Sandwell and West Birmingham Hospitals NHS
NHS Trust

AGENDA

Trust Board – Public Session

Venue Tower Hill Medical Practice, Perry Barr **Date** 6 November 2014; 1330h

Members attending

Mr R Samuda	(RSM)	[Chairman]
Ms C Robinson	(CRO)	[Vice Chair]
Dr S Sahota OBE	(SS)	[Non-Executive Director]
Mrs G Hunjan	(GH)	[Non-Executive Director]
Ms O Dutton	(OD)	[Non-Executive Director]
Mr H Kang	(HK)	[Non-Executive Director]
Dr P Gill	(PG)	[Non-Executive Director]
Mr T Lewis	(TL)	[Chief Executive]
Mr C Ovington	(CO)	[Chief Nurse]
Miss R Barlow	(RBA)	[Chief Operating Officer]
Mr T Waite	(TW)	[Director of Finance]
Dr R Stedman	(RST)	[Medical Director]

In attendance

Mr M Hoare	(MH)	[Non-Executive Director]
Miss K Dhami	(KD)	[Director of Governance]
Mrs C Rickards	(CR)	[Trust Convenor]

Guests

Patients for patient story
Mrs F Shorney

Secretariat

Mr S Grainger-Lloyd (SGL) [Trust Secretary]

Time	Item	Title	Reference Number	Lead
1330h	**1**	**Apologies**	**Verbal**	**SG-L**
	2	**Declaration of interests** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting*	**Verbal**	**SG-L**
	3	**Minutes of the previous meeting** *To approve the minutes of the meeting held on 2 October 2014 a true and accurate records of discussions*	**SWBTB (10/14) 177**	**Chair**
	4	**Update on actions arising from previous meetings**	**SWBTB (10/14) 177 (a)**	**SG-L**
	4.1	Coded outpatient procedures requiring consent	SWBTB (11/14) 179	RB
	4.2	Progress with strengthening the consent process	Verbal	RST
	5	**Questions from members of the public**	**Verbal**	**Public**
1345h	**6**	**Patient story**	**Presentation**	**CO**
1405h	**7**	**Chair's opening comments and Chief Executive's report, including feedback following recent CQC inspection and surgical reconfiguration plans**	**SWBTB (11/14) 181**	**RSM/ TL**
	MATTERS FOR DISCUSSION AND APPROVAL			
1415h	**8**	**Application of the Trust seal to the Homeless accommodation business case**	**SWBTB (11/14) 183**	**TL**
1420h	**9**	**Quarter 2 complaints and PALs update**	**SWBTB (11/14) 184** **SWBTB (11/14) 184 (a)**	**KD**

1435h	**10**	**Quarter 2 Board Assurance Framework update**	**SWBTB (11/14) 185** **SWBTB (11/14) 185 (a)**	**KD**
1445h	**11**	**Quarter 2 annual plan delivery update**	**SWBTB (11/14) 186** **SWBTB (11/14) 186 (a)**	**TW**
1455h	**12**	**Seven day working – update against standards**	**SWBTB (11/14) 187** **SWBTB (11/14) 187 (a)**	**RB**
1505h	**13**	**Corporate integrated performance dashboard**	**SWBTB (11/14) 188** **SWBTB (11/14) 188 (a)**	**TW**
1515h	**14**	**Financial performance – Month 6**	**SWBTB (11/14) 189** **SWBTB (11/14) 189 (a)**	**TW**
1525h	**15**	**Trust Risk Register update**		
	15.1	Update on actions agreed at previous meetings	SWBTB (11/14) 190 SWBTB (11/14) 190 (a)	KD
	15.2	New considerations		
1535h	**16**	**Last Year of Life update**	**SWBTB (11/14) 182** **SWBTB (11/14) 182 (a)** **SWBTB (11/14) 182 (b)**	**RST**
1545h	**17**	**Learning Disabilities month update**	**SWBTB (11/14) 191** **SWBTB (11/14) 191 (a)**	**CO**
1550h	**18**	**Briefing on Rotherham Safeguarding issues**	**SWBTB (11/14) 192** **SWBTB (11/14) 192(a)**	**CO**
	PRESENTATION			
1600h	**19**	**Community spinal services**	**Presentation**	**RB**
	UPDATES FROM THE COMMITTEES			
1615h	**20**	**Update from the meeting of the <u>Configuration Committee</u> on 31 October 2014 and minutes of the meeting held on 3 September 2014**	**SWBCC (9/14) 035**	**RSM/ TL**
	21	**Update from the meeting of the <u>Quality & Safety Committee</u> held on 31 October 2014 and minutes of the meeting held on 26 September 2014**	**SWBQS (9/14) 073**	**OD/ CO**
	22	**Update from the meeting of the <u>Audit & Risk Management Committee</u> held on 30 October 2014 and minutes of the meeting held on 31 July 2014**	**SWBAR (7/14) 048**	**GH/ KD**
	23	**Any other business**	**Verbal**	**All**
	MATTERS FOR INFORMATION			
1625h	**24**	**Midland Metropolitan Hospital project: monitoring report**	**SWBTB (11/14) 193**	
	25	**Nurse staffing levels**	**SWBTB (11/14) 195** **SWBTB (11/14) 195 (a)**	
	26	**Details of next meeting** *The next public Trust Board will be held on 4 December 2014 at **1330h** in the Churchvale/Hollyoak Rooms, Sandwell Hospital*		

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Trust Board (Public Session) – Version 0.1

Venue Churchvale/Hollyoak Rooms, Sandwell Hospital **Date** 2 October 2014

Present	In Attendance	Secretariat
Mr Richard Samuda [Chair]	Mr Mike Hoare	Mr Simon Grainger-Lloyd
Ms Clare Robinson	Miss Kam Dhami	
Dr Sarindar Sahota OBE	Mrs Chris Rickards	
Mrs Gianjeet Hunjan		
Ms Olwen Dutton	**Guests**	
Mr Toby Lewis	Patient for patient story	
Mr Tony Waite	Dr Suki Dhillon	
Mr Colin Ovington		
Miss Rachel Barlow		
Dr Roger Stedman		

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies for absence were received from Mr Kang and Dr Gill. The Board welcomed a member of the public and Mrs Pam Jones, Chair of Healthwatch, Sandwell.	
2 Declaration of Interests	
Mr Grainger-Lloyd advised that there had been no further declarations made since the last meeting.	
3 Minutes of the previous meeting	**SWBTB (9/14) 158**
The minutes of the Trust Board meeting held on 4th September 2014 were presented for consideration and approval.	
4 Update on Actions arising from Previous Meetings	**SWBTB (9/14) 158 (a)**

The Board received the updated actions log. It was noted that there were no actions outstanding or requiring escalation to the Board for resolution.	
4.1 Update on risks associated with bedside procedures	**Verbal**
Dr Stedman reported that a survey of the clinical teams had been undertaken to establish the depth and breadth of the issue concerning risks associated with bedside procedures. He advised that there were now few procedures of this nature, with most taking place in other more appropriate places in the Trust. The Board was also advised that there was a need to tighten up processes related to parasentesis and chest drains, which would be taken forward. Mr Lewis asked if there was a possibility of identifying a list of outpatient procedures requiring consent. Miss Barlow advised that there was a list of these, however there may be additional procedures still to be identified which needed to be coded. It was agreed that this would be considered further and be brought back at the next meeting.	
ACTION: Miss Barlow to present the list of coded outpatient procedures requiring consent at the next meeting	
5 Questions from members of the public	**Verbal**
The member of the public asked whether the Board received any negative stories from patients which were presented in public. He was advised that this was the case and there was a process where all the negative issues and learning matters were rigorously considered by the Board. Mr Lewis advised that it had been reported in the recent Sentinel Stroke National Audit Programme that the Trust had progressed to being a 'B' rating for the Trust's stroke service (on a rating of A, being excellent to E being very poor), which was pleasing. Mrs Jones asked what monitoring was in place within the Eye Hospital following the recent Never Events. Mr Lewis advised that all theatre lists were reviewed for 'always events' showing that the required checks were routinely made. He advised that this approach was reported to have delivered significant improvement and encouraged staff to challenge any potential issues before an error occurred. It was agreed that this information should be provided to Healthwatch. Dr Stedman added that the MaPSaf tool had been introduced which gauged the maturity of the safety culture in the Trust which had also promoted an error free environment. Mrs Jones noted that there was an intention to provide a note to outline how patients in the community were monitored. Mr Lewis advised that this had been prepared, which provided this overview. He noted that the questions had prompted the consideration of a double checking process to check that robust discharges had been made and therefore a sampled audit would be undertaken to	

ensure that when patients were promised District Nurse care, that this was received as expected.	
ACTION: Mr Lewis to provide Healthwatch with a summary of the additional 'always events' checks made following the Never Events reported in Ophthalmology	
6 Patient story	**Presentation**
The Board heard from a patient who had been treated for a stroke by the Trust. He was accompanied by Mrs Jackie Wilkinson, lead nurse for stroke. Dr Stedman noted that the patient had presented early and asked whether from his point of view, what else could be done to raise the need to present to Accident and Emergency as soon as possible to secure an outcome that was as positive as it could be. The patient noted the need to link into community very tightly in addition to the ambulance service and other partners in this respect. Ms Dutton asked whether there seen to be sufficient liaison with these organisations. The patient suggested that this was the case, however there was a need to continue to raise awareness. Dr Sahota noted that the symptoms for Bell's palsy were similar to those for stroke and noted the need to distinguish between these cases quickly. Mr Lewis asked what else could be done to handle young stroke patients. The patient noted the need to better educate and develop services for these individuals on sex, work, driving and other lifestyle choices after a stroke. Mrs Wilkinson advised that stroke follow ups and supporting mechanisms were in place already however she expressed the need to learn from the patients themselves and make the after care information as personal as possible. The patient suggested that establishing a stroke ambassador would be a worthy measure to undertake. Dr Stedman asked how the patient felt by being transferred between sites to gain the best care. The patient advised that within a city environment this was not an issue, however in other areas of this country this may not be as effective. The Chairman thanked the patient for his story and advised that the staff would be appraised of the good feedback.	
7 Chair's opening comments and Chief Executive's report	**SWBTB (10/14) 160** **SWBTB (10/14) 160 (a)** **SWBTB (10/14) 160 (b)**
The Chairman advised that the AGM had been well received. Ms Robinson suggested that although the event was good and there had been excellent engagement, there was a need to ensure that the timing of the individual slots were not too long. She also suggested that questions in advance would be helpful, with which Ms Dutton agreed. Ms Dutton suggested that there needed to be ways to engage with the public on a more continuous basis.	

Mrs Jones suggested that the AGM had been good and it was pleasing that there was a good deal of openness.

Mr Lewis noted that the questions at the AGM had been quite disparate and a quarterly engagement activity around key themes could be useful.

The Chairman advised that he had joined the League of Friends event which had been well a useful and enlightening experience.

Mr Lewis reported that he was pleased at the recent success of establishing an intermediate care facility in the Sheldon Block, with the service commencing on 8 December. He made mention of the Better Care Fund and highlighted that the submission made was not congruent with the needs or position of the Trust. Finally, he advised that the 'Look and View' report had been received and responded to and there were further external reviews planned in coming weeks, including that by the Care Quality Commission. Mrs Jones picking up the Better Care Fund issue, asked how much the Trust had been involved in the process to date. Mr Lewis advised that there had not been sufficient opportunity to engage with the process. Ms Dutton provided an overview of the context to the Better Care Fund process. She advised that there was a view that the plans submitted needed further work for a variety of reasons. Mr Lewis noted that better collaboration between providers and other parties was necessary to improve the quality of plans.

The Board was advised that the 'Sign Up to Safety' initiative had been launched which the Trust supported.

Mr Lewis reported that there was a plan to reduce the Trust's paybill to achieve the desired level for 2015/16 start. He advised that there was a plan to reduce the notional establishment by 450 WTE, with c. 160 of these posts currently being filled, meaning that individuals would be selected for displacement and redeployed. It was noted that there were a number of risks associated with the process, including those around financial and morale issues. Miss Dhami noted that the process as experienced previously was difficult, however the communication, openness and timeliness was good. The Chairman asked what assurances were in place that the process would not compromise quality and safety. Dr Stedman advised that all schemes had received a quality impact assessment, which identified the mitigations to any risks and the ongoing monitoring process for these. Ms Dutton noted that should there be an adverse impact then speedy mitigation was needed to address the position. Dr Stedman noted that the impact on back office and support functions was being given equal oversight to that for clinical areas. Mr Lewis advised that any 'red flags' would be addressed robustly and quickly. Ms Robinson asked how support would be given to addressing morale issues. Mr Lewis advised that a staff counselling hotline was in place and chaplaincy and Trade Union services would provide good support. It was noted that the majority of staff would know what redundancy pools had been arranged and which staff were at a risk of redundancy very swiftly. Ms Robinson noted that the key themes from concerns should be identified and collated. Mr Lewis advised that a log of all queries raised during the 45 day consultation

process would be kept and disseminated at the end of the process.	
8 Francis Report action plan – mid-year review	**SWBTB (10/14) 161** **SWBTB (10/14) 161 (a)**
Miss Dhami reminded the Board that in December 2013, the response to the Francis Report had been signed off, including the action plan to address the recommendations. A position statement against the themes was outlined and the Board was asked to note that progress had been made in most areas. Mr Lewis suggested that adequacy of the proposed end year position may need to be considered further in the next update. It was noted that there was a Non Executive and Executive pairing set up for the themes and agreed that this may need to be reinforced. It was agreed that these 'buddying' arrangements should be recirculated.	
ACTION: Miss Dhami to make an assessment of the adequacy of the proposed end year position against the actions raised in connection with the Francis Report **ACTION: Mr Grainger-Lloyd to circulate the NED/ED pairings for the Francis themes**	
9 Research and development plan 2014-17	**SWBTB (10/14) 162** **SWBTB (10/14) 162 (a)**
Dr Stedman presented the three year plan for Research and Development, which he highlighted was ambitious. He drew the Board's attention to the section of the plan which outlined why Research & Development was of importance to the Trust. He advised that the work directly supported the delivery of healthcare and that Research and Development needed to be better integrated within the 'business as usual' delivered by the Trust. The Board was advised that effort would be directed to engaging more patients in the work. It was noted that the strengths of the current service provision and working with the existing and additional partners would be given good priority and the scope of research would be extended. It was noted that Dr Gill had provided some comments, including how the number of patients participating in trials was monitored. Dr Stedman advised that there was a drive to engage 6000 patients, which was highlighted to be ambitious but realistic. Dr Sahota suggested that an even greater level of ambition should be sought in some areas in this respect. Dr Stedman advised that this could be addressed in the dedicated academic areas, however it was unrealistic to expect the same in some other areas of the Trust where there was a wider contribution base. Mr Lewis agreed that the citation index should be considered within a future meeting of the Research and Development Committee. Miss Barlow asked whether there was any research linked to Primary Care to address the Trust's integrated care ambitions. Dr Stedman advised that research	

in this field was undertaken by region and covered large number of patients. He added that looking at this interface would be considered as part of the plan. Ms Robinson asked how the cost benefit was secured from the research and how the work would benefit the patients for best effect. Dr Stedman advised that these indicators were monitored by the Research and Development Committee. He advised that the prioritisation process could be tightened up further however.	
ACTION: Dr Stedman to arrange for the citation index for Research & Development to be considered at the next meeting of the Research & Development Committee	
10 Cancer services update	**SWBTB (10/14) 163** **SWBTB (10/14) 163 (a)**
Mr Lewis presented a tabled paper which set out the planned approach to taking forward cancer services in the Trust and the issues that were associated with the service. He advised that the day to day governance of cancer services would be managed through the Chief Operating Officer, however a specific set of seven objectives would be addressed through a separate task group which would address the issues identified to a large degree. Ms Dutton asked whether the service covered Paediatric oncology and was advised that this was not the case. It was noted that the list of objectives proposed was ambitious. The relationship with partners as part of the work was discussed. Dr Stedman added that the current position reflected that interdependencies of the service with other areas and partners. It was noted that the current service was safe, however the structural delivery of the services needed to be amended for the benefit of the patients. Dr Sahota asked whether there was a risk that a private company could bid for cancer services delivery. He was advised that this was not likely to be the case.	
11 Learning plan 2014-17	**SWBTB (10/14) 164** **SWBTB (10/14) 164 (a)**
Miss Dhami reminded the Board that at the July informal session the Board had considered the learning plan and comments made had been incorporated. She highlighted that plan was wider than just when things went wrong and was wider than complaints and incidents. The Board was asked to note that the objectives and deliverables could be themed over several years. Mr Ovington highlighted that the plan was key to the current initiative for signing up for safety. Mr Lewis highlighted the challenges with implementing an organisational learning plan and that there was a need to take a robust and disciplined approach to focussing on individual themes by rotation. Ms Robinson asked how the Board would engage with the work, given the	

importance of showing a leadership role in delivering this. It was suggested that a rolling slide pack telling the story of change could be created. It was agreed that this could be included in a future informal session.	
ACTION: Mr Grainger-Lloyd to schedule a discussion about the rolling slide pack showing organisational change for a future Board Informal session	
12 Corporate integrated dashboard	**SWBTB (10/14) 165** **SWBTB (10/14) 165 (a)**
Mr Waite reported that it was clear that there was significant pressure operationally, with the Emergency Care target having not been met recently. In terms of delayed transfers of care, it was reported that there was continued pressure although pleasingly, there had been no mixed sex accommodation pressures. It was reported that the 18 week target for admitted and non-admitted care had been met in aggregate, however at a speciality level there was further work to do to generate an improvement. In this respect, Miss Barlow reported that there had been a request from the Secretary of State nationally to generate an improvement against the 18 week referral to treatment time target. It was reported that the Trust's plan was to achieve compliance with the target by December 2014. The Board was advised that a further review of some of the longest waiting times would be undertaken. Miss Barlow reported that the E-outcome form pilot had started recently which provided an opportunity to have access to real time data, with the outcomes to clinics being reviewed rigorously. It was noted that there was potential for this new form of reporting to suggest a degree of underperformance. Mr Lewis clarified that pre-2013 reported non-admitted waits has been recorded in an idiosyncratic manner, which was addressed, however the new pilot focussed on improving data quality concerning how pathways were closed which might report underperformance. Mr Ovington reported that a MRSA bacteraemia case had been reported and a review had been undertaken. It was highlighted that the review had determined that the case was unavoidable and the bacteraemia was associated with the current treatment rather than being as a result of an error or poor care.	
13 Financial performance – Month 5	**SWBTB (10/14) 166** **SWBTB (10/14) 166 (a)**
Mr Waite reported that for Month 5 a balanced financial position had been achieved, however the positon remained off plan. It was noted that the pay bill and agency costs had reduced however. It was reported that much effort was being directed to achieving stability in readiness for the start of 2015/16. A focus on non-pay was also noted to be being directed. The risks and measures to achieve a stable position were outlined. Capital expenditure was reported to remain below plan, however the works on Ward D47 and reprioritisation of some aspects of the programme would assist with addressing this position. The Chairman asked as a result, whether any schemes had needed to be delayed and if so what the impact this had caused. He was advised that some of the IT schemes had been delayed, however the quality impact assessment had	

highlighted that there was no expected adverse impact. In terms of the intended income position, Mr Lewis expressed his understanding that the year-end position would be adverse of £1.2m, taking into account proposed fines of £2m, receipt of £1m from the incentives and income associated with achieving most of CQUIN. He asked for confirmation that this was the case. Mr Waite reported that there was a risk looking forward for some areas in respect of income. He advised that discussions were needed with the Trust's commissioners to understand the penalties and incentives implications. Ms Robinson asked whether the fines were shown as expenses or reductions in income. She was advised that the fines would be shown as an expense.	
14 Trust risk register update	**SWBTB (10/14) 167** **SWBTB (10/14) 167 (a)** **SWBTB (10/14) 167 (b)**
14.1 Update on actions agreed at the last meeting	
Miss Dhami asked the Board to receive and note the Trust risk register.	
14.2 New considerations	
Miss Dhami provided an update on the maternity risk in terms of not having a second obstetrics theatre team. It was reported that no other Trusts had the benefit of a second theatre team, however the Board was asked for its view on the proposed mitigation. Mr Lewis suggested that on the basis that general emergency cover on the City Hospital site was adequate, there was little requirement to establish a second theatre team. It was noted that the circumstances which would prompt the need for a second theatre time were rare, however there was a need to better raise the awareness of the circumstances where this was needed with the general theatre team on the main spine at City Hospital. Mr Ovington advised that there was no greater probability that emergencies would arise out of hours and that the majority of elective work was undertaken during the day. On this basis, it was agreed that the risk should be included on the risk register as a tolerated risk. It was noted that the Women and Child Health Group had accepted the recommendation that the scoring of the risk associated with the Paediatrics HDU should be reduced.	
ACTION: Miss Dhami to arrange for the risks associated with a second obstetrics theatre team to be included in the risk register as a tolerated risk	
14.3 Risk assessment around industrial action	**SWBTB (10/14) 168**
Miss Barlow reported that the planning for the imminent industrial action was going well. It was reported that staff volunteers would be sought to assist with the inpatient breakfast rounds and other ancillary work. It was reported that the strike coincided with the announcements of the workforce review which provided additional challenges. Mr Lewis advised that the doctors needed to be redeployed onto wards to assist where needed. Miss Barlow	

advised that patients who were due to attend had been advised of the cancellations. It was noted that there was capacity to ensure that those staff not attending work would not receive pay for those hours not worked.	
15 Trust's equality plan	**SWBTB (10/14) 169** **SWBTB (10/14) 169 (a) - SWBTB (10/14) 169 (d)**
Mr Ovington reported that a self-assessment against the equality delivery system which was yet to be concluded. It was reported that an assessment by a local interest group was to be undertaken, which might alter the overall position. The Trust was asked to note the demographic and diversity information provided. Ms Dutton expressed concern that the impact of key decisions being taken by the Board on groups of patients with protected characteristics was not sufficiently robust. It was agreed that the Board paper template and cover sheets should take this into account.	
ACTION: Mr Grainger-Lloyd to work with Mr Lewis to update the Board paper front sheet & template to better capture any equality and diversity impacts associated with proposals that the Board was asked to consider	
16 Care for patients with learning difficulties	**Presentation**
The Board was asked to note the position in terms of the service provision for patients with learning difficulties. It was reported that in 2013/14, 129 patients has been discharged with learning difficulties. A number of key priorities for patients with learning difficulties were reported to have been identified. Mr Ovington outlined the plans to develop the services for patients with these challenges given that the offering was not as advanced or consistent as desired. It was highlighted that there were a number of opportunities available to improve the service. Dr Sahota asked whether the Trust was linking into the voluntary organisations that specialised in learning difficulties and was advised that work was now underway, however further linkages needed to be made. Mrs Hunjan asked what services would be provided at Orchard School. Mr Lewis reported that an Ophthalmic service was already offered and that it had been arranged for a surgeon to visit the clinic on a quarterly basis. Mr Lewis noted that the service provided a good opportunity to advance towards the Trust's integrated care ambition. He added that it also supported the scope to support the vulnerable adult agenda. It was suggested that a Board champion needed to be identified for this work.	
ACTION: The Chairman to identify a Non Executive champion for learning difficulties	

17 Service presentation - Audiology	**Presentation**
Dr Suki Dhillon joined the meeting to present an overview of the Trust's audiology services. Ms Dutton asked whether services were offered on a seven day a week basis. She was advised that this was not the case, although there was an opportunity to provide the service on a Saturday which would be popular with patients. Dr Stedman asked what research and development was undertaken in the area and was advised that there was much opportunity in this area and was part of the plans for developing the service. Mr Lewis noted that the economics of the maternity services were being reviewed and needed to include the newborn screening. He also suggested that consideration needed to be given to the future location of the service. It was agreed that dementia services needed to be built into the future of the service. Mr Lewis noted the size of the service and agreed that greater focus needed to be on the service in future.	
18 Update from the meeting of Finance & Investment Committee held on 26 September 2014 and minutes from the meeting held on 29 August 2014	**SWBFI (8/14) 049**
Ms Robinson presented an overview of the key discussions from the Finance & Investment Committee held on 26 September 2014. It was reported that the forward work for 2015/16 was to be a key focus of the Committee in future and that focus would be directed to the non-pay plan.	
19 Update from the meeting of the Quality & Safety Committee held on 26 September 2014 and minutes from the meeting held on 29 August 2014	**SWBQS (8/14) 062**
Ms Dutton presented an overview of the key discussions from the Quality & Safety Committee held on 29 August 2014.	
20 Update from the meeting of the Workforce & OD Committee held on 26 September 2014 and minutes from the meeting held on 27 June 2014	**SWBWO (6/14) 052**
Mr Samuda presented an overview of the key discussions from the Workforce & OD Committee held on 26 September 2014. The Chairman reported that much work had been devoted to looking at sickness absence. Mr Lewis reported that a decision had been taken to suspend the rolling three year checks, but consideration would be given to looking to an annual return for all employees which could incorporate any declarations of criminality.	
21 Update from the meeting of the Public Health, Community Development and Equalities Committee held on 29 September 2014 and minutes from the meeting held on 29 May 2014	
Mr Samuda presented an overview of the key discussions from the Public Health,	

Community Development and Equalities Committee held on 29 September 2014. The Chairman noted the powerful influences that could be exerted by the Trust's maternity services in respect of Public Health.	
22 Any Other Business	**Verbal**
There was none.	
Matters for Information	
The Board received the following for information: • Midland Metropolitan Hospital Project: Monitoring Report • Foundation Trust Application Programme: Monitoring Report • Chief Inspector's visit – preparation plan • Nurse staffing levels	**SWBTB (10/14) 171** **SWBTB (10/14) 172** **SWBTB (10/14) 173** **SWBTB (10/14) 174** **SWBTB (10/14) 174 (a)**
Details of the next meeting	**Verbal**
The next public session of the Trust Board meeting was noted to be scheduled to start at 1330h on 6 November 2014 and would be held at the Tower Hill Medical Centre, Perry Barr.	

Signed: …….

Name: …….

Date: ……

Next Meeting: 6 November 2014, Tower Hill Medical Practice, Perry Barr

Sandwell and West Birmingham Hospitals NHS Trust - Trust Board

2 October 2014, Churchvale/Hollyoak Rooms @ Sandwell Hospital

Members present: Mr R Samuda (RSM), Ms C Robinson (CRO), Dr S Sahota (SS), Mrs G Hunjan (GH), Ms O Dutton (OD), Mr T Lewis (TL), Miss R Barlow (RB), Mr T Waite (TW), Mr C Ovington (CO), Dr R Stedman (RST)

In Attendance: Miss K Dhami (KD), Mr M Hoare (MH), Mrs C Rickards (CR)

Apologies: Mr H Kang, Dr P Gill

Secretariat: Mr Simon Grainger-Lloyd (SGL)

Last Updated: 31 October 2014

Reference	Item	Paper Ref	Date	Action	Assigned To	Completion Date	Response Submitted	Status
SWBTBACT.317	Financial performance – Month 3	SWBTB (8/14) 126 SWBTB (8/14) 126 (a)	07-Aug-14	Present a benchmarked position concerning seven day working at the October meeting of the Board	RB	02/10/2014	Included on the agenda of the November meeting	Y
SWBTBACT.303	Never Events controls assurance	SWBTB (7/14) 099 SWBTB (7/14) 099 (a)	03-Jul-14	Establish a task and finish group to identify additional controls and sources of assurance around Never Event prevention	KD	06/11/14	Never events controls assurance deferred for discussion to the December meeting	Y
SWBTBACT.289	Chair's opening comments and Chief Executive's report	SWBTB (6/14) 075	05-Jun-14	Arrange for the Board to be appraised of the Trust's capacity to handle patients with learning difficulties at a future meeting	SGL	04/09/14	Included on the agenda of the October meeting of the Trust Board	B
SWBTBACT.290	Chair's opening comments and Chief Executive's report	SWBTB (6/14) 075	05-Jun-14	Present the revised research & development strategy to the Board in October	RST	02/10/14	Included on the agenda of the October meeting of the Trust Board	B
SWBTBACT.301	Never Event in Medicine & Emergency Care	Presentation	03-Jul-14	Oversee a review of the risks associated with bedside procedures, with specific reference to the possibility of a Never Event	RST	30/09/14	Included as a matter arising on the agenda of the October meeting of the Trust Board	B
SWBTBACT.318	Trust risk register update	SWBTB (8/14) 127 SWBTB (8/14) 127 (a)	07-Aug-14	Present an update on the future of acute Oncology at the October meeting of the Board	TL	02/10/2014	Included as an update on the agenda of the October 14 meeting	B
SWBTBACT.323	Questions from members of the public	Verbal	04-Sep-14	Prepare a note for Healthwatch, outlining the process for quality assuring the standards of care in the community	TL	02/10/2014	Prepared as requested	B
SWBTBACT.324	Chair's opening comments and Chief Executive's report including an update on NHS Mutual briefing	SWBTB (8/14) 118	04-Sep-14	Schedule a discussion around the Rotherham safeguarding issues at a future Board meeting	SG-L	06/11/2014	Included on the agenda of the November meeting	B

SWBTBACT.325	Progress with strengthening consent process	SWBTB (9/14) 141 SWBTB (9/14) 141 (a)	04-Sep-14	Schedule an update on the process for strengthening consent processes into the Board meeting planned for November 2014	SG-L	06/11/2014	Included as a matter arising on the agenda of the November Trust Board	B
SWBTBACT.326	Corporate integrated dashboard	SWBTB (9/14) 143 SWBTB (9/14) 143 (a)	04-Sep-14	Arrange for a crude mortality rate to be included in future versions of the integrated performance report	TW	31/12/2014		G
SWBTBACT.328	Update on risks associated with bedside procedures	Verbal	02-Oct-14	Present the list of coded outpatient procedures requiring consent at the next meeting	RB	06/11/2014	Included as a matter arising on the agenda of the November Trust Board	G
SWBTBACT.329	Questions from members of the public	Verbal	02-Oct-14	Provide Healthwatch with a summary of the additional 'always events' checks made following the Never Events reported in Ophthalmology	TL	06/11/2014	Summary note prepared	G
SWBTBACT.330	Francis Report action plan – mid-year review	SWBTB (10/14) 161 SWBTB (10/14) 161 (a)	02-Oct-14	Make an assessment of the adequacy of the proposed end year position against the actions raised in connection with the Francis Report	KD	08/01/2015	To be featured in next update to the Board in January 2015	G
SWBTBACT.331	Francis Report action plan – mid-year review	SWBTB (10/14) 161 SWBTB (10/14) 161 (a)	02-Oct-14	Circulate the NED/ED pairings for the Francis themes	SG-L	06/11/2014	Circulated as requested	G
SWBTBACT.332	Research and development plan 2014-17	SWBTB (10/14) 162 SWBTB (10/14) 162 (a)	02-Oct-14	Arrange for the citation index for Research & Development to be considered at the next meeting of the Research & Development Committee	RST	31/12/2014		G
SWBTBACT.333	Learning plan 2014-17	SWBTB (10/14) 164 SWBTB (10/14) 164 (a)	02-Oct-14	Schedule a discussion about the rolling slide pack showing organisational change for a future Board Informal session	SG-L	12/12/2014	Scheduled for the December meeting	G

SWBTBACT.334	Trust risk register update	SWBTB (10/14) 167 SWBTB (10/14) 167 (a) SWBTB (10/14) 167 (b)	02-Oct-14	Arrange for the risks associated with a second obstetrics theatre team to be included in the risk register as a tolerated risk	KD	06/11/2014	Added as requested	G
SWBTBACT.335	Trust's equality plan	SWBTB (10/14) 169 SWBTB (10/14) 169 (a) - SWBTB (10/14) 169 (d)	02-Oct-14	Work with Mr Lewis to update the Board paper front sheet & template to better capture any equality and diversity impacts associated with proposals that the Board was asked to consider	SG-L	30/11/2014	To be launched in time for December Board meeting	G
SWBTBACT.336	Care for patients with learning difficulties	Presentation	02-Oct-14	Identify a Non Executive champion for learning difficulties	Chairman	06/11/2014	To be advised as part of learning disability update included on the agenda of the November meeting	G

KEY:

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

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Coded Outpatient procedures requiring consent**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Rachel Barlow – Chief Operating Officer**
DATE OF MEETING:	**6th November 2014**

EXECUTIVE SUMMARY:

The Trust carried out 18,705 chargeable outpatient procedures in the first 6 months of this year. The main specialities and main procedural groups are as follows :

- Dermatology - cryotherapy, biopsies
- Gynaecology- Colposcopy of cervix
- ENT - Diagnostic endoscopic examination of nasopharynx and biopsies
- Gastroenterology- Endoscopies
- Urology- diagnostic endoscopic examination of bladder
- General Surgery- Endoscopies
- Ophthalmology- Digital imaging of retina

Most of these procedures are likely to be carried out on the day of attendance to an outpatient or diagnostic appointment , particularly with the increasing 1 stop service offered in the elective outpatient settings. Consent is more likely therefore to be on the day of procedure, compared to scheduled inpatient procedures.

The risk of never events as with surgical procedures remains those related to ;

- The correct patient (ID)
- Lateralisation errors
- Retention of swabs/ instruments

Assurance on the standard for consent for outpatient procedures for the key specialities is being sort in terms of assurance controls from specialities, based on the above themes.

Speciality audit will be completed in Q3 and presented to the Quality and Safety Committee.

REPORT RECOMMENDATION:

To support recommendation to follow up audit and assurance through Quality and Safety Committee.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	x
Clinical	**x**	Equality and Diversity		Workforce	
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Accessible and responsive care, safe and high quality care

PREVIOUS CONSIDERATION:
Matter arising from the October 2014 meeting

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE PUBLIC TRUST BOARD

Chief Executive's Report – November 2014

The integrated performance report provides considerable detail at the mid-year point with key safety and quality ambitions. Our current projection remains full delivery of the contracted CQuIN standards, as well as the 40+ quality goals given to us by our host commissioner. Because we are now mid-inspection by the Care Quality Commission we will not be banded by them with their latest quarterly issue of Intelligent Monitoring data later in November – albeit we know that if we were assessed we would remain in the top third of organisations nationally. Our Q2 Annual Plan review provides the board with a straightforward summary of full year expectations against our own ambitions, and is a key paper, in my view, in today's bundle. As an annex to this paper I provide the staff summary of the Year-To-Date issued with payslips in October. We continue to focus on improving further turnaround times for complaint responses, as well as learning lessons from mistakes and experiences reported to us. The latest quarterly report on this work is also at the Board this month for scrutiny.

1. Our patients

It is frustrating that we continue, despite concerted effort, to miss the four hour wait standard for emergency care. Our planning for winter takes a realistic view of the scale of demand change we might expect from the actions of partners and operates with an assumption that supply-side changes are needed to manage increased acuity in coming months. We are working with the CCG to try and understand their plans for care in spring 2015 so that we can plan the next four months with a view to the months that follow. This is critical given their Better Care Fund ambitions to see emergency admissions fall very sharply.

Board colleagues will be aware that in 2014-2015 we have had to substantially adjust our financial and workforce plans to retain beds open due to failures to reduce demand or delayed transfers of care (which have doubled compared to 13/14). The revised 10-point plan for emergency care in SWB now requires that by the end of November, ourselves and the CCG have reached an agreed position on these issues for 2015-16, and we will discuss at the next Board meeting any actions arising from those discussions. Although rising demand is, in no way, an excuse for missing the standard it is worth being explicit that we continue to see front-door demand rising:

- If we focus just on the two EDs (excluding eye casualty) and we discount the patients counted as deflected by the Malling Health front end in 2014-15, we have seen a 5% rise in ED attendances since 2012. Of course in 2013 we invested in ED staffing, but we did not do that with an expectation of growth in demand.
- In 2014, Sandwell has seen a significant rise in ambulance conveyance (arguably a cipher for acuity) with a 7% growth in demand compared to 2013. This includes a 28% rise in transfer

from Walsall, as that site has faced major pressures. Our 10-point plan seeks to agree more discrete geographical boundaries for ambulance conveyance in coming weeks.

Meanwhile, we remain committed to cutting planned care waits. Our Year of Outpatients work and other endeavours need to address the 37% of outpatient referrals that wait more than our own six week standard. The Trust does continue to meet diagnostic wait time standards, and the 18-week measure. As part of the changing landscape of national policy in this area, we have re-ordered our waiting list practices in October and November to prioritise faster some long wait patients, with a view to re-achieving 'Trust level' compliance in December, and specialty level compliance (for the first time in our history) in January 2015. Maintaining that position in 2015-16 will require action by CCG colleagues to address rising patterns of referral in some disciplines, as well as a transfer of contract income from UHB to SWBH in the next fiscal year.

Further to our upcoming Configuration Committee, I will add an oral update to the Board on discussions within the Clinical Leadership Executive about acute surgery. These deliberations have taken place intermittently over the last 12 months, and Board colleagues will recall that this is one of two issues (the other being cardiology) where we have consistently signalled a need to change the current state *before* 2018. Many Board members will recall the recommendations of the Independent Review Panel (IRP) seven years ago on surgical emergencies, which urged a single site model at Sandwell. The latest review of the position across senior leaders reaches the same conclusion and discussions are now taking place with the CCG and OSC about how to improve access to specialist surgical emergency care quickly for people living in Ladywood and Perry Barr. Around 5000 patient contacts a year represents the scale of service under consideration.

As I highlighted in Q1, we are now in the process of implementing some changes to front-line provision, which have a bearing on patients' experience of care. Positively, we expect by the end of November to have implemented our WiFi service, certainly on the City site where we withdrew Hospedia earlier this summer. October saw us begin changes to our bed-side food provision, with soup, sandwiches and salads replacing lunchtime cooked meals. The 'full' meal offer remains in the evening. In the week the Board meets our 'Going Green' Public Health Plans on canteen food pricing and choice start, alongside the removal of sugared drinks from our vending machines. Taken together, we are part way towards our public health commitments in this area for this year – with work to do on overnight hot food availability for staff which we expect to have in place by the end of March.

Finally, we continue to see improvements in our Friends and Family test scores, both in response rate and assessment by patients. In October we started our SMS based outpatient surveys, which are achieving good response and feedback scores and give us further data to overlay on our comment cards. We need to use multiple methods to get feedback from a wide variety of users, as part of our equality obligations, as part of Francis Response Action Plan, and because we want to provide care which meets people's needs. The CQC were clear that we had distinctively positive patient feedback both before and during their inspection, and we need to build on that strength – looking "out not up" as we develop services locally.

2. Our staff

Our workforce change consultation (Safe and Sound 2014-2016) continues. It commenced on October 3rd, after several weeks pre-consultation, and formally concludes on November 17th. I have made clear internally and to regional trade union colleagues that I would be open to extending to November 24th should they provide me with material evidence that information is unavailable currently to consult on individual schemes, of which there are over 80. Appeals against pooling selection have been heard in line with the timetable set out in the consultation document. Over the coming fortnight interviews will take place which, if enacted after consultation conclusion, will have the effect of reducing significantly the number of employees personally affected by the proposed changes. The vast majority of Trust employees are not affected, but of course changes in working practices in one team may require adjustments elsewhere, hence the very visible publication internally of details of each scheme. A number of schemes have been altered or indeed removed based on consultation feedback, including better ideas from teams, and this attests to the genuine nature of what is a dynamic but inevitably distressing process of change.

The Trust has continued recent success in awards. Our Staff Award ceremony saw an unprecedented number (400+) of nominations and success across community and hospital settings, and across professional and non-clinical roles. We benefitted from external sponsorship to meet our costs, and enjoyed Mayoral representation from both Birmingham and Sandwell. I was delighted in particular to see our clinic prep team recognising for their 'back office' work, the Acute Medical Units at City praised for their transformation in recent months, and of course our employee of the year – Maria De La Fosse, Ward Service Officer for our serenity maternity unit.

Meanwhile, the Trust won two top prizes (the most of any organisation) at the Health Education West Midlands Apprentice of the Year awards, and those two winners will visit the Board next month to share their stories. And the Nursing Times has confirmed that our iCares team (who spoke at the Board in August) are the best example of the country of Integrated Care. This is a fabulous accolade for a multi-professional team working across Sandwell, and shortly to be expanded into West Birmingham.

Into this mix of challenge and real success, I should draw attention to our continued work to reduce use of bank and agency staffing. In September we maintained the 30% fall in agency costs used by the Trust that we achieved in August. Our forward financial plan requires another 20% drop over the next two months. This will be helped by recruitment but also by steps to tackle our high sickness rate, which has been an issue for the Trust over many years. It was a failed objective for improvement in 2013-14 and remains stubbornly high in some areas. We have just written out to celebrate the work of more than 3,000 employees who have not been off work for over six months – as we continue to try and provide a balance of encouragement and greater scrutiny of departments struggling to improve this position. Our determination to be Fully Staffed is an important objective. Having agreed workforce numbers, we then need to re-double efforts to make sure that it is easy to recruit, we improve retention and we cut absence.

3. Our partners

The Trust has contributed to a shortlisted bid to become a genomics centre in the upcoming designation. Clearly UHB is leading the way alongside BCH and BWH. Karim Raza, whose research

plan we formally adopted at our last Board, is coordinating our contribution to those important agenda. In ten years what appears now rarified medicine will become commonplace in DGH practice and we need to gear up for that transformation.

We continue to meet with partners to explore the issues arising from the CCG/LA Better Care Fund submissions. 94 schemes nationally were approved, with 56 receiving binding remedial conditions. Our focus now is on ensuring success with the BCF to prevent admission. Of course, our contractual plans for 2015-16 need to provide for either success or failure, and we will need to determine in setting our financial plan for 2015-2016 how the excess costs of retaining spare capacity are handled. This does form part of our 10-point plan for this winter, in an effort to provide staff with a clear 'line of sight' across upcoming months.

Discussions continue this month with Birmingham City Council at a district level about service provision in West Birmingham. The Board will recall discussions over many months about how social care is developed around the City site. These continue. It is encouraging that 'ring-fenced' have now opened (12) for local people, to go alongside our proportion of the 100 social care placement beds across the City. There continue to be substantial delays in accessing these services, and our aim to halve the issue this year has been confounded as the problems have doubled. This remains a material risk to our winter plans and indeed to the financial stability of services. Every feasible discussion continues to ensure that we are able to offer West Birmingham residents the streamlined and manifestly improved quality of health/social care interface now being delivered in Sandwell.

4. Our regulators

Two parts of the Trust have had successful medical education inspections in recent weeks: Ophthalmology at Sandwell and paediatrics cross site. We await our upcoming plastics/trauma inspection, and continue to closely monitor the Sandwell ED position in preparation for the restoration of training status in February 2015.

The visit part of the CQC inspection concluded. Evidence submissions from the Trust have been extensive to ensure that the review team are able to assess oral evidence collated from their visits against other sources of data and assurance. Latest information suggests we will be into 2015 before our report is available. In the meantime, we continue to focus on issues of safety and quality previously highlighted to the Board. The CQC have now indicated that they will undertake a thematic evaluation of mental health services across Sandwell, in which the Trust will play an active part.

Toby Lewis,
Chief Executive

31 October 2014

Changes that make a difference for patients

On track	Annual Plan 2014/15 – our objectives
✓	**We have almost eliminated mixed sex inpatient accommodation**, after a great deal of hard work in stroke and cardiology. A small number of breaches of this national standard still arise when we cannot discharge someone from a Critical Care bed into a general bed, after their condition has improved. An external review of our work has concluded that we are doing everything we could to consistently meet the letter and spirit of this ambition, which we know matters greatly to our patients.
✓	**2014-15 is our Year of Outpatients.** We have eight Outpatient Quality standards that we are continuing to work towards delivering by the end of the fiscal year, including reducing waiting times for the 37% of patients who wait more than six weeks for an appointment. • E-outcome forms have been piloted and will now be introduced Trust-wide during November and December, reducing the risk of 'losing' patients and having duplicate outcomes from consultations • From January 2015 we will introduce outpatient kiosks after a very successful trial in BMEC, getting us more and quicker data about our patients' preferences, including enrolment in research trials. Reception staff will be out and about supporting patients at those kiosks and guiding them to where they need to go. 19,000 outpatient visitors gave us their opinion through our comment cards and over 98% were satisfied with what we do. The booking process (which we are changing) was the least well-regarded part of our offer, although one in ten patients did not feel welcomed when they arrived.
✓	**Our first ever Public Health plan is progressing at pace,** and we have already met our promise to end use of landfill with tens of thousands of pounds (and a lot of carbon) cut from our energy bills. • For staff and visitors, more healthy eating options and a new traffic light system for food will be introduced by the end of October, with 'green' healthy food being made cheaper. Our vending machines are also changing • Making Every Contact Count training will be launched in January 2015, focusing on the importance of each interaction we have with patients and their wider health and social needs • We have seen a huge increase in the number of midwives carrying out carbon monoxide monitoring and offering smoking cessation advice – 600 out of 800 new mums in September got this support. The Chief Executive of Public Health England, Duncan Selbie, has described our work as "setting the standard nationally for what Trusts can do."
✓	**We are beginning to make progress to improve our Friends and Family Test (FFT) results.** 36,000 patients each year give us their opinion across A&E, maternity and inpatient services. Four in ten inpatients give us their view, and we would like that figure to be much higher. • In July-September 2014, we saw a 2% improvement in our inpatient results compared to the previous three months. If we can keep that improvement going every quarter, then by the end of 2015 we will meet our aim to have the best results for satisfaction anywhere in the West Midlands • At the same time, we need to stay committed to other forms of feedback, which is why we are re-starting our ward level comment cards, and why we are expanding our text messaging feedback services from A&E into outpatients this month. The CQC told us that feedback from patients on our services is very good. We want to keep it that way, and to make sure we listen to the quieter voices asking for change from particular communities or perspectives. That is why in November we will focus Trust-wide on the views and opinions of patients with Learning Disabilities and their families and friends.
✓	**We continue to meet national cancer waiting times standards.** This is despite big rises in demand for services in breast cancer and endoscopy. We expect rises to continue as national campaigns on early detection gather pace. • We want to reduce diagnostic waiting times further as a Trust, both for those with query cancer referrals and others. We continue to explore with each multi-disciplinary team how we can have standard pathways for care which lead to faster decisions - with patients - about treatment options • The national cancer survey shows improvement for us in many categories of response. However, we have more work to do to talk with patients about their care and not discuss patients in their presence as if they were not there. There is a consistent picture in patient surveys that suggests that we can do better on this measure. Our Cancer Wellbeing Fair was well supported this October, and the Courtyard Team at Sandwell was shortlisted for a staff award. The Oncology Unit won the patient nominated Excellence in Care Award. The Trust Board will consider in December how we can ensure a common standard of excellence Trust-wide in providing information, advice and support to patients with cancer.
✓	**We have successfully launched the 10/10 programme** – a simple safety checklist intended to show our patients and relatives that key things happen within their first 24 hours of admission: • By the end of March, we expect this programme to be visible in every Trust ward, and our key indicators like VTE assessment and MRSA screening to be regularly reaching 100% completion • We are investing in ward managers to support this programme, with these posts being in charge of all professional care within the ward environment, able to ask for help from any other individual on our staff. We expect in January 2015 to start cutting down the number of ward level audits that we do, to reflect a changed focus on getting it right first time and correcting issues at a local level.
✓	**In July 2014 the Chancellor announced approval for our plans for the Midland Metropolitan Hospital.** Meanwhile, we continue to invest in other sites. • We are now completing the process of selecting our construction partner and finalising our design, with a view to contract signature in early 2016 • We have invested almost £1m in creating additional intermediate care beds in Sheldon Block, as part of our long-term estates strategy, and opened additional services at Leasowes this autumn • Plans for Rowley Regis are being finalised, as more clinics move onto site to join the new GUM service there, and the expanded PCAT unit. During 2015-16 we expect to 'finish' the hospital's makeover, as part of getting ready for Right Care, Right Here.
✓	**We have made real progress in expanding the range of support services we offer to our staff.** But there is much more to do, which is why we now collect information from new starters on health status so we can target our support. • We have invested £20,000 in our Occupational Health counselling team as part of our ambition to increase our support for staff with mental health and wellbeing issues • We are the first Trust in the UK to have developed a free Nicotine Replacement Support to assist staff in their efforts to stop smoking, with positive feedback from staff since its launch earlier this year • We have recently been accredited with a 'Top Cycling Location' Gold award and continue to work to install gym access at Sandwell to match that at City. We have also been shortlisted for a Nursing Times Award in Staff Excellence in Health & Wellbeing, and our Occupational Health team has been awarded Beacon status for 2015/16.

