Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Anne Gibson Boardroom, City Hospital **Date** 28 November 2013; 1330h

Members

Mr R Samuda	(RSM)	[Chairman]
Ms C Robinson	(CRO)	[Vice Chair]
Dr S Sahota OBE	(SS)	[Non-Executive Director]
Prof R Lilford	(RL)	[Non-Executive Director]
Ms O Dutton	(OD)	[Non-Executive Director]
Mr H Kang	(HK)	[Non-Executive Director]
Mr T Lewis	(TL)	[Chief Executive]
Mrs L Pascall	(LP)	[Interim Chief Nurse]
Miss R Barlow	(RB)	[Chief Operating Officer]
Mr R White	(RW)	[Director of Finance]
Dr R Stedman	(RST)	[Medical Director]

In attendance

Miss K Dhami	(KD)	[Director of Governance]
Mr M Sharon	(MS)	[Director of Strategy & OD]
Mrs F Sanders	(FS)	[Interim Chief Information Officer]
Mrs C Rickards	(CR)	[Trust Convenor]

Guests

Mr M Budhoo	(MB)	[Group Director – Surgery A]
Mr A Tyagi	(AT)	[Group Director – Surgery B]
Mr G Seager	(GS)	[Director of New Hospital Project]

Secretariat

Mr S Grainger-Payne (SGP) [Trust Secretary]

Time	Item	Title	Reference Number	Lead
1330h	**1**	**Apologies**	**Verbal**	**SGP**
	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**	**All**
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 31 October 2013 a true and accurate records of discussions*	**SWBTB (10/13) 227**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (10/13) 227 (a)**	**SGP**
	5	**Questions from members of the public**	**Verbal**	**Public**
1340h	**6**	**'Never Events' in Trauma & Orthopaedics and Ophthalmology**	**SWBTB (11/13) 246** **SWBTB (11/13) 246 (a)**	**RST/ MB/ AT**
1410h	**7**	**Chair's opening comments and Chief Executive's report**	**SWBTB (11/13) 229**	**RSM/ TL**
	7.1	Update on Data Quality	Verbal	TL
	MATTERS FOR DISCUSSION			
	8	**Safety, Quality and Governance**		
1425h	8.1	Emergency Care	SWBTB (11/13) 230	RB

	▶	Emergency preparation, resilience & response – self assessment and improvement action plan	SWBTB (11/13) 231 SWBTB (11/13) 231 (a) SWBTB (11/13) 231 (b)	RB
1440h	8.2	Action plan in response to the Francis Inquiry and related national reports	SWBTB (11/13) 232 SWBTB (11/13) 232 (a)	KD
1500h	8.3	Update from the meeting of the Quality & Safety Committee held on 22 November 2013, minutes from the meeting held on 25 October 2013	SWBQS (10/13) 149	OD
1510h	8.4	Quality report to include an update on performance against thrombolysis targets	SWBTB (11/13) 233 SWBTB (11/13) 233 (a)	LP/ RST
1515h	8.5	Board Assurance Framework – Quarters 1 & 2 update	SWBTB (11/13) 235 SWBTB (11/13) 235 (a)	KD
	9	**Finance & Performance Management**		
1525h	9.1	Update from the meeting of the Finance & Investment Committee held on 22 November 2013, minutes from the meeting held on 20 September 2013	SWBFI (9/13) 089	CR
1530h	9.2	Monthly finance report – Month 7	SWBTB (11/13) 236 SWBTB (11/13) 236 (a)	RW
1535h	9.3	Monthly performance monitoring report	SWBTB (11/13) 238 SWBTB (11/13) 238 (a)	RW
1545h	**10**	**Midland Metropolitan Hospital**		
	10.1	Resolution to reapprove the Outline Business Case to Commission the Midland Metropolitan Hospital	SWBTB (11/13) 242	TL
	10.2	Submission to the Trust Development Authority	SWBTB (11/13) 242 (a) - SWBTB (11/13) 242 (c)	GS
	10.3	10 Year LTFM, planning assumptions and outputs	SWBTB (11/13) 245 SWBTB (11/13) 245 (a)	RW
1630h	**11**	**Any other business**	**Verbal**	**All**
		MATTERS FOR INFORMATION		
	12	**Midland Metropolitan Hospital project: monitoring report**	**SWBTB (11/13) 239**	
	13	**Foundation Trust application programme: monitoring report**	**SWBTB (11/13) 240** **SWBTB (11/13) 240 (a)**	
	14	**Monitor Risk Assessment report**	**SWBTB (11/13) 241** **SWBTB (11/13) 241 (a)**	
	15	**Details of next meeting** *The next public Trust Board will be held on 19 December 2013 at **1330h** in the Boardroom, Sandwell Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.2

Venue Boardroom, Sandwell Hospital **Date** 31st October 2013

Present

Mr Richard Samuda [Chair]
Ms Clare Robinson
Dr Sarindar Sahota OBE
Mrs Gianjeet Hunjan
Mr Harjinder Kang
Mr Toby Lewis
Mr Robert White
Mrs Linda Pascall
Miss Rachel Barlow
Dr Roger Stedman

In Attendance

Miss Kam Dhami
Mr Mike Sharon

Guests

Dr Christine Wright [Consultant Haematologist]
Ms Charlotte Pisano [Ward Sister]
Ms Emma Ferguson [Matron]

Secretariat

Mr Simon Grainger-Payne

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Prof Richard Lilford and Ms Olwen Dutton.	
2 Declaration of Interests	**Verbal**
There had been no declarations of interest made since the last meeting and no Board member declared an interest with any item on the agenda of the meeting.	
3 Minutes of the previous meeting	**SWBTB (9/13) 203**
The minutes of the Trust Board meeting held on 26th September 2013 were	

presented for consideration and approval.	
AGREEMENT: The minutes of the last meeting were approved	
4 Update on Actions arising from Previous Meetings	**SWBTB (9/13) 203 (a)**
The Board received the updated actions log. Mr Grainger-Payne reported that the action concerning presentation of the Electronic Patient Record (EPR) options was due to be discharged in November given its linkage to the ongoing refinement of the Long Term Financial Model (LTFM). Mr Lewis highlighted that the update in in November would be confined to agreement of the financial investment attached to the implementation of an EPR system, with the detail of the options available being presented at a later date. It was reported that an update against the Better Payment Practice Code would be presented at the next meeting of the Finance & Investment Committee. Mr White addressed an issue concerning instances where formal quotes/tender procedures were waived for reasons referred to in the Trust's Standing Orders and Standing Financial Instructions. It was reported that where a waiver was requested and approved, the Trust would alert the supplier via the purchase order that the supply was to represent the best price for an equivalent service/goods to any other NHS body subject to certain exceptions, such as for suppliers who have actively not participated in framework agreements and would therefore not provide such an undertaking. Mr White was reported to be expecting a degree of challenge from suppliers in response to this additional note as part of the purchasing process and an update was planned in the New Year so that the Audit & Risk Management Committee could assess the benefit of such an approach.	
4.1 Establishments and rolling headcount	**Verbal**
Mr Lewis advised that work was ongoing at present where each Group was reconciling their establishment and headcount data and where necessary updating the Electronic Staff Record or Finance systems to address any inaccuracies and to determine whether there were approximately 173 WTE unfilled vacancies within the Trust that were not actively under recruitment. He advised that the position was being discussed on a routine basis by the Clinical Leadership Executive and it was anticipated that the position would be set in November. The Board was advised that there was rigour needed to ensure that the information was kept updated.	
4.2 Handling of cancelled outpatient appointments as part of the Outpatient Efficiency programme	
Miss Barlow advised that following the discussion of Mr Hodgetts' specific outpatient issues at the last meeting, she had investigated the situation.	

The Board was advised that at present, c. 14% outpatient appointments were cancelled and rescheduled at the instigation of the Trust, a position which it was agreed was unacceptable. It was highlighted however that the outpatient efficiency workstream of the Transformation Plan was seeking to address the position through in particular, the use of partial bookings. Dr Stedman advised that there was a degree of resistance to the use of this from the consultant body which was currently being worked through.	
5 Chair's Opening Comments and Chief Executive's report	**SWBTB (10/13) 212** **SWBTB (10/13) 212 (a)**
The Chairman advised that since the last meeting he had attended the FTN Conference. He advised that the conference had demonstrated the adoption of social media facilities to handle complaints. The Board was advised that the Trust had hosted a visit by Dr Daniel Poulter MP, Parliamentary Under Secretary of State for Health to the Halcyon and Serenity Midwifery Birth Centres on 17th October 2013. Mrs Hunjan confirmed that the visit by the minister had been well received. Mr Lewis advised that the Trust's latest PLACE inspection results were pleasing. He added that feedback from the recent staff awards had been very positive. The Board was asked to note the first of the mid-year reviews that would be attached to pay slips. Work to improve the uptake of 'flu vaccinations was reported to be underway, including an assessment of areas where there was a clinical risk to the patients if staff were not vaccinated. With reference to the staff awards ceremony, Mrs Hunjan suggested that representatives of the volunteer group should be included in the awards ceremony in 2014. In terms of the plans outlined to arrange additional clinics at Rowley Regis Hospital, she suggested that effort should be directed into arranging supplementary transport arrangements for patients.	
6 Questions from Members of the Public	**Verbal**
There were no members of the public in attendance.	
7 Patient story	**Presentation**
The Board was joined by Dr Christine Wright, Sister Charlotte Pisano and Matron Emma Ferguson. The Board was provided with a presentation giving an overview of the experience of a patient with sickle cell anaemia that the Trust had treated. The Board was given an overview of the key activities undertaken when the patient had been received into the Trust's Emergency Department and made aware of the aspects of care that had gone well, in addition to those where there was an evident need for improvement.	

It was highlighted that patients with sickle cell anaemia preferred to be treated within the Sickle Cell & Thalassaemia (SCAT) facility rather than the Emergency Department, given that a tailored care plan was more readily accessible in the former. Ms Robinson noted that the IV paracetamol that had been used to treat the patient had not been easily accessible within the Emergency Department and asked whether this was a particular issue for the team. She was advised that in this case, the need for IV paracetamol had needed to be sourced from theatres given that its use was confined to this area. It was agreed however, that by doing this it had been in the interests of the patient. Matron Ferguson was asked how the awareness of sickle cell anaemia and the most appropriate treatment for patients diagnosed with a sickle cell crisis that arrived in the Emergency Departments was ensured. She advised that the work was supported in a number of ways, including by designating Sister Pisano as a champion for Haematology in the area. The team was asked how consistency of care available from the SCAT facility with that available from elsewhere could be ensured. Ms Ferguson advised that the use of a patient passport that contained the details of the tailored care plan would assist in this respect. Miss Dhami, noting that the Trust was seen to be a centre of excellence in the care of sickle cell anaemia, asked whether the area participated in research. She was advised that, although this was limited at present, work was underway to learn from the wider research in the haematology field. The team was thanked for their useful and informative presentation.	
MATTERS FOR APPROVAL	
8 Business case for the replacement of a catheter laboratory at City Hospital	**SWBTB (10/13) 213** **SWBTB (10/13) 213 (a)**
Mr Sharon advised that the catheter laboratory at City Hospital was currently not fit for purpose and that the estate was aged, therefore the kit needed to be replaced and the area refurbished. In terms of considerations, it was noted that the work needed to be harmonised with the wider Cardiology reconfiguration plans. He suggested that a managed service for the catheter laboratory appeared to be the most appropriate from a value for money perspective. It was suggested that the work incorporated the need to seek a quote for a second catheter laboratory, should this be necessary. Mr Kang asked whether the equipment that would be purchased could be transferable to the new hospital. Mr White advised that this would be built into the plans. He advised that it was planned to invite the organisations that had already been identified through a national tender and accepted onto the national framework, from which a partner to work with the Trust would be selected. The Chairman noted that there appeared to be a cost saving as a result of the	

work and asked whether mobile facilities could be used in the interim. He was advised that although this was costly this was a possibility. Mr Sharon advised that the work would release some of the estates footprint which would yield savings. Mr Kang asked whether there were any quality and safety implications as a result of running with the existing set up in the meantime. Mr Sharon offered to check the background to the position. It was agreed that work would be undertaken to determine whether there was any more life-expired equipment within the Trust. Mr Lewis suggested that the business case needed to be approved subject to the conditions discussed at the Configuration Committee around Cardiology services plans. Ms Robinson asked whether the capital costs had been included in the capital plan for the current year. She was advised that this was not the case, however Mr Lewis explained that if necessary this would need to be identified from the 2014/15 capital plan.	
AGREEMENT: The Trust Board approved the business case for the replacement of a catheter laboratory at City Hospital subject to finalisation of the Cardiology plans	
9 Hallam Street properties lease/disposal	**SWBTB (10/13) 214** **SWBTB (10/13) 214 (a)** **SWBTB (10/13) 214 (b)**
Mr Lewis presented a proposal to establish an apprenticeship scheme for homeless individuals and that the current empty properties on Hallam Street could be used to support the work. It was suggested that potential bidders should be invited to present a proposal for their support. It was noted that one of the potential partners would be seeking funding from a charitable source. Mr Kang asked whether the Trust would be likely to be placed into a position where there was risk of liabilities arising as a result of the plans. Mr Lewis advised that this was not the case. Mrs Hunjan asked how the homeless apprentices would be integrated into the Trust. Mr Lewis advised that there were currently no apprentices in some key functions and that the planned apprentices could be introduced into the Trust through these areas and that staff would be made aware of the plans through various means of communication. It was highlighted that there was a degree of risk of failure of the scheme given its potential to prompt controversial reaction. Ms Robinson asked with a view to the future Midland Metropolitan Hospital (MMH) plans, whether some safeguards in terms of the lease could be incorporated, such as break clauses. Mr Lewis advised that the MMH proposals would not affect the site that would be used for the scheme. He added that there would be a very low likelihood that there would be a need to invoke a break clause as a result. He did offer to investigate any potential blight that would result from the plans however. Mr Sharon suggested that an exit strategy needed to be built into the plans.	

Mrs Rickards expressed concern over the plans to introduce apprenticeships if jobs were to be replaced. Mr Lewis suggested however, that this was not the case and that it was hoped that the existing workforce would be likely to welcome the individuals. Dr Sahota supported the plans however he suggested that there may be a need to safeguard against any reputation as a result of drugs abuse. Mr Lewis drew the Board's attention to the attraction of drugs issues in empty properties and therefore the plans were likely to have the opposite effect. It was highlighted that a taskforce would be established to oversee the plans and evaluate the bids when submitted.	
AGREEMENT: The Board supported the plans for the establishment of an apprenticeship scheme for homeless individuals	
10 Safety, Quality & Governance	
10.1 Update from the meeting of the Quality & Safety Committee held on 25th October 2013 and minutes from the meeting held on 20th September 2013	**SWBQS (9/13) 139**
In Ms Dutton's absence, the Chairman updated the Board on the key discussion points from the meeting of the Quality & Safety Committee that had been held on 25th October 2013. Dr Stedman advised that in terms of the site specific mortality rate differences, further work was to be undertaken to identify the reasons behind the position. The Chairman noted that this would also link into the plans for addressing readmission rates. In terms of falls resulting in harm, Mrs Pascall reported that there had been 15 cases reported year to date, each of which would be subject to a tabletop review. She advised that of these, five were considered preventable. It was noted that a range of injuries had occurred as a result of the falls, including fractured neck of femur and fractured humerus. Mr Lewis noted that overall there appeared to be an upward incidence of falls with harm. Mrs Pascall advised that the local Clinical Commissioning Group had been advised and that the matter would be presented to the Quality & Safety Committee at its next meeting. Ms Robinson asked whether complaints devolution remained planned for 4 November. Miss Dhami advised that this was the case. Ms Robinson asked whether the higher level of link complaints would be investigated. Miss Dhami advised that each of these would be reviewed to determine the reasons for these arriving. Ms Robinson highlighted the need for these to be resolved expeditiously. Miss Dhami advised that the new complaints model would provide additional opportunity to discuss the response with the complainants. Mr Lewis suggested that link responses were associated mainly with delayed responses and also for bereavement cases and therefore a revised link with the bereavement team was	

planned.	
10.2 Quality Report	**SWBTB (10/13) 215** **SWBTB (10/13) 215 (a)**
The Board was asked to consider the Quality Report. Mrs Pascall reported that cases of pressure damage had reduced, including those reported in the community. It was highlighted that to date there had not been any infection outbreaks. It was highlighted that in terms of Klebsiella infections, the estates issues were being addressed robustly and the cultural issues were also being addressed. In terms of patient experience, it was highlighted that the Emergency Department FFT response rate had improved to 13%, although overall the response rate was poorer than required. Mrs Pascall reported that the patient experience strategy was being developed. The Board was advised that the Trauma & Orthopaedics area had been placed in turnaround as a result of the infections position in the speciality. Dr Stedman asked the Board to note that the VTE assessment target had been achieved and that the mortality reviews had exceeded 80%. It was reported that the performance against the fractured neck of femur target had not been met during the month, although it was highlighted that the target had increased from 2012/13. The Board was advised that the HSMR had been rebased, which was reflected in a higher position overall, yet the level remained below that of regional peers. Mr Lewis advised that a CQC maternity outlier alert had been received in respect puerperal sepsis and other puerperal infections within 42 days of delivery.	
Thrombolysis performance	**Verbal**
Miss Barlow reported that in terms of stroke thrombolysis, there had been an improvement in performance against the target. It was reported that 52% of thrombolysis occurred during normal working hours, with the rest being out of hours where the longest waits were experienced. As such, it was reported that work was underway in terms of training and refinement of pathways that included the Imaging area. Dr Stedman advised that there had been a high number of stroke mimics reported which was impacting on the position. It was noted that the outcome for the patients was better if thrombolysis was undertaken within three hours. Mr Lewis noted the criticality of the work and encouraged all efforts to be made to improve the performance. Mrs Hunjan asked how many patients had missed the window of opportunity to be thrombolysed. Miss Barlow offered to determine the position and report back. Dr Stedman advised that patients needed to be CT scanned as part of the process to determine eligibility for thrombolysis.	

ACTION: Miss Barlow to determine the level of patients missing the window of opportunity for thrombolysis	
Readmissions update	**Verbal**
Miss Barlow reported that she would report back formally to the Quality & Safety Committee in November on the plans to address the Trust's admission rates. She advised that a predictive risk assessment tool had been developed which would be piloted in the acute assessment unit. She added that primary care was also being engaged in the work. Dr Sahota asked if the communication between GPs and consultants would be improved through this process. Miss Barlow advised that real time communication would be delivered. Mr Lewis advised that a survey of GPs would be undertaken in Quarter 4 which could pick up this issue. Mr Lewis noted that patients in the Birmingham part of the patch may be readmitted elsewhere and suggested that this position should be investigated. Mr White advised that this was picked up through the charging arrangements.	
10.3 Forward look of the delivery of the 18 week standard	**SWBTB (10/13) 216** **SWBTB (10/13) 216 (a)**
Miss Barlow asked the Board to receive and note the report which had also been discussed at the recent meeting of the Audit & Risk Management Committee. An update on the data quality validation work was provided, including the outcome of the letters written to patients. It was reported that there was little evidence of any adverse clinical impact, however it had been identified that some patients had waited in excess of 52 weeks. Dr Sahota asked whether there was sufficient assurance that there were now no data quality concerns. He was advised that this could not be confirmed as further auditing of the processes was needed, particularly in the light of the rejected internal audit report on data quality assurance. Ms Robinson asked, in terms of patients not responding to the letters, whether the pathways would be closed. She was advised that this was the case. Ms Robinson asked whether there were any age-related trends to the responses that had been received back. Miss Barlow advised that this trend analysis had not been done, although triangulation to mortality and complaints had not suggested that there was a concern. Miss Barlow clarified that the pathways of any patient who had a forward appointment would remain open. Mrs Hunjan noted that at the Audit & Risk Management Committee, a promise had been made to report the ongoing forward compliance with the 18 weeks target. Mr Lewis suggested that this should be presented to the Quality & Safety Committee.	
10.4 Trust's response to the Francis Inquiry and related national reports	**SWBTB (10/13) 217** **SWBTB (10/13) 217 (a)**
Miss Dhami reminded the Committee that following the publication of the Francis	

Inquiry outcome, a number of priority areas of focus had been agreed by the Board. It was reported that since the Inquiry report had been published, a number of related national reports had been published.

It was reported that since the Board had agreed the priority areas, risk management had been added to the list and that it was recommended that data quality also be added.

It was reported that an action plan to address the recommendations and areas of focus would be developed.

The Board was asked to review the proposed list of priorities for ongoing relevance. The Chairman noted that developing junior doctors as leaders needed to be a key consideration, particularly given his experience gained from patient safety walkabouts where the doctors did not appear to be widely consulted for opinion and input. Dr Stedman reported that there was a general need to engage with junior doctors and access their feedback, in addition to a need to elevate the junior doctors into being leaders within the Trust. He reported that a junior doctor forum was in place within the Trust which was a useful means of interacting with the doctors. He also advised that specific roles would be recruited to in order to promote the leadership agenda within the junior doctor cadre. The Chairman asked whether the Trust participated in peer review. Dr Stedman advised that the hosting arrangement for WMQRS facilitated harnessing good peer review and that this peer review informed the approach being adopted by the new Chief Inspector of Hospitals. The Chairman suggested that further means of engaging patients externally and innovatively should be considered.

Mr Sharon suggested that the results from the forthcoming 'What keeps you awake at night?' session planned for the Board Development session the following day, would inform the areas for priority, as would the introduction of the Autonomy & Accountability Framework. He suggested that there was merit to mapping out the early warning systems in place within the Trust. Mr Lewis added that there would be some good clinical engagement with the work within the next period. He suggested however, that a key priority needed to be the need for staff to gain feedback on incident reporting in particular. Miss Dhami advised that this was in place robustly for serious incidents, however this was not the case for the less serious incidents at present. Mr Lewis encouraged the matter to be given attention as a matter of priority, including the sharing of incidents reported with all staff.

Dr Sahota noted that the majority of complaints related to poor communication and that as part of the safety walkabouts the lack of feedback had been noted.

Ms Robinson noted the comprehensiveness of the work undertaken to date and asked how the Board would be kept updated on progress with the work underway. Miss Dhami advised that an action plan would be developed that would be monitored. The Chairman suggested that the action plan should be considered quarterly. It was highlighted that the some of the Board Committees and the Executive-led committees should retain a focus on key aspects of the action plan. Dr Stedman noted that the work was already integrated in many ways

to the current operation of the Trust. Mr Lewis suggested that the outcome of the actions needed to be given particular attention and that individual Board members should take responsibility for different aspects of the work. He further suggested that the use of an external perspective may also be useful.	
ACTION: Miss Dhami to present the Francis Inquiry action plan at the next meeting of the Trust Board	
10.5 Update from the meeting of the Audit & Risk Management Committee held on 25th October 2013 and minutes from the meetings held on 9th May and 6th June 2013	**SWBAC (5/13) 043** **SWBAC (6/13) 044**
Mrs Hunjan presented a summary of discussions held at the Audit & Risk Management Committee held on 25 October 2013. It was highlighted specifically that the recommendations and assessment of data quality by internal audit had been rejected. Mr Lewis advised that the incoming internal audit function would pick this up. It was suggested that the scope of the internal audit programme should include medical equipment.	
11 Finance & Performance Management	
11.1 Monthly Finance Report – Month 6	**SWBTB (10/13) 218** **SWBTB (10/13) 218 (a)**
Mr White advised that as at the end of Month 6, the financial position was slightly adrift of plan. The pay position was reported to be stable and cash remained strong. It was reported that a forecast of the year end position would be developed shortly to inform commissioner negotiations for 2014/15. Mr Lewis noted, in terms of cash flow, should the position in September be replicated in October to March, then the financial obligations in this respect would be met. He noted that medical pay was variable and suggested that the Finance & Investment Committee direct focus to understanding the reasons for this. Ms Robinson suggested that the spend on agency and bank expenditure also needed to be reviewed.	
ACTION: Mr Grainger-Payne to add medical pay position and bank & agency expenditure to the agenda of the next Finance & Investment Committee	
11.2 Monthly Performance Monitoring Report	**SWBTB (10/13) 219** **SWBTB (10/13) 219 (a)**
The Board was asked to receive and accept the monthly performance monitoring report. It was highlighted that there was better alignment between MRSA screening reporting and actual activity. Ambulance turnaround times were highlighted to be concerning at present,	

particularly in the light of the potential fining regime for underperformance in the area in future. Mr White reported that a target had been set for annual appraisal from each area to improve the position. Dr Sahota noted that there was an increasing number of cancelled operations. Mr Lewis noted that there was a particular concern in the Eye Hospital in this respect. Miss Barlow agreed to investigate and report back to the Board at the next meeting. Mr Lewis advised that issues with data quality did not fully explain disappointing performance in some areas. He added that the outcome of a regional review of cancer waiting times may impact on the Trust's performance, a matter that he highlighted was expected to crystallise within the next month. Ms Robinson noted the Emergency Care performance was poor at present and asked what measures were being taken to address the position. Miss Barlow advised that a new bed model had been implemented and the acute medical units would be expanded. It was highlighted that the flow through the assessment units was being given additional focus. Good progress was reported to concern the use of Medically Fit for Discharge wards at Rowley Regis Hospital, although work was underway to ensure that the use of this facility was maximised. The work with the social services was outlined, including the implementation of seven day working. Mr Lewis advised that the current position with delayed transfers of care was disappointing and that the issue was being addressed with Social Services. He advised that should a legal stance be needed to gain a further improvement, then this would be explored. In terms of mental adult care, it was reported that the use of the RAID team was pleasing and that a mental health centre would be set up in readiness for the winter. He advised that facilities for adolescents remained a concern however.	
11.3 Quarter 2 annual plan update	**SWBTB (10/13) 220** **SWBTB (10/13) 220 (a)**
Mr Sharon advised that the overall status had improved. In terms of the emergency care targets, it was reported that it had been concluded that an optimistic view of the year end position had been taken. Mr Lewis asked whether there was an expectation that the year-end position would be achieved against those indicators rated as being amber. He was advised that this was the case. Mr Kang noted that at the recent Workforce & Organisational Development Committee the plans for addressing sickness absence had been discussed.	
12 Board Committee update	
12.1 Update from the Configuration Committee held on 15th October 2013	**Verbal**
The Chairman provided an overview of discussions from the meeting of the	

Configuration Committee. It was highlighted that a further update on the outcome of the Pathology reconfiguration plans would be presented at the next meeting, in addition to further detail on the way in which activity and capacity would be tracked in relation to the 'Right Care, Right Here' programme.	
13 Any Other Business	**Verbal**
There was none.	
Matters for Information	
The Board received the following for information: Performance Management Regime – monthly submission Midland Metropolitan Hospital Project: Monitoring Report Foundation Trust Application Programme: Monitoring Report NHS Performance Framework & FT Compliance Framework Report	
Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1330h on 28th November 2013 and would be held in the Anne Gibson Boardroom, City Hospital.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 28 November 2013, Anne Gibson Boardroom @ City Hospital

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

31 October 2013, Boardroom @ Sandwell Hospital

Members present: Mr R Samuda (RSM), Ms C Robinson (CR), Dr S Sahota (SS), Mr H Kang, Mrs G Hunjan (GH), Mr H Kang (HK), Mr T Lewis (TL), Mrs L Pascall (LP), Miss R Barlow (RB), Mr R White (W), Dr R Stedman (RST)

In Attendance: Miss K Dhami (KD), Mr M Sharon (MS)

Apologies: Prof R Lilford (RL), Ms O Dutton (OD)

Secretariat: Mr Simon Grainger-Payne (SGP)

Last Updated: 22 November 2013

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.262	Health Informatics Services (HIS) –key decisions and timeline	SWBTB (7/13) 149 SWBTB (7/13) 149 (a)	25-Jul-13	Provide a further update on the procurement of an EPR system in September 2013	FS	26/09/13	Update on Trust's capability to deliver new EPR solution included on the agenda of the November 2013 meeting	B
SWBTBACT.263	Monthly finance report – Month 3	SWBTB (7/13) 155 SWBTB (7/13) 155 (a)	25-Jul-13	Present the position in terms of compliance with the better payments code at a future meeting of the Finance & Performance Management Committee	RW	20/09/13	Discussed at the meeting of the Finance & Investment Committee at its meeting on 22-11-13	B
SWBTBACT.262	Minutes of the previous meeting	SWBTB (8/13) 180	26-Sep-13	Add an item concerning non-pay expenditure variability to the agenda of the next Finance & Investment Committee	SGP	22/11/13	Discussed at the meeting of the Finance & Investment Committee at its meeting on 22-11-13	B
SWBTBACT.263	Questions from Members of the Public	Verbal	26-Sep-13	Present an update on cancelled outpatient appointments at a future meeting of the Quality & Safety Committee	RB	22/11/13	Discussed at the meeting of the Quality & Safety Committee at its meeting on 22-11-13	B
SWBTBACT.256	Single tender action: maintenance contract for Olympus video and ultrasonic endoscopes	SWBTB (5/13) 085	30-May-13	Arrange for the Trust's standard contract terms to be amended to include a warranty related to best NHS UK price	RW	30/09/13	Verbal update provide at the meeting of the Trust Board in October 2013	B
SWBTBACT.266	Thrombolysis performance	Verbal	31-Oct-13	Determine the level of patients missing the window of opportunity for thrombolysis	RB	28/11/13	Verbal update included on the agenda of the meeting planned for 28-11-13 under the Quality Report discussion	B

SWBTBACT.267	Trust's response to the Francis Inquiry and related national reports	SWBTB (10/13) 217 SWBTB (10/13) 217 (a)	31-Oct-13	Present the Francis Inquiry action plan at the next meeting of the Trust Board	KD	28/11/13	Included as an item for discussion on the agenda of the Trust Bord meeting scheduled for 28-11-13	B

KEY:

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Update on Never Events**
SPONSOR (EXECUTIVE DIRECTOR):	**Roger Stedman, Medical Director**
AUTHOR:	**Roger Stedman, Medical Director**
DATE OF MEETING:	**28 November 2013**

EXECUTIVE SUMMARY:

This paper is to brief the Trust Board on two newly reported never events, progress on actions with respect to previously reported never events and an outline of plans to seek some external assurance on the state of safety culture within the organisation – in particular operating theatres. It should however be noted that the most recent never event occurred in an outpatients setting.

REPORT RECOMMENDATION:

The Board is asked to:

RECEIVE and ACCEPT the update on the recent 'never events'

NOTE the actions that have been undertaken since to prevent reoccurrence

ACCEPT that a proposal outlining external support required to undertake review of safety culture in the organisation will be presented to the Trust Board in January 2014

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	

Comments:

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

Supports the Trust's plans to improve quality & safety

PREVIOUS CONSIDERATION:

The Trust Board periodically receives updates on Never Events and received at its last meeting an update on the Never Event assurance plan that has been developed

SWBTB (11/13) 246 (a)

Where EVERYONE Matters

Update on Recent Never Events

Briefing for Trust Board - Thursday 28th November 2013

Introduction

This paper is to brief the Trust Board on two newly reported never events, progress on actions with respect to previously reported never events and an outline of plans to seek some external assurance on the state of safety culture within the organisation – in particular operating theatres. It should however be noted that the most recent never event occurred in an outpatients setting.

"Never events" are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.

To be a "never event", an incident must fulfil the following criteria;

- The incident has clear potential for or has caused severe harm/death.
- There is evidence of occurrence in the past (i.e. it is a known source of risk).
- There is existing national guidance and/or national safety recommendations on how the event can be prevented and support for implementation.
- The event is largely preventable if the guidance is implemented.
- Occurrence can be easily defined, identified and continually measured.

This update is regarding the following never events that have occurred at the Trust in this financial year:

- Wrong Size Implant – Ophthalmology - Theatres – 17th June 2013 – Actions Update
- Wrong Site Surgery – Plastics – Theatres – 15th December 2012 – Actions Update
- Wrong Size Implant – Trauma & Orthopaedics - Theatres – 6th November 2013 – New
- Wrong Site Surgery – Ophthalmology – Outpatients – 12th November 2013 - New

Wrong Size Implant – Ophthalmology - Theatres – 17th June 2013 – Actions Update

1) Improving safety culture in Ophthalmology theatres, empowering staff to challenge unsafe practice and stop procedures.
    a. Whole team meeting with follow up letter clarifying individual responsibilities of staff with respect to implant checking.
    b. Replication on Sandwell site
    c. Modified Lens selection protocol developed and published
    d. Audit and re-audit of staff attitudes to challenging a wrong lens selection
2) Team Building and Human Factors training
    a. Training with theatre team on biometry
    b. Human factors training at governance afternoon
    c. LiA and workshop events scheduled for December
    d. Video reflexivity commissioned
    e. Individual feedback provided to staff in instances where they have had to challenge

3) Review shelf storage for lenses and approach manufacturers regarding colour coded packaging
    a. Both lens banks have been re-organised – with shelf labelling to facilitate correct size selection and increase in shelf capacity
    b. Manufacturers have replied to request to colour code lenses – but are unable to do this due to the large number of different sizes
4) Explore possibility of barcode scanning and linking to theatre information systems (Ormis) to identify and track implants
    a. Manufacturers have identified that barcodes contain insufficient information to identify implant size
    b. Trust wide implant tracking project has commenced led by medical director's team as part of SLR project
5) Transformation plan to improve theatre scheduling and flow – early lock down of lists to reduce order changes on day of surgery, explore possibility of 'left only' and 'right only' lists
    a. This is work that had commenced prior to event and is on-going – progress is evidenced through the audit of theatre start times, late list order changes and on the day cancellations.
6) Review and republication of 'Reps in theatre' policy
    a. Action completed and disseminated across all operating theatres in the trust
    b. Confirmed that involvement of reps in theatre process is against their rules
7) Modification and reconciliation of WHO check lists in ophthalmic theatres
    a. One checklist now in use with correct lens check included
8) Amend "Protocol for Selection and Management of Implantable Lenses" to make final check prior to insertion of lens mandatory and empower staff to stop the process until lens power is confirmed.
    a. Completed and presented at directorate governance
9) Review process of informing and feedback to staff regarding serious incidents
    a. In progress

Wrong Site Surgery – Plastics – Theatres – 15th December 2012 – Actions Update

1) Implementation of two stage consent and provision of printed patient information
    a. System of procedure specific stickers in notes implemented across Surgery A Clinical Group
    b. Now routine to copy patients with clinic letter detailing intended surgery
    c. Procedure specific information leaflets in development
2) Review clinic templates to allow time for consent in clinic
3) Transformation plan to improve theatre scheduling and list construction linking outpatients booking form to Ormis – on-going
4) Modifications to Ormis to improve pick list safety – outstanding
5) Improved turnaround of neurophysiology testing results – including communication of proposed operating date and also results being available on CDA
6) Investigation into individual failures to properly carry out pre-operative checks and report a critical incident. Investigation completed – draft report received.

Wrong Size Implant – Trauma & Orthopaedics - Theatres – 6th November 2013 – New

This event occurred during a total hip replacement. The incorrect femoral head size for the acetabular cup used was implanted. The error was identified and escalated by the orthopaedic registrar whilst the patient was in recovery. The patient had a re-operation under the same spinal anaesthetic and was discharged home at the expected time unharmed. Root Cause analysis took place on 14th November 2013

Root causes identified were:

- Human error – dispersion of responsibility between three individuals at the operating table each believing the other to have completed the check
- Human error – picking the wrong implant from the store room
- System error – Lack of written SOP for selection and checking of implant size

Contributory factors identified:

- Storage space for implants
- Lack of access to PACs and electronic templating in operating theatres (which can reduce the number of implant selections prior to operation)

Actions identified:

- Standard Operating Procedure (SOP) for implants to be written which includes a simple checklist to be used as a "Time Out" to ensure correct implant has been selected, and a requirement to write the implant size on the whiteboard in theatre
- SOP to be rolled out to all theatres where implants are used to ensure consistency across all specialities
- Stacker Trolley to be purchased with drawers to allow same size sets to be stored together to reduce risk of incorrect selection.
- Request implant supplier to provide advice on feasibility of colour coding implant boxes to differentiate between sizes
- Comprehensive review of IT ability to ensure electronic x-ray viewing capability in theatres
- Refresher training to be arranged to ensure staff understanding of what is to be checked and why

Wrong Site Surgery – Ophthalmology – Outpatients – 12th November 2013 – New

This event occurred in ophthalmology outpatient laser procedure clinic. A call to the patient in the waiting room resulted in the wrong patient standing up and following the doctor into the procedure room. A failure to correctly identify the patient prior to commencing procedure resulted in the procedure for another patient being carried out on this patient – 'Laser Iridotomy' instead of 'Selective Laser Trabeculectomy'. Error identified when subsequent patient was called and same patient returned.

Root Cause Analysis of the never event took place on 22nd November 2013 – report is not yet available. Emerging themes from the RCA include:

- There is not currently a robust or widely practiced (by doctors) patient ID checking process in outpatient settings – good practice to be copied from radiology.
- Poor clinic design – bringing in all patients at start of clinic, assessing, consenting and medicating all patients and then operating
- Sole practitioner – doctor was working alone with untrained support
- No formal scheduling or listing process for outpatient procedures
- One stage – on the day – consenting process
- Issues relating to up to date Laser safety rules and processes

Seeking external assurance on the level of 'Safety Culture' within the organisation

Given the number of never events within a relatively short space of time and some of the common themes emerging from the analysis of the root causes and contributing factors we have decided to commission an external review of safety culture in the organisation. In the first instance within operating theatres however given the recent event in outpatients this may be extended.

Since the disestablishment of the National Patient Safety Agency and the winding up of a number of national improvement programs centred on theatre safety and efficiency – there is currently not an obvious body from which to seek a review. A number of avenues are being explored including:

- Peer review from a nationally recognised exemplar organisation e.g. Salford Royal NHS Foundation Trust
- Commissioned review from Royal College of Anaesthetists or Surgeons
- Use of a recognised Safety Culture Measurement Tool e.g. Manchester Patient Safety Tool (MaPSaf)
- Approaching a consultant with a national profile to facilitate an internal review e.g. Professor Jane Reid RGN DPNS BSc; prominent safety campaigner, President of the Association of Perioperative Practice, Advisor the national WHO check list steering group and currently inspector with the new style CQC.

A full proposal will be brought to board in January 2013.

Dr Roger Stedman

Medical Director

22/11/2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE PUBLIC TRUST BOARD

Chief Executive's Report – October 2013

There is a triple focus to today's agenda: The right, rapid and proportionate response to our third and fourth Never events. Misra Budhoo and Ajai Tyagi will join us, once again, as we discuss what has happened since the two events of June 13 and December 12, as well as the learning from the events of earlier this month. Our overall response to the Francis report, which we have discussed many times, but which comes now to be formally approved. I believe it is crucial that we make our incident reporting culture even more transparent and responsive. And finally, we are discussing, potentially to a conclusion, our future plans for financing and advertising for construction of the Midland Metropolitan Hospital, and associated investments in Rowley, Sandwell and Sheldon Block at City. The recently published Keogh Review makes it once again clear why the balance of the most acute urgent care provided to people in West Birmingham and in Sandwell must be delivered through dedicated specialist facilities which operate at scale. This was the proposal consulted upon in public here through 'Right Care, Right Here'.

1. Our patients

It is encouraging that we continue to meet national standards for access and for low rates of infection. We have some work to do in certain key specialties to further reduce over the next twelve months waiting times for treatment and the Clinical Leadership Executive has begun to review the Chief Operating Officer's detailed proposals for our so-called "Year of Outpatient change" in 2014, which will include reducing first appointment waiting times below nationally mandated norms. We continue to deliver national standards for VTE assessment and MRSA screening, but have not yet achieved the very high standards [100%] we have sought to set as we develop our No-Harm programme of ten areas where we wish to excel over coming months [10/10]. We will revisit in December as a Board whether we are now persuaded that we can attest to NHS Constitution compliance as requested by the TDA in its licensing and regulatory model for NHS Trusts.

Emergency care continues to require considerable focus and leadership attention among clinicians and non-clinicians alike. The infection-busting estate changes that we funded are now in place. Likewise the model of care to cut ambulance handover waits is now fully operational, and the impact of that can be seen in consistent delivery of the standard to have waits below 30 minutes on both our acute sites. Quite understandably, professional, media and public scrutiny remains on the four-hour minimum wait standard. The Trust delivered this in the quarter (July, August, and September) but we deteriorated sharply in October. November has seen us regain compliance. The Winter Plan for Sandwell and West Birmingham is now deployed and we have met with both regulating bodies over recent weeks (The Trust Development Authority and NHSE Local Area Team) to review progress and assurance. There are encouraging signs in the changes we have deployed at Sandwell to create a separate surgical unit, a distinct mental health facility, and to move towards a purpose built ambulatory area. Similarly, at City, changes in practice are showing benefit for patients, so that only patients who truly need to be retained in ED are our focus.

Our forward risk continues to be around discharge practice, both from our hospitals, and once patients are in our and other's community based beds. It is extremely important that we have aligned expectations across the various NHS and Local Authority providers about joint work, responsibility, communication and pace. The weekly urgent care system discussions in which the CCG Accountable Officer and I participate are important in achieving that alignment. As we have discussed since June in our Board, there is more work to be done to translate intention into results. This means a focus on some key deliverables:

- Cutting the number of nights spent in hospital by so-called Delayed Transfer of Care patients
- Ensuring that social care assessments can commence seven days a week on admission
- Removing variation in admitting rules across community beds, including ensuring that all can take admissions at weekends
- Making sure access to equipment is equitable seven days a week
- Implementing fairly and consistently choice rules over home-care destinations
- Ensuring patients in Sandwell Hospital get equitable access to Birmingham Social Care resources

Managing emergency care is an hourly task, not a daily, weekly or monthly task, and all parts of the system need to reflect that reality if we are to succeed and do so in a way that is consistent with the experience for patients to which all of our organisations' employees are truly committed.

2. Our colleagues

We continue to seek to reduce sickness rates among our staff. We have agreed with our trade unions and others a variety of new approaches to be deployed from early 2014 to try and cut further both short term and longer-term sickness. These include the routine local visibility of sickness data within departments, as well as ensuring that our award-winning Occupational Health team are working with managers to help longer-term sick staff return to work either in their designated role or in an adapted role. Part of our sickness campaign is of course flu vaccination. We presently stand at 53% of patient-facing employees vaccinated and the total number has exceeded already last year's campaign. We press on over coming weeks with some night-time vaccination as well as material in November payslips about the importance of this work for safety and quality.

I am pleased to be able to confirm that we have repeated our success in the HSJ Annual Awards ceremony for the health service. Whereas in 2012 we won the staff engagement award, in 2013, our Learning Works Team triumphed in the overall Workforce category. The team work in our communities to create work experience and apprenticeship opportunities, as well as leading our own in-house training capability.

