>Our workforce</u>

The last Board meeting saw us **formally conclude workforce consultation**. Individual consultation work has continued from Safe and Sound 2, and individuals have now received job offers. A small number have yet to be matched to posts and this work will continue through the coming month. All trial periods from phase 1 have now concluded. The tracking of implementation and of safety is going to be very important, as ever, and weekly scrutiny of administrative delays is now embedded, complete with trajectories to address letter issue backlogs. Given the anxieties and issues raised by some staff, that data will be made available across the Board's membership.

Sickness rates continue to be significant concern in some but not all areas. Progress in surgery A has been notable, and surgery B and pathology continue to lead the way. We have major issues within women's and children's service, as well as in some parts of medicine. The Clinical Leadership Executive is focused on making sure that we embed return to work interviews, use our policy's sickness triggers, and explore how a better dialogue can take place to bring employees back into the workplace even if it is in a different area (so-called reasonable adjustments). Analysis of our current sickness position makes it plain that the issue is not driven by staff, who are subject to redeployment. Their sickness contributes only 0.07% to our overall position. Our longstanding issues remain and most be tackled. All options must be considered in the months ahead as we move towards and beyond 3.5%.

The three year Education, Learning and Development Plan is a pivotal document for us. We have significantly increased training investment over the last eighteen months. We want, through the plan, to create an expectation of a learning portfolio for all employees, not just related to their current role, but to their next role and wider career plans. Operationalising this intention will be a huge test of our management capacity and capability, as it depends on meaningful conversations between line managers and their teams.

Work on **recruitment** continues, and nursing vacancies are falling sharply. Some strong consultant appointments have been made recently, with candidates attracted by our clear plans for the future, including Midland Met, but also struck by the scope and ambition of the Black Country Alliance. It remains the case that we have pressures in ED, acute medicine, imaging and anaesthesia. The last is recent and will resolve, and the strength of the department is shown by the recent training QA visit. The first three reflect national and regional pressures but we must succeed better than currently if we are to sustain services and indeed enhance our seven day offer.

3. Our partners

The Trust is a key part of work on **genetics** at UoB and UHB. With others we form a partnership which is the largest implementation initiative nationally around the 100000 genome project. During autumn, we will be targeting help and support at specific clinics from which it is expected that this work may give rise to genetic counselling and additional care for patients. Crucial to the future of genetics in medicine is its application in day-to-day secondary, and indeed, primary care. The Trust is well placed to contribute to learning in that field, and this is an example of a UHB affiliated project which we are and should stand strongly behind. Dion Morton is leading this work there, and Karim Raza is leading for us.

The **Black Country Alliance** has made a vanguard submission under the latest acute care collaboration programme issued by NHS England. Clearly the partnership stands independent of that support programme, but we expect to be able to move further and faster if we are successful. It was clear from staff feedback at launch in July how much appetite and enthusiasm there is for this work, but also how vital IT connectivity will be. If we aim primarily to move expertise and knowledge between the partners, and maintain services locally, it will be critical that we can share information.

4. Our regulators

We continue to talk with **the CQC** about their various inspections. We are awaiting a response to issues we queried in their March report, and their report from their community children's visit in June is due with us we understand in September. We made a return against the improvement notice for imaging in time, and an on-site inspection of that issue will take place we understand in September.

A series of **educational visits** have taken place, and I mention the anaesthetic review above. Our Foundation Year visit was more mixed and an action plan has been submitted for that, including a response to GMC survey data from trainees. I am very satisfied with the credibility, accuracy and grip of our response. Taken together, and notwithstanding the outstanding educational leadership record of Drs Carruthers, Chilvers and Singhal, a member of the Trust Executive will now attend by invitation all junior doctor forums held monthly, while we continue to work to make sure that directorates and Groups take on primary responsibility for the workplace experience of doctors in training.

I have yet to have a reply from the **cancer peer review team** to our recent submissions, but I can confirm that in haemato-oncology our audit data shows continued compliance with nursing standards during July. The balance of issues raised related to oncology input and MDT functioning, which feature on the Board's risk register. Discussions with commissioners and regulators about our options continue.

5. Our annual plan progress

This is considered formally on the agenda. Looking across our top ten, as outlined at annex A, we can see that the major infrastructure work is making green progress. However, our Q1 performance gives rise to a worsening amber view of capacity and finance, alongside very limited progress on Q2 deliverables: Readmissions, community caseloads, health visiting, and ten out of ten. I think as a Board we need to now make time to discuss in detail how these specific will be advanced such that by October 1 clear plans are adopted seeing Q3 improvement and Q4 delivery.

6. Our equality and diversity plan – monthly update

At annex B I remind Board members of the things we agreed to do in stepping up the pace on these issues, most are due in October or January. However, I also attach a policy document on tolerance and exclusion which I would ask the Board to comment on and consider. We will look to implement this document after consultation during September.

Toby Lewis

Chief Executive

30th July 2015

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

Objective (listed by improvement quarter order)	End of June update	Improvement quarter	Success quarter	Likelihood of delivery assessment
Work within our agreed capacity plan for the year ahead	Plan in place. Trajectories need signing off, and April planned care delivery below expectations.	Q1	Q1-4	Worsened As before
Create balanced financial plan…	Anticipate 5 of 8 Groups having CEO agreed plans by end of August	Q1	Q1-4	Worsened As before
Agree EPR OBC and initiate procurement process	Infrastructure case with Board. Output specification needs agreeing for planning to go green.	Q1	Q1 and Q3	As before As before
Achieve the gains promised in our 10/10 programme	*Delivery plan was discussed at July Board, further update in September*	Q2	Q2	As before Improved
Implement our Rowley Regis expansion…	Plan for approval at July Board.	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.	Q2	Q3 and Q4	As before As before
Reduce readmissions by 2% at Sandwell	Delivery plan needs further work within the executive	Q2	Q3-4	As before As before
Deliver our plans for significant improvements in our universal health visiting offer	Plan development advanced within WCH. Review timetable at executive level set. Concern remains scale of improvement needed.	Q2	Q4	As before As before
Tackle caseload management in community teams	Planning arrangements clarified across teams, and budget established. Plan available in early August.	Q3	Q4	As before As before
Reach financial close on the Midland Met	External dependencies operating broadly to timetable and visibly, so assurance reinforced	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	Not yet due
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.	Not yet due
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.	Not yet due
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	This will require some further discussions across the leadership, to prioritise how we create interest groups with integrity. We will work with TU	Not yet due

Key deliverable	Commitment at July 15 board	Current state
emerging LGBT group]	colleagues and others to think through how this is best developed in time for the PHCD&E committee in September.	
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.	Not yet due

Sandwell and West Birmingham Hospitals NHS
NHS Trust

DRAFT

MUTUAL RESPECT AND TOLERANCE GUIDANCE

Context

SWBH serves one of the UK's most culturally and ethnically diverse population and these demographics are reflected in its unique work force. We are committed to deliver safe effective care to our patients in an environment that recognise and promote the principles of equality, diversity and non-discrimination. This means that there is mutual respect and tolerance for each other's age, race, gender, religious beliefs or sexual orientation and preferences. As an organisation we must be consistently challenge any behavior to or by any of our patients, or our colleagues, that can be perceived as prejudiced.

The Trust has undertaken to provide appropriately trained health care professionals to deliver the care required. Our tolerance policy means that we cannot support requests that discriminate against an individual based on their age, race, gender, religious beliefs or sexual orientation or preferences. Every adult has the right to refuse healthcare. When this refusal is based on a prejudice against the healthcare professional based on their age, race, gender, religious beliefs or sexual orientation and preferences then that is unacceptable and must be challenged in a timely way. In such circumstances the need to deliver care to the patient and the consequences of refusal of that care should be fully explained documented in the patient's notes.

Examples of such behavior might include:

- A white female refuses to be treated by a female wearing a headscarf.
- A male refuses to be treated by a man who is openly gay.
- An Asian man refuses to be treated by a white woman
- A man refuses to be treated by a woman wearing a crucifix
- A woman refuses to be treated by a transgender woman
- A patient refuses to be treated by a newly qualified doctor 'because they're too young'

Our guidance applies to the preferences of the patient, or, if they lack competence the decision maker acting on their behalf. Carers and other family members supporting patients, where they express views at odds with our policies and practices, will be excluded from our sites in line with standard practice.

The approach that we will take – 5 simple rules:

1. **Second opinions**: Importantly, we accept the right of a patient to ask for additional clinical advice if they are uncertain or confused by the advice offered by the supervising clinician. We will, within reason, facilitate this. This is not to be confused with the other issues covered in this guidance.

   Whilst patients do have the right to express a choice of healthcare professional, the Trust has no obligation to support that choice if a) it can compromise the safety of care delivered and /or b) it is based on prejudice. Sensitivity should be shown to patients in whom there is a genuine clinical

reason for a specific type of healthcare professional to, but this must be for clinical reasons alone.

2. **For planned or diagnostic care (including maternity provision), or urgent care that is not life our outcome threatening:** If a patient makes a request to change clinician in an elective situation, and they are unwilling to have an appropriately trained healthcare professional then they can be advised to seek a referral for care elsewhere within the healthcare system and discharged back to the GP. Where the Trust is commissioned as a monopoly/sole local supplier, we will inform the CCG Accountable Officer that alternative arrangements will need to be made (e.g. District nursing or community midwifery).

   We will implement yellow/red card policies associated with zero tolerance practices across the NHS. But we will only do this were the manner in which the patient expresses their view gives rise for concerns about the safety of our staff. This is to distinguish between opinions and threat.

   We will comply with our reporting obligations under HMG's Prevent strategy.

3. **In an emergency situation:** The consequences of refusal of that care and the impact of delayed care should be fully explained to the patient and documented in the notes. The situation should then be escalated to relevant Clinical Director (or CNP out of hours) in order that they are made aware and can support the individual staff members involved. Support can be sought from any other relevant personnel e.g. Special Faith Chaplains who are on-call 24 hours to help patients and staff to deal with sensitive matters.

   Having assessed the situation we will either provide an alternative clinician for immediate treatment, or proceed in the patient's best interests.

   Having completed treatment, a note will be placed on the patient's record, and our discharge information to the GP will confirm that we will not be able to support their expressed preferences on future occasions.

4. **If our staff refuse to provide care:** The only grounds on which an employee can decline to provide care is if they feel in immediate danger. In those circumstances they should remove themselves from the situation, and contact their clinical director (or CNP out of hours).

   In all other circumstances actions based on preferences of this nature are not consistent with employment here. They will be considered prima facie grounds for summary dismissal as gross misconduct. Again, this is not to be confused with the right to suggest a different clinician if the essential trust relationship has broken down.

5. **Staff team-working arrangements:** Existing Trust policies define a simple approach to expressions of prejudice, including those on religious grounds. All staff are expected to work with peers in an atmosphere of acceptance and tolerance. Views expressed on site or within working hours are considered to be covered by our existing policies. Staff who, in their own time, express views on matters related to this guidance are entitled to their opinions, unless those views are expressed in a manner directed clearly or probably at

individuals employed within the Trust. In these circumstances the Trust's disciplinary or dignity at work policies shall be applied as appropriate.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Plan Delivery Report 2015/16 – Q1 Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Director of Finance & Performance Management**
AUTHOR:	**Toby Lewis – Chief Executive**
DATE OF MEETING:	**6 August 2015**

EXECUTIVE SUMMARY:

The Q1 report on our annual plan reflects three underlying dynamics:

- Major projects and programmes are seeing strong success across IT, estates and care closer to home
- Distributed delivery within our directorates and groups shows weaker progress on many fronts
- Finalising plans for new or complex targets is moving more slowly than we wish, and we need to conclude plans for Q3 in the next six weeks

The executive now need to consider:

- Whether our information and performance management culture is reaching sufficiently into directorates, and whether it driving genuine change on a multi-professional basis
- How we resource parallel plan development on complex change projects

Notwithstanding the above, we remain confident of delivering the vast majority of the metrics set out in our annual plan. Key concerns remain around:

- Cutting sickness absence rates, which have risen
- Tackling emergency wait times and readmission rates
- Addressing continued pockets of staff disengagement, outwith our restructuring programme

REPORT RECOMMENDATION:

To discuss progress against achievement of the key objectives outlined in the Trust Annual Plan for Q1 and discuss those objectives that are currently behind schedule, and will not be achieved by the end of this year.

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

Accept	Approve the recommendation	Discuss
		x

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

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

Comments:

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

Aligned to Trust strategic objectives

PREVIOUS CONSIDERATION:

Annual Plan considered by the Board in April 2015

SWBTB (8/15) 130 (a)

Key to RAG rating:
- Significant delay
- Some delay
- On track
- Complete

Annual Plan 2015-16

Q1 Monitoring Report (August 2015)

Ref	2015/16 Priority	Exec Lead	Ops Lead	Current status	RAG	Ongoing actions
Safe, High Quality Care						
1	Reducing admissions by 2%*	RB	JH	The readmissions taskforce continues its work and has PMO support. Readmission rates are not showing a net downward shape, despite impact in cardiac and geriatric medicine.		Movement of surgical services in Q3 has potential to positively impact on position (5th highest contributor). But a scaled plan is now needed to embed LACE tool and GP communication which we believe can tackle this longstanding issue.
2	Improving outpatient care by implementing phase two of our outpatients programme	RB	SH	In 15-16 this is on track (was due in 14-15). Subject to CSC, recruitment and capacity implementation.		Deploying partial booking will dominate Q3, alongside implementing kiosks successfully
3	Achieving the gains promised within our 10/10 programme*	CO	DT	CNO clear that handful of wards are now fully engaged. Task in August and September is to 'spread' that learning across every ward.		By October 1st every ward must have a deployment plan. Weakest areas will be subject to Board level intervention.
4	Meeting the improvements agreed with the Care Quality Commission creating an inclusive, active and risk driven culture	KD	AB	Actions in plan largely on track, and changes to risk management system made. QIHD provide the basis for an inclusive action orientated QI culture.		We have work to do to both quicken and deepen the actions in our plan, and to make sure that November-March sees a cultural embedding of our change agenda
5	Tackling caseload management in community teams*	RB	FS	Work now started, and teams have met to devise final plan. The plan needs to be crystallised in August for deployment from Q3.		We need to agree the balance of recruitment and reform required – as left
Accessible & Responsive						
6	Meeting national elective and emergency wait time standards and deliver from October a guaranteed	RB	MD	Trust meeting elective wait standards but not emergency care standard. Full Trust compliance with local 6		We have to address the 3k growth in non-admitted WL, and ensure we have sufficient follow up capacity in place for

Ref	2015/16 Priority	Exec Lead	Ops Lead	Current status	RAG	Ongoing actions
	maximum six week wait for outpatient appointments			week standard now expected at end of Q3.		PB to be implemented successfully
7	Double the number of safe discharges each morning, and reduce by at least half the number of delayed transfers of care in Trust beds	RB	MD	UCC 2 has provided a focus for work on discharges and EDD. But DTOC progress with BCC is still limited, and home before lunch is not yet at volume.		The SRG has agreed to review progress with ADAPT at the end of September, now we have implemented it in full and had UCC 2. Influence points over BCC remain limited.
8	Implement Advice and Guidance support for GPs in all specialties, and expand use of video technology to consult with patients	RB	AT	This (AG) was implemented in full in April. We need to work with GPs to up their take up.		We need to develop much greater use of Skype. Our next step is in A&E, but we need to confirm a deployment for 16-17 contracts that goes beyond diabetes.
9	Deliver our plans for significant improvements in our Health Visiting provision so children 0-5 years and their families receive high standards of professional support at home	RB	SF	WCH must now produce a clear delivery plan, not based on revising the standards, but changing how HV works.		The next performance review for WCH will see this issue presented and concluded
10	Work within our agreed capacity plan for the year ahead	RB	MD	The Trust is within our capacity plan but is not delivering sufficient volume of care. Reform to remove premium rate working is strong in Surgery A and WCH, less so in medicine, imaging and especially Surgery B.		Urgent action is needed in August and September to make sure that our performance triangle is delivered with equity, without focusing disproportionately on wait times
				Care Closer to Home		
11	Expand our ICARES and heart failure services to provide improved care in West Birmingham	RB	FS	Good progress has been made with both developments, and new HF service is becoming operational.		We need to use these developments to create strong relationships with GPs in HOB – and to cut avoidable admissions on the City site
12	Implement our Rowley Regis expansion plans, so that by March 2016 we have in place our Right Care Right Here model on the site*	RB/AK		Plan supported by the Board after extensive patient and staff consultation. Due to start in next two months.		Deploy on time in 2015-16, consistent with infrastructure adjustments funded through the IT business case.

Ref	2015/16 Priority	Exec Lead	Ops Lead	Current status	RAG	Ongoing actions
13	Ensure that we improve the ability of patients to die in a location of their choosing, including their own home	RB	FS	Important audit work done on delayed assessment as EOLC. Decision made regarding data flows so that every patient is known as IP. Work to do on data transit of those decisions to community teams.		Understand impact of CCG EOLC tender, expected in late August. And implement changes to reporting to allow us to identify 'missed' or late cases using MR style system.
14	Support agreed projects with selected GP partners through the CCG's 'push sites' initiative, designed to fit care models to local populations	TL	DT	Progress with ICOF and YHP, both now operational. Slower progress with Vitality – senior leaders now involved to try and settle a solution.		We need now to get access to CCG outcome reporting data so that we can make an assessment of how much of £5m they have spent has had impact.
15	Move more of the respiratory medicine service into the community	RB	SC	Extensive work on the respiratory medicine community team across iCares. Job plans for specialty team now adopted.		Need to confirm DICE equivalent model, linked to readmissions project.
Good Use of Resources						
16	Implement successfully and safely the new tariff regime (Enhanced Tariff Offer) as the Trust moves to a payment by results system	TW	IK	We are managing to code and conclude a position quarterly. There is more work to do to make data available rapidly to clinicians and managers.		As we move towards Q3/4 need to understand how rationing project will apply to treatments as ETO 'budget' is consumed.
17	Create balanced financial plans for all directorates, and deliver Group level income & expenditure on a fully year basis*	TW	PS	Whilst Trust level finances are tolerable, we are seeing Group level positions deteriorate.		We need to conclude the 15-16 budget setting process and build now flow through budgets into 2016-17
18	Develop our capital plan, and spend in line with that plan	TW	CA	Spend in Q1 and 2 is behind plan, but clear systems and processes to both plan and report the position are now in place.		Two year capital plan being finalised for September Board, with 2017-2020 to be presented to October Board meeting.
19	Reform how corporate services support frontline care, ensuring information is readily available to teams from ward to	RB	MM	IPR has due to transfer to automated informatics function. This is four months behind.		Work has to be scoped on data flow through the organisation – and we need to conclude our discussions about an

Ref	2015/16 Priority	Exec Lead	Ops Lead	Current status	RAG	Ongoing actions
	Board					informatics 'front end' for staff
20	Reform how corporate services operate to create efficient transactional services by April 2016 that benchmark well against peers	TW	tbc	A clear scope is agreed but operationalization is slow. Work is needed now to be see real change during 2015-16.		By the end of September a clear project team and programme must be put in place.
21st Century Infrastructure						
21	Agree Electronic Patient Record Outline Business Case, and initiate the procurement process, whilst completing infrastructure investment programme*	AD		Case has been agreed and OJEU advert placed, based on defined OBS developed by clinicians across the Trust		Execute both infrastructure contract and EPR procurement timetable
22	Reach financial close on the Midland Met Hospital*	AK	DL	Progress is on time. FC by January 2016 is achievable, but requires national approvable to operate to timetable.		sABC approval, permitting PB status, followed by commercial conclusion in Q3. Advanced work will begin on site in November 2015.
23	Complete public engagement on, implement and evaluate the reconfiguration of interventional cardiology and acute surgery between our Sandwell and City sites	RB	JD	The engagement process was concluded and final details have been requested by the OSC from the CCG. Cardiology will relocate in August 2015.		Implement the surgery changes during Q3, and ensure safety is maintained and quality gains for emergency surgery waits are achieved
24	Develop, agree and publicise our final location plans for services in the Sandwell Treatment Centre	AK	RBanks	Complete planning work on STC across the ten domains of design, including medical education centre by mid-October		Achieve the Board-agreed position whereby staff know by December 2015 where their service will move to including locations at Sandwell
25	Finalise and begin to implement our Right Care Right Here (RCRH) plan for the current Sheldon block, as an intermediate care and rehabilitation centre for Ladywood and Perry Barr	RB	FS	A detailed plan has been developed (and the next step in it is to move cardiac rehab), but needs to pause while we settle the STC configuration.		Make a long term success of D47 by winning a long term intermediate contract from CCG and LA
An Engaged & Effective Organisation						
26	Cut sickness absence below 3.5% with a	RG	LB	There is a clear plan, but not yet an		We need to see our short term sickness

Ref	2015/16 Priority	Exec Lead	Ops Lead	Current status	RAG	Ongoing actions
	focus on reducing days lost to short term sickness*			agreed trajectory. Evidence of input impact is clear in many areas, but now needs to be converted into results.		plan deliver reduces absence, and need a newly effective approach to medium term sickness (1-3 months).
27	Finalise our long term workforce plan	RG	GD	The ask is well understood. Workshops in September are needed to address the detail of 2016-2018.		Undertaking workshops and turning those into a quantified model for the future.
28	Create time to talk within our Trust, so that engagement is improved	RG	GD	QIHD is now in place and well attended. Engagement scores at Trust level are improving. We still have significant disengaged number, which in some directorates is sizeable.		We need to develop a targeted plan for disengaged groups, by developing a better understanding of who they are and what their issues and concerns are
29	Agree and begin to implement our three year Education Plan	RG		Plan comes to August Board for approval.		Operationalisation work in Q3 will need a new approach by line managers and the OD function.
30	Complete the second year of our leadership development programme, providing clinical leaders with the skills and expertise to lead the organisation forward	RG	JP	We have a revised approach proposed by Hay, and developed across ops, OD and with the CEO. This seeks to make sure that the right network of managers are supported over the next 18 months.		Begin work with CLE from September.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Update – P03 June 2015
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance & Performance Management
AUTHOR:	Tim Reardon, Associate Director of Finance
DATE OF MEETING:	6 August 2015

EXECUTIVE SUMMARY:

- For the period to the end of June 2015 the Trust is reporting :
  - I&E deficit £248k being £423k adverse to plan
  - Capex of £1.3m being £1.6m below plan below plan
  - Cash balance £37.8m being £8.1m ahead of plan
- Key issues are 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 quarter by the 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.
- It is likely that the trust will be requested by the TDA to deliver a stretch I&E surplus target of c£5m. There is no complete delivery plan to secure that. There are significant recognised risks to the financial plan to which such a stretch requirement would be an addition.

REPORT RECOMMENDATION:

The Board is asked to receive and accept the update.

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

Accept	Approve the recommendation	Discuss
X		

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

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

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

- Good use of resources

PREVIOUS CONSIDERATION:

- Finance & Investment Committee – 31 July 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – June 2015 (month 3)

EXECUTIVE SUMMARY

- **For the period to the end of June 2015 the Trust is reporting :**
  - **I&E deficit £248k being £423k adverse to plan**
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- **It is likely that the trust will be requested by the TDA to deliver a stretch I&E surplus target of c£5m. There is no complete delivery plan to secure that. There are significant recognised risks to the financial plan to which such a stretch requirement would be an addition.**

Financial Performance Indicators - Variances					
Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	(426)	(423)	>= Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	(412)	(388)	>= Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	(15)	(1,643)	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	1,376	3,080	<= Plan	<= Plan	>1% above plan
WTEs Actual v Plan	234	148	<= Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000		8,104	>= Plan	>=95% of plan	<95% of plan
Note: positive variances are favourable, negative variances unfavourable					

- **Cash balance at 30th June £37.8m is £8.1m ahead of cash plan**. Plan in place to meet EFL without material undershoot
- Year to date capital expenditure of £1.3m is £1.6m behind plan.
- **No risk of undershoot has been identified in respect of the Capital Resource Limit**

2015/16 Summary Income & Expenditure Performance at June 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	399,165	33,196	31,421	(1,775)	99,483	98,053	(1,430)
Other Income	41,633	3,594	3,596	2	10,481	10,086	(395)
Pay Expenses	(286,757)	(24,421)	(24,436)	(15)	(71,950)	(73,593)	(1,643)
Non-Pay Expenses	(127,645)	(10,427)	(9,051)	1,376	(32,192)	(29,112)	3,080
EBITDA	**26,397**	**1,942**	**1,529**	**(412)**	**5,823**	**5,435**	**(388)**
Depreciation & Impairment	(14,881)	(1,240)	(1,240)	0	(3,720)	(3,720)	0
PDC Dividend	(6,000)	(500)	(500)	0	(1,500)	(1,500)	0
Net Interest Receivable / Payable	(2,084)	(174)	(178)	(4)	(521)	(532)	(11)
Other Finance Costs / P&L on sale of assets	0	0	0	0	0	0	0
Net Surplus/(Deficit)	**3,432**	**28**	**(388)**	**(416)**	**82**	**(318)**	**(400)**
IFRIC12/Impairment/Donated Asset Related Adjustments	372	31	21	(10)	93	70	(23)
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,804**	**59**	**(367)**	**(426)**	**175**	**(248)**	**(423)**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – June 2015 (month 3)

Overall Performance against DoH Plan

The Trust is reporting a year to date deficit of £248k which is £423k behind plan. Key issues are agency pay spend and elective income recovery.

Performance of Clinical Groups

- Medicine income, previously favourable is now adverse which, with the pay overspending is accelerating the rate of decline. The income target represents a risk to the full year position.
- Surgery A income is down against contract on elective and outpatient activity. Low levels of non-pay have partially offset income but savings not yet allocated are leading to a pay overspend.
- Additional charges for ante-natal maternity pathway billing account for £0.6m of the variance. The remainder is accounted for by interim staffing spend and income shortfalls. Income shortfalls relate to training income and activity income.
- Surgery B income is down against contract particularly around day cases and the administration of lucentis injections. This has led to lower than planned drug costs, however unallocated savings are leading to pay pressures.
- Community & Therapies is adverse due to £0.1m on pay overspend. This is largely driven by agency premium.
- Imaging variance is driven by lower level of income year on year together with interim pay levels.

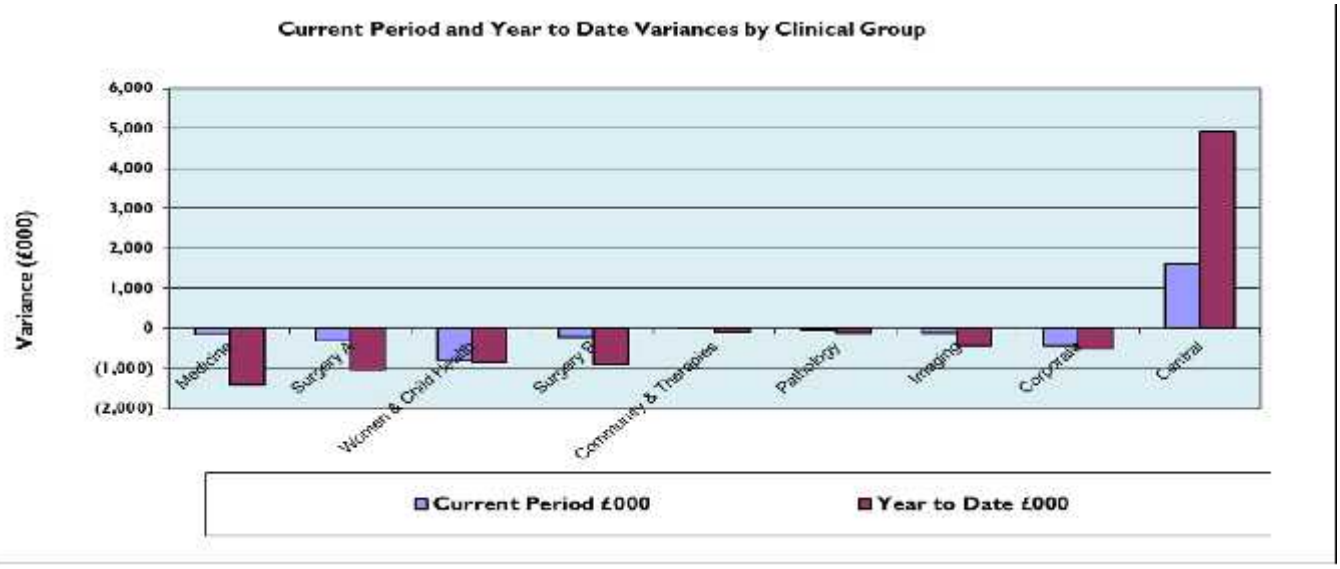
Corporate Areas

- A shortfall on SLA income apportioned to corporate areas, accounts for the adverse income variance. The largest cost pressure is the expenditure on D47 and McCarthy contracts for which there is now no contractual income.

Central

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

Group Variances from Plan (Operating income and expenditure)	Current Period £000	Year to Date £000
Medicine	(145)	(1,414)
Surgery A	(301)	(1,028)
Women & Child Health	(802)	(846)
Surgery B	(225)	(894)
Community & Therapies	8	(86)
Pathology	(39)	(105)
Imaging	(116)	(429)
Corporate	(415)	(522)
Central	1,623	4,935

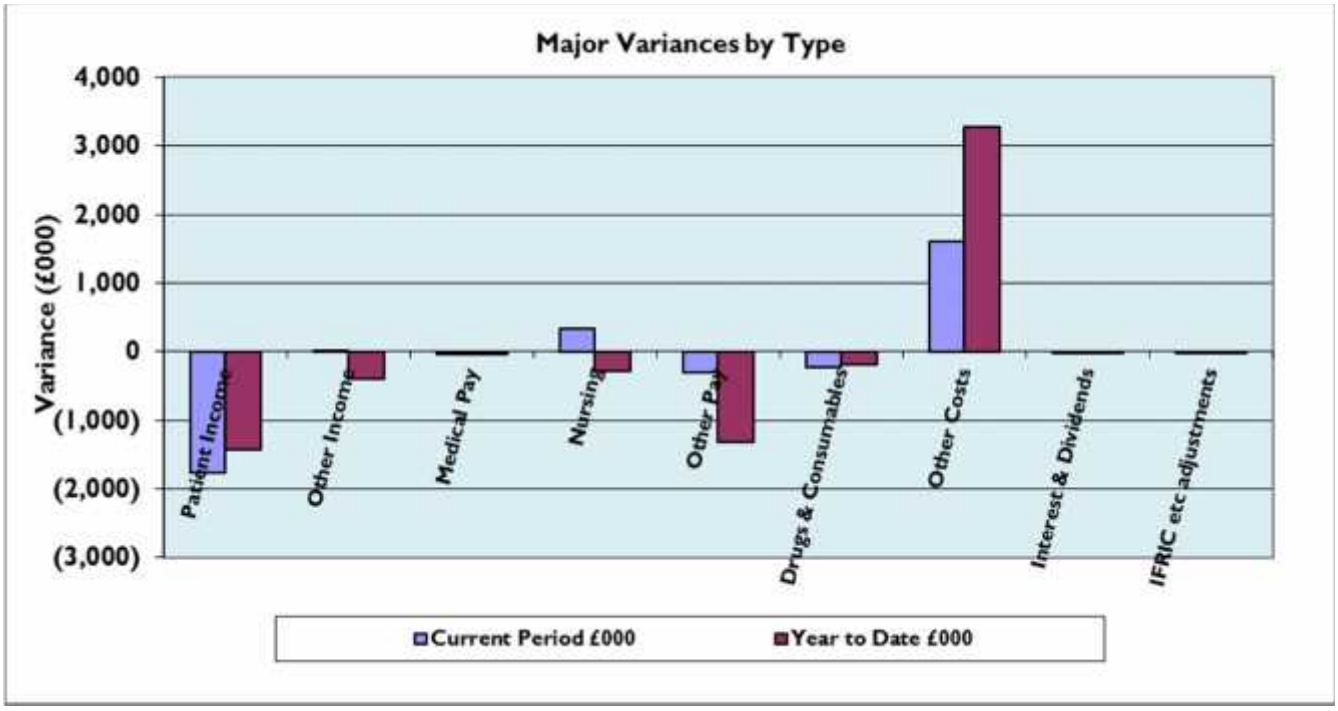


Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – June 2015 (month 3)

- Patient income under performing due to SLA income mainly on planned work (£2.4m). This is offset by over performance on emergency and cancer drugs fund.
- Other income reflects reduced levels of L&DA funding, though this will be mitigated by lower nursing student numbers. This line is also impacted by a shortfall on pathology income.
- Medical staffing overspends in medicine have been partially offset by underspends in the Women's and Surgery groups.
- Nursing overspends £0.6m to date in driven by premium usage in medicine and community and therapies.
- Savings targets that are yet to be allocated have been held within the Other Pay line of the I&E. The allocation exercise planned during period 3 has not been completed yet. This represents a concern for the full year financial position and is reflected in the risk relating to savings plans.
- Drugs/consumables variance to date is largely related to pass through items and so results in income gains reported elsewhere.
- Other costs reflects the net impact of maternity overspending and the release of provisions.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	(1,775)	(1,430)
Other Income	2	(395)
Medical Pay	(41)	(32)
Nursing	326	(290)
Other Pay	(301)	(1,321)
Drugs & Consumables	(223)	(189)
Other Costs	1,599	3,269
Interest & Dividends	(4)	(11)
IFRIC etc adjustments	(10)	(23)

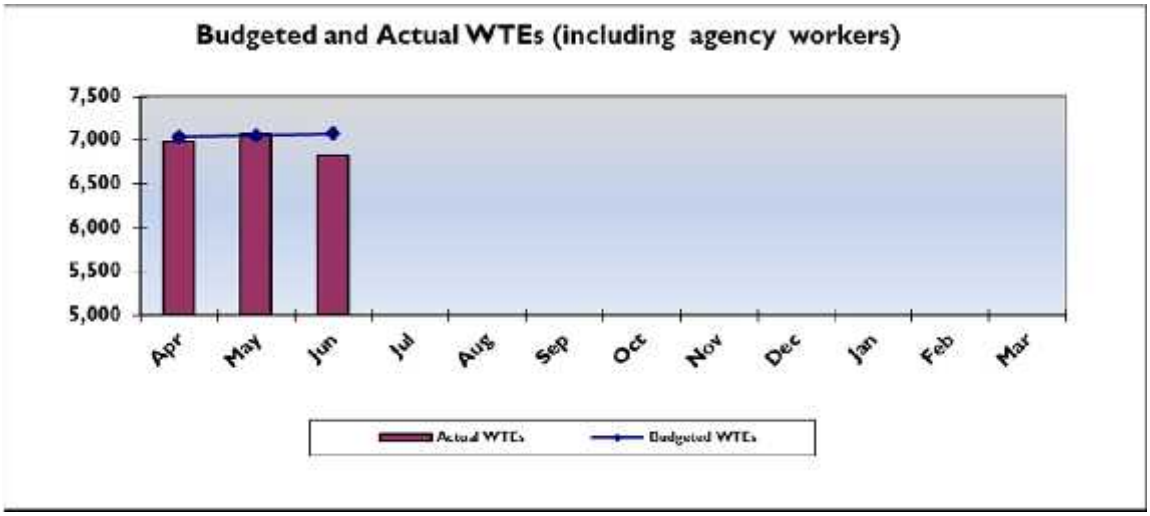


Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – June 2015 (month 3)

Paybill & Workforce

- Total workforce of 6,833 WTE [being 109WTE below plan] including 254 WTE of agency staff.
- Total pay costs (including agency workers) were £24.4m in June being in line with plan.
- **Agency staff cost in month was £1,326k and £4.4m for the quarter. 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.**
- Principal overspending is for healthcare assistants providing enhanced care support to vulnerable patients. The Trust is currently running with a social care ward staffed by agency which was budgeted for permanent staff. Spend on scientific and therapeutic staff and on management and admin is below plan.



	Total Pay Costs by Staff Group					
	Year to Date to June 2015					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	20,196	19,274	0	954	20,229	(32)
Management	3,497	3,091	0	0	3,091	407
Administration & Estates	7,623	6,675	552	360	7,587	36
Healthcare Assistants & Support Staff	7,738	7,076	963	7	8,046	(308)
Nursing and Midwifery	23,860	19,879	1,591	2,679	24,150	(290)
Scientific, Therapeutic & Technical	11,503	9,961	0	411	10,372	1,131
Other Pay / Technical Adjustment	(2,468)	119	0	0	119	(2,587)
Total Pay Costs	71,950	66,076	3,106	4,411	73,593	(1,643)

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – June 2015 (month 3)

Balance Sheet

- Cash at the end of June was £37.8m being £8.1m higher than plan due to timing differences. This reflects the higher than plan cash balance held at the end of the previous month and is primarily due to a better debtors and creditors position than planned. Debtors are better than planned due to the early receipt of 2014/15 contractual payments relating to activity above SLA plan levels. Within creditors disputed payments to NHS suppliers have been held and these are not expected to be resolved until the end of quarter 1. This creditors balance accounts for just under £6m of the difference.
- Capital payments are also behind the planned phasing (£1.6m), it is not expected that this will be corrected by the end of Q1 and so there is likely to be a favourable cash variance through Q2.
- 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.

STATEMENT OF FINANCIAL POSITION 2015/16

	Balance as at 31st March 2015	Balance as at 30th June 2015	TDA Planned Balance as at 30th June 2015	Variance to plan as at 30th June 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	230,996	234,010	(3,014)	246,555	246,555
Intangible Assets	677	621	617	4	437	437
Trade and Other Receivables	890	993	778	215	1,011	1,011
Current Assets						
Inventories	3,467	3,631	3,219	412	2,972	2,972
Trade and Other Receivables	16,318	14,602	16,551	(1,949)	15,966	15,966
Cash and Cash Equivalents	28,382	37,823	29,719	8,104	27,082	27,082
Current Liabilities						
Trade and Other Payables	(45,951)	(53,293)	(47,308)	(5,985)	(53,620)	(56,237)
Provisions	(4,502)	(3,367)	(3,883)	516	(3,355)	(3,437)
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)	(1,434)
Borrowings	(26,898)	(26,647)	(26,643)	(4)	(25,881)	(25,881)
DH Capital Loan	0	0	0	0	0	0
	200,689	**200,374**	**202,680**	**(2,306)**	**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)	(14,073)	(11,767)	(2,306)	(8,430)	(8,430)
Revaluation Reserve	43,179	43,179	43,179	0	43,179	43,179
Other Reserves	9,058	9,058	9,058	(0)	9,058	9,058
	200,689	**200,374**	**202,680**	**(2,306)**	**206,017**	**206,017**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

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PLAN, ACTUAL AND YEAR END FORECAST AT 30 JUNE 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	**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 Forecast £000s**	**August Forecast £000s**	**September Forecast £000s**	**October Forecast £000s**	**November Forecast £000s**	**December Forecast £000s**	**January Forecast £000s**	**February Forecast £000s**	**March Forecast £000s**
Receipts												
SLAs: SWB CCG	21,084	21,716	21,573	21,568	21,568	21,568	21,568	21,568	21,568	21,568	21,568	21,568
Associates	6,800	6,632	6,727	6,380	6,380	6,380	6,380	6,380	6,380	6,380	6,380	6,380
Other NHS	1,957	1,877	5,078	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	2,800
Specialised Services	3,042	5,448	4,272	3,292	3,292	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	466		0	0	4,666	0	0	4,666	0	0
Public Dividend Capital	0	0	0	0	0	0	0	0	0	0	0	0
Loans	0	0	0	0	0	0	0	0	0	0	0	0
Other Receipts	2,423	918	2,116	2,000	2,000	2,000	2,000	2,000	2,000	2,200	2,200	2,800
Total Receipts	**38,527**	**37,189**	**40,233**	**34,740**	**34,740**	**34,740**	**39,406**	**34,740**	34,740	39,606	**34,940**	36,835
Payments												
Payroll	13,364	13,207	13,374	13,600	13,600	13,600	13,600	13,600	13,600	13,600	13,600	13,600
Tax, NI and Pensions	3,638	9,224	9,111	9,250	9,250	9,250	9,250	9,250	9,250	9,250	9,250	9,250
Non Pay - NHS	3,099	1,659	1,564	4,448	500	750	1,200	700	750	1,250	750	650
Non Pay - Trade	10,987	8,519	9,184	11,483	8,121	9,965	12,259	8,144	8,144	11,817	7,910	6,309
Non Pay - Capital	459	1,070	4,544	1,455	1,151	1,151	2,014	1,963	1,913	2,066	2,443	3,066
PDC Dividend	0	0	0	0	0	3,105	0	0	0	0	0	3,000
Repayment of Loans & Interest	0	0	0	0	0	1,004	0	0	0	0	0	0
BTC Unitary Charge	0	429	444	440	440	440	440	440	440	440	440	880
NHS Litigation Authority	685	685	685	685	685	685	685	685	685	685	0	0
Other Payments	68	375	134	100	100	100	100	100	100	100	100	100
Total Payments	**32,300**	**35,168**	**39,040**	**41,461**	**33,847**	**40,050**	**39,548**	**34,882**	34,882	39,208	34,493	36,855
Cash Brought Forward	**28,382**	**34,609**	**36,630**	**37,823**	**31,101**	**31,994**	**26,684**	**26,542**	26,399	26,257	26,655	27,102
Net Receipts/(Payments)	**6,227**	**2,021**	**1,193**	**(6,721)**	**893**	**(5,310)**	**(142)**	**(142)**	**(142)**	398	447	(20)
Cash Carried Forward	**34,609**	**36,630**	**37,823**	**31,101**	**31,994**	**26,684**	**26,542**	**26,399**	**26,257**	26,655	27,102	27,082
Plan v Actual Carry Forward	**6,500**	**7,716**	**8,104**	**489**	**489**	**490**	**490**	**489**	489	490	490	(0)

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Capital Expenditure & Capital Resource Limit

- Capital expenditure to date of £1.3m being £1.6m below plan. There is no significant delay in or adverse impact of operational delivery of the schemes giving rise to this variance and which are set out below
  - •£307k relating to the MMH project for preparing the land for building.
  - •£325k relating to the schemes deferred from 2014/15, most notably the Catheterisation laboratory.
  - •£375k relating to the project of improvement work for the CQC plan.
  - •£367k of under spending on the medical equipment investment scheme.
- £2.4m of commitments have been made in addition to the £1.3m expenditure recorded to date.
- There is on-going work to re-assess and confirm the final programme and phasing of the programme.
- The Capital Resource Limit (CRL) charge forecast is £20.229m which is in line with plan. There is the potential for pressure on the programme with consequent requirement for CRL increase. This is the subject of routine discussion with the TDA.

Continuity of Service Risk Rating

- Down against plan to date reflecting less ability to service debt following the weaker Q1 I&E performance.

	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)	(mc 02)	(mc 03)	(mc 04)	(mc 05)	(mc 06)	(mc 07)
		£000s	£000s	£000s	£000s	£000s	£000s	£000s
Liquidity Ratio (days)	WORKING CAPITAL BALANCE	-7,770	-6,938	-6,251	687	-14,944	-17,643	-2,699
	ANNUAL OPERATING EXPENSES	421,427	103,407	102,705	-702	409,971	409,971	0
	Liquidity Ratio Days: (Working Capital Balance / Annual Operating Expenses)	-7	-6	-5	1	-13	-15	-2
	Liquidity Ratio Metric	3	3	3	0	2	1	-1
Capital Servicing Capacity (times)	REVENUE AVAILABLE FOR DEBT SERVICE	25,180	5,835	5,458	-377	26,450	26,450	0
	ANNUAL DEBT SERVICE	10,610	2,301	2,314	13	10,201	10,201	0
	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	-1

Service Level Agreements

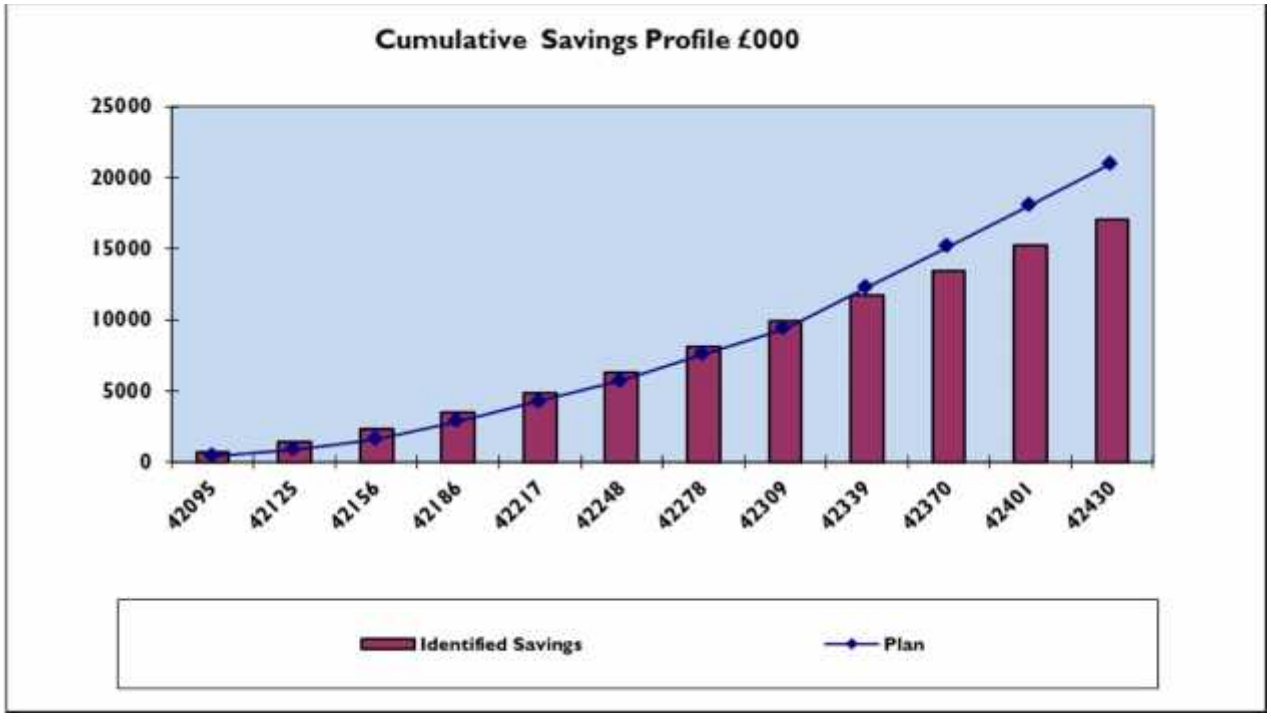
- Q1 NHS Commissioner activity and income under-performance of £1.9m being £0.5m in additional emergency activity offset by £2.4m shortfall on planned work.
- SLA income includes an income accrual which is in line with plan and provides for a smoothing of reported I&E performance across the financial year. The value of this is £1.6m and this approach is consistent with that adopted in previous years.
- CQUIN performance was 100%in quarter 1 but a risk remains that the Trust may not secure all of the CQUIN funding allocated in the contract and which was budgeted for. This is the subjected of discussion with the commissioner and constructive proposals have been tabled. A summary of the risk areas is provided in the risk section of this report.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – June 2015 (month 3)

Savings Programme

- Delivery to date is reported as £3,079k which is £1.4m favourable compared to phased plans.
- Schemes in delivery are forecast to realise £18.7m during 2015/16 and with full year effect of £22.2m in 2016/17 against plan target of £21.0m.
- A programme of work to identify and progress further pay and workforce change consistent with the delivery 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 £18.7m in year compared with £21.0m required. The full year effect of these schemes is £22.2m giving a carry forward benefit in 2016.17.

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

CQUIN. CQUIN has been assumed at 100% in the Trust's plan for 2015/16. The initial risk to this is the national target for mental health assessments in A&E. Throughout quarter 1 the Trust consistently achieved 77% and this needs to improve to 85%. Breast screening uptake and ward transfers for patients with dementia also represent a risk to the Trust's assumption of 100% achievement.

Readmissions and MRET. Trust readmission rates are currently running above peer average, this is likely to result in 2016/17 consequences if unchecked. MRET will not be reached in the 2015/16 year despite additional emergency activity.

Ante-natal pathway charges. The Trust is currently withholding NHS payments of £3m and accruing income of £2m for inter-provider charges relating to this pathway. In addition these charges are emerging as an area of overspend in the current financial year.

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

Emergency income. The plan level of emergency income includes a value for growth together with a value of £1m income increase for TSP. Given the performance in period 3 this may be emerging as a risk to the achievement of plan.

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

Over spending on pay costs, particularly premium rate staffing. Spending on interim staffing has spiked in the new financial year. Agency spend stands at £0.5m higher than in the month of September 2014. There are no indications of a change in this and this is a significant threat to the achievement of the required pay cost reductions for 2015/16. The new social care ward that is staffed using agency poses a risk to the Trust's position as this has been included within the budgeted pay costs at permanent rates not agency.

Mitigating action is required to address this issue:

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

Elective capacity management. Throughout quarter 1 the Trust has reported RTT breaches yet recorded activity levels for elective below plan and below prior year levels. Reasons given for cancellations do not suggest that non-elective activity is crowding out elective activity and so raises concerns that current capacity is not able to service current demand. Capacity planning and management is in its infancy and the ability to develop this cross team capability in a timely manner is a major challenge for the Trust.

Sandwell and West Birmingham Hospitals NHS
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Financial Performance Report – June 2015 (month 3)

Recommendations

The Finance & Performance Management Committee is asked to:

i. RECEIVE the contents of the report; and

ii. REQUIRE 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:	**Board Assurance Framework 2015/16 – Quarter 1 update**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Simon Grainger-Lloyd, Trust Secretary**
DATE OF MEETING:	**8 August 2015**

EXECUTIVE SUMMARY:

The latest version of the Board Assurance Framework is attached, which the Trust Board will note has been revised to incorporate latest updates on progress with management of the risks and feedback received at the last meeting and Board Committees since then.

At present, the BAF contains 39 risks to the delivery of the Trust's annual priorities. In the majority of cases, the treatment plans identified reduced the overall risk score, however the Committee is asked to note in particular the eight risks, which even when treated, remain red. As agreed when the BAF was first presented, these will be given particular oversight by the Board by being reviewed on a monthly basis.

The updates on the controls and assurances to mitigate the risks have in the majority, not impacted on the risk scores. The exception to this is the controlled residual score for risk 026-EEO, which relates to sickness absence. In this case, the score has been raised from 12 to 15 (red) which reflects the continued high levels of sickness absence across the Trust, despite the mitigations put into place to date. As such, additional measures are planned to strengthen the controls.

REPORT RECOMMENDATION:

The Committee is asked to receive and accept the updated Board Assurance Framework and discuss the assurances available that the risks are being managed.

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Relates to all annual priorities

PREVIOUS CONSIDERATION:

Monthly by the Board Committees
Audit & Risk Management Committee on 30 July 2015

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

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
COO	001 -SHQC	Reducing readmissions **MF**	There is a risk that re-admission rates for the Trust remain significantly in excess of national norms, particularly at Sandwell Hospital, as result of poor coding or failure to deliver pathway changes accessing urgent acute or community assessment and ambulatory care. This not only represents poor care for patients but also carries a significant financial risk where tariff rules are strictly applied.	Q&SC	5	3	15	The readmissions task force has been introduced and implemented targeted specialty specific measures to tackle the root causes of readmissions. Each high volume, high rate specialty has a target absolute reduction of readmission; this is accompanied by a delivery plan. The measures to demonstrate controls are working will be delivery of these trajectories and sustained performance. Targeted specialties are Acute Medicine, Elderly Care medicine, Respiratory medicine, Cardiology, Gastroenterology and General Surgery. Plans to be delivered over Q1 and Q2. Reporting arrangements are in place to Quality & Safety Committee and Trust Board.	Internal: Overall trust readmission rates are reported in the IPR as well as by Clinical Group. The readmissions task force meets monthly and reports by specialty holding each specialty lead accountable for delivery of practice as well as re-admission rate. Quarterly report to Quality & Safety Committee.	3	3	9		The full impact of certain actions from the task force has yet to be realised; significant practice change requires embedding throughout the organisation. Certain IT developments are required to support those behaviours. UPDATE: In October an Urgent Care Challenge Week will take place during which readmissions will be a focus. The week will roll out standardised use of the LACE tool, MDT review of the most frequent reattenders and the learning from the current ICARES inreach pilot to the AMUs which is showing impact on readmssions.	Q4 15/16	2	3	6
COO	002-SHQC	Improving outpatients by implementing phase 2 of our Year of Outpatients programme	There is a risk that the intended benefits of the projects in Year of Out Patients (YOOP) do not realise their full benefits due to failure to deliver technical infrastructure or change the workforce and organisational delivery model which may lead to long waits, poor patient experience and wasted capacity	Q&SC	3	4	12	YOOP delivery programme in place. Focus is on completion implementation of Self Check In Kiosks, Partial Booking and other developments in line with YOOP programme. This is overseen by a Year of Out Patients programme Board. Reporting into CLE, Q&SC and Trust Board. Control measures through OP dashboard include Patient surveys aiming at 98% satisfaction, no avoidable hospital clinic cancellations, reduce DNA rates by 4%.	Internal: IPR, programme exception report and minutes and action trackers from CLE, Q & SC and Trust Board. Patient satisfaction results. DNA rates. Communications on intended changes and benefits.	3	4	12		Work to strengthen staff and user engagement. UPDATE: Recruitment of Head of Elective Access and OP in train in July / August; appointment to this leadership role is crucial. IT works to be completed for partial booking and capacity in OP to be confirmed in line with project plan.	Sep-15	2	4	8
CN	003 -SHQC	Achieving the gains promised within our 10/10 programme **MF**	There is a risk that patient safety could be compromised as a result of not delivering fundamental checks and baseline assessments within the first 24 hours after admission to hospital which could lead to poor planning.	Q&SC	3	3	9	An ongoing training programme has been implemented and a monthly KPI dashboard has been introduced to report compliance. A set of smarter KPIs to be introduced from which assurance can be drawn	Internal and peer: Audit of compliance with 10/10	1	3	3		Introduction of a review of KPIs at Clinical Group review meetings UPDATE: Surgery A testing out new ways of implementing 10/10 in order to garner full staff support, successful elements will be cascaded across the trust	Sep-15	1	3	3

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

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DG	004-SHQC	Meeting the improvement requirements agreed with the Care Quality Commission	There is a risk that the scale of the task leads to inconsistent implementation of the required standards and practices across the organisation leading to a statutory breach of the fundamental standards of care,	Q&SC	3	4	12	Clearly defined outcomes set for each action. Planned and spot audits and unannounced visits to validate compliance. Evidence vault. Protected time for discussions at a local level at QIHDs. Monitoring and oversight of delivery by the CLE, QSC and Trust Board.	Internal: Observed practice during walkabouts and First Friday. Audit findings and action plans. Staff and patient feedback e.g. Your Voice, FFT, complaints. Incident data.	2	4	8		Improvement Plan evidence vault to be created and launched (May 2015). UPDATE: On track. Evidence vault created and currently being populated.	Oct-15	1	4	4
COO	005 -SHQC	Tackling caseload management in community teams **MF**	There is a risk that a caseload of community nursing teams remains too high and above benchmark as a result of poor management systems, too many patients being admitted to the case load, poor discharge patterns or the absence of team members leading to short appointments or too few appointments to be effective	Q&SC	4	3	12	Workload dependency tool (GEL) has been introduced for monitoring the position. Evaluation of outputs and confirmation of intended service redesign to be undertaken. Arrangements in place to monitor the financial consequences of the priority. GEL implementation completed in Q2.	Internal and peer: Results of audit of caseload management and data monitoring from GEL. Group reviews.	2	3	6		UPDATE: Development and delivery of service redesign plan to a timescale is being worked to be launched at the SPetmeber QIHD, to include: • Review SPA and triage , • improved scheduling to optimise time available for clinical care and reduce administration and travel through improved scheduling • 7 day services – Aim to smooth activity peaks on mondays and fridays over 7 days impacting on caseload by day of week. • Reducing unnecessary multiple practitioner input – Competency based development for non-complex interventions could impact on caseload by reducing duplicate visits and improve patient experience. Control measures to be agreed to track assurance	May-15	2	3	6
COO	006-AR	Meet national waiting time standards and deliver from October a guaranteed maximum six week outpatient wait	There is a risk that speciality compliance of the standards are not met due to failure to implement demand and capacity plans and associated workforce plans which may lead to unforecast underperformance, poor patient experience and financial penalties.	Q&SC	4	4	16	1. Demand and capacity plans are in development 2. A balanced scorecard has been introduced to track delivery in design 3. Job planning to be completed in line with capacity plan. 4. Tracking tool to be introduced. 5. Monitoring arrangements through Group Reviews, OMC, Q&SC and Trust Board.	Internal: IPR scorecard monitoring discussions. The minutes of Group reviews, OMC, Q&S, Trust Board. Balanced scorecard. Peer: CCG contract review meeting and TDA performance review	3	4	12		Tracking and delivery of weeks work and other assurance KPIs as implemented in Q1. UPDATE: This is behind plan but will be strenghtened in July/ August with weekly meetings to include COO and DOFP. Leadership appointment in elective access is a crucial appointment over the same period.	Sep-15	2	4	8

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

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
COO	007-AR	Double the number of safe discharges each morning and reduce by at least a half the number of delayed transfers of care in Trust beds	There is a significant risk that the volume of patient discharges from hospital beds each morning is insufficient as a result of poor understanding of expected date of discharge, poor discharge planning or the coordination of activities to effect a safe discharge leading to not enough beds available to admit patients with an emergency or urgent requirement for hospital care and financial penalties	Q&SC	4	4	16	1. An Urgent Care Board has been established and standard operating procedures for 7 day safe discharge across all Clinical Groups have been developed 2. Full realisation of benefits of ADAPT pathway. 3. Arrangements for delivery and monitoring of associated KPI daily / weekly are in place 4. Monitoring through Capacity meeting.	Internal: CLE discussions, Q&S reports up to Trust Board Peer: CCG contract review meeting, System Resilience Group and TDA performance review	4	4	16		On going training and reinforcement of good discharge practices Focused project on Expected Date of Discharge UPDATE: Urgent Care Challenge Week 2 held week in July focus included home before lunch. clincial time tables were trialled and advanced confirmed discharges and available beds have significantly improved. the goal for pre lunch dischrges is still not being acheived. Further work over the summer will aim to complete the development of ward clinical teams to acheive this goal by September.	Jul-15	2	4	8
MD	008-AR	Implement advice and guidance support for GPs in all specialities and expand the use of video technology to consult with patients	There is a risk that we fail to meet contractual requirements to implement A&G and lose engagement and reputation with our primary care partners. There are financial penalties in the contract if we fail to implement A&G	Q&SC	3	3	9	Implementation of advice and guidance is a key objective of the Year of Outpatients change program. At a national level the new electronic referral management system will be implemented on 15th June 2015	Each Clinical group has reported back to YOOP services that have made available A&G through current systems that are commensurate with requirements	2	3	6		New National ERMS (choose and book 2) to become available June 2015. UPDATE: National ERMS is now live and is operational. This has improved functionality and access to Advice and Guidance services. The roll out and uptake of A&G is being moniored through the YOOP program board.	Q3 15/16	1	3	3
CN	009-AR	Deliver our plans for significant improvements in our universal Health Visiting offer MF	There is a significant risk that children and families may not have adequate access to a comprehensive range of NHS, Local Authority and voluntary services as a result of lack of knowledge or poor co-ordination by health visitors which could lead to physical, mental or social developmental delay, or poor use of safeguarding facilities	Q&SC	3	4	12	1. A recruitment programme into health visitor vacancies is in place. 2. Leadership development programme 3. Portfolio of accessible services	Internal and peer: 1. Report describing improvements in Universal Health Visiting 2. Annual report of performance	2	4	8		Portfolio of services to be developed UPDATE: 11.28 wte vacancies with recruitment currently in the pipeline	Jul-15	2	4	8

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

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
COO	010-AR	Work within our agreed capacity plan for the year ahead, thereby cutting Do Not Attend rates, cancelled clinic and operation numbers, largely eliminate use of premium rate expenditure and accommodating patients declined NHS care elsewhere MF	There is a risk that sustainable demand and capacity plans are not delivered as a result of failure to resolve capacity gaps and / or optimise resources both workforce and service assets eg; theatres or out patients. This may leads to unplanned costs and activity .	FIC	4	4	16	1. Demand and capacity plans in development to be completed in Q1 2. Balanced scorecard to track delivery in design to be completed for May 3. Job planning to be completed in line with capacity plan in Q1 4. CCG contract review meeting and TDA performance review	Internal: Project group review and via IPR and direct update reports via Group reviews, OMC, FIC to Trust Board.	3	4	12		Tracking and delivery of weeks work and other assurance KPIs as implemented in Q1. UPDATE: This is behind plan but will be strenghtened in July/ August with weekly meetings to include COO and DOFP. Leadership appointment in elective access is a crucial appointment to be made over the same period.	Apr-15	2	4	8
COO	011-CCH	Expand iCares and heart failure services to provide improved provision in West Birmingham, by agreement with local practices	There is a risk that expansion of services fails lack of commissioning and a shortfall in workforce and marketing of new services which may lead to SWBH patients receiving varying levels of access to community services resulting in longer length of stay, readmission and differing satisfaction levels	Q&SC	4	4	16	1. Business case development to expand services in Q1. 2. Bid for resilience funding to expand Ibeds inreach team to be confirmed in April . 3. Ongoing recruitment campaign in train.4. delivery plan on track.	Internal: CLE scorecards and minutes , Group review External; CCG contract meeting	3	4	12		Marketing and engagement with selected GP practices	Dec-15	2	4	8
COO	012-CCH	Implement our Rowley Regis expansion plans (Rowley Max) so that by March 2016 we have in place our RCRH model on the site MF	There is a risk that the infrastructure required to deliver the plan is not in place as a result the delivery of the RCRH model for the Rowley site is delayed resulting in loss of market share and demand and the inability to redesign clinical service provision on the residual acute sites	CC	3	4	12	1. Developing a plan to be approved during spring 2015-16 2. Board Committee oversight	Internal: Board Committee minutes	3	4	12		Engagement and communication of final plan	Apr-16	2	4	6
CN	013-CCH	Ensure that we improve the ability of patients to die in a location of their choosing, including their own home	There is a risk that patients are not given a choice about the place they would prefer to die as a result of the Trust's inability to co-ordinate services in a timely manner which could lead to patients dying in one of our hospitals leading to high levels of dissatisfaction or complaints	Q&S	3	3	9	1. An End of life strategy is in place 2. An End of Life group has been established 3. A set of KPIs to monitor the position have been developed, with arrangements in place to monitor these on a monthly basis	Internal and peer: An audit of preferred place of death	2	3	6		Develop the pathway of services that require co-ordinating to help a patient to return home as smoothly and efficiently as possible Update: NICE consultation guidelines issued 29th July consultation closing December 2015. This will need to inform local practices Training of staff in the use of the pathway	Aug-15	2	3	6

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CEO	014-CCH	Support agreed GP partners through the CCG's 'push sites' initiative, designed to fit care models to local population	Diverse projects, structures and relationships militate against sufficient successful delivery in 11 months that 16-17 decisions can be made by Trust and commissioners	TB	4	2	8	Primary care liaison team to track projects, in liaison with CCG, reporting monthly to the Chief Executive, and through him to EG and CLE. Quarterly formal stocktake from July 2015.	Assurance via senior involvement, escalated to formal review with CCG at mid year if off track.	3	2	6		Focus detailed project plans developed for key impact schemes by end of Q2	Oct-16	2	2	4
COO	015-CCH	Respiratory medicine service sees material transfer into community setting, in support of GPs	There is a risk that the clinical service model remains with too much Direct Clinical Care time committed to routine clinic work in the acute hospital which will potentially result in late intervention on community patient pathways, which may result in a continued rate of readmissions	Q&SC	4	4	16	1. Community respiratory service in place across Sandwell (now part of iCares) 2. Respiratory pathways and service redesign through readmissions project and demand and capacity plan to be clarified by July.	Internal: Readmissions reports to Clinical Effectiveness Committee, Demand and Capacity reports to FIC, New clinical model through Group review is reported to CLE	3	4	12		Current work to be pulled together through project group to deliver the respiratory medicine equivalent of the DiCE project is in place. Further work to do to understand GP push sites	Oct-15	2	4	8
CEO	016-GUR	Implement successfully and safely the new tariff regime (ETO) as the Trust moves to a PBR system with all commissioners by 2017	Marginal rate for specialist services in ETO necessitates active rationing of care and care modalities. Risk that this creates inequity, and reduces quality of care offered (as distinct from safety).	QSC	3	4	12	Explicit approach with Board oversight, supported by written policy taken through CLE. Escalation to CCG CQMS meeting in Q3/4 as active rationing begins.	Patient level tracking of any delayed care decisions	3	4	12		Explicit approach to 16-17 contract form negotiation to seek to remove pass through marginal rate from national arrangements. This materially reduces risk of accumulated delays over years as distinct from brief 'year end' issue.		3	2	6

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOF	017a-GUR	Create financial balanced plans for all directorates and deliver Group-level I & E balance on a full year basis [2015.16 financial year] **MF**	There is a risk that the identified opportunity for financial improvement is insufficient to deliver balanced financial plans across each and all directorates. This could result in a failure to generate those financial surpluses necessary to underpin the approval & delivery of key strategic investments.	FIC	3	5	15	Effective use of comparative information including peer benchmarking, best practice review and expert scrutiny. Market share analysis to identify repatriation opportunity. Focussed executive support to directorates to develop plans. Transparent & explicit process for plan sign off.	Management assurance. Routine reporting of historic and prospective financial performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning, budgetary control, CIP delivery and data quality. External audit review of arrangements for securing VFM. Regulator scrutiny of safe, effective, financially viable services.	2	5	10		Complete demand and capacity work to confirm financial margin generated is in line with financial plan requirements. Development & execution of tailored marketing plan with GPs to secure referrals in line with repatriation requirement. Confirm budget control totals and delivery plans through CEO sign off process. Confirm downside contingency plan to deliver group level I&E balance on a full year basis. UPDATE: Stretch target surplus proposed of £4.4m [+£0.6m] in response to TDA request. Q1 under-delivery of planned care volume & income recovery. Re-run demand & capacity work to confirm remedial plans to secure SLA income for the year. Optimise cost of delivery to realise reserves as contingency. Secure ante-natal SLA consistent with budget costs. PMO & executive intensive support to continue. Conclude initial assessment of procurement savings opportunity & mobilise focussed workplan.	Aug-15	2	5	10

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DOF	017b-GUR	Create financial balanced plans for all directorates and deliver Group-level I & E balance on a full year basis [2015.16 financial year] **MF**	There is a risk that the scale & pace of financial improvement delivered is insufficient. This is caused by a lack of necessary capacity and capability. This could result in a failure to generate those financial surpluses necessary to underpin the approval & delivery of key strategic investments.	FIC	4	5	20	Expedited recruitment to fit for purpose senior management structures and follow through on senior leadership development programme. Utilisation of expert support as necessary and appropriate. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective financial performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning, budgetary control, CIP delivery and data quality. External audit review of arrangements for securing VFM. Regulator scrutiny of safe, effective, financially viable services.	3	5	15		Completion of necessary recruitment and leadership development programme. Embedding PMO arrangements in Group management teams & alignment of Change Team resources to support critical improvement projects. Review & amendment of SOPS for TPRS such that it is effective tool for monitoring and managing change programmes. Progression and conclusion of Safe & Sound 2 programme consistent with necessary scale of workforce and paybill change. Confirm downside contingency plan to deliver trust level I&E balance on a full year basis. UPDATE: 3/7 clincial groups remain tbc with balanced budgets & 2/7 of those with balanced plans now at risk. Substnative ops & finance recruitment on board from 1 September 2015. Agency demand controls, discipline in use of framework agencies and increase to bank rates. Secure TDA approval of expert support business case for theatres improvement. FIC to review first cut financial outlook scenarios and contingency plans. Consider monthly FIC meetings.	Sep-15	2	5	10