More to do to meet our commitments

More to do	Annual Plan 2014/15 – our objectives
1.	**We have around 700 formal complaints each year from patients.** We want to respond quickly and compassionately to each one. Our maximum wait time for response should be 30 days. To meet that aim, we need to do three things in the next six months – • Reduce complaints in emergency care in BMEC and A&E, and respond more quickly when we do have an issue raised. Most of these complaints are about explanations and communication not waiting times • Focus on meeting complainants where we can, and talking with them by telephone where that proves impossible. Repeat complaints often arise because we did not get to the heart of the complaint • Implementing Ten Out Of Ten consistently across all of our ward areas, and responding locally when something gets missed. This would cut complaints by about 5% - details on the back page!
2.	**We continue to not meet the minimum wait time standard in two of our three Emergency Departments. BMEC is our exception.** So far this year, 'four hour' performance Trust-wide is 93.87%. • Last winter, we did meet this standard, and we now need to repeat that success. To do that, we need to improve the pace of decision making and ensure we have freed beds to move patients to. That means cutting delayed transfers of care by implementing our new ADAPT pathway • We have had great success cutting ambulance handover times, and have the most improved position in the West Midlands. We now need to apply the skills learnt in turning around that position to initial triage and assessment.
3.	**Adult acute re-admissions at Sandwell remain more than we would expect.** Our target for 14/15 is to reduce readmissions by 1%. This means that we need to prevent 30 people being readmitted every week. • To address this, we are rolling out the LACE tool in October – this helps us to predict a patient's likelihood of readmission by scoring their spell (previous and current) and ensure adequate out of hospital support.
4.	We **have made a big start with cutting agency and bank use.** A 20% fall in expenditure and hours has been achieved so far without an increase or change in harms. • During September, we introduced new measures to make sure that complex patients had the extra staffing they needed, but that we only used agency HCAs when that was the best option. This work will continue • We will continue to focus on reducing agency use, especially in critical care and A&E, where we want to be providing care alongside people that we know • From April 2015 we will not be using 'Waiting List Initiatives' any more in our services, and work will continue over the next two months to provide specialty by specialty guarantees to the Trust Board that this can be safely achieved.
5.	**We said that we would cut the number of operations that we cancel, and eliminate repeat cancellations.** Since last year we have halved cancelled operation on the day of surgery, and so far this year, 0.8% of operations have been cancelled. We could halve that position again if we managed to eliminate cancelled operations in our eye hospital service and that is now the focus on detailed work. Meanwhile, we are implementing new protocols to "lock down" theatre lists and theatre list order not later than the day before the theatre list in line with international best practice.
6.	**Being fully staffed must mean cutting sickness rates in our Trust.** Long term sickness rates are falling by joint work across Occupational Health and Staff-side. We now need to cut short term sickness. To do that we need to: • Reduce the 'Monday effect' where we show consistently higher rates of sickness than on other days. Back to work interviews will be consistently conducted by local managers • Publish data on employee sickness locally, as we know this changes behaviour within teams, whilst ensuring that staff with a long term condition or disability get the help and reasonable adjustments their service deserves • Celebrate staff whose record of work attendance is outstanding Our year to date sickness absence rate is 4.40% which is above our Trust level target of 3.15%. We know that we spend approximately £8.5 million each year on salary costs alone. We intend to continue to focus on our 'hot spot' areas. We have an agreed sickness plan with the trade unions, which focuses on target dates for long term sickness cases, and on reasonable adjustments for a right of return.
7.	**Ensure we deliver on appraisal and mandatory training.** In 2013-14, every one in our Trust was appraised. We want to repeat that success this year. So far this year we are behind schedule with conducting appraisals and now need to catch up without impacting on the quality of the conversations. That means starting now, or we will have set our Training Plans for 2015-16 without knowing the outcome of appraisals! We have reduced the burden of mandatory training considerably. By October 2015 we want to be fully up to date with individual training, as well as with local training like fire evacuation work.

"We look after people with complex, long term needs and we provide a vital diagnostic service. Midland Met and Right Care, Right Here combines our determination to offer local care with specialist expertise. This is our big chance."

Sadia Noorani,
Consultant Immunologist and Specialty Lead Chief Nurse

'Ten out of Ten' patient safety standards checklist

'Ten out of Ten' is the Sandwell and West Birmingham NHS Trust's patient safety checklist. It is our commitment that each and every patient admitted on to our wards is taken through these standards within 24 hours of arriving.

Have you been told that your checklist is complete? If you believe the following checklist has not been completed within 24 hours of admission, then you (or your carer) should challenge ward staff immediately.

1. We will ask your name, address, date of birth and match these details to your wristband.
2. We will ensure you (and with your permission, your carer) have all the information you need to make decisions about your care and treatment options.
3. On admission, a registered nurse will observe and record your temperature, blood pressure, pulse, height, weight and breathing, and will take any appropriate action.
4. We will check and record your current medication and any allergies.
5. We will assess your levels of pain and offer you appropriate pain relief.
6. We will test you for MRSA, as well as other hospital bugs, and give you appropriate treatment.
7. We will assess your risk of developing a pressure ulcer (bed sore) or falling, and take all relevant action.
8. We will assess your risk of developing a blood clot (venous thrombo-embolism or VTE) and prescribe any appropriate treatment.
9. We will assess your fluid levels and identify and record any special dietary requirements.
10. We will review your lifestyle choices (healthy eating, smoking, alcohol, drug/solvent abuse) and offer appropriate support and advice.

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

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

We want your help.
We want to keep our promise.

Follow us on Twitter @SWBHnhs

Our promises to you...

1. I will... make you feel welcome
2. I will... make time to listen to you
3. I will... be polite, courteous and respectful
4. I will... keep you informed and explain what is happening
5. I will... admit to mistakes and do all I can to put them right
6. I will... value your point of view
7. I will... be caring and kind
8. I will... keep you involved
9. I will... go the extra mile

Jon Mannion, Patient: "I am so lucky that I was treated at Sandwell Hospital after my stroke. At 30 years old, it's not something I was expecting, but the hospital staff were amazing and explained everything that was happening. I can't believe I was able to go home so quickly, and have no lasting ill effects."

Where EVERYONE Matters

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Mid Year Review - 2014/15

Icares staff Kimberley Botfield, Lynn Drinkwater and Lesley Knight

Dear colleague,

The first six months of this year have been immensely busy and pressured ones. Demand for services continues to rise and there no longer seems to be a summer/winter difference in emergency care. The twin challenge of major workforce changes and accommodating the CQC is a very real presence in all our lives. Of course we had the very welcome resolution of the Midland Metropolitan Hospital business case, with the Chancellor's announcement in July. It seems a long time ago, but it had been a very long time coming.

This review picks out some real successes achieved by teams Trust-wide. It also highlights work that has started, which we need to bring to a conclusion over the remaining months. To meet the aims all of us would have for our organisation and for our patients, there are some things that need to change in the next little while.

Later this autumn we will hear back from the CQC with its suggestions. Equally importantly, we will be discussing internally and with partners our own 2020 vision. You may recall that in the spring, the Trust Board, after wide discussion with the leadership cadre, and through Heartbeat, adopted a clear, but very different definition of integrated care.

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

Our plans for the future need to help us to deliver that ambition. It does mean change in how we use IT, and this winter we will make some major choices about that. We have to tackle readmission rates by making the best use of our skilled community specialists. It means we need to create space for multi-disciplinary hospital and community clinics, so that complex patients with multiple conditions get the best of our expertise.

We need to work even harder to make sure issues around consent, mental capacity, Do Not Attempt Resuscitation (DNA-CPR), are consistently complying with best practice in all our wards. We hope that the recent introduction of Trust-wide Governance Half Days in which we halt all non-emergency practice gives us a monthly platform of precious time in which to address lessons from what we do very well in parts of the Trust, as well as those from where care is not as it should be.

Richard Samuda
Chairman

Toby Lewis
Chief Executive

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Use of the Trust Seal on lease of accommodation for homeless project**
SPONSOR (EXECUTIVE DIRECTOR):	**Toby Lewis, Chief Executive**
AUTHOR:	**Toby Lewis, Chief Executive**
DATE OF MEETING:	**6 November 2014**

EXECUTIVE SUMMARY:

The Board will recall the business case it approved in October 2013 to undertake a project specifically focussed on getting young (16-18 year olds) homeless people employment within the Trust via the apprenticeship scheme.

It was intended that the disused accommodation on Hallam Street, opposite Sandwell Hospital be used as a base for the project. Plans have progressed to such a point as to be able to sign the lease for the accommodation with St Basil's, the Charitable partner with which the Trust will conduct the project.

The Trust's SFI/SOs require Trust Board's approval to apply the Trust's seal to the lease.

REPORT RECOMMENDATION:

Approve the use of the Trust's seal in formalising this lease.

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	
Business and market share		Legal & Policy		Patient Experience	
Clinical		Equality and Diversity		Workforce	X

Comments:

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

21st Century Facilities

PREVIOUS CONSIDERATION:

The business case for the homeless project was approved by the Trust Board in October 2013.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Complaints & PALS report: 2014/15 quarter 2
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Karen Beechey, Head of PALS & Complaints
DATE OF MEETING:	6 November 2014

EXECUTIVE SUMMARY:

This report sets out details of Complaints and PALS enquiries received between July and September 2014 (Quarter 2).

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

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

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
✓		✓

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

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

Comments:

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

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

PREVIOUS CONSIDERATION:

Quality & Safety Committee – 31 October 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Complaints and PALS Report

2014/15: Quarter 2

COMPLAINTS MAKING A DIFFERENCE

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

What we were told	Our response	The difference
We should provide self-serve check in touch screens in languages that are spoken in our local community	Hindi had been missed off the list of languages and this was rectified as a result of the complaint.	Patients whose first language is not English will be able to check in themselves using this new technology where languages are more reflective of our local community.
A poor experience was reported as a result of a patient attending our weekend pharmacy service. They had taken advice from our website as to opening hours, and this turned out to be inaccurate, leading to inconvenience and frustration.	The Trust website has been updated. New arrangements have been made to ensure that it is easier to get repeat prescriptions for patients.	Patients will be able to access repeat medication more easily, including at weekends.
We failed to adequately meet the needs of a bereaving family in that they were misinformed about when they could view their relative in the mortuary, and that the leaflet that should help clarify this was inaccurate.	The bereavement leaflet is being re-written and once completed, a copy will be forwarded to the patient's family as evidence of change.	Grieving families will feel better informed and therefore more supported at a difficult time.
We told a patient that they could no longer park in a disabled parking spot even though she had a relevant car badge.	Training and information update given to security staff at Sandwell	Disabled patients can rely on the disabled parking facilities without their right to use them being challenged.
We served a patient Fortijuice that was out of date.	A new weekly audit system has been introduced so that out of date supplements are discarded once they are out of date.	Patients will not be served food supplements that are out of date
A child is admitted following a fall where a head injury was suspected. As the child was not weight bearing an x-ray was ordered for the top of the leg. The image of the top of leg was reviewed showing no fracture	New guidance is being developed that will recommend that the whole limb will be x-rayed and reviewed. Guidance from Birmingham Children's Hospital is being sought.	Children are much less likely to have their fractures missed even when these fractures are difficult to diagnose.

What we were told	Our response	The difference
but at the bottom of the image, another break was later identified lower down in the limb.		
Of the number of the issues raised in this complaint, one related to a cannula that had tissued and that this had been left unnoticed from one day to the next.	Additional auditing was undertaken to ensure that all documentation was being completed, and monitoring of cannula sites performed. At a meeting to be held on the 13th November 2014 the results of this audit will be shared.	Patients will have accurate medical records in relation to their cannula sites and the risk of tissueing going unnoticed will be minimised. Where cannula sites do tissue, evidence of monitoring will be documented to reassure patients and their families.
When taking their relative to the disabled toilets in outpatients, it was observed that there was only one hand rail in the toilet and that it in itself was too far away to be helpful. They had to go and use the disabled toilets in Tescos.	It was identified that these toilets were in need of refurbishment and renovation and this has been scheduled.	Disabled patients will have better access to essential facilities and not have to travel outside of the hospital grounds.

COMPLAINTS AND PALS: 2014/15

Quarter 2 highlights

1.	The total number of PALS concerns registered was 541, down by 79 although there was no one area that contributed to this drop over all Clinical Groups and Corporate Directorates. (page 14)
2.	The total number of Complaints logged was 239, an increase of 30 across the quarter. 22 of these were withdrawn by the complainant at some point in the quarter leaving 217 to manage. The most significant differences by month were in April and July although when comparing the two years by total, the numbers of complaints were similar. (page 6)
3.	The total number of compliments collected for the period of Q2 2014 was 504 and is a snap shot of the data that has started being collected during this quarter. There will be a much more comprehensive breakdown in the next report (Q3). Appendix 8 shows these compliments broken down by the Departments and Wards that provided this data this quarter. (page 27)
4.	The average number of days taken to resolve complaints saw an increase of 17 days from 45 to 62. This increase can be attributed to the resolution of some of the oldest complaints in the system, thus impacting on the average days to resolve these complaints. (page 8)
5.	It has been identified that by measuring complaints against 1000 bed days, certain Departments, like A&E can't be included in this measure. Given that Medicine, Surgery A, Surgery B and Women and Child Health made up 86% of the complaints received in Q2 2014 their complaints have also been measured against Finished Consultant Episodes (per 1000 FCE). This showed Surgery B with the highest complaints rate, and Woman and Child with the lowest. (pages 7 and 8)
6.	Complaints per 1000 beds days have remained at a similar rate to the previous quarter, with a slight increase in rate for July but an overall trend line as steady. (page 7)
7.	The three themes that emerged out of complaints this quarter are *Attitude of Staff*, *Clinical Care* and *Appointments*. Surgery B had significantly more complaints about their management of appointments than any other, and PALS enquiries about the same theme featured Surgery B as contributing to over 50% of the PALS enquiries made about appointment issues. (page 11)
8.	'Not Upheld' complaints made up 33% of closed complaints against 24% last quarter, but with no emerging trends in terms of Groups or themes. (page 12)
9.	Reopened cases totalled 34 and 9 of those re opened were due to not all the issues being answered in our first response. This compares to 37 reopened, 19 with outstanding issues from Q1 2014. (page 13)
10.	When the local complaints process is exhausted, all complainants can have their complaint reviewed independently by the Parliamentary and Health Services Ombudsman (PHSO) if they remain dissatisfied. There were no new PHSO enquiries of the Trust in this quarter, and two pervious enquiries were closed off. Of these closed enquiries one was not upheld and the other was partially upheld with a financial penalty. (pages 13 - 14)
11.	There is a new segment to the report that breaks down the results of our complaints satisfaction survey, which shows an overall satisfactory result in relation to the general handling of the complaint, and a poor result in terms of the time taken to manage it, and keeping complainants informed. (page 9)
12.	There is disproportionality of the ethnicity of the subjects of complaints and the general populous of our patients, particularly in Pakistani's and Black Caribbean's. (page 10)

COMPLAINTS AND PALS: 2014/15

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INTRODUCTION

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

This report sets out and provides commentary on the complaints, PALS enquiries and compliments that have been received between July and September 2014 (Q2). The way they were managed, who they were made against and what about. The important learning opportunities are evidenced and the subjects of the complaints are also profiled.

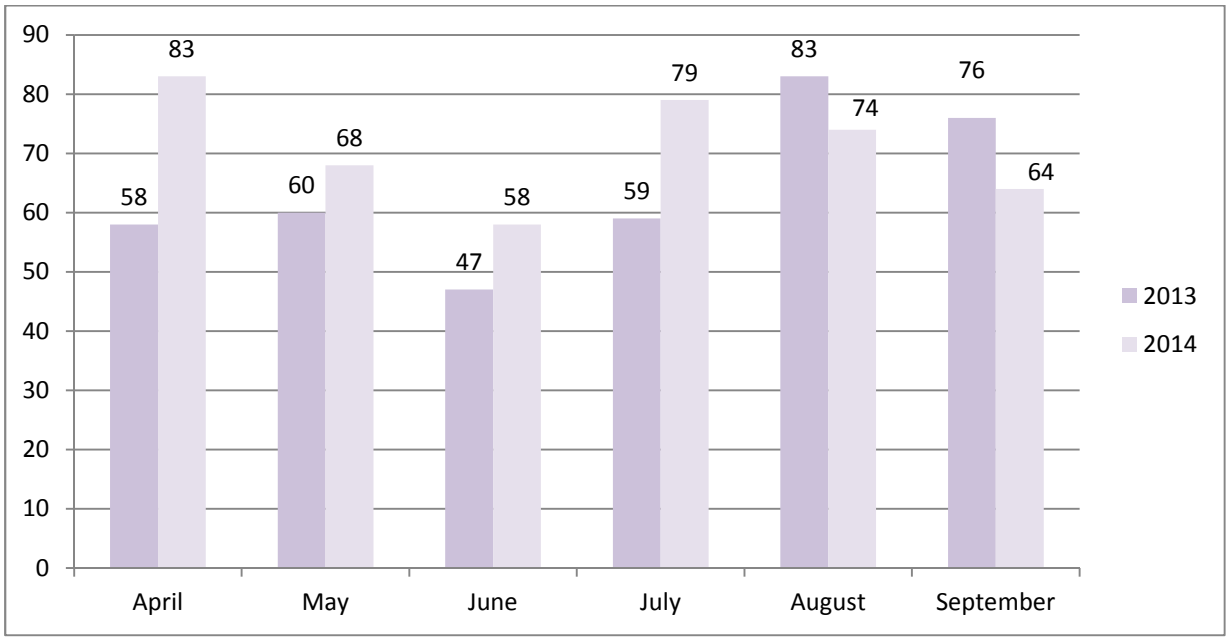
COMPLAINTS

1. Complaints Management

1.1 Total received

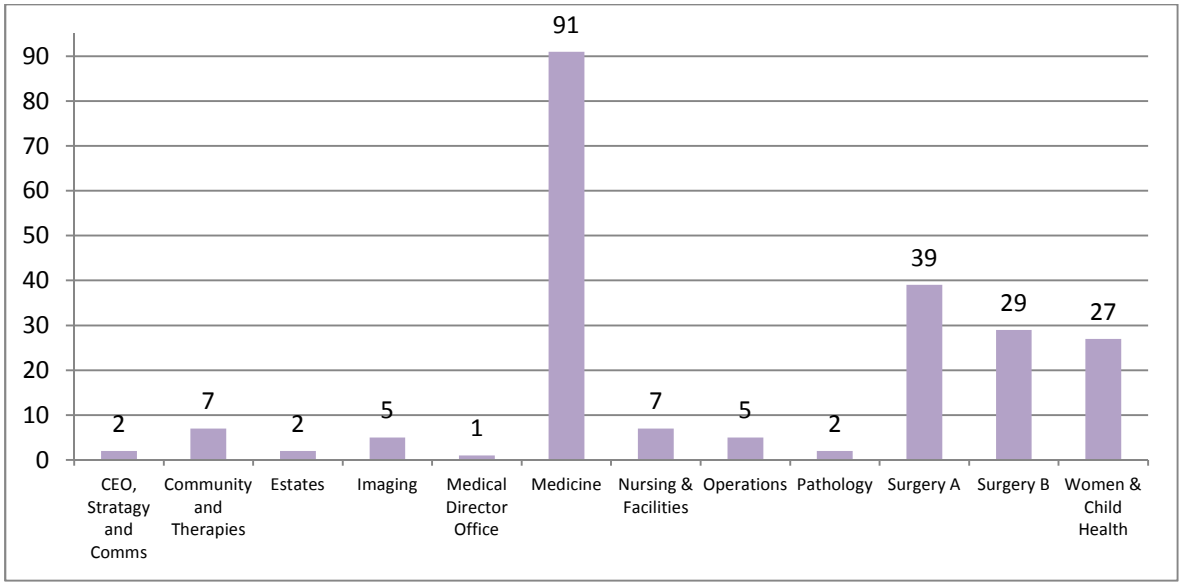
Whilst the total number of complaints received in Q2 (217) remained relatively consistent (218 in 2013/14) , there was a difference in those made to the Trust in April 2013 at 58 compared to 83 in April 2014 and July 2013 at 59 compared to July 2014 at 79.

Of the increase of 20 in July 2014, 11 of these complaints were made about Surgery B.



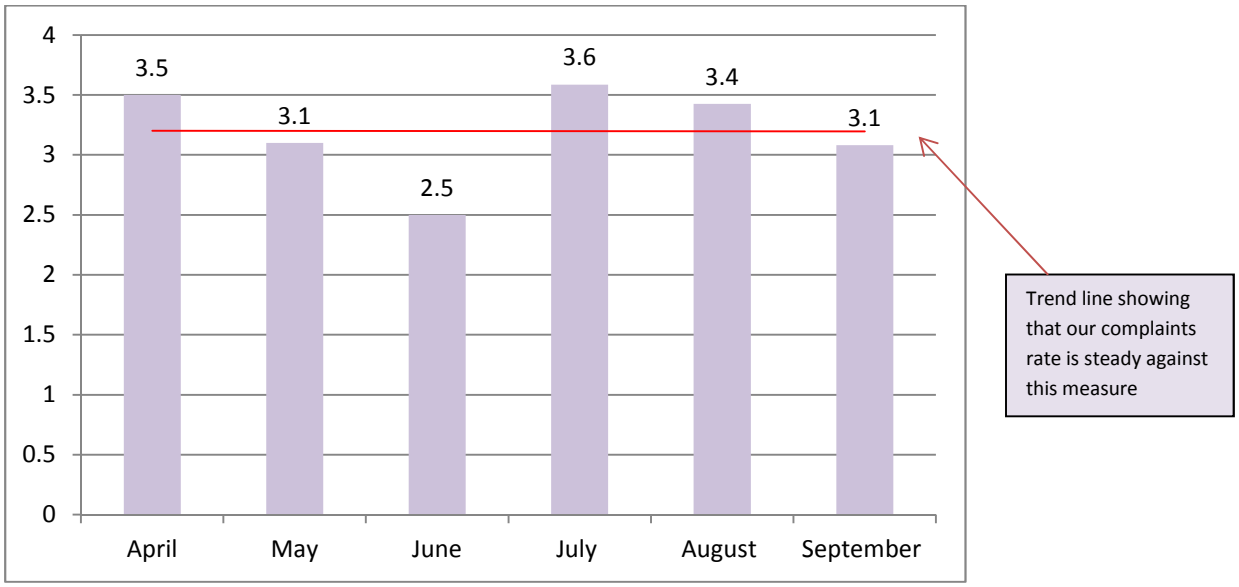
1.2 Complaints by Group

When analysing the 217 complaints received in Q2 2014, by Clinical Group and Corporate Directorate, Medicine continue to receive the most complaints. **Appendix 1** shows how these figures compare with the last quarter and the same period last year.



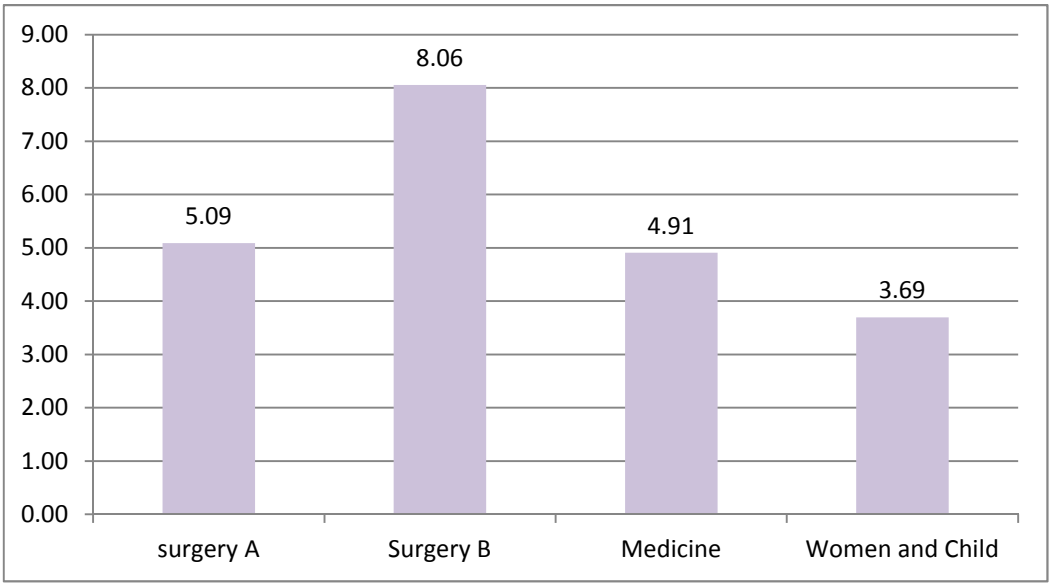
1.3 Complaints by 1000 bed days

The complaints rate as calculated as complaints by 1000 bed days is higher this quarter, sitting above the average rate for the last 6 months, and saw a particular spike in July, with Surgery B contributing to that months increase. That said, the trend for this rate is still steady, over the 6 month period.



1.4 Complaints received per 1000 FCE (Finished Consultant Episodes)

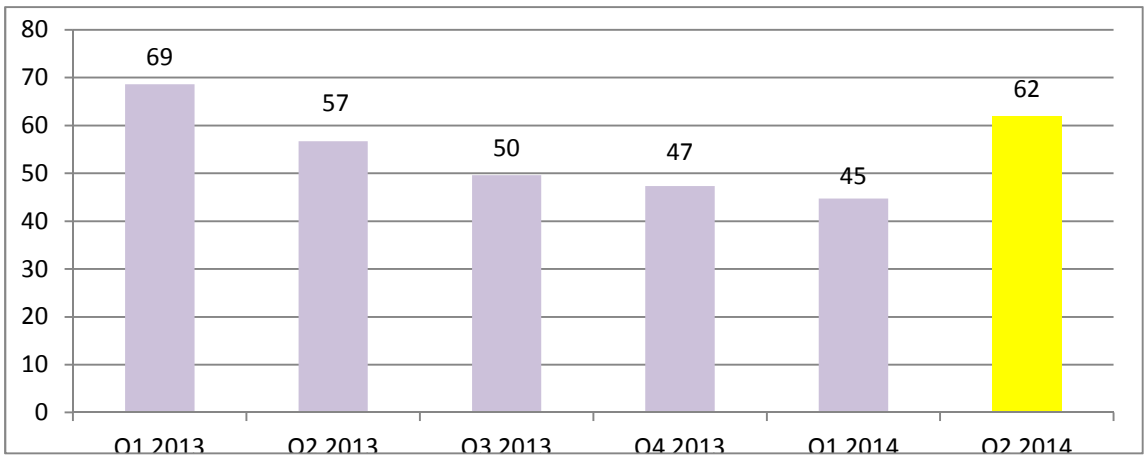
To more accurately compare which Clinical Group or Corporate Directorate received the most complaints, it is important to represent these not just as numbers of complaints, but as a proportion of the patients that have received care in these areas. This then puts these numbers into context. By comparing the numbers of complaints with FCE we can gauge better whether one service or another is attracting more dissatisfaction and once understood, drill down further into what aspect of that service needs to improve. This analysis was only applied to the largest of the Clinical Groups, as they contribute to 86% of the complaints.



Although a large majority of the complaints received are made about Medicine, it is Surgery B that have the highest number of complaints per 1000 FCE (so the highest complaints rate.)

1.5 Timeliness of Responses

We have shown a steady decrease in the amount of time it takes to turn a complaint around since Q1 2013. This month has however seen a steep increase. Throughout the year we have been very focused on our commitment to answering complaints within 30 working days. With the completion of some of our oldest complaints this quarter, there has been an impact on the 'average number of days' measure.



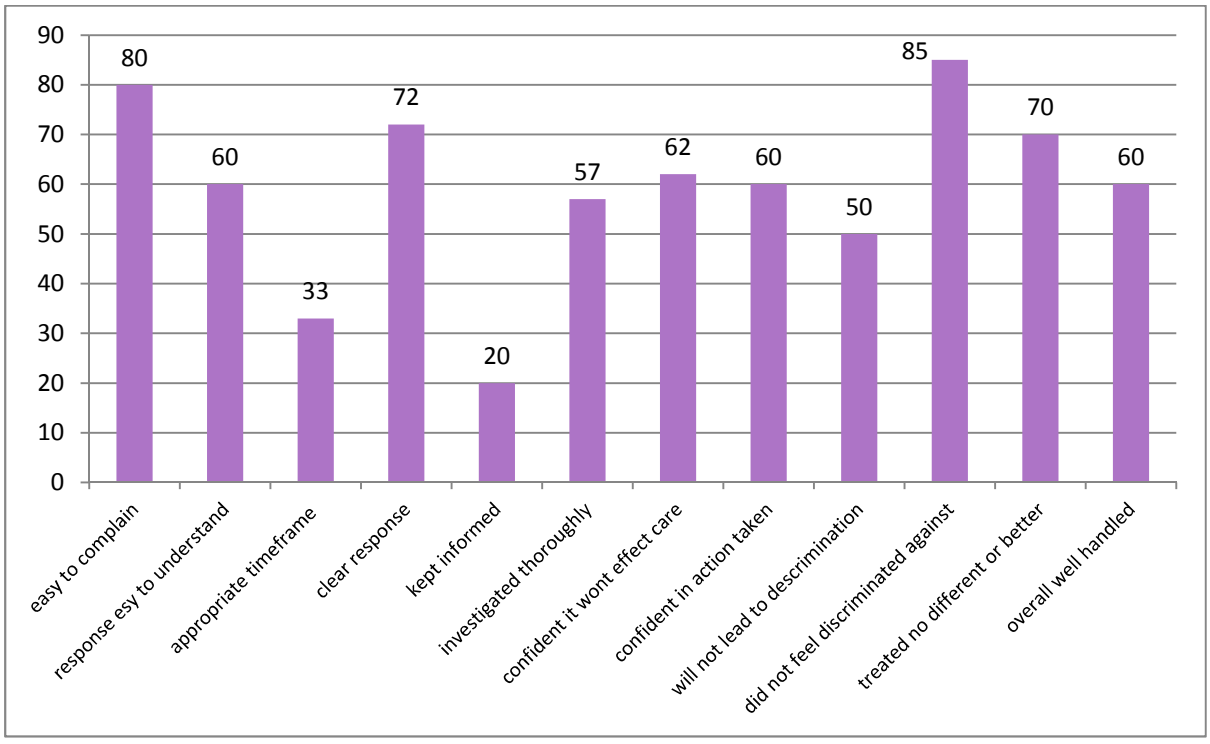
Appendix 2 shows a further breakdown of this data by Clinical Group in order to understand where complaints take the longest to answer. This breakdown will help the complaints team to ensure that appropriate resources are offered to the Clinical Groups and Corporate Directorates with most need. This allocation of support will be essential to achieve the aim that no complaint takes longer than 30 days to respond to from 1 January 2015. Underpinning this support is also the publication of the weekly SitRep, and the introduction of a new escalation process that will see any complaint that goes over 60 days, reported to the Chief Executive.

1.6 Complaint satisfaction survey

Everyone who makes a complaint is given the opportunity to provide feedback on how they found their experience via completion of a questionnaire that is sent with the final response. **Appendix 3** covers all results in detail, and shows that there is work to be done to improve how satisfied complainants are with the process.

In Q2 we have received 30 responses, representing a response rate of 14%. **Appendix 3** breaks down the survey into its component answers and includes all response received since the introduction of the devolved model (November 2013) - this is a total respondent group of 38.

Results of Q2 2014 satisfaction survey



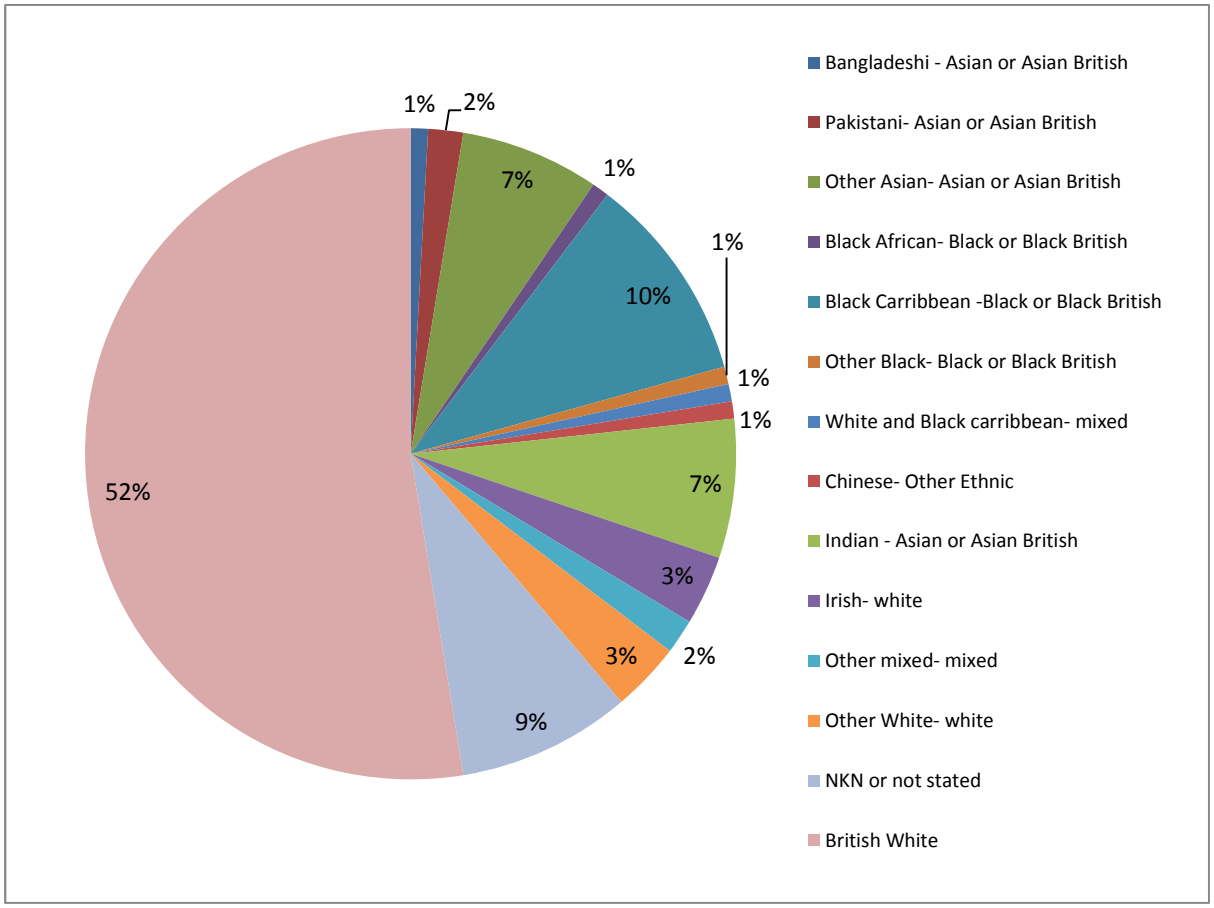
The two areas that score the lowest in terms of dissatisfaction are both in the control of the corporate Complaints team, and this has been shared with the Complaints team in order to ensure improved performance in keeping complainants informed and the time it takes to turn them around.

2. Complaints in detail

2.1 Profile of the subject of complaints

In order to check that our complaints process is accessible to all, it is important to understand the profile of complainants by certain protected characteristics. Gender, age and ethnicity are recorded and then compared to our hospital population and also the population of the geographic area that we serve in **Appendix 4**.

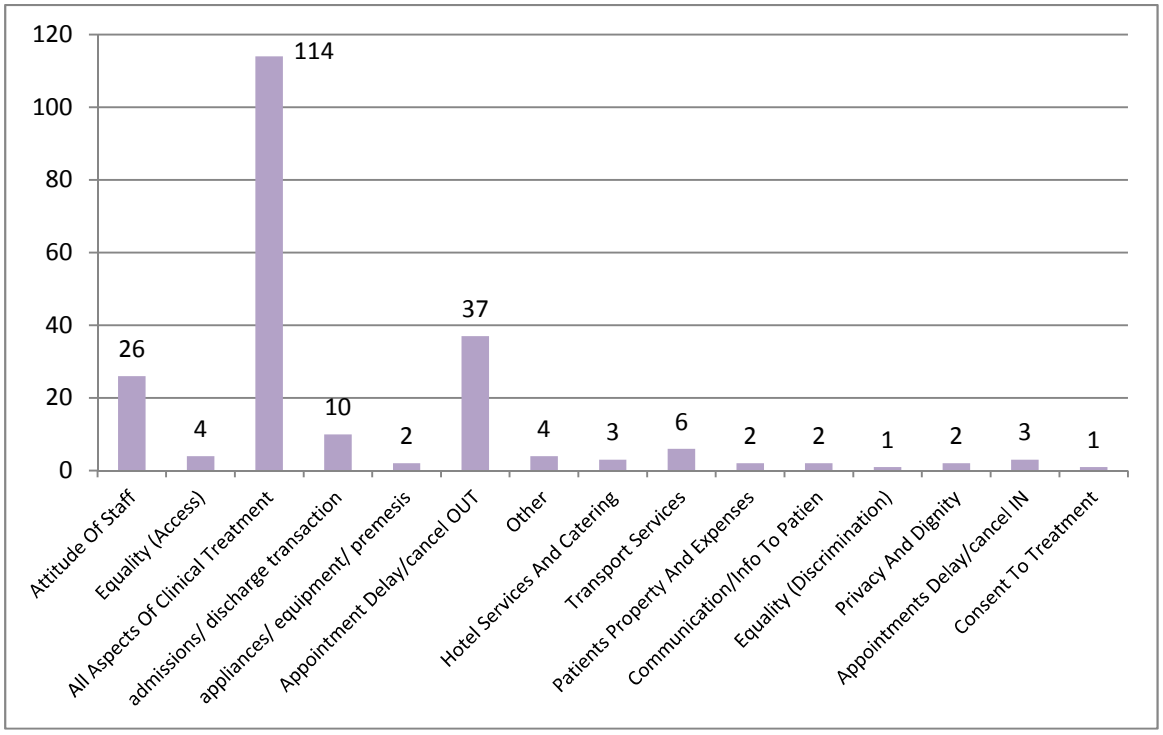
Ethnicity



Of interest, is the disproportionality of the ethnicity of the subjects of complaints and the general populous of our patients. Pakistanis make up 11% of our patient population, but only account for 2% as the subject of complaints. Transversely, Black Caribbean's are the subject of 10% of our complaints and only account for 4% of our Trust population. Should this trend continue, it will be important to ensure the Trust is confident that our complaints process is accessible, and we are not preventing complaints being made by putting up language and other cultural barriers.

2.2 Formal complaints by theme

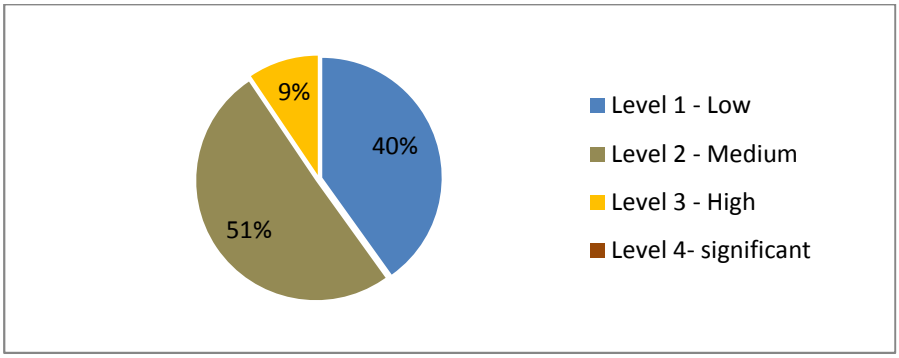
This table shows the broad themes that our complaints fell into in Q2 2014.



Similarly to Q1 2014, *'all aspects of clinical treatment'* and *'attitude of staff'* are amongst the top themes. **Appendix 5** breaks the top three themes down by Group showing that there is a disproportionately higher level of complaints about appointments in for Surgery B. *Similarly 'all aspects of medical care'* are disproportionately higher for Surgery A and Medicine when looking at this theme. **Appendix 5** also breaks down the profession that is being referred in the *'attitude of staff'* complaints.

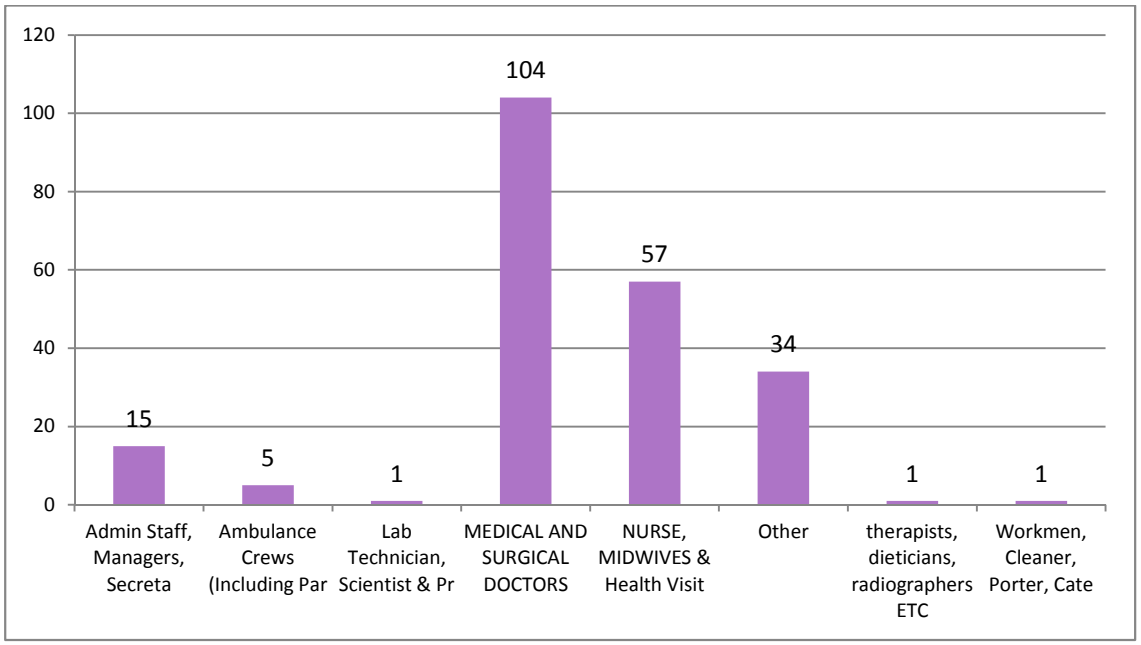
2.3 Formal complaints by severity

The following is break down of 212 of the 217 complaints received (the other 6 have since been withdrawn) and shows that once again complaints considered high or significant (Levels 3 and 4) remain in the minority. This quarter, Levels 1 and 2 made up 91% of the complaints where as in Q1 2014 they made up 84%.



2.4 Formal complaints by profession

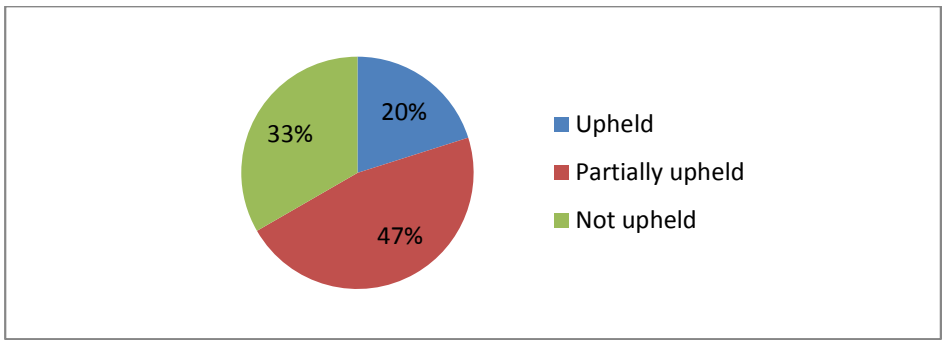
When looking at the professions that form the basis of the complaints themselves these again remain fairly consistent with Q1 2014. Whilst medical staff have been identified in the largest proportion of complaints there have been no particular themes or trends relating to specific doctors identified. The second highest number of complaints attributed to one group of staff was our Nursing team, who have the most interaction with any staff member involved in patient care.



3. Formal complaints outcomes

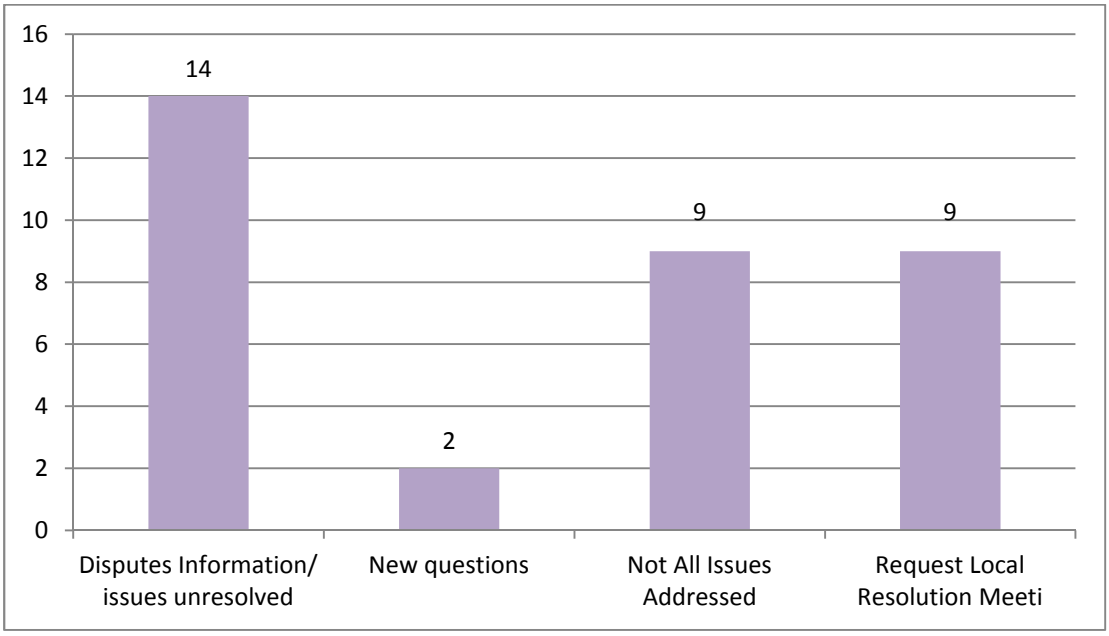
3.1 Formal complaints upheld.

The Trust responses remain heavily weighted toward upheld and partially upheld complaints, with this making up 67% of the overall responses for this quarter. In Q1 2014 upheld and partially upheld complaints made up just over 75%. There was however no significant trends in complaints that were not upheld, in terms of group or themes.



3.2 Reopened cases

Reopened cases totalled 34 and 9 of those re opened were due to not all the issues being answered in our first response. This compares to 37 reopened, 19 with outstanding issues from Q1 2014.



Of those complaints that were reopened because we had not addressed their issues first time, there is no particular Group that has contributed to this level of dissatisfaction. **Appendix 6** shows all reopened complaints by Group and Grade, and does also conclude that it is the medium grade (Level 2) complaints that are most likely to be reopened.

3.3 Parliamentary and Health Services Ombudsman enquiries.

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

There have been no new PHSO complaints logged in the three months of this quarter, and two enquiries completed during this period. These are detailed below.

Case 1

This complaint was originally made against the Trust in December 2012. This complaint was responded to but disputed, largely to do with discrepancies in our records relating to his attending (and not attending) appointments, and that he was turned away from an appointment with this having an impact on him losing his sight. Upon receipt of this dispute, a new response was sent. The PHSO asked for a copy of our letter which was duly forwarded to them, and with the need for further investigation, they have confirmed that they have closed their file without further action.

Case 2

This complaint was originally made in January 2012 and was primarily about how unhappy the patient's family was about the care received, that it wasn't sensitive to the that fact that the patient

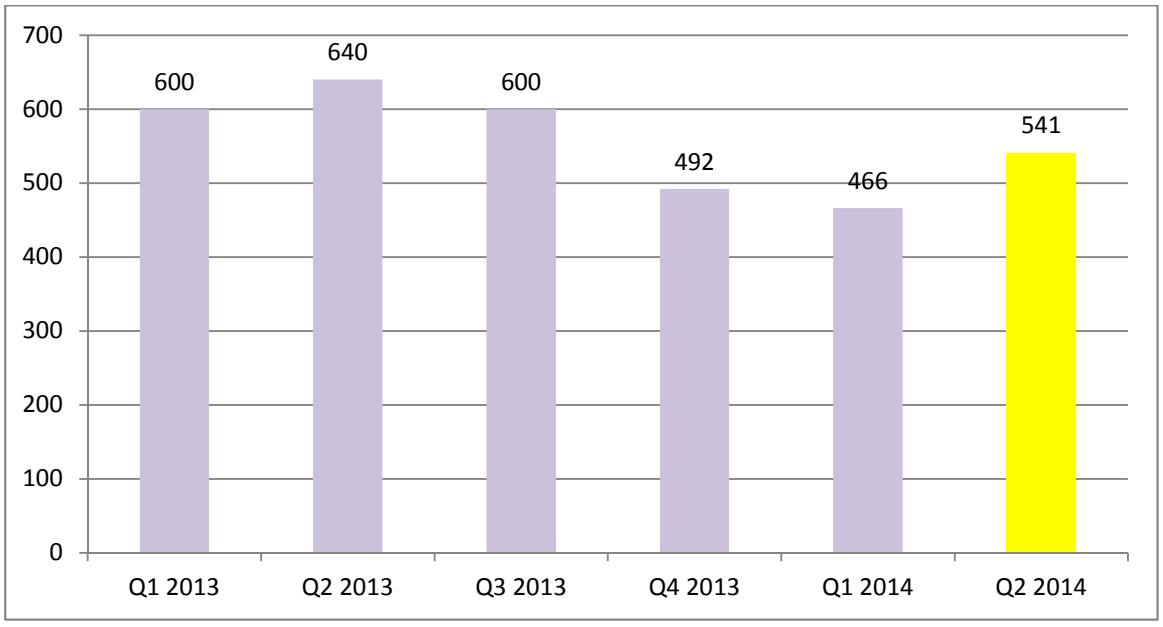
had Huntington's disease and that this lack of care contributed to his death. This complaint was responded to and disputed resulting in the Trust meeting with the family, following which they remained dissatisfied and referred the case to the PHSO. The PHSO investigated our care of the patient, and our complaint handling. Whilst the aspects of the complaint that related to the care provided were not upheld, our poor handling of the complaint was, mainly around the time it took to resolve. The Trust was asked to write an apology about this service failure and provide assurances that we have improved our practice. We were also directed to pay £250 by way of redress to the nephew who brought the complaint against the Trust. This has since been done.