From December, we commence the Clinical Leadership Executive's work on Patient and Staff Experience. This will give rise to our overall culture programme to adapt how the Trust operates internally. We will discuss as a Board how best to finalise and track those programmes, which reflect quite well developed work now on:

- Internal arrangements to create an organisation 'led from the middle' and clinically-led
- Ensuring that our leadership capability is enhanced and is multi-disciplinary
- Operationalising our commitment to improving morale
- Operationalising our commitment to improving patient satisfaction

3. Our partners

We were not successful in our Pioneers application. This reflects concern that as a local system we need to ensure nothing distracts from a focus on improving child protection in both authorities that we serve. That focus in Sandwell is evident in our organisation, although we recognise that we have some way to go in meeting our obligations in full on every occasion. Meanwhile, our work on changing pathways of care for people with Long Term Conditions, which was the focus of our Maisy bid, continues and during quarter 4 of this year we will implement a transformation in how diabetes care is provided, with substantial volumes of hospital based clinics being deleted and replaced by support to patients providing on a co-consulting basis in practices. This is a first step in our Right Care, Right Here outpatient agenda.

It is fantastic news that once again our local commissioners have been recognised for their success, in that the HSJ awards named SWB CCG as the best performing such organisation in the country. Less pleasingly, Cancer Research UK have decided not to renew the Birmingham Cancer Centre award, which colleagues will recall was a partnership we formally joined this spring.

4. Our regulators

The performance reports in our standard agenda, continue to suggest that the vast majority of measures on which we are assessed show good performance. The Quality and Safety Committee has assessed the latest update on the dataset being used by the CQC and this will be covered in our meeting. It suggests that we need to focus more attention on our PROMs results, principally in orthopaedics.

In line with our focus on children's services, we would expect a visit in coming weeks to examine local provision for at risk children. Self-assessment work continues, as well as joint working within the Sandwell Safeguarding structure.

5. 'Hot Topics' feedback

During November we have asked teams to contribute actively to our winter plans once again, and also sought to explore why those teams believe that this matters to us – if indeed they all do. This reflects the need here, as elsewhere, to address head-on perceptions about whether the focus on emergency services is a matter of safety, quality, reputation, instruction, or a mix of each.

From the round of staff meetings conducted earlier this month, the key emerging theme was an encouragingly frank discussion about safety and quality. This focused especially on discharge practice and on avoiding the practice of overnight discharge or poorly prepared discharge. Work to examine what incident reporting tells us about this has been undertaken and show concerning pattern, though we know that we do discharge a proportion of patients after 2000 or indeed 2200, and we have discussed our major project to tackle re-admission rates in certain specialties. Our focus from the feedback of senior staff is on making sure that individual team leaders in our community settings and our ward matrons speak with each 'in the moment' when a poor discharge is identified, and take the necessary steps to talk with the patient and family, and to share learning about any errors. Though none of us wish to see poor practice in anyway, I would suggest that it is again encouraging that

candid conversations across hierarchies and professional boundaries continue to happen in our organisation. Our discussion on the Francis Report needs to build on that further.

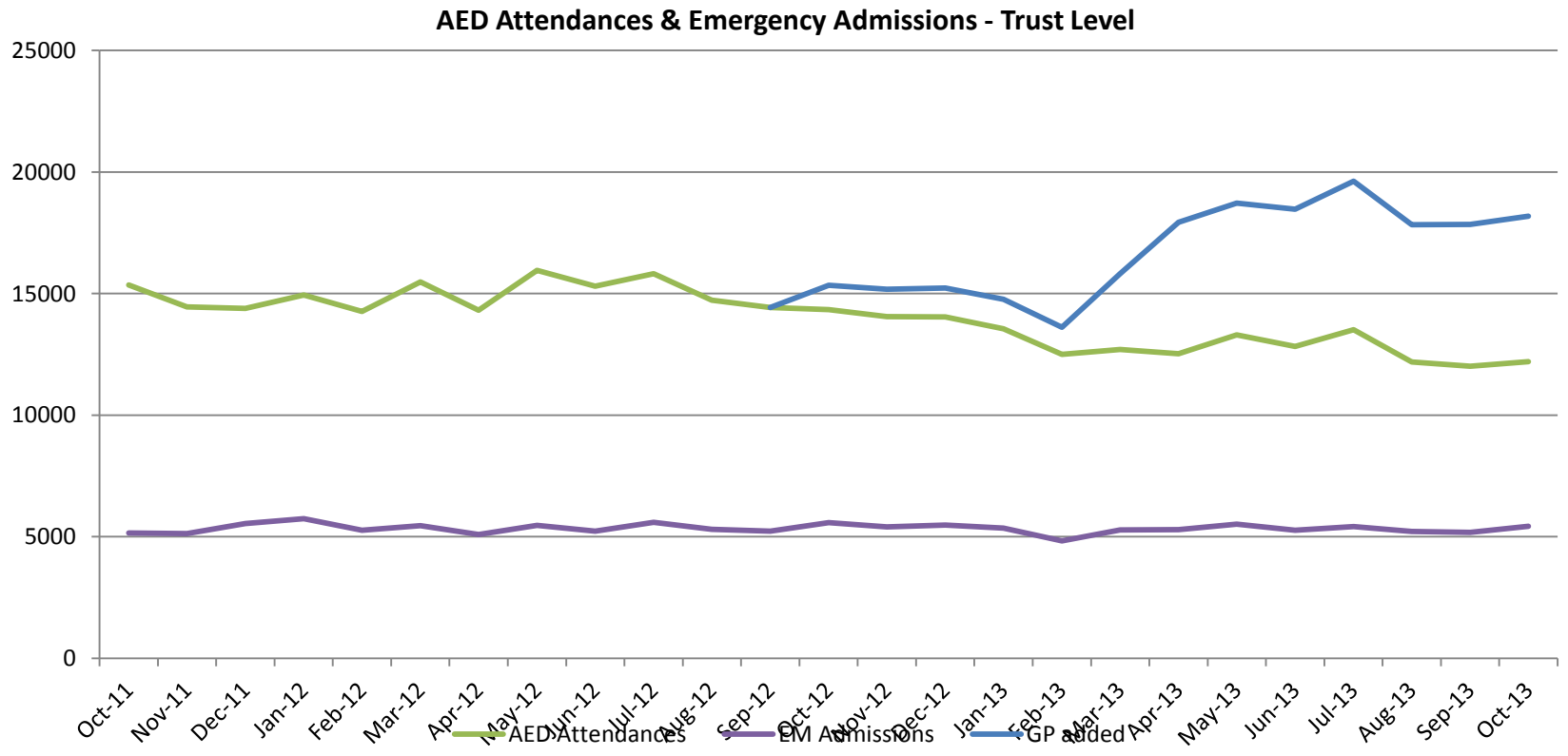
Toby Lewis
Chief Executive
November 22nd 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

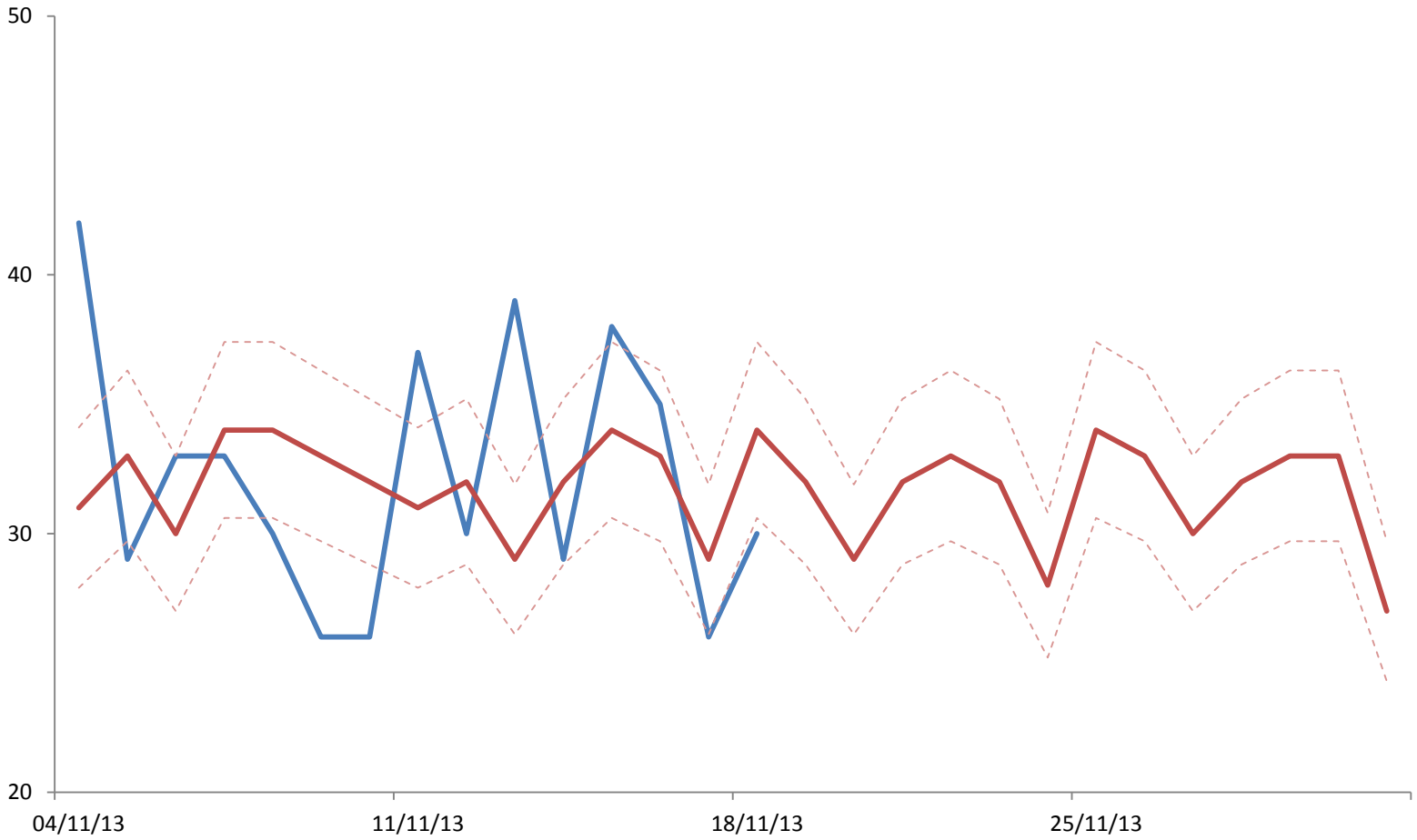
Winter 2013 Must Be Better

Safety, Compassion and Pace in Emergency Care in Sandwell and West Birmingham

1. Defining the problem: The Trust does not have a demand side rise month on month or year on year until this year. We cannot accommodate a rise in demand and benefit considerably from the continuation of primary care deflection projects on both acute sites.



2. Admissions across a week are generally on forecast but surges and variation across a week present a challenge.



3. ED breaches: achieved Q2 performance but position deteriorated in October.

4. Winter will be better - ED

- New Directorate leadership team
- Recruitment : nursing gone well, medical staff remain challenging
- Ambulance assessment – best improvement across city
- Rapid assessment and treatment model – slow to become embedded but has support now
- Diagnostic turnaround – bundles, pathology turnaround
- Single assessment documentation between ED and AMU
- Too many non admitted patients staying over 2 hours
- Our very long waits have significantly reduced. Psychiatric breaches are our longest waits; developments to address these include Sandwell Oak Suite, RAID consultant at weekend, lobbying for improved adolescent capacity
- Primary Care Assessment Centre at Rowley

5. How we measure performance : We have been successful in driving down our waits ambulance waits : new ambulance assessment model : best improvement in Birmingham area.

			Week Commencing	02-Sep	09-Sep	16-Sep	23-Sep	30-Sep	07-Oct	14-Oct	21-Oct	28-Oct	04-Nov	11-Nov
AMBULANCE														
Actual Journeys		No.		525	501	516	555	568	568	513	527	518	552	526
Predicted Journeys		No.		502	538	554	568	563	563	533	558	538	547	557
Variance		%		4.6%	-6.9%	-6.9%	-2.3%	0.9%	0.9%	-3.8%	-5.6%	-3.7%	0.9%	-5.6%
Clinical Handovers within 15 minutes	WMAS Report	%		90.9%	90.4%	90.5%	86.5%	89.8%	89.8%	86.2%	88.8%	90.9%	88.2%	91.6%
	Calculated (Exclude Not Recorded)	%		74.6%	77.3%	72.6%	69.2%	72.5%	83.6%	73.3%	69.7%	76.5%	78.3%	79.4%
Turnaround Time (Arrival to Clear Time)	Average	mins:secs		27:04	26:56	29:20	29:33	27:47	27:47	27:50	29:11	28:03	27:40	27:15
Turnaround Time (Arrival to Clear Time) Emergency Ambulance Arrivals) Only	0 - 15 minutes	No.		28	23	17	30	25	29	28	24	19	23	28
	15 - 30 minutes	No.		312	319	300	284	337	357	293	308	322	352	332
	30 - 45 minutes	No.		157	127	146	180	161	163	156	161	168	161	156
	45 - 60 minutes	No.		6	6	18	28	13	17	16	23	7	16	10
	>60 minutes	No.		1	1	9	9	2	2	1	10	2	0	1
Clinical Handover Time For Emergency Ambulance Arrivals (Arrival to Handover Time)	Average	mins:secs		13:19	13:29	15:15	15:28	14:11	12:50	14:25	14:42	13:26	13:28	16:03
	Time Not Recorded	No.		20	24	31	54	38	24	50	35	28	31	25
	0 - 15 minutes	No.		353	347	336	330	367	399	319	325	359	317	381
	15 - 30 minutes	No.		112	94	101	113	123	73	103	123	103	82	92
	30 - 60 minutes	No.		8	8	19	31	15	3	13	17	7	6	5
	60+ Minutes	No.		0	0	7	3	1	2	0	1	0	0	2

6. ED Sandwell

Waiting Time : Arrival to Departure (includes Acute, BMEC & GP Triage / Deflect)	0 - 4 hours	%	96.17%	93.85%	95.61%	94.13%	93.46%	90.92%	87.76%	93.16%	94.31%	93.17%	96.41%
	4 - 8 hours	%	3.50%	5.02%	4.28%	5.19%	5.99%	8.14%	9.92%	5.99%	5.47%	6.41%	3.43%
	> 8 hours	%	0.3%	1.1%	0.1%	0.7%	0.5%	0.9%	2.3%	0.9%	0.2%	0.4%	0.2%
	0 - 2 hours	No.	1174	1183	1281	1378	1264	1167	1138	1268	1081	1221	1241
	2 - 4 Hours	No.	582	480	571	546	623	586	605	583	575	566	587
	4 - 6 hours	No.	34	63	58	64	80	100	114	72	72	77	43
	6 - 8 hours	No.	30	26	25	42	41	57	83	47	24	46	22
	8 - 10 hours	No.	5	14	2	8	9	15	29	14	4	7	3
	10 - 12 hours	No.	1	6	0	4	2	3	17	3	0	1	0
	>12 hours	No.	0	0	0	2	0	0	0	0	0	0	0
Waiting Time : Arrival to Departure (includes Acute, BMEC)	Not Admitted 0 - 2 hours	%	58.64%	62.94%	61.20%	61.37%	51.99%	53.40%	48.35%	57.58%	56.16%	57.84%	59.69%
		No.	550	569	590	610	483	502	453	543	451	513	533
Waiting Time : Decided To Admit To Admit Time	0 - 30 mins	No.	3	10	8	3	6	12	27	16	9	13	5
	30 - 60 mins	No.	0	0	5	1	0	1	2	3	4	1	1
	60 - 90 mins	No.	1	0	1	0	2	0	3	3	2	3	0
	90 - 120 mins	No.	0	0	0	0	0	1	3	4	0	1	0
	> 120 mins	No.	2	10	2	2	4	10	19	6	4	8	4
Time to Initial Assessment (95th centile)		mins	12	13	12	16	17	18	18	17	18	14	15
Time to treatment in department (median)		mins	41	39	39	37	44	44	56	46	44	38	37
Unplanned re-attendance rate		%	6.0%	5.6%	5.8%	6.8%	6.9%	6.8%	5.3%	5.0%	3.5%	6.8%	7.5%
		No.	68	68	78	86	86	80	58	55	38	99	106
Left Department without being seen rate		%	1.9%	3.1%	3.1%	2.9%	1.9%	1.4%	1.7%	1.0%	1.2%	2.0%	2.8%
Breaches	Not Admitted	No.	20	30	26	28	28	37	66	31	23	22	12
	Admitted	No.	50	79	59	92	104	138	177	100	78	106	54
Actual ED Attendances	Type I	No.	1826	1772	1937	2044	2019	1928	1986	1987	1756	1918	1896
Friends and Family - ED	Score	No.	28.1					29.0				Updated Monthly	
	Repsonse Rate	%	11.5%					20.0%				Updated Monthly	
Clinical Incidents in ED		No.	27	20	32	28	26	30	34	31	12	19	24

7. ED City

Waiting Time : Arrival to Departure (includes Acute, BMEC & GP Triage / Deflect)	0 - 4 hours	%	94.62%	94.42%	93.97%	90.13%	95.84%	93.67%	88.43%	89.57%	94.07%	93.74%	94.15%
	4 - 8 hours	%	4.88%	5.12%	5.81%	7.93%	3.74%	5.74%	10.29%	9.73%	5.65%	5.80%	5.72%
	> 8 hours	%	0.5%	0.5%	0.2%	1.9%	0.4%	0.6%	1.3%	0.7%	0.3%	0.5%	0.1%
	0 - 2 hours	No.	1345	1292	1309	1433	1343	1266	1113	1263	1224	1293	1213
	2 - 4 Hours	No.	712	738	811	749	935	791	821	789	807	742	846
	4 - 6 hours	No.	79	76	90	133	55	81	151	153	82	92	92
	6 - 8 hours	No.	27	34	41	59	34	45	74	70	40	34	33
	8 - 10 hours	No.	7	8	4	36	9	7	20	14	5	7	3
	10 - 12 hours	No.	3	1	0	10	1	4	5	0	1	3	0
	>12 hours	No.	1	1	1	1	0	2	3	2	0	0	0
Waiting Time : Arrival to Departure (includes Acute, BMEC)	Not Admitted 0 - 2 hours	%	53.51%	51.06%	49.33%	48.70%	46.26%	50.57%	36.86%	41.74%	46.88%	52.36%	47.26%
		No.	587	555	552	600	563	573	408	490	510	600	534
Waiting Time : Decided To Admit To Admit Time	0 - 30 mins	No.	33	25	39	47	13	6	10	4	6	9	2
	30 - 60 mins	No.	12	3	9	4	4	1	0	1	4	1	1
	60 - 90 mins	No.	7	7	6	10	3	5	3	1	0	3	0
	90 - 120 mins	No.	1	4	10	2	1	0	2	1	0	2	0
	> 120 mins	No.	13	11	14	31	5	0	5	1	2	3	2
Time to Initial Assessment (95th centile)		mins	17	17	16	20	20	20	23	28	18	15	18
Time to treatment in department (median)		mins	57	51	52	58	61	55	71	63	60	46	60
Unplanned re-attendance rate		%	4.2%	5.1%	4.1%	6.1%	6.0%	6.2%	5.3%	4.7%	5.2%	6.6%	5.2%
		No.	69	78	65	98	95	98	79	71	77	111	91
Left Department without being seen rate		%	4.5%	4.0%	4.3%	5.9%	4.1%	2.7%	1.3%	1.9%	1.1%	3.7%	4.0%
Breaches	Not Admitted	No.	38	34	60	95	25	38	82	93	45	39	37
	Admitted	No.	79	86	76	144	74	101	171	143	81	93	88
Actual ED Attendances	Type I	No.	2174	2150	2256	2421	2377	2196	2187	2291	2159	2171	2187
Friends and Family - ED	Score	No.	41.5					35.8				Updated Monthly	
	Repsonse Rate	%	14.3%					25.3%				Updated Monthly	

8. Winter 13 – assessment units

Ambulatory assessment unit – slow to become embedded at city

- Agreement of chest pain pathways expected to increase significantly
- Sandwell unit to go live in December pending estates work to be completed

Expansion of AMU - 48 hour LOS – acute admitting model

- Identified goals for empty beds to be in AMU for evening and night
- City further developed – more beds available for medical take, increase and earlier discharges from AMU, strengthened middle grade rota

Surgical assessment unit opened at Sandwell

Respiratory hot clinics

9. Bed base and patient flow

- A majority of the beds came on line in September / October with MFFD
- Cardiology at City in December
- Revision to model and general medical bed base expansion in December – Sandwell
- Discharge focus – goals at ward level but too many later in the day
- Professional standards , board rounds, TTA, transport

- Intermediate care beds – slow to come on line
- DTOC position deteriorated in October
- Weekly reviews at Director level; social service engagement escalated
- 7 day social care started in November needs embedding

- Operations hub – war room – to drive actions , processes and behaviours to meet goals
- Where there is potential gap to mitigate this with speed

10. Bed flow at City

Avaikable Beds	Total Beds	No.	329	339	335	344	343	343	344	360	358	358	343
	Planned Staffed Beds	No.	Awaiting Data										
	Staffed MFFD Beds	No.											
Average Bed Occupation		%	82.7%	80.5%	81.2%	86.6%	81.6%	85.4%	82.8%	80.0%	77.7%	76.8%	78.4%
		No.	272	273	272	298	280	293	285	288	278	275	269
Emergency Admissions	Total	No.	489	468	505	492	513	480	451	464	483	408	473
	Before Midday	%	36.4%	31.4%	32.9%	38.4%	36.1%	32.5%	35.9%	33.6%	35.6%	35.0%	37.8%
	After Midday	%	63.6%	68.6%	67.1%	61.6%	63.9%	67.5%	64.1%	66.4%	64.4%	65.0%	62.2%
Emergency Discharges	Total	No.	450	432	465	495	464	471	397	450	477	369	473
	Before Midday	%	23.1%	23.1%	19.8%	22.4%	20.5%	20.6%	21.2%	24.2%	21.8%	23.3%	22.8%
	After Midday	%	76.9%	76.9%	80.2%	77.6%	79.5%	79.4%	78.8%	75.8%	78.2%	76.7%	77.2%
Admissions to Assessment Unit	Total	No.	322	330	335	336	320	307	282	306	305	249	286
	Before Midday	%	37.0%	30.9%	35.2%	39.6%	33.4%	32.2%	35.5%	35.9%	36.1%	33.3%	38.1%
	After Midday	%	63.0%	69.1%	64.8%	60.4%	66.6%	67.8%	64.5%	64.1%	63.9%	66.7%	61.9%
Discharges from Assessment Units	Total	No.	187	167	173	195	174	162	129	155	156	106	152
	Before Midday	%	31.0%	33.5%	26.0%	33.3%	30.5%	25.9%	33.3%	34.2%	30.1%	43.4%	40.8%
	After Midday	%	69.0%	66.5%	74.0%	66.7%	69.5%	74.1%	66.7%	65.8%	69.9%	56.6%	59.2%
Average Length of Stay	Hospital Spell	Days	2.76	3.10	3.82	3.30	2.65	3.87	3.10	3.42	3.37	3.38	3.51
	MFFD Ward	Days	-	1.86	7.21	6.00	8.71	12.50	9.67	7.41	10.86	8.21	10.11
% Admission on Day of Surgery	Elective Inpatients	%	88.2%	88.9%	45.0%	100.0%	93.1%	91.1%	94.6%	92.1%	97.8%	96.8%	96.8%
	Emergency Inpatients	%	78.9%	69.8%	78.0%	83.8%	64.2%	79.3%	98.8%	74.3%	77.2%	70.6%	71.4%

11. Patient flow and professional standards at City

Average Length of Stay	Hospital Spell	Days	2.76	3.10	3.82	3.30	2.65	3.87	3.10	3.42	3.37	3.38	3.51
	MFFD Ward	Days	-	1.86	7.21	6.00	8.71	12.50	9.67	7.41	10.86	8.21	10.11
% Admission on Day of Surgery	Elective Inpatients	%	88.2%	88.9%	45.0%	100.0%	93.1%	91.1%	94.6%	92.1%	97.8%	96.8%	96.8%
	Emergency Inpatients	%	78.9%	69.8%	78.0%	83.8%	64.2%	79.3%	98.8%	74.3%	77.2%	70.6%	71.4%
Readmissions (to any specialty) within 30 days of discharge		%	4.71%	4.82%	3.64%	4.05%	4.71%	4.26%	3.13%	3.63%	3.50%	4.14%	3.57%
		No.	67	71	51	61	67	65	45	53	52	57	54
Delayed Transfers of Care (Acute)	Total Delays	No.	10	15	13	15	14	12	20	14	11	12	9
	Health Delays	No.	6	8	7	4	3	0	6	5	7	3	5
	Social Delays	No.	4	7	6	11	11	12	14	8	7	8	4
	Total Rate	%	3.7%	5.5%	4.8%	5.0%	5.0%	4.1%	7.0%	4.9%	4.0%	4.4%	3.3%
Medical Outliers		No.	0	0	0	2	0	3	9	10	0	1	5
Medically Fit Patients		No.	67	70	88	76	71	71	62	80	63	63	68

What more?

Elderly care focus

- IST support
- Screening and acute elderly care model

7 day model

- Embed with social services
- Needs access to community beds 7 days

Learning from others

- Coventry and Warwick

Operational hub – war room 7 days

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Emergency Preparation, Resilience & Response Trust Self-Assessment: November 2013**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow, Chief Operating Officer**
AUTHOR:	**Matthew Dodd, Deputy Chief Operating Officer**
DATE OF MEETING:	**28 November 2013**

EXECUTIVE SUMMARY:

The work within the Trust around Contingency Planning / emergency preparedness has reduced over the last 18 months. There have been staff members providing temporary support to this function but currently there is no dedicated resource allocated to the HEPO role.

Key concerns are:
Infrastructure for EPRR needs to be 'reactivated' (meetings, training programmes, communication to wider organisation)
Lack of recent exercises for both ED and the wider hospital response/command & control teams
Ensuring that business continuity and emergency response planning actions/concepts are embedded throughout the organisation

Rectification work is being undertaken to improve the emergency preparedness of the Trust.

REPORT RECOMMENDATION:

To note the self-assessment undertaken by the Trust
To approve the work programme to address the acknowledged gaps in preparedness

ACTION REQUIRED - The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	x	

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

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

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

Compliance with Civil Contingencies Act, 2004

PREVIOUS CONSIDERATION:

None

Sandwell & West Birmingham Hospitals NHS Trust

Emergency Preparation, Resilience & Response
Trust Self-Assessment: November 2013

1.0 Summary:

The work within the Trust around Contingency Planning / emergency preparedness has reduced over the last 18 months. This has been due on the whole to the departure of the Health Emergency Planning Officer and the inability of the DCOO to provide adequate support to the function. There have been staff members providing temporary support to this function but currently there is no dedicated resource allocated to the HEPO role.

Key concerns are:
Infrastructure for EPRR needs to be 'reactivated' (meetings, training programmes, communication to wider organisation)
Lack of recent exercises for both ED and the wider hospital response/command & control teams
Ensuring that business continuity and emergency response planning actions/concepts are embedded throughout the organisation

Rectification work is being undertaken to improve the emergency preparedness of the Trust.

2.0 Contingency Planning Team:

Accountable Emergency Officer: Rachel Barlow, Chief Operating Officer
Clinical Lead: Colin Holburn, ED Consultant
Operational Management Lead: Matthew Dodd, Deputy Chief Operating Officer
Operational Support: Caroline Rennalls, Head of Capacity
Estates: Kevin Reynolds
HEPO: a band 6 post was offered in August 2013 however the successful candidate has since withdrawn. Discussions are now taking place with Birmingham Children's Hospital for a shared team built around their existing HEPO. The key role of the HEPO for SWBHT, while ensuring external liaison and representation is to undertake training at all levels throughout the organisation to ensure that business continuity planning and awareness of MIP procedures are well-established across the Trust
ED: Ian Gillespie, ED matron (currently undertaking HEPO diploma). Natasha Whiston-Gryce (SGH) & Dermot Reilly (City) have operational leads for CBRN training
Capacity Team: Caroline Rennalls, Head of Capacity has a key role in EPRR. The senior capacity managers once in post will also have an element of EPRR in their role and will be expected to undertake the role of silver commanders in the event of a command & control structure being established
SWBHT Contingency Planning Group: This has not met during 2013/14

3.0 Status of Policies

Policy/Procedure	Status	Comments
Major Incident Plan	Approved: Nov 12 Expires: Nov 14	Is being reviewed in line with EPRR requirements
Mass Casualty Plan	Approved: June 06 Expires: June 08	Reviewed with minor amendments – awaiting approval
Hospital Evacuation Plan	Approved: June 06 Expires: June 08	Reviewed with minor amendments – awaiting approval
Bomb Threat Procedure	Approved: June 06 Expires: June 08	Reviewed – awaiting feedback from NHSE regarding guidance on search parties
Business Continuity Plan	Approved: Dec 12 Expires: Nov 14	
Pandemic Flu Plan	Approved: Mar 09 Expires: Jan 10	Needs review
Heatwave Plan	Approved: July 13 Expires: July 14	

4.0 Training, Exercising & External Representation:

4.1 Training:

Training sessions have been limited in the last year to 2 sessions provided by Pete Jefferson from NHS England in July & August 2013 aimed at Silver Commanders outlining the new EPRR arrangements

Colin Holburn has undertaken training for Silver Commanders in November 2013. Training is undertaken regarding CBRN within the ED departments by the operational leads

4.2 Exercises/Incidents:

There have been no live casualty exercises in the last 2 years. The list of key planning and training events and dates is provided below:
Exercise Vengeance: May 2008
Exercise Deep Freeze: November 2008
Exercise Sealion: May 2010
Industrial action Nov 2011
Participation in Olympic planning events (Spring 2012)
Medical Industrial Action: June 2012

4.3 External Representation:

This year Trust has not been represented at the West Midlands Health Emergency Planners Group but in November started attending the Local Health Resilience Partnership. The latter meeting will now be attended by M Dodd, while the former will be attended by a mixture of M Dodd, C Rennalls and I Gillespie until a HEPO role is recruited into.

5.0 Level of Assurance

The 'NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)', self-assessment document has been compiled for the Trust (***Appendix 1***). The key weaknesses identified are around training in general and the degree to which business continuity planning is embedded into the organisation.

6.0 CBRN

The CBRN capacity was reviewed by WMAS in the summer 2013. A formal report is awaited, however verbal feedback is that there will be a recommendation to extend the life of the existing CBRN PPE by agreeing a maintenance contract with the company involved. This is currently being followed up by Ian Gillespie.

7.0 Future Plans

The actions agreed for Emergency Planning are:

7.1 Update Policies:

The Heatwave Plan, Hospital Evacuation Plan and Mass Casualty Plan have been reviewed. The Bomb Threat Procedure and the Pandemic Influenza Plan are currently being reviewed

7.2 Develop the infrastructure for contingency planning & emergency preparedness:

Recruit Band 6 Emergency Planning Officer and agree working arrangements with Birmingham Children's Hospital (Dec 13)

Develop annual plan for emergency planning which includes: live tests, training, review of procedures (Dec 13)

7.3 Review resilience of the organisation with a particular focus on business continuity planning at departmental level:

Review business continuity plans for all areas across the Trust (Dec 13)

7.4 Representation:

Ensure that the Trust is represented externally with local planning fora eg Local Health Resilience Partnership (Nov 13)

8.0 Recommendations:

To note the self assessment undertaken by the Trust

To approve the work programme to address the acknowledged gaps in preparedness

M Dodd
19th November 2013

SWBTB (11/13) 231 (b)

Please complete Cells E1-E5 with your organisational details

Sandwell & West Birmingham Hospitals NHS
Acute Hospital Trust
M Dodd
R Barlow, Chief Operating Officer
25th October 2013

Select dropdown menu for relevant organisation type

Filters have been provided to select only those questions relevant to each organisation type.

For example, if you represent an Acute Trust, click the down arrow for Acute trusts and check the X, this will hide the questions that are not relevant to acute trusts

If your organisation provides two types of service (eg: acute and community services, or mental health and community services) then you will need to select the appropriate columns sequentially, ensuring you have deselected the intial colum first.

For example, if you represent an Acute Trust, click the down arrow for Acute trusts and check the X and complete the relevant questions. Once completed, re-click the down arrow for acute trusts, ensure all boxes are checked, select the Community Trust down arrow, and check the X box under that field and complete any unanswered fields.

Specialist Trusts should use Acute Trust dropdown, however some areas may not be applicable to them

Select your organisation type using Autofilter dropdown arrow(s)							
Cat 1				Cat 2	ncategorise		
Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	

Suggested Minimum Level of Evidence to be submitted to review group

Submit a SINGLE COPY of the Incident Response Plan (MI Plan), appendices/ annexes and the Business Continuity Plan (Business Continuity Policy or Business Continuity Management System documents), appendices/ annexes and clearly reference where information can be found within the submitted documents in the *Assurance Commentary/ References to Evidence Supplied* column (Document Name, Section Number, Page Number).

There is no need to submit multiple copies of the same document.

DO NOT INCLUDE DOCUMENTS within the Assurance Spreadsheet or create an additional Word Document or PDF document with attached files.

Evidence can be submitted in .ZIP archives – preferably compressed in clearly identified folders; however ensure that FilePaths in .ZIP files are not excessively long. Use basic WinZip or the ZIP tool built into Windows, as NHS England does not have access to other .ZIP applications. Whilst it is appreciated that your submissions are very large, there are limitations to the NHS England IT system which makes it difficult for us to access Memory Sticks or CD ROMs.

There is a file size limit for NHS.net, please break your evidence into segments not exceeding 10mb

The Panel will review the checklist and evidence supplied, and assess whether the arrangements described and documented provide assurance. Feedback will be provided to organisations in the form of specific comments relating to each area, employing a Red/Amber/Green system to clearly communicate areas where further work is considered necessary.

The reason that an Amber or Red rating is applied should be explicit from the comments of the Review panel in the NHS England assessment column. Documents which are marked as DRAFT, or need to be ratified by a committee will automatically attract an Amber rating.

When the feedback from the Review meeting is prepared (usually within a day or two of the meeting) the Chair of the review panel will send an initial response (v1) to the Emergency Planning Officer, or a nominated contact.

The Emergency Planning Officer, who will have a 24hr period to address any Red or Amber rated questions highlighted by the Review Panel Chair where the evidence may not have been clearly referenced, or evidence was omitted in error, prior to formal feedback to CEOs and Accountable Executive Officers.

In the case of any RED or Amber rated questions where it is felt that a quick amendment will address the concern of the panel, or provide the missing information, the EPLO will have one working day from receipt of the initial feedback to clarify the item highlighted by a RED rating, by email or telephone conversation to the review meeting Chair (cc england.london-assurance@nhs.net).

If the information supplied provides sufficient assurance, the Review Panel Chair will amend the response, or will request one of the other reviewers to provide their input. A formal response will then be made to the organisation via the CEO, and Executive lead, cc the EPLO, within a week of the Review meeting.

If the EPLO/ submitter is not going to be in the office in the days immediately following the scheduled review meeting, please provide details of an alternative contact person with the submission (or personal contact details for the EPLO, if this is felt appropriate). The nominated individual should be able to amend the information, provide additional details or advise on where the information is located in the submitted documents.

After receiving feedback from the review meeting, each organisation should prepare their action plan in light of the comments received to address the gaps identified (where one has not been previously constructed). This is to be agreed with your EPRR Patch Manager and submitted to NHS England (London) within 4 weeks of receiving the return.

Sandwell & West Birmingham Hospitals NHS Trust
Acute Hospital Trust
M Dodd
R Barlow, Chief Operating Officer
25th October 2013

Select your organisation type using Autofilter dropdown arrow(s)

GREEN - arrangements in place now, compliant with core	GREEN - Assured
AMBER - draft or scheduled on action plan for completion by Dec	AMBER - Partially assured, seeking clarification/ draft
RED - arrangements not in place or scheduled for completion	RED - Not assured; insufficient evidence provided
N/A - Not applicable to organisation	N/A - Not applicable to organisation
N/R - Not rated by reviewing team	N/R - Not rated by reviewing team

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Cat 1				Cat 2	ncategorise		Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Review Team Assessment
		Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health					
1	**All NHS organisations and providers of NHS funded care must nominate an accountable emergency officer who will be responsible for EPRR and business continuity management.**	X	X	X	X	X	X	X	• Accountable Emergency Officer (AEO) details (name, role) • AEO job description •Evidence that AEO completed relevant training (SLC, witness familiarisation etc - dates completed) • Competency assessed against National Occupational Standards	Chief Operating Officer, Rachel Barlow			
2	**All NHS organisations and providers of NHS funded care must share their resources as necessary when they are required to respond to a significant incident or emergency.**	X	X	X	X	X	X	X	• Articulated in Incident Response Plans (IRP) • MoU/ mutual aid arrangements, evidence of participation in multiagency planning groups/ LHRP as appropriate	Major Incident Plan describes need to offer and receive mutual aid			
3	**All NHS organisations and providers of NHS funded care must have plans setting out how they contribute to co-ordinated planning for emergency preparedness and resilience (for example surge, winter & service continuity) across the area through LHRPs and relevant sub-groups. These plans must include details of:**	X	X	X	-	X	X	X	• Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) where applicable • Borough Resilience Forum (BRF)/ subgroup participation	Participation in Urgent Care Networks			
3 . 1	director-level representation at the LHRP; and	X	X	X	-	X	X	X	• LHRP Terms of Reference (ToR), membership list • most recent LHRP minutes	Participation at EPRR planning day in Sept - future attendance at LHRP			
3 . 2	representation at the LRF.	-	X	X	-	-	-	-	• LHRP ToR, membership list • most recent LHRP minutes	This has slipped recently - attendance to improve			
4	**All NHS organisations and providers of NHS funded care must contribute to an annual NHS England report on the health sector's EPRR capability and capacity in responding to national, regional and LRF incidents. Reports must include control and assurance processes, information-sharing, training and exercise programmes and national capabilities surveys. They must be made through the organisations' formal reporting structures.**	X	X	X	X	X	X	X	• Participation in annual NHS Safe System process • EPRR Board report/ formal reporting structure outlined • Training and exercise programmes • Post exercise reports, showing lessons identified, with an action plan to address gaps				
4 . 1	Organisations must have an annual work programme to reduce risks and learn the lessons identified relating to EPRR (including details of training and exercises). This work programme must link back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	X	X	X	X	X	X	• Work plan for EPRR • Risk Register reflects community risk register • EPRR Board report, issues/ lessons log	Work programme being developed in conjunction with other local providers			
4 . 2	Organisations must maintain a risk register which links back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	X	X	X	X	X	X	• Risk register • Details on the process/ schedule of review	Risk regsiter to be reviewed			
5	**All NHS organisations and providers of NHS funded care must have plans which set out how they plan for, respond to and recover from disruptions, significant incidents and emergencies. Incident response plans must:**	X	X	X	X	x	x	x	• PLEASE SUPPLY ONE COPY OF YOUR MAJOR INCIDENT/ INCIDENT RESPONSE PLAN AND APPENDICES	MIP available			
5 . 1	be based on risk-assessed worst-case scenarios;	X	X	X	X	X	X	X	• Page/ section reference in arrangements demonstrating how the organisation plans for incidents • Demonstration of risk assessments • ToR of MI/BC Planning Groups	Plans are based on types of presentation & impact on Trust rather than cause			
5 . 2	make sure that all arrangements are trialled and validated through testing or exercises;	X	X	X	X	X	X	X	• Testing and Exercising programme / log that complies with national exercising standards • Post exercise/ incident reports, showing lessons identified, with an action plan to address gaps	Training programmes need to be updated			
5 . 3	make sure that the funding and resources are available to cover the EPRR arrangements;	X	X	X	X	X	X	X	• Details of agreed budget • EPRR business cases/ papers for funding, • EPLO job description showing WTE	There is a pay/nonpay allocation for EPRR			
5 . 4	plan for the potential effects of a significant incident or emergency or for providing healthcare services to prisons, the military and iconic sites; and	X	X	-	X	-	X	X	• Demonstrate representation on relevant planning groups, ToR/ minutes (eg: Security Liaison Groups for COMAH sites etc) • Associated risk reflected on local risk register • IRPs recognise specific local challenges	Plans are based on types of presentation & impact on Trust rather than cause - the agreement with the Prison service is regarding patients treated on an individual basis rather than large numbers of patients requiring health care by the Trust			
5 . 5	include plans to maintain the resilience of the organisation as a whole, so that the Estates Department and Facilities Department are not planning in isolation.	X	X	-	X	-	X	X	• Business Continuity planning arrangements demonstrate joint working between EP and estates/ facilities staff (ToR for related meetings, task and finish groups) • Action card for E&F in IRP/ BCP	Business continuity plan is a trust-wide document. This is being reviewed & updated			
	Incident response plans must be in line with published guidance, threat-specific plans and the plans of other responding partners. They must:	X	X	X	X	X	X	X					
5 . 6	refer to all relevant national guidance, other supporting and threat-specific plans (eg pandemic flu, CBRN, mass casualties, burns, fuel shortages, industrial action, evacuation, lockdown, severe weather etc) and policies, and all other supporting documents that enhance the organisation's incident response plan;	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans	When plans expire they are reviewed in line with latest guidance from DH			
5 . 7	refer to all other associated plans identified by local, regional and national risk registers;	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans	See above			
5 . 8	have been written in collaboration with all relevant partner organisations;	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans	See above			
5 . 9	refer to incident response plans used by partners, including LRF plans;	X	X	X	X	X	-	-	• Page/ section references in IRP, annexes to plans or standalone plans	See above			
5 . 10	have been written in collaboration with PHE;	X	X	X	X	X	-	X	• Page/ section references in IRP, annexes to plans or standalone plans	See above			
5 . 11	have been written in collaboration with all burns, trauma and critical care networks; and	X	X	X	X	X	X	-	• Page/ section references in IRP, annexes to plans or standalone plans • Information how to access capabilities	See above			
5 . 12	define how the organisation will meet the Prevent strategy's objectives for health (1. prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support and 2. work with sectors and institutions where there are risks of radicalisation which we need to address, and the wider CONTEST strategy).	X	X	X	-	X	X	X	**Not rated in 2013**		N/R		N/R
	Incident response plans must follow NHS governance arrangements. They must:	X	X	X	X	X	X	X					
5 . 13	be approved by the relevant board;	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Notes from relevant approving Board meeting	Yes - by the Trust Management Board (now replaced by the Clinical Leadership Executive)			
5 . 14	be signed off by the appropriate Senior Responsible Officer;	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans	Yes			