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DOF	017c-GUR	Create financial balanced plans for all directorates and deliver Group-level I & E balance on a full year basis [2015.16 financial year] **MF**	There is a risk that the scale & pace of financial improvement delivered is insufficient. This is caused by a risk of compromise to the safety and quality of services provided. This could result in a failure to generate those financial surpluses necessary to underpin the approval & delivery of key strategic investments.	FIC	3	4	12	Fit for purpose QIA / EIA assessment and approval process.	Management assurance. Routine reporting through TPRS of QIA / EIA status of individual change projects. Management review through PMO and performance management structures. Independent assurance. Internal audit review of core systems & processes including financial planning, budgetary control, CIP delivery and data quality. External audit review of arrangements for securing VFM. Regulator scrutiny of safe, effective, financially viable services.	2	4	8		Confirmation of QIA / EIA sign off in advance of project imnplementation. Embed routine ex-post monitoring of KPIs related to QIA / EIA assessments. UPDATE: PMO continues to oversee QIA/EIA processes. Re-confirm nurse staffing establishments as safe having regard to emergent guidance. Post implementation assessment of medicine bed reduction trials. Challeneg & confirm QIA/EIA arrangements against best practice consitent with MMH approval condition requirement.	Ongoing assessment - keep in view	1	3	3
DOF	017d-GUR	Create financial balanced plans for all directorates and deliver Group-level I & E balance on a full year basis [2016.17 financial year] **MF**	There is a risk that the identified opportunity for financial improvement is insufficient to deliver balanced financial plans across each and all directorates. There is a risk that the scale & pace of financial improvement delivered is insufficient. This is caused by a lack of necessary capacity and capability and risk of compromise to the safety and quality of services provided. This could result in a failure to generate those financial surpluses necessary to underpin the approval & delivery of key strategic investments.	FIC	4	5	20	Effective use of comparative information including peer benchmarking, best practice review and expert scrutiny. Expedited recruitment to fit for purpose senior management structures and follow through on senior leadership development programme. Effective QIA / EIA process. Transparent & explicit process for plan sign off. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective financial performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning, budgetary control, CIP delivery and data quality. External audit review of arrangements for securing VFM. Regulator scrutiny of safe, effective, financially viable services.	3	5	15		Completion of necessary recruitment and leadership development programme. Focussed executive support to directorates to develop plans. Utilisation of expert support as necessary and appropriate. UPDATE: Workforce plan compliance & assurance assessment by TDA scheduled for September in line with MMH approval conditions. 2016-18 workforce change workshops confirmed for September. To consider accelerated solution event approach to enhance outputs & implementation planning. First cut group & directorate level financial targets including CIP by end Q2.	Sep-15	2	5	10

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOF	018a-GUR	Develop our capital plan and execute in line with that plan on a quarter by quarter basis [2015.16 financial year]	There is a risk that the capital plan is constrained by the requirement to secure key financial metrics and which compromises the timely progression of key estate development and necessary equipment replacement without compromise to key statutory standards. There is a risk that the scale and pace of capital programme delivery is delayed as a result of lack of necessary capacity and capability and which compromises the timely progression of key estate development and necessary equipment replacement.	FIC	3	5	15	Detailed review of absolute and sequenced capital requirements in particular for imaging, medical equipment replacement and retained estate development. IM&T programme confirmed. Routine consideration of full range of financing options to optimise flexibility within financial plan. Appropriate focus and development of senior leadership. Transparent & explicit process for plan sign off. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective capital plan performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning & budgetary control. External audit review of arrangements for securing VFM. Regulator scrutiny of arrangements for compliance with statutory standards.	2	5	10		Confirm absolute and sequenced capital requirements for imaging, medical equipment and retained estate. Confirm £2m capital contingency in financial plan sufficient to meet those requirements. Confirm named scheme executive / project lead for all schemes. Confirm inclusion of capital programme as standing item on group / directorate performance management agendas. UPDATE: £1.35m [7%] of capital programme completed in Q1. Re-assessment of capex requirements for 2015.16 & 2016.17 in light of emergent firm retained estate development plan & Informatics plan. Challenge & confirm necessary & sufficient investment in statutory standards in anticipation of MMH success. Engage TDA in securing any necessary increase in CRL. Challenge & confirm sufficiency of project resources to conclude MES to time.	Aug-15	2	4	8

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DOF	018b-GUR	Develop our capital plan and execute in line with that plan on a quarter by quarter basis [2016.17 financial year]	There is a risk that the capital plan is constrained by the requirement to secure key financial metrics and which compromises the timely progression of key estate development and necessary equipment replacement without compromise to key statutory standards. There is a risk that the scale and pace of capital programme delivery is delayed as a result of lack of necessary capacity and capability and which compromises the timely progression of key estate development and necessary equipment replacement.	FIC	4	5	20	Detailed review of absolute and sequenced capital requirements in particular for imaging, medical equipment replacement and retained estate development. IM&T programme confirmed. Routine consideration of full range of financing options to optimise flexibility within financial plan. Appropriate focus and development of senior leadership. Transparent & explicit process for plan sign off. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective capital plan performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning & budgetary control. External audit review of arrangements for securing VFM. Regulator scrutiny of arrangements for compliance with statutory standards.	3	5	15		Conclusion of MES contract during 2015.16 for delivery of key fixed equipment from 2016.17. Confirm retained estate investment programme. Establish and confirm necessary & sufficient management resources to deliver critical elements of the programme. Confirm financial plan for 2016.17 consistent with delivery delivery of necessary surplus to underpin capital programme investment [see risk 017d above]. UPDATE: Re-assessment of capex requirements for 2015.16 & 2016.17 in light of emergent firm retained estate development plan & Informatics plan. Challenge & confirm necessary & sufficient investment in statutory standards in anticipation of MMH success. Challenge & confirm sufficiency of project resources to conclude MES to time. Review impact of updated capex & taper relief programmes on liquidity position and consequent CoSRR in LTFM.	Dec-15	2	5	10

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DOF	017d-GUR	Create financial balanced plans for all directorates and deliver Group-level I & E balance on a full year basis [2016.17 financial year] **MF**	There is a risk that the identified opportunity for financial improvement is insufficient to deliver balanced financial plans across each and all directorates. There is a risk that the scale & pace of financial improvement delivered is insufficient. This is caused by a lack of necessary capacity and capability and risk of compromise to the safety and quality of services provided. This could result in a failure to generate those financial surpluses necessary to underpin the approval & delivery of key strategic investments.	FIC	4	5	20	Effective use of comparative information including peer benchmarking, best practice review and expert scrutiny. Expedited recruitment to fit for purpose senior management structures and follow through on senior leadership development programme. Effective QIA / EIA process. Transparent & explicit process for plan sign off. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective financial performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning, budgetary control, CIP delivery and data quality. External audit review of arrangements for securing VFM. Regulator scrutiny of safe, effective, financially viable services.	3	5	15		Completion of necessary recruitment and leadership development programme. Focussed executive support to directorates to develop plans. Utilisation of expert support as necessary and appropriate. UPDATE: accelerated solution programme in progress with Surgery B; facilitated plan development programme in progress with Surgery A; expert support re theatres commissioned Surgery A; facilitated plan development programme concluded with Medicine	Sep-15	2	5	10
DOF	018a-GUR	Develop our capital plan and execute in line with that plan on a quarter by quarter basis [2015.16 financial year]	There is a risk that the capital plan is constrained by the requirement to secure key financial metrics and which compromises the timely progression of key estate development and necessary equipment replacement without compromise to key statutory standards. There is a risk that the scale and pace of capital programme delivery is delayed as a result of lack of necessary capacity and capability and which compromises the timely progression of key estate development and necessary equipment replacement.	FIC	3	5	15	Detailed review of absolute and sequenced capital requirements in particular for imaging, medical equipment replacement and retained estate development. IM&T programme confirmed. Routine consideration of full range of financing options to optimise flexibility within financial plan. Appropriate focus and development of senior leadership. Transparent & explicit process for plan sign off. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective capital plan performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning & budgetary control. External audit review of arrangements for securing VFM. Regulator scrutiny of arrangements for compliance with statutory standards.	2	5	10		Confirm absolute and sequenced capital requirements for imaging, medical equipment and retained estate. Confirm £2m capital contingency in financial plan sufficient to meet those requirements. Confirm named scheme executive / project lead for all schemes. Confirm inclusion of capital programme as standing item on group / directorate performance management agendas.	Jun-15	2	4	8

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DOF	018b-GUR	Develop our capital plan and execute in line with that plan on a quarter by quarter basis [2016.17 financial year]	There is a risk that the capital plan is constrained by the requirement to secure key financial metrics and which compromises the timely progression of key estate development and necessary equipment replacement without compromise to key statutory standards. There is a risk that the scale and pace of capital programme delivery is delayed as a result of lack of necessary capacity and capability and which compromises the timely progression of key estate development and necessary equipment replacement.	FIC	4	5	20	Detailed review of absolute and sequenced capital requirements in particular for imaging, medical equipment replacement and retained estate development. IM&T programme confirmed. Routine consideration of full range of financing options to optimise flexibility within financial plan. Appropriate focus and development of senior leadership. Transparent & explicit process for plan sign off. Routine reporting & performance management of plan delivery at directorate level. Transparency & timely engagement in necessary remediation at group, executive & CLE level.	Management assurance. Routine reporting of historic and prospective capital plan performance and remedial action plans at all relevant meetings. Independent assurance. Internal audit review of core systems & processes including financial planning & budgetary control. External audit review of arrangements for securing VFM. Regulator scrutiny of arrangements for compliance with statutory standards.	3	5	15		Conclusion of MES contract during 2015.16 for delivery of key fixed equipment from 2016.17. Confirm retained estate investment programme. Establish and confirm necessary & sufficient management resources to deliver critical elements of the programme. Confirm financial plan for 2016.17 consistent with delivery delivery of necessary surplus to underpin capital programme investment [see risk 017d above]. UPDATE: indicative retained estate development sequencing established	Dec-15	2	5	10
COO	019-GUR	Reform how corporate services support frontline care, ensuring information is readily available to teams from ward to Board	The risk is that we do not achieve a performance cycle that drives changes required to delivery the annual and long term plan supported by an intelligent suite of business information . The impact is that may result in failure or delay to fully deliver efficiency, effectiveness in clinical services, with sound governance and assurance from board to ward	TB	4	4	16	1. A project team is in place to create standard cycle of directorate, Group and Trustwide reports. 2. Recruitment in train for BIU lead and Head of Performance 3. Procurement of an intelligent dashboard front end	Internal: Trust Board, CLE, Group review reports. A reporting tool is in place at frontline service level and standard reports are visible monthly to support performance improvement cycle	3	4	12		Specify and procure dashboard information system	Oct-15	2	4	8

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DOF	020-GUR	Reform how corporate services operate to create efficient transactional services by April 2016 that benchmark well against peers within the Black Country Alliance	There is a risk that corporate functions provide an inadequate level of support to front line teams as a result of an extended period of significant change and which may lead to a delay in service and financial improvement and failure to secure middle & back office efficiency at necessary scale.	TB	3	4	12	Recruitment to residual gaps in corporate team infrastructure. Routine reporting & coherent performance management arrangements. Transactional excellence improvement to be effected through robust programme management arrangements and with expert support as necessary and appropriate.	Management assurance. Routine reporting of transactional KPIs at performance review meetings. Independent assurance. Internal audit review of core systems and processes including performance management and data quality assurance programme. Regulator scrutiny of 'well led' assessment.	3	4	12		Establishment & implementation of effective transactional excellence improvement programme. Undertake baseline assessment and pilot diagnostic to include definition of what excellence looks like. Procure delivery partner to implement full diagnostic, solution design and change programme delivery. UPDATE: BCA launch with corporate transaction services in focus for early work. QIHD used to launch development programmes in informations & finance functions. Secure approval of TDA for expert support business case to complete baseline assessment. Review & confirm internal Change Team resource necessary and available to support implementation development.	Sep-15	2	4	8
MD	021-21CF	Agree EPR outline business case and initiate procurement process, whilst completing infrastructure investment programme MF	There is a risk that due to inadequate IT infrastructure and lack of management capacity and capability within the IT team that we fail to achieve or fully realise the benefits of the procurement and implementation of the EPR prior to the move to midland Met	FIC	5	4	20	External contractors have been brought in to conduct a deep dive review of IT infrastructure across the entire estate. A remedial investment and action plan will result from the deep dive which will be actioned in advance of the implementation phase of the EPR project. A departmental workforce review will take place during 15/16 in order to ensure a team structure fit for purpose	Internal: Progress on these will be reported regularly through IT committee and thence to CLE. Direct reporting to FIC on progress of the EPR procurement and to Configuration Committee on infrastructure and EPR implementation.	3	4	12		Until deep dive infrastructure review complete and work force review complete the risk remains. UPDATE: Infrastructure review is now complete, investment plan for remedial stabilisation work has been approved and this has gone to market. A schedule of works is in preparation which will identify operationally significant disruption over the course of Autumn/winter period.	Q2 15/16	2	4	8

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DOF	022-21CF	Reach financial close on the Midland Met Hospital MF	There is a risk that approving bodies [TDA, DH, HMT] delay or fail to approve the business case. This may be as a result of lack of confidence in the business case or trust ability to deliver, political or policy change, absence of a compliant bid, withdrawal of commissioner support or other significant reason. This would give rise to delay or absence of financial close an with potential requirement for expedient service change to secure safe, effective & financially viable services. There is a risk that the senior debt funding competition fails to secure sufficient funds as a result of lack of market appetite and which may cause the case to fail.	CC	4	5	20	Delivery of coherent appointment business case consistent with OBC evidenced with sufficient cost improvement and workforce plans. Ongoing delivery against approval conditions. Confirmation of compliant bid through conclusion of evaluation process. Effective engagement with EIB to secure their commitment to [part-] funding of the development. Routine oversight and management through Stakeholder Board and trust Reconfiguration Committee.	Management Assurance. Routine oversight and assurance through trust Configuration Committee. Independent assurance. Due diligence using external advisors of bid and key elements of business case.	3	5	15		Further development of cost reduction and workforce plans and commissioner confirmation of downside plans. UPDATE: Dialogue closed. Final bid evaluation on-going and expected to be compliant. Equity funding competition on-going. sABC submitted. Requires approval and confirmation of preferred bidder by 6 August to enable debt funding competition to commence. Focussed programme to deliver compliance with approval conditions. Configuration Committee and Stakeholder Board to challenge and confirm compliance.	Dec-15	2	5	10
COO	023a-21CF	Complete consultation on, implement and evaluate the reconfiguration of interventional cardiology and acute surgery between our acute sites	The risk is that the patient pathways and intended benefits of reconfiguration are delayed through late delivery of estates infrastructure or not realised due to pathway or clinical service model implementation resulting in unintended outcomes such as increased LOS and negative impact on patient / staff experience	CC	3	4	12	1. Public engagement successfully completed. 2. Estates plans and procurement identified and approved. 3. Detail of patient pathways in development and supporting clinical infrastructure in development 4. CCG Configuration / RCRH Partnership Board	Internal: Estates plans, pathway and clinical infrastructure via Group Review, project group and configuration committee reports.	2	4	8		Pathways to be confirmed and signed off. Provision of support services eg imaging model and transport to be implemented. Initial evaluation to be post 1.8.15	Aug-15	2	4	8
COO	023b-21CF	**Cardiology**	The risk is that the patient pathways and intended benefits of reconfiguration are delayed through late delivery of estates infrastructure or delays in procurement resulting in continue risk and down time from aging equipment and the challenge of dual site rotas	CC	3	4	12	1. Business case and procurement pathways agreed. 2. Project group and plan in place to deliver. 3.Assurance and control measures include key milestones in delivery programme and benefits identified post reconfiguration in business case. 4. Date for reconfiguration planned for August.	Internal: Estates plans, pathway and clinical infrastructure via Group Review, project group and configuration committee reports.	2	4	8		No further actions planned.	Aug-15	2	4	8

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

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
COO	023c-21CF	**Acute surgery**	The risk is that the patient pathways and intended benefits of reconfiguration are delayed because of a lack of complete multiprofessional engagement and ownership to deliver a standardised workforce and clinical model. This may result in delay in implementation resulting in unintended outcomes such as increased LOS and negative impact on patient / staff experience	CC	4	4	16	1.Change case and public engagement completed 2. Project group and plan in place to deliver. 3. job plans to be agreed - process in place 4. Estates work to be completed as per delivery plan 5. Assurance and control measures include key milestones in delivery programme and benefits identified post reconfiguration in business case.	Internal: Estates plans, pathway and clinical infrastructure via Group Review, project group and configuration committee reports.	3	4	12		Further staff engagement, finalisation of GP pathways and imaging model to support new acute surgery model	Aug-15	2	4	8
DENHP	024-21CF	Develop, agree and publicise our final location plans for services in the Sandwell Treatment Centre	There will remain a risk that the final location plans may need to change in response to service need, business plans funding constraints.	CC	3	4	12	Monitoring arrangements are in place through the Board and sub committee structures reports and risk registers. Draft plan to be available June 2015.	Reports to MMH Reconfiguration Committee. Inclusion in Group/service business plans. Outcomes inform 2016/17/18 capital programmes.	3	4	12		Current plans will be reviewed to confirm assumptions remain valid and identify material gaps/omissions. This work will inform preparation of the draft plan by June 2015.	Jun-15	3	3	9
COO	025-21CF	Finalise and begin to implement our RCRH plan for the current Sheldon Block as an intermediate care and rehabilitation centre for Ladywood and Perry Barr	The risk is that the commissioning of intermediate care is neither timely nor adequate for the demand and implementation. This may result in delay of gap in this level of care which may lead to increased delayed discharges and negatively impact on patient experience and outcomes	CC	3	4	12	1. Secure contract fro activity. 2. With Estates working to identify estates plans and capital investment in agreed timeframe. This will include decant programme from Sheldon block for other services that are not located their in the RCRH model. 3. Community workforce strategy includes workforce model for Sheldon services with supporting recruitment plan.	Internal: Confirmed estates plans. Workforce scorecard discussed at Clinical Group Review. Signed contract to provide service discussed at Clinical Group Review External; Contract meetings	3	3	9		Delivery of successful recruitment campaign (Community Clinical Group working jointly with Medicine on recruitment plan) supported by corporate recruitment and communications expertise. Assess any further implementation requirements based on contract.	Mar-16	2	2	4

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

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOD	026-EEO	Cut sickness absence below 3.5% with a focus on reducing days lost to short term sickness MF	High levels of sickness absence may persist which may adversely affect the development of high performing, cohesive teams to support the delivery of high quality care	W&ODC	5	3	15	Provision of detailed and regular management information including RTW interviews. Increased group focus monitored through CLE. Sickness absence training programme for line managers. Monthly case review of long term cases. Increased access to MSK services, counselling and health and well being services.	Internal: Assessed through sickness absence data, statistics around sickness cases. Your Voice and national staff survey results.	5	3	15	↑	Development of a cohesive plan that is constantly refreshed and updated, embracing effective leadership, group ownership, Health and wellbeing use of business intelligence, coupled with consistent application of sickness absence management processes. Sickness has not started to go down by July 2015 - so risk rating has increased.	Mar-16	4	3	12
DOD	027-EEO	Finalise our long terms workforce plan, explaining how we will safely remove the paybill equivalent of 1000 posts between 2016 and 2019	There is a risk that future staffing models and associated financial reductions, will not be well enough defined to identify sufficient posts to be removed which may lead to the non delivery of the required workforce and pay cost savings between 2016 to 2019	W&ODC	4	4	16	The LTWM sets out 5 year workforce forecast linked to clinical activity changes. In September 2015 groups will hold workshops to prepare for the the annual business planning template requires groups/directorates to describe workforce change requirements. Cross cutting strategic workforce change themes are developed. Monthly oversight of Workforce Delivery and quarterly oversight at board level Workforce and OD Committee. OMC monitoring and accountability through bi monthly group reviews.	Workforce change schemes tracked through TPRS. Executive led operational PMO. Regular TDA workforce returns. Financial oversight through corporate performance.	3	4	12		Closer alignment of workforce reductions with financial modelling . Further refinement on bottom up workforce modelling/scenario generation required. UPDATE: Agreed at CLE in July and events arranged for September 2015. Invites issued.	Mar-16	2	4	8
DOC	028-EEO	Create time to talk within our Trust so that engagement is improved. This will include implementing Quality Improvement half days, revamping Your Voice, Connect and Hot topics and committing more energy to First Fridays	Poor staff engagement levels that could be contributed to by ineffective internal communications systems and visibility, leading to lack of understanding of the Trust's vision and objectives, lack of ability to share good practice and improve services, low staff morale and high turnover.	W&ODC	4	3	12	Internal communications strategy in place and approved by June 2015. Quality Improvement Half Days implemented from April 2015. Improved engagement with Your Voice including how teams change and improve as a result of staff feedback, more profile at Patient & Staff Experience Committee . Increased attendance and team feedback at Hot Topics monthly briefings. Increased visibility of senior leaders including through social media. New intranet system for sharing information across the organisation.	Internal: Engagement scores on Your Voice and improved feedback rates on internal communications systems Independent: National staff survey results	2	3	6		Publish internal communications strategy - June 2015; Implement Quality Improvement Half Days - April 2015, Reshape staff experience element of PSEC. Relaunch Connect intranet site; December 2015,	Dec-15	2	3	6

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

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOD	029-EEO	Agree and begin to implement our three year Education Plan	The loss of highly skilled staff is a problem. The inability to recruit highly qualified staff is also a problem. The perception of staff is that there is no money to support training. The lack of visibility around who accesses the funding and the lack of clarity about Education Training and Development does affect staff morale and retention.	W&ODC	3	3	9	A draft strategy has been developed for agreement by the E,L&D Committee (April 15). Trust training plan has been collated and developed to show all Trust staff accessing development support and funding. Revision of the study leave policy is being progressed to address the issue of staff leaving upon completion of higher level education and training programmes. Consultation on draft plan with 120 top leaders, 23/6. Consultation with Trust Board in July 15. Final sign off by CLE on 28th July 2015.	Internal: Minutes from the E, L & D Committee. External: Assurance through Health Education West Midlands (HEWM) on education / future learning needs.	1	3	3		Publish the strategy in June 15 - finalise in July 15. Publish Trust Training plan in May 15. Monitor via E,L&D committee chaired by Chief Executive. UPDATE: Plan to be signed off by Trust Board on 6 August 2015. Implementation will be ongoing until the end of 2015/16.	Jul-15	1	3	3
DOD	030-EEO	Complete the second year of our leadership development programme, providing clinical leaders with the skills and expertise to lead the organisation forward	There is a risk of lack of engagement from staff due to delays in communicating the list of participants. Lack of engagement from the provider and willingness to continue with the programme delivery.	W&ODC	4	3	12	The list of participants is to be agreed and distributed. Promotional materials to be produced based on the success of the first year's programme. Second year of programme being reshaped in July / August 15 to focus on delivery of 2020 vision. Increased involvement with the provider and assurances agreed, ongoing commercial evaluation of invesment with provider.	Increased risk due to reshaping of elements of phase one of programme, now rescheduled in new format for early October 15.	1	3	6		UPDATE: Implementing year two of the programme. Regular reviews on commercial invetsment and monitorted through the Workforce & OD Committee	Mar-16	1	3	3

KEY

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Risk Registers
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Mariola Smallman, Head of Risk Management
DATE OF MEETING:	6 August 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 July 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
- **REVIEW and AGREE** the recommendation that the W&CH risk about paediatric HDU staffing is taken off the Trust Risk Register and monitored / managed by W&CH.

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 28 July 2015

FOR DECISION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Risk Register

Report to the Trust Board on 7 August 2015

1. EXECUTIVE SUMMARY

1.1 This report provides an overview of high (red) risks which have been previously accepted by the Board for inclusion on the Trust Risk Register. The current Trust Risk Register with lead Executive Director updates is at **Appendix A.**

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

1.3 There is one risk which has been downgraded by Women's and Child Health and it is proposed this risk is now removed from the Trust Risk Register and monitored / managed by Women's and Child Health (grey shaded cells in Appendix A):

Children that require but may not receive HDU 1:1 care - due to unpredictable demand, inadequate funding, poor staffing levels. Quality of care compromised for these and non HDU children due to inadequate staffing levels.

Staffing for HDU patients has been agreed in line with current demand and the risk significantly reduced. The risk was moved from the WCH Group Risk Register back to the Paediatric Directorate Risk Register in June 2015 where it is being monitored alongside current and future activity. HDU activity is also monitored at the monthly directorate meeting. Should activity to be noted to be increasing then the staffing levels will be reviewed.

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

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

2. PUBLICATION OF RISK REGISTERS ON CONNECT

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

3. ELECTRONIC RISK REGISTER

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

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

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

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

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

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

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

4. RECOMMENDATION(S)

4.1 The Board is recommended to:

- **RECEIVE** monthly updates on progress with treatment plans from risk owners for high (red) risks on the Trust Risk Register
- **REVIEW and AGREE** the recommendation that the W&CH risk about paediatric HDU staffing is taken off the Trust Risk Register and monitored / managed by W&CH.

Kam Dhami, Director of Governance
7 August 2015

Appendix B - Trust Risk Register (version as at 30 July 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	=
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	=

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TRR1401COO01	Management review	Corporate Operations		Operational	Lack of assurance of standard process and data quality approach to 18 weeks.	4	4	16	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	=

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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	=
1103PAE02	Risk Assessment	Women's and Child Health	Paediatrics	Clinical	Children that require but may not receive HDU 1:1 care - due to unpredictable demand, inadequate funding, poor staffing levels. Quality of care compromised for these and non HDU children due to inadequate staffing levels.	4	4	16	IAP submitted for HDU funds secured 12-13 to staff areas. Additional IAP submitted 13-14 for Paediatric Outreach team. Awaiting outcome from November IAP submission. Previous updates: Local escalation process is in place to ensure care is provided to HDU patients. Tracking occurrences to further quantify risk to those non-HDU patients. Current review of budgets and redeployment of resources. Monthly activity and staffing review of HDU care to be carried out and reported to paediatric clinical governance. Monitoring in place; monthly reports to Clinical Directorate Governance Group and activity monitored through monthly directorate meeting Update: W&CH propose risk is removed from TRR and continues to be managed at Clinical Group level.	Chief Operating Officer	TBC	Dec-14	Monthly	3	4	12	=

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1103PAN01	Risk Assessment	Women's and Child Health	Paediatrics	Clinical	Lack of Tier 4 beds for C&YP with Mental Health problems means that they are admitted to the paediatric ward. There is no specialist medical or nursing mental health team to care for their needs with limited access to in / out of hours CAMHS support. Care for these children is compromised and impacts also on other children and parents.	4	4	16	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	=
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	=

Appendix B - Trust Risk Register (version as at 30 July 2015)

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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	na
		Operations	Operations	Operational/Business	There is a risk that within a large group of open referrals that there are potentially patients whose clinical or administrative pathway is not fully completed as a result of historical and inadequate referral management which may lead to delayed treatment.	5	3	15	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	na

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:	6 August 2015

EXECUTIVE SUMMARY:

Attached is an update on progress with the delivery of the actions within the CQC improvement plan.

The Board is asked to note in particular the areas have been identified for targeted focus by the Executive because of their relative importance and due to possible delivery challenges.

REPORT RECOMMENDATION:

Trust Board is requested to receive and accept 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:

CLE on 28 July 2015
Quality & safety Committee on 31 July 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Our Improvement Plan – responding to the Care Quality Commission Report

Report to the Trust Board on 6 August 2015

1. Last month Board members reviewed the current position against the areas for improvement included in the Care Quality Commission's (CQC) inspection report published in March 2015. Of the **67** areas for improvement **17** were 'signed-off' as being completed.

2. Of the remaining actions there has been slippage on the completion dates for some, while others are still on track. Revised implementation dates have been set where required before October 2015, which is the date set to deliver the Improvement Plan in full. An update on all of the actions is provided in the attached Plan (Appendix 1), along with the delivery status.

3. The following areas have been identified for targeted focus by the Executive because of their relative importance and due to possible delivery challenges:

    a. **DNA-CPR:** establishing a way to consistently capture patients occupying an in-patient bed who have such an order in place. This is to be achieved through the eBMS system where a flag is set once a DNA-CPR order is in place.

    b. **Medicines storage:** secure medicines locks are being introduced in most places and 'vending' style cabinets in high use areas such as the Emergency Departments. This will ensure that medicines are never left unsupervised. A part order has been placed, and the locks and cabinets will be operational across all areas by October 2015.

    c. **Ward level documentation**: following a review of the current documentation work is happening to simply what is used to remove duplication. The aim is to make sure that we are Ten Out Of Ten on records of care for all our patients.

    d. **Surgical scheduling**: To address the last minuteness of our current processes, there will be a drive to embed 6-4-2 booking practices in all specialties. This will be overseen by the new Theatre Management Board.

    e. **Agency workers**: a heavy reliance on agency workers continues. Grip being retightened at local level based on a forward look tool, aimed at earlier roster booking. Changes to bank rates from August 2015 aimed at shifting staff from agency. A deep dive review of locum pod model takes place in September.

f. **Sickness rates**: A focus on return to work interviews, on fair management of sickness thresholds, and on supporting staff is on-going particularly in hot spot areas.

4. Good progress has been made so far in responding to the areas for improvement identified by the CQC last year. A concerted effort is now needed to deliver the outstanding work to plan and, most importantly, to ensure that this becomes embedded practice across the Trust.

Kam Dhami
Director of Governance

31 July 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Our Improvement Plan – responding to the Care Quality Commission Report

March 2015

Position as at 31 July 2015

Where EVERYONE Matters

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
Accident and Emergency								
MD1	The trust must put in place an effective system for learning from incidents and errors, and address the risk of 'less serious' incidents' being under-reported by doctors, and trends being missed	1) Monthly learning alerts and Patient Safety Notices. 2) Introduction of distribution of Serious Incident reports and request for learning / actions. 3) Advise on EIR to notify Clinical Tutors for feedback. 4) Develop questionnaire for doctors in training to understand what prevents them reporting incidents. 5) Introduce a quarterly report showing changes made as a consequence of staff reporting.	DG	October 2015	Learning Alerts and Patient Safety Notices Front page of the Electronic incident report form Questionnaire and resulting changes. Quarterly report on CONNECT.	A culture of learning through a reducing trend of similar typed incidents. An increase in doctors reporting.	Items 1) to 3) have all been introduced / commenced. 4) Is in development and will aim to get feedback before the August doctor changeover. 5) This is in development and will be shared with Q1 2015/16 data.	2
MD2	The trust must follow through from findings of safety audit data and follow-up absence of safety audit data.	In March 2015 we kicked off our 'OK to ask' campaign to support all staff who do challenge risky behaviours.	CN	March 2015	Formal communications, CEO Friday message.	Staff know about the initiative and are using it.	'OK to ask' started with a number of communications from March to date.	1
		Safety audit data will be reviewed during our Quality Improvement Half Days.		~~June 2015~~ September 2015	Safety metrics and KPI's included in our Safety Plan	Safety metrics specific to the Groups designed	**Update:** Safety metrics explored at the leadership conference on 23 June, with consultation over the Summer to help complete a safety plan for the end of September.	2
		We will ask patient representatives locally to join us in conducted unannounced inspections every quarter on these issues.		October 2015			Not yet started but will be achieved on time.	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
MD3	The trust must address systemic gaps in patient assessment records.	Record keeping standards have been reissued to teams and will be audited on a sample basis each month starting from March 2015	CN	~~June 2015~~ October 2015			Deputy Chief Nurse is researching evidence based care planning and Internal Auditors are conducting an audit during June 2015. Event planned for 24 June 2015. **Update:** Care plan workshop held with ward sisters and matrons 24th June, draft work undertaken which requires refining over the next two months. Assessment record structure is of good quality having been reviewed during 2014, checking of documentation is a routine activity as part of ward reviews	2
MD4	The trust must take steps to improve staff understanding of isolation procedures.	Visual prompts, including notices on rooms and cubicles, are being put in place to prompt the behaviours our policies and best practice require.	CN	March 2015	Photographs of new signage in ED. Teaching programme used to raise awareness.	Staff are able to describe isolation procedures. Several unannounced visits have been undertaken.	Visual prompts provided through new signage. Training programmes in place to raise staff awareness. **Update:** The last two TDA visits did not highlight any	1

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
						A review of ordering systems and process to reduce stock and programme to de – clutter.	issues. Replacement programme underway for damaged floor.	
		The Infection Control team are carrying out unannounced visits to check that procedures are being followed.		October 2015	Programme of inspections and reports from those visits reported to local managers and Infection Prevention and Control Advisory Committee.	Unannounced visits undertaken and the outputs shared with staff.	Inspection programme underway.	2
MD5	The trust must provide a consistent system for safe medicine storage.	We have begun procurement of sufficient automated dispensaries to cover all our wards and Emergency departments.	CN	~~June 2015~~ October 2015			**Update:** Vending machine approach to be placed in high usage areas, e.g. emergency department and new types of locks to be put into ward areas, some currently on order and all will be in place for October 2015 All grey drug boxes have been removed and additional drug trollies purchased	2
		In March 2015 we kicked off our 'OK to ask' campaign to support all staff who do challenge risky behaviours.		March 2015	Formal communications, CEO Friday message.	Staff know about the initiative and are using it.	'OK to ask' started with a number of ommunications from March to date.	1

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
MD6	The trust must review its governance arrangements in relation in relation to supporting the A&E department to more consistently achieve the national 4-hour target.	All employees working in A&E will be issued with written explanations of the governance processes, and local induction will include that briefing.	COO	March 2015	Governance structures documented with good staff participation and awareness. Introduction to governance is included in induction for new starters.	Staff are aware of the governance structure and are better informed of both ED and whole system urgent care improvement work KPI identified for stages of urgent care pathway across the system and improvements are evidence; assessment for bed within 30 minutes of arrival, DTA time, transfer time to assessment unit, % of patients home before lunch, meet available bed goals in the assessment units .	Written explanations of the governance processes provided to staff, and local induction includes that briefing. Additions to the governance structure include (a) QIHDs implemented from April 2015 and (b) Urgent Care Challenge Delivery Group established to include all key specialties in the delivery of Urgent Care.	1
		A review of emergency care governance, undertaken with the CCG in November 2014, has been completed – daily huddles now include presence from the Executive team with a specific brief to ensure multi-professional learning.		March 2015	Daily huddles continue at Directorate level.	KPI identified for stages of urgent care pathway across the system and improvements are evidence; assessment	Daily debrief expanded to include capacity team, all groups represented and the COO. Executive input through	1

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
						for bed within 30 minutes of arrival, DTA time, transfer time to assessment unit Local improvement actions are clearly defined and tracked.	Urgent Care Challenge Delivery Group	
MD7	The trust must improve its management of governance arrangements in the A&E department.	We will use the new monthly Quality Improvement Half Days to share learning and improve patient care. Participation and attendance is centrally tracked and we will report ED participation through our weekly Emergency Care scorecard, which is widely disseminated among senior clinical leaders.	DG	June 2015	QIHD agenda, attendance register and outcomes report.	Annual 80% attendance by core members at the QIHDs	Active participation in the first three QIHDs from the Emergency Care Directorate to facilitate shared learning and improved patient care. Participation and attendance is centrally tracked and will be reported through the weekly Emergency Care scorecard, which is widely disseminated among senior clinical leaders.	1
MD8	The trust must improve its management of inter-professional relationships within the A&E departments.	A bespoke development programme that began in December 2014, supported by Hay Group and our Learning Work Team, is in place. It will take several months to evaluate the impact of this major initiative.	COO	October 2015	Programme timetable in place. Registration and attendance tracked.	Improvement in local KPIs towards urgent care. Standardisation of approaches to running floor, resuscitation and	Development programme in place and remains on track	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
						escalation are evident. Staff are empowered and able to deliver local change.		
SD1	The trust should consider what the systemic gaps in the use of patients' early warning score records are indicating about usage of this tool.	The Trust has committed to tackled sepsis, and will meet the new national CQuin which commences assessment monitoring in ED.	MD	~~June 2015~~ October 2015	Meeting National Sepsis CQUIN criteria: Proportion of patients in emergency admission areas presenting with evidence of severe sepsis receiving sepsis 6 bundle including antibiotics within an hour	Delivery of CQUIN criteria: Q1 submit baseline data, Q2 – Q4 month on month improvement on Q1	Requirements in place for manual data collection for Q1 and data submission. Specification in place for developing electronic data collection.	2
		We are exploring implementing in Q1 15-16 the same VitalPacs system we have in place in our acute wards to track remotely and centrally vital signs monitoring status.		October 2015	Improvement in performance of 'missed or late observations' and 'Observations out of hours'	Improve our rankings amongst hospitals using VitalPacs for missed or late recording of observations	Learning clinic held on Wednesday 3rd June where data was present, Senior nursing present and agreement that this is incorporated into ward dashboard. IT specification for integration of VitalPac to make late observations visible in eBMS.	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							VitalPacs roll out to paediatrics, ED and indwelling catheters is taking place July/August.	
SD2	The trust should consider some analysis of staff practice of relying on patients' relatives for language interpretation, and what impact this has on the accuracy of assessment of a patient's condition.	We will monitor the scale and use of Language Line for immediate interpretation, and work with staff to see how this, and electronic translation material may help us. The use of relatives will only arise when absolutely necessary. Our training budget will provide some scope to support employees learning relevant local languages to support initial communication with patients.	CN	~~June 2015~~ September 2015	Monthly reports: activity and cost	Reduction in spend. No increase in complaints or incidents	The appropriate use of interpreting services including telephone interpreting has been raised in team meetings in Surgery A and Medicine/EC by GDON. The Interpreting service is up-dating list of telephone interpreting equipment and visiting wards/depts/team meetings to raise awareness re: interpretation of guidance on use of staff/family based on a risk assessment. Communication flash cards have been re-issued, as required (most wards still have packs). **Update:** Action plan in place to increase bank interpreters for the top 10	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							languages to improve quality. Meetings continuing with clinical managers. Functional problems accessing language line reports due to firewall being reviewed with company.	
SD3	The trust should consider how to better promote its complaint policy and procedure in the A&E departments.	1) Posters to be developed in top 5 languages and displayed. 2) Provision of 'Your Voice Matters' leaflets in then open waiting areas. 3) Translate the 'Your Views Matter' leaflet into the top 5 languages and make available in ED.	DG	March 2015	Photographs of leaflets and posters in place.	Access to raising concerns for those attending ED.	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.	**1**
SD4	The Trust should consider ways of improving multi-disciplinary communication within the A&E Department at City Hospital.	A review of emergency care governance, undertaken with the CCG in November 2014, has been completed – daily huddles now include presence from the executive team with a specific brief to ensure multi-professional learning.	COO	March 2015	Good visual management of communications and governance	KPI identified for stages of urgent care pathway across the system and improvements are evidence; assessment for bed within 30 minutes of arrival	Daily huddles continue at Directorate level. Daily debrief expanded to include capacity team, all clinical groups are represented and the COO. Executive input through Urgent Care Challenge Delivery Group fortnightly.	**1**

Status: **1** Complete | **2** On-track | **3** Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
						Evidence of visual management in ED on communications.		
Medicine								
MD9	The trust should ensure all medicines are stored in accordance with Trust procedures.	This is already our policy, and ward pharmacists will be asked to report any discrepancies or innovations that have not been risk assessed.	CN	~~March 2015~~ September 2015	Pharmacy and ward prevalence audit data	100% compliance	GDoN are undertaking random checks to monitor compliance to storage standards. Reported via ward dashboards. **Update:** Most areas achieving 100% on the audit, metrics reported to Trust board in the ward staffing paper Audit proforma for medication storage in theatres in development.	2
MD10	The Trust should ensure all care documentation, including food balance charts, are completed accurately and in a timely fashion.	Sample auditing of Ten Out Of Ten commences from May 2015, and we will ensure data on this issue is routinely reviewed during the first six months of 2015-2016 by the Nurse Executive, as part of our ward support programme.	CN	October 2015	Monthly prevalence audit data. IPR incident data Dashboard KPIs outlining monthly compliance.	Reduction in harm in KPI as per checklist	Ten out of Ten monthly prevalence monitoring undertaken and reported via Chief Nurse's Business Meeting. **Update:** Plan for 2015/16 to help embed 10/10 discussed at Trust Board, methods being tested in	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							Surgery A. Health Promotion is the main challenge for staff – support material is being sourced via MECC team. More in –depth review in indicated. A clinical documentation workshop with Ward Sisters was held by Chief Nurse on the 24th June to review FBC and clinical documentation. **Update:** Care plan workshop held with ward sisters and matrons 24th June, draft work undertaken which requires refining over the next two months. Assessment record structure is of good quality having been reviewed during 2014, checking of documentation is a routine activity as part of ward reviews Review of 'fluid	

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							management' module of vitalpak planned in August.	
SD5	The trust should take action to improve the compliance with staff's mandatory training targets.	In 2014-15 we have revised our training models to reduce time away from clinical practice. We expect by October 2015 to be consistently achieving 90%+ in all domains.	DOD	October 2015	Education Plan Hot Topics bulletin: July	Mandatory training compliance rates at 100%	Mandatory training is a Hot Topic in July's bulletin where the message given is that full compliance is an absolute requirement. Failure to achieve this will result in consequences. Mandatory Training components have been made similar, shorter and easier to complete. **Update:** Education Plan will be signed off at Board in August. At the end of July all Groups are above 85% with only three below 90% compliance rate with clear plans to address to meet October deadline.	2
		New arrangements to tackle trainee doctor recording compliance issues are in place within the Trust, which will improve delivery among medical staff.		~~June 2015~~ September 2015	Increase in compliance rates	Increase in compliance from doctor community	**Update:** Medical education leads are ensuring compliance rates are monitored and increased and that trainees complete	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							mandatory training in first few weeks of placement. The new intake joins on 3rd August 2015.	
SD6	The trust should ensure all patients have person centred care plans that reflect their current needs and provide clear guidance for staff to follow.	We have worked with our Matrons over recent weeks to make sure care documentation is complete, person-centred and up to date. We will hold a staff engagement event in May to explore ways of further individualising and personalising care planning.	CN	October 2015	Monthly prevalence documentation audit data as presented in ward dashboards	100% compliance with nursing process	The event on the 24th June as per MD10 will review person centred care planning – the way forward. No pyscho- social care plans are available in the electronic care plan library on the Corporate Nursing site. Plan to embed 10/10 to be developed further. **Update:** Care plan workshop held with ward sisters and matrons 24th June, draft work undertaken which requires refining over the next two months. Psycho –social care plan drafted along with other care plans as per MD10 Quality improvement	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							week re: 10/10 planned for Autumn Assessment record structure is of good quality having been reviewed during 2014, checking of documentation is a routine activity as part of ward reviews.	
		We will undertake structured reviews of individual case notes to assess both documentation completion and the accuracy of those care plans against delivery – as we did in January 2015 on D26.		October 2015	Monthly prevalence documentation audit data as presented in ward dashboards	100% compliance with nursing process	Wards are undertaking regular documentation audits in Surgery A and Med/EC and results are represented via ward dashboards along with exception reports and actions. A sample audit of Care Rounds has been completed by Corporate Nursing and due for submission to Chief Nurse's Business Meeting in June.	2
SD7	The trust should ensure all patients are aware of and in agreement with their treatment plan.	This is one of our Ten Out Of Ten, and so will be audited routinely. Care planning documentation is being changed to provide additional prompts to patient signature and confirmation of planning consent.	CN	~~June 2015~~ October 2015	Monthly prevalence documentation audit data as presented in ward dashboards	100% compliance with nursing process	As per SD6 above. Clarification of inclusion in audit proforma tbc	3

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							Update: Care plan workshop held with ward sisters and matrons 24th June, draft work undertaken which requires refining over the next two months this includes how patients and their family will be involved in the planning phase. Assessment record structure is of good quality having been reviewed during 2014, checking of documentation is a routine activity as part of ward reviews As part of care planning format review MD10 patients/carers will sign up to each plan of care – audit programme to then confirmed with clinical groups	
Surgery								
MD11	The trust must take action to ensure that general surgeons have up-to-date job plans.	Job plan final offers to in post general surgeons have been issued by the Medical Director and Group Director of Operations. Even if these go to regional appeal they	MD	June 2015	Consultant surgeons have agreed job plans.	Job plans agreed.	All consultant surgeons have an agreed job plan for the current service configuration.	**1**

Status: **1** Complete | **2** On-track | **3** Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
		should be in place by the end of Q1.						
		A revised configuration for acute surgery has been subject to a CCG-led public listening exercise with a view to reconfiguration of emergency provision from August 2015. The job plan offer above already makes a second-stage proposal on how this would be reflected in future job plans.		October 2015	Agreed job plans for new service reconfiguration.	Successful surgical reconfiguration.	A job plan offer has been made for post reconfiguration. This has not yet been agreed. There are outstanding questions regarding the post reconfiguration service model and how this relates to job plans. **Update:** A successful recruitment to general surgical posts has meant progress been made on post reconfiguration job plans. This includes daily timetabled presence on the City site.	2
MD12	The trust must take action to ensure that hand hygiene is carried out appropriately by all members of staff across the Trust at all times.	In March we launched our 'OK to ask' campaign to support staff in challenging behaviours.	CN	March 2015	Prevalence audit data	No HAI Staff demonstrate being able to ask	Launched in March 2015. Reinforced in multiple communications. Included in May QIHD. Reinforce by CN at senior nurse meetings and memos.	1
		The numbers of hand hygiene audits has increased and are now undertaken by ward managers and matrons. Results will be		~~June 2015~~	Prevalence audit data (Observation of practice)	No HAI	Key messages delivered in the June 2015 QIHD	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
		displayed at ward and theatre level.		September 2015	Ward infection rates		**Update:** Screen savers distributed. Role modelling and challenging continues and is helping achieve better results, although some staff visitors to wards are still not compliant all of the time. Good progress noted on external inspections by TDA	
		A more robust escalation process is in place for those not adhering to the hand hygiene requirements. This includes the executive triumvirate. Repeat escalation of individuals will be treated as a conduct issue.		October 2015	Communication with the CN or MD about staff who don't apply the policy standards	Compliance with hand hygiene policy demonstrated by audits undertaken on a monthly basis.	Escalation and message about consequences delivered to the CLE by email from the CN 16/6/2015	2
MD13	The trust must take action to ensure that a suitable system is in place to ensure that patient records are kept secure at all times.	Our all-areas audit and "speak up amnesty on local storage arrangements" will be complete by the end of April 2015. Remedial changes will be put in place in May and June.	DG (SIRO)	~~June 2015~~ September 2015	Publicity material on the amnesty. Audit findings	Reduction in IG breaches	Response to amnesty to be considered and areas for action identified addressed.	2
		Additional information governance publicity and training has been distributed organisation wide to encourage awareness of risks.		March 2015	Publicity material issued to staff	Reduction in IG breaches reported.	Information Governance 'top tips' devoted to Records Management.	1
		New lockable trolleys and other storage containers have been procured and will be fully deployed in coming weeks.		June 2015	Picture evidence of storage in use	Records held securely at all times	Trolleys purchased and in use.	1

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
MD14	The trust must take action to ensure that a suitable system is in place to regularly assess and monitor the quality of postoperative surgical care.	A post-operative standard care bundle is being developed, for consideration by the Clinical Effectiveness Committee. This will be widely discussed within our Quality Improvement Half Days.	MD	~~June 2015~~ October 2015	Care bundle proposal presented to Clinical Effectiveness Committee by clinical lead for general surgery.	Care bundle implemented and improvement in post-operative outcomes demonstrated over time (infection rates, surgical outcomes, pain scores).	Care bundle is in active development and has been discussed at Surgery QIHD. Not yet presented to the Clinical Effectiveness Committee. **Update:** Trust has been 'activated as an 'EPOCH' site this will mean that an emergency laparotomy pathway will be launched in August 2015. We will be using a pathway developed by our BCA partners DGHFT.	3
		Implementation of the bundle during Q2 will be part of our autumn audit programme.		October 2015	Care bundle implemented	Care bundle implemented and improvement in post-operative outcomes demonstrated over time (infection rates, surgical outcomes, pain scores).	Confirmation from surgery clinical lead the implementation time line is achievable.	2
SD8	The Trust should ensure that a safe system is in place, which all surgical staff have received appropriate training in, to safely book patients into the theatre suite and	The booking systems for our emergency theatres are via a standardised whiteboard. The Standard Operating Policy for that process will be reissued to all three surgical groups' staff during April. Wait times for emergency surgery are already tracked at senior level within the Trust and published.	MD	June 2015	Electronic booking system for emergency theatres	All emergency cases booked electronically.	Meeting scheduled 24th June 2015 to discuss taking forward current IT solution which fulfils the majority of required functionality but has issues which are inhibiting	3

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
	record same.						adoption.	
		Booking systems for elective booking, following our October 2013 Never Event, were re-designed and guidance was reissued to staff late in 2014. Error rates and near misses are tracked and a month's data for April will be presented to the Clinical Leadership Executive in May.		June 2015	Audit of operating list errors.	Reduced operating list errors.	Audited October 2014 – since then a working set up which meets every 6 weeks identifying and dealing with issues. There is a monthly break down of incidents of list errors discussed at the theatre governance board. Data not yet presented at CLE. Implementation of eDTA has greatly improved safety of process.	1
		Our new operating standard is to 'lock down' elective theatre lists one week prior to session. Compliance with this approach will be tracked and systems re-designed to meet this routinely through Q2.		October 2015	Audit of operating list changes	Reduction in on the day list changes	Lock down policy is 1 week for theatre availability and 2pm the day before for list content. It has been identified that 1 week lock down for list content will be un-feasible.	2
SD9	The trust should ensure that the World Health Organisation (WHO) surgical safety checklist and preoperative briefing	We have removed the need for staff to sign the WHO surgery checklist, which goes beyond WHO requirements. The new form goes into place at the start of April.	MD	June 2015	Revised WHO check list policy.	Full compliance with WHO check list in all operating theatres.	The new WHO checklists are now in use – compliance audit shows 99.9% performance	1

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
	follow the WHO guidelines. The trust should ensure that staff know what is expected of them and that the checklists are assessed and monitored for quality.	Observational audit of team behaviours around the checklist will become routine for 2015-2016, with all theatre sessions visited at least once over that period.		October 2015	Observational audit data.	Improvement in engagement of all staff in WHO checklist procedure.	Observational audit of WHO check list is routine and reported to the Theatre User Group (soon to be Board).	2
		Our highly successful video reflexivity project to allow teams to discuss their approach to working together will be rolled out from eye theatres, across general adult theatres.		October 2015	Video reflexivity projects across all theatres.	Each theatre suite to have had at least one video reflexivity exercise.	Video reflexivity taking place in BTC. Programme and timeline for remaining theatres published. **Update:** Video reflexivity program will be delivered over August, September and November 2015.	2
SD10	The trust should consider improving the environment in the pre-assessment unit at City Hospital because it is not patient friendly, has inadequate staff facilities and does not promote patients' dignity.	A risk assessment of this environment has been completed. The results of that assessment and any remedial work will be considered in April against competing priorities within our capital plans.	DE	June 2015	Photographs of the improved pre-assessment Unit.	Improvements to the environment of the pre-assessment unit have been made. Nurse call systems are now operational for the benefit of patients and staff. Improvements requested to the reception area by staff have been completed. The scope for further	The environment in the BTC pre-assessment unit has been reviewed with staff. The following works have been undertaken: - the Nurse Call system has been repaired. - the Unit's Reception area has been reconfigured. - options to improve staff facilities on the unit and through the wider use of facilities have developed with staff	1

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
						improvements are being considered e.g. utilisation of the BTC		
SD11	The trust should consider reviewing its process for booking bank and agency staff. The current system does not flow as the trust expects it to, and it obstructs staff in ensuring that shifts are staffed safely.	We moved approval of agency staffing back from Executive (started July 14) to Clinical Group level in December 2014. The Trust Board is monitoring whether this devolution is consistent with good practice Trust-wide and continued control of agency use.	CEO	~~March 2015~] October 2015	Tracking data on agency hours, and cost; alongside fill rates, and our harm index at local level	Reduction in agency use, improvement in fill rates, survey of team leaders in September shows satisfaction and suggestions for improvement.	Agency use growing. System offering less central data and grip. Significant work to do the join up operations, finance and professional functions. **Update:** Grip being retightened at local level based on forward look tool, aimed at earlier roster booking. Changes to bank rates from August 2015 aimed at shifting staff from agency. Deep dive review of locum pod model takes place in September.	2
		Late requests arise through sickness and rostering practices. Both are subject to extensive change work within the Trust, and central monitoring of e-rostering now provides comprehensive data on ward management of workforce issues.		~~June 2015~] October 2015	Example of roster report, together with clarity on how it is used to 'rate' rostering practices within ward review	All wards using rostering, and have clear six-eight week forward look rotas in place	**Update:** Forward plan of rostered shifts now monitored on a weekly basis through Executive group including feeds from e-rostering and locumpod. Used CLE and Group Performance Reviews to	3

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							monitor sickness rates on a monthly basis, extensive work taking place in groups on sickness management.	
Children and Young People								
MD15	The trust must ensure that the nurse staffing skill mix reflects the appropriate national guidance for staffing the specialty reviewed. Staffing skill mix and support on some shifts within the clinical areas were not always meeting national best practice guidance.	We will consider whether there is a case to go beyond current staffing as part of examining our future workforce plans for the Trust.	CN	October 2015	Safer Nursing Care data. Ward dashboards	100% compliance	**Update:** Skill mix signed off in September 2014; successful recruitment to fill vacancies for both Band 5 and Band 2 posts. Awaiting checks and start dates. Paper developed to support over recruitment of Band 5s due to Maternity leave. Awaiting sign off for VAF for 3 wte Band 5 posts. Lyndon One has reviewed model of nursing and improved efficiency and cover HDU patients.	2
MD16	The trust must ensure that at least one nurse per shift in each clinical area (ward or department) will be trained in advanced	We will fund additional training time for paediatric nursing staff in this area	CN	~~June 2015~~ October 2015	Dashboard data. EMRT audit reports	No avoidable EMRT/CA	There is always a registrar on duty with APLS. The % of qualified nurses with PiLS is improving – all	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
	paediatric life support or undertake a European paediatric life support course depending on service need.						ward managers are booked to attend EPLS	
MD17	The trust must ensure that staff receive appropriate training including mandatory training updates and supervision.	Our training plans and budget are openly displayed Trust-wide. The Board's Workforce and OD committee will review the 2015-2016 plan for paediatrics to ensure that it is satisfied with the sufficiency of proposals coming forward from local leaders.	DOD	June 2015	Full TNA published on Connect and individuals contacted in early June. Discussed in depth at Leadership Conference on 23rd June. Closing date for training plans 31st August 2015. Regularly monitored at CLE.	Understanding of importance of learning, mandatory training and CPD throughout SWBH career. Consistency of standards across Trust.	Training plans and budget are openly displayed Trust-wide. A new 3-year education, learning & development plan launched at the Leadership Conference on 23rd June that is to be signed off by the Board in August.	1
MD18	The trust must ensure that all records are kept securely for the purpose of carrying on the regulated activity.	Our all-areas audit and "speak up amnesty on local storage arrangements" will be complete by the end of April 2015. Remedial changes will be put in place in May and June.	DG	~~June 2015~~ September 2015	Publicity material on the amnesty. Audit findings	Reduction in IG breaches	Response to amnesty to be considered and areas for action identified addressed.	2
		Additional information governance publicity and training has been distributed		March 2015	Publicity material issued to staff	Reduction in IG breaches reported.	Review since the Inspection visit does not	1

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
		organisation wide to encourage awareness of risks.					suggest that this would merit a risk entry above 12 which is the trigger for Board escalation.	
		New lockable trolleys and other storage containers have been procured and will be fully deployed in coming weeks.		June 2015	Picture evidence of storage in use	Records held securely at all times	Trolleys purchased and awaiting delivery.	1
MD19	The trust must ensure that there is an accurate record in respect of each child that includes appropriate information and documents in relation to the care and treatment provided to each child	Paediatric Matrons and the specialty Clinical Director will ensure that this issue is discussed during May's Quality Improvement Half Day to understand any constraints that staff feel exist in achieving this basic standard.	CN	~~June 2015~~ September 2015	Prevalence documentation audits via ward dashboards	100% compliance Reduction/removal in avoidable harms	Joint assessment documentation has been reviewed and amended. **Update:** Work is ongoing. Ward Managers reviewing the nursing process in their areas with emphasis on planning and evaluation of nursing care. **UPDATE:** Work is ongoing. **UPDATE:** Documentation awareness raised with the multi-disciplinary team. Vitalpac launch in Paediatric areas is delayed, with this now happening in September 2015 due to technical updates being applied. Paediatric Safety Thermometer under	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							discussion first webinar attended.	
		A specific audit of the accuracy of paediatric record keeping will be included in our Clinical Audit Plan for 2015-2016.		October 2015	Audit ref 2.2 in the annual plan	Audit completed and results have an action plan	Health care records audit is in the annual plan	2
		We will ask patient representatives locally to join us in conducted unannounced inspections every quarter on these issues.		October 2015			Not started but will be achieved on time.	2
Maternity and Gynaecology								
SD12	The trust should display the results of safety checks prominently so that the information is accessible to staff, patients and visitors.	We will ensure that our measures boards in both maternity and gynaecology reflect our Trust-wide standards	CN	~~March 2015~~ September 2015	Boards available outside of wards	Information available in public areas for patients and public to see.	**Update:** Work underway on regional dashboards, which will need to inform our work locally.	3
		We will undertake listening and survey activity with families to understand if there is additional data on our performance that they would value being displayed.		~~June 2015~~ September 2015	Results of the survey feed the dashboard	Information available in public areas for patients and public to see	Not completed yet	3
SD13	The trust should take active steps to ensure that all staff consistently follow best practice guidance in relation to hand cleansing and infection control dress code.	In March 2015 we kicked off our 'OK to ask' campaign to support all staff who do challenge risky behaviours.	CN	March 2015	Formal communications, CEO Friday message.	Staff know about the initiative and are using it.	'OK to ask' started with a number of communications from March to date.	1
		We will ask patient representatives locally to join us in conducted unannounced inspections every quarter on these issues.		October 2015			Not started but will be completed on time.	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
		A more robust escalation process is in place for those not adhering to the hand hygiene requirements. This includes the executive triumvirate. Repeat escalation of individuals will be treated as a conduct issue.		October 2015	Communication with the CN or MD about staff who don't apply the policy standards	Compliance with hand hygiene policy demonstrated by audits undertaken on a monthly basis	Escalations to CN and MD if indicated – reinforced at MDT meetings in June 15 and in emails from the CN and MD 16/06/2015	2
SD14	The trust should ensure that resuscitation equipment is checked daily in keeping with best practice guidance provided by Resuscitation Up 2010 in all areas.	We will monitor during the first three months of the new year data and report the results to our Patient Safety Committee of the Clinical Leadership Executive.	CN	June 2015	Prevalence audit data	100% compliance SI data	Equipment and trolley checking audits presented as part of KPIs – and reported via the Patient Safety Committee. To be uploaded to Corporate Nursing s drive to facilitate easy access for ward managers to review and action. **Update:** Resuscitation trolley checks are in place and the checks are made by matrons and GDoNs	1
SD15	The trust should ensure that all medication on the maternity unit is securely stored at all times.	We have begun procurement of sufficient automated dispensaries to cover all our wards and Emergency Departments	CN	~~June 2015~~ October 2015			Equipment explored but not yet ordered. **Update:** Vending machine approach to be placed in high usage areas, e.g. emergency department and new types of locks to be put into ward areas some currently on order and all will be in place for	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							October 2015.	
SD16	The trust should consider placing the record keeping on the trust risk register to ensure that monitoring occurs at the highest level of the organisation.	We will consider a risk assessment on this issue at April's Risk Management Committee. Review since the visit does not suggest that this would merit a risk entry above 12 which is the trigger for Board escalation.	DG	June 2015	Meeting note of discussion.	Raised awareness of the risk.	Review since the Inspection visit does not suggest that this would merit a risk entry above 12 which is the trigger for Board escalation.	**1**
SD17	The trust should consider separating out the number of hospital-acquired pressure ulcers into specific wards so that action can be targeted accordingly.	The Trust Board will continue to monitor pressure ulcer information at specialty level, adding a further data item to our Board reports for any ward reporting more than one pressure ulcer in a given month.	CN	June 2015	Safety Thermometer IPR monthly incident data	Eradication of avoidable pressure ulcers	Incident reports are presented at corporate, group and ward level monthly to IPR, CN Business Meeting and up-loaded onto the shared drive for access by senior nurses to review and action. Wards with increased need are targeted for support by the Tissue Viability Service with use of concepts from the national Eradicate rapid improvement change model. Prevalence via safety thermometer accessed via same shared drive.	**1**

Status: **1** Complete | **2** On-track | **3** Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
SD18	The trust should consider updating all midwifery staff about the rationale and outcomes for 'high-risk' women who choose to give birth at the midwifery-led units, so that all staff can be confident that the maternity service promotes the best emotional and physical outcomes for women and babies.	The dataset implied by the CQC will be routinely shared within maternity services over the coming year.	COO	October 2015	Data available and regularly considered by staff.	Improved outcomes for women and babies.	Existing communication and engagement channels to be used to discuss, review and act on the data.	2
SD19	The trust should investigate further ways of improving communication for women who do not understand English.	In addition we are going to review maternity information for patients to see what gaps can be identified. We will also develop a range of audio-visual support guides. We will identify best practice from other areas and work with different community groups to make sure our information is comprehensive and available in the right formats and languages.	DC	October 2015	Literature in other languages and formats. Evidence of engagement with local community representatives.	More women will be able to access information in their first language or be able to see information about the maternity services on offer through development of patient films.	All maternity information for patients has been reviewed. All is accredited and has received the Patient Information Standard. Key information will be translated into our top 10 languages. **Update:** Seven leaflets are being revised with new content and there are two new leaflets being produced The key patient information leaflets are	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							being translated into our top languages. Through our community engagement network we will engage community groups in updates to the patient information literature as well as development of films about the maternity department.	
SD20	The trust should ensure that staff who are expected to translate are provided with the skills required to carry out this function well.	We will monitor the scale and use of Language Line for immediate interpretation, and work with staff to see how this, and electronic translation material may help us. The use of relatives will only arise when absolutely necessary. Our training budget will provide some scope to support employees learning relevant local languages to support initial communication with patients.	CN	June 2015	Monthly reports: activity and cost	Reduction in spend. No increase in complaints or incidents	The appropriate use of interpreting services including telephone interpreting has been raised in team meetings in Surgery A and Medicine/EC by GDON. The Interpreting service are up-dating list of telephone interpreting equipment and visiting wards/depts./team meetings to raise awareness re: interpretation of guidance on use of staff/family based on a risk assessment.	**1**

Status: **1** Complete | **2** On-track | **3** Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							Communication flash cards have been re-issued, as required (most wards still have packs). Six new phones purchased for access to language line.	
SD21	The trust should consider improving how the outcome of an investigation and resulting action are communicated to complainants	We are introducing new approaches to try and involve complainants in examining whether our actions to tackle the issues they highlighted have been effective	DG	October 2015	Audit reports. Letters to complainants.	Substantive and effective changes made. Complainants can see changes in practice.	Currently developing systematic process to enact.	2
SD22	The trust should consider ensuring that all risks and issues of high concern are included on the corporate risk register to ensure that senior directors are aware of the progress in reducing and managing the risk.	A list of all pre-mitigated 'red' rated risks is shared with our Clinical Leadership Executive and the Trust Board. We will make this our standard every three months.	DG	~~June 2015~~ September 2015	Reports presented to the relevant meetings. CLE and Board agenda / minutes.	Mitigation plans are managed to time and risk scores assessed in light of regular reviews.	All risk registers are available on CONNECT for any member of staff to view. A note in will be issued in the Staff Bulletin to remind colleagues. All pre-mitigated red risks have previously been presented to the Trust Board. This will happen again in ~~August~~ September and quarterly thereafter. The same report will be shared with CLE.	2
SD23	The trust should find a way of increasing feedback	We will hold a specific open event for the Women and Child Health group in May 2015.	DOD	~~June 2015~~	Your Voice survey results.	Clear voice from WCH on specific	Chairman met with WCH for Chairman's breakfast	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
	about working for the Trust from obstetric and midwifery staff.	DOD leading intervention with WCH senior team on culture / team working / behaviours and working practises. Observation of working practises in WCH by senior leaders Intervention on leadership using external facilitators Hay Group. 360 for consultants and team building event for senior leadership team. Use QIHD to talk about behaviours and culture in WCH – happened in July 2015 Group Director of W&CH leading 'ethics' piece of work with Chief Executive and Director of OD		October 2015		issues. Developed action plan on culture in obstetric and midwifery.	in May 2015. Issues have been fed back to director of OD. Chief Exec met with reps from WCH on specific equalities issues. DOD capturing views of midwifery staff in particular around recruitment. New midwifery union rep inducted on to JCNC Need to develop plan that captures outputs of all interventions to date. DOD leading intervention with WCH senior team on culture / team working / behaviours and working practises. QIHD in July used to launch culture change and 'listening' DOD observed MDT and surgery session - leading	

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							external intervention planned for 30th September 2015.	
		We will use the Kirkup Review, within our Quality Improvement Half Days, to develop a specific response plan for maternity services at the Trust.		June 2015				
End of Life Care								
SD24	The trust should schedule repairs to the previously reported cracked concrete floor in the mortuary. This presented an infection control risk and did not comply with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.	This was resolved in December 2014 (i.e. before the report was received by the Trust)	DE	March 2015	Photographs of the mortuary floor		This was resolved in December 2014 (i.e. before the report was received by the Trust).	1
SD25	The trust should review the hospital discharge processes. These have an impact on patients' ability to achieve their preferred place for end of life care	A Trust-wide piece of work, led directly by the Trust Board, will analyse the last year of life of palliative patients for additional improvements. When we have the outcome of that audit the Board will oversee a focused improvement plan in this area. This is	COO	October 2015	Completed audit Focussed improvement plan with evidence of delivery.	Improvement from baseline audit over the course of the year.	Palliative care services are being moved to the Community and Therapy Clinical Group, with the opportunity of aligning the palliative care team with	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
	and fast-track discharges. This is contrary to national best practice guidance including *One chance to get it right*, Department of Health, 2014.	identified as a priority in our Annual Plan for 2015-16.					the District Nurse Team who are linked to GP locations. A dedicated operational manager will support the integrated service	
SD26	Review how the reduced chaplaincy services can continue to provide a caring and responsive service to patients when required. The reduction in these services is contrary to national guidance including the NICE *Quality standards for end of life care*, 2011, updated 2013.	The chaplaincy service was included in the staffing consultation undertaken in October 2014. In November 2014 we took the decision not to proceed with changes outlined in that consultation. There will be denominational changes, but we remain consistent with the guidance cited, and guidance issued last month to the NHS as a whole.	CN	March 2015			The chaplaincy service was included in the staffing consultation undertaken in October 2014. In November 2014 the decision was taken to not proceed with changes outlined in that consultation. There will be denominational changes, but the Trust remains consistent with the guidance cited, and guidance issued to the NHS as a whole. Recruitment to a Roman Catholic post is to be undertaken but covered by on-call arrangements until this is complete.	1
SD27	The trust should ensure processes are in place to ensure that doctors consistently complete 'do	Using our extant IT system which centrally records those inpatients with a DNACPR order, we will comprehensively test, ward-by-ward, week-by-week, whether we have	CN	October 2015	Prevalence monthly audit data		DNACPR audits undertaken monthly- to be submitted to the Patient Safety Committee	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
	not attempt cardio-pulmonary resuscitation' (DNA CPR) forms correctly in line with national guidance published by the General Medical Council.	accurate information held locally. This analysis will be made available on an ongoing basis to the Chief Executive, and through him to the Board.					from July 2015 for review at strategic and operational level. IT system information relies on data being inputted to eBMS via the alert system / patient safety briefing. **Update:** Flags exist on eBMS. Communications plan to be delivered during August. Doctors to indicate DNA-CPR order in place by using the flag. Patient's status to be discussed on daily ward rounds. Monitoring of usage from September 2015	
		In March we launched our 'OK to ask' campaign to support staff in challenging behaviours. This asked teams to examine whether at local level they know the DNA CPR status of all their patients.		March 2015	Formal communications, CEO Friday message.	Staff know about the initiative and are using it.	'OK to ask' started with a number of communications from March to date and shared via QIHD.	1
Outpatients and Diagnostic Imaging								
MD20	The trust must maintain adequate records regarding the qualifications	We hold full records already on qualifications of imaging staff and have extensive training in place. Full competency assessment records	COO	March 2015	Compliance with the SOP detailing how competency records	All practitioners and operators fully trained and	98% of operators (123 people) all have the required competency	1

