Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue: Board Room, Sandwell General Hospital **Date:** 5 November 2015; 1330h – 1630h

Members attending:

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

In attendance:

Mrs C Rickards	CR)	Trust convenor

Secretariat

Mr D Whitehouse	(DW)	Head of Corporate Governance

Time	Item	Title	Reference Number	Lead
1330h	1.	**Apologies** – Mike Hoare	Verbal	**DW**
	2.	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	Verbal	**Chair**
	3.	**Patient story** (discussion to follow in private Board meeting)	Presentation	**CO**
	4.	**Minutes of the previous meeting** To approve the minutes of the meeting held on 1 October 2015 as a true and accurate records of discussions	SWBTB (10/15) 172	**Chair**
	5.	**Update on actions arising from previous meetings**	SWBTB (10/15) 172 (a)	**DW**
	6.	**Questions from members of the public**	Verbal	**Chair**
	7.	**Chair's opening comments**	Verbal	**Chair**
	8.	**Chief Executive's report**	SWBTB (11/15) 173	**TL**
	9.	**Trust Risk Register**	To follow	**KD**
	10.	**Staff safety and security at work**	To follow	**TL**
	11.	**Change plan for imaging scans and reports**	Presentation	**RB**
	12.	**Corporate integrated performance report**	SWBTB (11/15) 176 SWBTB (11/15) 176 (a)	**TW**
	13.	**Financial performance - period 6 September 2015**	SWBTB (11/15) 177 SWBTB (11/15) 177 (a)	**TW**

Time	Item	Title	Reference Number	Lead
	14.	**Safe nurse staffing**	SWBTB (11/15) 178 SWBTB (11/15) 178 (a)	**CO**
	15.	**CQC improvement plan update**	SWBTB (11/15) 179 SWBTB (11/15) 179 (a)	**KD**
	16.	**Trust response to the Kirkup Report into Morecambe Bay Maternity Services**	SWBTB (11/15) 180 SWBTB (11/15) 180 (a)	**CO**
		FOR INFORMATION		
	17.	**Complaints AND PALS Report – 2015/16 Quarter 2**	SWBTB (11/15) 181 SWBTB (11/15) 181 (a)	**KD**
		UPDATES FROM THE BOARD COMMITTEES		
	18.	Update from the meeting of the **Audit and Risk Management Committee** held on 29 October 2015 and minutes of the meeting held on 30 July 2015	SWBAR (7/15) 051 To Follow	**RR/ KD**
	19.	Update from the meeting of the **Quality & Safety Committee** held on 30 October 2015 and minutes of the meeting held on 25 September 2015	SWBQS (9/15) 094 To Follow	**OD/ CO**
	20.	Update from the meeting of the **Finance and Investment Committee** held on 30 October 2015 and minutes of the meeting held on 25 September 2015	SWBFI (9/15) To Follow To Follow	**RSM/ TW**
	21.	**Any other business**	Verbal	**All**
	22.	Details of next meeting *The next public Trust Board will be held on 3 December 2015 at 1330h. Venue: tbc*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD PUBLIC

Venue Anne Gibson Board Room, City Hospital **Date** 1 October 1.30pm – 5.30pm

Members Present		**In Attendance**	
Mr. Samuda	Chair		
Mr. H. Kang	Non- Executive Director	**Mrs. R. Goodby**	Director of Organisational Development
Mr. M. Hoare	Non -Executive Director	**Miss Al Binns**	Assistant Director of Governance
Dr. P. Gill	Non- Executive Director	**Mrs. C. Rickards**	Trust Convenor
Cllr. W Zaffar	Non-Executive Director	**Mrs R Wilkin**	Director of Communications
Mr. R. Russell	Non -Executive Director		
Mr. T. Lewis	Chief Executive		
Miss R Barlow	Chief Operating Officer	**Secretariat**	
Mr. T. Waite	Director of Finance & Perf. Mgt	**Lynn Fairfield**	Interim Trust Secretary
Dr. R. Stedman	Medical Director		
Mr. C. Ovington	Chief Nurse		

Minutes	**Paper Reference**
1 Apologies	
Apologies were received from: Miss K. Dhami, Ms. O. Dutton	Verbal
2 Declaration of interests	
No declarations of interests were recorded.	Verbal
3 Patient Story (discussion to follow in private board meeting)	Presentations
Mr. C. Ovington introduced a short video of 4 patients' experiences 1. A young patient with lupus talked about how she is made to feel on her often frequent hospital visits and the sometimes insensitivity of staff to her pain thresholds. 2. A 71 –year old gentleman underwent an invasive procedure for the first time in his life and was apprehensive about what would happen, but was moved by the level of care he received. 3. A gentleman who is an eye ward inpatient is having a positive experience during his stay, he is happy with the way his condition has been explained and his treatment planned. He 'generally likes' hospital food. 4. A 91 year old, is full of praise for the staff and 'nice hospital room', but she wants to be	

on her feet quickly again and go home to her normal life routines. The Board discussed the implications of the stories in its private session.	
4 Minutes of previous meeting – 3 September 2015	SWBTB (10/15) 153
The minutes were agreed as an accurate record subject to the following amendment: In Attendance: Mr N Rogers was attending as the Deputy Chief Operating Officer.	
5 Update on actions arising from previous meetings held on 3 September 2015	SWBTB(10/15)153 (a)
Mr. T. Lewis advised that action SWBACT 486 consent on the day of surgery is not complete.	
Actions: **1. Ms Lynn Fairfield will reinstate SWBACT 486 on action list.** 2. **Miss Rachel Barlow to provide an update percentage of patients on the waiting list who have been through eDTAs .**	
5.1 DNACPR: Presentation of audit data	SWBTB (10/15)154
Dr R Stedman introduced an assurance report on the audit of the use of the DNACPR flag covering May and June 2015. He advised that a number of interventions had taken place which is listed in the report including the launch of the Board Round Peer Review Tool. The audit will be repeated for September and October 2015. Mr. H. Kang sought assurance that all the paperwork is in order, given a manual system is being used and suggested that it should be a requirement to record the data electronically. Dr R Stedman concurred and stated that we are on a journey; data will be gathered electronically going forward. Mr. T. Lewis reiterated that the flag is for multidisciplinary use and it is critical that the Trust reach 100% coverage. He advised that this is one if the CQC improvements therefore it will be managed through the Executive Team.	
Action: The Executive Team will identify a mechanism for the data to feed into the Integrated Performance Report on a routine basis.	
5.2 Public Health Committee escalated matter: volunteer service	Presentations
Mr C Ovington presented the updated position with the volunteer service, arising from a committee of the Board who had been insufficiently assured. He provided additional information on the number of volunteers recruited to date, the plans to build on this and the arrangements in place to ensure that the Trust is representative of the community in terms of equality and diversity; ethnicity and projected characteristics. Councillor W Zaffar welcomed the presentation and the plans for Trust employees to engage with the local population.	

Miss R Barlow requested clarification on the priorities for deploying volunteers in the Trust and commented that we should use the service improvement, patient experience feedback data to evidence that we are making an informed decision. Mr C Ovington advised that in the first instance volunteers will be placed at check in points to assist with patients finding their way, which will require considerable input from the Trust to prepare volunteers. Mr H Kang raised the reciprocal arrangements and asked whether the Trust markets the opportunity for organisation to engage. In response Mrs R Wilkin reflected on the work over the past year to build links with corporate organisations. The cross over between the Trust Charity, members and volunteering was highlighted. Mr T Lewis commented that, although, we have moved forward we still need a clear aim, an agreed timeframe with a clear set of success criteria, for example grounded in a enable benchmarking against volunteering services at other Trusts. Without this he suggested the report could be accepted.	
Action: Mr. C. Ovington to provide a report on what success looks like for the Trust volunteer service at the, December 2015 Board.	Mr. C. Ovington
6 Questions from members of the public	
Mr Samuda invited questions from members of the public A member of the public asked whether we have any feedback on cardiology since its move. Miss R Barlow responded the move went to plan and the service is running smoothly. The environment has improved and there is good team cohesiveness, but it too early for a formal evaluation. Mr C Ovington reflected on Dr Varma's positive comments during his presentation to the Members meeting on 21 September 2015. Mr. T. Lewis questioned when the performance data will be available. Miss Barlow felt over the next two months.	
Action: The performance data on the cardiology move will go to Quality and Safety and report up to Board.	
A 2nd member of the public raised the CQC inspection report and the impact on progress with the Trust's aspiration to become a Foundation Trust. Mr. T. Lewis responded that there is not a particularly clear national FT approval process at the moment. The approvals process should be clearer next year. The Trust expects to progress through the pipeline in 2016/17. The CQC evaluation now includes use of resources and is expected to become the focus of the FT approval process. The Trust will work with CQC in 2016 on re-inspection.	
7 Chair's opening comments	
Mr. Samuda recorded a thank you to Mr John Cash for his valued contributions and skills as the patient the representative on the panel for the Beacon service bids. The Trust received 5 excellent presentations. He reported that: • The Trust has received the planning consent for MHH.	

• He had attended with Mr T Lewis, on behalf of the Trust, the first Black Country Alliance (BCA) Programme Board. He noted that a number of Executive meetings had already taken place, but this was the first meeting representing the Trust Board. Mr T Lewis added that the next six months will be interesting as we have the opportunity to make it real for local people and patients and cited a number of examples; the interventional radiology service, which expect to launch on the network basis in January 2016; the setting up the BCA oncology service with a target date April 17; and the sourcing of joint procurement opportunities to be discussed in late November. A BCA conference is expected to be held towards the end of January 2016.	
8 Chief Executive's Report	SWBTB (10/15) 156
Mr. T. Lewis introduced his report and highlighted the following: • **Flu vaccination;** the Trust had been in the top ten NHS organisations for take up. Management can make a difference by encouraging staff to take up the Trust's offer of vaccination, which fits with the sickness absence challenge. • **Rhapsody;** the Board had been alerted to the possibility of the IT integration engine failure, which was not supported by the supplier; the engine failed 2 days later. Mr T Lewis thanked Dr. R. Stedman, Miss A Dailly and Miss R Barlow's operational teams for their efforts in resolving the matter and returning to state. • **A&E target for September;** finished at 93.7% against the reported 94% in his report. Cllr. W Zaffar referred to the BCA Partnerships and asked whether similar conversation had taken palace with Birmingham City Council (BCC). Mr T Lewis advised that the Trust has tried to have similar conversations with Birmingham City Council, but they have not come to fruition. In the meantime we are moving forward with Sandwell Council, notably around health visiting and GUM. The door to discussions with BCC was always open.	
9 Trust Risk Register	SWBTB (10/15) 157
Miss A Binns reported that no new risks had been added; existing risks have been updated to reflect changes. The risk register is currently being refreshed and will be produced electronically going forward. Miss R Barlow reported that a small amount BCG vaccine has been released nationally, but without a clear steer. The Trust has 1,500 babies on the list and holds the responsibility for recall. The Trust is currently only vaccinating babies in front of them, which is being done under a risk assessment and will not be in a position to recall until assurance is, received that further vaccine will be made available to the Trust. The Board noted that although this is a national problem, it is different problem in different parts of England and the Trust is doing all it can to meet this concern. Mr T Lewis agreed to Board members' suggestion that he should write formally to the Chief Executive of PHE expressing concern. Mr. Samuda requested an update on sonographers. Mr. T. Lewis reflected on the Imaging discussions at the Clinical Leadership Executive (CLE) on 22 September 2015 and noted that CLE will discuss ultra-sonography in detail at their next meeting on 27 October 2015.	

The Board will receive an update at their next meeting on 5 November 2105.	
Action: The Board will receive an update on sonographers at the 5 November Board Meeting.	**Mr. T. Lewis**
10 Wider safe staffing report	SWBTB (10/15) 158
Mrs. R. Goodby introduced a position update report which explained the meaning of safe staffing and alerted the Board to piece of work to establish an accurate and live data flow which will be completed over the next 12 weeks (ie by the end of December 2015). She drew attention to national work, led by Mike Durkin, in similar vein (ie beyond simply nursing). The Board had agreed not to await this work when it resolved in spring 2015 to move forward on this issue. The January Trust Board meeting will receive a first cut of data, from which we will need to form a view on sufficiency. The timing of this is important, in advance of setting budgets for 2016-17. The Board welcomed the commitment, and asked to be advised of any delay to this timetable.	
11 Safe nurse staffing	SWBTB (10/15) 159
Mr. C. Ovington introduced the safe nurse staffing report and advised that it is an update on the August 2015 report which included data inaccuracies. The Board was advised that a programme of work is in place to correct this by 15 October 2016. The Board will receive a further update on 5 November 2015 Mr. C. Ovington highlighted: • The operational changes which have been put in place. • The review of systems and process requested by internal audit, which will be testing the accuracy of the September 2015 data. • The information presented is part way through the journey. As he predicted last month proves that the system in place does not allow the addition of temporary staffing into the system. The planned staffing data is correct. • Changes to address data inaccuracies include weekly meetings with group directors of nursing, daily meeting with matrons and or ward sisters to check the staff data flow. This is highlighting that there is no interface between the electronic systems being used to collect staffing data Mr. Samuda, sought assurance on the level confidence in the existing arrangements. Mr. C. Ovington advised the operational changes put in place to maintain safe are staffing are mitigating the issues with the electronic data. Mr. T. Lewis led a discussion on addressing some of the leadership gaps. He asked Mr. C. Ovington whether he could provide assurance to the Board that, on 15 October 2015, there will be one an electronic system in place with the correct data output as agreed with the regulators. Mr. C. Ovington advised that there will not be one electronic system; rather we will make sure that we have the right data coming out the systems, which bank and agency will bring together. Mr. T. Lewis stated that failure of the electronic systems to provide accurate data will result in a paper based system.	

Action: The Board will receive an update at the Board meeting to be held on 5 November.	**Mr. C. Ovington**
12 Corporate integrated performance report (IPR)	**SWBTB (10/15) 160**
Mr. T. Waite presented the IPR summary performance for April 2014 to August 2015 and noted that the report is still evolving. He highlighted: • That in addition to the information presented in the IPR on Cancer Performance by Speciality the cover paper include a summary of the July 2015, 62 day cancer waits which compliments the group by group in the body of the report. The Board will receive this update as part routine transparency. • Breast, Skin and Gynae are holding up the performance in other areas in meeting the overall standards. • Effectiveness-Cancer care introduces an urgent cancelation measure which aligns with the national measure 7 in month. • The kite mark is being progressed by the Executive Team, to managing data quality • Complaint responses show an improvement.	
13 Financial performance (Period 5 August 2015	**SWBTB (10/15) 161**
Mr. Waite introduced the paper and requested the Board to support the actions necessary to secure financial targets consistent with safe high quality care. He reported: • The Trust is off plan. A £14m improvement is required which will require a stepped performance of £2m per month in our bottom line position from PO6 September going forward, which is not likely to be achieved for September, October is indicating some improvement. Remedying this with the workforce changes will put the Trust in position where we exit the year in line with plan. • Progress in respect of the demand and capacity, the Trust will fall short in September in meeting the stretch target, there is an improvement for October but further work is required. • **Agency staffing**, there was more significant change in agency hours than in money in August 2015, with a small switch from agency use to bank, the outcome was cost neutral. • **The temporary staff pay bill**, there was a marginal improvement in September. The Executive Directors are working with the organisation to make improvements. • **CIP against plan,** the Trust is in a good position, there is ongoing validation of the schemes which are critical to the step in performance. Mr. T. Lewis sought assurance on the confidence level for delivery of the £700k**.** Miss R Barlow reported 14 schemes coming on line in September about 70% should deliver. The closed bed programme has a risk around it, there is more winter money available and there are some risk areas, with a 50% confidence level for delivery. The schemes will be reviewed further at the next finance committee on 30 October 2015. Mr R Samuda noted the work that was going into remedying the position. But he took note that the executive was expressing guarded confidence on only two of three issues, and at best might address half of the ask, and with September missed. On that basis, Mr T	

Lewis agreed to bring back a discussion paper to the November Board on plan B options for Q4 remedy.	
14 CQC improvement plan update	SWBTB (10/15)162
Mr. T. Lewis introduced an update on the progress against the CQC improvement plan as at the end of September 2015. Mr. T. Lewis reported: • The Executive reviews the plan at the weekly Team meeting • The at a glance table is colour coded • 26 of the 67 (40%) actions have been completed, marked in purple • Work is progressing with the three reds • Clear evidence to support completed actions • The Trust is developing a CQC style, in house inspection regime, which deliberately being run outside the normal professional siloes, to provide a more objective approach and shared learning. Mr. T. Lewis invited the Executive's to share their experience with the process. • Mrs. R. Goodby reflected that the exercise had provided some useful learning; areas under her remit which are completed require documented procedures for completeness. • Mr. C. Ovington reflected that it had involved some big pieces of work, particularly around the nursing documentation changes, which has resulted in considerable progress • Dr. R. Stedman raised the need for mechanisms to record the evidence to demonstrate that changes have been in embedded in the Trust. Mr. H. Kang asked whether there are corporate sign off mechanisms in place to evidence delivery. Mr. T. Lewis advised that there are clear lines of accountability, however as this is filtered down the organisation it is less certain, there is evidence of some improvement, but this has been delayed at ward level because of the nurse recruitment problems. The Board noted the 'theme report' in support of the actions, and advice that it will take through to late March to form a final view about success on this programme.	
15 Annual plan priorities	
15.1 **Ten out of Ten Safety Standards**	SWBTB (10/15) 163
Mr. C. Ovington introduced the paper on the progress over the last three months. He highlighted: • The Ten out of Ten Safety Standards were implemented last year, but the difference in culture change failed to reach the level expected. The programme was re-launched using the leaning from Surgery A, where some good work had taken place to embed the standards. • In response to the Surgery A, individual patient safety standards checklist has been designed in the same format as the Single Assessment and Care Round documents.	

• Some Patient Satisfaction Surveys have been undertaken to test patient's views, the results are included in the paper. • The multi-disciplinary team (MDT) approach rather than just nursing, which has worked well in Surgery A continues to be promoted; there is no evidence as yet to suggest that is working well on other wards. • Monthly ward audits take place against a set of key indicators which are used for a comparative analysis against the data in the Trust dashboard. This analysis is showing inconstancies and gaps. Mr. T. Lewis reflected on the cultural intervention aim, where the ward leader is accountable and knowledgeable about all the patients under their care and not reliant on retrospective systems; where they feel empowered to contact any given professional outside of their accountability line to discuss patient care. Miss R Barlow commented that the leadership and effectiveness of the wards and teams in knowing and understanding patients is critical to patient care; only a limited numbers of the wards display this level of knowledge. A discussion followed on the way forward with leadership and the multi-disciplinary approach to patient care and safety. The Board was not satisfied with progress nor assured about delivery. The executive agreed to work through the issues raised.	
Action: Mr. C. Ovington to report back to the Board at its December meeting with a remedy plan for Ten out of Ten	**Mr. C. Ovington**
15.2 Reducing readmissions	
Miss R Barlow introduced the paper and request the Trust Board discuss the improvement plan and approach to readmissions. She highlighted : • The reduction in readmissions has been objective of the Trust for some time but to date there is no evidence of sustained change or a constant approach to improvement. • The paper set out the current position, the top six specialities, for readmission, the work to date, using the LACE tool to predict the likelihood that a patient would be readmitted, readmissions work in AMU, the work undertaken by the specialities leads in the redesign of care pathways, which enables clinical teams to easily identify patients at risk of readmission and the development of the improvement plan. • The approach to change so far has been through the task force with mainly clinical membership, with CCG, operational and change team input. • Inviting GPs Mental Health Psychologists and social workers, to the discharge planning meeting will check the robustness of the discharge plan. • The Trust is holding a readmission focus week starting on 12 October 2015 to raise awareness. Mr. T. Lewis noted the general surgery changes from 9 November 2015 will include hot clinics on the ward so patients can return without going to A&E.	

15.3 Community caseload	
Miss R Barlow introduced the paper and requested the Board consider the forward plan to achieve improved caseload management in the community. A further paper on defined change plan will come to the Board in December.	
15.4 Sickness- way forward and plan 'B'	SWBTB (10/15)166
Mrs. R. Goodby introduced the paper and reported that the Trust's sickness absence rates remain a serious concern and flagged as red o the Trust Risk Register. The 12 month rolling sickness absence level at August 2015 is 4.9% a slight improvement from July which was 4.2%. She requested the Board: 1. Introduce a centralised system reporting sickness absence to Group Director of Nursing or equivalent- **Approved** 2. Commit to improve completion of return to work interview and to promote staff health and wellbeing invention with staff- **Agreed** 3. Note the sickness panels that are being set up in groups to support sickness – **Noted** 4. Note the support Health and Well Being offer as detailed in the paper- **Noted**	
16 R&D Plan 2015- 2018 – likelihood of delivery assessment	SWBTB (10/15)167
Dr R Stedman introduced paper and requested the Board review the progress of the 9 objectives in the context of the recent restructuring of the R&D department. Performance against these is monitored at the CLE R&D committee. Dr R Stedman gave an update of the likelihood of delivery against each of the, risk assessed, objectives, with trajectories to illustrate performance. He noted the diminishing likelihood of achieving March 2016 trajectory on trial recruitment. Given this, and that this pays for the investment to date, it was agreed that the Board would discuss progress on all 9 objectives, with a focus on this one, at its February meeting.	
17 Patient, staff and visitor food- current state and future plans	SWBTB (10/15)168
Mr. C. Ovington highlighted the key message in the report. He commented that patient feedback since the change has been positive. Mrs. C. Rickards, following a discussion in on the option being explored to recruit specialist chefs for Halal meals, raised concerns on the recent review on catering services which resulted in a number of long serving chef redundancies and the impact on them and advised that the Trust should have a long term focus on staffing requirements to avoid this sort upset in the future. Mr. M. Hoare asked whether there are other ways for patients, who are mobile and would like an alternative, to receive their food apart from on the ward. Mr. C. Ovington advised that there are other eating facility options for patients in the Trust. Mr. T. Lewis commented that we need to think what more we could do to encourage ward clinical teams to create an environment for patients to prepare their own food to encourage mobility as part of the recuperation of care. He reflected on previous discussion on the stroke care breakfast club.	

Mr. T. Lewis commented that the paper does not respond to the patient comment from the last Board meeting on temperature and presentation from plating to delivery. Mr. C. Ovington gave assurance that changes where put in place immediately after the meeting; changes introduced require staff to maintain the correct food temperature on the ward while a team of nurses deliver the food for patients.	
Action: C. Ovington will report back orally to the Board on the monitoring of the arrangements in place for serving food to patients.	**Mr. C. Ovington**
18 Our 2020 vision: consultation response	SWBTB (10/15)170
Mrs R Wilkin presented an updated document following feedback from patients, staff and stakeholders. Comments had mostly been positive. The updated version includes increased reference to palliative care, commissioning and the role of the 3rd sector in delivering better integrated care and group section feedback. The launch will take place in November 2015, which will be very visible both internally and to stakeholders	
Action: Mrs R Wilkin will present to the next informal Board on 16 October 2015	**Mrs R Wilkin**
19. Revalidation for nurses and midwives	SWBTB (10/15)171
Mr. C. Ovington introduced the paper, which outlined the plans to support the Trusts registered nursing and midwifery workforce in meeting the NMC revalidation requirements to be introduced in April 2016. This will require all nurses and midwives undertake re- registration every 3 years. We are waiting for some final guidance from the NMC in October2015. He noted that this is personal accountability not an organisational accountability. The Board engaged in a discussion on the impact on nurse staffing levels particularly nurses who are close to retirement and choose not to revalidate.	
Action: Mr. C. Ovington will routinely present revalidation for nurses and midwifes to the Workforce and Organisational Development Committee.	**Mr. C. Ovington**
20 Update from the Quality & Safety Committee held on 28 August, Minutes and 25 September	SWBQS (9/15)94
Mr. Samuda provided an update. He raised 2 matters; under matters of National Interest the 28 day Cancer referrals and the impact on the Trust. Mr. T. Lewis advised various pieces of guidance has been published nationally which is not cohered and the return visit by the TDA to inspect the improvements and the Q&S receive assurance on the Trusts delegation arrangements.	
21 Update from the Finance & Investment Committee held on 31 July Minutes and 25 September	SWBF1 (9/15)028
Mr. Samuda provided an update He raised the Lord Carter review, which will involve benchmarking data against other Trusts which the FIC will be responding to.	
22 Update from Workforce and Organisational Development Committee. 29 July & 25 September	SWWO (9/15)012
Mr. H. Kang provided an update. He highlighted that the TDA had attended the meeting	

on 25 September as observers; the Trust sickness levels and the plans in place to reduce them; the discussions on inclusive and diversity BME leadership and the Safe and Sound workforce change – Phase 2	
23 Any Other Business	Verbal
1. Mr. T. Lewis reported: Chairs' action to the discretion to implement the redundancy arrangements for Staff under Phase 1 & 2, in with our prior agreements which had lapsed in July 2015. 2. Dr. R. Stedman raised the national junior doctors' forthcoming strike vote. A local contingency plan would be developed.	

Signed ……..

Print ……..

Date ……..

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

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

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

In Attendance: Miss A Binns Mrs R Goodby (RW), Mr A Kenny (AK)

Apologies: Miss K Dhami, Ms O Dutton (OD),

Secretariat: Miss L Fairfield

Last Updated: 29 October 2015

	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.371	Nurse staffing levels	SWBTB (4/15) 062 SWBTB (4/15) 062 (a)	02-Apr-15	Examine by October how we can seek to create a broader Safe Staffing report for the Trust	RG	01/10/2015	On October Agenda	G
SWBTBACT.475	2014/15 annual governance statement and report	SWBTB (6/15) 080 SWBTB (6/15) 080 (a) SWBTB (6/15) 091	04-Jun-15	Present the Business Continuity arrangements at the next meeting of the Audit & Risk Management Committee	RB	30/07/2015	Scheduled for presentation at the October meeting of the Audit Committee	G
SWBTBACT.477	Quarter 1 financial update	SWBTB (6/15) 087 SWBTB (6/15) 087 (a)	04-Jun-15	Arrange for the Women and Child Health Group to be invited to a future Board Informal session	SGL	17/07/2015	Arranged for October Board informal meeting	B
SWBTBACT.484	Ten out of Ten deployment	SWBTB (7/15) 105 SWBTB (7/15) 105 (a) SWBTB (6/15) 091	02-Jul-15	Present an update on Ten out of Ten deployment in October	CO	01/10/2015	On October Agenda	G
SWBTBACT.485	DNACPR Plan	SWBTB (7/15) 121	06-Aug-15	Feedback to the board when 3 month data is available and mid point report to board in October	RSt	01/10/2015	On October Agenda	B
SWBTBACT.486	Consent on the day of surgery	SWBTB (7/15) 122	06-Aug-15	Provide update with analysis of how many people on our waiting list pre-date eDTAs introduction	RB		Reinstated following 1 October 2015 Board Meeting	G
SWBTBACT.487	CEO Report	SWBTB (8/15) 123	06-Aug-15	100,000 Genome Project - R&D team to prepare a paper for future board	TL	03/12/2015	Provide report to December board	G
SWBTBACT.488	CEO Report	SWBTB (8/15) 123	06-Aug-15	Mutual Tolerance Report at 6 months	TL	01/03/2016	Provide report to March 2016 board	G
SWBTBACT.489	Annual Plan Delivery Report - Q1 - update	SWBTB (8/15) 130	06-Aug-15	Workforce delivery Board to look at sickness and the way forward. Inform board with a plan B	RG	01/10/2015	Present report to October Board	G
SWBTBACT.491	Board Assurance Framework 2015/16 - Q1	SWBTB (8/15) 129	06-Aug-15	Health Visiting staff position to be updated at September board	RB	03/09/2015	completed	B

SWBTBACT.492	Trust Risk Register	SWBTB (8/15) 128	06-Aug-15	Update position on Ultrasound at September Board	RB	03/09/2015	completed	G
SWBTBACT.493	Matters arising	SWBTB (8/15) 135(a)	03-Sep-15	Schedule of Organisational Change to be included on agenda for Board Informal	KD	18/09/2015	completed	B
SWBTBACT.494	Approach to Near Misses	SWBTB (9/15) 137	03-Sep-15	Obtain data from other Trust on what they report on Near Misses	KD	01/10/2015	Update to October meeting	G
SWBTBACT.495	Approach to Near Misses	SWBTB (9/15) 137	03-Sep-15	Video Reflexology presentation at November Trust Board	RB	05/11/2015	November Trust Board	G
SWBTBACT.496	Staff Staffing Data Quality	SWBTB (9/15) 140	03-Sep-15	Update report to be presented to a future Trust Board	CO	05/11/2015	November Trust Board	G
SWBTBACT.497	Chief Executives report	SWBTB (9/15) 141	03-Sep-15	Freedom to Speak Up to be included on Board Informal agenda	KD	18/09/2015	completed	B
SWBTBACT.498	Trust Risk Register	SWBTB (9/15) 142	03-Sep-15	Risks to be reviewed and any obsolete to be removed	KD	01/10/2015	Update Trust Board	G
SWBTBACT.499	Forward Capital Plan 2015-17	SWBTB (9/15) 149	03-Sep-15	Update the Trust Board on the capital programme review	TW	05/11/2015	Update Trust Board	G
SWBTBACT.500	CQC Improvement Plan Update	SWBTB (9/15) 150	03-Sep-15	Update on areas where practices have improved following CQC inspection	KD	05/11/2015	Update Trust Board	G
SWBTBACT.501	CQC Improvement Plan Update	SWBTB (9/15) 150	03-Sep-15	A paper on successes following the CQC inspection to be presented to the Q&S Committee	KD	03/12/2015	Update Trust Board	G
SWBTBACT.502	Trust volunteer service	Presentaion	01-Oct-15	A report on what success looks like for the Trust volunteer service at the, December 2015 Board.	CO	03/12/2015	Update Trust Board December 2015	G
SWBTBACT.503	DNACPR Integrated Performance Report	SWBTB (10/15)154	01-Oct-15	Identify a mechanism for the DNACPR data to feed into the Integrated Performance Report on a routine basis.	The Executive Team			G
SWBTBACT.504	Cardiology performance data	Question from member oF the Public	01-Oct-15	The performance data on the cardiology move will go to Quality and Safety and report up to Board.	RB			G
SWBTBACT.505	sonographers	SWBTB (10/15) 157	01-Oct-15	The Board will receive an update on sonographers at the 5 November Board Meeting.	**TL**		Update at the 5 November	G

SWBTBACT.506	Safe nurse staffing	SWBTB (10/15) 159	01-Oct-15	The Board will receive an update on Safe Nurse Staffing at the 5 November Board Meeting.	CO		update at the 5 November	
SWBTBACT.507	Ten out of Ten	SWBTB (10/15) 163	01-Oct-15	The Board will receive an update with a remedy plan on Ten out of Ten at the December Board Meeting.	CO		Update Trust Board December 2015	
SWBTBACT.508	Serving Food to Patients	SWBTB (10/15)168	01-Oct-15	Board on the monitoring of the arrangements in place for serving food to patients	CO		Oral update to the Board	

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

REPORT TO THE TRUST BOARD HELD IN PUBLIC

Chief Executive's Report – November 2015

The Board papers show our performance in September, and therefore to half year. As is our tradition we have issued a summary of annual plan delivery with October pay slips to all employees. It highlights lots of delivered objectives, and some with more work needed. The key message from the Chairman and I is that our future is clear and bright, but that it does depend on tackling successfully sickness and vacancy rates in coming months. We will discuss progress at the Board.

During November we formally launch our 2020 Vision. This is SWBH's very own Five Year Forward View. It comprises a familiar right care, right here story. It is explicit that changing our estate is only one of three drivers for transformational change, along with technology and workforce development. Crucially it focuses on our coordinated care intention and takes us beyond and above the ambition of a new hospital in 2018. I am encouraging by the engagement we have seen in developing the vision and by the enthusiasm for the story – it is about hope and possibility.

I would draw the Board's attention to the three regulatory related messages in this report.

1. Our patients

The last month saw focused work, as well as a consultant conference emphasis, on unplanned readmission rates. Long high at Sandwell, we remain determined to tackle the issue. Our approach is based on international evidence of what works, focused around the LACE tool. And our own learning about mobilisation, with the urgent care week model. Rachel Barlow will report to next month's Board on progress from the work done – our aim is to prevent 28 admissions each week.

Our Improvement Plan is very much the heart of the Board agenda. Core to the plan is changing the ward clinical team culture to ensure that care planning is highly personalised. We have completed analytical work across all our wards on what will work best and the focus is on implementing change initially in our assessment units – as those care plans travel throughout a patient's stay. The unannounced inspection model we will be deploying during November will test progress and compliance with the new approach.

On November 16th we adopt our partial booking model in 9 specialties. Our readiness assessment for the planned October launch led to deferral to that date. Whilst disappointing on one level, it reflects the governance grip we want to have that we will make inconvenient decisions to make sure that implementation is wise and safe. Partial booking is a huge change for clinics, and will be applied Trust wide from late February. Because instead of booking someone into a slot in many months' time and then rescheduling it, we will only book then what we know we can deliver. The Board's paper reflect major productivity increases in booked care in October and November as we work to deliver our annual plan, but without premium working rates. If we can, through partial booking and

text reminders, tackle DNA rates then we have a chance to bring down wait times further. We are, with a handful of exceptions, on track to achieve our self-imposed six week maximum wait by Christmas. This guarantee is a key part of changing our promise to patients and GPs for 2016. The Trust should be proud of delivering NHS wait times that others are now not able to deliver, but we want to use that success to go further.

The Royal College of Radiologists has just reported their Q2 snapshot audit of wait times for scan reporting. The Trust is definitely average or better in that study of over 75 major units. We committed to, and this summer failed to sustain, a two week report wait. The weekly tracking scorecard, overseen by myself, the medical director and COO, now shows deliver on that pledge. At the Clinical Leadership Executive earlier in the week we were able to agree maximum wait standards – for urgent cases, routine waits and then scans. Within our risk register we are now able to outline the overall strategy for ultrasound – tackling our own recruitment issues and the issues arising from the service fragmentation of the CCG decision to outsource GP scans from early 2016. The Board has endorsed the MES model for imaging equipment, and within the LTFM which underpins Midland Met, we will be committing the equivalent of around £18m to imaging kit across our sites in the next three years. At December's Board we will illustrate what will go where when.

Last month we have had an MRSA case reported. This is our second unavoidable case in 2015-16. The quality and safety committee will examine any lessons arising. It remains, looking at our Integrated Performance Report, deeply encouraging that we are on track to again cut c-difficile rates. Our Ten Out Of Ten programme must see us improve screening rates further.

Although October performance is beyond the papers' scope, it is worth being explicit that we are seeing some significant, if temporary, planned care delivery issues. In cancer we will have almost twice as many breaches as in prior months and will fall short of 85%. From November 1 a new model of urology pathway starts both at SWBH and UHB which should ensure improvement. The Board is aware of both national RTT 'counting changes' and our own Q1/2 growing waiting list. In Q3 we will address this whilst remaining inside the so-called 'incompletes standard'.

2. Our workforce

Considerable attention remains on nurse recruitment. Work with major universities to develop a more routine pipeline model is in hand, given our very positive student reports of study in our sites. Linked to that, we are working through how different providers will integrate when our students are based on one acute site in 2018: Historically we have drawn from Wolverhampton into Sandwell and BCU into City.

At the same time the workforce development committee is focused on the retention heat-map. We know that hiring costs in time, money and displaced effort and that there is more we can do to support new joiners to remain with us beyond their first year. The workforce committee of the Board in December will focus considerable attention on how we best address this, and the role the Board needs to play in making sure that working here is what we would all want it to be.

Flu vaccination rates are progressing well. I will provide an oral update on the latest position, but after a fortnight we had vaccinated over 1000 employees, and the time-of-writing position was 49% of patient facing staff vaccinated already! Five staff have already achieved 50 vaccinations of their

colleagues and earned time off work. As always it will take sustained effort to maintain momentum through November and early December. Our aim is 80%+ coverage again.

We have now confirmed our revised bank rates through winter. This summer and again in late autumn as part of our agency drive we upped rates, indicating that the spike would be temporary. Based on analysis we have now settled on a rate from November 1 – March 31st. We recognise that we will need bank staff throughout that period, even as we hire, retain better and cut sickness. The NTDA have issued guidance on agency hourly rates, including signalling the intent to cap rates progressively to a base level by April. We will discuss how operationally we will adopt that approach, conscious that in particular our A&E departments remain dependent on agency doctors, and if we err on pay rates we will not be able to sustain the departments 24-7: It is that simple.

Your Voice continues, and over recent weeks 800 employees have had chance to contribute to the NHS wide staff survey. This is useful barometer of engagement, which we know has suffered over the last year as we made difficult changes in staffing. Of course, for most staff they want to have a great experience of work and a clear future. The 2020 Vision, the impending contract signature on Midland Met, and progress on key issues like functioning IT, will all help to address those issues.

Quality Improvement Half Days remain at the heart of our work to build teams. Over 1,500 employees are participating each month which is an extraordinary mobilisation of effort and energy. We have used both the Hot Topics team brief in August and standard survey method to assess room for improvement in those events. Across Community and Therapies, with over 600 staff, more than 300 took part in October's QIHD, which was also the second birthday of this integrated care group. Myself and Colin Ovington attended the event, and were struck not merely by the engagement and determination to talk about success and weakness but also by the focus on leadership and on improvement capability. In terms of developing out of hospital services, the attendees are the future of local care, working alongside GPs, but also in-reaching into our wards and teams.

Security is always an issue of concern for us. Board members will recall the discussions held in August's meeting about tolerance and aggression, and the quality and safety committee reviewed the approach adopted in several high profile ward incidents during the spring. A summary paper comes to the Board today in light of the violent attack on a member of staff in a department during daylight hours earlier in October. Since that time over 3000 attack alarms have been distributed, and we have changed or strengthened a variety of processes in departments to help create a climate of mutual aid and safety. Whilst the specific incident was exceptional in various ways, I am determined to make sure that we do not tolerate nor become accepting of violence. The use of our yellow and red card scheme will be scrutinised and reported routinely centrally through our Risk Management Committee.

3. Our partners

Both the local CCG and NHSE have published commissioning intentions for 2016-17. The operating framework for provider plans is awaited, as is the tariff and the contract form. On first glance the CCG outline plan is not inconsistent with the agreed trajectory within RCRH, although it does not set out how referral management either away from (reduced demand) or towards (provider rationalisation) will be tackled. The Trust has indicated in writing and in due time that some decisions do need to be made before mid-December if certain services are to remain open by

beyond the end of March. The pattern of short term funding decisions is inconsistent with good care, good team work, and national guidance on agency use.

Albert Bore's resignation as City Council leader clearly marks a major change in local arrangements. We continue to look to work constructively with the City Council, both on regeneration matters related to the Dudley Road site, and on service provision. The recently imposed coming together of HEFT and UHB may simplify constructively the network of organisations with whom BCC work. Needs in Ladywood and Perry Barr are different to those in some other parts of the city, and it is imperative that service providers can reflect that difference in the best interests of the outcomes of those we serve.

Board members will recognise that the developing relationship between Birmingham Children's Hospital and Birmingham Women's Hospital is an important change. The flow of complex gynaecological care to SWBH that BWH cannot, with their general partner UHB, provide is something that we are now monitoring, as we consider the right approach and footprint on which to offer major surgery to local patients. Work continues meanwhile with Birmingham GPs to better understand what paediatric services need to be in place in support of Midland Met, perhaps especially when BCH relocates to Edgbaston in the early part of the next decade.

4. Our regulators

I am pleased to be able to confirm that the improvement notice associated with poor record keeping around annual update training for radiographers and others has now been lifted. This arose from the October 2014 CQC inspection, and whilst then inspectors found good training they found poor records of that work. Our submission in June was reviewed on October 21st and immediately accepted. This is a tribute to hard work in the department but obviously needs to be maintained.

During November we will undertake the quality summit associated with our Community Children's Service CQC re-inspection. The inspection was previously inadequately undertaken and was re-done in June 2015. The report will be presented to Trust leaders, alongside key stakeholders such as the Local Authority and CCG. It will be published immediately thereafter. Clearly children's care in the borough is rightly the focus of great attention and so this an important moment for the Trust – as this team includes both beacon award winning services and others like health visiting that have been the focus of considerable improvement attention in recent months.

In mid-November, the Trust attends an important meeting with the NTDA Investment Committee to make a final assessment on proceeding with Midland Met. This will test our compliance with the various conditions specified at approval business case stage, against the confirmatory business case submitted last month. Given the vital strategic necessity of the changes to urgent and emergency care locally and the fragile nature of the current configuration, support from our regulators should be expected – allowing us to move to contract signature in the weeks that follow.

5. Routinely reported matters

I attach my top ten annual plan priorities report. It remains the case that we have three greens: Two estates and one IT related. Of our seven red/amber items three look like high prospects for green year end. The greatest concern areas are set out explicitly with a recognition that November has to either see real change or greater plan clarity.

Toby Lewis – Chief Executive

October 27th 2015

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

Objective (listed by improvement quarter order)	End of Sept update	Improvement quarter	Success quarter	Likelihood of delivery assessment
Work within our agreed capacity plan for the year ahead	The recovery plan is in place to cover finance plan not full year volumes. Demonstrated grip – but Sept u-delivered. **November pivotal.**	Q1	Q1-4	As before As before
Create balanced financial plan…	At Trust level this remains feasible. Run-rate at Group level problematic in 5 of 7 groups. Board discussing plan B as a specific item.	Q1	Q1-4	Worsening As before
Agree EPR OBC and initiate procurement process	EPR shortlist moderation meeting on Nov 16th. Cost and timetable risk assessment to be made thereafter.	Q1	Q1 and Q3	As before As before
Achieve the gains promised in our 10/10 programme	Delivery plan was discussed at October Board. Not convincing. Remedial plan needed at December board based on 10-10 in some wards and then spread. **November pivotal.**	Q2	Q2	Worsening Worsening
Implement our Rowley Regis expansion…	Plan partly delivered and on track to complete to time. Assessment of workflow changes to be made. No decision yet on eye service.	Q2	Q3	As before As before
Cut sickness absence below 3.5%...	Limited actual improvement in 5 of 7 Groups. Work well developed to tackle 2 month+ long term sickness. Good mobilisation and staff-side partnership.	Q2	Q3 and Q4	As before As before
Reduce readmissions by 2% at Sandwell	Impetus from focused week. Need to track figures weekly now and plan further 'intervention' in December.	Q2	Q3-4	Improved Improved
Deliver our plans for significant improvements in our universal health visiting offer	Continued improved delivery improvement and real leadership focus. Optimistic of delivery from early Q4 for most measures.	Q2	Q4	As before Improved
Tackle caseload	Need to rapidly define actual change plan as	Q3	Q4	As before

management in community teams	distinct from analysis if intent is to ensure that item goes green in Q4. **November work pivotal.**			Improved
Reach financial close on the Midland Met	Reached PB stage, with planning consent due in late September.	Q4	Q4	As before

Annex B – Board Equality and Diversity Plan (vs. October 2014 version – July 15 revisions)

Key deliverable	Commitment at July 15 board	Current state – Sept 15
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.	Needed during November
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	Will be completed at November Committee.
Collect, collate and examine protected characteristics data on our workforce and, largely, on our staff: We will undertake a one off ESR data validation.	The use of outpatient kiosks (from Q3) will be our vehicle to improving patient data. Both will be compared through our Board committee against the demographic for SWB as per the ONS.	Need to confirm timetabling.
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.	Starts from December.
Add into our portfolio of leadership development activities a series of structured programmes for people with PC	Raffaela Goodby will determine how we move ahead by October 2015 with an unambiguous programme which will certainly include a specific BME leadership offer.	Plan developed, implementation date to commence Q4.
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.	Method agreed, timetabling to be shared for completion by end of Dec
With partners to ensure a peer group in each protecting characteristic is active [we have BMSOG and there is an emerging LGBT group]	This will require some further discussions across the leadership, to prioritise how we create interest groups with integrity. We will work with TU colleagues and others to think through how this is best developed in time for the PHCD&E committee in September.	Need to confirm programme at next PH committee (Nov).

Key deliverable	Commitment at July 15 board	Current state – Sept 15
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.	Plan developed, implementation date to commence Q4.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Performance Report (September 2015)
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Mngt
AUTHOR:	Yasmina Gainer, Head of Performance Management
DATE OF MEETING:	5 November 2015

EXECUTIVE SUMMARY:

The report is to inform the Trust Board of the summary performance of the Trust covering the period to September 2015.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

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

Sandwell and West Birmingham Hospitals NHS Trust

Integrated Quality & Performance Report

Month Reported: September 2015

Reported as at: 28/10/2015

Contents

At Glance - September 2015

Infection Control

There was 1 case of C. Diff reported during the month of September (Surgery A). The number of cases year to date is at 14 against a year to date target of 15.

No cases of MRSA Bacteraemia reported within the month of September. There is 1 case reported in October subject to root cause analysis.

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

Both MRSA elective and non-elective screening remain above the 80% target overall; however Medicine elective screening is below the target for the month of September at 62%.

Harm Free Care

Overall Harm Free Care as assessed through the NHS Safety Thermometer indicates a level of Harm Free Care of 94.7% for September, beneath the 95.0% operational threshold, but an improvement on last month.

There were 78 falls reported in September (51 Acute; 27 Community) being consistent with recent levels.
1 serious injury resulted from the falls in September.

There were 9 cases of avoidable pressure sores reported in September (6 cases in Medicine and 3 cases in Surgery A). These were graded at Grade 3: 3 cases and Grade 2: 6 cases.

There were 4 serious incidents reported in September; all 4 cases in Women's & Children.
There were no medication errors reported in September.
Venous Thromboembolism (VTE) Assessments just below target in September at 94.7% (target of 95%).

There were 8 Open CAS Alerts reported at the end of September, of which 2 were overdue at the end of the reporting period.

Obstetrics

The overall Caesarean Section rate for September is 27.8 % (August at 26.2%), 25.5% on a cumulative year to date basis and are therefore above the target of 25.0%. Elective and Non-Elective rates for the month were 9.3% (8.8%LM) and 18.4% (17.4%LM) respectively - an increase across both pathways.