PALS

PALS continues to play a vital role in providing patients with a local advocate who can take on a concern from patients or their representatives and investigate this for a speedy resolution.

As well as reporting the standard enquiries directed to the team PALS have been working on a method of collecting compliments received by the Trust as a whole. They will also be collecting information about the locally resolved complaints that occur during our everyday management of patients and their families during Q3 2014. These are often well managed concerns with effective and caring solutions, but go unrecorded because they weren't managed by the Complaints team and as such will be reported next quarter and thereafter.

The following is the total number of PALS enquiries received for this quarter in comparison to previous quarters.



Appendix 7 reports these enquiries by Group and the top three issues resolved by PALS.

Appendix 8 shows the compliments collected this quarter, and will again feature in every quarter thereafter. Collecting this data is very new and it is likely as Wards become accustomed to reporting this information, these reported numbers will increase over time.

Summary

Total number of complaints logged during Q2 2014 was 217; this number has remained steady when compared to Q1 2014.

Work continues as we acknowledge that not all complaints are being managed in appropriate timeframes, and those complainants whose complaints do go over their target dates are not always being kept informed.

Local ownership of lessons learned, and the overall management of complaint is still continuing to improve. An evaluation of the first year impact of the devolved model of complaints handling is underway. The results will inform further development in this area and be presented to the Clinical Leadership Executive and Quality and Safety Committee in December 2014.

Key areas for focus in Quarters 3 and 4 2014/15

- Compliments to be collected across all wards, services and department and reported more comprehensively in the Q3 report.

- Local departmentally resolved complaints (concerns) to be collected across all wards, services and department and reported more comprehensively in the Q3 report.

- Complaints that are over their target date for completion will be cleared by the end of December 2014.

- A system will be developed that will monitor how many complainants are offered resolution meetings, and whether this has an impact on whether this improves our rate of reopened cases.

- An 'Action Tracker' is to be developed to monitor achievement of actions resulting from complaints. This will be developed and tested in Q4 2014 and fully introduced in Q1 2015/16.

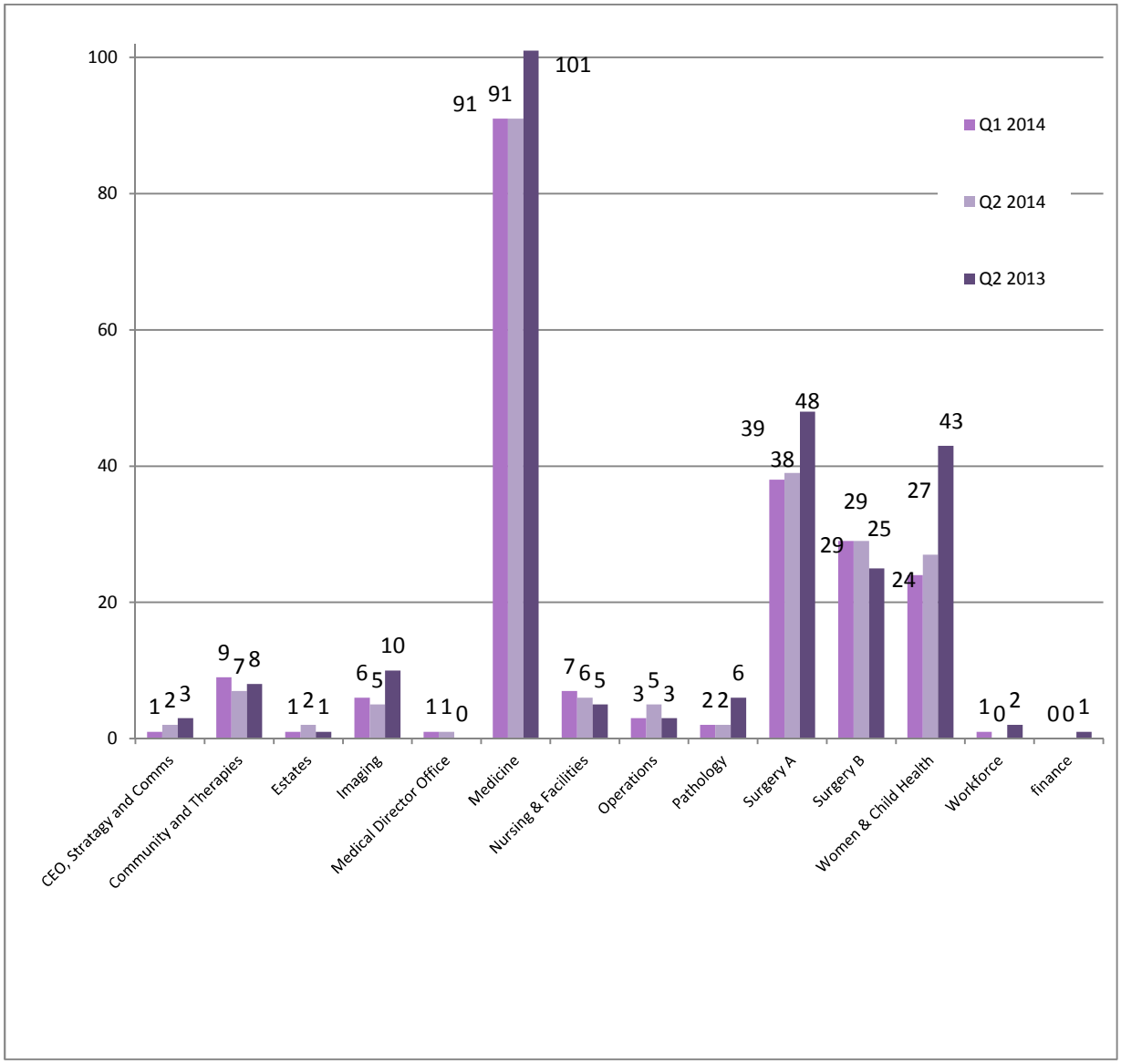
- We intend to:

    - establish a process where complainants are invited to attend a meeting at the Trust, after their complaint has been concluded to share their experience (of making a complaint); and

    - update complainants when we have put in place the service improvement and/ or honoured the promise made in our final response

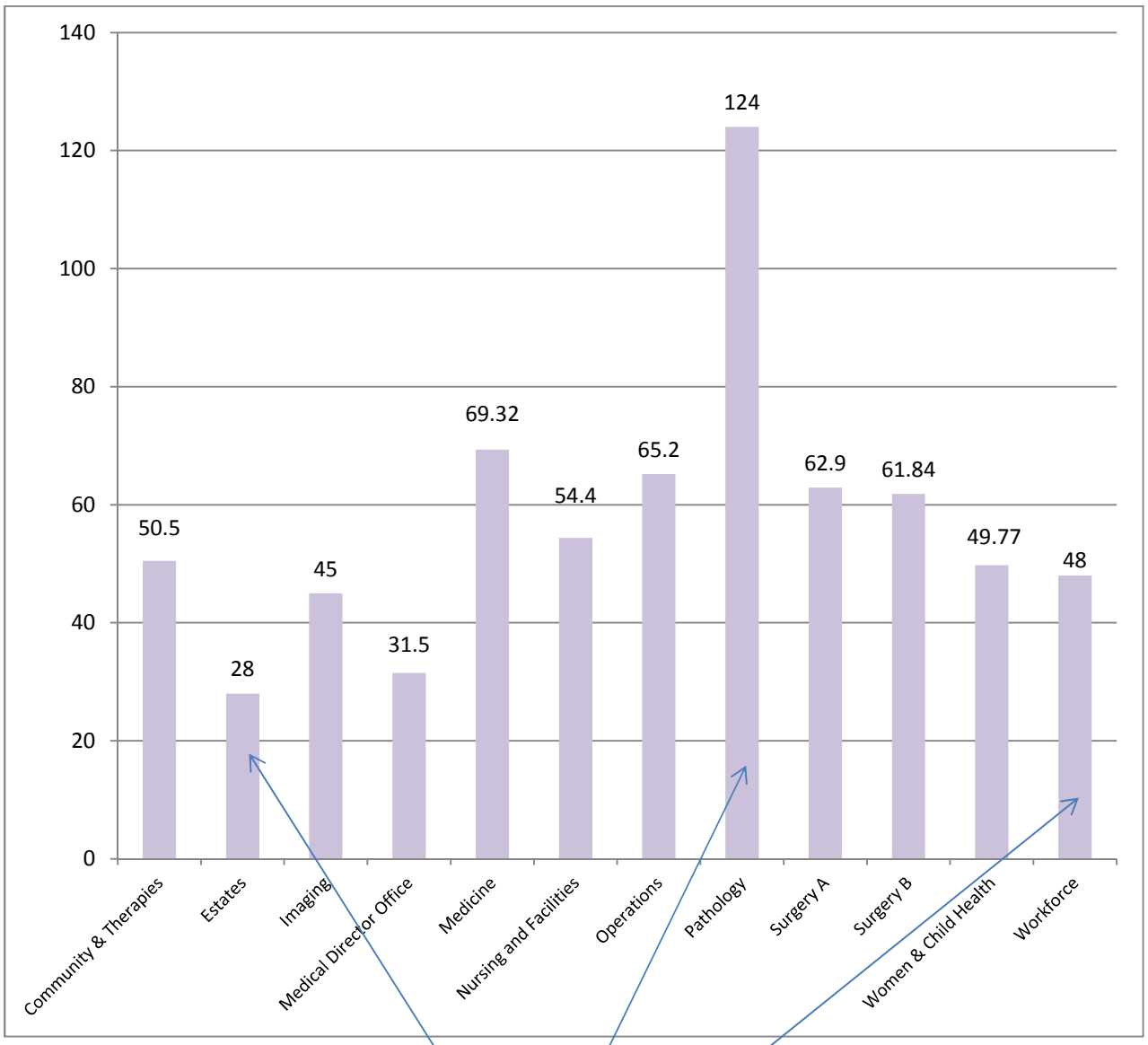
Appendix 1

Complaints received by Clinical Group and Corporate Directorate for Q2 2014, compared to Q1 2014 and Q2 2013



Appendix 2

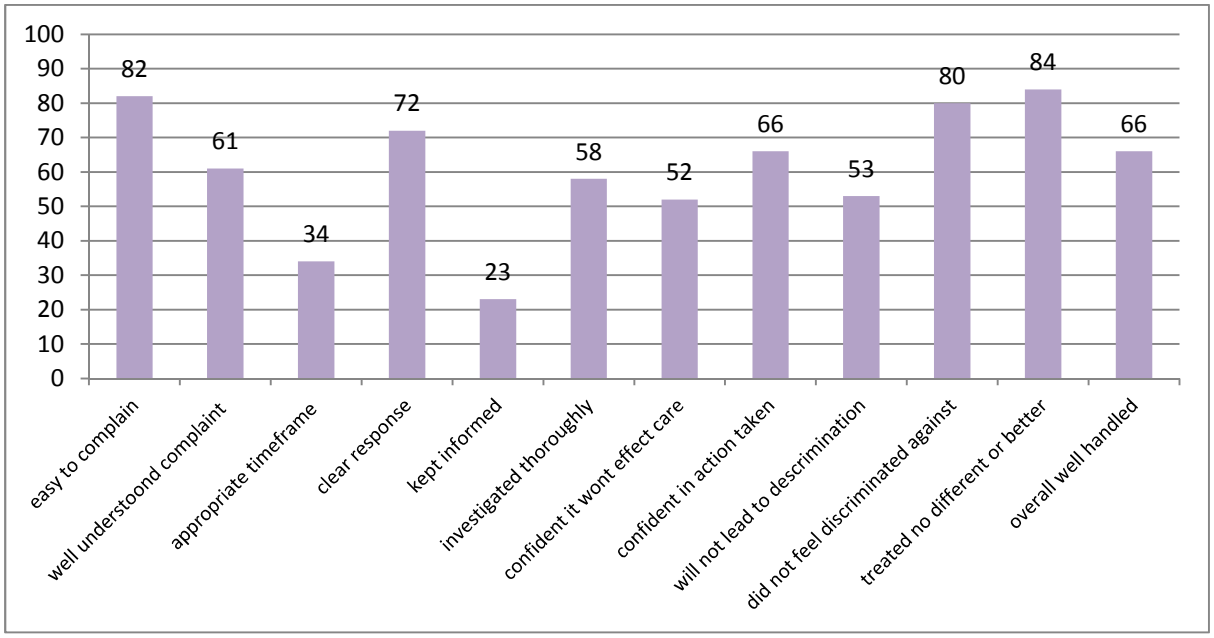
Complaints turn around by Clinical Group for Q2 2014, showing the number of days that each new, or reopened complaint took to close from the time it was received by the Complaints team to the time that it was signed off.



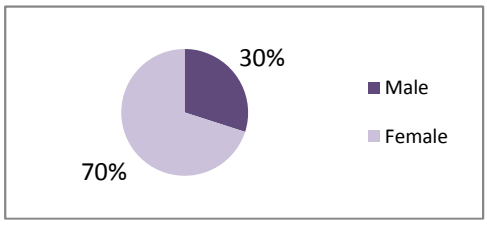
In these areas there was only one complaint made so not an average, but the actual time taken for that one complaint

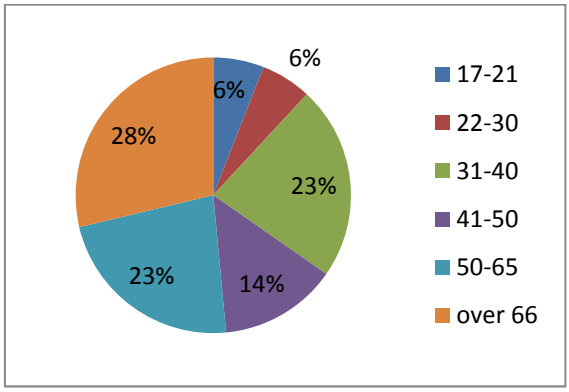
Appendix 3

The Complaints satisfaction survey questions and the % of respondents that answered in the positive to each question.

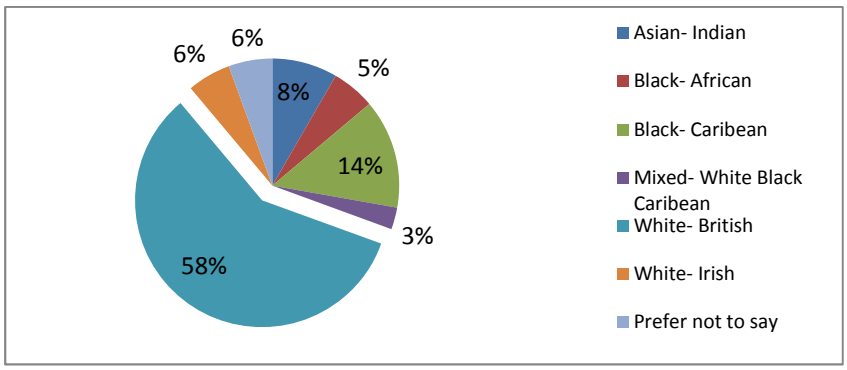


Respondents profile by gender and age



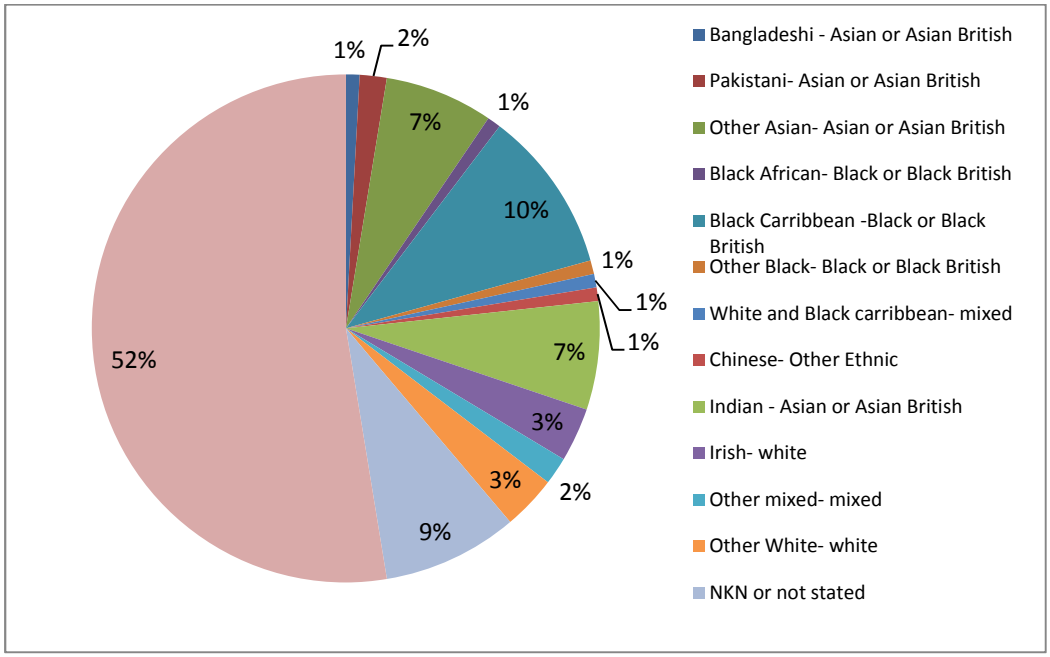


Respondents profile by ethnicity

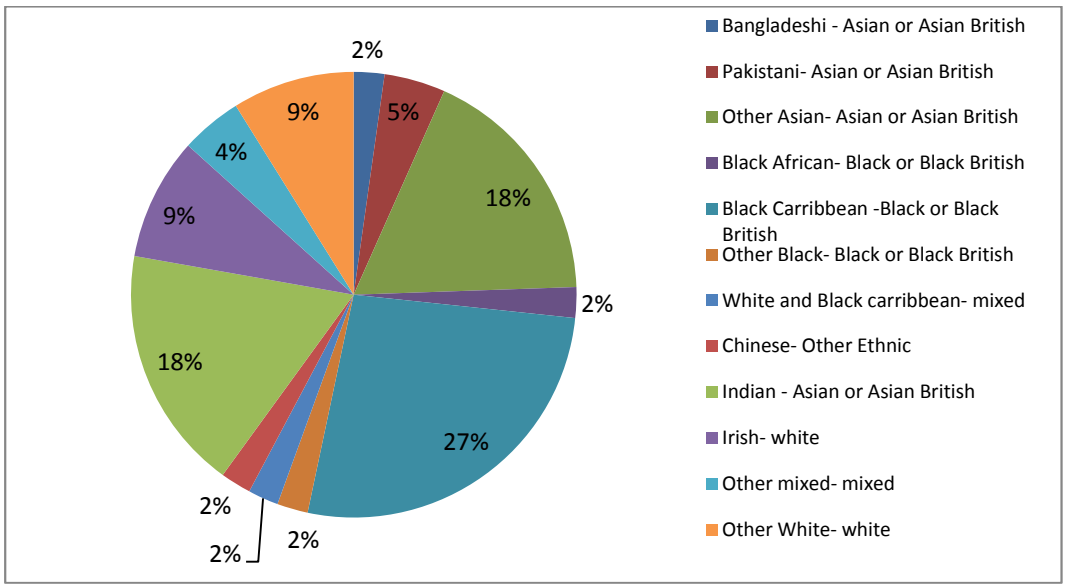


Appendix 4

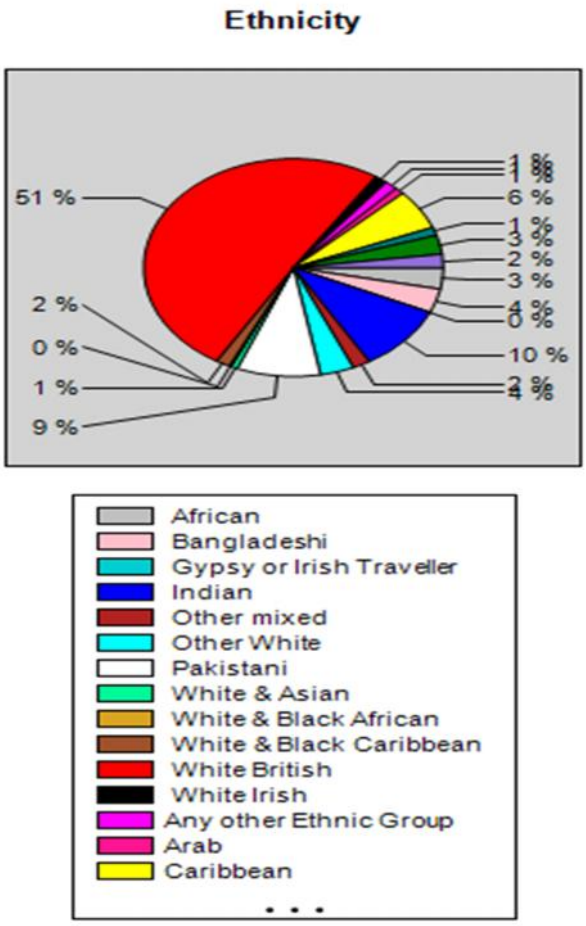
A breakdown of all complainants by % of those where ethnicity was recorded (116 complainants)



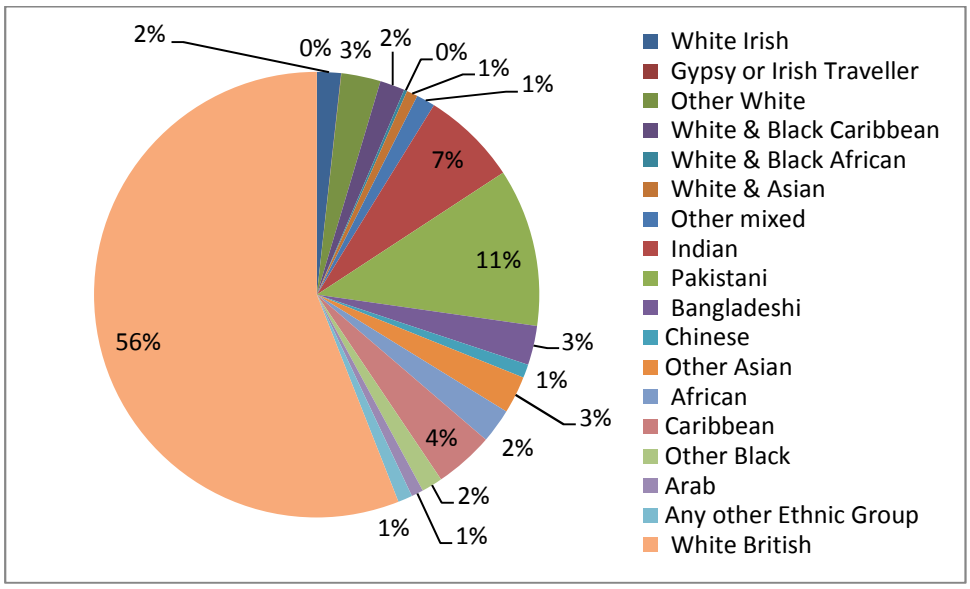
A breakdown of all complainants by % of those where ethnicity was recorded (116 complainants) taking out those 'not known' and White British



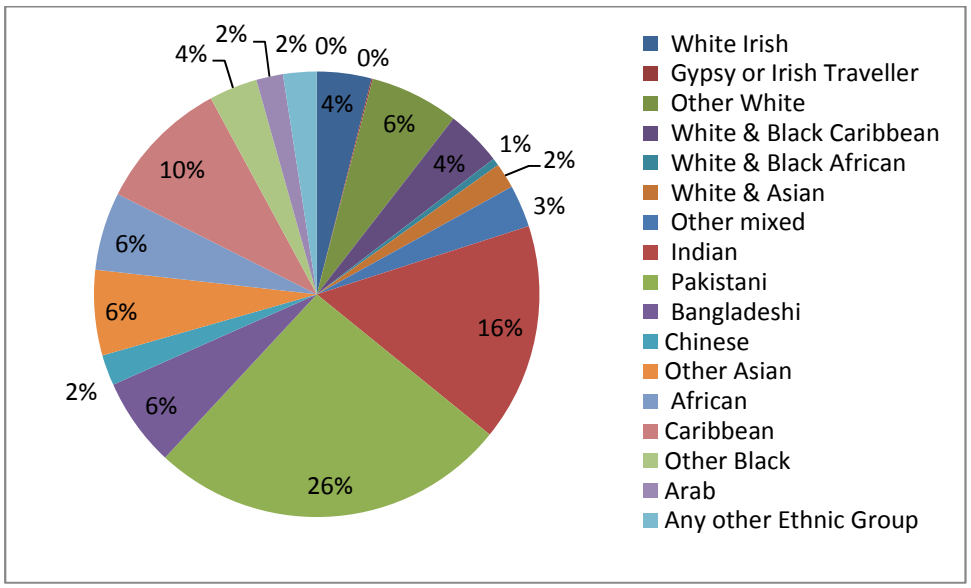
Ethnicity split of patient population



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

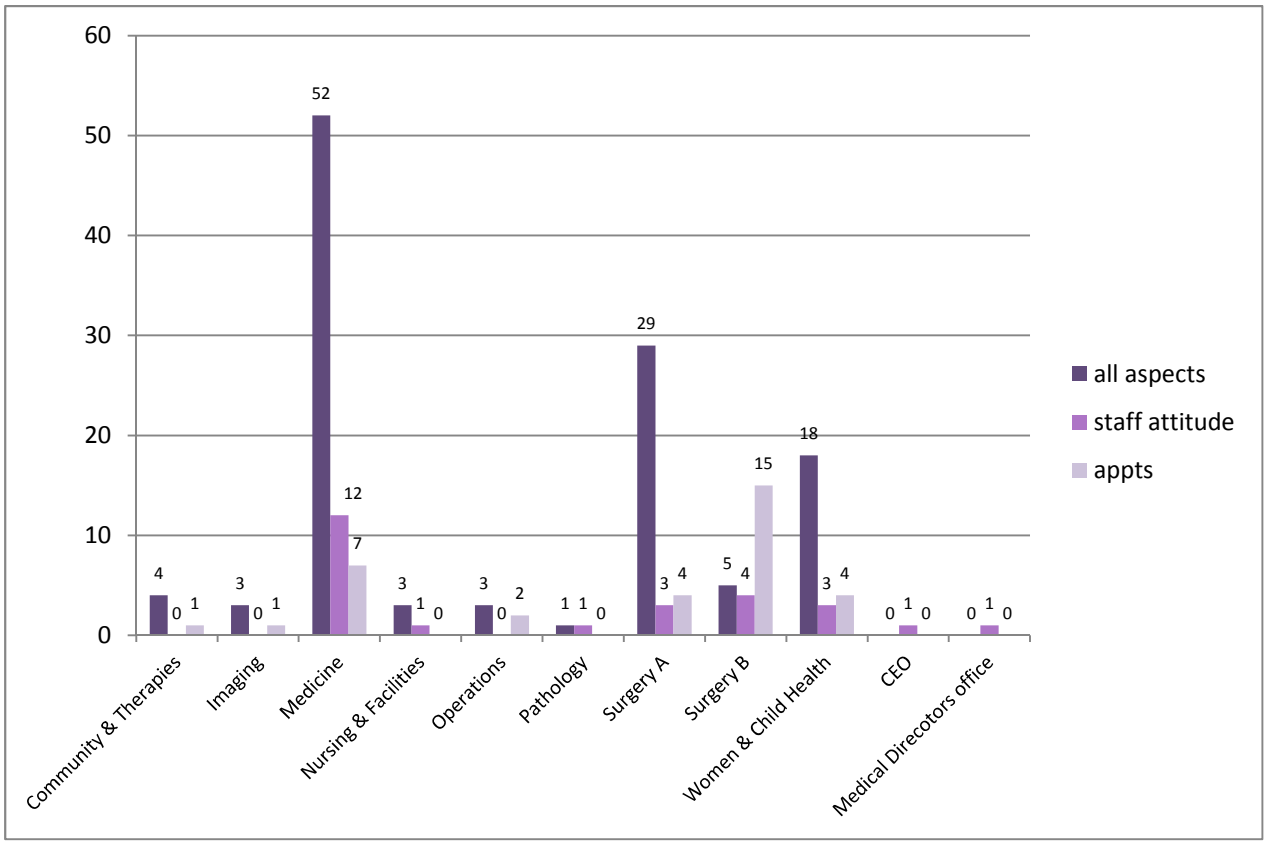


Ethnicity split by Sandwell and West Birmingham Population as taken from the 2011 census and quoted out to the Local Demography report prepared by Equality and Diversity in 2013, without White British.

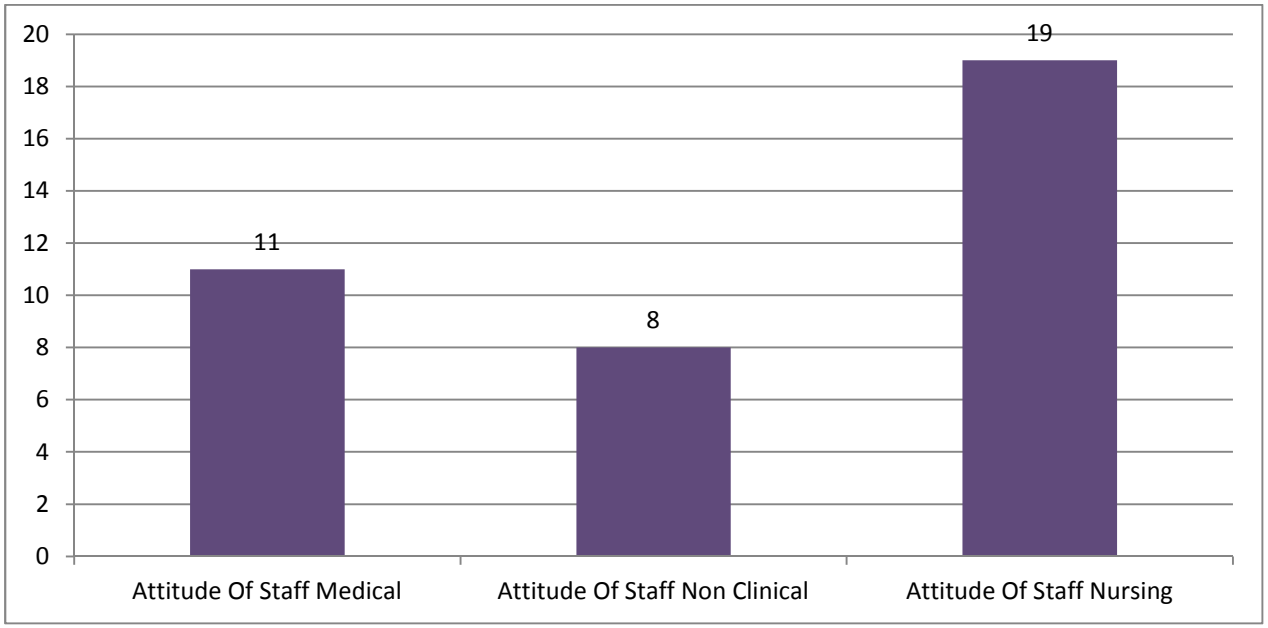


Appendix 5

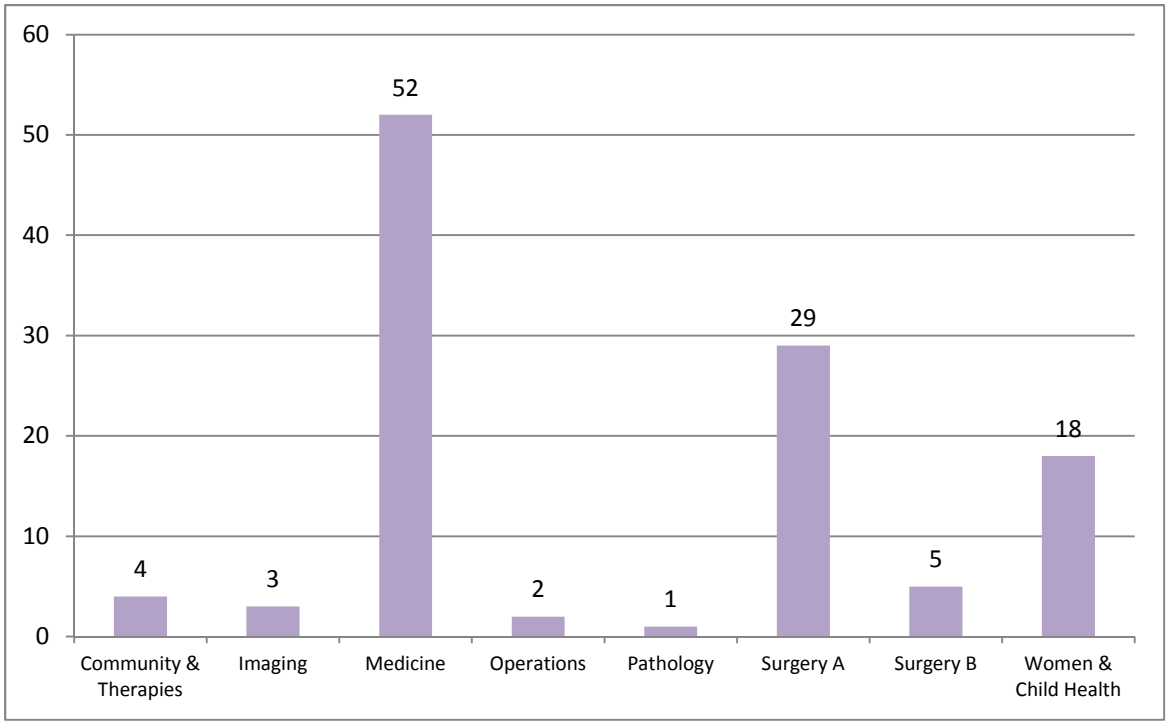
A breakdown of the top three themes complained about, broken down by Clinical Group or Corporate Directorate. Where there were no complaints for this theme for a Clinical Group or Corporate Directorate, then they are not featured in this breakdown.



A breakdown of the 'attitude of staff' theme by staff groups

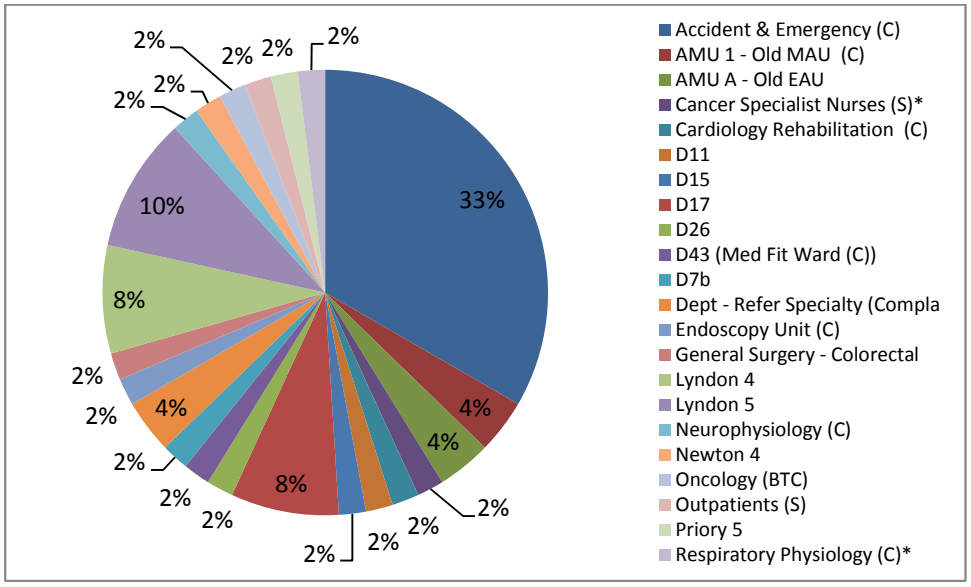


A breakdown of the *'all aspects of clinical treatment'* theme clinical groups

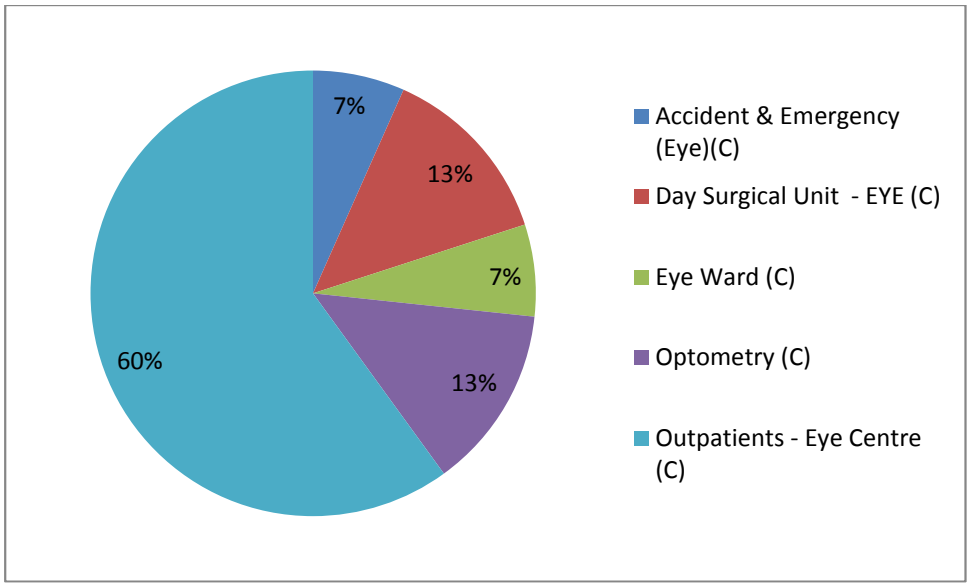


When comparing departments and wards within these groups, no one area stands out except for A&E, but this is to be expected given their footfall; 18 of the 52 were made against Medicine.

A breakdown of areas that contributed to all complaints in relation to *'all aspects of clinical care'* in Medicine

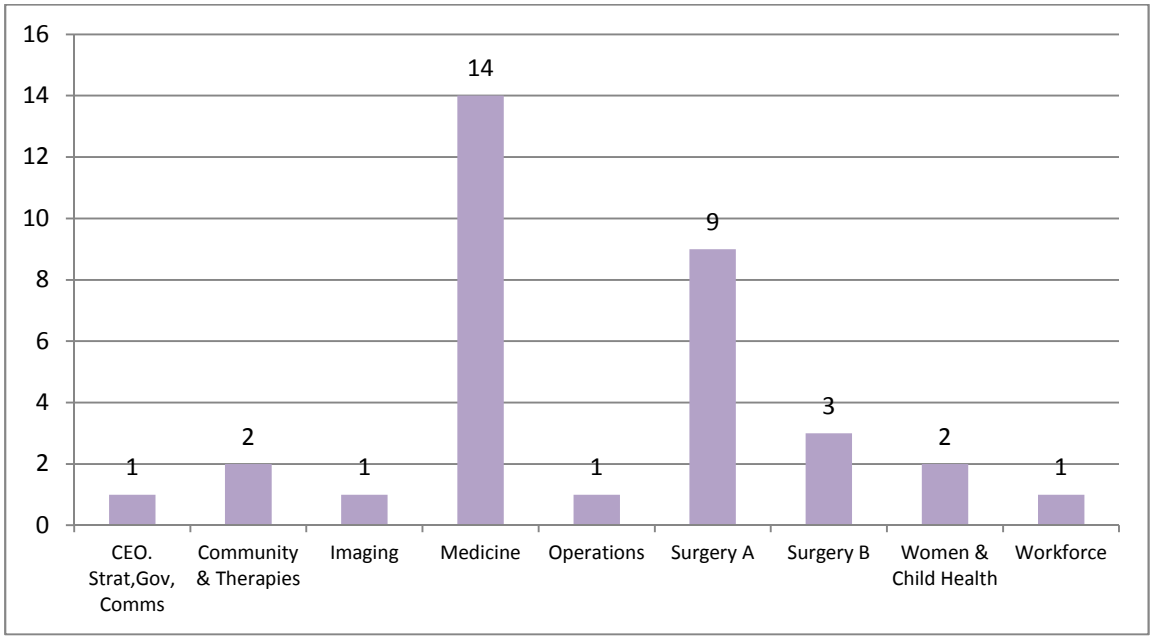


A breakdown of departments that contributed to all complaints in relation to appointment issues in Surgery B

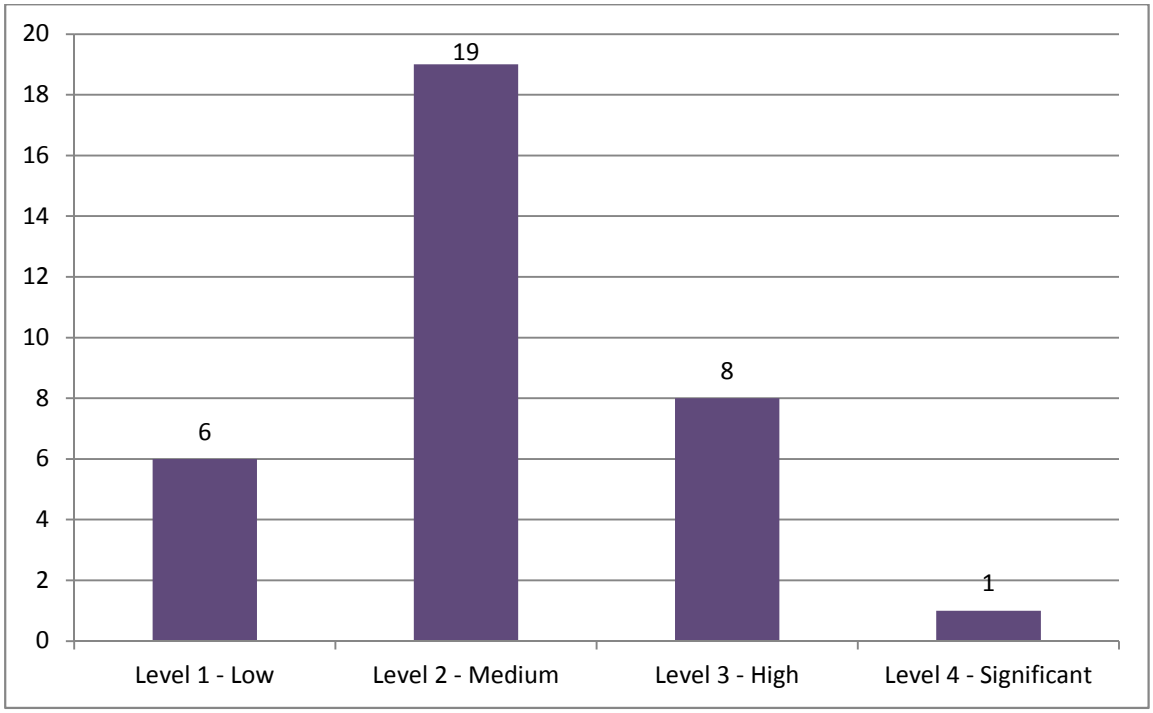


Appendix 6

Complaints that have been reopened in Q2 2014 by Clinical Group and Corporate Directorate



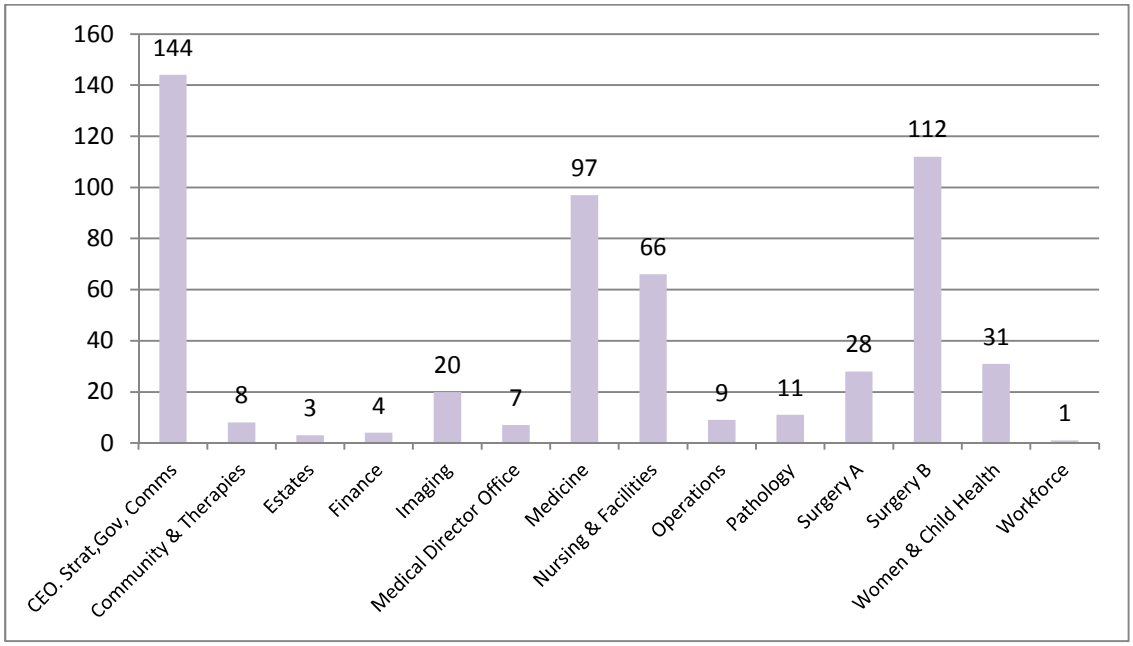
Complaints that have been reopened in Q2 2014 by Grade



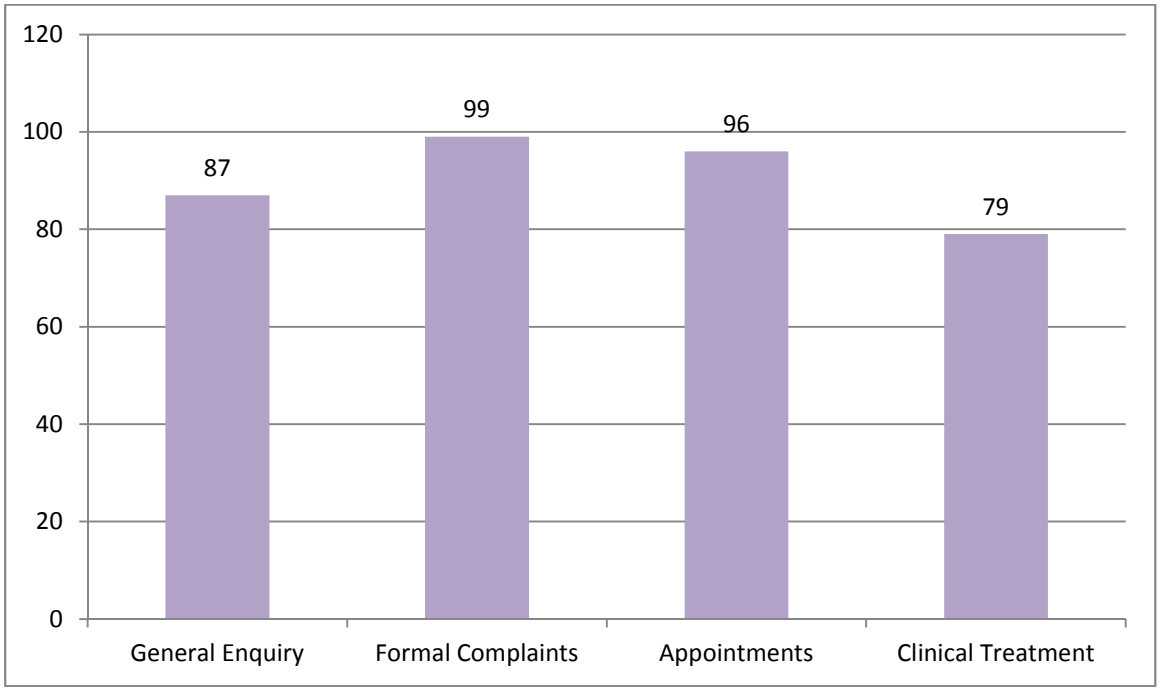
Appendix 7

PALS enquiries broken down by group

NB: *Enquiries categorised as 'CEO' relate to the enquirer needing information about either our complaints process, or where they actually want to make a formal complaint thinking that the route to do this is through PALS. PALS always ensure that there isn't anything they can help with first before directing them to their colleagues in complaints.*



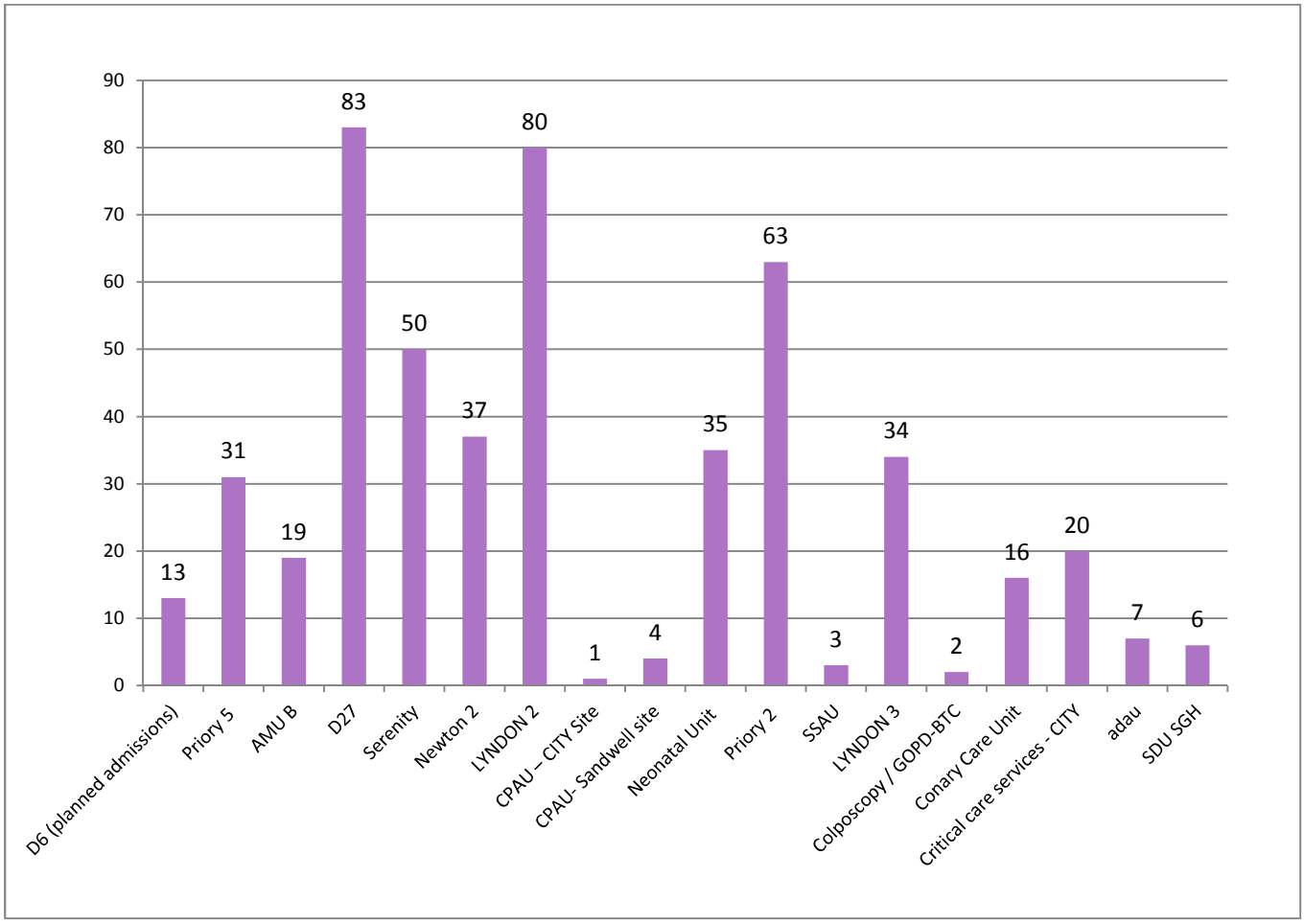
The Top 4 PALS enquiries are shown below. Of note, these top four themes made up 2/3 of all enquiries and of the 96 appointment enquiries, over 50% of them were about Surgery B.