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
	and training of imaging department staff.	were found to be missing and we have an action plan in place that we submitted to the submitted to the CQC in November 2014 that will ensure we are fully compliant by March 2015 (three months ahead of the compliance notice sent to us in January 2015 for resolution by July).			will be produced, stored, and Maintained. Training matrix (operators divided by group and equipment type) Completed competency forms.	competent under the IR(ME)R Regulations.	records completed and available (radiologists, radiographers, nuclear medicine technologists, physics staff, cardiologists, staff in ophthalmology and oral surgery and agency workers). The outstanding records relate to two operators who have been absent from work due to long-term absence. A letter confirming the Trust's compliance against the Improvement Notice was sent to the CQC on 18/6/2015.	
MD21	The trust must ensure guidance be available for imaging staff regarding exposure parameter guidance or information surrounding expected dose values.	This was largely in place at the time of the CQC visit and is now fully implemented.	COO	March 2015	Photographs of the Diagnostic Reference Levels posted on the walls.		Lists of local Diagnostic Reference Levels have been posted on the walls in all radiography, fluoroscopy and CT rooms at City Hospital and Sandwell Hospital. Nuclear Medicine DRLs are posted in the injection room.	1
SD28	The trust should ensure that communications to staff about workforce changes are timely, clear	Having examined the specific outpatient and diagnostic imaging concern it is clear that open team meetings were sparse in some areas. The introduction of Quality	CEO	~~June 2015~~ October	Your Voice survey on morale, trade union feedback on process and clarity,	We need to agree as a Board what measure we plan to use, as it surely	TU perception is phase 2 is working in a better way than phase 1.	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
	and consistent.	Improvement Half Days from April 2015 should resolve this issue in key clinical support departments. We will use Your Voice to test the outcome.		2015	management review of phase 1 and in time of phase 2	cannot be morale	Fewer communication complaints from those directly affected. Medical staff concern about specific scheme and change load. **Update:** Redeployment expected to conclude in September 2015. Will undertake post project review, and involve TDA. Preparation for 2016 and 2017 commences in earnest through group workshops in September 2015. Organisational learning exercise extensive including industry examples of long term large scale restructuring (NHS has few)	
SD29	The trust should ensure that the outpatient risk register captures all known risk issues.	The new Quality Improvement Half Days commencing in April 2015 will provide an opportunity for multi-disciplinary review and learning regarding potential and actual risks.	COO	June 2015	Risk register updated and evidence of review and progress to reduce and effectively manage risk.	Reduction and management and identified risks.	The new Quality Improvement Half Days introduced in April 2015 provide an opportunity for multi-disciplinary review and learning regarding potential and actual risks. The local risk register is reviewed and updated at	1

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							this monthly meeting.	
SD30	The trust should ensure that support for people with dementia and learning disabilities is available in the outpatients department.	November 2014 was learning disabilities month Trust-wide. This was an opportunity to promote Reasonable Adjustments in all clinical areas. We have asked Changing Our Lives to examine our practice for LD and advise us on any further changes and improvements required.	CN	~~June 2015~~ October 2015	Practice review information	Improvement plan No red flag concerns identified.	**Update:** Meeting held with Changing Our Lives to explore how we can work together, audit of LD arrangements to be the priority. Bid to CCG for additional senior nursing post to support LD.	3
		We are actively exploring how to put memory loss scoring methods into key relevant outpatients departments. Part of that work will be providing additional training and support to outpatient staff.		October 2015	Screening tool kit enhanced for use in OPD.	Results of screening available.	**Update:** Plans being developed to implement screening in ophthalmology and audiology outpatient departments.	2
SD31	The Trust should ensure that the planned review to assess the current and future capacity in outpatients is undertaken urgently so that the findings can inform the current change programme.	Our annual capacity planning exercise, using the Intensive Support Team template, is being finalised. This will be the basis for distinguishing backlog supply from routine capacity. We will monitor volumes against this capacity quarterly.	COO	June 2015	Completed demand and capacity plan with trajectories for delivery	Waiting times to a maximum of 6 weeks in Q3.	Demand and capacity plan complete for all groups with the exception of Surgery B which will be finalised by end June. **Update:** Demand and capacity plans revised post Quarter 1 performance. This includes trajectory to 6 week waits for OP in Q3 in line with Trust annual objectives.	1

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
SD32	The trust should ensure that, when complaints about outpatients are resolved at the time they arise, records are kept so that lessons can be learned from the incidents.	We will introduce a simple proforma to capture these resolutions and share the results across all Outpatient Departments through our Quality Improvement Half Days.	DG	October 2015	Proforma completed. Section in quarterly report.	Reduced similar complaints and continuous improvement.	Proforma developed and shared with DCOO for comment	2
SD33	The trust should ensure that urgent action is taken to improve the privacy of patients in the eye clinic.	This features explicitly on the corporate risk register, which was provided to the CQC, along with evidence that this has been resolved at Board level. The delay in implementation is because we need to move a third party occupier, which we are working to resolve.	CEO	October 2015	Actual change in environment	Separated diagnostic functions in SGH unit, clear platform for what will be done at Rowley Regis	Work has started on part of the scheme. Dental theatre remains to be relocated. May slip towards December for final completion.	2
SD34	The Trust should ensure that urgent action is taken to improve the confidentiality of patient records in outpatients, and that patients' privacy and dignity are maintained at all times.	Our all-areas audit and "speak up amnesty on local storage arrangements" will be complete by the end of April 2015. Remedial changes will be put in place in May and June.	DG	~~June 2015~~ September 2015	Publicity material on the amnesty. Audit findings	Reduction in IG breaches	Response to amnesty to be considered and areas for action identified addressed.	2
		Additional information governance publicity and training has been distributed organisation wide to encourage awareness of risks.		March 2015	Publicity material issued to staff	Reduction in IG breaches reported.	Information Governance 'top tips' devoted to Records Management.	1
		New lockable trolleys and other storage containers have been procured and will be fully deployed in coming weeks.		June 2015	Picture evidence of storage in use	Records held securely at all times	Trolleys purchased and in use.	1
SD35	The trust should provide Safeguarding adults level 2 training to all staff who run	Training is provided on the basis described. However, our mandatory training policy distinguished face to face from cascade	CN	~~March 2015~~	Validated Training matrix (PSC)	Training compliance 95%	Relevant staff in OP identified and training at Level 2 accessed.	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
	clinics and are likely to have contact with vulnerable people.	training. This has now been revised.		October 2015			**Update:** All trained staff booked on or completed Level 2 by October 2015 Review of training matrix planned.	
SD36	The trust should improve staff understanding and knowledge of responsibilities regarding the Mental Capacity Act 2005.	Mental Capacity Act training and Deprivation of Liberty training is included within Safeguarding Level 2 training. We will update training packages for staff and monitor who has been trained, making sure that people keep up to date with their training and knowledge of this important area.	CN	June 2015	Validated Training matrix (PSC)	Training compliance 95%	Adult Safeguarding team attended OP QIHD to undertake training and raising awareness.	1
Community Services: Inpatients								
SD37	The trust should ensure sufficient numbers of staff in the early evening and at night**.**	Staffing levels were examined as part of the establishment review which was taking place when the CQC visited the Trust. That review concluded that additional qualified night staff should be added to the ward roster. This has been implemented, using agency staff where vacancies currently prevent full cover.	CN	March 2015			This was previously completed to the CQC comments. Establishment budgets are in place and recruitment to vacancies under way. Temporary staff are filling gaps on rosters.	1
SD38	The trust should ensure sufficient supply of hoists resulting in people not having to wait to be transferred at busy times	This recommendation was reviewed on receipt. The local 'frontline' staff teams have examined it. They then met with the Chief Executive and recommended no action was taken. That recommendation has been	COO	March 2015	Transfer equipment including hoists are available in clinical areas.	No evidence of delays in transfer through incident forms.	This recommendation was reviewed on receipt. The local 'frontline' staff teams have examined it. They then met with the Chief	1

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
	(for example, after meal times and at bed times.)	accepted.					Executive and recommended no action was taken. That recommendation has been accepted.	
Community Services: Adults								
SD39	All out-of-date stock should be removed from clinical areas. The trust should put processes in place to identify and remove out-of-date stock.	We already have processes in place to do this and will check the compliance in community locations, reporting this to the Board.	CN	June 2015	No out of date stock located on inspection.	No out of date stock in circulation.	Processes were already in place to do this and have been checked, including compliance in community locations.	1
SD40	The trust should ensure that medication is stored appropriately.	We have begun procurement of sufficient automated dispensaries to cover all our wards.	CN	~~June 2015~~ October 2015			**Update:** Vending machine approach to be placed in high usage areas, e.g. emergency department and new types of locks to be put into ward areas some currently on order and all will be in place for October 2015	3
SD41	The trust should complete recruitment processes to fill vacancies across the organisation in a timely fashion.	We are revising band 4-6 notice periods to reduce the risk of gaps, in line with practice elsewhere in West Midlands.	DOD	March 2015	Contract paperwork 'Recruitment Revolution' papers. JCNC minutes	Reduction in turnover rates for Bands 4-6. Reduction in time to fill rates across the Trust	The notice period for Bands 4 -6 changed, w.e.f. from 1 July 2015. **Update:** Monthly reporting has been put in place on time to fill rates for each group, with updates for managers on	1

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							arranging interviews / shortlisting dates at the same time as advertising their jobs on NHS jobs. Review of recruitment processes and practises commenced including regional streamlining group with other Trusts in the West Midlands.	
SD42	The trust should ensure that community staff are supplied with appropriate equipment when providing care at low levels.	The intermediate care wards have hoists to transfer patients. We also have other equipment available to support patient's rehabilitation. We will complete an equipment inventory for community teams to make sure the right equipment is available at the right time.	COO	June 2015	Equipment inventory	No delays in transferring patients and timely delivery of rehabilitation	Inventory on track for completion. **Update:** Inventory completed and assurance on adequate equipment provided by the Group Director.	**1**
Community Services: End of Life Care								
To carry out a review of Bradbury House Day Hospice to include:								
MD22	The trust should ensure safe staffing levels, particularly at pick-up and drop-off times and times of absenteeism, such as training, annual leave and sickness.	A full review of staffing and rostering models at Bradbury Day Hospice will be complete by May 2015	CN	June 2015	Briefing and risk assessment via RMC	Completed action plan SIs	Review of the staffing in the day hospital identified 1.5hrs per day when a RN would be in the hospital alone with mobile attendees. A risk assessment	**1**

Status: **1** Complete | **2** On-track | **3** Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
							regarding potential of attendees falling or deteriorating was completed and presented to RMC. Mobile phones are available to access other staff in the building or 999. A&C staff to be BLS trained. **Update:** 2 additional B6 nurses recruited to community team in Q1 with a remit to support day hospice Working to extend bank support through supported bank shifts The casemix, dependency and acuity of the day hospice attenders remains low as such current staffing levels appear safe and meeting assessment needs. This is under constant review	
MD23	The trust should ensure	Staffing levels were examined as part of the	CN	March	Roster compliance		Staffing levels were	**1**

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
	adequate registered nurse staffing levels on night shifts at the Leasowes Intermediate Care Centre.	establishment review which was taking place when the CQC visited the Trust. That review concluded that additional qualified night staff should be added to the ward roster. This has been implemented, using agency staff where vacancies currently prevent full cover.		2015	with standards		examined as part of the establishment review which was taking place when the CQC visited the Trust. That review concluded that additional qualified night staff should be added to the ward roster. This has been implemented, using agency staff where vacancies currently prevent full cover. Establishment budgets are in place and recruitment to vacancies under way. Temporary staff are filling gaps on rosters.	
MD24	The trust should ensure a variety of activities provided on a daily basis.	An audit of activities, and survey work on client's views of them, will be completed by the end of May 2015**.**	CN	October 2015	Survey	Survey outcome positive	General patient surveys undertaken- attendees generally happy with service (crafts and social), need to be more specific regarding activity options. **Update:** The day hospice model is under review as part of the procurement activity with the CCG.	2

Status: 1 Complete | 2 On-track | 3 Off-track

Ref	Issue identified	Action to be taken	Lead[1]	By when	Evidence Required	Outcome/success criteria	Update as at 31 July 2015	Status
MD25	The trust should ensure reliability of ambulance transport.	Ambulance reliability will be monitored and reported to the End of Life Care group (chaired by the Chief Nurse) for six months, so that we can make sure improvements have been made, if that is necessary.	CN	October 2015	IR1 /service data re breakdowns	All breakdowns covered internally resulting in no attendee cancellation	2014/15 – ambulance at Bradbury Day Hospital had broken down 6 times. Contingency plan is support by wider transport vehicles which will improve with purchase of new fleet.	1

[1] **Leads**

DG	Director of Governance	CN	Chief Nurse
COO	Chief Operating Officer	MD	Medical Director
DE	Director of Estates	DOD	Director of Workforce and Organisational Development
CEO	Chief Executive	DC	Director of Communications

Status: 1 Complete | 2 On-track | 3 Off-track

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Education Learning & Development Plan 2015-2018**
SPONSOR (EXECUTIVE DIRECTOR):	**Raffaela Goodby, Director of Organisation Development**
AUTHOR:	**Jim Pollitt, Associate Director of Education, Learning & Development** **Raffaela Goodby, Director of Organisation Development**
DATE OF MEETING:	**8th August 2015**

EXECUTIVE SUMMARY:

The Education, Learning and Development Plan sets out an ambitious 3 year strategy to enable the Trust to effectively attract, develop, stretch and retain skilled colleagues, to build a long and varied career with us, delivering fantastic care to patients.

There has been a robust period of consultation on the plan through Trust committees, but also significantly through a workshop at the Leadership Conference in June, attended by 150 senior colleagues. This feedback has been made widely available through Connect and through the representatives who attend the Education Committee.

The investment in Education Learning and Development is £1 million for this year for the first time. This reflects the Trust's commitment to lifelong learning and demonstrates its commitment to a high quality competent workforce.

REPORT RECOMMENDATION:

It is recommended that Trust Board approves the Education, Learning and Development Plan and endorse the aims and objectives.

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

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

Trust objective to reduce sickness absence to 3.5% by 31st March 2016

PREVIOUS CONSIDERATION:

Education Committee May 2015
Leadership Conference 23rd June 2015
Trust Board July 2015
Education Committee July 2015
Clinical Leadership Executive July 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Education, Learning & Development Plan 2015-2018

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

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

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

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

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

This plan sets out an ambitious 'offer' for colleagues at all levels and tenures of service. The Trust knows it needs to 'invest in the middle' and to offer something for everyone to retain the best people to deliver quality care to our patients. SWBH can offer a vibrant, interesting and varied career for all, and our education, learning and development plan aims to be a significant vehicle to enable and support our talented colleagues to enjoy a long, challenging and varied career, delivering fantastic care to the patients of Sandwell and West Birmingham.

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

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

Toby Lewis – Chief Executive

Your learning journey at SWBH

SWBTB (8/15) 126 (a)

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

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

1. Attracting Talented People

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

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

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

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

CASE

Deve

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

Development Solution

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

2. Induction & first year in post

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

To provide a welcoming 'on-boarding' to new recruits	
To provide a welcome to the Trust that clearly demonstrates 'what is expected' as well as 'what you can expect'.	100% of new recruits have attended a refreshed corporate induction programme Enable 'e learning' of standard parts of induction Local induction to include developing a personal development plan as part of your appraisal Clear and consistent standards on equality & diversity set out during induction All new starters to have a PDR within the first 3 months
Enable a positive and engaging 'first year experience' to newly qualified staff.	Consistent offer to 100% of newly qualified staff to enable them to develop practical skills in first year in post Coaching & mentoring available to all staff who are new in post Peer support networks set up for newly qualified staff

3. Developing and retaining skilled colleagues

By the end of someone's second year in the Trust, or sooner if they wish, we would expect to have a personal development portfolio in place and agreed. This multi-year training and development commitment will not only be aimed at developing in-post skills but also ensuring that someone's potential is developed, and any future career ambitions within the Trust, or across our strategic partnerships, is clear. Our ambitions go beyond either revalidation minimums or KSF compliance. These are baseline expectations of employment. This may mean that an employee needs a mentor or advisor able to look beyond their immediate work role and think about their development into future roles within the Trust. As an organisation with a clearly defined long-term workforce model we are well placed to support that approach.

Directorate level training plans, built from local team plans, will need to identify funding priorities within these portfolios. But the emphasis, over a three year cycle, will be on significant development time consistent with individual's ambitions. Our new appraisal system, to be deployed from 2015-16, identifies high potential, as well as assessing performance, and this will be used to prioritise individuals for additional development with a focus on rewarding high potential and supporting high performance. The use of a peer review process, outside

the line management relationship, for appraisal will ensure that issues of diversity and equality are managed excellently. The Trust's Equality and Diversity Plan is explicit that we intend to not only comply with statutory obligations but actively promote a diverse leadership and a diverse workforce in line with our local population and its needs.

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

Ensure that performance is managed and colleagues have an annual conversation about their performance and a 3 year personal development portfolio\plan	
In order to achieve this we will:	**By 2018 we aim:**
Ensure all staff will have an annual appraisal and a personal development plan which identifies their development needs for the next 3 years	1. Issue all staff a personal development portfolio that can be used to support revalidation, CPD and appraisal. 2. Evidence all staff in leadership positions have had a 360 degree appraisal.
Ensure all staff will meet the core requirements of their current role with development for stretch and working to best practise.	All staff will demonstrably meet the clinical or professional competencies for their role measured through their annual appraisal.
Promote the retention of key skills & motivation by offering flexible moves inside the organisation	Staff are supported by their managers to undertake flexible development opportunities including job shadowing, short term secondments, mentoring & 'job tasters'
Develop a network of coaches and mentors to support staff in their current role.	To be in a position where we can offer all staff the opportunity to access coaching or mentorship support.
Use the 6 core dimensions of the KSF to ensure consistent standards, developing skills that are transferable to all levels across the Trust.	
We will identify and embed transferable skills, based on the six KSF Core Dimensions, in our development offer. Communication Personal and People Development Health, Safety & Security Service improvement Quality Equality & Diversity	Bands 1-3 should have achieved level 1 in all dimensions and Bands 4-5 should meet level 2. Bands 6 & 7 should meet level 3; this includes middle grade doctors. Band 8 and above, including consultants, should achieve level 4 in all The Trust will have adequate provision to sustain this level of development

KSF EXAMPLES

Using the Knowledge and Skills Framework as a development tool

The KSF is a tool that sets out competence in four levels, under six core dimensions. These are observable skills that can developed as you progress throughout your career, and measured through your annual appraisal or performance conversations, in one to ones, in development conversations, or when you are planning with a mentor or assessor for the year ahead. The KSF was introduced under Agenda for Change but was not applicable to very senior managers or doctors. We think it can be used as a measure of competence for all staff and sticking with it prevents us reinventing the wheel

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

Dr Roger Stedman. Medical Director

4. Develop & stretch senior leaders & specialists

The Trust has an ambition to enable our people to further develop and learn, to access promotions and to build their leadership careers within the SWBH family. This may be a clinical specialist role or general leadership role. It may include research and development, clinical trials or a complete career change from one

focus to another. Preparation for academic study to support those making the transition from vocational training to a higher level education should also be encouraged and supported.

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

Develop and retain confident & competent senior leaders and clinical specialists within the Trust	
For those who wish to develop as leaders the Trust will provide a structured framework with tailored coaching & support to embed practise across leadership cadre	New and aspiring leaders will be offered a Band 2-5 programme Develop a tailored programme for bands 6/7/8 Top leaders programme for all senior leaders All leaders will undertake a 360 degree appraisal every 3 years Coaching & mentoring to develop advanced leadership skills
We will make more opportunities available for clinical development to attract and retain talented clinical staff	We will create and fund research posts to attract and retain talented clinical staff Offer advanced levels of clinical qualifications through our links to local universities and national institutes We will enable opportunities for shadowing and secondments to share learning
Education & continuous learning will become a key component in the Trust's executive structure	Medical education will be fully integrated in to the delivery and future requirements of each service Full use of interventions such as quality improvement half days to share and learn right across the Trust Develop holistic approach to learning from mistakes and successes that is Trust wide

CASE STUDY

Health Visiting and Midwifery

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

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

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

How will this plan be used?

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

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

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

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

Team manager in Surgery

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

CO

Exe
Dir

Jame
Associate Director of Education, Learning & Deve ment james.pollitt@nhs.net

Dr Julian Chilvers and Dr Saket Singhal
Medical Education Leads for Doctors in Training heather.matthews3@nhs.net

David Carruthers
Medical Undergraduate Education Lead david.carruthers@nhs.net

Cath Greenway/Lorna Kelly
Nurse Education lorna.kelly@nhs.net cgreenway@nhs.net

Quick Reference. Education, Learning & Development Summary

Choose Your Band

Then find your pages ì

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

Opportunities for All Staff

Refer to Green Page

Post Registration
Professional Development

Refer to Blue Page

Undergraduate Programmes
Refer to Red Page

Support Post Programmes

Refer to Orange Page

Widening Participation
Refer to Black Page

Leadership Development

Refer to Purple Page

Leadership Development

Refer to Yellow Page

Opportunities for All Staff

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

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

Post Registration Professional Development

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

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

Undergraduate Programmes

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

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

Support Post Programmes

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

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

Widening Participation Initiatives

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

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

Leadership Development

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

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

Leadership Development

- Band 2-5 Leadership Programme
- Action Centred Leadership

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

Summary descriptions of 6 KSF core dimensions

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

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

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

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

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

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

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

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

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	TDA feedback on environmental visit
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington Chief Nurse
AUTHOR:	Colin Ovington Chief Nurse
DATE OF MEETING:	6th August 2015

EXECUTIVE SUMMARY:

Board members will recall previous briefings about the work the TDA have undertaken to inspect the environmental cleanliness of the trust. Since the last meeting we have been part of infection prevention and control summit on 7th July and a further planned inspection which took place on 20th July. The attached documents detail their findings on these two occasions. In summary the TDA were assured by our plans which were discussed at the summit and their verbal summary at the conclusion of the visit was 'much improved'.

The TDA have asked us to ensure that planned maintenance work which they have been told about happens, we are confident about these plans, the most major of these involves replacing flooring in the emergency department and will take in the region of three weeks to complete and started 29th July.

The TDA colleagues have been invited to return on 21st September to inspect whether we have sustained the progress made to date.

Board members are requested to continue to help by undertaking visits to clinical areas departments and wards, this was enormously supportive and encouraging for staff.

REPORT RECOMMENDATION:

Board members are requested to receive and accept the update, and continue their efforts to ensure that the Trusts remains complaint with standards

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Annual plan - Safe high quality care objectives

PREVIOUS CONSIDERATION:

Quality & Safety Committee

St Chads Court
213 Hagley Road
Birmingham
B16 9RG
20th July 2015.

Colin Ovington; Chief Nurse/Director of Infection Prevention and Control (IPC).
Dudley Road,
Birmingham,
West Midlands,
B18 7QH

Dear Colin,

Re: *NHS Trust Development Authority HCAI Visit 20th July 2015.*

Summary of findings and recommendations

On the 16th and 27th April 2015 I undertook planned visits to the Trust to review the provision of IPC. The visit was part of the TDA development offer. As you are aware I identified breaches in cleanliness and basic IPC on the wards visited and therefore identified that the Trust was **not meeting Criterion 2**; Code of Practice on the prevention and control of infections and related guidance (DH, 2010).

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Further visits were undertaken on 18th May 2015 and 15th June 2015, where again I observed practices which meant the Trust remained non-compliant with **Criterion 2** and in addition **Criterion 9.3.b.**

9.3.b. Clinical procedures should be carried out in a manner that maintains and promotes the principles of asepsis.

Due to the ongoing concerns relating to cleanliness an IPC summit was convened with partners in the CCG and PHE. This was held on 7th July 2015.

Todays visit was to observe how actions to address the identified issues had been implemented.

As we discussed at the feedback, I left the Trust assured that traction was now being garnered to produce a clean environment where staff are again knowledgeable about their roles and responsibilities for IPC.

Key findings for your attention.

- D25: there appeared to be a breakdown in communication between cleaners and ward staff as a side room with two beds was identified by staff as clean and awaiting patients. However, bins had not been emptied, high dust observed, chairs dirty.
- D7: 5 out of 5 chairs checked; all had body fluid ingress.
- Staff group who were not BBE; porters.

Process Undertaken

This was a further formal IPC visit to review the wards at City Hospital following three previous visits (City site and Sandwell site) where concerns had been identified. I was accompanied by Rebecca Evans at all times.

Clinical Findings.
Emergency Department.
Positive Observations.

- Identified IPC Champion.
- Staff were BBE.
- Trolleys were clean.
- Floor was being repaired.
- Ceiling tiles were being replaced.
- Wipes available on BP machines.
- Sharps boxes signed for with temporary lids closed.
- Sluice; cupboard removed.
- All kit PAT tested.
- Washable key boards on order.
- Staff could describe actions being taken and roles and responsibilities.
- Hand wash basins: soap, paper towels and sealant intact.
- Hand hygiene observed.
- Staff were observed wearing appropriate PPE.
- Alcohol hand gel available.
- Cleaners trolley was clean.
- Bins in working order.
- No high dust observed.
- Curtains were clean.
- No high/low dust in resus, ambulance bay.
- Water dispenser clean.
- Crash trolley clean.

Observations Requiring Attention.

- Sluice door not locked.

AMU.

Positive Observations.

- Alcohol hand gel available.
- Cleaning schedules displayed: need version control information.
- PPE available.
- Sluice clean and tidy.
- Ebola posters available.
- Shower clean.
- PAT testing in date.
- Wipeable pull cords in use.
- Hand hygiene observed.
- Chairs intact.
- Equipment trolley clean.
- Dr. observed decontamination stethoscope between patient use.
- Staff were BBE.
- Clean bed space; clean.

Observations Requiring Attention.

- Sharps trays dirty.

D11.

Positive Observations.

- Cleaning schedule displayed.
- Hand gel available.
- Kitchen clean and tidy.
- Hand wash basin seals intact.
- Clean bed space clean.
- No high dust observed.
- Catheter documentation correct.
- Wipes available on BP machine.
- Wipable pull cords.
- Commodes and raised toilet seat clean.
- Sluice clean and tidy.
- Sharps boxes signed for.
- VIP: 2/3 correctly completed.
- No ingress noted on pressure cushion.
- Cleaners trolley clean.
- Pull cords clean.
- New shower chairs clean.
- Toilet brushes clean.
- No kit under U bends.
- Crash trolley clean.

Observations Requiring Attention.

- 3/3 patient tables dirty underneath.
- Patient property in store room not name labelled.
- Crash mat ripped.
- X2 visiting staff were not BBE- ward staff did not challenge them.

D26.

Positive Observations.

- Hand gel available.
- Cleaning schedules visible: version control information required.
- Kitchen clean and tidy.
- Legionella flushing records available.
- Water close to patients so they can rehydrate.
- Wipes available on BP machine.
- Crash trolley clean.
- Bathrooms clean and tidy.
- Clinical room clean and tidy.
- Fans clean.
- Bins in working order.
- Clean bed space; clean.
- Pull cords clean.
- Shower curtains clean.
- Hand hygiene observed.
- Commodes clean.
- Chlorclean records completed.
- PPE worn appropriately.
- Staff could eloquently discuss roles and responsibilities.
- VIP scores documented.
- Catheter care documented.

D25.

Positive Observations.

- Hand gel available.
- Cleaning schedules visible; see previous comments.
- Fan clean.
- Showers clean.
- Hand wash basin seals intact.
- Wipes available on BP machines.
- No kit under U bends.
- Crash trolley clean.
- PAT slide off floor.

Observations Requiring Attention.

- High dust in bathroom.
- "Clean" bed space dirty x2: waste bins, high dust, dirty chairs. There may be a communication breakdown between cleaners and ward staff.
- Sluice requires a Danicentre and paper towel dispenser to be re-sited.

D7.

Positive Observations.

- Hand gel available.
- No high dust observed.
- Disposable wash bowls in use.

Observations Requiring Attention.

- Clean bed space; bed dirty.
- Patient chairs; 5/5 had body fluid ingress. Requested a review of chairs by the end of the day. Escalated at feedback meeting.

- Fabric chairs in day room were stained.
- 1/3 BP machines had decontamination wipes.
- Staff observed not wearing appropriate PPE.

Next Steps

- A further planned review visit: 21st September 2015.
- Progress to be discussed at IDM meetings.

Yours sincerely

Dr. Debra Adams
Head of Infection Prevention and Control (Midlands and East)
NHS Trust Development Authority

SWBTB (8/15) 125 (b)

St Chads Court
213 Hagley Road
Birmingham
B16 9RG
7th July 2015.

Colin Ovington; Chief Nurse/Director of Infection Prevention and Control (IPC).
Dudley Road,
Birmingham,
West Midlands,
B18 7QH

Dear Colin,

Re: *NHS Trust Development Authority led IPC Summit; 7th July 2015.*

Below are the Minutes of today's IPC summit.

Agenda:

Sandwell and West Birmingham NHS Trust
IPC Summit
Venue: City site venue: D29 in the meeting room.
7th July 2015: 11.30 – 13:00

NATIONAL 1 minute silence for victims of 7/7 London bombings at 11.30.

ITEM		
1	Welcome and Introductions	Joint Chairs **Dr. Debra Adams and Michelle Norton** Trust Development Authority **Colin Ovington** Chief Nurse SWB
2	Scene setting / confirmation of why the IPC summit has been called. Poor compliance with: **Criterion 2**: Provide and maintain a clean and appropriate environment. **Criterion 9.3b:** Clinical procedures should be carried out in a manner that maintains and promotes the principles of asepsis.	**Dr. Debra Adams and Michelle Norton**
3	Trust presentation.	**Colin Ovington**
4	Table discussion; what contribution can be made to facilitate the DIPC ensuring the key issues are addressed: a. Governance b. Cleanliness: environment. c. Cleanliness: equipment d. Medical engagement with hand hygiene. e. Asepsis.	Chair / All (external stakeholders e.g. PHE and CCG).
5	Confirm consensus on risks identified and the actions to be taken. Note this must be timely and agree daily, weekly, monthly actions for the key stakeholders as appropriate.	Chair / All
6	Summing up, confirmation of agree actions and timescales	Chair
7	Decide what future action is required. Outcomes of the meeting to be reported to Trust Board and TDA IDM.	Chair

Examples of key people to be invited:

- CCG
- PHE
- TDA: Head of IPC, Quality, DD.
- Trust: DIPC, Medical Director, Estates, Facilities, IPC team, Matrons.

1a Attendees:
Dr. Debra Adams: Head of IPC (Midlands and East) TDA
Michelle Norton: Head of Quality (PD3) TDA
Giles Tinsley: Senior Delivery and Development Manager TDA
Rachael Harrison: Health Protection Nurse West Midlands East - Health Protection Team
Claire Parker: Sandwell and West Birmingham CCG.
Roger Stedman: Medical Director, Sandwell and West Birmingham NHST.
Colin Ovington: Chief Nurse, Sandwell and West Birmingham NHST.
Toby Lewis: Chief Executive Officer, Sandwell and West Birmingham NHST.
Alan Kenny: Director of Estates, Sandwell and West Birmingham NHST.
Steve Clarke: Deputy Director of Facilities, Sandwell and West Birmingham NHST.
Rebecca Evans: Head of IPC Nursing Services, Sandwell and West Birmingham NHST.

1b Apologies: none.

2 Scene Setting.

DA gave an overview of the issues identified at the 4 visits undertaken as follows:

16th April 2015: City	Identified good IPC systems and processes. Poor cleanliness, lack of awareness of roles and responsibilities
27th April 2015: Sandwell	Poor cleanliness and issues with BBE
18th May 2015: City	Poor cleanliness- Findings matched Trusts internal data. Ward staff identified that they had their ward cleaning reduced by two hours/day. They identified that they were now expected to pick up this shortfall and did not have time to undertake this e.g. emptying bins etc.
15th June 2015: City	Poor cleanliness- Findings matched Trusts internal data. Poor doctors HH identified. Dr observed not compliant with ANTT.

IPC Summit called by TDA in agreement with the Trust to discuss issues surrounding:

Poor compliance with:
Criterion 2: Provide and maintain a clean and appropriate environment.
Criterion 9.3b: Clinical procedures should be carried out in a manner that maintains and promotes the principles of asepsis.

3 Trust Presentation.

CO gave an overview of:

The immediate actions taken, areas of focus, short term actions, medium term actions and governance processes.

4 Table Discussion.

The group discussed issues as they were raised during CO's presentation.

- Staff engagement is being garnered utilising a variety of communication mechanisms.
- Staff are being held to account over failures to comply with policy.
- Introduced “OK to ask / OK to act” e.g. challenging staff who do not comply with hand hygiene.
- MN requested assurance that Patient Safety culture tools are being utilised.
- Executive support.
- Key issue that potentially triggered this issue: change in cleaning provision to the wards (reduction of 2hrs/day), reduction in supervisor’s role which occasionally leads to gaps in the rota. This was offset by an increasing nursing workforce to take on equipment cleaning. However, a lack of awareness of new roles and responsibilities has impacted on the plan to introduce the changes. Optimistic cleanliness audit reporting to the Board delayed Trust identification of the emerging concerns.
- GT requested assurance that the Trust had ensured that false board assurance was not being received in other areas. CO confirmed that they now triangulate data to ensure that “optimistic” audits do not provide false assurance.
- RH asked what staff morale was like and did this have a potential to impact on the ability to deliver the changes required. TL responded; he acknowledged that morale was poor at present. However, the Trust had put in systems and process to aim to reduce this.
- RS identified actions associated with medical engagement e.g: training; ANTT/blood cultures, hand hygiene etc. Issues associated with ensuring the training of locums is on the risk register.
- CO described how Matrons/ward managers were working with estates and facilities to provide a robust review of their areas.
- AK described how they had instigated a rapid response team. MN questioned how this would be sustained. The Trust provided assurance that after the initial actions had been undertaken staffing would be provided to continue the snagging requirement.
- RE discussed the introduction of VITAL-PAK which would provide assurance on the care and assessment of patients with devices.
- SC described how cleaning trolleys were now decontaminated on a daily basis and a system was being introduced to undertake an exchange system so that they could be steam cleaned off the ward.
- TL described how the Trust was rewarding good practice, “Chairman’s Award for cleanest ward”.

5 Risks and Action Timeline.

The Trust described their two main risks to not being able to deliver on the required actions in a timely manner: staff engagement/culture and documentation.

Action timeline: TDA revisit July 20th; the group agreed that they would expect to see;

- A clean environment.
- The majority of staff being able to articulate their roles and responsibilities associated with cleanliness.

Next Steps

- A further planned review visit: 20th July 2015 and then 24th September 2015.
- CCG to undertake quality visits to provide assurance.
- To be discussed at the next IDM meeting.

Yours sincerely

Dr. Debra Adams
Head of Infection Prevention and Control (Midlands and East)
NHS Trust Development Authority

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Infection prevention & Control Summit

7th July 2015

Where EVERYONE Matters

Immediate actions

- **Communication**
  - **Urgent meetings – accountability and consequences**
  - **Its OK to ask**
  - **Its OK to act**
  - **Governance - Board discussion**
  - **Discussion at Quality Improvement half day**
  - **Focused communications from Medical Director and Chief Nurse**
  - **Chief Exec Friday message**
  - **Hot topics**

- **Action Plan**
  - **Detailed action plan developed with key lines of responsibility**

- **Monitoring**
  - **Intensified audit processes and supervision**

Areas of focus

- **Cleaning Schedule changes**
  - We did take out two hours of medical equipment cleaning per ward per day as equipment should be cleaned between patient use by the staff who are using the equipment as it is done in almost every trust. We did not take out any environmental cleaning time.
  - Our current schedules Average 16.5 hours per acute ward – this is equivalent to 0.6 hours per bed, in neighbouring trusts the average is 0.5 hours per bed.
- **Dust**
  - There has been increased intensity of damp dusting across the trust, and where necessary retraining of some staff to use equipment provided
  - Radiator covers are now on a rotation to be removed and cleaned, and where necessary walls and paint work beneath the covers made safe
  - Resuscitation trolleys are being checked and form part of the matron audit
- **Supervision**
  - WSO supervision has had increased focus and reinforcing the required standards being assessed
  - Since the last visit daily ward audits have been conducted by supervisors and matrons in conjunction with ward sisters/charge nurses
- **PPE, HH, ANTT, & BBE**
  - OK to ask – and OK too act, remains a cultural challenge for us, there has been lots of communications and we know staff are being challenged from the feedback we get.
  - Staff have been warned about the potential consequences if they don't follow policy.
  - Matrons have an increased focus on documentation of care for VIP, Catheter insertion and ANTT
- **Cleaners trolleys**
  - WSO's have been alerted to this failing and expected to keep their equipment in good state of repair and cleanliness
- **Ward Kitchens**
  - Increased attention, inspection and maintenance activities on the room and the equipment

Next two weeks

- **Keep action plan on track**
- **Additional activities including**
    - **Daily Chief Nurse & Chief Exec walk abouts**
    - **Routine deep cleaning/ decontamination of cleaners trolleys**
    - **Routine maintenance inspections across all sites, to check out any additional works required which has not been previously reported**
    - **Dump the junk day – to help make keeping the ward clean an easier task**
    - **Start to change melamine plates to crockery – pilot on two wards**

Next three months

- **Build in sustainable cultural changes**

    - Continue the use of a check list at the end of a duty period for the ward sister to sign off that the WSO has completed duties to a satisfactory standard and to build in accountability and ownership

    - ‘Chairman's award for the cleanest ward or department’ – some form of reward structure, generating healthy competition, monthly but with a cumulative points for the annual staff awards. This will require on-going validated audit and checking

Governance

- Clinical Leadership Executive
- Patient safety Committee
- Infection Prevention & Control Advisory Committee (IPCAC)
- Link to Quality & Safety sub committee of the board
- Operational discussion at Chief Nurse Business meeting and Matrons meeting
- IPC risk register and assurance framework routinely monitored at IPCAC

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

City Hospital wards D26 /D12	Infection, Prevention and Control Advisory Committee
Reason for action plan:	Poor standards
Date of action plan	17.04.2015
Operational Lead:	S Clarke /J Clarke
Expected completion of action plan:	Physical application to begin immediately
Version	2 – 18.0515
Up dated Monday the 15th of June	

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

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

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

Table 1 – Specific issues identified by ward and department

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

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

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

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

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

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

	Issues identified and Action Required	Person Responsible	Action Required	Completed
	• Bread bin , no lid and requires cleaning	K.Godwin-Facilities/J Briant	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Beverage machine requires cleaning	K.Godwin-Facilities/J Briant	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Condiment holders need cleaning	K.Godwin-Facilities/J Briant	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Domestic hat on top of regen trolley(hat soiled)	K.Godwin-Facilities/J Briant	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	• Plate stand needs cleaning	K.Godwin-Facilities/J Briant	Schedules/procedure /audit/ staff on the spot training all areas	Complete
	Visit 18.04.15			
	• High Dust observed	K.Godwin-Facilities/J Briant	• Need to review cleaning tools and practices	Complete
	• Bed pans visibly contaminated	Tracy Weston- Ward Manager	• Need to reinforce to staff need to clean between each patient use	Daily checklist now in place for cleaning
	• Commodes Contaminated	Tracy Weston – Ward Manager	• Need to reinforce to staff need to clean between each patient use	Daily checklist now in place for cleaning
	• Microwave dirty	K. Godwin	• Need to review monitoring process	Complete
	• Workmen observed putting dirty tools on top of drinks machines	R.Evans	• Challenged at time of audit. • Email to Kevin Reynolds to reinforce to workmen and contractors staff practices.	Completed
	• Wipes not available on all BP machines	Tracy Weston – Ward Manager	• Need to ensure wipes are readily available	Additional wipes ordered to ensure one for each Bp machine
	• Toilet Seat Contaminated	K.Godwin	• Needs review as part of cleaning process	Complete
	• Crash Trolley dusty	Tracy Weston – Ward Manager	• Need to review monitoring process for cleaning	On part of daily check list for cleaning
	• Shower curtain stained	K.Godwin-Facilities/J Briant	• Needs replacing	Complete
	• Multi – use skin cleansers – should be single patient use	Tracy Weston – Ward Manager	• Challenged at time of audit.	Completed
	• Chairs ripped	Tracy Weston – Ward Manager	• Need repair or replacement	Chairs discarded
	• No lid on chlor clean bottles	Tracy Weston – Ward Manager	• Need to ensure staff adhere to H&S and COSHH guidelines	Completed
D25	Visit 18.05.15			
	• Kitchen surface damaged	Jo Mansell – Ward Manager	• Need to report to estates	Reported on

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

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

Table 2 – Corporate Actions

	Action taken by Facilities.	By whom	Date Completed
	Review and monitor staffs adherence to working procedures.	K.Godwin-Facilities/Departmental Managers	24th April

	Raise awareness to working schedules for wards and departments.	K.Godwin-Facilities/Departmental Managers	Complete
	Re-issue of pocket schedules for all wards.	K.Godwin-Facilities/Departmental Managers	24th April
	Re-introduction of random departmental and senior manages audits of the audit process.	K.Godwin-Facilities/Departmental Managers/Monitory officer	24th April
	Reinforcement of daily positive/productive communication/hand over of service information.	K.Godwin-Facilities/Departmental Managers/Supervisors	24th April
	Strengthening of audit process, audit/rectification officers to be trained by infection control to ensure an aligned approach to the audit process.	K.Godwin-Facilities/Infection control/Departmental Managers/Supervisors	28th/2nd June
	Proactive back to the floor daily tours of inspection by departmental managers.	Departmental Managers	24th April
	Re-introduction of senior manager's weekly inspections.	Deputy director of Facilities/Head of Facilities/Infection Control/Estates/Catering Manager/Departmental Managers	24th April
	Reinforcement of the use of documented rectification process for poor standards.	K.Godwin-Facilities/Infection control/Departmental Managers/Supervisors	24th April
	Staff on D11/D26 booked on domestic retraining program.	Departmental Managers/Training Supervisor.	8th May
	Re-introduction of deep cleaning program of Burlodge trolleys	K.Godwin-Facilities/Catering Manager/ Departmental Managers	29th April
	Deep clean of ward/departments radiators	K.Godwin-Facilities/Estates Manager/ Departmental Managers/Supervisors	27TH April
			17th April
	Sharps container on wards with wrong colour lids - requires Facilities to review sharps container and training at ward level	Dawn Hall	
	Facilities Action plan following revisit by TDA on the 18th of May.	By whom	Date Completed
	Equipment audit /purchase of replacement and additional tools where requirement identified.	K.Godwin-Facilities/Departmental Managers	12th June
	Revises local ordering of cleaning materials/stock control.	K.Godwin-Facilities/Departmental Managers	12th June
	Additional adjustments of work schedules on City wards to ensure clarity for allotted time for cleaning of sanitary areas.	K.Godwin-Facilities/Departmental Managers	Complete 31/05/2015
	Retraining of Supervisors in the poor audit rectification process.		20th May
	Introduction of Schedules for the audit process.	K.Godwin-Facilities/Departmental Managers/Supervisors	12th June
	Introduction of weekly formal handover/feedback audit meetings with Departmental managers and Supervisors.	K.Godwin-Facilities/Departmental Managers/Monitory officer	12th June
	Reinforcement/clarity of escalation procedure for poor standards. .	K.Godwin-Facilities/Departmental Managers	20th May
	Increases re-training on cleaning techniques to 6 monthly for staff that are under performing were identified through the audit process or complaints from Ward/Departmental managers.	K.Godwin-Facilities/Estates Manager/ Departmental Managers/departmental trainer.	12th June
	Reintroduction on the job assessment of staff against cleaning procedures.	K.Godwin-Facilities/Estates Manager/ Departmental Managers/departmental trainer.	12th June
	Action by IPCS and Risk Management following TDA visit	By whom	Completed
	All wards were audited by IPC and Risk Management week commencing 11.05.15 findings were disseminated as outlined below.	IPCS/ Risk Management	Completed
	• Verbal Feedback was given to all ward Managers at the time of the audit.	IPCS/ Risk Management	Completed
	• Where cleaning labels had been removed these have been replaced with instruction	IPCS/ Risk Management	Completed

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

	implemented on Monday the 15th of June by Colin Ovington chief Nurse		
	Action taken by Nursing /Facilities.	By whom	Date Completed
	Daily Cleaning Audits on all clinical areas by ward Managers/Matrons	Departmental Managers/Matrons	Ongoing
	Cleaning Audits on areas by senior ward service officers as per National standards of Cleanliness to be carried out with the Ward Managers.	K.Godwin-Facilities/Departmental Managers	Ongoing
	Ward services Daily briefing meetings with Hotel services Manager/Departmental managers/senior ward services officers	K.Godwin-Facilities/Departmental Managers/Senior Ward Service officers	Ongoing

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:	6th August 2015

EXECUTIVE SUMMARY:

This report is an update using the data collected during June 2015.
The data from the national reporting system has been applied to our own expected staffing data to help understand our nurse staffing position.
Data accuracy continues to be a concern as I have reported in previous months, this month colleagues from the TDA have helped us unpick the data and revealed an issue with the collection of planned staff data. We have been applying the actual rota rather than the planned establishment into the data return. This will increase the fill rate artificially, our team are working to correct the methodology to ensure that the July data is reported in accordance with the rules

Quality indicators are presented in the appendices medicine and emergency care have given their quarterly review as part of this paper which demonstrates how they are using the dashboard to ensure performance and to action plan for improvements.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
X		

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

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

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

Relates to our safety objectives and BAF

PREVIOUS CONSIDERATION:

Monthly at Trust Board

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAFE NURSE STAFFING

Report to Trust Board on 6th August 2015

1 EXECUTIVE SUMMARY

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

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

1.3 Last month I reported that the TDA were to make an advisory visit to explore the staffing return, this visit took place 16th July, a written response is expected during the week commencing 3rd August. Their verbal feedback was supportive, but did identify a potential gap in our baseline plan data.

2 JUNE 2015 POSITION

Table 1. is the output data from the national data collection for June 2015 which demonstrates that we achieve higher fill rates against our rota's in most areas. These data are closely aligned to the previous months, however given the work that we have undertaken with the TDA there is a note of caution about the accuracy. As a result of our work with the TDA a revised methodology will be applied to the July data which gets reported in the September Board meeting

Table 2 gives the individual ward data. Although some of the variances previously seen are less obvious, Newton 4 has a fill rate of over 300% at night. This I believe to aligned to the methodological problems we have unearthed with colleagues from the TDA.

The acute ward quality indicators are presented in appendices 1 and 2 to help add context to the staffing numbers and fill rates.

3. TDA ADVISORY VISIT 16th JULY

Colleagues from the senior nursing and HR teams at the TDA visit to the trust to see if there was anything in the way we submit monthly nurse staffing data which is reported to the Board could be improved. Members will recall that I have consistently reported fill rate percentages which are above 100% and that we have been undertaking randomised audits every month to check the data. I welcomed the visit on the basis that over 100% fill rate doesn't feel reflective of actual ward staffing.

Their written report has not yet been received by the trust however summary verbal feedback was in the main complimentary, ward staff were interviewed across the City hospital wards and the general view, supported by TDA colleagues is that we have the right numbers of staff on the ward establishments but that the gap created by vacancies and sickness are a problem. This is reflective of information to the board in previous reports. They were very assured by our safe staffing model.

The gap in the planned data is explained as changing every month. The only variation expected to be identified in the plan would be the changes in numbers that reflect the number of days in the month, so there are more staff on the plan in a 31 day month compared to a 30 day month. However our plan has been moving more than this level of variation. These data are derived from our e-rostering system. The summary problem that we collectively unearthed is that the data submitted has not been the plan, but the actual calculated rota at the point it is signed off and before any temporary staff are added. This is not the planned establishment which the board signed off. The working hypothesis is that we have been submitting the actual numbers on the roster when it is signed off and not the planned numbers as the denominator. This is a crucial difference as the fill against plan will look higher if what can be achieved on the original rota is less than the planned. This problem is currently being worked through by the e-rostering and information teams and have a corrected methodology for the data that is due to be submitted on 15th August. An example calculation is given at the end of this note to help illustrate the problem.

Members will also recall that the information team have checked our methods with colleagues at the TDA and were previously thought to be correct; hence our data is signed off on a monthly basis.

Worked example to aid understanding of the variance to illustrate the problem

Our planned establishment is to have 5 registered nurses on a shift
Because of vacancies and sickness we can only manage to achieve 3 on the rota
Because we fill the gap with temporary staff and accommodate a focused care with one additional nurse we end up with 6 nurses on duty

Denominator is 5, the numerator is 6, the percentage fill rate is 120% (right calculation)

However it appears that we have used the actual rota as the denominator

Denominator 3, the numerator is 6, the percentage fill rate is 200% (Wrong calculation)

Table 1.

	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 (%)
Jan-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2123.25	2227.333	505.5	492.25	582.75	555	129.5	157.5	104.9%	97.4%	95.2%	121.6%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
	RXK02	CITY HOSPITAL	30328.5	30574.63	15962.5	15937.82	18989.5	20653.42	7731	8767.25	100.8%	99.8%	108.8%	113.4%
	RXK10	ROWLEY REGIS HOSPITAL	2919	3183.5	3472.5	3411.5	1333	1558.5	1429	1542.25	109.1%	98.2%	116.9%	107.9%
	RXK01	SANDWELL GENERAL HOSPITAL	29286.5	30702.12	17609.5	19883.43	16561.5	18341	8455	11660.25	104.8%	112.9%	110.7%	137.9%
			64657	66688	37550	39725	37467	41108	17745	22127	103.1%	105.8%	109.7%	124.7%
Feb-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1867.25	2053.5	464.5	462	490.25	518	129.5	101.75	110.0%	99.5%	105.7%	78.6%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
	RXK02	CITY HOSPITAL	27390.25	27677.75	14544.5	14620.48	17409.5	18193.92	6915.5	7414.25	101.0%	100.5%	104.5%	107.2%
	RXK10	ROWLEY REGIS HOSPITAL	2542	2743.25	3000.5	3185.5	1194.5	1192	1457.5	1407	107.9%	106.2%	99.8%	96.5%
	RXK01	SANDWELL GENERAL HOSPITAL	25298.5	27136.1	14521.5	16240.82	14720	16798	7292	9867.25	107.3%	111.8%	114.1%	135.3%
			57098	59611	32531	34509	33814	36702	15795	18790	104.4%	106.1%	108.5%	119.0%
Mar-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2353.25	2352.417	501.5	447	573.5	565.25	148	139.5	100.0%	89.1%	98.6%	94.3%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
	RXK02	CITY HOSPITAL	29823.73	30744.15	16727.5	15515.32	18670	21136.23	7507.5	7752	103.1%	92.8%	113.2%	103.3%
	RXK10	ROWLEY REGIS HOSPITAL	2702.5	3084.9	3546.75	3896.583	1211.5	1717.75	1670.5	2067	114.1%	109.9%	141.8%	123.7%
	RXK01	SANDWELL GENERAL HOSPITAL	28133.5	30365.28	15989.5	17373.25	15995	20147.07	7760.517	10975.02	107.9%	108.7%	126.0%	141.4%
			63013	66547	36765	37232	36450	43566	17087	20934	105.6%	101.3%	119.5%	122.5%
Apr-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	1502	1941	305.5	396.25	444	536.5	92.5	101.75	129.2%	129.7%	120.8%	110.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
	RXK02	CITY HOSPITAL	30171.5	31776.33	16684	15468.25	18810.5	20221.75	7285.5	8325	105.3%	92.7%	107.5%	114.3%
	RXK10	ROWLEY REGIS HOSPITAL	2614	2568.5	3772	3448.067	1116.5	1351.5	1763	1778	98.3%	91.4%	121.0%	100.9%
	RXK01	SANDWELL GENERAL HOSPITAL	27100	29153.3	15850.25	17460.35	16443.5	18445.28	7508	10431.5	107.6%	110.2%	112.2%	138.9%
			61388	65439	36612	36773	36815	40555	16649	20636	106.6%	100.4%	110.2%	123.9%
May-15	RXK03	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	2034.5	1941	434	402.25	573.5	527.25	138.75	138.75	95.4%	92.7%	91.9%	100.0%
	RXKTC	BIRMINGHAM TREATMENT CENTRE	0	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%
	RXK02	CITY HOSPITAL	32094.5	32675.33	16822.25	16256	19465	21176.25	7493	8437	101.8%	96.6%	108.8%	112.6%
	RXK10	ROWLEY REGIS HOSPITAL	2645.5	2576.067	3508.5	3169.083	1083.5	1475.067	1842.5	2033	97.4%	90.3%	136.1%	110.3%
	RXK01	SANDWELL GENERAL HOSPITAL	26561	27802.15	15591.5	17242.17	16839	17383.17	8199.5	10655	104.7%	110.6%	103.2%	129.9%
			63336	64995	36356	37070	37961	40562	17674	21264	102.6%	102.0%	106.9%	120.3%
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%
3-month Avges	*RXK03*	*BIRMINGHAM MIDLAND EYE CENTRE (BMEC)*	*1937.583*	*2018.056*	*386.1667*	*408.1667*	*524.1667*	*530.3333*	*132.5833*	*141.75*	106.7%	108.0%	102.6%	107.0%
	RXKTC	*BIRMINGHAM TREATMENT CENTRE*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0.0%	0.0%	0.0%	0.0%
	RXK02	*CITY HOSPITAL*	*30191.83*	*31306.61*	*16305.48*	*15493.17*	*18852.17*	*20345.26*	*7175.667*	*8088.772*	103.7%	95.0%	107.9%	112.7%
	RXK10	*ROWLEY REGIS HOSPITAL*	*2567.167*	*2506.439*	*3652.333*	*3293.383*	*1167.5*	*1440.189*	*1730.833*	*1909.167*	97.6%	90.2%	124.0%	110.7%
	RXK01	*SANDWELL GENERAL HOSPITAL*	*26829*	*28511.18*	*15652.75*	*17356.27*	*16140.67*	*17683.73*	*8046.667*	*10423.17*	106.3%	110.9%	109.7%	129.9%
	Total	*Latest 3 month average====>*	61526	64342	35997	36551	36685	40000	17086	20563	104.6%	101.6%	109.1%	120.4%

Table 2

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during June 2015	Percentage night time fill rate during June 2015		Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during June 2015	Percentage night time fill rate during June 2015
Medicine & Emergency care	D5	City	13	5	5	5	95.2	114		1	1	0	84.5	
	D7	City	19	3	3	3	joint with	D5		1	1	0	Joint with	D5
	D11	City	21	3	3	3	98.1	123.8		2	2	1	87.5	117.4
	D12	City	10	2	2	2	94.5	89.6		1	1	1	89	78.9
	D15	City	24	3.5	3.5	3	124.5	100.3		2	2	1	112.4	120.7
	D17	City	25	3.5	3.5	3	97.8	100		2	2	1	97.7	127.6
	D26	City	21	3	3	3	90.7	90.2		2	2	1	73.8	99.8
	AMU 1	City	41	10	10	10	102.5	131		4	4	4	94.5	97.8
	AMU 2	City	19	5	5	5	97.1	121.5		1	1	1	90.1	116
	CCU Sandwell	Sandwell	10	3	3	3	108	95.9		0	0	0		
	PR4	Sandwell	25	7	7	7	100.9	104		3	3	3	118.1	115
	PR5	Sandwell	34	5	5	4	96.8	116.5		3	3	2	101.6	101.3
	NT4	Sandwell	28	4	4	4	132.8	160.9		3	3	3	175.9	316.5
	LY 4	Sandwell	34	5	5	4	133.1	184		3	3	2	121.6	106.3
	LY5	Sandwell	29	4	4	4	95.7	90.6		4	4	2	97.4	112.2
	N5	Sandwell	15	5	5	2	102.8	100		1	1	1	98.6	83.3
	AMU A	Sandwell	32	11	11	11	103.3	114.5		4	4	3	96.4	104.5
	AMU B	Sandwell	20	3.5	3.5	3	114	102		3	3	3	115.9	121.4

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during June 2015	Percentage night time fill rate during June 2015		Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during June 2015	Percentage night time fill rate during June 2015
Surgery A	D21	City	23	4	4	2	101.4	110		2	2	2	82.3	99.2
	D25	City	19	4	4	2	101.1	104.2		2	2	2	103.5	109.3
	SAU	City	14	4	4	3	100.9	109.5		1	1	1	113.5	159.5
	N2	SGH	24	4	4	2	103.8	111.8		2	2	1	111.5	158.8
	L2	SGH	20	6	6	4	105.9	142.4		3	3	2	94.1	95
	P2	SGH	20	5	5	3	103.6	106.6		4	4	3	114.7	131.8
	N3	SGH	33	5	5	3	110.7	145.3		4	4	3	111.6	113.7
	L3	SGH	33	5	5	3	102.7	108.4		4	4	3	96.2	91.9
	CCS	City		Staff flexed to the dependency/number of patients in the units			99.5	102.2		Staff flexed to the dependency/number of patients in the units			92.2	
	CCS	SGH					98.8	103.4					110.5	

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during June 2015	Percentage night time fill rate during June 2015		Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during June 2015	Percentage night time fill rate during June 2015
Community & Therapies	Henderson	RH	24	3	3	2	85.1	123.2		3.5	3.5	2.5	85.4	99.6
	Elisa Tinsley	RRH	24	3	3	2	100.6	93.2		3.5	3.5	2.5	83.9	116.7
	D43	City	24	6	6	4	99.6	165.8		5	5	2	92.6	104.4
	Leasowes	RH	20	3	3	2	103.9	152.9		3	3	2	96.9	158.2

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during June 2015	Percentage night time fill rate during June 2015		Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during June 2015	Percentage night time fill rate during June 2015
Surgery B	Eye ward	City	10	2	2	2	95.4	101.7		1	1	0	95	111

	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 June 2015	Percentage night time fill rate during June 2015		Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during June 2015	Percentage night time fill rate during June 2015
Womens & Children's	L G	SGH	14	3	3	2	112.1	102.4		1	1	1	102.4	
	L1	SGH	26	5	5	4	123	126.4		3	3	2	146.1	172.4
	D19	City	8	3	3	2	105.6	94.6		1	1	0	120	
	D27	City	18	4	3	2	101.3	105.7		2	2	1	119.7	173.9
	Maternity	City	42	6	5	4	95.5	101.9		4	4	2	92.4	112

3 RECOMMENDATION(S)

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

3.2 To receive an update at the September Trust Board meeting

Colin Ovington

Chief Nurse

30th July 2015

Appendix 1. Medicine & Emergency Care

CONDITION REPORT – ACUTE WARDS

MEDICINE & EMERGENCY CARE (April 15- June 15 Q1)

Background

Ward dashboards were introduced across all wards in October 2014. Audits that support the KPIs were introduced during December and January 2015. There has been significant improvement in data collection across all the domains. Therefore, the Group has a better understanding of 'hot spot' areas, thus allowing for a more focused response and support to key areas. Attached in appendix 1 is a three month profile of the wards for Q1

There are two red risk assessments currently on the Group Risk Register:-

- Additional beds being open and the inability to safely staff.
- Safe staffing levels due to high numbers of vacancies.

This Condition report is based on data provided by the dashboards, Matron Condition reports and quarterly ward reviews with the Ward Clinical Teams.

D17 – Remains in special measures. A position report was sent to the Chief Nurse on the 10Th July 15. Dashboard indicates some key issues which was supported by an independent review of the area in June 2015 (Lorna Kelly – Corporate Nursing)

This Condition report will follow the format of the ward dashboard, highlighting the key areas against agreed KPIs.

Patient Safety

Medicine safety crosses have been introduced across Medicine and Emergency Care since

February 15. Compliance remains variable across the acute wards. However, early indicators

suggest some improvement within the Group relating to drug errors .There were 38 IR1s

generated in Q4 relating to drug errors, this has reduced to 22 IR1s within Q1 .

Audits against fluid balance audits suggest on-going work is required, particularly cumulative balances. It has also been identified that further education and training is required so that nursing staff have the ability to triangulate data with blood results, medication and observations. The aim is to provide a greater understanding of the importance of accurate fluid balance recording.

There were 53 falls recorded during the three month period of which 5 were reported as

causing harm to patients. Only one of the five to date has had a TTR recorded as unavoidable.

There were no identifiable trends identified specific to individual wards or sites.

During Q1 86 pressures sores were identified as being non-hospital acquired. 20 pressure sores were identified as hospital acquired.13 incidents related to the City site and 7 incidents related to the

Sandwell site. 17 IR1s generated related to grade 3 pressure sores of these 5 were hospital acquired.

FFT compliance remains variable across the Group. Some of these issues are due to ipads not functioning that require replacing. Areas where there is poor compliance. Matrons have been requested to complete an action plan for improvement.

During Q1 there were 8 red IR1s reported these related to falls with harm, 1 V& A, grade 3 pressure sores and a BB bacteraemia. 64 amber incidents were recorded across the Group for Q1. P4 recorded as 12 amber incidents relating to V & A the patient lacks capacity and is MFFD, requiring two RMNs and a security guard 24/7.

Infection Control

Full clean and decant of L4 and N4 completed in June 2015.This was following an outbreak of

norovirus and CDiff during the winter months.

One MRSA bacteraemia within D26 – TTR outcome unavoidable.

One ecoli blood borne infection D11.

Staffing

Staffing levels remain an ongoing concern. With high usage of bank and agency, ED is a

particular area of concern with 19 vacancies across the two sites. Whilst there is on-going recruitment, it has been reported that there is a reliance on agency as the fill rate from bank is not able to meet demand. The vacancy position statement is attached in appendix 2.

A Recruitment day has been held on one Saturday every month since April 15, reducing the Groups vacancies to 32.37 wte. However, many of the appointed candidates are new recruits and will not be in a position to commence in post until September 15. Therefore the reduction in bank and agency usage will not be seen until October 15.

Mandatory training and PDR compliance has improved significantly in most areas with many of the wards achieving Trust target. Group PDR 87.17 %, Group Mandatory Training 86.07%

Sickness remains above the Trust trajectory at 4.75 % for the Group. Focused meetings with HR, /Finance, GDoN and the ward clinical teams have been undertaken.

Issues have been identified re the recording of data between ESR and E rostering. Staff were advised to record on E roster closing of sickness and return to work interviews. However, there appears to be an issue with extracting data from one system to another. Therefore the ward teams have been requested to dual record on both systems.

City wards have raised concerns regarding the 'new ward establishments' with geography of the wards and high acuity being the main issues. A paper outlining proposals to increase staffing on the City wards was submitted to the Chief Nurse on the 22nd May 15.

L4 remains a high risk area for the Group with an early warning trigger tool score of 48 (high risk) . The ward has 10.52 wte band 5 vacancies some of these post have been recruited into but will not commence in post until September 15. Controls agreed to mitigate some of the risk was to reduce the ward by 6 beds from 34 to 28 beds.

A proposal to merge L4 and L4 as part of the bed closure scheme would certainly help alleviate the nurse staffing issues within the Group.

Finance

Overspend analysis across nursing:

Total of £538,504 relates to Admitted Care Directorate. Outline of key areas:

- £309k extra capacity.
- Stroke - £180k of this £137 K relates to one patient requiring 2 RMNs and 1 security office 24/7. On-going discussion with CCG to progress discharge.
- D17/16 - £91k due to agreement for additional staffing relating to special measures.D17 have reduced bed compliment from 25 beds to 19 beds following concerns raised about quality safe care. Following the move to D16 it is anticipated the need for additional staff will no longer be required and that the ward will stay within financial balance.
- All additional band 2s as part of the new ward establishment have been redeployed across Medicine, this net effect will be seen within until 15 budgets.
- A total of £130k relates to Emergency care – ED

ED has 19 vacancies across the two sites of all grades. 6 band 5s have already been recruited with a further recruitment day booked for the 8th August 15.PDNs have been tasked with organising a recruitment event as an open day within the departments to attract the more senior grades.

Scheduled Care generating an under spend against nursing Q1.

Action agreed for Q2 as part of ward review process

FFT Compliance – All wards set a target to achieve 45 % response rate by the end of Q2.

ED leads for FFT to develop action plan to improve response rates.

All wards to confirm one discharge the day before and plan for discharge before lunch.

Key Successes

Ten out of Ten well embedded across the wards with many areas achieving 100 %.

D15 and P5 commended for their work relating to board rounds and patient flow.

D26 commended by the TDA for making significant improvement against hygiene standards.

Many of our ward areas have maintained a financial balance CCU, AMUs across the two sites. We suggest that areas that have demonstrated financial balance have the freedom to book additional bank/agency staff without going through the GDoN for approval.

Sepsis flow chart introduced on N4 – evidence indicates EMRT calls reduced by 40 %.

- L4 has been successful in winning a joint award with Black Country Mental Health for their work on Delirium.

Required Support

During the ward reviews many of the wards raised concerns about the new mattresses purchased for the Trust. It has been reported that our patients are developing early signs of pressure damage to heals. This will require monitoring to identify if there is an increase in grade 2 pressure sores across the Trust during the next few months. Lead for tissue viability has been informed and made aware of our concerns.

Concerns have been raised regarding the amount of transfers from Critical Care at Sandwell with VRE, particularly patients transferred to N5 requiring isolation. With limited isolation facilities within N5 this could potentially pose a significant risk to immune compromised patients.