Adjusted perinatal mortality rate (per 1000 births) decreased during the month of September to 4.27 (10.0LM) below the target of 8.0 or less.

Early Booking Assessment (<12 + 6 weeks) - SWBH Specific definition target has not been met (75.69% against that target), but delivering to national target in September.

Registrations convert to lower deliveries at the Trust, as other centres pick up the births element.

Breastfeeding initiation is at 74.22% on a cumulative basis, below the target of 77% in the quarter.

Mortality & Readmissions

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

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

During the most recent month of June the mortality review rate is 87%. The trajectory currently is 100%, but the target is under review (Medical Director) and will be reflected in the next IPR.

Total readmissions rate for September is 8.1% (vs. 9.1%); 12 mth rolling rate at 8.4% (unchanged).
CQC diagnostics group Emergency Readmissions (within 30 days) 8.7% (vs. peer 6%) with biggest volumes reported against Medicine and Surgery A.

The Trust just completed a 'readmissions focus week' in October, improvements from this exercise are anticipated to be realised over the next period.

Stroke Care & Cardiology

Stroke data for September indicates patients spending >90% of their time on a stroke ward was 88.7% just below the 90% operational threshold (year to date delivery at 90.5%).

September admittance to an acute stroke unit within 4 hours remains relatively stable at 80.9% (falling short on 90% local target, but meeting 80% national target).

The September percentage of patients receiving thrombolysis within 60 minutes of admission was a second month running at 100% compared with a target of 85% - a significant improvement now for the second month. September patients receiving a CT scan within 1 hour and 24 hours of presentation was at 75.0% (target 50%) and 100% respectively (target 100%).

For September the Primary Angioplasty Door to balloon time (<90 minutes) was 84.6% against an 80% target; and Call to balloon time (<150 minutes) was also at 84.6% for the same period, also against an 80% target - both targets are delivering year to date.

RACP performance for September at 92.1% (worsening from last month), with a year to date performance is at 97.8% just below the target 98%.

Cancer Care

The Trust has failed the 62-day urgent GP referral to treatment target of 85% during August, with performance of 80.0%.
Key issue urology [8 breaches; 46% compliance]
Other high level targets were met in August (2WW and 31day).

Groups that failed the 62 day target : Surgery A - 70.8% Women's 82.4%
Other high level targets were met in August (2WW and 31day).
However, 2ww none achievement by : Surgery B & Women's is due to patient choice.

The projection is that all targets will be met in September, failed in October and November delivery.

In September, 12 patients are waiting over 62 days and 7 patients are waiting more than 104 days. There is now a national focus on this cohort of patients and the trust will be required to submit detailed patient level information for this indicator.

The longest waiting patient is at 147 days (Urology). Action plan is in place for Urology which will change the pathway from 1 November. This will enable a cohort of patients to have their TRUS biopsy before there MRI and therefore reducing the pathway before referral onto the tertiary centre for surgery.

Patient Experience - MSA & Complaints

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

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.

Inpatient FFT response rate and score are tracking close to the target or above, however the Emergency FFT rate is below target of 20% reporting at 7.5% in September (consistently below target since March).

The percentage of complaints exceeding the original agreed response date (within 3 days) was 7.7% (vs. 7.1% last mnth).

100% of complaints received during the month were acknowledged within 3 days of receipt. Oldest complaint in medicine at 136 days.

The Learning Disability indicator is red. The service is under-going a review to ensure compliance is as per latest guidance.

Patient Experience - Cancelled Operations

The number of Last Minute Cancelled Operations (elective) decreased in September to 0.70% (1.0%LM) against a 0.8% target. The cancellations are in Surgery A (1.26%) followed by WCH (2.15%).

There was 1 breach of the 28 day late cancelled operation guarantee reported during the month of September.

The trust has reviewed its reporting of the 'urgent operations cancelled on the day' and introduced a new KPI 'Urgent Cancellations' which report 3 cases in September (2 Surgery A and 1 Medicine). The KPI trend has been shown from April onwards. Further group review is under-way.

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

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

Emergency Care

The Trust's performance against the 4-hour ED wait target of 95.0% during the month of September was 93.74% (vs. 95.84%).
Performance for the second Quarter was 94.57% (vs. Q1 92.99%).
October up to 26/10 is at 94.09%.

WMAS fineable 30 - 60 minutes delayed handovers at 76 in September.
Over 60 minutes reported 1 delayed handover.
As a %age of the overall conveyances the over 60 min delays are at 0.02% (target at 0.02%) in the month, cumulatively at 0.12%.

Fractured Neck of Femur who received an operation within 24 hours of admission has fallen significantly in September to 50.0% delivery (67% LM) against a target of 85% .

DTOC at 2.2% for the month of September against a target maximum of 3.5%.

Referral To Treatment

RTT overall is meeting targets against all pathways (90.78% in September). The forecast is that RTT will be met over the next 3 months across all pathways.

At the end of September 2 patients were waiting more than 52 weeks for commencement of treatment.

The TDA will from October monitor only the incomplete pathways, the trust still monitors itself still across all pathways. In this respect, 12 Treatment Functions failed the respective RTT pathway performance thresholds for the month (this is an increase to recent periods). The split of those is as follows:
Completed Pathway – Admitted (T&O 70.7%, General Surgery 82.6%, Plastic 83.2%);
Completed Pathway – Non Admitted (Plastic 92%, T&O 93.7%, Oral 88.8%, Respiratory 90%, Urology 76.7%);
Incomplete Pathway (Urology 90.4%, T&O 89.7%, Cardiology 89.9%, Respiratory 90%)

Diagnostic waits (September) beyond 6 weeks were 0.2%, remaining well beneath the operational threshold of 1.00% and improving to previous already low trends.

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

The Trust's internal assessment of the completion of valid NHS Number Field within inpatient data sets remains below the 99.0% operational threshold, with actual performance (completeness) during September reported as 96.5%. Outpatient, Community 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 September of 38.9%.

Open Referrals are at 208,990 as at the end of September.
This represents further 6000 growth on previous month. A process if being developed for a review process.

Staff

PDR overall compliance as at the end of September at 87.9%. The Medical Appraisal / Revalidation rate as at August is 87.99% measuring only validated appraisals not carried out. Below targets of 95%.

Mandatory Training at the end of September at 87.47% overall against target of 95%. Health & Safety mandatory training at 97.8%

Sickness Absence at 4.94% in September (4.91%LM) which represents a 12-month rolling period, a 0.03% worsening to last month. The Return to Work interview rate following Sickness Absence is at 65.65% in September (63.16% LM) for the 12-month cumulative period.

Qualified nurse vacancies as at September reported as 320WTE. The Trust turnover rate is at 13.9% as at September.

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

CQUIN

Q2 performance is in the process of being submitted to the CCG and SCG. Feedback will then be received as appropriate.
It is anticipated that most schemes will deliver to targets subject to commissioners feedback; with one failing scheme (Sepsis A) which will have failed the quarter despite a good recovery in the month of September. The value of this is c£65-100k.
From October onwards monthly meetings have been in place to monitor and the delivery.

Ext Assessment Frameworks & Data Quality

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

Data Quality - the Performance Committee has agreed to re-visit all data quality kitemark assessments as part of an ongoing improvement cycle. The initiative completes at the end of December 2015 when all data reported in the IQ&PR will have a completed kitemark (or with clear actions in place). The project is under-way and delivering to milestones at this stage.

Summary Scorecard - September (Month)

Section	Red Rated	Amber Rated	Green Rated	None	Total
Infection Control	0	0	6	0	**6**
Harm Free Care	6	1	5	2	**14**
Obstetrics	1	1	5	6	**13**
Mortality and Readmissions	1	0	0	11	**12**
Stroke and Cardiology	3	0	8	0	**11**
Cancer	1	0	6	5	**12**
FFT. MSA, Complaints	3	1	4	6	**14**
Cancellations	5	1	3	0	**9**
Emergency Care & Patient Flow	6	0	6	4	**16**
RTT	2	0	4	0	**6**
Data Completeness	3	0	7	1	**11**
Staff	9	0	1	11	**21**
Total	**40**	**4**	**55**	**46**	**145**

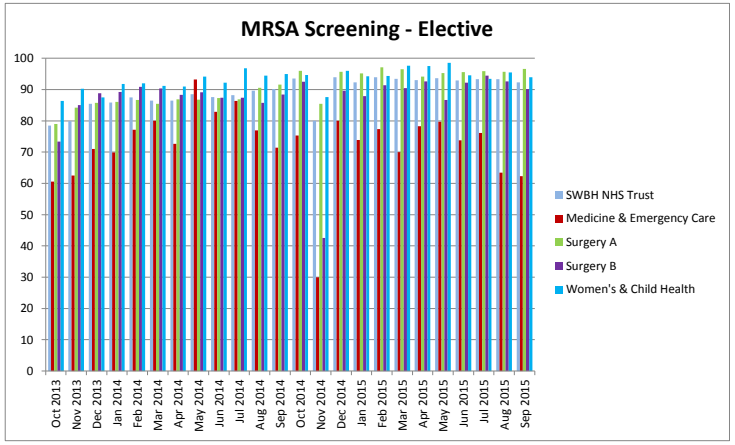
40 exceptions (red rated) reported indicators at September. The CCG has issued 4 Exceptions to the trust, in respect of August RTT, 62 day Cancer target and MSA. The TDA has issued 1 exception in respect of September incomplete RTT

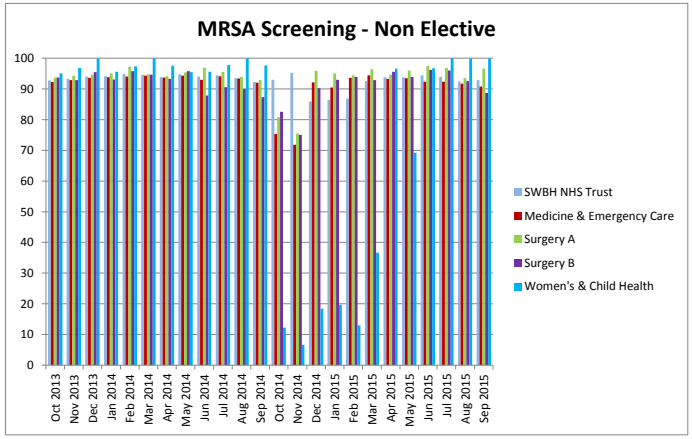
Summary Scorecard

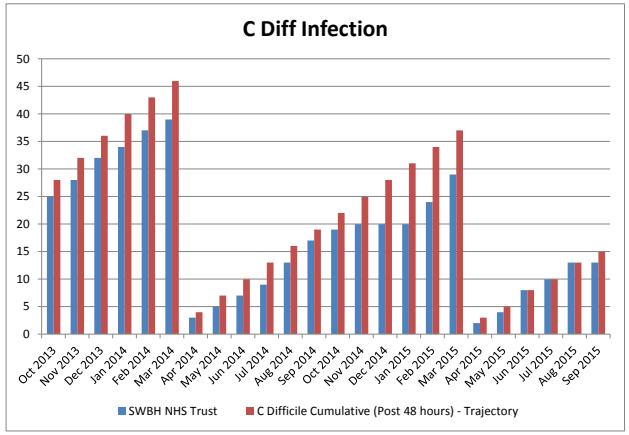
Section	Red Rated	Amber Rated	Green Rated	None	Total
Infection Control	0	0	6	0	**6**
Harm Free Care	6	1	5	2	**14**
Obstetrics	1	1	5	6	**13**
Mortality and Readmissions	1	0	0	11	**12**
Stroke and Cardiology	3	0	8	0	**11**
Cancer	1	0	6	5	**12**
FFT. MSA, Complaints	3	1	4	6	**14**
Cancellations	5	1	3	0	**9**
Emergency Care & Patient Flow	6	0	6	4	**16**
RTT	2	0	4	0	**6**
Data Completeness	3	0	7	1	**11**
Staff	9	0	1	11	**21**
Total	**40**	**4**	**55**	**46**	**145**

Patient Safety - Infection Control

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From Apr 2014) A M J J A S O N D J F M A M J J A S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
4			C. Difficile	<= No	30	2		Sep 2015	0	1	0	0					1	14			
4			MRSA Bacteraemia	<= No	0	0		Sep 2015	0	0	0	0					0	1			
4			MSSA Bacteraemia (rate per 100,000 bed days)	<= Rate2	9.42	9.42		Sep 2015									5.6	1.1			
4			E Coli Bacteraemia (rate per 100,000 bed days)	<= Rate2	94.9	94.9		Sep 2015									28.0	21.0			
3			MRSA Screening - Elective	=> %	80	80		Sep 2015	62	97	90	94					92.3				
3			MRSA Screening - Non Elective	=> %	80	80		Sep 2015	91	97	89	100					92.9				

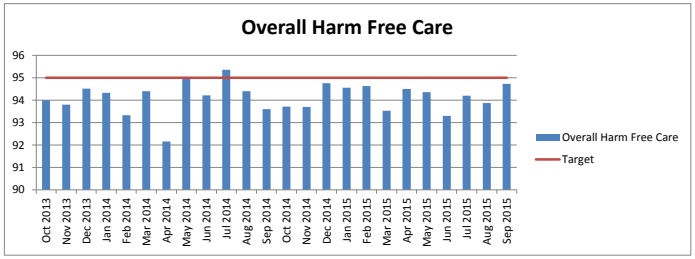


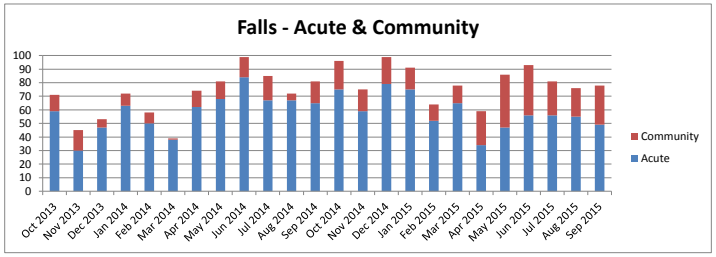


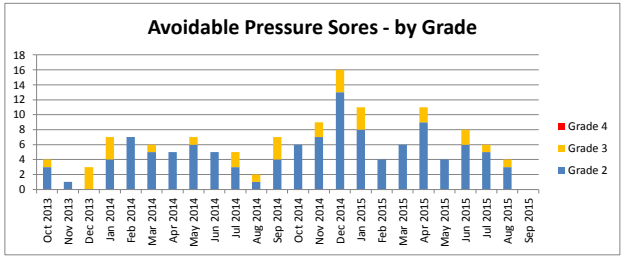


Patient Safety - Harm Free Care

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Apr 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																				Sep 2015									94.7				
8		d	Patient Safety Thermometer - Catheters & UTIs	%			0.53	0.48	0.51	0.49	0.42	0.41	0.40	0.25	0.31	0.41	0.40	0.64	0.25	4.00	2.00	1.00	9.00	3.00		Sep 2015									0.26				
8			Falls	<= No	804	67	74	81	99	85	72	81	96	75	99	91	64	78	80	106	90	70	76	78		Sep 2015	40	4	0	2	0	0	29		78	500			
9			Falls with a serious injury	<= No	0	0	1	5	4	1	5	1	1	2	1	1	0	1	1	1	1	5	0	1		Sep 2015	1	0	0	0		0	0		1	9			
8			Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	5	7	5	5	2	7	6	9	16	11	4	6	11	4	8	6	4	9		Sep 2015	0	1	0	1			2		4	33			
3		d	Venous Thromboembolism (VTE) Assessments	=> %	95	95																				Sep 2015	93.9	97	99.1	89.1					94.7				
3			WHO Safer Surgery - Audit - 3 sections (% pts where all sections complete)	=> %	98	98																				Sep 2015	98.5	99.9	100.0	99.8		0.0			99.6				
3			WHO Safer Surgery - brief (% lists where complete)	=> %	95	95																				Sep 2015	99	99	100	99		0			99				
3			WHO Safer Surgery - Audit - brief and debrief (% lists where complete)	=> %	85	85																				Sep 2015	99	99	100	99		0			99.46				
9		d	Never Events	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0		Sep 2015	0	0	0	0	0	0	0		0	3			
9		d	Medication Errors causing serious harm	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0		Sep 2015	0	0	0	0	-	0	0		0	1			
9		d	Serious Incidents	<= No	0	0	3	2	2	2	2	1	1	2	3	4	4	6	4	3	4	1	1	4		Sep 2015	0	0	0	4	0	0	0	0	4	17			
9			Open Central Alert System (CAS) Alerts	<= No			9	5	7	5	6	5	5	15	17	10	9	4	8	5	4	8	11	8		Sep 2015									8				
9		d	Open Central Alert System (CAS) Alerts beyond deadline date	No	0	0	-	1	1	1	0	0	0	4	0	1	0	1	0	3	2	0	1	2		Sep 2015									2				

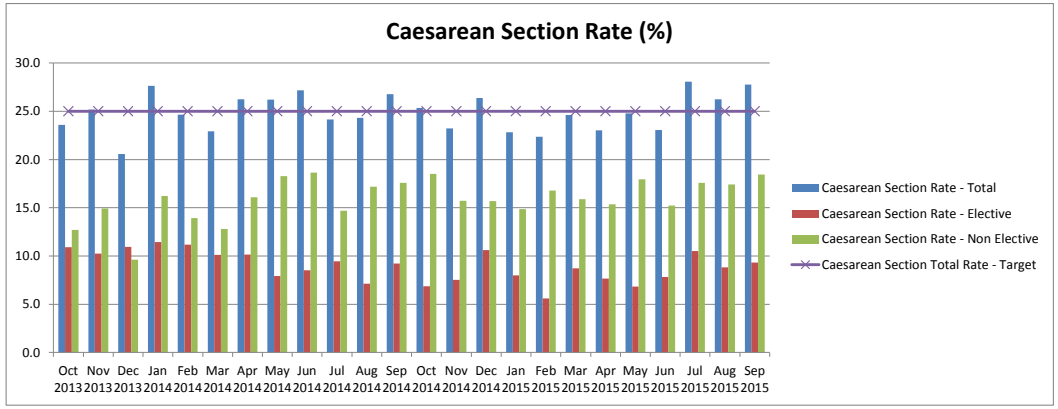


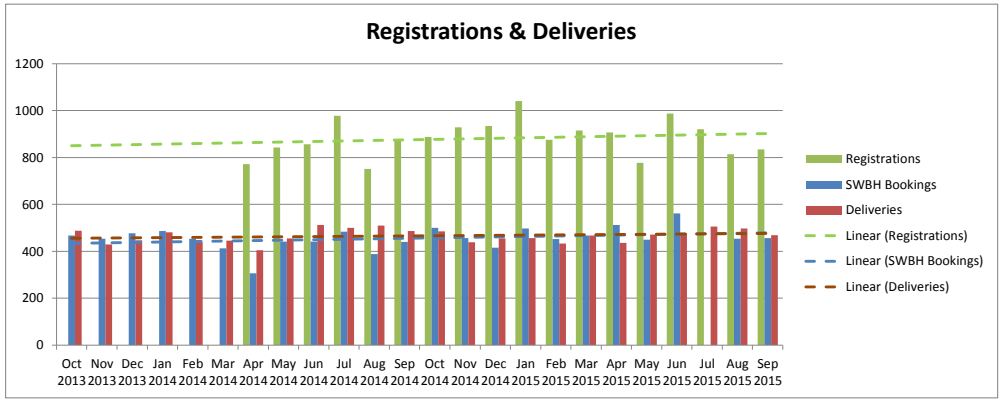




Patient Safety - Obstetrics

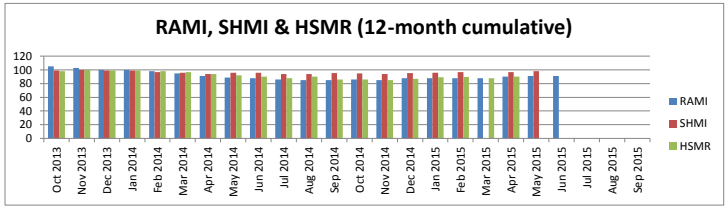
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Apr 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Month	Year To Date	Trend	Next Month	3 Months
3			Caesarean Section Rate - Total	<= %	25.0	25.0																			Sep 2015	27.8	25.5			
3			Caesarean Section Rate - Elective	<= %			10	8	9	9	7	9	7	8	11	8	6	9	8	7	8	11	9	9	Sep 2015	9.3	8.5			
3			Caesarean Section Rate - Non Elective	<= %			16	18	19	15	17	18	19	16	16	15	17	16	15	18	15	18	17	18	Sep 2015	18.4	17.0			
2			Maternal Deaths	<= No	0	0																			Sep 2015	0	0			
3			Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Sep 2015	4	14			
3			Admissions to Neonatal Intensive Care (Level 3)	<= %	10.0	10.0																			Sep 2015	1.50	2.59			
12			Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Sep 2015	4.27				
12			Early Booking Assessment (<12 + 6 weeks) - SWBH Specific	=> %	90.0	90.0																			Sep 2015	75.69				
12			Early Booking Assessment (<12 + 6 weeks) - National Definition	=> %	90.0	90.0																			Sep 2015	135.0				
2			Breast Feeding Initiation (Quarterly)	=> %	77.0	77.0	-->	-->		-->	-->		-->	-->		-->	-->		-->	-->		-->	-->		Sep 2015	-	74.29			
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	1.3	0.5	2.1	2.1	2.1	1.3	1.6	1.6	1.6	Sep 2015	1.60	1.72			
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	1.6	1.0	1.3	1.0	1.1	1.3	Sep 2015	1.34	1.23			
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	0.2	0.5	0.8	Sep 2015	0.80	0.64			

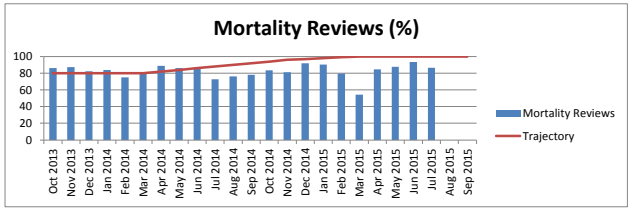


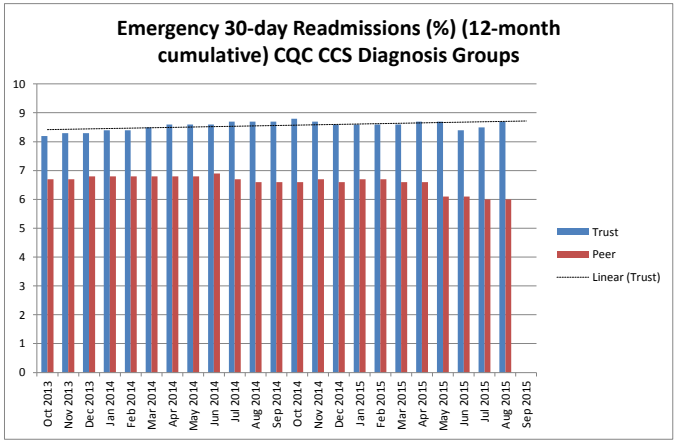


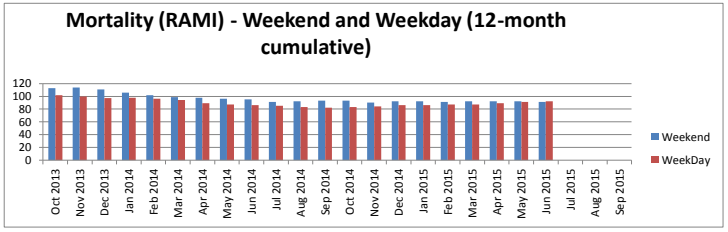
Clinical Effectiveness - Mortality & Readmissions

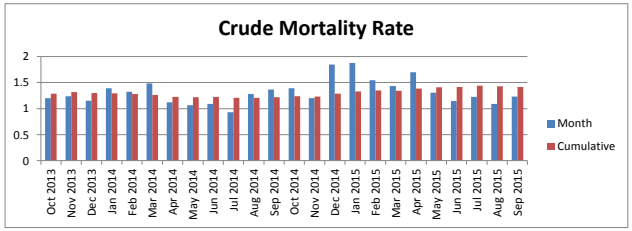
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Apr 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
5		C	Risk Adjusted Mortality Index (RAMI) - Overall (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	91	89	88	86	85	85	86	85	88	88	88	88	90	91	91	-	-	-	Jun 2015									272			
5		C	Risk Adjusted Mortality Index (RAMI) - Weekday Admission (12-month cumulative)	RAMI	Below Upper CI	Below Upper CI	89	87	86	85	83	82	83	84	86	86	87	87	89	91	92	-	-	-	Jun 2015									272			
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	92	92	91	-	-	-	Jun 2015									275			
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	-	97	98	-	-	-	-	May 2015									195			
5		C	Hospital Standardised Mortality Rate (HSMR) - Overall (12-month cumulative)	HSMR			94	92	90	88	90	86	86	85	87	89	90	88	90	-	-	-	-	-	Apr 2015									90.0			
5		C	Deaths in Low Risk Diagnosis Groups (RAMI) - month	RAMI	Below Upper CI	Below Upper CI	66	75	47	51	71	89	80	76	111	105	94	93	75	84	53	-	-	-	Jun 2015									53			
3			Mortality Reviews within 42 working days	=> %	100	99																-	-		Jul 2015	85	93	100	100					87			
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (by month)	%			1.1	1.1	1.1	0.9	1.3	1.4	1.4	1.2	1.8	1.9	1.5	1.4	1.7	1.3	1.1	1.2	1.1	1.2	Sep 2015									1.23			
3			Crude In-Hospital Mortality Rate (Deaths / Spells) (12-month cumulative)	%			1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.3	1.3	1.3	1.3	1.4	1.4	1.4	1.4	1.4	1.4	Sep 2015										1.41			
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	%			8.5	8.6	7.8	8.1	8.3	7.8	8.2	7.5	8.0	8.5	8.3	8.4	9.4	8.7	8.5	9.1	8.1	-	Aug 2015									8.08			
20			Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) 12-month cumulative	%			8.1	8.2	7.9	7.8	7.8	7.7	7.7	7.7	7.7	8.1	8.1	8.2	8.2	8.2	8.3	8.4	8.4	-	Aug 2015										8.30			
5		C	Emergency Readmissions (within 30 days) - CQC CCS Diagnosis Groups (12-month cumulative)	%			8.6	8.6	8.6	8.7	8.7	8.7	8.8	8.7	8.6	8.6	8.6	8.6	8.7	8.7	8.4	8.5	8.7	-	Aug 2015	-	-	-	-						8.60			





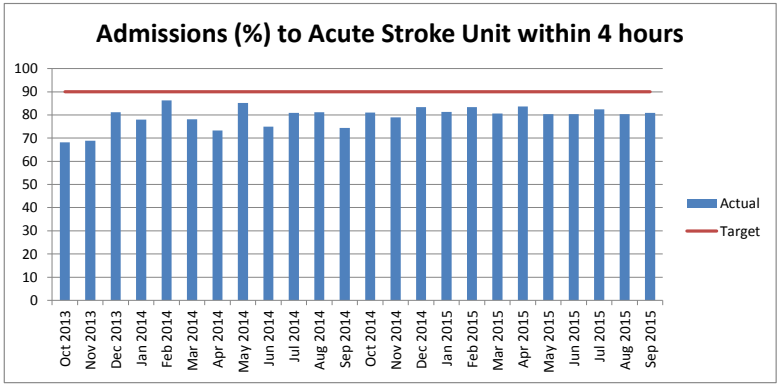


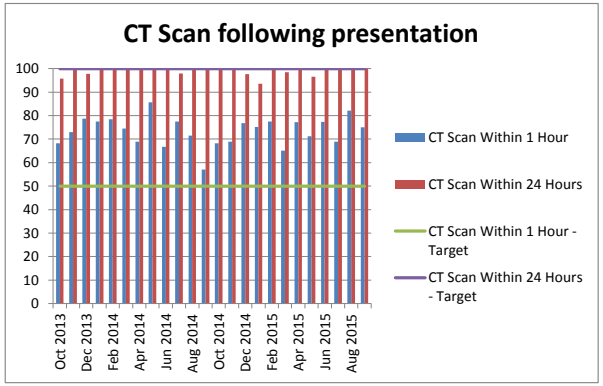


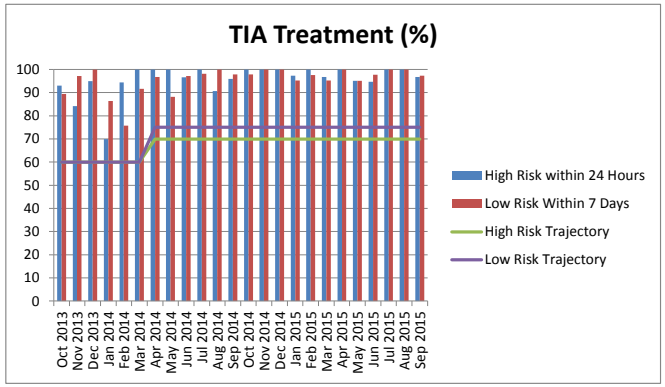


Clinical Effectiveness - Stroke Care & Cardiology

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (Since Apr 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		Sep 2015	88.7	90.5			
3			Pts admitted to Acute Stroke Unit within 4 hrs	=> %	90.0	90.0		Sep 2015	80.9	81.3			
3			Pts receiving CT Scan within 1 hr of presentation	=> %	50.0	50.0		Sep 2015	75.0	75.2			
3			Pts receiving CT Scan within 24 hrs of presentation	=> %	100.0	100.0		Sep 2015	100.0	99.4			
3			Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0		Sep 2015	100.0	82.4			
3			Stroke Admissions - Swallowing assessments (<24h)	=> %	98.0	98.0		Sep 2015	100.0	100.0			
3			TIA (High Risk) Treatment <24 Hours from receipt of referral	=> %	70.0	70.0		Sep 2015	96.8	97.6			
3			TIA (Low Risk) Treatment <7 days from receipt of referral	=> %	75.0	75.0		Sep 2015	97.3	98.3			
9			Primary Angioplasty (Door To Balloon Time 90 mins)	=> %	80.0	80.0		Sep 2015	84.6	92.7			
9			Primary Angioplasty (Call To Balloon Time 150 mins)	=> %	80.0	80.0		Sep 2015	84.6	93.1			
9			Rapid Access Chest Pain - seen within 14 days	=> %	98.0	98.0		Sep 2015	92.1	97.8			



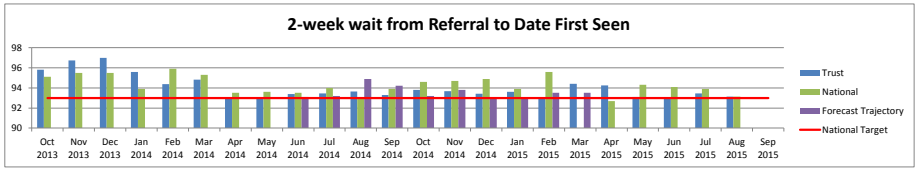


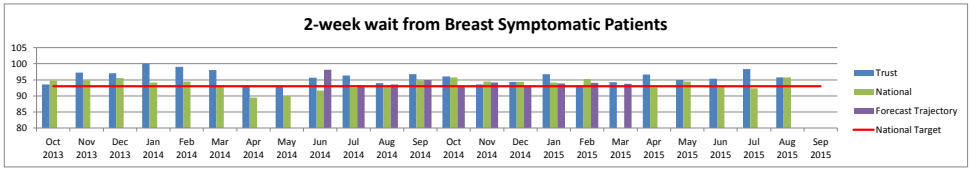


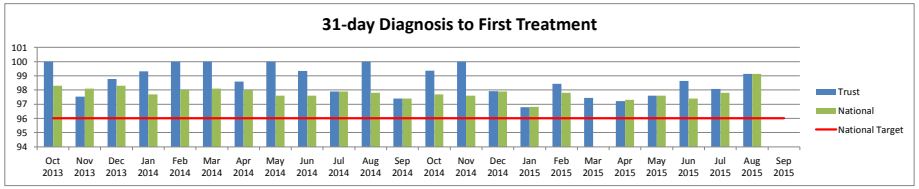
Clinical Effectiveness - Cancer Care

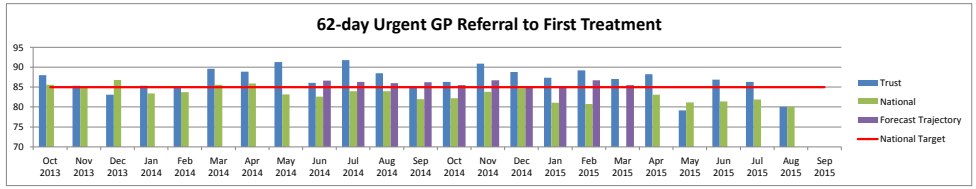
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Apr 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
1			2 weeks	=> %	93.0	93.0																			Aug 2015	93.6	92.4	95.2	92.6					93.1	93.4			
1			2 weeks (Breast Symptomatic)	=> %	93.0	93.0																			Aug 2015		-							95.8	96.3			
1			31 Day (diagnosis to treatment)	=> %	96.0	96.0																			Aug 2015	100.0	98.6	100.0	100.0					99.1	98.1			
1			31 Day (second/subsequent treatment - surgery)	=> %	94.0	94.0																		Nil	Aug 2015									-	98.4			
1			31 Day (second/subsequent treatment - drug)	=> %	98.0	98.0																			Aug 2015									100.0	98.3			
1			31 Day (second/subsequent treat - radiotherapy)	=> %	94.0	94.0																			Aug 2015									-	0.0			
1			62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																			Aug 2015	93.3	70.8	100.0	82.4					80.0	84.7			
1			62 Day (referral to treat from screening)	=> %	90.0	90.0																			Aug 2015	0.0	94.4	0.0	0.0					94.4	95.9			
1			62 Day (referral to treat from hosp specialist)	=> %	90.0	90.0																			Aug 2015	100.0	100.0	100.0	100.0					100.0	89.6			
1			Cancer - Patients Waiting over 62 days	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	12	-	Aug 2015	1.0	9.5	0.0	1.5					12.0	12.0			
1			Cancer - Patients Waiting over 104 days	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	4.5	7.0	-	Aug 2015	0.0	6.0	0.0	1.0					7.0	11.5			
1			Cancer - Longest Waiter in days	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	180	147	-	Aug 2015	97	147	51	130					147				

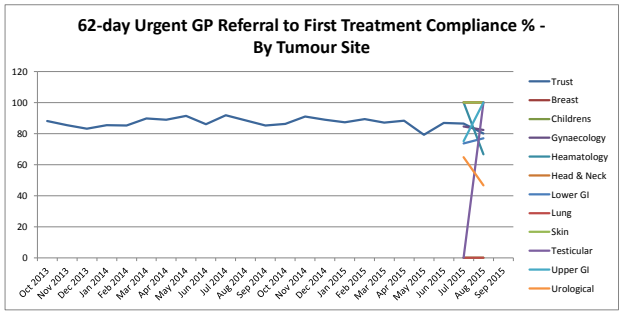
Cancer - Patients Waiting (over 62 days) By Tumour Site				Data Period	Breast	Childrens	Gynae	Haematology	Head & Neck	Lower GI	Lung	Skin	Testicular	Upper GI	Urology	Total
Breaches	No			Aug 2015	0.0	0.0	1.5	1.0	0.0	1.5	0.0	0.0	0.0	0.0	8.0	12.0
Compliance	%			Aug 2015	100.0	-	82.4	66.7	100.0	76.9	-	100.0	100.0	100.0	46.7	80.0

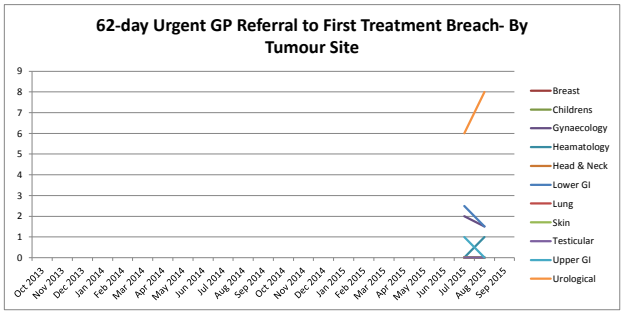












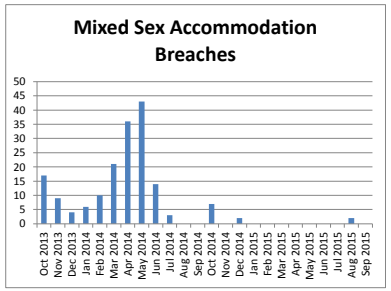
NOTES:

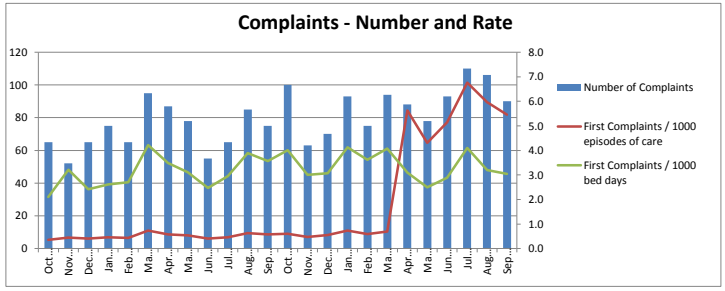
The longest waiting patient is at 147 days (Urology). Action plan is in place for Urology which will change the pathway from 1 November. This will enable a cohort of patients to have their TRUS biopsy before there MRI and therefore reducing the pathway before referral onto the tertiary centre for surgery.

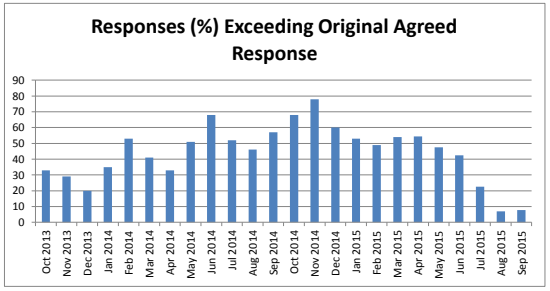
The service projects to achieve the September 62 day target, hence will deliver Q2 performance. However, predication are that in October the 62day target will be missed.

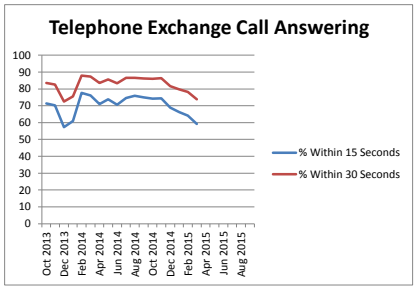
Patient Experience - FFT, Mixed Sex Accommodation & Complaints

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Apr 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	=> %	30.0	30.0	36	44	45	41	32	31	28	31	28	33	43	43	29	31	31	28	25	22	Sep 2015									22				
8		a	FFT Score - Inpatients	=> No	60.0	60.0	74	74	70	73	76	74	73	73	69	70	68	72	95	95	95	96	95	95	Sep 2015									95				
8		b	FFT Response Rate Emergency Department (Type 1 Only)	=> %	20.0	20.0	15	16	16	16	17	17	17	18	17	18	21	22	9.9	8.4	7.2	9.4	9.6	7.5	Sep 2015	7.5								7.5				
8		a	FFT Score - Emergency Department (Type 1 Only)	=> No	46.0	46.0	47	49	48	47	49	47	48	49	49	50	44	52	79	79	79	84	88	83	Sep 2015	83								83				
13		a	Mixed Sex Accommodation Breaches	<= No	0.0	0.0	36	43	14	3	0	0	7	0	2	0	0	0	0	0	0	0	2	0	Sep 2015	0	0	0	0		0	0		0	2			
9			No. of Complaints Received (formal and link)	No			87	78	55	65	85	75	100	63	70	93	75	94	88	78	93	110	106	90	Sep 2015	29	15	16	10	0	4	5	11	90	565			
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	170	174	143	Sep 2015	58	23	19	13	0	7	7	16	143				
9		a	No. of First Formal Complaints received / 1000 bed days	Rate1			3.5	3.1	2.5	2.9	3.9	3.6	4.0	3.0	3.1	4.1	3.6	4.1	3.1	2.5	2.9	4.1	3.2	3.0	Sep 2015	2	4	23	2.2					3.04	3.13			
9			No. of First Formal Complaints received / 1000 episodes of care	Rate1			0.6	0.5	0.4	0.5	0.6	0.6	0.6	0.5	0.6	0.7	0.6	0.7	5.6	4.3	5.1	6.8	6.0	5.5	Sep 2015	4.3	7.2	11	3.8			0		5.46	5.55			
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	100	99	98	100	99	100	100	100	100	100	Sep 2015	100	100	100	100	0	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	54	47	42	22	7.1	7.7	Sep 2015	14	3.6	5.3	0	0	14	0	0	8				
9			No. of responses sent out	No			117	30	4	138	66	42	35	26	198	59	52	84	56	115	102	129	77	107	Sep 2015	45	15	15	10	1	7	3	11	107				
9			Oldest' complaint currently in system	No			104	124	145	127	133	131	174	161	182	192	213	234	254	188	210	186	208	136	Sep 2015	136	125	83	57	0	62	10	27	136				
14		e	Access to healthcare for people with Learning Disability (full compliance)	Yes / No	Yes	Yes																	-	-	Sep 2015	N	N	N	N	N	N	N	N	No				



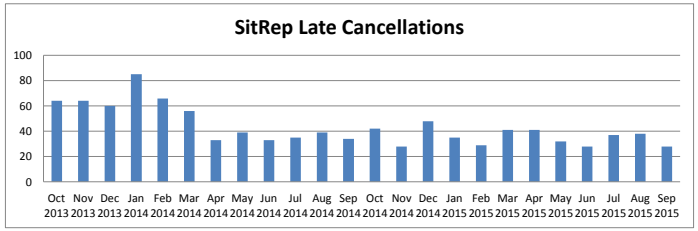


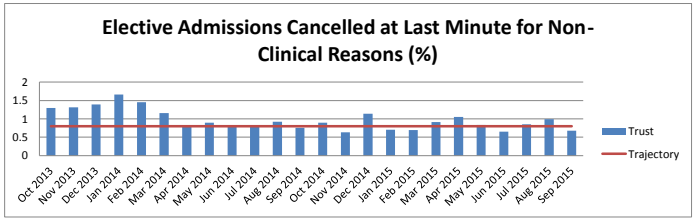


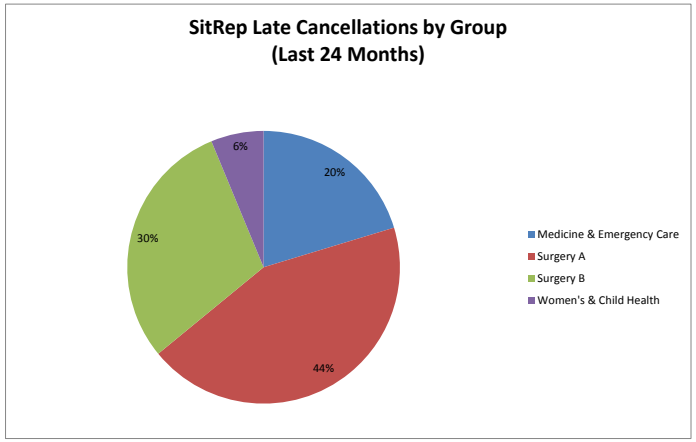


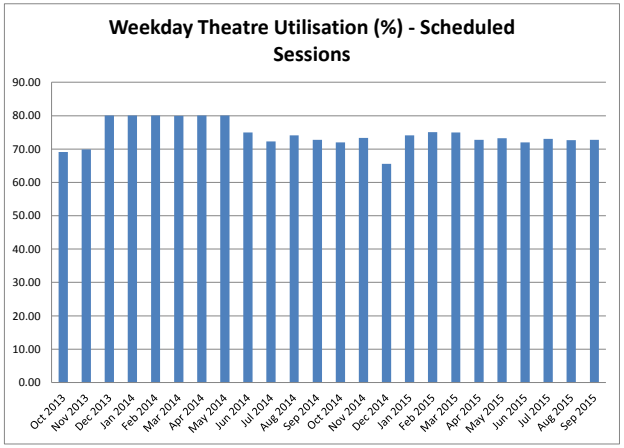
Patient Experience - Cancelled Operations

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Apr 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																				Sep 2015	0.06	1.26	0.67	2.15					0.7	0.8			
2			Number of 28 day breaches	<= No	0	0	1	1	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1		Sep 2015	0	1	0	0					1	1			
2			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	0	0	0		Sep 2015	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	32	28	37	38	28		Sep 2015	0	13	8	7					28	204			
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	4	1	0	0	0		Sep 2015	0	0	0	0					0	5			
3			Multiple Cancellations experienced by same patient (all cancellations)	<= %	0.0	0.0	12	7	10	12	11	13	11	14	10	11	13	12	11	13	13	13	10	10		Sep 2015	7.1	15.8	8.7	5.9					10.5				
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	5	5	5	5	6	5		Sep 2015	1.7	6.9	8.8	7.4					5.32				
3			Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0																				Sep 2015	33.4	77.9	73.6	78.9					72.7				
2			Urgent Cancellations	<= No	0.0	0.0	-	-	-	-	-	-	-	-	-	-	-	-	11	5	6	0	7	3		Sep 2015	1.0	2.0	0.0	0.0					3.0	32			