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Review Team Assessment
5 . 15	set out how legal advice can be obtained in relation to the CCA;	X	X	X	X	X	-	X	• Page/ section references in IRP, annexes to plans or standalone plans	No			
5 . 16	identify who is responsible for making sure the plan is updated, distributed and regularly tested;	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans	Yes			
5 . 17	explain how internal and external consultation will be carried out to validate the plan;	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans	Yes			
5 . 18	include version controls to be sure the user has the latest version;	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans	Yes			
5 . 19	set out how the plan will be published – for example, on a website;	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans	Published on Trust intranet			
5 . 20	include an audit trail to record changes and updates;	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans	Yes			
5 . 21	explain how predicted and unexpected spending will be covered and how a unique cost centre and budget code can be made available to track costs; and	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans	Yes			
5 . 22	demonstrate a systematic risk assessment process in identifying risks relating to any part of the plan or the identified emergency.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans	Yes			
	Staff must be aware of the Incident Response Plan, competent in their roles and suitably trained.	X	X	X	X	X	X	X					
5 . 23	Key staff must know where to find the plan on the intranet or shared drive.	X	X	X	X	X	X	X	• Training plan for staff with a specific role • Training Needs Analysis for those staff • Training materials • Training records	Yes			
5 . 24	There must be an annual work programme setting out training and exercises relating to EPRR and how lessons will be learnt.	X	X	X	X	X	X	X	• Testing and Exercising schedule • Details on process for reviewing plans in light of lessons learnt	Yes			
5 . 25	Key knowledge and skills for staff must be based on the National Occupation Standards for Civil Contingencies. Directors on NHS on-call rotas must meet NHS published competencies.	X	X	X	X	X	X	X	• Training Needs Analysis • Training schedule • Training materials • Training records	Revised training programme to be implemented			
5 . 26	It must be clear how awareness of the plan will be maintained amongst all staff (for example, through ongoing education and information programmes or e-learning).	X	X	X	X	X	X	X	• Training Needs Analysis • Training schedule • Training materials • Training records	Yes			
5 . 27	It must be clear how key staff can achieve and maintain suitable knowledge and skills.	X	X	X	X	X	X	X	• Training Needs Analysis • Training schedule • Training materials • Training records	Yes			
	Set out responsibilities for carrying out the plan and how the plan works, including command and control arrangements and stand-down protocols.	X	X	X	X	X	X	X					
5 . 28	Describe the alerting arrangements for external and self-declared incidents (including trigger points, decision trees and escalation/de-escalation procedures)	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans	Yes			
5 . 29	Set out the procedures for escalating emergencies to NHS England area teams, regions, national office and DH	-	-	X	X	-	X	-	• Page/ section references in IRP, annexes to plans or standalone plans • Responsibility assigned to an Action Card	N/A			
5 . 30	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	X	X	X	X	-	X	-	• Provide detail on how this is delivered • Provide detail on contingency arrangements regarding call-out • Function assigned to IRP/ ICC Action Card	Yes			
5 . 31	Include 24-hour arrangements for alerting managers and other key staff, and explain how contact lists will be kept up to date.	X	X	X	X	X	X	X	• On-call arrangements/ processes, On-call pack, On-call staff lists • Responsibility assigned to an Action Card • Admin / support role assigned to maintain systems • Reports from COMMEX/ regular cascades using contact lists	Yes			
5 . 32	Set out the responsibilities of key staff and departments.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	Yes			
5 . 33	Set out the responsibilities of the appropriate Senior Responsible Officer or nominated Executive Director.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	Yes			
5 . 34	Explain how mutual aid arrangements will be activated and maintained.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	Yes - not in detail as this will be done through discussions wiith West Mids Major Incident Response Arrangements			
5 . 35	Identify where the incident or emergency will be managed from (the ICC).	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	Yes - details of Trust Command & Control infrastructure			
5 . 36	Define the role of the loggist to record decisions made and meetings held during and after the incident, and how an incident report will be produced.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	Yes - covers need for debrief but does not prescribe format			
5 . 37	**Best Practice:** Use an electronic data-logging system to record the decisions made.	X	X	-	-	-	-	-	**Not rated in 2013, unless organisation provides evidence**	E recording undertaken but not on specific system			
5 . 38	**Best Practice:** Use the National Resilience Extranet.	X	X	X	X	-	X	-	**Not rated in 2013, unless organisation provides evidence**	Use of local EMS systems			
5 . 39	Refer to specific action cards relating to using the incident response plan.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	Yes			
5 . 40	Explain the process for completing, authorising and submitting NHS England standard threat-specific situation reports and how other relevant information will be shared with other organisations.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	No			
5 . 41	Explain how extended working hours will apply and how they can be sustained. Explain how handovers are completed.	X	X	X	-	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	Not in details - this is a role for the Silver Command during the incident and depending on local requirements at the time			
5 . 42	Explain how to communicate with partners, the public and internal staff based on a formal communications strategy. This must take into account the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public'. Social networking tools may be of use here.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	Need more work on use of social media			
5 . 43	Have agreements in place with local 111 providers so they know how they can help with an incident	X	X	X	X	X	X	-	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	This is via WMAS			
5 . 44	Consider using helplines in an emergency. Set up procedures in advance which explain the arrangements. Make sure foreign language lines are part of these arrangements.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	This is an option that has been used previously - provision of a range of languages needs improvement			

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Review Team Assessment
5 . 45	Describe how stores and supplies will be maintained.	X	X	-	-	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	Yes			
5 . 46	Explain how specific casualties will be managed – for example, burns, paediatrics and those from certain faiths.	X	X	-	-	-	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	No specific instructuions on managing certain faiths within MIP - this is covered within other policies of the Trust			
5 . 47	Explain how VIPs will be managed, whether they are casualties or visiting others who are casualties.	X	X	-	X	-	-	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	Yes			
5 . 48	Explain the process of recovery and returning to normal processes.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	Yes			
5 . 49	Explain the de-briefing process (hot, local and multi-agency)at the end of an incident.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	Yes			
5 . 50	Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards	No specific guidance given by Trust on support before an incident - unless this means training & preparation for staff?			
	Set out how surges in demand will be managed.	X	X	X	X	X	X	X					
5 . 51	Explain who will be responsible for managing escalation and surges.	X	X	X	X	X	X	X	• Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans • Action Cards	Yes - Silver Command has tactical responsibility throughout an incident			
5 . 52	Describe local escalation arrangements and trigger points in line with regional escalation plans and working alongside acute, ambulance and community providers.	X	X	X	X	X	X	X	• Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans • Escalation framework including trigger points for ambulance, acute and community • Action Cards	Yes			
	Link the Incident Response Plan to threat-specific incidents	X	X	X		X	X	X					
5 . 53	CBRN incidents;	X	X	-	-	-	X	X	• Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans • Specific CBRN plans	Yes			
5 . 54	mass casualty incidents;	X	X	-	-	-	X	X	• Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans • Specific Mass Casualties plans	Yes			
5 . 55	pandemic flu;	X	-	X	-	-	X	X	• Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans • Specific Pandemic Flu plans	Existing plans need updating			
5 . 56	patients with burns requiring critical care; and	X	-	-	-	-	X	X	• Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans • Specific Burns plans	Yes			
5 . 57	severe weather.	X	X	X	-	X	X	X	• Page/ section references in IRP/ Surge Management arrangements, annexes to plans or standalone plans • Specific Severe Weather plans	Yes - plan deals with impacts on Trust rather than specific causes (eg sudden reduction in staff numbers regardles of cause)			
6	**All NHS organisations must provide a suitable environment for managing a significant incident or emergency (an ICC). This must include a suitable space for making decisions and collecting and sharing information quickly and efficiently.**	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone ICC plans • Action Cards	Control rooms identified as part of MIP			
6 . 1	There must be a plan setting out how the ICC will operate.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone ICC plans • Action Cards	Yes			
6 . 2	There must be detailed operating procedures to help manage the ICC (for example, contact lists and reporting templates).	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone ICC plans • Action Cards	Need review			
6 . 3	There must be a plan setting out how the Incident Coordination Team will be called in and managed over any length of time	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone ICC plans • Action Cards	Yes			
6 . 4	Facilities and equipment must meet the requirements of the NHS England Corporate Incident Response Plan.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone ICC plans • Action Cards • Provide detail on equipment available within ICC • Provide detail on the programme for exercising ICC arrangements	Need to check against these requirements			
7	**All NHS organisations and providers of NHS funded care must develop, maintain and continually improve their business continuity management systems. This means having suitable plans which set out how each organisation will maintain continuity in its services during a disruption from identified local risks and how they will recover delivery of key services in line with ISO22301. Organisations must:**	X	X	X	X	X	X	X	• PLEASE SUPPLY ONE COPY OF YOUR BUSINESS CONTINUITY POLICY, BUSINESS CONTINUITY PLAN AND APPENDICES • Arrangemetns dealing with site/organisation specific risks (eg: flooding) • Action plan for transition to/ alignment with ISO22301	Outlined in Business Continuity Plan			
7 . 1	make sure that there are suitable financial resources for their BCMS and that those delivering the BCMS understand and are competent in their roles;	X	X	X	X	X	X	X	• Page/ section references in Business Continuity Management System arrangements/ Business Continuity Policy/ Business Continuity Plan, annexes to plans or standalone plans	Outlined in Business Continuity Plan			
7 . 2	set out how finances and unexpected spending will be covered, and how unique cost centres and budget codes can be made available to track costs;	X	X	X	X	X	X	X	• Page/ section references in BC arrangements	Outlined in Business Continuity Plan			
7 . 3	develop business continuity strategies for continuing and recovering critical activities within agreed timescales, including the resources required such as people, premises, ICT, information, utilities, equipment, suppliers and stakeholders; and	X	X	X	X	X	X	X	• Page/ section references in BC arrangements	Outlined in Business Continuity Plan			
7 . 4	develop, use and maintain business continuity plans to manage disruptions and significant incidents based on recovery time objectives and timescales identified in the business impact analysis	X	X	X	X	X	X	X	• Page/ section references in BC arrangements	Outlined in Business Continuity Plan			
	Business continuity plans must include governance and management arrangements linked to relevant risks and in line with international standards.	X	X	X	X	X	X	X		Outlined in Business Continuity Plan			
7 . 5	Each organisation's BCMS must be based on its legal responsibilities, internal and external issues that could affect service delivery and the needs and expectations of interested parties.	X	X	X	X	X	X	X	• Page/ section references in BC arrangements	Outlined in Business Continuity Plan			

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Review Team Assessment
7 . 6	Organisations must establish a business continuity policy which is agreed by top management, built into business processes and shared with internal and external interested parties.	X	X	X	X	X	X	X	• Page/ section references in BC arrangements	Further work required to ensure that BCM principles embedded across the whole organisation			
7 . 7	Organisations must make clear how their plan will be published, for example on a website.	X	X	X	X	X	X	X	• Page/ section references in BC arrangements	Available internally on Trust intranet			
7 . 8	The BCMS policy and business continuity plan must be approved by the relevant board and signed off by the appropriate Senior Responsible Officer.	X	X	X	X	X	X	X	• Page/ section references in BC arrangements	Yes			
7 . 9	There must be an audit trail to record changes and updates such as changes to policy and staffing.	X	X	X	X	X	X	X	• Page/ section references in BC arrangements	Yes			
7 . 10	The planning process must take into account nationally available toolkits that are seen as good practice.	X	X	X	X	X	X	X	• Page/ section references in BC arrangements	Need to audit against this guidance			
	Business continuity plans must take into account the organisation's critical activities, the analysis of the effects of disruption and the actual risks of disruption.	X	X	X	X	X	X	X					
7 . 11	Organisations must identify and manage internal and external risks and opportunities relating to the continuity of their operations.	X	X	X	X	X	X	X	• Page/ section references in BC arrangements	Outlined in Business Continuity Plan			
7 . 12	Plans must be maintained based on risk-assessed worst-case scenarios.	X	X	X	X	X	X	X	• Page/ section references in BC arrangements • Risk assessments/ methodology	Outlined in Business Continuity Plan			
7 . 13	Risk assessments must take into account community risk registers and at very least include worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment; • fuel shortages; • surges in activity; • IT and communications; • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites).	X	X	X	X	X	X	X	• Page/ section references in BC arrangements • Risk registers and arrangements for review	Outlined in Business Continuity Plan			
7 . 14	Organisations must develop, use and maintain a formal and documented process for business impact analysis and risk assessment.	X	X	X	X	X	X	X	• Page/ section references in BC arrangements	Outlined in Business Continuity Plan			
7 . 15	They must identify all critical activities using a business impact analysis. This must set out the effect business disruption may have on the organisation and how this will be overcome, including the maximum period of tolerable disruption.	X	X	X	X	X	X	X	• Prioritised list of critical activities/ services • Business Impact Analysis methodology	Outlined in Business Continuity Plan			
7 . 16	Organisations must highlight which of their critical activities have been put on the corporate risk register and how these risks are being addressed.	X	X	X	X	X	X	X	• Appropriate risk register	Need to audit against the corporate risk register			
	Business continuity plans must set out how the plans will be called into use, escalated and operated.	X	X	X	X	X	X	X					
7 . 17	Organisations must develop, use, maintain and test procedures for receiving and cascading warnings and other communications before, during and after a disruption or significant incident. If appropriate, business continuity plans must be published on external websites and through other information-sharing media.	X	X	X	X	X	X	X	• Page/ section references in BC plans, annexes to plans or standalone plans • Action Cards	Need further work on information sharing media			
7 . 18	Plans must set out: the alerting arrangements for external and self-declared incidents, including trigger points and escalation procedures;	X	X	X	X	X	X	X	• Page/ section references in BC plans, annexes to plans or standalone plans • Action Cards	Outlined in Business Continuity Plan			
7 . 19	the procedures for escalating emergencies to CCGs and the NHS England area, regional and national teams;	X	X	X	X	X	X	X	• Page/ section references in BC plans, annexes to plans or standalone plans • Responsibility assigned to Action Card	Needs revision to reflect new structures			
7 . 20	24-hour arrangements for alerting managers and other key staff, including how up-to-date contact lists will be maintained;	X	X	X	X	X	X	X	• On-call arrangements/ processes, On-call pack, On-call staff lists • Responsibility assigned to an Action Card • Admin / support role assigned to maintain systems • Reports from COMMEX/ regular cascades using contact lists	Use of existing MIP call out procedures			
7 . 21	the responsibilities of key staff and departments;	X	X	X	X	X	X	X	• Page/ section references in BC plans, annexes to plans or standalone plans • Action Cards	Outlined in Business Continuity Plan			
7 . 22	the responsibilities of the appropriate Senior Responsible Officer or Executive Director;	X	X	X	X	X	X	X	• Page/ section references in BC plans, annexes to plans or standalone plans • Action Cards	Outlined in Business Continuity Plan			
7 . 23	how mutual aid arrangements will be called into use and maintained;	X	X	X	X	X	X	X	• Page/ section references in BC plans, annexes to plans or standalone plans • Action Cards	Outlined in Business Continuity Plan			
7 . 24	where the incident or emergency will be managed from (the ICC);	X	X	X	X	X	X	X	• Page/ section references in BC plans, annexes to plans or standalone plans • Action Cards	Outlined in Business Continuity Plan			
7 . 25	how the independent healthcare sector may help if required; and	X	X	X	X	X	X	X	• Page/ section references in BC plans, annexes to plans or standalone plans • Action Cards	Outlined in Business Continuity Plan			
7 . 26	the insurance arrangement that are in place and how they may apply.	X	X	X	X	X	X	X	• Page/ section references in BC plans, annexes to plans or standalone plans • Action Cards	No - needs to be considered			
	Business continuity plans must describe the effects of any disruption and how they can be managed. **Plans must include:**	X	X	X	X	X	X	X		Based on an impacts approach rather than linking in to specific causes			
7 . 27	contact details for all key stakeholders;	X	X	X	X	X	X	X	• Page/ section references in BC plans, annexes to plans or standalone plans	Outlined in Business Continuity Plan			
7 . 28	alternative locations for the business;	X	X	X	X	X	X	X	• Page/ section references in BC plans, annexes to plans or standalone plans	Outlined in Business Continuity Plan			
7 . 29	a scalable plan setting out how incidents will be managed and by whom;	X	X	X	X	X	X	X	• Page/ section references in BC plans, annexes to plans or standalone plans • Action Cards	Outlined in Business Continuity Plan			
7 . 30	recovery and restoration processes and how they will be set up following an incident;	X	X	X	X	X	X	X	• Page/ section references in BC plan, annexes to plans or standalone plans • Action Cards • Link to IRP (Standard 5.48) if using these arrangements	Outlined in Business Continuity Plan			
7 . 31	how decisions and meetings will be recorded during and after an incident, and how the incident report will be compiled;	X	X	X	X	X	X	X	• Page/ section references in BC plan, annexes to plans or standalone plans • Action Cards • Sample incident log • Post exercise/ incident reports, showing lessons identified, with an action plan to address gaps	Outlined in Business Continuity Plan			
7 . 32	how the organisation will respond to the media following a significant incident, in line with the formal communications strategy;	X	X	X	X	X	X	X	• Page/ section references in BC plan, annexes to plans or standalone plans • Spokespersons identified and assigned to an Action Card	Outlined in Business Continuity Plan			
7 . 33	how staff will be accommodated overnight if necessary;	X	X	X	X	X	X	X	• Page/ section references in BC plan, annexes to plans or standalone plans	There are existing contingency arrangements for accommodating staff			
7 . 34	how stores and supplies will be managed and maintained; and	X	X	-	-	X	X	X	• Page/ section references in BC plan, annexes to plans or standalone plans	Outlined in Business Continuity Plan			
7 . 35	details of a surge plan to maintain critical services.	X	X	X	X	X	X	X	• Page/ section references in BC plan, annexes to plans or standalone plans	Outlined in Business Continuity Plan			

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Review Team Assessment
	Business continuity plans must specify how they will be used, maintained and reviewed.	X	X	X	X	X	X	X					
7 . 36	Organisations must use, exercise and test their plans to show that they meet the needs of the organisation and of other interested parties. If possible, these exercises and tests should involve relevant interested parties. Lessons learnt must be acted on as part of continuous improvement.	X	X	X	X	X	X	X	• Testing and Exercising programme / log that complies with national exercising standards • Post exercise/ incident reports, showing lessons identified, with an action plan to address gaps	Further testing required			
7 . 37	Plans must identify who is responsible for making sure the plan is updated, distributed and regularly tested.	X	X	X	X	X	X	X	• Page/ section references in BC plan, annexes to plans or standalone plans	Outlined in Business Continuity Plan			
7 . 38	Organisations must monitor, measure, analyse and assess the effectiveness of their BCMS against their own requirements, those of relevant interested parties and any legal responsibilities.	X	X	X	X	X	X	X	• Page/ section references in BC plan, annexes to plans or standalone plans • Reports to Board or Management Teams	Done through policy review process			
7 . 39	Organisations must identify and take action to correct any irregularities identified through the BCMS and must take steps to prevent them from happening again. They must continually improve the suitability and effectiveness of their BCMS.	X	X	X	X	X	X	X	• Page/ section references in BC plan, annexes to plans or standalone plans • Business Continuity strategies developed in response to problems identified • Reports to Board or Management Teams • Post incident / exercise debrief reports • Details of expenditure/ investment	Work is currently being undertaken to ensure BCM is embedded in the organisation			
	Business continuity plans must specify how they will be communicated to and accessed by staff. Plans must include:	X	X	X	X	X	X	X					
7 . 40	details of the training provided to staff and how the training record is maintained;	X	X	X	X	X	X	X	• Training Needs Analysis • Training schedule • Training materials • Training attendance records	More detail is required within the plan			
7 . 41	reference to the National Occupation standards for Civil Contingencies and NHS England competencies when identifying key knowledge and skills for staff; (directors of NHS England on-call rotas to meet NHS England published competencies);	X	X	X	X	X	X	X	• Training Needs Analysis • Training schedule • Training materials • Training attendance records	More detail is required within the plan			
7 . 42	details of the tools that will be used to make sure staff remain aware through ongoing education and information programmes (for example, e-learning and induction training); and	X	X	X	X	X	X	X	• Training Needs Analysis • Training schedule • Training materials • Training attendance records	More detail is required within the plan			
7 . 43	details of how suitable knowledge and skills will be achieved and maintained.	X	X	X	X	X	X	X	• Training Needs Analysis • Training schedule • Training materials • Training attendance records	More detail is required within the plan			
8	**NHS Acute Trusts must also include:**	X	-	-	-	-	-	-					
8 . 1	detailed lockdown procedures;	X	-	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	Separate plans exist			
8 . 2	detailed evacuation procedures;	X	-	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	Hospital Evacuation plan & Fire plan			
8 . 3	details of how they will manage relatives for any length of time, how patients and relatives will be reunited and how patients will be transported home if necessary;	X	-	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	Part of MIP			
8 . 4	details of how they will manage fatalities and the relatives of fatalities; and	X	-	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	Part of MIP			
8 . 5	**Best Practice:** reference to the Clinical Guidelines for Major Incidents.	X	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	Need to audit against this guidance			
9	**NHS Ambulance Trusts must also:**	-	X	-	-	-	-	-		N/A			
9 . 1	refer to the National Ambulance Service Command and Control Guidance 2012 and any other relevant ambulance specific guidance relating to major incidents;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 2	manage up to four incidents at a time in urban areas and two in rural areas;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 3	have flexible IT and staff arrangements so that they can operate more than one control centre and manage any events required;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 4	have formal arrangements for recalling staff to duty if necessary;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 5	be able to provide a forward control team if necessary;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 6	have an on-call and an on duty loggist drawn from a wide pool of staff;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans • Action Card	N/A			
9 . 7	have arrangements to communicate with and control resources from other ambulance providers;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 8	have a 24-hour specialist adviser for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support gold and silver command in managing these events;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans for Tactical Adviser or other specialist (eg HART team)	N/A			
9 . 9	have 24-hour radiation protection supervisor arrangements in line with local and national mutual aid arrangements;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans for Tactical Adviser or other specialist (eg HART team) • Action Card	N/A			
9 . 10	make sure all commanders maintain a continuous personal development portfolio;	-	X	-	-	-	-	-	• Demonstrate individual use of Personal Development Programme logs	N/A			
9 . 11	have a Hazardous Area Response Team (HART) in line with the current national service specification, including a vehicles and equipment replacement programme;	-	X	-	-	-	-	-	• Most recent HART review report	N/A			
9 . 12	be able to respond to firearms incidents in line with National Joint Operating Procedures;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 13	have a Mobile Emergency Response Incident Team (MERIT) to cover the area in line with Department of Health guidance;	-	X	-	-	-	-	-	**Not rated in 2013, unless organisation provides evidence**	N/A			
9 . 14	be able to manage a casualty clearing station with large numbers of patients for a long period of time in line with Department of Health guidance;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 15	be able to identify the location and availability of assets across the organisation and the country;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans • Action Card	N/A			
9 . 16	be able to respond with assets across the organisation and the country and provide situation reports to the National Ambulance Co-ordination Centre;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans • Action Card	N/A			
9 . 17	be able to dispatch and receive assets following an agreed trigger mechanism, supported by a robust audit process;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Review Team Assessment
9 . 18	have a trigger mechanism for requesting mutual aid and a nominated person to agree to these requests, supported by a clear profile of what is required, what can be provided and how the response will be managed in the field;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans • Action Card	N/A			
9 . 19	have systems to manage the media at Emergency Operational Centres, fall-back locations and across the organisation;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans • Action Card	N/A			
9 . 20	have arrangements in place for routine public events, for example, demonstrations and public gatherings;	-	X	-	-	-	-	-	• Detail planning processes employed for routine events	N/A			
9 . 21	attend safety advisory groups to reduce organisational risk during planning and at the actual event;	-	X	-	-	-	-	-	• Detail planning processes • Demonstrate attendance at SAG/ Tor/ Minutes	N/A			
9 . 22	have arrangements in place to deal with public disorder incidents;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans • Action Card	N/A			
9 . 23	have arrangements in place to provide radiation protection supervisors;								**repetition of 9.9 so no need to answer**				
9 . 24	have arrangements in place to train voluntary and community first responders	-	X	-	-	-	-	-	• Detail arrangements	N/A			
9 . 25	have arrangements in place to provide training support to NHS partners in the use of personal protective equipment for chemical, biological, radiological, nuclear, hazardous material and casualty clearing.	-	X	-	-	-	-	-	• Detail training arrangements • Training needs analysis • Training materials • Training records	N/A			
9 . 26	have processes and an audit trail which allow all staff to train with partner agencies;	-	X	-	-	-	-	-	• Detail training arrangements • Training needs analysis • Training materials • Training records	N/A			
9 . 27	have arrangements in place to train with the voluntary sector;	-	X	-	-	-	-	-	• Detail training arrangements • Training needs analysis • Training materials • Training records	N/A			
9 . 28	have arrangements in place to train with acute trusts;	-	X	-	-	-	-	-	• Detail training arrangements • Training needs analysis • Training materials • Training records	N/A			
9 . 29	have arrangements in place to share the outcome of training and exercises with other ambulance trusts and government stakeholders across the country;	-	X	-	-	-	-	-	• Detail training and exercising arrangements •Training log/ records/ outcomes report • Exercising programme/ log that complies with national exercising standards • Post exercise/ incident reports, showing lessons identified, with an action plan to address gaps	N/A			
9 . 30	have strong processes for profiling staff and managing facilities to accommodate EPRR and store assets in line with CCA requirements;	-	X	-	-	-	-	-	**Not rated in 2013, unless organisation provides evidence**		N/R		N/R
9 . 31	have arrangements in place for counselling and supporting staff, and advising on long-term clinical care following a traumatic or high-profile incident;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 32	have suitable IT arrangements in place to support a significant incident or any event that requires specialised IT;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 33	explain the systems for alerting, mobilising and co-ordinating all primary NHS resources necessary to deal with an incident on the scene (in coordination with NHS England area team gold command);	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans • Action Card	N/A			
9 . 34	list their key strategic, tactical and operational responsibilities as set out in the NHS Emergency Planning Guidance 2005 (or subsequent relevant guidance);	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans • Action Card	N/A			
9 . 35	explain how and when MERIT, HART and MIA (the Medical incident Adviser) will be used;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans • Action Card	N/A			
9 . 36	identify how voluntary aid societies will be used;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 37	explain working arrangements with all emergency services;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 38	explain the arrangements for managing triage, treatment and transport for casualties;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 39	state who will represent the service at LHRP, LRF and similar groups;	-	X	-	-	-	-	-	• ToR from LHRP, LRF • Meeting minutes	N/A			
9 . 40	explain the roles of the Hospital Ambulance Liaison Officer (HALO) and Hospital Ambulance Liaison Control Officer (HALCO) in acute trusts;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans • Action Card	N/A			
9 . 41	refer to other relevant plans such as REAP;	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
9 . 42	explain how the Mobile Privileged Access Scheme (MTPAS) and Fixed Telecommunications Privileged Access Scheme (FTPAS) will be provided across the organisation; and	X	X	-	-	X	X	X	• Detail arrangements for MTPAS enabled telecoms in the service/ invocation arrangements	N/A			
9 . 43	describe how Airwave systems will be managed within the organisation and how talk groups will be used to communicate with the emergency services.	-	X	-	-	-	-	-	• Detail arrangements for use of Airwave	N/A			
10	**NHS England area teams must also:**	-	-	X	-	-	-	-		N/A			
10 . 1	make sure that the incident response plans for all providers in an LRF are co-ordinated and compatible;	-	-	X	-	-	-	-	• Evidence from LHRP - statement to CCG commissioners that plans of healthcare providers in LRF boundary are coordinated • Distribution processes for IRP • Briefing to organisations • Peer assessment from other area teams • Meeting minutes	N/A			
10 . 2	define when the NHS will take the leading role in a significant incident or emergency`;	-	-	X	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
10 . 3	mobilise primary and secondary care resources to support acute and non-acute trusts;	-	-	X	-	X	-	-	• Page/ section references in IRP, annexes or standalone plans • Action Card	N/A			
10 . 4	describe the arrangements for setting up a Science and Technical Advice Cell (STAC) in consultation with local Public Health England centres;	-	-	X	X	-	-	-	• STAC Plan • Page/ section references in IRP, annexes or standalone plans • Page/ section references to PHE incident response plan	N/A			
10 . 5	identify who will attend the Strategic Co-ordination Group (SCG);	-	-	X	X	-	-	-	• Page/ section references in IRP, annexes or standalone plans References to tactical coordination group	N/A			
10 . 6	provide a co-chair and secretariat for LHRPs;	-	-	X	-	-	-	-	• TOR for LHRP	N/A			
10 . 7	define the roles and responsibilities of LHRP; and	-	-	X	-	-	-	-	• TOR for LHRP	N/A			

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Review Team Assessment
10 . 8	develop plans which demonstrate the command and control of resources from all NHS organisations and providers of NHS funded care within an LRF area to respond to a significant incident or emergency; and	-	-	X	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
10 . 9	outline how GP services will be delivered 24 hours a day – either directly or through out-of-hours services.	-	-	-	-	X	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
11	**NHS England corporate and regional offices must also:**	-	-	-	X	-	-	-		N/A			
11 . 1	assign an NHS England area team to each LHRP or LRF;	-	-	-	X	-	-	-	• Refer to State of Readiness provided in transitional assurance	N/A			
11 . 2	define how strategic EPRR advice and support will be given to these teams;	-	-	-	X	-	-	-	• TOR heads of EPRR and minutes	N/A			
11 . 3	make sure that area team incident response plans in a region are co-ordinated and compatible;	-	-	-	X	-	-	-	• Evidence from LHRP - statement to CCG commissioners that plans of healthcare providers in LRF boundary are coordinated • Distribution processes for IRP • Briefing to organisations • Peer assessment from other area teams • Meeting minutes	N/A			
11 . 4	outline the procedure for responding to incidents which affect two or more LHRPs or LRFs;	-	-	-	X	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
11 . 5	outline the procedure for responding to incidents which affect two or more regions;	-	-	-	X	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
11 . 6	define how links will be made between the NHS England, the Department of Health and PHE	-	-	X	X	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
11 . 7	define how the NHS's ability to respond to emergencies will be measured and controlled;	-	-	-	X	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
11 . 8	outline how the Department of Health will be supported in its emergency response role;	-	-	-	X	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
11 . 9	outline how information relating to national emergencies will be co-ordinated and shared; and	-	-	X	X	-	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
11 . 10	establish a link between the Regional Prevent Co-ordinator in the NHS England local area and those involved in Protect.	-	-	-	X	-	-	-	**Not rated in 2013, unless organisation provides evidence**		N/R		N/R
12	**CCGs will, in addition:**	-	-	-	-	X	-	-		N/A			
12 . 1	carry out their duties as category two responders under the CCA and provide details of how they will do this;	-	-	-	-	X	-	-	• Page/ section references in IRP, annexes or standalone plans • Demonstrate attendance at BRF meetings and other planning forums	N/A			
12 . 2	**Core Standard 12.2 has been TRANSFERRED to 10.9 above.**									N/A			
12 . 3	make sure agreements with providers of NHS funded care include suitable EPRR provisions and categorise funds allocated to EPRR activities (for example, testing and exercising);	-	-	-	-	X	-	-	• Terms of National Contract passed on to providers • Details of negotiations/ funding lines	N/A			
12 . 4	**Core Standard 12.4 has been DELETED.**	-	-	-	-	X	-	-		N/A			
12 . 5	define a route for their commissioned providers to escalate issues 24 hours a day, supported by trained and competent people, in case they cannot maintain delivery of core services;	-	-	-	-	X	-	-	• Details of escalation procedure • Details of On-call arrangements • On-call manual • If the rota is provided on a cluster arrangement copies of service level agreements that the individual On-call can assume command and control and commit resources, including financial, of the partner organisations	N/A			
12 . 6	outline how the CCG will carry out its supporting role during and after an incident;	-	-	-	-	X	-	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
12 . 7	Demonstrate the annual plan for training and exercises as part of the duties of a category two responder; and	-	-	-	-	X	-	-	• Detail training and exercising arrangements •Training log/ records/ outcomes report • Exercising programme/ log that complies with national exercising standards • Post exercise/ incident reports, showing lessons identified, with an action plan to address gaps	N/A			
12 . 8	those CCG's with ambulance Trust commissioning responsibilities must ensure, in relation to both planned and non-planned events, that specific EPRR-related services in response are itemised.	-	-	-	-	X	-	-	• Terms of National Contract passed on to providers • Details of negotiations/ funding lines	N/A			
13	**Community pharmacists must also:**	-	-	-	-	-	-	-		N/A			
13 . 1	explain how they will support essential care in the community during a significant incident or emergency;	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
13 . 2	support hospitals, GPs and ambulance services during the treatment phase of an influenza pandemic or any other public health emergency;	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
13 . 3	outline how they will give accurate and specific clinical advice;	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
13 . 4	outline how they will share information with other relevant organisations; and	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
13 . 5	describe how the police or other emergency services can get access to a key-holder list for any pharmacy.	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
14	**NHS Logistics must also:**	-	-	-	-	-	-	-		N/A			
14 . 1	outline how healthcare products and supply chain services can be provided 24 hours a day in times of crisis; and	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
14 . 2	explain how an efficient and effective procurement service can be maintained for NHS organisations.	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
15	**NHS Protect must also:**	-	-	-	-	-	-	-		N/A			
15 . 1	refer to all relevant guidance that provides a safe and secure environment for NHS staff and resources	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
15 . 2	define its aims for managing security issues across the NHS;	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
15 . 3	outline how conflict resolution training can be used by all NHS organisations to prevent violence against staff and patients;	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
15 . 4	outline how NHS organisations can manage risks relating to economic crime such as fraud, bribery and corruption;	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
15 . 5	describe how their plans will be related to the national threat levels for counter terrorism security;	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
15 . 6	explain how threat levels will be based on the broad nature of the threat but could include specific areas of business, geographic vulnerabilities, acceptable risk and specific events;	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
15 . 7	describe how NHS sites can be locked down by managing site security and the security of staff, patients and visitors;	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
15 . 8	outline how NHS organisations can access Project Artemis and Project Argus Health;	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
15 . 9	outline how local security management specialists (LSMS) can advise on managing a security culture;	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
15 . 10	outline how NHS organisations can manage specific security issues, for example, VIPs and bomb threats;	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
15 . 11	explain how it will use effective communication strategies to work in partnership with EPRR stakeholders; and	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			
15 . 12	establish links with LSMS and Prevent leads in trusts.	-	-	-	-	-	-	-	Not to be reviewed in 2013	N/A			

	NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England area teams	NHS England regional &	CCGs	Community providers	Mental health	Suggested Minimum Level of Evidence to be submitted to review group	Commentary/ References to Evidence Supplied	Self Assessment	Review Team Comment	Review Team Assessment
16	**NHS Direct / 111**	-	X	-	-	-	-	-		N/A			
16 . 1	must also outline how they will support NHS organisations affected by service disruption, including communications and response procedures for significant incidents and emergencies (for example, informing the public and GPs if local emergency departments are closed).	-	X	-	-	-	-	-	• Page/ section references in IRP, annexes or standalone plans • BCP should cover loss of staff, premises, telephony, mutual aid and cross boundary issues • Commissioning specifications should include provisions for appropriate support	N/A			
17	**Community providers must also:**	-	-	-	-	-	X	-		N/A			
17 . 1	take into account how vulnerable adults and children can be managed to avoid admissions, with special focus on providing healthcare to displaced populations in rest centres;	-	-	-	-	-	X	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
17 . 2	outline how they can assist acute trusts and ambulance services during and after an incident (with reference to specific roles that support discharge from hospital);	-	-	-	-	-	X	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
17 . 3	where relevant, set out detailed plans for lockdown, evacuation and managing relatives.	-	-	-	-	-	X	-	• Page/ section references in IRP, annexes or standalone plans	N/A			
18	**Mental healthcare providers must also:**	-	-	-	-	-	-	X		N/A			
18 . 1	co-ordinate and provide mental health support to staff, patients and relatives in collaboration with Social Services;	-	-	-	-	-	-	X	• Page/ section references in IRP, annexes or standalone plans	N/A			
18 . 2	outline how, when required, Ministry of Justice approval will be gained for an evacuation;	-	-	-	-	-	-	X	• Page/ section references in IRP, annexes or standalone plans	N/A			
18 . 3	identify locations which patients can be transferred to if there is an incident;	-	-	-	-	-	-	X	• Page/ section references in IRP, annexes or standalone plans	N/A			
18 . 4	support local acute trusts by managing physically unwell inpatients if there is an infectious disease outbreak; and	-	-	-	-	-	-	X	• Page/ section references in IRP, annexes or standalone plans	N/A			
18 . 5	make sure the needs of mental health patients involved in a significant incident or emergency are met and that they are discharged home with suitable support.	-	-	-	-	-	-	X	• Page/ section references in IRP, annexes or standalone plans	N/A			
19	**Urgent care centres must also:**	X	-	-	-	-	X	X		N/A			
19 . 1	outline how they can support NHS organisations affected by service disruption, especially by treating minor injuries to reduce the pressure on emergency departments. They will need to develop procedures for this in partnership with local acute trusts and ambulance and patient care transport providers.	X	-	-	-	-	X	X	• Page/ section references in IRP, annexes or standalone plans • Commissioning specifications should include provisions for appropriate support	N/A			

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Response to the Francis Inquiry and associated reports**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Kam Dhami, Director of Governance**
DATE OF MEETING:	**28 November 2013**

EXECUTIVE SUMMARY:

The attached paper provides a further update on the Trust's response to the Francis Inquiry and the associated national reports that have been issued since.

As advised at the meeting of the Board in October, the appendix to the paper sets out the actions being undertaken to take forward the recommendations which are relevant to our Trust and have been assessed as requiring attention.

REPORT RECOMMENDATION:

The Board is asked to:

Formally ACCEPT the recommendations contained in the Francis Report.

Discuss and APPROVE the detailed action plan.

APPROVE the proposed monitoring arrangements

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

Accept	Approve the recommendation	Discuss
	X	

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

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

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

Supports the Trust's plans to improve quality & safety

PREVIOUS CONSIDERATION:

The Trust Board has discussed the outcome of the Francis Inquiry on a number of occasions, including at the formal Board meetings in February 2013 and September 2013. The Board also received a further response to the Francis Inquiry & associated national reports at the meeting of the Board held in October 2013.

SWBTB (11/13) 232 (a)

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Trust response to the Francis Inquiry and associated reports

1. Introduction

1.1 In February 2013 the final report into the care failings at Mid Staffordshire Hospitals NHS FT was published. The Inquiry, led by Sir Robert Francis QC, detailed 290 recommendations relevant for the NHS and a range of external organisations.

1.2 At the time of publication there was a clear expectation from the Department of Health that the report would be shared and discussed with staff and for there to be in-depth discussion at Board level so that the lessons from Stafford Hospital are learned across the NHS. There was also the expectation for Trusts to develop a comprehensive action plan detailing its response to the recommendations.

1.3 The Secretary of State for Health required all healthcare organisations to respond in two ways by the 31 December 2013:

> Organisations should hold listening events with their staff to hear about how the NHS can remain true to its core values of compassion and care; and
> NHS hospitals must set out publicly how they intend to respond to the Inquiry's conclusions.

1.4 The depth and breadth of the recommendations and interventions outlined in the Francis Report are immense. The Secretary of State acknowledged this by giving organisations until the end of 2013 to review and consider their approach prior to the publication of their formal response.

2. Trust response to the Francis Report

2.1 At its meeting in February 2013 the Trust Board agreed its initial response to the Francis Report and how decided it intended to take forward the recommendations that applied to provider organisations.

2.2 Also at that time, the priority areas for improvement in response to the Francis Report were agreed by the Board as: culture, mortality, care of the frail elderly, complaints, patient experience and nurse staffing. Several relevant pieces of work were underway within the Trust pre-dating the publication of the report in these areas.

2.3 In relation to the organisation understanding and reviewing the Francis Report the Trust:

> Held five special Hot Topics briefings for senior leaders in March 2013 at City, Sandwell and Rowley Regis hospitals to discuss the report and the key learning points for the Trust.

In order to ensure information cascade throughout the organisation, a PowerPoint presentation was produced for managers to use in their conversations with staff at team meetings.

The following questions were set for teams to discuss in the workplace.

- How does the Francis report affect my team?
- What will my team do to improve patient experience, quality and safety in the light of the Francis report and recommendations?
- What immediate improvements could the Trust do to improve the quality and safety of patient care in the light of the Francis report and recommendations?
- What ideas do you have for how the Trust could improve quality and safety in the long term, within available resources?

The feedback received was shared across the organisation.

Quality was decided as the theme for the 2013 Leadership Conference held in April 2013. This included a presentation by the Chair of the Quality and Safety Committee, Olwen Dutton, who spoke about the Board's view of quality and safety and the Francis Report.

Articles in Heartbeat, the staff newsletter.

2.4 At its meeting in October 2013 the Board received an update on the reports published in direct response to the Francis Inquiry (the Government's response, Keogh, Berwick and Cavendish). The paper brought together the recommendations made in the reports to assist the Trust in determining its priority areas for focus to further improve quality and safety. The high level response set out:

What we are already doing in this area;
Work planned for 2013/14; and
Where we know we need to improve

The Board reaffirmed the approval of the priority areas for improvement previously agreed and accepted the addition of risk management and data quality / analysis.

It was agreed that a detailed action plan would be presented to the Board in November 2013.

3. Action plan overview

3.1 The attached plan (Appendix 1) sets out the actions being undertaken to take forward the recommendations which are relevant to our Trust and have been assessed as requiring attention.

3.2 The action plan is split into the themes identified by Sir Robert Francis in his report:

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

4. Monitoring and reporting arrangements

4.1 The national expectation is for Trust Boards to approve their action plan and put in place effective arrangements for gaining assurance that recommendations of the report are being addressed.

4.2 The expectation is for there to be an update published at least annually detailing progress. It is therefore recommended that the Trust Board receives a report once a year updating on progress to date with the substantive monitoring driven through the Quality and Safety Committee on a quarterly basis.

4.3 The existing performance management arrangements will be used as a prompt for clinical groups and corporate directorates to ensure they are considering the implications of the Francis Inquiry in the running of their services. This will take place through the bi-monthly performance reviews and will ensure that the changes made as a result of the Francis Inquiry are sustained.

4.4 The Trust will submit the action plan for consideration by our Commissioners through the Clinical Quality Review Meeting and agree a schedule of reporting.