MEDICINE AND EMERGENCY CARE
VACANCIES - 23.07.2015

WARD/DEPT	Current Establishment		BAND 7	BAND 6	BAND 5	BAND 4	BAND 3	BAND 2	STATUS	Total B5 Vacancies following Recruitment Days
CITY	**Qualified**	**Unqualified**								
AMU1	44.24	20.35							No vacancies, all appointed to. 13 candidates commencing in	
AMU2	26.44	5.09							September 2015. 1 B5 appointed from Recruitment day 18/07	
ED - City	72.88	20.06	1.51	4.61	6.95	0.2	2.92	2.55	1 WTE Band 5 on Secondment. 1 B5 appointed from Recruitment day 18/07	4.95
D5/D7	51.96	7.08							recruited 3WTE at B6 in 9/7/15 New establishment confirmed post reconfiguration as both D5/D7 and CCU joining together.	
D11	17.04	8.71			4.64			<0.45	Appointed 1.0 wte B5 on Recruitment Day 16/05/2015	3.64
D12	11.48	5.15			1.58			0.2	1wte appointed on Recruitment Day on 16/05/2015	0.58
D15	18.82	8.51	1	0.2	5.31				3 wte appointed on Recruitment Day on 20/06/2015 and 16/05/2015	2.31
D17	18.82	8.51	1	1	6.88				4 wte B5 appointed on 16/05/2015 and 20/06/2015 recruitment days. 2 B5 appointed from Recruitment day 18/07	0.88
D26	13.24	8.6			1.81			>1.14	Appointed 2.0 wte B5 on Recruitment Day 16/05/2015.	1.81
SANDWELL	**Qualified**	**Unqualified**								
AMUA	50.45	18.71			5.92				3 B5 candidates appointed across AMUA/B. 2 B5 appointed	
AMUB	18.81	7			4				from Recruitment day 18/07	4.92
ED - SGH	67	14			3			1	1.0 wte B7 on secondment. 2 B5 appointed from Recruitment day 18/07	4
Priory 4	31.47	12.25		1	2.02			1.34	B6 appointed to start date 03.08.2015 B5 starting 10.08.2015, x3 starting 12.09.2015, Interviews for	0
Newton 4	19.12	13.76		1	2.73			0.81	Interviews for Band 6 July 2015, 1x Band 5 starting July 2015, 0.6 Band 5 starting October 2015, 1x Band 5 out to advert closes 29.07.2015(speciality interview). 1 B5 appointed from Recruitment day 18/07	1.73
Lyndon 4	21.67	13.27			10.52				3.0 wte B5 appointed on Recruitment Day 20/06/2015 & 16/05/2015. 1 B5 appointed from Recruitment day 18/07.	6.52
Lyndon 5	19.12	15.77			3.55			0.17	1 wte B5 appointed on Recruitment Day on 20/06/2015	2.55
Newton 5	15.11	5.15						0.4		
Priory 5	21.67	14.8			3.34				Interview date being arranged as speciality ward organising own interviews	0
CCU	16.26			0.39				0.24	Band 2 0.24 wte Ward Clerk post	
TOTAL					**62.25**					**33.89**

RECRUITMENT DAYS

Recruitment Open Day planned for 18th July 2015 (City) - 25 candidates invited
Recruitment Open Day planned for 8th August 2015 (Sandwell).

25 Band 5 Appointments made in Recruitment Days held in April, May and June 2015. 4 Candidates have withdrawn.
2 Candidates not appointed

Appendix 2 – Surgery A

Ward Clinical Teams - Quality, Safety and Patient Experience Dashboard June

Leading the Culture of Compassionate Care

	Area	Unit	CITY									Sandwell								
			D11	D12	D15	D17	D26	AMU1	AMU2	D5	D7	L4	P4	N4	L5	N5	P5	CCU	AMU A	AMU B
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	97	100	100	87	92.5	100	100	100	100	100	100	100	100	100	100	100	95	100
	Nutrition Audit (MUST)	Score %	100	100	100	63	100	100	90	100	100	92.8	100	100	92.8	100	100	100	95	66.6
	Fluid Balance Audit	Score %	70	100	100	100	70	100	100	100	100	60	100	100	85	100	92	90	86	45.45
	Pain Audit (CQUIN)	Score %	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	71.23
	Safe storage of drugs audit	Score %	100	100	100	88	100	Not done	100	89	89	100	100	100	100	100	89	N/A due Jul	92	94.74
	Compliance against drug safety cross	Score %	66	90	77	37	90	83	60	90	83	50	87	95	80	90	100	100	73	95.65
	Observation Chart Audit	Score %	100	99	99	99	100	Vitalpac	Vitalpac	100	100	57	100	100	88	100	100	100	94	71.23
	Falls Risk Assessment Audit	Score %	100	100	100	95	90	100	100	100	100	100	100	100	100	100	100	100	80	100
	Safety/Privacy & Dignity	Score %	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	0
	Pressure Ulcers Avoidable (none hospital acquired)	Score %	3	1	0	0	0	0	0	0	0	1	2	1	1	0	1	0	4	1
	Pressure Ulcers Avoidable (hospital acquired)	Score %	2	0	0	3	2	1	0	0	0	0	1	3	0	0	4	0	0	0
	Falls (target <) no harm	Score %	2	0	0	2	3	0	0	1	1	0	2	1	7	2	1	0	0	
	Falls (target <) resulting in harm	Score %	0	0	0	0	1	0	0	0	0	1	0	0	1		0	0	0	0
	Dementia screening audit	Score %	90	N/A	100	100	100	100	100	100	100	100	100	100	100	100	100	100	85	100
	Safety Thermometer (No new harm)	Score %	100	66.6	100	91.3	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	Incidents Total (inc Falls)	No of	22	10	12		19	24	9	7	4	16	10	6	25	4	17	20	40	18
	Incidents (red)	No of	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0	0	0
	Incidents (amber)	No. of	0	0	0	2	1	7	1	0	1	1	1	2	0	0	0	0	1	0
	PALS Queries	No of	0	0	0	2	1	1	0	0	0	0	1	0	0	1	2	0	1	0
	Compliments	No. of	1	7	8	10	14	1	1	5	3	6	11	36	5	15	23	3	5	13
	Complaints	No. of	0	0	1	1	1	1	1	0	0	0	1	1	0	1	1	0	0	1
	Likely to/Extremely Likely to Recommend our Hospital	Score (%)	95.45	0	96.8	75	96.23	95.2	93.33	100	100	26	79	100	34	100	85	90.32	70.59	92.73
	Mixed Sex Breaches	No. of	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	10/10 Standard	Score (%)	100	100	100	50	100	100	100	100	100	100	100	100	100	100	100	100	100	90
Infection Prevention and Control	MRSA Screening	Total Eligible Screened within 28 days (%)	100	0	0	0	50	0	0	86	71	100	0	2	100	0	0	93.75	90	100
	C Diff	No. of	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
	E-Coli	No. of Bloodstream	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
		No. of Bloodstream YTD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	Hand Hygiene	Score (%)	98	100	100	100	100	Variable, done daily	94	92	90	100	100	100	97	100	100	100	100	100
	ESBL	Score (%)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	VRE	No of	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0
	Ward Cleanliness	Score (%)	100	100	87	40	100	No issues. Daily inspections since TDA report	No issues. Daily inspections since TDA report	92	96	90	100	100	92	100	100	97.25	89	87
	Compliance against environmental standards	Score (%)	100	98.4	95	72	100	100	100	100	100	90	98	98	90	100	92	50	89	87
	Outbreaks	No. of	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Post infection reviews	No. of	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	N/A	0	0
	Cannulas (VIP), (CAUTI's)	Score (%)	96	100	65	80	93	70	100	100	100	87.7	95	100	0	80	95	100	81	80
Patient Flow	No of days daily discharge goals achieved No of days where 16 beds are available at 9pm (AMUs)	No. of	5	19	19	11	7	N/A	N/A	50%	57%	22	6	3	20	12	14	21	N/A	N/A
	No of days where patient discharged before lunch	No. of	13	2	25	16	10	N/A	N/A	7	8	2	2	5	0	3	8	13	N/A	N/A
Staffing	Vacancies Band 7	No. of	0	0	1	1	0	0	0	1	1	0	0	0	0	0	0	0	0	0
	Vacancies Band 6	No. of	0	0	0.2	1	0	1	0	4.02	4.02	0	1	1	0	0	0	0.39	0	0
	Vacancies Band 5	No. of	4.73	1.58	5.31		4.81	0	5.61	2.48	2.48	8.87	0	1	3.35	0	4	0	6	5
	Vacancies Band 2	No. of	3.83	0.2	0	0	2.34	0	0	0	0	0	4	2	0.17	0.4	-3	0	0	0.08
	Sickness long term	%				0		2.25	2.39	0	0	1	0	0	5.76	3.63	4.76	6.2	0	0
	Sickness short term	%	0					1.27	2.13	4.3	4.3	4.9	6.5	1.4	4.62	3.47	2.98	1.9	5.6	5.6
	Sickness total	%						3.51	4.52	4.3	4.3	5.9	4.28	4.8	10.38	7.09	7.74	8.1	5.6	5.6
	No of specials used	No. of		0	0	48	4.09	0	0	0	0	3.8	43.14 hrs	160 hrs	9	1	17.2 wte	0	0	0
	Is the ward compliant with Erostering rules?	Y/N?	Y	Y	Y	Y	Y	Y	Y	Y	Y	y	Y	Y	Y	Y	Y	Y	Y	Y
	Brad Score		39.68	a/w data	a/w data	No data	42.24	N/A	N/A	Not complete	Not complete	100	41.85	34.9	100	No data	91.86	100	n/a	n/a
	PDR %	%	100	86.67	86.36	70.37	82.14	91.26	91.26	100	100	96	100	100	92.1	92	100	100	96	96
	Mandatory Training %	%	93.58	87.9	82.34	82.8	82.23	83.47	89.94	94	94	79	83.86	83.36	85	93.14	82.2	90.52	83.2	83
Finance	Is the ward in budget? (Record overall position)	Y/N	N	N	N	N	N	N	N	N (-£13,112)	N (-£13,112)	N	N (-£129,189)	N (-£129,189)	N	N	N (-£30,000)	Y £907	Y	Y
	Did monthly finance meeting take place?	Y/N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

SANDWELL CRITICAL CARE DASHBOARD													
Month		**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
Single Sex Breach		0	0	0									
Cancelled Electives		2	0	0									
Delayed Discharges	**>12hrs**	0	3	1									
	>24hrs	1	1	0									
Discharges to the ward 22.00hrs - 06.00hrs		1	2	2									
External transfer	**In**	0	0	0									
	Out	0	0	1									
Sickness	**ST**	1.47	2.16	2.92									
	LT	5.08	4.97	3.19									
Complaints		0	0	0									
Thank you's		£300	£109.00	£400.00									
Friends & Family Audit		green	green	green									
Overall Compliance MT %		96%	92.75%	94.36%									
PDR - Outstanding/ Due		94.64	90.91%	89.29									
VIP %		100%	89.50%	78%/93%									
CDIFF > 48hrs		1	2	0									
VRE		2	0	2									
HAND HYGIENE		100%	99	99									
ENVIRONMENTAL AUDITS		99%	99	100%									
Pressure ulcers - all		0		0									
Falls with pt harm		0	0	0									
Catheter UTI		0	0	0									
MRSA/MSSA		0	0	0									
Budget	**Non-Pay**	not avalable	-15130	-11601									
	Pay	not available	47252	£0									
	Overspent	not available		standing order renewals									
	Underspent	not available	-										
Bank WTE		12.16	7.27	9.38									
Agency WTE		11.56	15.7	6.53									
Thornbury		2	0.88	0.52									
WTE to City		3	0.36	1.9									
WTE from City		0	2.13	1									
%		100	100	N/A									
DCD Referrals %		66.7	0	100/ 6 POTENTIAL PT									
NIV Outside CCS		15	10	7									
New Referrals to O/R		58	87	70									
Follow-up referrals O/R		40	54	47									
Unit re-admissions		1	1	2									
CCMDS Average points	**City**	17	13.8	13.6									
	Sandwell	14	13.8	13.6									
	X Site	31.5	27.6	27.2									

CRITICAL CARE DAS						
Month		**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**
Single Sex Breach		0	0	0		
Cancelled Electives		1	0	0		
Delayed Discharges	>12hrs	0	0	0	1	
	>24hrs	1	2	0		
Discharges to the ward 22.00hrs - 06.00hrs		1	3	0	1	
External Transfers	In	0	1	1		
	Out	1	3	3		
Sickness Overall target 3.5%	ST	2.16	2.13	0.74		
	LT	5.93	5.49	3.32		
	Total	8.09	7.62	4.06		
Complaints		0	0	1		
Thank you's		4	9	5		
Friends & Family Audit		96%	100%	100%		
Overall Compliance MT %		93%	94.7%	96.83%		
PDR - Outstanding/Due		1	2	4		
VIP %		100%	80%	100%		
CDIFF > 48hrs		0	0	0		
VRE		0	0	0		
MRSA/MSSA Bactereamia		0	0	0		
Hand Hygiene		99%	99%	99%	99%	
Ward Cleaning Audits		93%				
Budget	Non-Pay	not Available	-£8,889	-12,132		
	Pay	not Available	-£31,772	3,574		

	Overspent	not Available	-£40,661	-£8,558		
	Underspent	not Available				
Bank WTE		9.8	9.73	9.68		
Agency WTE		23.02	7.89	11.24		
Thornbury WTE		4.76	0	0.73		
Hours to Sandwell		0	150.5	94.5		
Hours from Sandwell		109.5	33	77.5		
DBD Referral %		N/A	100%	N/A		
DCD Referrals %		60%	100%	50%		
NIV Outside CCS		10	5	11		
New Referrals to O/R		70	97	84		
Follow-up referrals O/R		32	42	47		
Unit re-admissions		1	1	1		
CCMDS Average points	City	17	13.8	13.6		
	Sandwell	14	13.8	13.6		
	X Site	31.5	27.6	27.2		

Ward Clinical Teams - Quality, Safety and Patient Experience Dashboard June

Leading the Culture of Compassionate Care

Area								Sandwell								
	D15	D17	D26	AMU1	AMU2	D5	D7	L4	P4	N4	L5	N5	P5	CCU	AMU A	AMU B
Patient Safety	100	87	92.5	100	100	100	100	100	100	100	100	100	100	100	95	100
	100	63	100	100	90	100	100	92.8	100	100	92.8	100	100	100	95	66.6
	100	100	70	100	100	100	100	60	100	100	85	100	92	90	86	45.45
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	71.23
	100	88	100	Not done	100	89	89	100	100	100	100	100	89	N/A due July	92	94.74
	77	37	90	83	60	90	83	50	87	95	80	90	100	100	73	95.65
	99	99	100	Vitalpac	Vitalpac	100	100	57	100	100	88	100	100	100	94	71.23
	100	95	90	100	100	100	100	100	100	100	100	100	100	100	80	100
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	0
	0	0	0	0	0	0	0	1	2	1	1	0	1	0	4	1
	0	3	2	1	0	0	0	0	1	3	0	0	4	0	0	0
	0	2	3	0	0	1	1	0	2	1	7	2	1	0	0	
	0	0	1	0	0	0	0	1	0	0	1		0	0	0	0
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	85	100
	100	91.3	100	100	100	100	100	100	100	100	100	100	100	100	100	100
	12		19	24	9	7	4	16	10	6	25	4	17	20	40	18
	0	0	1	0	0	0	0	0	0	0	1	0	1	0	0	0
	0	2	1	7	1	0	1	1	1	2	0	0	0	0	1	0
	0	2	1	1	0	0	0	0	1	0	0	1	2	0	1	0
	8	10	14	1	1	5	3	6	11	36	5	15	23	3	5	13
	1	1	1	1	1	0	0	0	1	1	0	1	1	0	0	1
	96.8	75	96.23	95.2	93.33	100	100	26	79	100	34	100	85	90.32	70.59	92.73
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	100	50	100	100	100	100	100	100	100	100	100	100	100	100	100	90
Infection Prevention and Control	0	0	50	0	0	86	71	100	0	2	100	0	0	93.75	90	100
	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	100	100	100	Variable, done daily	94	92	90	100	100	100	97	100	100	100	100	100
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0
	87	40	100	No issues. Daily inspections since TDA report	No issues. Daily inspections since TDA report	92	96	90	100	100	92	100	100	97.25	89	87
	95	72	100	100	100	100	100	90	98	98	90	100	92	50	89	87
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	1	0	0	0	0	0	0	0	0	0	0	N/A	0	0
	65	80	93	70	100	100	100	87.7	95	100	0	80	95	100	81	80
Patient Flow	19	11	7	N/A	N/A	50%	57%	22	6	3	20	12	14	21	N/A	N/A
	25	16	10	N/A	N/A	7	8	2	2	5	0	3	8	13	N/A	N/A
Staffing	1	1	0	0	0	1	1	0	0	0	0	0	0	0	0	0
	0.2	1	0	1	0	4.02	4.02	0	1	1	0	0	0	0.39	0	0
	5.31		4.81	0	5.61	2.48	2.48	8.87	0	1	3.35	0	4	0	6	5
	0	0	2.34	0	0	0	0	0	4	2	0.17	0.4	-3	0	0	0.08
		0		2.25	2.39	0	0	1	0	0	5.76	3.63	4.76	6.2	0	0
				1.27	2.13	4.3	4.3	4.9	6.5	1.4	4.62	3.47	2.98	1.9	5.6	5.6
				3.51	4.52	4.3	4.3	5.9	4.28	4.8	10.38	7.09	7.74	8.1	5.6	5.6
	0	48	4.09	0	0	0	0	3.8	43.14 hrs	160 hrs	9	1	17.2 wte	0	0	0
	Y	Y	Y	Y	Y	Y	Y	y	Y	Y	Y	Y	Y	Y	Y	Y
	a/w data	No data	42.24	N/A	N/A	Not complete	Not complete	100	41.85	34.9	100	No data	91.86	100	n/a	n/a
	86.36	70.37	82.14	91.26	91.26	100	100	96	100	100	92.1	92	100	100	96	96
	82.34	82.8	82.23	83.47	89.94	94	94	79	83.86	83.36	85	93.14	82.2	90.52	83.2	83
Finance	N	N	N	N	N	N (-£13,112)	N (-£13,112)	N	N (-£129,189)	N (-£129,189)	N	N	N (-£30,000)	Y £907	Y	Y
	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

WARD ASU

Leading the Culture of Compassionate Care

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%										100%
	Nutrition Audit (MUST)	Score %	100%	96%	100%										99%
	Documentation Audit	Score %	95%	99%	96%										97%
	Fluid Balance Audit	Score %	100%	100%	100%										100%
	Pain Audit (CQUIN)	Score %	100%	100%	100%										100%
	Missed Dose Audit	Score %	100%	100%	100%										100%
	Medications Audit	Score %	100%	100%	100%										100%
	Drugs Storage	Score %	100%	80%	90%										90%
	CD Audit	Score %	100%	100%	90%										97%
	Falls Risk Assessment Audit	Score %	100%	100%	100%										100%
	Safety/Privacy & Dignity	Score %	100%	100%	100%										100%
	Pressure Ulcers Avoidable	No. of	0	0	0										0
	Pressure Ulcers Unavoidable	No.of	0	0	0										0
	Falls (target =0)	No. of	0	0	0										0
	10 Out of 10	Score %	90%	90%	90%										90%
	Incidents Total (inc Falls)	No of	7	2	6										15
	Incidents (red)	No of	1	0	0										1
	Incidents (amber)	No. of	0	0	0										0
Patient Experience	PALS Queries	No of	0	0	0										0
	Compliments	No. of	4	6	5										15
	Complaints	No. of	0	0	0										0
	Patient Experience	Score (%)	100.00%	100.00%	100.00%										100.00%
	FFT Overall Results	Score (%)	100%	94.93%	100.00%										98.31%
	FFT Reponse Rate	Score (%)	119%	100.00%	100% +										109.50%
	Mixed Sex Breaches	No. of	0	0	0										0
Infection Prevention and Control	MRSA	Screening % Emergency	95.20%	98.67%	97.71%										97.19%
		No. of Bloodstream	0	0	0										0
		No. of Clinicals	0	0	0										0
	C Diff	No. of	0	0	0										0
	MSSA	No. of Bloodstream	0	0	0										0
	E-Coli	No. of Bloodstream	0	0	0										0
	Hand Hygiene	Score (%)	100%	100%	100%										100.00%
	Ward Cleanliness	Score (%)	99%	98.00%	96.00%										97.67%
	Outbreaks	No. of	0	0	0										0
	Cannulas (VIP)	Score (%)	95%	100.00%	100.00%										98.33%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	1.6WTE	1.0WTE	1.0WTE										
	Sickness in Month with Trajectory of management	ST/LT Added Together %	12.99%	16.04%	9.52%										12.85%
	Sickness long term	%	10.14%	11.44%	6.36%										9.31%
	Sickness short term	%	2.84%	4.60%	3.16%										3.53%
	Did monthly HR meeting take place?	Y/N	no	NO	no										
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	83	225	45										118
		No. of HCA's in Hrs	8	8	15										10
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	yes	YES	YES										
	PDR %	%	100%	92%	92%										94.67%
	Mandatory Training % by Month	%	96.65%	95.65%	96.93%										96.41%
	Uniform Audit	%	75.00%	100%	100%										91.67%
Finance	Is the ward in budget? This month, last month, projection	Y/N	yes	YES	YES										
	Did monthly finance meeting take place?	Y/N	no	NO	NO										

CRITICAL CARE DASHBOARD

Month		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
Single Sex Breach		0	2	0	1	0	0
Cancelled Electives		0	1	1	1	0	0
Delayed Discharges	>12hrs	1	1	0	1	0	0
	>24hrs	5	6	2	0	0	0
Discharges to the ward 22.00hrs - 06.00hrs		1	1	0	0	0	0
External Transfers	In	2	0	2	1	0	0
	Out	0	0	0	2	1	0
Sickness	ST [1.5]	1.37%	1.95%	0.38%	1.70%	1%	2.57%
	LT [2.66]	6.76%	8.89%	7.23%	6.69%	5.39%	3.54%
Complaints		1	0	0	1	0	0
Thank you's		4	5	3	7	6	4
Friends & Family Audit		98%	85%	86%	98%	91%	91%
Overall Compliance MT %		94.83%	93.91%	93.19%	93.15%	93%	94%
PDR - Outstanding/Due		1	0	2	0	12	2
VIP %		91.6	71	92.8	88%	100%	97%
CDIFF > 48hrs		0	0	0	0	0	0
VRE		0	0	0	1	0	0
MRSA/MSSA		0	0	0	0	0	0
Hand Hygiene		99%	99%	99%	99%	99%	100%
Ward Cleaning Audits		96%	96%	96%	95%	96%	97%
Budget	Non-Pay	£49,989	£34,304	£38,396	£29,574	£43,273	£26,381
	Pay	£215,080	£189,106	£201,957	£205,424	£209,272	£204,712
	Overspent	£10,512	0	0	0	0	0

	Underspent		£23,189	£42,412	£58,900	£63,136	£84,664
Bank WTE		0.69	1.49	0.29	3.15	8.5	7.35
Agency WTE		4.51	3.33	5.24	7.71	3.01	2.86
Thornbury WTE		0.4	0.2	2.4	0.98	0	0
Hours to Sandwell		211	135.5	157	104	44	199
Hours from Sandwell		31.5	14.5	0	57	132	72
DBD Referral %		100%	100%	100%	N/A	100%	N/A
DCD Referrals %		100%	100%	100%	100%	100%	100%
NIV Outside CCS		6	11	7	4	9	14
New Referrals to O/R		82	67	85	97	81	72
Follow-up referrals O/R		42	47	48	46	37	33
Unit re-admissions		3	1	1	2	1	2
CCMDS Average points	City	10.9	10.3	12.6	14.5	13.6	11.4
	Sandwell	13.1	11.6	14.3	15.9	12.2	13.7
	X Site	24.1	22.9	26.9	30.4	25.9	25.1

CRITICAL CARE DASHBOARD

Month		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Single Sex Breach		0	0	0									
Cancelled Electives		1	0	0									
Delayed Discharges	>12hrs	0	0	0	1								
	>24hrs	1	2	0									
Discharges to the ward 22.00hrs - 06.00hrs		1	3	0	1								
External Transfers	In	0	1	1									
	Out	1	3	3									
Sickness Overall target 3.5%	ST	2.16	2.13	0.74									
	LT	5.93	5.49	3.32									
	Total	8.09	7.62	4.06									
Complaints		0	0	1									
Thank you's		4	9	5									
Friends & Family Audit		96%	100%	100%									
Overall Compliance MT %		93%	94.7%	96.83%									
PDR - Outstanding/Due		1	2	4									
VIP %		100%	80%	100%									
CDIFF > 48hrs		0	0	0									
VRE		0	0	0									
MRSA/MSSA Bactereamia		0	0	0									
Hand Hygiene		99%	99%	99%	99%								
Ward Cleaning Audits		93%											
Budget	Non-Pay	not Available	-£8,889	-12,132									
	Pay	not Available	-£31,772	3,574									
	Overspent	not Available	-£40,661	-£8,558									
	Underspent	not Available											
Bank WTE		9.8	9.73	9.68									
Agency WTE		23.02	7.89	11.24									
Thornbury WTE		4.76	0	0.73									
Hours to Sandwell		0	150.5	94.5									
Hours from Sandwell		109.5	33	77.5									
DBD Referral %		N/A	100%	N/A									
DCD Referrals %		60%	100%	50%									
NIV Outside CCS		10	5	11									
New Referrals to O/R		70	97	84									
Follow-up referrals O/R		32	42	47									
Unit re-admissions		1	1	1									
CCMDS Average points	City	17	13.8	13.6									
	Sandwell	14	13.8	13.6									
	X Site	31.5	27.6	27.2									

SANDWELL CRITICAL CARE DASHBOARD							
Month		**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**
Single Sex Breach		4	1	3	0		
Cancelled Electives		4	1	0			
	>12hrs	0	2	2	0		
Delayed Discharges	>24hrs	7	2	1	0		
Discharges to the ward 22.00hrs - 06.00hrs		0	1	3	1		
External transfer	In	0	0	0	0		
	Out	0	0	0	0		
Sickness	ST	13.42	7.97	17	8		
	LT	7	8	3	2		
Complaints		0	0	0	0		
Thank you's		0	9	29			
Friends & Family Audit		88	75	100			
Overall Compliance MT %							
PDR - Outstanding/Due				82.26			
VIP %		86	88	78			
CDIFF > 48hrs							
VRE							
MRSA/MSSA		0	0	0			
Budget	Non-Pay						
	Pay						
	Overspent						
	Underspent						
Bank WTE		5.19	3.1	2.31			
Agency WTE		13.07	7.24	15.65			
WTE to City		0.32	0.28	0			
WTE from City		1.32	1.98	2.77			
DBD Referral %							
DCD Referrals %							
NIV Outside CCS							
New Referrals to O/R							
Follow-up referrals O/R							
Unit re-admissions		0	1	1			
CCMDS Average points	City	10.1	9.7	11.5			
	Sandwell	12	10.8	13.8			
	X Site	22.1	20.5	25.3			

SANDWELL CRITICAL CARE DASHBOARD													
Month		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Single Sex Breach		4	1	3	1	1	0	0	0	1	0	0	0
Cancelled Electives		4	1	0	4	0	4	2	3	6	0	1	3 by surgeon
Delayed Discharges	>12hrs	0	2	2	0	2	1	1	0	1	0	2	0
	>24hrs	7	2	1	2	0	2	1	0	0	0	2	1
Discharges to the ward 22.00hrs - 06.00hrs		0	1	3	2	2	2	1	2	3	0	2	1
External transfer	In	0	0	0	1	1	0	0	0	1	0	0	0
	Out	0	0	0	0	0	0	0	0	2	1	0	0
Sickness	ST	3.22	1.47	2.18	2.18	4.68	3.1	2.82	3.6	2.84	4.06	5.32	2.92
	LT	5.70	5.41	6.69	4.97	6.17	6.19	5.3	3.92	1.81	3.65	4.06	3.19
Complaints		0	0	0	0	0	0	0	0	0	0	0	1
Thank you's		0	9	29	12	9	12 + £1,223.00	14	47+ £725.00	18	14	12	£1,365 / 14 Boxes choclate
Friends & Family Audit		88	75	100	95	85	100	16	100	81	95	97	91.18
Overall Compliance MT %					94.61		93.24	94	91.39%	90.16	92%	93%	96%
PDR - Outstanding/Due				80.65% [1]	81.97 [5]	85.25 [7]	82.76	74.14	69	72.41	84.48	87.72	94.64
VIP %		86	88	78	88.8	86%	66% :(	95%	92%	98%	98%	96%	100%
CDIFF > 48hrs		1	0	0	0	0	0	0	0	0	0	0	0
VRE		2	1	1	0	3 on admission	0		5 in tot 2 unit aquired	3	2	3	2
HAND HYGIENE		100%	97%	100%	100%	98%	100%	95%	98%	100%	92% :(	98%	98
ENVIRONMENTAL AUDITS							100%	96	100%	98%	93%	98%	96%
Pressure ulcers - all							9	11	4		0	0	0
Falls with pt harm							0	0	0	0	0	0	0
Catheter UTI							0	0	0	0	0	0	0
MRSA/MSSA		0	0	0	0	4 on admission	0	0	1 non unit aquired	0	0	0	0
Budget	Non-Pay	£38352	£42742	£40650	£39600	£40113	£40,083	£38,229	£37,640	37,950		£38,557	
	Pay	£218129	£22744	£219342	£219404	£219404	219,404	£219,404	£240,245	£254,912		£264,358	
Bank WTE		5.19	3.1	2.31	4.24	3.62	9.34	9.31	7.87	3.97	15.66	10.52	11.72
Agency WTE		13.07	7.24	15.65	19.71	8.23	11.8	11.8	23.4	13.77	42.63	23.9	32.57
Thornbury											9.07	2.45	5.94
WTE to City		0.32	0.28	0	1.91	3.65	1.22	0.21	3.45	1.04	0.58	0.2	0.49
WTE from City		1.32	1.98	2.77	0.69	0.88	4.75	3	1.89	0.92	1.28	1.04	0.98
DBD Referral %		0	100	0	100	100	100	0	N/A	N/A	100	N/A	N/A
DCD Referrals %		0	83.3	50	100	100	66.7	0	100	N/A	100	N/A	80% [4/5]
NIV Outside CCS		11	19	11	10	8	6	5	12	22	23	10	14
New Referrals to O/R		54	79	66	77	64	79	77	90	88	90	59	75
Follow-up referrals O/R		51	42	42	47	48	45	53	43	38	57	37	53
Unit re-admissions		3	1	2	4	1	1	1	2	2	1	2	1
CCMDS Average points	City	10.1	9.7	11.5	13.8	13.5	11.7	11.7	15	16.1	15.7	11.4	13.6
	Sandwell	12	10.8	13.8	15.2	11.9	13.4	12.9	12.1	15.5	15	13.6	13.6
	X Site	22.1	20.5	25.3	29.0	25.4	25.1	24.6	27.1	31.6	30.7	25	27.2

SANDWELL CRITICAL CARE DASHBOARD													
Month		**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**
Single Sex Breach		0	0	0									
Cancelled Electives		2	0	0									
Delayed Discharges	**>12hrs**	0	3	1									
	>24hrs	1	1	0									
Discharges to the ward 22.00hrs - 06.00hrs		1	2	2									
External transfer	**In**	0	0	0									
	Out	0	0	1									
Sickness	**ST**	1.47	2.16	2.92									
	LT	5.08	4.97	3.19									
Complaints		0	0	0									
Thank you's		£300	£109.00	£400.00									
Friends & Family Audit		green	green	green									
Overall Compliance MT %		96%	92.75%	94.36%									
PDR - Outstanding/Due		94.64	90.91%	89.29									
VIP %		100%	89.50%	78%/93%									
CDIFF > 48hrs		1	2	0									
VRE		2	0	2									
HAND HYGIENE		100%	99	99									
ENVIRONMENTAL AUDITS		99%	99	100%									
Pressure ulcers - all		0		0									
Falls with pt harm		0	0	0									
Catheter UTI		0	0	0									
MRSA/MSSA		0	0	0									
Budget	**Non-Pay**	not avalable	-15130	-11601									
	Pay	not available	47252	£0									
	Overspent	not available		standing order renewals									
	Underspent	not available	-										
Bank WTE		12.16	7.27	9.38									
Agency WTE		11.56	15.7	6.53									
Thornbury		2	0.88	0.52									
WTE to City		3	0.36	1.9									
WTE from City		0	2.13	1									
DBD Referral %		100	100	N/A									
DCD Referrals %		66.7	0	100/ 6 POTENTIAL PT									
NIV Outside CCS		15	10	7									
New Referrals to O/R		58	87	70									
Follow-up referrals O/R		40	54	47									
Unit re-admissions		1	1	2									
CCMDS Average points	**City**	17	13.8	13.6									
	Sandwell	14	13.8	13.6									
	X Site	31.5	27.6	27.2									

WARD CPAU City

Leading the Culture of Compassionate Care

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100.00%	100.00%	100.00%										100.00%
	Documentation Audit	Score %	80.00%	100.00%	80.00%										86.67%
	Nutrition Audit (MUST)	Score %	90.00%	90.00%	100.00%										93.33%
	Drugs Storage	Score %	100.00%	100.00%	100.00%										100.00%
	Falls Risk Assessment Audit	Score %	100.00%	100.00%	90.00%										96.67%
	Safety/Privacy & Dignity/ Documentation Audit	Score %	100.00%	100.00%	100.00%										100.00%
	Falls (target =0)	No. of	0	0	0.00%										0
	Wasted clinic slots	No. of	115	68	75										258
	Incidents Total (inc Falls)	No of	4	2	1										7
	Incidents (red)	No of	0	0	0										0
	Incidents (amber)	No. of	0	0	0										0
Patient Experience	PALS Queries	No of	0	0	1										1
	Compliments	No. of	1	0	0										1
	Complaints	No. of	0	0	0										0
	FFT Overall Results	Score (%)	NA	NA	NA										#DIV/0!
	FFT Response Rate	Score (%)	NA	NA	NA										#DIV/0!
Infection control	MRSA	Screening % Elective	100.00%	100.00%	100.00%										100.00%
	CRO	Screening % Elective	100.00%	100.00%	100.00%										100.00%
	Hand Hygiene	Score (%)	100.00%	100.00%	100.00%										100.00%
	Ward Cleanliness	Score (%)													#DIV/0!
Staffing	Vacancies (Exclude Ward Clerks)	No. of	1.80	1.80	1.00										1.53
	Sickness in Month with Trajectory of management	ST/LT Added Together %	16%	11%	6%										8%
	Sickness long term	%	15%	11%	6%										11%
	Sickness short term	%	1%	0%	0%										0%
	Did monthly HR meeting take place?	Y/N	no	no	no										
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	0.00	0.00	0.00										0.00
		No. of HCA's in Hrs	0.00	0.00	0.00										0.00
	PDR %	%	88.24%	100.00%	100.00%										96.08%
	Mandatory Training % by Month	%	95.28%	96.07%	96.62%										95.99%
	Uniform Audit	%	100.00%	100.00%	90.00%										96.67%
Finance	Is the ward in budget? This month, last month, projection	Y/N	Y	Y	Y										
	Did monthly finance meeting take place?	Y/N	no	no	no										

WARD CPAU Sandwell

Leading the Culture of Compassionate Care

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100.00%	100.00%										100%
	Documentation Audit	Score %	98%	100.00%	100.00%										99%
	Nutrition Audit (MUST)	Score %	80%	100.00%	100.00%										93%
	Drugs Storage	Score %	100.00%	100.00%	100.00%										100.00%
	Falls Risk Assessment Audit	Score %	100%	100.00%	100.00%										100%
	Safety/Privacy & Dignity/ Documentation Audit	Score %	98%	100.00%	98.00%										99%
	Falls (target =0)	No. of	0	0	0										0
	Wasted clinic slots	No. of	130	86											216
	Incidents Total (inc Falls)	No of	1	2											3
	Incidents (red)	No of	0	0	0										0
	Incidents (amber)	No. of	0	0	0										0
Patient Experience	PALS Queries	No of	0	0	0										0
	Compliments	No. of	0	0	0										0
	Complaints	No. of	0	0	0										0
	FFT Overall Results	Score (%)	n/a	n/a	n/a										#DIV/0!
	FFT Response Rate	Score (%)	n/a	n/a	n/a										#DIV/0!
Infection control	MRSA	Screening % Elective	100.00%	100.00%	100.00%										100.00%
	CRO	Screening % Elective	100.00%	100.00%	100.00%										100.00%
	Hand Hygiene	Score (%)	100.00%	100.00%	100.00%										100%
	Ward Cleanliness	Score (%)	95.00%	99.00%											97.00%
Staffing	Vacancies (Exclude Ward Clerks)	No. of	1.80	1.80	1.60										1.73
	Sickness in Month with Trajectory of management	ST/LT Added Together %	16%	11%	6%										8%
	Sickness long term	%	15%	11%	6%										11%
	Sickness short term	%	1%	0%	0%										0%
	Did monthly HR meeting take place?	Y/N	no	no	no										
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	0.00	0.00	0.00										0.00
		No. of HCA's in Hrs	0.00	0.00	0.00										0.00
	PDR %	%	87.51%	83.33%	94.44%										88.43%
	Mandatory Training % by Month	%	93.55%		96.97%										95.26%
	Uniform Audit	%	97.50%	100.00%	98.33%										98.61%
Finance	Is the ward in budget? This month, last month, projection	Y/N	y	y	y										
	Did monthly finance meeting take place?	Y/N	no	no	no										

Leading the Culture of Compassionate Care

WARD D25

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%										100%
	Nutrition Audit (MUST)	Score %	100%	100%	100%										100%
	Documentation Audit	Score %	100%	90%	99%										96%
	Fluid Balance Audit	Score %	97%	88%	100%										95%
	Pain Audit (CQUIN)	Score %	100%	100%	100%										100%
	Protected Meal Time Audit	Score %	100%	97%	100%										99%
	Missed Dose Audit	Score %	100%	100%	100%										100%
	Medications Audit	Score %	100%	100%	100%										100%
	Drugs Storage	Score %	100%	100%	100%										100%
	CD Audit	Score %	100%	95%	100%										98%
	Falls Risk Assessment Audit	Score %	100%	100%	100%										100%
	Safety/Privacy & Dignity	Score %	100%	100%	100%										100%
	Pressure Ulcers Avoidable	No. of	0	0	0										0
	Pressure Ulcers Unavoidable	No.of	0	0	0										0
	Falls (target =0)	No. of	0	1	0										1
	Dementia screening audit results	Score %	100%	100%	100%										100%
	Safety Thermometer (No new harm)	Score %	100%	100%	100%										100%
		No. of Harms	0	0	0										0
	10 Out of 10	Score %	100%	78%	100%										93%
	Incidents Total (inc Falls)	No of	0	0	0										0
	Incidents (red)	No of	0	0	0										0
	Incidents (amber)	No. of	0	0	0										0
Patient Experience	PALS Queries	No of	0	0	0										0
	Compliments	No. of	9	14	16										39
	Complaints	No. of	0	0	0										0
	Patient Experience	Score (%)	100%	100%	100%										100%
	FFT Overall Results	Score (%)	96%	94%	95%										95%
	FFT Reponse Rate	Score (%)	61%	60%	75%										65%
	Mixed Sex Breaches	No. of	0	0	0										0
	MRSA	Screening % Elective	100%	100%	100%										100%
		No. of Bloodstream	0	0	0										0
		No. of Clinicals	0	1	1										2
	C Diff	No. of	0	0	0										0
	MSSA	No. of Bloodstream	0	0	0										0
	E-Coli	No. of Bloodstream	0	0	0										0
	Hand Hygiene	Score (%)	91%	97%	100%										96%
	Ward Cleanliness	Score (%)	99%	88%	90%										92.33%
	Outbreaks	No. of	0	0	0										0
	Cannulas (VIP)	Score (%)	100%	100%	100%										100%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	1	1	2										
	Sickness in Month with Trajectory of management	ST/LT Added Together %	10.55%	13.35%	7.81%										10.57%
	Sickness long term	%	9.82%	11.90%	7.81%										9.84%
	Sickness short term	%	0.73%	1.46%	0.00%										0.73%
	Did monthly HR meeting take place?	Y/N	Y	N	y										
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	209.1												209
		No. of HCA's in Hrs	22.8												23
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y	y										
	Brad Score	Reccommended	29.29	26.70											
		Actual	27.54	25.76											
		Budgeted	29.41	29.41											
	PDR %	%	96.55%	96.55%	96.55%										96.55%
	Mandatory Training % by Month	%	90.21%	91.42%	92.92%										91.52%
	Uniform Audit	%	100%	100%	100.00%										100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	Y	Y	N										
	Did monthly finance meeting take place?	Y/N	N	N	Y										

WARD Lyndon 2

Leading the Culture of Compassionate Care

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	100%	100%	100%										100%
	Nutrition Audit (MUST)	Score %	100%	100%	100%										100%
	Documentation Audit	Score %	79%	99%	89%										89%
	Fluid Balance Audit	Score %	93%	77%	100%										90%
	Pain Audit (CQUIN)	Score %	100%	100%	100%										100%
	Protected Meal Time Audit	Score %	100%	97%	100%										99%
	Missed Dose Audit	Score %	100%	88%	95%										94%
	Medications Audit	Score %	97%	95%	96%										96%
	Drugs Storage	Score %	80%	100%	100%										93%
	CD Audit	Score %	85%	90%	85%										87%
	Falls Risk Assessment Audit	Score %	100%	100%	100%										100%
	Safety/Privacy & Dignity	Score %	90%	97%	98%										95%
	Pressure Ulcers Avoidable	No. of	0	0	0										0
	Pressure Ulcers Unavoidable	No.of	2	0	0										2
	Falls (target =0)	No. of	2	0	1										3
	Dementia screening audit results	Score %	100%	100%	100%										100%
	Safety Thermometer (No new harm)	Score %	100%	100%	100%										100%
		No. of Harms	0	0	0										0
	10 Out of 10	Score %	87%	100%	100%										96%
	Incidents Total (inc Falls)	No of	25	8	10										43
	Incidents (red)	No of	0	0	0										0
	Incidents (amber)	No. of	1	0	0										1
Patient Experience	PALS Queries	No of	0	0	0										0
	Compliments	No. of	28	29	26										83
	Complaints	No. of	1	0	0										1
	Patient Experience	Score (%)	98%	100%	100%										99%
	FFT Overall Results	Score (%)	55%	63%	58%										59%
	FFT Reponse Rate	Score (%)	68%	58%	37%										54.33%
	Mixed Sex Breaches	No. of	0	0	0										0
Infection Prevention and Control	MRSA	Screening % Emergency	91%	85.71%	100%										92%
		No. of Bloodstream	0	0	0										0
		No. of Clinicals	0	0	0										0
	C Diff	No. of	1	0	0										1
	MSSA	No. of Bloodstream	0	0	0										0
	E-Coli	No. of Bloodstream	0	0	0										0
	Hand Hygiene	Score (%)	62%	78%	49%										63%
	Ward Cleanliness	Score (%)	95%	95%	99%										96.33%
	Outbreaks	No. of	0	0	0										0
	Cannulas (VIP)	Score (%)	83%	90%	100%										91%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	3.01.	3.01.	3.01.										#DIV/0!
	Sickness in Month with Trajectory of management	ST/LT Added Together %	11.56%	7.31%	2.39%										7.09%
	Sickness long term	%	6.06%	5.60%	0.00%										3.89%
	Sickness short term	%	5.50%	1.70%	2.39%										3.20%
	Did monthly HR meeting take place?	Y/N	Y	Y	Y										
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	82.8	62.5											73
		No. of HCA's in Hrs	260.8	47.8											154
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y	Y										
	Brad Score	Reccommended	33.63.	32.65.	33.86.										
		Actual	25.76.	24.08.	25.80.										
		Budgeted	26.01.	26.01.	26.01.										
	PDR %	%	88.89%	88.46%	92.31%										89.89%
	Mandatory Training % by Month	%	92.38%	92.33%	95.78%										93.50%
	Uniform Audit	%	100%	100%	100%										100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	N/A	N	N										
	Did monthly finance meeting take place?	Y/N	N	N	N										

WARD Newton 3

Leading the Culture of Compassionate Care

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	98%	98%	100%										99%
	Nutrition Audit (MUST)	Score %	96%	100%	100%										99%
	Documentation Audit	Score %	94%	89%	96%										93%
	Fluid Balance Audit	Score %	84%	75%	93%										84%
	Pain Audit (CQUIN)	Score %	100%	100%	100%										100%
	Protected Meal Time Audit	Score %	100%	100%	100%										100%
	Missed Dose Audit	Score %	100%	100%	100%										100%
	Medications Audit	Score %	100%	100%	100%										100%
	Drugs Storage	Score %	100%	100%	100%										100%
	CD Audit	Score %	100%	100%	100%										100%
	Falls Risk Assessment Audit	Score %	90%	78%	96%										88%
	Safety/Privacy & Dignity	Score %	83%	83%	100%										89%
	Pressure Ulcers Avoidable	No. of	0	0	2										2
	Pressure Ulcers Unavoidable	No.of	0	0	0										0
	Falls (target =0)	No. of	0	0	0										0
	Dementia screening audit results	Score %	100%	100%	100%										100%
	Safety Thermometer (No new harm)	Score %	96%	88%											92%
		No. of Harms	1												1
	10 Out of 10	Score %	100%	100%	100%										1
	Incidents Total (inc Falls)	No of													0
	Incidents (red)	No of	0	0	0										0
	Incidents (amber)	No. of	0	0	0										0
Patient Experience	PALS Queries	No of	2	2	2										6
	Compliments	No. of	13	10	15										
	Complaints	No. of	0	0	1										1
	Patient Experience	Score (%)	100%	100%	100%										100.00%
	FFT Overall Results	Score (%)	71%	98%	89%										86%
	FFT Reponse Rate	Score (%)	30%	36%	32%										32.67%
	Mixed Sex Breaches	No. of	0	0	0										0
Infection Prevention and Control	MRSA	Screening % Emergency	96%	98%											97.00%
		Screening % Elective	100%	100%	100.00%										100.00%
		No. of Bloodstream	0	0	0										0
		No. of Clinicals	0	0	0										0
	C Diff	No. of	0	0	0										0
	MSSA	No. of Bloodstream	0	0	0										0
	E-Coli	No. of Bloodstream	0	0	0										0
	Hand Hygiene	Score (%)	82%	80%	86%										83%
	Ward Cleanliness	Score (%)	95%	96%	97.00%										96.00%
	Outbreaks	No. of	0	0	0										0
	Cannulas (VIP)	Score (%)	100%	100%	100.00%										100.00%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	3												
	Sickness in Month with Trajectory of management	ST/LT Added Together %	7.61%	4.12%	0.70%										4.14%
	Sickness long term	%	4.66%	3.60%	0.00%										2.75%
	Sickness short term	%	2.95%	0.60%	0.70%										1.42%
	Did monthly HR meeting take place?	Y/N	y	y	y										
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs													#DIV/0!
		No. of HCA's in Hrs													#DIV/0!
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	y	y	y										
	Brad Score	Reccommended	57.00	57.11	41										
		Actual	18.00	35.38	35										
		Budgeted	20.00	39.98	39										
	PDR %	%	86.96%	90.91%	37.21%										71.69%
	Mandatory Training % by Month	%	83.53%	85.53%	84.84%										84.63%
	Uniform Audit	%	100%	100%	100.00%										100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	y	y	y										
	Did monthly finance meeting take place?	Y/N	N	n	n										

Leading the Culture of Compassionate Care

WARD Priory 2

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	90%	100%	77%										89%
	Nutrition Audit (MUST)	Score %	100%	100%	100%										100%
	Documentation Audit	Score %	90%	100%	96%										95%
	Fluid Balance Audit	Score %	90%	100%	99%										96%
	Pain Audit (CQUIN)	Score %	100%	100%	100%										100%
	Protected Meal Time Audit	Score %	100%	100%	100%										100%
	Missed Dose Audit	Score %	100%	100%	94%										98%
	Medications Audit	Score %	100%	100%	94%										98%
	Drugs Storage	Score %	100%	100%	100%										100%
	CD Audit	Score %	95%	100%	100%										98%
	Falls Risk Assessment Audit	Score %	100%	100%	100%										100%
	Safety/Privacy & Dignity	Score %	100%	100%	100%										100%
	Pressure Ulcers Avoidable	No. of	0	0	0										0
	Pressure Ulcers Unavoidable	No.of	0	0	0										0
	Falls (target =0)	No. of	0	2	1										3
	Dementia screening audit results	Score %	100%	100%	100%										100%
	Safety Thermometer (No new harm)	Score %	100%	100%	100%										100%
		No. of Harms	0	0	0										0
	10 Out of 10	Score %	100%	100%	100%										1
	Incidents Total (inc Falls)	No of	16	12	5										33
	Incidents (red)	No of	0	0	0										
	Incidents (amber)	No. of	0	0	0										
Patient Experience	PALS Queries	No of	1	0	0										
	Compliments	No. of	52	55	41										
	Complaints	No. of	0	0	1										
	Patient Experience	Score (%)	100%	100%	100%										100%
	FFT Overall Results	Score (%)	97%	100%	98%										98%
	FFT Reponse Rate	Score (%)	59%	70%	72%										67%
	Mixed Sex Breaches	No. of	0	0	0										0
	MRSA	Screening % Elective	87.50%												87.50%
		No. of Bloodstream	0	0	0										0
		No. of Clinicals	0	0	0										0
	C Diff	No. of	0	0	0										0
	MSSA	No. of Bloodstream	0	0	0										0
	E-Coli	No. of Bloodstream	0	0	0										0
	Hand Hygiene	Score (%)	65%	89%	94%										83%
	Ward Cleanliness	Score (%)	79%	89%	95%										88%
	Outbreaks	No. of	0	0	0										0
	Cannulas (VIP)	Score (%)	79%	100%	100.00%										93.00%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	3.8	5	5										
	Sickness in Month with Trajectory of management	ST/LT Added Together %	10.29%	14.40%	11.51%										12.07%
	Sickness long term	%	8.76%	10.22%	6.73%										8.57%
	Sickness short term	%	1.53%	4.88%	4.78%										3.73%
	Did monthly HR meeting take place?	Y/N	Y	Y	Y										
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	145	625	293										354
		No. of HCA's in Hrs	398	334	404										379
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Y	Y	Y										
	Brad Score	Reccommended	40.98	38	33										
		Actual	29.91	31	30										
		Budgeted	29.60	30	30										
	PDR %	%	100%	100%	82.76%										94%
	Mandatory Training % by Month	%	87.02%	86%	88.78%										87.27%
	Uniform Audit	%	100%	100%	100%										100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	N	N	N										
	Did monthly finance meeting take place?	Y/N	N	N	N										

WARD SSAU

Leading the Culture of Compassionate Care

	Area	Unit	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Average/YTD
Patient Safety	Tissue Viability Audit (Waterlow)	Score %	93%	100%	100%										98%
	Nutrition Audit (MUST)	Score %	100%	100%	100%										100%
	Documentation Audit	Score %	88%	92%	94%										91%
	Fluid Balance Audit	Score %	96%	100%	100%										99%
	Pain Audit (CQUIN)	Score %	100%	100%	100%										100%
	Protected Meal Time Audit	Score %	100%	97%	100%										99%
	Missed Dose Audit	Score %	100%	100%	100%										100%
	Medications Audit	Score %	100%	93%	95%										96%
	Drugs Storage	Score %	100%	100%	100%										100%
	CD Audit	Score %	85%	90%	85%										87%
	Falls Risk Assessment Audit	Score %	92%	100%	100%										97%
	Safety/Privacy & Dignity	Score %	100%	100%	100%										100%
	Pressure Ulcers Avoidable	No. of	0	0	0										0
	Pressure Ulcers Unavoidable	No.of	0	0	0										0
	Falls (target =0)	No. of	0	0	0										0
	Dementia screening audit results	Score %	100%	100%	100%										100%
	Safety Thermometer (No new harm)	Score %	100%	100%	100%										100%
		No. of Harms	0	0	0										0
	10 Out of 10	Score %	88%	92%	50%										1
	Incidents Total (inc Falls)	No of	5	4	4										13
	Incidents (red)	No of	0	0	0										0
	Incidents (amber)	No. of	0	0	0										0
Patient Experience	PALS Queries	No of	1	1	1										3
	Compliments	No. of	11	15	14										40
	Complaints	No. of	0	0	0										0
	Patient Experience	Score (%)	100%	100%	100%										100%
	FFT Overall Results	Score (%)	100%	92%	96%										96%
	FFT Reponse Rate	Score (%)	15%	22%	19%										18.67%
	Mixed Sex Breaches	No. of	0	0	0										0
Infection Prevention and Control	MRSA	Screening % Emergency	93.15%	96.47%	91.67%										93.76%
		No. of Bloodstream	0	0	0										0
		No. of Clinicals	0	0	0										0
	C Diff	No. of	0	0	0										0
	MSSA	No. of Bloodstream	0	0	0										0
	E-Coli	No. of Bloodstream	0	0	0										0
	Hand Hygiene	Score (%)	79%	65%	69.00%										71%
	Ward Cleanliness	Score (%)	95%	95%	99%										96.33%
	Outbreaks	No. of	0	0	0										0
	Cannulas (VIP)	Score (%)	67%	100%	100%										89%
Staffing	Vacancies (Exclude Ward Clerks)	No. of (in wte)	2. 08	2. 08	2. 08										
	Sickness in Month with Trajectory of management	ST/LT Added Together %	4.91%	0.00%	0.00%										1.64%
	Sickness long term	%	0.00%	0.00%	0.00%										0.00%
	Sickness short term	%	4.91%	0.00%	0.00%										1.64%
	Did monthly HR meeting take place?	Y/N	Yes	Yes	Yes										
	No of temporary staff used above Establishment or Budget	No. of Qualified in Hrs	129.2	64.5											97
		No. of HCA's in Hrs	111.2	75.2											93
	Is the ward compliant with Erostering rules? (to be confirmed by matron)	Y/N?	Yes	Yes	Yes										
	PDR %	%	100%	88.89%	91.67%										94%
	Mandatory Training % by Month	%	89.54%	95.41%	94.81%										93.25%
	Uniform Audit	%	100%	100%	100%										100%
Finance	Is the ward in budget? This month, last month, projection	Y/N	Yes	Yes	No										
	Did monthly finance meeting take place?	Y/N	No	No	No										

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Complaints & PALS report: 2015/16 quarter 1
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Karen Beechey, Head of PALS & Complaints
DATE OF MEETING:	6 August 2015

EXECUTIVE SUMMARY:

This report sets out details of Complaints and PALS enquiries received between April and June 2015 (Quarter 1).

The report provides high level data on PALS and Complaints, demographics of the subject of the complaint if a patient and the reasons those complaints were made.

The report also details some of the lessons learned and the changes which have been made in wards/departments as a result of the enquiry or complaint.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
✓		✓

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Complaints and PALS Report

2015/16: Quarter 1

COMPLAINTS MAKING A DIFFERENCE

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

What we were told	Our response	The difference
The complainant is bed bound and having difficulties booking hospital transport. This has resulted in them missing appointments.	In light of the difficulties the patient encountered the system has now been updated and bookings will be taken over the phone without the need to complete a booking form, thus ensuring that bookings are made more quickly and efficiently.	All patients, regardless of circumstance or disability will be able to easily book the transport they need. This in turn will ensure easy and equal access to appointments for all patients.
The complainant was pregnant and was to have an internal scan. She was told to go to the toilet prior to the scan and was left distressed as she found a sample bowl in the toilet where someone had miscarried. On 3 March 2015 she received a letter from the department querying how she would like her own miscarriage disposed of when she had not had a pregnancy loss.	An apology was sent for the distress these two incidents caused. The process for confirming histology reports has been amended so that two nurses now have to sign them off, to prevent a repeat of this error. The bathrooms are now checked hourly and a form is signed for audit purposes as evidence that this has taken place.	Patients using the facilities of the Unit will not be subject to unhygienic toilets, and upsetting incidents such as is described in this complaint. Patients will also only receive accurate information about their pregnancies avoiding such sensitive mistakes occurring again.
The complainant was unhappy with the information that she had received about the screening tests that her new born baby should undergo soon after birth. She states that she chose not to attend future appointments based on advice given to her at this time, and that our follow up letters did not contain enough information to help her make an informed decision as to whether to attend or not. She did not attend, and her son was recently diagnosed with profound deafness.	Appointment letters now include information and helpful contact details of local and national organisations that can assist and support parents in making decisions about whether to participate in screening programmes. It was also identified that an important leaflet about screening was not included in the original appointment letter and this has been addressed with the team responsible for sending these letters.	Parents in future will have all the information they need to assess whether they should attend screening appointments.
The complaint was centred on the length of time spent waiting in A&E to be seen. It is also felt that the doctor should have referred the patient immediately to the Plastics Team. It was then identified that there were no beds	The need for a Plastic Surgery Out of Hours Pathway has been identified and is now in the process of being developed.	Patients will not be left waiting with uncertainly about when they will receive treatment.

What we were told	Our response	The difference
at City Hospital therefore surgery would be carried out at Sandwell the following morning. The patient then received a call in the morning advising a mistake had been made and surgery should be at City and to wait for a call.		
The complainant attended Radiology for an X-ray. Staff seemed unsure and not confident in what they were doing, which was extremely disconcerting and worrying. The patient stopped the proceedings twice telling them of their concerns.	The Imaging team have now implemented equipment competencies check lists for all radiographic staff to ensure they are skilled and confident in operating the x-ray equipment. This includes all agency staff.	Patients will have more confidence in the service that we are providing and the risk of errors will also be reduced.
Patient had botox injections as directed by the urologist. At the pre-op appointment the Nurse advised that the patient would be able to self-catheterise. However the patient wasn't shown how to do this and this resulted in a return to hospital to have their bladder emptied.	At the time of the patient's procedure it was not standard practice to teach patients how to self-catheterise. However as a result of the complainant's concerns, our standard practice has changed in that all patients, undergoing this procedure will be instructed in self-catheterisation. We have reviewed and changed our practice due to the concerns and all patients will now also be given the appropriate written information as standard.	Patients will not be at risk of having a readmission and can manage their post-operative recovery more effectively themselves.

COMPLAINTS AND PALS: 2015/16

Quarter 1 highlights

1.	The total number of PALS concerns registered was 564, up by 10. Unlike previous quarters, these enquiries have been largely unaffected by specific initiatives that PALS have been supporting, they simply represent the number of patient enquiries. (page 17)
2.	The total number of Complaints logged was, 237 an increase of 30 complaints across the quarter compared to Q4 2014. 30 of these were withdrawn by the complainant at some point during the quarter leaving 207 to manage. There were 13 less complaints made in April 2015 compared to April 2014, 6 less complaints made in May 2015 compared to May 2014, and 19 more made in June 2015 compared to June 2014. (page 6)
3.	The total number of compliments collected for was 358 compared to 359 in Q4 2014/15 and 397 in Q3 2014/15. It is now clear that the collection method is not supporting accurate data reporting, and a new method of collection will need to be trialled. (Appendix 10 page 30)
4.	The average number of days taken to resolve complaints saw a decrease of 10.84 days from 62.46 (Q4 2014/15) down to 51.62 (Q1 2015/16). This decrease continues to be attributed to the resolution of fewer older complaints as well as a higher proportion of newer complaints being managed within their target dates. (page 9)
5.	Complaints per 1000 bed days have decreased when compared to the previous quarter, with an average rate 2.3 of against 3.1 in the previous quarter. This rate is a lower comparative rate to the same quarter for 2014/15 (at 3.0 2014/15). This decrease also now shows a downward trend over the last 5 quarters. (page 7)
6.	When looking at the complaints rate per 1000 FCE it is still Surgery B that has the highest complaints rate at 7.1 but this has shown a steady decline from 8.99 Q4 2014/15, which was a decrease from 9.3 from Q2 2014/15. Woman and Child Health still has the lowest but has increased from 2.5 in Q3 2015/16, up to 3.61 in Q4 2014/15 and again to 3.9 in Q1 2015/16. (page 8)
7.	'Not Upheld' complaints made up 24% of closed complaints against 26% in Q4 2014/15 and 20% in Q3 2014/15 but with no emerging trends in terms of Groups or themes. (page 14)
8.	The three themes that emerged out of complaints this quarter remain the same as the previous three quarters and are Attitude of Staff, Clinical Care and Appointments. Unlike previous quarters, Surgery A has the highest proportion of complaints (29%) in this category. Previously, the most complained about Clinical Group had been Surgery B. A review of the PALS data however for the same theme, it is appointments within Surgery B that is most commonly enquired about. (page 12)
9.	Reopened cases totalled 49 with 7 of those re opened were due to not all the issues being answered in our first response. This compares to 44 reopened with 5 where not all issues were addressed in Q4 2014/15 and 23 reopened with 5 where not all issues were addressed in Q3 2014/15. There has been a steady reduction in the % of those reopened where not all issues were addressed, from 26% in Q2 2014/15, down to 22% in Q3 2014/15, 11% in Q4 2014/15 with a slight increase at 14% in Q1 2015/16. (page 15)
10.	There was 1 new PHSO enquiry of the Trust in this quarter, and 3 previous enquiries were closed off. Of those closed, 1 was not upheld, 1 was identified as a partially service failure and PHSO decided not to investigate the third, following a review of our complaint response, and the supporting documentation supplied to them. (pages 16)
11.	Complaints satisfaction survey return rate was 12%, lower than the previous 2 quarters, (19% for Q4 2014/15 and 20% for Q3 2014/15). The overall satisfaction remained similar to that of the previous quarter at 45% compared to 46% in Q4 2014/15 and 33% in Q3 2014/15. (page 10)
12.	There is still disproportionality of the ethnicity of the subjects of complaints when considering the number of complaints received from Pakistani's but this quarter saw a reduction in the number of complaints received by Black Caribbean's, bringing the complaint % vs the patient population % in line. (page 11 and Appendix 6)

COMPLAINTS AND PALS: 2014/15

Index

INTRODUCTION

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

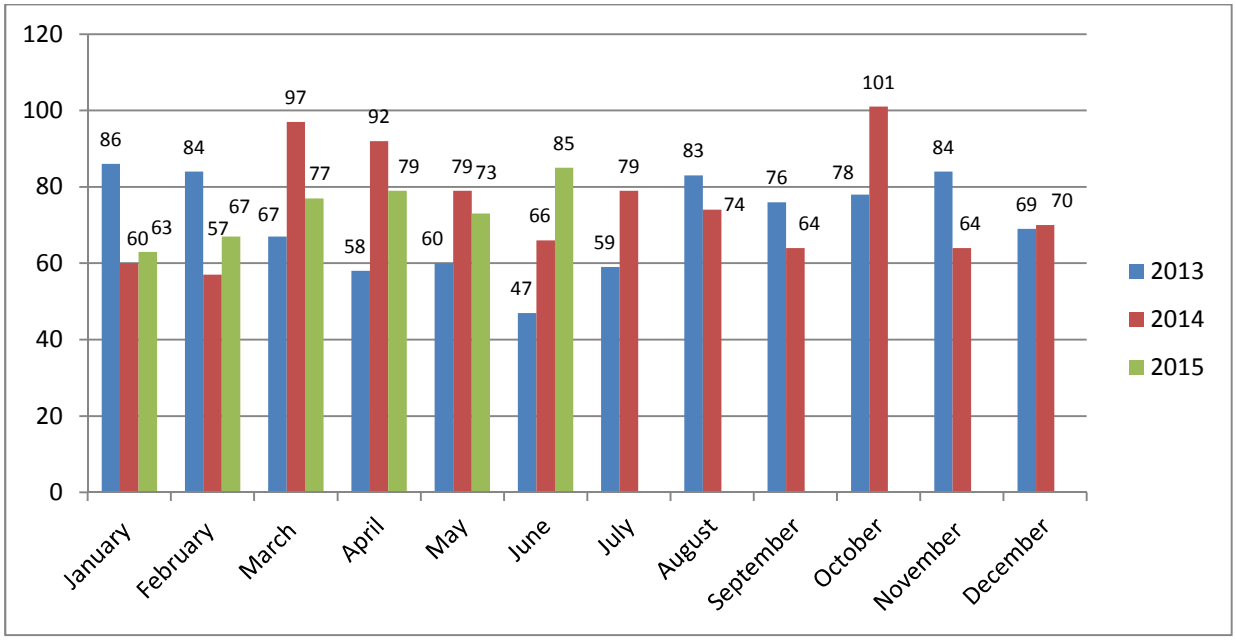
This report sets out and provides commentary on the complaints, PALS enquiries, local departmentally resolved concerns and compliments, the way they were managed, who they were made against and what about. The important learning opportunities are evidenced and the subjects of the complaints are also profiled.

COMPLAINTS

1. Complaints Management

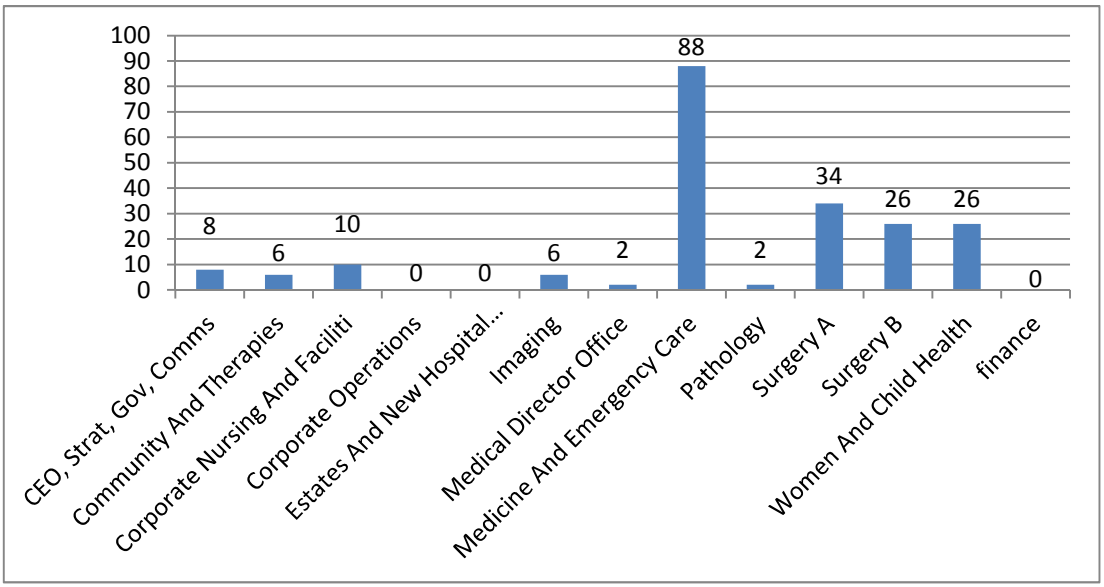
1.1 Total received

The total number of complaints received in Q1 2015/16 was 237 compared to 207 in Q4 2014/15, a reduction of 30. In the same period the previous year, Q1 2014/15 237 complaints were also received. When broken down by month, year on year, there were 13 less complaints made in April 2015 compared to April 2014, 6 less complaints made in May 2015 compared to May 2014 and 19 more made in June 2015 compared to June 2014. It should also be noted that 30 complaints were withdrawn in this quarter, slightly more than in the previous quarter leaving 207 actively managed this quarter.