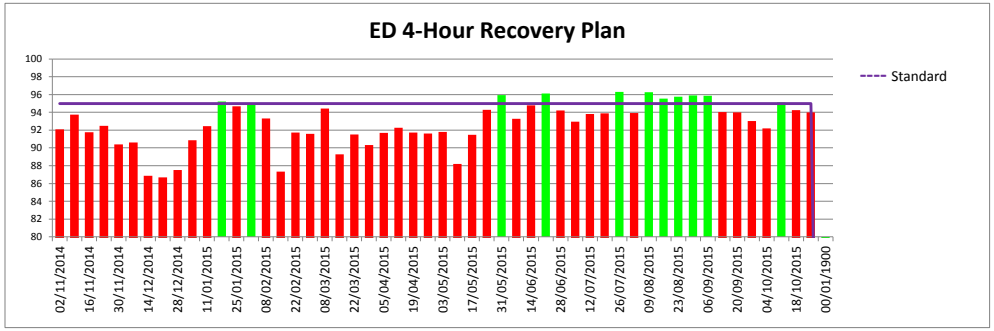


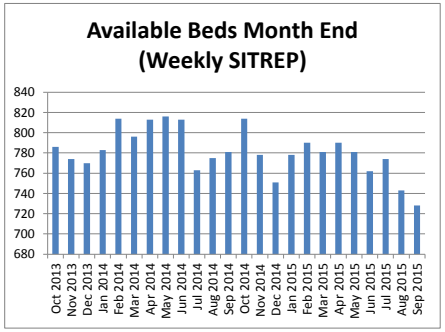


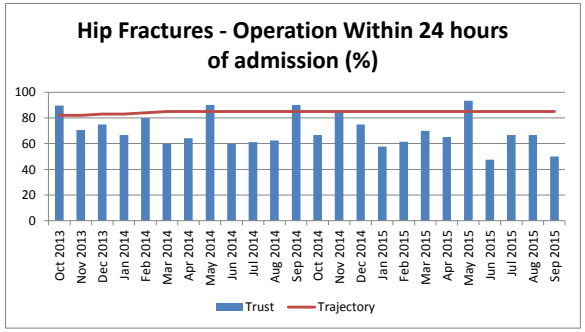


Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (From) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend	Next Month	3 Months
2			Emergency Care 4-hour waits	=> %	95.00	95.00																			Sep 2015	94.2	92.6	96.9	93.74	93.77			
2			Emergency Care 4-hour breach (numbers)	No			741	1210	1277	1122	876	1460	1636	1440	2234	1054	1481	1695	1527	1406	1037	1086	741	1138	Sep 2015	430	643	65	1138	6935			
2			Emergency Care Trolley Waits >12 hours	<= No	0.00	0.00																			Sep 2015	0	0		0	0			
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.00	15.00																			Sep 2015	16	16	14	16	17			
3			Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			Sep 2015	43	55	17	44	50			
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			Sep 2015	7.78	7.95	3.24	7.27	7.66			
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Sep 2015	3.54	5.46	1.87	4.23	4.43			
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	43	116	90	72	58	76	Sep 2015	19	57		76	455			
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	13	8	8	8	1	13	21	14	31	7	6	8	9	8	3	3	2	1	Sep 2015	1	0		1	26			
11			WMAS - Handover Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Sep 2015	0.06	0.00		0.02	0.12			
11			WMAS - Emergency Conveyances (total)	No			4044	4227	4093	4278	3994	4067	4193	4168	4470	4001	3829	4182	3981	4214	114	4256	4241	4016	Sep 2015	1687	2329		4016	20822			
2			Delayed Transfers of Care (Acute) (%)	<= %	3.5	3.5																			Sep 2015	1.4	3.1		2.2	2			
2			Delayed Transfers of Care (Acute) (Av./Week) attributable to NHS	<= No	<10 per site	<10 per site																			Sep 2015	4.5	8		13				
2			Patient Bed Moves (10pm - 8am) (No.) -ALL	No			668	751	722	751	694	681	720	646	806	651	683	743	675	737	612	682	646	731	Sep 2015				731	4083			
2			Patient Bed Moves (10pm - 8am) (No.) - exc. Assessment Units	No			312	331	330	329	339	276	353	293	323	250	302	293	267	333	270	284	272	318	Sep 2015				318	1744			
3			Hip Fractures - Operation < 24 hours of admission (%)	=> %	85.0	85.0																			Sep 2015				50	65.2			

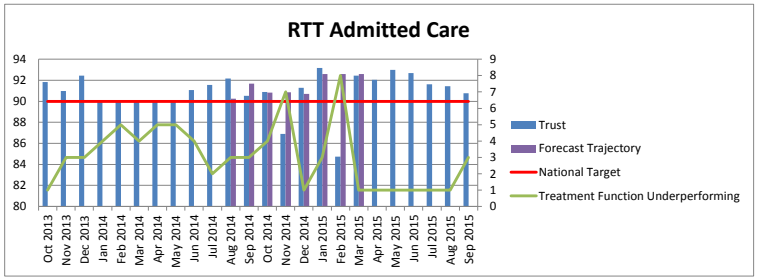


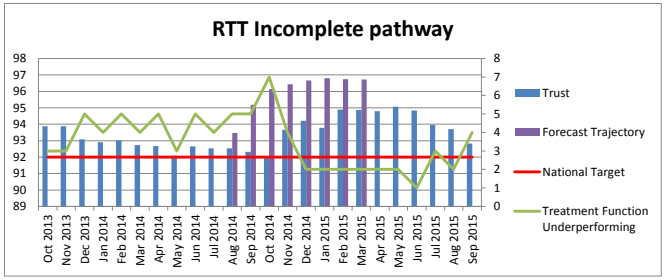


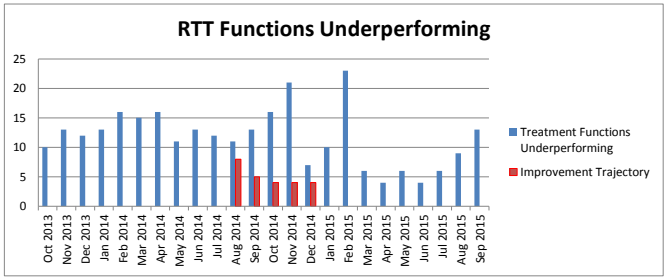


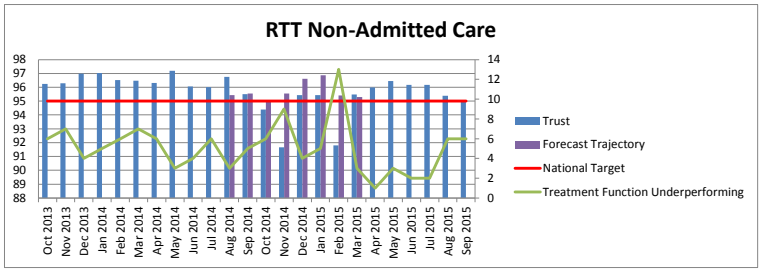
Referral To Treatment

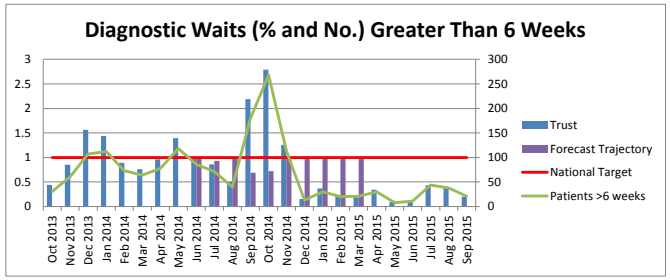
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Apr 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2		e	RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Sep 2015	92.5	80.8	91.1	93.9					90.78				
2		e	RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Sep 2015	95.9	93.0	95.7	97.4					95.01				
2		e	RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Sep 2015	92.2	91.5	92.8	97.8					92.83				
2		e	Patients Waiting >52 weeks	<= No	0	0	1	2	2	3	4	4	3	3	0	4	3	4	1	2	1	3	5	2	Sep 2015	0	1	1	0.0					2				
2			Treatment Functions Underperforming	<= No	0	0	16	12	13	12	11	13	16	19	8	10	23	6	4	6	4	6	9	12	Sep 2015	3	8	1	0.0					13				
2		e	Acute Diagnostic Waits in Excess of 6-weeks	<= %	1.0	1.0	1	1.4	1	0.9	0.5	2.2	3.2	1.1	0.2	0.4	0.2	0.2	0.3	0.1	0.1	0.4	0.4	0.2	Sep 2015	1.0	0.8	0.0	0.0		0.0			0.20				

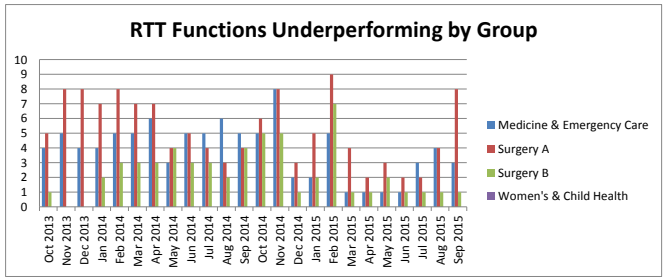










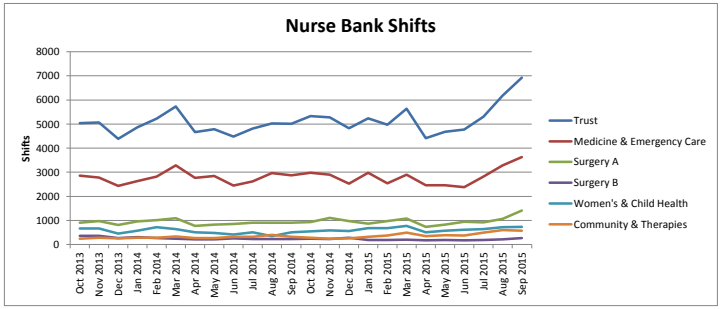


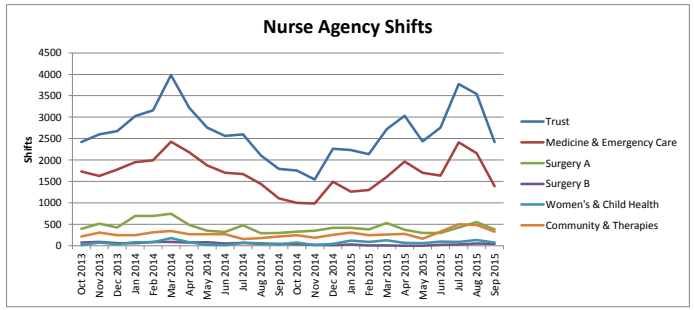
Data Completeness

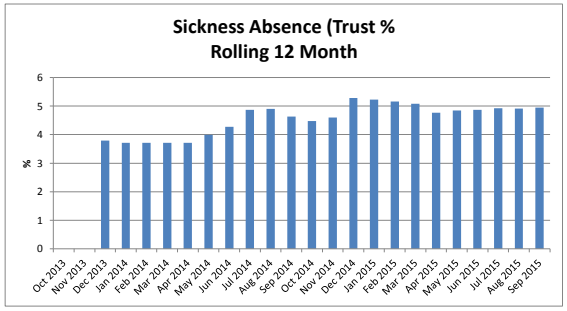
Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Apr 2014) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Data Completeness Community Services	=> %	50.0	50.0																			Sep 2015								61	61.19				
2			Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Aug 2015									99.43				
2			Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Aug 2015									98.57				
2			Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	=> %	99.0	99.0																		-	Aug 2015									99.16				
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	96.6	96.3	96.5	95.8	96.5	Sep 2015										96.5	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	99.5	99.4	99.5	Sep 2015										99.5	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	96.9	96.9	96.3	96.0	96.7	Sep 2015										96.7	96.6			
2			Ethnicity Coding - percentage of inpatients with recorded response	=> %	90.0	90.0																			Sep 2015										90.73	91.32			
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	indicator no longer reported										Dec 2014										98.7				
2			Maternity - Percentage of invalid fields completed in SUS submission	<= %	15.0	15.0																			Sep 2015										38.91	38.9			
2			Open Referrals	No			-	-	-	-	-	-	-	-	-	-	-	-	173,131	180,758	183,245	191,411	203,025	208,990	Sep 2015	72,441	40,315	66,371	26,342	3,276	198	47		208,990				

Staff

Data Source	Data Quality	PAF	Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend (since Apr 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	689	888	831	733	763	823	842	Sep 2015	261.3	122	57	97	40	50	114	100	842				
3		b	PDRs - 12 month rolling	=> %	95.0	95.0																			Sep 2015	84.23	83.7	79	86	91	72	87	84		87.91			
7		b	Medical Appraisal and Revalidation	=> %	95.0	95.0													-						Sep 2015	82.22	81.5	77	79	69	86	0	100		87.99			
3		b	Sickness Absence (Rolling 12 Months)	<= %	3.15	3.15																			Sep 2015	5.01	5.24	3.2	5.6	4.4	4.5	5.3	4.8	4.94	4.88			
3			Return to Work Interviews following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-		-	-					Sep 2015	61.1	64.3	53.6	60.4	79.7	46.6	79.6	72.3	65.65	64.09			
3			Mandatory Training	=> %	95.0	95.0																			Sep 2015	81.8	87.6	85.3	82.5	95.3	84.9	88.4	89.5		87.47			
3			Mandatory Training - Health & Safety (% staff)	=> %	95.0	95.0																			Sep 2015	96.48	98.4	96	96	100	95	98	99		97.8			
7		b	Staff Turnover (rolling 12 months)	<= %	10.0	10.0																			Sep 2015									13.9	13.4			
7			New Investigations in Month	No			1	4	6	5	2	15	3	1	0	3	4	5	8	11	5	8	4	5	Sep 2015	3	0	0	1	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	25	27	25	Sep 2015									25				
7			Professional Registration Lapses	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	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	303	321	320	Sep 2015									320.2				
10			Nurse Bank Fill Rate	=> %	100.0	100.0	76	82	82	80	77	78	78	82	73	78	78	78	75	81	81	79	80	87	Sep 2015	84.22	85.8	96	95	100	99	92	99	87.22	81.0			
10			Nurse Bank Shifts Not Filled	<= No	0	0	1723	969	919	1087	1802	1370	1086	1440	1727	1716	1432	1487	1532	1378	1073	1622	1423	1207	Sep 2015	811	272	13	51	0	2	56	2	1207	8235			
10			Nurse Bank Use (shifts)	<= No	46980	3915																			Sep 2015	3633	1408	267	737	8	145	574	157	6929	32279			
10			Nurse Agency Use (shifts)	<= No	0	0																			Sep 2015	1389	377	44	69	5	190	327	20	2421	17962			
10			Admin & Clerical Bank Use (shifts)	<= No	0	0	-																		Sep 2015	1069	230	148	60	561	171	290	###	5682	32742			
10			Admin & Clerical Agency Use (shifts)	<= No	0	0	-																		Sep 2015	0	48	22	0	0	0	0	104	174	1106			
			Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-	-	-	-	-	-	-			
15			Your Voice - Response Rate	No			-->	19.8	-->	-->	18.2	-->	-->	17.4	-->	12.6	12.7	-->	-->	-->	13.9	-->	-->	15.3	Sep 2015	6	10	15	12	24	24	31	19	15.3				
15			Your Voice - Overall Score	No			-->	3.63	-->	-->	3.68	-->	-->	3.65	-->	3.57	3.55	-->	-->	-->	3.59	-->	-->	3.51	Sep 2015	3.45	3.37	3.6	3.6	3.6	3.1	3.7	3.5	3.51				







CQUIN (I)

	Data Quality	CQUIN	Values (£000)	Indicator	Trajectory / Notes	Q1	Q2	Q3	Q4	Monthly Trend A M J J A S O N D J F M	Comments	Data Period	Year To Date	Trend	Next Month	3 Months
1		National	£795	Acute Kidney Injury	Improvement from previous Quarter	Derive Base Data	Improvement to last Qtr - GP Letter Pilot Oct	Improvement to last Qtr	Improvement to last Qtr	Q1 Met ● ● ● - - - - -		Sep-15	●	●	●	●
2		National	£396	Sepsis Screening	Improvement from base to agreed target	Derive Base Data	Target set at 32.5%	Improvement to Target	Improvement to Target	Q1 Met ● ● ● - - - - -	Patient correctly assessed and treated, however the process does not fully qualify. In October Patient First implemented.	Sep-15	●	●	●	●
3		National	£400	Sepsis Antibiotic Administration	90% by Q4	Establish Audit Mech.	CCG aware - small samples	Work towards 90%	90% Achieved	Q1 Met ● ● ● - - - - -		Sep-15	●	●	●	●
4		National	£455	Dementia - Find, Assess, Investigate, Refer & Inform	90% (each of 3 elements) in Q4	Carry fwd from last year	Query with CCG - inform?	Work towards 90%	90% Achieved	Q1 Met ● - - - - -		Sep-15	●	●	●	●
5		National	£170	Dementia - Staff Training	Target tba - Qly reports to Board	Carry fwd from last year	Work towards 90%	Work towards 90%	90% Achieved	Q1 Met ● - - - - -		Aug-15	●	●	●	●
6		National	£170	Dementia - Supporting Carers	Bi-annual reports to Board	Carry fwd from last year	Work towards 90%	Work towards 90%	90% Achieved	Q1 Met ● - - - - -		Sep-15	●	●	●	●
7		National	£1,591	Improvement in diagnosis recording in HES Data Set of Mental Health presentations	85% in one month	Qly Data Collection	Achieve 85% in one month to complete CQUIN - already achieved in July & August at 99%			Q1 Met ● ● ● ● ● ● ● ●		Sep-15	●	●	●	●
8		Local	£406	Community Therapies - Dietetics Community Communication with GPs	Deliver outstanding actions from 14 / 15	One data submission at end of Q2				Met		Sep-15	●			
9		Local	£989	Reduce Number of Ward Transfers experienced by patients with Dementia	Agree improvement trajectory from base	Derive Base Data	Improvement Required	Improvement Required	Improvement Required	Q1 Met ● ● ● - - - - -		Sep-15	●	●	●	●
10		Local	£989	Reduce Number of Out Of Hours Patient Transfers	Agree improvement trajectory from base	Derive Base Data	Improvement Required	Improvement Required	Improvement Required	Q1 Met ● ● ● - - - - -		Sep-15	●	●	●	●
11		Local	£1,591	Safeguarding	Carry Forward from last year	Report to Board (Pat Story)	Report to Board (Pat Story)			Q1 Met ● ● ●		Sep-15	●	●	●	●
12		Spec.	£118	Reduce Number of Consultant-Led Follow Up OP Attendances	Implement plans to & monitor FUN ratio	Formulate Plans	Sign Off of Plans	Monitor & Improve	Monitor & Improve	Q1 Met ● ● ● - - - - -	Discussion with SCG required (IK)	Sep-15	●	●	●	●
13		Spec.	£118	HIV - Reducing Unnecessary CD4 Monitoring	90% pts have no more than 1 CD4 count in 9m	Qly Data Collection	Qly Data Collection	Qly Data Collection	Qly Data Collection	Q1 Met ● ● ● - - - - -		Sep-15	●	●	●	●
14		Spec.	£118	Haemoglobinopathy Networks - develop partnership working, define pathways and protocol	Publish agreed care p'ways and protocols	Set Up initial network meet				Q1 Met ● ● ● - - - - -	Discussion with SCG required (JS)	Sep-15	●	●	●	●
15		Spec.	£118	Breast Cancer - help patients make more informed choices regarding treatment	Provion of anon. pt. Datasets	Derive Base Data	Qly Data Collection	Qly Data Collection	Qly Data Collection	Q1 Met ● ● ● - - - - -		Sep-15	●	●	●	●
16		Spec.	£118	Bechet's Disease (Highly Specialised Service) - set up clinical outcome collaborative workshop	Submit Quarterly return	Qly Data Collection	Qly Data Collection	Qly Data Collection	Qly Data Collection	Q1 Met ● ● ● - - - - -		Sep-15	●	●	●	●

CQUIN (II) and summary

	Data Quality	CQUIN	£ Values	Indicator	Note	Trajectory		Previous Months Trend											Data Period	Comments	Year To Date	Trend	Next Month	3 Months
						Year	Month	A	M	J	J	A	S	O	N	D	J	F	M					
17		Public Health	£94	Breast Screening - improvement in uptake	Annual Report			Q1 Met		●	●	●	-	-	-	-	-	-	-	Sep-15	Patient letter gone out, but 6mths period in which to attend screening so results not visible as yet	●	●	●	●
18		Public Health	£42	Bowel Screening - improvement in uptake	Annual Report			Q1 Met		●	●	●	-	-	-	-	-	-	-	Sep-15	Patient letter gone out, but 6mths period in which to attend screening so results not visible as yet	●	●	●	●
19		Public Health	£154	Maternity and Health Visiting Services - Integrated working	Implement Shared Assessment Framework			Q1 Met		●	●	●	-	-	-	-	-	-	-	Sep-15	BadgerNet used to facilitate sharing	●	●	●	●
20		Local	£0	Falls Medication	Still pending base-lining			Not active Q1		Not active Q2		-	-	-	-	-	-	-	-	Sep-15	Starting after Q2, baseline discussions being held	-	-		

The Trust is contracted to deliver a total of 20 CQUIN schemes during 2015 / 2016. 7 schemes are nationally mandated, a further 5 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.**

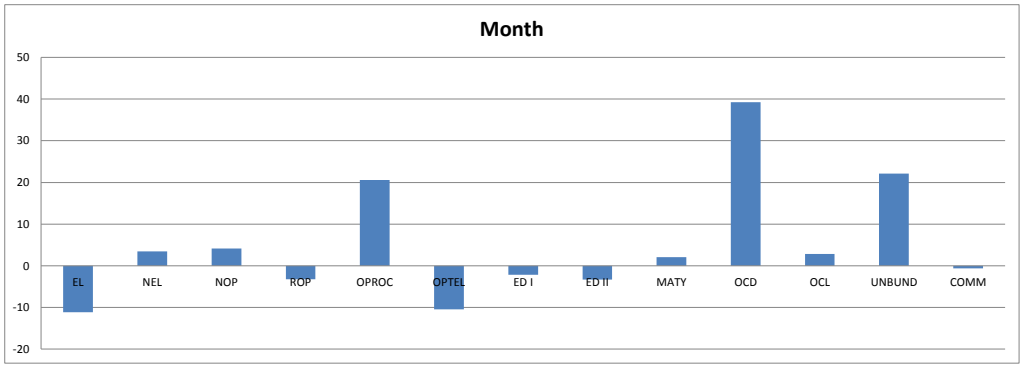
Q2 reporting is progressing for the end of October and submissions are due to CCG and SCG following which feedback will be received. Public Health has yet to issue returns requirements.

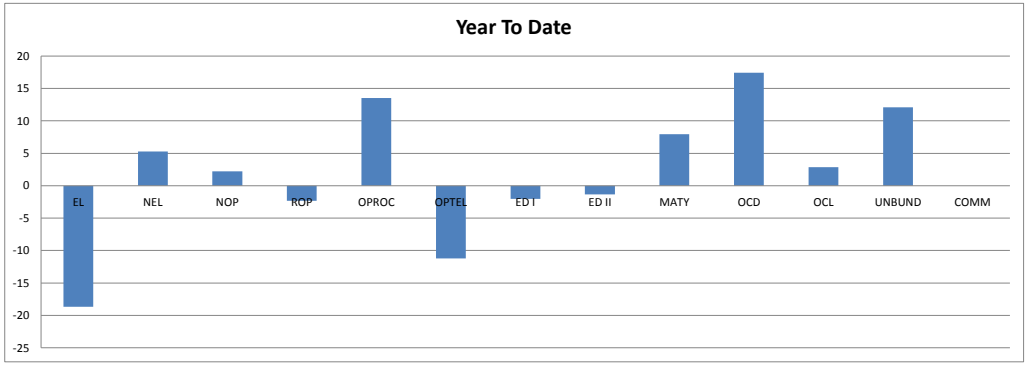
As at September month reporting, a failing scheme will be reported (Sepsis A). The financial impact is c£65-100k. Failure lies mainly in the process rather than not treating patients appropriately. Other schemes (rated amber) have elements which are delivering but are not holistically doing so; further discussions with SCG and Public Health need to take place and Head of Income/CQUIN Lead is progressing. Monthly meetings have now been put in place to monitor CQUIN performance with relevant group leads and senior group leadership. The CQUIN summaries here present a reasonable assessment based on CQUIN leads' assessments.

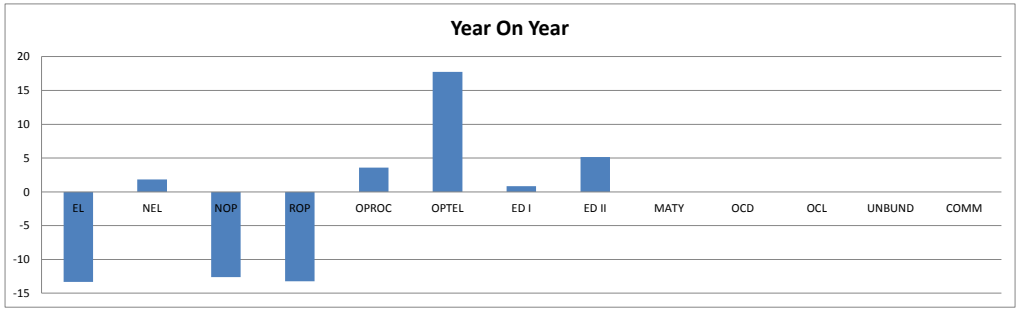
Monthly performance meetings have been put in place to monitor performance more regularly. Quarterly confirm and challenge meetings with Lead Executive also take place.

Activity Summary

Data up to Sept 2015







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.

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

There has been some movement in point of activity delivery since plans were set with activity in plans as daycase procedures now recorded in the outpatient setting, however performance in the month of September does demonstrate improved elective (including daycase) and OP Procedure delivery as recovery plans are implemented.

Occupied cot day overperformance in month is driven by a greater number of high dependency days against plan

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

Finance Summary

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (O N D J F M A M J J A S O N D J F M)	RAG	Data Period	Group (M A W B C P I CO)	Month	Year To Date	Trend	Next Month	3 Months
						100 200 300 400 500 600 700 800								
18		f	Bottom Line Income & Expenditure position - Forecast compared to plan £m	£0.0			GREEN	Sep-15		£0.000				
18		f	Bottom Line Income & Expenditure position - Year to Date Actual compared to plan £m	£0.0	£0.0		RED	Sep-15	-3.1 -2.4 -1.5 -1.5 -0.1 -0.2 -1.2 -0.5		-£2.004			
18		f	Actual efficiency recurring / non-recurring compared to plan - Year to Date actual compared to plan	£0.0	£0.0		GREEN	Sep-15	-0.1 -1.2 0.2 -0.3 0.2 0.2 0.3 -0.4		£0.155			
18		f	Actual efficiency recurring / non-recurring compared to plan - Forecast compared to plan	£0.0			AMBER	Sep-15	1.1 -3.0 -0.3 -0.3 0.1 0.0 0.9 -2.6		£0.000			
18		f	Forecast underlying surplus / deficit compared to plan	£0.0			GREEN	Sep-15			£0.000			
18		f	Forecast year end charge to capital resource limit	£22.8			GREEN	Sep-15		£20.153				
18		f	Is the Trust forecasting permanent PDC for liquidity purposes?	No			GREEN	Sep-15		£0.000				
18		b	Temporary costs and overtime as % total paybill	2.6%	2.6%		RED	Sep-15	11.7% 4.8% 1.4% 1.3% 10.5% 0.0% 7.2% 3.2%	6.0%	6.1%			
18			Financial Sustainability Risk Ratings from M6 (Continuity of Services Risk Ratings for M3 to M5)	3			GREEN	Sep-15			3.0			

MONTHLY: PASTE IN TDA KEY METRICS PAGE TO THIS FILE

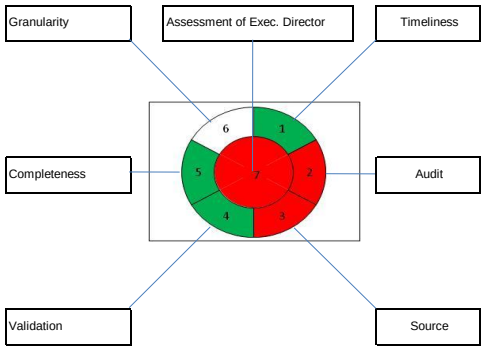
Legend

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

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

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

Data Quality - Kitemark



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

Red	Insufficient
Green	Sufficient
White	Not Yet Assessed

The centre of the indicator is colour coded as follows:

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

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

Medicine Group

Indicator	Measure	Trajectory		Previous Months Trend																Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
C. Difficile	<= No	30	3																			Sep 2015	0	0	0	0	12			
MRSA Bacteraemia	<= No	0	0																			Sep 2015	0	0	0	0	1			
MRSA Screening - Elective (%)	=> %	80	80																			Sep 2015	78	74	35	62.3				
MRSA Screening - Non Elective (%)	=> %	80	80																			Sep 2015	91	92	93	90.8				
Falls	<= No	0	0	33	40	61	42	44	41	67	50	66	63	42	52	43	47	42	39	41	40	Sep 2015	16	18	6	40	252			
Falls with a serious injury	<= No	0	0	1	3	3	1	4	1	1	2	0	1	0	1	1	0	1	5	0	1	Sep 2015	1	0	0	1	8			
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	2	3	3	3	0	5	3	6	7	10	1	1	8	3	6	2	0	6	Sep 2015	0	0	0	6	25			
Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Sep 2015	92.2	84.2	98.0	93.9				
WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0	98.0																			Sep 2015	98.2	100.0	100.0	98.5				
WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0	95.0																			Sep 2015	99	0	0	99.2				
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0	85.0																			Sep 2015	99	0	0	99.2				
Never Events	<= No	0	0																			Sep 2015	0	0	0	0	0			
Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	Sep 2015	0	0	0	0	1			
Serious Incidents	<= No	0	0																			Sep 2015	0	0	0	0	7			
Mortality Reviews within 42 working days	=> %	100	98																	-	-	Jul 2015	88	86	82	85				

Indicator		Trajectory		Previous Months Trend																		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																			Sep 2015		88.7		88.7	90.5			
Pts admitted to Acute Stroke Unit within 4 hrs (%)	=> %	90.0	90.0																			Sep 2015		80.9		80.9	81.3			
Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			Sep 2015		75.0		75.0	75.2			
Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.0																			Sep 2015		100.0		100.0	99.4			
Stroke Admission to Thrombolysis Time (% within 60 mins)	=> %	85.0	85.0																			Sep 2015		100.0		100.0	82.4			
Stroke Admissions - Swallowing assessments (<24h) (%)	=> %	98.0	98.0																			Sep 2015		100.0		100.0	100.0			
TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=> %	70.0	70.0																			Sep 2015		96.8		96.8	97.6			
TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=> %	75.0	75.0																			Sep 2015		97.3		97.3	98.3			
Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=> %	80.0	80.0																			Sep 2015		84.6		84.6	92.7			
Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=> %	80.0	80.0																			Sep 2015		84.6		84.6	93.1			
Rapid Access Chest Pain - seen within 14 days (%)	=> %	98.0	98.0																			Sep 2015		92.1		92.1	97.8			
2 weeks	=> %	93.0	93.0																		-	Aug 2015			93.6	93.6				
31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Aug 2015			100.0	100.0				
62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Aug 2015			93.3	93.3				
Mixed Sex Accommodation Breaches	<= No	0.0	0.0	36	43	14	0	0	0	7	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0	0	0	0	0			
No. of Complaints Received (formal and link)	No			-	38	28	28	32	36	48	18	31	30	36	38	41	35	41	53	36	29	Sep 2015	18	7	4	29	235			
No. of Active Complaints in the System (formal and link)	No			-	117	129	106	130	131	156	149	93	106	126	117	112	104	87	90	74	58	Sep 2015	31	16	11	58				
Oldest' complaint currently in system (days)	No			-	124	145	127	133	131	174	161	182	188	209	230	250	188	210	186	208	136	Sep 2015	62	136	46	136				

Indicator	Measure	Trajectory		Previous Months Trend																		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																			Sep 2015	-	-	0.06	0.06				
28 day breaches	<= No	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0.0	0.0	0.0	0	0			
Sitrep Declared Late Cancellations	<= No	0	0	10	2	7	7	3	2	5	4	1	0	0	9	8	1	2	4	7	0	Sep 2015	0.0	0.0	0.0	0	22			
Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	43	43	60	50	61	54	57	60	62	61	49	48	54	60	46	47	45	33	Sep 2015	0.0	0.0	33.4	33.4				
Emergency Care 4-hour waits (%)	=> %	95.0	95.0																			Sep 2015	94.2	92.6	Site S/C	93.3	93.1			
Emergency Care 4-hour breach (numbers)	No			570	1003	1016	907	736	1201	1390	1181	1913	940	1242	1412	'	'	'	'	'	'	Mar 2015	1361	4	47	1412	13511			
Emergency Care Trolley Waits >12 hours	<= No	0	0																			Sep 2015	0.0	0.0	Site S/C	0	0			
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15.0	15.0																			Sep 2015	16.0	16.0	Site S/C	16	17			
Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60.0	60.0																			Sep 2015	43.0	55.0	Site S/C	50	57			
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5.0	5.0																			Sep 2015	7.8	8.0	Site S/C	7.9	8.3			
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5.0	5.0																			Sep 2015	3.5	5.5	Site S/C	4.6	4.8			
WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	<= No	0	0	119	136	125	145	51	136	219	159	282	185	149	164	43	116	90	72	58	76	Sep 2015	19	57		76	455			
WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	<= No	0	0	13	8	8	8	1	13	21	14	31	7	6	8	9	8	3	3	2	1	Sep 2015	1	0		1	26			
WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	<= %	0.02	0.02																			Sep 2015	0.06	0.00		0.02	0.12			
WMAS - Emergency Conveyances (total)	No			4044	4227	4093	4278	3994	4067	4193	4168	4470	4001	3829	4182	3981	4214	114	4256	4241	4016	Sep 2015	1687	2329		4016	20822			

Indicator	Measure	Trajectory		Previous Months Trend																	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																			Sep 2015	0.0	91.5	93.1	92.5				
RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0	95.0																			Sep 2015	0.0	96.9	95.4	95.9				
RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0	92.0																			Sep 2015	0.0	92.1	92.2	92.2				
Patients Waiting >52 weeks	<= No	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0	Sep 2015	0	0	0	0				
Treatment Functions Underperforming	<= No	0	0	6	3	5	5	6	5	5	7	2	2	6	1	1	1	1	3	4	3	Sep 2015	0	1	2	3				
Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Sep 2015	0	1.41	0	1.01				
WTE - Actual versus Plan	No			171	161	157	151	166	160	166	197	232	242	244	176	200	200	219	236	262	261	Sep 2015	119.1	74.1	64.1	261				
PDRs - 12 month rolling (%)	=> %	95.0	95.0																			Sep 2015	87.57	81.79	84.49		86.6			
Medical Appraisal and Revalidation	=> %	95.0	95.0													-						Sep 2015	86.36	93.55	70.27		84.2			
Sickness Absence (%)	<= %	3.15	3.15																			Sep 2015	4.82	5.38	4.68	5.01	4.84			
Return to Work Interviews (%) following Sickness Absence	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-		-	-					Sep 2015	61.2	68.9	35.0		59.81			
Mandatory Training (%)	=> %	95.0	95.0																			Sep 2015	82.82	80.86	82.09		83.1			
New Investigations in Month	No			1	1	1	2	1	2	1	0	0	1	2	2	2	1	1	2	1	3	Sep 2015	3	0	0	3				
Nurse Bank Fill Rate %	=> %	100	100	'	'	'	'	'	'	'	'	'	'	'	72	2528	3008	2311	3287	3019	4330	Sep 2015				84				
Nurse Bank Shifts Not Filled (number)	<= No	0	0	'	'	'	'	'	'	'	'	'	'	'	1031	1136	1055	771	1146	977	811	Sep 2015				811				
Nurse Bank Use	<= No	34560	2880																			Sep 2015				3633	17036			
Nurse Agency Use	<= No	0.00	0.00																			Sep 2015				1389	11254			
Admin & Clerical Bank Use (shifts)	<= No	0.00	0.00	-																		Sep 2015				1069	5917			
Admin & Clerical Agency Use (shifts)	<= No	0.00	0.00	-																		Sep 2015				0	249			
Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00				-	-			
Your Voice - Response Rate (%)	No			-->	8	-->	-->	9	-->	-->	9	-->	-->	6	-->	-->	-->	6	-->	-->	6	Sep 2015	5.0	3.0	15.0	6.0				
Your Voice - Overall Score	No			-->	3.68	-->	-->	3.76	-->	-->	3.76	-->	-->	3.57	-->	-->	-->	3.49	-->	-->	3.45	Sep 2015	3.35	3.79	3.36	3.45				

Surgery A Group

Indicator	Measure	Trajector Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Directorate A	B	C	D	Month	Year To Date	Trend	Next Month	3 Months
C. Difficile	<= No	1																			Sep 2015	1	0	0	0	1	2			
MRSA Bacteraemia	<= No	0																			Sep 2015	0	0	0	0	0	0			
MRSA Screening - Elective	=> %	80																			Sep 2015	96.3	97.35	96.03	0	96.6				
MRSA Screening - Non Elective	=> %	80																			Sep 2015	98.14	95.43	95.89	80	96.7				
Falls	<= No	0	9	7	4	8	3	9	9	6	6	0	4	4	5	9	5	4	2	4	Sep 2015	2	1	1	0	4	29			
Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	Sep 2015	0	0	0	0	0	0			
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	1	0	0	0	1	1	0	0	4	0	0	2	0	0	1	1	1	3	Sep 2015	1	0	0	0	3	6			
Venous Thromboembolism (VTE) Assessments	=> %	95.0																			Sep 2015	97.03	95.64	97.98	98.95	97.0				
WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0																			Sep 2015	99.66	100	100	100	99.9				
WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0																			Sep 2015	98.28	100	100	0	99.3				
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0																			Sep 2015	98.28	100	100	0	99.3				
Never Events	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	Sep 2015	0	0	0	0	0	2			
Medication Errors	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0	0	0	0	0	0			
Serious Incidents	<= No	0																			Sep 2015	0	0	0	0	0	2			
Mortality Reviews within 42 working days	=> %	98.0																	-	-	Jul 2015	89	100	0	100	93.3				

Indicator	Measure	Trajector Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Directorate A	B	C	D	Month	Year To Date	Trend	Next Month	3 Months
2 weeks	=> %	93.0																		-	Aug 2015	92.9		91.0		92.44				
2 weeks (Breast Symptomatic)	=> %	93.0																		-	Aug 2015	95.8				95.75				
31 Day (diagnosis to treatment)	=> %	96.0																		-	Aug 2015	100.0		96.3		98.57				
62 Day (urgent GP referral to treatment)	=> %	85.0																		-	Aug 2015	91.4		46.7		70.77				
Mixed Sex Accommodation Breaches	<= No	0	0	0	0	3	0	0	0	0	2	0	0	0	0	0	0	0	2	0	Sep 2015	0	0	0	0	0	2			
No. of Complaints Received (formal and link)	No		-	12	11	8	19	15	13	13	7	15	9	16	16	8	16	16	15	15	Sep 2015	7	5	3	0	15	86			
No. of Active Complaints in the System (formal and link)	No		-	50	50	34	39	49	57	78	53	45	40	45	46	27	32	23	26	23	Sep 2015	8	10	5	0	23				
Oldest' complaint currently in system (days)	No		-	124	131	118	99	109	133	143	171	192	213	234	254	97	157	108	122	125	Sep 2015	27	125	27	0	125				
Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8																			Sep 2015	1.47	1.17	1.98	-	1.26				
28 day breaches	<= No	0	1	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	1	Sep 2015	0	0	1	0	1	1			
Sitrep Declared Late Cancellations	<= No	0	13	16	5	6	16	10	18	6	33	11	13	17	12	10	8	21	13	13	Sep 2015	5	3	5	0	13	77			
Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	78	75.3	80.2	76.8	76.1	78	75	76.8	70.8	77.6	78.7	75.1	78.5	77.8	78.75	80.2	78.2	77.9	Sep 2015	75.0	80.3	77.7	87.4	77.87				
Emergency Care 4-hour breach (numbers)	No		81	100	100	119	52	103	118	94	121	43	108	127	-	-	-	-	-	-	Mar 2015	66	53	8	0	127	1166			
Hip Fractures - Operation < 24 hours of admission (%)	=> %	85																			Sep 2015		50.0			50.0	65.2			

Indicator	Measure	Trajector Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Directorate A	B	C	D	Month	Year To Date	Trend	Next Month	3 Months
RTT - Admittted Care (18-weeks) (%)	=> %	90.0																			Sep 2015	82.8	70.7	90.2	0.0	80.8				
RTT - Non Admittted Care (18-weeks) (%)	=> %	95.0																			Sep 2015	96.8	93.7	76.7	0.0	93.0				
RTT - Incomplete Pathway (18-weeks) (%)	=> %	92.0																			Sep 2015	94.1	89.8	90.4	0.0	91.5				
Patients Waiting >52 weeks	<= No	0	1	1	0	2	4	2	1	2	0	3	1	2	1	0	0	0	2	1	Sep 2015	0	0	1	0	1				
Treatment Functions Underperforming	<= No	0	7	5	5	4	3	4	6	7	4	5	8	4	2	3	2	2	4	8	Sep 2015	3	3	2	0	8				
Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0																			Sep 2015	0.5	0.0	1.2	0.0	0.76				
WTE - Actual versus Plan	No		64	71	77	78	71	71	71	76	66	62	70	70.1	88.3	97.1	102.7	110	120	122	Sep 2015	32.5	22.8	40.6	23.6	122.1				
PDRs - 12 month rolling	=> %	95.0																			Sep 2015	77.9	71.5	90.4	86.9		88.0			
Medical Appraisal and Revalidation	=> %	95.0													-						Sep 2015	100	53.85	100	78.05		86.5			
Sickness Absence	<= %	3.15																			Sep 2015	5.5	4.4	6.0	4.4	5.2	5.2			
Return to Work Interviews (%) following Sickness Absence	=> %	100	-	-	-	-	-	-	-	-	-	-	-		-	-					Sep 2015	55.3	37.4	74.7	74.0	64.3	62.2			
Mandatory Training	=> %	95.0																			Sep 2015	84.8	82.2	91.5	87.6		89.3			
New Investigations in Month	No		0	0	0	0	0	2	0	1	0	1	1	2	3	3	1	2	1	0	Sep 2015	0	0	0	0	0				
Nurse Bank Fill Rate	=> %	100.0	-	-	-	-	-	-	-	-	-	-	-	76	71	80	82.22	75.6	76.4	85.8	Sep 2015					85.77	79			
Nurse Bank Shifts Not Filled	<= No	0	'	'	'	'	'	'	'	'	'	'	'	335	313	247	197	347	303	272	Sep 2015					272	1679			
Nurse Bank Use	<= No	826																			Sep 2015					1408	5912			
Nurse Agency Use	<= No	0																			Sep 2015					377	2310			
Admin & Clerical Bank Use (shifts)	<= No	0	-																		Sep 2015					230	1113			
Admin & Clerical Agency Use (shifts)	<= No	0	-																		Sep 2015					48	151			
Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00					-	-			
Your Voice - Response Rate	No		-->	13	-->	-->	11	-->	-->	11	-->	-->	9	-->	-->	-->	10	-->	-->	10	Sep 2015	12	3	11	8	10				
Cancer = Patients Waiting Over 62 days for treatment	No		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	10	-	Aug 2015	-	-	-	-	9.5	10			

Surgery B Group

Indicator	Measure	Trajectory		Previous Months Trend																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	<= No	0	0																			Sep 2015	0	0	0	0			
MRSA Bacteraemia	<= No	0	0																			Sep 2015	0	0	0	0			
MRSA Screening - Elective	=> %	80	80																			Sep 2015	74.1	98.2	90.1				
MRSA Screening - Non Elective	=> %	80	80																			Sep 2015	81.8	94.7	88.7				
Falls	<= No	0	0	1	0	0	2	0	0	0	0	1	1	0	0	0	0	2	1	0	0	Sep 2015	0	0	0	3			
Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0	0	0	0			
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0	0	0	0			
Venous Thromboembolism (VTE) Assessments	=> %	95	95																			Sep 2015	98.9	99.7	99.1				
WHO Safer Surgery Checklist - Audit 3 sections	=> %	98	98																			Sep 2015	100	100	100				
WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95	95																			Sep 2015	100	100	100				
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85	85																			Sep 2015	100	100	100				
Never Events	<= No	0	0																			Sep 2015	0	0	0	0			
Medication Errors	<= No	0	0																			Sep 2015	0	0	0	0			
Serious Incidents	<= No	0	0																			Sep 2015	0	0	0	0			
Mortality Reviews within 42 working days	=> %	100	97			-	-	-		-	-	-	-	-	N/A	N/A	N/A	N/A		-	-	Jul 2015	0	100	100				

Indicator	Measure	Trajectory		Previous Months Trend																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	93																		-	Aug 2015		95.2	95.2				
31 Day (diagnosis to treatment)	=> %	96	96									-									-	Aug 2015		100	100				
62 Day (urgent GP referral to treatment)	=> %	85	85	-					-												-	Aug 2015		100	100.0				
Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0	0	0	0			
No. of Complaints Received (formal and link)	No			-	9	3	10	11	8	12	11	14	14	12	16	14	9	6	15	15	16	Sep 2015	14	2	16	75			
No. of Active Complaints in the System (formal and link)	No			-	31	40	34	37	36	37	47	33	35	35	36	39	35	17	17	22	19	Sep 2015	16	3	19				
Oldest' complaint currently in system (days)	No			-	117	100	103	129	98	63	138	109	102	123	144	164	135	102	126	148	83	Sep 2015	83	24	83				
Elective Admissions Cancelled at last minute for non-clinical reasons	<= %	0.8	0.8																			Sep 2015	0.76	0.49	0.67				
28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0	0	0	0			
Sitrep Declared Late Cancellations	<= No	0	0	3	22	17	16	14	16	12	11	7	24	11	8	15	17	16	10	14	8	Sep 2015	6	2	8	80			
Weekday Theatre Utilisation (as % of scheduled)	=> %	85	85	74	74.4	72.5	74.5	72	73.6	72	73	68	74.1	72	75.2	73.3	71.4	73.1	73.9	70.5	73.6	Sep 2015	75.7	67.9	73.64				
Emergency Care 4-hour waits (%)	=> %	95	95																			Sep 2015	96.9		96.9	99.0			
Emergency Care 4-hour breach (numbers)	No			10	15	80	13	26	29	10	27	25	8	8	39	-	-	-	-	-	-	Mar 2015	29	10	39	290			
Emergency Care Trolley Waits >12 hours	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-								Sep 2015	0		0	0			
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	<= No	15	15																			Sep 2015	14		14	14			
Emergency Care Timeliness - Time to Treatment in Department (median)	<= No	60	60																			Sep 2015	17		19	20			
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	<= %	5	5																			Sep 2015	3.24		3.24	3.47			
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	<= %	5	5																			Sep 2015	1.87		1.87	1.89			