Appendix 8

Compliments

This shows the breakdown of compliments collated by the wards that responded for Q2 2014. During Q3, Wards within Clinical Groups will be consistently collecting all compliments to report more comprehensively in the Q3 report. Until the method of collection is more consistent, it is not possible to comment on whether those wards with the most compliments are reported as such because they are good at collating and reporting them, or that they genuinely get more praise than other areas.



Karen Beechey
Head of PALS & Complaints

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Quarter 2 update**
SPONSOR (EXECUTIVE DIRECTOR):	**Kam Dhami, Director of Governance**
AUTHOR:	**Simon Grainger-Lloyd, Trust Secretary**
DATE OF MEETING:	**6 November 2014**

EXECUTIVE SUMMARY:

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

At present, the BAF contains 22 risks, the majority of which are to the delivery of the key Annual Priorities. In the majority of cases, the treatment plans identified reduced the overall risk score, however the Committee is asked to note in particular the three risks, which even when treated, remain red.

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
		X

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

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

Comments:

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

Relates to all annual priorities

PREVIOUS CONSIDERATION:

By the Audit & Risk management Committee on 30 October 2014 and previously in turn by the various Board Committees.

Executive Lead	Risk Ref and Date Added	Risk Description	Strategic Objectives						Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
			Safe high quality care	Accessible and responsive	Care closer to home	Good use of resources	21st Century infrastructure	Engaged and Effective Organisation		Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
COO	201406_COO_001	There is a risk that high readmission rates following emergency admission remain high because of failure to deliver changes patient pathways or quality assure clinical coding could result in not meeting the ambition to reduce emergency readmissions by 1%.	✓			✓			Q&S	4	3	12	**Controls:** **Readmission taskforce in place. Risk assessment tool developed. Information reports and readmission alerts set up for clinical teams.** **Treatment Plan: Project plan focuses on 3 core themes: 1. Coding project - to be established in Q2 with milestones to deliver coding review by end Q3. 2. enhanced discharge support for patients at risk of readmission (this will be supported by the addition of CCG membership to the Readmissions Project) 3. Pathway redesign and admission avoidance.** **The Project has a delivery plan with leads and milestones and is supported by the Change Team.**	**Internal:** **Minutes of Readmissions taskforce.** **Readmissions rate (on IPR)** **Q&S minutes** **Peer:** **Benchmark against peer group (CHKS dashboard)**	3	3	9	→	**New coding project to be established in Q2 led by COO. Delivery plan to be established and complete review by end Q3.** **Q2 update: Coding project deferred to align with incoming support.**	Q4	2	3	6

Executive Lead	Risk Ref and Date Added	Risk Description	Strategic Objectives						Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
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COO	201406_COO_002	There is a risk that the Trust does not comply with Emergency Care Standards because of failure to deliver the key components of the recovery plan which could result in failure of quarterly and year end targets and incurrence of fines	✓			✓			Q&S	4	4	16	**Controls:** **Internal Urgent Care Performance Board; partnership working and projects.** **Key areas of focus for delivery: 1. ED staffing and leadership development, 2. Reduce DTOC and improve patient flow, 3. Reduce mental health breaches, 4. Eliminate non admitted breaches with improved staffing ED and clinical processes** **External partnership forum - System Resilience Group - oversees delivery of plan** **Treatment Plan: Continue recruitment plan to achieve establishment of senior clinical leaders, Implement Joint health and social discharge team in the AMUs; establish lean mental health assessment pathways with assessment / place of safety 24/7 on both sites;** **Q2 update: Winter resilience monies have been allocated to support the above prioirities**	**Internal:** **Urgent Care Performance Board; DTOC system wide weekly meeting** **Peer/Independent:** **System Resilience Group, Contract Review meetings**	3	3	9	→	**Joint health social discharge team to be established in Q2. Full engagement of both social service providers required; commitment at senior level from both providers at Chief Officer / deputy level;** **Q2 update: ADAPT (health and social care team) established on both AMUs. Issues remain with BCC staffing over 7 days which is impacting on assessment. A focus on City ED particularly is in train overseen by the Executive triumverate with the Medicine and Emergency Care team.**	Q3	2	3	6

Executive Lead	Risk Ref and Date Added	Risk Description	Strategic Objectives						Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
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CN	201406_CN_003	There is a risk that there is under delivery on CQUIN schemes because of failure to deliver plans which could result in underperformance and financial penalties.	✓			✓			Q&S	4	4	16	**Controls: Lead managers identified for each CQUIN and monitor achievement each month via Q&S committee** **Treatment Plan: Each CQUIN lead manager has individual action plans in place to manage maximum achievement**	**Internal: Performance dashboard reported to Performance Management and Q&S committees and to Trust Board External: reports to CQRM**	3	4	12		**Greater scrutiny of CQUIN via an assurance meeting to be held with all of the CQUIN lead mangers by the Chief Nurse and Medical Director to identify any specific issues and ensure appropriate and timely action by accountable officers**	Q2	2	4	8

Executive Lead	Risk Ref and Date Added	Risk Description	Strategic Objectives						Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
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COO	201406_COO_004	There is a risk that delivery of the 18 week standard at specialty level is not met because of increased demand and supply mismatch or operational delivery of the 18 week standard which could result in underperformance, financial penalties and reputational risk.	✓	✓		✓			Q&S / FIC	4	4	16	**Controls:** **18 week recovery plan submitted to NTDA and CCG. weekly operational delivery meetings. strengthened capability in senior leadership: New Head of Elective Access started in July with experience of delivery. Director of Operations for Surgery A has previous Intensive Support Experience.** **Treatment Plan: Agree demand management approach for increasing referral specialties with CCG. Delivery of monthly activity profile to clear backlog in line with delivery plan. secure Resilience funding to deliver recovery plan. Sustainability will be through working differently with lean redesigned processes. YOOP supports automation and best practice standardisation.**	**Internal: Performance dashboard reported to OMC, Performance Management and Q&S committees and to Trust Board. Reports to weekly waiting list meetings.** **Peer/Independent: Reports to CQRM & contract meetings and System Resilience Group.**	3	3	9	→	**Demand management approach yet to be agreed with CCG, will be pursued through System Resilience Group**	Q4	2	3	6
CN	201406_COO_005	There is a risk that compliance with the letter and spirit of the safe staffing promise made after the Francis Enquiry may not be met , kleading to compromised quality of treatment and patient care		✓					QSC	3	4	12	**Controls: Monthly review of nurse staffing numbers, daily public presentation of ratio of patients to RN's on every ward** **Treatment Plan: Use of temporary staffing to remedy gaps in staffing rotas**	**Internal: Monthly Board report** **External: all reports and monthly data collection submitted to NHS Choices and presented on the trust web page Monthly data collection submitted to NHS England**	2	4	8		**Update Q2: A reprofiling and recovery plan has been submitted in line with a national agenda to rapidly decrease backlog of RTT patients. This results in Trust and specialty level performance from January 2015. Funding of additional work yet to be finalised .**	Q2	2	4	8

Executive Lead	Risk Ref and Date Added	Risk Description	Strategic Objectives						Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
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COO	201406_COO_006	There is a risk that our intended model of intermediate care at Leasowes, Rowley Regis and in Sheldon is not realised because of potential threats through commissioning intentions or affordability / competition which could result in failure to deliver our strategic vision and delayed transfers of care persisting at high levels	✓	✓	✓	✓	✓		~~PHCDE~~ Config .	4	4	16	**Controls:** **Activity and capacity model determined in long term plan** **Treatment Plan:plan to increase IC capacity on current Trust estate is in train. Business case to establish financial viability of this model TBC by mid August . Work to establish a strategic partner to deliver a affordable and quality service model. Estates work to be included in capital plan. Respond to current tender for 20 beds in August. Work with commissioners to ensure demand and capacity modelling is right sized for future commissioning.**	**Internal:** **Group performance reviews, Urgent Care performance meeting, Task / finish group** **Peer/Independent:** **Commissioning and contract meetings, System Resilience Group**	3	4	12	→	**Determine a commercial model for delivery of IC by mid August for current tender. Influence CCG for longer term commissioning intentions.** **Update Q2: IC in Sheldon block: contract awarded; estates work on track and workforce partner appointed . Due to open December 2014.**	Q3	1	4	4
COO	201406_COO_007	There is a risk that the transfer of 27 clinics into Rowley Regis Hospital as part of the Rowley Max' project does not happen because of failure to deliver project and staff engagement.			✓	✓	✓		Config .	3	3	9	**Controls:** **Plan detailed and is part of YOOP. Year of Out Patients Programme governance oversees delivery - included in programme plan** **Treatment Plan:deliver implementation plan by end Q3.** **Q2 update: Transistion of clinic to Rowley on track.**	**Internal:** **YOOP programme Board, CLE**	2	3	6	→		Q3	2	3	6

Executive Lead	Risk Ref and Date Added	Risk Description	Strategic Objectives						Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
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CN	201406_COO_008	There is a risk of over reliance on temporary nurse agency, and bank staff to ensure patient safety and specialling of patients which will adversely impact the Trust's financial position	✓			✓			QSC/FIC	5	4	20	**Controls: Daily requesting for temporary staff is controlled by group Director of Nursing** **Treatment Plan: Any requirement for external agency usage is controlled by the Chief Nurse**	**Internal: Monthly reports to Trust Board** **Independent: Monthly data scrutinised by NHS England and available on NHS Choices and trust web pages**	4	4	16		**Continue with controls and review of establishments to ensure that they are fit for purpose and meet guidelines. Review usage for specialling and explore alternative ways of supporting patients who are at risk of falling**	Q2	3	4	12
CX until DOD appointed	201406_DOD_009	Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment reduction of 1300 wte's, leading to excess pay costs.					✓	✓	WOD	4	5	20	**Controls: Review of existing policy levers to ensure options are maximised and are executed sufficiently early. Strong governance oversight by the Trust Board** **Treatment Plan: A detailed plan is being developed through CLE workforce committee, led personally by the Chief Executive. Will culminate in review at Board's Workforce and OD committee in September 2014.** **Update Q2: Workforce consultation process underway which concludes w/c 10 November 2014**	**Internal: Reports to Trust Board and Workforce & OD Cttee; CEO's weekly message; minutes of JCNC** **Peer/Independent: Updates to TDA**	3	5	15	→		Q4	3	5	15

Executive Lead	Risk Ref and Date Added	Risk Description	Strategic Objectives						Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
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DOF	201406_DOF_010	Failure to deliver efficiency improvement and cost reduction at necessary scale and pace resulting in key financial targets being compromised. ~~Consequent risk of adverse scrutiny by regulators and risk to approval of key strategic developments and authjorisation as an FT.~~ Consequent risk of adverse scrutiny by regulators and risk to approval of key strategic developments.	✓			✓	✓	✓	FI	5	5	25	Controls: Corporate PMO established aligned to dedicated change team resources. Single system for recording of detailed savings schemes [TPRS]. Routine granular reporting & challenge / confirm meetings with group & project leads. Treatment Plan: Development of PMO functions embedded within groups. Development of capacity & capability of change team. Prioritisation to create the time to do this well. Q2 update: No change	Internal: Routine oversight by CLE; challenge & confirm by FIC. Self assessment against Audit Commission / Monitor best practice guidance on CIP design & delivery. Independent: Internal Audit review of CIP processes. Expert support [Capita / KMT] in design & development of PMO & Change Team.	3	5	15	→	Development of 'route to success' line of sight for 2014-16 savings programme by end Q2; detailed schemes by end Q3. Assessment & establishment of necessary capacity & capability in organisation structures to deliver multiple objectives. Q2 update: Determine & secure level of income consistent with maximum annual CIP requirement not in excess of £25m [5%].	Q3	2	4	8
DOF	201406_DOF_011	Excess overheads reduce resources available for front line care resulting in key safety and quality standards / service development & excellence being compromised. Consequent risk of adverse scrutiny by regulators and loss of business risking organisational sustainability.				✓	✓		FI	3	4	12	Controls: Transparency of cost base; clear strategic plan to consolidate estate infrastructure & prioritisation of statutory maintenance programme; . Treatment Plan: differential cost reduction targets for non front-line services. Q2 update: No change	Peer: Benchmarking of overhead costs & performance against relevant peer [e.g. estate condition; estate utilisation; corporate functions]	3	4	12	→	Development & execution of middle & back office programme of change. Definition & agreement of 'business partner' model for corporate functions; of 'customer relationship manager' model for middle office functions.	Q4	2	3	6

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DNHP	201406_DNHP_012	There is a risk that the Trust may be unable to or delayed in completion of the procurement of a private sector partner to design , build , finance and operate the Midland Metropolitan Hospital because the Trust is unable to construct a viable Appointments Business Case due to changes in financial environment (e.g. LHE problems , construction inflation, insufficient competition, interest rate increases) resulting in project delay or no project.				Y	Y		Config.	3	5	15	**Controls:** **Stakeholder Board ongoing scrutiny and assistance** **Regular Monitoring of Risks through Config Committee** **Treatment Plan:** **Tight project controls** **Gateway Action Plan** **Q2 update: No change**	**Internal:** **Reports to Configuration Committee and Trust Board** **Independent:** **Gateway report**	2	5	10	→	**Stakeholder Board to be formed including HMT, DH and NTDA representation**	Q3	2	5	10
MD	201406_MD_013	There is a risk that the delivery of the IT elements of the 2014/15 capital plan will be delayed causing slippage in the delivery of the replacement of the Trust's EPR system and its associated integrated functionality				✓	✓	✓	FI	2	3	6	**Controls: The Informatics capital plan is aligned with the Informatics Strategy, the LTFM and the overall Trust Capital Plan** **Treatment Plan: The Informatics capital programme is monitored and expenditure scrutinised at the monthly Capital Management Group. The projects identified in this year's capital plan have been subject to an element of agreed rephrasing in line with the overall Trust Capital Programme within 2014/15 and the LTFM. Progress against projects within the 2014/15 Capital Plan is monitored by the CLE Informatics Committee. The progress and decision making in relation to EPR Procurement is currently monitored monthly by Trust Board. Initial appointments have been made to the EPR procurement team** **Treatment Plan: The capital plan**	**Internal: Minutes from IT Committee; minutes of Trust Board**	2	3	6		**Detailed Informatics plan developed**	Q3	2	3	6

Executive Lead	Risk Ref and Date Added	Risk Description	Strategic Objectives						Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
			Safe high quality care	Accessible and responsive	Care closer to home	Good use of resources	21st Century infrastructure	Engaged and Effective Organisation		Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DOF	201406_DOF_014	Failure to deliver key milestones delays approval by TDA to be considered for FT status by Monitor. Consequent risk of compromise to approval of key strategic projects and view of organisational sustainability.				✓		✓	WODC	3	5	15	**Controls: Clear & coherent timeline agreed with TDA covering Midland Met & FT development. Alignment of key deliverables to minimise duplication of effort. Routine oversight by Board.** **Treatment Plan: Review & establish necessary capacity & capability to run Midland Met & FT programmes concurrently.** **Q2 update: No change**	**Internal: Routine oversight by Board.** **Peer/Independent: TDA oversight of FT development path.**	2	5	10	→	**Organisational development programme defined & rolled out to secure agile & effective devolved management arrangements which better secure delivery, change & improvement.**	Q4	1	5	5
CX until DOD appointed	201406_COO_015	There is a risk that if we fail to invest in our leadership cadre, by not providing them with the knowledge, skills and behavioural changes required to bring about organisational change there is a likelihood that we will be unable to meet our organisational objectives.				✓		✓	WOD	3	4	12	**Controls: operational control group set up consisting of Trust leaders, programme participants and Hay group to ensure programme delivery and consistency. Robust set of ROI criteria put in place for Hay group which will give evidence/assurance required.** **Treatment Plan: progress monitored via Education, Learning and Development Committee, chaired by CEO and reporting to CLE.** **Q2 update: No change**	**Internal: Communications around leadership development plans; reports to W & OD Committee; reports to Clinical Leadership Executive; new consultant leadership development plan discussed at CLE in July** **Independent: Material from Hay Group Ltd.**	1	4	4	→	**Ongoing roll out of leadership development programme through to March 2015**	Q4	1	4	4

Executive Lead	Risk Ref and Date Added	Risk Description	Strategic Objectives						Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
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DOF	201406_DOF_016	There is a risk of not achieving compliance with the PAF framework, Monitor Compliance Framework and NHS Performance Assessment Framework leading to adverse scrutiny and punitive measures imposed by the Trust's regulators					✓		QSC	4	4	16	**Controls: Integrated Performance Report [IPR] produced monthly and includes specific assessment against relevant performance frameworks. Routine scrutiny of IPR at all Board & Committees. Routine use of IPR dashboards in Group performance reviews.** **Treatment Plan: IPR development to include granular reporting at directorate level. Data quality assessment roll out. Regular review for update of frameworks.**	**Internal: Monthly Integrated Performance Report**	3	4	12	→	**Development of prospective view of performance [foresight] and development of necessary & sufficient remedial action plans.**	Q3	2	4	8
DOF	201406_DOD_017	Failure to secure levels of activity and income from key commissioners consistent with medium term strategic and financial plans. Consequent risk to service & financial sustainability.				✓	✓		FI	3	5	15	**Controls: Ensure coherent 5 year activity & income planning assumptions with key commissioners.** **Treatment Plan: Develop prospective market assessment and plan and work with commissioners to secure necessary contracts.** **Q2 update: No change**	**Internal: Monthly financial performance report**	3	4	12	→	**In line with requirements of the approval letter for Midlanad Met: 1. the Trust and Right Care, Right Here commissioning partners must submit by ABC a jointly agreed plan for managing stranded fixed costs in the event of an income downturn at the Trust after the scheme opens compared to the income figures assumed at OBC. 2. The Trust further develops a robust set of mitigation plans that it can call on in a downside scenario, before draft Appointment Business Case approval, and the key commissioners must approve any that involve service changes in principle at or by that point and commit themselves to supporting the Trust in sustaining its CSSR.**	Q1 2015.16	2	4	8

Executive Lead	Risk Ref and Date Added	Risk Description	Strategic Objectives						Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
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DOF	201406_DOD_018	There is a risk of failing to develop robust 3 year outline CIP plans as part of the FT application (16/17, 17/18, 18/19) meaning the Trust falls short of its financial obligations which could potentially impact on the achievement of the Trust's long term strategic objectives to become a FT and to deliver a viable new hospital				✓	✓		FI	4	5	20	**Controls:** Annual planning process including routine update of Integrated Business Plan & Long Term Financial Plan. **Treatment Plan:** Embed CHKS Insight & Activity, Capacity, Income tools to underpin line of sight to models of care and efficiency. **Q2 update: No change**	**Internal:** Routine oversight by CLE; challenge & confirm by FIC. Self assessment against Audit Commission / Monitor best practice guidance on CIP design & delivery. **Peer/Independent:** TDA review of APR, LTFM & IBP. Internal Audit review of CIP processes. Expert support [Capita / KMT] in design & development of PMO & Change Team.	3	4	12	→	**Development of Midland Met Appointments Business Case to include future proof clinical models and necessary efficiency improvement. Specific attention to be given to workforce plan and financial assessment of safe, bottom up view.**	Q4	2	4	8
~~DOF~~	~~201406_DOF_019~~	~~There is a risk of failing to develop robust rolling 2 year detailed CIP plans as part of the FT application (14/15 & 15/16), which could lead to a delay with the Trust's authorisation as a FT~~				~~ü~~	~~ü~~		~~FI~~	~~4~~	~~5~~	~~20~~	~~**Controls: Corporate PMO established aligned to dedicated change team resources. Single system for recording of detailed savings schemes [TPRS]. Routine granular reporting & challenge / confirm meetings with group & project leads.**~~ ~~**Treatment Plan: Development of PMO functions embedded within groups. Development of capacity & capability of change team. Prioritisation to create the time to do this well.**~~	~~**Internal: Routine oversight by CLE; challenge & confirm by FIC. Self assessment against Audit Commission / Monitor best practice guidance on CIP design & delivery.**~~ ~~**Independent: Internal Audit review of CIP processes. Expert support [Capita / KMT] in design & development of PMO & Change Team.**~~	~~3~~	~~4~~	~~12~~		~~**Development of 'route to success' line of sight for 2014-16 savings programme by end Q2; detailed schemes by end Q3. Assessment & establishment of necessary capacity & capability in organisation structures to deliver multiple objectives.**~~	~~Q3~~	~~2~~	~~4~~	~~8~~

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COO	201406_COO_020	The validity and reliability of reports produced for management of the Trust key activities are bespoke, variable and lack controls on release. This results in variability in multiple reports and potential data quality issues.				✓	✓		ARC	4	4	16	**Controls:** **Dashboard development in place for key operational activities, Standard information tools (CHKS insight) purchased and implemented for use across the Trust. These are intuitive tools and give Board to patient level view of service delivery and performance. IPR kite marked for Data quality.** **Treatment Plan:Establish a Business Information Unit (BIU) and under the leadership of the Head of BIU in conjunction with the Performance Team review the production of information reports, establishing kite marks linking to the IPR.**	**Internal:** **OMC, PMC, Group Reviews, CLE, Audit and Risk Committee, IPR**	2	4	8	→	**BIU to be established in Q2.** **Q2 update: Information department BIU moved to Operations Directorate end of Q2. A review of information function in collaboration with performance, contracting, finance and change team function will take place Q3-4. Plan for external expertise / leadership for this has recently fallen through. The COO will urgently review this to enable capacity for a review to be secured and establishment of a new BIU function for 2015.**	Q2	2	4	8

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DG	201406_DG_021	Inability to achieve external validation of QGAF / BGAF standards adversely affecting the timescales associated with the Trust's FT application.	✓				✓		TB	3	5	15	**Controls: BGAF improvement action plan and self-assessments against frameworks. Monitoring through FT Project Team, PMC and Trust Board** **Treatment Plan: Refresh of the self assessments and action plans to achieve a higher rate of compliance against the frameworks. Use of peer review to inform judgement of performance and/or compliance. Quality review as part of Monitor assessment process.** **Q2 update: Recent self-assessments to Trust Board have indicated that a score of 3.5 for QGAF may be achievable. BGAF self-assessment has also shown an improved position.**	**Internal: Reports to PMC and Trust Board formal and informal sessions** **Independent: Assessment by Deloitte and Finnamore Ltd.**	2	4	8	↓	**Further self-assessments to be undertaken in Q4, with further monitoring of action plans**	Q3	2	4	8
CX until DOD appointed	201406_DOD_022	Organisation is unable to design and implement arrangements for the body of the organisation to be well-led which has the potential to delay the Trust's FT application					✓		WOD	4	5	20	**Controls: leadership development programme in place and new leadership competance framework developed. See line 17.** **FT programme with key OD deliverables and milestones in place** **Treatment Plan: as per line 17 for leadership. Deliver FT programme and manage FT approval risks through FT risk register**	**Internal: Routine reporting to E,L&D Committee. FT programme management team in place. FT CLE sub committee will oversee progress against key deliverables.**	2	5	10	→	**Continued roll-out of leadership development programme**	Q4	2	4	8

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DOF	201406_DOD_023	Failure to secure business from competitive tender processes as a result of lack of capacity, skills and capability to respond successfully to procurement opportunities for existing and new services resulting in a loss of income and risk to service reputation or sustainability.				✓	✓		FI	4	4	16	**Controls: Dedicated business development resource to scan market for opportunity and to administer any bidding process.** **Treatment Plan: Establish clear process for bid development & assurance. To include effective utilisation of specialist corporate functions [e.g. finance; procurement; HR]** **Q2 update: No change**	**Internal: Routine oversight by CEO & DoF.**	3	4	12	→	**Establishment of coherent business development, bid management & assurance and contract management function. Internal Audit input to fitness for purpose design & subsequent review of effectiveness of operation.**	Q3	2	4	8

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Plan Delivery Report 2014/15 – Q2 Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Tony Waite – Director of Finance & Performance Management**
AUTHOR:	**Neetu Sharma – Head of Strategic Planning**
DATE OF MEETING:	**6 November 2014**

EXECUTIVE SUMMARY:

The document provides an update on progress of delivery for the key activities and objectives included in the Trust Annual Plan for Q2. Each action is reported via a Trust Board or Executive Committee on a monthly/bi-monthly basis and this provides more regular monitoring of the various projects/schemes that sit beneath each objective.

This report is split into 3 sections:

1. Objectives we have already met / are on track to meet
2. Objectives we are behind with, but can still achieve
3. Objectives we are unlikely to meet by the end of 14/15

REPORT RECOMMENDATION:

To discuss progress against achievement of the key objectives outlined in the Trust Annual Plan for Q2 and discuss those objectives that are currently behind schedule, and will not be achieved by the end of this year.

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

Accept	Approve the recommendation	Discuss
		x

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

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

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

Aligned to Trust strategic objectives

PREVIOUS CONSIDERATION:

August 2014 (Q1 update)

Annual Plan (2014/15) – Our Objectives

Key: Complete | Part achievement/some delay, but on track | On track | Significant delay – unlikely to meet year-end deadline

1. Objectives we have met/are on track to meet

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
Safe, High Quality Care						
S1	**Improve our Friends and Family results**, towards being the best in the region	CO	Q1 & Q2 2014/15 FFT data: • IP FFT score: 72 : (+4.6 points from 2013/14) • ED FFT score: 47.8 (-0.9 points from 2013/14) • IP FFT response rate: 38.2% (+7.9% from 2013/14) • ED FFT response rate: 16.2% (+4.8% from 2013/14)		✓ - continuing to improve both scores & response rate (currently 2% improvement per quarter)	• Expansion of FFT programme to Outpatients & Day cases – to be completed by April 15 • Continue to work in partnership with 'Edna's Army • Trust wide focus on views & opinions of patients with learning disabilities • Increase access to FFT for all groups of patients to reflect the broad and diverse population we serve (comply with new DoH guidelines) - to be completed by April 2015
S2	**Implement year one of our Public Health plan**, making every contact count	TL	• New traffic light system for food introduced by end of Oct '14 • Huge improvement in number of midwives carrying out carbon monoxide monitoring & smoking cessation advice • Nicotine Replacement Therapy programme implemented • Use of landfill ended		✓ - 14/15 deliverables (most objectives due to complete in 15/16 or 16/17)	• Devise focused plan for audited community asthma advice • Review options for gym facilities at Sandwell • Launch MECC training in January 2015, along with promotional materials.

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
S3	**Deliver our Year of Outpatient programme**, to reach 98% patient satisfaction	RB	• Patient experience surveys undertaken across all sites in April 2014 & July 2014. Over 18,000 patients gave us their view: o 98% were made to feel very welcome by our teams o 93% would recommend our service to family and friends o 92% understood the consultation (1% did not and 7% left this blank) o 88% felt that the environment was suitable to their needs o 77% found the process for choosing their clinic date was satisfactory • Electronic outcomes introduced in Ophthalmology in October, evaluated and recommended a phased role out over the next few months		✓ - Supporting programmes on track to be delivered by the end of the year	• Acknowledgement of a referral to a patient built into electronic referral management service- fully operational by March 2015 • Moving to a follow up partial booking system from February 2015 • Self-check-in kiosks will come into use across Trust in 2015 • Specialities putting plans together to create different relationships with GPs (especially in LTC) to help sustain and improve satisfaction rates • Review DoS and make it more user-friendly. Develop A&G services.
Accessible & Responsive Care						
A1	**Deliver national cancer wait times,** even where other Trusts deliver part of the care	RB	<u>YTD performance:</u> • 2 week: 93.3% (93%) • 31 day: 99.2% (96%) • 62 day: 89.3% (85%) <u>In September 2014:</u> • 1 group narrowly failed to meet 93.0% threshold for 2WW: Surgery B (91.3%). • 2 groups failed to meet the 85% threshold for the 62 day GP RTT treatment: Surgery B (75%) and Women & Child Health (58.8%)		✓ - meeting national cancer targets consistently	• Reduce diagnostic waiting times further • Improvement needed when discussing patient's care with them (as reflected in patient survey feedback). Trust Board will consider in December how to ensure common standard of excellence in providing information & support to patients with cancer.

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
A2	**Comply with both the letter and the spirit of the Safe Staffing promise** made after the Francis Inquiry	CO	• All daily requests for additional staffing are reviewed by Chief Nurse & Deputies to ensure productive use of existing workforce • The NICE guidance requires 6 monthly establishment reviews and monthly board reports, both of which we have completed (Board report details our normal expected staffing numbers and the percentage fill rate for shifts which is taken from a national data return.) • A review of establishments has taken place as part of the workforce review - this data has just been issued and will be presented to Trust Board in November		✓ - following current NICE guidance with monthly reporting at Board level	• Chief Nurse has discussed with Group Directors of Nursing & Deputies the option of moving to the Association of UK University Hospitals safer staffing tool as our assessment method. • We will test out the method in the coming months and begin using the tool to do our six month reviews from early 2015. • Further NICE guidance expected in 2015
Care Closer to Home						
C1	**Develop further our model of intermediate care at Leasowes, Rowley Regis and in Sheldon**	RB	• Invested almost £1m in creating additional intermediate care beds in Sheldon • Additional services opened at Leasowes		✓ - PCAT unit expanded, additional clinics at Rowley, IC beds bid successful.	• Complete estates work and recruitment (in association with workforce partner) • IC beds on track to open in December.
C2	**Implement our pacesetting project to change the shape of district nursing delivery,** making our services part of the primary health care team	RB	• Mapping community nursing services around multi professional teams to further enhance primary care and district nursing model. • District Nursing Teams have been divided into 25 alignments with GP Practices, therefore all GP's have a		✓ - improved relations between GP practices/DN team	• Monitor KPI to measure benefits realisation • Recruitment to vacancies • Complete leadership development of top team.

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
			named team with nurses they know and communicate with. • MDT meetings have now started on average a 2 monthly basis, records of these are collected by the CCG to monitor any teams/GP Practices that are not adhering to the agreement. • Quarterly Operational Group meetings are held with CCG, SWBH and BCHC providers, information from this is passed on to Pace Setting Board. • KPI's have been agreed and signed off with CCG and SWBH. • Each team/GP Practice have now met and agreed their own personalised Standard Operating Procedure, this is for review March'15.			
Good Use of Resources						
G1	**Investing in our occupational health services counselling teams** to tackle workplace stress	TL	• £20k investment in counselling service provision		✓ - Complete	N/A
G2	**Introducing an in-house medical bank**	RS	• Phased launch – currently live in ED. Gradual process to iron out any potential issues.		✓ - managing any issues as they arise to ensure successful rollout	• Medicine go-live 3rd Nov • WCH go-live 10th Nov • Surgery A& B go –live 17th Nov • Diagnostics go-live 24th Nov

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
21st Century Infrastructure						
I1	**Proceed with MMH**	GS	• OJEU process commenced with issue of PQQ. Process of Competitive Dialogue has now commenced with two bidders.		✓ - progressing according to current programme	• Evaluation process to take place in December 2014 • Continue with two bidders until March 2015
An Engaged & Effective Organisation						
E1	**Improve employee wellbeing** by implementing our Public Health plan	TL	• Implemented staff nicotine replacement programme– 29% quit rate over 12 weeks. • Phase 1 of mental health support for managers launched from 7th August. • From Sept 2014, all new inductees complete assessment for lifestyle behaviours. • Vending machines have undergone change with regards to sugary drinks being removed and the lunch time service for patient meals has also changed.		✓ - positive results from NRT programme and further health promotion will be launched alongside MECC training	• Continue to work to install a gym at Sandwell • Food traffic light system to be introduced with promotional campaign early Q3. • Nicotine Replacement Programme will be evaluated, in its entirety, at the end of January 2015. • Mental health training weds some minor adaptations following feedback from the pilot.
E2	**Invest in our leaders**, through partnership with Hay Group and others	TL	• Several cohorts of the first top leader programme have commenced - 150+ leaders on programme		✓ - phased programme on track	• Next cohort will begin leadership programme early 2015 • Top leaders cadre continue with 1:1 coaching and peer support

2. Objectives we are behind with, but can still achieve

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
Safe, High Quality Care						
S4	**Reduce preventable deaths**, in particular by focusing on the Sepsis Six Care Bundle	RS	• Q2 14/15 HSMR relative risk – 67.49 (3rd successive quarter of low relative risk) • Of the patients commenced on the sepsis pathway (79%), 44% received the sepsis care bundle within the Golden Hour. This is an improvement from 2013/14 and our highest performance to date (we are the only Trust currently reporting this data) • Target not met for mortality reviews carried out in within 42 days (July '14)		✓ - previously meeting 42 day review target on monthly basis. Sepsis trajectory showing improvement	• Introduction of an electronic sepsis 6 bundle that will automatically populate a dashboard, removing the need to complete a paper version of the tool. This will improve data quality across both sites (currently data not collected consistently)
S5	**Reduce readmissions** by 1%, through integrating care and better managing risk	RB	• Adult readmission rate: 6.9% (Q1 & Q2 14/15) as compared with 8% for the same period last year. • Total adult acute readmissions (Q1 & Q2 14/15): 2,856 as compared with 3,589 for the same period last year. • Split by site - Sandwell: City:		✓ - showing improvement – need to improve adult acute readmissions at Sandwell	• Roll out of LACE predictor tool and supporting work to 3 key areas • Delivery of plans to enable specialties to reach end of year target • Development and roll out of new discharge summary to assist with care plans in the community
S6	**Reduce the number of complaints**, especially repeat complaints	KD	• Number of formal and link complaints in Q1 & Q2 2014: 426 (an increase of 26 on same period in 2013) • Repeat complaints reduced - Q1 saw 19 complaints reopened because we had not addressed all their issues but only 9		✓ - repeat complaints, however difficult to predict overall number of complaints	• Continue to implement the devolution process to improve accountable and commitment to delivering the best possible care/ service • Complaints are signed off at

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
			in Q2.			three levels, ensuring that all complaints are checked for accuracy& appropriateness, including a focus on ensuring that all issues are covered. • Reduce complaints in emergency care in BMEC and A&E
Accessible & Responsive Care						
A3	**No mixed sex breaches of our privacy and dignity standard,** now reported from eBMS	RB	• Mixed sex breaches: Q1 = 93 / Q2 = 3 • August & September 2014 - two consecutive months with 0 breaches.		✓ - Significant improvement made from Q1 to Q2	• Continue audit • Review gender demands on capacity through daily capacity meetings
A4	**Achieve the emergency care standard,** and **meeting our own ambitions around mental health care** in an acute setting	RB	• The trend of mental health breaches increased in Q1 and the length of time spent in ED is also increasing and remains higher than acceptable .		✓ - New processes to be introduced mid Q3	• Working with both providers to establish place of safety / assessment space outside of ED; pathway mapping to be complete to set new standard operating procedures and shared care protocols to decrease waits within pathways. • New processes to be in place end November 2014 using winter funding.
A5	By October 2014, **specialty delivery of 18 week wait standards,** and introducing these standards into therapy services	RB	• Trust consistently meeting 18wk target <u>Treatment functions underperforming in Q1 & Q2 by month:</u> • April (16), May (11), June (13) July (12), August (11), September (13)		✓ - Original October deadline superseded by national requirements	• National requirements to reduce national backlog has required a re-profile in year of trajectory which is now Trust and specialty level compliance by January 2015.

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
A6	**Cut cancelled operations numbers,** and eliminating repeat cancellations	RB	• Cancelled ops: 221 SITREP declared late cancellations in Q1 & Q2 of this year. • Performance improving from Q4 2013/14 but still above monthly trajectory • One patient has experienced late cancellation on more than one occasion (target = 0) • 13.05% of cancellations are multiple cancellations experienced by the same patient (target = 0%)		✅ - Focus on particular clinic group	• Focus on Surgery B where a majority of cancellations exist. Trajectory and delivery plan agreed with team
Care Closer to Home						
C3	**Complete the transfer of 27 clinics into Rowley Regis,** as agreed by the Clinical Leadership Executive	RB	• Two new GUM clinics are being delivered as well as clinics delivered by Surgical Care Practitioners. • Modifications required at Rowley to allow for additional clinics to be transferred (including Respiratory Oxygen Assessment)		✅ - OP programme on track	• Estates plans finalised at Rowley Regis to allow for further clinics to be transferred
C4	**Resolve the long term configuration of midwifery services for 2015-16,** with our CCG partners, local families and the Local Authorities	RB	• CEO/ AO and teams meeting held in Q2. Awaiting workshop to be set up by CCG to take forward review. • Short term actions agreed & completed.		✅ - expected to have plan in place before end of year for implementation in 15/16	• Initial planning meeting arranged for 31.10.14 to discuss long term configuration of community care. • Agree programme governance with CCG, building on success of pace setting board.

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
C5	Ensure that our **plans for winter 2014 are supported by consistent models of our of hospital care in nursing homes** and the other settings of risk	RB	• To support our frail elderly service model, we have recruited an additional two consultant geriatricians and are continuing to expand on the level of support we provide to nursing homes. • Additional intermediate care beds at Sheldon		✓ - Expected to achieve by end of Q3	• Recruitment going well. Job plans to be reviewed and finalised to provide nursing home cover Q3.
C6	**Reform another long term conditions specialty into general practice,** year two of what we have achieved with Diabetes	RB	• Plan for Respiratory service to be reformed into General Practice • Working with CCG through readmissions work to design Long Term Condition Pathway to general practice		✓ - using best practice from Diabetes/DICE model	• Agree delivery plan by end of December 14 • Implement in Q4
Good Use of Resources						
G3	**Cut our reliance on agency, overtime and bank staffing,** on which last year we spent over £25m	RB	• Our expenditure this financial year to August 2014 is: Bank- £4,577,000 and Agency - £5,322,000. • This is a 20% reduction in expenditure (and hours)		✓ - aligned to workforce change programme	• Complete implementation of workforce review • Reduce reliance on WLI • Recruit further to ED
G4	**Standardise our consumables & equipment,** especially in theatres to reduce the costs and safety risks of variation	TW	• Extant Product Rationalisation Group [PRG]. • Non-pay review on-going with target of specific improvement proposals by end Q3		✓ - majority of work due to take place in Q4 (see right).	• Invigorate PRG to include senior clinical leadership and focussed work plan to provide sharper route to standardisation for safety and cost efficiency improvement. To include revised arrangements for working with groups/ directorates & decision assurance; identify clinical

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
						champions including evaluation of peer models of clinical expertise embedded within procurement function. Re-launch Q4. • Conclude non-pay improvement process.
G5	**Make sure that the way we work is productive and efficient,** across the week and in every month of the year, **making smarter use of technology**	RB	• Extant projects include Year of Outpatients, 7/7 working, EPR. TSP programme includes schemes to improve productivity through more effective production planning, workforce re-design and improved discipline in leave & sickness management.		✓ - supporting programmes on track.	• Follow through on extant projects. • Embed capability to assess, plan & manage demand & capacity across the year consistent with sustained delivery of key operational standards and cost effective working. • Create fit for purpose contracting / business development function to better align corporate and devolved activity & capacity plans. • EPR OBC developed for January Trust Board. • Establish fit for purpose business intelligence function to be designed by end of year with implementation started.

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
G6	**Reduce overheads** in our system, so that **more of every pound is spent on patient care**	TW	• MMH retained estate plans in development. Capital programme provides for progression in line with future model. • Middle & back office functions cost effectiveness improvement being transacted initially through TSP & workforce change programmes.		✓ - plan for retained estate ✓ - deliver workforce change programme ✓ – middle & back office function	• Target to identify & remove 18000m2 of occupied space by March 2016. • Implement workforce change programme • To realise further necessary service & cost effectiveness in middle & back office establish specific improvement programme with expert support as necessary. Project scoping & way forward tbc.
G7	**Eliminate the costs of poor quality care,** where patients need more expensive treatment because of errors or omissions that we have contributed to	RB/ CO	• 10/10 programme launched with series of workshops, and phased implementation across the Trust • MRSA screening – consistently meeting target • VTE assessment – Sept '14 – 95.55%		✓ - ongoing objective, improved through achievement of key programmes	• Investing in ward managers to support 10/10 programme • Work towards 100% compliance for MRSA screening & VTE
G8	**Providing extra support to high-turnover departments** and those with long-term vacancies	TL	• Focused work on medical and surgical staff nurses (Band 5) – losing 40% within 2 years of commencement • Improved exit questionnaires		✓ - proactive approach to gaining feedback as to high level of turnover	• Plan to develop rotational schemes (different specialties and into community) • Specific group management feedback sought through Your Voice and exit questionnaires

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
G9	Ensure that our **training expenditure supports career and skill development**	TL	• Group training plans will be submitted via the business planning process in Feb/March 2015 and quality assured by L&D department and Workforce planning.			• Expenditure against plans to be monitored by E,L&D committee. All study leave applications to be submitted by 1 December 2014. • Groups to be held accountable for any underspend against training plans (to explain why the development has not taken place and the impact it will have on the individual, service delivery or transformation) as it has been identified it as a priority.
21st Century Infrastructure						
I2	**Invest in estate that we are keeping for the long-term** including Sandwell General Hospital, Rowley Regis and Sheldon	GS	• Almost £1m invested in intermediate care beds at Sheldon • Refresh & update of Development Control Plans for Community Estates, Sandwell, City & Rowley has commenced.		✓ - approval of schemes expected Q3	• The Development Control Plans for community locations are in the process of being updated. • Drawings are being prepared to show existing and proposed schedules of accommodations and will be presented to CLE in November for approval.
I3	**Resolve issues with the Birmingham Treatment Centre** to ensure **better staff and patient experience**	GS	• Deed of Settlement and Variation to Project Agreement currently being developed with Legal Advisors • Finalisation of the Deed of Settlement and Variation has been delayed due to agreement to the final wording by both parties and Legal Advisors.		✓ - Trust Board approval of Deed of Settlement expected Q3	• The Deed of Settlement and Variation to be presented to Trust Board for approval and application of the Trust's seal, November Trust Board.

3. Objectives we are unlikely to meet

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
Safe, High Quality Care						
S7	**Meet the emergency care waiting time standard**, as we did in April 2014	RB	• Trust did not meet the 4-hour ED wait target during September with performance of 91.76% for the month. Year to date performance is 93.87%.		X –95% target not met since April 2014	• Implement the ADAPT process to remove three quarters of DTOCs • Recruit to extant ED consultant roles to extend hours of coverage • Reduce mental health breaches by establishing 7 day assessment suites on acute sites • Change culture in city ED • Confirm ambulance conveyance boundaries • Confirm West Birmingham social care bed capacity
Good Use of Resources						
G10	**Improving our 'time to hire'** from vacancy to recruitment	TL	• Reduced pre-employment check part of process • Improved reporting mechanism to identify the delays • Current 'time to hire' (Sept 2014)= 19 weeks. YTD average is 19 weeks (compared with 13/14 average of 18 weeks)		X – Affected by workforce change programme (all vacancies held until redeployment started)	• Improved dialogue with groups – groups to take ownership over the delays in recruitment

Ref	What we said we would do	Exec Lead	Current status	Current RAG	Will we achieve this by the end of 2014/15?	What we still need to do
An Engaged & Effective Organisation						
E3	**Achieve 100% PDR and mandatory training compliance** by March 2015	TL	• PDR compliance: Q2 Overall compliance: 83.72% • Mandatory training compliance: Q2 Overall compliance: 84.4%		✓ - have shown in 13/14 that target can be met X – YTD performance indicates that we will not meet 100% for MT	• Focused campaign with managers in Q4 to achieve compliance
E4	**Cut sickness rates from their current 4.5%** by focusing on our fifty hot spots	TL	• YTD Sickness Absence is reported as 4.40% (range 3.3% - 5.7%) • It is acknowledged that reducing sickness absence at the same time as implementing large scale workforce changes across the organisation is challenging given that many of our employees are extremely anxious and concerned as a consequence. • HR capacity to support local managers with managing poor attendance is currently limited given the need to support workforce reductions.		X – workforce change programme likely to impact upon reducing sickness absence rates	• Continuing to focus on 50 fifty hot spots • Priority will be given to those departments within the top 50 and long-term absence. • Clear expectation that routine sickness absence management is undertaken independently by line managers and HR intervention is reserved for more complex cases.
E5	**Introduce 360-degree appraisal into all leadership roles**	TL	• 150 leaders have had 360 degree appraisal introduced into their role • Charitable fund bid submitted to develop in house function / internal feedback facilitators. A number have already been trained.		X – 700/1000 leaders identified across Trust – this number will not be met by end of 2014/15	• 150 additional leaders beginning leadership programme early 2015

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**7 day working – update against standards**
SPONSOR (EXECUTIVE DIRECTOR):	**Rachel Barlow – Chief Operating Officer**
AUTHOR:	**Rachel Barlow – Chief Operating Officer**
DATE OF MEETING:	**6 November 2014**

EXECUTIVE SUMMARY:

The attached document summarises the Trust self-assessment against the 10 clinical standards for 7 day working. These standards, whilst they appear very acute hospital focus are a whole health and social care system set of standards.

Elective activity / non urgent activity is undoubtedly less at the weekends. Urgent care is fairly consistent in its profile across the week.

The Trust is generally well placed in terms of compliance with the clinical standards across 7 days and has worked over the past 3 years to increase the senior decision maker cover particularly at the weekends. Investment has been made in imaging to provide a more responsive diagnostics service over 7 days in urgent care.

Whilst the essential standards are met for consultant clinical cover, the Trust is making determined effort to increase hours of rostered shifts for ED consultants from 6 hours to 12 hours at weekends, rather than rely on the on-call consultant responses, the frequency of which is demanding for this staff group. The acute assessment units and wards have separate consultant cover at the weekends.

A 7 day capacity team has been put in place, providing on site senior management cover 7 days a week.

The exception areas against the clinical standards for the Trust include:

- some diagnostic response to non-urgent patient pathways eg MRI
- elderly care specialist cover 7 days – although successful recruitment has enabled a more responsive urgent care service to be developed into the future
- Interventional radiology – is provided 7 days a week, but in longer term resilience for this small but important sub specialty will be strengthened by a network partnership
- Hospital at Night – the current model is currently under review under the leadership of Carol Cobb, Associate Medical Director

In terms of our partner organisations, exceptions to the national standards are focused in :

- Adult and children's mental health services fall short of 7 day standards – the Trust is working with mental health partners to establish dedicated assessment suites on the main hospital sites for adults requiring mental health assessment. This will improve the patient experience. A workforce review is accompanying this piece of work particularly in respect to social worker capacity for formal mental health assessments, which currently causes delay.
- Social workers responding within 14 hours of admission is non-compliant , although significant improvements to a 7 day working week have been made and should be seen

as positive progress with social workers join the acute assessment teams. Sandwell Council staff do not work bank holidays.

- Access to primary care to continue patient care post discharge or attendance to ED is not accessible in a planned way with handover of care. The Trust is exploring the potential of direct booking to GP appointments.

REPORT RECOMMENDATION:

Consider the compliance with standards and gaps. Discuss workforce implications and stakeholder engagement and delivery on complaint standards.