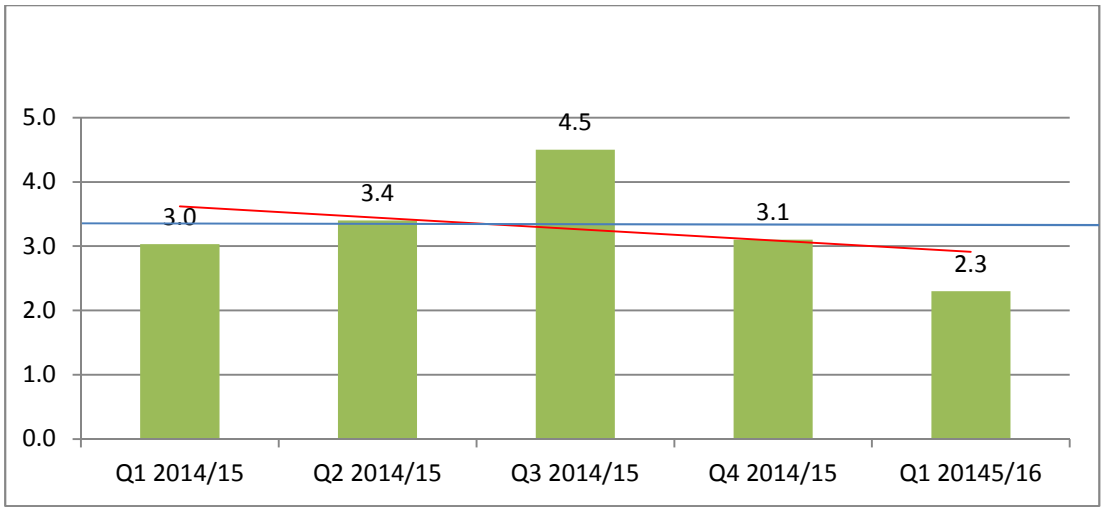
1.2 Complaints by Group

When analysing the complaints received in Q1 2015/16, by Clinical Group and Corporate Directorate, Medicine continue to receive the most complaints. **Appendix 1a** shows how these figures compare over the last 4 quarters. **Appendix 1b** shows how this is broken down by ward (where applicable).



1.3 Complaints by 1000 bed days

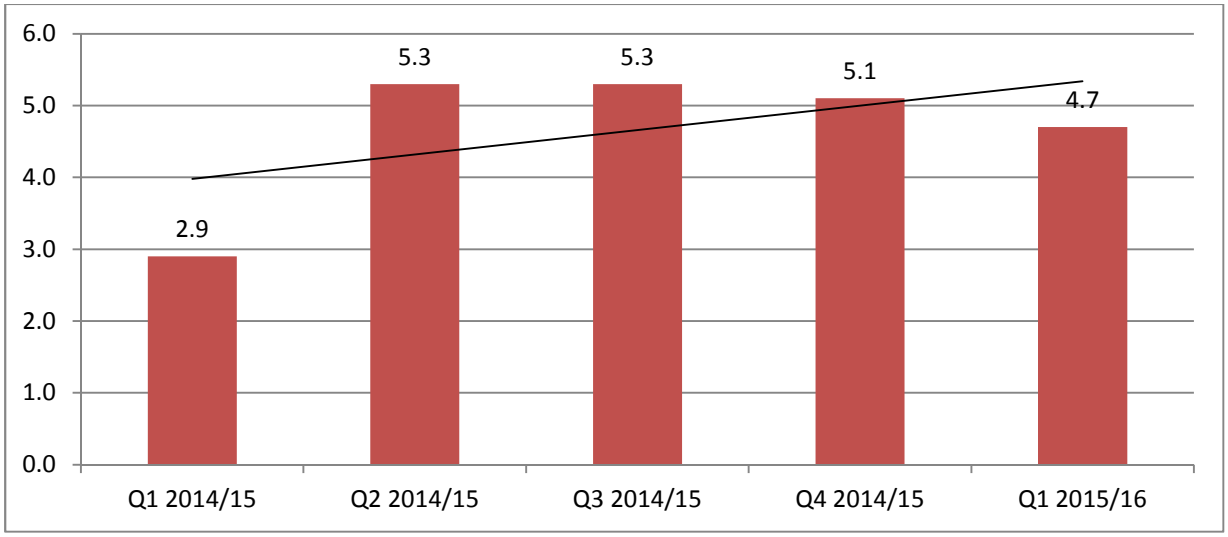
The complaints rate, calculated as complaints per 1000 bed days for Q1 2015/16 is lower than the previous four quarters. This has sent the trend line downward, reducing the 12 month rolling average to 3.3 compared to 3.6, reported last quarter. The trend line is shown in red and the rolling average is shown in blue.



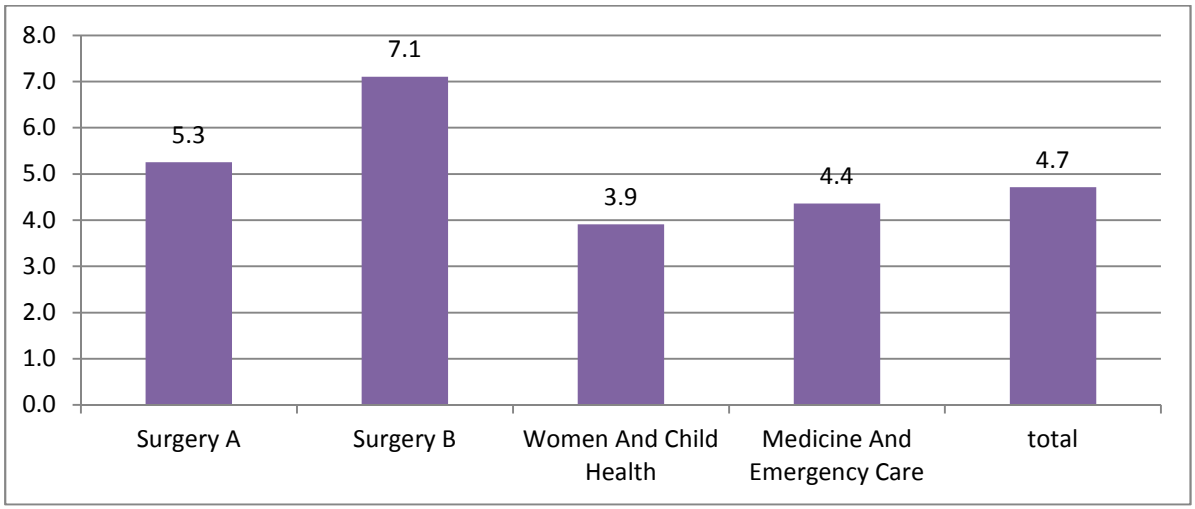
1.4 Complaints received per 1000 FCE (Finished Consultant Episodes)

To more accurately compare which Clinical Group is receiving the most complaints, it is important to represent these not just as numbers of complaints, but as a proportion of the patients that have received care in these areas. This then puts these numbers into context. By comparing the numbers of complaints with FCE we can gauge better whether one service or another is attracting more dissatisfaction and once understood, drill down further into what aspect of that service needs to improve. This analysis was only applied to the largest of the Clinical Groups, as they contribute to 81% of the complaints. This is a small decrease from the 83% proportion from Q4 2014/15 and exactly the same as the 81% of Q3 2014/15.

Complaints received per 1000 FCE (Finished Consultant Episodes)



Although the majority of complaints received are still made about Medicine, it is again Surgery B that has the highest number of complaints per 1000 FCE and as shown in **Appendix 2** this rate is slightly lower than it was in Q4 2014/15. Reference is also made to the theme of complaints in section 2.2 and **Appendix 6** In order to better understand the types of complaints made against Surgery B.

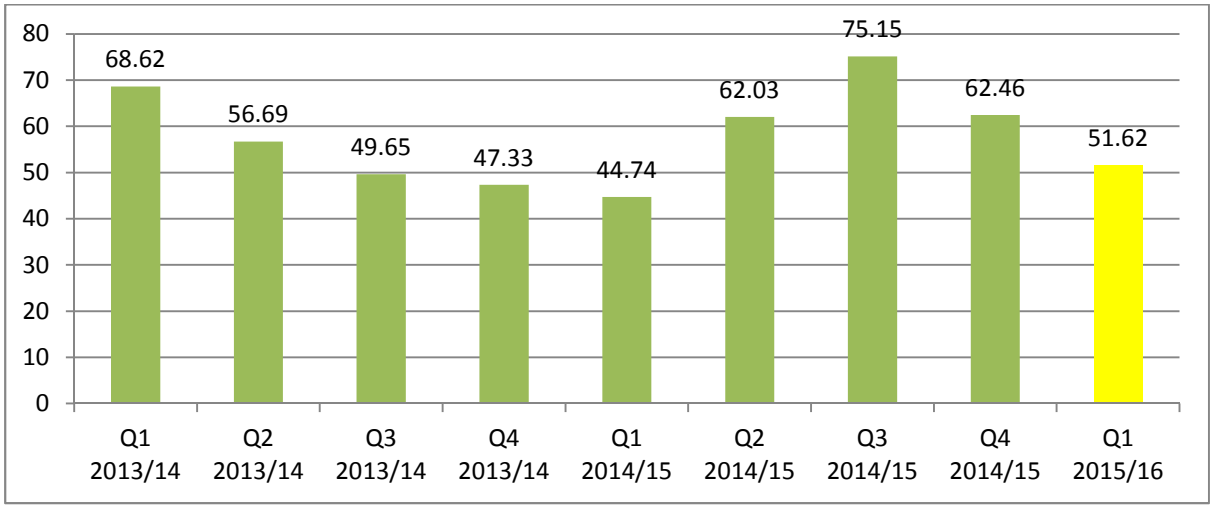


1.5 Timeliness of Responses

As previously reported, Q2 and Q3 2014/15 saw an increase in the average days taken to respond to complaints, and this was largely due to the volume of older cases that had been finalised. Q4 2014/15 saw a predicted decrease, as cases were managed within agreed timeframes and the number of cases being closed (that had exceeded their response dates) became fewer. This has continued into Q1 2015/16 and has had the same positive effect on the average number of days to complete a complaint. This has gone from 62.46 days to 51.62.

A renewed commitment was made that no complaint would be managed outside of its agreed response date. Of the 207 complaints made in Q1 2015/16, (F15 cases) all but three have been managed within their agreed timeframes. This represents a 97% 'in date' turn around, with an 'average days to manage' result of 26.53. There are still a comparatively small number of cases that are still to be managed from the 2014/15 but these are planned for completion by the end of July.

Average days to respond by quarter

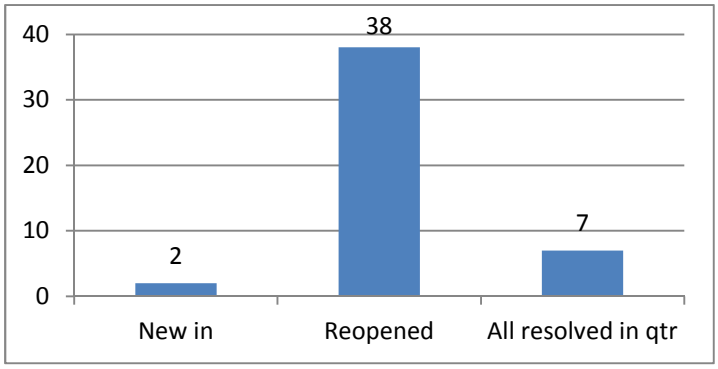


Appendix 3 shows a further breakdown of this data by Clinical Group. It should be noted that this is the total time that the complaint took to respond to and includes all stages of the process.

1.6 Complaints managed by resolution meeting

It is recognised that for some complaints, a resolution meeting, as opposed to a written response can be more effective in addressing concerns. Commonly, those complaints relating to the death of a patient, where the patient is a child, or where there may be concerns around how well a written response could be comprehended, are best resolved through a resolution meetings. Some complainants will also express a preference to meet with the Trust, and it remains an important aspect of the complaints resolution process. In Q4 2014/15 a system for recording when a complaint was resolved through a meeting was developed and implemented in mid-February. The new monitoring system has highlighted an issue around how many complaints meetings are being offered. The complaints team have been reminded that it is an essential part of the process to offer all complainants the opportunity to meet with the Trust and this message is reiterated to all involved in devolved complaints across the Trust. This must be the default position for all mortality complaints. In Q2 2015/16 there will be an increase in the number of cases that are managed in this way, with many Q2 complaints already earmarked for meetings in July 2015.

% of complaints that were managed by a resolution meeting as opposed to a written response Q1 2015/16

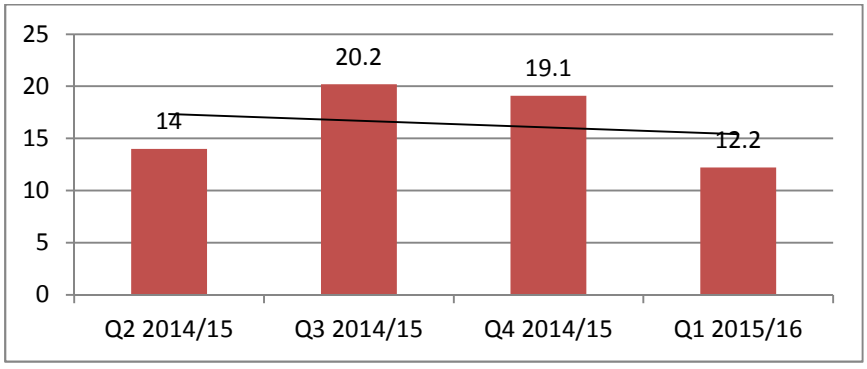


1.7 Complaint satisfaction survey

Everyone who makes a complaint is given the opportunity to provide feedback on how they found their experience via completion of a questionnaire that is sent with the final response. There was a decrease in returns with a response rate of 12.2% (32 returns) compared to 19.1% in Q4 2014/15 (36 returns.)

This return rate has steadily decreased over the last three quarters. In an attempt to improve the rate at which we get this feedback, and the quality of the information we can derive from the survey, the process has undergone a review. From 1 July 2015 surveys are no longer sent out with the original complaint response. It is sent 4 weeks later, in order to give the complainant time to reflect on their complaints experience. Over the next 2 quarters, return rates will be closely monitored. The survey will also undergo a revamp to ensure that the questions asked provide the most valuable data; data that can be used to enhance the way that the complaints service is managed.

Complainant satisfaction return rate

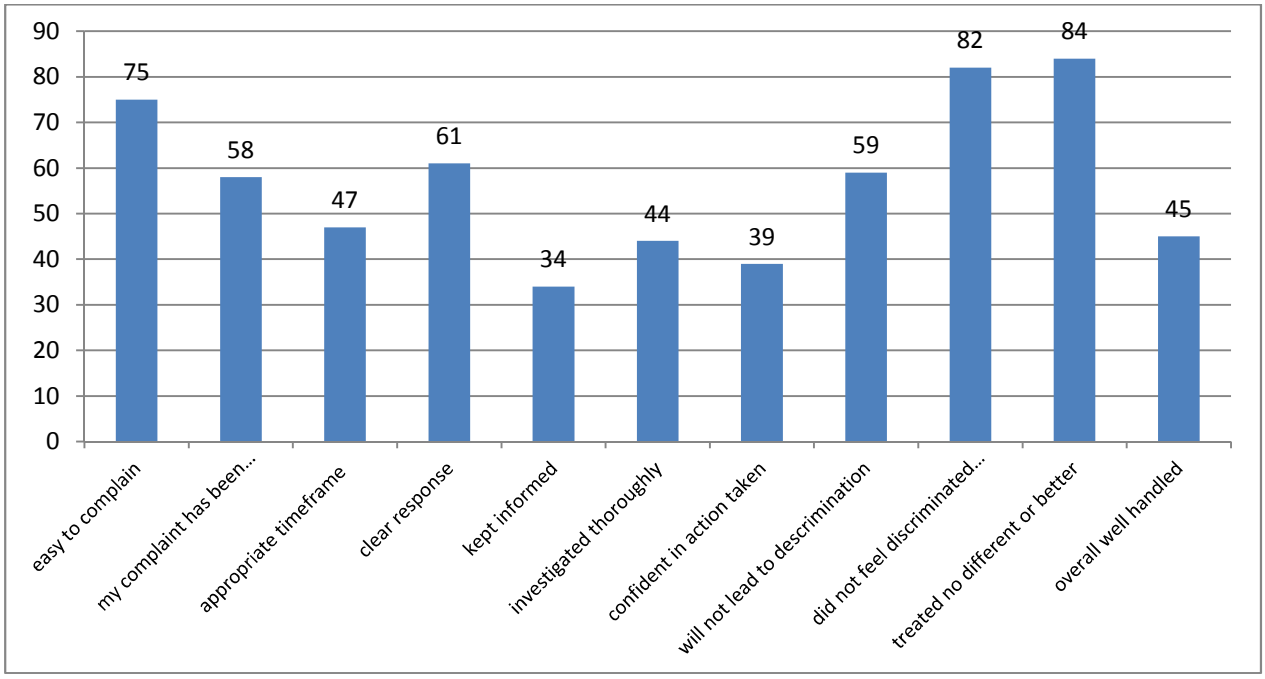


Appendix 4 covers all results in detail, and shows that there is still work to be done to improve how satisfied complainants are with many aspects of the process, particularly when compared with the results reported in Q2, Q3 and Q4 2014/15.

There has been a slight increase in complainants reporting how easy the complaint response was to understand, and a notable increase in those that felt kept informed (although still not at the rate that would be acceptable when managing complaints within agreed timeframes.) There is still an

overall sense that complainants do not feel discriminated against when making a complaint, and that most people find it easy to complain to the Trust.

Compliant survey results as a % of respondents Q1 2015/16



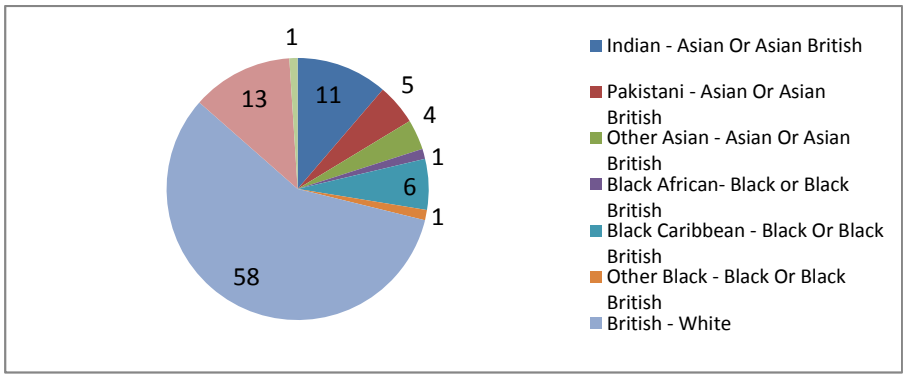
Appendix 5 shows a profile (where given) of the respondents in terms of their gender, age and ethnicity.

2. Complaints in detail

2.1 Profile of the subject of complaints

In order to check that our complaints process is accessible to all, it is important to understand the profile of complainants by certain protected characteristics. Gender, age and ethnicity are recorded and then compared to our hospital population and also the population of the geographic area that we serve in **Appendix 6**.

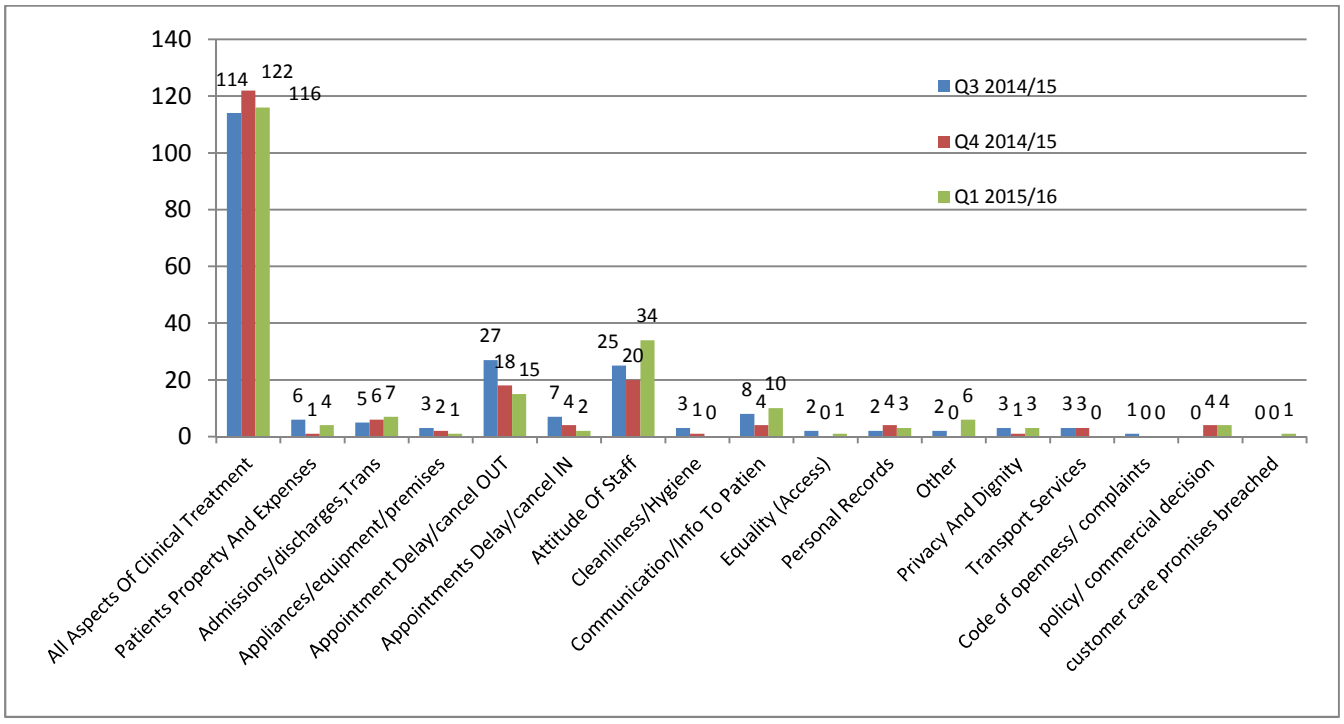
Subject of complaint by Ethnicity Q1 2015/16



In Q2, Q3 and Q4 2014/15 there was disproportionality in the ethnic mix of complainant's versus our patient population. This trend has continued into Q1 2015/16 with a lower rate of complaints from Asian complainants (mainly Pakistani with 10% patient population and a 5% complaints rate). In Q2, Q3 and Q4 2014/15 it was reported that Black Caribbean complainants made a disproportionate number of complaints (14% in Q3 2014/15 and 16% in Q4 2014/15) against 6% in our patient population. This disproportionality changed in this quarter however, where the complaints rate in this ethnic group dropped to just 6%, in line with their representation in our patient population.

2.2 Formal complaints by theme

This table shows the broad themes that our complaints fell into in Q1 2015/16 compared to Q4 and Q3 2014/15.



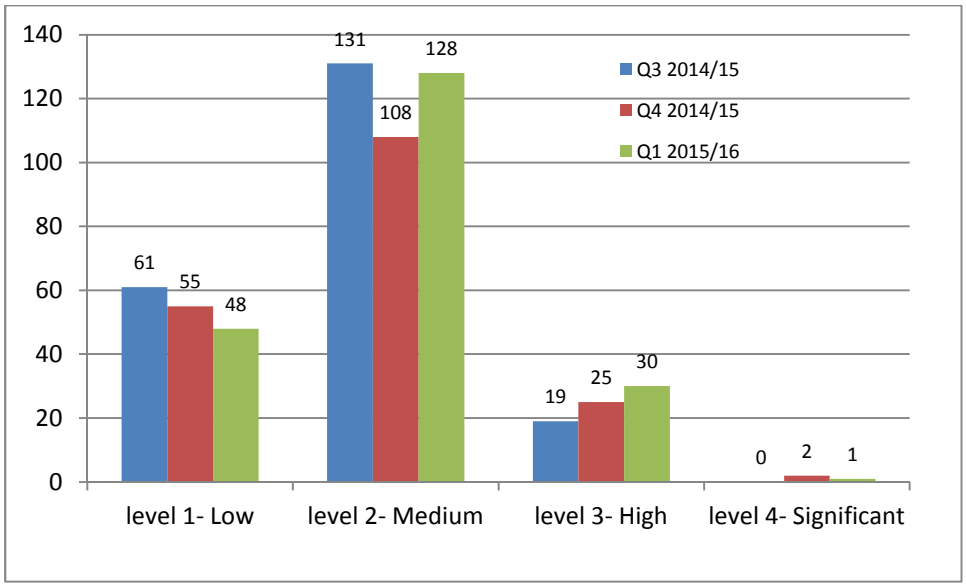
When analysing the top three themes complained about, these remain 'all aspects of clinical treatment', 'appointment delays', and 'staff attitude'. **Appendix 7** breaks down the themes of complaints by Group, profession and department for the most complained about themes.

In Q2 and Q3 2014/15 it was reported that Surgery B had a disproportionately higher rate of complaints about their management of appointments but had decreased in Q4 2014/15 (from 32% down to 26%) and again further in Q1 2015/16.

2.3 Formal complaints by severity

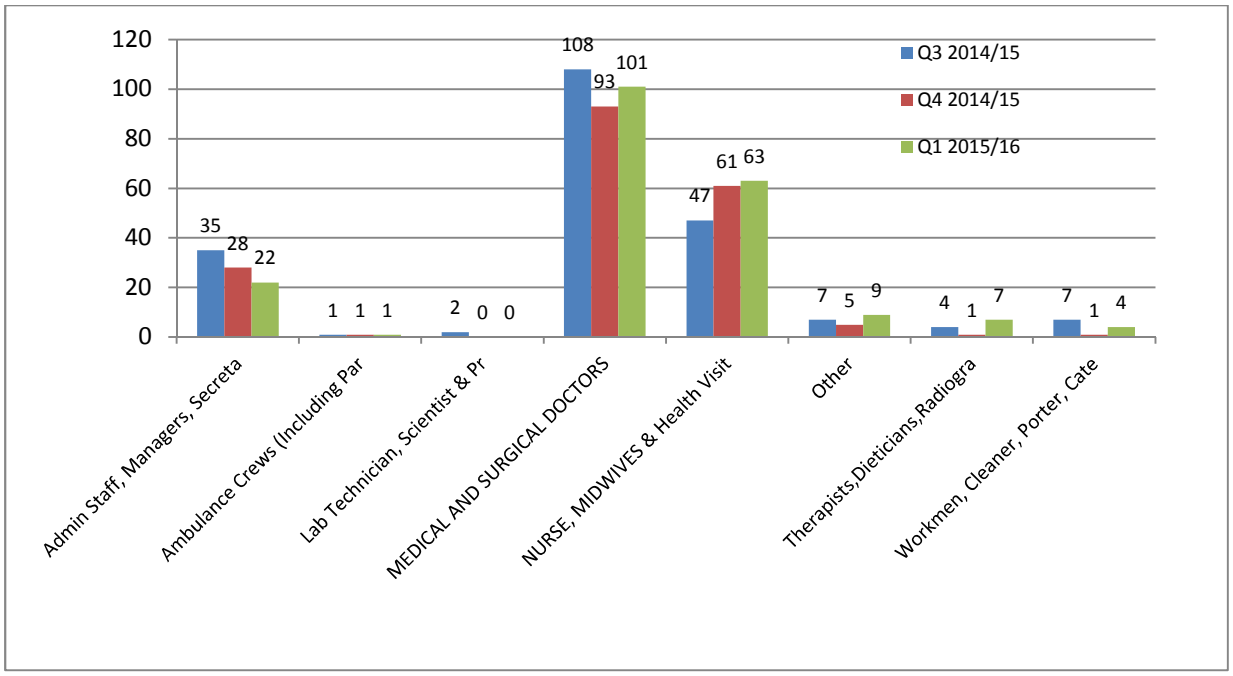
The following is a breakdown of the 207 actively managed complaints by severity and shows that once again complaints considered high or significant (Levels 3 and 4) remain in the minority. This quarter, Level 1 and 2 complaints made up 85% (176) those received which was 1% lower than the last quarter (86% in Q4 2014/15), 6% lower than the quarter before that (91% in Q3 2014/15) and 2% higher than in Q2 2014/15. There was 1 Level 4 complaint, involving the death of a new born baby.

A breakdown the severity grade of complaint



2.4 Formal complaints by profession

There were no significant changes in the number of complaints received across the seven professional groups, except for that of Therapists, dieticians and Radiographers. With that said, there was no specific Clinical Group that attracted these complaints. Just under half of these complaints were about the attitude of these staff members.



3. Formal complaints outcomes

3.1 Resolved complaints

The renewed focus from Q1 2015/16 on resolving all complaints within their target response date continues as improved work practices are embedded. Feedback is still provided regularly to Investigation Leads about the quality of the complaint responses to ensure that this focus on time does not come at the sacrifice of quality. 225 responses were sent for this quarter compared to 187 for Q4 2014/15 and 202 in Q3 2014/15. A review of the way complaints are planned, monitored and escalated saw all but 3 F15 (received from 1 April 2015) complaints remain in date, with 86 (97%) sent within their specified completion date

3.2 Formal complaints upheld.

At the conclusion of a complaint, we categorise the outcome as one of the following three categories.

Upheld – we agreed that the complainant was found to have experienced poor care/ treatment/ customer service.

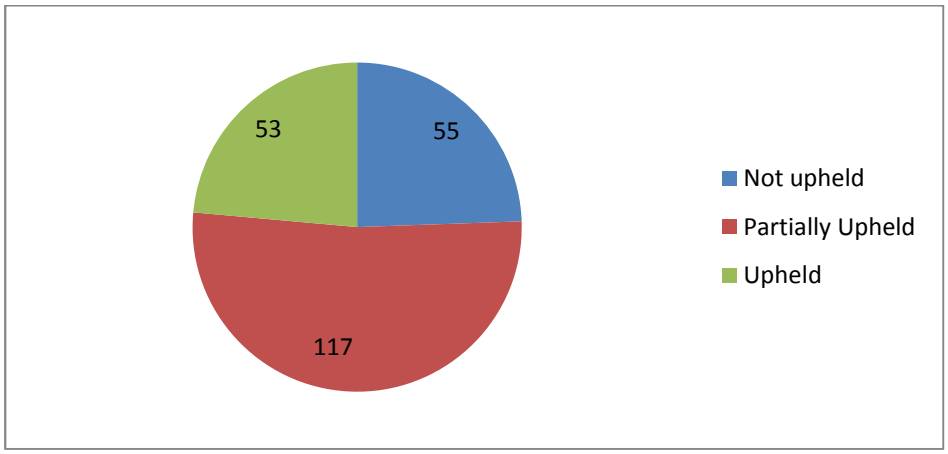
Partially upheld- elements of the complaint were found to be the case, but not all.

Not upheld- The investigation did not uncover any failings on behalf of the Trust.

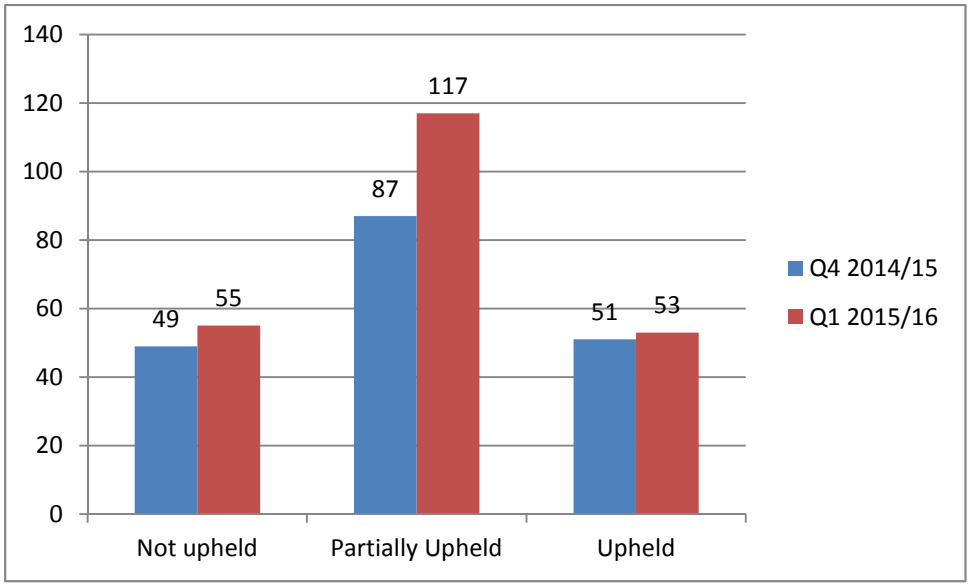
The outcome of complaint responses remain mostly either upheld or partially upheld, but there was a disproportionate increase, up by 30%, of partially upheld complaints, compared to 87% in Q4 2014/15. There was however no significant work group, or complaint trends in those cases that were partially upheld.

This high percentage for these outcomes does still demonstrate a continued commitment to 'Being Open' and integrity in general in complaints management

Q1 2015/16 complaint outcomes



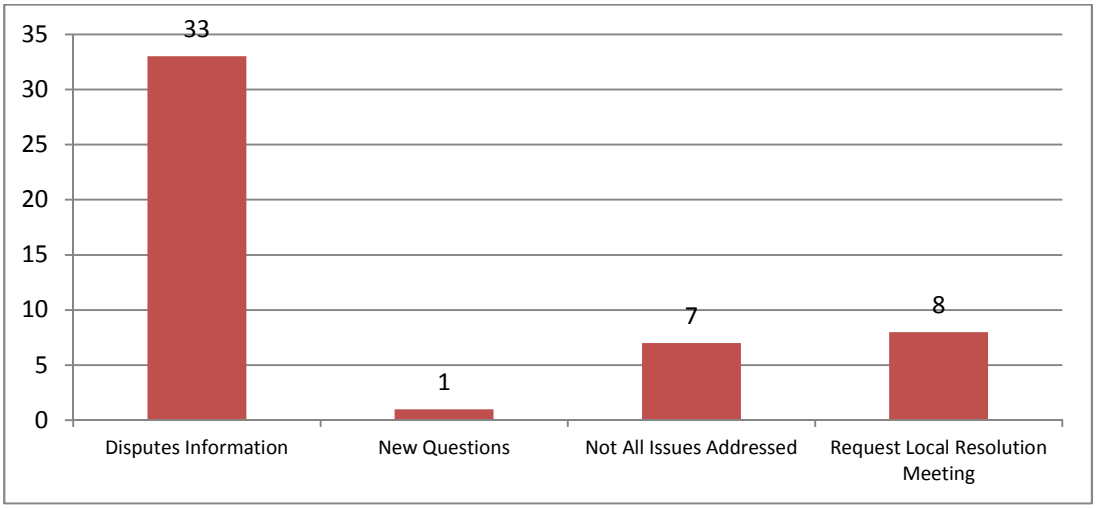
Complaints outcome Q1 2015/16 compared to Q4 2014/15



3.2 Reopened cases

Reopened cases totalled 49 in Q1 2015/16 and 7 (14%) of these were because not all the issues were addressed in our first response. This compares to 11% in Q4 2014/15. The total number that were reopened is higher than in Q4 2014/15, and the rate that complainants come back to us concerned about the thoroughness of investigation has increased slightly. It should be noted that there has been an increase in the number of complaints that have been finalised in Q3, Q4 2014/15 and Q1 2015/16. Whilst our overall aim is to reduce the amount of complaints disputing their response, an increased number of finalised complaints can impact on the reopen rate.

Total number of cases reopened and why Q1 2015/16



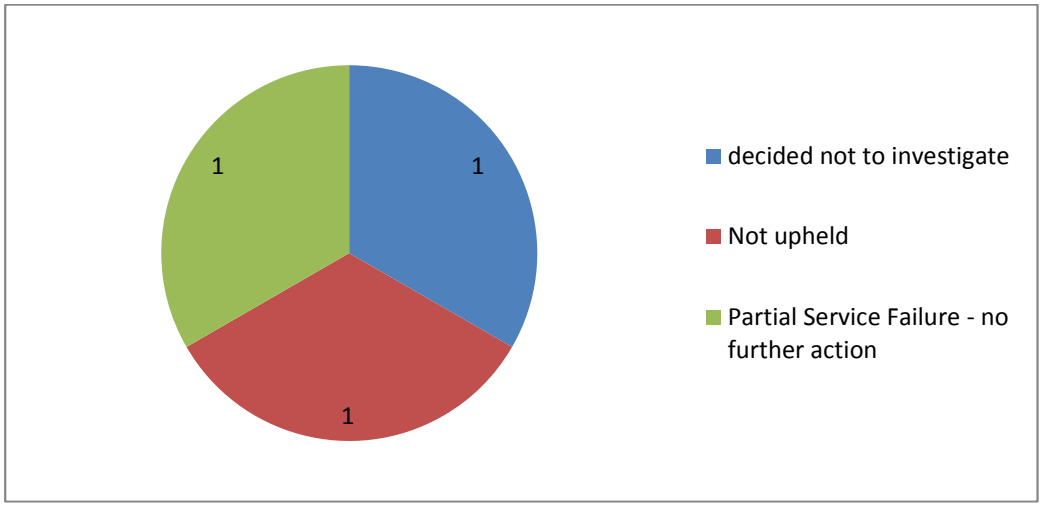
Of those complaints that were reopened because we had not addressed issues first time, Medicine and Emergency Care can be attributed to 5 out of the 7 that were disputed for this reason on Q1 2015/16. Over the past 3 quarters, there has been no particular Group that has contributed to this type of dissatisfaction in this way, and this emerging trend will be monitored in terms of the quality of the response, and the continued themes around their reopened cases. **Appendix 8** shows all reopened complaints by Group and Grade, and does also conclude that it is the medium grade (Level 2) complaints that are most likely to be reopened. There is also a breakdown of the Medicine and Emergency care Group as this remains the group that received the most reopened cases. This breakdown is shown by both reason and grade.

3.3 Parliamentary and Health Services Ombudsman enquiries.

When the local complaints process is exhausted, any complainant who remains dissatisfied can have their complaint reviewed independently by the Parliamentary and Health Services Ombudsman (PHSO).

One new PHSO complaint was logged in the three months of this quarter, and 3 enquiries were concluded during this same period. These are shown below.

The outcome of the 3 cases closed in Q1 2015/16



Partially upheld case

A maternity patient was scanned in the EPAU and it was identified that she had suffered a missed miscarriage. Medical intervention was offered that would result in her passing the non-viable pregnancy but this was declined by the patient. She opted for conservative management. The pregnancy did not miscarry and she went onto to carry the pregnancy to term. The patient complained to the Trust that she was at risk of terminating a healthy pregnancy as a result of the misdiagnosis.

During the investigation it was established that the scanning equipment used was not sufficiently sensitive to be used on early pregnancies and it had been decommissioned for use in the EPAU following this incident. The complaints response accepted responsibility for the error and offered a

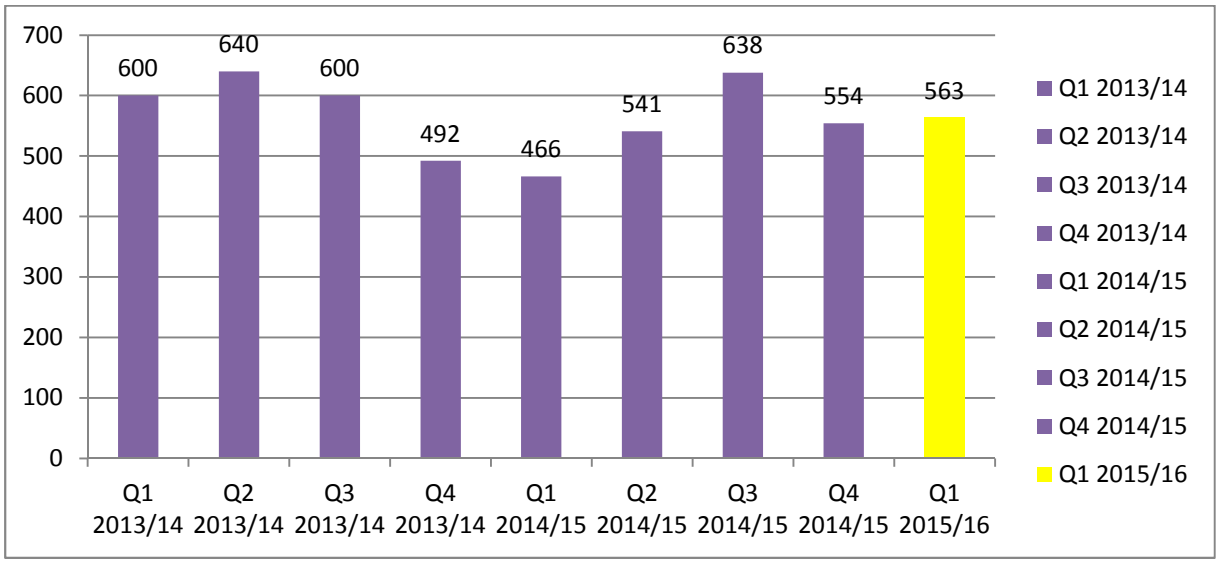
resolution meeting to explain our findings. This meeting took place, but the case was referred to the PHSO as the patient was not sufficiently assured that the Trust was empathetic to the distress this incident had caused her.

The PHSO found that the complaint responses had been thorough as was our investigation, and the action taken appropriate. However they didn't feel that our responses were sensitive enough and awarded the complainant £250 compensation.

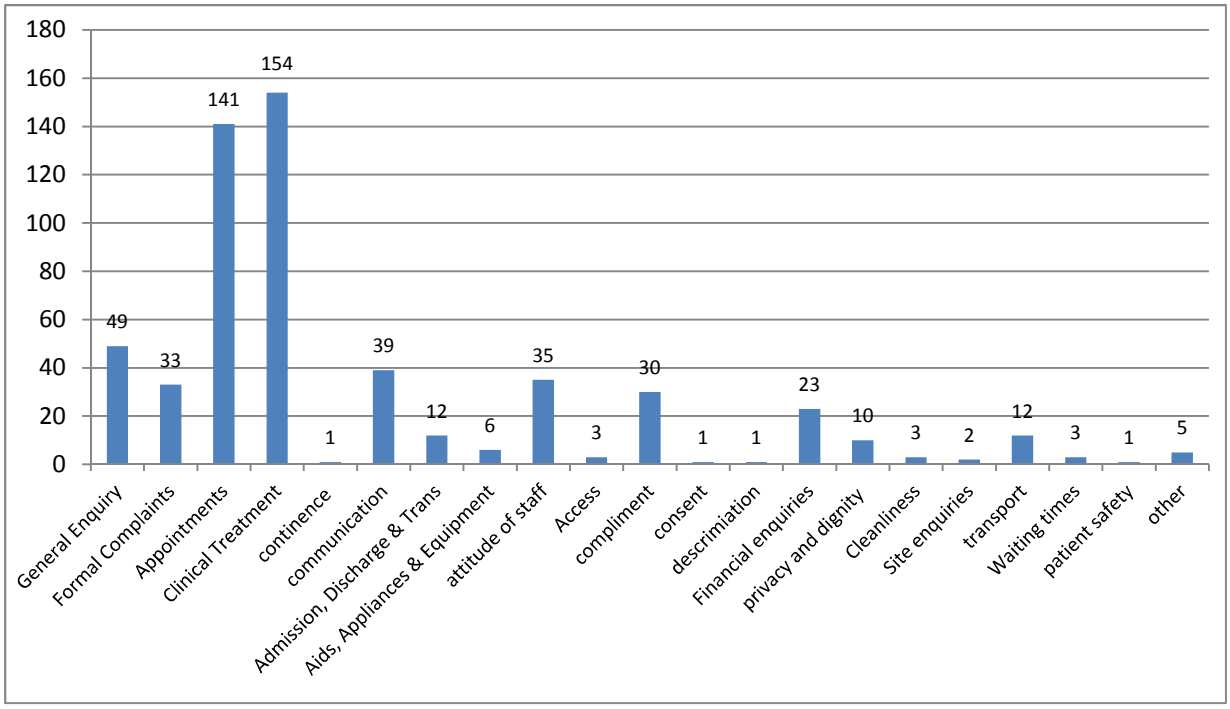
PALS

PALS continue to play a vital role in providing patients with a local advocate who can investigate concerns. As well as reporting the standard enquiries, work has continued in the collection of compliments for this quarter; Clinical Groups also reported how many concerns were addressed at departmental level (those that were resolved by the Trust without the need to escalate to PALS or Complaints). These concerns are often well managed with effective and caring solutions.

The total number of PALS enquiries made for Q1 2015/16 was 564 compared to 554 in Q4 2014/15, 638 in Q3 2014/15 and 541 in Q2 2014/15 and the following graph shows the number of enquiries of PALS by quarter over the past 2 years.



The following are the enquiries taken by PALS in Q1 2015/16



In past reports, the top 5 enquiry types have been reported, but with a renewed focus on recording PALS enquiries, across standard themes, from Q1 2015/16 all enquiries can be reported upon and comparisons made over the coming quarters. **Appendix 9** reports all PALS enquiries broken down by Clinical Group and in future reports, will also compare this Clinical Group with previous quarters.

Appendix 10 shows the compliments collected this quarter. This includes the 30 compliments that are reported in the recorded PALS enquiries, added to the compliments that are collected manually from all wards across the Trust.

Summary

The total number of complaints managed during Q1 2015/16 was **207**, with 30 being withdrawn. There was also 1 new case which has been referred to the PHSO by a complainant. This number compares to 207 logged in Q4 2015/16 (with 17 withdrawn) and 235 logged in Q3 2014/15 (with 24 withdrawn.) **358** compliments were also recorded. PALS received **564** enquiries, an increase of 10 enquiries for the same period last quarter.

The average days to complete a complaint has decreased to an average of 51.62 days, and Q1 2015/16 has seen a continued decrease as complaints are kept in date, with fewer older complaints left to resolve. The satisfaction survey reported that complainants felt slightly better informed as to the progress of their complaint with the overall satisfaction level remaining largely the same.

Of the Clinical Groups, Medicine continues to attract the highest number of complaints, and Women and Child Health the lowest (of the four Clinical Groups that make up the majority of complaints).

Surgery B still has the highest complaints rate but not as many of these are about appointments and this increased complaint rate has seen a steady decline across the last 3 quarters.

Development work from previous quarters now implemented.

- A review of the way that complaints are planned, monitored and escalated was implemented from April 2015 and has resulted in a 97% in date case load for complaints logged from 1 April 2015. In real terms, this meant that 3 cases were sent between 2-5 days post their agreed target date. A review of how this happened has strengthened the procedure already in place and July has seen no repeat of this beach (to date).

- The Action Tracker is now being used to record specific changes required and includes, where applicable the ability to flag where the complainant needs to be contacted again with an update.

- A new process for triaging complaints was established in Q1 2015/16 to ensure they are categorised as one of the following types of complaints.

    1. Fast track complaints - telephone or face to face meetings where issues are resolved quickly (likely level 1 and some level 2 grade complaints.)
    2. Standard complaints in need of investigation and in need of a written response (letter or report.)
    3. Complaints involving the death of a patient, where a specific pathway for the management of the compliant is being developed.

       This work has now been completed, but more work needs to be done to embed the concept of meeting all bereaved complainants and further reducing the time it takes to manage a fast track complaint.

- Work has started on analysing the reason why complaints are disproportionately received from certain ethnic groups. **Appendix 11** highlights the types of complaints made by Black- Caribbean patients compared to the wider patient population.

Key areas for focus in Quarter 2 2015/16

- A recent development in the Safeguard database has enabled us to record how long each stage of a complaint takes rather than just reporting the time taken for the whole complaint. By understanding this, more work and coaching can be concentrated on the right part of the process to further improve the time it takes to manage a complaint. Whilst the fields on Safeguard have now been implemented, the reporting mechanism has not yet been finalised, so this is on hold until Ulysses complete this work. As at Q1 2015/16 this is still not resolved and therefore this reporting has not started.

- Integrate across Governance in order to better understand the link between an incident that results in a complaint and in turn may result in a legal claim.

- Consideration is being given to the collection of compliment data. The current method of collection relies too heavily on a manual tick sheet that is not consistent, making the analysis of trends difficult. Safeguard does have to facility to record compliments when staff are committed to recording compliments in this way and this work is being discussed through the Patient and Staff Engagement Committee.

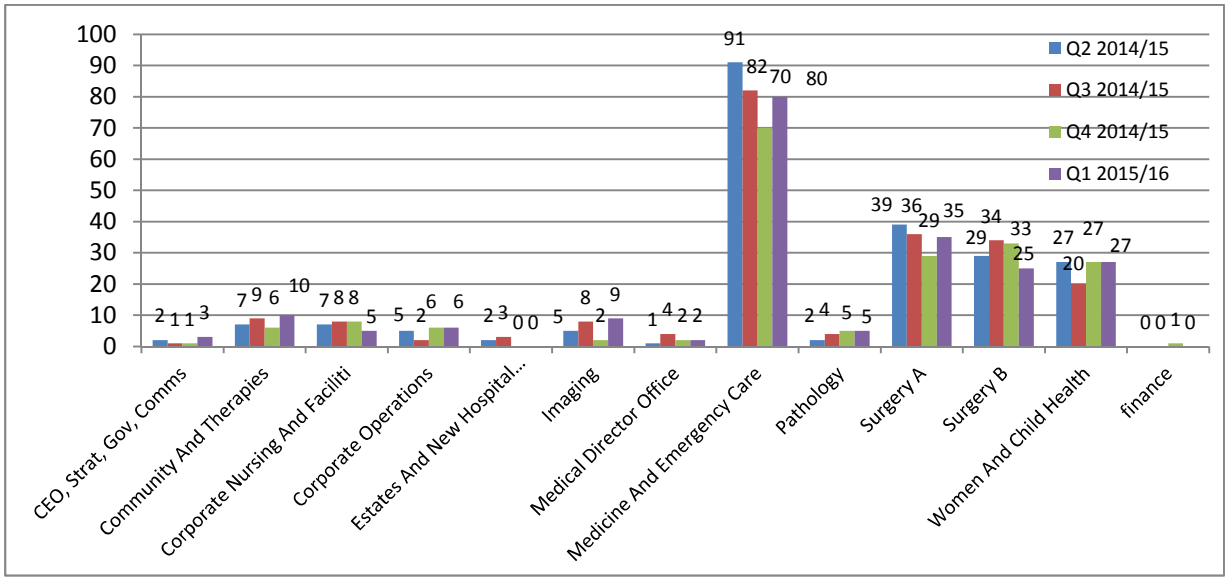
- The second stage of the use of the Action Tracker tool in Safeguard is to develop a method of not only recording the future actions but that these commitments are monitored to ensure that they have taken place and that the complainant is re-contacted to reassure them that we have done what we said we were going to, and where applicable, enclose evidence.

- Further work still needs to be done to understand the implications of the work already started in analysing complaints from Black Caribbean complainants. It is also planned that the Head of PALS and Complaints make contact with the local Pakistani community to promote the appropriateness of making complaints to the NHS when patients feel let down.

Karen Beechey
Head of PALS & Complaints

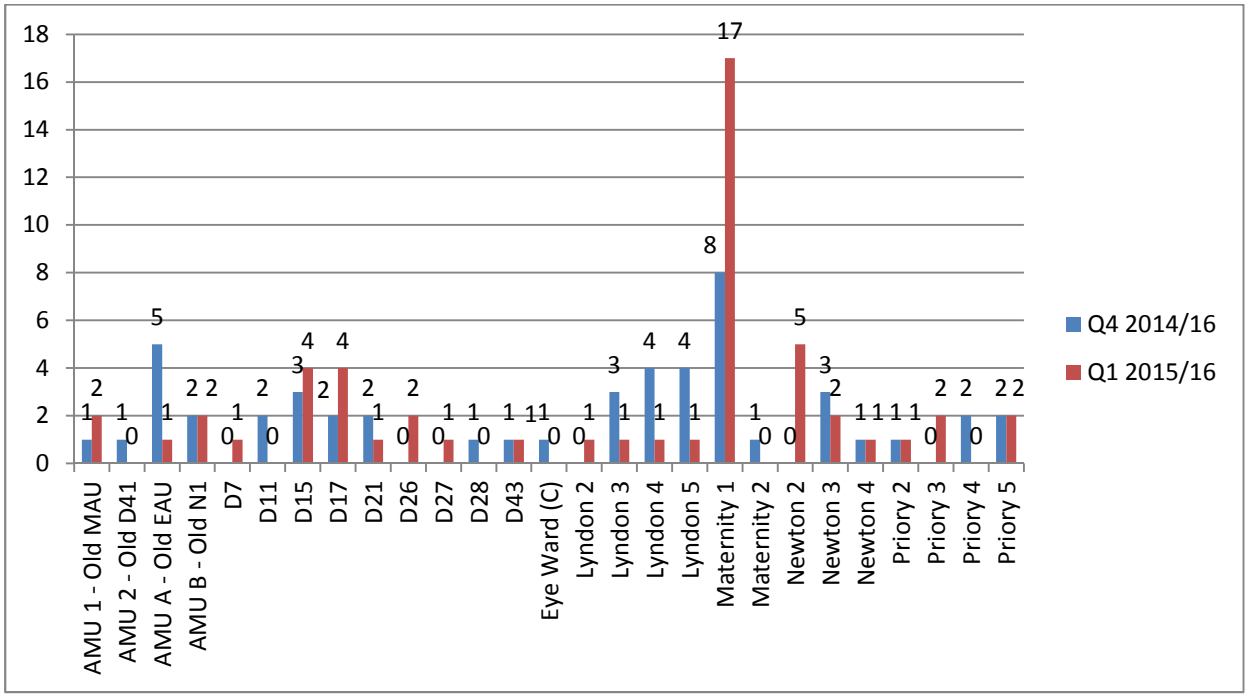
Appendix 1a

Complaints received by Clinical Group and Corporate Directorate for Q1 2015/16 compared to 2014/15 quarters.



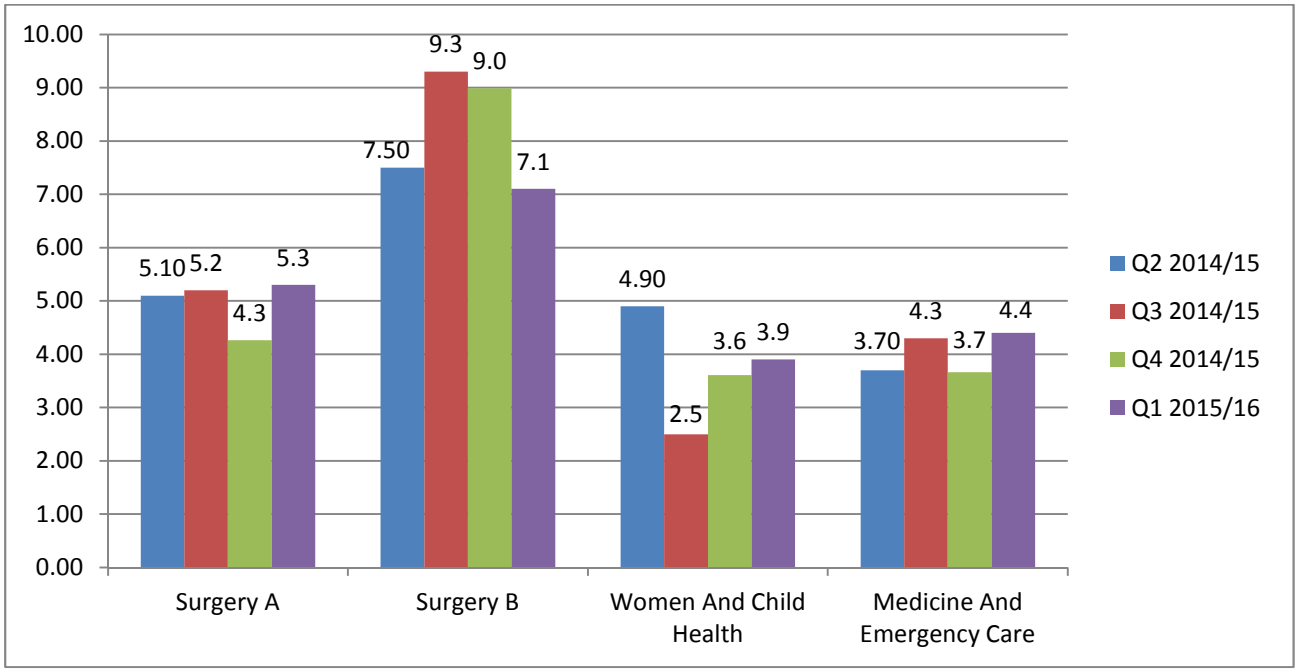
Appendix 1b

Complaints received by Ward (where applicable) for Q1 2015/16



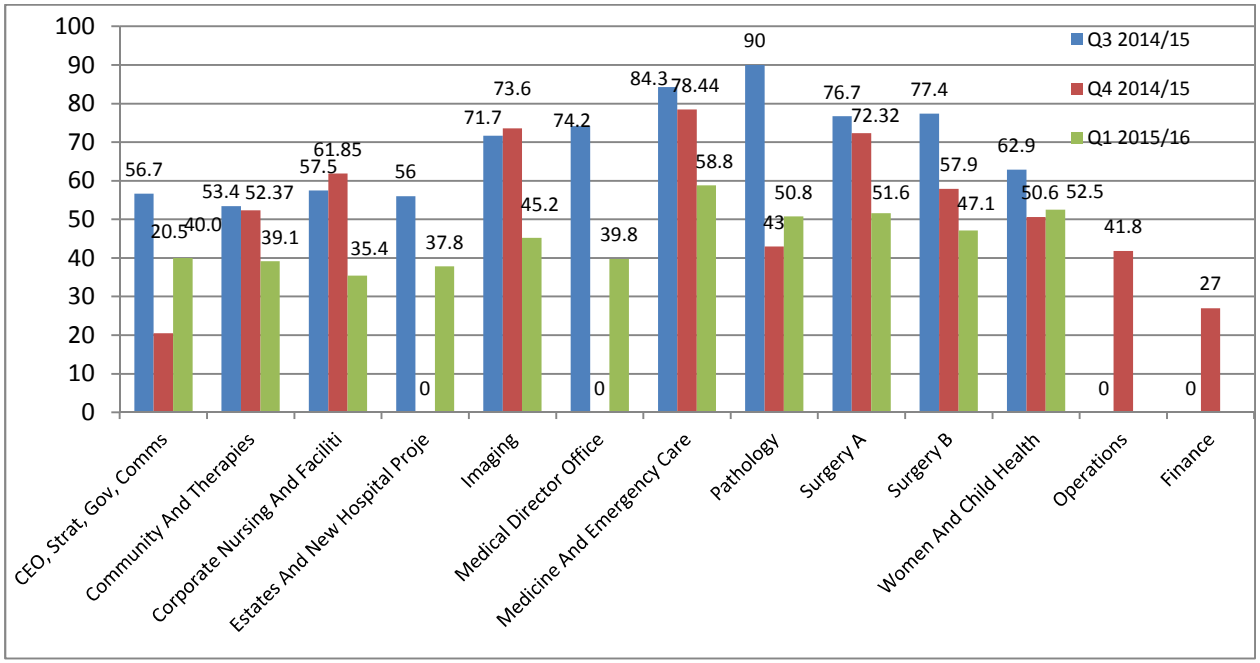
Appendix 2

Complaints rates by FCE for Q1 2015/16, Q2 - Q4 2014/15by the top four Clinical Groups



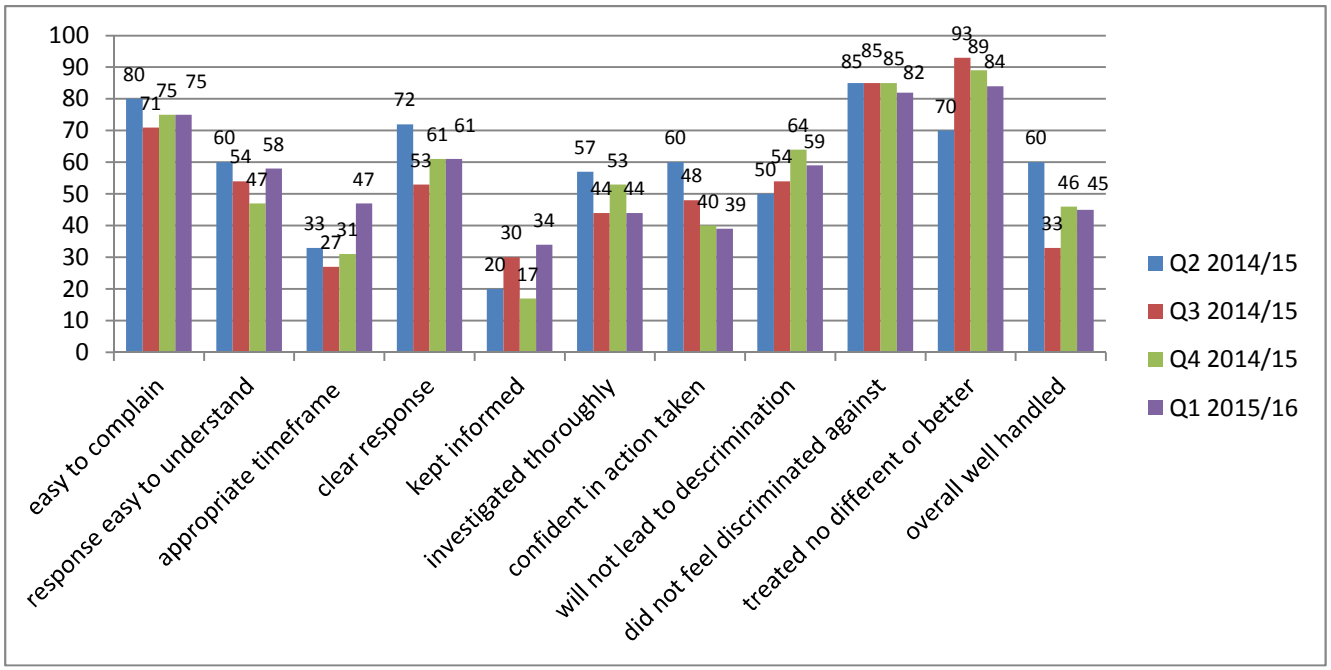
Appendix 3

Complaints turn around by Clinical Group for Q1 2015/16, showing the number of days that each new, or reopened complaint took to close from the time it was received by the Complaints team to the time that it was signed off (compared to Q4 2014/15 and Q3 20145/15).



Appendix 4

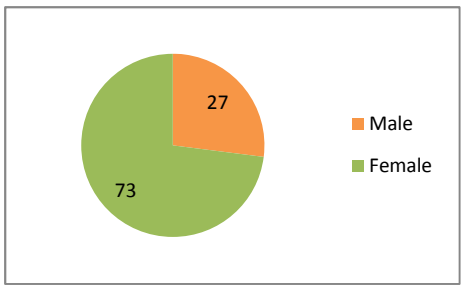
The Complaints satisfaction survey questions for Q1 2015/16 compared to Q4 2014/15, Q3 2014/15 and Q2 2014/15 (and the % of respondents that answered in the positive to each question.)