Indicator	Measure	Trajectory		Previous Months Trend																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	90																			Sep 2015	90.6	92.2	91.1				
RTT - Non Admittted Care (18-weeks) (%)	=> %	95	95																			Sep 2015	95.9	95.2	95.7				
RTT - Incomplete Pathway (18-weeks) (%)	=> %	92	92																			Sep 2015	92.4	93.7	92.8				
Patients Waiting >52 weeks	<= No	0	0	0	1	1	0	0	2	2	1	0	0	1	1	0	1	0	3	2	1	Sep 2015	1	0	1				
Treatment Functions Underperforming	<= No	0	0	3	4	3	3	2	4	5	5	1	2	7	1	1	2	1	1	1	1	Sep 2015	0	1	1				
Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1	1																			Sep 2015	0	0	0.00				
WTE - Actual versus Plan	No			28	34	38	33	32	28	30	27	30	32	29	28.5	35.3	35.1	46.6	43	49.7	57.2	Sep 2015			57.2				
PDRs - 12 month rolling	=> %	95	95																			Sep 2015	76.6	84.9		89.7			
Medical Appraisal and Revalidation	=> %	95	95													.						Sep 2015	72	100	79.3	92.36			
Sickness Absence	<= %	3.15	3.15																			Sep 2015	3.58	2.28	3.22	3.23			
Return to Work Interviews (%) following Sickness Absence	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-		-	-					Sep 2015	44.9	79.8	53.56	51.72			
Mandatory Training	=> %	95	95																			Sep 2015	83.5	90.5		86.88			
New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	Sep 2015			0				
Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	100	99	99.6	98.4	98.2	96.9	96	Sep 2015			96.02	97.9			
Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	1	2	1	3	4	7	13	Sep 2015			13	30			
Nurse Bank Use	<= No	2796	233																			Sep 2015			267	1231			
Nurse Agency Use	<= No	0	0																			Sep 2015			44	138			
Admin & Clerical Bank Use (shifts)	<= No	0	0	.																		Sep 2015			148	788			
Admin & Clerical Agency Use (shifts)	<= No	0	0	.																		Sep 2015			22	107			
Medical Staffing - Number of instances when junior rotas not fully filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Jan-00	-	-	-	-			
Your Voice - Response Rate	No			-->	18	-->	-->	17	-->	-->	17	-->	-->	14	-->	-->	-->	12	-->	-->	15	Sep 2015	7	32	15				
Your Voice - Overall Score	No			-->	3.72	-->	-->	3.52	-->	-->	3.52	-->	-->	3.54	-->	-->	-->	3.59	-->	-->	3.63	Sep 2015	3.65	3.64	3.63				

Women & Child Health Group

Indicator	Measure	Trajectory		Previous Months Trend																	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	<= No	0	0																			Sep 2015	0	0	0	0	0	0			
MRSA Bacteraemia	<= No	0	0																			Sep 2015	0	0	0	0	0	0			
MRSA Screening - Elective	=> %	80.00	80.00																			Sep 2015	94				94.0				
MRSA Screening - Non Elective	=> %	80.00	80.00																			Sep 2015	0	100			100.0				
Falls	<= No	0	0	0	0	2	0	1	0	0	0	0	0	0	0	1	2	1	0	1	2	Sep 2015	2	0	0	0	2	7			
Falls with a serious injury	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0	0	0	0	0	0			
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	<= No	0	0	0	0	0	0	0	0	2	0	0	0	2	0	0	0	0	0	1	0	Aug 2015	0	1	0	0	1	1			
Venous Thromboembolism (VTE) Assessments	=> %	95.0	95.0																			Sep 2015	98.3	81.1			89.1				
WHO Safer Surgery Checklist - Audit 3 sections	=> %	98.0	98.0																			Sep 2015	100	99.4			99.8				
WHO Safer Surgery Checklist - Audit 3 sections and brief	=> %	95.0	95.0																			Sep 2015	98.4	100			98.6				
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=> %	85.0	85.00																			Sep 2015	98.4	100			98.6				
Never Events	<= No	0	0																			Sep 2015	0	0	0	0	0	1			
Medication Errors	<= No	0	0																			Sep 2015	0	0	0	0	0	0			
Serious Incidents	<= No	0	0																			Sep 2015	0	4	0	0	4	7			

Indicator	Measure	Trajectory		Previous Months Trend																		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																			Sep 2015		27.8			27.8	25.5			
Caesarean Section Rate - Elective	%			10	8	9	9	7	9	7	8	11	8	6	9	8	7	8	11	9	9	Sep 2015		9.33			9.3	8.5			
Caesarean Section Rate - Non Elective	%			16	18	19	15	17	18	19	16	16	15	17	16	15	18	15	18	17	18	Sep 2015		18.4			18.4	17.0			
Maternal Deaths	<= No	0	0																			Sep 2015		0			0	0			
Post Partum Haemorrhage (>2000ml)	<= No	48	4																			Sep 2015		4			4	14			
Admissions to Neonatal Intensive Care	<= %	10.0	10.0																			Sep 2015		1.5			1.5	2.6			
Adjusted Perinatal Mortality Rate (per 1000 babies)	<= Rate1	8.0	8.0																			Sep 2015		4.27			4.3				
Early Booking Assessment (<12 + 6 weeks) (>=%) - SWBH Specific	=> %	90.0	90.0																			Sep 2015		75.7			75.7				
Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=> %	90.0	90.0																			Sep 2015		135			135.0				
Mortality Reviews within 42 working days	=> %	100.0	97.0				-						-				N/A			-	-	Jul 2015	100	0	0		100.0				
2 weeks	=> %	93.0	93.0																		-	Aug 2015	92.6		0		92.6				
31 Day (diagnosis to treatment)	=> %	96.0	96.0																		-	Aug 2015	100				100.0				
62 Day (urgent GP referral to treatment)	=> %	85.0	85.0																		-	Aug 2015	82.4				82.4				
Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0				0	0			
No. of Complaints Received (formal and link)	No			-	4	6	11	8	8	8	12	7	11	9	11	7	9	14	14	12	10	Sep 2015	3	4	2	1	10	66			
No. of Active Complaints in the System (formal and link)	No			-	15	21	21	24	29	29	33	12	21	27	32	28	28	20	18	17	13	Sep 2015	0	0	0	0	13				
Oldest' complaint currently in system (days)	No			-	61	82	52	66	87	104	123	151	52	73	94	113	128	96	50	57	57	Sep 2015	21	57	10	16	57				

Indicator	Measure	Trajectory		Previous Months Trend																		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																			Sep 2015	2.79		-		2.2				
28 day breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0				0	0			
Sitrep Declared Late Cancellations	<= No	0	0	12	3	4	7	6	6	7	7	7	1	5	7	6	4	2	2	4	7	Sep 2015	7				7	25			
Weekday Theatre Utilisation (as % of scheduled)	=> %	85.0	85.0	83	83	81	83	78	76	77	77	80	77	78	79	76	78	74	75	76	79	Sep 2015	78.9	-			78.9				
Emergency Care 4-hour breach (numbers)	No			18	14	14	18	14	30	23	36	82	5	30	16	-	-	-	-	-	-	Mar 2015	8	0	8	0	16	300			
RTT - Admittted Care (18-weeks)	=> %	90.0	90.0																			Sep 2015	93.9				93.9				
RTT - Non Admittted Care (18-weeks)	=> %	95.0	95.0																			Sep 2015	97.4				97.4				
RTT - Incomplete Pathway (18-weeks)	=> %	92.0	92.0																			Sep 2015	97.8				97.8				
Patients Waiting >52 weeks	<= No	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0				0				
Treatment Functions Underperforming	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0				0				
Acute Diagnostic Waits in Excess of 6-weeks	<= %	0.1	0.1																			Sep 2015	0				0.0				

Indicator	Measure	Trajectory		Previous Months Trend																	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	No			48	58	60	67	81	61	60	59	66	67	68.6	66.9	67.9	70.8	87.2	95.8	111	96.6	Sep 2015	27	37.3	17.9	15.3	96.6				
PDRs - 12 month rolling	=> %	95.0	95.0																			Sep 2015	84.1	88.8	84.3	83.7		88.6			
Medical Appraisal and Revalidation	=> %	95.0	95.0													-						Sep 2015	73.7	81.8	83.3	0		90.4			
Sickness Absence	<= %	3.15	3.15																			Sep 2015	4.93	6.01	4.48	6.55	5.6	5.5			
Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-		-	-					Sep 2015	63	56.3	62.1	71.5	60.42	57.25			
Mandatory Training	=> %	95.0	95.0																			Sep 2015	88.7	76.9	87.1	88		84.6			
New Investigations in Month	No			0	0	0	2	0	0	0	0	0	0	1	1	1	3	2	2	1	1	Sep 2015	1	0	0	0	1				
Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	90	93.6	95.4	91.9	93.9	90.9	94.7	Sep 2015					94.7	93.5			
Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	81	37	35	53	50	68	51	Sep 2015					51	94			
Nurse Bank Use	<= No	6852	571																			Sep 2015					737	3788			
Nurse Agency Use	<= No	0	0																			Sep 2015					69	511			
Admin & Clerical Bank Use (shifts)	<= No	0	0	-																		Sep 2015					60	397			
Admin & Clerical Agency Use (shifts)	<= No	0	0	-																		Sep 2015					0	87			
Medical Staffing - Number of instances when junior rotas not fully filled	0	0																													
Your Voice - Response Rate	No			-->	11	-->	-->	12	-->	-->	12	-->	-->	9	-->	-->	-->	13	-->	-->	12	Sep 2015	17	6	16	18	12				
Your Voice - Overall Score	No			-->	3.79	-->	-->	3.65	-->	-->	3.65	-->	-->	3.53	-->	-->	-->	3.66	-->	-->	3.64	Sep 2015	3.8	3.57	3.42	3.73	3.6				

Pathology Group

Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Directorate HA	HI	B	M	I	Month	Year To Date	Trend	Next Month	3 Months
Never Events	<= No	0	0																			Sep 2015	0	0	0	0	0	0	0			
No. of Complaints Received (formal and link)	No			-	0	1	0	1	1	3	0	2	3	1	5	0	2	3	0	2	0	Sep 2015	0	0	0	0	0	0	7			
No. of Active Complaints in the System (formal and link)	No			-	1	2	1	2	3	6	5	5	8	7	6	4	6	5	2	3	0	Sep 2015	0	0	0	0	0	0				
Oldest' complaint currently in system (days)	No			-	91	112	27	46	68	92	111	90	96	117	138	73	92	27	23	18	0	Sep 2015	0	0	0	0	0	0				
WTE - Actual versus Plan	No			30	32	31	32	29	27	25	27	27	24	16	16	20.4	22.8	32.5	34	33.7	40.3	Sep 2015	5.4	2.4	14	5	3.8	40				
PDRs - 12 month rolling	=> %	95.0	95.0																			Sep 2015	81	90	94	98	93		92.84			
Medical Appraisal and Revalidation	=> %	95.0	95.0													-						Sep 2015	80	57	0	0	100		86.81			
Sickness Absence	<= %	3.15	3.15																			Sep 2015	5.6	1.4	4.3	3.7	5.5	4.39	4.32			
Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-		-	-					Sep 2015	81	91	86	93	100	79.7	79.0			
Mandatory Training	=> %	95.0	95.0																			Sep 2015	92	95	96	96	97		95.7			
New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0	0	0	0	0	0				
Admin & Clerical Bank Use (shifts)	<= No	0	0	-																		Sep 2015						561	3168			
Admin & Clerical Agency Use (shifts)	<= No	0	0	-																		Sep 2015						0	0			
Your Voice - Response Rate	No			-->	30	-->	-->	31	-->	-->	31	-->	-->	12	-->	-->	-->	21	-->	-->	24	Sep 2015	15	41	22	28	63	24				
Your Voice - Overall Score	No			-->	3.43	-->	-->	3.74	-->	-->	3.74	-->	-->	3.76	-->	-->	-->	3.69	-->	-->	3.58	Sep 2015	3.1	3.3	3.5	3.9	4.3	3.58				

Imaging Group

Indicator	Measure	Trajectory Year	Trajectory Month	Previous Months Trend 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	<= No	0	0																			Sep 2015	0	0	0	0	0	0			
Medication Errors	<= No	0	0																			Sep 2015	0	0	0	0	0	0			
Unreported Tests / Scans	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-											
Outsourced Reporting	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-											
IRMA Instances	No			-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-											
Pts receiving CT Scan within 1 hr of presentation (%)	=> %	50.0	50.0																			Sep 2015			75		75	75.23			
Pts receiving CT Scan within 24 hrs of presentation (%)	=> %	100.0	100.00																			Sep 2015			100		100	99.39			
Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0	0	0	0	0	0			
No. of Complaints Received (formal and link)	No			-	4	2	3	3	0	4	2	2	3	2	1	0	4	3	5	8	4	Sep 2015	4	0	0	0	4	24			
No. of Active Complaints in the System (formal and link)	No			-	5	7	8	5	5	8	10	8	9	7	5	0	5	5	7	11	7	Sep 2015	6	1	0	0	7				
Oldest' complaint currently in system (days)	No			-	19	40	59	30	52	76	72	75	83	75	96	123	102	27	24	43	62	Sep 2015	62	6	0	0	0				
Emergency Care 4-hour breach (numbers)	No			30	39	41	32	34	49	50	52	45	41	49	51	-	-	-	-	-	-	Mar 2015	51	0	0	0	51	513			
Acute Diagnostic Waits in Excess of 6-weeks (%)	<= %	1.0	1.0																			Sep 2015	0.01				0.01				
WTE - Actual versus Plan	No			15	13	11	13	22.1	14	16	15	21	21	33	33.6	41.4	46.3	57.9	58.9	55.9	50	Sep 2015	31.9	0.8	1.5	7.3	50.0				
PDRs - 12 month rolling	=> %	95.0	95.0																			Sep 2015	72.9	92.3	93.6	67.3		82.5			
Medical Appraisal and Revalidation	=> %	95.0	95.0													-						Sep 2015	85.2	0	100	0		95.9			
Sickness Absence	<= %	3.15	3.15																			Sep 2015	3.1	7.5	2.8	5.2	4.51	4.68			
Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-		-	-					Sep 2015	48.6	94.7	76.9	19.3	46.6	44.3			
Mandatory Training	=> %	95.0	95.0																			Sep 2015	82.5	84.3	84.1	90.7		87.4			
New Investigations in Month	No			0	2	2	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015					0				
Nurse Bank Use	<= No	288	24																			Sep 2015					145	359			
Nurse Agency Use	<= No	0	0																			Sep 2015					190	1398			
Admin & Clerical Bank Use (shifts)	<= No	0	0	-																		Sep 2015					171	1147			
Admin & Clerical Agency Use (shifts)	<= No	0	0	-																		Sep 2015					0	0			
Your Voice - Response Rate	No			-->	19	-->	-->	33	-->	-->	33	-->	-->	18	-->	-->	-->	19	-->	-->	24	Sep 2015	17	0	55	11	24				
Your Voice - Overall Score	No			-->	3.72	-->	-->	3.73	-->	-->	3.73	-->	-->	3.28	-->	-->	-->	3.41	-->	-->	3.11	Sep 2015	2.79	0	3.55	3.67	3.11				

Community & Therapies Group

Indicator	Measure	Trajectory		Previous Months Trend																		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	=> %	80.0	80.0													-	-	-	-	-	-	Sep 2015	-	-	-	-				
Falls	<= No	0	0	8	9	11	13	4	14	20	17	21	22	16	13	30	47	37	25	27	29	Sep 2015	0	28	1	29	195			
Falls with a serious injury	<= No	0	0	0	2	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	Sep 2015	0	0	0	0	1			
Grade 3 or 4 Pressure Ulcers (avoidable)	<= No	0	0	2	4	2	2	1	1	1	3	5	2	1	3	3	1	1	3	2	0	Aug 2015	0	2	0	0	10			
Never Events	<= No	0	0																			Sep 2015	0	0	0	0	0			
Medication Errors	<= No	0	0																			Sep 2015	0	0	0	0	0			
Serious Incidents	<= No	0	0																			Sep 2015	0	0	0	0	0			
FFT Response Rate - Wards (Community)	=> %	25.0	25.0	39	67.9	42.9	60	59.5	56.7	47	37.5	32.6	33	41.3	101	27.7	40.4	28.2	30.7	33.2	34.2	Sep 2015	-	-	-	34.19				
FFT Score - Wards (Community)	=> No	68.0	68.0	81	95	87	83	91	82	88	73	87	100	95	92	98.6	96.7	91.4	91.3	91	91.3	Sep 2015	-	-	-	91.25				
Mixed Sex Accommodation Breaches	<= No	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep 2015	0	0	0	0	0			
No. of Complaints Received (formal and link)	No			-	3	0	0	5	2	5	1	1	2	1	1	0	1	2	1	3	5	Sep 2015	3	0	2	5	12			
No. of Active Complaints in the System (formal and link)	No			-	10	8	3	8	8	10	12	3	4	3	6	0	7	6	4	5	7	Sep 2015	5	0	2	7				
Oldest complaint currently in system (days)	No			-	94	115	75	38	60	64	81	75	61	82	103	158	0	99	118	140	10	Sep 2015	17	0	10	10				
WTE - Actual versus Plan	No			27	36	45	45	61.8	65	67	71	75	76	72.2	77.4	174	92.8	77.3	85.3	87.7	114	Sep 2015	9.2	60.3	44.6	114.13				
PDRs - 12 month rolling	=> %	95.0	95.0																			Sep 2015	90.1	83	88.2		89.2			
Sickness Absence	<= %	3.15	3.15																			Sep 2015	3.59	5.82	5.39	5.27	5.22			
Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-		-	-					Sep 2015	93.6	81.3	73.1	79.6	79.54			

Indicator	Measure	Trajectory		Previous Months Trend																		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																			Sep 2015	89.4	86.1	90		89.3			
New Investigations in Month	No			0	0	0	0	0	0	0	0	0	0	0	0	1	3	0	0	0	0	Sep 2015				0				
Nurse Bank Fill Rate	=> %	100	100	-	-	-	-	-	-	-	-	-	-	-	93	89.5	94.2	89.2	89	89.7	92.2	Sep 2015	-	-	-	92.23	90.72			
Nurse Bank Shifts Not Filled	<= No	0	0	-	-	-	-	-	-	-	-	-	-	-	36	41	31	46	72	62	56	Sep 2015	-	-	-	56	308			
Nurse Bank Use	<= No	5408	451																			Sep 2015				574	2772			
Nurse Agency Use	<= No	0	0																			Sep 2015				327	2068			
Admin & Clerical Bank Use (shifts)	<= No	0	0	-																		Sep 2015				290	1480			
Admin & Clerical Agency Use (shifts)	<= No	0	0	-																		Sep 2015				0	0			
Your Voice - Response Rate	No			-->	18	-->	-->	32	-->	-->	32	-->	-->	28	-->	-->	-->	26	-->	-->	31	Sep 2015	45	31	26	31				
Your Voice - Overall Score	No			-->	3.75	-->	-->	3.88	-->	-->	3.88	-->	-->	3.76	-->	-->	-->	3.77	-->	-->	3.68	Sep 2015	3.58	3.65	3.8	3.68				
DVT numbers	=> No	730	61	53	62	87	39	33	70	35	42	47	54	53	55	56	53	67	64	-	-	Jul 2015				64	240			
Therapy DNA rate OP services	<= %	9	9	12	16	11	10.6	10.5	11.3	12	13.6	12	12.3	13.9	12.9	13.3	12	14.5	10.7	9.85	10.5	Sep 2015				10.5	11.7			
FEES assessment	<= No	100	8	7	10	3	4	4	5	5	3	2	14	1	2	0	2	0	0	-	-	Jul 2015				0	2			
ESD Response time	<= Hr	48	48												-	-	-	-	-	-	-	Feb 2015				0	0			
STEIS	<= No	0	0	0	2	1	0	1	0	0	0	1	0	0	-	-	-	0	0	0	0	Sep 2015				0	0			
Rapid response to AMU, RRTS	<= mins	60	60	75	71	72	73	68	81	79	82	86	79	98	-	-	-	-	-	-	-	Feb 2015				98	864			
Avoidable weight loss	<= %	20.0	20.0	18	0	8	0	0	0	0	0	9	0	0	8	0	25	20	0	-	-	Jul 2015				0.0	11.8			
Green Stream Community Rehab response time for treatment (days)	<= No	11.0	11.0	12	7.9	11.2	16.1	15.6	17.1	14.3	12.3	13.1	9.5	12.1	13.7	16	14	11	15	-	-	Jul 2015				15	56			

Indicator	Measure	Trajectory		Previous Months Trend																		Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	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	1	1	1	1	1	1	-	-	-	-	6	1	1	Sep 2015				0.69				
Falls Assessments - DN service only	%			-	-	-	-	72	58	49	45	45	62	54	65	47	55	50	46	44	43	Sep 2015				43.25				
Pressure Ulcer Assessment - DN service only	%			-	-	-	-	73	61	50	48	46	63	57	65	51	55	51	48	44	43	Sep 2015				43.12				
Healthy Lifestyle Assessments - DN Service only	%			-	-	-	-	61	54	48	39	43	58	54	36	47	57	45	37	37	37	Sep 2015				36.58				
At risk of Social Isolation Referrals to 3rd sector DN service only	%			-	-	-	-	46	75	67	57	65	95	77	-	-	-	-	50	75	50	Sep 2015				50				
MUST Assessments - DN Service only	%			-	-	-	-	9	11	10	11	10	19	18	-	22	22	24	21	23	23	Sep 2015				23.23				
Incident Rates - per 1000 charge	Rate1			-	-	-	-	4	5	5	4	4	5	4	-	4	5	5	4	4	-	Aug 2015				4.4				
Dementia Assessments - DN Service only	%			-	-	-	-	72	62	55	52	51	61	62	-	46	56	40	48	45	50	Sep 2015				49.81				
48 hour inputting rate	%			-	-	-	-	91	83	81	85	86	89	83	-	87	89	92	91	94	90	Sep 2015				90.04				

Corporate Group

Indicator	Measure	Trajectory		Previous Months Trend																	Data Period	Directorate							Month	Year To Date	Trend	Next Month	3 Months
		Year	Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S		CEO	F	W	M	E	N	O					
No. of Complaints Received (formal and link)	No			-	8	4	5	6	5	7	6	6	15	5	6	5	7	8	6	15	11	Sep 2015	3	0	0	2	0	2	4	11	52			
No. of Active Complaints in the System (formal and link)	No			-	16	13	12	13	21	21	25	12	21	16	18	14	12	14	9	16	16	Sep 2015	3	0	0	4	0	3	6	16				
Oldest' complaint currently in system (days)	No			-	69	90	77	99	121	106	104	104	123	145	138	158	99	121	53	24	27	Sep 2015	-	-	-	-	-	-	-	27				
WTE - Actual versus Plan	No			149	154	162	176	162	183	194	203	168	175	200	220	260	267	110	99.6	103	100	Sep 2015	14.2	2.8	-9.4	15.3	-0.7	47.7	30.1	100				
PDRs - 12 month rolling	=> %	95.0	95.0																			Sep 2015	91	78	81	87	84	89	73		87.6			
Medical Appraisal and Revalidation	=> %	95.0	95.0													-						Sep 2015			95						100			
Sickness Absence	<= %	3.15	3.15																			Sep 2015	2.35	2.15	3.46	3.15	2.51	5.88	5.42	4.77	4.71			
Return to Work Interviews (%) following Sickness Absence	=> %	100.0	100.0	-	-	-	-	-	-	-	-	-	-	-		-	-					Sep 2015	70.6	70.3	38.3	85.1	44.7	79.4	72.5	72.3	71.1			
Mandatory Training	=> %	95.0	95.0																			Sep 2015	94	95	94	89	91	88	89		90			
New Investigations in Month	No			0	1	3	1	0	5	0	0	0	1	0	0	1	0	1	2	1	1	Sep 2015	0	0	0	0	0	0	1	1				
Nurse Bank Use	<= No	1088	91																			Sep 2015								157	1154			
Nurse Agency Use	<= No	0	0																			Sep 2015								20	278			
Admin & Clerical Bank Use (shifts)	<= No	0	0	-																		Sep 2015	-	-	-	-	-	-	-	3153	18732			
Admin & Clerical Agency Use (shifts)	<= No	0	0	-																		Sep 2015	-	-	-	-	-	-	-	104	512			
Your Voice - Response Rate	No			-->	26	-->	-->	24	-->	-->	21	-->	-->	15	-->	-->	-->	16	-->	-->	19	Sep 2015	60	23	38	18	15	15	12	19				
Your Voice - Overall Score	No			-->	3.76	-->	-->	3.60	-->	-->	3.49	-->	-->	3.48	-->	-->	-->	3.50	-->	-->	3.46	Sep 2015	3.66	3.36	3.76	3.69	3.45	3.31	3.23	3.46				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Financial performance – P06 September 2015**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Finance Director**
AUTHOR:	**Tim Reardon – Associate Director of Finance**
DATE OF MEETING:	**5 November 2015**

EXECUTIVE SUMMARY:

Key messages:

- Off plan year to date and requiring a step improvement in monthly run rate of minimum £2m per month from P07 October. Necessary reliance on significant contingencies to meet key targets.
- TDA proposed stretch surplus of £6m being £2.2m above plan. Any contribution to this stretch to be delivered on a non-recurrent basis. Focus of organisation firmly on remedy to deliver original plan.
- To secure exit run-rate consistent with 2016.17 plan requires remedy to current year performance, delivery of CIP to full year effect value and progression of workforce change plan for 2016-18.
- Capital programme reviewed and re-profiled to be consistent with emergent firm requirements of retained estate and IM&T strategies consistent with effective delivery of MMH models of care.

Key actions:

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

Key numbers:

- Month deficit £(382)k being £(537)k adverse to plan; YTD deficit £(1,361)k being £(1,985)k adverse.
- Forecast surplus £3.8m in line with financial plan. Any stretch to be delivered on N/R basis.
- Agency spend £1.5m in month; £9.0m YTD. Rate of spend double that achieved during 2014.15.
- CIP delivery to date £6.5m being £0.7m favourable to TDA plan. Step up in CIP in Q3 / Q4 required.
- Capex YTD £5.7m being £3.4m below plan. Revised profile agreed in line with updated programme.
- Cash at 30 September £32.5m being £6.3m above plan due to timing differences
- New FSRR 3 to date being as plan despite adverse EBITDA performance; forecast 4 vs. plan 3 Capital Resource Limit (CRL) charge forecast at £20.2m being as plan
- External Finance Limit (EFL) charge forecast at £(0.7)m being consistent with approved EFL.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Good use of resources

PREVIOUS CONSIDERATION:

Finance & Investment Committee

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – September 2015 (period 6)

EXECUTIVE SUMMARY

- **For the 6 months to 30 September 2015 the Trust is reporting :**
  - **I&E deficit of £1,361k being £1,985k behind plan**
  - **Capital spend of £5.7m, £3.4m below plan**
  - **Cash held at the end of September is £32.5m being £6.3m more than plan.**
- **Key issues remain an under-recovery of SLA income driven by below plan delivery of planned care activity, excess pay costs driven by volume and unit cost of temporary staffing and ante-natal charges. These issues have been moderated in the period to date by the significant use of contingencies and balance sheet flexibility.**
- **The current forecast is that the trust will deliver all key financial targets. This will require the delivery of significant remedial actions to improve income & margin recovery, reduced pay costs specifically agency costs & CIP step up as Q3/Q4 plan. Further expedient measures are likely to be required to secure the current year and an exit run rate expenditure in line with medium term plan obligations.**
- **The Trust has indicated a stretch surplus forecast of £5.0m (vs. £6m target) may be deliverable on a strictly non-recurrent basis. This will require the effective mitigation of key financial risks and CCG support.**

Financial Performance Indicators - Variances

Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	(537)	(1,985)	>= Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	(575)	(1,758)	>= Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	(1,221)	(3,347)	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	944	5,061	<= Plan	<= Plan	>1% above plan
WTEs Actual v Plan	214	363	<= Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000		6,261	>= Plan	>=95% of plan	<95% of plan

Note: positive variances are favourable, negative variances unfavourable

- **Delivery of key results requires step change improvement in run rate.**
- This was planned for P06 but was not secured; pay bill increased rather than decreased in September.
- Non-cash technical items are now integral to I&E forecast delivery.
- Consequent requirement for working capital management to hit EFL target.

2015/16 Summary Income & Expenditure Performance at September 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	399,911	33,413	32,754	(660)	199,893	196,401	(3,491)
Other Income	39,747	3,173	3,536	362	19,970	19,990	19
Pay Expenses	(286,615)	(23,707)	(24,929)	(1,221)	(143,412)	(146,758)	(3,347)
Non-Pay Expenses	(126,692)	(10,846)	(9,903)	944	(64,547)	(59,487)	5,061
EBITDA	**26,352**	**2,033**	**1,459**	**(575)**	**11,904**	**10,146**	**(1,758)**
Depreciation & Impairment	(14,881)	(1,240)	(1,240)	0	(7,440)	(7,440)	0
PDC Dividend	(6,000)	(500)	(500)	0	(3,000)	(3,000)	0
Net Interest Receivable / Payable	(2,039)	(169)	(163)	6	(1,027)	(1,016)	11
Other Finance Costs / P&L on sale of assets	0	0	0	0	0	0	0
Net Surplus/(Deficit)	**3,432**	**124**	**(445)**	**(569)**	**437**	**(1,310)**	**(1,747)**
IFRIC12/Impairment/Donated Asset Related Adjustments	372	31	63	32	186	(52)	(238)
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,804**	**155**	**(382)**	**(537)**	**623**	**(1,362)**	**(1,985)**

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2015 (period 6)

Overall Performance against DoH Plan

The Trust is reporting a year to date deficit of £1,361k which is £1,985k behind plan. Key issues are agency pay spend and elective income recovery.

Performance of Clinical Groups

- Key risks for **Medicine** continue to be use of medical and nursing agency and delivery of savings plans. Of the £3.1m YTD variance £2.1m relates to staffing cost overspending. The remaining £1m is spread over drugs and medical consumables.
- **Surgery A** is key to the capacity and demand work to deliver contracted levels of activity including ambitious growth and repatriation. Of the £2.4m adverse variance to date £1.9m relates to income shortfall with a further £0.7m relating to unallocated/unidentified CIP schemes.
- **Women & Child Health** key variance (£1.4m YTD) driven by estimated maternity pathway charges.
- **Surgery B** is also closely involved in capacity and demand planning to recover SLA income position. Of the £1.5m adverse variance to date £1m relates to income shortfall while £0.8m relates to unidentified/unallocated savings. Savings on substantive pay have partially recovered this position.
- **Community & Therapies** position includes significant reliance on vacancy control to deliver savings targets. This is the subject of on-going scrutiny to assure safety. Agency spend driven by additional bed capacity.
- **Imaging** is underachieving on income and overspending on pay (lack of savings delivery) and non-pay (consumables and maintenance).
- **Pathology** underlying position in balance

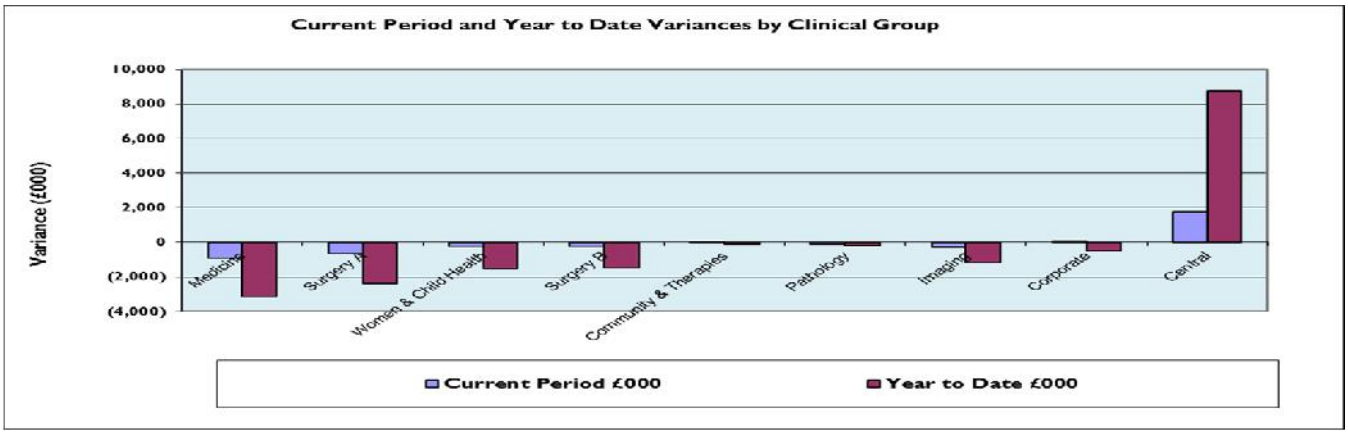
Corporate Areas

- Pay underspends on management and administration of £0.7m are offset by SLA underperformance, savings under-delivery of £0.2m and non-pay overspending.

Central

- Year to date use of £4.3m balance sheet flexibility
- Reserves expenditure being £4.7m below plan.

Group Variances from Plan (Operating income and expenditure)	Current Period £000	Year to Date £000
Medicine	(895)	(3,141)
Surgery A	(666)	(2,394)
Women & Child Health	(252)	(1,528)
Surgery B	(248)	(1,469)
Community & Therapies	43	(99)
Pathology	(131)	(210)
Imaging	(277)	(1,167)
Corporate	90	(504)
Central	1,762	8,753

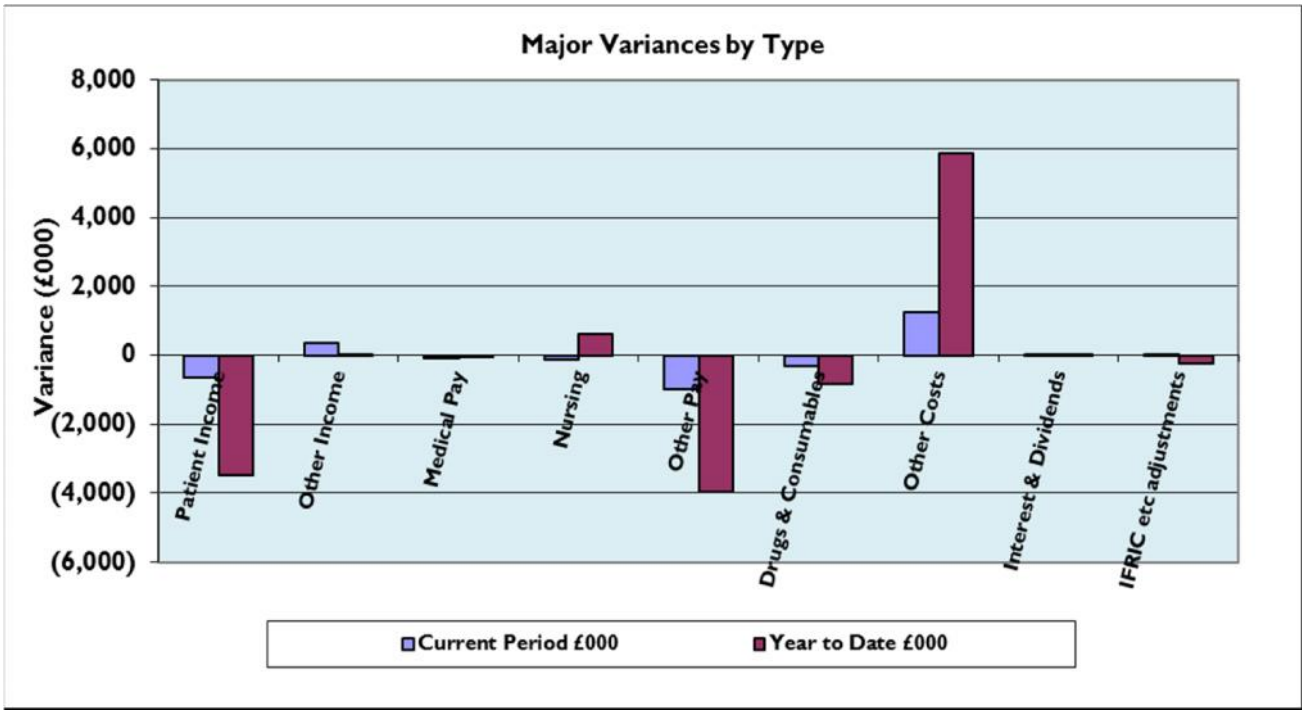


Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2015 (period 6)

- **Patient income** £5.3m under-performance YTD on elective inpatients and day cases under-performance on A&E £0.6m; £0.6m over-performance on non-elective, £0.7m on maternity and £0.3m over on outpatient. £1.1m on pass through and cancer drugs fund.
- **Other income** £0.4m under-recovery on LDA offset by donated income and technical adjustments.
- **Medical staffing** YTD includes £5.1m spend on locum and agency [being 13% of medical pay bill].
- **Nursing** YTD includes £8.0m bank & agency spend [being 17% of nursing pay bill]; offset by £8.0m underspend on substantive staff.
- **Other pay** YTD includes £6.1m bank & agency spend. Over-spending reflects savings targets not yet allocated to specific.
- £0.9m of the **drugs/consumables** variance is pass through.
- **Other costs** favourable variance reflects use of balance sheet flexibility and that reserves actual costs are below plan; £1.4m over-spend on maternity pathway charges. It also includes overspending on other imaging non-pay and corporate postage.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	(660)	(3,491)
Other Income	362	19
Medical Pay	(108)	(14)
Nursing	(145)	631
Other Pay	(969)	(3,963)
Drugs & Consumables	(311)	(817)
Other Costs	1,255	5,878
Interest & Dividends	6	11
IFRIC etc adjustments	32	(238)
Total	(537)	(1,985)



Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2015 (period 6)

Paybill & Workforce

- Total workforce 6,856 WTE [being 214 WTE below plan] including 191 WTE [vs. 224 wte P05] agency staff.
- Total pay costs in P06 were £24.9m [vs. £24.0 P05] being £1.2m over plan.
- Successful switch of temporary staff from agency to bank with agency hours reduced by 4,000 in month and bank increased by 10,000. Enabled by enhanced bank rates which enabled successful elimination of off-framework agency usage and is consistent with safe staffing and improved staff continuity.
- Significant reduction in temporary pay costs required to be consistent with delivery of key financial targets. Focus on improvement in recruitment time to fill and effective sickness management.
- Compliance with new national agency framework suppliers effected during October as required. Minimal number of shifts procured outside of this and driven by strict commitment to maintaining safe staffing.

Pay & workforce	P06 month	P05 month	Change in month	
Pay - total spend	24,929	24,020	909	4%
Pay - agency spend	1,494	1,490	4	0%
Pay - bank [inc locum] spend	2,233	1,737	496	29%
WTE - total	6,856	6,786	70	1%
WTE - substantive	5,987	5,967	20	0%
WTE - agency	191	224	-33	-15%
WTE - bank [inc. locum]	678	594	84	14%

	Total Pay Costs by Staff Group					
	Year to Date to September 2015					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	40,309	38,243	0	2,080	40,323	(14)
Management	6,947	6,096	0	0	6,096	852
Administration & Estates	15,273	13,140	1,145	932	15,218	55
Healthcare Assistants & Support Staff	15,577	13,986	2,230	642	16,858	(1,281)
Nursing and Midwifery	47,797	39,190	3,773	4,203	47,166	631
Scientific, Therapeutic & Technical	23,274	19,638	0	1,118	20,756	2,518
Other Pay / Technical Adjustment	(5,765)	342	0	0	342	(6,107)
Total Pay Costs	143,412	130,635	7,149	8,975	146,758	(3,347)

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2015 (period 6)

Balance Sheet

Cash at the end of August was £32.5m being £6.3m higher than plan. This reflects lower than planned capital expenditure to date of £3.4m and higher than planned payables which continue to reflect disputed payments to NHS suppliers, including those for maternity pathway attendances at other Trusts.

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

Sandwell & West Birmingham Hospitals NHS Trust

STATEMENT OF FINANCIAL POSITION 2015/16

	Balance as at 31st March 2015		Balance as at 30th September 2015	TDA Planned Balance as at 30th September 2015	Variance to plan as at 30th September 2015		TDA Plan at 31st March 2016	Forecast 31st March 2016
	£000		£000	£000	£000		£000	£000
Non Current Assets								
Property, Plant and Equipment	233,309		231,669	234,107	(2,438)		238,898	187,539
Intangible Assets	677		555	557	(2)		437	437
Trade and Other Receivables	890		967	856	111		1,011	1,011
Current Assets								
Inventories	3,467		3,528	3,138	390		2,972	2,972
Trade and Other Receivables	16,318		16,862	16,356	506		15,966	15,966
Cash and Cash Equivalents	28,382		32,455	26,194	6,261		27,082	27,082
Current Liabilities								
Trade and Other Payables	(45,951)		(53,378)	(43,922)	(9,456)		(48,974)	(48,974)
Provisions	(4,502)		(2,898)	(3,883)	985		(3,437)	(3,437)
Borrowings	(1,017)		(1,017)	(1,017)	0		(1,017)	(1,017)
DH Capital Loan	(1,000)		0	0	0		0	0
Non Current Liabilities								
Provisions	(2,986)		(2,969)	(2,363)	(606)		(1,434)	(1,434)
Borrowings	(26,898)		(26,395)	(26,388)	(7)		(25,881)	(25,881)
DH Capital Loan			0	0	0		0	0
	200,689		**199,379**	**203,635**	**(4,256)**		**205,623**	**154,264**
Financed By								
Taxpayers Equity								
Public Dividend Capital	162,210		162,210	162,210	0		162,210	162,210
Retained Earnings reserve	(13,758)		(15,068)	(10,812)	(4,256)		(8,824)	(22,362)
Revaluation Reserve	43,179		43,179	43,179	0		43,179	5,358
Other Reserves	9,058		9,058	9,058	0		9,058	9,058
	200,689		**199,379**	**203,635**	**(4,256)**		**205,623**	**154,264**

Sandwell and West Birmingham Hospitals NHS Trust

Financial Performance Report – September 2015 (period 6)

Cash

The favourable cash position at 30 September is reported above.

Delivery of the trust's financial plan is necessarily reliant on the use of balance sheet flexibilities. This will represent a drain on the trust's cash balances. Whilst this does not represent a near term risk but may be relevant to the trust's medium term plans. Appropriate options to remedy any such impact will be considered and effected in due course consistent with securing the trust's medium term financial plans.

Necessary near term working capital management, including a stretch on payables, will be progressed to manage year end EFL target delivery.

Sandwell & West Birmingham Hospitals NHS Trust
CASH FLOW 2015/16

PLAN, ACTUAL AND YEAR END FORECAST AT 30 SEPTEMBER 2015

	April £000s	May £000s	June £000s	July £000s	August £000s	September £000s	October £000s	November £000s	December £000s	January £000s	February £000s	March £000s
Planned Cash Balance (Sept15)	28,109	28,914	29,719	30,612	31,505	26,194	26,052	25,910	25,768	26,165	26,612	27,082
ACTUAL/FORECAST	April Actual £000s	May Actual £000s	June Actual £000s	July Actual £000s	August Actual £000s	September Actual £000s	October Forecast £000s	November Forecast £000s	December Forecast £000s	January Forecast £000s	February Forecast £000s	March Forecast £000s
Receipts												
SLAs: SWB CCG	21,084	21,716	21,573	21,841	21,454	21,462	21,568	21,568	21,568	21,568	21,568	21,568
Associates	6,800	6,632	6,727	6,548	6,328	7,054	6,380	6,380	6,380	6,380	6,380	6,380
Other NHS	1,957	1,877	1,368	845	854	358	1,500	1,500	1,500	1,500	1,500	2,800
Specialised Services	3,042	5,448	4,272	4,863	3,718	5,479	3,292	3,292	3,292	3,292	3,292	3,287
Over Performance	2,758	598		0	0	0	0	0	0	0	0	0
Education & Training	463	0	4,666	0	4,146	0	4,666	0	0	4,666	0	0
Public Dividend Capital	0	0	0	0	0	0	0	0	0	0	0	0
Loans	0	0	0	0	0	0	0	0	0	0	0	0
Other Receipts	2,423	918	1,626	2,479	1,631	2,025	1,004	2,000	2,000	2,200	2,200	2,800
Total Receipts	38,527	37,189	40,233	36,575	38,131	36,378	38,410	34,740	34,740	39,606	34,940	36,835
Payments												
Payroll	13,364	13,207	13,374	13,387	13,193	13,366	13,600	13,600	13,600	13,600	13,600	13,600
Tax, NI and Pensions	3,638	9,224	9,111	9,177	9,028	9,054	9,250	9,250	9,250	9,250	9,250	9,250
Non Pay - NHS	3,099	1,659	1,564	2,422	1,849	1,598	8,061	1,500	1,550	1,500	1,550	1,550
Non Pay - Trade	10,987	8,519	9,184	9,998	9,541	11,269	10,811	7,932	7,844	12,067	7,610	6,263
Non Pay - Capital	459	1,070	4,544	1,658	840	1,549	1,866	1,375	1,413	1,566	1,943	2,322
PDC Dividend	0	0	0	0	0	3,105	0	0	0	0	0	2,400
Repayment of Loans & Interest	0	0	0	0	0	1,004	0	0	0	0	0	0
BTC Unitary Charge	0	429	444	438	443	404	440	440	440	440	440	880
NHS Litigation Authority	685	685	685	685	685	685	685	685	685	686	0	0
Other Payments	68	375	134	408	113	552	100	100	100	100	100	100
Total Payments	32,300	35,168	39,040	38,173	35,693	42,586	44,813	34,882	34,882	39,209	34,493	36,365
Cash Brought Forward	28,382	34,609	36,630	37,823	36,225	38,663	32,455	26,052	25,910	25,768	26,165	26,612
Net Receipts/(Payments)	6,227	2,021	1,193	(1,598)	2,438	(6,208)	(6,403)	(142)	(142)	397	447	470
Cash Carried Forward	34,609	36,630	37,823	36,225	38,663	32,455	26,052	25,910	25,768	26,165	26,612	27,082
Plan v Actual Carry Forward	6,500	7,716	8,104	5,613	7,158	6,261	(0)	(0)	(0)	(0)	(0)	(0)

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2015 (period 6)

Capital Expenditure & Capital Resource Limit

- Capital expenditure to date £5.7m [vs. plan £9.1m]. A further £4.9m of firm commitments have been made.
- A revised programme has been established with an updated profile of expenditure over the remainder of the financial year. The revised programme is consistent with the trust's notified capital resource limit.
- The Capital Resource Limit (CRL) charge forecast is £20.229m which is in line with plan.
- The Trust has sufficient cash to support the full capital programme and is not anticipating the use of external cash to fund the programme.