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		X

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

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		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

PREVIOUS CONSIDERATION:

None

Clinical Standards Proforma

The following table summarises compliance with the 10 national clinical standards for 7 day working.

RAG rating:
Red – Does not meet this standard
Amber – Partially meets this standard
Green – Meets this entire standard

There is also a column to add any comments you wish, and to insert any interdependencies.

Clinical Standard	**Red** / **Amber** / **Green** *(Please indicate below)*	**Comments** *Please give examples of evidence demonstrating your RAG status*	**Interdependencies'/ comments** *Please detail roles or functions that you require to be completed by any other organisation in order for you to meet this standard.*
Patient Experience: Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.	Amber	Overall rating AMBER: RAG rating in association with surveys and patient feedback, FFT and self-assessment of local services;	
	Green	Gynaecology - CNS Team on EGAU will always see any emergency admissions between 8am – 8pm 7 days per week. They are the lead clinician in this area in conjunction with On-Call Registrar	SAU nursing team out of hours provide care in line with agreed pathways and protocols
	Amber	ED	
	Amber	Wards	ADAPT health and social care team based on AMU will involve patients and relatives earlier in discharge planning
	Amber	Diagnostics	

				Paediatrics- Offer 24hrs open access –Good practice and gives parents confidence to take children home	
				Community Examples of GREEN • diabetes results at home • patient knows best pilots	
Time to first consultant review All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.				Acute Medicine	
				Mental Health	Mental health is a focus area within the System Resilience Group. The Trust is working to establish new pathway and response standards for mental health patients with specialist Trusts. A pilot of mental health assessment units on the acute sites for winter with 7 day mental health nurse experts will start in Q3.
				Surgery	
				Paediatrics	Offer 24hrs open access –Good practice and gives parents confidence to take children home
				Gynaecology	
				Elderly Care	Elderly care consultant numbers increasing and will offer same response times Monday to Friday initially. A workforce review will determine trajectory to 7 day cover.

Multi-disciplinary Team (MDT) review All emergency inpatients must have prompt assessment by a multi-professional team to identify complex or on-going needs, unless deemed unnecessary by the responsible consultant. The multi-disciplinary assessment should be overseen by a competent decision-maker, be undertaken within 14 hours and an integrated management plan 14 with estimated discharge date to be in place along with completed medicines reconciliation within 24 hours				Acute Medicine	
				Rapid Response Treatment	
				Social Workers	Multi professional team joint with AMU staff established 7 days on both sites, working hours of social workers is 9-5 so cannot meet 14 hour standard yet.
				Medicine Reconciliation (with pharmacy)	
				Critical Care	
				Stroke	
				Emergency Gynaecology:	
				Paediatrics	
Shift handovers Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.				Emergency Department	
				Hospital at Night	Work to do to integrate H@N and capacity 24/7 handover. No recent audit has been completed to give evidence of GREEN; current hospital project to review H@N being led by Associate Medical Director.

				Paediatrics	
				Gynaecology	
Diagnostics Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and their reporting will be available seven days a week: • Within 1 hour for critical patients; • Within 12 hours for urgent patients; and • Within 24 hours for non-urgent patients				Pathology	Oncall Biochemist, Microbiologist and Haematologist available 24hours 7 days a week.
				X-Ray	
				Ultrasound	
				CT	
				MRI	The amber rating is only applicable to non urgent patients otherwise standards are met.
				Echocardiography	The amber rating is only applicable to non urgent patients otherwise standards are met.
				Endoscopy	The amber rating is only applicable to non urgent patients otherwise standards are met.
				Bronchoscopy	The amber rating is only applicable to non urgent patients otherwise standards are met.
Intervention / key services: Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements				Critical care	
				Interventional Radiology	Need to strengthen 7 day cover through a network approach for resilience

with clear protocols, such as: • Critical care; • Interventional radiology; • Interventional endoscopy; • Emergency general surgery.				Interventional Endoscopy	
				Emergency General Surgery	
				Gynaecology	
				Paediatrics	
Mental health: Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week: • Within 1 hour for emergency* care needs • Within 14 hours for urgent** care needs				RAID adult assessment team on site at city 7 days a week. Day time mental health service at Sandwell provided by Black Country Partnership. Paediatrics- All young adults with mental health needs are seen and reviewed by CAMHS team within 24 hours of admission.	Bed capacity for Tier 4 children is a major issue and is on the Trust risk register. A 24/7 assessment service is required.
On-going review: All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.				Acute Medical Units	
				Surgical Assessment Units	
				Paediatrics	
				Intensive Care Unit	
				High Dependency Unit	
				Coronary Care Unit/Stroke Medicine	
				Gynaecology	

Transfer to community, primary and social care: Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.				Primary Care	Perceived difficulty accessing to register new with GP at weekends No ability to book direct into appointments from ED to follow up patients care ? profile of bank holiday capacity
				Paediatrics -	Community nurses visiting ward areas daily and will be able to identify / target those patients for discharge (ie gastroenteritis, eczema and patients on antibiotic therapy
				Mental Health – Paediatrics; CAMHS available only weekdays and not weekends.	
				Mental Health – long delays waiting for beds in ED	Packages of care, home placements needed, lack of IP bed provision
				iCares	
				Community Respiratory Service	
	*			Social services – 7 days service available but only 9am-5pm currently	*Providers of beds not 7 day compliant causing outflow delays; needs recontracting by Social Services
Quality improvement: All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must				Audits undertaken regularly. Clinical incidents reported and investigated, Table top reviews with recommendations, Morbidity and Mortality meetings held monthly for Emergency Care specialties, Junior Drs forum, Risk registers for each specialty with	We have a comprehensive approach to quality improvement, some of which has a 7 day profile view. More focus will be given to audit and learning over a 7 day

be consistent with the delivery of high- quality, safe patient care, seven days a week.				action plans on how to reduce risks in our areas, operational meetings for Acute Medicine and Emergency Medicine.	profile.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Integrated Quality, Performance and Finance Report
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Mgt
AUTHOR:	Gary Smith, Head of Performance Management (acting)/ Mike Harding.
DATE OF MEETING:	6 November 2014 (Report prepared 30 October 2014)

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

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

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
		x

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

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

Comments:

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

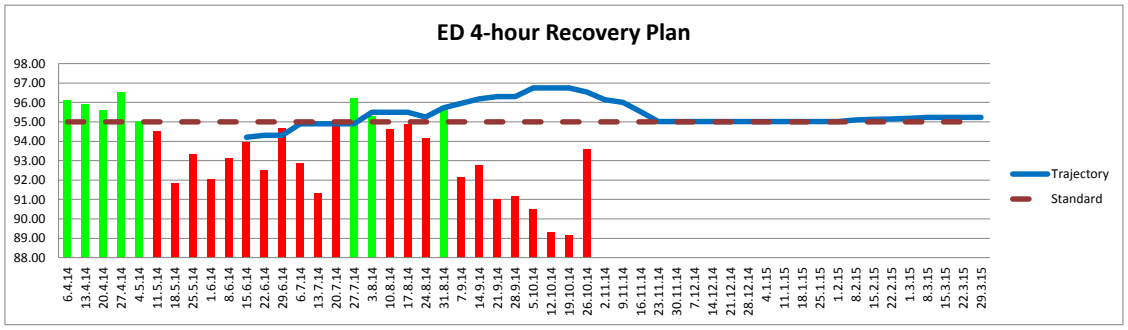
Accessible and Responsive Care, High Quality Care and Good Use of Resources. National targets and Infection Control. Internal Control and Value for Money

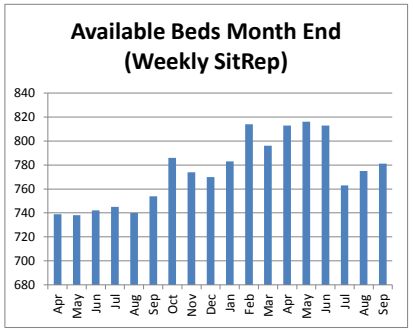
PREVIOUS CONSIDERATION:

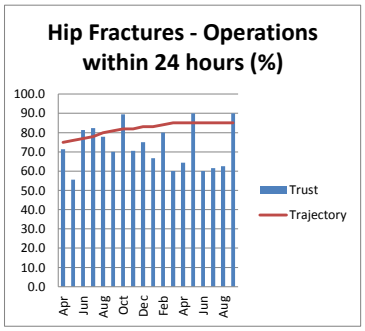
Operational Management Committee, Performance Management Committee, Clinical Leadership Executive and Quality & Safety Committee.

Access To Emergency Care & Patient Flow

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Unit S	Unit C	Unit B	Month	Year To Date	Trend	Next Month	3 Months
2		e	Emergency Care 4-hour waits (%)	=>95.0	=>95.0																			Sep-14	93.3	88.8	98.6	91.76	93.87			
2			Emergency Care 4-hour breach (numbers)															741	1210	1277	1122	876	1460	Sep-14	487	944	29	1460	6686			
2		e	Emergency Care Trolley Waits >12 hours	0	0	1																		Sep-14	0	0	0	0	0			
3			Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins																			Sep-14	15	16	15	16	17			
3			Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins																			Sep-14	55	75	24	58	51			
3			Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0																			Sep-14	7.38	7.29	4.15	6.91	6.76			
3			Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0																			Sep-14	3.42	6.36	2.25	4.66	4.1			
11			WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	0	0													119	136	125	145	51	136	Sep-14	33	103		136	712			
11			WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	0	0													13	8	8	8	1	13	Sep-14	1	12		13	51			
11		•	WMAS - Handover Delays > 60 mins (% all emergency conveyances)	=<0.02	=<0.02																			Sep-14	0.06	0.51		0.32	0.18			
11			WMAS - Emergency Conveyances (total)			3590	5071	3672	4031	3762	3658	3991	3927	4122	4009	3826	4271	4044	4227	4093	4278	3994	4067	Sep-14	1735	2332		4067	24703			
2			Delayed Transfers of Care (Acute) (%)	=<3.5	=<3.5																			Sep-14	2.5	4.8		3.4	3.7			
2			Delayed Transfers of Care (Acute) (Av./Week)	<10 per site	<10 per site																			Sep-14	6.5	7		13.5				
2			Patient Bed Moves (10pm - 8am) (No.) -ALL															668	751	722	753	697	680	Sep-14				680	4271			
2			Patient Bed Moves (10pm - 8am) (No.) - exc. Assessment Units															312	331	330	329	337	270	Sep-14				270	1911			
3			Hip Fractures - Operation < 24 hours of admission (%)	=>85.0	=>85.0																			Sep-14				90.0	66.0			

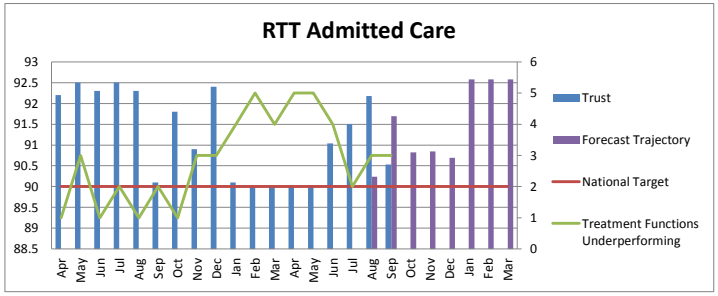


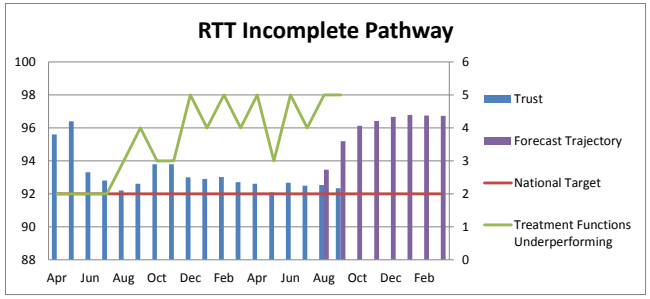


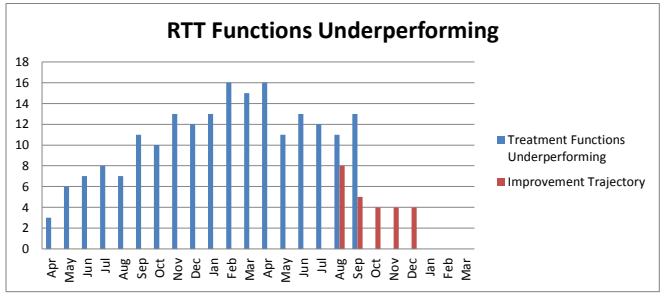


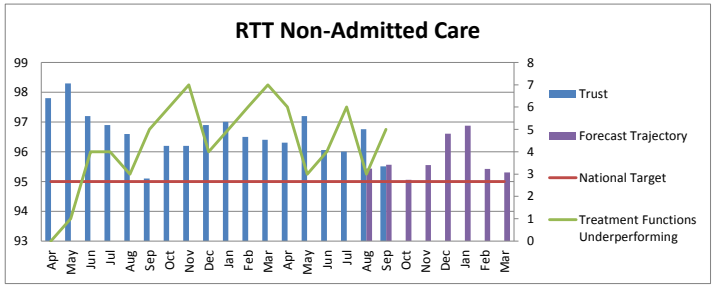
Referral To Treatment

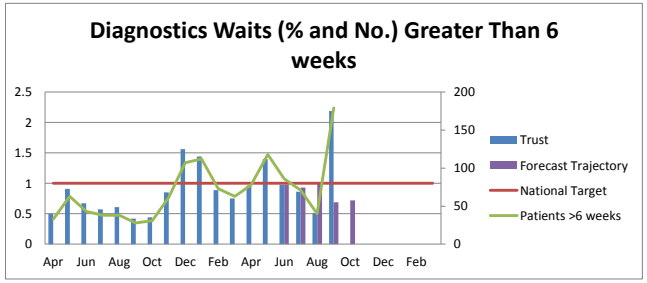
Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
2			RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0																			Sep-14	94.8	81.6	89.2	97.1					90.53				
2			RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0																			Sep-14	90.2	96.8	96.7	98.8					95.51				
2			RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0																			Sep-14	91.9	89.7	93.9	99.6					92.33				
2			Patients Waiting >52 weeks	0	0	8	28	50	57	29	20	66	36	12	3	1	1	1	2	2	3	4	4	Sep-14	0	2	2	0					4				
2			Treatment Functions Underperforming	0	0	3	6	7	8	7	11	10	13	12	13	16	15	16	11	13	12	11	13	Sep-14	5	4	4	0					13				
2			Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0																			Sep-14	10.1	1.6	0.5	0.0		0.5			2.19				

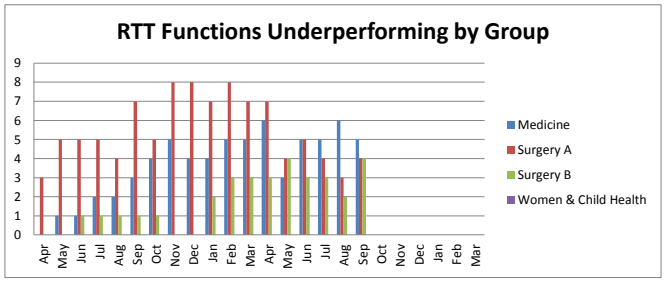










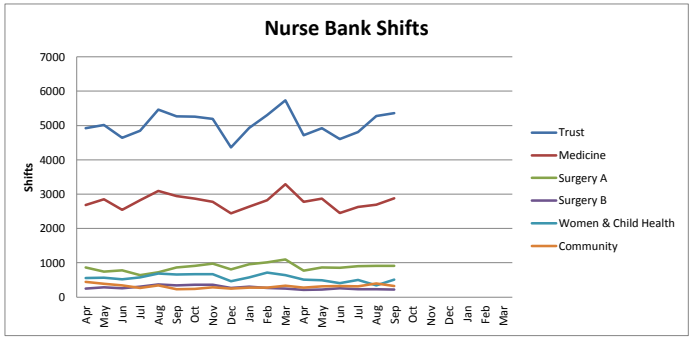


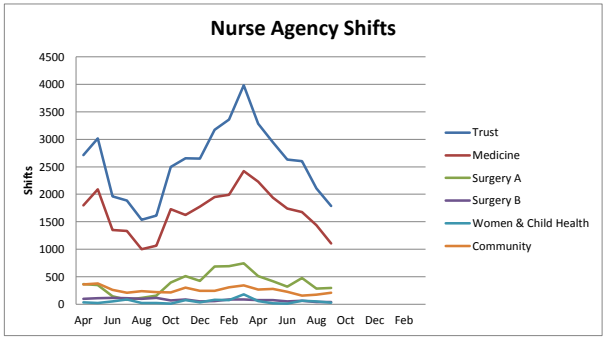
Data Completeness

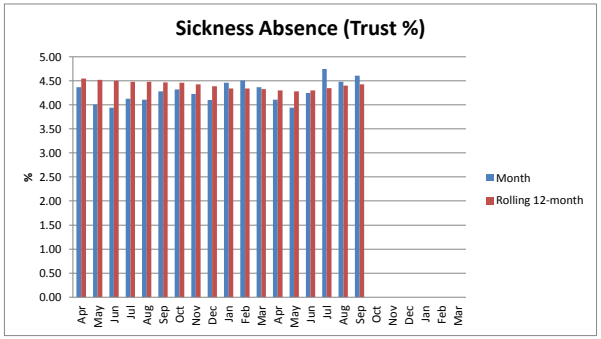
Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Data Completeness Community Services	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14								>50	>50		●		
2		●	Percentage SUS Records for AE with valid entries in mandatory fields - provided by HSCIC	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Jul-14									99.32		●		
2		●	Percentage SUS Records for IP care with valid entries in mandatory fields - provided by HSCIC	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Jul-14									99.43		●		
2		●	Percentage SUS Records for OP care with valid entries in mandatory fields - provided by HSCIC	=>99.0	=>99.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●			Jul-14									99.32		●		
2			Completion of Valid NHS Number Field in acute (inpatient) data set submissions to SUS	=>99.0	=>99.0	99.3	99.3	99.2	99.2	99.1	99.1	99.1	98.9	99.2	98.9	98.9	98.7	98.7	97.0	95.6	95.4	95.2	95.7	Sep-14									95.7	96.3	●		
2			Completion of Valid NHS Number Field in acute (outpatient) data set submissions to SUS	=>99.0	=>99.0	99.7	99.8	99.7	99.7	99.7	99.7	99.7	99.7	99.7	99.7	99.6	99.5	99.5	99.5	99.5	99.5	99.4	99.4	Sep-14									99.4	99.5	●		
2			Completion of Valid NHS Number Field in A&E data set submissions to SUS	=>95.0	=>95.0	97.8	97.3	97.4	97.2	97.4	97.3	97.5	97.2	97.1	97.6	96.8	95.9	96.3	95.8	96.3	96.1	96.1	96.2	Sep-14									96.2	96.2	●		
2			Ethnicity Coding - percentage of inpatients with recorded response	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14									92.37	92.38	●		
2		●b●	Data Quality of Trust Returns to the HSCIC (provided by TDA)	=>96.0	=>96.0										94.9	94.9	95.0	95.0	95.0	95.0	95.0			Jul-14									95.0		●		
2			Maternity - Percentage of invalid fields completed in SUS submission	=<15.0	=<15.0	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14									39.65	32.88	●		

Staff

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (since April 2013) A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
7		b	WTE - Actual versus Plan (FTE)			312	456	465	458	511	610	643	626	572	541	567	567	531	558	580	584	626	608	Sep-14	160	71	28	61	27	14	65	183	608				
3		b	PDRs - 12 month rolling	=>95.0	=>95.0																			Sep-14	80	81	89	89	88	76	90	75		80.85			
7		b	Medical Appraisal and Revalidation	=>95.0	=>95.0																			Sep-14	87	76	87	81	95	97		100		84.6			
3		b	Sickness Absence	=<3.15	=<3.15																			Sep-14	5.0	4.9	4.0	5.1	3.8	4.7	4.9	4.0	4.61	4.43			
3			Mandatory Training	=>95.0	=>95.0																			Sep-14	79	84	84	83	92	89	91	90		85.1			
3			Mandatory Training - Health & Safety (% staff)	=>95.0	=>95.0																			Sep-14	91	93	92	94	98	98	99	98		95.0			
7		b	Staff Turnover (rolling 12 months) (%)	=<10.0	=<10.0																			Sep-14									11.88	11.99			
7			New Investigations in Month			4	5	8	9	1	4	3	1	4	2	4	5	1	4	6	5	2	15	Sep-14	2	2	0	0	0	6	0	5	15				
7			Vacancy Time to Fill (weeks)			15	19	18	18	18	18	18	17	18	20	18	19	19	20	19	18	19	19	Sep-14									19				
7			Professional Registration Lapses	0	0	3	0	0	1	0	4	7	0	0	0	0	0	0	0	0	0	0	0	Sep-14	0	0	0	0	0	0	0	0	0	0			
7			Qualified Nursing Variance (FIMS) (FTE)			26	108	138	143	181	236	177	199	210	163	162	162	161	169	173	177	201	200	Sep-14									200	200			
10			Nurse Bank Fill Rate			72	77	75	77	78	76	75	76	71	73	75	76	76	82	82	80	77	78	Sep-14									77.6	78.7			
10			Nurse Bank Use (shifts)	46980	3915																			Sep-14	2875	908	224	512	7	5	323	161	5017	29507			
10			Nurse Agency Use (shifts)	0	0																			Sep-14	1106	297	39	26	0	98	211	14	1786	15446			
10			Admin & Clerical Bank Use (shifts)	0	0																			Sep-14	635	273	196	70	574	118	325	3185	5376	30377			
10			Admin & Clerical Agency Use (shifts)	0	0																			Sep-14	27	0	44	9	0	0	0	39	119	660			
15			Your Voice - Response Rate															19.8		18.2				Aug-14	9	11	17	12	31	33	32	24					
15			Your Voice - Overall Score															3.63		3.68				Aug-14	3.8	3.6	3.5	3.7	3.7	3.7	3.9	3.6					





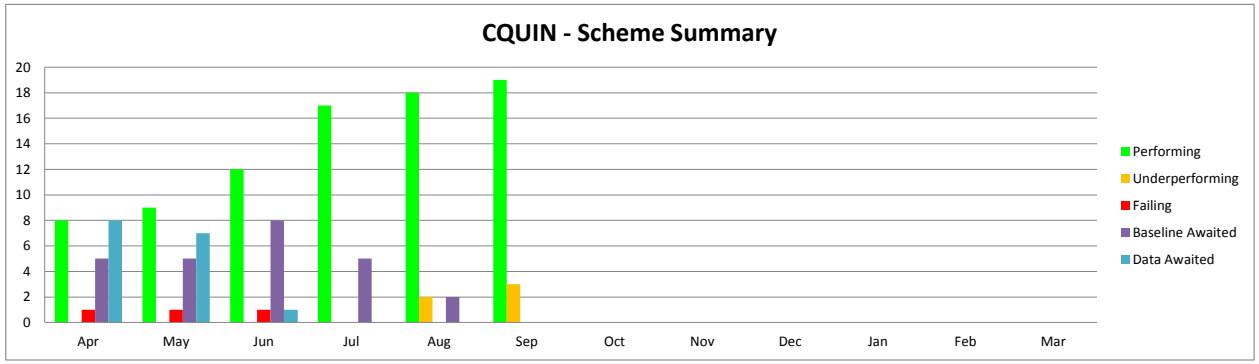


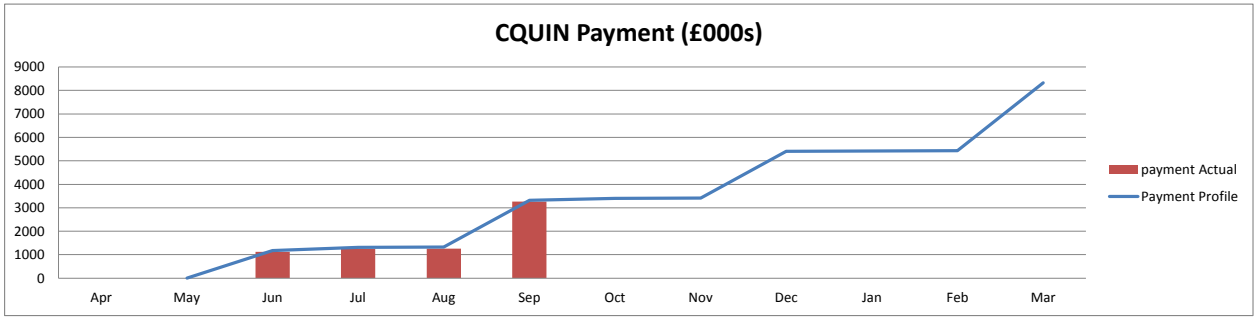
CQUIN (I)

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
8			FFT - Implementation of Staff FFT	Implement by end July		●	●	●	●	●	●							Sep-14									On Track	On Track	●	●	●
8			FFT - Early Implementation of Patient FFT in OP / DC Departments	Implement by end Oct		●	●	●	●	●	●							Sep-14									may be a delay	may be a delay	●	●	●
8			FFT - Increase and / or Maintain Response Rate in ED areas	>Q1 rate		15	16	16	16	17	17							Sep-14									On Track	On Track	●	●	●
8			FFT - Increase and / or Maintain Response Rate in IP areas	>Q1 rate		36	44	45	41	32	31							Sep-14									On Track	On Track	●	●	●
8			FFT - IP Response Rate (March 2015 target 40%) - replaces Reduce Negative Responses	40		●	●	●	●	32	31							Sep-14									Not On Track	Not On Track	●	●	●
8			NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers (community avoidable)	10% reduction		●	●	●	●	●	●							Jun-14									On Track	On Track	●	●	●
8			Dementia - Find, Assess and Refer	=>90	=>90	●	●	●	●	●	●							Sep-14									3 of 3 met	3 of 3 met	●	●	●
8			Dementia - Clinical Leadership and Staff Training			●	●	●	●	●	●							Sep-14									On Track	On Track	●	●	●
8			Dementia - Supporting Carers of People with Dementia	Monthly Audit	Monthly Audit	●	●	●	●	●	●							Sep-14									On Track	On Track	●	●	●
9			Learning From Safeguarding Concerns	Quarterly report to Board			●			●								Sep-14									On Track	On Track	●	●	●
2			Quality of Outpatient and Discharge Letters	Trust/CCG to agree assess. criteria			●		●	●	●							Sep-14									On Track	On Track	●	●	●
4			Sepsis - Use of Sepsis Care Bundles	Informed by base data			●		●	●	●							Sep-14									On Track	On Track	●	●	●
8			Pain Relief - Use of Pain Care Bundles	Informed by base data			●		●	●	●							Sep-14									On Track	On Track	●	●	●
9			Medication and Falls	Informed by base data			●		●	●	●							Sep-14									actions in place	actions in place	●	●	●
9			Serious Untoward Incidents (Never Events)	Informed by base data			●			●								Sep-14									On Track	On Track	●	●	●
14			Community Therapies - Effective Referral Management	Informed by base data			●			●								Sep-14									On Track	On Track	●	●	●

CQUIN (II) and summary

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend A	M	J	J	A	S	O	N	D	J	F	M	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
14			Community Therapies - Community Dietetics	Informed by base data				●		●	●							Sep-14									On Track	On Track	●	●	●
12			Maternity - Low Risk Births	Quarterly audit / action plan			●		●									Sep-14									On Track	On Track	●	●	●
16			Bechet's Disease	Submit Quarterly return			Met (Q1)		Met (Q2)									Sep-14									On Track	Met (Q2)	●	●	●
17			HIV Home Delivery Medicines (% patients receiving)	70			Met (Q1)		Met (Q2)									Sep-14									On Track	Met (Q2)	●	●	●
17			Retinopathy of Prematurity Screening (%)	95			Met (Q1)		Met (Q2)									Sep-14									On Track	Met (Q1)	●	●	●
17			Timely Administration of TPN for preterm infants	95			Met (Q1)		Met (Q2)									Sep-14									On Track	Met (Q1)	●	●	●





The Trust is contracted to deliver a total of 22 CQUIN schemes during 2014 / 2015. 9 schemes are nationally mandated, a further 9 have been agreed locally, with the remaining 4 identified by the West Midlands Specialised Commissioners. The collective financial value of the schemes is c.£8.3m.

In summary, no schemes are currently classified as failing, 19 are performing and 3 are classified as underperforming.

Underperforming schemes are the Early Implementation of Patient FFT in OP / DC areas, where there may be a delay in its implementation. The national FFT scheme to reduce Negative Responses has been replaced by the requirement to deliver an inpatient FFT response rate of 40% during March 2015, which was already being achieved until recently, this has however fallen back during the most recent two months. Actions have been identified to achieve compliance with the Medication and Falls CQUIN.

To date two confirm and challenge meetings have been held with scheme leads. A further meeting to ascertain progress is scheduled for 29 October 2014.

External Assessment Frameworks

TRUST DEVELOPMENT AUTHORITY (TDA) ACCOUNTABILITY FRAMEWORK - SUMMARY

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
QUALITY SCORE		5	3	3	3	3	2						
Domain													
Responsiveness	Initial Score	5	4	4	4	4	5						
	Override Rules Applied	No	Yes	Yes	Yes	Yes	Yes						
	Revised Score	5	3	3	3	3	2						
	Indicators Not Achieving TDA Standard	RTT >52weeks 28 day canc. Ops	RTT >52weeks 28 day canc. Ops Diagnostic Waits ED 4-hours	RTT >52weeks ED 4-hours DTOC	RTT >52weeks ED 4-hours DTOC	RTT >52weeks ED 4-hours DTOC	28-day canc. Op. ED 4-hours						
Effectiveness	Initial Score	5	5	5	5	5	5						
	Override Rules Applied	No	No	No	No	No	No						
	Revised Score	5	5	5	5	5	5						
	Indicators Not Achieving TDA Standard												
Safe	Initial Score	4	5	5	5	5	4						
	Override Rules Applied	No	No	No	No	No	No						
	Revised Score	4	5	5	5	5	4						
	Indicators Not Achieving TDA Standard	Pt. Safety Incidents Open CAS Alerts Harm Free Care	Open CAS Alerts	Open CAS Alerts Harm Free Care	Open CAS Alerts	Harm Free Care	Harm Free Care MRSA Bact.						
Caring	Initial Score	5	5	5	5	5	5						
	Override Rules Applied	No	No	No	No	No	No						
	Revised Score	5	5	5	5	5	5						
	Indicators Not Achieving TDA Standard	MSA Breaches	MSA Breaches	MSA Breaches	MSA Breaches								
Well Led	Initial Score	3	3	3	3	3	3						
	Override Rules Applied	No	No	No	No	No	No						
	Revised Score	3	3	3	3	3	3						
	Indicators Not Achieving TDA Standard	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs	ED FFT Resp. Rate DQ Returns to HSCIC Temp. Staff Costs						
FINANCE SCORE		AMBER	AMBER	AMBER	AMBER	AMBER	AMBER						

Override Rules

Metric	Override Rule	Domain	Domain Score Affected	Max Domain Score Achievable	Quality Score Affected	Max Quality Score Achievable
RTT - Admitted	Below 90%	Responsiveness	Yes	3	Yes	3
Accident & Emergency	Between 92% and 95%	Responsiveness	Yes	3	Yes	3
Accident & Emergency	Below 92%	Responsiveness	Yes	2	Yes	2
Cancer 62-day Standard	Below 85%	Responsiveness	Yes	3	Yes	3
HSMR or SHMI	High Outlier for 1 Quarter	Effectiveness	Yes	3	No	n/a
HSMR or SHMI	High Outlier for 1 Quarter	Effectiveness	Yes	2	No	n/a
HSMR or SHMI	High Outlier for 2 Quarters or more	Effectiveness	Yes	2	Yes	3
HSMR or SHMI	High Outlier for 1 Year or more	Effectiveness	Yes	2	Yes	2
HSMR and / or SHMI	High Outlier for 2 Years	Effectiveness	Yes	1	Yes	1

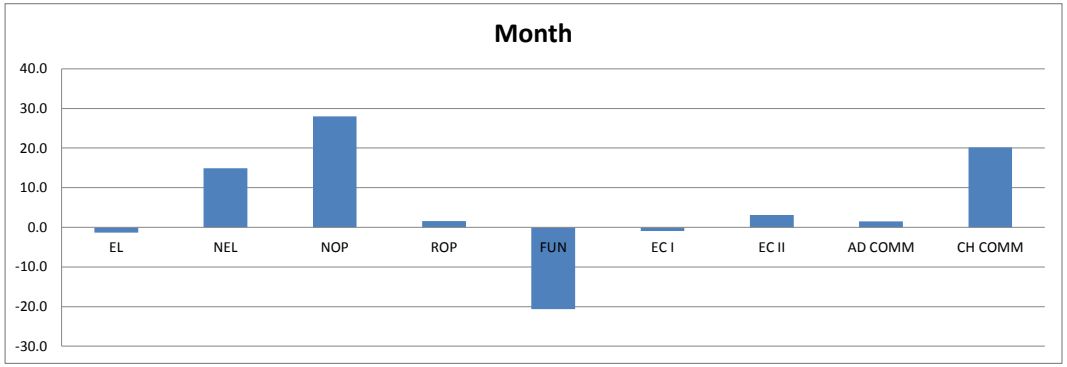
MONITOR RISK ASSESSMENT FRAMEWORK - SUMMARY

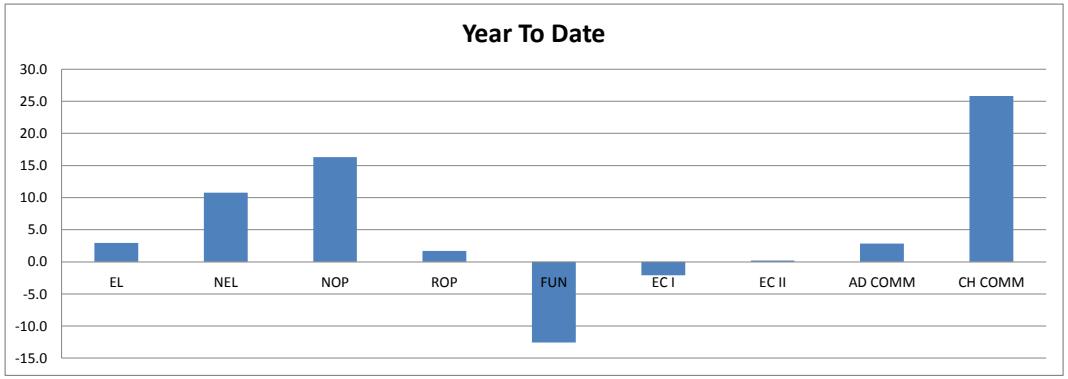
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Indicators Achieving Monitor Standard	15	14	14	14	14	14						
Indicators Not Achieving Monitor Standard	0	1	1	1	1	1						
		ED 4-hours	ED 4-hours	ED 4-hours	ED 4-hours	ED 4-hours						
GOVERNANCE RATING	0.0	1.0	1.0	1.0	1.0	1.0						

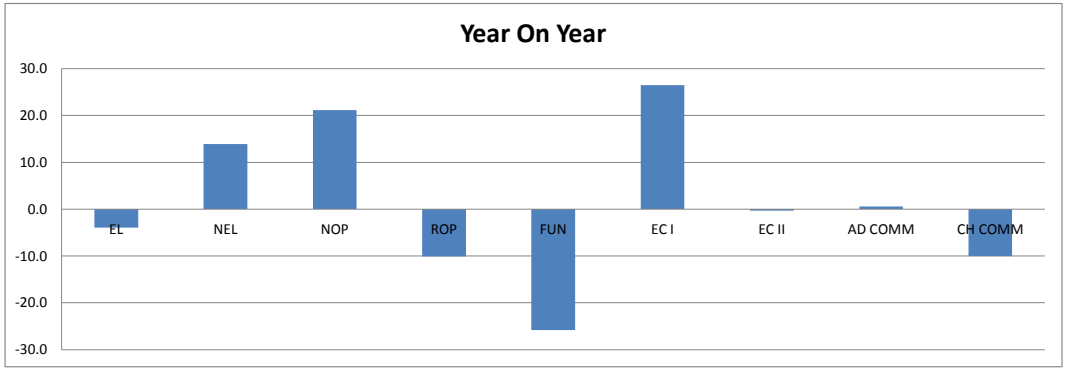
PLEASE NOTE:

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

Activity Summary







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

High level Elective activity is slightly off plan for the month by 1.4%, but remains ahead of plan for the year to date by 2.9%. Non-Elective activity during the month is 14.9% greater than plan, is 10.7% higher than plan for the year to date, and 13.9% higher than the corresponding period last year. New outpatient attendance numbers are ahead of plan by 16.3% for the year to date. With OP Review attendances 1.7% above plan for the year to date, the Follow-Up to New OP Ratio for the period to date is 2.21, compared with a plan derived from contracted activity of 2.53. Type I Emergency Care activity for the month is 0.9% down on plan, and is 2.1% less than plan for the year to date. although remains in excess of activity delivered for the corresponding period last year, due to the inclusion within plan of GP Triage Activity. Type II activity is ahead of plan for the month by 3.1%, and essentially on plan for the year to date. Adult Community and Child Community activity exceeds plans for the year to date by 2.9% and 25.8% respectively, although the latter is 10.0% less than the corresponding period last year, due to the transfer of School Health Nursing to another provider.

Finance Summary

Data Source	Data Quality	PAF	Indicator	Trajectory Year	Trajectory Month	Previous Months Trend (data from July 13) J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	Data Period	Group M	A	B	W	P	I	C	CO	Month	Year To Date	Trend	Next Month	3 Months
18		f	Bottom Line Income & Expenditure position - Forecast compared to plan £m	£0.0		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14									£0.0		●	●	●
18		f	Bottom Line Income & Expenditure position - Year to Date Actual compared to plan £m	£0.0	£0.0									●	●	●	●	●	●	●	Sep-14	-2.2	-1.0	-1.1	-0.6	0.2	-0.8	0.2	-0.2		-£1.4	●	●	●
18		f	Actual efficiency recurring / non-recurring compared to plan - Year to Date actual compared to plan	£0.0	£0.0									●	●	●	●	●	●	●	Sep-14	-0.6	-0.4	-0.3	-0.3	-0.3	-0.4	-0.3	-0.2		-£2.7	●	●	●
18		f	Actual efficiency recurring / non-recurring compared to plan - Forecast compared to plan	£0.0										●	●	●	●	●	●	●	Sep-14	-1.1	-0.9	-1.2	-1.1	-0.9	-0.6	-0.4	-0.8		-£7.0	●	●	●
18		f	Forecast underlying surplus / deficit compared to plan	£0.0										●	●	●	●	●	●	●	Sep-14										-£0.1	●	●	●
18		f	Forecast year end charge to capital resource limit	£21.3										●	●	●	●	●	●	●	Sep-14									£22.6m		●	●	●
18		f	Is the Trust forecasting permanent PDC for liquidity purposes?	No		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14									No		●	●	●
18		b	Temporary costs and overtime as % total paybill	2.6%	2.6%	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	#####	4.0%	1.9%	1.5%	0.0%	2.0%	2.0%	1.1%	3.6%	4.2%	●	●	●
18			Continuity of Service Risk Rating - Year to Date	2.5										●	●	●	●	●	●	●	Sep-14										3.0	●	●	●

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

Data Source	Data Quality	OS / NQR	Indicator	Threshold	QUARTER 1 (£000s)									JULY (£000s)									AUGUST (£000s)									SEPTEMBER (£000s)									YEAR TO DATE (£000s)								
					M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		OS	RTT Admitted Care (£400 per breach by specialty)	=>90.0%	0.0	94.8	10.4	0.0					105.2	0.0	23.2	2.4	0.0						25.6	1.6	18.0	2.0	0.0					21.6	0.0	31.2	4.8	0.0					36.0	1.6	167.2	19.6	0.0					188.4
2		OS	RTT Non-Admitted Care (£100 per breach by specialty)	=>95.0%	12.9	6.4	0.0	0.0					19.3	5.5	1.4	0.8	0.0						7.7	4.4	0.0	0.0	0.0					4.4	9.9	0.6	0.1	0.0					10.6	32.7	8.4	0.9	0.0					42.0
2		OS	RTT Incomplete Pathway (£100 per breach by specialty)	=>92.0%	38.5	76.4	22.0	0.0					136.9	17.4	23.7	9.7	0.0						50.8	18.7	23.5	9.3	0.0					51.5	16.9	27.9	6.5	0.0					51.3	91.5	151.5	47.5	0.0					290.5
2		OS	Diagnostic Waits (£200 per breach)	=>99.0%	0.0	5.4	0.0	0.0		1.4			6.8	0.0	0.0	0.0	0.0		0.0				0.0	0.0	0.0	0.0	0.0		0.0			0.0	16.8	2.6	0.0	0.0		0.0			19.4	16.8	8.0	0.0	0.0		1.4			26.2
2		OS	ED Waits >4 hours (£200 per breach between 92.0% and 95.0%)	=>95.0%	123.2		0.0						123.2	33.8		0.0						33.8	5.8		0.0						5.8	106.2		0.0						106.2	269.0	0.0	0.0						269.0
1		OS	Cancer Waits (2 weeks, 31 days and 62 days - £200, £1000 and £1000 per breach respectively)	Various	0.0	0.0	0.0	0.0					0.0	Assessed Quarterly										Assessed Quarterly																	0.0	0.0	0.0	0.0	0.0					0.0
13		OS	Mixed Sex Accommodation Breaches (£250 per day per Service Uder affected)	0	32.8	0.0	0.0	0.0					32.8	0.0	1.3	0.0	0.0						1.3	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	32.8	1.3	0.0	0.0					34.1
2		OS	Cancelled Operations 28-day (non-payment of rescheduled episode of care)	0	1.8	1.3	0.0	0.0					3.1	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0	0.0	1.3	0.0	0.0					1.3	1.8	2.6	0.0	0.0					4.4
4		NQR	MRSA Bacteraemia (£10,000 per incidence)	0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0			0.0	0.0	0.0	0.0	0.0			0.0		0.0	10.0	0.0	0.0	0.0			0.0		10.0	10.0	0.0	0.0	0.0			0.0		10.0
4		NQR	C Diff (differential impact if annual target exceeded)	37	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0			0.0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0	0.0	0.0	0.0	0.0			0.0		0.0
2		NQR	RTT Waits >52 weeks Incomplete Pathway (£5,000 per breach)	0	0.0	5.0	5.0	5.0					15.0	0.0	10.0	0.0	0.0						10.0	0.0	10.0	0.0	0.0					10.0	0.0	0.0	0.0	0.0					0.0	0.0	25.0	5.0	5.0					35.0
11		NQR	WMAS Handovers to ED (£200 per breach 30 - 60 minutes)	0	76.0								76.0	29.0									29.0	10.2								10.2	27.2								27.2	142.4								142.4
11		NQR	WMAS Handovers to ED (£1000 per breach >60 minutes)	0	29.0								29.0	8.0									8.0	1.0								1.0	13.0								13.0	51.0								51.0
2		NQR	ED Trolley Waits >12 hours (£1,000 per breach)	0	0.0								0.0	0.0									0.0	0.0								0.0	0.0								0.0	0.0								0.0
2		NQR	Cancelled Operations - no urgent operation cancelled for second time (£5,000 per breach)	0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
3		NQR	VTE Risk Assessment (£200 per breach)	=>95.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
13		NQR	Publication Of Formulary (withholding of 1% of actual monthly contract value for non publication)	0								0.0	0.0								0.0	0.0								0.0	0.0								0.0	0.0	0.0							0.0	0.0
9		NQR	Duty Of Candour (Non-payment for cost of care or £10,000 if cost of care unknown / indeterminate)	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
2		NQR	Completion of valid NHS Number in Acute Commissioning Data Set (£10 per breach)	=>99.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0						0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2		NQR	Completion of valid NHS Number in A&E Commissioning Data Set (£10 per breach)	=>95.0%	0.0		0.0						0.0	0.0		0.0							0.0	0.0		0.0						0.0	0.0		0.0						0.0	0.0		0.0						0.0
			ALL		314.2	189.3	37.4	5.0	0.0	1.4	0.0	0.0	547.3	93.7	59.6	12.9	0.0	0.0	0.0	0.0	0.0	166.2	41.7	51.5	11.3	0.0	0.0	0.0	0.0	0.0	104.5	200.0	63.6	11.4	0.0	0.0	0.0	0.0	0.0	275.0	649.6	364.0	73.0	5.0	0.0	1.4	0.0	0.0	1093.0

Contractual Requirements - Local Quality Requirements

Data Source	Data Quality	Req	Indicator	Threshold	QUARTER 1 (£000s)									JULY (£000s)									AUGUST (£000s)									SEPTEMBER (£000s)									YEAR TO DATE (£000s)								
					M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
3		LQR	Maternity - various (8)	Various									0.0									0.0									0.0									0.0									0.0
3		LQR	Stroke - thrombolysis (non payment for any >30 hours if 3 consecutive months of failure)	=>50.0%	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0
3		LQR	Stroke - >90% stay on ASU (non payment for breach if 3 consecutive months of failure)	=>90.0%	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0	0.0								0.0
3		LQR	Stroke - CT Scan <1 hr presentation (non payment for any >2 hours if 3 consec. months failure)	=>50.0%	0.0					0.0			0.0	0.0					0.0			0.0	0.0								0.0	0.0								0.0	0.0					0.0			0.0
3		LQR	Stroke - CT Scan <24 hr presentation (non pay't for any >30 hours if 3 consec. months failure)	100%	0.0					0.0			0.0	0.0					0.0			0.0	0.0								0.0	0.0								0.0	0.0					0.0			0.0
3		LQR	ED - Time to Initial Assessment <15 mins (£50 per breach between 92.0% and 95.0%)	=>95.0%	44.0		0.0						44.0	14.4		0.0						14.4	7.6		0.0						7.6	12.9		0.0						12.9	78.9		0.0						78.9
3		LQR	ED - Unplanned Reattendance within 30 days (£50 per breach between 5.00% and 8.00%)	=<5.00%	29.5		0.0						29.5	18.9		0.0						18.9	16.5		0.0						16.5	14.5								14.5	79.4		0.0						79.4
3		LQR	ED - Left Without Being Seen (lower £23 pay't per pt., & £15 per breach between 5.00% and 8.00%)	=<5.00%	0.0		0.0						0.0	0.0		0.0						0.0	0.0		0.0						0.0	0.0		0.0						0.0	0.0		0.0						0.0
2		LQR	DTOC - Less than 10 (provider responsible) per site (non pay't XS bed days)	<10 per site	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2		LQR	Letters for Evictions from Wards (non pay't XS bed days)	100%									0.0									0.0									0.0									0.0	0.0	0.0	0.0	0.0					0.0
2		LQR	Morning Discharges (< m'day) (no conseq. breach, traj. Q1(23%),Q2(27%),Q3(31%),Q4(35%))	Q1 (23%) - Q4 (35%)	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
2		LQR	DTA (delay in unplanned admiss. to clinically appro. bed) (8 hr(£250),10hr(£500),12hr(£1000)	0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
19		LQR	Pt's with small-cell lung cancer have t'ment initiated =<2w path. diagnosis (non pay't for breach)	=>80.0%	6.3								6.3	2.1								2.1	0.0								0.0									0.0	8.4								8.4
2		LQR	Paeds. have OP F/U app't <6 w discharge post meningoccal septicaemia (non pay't OP app't >6w)	100%				0.1					0.1				0.1					0.1				0.0					0.0				0.0					0.0				0.2					0.2
19		LQR	Pts. Admit. with MI presc. antiplatelet,statin or b. blocker(non pay for breach if 3 consec. m'ths fail.)	=>98.0%	0.0								0.0	0.0								0.0	0.0								0.0									0.0	0.0								0.0
8		LQR	EOL Care (pt's (on SCP) achieving pref. place of death) (Consec. Fail triggers contract clause)	=>75.0%	0.0	0.0		0.0					0.0	0.0	0.0		0.0					0.0									0.0									0.0	0.0	0.0		0.0					0.0
3		LQR	WHO Safer Surgery Checklist Compliance (3 components) (Consec. Breaches £1000 / month)	98%, 95% and 85%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
3		LQR	MRSA Screening (EL and NEL) (£1000 per month after 4 months consecutive breaches)	=>80.0% matched	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
4		LQR	Appro. Antimicrobial Stewardship (Q'ly Reporting (cc. CCG) (£1000 / Q'ter after 2 Q'ters breaches)	Submit Report					0.0				0.0	Assessed Quarterly									Assessed Quarterly													0.0					0.0					0.0					0.0
19		LQR	HbA1c (pt's achieved target <6 m after being set) (non pay't for breach after 3 m'ths fail)	=>75.0%	Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly									0.0									Assessed 6-monthly								
19		LQR	HbA1c (pt's receiving written care plan with agreed targets) (£50 per breach)	=>90.0%	Assessed 6-monthly									Assessed 6-monthly									Assessed 6-monthly									0.0									Assessed 6-monthly								
2		LQR	Ethnicity Coding (£1000 per month after 2 months failure)	=>90.0%	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0	0.0	0.0	0.0	0.0					0.0
			ALL		79.8	0.0	0.0	0.1	0.0	0.0	0.0	0.0	79.9	35.4	0.0	0.0	0.1	0.0	0.0	0.0	0.0	35.5	24.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	24.1	27.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	27.4	166.7	0.0	0.0	0.2	0.0	0.0	0.0	0.0	166.9

Contractual Requirements - CQUIN (CQ)

Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	QUARTER 1 (£000s) M	A	B	W	P	I	C	CO	ALL
8		CQ	FFT - Implementation of Staff FFT	125	Implement by end July	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8		CQ	FFT - Early Implementation of Patient FFT in OP / DC Departments	67	Implement by end Oct	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
8		CQ	FFT - Increase and / or Maintain Response Rate in ED areas	33.5	>Q1 rate	0.0								0.0
8		CQ	FFT - Increase and / or Maintain Response Rate in IP areas	33.5	>Q1 rate	0.0	0.0	0.0	0.0			0.0		0.0
8		CQ	FFT - IP Response Rate (March 2015 target 40%) - replaces Reduce Negative Responses	167	0	0.0	0.0	0.0	0.0			0.0		0.0
8		CQ	NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	42	50% reduction	0.0	0.0	0.0	0.0			0.0		0.0
8		CQ	Dementia - Find, Assess and Refer	250	=>90.0%	47.3	15.8	0.0	0.0					63.0
8		CQ	Dementia - Clinical Leadership and Staff Training	42	In Place	0.0	0.0	0.0	0.0				0.0	0.0
8		CQ	Dementia - Supporting Carers of People with Dementia	133	Monthly Audit								0.0	0.0
9		CQ	Learning From Safeguarding Concerns	1332	Q'ly Report to Board								0.0	0.0
2		CQ	Quality of Outpatient and Discharge Letters	489	Derived from base	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
4		CQ	Sepsis - Use of Sepsis Care Bundles	1237	Derived from base	0.0	0.0	0.0	0.0					0.0
8		CQ	Pain Relief - Use of Pain Care Bundles	77	Derived from base	0.0	0.0	0.0	0.0					0.0
9		CQ	Medication and Falls	1237	Derived from base	0.0	0.0	0.0	0.0			0.0		0.0
9		CQ	Serious Untoward Incidents (Never Events)	1237	Derived from base								0.0	0.0
14		CQ	Community Therapies - Effective Referral Management	83	Derived from base							0.0		0.0
14		CQ	Community Therapies - Community Dietetics	1237	Derived from base							0.0		0.0
12		CQ	Maternity - Low Risk Births	70	Q'ly Audit / Action Plan				0.0					0.0
16		CQ	Bechet's Disease	109	Quarterly Return			0.0						0.0
17		CQ	HIV Home Delivery Medicines (% patients receiving)	109	Derived from base				0.0					0.0
17		CQ	Retinopathy of Prematurity Screening (%)	109	Derived from base				0.0					0.0
17		CQ	Timely Administration of TPN for preterm infants	109	Derived from base				0.0					0.0
			ALL	8328		47.3	15.8	0.0	0.0	0.0	0.0	0.0	0.0	63.0

Indicator	JULY (£000s) M	A	B	W	P	I	C	CO	ALL
FFT - Implementation of Staff FFT	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
FFT - Early Implementation of Patient FFT in OP / DC Departments	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
FFT - Increase and / or Maintain Response Rate in ED areas	0.0								0.0
FFT - Increase and / or Maintain Response Rate in IP areas	0.0	0.0	0.0	0.0			0.0		0.0
FFT - IP Response Rate (March 2015 target 40%) - replaces Reduce Negative Responses	0.0	0.0	0.0	0.0			0.0		0.0
NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	0.0	0.0	0.0	0.0			0.0		0.0
Dementia - Find, Assess and Refer	0.0	0.0	0.0	0.0					0.0
Dementia - Clinical Leadership and Staff Training	0.0	0.0	0.0	0.0				0.0	0.0
Dementia - Supporting Carers of People with Dementia								0.0	0.0
Learning From Safeguarding Concerns	Assessed Quarterly								
Quality of Outpatient and Discharge Letters	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
Sepsis - Use of Sepsis Care Bundles	0.0	0.0	0.0	0.0					0.0
Pain Relief - Use of Pain Care Bundles	0.0	0.0	0.0	0.0					0.0
Medication and Falls	0.0	0.0	0.0	0.0			0.0		0.0
Serious Untoward Incidents (Never Events)	Assessed Quarterly								
Community Therapies - Effective Referral Management							0.0		0.0
Community Therapies - Community Dietetics							0.0		0.0
Maternity - Low Risk Births									0.0
Bechet's Disease	Assessed Quarterly								
HIV Home Delivery Medicines (% patients receiving)	Assessed Quarterly								
Retinopathy of Prematurity Screening (%)	Assessed Quarterly								
Timely Administration of TPN for preterm infants	Assessed Quarterly								
ALL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Indicator	AUGUST (£000s) M	A	B	W	P	I	C	CO	ALL
FFT - Implementation of Staff FFT	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
FFT - Early Implementation of Patient FFT in OP / DC Departments	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
FFT - Increase and / or Maintain Response Rate in ED areas	0.0								0.0
FFT - Increase and / or Maintain Response Rate in IP areas	0.0	0.0	0.0	0.0			0.0		0.0
FFT - IP Response Rate (March 2015 target 40%) - replaces Reduce Negative Responses	0.0	0.0	0.0	0.0			0.0		0.0
NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	0.0	0.0	0.0	0.0			0.0		0.0
Dementia - Find, Assess and Refer	0.0	0.0	0.0	0.0					0.0
Dementia - Clinical Leadership and Staff Training	0.0	0.0	0.0	0.0				0.0	0.0
Dementia - Supporting Carers of People with Dementia								0.0	0.0
Learning From Safeguarding Concerns	Assessed Quarterly								
Quality of Outpatient and Discharge Letters	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
Sepsis - Use of Sepsis Care Bundles	0.0	0.0	0.0	0.0					0.0
Pain Relief - Use of Pain Care Bundles	0.0	0.0	0.0	0.0					0.0
Medication and Falls	0.0	0.0	0.0	0.0			0.0		0.0
Serious Untoward Incidents (Never Events)	Assessed Quarterly								
Community Therapies - Effective Referral Management									0.0
Community Therapies - Community Dietetics									0.0
Maternity - Low Risk Births									0.0
Bechet's Disease	Assessed Quarterly								
HIV Home Delivery Medicines (% patients receiving)	Assessed Quarterly								
Retinopathy of Prematurity Screening (%)	Assessed Quarterly								
Timely Administration of TPN for preterm infants	Assessed Quarterly								
ALL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Indicator	SEPTEMBER (£000s) M	A	B	W	P	I	C	CO	ALL
FFT - Implementation of Staff FFT	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
FFT - Early Implementation of Patient FFT in OP / DC Departments	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
FFT - Increase and / or Maintain Response Rate in ED areas	0.0								0.0
FFT - Increase and / or Maintain Response Rate in IP areas	0.0	0.0	0.0	0.0			0.0		0.0
FFT - IP Response Rate (March 2015 target 40%) - replaces Reduce Negative Responses	0.0	0.0	0.0	0.0			0.0		0.0
NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	0.0	0.0	0.0	0.0			0.0		0.0
Dementia - Find, Assess and Refer	0.0	0.0	0.0	0.0					0.0
Dementia - Clinical Leadership and Staff Training	0.0	0.0	0.0	0.0				0.0	0.0
Dementia - Supporting Carers of People with Dementia								0.0	0.0
Learning From Safeguarding Concerns								0.0	0.0
Quality of Outpatient and Discharge Letters	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
Sepsis - Use of Sepsis Care Bundles	0.0	0.0	0.0	0.0					0.0
Pain Relief - Use of Pain Care Bundles	0.0	0.0	0.0	0.0					0.0
Medication and Falls	0.0	0.0	0.0	0.0			0.0		0.0
Serious Untoward Incidents (Never Events)								0.0	0.0
Community Therapies - Effective Referral Management							0.0		0.0
Community Therapies - Community Dietetics							0.0		0.0
Maternity - Low Risk Births				0.0					0.0
Bechet's Disease			0.0						0.0
HIV Home Delivery Medicines (% patients receiving)				0.0					0.0
Retinopathy of Prematurity Screening (%)				0.0					0.0
Timely Administration of TPN for preterm infants				0.0					0.0
ALL	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Indicator	YEAR TO DATE (£000s) M	A	B	W	P	I	C	CO	ALL
FFT - Implementation of Staff FFT	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
FFT - Early Implementation of Patient FFT in OP / DC Departments	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
FFT - Increase and / or Maintain Response Rate in ED areas	0.0								0.0
FFT - Increase and / or Maintain Response Rate in IP areas	0.0	0.0	0.0	0.0			0.0		0.0
FFT - IP Response Rate (March 2015 target 40%) - replaces Reduce Negative Responses	0.0	0.0	0.0	0.0			0.0		0.0
NHS Safety Thermometer - Reduction in Prevalance of Pressure Ulcers	0.0	0.0	0.0	0.0			0.0		0.0
Dementia - Find, Assess and Refer	47.3	15.8	0.0	0.0			0.0		63.0
Dementia - Clinical Leadership and Staff Training	0.0	0.0	0.0	0.0			0.0		0.0
Dementia - Supporting Carers of People with Dementia								0.0	0.0
Learning From Safeguarding Concerns		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Quality of Outpatient and Discharge Letters	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0
Sepsis - Use of Sepsis Care Bundles	0.0	0.0	0.0	0.0					0.0
Pain Relief - Use of Pain Care Bundles	0.0	0.0	0.0	0.0					0.0
Medication and Falls	0.0	0.0	0.0	0.0			0.0		0.0
Serious Untoward Incidents (Never Events)		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Community Therapies - Effective Referral Management							0.0		0.0
Community Therapies - Community Dietetics							0.0		0.0
Maternity - Low Risk Births				0.0					0.0
Bechet's Disease			0.0						0.0
HIV Home Delivery Medicines (% patients receiving)				0.0					0.0
Retinopathy of Prematurity Screening (%)				0.0					0.0
Timely Administration of TPN for preterm infants				0.0					0.0
ALL	47.3	15.8	0.0	0.0	0.0	0.0	0.0	0.0	63.0

Contractual Requirements - Outcome Thermometer (OT) Incentive Scheme

Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	QUARTER 1 (£000s)									QUARTER 2 (£000s)									QUARTER 3 (£000s)									QUARTER 4 (£000s)									YEAR TO DATE (£000s)								
						M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		OT	ED Waits >4 hours (=>95.0% each Quarter)	400	=>95.0%	100.0		0.0						100.0	100.0								100.0									0.0									0.0	200.0		0.0						200.0
2		OT	RTT Admitted Care (0 failing specialties after Q1)	200	0	na	na	na	na					0.0	8.3	25.0	33.3	0.0					66.6	22.2	22.2	22.2	0.0					66.6									0.0	30.5	47.2	55.5	0.0					133.2
2		OT	RTT Non-Admitted Care (0 failing specialties after Q1)	200	0	na	na	na	na					0.0	42.9	14.3	9.5	0.0					66.7	66.7								66.7									0.0	109.6	14.3	9.5	0.0					133.4
1		OT	Cancer Waits (2 weeks)	400	=>93.0%	0.0	0.0	0.0	0.0					0.0									0.0									0.0									0.0	0.0								0.0
19		OT	Urgent & Emergency Care - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0									0.0	0.0								0.0
19		OT	Lipid Management in OP Clinics - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0									0.0	0.0								0.0
2		OT	Community Nursing (Quality & Info Requirements) - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0									0.0	0.0								0.0
14		OT	Dev'ment of Advice & Guidance Service and Map of Medicine - achieve quarterly milestones in SDIP	100	Yes / No									0.0									0.0									0.0									0.0	0.0								0.0
2		OT	Cardiology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.61	0.0								0.0	0.0								0.0									0.0									0.0	0.0								0.0
2		OT	Paediatrics - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.64				0.0					0.0				14.3					14.3									0.0									0.0	0.0								0.0
2		OT	Dermatology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<2.48	14.3								14.3	14.3								14.3									0.0									0.0	28.6								28.6
2		OT	Geriatric Medicine - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.76	0.0								0.0	14.3								14.3									0.0									0.0	14.3								14.3
2		OT	Rheumatology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<4.99	14.3								14.3	14.3								14.3									0.0									0.0	28.6								28.6
2		OT	Gastroenterology - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<1.45	14.3								14.3	0.0								0.0									0.0									0.0	14.3								14.3
2		OT	General Medicine - Reduce OP FUN Ratio to West Mids average in Q4 or overall for the year.	57.1	=<2.38	0.0								0.0									0.0									0.0									0.0	0.0								0.0
9		OT	Never Events (reduced incentive available (1 = 85% available, 2 (65), 3 (40), 4 (10), 5 (0)	-2000	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0									0.0									0.0	0.0								0.0
			ALL			142.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	142.8	194.1	39.3	42.8	14.3	0.0	0.0	0.0	0.0	290.5	88.9	22.2	22.2	0.0	0.0	0.0	0.0	0.0	133.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	425.8	61.5	65.0	0.0	0.0	0.0	0.0	0.0	552.3

Contractual Requirements - Price Activity Matrix (PAM)

Data Source	Data Quality	Req	Indicator	Value (£000s)	Threshold	QUARTER 1 (£000s)									JULY (£000s)									AUGUST (£000s)									SEPTEMBER (£000s)									YEAR TO DATE (£000s)								
						M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL	M	A	B	W	P	I	C	CO	ALL
2		PAM	Elective (IP and DC)	52721	Contract Plan	48	75	-62	-26	2	0			37	51	-25	32	-32	1	-1			26	30	5	11	-33	3	-1			15								0	129	55	-19	-91	6	-2			78
2		PAM	Non-Elective	82299	Contract Plan	152	-21	-45	-2					84	24	66	-4	-27					59	19	31	2	26					78								0	195	76	-47	-3					221
2		PAM	Excess Bed Days	20352	Contract Plan	74	25	-21	-60					18	23	8	-8	-23					0	11	-4	-10	3					0								0	108	29	-39	-80					18
2		PAM	Accident & Emergency	20352	Contract Plan	-11		-86						-97	9		-25						-16	10		-19						-9								0	8		-130						-122
2		PAM	Outpatient New	26337	Contract Plan	23	5	-20	-36	-3	0	0		-31	-10	-6	-5	-15	-1	0	0		-37	-10	-5	9	-16	0	0	0		-22								0	3	-6	-16	-67	-4	0	0		-90
2		PAM	Outpatient Review	33208	Contract Plan	58	-34	-10	-27	0	0	-1		-14	7	-7	-12	-8	1	0	-1		-20	-12	-11	-18	-13	1	0	0		-53								0	53	-52	-40	-48	2	0	-2		-87
2		PAM	Outpatient with Procedure	7336	Contract Plan	-22	44	-138	12					-104	15	20	-56	8					-13	5	14	-51	3					-29								0	-2	78	-245	23					-146
2		PAM	Outpatient Telephone Conversation	196	Contract Plan	3	0							3	1	0							1	1	0							1								0	5	0							5
2		PAM	Maternity	14219	Contract Plan				72					72				129					129				73					73								0				274					274
2		PAM	Occupied Cot Days	6000	Contract Plan				18					18				-16					-16				-49					-49								0				-47					-47
2		PAM	Unbundled Activity	9520	Contract Plan	28	1	-8	6	1	0			28	59	-1	1	1	1	0			61	98	-2	4	1	0	0			101								0	185	-2	-3	8	2	0			190
2		PAM	Other Contract Lines	89552	Contract Plan	118	-6	331	11	-9	-78	0		367	229	4	98	-86	-4	-11	0		230	185	-1	62	29	-12	-41	0		222								0	532	-3	491	-46	-25	-130	0		819
2		PAM	Community	36003	Contract Plan	0	0		-8		0	0		-8	0	0		-4		0	4		0	0	0		-4		0	1		-3								0	0	0		-16		0	5		-11
			ALL			471	89	-59	-40	-9	-78	-1	0	373	408	59	21	-73	-2	-12	3	0	404	337	27	-10	20	-8	-42	1	0	325	0	0	0	0	0	0	0	0	0	###	175	-48	-93	-19	-132	3	0	###

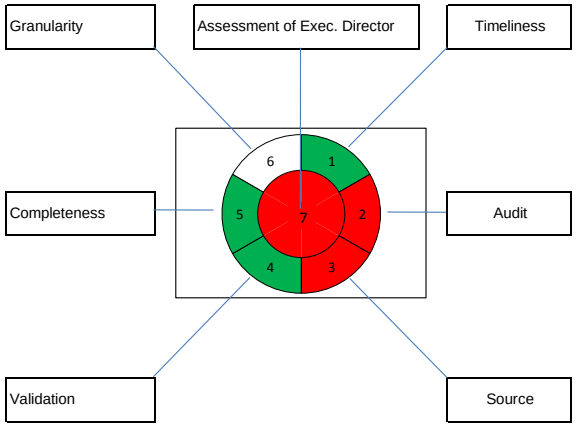
Legend

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

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

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

Data Quality - Kitemark



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

Red	Insufficient
Green	Sufficient
White	Not Yet Assessed

The centre of the indicator is colour coded as follows:

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

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

Medicine Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
C. Difficile	30	3	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	2	0	2	10	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	1	1	1	●		
MRSA Screening - Elective (%)	80	80	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	69	86	61	76.4		●		
MRSA Screening - Non Elective (%)	80	80	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	92	91	88	91.39		●		
Falls	0	0							33	40	61	42	44	41	Sep-14	12	21	8	41	261	●		
Falls with a serious injury	0	0	5	2	5	1	1	1	1	3	3	1	4	1	Sep-14	1	0	0	1	13	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	3	0	0	2	3	3	2	3	3	3	0		Aug-14	0	0	0	0	11	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	98.2	98.9	98.5	98.37		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	100	99.7	98.8	99.9		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	100	100	100	100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	●		
Serious Incidents	0	0					●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	7	●		
Mortality Reviews within 42 working days	100	=>88.0	●	●	●	●	●	●	●	●	●	●			Jul-14	37	76	74	70		●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
Pts spending >90% stay on Acute Stroke Unit (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		83.7		83.7	88.4	●		
Pts admitted to Acute Stroke Unit within 4 hrs (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		71.7		71.7	78.6	●		
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		55.1		55.1	71.7	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		98		98.0	99.3	●		
Stroke Admission to Thrombolysis Time (% within 60 mins)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		44		44.4	76.6	●		
Stroke Admissions - Swallowing assessments (<24h) (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		100		100.0	100.0	●		
TIA (High Risk) Treatment <24 Hours from receipt of referral (%)	=>70.0	=>70.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		96		96.0	97.8	●		
TIA (Low Risk) Treatment <7 days from receipt of referral (%)	=>75.0	=>75.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		97.9		97.9	96.6	●		
Primary Angioplasty (Door To Balloon Time 90 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		90.9		90.9	85.0	●		
Primary Angioplasty (Call To Balloon Time 150 mins) (%)	=>80.0	=>80.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		100 (S)		100 (S)	88.5	●		
Rapid Access Chest Pain - seen within 14 days (%)	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		100 (S)		100 (S)	97.7	●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●		Aug-14			93.6	93.6		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●		Aug-14			100	100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●		Aug-14			92.9	92.9		●		
Mixed Sex Accommodation Breaches	0	0	5	4	2	3	7	21	36	43	14	0	0	0	Sep-14	0	0	0	0	93	●		
No. of Complaints Received (formal and link)										38	28	28	32	36	Sep-14				36	162			
No. of Active Complaints in the System (formal and link)										##	##	##	##	##	Sep-14				131				
Oldest' complaint currently in system (days)										##	##	##	##	##	Sep-14				133				

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0.00	0.49	0.06	0.11		●		
28 day breaches	0	0	●	●	●	●	●	●	●	1	●	●	●	●	Sep-14	0	0	0	0	1	●		
Sitrep Declared Late Cancellations	0	0	13	2	2	7	7	4	10	2	7	7	3	2	Sep-14	0	1	1	2	31	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0											61	54	Sep-14		63.7	54.4	61.4		●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	93.3 (s)	88.8 (c)		90.9	93.2	●		
Emergency Care 4-hour breach (numbers)									570	1003	1016	907	736	1201	Sep-14	1172	3	26	1201	5433			
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0 (s)	0 (c)		0	0	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	15 (s)	16 (c)		16	17	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	55 (s)	75 (c)		58	51	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	7.38 (s)	7.29 (c)		6.91	6.76	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	3.42 (s)	6.36 (c)		4.66	4.4	●		
WMAS - Finable Handovers (emergency conveyances) 30 - 60 mins (number)	0	0	●	●	●	●	●	●	119	136	125	145	51	136	Sep-14	33 (s)	103 (c)		136	712	●		
WMAS -Finable Handovers (emergency conveyances) >60 mins (number)	0	0	●	●	●	●	●	●	13	8	8	8	1	13	Sep-14	1 (s)	12 (c)		13	51	●		
WMAS - Turnaround Delays > 60 mins (% all emergency conveyances)	=<0.02	=<0.02	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0.057(s)	0.51 (c)		0.32	0.21	●		
WMAS - Emergency Conveyances (total)			3991	3927	4122	4009	3826	4271	4044	4227	4093	4278	3994	4067	Sep-14	1735 (s)	2332 (c)		4067	24703			

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		EC	AC	SC					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		98.7	92.6	94.8		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		88.9	90.8	90.2		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		89.0	92.8	91.9		●		
Patients Waiting >52 weeks	0	0	17	6	4	0	0	0	0	0	0	0	0	0	Sep-14	0	0	0	0		●		
Treatment Functions Underperforming	0	0	4	5	4	4	5	5	6	3	5	5	6	5	Sep-14	0	2	3	5		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0.0	12.8	1.5	10.1		●		
WTE - Actual versus Plan			176	158	165	135	163	163	171	161	157	151	166	160	Sep-14				159.81				
PDRs - 12 month rolling (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	84	76	81		79.8	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	91	83	87		87	●		
Sickness Absence (%)	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	5.31	5.24	3.82	4.97	4.37	●		
Mandatory Training (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	79	79	79		78.9	●		
New Investigations in Month			2	0	0	0	0	1	1	1	1	2	1	2	Sep-14				2				
Nurse Bank Use	34560	2880	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14				2875	16612	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14				1106	9972	●		
Admin & Clerical Bank Use (shifts)	0	0								●	●	●	●	●	Sep-14				635	3557	●		
Admin & Clerical Agency Use (shifts)	0	0								●	●	●	●	●	Sep-14				27	174	●		
Your Voice - Response Rate (%)			11		8		7			9					Aug-14	7	8	14	9				
Your Voice - Overall Score			3.73		3.68		3.58			3.76					Aug-14	3.68	3.81	3.76	3.76				

Surgery A Group

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
C. Difficile	7	1	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	1	0	0	0	1	6	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	98	99	76	7	92.5		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	92	91	96	93	92.0		●		
Falls	0	0							9	7	4	8	3	9	Sep-14	3	1	4	1	9	39	●		
Falls with a serious injury	0	0	1	0	1	1	0	1	0	0	0	0	0	0	Sep-14	0	0	0	0	0	0	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	1	0	2	0	1	0	1	0	0	0	1		Aug-14	0	1	0	0	1	2	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	89	97	95	98	93.1		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	99.9	100	99.8	100	99.89		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	100	100	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	100	98.3	100	100	99.4		●		
Never Events	0	0	●	1	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	0	●		
Serious Incidents	0	0				●	●	●	●	●	●	●	●	●	Sep-14	0	0	1	0	1	2	●		
Mortality Reviews within 42 working days	100	=>88.0	●	●	●	●	●	●	●	●	●	●			Jul-14	100			95	95.7		●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●		Aug-14	93.2		95.1		93.6		●		
2 weeks (Breast Symptomatic)	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●		Aug-14	94.0				94.0		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●		Aug-14	100		100		100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●		Aug-14	94.4		96.0		95.1		●		
Mixed Sex Accommodation Breaches	0	0	12	5	2	3	3	0	0	0	0	3	0	0	Sep-14	0	0	0	0	0	3	●		
No. of Complaints Received (formal and link)										12	11	8	19	15	Sep-14					15	65			
No. of Active Complaints in the System (formal and link)										50	50	34	39	49	Sep-14					49				
Oldest' complaint currently in system (days)										124	131	118	99	109	Sep-14					109				
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0.7	1.3	1.0	0.0	0.83		●		
28 day breaches	0	0	0	0	0	0	0	1	1	0	0	0	0	1	Sep-14	1	0	0	0	1	2	●		
Sitrep Declared Late Cancellations	0	0	28	35	25	28	37	18	13	16	5	6	16	10	Sep-14	3	4	3	0	10	66	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0											76	78	Sep-14	78	80	74	87	78.0		●		
Emergency Care 4-hour breach (numbers)									81	100	100	119	52	103	Sep-14	53	47	3	0	103	555			
Hip Fractures - Operation < 24 hours of admission (%)	85	85	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		90			90.0	67.0	●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		A	B	C	D					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	91.2	63.4	92.1		81.6		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	98.3	96.6	96.8		96.8		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	95.6	85.4	87.5		89.7		●		
Patients Waiting >52 weeks	0	0	28	13	3	3	0	0	1	1	0	2	4	2	Sep-14	0	2	0	0	2		●		
Treatment Functions Underperforming	0	0	5	8	8	7	8	7	7	5	5	4	3	4	Sep-14	0	2	2	0	4		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	1.6	0.0	0.0	0.0	1.6		●		
WTE - Actual versus Plan			70	71	72	88	76	76	64	71	77	78	71	71	Sep-14					70.67				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	64	92	75	76		75.6	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	63	86	89	83		79.76	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	4.62	3.45	6.61	3.72	4.91	5.47	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	78	77	90	85		84.3	●		
New Investigations in Month			0	0	2	1	1	1	0	0	0	0	0	2	Sep-14					2				
Nurse Bank Use	9908	826	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14					908	5263	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14					297	2411	●		
Admin & Clerical Bank Use (shifts)	0	0								●	●	●	●	●	Sep-14					273	1361	●		
Admin & Clerical Agency Use (shifts)	0	0								●	●	●	●	●	Sep-14					0	0	●		
Your Voice - Response Rate			16		13			12			11				Aug-14	7	12	10	13	11				
Your Voice - Overall Score			3.03		3.55			3.53			3.57				Aug-14	3.5	3.6	3.5	3.7	3.57				

Surgery B Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		O	E					
C. Difficile	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	97	95	95.9		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	93	84	87.3		●		
Falls	0	0							1	0	0	2	0	0	Sep-14	0	0	0	3	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep-14	0	0	0	0	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0		Aug-14	0	0	0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	98.48	96.19	97.67		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	100	99.8	99.95		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	100	100	100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	100	100	100		●		
Never Events	0	0	●	1	●	1	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	●		
Serious Incidents	0	0				●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	2	●		
Mortality Reviews within 42 working days	=>88.0	=>88.0	●	●	●	●	●	●	●	●					Jul-14					●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		O	E					
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●		Aug-14		91.3	91.3		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●			●	●	●	●	●	●	●		Aug-14		100	100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0		●	●	●	●	●		●	●	●	●		Aug-14		75	75.0		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep-14	0	0	0	0	●		
No. of Complaints Received (formal and link)										9	3	10	11	8	Sep-14			8	41			
No. of Active Complaints in the System (formal and link)										31	40	34	37	36	Sep-14			36				
Oldest' complaint currently in system (days)										117	100	103	129	98	Sep-14			129				
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	1.8	0.76	1.44		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep-14	0	0	0	0	●		
Sitrep Declared Late Cancellations	0	0	19	14	19	36	15	22	3	22	17	16	14	16	Sep-14	13	3	16	88	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0											72	74	Sep-14	74	73	74.0		●		
Emergency Care 4-hour waits (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	98.59		98.6	98.77	●		
Emergency Care 4-hour breach (numbers)									10	15	80	13	26	29	Sep-14	29	0	29	153			
Emergency Care Trolley Waits >12 hours	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0		0	0	●		
Emergency Care Timeliness - Time to Initial Assessment (95th centile)	=<15 mins	=<15 mins	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	15		15	14	●		
Emergency Care Timeliness - Time to Treatment in Department (median)	=<60 mins	=<60 mins	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	24		24	21	●		
Emergency Care Patient Impact - Unplanned Reattendance Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	4.15		4.15	3.53	●		
Emergency Care Patient Impact - Left Department Without Being Seen Rate (%)	=<5.0	=<5.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	2.25		2.25	1.76	●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate		Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		O	E					
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	90.79	86.43	**89.2**		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	96.9	96.26	**96.7**		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	95.7	90.1	**93.9**		●		
Patients Waiting >52 weeks	0	0	9	9	2	0	1	1	0	1	1	0	0	2	Sep-14	1	1	**2**		●		
Treatment Functions Underperforming	0	0	1	0	0	2	3	3	3	4	3	3	2	4	Sep-14	0	4	**4**		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0.0	0.5	**0.5**		●		
WTE - Actual versus Plan			31	24	23	27	37	37	28	34	38	33	32	28	Sep-14			**28.21**				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	87.5	95.54		**88.8**	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	92.3	60		**87.1**	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	4.75	2.47	**4.01**	**3.26**	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	81	92		**84.3**	●		
New Investigations in Month			0	0	0	1	0	0	0	0	0	0	0	0	Sep-14			**0**				
Nurse Bank Use	2796	233	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14			**224**	**1402**	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14			**39**	**366**	●		
Admin & Clerical Bank Use (shifts)	0	0								●	●	●	●	●	Sep-14			**196**	**1156**	●		
Admin & Clerical Agency Use (shifts)	0	0								●	●	●	●	●	Sep-14			**44**	**183**	●		
Your Voice - Response Rate			17			18			19			17			Aug-14	9	33	**17**				
Your Voice - Overall Score			3.66			3.72			3.73			3.52			Aug-14	3.54	3.49	**3.52**				

Women & Child Health Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
C. Difficile	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	1	0	0	0	1	1	●		
MRSA Bacteraemia	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	0	●		
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	98				98.0		●		
MRSA Screening - Non Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		98			97.56		●		
Falls	0	0							0	0	2	0	1	0	Sep-14	0	0	0	0	0	3	●		
Falls with a serious injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep-14	0	0	0	0	0	0	●		
Grade 2,3 or 4 Pressure Ulcers (hospital aquired avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0		Aug-14	0	0	0	0	0	0	●		
Venous Thromboembolism (VTE) Assessments	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	97	78			86.67		●		
WHO Safer Surgery Checklist - Audit 3 sections	=>98.0	=>98.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	98.7	98.8			98.7		●		
WHO Safer Surgery Checklist - Audit 3 sections and brief	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	100	100			100		●		
WHO Safer Surgery Checklist - Audit 3 sections, brief and debrief	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	100	100			100		●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	0	●		
Serious Incidents	0	0				●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	2	●		

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
Caesarean Section Rate - Total (%)	=<25.0	=<25.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		26.8			26.8	25.8	●		
Caesarean Section Rate - Elective (%)			11	10	11	12	11	10	10	8	9	9	7	9	Sep-14		9.2			9.2	8.7			
Caesarean Section Rate - Non Elective (%)			13	15	10	16	14	13	16	18	19	15	17	18	Sep-14		17.6			17.6	17.1			
Maternal Deaths	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		0			0	0	●		
Post Partum Haemorrhage (>2000ml)	48	4	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		1			1	4	●		
Admissions to Neonatal Intensive Care (%)	=<10.0	=<10.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		1.7			1.65	2.97	●		
Adjusted Perinatal Mortality Rate (per 1000 babies)	<8.0	<8.0	●	●	●	●	●	●	●	●	●	●	●		Aug-14		9.7			9.74				
Early Booking Assessment (<12 + 6 weeks) (%) - SWBH Specific	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14		76			78.45		●		
Early Booking Assessment (<12 + 6 weeks) (%) - National Definition	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●		Aug-14		136			136		●		
Mortality Reviews within 42 working days	=>88.0	=>88.0	●	●	●		●	●	●	●	●				Jul-14							●		
2 weeks	=>93.0	=>93.0	●	●	●	●	●	●	●	●	●	●	●		Aug-14	96.1				96.1		●		
31 Day (diagnosis to treatment)	=>96.0	=>96.0	●	●	●	●	●	●	●	●	●	●	●		Aug-14	100				100.0		●		
62 Day (urgent GP referral to treatment)	=>85.0	=>85.0	●	●	●	●	●	●	●	●	●	●			Aug-14	58.8				58.8		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep-14	0				0	0	●		
No. of Complaints Received (formal and link)										4	6	11	8	8	Sep-14					8	37			
No. of Active Complaints in the System (formal and link)										15	21	21	24	29	Sep-14					29				
Oldest' complaint currently in system (days)										61	82	52	66	87	Sep-14					87				

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
Elective Admissions Cancelled at last minute for non-clinical reasons	=<0.8	=<0.8	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	2.2				1.8		●		
28 day breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep-14	0				0	0	●		
Sitrep Declared Late Cancellations	0	0	4	13	14	13	7	12	12	3	4	7	6	6	Sep-14	6				6	38	●		
Weekday Theatre Utilisation (as % of scheduled)	=>85.0	=>85.0											78	76	Sep-14	76.0				76.0		●		
Emergency Care 4-hour breach (numbers)									18	14	14	18	14	30	Sep-14	11	0	19	0	30	108			
RTT - Admittted Care (18-weeks) (%)	=>90.0	=>90.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	97.1				97.1		●		
RTT - Non Admittted Care (18-weeks) (%)	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	98.8				98.8		●		
RTT - Incomplete Pathway (18-weeks) (%)	=>92.0	=>92.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	99.6				99.6		●		
Patients Waiting >52 weeks	0	0	4	4	2	0	0	0	0	0	1	1	0	0	Sep-14	0				0		●		
Treatment Functions Underperforming	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep-14	0				0		●		
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0.0				0.0		●		

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		G	M	P	C					
WTE - Actual versus Plan			64	39	42	41	34	34	48	58	60	67	81	61	Sep-14					**60.7**				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	86	87	89	93		**88.5**	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	70	74	100			**81**	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	3.96	5.27	6.38	5.29	**5.09**	**4.67**	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	88	83	79	88		**82.7**	●		
New Investigations in Month			1	0	0	0	0	0	0	0	0	2	0	0	Sep-14					**0**				
Nurse Bank Use	6852	571	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14					**512**	**3075**	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14					**26**	**250**	●		
Admin & Clerical Bank Use (shifts)	0	0								●	●	●	●	●	Sep-14					**70**	**286**	●		
Admin & Clerical Agency Use (shifts)	0	0								●	●	●	●	●	Sep-14					**9**	**9**	●		
Your Voice - Response Rate			17			11			14			12			Aug-14	17	7	16	16	**12**				
Your Voice - Overall Score			3.74			3.79			3.74			3.65			Aug-14	3.8	3.5	3.4	3.9	**3.65**				

Pathology Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate					Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		HA	HI	B	M	I					
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	0	0	●		
No. of Complaints Received (formal and link)										0	1	0	1	1	Sep-14						1	3			
No. of Active Complaints in the System (formal and link)										1	2	1	2	3	Sep-14						3				
Oldest' complaint currently in system (days)										91	##	27	46	68	Sep-14						68				
WTE - Actual versus Plan			31	32	30	37	33	33	30	32	31	32	29	27	Sep-14						26.76				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	90	93	77	93	100		88.1	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	100	100	100	75	100		95.2	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	7.37	0.26	2.16	5.74	0.23	3.79	3.80	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	91	88	93	93	97		92.3	●		
New Investigations in Month			0	0	0	0	0	0	0	0	0	0	0	0	Sep-14						0				
Admin & Clerical Bank Use (shifts)	0	0								●	●	●	●	●	Sep-14						574	2891	●		
Admin & Clerical Agency Use (shifts)	0	0								●	●	●	●	●	Sep-14						0	0	●		
Your Voice - Response Rate			17		36		30			31					Aug-14	27	31	25	52	40	31				
Your Voice - Overall Score			3.31		3.6		3.43			3.74					Aug-14	3.6	3.7	3.8	3.7	4.13	3.74				

Imaging Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate				Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		DR	IR	NM	BS					
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	0	●		
Pts receiving CT Scan within 1 hr of presentation (%)	=>50.0	=>50.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14			55.1		55.1	71.7	●		
Pts receiving CT Scan within 24 hrs of presentation (%)	100	100	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14			98.0		98.0	99.3	●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep-14	0	0	0	0	0	0	●		
No. of Complaints Received (formal and link)										4	2	3	3	0	Sep-14					0	12			
No. of Active Complaints in the System (formal and link)										5	7	8	5	5	Sep-14					5				
Oldest' complaint currently in system (days)										19	40	59	30	52	Sep-14					52				
Emergency Care 4-hour breach (numbers)									30	39	41	32	34	49	Sep-14	46				49	225			
Acute Diagnostic Waits in Excess of 6-weeks (%)	=<1.0	=<1.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0.4				0.4		●		
WTE - Actual versus Plan			26	20	21	18	28	28	15	13	11	13	22	14	Sep-14					14.47				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	78	62	77	85		76.2	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	96		100			96.7	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	4.5	0.6	0.42	3.5	4.67	4.40	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	86	90	94	91		88.6	●		
New Investigations in Month			0	0	1	0	0	0	0	2	2	0	0	6	Sep-14					6				
Nurse Bank Use	288	24	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14					5	70	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14					93	839	●		
Admin & Clerical Bank Use (shifts)	0	0								●	●	●	●	●	Sep-14					118	584	●		
Admin & Clerical Agency Use (shifts)	0	0								●	●	●	●	●	Sep-14					0	0	●		
Your Voice - Response Rate			30		19		30			33					Aug-14	29	18	43	45	33				
Your Voice - Overall Score			3.73		3.72		3.73			3.73					Aug-14	3.6	4.6	4.2	3.8	3.73				

Community & Therapies Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		AT	IB	IC					
MRSA Screening - Elective	80	80	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14				100		●		
Falls	0	0							8	9	11	13	4	14	Sep-14	0	14	0	14	59	●		
Falls with a serious injury	0	0							0	2	0	0	1	0	Sep-14	0	0	0	0	3	●		
Grade 3 or 4 Pressure Ulcers (avoidable)	0	0							1	2	0	2	1		Aug-14		1		1	6	●		
Never Events	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	●		
Medication Errors	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	●		
Serious Incidents	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	0	0	0	0	0	●		
FFT Response Rate - Wards	>25%	>25%							39	68	43	60	59	57	Sep-14				56.7		●		
FFT Score - Wards	=>68.0	=>68.0	94	100	93	85	83	82	81	95	87	83	91	82	Sep-14				82		●		
Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Sep-14	0	0	0	0	0	●		
No. of Complaints Received (formal and link)										3	0	0	5	2	Sep-14				2	10			
No. of Active Complaints in the System (formal and link)										10	8	3	8	8	Sep-14				8				
Oldest' complaint currently in system (days)										94	##	75	38	60	Sep-14				60				
WTE - Actual versus Plan			55	70	32	34	34	34	27	36	45	45	62	65	Sep-14				64.88				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	94	97	84		89.5	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	5.62	3.7	5.45	4.93	4.14	●		

Indicator	Trajectory		Previous Months Trend												Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		AT	IB	IC					
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	94	93	89		91.4	●		
New Investigations in Month			0	0	1	0	1	1	0	0	0	0	0	0	Sep-14				0				
Nurse Bank Use	5408	451	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14				323	2028	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14				211	1529	●		
Admin & Clerical Bank Use (shifts)	0	0								●	●	●	●	●	Sep-14				325	1223	●		
Admin & Clerical Agency Use (shifts)	0	0								●	●	●	●	●	Sep-14				0	0	●		
Your Voice - Response Rate			28		18		33			32					Aug-14	44	31	28	32				
Your Voice - Overall Score			3.71		3.75		3.78			3.88					Aug-14	3.76	3.95	3.89	3.88				
DVT numbers	730	>61			30	40	57	53	53	62	87	39	33	70	Sep-14				70	344	●		
Therapy DNA rate OP services (%)	=<9	=<9					11	12	12	16	11	11	11		Aug-14				11	12.0	●		
FEES assessment	>100	>8.3						1	7	10	3	4	4	4	Sep-14				5	32	●		
ESD Response time	<48 hrs	<48 hrs				●	●	●	●	●	●	●	●		Aug-14						●		
STEIS	0	0			2	0	0	1	0	2	1	0	1	0	Sep-14				0	4	●		
Rapid response to AMU, RRTS	<60 mins	<60 mins			77	75	75	75	75	71	72	73	68		Aug-14				68	71.7	●		
Avoidable weight loss	<20%	<20%		●	●	●	●	●	18	0	8	0	0		Aug-14				0	6.5	●		
Green Stream Community Rehab response time for treatment (days)	=<11	=<11					15	11	12	7.9	11	16	16	17	Sep-14				17.1	13.3	●		

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate			Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		AT	IB	IC					
DNA/No Access Visits		%											3.3		Aug-14				3.3				
Falls Assessments - DN service only		%											72		Aug-14				72.3				
Pressure Ulcer Assessment - DN service only		%											73		Aug-14				73.4				
Healthy Lifestyle Assessments - DN Service only		%											61		Aug-14				61.2				
At risk of Social Isolation Referrals to 3rd sector DN service only		%											46		Aug-14				45.5				
MUST Assessments - DN Service only		%											9.4		Aug-14				9.4				
Incident Rates		per 1000 charge											3.6		Aug-14				3.6				
Dementia Assessments - DN Service only		%											72		Aug-14				72.1				
48 hour inputting rate		%											91		Aug-14				91.3				

Corporate Group

Indicator	Trajectory		Previous Months Trend											Data Period	Directorate							Month	Year To Date	Trend	Next Month	3 Months
	Year	Month	O	N	D	J	F	M	A	M	J	J	A	S		CEO	F	W	M	E	N	O					
No. of Complaints Received (formal and link)										8	4	5	6	5	Sep-14								5	28			
No. of Active Complaints in the System (formal and link)										16	13	12	13	21	Sep-14								21				
Oldest' complaint currently in system (days)										69	90	77	99	##	Sep-14								121				
WTE - Actual versus Plan			191	215	187	161	164	164	149	154	162	176	162	183	Sep-14								182.69				
PDRs - 12 month rolling	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	71	83	76	93	82	74	68		75.2	●		
Medical Appraisal and Revalidation	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14			100						100	●		
Sickness Absence	=<3.15	=<3.15	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	2.22	3.57	1.38	2.62	3.29	5.03	3.90	4.01	4.20	●		
Mandatory Training	=>95.0	=>95.0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14	94	94	95	81	96	96	92		90.3	●		
New Investigations in Month			0	1	0	0	2	2	0	1	3	1	0	5	Sep-14								5				
Nurse Bank Use	1088	91	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14								161	1010	●		
Nurse Agency Use	0	0	●	●	●	●	●	●	●	●	●	●	●	●	Sep-14								14	71	●		
Admin & Clerical Bank Use (shifts)	0	0								●	●	●	●	●	Sep-14								3185	19319	●		
Admin & Clerical Agency Use (shifts)	0	0								●	●	●	●	●	Sep-14								39	294	●		
Your Voice - Response Rate					26			29			24				Aug-14	53	31	27	24	18	22	22	24				
Your Voice - Overall Score					3.56			3.57			3.6				Aug-14	3.77	3.38	3.77	3.50	3.32	3.61	3.59	3.6				

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Financial Performance Report – P06 September 2014
SPONSOR (EXECUTIVE DIRECTOR):	Tony Waite, Director of Finance and Performance Management
AUTHOR:	Chris Archer, Associate Director of Finance - Corporate
DATE OF MEETING:	6th November 2014

EXECUTIVE SUMMARY:

Key messages:

- Forecast remains delivery of £3.4m plan surplus in line with LTFM commitment – plausible route to delivery established and reliant on delivery of pay run rate reduction, cost effective utilisation of resilience funding and expedient measures including application of contingency. Key risks to be mitigated include cost effective delivery of workforce change and delivery to operational standards to secure income base.
- In month headline performance £0.3m surplus being consistent with break-even position reported in each of last two months. Year to date off plan by £1.9m. Reported position moderated by benefit of £3.2m reserves as contingency and £3.2m balance sheet flexibility as plan. There is no further planned benefit of the latter.
- CIP delivery continues below plan – workforce reviews set in train with a view to addressing 2015/16 requirements.
- Capex continues to be modest; review of programme under way to reflect emergent in year schemes consistent with retained estate strategy following Midland Met approval and re-phasing of flexible IM&T spend.
- Cash in line with plan.

Key actions:

- Secure expenditure run rate reductions and in particular in premium rate temporary pay costs.
- Confirm cost effective arrangements for use resilience funding & secure expedient measures.
- Conclude & progress workforce change to secure pay bill consistent with the safe delivery in full of necessary cost reduction for 2014-16.
- Secure service delivery to operational and CQUIN standards to minimise avoidable income losses
- Complete work to confirm capital programme with forward look to 2015/16.

Key numbers:

- Month £323k surplus being £125k adverse to budget; YTD deficit £368k being £1,964k adverse.
- CIP delivery to date £4,233k being £2.7m adverse to revised plan and £3.3m adverse to TDA plan
- Forecast surplus £3.4m in line with financial plan.
- Capex YTD £2,528k being £2,026 below plan.
- Cash at 30 September £35.2m being £0.7m above plan.
- CoSRR 3 to date as plan; forecast 3 as plan.
- Capital Resource Limit (CRL) charge forecast at £22.7m being within approved CRL of £21.3m to be adjusted for anticipated £1.5m project funding.
- External Finance Limit (EFL) charge forecast at £16.6m being consistent with approved EFL ditto.

REPORT RECOMMENDATION:
The Trust Board is requested to RECEIVE the contents of the report and to require that the Trust takes those actions necessary and safe to achieve key financial targets.

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
PREVIOUS CONSIDERATION:
Considered by Performance Management Committee, CLE & Finance & Investment Committee

Sandwell and West Birmingham Hospitals NHS

NHS Trust

Financial Performance Report – September 2014 (month 6)

EXECUTIVE SUMMARY

- For the **month** of September 2014 against the DoH target, the Trust delivered a **"bottom line" surplus of £323k being £125k adverse** to a flex budget surplus of £448k. The **year to date deficit of £368k is £1,964k adverse** to flex budget to the end of September.
- Forecast continues to anticipate that the position will be recovered and the annual surplus target of £3.374m will be met through margin optimisation, pay reduction and with non-recurrent measures and uncommitted reserves as contingency.
- Actual **savings delivery year to date is assessed at £4,233k being £2,721k adverse to trust phased plan** [£3.3m adverse vs TDA plan].
- At month end there were 6,803 whole time equivalent (WTE) staff in post (excluding use of agency), 280 below the currently planned level. After 201 WTE agency staff, total **WTE's were 79 below plan plan**. Total **pay expenditure for the month is at the same level as August** at £24.4m although against a lower plan, now being **£733k above plan. Agency spend at £879k in September was 17% below the year to August average.**
- Key risks include scale & pace of savings delivery, management of cost pressures and income recovery compromised by shortfall in delivery of operational standards. Work is ongoing locally to secure resilience funding for Winter pressures and to achieve referral to treatment time standards.

Financial Performance Indicators - Variances					
Measure	Current Period	Year to Date	Thresholds		
			Green	Amber	Red
I&E Surplus Actual v Plan £000	(125)	(1,964)	>= Plan	> = 99% of plan	< 99% of plan
EBITDA Actual v Plan £000	(132)	(1,973)	>= Plan	> = 99% of plan	< 99% of plan
Pay Actual v Plan £000	(733)	(2,936)	<=Plan	< 1% above plan	> 1% above plan
Non Pay Actual v Plan £000	185	(800)	<= Plan	<= Plan	> 1% above plan
WTEs Actual v Plan	78	(98)	<= Plan	< 1% above plan	> 1% above plan
Cash (incl Investments) Actual v Plan £000		729	>= Plan	> = 95% of plan	< 95% of plan
Note: positive variances are favourable, negative variances unfavourable					

- **30th September cash balance £35.2m is £0.7m ahead of revised cash plan**.
- Year to date spend on capital is £2,528k being £2,026k below plan. A further £1.6m of capital orders have been placed.
- On-going review of capex priorities.