5. The Government's response

5.1 At the time of writing this report, the Government published its report '*Hard Truths: The journey to putting patients first'* – its response to the Mid Staffordshire NHS Foundation Trust Public Inquiry recommendations and the several independent reviews (Keogh, Cavendish, Berwick, Clywd/Hart, NHS Confederation and Lewis/Lenehan).

5.2 It includes a report which outlines what the Department of Health and national bodies have been working on since the report was published in February 2013. It also provides responses to each of the 290 Francis recommendations, accepting 204 in full, 57 in principle, 20 part accepted and 9 have not been accepted.

5.3 The Government's response and the associated commissioned reports (which make up two large volumes) will be reviewed and the Trust action plan refreshed as required.

6. Recommendations

The Board is asked to:

6.1 Formally **ACCEPT** the recommendations contained in the Francis Report.

6.2 Discuss and **APPROVE** the detailed action plan.

6.3 **APPROVE** the proposed monitoring arrangements

Kam Dhami
Director of Governance

November 2013

APPENDIX 1

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Response to the Francis Inquiry and associated publications

Action Plan

Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
Creating the right culture with values that put patients first *[Francis recommendations: 4, 7, 8 and 178]*					
1. Raise the profile of the Trust values and promises and align more closely to workforce practices and training.	April 2014	Director of Strategy	Clear expectations for staff set out in Trust values and reinforced through customer care promises and induction process Business case developed to resource values based recruitment Internal communications campaign to reinforce Customer Care Promises being planned for Q4 in 2013/14.	**3**	Improved staff and patient satisfaction scores Reduction in patient complaints related to poor communication and staff attitude
2. Reinforce the requirement to abide by the NHS values and Constitution in staff recruitment, selection, appointment, training and development.		Chief Executive	Customer Care Promises included as a standard item in all non-medical advertisements. Improvements on-going to develop recruitment 'micro-sites' to support hard to fill posts – and will include clear statements about Trust values. Reference to values and NHS Constitution included within Non-medical contract of employment. Medical contract currently being	**4**	Improved quality of candidates submitting applications to the Trust Improvements in the quality of applicants shortlisted for interview. Reduced turnover consequent on 'poor fit' at selection stage. Reduction in complaints linked to poor behaviours.

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
				updated. Non-medical recruitment requires all managers to focus on 'values based recruitment' as part of the selection process. Guidance and details now subject to further review. Trust Code of Conduct issued at Induction stage – currently being updated. Trust values and details of customer care promises covered within Corporate Induction. Case for investment submitted to IAP to support introduction of a comprehensive 'values based recruitment' including pre-application sifting, psychometric testing and 'values based interview assessment' training Reference to the NHS Code of Conduct and SWBH Code of Conduct to be included as standard clause within job descriptions w.e.f. December 2013 Development of Trust Leadership Framework.		
3.	Strengthen standard statements in job descriptions and contracts of employment requiring an express commitment from staff to abide by both the NHS values and the Constitution.	February 2014	Chief Executive	Standard clause to be introduced from December 2013 and will be included on all posts advertised from this point forward. Non-medical contract has been updated. Medical contract is	**4**	Statement included as a standard clause. Statement included within both medical and non-medical contracts of employment.

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
				currently being updated.		
4.	Incorporate the requirement to abide by the NHS values and Constitution into SLA templates and approaches to procurement.	In place for SLAs during preparatory Q4 phase re: 14/15 agreements	Director of Finance and PM	Process in place for harnessing contractual information outside of agreements with CCGs as these will be compliant as written by NHSE	**3**	For non-standard NHS contracts, wording references NHS terms of trading inclusive of values / constitution. Standard wording to appear as part of purchase order documentation.
5.	Finalise the culture programme for the Trust's organisational development.	March 2014	Director of Strategy	Best practice research to commence in December	**3**	Improved staff and patient satisfaction scores Positive CQC inspection outcomes Positive (scores to be defined) CQC banding indicator scores Internal set of measures agreed by Board
6.	Introduce 'Your Voice', an employee on-line survey of 2500 staff each month.	September 2013	Director of Strategy	Monthly employee polling at 'team level' introduced in Sept 2013 Local feedback and action planning process being strengthened	**5**	Increased levels of staff engagement
7.	Launch the Patient Experience and Staff Engagement long-term strategy.	March 2014	Chief Nurse	Original strategy redrafted and currently out for patient and staff consultation	**4**	Positive feedback from patients and carers. Improved positive returns in FFT
8.	Pilot the 'Patient knows best' electronic system in selected specialities.	March 2014	Chief Nurse	You said – we did' posters in place on ward measures boards	**4**	Reflected through patient feedback and increased

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
						positive returns in FFT
9.	Improve people's experience in outpatients (as this is where most have contact with the Trust) through implementation of eight outpatient standards.	January 2014 *(programme finalised)*	Chief Operating Officer	OP standards set as part of 2013 transformation programme. The programme for 2014 has OP as a major focus. The CLE Committee has received a presentation in November on this and had a robust discussion. The programme will be finalised by January 2014.	**4**	OP transformation standards met: All patients will be seen within 6 weeks of the hospital receiving their referral. All referral letters will be scanned into CDA within 24hrs of receipt. (June 2013) No patient will wait more than 20 minutes later than their appointment time to be seen (April 2013) No patient will have their clinic appointment cancelled by the hospital (March 2014). All patients will have their first appointment for diagnostics within locally agreed targets (June 2014) A documented outcome of an outpatient visit will be available to the GP electronically within 2 working days. All communications will be easily accessible within the Electronic Patient Record. All patients will receive a copy letter within 5 working days (March 2014) All patients will be given an opportunity to comment on

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
						the outpatient service that they have received (March 2014)
10.	Plans to be developed to reinforce leadership development in the Trust.	April 2014	Director of Strategy	Leadership & Management Development centre approach being established Leadership behaviours being piloted in W&CH clinical group	**4**	Number of leaders/managers accessing development programmes Improved leadership quality scores in employee surveys
11.	Introduce 360 degree appraisal for all staff, including Board members.	April 2014	Director of Strategy	New appraisal policy drafted Investment plan developed to implement for 360 degree appraisal for 160 employees by April 2014 (subject to procurement)	**4**	100% appraisal compliance Improved appraisal and leadership quality scores in employee surveys
12.	Expand existing staff reward and recognition schemes, ensuring awards criteria linked to the NHS values and Constitution.		Chief Executive	Annual Staff Awards reinvigorated to include greater staff and patient involvement. Beacon 'Status' awards introduced Review Long Service Recognition.	**4**	Improved staff satisfaction scores measured via 'Your Voice' and national staff survey. Reduction in adverse HR indicators (sickness, turnover, complaints) Improvements in productivity.
13.	Introduce arrangements to demonstrate to staff, patients and the public changes made as a direct result of staff and patient feedback.	March 2014	Chief Nurse	'You said – we did' posters in place on ward measures boards	**4**	Reflected through patient feedback and increased positive returns in FFT

Getting fundamental standards right *[Francis recommendations: 11 and 12]*

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
14.	Identify key areas of practice for development of standard operating procedures.		Chief Operating Officer	Benchmark SOP across organisation and develop register for Trust (February 2014) Set standard format for SOP and register (March 2014) Audit compliance against the standards programmed to start in May (September 2014)	**1**	Review register and determine gap analysis on areas without an SOP
15.	Improve the consistent application of existing standard operating procedures.		Chief Operating Officer	Benchmark SOP across organisation and develop register for Trust (February 2014) Set standard format for SOP and register (March 2014) Audit compliance against the standards programmed to start in May (September 2014)	**1**	Review register and determine gap analysis on areas without an SOP.
16.	Review all relevant Quality Standards and produce a 'gap' analysis and associated development plans in line with commissioning requirements as part of the contracts.	April 2014	Director of Finance and PM	Progress on CQUIN indicators and delivery trajectories undertaken. Timeline established for joint clinical commissioning group & contracting process for 14/15 which will subsume the joint assessment of areas in need of improvement	**3**	Presence of SDIP (service development improvement plans) which feature as part of the preparation of the final contract documentation in any given year

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
Responsibility for, and effectiveness of, healthcare standards						*[Francis recommendation: 37]*
17.	Review the format of the Quality Account in line with national guidance, as required.	April 2014	Medical Director	Successfully completed two quarterly audits for year 2013-14 in accordance with the QA 2013-14 at the Trust Board. QA 2014-15 processes will commence in December 2013.	**4**	Set up a working paper file for production of Quality Accounts (QA) to allow external audit to review progress of QAs. Agree data/ information assurance framework identify key indicators/ targets, data sources, control framework. QMF is used as monitor for national and locally agreed targets Identify group that will be responsible for monitoring the audit pathway. Identify other sources of external audit which can be used to provide evidence to the Quality Account.
Effective complaints handling						*[Francis recommendations: 109 to 116 and 118]*
18.	Introduce a devolved model of complaints investigation and management, with responsibility transferring from the corporate Complaints team to Clinical Groups and directorates.	November 2013	Director of Governance	Project went live on 4 November. All except 2 new formal complaints received have been devolved, the remaining are being led corporately.	**5**	Real time changes to service delivery or processes.

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
19.	Ensure the key performance indicators for the new devolved model are achieved, including meeting the response date agreed with the complainant.	On-going	Director of Governance	KPI's developed and will be used in Dashboards from December 2013	**4**	Process dates are met 100% of the time
20.	Assess the complainant's satisfaction with the process.	December 2013	Director of Governance	Feedback form under review.	**4**	Reducing number of link complaints and greater returns and satisfaction.
21.	Capture action taken by clinical services following a complaint and to make this information available and share learning.	January 2014	Director of Governance	Framework in development to ensure actions are captured monitored and shared both internally and externally.	**4**	All actions are captured on the complaints database and closed in a timely manner, reflected through dashboard data.
22.	Publish the main issues patients complain about and what we are doing about them.	January 2014	Director of Governance	As Above	**4**	Information visible on both intranet and internet.
23.	Publish themes and trends about compliments, concerns, complaints.	January 2014	Director of Governance	As above	**4**	As above
24.	Devise a system to inform individual complainants what we have learned and what we will do differently as a result of their complaint.	December 2013	Director of Governance	Actions being identified as part of the investigation and plans drawn up prior to CEO validation. Letters to reflect these changes.	**4**	Complaint responses identify lessons learned and action plans produced. These will be reflected in the letter sent to conclude the case.
25.	Proactively share details of complaints (suitably anonymised) with the CQC, health scrutiny committees etc	January 2014	Director of Governance	Process for identifying such complaints and actively sending out in development as part of the	**4**	Complaints database to show numbers of complaints shared across the wider

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
				framework at 24.		health economy.
Medical education and training						*[Francis recommendation: 160]*
26.	Encourage openness on the part of medical trainees in relation to raising concerns and provide protection from any adverse consequences.	April 2014	Medical Director	At Induction, all Trainees (all grades) are informed of the importance of raising concerns at the earliest possible opportunity. Trainees are informed of the routes they can use to raise concerns about any aspect of their training or indeed about patient safety: a. Educational and/or Clinical Supervisor b. College/Specialty Tutor c. Either of the Postgraduate Clinical Tutors or the support teams in the two Centres d. Medical Staffing, in particular with relation to rota issues All Specialties hold 'Forum' meetings on regular basis chaired by College / Specialty Tutor at which any issues/ concerns can be raised. The Postgraduate Clinical Tutors chair monthly Forum meetings open to all trainees so that any issues not resolved locally can be discussed and raised directly (publicly or privately) with the Clinical Tutors. Trainee Reps attend the bi-monthly cross-site Medical Education Committee meetings at which	**5**	Available opportunities for open discussions and any concerns raised.

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
				concerns can be raised. All trainees are mandated to complete proscriptive feedback evaluations (JEST/PHEEM) on all of their posts at each rotation time point (every 4 months for Foundation Trainees, every 6-12 months for other Trainees). In addition, they complete an annual GMC Trainee Survey and surveys about the quality of their Appraisals (and Appraisers).		
27.	Junior doctors to routinely participate in the Trusts' mortality and morbidity review meetings.	October 2014	Medical Director	This needs to be audited and reported on new clinical group/directorate structure in association with dashboard items Direct junior doctor involvement has been developed but is patchy with medicine more developed. Grand rounds have included mortality presentations and learning on both sites. Sandwell had a monthly grand round put aside for mortality case learning. Clinical Governance reporting structure to be agreed.	**3**	Directorate and now specialty clinical governance meetings are expected to include mortality and morbidity review and learning as well as expect attendance from junior doctors at specialty level. Directorate and specialty level mortality information such as review performance data are regularly shared. Grand rounds to include Mortality case learning. Junior Drs involvement of Mortality reviews when

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
						involved with patient care.
28.	Develop ways in which to tap into the latent energy of junior doctors.	April 2014	Medical Director	Junior Doctors attend a monthly forum to discuss any projects are activities requiring a Junior Doctor. Development of Medical Fellows in MD plan and will be established in 2014. Clinical ward teams have a regular junior doctor involved and engaged, communicating with the team and contributing to newsletters.	**3**	Junior Doctors Forum attendance.
Openness, transparency and candour					*[Francis recommendations: 173-177, 179 and 1 08]*	
29.	Active promotion of Board meetings to encourage members of the public to attend.	January 2014	Director of Governance	The following work is underway to improve public involvement in Board discussions and decisions: Publicising Board meetings in the local media and the FT members' quarterly newsletter. Displaying forthcoming Board meetings more prominently on the Trust website Reviewing the distribution list of external recipients of Board papers. Improving on-site signage of Board meetings.	**4**	Sustained increase in public attendance at monthly Board meetings. Questions received from members of the public at Board meetings Increased use of the enquiry facility on the Trust website
30.	Only necessary items to be discussed in the private sessions of Board meetings	January 2014	Director of Governance	Justification criteria for items being accepted in private to be agreed.	**4**	Reduction in the number of items on the private Board

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
	and for clear guidance on what is considered 'private' to be agreed.			Amend the cover sheet to include the reasons for the item to be considered in private.		agenda. Adherence to the 'private' items agreed criteria.
31.	Put in place a robust process to examine the aggregate analysis of incidents, claims and complaints to ensure all of this information is being triangulated effectively.	January 2014	Director of Governance	Framework and process being developed to encompass integration of information, triangulation and learning.	**4**	Integrated governance process identifying 'early warnings' to affected services or systems.
32.	Introduce a formal framework to support organisational learning from reported incidents, claims and complaints.	January 2014	Director of Governance	Framework in development.	**4**	Minimising the risk of the event happening again. Outcomes and learning from investigations shared across and beyond the Trust.
33.	Revise and re-launch the Whistleblowing Policy, making it easy and safe for staff to raise concerns.	December 2013	Director of Governance	Policy under revision and to be launched at CLE in December 13.	**3**	Increasing number of concerns raised under the policy. Staff survey and other feedback routes show positive attitude and staff feel safe in reporting.
34.	Check that all serious incidents are disclosed to those affected in a timely manner, appropriately reported and investigated, with the findings shared with those involved in accordance with the Being Open Policy.	January 2014	Director of Governance	Policy under review to include Duty of Candour sanctions and improved process of notification.	**4**	Patients, relatives and staff are all informed of outcomes. Dashboard shows 100% compliance.
35.	Ensure all teams and services can	February	Director of	To be discussed with Group	**4**	Compliments on changes

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
	demonstrate they share learning and the improvements or changes that have resulted.	2014	Governance	management at Quality meetings.		from patients. Prevention of similar issues in other services.
Compassionate caring and committed nursing				*[Francis recommendations: 185, 191, 194, 195, 199, 202, 204, 207 and 208]*		
36.	Participate in the 'Care Makers' campaign to embed the 6 Cs in practice.	October 2013	Chief Nurse	Achieved	**5**	Active enrolment of a minimum 10 care makers.
37.	Nursing competences and expectations to be explicit in job descriptions.	January 2014	Chief Nurse	HCA band 0-4 complete. Bands 5 and 6 complete. Work commenced for Band 7s KPI's agreed for Band 8s	**4**	All JD's will have competency framework.
38.	Further embedding QUEST (an on-line competency framework) and expansion of clinical MOT.	May 2014	Chief Nurse	15% achieved to date.	**3**	30% of nursing staff to have completed QUEST in year one.
39.	Introduce a process of sharing information on staff on duty, per shift, per grade with patients and carers.	December 2013	Chief Nurse	E-roster and BRAD to be aligned.	**3**	All measures boards have explicit information.
40.	Strengthen the nurse recruitment process to incorporate more values based questions and activities such as discussion groups to explore behavioural responses to scenarios.	March 2014	Chief Nurse	Pilot for Nurse Bank recruitment scheduled for January 2014	**3**	FFT comments and patient feedback are positive in relation to care.
41.	Develop ways to harness the loyalty and innovation of student nurses, who move from ward to ward, so they become ambassadors for their hospital and for	March 2014	Chief Nurse	Stakeholder event with pre-registration scheduled December 2014. Increased support from practice placement.	**3**	Maximum number of student nurses are retained as substantive staff

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
	promoting innovative nursing practice.					
42.	Ward Nursing Leaders are visible and accessible to patients and carers out of hours.	September 2013	Chief Nurse	Ward based matrons in post. Matrons clinics undertaken in many wards	**4**	Reduction in complaints, increase in positive FFT.
43.	Further develop clinical competencies and effective role models.	August 2013	Chief Nurse	Introduction of 'Nursing with Pride' hospital badges and 'I pledge' badge.	**5**	Reduction in complaints, increase in positive FFT.
44.	Ensure adequate supervision of non-registered nurses.	January 2014	Chief Nurse	In-house regulation of HCA's introduced. Mandatory 2 day post appointment prep agreed.	**4**	No increase in incidents or complaints.
45.	Ensure care provided meets a minimum in relation to Quality, Safety and Experience.	March 2014	Chief Nurse	All serious incidents are examined through TTR. Ward Review audited.	**4**	Safety Thermometer, Ward Review and Quality Audit all positively reflect this.
46.	Patients will know who is caring for them and regular monitoring will be achieved.	December 2013	Chief Nurse	Care rounding introduced and each patient assigned a key nurse.	**4**	Positive FFT. Reduction in incidents. Reduction in complaints
Caring for the elderly					*[Franics recommendations: 236 to 243]*	
47.	Develop our frail elderly services in partnership with SWB CCG in order to ensure safe, high quality care, early senior assessment , alternative pathways to admission where clinically appropriate, integrated care and supported discharge.	April 2014	Chief Nurse	Discussions to take place	**1**	Positive FFT. Reduced re-admission

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
48.	Work with staff and patients / carers to decide on how the money secured (£904k) from the DH '*Enhancing the Acute Environment for Patients with Dementia*' fund is spent.	December 2013	Chief Nurse	Completed upgrades on wards Sandwell and City sites.	**5**	Positive FFT. Patient/carer feedback. CQUIN achieved.
49.	Implement the dedicated team to progress the dementia agenda to improve the patient and carer experience.	March 2014	Chief Nurse	Dementia champion in place. Therapy support appointment Band 6 interview imminent.	**3**	Positive FFT. Patient/carer feedback. CQUIN achieved.
50.	Development of a 'dementia survival guide' for staff (based on a version produced by staff at Worcester University) and an information folder for all wards and departments.	November 2013	Chief Nurse	Complete.	**5**	Positive FFT. Patient/carer feedback. CQUIN achieved.
51.	Review and update the 'Managing Challenging Behaviours' policy to reflect best practice.	March 2014	Chief Nurse	Awaiting appointment of key team members.	**3**	Positive FFT. Patient/carer feedback. CQUIN achieved.
52.	Standards of appropriate discharge to be set and effectively communicated and monitored.		Chief Operating Officer	Discharge standard to be revisited (December 2013) Standards measured include TTA prescribed on day of discharge, transport before 12pm, discharges after 10pm. (January 2014) Readmission taskforce work includes work on discharges for those patients assessed as high risk	**4**	Full compliance with the discharge standards A reduction in avoidable readmissions

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
				of readmission. The discharge standard for this group will be developed. (February 2014) A readmission review meant will be established to review the readmissions and discharge standard to determined if the readmission was avoidable.		
53.	Review current arrangements for ensuring consultant led care for every patient so that the patient and their supporters are clear who is in overall charge of a patient's care.	April 2014	Medical Director	SWBH operates a ward based system; as patients move through the system, the Consultant in charge of care is identified through eBMS which in turn updates other systems. The Board Round process updates this as the patients moves through the hospital. Notifying relatives is done via the bed –board details rather than any form of electronic input.	**4**	Electronic Bed Management System (eBMS) is updated and accurate throughout the patient journey. Patient and relatives communication of consultant changes.
54.	Patients will know who is caring for them and regular monitoring will be achieved.	December 2013	Chief Nurse	Care rounding introduced and each patient assigned a key nurse.	**4**	Positive FFT. Reduction in incidents. Reduction in complaints
Accurate, useful and relevant information				*[Francis recommendations: 244, 245, 252, 253, 255, 256, 262, 263, 268 and 269]*		
55.	The current quality and performance reports to be replaced with an Integrated	March 2014	Director of Finance &	In support of Trust level information, indicators within	**3**	Draft format of report agreed Implementation during 13/14

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
	Quality, Performance and Finance report.		PM	Groups, Directorates and Wards/Departments under review to assist in final format of the Accountability & Autonomy Framework.		for permanent embedding
56.	Develop a system to provide an assessment of data quality so that the reader can understand whether weaknesses exist in terms of the robustness of the source and consistency.	March 2014	Director of Finance & PM	Forms part of agreed assurance/risk workplan of new Internal Audit provider over next 5 months	**4**	Single indicator influenced by a pre-agreed set of criteria regarding DQ resulting in visual assignment of rating to each KPI
57.	Undertake rolling systematic audits of data quality, with various factors taken into account when ranking data quality.	April 2014	Director of Finance & PM	Included in agreed workplan, specific SOPs, routines to be scheduled	**4**	Audit & Risk Management Committee in receipt of pre-planned timely output from rolling audits with recommendations and response plans in place.
58.	Improve systems which provide effective real-time information on the performance of each service, consultant and teams in relation to mortality, morbidity, outcome and patient satisfaction.	July 2014	Medical Director	SWBH has Dr Foster access – Team data is published by specialty level and, if needed, Consultant level. Hospital Standardised Mortality Ratio (HSMR) is calculated externally based upon the results provided to Department of Health. Alerts are actively monitored by Clinical Governance Team. SLR under procurement – to commence April-June 2014	**4**	Dr Foster access. Hospital Standardised Mortality Radio data. SLR provides real time activity/costs of

	Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
				Report produced on Mortality & Re-admissions by Group and Specialty for MQAC. Patient satisfaction outcomes are recorded by wards using a Meridian survey platform system. Results are accessible to ward leadership and where by speciality. Friends and Family Test based upon national programme is measured in terms of inpatients (this does not currently cover day-case patients).		service/ward/ consultant. MQAC monthly meetings review performance or each service. Patient satisfaction results show an upwards trend.
59.	Make available to all stakeholders in as near "real-time" as possible, results and analysis of patient feedback.	March 2013	Chief Nurse	Meridian tool in use which gives real time feedback to clinicians. Monthly stats update on wards measures boards.	**4**	Positive feedback FFT
Coroners and inquests						*[Francis recommendation: 279]*
60.	Review compliance with the requirement that, as far as is practicable, the responsibility for certifying the cause of death is undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment.	February 2014	Medical Director	A training presentation has been developed for use with Junior Doctors and registrars. The mechanisms for further monitoring the accuracy of death certification need to be informed by the emerging Medical Examiner Role.	**4**	Improved accuracy of death certification by ensuring senior input into the process.

Key action	Timeline	Executive Lead	Progress update	RAG	Measures of success
			An audit of senior input to be established. This policy is available in the certificate offices and included in the new doctors training programme. Death Certification checklist completed by Clinician for patients notes.		Death Certificate Policy (2010) states to discuss the death with the consultant in charge, or if unavailable, the relevant consultant on call before completing the medical certificate of cause of death.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.1

Venue D29 Meeting Room, City Hospital **Date** 25 October 2013; 0800h – 1000h

Present		**In Attendance**
Ms O Dutton	[Chair]	Mr S Parker
Mr R Samuda		
Mrs G Hunjan	[Part]	
Dr S Sahota OBE		
Mr T Lewis	[Part]	
Dr C Cobb	[For Dr Stedman]	
Mrs J Wakeman	[For Mrs Pascall]	
Miss R Barlow	[Part]	**Secretariat**
Mr C Archer	[For Mr White]	Mr S Grainger-Payne
Miss K Dhami		

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
The Committee received apologies for absence from Prof Richard Lilford, Dr Roger Stedman, Mrs Linda Pascall, Mr Robert White and Mrs Debbie Talbot.	
2 Minutes of the previous meeting	**SWBQS (9/13) 139**
The minutes of the Quality and Safety Committee meeting held on 20 September 2013 were approved as a true and accurate reflection of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
3 Matters arising from the previous meeting	**SWBQS (9/13) 139 (a)**
The updated actions list was received and noted by the Committee.	
MATTERS FOR DISCUSSION/DEBATE	
4 Update on 'Winter 2013 Must Be Better' programme	**Verbal**

Mr Lewis reported that in terms of bed capacity, the current quantity of beds open was acceptable, although at present twelve more were open at Sandwell Hospital than planned at this point, with ten less open than expected at City Hospital. It was highlighted that not all processes were functioning with respect to the assessment units however, therefore work was to be directed to addressing this position. The Committee was advised that the medically fit for discharge ward model was not working as well as it should which was also impacting on the overall position. The changes planned to address this were outlined to centre on the release patients, from other inpatient areas, therefore generating an improvement to patient flow. Work to achieve discharges earlier in the day was also reported to be underway. It was reported that the Trust was experiencing a high level of delayed transfers of care at present which was presenting issues although the matter was being addressed jointly with Social Services. Mr Samuda asked how patient resistance to being relocated to Rowley Regis Hospital was being handled. Miss Barlow advised that it was critical that patient expectations were managed using appropriate communications. In terms of offering choices regarding nursing homes, it was reported that a policy had been developed which outlined robust measures which would be taken as a last resort if agreement could not be reached. Dr Cobb advised that in terms of patient choice, transport was a key concern. Miss Barlow offered to check that these considerations were included in the policy. Dr Sahota asked when seven day working would be implemented by Social Services. He was advised that this practice was due to start imminently. Miss Barlow advised that patient transport had been strengthened at present to support the flow to Rowley Regis Hospital.	
ACTION: **Miss Barlow to check that transport considerations are incorporated within the patient choice policy**	
5 Quality Report	**SWBQS (10/13) 141** **SWBQS (10/13) 141 (a)**
The key highlights within the Quality Report were presented to the Committee. Ms Wakeman highlighted that there had been a reduction in pressure sores during the period. Dr Sahota asked for the reason why the performance was reported several months retrospectively. He was advised that the current data feed did not permit any more timely reporting. Dr Cobb highlighted that there appeared to be a high number of pressure sores identified in patients undergoing a fractured neck of femur procedure which would be investigated further. It was agreed that an update would be provided at the next meeting. No reported outbreaks of infections were reported.	

Dr Cobb reported that there were no ward review results included in the report as the reviews were undertaken quarterly. It was highlighted that compliance with the WHO checklist and VTE assessments had improved significantly. Ms Dutton noted that the mortality review staff had received an award at the recent Staff Awards Ceremony.

In terms of fractured neck of femur performance target, Ms Dutton noted that this was an internal priority, however performance appeared to be disappointing at present. She asked whether an action plan was in place to address this issue. Mrs Wakeman offered to determine the arrangements in place and it was agreed that this would be considered by the Clinical Effectiveness Committee at its next meeting.

Mrs Wakeman highlighted that the Friends and Family Test results had deteriorated, influenced in part by the Accident & Emergency target performance. It was highlighted that there were difficulties with ensuring that patients completed the surveys.

Dr Cobb noted that Trauma & Orthopaedics speciality was being given some targeted supported in light of its infection control issues at present.

Dr Sahota observed that the proportion of caesarean section rates appeared to be above the national average. It was noted that this did not represent a serious issue and that an audit of the appropriateness of the procedures had been undertaken which did not reveal any serious concerns.

Dr Sahota noted that in terms of the patient safety walkabouts he was unsure how the actions on the patient safety walkabouts were communicated back to the Non Executives attending the visit. Miss Dhami advised that an additional step would be added to the process to ensure that feedback on the completion of actions was provided.

Ms Dutton noted that bank and agency staff usage was high and suggested that the reasons behind this in the light of the risks with the use of these staff should be investigated. Dr Cobb advised that there was some need to use bank and agency staff at present to support patients with a high dependency. Mrs Wakeman advised that work was also underway to implement the acuity tool which would assist this position.

Mr Samuda noted that the performance against the nutrition indicators was deteriorating. Mrs Wakeman advised that there were some issues concerning the data that informed this position.

Mr Samuda asked how the Trust compared with other organisations in respect of the level of incidents reported. Miss Dhami advised that the data was submitted nationally and the Trust compared favourably in terms of reporting rates. It was highlighted that the Care Quality Commission (CQC) Quality Risk Profile (QRP) reported the Trust favourably. Miss Dhami outlined the process by which incidents and complaints were linked. She added that reporting of near misses had improved. Ms Dutton emphasised the need to harness and act on learning from

the incidents reported. Mr Samuda asked how there was certainty that medication was given when required. Mrs Wakeman advised that in the previous financial year reduction in missed doses had been set as a CQUIN target and although this had not been set as a performance target this year, the good practice in this respect had been continued. It was highlighted that in some cases missed doses, particularly those that caused harm, would be reported through the incident reporting process. Dr Cobb advised that there was a particular focus on elderly care wards. Ms Dutton reported that as part of a recent patient safety walkabout, it had been reported that there was an issue concerning nurses being interrupted during ward rounds. Mrs Wakeman advised that the use of red tabards when undertaking drugs rounds had assisted to some degree. The difficulties with preventing all interruptions were discussed. In terms of incidents reported, Ms Dutton expressed her disappointment with the high level that were attributed to poor communication. The performance against the stroke care targets was noted to be poorer than required. Dr Cobb advised that the high number of stroke alerts was impacting to some degree. It was noted however, that the performance against the target concerning admission to a stroke unit was particularly concerning. Mr Archer highlighted that there was an apparent issue concerning data quality of this information. It was agreed that an update would be presented at the next meeting. Mr Samuda asked what plans were in place to improve staff surveys. It was reported that 'The Voice' had been implemented that allowed staff to participate in polling on-line on a rolling basis. Mandatory training compliance was noted to be poor. Dr Cobb advised that recent operational pressures had influenced the training rates. High sickness rates on some wards were noted, particularly that on Lyndon 2. Mrs Wakeman advised that measures had been implemented to address this position.	
ACTION: **Mrs Wakeman to determine the reason behind the fractured neck of femur pressure sore position and report back at the next meeting** **ACTION:** **Mrs Wakeman to ensure that the performance against the fractured neck of femur target is discussed at the meeting of the Clinical Effectiveness Committee** **ACTION:** **Miss Barlow to provide an update on plans to improve performance against the stroke care targets at the next meeting**	
6 Mortality	
6.1 Site variation in mortality	**SWBQS (10/13) 143** **SWBQS (10/13) 143 (a)**

Mr Parker advised that the Trust's HSMR had been around 100 for a number of months, although the position reflected a composite of a higher than expected level at Sandwell Hospital and a significantly lower than expected rate at City Hospital. It was reported that a piece of work had commenced to understand the reasons behind the position at Sandwell Hospital by reviewing data from 2012. The case mix between the sites was highlighted to have been investigated, as had coding practice. It was found that Sandwell demographic was slightly older than around City Hospital, although these patients had a lower level of co-morbidities. As such, it was reported that further investigations were planned to understand the coding practice that determined this position, including a review of this at a consultant level. Mr Samuda asked what measures had been taken to determine the position against other trusts' positions. It was highlighted that the Trust's own position would need to be understood firstly. The Committee was advised that the work had suggested that a closer focus should be directed to pneumonia cases. Ms Dutton asked whether there was a variance in mortality rates according to the day of week that patients were admitted. She was advised that statistically this had been reviewed and that this would be investigated further in due course, however it had not been identified that there was a particular issue to date. Mr Samuda suggested that the Trust Board should be made aware of the process and outcome to date of the work. Ms Dutton highlighted the value of the work. She asked whether this linked to work on readmissions. She was advised that this was the case as this was a key recommendation of the work. Dr Sahota asked how this information would be communicated to and acted on by staff. Mr Parker advised that this was an integral part of the mortality development plan and in particular the actions within the remit of the Chief Clinical Officer. It was reported that the death certificate information and practice would also be reviewed and in particular the difference between the initial diagnosis cited and the cause of death. It was noted that GP practices and palliative care provision also had a potential to influence the position. Mrs Hunjan joined the meeting.	
6.2 Mortality development plan: update	**SWBQS (10/13) 144** **SWBQS (10/13) 144 (a)**
Mr Parker advised that a number of the actions in the mortality development plan that were due for completion in October had been delayed pending the recruitment of staff to assist with the work. It was reported that as a result, the actions had been reviewed and reprioritised.	
7 Corporate Quality & Performance dashboard	**SWBQS (10/13) 142** **SWBQS (10/13) 142 (a)**
Mr Archer reported that performance against a number of indicators was influencing the position against the NHS Performance Framework and FT Compliance Framework. Mrs Hunjan asked whether the categorisation of same sex accommodation breaches had now been finalised and asked for an explanation of the position	

reported. Mr Lewis advised that five breaches were reported in Critical Care and that the position would be closely monitored nothwithstanding the much improved position from the previous year. It was reported that the low score for the Medicine & Emergency Care Group's position against MRSA screening was influencing the overall performance. Ms Dutton noted that the ambulance turnaround times needed to be improved. Mr Archer reported that performance had improved since the end of 2012/13, although the position appeared to have stabilised at present. Ms Dutton noted that there had been a high number of cancelled outpatient appointments for non-clinical reasons. Dr Cobb advised that there was much attention directed to improving this. Ms Dutton suggested that a report on the position and measures to improve performance should be presented at the next meeting. Ms Dutton noted that there had been 10 falls that had resulted in severe injury and/or death year to date. It was agreed that the position would be investigated and an update provided at the Trust Board meeting.	
ACTION: Miss Barlow to present an update on plans to reduce the number of cancelled outpatient appointments at the next meeting	
8 'Never Events' assurance plan update	**SWBQS (10/13) 145** **SWBQS (10/13) 145 (a)**
Miss Dhami reminded the Committee that the level of assurance concerning controls in place to prevent the reoccurrence of 'Never Events' had been considered at the last meeting. She asked the Committee to note the actions now planned to strengthen the assurance, highlighting that they had been considered recently by the Clinical Leadership Executive. As a next step it was reported that an assessment of the controls in place to prevent an occurrence of the full gamut of 'Never Events' was planned. It was agreed that an update would be provided in January 2014. Mr Samuda suggested that a review of practice in other organisations may be beneficial.	
ACTION: Miss Dhami to present an update on the Never Event assurance plan at the January 2014 meeting	
9 Complaints development plan: update	**SWBQS (10/13) 146** **SWBQS (10/13) 146 (a)**
The Committee was asked to receive and note the complaints development plan. It was highlighted that the devolution process to Clinical Groups would commence from 4 November 2013. Training of key individuals was reported to be a particular focus at present. Miss Dhami circulated a diagram of the new complaints model and talked the Committee through the process. It was highlighted that a target	

timescale of 23 working days had been set for the process from logging, acknowledging & distributing to the pre-CEO check. The process was reported to include engagement with the complainant. Mr Lewis advised that the feedback using the complaints responses would be undertaken. He added that work was underway in parallel to the handle the existing cadre of complaints and to harness and act on learning from the complaints received. Mrs Hunjan emphasised the need for staff to receive feedback on complaints reported. Ms Dutton noted that there had been a significant number of incidents concerning verbal aggression and suggested that consideration needed to be given to staff being subject to these incidents.	
10 Red and amber complaints report	**SWBQS (10/13) 147** **SWBQS (10/13) 147 (a)**
The Committee was asked to receive and note the serious complaints report, highlighting that two had been graded as red during the month and that there had been a number of linked complaints.	
11 Serious Incident report	**SWBQS (10/13) 148** **SWBQS (10/13) 148 (a)**
The Committee was asked to receive and note the serious incident report. Ms Dutton noted that sepsis featured prominently in the set of incidents reported. Mr Lewis advised that work was being directed to understand the data feeds for sepsis. Mr Lewis asked how many incidents had been closed. It was agreed that it would be useful to include this information in future and Miss Dhami agreed to arrange. Dr Sahota advised that there needed to be learning on better communication between junior doctors and the consultants, which was a notable issue in one of the incidents.	
ACTION: Miss Dhami to ensure that information on the number of closed incidents is included in future versions of the serious incident report	
MATTERS FOR RECEIPT AND ACCEPTANCE	
12 Clinical Audit forward plan: monitoring report	**SWBQS (10/13) 149** **SWBQS (10/13) 149 (a)**
The Committee was asked to receive and note the report. Mr Parker advised that the submissions to the national heart failure audit needed to be improved. It was highlighted that the national hip fracture database revealed a higher level of pressure damage that did not accord with the Trust's internal view	

and therefore this would be investigated. Ms Dutton emphasised the need to ensure that the links with the relevant bodies there in place to support the outcome of the Paediatrics audit.	
13 Foundation Trust Quality Governance	**Verbal**
Miss Dhami advised that the BGAF and QGAF action plans had been issued for completion by December 2013.	
14 – 16 REPORT BACK FROM THE COMMITTEES	
A brief summary of key points of discussion at the Quality Committees was provided.	
17 Matters of topical or national media interest	**Verbal**
It was agreed that there were no matters to raise.	
18 Any other business	**Verbal**
Miss Barlow advised that a turnaround process had been applied to the Cardiology speciality and the programme of work that had been put into place would presented at the next meeting. Mr Lewis thanked Miss Dhami and team for the work to prepare the organisation for the recent CQC hospital scores that had been published. He guided the Committee through the four areas of higher risk that had been identified by the process. It was agreed that the actions to improve the position against these would be presented at the next meeting.	
ACTION: Miss Barlow to present the Cardiology turnaround action plan at the next meeting	
19 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 22 November 2013 at 1030h in the D29 (Corporate Suite) Meeting Room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Quality Report
SPONSOR (EXECUTIVE DIRECTOR):	Linda Pascall (Interim Chief Nurse), Dr Roger Stedman (Medical Director) and Kam Dhami (Director of Governance)
AUTHOR:	Various
DATE OF MEETING:	28 November 2013

EXECUTIVE SUMMARY:

The attached report presents a composite picture of performance against a number of key Quality metrics and qualitative information, responsibility for which currently sits within the remits of three members of the Executive Group.

The Committee is invited to accept the report, noting in particular the key points highlighted in Section 2 of the report.

REPORT RECOMMENDATION:

The Board is recommended to 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
✓		

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

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

Comments:

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

Improve and heighten awareness of the need to report and learn from incidents.
NHSLA Acute and Community risk management standards – 'Learning from experience'
Includes performance against a number of CQuIN targets and national & local targets and priorities
Aligned to the priorities set out within the Quality Account

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 22 November 2013

Sandwell and West Birmingham Hospitals NHS
NHS Trust

QUALITY REPORT

A monthly report presenting an update on Patient Safety, Clinical Effectiveness and Patient Experience in the Trust

November 2013

CONTENTS

QUALITY REPORT

1 INTRODUCTION

This report presents a composite picture of the performance against the various key Quality metrics to which the Trust works, both in terms of those mandated at a national or regional level and those set by the organisation.

The report has been populated with latest performance information for the period up until this Board meeting, across a range of areas within three domains: patient safety, clinical effectiveness and patient experience.

2 KEY POINTS TO NOTE

The Trust Board's attention is drawn to the following this month:

PATIENT SAFETY

The number of falls with fractures has increased in October with six patients recorded which is the highest number seen. These incidents are not confined to our area and each has been allocated a TTR date

There is no IPC update at time of report.
The Trust's harm free rate increased to 94% in October 2013 which is an increase of 2%
The number of pressure ulcers dropped to 62 from 68, from and Catheter related UTIs dropped from 8 to 2 in October

CLINICAL EFFECTIVENESS

There are no ward review reports due to be completed for this quarter.

The ward dashboard has been withdrawn until the data flow and IT issues are resolved; this work is being undertaken by a senior nurse in collaboration with Information and IT

Compliance with the use of the World Health Organisation (WHO) checklist was 99.6% across all patients who underwent surgery.

VTE risk assessments were carried out on 95.02% of admitted patients against a standard of 95%.

Mortality Reviews of August deaths was 81.3% reviewed within 42 days which exceeds the target of 80%.

Fractured Neck of Femur being operated on within 24 hours of admission during October was 89.5% which is below the target of 85%.

The Trusts 12-month cumulative HSMR is 92.7 and remains below 100, and is less than the lower statistical confidence limit. The HSMR of the SHA (Peer) remains higher than that of the Trust at 101.7.

PATIENT EXPERIENCE

Inpatient FFT score 71 with a response rate of 29%,the latter being a increase from October

ED FFT score 46 with a response rate of 21 % which is a significant increase

Trust combined (Inpatients + ED) FFT score was 54 with a response rate of 23%.

The number of link complaints has shown a persistent rise since June 2013 and a review is being undertaken

3 TARGETED AREAS OF SUPPORT

T&O – infection control
Theatres – infection control

4 PATIENT SAFETY

4.1 Safety Thermometer

The Trust's harm free rate increased to 94% in October 2013 which is an increase of 2% compared with last month's figure. The number of pressure ulcers dropped to 62 from 68, the falls rose from 2 to 5 and Catheter related UTIs dropped from 8 to 2 in October.