Financial Sustainability Risk Rating

- This replaces the COSRR and incorporates new measures for I&E margin performance.
- Performance is assessed against original plan not stretch plan delivery..
- Rating of 3 year to date compared with planned rating of 3 despite lower EBITDA than plan
- Rating of 4 forecast reflecting stretch forecast delivery over original plan. The liquidity rating component reflects an appropriate recognition of the proposed release of provisions.

Risk Ratings	Financial Metric	Historic Year to 31-Mar-15 £000s	Current Month Metrics Plan £000s	Current Month Metrics Actual / Forecast £000s	Current Month Metrics Variance £000s	Forecast Outturn Metrics Plan £000s	Forecast Outturn Metrics Actual / Forecast £000s	Forecast Outturn Metrics Variance £000s
Financial Risk Ratings applied to pre stretch target plans								
I&E Margin	I&E Margin Variance from Plan based on revised stretch target		(1.7)	(0.8)	0.9	(1.7)	0.0	1.7
Variance From Plan	Movement due to revised Plan stretch target		0.0	0.0	0.0	0.0	0.3	0.3
	I&E Margin Variance based on original Plan submission		(1.7)	(0.8)	0.9	(1.7)	0.3	2.0
	I&E Margin Variance Risk rating based on original Plan submission		**2**	**3**	**1**	**2**	**4**	**2**
Financial	Liquidity Ratio Metric (as sc 445 above)		2	3	1	2	2	0
Sustainability	Capital Servicing Capacity metric (as sc 450 above)		3	3	0	4	4	0
Risk Rating	I&E Margin rating (as sc 455 above)		3	2	(1)	3	4	1
Summary	I&E Margin Variance From Plan rating (based on Original Plan)		2	3	1	2	4	2
Financial Sustainability Risk Rating		**3**	**3**	**3**	**0**	**3**	**4**	1

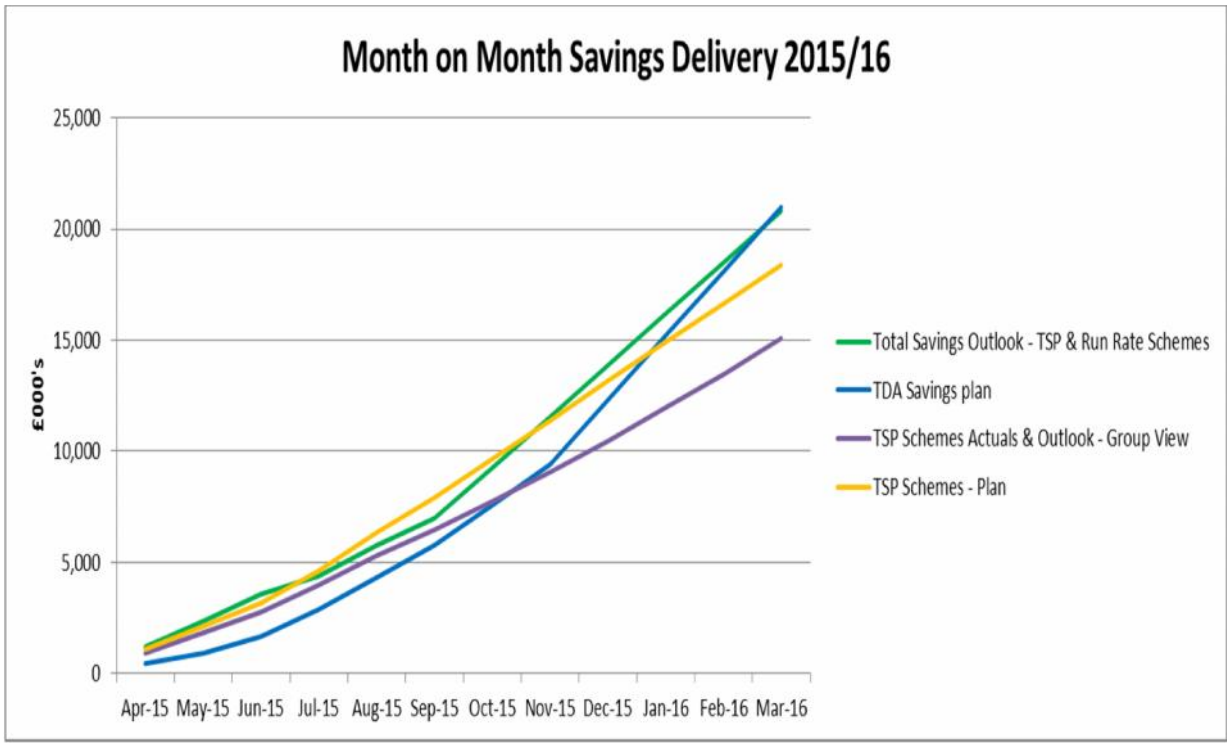
Service Level Agreements

- NHS Commissioner activity and income data year to date shows a shortfall of £4.3m. This reflects £5.3m shortfall on elective and day case activity and a £641k shortfall on A&E, offset by £0.6m over-performance on non-elective and £0.7m over performance on maternity . Outpatients as a whole is £311k over plan, largely due to more procedures and fewer follow up attendances t.
- Pass through drugs and devices, cancer drugs fund and Lucentis are all over-performing resulting in overspending on the related non-pay areas.
- The year to date smoothing adjustment reflecting the differential phasing of activity over the year against the broadly flat profile of spending is £1.1m.
- The position assumes 100% delivery of CQUIN income and fines consistent with the fines cap of £2.0m for the year. As a contribution to stretch surplus improvement a revised fines cap of £1.75m has been proposed to commissioners.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2015 (period 6)

- **Savings Programme**
- At P06 [TSP] savings delivery was ahead of TDA plan with £6.5m of savings delivered against a plan of £5.8m.
- TSP savings delivery was, however, below the plan value of those schemes with £6.5m delivered against a plan of £7.9m.
- A group view of the outlook suggests a shortfall in TSP delivery of £5.9m against TDA plan target £21.0m. This represents a significant deterioration in the group view of TSP savings delivery outlook from that at P05
- The chart below shows the savings profile in our plan submission to TDA; the plan value of identified TSP savings schemes; the value of those TSP schemes delivered to date and outlook..
- The chart also shows a total savings plan from TSP & run rate schemes included in our forecast reported to TDA.



Risks

Identification and delivery of savings at necessary scale and pace; the latest indications are that the forecast for savings will be FY delivery of £15.1m in year which is a £5.9m shortfall against plan. This shortfall is made up of £2.6m of schemes yet to be identified and £3.3m of under-delivery against scheme plan value.

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

CQUIN. CQUIN has been assumed at 100% in the Trust's plan for 2015/16. Q1 has been secured on this basis. There is a risk that Q2 sepsis achievement will result in a financial penalty, discussions with the CCG are underway.

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

Over spending on pay costs, particularly premium rate staffing. Spending on interim staffing has spiked in the new financial year. At an average spend of £1.5m per month in Q2 spending continues to run £0.7m per month more than the average of £875k per month used between November 2014 and February 2015.

Oncology service. Revisions to the oncology service may exceed the current forecast cost base.

Winter pressures. Cost increases associated with extended stays during winter months, if not funded, would exceed forecast expenditure levels.

Action required to secure key financial targets

Significant and sustained improvement in monthly run rate driven by

- Increased planned care activity to secure Q3/Q4 income as contract and delivered through core capacity to secure necessary margin
- CIP step up as Q3/Q4 plan requiring delivery of plan schemes to value and remediation of residual gaps to target
- Reduced premium rate temporary pay costs through expedited recruitment and attention to sickness mngt

Crystallisation of specific identified opportunities including review of residual reserves, commissioner funding for safe care through winter and recovery of any charges to local authority for delayed transfers of care.

Identification and progression at pace of necessary expedient measures consistent with safe, high quality care.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2015 (period 6)

Recommendations

The Board is asked to:

i. RECEIVE the contents of the report; and

ii. REQUIRE & ENDORSE those actions necessary to ensure that the Trust achieves key financial targets.

iii. Run rate improvement in excess of £2m per month required to secure original plan & stretch surplus commitments.

Tony Waite

Director of Finance & Performance Management

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:	5th November 2015

EXECUTIVE SUMMARY:

1.1 This report is an update on safe nurse staffing August data.
1.2 A programme of work to correct inaccurate data about nurse staffing has been undertaken and with several checks made during the month the data submitted and tested against our daily understanding gives an accurate position. Notable exceptions to this are where we have made changes to wards e.g. merger of Lyndon 4 and 5 has created a problem in reporting the data onto the national system, this has been reported to the Trust development Authority.
1.3 A daily and weekly checking mechanism has been put in place which included a record of actual staff on duty, this is our double check of data being taken from information systems.
1.4 Internal audit have started work to validate our data submission, and checking systems and procedures.
1.5 Next steps are to keep the double checking on a daily and weekly basis until we have confidence in the systems to deliver an accurate and consistent reflection of our staffing position.

REPORT RECOMMENDATION:

To receive an update at the November Trust Board meeting

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Relates to our safety objectives and BAF

PREVIOUS CONSIDERATION:

FOR INFORMATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAFE NURSE STAFFING UPDATE

Report to Trust Board on 5th November 2015

1 EXECUTIVE SUMMARY

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

1.2 The programme of work undertaken over the last two months to improve data accuracy has concluded, the results of these efforts will continue to be tested to ensure that the new systems that have been put in place are effective. Internal audit are also undertaking a retrospective audit on the September data as a validation exercise of the work undertaken. The results of this work will be in a future board report.

1.3 Daily and weekly checking of staff on duty against plan has continued, with summary records being kept. The daily public view of staff on duty on each ward has been updated

1.4 Six weekly planning cycles are in place to predict gaps in ward nurse staffing and this is fed to the nurse bank as the temporary requirement.

1.5 The roll out of the nurse bank module of e-rostering has begun with a plan to be implemented by the end of December.

2 SEPTEMBER DATA UPDATE

Since the last Board meeting our intensive programme of work has continued to enable the accuracy of data submitted in mid-October onto the national reporting system. We will continue checking that these renewed procedures are working effectively. The September data demonstrates reality for most wards. Where we have changed a ward in month e.g. merged Lyndon 4 and 5 this has been difficult to reflect in the information system provided to us. The Trust Development Authority has been alerted to this problem. This problem should resolve itself for the October data collection, however given other ward moves in coming months I will ensure that we check for this variable at that time.

The September data is in table 1, I have applied a 10% variation parameter to the fill rate percentage. Areas that demonstrate a shortfall have been checked to explore whether the gaps in the roster were real. Daily checking has always been a senior nurse activity, we have started to keep records of these checks on a daily basis since the end of September. We do know that not all temporary staffing shifts get filled and for those wards that carry a higher level of

vacancies this can be problematic. Where necessary staff get moved from one ward to another, sometimes at short notice, to ensure that wards have staffing as close to the planned establishment as possible. Our rules of no more than eight patients per registered nurse is applied to decisions about staffing and also to have a stronger balance of our own staff to agency staff. Group Directors of Nursing have verified that all temporary staff used during September have been added to the data collection.

Table 2 gives the trending data, given for comparison and to help Board members see the differences we are seeing in the data over the last three months.

The majority of our nursing vacancies are in medicine and emergency care, and mostly at the City Hospital. We have seen large numbers of staff start work with us and our recruitment plans continue to yield staff on a fortnightly basis. We now have a pattern of new starters through to the end of March 2016 in medicine where we have had the largest numbers of vacancies (currently 51.57 wte). There is also evidence that he retention of qualified nurses in medicine has improved over the last three months.

We increase the rate of pay of our bank staff on 1st September and this has helped fill more of our shifts with our own staff and enabled us to stop using Thornbury Nursing Agency at the same time. We have continued the slightly higher pay rate for an additional month, reducing this slightly from 1st November, but still higher than the base rate till the end of March 2016 to help us manage temporary staffing requirements over the winter months.

Table 1.

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during Sept 2015	Percentage night time fill rate during Sept 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during Sept 2015	Percentage night time fill rate during Sept 2015
Medicine & Emergency care	D5	City	13	5	5	5	141.9%	97.9%	1	1	0	120.7%	-
	D7	City	19	3	3	3	joint with	D5	1	1	0	Joint with	D5
	D11	City	21	3	3	3	75.0%	81.1%	2	2	1	107.0%	139.3%
	D12	City	10	2	2	2	143.3%	70.4%	1	1	1	118.6%	98.8%
	D15	City	24	3.5	3.5	3	84.7%	68.1%	2	2	1	103.5%	136.8%
	D26	City	21	3	3	3	110.0%	90.0%	2	2	1	152.0%	189.0%
	AMU 1	City	41	10	10	10	80.1%	74.3%	4	4	4	145.0%	72.1%
	AMU 2	City	19	5	5	5	89.9%	74.8%	1	1	1	100.7%	88.7%
	PR4	Sandwell	25	7	7	7	117.8%	90.8%	3	3	3	118.4%	63.3%
	PR5	Sandwell	34	5	5	4	100.1%	99.1%	3	3	2	155.6%	171.2%
	NT4	Sandwell	28	4	4	4	106.4%	99.2%	3	3	3	220.0%	188.9%
	LY 4	Sandwell	34	5	5	4	69.7%	35.8%	3	3	2	74.0%	62.2%
	LY5	Sandwell	29	4	4	4	86.4%	58.4%	4	4	2	74.0%	116.9%
	N5	Sandwell	15	5	5	2	89.9%	100.0%	1	1	1	136.1%	103.3%
	AMU A	Sandwell	32	11	11	11	93.6%	93.0%	4	4	3	144.1%	113.2%
	AMU B	Sandwell	20	3.5	3.5	3	105.1%	83.4%	3	3	3	51.7%	38.8%

	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 Sept 2015	Percentage night time fill rate during Sept 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during Sept 2015	Percentage night time fill rate during Sept 2015
Surgery A	D21	City	23	4	4	2	102.1%	90.2%	2	2	2	100.5%	78.5%
	D25	City	19	4	4	2	90.9%	101.5%	2	2	2	103.1%	81.2%
	SAU	City	14	4	4	3	89.1%	98.4%	1	1	1	208.4%	86.7%
	N2	SGH	24	4	4	2	79.6%	103.2%	2	2	1	91.6%	129.4%
	L2	SGH	20	6	6	4	91.8%	95.4%	3	3	2	95.7%	106.7%
	P2	SGH	20	5	5	3	83.4%	92.9%	4	4	3	103.1%	110.0%
	N3	SGH	33	5	5	3	81.6%	97.8%	4	4	3	100.8%	95.6%
	L3	SGH	33	5	5	3	74.7%	98.6%	4	4	3	92.2%	105.5%
	CCS	City		Staff flexed to the dependency/number of patients in the units			137.1%	105.7%	Staff flexed to the dependency/number of patients in the units			155.4%	-
	CCS	SGH					115.6%	92.9%				225.9%	-

	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 Sept 2015	Percentage night time fill rate during Sept 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during Sept 2015	Percentage night time fill rate during Sept 2015
Community & Therapies	Henderson	RH	24	3	3	2	87.0%	89.1%				85.8%	102.2%
	Elisa Tinsley	RRH	24	3	3	2	97.1%	97.1%	3.5	3.5	2.5	89.6%	86.7%
	D43	City	24	6	6	4	93.8%	89.1%	5	5	2	93.6%	135.0%
	Leasowes	RH	20	3	3	2	73.2%	86.4%	3	3	2	120.4%	102.5%

	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 Sept 2015	Percentage night time fill rate during Sept 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during Sept 2015	Percentage night time fill rate during Sept 2015
Surgery B	Eye ward	City	10	2	2	2	103.9%	85.0%	1	1	0	84.1%	117.0%

	Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during Sept 2015	Percentage night time fill rate during Sept 2015	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during Sept 2015	Percentage night time fill rate during Sept 2015
Womens & Children's	L G	SGH	14	3	3	2	84.4%	104.0%	1	1	1	76.6%	37.1%
	L1	SGH	26	5	5	4	72.7%	87.7%	3	3	2	116.1%	113.8%
	D19	City	8	3	3	2	99.0%	101.8%	1	1	0	53.3%	-
	D27	City	18	4	3	2	75.3%	84.7%	2	2	1	88.5%	98.3%
	Maternity	City	42	6	5	4	88.8%	98.3%	4	4	2	82.6%	100.0%

Table 2

	Site Co	Site Name	Total monthly planned RN staff hours days	Total monthly actual RN staff hours days	Total monthly planned HCA staff hours days	Total monthly actual HCA staff hours days	Total monthly planned RN staff hours Nights	Total monthly actual RN staff hours nights	Total monthly planned HCA staff hours nights	Total monthly actual HCA staff hours nights	Average day fill rate - registered nurses/midwives (%)	Average day fill rate - care staff (%)	Average night fill rate - registered nurses/midwives (%)	Average night fill rate - care staff (%)
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE	930	1951.583	465	512.75	589	555	0	166.5	209.8%	110.3%	94.2%	0.0%
Jul-15	RXK02	CITY HOSPITAL	32069.5	27187.57	13190.5	13134.5	27450.5	19260.02	8199.5	7613.267	84.8%	99.6%	70.2%	92.9%
	RXK10	ROWLEY REGIS HOSPITAL	3208	2495	3565	2970.667	2139	1486.75	2495.5	1923	77.8%	83.3%	69.5%	77.1%
	RXK01	SANDWELL GENERAL HOSPITAL	30178.5	26279.73	15686	15236.02	23885.5	17973.25	11764.5	11337.25	87.1%	97.1%	75.2%	96.4%
			66386	57914	32907	31854	54064	39275	22460	21040	87.2%	96.8%	72.6%	93.7%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE	930	806	465	370.75	573	518.25	0	171	86.7%	79.7%	90.4%	0.0%
Aug-15	RXK02	CITY HOSPITAL	31861.5	24502	13158.25	11459.75	27419.5	18006.17	7843	7162.517	76.9%	87.1%	65.7%	91.3%
	RXK10	ROWLEY REGIS HOSPITAL	3208.5	2431.5	3565	3108.117	2139	1589.75	2495.5	2150.5	75.8%	87.2%	74.3%	86.2%
	RXK01	SANDWELL GENERAL HOSPITAL	29192	24223	14735.5	15146	22765.5	17481.07	11251	11176.75	83.0%	102.8%	76.8%	99.3%
			65192	51963	31924	30085	52897	37595	21590	20661	79.7%	94.2%	71.1%	95.7%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE	900	935	450	378.5	555	472	166.5	194.75	103.9%	84.1%	85.0%	117.0%
Sep-15	RXK02	CITY HOSPITAL	28394	26595.9	11679	13003.83	24495	20277.5	7651	7903	93.7%	111.3%	82.8%	103.3%
	RXK10	ROWLEY REGIS HOSPITAL	3105	2663	3450	3364.5	2070	1881.25	2415	2336	85.8%	97.5%	90.9%	96.7%
	RXK01	SANDWELL GENERAL HOSPITAL	27587	25604	14651	16277.83	21016	18495	11561.5	11814.52	92.8%	111.1%	88.0%	102.2%
			59986	55798	30230	33025	48136	41126	21794	22248	93.0%	109.2%	85.4%	102.1%
	RXK03	BIRMINGHAM MIDLAND EYE CENTRE	920	1230.861	460	420.6667	572.3333	515.0833	55.5	177.4167	133.8%	91.4%	90.0%	319.7%
3-month Avges	RXK02	CITY HOSPITAL	30775	26095.16	12675.92	12532.69	26455	19181.23	7897.833	7559.594	84.8%	98.9%	72.5%	95.7%
	RXK10	ROWLEY REGIS HOSPITAL	3173.833	2529.833	3526.667	3147.761	2116	1652.583	2468.667	2136.5	79.7%	89.3%	78.1%	86.5%
	RXK01	SANDWELL GENERAL HOSPITAL	28985.83	25368.91	15024.17	15553.28	22555.67	17983.11	11525.67	11442.84	87.5%	103.5%	79.7%	99.3%
	Total	*Latest 3 month average====>*	63855	55225	31687	31654	51699	39332	21948	21316	86.5%	99.9%	76.1%	97.1%

3 RECOMMENDATION(S)

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

Colin Ovington

Chief Nurse

28th October 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	CQC Improvement Plan
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Kam Dhami, Director of Governance
DATE OF MEETING:	5 November 2015

EXECUTIVE SUMMARY:

The attached paper provides an update on some of the outstanding actions in the Improvement plan (Appendix 1). The majority of the 67 actions have been completed; those that are not are receiving Executive attention to achieve planned delivery as quickly as possible.

The paper also provides an outline plan to check whether the work that has been carried out has been effectively implemented across the Trust and real change has resulted (Appendix 2). This will be achieved by carrying out unannounced 'mock' CQC inspections throughout November.

REPORT RECOMMENDATION:

The 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

Appendix 1

Sandwell and West Birmingham Hospitals NHS Trust

CQC Improvement Plan: Progress update on some outstanding actions

Ref:	Action required	Update
Accident and Emergency		
MD2	Patient representatives to join in conducted unannounced inspections every quarter in response to safety audit data	• Unannounced visits in all areas in A&E as part of PLACE and TDA.
MD4	The Infection Control team carrying out unannounced visits to check that isolation procedures are being followed.	• Isolation plans for A&E reviewed by IPC team as part of Ebola preparedness, undertaken specific training for A&E staff, produced a DVD re: PPE. • Isolation rooms for City not adequate – contingency in place to use rooms on AMU1. No rooms to isolate Category 4 patients at Sandwell – contingency in place to utilise 2 rooms. • Monthly walkabouts on both sites to review practices.
MD5	Procurement of vending machines and locking system for medicines storage.	• Vending machines on site. Implementation in clinical areas commenced with the Assessment Units and ITU. SOP drafted.
SD2	Raise awareness re: application of guidance on use of staff / family, based on a risk assessment, for language interpretation. • Increase bank interpreters for the top 10 languages. • Address functional problems in accessing Language Line.	• Bank interpreters increased to around 90 covering top 10 languages plus others. • Increased use of Language Line by A&E: o April to September 2014 – 29 calls o April to September 2015 – 144 calls
Medicine		
MD10	Care documentation: Revised methods being used in Surgery A which include individualised checklists in patients notes and sign off in the medical notes to demonstrate that they have been completed to ensure that the mechanisms to embed 'Ten out Ten' are more robust than over the last year. Success of these methods will be rolled out across the Trust during 2015. • Review of fluid management module of VitalPacs	• Individual Ten out of Ten checklist has been reformatted, redrafted and issued. • All Assessment Units to be visited by the end of October and hard copies of the checklist inserted into patient folders and updated with information. • The new checklist to uploaded onto the Intranet. • Training material to support timely and accurate completion of Ten out of Ten to be provided by end of October. • Audit of compliance is already undertaken monthly and on ward dashboards but ad hoc audits are being supported by Corporate Nursing.

Ref:	Action required	Update
SD6	Ensure care documentation is complete, person-centred and up-to-date. Introduce ways of further individualising and personalising care planning.	• Person-centred care planning has been promoted at meetings, on screen savers, in Heartbeat and with Staff Comms. • The care plan has format has been amended in response to user feedback and the CQC findings; new care plans have been developed by specialty leads and frontline practitioners. • All are on available on the care plan library on the Intranet. These will continue to be added to. • All Assessment Units are being visited and a set of new care plans provided for immediate use with patients following assessment of needs. Other wards to follow. • Care plans require personalisation and signatures of patients / carer. • The care plan and patient signature audit is being undertaken by Corporate Nursing w\c 26 October.
Surgery		
MD12	Hand hygiene: some staff visitors to wards still not compliant all of the time.	• Hand washing results remain variable; they are displayed weekly at ward level. Issues mainly relate to doctors and other staff visiting the wards. • Devices installed that give a voice prompt / reminder to wash hands as staff enter theatres.
Children and Young People		
MD15	Consider if whether there is a case to go beyond current staffing as part of examining future workforce plans.	• A successful recruitment drive – 1wte Band 5 outstanding and 1wte Band 7 vacancy approved.
MD16	Improve % of qualified nurses with PiLS. All ward managers to attend EPLS.	• 88% of ward managers (2 out of 3) are EPLS trained, plus the matron. % of staff with PiLS across the unit to be confirmed.
MD17	W&OD Committee to review the 2015/16 training plan and budget for paediatrics to check adequacy.	• The TNA for paediatrics was signed-off for adequacy and assurance in Spring 2015. This training plan is regularly reviewed at Group management level. It is also monitored through the Executive-led Education, Learning and Development Committee. • There is oversight on underspend or underuse on a monthly basis, with appropriate changes put in place to access the learning and development for the Group. • The Workforce and OD Committee has oversight on spend and workforce impact.
MD19	Accurate record in respect of each child – joint documentation reviewed and amended, ward managers reviewing	• VitalPacs introduced in totality at Sandwell. At City D19 currently using paper version plus VitalPacs. • Work on-going in review of admission assessment

Ref:	Action required	Update
	nursing process with emphasis on planning and evaluation of nursing care.	documentation.
Maternity		
SD12	Measures boards in maternity and gynaecology to reflect Trust-wide standards.	• Measures boards in place.
SD12	Undertake listening and survey activity with families to understand if there is additional data on our performance that they would value being displayed.	• The matrons for maternity and neonatal services are conducting regular 'ward rounds' and are discussing with families where additional information may prove valuable.
SD13	Patient representatives to join in conducted unannounced inspections every quarter on hand hygiene and infection control dress code.	• Will be in place by the end of October.
SD13	Hand hygiene: repeat escalation of individuals to be treated as a conduct issue.	• Discussed at monthly departmental performance meetings.
SD15	Procurement of vending machines and locking system for medicines storage.	• Vending machines on site. Implementation in clinical areas commenced with the Assessment Units and ITU. SOP drafted.
SD18	The dataset implied by the CQC will be routinely shared within maternity services over the coming year. Existing communication channels to be used to discuss, review and act on the data.	• Report circulated with the *Risky Business* newsletter. Presentation carried out at the October QIHD.
SD23	Find a way to of increasing feedback about working for the Trust from obstetric and midwifery staff. Need to capture a plan that captures outputs of all interventions to date.	• Local engagement and communication channels, as well as corporate interventions, to enable staff in obstetrics and midwifery to give confidential feedback on their work or suggestions. • Directory of Midwifery holds monthly Ward meetings in the acute settings. As part of these meetings the staff are encouraged to give feedback, raise issues or suggestions and feed these back to Group management. • The Chairman held one of his Breakfast Meeting in obstetrics and midwifery in May 2015 and fed back the comments anonymously to the Director of Ok who was able to act on some of the comments on working practices and some misunderstandings on work policies.
SD23	We will use the Kirkup Review, within our QIHDs, to develop a specific plan for maternity services at the Trust.	• Discussions on the future of maternity services at the Trust held at the Board informal session in October 2015.

Ref:	Action required	Update
		• Trust response to the Kirkup review being presented to the Board in November 2015.
Outpatients and Diagnostic Imaging		
SD30	Support for dementia and LD patients in Ops – audit arrangements for LD patients. Bid to CCG for additional senior nursing post to support LD.	• CCG informed Trust of agreement to fund an LD nurse – awaiting further information. Draft JD and person specification produced.
SD30	Memory loss scoring methods - plans being developed to implement screening in ophthalmology and audiology departments.	• Discussions between ophthalmology and audiology Ops taken place. Cards to hand to patient to give to their GP are being developed.
SD32	Introduce a simple proforma to capture complaints resolutions and share the results across all OPs through QIHDs.	• Proforma developed and in use.
SD35	Safeguard Level 2 training for all staff that run OP clinics – All trained staff booked on or completed L2 training by October. • Review of training matrix planned.	• A training matrix for Adult Safeguarding is being drafted.
Community Services: Adults		
SD40	Procurement of vending machines and locking system for medicines storage.	• Vending machines on site. Implementation in clinical areas commenced with the Assessment Units and ITU. SOP drafted.
Community Services: End of Life Care		
MD24	Ensure a variety of activities provided on a daily basis – the day hospice model is currently under review as part of the procurement of activity with the CCG.	• Money is allocated as part of the EOLC bid with the CCG to redevelop day hospice services. Decision from the CCG is awaited. • In the interim, staff are undertaking a review of current services with service user opinion. • Also being arranged is Liaison between OT, phyios and dieticians within the Community and Therapies clinical group to provide weekly session for patients in relaxation, chair based exercise and dietary advice. • The community specialist palliative care nurses are to work 1 day per week in the day hospice to ensure sound symptoms control advice is available. • The fatigue and breathlessness (FAB) clinic has restarted a 6-weekly programme for patients within Bradbury Day Hospice.

Appendix 2

Outline plan to carry out unannounced 'mock' CQC inspections

1. Introduction

1.1. In October 2014 the CQC undertook a planned inspection of the Trust which involved reviews of a number of areas, discussions with staff and users of our services and observational assessments.

1.2. Their report was published in March 2015 and identified 67 areas for improvement across which we needed to carry out to improve the care and services provided to our patients. In response, an Improvement Plan was developed that we set out to achieve by the end of October 2015. Over the past 6 months work has been on-going to address the areas of poor practice found.

1.3. This paper provides an outline plan to check whether the work that has been carried out has been effectively implemented across the Trust and real change has resulted.

2. Inspection regime

2.1. Using the comments from the CQC report and the Trust's Improvement Plan a generic inspection checklist has been drafted. Other checklists will be developed where a more focussed approach is required.

2.2. The checklist involves those carrying out the inspection to observe practices and to ask specific questions of staff and patients in the areas visited.

2.3. The inspectors will be volunteers taken from Trust staff, including some who are CQC Inspectors, Board members, the CCG Clinical Quality Review membership, Trust members and Healthwatch.

2.4. Throughout November this group of volunteer 'inspectors' will visit wards and departments and review them against the checklist and rate the area. This will ensure independence and consistency in approach.

2.5. As with the CQC inspection last year, the areas to be inspected will be chosen at random but will cover all Clinical Groups and all types of wards and departments, hospital and community. It is likely that areas mentioned in the report will visited again.

2.6. All inspections will be unannounced and will occur at any time through the day or night, including weekends.

2.7. At any point during the inspection period, if the inspectors see staff not carrying out the observable tasks or a question is answered negatively, the whole criterion will be marked as a 'fail' which is representative of the assessment undertaken last year.

2.8. Following the series of inspections the 'ratings' will be collated and shared identifying any continuing gaps in practice and suggesting further actions to be taken. Feedback will be provided to the lead for that area, as well as the relevant directorate and clinical group.

2.9. The outcomes of the inspections will be shared widely so that improved good practice can be celebrated and the areas needing to improve can receive attention and support.

3. Next steps

3.1. To 'recruit' inspectors through personal approach and via staff communications.

3.2. Finalise the inspection checklist.

3.3. Identify dates and select departments to be inspected

3.4. Meet with all the volunteer inspectors to outline the process and review availability.

3.5. Publicise that the inspections will be happening in November.

Kam Dhami
Director of Governance

28 October 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Report into the Morecambe Bay Investigation: SWBH response**
SPONSOR (EXECUTIVE DIRECTOR):	**Colin Ovington, Chief Nurse**
AUTHOR:	**Miss Gabrielle Downey, Group Director – Women's & Child Health, Elaine Newell, Group Director of Midwifery**
DATE OF MEETING:	**5th November 2015**

EXECUTIVE SUMMARY:

The report into the Morecambe Bay Investigation was well publicised in the media following higher than normal death rates in mothers and babies and untoward incidents in the maternity services at that trust between 2004 and 2013. The investigation concluded that concerns over clinical practice were confined to Furness general hospital (FGH) stating that the maternity unit at FGH was "dysfunctional" and that "serious failures of clinical care led to unnecessary deaths of mothers and babies". (Kirkup, 2015). The report makes 44 recommendations in total, 18 for FGH and 26 for the consideration of the wider NHS and partner stakeholders.

The arrangements at Sandwell and West Birmingham Hospitals NHS Trust for managing risk and promoting safety are detailed in the Maternity Service Risk Management Strategy (SWBH/MAT 100). All risk and Governance processes have been subject to scrutiny at the highest level, with the service awarded CNST level 3 in February 2014. The service was recently awarded a CQC rating of good, across each of the 5 core domains in April12015. Despite this level of external assurance we are not complacent about risk and safety, this paper and action plan demonstrates our assessment against the recommendations and the areas for action which we are taking to ensure safety in our maternity services. This plan will be monitored by the Maternity and Perinatal Medicine Governance Group, and by exception to the Group Governance Board in order to prevent the level of systematic failure described at Morecambe Bay Hospitals NHS Trust.

REPORT RECOMMENDATION:

The Board is asked to **DISCUSS** and **ACCEPT** 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
		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	X

Comments:

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

SWBH Gap analysis of Dr Bill Kirkup's Morecombe Bay Investigation – March 2015

1.0 Introduction:

The Morecombe Bay Investigation was established by Jeremy Hunt, Secretary of State for Health, in September 2013, following concerns over several serious untoward incidents in the maternity department at Furness General Hospital (FGH). The investigation covered the period January 2004 to June 2013. The Investigation Panel also reviewed pregnancy and births at all maternity units run by University Hospitals of Morecombe Bay NHS Foundation Trust. The investigation concluded that concerns over clinical practice were confined to FGH stating that the maternity unit at FGH was "dysfunctional" and that "serious failures of clinical care led to unnecessary deaths of mothers and babies". (Kirkup, 2015). The report makes 44 recommendations in total, 18 for FGH and 26 for the consideration of the wider NHS and partner stakeholders.

Morecombe Bay NHS Foundation Trust consists of three hospital sites, Royal Lancaster Infirmary (RLI), Furness General Hospital (FGH) and West Moorland General Hospital (WGH). The service spans a large geographical range with up to 52 miles distance between sites.

The maternity services at each site are described as below;

<u>Morecombe Bay National Health Service (NHS) Trust (3 Sites) vs Sandwell and West Birmingham Hospitals NHS Trust</u>

Trust	Royal Lancaster Infirmary (RLI)	Furness General Hospital (FGH)	Westmorland General Hospital (WGH)	SWBH
Deliveries per annum:	2000	1000	500	5650
Type of Service:	Consultant led / Midwifery led	Consultant led / Midwifery led	Midwifery Led Only Stand alone birth centre	Consultant led / Midwifery led
In Patient Services:	Antenatal/Postnatal Ward	Antenatal/Postnatal Ward		Antenatal/Postnatal Ward
Community Service:	Traditional Community Midwifery model	Traditional Community Midwifery model	Traditional Community Midwifery model	Traditional Community Midwifery model
Neonatal Service:	Level 2 Neonatal Unit	Level 1 Special Care Baby Unit	None	Level 2 Neonatal Unit

2.0 Background to the Kirkup Report

The Kirkup review was established following a series of serious incidents involving mothers and babies spanning the period 2004 – 2011. The final report described a dysfunctional service *'a lethal mix ..that led to the unnecessary deaths of mothers and babies'.*

The Investigation Panel included expert advisers in nursing, midwifery, obstetrics, paediatrics, governance and ethics. The investigation panel reviewed a variety of documents from across all partner agencies and the Trust. The final report was comprised from extensive evidence, consisting of governance materials, interviews, Care Quality Commission (CQC) maternity service surveys, NHS Staff survey, communication with families, Hospital Episode Statistics (HES) data, Centre for Maternal and Child Enquires (CMACE). The full report can be found at https://www.gov.uk/government/publications

In summary, the report found that;

- Clinical competence was substandard with deficient skills and knowledge
- Working relationships were extremely poor, particularly between different staff groups, such as obstetricians, paediatricians and midwives
- There was a growing move amongst midwives to pursue normal childbirth 'at any cost`
- There were failures of risk assessment and care planning that resulted in inappropriate and unsafe care
- The response to adverse incidents was grossly deficient
- Repeated failure to investigate properly and learn lessons

The investigation report details 20 instances of significant failures of care in the FGH maternity unit which may have contributed to the deaths of 3 mothers and 16 babies. Different clinical care in these cases would have been expected to prevent the death of 1 mother and 11 babies. This was almost 4 times the frequency of such occurrences at the Trust's other main maternity unit, the RLI.

The report states that the maternity department at FGH was dysfunctional with serious problems in 5 main areas:

- Clinical competence of a proportion of staff fell significantly below the standard for a safe, effective service. Essential knowledge was lacking, guidelines not followed and warning signs in pregnancy were sometimes not recognised or acted on appropriately.
- Poor working relationships between midwives, obstetricians and paediatricians. There was a 'them and us' culture resulting in poor communication which hampered clinical care.
- Midwifery care became strongly influenced by a small number of dominant midwives whose 'over-zealous' pursuit of natural childbirth 'at any cost' led at times to unsafe care.
- Failures of risk assessment and care planning resulted in inappropriate and unsafe care.

- There was a grossly deficient response from unit clinicians to serious incidents with repeated failure to investigate properly and learn lessons.

  "*There was a disturbing catalogue of missed opportunities, initially and most significantly by the Trust but subsequently involving the North West Strategic Health Authority, the Care Quality Commission, Monitor, the Parliamentary and Health Service Ombudsman and the Department of Health." (Kirkup, 2015)*

3.0 Next steps

The reports main findings and recommendations are summarised in the Gap Analysis of all 44 recommendations detailed in Appendix 1. SWBH maternity services can demonstrate full or partial compliance against the majority of the recommendations outlined within the report. 4 additional actions are summarised as follows:

1. Maternity services should review the Local Training Needs Analysis in light of this report and ensure that exception reports are provided to the Group Governance Board on a monthly basis (Rec' 28).
2. The Department should ensure that there are clearly communicated arrangements for the introduction and monitoring of midwifery revalidation (Rec' 30).
3. The department should ensure that there are agreed processes for the reporting of Red Flag events in accordance with NICE safe Midwifery staffing (Feb 15). In addition, the GDOM and GD will develop a formal medical and midwifery recruitment strategy (Rec' 34).
4. The GDOM and GD will include a clear succession planning programme into the workforce planning strategy (Rec' 40).

Monitoring of these actions will be via the Maternity and Perinatal Medicine governance group, and by exception to the Group Governance Board.

The Maternity service risk and governance arrangements are detailed in the Maternity Service Risk Management Strategy (SWBH/MAT 100). All risk and Governance processes have been subject to scrutiny at the highest level, with the service awarded CNST level 3 in February 2014. The service was recently awarded a CQC rating of good, across each of the 5 core domains in April12015.

4.0 Recommendation

The Board is asked to **DISCUSS** and **ACCEPT** the contents of the report.

Elaine Newell –Group Director of Midwifery
Gabrielle Downey – Group Director

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Trust response to the Report of the Morecambe Bay Investigation by Dr Bill Kirkup, CBE

Recommendation		Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
6.	We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. **Action: the Care Quality Commission, NHS England.**	Yes	Partial		SWBH to await further advice from relevant bodies				It should be noted that whilst parents and relatives are not directly involved in the investigation of serious incidents, the department has an established process for providing open and honest feedback on serious incidents where failings in care may have contributed towards a negative outcome. Being open policy followed when moderate or above harm is experienced as a result of a patient safety incident. Trust policy requires involvement of patients in SI investigations either as a direct part of the gathering of information and/or as part of

	Recommendation	Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
									the Duty of candour process.
9.	Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. **Action: the Department of Health**	Yes	Partial	Medium	Corporate records policy to be approved	Dec 15	KD	N	Directorate central repository of electronic documents. Corporate policy reflecting NHS England corporate records retention & disposal retention & Guidance has been drafted and requires consultation and approval.
28.	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional	Yes	Partial	Low	Yes – Local mandatory training requirements not fully met (Target 95%). Training compliance reports quarterly to	Monthly	NR	N	Rolling mandatory training programme in place / compliant with CNST recommendations. Monthly MDT training days in place. Clinical Educators in post (3WTE). Local training database in place for monitoring. Local training needs analysis in place in accordance with CNST requirements.

	Recommendation	Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
	and regulatory bodies.				MN&P Governance group				Level 2 HDU competency document in place for staff caring for critically ill patients
30.	Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for 186 continuing professional development of staff and link this explicitly with professional requirements including revalidation.	Yes	Partial	Low	Introduction / implementation of revalidation for midwives	Oct 2015	EN	TBC	Training needs analysis / Training plan reviewed / revised annually in accordance with training needs, identified at annual reviews. Medical revalidation processes already in place – led by Medical Director. PREP requirements for midwifery staff remains in place until systems for revalidation introduced in late 2015. Supervision of midwives currently in place. Training database in place. Evidence based guidance in place.
34.	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with	Yes	Partial	Medium	Yes. 6 monthly midwifery staffing analysis in accordance with NICE safer staffing guidance – report to Trust	Dec 15	EN/ GD	TBC	Medical, Nursing and midwifery Workforce issues discussed and monitored at directorate and group governance boards. Nursing and Midwifery staffing monitored daily and reviewed annually. Escalation policy in place and well embedded.

	Recommendation	Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
	one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought.				Board via Chief Nurse. Safer staffing red flag events to be agreed and reported via dashboard. Medical and midwifery recruitment / retention strategy to be developed				Concerns regarding staffing escalated via risk registers. Neonatal workforce strategy in place. Community Midwifery and Neonatal nurse staffing currently on risk register. Neonates currently experiencing medical staffing issues – also on risk register. High levels of sickness absence are impacting on staffing levels – a separate action plan is in place to address this. Current links with BCU & Wolverhampton University with some courses looking to be accredited.
39.	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants.	Yes	Partial	Low	Increased use of meetings to resolve complaints	Dec 15	AB/ EN	TBC	Complaints process reviewed and revised in 2014. All responses are reviewed by the Director of Midwifery and subsequently undergo rigorous scrutiny by the executive team prior to release. The Trust does not have access

	Recommendation	Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
	The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee.								to an established MSLC Complaints are shared with staff and actions put in place where required. The Complaints team promote the use of meetings for complaint resolution so that patients are more involved in the improvement of care and services.
40.	The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events.	Yes	Partial	Low	Include a clear succession planning programme into workforce planning strategy	Dec 15	GD/ EN	N	Top Leaders programme in place and attended by triumvirate team, HoS and Clinical Directors. West Midlands HoM group established a competency based leadership programme which has been attended by midwifery matrons and some Band 7 staff. Trust has established leadership programmes in place for nursing and midwifery staff. Revised PDR process in place to ensure that all staff have clearly identified roles and responsibilities with associated

	Recommendation	Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
									objectives.
	Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff. We recommend that this build on national work already begun on how such a process would work. **Action: the Care Quality Commission, NHS England, the Department of Health.**	Yes			SWBH to await further advice from relevant bodies				Maternity Risk management strategy & Trust incident reporting policy in place. All staff received Incident reporting and investigation training from Maternity Risk Lead as part of the TNA. It should be noted that SWBH maternity services currently review all maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. Those with potentially avoidable factors are subject to rigorous scrutiny via well embedded risk management processes and are reported externally via STEIS SUI reporting process. SUI's are independently chaired to avoid a conflict of interest. Feedback to families in such instances is routinely undertaken.
8.	We commend the introduction of a clear national policy on	Yes	Yes						SWBH have a whistleblowing policy which is well publicised.

	Recommendation	Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
	whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. **Action: the Department of Health.**								Feedback from staff indicates that staff are aware of where to access the policy and how / when to use this.
9.	Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. **Action: the General Medical Council, the Nursing and Midwifery Council, the Professional Standards Authority for Health and Social Care.**	Yes	Yes		SWBH to await further advice from relevant bodies				Duty to report concerns is clearly stated within Job descriptions and forms a fundamental tenet of professional codes and standards. The contract of employment for SWBH staff requires all staff to act in accordance with the statutory requirements of professional bodies. The requirement to report concerns about clinical services is also articulated in the trust risk Management policy and the Maternity Services risk Management Strategy
10.	Clear national standards should be drawn up setting out the professional duties and expectations of clinical	Yes	Yes		SWBH to await further advice from relevant				As above. In addition. These roles and responsibilities in relation to risk and governance

	Recommendation	Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
	leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. **Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.**				bodies				are also clearly stated in the Maternity Risk Management strategy in accordance with NHSLA CNST requirements. Evidence has been provided to CNST and the CQC in relation to appropriate policies and training. Both bodies were assured that standards were met.
11.	Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. **Action: NHS England, the Care Quality Commission, all Trusts.**	Yes	Yes		SWBH to await further advice from relevant bodies				As above

Recommendation		Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
12.	A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. **Action: NHS England, the Care Quality Commission.**	Yes	Yes		SWBH to await further advice from relevant bodies				Policy in place SWBH\ORG\058. Policy and procedure on dealing with requests from HM Coroner sets out duties of staff in relation to reporting to and involvement with Coroner / inquests. Support for staff writing statements is provided, in addition to interviews to ascertain sequence of events in relation to inquests.
13.	The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system	Yes	Yes		SWBH to await further advice from relevant bodies				Complaints process reviewed and revised in 2014. All responses are reviewed by the nominated group Leads and subsequently undergo rigorous scrutiny by the executive team prior to release.

	Recommendation	Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
	is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. **Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman.**								
20.	Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as	Yes	Yes		SWBH to await further advice from relevant bodies				All perinatal deaths occurring within SWBH are systematically recorded onto a local and national database (MBBRACE & every baby counts/ RCOG).

	Recommendation	Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
	MBRRACE-UK, and include the provision of comparative information to Trusts. **Action: NHS England.**								
25.	We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, High Quality Care for All, and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. **Action: NHS England, the Department of Health.**	Yes	Yes		SWBH to await further advice from relevant bodies				Strong corporate focus on quality reflected in corporate meeting structures. Annual plan -Top 10 priorities.