2014/15 Summary Income & Expenditure Performance at September 2014	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	391,002	32,724	32,953	229	195,547	197,152	1,605	390,668
Other Income	42,468	3,544	3,730	186	20,933	21,091	158	42,777
Pay Expenses	(284,660)	(23,702)	(24,435)	(733)	(144,859)	(147,794)	(2,936)	(284,591)
Non-Pay Expenses	(124,410)	(10,365)	(10,180)	185	(59,513)	(60,312)	(800)	(124,386)
EBITDA	**24,400**	**2,200**	**2,068**	**(132)**	**12,109**	**10,136**	**(1,973)**	**24,468**
Depreciation & Impairment	(13,734)	(1,145)	(1,145)	0	(6,867)	(6,867)	0	(18,734)
PDC Dividend	(5,220)	(435)	(435)	0	(2,610)	(2,610)	0	(5,288)
Net Interest Receivable / Payable	(2,150)	(179)	(172)	7	(1,075)	(1,066)	9	(2,150)
Other Finance Costs / P&L on sale of assets	(150)	(13)	(13)	0	(75)	(75)	0	(150)
Net Surplus/(Deficit)	**3,146**	**429**	**304**	**(125)**	**1,482**	**(482)**	**(1,964)**	**(1,854)**
IFRIC12/Impairment/Donated Asset Related Adjustments	228	19	19	0	114	114	0	5,228
SURPLUS/(DEFICIT) FOR DOH TARGET	**3,374**	**448**	**323**	**(125)**	**1,596**	**(368)**	**(1,964)**	**3,374**
Surplus / (Deficit) against TDA plan	3,374	309	323	14	1,015	(368)	(1,383)	3,374

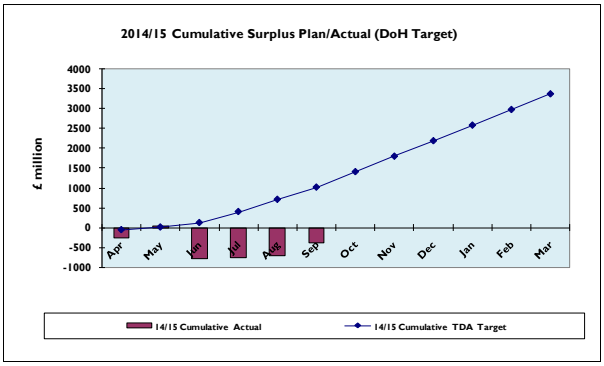
In year Trust phasing of budgets reflects updated local plans

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Financial Performance Report – September 2014

Overall Performance against DoH Plan

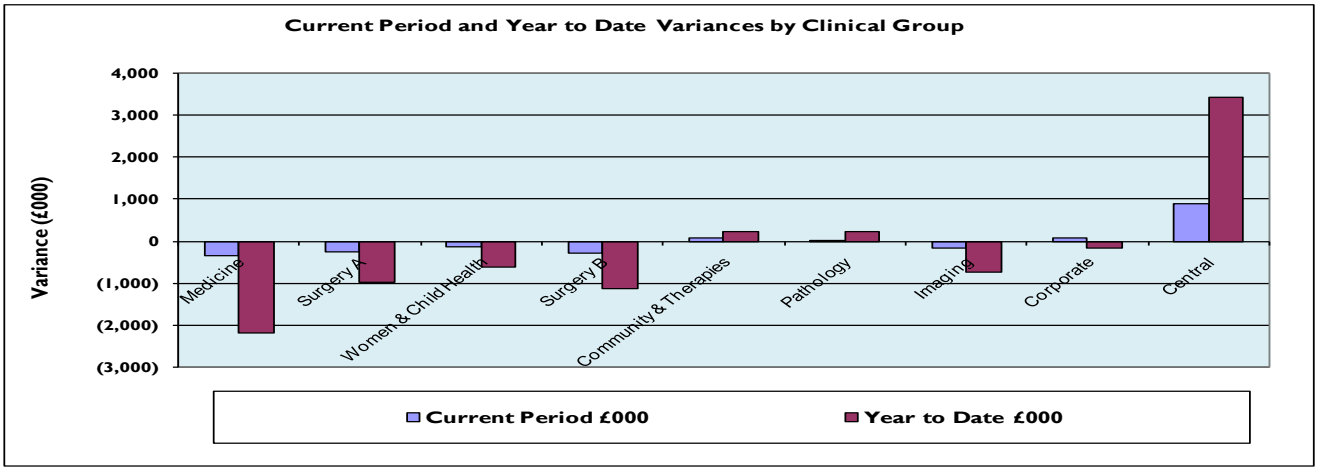
The Trust delivered an actual surplus of £323,000 against a planned surplus of £448,000 in September. It is anticipated that this will be recovered in order to achieve the year end surplus target of £3.374m surplus.



Performance of Clinical Groups / Corporate Areas

- Medicine pay overspend of £2.0m includes £857k on HCAs and £748k on medical staff. Part of the drugs and cardiology non-pay over spends are offset by additional income.
- Surgery A overspend includes waiting list initiatives and shortfall on savings target delivery.
- Women & Child overspend includes £715k to date on costs of antenatal pathways at other providers.
- Surgery B is over-performing on ophthalmology Lucentis although the capped SWB CCG contract results in a net pressure of £400k to date. Premium rate working continues.
- Imaging premium rate working and saving shortfall.
- Corporate over spending on advisor fees.

Group Variances from Plan (Operating income and expenditure)	Current Period £000	Year to Date £000
Medicine	(351)	(2,197)
Surgery A	(260)	(969)
Women & Child Health	(130)	(617)
Surgery B	(292)	(1,139)
Community & Therapies	64	226
Pathology	10	231
Imaging	(155)	(751)
Corporate	90	(168)
Central	892	3,412



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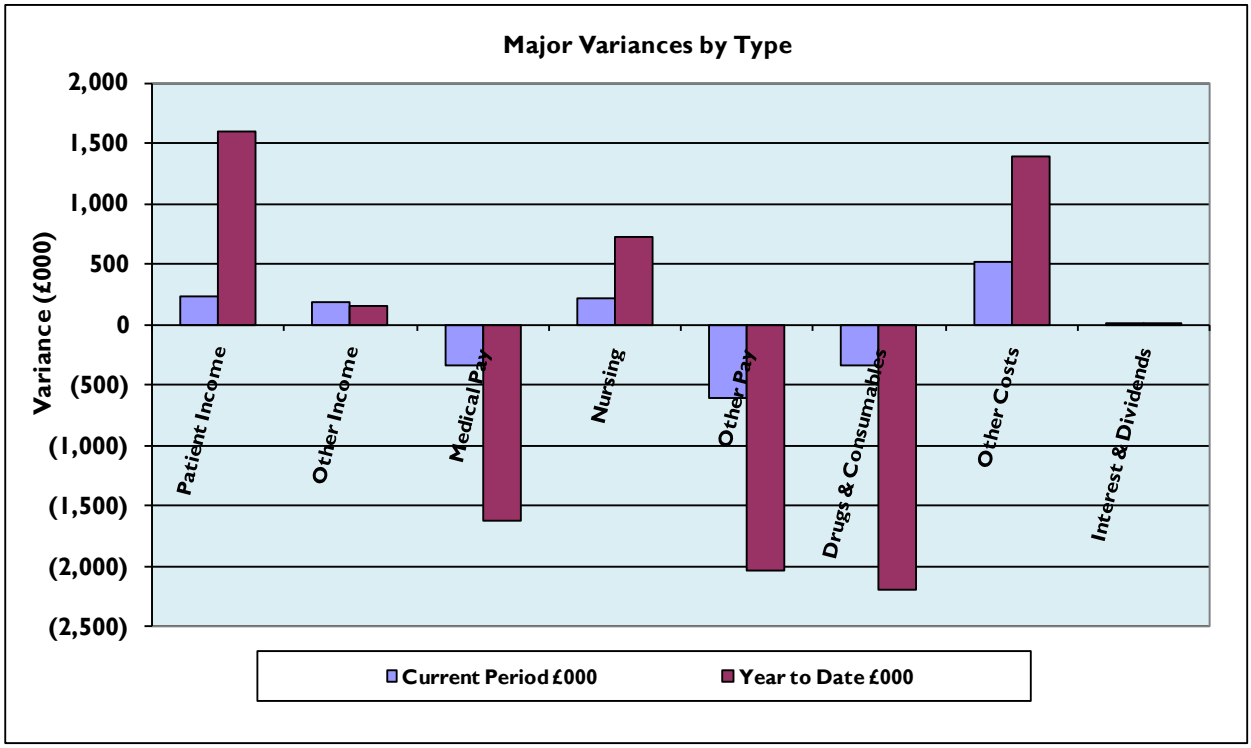
- Overall headline adverse variance to plan £125k in September, £1,964k year to date.
- Patient income over performed in month due to pass through drugs and devices.
- Medical staff pay in month overspend in Medicine junior doctor agency and premium rate working in Surgery A and B
- Nursing underspends £446k to date in W&CH.
- £1,157k of drugs / consumables overspend to date is pass through recovered through income.
- Other costs includes maternity pathway payments overspend £715k to date and release of unallocated reserves.

Variance From Plan by Expenditure Type	Current Period £000	Year to Date £000
	(Adv) / Fav	(Adv) / Fav
Patient Income	229	1,605
Other Income	186	158
Medical Pay	(339)	(1,623)
Nursing	221	723
Other Pay	(615)	(2,036)
Drugs & Consumables	(343)	(2,199)
Other Costs	528	1,399
Interest & Dividends	7	9



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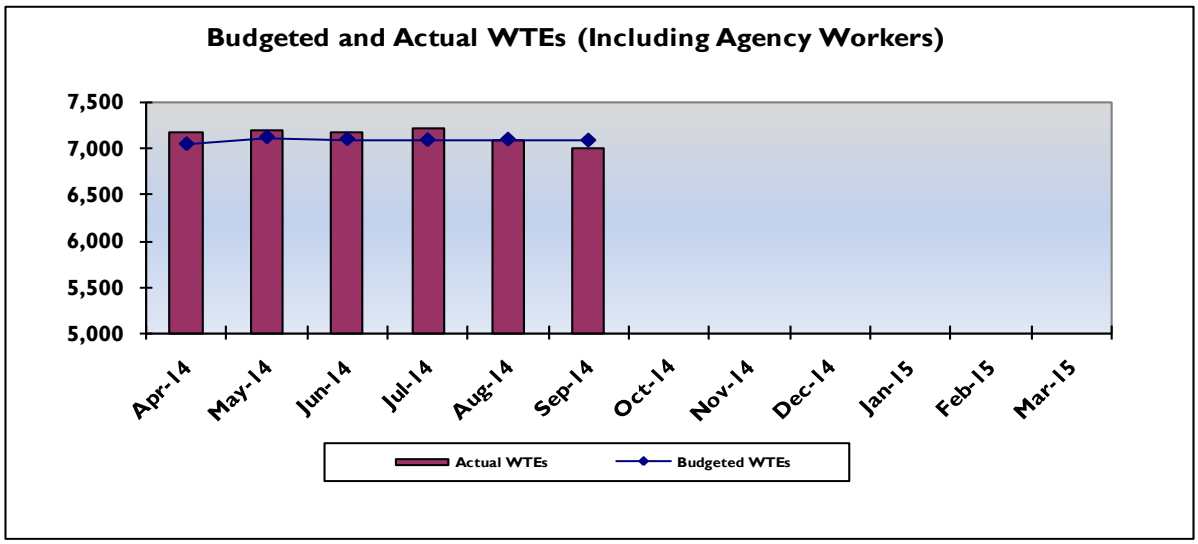
Paybill & Workforce

- There were 6,803 WTE in post in September plus an estimated 201 WTE of agency staffing across the month. In total this is **79 WTE below planned establishments.**
- Total pay costs (including agency workers) **the same as in August at £24.4m being £733k adverse to budget (which is lower than at August)**; year to date £2,936k adverse to budget.
- Principal overspending is for medical staff premium rate working and for healthcare assistants providing enhanced care support to vulnerable patients, as well as savings targets on pay not being met.
- Gross expenditure for **agency staff in month at £879k was 17% lower than the average year to date spending to August**. Reductions are reflected across all staff groups.



Analysis of Total Pay Costs by Staff Group

	Year to Date to September 2014					
		Actual				
	Budget £000	Substantive £000	Bank £000	Agency £000	Total £000	Variance £000
Medical Staffing	39,388	38,402	0	2,609	41,011	(1,623)
Management	7,712	7,021	0	0	7,021	691
Administration & Estates	15,888	14,083	1,155	457	15,694	194
Healthcare Assistants & Support Staff	16,195	14,711	2,116	425	17,252	(1,057)
Nursing and Midwifery	46,032	40,812	2,248	2,248	45,309	723
Scientific, Therapeutic & Technical	22,316	20,569	0	462	21,031	1,285
Other Pay / Technical Adjustment	(2,673)	476	0	0	476	(3,149)
Total Pay Costs	144,859	136,074	5,519	6,201	147,794	(2,936)

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Balance Sheet & External Finance Limit

- Cash at 30th September £35.3m; decrease of £3.0m over the month which is consistent with plan and primarily driven by the half yearly payment of PDC dividend and loan repayment of £1m. Overall cash balances remain £0.7m higher than plan.
- External Finance Limit (EFL) charge forecast at £16.6m being consistent with revised approved EFL. EFL has been uplifted in month to reflect adjustments in respect of PDC funding for the Central Care Record Project.

STATEMENT OF FINANCIAL POSITION 2014/15

	Balance at 31st March 2014 £000	Balance as at 30th September 2014 £000	TDA Planned Balance as at 30th September 2014 £000	Variance to plan as at 30th September 2014 £000	TDA Plan at 31st March 2015 £000	Forecast 31st March 2015 £000
Non Current Assets						
Property, Plant and Equipment	226,403	222,064	222,662	(598)	228,768	230,944
Intangible Assets	886	886	718	168	562	562
Trade and Other Receivables	1,011	1,296	700	596	700	700
Current Assets						
Inventories	3,272	2,930	3,600	(670)	3,600	3,600
Trade and Other Receivables	16,177	15,424	10,286	5,138	11,746	16,746
Cash and Cash Equivalents	41,808	35,228	34,499	729	24,252	24,252
Current Liabilities						
Trade and Other Payables	(53,867)	(50,279)	(43,457)	(6,822)	(43,546)	(47,319)
Provisions	(8,036)	(2,993)	(7,654)	4,661	(3,724)	(3,886)
Borrowings	(1,064)	(1,059)	(1,029)	(30)	(1,029)	(1,029)
DH Capital Loan	(2,000)	(2,000)	(2,000)	0	(1,000)	(1,000)
Non Current Liabilities						
Provisions	(2,562)	(2,440)	(3,262)	822	(2,522)	(2,360)
Borrowings	(27,915)	(26,428)	(27,884)	1,456	(27,884)	(27,884)
DH Capital Loan	(1,000)	0	0	0	0	0
	193,113	**192,629**	**187,179**	**5,450**	**189,923**	**193,326**
Financed By						
Taxpayers Equity						
Public Dividend Capital	161,640	161,640	161,712	(72)	162,211	163,707
Retained Earnings reserve	(19,484)	(19,968)	(12,500)	(7,468)	(10,255)	(21,338)
Revaluation Reserve	41,899	41,899	28,909	12,990	28,909	41,899
Other Reserves	9,058	9,058	9,058	0	9,058	9,058
	193,113	**192,629**	**187,179**	**5,450**	**189,923**	**193,326**

Financial Performance Report – September 2014

CASH FLOW

12 MONTH ROLLING FORECAST AT September 2014

ACTUAL/FORECAST	Sep-14 £000s	Oct-14 £000s	Nov-14 £000s	Dec-14 £000s	Jan-15 £000s	Feb-15 £000s	Mar-15 £000s	Apr-15 £000s	May-15 £000s	Jun-15 £000s	Jul-15 £000s	Aug-15 £000s	Sep-15 £000s
Receipts													
SLAs: SWB CCG	**22,366**	21,084	21,084	21,084	21,084	21,084	21,084	21,165	21,165	21,165	21,165	21,165	21,165
Associates	**6,640**	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417	6,417
Other NHS income	**740**	850	850	850	850	850	850	1,461	1,461	1,461	1,461	1,461	1,461
Specialised Service (LAT)	**4,461**	4,150	4,150	4,150	4,150	4,150	4,150	3,260	3,260	3,260	3,260	3,260	3,260
Over/(Under) Performance Payments													
Education & Training		4,608			4,608			4,608			4,608		
Public Dividend Capital							571						
Loans													
Other Receipts	**3,023**	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755	1,755
Total Receipts	**37,230**	38,864	34,256	34,256	38,864	34,256	34,827	38,666	34,058	34,058	38,666	34,058	34,058
Payments													
Payroll	**13,729**	13,360	13,360	13,360	13,360	13,360	13,360	13,360	13,613	13,613	13,613	13,613	13,613
Tax, NI and Pensions	**9,106**	9,480	9,218	9,218	9,218	9,218	9,218	9,218	9,076	9,076	9,076	9,076	9,076
Non Pay - NHS	**1,775**	977	1,071	910	977	1,071	910	910	2,148	2,148	2,148	2,148	2,148
Non Pay - Trade	**10,304**	10,491	10,665	9,403	10,491	10,665	11,676	11,676	8,282	8,282	8,282	8,282	8,282
Non Pay - Capital	**873**	1,263	1,363	1,086	2,180	1,956	2,689	2,775	2,775	2,775	2,775	2,775	2,775
PDC Dividend	**2,610**						2,610						2,610
Repayment of Loans	**1,000**						1,000						1,000
Interest	**13**						8	178	178	178	178	178	178
BTC Unitary Charge		439	439	439	439	439	439	375	375	375	375	375	375
NHS Litigation Authority	**710**	668	668	668	668	0	0	668	668	668	668	668	668
Other Payments	**199**	300	300	300	300	300	300						
Total Payments	**40,319**	36,978	37,084	35,384	37,633	37,009	42,210	39,160	37,114	37,114	37,114	37,114	40,724
Cash Brought Forward	**38,317**	35,228	37,114	34,286	33,157	34,388	31,635	24,252	23,757	20,701	17,644	19,196	16,139
Net Receipts/(Payments)	**(3,089)**	1,886	(2,828)	(1,128)	1,231	(2,753)	(7,383)	(494)	(3,057)	(3,057)	1,552	(3,057)	(6,667)
Cash Carried Forward	**35,228**	37,114	34,286	33,157	34,388	31,635	24,252	23,757	20,701	17,644	19,196	16,139	9,473

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Capital Expenditure & Capital Resource Limit

- Year to date capital expenditure is £2,528 being £2,026k below plan.
- Capital commitments through orders placed £1.6m.
- Capital Resource Limit (CRL) charge forecast at £22.7m being consistent with the currently approved CRL and incorporating planned spend of £1.5m on the Central Care Record Project and £2m on MMH project costs.

Continuity of Service Risk Rating

- Year to rate rating 3 being in line with plan

Memorandum Continuity of Services Risk Ratings	Sub Code	SIGN	Current Month Metrics			Forecast Outturn Metrics		
			Plan (mc 01) £000s	Actual / Forecast (mc 02) £000s	Variance (mc 03) £000s	Plan (mc 04) £000s	Actual / Forecast (mc 05) £000s	Variance (mc 06) £000s
Liquidity Ratio (days)								
Working Capital Balance	780	+/-	(9,355)	(5,679)	3,676	(13,301)	(12,236)	1,065
Annual Operating Expenses	790	+/-	203,174	208,107	4,933	405,044	408,343	3,299
Liquidity Ratio Days	800	+/-	(8)	(5)	3	(12)	(11)	1
Liquidity Ratio Metric	810	+/-	**2.00**	**3.00**	**1.00**	**2.00**	**2.00**	**0.00**
Capital Servicing Capacity (times)								
Revenue Available for Debt Service	820	+/-	11,749	10,147	(1,602)	24,842	24,484	(358)
Annual Debt Service	830	+/-	5,266	5,222	(44)	10,532	10,534	2
Capital Servicing Capacity (times)	840	+/-	2.2	1.9	(0.3)	2.4	2.3	(0.0)
Capital Servicing Capacity metric	850	+/-	**3.00**	**3.00**	**0.00**	**3.00**	**3.00**	**0.00**
Continuity of Services Rating for Trust	860	+/-	**2.50**	**3.00**	**0.50**	**2.50**	**2.50**	**0.00**

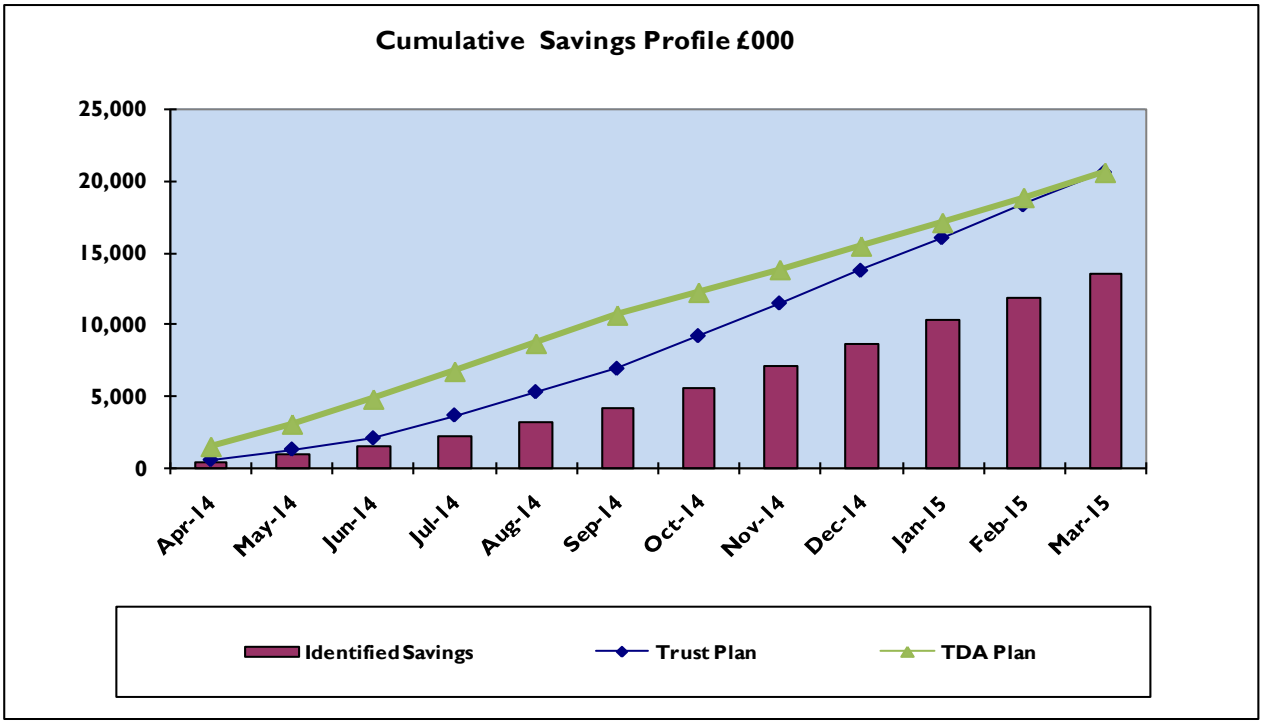
Service Level Agreements

- NHS Commissioner activity and income data for the first five months of the year indicates an activity based over-performance of £1,090k including pass through drugs and devices; the block arrangement with Sandwell CCG worsens the position by £210k for the first five months. Pass through items of £1,157k are in the position to September.
- Fines notices received to date are within fines cap levels.

Financial Performance Report – September 2014

Savings Programme

- **Delivery to date is £4,233k which is £2.7m adverse to trust phased plan** [£3.3m adverse vs TDA plan].
- £13.6m of in-year savings have been identified (as at 11th September) against the annual target of £20.6m. These have a full year effect of £19.2m.
- A programme of work to identify and progress further pay and workforce change consistent with the delivery in full of necessary cost reduction for 2014-16 is underway. This work is underpinned by robust arrangements to assess and assure the impact of any proposals on safety & quality.
- The forecast profile of savings delivery is shown below together with the original plan against which the TDA continues to monitor the Trust



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Key risks

- **Identification and delivery of savings at necessary scale and pace**; The plan required level of savings ran at £1.6m per month for quarter two; actual savings were only just over half of that. Monthly savings targets for the remainder of the year rise to £2.3m
- **Over spending on pay costs, particularly premium rate staffing**. Although September has seen a slight reduction in agency spending compared with August (which itself was lower than previous months), overall pay expenditure has remained the same. The detailed programme of work to identify and progress further pay and workforce change consistent with the delivery in full of necessary cost reduction for 2014-16 continues at pace. This may give rise to restructuring costs which exceed sums provided and available.
- **Demand risk in respect of SWB CCG contract**. The Trust carries demand risk which is giving rise to some cost pressures in areas of additional activity such as Lucentis; there remains limited opportunity to release costs beyond marginal costs in under-performing areas of service.
- **Operational standards not met giving rise to contract penalties and fines** beyond £2m in plan. Current run rate is consistent with plan but pressures on CQUIN delivery and incentive scheme elements.
- **Cost pressures which cannot be absorbed without risk to safety and quality**. Includes estimated maternity payments to other providers (pending receipt of invoices) continues to be anticipated as giving rise to a financial pressure which stands at £0.6m for the first six months of the year.

Recommendations

The Finance & Performance Management Committee is asked to:

i. RECEIVE the contents of the report; and

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

Tony Waite

Director of Finance & Performance Management

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Risk Register Update
SPONSOR (EXECUTIVE DIRECTOR):	Kam Dhami, Director of Governance
AUTHOR:	Mariola Smallman, Head of Risk Management
DATE OF MEETING:	6 November 2014

EXECUTIVE SUMMARY:

The Trust Risk Register is reported to the Board to ensure oversight of the high red risks managed by the Clinical Groups, Corporate Directorates and Corporate Project Teams under the direction of Executive Leads.

This report provides an overview of high (red) risks which have been previously accepted by the Board for inclusion on the Trust Risk Register and includes lead Executive Director updates.

As at writing there is one proposed additional risk for Trust Board to review:

- Women's and Child Health (WCH) risk related to "Unpredictable birth activity and the impact of cross charging from other providers against the Antenatal / Postnatal tariff is significantly affecting the financial position of the service impacting on the affordability and quality provision of the service"

REPORT RECOMMENDATION:

- **REVIEW** the Trust Risk Register and updates provided by Executive Directors;
- **REVIEW** the WCH unpredictable birth activity risk and the impact of cross charging from other providers against the Antenatal / Postnatal tariff is significantly affecting the financial position of the service impacting on the affordability and quality provision of the service" to **DECIDE** whether the risk is included within the Trust Risk Register or whether it continues to be managed by the Clinical Group.

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

Accept	Approve the recommendation	Discuss
	✓	✓

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

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

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

Aligned to BAF, quality and safety agenda and requirement for risk register process as part of external accreditation programmes.

PREVIOUS CONSIDERATION:

The Board receives regular risk register updates.

FOR DECISION

SWBTB (11/14) 190 (a)

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Trust Risk Register

Report to the Trust Board on 6 November 2014

1. EXECUTIVE SUMMARY

1.1 This report provides an overview of high (red) risks which have been previously accepted by the Board for inclusion on the Trust Risk Register. The current Trust Risk Register with lead Executive Director updates is at **Appendix A.** As at writing there is one proposed additional risk for Trust Board to review:

- Women's and Child Health (WCH) risk related to "Unpredictable birth activity and the impact of cross charging from other providers against the Antenatal / Postnatal tariff is significantly affecting the financial position of the service impacting on the affordability and quality provision of the service"
  The Clinical Group has provided the associated risk assessment. See **Appendix B.**

1.2 Trust Board previously reviewed Women's and Child Health (WCH) risk related to lack of 2nd theatre team OOH and agreed to tolerate the risk. It has been added to the Trust Risk Register so that Trust Board can maintain an oversight.

1.3 The RMC reviews and reports on high (red) risks to CLE on a monthly basis, including highlighting new risks or changes to existing risks. The CLE will update the Board on existing risks and escalate 'new' risks.

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

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

2. RECOMMENDATION(S)

2.1 The Board is recommended to:

- **REVIEW** the Trust Risk Register and updates provided by Executive Directors;
- **REVIEW** the WCH unpredictable birth activity risk and the impact of cross charging from other providers against the Antenatal / Postnatal tariff is significantly affecting the financial position of the service impacting on the affordability and quality provision of the service" to agree whether the risk is included within the Trust Risk Register or whether it continues to be managed by the Clinical Group.

Kam Dhami, Director of Governance
30 October 2014

Reference Number	Source of Risk	Clin Grp / Corp Dir / Corp project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
1414MARWK03		Chief Executive	Workforce Strategy	Organisational (Strategic)	Insufficient policy levers to ensure effective delivery of Trust workforce plan establishment reduction of 1400 wtes, leading to excess pay costs.	4	5	20	Review of existing policy levers to ensure options are maximised and are executed sufficiently early. Strong governance oversight by the Trust Board. **Previous update:** A more detailed plan is being developed through CLE workforce committee, led personally by the Chief Executive. Will culminate in review at Board's Workforce and OD committee in September 2014. **Update:** Detailed plans for 14/15 and 15/16 in development due for implementation during Q3 and Q4 of 2014. Key planning assumptions for 2016 onwards in development.	Chief Executive pending appointment of Director of OD.	Mar-20	Jun-14	bi-monthly	3	5	15
2013HASU01	CCG	Medicine	Stroke/Admitted Care	Operational	Potential loss of the Hyper Acute Stroke Unit which is subject to an external commissioner led review.	4	4	16	Trust representatives on Strategic Review sub groups; SWBH Stroke Action Team continues to monitor stroke activity and performance on a monthly basis and to develop actions plans for service improvement; Implement action plans to improve data capture and accuracy. **Previous updates:** Standard operating procedure agreed and in place for data collection and validation. KPI improving new pathways, e.g., thrombolysis pathways direct from ambulance to CT scanner and strengthened capacity planning to ensure availability of gender specific beds to support timely admission. Feedback received from Stroke Review Advisory panel to be considered to strengthen position as preferred provider.	Chief Operating Officer	TBC - Commissioner led review	Jun-14	Monthly	4	3	12

Reference Number	Source of Risk	Clin Grp / Corp Dir / Corp project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
TRR1401COO01	Management review	Corporate Operations		Operational	Lack of assurance of standard process and data quality approach to 18 weeks.	4	4	16	Task and Finish Group established to oversee rapid improvement programme; SOP to be agreed and implemented in March for new processes; Elective access team structure to be reviewed; Central booking process to be strengthened to ensure real time data quality management; IST visit will inform work programme content. **Previous update:** New Waiting List Manager recruited and starting in July. Year of Out Patients programme will deliver automation to strengthen real time data. Plans to centralise elective access team in Q2. Data Validation Team still required - funding until end Q2. Perceived knowledge deficit in some services regarding 18 weeks - New Elective Access Manager to assess competency of teams and provide re-training in Q2.	Chief Operating Officer	Jul-14	Jun-14	Jul-14	2	4	8
TRR1401COO02	Management review	Corporate Operations		Operational	Sustained high Delayed Transfers of Care (DTOC) patients remaining in acute bed capacity.	4	4	16	Joint working through joint discharge teams on both acute sites established; 7 day working pilot; Weekly urgent care call with Chief Executives and Chief accountable officers from LAT, CCG, NTDA, acute Trust and social services includes DTOC review, strategic and operational work; Commissioning plans for 7 day working in 2014 in train. **Previous update:** Additional capacity closed end July although DTOC remains high. Plan will remain in place to re-open additional beds if required and triggers are agreed and activated through Operations Centre and authorised by COO or on call Executive Directors. Resilience System Plan (winter) submissions includes additional beds in community and social care – outcome of funding decision to be agreed in July. This will impact on DTOC reduction. Work to establish a Joint Health Social Care assessment and discharge team continues – now in training phase for go live at Sandwell in August and then at City.	Chief Operating Officer	Jun-14	Jun-14	Jul-14	2	4	8

Reference Number	Source of Risk	Clin Grp / Corp Dir / Corp project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
0907SOP15	Inspections: H&S and PEAT	Surgery B	Ophthalmology	Clinical	Risk of Breach of Privacy and Dignity Standard, Information Governance Risk and Infection Control Risk at SGH Outpatient Department as a consequence of poor building design in SGH Ophthalmology OPD. Clean/dirty utility failings cannot be addressed without re-development of the area.	5	4	20	Trust Solution fitting in with RCRH required; Compliance with Medical Device and ICOC standards; Service Improvement application to Sandwell OPD; Greater use of Rowley facilities. **Previous update:** Rowley Max has been scoped and will be delivered in Year of Out Patients programme on track for completion Q2. Plans for relocation of oral surgery OP to enable ophthalmology to meet privacy and dignity standards in development with intention to complete in Q3.	Chief Operating Officer	31/12/2015	Jun-14	GBM	3	3	9
1103PAE02	Risk Assessment	Women's and Child Health	Paediatrics	Clinical	Children that require but may not receive HDU 1:1 care - due to unpredictable demand, inadequate funding, poor staffing levels. Quality of care compromised for these and non HDU children due to inadequate staffing levels.	4	4	16	IAP submitted for HDU funds secured 12-13 to staff areas. Additional IAP submitted 13-14 for Paediatric Outreach team. Awaiting outcome from November IAP submission. **Previous updates:** Local escalation process is in place to ensure care is provided to HDU patients. Tracking occurrences to further quantify risk to those non-HDU patients. Current review of budgets and redeployment of resources. Update: Monthly activity and staffing review of HDU care to be carried out and reported to paediatric clinical governance.	Chief Operating Officer	TBC	Oct-14	Monthly	3	4	12

Reference Number	Source of Risk	Clin Grp / Corp Dir / Corp project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
1103PAN01	Risk Assessment	Women's and Child Health	Paediatrics	Clinical	Lack of Tier 4 beds for C&YP with Mental Health problems means that they are admitted to the paediatric ward. There is no specialist medical or nursing mental health team to care for their needs with limited access to in / out of hours CAMHS support. Care for these children is compromised and impacts also on other children and parents.	4	4	16	Bank and agency staff utilised where available. Incidents to be escalated to the Health Forum / SSCB / PAB LA. Monthly report to be developed and reviewed at Paediatric Governance meeting and information provided to risk, Health Forum / SSCB / PAB. Honorary contracts for psychiatrists to be explored. **Previous update:** Mental health commissioners report that they are working up enhanced assessment service for children's mental health which intends to reduce numbers of children needing admission. Impact expected in autumn. Confirmed new assessment service and intended benefits will enable review of residual risk. The Trust continues working closely to support this work. Agreed with both adult providers access to mental health bank to support specialist staffing. Guidance on booking process to be agreed in July. **Update:** Direct access to agency booking approved by Chief Nurse 11.08.14	Chief Operating Officer	TBC	Jun-14	Monthly	4	4	16
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Oncology Service is currently unable to treat approx. 120 patients a month due to workforce issues.	5	4	20	**Previous update:** SLA with Royal Wolverhampton Hospital NHS FT to provide consultant AOS – 2 sessions to augment the 2 sessions provided by UHB Update: Provision of replacement locum through New Cross Hospital, Wolverhampton to provide Consultant AOS - 2 sessions to aument the 2 sessions provided by UHB.	Chief Operating Officer	TBC	Oct-14	Monthly	3	4	12

Reference Number	Source of Risk	Clin Grp / Corp Dir / Corp project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Trust non-compliant with Oncology Standards.	5	4	20	**Previous update:** Workforce and service design issues (hot clinics) to be negotiated through enhanced SLA with oncology provider. Meeting scheduled with QE for September. Intention is to agree model of service and agree workforce model and SLA for Q3. Developing nurse led services to see pre-chemotherapy patients – to mitigate oncology demand issues. Update: Clinic Modelling and AOS proposal completed as a pre-requisite to negotiations with UHBFT re: SLA provision. Pilots to commence re: oral chemotherapy pharmacist role and rescheduling of chemotherapy in BTC.	Chief Operating Officer	TBC	Oct-14	Monthly	1	4	4
	Oncology Peer Review	Medicine	Scheduled Care	Operational	Trust has inconsistent cancer pathways between its sites and mixed visiting oncology MDT attendance patterns.	3	5	15	**Previous update:** Trust has extended discussions with UHB and executive led cancer futures workshop now scheduled for early September. Update: Workshop has taken place and proposal for oncology clinic model has been submitted to UHBFT.	Chief Operating Officer	TBC	Oct-14	Monthly	1	5	5
201109DEL30	Risk Assessment	Womens and Child Health	Maternity	Clinical	The existing provision of a 2nd theatre team for an obstetric emergency.	2	5	10	Process to request opening of a second theatre in and out of hours for obstetrics is in place. Ongoing monitoring of any second theatre team issues through the incident reporting process. (Risk initially RED, downgraded to AMBER due to reduced frequency). Update: TB has previously reviewed the risk and agreed it is to be tolerated.	COO	TBC	Oct 14	Monthly	2	5	10

Reference Number	Source of Risk	Clin Grp / Corp Dir / Corp project	Specialty / Ward / Team	Risk Category	Risk	Likelihood	Severity	Risk Rating (LxS)	Summary of Risk Controls and Treatment Plan	Executive Lead Director	Expected date of completion	Date of Latest Review	Review frequency	Likelihood	Severity	Residual risk rating
Proposed additional risks																
TBC	Risk assessment	Women and Child Health	Maternity	Financial	Unpredictable birth activity and the impact of cross charging from other providers against the AN / PN tariff is significantly affecting the financial position of the service impacting on the affordability and quality provision of the service.	4	4	16	**Update:** Maximise tariff income through robust electronic data capture. Review of activity and income data 6 months post BadgerNet roll out. Comprehensive review of maternity pathway payment system underway for presentation to FD.	Chief Operating Officer	Ongoing	Oct-14	Monthly	3	4	12

Appendix B: WCH risk assessment

RISK ASSESSMENT: Unpredictable birth activity and the impact of cross charging from other providers against the AN / PN tariff is significantly affecting the financial position of the service impacting on the affordability and quality provision of the service.

DIVISION	Women and Child Health	**WARD/DEPARTMENT**	Maternity		
ASSESSOR	Elaine Newell	**ASSESSMENT DATE**	April 2013	**REVIEW DATE**	Sept 2013
DATE RISK MAY BE REALISED	2014/15	**DATE REVIEWED**	April 2014	**REVIEW DATE**	Sept 2014
SCOPE OF ASSESSMENT		**DATE REVIEWED**		**REVIEW DATE**	
To assess the financial impact relating to loss of income due to: • Decreasing births • Change to Maternity Tariff payment system (13/14) • Block contract arrangements with host CCG (14/15) • Inability to validate invoices submitted by external providers		**DATE REVIEWED**		**REVIEW DATE**	
		DATE REVIEWED		**REVIEW DATE**	
		DATE REVIEWED		**REVIEW DATE**	

RISK TREATMENT PLAN			
ACTION (inc Cost/Resource implications)	**BY WHEN**	**BY WHOM**	**DATE ACHIEVED**
Agree minimum data set for invoicing	31st Dec 2014	AG/EN	
Holding letter from FD to other secondary providers re payment of invoices	31st Oct 2014	TW	31 Oct
Agree terms of proposed SLA with other secondary providers	31st Dec 2014	TW / AG / EN	
Negotiate SLA	31st March 2014	TBC	
Continue to monitor monthly birth activity	ongoing	EN	

Ref: TBC

RISK TREATMENT PLAN										
HAZARD	**WHO/WHAT COULD BE HARMED/ DAMAGED?**	**EXISTING CONTROLS**	**L**	**S**	**RR**	**ADDITIONAL CONTROLS**	**L**	**S**	**RRR**	**FI**
1. Failure to contribute to Trust overheads. 2. Reluctance to invest in service development / improvements 3. Inability to reduce fixed cost based due to competing clinical imperatives / standards. 4. Inability of service to achieve financial balance – long term sustainability is of concern	Reputational damage Potential impact on the ability to deliver a quality service in line with new guidance and local targets Potential for damage to inter provider relationships due to failure to reach consensus around maternity ante / post natal cross charges	• Promotion of City Hospital as provider of Choice for Sandwell women. • Implementation of Badgernet (BN) system – allowing improved data capture for SWBH booked women. • Maintenance of paper based database until BN system fully implemented. • Defined roles and responsibilities between finance, contract and maternity teams for management of invoices in and out of organisation. • Failure to manually capture Post natal activity acknowledged and rectified – currently reported via BN system.	4	4	16	• Agree minimum data set for invoicing. • Holding letter from FD to other secondary providers re payment of invoices • Agree terms of proposed SLA with other secondary providers • Negotiate SLA • Continue to monitor monthly birth activity.	3	4	12	

Key:

L = Likelihood
S = Severity
RR = Risk Rating (LxS)
RRR = Residual Risk Rating
FI = Financial impact of Risk Treatment Plan

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Last Year of Life Audit
SPONSOR (EXECUTIVE DIRECTOR):	Dr Roger Stedman, Medical Director
AUTHOR:	Dr Roger Stedman / Dr Pablo Garcia de Passo
DATE OF MEETING:	6 November 2014

EXECUTIVE SUMMARY:

As part of our commitment to continually improve the quality of care the Trust routinely reviews all deaths that have occurred as in-patients. The mortality review system has been invaluable in identifying causes of death amenable to intervention and improvement - an example being our approach to identifying and treating sepsis.

The main limitation of MRS is that it focuses almost exclusively on the last episode of care, and is designed to identify causal or contributory factors in the death that may have been otherwise preventable.

There are large numbers of deaths in the Trust that fall in to the category of expected or un-preventable. Our duty in these cases is to identify areas for improvement in the provision of comfortable and dignified death in the place of the patient's (or their carer's) choosing. Central to this is identifying inappropriate or excessive interventions that result in futile or over treatment in the last weeks or months of life - such as inappropriate hospital admission, cardiopulmonary resuscitation or other burdensome treatment.

This paper outlines our planned approach to auditing the care of patients in their last year of life. In particular aims to answer the following questions:

In the last year of life how many acute admissions to hospital take place?
How long prior to death is a discussion had regarding palliative care?
At what point in the last year of life does the patient fulfil SPICT criteria?
Is there documentary evidence of advance care planning:
DNACPR
Ceiling of treatment
Re-admission plan
Best interests discussion?
If an ACP is in place is it communicated (for example in a discharge letter from a prior admission)?
If an ACP is in place is it respected?
Is there evidence of futile care (e.g. inappropriate CPR, ITU admission, hospital re-admission)?

REPORT RECOMMENDATION:

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

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

Accept	Approve the recommendation	Discuss
✓		✓

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy	✓	Patient Experience	✓
Clinical	✓	Equality and Diversity		Workforce	
Comments:					

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

Safe, High Quality Care
Accessible and Responsive

PREVIOUS CONSIDERATION:

None

SWBTB (11/14) 182 (a)

The Last Year of Life Audit

Dr Roger Stedman
Medical Director

Introduction

As providers of healthcare one of our primary duties is to uphold the principle 'Primum non nocere' - 'First do no harm'. In the context of a modern healthcare setting assuring the avoidance of harm is the focus of much management and leadership activity at all levels of the organisation - and this is reflected in much of the reporting that is seen at board and reported internally and external to the Trust. The conventional view is that harm to patients results from commission (things we do to patients that we shouldn't) or omission (things we don't do for patients that we should have done). However this simplistic view of harm ignores the fact that in modern medicine we tolerate a great deal of harm as part of the normal course of treatment in order to gain the benefit that treatment confers, be it a cure for the condition, a diminishment of other more distressing symptoms, or a modification of the risk of death. Thus the harm from major surgery or a course of chemotherapy is an unavoidable harm that we tolerate in order to benefit from a potential cure for cancer. We are balancing harms and benefits all of the time and in doing so we are making judgements about the degree of harm we tolerate against the potential health benefit - both in qualitative and quantitative terms. For the majority of the patients we treat in hospital these calculations are well rehearsed and understood and usually backed up by good research evidence of clinical outcomes.

However, as patients near the end of their lives there comes a material shift in the balance between the risk and benefit. Benefits in terms of quality and quantity of life are clearly diminished, at the same time the risks of harm associated with many treatments are increased. There comes a point where the primary objective of treatment ceases to be the pursuit of cure and becomes the pursuit of a comfortable and dignified death. In many situations that point is self evident - when for example a terminal cancer diagnosis is made. However in many other situations the transition from the pursuit of added quantity of life to the pursuit of quality of death is more gradual one. This is particularly true in long term conditions such as heart failure and chronic obstructive lung disease. In these conditions the course is an inevitable decline in organ function over time - punctuated by increasingly frequent acute exacerbations, which whilst amenable to treatment often result in an acceleration of the background decline. Eventually a point is reached in chronic disease where quality of life is so diminished and acute exacerbation so frequent that an active decision is taken to mitigate symptoms but not escalate treatment beyond a point at which the intervention harms are not justified by the quality or quantity of life gained. A palliative phase of chronic disease management is entered and care plans are made that specifically exclude burdensome interventions - such as CPR, Invasive or non-invasive ventilation, parenteral antibiotics or even hospital admission.

Unlike in cancer diagnoses, the palliative phase of a long term condition is less certain both in the point in time it commences and the duration over which it might take place. The decision to enter a palliative phase is a joint decision between physician and patient and their carers, it requires sensitive and sustained consultation, it involves uncertainty and there may be changes of mind along the way. Even if a firm decision is made, quite often it is over ridden by other agents in the healthcare system, either because the decision has not been well communicated or because of a last minute loss of courage or simply because the system is setup and designed to automatically treat and ask questions later. The consequence of this is that despite our best efforts many patients do not die in their preferred place of death and instead die in hospital often after receiving unwanted, unwarranted and futile invasive treatment. The other truth of the matter is in very many cases we fail even to have the conversations necessary to come to a decision to enter a palliative phase of treatment until very late in disease progression and not before several admissions and re-admissions to hospital and experiencing the harm of futile interventions. This is despite the availability of tools such as SPICT that help create clarity in when to transition patients with long term conditions to a palliative phase of care.

Audit Proposal

At Sandwell and West Birmingham Hospitals NHS Trust we operate a mortality review system (MRS) that ensures every death in the hospital is reviewed by a consultant that was not directly involved in the patients care. The system is designed primarily to identify errors of omission or commission that may have contributed or been causal in an otherwise avoidable death. The review generally only looks at the last and sometimes penultimate admission. The review system has been invaluable in identifying avoidable causal factors contributing to mortality in hospital - in particular the primary role of sepsis. The MRS is not designed and is less good at identifying how good we are at providing care in the 'expected' death situation i.e. care for patients in the palliative phase of a long term condition.

The last year of life audit proposes to conduct a retrospective review of the last 12 months of care of a sample of 50 cases from the MRS where death is deemed to have been expected and answer the following questions:

1) In the last year of life how many acute admissions to hospital take place?
2) How long prior to death is a discussion had regarding palliative care?
3) At what point in the last year of life does the patient fulfil SPICT criteria?
4) Is there documentary evidence of advance care planning:
    1) DNACPR
    2) Ceiling of treatment
    3) Re-admission plan
    4) Best interests discussion?
5) If an ACP is in place is it communicated (for example in a discharge letter from a prior admission)?
6) If an ACP is in place is it respected?
7) Is there evidence of futile care (e.g. inappropriate CPR, ITU admission, hospital re-admission)?

Intervention

It is proposed once this audit is completed a concerted campaign (LiA, training and marketing) is launched to promote the use of Advance Care Plans and SPICT in hospital and in the community and communicated throughout the emergency care axis.

The Audit should be repeated in 12 months time.

Dr Roger Stedman
Dr Pablo Garcia de Paso
Dr Anna Lock
Dr Diane Webb

SWBTB (11/14) 182 (b)

Supportive and Palliative Care Indicators Tool (SPICT™)

The SPICT™ is a guide to identifying people at risk of deteriorating and dying. Assessment of unmet supportive and palliative care needs may be appropriate.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating, with limited reversibility. (needs help with personal care, in bed or chair for 50% or more of the day).
- Two or more unplanned hospital admissions in the past 6 months.
- Weight loss (5 - 10%) over the past 3 - 6 months and/or body mass index < 20.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Lives in a nursing care home or NHS continuing care unit, or needs care to remain at home.
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of advanced conditions

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Choosing to eat and drink less; difficulty maintaining nutrition.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive dysphagia.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart/ vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Supportive and palliative care planning

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals/ plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Handover: care plan, agreed levels of intervention, CPR status.
- Coordinate care (eg. with a primary care register).

SPICT™, March 2014

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Learning Disability
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Nik Ellis – Communications team
DATE OF MEETING:	6th November 2014

EXECUTIVE SUMMARY:

The board received a presentation in relation to how we care for our patient who also have a learning disability. November is Learning Disability month the attached document is to keep the board aware of activities we are undertaking to raise awareness across the trust

Learning disabilities are many and varied. Most people recognise some of the better known syndromes such as Down's syndrome, however there is quite a range of syndromes and for some people there may not be a name or known cause of their learning disability.

A learning disability can affect someone in a wide variety of ways. The terms 'mild', 'severe' and 'profound' learning disability are sometimes used. Some people with learning disabilities live independently without much support whereas others require 24 hour care to perform most daily living skills.

Our staff who work in the acute setting and in the community will from time to time have patients in their care, to help with this the activities that we have organised during the month include awareness raising sessions and displays of our work with people with LD in the main entrances to Sandwell hospital and City Hospital. We have colleagues who work with people who have learning disabilities joining us on these occasions.

To start the month we have our patient story at the Board as a reminder of how we need to organise ourselves, and make reasonable adjustments to help people with a LD navigate the services offered to them by the NHS.

A key element is the work to publicise our efforts on the front page of Heartbeat, beginning with a descriptions of how we can keep our nine promises in the context of supporting people with a LD. The attached document is a draft of how we might get this message across.

Our efforts will focus on addressing

- How to Involving patients and carers
- How to make reasonable adjustments
- How to communicate with the patient including access to easy read and the communication boxes
- Training on challenging behaviour
- Specialist teams such as Speech & Language Therapy, physiotherapy, behaviour support visiting the trust to give specialist advice
- Mental Capacity Act / decision making

REPORT RECOMMENDATION:

The Board is requested to

1. Discuss the importance of proactively managing diversity in support of our patients who have a learning disability

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		X

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

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

Comments:

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

Relates to our Equality and Diversity objectives and BAF

PREVIOUS CONSIDERATION:

None

Learning Disability Awareness Month

Sandwell and West Birmingham Hospital Trust has developed a set of customer care promises to reflect how we expect our staff to treat patients and their visitors.

These promises were developed by frontline staff who felt that even though we were providing excellent clinical care, we also need to provide great customer care and that we were not always doing that in every area, all the time.

It is important that all trust staff consider these promises in relation to people with learning disabilities and what reasonable adjustments they need to make to meet the 9 customer care standards.

The 9 promises are;

1) We will make you feel welcome.

See me as a person not the disability.

We have the same human rights as everyone else.

2) We will make time to listen to you.

Listen to me, show me you are listening.

You might need to give me extra time.

Think about the different ways I might communicate, use my communication passport.

3) We will admit to mistakes and do all we can to put them right.

Be open and honest with me.

Act on my concerns.