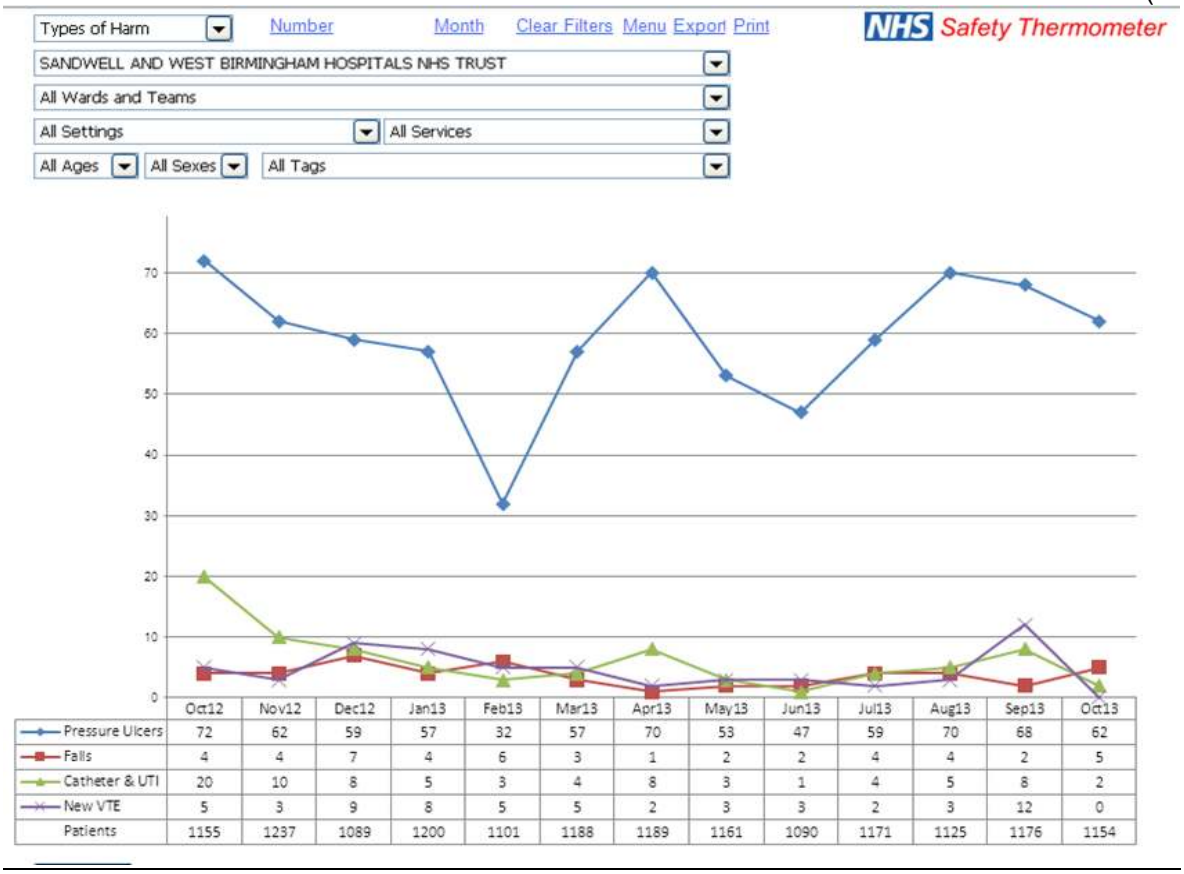
'Harm Free Care' Monthly Percentage - Acute and Community combined

1154	Patients were included in the data collection and	1085	were HARM FREE

Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sept-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
95%	93.5%	94.8%	95.3%	94.2%	93%	93%	94%					

18 patients experienced 1 New Harm across the Trust in October

Figure 1: *Harm free care trend*



	Oct12	Nov12	Dec12	Jan13	Feb13	Mar13	Apr13	May13	Jun13	Jul13	Aug13	Sep13	Oct13
Pressure Ulcers	72	62	59	57	32	57	70	53	47	59	70	68	62
Falls	4	4	7	4	6	3	1	2	2	4	4	2	5
Catheter & UTI	20	10	8	5	3	4	8	3	1	4	5	8	2
New VTE	5	3	9	8	5	5	2	3	3	2	3	12	0
Patients	1155	1237	1089	1200	1101	1188	1189	1161	1090	1171	1125	1176	1154

Figure 2: *Number of patients by type*

a) Falls

Figure 3: *Trend of falls April 2012 – September2013*

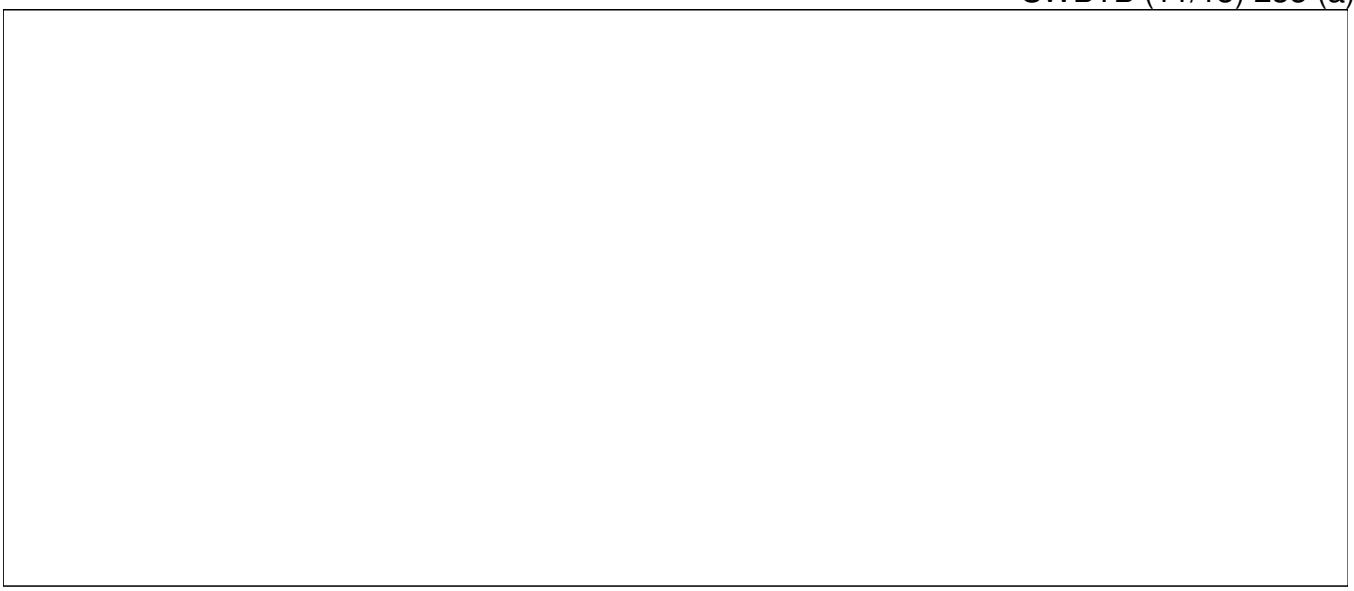


Figure 4: *Incidence of falls per 1000 bed days across Acute Inpatient Divisions*

MONTH	Ward/Area	Grade of Fall	Injury	TTR outcome
April	N4	RED	# Ankle	Preventable
April	N2	RED	# Wrist and clavicle	Preventable
April	D21	RED	# Facial bones	Non-Preventable
May	Eye In patients	RED	#Humerus	Non-Preventable
May	MAU	RED	# NOF	Preventable
May	P3	RED	Peri prosthetic #	Preventable
June	P3	RED	#Humerus	Preventable
June	MAU	RED	#Gt Trochanter	Non-Preventable
June	L5	RED	#Sub/Ex dural haemorrhage (RIP)	Preventable
June	P4	RED	#Rt NOF	Non-Preventable
September	P3	RED	#NOF	12/11/13
October	P3	RED	# NOF	12/11/13
October	ET	RED	Peri prosthetic #	12/11/13
October	ET	RED	# NOF	12/11/13
October	ED	RED	# FEMUR	13/11/13
October	P2	RED	Head Injury	12/11/13
October	N1	RED	#wrist	12/11/13

Figure 5: *Falls resulting in serious injury from April 2013-October 2013 (City and Sandwell Hospital)*

b) Pressure Damage

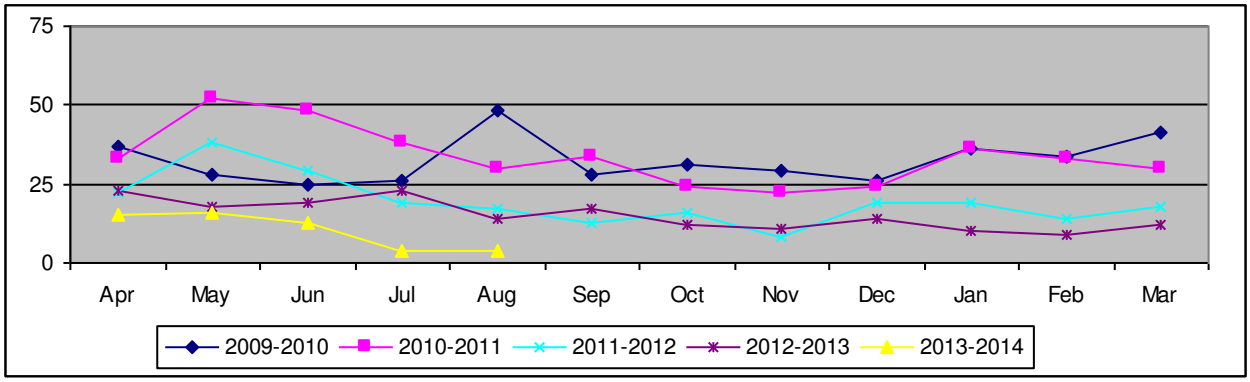


Figure 6: *Number of hospital acquired pressure damage Grade 2, 3 & 4, April 2009 –August2013*

Grade of Sore	2012-2013										2013-2014						
	Apr-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	12/13 Total	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	13/14 Total
Grade 1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Grade 2		11	14	11	11	11	7	9	9	158	13	15	12	2	3		45
Grade 3		3	3	1	0	3	3	0	3	24	2	1	1	2	1		7
Grade 4		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Trust Total		**14**	**17**	**12**	**11**	**14**	**10**	**9**	**12**	**182**	**15**	**16**	**13**	**4**	**4**		**52**

Figure 7: *Table of avoidable hospital acquired pressure ulcers by grade*

c) VTE Risk Assessment

The VTE Risk Assessment CQUIN target is 95%. Intensive work has continued to improve the VTE assessment position. Performance during October was 95.02% which meets the target of 95%. The particular areas of focus are the assessment units where many patients are admitted as emergencies. The Medical Director's teams are working closely with the clinical leads to ensure that all patients are VTE assessed on admission.

Quarter 2 Root Cause Analyses (RCAs)
RCAs of all patients flagged by the Imaging Department as identified as having a DVT or PE whilst they were either inpatients or within 90 days of having been being inpatients have been carried out. The report will be presented at the Trust Thrombosis Committee in November and a report will be made available to the CCG at the following scheduled CQRM. *CQUiN*

4.2 Nutrition/Fluids

Figure 8: *Nutrition Audit Results*

4.3 Infection Control

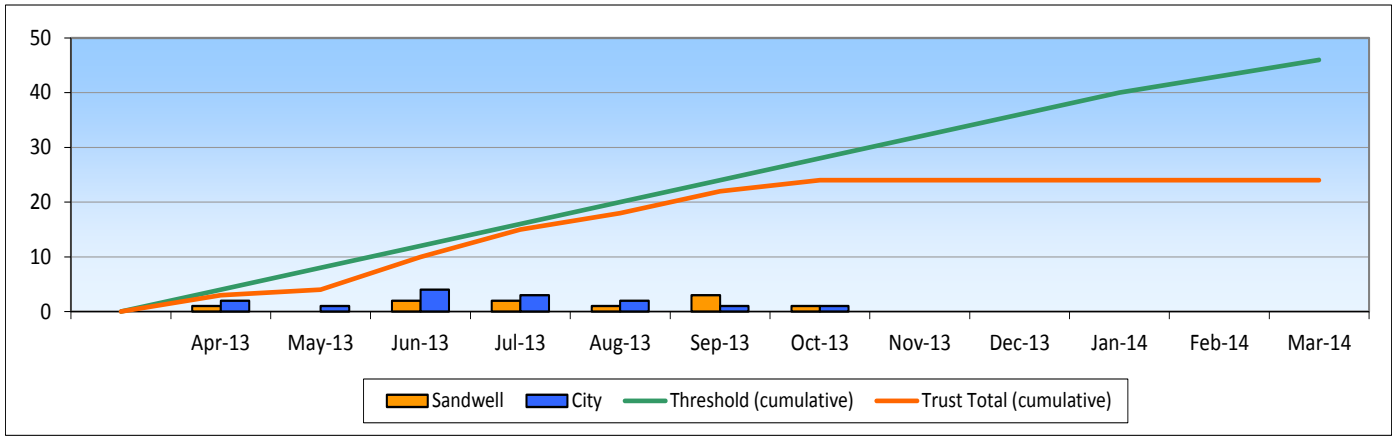
MRSA

			To Date (*=most recent month)	TARGET	
				YTD	2013/14
MRSA Screening - Elective	Patient Not Matched	%	**249.5***	88	90
	Best Practice - Patient Matched	%	**81.9***	77	80
MRSA Screening -	Patient Not Matched	%	**89.5***	88	90

Non Elective	Best Practice - Patient Matched	%	**92.0***	77	80

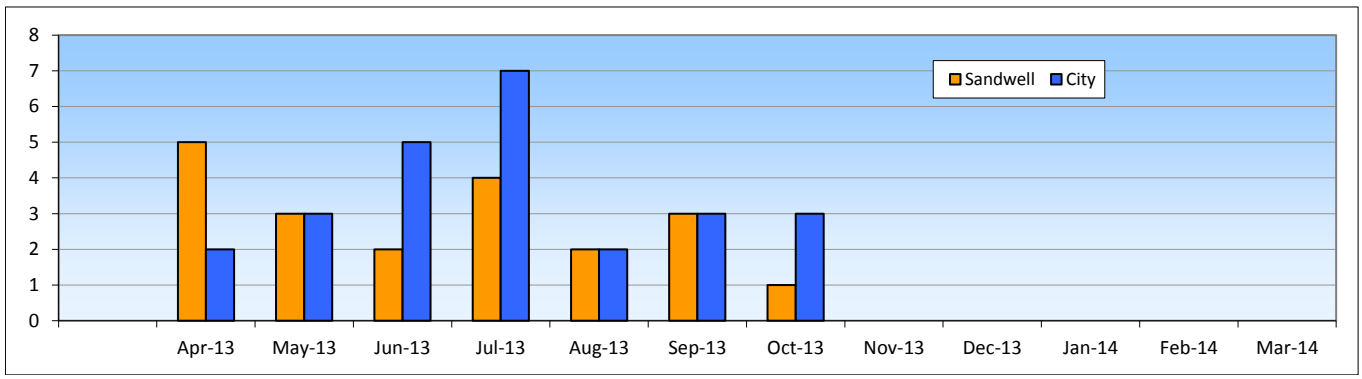
Figure 9: *MRSA screening eligibility*

Clostridium Difficile



	2013-2014												
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Sandwell	1	0	2	2	1	3	1						**10**
City	2	1	4	3	2	1	1						**14**
Trust	3	1	6	5	3	4	2	0	0	0	0	0	**24**
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0	**0**
DoH Trajectory	4	4	4	4	4	4	4	4	4	4	3	3	**46**
Trust Total (cumulative)	3	4	10	15	18	22	24	24	24	24	24	24	-
Threshold (cumulative)	4	8	12	16	20	24	28	32	36	40	43	46	-

Figure 10: *SHA Reportable CDI*



	2013-2014												
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total
Sandwell	5	3	2	4	2	3	1						**20**
City	2	3	5	7	2	3	3						**25**
Trust	7	6	7	11	4	6	4	0	0	0	0	0	**45**
Intermediate Care	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Trust Total (cumulative)	7	13	20	31	35	41	45	45	45	45	45	45	-

Figure 11: *Trust Best Practice Data*

Blood Contaminants

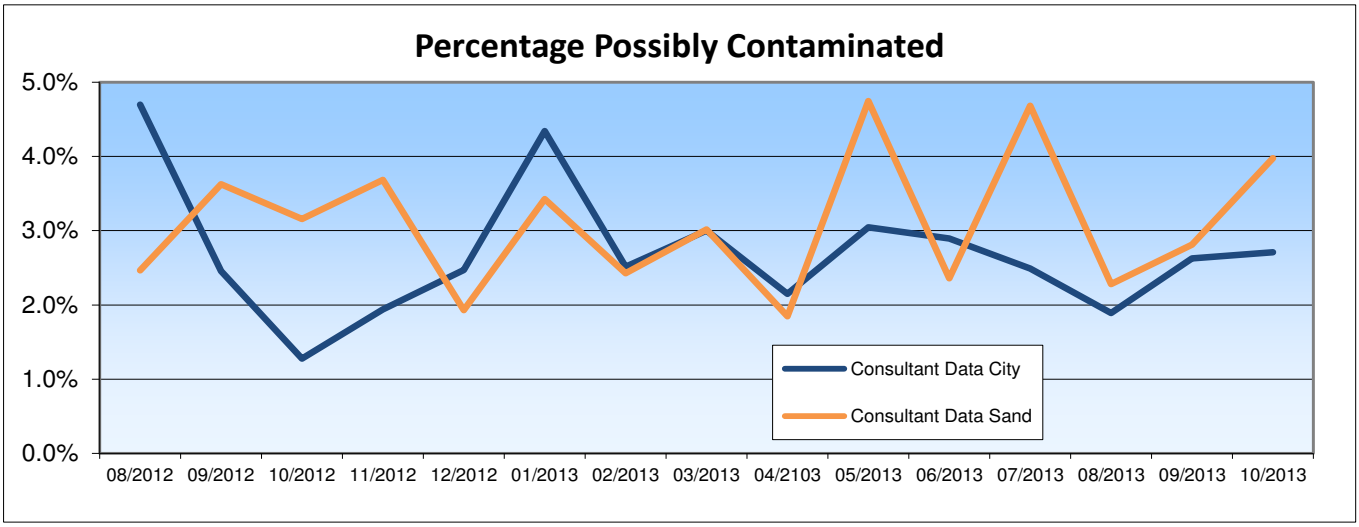


Figure 12: *Blood Contaminants*

E Coli Bacteraemia

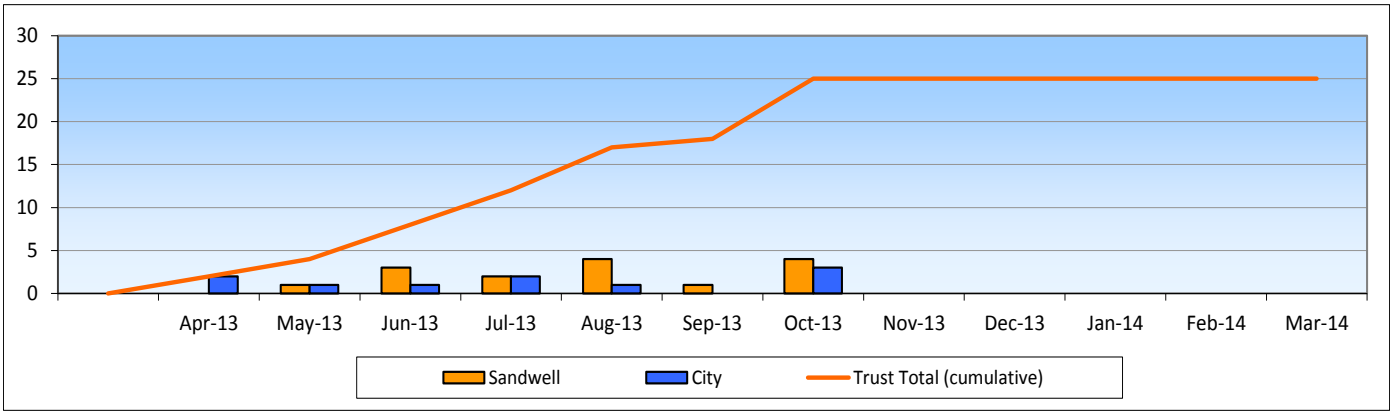


Figure 13: *E Coli Bacteraemia*

MSSA

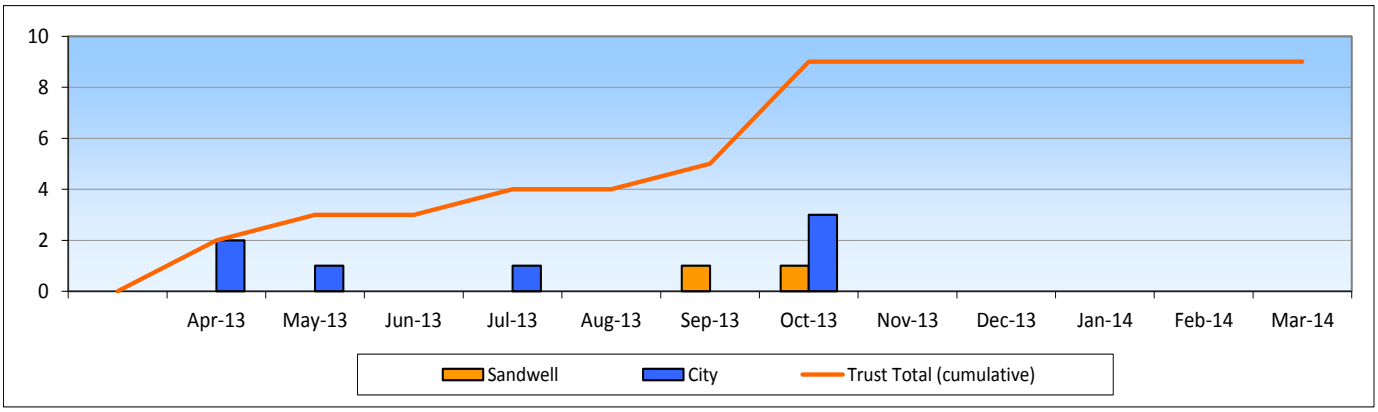


Figure 14: *MSSA*

4.4 Maternity

The Obstetric Dashboard is produced on a monthly basis. The data below is what was reported the previous month (August Quality Report):

*Post-Partum Haemorrhage (PPH)(>2000ml): t*here were0 patients recorded to have had a PPH of >2000ml in September.

*Adjusted Perinatal Mortality Rate (per 1000 babies):*the adjusted perinatal mortality rate for September was 12.2 which was higher than the trajectory (8)and was higher than the previous month(5.9). Perinatal mortality rates must be considered as a 3 year rolling average due to the small numbers involved and the significant variances from month to month.

Caesarean Section Rate: the number of caesarean sections carried out in September was 29.0%, which is above the trajectory of 25% over the year and slightly higher than the previous month (25.5%).

Delivery Decision Interval (Grade I, CS) >30 mins: the delivery decision interval rate for Septemberwas9% which is below the trajectory (15) and higher than the previous month (6%).

Community Midwife Caseload (bi-monthly): The community midwife caseload in September was 124, which is below the trajectory of 140and is lower than the previous month (124).

4.5 Medicine Management (Last updated 25th July)

The 2013/14 CQUINs include safe storage of medicines; the aim is to improve safe storage of medicines in ward areas.

The threshold for improvement is to be agreed following review of the Q1 baseline audit results.

Drug storage audits are being undertaken quarterly across inpatient areas in 2013/14 using a revised audit tool. Nursing and Pharmacy colleagues have developed the audit plan and a process for reviewing audit results. Following review of audit results action plans are being developed to deliver improvements. An improvement trajectory is to be agreed following review of the Q1 audit results.

The Q1 audits have been carried out and data quality checks are being done. The findings of the audits will be available for the next Quality Report and will be presented to the August meeting of the Medicines Safety Group.

4.6 Incidents

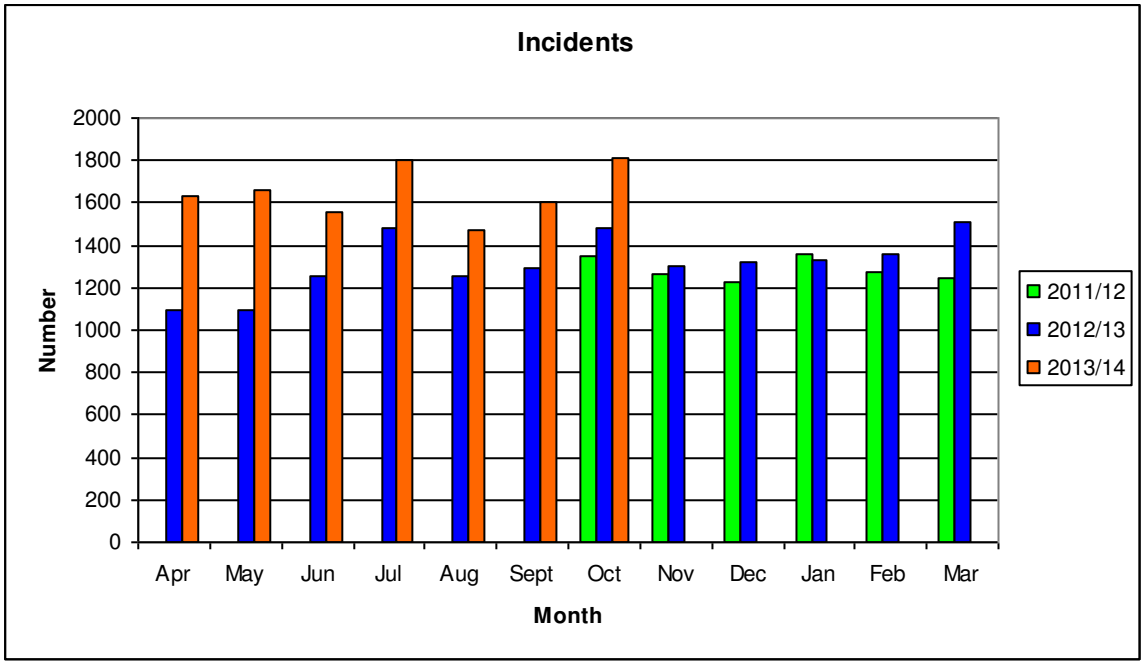


Figure 15: *Incidents 2011/12 – 2013/14*

Incidents in October 2013

Total Number of Incidents reported		**1813**
Of the total: *(* incidents still under investigation)*		
Near miss		277
No Harm		948
Low (minimal harm)		477
Moderate		103
Severe (permanent or long term harm)		7
*Death (related to the patient safety incident)		1
"Top 5" Reporters (Acute)		
1	Emergency Departments (both)	322
2	Labour ward	70
3	Neonatal unit	50

4	Acute Medical Unit (1) – old MAU	44
5	Acute Medical Unit (A) – old EAU	44
"Top 3" Reporters (Community)		
1	Community Nurses Glebefields	22
2	Henderson Ward	20
3	Health Visiting VHC	19
"Top 5" Type**		
1	Non SWBH pressure sore	74
2	Communication failure with patient/team	65
3	Verbal abuse – Patient on Staff	64
4	Staffing – Lack of suitably trained/skilled	51
5	Organisational issues	37

*** 472 incidents are not yet assigned to a causative group*

4.7 Serious Incidents (SIs)

In **October 2013** there were 2 new SI's reported to CCG.

1 2013/29405 – Maternity
Term Stillbirth.

2 2013/231484 – Pathology/Maternity
Incorrect lab results – communicable diseases..

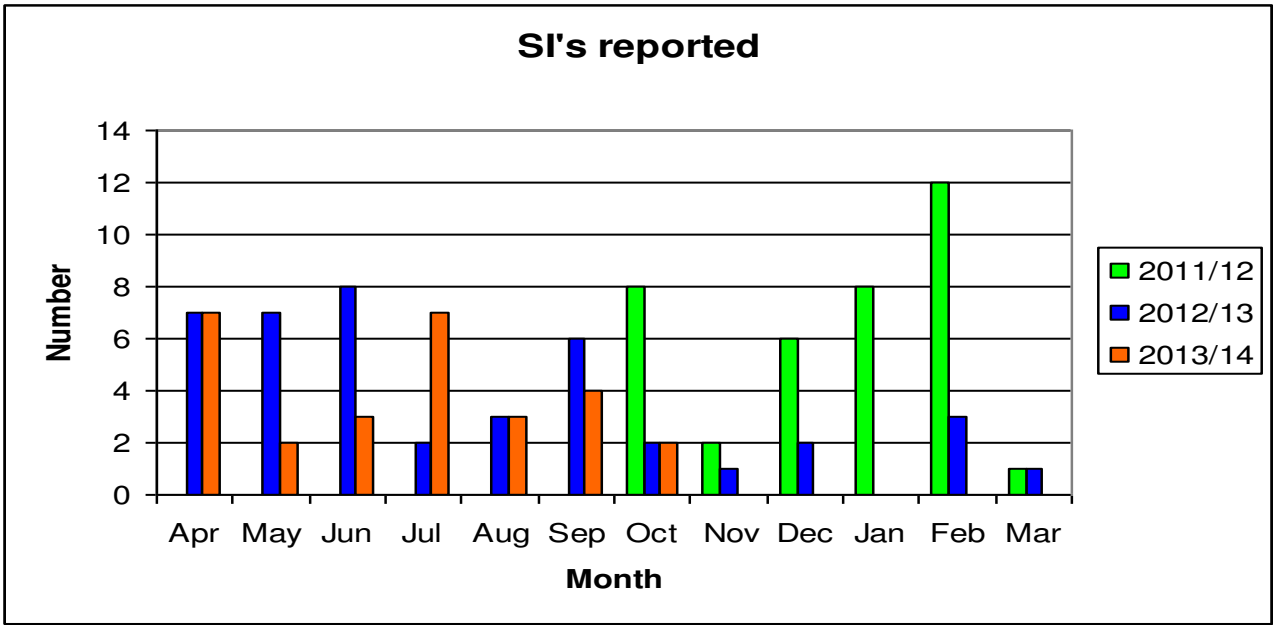


Figure 16: *Incidents 2011/12 – 2013/14*

The serious incidents reported in the graph above do not include pressure sores, fractures resulting from falls, ward closures, or some infection control issues.

Issue/Risk	Action to take/taken	Who by	When by
High level of incidents awaiting action to progress to allow for meaningful data.	Meeting with senior staff in each clinical group and review of processes within their areas.	Head of Risk	December 13

4.8 Patient Safety Walkabouts

The Patient Safety Walkabouts continue to take place. In October the District Nursing team had a visit and a visit to D5 is planned for November 2013.

4.9 Inquests

During October 2013 **6** new Inquest cases were notified to the Trust.

During October 2013 **9** cases were closed following Inquest.

Figure 17: *Inquests 2011/12 – 2013/14*

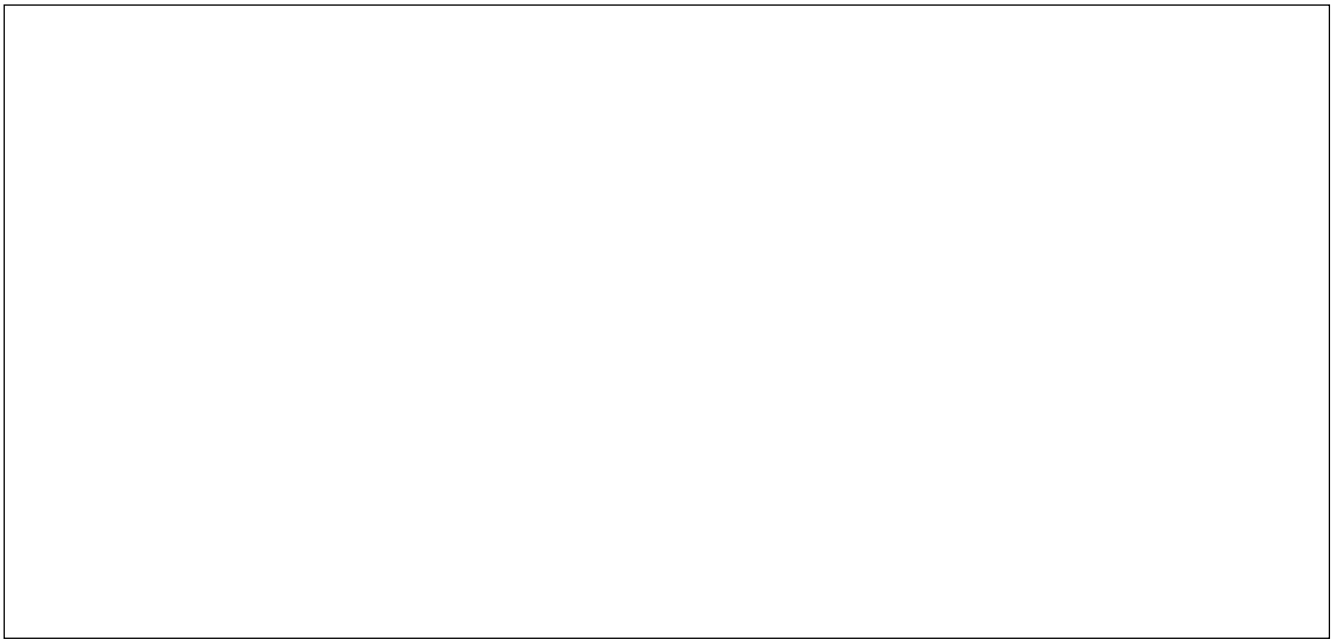


Figure 18: *Inquests closed 2011/12 – 2013/14*

4.10 Claims

There were 24 new claims opened in October 2013. 8 were employer/public liability and 16 were clinical negligence cases.

During October 2013 no clinical negligence claims were closed however 6 employer/public liability claims were closed

Figure 19: *Claims 2011/12 – 2013/14*

4.11 Nurse Staffing Levels

Bank & Agency

The Trust's nurse bank/agency rates are detailed below and show year on year comparison.Notably we are now using more nurse bank/agency than we have for the past 4 years.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011 - 2012	5533	5445	5369	4816	4323	4535	5292	5449	5251	5356	5617	6380
2012 - 2013	5105	5030	5259	5384	6059	5649	6011	6656	6220	6346	7122	8611
2013 - 2014	7516	7902	6312	6682	6971	6825	7549					
2014 - 2015												

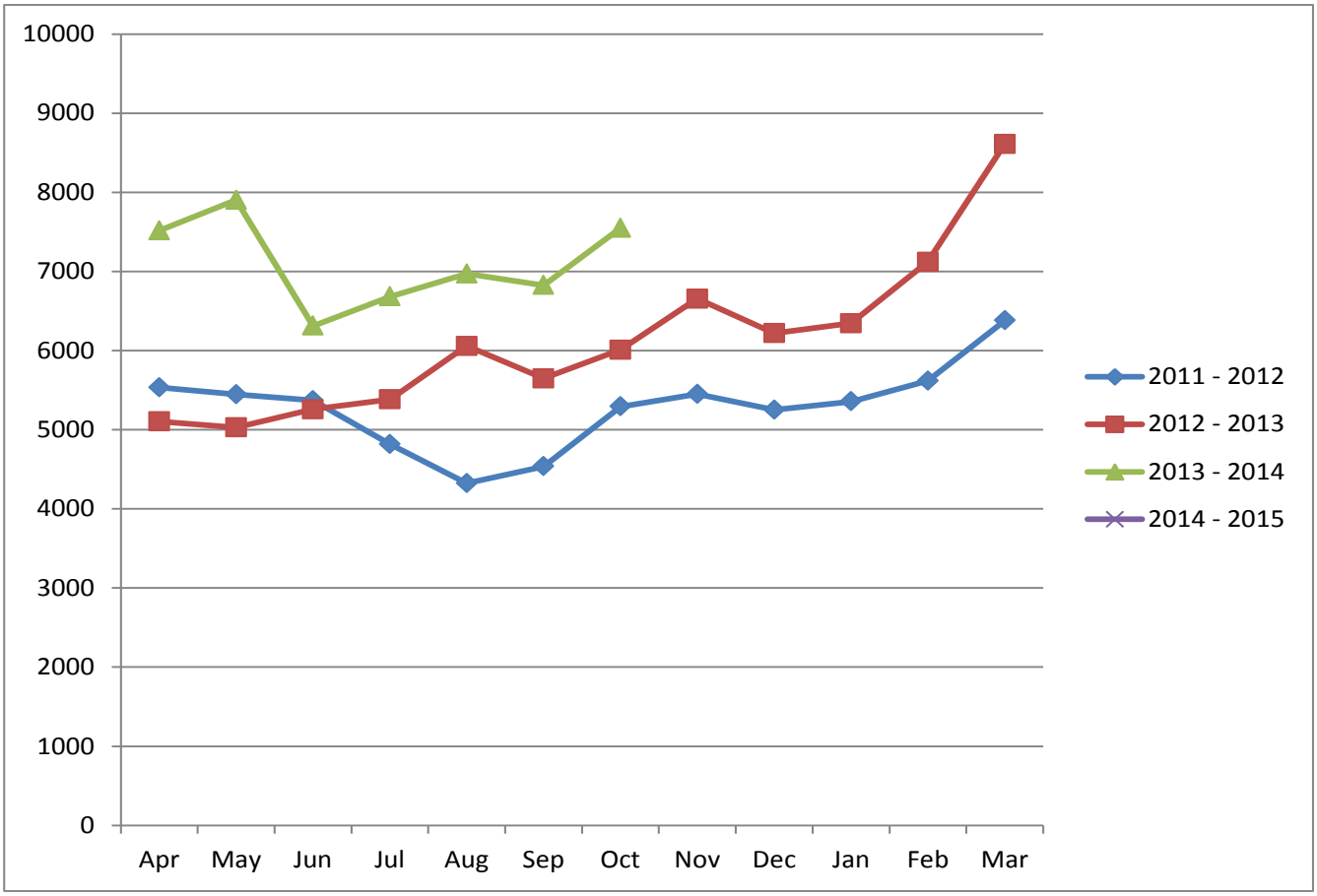


Figure 20: *Total Bank & Agency Use Nursing*

5 CLINICAL EFFECTIVENESS

5.1 Mortality

As part of the Trust's annual contract agreement with the commissioners the Trust has agreed a CQUIN scheme which requires the Trust to review 80% of adult inpatient deaths within 42 working days. 42 days have to elapse after the end of the reported month so that all deaths which occurred within the month can be included.

By the end of October the mortality reviews for deaths during the month of August were completed. This is the most recent month for which complete data is available. The Trust reviewed 81.3% of deaths compared with a target trajectory for the month of 80%.

This is the second consecutive month that the Trust has exceeded the target of 80%. This is because of an increased focus on directed performance management interventions. The Medical Director's Team is also producing personalised weekly prompt messages to remind consultants to carry out their allocated reviews.

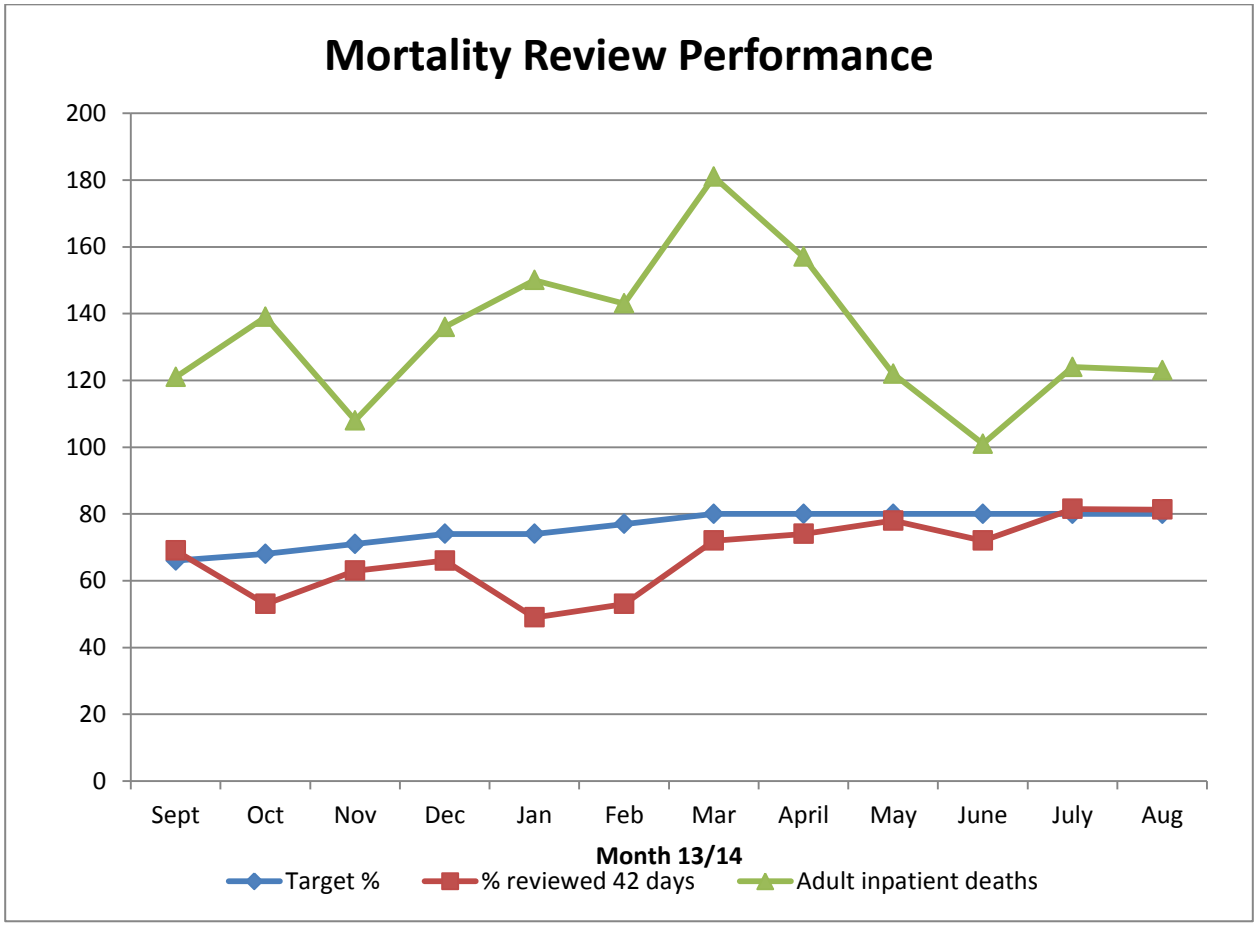


Figure 21: *Mortality review performance 2013/14*

2013/14	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Target %	66	68	71	74	74	77	80	80	80	80	80	80
% reviewed within 42 days	69	53	63	66	49	53	72	74	78	72	81.5	81.3
Adult inpatient deaths	121	139	108	136	150	143	181	157	122	101	124	123

HSMR (Source: Dr Foster)

The Hospital Standardised Mortality Ratio (HSMR) is a standardised measure of hospital mortality and is an expression of the relative risk of mortality. It is the observed number of in- hospital spells resulting in death divided by an expected figure.

The Trust's HSMR for the most recent 12-month cumulative period is 92.7 and remains beneath the lower statistical confidence limit. The HSMR for the City site is 79.9 and 105.9 for the Sandwell site. The Sandwell site HSMR has increased slightly but remains within statistical control limits. The HSMR of the SHA (Peer) remains higher than that of the Trust at 101.7.