Recommendation		Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
27.	The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act.	Yes	Yes	Low	No				Being open / Duty of Candour policy in place. Investigation reports include actions / information on Being Open / Duty of Candour. Actions monitored at monthly clinical risk meetings
31.	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment.	Yes	Yes	Low	No				SWBH are able to provide evidence of MDT working – Monthly QIHD sessions, joint daily handover meetings, training events, joint unit based meetings. Evidenced by attendance registers. In addition, junior doctors also undertake a placement period within the Birth Centre to enhance joint working arrangements

Recommendation		Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
32.	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment.	Yes	Yes	Low	No - Continued monitoring arrangements already in place				Risk assessment policy already in place, subject to regular audit and monitoring – compliant at CNST level 3. Completion and update of management plans undertaken. In addition, spot check reviews take place daily at DS handover meetings. Women who choose to deliver outside of recommended guidance are risk assessed and have documented individualised plans of care.
33.	The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity services, to ensure that they	Yes	Yes	Low	No				As above. In addition, the need for review of risk assessment included in all transfer of care guidance. Transfers are

	Recommendation	Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
	follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups.								discussed / reviewed by the MDT at daily handover. Concerns regarding breach of guidelines are addressed via established risk management processes. Audit programmes in place – outcomes monitored by M&PM governance group.
36.	The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying' and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy.	Yes	Yes	Low	No				As above. In addition, SWBH has forged strong working relationships with neighbouring units largely facilitated by the maternity and Newborn Network. The Trust has recently forged partnership arrangements as part of the Black Country alliance which will provide further opportunities for shared learning opportunities. The department also has strong links with local universities.
37.	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a	Yes	Yes	Low	No				Maternity and Neonatal services are supported by a dedicated risk and governance lead. In

Recommendation		Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
	programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy.								addition there are dedicated PA allocations for medical staff to lead on risk management. Reports to the Directorate risk group include information on the numbers of risks reported and the type / location of staff reporting. Fortnightly risk meetings are held where this information is monitored. The maternity services risk management strategy promotes an open culture of incident reporting and the effectiveness of this is evident by the number and nature of incidents reported and managed. All information is shared with clinical staff on the monthly QIHD sessions.
38.	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from	Yes	Yes	Low	No				Key Staff identified with responsibility for undertaking investigations of serious incidents have all had training in RCA. Documentation used to investigate and report findings have been agreed corporately

	Recommendation	Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
	incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident.								and comply with best practice guidance. Report templates include information on lessons learned / service improvements and debriefing / support of staff. SUI RCA panel meetings are independently chaired. Actions plans are monitored via the perinatal risk management group – which includes representation from corporate risk services to ensure objectivity. Lessons learned from complaints and clinical incidents are shared at monthly QIHD, via newsletters, meetings and individual feedback.
41.	The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This	Yes	Yes	Low	No				There are a number of external and internal processes currently in place to provide assurance to the Board regarding quality of care. These include: • CNST / CQC assessments • Monthly reporting via clinical / IPR dashboards. • Monthly Governance

	Recommendation	Relevance to SWBH	Compliance	Associated risk High / Medium / Low / None	Action required	By When	By Whom	Resource Implications Y / N	Progress noted:
	work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed.								meetings (corporate, group and local) • Monitoring via group and directorate performance reviews. • Established Audit programmes • Annual LSA audits
42.	As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training.	Yes	Yes	Low	No				SWBH M&PM have a dedicated risk and governance team. In addition there are dedicated PA allocations for medical staff to lead on Governance and risk management. Responsibilities in relation to quality are clearly outlined in Job descriptions of senior and middle managers. These roles and responsibilities are also clearly stated in the Maternity Risk Management strategy in accordance with NHSLA CNST requirements.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Complaints & PALS report: 2015/16 quarter 2
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Karen Beechey, Head of PALS & Complaints
DATE OF MEETING:	4 November 2015

EXECUTIVE SUMMARY:

This report sets out details of Complaints and PALS enquiries received between July and September 2015 (Quarter 2).

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.

In this quarter, it is reported that the complaints activity has increased, and shows that 97% of complaints have been managed within their target date, following a similar result in the previous quarter. Themes and outcomes remain consistent with previous quarters and shows a continued focus on lessons learned, 'action tracking' and quality responses that are caring, transparent, timely and responsive to the needs of complainants.

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:

Safe, high quality care
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 2

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.

Hello Loretto (*Complaints coordinator),*

Thank you so much for the letters which you sent both my father and myself. I was very happy with the meeting we had on the 9th October and was pleased with the outcome. My Dad is delighted with the apologies made to him and feels that some good will come out of it. Hopefully a review of your procedures will stop the same thing happening to anyone else. We can now put the matter to rest and move on with our lives.

We would like to thank everyone again for the excellent work they do. In particular Miss K Gill for everything she has done for my father, Mr Edward Harper for his professionalism and apologies on behalf of the NHS, Sharon Reynolds / Colin Ovington for the detailed investigation they conducted and Allison Binns for ongoing reviews.

Lastly we would like to thank you for coordinating the complaints procedure in an independent way.

Yours sincerely,

What we were told	Our response	The difference
During the recovery of a shoulder operation, this patient had a cannula removed by an experienced nurse. Part of the cannula sheath was noticed to be missing and the patient was monitored before being transferred to Queen Elizabeth Hospital for corrective surgery to remove the sheath from the vein in his hand.	An apology was offered for the poor outcome of this clinical incident. It was reported as a clinical incident and a table top review convened to ensure learning. As a result of the incident, it is now policy that arterial and venous cannulas are not placed close too close together, and sharp scissors are no longer used to remove dressings. Documentation also has to be completed once the cannula is removed.	That when removing cannulas from patients, the risk of part of it being retained is reduced. The need for additional surgery is also minimised, improving patient safety.

What we were told	Our response	The difference
Patients relative received an invoice for the patient's treatment, as they were an overseas visitor. The relative disputes the information they were given about how the daily rate is calculated, asking that that the invoice be reduced.	Whilst it was conceded that the Trust could provide written information about the costs of NHS treatment to overseas visitors, it was felt that the charges were communicated to the family and that the invoice was appropriate.	Written information will provide clarity to all patients who are invoiced for treatment and care, and also support the position of the Trust when invoice disputes arise.
This patient is a paraplegic in need of regular bowel support. This support was not provided appropriately during an inpatient stay. The complaint centred around the lack of provision for this type of bowel care, and the lack of training that was apparent on the ward.	During the investigation the General Manager established a link with the FINCH team (specialist faecal/ bowel management team). The FINCH team provide bowel management care and advice predominantly for surgical patients, and it was recognised that a referral pathway did not exist for patients on nonsurgical wards. This has now been established.	This patient can be confident that his needs during future admissions will be met more appropriately. This will also impact on other patients with a similar disability or need, and demonstrates a commitment to diversity and equality in the delivery of nursing care.
A baby born at Birmingham Women's Hospital was brought into A&E at City Hospital because of feeding concerns. The feeding regime was monitored and a nasal gastric tube was inserted to encourage weight gain. Once this was achieved the baby was discharged. The baby was later diagnosed with a cleft palette.	Because this baby had been recently born in another hospital, we did not repeat the routine checks made at birth. A new policy has been implemented as a result of this complaint, to ensure that any baby being admitted within 7 days of birth, regardless of where they were born, will undergo a repeat of the new born screening and tests done at birth.	The policy will provide a safety net for issues not apparent, or missed at birth and provide reassurance to parents when their new born babies are readmitted to hospital at such a young age.
A concern was raised that the self-check in kiosks used in the Birmingham Midland Eye Centre were not user friendly for visually impaired patients.	The investigation highlighted that an icon could be selected that changed the display to black writing on a yellow background, the recognised standard for the visually impaired. The Trust conceded however that it would be difficult to select the icon if the screen was difficult to read in the first place, and all kiosks have now been changed so that the default display is black writing on yellow background.	That visually impaired patients will not be at a disadvantage over and above other patients, ensuring that information is available equally to all. All patients will be able to use the self-check in kiosks, improving the impact that self-check in kiosks have on staff resources.

COMPLAINTS AND PALS: 2015/16

Quarter 2 data highlights

1.	The total number of PALS concerns registered was 657, up by 93. Much of this increase can be attributed to a proportionate increase across all topics and Groups, except for Surgery B and Chief Execs Group (mainly legal services.) (page 17)
2.	The total number of Complaints logged was, 297 an increase of 60 complaints across the quarter compared to Q1 2015/16. 25 of these were withdrawn by the complainant at some point during the quarter leaving 272 to manage. There were 28 more complaints made in July 2015 compared to July 2014, 24 more complaints made in August 2015 compared to August 2014, and 28 more made in September 2015 compared to September 2014. (page 6)
3.	The total number of compliments collected for Q2 2015/16 was 253 compared to 358 in Q1 2015/16 and 359 in Q4 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 8 page 30)
4.	The average number of days taken to resolve complaints saw a decrease of 6.79 days from 51.62 (Q1 2015/16) down to 44.65 (Q2 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 increased when compared to the previous quarter, with an average rate of 3.4 of against 2.3 in the previous quarter. This rate is exactly the same rate when compared to the Q2 2014/15 (at 3.4 for both). This increase has not affected the downward trend over the last 6 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 9.5 but all groups have seen an increase in rate compared to Q1 2015/16. Woman and Child Health still has the lowest but has increased steadily from 2.5 in Q3 2015/16, up to 3.61 in Q4 2014/15, 3.9 in Q1 2015/16 and 4.6 in Q2 2015/16 (page 7)
7.	'Not Upheld' complaints made up 24% of closed complaints against 24% in Q1 2015/16 and 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 four quarters and are Attitude of Staff, Clinical Care and Appointments. Medicine have the highest percentage of complaints across these categories 38%. (page 12)
9.	Reopened cases totalled 40 with 4 of those re opened due to not all the issues being answered in our first response. This compares to 49 reopened with 7 where not all issues were addressed in Q1 2015/16 and 44 reopened with 5 where not all issues were addressed in Q2 2014/15. There has been a reduction in the % of those reopened where not all issues were addressed, from 26% in for the same quarter last year, Q2 2014/15, down to 22% in Q3 2014/15, and down further to 11% in Q4 2014/15 There was however a slight increase to 14% in Q1 2015/16, but back down to 10% for this quarter. (page 16)
10.	There were 3 new PHSO enquiry of the Trust in this quarter, and 3 previous enquiries were closed off. Of those closed, 2 were not upheld, and 1 was identified as a partially service failure with no further action to take. (pages 17)
11.	Complaints satisfaction survey activity was suspended for this quarter, whilst a review of the process, the design and style of the questionnaire and the questions were refreshed. Reporting on this activity will resume in Q3 2015/16.
12.	There is no disproportionality the number of complaints made by (or on behalf of) either Pakistani patients (at 10% complaints vs 11% local population) or Black Caribbean patients (at 5% complaints vs 6% local population) as previously reported.

COMPLAINTS AND PALS: Q2 2015/16

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.

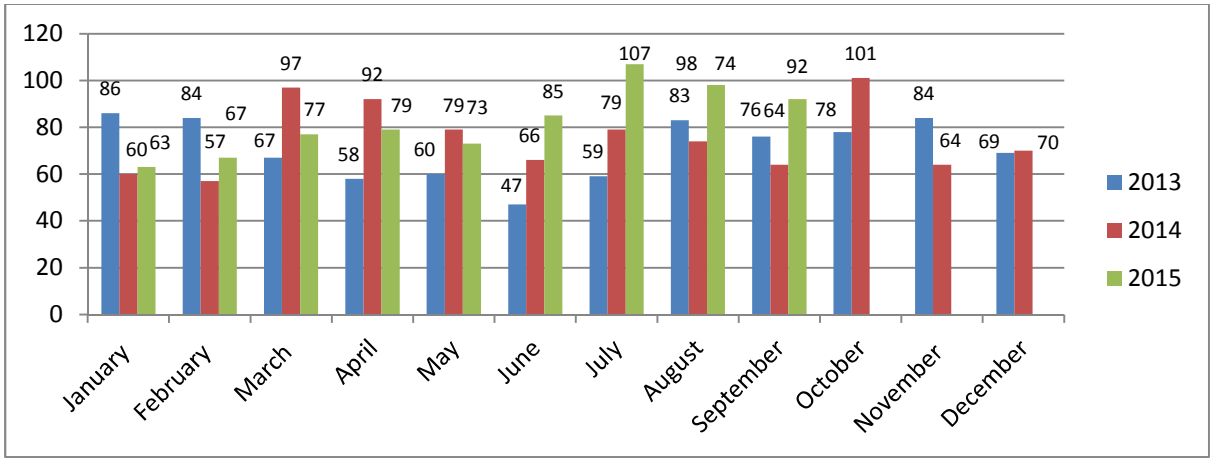
COMPLAINTS

1. Complaints Management

1.1 Total received

The total number of complaints received in Q2 2015/16 was 297 compared to 237 in Q1 2015/16, an increase of 60. In the same period the previous year, Q2 2014/15 217 complaints were received. When broken down by month, year on year, there were 28 more complaints made in July 2015 compared to July 2014, 24 more complaints made in August 2015 compared to August 2014 and 28 more made in September 2015 compared to September 2014. It should also be noted that 25 complaints were withdrawn in this quarter, 5 less than in the previous quarter leaving 272 actively managed this quarter.

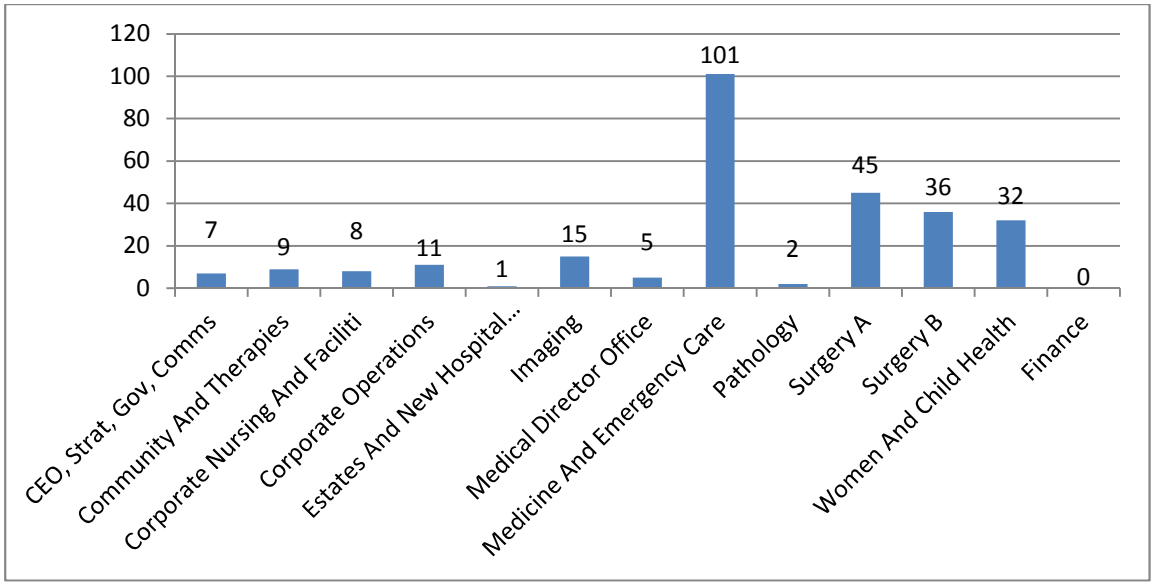
Q2 2015/16 complaints received by month



1.2 Complaints by Group

When analysing the complaints received in Q2 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).

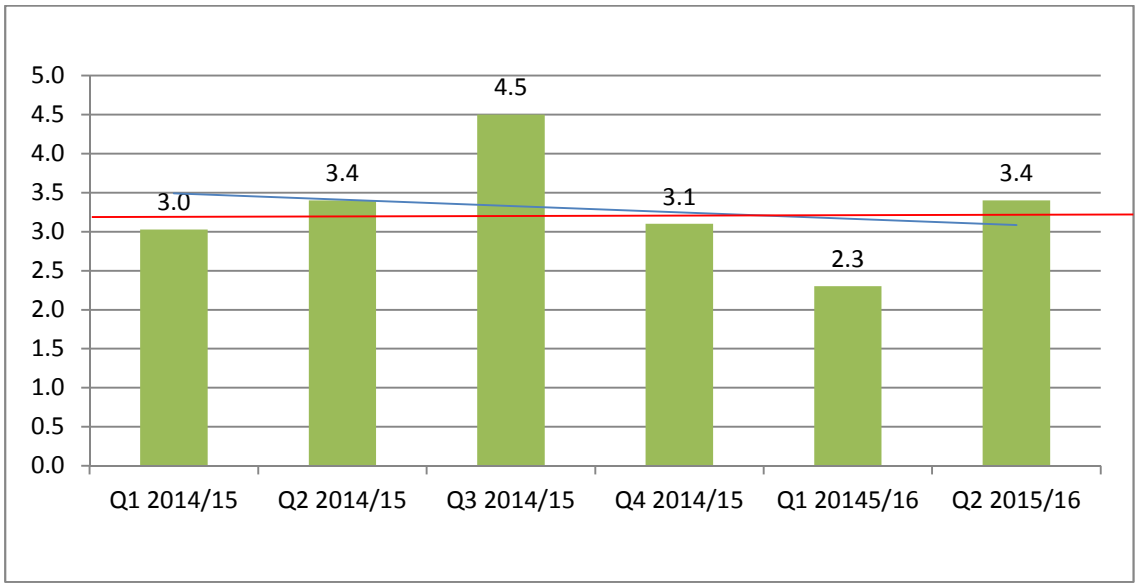
Q2 2015/16 complaints received by Clinical Group/ Corporate Direcotrate



1.3 Complaints by 1000 bed days

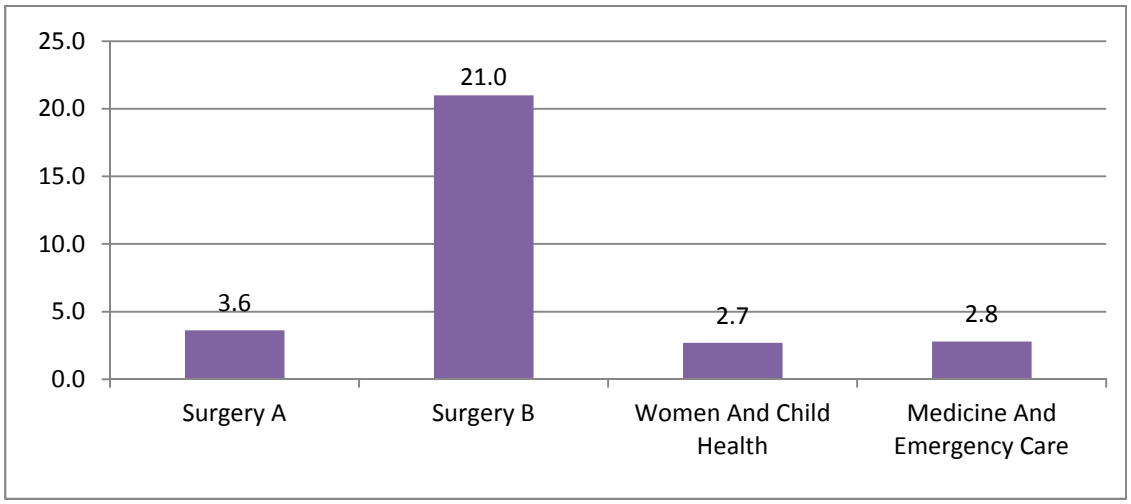
The complaints rate, calculated as complaints per 1000 bed days for Q2 2015/16 is higher than the previous two quarters. The trend line is still downward, but this increase has seen it flatten somewhat. The 12 month rolling average is still 3.3, the same as in Q1 2015/16. The trend line is shown in red and the rolling average is shown in blue.

Complaint rate over last 6 quarters showing trend and average



When comparing the rates of complaints by Clinical Group Surgery B appears very much higher, but it is worth noting that many patients in this group do not occupy a bed therefore the more accurate measure for this Group is the FCE rate.

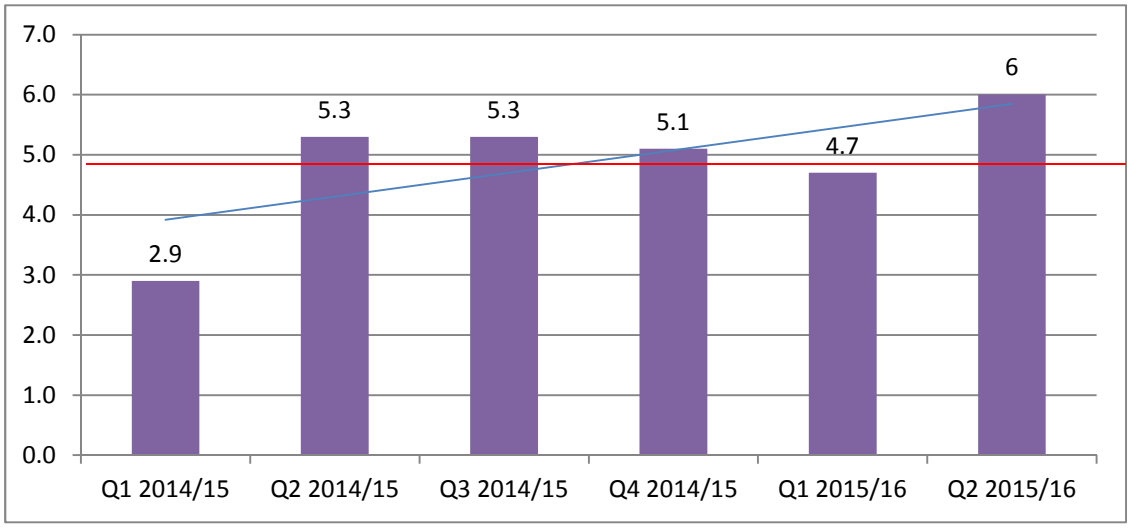
Complaint rate per 1000 bed days for Q2 2015/16 by Clinical Group



1.4 Complaints received per 1000 FCE (Finished Consultant Episodes)

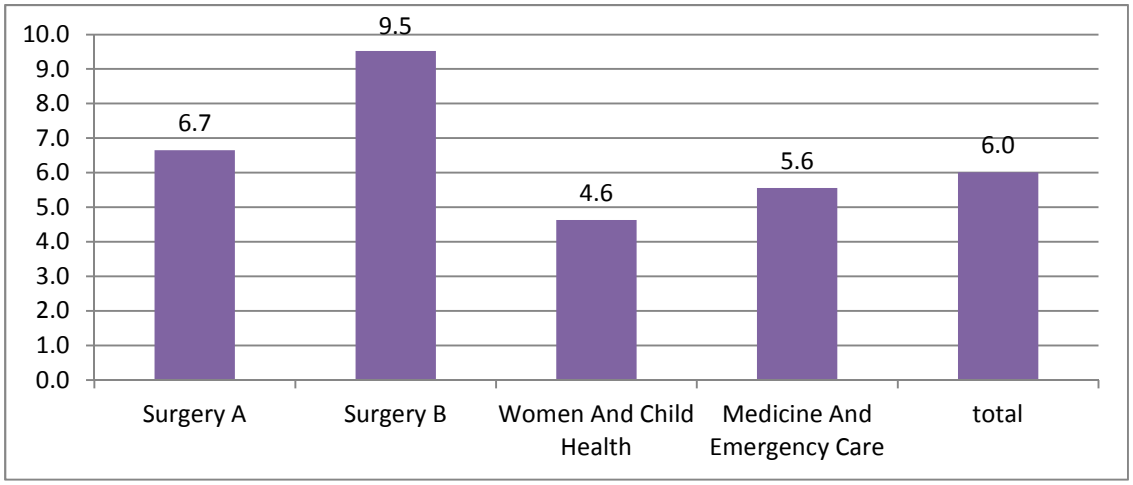
To more accurately compare which Clinical Group is receiving the most complaints, it is important to represent these not just as numbers of complaints, but as a proportion of the patients that have received care in these areas. This then puts these numbers into context. By comparing the numbers of complaints 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 79% of the complaints. This is a small decrease from the 81% proportion from Q1 2015/16 and the 83% of Q4 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. 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. **Appendix 2a and 2b** show the breakdown of complaints rates for both 1000 Bed days and 1000 FCEs by group.

Complaint rate per 1000 FCE for Q2 2015/16



Surgery B has been working closely with the Elective Access Team to improve the way that appointments are managed and utilised across the Group. The plan is to speed up and streamline the triaging process, set up clinic appointment schedules to maximise capacity, and review (looking forward) all clinics regularly at 1 week hence and 6 weeks hence. There is also much work being done to cleanse that data available to management in order that they have the most accurate statistics to work with on the planning of clinics. The aim of these actions is to ensure that clinics run at maximum capacity, patients are slotted into empty clinic appointments when they become available and high and low priority patients are not kept waiting, or have clinics cancelled inappropriately.

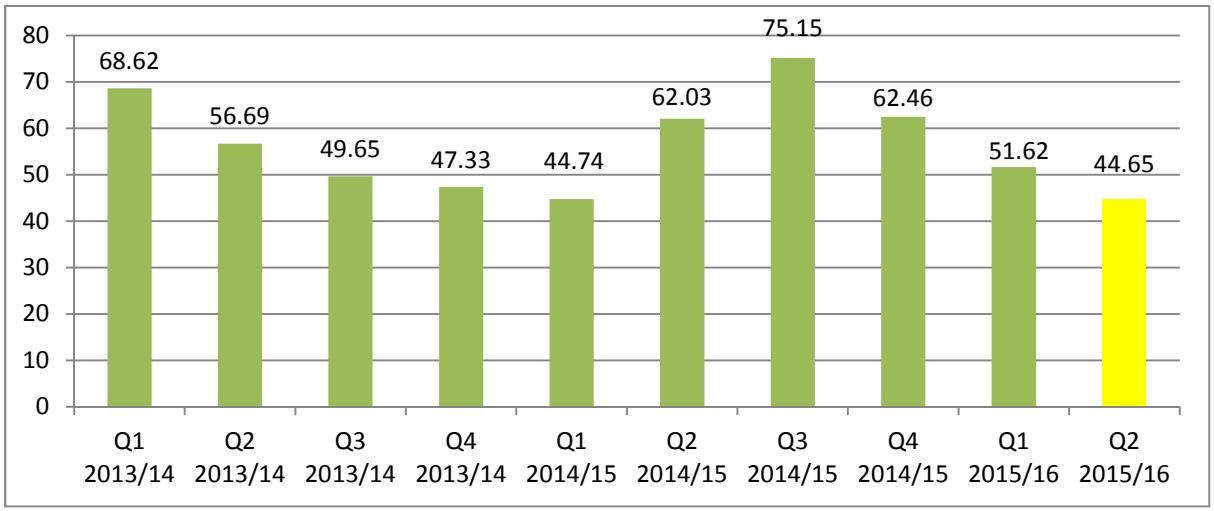
1.5 Timeliness of Responses

As previously reported, Q2 and Q3 2014/15 showed a spike 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, and this has continued through Q1 2015/16 into Q2 2015/16 as cases continue to be managed within agreed timeframes and the number of cases being closed (that had exceeded their response dates) becomes fewer still. This continuation into Q2 2015/16 has had the same positive effect on the average number of days to complete a complaint. This has gone from 51.62 down to 44.65.

Of the complaints made in Q2 2015/16, which have since been closed, 97% (200 out of 206) were managed in date and the 'average days to manage' was 27.2 days. This compares to 97% (86 out of 89) managed within date in Q1 2015/16 and an 'average days to manage' of 26.57.

Of note is the fact that the breached cases remain in the minority, and the reasons for these breaches do not show a systemic flaw in the process. The breaches are identified as they happen, and are sent within a few days of their target date.

Average days to respond by quarter in Q2 2015/16 compared to Q1 2015/16



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 resolve and includes all stages of the process.

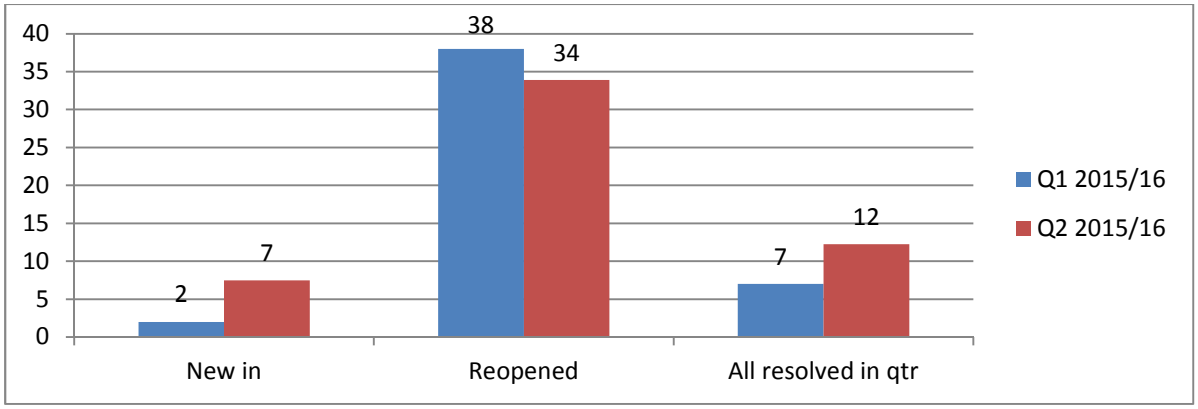
1.6 Complaints managed by resolution meeting

It is recognised that for some complaints, a resolution meeting, as opposed to a written response can be more effective in addressing concerns. Complainants whose concerns relate to a patient who has died will always be offered a meeting. Some complainants will express a preference to meet with the Trust as opposed to receiving a written response, and other complainants may present cases or stories that would suggest a meeting is the more appropriate way to resolve it. 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. This must also be the default position for all mortality complaints. In Q2 2015/16 the number of meetings increased from 19 to 40 (7% to 12%.)

There is still work to be done to increase this further recording all feedback from complainants who do not wish to participate in a meeting, so that our offer of a meeting can be more targeted. This includes those cases that involve a patient who has died.

A question about the preference for complainants to attend meetings is also included in the revised complaints satisfaction survey.

% of complaints that were managed by a resolution meeting as opposed to a written response. Q2 2015/16 compared to Q1 2015/16



1.7 Complaint satisfaction survey

It has been previously reported that there was a decline in the number of response rate of the complaint satisfaction survey. The questions did not provide feedback about some aspects of the complaints process, and so the decision was taken to suspend the current survey and refresh the style, questions and timing of when complainants are asked for feedback

All complaints closed from 1 October 2015 onwards will receive a survey 4 weeks after they have received their final response. They will be asked to complete and return it, in order that data can be collated and used to assess the effectiveness of the service.

KEY POINTS

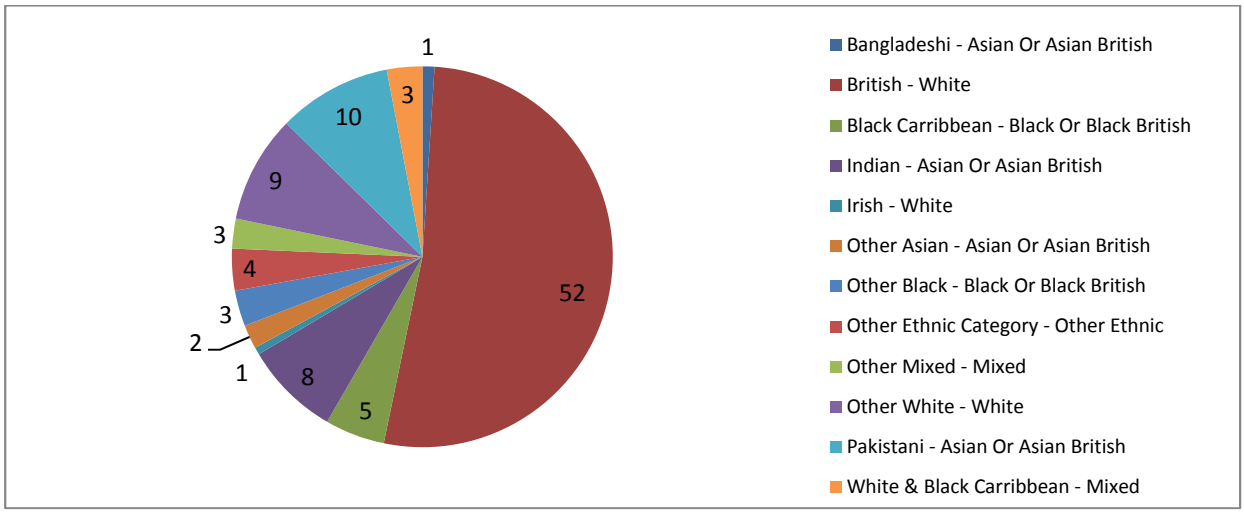
- Surgery B has an action plan in place to reduce complaints about their appointments system.
- 97% of complaints resolved in this quarter were sent within their target date. This has remained consistent with the Q1 2015/16 and is the first time for many years that the Trust has been able to report such compliance.
- All complaints relating to a patient who has died are identifiable over and above other complaints and are all offered meetings by way of resolution.

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 4**.

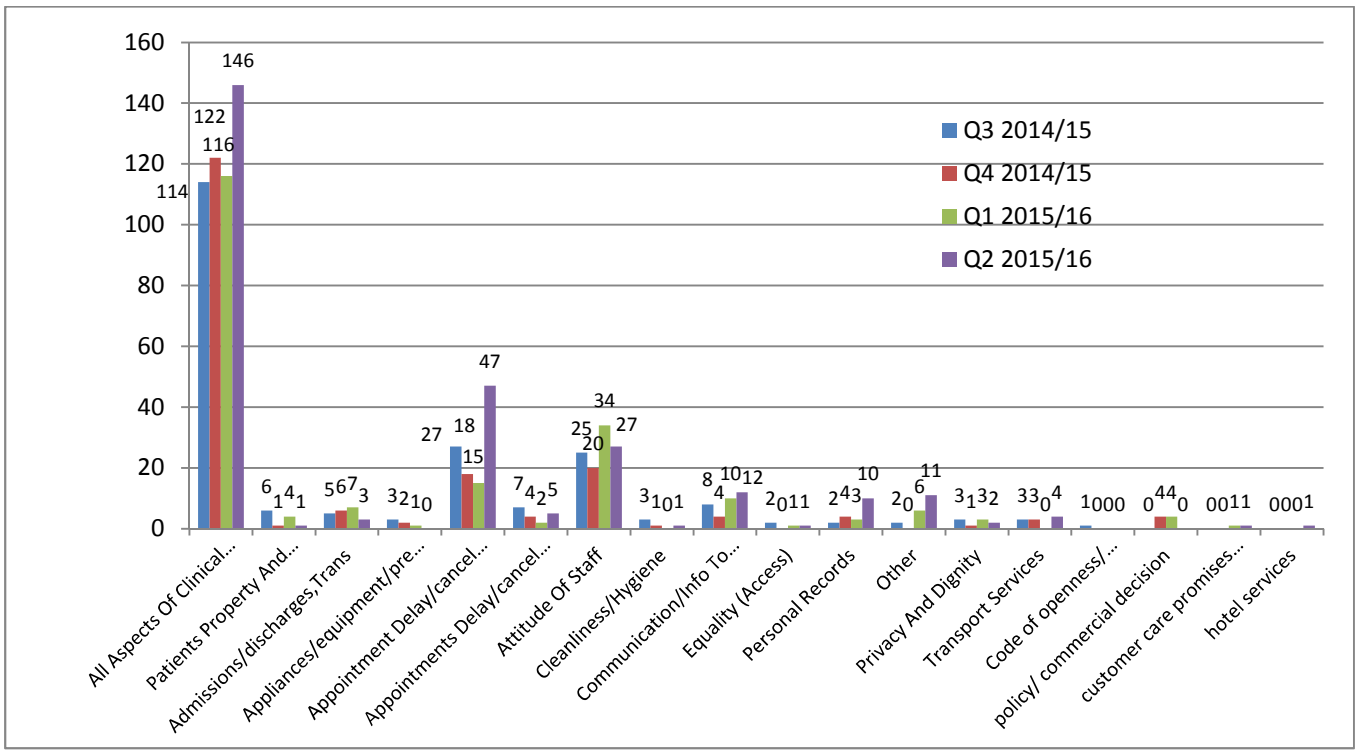
Subject of complaint by Ethnicity Q2 2015/16



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 to a degree into Q1 2015/16 with a lower rate of complaints from the Asian community. In Q2 2015/16 the rate has steadied and complaints rate for this quarter is proportionate at a 10% complaints rate, with the Pakistani community making up 10% of our local population. The same has been reported for Black Caribbean complainants although this was proportionate in Q1 2015/16 and remains so this quarter at 5% complaints rate and 6% of our local population.

2.2 Formal complaints by theme

Broad themes that complaints fell into in Q2 2015/16 compared to Q1 2015/16, Q4 2014/15 and Q3 2014/15.



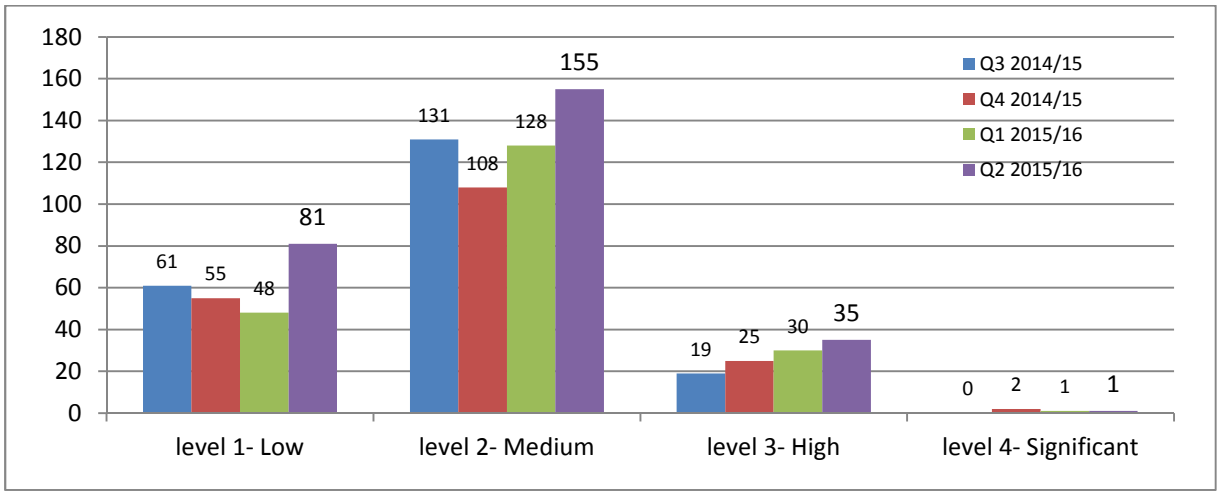
When analysing the top three themes complained about, these remain 'all aspects of clinical treatment', 'appointment delays', and 'staff attitude'. **Appendix 5** breaks down the themes of complaints by Group, profession and department for the most complained about themes.

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 this decreased in Q4 2014/15 and again in Q1 2015/16. In Q2 2015/16 this has continued to be the case.

2.3 Formal complaints by severity

The following is a breakdown of the 272 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 87% (236) those received which was 2% higher than the last quarter (85% in Q1 2015/16), and 1% lower than the quarter before. (86% in Q4 2014/15). There was 1 Level 4 complaint, involving the death of a patient.

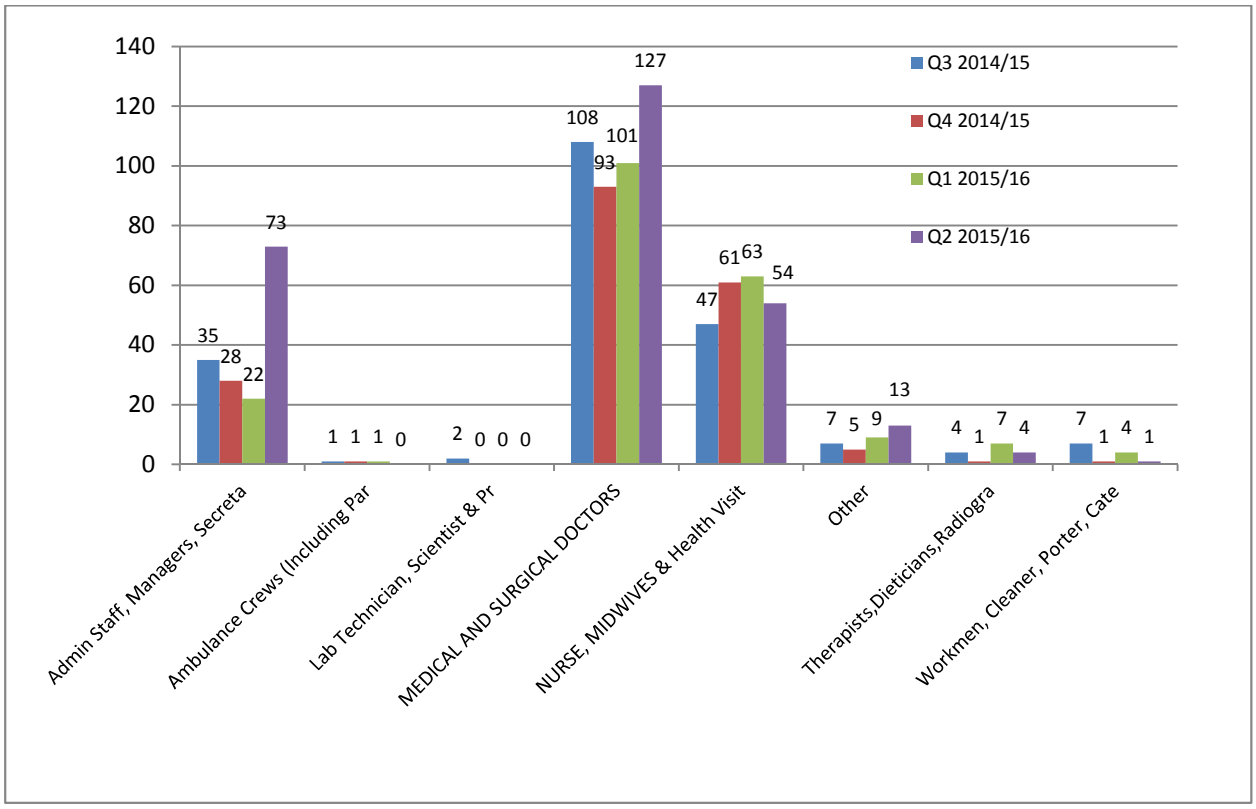
A breakdown the severity grade of complaint for Q2 2015/16



2.4 Formal complaints by profession

It has previously reported that there were no significant changes in the number of complaints received across the seven professional groups. In Q2 2015/16 there was a notable increase in the number of complaints about administrative and managerial staff. In Q1 2015/16 this staff group made up 10% of those complained about, and in Q2 2015/16 this went up to 27%. Of those staff complained about, they were mainly in Governance Department (Legal Services) and the Clinical Group of Imaging. There was a small increase in the Clinical Group Surgery B also. Work has already started in Legal Services to understand the nature of the complaints they have been received, and an improvement plan is being implanted to ensure greater customer satisfaction of their Subject Access Request (SARS) service.

Complaints by staffing group Q2 2015/16 compared to Q1 2015/16, Q4 2014/15, Q3 2014/15



KEY POINTS

- Complaints are now more proportionate when analysed by ethnicity negating the need to investigate this further for the time being.
- Elective access are working to a plan to improve the way that appointments are managed across many clinical areas.
- Legal Services are implementing a service improvement plan to improve customer service of their SARS service**.**

3. Formal complaints outcomes

3.1 Resolved complaints

257 responses were sent out this quarter compared to 225 in Q1 2015/16, 187 in Q4 2014/15 and 202 in Q3 2014/15.

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.

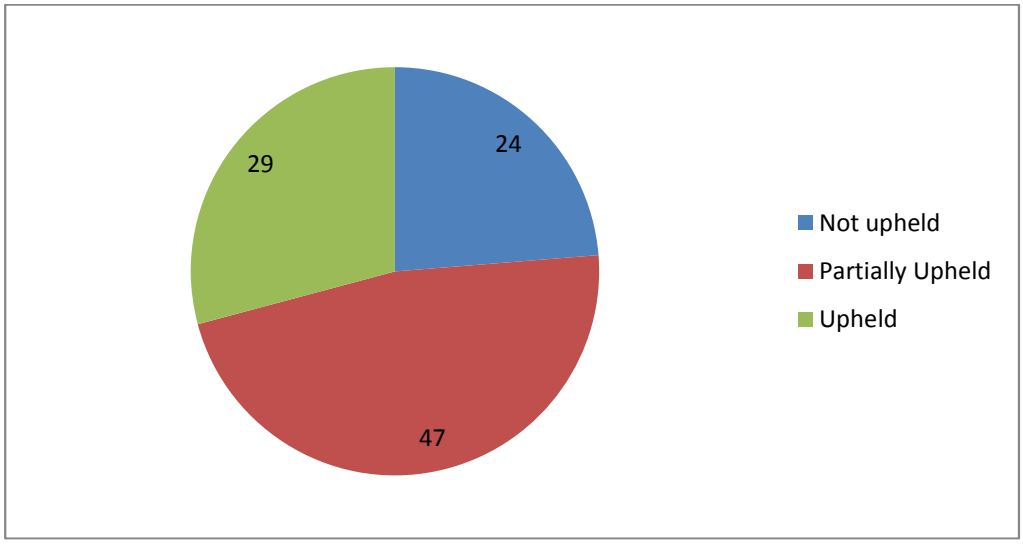
Partially upheld- elements of the complaint were found to be the case, but not all.