Share the learning with others.

4) We will value your point of view.

Talk to me first, not to my carers.

Check with me what I think.

Give me time to understand what is happening.

5) We will be caring and kind.

Show you are interested in me.

I have the same human rights as everyone else.

Think about my preferences, look at my hospital passport.

6) We will keep you involved.

Discuss decisions and options with the person.

Help the person to look after their own health.

Discuss one decision at a time.

7) We will go the extra mile.

Reasonable adjustments.

Look at my hospital and communication passport.

Think about involving specialist professionals e.g. LD Community Team.

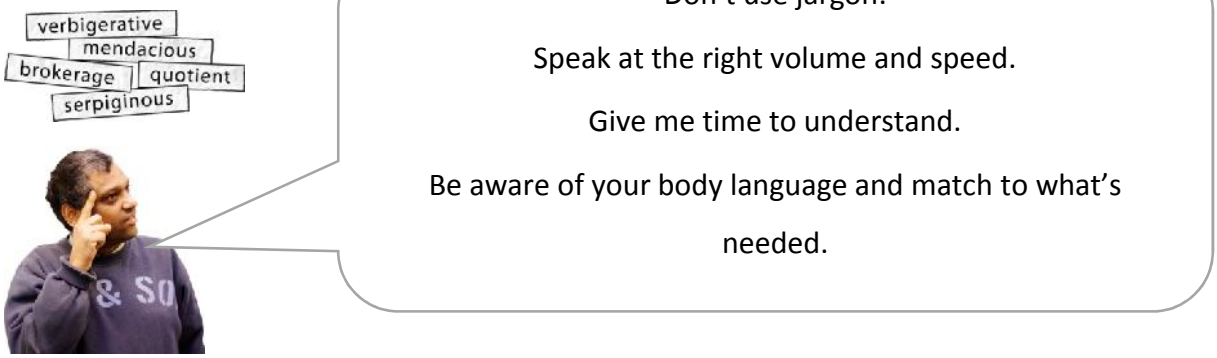
8) We will be polite, courteous and respectful.

Talk to me first.

Pitch information at a level I can understand.

Be age appropriate.

9) We will keep you informed and explain what is happening.



Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Briefing Paper – Rotherham CSE Inquiry
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Jayne Clarke- Safeguarding Children Lead
DATE OF MEETING:	6th November 2014

EXECUTIVE SUMMARY:

A Review of the Independent Inquiry report commissioned by Rotherham Metropolitan Borough Council in October 2013 has been undertaken to determine key themes emerging from the report findings and to consider key actions SWBH may need to take in response.

REPORT RECOMMENDATION:

For Trust Board to read and accept briefing paper and accompanying action plan

Chief Nurse to monitor the delivery of the action plan via the Patient Safety Committee

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

CQC standard 7 (safeguarding)
Section 11 audit

PREVIOUS CONSIDERATION:

Considered by the Safeguarding Children Team

FOR INFORMATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Rotherham Inquiry Child Sexual Exploitation

Report to Trust Board on 6 November 2014

1 EXECUTIVE SUMMARY

1.1 A Review of the Independent Inquiry report commissioned by Rotherham Metropolitan Borough Council in October 2013 has been undertaken to determine the key themes emerging from the report findings and to consider key actions SWBH may need to take in response.

The Independent Review covers the period from 1997-2009 and 2009-2013. The review looked at the quality of work during this period and whilst highlighting failing's across agencies also noted time had not stood still during the course of the review by reporting on actions agencies had already taken to improve services and provide protection to those at risk of experiencing sexual exploitation. Rotherham Safeguarding Children Board (SCB) now includes a Child Sexual Exploitation (CSE) Strategy Group; and the development of a multi-agency team to investigate and support young people at risk/subject of abuse. Awareness raising has been on the SCB agenda to work with communities and schools etc. The Inquiry Report produced 15 recommendations (appendix1)

2 Key findings

2.1 The true scale of CSE in Rotherham over the years is unknown, and a conservative estimate suggests approximately 1400 children were sexually exploited over the full enquiry period. From the beginning there was growing evidence of the seriousness of the CSE problem in Rotherham but this was downplayed by senior managers in social care and police gave no priority to CSE by failing to act on their abuse as a crime. The report has identified a widespread pattern of weakness and failings across all agencies at an organisational level. The repeated nature of these failures led to fundamental problems and obstacles at a strategic level which undermined a number of agencies ability to protect and safeguard young people due to the lack of co-ordination, information sharing and direction to act.

2.2 These findings and inadequacies included:

- Policy and procedures either not available or poorly understood and implemented by frontline practitioners (i.e. missing children procedures/focused risk assessment)

- Need for earlier intervention when CYP exposed to 'toxic trio factors' resulting in highly damaging experiences for young people over a number of years before being sexually exploited
- Poor response from local authority and police
- CYP inappropriately signposted to support services as opposed to being routed through strategy meetings and S47 enquiries
- Quality of referrals , either incomplete or poorly completed, in 2001 CSE was introduced as a category for referral however many were wrongly categorised as being 'out of control' and this made it difficult to further evidence the scale of the problem and respond appropriately
- Lack of high quality supervision, challenge and line manager oversight
- Lack of training on CSE and thresholds
- Resource pressures for all agencies and teams including the CSE specialist team resulting in high caseloads which were unmanageable
- Under resourcing resulted in high workloads and decision making being determined by budget constraints and not outcomes for CYP
- Poor leadership across all levels resulting in a lack of a co-ordinated response
- Element of confusion of responsibilities for strategic responses and decision making on individual children
- Long standing difficulties in achieving effective multi-agency working which resulted in missing agencies at strategy meetings and poor information sharing
- Lack of focus on the experience of young people (voice of the child)

3 Action Plan

3.1 SWBH Response to issues highlighted in Section 2.2

Findings	Current status	Action
Poor quality social care referrals	System in place with MASH to audit and review all referrals and feedback to practitioner and Safeguarding Named professional where inadequate	Continue to monitor referrals and feedback via SGC Operational Meeting. Emerging themes to be included in safeguarding children training
Policies inadequate/not available	Safeguarding team currently reviewing all policies and information shared via SGC training to sign post to CSE intranet link (SSCB/BSCB) for policy and CSE strategy Missing/untraceable child in progress for circulation	Child Protection/Safeguarding Children Policy for ratification 07.11.14 Missing/untraceable child policy – aim ratification December 2014

Training to raise awareness of CSE and impact of neglect at an earlier juncture	Included in single agency training and staff signposted to SCB multi-agency training	Need to undertake specific training with staff in high risk areas ie FNP/sexual health services and ED around recognition of young people at risk of CSE (risk factors) and to include the use of CSE assessment tools
Lack of high quality supervision	Named Nurses currently providing CP and FNP supervision and safeguarding supervisors in HVS offering supervision to those assessed as universal plus.	Map needs of the organisation across all services and specialities Need to identify link with sexual health services/ED and information sharing of children at risk of CSE
Poor leadership at strategic level	Representation at both SCB by Chief and Deputy Chief Nurse. Safeguarding Children Lead attends CSE Strategy Meeting and Named Nurse Operational Group (Young People at risk of Sexual Exploitation and Missing (YPSEM) Multi-agency CSE Action Plan and Strategy in place (Sandwell)	Information to be forwarded to staff in CASH/ED re CSE and escalation, referral processes to YPSEM. Safeguarding Children lead/Named Nurses to develop link with same process in Birmingham November 2014
Ineffective multi-agency meetings	Attendance and report submission by SWBH staff monitored and reported on for all initial case conferences (Report to SSCB). CSE referrals to be managed in the MASH in order to gain a co-ordinated response and information sharing (CSE Co-ordinator appointed by LA September 2014)	Service areas to develop a process in order to monitor report submission and attendance- quarterly reports to SGC Operational Group. Meeting to discuss with CCG and service leads planned November 2014
Lack of evidence of the child's voice	Guidance produced on how to evidence this by Safeguarding Children Team (Named Nurse)	Presented to September SGC Operational Group-amendments and then re-present to SGC Operational Group November 2014

4 OPTIONS

4.1 Develop measurable aims and objectives against the action plan

4.2 Develop an implementation plan

4.3 Monitor delivery of the plan at the SSG and report to the Patient Safety Committee

5 RECOMMENDATION(S)

5.1 For Trust Board to read and accept briefing paper and accompanying action plan

5.2 Identify and consider any resource implications (Training/Supervsion)

Colin Ovington
Chief Nurse

29th October 2014

APPENDICES:

Appendix 1 – Independent Review Recommendations

Appendix 1 Recommendations

As a consequence of several reviews, reports and inspections over the last two years, the Council, its partners and the Safeguarding Board are already in receipt of many recommendations for improvement in their approach to CSE. The Safeguarding Board has brought these together into a single document. It includes the recommendations from the CSE Diagnostic Report, the Barnardo's CSE Practice Review, the HMIC South Yorkshire Police Response to CSE, and the report of the Office of the Children's Commissioner. The document is reproduced in Appendix 5.

The Inquiry took the view that it was unnecessary to repeat the recommendations listed in these reports. We have identified 15 areas which we consider should be a priority.

It should also be noted that the National Working Group Network on Tackling Child Sexual Exploitation has also recently produced a 'Summary of Recommendations for All Agencies', from a range of reports, inquiries, serious case reviews and research. This provides a helpful checklist, which could be used by the Council and its partners in conjunction with the list compiled by the Safeguarding Board.

Risk assessment

Recommendation 1: Senior managers should ensure that there are up-to-date risk assessments on all children affected by CSE. These should be of consistently high quality and clearly recorded on the child's file.

Recommendation 2: The numeric scoring tool should be kept under review. Professional judgements about risk should be clearly recorded where these are not adequately captured by the numeric tool.

Looked after children

Recommendation 3: Managers should develop a more strategic approach to protecting looked after children who are sexually exploited. This must include the use of out-of-area placements. The Borough should work with other authorities to minimise the risks of sexual exploitation to all children, including those living in placements where they may become exposed to CSE. The strategy should include improved arrangements for supporting children in out-of-area placements when they require leaving care services.

Outreach and accessibility

Recommendation 4: The Council should make every effort to make help reach out to victims of CSE who are not yet in touch with services. In particular, it should make every effort to restore open access and outreach work with children affected by CSE to the level previously provided by Risky Business.

Joint CSE team

Recommendation 5: The remit and responsibilities of the joint CSE team should be urgently decided and communicated to all concerned in a way that leaves no room for doubt.

Recommendation 6: Agencies should commit to introducing a single manager for the multi-agency CSE team. This should be implemented as quickly as possible.

Recommendation 7: The Council, together with the Police, should review the social care resources available to the CSE team, and make sure these are consistent with the need and demand for services.

Collaboration within CYPS

Recommendation 8: Wider children's social care, the CSE team and integrated youth and support services should work better together to ensure that children affected by CSE are well supported and offered an appropriate range of preventive services.

Ongoing work with victims

Recommendation 9: All services should recognise that once a child is affected by CSE, he or she is likely to require support and therapeutic intervention for an extended period of time. Children should not be offered short-term intervention only, and cases should not be closed prematurely.

Post abuse support

Recommendation 10: The Safeguarding Board, through the CSE Sub-group, should work with local agencies, including health, to secure the delivery of post-abuse support services.

Quality Assurance

Recommendation 11: All agencies should continue to resource, and strengthen, the quality assurance work currently underway under the auspices of the Safeguarding Board.

Minority ethnic communities

Recommendation 12: There should be more direct and more frequent engagement by the Council and also the Safeguarding Board with women and men from minority ethnic communities on the issue of CSE and other forms of abuse.

Recommendation 13: The Safeguarding Board should address the under-reporting of sexual exploitation and abuse in minority ethnic communities.

The issue of race

Recommendation 14: The issue of race should be tackled as an absolute priority if it is a significant factor in the criminal activity of organised child sexual abuse in the Borough.

Serious Case Reviews

Recommendation 15: We recommend to the Department of Education that the guiding principle on redactions in Serious Case Reviews must be that the welfare of any children involved is paramount.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Configuration Committee – Version 0.1

Venue Meeting Room 1, Old Management Block, City Hospital

Date 3 September 2014 at 1500h

Members present		In attendance	Secretariat
Mr R Samuda	[Chair]	Mr G Seager	Mr S Grainger-Lloyd
Mrs G Hunjan		Mrs J Dunn	
Mr T Lewis		Ms D Lewsley	

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies for absence were received from Ms Robinson, Mr Waite and Dr Stedman.	
2 Minutes of the previous meetings	**SWBCC (6/14) 028**
The minutes of the meeting of the Configuration Committee held on 27 June 2014 were approved.	
AGREEMENT: The minutes of the previous meetings were approved	
3 Matters arising from the previous meeting	**SWBCC (6/14) 028 (a)**
The Committee received and noted the updated actions log. It was noted that there were no matters requiring escalation.	
4 MMH Project status update	**SWBCC (9/14) 030**
Mr Seager reported that the Midland Met Outline Business Case had been published and bidders following the recent PQQ exercise had been shortlisted. Competitive dialogue training sessions were reported to have commenced. Site demolitions were reported to be underway, with remediation being a possibility before financial close. Mr Samuda asked whether there had been any unexpected findings at present as part of the demolition work and asked what the budget allocation was. He was advised that it was difficult to speculate on the budget for this work with very different estimates having been received depending on the scale of demotion and timeframes involved. It was noted that a worst case scenario	

estimate was provided for in the event that the timetable for demolition required acceleration. Ms Lewsley advised that there was a funding plan if the remediation was needed prior to financial close by drawing down some of the Public Dividend Capital early. It was reported that there were no timetable risks associated with the work at present. The timescale for agreeing the definitive plan was noted to be later in the Autumn 2014. Mr Lewis arrived. He asked what the route for remediation was thought to be and it was agreed to discuss the matter outside of the meeting. Mr Seager advised that a key risk was the reconsideration of the Emergency Department and AMU designs, which was noted to impact on the timescale in terms of finalising the overall design within the dialogue process.	
5 Shortlist of bidders following PQQ for Midland Met	**SWBCC (9/14) 031** **SWBCC (9/14) 031 (a)**
Ms Lewsley reported that the PQQ evaluation process had happened as planned and submissions had been received from three bidders, all of which had surpassed the requirements of the PQQ evaluation criteria. It was proposed that the bidders be recommended to the Trust Board for shortlist. The Deloitte PQQ financial evaluation was tabled. It was noted that the scores for each company suggested a robust financial position for each of the bidders. The Committee was asked to note the details of the consortia provided. Mr Lewis asked whether the scores of the PQQ were carried forward to later stages of the evaluation process. He was advised that this was not the case and that the scores were ringfenced. It was reported that not having a reserve bidder would not be problematic to the Treasury. It was noted that the number of bidders would reduce from three to two at Christmas as the next part of the evaluation happened. It was agreed that the list of bidders should be recommended to the Trust Board.	
AGREEMENT: It was agreed that the shortlist of bidders, following the recent Midland Met PQQ exercise should be recommended to the Trust Board	
6 Midland Met opening delay risk	**SWBCC (9/14) 032** **SWBCC (9/14) 032 (a)**
Mr Seager presented a report which highlighted that the risk to the delay of the opening of the new hospital should be considered as this impacted on project cost. It was noted that impact of the practical completion of the new hospital in the winter period would be significant and was suggested that should this be the case, it was the onus of the Trust to manage the risk and therefore options needed to be considered in advance.	

Mr Lewis reported that there was not a formal commitment to the Treasury to check the financial implications of the scheme should it be finished in the summer period as opposed to the winter months and to seek confirmation that the access to the scheme was provided following a 27 month period of construction. It was noted however, that commissioning was expected to be a period of 12 weeks, with a period of preferential access for some pieces of equipment being slightly before this and therefore if, assuming the scheme was ready for occupation by late October 2018, access was needed at the beginning of July 2018. Therefore, a start on site was needed in April 2016 with the build programme commencing immediately after financial close, with a period prior to this where the contractor would gear up ready to start. The criticality of the start date of April 2016 and the 27 month build period to the workability of the project was noted to be paramount. Ms Lewsley reported that the notification to the successful bidder would be given in August 2015. Mr Samuda asked when the confirmation that the contractor could meet these timescale requirements should be sought. He was advised that when the number of bidders was reduced to two then this confirmation was needed, meaning January 2015. Mr Lewis emphasised that it needed to be made clear that the start for construction was April 2016, with a following 27 month build period. Ms Lewsley reported that there were alternative risks to the delivery in addition to the construction influence and therefore it was suggested that consideration should be given to investigating possible insurance that could be taken. Ms Lewsley agreed to investigate this with the legal advisers. In terms of the unitary payment, it was noted that these payments could start if the scheme reached practical completion later than planned, even if the Trust was not ready operationally to move into the building. It was suggested that the cost of a four month delay to the building timetable was c. £9m in unitary payments. Mr Seager reported that should there be a likelihood of delay then there would be adequate indication of this in advance of the planned completion being reached. Mrs Hunjan asked what safeguards were in place should the contractors incur losses due to construction issues and need to pass this financial liability onto the Trust. She was advised that there was a possibility of a variation to contract being issued which set out a schedule of costs for consideration should this be the case.	
ACTION: **Ms Lewsley to investigate with legal advisers, the insurance options for project delay for matters other than construction issues**	
7 Midland Met project risk register	**SWBCC (9/14) 033** **SWBCC (9/14) 033 (a)**
The Midland Met risk register was considered as suggested as part of the recent Gateway Review. It was noted that there was some updating of the risks underway. The risk of delay in approval process due to the structural change in the health and social care bodies was discussed and agreed that this should reflect that the twelve	

approvals criteria needed to be assessed separately. It was noted that the different risks need to reflect those reflected in the BAF, Trust Risk Register and those that were project-based only. It was also agreed that the risk register needed to be annotated to highlight at which level the risk was being managed, in terms of Trust Board, CLE subcommittee or the Configuration Committee. It was agreed that the format needed to be consistent with the Trust Risk Register.	
ACTION: **Ms Lewsley to amend the risk register to reflect the level of ownership of the risks and to cross-check to other documents which featured the risks** **ACTION:** **Ms Lewsley to reframe the risk concerning project delay due to health and social care body changes to provide an assessment against the twelve separate criteria**	
8 Clinical reconfiguration summary update	**SWBCC (9/14) 034** **SWBCC (9/14) 034 (a)**
The Committee received the update and it was highlighted that a letter from the CCG had been received support for the case for change in Cardiology and that the decision as to whether public consultation needed to be taken was to be taken by the 'Right Care, Right Here' Partnership Board. In terms of Stroke, it was reported that the agreed number of hyper acute stroke units had not yet been clarified and therefore it was unclear as to whether a formal tender process was necessary. Mr Lewis advised that he would write to the CCG to seek clarity on the basis for the tendering if this was necessary. It was agreed that there needed to be a check as to whether this risk featured on the Trust Risk Register. Mr Samuda asked whether breast screening was subject to consultation. He was advised that this would only impact if there was a suggestion that breast screening but not surgery could be undertaken.	
9 Meeting effectiveness	**Verbal**
It was agreed that the meeting had been productive.	
10 Matters to raise to the Board	**Verbal**
It was noted that the PQQ shortlist was to be considered by the Trust Board at the meeting on 4 September 2014. It was agreed that the Board should be advised that the scheme was running to time.	
11 Any other business	**Verbal**

Mr Lewis asked for progress on the IT part of the ITPD. Mr Seager advised that bidders were required to provide a technology infrastructure and demonstrate that it worked wirelessly and maintain it for five year after which time a tendering exercise could be taken. Ms Lewsley reported that a review of the IM & T requirements had been undertaken and they were ready to include within the ITPD subject to consideration by the new Chief Information Officer. It was agreed that the plans for selling the retained estate should be considered as part of the forward agendas. It was agreed that the estates strategy needed to be updated and presented to the Trust Board and most particularly how the machinations at the Sandwell site were to be executed. Ms Lewsley was thanked for her efforts in relation to the recent PQQ work.	
ACTION: **Mr Grainger-Lloyd to add consideration of the retained estate to the agenda of future meetings** **ACTION:** **Mr Seager to present the updated estates strategy to the Board at a future meeting**	
12 Details of the next meeting	**Verbal**
The next meeting is to be held on 31 October 2014 at 0800h in the D29 (Corporate Suite) Meeting Room, at City Hospital.	

Signed ……..

Print ……..

Date ……..

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Quality and Safety Committee – Version 0.2

Venue Anne Gibson Committee Room, City Hospital **Date** 26th September 2014; 1030h – 1230h

Present

Ms O Dutton
Mrs G Hunjan
Mr R Samuda
Mr C Ovington
Miss K Dhami
Miss R Barlow
Dr Stedman

In Attendance

Mrs D Talbot
Mr G Smith
Ms A Binns

Apologies

Dr S Sahota OBE
Mr T Waite

Secretariat

Mrs Amanda Winwood

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Dr Sarindar Sahota and Mr Tony Waite.	
Ms Dutton noted that business on the agenda was to be concluded within one hour and an extraordinary meeting would follow to discuss the workforce consultation which would be attended by Executive Directors only.	
2 Minutes of the previous meeting	**SWBQS (8/14) 062**
The minutes of the Quality and Safety Committee meeting held on 29 August 2014 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 (8/14) 062 (a)**
The updated actions list was received and noted by the Committee.	
MEDIUM TERM FOCUS	
4 Quality & Safety elements of the Board Assurance Framework	**SWBQS (9/14) 063** **SWBQS (9/14) 063 (a)**
It was noted that the Board Assurance Framework had been reviewed by the Trust	

Board previously. Miss Dhami assured the committee that the checks/controls included in the report were in place and advised that a report would be issued to the Audit & Risk Management Committee, which would then be cascaded to the other committees showing how responsibilities are shared. Ms Dutton asked if there are any plans for coding projects and applying data quality kite marks. Dr Stedman advised that there were strict rules around clinical coding and that the Trust was subject to external review in this respect. He added that there was a need to be scrupulous in terms of the data reported nationally and that good effort was being made to improve the quality of coding with clinicians and coders, particularly on documenting what procedures had been carried out. It was reported that training would be given to clinicians particularly in outpatients when the new discharge letter was rolled out across the Trust. Ms Barlow advised that she has asked CHKS to take a detailed look at the Trust's coding position and benchmark it against other local trusts. She added that a meeting was scheduled to look at the outcome of the work currently undertaken. Ms Dutton raised a query on page two of the report regarding Emergency Care and Senior Clinical leadership, asking what progress had been made regarding securing more robust staffing model. Ms Barlow advised that the recruitment into this area was going well, however two doctors recently recruited had not proved suitable. It was reported that work was underway to look at changing shifts and additional clinicians working during the day. Ms Dutton also asked in respect of the risk concerning the use of temporary staffing, whether the residual rating could be lowered, given the trends reported recently. Mr Ovington advised this was a possibility shortly, however he would like to monitor the position for a further month.	
ACTION: **Ms Barlow to provide a report to the next Quality and Safety committee on the CHKS benchmarking work, which should then be reported to the Audit & Risk Committee**	
5 Infection Control Report	**SWBQS (8/14) 048** **SWBQS (8/14) 048 (a)**
Mr Ovington presented the annual infection control report and advised it had been presented at Trust Board. He advised that there had been a challenge from Mr Lewis to reduce the list of over twenty objectives down to four/five key strategic actions and that they needed to be represented to the Trust Board in October. Mr Ovington also presented the August report and stated there was nothing major to report. Attention was brought to the MRSA bacteraemia infection of the patient during the previous period and that root cause analysis for the infection was underway and would be reported at the next meeting. Ms Dutton highlighted her disappointment in relation to the dip in compliance with infection control mandatory training and suggested that every effort should be made to achieve a rate of 95%. Mr Ovington advised that work was underway to consider how training is provided without taking clinical staff out of the clinical area.	
ACTION: **Mr Ovington to update the Committee at the next meeting on the**	

outcome of the investigation into the MRSA bacteraemia infection	
6 Integrated Performance Report	**Presentation**
Ms Barlow presented the latest version of the Integrated Performance Report, highlighting that the Emergency Care target had not been met for September or the quarter. She advised that the Medicine & Emergency Care Group would increase its focus on addressing the position, with the hope that the performance would be addressed in October. It was reported that there were a number of DTOC issues at Sandwell Hospital, however good engagement was in place with Social Services to address this situation in coming weeks. It was highlighted that there had been a number of very poor days at City Hospital with regard to beds in the system and on the assessment unit and it appeared that between 1000h - 1300h not enough patients were being discharged. Ms Barlow acknowledged that A&E was not functioning as it should be. Ms Dutton noted that she remembered the Trust being in the same position previously which identified issues around staff involvement and leadership style. Ms Barlow confirmed that this remained an issue. Miss Barlow reported that in terms of performance against the 18 week referral to treatment target, the Trust was still underperforming, however work continued to address the position. It was noted that performance against the diagnostics and mixed sex targets was pleasing at present. Dr Stedman advised a SNAP audit on stroke had been undertaken and that the Trust was recorded as being within the top 16% of performing trusts, with a Grade B (on an scale of A (excellent) to E (poorly performing)). Dr Stedman also advised that mortality was reducing which was pleasing. Ms Dutton commented on the kite mark, stating it was a useful indicator, however the degree of missing information in the report concerned her. She pointed out that Page 25 was notably absent of much information, with external review and the CQC data quality not being evidenced. Ms Dutton emphasised that there was a need to capture data comprehensively and consistently. Mr Smith advised that an updated paper would be presented to the Trust Board, which would contain much of the missing information, explaining that the version being considered by the Quality & Safety Committee was absent of some data due to the data cut off points. Ms Dutton noted that the number of days to acknowledge complaints was on the increase and suggested that the response rate could be improved. Miss Dhami advised the standard response was 30 day and that by December it was anticipated that all those complaints exceeding the target response time would be cleared. It was reported that from January 2015, the Trust would be in a better position overall, with the Clinical Groups processing complaints more robustly under the devolved model. Ms Dutton noted that one complaint remained unanswered after 133 days and commented that this should have been addressed in a more timely way. Ms Binns advised that this was a joint complaint with University Hospitals Birmingham FT (UHBFT), which had caused a slight delay in arranging a response.	

Mrs Hunjan asked if the Trust was the primary responder to the complaint and was advised that UHBFT was leading the complaint. Ms Dhami advised that all efforts would be made to respond to the complaint now, even if this meant that the Trust issued a response independently of UHBFT.	
ACTION: Mr Ovington to have a discussion with Mr Waite around system processes for kite marking and obtaining Executive sign off of the information in the IPR	
6.1 52 week breaches	**SWBQS (9/14) 067**
Ms Barlow talked the committee through the slide deck, which outlined the current position around 52 week breaches to the referral to treatment time target. She advised that the underlying reasons for the breaches were due to administrative errors. It was reported that an audit had been undertaken for each. The Committee was also advised that the Deputy COO, had pulled the team together and looked at the data quality checks. It was reported that there were 59,000 with a clock stop but a future OPD appointment and many more where the clock had been stopped but they have not been discharged from care. It was reported that the plan was to get real time system information and to focus resources on data quality/data validation.	
6.2 Performance against CQUIN targets	**SWBQS (9/14) 068**
Mr Ovington presented the update report and stated there was nothing particularly to highlight and the paper was self-explanatory.	
7 TSP Quality Impact Assessment Report	
Mr Ovington presented the paper for information. No comments were made.	
8 Preparation for Chief Inspector's visit	
Miss Dhami advised that work was being undertaken to prepare for the forthcoming visit by the Care Quality Commission that was scheduled for the week commencing 13th October. It was highlighted that one of the difficulties being experienced was that a timetable for the visit was yet to be received from the CQC. It was reported that Karen Proctor was to be the chair of the team. Miss Dhami advised that staff were asking what topics they were going to be questioned on as they were feeling unprepared. It was highlighted that over the next few weeks packs will be made available to staff involved and preparation sessions would be available along with mock CQC visits that were being carried out by members of the board and senior managers. Miss Dhami added that work overall was progressing well and regular updates would be shared.	
9 Patient Story	
Mr Ovington advised that the next patient story would be around learning disabilities in November.	
MATTERS FOR RECIVING AND ACCEPTANCE	

10 Serious incident report	**SWBQS (8/14) 071** **SWBQS (8/14) 071 (a)**
The Committee received and accepted the update.	
11 Clinical audit forward plan: monitoring report	**SWBQS (8/14) 070** **SWBQS (8/14) 070 (a)**
The Committee received and accepted the update.	
12 Forward Plan for the Committee	**Verbal**
Mr Ovington apologised that no work had been carried out due to annual leave.	
ACTION: Mr Grainger-Lloyd to add the Forward Plan for the Committee onto the agenda of the October meeting of the Quality & Safety Committee	
OTHER MATTERS	
13 Matters of topical or national media interest	**Verbal**
No matters were raised as the workforce issues were to be addressed at a separate meeting.	
14 Meeting effectiveness	**Verbal**
It was agreed that the meeting had been productive.	
15 Matters to raise to the Board	**Verbal**
There were no matters to raise to the Board.	
16 Any other business	**Verbal**
16.1 Readmission Work stream	
Dr Stedman tabled a paper discussing the work being undertaken to understand and address the current level of readmission rates. It was reported that there would be a clinical lead for each specialty with an agreed action plan to tackle the readmissions. It was noted that the work would be monitored closely and then reported back to the committee.	
ACTION: Dr Stedman to present the first of a quarterly report to the Committee in December	
16.2 Patient Safety walkabout	
Mr Samuda had recently visited D43 and commented how impressed he was with Justine Irish. He asked what the Non-Executives should do with any information they get. He added that staff feel exposed and don't feel they are trained to deal with dementia effectively. Ms Dutton stated she had found the walkabouts she had been involved in very valuable and that we need to publicise what the findings are. Miss Dhami advised that from next month Non-Executive walkabouts were being featured in heartbeat. Miss Dhami also stated that feedback from the	

walkabouts was to be returned to Executive Directors and then action plans developed with team leaders. Mrs Hunjan advised she has distributed paperwork and the team leaders have come back with comments so this proves that they are working.	
ACTION: Mr Grainger-Lloyd to ensure that Patient Safety Walkabouts action plans are presented to the Committee from October	
17 Details of the next meeting	**Verbal**
The date of the next meeting of the Quality and Safety Committee was reported to be 31 October 2014 in the D29 meeting room, City Hospital.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS
NHS Trust

MINUTES

Audit and Risk Management Committee – Version 0.1

Venue Anne Gibson Boardroom, City Hospital **Date** 31 July 2014

Members Present		**In Attendance**	**Observer**
Mrs G Hunjan	[Chair]	Mr R Chidlow	Ms E Sims
Ms C Robinson		Mr G Palethorpe	
Mr H Kang		Mr G Ball	
Mr M Hoare		Mr A Hussain	
		Miss K Dhami	
		Mr T Waite	
		Mr C Ovington	
Secretariat		Mr T Wharram	
Mr S Grainger-Lloyd		Miss R Barlow [Part]	

Minutes	**Paper Reference**
1 Apologies for absence	**Verbal**
Apologies were received from Ms Olwen Dutton.	
2 Minutes of the previous meeting	**SWBAR (4/14) 030** **SWBAR (6/14) 037**
The minutes of the meeting held on 24 April and 5 June 2014 were considered and approved as a true and accurate reflection of discussions held.	
3 Matters arising	**SWBAR (6/14) 037 (a)**
The Audit and Risk Management Committee received and noted the updated actions log. It was noted that more actions needed to be drawn out of the discussions better in some cases.	

Minutes	Paper Reference
3.1 Breaches to SOs/SFIs and link to the disciplinary policy	**Verbal**
Mr Waite reported that discussions had commenced regarding the link to the disciplinary policy which would be concluded by the October meeting. Mrs Hunjan noted that this was wider than the breaches to the SOs/SFIs and asked that discussions encompassed this.	
3.2 Progress with actions arising in the ISA260	**SWBAR (7/14) 039** **SWBAR (7/14) 039 (a)**
Mr Wharram presented a summarised version of the actions arising from the ISA260. It was noted that the majority were open but were in hand. Mrs Hunjan asked what timescale was applied to the restructuring of the Finance team. Mr Waite advised that the new structure would be devised by September, with recruitment being progressed through Quarter 3. In terms of the paperwork for the bank reconciliation, it was reported that this was being simplified. The Committee approved the follow up recommendations.	
4 Intensive Support Team recommendations – 18 weeks RTT data quality	**SWBAR (7/14) 046** **SWBAR (7/14) 046 (a)**
Miss Barlow presented a report back from the Intensive Support Team following a visit agreed by the Contract Query Notice project team, which looked specifically at the information being submitted externally around 18 weeks RTT performance. The recommendations were noted to have been accepted, bar one, which related to access rights for information relating to deceased patients. It was noted that the observational work included identifying areas for best practice, with some of the work informing the Year of Outpatients and the future audit programmes. Mr Palethorpe agreed that this was the case. Ms Robinson asked how the learning fed into the change programme for the Trust. Miss Barlow advised that all diagnostic outputs had been fed into a generic SOP and the transformation work. Ms Robinson highlighting the recommendation relating to the administration processes which was suggested to be completed. Miss Barlow advised that this was captured in the change management project and processes. In terms of the pooling of the booking waiting lists, it was noted that this was in relation to the Orthopaedic review. It was reported that this practice was working well in the Trust and that there were no particular complaints in this respect. The Committee was advised that partial booking was being offered, which	

Minutes	Paper Reference
would strengthen patient choice. Current DNA rates was noted to be high across all specialities at 11-12%, however the measures being put into place would address this.	
5 Board Assurance Framework 2014/15	**Hard copy**
Miss Dhami advised that work had been undertaken with Internal Audit to develop a more robust approach to the Board Assurance Framework (BAF). It was highlighted that there was more work to be done to strengthen it further, although the risk descriptions were better than those in the previous version of the BAF. It was noted that a link had been made against the Trust's strategic objectives as well as the annual priorities. All were asked for views and comments, in view of it being presented to the Board at the meeting planned for August. It was noted that the Primary Assurance Committee of the Board was cited which was useful. The Committee was asked to note three risk scores that remained red after treatment. Mr Ovington asked whether there was an expectation that the tolerable score should be lower than the treated risk score. It was noted that in this particular instance this was the case as further actions were not in place to lower this. Mr Palethorpe advised that it was necessary for the Board to confirm with the relevant Committees that it was comfortable with the level of risk being carried and the assurances that the risks were being managed. It was noted that the Board Assurance Framework was to be received and discussed by the Board Committees in turn. Mr Waite suggested that the Board needed to consider whether the proposed controlled residual scores were fair and reasonable; what the Board's view was of the tolerable risks scores and the actions necessary and sufficient to achieve the tolerable score. It was suggested that the Board Committees had a role in confirming that the assurances were in place to manage the risks and to confirm that the suggested tolerable scores were appropriate. It was highlighted that there was an expectation that there would be movement in the scores over time. The mechanism for adjust the scores and making the BAF live were discussed. Ms Robinson noted that the work to develop the BAF was pleasing. It was suggested that looking to the regulator for assurance was not appropriate however, particular in respect of the risk around the FT risk. Mr Ovington advised that a piece of work had been commissioned by the Trust Development Authority around infection control and in this case it was a	

Minutes	Paper Reference
good source of assurance. Mr Palethorpe noted that this was for the purposes of the TDA rather than the Trust so to list it as the only source of assurance was inappropriate, however as part of a suite of assurance, this was appropriate. It was agreed that an initial list of sources of assurance needed to be developed. Mr Hussain suggested that assurances provided by clinical audits needed to be included. Ms Robinson suggested that each risk needed to be considered in turn, to ensure that there was a greater sense of understanding of the assurance. Mr Waite suggested that the assurances needed to be classified into internal, regulatory and independent. Rather than regulatory assurances, it was agreed that peer assurances needed to be captured. It was agreed that the next version of the BAF needed to capture the suggestions. In terms of the role of the Board Committees, it was suggested that each Committee chair would consider the relevant elements of the BAF and Trust Risk Register. It was agreed that the role of the Committees and chairs would be developed. Mr Palethorpe advised that the major discussions needed to be at the Committees, rather than the Audit & Risk Management Committee. It was suggested that this should be a matter for consideration at the Board Informal session. Mr Waite suggested that all the dependencies with other governance documents needed to be clarified. Ms Robinson suggested the agenda of the Audit & Risk Management Committee needed to be closely linked to the risks on the Board Assurance Framework.	
ACTION: Miss Dhami to oversee the changes to the BAF process and document as suggested by the Audit & Risk Management Committee	
6 Risk management and governance matters	
6.1 Waived tenders update	**SWBAR (7/14) 040** **SWBAR (7/14) 040 (a)**
Mr Wharram presented a report on the use of tender waivers, where it was noted that there had been 220 waivers to the value of c. £18m. It was noted that there was a potential for misusing the facility and that this needed to be closely monitored. It was noted that there were some clear instances where tendering was not appropriate, however Miss Dhami suggested that there appeared to be a degree of complacency with identifying potential suppliers. It was noted that there was some good internal audit work to validate the position. Mr Waite reported that there was varying levels of concern; there were issues with the controls process to challenge and confirm the need for waivering tenders and in terms of	

Minutes	Paper Reference
foresight, renewals needed to be planned out to ensure that scheduling was better. Mr Kang suggested that care needed to be taken to avoid business as usual and familiarity, using the same suppliers, which led to single tender requests. Mr Waite advised that there appeared to be an opportunity for aggregating some maintenance contracts. Mr Ball suggested that care needed to be taken that the lack of foresight did not represent any dishonesty. Ms Robinson expressed her concern at the position. She advised that having reviewed the instances of waived tenders, there appeared to be insufficient assurance that the Trust was obtaining best value for money given the frequency with which a tendering process was not being used. She suggested that the work aligned with the transformation programme and that clear timescales for change in practice was needed. It was highlighted that the spend on Thornbury agency staff was all coded against community and therapies, which appeared to be an anomaly but suggested that further work was needed to review the coding. In terms of timescales, Mr Waite reported that work was underway to improve the governance processes, including the introduction of a new single tender process with an education and communication programme. Work also underway was that to guide the procurement team into being more proactive and influential. It was noted that business management and culture change would also assist, such as a reduction in the use of agency staffing. It was agreed that future reports needed to include include analysis that could better inform the discussion. Ms Robinson highlighted for instance that the rates paid to the Council are included as single tender waivers however the Trust has no choice on these items.	
ACTION: Mr Waite to ensure that future updates on waived tenders included more contextual and explanatory information to aid discussion	
6.2 Annual Report 2013/14 – final draft	**SWBAR (7/14) 041** **SWBAR (7/14) 041 (a)**
A draft version of the annual report was presented which it was noted remained a working draft. It was suggested that a reference to the Charitable Funds annual report needed to be included.	
7 External Audit matters	
7.1 External Audit progress report	**SWBAR (7/14) 042**
Mr Chidlow presented the external audit progress report for receiving and	

Minutes	Paper Reference
acceptance and asked the Committee to note that a number of actions following the audit in 2013/14 had been raised, which mainly concerned timetabling in view of bringing the timescales for the preparation of the annual accounts forward.	
7.2 Annual audit letter	**SWBAR (7/14) 043**
The Committee received and noted the annual audit letter. In terms of the annual audit fee, it was noted that there was a degree of discrepancy listed with that cited in the Annual Report. It was agreed that this should be checked and amended where needed. It was reported that the letter would be published on the Trust's internet site.	
ACTION: Mr Wharram to work with Mr Chidlow to resolve the discrepancy regarding the annual audit fee **ACTION: Mr Grainger-Lloyd to publish the annual audit letter on the internet**	
8 Internal Audit matters	
8.1 Internal audit progress report and recommendation tracking	**SWBAR (7/14) 044**
Mr Palethorpe reported that four reports had been finalised since the start of the year. It was noted at present there were no concerns which would impact on the year end opinion. The detail of the recommendation tracking was noted as was progress against plan. It was noted that there remained good relationships with the Directors of Finance and Governance. Two changes to the plan were highlighted around key financial controls and a new focus on accruals. Mrs Hunjan highlighted that some of the information reported by internal audit accorded with her view on a recent walkabouts. The outstanding recommendations were highlighted and reported that all responses had been received. Mr Waite reported that the report would be shared with the Executive Group at one of its routine meetings. As of the date of the report 13 recommendations had not been implemented. Ms Robinson asked whether there were any gaps in best practice that the auditors had identified over the few months in post. Mr Palethorpe advised that there were no matters to raise specifically, other than those raised	

Minutes	Paper Reference
and shared with the Executive in the course of the work.	
8.2 Counter fraud progress report	**SWBAR (7/14) 045**
Mr Ball presented the overview of progress with counter fraud work. It was noted that much work was in train. It was noted that there was work underway to strengthen the overseas visitors processes. The Trust was noted to have a green rating from NHS Protect as a result of the submission of the Self Review Tool. The detail of the investigations was discussed and in particular Investigation 2. It was noted that any HR action raised as a result of the work would be presented at the next meeting and that this would be promoted should this be the case. The Committee confirmed that the counterfraud activity and proportionate to the level of risk. It was suggested that Heartbeat could be used promote the services of counterfraud. Mr Ovington advised that it would be useful for the counterfraud to attend targeted meetings and audiences.	
8.3 Clinical audit – exceptions to report	**SWBAR (7/14) 047** **SWBAR (7/14) 047 (a)**
Miss Dhami reminded the Committee that it had previously considered the Trust's clinical audit plan and presented a high level report highlighting any issues arising from the audit work. She highlighted that the matter had been discussed in detail by the Quality & Safety Committee previously. Mr Palethorpe suggested that following the discussions at the Quality & Safety Committee, the impact of this on clinical risk needed to be assessed.	
9 Updates from the Chairs of the Trust Board Committees	**Verbal**
Mr Kang advised that the focus of the Committee was to concentrate on the use of temporary staffing and sickness absence, which showed that three quarters of sickness absence was derived from a small number of hot spots. The use of temporary staff was a concern financially and that controls had been put into place to limit sign off. It was suggested that the risks around this needed to be better articulated and a plan of action needed to be developed. Ms Robinson reported that the Finance & Investment Committee was meeting monthly to look at financial outturn and the development and delivery of the Transformation Savings Plan. She added that the use of temporary staffing was also a preoccupation of the Committee and therefore some internal audit work had been commissioned. It was	

Minutes	Paper Reference
reported that financial risks were being considered. It was agreed that views from the chairs of the Committees who were not present needed to be formalised, including the use of the a written update.	
10 Meeting effectiveness	**Verbal**
It was noted that the meeting had run to time and that a proportionate approach had been directed to the items of significance. It was noted that the discussions needed to be by exception.	
11 Any Other Business	**Verbal**
There was none.	
12 Date and time of next meeting	**Verbal**
It was noted that the date and time of the next meeting would be 30 October 2014 at 1400h in the Anne Gibson Boardroom, City Hospital	

Signed:……..

Name:……

Date:…….

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Midland Metropolitan Hospital Status Report October 2014

Activities Last Period

- Dialogue progressing
- Site Investigations Continued
- Demolition Completed

Planned Next Period

- Complete detailed site investigations
- Prepare site remediation plan
- Continue Dialogue process

Issues for Resolution/Risks for Next Period

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Safe Nurse Staffing
SPONSOR (EXECUTIVE DIRECTOR):	Colin Ovington – Chief Nurse
AUTHOR:	Colin Ovington – Chief Nurse
DATE OF MEETING:	6th November 2014

EXECUTIVE SUMMARY:

This report is an update using the data collected during September 2014.
The data from the national reporting system has been applied to our own expected staffing data to help understand our nurse staffing position.
The board were alerted to the pilot of the risk assessment tool we had developed, this is currently under evaluation.
The ward nursing establishments have been reviewed and these along with the expected patient to nurse ratio's is given at appendix 1.

REPORT RECOMMENDATION:

To publish patient to RN ratio's on our public web site and on NHS Choices on a monthly basis as per national requirement.
To approve the revised nursing establishments
To receive an update at the December Trust Board meeting.

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

Accept	Approve the recommendation	Discuss
	X	X

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

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

Comments:

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

Relates to our safety objectives and BAF

PREVIOUS CONSIDERATION:

FOR INFORMATION

Sandwell and West Birmingham Hospitals NHS
NHS Trust

SAFE NURSE STAFFING

Report to Trust Board on 6th November 2014

1 EXECUTIVE SUMMARY

1.1 This report is an update using the data collected during August 2014.

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

1.3 An internal audit of the data has been completed during this data collection in order to provide reassurance about the accuracy. The auditing process will continue in successive months as we identified a rounding problem with the way data was input into unify.

2 AUGUST POSITION

2.1 Table one is the output data from the national data collection for August 2014 which demonstrates that we achieve higher fill rates against our rota's but closer to the expected levels as per our planned rota's.

Table 1.

		Day		Night	
	Site Name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Aug-14	BIRMINGHAM MIDLAND EYE CENTRE (BMEC)	98.3%	95.6%	118.7%	0.0%
	CITY HOSPITAL	102.5%	106.4%	117.2%	120.0%
	ROWLEY REGIS HOSPITAL	107.9%	103.2%	152.6%	119.8%
	SANDWELL GENERAL HOSPITAL	103.3%	114.5%	112.5%	143.5%

The table two demonstrates the expected numbers of registered Nurses and Health Care Support staff we plan to be on our rosters over the 24 hour day. Where there are shortfalls in meeting this requirement or when individual patients require closer attention (focused care) additional staff will be booked on a temporary basis either via our nurse bank or via external agencies if there are no staff available. The fill rate percentage informs us that most of our wards continue to use additional capacity but more wards than in previous months appear to be closer to their planned roster levels.

Table 2

Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during August 2014	Percentage night time fill rate during August 2014	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during August 2014	Percentage night time fill rate during August 2014
D7	City	13	4	4	3	104.7	152.2	1	1	1	121.6	123.1
D5	City	19	6	6	5	104.7	152.2	1	1	0	121.6	123.1
D11	City	21	3	3	2	96.6	99.1	3	3	2	100.9	148
D12	City	10	2	2	2	99	83.3	1	1	1	134.9	129.8
D15	City	24	4	4	3	130.5	134	3	3	2	139.3	228
D17	City	25	4	4	3	108.7	137.3	3	3	2	114.7	128.5
D26	City	21	3	3	2	90.2	95.9	3	3	2	101.8	100
AMU 1	City	41	10	10	9	105.1	93.9	4	4	3	131.4	101
AMU 2	City	19	5	5	4	89.1	99.1	1	1	1	107.6	90
D43	City	24	4	4	3	109.5	106.5	3	3	2	173.5	127.1
CCU Sandwell	Sandwell	10	3	3	2	120	236.7	0	0	1	109.9	0
PR3	Sandwell	29	5	4	3	96.4	127.4	4	3	2	99.9	135.7
PR4	Sandwell	25	8	8	5	93.1	105.5	2	2	1	102.8	136.4
PR5	Sandwell	34	6	5	3	97.3	98.9	4	4	3	114.9	128.3
NT4	Sandwell	28	5	4	3	131.5	174.2	3	3	3	130.9	188.6
LY 4	Sandwell	34	6	4	3	99.7	104.6	4	4	3	105	103
LY5	Sandwell	29	5	4	3	121.2	123	4	3	2	166.7	105.6
N5	Sandwell	15	3	3	2	98	107.9	1	0	1	98.4	1237
AMU A	Sandwell	32	8	8	8	102.3	120.4	4	4	3	114.9	132.7
AMU B	Sandwell	20	4	3	2	95.4	133.2	4	3	2	98.1	207.6
Elisa Tinsley	RRH	24	4	3	2	106.6	92.5	3	3	3	194.6	111.9

Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during August 2014	Percentage night time fill rate during August 2014	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during August 2014	Percentage night time fill rate during August 2014
D21	City	23	4	4	2	101.2	96.6	2	2	2	142	93.7
D25	City	19	4	4	2	104.6	123.6	2	2	2	108.3	133.1
SAU D42	City	14	4	4	2	97.8	125.2	1	1	1	97	140
N2	SGH	24	4	3	2	86.4	98.5	2	2	1	108.6	199.6
L2	SGH	20	4	3	2	107.7	101.6	3	2	2	104.7	92.1
P2	SGH	20	4	3	2	103.8	106.9	3	2	2	107	111.1
N3	SGH	33	6	6	3	107.9	105.6	4	4	3	129.1	137.1
L3	SGH	33	6	6	3	95.9	101.8	4	4	3	120.5	92.5

Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during August 2014	Percentage night time fill rate during August 2014	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during August 2014	Percentage night time fill rate during August 2014
Henderson	RH	24	2	2	2	99.7	122.9	2	2	2	145.5	153.1
Leasowes	RH	20	2	2	1	120.4	98.5	4	3	2	107.6	109.4

Ward	site	No. Beds	Morning shift RN's expected	Afternoon /Evening shift RN's expected	Night shift RN's expected	Percentage day time fill rate during August 2014	Percentage night time fill rate during August 2014	Morning HCSW expected	Afternoon /Evening HCSW expected	Night Shift HCSW expected	Percentage day time fill rate during August 2014	Percentage night time fill rate during August 2014
Eye ward	City	10	2	2	2	98.3	95.6	1	1	0	118.7	0

3 CURRENT ISSUES

3.1 The additional controls on the use of temporary nurse staff at the start of August appear to have brought staff fill rates closer towards the expected levels, although there is still work to be done to progress this further.

A specific piece of work to tighten our risk assessment of patients deemed to require additional nursing time has commenced this is being tested and I expect to report at the November Board meeting on progress with the tool.

4 RECOMMENDATION(S)

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

4.2 To receive an update at the November Trust Board meeting

Colin Ovington

Chief Nurse

24th September 2014