Summary Hospital – Level Mortality Indicator (SHMI)

The SHMI is a national mortality indicator launched at the end of October 2011. The intention is that it will complement the HSMR in the monitoring and assessment of Hospital Mortality. One SHMI value is calculated for each trust. The baseline value is 1. A trust would only get a SHMI value of 1 if the number of patients who die following treatment was exactly the same as the number expected using the SHMI methodology. SHMI values have also been categorised into the following bandings.

1	where the Trust's mortality rate is 'higher than expected'
2	where the trust's mortality rate is 'as expected'
3	where the trust's mortality rate is 'lower than expected'

The last SHMI data was published on 29/10/13 for the period April 12 – March 13. For this period the Trust has a SHMI value of 0.97 and was categorised in band 2.

7 trusts had a SHMI value categorised as 'higher than expected'
17 trusts had a SHMI value categorised as 'lower than expected'
118 trusts had a SHMI value categorised as 'as expected'

In addition**,** the UHBT Healthcare Evaluation Data (HED) tool provides data in month based on the SHMI criteria. The SHMI includes all deaths up to 30 days after hospital discharge. The Trust SHMI is currently 97.8 for the most recent period for which data is available, and this is consistent with recent reporting periods.

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Mortality table

		2012/13			2013/14			
		Jan	Feb	Mar	Apr	May	June	July
Internal Data:								
Hospital Deaths	Trust	157	148	179	158	123	103	126
	City	64	69	75	64	44	43	46
	Sandwell	92	79	104	94	79	60	80
Dr Foster 56 HSMR Groups:								
HSMR (Month)	Trust	81.4	102.5	103.7	93.9	82.9	87.8	94.8
	City	73.9	89.1	85.1	75.1	66.4	77.9	65.9
	Sandwell	88.3	121.4	124.9	112.0	98.4	98.7	124.4
HSMR (12 month cumulative)	Trust	87.8	88.1	88.9	89.1	88.4	92.2	92.7
	City	78.2	77.2	78.1	77.5	77.3	80.6	79.9
	Sandwell	99.7	99.3	100.2	101.2	100.1	104.2	105.9
HSMR (Peer SHA 12 month cumulative)		96.7	97	98.0	97.5	97.6	101.9	101.7
Healthcare Evaluation Data (HED) SHMI (12 month cumulative)		94.3	95.5	95.9	99.2	98.1	97.2	97.8

CQC Mortality Alerts received in 2013/14

The Trust received notification from the CQC of being an outlier for the Maternity indicator 'puerperal sepsis and other puerperal infections within 42 days of delivery'. The Commission has requested further information from the Trust in order to investigate the matter further. This includes conducting a case note review of a sample of relevant cases. This work has commenced and the deadline for the submission of relevant information is 12/12/13.

Dr Foster generated alerts)

In the data period September 2012 – August 2013 there were no new diagnoses groups within the HSMR basket alerting with a significant variation from the benchmark.

National Clinical Audit Supplier – Potential Outlier Alerts

No new potential outlier alerts have been notified.

5.2 Clinical Audit

Clinical Audit Forward Plan 2013/14

The Clinical Audit Forward Plan for 2013/14 contains 79 audits that cover the key areas recognised as priorities for clinical audit. These include both the 'external must do' audits such as those included in the National Clinical Audit Patient Outcomes Programme (NCAPOP), as well as locally identified priorities or 'internal must do' audits.

Status as at end of October 2013	Total
0 – Further Information requested	1
1 - Audit not yet due to start	4
2- Significant delay	1
3- Some delay - expected to be completed as planned	11
4- On track - Audit proceeding as planned	41
5- Data collection complete	10
6- Finding presented and action plan being developed	1
7- Action plan developed	9
D- Discontinued	1
Grand Total	79

The status of the audits that have been included in the plan as at the end of October 13 is shown in the table above. No further audits have been identified as experiencing 'significant delay'.

5.3 Compliance with the 'Five Steps for Safer Surgery'

Close monitoring of compliance with the WHOCL continues. Performance for September was 99.6% across all areas.

5.4 Stroke care

Performance against the principal stroke care targets was as outlined in the table below at the end of October. The validated data for the % admitted to a stroke unit within 4 hours of arrival at hospital are not yet available for October (13/11/13).

Month 2013/14	target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
% Spending >= 90% of stay on stroke unit	83%	88.3	96.23	91.5	95	91.5	94.6	90.5					
% Admitted to stroke unit within 4 hrs of arrival at hospital	90%	69.35	84.1	92.3	92.1	76.3	72.1	Not available					
% pts receiving brain imaging in 24 hrs of presentation	100%	93.18	86.1	85.2	85	95.7	97.7	95.9					
% Pts scanned within 1 hr of presentation	50%	61.54	63.2	67.3	64.1	71.1	71.7	69.4					
% high risk TIA treated within 24 hours	60%	66.6	63.2	81.3	83.3	72	75.9	65.5					
% low risk TIA treated within 7 days	60%	74.07	88.4	88.2	91.2	92.5	87.9	83.3					

Figure 22: *Performance against stroke care targets (data Trust Performance Report13/11/13)*

5.5 Treatment of Fractured Neck of Femur within 24 hours

The Trust has an internal Clinical Quality target whereby 85% of patients with a Fracture Neck of Femur receive an operation within 24 hours of admission. Data for October (Source- QMF Dashboard *12/11/13*) indicates 89.5% of patients with a Fractured Neck of Femur received an operation within 24 hours of admission. *Internal Priority*

5.6 Ward Reviews

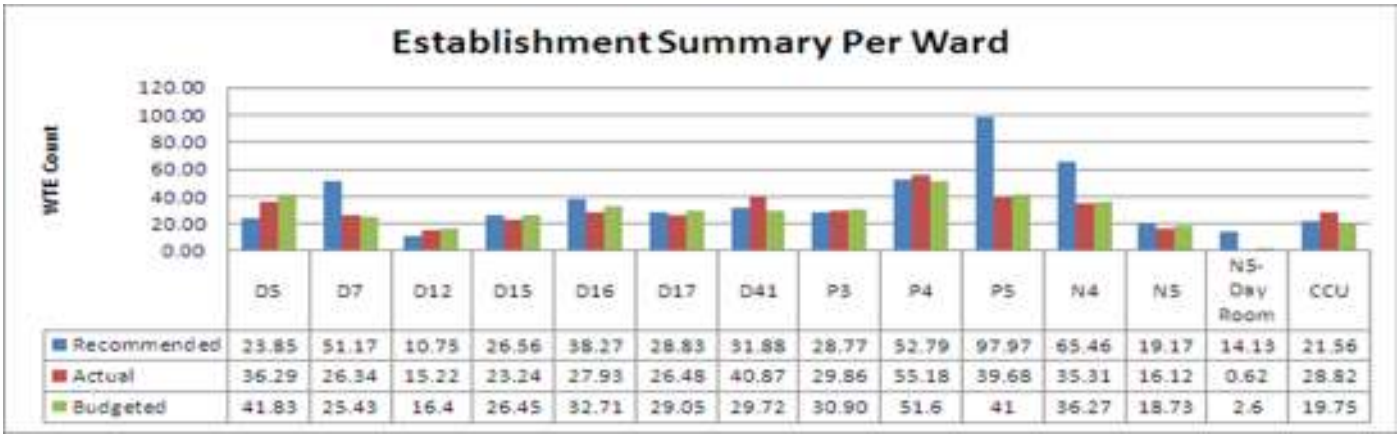
The Ward Review results are not for reporting this month.

5.7 Quality Audits

The Quality Audits are not due for reporting this month.

5.8 BRAD/SNCT (acuity tool) Summary

Medicine



	D5	D7	D12	D15	D16	D17	D41	P3	P4	P5	N4	N5	N5-Day Room	CCU
Recommended	23.85	51.17	10.75	26.56	38.27	28.83	31.88	28.77	52.79	97.97	65.46	19.17	14.13	21.56
Actual	36.29	26.34	15.22	23.24	27.93	26.48	40.87	29.86	55.18	39.68	35.31	16.12	0.62	28.82
Budgeted	41.83	25.43	16.4	26.45	32.71	29.05	29.72	30.90	51.6	41	36.27	18.73	2.6	19.75

Miscellaneous

Surgery A

6 PATIENT EXPERIENCE

6.1 Friends and Family Test

SWBH NHS Trust's Friends and Family Test (FFT) results – October 2013

The Trust has made good improvements in response rates with the overall FFT responses increasing by 10% in October 2013 compared to the previous month. This can be largely attributed to the blended patient feedback approach now being used which includes electronic surveys via ipads on the inpatient wards, SMS/text solution and Token Survey Box system on the Emergency departments and a postal/SMS/ipads combination for the Maternity Services. The Maternity Services joined the FFT programme from October 2013.

The overall October 2013 Trust FFT score (Inpatients + ED) dropped by 4 points to 54 which reflected the decrease in the ED FFT score for this month.

FFT result figures for October 2013

Trust combined Response Rate *(Inpatients + ED)*: 23.41%

Trust combined FFT Score (Inpatients + ED): 54 based on 2630 responses

Inpatients response rate: 29.2%

Inpatients FFT Score: 71 based on 925 responses

A&E response rate: 21.1%

A&E FFT Score: 46 based on 1705 responses

Maternity response rate: 9.04% (*started Oct 13*)

Maternity FFT Score: 48 based on 160 responses

Figure 23: *FFT results and response rates Apr 13 – Oct 13*

Adult Inpatients, Emergency Department and Maternity Services
Comparison of FFT Scores

Note: The Maternity Services joined the FFT survey programme from October 2013
Figure 24:*Net Promoter position & Friends and Family Test*

6.2 Complaints

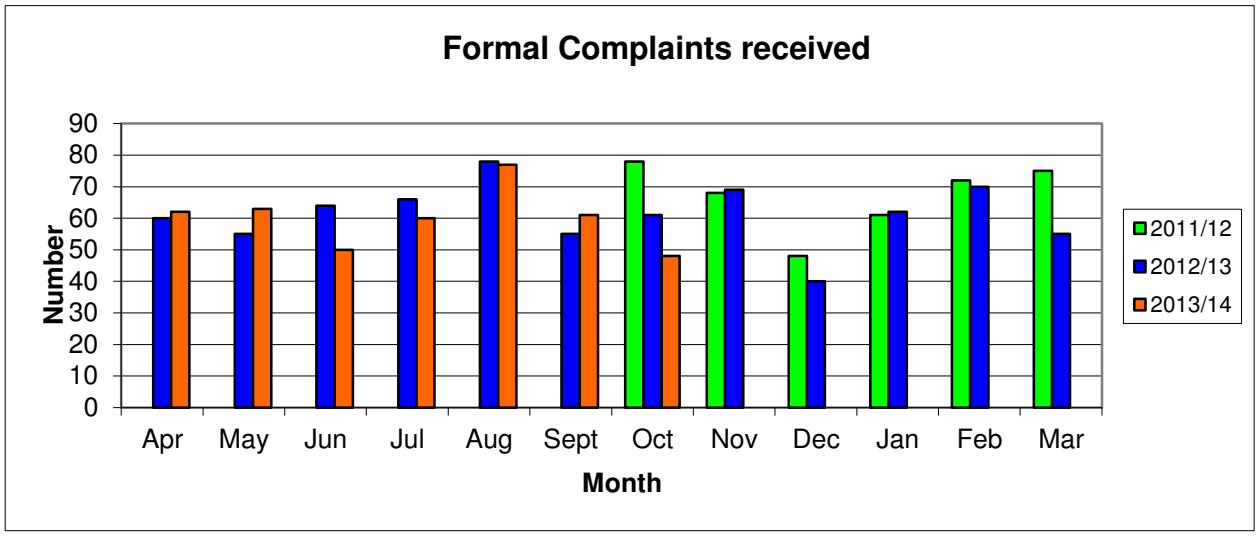
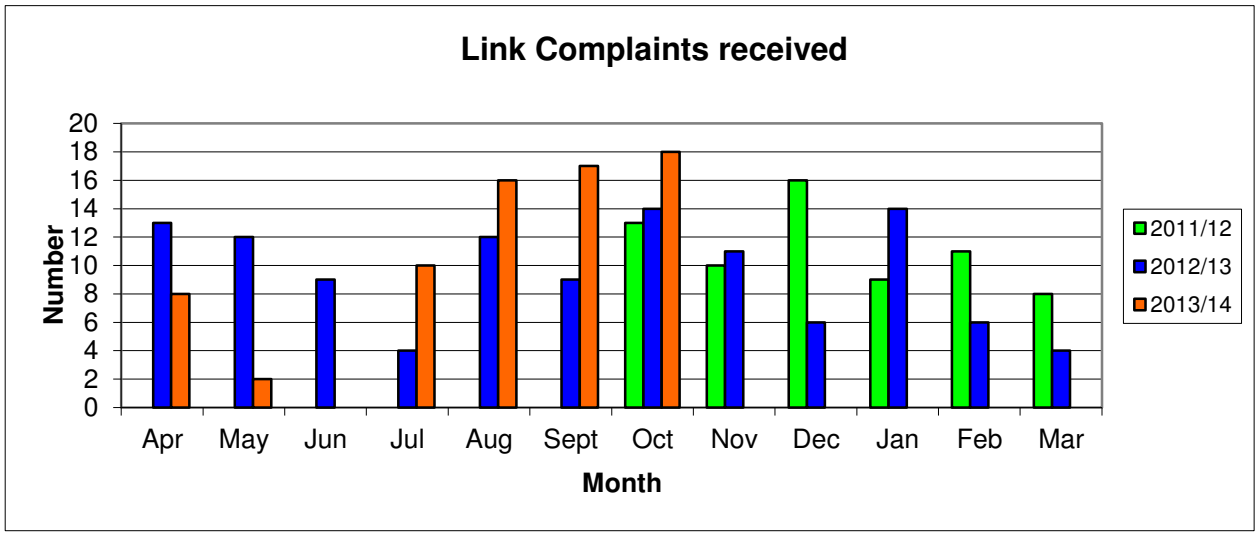


Figure 25: *Complaints received 2011/12 – 2013/14*



***Link complaint**: the complainant has received the substantive response to their complaint but has returned as they remain dissatisfied and/or require additional clarification.*

Figure 26: *Link complaints received 2011/12 – 2013/14*

Complaints comparative data

Context

The total formal and link complaints received requiring a response in October 2013 (n =66) has reduced compared with September 2013 (n = 78).

October 2013 shows a decrease in formal complaints received when compared with the same month last year (n = 61). There is a slight increase in link cases.

A review of the Link cases received in September 2013 is being carried out to identify any themes or trends in view of the slight increased numbers since June 2013.

Categorisation

The 48 formal complaints received in October 2013 were graded as follows:

Red		**Amber**	**13**	**Yellow**	**18**	**Green**	**11**
Level 4		**Level 3**		**Level 2**	**4**	**Level 1**	**2**

Themes
The top 5 themes are: Dissatisfied with Medical treatment (n = 14) Breakdown in Communication (n=6) Dissatisfied with Nursing care (n = 4) Attitude of staff (n = 5) Failure/Delay in Diagnosis (n = 3)

Learning
The complaints received in October are in the process of being investigated. Learning from complaints September include: Infection control issues - Action plan is in place to raise awareness amongst staff to regularly audit the environment. Staff identified with consistent non-compliant practice in this area will be required to attend relevant mandatory training updates and will be observed to ensure compliance. Training for staff identified in relation to customer focus practices The prescribing of Co Codamol with a documented allergy and in conjunction with Paracetamol will be shared with medical staff as a learning case and fed back to junior doctors as part of the on-going governance programme. All the nurses on EAU to ensure that all checks are made when dispensing medication. For patients discharged on a Sunday at Sandwell, staff reminded to check that patients are able to collect their medication.

6.3 Parliamentary and Health Service Ombudsman (PHSO)

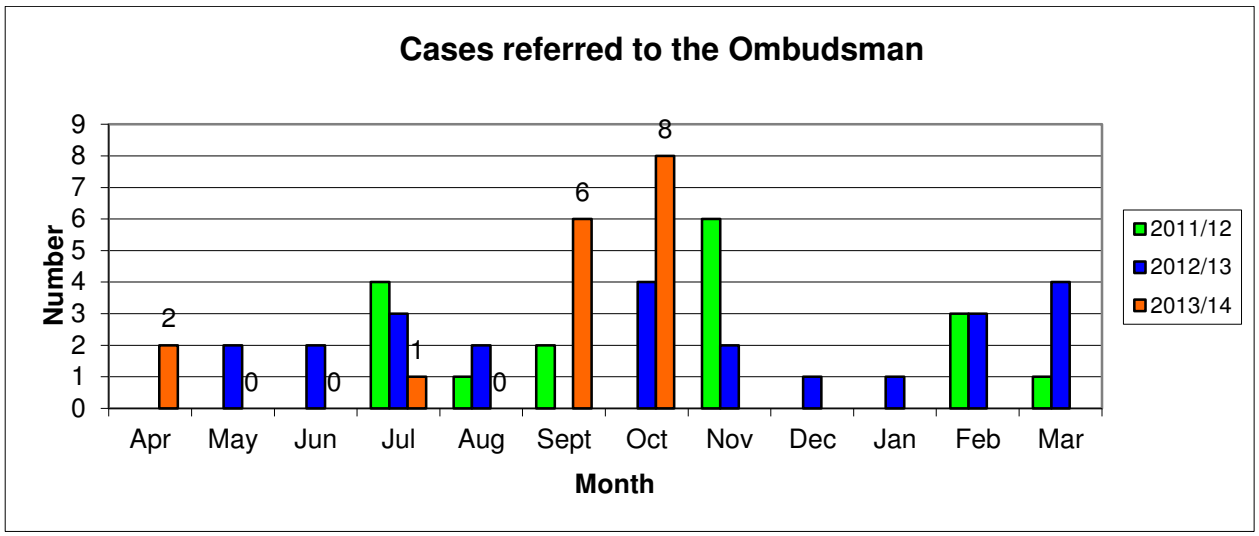


Figure 27: *Cases referred to the Ombudsman 2011/12 – 2013/14*

The Trust currently has 8 active cases with the PHSO

6.4 PALS

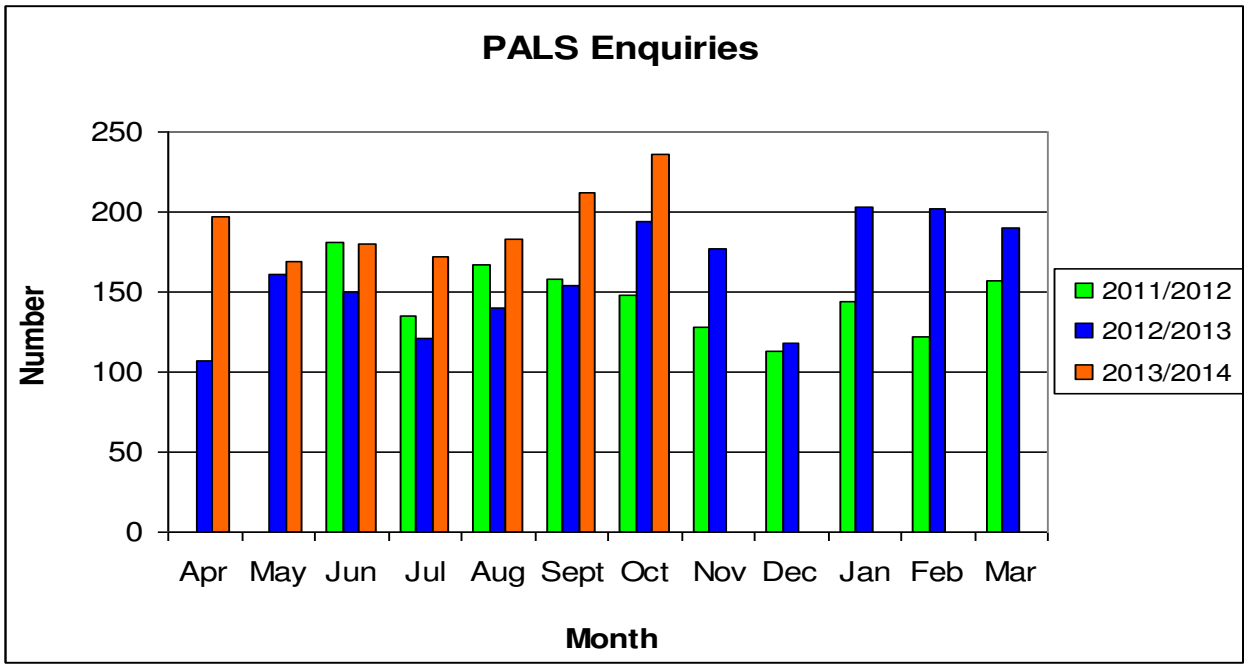


Figure 28: *PALS cases 2011/12 – 2013/14*

PALS comparative data

Context

Total PALS enquiries received in October 2013 (n=236) have increased when compared to September 2013 (n=212). There was 1 PALS case related to the community.

October 2013 also shows a **significant increase** compared with the same month last year (n =194). However, the Patient Support Centre also deals with general enquiries and these were significantly increased October (2012/13 n = 189 compared with October 2013/14 n = 257).

Themes

The top 5 themes are:

- Issues relating to clinical treatment
- Cancellation of appointments, mainly relating to cancellation, delays and notification of appointments.
- Issues relating to the request for formal complaints advice.
- Lack of communication, mainly with relatives.
- Formal Complaints, mainly regarding advice, process or referral.

Learning

In October 2013, PALS have investigated concerns and have assisted with a number of initiatives to improve the patient experience including:

Issue raised by a patient who attended ED, felt that despite him being triaged quickly, he remained dissatisfied with the length of time he was left without being seen by a Doctor, felt that he should have been given pain relief, as an immediate form of treatment. Patient felt that this should be highlighted with staff. Patient's experience and journey via A/E sent to Matron who agreed to highlight this with staff , highlighting the importance assessing the need for pain relief at an early stage, depending on symptoms patient is admitted with.

Patient under-going chemotherapy treatment, had routine blood test and experienced problems, advised by emergency helpline to attend ED. On arrival patient felt that waiting time was unacceptable and self discharged. Details forwarded to Matron who advised that a flowchart had been devised to help staff to assess the importance of timely assessments for cancer/chemotherapy patients.

6.4 End of Life

End of Life Report

The number of patients achieving their preferred place of care/death irrespective if they were on the SCP for September was 81%.

Apr-13	81%
May-13	76%
Jun-13	80%
Jul-13	64%
Aug-13	76%
Sep-13	81%

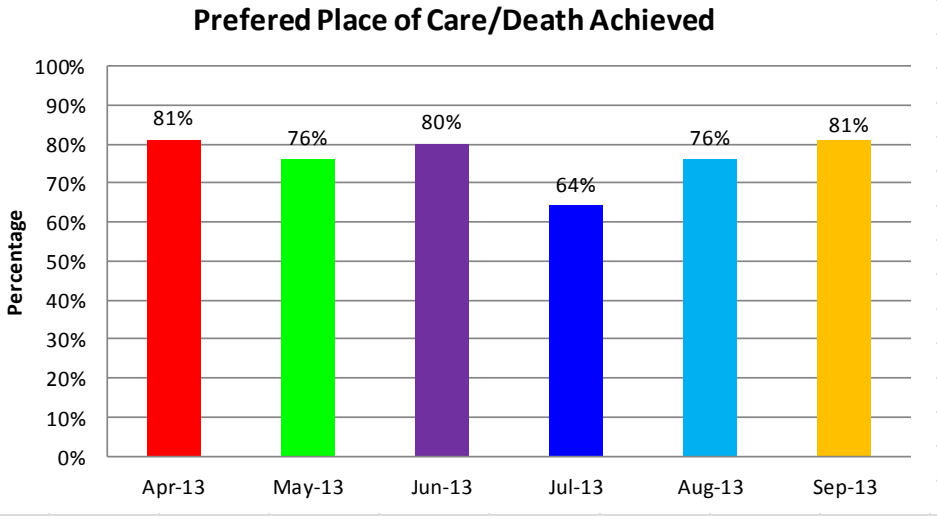


Figure 29: *Place of Care/Death achieved Apr 13 – Sep 13*

7 RECOMMENDATION

The Quality & Safety Committee is asked to:

NOTE in particular the key points highlighted in Section 2 of the report and **DISCUSS** the contents of the remainder of the report.

APPENDIX 1

Glossary of Acronyms

Acronym	Explanation
CAUTI	Catheter Associated Urinary Tract Infection
C Diff	*Clostridium difficile*
CRB	Criminal Records Bureau
CSRT	Clinical Systems Reporting Tool
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
ED	Emergency Department
DH	Department of Health
HED	Healthcare Evaluation Data
HSMR	Hospital Standardised Mortality Ratio
HV	Health Visitor
ID	Identification
LOS	Length of Stay
MRSA	Methicillin-Resistant Staphylococcus Aureus
MUST	Malnutrition Universal Screening Tool
NPSA	National Patient Safety Agency
OP	Outpatients
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
RAID	Rapid Assessment Interface and Discharge
RTM	Real Time Monitoring
SHA	Strategic Health Authority
SHMI	Summary Hospital-level Mortality Indicator
TIA	Transient Ischaemic Attack ('mini' stroke)
TTR	Table top review
UTI	Urinary tract infection
VTE	Venous thromboembolism
Wards:	
EAU	Emergency Assessment Unit
MAU	Medical Assessment Unit
D	Dudley
L	Lyndon
N	Newton
P	Priory
A&E	Accident & Emergency
ITU	Intensive Therapy Unity
NNU	Neonatal Unit
WHO	World Health Organisation
WTE	Whole time equivalent
YTD	Year to date

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Quarter 3 update**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Simon Grainger-Payne, Trust Secretary**
DATE OF MEETING:	**28 November 2013**

EXECUTIVE SUMMARY:

The combined Quarter 1 & 2 update on the plans to address the gaps in control and assurance against the risks to the delivery of the Trust's annual priorities is attached.

The pre-mitigation risk scores are taken directly from the risk assessments prepared by the Executive Directors for those annual priorities for which they are individually responsible in 2013/14.

The Board is asked to note that those risks rated as red, following the closure in the gaps in control and assurance relate to:

Alignment of the Trust's FT application with MMH timescales given the overlap between required outputs for both processes

The Board will note that risk assessments remain awaited for a number of entries and these will be completed for the next update of the BAF which will be presented the Audit Committee in December 2013.

Work is underway to consider how the BAF may be more strategically used in future and in particular the linkage to the work planned to strengthen the Trust's risk management culture and Board's focus on key risks.

REPORT RECOMMENDATION:

The Board is asked to receive and accept the Board Assurance Framework and measures in place to address the gaps in control & assurance where relevant

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

Relates to all annual priorities

PREVIOUS CONSIDERATION:

Routine quarterly update

Sandwell and West Birmingham Hospitals NHS
NHS Trust

BOARD ASSURANCE FRAMEWORK 2013/14 – QUARTERS 1 & 2 UPDATE

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
Provide the detail of the annual priority 2013/14 to which this entry relates	*Which member of the Executive Group is responsible for the delivery of the annual priority?*	*Which Board or Committee considers a report discussing the risk and its management?*	*What factors could prevent the priority being achieved?*	*What controls or systems do we have in place to assist in securing the delivery of the priority and managing the associated risks?*	*Provide examples of recent initiatives or reports considered by the Board and/or Committee where delivery of the priorities is discussed AND where can the Board gain evidence that the controls and systems are effective to manage the risks and secure delivery of the priority?*	*What gaps in systems, controls and assurance have been identified?*	*What actions are planned and what progress has been made to address the gaps identified?*	*When will the action be completed?*	*Which standard/ aim/ target does the risk relate to or in which other document is the risk reported?*	*Before the actions to address the gaps in control & assurance have been taken , what risk severity score applies?*	*After the actions to address the gaps in control & assurance have been taken, what risk severity score applies ?*
STRATEGIC OBJECTIVE 1:		**SAFE, HIGH QUALITY CARE**									
Deliver Year 2 of the Quality & Safety strategy	MD	Quality & Safety Committee	Lack of clarity about the standards to be achieved in the Q&S Strategy Lifespan Objective (Dec 12)- many remain TBC. The level of risk varies between quality goal.	A structure of clinically led committees is in place to oversee the quality and safety agenda from all aspects of the organisation.	Performance is measured and reported against plan. Action plans are agreed and completion of actions is reviewed at the	Changes in systems and reporting hierarchies have led to some lack of clarity in reporting responsibilities. Additional	Clear communication of expectations, TOR & membership.	By end Q3	Risk management, Quality & Safety, PH development committee, patient safety committee, clinical Effectiveness	**16**	**12**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				The Q&S Board Committee is the principal mechanism of board level scrutiny of quality and safety issues of concern and debate are escalated to Trust board. The Trust is also scrutinised by the CCG at the CQRM	committees review cycle.	committees have been set up for which the TOR and membership is still under development eg Public Health, community Development & Equality committee					
Deliver all CQUINs	MD/CN	Mortality, VTE, Sepsis, MQuAC Quality & safety Committee	Non achievement of CQUINs. This can be due to lack of focus on the achievement of patient safety measurements e.g. VTE, sepsis six, think alcohol, Mortality reviews	Significant resources are going into supporting clinicians to carry out data recording and developing computer-aided systems to reduce bureaucracy.	Quarterly CQUIN confirm & challenge meeting with execs	No framework yet in place for the meetings and CQUINs at different stages of development.	Ensure frameworks are developed and action plans are rigorously followed up.	By end Q3	National CQUIN and local contract agreements	**12**	**12**
STRATEGIC OBJECTIVE 2:		**ACCESSIBLE & RESPONSIVE CARE**									
Deliver Year 1 of the Dementia Strategy and support to carers	CN	Quality and Safety	Environmental works not being completed by deadline of 31st March 2014.	Project team continues to negotiate with Group directors and contractors	2 weekly environmental meetings	N/A	N/A	By end of quarter 3	DH conditions on environmental monies	**15**	**12**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
			Delay in recruitment of Activity co-ordinators and use of DTRS software. Non-achievement of quality and CQUIN standard of 90% in 3 consecutive months of the memory screening tool. Survey of carers developed and distributed to wards - poor uptake and return.	timescales. Staff have been booked as agency staff to increase activity and DTRS delivered to MFFD ward for use. Waiting EBMS icon All adults to be asked memory screening question On-going raising awareness of carer survey	Weekly audit instead of monthly Confirm and challenge meetings with CN				received. CQUIN agreements		
Develop comprehensive marketing plans for at least three services	DSOD		Failure to develop comprehensive marketing plans for at least three services resulting in the inability to actively promote and target services to particular audiences	Criteria identified and process commenced	Programme commenced and initial work in developing marketing strategies has started	Programme for wider strategy development not established	Additional interim resource to support this process secured	March 2014		9	6
STRATEGIC OBJECTIVE 3:		**CARE CLOSER TO HOME**									
Reconfigure a number of services across acute & community to provide integrated	DSOD	MMH & Configuration CLE Sub Committee Configuration	***Delay in reconfiguration across & community will***	Change in management structures to combine specialist	Bi-monthly reports to Configuration Board Committee		Clarify how new structures (in Medicine & Emergency Care and Community &	Q4	2013/14 annual priority: to reconfigure a number of	**16**	**12**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
care		Board Committee	***Continue to:*** Duplicate services, assessment, investigations etc.; Offer patients disjointed services in an acute central service when care closer to home may be possible. ***Delay in acute service reconfiguration cross site*** could impact on sustainability of the service ahead of MMH. ***Reconfiguration itself*** may have an adverse impact on sustainability.	community services with relevant specialist acute service & combine acute and community therapy services in one clinical group Agreed process for reconfiguration Early & on-going staff engagement & liaison with JHSC, CCG, GPs, patients and any other key external stakeholders Robust project management methodology & reporting with relevant external Gateway Reviews Formal public consultation where appropriate External Benchmarking/	(from Oct 13)		Therapies) will deliver greater integration across acute and community. Early identification (via Specialty Strategies) of potential reconfiguration. Oversight by MMH & Configuration CLE Committee.	Q3 & on-going Bi monthly from Nov 13	services across acute & community to provide integrated care		

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				cross reference							
Implement a number of 'Right Care, Right Here' pathways	DSOD	MMH & Configuration CLE Sub Committee Configuration Board Committee	RCRH pathways are not implemented or delivered or activity significantly departs from the trajectory. Adverse impact on delivery of QIPP savings and relationships with GPs/CCG.	QIPP Savings target embedded in 2013/14 contract along with broad scheme headings. Contract for 2013/14 includes block contracts with tolerance thresholds Income removed within SWBH financial plan & level of TSP takes account of this loss of income Agreed list of procedures of limited clinical value. . Activity reduction targets based	Regular QIPP scheme meetings with external stakeholders	Corporate overview of progress Clear implementation plans at specialty level	Bi-monthly reports against RCRH trajectory to Configuration Board Committee Clear process for implementation of agreed POLCV agreed with CCG via Joint Clinical Commissioning Group Respond to new commissioning specifications for RCRH pathways - Dermatology. Agree revised Activity and Capacity Model that underpins LTFM with CCG. Implement new model of care in	From Dec 13 Q3 Q4 Q3 Q3	Risk: 1107EXE09	**16**	**12**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				on benchmarked data RCRH pathway review programme and governance structure			Diabetes.				
STRATEGIC OBJECTIVE 4:		**GOOD USE OF RESOURCES**									
Deliver a 1-2% surplus	DFPM	Finance & Investment Committee considers this ad other financial risks as a standing item on its routine agendas	Unforeseen reductions in income where activity falls well below plan. Excessive costs owing to capacity and/or recruitment constraints. Non delivery of annual efficiency savings plans.	Risk sharing agreements with commissioners. Use of contingency reserves. System of close monitoring and requirement to identify mitigating savings schemes.	Preparation and presentation of detailed financial reports (TB) and transformation plan progress reports to F&I.	Contract review meetings planned with main commissioner to review activity and performance as its position is under pressure.	Gaining clarity internally and externally on final winter pressure allocation funds and outturn forecasts so that each party can executive financial management strategies.	Q4 – 13/14	Use of Resources	**12**	**6**
Enable clinically-led decision-making processes via SLR as part of SLM	DFPM	Clinical Leadership Executive via the AAF (autonomy & accountability framework)	No decision on the systems required to support the absorption of SLR into performance management regime which supports the AAF. Sufficient personnel in place to move project forward.	SLR information provided to F&I Committee as well as incorporated into Group reviews and ultimately CD based reviews. Temporary staffing specification being scoped.	MD&FD finalised front end system procurement decision made. Technical group established.	Timeline in development for integration of costing systems with front-end SLR reporting.	Internal resourcing case agreed. Consider secondments and/or use of temporary external personnel	6 month implementation planned.	Use of Resources	**8**	**6**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
STRATEGIC OBJECTIVE 5: 21ST CENTURY FACILITIES											
Refresh the financial modelling for MMH via PF2	DFPM	F&I committee 22nd November 2013, Trust Board 28th November 2013	Inability to identify an affordable solution and identify acceptable efficiency levels. Ensuring sufficient capacity with central planning team.	Construction of base and mitigated downside LTFMs with robust assumptions and plan detail supporting plans. Incorporating a ceiling limit on MMH capex and resultant UP.	Culminating presentation of detailed planning papers at committee and Trust Board with disclosure of planning parameters and costs	Further work ongoing on vfm elements of PF2	Project Director preparing output of risk transfer work to compliment other considerations by the Board	Q3-13/14	21st Century facilities	**8**	**6**
Maintain estates compliance with CQC Outcome 10 (Safety & suitability of premises) and 11 (safety, availability and suitability of equipment)	DENHP	CQC External Assurance – Capita	Failure to demonstrate compliance and/or actual failure of environmental issue impacting on patient care	Risk management and safe systems of works	Appointment of external assurance company	None identified				**9**	**4**
Invest in the estate through capital schemes to support clinical strategy and in particular Pathology, Endoscopy & Stroke	DENHP	Configuration Committee	Failure to meet capital programme and environmental improvement	Project management arrangements	Project plans. Project cash flow	Not achieving planned cash flow	Performance management of Capital Project Leads			**6**	**4**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
STRATEGIC OBJECTIVE 6:		**ENGAGED & EFFECTIVE ORGANISATION**									
Deliver the milestones in the Foundation Trust timeline	DSOD	FT Programme Team	Failure to deliver milestones and adhere to key timescales as agreed with the TDA. This will result in escalation of the Trust's progress with the FT application to the NTDA respectively	Dedicated programme management in place Review of milestone delivery fortnightly at FT programme Team Monitor delivery of Integrated Development Plan (IDP) on a monthly basis which looks to incorporate all areas of work/actions required to support delivery of a successful FT application	Progress monitored and escalated via FT Programme Team on a fortnightly basis	None identified	None identified	July 2014		**20**	**8**
		FT Programme Team	Alignment of the Trust's FT application	A review of timescales for	Progress monitored and	None identified	None identified	July 2014		**20**	**16**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
			with MMH timescales given the overlap between required outputs for both processes	both processes has been undertaken A high level project plan incorporating both programmes has been developed to ensure key activities and dependent activities are aligned A revised timeline for FT has been developed and informally agreed with the NTDA which ensure the scheduling of key deadlines for both processes are harmonised.	escalated via FT Programme Team on a fortnightly basis						

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
Improve the Trust's performance in the National Staff Survey	DSOD	Workforce Delivery Committee Workforce & OD Committee	Reputational risk if staff do not advocate their service and place of work Poor regulatory performance ratings e.g. CQC	Implement Workforce strategy through annual work programme 2013/14 Continue to embed LiA methodology Implement staff survey improvement action plan	Staff survey outcomes (annual NHS staff survey and monthly employee polling through 'Your Voice'	Poor response rates to staff surveys means that there is limited information available to gauge opinion	Enhance communication process for surveys Robust feedback and action planning process ('You said, we did')	31-Mar-14	National staff survey Reports presenting results of 'Your Voice'	**12**	**8**
Attain 10% better than the national mean for sickness/ absence rates	DSOD	Workforce and OD Assurance Committee	Adverse impact of sickness absence on quality of care, staff satisfaction and cost.	Detailed action plan. Including: Focused attention on hot spot areas. Rigorous delivery of key sickness absence stages. Management training. Case management of non-nursing/midwifery long-term sickness cases from 3 months plus. Case management of	Action plan monitored via Workforce Operational Committee. Group performance monitored via Group Reviews. Trust sickness % for nursing and midwifery has deteriorated from 4.69% in April '13 to 5.07% in Sept '13 which triggered the decision to case	Key issue identified is timely and consistent management intervention in accordance with policy requirements and inability for current systems to easily record/report.	Delivery of IT system is seen as critical to support this and enable focused case management activity. An IT solution is being developed with Kronos Ltd through SMART.	Q2 2014	Reported in the corporate performance dashboard on a monthly basis	**9**	**6**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
				nursing and midwifery long term sickness cases from 1 month plus Development of an IT solution to support managers. Table top review of cases longer than 9 months.	manage nursing and midwifery sickness cases from one month. National information centre is currently reporting national sickness data up to March '13 - for nursing, midwifery and health visiting as 4.72%. Learning from Table Top Reviews shared with Group managers and HR team and where appropriate guidance material and training updated accordingly.						
Identify three Beacon Services: Gastroenterology	MD	Autonomy & Accountability framework-	Services performance both in quality and performance terms	Monitoring the Beacon Services performance	The BSs are required to provide	Specifically noting the services as BS's	Cross reference performance issues across all	quarterly	Exec review action notes	**4**	**4**

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
Breast Gynae Oncology		Executive review	drops below excellent standards. Services unable to access innovation funds due to financial constraints and bureaucracy. Prepare for the next round of Beacon Status services	across the qualitative and quantitative measures stipulated in their bids to attain Beacon status on quarterly basis. Planning the selection cycle well in advance of commencement of the required work. Working with Comms to ensure potential services are ready and prepared to submit bids.	evidence to achieving performance targets against plan. Utilising the A&A Framework Patient feedback and patient experience work. Regular Exec review with MDO team Project plan generation and progress checking.	at their exec performance reviews (although we might be). Seeking plans for further improvement.	domains in the Quality & Safety strategy as well as measuring against a variety of standards eg CNST, CQC, CQUINs, best practice standards.				

KEY:

CN	Chief Nurse
MD	Medical Director
COO	Chief Operating Officer
DENHP	Director of Estates/New Hospital Project
DSOD	Director of Strategy & Organisational Development
CIO	Chief Information Officer

RISK ASSESSMENTS REMAIN TO BE COMPLETED FOR THE FOLLOWING ENTRIES AND WILL BE POPULATED FOR THE NEXT UPDATE:

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
Provide the detail of the annual priority 2013/14 to which this entry relates	*Which member of the Executive Group is responsible for the delivery of the annual priority?*	*Which Board or Committee considers a report discussing the risk and its management?*	*What factors could prevent the priority being achieved?*	*What controls or systems do we have in place to assist in securing the delivery of the priority and managing the associated risks?*	*Provide examples of recent initiatives or reports considered by the Board and/or Committee where delivery of the priorities is discussed AND where can the Board gain evidence that the controls and systems are effective to manage the risks and secure delivery of the priority?*	*What gaps in systems, controls and assurance have been identified?*	*What actions are planned and what progress has been made to address the gaps identified?*	*When will the action be completed?*	*Which standard/ aim/ target does the risk relate to or in which other document is the risk reported?*	*Before the actions to address the gaps in control & assurance have been taken , what risk severity score applies?*	*After the actions to address the gaps in control & assurance have been taken, what risk severity score applies ?*
STRATEGIC OBJECTIVE 1:		**SAFE, HIGH QUALITY CARE**									
Improve emergency readmission rates	COO										
STRATEGIC OBJECTIVE 2:		**ACCESSIBLE & RESPONSIVE CARE**									
Consistently achieve the national A & E targets	COO										
Waiting times in at least 90% of specialities will be	COO										

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
at least as good as neighbours											
Increase the range of alternative models to face to face contact	COO										
Pilot the process of developing GP letters with a view to providing patients and GPs with clinical letters within two working days	COO										
STRATEGIC OBJECTIVE 3:		**CARE CLOSER TO HOME**									
Implement a virtual ward in the community	COO										
Establishing 15 wte Health Visitors posts and reduce caseload	CN										
STRATEGIC OBJECTIVE 4:		**GOOD USE OF RESOURCES**									
Deliver Year 2 of the Transformation Programme without compromising safety and quality of care	COO										
STRATEGIC OBJECTIVE 6:		**ENGAGED & EFFECTIVE ORGANISATION**									

Annual Priority	Executive Lead	Scrutiny/ Assurance Body	Principal Risk	What are we doing about it? *[Key Controls]*	How do we know we are doing it? *[Key Assurances]*	What are we not doing? *[Gaps in Control & Assurance]*	How can we fill the gaps or manage the risk better? *[Actions to address Gaps]*	Timescale	Cross reference	Risk assessment	
Review of Health Informatics systems and capabilities	CIO										

RISK SEVERITY MATRIX

1. **LIKELIHOOD:** What is the likelihood of the harm/damage/loss occurring?