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

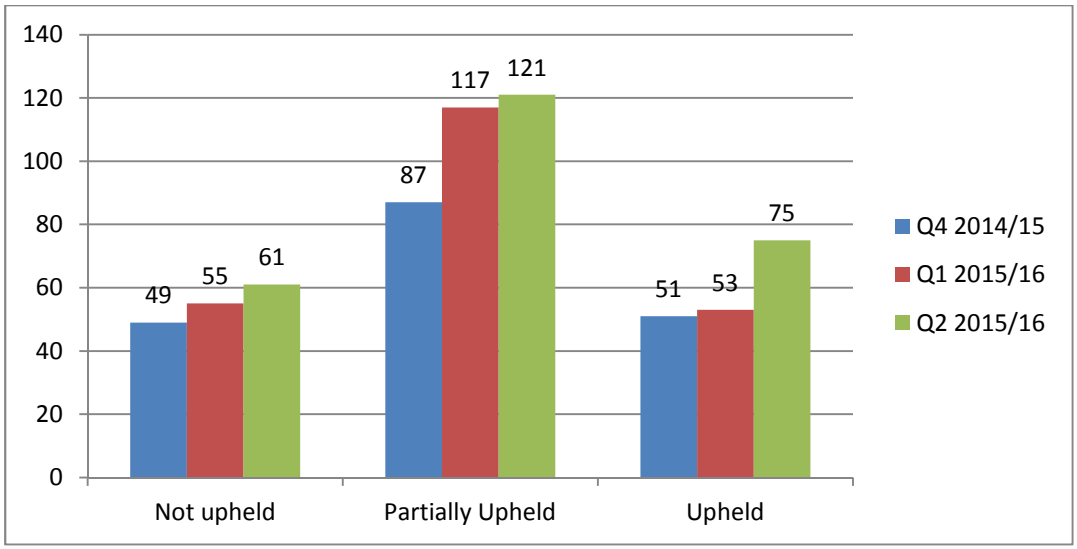
The outcome of complaint responses remain mostly either upheld or partially upheld, and whilst there was a slight increase in the instances of partially upheld in the last quarter, Q2 2015/16 results have reverted back to outcomes that are more consistent with previous quarters.

The high percentage of these outcomes still demonstrates a continued commitment to 'Being Open' and integrity in general in complaints management

Q2 2015/16 complaint outcomes



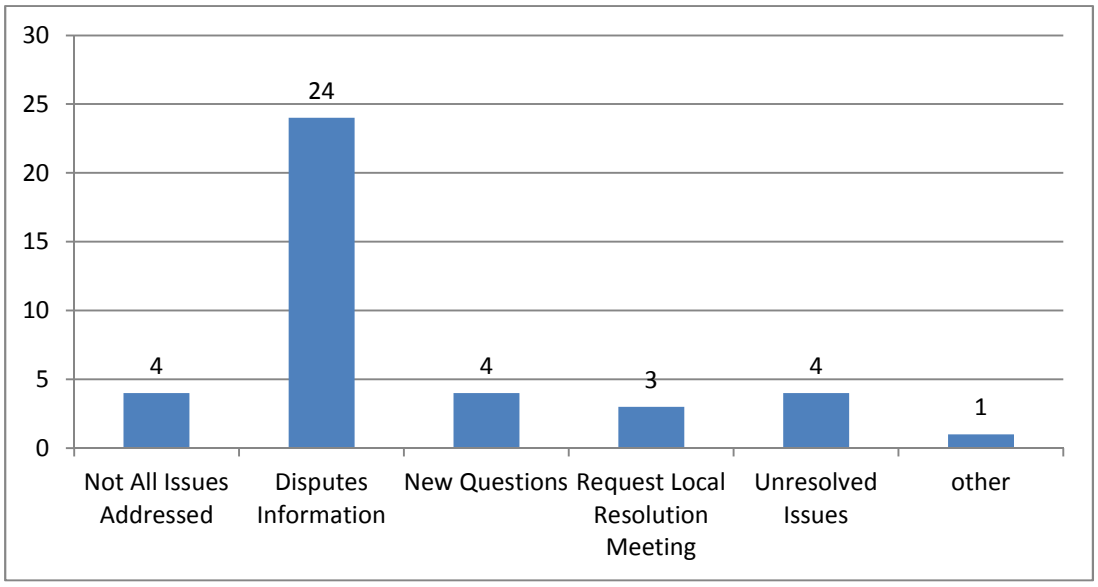
Complaints outcome Q2 2015/16 compared to Q1 2015/16, Q4 2014/15, Q3 2014/15



3.2 Reopened cases

Reopened cases totalled 40 in Q2 2015/16 and 4 (10%) of these were because the complainant felt that not all the issues were addressed in our first response. This compares to 7% in Q1 2015/16. The total number of cases that were reopened has decreased since Q1 2015/16 (down by 3 cases). Those cases reopened because the complainant felt that not all issues were addressed has also decreased since Q1 2015/16 (down by 3 cases).

Total number of cases reopened and why Q2 2015/16



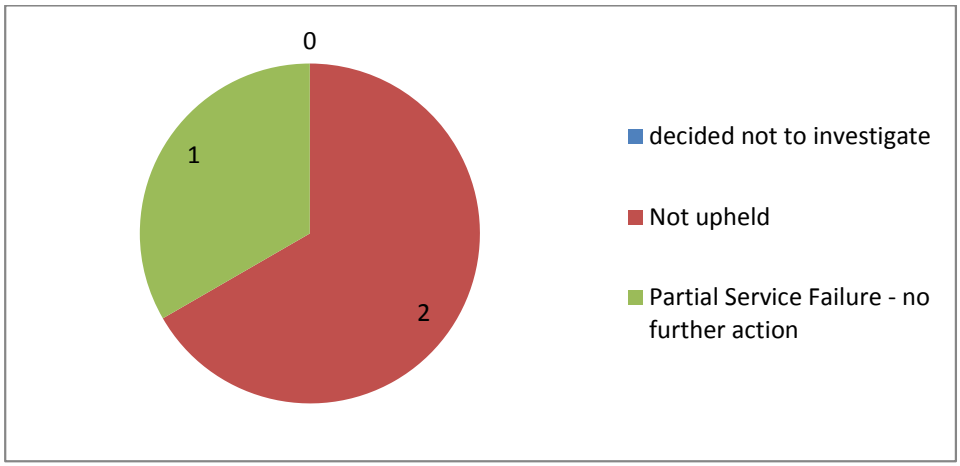
Of those complaints that were reopened because we had not addressed issues the first time, Medicine and Emergency Care had 1 case, Imaging had 1 case and Surgery A had 2. Over the past 3 quarters, there has been no particular Group that has contributed to this type of dissatisfaction in this way, and this has continued to be the case this quarter. **Appendix 6** shows all reopened complaints by Group and Grade, and continues to show that it is the medium grade (Level 2) complaints that are most likely to be reopened. Also shown in **Appendix 6** is 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).

3 new PHSO complaints were 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 Q2 2015/16



3.5 SWBH complaints featuring in external publications-

Parliamentary and Health Services Ombudsman (PHSO) Q1 2015/16

The PHSO reported that they received 2393 enquiries in Q1 2015/16 with 659 being investigated. Of those, 45% were upheld by the PHSO. Sandwell and West Birmingham was quoted as having received 67 of these enquiries with 13 accepted for investigation. This is a relatively low % of investigation rate compared to other Trusts quoted in the report.

Data on written complaints in the NHS- Health and Social Information Centre (HSIC)

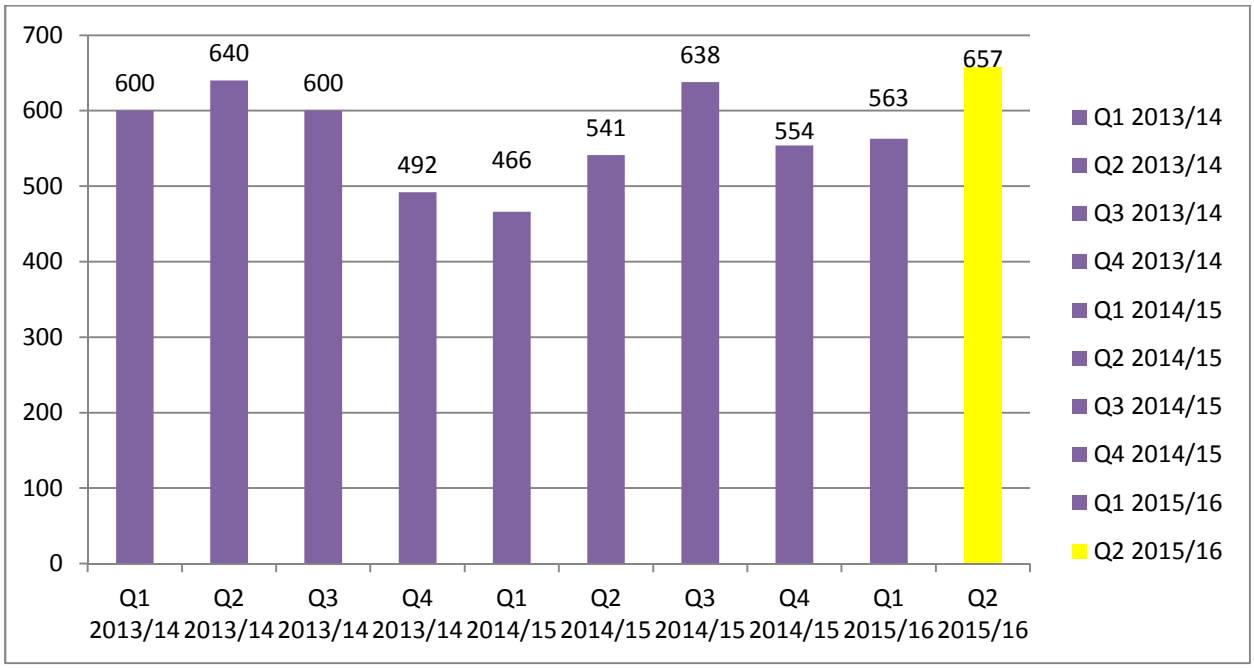
This report does not feature the trust per se but summarises the NHS Complaints activity by theme, provider type (Acute Hospital Trust, Ambulance Service, Primary Care etc) and was published in August 2015 following the collection of annual data that is submitted historically annually, but from 1 April 2015, quarterly.

4. PALS

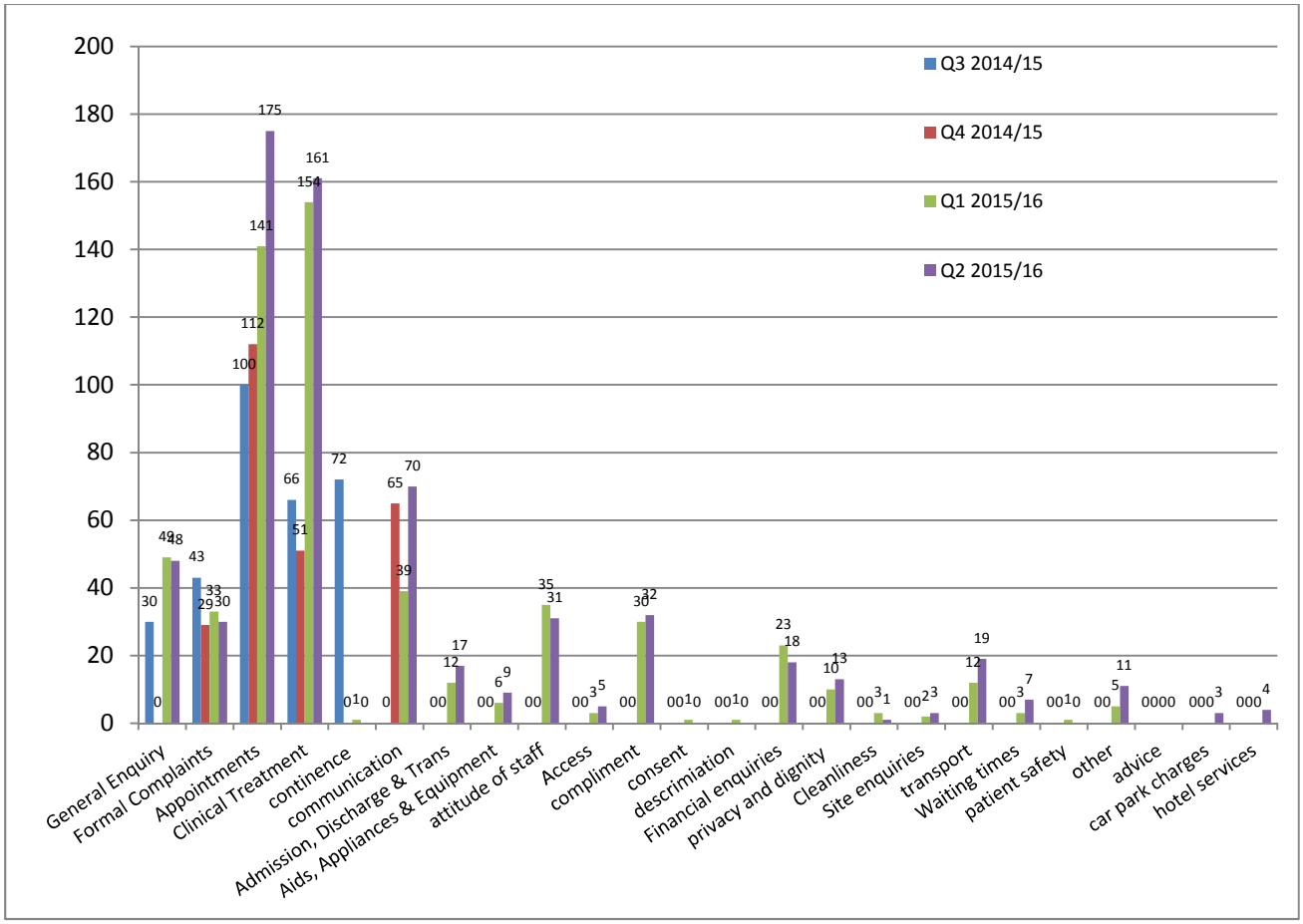
The Patient Advice and Liaison Service (PALS) continue to play a vital role in providing patients with a local advocate who can investigate concerns. As well as reporting the standard enquiries, work has continued in the collection of compliments for this quarter, of which there were 253; Clinical Groups 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 Q2 2015/16 was 657 compared to Q1 2015/16 at 564 and 554 in Q4 2014/15. This is also higher than the number of enquiries made at in Q3 2014/15 at 638 and 541 for the same quarter last year (Q2 2014/15).

Graph shows the number of enquiries of PALS by quarter over the past since Q2 2013/14.



The following are the enquiries taken by PALS in Q2 2015/16



Appendix 7 reports all PALS enquiries broken down by Clinical Group and in future reports, will also compare this Clinical Group with previous quarters.

Appendix 8 shows the compliments collected this quarter. This includes the 32 compliments that are reported directly via PALS, added to the compliments that are collected manually from all wards across the Trust.

5. Development work from previous quarters now implemented.

- 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 complaints management. There had been an issue with the reporting of this new field in Safeguard, that was resolved during Q2 2015/16. In Q3 2015/16 the 'average days to complete' analysis will include a breakdown of the stages themselves.

- An **action tracker** monitoring anything agreed as an outcome of a complaint is now fully operational on Safeguard. This tracker focuses on the implementation of specific actions that could not be evidenced as implemented at the time of the complaint response, and needs to be tracked to ensure that it is completed by specific timeframe. The monitoring tool reminds those accountable for the action and the complaints team monitor this activity, via the Action Tracker to ensure that this commitment is fulfilled. Assurance of this completed action is then communicated to the complainant.

6. Key areas for focus in Quarter 3 2015/16

- **Integrated reporting 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. This involves using the Safeguard database system to ensure that episodes that are reported as incidents, logged as complaints and claimed for as medical negligence, are linked together. This reduces duplicated work and ensures cohesive responses to all stakeholders.

- Some consideration needs to be given to the collection of the **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 can record compliments, relying on staff to record compliments in this way. This work is being discussed through the Patient and Staff Engagement Committee in order to implement this across the Trust.

- Work started to understand from **Black Caribbean and Pakistani** their complainant behaviour on the basis of the disproportionality of the rate vs population percentage. This trend however started to even out in Q1 2015/16. In Q2 2015/16 is it reported that there is no disproportionality and so this work has been suspended.

7. Conclusion

The total number of complaints has increased this quarter and there has been an increase in complaints about Legal Services, and the way appointments are managed. There are plans in place to improve however, and this will be monitored in terms of the impact that this has on complaints.

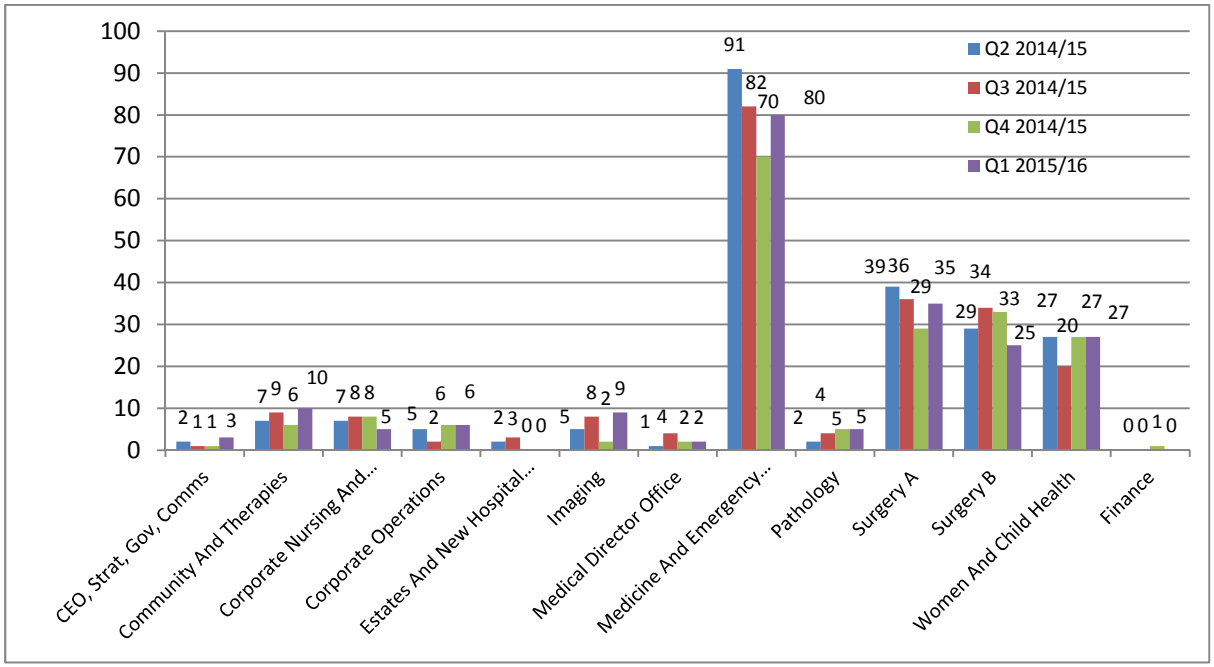
Surgery B still stands out as a receiving a disproportionate amount of complaints but a reduction in these numbers lies in part in the work being done to improve appointment management.

Complaints continue to be sent out largely on time, and a new satisfaction survey will be rolled out in Q3 to test what complainants feel about the overall service being provided by the complaints team.

PALS enquiries have increased and more work needs to be done to ensure that compliments are captured more accurately.

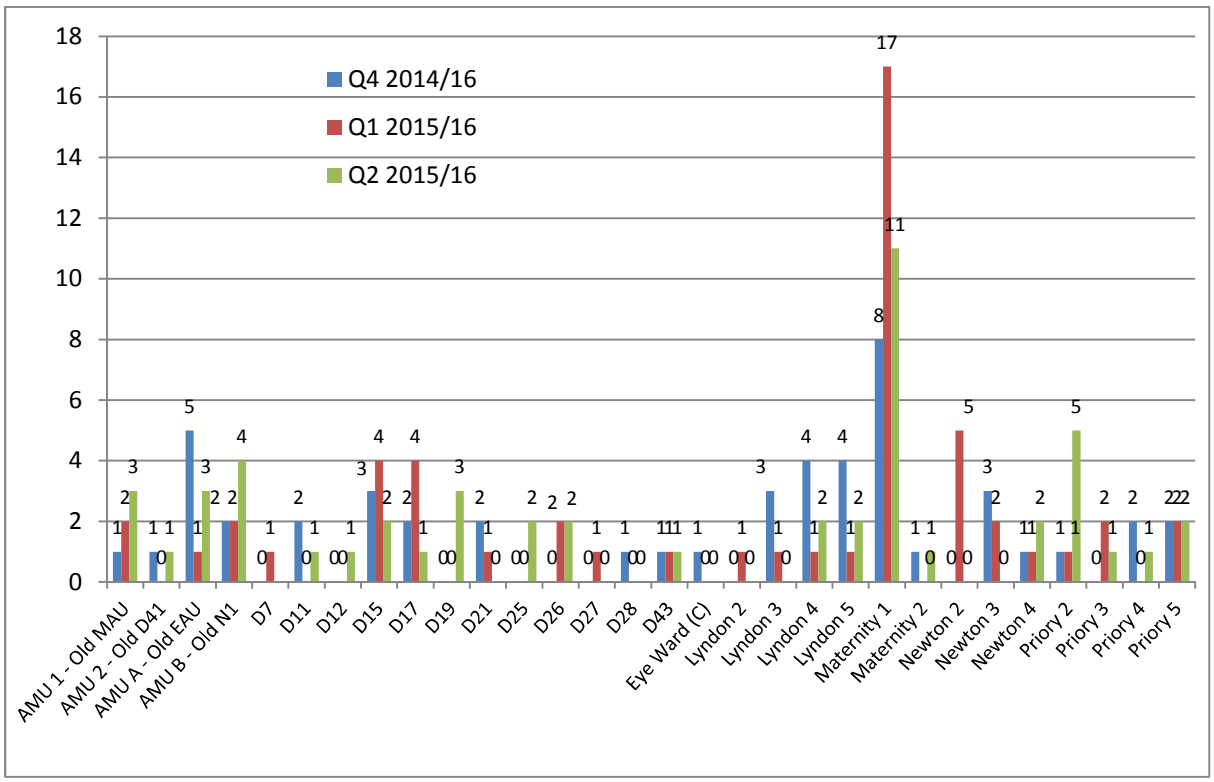
Appendix 1a

Complaints received by Clinical Group and Corporate Directorate for Q2 2015/16 compared to Q1 2015/16 Q4 2014/15 Q3 2014/15.



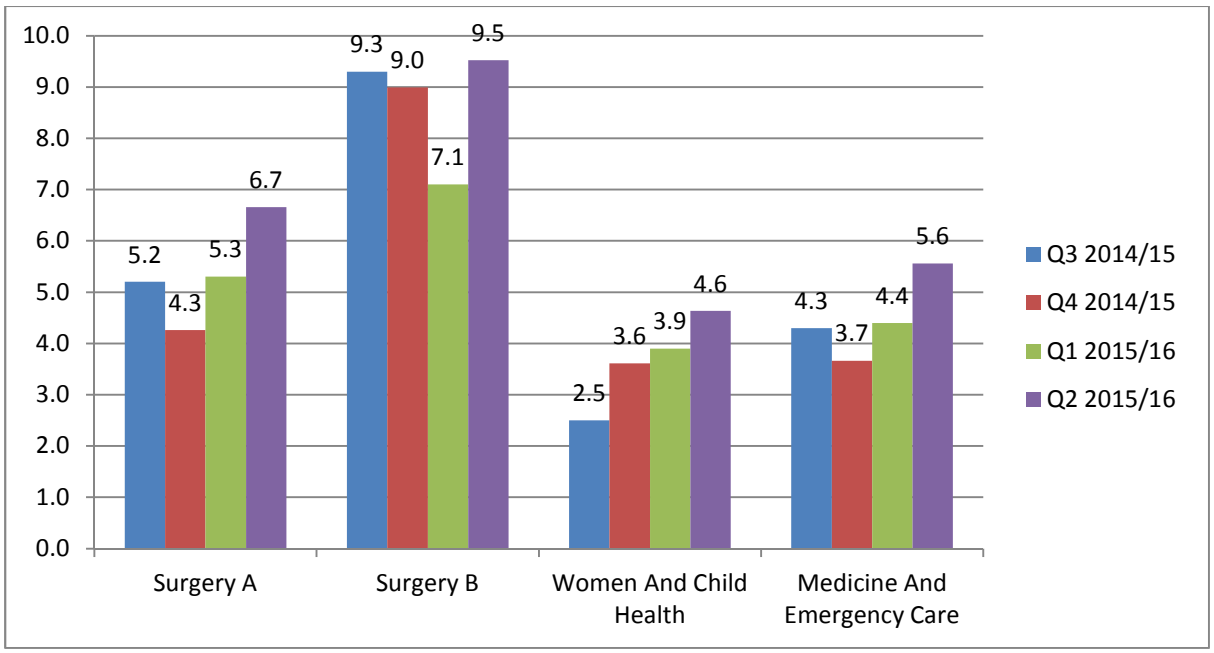
Appendix 1b

Complaints received by Ward (where applicable) for Q2 2015/16



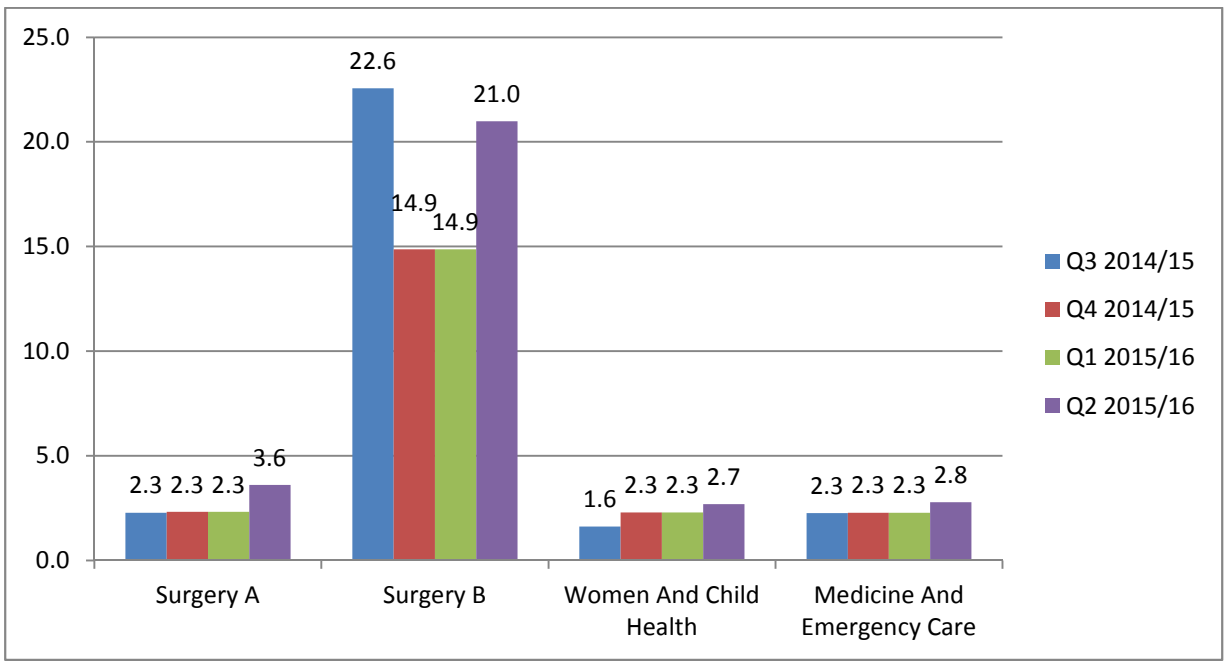
Appendix 2a

Complaints rates by 1000 FCE for Q2 2015/16, Q1 2015/16, Q2 2014/15 and Q3 2014/15- by the top four Clinical Groups



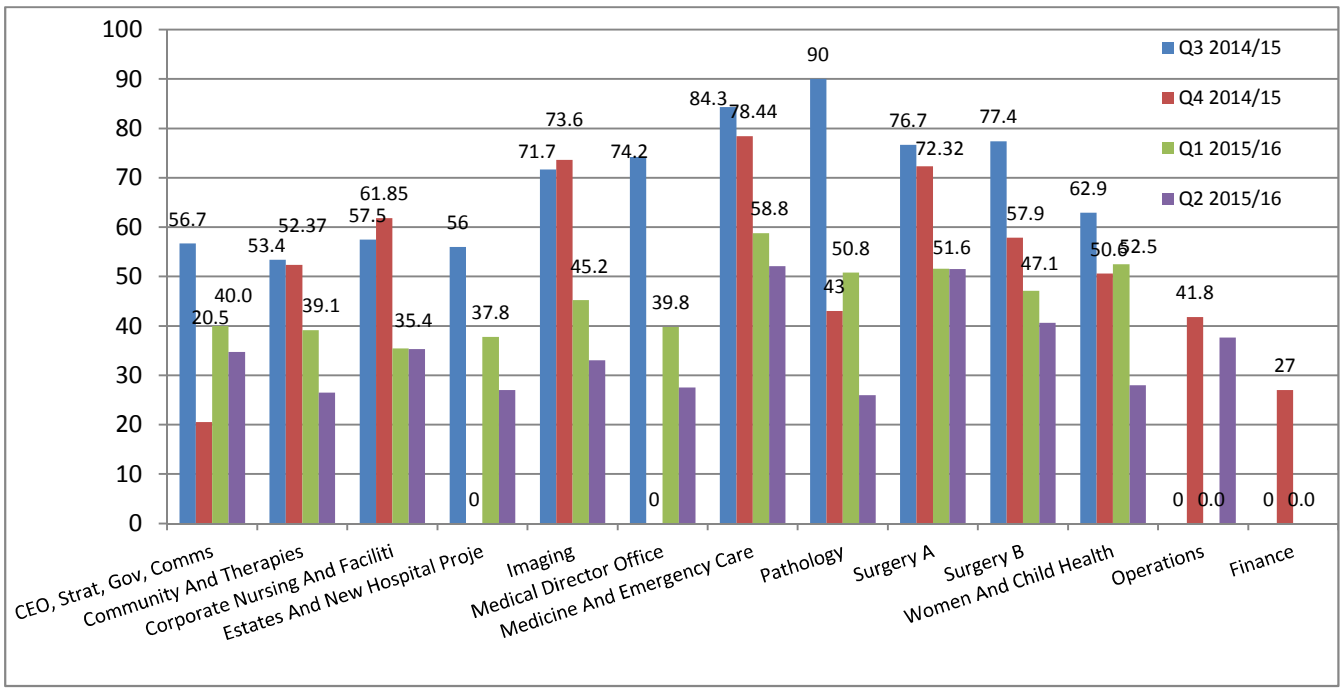
Appendix 2b

Complaints rates by 1000 bed days for Q2 2015/16, Q1 2015/16, Q2 2014/15 and Q3 2014/15- by the top four Clinical Groups



Appendix 3

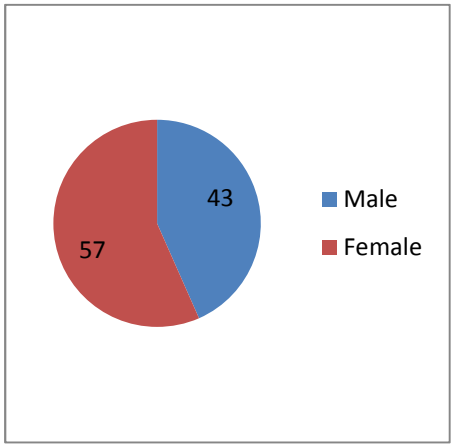
Complaints turn around by Clinical Group for Q2 2015/16, showing the number of days that each new, or reopened complaint took to close from the time it was received by the Complaints team to the time that it was signed off (compared to Q1 2015/16, Q4 2014/15 and Q3 2014/15).



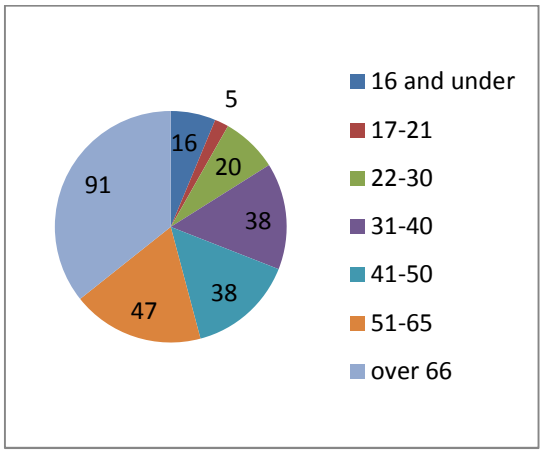
Appendix 4

A breakdown of all complainants by % by age and gender where specified for Q2 2015/16

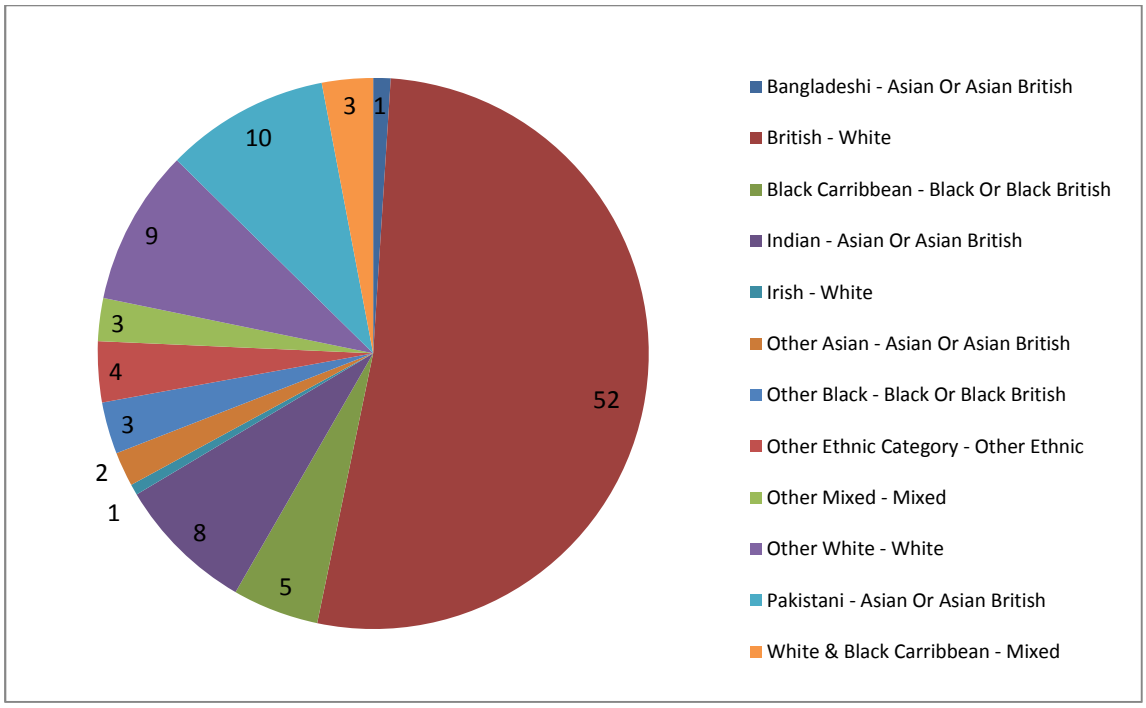
Gender (%)



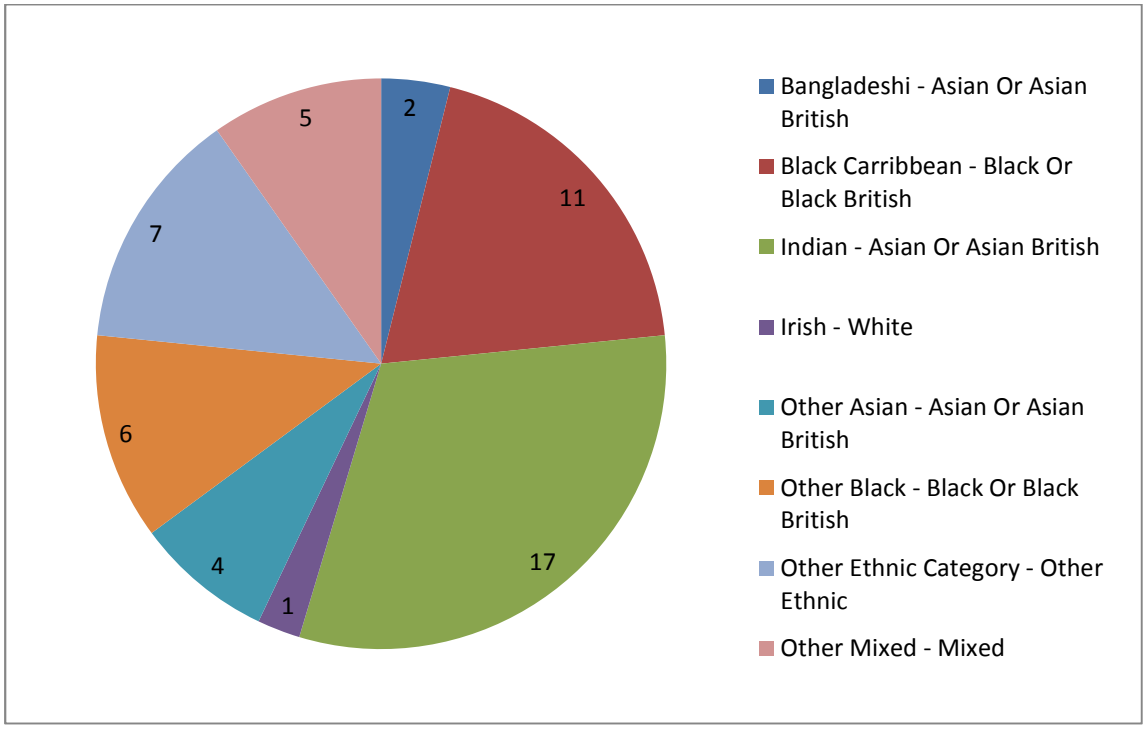
Age (%)



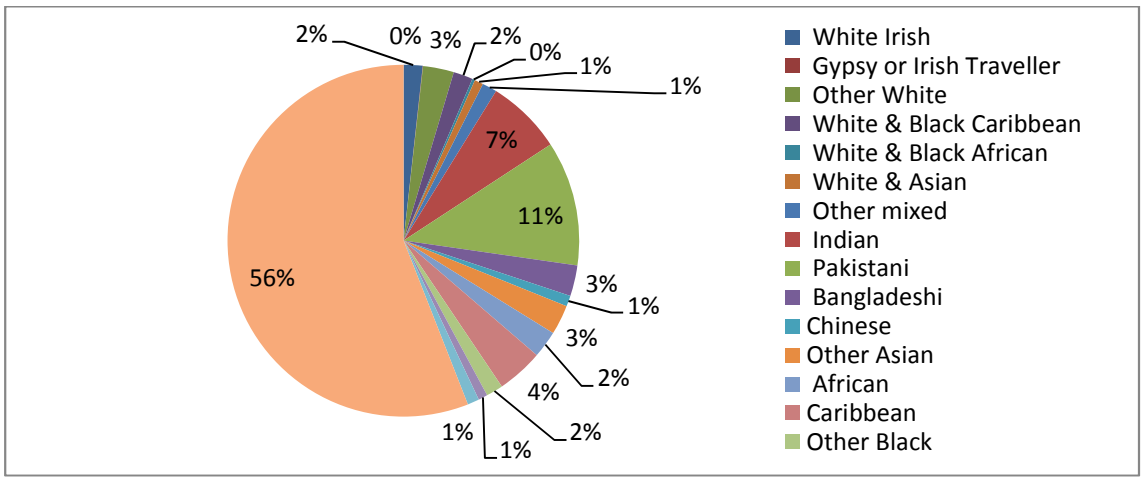
A breakdown of all complainants by % of those where ethnicity was recorded for Q2 2015/16



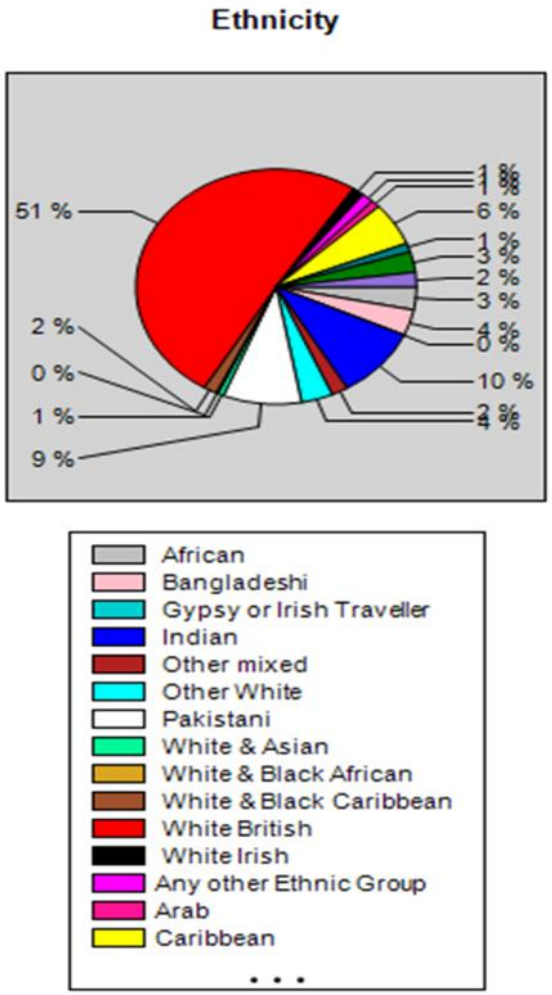
A breakdown of all complainants by % of those where ethnicity was recorded taking out those White British for Q2 2015/16



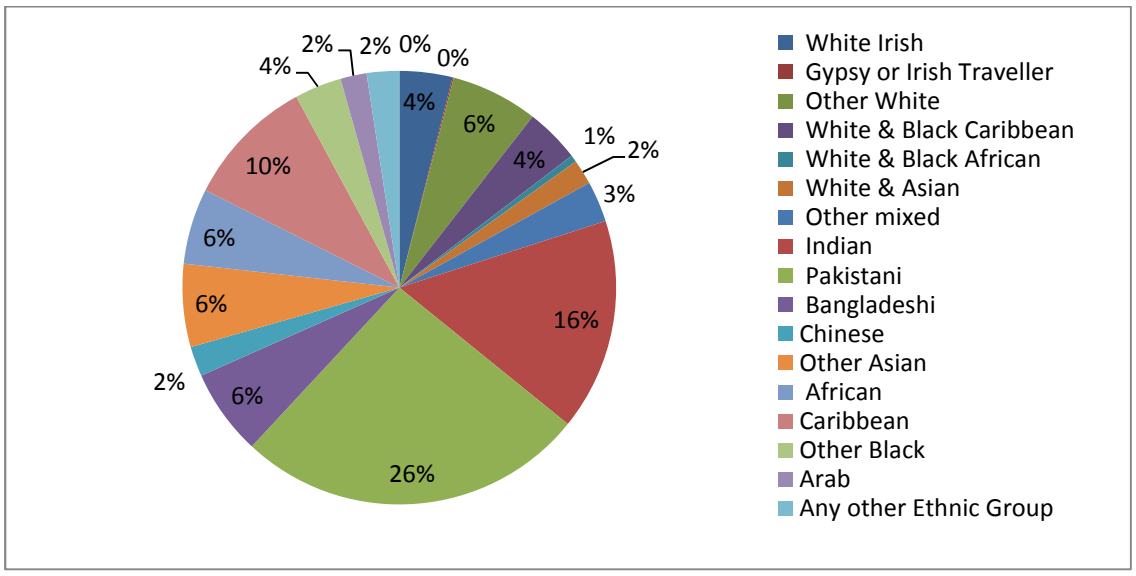
Ethnicity split by Sandwell and West Birmingham Population as taken from the 2011 census and quoted out to the Local Demography report prepared by the Trusts Equality and Diversity team in 2013.



Ethnicity split of patient population

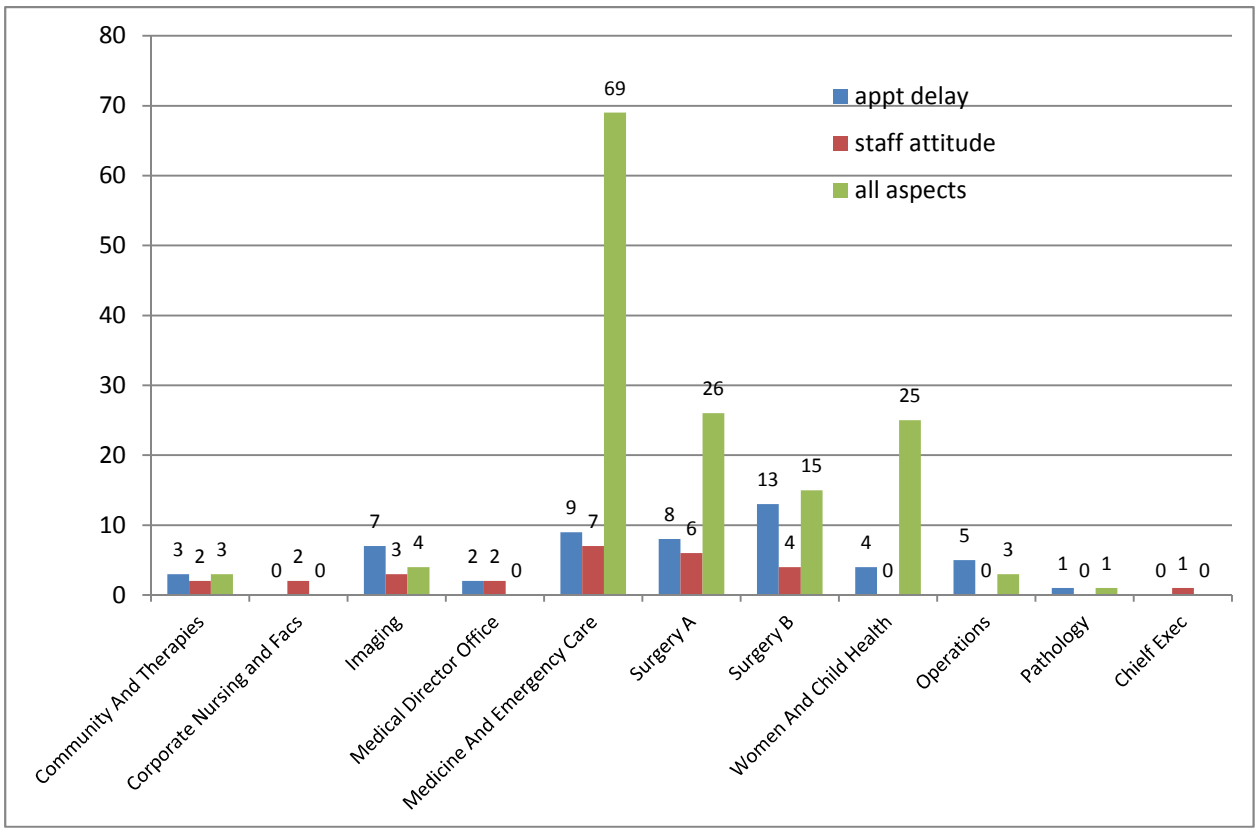


Ethnicity split by Sandwell and West Birmingham Population as taken from the 2011 census and quoted out to the Local Demography report prepared by Equality and Diversity in 2013, without White British.