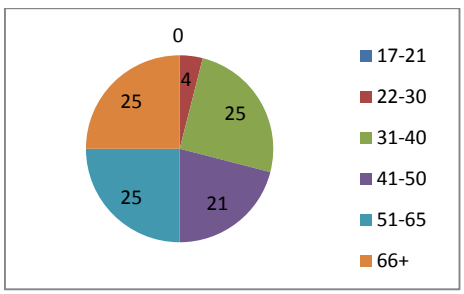
Appendix 5

The profile of respondents to the Complaints satisfaction survey for Q1 2015/16

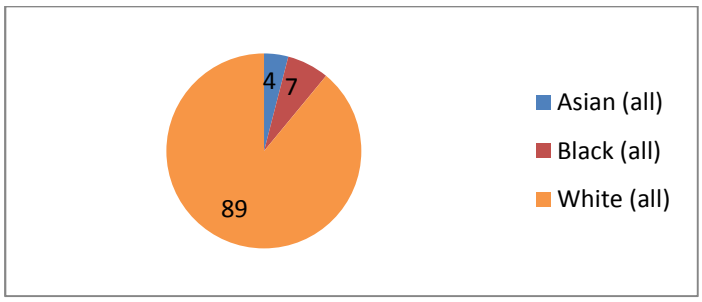
Gender (%)



Age (%)

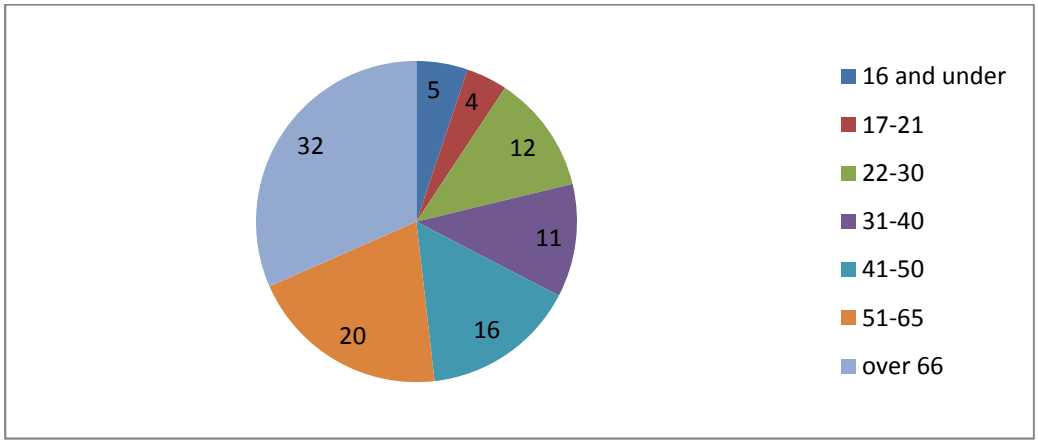


Ethnicity (%)

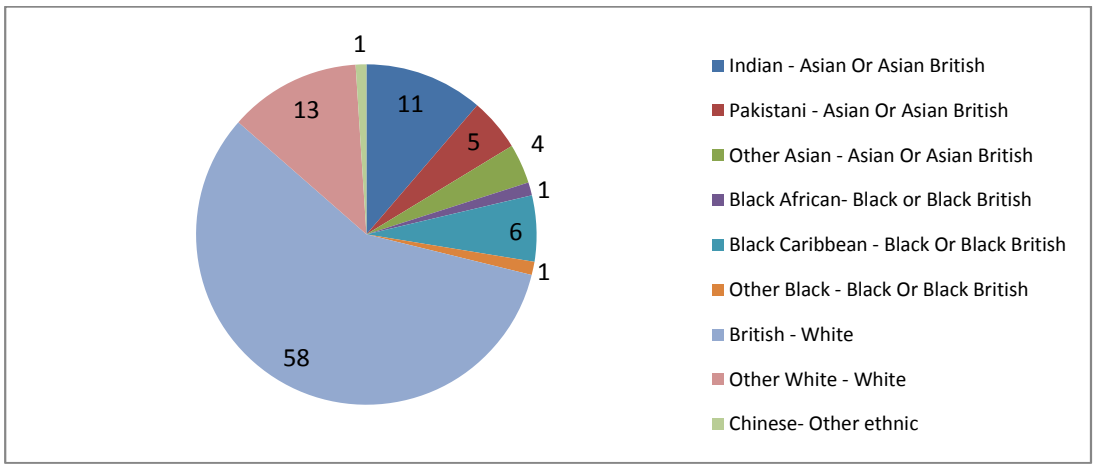


Appendix 6

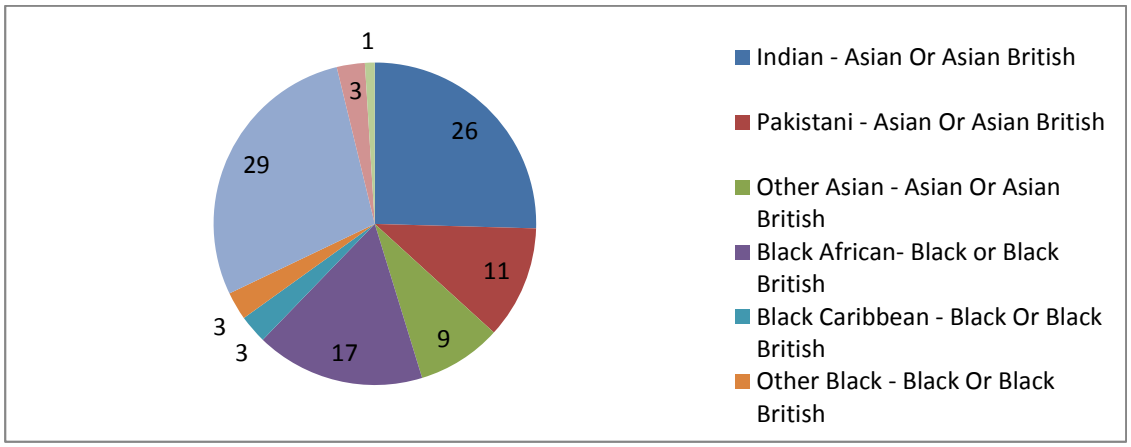
A breakdown of all complainants by % by age where specified for Q1 2015/16



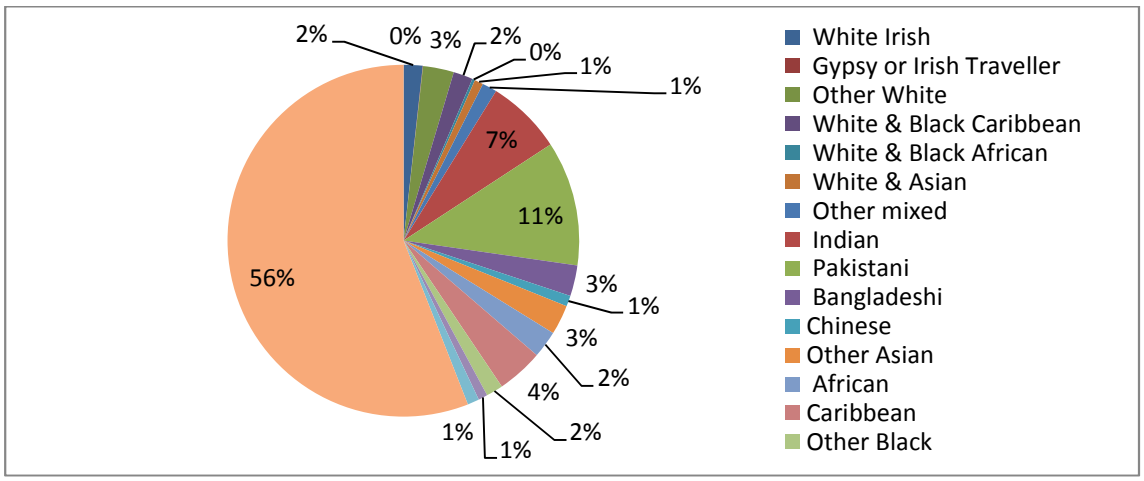
A breakdown of all complainants by % of those where ethnicity was recorded for Q1 2015/16



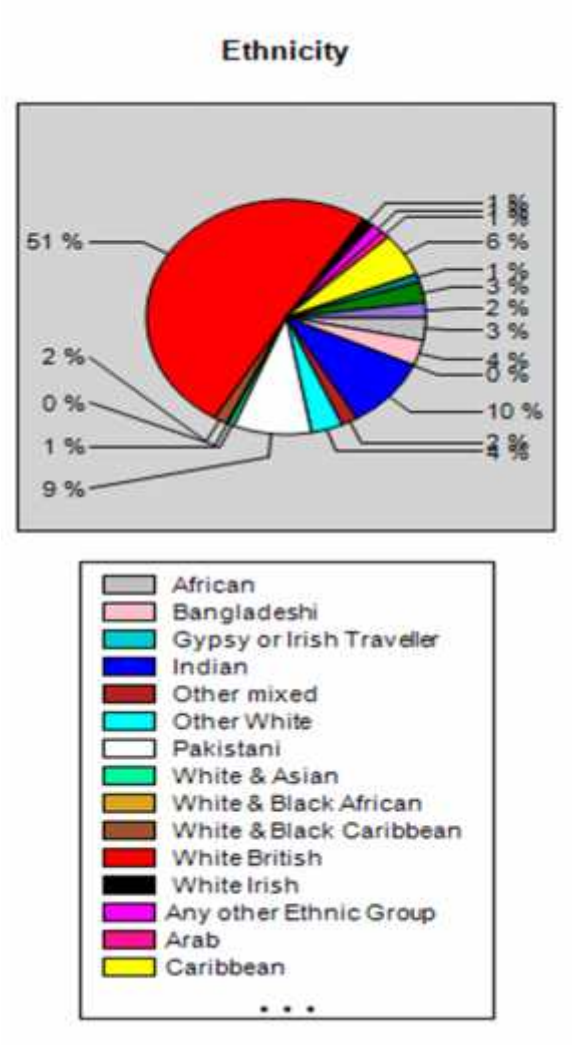
A breakdown of all complainants by % of those where ethnicity was recorded taking out those White British for Q1 2015/16



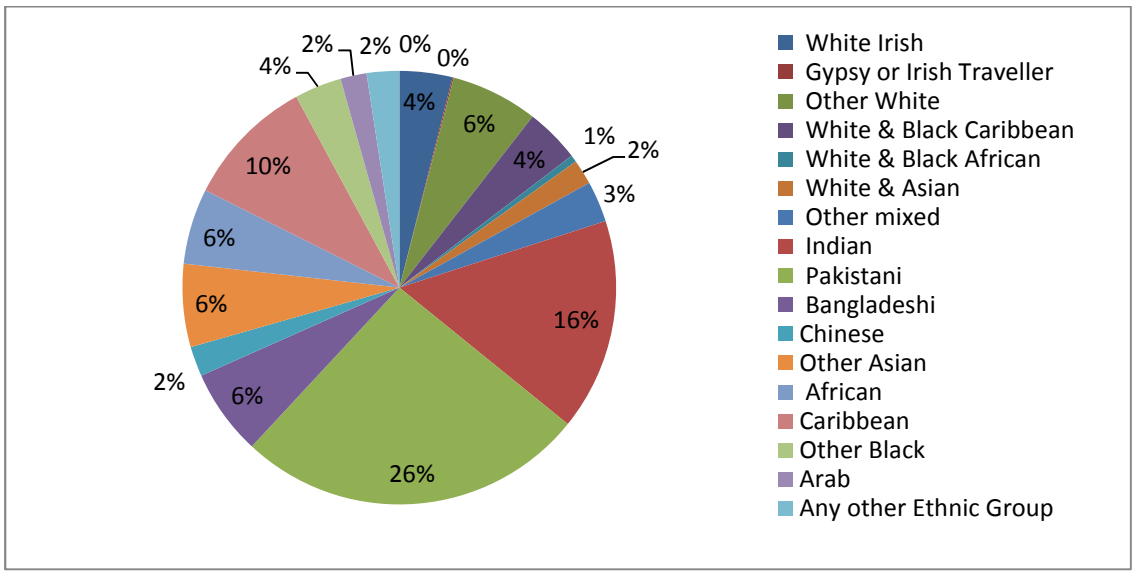
Ethnicity split by Sandwell and West Birmingham Population as taken from the 2011 census and quoted out to the Local Demography report prepared by the Trusts Equality and Diversity team in 2013.



Ethnicity split of patient population

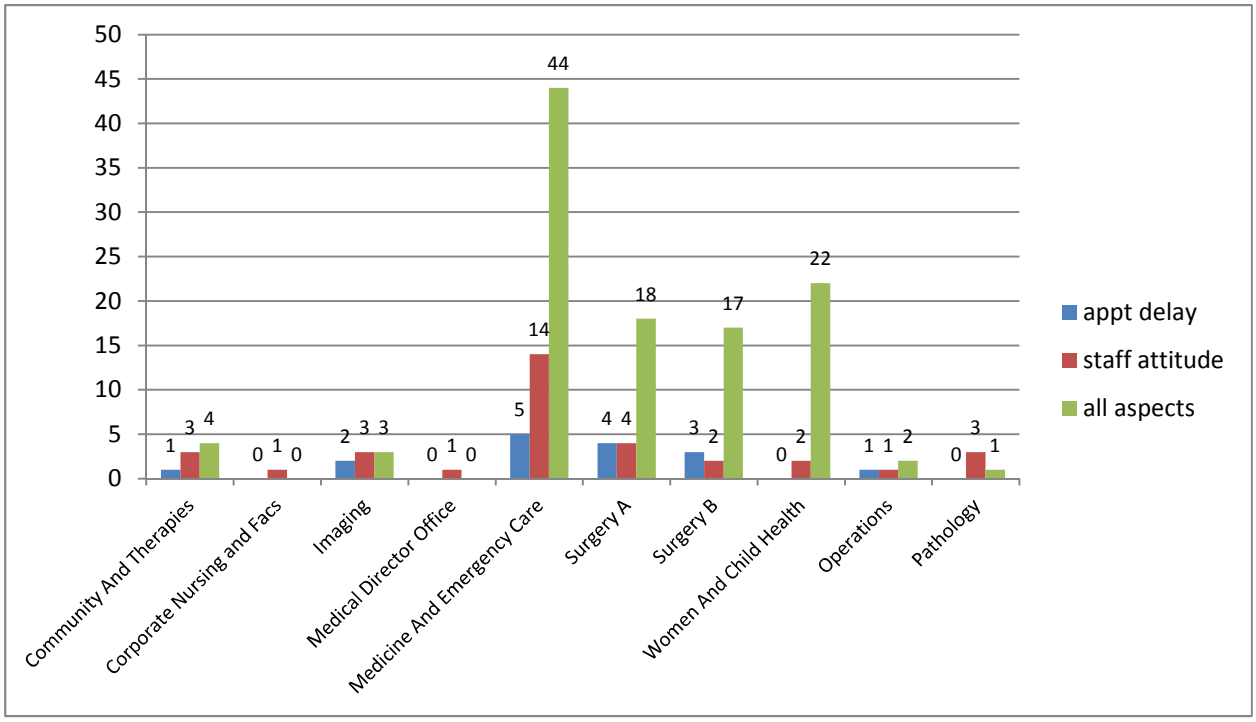


Ethnicity split by Sandwell and West Birmingham Population as taken from the 2011 census and quoted out to the Local Demography report prepared by Equality and Diversity in 2013, without White British.

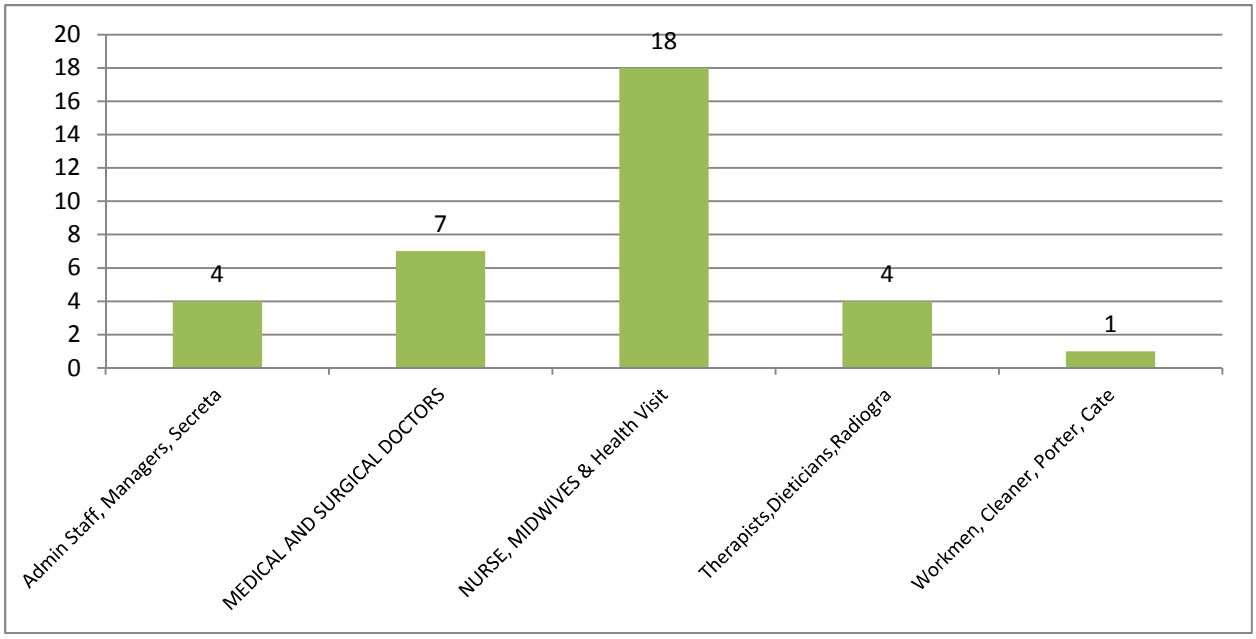


Appendix 7

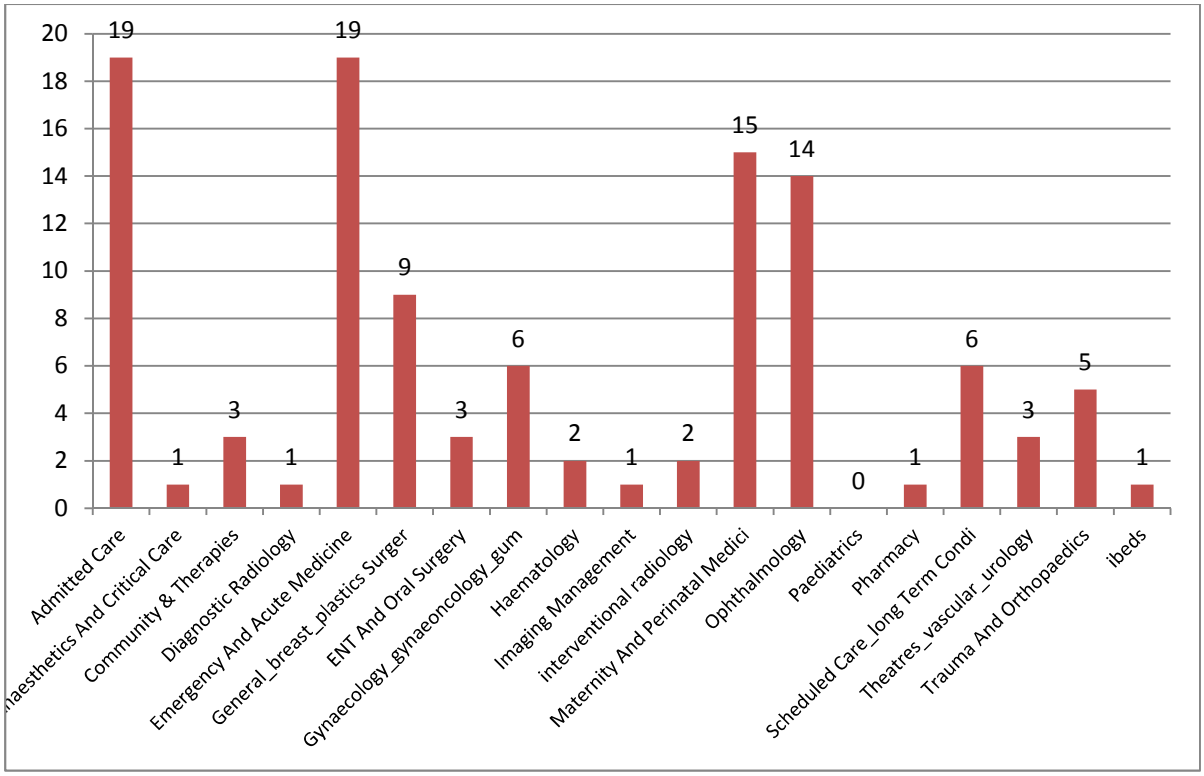
A breakdown of the top three themes complained about, broken down by Clinical Group or Corporate Directorate for Q1 2015/16. Where there were no complaints for this theme for a Clinical Group or Corporate Directorate, then they are not featured in this breakdown.



A breakdown of the 'attitude of staff' theme by staff groups for Q1 2015/16

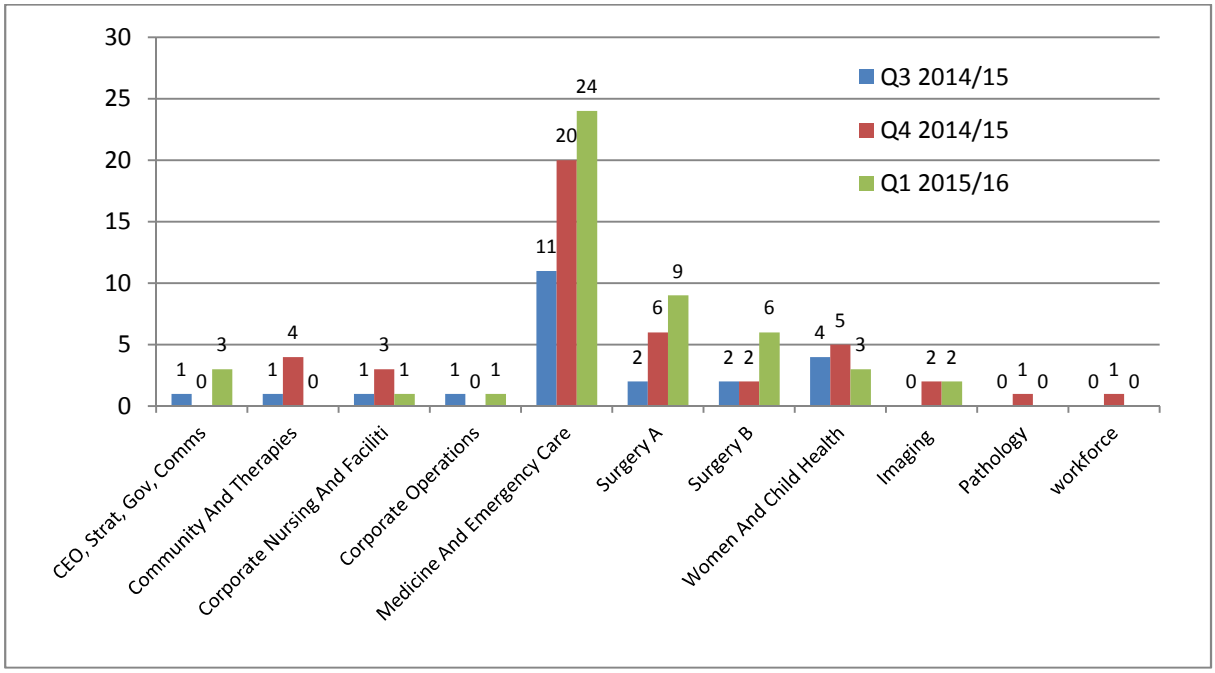


A breakdown of the 'all aspects of clinical treatment' theme by Trust wide clinical directorate Q1 2015/16

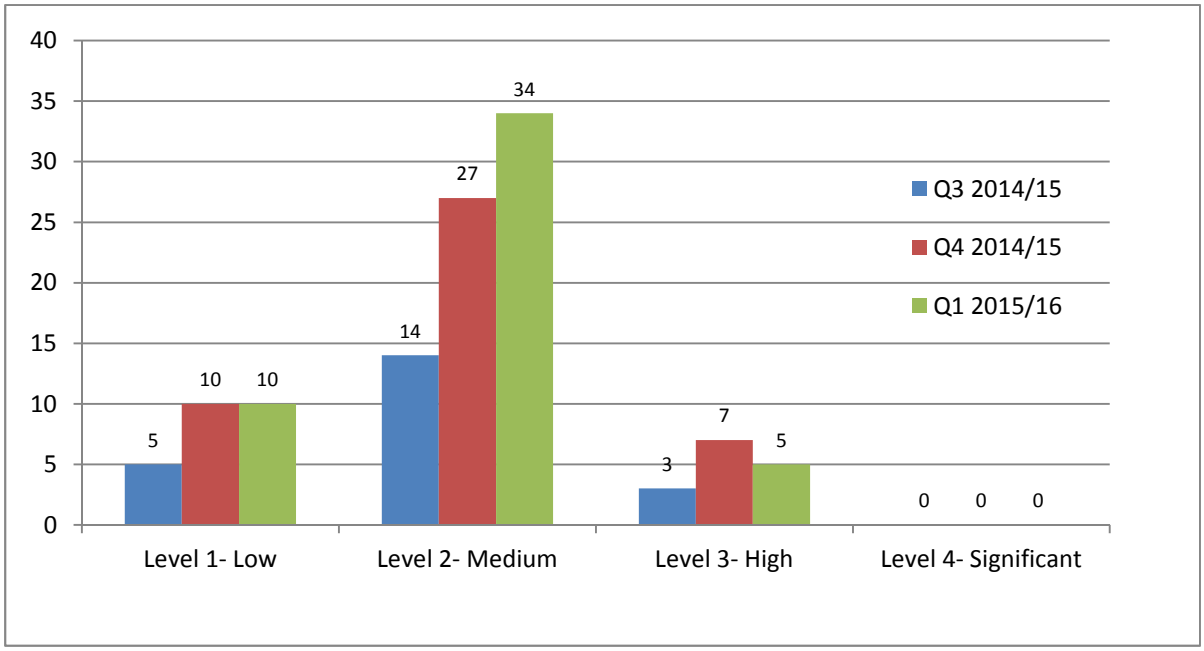


Appendix 8

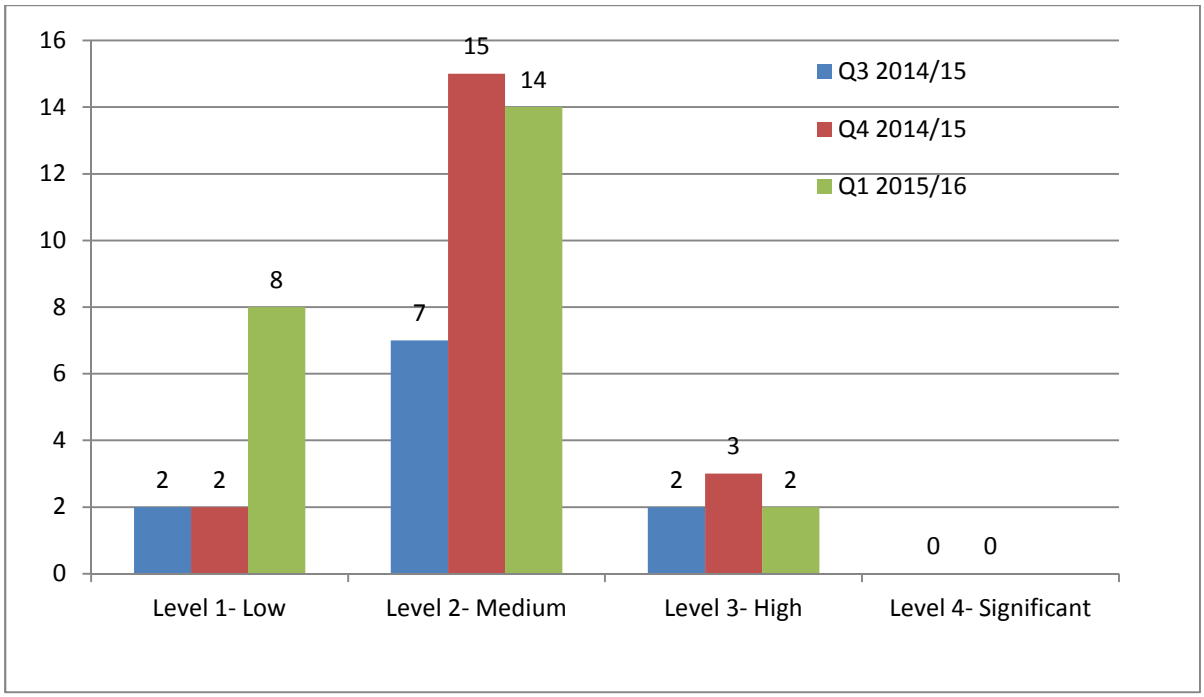
Complaints that have been reopened in Q1 2015/16 by Clinical Group and Corporate Directorate



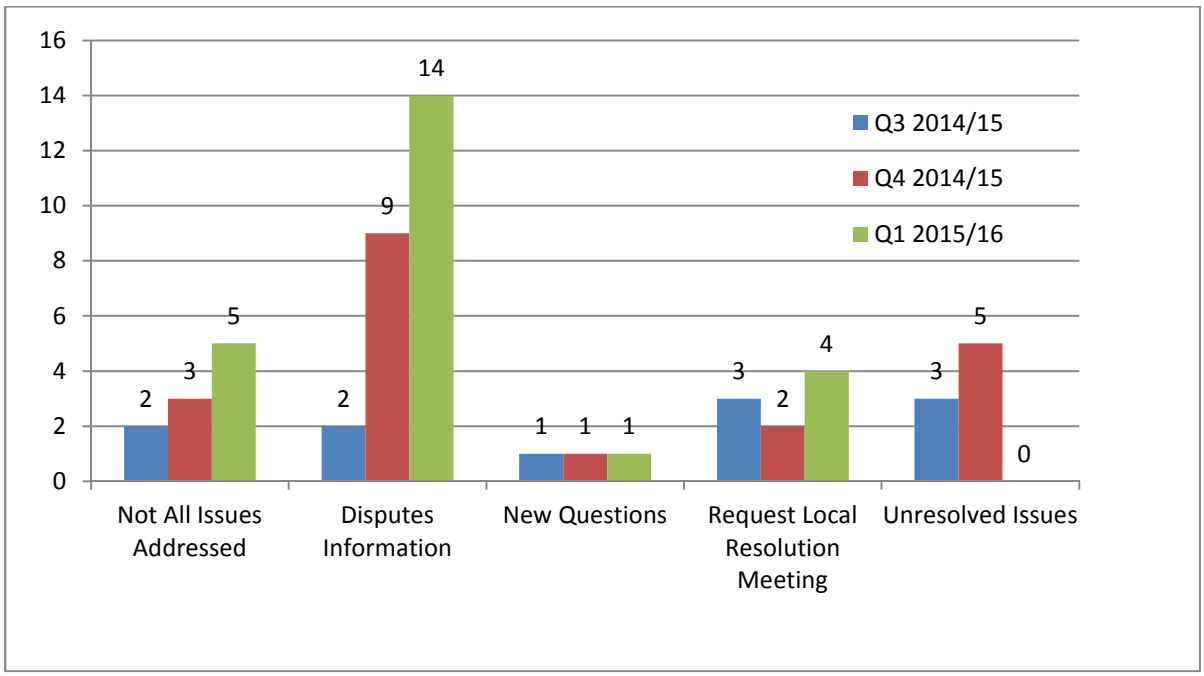
Complaints that have been reopened in Q1 2015/16 by Grade compared to Q4 and Q3 2014/15



Reopened complaints for Medicine and Emergency Care by grade for Q1 2015/16 compared to Q4 and Q3 2014/15

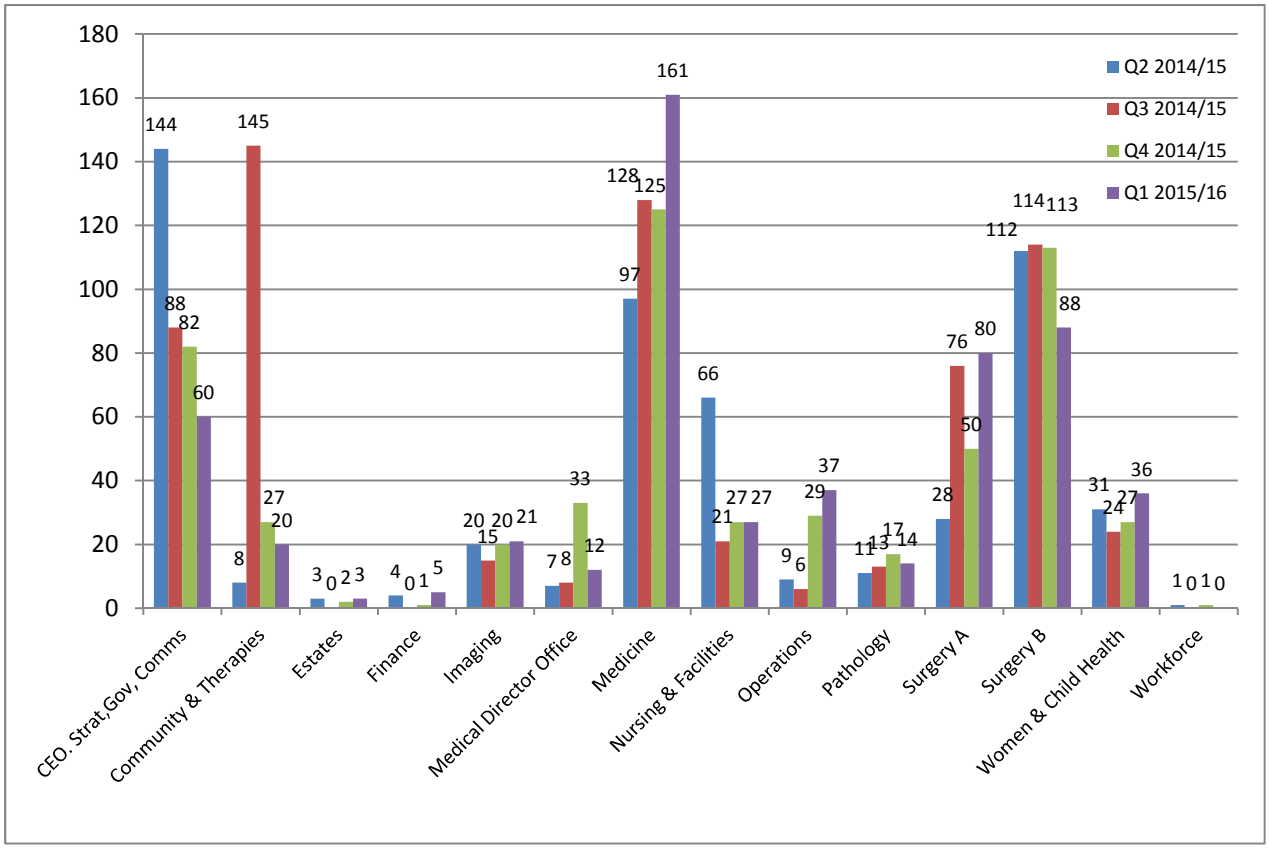


Reopened complaints for Medicine and Emergency Care by reason Q1 2015/16 compared to Q4 and Q3 2014/15



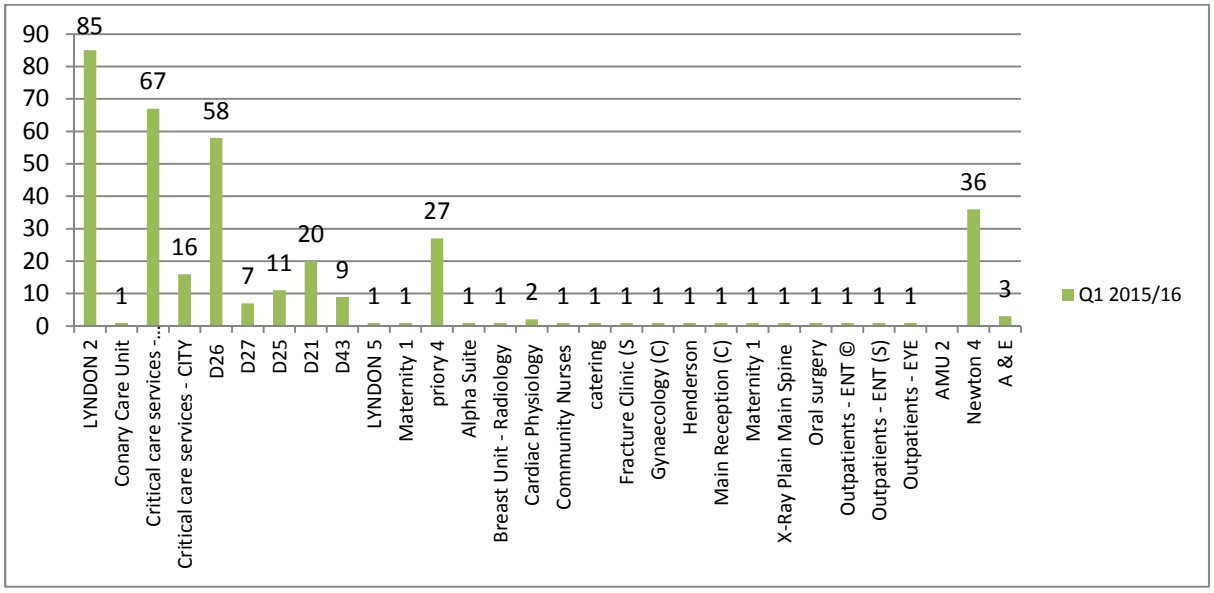
Appendix 9

PALS enquiries broken down by group Q1 2015/16 compared to Q4 and Q3 2014/15



Appendix 10

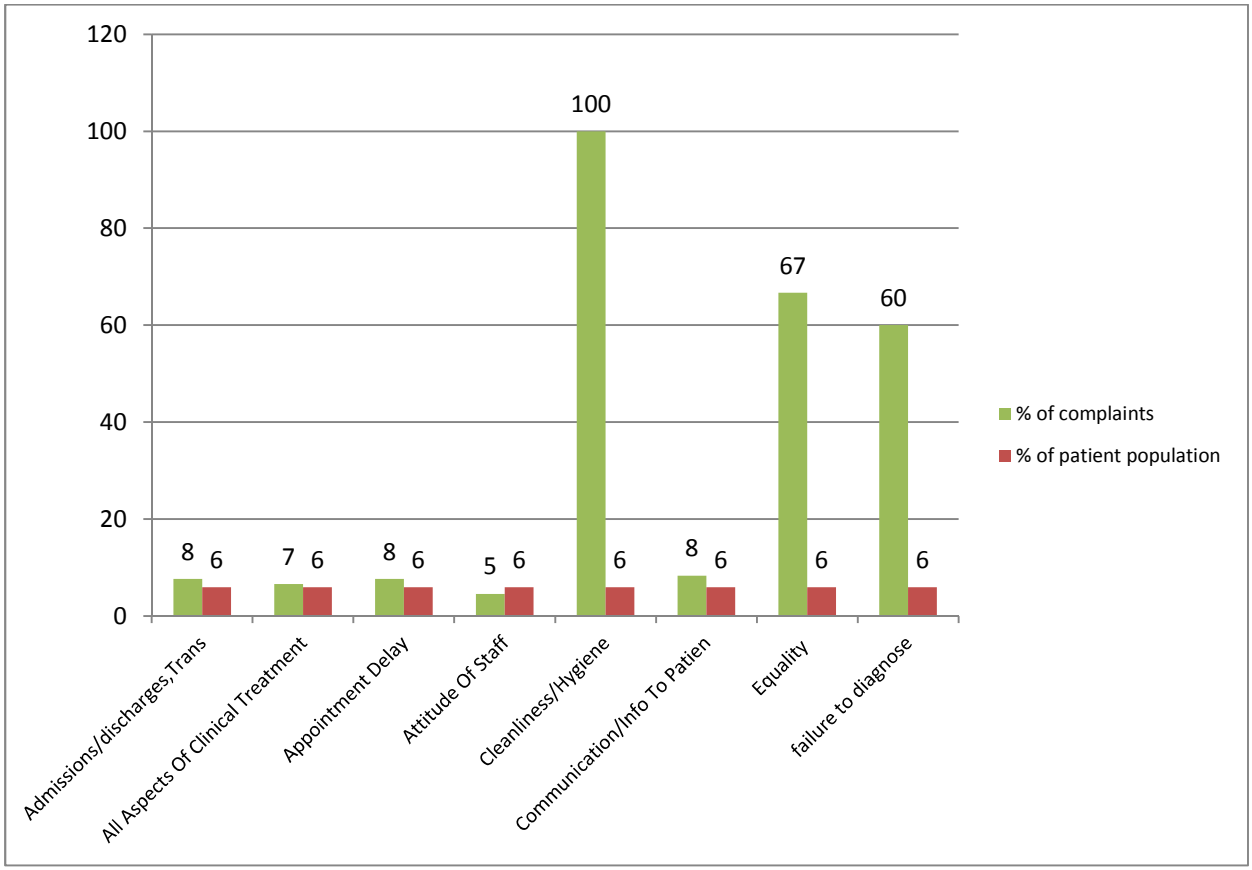
Compliments Q1 2015/16



This shows the breakdown of compliments collated by the wards that responded for Q1 2015/16, totalling 222. The total number of compliments, when we started collecting the data in Q2 2014/15 was 507, against 397 in Q3 2014/15 and 359 in Q4 2014/15. Without a more comprehensive reporting tool (as opposed to the manual tick sheet currently in use) it is still not clear whether this is a drop in compliments, or a lack of commitment in reporting this activity.

Appendix 11

Analysis of complaints made where the subject of the complaint is Black Caribbean.



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Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Quality, Performance and Finance Report
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Performance Management
DATE OF MEETING:	6 August 2015 (Report finalised 30 July 2015)

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

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

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

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

Sandwell and West Birmingham Hospitals
NHS Trust

Integrated Quality and Performance Report

June 2015

Contents

At A Glance

Infection Control

There were 4 cases of C. Diff reported during the month of June (2 Medicine, 1 Surgery A and 1 Women & Child Health). The number of cases for the month are outside of the trajectory of 3, but the total of 8 cases remain within the trajectory (8) for the year to date.

There was 1 case of MRSA Bacteraemia reported within the month of June within Medicine (Admitted care). Table Top Review Undertaken.

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

Both MRSA elective and non-elective screening remain above the 80% target at 97.3% and 94.4% respectively for June.

Harm Free Care

Overall Harm Free Care as assessed through the NHS Safety Thermometer indicates a level of Harm Free Care of 93.3% for June, beneath the 95.0% operational threshold.

There were 93 falls reported in June, an increase from the previous month (86). 2 of the falls reported sustained serious injury.

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

There was 1 never event in June in Obstetrics - retained swab. Fully investigated. Learning through Theatre Management Board.

There were 4 Open CAS Alerts reported at the end of June, 2 of which were overdue at the end of the reporting period.

Obstetrics

The overall Caesarean Section rate for June of 23.0% remained beneath the target of 25.0%. Elective and Non-Elective rates for the month were 7.8% and 15.2% respectively.

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

Mortality & Readmissions

The Trust's RAMI for the most recent 12-month cumulative period is 88, identical to that of the National HES Peer. City and Sandwell site RAMIs are 75 and 99 respectively.

Mortality rates for weekday and weekend and low risk diagnoses remain within statistical confidence limits. RAMI values for all CQC diagnosis groups are also within or beneath statistical confidence limits.

During the most recent month for which complete data is available (April) the overall Trust performance for review of deaths within 42 days improved to 90% (from 81% the previous month). The trajectory is now 100%.

The Crude Mortality Rate for June is 1.15%. 12 month figure is 1.43%

Stroke Care & Cardiology

Stroke data for the month of June indicates Patients spending >90% of their time on a stroke ward was 86.7% compared with a the 90% operational threshold. Admittance to an acute stroke unit within 4 hours remains relatively stable at 80.3% (90% target). The percentage of patients receiving thrombolysis within 60 minutes of admission was 71.4% (5 of 7 patients) compared with a target of 85%. Patients receiving a CT scan within 1 hour and 24 hours of presentation was 77.4% and 100% respectively.

Primary Angioplasty Door to balloon time (<90 minutes) was 94.1% for May against an 80% target and Call to balloon time (<150 minutes) was 93.8% for the same period, also against an 80% target. RACP performance for June and Year to Date is 100%.

Cancer Care

The Trust did not meet the 62-day urgent GP referral to treatment target of 85% during May, with performance of 79.1% (84.6% for April plus May). June projected performance suggests the target will be met for the quarter. Other high level targets were met.

3 Groups narrowly failed to meet the Cancer 2-week wait target of 93.0%; Medicine (90.9%), Surgery B (92.6%) and Women & Child Health (89.1%) for the month of May. Escalation processes up to COO have been introduced to align capacity with demand.

Women & Child Health (Gynaecological Cancer) did not meet the 31 day diagnosis to treatment target of 96% during May, with performance of 88.0%.

As referenced above, the 62-day urgent GP referral to treatment target of 85% during May was not met, with 3 of the 4 Clinical Groups failing to meet the target; Medicine (82.6%), Surgery A (80.0%) and Women & Child Health (70.5%).

Patient Experience - MSA & Complaints

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

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 further improved to 42% in June.

The oldest complaint currently in the system is in Medicine at 210 days

Patient Experience - Cancelled Operations

The number of Last Minute Cancelled Operations reduced further during June to 28, equivalent to 0.6%, against a 0.8% target. The majority of cancellations (16) occured in Surgery B.

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

Emergency Care

The Trust's performance against the 4-hour ED wait target of 95.0% during the Month (June) was 94.54%. Performance for the first Quarter is 92.99%. Performance to date for the month of July is 93.2% (up to and including 28 July).

WMAS fineable 30 - 60 minute and greater than 60 minute handover delays have shown consistent improvement (reduction) over the most recent 3 month period.

The proportion of patients admitted with a Fractured Neck of Femur who received an operation within 24 hours of admission during June was 42.1% (8 of 19 patients).

Referral To Treatment

Trust level Admitted, Non-Admitted and incomplete RTT Pathway targets were all met for June.

At the end of June 1 patient was waiting more than 52 weeks for commencement of treatment on the Incomplete RTT pathway in Ophthalmology, whilst 1 patient waited more than 52 weeks for commencement of treatment on the Admitted Pathway in Paediatric Ophthalmology.

4 Treatment Functions failed the respective RTT pathway performance thresholds for the month, a reduction from 6 the previous month.

Diagnostic waits (June) beyond 6 weeks were 0.11%, remaining well beneath the operational threshold of 1.00%. There were a total of 11 patients waiting in excess of 6 weeks for a diagnostic test / investigation.

Data Completeness

The Healthcare and Social Care Information Centre (HSCIC) assess the percentage of Trust submitted records for A&E, Inpatients and Outpatients to the Secondary Uses Service (SUS) for completeness of valid entries in mandatory fields. AE and OP parameters remain above target, but IP data with valid entries has fallen to just below the required threshold. (latest data provided May)

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 June reported as 96.0%. 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 June of 39.07%.

Staff

PDR overall compliance as at the end of June reduced slightly to 89.1%. The Medical Appraisal / Revalidation Rate for the month also reduced to 89.4%.

Mandatory Training at the end of June improved to 89.1% overall.

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

Sickness Absence reduced slightly to 4.58% for June, and is 4.87% for the 12-month rolling period. (Range by Clinical Group during June is 3.1% to 6.0% and by Corporate Directorate 0.56% to 6.45%).

The Return to Work interview rate following Sickness Absence improved slightly to 63.49% for the 12-month cumulative period concluding June(range by Clinical Group 44.1% - 79.7% and Corporate Directorate (38.1% - 83.3%)).

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

CQUIN

In summary 12 schemes are classified as performing and a total of 8 schemes require baseline data to be gathered / trajectories and targets set, based upon these. For one scheme 'Improvement in diagnosis recording in HES Data Set of Mental Health presentations in A&E', agreement has been reached with commissioners to revise the original (locally modified) definition of the scheme, and revert to the national definition, whereby the first quarter's requirment has been met by the provision of base data. Performance for this scheme is currently is 77% data recording, with a requirement to improve to meet an end of year 90% target. Consequential to this is an additional scheme, 'Medication and Falls', for which data capture processes are currently being finalised and baseline data acquired. Formal submission of CQUIN performance to commissioners will also be required each quarter. Confirmation has been received from Specialised Commissioners that the requirements for Quarter 1 have been fully met for all Specilaised CQUIN schemes.

External Assessment Frameworks

TDA Accountability Framework - Quality Scores for each of the 5 domains which comprise the framework are indicated in the main body of this report, with the areas of 'adverse' performance against each domain identified. The sum of the domain scores are used to derive the overall quality score which for the most recent period is 3 (1 is highest risk rating and 5 is lowest risk rating). The overall score is also influenced by the application of any override rules which may be applied, which during June related to ED 4-hour performance of 94.54%.

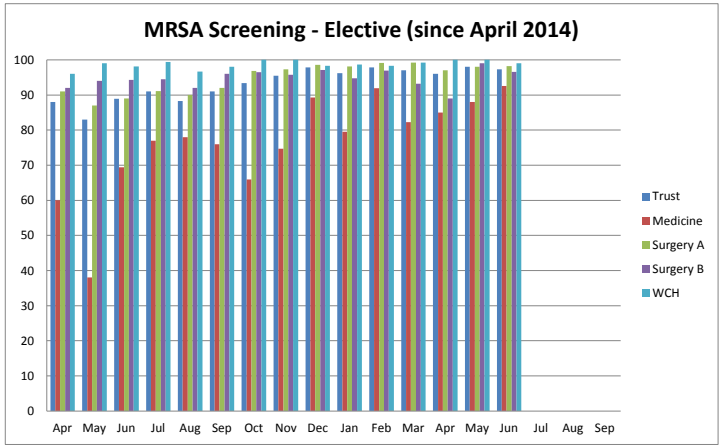
Monitor Risk Assessment Framework - compliance against this framework is also indicated. For the month of June performance (actual and projected) attracts a Governance Rating of 1.0 (Amber / Green), influenced adversely by ED 4-hour wait performance during the month.

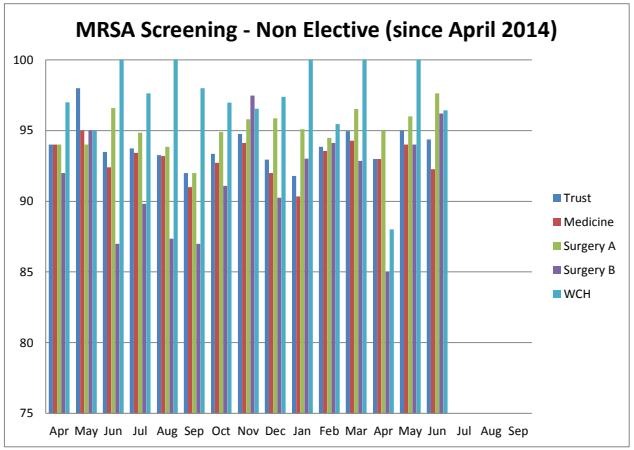
Data Quality

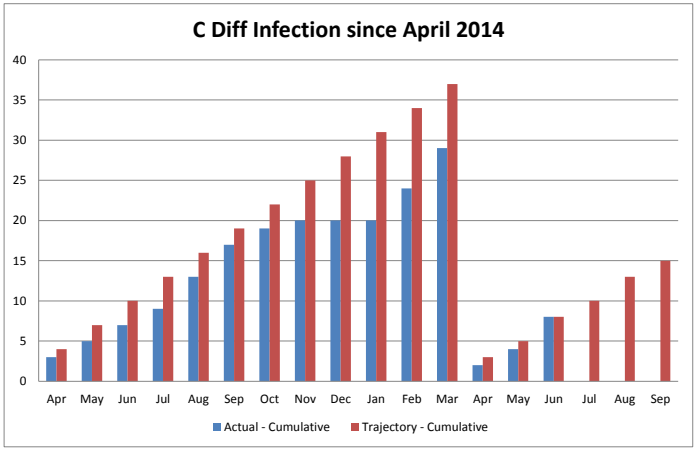
Baker Tilly are to provide a summary of any incomplete or over due tracker actions relating to any previously completed audits and reports. Additionally, a list of 'closed off' actions is to be provided as well as assurance that those closed items have been re-tested and are working. It is intended that any outstanding actions are followed up with the appropriate Executive Director.

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A M J J A S O N D J F M A M J J A S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
4			C. Difficile	No.	30	3		Jun-15	2	1	0	1					4	8			
4			MRSA Bacteraemia	No.	0	0		Jun-15	1	0	0	0					1	1			
4			MSSA Bacteraemia (rate per 100,000 bed days)	Rate	<9.42	<9.42		Jun-15									4.6	1.5			
4			E Coli Bacteraemia (rate per 100,000 bed days)	Rate	<94.9	<94.9		Jun-15									27.7	23.0			
3			MRSA Screening - Elective	%	80	80		Jun-15	93	98	97	99					97.3				
3			MRSA Screening - Non Elective	%	80	80		Jun-15	92	98	96	96					94.4				

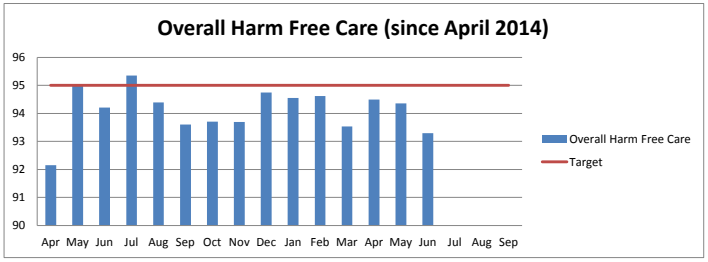


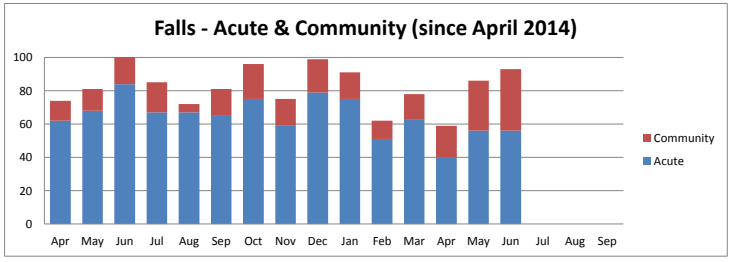


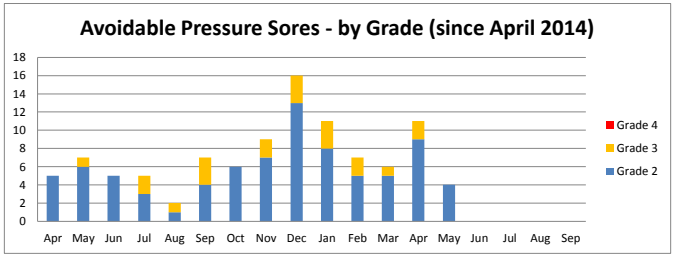


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		d	Patient Safety Thermometer - Overall Harm Free Care	%	=>95	=>95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15									93.3		●		
8			Patient Safety Thermometer - Catheters & UTIs	%			0.53	0.48	0.51	0.49	0.42	0.41	0.40	0.25	0.31	0.41	0.40	0.64	0.25	0.33	0.17				Jun-15									0.17				
8			Falls	No.	804	67	74	81	102	85	72	81	96	75	99	91	62	78	59	86	93				Jun-15	44	3	0	0	0	0	37		93	238	●		
9			Falls with a serious injury	No.	0	0	1	5	4	1	5	1	1	2	1	1	0	1	2	0	2				Jun-15	2	0	0	0		0	0		2	4	●		
8			Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	No.	0	0	5	7	5	5	2	7	4	9	16	11	4	6	11	4					May-15									4	15	●		
3		d	Venous Thromboembolism (VTE) Assessments	%	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	96.4	97.1	98.3	84.4					95.2		●		
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	%	98	98	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	99.1	99.9	100	100		100			99.8		●		
3			WHO Safer Surgery - 3 sections and brief (% lists where complete)	%	95	95	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	100	99.6	100		100			99.8		●		
3			WHO Safer Surgery - Audit - 3 sections, brief and debrief (% lists where complete)	%	85	85	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	100	99.2	100		100			99.5		●		
9		d	Never Events	No.	0	0	●	●	●	●	●	●	●	●	●	●	●	●	1	1	1				Jun-15	0	0	0	1	0	0	0		1	3	●		
9		d	Medication Errors causing serious harm	No.	0	0	●	●	●	●	●	●	●	●	●	●	●	1	●	●	●				Jun-15	0	0	0	0	0	0	0		0	0	●		
9		d	Serious Incidents	No.	0	0	3	2	2	2	2	1	1	2	3	4	4	6	4	3	4				Jun-15	2	0	0	1	0	0	0	1	4	11	●		
9			Open Central Alert System (CAS) Alerts	No.			9	5	7	5	6	5	5	15	17	10	9	4	8	5	4				Jun-15									4		●		
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				Jun-15									2		●		

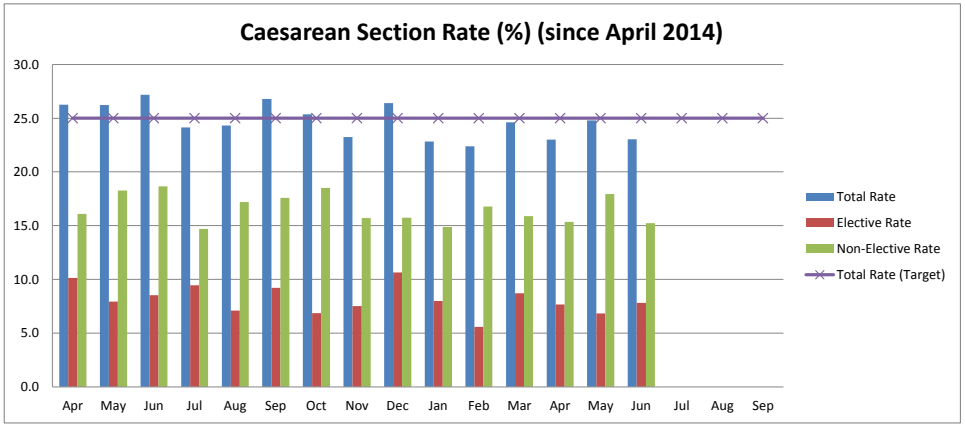


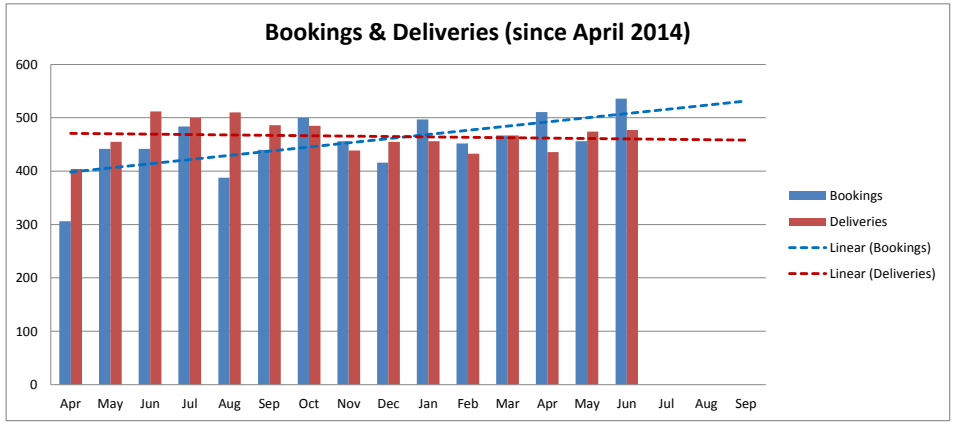




Patient Safety - Obstetrics

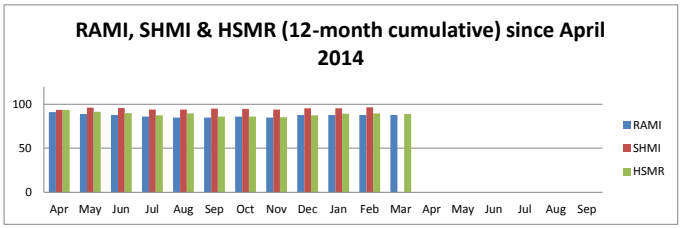
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Caesarean Section Rate - Total	%	=<25.0	=<25.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	23.0	23.6	●		
3		●	Caesarean Section Rate - Elective	%			10	8	9	9	7	9	7	8	11	8	6	9	8	7	8				Jun-15	7.8	7.4			
3		●d●	Caesarean Section Rate - Non Elective	%			16	18	19	15	17	18	19	16	16	15	17	16	15	18	15				Jun-15	15.2	16.2			
2			Maternal Deaths	No.	0	0	●	●	●	●	●	●	●	●	1	●	●	●	●	●	●				Jun-15	0	0	●		
3			Post Partum Haemorrhage (>2000ml)	No.	48	4	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	●		
3			Admissions to Neonatal Intensive Care	%	=<10.0	=<10.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	1.68	1.44	●		
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	Rate	<8.0	<8.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	9.1		●		
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	78.7		●		
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	154.2		●		
2			Breast Feeding Initiation (Quarterly)	%	=>77.0	=>77.0		●		●			●			●			●						Jun-15	78.98	78.98	●		
2		●	Puerperal Sepsis and other puerperal infections (variation 1) (%)	%			2.3	1.8	2.6	1.8	0.9	0.9	0.7	1.5	1.2	1.4	0.5	2.1	2.1	2.1	1.2				Jun-15	1.17	1.85			
2		●	Puerperal Sepsis and other puerperal infections (variation 2) (%)	%			1.5	1.8	1.6	1.6	0.7	0.3	0.7	1.3	0.8	0.3	0.5	1.5	1.7	1.1	1.2				Jun-15	1.17	1.29			
2		●	Puerperal Sepsis and other puerperal infections (variation 3) (%)	%			0.8	0.7	0.4	0.4	0.2	0.0	0.0	1.0	0.4	0.0	0.0	1.2	0.7	0.8	0.9				Jun-15	0.88	0.80			

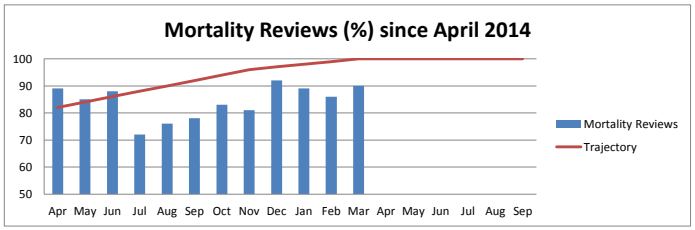


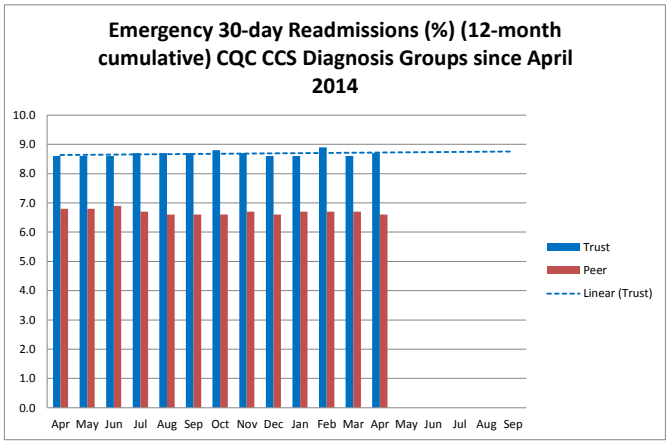


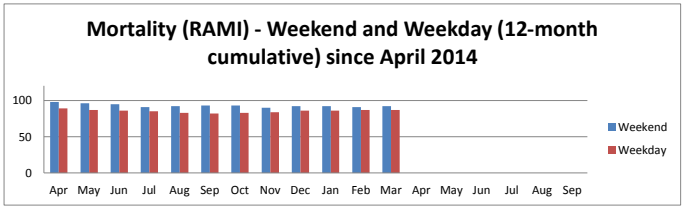
Clinical Effectiveness - Mortality & Readmissions

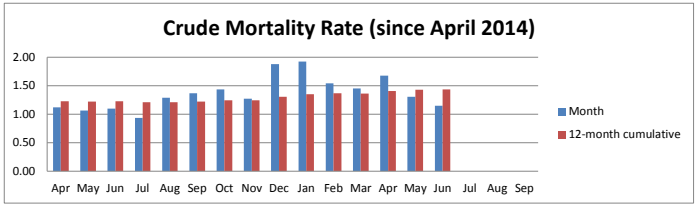
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	91	89	88	86	85	85	86	85	88	88	88	88							Mar-15										88			
5			Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	89	87	86	85	83	82	83	84	86	86	87	87							Mar-15										87			
5		C	Risk Adjusted Mortality Index (RAMI) - Weekend Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	98	96	95	91	92	93	93	90	92	92	91	92							Mar-15										92			
6		C	Summary Hospital-level Mortality Index (SHMI) (12-month cumulative)	SHMI	Below Upper CI	Below Upper CI	94	96	96	94	94	95	95	94	96	96	97								Feb-15										96.7			
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			94	92	90	88	90	86	86	85	87	89	90	89							Mar-15										89.0			
5			Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	66	75	47	51	71	89	80	76	111	105	94	93							Mar-15									93				
3			Mortality Reviews within 42 working days	%	100	100																			Apr-15	91	85		100					90				
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			1.1	1.1	1.1	0.9	1.3	1.4	1.4	1.3	1.9	1.9	1.6	1.5	1.8	1.3	1.2				May-15									1.15				
3		C	Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.3	1.4	1.4	1.4	1.4	1.4	1.4				May-15										1.43			
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month - internal data	%			8.1	8.2	7.3	7.6	7.9	7.4	7.8	7.6	8.2	8.7	8.4	8.5	9.5	8.7					May-15									8.72				
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative - internal data	%			8.1	8.2	7.9	7.8	7.8	7.7	7.7	7.7	7.7	7.9	8.0	8.2	8.4	8.2					May-15										8.23			
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative) - CHKS data	%			8.6	8.6	8.6	8.7	8.7	8.7	8.8	8.7	8.6	8.6	8.9	8.6	8.7						Apr-15	11.2	8.1	2.2	7.8						8.7			





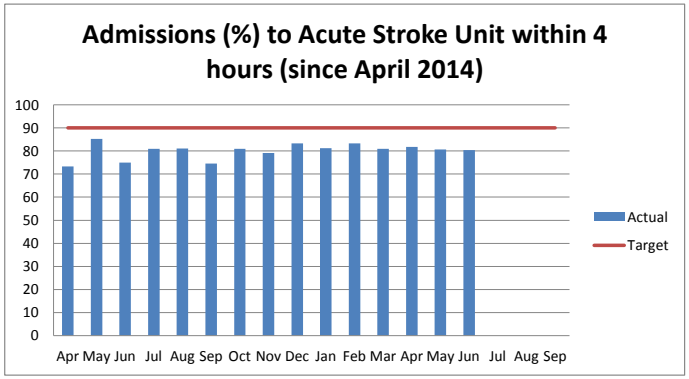


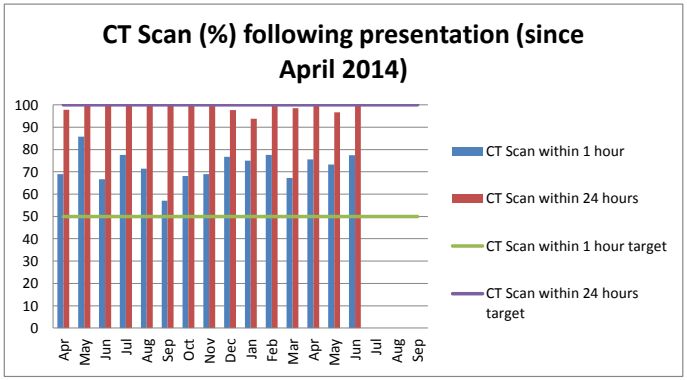


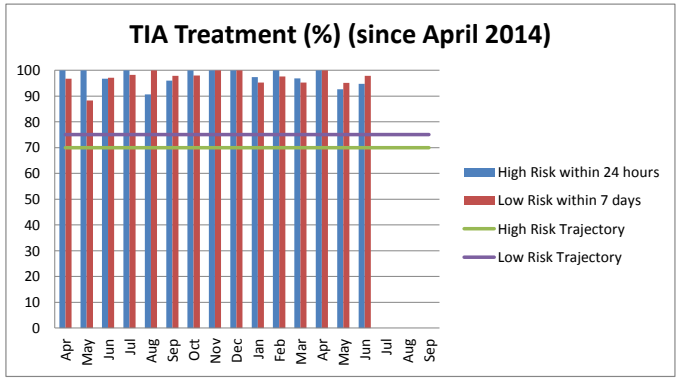


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A M J J A S O N D J F M A M J J A S	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Pts spending >90% stay on Acute Stroke Unit	%	=>90.0	=>90.0		Jun-15	86.7	90.1			
3			Pts admitted to Acute Stroke Unit within 4 hrs	%	=>90.0	=>90.0		Jun-15	80.3	81.3			
3			Pts receiving CT Scan within 1 hr of presentation	%	=>50.0	=>50.0		Jun-15	77.4	75.2			
3			Pts receiving CT Scan within 24 hrs of presentation	%	100	100		Jun-15	100.0	98.8			
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	%	=>85.0	=>85.0		Jun-15	71.4	70.6			
3			Stroke Admissions - Swallowing assessments (<24h)	%	=>98.0	=>98.0		May-15	100.0	100.0			
3			TIA (High Risk) Treatment <24 Hours from receipt of referral	%	=>70.0	=>70.0		Jun-15	94.7	96.4			
3			TIA (Low Risk) Treatment <7 days from receipt of referral	%	=>75.0	=>75.0		Jun-15	97.8	97.5			
9			Primary Angioplasty (Door To Balloon Time 90 mins)	%	=>80.0	=>80.0		May-15	94.1	94.6			
9			Primary Angioplasty (Call To Balloon Time 150 mins)	%	=>80.0	=>80.0		May-15	93.8	94.1			
9			Rapid Access Chest Pain - seen within 14 days	%	=>98.0	=>98.0		Jun-15	100.0	100.0			

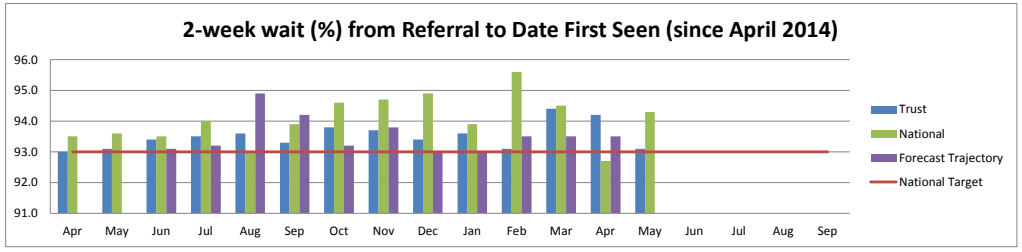


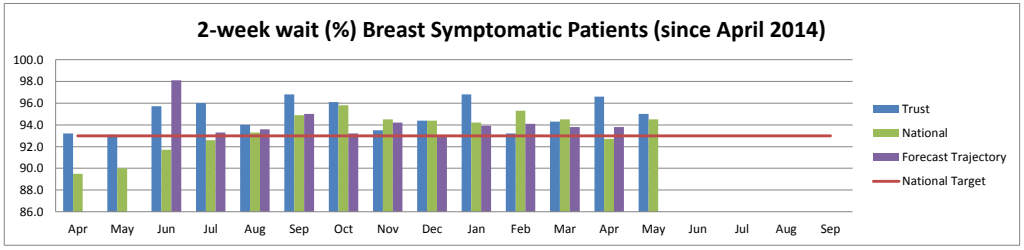


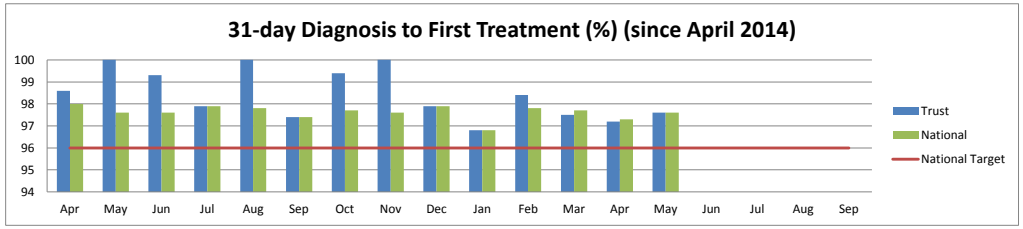


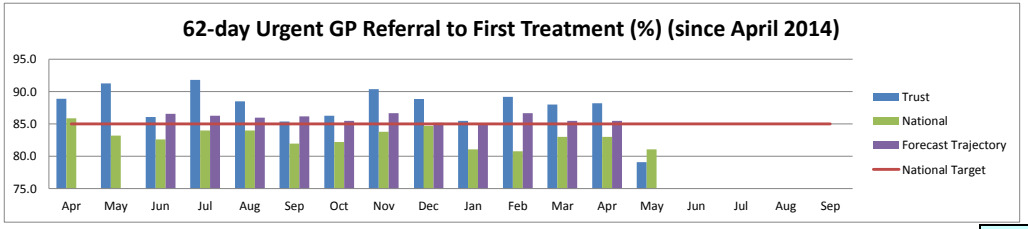
Clinical Effectiveness - Cancer Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
1			2 weeks	%	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	90.9	95.5	92.6	89.1					93.1	93.6	●		
1			2 weeks (Breast Symptomatic)	%	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		95.0							95.0	95.9	●		
1			31 Day (diagnosis to treatment)	%	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100	100	100	88.0					97.6	97.4	●		
1			31 Day (second/subsequent treatment - surgery)	%	=>94.0	=>94.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15									100	100	●		
1			31 Day (second/subsequent treatment - drug)	%	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15									100	100	●		
1			31 Day (second/subsequent treat - radiotherapy)	%	=>94.0	=>94.0	n/a	n/a	n/a	n/a	n/a	n/a	●	n/a	n/a	n/a	●	n/a	●	n/a					May-15										100	●		
1			62 Day (urgent GP referral to treatment)	%	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	82.6	80.0	100	70.5					79.1	84.6	●		
1			62 Day (referral to treat from screening)	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		90.9		100					91.3	95.6	●		
1			62 Day (referral to treat from hosp specialist)	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	90.5	100	100	33.3					90.7	92.3	●		