LEVEL	DESCRIPTOR	DESCRIPTION
1	Rare	The event may only occur in exceptional circumstances
2	Unlikely	The event is unlikely to occur (remote chance)
3	Possible	The event may occur occasionally (25-50% likelihood)
4	Likely	The event is likely to occur (above 50% likelihood)
5	Almost Certain	The event will happen (and frequently)

2. SEVERITY: **What is the highest potential consequence of this risk?** ***(If there is more than one level, choose the highest)***

Descriptor	Potential Impact on Individual(s)	Potential Impact on Organisation	Financial Impact	Number of people affected	The potential for complaint / Litigation
Insignificant **1**	No / superficial harm	▸ No impact	▸ No litigation ▸ Less than £100 to reduce risk ▸ Financial risk less than £50K	Only 1 person	Unlikely to cause complaint / litigation
Minor **2**	Short term injury / damage e.g. injury that is likely to be resolved within one month Increased level of care 1-7 days	▸ Minimal risk to organisation	▸ Litigation between £100-£25k ▸ £100-£10k to reduce risk ▸ Financial risk £51k - £500k	Greater than 1 but less than 5 people	Complaint possible Litigation unlikely
Moderate **3**	Semi-permanent injury / damage e.g. injury that may take up to 1 year to resolve. Increased level of care 8-15 days	▸ Some disruption in service with unacceptable impact on patient ▸ Short term sickness	▸ Litigation between £25k-£250k ▸ £10k-£50k to reduce risk ▸ Financial risk £501K - £2M	Greater than 5 but less than 50 people	High potential for complaint Litigation possible but not certain.
Major **4**	Permanent injury e.g. Loss of body part(s). Loss of sight. Increased level of care over 15 days	▸ Long term sickness ▸ Service closure ▸ Service/dept external accreditation at risk	▸ Litigation between £250k-£1m ▸ £50k-£250k to reduce risk ▸ Financial risk £2M - £4M	Greater than 50 but less than 200 people	Litigation expected / certain Multiple justified complaints
Catastrophic **5**	Death Suspected Homicide Suicide	▸ National adverse publicity ▸ External enforcement body investigation ▸ Trust external accreditation at risk	▸ Litigation greater than £1m ▸ Greater than £250k to reduce risk ▸ Financial risk greater than £4m	Greater than 200 people	Multiple claims or a single major claim

3. RISK RATING: Use the matrix below to rate the risk *(e.g. 2 x 4 = 8 = Yellow, 5 x 5 = 25 = Red)*

ELEMENT OF RISK	SEVERITY				
LIKELIHOOD	**Insignificant 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
1 Rare	**1**	**2**	**3**	**4**	**5**
2 Unlikely	**2**	**4**	**6**	**8**	**10**
3 Possible	**3**	**6**	**9**	**12**	**15**
4 Likely	**4**	**8**	**12**	**16**	**20**
5 Almost Certain	**5**	**10**	**15**	**20**	**25**

Green = LOW risk **Yellow = MODERATE risk** **Amber = MEDIUM risk** **Red = HIGH risk**

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Finance & Investment Committee – Version 0.2

Venue D29 Meeting Room, City Hospital **Date** 20 September 2013; 0800 – 1000h

Present	In attendance	Secretariat
Ms Clare Robinson	Mr Mike Harding	Mr Simon Grainger-Payne
Mr Richard Samuda		
Mr Harjinder Kang		
Mr Robert White		
Ms Rachel Barlow		

Minutes	Paper Reference
1 Apologies for Absence	**Verbal**
Apologies for absence were received from Toby Lewis, Mike Sharon and Chris Archer.	
2 Minutes from the previous meeting	**SWBFC (8/13) 081**
The minutes of the meeting held on 23 August 2013 were accepted as a true and accurate record of discussions held.	
AGREEMENT: The minutes of the previous meeting were accepted as a true and accurate reflection of the discussions held	
3 Matters arising from previous meeting	**SWBFC (8/13) 081 (a)**
The Committee was asked to receive and note the action tracker. Mr White suggested that the NHS England seven day working guidance should be reviewed prior to presentation of an update on the implications of this to the Committee. Ms Robinson emphasised the need to consider the implications proactively, however and therefore it was agreed that a summary would be presented at a future meeting.	
3.1 Monitoring social services response times	**Verbal**
Miss Barlow advised that Social Services referrals that were made were responded to within 24 hours. It was highlighted that support on a seven day per	

week basis was being pursued with Social Services. Ms Robinson asked whether other measures were monitored, in addition to responding to referrals. Miss Barlow advised that delayed transfers of care performance was reported within the corporate scorecard. It was highlighted that holiday shortages and sickness could adversely impact performance and therefore planning by Social Services was underway.	
3.2 Double running of Pathology process	**Verbal**
It was reported that the use of the new Pathology analysers would take effect from 24 September however existing technology would continue to be used in parallel initially. Mr Samuda asked whether the financial impact of this 'double running' had been factored into the business case for the analysers. He was advised that although this was not the case, the financial exposure was very small. It was agreed that a further update be presented at the next meeting.	
ACTION: Miss Barlow to present a further update on the financial liability associated with the double running of the Pathology analysers at the next meeting	
3.3 Operational impact of use of bank and agency staff	**Verbal**
It was reported that the forecast financial position for the Medicine & Emergency Care took into account the operational impact of the use of bank and agency staff. Miss Barlow reported that recruitment was underway to alleviate the use of bank and agency staff where possible however. Ms Robinson noted that this effect was not yet reflected in the workforce figures within the financial performance report. Miss Barlow advised that there was an element of staff turnover that was offsetting to some degree the effect of the recruitment. It was agreed that an update on staff turnover and time to hire needed to be reviewed and provided at the next meeting. Ms Robinson asked what measures were in place to ensure that agency staff were not being used instead of bank staff. She was advised that all temporary staffing requests were processed centrally through the Trust bank. Miss Barlow advised that meetings were held weekly to review establishments and forecast use of bank & agency staff on key wards in Medicine & Emergency Care. The Committee discussed the recent media publicity around the proposals to publish nurse levels per ward. It was highlighted that this information was potentially misleading without the associated information on bed numbers.	
ACTION: Miss Barlow to present an update on financial implications of staff turnover and time to hire at the next meeting	
3.4 Progress with updating the Business Development Register	**Verbal**
Mr White tabled an update on the progress with the broadening of the business development register. It was highlighted that the register contained information concerning the management of existing contracts and could be used to provide a	

view of the contracts due to expire and inform the tendering process. Ms Robinson asked where the ownership of the contracts lay. She was advised that most were within the ownership of the Clinical Groups, although there were few individuals who could sign off contracts according to the Trust's Standing Financial Instructions & Standing Orders. Ms Robinson asked whether the contracts were audited to ensure that there were robust controls in place for the management of contracts. Mr White advised that at an individual level, contracts were closely managed, however no overarching audit or management process was in place. It was agreed that Mr White would seek a view as to how contract pricing using the catalogue management approach worked.	
ACTION: **Mr White to provide an update on contract pricing using the catalogue management approach**	
4 Trust financial management	
4.1 2013/14 Month 5 financial position, forecast forward income position and recurrent/non-recurrent view	**SWBFC (9/13) 083** **SWBFC (9/13) 083 (a)** **SWBFC (9/13) 083 (b)**
Mr White reported that in month the financial position had stabilised. It was noted that the adverse variance last month had attracted the attention of the Trust Development Authority. The Committee was advised that income performance had improved and some of the cost profile in the Medicine & Emergency Care Group moved favourably. Miss Barlow advised that the financial position and performance of the Group was improving. Cash was reported to remain healthy and commissioner positions were reported to remain stable. At a Group level, performance was reported to remain as expected, although the adverse position of the Sandwell Community Adult Health Group had been reviewed and had been identified to relate to non-pay expenditure predominantly, including the impact of incontinence produce spend. Ms Robinson asked how the incontinence stock supply and needs were being managed. Mr White noted that this was an area that required further investigation and attention. Ms Robinson suggested that the supply of these products by individual teams or individuals should be monitored. Miss Barlow advised that this was being considered with the Operations Director of the Sandwell Community Adult Health Group at present. Mr Kang suggested that this close monitoring should be extended to other products supplied by the Trust. Ms Robinson suggested that the protocol for collecting excess supplies from patients needed to be considered and encouraged the use of the Transformation Team to assist with reviewing the wider processes such as this. Miss Barlow advised that the Community Services area was supported by a dedicated Transformation resource. Ms Robinson asked how the additional Accident & Emergency funds would be reflected in the accounts. It was noted that the Trust had not yet been awarded the funds, although the local CCG had been successful with the bid. Mr White advised that some of the Trust's reserves had already been used to support the plans for preparing for winter and therefore the funds when received would be	

used to replace these committed reserves. Ms Robinson noted that SLA income was below plan, which it was noted reflected the lower Accident & Emergency admissions. Mr White advised that this had been taken into account in the longer term forecast. It was highlighted that a significant number of attendances were deflected using a GP triage service. Ms Robinson suggested that there was a need to educate the public to ensure that individuals attended primary care settings in preference to Accident & Emergency departments.	
4.2 Long term financial forecasting	**Verbal**
Mr White provided an update on the development of the long term financial model in the context of the Midland Metropolitan Hospital plans. It was highlighted that catchment loss had been factored into the model. It was reported that the model assumed a static RPI and should this rise, then the Financial Risk Ratings could be impacted. Ms Robinson asked that a standing item to be added to the agenda of future meetings to capture external factors which could affect the Trust's financial assumptions.	
4.3 Financial risks to the organisation, including delivery of CQUIN targets	**Verbal**
Mr Harding presented the list of CQUIN schemes, which he reported represented an overall of a value of c.£9m. It was noted that to date £1.25m had been secured, although an amount had also been lost due to under performance against some of the targets. It was highlighted that the achievement of four schemes was at risk amounting to £677k. It was noted that the annual staff survey results represented a further risk, although it was at present difficult to assess the level of risk associated with this. The Committee noted that the schemes were assigned to individual Executive leads, however a number were cross-cutting. The detail of the dementia CQUIN scheme was discussed, including the need for IT support.	
5 Transformation Plan	
5.1 TSP delivery report 2013/14	**SWBFC (9/13) 084** **SWBFC (9/13) 084 (a)** **SWBFC (9/13) 084 (b)**
The Committee received and noted the report. It was highlighted that delivery was largely on track, apart from the element associated with Sandwell Community Adult Health Group. It was reported that the schemes proposed by the Medicine & Emergency Care Group had been signed off from a quality and safety perspective by the interim Chief Nurse and the Medical Director. It was highlighted that a significant element was associated with outpatient efficiency.	

5.2 Progress update	**Verbal**
The Committee was provided with a future view of the delivery of Transformation Plan, including a number of innovations expected. Mr Kang suggested that a flexible approach be adopted, including the canvassing of 'bottom up' views. Ms Robinson suggested that it would be beneficial to use strategic communications resource as part of the plans. Miss Barlow confirmed that a refreshed approach would be pursued which would deliver a step change in delivery. Ms Robinson agreed that investment was needed to support innovation. It was agreed that a further discussion would be held at the next meeting to agree how the Committee should operate, including its enabling role.	
ACTION: Mr Grainger-Payne to add an item onto the agenda of the next meeting to prompt discussion of the future operation of the Committee	
6 Trust performance monitoring	
6.1 Performance Monitoring Report	**SWBFC (9/13) 085** **SWBFC (9/13) 085 (a)**
It was highlighted that there were two areas of underperformance against the NHS Performance Framework related to Delayed Transfers of Care and Referral to Treatment Time (RTT) in all specialities, although the classification remained as 'performing'. It was reported that there were no matters of underperformance against the FT Compliance Framework and therefore performance was rated as being 'green'. In terms of performance against the stroke care targets, it was highlighted that performance against the elements related to stroke patients being admitted within 4 hours and undergoing a CT scan within 24 hours was currently below the required level. Further work was reported to be underway to reconcile this reported performance with the view of the stroke team. Ms Robinson underlined the need for the data to be harmonised as a priority. Miss Barlow agreed to circulate an update on progress with achieving this prior to the next meeting. It was reported that performance against the PDR target had improved. Mr Samuda suggested that due focus needed to be directed to ensuring that the quality of the appraisals was satisfactory. Mr Harding advised that a number of breaches to the 28 day guarantee for cancelled operations had been identified contrary to previous information that suggested that this had not been the case. The Committee was advised that a detailed investigation was underway to uncover the cause of the misreporting and plans address the position were being developed. Mr Samuda underlined the gravity of this position. Ms Robinson asked that a level of confidence be assigned to the quality of data entries within the current performance dashboard. It was noted that this work had been undertaken previously which had been presented to the Audit Committee and informed a data quality audit by the Trust's Internal Audit function.	

ACTION: **Miss Barlow to circulate an update on the progress with harmonising the stroke care performance data prior to the next meeting** **ACTION:** **Mr Harding to present an indication of the confidence of the quality of data entries within the corporate performance dashboard**	
6.2 NHS Performance Framework	**SWBFC (9/13) 086** **SWBFC (9/13) 086 (a)**
It was noted that this was covered as part of previous discussions.	
6.3 FT Compliance Framework	**SWBFC (9/13) 087** **SWBFC (9/13) 087 (a)**
It was noted that this was covered as part of previous discussions.	
6.4 Service Line Reporting update	**SWBFC (9/13) 088** **SWBFC (9/13) 088 (a)**
The Committee was asked to receive and accept the report. It was noted that in future a cumulative view of the Service Line Reporting position would be presented. Ms Robinson asked that a forecast outturn be presented if possible.	
7 Matters to highlight to the Board	**Verbal**
It was agreed that the Month 5 position and TDA attention on the Month 4 performance, long term financial forecasting, risk to the achievement of the CQUIN targets and the plans to work with Miss Barlow on the refresh of the Transformation Plan should be highlighted to the Board. It was agreed that the future focus of the Committee in terms of its enabling role should also be raised to the Board.	
8 Meeting effectiveness feedback	**Verbal**
It was agreed that the meeting had included a number of productive discussions.	
9 Minutes for Noting	
9.1 Minutes from Performance Management Board – 20 August 2013	**SWBPM (8/13) 077**
The Finance and Investment Committee received and noted the minutes of the PMB meeting of the 20 August 2013.	
10 Any Other Business	**Verbal**
There was none.	
11 Details of the next meeting	
The next meeting of the Finance and Investment Committee was noted to be	

scheduled for 22 November 2013 at 0800h in the D29 (Corporate Suite) meeting room at City Hospital.	

Signed: …….

Name: …….

Date: ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – October 2013
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Management
AUTHOR:	Robert White / Chris Archer
DATE OF MEETING:	28th November 2013

EXECUTIVE SUMMARY:

The report presents the financial performance for the Trust, clinical groups and corporate directorates for the period to 31st October 2013.

The Trust's Monitor continuity of service risk rating for the year to September is 4 which is satisfactory ("no evident concerns").

Measured against the DH target, the Trust generated an actual surplus of £1,141,000 during October against a planned surplus of £647,000. This performance remains consistent with the annual planned surplus of £4,600,000 agreed with the Local Area Team of NHS England.

The cash balance of £40.8m is £1.0m higher than plan as at 31st October.

REPORT RECOMMENDATION:

The Trust Board is requested to RECEIVE the contents of the report and ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

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

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

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

Good use of Resources (under 12/13 OfE, key Strategies & Programmes)

PREVIOUS CONSIDERATION:

Monthly at Clinical Leadership Executive, Performance Management Committee and by the Finance & Investment Committee on alternate months.

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – October 2013

EXECUTIVE SUMMARY

• For the month of October 2013, the Trust delivered a "bottom line" surplus of £1,141,000 compared to a planned surplus of £647,000 (as measured against the DoH performance target). Actual in month performance is consistent with the year end target of 1.1% of turnover.

• For the year to date, the Trust has produced a surplus of £3,318,000 compared with a planned surplus of £3,016,000 so generating a favourable variance from plan of £302,000, above the Trust's year to date target.

•At month end, WTE's (whole time equivalents), excluding the impact of agency staff, were 232 below planned levels. After taking account of the impact of agency staff, WTE's were 38 above plan. Total pay expenditure for the month, inclusive of agency costs, is £654,000 below the planned level, which includes some year to date adjustments.

• The month-end cash balance was £40.8m. Year to date spend on capital is £4.7m against a £21.4m annual programme.

•The forecast year end I&E position now includes an estimate of impairments to fixed assets. This is treated as a technical adjustment and does not affect delivery against the DH target surplus of £4.6m.

Financial Performance Indicators - Variances					
Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	494	302	>= Plan	>=99% of plan	<99% of plan
EBITDA Actual v Plan £000	287	9	>= Plan	>=99% of plan	<99% of plan
Pay Actual v Plan £000	654	438	<=Plan	<1% above plan	>1% above plan
Non Pay Actual v Plan £000	(836)	(1,946)	<= Plan	<= Plan	>1% above plan
WTEs Actual v Plan	(38)	(98)	<= Plan	<1% above plan	>1% above plan
Cash (incl Investments) Actual v Plan £000	983	983	>= Plan	>=95% of plan	<95% of plan
Note: positive variances are favourable, negative variances unfavourable					

Performance Against Key Financial Targets		
	Year to Date	
Target	Plan	Actual
	£000	£000
Income and Expenditure	3,016	3,318
Capital Resource Limit	11,904	11,904
External Financing Limit	---	983
Return on Assets Employed	3.50%	3.50%

2013/14 Summary Income & Expenditure Performance at October 2013	Annual Plan £000's	CP Plan £000's	CP Actual £000's	CP Variance £000's	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's	Forecast Outturn £000's
Income from Activities	392,384	32,806	33,502	696	228,893	230,176	1,283	392,384
Other Income	38,414	3,760	3,533	(227)	22,947	23,181	234	38,414
Operating Expenses	(405,077)	(34,158)	(34,340)	(182)	(236,502)	(238,010)	(1,508)	(405,077)
EBITDA	25,721	2,408	2,695	287	15,338	15,347	9	25,721
Interest Receivable	100	8	10	2	58	78	20	100
Depreciation, Amortisation & Profit/(Loss) on Disposal	(13,962)	(1,164)	(1,164)	0	(8,145)	(8,145)	0	(16,462)
PDC Dividend	(5,027)	(419)	(216)	203	(2,933)	(2,682)	251	(5,027)
Interest Payable	(2,232)	(186)	(184)	2	(1,302)	(1,280)	22	(2,232)
Net Surplus/(Deficit)	**4,600**	**647**	**1,141**	**494**	**3,016**	**3,318**	**302**	**2,100**
IFRIC12/Impairment/Donated Asset Related Adjustments	0	0	0	0	0	0	0	2,500
SURPLUS/(DEFICIT) FOR DOH TARGET	**4,600**	**647**	**1,141**	**494**	**3,016**	**3,318**	**302**	**4,600**

The Trust's financial performance is monitored against the DoH target shown in the bottom line of the above table. Some adjustments are technical, non cash related items which are discounted when assessing performance against this target.

Sandwell and West Birmingham Hospitals NHS

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Overall Performance against Plan

The overall performance of the Trust against the DoH planned position is shown in the graph. Net bottom-line performance delivered an actual surplus of £1,141,000 in October against a planned surplus of £647,000. as assisted by an update to PDC and ICR revenue receipts. The resultant £494,000 favourable variance results in a year to date return on income of 1.3%, in line with the plan of a 1.1% return.

Performance of Clinical Groups and Directorates

- Medicine in month reflects year to date support for difficult to recruit posts and supernumerary staffing on winter wards
- Medicine year to date variance remains principally in health care assistants.
- Community & Therapies in month position reflects issue of 181 wheelchairs in September compared with an average 157 in previous months.

Group Variances from Plan (Operating income and expenditure)	**Current Period £000**	**Year to Date £000**	**Budget £000**
Medicine	195	(612)	102,810
Surgery A	8	29	62,078
Women & Child Health	23	(108)	50,282
Surgery B	2	49	25,850
Community & Therapies	(65)	(134)	27,624
Pathology	23	13	19,902
Imaging	2	211	17,911
Corporate	27	106	85,915
Central	72	453	17,306

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Trust in month favourable variance of £494,000 reflects £203,000 benefit from review of PDC dividend payments following changes to Dept of Health methodology for calculation and £208,000 in month improvement in Injury Cost Recovery scheme income.

Patient income overperformance in month includes £296,000 relating to drugs and direct access activity which is also reflected in the expenditure variance. This totals £1,161,000 year to date.

Income (other income) and expenditure (nursing and other pay) budgets of £383,000 for key R&D schemes have now been adjusted year to date which is reflected in the current period variance

The nursing pay variance in month reflects budget recognition of the costs of supernumerary staff as new capacity is brought on stream.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
Patient Income	696	1,283
Other Income	(227)	234
Medical Pay	(172)	(863)
Nursing	406	917
Other Pay	420	384
Drugs & Consumables	(499)	(1,053)
Other Costs	(337)	(893)
Interest & Dividends	205	271

Introduction of flexible budgeting for pass through drugs and consumables relating to direct access activity is being considered for future reporting,

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Paybill & Workforce

• Workforce numbers, including the impact of agency workers, are 38 above plan . Excluding the impact of agency staff, whole time equivalent (WTE) numbers are 232 below plan.

• Total pay costs (including agency workers) are £654,000 below budgeted levels for the month, though this includes £382,000 of year to date budget adjustments relating to R&D as well as year to date recognition of supernumerary staffing and difficult to recruit medical posts.

•Overspends on healthcare assistants and medical staff continue and are offset by underspending management and scientific staff budgets.

•Expenditure for agency staff in October was £939,000, the highest spend since May.

Analysis of Total Pay Costs by Staff Group

	Year to Date to October					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	44,720	43,294	0	2,289	45,583	(863)
Management	8,948	8,264	0	0	8,264	684
Administration & Estates	18,523	16,777	1,354	693	18,824	(301)
Healthcare Assistants & Support Staff	18,704	16,594	2,438	643	19,675	(971)
Nursing and Midwifery	53,479	47,748	2,421	2,393	52,562	917
Scientific, Therapeutic & Technical	25,442	24,373	0	250	24,623	819
Other Pay	166	13	0	0	13	153
Total Pay Costs	169,982	157,063	6,213	6,268	169,544	438

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Financial Performance Report – October 2013

Balance Sheet

•A further payment against the loan for Grove Lane land purchase was made in September.

•Cash balances at 31st October stood at £40.8m, £1.0m higher than the planned figure. The forecast cash flow for the next twelve months is shown overleaf.

•The forecast balance sheet assumes impairment in the value of tangible assets also reflected in the I&E statement.

Sandwell & West Birmingham Hospitals NHS Trust

STATEMENT OF FINANCIAL POSITION 2013/14

		Opening Balance as at 1st April 2013	Balance as at end Sept 2013	Balance as at end October 2013	Forecast at 31st March 2014
		£000	£000	£000	£000
Non Current Assets	Intangible Assets	924	506	506	1,421
	Tangible Assets	216,669	213,548	213,671	222,401
	Investments	0			
	Receivables	1,048	966	966	1,000
Current Assets	Inventories	3,604	3,608	3,536	3,600
	Receivables and Accrued Income	10,432	17,289	19,134	11,500
	Investments	0	0	0	
	Cash	42,448	41,257	40,820	38,335
Current Liabilities	Payables and Accrued Expenditure	(43,040)	(44,935)	(45,472)	(44,434)
	Loans	(2,000)	(2,000)	(2,000)	(2,000)
	Borrowings	(914)	(1,145)	(1,134)	(914)
	Provisions	(10,355)	(10,535)	(10,330)	(11,401)
Non Current Liabilities	Payables and Accrued Expenditure	0			
	Loans	(3,000)	(2,000)	(2,000)	(1,000)
	Borrowings	(29,263)	(28,426)	(28,336)	(28,706)
	Provisions	(3,168)	(2,570)	(2,661)	(2,648)
		183,385	185,564	186,700	187,154
Financed By					
Taxpayers Equity	Public Dividend Capital	160,231	160,231	160,231	161,135
	Revaluation Reserve	34,356	34,355	34,355	33,320
	Other Reserves	9,058	9,058	9,058	9,058
	Income and Expenditure Reserve	(20,260)	(18,080)	(16,944)	(16,359)
		183,385	185,564	186,700	187,154

Financial Performance Report – October 2013

Sandwell & West Birmingham Hospitals NHS Trust

CASH FLOW

12 MONTH ROLLING FORECAST AT October 2013

ACTUAL/FORECAST	Oct-13 £000s	Nov-13 £000s	Dec-13 £000s	Jan-14 £000s	Feb-14 £000s	Mar-14 £000s	Apr-14 £000s	May-14 £000s	Jun-14 £000s	Jul-14 £000s	Aug-14 £000s	Sep-14 £000s	Oct-14 £000s
Receipts													
SLAs: SWB CCG	**20,706**	20,684	20,684	20,684	20,684	20,684	20,978	20,978	20,978	20,978	20,978	20,978	20,978
Associates	**6,533**	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900	6,900
Other NHS income	**888**	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Specialised Service (LAT)	**4,427**	3,372	3,372	3,372	3,372	3,372	3,372	3,372	3,372	3,372	3,372	3,372	3,372
Education & Training		4,835		4,429			4,700	0	0	4,700	0	0	4,700
Loans													
Other Receipts	**3,496**	2,100	2,100	2,100	2,100	2,100	1,800	1,800	1,800	1,800	1,800	1,800	1,800
Total Receipts	**36,050**	39,091	34,256	38,684	34,256	34,256	38,950	34,250	34,250	38,950	34,250	34,250	38,950
Payments													
Payroll	**13,730**	13,400	13,400	13,400	13,400	13,400	14,100	14,100	14,100	14,100	14,100	14,100	14,100
Tax, NI and Pensions	**9,406**	9,500	9,500	9,500	9,500	9,500	9,650	9,650	9,650	9,650	9,650	9,650	9,650
Non Pay - NHS	**2,897**	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200	2,200
Non Pay - Trade	**7,807**	7,540	6,600	7,540	7,540	9,826	7,625	7,625	7,625	7,625	7,625	7,625	7,625
Non Pay - Capital	**1,262**	1,115	1,257	2,063	2,771	3,793	1,308	1,308	1,308	1,308	1,308	1,308	1,308
PDC Dividend						2,577						2,750	
Repayment of Loans						1,000						1,500	
Interest						15	0	0	15	0	0	15	0
BTC Unitary Charge	**409**	428	428	428	428	428	225	225	225	225	225	225	225
Other Payments	**976**	350	350	350	350	350	92	92	92	92	92	92	92
Total Payments	**36,487**	34,533	33,735	35,481	36,189	43,089	35,200	35,200	35,215	35,200	35,200	39,465	35,200
Cash Brought Forward	**41,257**	40,820	45,378	45,898	49,102	47,168	38,335	42,085	41,135	40,170	43,920	42,970	37,755
Net Receipts/(Payments)	**(437)**	4,558	521	3,203	(1,933)	(8,833)	3,750	(950)	(965)	3,750	(950)	(5,215)	3,750
Cash Carried Forward	**40,820**	45,378	45,898	49,102	47,168	38,335	42,085	41,135	40,170	43,920	42,970	37,755	41,505

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – October 2013

Capital Expenditure

• Year to date capital expenditure is £4.7m, mainly on blood sciences, statutory standards and estates rationalisation. Spending has begun on the medical equipment programme, "Winter Must Be Better" and "Dementia Friendly Environment" programmes of ward works and on the IM&T programme.

Continuity of Service Risk Rating

•The previous Monitor Financial Risk Rating has now been retired and has been replaced by the new Continuity of Service Risk Rating. The new financial risk rating position is shown below (out of 4). Revised threshold for liquidity have been published by Monitor which are now reflected in the rating below.

•The in month score of 4 reflects the improved I&E position and increased current assets.

•The forecast year end score is now 3 which reflects a reduced liquidity position.

Risk Ratings		Current Month		Year to Date		Forecast Outturn	
Measure	**Description**	Value	Score	Value	Score	Value	Score
Capital Service Capacity	Revenue available for debt service/capital servicing costs	3.93	4	2.58	4	2.64	4
Liquidity	Cash for liquidity purposes * 360/annual operating expenses	0.89	4	0.90	4	-7.92	2
Overall Rating			**4**		**4**		**3**

Transformation Programme

•An update on TSP progress is provided separately. The plan for delivering savings in 2014/15 is receiving focus as is setting the programme for 2015/16.

Sandwell and West Birmingham Hospitals NHS

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Performance Against Service Level Agreement Target

•Performance for April to September is ahead of plan overall , including pass through high cost drugs and direct access imaging and pathology work for GPs. A&E activity is below plan as is the number of births.

• Dialogue with commissioners has begun about plans for 2014/15.

Sandwell and West Birmingham Hospitals NHS
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Financial Performance Report – October 2013

Key risks

•Discussions with commissioners are under way to understand and manage the key risks and uncertainties in the contractual position for the year. This includes referral trends, activity levels, particularly in A&E, maternity, direct access work and pass through drugs, contract penalties including ambulance turnaround time and delivery of targets such as CQUIN.

• School nursing services are out to tender and the outcome of this is relevant to ongoing discussions regarding this year's contract.

•The capacity plan has now been approved and plans are being put in place for Winter 2013. Current capacity is being run at a premium cost which remains a cause of concern and is the focal point for a number of targeted measures within Medicine.

External Focus

•The development of seven-day services in the NHS should first focus on bringing urgent and emergency services up to the best standards all day, every day, the British Medical Association has said. Only then, should the NHS explore if offering a weekday service at nights, weekends and bank holidays is affordable. A statement added that in the current economic climate and with huge financial pressures on the NHS, it did not believe resources could be released to deliver routine services seven days a week. The NHS seven-day services forum is due to report in November.

•The Healthcare Financial Management Association (HFMA) will publish a report on costing seven day services once the NHS England "NHS Services, Seven Days a Week" forum report is published on the consequences of the non-availability of clinical services across the seven day week.

•The National Audit Office has published a report: 'Emergency admissions to hospital: managing the demand'. The report states that emergency admissions continue to rise, though the pace of growth had slowed. More patients who attend A&E are being admitted – more than a quarter in 2012/13 compared with 19% in 2003/04. The rise in admissions was dominated by patients who stayed less than two days. It called on health and social care organisations to work together; on providers to reduce the variations in performance; and on the Department of Health and NHS England to remove the barriers to seven-day working.

•The Department of Health has issued updated guidance on charging overseas visitors for hospital care. Many of the changes relate to new organisations created by the reforms introduced in April 2013.

Recommendations

The Trust Board is asked to:

i. RECEIVE the contents of the report; and

ii. ENDORSE any actions taken to ensure that the Trust remains on target to achieve its planned financial position.

Robert White

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monthly Corporate Performance Monitoring Report
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Performance Management
DATE OF MEETING:	28 November 2013 (Report prepared 21 November 2013)

EXECUTIVE SUMMARY:

The report is designed to inform the Trust Board of the summary performance of the Trust for the period April – October 2013.

REPORT RECOMMENDATION:

The Trust Board is asked to NOTE the 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:

Performance Management Committee, Clinical Leadership Executive and Finance & Investment Committee

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST INTEGRATED PERFORMANCE CORPORATE DASHBOARD - OCTOBER 2013

EXECUTIVE SUMMARY

External Assessment Frameworks

Introduction:

The **NHS TDA** has published an ***Accountability Framework for NHS Trust Boards.*** *This sets out five different categories by which the performance of Trusts is defined:*

- No Identified concerns	Level 1		
- Emerging concerns	Level 2		
- Concerns requiring investigation	Level 3	↓	Increasing Concern
- Material issue	Level 4		
- Formal action required	Level 5		

Trusts are placed in one of these categories depending on performance across three domains; **Quality & Governance, Finance and Delivering Sustainability.** Triggers for escalation include performance against the three domains identified and trends in the data in previous months, an assessment of the capacity and capability of the organisation to deliver recovery plans, and, 'soft' intelligence based on routine interactions with the Trust and with partner organisations. Indicators used to assess ***Quality & Governance*** are grouped into five categories. Metrics aligned to Access, Outcomes and Quality Governance are reflected in the External Assessment Framework section of this report, the remaining categories are; CQC concerns and Third Party reports.
The NHS TDA recently published its first (Summer) report on organisations performance based upon the period April - July 2013 inclusive, with a limited range of the metrics within the accountability framework included within the report. The Trust was assessed at Level 2 - ***Emerging Concerns.*** In future the TDA intend to produce a quarterly public statement, which identifies the Trust's level of escalation, and the factors driving this.

Guidance is awaited on the specific definition and the thresholds to be applied to a number of metrics within the framework, and the NHS TDA has not yet published how aggregated performance translates into one of the five categories of escalation. As such in this report previously published thresholds have been applied where appropriate.

Monitor introduced its ***Risk Assessment Framework*** for NHS Foundation Trusts with effect from 1 October 2013, which replaces its previous Compliance Framework. The range of indicators utilised by Monitor within this framework is less extensive than those used by the NHS TDA. The metrics are identified within the Access, Outcomes and Quality Governance categories of this report. The Access and Outcome metrics used by Monitor have thresholds identified and weightings attributed. The principal differences between the Access and Outcome metrics aligned to the Risk Assessment Framework, compared with the 'Service Performance' metrics within the previous Monitor Compliance Framework, is that meeting the MRSA Bacteraemia objective no longer features and weightings assigned to Cancer 31-day waits and Access to Healthcare for People with a Learning Disability have been increased.

Monitor will also track indicators of quality governance, such as, trends in a number of staff and patient metrics, such as satisfaction ratings, staff turnover and absenteeism. The Governance Rating will be generated by:
- Performance against selected national access and outcomes standards
- CQC judgements on quality of care
- Third party information
- Other information available to reflect quality governance
- Degree of risk to continuity of services and other aspects of risk relating to financial governance

Access and Outcome metrics will be formally monitored quarterly. A potential governance concern is triggered by; an aggregate weighted score is 4.0 or more, **or** by failing the same indicator for at least 3 consecutive quarters **or** by breaching the A&E waiting times target in two quarters over any four-quarter period and in any additional quarter over the subsequent three quarters.

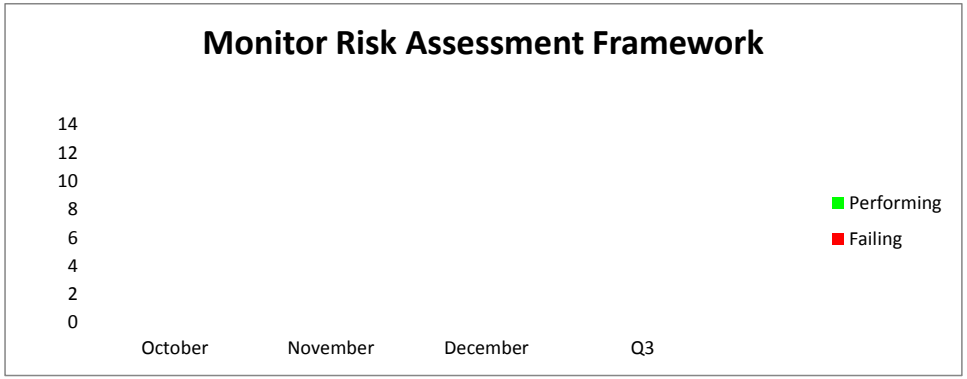
Performance against metrics contained within the NHS TDA Accountability Framework:

Access Metrics- **Emergency Care 4-hour wait** performance during October was 92.6% and 94.27% for the year to date, below the operational threshold of 95.0%. Areas of focus for improvement are; availability of real time activity & patient flow data, improving patient flow and emergency care performance to consistently higher levels and multi-agency engagement in improvement.

Outcome Metrics - the Trust'sassessment of **Harm Free Care** derived from an audit conducted on 'Safety Thermometer Day' identified an overall level of harm free care of 94%, a slight improvement from the previous month of 93%. During the month (October) there were **9 Open Serious Incidents Requiring Investigation** (SIRIs) and **7 Open Central Alerting System** (CAS) Reports identified.

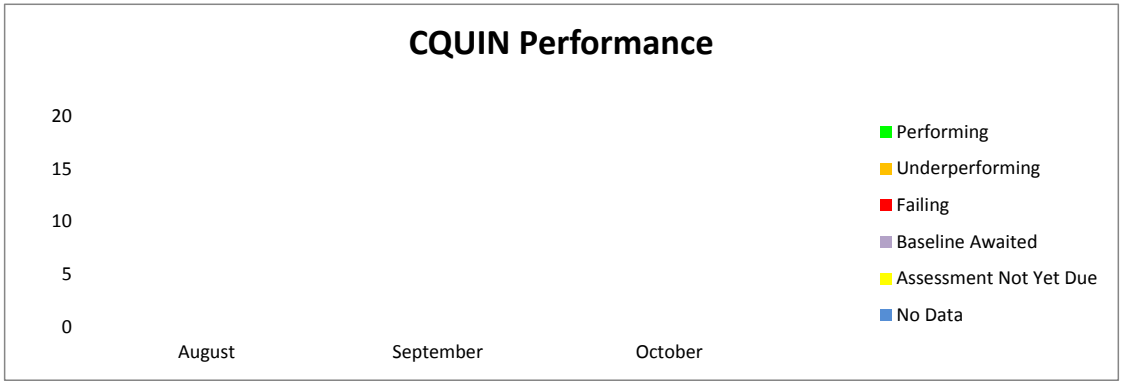
Quality Governance - During the month of October there were a total of 13 **Mixed Sex Accommodation** breaches reported. 8 of these relate to City Hospital Critical Care, the remaining 5 relate to Coronary Care at Sandwell. The Trust combined (Inpatient and Emergency Care) **Friends and Family** response rate has increased significantly to 23.41% from 10.7% in August, with the actual number of responses during that time also increasing from 1516 to 2630.

Performance against metrics contained within the Monitor Risk Assessment Framework:



The Trust underperformed against the Emergency Care 4-hour wait target, but met the required thresholds for each of the other weighted Access and Outcomes indicators. As such the overall weighted score for the month is 1.0, which attracts an AMBER / GREEN Governance Rating. The Trust is projected to meet performance thresholds for all high level RTT and Cancer targets for the month.

CQUIN



CQUIN - A summary of the current performance against the various acute, community and specialised CQUIN schemes is reflected in the table above. Of the 20 summary schemes,15 are performing, with either year to date targets being met or progress in accordance with plan. One scheme is currently failing, the expansion of the Friends and Family Test to Maternity services required a 30% response rate during the month of October. The actual response rate was 9.04%. A response rate of 65% is required by the end of March 2014 to meet the second milestone for this scheme. A total of 3 schemes are currently underperforming. Dementia (Find, Assess & Refer) with a maximum of only 2 of the 3 components of this scheme being met for any month year to date. The Safe Storage of Medicines scheme requires improvement from a base of 19.5% wards being fully compliant with all aspects of this standard, to 75% by end Quarter 3 and 90% by end Quarter 4. Compliance assessed at the end of Quarter 2 was 46%. All non-compliant wards are being asked for an action plan to achieve full compliance and action at Corporate level, such as installation of locks on all clean utility areas, and increased frequency of audit is being undertaken. An initial delay in procurement of equipment and appointment of staff impacted adversely upon progress with certain components of the Dementia Patient CQUIN scheme, this has now been addressed by the Nursing Directorate, with equipment in place and in use, supported by appropriate personnel. One remaining scheme, Annual Staff Survey, is not yet due for assessment.

Clinical Quality & Outcomes

Stroke Care - the proportion of patients spending greater than 90% of their stay on an Acute Stroke Unit remains in excess of 90%, with 100% of patients receiving a swallowing assessment within 24 hours of admission. Similarly, operational performance thresholds for the treatment of TIA High and Low Risk patients continue to be met. Further improvement is required in the proportion of patients receiving thrombolysis within 60 minutes of admission and in the proportion of patients receiving CT Scans within 24 hours, although the performance against the latter remains in excess of 90%. Data flows to information are now consistent with the data being recorded locally within SSNAP. Data sign-off processes and Data Quality processes are currently being finalised and implemented.

WMAS - the number of ambulances subject to turnaround delays in excess of 30 minutes is reported by WMAS as 1576 during the month, with 71 of these delays in excess of 1 hour. There remain concerns regarding differences between locally captured data (fewer delays) and that reported by WMAS, with limited progress made to date These concerns have now been escalated.

Patient Experience

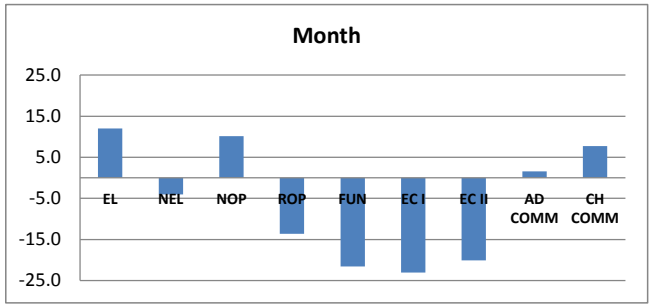
Cancelled Operations - Elective Admissions cancelled at the last minute for non-clinical reasons remains stable at 1.3%, affecting 64 patients (7 on more than 1 occasion). Of the 64 cancellations by Clinical Group, 19 related to Surgery B, 28 Surgery A, 4 Women / Child Health and 13 Medicine. A specific action identified for patients who have experienced a previous cancellation, is that they are scheduled first on an operating list, to avoid the risk of a further cancellation due to lack of theatre time or beds.

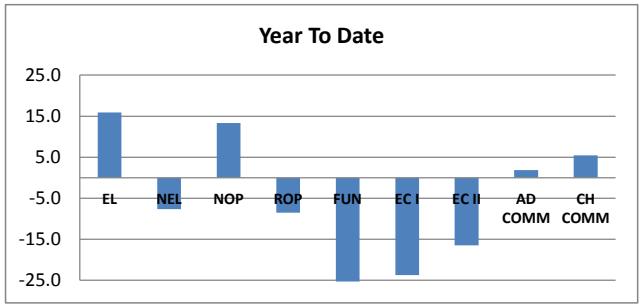
Staff Experience

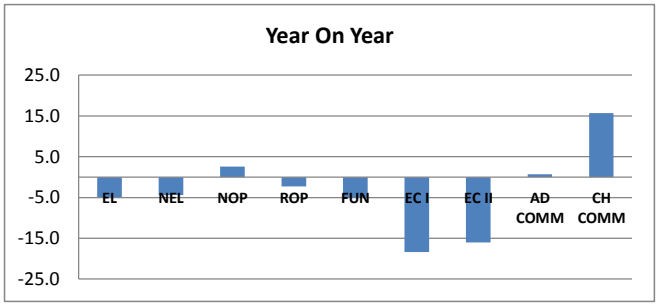
PDR - overall compliance for the most recent 12-month cumulative period has not shown any improvement during the past month, and is currently 79.68% overall (Clinical Groups 78.4%, Corporate Group 82.84%). An ESR helpline to address data entry and training issues has been well received by users. **Mandatory Training** compliance has fallen steadily steadily over the course of the last few months to 85.2%. **Nurse Bank and Agency** Shifts covered remain higher than the corresponding period last year by 1509 and 10273 respectively.