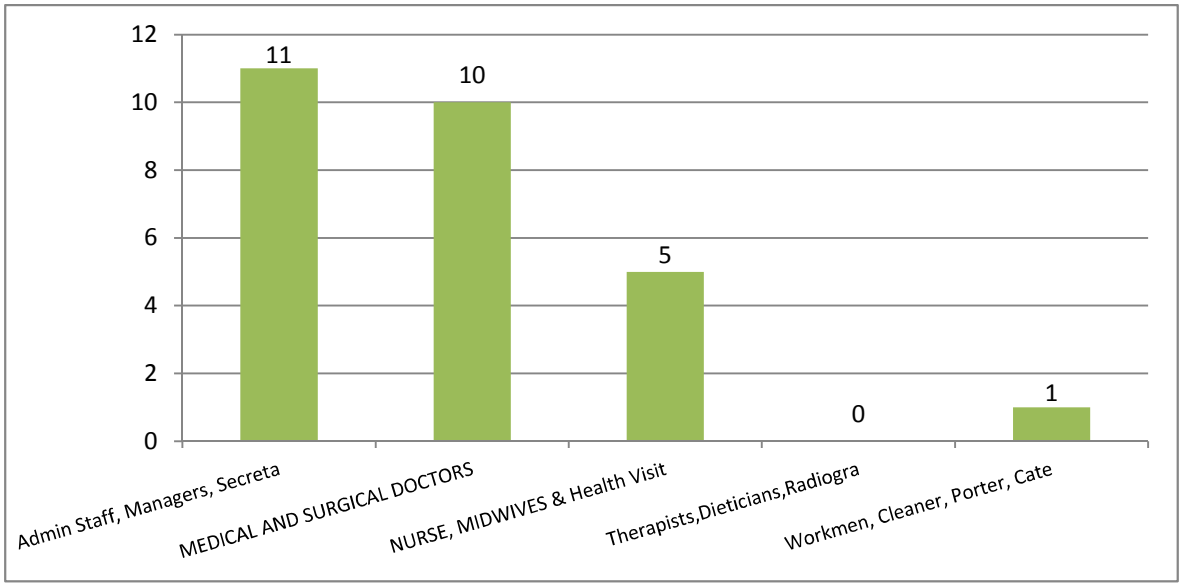


Appendix 5

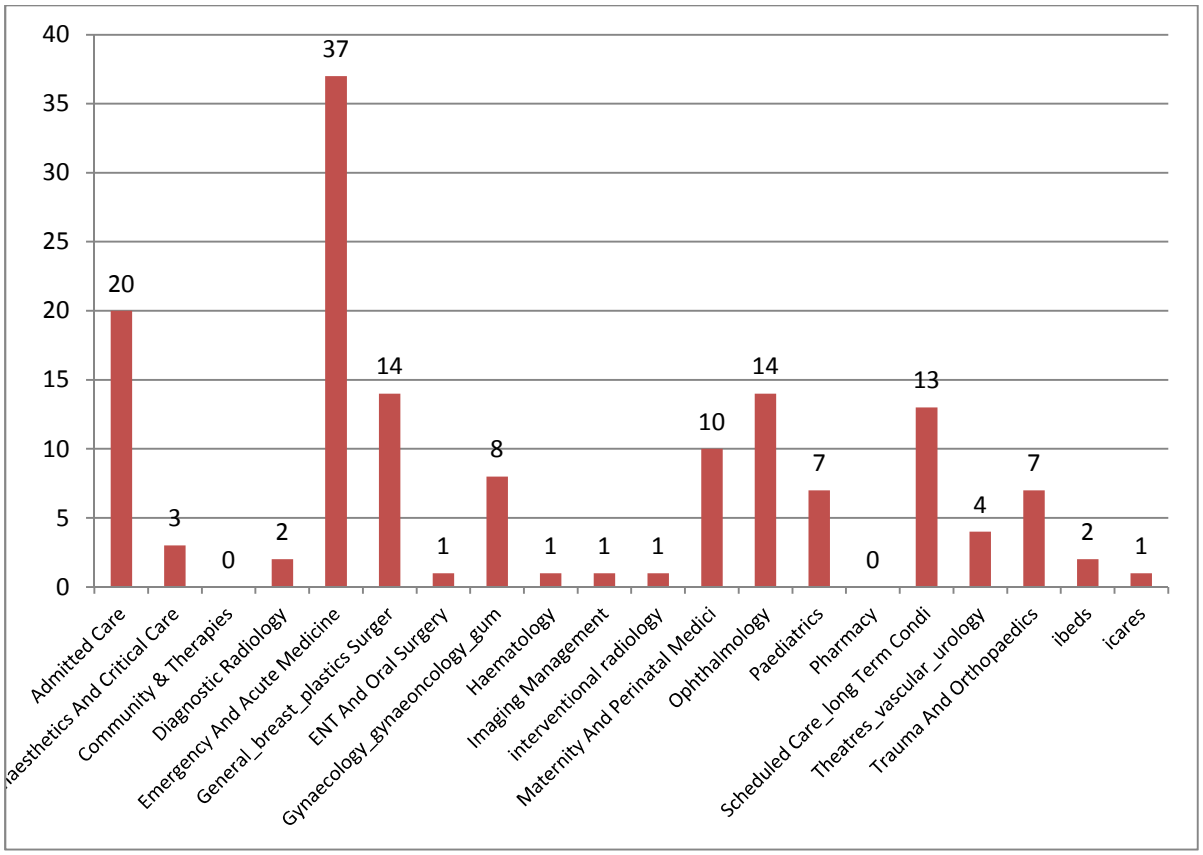
A breakdown of the top three themes complained about, broken down by Clinical Group or Corporate Directorate for Q2 2015/16. Where there were no complaints for this theme for a Clinical Group or Corporate Directorate, then they are not featured in this breakdown.



A breakdown of the 'attitude of staff' theme by staff groups for Q2 2015/16

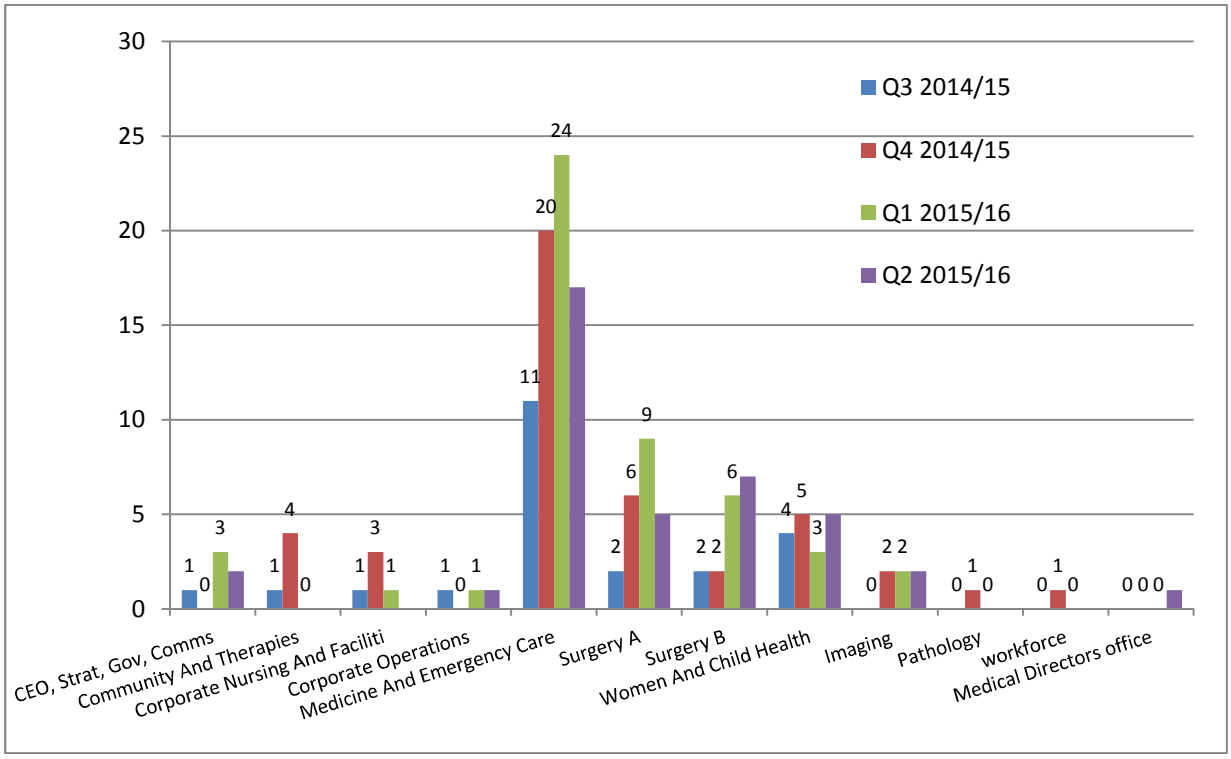


A breakdown of the 'all aspects of clinical treatment' theme by Trust wide clinical directorate Q2 2015/16

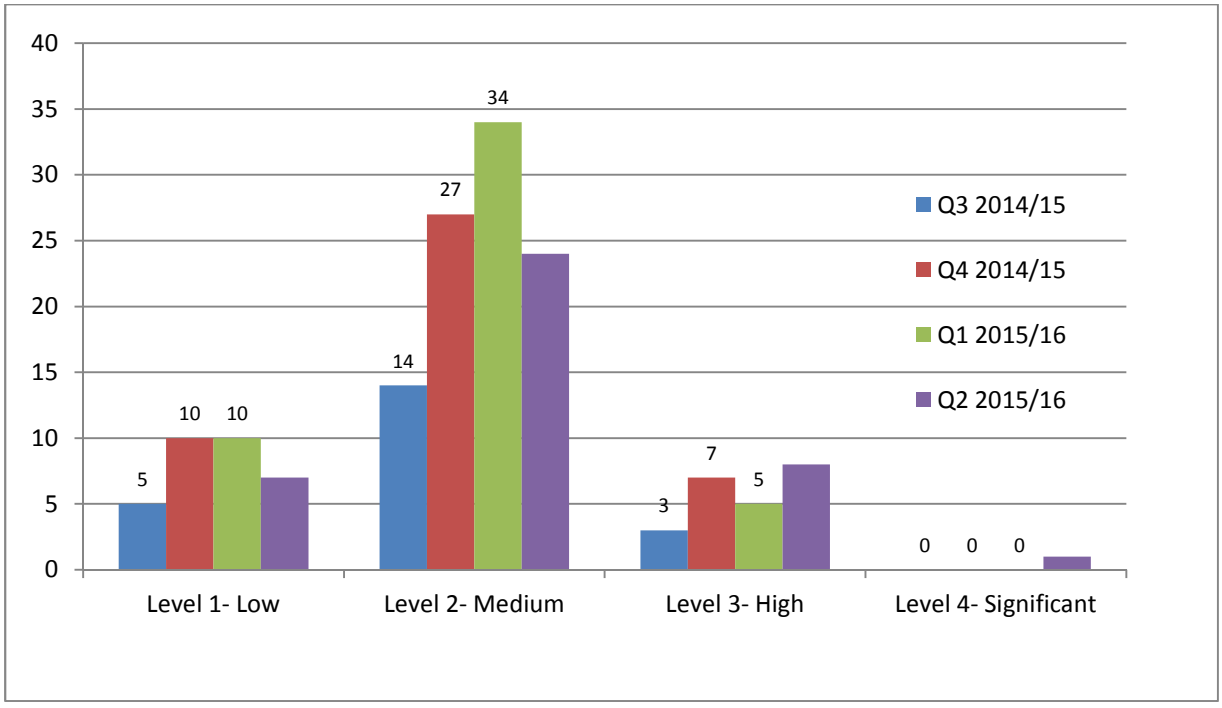


Appendix 6

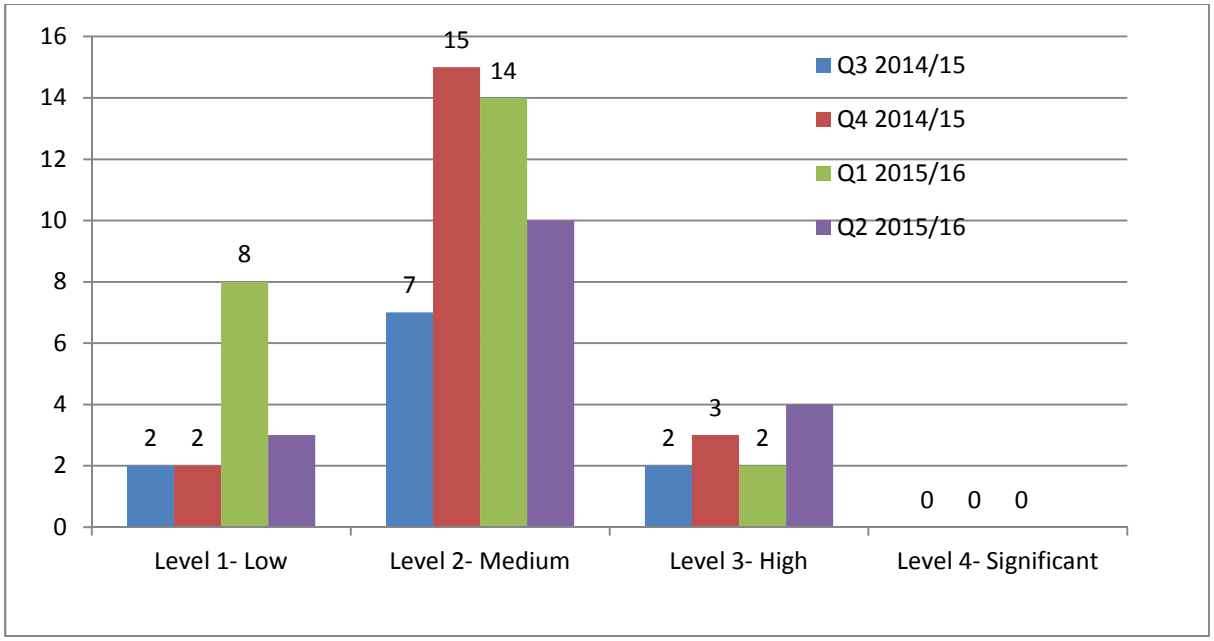
Complaints that have been reopened in Q2 2015/16 by Clinical Group and Corporate Directorate compared to Q1 2015/16, Q4 2014/15 and Q3 2014/15



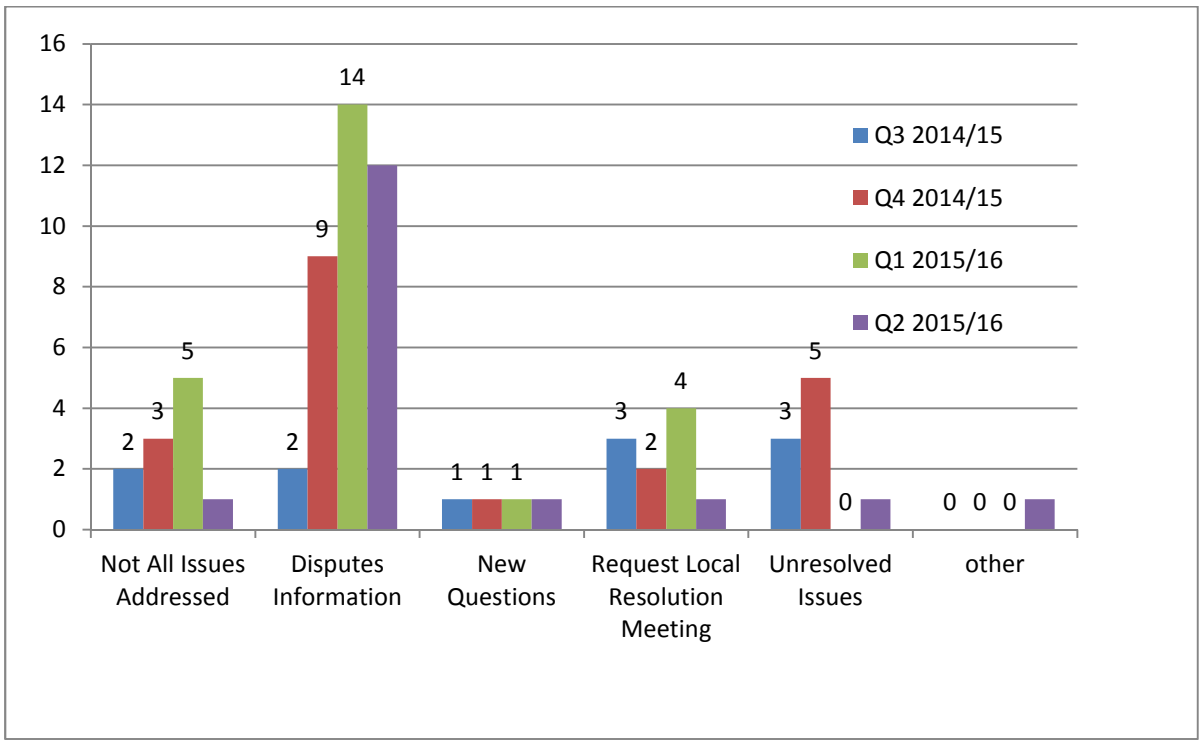
Complaints that have been reopened in in Q2 2015/15 compared to Q1 2015/16, Q4 2014/15 and Q3 2014/15 by Grade.



Reopened complaints for Medicine and Emergency Care by grade for Q2 2015/16 compared to Q1 2015/16, Q4 2014/15 and Q3 2014/15

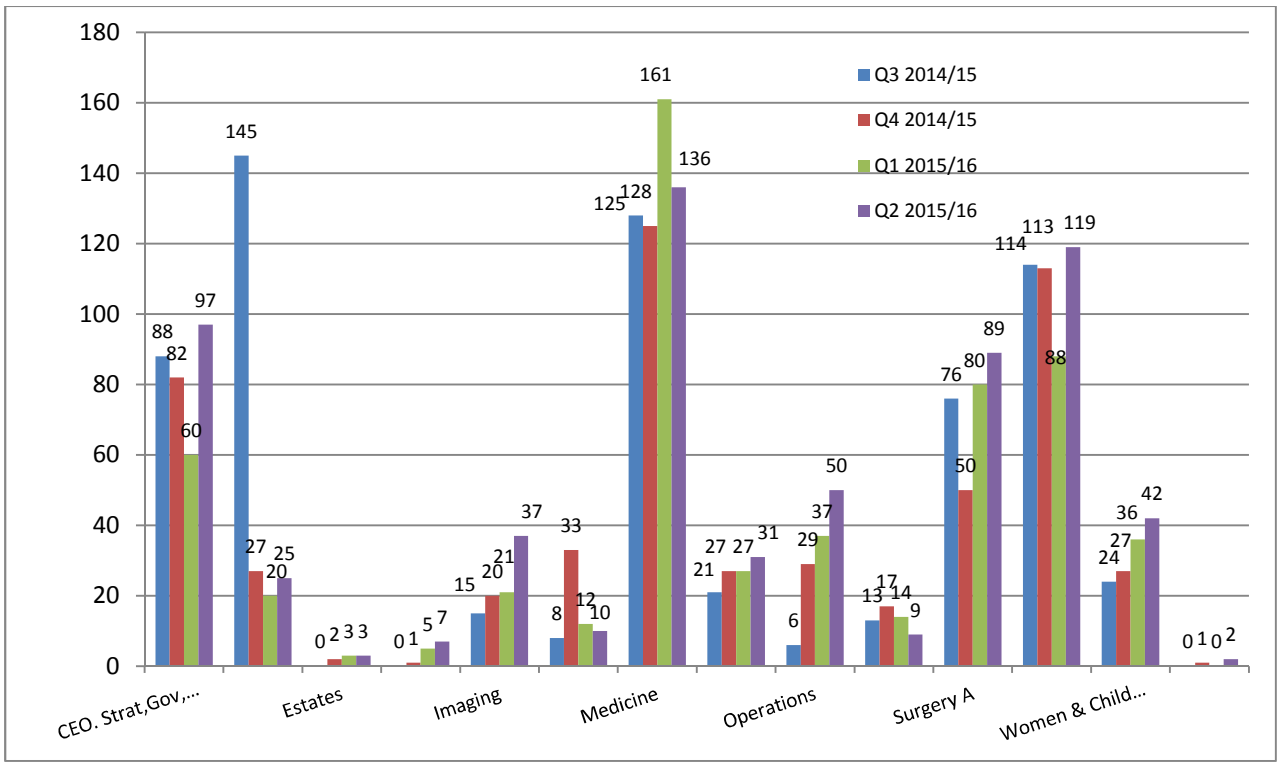


Reopened complaints for Medicine and Emergency Care by reason Q2 2015/16 compared to Q1 2015/16, Q4 2014//15 and Q3 2014/15



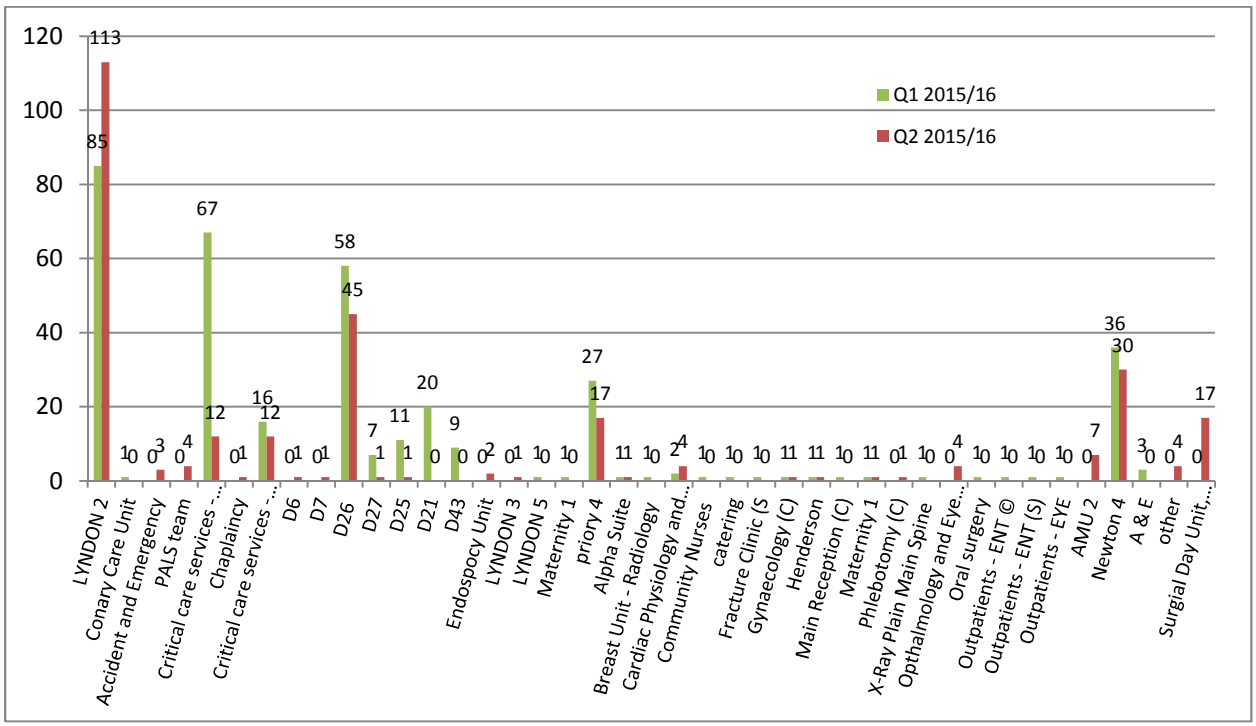
Appendix 7

PALS enquiries broken down by group for Q2 2015/16, compared to Q1 2015/16, Q4 2014/15 and Q3 2014/15



Appendix 8

Compliments Q2 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.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit and Risk Management Committee – Version 0.1

Venue Anne Gibson Board Room, City Hospital **Date** 30 July 2015; 1400h

Members Present		**In Attendance**
Mrs G Hunjan	[Chair]	Miss K Dhami
Dr S Sahota		Mr T Waite
Mr R Russell		Mr T Reardon
Cllr. W Zaffar	[part]	Mr R Chidlow
		Mr A Hussain
		Mr B Vaughan
		Ms E Sims

Secretariat

Mrs E Quinn

Minutes	Paper Reference
1 Apologies for absence	**Verbal**
Apologies for absence were received from Mr Colin Ovington, Mr Harjinder Kang and Mr Andrew Bostock. The Chair welcomed Mr Robin Russell and Cllr. Waseem Zaffar, both new Non-Executive Directors. Mr Russell will also be the new Chair of the Audit and Risk Management Committee, with effect from the next meeting in October 2015.	
2 Minutes of the previous meeting	**SWBAR (4/15) 031** **SWBAR (6/15) 037**
The minutes of the meeting held on 30 April 2015 were considered and approved as a true and accurate reflection of discussions held. The minutes of the meeting held on 4 June 2015 were considered and approved as a true and accurate reflection of discussions held. Mrs Hunjan	

suggested that the paragraph at item 2 should be rephrased to reflect the prioritisation of the controls around the financial systems in terms of the three year rolling programme of internal audit. The paragraph at item 3 was rephrased to reflect that the audit recommendations needed to be submitted as part of the routine agenda of the Committee. Finally, the paragraph at item 6 was rephrased to reflect that the annual accounts were prepared and submitted to the revised timescales.	
3 Matters arising	**SWBAR (6/15) 037 (a)**
The Audit and Risk Management Committee received and noted the updated actions log.	
3.1 Update on Overseas visitor policy	**Verbal**
Miss Dhami reported that there had been a delay with progress on the work to embed the overseas patient policy due staff sickness, however, the policy would now be presented to the next CLE meeting in August. It was agreed that a further update would be presented at the October meeting, by which time, it was anticipated that significant progress will have been made.	
ACTION: Miss Dhami to present an update on embedding the overseas visitor policy at the October meeting.	
4 Risk Management and Governance Matters	
4.1 Board Assurance Framework 2015/16 – Quarter 1 update	**Tabled Paper**
Miss Dhami tabled the latest version of the Board assurance Framework. She reported that the updates on the controls and assurances to mitigate the risks have, in the majority, not impacted on risk scores. She highlighted that the exception to this is the controlled residual score for risk 026-EEO, which relates to sickness absence. The score was noted to have 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. Additional measures are planned to strengthen controls and this work is being undertaken by Mrs Raffaela Goodby and the Workforce Committee. Mr Sahota was concerned that the mitigations put into place had not, to date, been effective and felt it was appropriate to seek assurance from the Workforce Committee. Miss Dhami informed the Committee that the Trust's Board were already sighted on this data and that additional work is being undertaken to strengthen controls, as the Board needed to be assured that sickness levels are not affecting patient care. If no further positive improvements had been achieved by the next meeting in October, it was suggested it would be appropriate to invite Mrs Goodby to attend. Mr Russell asked where the financial impact of staff sickness was recorded	

and reported. Mr Waite assured Mr Russell that this element is monitored by the Finance and Investment Committee. Mr Waite asked the Committee to be sighted on risk 017a, which suggests moving the Finance and Investment Committee (FIC) to monthly, rather than bi-monthly. This will be discussed at the next meeting of the FIC on 31 July.	
4.2 Governance Pack	**SWBAR (7/15) 040** **SWBAR (7/15) 040 (a)**
Mr Reardon presented the latest version of the Governance pack. It was noted that the Trust had written off £70k of overseas payments; £40k of which related to one specific case. Mr Reardon informed the Committee that work was being undertaken locally and nationally with the Department of Health and the Home Office in relation to overseas patients. The total value of salary overpayments was reported to have reduced. Mr Hussain suggested that it would be good practice to include the amount recovered, as well as the overpayment amount. It was agreed that the report would be refined accordingly for the next meeting. There was a general discussion in relation to tender waivers to ascertain the reason why, in a large majority of cases, formal tendering was deemed as not practical. Mr Waite felt that this would largely be due to existing contracts in place, however, Mr Reardon agreed to refine the report for the next meeting to give more details/examples of the reasons for this.	
4.3 Whistleblowing update	**SWBAR (7/15) 041** **SWBAR (7/15) 041 (a)**
Miss Dhami presented a summary of the Trust's whistleblowing arrangements and guided the Committee through the future plans for improving whistleblowing within the organisation. The Committee received and noted the update and endorsed the future plans. It was agreed that a further update would be presented at the next meeting in October.	
ACTION: Miss Dhami to present an update on the Trust's plans for improving whistleblowing at the October meeting.	
4.4 Plans to update Standing Orders, Standing Financial Instructions and Scheme of Delegation	**SWBAR (7/15) 042**
Mr Waite reported that the Standing Financial Instructions, Standing Orders and Scheme of Delegation were last reviewed in January 2014, when the changes proposed were to reflect the new Board Committee structure that had been introduced during the prior year. A more significant review was now needed, to include in particular, the impact on the SFIs in respect of on-going work to improve the effectiveness	

and ease of operation of the Trust's electronic procurement system (iProc). A programme of work is planned during the next three months to review the SFIs/SOs and SoD in detail, with the proposed changes being presented at the October meeting of the Audit & Risk Management Committee and thereafter to the Board in November for approval. The Committee agreed to support the proposed approach.	
ACTION: Mr Waite to present the proposed changes to the SFIs, SOs and SoD at the October meeting.	
5 External Audit Matters	
5.1 External Audit progress report	**SWBAR (7/15) 043**
Mr Chidlow reported that the audit responsibilities for 2014/15 had been concluded. The key issues arising have been summarised in the Annual Audit letter. A timetable for completing the Trust's annual accounts, Quality Account and Annual Report for 2015/16 was suggested. It was noted that work in respect of the Trust's Quality Account had been completed in line with the submission deadline of 30 June 2015.	
5.2 Annual Audit letter	**SWBAR (7/15) 044**
The Committee received and noted the Annual Audit Letter.	
6 Internal Audit Matters	
6.1 Internal Audit progress report and recommendation tracking	**SWBAR (7/15) 046**
Mr Hussain presented an overview of the internal audit work completed since the last meeting and advised that a further three reports had been finalised. It was noted that the Board Assurance Framework was an advisory review and therefore no Internal Audit opinion was provided. The Charitable Funds and Nursing Documentation reviews were both noted to be amber/red. It was reported that there were a number of Data Quality reports that are awaiting responses from the Trust's management and have now been escalated to the Chief Executive. It was noted that the Trust had made a concerted effort to record closure of outstanding recommendations on the Trust's recommendation tracking system from previous internal audits. This was considered a marked improvement.	
6.2 Counter fraud annual report	**SWBAR (7/15) 047**
Mr Vaughan presented an overview of the activities undertaken by the	

LCFS during the year and reported that the counter fraud programme was progressing well.	
6.3 Counter fraud progress report	**SWBAR (7/15) 048**
Mr Vaughan presented an update in respect of counter fraud work undertaken during the reporting period April to June 2015. He summarised the key findings as follows: • An NHS Protect video was placed on the Counter Fraud intranet pages by the Communications team, to enable staff to be updated and kept aware of the types of fraud and how to report any instances. The video was also disseminated via Twitter; • During the2014/15 workplan year, eight referrals were received by the LCFS, not including non-fraud advice matters. This quarter, the LCFS has received 12 referrals. This increase is seen as a result of continued efforts to publicise the role of the LCFS; • Following the submission of the NHS Protect Self-Review Tool in May 2015, the Trust has been selected for a focused Quality Assessment in the standards: Inform and Involve and Hold to Account. The inspector will be attending the Trust on 12 and 13 August 2015 to undertake the review.	
6.4 Clinical Audit Outturn Report 2014/15	**SWBAR (7/15) 049** **SWBAR (7/15) 049(a)**
Miss Dhami presented an overview of the stages reached by the audits that were included in the 2014/15 Clinical Audit Forward Plan by the end of the financial year. The Committee noted that five national audits that were included in the 2014/15 plan did not subsequently collect data in the financial year. The audits were:- • National Audit of Dementia • National Audit of Parkinson's Disease • National BTS Audit – Paediatric Pneumonia • National BTS Audit – Bronchiectasis • National BTS Audit – NIV The report was noted to highlight areas where practice requires to be improved, but also reports on some areas of good practice. In comparison to 2013/14, the percentage of Forward Plan audits considered to have fully met the process requirements has increased. It was considered that this was a result of developing more robust reporting arrangements through the Clinical Effectiveness Committee. The percentage of audits included in the plan considered to illustrate an aspect	

of poor compliance remains low.	
6.5 Clinical Audit – exceptions to report	**SWBAR (7/15) 050** **SWBAR (7/15) 050 (a)**
Miss Dhami presented the clinical audit plan. It was reported that the plan contains 89 audits that cover the key areas recognised as priorities. In Quarter 1, monitoring has shown that the majority of national clinical audits are on-track and that there are no audits reported as experiencing a significant delay with data submission. The Trust will no longer participate in the National Audit of Intermediate Care, as the CCG has decided not to register for this round. No significant delays with the conduct of local audits were reported in Quarter 1. The Committee noted the key learning arising from the participation in clinical audits that were included in the forward plan in Q1 of 2015-16.	
7 Updates from the Chairs of the Trust Board Committees	**Verbal**
There were no Board Committee chairs present at the meeting to provide an update.	
8 Matters to raise to the Trust Board	**Verbal**
The Committee agreed that the Trust Board should be sighted on the future plans for improving whistleblowing in the Trust.	
9 Meeting effectiveness	**Verbal**
The Committee agreed that the effectiveness of the meeting was positive.	
10 Any Other Business	**Verbal**
As this was her last meeting as Chair of the Committee, Mrs Hunjan thanked the members for their attendance during her time as Chair. On behalf of the Committee, Mr Russell thanked Mrs Hunjan for her service and contributions to the Audit & Risk Management Committee during her time in post.	
11 Date and time of next meeting	**Verbal**
It was noted that the date and time of the next meeting would be 29 October 2015 at 1400h in the Anne Gibson Board Room, City Hospital	

Signed:……..

Name:……

Date:……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 1.2

Venue Anne Gibson Committee Room, City Hospital **Date** 28th September 2015; 1030h – 1230h

Present

Members		**In Attendance**
Mr R Samuda	[Chair]	Ms A Binns
Ms R Barlow		Mr A Kenny
Dr R Stedman		Mrs J Wakeman
Miss K Dhami		Ms Emma Loosley
		Secretariat
		Lynn Fairfield

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies for absence were received from, Olwen Dutton, Colin Ovington, Debbie Talbot.	
2 Minutes of the previous meeting	**SWBQS (9/15) 095**
The minutes of the Quality and Safety Committee meeting held on 28 August were approved subject to the following amendments: 1. Actions are to be added to the minutes where required and included in the action log, for completeness, before the minutes are presented to the Board. 2. The updated actions list was received and noted by the Committee.	
3 Matters arising from the previous meeting	**SWBQS (9/15) 095**
1. **Item 6:** Safeguarding adults and children, Action Colin Ovington to provide an update to include adult trafficking 2. **Item 8:** Open referral update, Rachel Barlow to provide an update on medical secretaries and patients still waiting to be reviewed 3. **Item 9**: Patient Story for the Board last paragraph should read *anecdotal* rather than *antidotel.* 4. **Item 12:** BAF Action: Quality & Safety to receive further updates on red actions.	

3.1 Best practice knee related PROMs Result	**SWBQS (7/15) 096**
Dr Stedman presented an update on his findings from discussions with NHS organisations listed in the report. He commented that there had been a useful exchange of learning from the peer to peer exchange visits and as a direct result there have been a number of changes and improvements to the administration process. The changes should improve the Trust's return rate, which is dependent on patients returning the feedback questionnaire. The data provides a comparative trend analysis.	

MATTERS FOR DISCUSSION/DEBATE

5 Safe nurse staffing update	
Jo Wakeman introduced the report on behalf of Colin Ovington. The Committee engaged in a discussion which focused on: 1. Nurse staffing data accuracy, which is more accurate for August than July and June, although some accuracy gaps remain. 2. The programme of work to correct the data by 15 October 2015. 3. The operational changes to maintain safe nursing establishments. M Samuda sought assurance that resources are available to achieve data accuracy, the use of incident reporting to escalate unsafe staffing levels and that the Trust is on schedule to deliver the update to the October Board and the TDA. Jo Wakeman stated that: • The reports to the Board and the TDA will be delivered as previously agreed and that the resources are available to achieve data accuracy, which is validated at ward level, group directors and by Colin Ovington. • Data sourcing from a combination of e-rostering and nurse bank are the main causes of the data anomalies. More robust measures are now in place to solve the problem, which include planning rotas 6 weeks in advance, real time ward data updates and daily meeting with the matrons. • Sickness and vacancies are the main reason for gaps. The Trust has introduced more robust sickness reporting and holding regular recruitment days with the view to recruit over establishment. Interested candidates are invited to take numeracy and literacy test on the day and successful candidates leave the event with a firm job offer subject to CRB checks. • Incident reporting to the group director of nursing is actively encouraged to escalate any unsafe staffing levels and evidence exists to prove that incidents are being reported on a regular basis.	

Ms Dhami requested some further clarification on specific gaps in the data. The discussion which followed highlighted some limitations with the data accuracy and filling the gaps. Ms Wakeman advised that the figures referred to where not an accurate reflection of the position as some of the gaps had been filled, but not yet recorded from ward level and that the pay incentives to work weekend and night shifts resulted in a struggle to fill day shifts. Ms Barlow suggested testing the market forces by rostering the night shifts before the day shifts. Ms Wakeman, following a question from Rachel Barlow requesting details on the Trust's biggest risk area, advised that the City wards and both emergency departments have the most vacancies. The matron filling the gaps on the night rota mitigates some of the risk. The agency sending the wrong grade of staff to the wrong ward compound the problem, which the Trust has no leverage to address. Mr Samuda summarised the discussion by stating that improving staffing levels and testing market forces will influence behaviours.	
Action: The Board will continue to receive monthly updates on Nurse Staffing	Colin Ovington
5. Infection Control Update	
Ms Wakeman reported an increase in C.difficile post 48 hours, which relates to antibiotics and the time of year rather than to post contamination. Dr Stedman raised training in blood cultures. Ms Wakeman will revert back to Dr Stedman with a response.	
TDA Visit on 21 September 2015	
Ms Wakeman reported that: • City had received positive feedback from the TDA which demonstrates that the changes had been sustained, this is good result for D26 following the immense scrutiny since the CCQ inspection. • The Sandwell feedback shows a retrograde step on previous inspections. The issues identified by the TDA are similar to the ones initially identified at City such as Personal Protective Equipment (PPE), hand washing, general dust, poor documentation, damaged and faulty equipment. • Mr C Ovington has invited the TDA back to the Trust on the 14 October 2015. An action plan is under development, similar to the one used for City. Ms Dhami commented that the areas for improvement raised by the TDA at Sandwell should have been picked and addressed as a result of daily checks and asked Ms Wakeman her view on the dust feedback. Ms Wakeman commented that staff state that the dust is a big problem and despite regular routine dusting the problem remains. Hotel Service have helped with some reviews but do not have the resources to help further. The matrons are doing cross monthly audits across surgery and medicine.	

Mr Samuda raised theatre cleanliness. Dr Stedman commented that there are no issues; and that very active conversations take place with the matrons.	
5. Safe and Sound 2 Update	**SWBQS (9/15) O97**
Ms Goodby introduced the paper and reported that since the last report to the Quality and Safety Committee, good progress had been made. The key points: • 280 employees put at risk in Phase 2, 6 have not yet been offered suitable alternative employment. • 4 are TUPE'd public health employees, who transferred across on higher bands than their peers. One is a speciality doctor who does not wish to retrain. Dr Stedman is working to establish whether it is possible for the doctor to be redeployed to another Trust. • 2 employees were on trial periods where the job did not work out. For one individual the role was above her skill, so it was jointly agreed with the manager that it would be risk for the individual to continue in the trail period, the individual is looking for another role. The Committee engaged in a discussion. Ms Binns advised that the general feeling is that in some instances managers had people imposed upon them. She cited an example, where the person may appear suitable on paper, but requires further development within twelve months. Mr Samuda asked what lessons have been learnt from the two phases. Ms Goodby reflected that • In Phase 1 some people with sickness or performance issues were positively encouraged to enter the redeployment pool. Lessons were learnt as result of the concerns raised by managers, so there was no active encouragement in for this in Phase 2 • The group directors of nursing were told that all nurses in the redeployment pool must be redeployed because the Trust vacancy shortage. This was not a popular decision and is an ongoing issue. Steps need to be taken if it turns into a quality and safety issue. • We need to be open with managers who take on redeployed people with performance issues or sickness issues and offer them support in managing the performance sickness and capability issues. • Feedback from staff side is that Phase 1 was successful as it redeployed a number of	

colleagues with minimal redundancies and that Phase 2 has been much smoother and lessons were learnt from Phase 1. • Dr Stedman asked how the learning from the medical secretaries has been applied. Raffaela Goodby advised that although she agreed with the recruitment and selection process, in her view there should have been more consultation with the Consultants at the beginning of the process to explain the rationale for change. Dr R Stedman raised redundancy arrangements. Ms Goodby advised that redundancies are on individual basis dependent on transferable skills. The Board has to demonstrate to the TDA that everything possible has been done to deploy the person.	
7. CQC Improvement Plan update	**SWBQS (9/15)100** **SWBQS (9/15)100a**
Ms Dhami advised this report is going to the Board held in public on 1 October 2015.	
8. Patient Story for the Board	
Ms Wakeman reported that Board held in public on 1 October 2015 will receive a video on patient experience as an inpatient .	
9. Integrated Performance Report	**SWBQS (9/15) 103**
The dashboard was received by the committee.	
10. MMH Assurance process for clinical space derogations	**SWBQS (9/15) 104**
Mr Kenny, summarised the background to the derogations which had been made during the design development process associated with the Midland Metropolitan Hospital, MMH and the reviews which had previously been undertaken to review and test the derogations. Mr Kenny presented a paper which outlined the proposed process and timeline required to provide assurance around derogated clinical spaces in the MMH design, to both the Quality and Safety Committee, Trust Board and external approval bodies. He advised that a similar process was also being undertaken with regard Hard and Soft Technical derogations from guidance in Health Building Notes, HBN or Health Technical Memorandum HTMs, or the Trusts Construction Requirements. Mr Kenny reported that the need to provide assurance with regard to the derogations was approval condition of the Confirmatory Business Case for the Midland Metropolitan Hospital, and that a range of	

key actions would be undertaken to support the process, and test and provide assurance, these included: • An initial risk assessment of each derogation utilising the Trusts existing risk management / assessment framework. • Live (MDT) risk assessment scenario testing to enable actions necessary to manage, mitigate any impact of the derogations to be developed and tested. • Construction of full scale mock ups of each of the clinical and utility rooms where derogations had been made had been constructed to support/facilitate the assessment of the derogations. • Reports on the assessments, findings and actions/measures to be taken would be prepared and received by the Quality and Safety Committee and Trust Board prior to submission to the Trust Development Agency.	
11 QIA Quarterly Process	
Dr Stedman reported quarterly assurance process has been set up to review and sign off CIP,TSPs and improve KIPs	
12 BAF 2015/16 Updates on progress, addressing gaps in controls and assurance	
12.1 Reducing readmissions	**SWBQS (9/15) 106 (a)**
Ms Barlow introduced the paper and reported failure to deliver a reduction against the readmission rate to date, has warranted a refocus on approach to delivery. She raised discharge and commented that we are not advocating discharging patient early, rather the right patients, subject to risk assessment; there are people who should be in other places rather than a hospital setting. The Trust is holding a focus week on 12 October. The aim is to standardise practice around risk assessments and discharge planning to reduce the risk of readmissions and establish MDT reviews for most frequent readmitted patients.	
12.2 Improving the ability of patients to die in a place of their choosing	**SWBQS (9/15) 106 (b)**
Ms Barlow reported: That the audit has made progress against the benchmark since Quater1 **Quality and Safety Committee noted the update.**	

12.3 National waiting times	**SWBQS (9/15) 106 (c)**
Rachel Barlow reported: • That the risk rating against the initial controls has been increased as delivery of referral to treatment and 6 week new OP appointments is behind plan. Initial score 12 now 16 • The new Deputy COO for Planned Care , is bringing new capacity and skill, their focus is to support the work is to improve the demand in the capacity plan, treating the right patients at the right time and bring waiting times down. • Progress with theatre list. This week every clinician in the Trust will have received their theatre list for 19 October. All list with the exception of two should proceed as planned. • Improvement of discharge rates and DTOC – progress has been made, the 2 approached to further improvements are listed in the report. • Urgent Care 3 – still some work to do but on what needs to be done clear will be deliver October / November	
MATTERS FOR RECEIPT AND ACCEPTANCE	
13 Serious Incident report	**SWBQS (9/15) 107**
The item was received and noted by the Committee.	
14 Clinical audit forward plan: monitoring report	**SWBQS (9/15) 108**
The item was received and noted by the Committee.	
OTHER MATTERS	
15 Matters of topical or national media interest	**Verbal**
Mr Samuda sought clarification on impact of the 28 day national cancer referral on the Trust. Dr Stedman advised that patients will receive either a diagnosis leading to treatment or the all clear within 28 days of a GP referral. This has resulted in more referrals.	
16 Meeting effectiveness	**Verbal**
The Committee agreed that the effectiveness of the meeting was positive.	
17 Matters to raise to the Board and Audit & Risk Management Committee	**Verbal**
None	

18 Any other business	**Verbal**
There was no other business.	
20 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 30 0ctober 2015 at 1030h in the Anne Gibson Committee Room, City Hospital.	

Signed ……

Print ……	
Date ……	