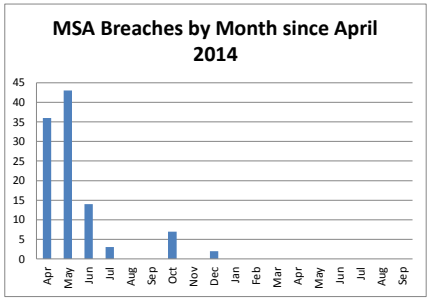


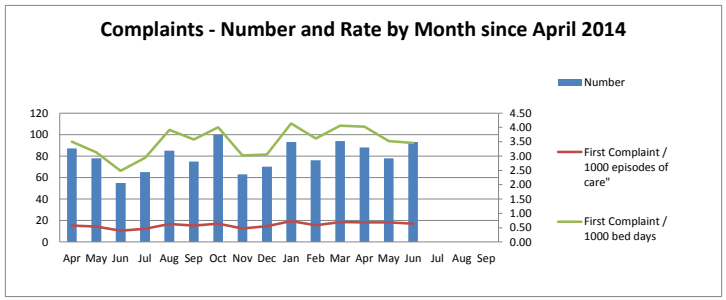


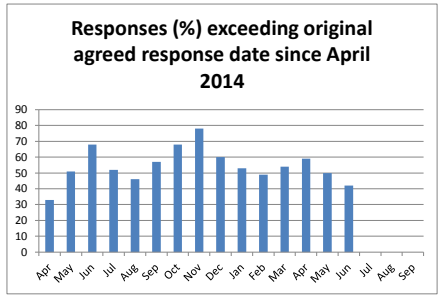


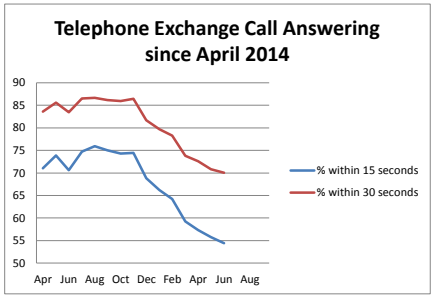
Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8		b	FFT Response Rate - Inpatients - definition revised April 2015	%	Above lowest national decile		36	44	45	41	32	31	28	31	28	33	43	43	21	21	20				Jun-15									20				
8		a	FFT Score - Inpatients - definition revised April 2015 - now measured as would recommend rating	No.	Above lowest national decile		74	74	70	73	76	74	73	73	69	70	68	72	95	95	95				Jun-15									95				
8		b	FFT Response Rate Emergency Department - definition revised April 2015	%	Above lowest national decile		15	16	16	16	17	17	17	18	17	18	21	22	10	8	7				Jun-15									7				
8		a	FFT Score - Em. Department - definition revised April 2015 - now measured as would recommend rating	No.	Above lowest national decile		47	49	48	47	49	47	48	49	50	50	44	52	79	79	80				Jun-15									80				
8		b	FFT Score - Response Rate - Walk In Centre	No.	Above lowest national decile														1.0	0.3	0.3				Jun-15									0.3				
8		a	FFT Score - Walk In Centre - measured as would recommend rating	No.	Above lowest national decile														93	100	100				Jun-15									100				
8		a	FFT Score - Maternity - measured as would recommend rating	No.	Above lowest national decile														95	96	95				Jun-15									95				
8		a	FFT Score - Outpatients - measured as would recommend rating	No.	Above lowest national decile														87	88	88				Jun-15									88				
13		a	Mixed Sex Accommodation Breaches	No.	0	0	36	43	14	3	0	0	7	0	2	0	0	0	0	0	0				Jun-15	0	0	0	0		0	0		0	0	●		
9			No. of Complaints Received (formal and link)	No.			87	78	55	65	85	75	100	63	70	93	76	94	88	78	93				Jun-15	42	16	6	14	2	3	2	8	93	259			
9			No. of Active Complaints in the System (formal and link)	No.			194	245	270	219	258	282	324	359	219	249	266	265	278	225	186				Jun-15	88	32	17	20	4	5	6	14	186				
9		a	No. of First Formal Complaints received / 1000 bed days	Rate			3.5	3.1	2.5	2.9	3.9	3.6	4.0	3.0	3.1	4.1	3.6	4.1	4.0	3.5	3.5				Jun-15	2.5	2.9	8.6	3.1					3.46	3.43			
9			No. of First Formal Complaints received / 1000 episodes of care	Rate			0.6	0.5	0.4	0.5	0.6	0.6	0.6	0.5	0.6	0.7	0.6	0.7	0.7	0.7	0.6				Jun-15	0.8	1.6	0.3	1.2			0.1		0.64	0.64			
9			No. of Days to acknowledge a formal or link complaint (% within 3 working days after receipt)	%	100	100	100	100	100	99	99	100	99	100	99	99	98	100	99	100	100				Jun-15	100	100	100	100	100	100	100	100	100		●		
9			No. of responses which have exceeded their original agreed response date (% of total active complaints)	%	0	0	33	51	68	52	46	57	68	78	60	53	49	54	59	50	42				Jun-15	43	53	59	25	0	0	33	50	42		●		
9			No. of responses sent out	No.			117	30	4	138	66	42	35	26	198	59	52	84	56	115	102				Jun-15	38	10	21	17	3	4	3	6	102				
9			Oldest' complaint currently in system	Days			104	124	145	127	133	131	174	161	182	192	213	234	254	188	210				Jun-15	210	157	102	116	27	27	99	121	210				
14			Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	Y	Y	Y	Y	Y	Y	Y	Y	Yes		●		



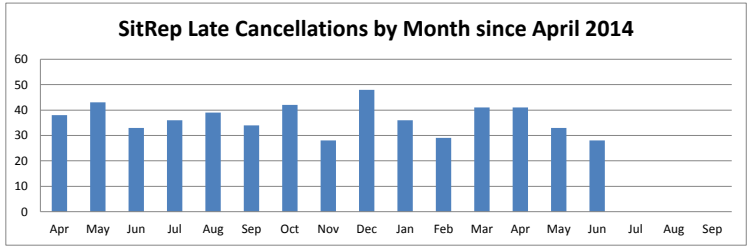


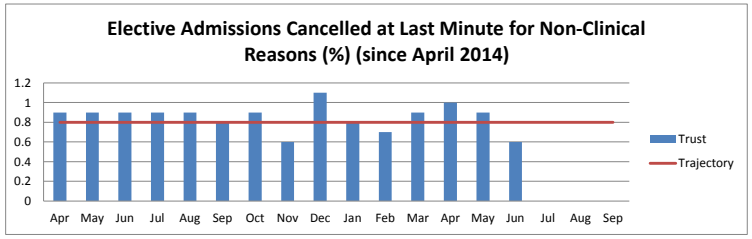


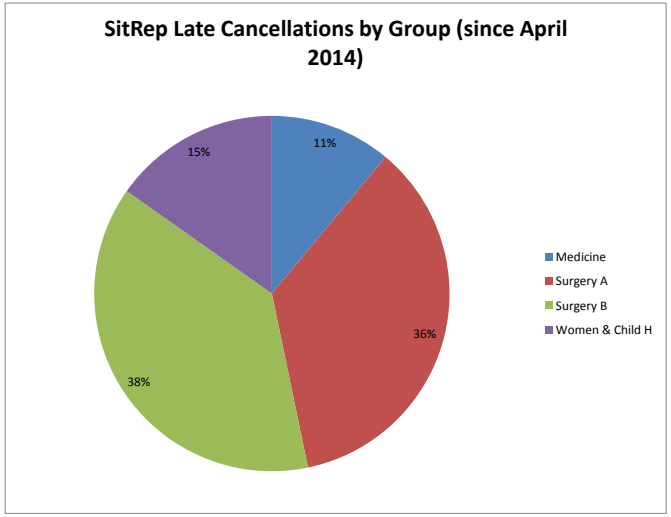


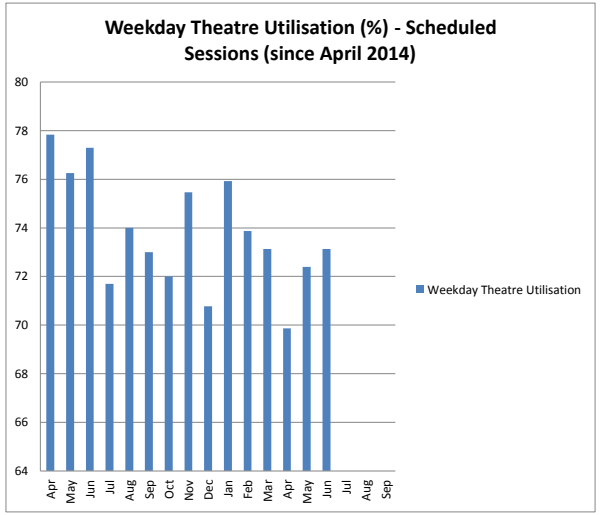
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2		●	Elective Admissions Cancelled at last minute for non-clinical reasons	%	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●						Jun-15	0.12	0.75	1.43	0.66					0.6	0.8	●		
2		●e●	Number of 28 day breaches	No.	0	0	1	1	0	0	0	1	0	0	1	0	0	0	0	0						Jun-15	0	0	0	0					0	0	●		
2		●e	No. of second or subsequent urgent operations cancelled	No.	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	1	0					Jun-15	0	0	0	0					0	1	●		
2			No. of Sitrep Declared Late Cancellations	No.	320	27	38	43	33	36	39	34	42	28	48	36	29	41	41	33	28					Jun-15	2	8	16	2					28	102	●		
3			No. of Sitrep Declared Late Cancellations (Pts. >1 occasion)	No.	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0					Jun-15	0	0	0	0					0	0	●		
3			Multiple Cancellations experienced by same patient (all cancellations)	%	0	0	12	7	10	12	11	13	11	14	10	11	13	12	11	14	14					Jun-15	17.6	15.1	13.2	11.1					13.94		●		
3			All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	%	3.1	3.1	5	6	5	5	6	7	6	6	8	6	7	5	6	5	6					Jun-15	1.8	6.4	8.1	13.1					5.6		●		
3			Weekday Theatre Utilisation (as % of scheduled)	%	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●					Jun-15	52.6	78.7	72.3	73.2					73.1		●		



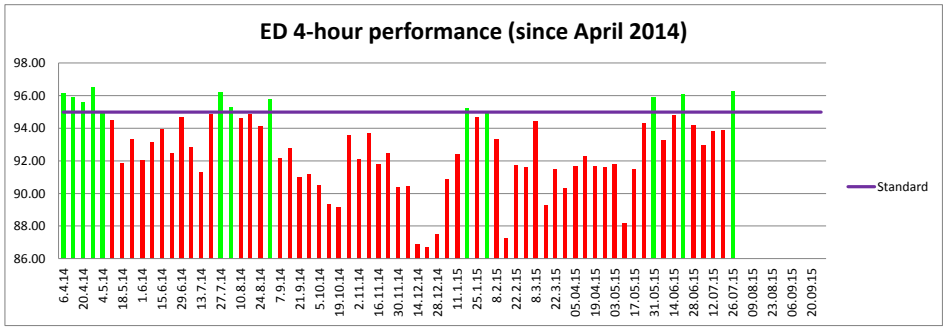


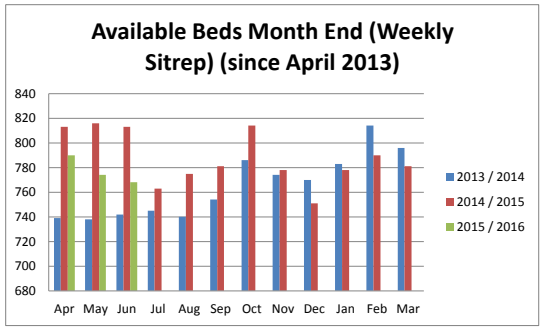


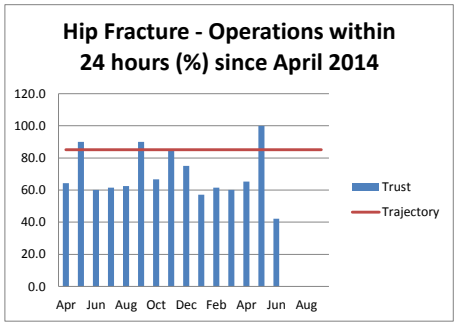


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Unit S	C	B	Month	Year To Date	Trend	Next Month	3 Months
2		e	Emergency Care 4-hour waits	%	=>95.0	=>95.0																			Jun-15	95.3	92.7	99.5	94.54	92.99			
2			Emergency Care 4-hour breach (numbers)	No.			741	1210	1277	1122	876	1460	1636	1440	2234	1054	1481	1695	1527	1406	1037				Jun-15	365	660	12	1037	3970			
2		e	Emergency Care Trolley Waits >12 hours	No.	0	0																			Jun-15	0	0	0	0	0			
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	mins	=<15	=<15																			Jun-15	16	18	15	17	17			
3			Emergency Care Timeliness - Time to Treatment in Department (median)	mins	=<60	=<60																			Jun-15	51	65	27	52	53			
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	%	=<5.0	=<5.0																			Jun-15	8.42	7.89	4.19	7.63	7.63			
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	%	=<5.0	=<5.0																			Jun-15	3.22	6.14	2.33	4.44	4.53			
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	No.	0	0	119	136	125	145	51	136	219	159	282	185	149	164	144	136	106				Jun-15	26	80		106	386			
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	No.	0	0	13	8	8	8	1	13	21	14	31	7	6	8	8	8	3				Jun-15	0	3		3	19			
11			WMAS - Handover Delays > 60 mins (% all emergency conveyances)	%	=<0.02	=<0.02																			Jun-15	0.00	0.13		0.07	0.15			
11			WMAS - Emergency Conveyances (total)	No.			4044	4227	4093	4278	3994	4067	4193	4168	4470	4001	3829	4182	3981	4214	4071				Jun-15	1801	2270		4071	12266			
2		e	Delayed Transfers of Care (Acute) (%)	%	=<3.5	=<3.5																			Jun-15	1.2	4.6		2.7	2.5			
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	No.	<10 per site	<10 per site																			Jun-15	2	5		7				
2			Patient Bed Moves (10pm - 8am) (No.) -ALL	No.			668	751	722	751	694	681	720	646	806	651	683	743	675	736	614				Jun-15				614	2025			
2			Patient Bed Moves (10pm - 8am) (No.) - exc. Assessment Units	No.			312	331	330	329	339	276	353	293	323	250	302	293	267	332	269				Jun-15				269	868			
3			Hip Fractures - Operation < 24 hours of admission (%)	%	=>85.0	=>85.0																			Jun-15				42.1	64.9			

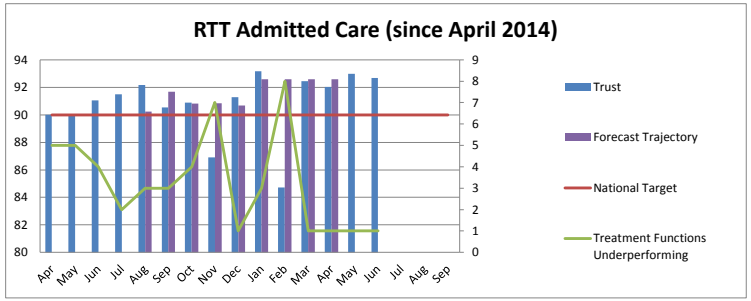


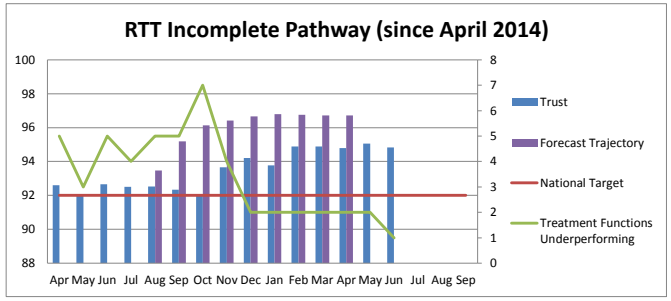


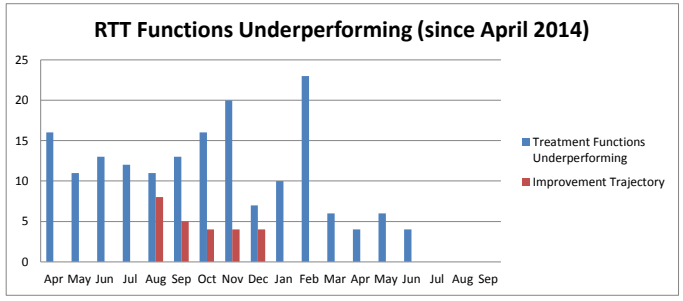


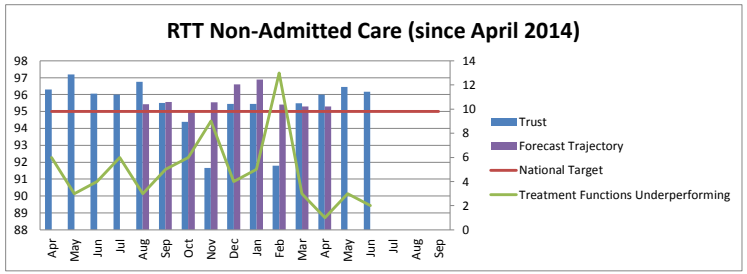
Referral To Treatment

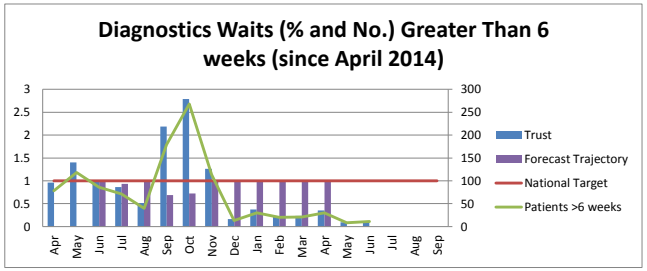
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2			RTT - Admittted Care (18-weeks)	%	=>90.0	=>90.0																				Jun-15	97.5	84.6	91.8	95.0					92.68				
2			RTT - Non Admittted Care (18-weeks)	%	=>95.0	=>95.0																				Jun-15	95.6	95.1	96.7	97.6					96.17				
2			RTT - Incomplete Pathway (18-weeks)	%	=>92.0	=>92.0																				Jun-15	94.3	94.6	94.2	98.7					94.83				
2			Patients Waiting >52 weeks	No.	0	0	1	2	2	3	4	4	3	3	0	4	3	4	1	2	2					Jun-15	0	0	2	0					2				
2			Treatment Functions Underperforming	No.	0	0	16	11	13	12	11	13	17	20	7	10	23	6	4	6	4					Jun-15	1	2	1	0					4				
2			Acute Diagnostic Waits in Excess of 6-weeks	%	=<1.0	=<1.0																				Jun-15	0.2	0.6	0.0	0.0		0.1			0.11				

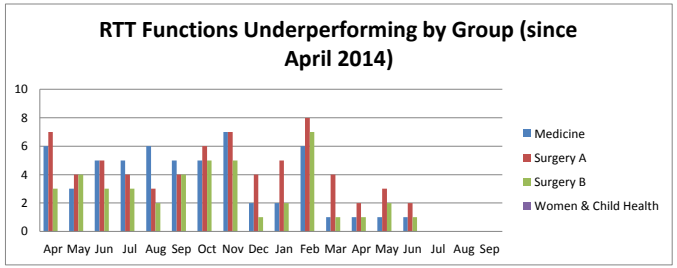










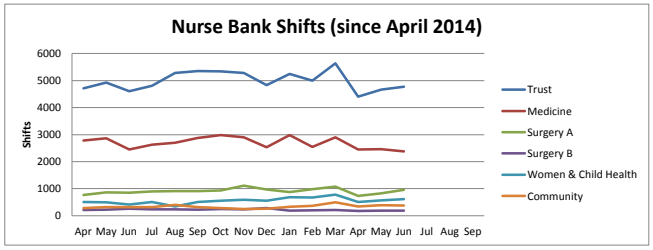


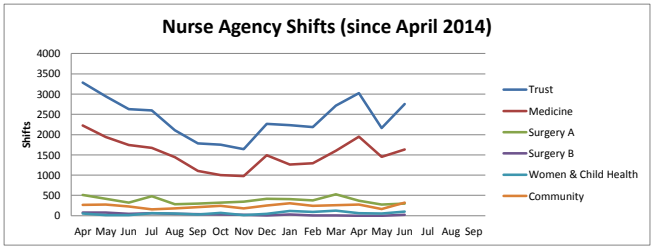
Data Completeness

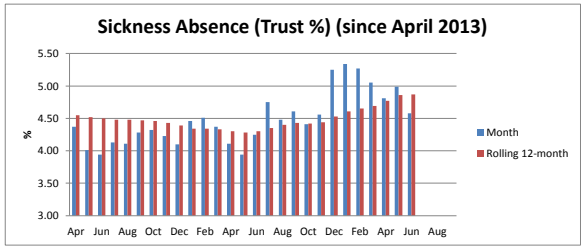
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Data Completeness Community Services	%	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15								>50	>50		●		
2		●	Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	%	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15									99.41		●		
2		●	Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	%	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15									98.60		●		
2		●	Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	%	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15									99.18		●		
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	%	=>99.0	=>99.0	98.7	97.0	95.6	95.4	95.2	95.7	95.3	95.7	96.0	96.5	96.9	96.6	96.9	96.3	96.0				Jun-15									96.0	96.5	●		
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	%	=>99.0	=>99.0	99.5	99.5	99.5	99.5	99.4	99.4	99.5	99.5	99.5	99.6	99.6	99.6	99.6	99.6	99.6				Jun-15									99.6	99.6	●		
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	%	=>95.0	=>95.0	96.3	95.8	96.3	96.1	96.1	96.2	96.4	96.6	96.2	97.0	96.7	96.8	96.8	96.8	96.9				Jun-15									96.9	96.9	●		
2			Ethnicity Coding - percentage of inpatients with recorded response	%	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15									91.65	91.95	●		
2		●	Data Quality of Trust Returns to the HSCIC (provided by TDA)	%	=>96.0	=>96.0	95.0	95.0	95.0	95.0	95.0	95.0	95.0	95.5	98.7										Dec-14									98.7		●		
2			Maternity - Percentage of invalid fields completed in SUS submission	%	=<15.0	=<15.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15									39.07	38.84	●		

Staff

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
7		b	WTE - Actual versus Plan (FTE)	No.			531	558	580	584	626	608	628	674	685	701	732	807	777	849	758					May-15	236	109	45	93	35	59	81	101	758				
3			PDRs - 12 month rolling	%	=>95.0	=>95.0																				Jun-15	89	89	93	86	93	85	91	89		89.1			
7			Medical Appraisal and Revalidation	%	=>95.0	=>95.0																				Jun-15	86	89	97	93	90	88		100		89.4			
3		b	Sickness Absence	%	=<3.15	=<3.15																				Jun-15	3.6	4.7	3.1	5.1	3.9	6.0	5.1	5.1	4.58	4.87			
3			Return to Work Interviews following Sickness Absence	%	100	100																				Jun-15	59.8	61.1	49.6	56.0	78.5	44.1	79.7	70.7		63.49			
3			Mandatory Training	%	=>95.0	=>95.0																				Jun-15	85.9	91.5	88.2	87.2	96.1	89.8	89.9	91.2		89.1			
3			Mandatory Training - Health & Safety (% staff)	%	=>95.0	=>95.0																				Jun-15	95.7	98.1	95.4	96.4	99.4	99.2	98.4	98.8		97.5			
7		b	Staff Turnover (rolling 12 months)	%	=<10.0	=<10.0																				Jun-15									13.28	13.18			
7			New Investigations in Month	No.			1	4	6	5	2	15	3	1	0	3	4	5	8	11	5					Jun-15	1	1	0	2	0	0	0	1	5				
7			Vacancy Time to Fill	weeks			19	20	19	18	19	19	20	21	20	20	23	22	23	24	26					Jun-15									26				
7			Professional Registration Lapses	No.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					Jun-15	0	0	0	0	0	0	0	0	0	0			
7			Qualified Nursing Variance (FIMS) (FTE)	No.			161	169	173	177	201	200	188	200	228	238	247	263	221	247	288					Jun-15									288.1				
10			Nurse Bank Fill Rate	%	100	100	76	82	82	80	77	78	78	82	73	78	78	78	75	80	81					Jun-15	75.0	82.2	98.4	91.9			89.2	98.7	81.2	78.3			
10			Nurse Bank Shifts Not Filled	No.	0	0	1723	969	919	1087	1802	1370	1036	1440	1727	1716	1432	1487	1857	1165	1073					Jun-15	771	197	3	53			46	3	1073	4095			
10			Nurse Bank Use (shifts)	No.	60912	5076																				Jun-15	2378	952	183	619	0	22	375	241	4770	13848			
10			Nurse Agency Use (shifts)	No.	0	0																				Jun-15	1634	299	18	98	0	294	323	91	2757	7942			
10			Admin & Clerical Bank Use (shifts)	No.	0	0																				Jun-15	915	186	126	62	519	187	184	3223	5402	15774			
10			Admin & Clerical Agency Use (shifts)	No.	0	0																				Jun-15	62	12	16	18	0	0	0	127	235	536			
			Medical Staffing - Number of instances when junior rotas not fully filled	No.	0	0																																
15			Your Voice - Response Rate	%			19.8		18.2			17.4			12.6	12.7	13.5		13.9							Jun-15	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	3.57		3.59							Jun-15	3.5	3.6	3.6	3.7	3.7	3.4	3.8	3.5	3.59				





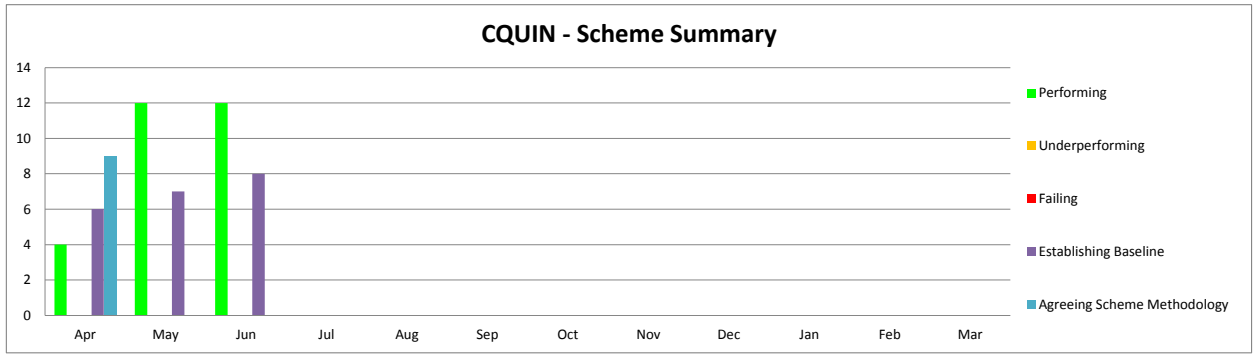


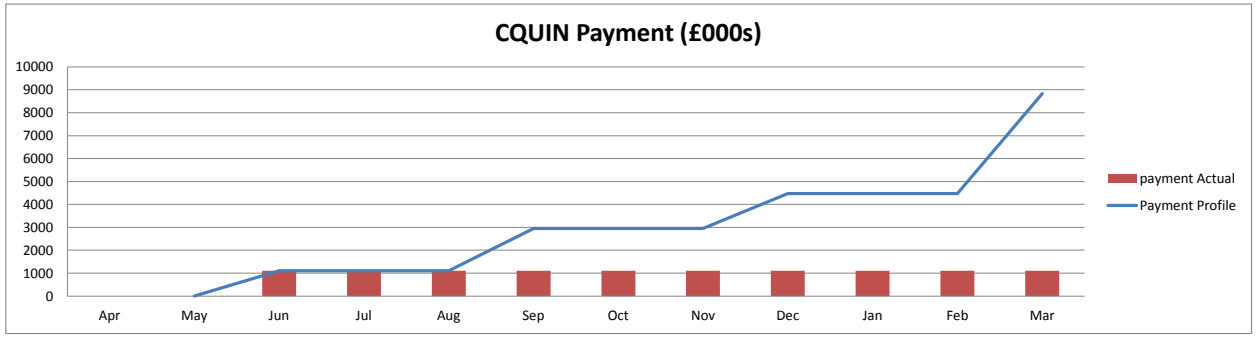
CQUIN (I)

Data Source	Data Quality	CQUIN	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
		National	Acute Kidney Injury	Improvement from previous Quarter		Derive Base Data												Jun-15									Manual Audit	On Track	●		
4		National	Sepsis Screening	Improvement from base to agreed target		Derive Base Data												Jun-15									On Track	On Track	●		
4		National	Sepsis Antibiotic Administration	90% by Q4		Establish Audit Mech.		Derive Base Data										Jun-15									On Track	On Track	●		
8		National	Dementia - Find, Assess, Investigate, Refer & Inform	90% (each of 3 elements) in Q4		●	●	●										Jun-15									3 of 3 Met	3 of 3 Met	●		
8		National	Dementia - Staff Training	Target tba - Qly reports to Board		Agree programme												Jun-15									On Track	On Track	●		
8		National	Dementia - Suporting Carers	Bi-annual reports to Board		Agree survey & process		Report to Board										Jun-15									On Track	On Track	●		
2		National	Improvement in diagnosis recording in HES Data Set of Mental Health presentations in A&E	90% by Q4		Qly Base Data Collection												Jun-15									77.1	77.0	●		
14		Local	Community Therapies - Dietetics Community Communication with GPs	Deliver outstanding actions from 14 / 15		One data submission at end of Q2												Jun-15									Met	Met	●		
8		Local	Safeguarding - continue to embed into practice, implement lessons learnt, reflect on practice.	Submit completed proforma to CCG		Q. Proforma Submission												Jun-15									On Track	On Track	●		
		Local	Reduce Number of Ward Transfers experienced by patients with Dementia	Agree improvement trajectory from base		Derive Base Data												Jun-15									On Track	On Track	●		
2		Local	Reduce Number of Out Of Hours Patient Transfers	Agree improvement trajectory from base		Derive Base Data												Jun-15									On Track	On Track	●		
		Local	Falls Medication	Agree improvement trajectory from base		New Scheme wef July		Finalise data capture / base period																							
		Spec.	Reduce Number of Consultant-Led Follow Up OP Attendances	Implement plans to & monitor FUN ratio		Formulate Plans		Sign Off of Plans										Jun-15									On Track	Q1 met - confirmed	●		
17		Spec.	HIV - Reducing Unnecessary CD4 Monitoring	90% pts have no more than 1 CD4 count in 9m		Qly Data Collection		Qly Data Collection				Qly Data Collection						Jun-15									On Track	Q1 met - confirmed	●		
		Spec.	Haemoglobinopathy Networks - develop partnership working, define pathways and protocol	Publish agreed care p'ways and protocols		Set Up initial network meet												Jun-15									On Track	Q1 met - confirmed	●		
		Spec.	Breast Cancer - help patients make more informed choices regarding treatment	Provision of anon. pt. Datasets		Derive Base Data												Jun-15									On Track	Q1 met - confirmed	●		

CQUIN (II) and summary

Data Source	Data Quality	CQUIN	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
16		Spec.	Bechet's Disease (Highly Specialised Service) - set up clinical outcome collaborative workshop	Submit Quarterly return		●												Jun-15									On Track	Q1 met - confirmed	●	●	●
		Public Health	Breast Screening - improvement in uptake	Annual Report		Agree Strategy			Demonstrate Improvement			Demonstrate Improvement			Demonstrate Improvement			Jun-15									Work in Progress On Plan	On Track	●		
		Public Health	Bowel Screening - improvement in uptake	Annual Report		Agree Strategy			Demonstrate Improvement			Demonstrate Improvement			Demonstrate Improvement			Jun-15									Work in Progress On Plan	On Track	●		
		Public Health	Maternity and Health Visiting Services - Integrated working	Implement Shared Assessment Framework		Baseline of existing			Develop Integrated Framework			Action plan & mobilisation			Implement			Jun-15									On Track	On Track	●		





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

In summary 12 schemes are classified as performing and a total of 8 schemes require baseline data to be gathered before improvement trajectories and targets are finalised. For one scheme 'Improvement in diagnosis recording in HES Data Set of Mental Health presentations in A&E', agreement has been reached with commissioners to revise the original (locally modified) definition of the scheme, and revert to the national definition, whereby the first quarter's requirment has been met by the provision of base data. Performance for this scheme is currently is 77% data recording, with a requirement to improve to meet an end of year 90% target. Consequential to the revision of the A&E diagnosis recording scheme, a scheme, 'Medication and Falls' has been added, for which data capture processes are currently being finalised and baseline data acquired

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

External Assessment Frameworks

TRUST DEVELOPMENT AUTHORITY (TDA) ACCOUNTABILITY FRAMEWORK - SUMMARY

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

Override Rules

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

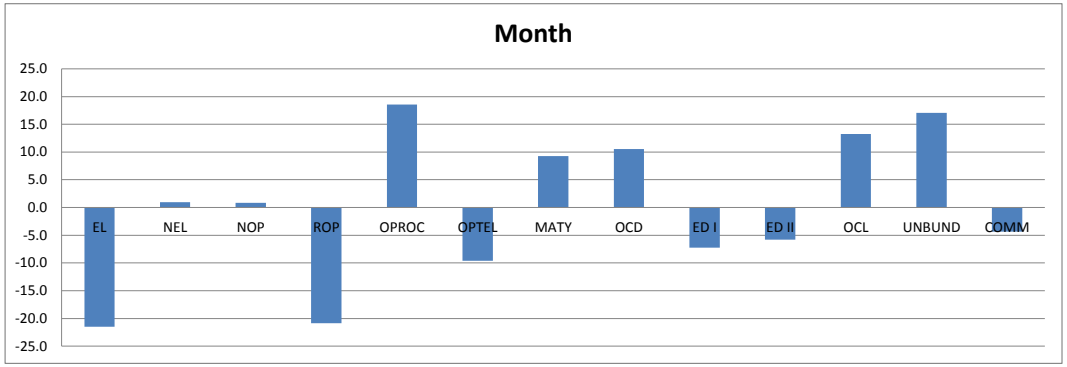
MONITOR RISK ASSESSMENT FRAMEWORK - SUMMARY

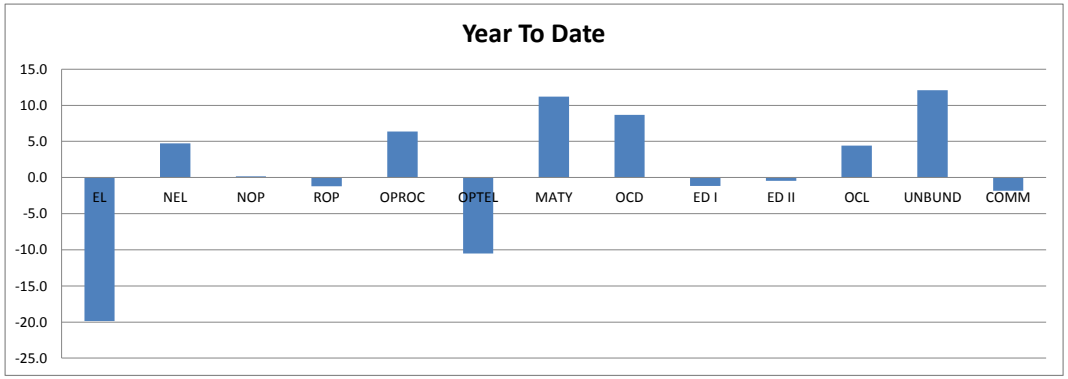
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Indicators Achieving Monitor Standard	14	13	14									
Indicators Not Achieving Monitor Standard	1	1	1									
	ED 4-hours	ED 4-hours Cancer 62-day	ED 4-hours									
GOVERNANCE RATING	1.0	2.0	1.0									

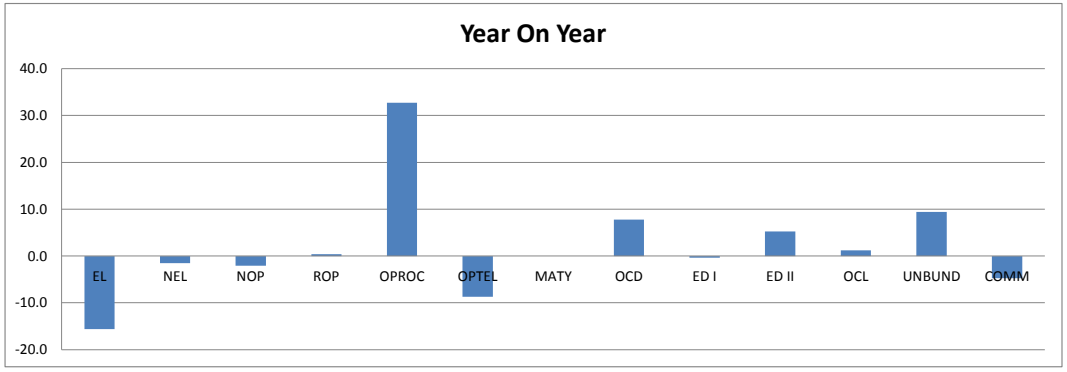
PLEASE NOTE:

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

Activity Summary







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

The volume of overall Elective activity for the month of June, and year to date is significantly less than plan for the period and for the corresponding period last year. Overall Non Elective activity is essentially on plan for the month of June, and 4.7% ahead of plan for the year to date, with a similar level to that delivered during the corresponding period last year. Both Outpatient New activity and Review activity are both on plan for the year to date. Maternity pathway activity is reported as 9.3% above plan for the month, and 11.2% year to date. Comparison with 2014 / 2015 is not included as there were recording issues during the initial period of the Badgernet Information System implementation. ED Type I activity is down on plan for the month (7.3%), year to date (1.2%) and similar to that for the corresponding period last year. ED Type II activity is also below plan for the month (5.8%), year to date (0.5%), although above (5.2%), that delivered for the corresponding period last year.

KEY

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

Finance Summary

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
18		f	Bottom Line Income & Expenditure position - Forecast compared to plan £m	£0.0		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15									£0.000				
18		f	Bottom Line Income & Expenditure position - Year to Date Actual compared to plan £m	£0.0	£0.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15										-£0.420			
18		f	Actual efficiency recurring / non-recurring compared to plan - Year to Date actual compared to plan	£0.0	£0.0	●	●	●	●	●	●	●	●	●	●	●	●		●	●				Jun-15										£1,430			
18		f	Actual efficiency recurring / non-recurring compared to plan - Forecast compared to plan	£0.0		●	●	●	●	●	●	●	●	●	●	●	●		●	●				Jun-15										£0.000			
18		f	Forecast underlying surplus / deficit compared to plan	£0.0		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15										£0.000			
18		f	Forecast year end charge to capital resource limit	£22.8		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15									£20,153				
18		f	Is the Trust forecasting permanent PDC for liquidity purposes?	No		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15									£0.000				
18		b	Temporary costs and overtime as % total paybill	2.6%	2.6%	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15									11.9	12.3			
18			Continuity of Service Risk Rating - Year to Date	2.5		●	●	●	●	●	●	●	●	●	●	●	●		●	●				Jun-15										3.0			

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

Data Source	Data Quality	OS / NQR	Indicator	Threshold	APRIL (£000s)									MAY (£000s)									JUNE (£000s)									YEAR TO DATE (£000s)								
					M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		OS	RTT Admitted Care (£400 per breach by specialty)	=>90.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2		OS	RTT Non-Admitted Care (£100 per breach by specialty)	=>95.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2		OS	RTT Incomplete Pathway (£150 per breach by specialty)	=>92.0%	0.0	14.1	1.8	0.0					15.9	0.0	5.7	5.3	0.0						11.0	0.0	0.0	1.2	0.0					1.2	0.0	19.8	8.3	0.0					28.1
2		OS	Diagnostic Waits (£200 per breach)	=>99.0%	0.0	0.0	0.0	0.0		0.0			0.0	0.0	0.0	0.0	0.0		0.0				0.0	0.0	0.0	0.0	0.0		0.0			0.0	0.0	0.0	0.0	0.0		0.0			0.0
2		OS	ED Waits >4 hours (£120 per breach between 85.0% and 95.0%)	=>95.0%	72.1		0.0						72.1	53.8		0.0						53.8	10.6		0.0						10.6	136.4		0.0						136.4
1		OS	Cancer Waits (2 weeks, 31 days and 62 days - £200, £1000 and £1000 per breach respectively)	Various	0.0	0.0	0.0	0.0					0.0	1.0	1.0	0.0	1.0						3.0									0.0	1.0	1.0	0.0	1.0					3.0
13		OS	Mixed Sex Accommodation Breaches (£250 per day per Service User affected)	0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2		OS	Cancelled Operations 28-day (non-payment of rescheduled episode of care)	0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
4		NQR	MRSA Bacteraemia (£10,000 per incidence)	0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0			0.0	10.0	0.0	0.0	0.0			0.0		10.0	10.0	0.0	0.0	0.0			0.0		10.0
4		NQR	C Diff (differential impact if annual target exceeded)	37	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0			0.0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0
2		NQR	RTT Waits >52 weeks Incomplete Pathway (£5,000 per breach)	0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	10.0	0.0						10.0	0.0	0.0	5.0	0.0					5.0	0.0	0.0	15.0	0.0					15.0
11		NQR	WMAS Handovers to ED (£200 per breach 30 - 60 minutes)	0	28.8								28.8	27.2									27.2	21.2								21.2	77.2								77.2
11		NQR	WMAS Handovers to ED (£1000 per breach >60 minutes)	0	8.0								8.0	8.0									8.0	3.0								3.0	19.0								19.0
2		NQR	ED Trolley Waits >12 hours (£1,000 per breach)	0	0.0								0.0	0.0									0.0	0.0								0.0	0.0								0.0
2		NQR	Cancelled Operations - no urgent operation cancelled for second time (£5,000 per breach)	0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	5.0						5.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	5.0					5.0
3		NQR	VTE Risk Assessment (£200 per breach)	=>95.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
9		NQR	Never Events (cost of original procedure plus any rectification)	0	0.0	0.4	0.0	0.0	0.0	0.0	0.0		0.4	0.0	8.4	0.0	0.0	0.0	0.0	0.0			8.4	0.0	0.0	0.0	7.4	0.0	0.0	0.0		7.4	0.0	8.8	0.0	7.4	0.0	0.0	0.0		16.2
13		NQR	Publication Of Formulary (withholding of 1% of actual monthly contract value for non publication)	0								0.0	0.0								0.0	0.0								0.0	0.0	0.0							0.0	0.0
9		NQR	Duty Of Candour (Non-payment for cost of care or £10,000 if cost of care unknown / indeterminate)	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
2		NQR	Completion of valid NHS Number in Acute Commissioning Data Set (£10 per breach)	=>99.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2		NQR	Completion of valid NHS Number in A&E Commissioning Data Set (£10 per breach)	=>95.0%	0.0		0.0						0.0	0.0		0.0						0.0	0.0		0.0						0.0	0.0		0.0						0.0
			ALL		108.9	14.1	1.8	0.0	0.0	0.0	0.0	0.0	124.8	90.0	15.1	15.3	6.0	0.0	0.0	0.0	0.0	126.3	44.8	0.0	6.2	7.4	0.0	0.0	0.0	0.0	58.4	243.6	29.6	23.3	13.4	0.0	0.0	0.0	0.0	309.8

Contractual Requirements - Local Quality Requirements (Acute Services)

Data Source	Data Quality	Req	Indicator	Threshold	APRIL (£000s)									MAY (£000s)									JUNE (£000s)									YEAR TO DATE (£000s)								
					M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
3		LQR	Mat'y health and social risk assessment (£1000 / month if 4 consecutive months of failure)	=>90.0%				0.0					0.0				0.0					0.0				0.0					0.0				0.0					0.0
3		LQR	Mat'y - % of babies at risk of TB vaccinated (non payment if 3 consecutive months failure)	=>98.0%									0.0									0.0									0.0				0.0					0.0
3		LQR	Mat'y - % mothers who have initiated breasfeeding within 48 hours. (£50 each breach)	=>77.0%	Assessed Quarterly									Assessed Quarterly												0.0					0.0				0.0					0.0
3		LQR	Mat'y - BMI recorded by 12+6 weeks pregnancy (£1000/month if 4 consecutive months of failure)	=>90.0%				0.0					0.0				0.0					0.0				0.0					0.0				0.0					0.0
3		LQR	Mat'y - % with BMI >35 referred to weight m'ment (£1000/month if 4 consecutive months of failure)	=>90.0%				0.0					0.0				0.0					0.0				0.0					0.0				0.0					0.0
3		LQR	Mat'y - % with BMI =<18 referred to weight m'ment (£1000/month if 4 consecutive months of failure)	=>90.0%				0.0					0.0				0.0					0.0				0.0					0.0				0.0					0.0
3		LQR	Mat'y - CO recorded & documented by 12+6 weeks. (£1000/month if 4 consecutive months of failure)	=>90.0%				0.0					0.0				0.0					0.0				0.0					0.0				0.0					0.0
3		LQR	Mat'y - report on no.'s ceased smoking / referred (£1000/month if 4 consecutive months of failure)	=>90.0%				0.0					0.0				0.0					0.0				0.0					0.0				0.0					0.0
3		LQR	Mat'y - AN detection of IUGR (£1000/month if 4 consecutive months of failure) (def'n tba)	100%																																				
3		LQR	Stroke - thrombolysis (non payment for any >30 hours if 3 consecutive months of failure)	=>50.0%	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0
3		LQR	Stroke - >90% stay on ASU (non payment for breach if 3 consecutive months of failure)	=>90.0%	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0
3		LQR	Stroke - CT Scan <1 hr presentation (non payment for any >2 hours if 3 consec. months failure)	=>50.0%	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0
3		LQR	Stroke - CT Scan <24 hr presentation (non pay't for any >30 hours if 3 consec. months failure)	100%	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0	0.0					0.0			0.0
3		LQR	ED - Time to Initial Assessment <15 mins (£25 per breach between 92.0% and 95.0%)	=>95.0%	6.1		0.0						6.2	7.0		0.1						7.1	6.3		0.0						6.3	19.4		0.1						19.5
3		LQR	ED - Unplanned Reattendance within 30 days (£50 per breach between 5.00% and 8.00%)	=<5.00%	19.4		0.0						19.4	21.6		0.0						21.6	21.3		0.0						21.3	62.3		0.0						62.3
3		LQR	ED - Left Without Being Seen (lower £23 pay't per pt., & £15 per breach between 5.00% and 8.00%)	=<5.00%	0.0		0.0						0.0	0.0		0.0						0.0	0.0		0.0						0.0	0.0		0.0						0.0
2		LQR	Morning Discharges (< m'day) (£50 per breach, traj. Q1(23%),Q2(27%),Q3(31%),Q4(35%))	Q1 (23%) - Q4 (35%)									0.0									0.0									0.0	0.0	0.0	0.0	0.0					0.0
11		LQR	WMAS CAD Compliance Minimum Standard (penalty dependent upon magnitude of breach)	=>80%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
		LQR	WMAS Patient Level MDS - inclusion of CAD number (method of measurement tba)	=>80%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
		LQR	WMAS - Reduce non-ED Clinical Hanover Delays >1 hour (method of measurement tba)	=<20%									0.0									0.0									0.0	0.0	0.0	0.0	0.0					0.0
		LQR	WMAS - Reduce non-ED Clinical Hanover Delays >30 mins(method of measurement tba)	=<25%									0.0									0.0									0.0	0.0	0.0	0.0	0.0					0.0
2		LQR	Paeds. have OP F/U app't <6 w discharge post meningoccal septicaemia (non pay't OP app't >6w)	100%				0.0					0.0				0.0					0.0				0.0					0.0				0.0					0.0
19		LQR	Pts. Admit. with MI presc. antiplatelet,statin or b. blocker(non pay for breach if 3 consec. m'ths fail.)	=>98.0%	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0
3		LQR	WHO Safer Surgery Checlkist Compliance (3 components) (Consec. Breaches £1000 / month)	98%, 95% and 85%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
19		LQR	HbA1c (pt's achieved target <6 m after being set) (non pay't for breach after 3 m'ths fail)	=>75.0%	Assessed 6-monthly									Assessed 6-monthly												Assessed 6-monthly									Assessed 6-monthly						
19		LQR	HbA1c (pt's receiving written care plan with agreed targets) (£50 per breach)	=>90.0%	Assessed 6-monthly									Assessed 6-monthly												Assessed 6-monthly									Assessed 6-monthly						
2		LQR	Ethnicity Coding (£1000 per month after 2 months failure)	=>90.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
		LQR	High Cost Drug Prior Appoval (non payment by CCG)	=>95%									0.0									0.0									0.0	0.0	0.0	0.0	0.0					0.0
1		LQR	Cancer - Inter-provider tertiary referrals for 62-day cancer, referrals <42days. (£500 per breach)	100%									0.0									0.0									0.0	0.0	0.0	0.0	0.0					0.0
2		LQR	ED - Coding should include diagnosis (£1000/month after 3 consequetive breaches)	=>90%	0.0		0.0						0.0	0.0		0.0						0.0	1.0		0.0						1.0	1.0	0.0	0.0	0.0					1.0
		LQR	MASH - Compliance with MASH Protocol (£25,000 per quarter for breach)	100%	Assessed Quarterly									Assessed Quarterly																	0.0	0.0	0.0	0.0	0.0					0.0
			ALL		25.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	25.6	28.6	0.0	0.1	0.0	0.0	0.0	0.0	0.0	28.7	28.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	28.6	82.7	0.0	0.1	0.0	0.0	0.0	0.0	0.0	82.8

Contractual Requirements - Local Quality Requirements (Community Services)

Data Source	Data Quality	Req	Indicator	Threshold	APRIL (£000s)									MAY (£000s)									JUNE (£000s)									YEAR TO DATE (£000s)								
					M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
14		LQR	Corporate - Ethnicity Coding - (£1000/month if 4 consecutive months of failure)	=>90%							0.0		0.0								0.0		0.0							0 (66%)		0.0							0.0		0.0
14		LQR	Community Nursing - Flu vaccinations (£25 per patient breach)	100% (who have agreed)							0.0		0.0								0.0		0.0							0.0		0.0							0.0		0.0
14		LQR	Community Nursing - Pts. on caseload with a care plan (£1000 / Qtr if 2 consecutive q'ly breaches)	100%	Assessed Quarterly									Assessed Quarterly															0 (95%)		0.0							0.0		0.0
14		LQR	Community Nursing - Dementia Screening (£1000 / Qtr if 2 consecutive q'ly breaches)	100%	Assessed Quarterly									Assessed Quarterly															0 (48%)		0.0							0.0		0.0
14		LQR	Community Nursing - EOL patients on SCP (£1000 / Qtr if 2 consecutive q'ly breaches)	100%	Assessed Quarterly									Assessed Quarterly															0 (81%)		0.0							0.0		0.0
14		LQR	Community Nursing - Compliance with wound m'ment formulary (Non compliant = no payment)	=>90%	Assessed Quarterly									Assessed Quarterly															0 (95%)		0.0							0.0		0.0
14		LQR	Community Nursing - Falls Risk Assessment (£1000 / Qtr if 2 consecutive q'ly breaches)	100%	Assessed Quarterly									Assessed Quarterly															0 (50%)		0.0							0.0		0.0
14		LQR	Community Nursing - Staff S'guarding/COI Training (£1000 / Qtr if 2 consecutive q'ly breaches)	=>95%	Assessed Quarterly									Assessed Quarterly															0 (100%)		0.0							0.0		0.0
17		LQR	Community Gynaecology - Referral to first OP appointment <4 weeks (no penalty)	100%	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
17		LQR	Community Gynaecology - One Stop Service (£1000 / Qtr if 2 consecutive q'ly breaches)	=>90%	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
17		LQR	Community Gynaecology - FUN Ratio (no penalty)	<1.2	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
17		LQR	Community Gynaecology - Onward Referral Rate <10% (£1000 / Qtr if 2 consecutive q'ly breaches)	100% <10%	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
17		LQR	Community Gynaecology - Reports to referring GP <1 working week of appointment (no penalty)	100%	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
17		LQR	Community Gynaecology - Patient Experience Satisfaction Rate (no penalty)	=>95%	Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly								
17		LQR	Community Gynaecology - No. clinics / sessions cancelled (no penalty)	100%	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
17		LQR	Community Gynaecology - Same day ultrasound available within clinic (no penalty)	=>95%	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
17		LQR	Community Gynaecology - Adherance to Formulary & Wound M'ment Formulary (no penalty)	Annual Report	Assessed Annually									Assessed Annually									Assessed Annually									Assessed Annually								
14		LQR	Community MSK-Pts ref. for Card. Rehab who complete course(£1000/Q if 2 consec.Q breaches)	tba									0.0										0.0									0.0							0.0		0.0
14		LQR	Community MSK-Pts ref. for Hydrotherapy who complete course(£1000/Q if 2 consec.Q breaches)	tba							29 pts		0.0								30 pts		0.0							22 pts		0.0							81 pts		0.0
14		LQR	Community MSK-Pts ref. for Group Gym who complete course(£1000/Q if 2 consec.Q breaches)	tba							61 pts		0.0								74 pts		0.0							45 pts		0.0							180 pts		0.0
14		LQR	Community MSK-Pts ref. for Pain M'ment who complete course(£1000/Q if 2 consec.Q breaches)	tba							9 pts		0.0								4 pts		0.0							22 pts		0.0							35 pts		0.0
14		LQR	Community Resp. - Urgent referrals seen <48hrs (£1000/Qtr if 2 consecutive quarterly breaches)	=>90%							0 (92%)		0.0								0 (97%)		0.0							0 (96%)		0.0							0.0		0.0
14		LQR	Community Resp. - COPD referrals to Pulmonary Rehab. (no penalty)	100%	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
14		LQR	Community Continence - Referrals to assessment <2 weeks (no penalty)	=>95%	Assessed Quarterly									Assessed Quarterly															0 (44%)		0.0							0.0		0.0
14		LQR	Community Home O2-Av. wait for LTOT assessment <48 hrs(£1000/Q if 2 consec.Q breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
14		LQR	Community Home O2-Pts. Who have a F/U home visit <4weeks (£250/Q if 2 consec.Q breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
14		LQR	Community Home O2-Pts. Who have a F/U home visit <3 months (£250/Q if 2 consec.Q breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
14		LQR	Community Home O2-Pts. Who have a F/U home visit <6 months (£250/Q if 2 consec.Q breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
14		LQR	Community Home O2-Pts. Who have a F/U home visit <12 months (£250/Q if 2 consec.Q breaches)	100%	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
14		LQR	Community Home O2-Pts. With CO2 retention given O2 alert cards (£1000/Q if 2 consec.Q breaches)	tba	Assessed Quarterly									Assessed Quarterly																	0.0							0.0		0.0
			ALL		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Contractual Requirements - CQUIN (CQ)

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

Contractual Requirements - Price Activity Matrix (PAM)

Data Source	Data Quality	Req	Indicator	Threshold	APRIL (£000s)									MAY (£000s)									JUNE (£000s)									YEAR TO DATE (£000s)								
					M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		PAM	Elective (IP and DC)	Contract Plan	-136	-533	-136	-89	1	1			-892	-41	-297	-166	-24	1	4			-523	-265	-514	-132	-115	1	7			####	-442	####	-434	-228	3	12			####
2		PAM	Non-Elective	Contract Plan	207	199	-36	-39					331	155	272	-24	85					488	-394	149	-33	-27					-305	-32	620	-93	19					514
2		PAM	Excess Bed Days	Contract Plan	-67	-22	-4	-2					-95	-47	-27	2	44					-28	-70	-56	-7	64					-69	-184	-105	-9	106					-192
2		PAM	Accident & Emergency	Contract Plan	-62		-21						-83	-8		-3						-11	-175		-31						-206	-245		-55						-300
2		PAM	Outpatient New	Contract Plan	23	-18	21	-18	-3	0	8		13	-9	-46	-13	1	-1	0	6		-62	-5	-18	2	10	-4	0	10		-5	9	-82	10	-7	-8	0	24		-54
2		PAM	Outpatient Review	Contract Plan	-36	-40	19	-34	-2	0	11		-82	-34	-26	15	-16	-2	0	10		-53	-66	-33	21	-25	-24	0	13		-114	-136	-99	55	-75	-28	0	34		-249
2		PAM	Outpatient with Procedure	Contract Plan	55	-28	1	8					36	48	-19	0	25					54	157	-7	32	23					205	260	-54	33	56					295
2		PAM	Outpatient Telephone Conversation	Contract Plan	-1	0							-1	-1	0							-1	-1	0							-1	-3	0							-3
2		PAM	Maternity	Contract Plan				159					159				131					131				184					184				474					474
2		PAM	Occupied Cot Days	Contract Plan				-25					-25				-1					-1				-14					-14				-40					-40
2		PAM	Unbundled Activity	Contract Plan	30	-14	0	-1	0	0			15	85	-10	6	-3	0	0			78	95	-6	-1	0	0	0			88	210	-30	5	-4	0	0			181
2		PAM	Other Contract Lines	Contract Plan	121	-2	-130	-71	-14	-34	0		-130	93	-2	-235	-35	-14	-26	0		-219	197	-2	-25	-23	59	30	0		236	411	-6	-390	-129	31	-30	0		-113
2		PAM	Community	Contract Plan	-2	0		0		0	-10		-12	-1	0		-1		0	-6		-8	0	0		24		0	14		38	-3	0		23		0	-2		18
			ALL		132	-458	-286	-112	-18	-33	9	0	-766	240	-155	-418	206	-16	-22	10	0	-155	-527	-487	-174	101	32	37	37	0	-981	-155	####	-878	195	-2	-18	56	0	####

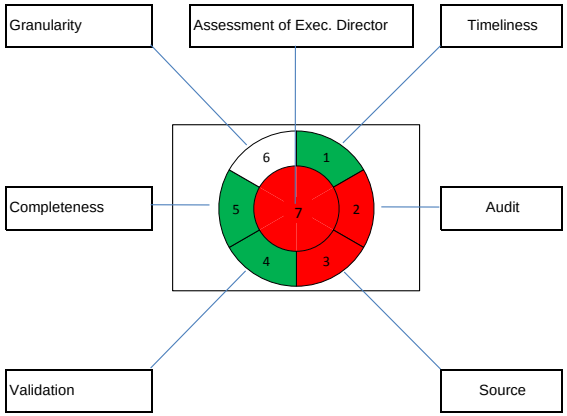
Legend

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

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

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

Data Quality - Kitemark



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

Red	Insufficient
Green	Sufficient
White	Not Yet Assessed

The centre of the indicator is colour coded as follows:

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

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

Medicine Group

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
C. Difficile	30	3	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	1	1	0	2	5	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	1	0	1	1	●		
MRSA Screening - Elective (%)	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	94	98	79	92.6		●		
MRSA Screening - Non Elective (%)	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	93	91	90	92.3		●		
Falls	0	0	33	40	61	42	44	41	67	50	66	63	42	52	28	37	44				Jun-15	5	30	9	44	109	●		
Falls with a serious injury	0	0	1	3	3	1	4	1	1	2	0	1	0	1	1	0	2				Jun-15	0	1	1	2	3	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	2	3	3	3	0	5	1	6	7	10	1	1	10						Apr-15				10	10	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	95	92.2	99	96.4		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	100	99	99.1		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	100	100	100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	1	●	●	●				Jun-15	0	0	0	0	0	●		
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	1	1	0	2	5	●		
Mortality Reviews within 42 working days	100	=>98	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	90	91	92	91		●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
Pts spending >90% stay on Acute Stroke Unit (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		86.7		86.7	90.1	●		
Pts admitted to Acute Stroke Unit within 4 hrs (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		80.3		80.3	81.3	●		
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		77.4		77.4	75.2	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		100		100.0	98.8	●		
Stroke Admission to Thrombolysis Time (% within 60 mins)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		71.4		71.4	70.6	●		
Stroke Admissions - Swallowing assessments (<24h) (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		100		100.0	100.0	●		
TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=>70.0	=>70.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		92.7		94.7	96.4	●		
TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=>75.0	=>75.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		95.1		97.8	97.5	●		
Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		95.0		94.1	94.6	●		
Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		94.4		93.8	94.1	●		
Rapid Access Chest Pain - seen within 14 days (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		100		100.0	100.0	●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15			91	90.9		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15			100	100		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15			82.6	82.6		●		
Mixed Sex Accommodation Breaches	0	0	36	43	14	0	0	0	7	0	0	0	0	0	0	0	0				Jun-15	0	0	0	0	0	●		
No. of Complaints Received (formal and link)				38	28	28	32	36	48	18	31	30	36	38	41	35	42				Jun-15	19	15	8	42	118			
No. of Active Complaints in the System (formal and link)				##	##	##	##	##	##	##	93	##	##	##	##	##	88				Jun-15	31	43	14	88				
Oldest' complaint currently in system (days)				##	##	##	##	##	##	##	##	##	##	##	##	##	##				Jun-15	188	210	88	210				

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0.00	1.16	0.00	0.12		●		
28 day breaches	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0				Jun-15	0	0	0	0	0	●		
Sitrep Declared Late Cancellations	0	0	10	2	7	7	3	2	5	4	1	0	0	9	8	1	2				Jun-15	0	2	0	2	11	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0					61	54	57	60	62	61	49	48	56	46	53				Jun-15			52.9	52.62		●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	95.3 (S)	92.7 (C)		93.9	92.1	●		
Emergency Care 4-hour breach (numbers)			570	1003	1016	907	736	1201	1390	1181	1913	940	1242	1412	1310	1106	828				Jun-15	809	2	17	828	3244			
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0 (s)	0 (c)		0	0	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	16 (s)	18 (c)		17	17	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	51 (s)	65 (c)		59	61	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	8.42 (s)	7.89 (c)		8.14	8.25	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	3.16 (s)	6.14 (c)		4.76	4.90	●		
WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	0	0	119	136	125	145	51	136	219	159	282	185	149	164	144	136	106				Jun-15	26 (s)	80 (c)		106	386	●		
WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	0	0	13	8	8	8	1	13	21	14	31	7	6	8	9	8	3				Jun-15	0 (s)	3 (c)		3	19	●		
WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	=<0.02	=<0.02	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0 (s)	0.13 (c)		0.07	0.15	●		
WMAS - Emergency Conveyances (total)			4044	4227	4093	4278	3994	4067	4193	4168	4470	4001	3829	4182	3981	4214	4071				Jun-15	1801 (s)	2270 (c)		4071	12266			

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		99.3	96.2	97.5		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		94.1	96.4	95.6		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		95.0	93.9	94.3		●		
Patients Waiting >52 weeks	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0				Jun-15	0	0	0	0		●		
Treatment Functions Underperforming	0	0	6	3	5	5	6	5	5	7	2	2	6	1	1	1	1				Jun-15	0	1	0	1		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0.0	0.3	0.0	0.20		●		
WTE - Actual versus Plan			171	161	157	151	166	160	166	197	232	242	244	328	195	207	236				Jun-15	106	73	58	236				
PDRs - 12 month rolling (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	90	88	89		88.5	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	76	90	88		86.0	●		
Sickness Absence (%)	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	2.23	3.45	5.90	3.56	4.75	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●	●				Jun-15	56.2	70.5	36.1		59.8	●		
Mandatory Training (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	86.6	85.7	85.1		85.9	●		
New Investigations in Month			1	1	1	2	1	2	1	0	0	1	2	2	2	1	1				Jun-15	1	0	0	1				
Nurse Bank Fill Rate %	100	100												72	69	73	75				Jun-15				75.0		●		
Nurse Bank Shifts Not Filled (number)	0	0												1031	1392	889	771				Jun-15				771	3052	●		
Nurse Bank Use	34560	2880	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15				2378	7290	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15				1634	5031	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15				915	2664	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15				62	163	●		
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																											
Your Voice - Response Rate (%)			8		9		9		6				7	6							Jun-15	5	5	11	6				
Your Voice - Overall Score			3.68		3.76		3.76		3.57				3.5	3.49							Jun-15	3.5	3.5	3.4	3.49				