Activity & Contractual

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 below. Additionally, there is a year on year comparison of current year with previous year for the corresponding period of time. High level Elective activity continues to exceed the plan for the month and year to date, although remains (4.8%) less than that delivered during the corresponding period last year. Non-Elective activity is currently 7.7% less than the plan for the year to date, and 4.4% less than the corresponding period last year. Overperformance against the New Outpatient activity plan and an underperformance against the Review OP activity plan, gives a Follow Up:New OP Ratio of 2.18 for the year to date, significantly less than the ratio derived from plan (2.73), and that for the same period last year. Type I and Type II Emergency Care activity to date remains less than plan and for the corresponding period in 2012 / 2013. Adult Community and Child Community activity is currently exceeding plan for month, year to date and 2012 / 2013.







OCTOBER 2013	EXTERNAL ASSESSMENT FRAMEWORKS - TDA ACCOUNTABILITY FRAMEWORK & MONITOR RISK ASSSESSMENT FRAMEWORK

Exec Lead	KPI Source	Data Source	Category / Indicator			June	July	August	September			October			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
			Access Metrics			Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RB	B*	1	Cancer	2 weeks	%	93.1 ▼	94.0 ▲	95.5 ▲	→		93.9 ▼	→			94.2	=>93	=>93	No variation		Any variation	●	94.8	94.7
	B*			2 weeks (Breast Symptomatic)	%	93.9 ▲	96.2 ▲	96.6 ▲	→		97.8 ▲	→			95.6	=>93	=>93	No variation		Any variation	●	95.8	95.9
	B*			31 Day (diagnosis to treatment)	%	98.6 ▲	100 ▲	100 ■	→		99.4 ▼	→			99.1	=>96	=>96	No variation		Any variation	●	99.5	99.5
	B*			31 Day (second/subsequent treatment - surgery)	%	97.6 ▲	100 ▲	100 ■	→		99.0 ▼	→			98.5	=>94	=>94	No variation		Any variation	●	100.0	99.2
	B*			31 Day (second/subsequent treatment - drug)	%	100 ■	100 ■	100 ■	→		100 ■	→			100	=>98	=>98	No variation		Any variation	●	99.2	99.8
	B*			31 Day (second/subsequent treat - radiotherapy)	%	n/a	n/a	n/a	→		n/a	→			n/a	=>94	=>94	No variation		Any variation	●	100	100
	B*			62 Day (urgent GP referral to treatment)	%	86.2 ▼	86.2 ■	85.3 ▼	→		85.2 ▼	→			87.8	=>85	=>85	No variation		Any variation	●	86.9	87.1
	B*			62 Day (referral to treat from screening)	%	100 ■	96.0 ▼	100 ▲	→		93.8 ▼	→			98.3	=>90	=>90	No variation		Any variation	●	98.5	96.9
	A*			62 Day (referral to treat from hosp specialist)	%	89.3 ▼	83.3 ■	94.1 ■	→		92.0 ▼	→			88.4	=>85	=>85	No variation		Any variation	●	91.6	93.2
RB	B*	2	Emergency Care 4-hour waits		%	95.5 ■	94.7 ■	95.5 ■	94.9 ■	94.6 ▲	94.7 ■	91.7 ▼	93.3 ▼	92.6 ▼	94.27	=>95	=>95	=>95		<95	●	95.38	92.54
RB	B*	2	Referral To Treatment	Admitted Care (RTT <18 weeks)	%	92.3 ▼	92.5 ▲	92.3 ▼	→		90.1 ▼	→			90.1*	=>90.0	=>90.0	=>90.0	85-90	<85.0	●	93.2	93.7
	B*			Non-Admitted Care (RTT <18 weeks)	%	97.2 ▼	96.9 ▼	96.6 ▼	→		95.1 ▼	→			95.1*	=>95.0	=>95.0	=>95.0	90 - 95	=<90.0	●	97.5	98.6
	B*			Incomplete Pathway (RTT <18 weeks)	%	93.3 ▼	92.8 ▼	92.2 ▼	→		92.6 ▲	→			92.6*	=>92.0	=>92.0	=>95.0	87 - 92	=<87.0	●	97.2	95.3
				Treatment Functions Underperforming	No.	7 ■	8 ▼	7 ▲	→		11 ▼	→			11*	0	0	0 / month	1 - 6 / month	>6 / month	●	10 (Q4)	11 (Q4)
	A			Waits >52 weeks	No.	50 ■	57 ▼	29 ▲	→		20 ▲	→			20*	0	0	<0		>0	●		
RB	A*	2	Diagnostic Waits	Acute Diagnostic Waits greater than 6 weeks	%	0.67 ▲	0.57 ▲	0.61 ▼	→		0.42 ▲	→		0.44 ▼	0.44*	<1.0	<1.0	<1.0	1.0 - 5.0	>5.0	●	0.99	0.88
RB	A	2	Cancelled Operations	28 day breaches	No.	5 ▼	1 ▲	0 ■	→		0 ■	→		0 ■	11	0	0	3 or less	4 - 6	>6	● ●	1	2
	A	2		No. of second or susequent urgent operations cancelled	No.	0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0	<0		>0	●		0
			Outcome Metrics																				
LP	B*	4	Infection Control	C. Difficile (DH Reportable)	No.	6 ■	5 ▲	3 ■	3 ■	1 ▲	4 ▼	1 ■	1 ■	2 ▲	24	28	46	No variation		Any variation	●	95	37
	A*			MRSA Bacteraemia	No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	1	0	0	No variation		Any variation	●	2	1
	A			MSSA Bacteraemia	No.	0	1	0	1	0	1	1	3	4	9	No. Only	No. Only					12	15
	A			E Coli Bacteraemia	No.	4	4	5	1	0	1	3	4	7	25	No. Only	No. Only					50	48
RB	A	6	Emergency Readmissions (CCS Diagnostic Groups) within 30 days - CQC definition - QUARTERLY	Following an initial Elective or Non-Elective Admission	%	8.92 Oct'12 - Dec'12	→	→	→		9.05 Jan'13 - Mar'13	→		→	9.05*								
	A			Following an initial Elective Admission	%	3.60	→	→	→		3.59	→		→	3.59*								
	A			Following an initial Non-Elective Admission	%	12.71	→	→	→		13.12	→		→	13.12*								
RS		3	Mortality Reviews within 42 working days		%	72 ▼	82 ■	81 ▼	→			→			81.3*	80	80	No variation		Any variation	●	66.9	
RS	A	6	Mortality in Hospital (12-month cumulative data)	Hospital Standardised Mortality Rate	HSMR	88.9 Apr'12 to Mar'13	89.1 May'12 to Apr'13	88.4 Jun'12 to May'13	→		92.2 Jul'12 to Jun'13	→		92.7 Aug'12 to Jul'13	92.7								
				Peer (SHA) HSMR	HSMR	98.0	97.5	97.5	→		101.9	→		101.7	101.7								
				Peer (National) HSMR - Quarterly	HSMR	94.0	→	→	→		98.1	→		→	98.1								
	A	19		SHMI	SHMI	95.9 Apr'12- Mar'13	99.2 May'12 - Apr'13	98.1 Jun'12 - May'13	→		97.2 Jul'12- Jun'13	→		97.8 Aug'12- Jul'13	97.8								
RS	A	12	Obstetrics	Caesarean Section Rate - Elective and Non-Elective	%	25.1 ▲	25.7 ▼	25.5 ▲	→		26.3 ▼	→		23.6 ■	25.3	<25.0	<25.0	=<25.0	25-28	>28.0	●	22.2	23.6
	A			Caesarean Section Rate - Elective	%	12.6	11.2	10.7	→		8.8	→		10.9	11.3								
	A			Caesarean Section Rate - Non-Elective	%	12.6	14.5	14.8	→		17.4	→		12.7	14.0								
	A			Maternal Deaths	No.	0	0	0	→		0	→		0	0								
	A			Admissions of full term babies to Neonatal Care	No.	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited												
LP	A*	8	Patient Safety Thermometer - Harm Free Care		%	95.3 ■	94.2 ■	93.0 ▼	→		93.0 ■	→		94.0 ▲	94.0	=>95	=>95	=>95		<95	●		

Exec Lead	KPI Source	Data Source	Category / Indicator				June	July	August	September			October			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
			Outcome Metrics (Cont'd)				Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
KD	A	14	Medication Errors causing serious harm			No.	0	0	0	→		0	→		0	0	0	0	No variation		Any variation	●		
KD	A	14	Open Serious Incidents Requiring Investigation (SIRI)			No.	8	11	8	→		6	→		9	9*	0	0	No variation		Any variation	●		2
KD	A	14	Never Events - in month			No.	1	0	1	→		0	→		0	0	0	0	No variation		Any variation	●		2
KD	A	14	Open Central Alert System (CAS) Alerts			No.	3	6	6	→		8	→		7	7*	0	0	No variation		Any variation	●		10
RS	A*	3	VTE Risk Assessment			%	95.3	95.9	94.4	→		95.1	→		95.0	95.0*	95	95	=>90		<90	●	92.4	90.8
RS	A	3	WHO Safer Surgery Checklist	Audit - 3 sections		%	99.6	99.8	99.2	→		99.6	→		99.5	99.5*	100	100	=>98		<98	●		
RS		3		Audit - 3 sections and brief		%	90.4	92.6	89.5	→		91.6	→		91.7	91.7*	100	100	=>95		<95	●		
RS		3		Audit - 3 sections, brief and debrief		%	75.3	76.0	76.3	→		78.4	→		80.2	80.2*	100	100	=>85		<85	●●		
RB	C	11	Data Quality	Data Completeness Community Services		%	>50	>50	>50	→		>50	→		>50	>50	=>50	=>50	=>50		<50	●		>50
LP	C	8	Access to healthcare for people with Learning Disability (full compliance)			Y / N	Y	Y	Y	→		Y	→		Y	Yes	Full	Full	Y		N	●	N	Y
			Quality Governance																					
RB	A	2	Mixed Sex Accommodation Breaches	As percentage of completed FCEs		%	0.02	0.00	0.00	→		0.02	→		0.10	0.07	0.0	0.0	0.00		>0.00	●	0.07	
RB	A*	2		Numerical		No.	2	0	0	→		3	→		13	64	0	0	0		>0	●		
RB				Chargeable Days		No.	4	0	0	→		5	→		18	161	0	0	0		>0	●		
LP	B	8	Patient Satisfaction (Friends & Family)	Response Rate	Inpatient Wards	%	30.0	36.0	31.4	→		18.7	→		29.2	29.2*								
LP	B	8			Emergency Care Department	%	9.0	5.0	5.3	→		11.6	→		21.1	21.1*								
LP	B*	8			IP Wards plus Emergency Care Department	%	14.0	12.0	10.7	→		13.4	→		23.4	23.4*								
LP	B	8		Score	Inpatient Wards	No.	67	68	67	→		72	→		71	71*								
LP	B	8			Emergency Care Department	No.	50	49	50	→		51	→		46	46*								
LP	B*	8			IP Wards plus Emergency Care Department	No.	57	61	60	→		58	→		54	54*								
LP	A	8	Patient & Carer Voice							Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
RB	B	7	Sickness Absence	Long Term (> 28 days)		%	2.60	2.62	2.75	→		2.75	→			2.71	<2.15	<2.15	<2.15	2.15-2.50	>2.50		2.95	3.39
RB	B	7		Short Term (<28 days)		%	1.43	1.48	1.31	→		1.23	→			1.44	<1.00	<1.00	<1.00	1.00-1.25	>1.25		0.95	0.99
RB	B	7		Total		%	4.03	4.10	4.05	→		3.98	→			4.15	<3.15	<3.15	<3.15	3.15-3.75	>3.75	●●●	3.90	4.38
RB	A	7	Staff Appraisal	PDRs (12-month rolling)		No. (%)	5293 (71.5)	5374 (72.9)	5779 (78.8)	→		5887 (79.6)	→		5925 (79.7)	5925 (79.7)	7389 (100)	7389 (100)	0-15% variation	15 - 25% variation	>25% variation	●●	5348	5127
RS	A	14		Medical Appraisal and Revalidation		%	77	81	81	→		81	→		84	84*	No. Only	No. Only						77
RB	B	7	Temporary Staff	Proportion Temporary Staff - Clinical		%	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
RB	B	7		Proportion Temporary Staff - Non Clinical		%	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
LP	A	7	Nursing Staff	Registered Nurses as percentage of Nurses		%	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
LP	A	7		Nurse : Bed Ratio		Ratio	→	→	→	Metric within TDA Accountability Framework - Definition Awaited			Metric within TDA Accountability Framework - Definition Awaited											
MS	B	7	Staff Turnover	All Staff		%	0.88	1.06	4.43	→		1.97	→			1.97*								
MS	B	7		All Staff (Excluding Medical & Dental)		%	0.89	0.95	0.98	→		1.50	→			1.50*								

(* Indicators assessed by NHS TDA as part of Summer Report)

OCTOBER 2013	CQUINs

Exec Lead	KPI Source	Data Source	Indicator					June	July	August	September			October			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
								Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RS	D	3	VTE	Risk Assessment		224	%	95.3 ■	95.9 ▲	94.4 ■	→		95.1 ■	→		95.0 ▼	95.0*	95	95	=>90		<90	●	92.4	90.8
RS	D	5		Root Cause Analysis		224	%	100 Base	→	→	→		100 ■	→		→	100	100	100				●		
LP	D	8	NHS Safety Thermometer	Reduction in Prevalence of Pressure Ulcers	ACUTE	224	%	11 ■	5 ■	4 ▲	→			→			52	10% reduction on aggregate 6-month base (Oct 2012 - March 2013) of 81 (68 Acute + 13 Comm)					●		
LP	D				COMMUNITY	224	%	0 ■	0 ■	0 ■	→		0 ■	→			2						●		
LP	D	8	Dementia	Find, Investigate and Refer		269	%	2 of 3 met	1 of 3 met	0 of 3 met	→		2 of 3 met	→		2 of 3 met	2 of 3 met*	90% (F, I and R) for 3 consec. months		No variation		Any variation	● ●		
LP	D			Clinical Leadership		45		→	→		→			→			Identified	In Place	In Place	No variation		Any variation	●		
LP	D			Supporting Carers of People with Dementia		135		On Track	On Track	Survey Undertaken	→		Survey Undertaken	→			Survey Undertaken	Monthly Audit		No variation		Any variation	●		
LP	D	8	Friends & Family Test	Phased Data Collection Expansion - Maternity		137	%	→			By October with 30% response rate			→		9.04	9.04	30	60				● ●		
LP	D			Increased Response Rate (Emergency Care plus All Wards)		175	%	10.61 Base	→	10.7	→		13.4	→		23.4	23.4	>20					●		
LP	D			Improve Performance on Staff FFT		137	Score	→	→		Autumn Annual Staff Survey			Autumn Annual Staff Survey											
RB	D	20	Safe Storage of Medicines			1105	%	Base identified	→	→	→		46 ■	→			46	60	90	No variation		Any variation	●		
LP	D	8	Dementia Patient Stmulation			1138		On Track	→	→	→		Progress Delayed	→			Progress Delayed			No variation		Any variation	●		
RS	D	9	Use of Pain Care Bundles			1138	%	On Track	→	On Track	Baseline August - October		On Track	Baseline August - October		On Track	On Track	To be agreed		No variation		Any variation	●		
RS	D	4	Use of Sepsis Care Bundles			1105	%	→	→	On Track	Baseline Sept. - November		On Track	Baseline Sept. - November		On Track	On Track	To be agreed		No variation		Any variation	●		
LP	D	11	Community Risk Assessment & Advice			1105	%	→	→	→	Baseline August - September		Base identified	→			Base identified	To be agreed		No variation		Any variation	●		
RS	D	8	Recording DNAR Decisions			1105	%	→	→	→	Audit 6 months & re-audit 12 months		95 Base	→		→	95 (Base)			No variation		Any variation	●		
RS	D	Oct-13	Specialised Commissioners (Quarterly Returns)	Clinical Quality Dashboards		60		Compliant	→	→	→		Compliant	→		→	Compliant			No variation		Any variation	●		
RS	D	22		Behcets Highly Specialised Service		60		On Track	→	→	→		On Track	→		→	On Track			No variation		Any variation	●		
RS	D	12		HIV - Communication with GPs		180		Compliant	→	→	→		Compliant	→		→	Compliant			No variation		Any variation	●		
RS	D	12		Neonatal - Retinopathy Of Prematurity (Screening)		180		Compliant	→	→	→		Compliant	→		→	Compliant			No variation		Any variation	●		

Exec Lead	KPI Source	Data Source	Indicator				June	July	August	September			October			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RS	D	3	Stroke Care	Pts spending >90% stay on Acute Stroke Unit		%	91.5 ▼	95.0 ▲	91.5 ▼	→		94.6 ▲	→		90.5 ▼	91.8	83	83	No Variation	0 - 2% Variation	>2% Variation	●	85.9	85.6
	D			Pts admitted to Acute Stroke Unit within 4 hrs		%	92.3 ■	92.1 ▼	76.3 ■	→		72.1 ▼	→			74.7	90	90	No Variation	0 - 2% Variation	>2% Variation	●	68.7	59.1
	D			Pts receiving CT Scan within 24 hrs of presentation		%	89.3 ▲	97.7 ▲	96.0 ▲	→		98.1 ▲	→		95.9 ▼	93.0	100	100	No Variation	0 - 2% Variation	>2% Variation	●	100	92
	D			Pts receiving CT Scan within 1 hr of presentation		%	66.0 ▲	72.7 ▲	71.1 ▼	→		71.7 ▼	→		69.4 ▼	67.9	50	50	No Variation	0 - 2% Variation	>2% Variation	●	37.5	52.0
	D			Admission to Thrombolysis Time (% within 60 mins)		%	0.0 ▼	33.0 ▲	67.0 ▲	→		0.0 ▼	→			22.2	85	85	=>85		<85	● ● ●		
	D			Admission to Thrombolysis Time (% over 90 mins)		%	67.0 ▼	33.0 ▲	0.0 ■	→		0.0 ■	→			38.9	0	0	0		>0	● ●		
	D			Stroke Admissions - Swallowing assessments (<24h)		%	92.9 ■	100.0 ■	100.0 ■	→		100.0 ■	→		100.0 ■	97.8	100	100	=>98		<98	●		
	D			TIA (High Risk) Treatment <24 h from initial presentation		%	81.3 ▲	83.3 ▲	72.0 ▼	→		75.9 ▲	→		65.5 ▼	72.6	60	60	No Variation	0 - 2% Variation	>2% Variation	●	53.2	69.8
	D			TIA (Low Risk) Treatment <7 days from initial presentation		%	88.2 ▼	91.2 ▲	92.5 ▲	→		87.9 ▲	→		83.3 ▼	86.0	60	60	No Variation	0 - 2% Variation	>2% Variation	●	30.4	75.9
RB		3	Infection Control	MRSA Screening - Elective	Patient Not Matched	%	196.9 ▲	249.9 ▲	217.1 ▼	Numerator = 3212	Denominator = 1268	253.3 ▲	Numerator = 3683	Denominator = 1476	249.5 ▼	249.5*	88	90	No variation		Any variation	●		138.9
					Best Practice - Patient Matched	%	67.2 ▲	80.7 ■	75.9 ▼	Numerator = 1135	Denominator = 1268	89.5 ▲	Numerator = 1209	Denominator = 1476	81.9 ▼	81.9*	77	80	No variation		Any variation	●		59.5
				MRSA Screening - Non Elective	Patient Not Matched	%	81.3 ▼	84.1 ▲	87.1 ■	Numerator = 1872	Denominator = 2130	87.9 ▲	Numerator = 2090	Denominator = 2336	89.5 ▲	89.5*	88	90	No variation		Any variation	●		76.8
					Best Practice - Patient Matched	%	74.5 ▲	72.6 ▼	77.3 ▲	Numerator = 1872	Denominator = 2060	90.9 ▲	Numerator = 2090	Denominator = 2271	92.0 ▲	92.0*	77	80	No variation		Any variation	●		64.9
LP		14	Falls Resukting In Severe Injury or Death			No	5 ▼	0 ■	0 ■	→		1 ■	→		7 ▼	18	0	0	No variation		Any variation	●		22
LP		8	Grade 3 or 4 pressure ulcers - avoidable			No	1	1	1	→		0	→		0	6								
LP		8	High Impact Nursing Actions	Inpatient Falls reduction	Acute	No	51 ▼	67 ■	54 ■	→		53 ▲	→			330	330	660	=<55/m		>55/m	●		737
					Community	No	7 ▲	8 ▼	10 ▼	→		11 ▼	→			61	72	144	=<12/m		>12/m	●		
RS		3	Obstetrics	Post Partum Haemorrhage (>2000 ml)		No.	0 ▲	0 ■	0 ■	→		0 ■	→		0 ■	2	24	48	=<2	3 - 4	>4	●	7	10
				Admissions to Neonatal ICU		%	8.1	9.2 ▼	9.5 ▼	→		11.0 ■	→			9.7	=<10	=<10	=<10	10.0-12.0	>12.0	●	10.7	10.2
				Adjusted Perinatal Mortality Rate (per 1000 babies)		/1000	6.0 ▲	8.0 ■	5.9 ■	→		12.2 ■	→			12.2*	<8.0	<8.0	<8	8.0 - 10.0	>10	●	11.9*	4.5
	D			Early Booking (Completed Assessment <12+6 weeks)	National Definition	%	122.0 ▼	152.0 ▲	110.0 ▼	→		137.0 ▲	→			137.0*	=>90	=>90	=>90	75-89	<75	●	76.0	78.0
	D				SWBH Early Booking (Bookings > Births)	%	79.0 ▼	79.0 ■	78.0 ▼	→		70.0 ■	→			70.0*	=>90	=>90	=>90	75-89	<75	● ●	76.0	78.0
LP		2	Infant Health & Inequalities	Maternal Smoking Rates		%	9.4 ▼	→	→	→		7.83 ▲	→		→	8.6	<11.5	<11.5	<11.5	11.5 - 12.5	>12.5	●	9.8	9.9
				Breast Feeding Initiation Rates		%	77.0 ▲	→	→	→		76.7 ▼	→		→	76.9	>63.0	>63.0	>63.0	61-63	<61.0	●	73.0	72.6
RB		3	Hip Fractures	Operation <24 hours of admission		%	72.0 ■	63.0 ■	85.7 ■	→		81.8 ▼	→		89.5 ▲	89.5*	82.0	85.0	No Variation	0 - 2% Variation	>2% Variation	●	66.4	76.7
RB	D	3	Data Quality	Valid Coding for Ethnic Category (FCEs)		%	93 ■	93 ■	92 ▼	→		93 ■	→		93 ■	93	90	90	>/=90	89.0-89.9	<89	●	95	93
		3		Maternity HES		%	6.6 ▲	6.8 ▼	6.7 ▲	→		7.1 ▼	→		6.8 ▲	7.0	<15	<15	=<15	16-30	>30	●	6.0	6.6
	D	3	Emergency Care Timeliness	Total Time in Department (95th centile)		h : m	4:39 ▲	4:56 ▼	4:34 ▲	→		5:05 ▼	→		5:45 ▼	5:09	=<4hrs	=<4hrs	=<4hrs		=<4hrs	● ●	3 : 59	5 : 15
	D			Time to Initial Assessment (=<15 mins)(95th centile)		mins	18 ■	18 ■	16 ▲	→		16 ■	→		20 ▼	17	=<15	=<15	<15		<15	●	21	17
	D			Time to treatment in department (median)		mins	50 ▲	51 ▼	42 ▲	→		41 ▲	→		48 ▼	48	=<60	=<60	=<60		>60	●	59	58
	D		Emergency Care Patient Impact	Unplanned re-attendance rate		%	8.38 ▼	8.31 ▲	5.75 ▲	→		5.44 ▲	→		6.16 ▼	6.73	=<5.0	=<5.0	=<5.0		>5.0	● ●	8.66	7.81
	D			Left Department without being seen rate		%	4.03 ▼	4.73 ▼	3.35 ▲	→		3.44 ▼	→		3.47 ▼	3.81	=<5.0	=<5.0	=<5.0		>5.0	●	4.83	4.67
	D		Emergency Care Trolley Waits >12 hours			No.	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	0 ■	1	0	0	0		>0	●		
RB	D	18	Ambulance Turnaround	Clinical Handovers completed within 15 minutes		%	83.9 ▼	85.4 ■	85.1 ▲	78.5 ▼	89.6 ▲	84.9 ■	85.7 ■	89.3 ▼	87.7 ■	87.7*	=>85	=>85	=>85		<85	●		71.3
	D			Average Turnaround Time		m : s	27:30 ▲	27:52 ▼	27:57 ▼	29:03 ▼	28:08 ▼	28:46 ▼	30:47 ■	28:01 ▲	29:02 ▼	29:02*	=<30:00	=<30:00	=<30:00		>30:00	●	29:23	34:24
	D			30 - 60 minutes	All Journeys	No.	1237 ▲	1376 ▼	1333 ▲	579 ▲	722 ▲	1301 ▲	748 ▼	757 ▼	1505 ▼	9615	0	0	0		0	● ● ●		22089
	D				Hospital Fines (WMAS report)	No.	238 ▲	294 ▼	252 ▲	88 ▲	35 ▲	123 ▲	181 ▼	109 ▼	290 ▼	2072	0	0	0		0	● ● ●		
	D			In Excess of 60 minutes	All Journeys	No.	23 ▲	24 ▼	32 ▼	27 ▼	23 ▼	50 ▼	54 ▼	17 ▲	71 ▼	346	0	0	0		0	● ● ●	1256	2354
	D				Hospital Fines (WMAS report)	No.	13 ▲	12 ▲	21 ▼	13 ▼	3 ▲	16 ▲	44 ▼	10 ▼	54 ▼	201	0	0	0		0	● ● ●		

OCTOBER 2013	PATIENT EXPERIENCE

Exec Lead	KPI Source	Data Source	Indicator				June	July	August	September			October			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
							Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RB		21	Reporting Times of Imaging Requests from Emergency Care - % **reported within 24 hours / next day**	Plain Radiography	%		99 ▼	99 ■	99 ■	→		98 ▼	→		99 ▲	99*	90	90	No variation		Any variation	●		99
				Ultrasound	%		95 ▼	100 ▲	100 ■	→		100 ■	→		100 ■	100*	90	90	No variation		Any variation	●		100
				MRI	%		90 ■	70 ■	84 ▲	→		65 ▼	→		100 ■	100*	90	90	No variation		Any variation	●		84
				CT	%		97 ▼	99 ▲	99 ■	→		99 ■	→		99 ■	99*	90	90	No variation		Any variation	●		99
KD	D	14	Complaints	No. of Complaints Received formal and link)	No.		50	72	94	→		86	→		65	495	No. Only	No. Only					834	724
				No. of Active Complaints in the System (formal and link)	No.		336	272	254	→		238	→		201	201*	No. Only	No. Only						
				No. of First Formal Complaints received / 1000 episodes of care	No.		0.625	0.45	0.88	→		0.52	→		0.36	0.36*	No. Only	No. Only						
				No. of Days to acknowledge a formal or link complaint (% within 3 working days)	%		78 ▼	94 ▲	97 ▲	→		76 ▼	→		97 ▲	97*	100	100	100		<100	●		
				No. of responses which have exceeded their original agreed response date (% of total active complaints)	%		32 ▼	36 ▼	25 ▲	→		22 ▲	→		33 ▼	33*	0	0	0		>0	● ●		
				No. of responses sent out	No.		5	128	73	→		78	→		109	109*	No. Only	No. Only						
				Oldest' complaint currently in system	Days		155	165	147	→		150	→		107	107*	No. Only	No. Only						
RB		15	Elective Access Contact Centre	Number of Calls Received	No.		11687	13089	11250	→		13181	→		13978	88298	No. Only	No. Only					111793	150454
				Average Length of Queue	mins		0.22 ▲	0.25 ▼	0.22 ▲	→		0.39 ▼	→		0.27 ▲	0.27*	<1.0	<1.0	<1.0	1.0-2.0	>2.0	●	0.21	0.25
				Maximum Length of Queue	mins		11.2 ▼	15.5 ■	17.2 ▼	→		17.3 ▼	→		13.0 ▲	13.0*	<6.0	<6.0	<6.0	6.0-12.0	>12.0	●	10.1	14.2
			Telephone Exchange	Number of Calls Received	No.		65266	71422	67671	→		70460	→		76416	436561	No. Only	No. Only					849502	901987
				Calls Answered	%		92.0	92.2	91.2	→		91.0	→		90.5	91.0	No. Only	No. Only					90.2	90.7
				Answered within 15 seconds	%		74.3	73.8	70.6	→		72.0	→		71.3	68.9	No. Only	No. Only					52.5	58.2
				Answered within 30 seconds	%		85.5	85.4	83.4	→		84.1	→		83.5	81.5	No. Only	No. Only					68.1	73.0
				Average Ring Time	Secs		12.3	12.3	13.8	→		12.9	→		13.1	13.1*	No. Only	No. Only					25	18
				Longest Ring Time	Secs		366	411	280	→		433	→		341	341*	No. Only	No. Only					718	349
RB		2	Patient Flow	Average Length of Stay	Days		3.4 ▲	3.5 ▼	3.5 ■	4.6 ■	3.4 ▼	4.0 ▼				3.6	4.3	4.3	No Variation	0 - 5% Variation	>5% Variation	●	4.2	3.8
				Day of Surgery (IP Elective Surgery)	%		94.7 ▲	96.6 ▲	92.7 ▼	96.9 ▲	93.7 ▼	94.9 ▲	95.3 ▼	93.8 ▲	94.4 ▼	94.2	82.0	82.0	No Variation	0 - 5% Variation	>5% Variation	●	89.5	92.0
				Daycase Rate - All Procedures	%		82.5 ▲	82.5 ■	83.9 ▲	82.3 ▼	84.6 ▲	83.7 ▼	82.3 ■	84.5 ▼	83.7 ▼	84.5	80.0	80.0	No Variation	0 - 5% Variation	>5% Variation	●	82.7	83.9
				Available Beds at Month End	No.		742	745	740	→		754	→		786	786								
RB		2	Cancelled Operations	Elective Admissions Cancelled at last minute for non-clinical reasons	%		0.6 ■	0.8 ■	0.8 ■	1.2 ■	1.5 ■	1.4 ■	1.4 ▼	1.2 ▲	1.3 ▲	0.9	<0.8	<0.8	<0.8	0.8 - 1.0	>1.0	●	0.6	0.7
	D			28 day breaches	No.		5 ▼	1 ▲	0 ■	→		0 ■	→		0 ■	11	0	0	3 or less	4 - 6	>6	● ●	1	2
	D			No. of second or susequent urgent operations cancelled	No.		0 ■	0 ■	0 ■	→		0 ■	→		0 ■	0	0	0	<0		>0	●		0
				Sitrep Declared Late Cancellations	No.		29 ▲	41 ▼	36 ▲	21 ■	45 ▼	66 ▼	26 ▼	38 ▲	64 ▲	318	187	320	0-5% variation	5 - 15% variation	>15% variation	● ●	363	425
				Sitrep Declared Late Cancellations (Pts. >1 occasion)	No.		6 ■	2 ▲	9 ▼	3 ■	7 ▼	10 ▼	1 ▲	6 ▲	7 ▲	7*	0	0	No variation		Any variation	●		60
				Multiple Cancellations experienced by same patient (all cancellations)	%		17.3 ▼	12.1 ▲	18.6 ▼	→		13.6 ▲	→		12.4 ▲	12.4*	5.0	0.0	No variation		Any variation	● ●		13.6
				All Cancellations, with 7 or less days notice (expressed as % overall elective activity)	%		6.0 ▼	5.8 ▲	5.3 ▲	→		5.6 ▼			5.7 ▼	5.7*	4.1	3.1	No variation		Any variation	●		6.2
RB		10	Cardiology	Primary Angioplasty	Door To Balloon Time (90 mins)	%	85.7 ▼	75.0 ■	100.0 ■							86.6	=>80	=>80	=>80	75-79	<75	●	80.1	85.4
					Call To Balloon Time (150 mins)	%	92.3 ▼	88.9 ▼	100.0 ▲							91.3	=>80	=>80	=>80	75-79	<75	●	88.4	91.2
				Rapid Access Chest Pain		%	100 ▲	98.4 ▼								98.3	100	100	=>98	96.0 - 97.9	<96	●	99.1	95.7
RB		12	GU Medicine	Patients offered app't within 48 hrs		%	100 ■	100 ■	100 ■	→		100 ■	→		100 ■	100	=>98	=>98	=>98	95-98	<95	●	100	100

Exec Lead	KPI Source	Data Source	Indicator			June	July	August	September			October			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
MS	D	7	Staff in Post	Establishment	wte	6994	6948		→		7139	→			7139*								
				Staff In Post (contracted)	wte	6529	6491	6497	→		6529	→			6529*								
				Staff In Post (headcount)	no.	7521	7479	7485	→		7503	→			7503*								
				Staff In Post - FTE / Headcount ratio	Ratio	1.15	1.15	1.15	→		1.15	→			1.15*								
				Potential Vacancies (All)	wte	464	457		→		610	→			610*								
				Potential Vacancies (Qualified Nursing)	wte	138	143		→		236	→			236*								
				Posts Advertised in Month (NHS Jobs)	wte	154	258	178	→		105	→			105*								
			Induction		%	86 ■	92 ▲	93 ▲	→		93 ■	→			93*	100	100	=>85		<85			91.3
RB	D	7	Learning & Development	PDRs (12-month rolling)	No. (%)	5293 (71.5) ▲	5374 (72.9) ▲	5779 (78.8) ■	→		5887 (79.6) ▲	→		5925 (79.7) ▲	5925 (79.7)	7389 (100)	7389 (100)	0-15% variation	15 - 25% variation	>25% variation	● ●	5348	5127
RS		14		Medical Appraisal and Revalidation	%	77	81	81	→		81	→		84	84*	No. Only	No. Only						77
MS		3		Mandatory Training Compliance	%	88.6 ▲	87.9 ▼	86.4 ▼	→		86.1 ▼	→		85.2 ▼	85.2	100	100	=>95	90 - 95	<90	● ●	71.9	86.4
RB		7	Sickness Absence	Long Term (> 28 days)	%	2.62 ▲	2.64 ▼	2.78 ▼	→		2.79 ▼	→		2.78 ▲	2.74	<2.15	<2.15	<2.15	2.15-2.50	>2.50		2.95	3.39
				Short Term (<28 days)	%	1.44 ▲	1.49 ▼	1.33 ▲	→		1.49 ▼	→		1.54 ▼	1.49	<1.00	<1.00	<1.00	1.00-1.25	>1.25		0.95	0.99
	D			Total	%	4.06 ▲	4.13 ▼	4.11 ▲	→		4.28 ▼	→		4.32 ▼	4.23	<3.15	<3.15	<3.15	3.15-3.75	>3.75	● ● ●	3.90	4.38
RB		17	Bank & Agency Use	Nurse Bank Fill Rate	%	74.7	76.8	78.0	→		75.9	→		75.0	75.7	No. Only	No. Only					87.2	82.9
				Nurse Bank Shifts covered	No.	4642 ▲	4842 ▼	5457 ▼	→		5265 ▲	→		5168 ▲	35306	27405	46980	0 - 2.5% Variation	2.5 - 5.0% Variation	>5.0% Variation	● ● ●	56396	60463
				Nurse Agency Shifts covered	No.	1950 ▲	1880 ▲	1514 ▲	→		1560 ▼	→		2381 ▼	15015	2234	3830	0 - 5% Variation	5 - 10% Variation	>10% Variation	● ● ●	6948	12874
				Agency Spend as % Employee Benefit Expenditure	%	2.60	3.70	3.27	→		3.84	→			3.84*								

OCTOBER 2013 | **ACTIVITY & CONTRACTUAL**

Exec Lead	KPI Source	Data Source	Indicator			June	July	August	September			October			To Date (*=most recent month)	TARGET		THRESHOLDS			13/14 Forward Projection	11/12 Outturn	12/13 Outturn
						Trust	Trust	Trust	S'well	City	Trust	S'well	City	Trust		YTD	13/14						
RB		2	Spells	Elective IP	No.	748 ■	786 ■	640 ▼	→		726 ▲	→		764 ▼	5082	5906	10141	No Variation	0 - 2% Variation	>2% Variation		10610	9596
				Elective DC	No.	4088 ▲	4495 ▼	3804 ▼	→		4062 ▲	→		4452 ▼	29770	23411	40198	No Variation	0 - 2% Variation	>2% Variation		53685	52875
				Total Elective	No.	4836 ▲	5281 ▼	4444 ▼	→		4788 ▲	→		5216 ▼	34852	29317	50339	No Variation	0 - 2% Variation	>2% Variation	●	64295	62471
				Total Non-Elective	No.	4567 ▼	4687 ▲	4537 ▲	→		4402 ▼	→		4742 ▲	32024	34474	60931	No Variation	0 - 2% Variation	>2% Variation	●	55675	56982
			Outpatient Attendances	New	No.	13784 ▲	16158 ▲	12948 ▼	→		14415 ▲	→		15991 ▼	102467	88796	152466	No Variation	0 - 2% Variation	>2% Variation	●	159051	171540
				Review	No.	30650 ▲	32671 ▼	29244 ▼	→		30313 ▲	→		32500 ▼	223311	242386	410406	No Variation	0 - 2% Variation	>2% Variation	●	421494	382248
			Emergency Care Attendances	Type I (Sandwell & City Main Units)	No.	12823 ▲	13510 ▲	12180 ▼	5443 ▼	6563 ▼	12006 ▼	5540 ▼	6661 ▼	12201 ▼	88557	109528	184483	No Variation	0 - 2% Variation	>2% Variation	● ●	177201	171701
				Type II (BMEC)	No.	2067 ▼	1786 ▼	2061 ▲	→	2189 ▲	2189 ▲	→	1944 ▼	1944 ▼	14426	16804	28304	No Variation	0 - 2% Variation	>2% Variation	● ●	36362	26649
				All - Contracted plus Non-Contracted	No.	17392 ▲	21401 ▲	19883 ▲	8161 ▲	11865 ▲	20026 ▲	8474	11646	20120	142998	122687	207128						207128
		16	Community	Adult - Aggregation of 18 Individual Service Lines	No.	44725 ■	49577 ▼	46370 ▲	→		45642 ▲	→			278890	273735	540982	No Variation	0 - 2% Variation	>2% Variation	●	493163	538147
				Children - Aggregation of 4 Individual Service Lines	No.	15290 ■	16106 ▼	12147 ■	→		14855 ■	→			88495	83699	165757	No Variation	0 - 2% Variation	>2% Variation	●	143400	155412
			Contract	Improvement Notices	No.	2 ■	0 ■	0 ■	→		0 ■	→		1 ■	1*	0	0				●		
RB	D	2	Delayed Transfers of Care	Acute	%	2.7 ▲	2.7 ■	3.7 ■	3.5 ▲	4.3 ▼	3.9 ▼	2.3 ■	5.2 ■	3.6 ▲	3.3	<3.5	<3.5	<3.5	3.5 - 5.0	>5.0	●	5.2	2.9
				Pt's Social Care Delay	No.	9 ▲	5 ▲	9 ▼	3 ▲	11 ■	14 ▼	3 ■	6 ■	9 ▲	9*	<18	<18	No Variation	0 - 10% Variation	>10% Variation		13	7
				Pt.'s NHS & NHS plus S.C. Delay	No.	7 ▲	13 ■	11 ■	3 ■	4 ■	7 ■	5 ■	5 ■	10 ■	10*	<10	<10	No Variation	0 - 10% Variation	>10% Variation		20	8
RB		2	Outpatient Efficiency	New : Review Rate	Ratio	2.22 ▼	2.02 ▲	2.26 ▼	2.24 ■	2.03 ▲	2.10 ▲	2.28 ▼	1.91 ▲	2.03 ▲	2.18	2.30	2.30	No Variation	0 - 5% Variation	>5% Variation	●	2.65	2.23
				DNA Rate - New Referrals	%	11.7 ▲	12.9 ▼	13.9 ▼	→		12.4 ▲	→		12.9 ▼	11.7	10.0	10.0	No variation		Any variation	● ●	11.8	11.3
				DNA Rate - Reviews	%	10.8 ▲	12.3 ▼	11.9 ▲	→		12.4 ▼	→		12.6 ▼	10.7	10.0	10.0	No variation		Any variation	●	11.9	10.3

LEGEND

DATA SOURCES	
1	Cancer Services (National Cancer Database)
2	Information Department
3	Clinical Data Archive
4	Microbiology Department
5	Medical Director's Directorate
6	Dr Foster
7	Workforce Directorate
8	Nursing Directorate
9	Surgery A Group
10	Medicine Group
11	Community & Therapies Group
12	Women & Child Health Group
13	Neonatology
14	Governance Directorate
15	Operations Drectorate
16	Finance Directorate
17	Nurse Bank
18	West Midlands Ambulance Service
19	Healthcare Evaluation Data Tool (HED)
20	Pharmacy Department
21	Imaging Group
22	Surgery B Group

INDICATORS WHICH COMPRISE THE PERFORMANCE ASSESSMENT FRAMEWORKS	
A	TDA Accountability Framework
B	TDA Accountability Framework and Monitor Risk Assessment Frameowk
C	Monitor Risk Assessment Framework
D	Local & Contract (inc. CQUIN)

FORWARD PROJECTION ASSESSMENT	
●	Maintain (at least), existing performance to meet target
●	**Improvement** in performance required to meet target
● ●	**Moderate Improvement** in performance required to meet target
● ● ●	**Significant Improvement** in performance required to meet target
XXX	**Target Mathmatically Unattainable**

PERFORMANCE ASSESSMENT SYMBOLS	
▲	Fully Met - Performance continues to improve
■	Fully Met - Performance Maintained
▼	Met, but performance has deteriorated
▲	Not quite met - performance has improved
■	Not quite met
▼	Not quite met - performance has deteriorated
▲	Not met - performance has improved
■	Not met - performance showing no sign of improvement
▼	Not met - performance shows further deterioration