Surgery A Group

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
C. Difficile	7	1	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	1	1	3	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	99	100	98	0	98.2		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	99	95	97	100	97.6		●		
Falls	0	0	9	7	4	8	3	9	9	6	6	0	4	4	3	7	3				Jun-15	2	0	1	0	3	13	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0				Jun-15	0	0	0	0	0	0	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	1	0	0	0	1	1	0	0	4	0	0	2	0						Apr-15					0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	97.3	96.3	96.4	99.5	97.1		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	100	100	99.5	99.9		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	100	100	100	100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	1	1	●				Jun-15	0	0	0	0	0	2	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	0	0	●		
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	0	3	●		
Mortality Reviews within 42 working days	100	=>98	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15	25	100		95	85		●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	96.4		93.0		95.5		●		
2 weeks (Breast Symptomatic)	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	95.0				95.0		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	100		100		100		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	82.8		76.2		80.0		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	3	0	0	0	0	2	0	0	0	0	0	0				Jun-15	0	0	0	0	0	0	●		
No. of Complaints Received (formal and link)				12	11	8	19	15	13	13	7	15	9	16	18	8	16				Jun-15	5	6	5	0	16	42			
No. of Active Complaints in the System (formal and link)				50	50	34	39	49	57	78	53	45	40	45	47	27	32				Jun-15	13	13	6	0	32				
Oldest' complaint currently in system (days)				124	131	118	99	109	133	143	171	192	213	234	254	97	157				Jun-15	84	157	136	0	157				
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0.8	1.2	0.9	0.0	0.75		●		
28 day breaches	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	0	0				Jun-15	0	0	0	0	0	0	●		
Sitrep Declared Late Cancellations	0	0	13	16	5	6	16	10	18	6	33	11	13	17	12	10	8				Jun-15	3	3	2	0	8	30	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0					76	78	75	77	71	78	79	75	77	77	79				Jun-15	80.1	78.1	76.3		78.7		●		
Emergency Care 4-hour breach (numbers)			81	100	100	119	52	103	118	94	121	43	108	127	59	67	36				Jun-15	24	9	2	1	36	162			
Hip Fractures - Operation < 24 hours of admission (%)	85	85	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				May-15		42.1			42.1	64.9	●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	92.0	67.8	92.0		84.6		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	97.5	95.1	87.6		95.1		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	96.1	92.7	96.4		94.6		●		
Patients Waiting >52 weeks	0	0	1	1	0	2	4	2	1	2	0	3	1	2	1	0	0				Jun-15	0	0	0	0	0		●		
Treatment Functions Underperforming	0	0	7	5	5	4	3	4	6	7	4	5	8	4	2	3	2				Jun-15	0	1	1	0	2		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0.7	0.0	0.5	0.0	0.59		●		
WTE - Actual versus Plan			64	71	77	78	71	71	71	76	66	62	70	71	77	102	109				Jun-15	30.6	13.6	34.3	28.6	109				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	87.4	79.4	96	88		89.5	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	83	92	88	90		88.8	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	5.09	2.10	5.69	4.52	4.73	5.21	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●	●				Jun-15	51.9	36.3	71.5	69.6		61.1	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	88.5	84.8	95.2	92.6		91.5	●		
New Investigations in Month			0	0	0	0	0	2	0	1	0	1	1	2	3	3	1				Jun-15	0	1	0	0	1				
Nurse Bank Fill Rate	100	100												76	71	79	82				Jun-15					82.2		●		
Nurse Bank Shifts Not Filled	0	0												335	369	214	197				Jun-15					197	780	●		
Nurse Bank Use	9908	826	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15					952	2516	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15					299	944	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15					186	511	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15					12	12	●		
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																												
Your Voice - Response Rate			13			11			11				9			10					Jun-15	12	5	9	10	10				
Your Voice - Overall Score			3.55			3.57			3.57				3.41			3.56					Jun-15	3.31	3.43	3.76	3.53	3.56				

Surgery B Group

Indicator	Trajectory		Previous Months Trend (since April 2014)																	Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		O	E				
C. Difficile	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	97	97	96.6		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	97	96	96.2		●		
Falls	0	0	1	0	0	2	0	0	0	0	1	1	0	0	0	0	0				Jun-15	0	0	0	0	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				Jun-15	0	0	0	0	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0						Apr-15	0	0	0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	98.88	97.5	98.3		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	98.6	99.6		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	99.4	98.6	99.2		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	●		
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	●		
Mortality Reviews within 42 working days	100	=>97	●	●				●													Apr-15					●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		O	E					
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15		92.6	92.6		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●		●	●	●	●	●					May-15		100	100		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0		●	●	●	●		●	●	●	●	●	●	●	●					May-15		100	100		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0					Jun-15	0	0	0	0	●		
No. of Complaints Received (formal and link)				9	3	10	11	8	12	11	14	14	12	16	14	9	6				Jun-15	6	0	6	29			
No. of Active Complaints in the System (formal and link)				31	40	34	37	36	37	47	33	35	35	36	44	35	17				Jun-15	15	2	17				
Oldest' complaint currently in system (days)				117	100	103	129	98	63	138	109	102	123	144	164	80	102				Jun-15	102	70	102				
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	1.7	0.9	1.43		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				Jun-15	0	0	0	0	●		
Sitrep Declared Late Cancellations	0	0	3	22	17	16	14	16	12	11	7	24	11	8	15	18	16				Jun-15	12	4	16	49	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0					72	74	72	73	68	74	72	75	71	72	72				Jun-15	73	71	72.3		●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	99.46		99.5	99.5	●		
Emergency Care 4-hour breach (numbers)			7	14	72	6	25	29	5	25	21	8	8	39	10	20	14				Jun-15	12	2	14	44			
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0		0	0	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	34		15	15	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	26		27	25	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	3.31		4.19	3.52	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	2.07		2.33	2.08	●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		O	E					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	91.8	91.7	91.8		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	97.1	95.5	96.7		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	94.3	94.2	94.2		●		
Patients Waiting >52 weeks	0	0	0	1	1	0	0	2	2	1	0	0	1	1	0	2	2				Jun-15	2	0	2		●		
Treatment Functions Underperforming	0	0	3	4	3	3	2	4	5	5	1	2	7	1	1	2	1				Jun-15	0	1	1		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0.0	0.0	0.00		●		
WTE - Actual versus Plan			28	34	38	33	32	28	30	27	30	32	29	32	33	35	45				Jun-15	33.34	12	45				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	92.66	94.59		93.1	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	96	100		96.9	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	3.72	1.67	3.10	3.24	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●	●				Jun-15	40.3	77.5		49.6	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	87.1	92.1		88.2	●		
New Investigations in Month			0	0	0	0	0	0	0	0	0	0	0	0	0	1	0				Jun-15	0	0	0				
Nurse Bank Fill Rate	100	100												100	99.6	100	98.4				Jun-15			98.4		●		
Nurse Bank Shifts Not Filled	0	0												1	1	1	3				Jun-15			3	5	●		
Nurse Bank Use	2796	233	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15			183	554	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15			18	18	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15			126	351	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15			16	59	●		
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																										
Your Voice - Response Rate			18			17			17			14			12						Jun-15	6	27	12				
Your Voice - Overall Score			3.72			3.52			3.52			3.54			3.59						Jun-15	3.38	3.75	3.59				

Women & Child Health Group

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
C. Difficile	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	1	0	0	0	1	1	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	99.1				99.1		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		96.4			96.4		●		
Falls	0	0	0	0	2	0	1	0	0	0	0	0	0	0	0	0	0				Jun-15	0	0	0	0	0	0	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				Jun-15	0	0	0	0	0	0	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	0	0	0	0	0	0	2	0	0	0	2	0	0						Apr-15	0	0	0	0	0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	95.9	74.0			84.4		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	100			100		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	100			100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	100			100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	1				Jun-15	0	1	0	0	1	1	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	0	0	●		
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	1	0	0	1	2	●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
Caesarean Section Rate - Total (%)	=<25.0	=<25.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		23.0			23.0	23.9	●		
Caesarean Section Rate - Elective (%)			10	8	9	9	7	9	7	8	11	8	6	9	8	7	8				Jun-15		6.84			7.8	7.4			
Caesarean Section Rate - Non Elective (%)			16	18	19	15	17	18	19	16	16	15	17	16	15	18	15				Jun-15		18.0			15.2	16.2			
Maternal Deaths	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		0			0	0	●		
Post Partum Haemorrhage (>2000ml)	48	4	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		0			0	0	●		
Admissions to Neonatal Intensive Care (%)	=<10.0	=<10.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		1.7			1.68	1.44	●		
Adjusted Perinatal Mortality Rate (per 1000 babies)	<8.0	<8.0	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15		9.1			9.1		●		
Early Booking Assessment (<12 + 6 weeks) (%) - SWBH Specific	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		78.7			78.7		●		
Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15		154			154.2		●		
Mortality Reviews within 42 working days	100	=>97	●	●	●		●	●	●	●	●			●	●						Apr-15	100				100		●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	89.1				89.1		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	88.0				88.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	70.5				70.5		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				Jun-15	0				0	0	●		
No. of Complaints Received (formal and link)				4	6	11	8	8	8	12	7	11	9	11	7	9	14				Jun-15	2	11	0	1	14	30			
No. of Active Complaints in the System (formal and link)				15	21	21	24	29	29	33	12	21	27	32	28	28	20				Jun-15	7	12	1	0	20				
Oldest' complaint currently in system (days)				61	82	52	66	87	104	123	151	52	73	94	113	128	26				Jun-15	92	116	96	0	116				

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0.9		0.0		0.66		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				Jun-15	0				0	0	●		
Sitrep Declared Late Cancellations	0	0	12	3	4	7	6	6	7	7	7	1	5	7	6	4	2				Jun-15	2				2	12	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0					78	76	77	77	80	77	78	79	73	78	73				Jun-15	73.2				73.2		●		
Emergency Care 4-hour breach (numbers)			18	14	14	18	14	30	23	36	82	5	30	16	11	13	9				Jun-15	9	0	0	0	9	33			
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	95.0				95.0		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	97.6				97.6		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	98.7				98.7		●		
Patients Waiting >52 weeks	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0				Jun-15	0				0		●		
Treatment Functions Underperforming	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				Jun-15	0				0		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0.0				0.0		●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
WTE - Actual versus Plan			48	58	60	67	81	61	60	59	66	67	69	70	69	73	93				Jun-15	25.1	63.2	26.3	12.1	93				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	82.2	81.6	92.2	88.5		85.8	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	89	92	100			93.3	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	5.82	5.48	2.43	9.15	5.14	5.56	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●	●				Jun-15	55.3	55.0	57.5	64.5		56.0	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	92.1	84.3	90.5	90.7		87.2	●		
New Investigations in Month			0	0	0	2	0	0	0	0	0	0	1	1	1	3	2				Jun-15	0	1	0	1	2				
Nurse Bank Fill Rate	100	100												90	94	96	92				Jun-15					91.9		●		
Nurse Bank Shifts Not Filled	0	0												81	45	25	53				Jun-15					53	123	●		
Nurse Bank Use	6852	571	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15					619	1695	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15					98	214	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15					62	216	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15					18	49	●		
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																												
Your Voice - Response Rate			11		12			12			9				13						Jun-15	18	8	18	14	13				
Your Voice - Overall Score			3.79		3.65			3.65			3.53				3.66						Jun-15	3.79	3.7	3.57	3.58	3.66				

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
HV (C1) - No. of mothers who receive a face to face AN contact with a HV at =>28 weeks of pregancy	No threshold														17	26	56				Jun-15				56	56 pts				
HV (C2) - % of births that receive a face to face new birth visit by a HV =<14 days	=>95.0	=>95.0													83	81	87				Jun-15				87	87.0				
HV (C3) - % of births that receive a face to face new birth visit by a HV >days	No threshold														17	16	9				Jun-15				9	9.0				
HV (C4) - % of children who received a 12 months review by 12 months	=>95.0	=>95.0													59	62	71				Jun-15				71	71.0				
HV (C5) - % of children who received a 12 months review by the time they were 15 months	No threshold														88	79	77				Jun-15				77	77.0				
HV (C6i) - % of children who received a 2 - 2.5 year review	=>95.0	=>95.0													85	80	91				Jun-15				91	91.0				
HV (C6ii) - % of children who receive a 2 - 2.5 year review using ASQ 3	No threshold																													
HV (C7) - No. of Sure Start Advisory Boards / Children's Centre Boards witha HV presence	100%	100%													100	100	100				Jun-15				100	100				
HV (C8) - % of children who receive a 6 - 8 week review	=>95.0	=>95.0													74	74	79				Jun-15				79	79.0				
HV - % of infants for whom breast feeding status is recorded at 6 - 8 week check	100	100													63	65	65				Jun-15				65	65.0				
HV - % of infants being breastfed at 6 - 8 weeks	Min. 5% increase on base														39	40	38				Jun-15				38	38.0				
HV - % HV staff who have completed mandatory training at L1,2 or 3 in child protection in last 3 years	=>95.0	=>95.0															100				Jun-15				100	100				
HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 10 - 14 day developmental check																														
HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 10 - 14 day developmental check	100	100													88	87	86				Jun-15				86	86.0				
HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 6 - 8 week developmental check																														
HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 6 - 8 week developmental check	100	100													74	81	79				Jun-15				79	79.0				
HV - No. of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 9 - 12 months developmental check																														
HV - % of babies from 0 - 1 year who have a conclusive newborn bloodspot status documented at the 9 - 12 months developmental check	100	100													76	69	66				Jun-15				66	66.0				
HV - movers into provider <1 year of age to be checked =<14 d following notification to HV service																														
HV - all untested babies <1 year of age will be offered NBBS screening & results to HV.															Y	Y	Y								Y	Yes				

Pathology Group

Indicator	Trajectory		Previous Months Trend (since April 2014)																	Data Period	Directorate					Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		HA	HI	B	M	I					
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	0	**0**	**0**	●		
No. of Complaints Received (formal and link)				0	1	0	1	1	3	0	2	3	1	5	0	2	2				Jun-15	2	0	0	0	0	**2**	**4**			
No. of Active Complaints in the System (formal and link)				1	2	1	2	3	6	5	5	8	7	6	7	7	4				Jun-15	3	1	0	0	0	**4**				
Oldest' complaint currently in system (days)				91	112	27	46	68	92	111	90	96	117	138	158		27				Jun-15	27	1	0	0	0	**27**				
WTE - Actual versus Plan			30	32	31	32	29	27	25	27	27	24	16	18	20	26	35				Jun-15	3	3	14	5	3	**35**				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	87.3	94.9	89.2	98.3	100		**92.9**	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	100	71	100	100	100		**90.0**	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	7.41	2.04	2.42	3.35	7.98	**3.91**	**4.34**	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●	●				Jun-15	80.9	91.9	84.6	92.2	100		**78.5**	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	92.8	97.2	96.6	96.5	94.6		**96.1**	●		
New Investigations in Month			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				Jun-15	0	0	0	0	0	**0**				
Admin & Clerical Bank Use (shifts)	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15						**519**	**1542**	●		
Admin & Clerical Agency Use (shifts)	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15						**0**	**0**	●		
Your Voice - Response Rate			30		31		31		12		27		21								Jun-15	24	26	12	28	69	**21**				
Your Voice - Overall Score			3.43		3.74		3.74		3.76		3.7		3.69								Jun-15	3.37	3.49	3.58	3.71	4.15	**3.69**				

Imaging Group

Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Directorate DR	IR	NM	BS	Month	Year To Date	Trend	Next Month	3 Months
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	0	0	●		
Unreported Tests / Scans																														
Outsourced Reporting																														
IRMA Instances																														
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15			77.4		77.4	75.2	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15			100		100.0	98.8	●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				Jun-15	0	0	0	0	0	0	●		
No. of Complaints Received (formal and link)				4	2	3	3	0	4	2	2	3	2	1	2	4	3				Jun-15	1	2	0	0	3	9			
No. of Active Complaints in the System (formal and link)				5	7	8	5	5	8	10	8	9	7	5	5	5	5				Jun-15	1	4	0	0	5				
Oldest' complaint currently in system (days)				19	40	59	30	52	76	72	75	83	75	96	73	92	27				Jun-15	27	24	0	0	27				
Emergency Care 4-hour breach (numbers)			30	39	41	32	34	49	50	52	45	41	49	51	46	35	44				Jun-15	44				44	125			
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●					May-15	0.4				0.00		●		
WTE - Actual versus Plan			15	13	11	13	22	14	16	15	21	21	33	40	43	51	59				Jun-15	34	3	3	8	59				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	81	100	97	91		85.1	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	87		100			87.5	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	4.58	6.79	0.81	2.13	5.95	4.78	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●	●				Jun-15	46.8	88.0	71.4	20.8		44.1	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	88.8	91.4	91.3	91.3		89.8	●		
New Investigations in Month			0	2	2	0	0	6	0	0	0	0	0	0	0	0	0				Jun-15	0	0	0	0	0				
Nurse Bank Use	288	24	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15					22	43	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15					294	743	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15					187	585	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15					0	0	●		
Your Voice - Response Rate			19		33		33		18			19									Jun-15	15		35	22	19				
Your Voice - Overall Score			3.72		3.73		3.73		3.28			3.41									Jun-15	3.2		3.6	3.6	3.41				

Community & Therapies Group

Indicator	Trajectory		Previous Months Trend (since April 2014)																	Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		AT	IB	IC					
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15				100		●		
Falls	0	0	8	9	11	13	4	14	20	17	21	22	16	13	25	39	37				Jun-15	0	37	0	37	101	●		
Falls with a serious injury	0	0	0	2	0	0	1	0	0	0	0	0	0	0	1	0	0				Jun-15	0	0	0	0	1	●		
Grade 2,3 or 4 Pressure Ulcers (avoidable)	0	0	2	4	2	2	1	1	1	3	5	2	1	3	1						Mar-15		1		1	1	●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	0	0	0	0	●		
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	1	●	●	●					Jun-15	0	0	0	0	0	●		
FFT Response Rate - Wards	>25%	>25%	39	68	43	60	59	57	47	38	33	33	41	59	38						Apr-15				38.0		●		
FFT Score - Wards	=>68.0	=>68.0	81	95	87	83	91	82	88	73	87	100	95	90	94						Apr-15				94		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				Jun-15	0	0	0	0	0	●		
No. of Complaints Received (formal and link)				3	0	0	5	2	5	1	1	2	1	1	1	1	2				Jun-15	0	1	1	2	4			
No. of Active Complaints in the System (formal and link)				10	8	3	8	8	10	12	3	4	3	6	2	7	6				Jun-15	1	5	0	6				
Oldest' complaint currently in system (days)				94	##	75	38	60	64	81	75	61	82	103	123	##	99				Jun-15	99	94	0	99				
WTE - Actual versus Plan			27	36	45	45	62	65	67	71	75	76	72	15	80	86	81				Jun-15	6	31	44	81				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	95	87	93		91.0	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	3.04	5.92	5.18	5.11	5.20	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●	●				Jun-15	94.7	80.8	73.3		79.7	●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																	Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		AT	IB	IC					
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	94.8	88.1	90.0		89.9	●		
New Investigations in Month			0	0	0	0	0	0	0	0	0	0	0	0	1	3	0				Jun-15	0	0	0	0				
Nurse Bank Fill Rate	100	100												93	90	93	89				Jun-15				89.2		●		
Nurse Bank Shifts Not Filled	0	0												36	47	29	46				Jun-15				46	122	●		
Nurse Bank Use	5408	451	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15				375	1110	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15				323	760	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15				184	568	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15				0	0	●		
Your Voice - Response Rate			18		32		32			28			30	26							Jun-15	42	22	23	26				
Your Voice - Overall Score			3.75		3.88		3.88			3.76			3.8	3.77							Jun-15	3.7	3.8	3.9	3.77				
DVT numbers	730	>61	53	62	87	39	33	70	35	42	47	54	53	55	70						Apr-15				70	70	●		
Therapy DNA rate OP services (%)	=<9	=<9	12	16	11	11	11	11	12	14	12	12	14	13							Mar-15				12.9	12.3	●		
FEES assessment	>100	>8.3	7	10	3	4	4	5	5	3	2	14	1	3	0						Apr-15				0	0	●		
ESD Response time	<48 hrs	<48 hrs	●	●	●	●	●	●	●	●	●	●	●	●	●						Apr-15						●		
STEIS	0	0	0	2	1	0	1	0	0	0	1	0	0	1	1	0					May-15				0	1	●		
Rapid response to AMU, RRTS	<60 mins	<60 mins	75	71	72	73	68	81	79	82	86	79	98								Feb-15				98	78.5	●		
Avoidable weight loss	<20%	<20%	18	0	8	0	0	0	0	0	9	0	0	8.1	0	25					May-15				25		●		
Green Stream Community Rehab response time for treatment (days)	=<11	=<11	12	7.9	11	16	16	17	14	12	13	9.5	12	14	16						Apr-15				15.8	15.8	●		

Indicator	Trajectory		Previous Months Trend (since April 2014)																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		AT	IB	IC					
DNA/No Access Visits (%)							3.3	0.9	0.7	0.9	0.9	0.9	0.8	0.9	0.8	0.6	0.7				Jun-15				0.7				
Falls Assessments - DN service only (%)							72	58	49	45	45	62	54	65	47	55	50				Jun-15				50				
Pressure Ulcer Assessment - DN service only (%)							73	61	50	48	46	63	57	65	51	55	51				Jun-15				51				
Healthy Lifestyle Assessments - DN Service only (%)							61	54	48	39	43	58	54	56	47	57	45				Jun-15				45				
At risk of Social Isolation Referrals to 3rd sector DN service only (%)							46	75	67	57	65	95	77	53	100	33	88				Jun-15				88				
MUST Assessments - DN Service only (%)							9.4	11	9.9	11	9.8	19	18	36	22	22	24				Jun-15				24				
Incident Rates (per 1000 charge)							3.6	4.8	4.9	3.5	3.5	5.1	4.1	4.9	3.9	5.1	5.1				Jun-15				5.1				
Dementia Assessments - DN Service only (%)							72	62	55	52	51	61	62	62	46	56	40				Jun-15				40				
48 hour inputting rate (%)							91	83	81	85	86	89	83	88	87	89	92				Jun-15				92				

Corporate Group

Indicator	Trajectory		Previous Months Trend (since April 2014)																	Data Period	Directorate							Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		CEO	F	W	M	E	N	O					
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	1				Jun-15	0	1	0	0	0	0	0	1	1			
No. of Complaints Received (formal and link)				8	4	5	6	5	7	6	6	15	5	6	5	7	8				Jun-15	2	0	0	0	0	2	4	8	20			
No. of Active Complaints in the System (formal and link)				16	13	12	13	21	21	25	12	21	16	18	14	12	14				Jun-15	4	0	0	1	0	5	4	14				
Oldest' complaint currently in system (days)				69	90	77	99	121	106	104	104	123	145	138	158	99	121				Jun-15	67	0	0	25	0	121	82	121				
WTE - Actual versus Plan			149	154	162	176	162	183	194	203	168	175	200	234	259	271	101				Jun-15	9	8	-8	19	-2	37	37	101				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	73	89	86	91	92	94	82		89.5	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15			100						100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	3.67	0.56	3.80	2.40	2.45	6.45	6.09	5.12	4.75	●		
Return to Work Interviews (%) following Sickness Absence	100	100												●	●	●	●				Jun-15	73.0	70.2	38.1	83.3	47.6	76.7	70.3		70.7	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	93.9	96.1	93.0	93.4	96.3	89.5	91.3		91.2	●		
New Investigations in Month			0	1	3	1	0	5	0	0	0	1	0	0	1	0	1				Jun-15	0	0	0	0	0	1	0	1				
Nurse Bank Use	1088	91	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15								241	624	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15								91	232	●		
Admin & Clerical Bank Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	8	113	40	30	0	2443	589	3223	9337	●		
Admin & Clerical Agency Use (shifts)	0	0		●	●	●	●	●	●	●	●	●	●	●	●	●	●				Jun-15	0	44	0	0	0	22	61	127	253	●		
Your Voice - Response Rate			26		24		21			15			14		16						Jun-15	76	24	38	24	16	9	11	16				
Your Voice - Overall Score			3.76		3.6		3.49			3.48			3.5		3.50						Jun-15	3.71	3.34	3.72	3.39	3.24	3.46	3.32	3.50				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue Anne Gibson Committee Room, City Hospital **Date** 26 June 2015; 1030h – 1230h

Present

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

In Attendance

Ms A Binns
Mr M Harding
Mr T Lewis

Secretariat

Mr S Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies for absence were received from Ms Olwen Dutton and Mr Tony Waite.	
2 Minutes of the previous meeting	**SWBQS (5/15) 060**
The minutes of the Quality and Safety Committee meeting held on 29 May 2015 were approved as a true and accurate reflection of discussions held. In terms of the Coroner's item, Dr Stedman reported that agreement was needed regarding the differing approaches to deaths involving falls between the Birmingham & Black Country Coroners. The consultants were reported to have been asked to ensure that all deaths due to fractured neck of femur were to be referred. The training implications were reported to be being picked up. It was noted that all these deaths were included within the mortality review process. Mrs Hunjan asked whether still birth cases were referred to the coroner and was advised that neonatal deaths were reviewed as part of child death review process; antenatal deaths are reviewed locally and reported nationally.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBQS (5/15) 060 (a)**

The updated actions list was received and noted by the Committee.	
3.1 CCG/SWBH joint learning from complaints	**Verbal**
Ms Parker reported that a meeting had been arranged.	
3.2 Down's syndrome screening – SWBH positon vs. other organisations	**Verbal**
Dr Stedman reported that there was no benchmarking data available to determine the Trust's position against other organisations in respect of Down's syndrome screening position.	
MATTERS FOR DISCUSSION/DEBATE	
Safe and Sound	
Mrs Goodby presented a tabled paper concerning the quality aspects of Safe & Sound Phase II. She reminded the Committee that the consultation process had concluded on 13 June and a number of schemes had changed as a result. Quality Impact Assessments were reported to have been undertaken. A number of medical secretary schemes were reported to have changed in particular. Three schemes were being given particular attention: • SB 515 – Audiometric maintenance and calibration. • SA610 – Theatre and Sterile Services portering • WC502 – GUM/CASH Clinic – redundancy of a specialty It was noted that 31 QIAs needed to be completed within the next week. The process for Safe & Sound II was reviewed, including the appeals process and redeployment. Mr Lewis reported that the decisions around the schemes would be made by the Workforce & OD Committee on 29 June. He provided additional detail on schemes SB515 and SA610. Dr Stedman reported that the proposed change in portering arrangements would not impact on theatre throughput at the weekends, including emergency transits. Mr Lewis suggested that a forward view of the schemes KPIs was needed and a track would be kept of the impact on patient administration. It was suggested that monitoring the KPIs needed to be kept within the remit of the Quality & Safety Committee, even if some of the indicators were already included in the Integrated Performance Report. It was noted that clarity as to whether the WTE detail in the report concerned posts or people. The paperwork supporting the process and being completed by managers needed to be improved. Mr Lewis reported that balanced budgets were in place largely, based on deleting vacancies or holding vacancies, therefore the situations where this was the case would be reviewed by the Chief Operating Officer. It was suggested that the overall position would be presented at the next meeting with a view to assessing the	

collective impact. Mr Samuda suggested that hot spots needed to be identified and robust recruitment plans were to be executed to address these local issues. He was advised that this would be considered by the Workforce & OD Committee.	
ACTION: Mrs Goodby to present a further update on the impact of Safe & Sound II at the August meeting	
4 Never Event in obstetrics	**Verbal**
Dr Stedman reported that a Never Event had occurred in the obstetrics area. He provided the detail of the incident. It was reported that the investigation was yet to conclude. The patient was reported to be recovering well. Information on the documentation and witness statements were reported to be being sought. Mrs Hunjan asked whether a signing process was in place to verify that the swab count had been reconciled and was advised that this was the case. Ms Binns reported that to ensure that the entire situation, included the need for a hysterectomy was being reviewed, in addition to the Never Event. Dr Stedman reported that a full investigation would occur during week commencing 29 June, with the table top review occurring afterwards. Mr Lewis reported that the approach to handling Never Events more widely would be reviewed. Ms Parker reported that the CCG had been updated and was expecting to be invited to the tabletop review.	
5 Outcome of TDA ward environment hygiene inspection – 15 June 2015	**SWBQS (6/15) 062** **SWBQS (6/15) 062 (a)** **SWBQS (6/15) 062 (b)**
Mr Ovington reported that a follow up visit had been conducted by the Trust Development Authority in respect of environmental hygiene. He advised that the inspection found that some of the actions had been completed, however additional concerns had been raised. Feedback from the review had been communicated quickly and the actions to be taken in the immediate, including addressing hand hygiene and dust beneath the beds. The result was noted to be disappointing, however a robust action plan would be put in place in advance of an infection control summit with the TDA and a visit later in July. It was reported that there was anticipation that the issues would be resolved. Mrs Hunjan asked what action could be taken if the situation was not found to have improved. She was advised that the Trust could be referred to the Care Quality Commission. Ms Parker noted that it was particularly disappointing that hand hygiene had been found to be poor. Mr Ovington suggested that the 'OK to Ask' initiative needed to be accompanied by staff acting and escalating non-	

compliance. Dr Sahota expressed his dismay at the outcome and asked how some of the actions were being taken forward. Mr Ovington noted that there was clear accountability for the state of the wards. The Director of Estates was being engaged to ensure that some of the ward team requests were acted upon. It was reported that visitors were asked to clean hands however the risk of spread of infection via this route was small. Mr Lewis suggested that the change in ward establishments and the change in cleaning regimes were not contributory to the situation. However, the cleaning duties would be reviewed. It was suggested that a random checking process was needed which would need to involve the Non Executives. A specific point around flat keyboards was highlighted. It was suggested that the action plan presented an overly optimistic view of the response.	
6 CQC Improvement Plan update – outcome of Board informal discussions	**Verbal**
Miss Dhami reported that the Board had spent some time reviewing the improvement plan in detail. It was noted that a number of actions were not progressing to plan and a number of matters would be presented to the Board at its meeting on 2 July, including job planning and rostering. It was noted that those items where it may take longer than October to deliver needed to be identified.	
7 Ward concerns update	**Verbal**
Mr Ovington reported that work continued on Ward D17 and a programme of development was underway including the recruitment of substantive staff into key roles. It was reported that work was underway to review the patterns of care and observations using VitalPACS. Miss Barlow suggested that the work needed to feed into the Urgent Care Challenge.	
8 PROMs update	**Hard copy**
Miss Binns reported that the situation would be reviewed at the next Clinical Effectiveness Committee. The positon concerning responses from knee replacements was improving and a fuller update would be presented at the July meeting.	
9 Open referrals update	**Hard copy**
Miss Barlow reminded the Committee of the position concerning open referrals. The progress with closing down pathways was reported to be on track and the majority of letters needing to be sent had been issued.	

The group of 27,000 high risk patients was being given good focus at present. It was reported that some deceased patients had been written to in error and was being handled as a serious incident. Responses from those receiving the letters were reported to be mixed. A review of SOPs was reported to be being undertaken and these would be signed off shortly. Ms Parker reported that the issue would be discussed at the forthcoming contract review meeting.	
10 Patient story	**Verbal**
Mr Ovington provided an overview of the patient story that would be presented at the next Board meeting. The patient had been treated for stroke. Mr Samuda suggested that a process for summarising the learning points from patient stories needed to be put into place and a review of the actions taken to address the issues. Miss Dhami added that a tracking of the actions that we agreed we would undertake was needed in addition to feeding back to the patients. Dr Sahota suggested that the completion of action plans from Patient Safety Walkabouts needed to be tracked more robustly. It was suggested that video could be used to assist with the tracking and disseminating of stories. Mr Ovington suggested that patient stories could be incorporated within Quality Improvement Half Days. Dr Stedman noted that no child patients had been seen and some additional stories that picked up areas outside the usual ward areas needed to be discussed. It was agreed that the approach would be discussed at the August meeting of the Board.	
ACTION: Mr Ovington to lead a discussion around patient stories at the August meeting of the Board	
11 Integrated performance report	**SWBQS (6/15) 066** **SWBQS (6/15) 066 (a)**
Mr Harding reported that there had been an increase in falls and pressure damage during the month. Mr Ovington reported that the Trust continued to perform well against the national position. Ms Parker reported that at a regional level falls were reducing and a downward trend had been seen. In terms of stroke care, it was reported that an improvement had been seen and thrombolysis had also improved. Responses within three days of the receipt of a complaint was reported to have improved and only 3 complaints had breached the response target. It was reported that the emergency care target was 94.68% and DTOCs had reduced. The diagnostics waits position was noted to have improved to pleasing levels. An update on CQUINs was provided and progress was on track for 18/19 schemes.	

Mr Ovington reported that during June a MRSA bacteraemia case had been reported and a verbal update would be provided at the Board on 2 July. There had been a change to the Friends and Family Test scheme and Mr Ovington offered to present a briefing at the next meeting. It was reported that there was good progress against the 62 day cancer waiting time target, although there remained a risk around ongoing compliance with this. Ms Parker asked for an update against the cancer two week waits. Mr Harding reported that the position related to a small level of patients. Miss Barlow noted that there was a particular issue with dermatology compliance. Miss Barlow reported that work was planned to work with the Ambulance Service to improve the position regarding turnaround. Dr Stedman highlighted that mortality reviews had deteriorated and work was underway to better allocate reviews to correct individuals and to challenge those who were not performing. Readmissions continue to be a key focus with a view to improving the position. Dr Sahota noted that sickness absence remained high although return to work interviews had improved. The number of new investigations was reported to have increased.	
ACTION: **Mr Ovington to present an update on the Friends & Family Test at the next meeting**	
11 Board Assurance Framework 2015/16 updates	
11.1 Bank and agency staff usage	**Verbal**
Mr Ovington reported that the increased use of agency shifts had been mirrored by a drop in bank usage. The higher levels were noted to reflect the use of more expensive agency staff and to staff additional capacity, although overall it was reported that there was not a sense that much additional staffing had been used. Dr Sahota asked whether bank rates were sufficient to retain staff. Mr Ovington reported that although rates had increased, they remained below the national average.	
11.2 Cancelled operations	**Verbal**
Miss Barlow reported that there had been an improvement in cancelled operations and the process to manage these was being made more robust. Additionally, some work on scheduling was underway which was expected to deliver a further improvement.	
12 BAF 2015/16: updates on progress with addressing gaps in control & assurance	**SWBQS (6/15) 067** **SWBQS (6/15) 067 (a)**

12.1 National waiting times performance	**Verbal**
It was reported that the national waiting time programme was largely on track, however Surgery B's plan is predicated on investment.	
12.2 Reducing readmissions	**Verbal**
Miss Barlow reported that a pilot was underway in iCares which could be rolled out across the Trust and an Urgent Care Challenge in the autumn would pick up readmissions. It was noted that IT developments were needed to facilitate an improved position.	
12.3 Addressing caseload management in community teams	**Verbal**
It was reported that the adult community group was addressing caseloads and there had been good engagement to date.	
MATTERS FOR RECEIPT AND ACCEPTANCE	
13 Serious Incident report	**SWBQS (6/15) 068 SWBQS (6/15) 068 (a) - SWBQS (6/15) 068 (b)**
The item was noted.	
14 NRLS update	**SWBQS (6/15) 069 SWBQS (6/15) 069 (a)**
The item was noted. Ms Binns noted that the denominator had been changed to include a significantly more trusts and the Trust performed well against the national position.	
15 Forward plan for the Committee	**SWBQS (6/15) 070 SWBQS (6/15) 070 (a)**
The item was noted.	
OTHER MATTERS	
16 Matters of topical or national media interest	**Verbal**
Dr Sahota noted that Safeguarding was a key interest for the media at present. Ms Parker reported that work was underway with the MASH and strategies for Birmingham and Sandwell had been approved.	
17 Meeting effectiveness	**Verbal**
It was noted that the meeting had overrun.	
18 Matters to raise to the Board and Audit & Risk Management Committee	**Verbal**
It was noted that there were several matters to raise to the Board, including	

infection control, Safe & Sound, patient stories and the Never Events in obstetrics.	
19 Any other business	**Verbal**
Mr Samuda asked for an update on security at a future meeting.	
ACTION: Mr Ovington to present an update on security incidents at a future meeting	
20 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 31 July 2015 at 1030h in the Anne Gibson Committee Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit and Risk Management Committee – Version 0.1

Venue Meeting Room 1, Old Management Block, City Hospital **Date** 30 April 2015; 1400h

Members Present		**In Attendance**
Mrs G Hunjan	[Chair]	Mr R Chidlow
Dr S Sahota		Mr M Gennard
Mr H Kang		Mr B Vaughan
Ms O Dutton		Ms E Sims
		Mr A Hussain
		Miss K Dhami
		Mr T Waite
		Mr C Ovington
Secretariat		Mr M Zaman
Mr S Grainger-Lloyd		Ms R Wilkin

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies for absence were received from Andy Bostock. Mrs Hunjan welcomed Mike Gennard from Baker-Tilly to his first meeting and thanked Clare Robinson, who had resigned since the last meeting, for her time and contributions to the Audit & Risk Management Committee during her time in post.	
2 Minutes of the previous meeting	**SWBAR (1/15) 013**
The minutes of the meeting held on 29 January 2015 were considered and approved as a true and accurate reflection of discussions held.	
3 Matters arising	**SWBAR (1/15) 013 (a)**
The Audit and Risk Management Committee received and noted the	

updated actions log.	
3.1 Overseas visitor policy	**Verbal**
Miss Dhami reported that there was further work to embed the overseas patient policy in outpatients and the policy would be presented to the next CLE meeting. It was agreed that a further update would be presented at the July meeting.	
ACTION: Miss Dhami to present an update on embedding the overseas visitor policy at the July meeting	
4 Progress reports	
4.1 Internal Audit progress report	**SWBAR (4/15) 015** **SWBAR (4/15) 015 (a)**
Mr Hussain presented an overview of the internal audit work completed since the last meeting and advised that a further nine reports had been finalised. The management of professional and study leave report was noted to be amber/red, where in 34 out of 64 requests it was noted that the leave had resulted in clinics being cancelled. It was also highlighted that mechanisms to ensure that the capture of leave was improved. It was noted that some manual workaround would be put in place to address this. Mrs Hunjan asked whether the professional leave showed any trends and was advised that there was none and there was no audit trail behind the approval of leave. It was reported that the 2015/16 internal audit plan would commence shortly including charitable funds and 18 weeks. Ms Dutton suggested that it was concerning that a nurse staffing report had not been submitted for three months by one ward at City Hospital. Mr Ovington reported that this related to Ward D17 which was currently in special measures and this had been picked up going forward. In terms of the data quality regarding nurse staffing relating to qualified to unqualified staff, Mr Hussain reported that post 'Francis' there had been a requirement to publish safe staffing levels and that due to the timescales involved it took some time to correct the areas reported in May 2014. Mr Ovington reported that the Trust was not an outlier in May 2014. Ms Dutton noted that readmission data was of sound quality which was pleasing. Miss Dhami reported that management responses to all outstanding actions would be provided by mid-May.	
4.2 Counter fraud progress report	**Verbal**
Mr Vaughan reported that the induction events had continued and the	

local LSMS had been met and a workplan had been agreed. It was noted that the screensavers, Twitter and Facebook pages included counterfraud matters. A quarterly newsletter had been issued. Webinars were reported to be being organised and this would be used in the light of guidance with NHS Protect. It was noted that the annual report would be presented in July. Mr Waite suggested that consideration should be given to linking in with the Quality Improvement Half Day events.	
ACTION: Mr Vaughan to present the annual report for counterfraud at the July meeting	
4.3 External Audit progress report	**SWBAR (4/15) 017**
Mr Chidlow reported that the audit of the annual accounts was due to commence shortly and in the interim time the controls were being considered and year end substantive testing was being reviewed including capitalised cost handling, restructuring and a positive way of bringing work forward. It was reported that there was confidence that the previous year's recommendations would be delivered. Some work around the CQC action plan and response was included. In terms of the Quality Account work, the indicator testing had been completed, which was being concluded and the quality report would be reviewed. In terms of the technical update on CQC results comparison, it was noted that no hospital site was rated as outstanding on safety across the country. Miss Dhami noted that even for Salford NHSFT, the rating for safety was not 'outstanding' despite its reputation for a safety culture and practice. It was highlighted that the whistleblowing policy would need to be refreshed in the light of the technical update.	
5 2014/15	
5.1 Draft accounts 2014/15	**SWBAR (4/15) 018** **SWBAR (4/15) 018 (a)** **SWBAR (4/15) 018 (b)**
Mr Waite reported that in January a number of areas of accounting judgement had been signed off and the accounts had been prepared in accordance with these. The accounts were reported to have been submitted on time. Headline results were reported to be a surplus of ahead of plan; external financial limit and modest undershoot and CRL of £35k. Mrs Hunjan noted some specific amendments required. There was a discussion around the entries that related to the maternity pathway, associated with payment by results tariff introduced in 13/14	

having a full year effect in 14/15. Average staffing was noted to be a reduction from the previous year and the 'other' category would be staff bank and agency staff. Data for sickness was reported to be provided by the Department of Health and was based on calendar year, rather than financial year. Performance against the better payments code was reported to have deteriorated. Mr Chidlow reported that this was a similar positon elsewhere although there were no specific sanctions imposed for the position. It was noted that the Trust was committed to this within the Public Health Plan with local businesses. It was reported that there were no late payments which incurred interest. Work was reported to be underway with the Procurement department to improve and streamline the processes for making payments. Mr Hussain noted that the performance of the Trust compared to peers was pleasing despite the apparent deterioration. Dr Sahota asked what work was underway to reduce losses and special payments, given that the level of payments appeared to be significant. Mr Zaman reported that this reflected some write offs for overseas debt which could not be recovered from bills issued. Key losses included dentures and patient glasses. Mr Kang asked whether the termination payments reflected the Phase I of Safe and Sound, given that this was low. It was noted that this only reflected payments made to date. Sickness was discussed and it was noted that this information had been sourced from the Department of Health, however it was suggested that reconciliation with the internal figures was needed. Mr Waite reported that there was clear evidence that the workforce changes were reflected in the pay bill. Ms Dutton left the meeting.	
5.2 Draft Internal Audit annual report, including Head of Internal Audit Opinion and assessment of Board Assurance Framework 2014/15	**SWBAC (4/15) 020** **SWBAC (4/15) 020 (a)**
Mr Gennard presented the annual internal audit report, which provided **significant** assurance, albeit with a number of exceptions. In terms of weaknesses, three reports were amber/red, although these were not significant to be disclosed within the Annual Governance Statement. Both governance and risk management assurance was reported to have attracted a green rating, with internal control being amber. It was noted that this was consistent with peers. It was noted the opinion included the efficiency of closure of internal audit recommendations, which reflected some issues with delayed closure. Mr Kang asked whether the scale skewed the opinion and was advised that	

this was not the case and the opinion fairly recognised the matters needing correcting. Miss Dhami gave assurances that the Executive was reviewing the reports and taking the recommendations very seriously. It was noted that there was comfort with the progress of closure of the internal audit recommendations with the majority now being closed. Mr Gennard reported that there was a self-assessment included within the annual report. The outcome of the data quality work was reviewed. Mrs Hunjan reported that any red or amber reports needed to be received in readiness for relevant managers to be held to account by being brought to the Committee to explain.	
5.3 Draft Annual Governance Statement	**SWBAC (4/15) 021** **SWBAC (4/15) 021 (a)**
Miss Dhami advised that a further version of the Annual Governance Statement would be presented again for approval in June 2015. It was noted that better conversations on the BAF had been held through the year. In terms of the Committee structure, it was reported that additional CLE subcommittees had been set up: theatre management board, children's board and critical care board. It was reported that the Board's agenda and Committees agendas would be informed by the BAF and that risk management was now better embedded. The Committee was advised that for April – September 2014, the Trust remained in the top 25% of Trust's for incident reporting and was ahead of other peer organisations. Good work was reported to have been undertaken on Data Quality. The five areas for further attention in 2015/16 were outlined, including the delivery of the CQC Improvement Plan and whistleblowing. It was noted that the Trust benefited from a counterfraud service and that this needed to be reflected separate from the other internal audit services in the AGS. The prosecutions in the year disclosed in the AGS were noted to not relate to in-work activity. Mr Gennard agreed to consider this wording. Mr Chidlow reported that further assurance in terms of 18 weeks performance was needed and it was agreed that the work of internal audit in this respect needed to be reflected. Mr Waite suggested that the obligations of an FT in this respect needed to be understood. The work to improve procurement processes to generate non-pay savings was discussed and it was noted that work was underway to reduce the use of single tender arrangements.	

Some technical amendments were suggested. It was agreed that the conclusion reached by the AGS was sufficient and reflective of the internal control processes.	
ACTION: Mr Grainger-Lloyd to amend the AGS to reflect suggestions made at the meeting	
5.4 Annual Report timetable	**SWBAC (4/15) 022** **SWBAC (4/15) 022 (a)**
Ms Wilkin joined the meeting to provide an overview of the requirements and content plan of the Annual Report for 2014/15. In terms of the timescales, all draft text is to be developed by 1 May and a proofing and editing of text would be undertaken, with the draft document to be issued to a subset of the Audit Committee as part of the review. A draft of the report would be presented to the Audit Committee on 4 June and to the AGM on 25 June. It was noted that the Quality Account was in current draft format and was being circulated to stakeholder shortly. Mr Chidlow suggested that it was pleasing that the timetable was so clearly articulated.	
6 2015/16	
6.1 Internal audit programme 2015/16	**SWBAC (4/15) 023**
Mr Gennard presented the updated strategy for internal audit, which would be subsequently discussed by the Executive Group in due course. It was noted that there was a clear link to the Annual Plan and the BAF. The planned reviews were discussed. It was noted that there were fewer audits than during the previous year, but bigger reviews were envisaged, including Data Quality. The internal audit charter was considered. It was noted that the plan was flexible to allow deferment if needed however these instances would be presented to the Audit & Risk Management Committee.	
6.2 Draft counter fraud workplan 2015/16	**SWBAC (4/15) 024**
Mr Vaughan presented the proposed work plan for 2015/16. It was noted that the plan included whistleblowing and the declarations of interest. Cybercrime was also reported to be included. The linkage to the NHS Protect standards was highlighted. Mrs Hunjan asked what level of confidence there was that the LCFS workplan would be delivered by 31 March. She was advised that there was	

a high degree of confidence that this would be the case, with only a small amount of work being left to deliver in 2016/17. It was agreed that the target to issue draft reports within ten working days should be increased to 100%.	
6.3 Clinical audit plan 2015/16	**SWBAC (4/15) 026** **SWBAC (4/15) 026 (a)**
Miss Dhami presented the clinical audit plan. It was reported 88 audits were included in plan and the outturn report would be presented in July. Out of the 88, 46 are nationally mandated. The corporate and internal must do audit were reported to include any CQC requirements. The directorate breakdown in terms of external must dos, corporate priorities and directorate priorities was reviewed. Dr Sahota asked what work was being done to participate in audits such as PROMs. It was reported that encouragement would be given at the hip and knee clubs. It was noted that this was better now than previously in Orthopaedics. Mr Gennard suggested that these controls should be included in the BAF where appropriate.	
ACTION: Miss Dhami to present the clinical audit plan outturn report at the July meeting	
7 Governance matters	
7.1 Board Assurance Framework 2015/16	**SWBAC (4/15) 027** **SWBAC (4/15) 027 (a)**
Miss Dhami reported that there had been much discussion on the BAF 2015/16 in a Board Informal Session. It was reported that a further discussion was needed in terms of reporting progress with addressing the control and assurance gaps at Committee level as distinct from the delivery plans. It was suggested that the recommendations from the internal audits needed to included in the delivery of the annual priorities, such as the education plan. Mr Hussain reported that the recommendation follow up would pick this matter up. It was noted that some of the risks remained red post mitigation, including that concerning the delivery of the cost savings targets.	
7.2 Audit & Risk Management Committee self-assessment and action plan	**SWBAC (4/15) 028** **SWBAC (4/15) 028 (a)**
The Committee reviewed the list of suggested improvements following the review of the audit committee self-assessment. It was suggested that counterfraud should be pulled out specifically in the future assessments.	

7.3 Governance pack	**SWBAC (4/15) 029** **SWBAC (4/15) 029 (a)**
It was reported that the receivable debt peaked in 2014/15, which related to CCG SLAs and that active processes were in place to better collect overseas visitors fees before it aged too greatly. It was agreed that a table for NHS vs. non-NHS debt was needed and a separate analysis of the over 60 days debts was required. A breakdown of losses and special payments was reviewed, a large amount of which related to clinical negligence payments. One case of write offs associated with overseas payments was noted to be £64k. It was noted that there was a pleasing reduction in losses associated with Pharmacy stock write-offs. In terms of salary overpayments, it was reported that the total value outstanding had fallen by £72k. A significant recovery rates was reported. It was agreed that sanctions for those causing overpayments needed to be identified. It was agreed that trajectories was needed.	
ACTION: Mr Zaman to amend the 'governance pack' in line with the suggestions made at the meeting	
7.4 Audit & Risk Management Committee workplan 2015/16	**SWBAC (4/15) 030** **SWBAC (4/15) 030 (a)**
The Committee received the workplan for 2015/16 and it was agreed that breaches of SFIs/SOs needed to be reflected in the governance pack.	
8 Updates from the Chairs of the Trust Board Committees	**Verbal**
Mr Kang reported that the Workforce & OD Committee had considered sickness absence and Safe and Sound. Further work was needed to develop the medium term work plan.	
9 Any Other Business	**Verbal**
There was none.	
10 Date and time of next meeting	**Verbal**
It was noted that the date and time of the next meeting would be 4 June 2015 at 1230h in the Churchvale/Hollyoak Rooms, Sandwell Hospital	

Signed:……..

Name:……

Date:……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit and Risk Management Committee – Version 0.1

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 4 June 2015; 1400h

Members Present		**In Attendance**	
Mrs G Hunjan	[Chair]	Mr R Chidlow	
Dr S Sahota		Mr A Bostock	
Mr H Kang		Mr T Lewis	
Dr P Gill		Mr R Samuda	
		Miss K Dhami	
		Mr T Waite	[Part]
		Mr M Zaman	
		Mr T Reardon	

Secretariat

Mr S Grainger-Lloyd

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies for absence were received from Mr Robin Russell and Mr Colin Ovington. The Chair welcomed Mr Tim Reardon, new Associate Director of Finance.	
2 2014/15 annual accounts	**SWBAR (6/15) 033** **SWBAR (6/15) 033 (a)** **SWBAR (6/15) 033 (b)**
Mr Zaman reported that there had been no fundamental changes to the annual accounts from the version seen by the Committee in April, however further work had been done to make the text more accessible. It was reported that an initial target of £374m had been revised upwards in year, which had been achieved with a small variation. The Trust was reported to have undershot the CRL and ERL. Classification of deferred income and provision was reported to have been	

challenged by external audit. Good work had been undertaken to address good received not receipted. A provision for a credit note for SLA had been made, however this had now been resolved.

Mr Lewis asked for further information on invoices that had not been met. It was noted that work would be undertaken to resolve the position rather than restating the accounts for 2014/15. Mr Bostock reported that the matter was not material and as such this would be resolved in 2015/16.

Mrs Hunjan asked for further clarity on the oldest outstanding commitment in the system and it was reported that there was an invoice of £3.8m which had not been settled. The matter was reported to have been discussed at the Finance & Investment Committee. It was reported that work would be done to clear the matter and a new system would be procured to assist with the work. Mr Zaman reported that work had been done to assist with the reconciliation process and provided detail of this. Assurance was given that there were no further issues arising from the previous financial practice that would present a liability to the organisation. It was reported that the areas of receipting and spend could be analysed by a Group level now, which was a step change from previous practice. It was suggested that the issue was a multi-year issue stretching back several years. Mr Bostock reported that granularity around the balance sheet and matching process was needed and the process going forward would focus on this. Mr Kang asked whether there were any prior year accounts that needed to be adjusted and was advised that this was not the case.

It was agreed that a monthly tracking system was needed for review by the Finance & Investment Committee that demonstrated an improved position.

Mrs Hunjan asked whether the work of internal audit could have picked this issue up sooner. She was advised that potentially, although the practice should have been picked up by the finance team and additional governance added to provide greater assurance. It was suggested that additional KPIs could be added which could be tracked.

It was reported that no additional cost savings had been made during the year as a result of the situation.

Mr Chidlow suggested that the three year rolling programme of internal audit needed to be considered in terms of fitness for purpose in terms of assurance on the controls around the financial systems.

It was noted that progress against the revised CRL was being reported externally and it was suggested that a note be added to highlight that this reflected the revised target.

Sickness information was noted to be included. It was noted that it highly likely that the position reflected under reporting on medical absence.

It was agreed that the adoption of the accounts should be recommended

to the Trust Board.	
3 2014/15 audit memorandum	**SWBAR (6/15) 034**
The Audit and Risk Management Committee received and noted 2014/15 audit memorandum. Mr Bostock reported that clean opinions had been issued on the Use of Resources and the Accounts. It was reported that much focus had been given on financial resilience which was noted to be sound. The business case for the new hospital and the growing CIP requirement was noted. It was reported that the CQC action plan and the single bidder situation around the new hospital programme had been considered. Thanks were given to KPMG for their work. Mr Chidlow reported that the accounts were compliant with the NHS Manual of Accounts and the annual report was a positive opinion in that the sign off of the annual report had been brought forward. Three unadjusted audit misstatements were reported around the treatment of enabling monies; good received not invoiced; credit note provision of £0.8m to capture any debits arising from cancelled or disputed NHS invoices. Some presentational changes that had been made had been discussed. The remuneration report and Annual Governance Statement due for inclusion in the Annual Report were reported to have been reviewed. It was noted that the capability and capacity issues in the financial team had been fully embraced. It was suggested however that the process for capitalisation of staff costs was to be made more robust in future. It was noted that the Audit Committee had considered this at the January meeting. It was reported that the Trust was a non-sampled significant component meaning that the auditors only needed to report to the NAO on an exception basis. The Committee's attention as drawn to the key risks to the Trust including valuation; income recognition and associated fraud; the reduction of the paybill & restructuring, including Safe and Sound; and management override of controls. Mr Lewis suggested that clarity be given to the fact that cost savings were not needed as a result of the new hospital business case. It was agreed that this was needed prior to submission. Mrs Hunjan suggested that the recommendations needed to be tracked as part of the routine agenda of the Audit & Risk Management Committee.	
4 Letter of Representation	**SWBAR (6/15) 035**

The letter of representation was received and noted that there were no issues which needed to be raised to the auditors. The detail was discussed.	
5 Annual Governance Statement	**SWBAR (6/15) 036** **SWBAR (6/15) 036 (a)**
The Annual Governance Statement was discussed and the 18 weeks data quality issue was noted to be included. The five areas of concern and for focus in 2015/16 were drawn out including CQC review; DNACPR; BCP to be monitored through CLE; non-pay expenditure; capital project implementation. It was agreed that BCP would be presented at the next meeting. It was agreed that the wording in the annual report needed to be made consistent with the AGS.	
ACTION: Mr Grainger-Lloyd to arrange for Business Continuity arrangements be presented at the July meeting	
6 Any Other Business	**Verbal**
The finance team was thanked for their work to ensure that the annual accounts were developed to the revised timescales.	
7 Date and time of next meeting	**Verbal**
It was noted that the date and time of the next meeting would be 30 July 2015 at 1400h in the Anne Gibson Boardroom, City Hospital	

Signed:……..

Name:……

Date:……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance & Investment Committee – Version 0.1

Venue Anne Gibson Committee Room, City Hospital **Date** 29 May 2015; 0800 – 1000h

Present

Mr Richard Samuda
Mr Harjinder Kang
Mr Tony Waite
Miss Rachel Barlow

Secretariat

Mr Simon Grainger-Lloyd

Minutes	**Paper Reference**
1 Apologies for Absence	**Verbal**
Apologies for absence were received from Mr Lewis.	
2 Minutes from the previous meeting	**SWBFI (4/15) 018**
The minutes of the meeting held on 2 April 2015 were accepted as a true and accurate record of discussions held.	
AGREEMENT: The minutes of the previous meeting were accepted as a true and accurate reflection of the discussions held	
2.1 Matters arising and update on actions from previous meetings	**SWBFI (4/15) 018 (a)**
It was noted that a number of actions were off track, most notably the development of the Procurement function. It was reported that a programme of work around Procurement was in train and the resourcing of the workplan was being developed. The current interim was reported to be in place until June 2015. A programme of product standardisation was reported to be progressing well. It was noted that the change management and transactional excellence work would be discussed at the Board informal session in June. It was reported that the revised financial reporting was to be developed over the next couple of months, including the work arising from the recent work undertaken by Baker-Tilly.	
3 2014/15	

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3.1 Prior year outturn	**Verbal**
Mr Waite reported that all key financial targets had been met, including over delivery on surplus. It was reported that a clean audit opinion on the accounts and positive opinions on Use of Resources was anticipated. Unadjusted audit differences concerns deferred income in respect of transitional financial funding. It was also reported that the goods received not invoiced accrual had been highlighted to be significant and needed to be reviewed and addressed over the coming year. A supply statement reconciliation was reported to be underway and the position overall was improving. Some credit note provisions had also been made against some SLA income was also highlighted as part of the audit, in that there should not be dispute between NHS organisations. It was reported that the auditors had confidence in the Trust's accounting practices following the current year review.	
4 2015/16	
4.1 Financial plan and risks	**SWBFI (5/15) 020** **SWBFI (5/15) 020 (a)**
The waterfall chart that summarised the plan for 2015/16 was reviewed, which was highlighted to include an element of saving to invest. The savings challenge for the year was reported to be £21m. In terms of incremental drift an £8m provision had been made for pay inflation. Inflation and SLA changes were noted to be the key drivers of negativity for the position. The year start was noted to be a breakeven position. It was reported that a modest surplus had been delivered for Month 1. Activity fluctuated in some areas however, including outpatients and ED. The factors driving the activity position were discussed. Miss Barlow reported that the booking of activity needed to be robust and through the demand and capacity work a dashboard would be launched to look at expected demand vs. capacity. Repatriation of income will also be monitored through this work. Based on work done to date it was reported that much capacity was to be yielded through efficiencies and £1.5m of work to be repatriated would be pursued. It was noted that there was space on both sites to allow elective work to continue even through issues such as Norovirus outbreaks. Proactive work to attract the referrals was needed to be able to benefit from the repatriation. In terms of the April paybill, this was c.£24m. The agency position was discussed, which had increased from the Autumn position, which was noted to reflect additional operational pressures and sickness absence cover. An agency paybill of £1.3m was noted and agreed to be unsustainable. It was noted that the position was dependent on the conclusion of the Safe and Sound II once the consultation period had ended. Miss Barlow reported that Pharmacy and Imaging needed significant agency cover at present as a result of sickness absence, however there was a likelihood that this would reduce in the next months. The cover of the social care ward at Rowley Regis Hospital was also noted to require cover by agency staffing. Mr Samuda suggested that the agency usage needed to be	

presented at a more granular level. Strengthening of the work to improve bank staff usage was discussed. It was noted that the majority of agencies work through framework arrangements, with the exception of Thornbury.

The key risks were highlighted to focus on: group budget positions including CIP; SLA income recovery; CQUIN income recovery; and antenatal pathway changes.

The detail of the group positions was discussed. Should all meet control totals, some resources within reserves would be created. The use of some the flexibility will be needed to assist team with meeting their control totals on a recurrent basis. All corporate teams have a route to delivery of budgets. Three of the seven clinical groups were reported to need further work, namely Medicine & Emergency Care, Surgery A and Surgery B. At present, a gap of £5m has been identified, with the majority relating to Surgery. It was noted that budget control totals for the forthcoming two years would be set by the end of Quarter 2. The Surgery A position was discussed specifically, with theatre utilisation needing to be improved. Miss Barlow reported that some specific support was to be arranged for this and a Theatre Management Board would be set up. Anaesthetic job planning also needed further work to deliver efficiencies. Benchmarked data was reported to be provided for this purpose. Miss Barlow reported that there was an expectation that theatre utilisations rates could be improved swiftly. A number of actions to ensure that the residual gap is closed were discussed. Miss Barlow reported that vacancy rates were being reviewed in detail and some decisions around structures and having a smaller vacancy factors were being made.

In terms of CIP, schemes that total £14m part year basis had been identified, with an £18m full year effect against a target of £24.84m.

CQUIN recovery was discussed, with £9m income attached to this. It was noted that the definitions and requirements of the CQUINs was much more robust than the previous year and a better assurance process was in place. A small budget to support the implementation of the CQUINs was reported to be provided for. The Medical Directors Office was reported to monitor delivery of the CQUINs. It was agreed that the definitions and milestones for each CQUIN should be circulated. Miss Barlow provided an update on the work involved with addressing the open referrals and advised that the scale of the challenge was not yet clear as the patient responses was still to be determined.

Mr Waite reported that there were changes previously to the tariff regime for antenatal work. It was reported that during an antenatal pathway a women may use more than more than one provider and therefore a charging mechanism was in place to recover income via the CCG. It was reported that a challenge process for some of the charges was underway, with no SLA governing the relationship. A more robust SLA that involved Birmingham Women's, Walsall, Dudley and HEFT Trusts was agreed to be needed, with a draft created at present. Budgets for the coming year assume that fewer charges will be levied to the £4.2m, notwithstanding the risks to the achievement of this.

The risk register associated with the financial plan was discussed, including specialised services margin rate, particularly regarding pass through over performance; maternity pathways; CIP scale and pace; and additional support

needed to meet safety and quality standards. The planned investments were discussed. The bulk of the IT infrastructure work was noted to be within the capital plan. It was reported that every effort would be made to ensure that the profiling of the spend in the capital plan was more even. The granular plan associated with the IT spend was noted to be a major enabler to this. The plan for fixed imaging equipment will be included via a MES which would be concluded by March 2016. Retained estate refurbishment was noted to be planned for the end of the year. The IT capacity was discussed, with a significant element of this being captured within the capital plan.	
4.2 Board Assurance Framework	**SWBFI (5/15) 021** **SWBFI (5/15) 021 (a)**
It was noted that the majority of the risks in the BAF had been discussed already.	
5 Matters to highlight to the Board and Audit & Risk Management Committee	**Verbal**
It was suggested that the key risks and temporary staffing should be highlighted to the Board. An update on the maternity pathway was needed.	
6 Meeting effectiveness feedback	**Verbal**
There was no specific feedback.	
7 Any Other Business	**Verbal**
Mr Samuda reported that a new Non Executive Director, Robin Russell had been appointed who was a qualified Accountant and it was proposed that he joined the meeting of the Finance & Investment Committee.	
8 Details of the next meeting	
The next meeting of the Finance and Investment Committee was noted to be scheduled for 31 July 2015 at 0800h at City Hospital.	

Signed: …….

Name: …….

Date: ……

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Sandwell and West Birmingham Hospitals NHS
NHS Trust

Charitable Funds Committee – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 7 May 2015 at 1100h

Trustees Present		In attendance	Secretariat
Dr S Sahota	[Chair]	Mr M Zaman	Mr S Grainger-Lloyd
Mr R Samuda		Ms R Wilkin	
Mr T Lewis		Mr M McLaughlin	
Mr C Ovington		Mrs R Goodby	

Minutes	Paper Reference
1 Apologies	**Verbal**
Apologies for absence were received from Tony Waite. Dr Sahota welcomed Mr McLaughlin, Mr Zaman and Mrs Goodby to their first meeting.	
2 Minutes of the previous meeting	**SWBCF (12/14) 022**
The minutes of the meeting held on 4 & 12 December 2014 were approved.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meeting	**SWBCF (12/14) 022 (a)**
The Committee received and noted the updated actions log. Ms Wilkin reported that plans were in place to reenergise the branding of the Charity and that the interim branding proposals would be circulated prior to the next meeting. Dr Sahota highlighted that much work had been undertaken previously which could be used to inform the proposals. Mr Zaman highlighted that many funds had not been accessed well previously and there was a plan to amalgamate some of these. It was reported that spending plans had been requested from all fund holders which would inform the plans. Mr Lewis reported that amalgamation of funds was planned which would be used to provide a general pool for bidding as had happened previously. Mr Lewis suggested that clear focus needed to be directed to those funds holding in excess of £1000, where	

in the event that spend plans were not received then funds would be sequestered. Mr Ovington suggested that consideration needed to be given to the creation of new funds. Mr Lewis agreed that good governance was needed around the rules for creation of new funds. It was suggested that the narrative to fund holders needed to be aligned with the future direction of the Charity and that Mr Zaman and Ms Wilkin would discuss this. Mr Samuda highlighted that there may be discontent with the plans for sequestering the funds where needed, however it was noted that funds would bear risks and losses associated with the movements in the overall fund position in the previous year. Dr Sahota asked how restricted funds were to be handled. It was reported that a discussion with the auditors was needed in this respect and the guidance from the Charity Commission would be sought. It was reported that the majority of arms-related stock had been disposed of and that Barclays Wealth would confirm the position in due course which would be circulated to the Committee. It was noted that in some cases some subsidiary companies shares needed to be addressed. Mr Lewis underlined the need for the statement to be reflected in the annual report.	
ACTION: Mr Zaman to confirm the position regarding arms-related stocks with Barclays Wealth **ACTION: Mr Zaman to provide an update on progress with the amalgamation of funds at the next meeting**	
4 Charitable Funds bids 2014/15 – progress update	**SWBCF (5/15) 002** **SWBCF (5/15) 002 (a)**
Ms Wilkin reported that an update would be secured from bid leaders during July to demonstrate benefits and progress or otherwise with the implementation of the initiatives funded by the Charity. It was reported that in general terms, where the funds had been used for equipment purchase, these schemes were progressing well, with the ones associated with projects progressing variably. It was reported that the bid leaders would be supported by the Fundraising Team over coming months in this respect. It was highlighted that there was a degree of risk associated with two of the larger bids where leaders were moving on. Mr Lewis suggested that the progress of the bids needed to be judged against the deliverables agreed when the funding had been agreed. It was suggested that the Committee needed to meet in July to review the bids and that the Committee needed to direct its attention to the branding work. Dr Sahota suggested that milestones needed to be set against which progress could be judged. Mr McLaughlin reported that departments had been contacted to develop some case studies where funding had been used and would be promoted and built into the wider awareness-raising work.	

Mr Lewis suggested that on a week by week basis an article and photo could be used to promote the charity work.	
ACTION: **Mr Grainger-Lloyd to arrange an additional meeting of the Charitable Funds Committee in July 2015** **ACTION:** **Ms Wilkin to present an update on progress with the charitable funds bid schemes at the July meeting**	
5 Annual accounts and report 2014/15	**SWBCF (5/15) 003** **SWBCF (5/15) 003 (a)**
Mr Zaman guided the Committee through the annual accounts for the Charity. It was reported that the income received during the year was £1.6m against a spend of £868k. It was noted that the growth was attributable to a slower rate of expenditure combined with a growth in investments through donations and legacies. It was noted that the Pathology funding arrangements needed to be considered specifically in this respect. It was agreed that a benchmarking table was needed; the investment markets were reported to have performed significantly better over recent months. Mr Lewis suggested that the Committee needed to consider priorities, investments made and the work planned, being supported by an annex detailing the governance and finance arrangements. Ms Wilkin reported that the Charity annual account would be included in the overall annual report which would provide the narrative around the charity. It was agreed that some of the case studies needed to be included in the annual report and consideration would need to be given to the mechanism by which the charity could be better highlighted. Dr Sahota noted that the cash holding was high. It was noted that £600k was available for Barclays Wealth to hold and invest as required. It was agreed that the dividends could be reinvested. The Committee was reminded of previous discussions where funds could be shifted into higher risk bonds which could yield better benefits. It was agreed that this needed to be a discussion at the July meeting of the Committee. The change in the risk profile was agreed at a previous meeting. It was noted that the charity annual report would be presented to the Audit & Risk Management Committee and subsequently at the Trust Board on 4 June. It was noted that the external auditors would review the accounts shortly.	
ACTION: **Mr Zaman to present a benchmarking analysis of the Charitable Fund portfolio for consideration at the September meeting** **ACTION:** **Include an item on the agenda of the July meeting to discuss the**	

investment strategy	
6 Matters to raise to the Board and Audit & Risk Management Committee	**Verbal**
It was agreed that the progress with the projects would be discussed and the overall fund performance would be highlighted to the Board. An additional meeting of the Committee was reported to be needed in July which Mr Grainger-Lloyd would arrange.	
7 Any Other Business	**Verbal**
It was noted that a quarterly income and expenditure report, including spend using delegated authorities was needed, although this did not need to be published. The process for thanking people for donations was reported to be in place and a certificate of thanks had also been devised. It was noted that a photo opportunity was taken when appropriate. Gift aid was reported to be progressing well. It was reported that local businesses had been approached and Marks and Spencer & Pure Gym had taken a positive interest in the charity and support it. Mrs Goodby reported that staff awards would be used to raise awareness of the charity and showcase some awards. The use of digital means to promote the charity was discussed which was well received.	
8 Details of the next meeting	**Verbal**
The next scheduled meeting was reported to be planned for 3 September 2015 at 1100h in the Anne Gibson Committee Room, at City Hospital, however an additional meeting would be scheduled for July 2015.	

Signed ……..

Print ……..

Date ……..